BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 22 MARCH 2022 AT 15:00 HOURS
IN BMI MAIN HALL, 9 MARGARET STREET, BIRMINGHAM, B3 3BS

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.

2 **DECLARATIONS OF INTERESTS**

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

3 **APOLOGIES**

To receive any apologies.

4 **DATES OF MEETINGS**

To note the dates of meetings of the Board for 2022/2023 as follows:-

2022
Tuesday 17 May
Tuesday 26 July 2022
Tuesday 20 September 2022
Tuesday 29 November

2023
Tuesday 17 January
Tuesday 21 March

All meetings will commence at 1500 hours.

5 - 16

5 **MINUTES (1500 -1510)**

To confirm and sign the Minutes of the meeting held on the 8th February 2022.

6 **ACTION LOG (1510 - 1515)**

To review the Actions arising from previous meetings.

7 **CHAIR'S UPDATE (1515 - 1520**

To receive an oral update.

8 **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.
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 meeting You Tube site(www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw)
NB: The questions and answers will not be reproduced in the minutes.

9 **CORONAVIRUS-19 POSITION AND VACCINE UPDATE STATEMENT (1525 - 1530)**

Dr Justin Varney, Director of Public Health will present the item.

10 **COMMONWEALTH GAMES UPDATE (1530 -1535)**

Dr Justin Varney, Director of Public Health will give a verbal update on this item.
.

11 **UKRAINE CRISIS UPDATE (1535 - 1540)**

Dr Justin Varney, Director of Public Health will give a verbal update on this item.

17 - 108

12 **BIRMINGHAM AND LEWISHAM AFRICAN CARIBBEAN HEALTH INEQUALITIES REVIEW (BLACHIR)**

Dr Justin Varney, Director of Public Health will present this item

109 - 258

13 **BIRMINGHAM JOINT HEALTH AND WELLBEING STRATEGY**

Dr Justin Varney, Director of Public Health will present this item

259 - 378

14 **THE DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2020/21**

Dr Justin Varney, Director of Public Health will present this item

379 - 388

15 **PERINATAL AND INFANT MORTALITY TASKFORCE**

Dr Justin Varney, Director of Public Health will present this item

389 - 396

16 **FORWARD PLAN**

Item Description

17 **LINK TO MINITES FROM THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD MEETINGS**

This item is for information.

LCOEB 26 Jan 2022 - Public

18 **OTHER URGENT BUSINESS**

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

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING TUESDAY, 8 FEBRUARY 2022

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 8 FEBRUARY 2022 AT 1500 HOURS IN MAIN HALL, BMI, MARGARET STREET BIRMINGHAM B3

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Chair of Birmingham Health and Wellbeing Board
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Andy Cave, Chief Executive, Healthwatch Birmingham
Mark Garrick, Director of Strategy and Quality Development, UHB
Chief Superintendent Richard North, West Midlands Police
Karen Helliwell, Interim Accountable Officer, NHS BSol CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Professor Robin Miller, Head of Department, Social Work and Social Care, University of Birmingham
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Peter Richmond, Birmingham Social Housing Partnership
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:-

Paul Athey, Chief Finance Officer, NHS Birmingham and Solihull CCG
Anna Hammond, BSol Place Development Director
Harvir Lawrence, Director of Planning and Delivery
Ian Sharp, Elective Recovery Clinical Lead, BSol
Dr Shiraz Sheriff, Service Lead – Governance, Public Health Division
Michael Walsh, Head of Service Commissioning, BCC
Errol Wilson, Committee Services

****

NOTICE OF RECORDING/WEBCAST

601 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

602 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

603 Apologies for absence were submitted on behalf of Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG,
Professor Graeme Betts, Director of Adult Social Care (but Michael Walsh as substitute), Andy Couldrick, Richard Kirby, Birmingham Community Healthcare NHS Foundation Trust and Douglas Simkiss.

DATES OF MEETINGS

604 The Board noted the following meeting date for the rest of the Municipal Year 2021/22:

Tuesday 22 March 2022

This meeting will commence at 1500 hours.

EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC

The Chair highlighted the reports at Agenda items 6 and 7 and appendices which officers had identified as containing exempt information within the meaning of Section 100I of the Local Government Act 1972, and where officers considered that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report:

605 **RESOLVED:**

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

EXCLUSION OF THE PUBLIC

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

(Exempt Paragraph 3 of Schedule 12A)

READDMITTANCE OF THE PUBLIC TO THE MEETING

609 The public was readmitted to the meeting.

At this Juncture the Chair then handed over the chairing of the meeting to the Deputy Chair, Dr William Taylor due to prior commitments.

Dr William Taylor in the Chair.

ACTION LOG

The following Action Log was submitted:-

(See document No. 3)

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

610 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

611 The Chair commented that as this was our first meeting of the New Year as we had just had a discussion in the private session looking back over the last couple of years and what had gone on there was a huge amount of looking forward to the future.

The Chair stated that he noted that Sajid Javid, MP Health Secretary had announced that the NHS Plan which was on the back of the … One of the things we will see from the Agenda in front of us today was what we were going to do and looking forward into the future and what we were going to do with the future system, whether it was how we were going to work at Place and as an ICS, bringing health and social care together and making decisions to be closer to people as we possibly could regarding their health, welfare and wellbeing and about the things we spoke about earlier.

It was quite an exciting time and looking in terms of our own plans and the legacy effects of … and looking forward to the outcomes of the Commonwealth Games and the legacy that that would bring. This was exciting for Birmingham and Solihull and the surrounding areas. It will have a legacy effect which would heavily impact some of those items we had discussed earlier around health and the wider determinants. This was really something to look forward to on the Agenda.

PUBLIC QUESTIONS

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

CORONAVIRUS-19 POSITION STATEMENT

613 Dr Justin Varney, Director of Public Health introduced the item and gave the following verbal presentation:-

1. We were seeing case numbers coming down and the testing rates had fallen slightly. We were also monitoring Covid cases in wastewater which allowed us to keep an eye on what was happening in doing the tests.
2. The good news was that it was coming down in our wastewater which gave us some confidence in the pattern and the direction of travel. There remained a significant pressure in our NHS system in terms of our Covid patients, but we had seen clear evidence that our vaccine *does what it states on the tin* in terms of reducing the risk of death and the risk of requiring oxygen and intensive care support. This was validated nationally as well as locally.
3. We had seen quite a shift from the patterns we saw in terms of pressures on the NHS in the previous waves.
4. Omicron was by far the dominant variant across Birmingham and we were now seeing a subset of Omicron emerging, but the good news was that the vaccine was still holding its defence in terms of death and severe illness.
5. Every time a new variant appeared across the world, there was an international effort to look at what the impact was on vaccinations because across the world we were using the same group of vaccines.
6. Until the rate of vaccination improved across the whole world, we will continue to see variants here and that will now mean we were moving into the phase of living with Covid.
7. Covid was not going to disappear in the short term and adopting our society and our way of being through navigating this serious illness, for people who were vaccinated. It could still be pretty unpleasant for people who were vaccinated.
8. Several colleagues who had Omicron recently had testify to the fact that it was not a nice condition to have. More people who were reporting Omicron wee finding that it was a rough experience even though they were showing no symptoms.
9. It was important to stressed that Omicron was more effective at re-infecting people and we were seeing clear evidence that people who

have had the Delta strain in December 2021 then had Omicron in January 2022.

10. The nature of the Omicron variant was that it by-passes our defence that we learnt through natural immunity from previous strains.
11. The good news was that when you had Omicron it did seemed to protect you against Delta and what we were not seeing was this happening the other way, which in some sense gave us some hope that if we saw more variants of Omicron, Omicron protection and our natural immunity plus our vaccination protection was likely to be pretty strong.
12. It was useful to put some numbers against some of the differences we were seeing.
13. There were two things that should be highlighted – Post Covid syndrome - Long Covid, we were seeing more information about this now.
14. The estimates from the Office for National Statistics (ONS) survey and the Department of Health Agencies were that 7.5% of confirmed cases with Covid still had symptoms 12 weeks after infection by limiting their activities.
15. 12 weeks after their initial infection they were still exhibiting symptoms that they were struggling to do certain things like dressing themselves, going to the shops being able to hold conversations and being able to go to work. If we think about the number of people who had Covid, that was a significant burden.
16. The NHS was working hard on a Covid pathway, but we were also still learning about them. This was a new disease and a new set of syndrome. What we were also seeing from the international evidence was that the vaccination reduces the risk of getting Long Covid through any age.
17. One of the things about Long Covid was that it was not particularly an ageist effect. Unlike a severe illness with Covid, where there was a definite age bias where the older you were you were more likely to be sicker, with Long Covid we did not see the same age distribution.
18. We were seeing 20 – 30-year olds with quite severe symptoms. Vaccination does reduce the risk of Long Covid and if you did develop Long Covid and you were vaccinated your symptoms with Long Covid was less severe.
19. There was something going on with Long Covid which probably linked into our immune system, but we do not yet fully understand this which then explained why vaccination was so crucial.
20. The other important thing to mention was the numbers behind the evidence of the impact of vaccine on hospitalisation and death. This was from a report that was published in late January 2022 from the UKHSA.
21. What that showed was that the risk of death within 28 days of a positive test from Covid, if you were aged 30 – 39 years old it was relatively small. It was 1.3 per 100,000 people affected if you were unvaccinated. However, if you were vaccinated it falls to 0.4 per 100,000 people. There was a big drop-off even at a younger age in terms of protection.
22. If we looked at older age groups, there was a difference between unvaccinated and vaccinated in the 70 – 79-year olds the difference between 81 people dying per 100,000, in the unvaccinated populated and 10 in the vaccinated population.

23. Now we started to see some concrete numbers coming through about the evidence and the impact of the vaccination and protecting people. We knew that with Omicron the booster became more important, but what we were seeing from the early data with Omicron was that with the booster, there was an 89% reduction in hospitalisation.
24. These were huge numbers and therefore it was important to encourage people to get vaccinated and answer their questions and respond to their concerns. We were seeing an improvement across the vaccination programme.
25. We were visited earlier today by a member of NHSE national team to review what we were doing, and she was much impressed and that we were doing everything everywhere all the time in a truly global city and the challenges we had in a big city.
26. It was important to remember that we had already vaccinated over 2m people across Birmingham and Solihull which was a huge success.

The Chair commented that this highlighted the importance of vaccination and enquired what the future of the vaccination programme would be.

Dr Varney stated that we will see another wave in autumn/winter across the world. If we look at the Covid-19 pandemic there were five waves before it burnt itself out and we had four of Covid so far. It made sense to suspect that the majority of the world and the southern hemisphere was not yet vaccinated. Covid was to some extent will be like the seasonal flu. It was expected to see a new variant in the southern hemisphere as they come through winter and they started to move into the northern hemisphere in the autumn. By that time we will be able to adjust to the vaccine.
Dr Varney further stated that it was strongly suspected that there will be an annual vaccination programme for Covid alongside flu. It was not thought that this would be for all ages as we were seeing immunity in younger adults once they were vaccinated maintained pretty much good immune system but in older adults this was not so good. It was suspected that we would have an annual Covid jab for vulnerable groups and possibly over the next two years.

Whether it became a permanent thing was dependent on what happened to Covid. There was also a promising research on all the coronavirus vaccines which was something being developed for over a decade since we had SARS. They had been working on these variants since SARS 1. It was expected that by July/August 2022 we will have a sense of what would be happening.

CORONAVIRUS -19 VACCINE UPDATE

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

i. In line with the national offer we were still seeing people coming in for their first dose. People were coming when they wanted to come along and we were trying to make the offer as flexible as possible.
ii. There was an audit around all of the ways in which we deliver the vaccination particularly the inequalities and those hard to reach groups.

iii. We were based in all of the areas in relation to the homeless and around the maternity providers. We were trying to be as bespoke as possible using every opportunity.

iv. In line nationally, we had seen a drop off in the booster, but it was a fantastic effort over the Christmas period by all providers having to deliver that piece of the programme. But it was still something that we would continue to work through.

v. In terms of local gaps we still had to offer and deliver the flu vaccine so that up take was a little bit lower. We had just appointed a new director of vaccination. There was still a huge amount of work to do but we needed to look at how we develop it going forward as a flu programme.

COMMONWEALTH GAMES UPDATES UPDATE

615 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. 4)

A brief discussion then ensued following the slide presentation. In response to comments and questions, Dr Varney made the following statements:-

- Dr Varney noted Ms Jones query concerning the wider determinants of health and advised that this was the case but not within the Commonwealth Games legacy.
- The Food Strategy which was going to the next Cabinet meeting for approval and consultation, many colleagues were involved in the pre-consultation engagement ad we hope it would allow for affordability.
- We added in a 9th workstream in the strategy on food security which was specifically around food policy so that it was absolutely clear that that was a priority in the dedicated workstream.
- As you were aware the challenge of how we addressed food poverty was that we were looking at the system, how we changed what was being sold, how it was sold as well as what we could to influence national policy and welfare and the amount of money that goes into this.
- We were trying to get past the sticking plaster of food banks and to really start getting into how we create a city which was truly to celebrate the culture we have.
- There was a separate workstream on education and skills and adults and schools which we input into some of which was around the relationship with the Games and partnership as different partners were leading on different bits.
- This was something we could request through the Secretariat and get some update from Education and Skills Directorate.
- One of the things we started to do if the Board recalled that when Sue Harrison came to the previous Board and spoke of her ambition as the new director for Education and Skills to take a different look on how we create health schools.
- This builds on some of the practice in West Birmingham where there were some interesting examples of GPs working with local schools to help working together with the PCN system and the wider public health system.

- As a result of the Covid pandemic it has not been as fast as we would like but it was on the agenda for going forward. Where we have moved it faster was to secure money on mental health prevention … where we were able to commission Birmingham Education partnership to work with a number of primary schools to create a mentally healthy school environment and this has been really successful.
- One of the challenges was that this was quite expensive, but we could not afford to implement it across the whole city. The aim was to move it forward across the whole city in a step by step way.
- It was not about the curriculum, but the environment of the school, the culture, the physical and social environment of the whole structure and creating an environment where health and wellbeing was implemented across the entire school in the same way we try to get health and wellbeing across the entire health and social care system.

ICS TRANSITION UPDATE INCLUDING DESIGN AT PLACE

616 Karen Helliwell, Interim Accountable Officer, NHS BSol CCG introduced the item and drew the attention of the Board to the information contained in the report. Ms Helliwell then gave a quick whistle-stop tour of where they were at concerning the ICS transition update.

(See document No. 4)

Dr Varney stated that it was useful to understand that at the Integrated Care Partnership (ICP) level where this Board sat. The Integrated Care System (ICS) was like a super drug and enquired how this would be made meaningful. Ms Helliwell stated that it was recognised at pace where the strength was around engagement with communities and tapping into the resources through the local authorities was going to be key in those local communities, local partners whether that be the Police or GPs.

It was not thought that we would want to construct something on top of that to duplicate, but certainly in terms of membership on the ICP, that was being discussed with Healthwatch through the partners on how we embed that into the ICP. The organisation of the ICP would take that view from the ICP and other stakeholders. It was utilising and developing what we have straight from what we learnt from vaccinations for example and communicating with communities and tapping into it and supporting and developing what we have rather than a big organisation at the top that was trying to develop its own communication infrastructure. This was work in progress and definitely one that we would want to input into.

The Chair commented that it was partnership working through local authorities and other organisations and businesses.

Professor Miller commented that the services were important to the local authority areas in terms of things like housing, exercise and enquired whether this would be incorporated within the ICP or whether there would be something parallel or would local authority be responsible for that aspect and the ICP

would be responsible for deliver or whether this would take a bit of working through.

Ms Helliwell stated that it will take a bit of working through, but that the ICP was the group that would be the most important part of the overall strategy. This was the broad-church strategy. The membership of that will be from local authorities and community lay members spear setting the local framework and the delivery for all partners. This will involve the expertise and an understanding of the population health management and links with the communities, getting a rich diverse view of what that Masterplan will be about and using that information.

We knew that every organisation could not be represented but we were trying to get that connection and the Health and Wellbeing Board would be a key part of that. The delivery of that whether it was around the wider determinants of health to tap in at different levels. If there was some service that would be key to acting by itself that could be delegated to the Board.

The issue would be where was the best approach. If it was a consistent policy around early years or alternately it could be that it was decided that that could go across Birmingham and Solihull. It was thought that where some of this could be delegated to depended on what makes sense or where it was best to make those decisions safely.
Clearly if it was housing or social care for those local communities you would not want to delegate it to place. This was going to be the key once the Masterplan was set how to delegate it to the right level.

Dr Varney referred to the two ICS Boards and the ICS he and his colleague from Solihull was involved with and commented that there was no prerequisite for a Health and Wellbeing Board which had a statutory footing which had the right partners. Looking at some of those challenges through the principles of the NHS as the employer, the NHS as the economic power, there was a lot of work and it sounded that it was leaning on the networks and how it took some great learning from UHB team which was known for a while and how we take that learning and apply it to GP practices, the PCNs and work that through.

The Prevention Board was more focussed on commitments and the long-term plan where there was a series of things that the NHS must do as part of the 10-year plan and the Prevention Board was taking that on with the programme management. We were still working through all of that and the Population Health Management bit as he was responsible for the inside intelligence thinking. We were dividing this up between each other and trying to avoid replication with everyone sitting in the same room.

Ms Helliwell commented that we will start to see practical way of working on issues with a particular programme to understand how it might work so that we could work and learn together.

Councillor Bennett commented that from his perspective this looked rather complex and potentially bureaucratic. He added that we have an ICP and a Health and Wellbeing Board, the ICB, 8 place bases committees etc which had the potential to be incredibly bureaucratic. Although we had no control over this

if we were starting from scratch it was not certain why we needed to have the Health and Wellbeing Board and an ICB as separate organisations. The question was how we were going to prevent this from becoming bureaucratic.

Ms Helliwell stated that if you took away the governance a lot of what we were trying to do was to get partners to work clever and to integrating services in a better way. It was going to be about how we work with partners and used the best way of navigating this at the lowest possible level. Ms Helliwell added that she saw the Place Board and the Health and Wellbeing Board being absolutely critical and that delegation at place was going to be critical. From that level down there were some real opportunities to have concerning resources the dimension of what we wanted to do but not giving you the prescriptive way of doing it which was what we did not have.

To a large degree it was about assurance and we have learnt how not to do it and to do it properly and to make that as simple as possible. We were all trying to make it as understandable, but for the citizens who were going to receive it we needed to understand what our priorities were. If we pick those priorities whether it be vaccinations, maternity etc we had to learn by doing some of these examples. Some of these were statutory and with the ICP and the ICB it was how we could make them as best as we possible could to be flexible.

Dr Varney commented that we do quite a lot of wrestling with whether we should make the Place board and the Health and Wellbeing Board the same both in Birmingham and Solihull. Where we got to was that in the initial first couple of years the Place Board was going to focus on delivery of the NHS Trust vaccinations more than the strategic discussions about the environment etc. It was becoming clearer that the Place Board was around operational delivery driving operation transformation at place and in the first couple of years the ICP and ICB would be where the strategic system sat and trying to merge it was not practical. In Solihull, independently they came to the same conclusion.

Speaking with colleagues nationally, everyone has got to the same place that in the first two years they needed to stay separate, but this was not a forever decision. What was impressive comparing with colleagues nationally, was that here we had grown up conversations about what we could do – could we make it work as there were national hoops to jump through. In other areas it was not so positive. This would be how we navigate the years of transition.

The other issue which we should not forget which was seismic was West Birmingham as we will for the first time have Birmingham Place with one set of meetings for Birmingham which was an important step forward. Part of this was the locality structure and recognising that West Birmingham locality worked well navigating the Black Country and West Birmingham CCG. There was also the issue of what we could learn from West Birmingham about our delivery at place as this has not yet been incorporated into Birmingham.

Ms Helliwell stated that there were still some opportunities to get more views particularly about the Place Committee with this Board. Any comments or suggestions about that would be helpful. Given the work to date, we had the priorities for this Board would prove that this work in today's localities and those forums. There were opportunities to engage in that and the next steps was to

refine the functions and look at the opportunities to delegate out and what would be retained.

The Chairman commented that this was a work in progress.

BIRMINGHAM AND SOLIHULL SYSTEM RECOVERY PLAN

Harvir Lawrence, Director of Planning and Delivery and Ian Sharp, Elective Recovery Clinical Lead, BSol presented the item and drew the Board's attention to the information contained in the report.

(See document No. 5)

Dr Varney enquired whether there was some active strands of work to ensure we were addressing inequalities proactively.

Mr Sharp advised that this was something that was at the front of what they were doing both in terms of the backlog recovery and the wider investment planning that we were trying to make with regard to the capital for next year. It was fair to say that meaningful assessment of inequalities within our system and the impact of whatever step we might take was built into that planning guidance. It was thought that this was not deliberate as previously we knew about inequalities as being an issue, but we did not really have to address it operationally whereas now it was built into the operational decision making much more effectively which helped.

We had some data but there was quite some way to go in terms of building more meaningful datasets around all the various aspects of inequalities. It was in our thinking and was close to the front of our planning and our decision making about what we do next. But as all the members of the Board would know, there was significant amount of work to do on it.

617 **RESOLVED: -**

The Board noted the contents of the BSol System Recovery Plan update presentation.

AGENDA ITEMS 16 - 20

Dr Justin Varney, Director of Public Health drew the attention of the Board to items 16 – 20 on the Agenda and advised that in terms of the Sexual Health Strategy, that was now moving forward to the consultation stage which will go to March's Cabinet meeting for consultation. We would welcome any feedback from the Board to the Committee Manager or Mr Sherriff during the consultation period. In terms of the Deep Dive report, this has been a long time coming, but unfortunately Covid had got in the way, but he was pleased that this was now finally published. The report sets out some clear opportunities for action which had already been taken forward.

The Health Protection Forum was our annual report and as you would understand Covid did slightly got in the way, but he would request that Board members took some time to read the report as it does reiterate that whilst Covid was happening there were lots of other things that was challenging in the city. The final BLCHIR report will be presented at March Board meeting and that entered its journey through committees to get to us as of yesterday.

There were 39 opportunities for action set out in the BLACHIR review community partners reiterated that the breath of the Health and Wellbeing Board listened and take part in this report. The two years had identified decades of inequality and the loss of trust and confidence in our African/Caribbean communities in the public sector and this report gives us the opportunity to address that. Finally the City of Nature Update report was approved by Cabinet this morning for the Council will be moving forward into operational delivery.

618 **RESOLVED: -**

The Board noted the information in items 16 -20.

AGENDA ITEMS 18 - 22

619 The Chair acknowledged Items 21 - 24 on the Agenda were for information only.

OTHER URGENT BUSINESS

620 There was no other urgent business for this meeting.

The meeting ended at 1650 hours.

……
CHAIRPERSON

Birmingham Health and Wellbeing Board

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22nd March 2022**
TITLE:	**BIRMINGHAM AND LEWISHAM AFRICAN CARIBBEAN HEALTH INEQUALITIES REVIEW (BLACHIR)**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney**

Report Type:	**Information**

1. Purpose:

1.1 The report consolidates findings and opportunities for action identified during the Birmingham and Lewisham Black African and Caribbean Health Inequalities Review, the purpose of which has been to explore what underpins health inequalities being experienced by the Black African and Black Caribbean populations in Birmingham and Lewisham, and what interventions or actions could be developed to address those issues.

1.2 We are currently developing an accessible designed version of the report which is scheduled to be completed by 22nd March 2022. The attached is a final word version as submitted for design.

2. Implications:

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

3.	Recommendation

3.1 The Health and Wellbeing Board is asked to approve the content of the report from the Birmingham and Lewisham Black African and Caribbean Health Inequalities Review (BLACHIR).

We are submitting these opportunities for action for the Health & Wellbeing Board's consideration and for the partners to take forward this work to build a better future and to break these cycles of inequality and disadvantage for African and Caribbean communities.

The Board is requested to consider nominating a champion who will be responsible to ensure the Board partners respond to the review.

It is suggested that regular 6 monthly progress updates will be provided to the Board, whilst the overall progress on the implementation of the relevant opportunities for action will be monitored by the Creating a City Without Inequality Forum.

4.	Report Body

4.1. For too long our Black African and Black Caribbean populations have experienced health inequalities. These have often been ignored and their voices unheard, with these inequalities often accepted as fact rather than an unacceptable wrong to be addressed.

4.2. The review sets out clear opportunities for action driven by evidence from both published data and research and insight from lived experience. We have used a unique compilation of methodologies to collect, analyse and validate data, intelligence and insight, including rapid reviews of published research, input and validation from academic experts (Academic Board), input and testimonies from experts by experience (Advisory Board) and a number of public engagement activities such as online surveys, online events, focus groups and interviews.

4.3. The expectation is that the final 39 opportunities for action set out in this report will be considered for implementation locally by the Health and Wellbeing Board partners, new Integrated Care System partners, local service providers and communities who will work with some of the national agencies as required.

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	None

5.2	Management Responsibility
	This project has been led by the Service Lead in Inequalities with oversight from Director of Public Health.

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

Appendices
Appendix 1. BLACHIR Report

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

Monika Rozanski, Service Lead
Lucy Bouncer, Public Health Officer

Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)

Publication date: March 2022

Contents

Figures

Foreword

Birmingham and Lewisham are global communities that thrive from the many cultures and communities, including large, diverse and vibrant Black African and Black Caribbean populations.

For too long our Black African and Black Caribbean populations have experienced health inequalities. These have often been ignored and their voices unheard, with these inequalities often accepted as fact rather than an unacceptable wrong to be addressed.

Although it has been hard, the journey over the last eighteen months has been worth it. It has also underlined the critical need for the work as our Black African and Black Caribbean residents have been disproportionately affected by COVID-19 pandemic, both directly through infections and deaths, and indirectly economically and socially. This review has opened difficult conversations, analysed the published research alongside lived experience, and talked head on about the practical steps needed to make lasting change.

We are grateful for the honesty, passion and commitment of the individuals and groups who have been part of the boards or taken part in the community sessions that have guided our work and offered challenge through every stage of this review. Their personal contributions led to the review identifying not just the challenges, but also important opportunities for action to be taken forward in our local communities and systems; as well as further afield in other local, regional, national and international settings.

The review is the first step in a longer journey of transformation and resolution. It shines a light on the unfairness our Black African and Black Caribbean citizens live with every day which damages their health and wellbeing. This is the reality for too many citizens who live within our communities. They experience racism and discrimination, ignorance and invisibility existing within structural and institutional processes that underpin and perpetuate these inequalities.

This is a reality that must change.

The review sets out clear opportunities for action driven by evidence and it is now for us as leaders to work together through the Health and Wellbeing Boards, new Integrated Care System Partnerships and most importantly with our communities themselves, to take them forward.

We are already implementing some of these opportunities for action locally in our areas, through programmes such as Community Champions and pilots of culturally competent health and wellbeing programmes, and we have begun to engage national partners in responding to these opportunities nationally.

We must be committed to a better future for our citizens, and we must work together to seize every opportunity set out in this report to make our communities fairer and healthier for all.

Councillor Paulette Hamilton

Cabinet Member for Adult Social Care and Health/ Chair of the Birmingham Health and Wellbeing Board

Councillor Chris Best

Leader of the Lewisham Council/ Chair of the Lewisham Health and Wellbeing Board

Executive summary

Health inequalities are not inevitable and are unfair. Many people from different backgrounds across our society suffer health inequalities which can negatively impact the whole community, not just those directly affected. Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) set out to urgently reveal and explore the background to health inequalities experienced by our Black African and Black Caribbean communities.

Birmingham is home to 8% of the Black African and Black Caribbean populations in England and 23% of Lewisham's population is of Black African or Black Caribbean heritage (ONS 2011). Therefore, we are uniquely placed to take on this project to improve the health and wellbeing of our populations.

We recognised the need to think and act differently, looking at not just published data and evidence but also listening professional and lived experiences to better understand health inequalities, the reasons why they exist and identify opportunities for action to address them.

The main aim of the Review is to improve the health of Black African and Black Caribbean people in our communities by listening to them, recognising their priorities, discussing, and reflecting on our findings and coproducing recommended solutions for the Health and Wellbeing Board and NHS Integrated Care Systems to consider and respond to.

Addressing the layers of disadvantage

This Review clearly demonstrates and reinforces the evidence that there are social, economic and environmental reasons that determine significant inequalities in health outcomes amongst Black African and Black Caribbean communities, both locally and nationally.

These reasons lead to growing inequalities which have continued to worsen throughout the course of the COVID-19 pandemic, with many ethnic communities, especially our Black African and Black Caribbean communities, disproportionately impacted by disease and death.

BLACHIR supports previous research into health inequalities such as the Marmot Reviews[1,2], demonstrating that widespread inequality creates barriers to healthy behaviours, as faced by Birmingham and Lewisham's Black African and Black Caribbean communities. The Review highlights that must address the root causes and not just the results of bad health by focusing on fairness, a good start in life, supporting individuals at key stages and planning interventions better in partnership with our communities. We must make sure that we offer appropriate and accessible interventions at critical times in people's lives, whilst also continuously improving the way services work with them in culturally competent ways designed with communities in collaboration.

Poor housing, lack of green spaces, pollution, unemployment, food and fuel poverty, violence and crime and inadequate education all contribute to worse health and inequalities in these must be improved alongside action in health and social care services, otherwise the gaps will persist.

Structural racism and discrimination, and associated trauma is also a negative determinant faced by our Black African and Black Caribbean communities and one that was a clear and

[1] Marmot, M., Goldblatt, P. and Allen, J. (2010) *Fair Society, Healthy Lives, Strategic Review of Health Inequalities in England post 2010.* Institute of Health Equity

[2] Marmot, M. et al (2020) *Build Back Fairer: The COVID-19 Marmot Review*. The Health Foundation

constant theme throughout the Review. This layer of disadvantage cannot be ignored and addressing it must be at the heart of the response.

This Review's purpose is to break down the layers of disadvantage by bringing them to the fore and offering opportunities for actions from the BLACHIR Academic and Advisory Boards made up of volunteer professionals and academics and volunteers from our African and Caribbean communities.

We present key findings from across eight themes and offer opportunities for action to help address them.

Our methodology

"There is an urgent need to do things differently, to build a society based on the principles of social justice" (Marmot 2020).[3]

In line with the need to think and act differently, BLACHIR took a relatively unique approach to collate and analyse data and evidence, taking a balanced approach with proper consideration for published data and evidence, expert knowledge, lived experience and community voice. This helped the review obtain both quantitative and qualitative information over the course of eighteen months.

We identified eight themes related to the health and wellbeing of our populations based on the life course and areas already highlighted in the literature. For each theme a rapid evidence review was conducted to collate the published evidence, in some cases this was done by the local public health teams, in others it was commissioned from external providers. Our board of academics discussed the results from the literature and the evidence review to identify gaps, key issues and opportunities for action. The community advisory board and public engagement events provided an 'expert by experience' perspective to further build the opportunities for action and also provide challenge to the ambition and approaches suggested.

Public engagement activities included four online surveys using the Be Heard and Survey Monkey platforms, six focus groups, five individual interviews and five online community engagement events.

Our main findings

Seven key areas that need to be addressed were identified as cutting across the eight themes explored. These are deemed as being fundamental to closing the inequality gap, providing fairer access to health and social care services, and improving health outcomes for Black African and Black Caribbean communities. The Review calls on the Health and Wellbeing Board and NHS Integrated Care System Boards to prioritise taking forward work to address the seven fundamental areas that need to change.

1. Fairness, inclusion and respect

Across settings and life stages, people of Black African and Black Caribbean heritage are exposed to structural racism and discrimination which accumulates over time leading to chronic stress and trauma. There is a need to recognise, identify, address and mitigate structural racism and discrimination as a driver of health inequalities.

The Review calls for the Health and Wellbeing Board and NHS Integrated Care Systems to explicitly recognise structural racism and discrimination as drivers of ill health, systematically identify and address discrimination within systems and practices, and engage

[3] Marmot, M. et al (2020) *Build Back Fairer: The COVID-19 Marmot Review*. The Health Foundation

with Black African and Black Caribbean individuals and organisations to ensure community voice and their leadership in driving this work.

2. Trust and transparency

Trust is lacking between the Black African and Black Caribbean communities and public sector organisations, and connections with communities need to be built. A long history of discrimination, biases, poor experience and poor outcomes has destroyed trust in statutory services.

The Review calls for cultural competence training of health and social care professionals led by the NHS Integrated Care Systems and the Councils. This will require working with trusted community organisations and partners to coproduce training for professionals and volunteers that includes cultural awareness, is trauma informed and recognises the short and long-term impacts of discrimination and racism, values lived experiences and embeds and delivers inclusion in practices and policies.

3. Better data

Treating all ethnic minority or 'Black' communities as a single 'Other' group does not consider the cultural differences between Black African and Black Caribbean people. This has led to gaps in available data and limits our understanding of our communities and their needs. These communities are often grouped in research and data with other non-White British ethnic communities, denying their visibility and muting their needs to commissioners and service providers.

The Review calls for the Health and Wellbeing Boards to act across their partnerships to strengthen granular culturally sensitive data collection and analysis. Collaboration with professionals who represent these ethnic backgrounds can create a more sensitive, informed and appropriate approach to data collection and commitment that when data is collected it is used to drive better services and outcomes.

4. Early interventions

Investing early in people is essential. Too many children and young people from Black African and Black Caribbean communities are facing additional challenges that could be reduced through evidence-based interventions and this would benefit them through their whole life. Supporting children and young people's key periods of change, from birth and infancy to primary and secondary school, and then to young adulthood in culturally competent ways is essential.

The Review calls for the Health and Wellbeing Board to work with the Children's Trusts and Children's Strategic Partnerships to develop a clear action plan to provide support at critical life stages to mitigate disadvantage and address the inequalities affecting Black African and Black Caribbean children and young people. Investing early in local opportunities and partnerships is key to helping households and improving the lives of local children and young people.

5. Health checks and campaigns

Early detection and diagnosis of disease and identification of risk factors is critical for improving outcomes and empowering people to control their own health and wellbeing. Black African and Black Caribbean populations are at greatest risk of many health conditions but have lower uptake of health checks and screening services.

The Review calls for the Health and Wellbeing Board to act across their partnerships to promote health checks through public campaigns to increase the uptake of

community-based health checks in easy to access locations. This should also include specific work on mental health and wellbeing, working with community organisations and partners to increase peoples' understanding of the different types of mental illness and to encourage self-help, early intervention and self-referral to the NHS mental health services.

6. Healthier behaviours

The awareness about healthier life choices must be increased by using appropriate representation and amplified community voices to help identify and promote better health and reduce stigma. Unhealthy behaviours such as not taking enough exercise, eating an unhealthy diet and use of recreational drugs are a growing concern amongst Black African and Black Caribbean people. As with other ethnic minorities, these unhealthy behaviours can be driven by experiences of discrimination and racism. This is not helped by a lack of quality data, culturally competent resources and services to support healthier life choices.

The Review calls for the Public Health Teams and their partners to assess current service provision and health improvement campaigns through a cultural competency lens to improve support and access for these communities. This should be built on coproducing interventions with supplementary training for professionals such as health education and racial trauma awareness to help understand the psychological reasons for unhealthy behaviours and the role of lived experiences of discrimination in causing unhealthy habits.

7. Health literacy

Increasing people's skills, knowledge, understanding and confidence (health literacy) to find and use health and social care information and services to make decisions about their health is key to achieving healthier communities. Many in the Black African and Black Caribbean communities have not been supported to develop in this area in ways that work with their culture and community.

The Review calls for the Health and Wellbeing Boards and NHS Integrated Care Systems to work with local community and voluntary sector partners to develop targeted programmes on health literacy for Black African and Black Caribbean communities. Improving health literacy has been shown to have a positive impact on reducing health inequalities and helping people to manage long-term conditions effectively and to reduce the burden on health and social care services.

Opportunities for action

There are 39 opportunities for action across the eight themes explored as part of this review summarised below, they are also included in Appendix 1.

In some areas these opportunities are suggested as pilots of approaches as the evidence base and live experience supports action but there is limited evidence on effectiveness. This reflects the lack of detailed and focused research into ethnic communities' specific needs and how best to respond to them. Appendix 4 sets out the recommendations for research questions that could help close some of these gaps for the future.

These opportunities outline the potential next steps proposed to address the findings from the Review and are for the Health and Wellbeing Board and the NHS Integrated Care System Boards to consider and respond to alongside the 7 key areas for action.

Theme 1: Racism and discrimination	
Who	**Opportunities for action**
Local Councils and Health and Wellbeing Board Partners	**1.** Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.
Local Councils and Children's Trusts	**2.** Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
Local Councils and Health and Wellbeing Board Partners	**3.** Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
Local Councils and Education Partners	**4.** Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

Theme 2: Maternity, parenthood and early years	
Who	**Opportunities for action**
Local Integrated Care Systems (ICS) and NHS Provider Collaboratives	**5.** Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
Local NHS Integrated Care Systems (ICS)	**6.** Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.
Local Maternity System Partnerships and Health Child Programme Providers	**7.** Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
Local Maternity System Partnerships (LMS) working with Local Council Housing Teams	**8.** Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through appropriate support and protecting them from relocation or eviction.

Local Public Health and NHS services	**9.** Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

Theme 3: Children and young people	
Who	**Opportunities for action**
Education settings supported by the Regional Schools Commissioner and local Councils	**10.** Provide guidance and support for Black African and Black Caribbean parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.
Local Integrated Care Systems (ICS), Mental Health Trusts & Council commissioned Healthy Child Programme Providers	**11.** Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.
Education settings supported by the Regional Schools Commissioner and local Councils	**12.** Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people.
Local Health and Wellbeing Board and NHS Integrated Care System	**13.** Address low pay and associated poverty for frontline workers who are disproportionately of Black African and Black Caribbean heritage.
Local Council Director of Children's Services and Strategic Children's Partnerships	**14.** Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.
Local Councils and climate change and air quality partners	**15.** Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.
NHS Integrated Care Systems and Health and Wellbeing Board	**16.** Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Theme 4: Ageing well	
Who	**Opportunities for action**
Regional NHS England teams and Local Public Health teams	**17.** Provide targeted and culturally appropriate screening services Black African and Black Caribbean older adults.
Local Public Health Teams	**18.** Campaign to raise awareness and increase uptake of community-based NHS health checks in Black African and Black Caribbean older adults.

NHS Integrated Care System Boards	**19.** Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.
NHS England and NHS Integrated Care System Boards	**20.** Support initiatives to improve uptake of vaccinations in older African and Caribbean people, focusing on areas of higher deprivation.
Local Health and Wellbeing Boards and NHS Integrated Care System Partnerships	**21.** Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

Theme 5: Mental health and wellbeing	
Who	**Opportunities for action**
Local Public Health and Community Mental Health Trusts	**22.** Coproduce awareness campaigns aimed at Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Local NHS providers and Community Mental Health Trusts	**23.** Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
NHS Mental Health Providers and Commissioners	**24.** Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.
Local Health and Wellbeing Boards and NHS Integrated Care Partnerships Boards	**25.** Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and NHS Integrated Care Systems	**26.** Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

Theme 6: Healthier behaviours	
Who	**Opportunities for action**
Local Directors of Public Health	**27.** Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.
Health Education England	**28.** Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
Local Councils and NHS Integrated Care Systems	**29.** Provide long-term investment for trusted Black African and Black Caribbean grass roots organisation such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Local Directors of Public Health	**30.** Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.
Research funding bodies such as National Institute for	**31.** Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for

Health Research (NIHR)	community providers in 'action research' to concurrently deliver and evaluate interventions.
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	**32.** Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

Theme 7: Emergency care, preventable mortality and long-term physical health conditions	
Who	**Opportunities for action**
NHS England NHS Integrated Care Systems Local Councils	**33.** Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations. This should be supported by clear commissioning that requires data collection and analysis linked to all key relevant performance indicators. A specific example of where this can be rapidly done is through better use of the Friends and Family Test (FFT) and working with African and Caribbean communities so they engage with the tool and understand how it is used. There should also be better scrutiny and use of data from complaints and complements and this should be reviewed as part of contract monitoring and output data reported into system-leaders. This can also be strengthened through undertaking qualitative research to understand and overcome negative perceptions and experiences of health care for Black African and Black Caribbean communities to avoid delays in accessing care, including the influence of structural racism and discrimination. Through this better data and engagement, local areas should develop a more in depth understanding of the needs of communities in relation to emergency care, preventable mortality and long-term physical health conditions.
Local Health and Wellbeing Board and NHS ICS Partnership Board	**34.** Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include: • A team of community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support (e.g. social prescribing). • Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health. • Investment in grass-roots organisations to recruit volunteers who can support Black African and Black Caribbean

	communities that may experience structural institutional racism when accessing services.
Local Directors of Public Health and NHS Prevention Leads	**35.** Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include: • Services considering evidence-based ethnic differences in outcome measures (e.g. BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood and influence on life-time physical health). • Work with communities to co-develop services that are accessible for Black African and Black Caribbean communities (e.g. opening times, location of delivery). • Work with communities to encourage and raise awareness about how to access health services, including investment and development of multi-service hubs and pop-ups based in community locations (e.g. Youth Centres, libraries, leisure centres, faith-based sites, universities, colleges, schools) • Contractual clauses that strengthen support for Black African and Black Caribbean communities when they experience racism while accessing services and offer tiered positive approaches that address reported issues. • Meaningful measurement of change and learning from communities and grass roots organisations being captured and informing service design, monitoring, improvement, and review • Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation • Early help provision that supports communities when they do not meet statutory thresholds such as improved investment in grassroot organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

Theme 8: Wider determinants	
Who	**Opportunities for action**
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**36.** Consider cultural and religious influences when developing interventions to address the wider determinants of health inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.
Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations	**37.** Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.

Local Health and Wellbeing Boards	**38.** Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**39.** Take action to address employment inequalities and issues around racism and discrimination affecting in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations.

Introduction

"Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane"

Dr Martin Luther King Jr

There are clear and significant differences in the health status of Ethnic communities compared with their White counterparts in many local areas across the United Kingdom[4]. These reflect inequalities in the wider determinants of health such as education and housing, in health behaviours such as diet and physical activity, across many health outcomes from birth to premature death and in unequal access to health and social care support when it is needed.

The COVID-19 pandemic revealed how the impact of poverty, ethnicity, health, work and housing led to a higher rate of deaths in Black African and Black Caribbean people.[5] This simply shone a light on inequalities that have persisted for decades. The Black Lives Matter (BLM)[6] movement was also re-energised in 2020 highlighting the longstanding racism, discrimination and inequality experienced by Black people in the UK and internationally.

Health inequalities relate to the social, economic and environmental reasons that shape people's lives and are often called the wider determinants. Recent conversations across social and mainstream media steered by these issues have shown the inadequate support and unfair access to healthcare in our Black communities. This has led us to take action through a different type of partnership.

An innovative partnership

Over 96,000 people living in Birmingham identify with the Black African, Black Caribbean and 'Black Other' ethnic identities in the 2011 Census, and in Lewisham these communities represented over a quarter of all ethnic identities in the population. These are big communities and their health inequalities are reflected in the overall picture for the populations.

The public health divisions of Birmingham City Council and the London Borough of Lewisham Council felt more serious action was needed to understand and tackle health inequalities in their communities but recognised that this needed a different partnership approach which was better done together than individually. Building from these conversations the respective Health and Wellbeing Board Chairs commissioned BLACHIR – the Birmingham and Lewisham African and Caribbean Health Inequalities Review, to be led by the respective Directors of Public Health and their teams to move forward.

Despite the challenges of the last two years of the Pandemic this work has continued to move forward which is testament to the commitment of all those involved to make this happen.

Listening to our communities

Our Councils shared the common goal of addressing health inequalities through a greater understanding and appreciation of, and engagement with, our community groups. We

[4] Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund.
[5] Office for National Statistics (2022) *Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 8 December 2020 to 1 December 2021*
[6] Black Lives Matter (2022) *Home*

created an environment that enabled honest conversations throughout this review. The discussions were held with professionals and members of the public from the Academic and Advisory Boards. Fifteen academic professionals and nine Advisory Board members volunteered and attended five engagement sessions organised by each local authority's public health team. The review took place from July 2021 to January 2022 covering eight themes:

- Racism and discrimination in health inequalities
- Maternity, parenthood and early years
- Children and young people
- Ageing well
- Mental health and wellbeing
- Healthier behaviours
- Emergency care, preventable mortality and long-term physical health conditions
- Wider determinants of health

Our Black African and Black Caribbean Communities

Our Black African and Black Caribbean residents are important members of our community, many of whom were born and raised within our local areas. Irrespective of country of birth, many also have links and heritage with Africa and the Caribbean through cultural, ethnic identities and belief systems. Many Black African communities in the UK and elsewhere have roots in Sub-Saharan Africa with its rich and varied cultures, made up of mainstream and traditional belief systems. Black Caribbean communities also have distinctive cultural and ethnic identities across different Caribbean states with links to sub-Saharan Africa.

Black African and Black Caribbean groups share common ethnicities and cultures (African-Caribbean), and also identify with oppression, discrimination, marginalisation, inequalities and migration. However, there are also differences and we should not make assumptions when people from these groups access services that they all are the same.

The most recent standardised data on our communities locally comes from the 2011 Census as the 2021 Census results have not yet been released. While Birmingham has a much larger population than Lewisham, the ethnic landscape is similar with both being home to a significant proportion of Black African and Black Caribbean people.

There are some differences: a larger proportion of Birmingham's Black African and Black Caribbean citizens were born overseas (48% compared to 46% in Lewisham). The Lewisham's Black African and Black Caribbean population is younger than the general population and although this is similar in Birmingham, it is less pronounced. In general, the African populations are younger than the Caribbean populations and have much smaller proportion of very elderly citizens.

Figure 1: Local communities by ethnicity based on the 2011 Census data

[INFOGRAPHIC]

	Birmingham	Lewisham
Ethnic Identity		
White British	53.1% / 570,217	41.5% / 275,885
Black African	2.8% / 29,991	11.6% / 32,025
Black Caribbean	4.4% / 47,641	11.2% / 30,854
Black Other	1.7% / 18,728	4.4% / 12,063
Total of Black ethnicity	8.9% / 96,360	27.2% / 350,827
Country of Birth		
African Countries	3.2% / 34,549	9.2% / 25,277
• North Africa	0.3% / 2,696	0.4% / 1,180
• Central & West Africa	0.8% / 8,171	6.1% / 16,760
• South & East Africa	2.1% / 23,070	2.6% / 7,201
Caribbean Countries	1.9% / 20,043	4.6% / 12,788
• Jamaica	1.4% / 15,100	3.5% / 9,697
• Other nations	0.5% / 4,943	1.1% / 3,091
Age of arrival in the UK		
• 0 to 15yrs	37.5% / 17,417	29.6% / 10,224
• 16 to 24yrs	25.5% / 11,854	28.9% / 9,989
• 25 to 34yrs	24.3% / 11,310	28.6% / 9,859
• 35 to 49yrs	10.7% / 4,965	10.6% / 3,659
• >50yrs	2.1% / 956	2.3% / 792

Alternative text: Lewisham houses a higher percentage of people of Black ethnicity (27.2% compared to 8.9% in Birmingham). A larger proportion of Birmingham's Black African and Caribbean citizens were born overseas (48% compared to Lewisham's 46%). 37.5% of Birmingham's Black African and Caribbean population arrived between ages 0 to 15, which is higher than Lewisham (29.6%).

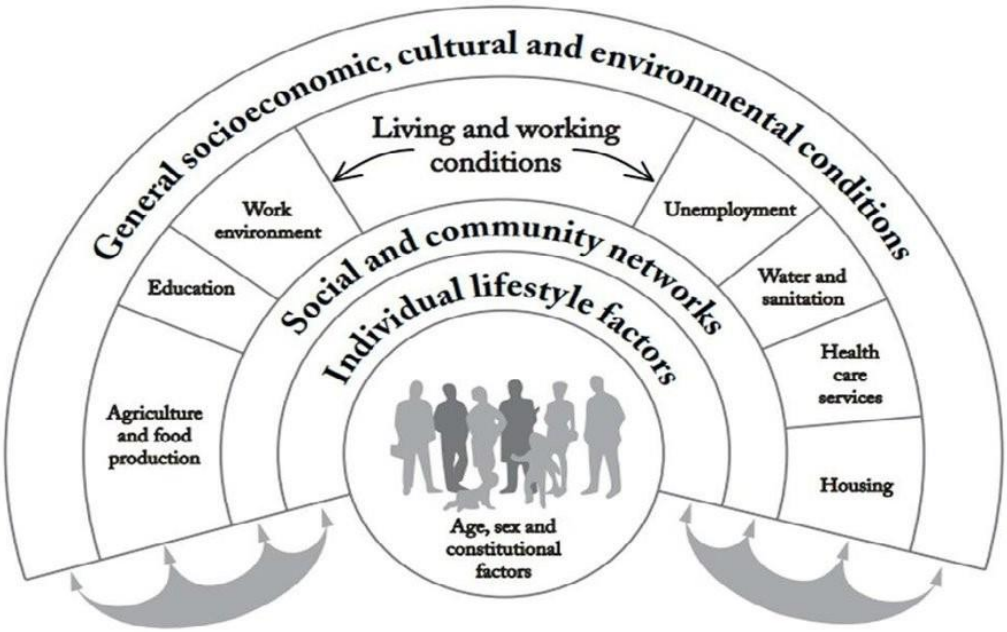
Methodology

The Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) took eighteen months due to the impact of the COVID-19 pandemic. It involved capturing the lived experiences of Black African and Black Caribbean communities alongside exploration of the published data and evidence. The main topic themes were established based on the recognised wider determinants of health (See Figure 2) and initial scoping engagement.

In addition to disproportionate exposure to negative determinants of health, it is increasingly recognised that many ethnic minority populations also suffer from racism and discrimination as an additional determinant of health[7].

BLACHIR wanted to hear from real people and their voices informed our study, revealing what we could do to ensure better opportunities for them now and in the future.

Figure 2: Dahlgren and Whitehead model of health determinants[7]



Alternative text: Dahlgren and Whitehead's model of health determinants shows the many factors that can influence an individual's health. These are:

- personal characteristics that occupy the core of the model and include sex, age, ethnic group, and hereditary factors
- individual 'lifestyle' factors which include behaviours such as smoking, alcohol use, and physical activity
- social and community networks which include family and wider social circles
- living and working conditions that include access and opportunities in relation to jobs, housing, education and welfare services
- general socioeconomic, cultural and environmental conditions that include factors such as disposable income, taxation, and availability of work.

The evidence was collected using the following methods:

[7] Dahlgren, G. and Whitehead, M. (2021) 'The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows', *Public Health* 199, pp 20-24.

- A rapid review of published research and evidence from the past ten years
- Data collation from existing data sources accessible to the Council public health teams
- An appraisal of the outcomes from the rapid review of literature and discussion on its findings by the board of academics
- A discussion on the outcomes from the evidence review and the Academic Board, and feedback from the experts by experience from the Advisory Board
- Public engagement activity including:
    - 4 online surveys
    - 5 online public events
    - 6 focus groups sessions
    - 5 one-to-one interviews.

We listened and we heard

Many groups of people remain under-represented in engagement due to barriers in society. The BLACHIR was important because it heard from people with diverse lived experiences, leading to innovative ideas for better decisions and health outcomes.

We adopted a different way to engage by allowing members of the community to comment on the opportunities for action as they were developed rather than just reading them from the published review.

People from Black African and Black Caribbean communities were invited through targeted engagement to submit responses to an online survey and participate in live Mentimeter© polls at online events. Birmingham City Council opened the last local survey to the wider public on 5 January 2022 and this closed on 20 January 2022. In total, 173 Birmingham citizens participated in the engagement events. In Lewisham, three local grass roots organisations were involved in carrying out local engagement activities. Across Lewisham, a total of 71 people engaged in these activities.

There was specific promotion through targeted media and direct networking to try and engage citizens in these opportunities to comment. As we went through the process we evolved and developed the approach. For example, we captured the ethnicity of participants in digital engagement workshops as a simple step to really understand the voices in the room.

The reality of the COVID-19 pandemic prohibited face-to-face engagement and it has been recognised that this was a significant limitation for the review process.

External boards

External Academic Board

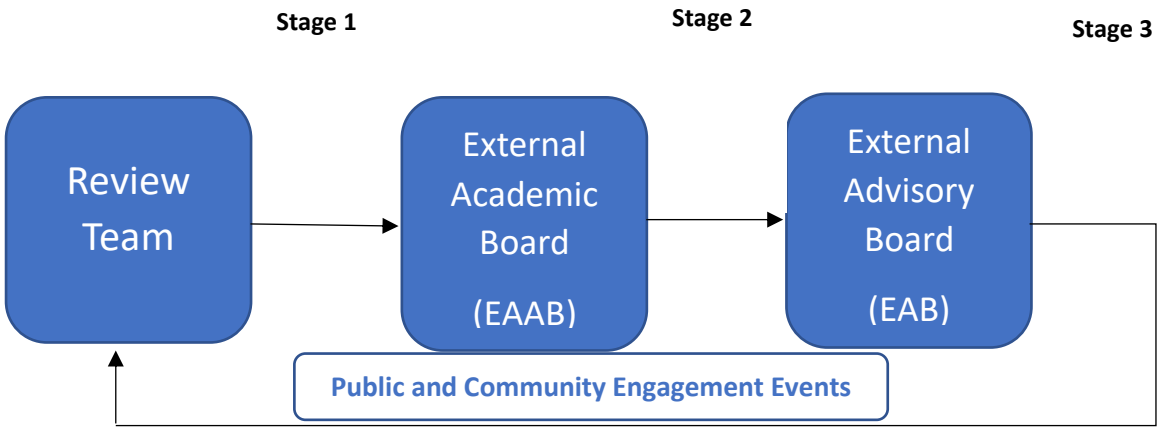
Fifteen academics were appointed as volunteers to the external Academic Board. The main purpose of the external Academic Board was to provide a network of academics who have a research interest in African and Caribbean health inequalities to support and inform the Birmingham and Lewisham review. The Academic Board members represented different aspects of the Black African and Black Caribbean communities in Lewisham, Birmingham and nationwide. They conducted a two-way conversation with communities, not representing individual views and maintained wider community networks to gain and share information relevant to each theme.

External Advisory Board

The Advisory Board consists of five voluntary members from Lewisham and four voluntary members from Birmingham who are actively involved in their communities and live in the local areas. They collected and reported lived experiences from both these local authorities. The external Advisory Board's purpose was to enable regular discussions to inform the

review process from a group of individuals who represented different views of Black African and Black Caribbean communities in Lewisham, Birmingham and nationwide.

Figure 3: Meeting cycle process



Alternative text: decorative (information explained above)

Recruiting participants using internal and external communications

We reached out to relevant audiences using both external and internal communications to find out directly about the issues affecting our Black African and Black Caribbean communities. Both councils' websites and other communication channels were used to provide information to all our targeted stakeholders.

The invitations were created to attract people to our engagement events and the online surveys were used to capture under-represented voices in the workplace.

The methods we applied were:

- email communications to community groups and representatives, including a list of targeted African and Caribbean organisations following a mapping exercise completed by the review team and local media outlets
- promotion of the surveys in all engagement events using slideshows and posting the link in the live MS Teams chats
- advertising using social media channels such as LinkedIn forums, Twitter, and Instagram Healthy Brum accounts.

Figure 4: Information from engagement events and surveys

	Birmingham	Lewisham

	Engagement Events	Survey and Mentimeter© responses	Focus groups and interviews	Survey
Number of participants	129	44	33	38
% of Black ethnicity	50%		100%	
% male	33%		24%	
% female	67%		76%	
Most common age group of respondents	55-64 and 35-44 years		40-59 years	

Alternative text: Birmingham's engagement involved engagement events, featuring a total participant number of 129, and survey and Mentimeter© responses (n = 44). Lewisham's engagement was completed via use of focus groups and interviews (n = 33) and surveys (n = 38).100% of the participants in Lewisham's engagement were people of Black ethnicity, compared to 50% in Birmingham's. Engagement in both councils was completed by a higher percentage of females than males.

Limitations

This review collated and analysed published evidence and available data, collected professional opinion and lived experience evidence, and utilised Academic Board, Advisory Board and community engagement processes to develop and prioritise its findings and proposed opportunities for action.

Each process had inherent limitations and potential biases, e.g. quantity and quality of published evidence and data, lack of available data collection and analyses for ethnicity beyond Black, Asian and Minority Ethnic (BAME), breadth of board membership, reach of community engagement, etc. Findings are not a comprehensive approach to addressing health inequalities for Black African and Black Caribbean communities, and other evidence-based opportunities to address health inequalities and improve health and wellbeing equity for these populations may also be beneficial.

As the Review progressed due to the pressure of the Covid response some of the evidence collation was commissioned from external providers and this led to more variability in the evidence collation.

It should also be noted that long-standing and structural drivers of health inequalities can only be addressed through long-term, progressive action. Therefore, rather than identifying a 'solution', this work represents the start of a new way to co-create action to reduce health inequalities with and by – rather than to or for - the community.

People from ethnic minorities who are not White British are often grouped together as Black, Asian and Minority Ethnic (BAME). The BAME term can mask variations between different ethnic groups and create misleading interpretations of data. The consequences of this are that we don't often get to truly understand the specific different inequalities affecting different ethnic groups or what their specific needs, or issues are.

Due to capacity and also the absence of data and evidence across the general population, this work has not looked at how minority groups within the Black African and Black Caribbean are affected by multiple inequalities ('intersectionality'). For example, evidence suggests LGBT people of Black heritage are more likely to face discrimination from other

LGBT people because of their ethnicity[8], be victims of hate crime[9] and less likely to access services[10] than White LGBT people. There is a need to look at intersectionality for people of Black African and Black Caribbean heritage who have other inequality characteristics or are in inclusive health demographics.

[8] Stonewall (2018) *LGBT in Britain – Home and communities*
[9] Stonewall (2017) *LGBT in Britain - Hate crime and discrimination*
[10] Witzel, T.C., Nutland, W. and Bourne, A. (2019) 'What are the motivations and barriers to pre-exposure prophylaxis (PrEP) use among Black men who have sex with men aged 18-45 in London? Results from a qualitative study,' *Sexually Transmitted Infections* 95(4), pp 262–266. doi: 10.1136/sextrans-2018-053773

Theme: Racism and discrimination

"'Whenever we see racism, we must condemn it without reservation, without hesitation, without qualification."

Antonio Guterres, United Nations Secretary-General

The review into the drivers of health inequality being experienced by Black African and Black Caribbean communities started from a discussion on the role of racism and discrimination.

Racism is "a conduct or words, or practices which disadvantage or advantage people because of their colour, culture, or ethnic origin"[11]. It can happen at both individual and institutional levels, with a collective failure to provide an inclusive environment or detect and outlaw racism termed 'institutional racism'.

Discrimination is treating someone in a negative way because of a personal characteristic such as race, age, sex or disability.

The historical aspect of these issues cannot be ignored. Racism has its roots in colonialism and slavery. A history of hierarchical states with White Europeans at the top and Black Africans and Black Caribbean's at the bottom has resulted in racism becoming embedded into the nation's structures of power, culture, education and identity.

The disproportionate impacts of COVID-19 on people of ethnic minority heritage, especially people from Black ethnic groups, shone a light on persistent and often ignored health inequalities. Recognition is a step in the right direction, but insufficient to create change.

A recent review of the principle of the determinants of health recognised racism as a *"driving force influencing almost all determinants of health"* operating through the mechanisms of racial discrimination and stigma, institutional racism, and structural racism[5].

A position statement from the Association of Directors of Public Health declared *"Racism is a public health issue"*[12]. They set out an action plan based on: trust and cohesion; co-production with communities; improving ethnicity data collection and research; embedding public health work in social and economic policy; diversifying the workforce and encouraging systems leadership.

What did we find from the rapid review?

There has been a steady increase in hate crime, including racially aggravated incidents, over the past 10 years with the number of the crimes rising by 159% since 2012 (Figure 5). The rise can also be attributed to a better recording system and higher reporting rates, as the awareness of hate crime and how to report it increases. Nevertheless, the statistics are worrying and demonstrate deep rooted societal issues[13].

[11] Macpherson, W. (1999) *The Stephen Lawrence inquiry*
[12] The Association of Directors of Public Health London (2021) *Policy position: Supporting Black, Asian and minority ethnic communities during and beyond the COVID-19 pandemic.*
[13] Allen, G. and Zayed, Y. (2021) *Hate crime statistics*. House of Commons Library.

Figure 5: Number of recorded hate crimes based on Home Office statistics for 2021

Police recorded hate crimes by monitored strand
England & Wales, year ending 31 March

	2012	2013	2014	2015	2016	2017[c]	2018[c]	2019[d]	2020[e]	2021	% Change 2020 to 2021	% Change 2012 to 2021
Race	32,969	33,116	34,874	39,666	45,440	58,294	64,829	72,051	76,158	85,268	+12%	+159%
Religion	1,438	1,421	2,067	3,006	3,962	5,184	7,103	7,202	6,856	5,627	-18%	+291%

Alternative text: The number of recorded racially aggravated hate crimes has risen by 159% from 2012 to 2021. This has risen by 12% from 2020 to 2021. The number of recorded aggravated hate crimes due to religion has risen by 291% from 2012 to 2021, but has reduced by 18% from 2020 to 2021.

Racially motivated hate crime in England spiked following the EU referendum, 2017 terrorist attacks and the Covid-19 lockdown[13].

Between 2017 and 2020, 0.9% of all Black adults aged 16 and over were victims of racially motivated hate crime compared to 0.1% of White adults, 1.0% of Asian adults and 1.1% of other ethnic minority groups, with the White Other group being most affected[13] (Figure 6).

Figure 6: Percentage of adult victims of racially motivated hate crime by ethnicity based on Home Office statistics for 2021

Percentage[a] of adults aged 16 and over who were victims of racially-motivated hate crime, by ethnicity and religion
England and Wales

	2007/08 & 2008/09	2009/10 to 2011/12	2012/13 to 2014/15	2015/16 to 2017/18	2017/18 to 2019/20
Ethnic group[b]					
White	0.1	0.1	0.1	0.1	0.1
Mixed/multiple ethnic groups	3.0	0.9	1.1	0.5	0.3
Asian/Asian British	2.1	1.8	1.0	1.1	1.0
Black/African/Caribbean/Black British	1.7	0.8	0.7	0.6	0.9
Other ethnic group	2.0	1.5	0.8	1.0	1.1

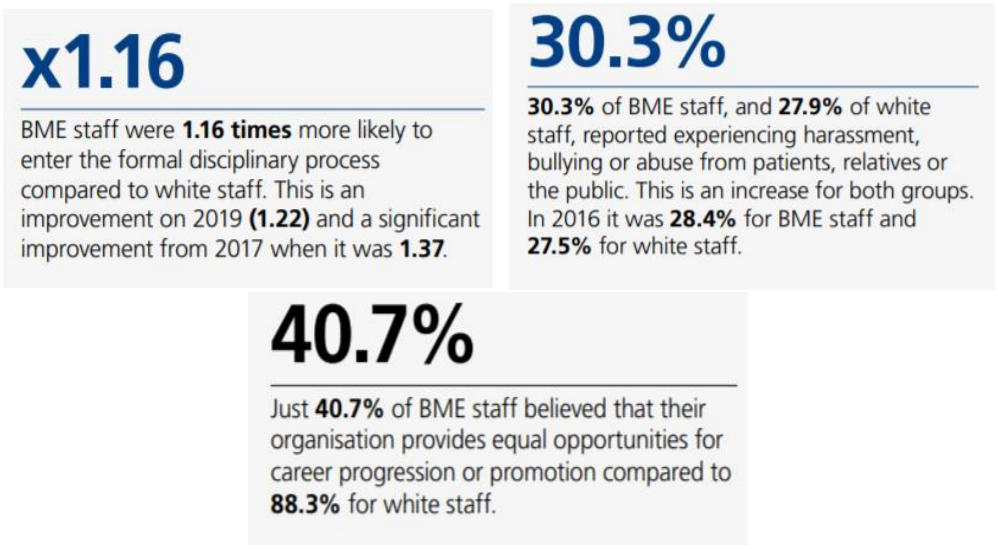
Alternative text: Between 2017 and 2020, 0.9% of all Black adults aged 16 and over were victims of racially motivated hate crime compared to 0.1% of White adults, 1.0% of Asian adults and 1.1% of other ethnic minority groups, with the White Other group being most affected.

There is clear evidence that racism has a detrimental effect on health and those who experience it have worse outcomes across many areas of mental and physical health.[14]People from Black, Asian and Ethnic Minority (BAME) backgrounds are more likely to have a negative experience of health care, which may include insensitivity and racism, and may limit access to those vital services, e.g. racism may cause delays in treatment and mistrust in services.**Error! Bookmark not defined.** Prejudice exists within the NHS staff towards BAME

[14] White, M. (2020) *What are the effects of racism on health and mental health?* Medical News Today

staff and more bullying and harassment has been reported by BAME staff compared to White British staff[15]. (Figure 7)

Figure 7: NHS staff statistics from NHS England 2021[15]



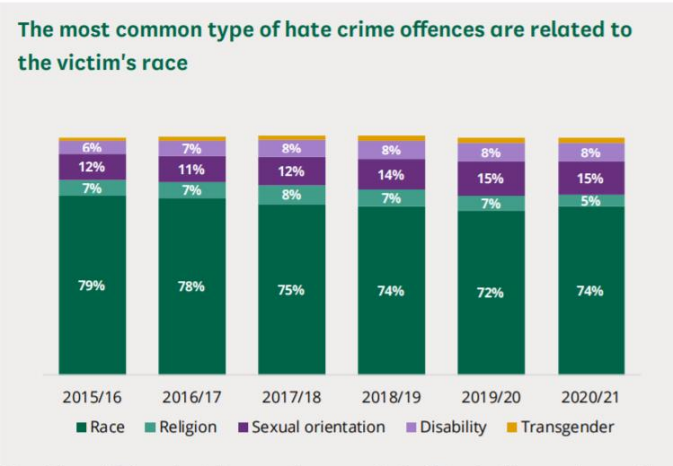
Alternative text: Black and Minority Ethnic (BME) staff were 1.16 times more likely to enter the formal disciplinary process compared to White staff. This is an improvement on 2019 (1.22) and a significant improvement from 2017 when it was 1.37. 30.3% of BME staff and 27.9% of White staff reported experiencing harassment, bullying or abuse from patients, relatives or the public. This is an increase for both groups. In 2016 it was 28.4% for BME staff and 27.5% for White staff. Just 40.7% of BME staff believed that their organisation provides equal opportunities for career progression or promotion compared to 88.3% for White staff.

Key findings [INFOGRAPHICS]

Headline: **West Midlands has the second highest rate for racially motivated crimes across all Police Force Areas in England and Wales**
West Midlands – 269 per 100,000 population
Metropolitan Police – 224 per 100,000 population
England and Wales average – 208 per 100,000 population

Headline: **Proprtion of racially motivated hate crime in England in 2020-21**
74%
[refer to the stats below]

[15] National Health Service (2021) *Workforce Race Equality Standard. 2020 Data analysis report for NHS Trusts and Clinical Commissioning Groups*



Notes: It is possible for a crime to have more than one motivating factor. For this reason the sum of the percentages of the FIVE motivating factors exceeds a 100%.

Headline: **Proportion of British adult (16+ yrs) victims of racially motivated hate crime**
Black adults – 0.9%
White adults – 0.1%

Headline: **Risk of disciplinary action against NHS staff**
BME staff have a 1.16 times higher risk than White staff

What did we find from the community & Board engagement?

"As I entered the surgery the GP said to me: *So many people from your country coming in with HIV!'"*
Lewisham community member

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

"[Services] take all Black people to be the same."
Lewisham community member

Throughout the review, participants from across the community shared with us their own stories of lived experience of racism and discrimination. Most of these stories reflected on the structural and systemic issues of racism and discrimination present within some areas of public services, such as the NHS and the Criminal Justice System.

Stories about the experiences of racism and discrimination emerged at every discussion and engagement session during the review highlighting their deep and widespread impact on health and wellbeing, particularly on mental health and wellbeing.

The most common issues raised by the communities included:

- Racially charged/discriminatory language from healthcare professionals
- Racial abuse and attacks experienced in childhood having a traumatising effect and potentially lifelong negative impacts on self-esteem and mental wellbeing
- The use of colour language in ethnic coding having the potential to create bias and negative associations from the very first point of contact
- The importance of recognising and understanding the differences in different communities' history and experiences as even within the African and Caribbean

communities there are important and significant differences between different nationalities and cultural identities.

The review welcomed the brave and difficult discussions throughout this segment of the process and highlighted the need for the public sector to invest in creating more spaces for an open and authentic exploration of racism and discrimination in ways that support individuals to be safe in their exploration and learn together from others' lived experience.

Opportunities for action

Theme 1: Racism and discrimination	
Who	**Opportunities for action**
Local Councils and Health and Wellbeing Board Partners	1. Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.
Local Councils and Children's Trusts	2. Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
Local Councils and Health and Wellbeing Board Partners	3. Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
Local Councils and Education Partners	4. Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

Theme: Maternity, parenthood and early years

"It's been so bad for so many years, I don't think Black women will ever trust the NHS again."

BLACHIR engagement participant

The physical and mental health of parents are essential for the development of children with mothers playing an important role after conception and then from birth. The way in which they are supported during pregnancy can affect not only the first few years of a child's growth but also their prospects into adulthood.

In the UK, Black women are five times more likely to die in pregnancy or childbirth than White women.[16] During the Covid-19 pandemic, 55% of pregnant women admitted to hospital with coronavirus were from ethnic minority backgrounds.[17]

Prevention and early intervention are most effective when delivered in those early life stages. Prof. Sir Michael Marmot[18] who wrote the study Fair Society, Heathy Lives (The Marmot Review) notes 'giving every child the best start in life crucial to reducing health inequalities across the life course.' The *"first 1,000 days of life"* for lifetime health and wellbeing opportunities and outcomes is now recognised as critical[19].

We present the main findings from the evidence review, community engagement and stakeholder group sessions. The members of the boards suggest Opportunities for action to help improve support for African and Caribbean parents and children.

What did we find from the rapid review?

In local data, there were some interesting differences between the two areas.

Maternity

The outcomes for infant death and low birth weight in Birmingham is consistently poorer compared to England and Lewisham. In Birmingham, the highest infant mortality rates in the BLACHIR communities were found in mothers born in the Caribbean (9.0 deaths per 1000 live births) and Central Africa (8.3 deaths per 1000 live births) and this has remained so over time.[20]

Babies of Black or Black British ethnicity have greater than two times the risk of still birth than those of White British ethnicity.[21]

There are increasingly positive outcomes for continuity of care for Birmingham's Black African, Black Caribbean, and Black Mixed ethnicity mothers.

Pre-term birth rates are higher for Birmingham's Black Caribbean and Black Other women in 2020 compared to Black African and White British women.

[16] MBRRACE-UK (2021) *Mothers and Babies: Reducing risk through audits and confidential enquiries across the UK*
[17] Royal College of Obstetricians and Gynaecologists (2020) *RCOG and RCM respond to UKOSS study of more than 400 pregnant women hospitalised with coronavirus*
[18] Marmot, M. et al (2020) *Health Equity in England: The Marmot Review 10 Years on*
[19] House of Commons Health and Social Care Committee (2019) *First 1000 days of life*
[20] Public Health England (2016) *Infant and perinatal mortality in the West Midlands*
[21] Office for National Statistics (2021) *Births and infant mortality by ethnicity in England and Wales: 2007 to 2019*

Emergency caesarean rates, from 2019 to 2020 for Black women, show an increase across all groups with higher rates seen in Black African women. However, there is a need to compare to the service standards as this can be an indicator of high-risk pregnancy or underlying medical conditions.

Parenthood and early years

The evidence base around parenting and early years that is specific to Black African and Black Caribbean communities is very limited in a UK context. The academic evidence highlighted the following issues driving inequalities in early years outcomes:

- Socioeconomic factors
- Barriers to accessing prenatal, postnatal, and maternity services
- Lack of culturally competent and sensitive approaches
- Poor perinatal mental health support
- Parental feeding practices such as greater eating pressures and concerns
- Black men and young Black women facing barriers and stigmatisation
- Intergenerational care not being recognised as an obvious aspect of family care.

Fewer children are assessed as being school ready at the end of Reception in Birmingham (68%) compared to England (71.8%) and Lewisham (76.4%)[22]. In 2018-19 only 68% of all Black children achieved the expected standard of development in Reception in comparison with 72% of all White children in England[23].

Key findings [INFOGRAHPICS]

Headline: **Highest infant mortality rates in Birmingham by place of mother's birth**

Caribbean - 9 deaths per 1000 live births

Central Africa - 8.3 deaths per 1000 live births

Headline: **Risk of still birth in the UK**

Black or Black British babies more 2 X more likely than White babies

Headline: **Risk of maternal mortality**

Black mothers 5 X more likely than White mothers

Headline: **Good level of development of children in Reception in England**

All White children – 72%

All Black children – 68%

What did we find from the community & Board engagement?

[22] Public Health England (2022) *Fingertips: Public Health Profiles*
[23] Office for National Statistics (2021) *Development goals for 4 to 5 Year Olds*

"The NHS staff have to be anti-racist, not just less racist"
Birmingham community member

"More people that look like me"
Birmingham community member

"If you are not counted, you do not count"
Advisory Board member

Lack of cultural awareness

Maternity care processes (pathways) do not recognise cultural differences between Black African and Black Caribbean women which can lead to barriers and result in stigmatisation and stereotyping. There is a need to develop and apply a pregnancy needs assessment model inclusive of lived experiences and accounting for cultural traditions. Community led initiatives or models should be considered.

Conscious and Unconscious bias

Communities told us that healthcare professionals tend to have more dismissive attitudes towards ethnic minority women, preventing them from accessing services. The uniting of education, policy and practice through cultural competency (understanding) training could remove bias and stereotypical views which influence assumptions and treatment.

The bias was also visible and present in the way data on ethnicity and culture are collected by services and there seemed to be a conscious bias to not looking at when it was collected. There are significant gaps in collecting and using data about ethnicity to understand the inequalities and underpin needs assessments as well as provision of appropriate services and the discussions with community highlighted the need for this to be much more granular and not lump all communities together.

"Transparency and trust are words that have very little meaning in many deprived areas of Birmingham."

BLACHIR engagement participant

Opportunities for action

Theme 2: Maternity, parenthood and early years	
Who	**Opportunities for action**
Local Integrated Care Systems (ICS) and NHS Provider Collaboratives	1. Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
Local NHS Integrated Care Systems (ICS)	2. Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.

Local Maternity System Partnerships and Health Child Programme Providers	3. Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
Local Maternity System Partnerships (LMS) working with Local Council Housing Teams	4. Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through appropriate support and protecting them from relocation or eviction.
Local Public Health and NHS services	5. Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

Theme: Children and young people

"I had Black teachers who acted as good role models."
Birmingham community member

"[I am] reluctant to go out because I don't feel safe."
Young Lewisham community member

*"Food poverty is caused by **the social exclusion** and spiralling associated costs for many living in these communities."*

BLACHIR engagement participant

Black children in the UK are now the second largest group living in poverty after White children. These are households defined as being below 60% of the median and it is the standard definition for poverty.[24]

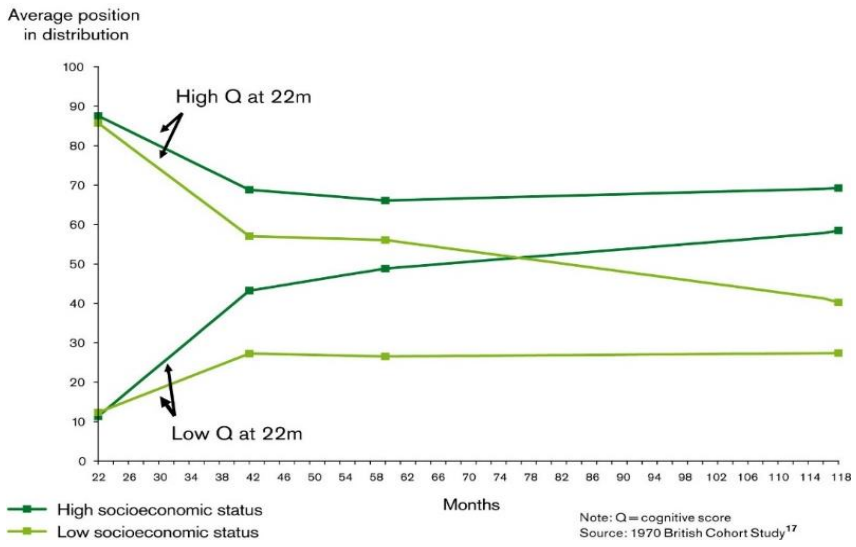
We focused in this review on the data and literature reporting the health inequalities and determinants for Black African and Black Caribbean children and young people (CYP).

So, why are children from these communities missing out on opportunities that lead to better health and life experiences?

Inequality is the main reason and can be seen in the children and young people's wider family and home environment. There is also significant evidence to suggest that these important earlier years can determine health inequalities over a lifetime.

We refer again to the seminal Marmot Review that explains where we sit in society and determines economic benefits. It presents the evidence that those with lower intellectual ability but with higher social status can overtake higher intellectual potential with lower social status in the early years by the time children are 7yrs old as demonstrated in Fig. 13.

Figure 8: The Marmot Review: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years[16]



Alternative text: decorative (information explained above)

[24] Sparrow, A. (2022) *More than half of UK's Black children live in poverty, analysis shows*. The Guardian

Across both Councils there are clear commitments to reducing the social gradient (being less advantaged) in skills and qualifications, ensuring school, families, and communities work in partnership to reduce the gradient in health, wellbeing and resilience and improving access and use of quality lifelong learning across the social gradient.

We know that children and young people thrive in warm, stimulating, and safe homes with loving and supportive caregivers. But for Black African and Black Caribbean people inequalities often caused by structural racism can impact on being able to access parental help across health and social services when things are challenging and this in turn impacts on children.

One of the ways that we think about challenges to this positive thriving environment is through the ACE framework. The Adverse Childhood Events framework considers things that might happen to a child that have been shown to have impact on their lives in the short term and across the whole of their lifetime.

Adverse childhood events (ACE) are:

1. physical abuse
2. sexual abuse
3. psychological abuse
4. physical neglect
5. psychological neglect
6. witnessing domestic abuse
7. having a close family member who misused drugs or alcohol
8. having a close family member with mental health problems
9. having a close family member who served time in prison
10. parental separation or divorce on account of relationship breakdown.

Exposure to ACE does not automatically mean that children are 'destined' to have worse outcomes but it does highlight the potential risk, especially of negative health behaviours such as smoking, and the risks that come from having less well established personal and social connections and resilience. ACE exposure should not be used to label children but is a prism through which we can identify and consider need and step in earlier to support children and young people to achieve their potential.

There are already calls in academic papers racism to be considered *"an ACE exposure risk factor, a distinct ACE category and a determinant of post-ACE mental health outcomes among Black youth"*[25]. This reflects the sustained and long term impacts of racism on young people that can persist into adulthood and was a discussion that was reflected strongly in the Review.

What did we find from the rapid review?

We included data analysis of outcomes for children and young people locally and nationally, and a literature review of 65 sources.

Children and young people in Black ethnic groups have higher proportions of:

- excess weight[26]

[25] Bernard, D. L. et al (2021) 'Making the "C-ACE" for a culturally-informed Adverse Childhood Experiences framework to understand the pervasive mental health impact of racism on Black youth,' *Journal of Child & Adolescent Trauma* 14, pp 233-247. doi:10.1007/s40653-020-00319-9

[26] Office for National Statistics (2020) *Overweight children*

- living in low-income families[27]
- low birth weight[28].

Children and young people in Black Caribbean groups have significantly worse levels of:

- readiness for school[29]
- not (being) in Education, Employment or Training (NEET)[30].

The recent national YMCA research report: *Young and Black, The Young Black Experience of Institutional Racism in the UK* (October 2020)[31] emphasised four main issues:

- Racist language (school & workplaces) – 95% & 78%
- Stereotypes & pressure to conform – 70% & 50%
- Employer recruitment prejudice – 54%
- Distrust in police & NHS - 54% & 27%.

Black African and Black Caribbean children and young people often suffer the greatest inequalities resulting in Black Caribbean children and young people being 2.5 times more likely than a White British child to be permanently excluded.[32]

However, it must be noted that limited data by specific ethnicities and the lack of evidence doesn't mean inequalities are absent. We must avoid assumptions in the shared outcomes between Black Caribbean and Black African communities.

We are all in it together?

"Healthcare workers have been exposed to risk for years long before COVID."
BLACHIR engagement participant

As we have discussed in the introduction and will continue to reference in this review, Black ethnicities are more likely to be diagnosed or die from COVID-19. Statistics revealed that Black Caribbean and Black Other ethnicity categories have a 10-50% increase in deaths compared to other groups.[33]

The COVID-19 pandemic and our response to the virus had an unfair impact on minority ethnic households. People from these groups have reported greater financial impact leading to an increased use of food banks because their basic needs were not being met. For example, the IFS found that Black African and Black Caribbean men were both 50% more likely than White British men to work in shutdown sectors (areas that had been closed due to the initial lockdown).[34]

Whether the virus's impact is on an individual, or indirectly through a family member, the negative result of COVID-19 is likely to be greatest on Black children and young people given increased exposure to five risk factors:

- Negative financial impacts
- Unemployment
- Bereavement
- Mental health issues

[27] Birmingham City Council (2022) *Supporting healthier communities*
[28] Office for National Statistics (2021) *Births and infant mortality by ethnicity in England and Wales*
[29] Office for National Statistics (2021) *Development goals for 4 to 5-year olds*
[30] Powell, A. (2021) *NEET: Young people not in education, employment or training. UK Parliament: House of Commons Library*
[31] YMCA (2020) *Young and Black. The young Black experience of institutional racism in the UK*
[32] Office for National Statistics (2021) *Statistics: Exclusions*
[33] Public Health England (2020) *Disparities in the risk and outcomes of Covid-19*
[34] House of Commons. Women and Equalities Committee (2020) *Unequal impact? Coronavirus and BAME people*

- Widening educational gap related to socioeconomics (status in society).

Black and minority ethnic young people have shown more increases in seeking help for mental health during the first wave of the pandemic than White young people.[35] While not identified by the literature, disproportionate COVID-19 deaths in Black and minority ethnic communities are likely to have created unequal levels of bereavement in children and young people.

Physical health
There are limited indicators for physical health in children and young people which can be reviewed in the context of ethnicity.

Black African and Black Caribbean girls have a higher body mass index (BMI) than White girls at age 11-13 (data for boys it was unclear with variation between studies). However, BMI was shown to overestimate the negative health effects of being overweight or obese in Black children because it fails to account for body composition. The body fat on average is lower in Black children and their increased height plays a part too.

The overweight and social economic status (SES) patterning varied by ethnicity with lower SES awarding higher risk of being overweight or obese for White children than Black children. However, for adolescents having overweight or obese parents could suggest they may be on the path of following suit.

Mental health and emotional wellbeing
Black African and Black Caribbean children and young people generally reported higher levels of mental wellbeing than White participants in the same studies. However, one study found that Black Caribbean children described higher levels of social difficulty at seven years old. Family activities and cultural integration (identified as ethnically diverse friendship circles) were also shown to have a protective 'bubble' effect.

Risky behaviours
White and Mixed ethnicity young people reported higher levels of substance misuse than Black young people, and Black Caribbean young people were most likely to report having unprotected sexual intercourse. Black African young people generally had fewer risky behaviours than Black Caribbean young people.

Physical activity levels were not lower in Black children, but cultural factors may affect parents' engagement with out-of-school sporting and exercise activities.

Educational attainment
Black African and Black Caribbean children on average report higher levels of aspiration than White children in areas including school. However Black Caribbean pupils on average have lower levels of academic attainment, including after adjustment for socioeconomic status (SES). The determining factors such as status in society and family achievement explain some but not all the reasons for poorer results. Black Caribbean and Black African children are less likely to be entered into higher-tier examinations by teachers compared to White children even where prior academic attainment is the same, so this is limiting their grades.

The high achievement by Black children was associated with a range of individual, family and school factors. Individual factors included good attendance at school, completing homework, aspiration to attend school beyond GCSE and the development of resilience, protecting against negative school experiences. Family factors included maternal education and employment with parental involvement in education. The education factors included the

[35] Campbell, D. (2020) *Covid-19 affects BAME youth mental health more than White peers – study*. The Guardian

recognition and celebration of cultural diversity especially the cultural identities of Black pupils in the school setting.

Social inclusion
Black young people in contact with Youth Offending Services may not have equal access to healthcare, with mental health needs less likely to be identified and supported. Young Black men's early exposure to 'adult' styles of policing may create feelings of unsafety and social exclusion.

Black children's on-average over-representation in the care system is heavily characterised by SES, locality, and type of intervention. The variation includes under-representation in more disadvantaged areas compared to White children, but over-representation in less deprived areas compared to White children.

In Black African and Black Caribbean populations engagement with a variety of health services may be lower, including immunisation, Child and Adolescent Mental Health Services (CAMHS), and being registered with a dentist. The causes of variation will be noted to sub-populations, with culture, language and prior experience of health services affecting individuals' engagement.

Key findings [INFOGRAHPICS]

Headline: **Black children and young people are more likely to:**

- be overweight
- live in low-income families
- be identified as NEET (Not in Employment, Education or Training)

Headline: **Child poverty in the UK**
Black children are now **more than twice** as likely to be growing up poor as white children

Headline: **Black child poverty in the UK**
The proportion of Black children living in poverty went up from 42% in 2010-11 to 53% in 2019-20

Headline: **Permanent exclusions in the UK**
Black Caribbean children and young people are 2.5 times more likely to be permanently excluded than White British children

What did we find from the community & Board engagement?

In Birmingham, Black young people were consulted as a group, whilst in Lewisham, we conducted one-to-one interviews. This gave us the opportunity to understand their overall experiences including those in education, physical environment, family, social environment, money, employment, and activities that influenced health.

Positive changes in health behaviour

The conversations being heard in our engagement activities with local communities were very different. We discovered that the participants all took part in physical exercise and had access to healthy food. Young people's primary school educational experience was positive, and they had lots of support. Inevitably, as the participants became older, they encountered more social and emotional challenges in life.

What did young people say?

Physical environment and family

"Having to move from my family to foster care was very scary, not knowing where I was going at the time affected me mentally."

Food

"Chicken and chips after school, for a lot of people is a trendy thing to do and I am not sure if people generally want it."

Belonging

"Especially in university because I felt like I no longer fit into Lewisham (and with friends I had growing up) and neither did I fit in the university context."

Opportunities for action

Theme 3: Children and young people	
Who	**Opportunities for action**
Education settings supported by the Regional Schools Commissioner and local Councils	1. Provide guidance and support for Black African and Black Caribbean parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.
Local Integrated Care Systems (ICS), Mental Health Trusts & Council commissioned Healthy Child Programme Providers	2. Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.
Education settings supported by the Regional Schools Commissioner and local Councils	3. Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people.
Local Health and Wellbeing Board and NHS Integrated Care System	4. Address low pay and associated poverty for frontline workers who are disproportionately of Black African and Black Caribbean heritage.
Local Council Director of Children's Services and Strategic Children's Partnerships	5. Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.
Local Councils and climate change and air quality partners	6. Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.

NHS Integrated Care Systems and Health and Wellbeing Board	7. Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Theme: Ageing well

"Black people in their 50s and 60s have significantly lower weekly income than their White peers, are less likely to own their home outright and are more likely to live in deprived areas".

Centre for Ageing Better[36]

One of the ways of considering how well people are living in later life is to look at healthy life expectancy, this is a measure of the number of years and individual living in a particular area can expect to live without chronic disease or disability and it is calculated at birth and at 65yrs.

Within the UK, males at age 65 in the least deprived areas could expect to live 7.5 years longer in "Good" health than those in the most deprived areas. For females, the difference is 8.3 years.[37] Within Birmingham, the difference in life expectancy when comparing the most deprived and least deprived areas is 8.9 years for males and 6.6 years for females.[38] Between the most and least deprived areas in Lewisham, there is a difference in life expectancy of 7.4 years for males and 5.6 years for females.[39] People living in the most disadvantaged areas of England spend nearly a third of their lives in poor health.[40]

According to the Office for National Statistics, a disproportionate percentage of those living in the ten per cent most deprived neighbourhoods are from ethnic minorities. 15.6% of Black African people and 14.1% of Black Caribbean people live in the most 10% of deprived areas.[41] This correlation between ethnicity and place is particularly important for older adults who are less likely to move between areas in later life, this makes 'place based approaches[42]' even more important for older adults from ethnic communities.

The British Medical Journal (BMJ) discusses in an article: "older people from ethnic minorities are one of the most disadvantaged and excluded groups in society. Understanding the pathways leading to ethnic inequalities in older age requires research on these complex processes and how they link different life experiences to health and social outcomes in later life. This nuanced understanding would allow us to develop responses to these inequalities."[43]

We discussed several themes and trends relating to the health inequalities experienced by Black African and Black Caribbean older adults:

- Life expectancy
- Chronic conditions
- Suicide
- Loneliness
- Mental Health
- Frailty falls and hip fractures.

[36] Centre for Ageing Better (2020) *Ethnic inequalities among over 50s revealed in new research*
[37] Office for National Statistics (2016) *Population, People and the Community: Healthy life expectancy at birth and age 65 by upper tier local authority and area deprivation: England, 2012 to 2014*
[38] Public Health England (2018) *Protecting and improving the nation's health*
[39] Lewisham Health Inequalities Toolkit (2021)
[40] Public Health England (2018) *Chapter 5: Inequalities in Health*
[41] Office for National Statistics (2020) *People living in deprived neighbourhoods*
[42] Public Health England (2021) *Place-based approaches for reducing health inequalities: Main report*
[43] Bécares, L., Kapadia, D. and Nazroo, J. (2020) 'Neglect of older ethnic minority people in UK research and policy', *British Medical Journal* 368, doi:10.1136/bmj.m212

Health behaviours influences include:

- Smoking
- Physical activity
- Diet
- Drugs
- Alcohol
- Vaccinations.

Wider health determinants include:

- Income and debt
- Housing
- Education and skills
- Natural and built environment
- Access to goods and services
- Racism and discrimination.

What did we find from the rapid review?

Smoking: The rates remain high for White British and Black Caribbean men. Elderly smokers are twice as likely as non-smokers to develop certain cataracts, and smoking can double the likelihood of developing advanced diabetic retinopathy.[44]

Indicators of wellbeing: In older people aged 65 to 74 it was revealed that Black people are more likely to report life satisfaction and happiness compared to White people. However, some were also likely to report anxiety compared to other groups.

Depression: There is some evidence of a higher prevalence of depressive symptoms within the Black Caribbean communities than people of White ethnicity; in addition, being aged 75 and above combined with being from an ethnic minority community is a risk factor for loneliness.[45] [46]

Dementia: Black African and Black Caribbean communities have a higher prevalence of dementia (9.6%) than in White groups (6.9%). They are also at risk of developing vascular dementia nearly eight years earlier than their White British counterparts[47].

Cancer: While the overall rate of emergency colorectal cancer surgery is reducing, elderly patients, those from a lower income background and Black African and Black Caribbean patients remain at high risk of emergency attendance.[48]

Falls: Black women are at higher risk of death after a fall compared to White women. Exploring frailty, falls, and hip fractures by gender, older black Caribbean women are more at risk of frailty than men of the same age.[49] [50]

---

[44] National Health Service (2022) *Smoking and your eyes*

[45] Scharf, T. et al. (2002) *Growing older in socially deprived areas: Social exclusion in later life*. Help the Aged.

[46] Victor, C. R., Burholt, V. and Martin, W. (2012) 'Loneliness and ethnic minority elders in Great Britain: an exploratory study,' *J Cross Cult Gerontol* 27(1), pp 65-78. doi: 10.1007/s10823-012-9161-6.

[47] Adelman, S. et al. (2011) 'Prevalence of dementia in African–Caribbean compared with UK-born White older people: Two-stage cross-sectional study,' *British Journal of Psychiatry*, 199(2) pp 119-125. doi:10.1192/bjp.bp.110.086405

[48] Askari, A. et al. (2015) 'Elderly, ethnic minorities and socially deprived patients at high risk of requiring emergency surgery for colorectal cancer,' *Gut*

[49] Klop, C. et al. (2017) 'The epidemiology of mortality after fracture in England: variation by age, sex, time, geographic location, and ethnicity,' *Osteoporos Int*. 28(1), pp 161-168. doi: 10.1007/s00198-016-3787-0.

[50] Williams, E. D., Cox, A. and Cooper, R. (2020). 'Ethnic differences in functional limitations by age across the adult life course', *The Journals of Gerontology* 75(5), pp 914–921

Cardiovascular: The risk factors are higher in Black Caribbean populations compared to the White population.[51]

Death at home: This was significantly less likely in Black African and Black Caribbean individuals. Compared to the White population, Black Africans and Black Caribbean's are less likely to die at home (52% and 22%, respectively). The evidence suggests that African and Caribbean older adults make end-of-life decisions with a significant emphasis on family structure, religion and spirituality, cultural identity, migration, and communication. Other research suggests the differences become barriers when trying to access specialist care in various settings.

The main causes of inequalities in this age group are:

- poorer mental health for people of Black ethnicity
- higher deprivation levels
- barriers in accessing specialist care in different healthcare settings
- lack of culturally competent and sensitive approaches
- lack of culturally and religiously sensitive services to support with end-of-life care.

Key findings [INFOGRAHICS]

Headline: **Scores of wellbeing in older people (65-74 years) by ethnicity (out of 10)**

- Life satisfaction – Black (7.9), White (7.7)
- Happiness – Black (8.0), White (7.7)
- Worthwhileness - Black (7.9), White (7.9)
- Anxiety - Black (3.2), White (2.7)

Headline: **Dementia prevalence by ethnicity**
Black people – 9.6%
White people – 6.9%

Headline: **Risk of developing cardiovascular dementia**
Black African and Black Caribbean 10 years earlier than other ethnic groups

Headline: **Proportion of deaths at home by ethnicity**
White population – 52%
Black Africans and Black Caribbean's - 22%

[ADD IMAGE BELOW AS INFOGRAPHIC]

[51] Birmingham City Council (2021) *What is the impact of health inequalities on Black African and Black Caribbean older people in the UK?*

What did we find from the community and Board engagement?

"Sense that care homes are uncaring and prefer end of life being at 'home'. Elderly feel they are not getting the care they deserve in care homes"
Lewisham community member

Accessibility
We need to gather further research on the accessibility issues older Black African and Black Caribbean individuals face when accessing good quality care and health screening opportunities. We can consider topics such as othering (not fitting in with the norms of a social group) and deprivation. Surveys will help us to obtain the information about the lived experience using focus groups from this community.

Cultural expertise
Cultural expertise needs to improve through providing cultural awareness training in care homes and hospitals. The needs of older Black African and Black Caribbean individuals must be met in an institutional setting. This can be achieved by using a peer development support model.

Unpaid care
To achieve better understanding through a specialised focus group with older Black people and their unpaid carers. This will help us to understand the experience older adults face within social care services and the reasoning for opting to care at home rather than in an institutionalised setting.

End of life treatment
A personalised end of life care treatment programme needs to be put in place for older Black African and Black Caribbean people based upon better cultural understanding. This will be co-developed with the individual and their carer to appreciate family practices and the importance of culturally sensitive issues.

Training
Elderly Black African and Black Caribbean people have different cultural attitudes to care and support needs. It is important to think beyond faith settings to engage with older Black African and Black Caribbean adults appropriately. There is a need to provide training to ensure expertise in cultural awareness for health care professionals.

Community
Black African and Black Caribbean older adults frequently suffer from loneliness and isolation. However, there is a lack of evidence to suggest whether interventions offering tailored support for elderly Black African and Black Caribbean adults effectively reduce loneliness and isolation.

Opportunities for action

Theme 4: Ageing well	
Who	**Opportunities for action**
Regional NHS England teams and	1. Provide targeted and culturally appropriate screening services Black African and Black Caribbean older adults.

Local Public Health teams	
Local Public Health Teams	2. Campaign to raise awareness and increase uptake of community-based NHS health checks in Black African and Black Caribbean older adults.
NHS Integrated Care System Boards	3. Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.
NHS England and NHS Integrated Care System Boards	4. Support initiatives to improve uptake of vaccinations in older African and Caribbean people, focusing on areas of higher deprivation.
Local Health and Wellbeing Boards and NHS Integrated Care System Partnerships	5. Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

Theme: Mental health and wellbeing

"There are still strong religious connections and thoughts about mental health and these needs changing and tackling as does the perception [of mental health] within the community and shame in the family."

Birmingham community member

"[Mental health is] not spoken about. Awareness raising is needed within the community as well as in the health care services."

Lewisham community member

Mental health and wellbeing are fundamental parts of our overall health, there is no physical health without mental health and we cannot be fully well without being in a positive state of wellbeing. While this is an incredibly important part of our overall health there is very limited data available on wellbeing or on mental health in African and Caribbean communities.

Stereotypes create a misconception of how people are and how they live in other cultures, religions, or countries causing problems such as discrimination and fuelling hate crimes. Negative and even positive stereotyping can lead to prejudging others based on interpreting one side of the story. These can damage individual and community wellbeing and also lead to mental health issues. Stigma is also a major barrier within communities to seeking help and support when mental health issues are developing and this can lead to worse outcomes for individuals and a vicious downwards spiral of isolation and marginalization.

We explored in this theme research literature reporting on mental health inequalities for men and women from Black African and Black Caribbean communities in the UK. As well as disproportionately high rates of mental health need, these groups face, in some circumstances, stigmatised views held by mental health service providers that Black people are dangerous, leading to misinterpretations of the nature and degree of their illnesses.

The evidence highlighted that Black African and Black Caribbean people have less access to effective and relevant support for their mental health. Where support is accessed, the experiences and results for Black individuals are often less effective and, in some circumstances, can cause harm. Therefore, BLACHIR considered mental health inequalities for topical research including collaborative community participation.

We identified evidence of inequalities in mental health experiences and results for African and Caribbean communities. The findings were reinforced by qualitative evidence from their lived experiences shared by representatives of the communities through local engagement and observations from members of the Advisory Board.

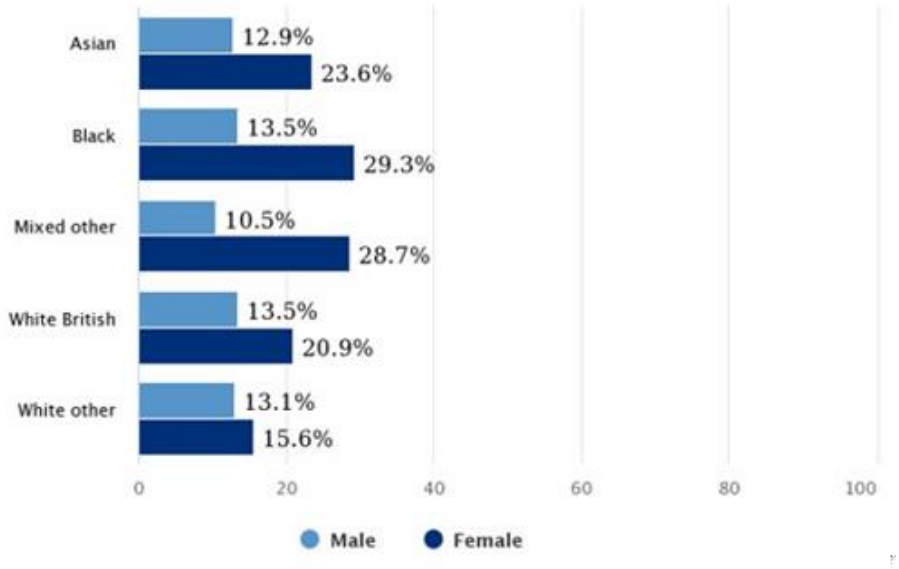
What did we find from the rapid review?

Insight was obtained from the evidence review, community engagement and stakeholder group sessions. It provides opportunities for action to improve African and Caribbean populations' access to support and services.

According to a national survey completed in 2014, 29% of Black women had experienced a common mental disorder in the past week, a higher rate than for women from all other ethnicities including Asian, White British and White other ethnic groups[52] (Figure 14).

[52] NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*

Figure 9: The percentage of adults who experienced a common mental disorder in the past week by sex and ethnicity



Alternative text: According to a national survey completed in 2014, 29% of Black women had experienced a common mental disorder in the past week, a higher rate than for women from all other ethnic groups including Mixed Other (28.7%) Asian (23.6%), White British (20.9%) and White other (15.6%) ethnic groups. Black men (13.5%) also had high rates of a common mental disorder, compared to White British (13.5%), White Other (13.1%), Asian (12.9%) and Mixed Other (10.5%).

Black Caribbean young men are three times more likely to have been in contact with mental health services before committing suicide, compared to their White counterparts.[53] Psychosis was consistently higher in Black populations, in particular males; findings were less conclusive regarding depression and anxiety.**Error! Bookmark not defined.**

Despite this evidence of increased mental health need, Black African and Black Caribbean people of all ages reported to under use mental health services due to social stigma, language barriers, poor mental health literacy and reluctance to discuss psychological stress.[54]

White British people are more likely to have received treatment for emotional and mental health problems compared to all other ethnic groups (14.5%). In comparison, Black adults had the lowest treatment rate (6.5%).[55]

Looking specifically at talking therapy treatment, in the NHS Improving Access to Psychological Therapies (IAPT) there is a lower rate of Black African and Black Caribbean people being offered IAPT services, and where services are offered individual drop out is more likely.[56]

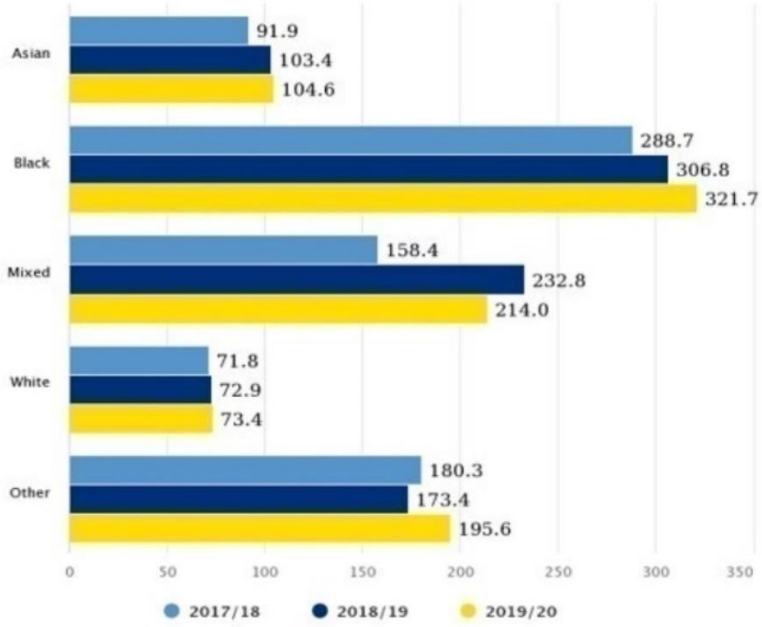
Black populations were less likely to access mental health support through traditional services. Black Africans found help from community leaders, particularly those associated with religion.**Error! Bookmark not defined.** Seeking help elsewhere, I.e. not from clinical increased the likelihood of accessing treatment at the point of crisis or breakdown. This increased risk of

[53] Lankelly Chase Foundation, Mind, The Afiya Trust and Centre for Mental Health (2014) *Ethnic inequalities in mental health: Promoting lasting positive change*
[54] NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*
[55] NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*
[56] Public Health England (2022) *Fingertips: Public Health Profiles*

being detained under the mental health act and through the Criminal Justice System. Black populations were also more likely than British White populations to experience re-admission.[Error! Bookmark not defined.]

Hospital admissions for Black Caribbean and Black African patients were more frequent, longer, and often involved the police, when compared to White patients.[Error! Bookmark not defined.] One of the most serious forms of intervention for people who are mentally unwell is to detain them under the Mental Health Act. Black people are four times more likely to be detained under the Mental Health Act than White people.[57] Black Caribbean people had the highest rate of detention out of all ethnic groups (excluding groups labelled 'Other'), with 275.8 detentions per 100,000 people in the year ending March 2020. The highest rates of detention were for the Black Other, Any Other, and Mixed Other ethnic groups – but these are overestimates because 'Other' categories may have been used for people whose specific ethnicity wasn't known[58] (Figure 10).

Figure 10: The number of detentions under the mental health act, per 100,000 people, by aggregated ethnic group



Alternative text: In the year ending March 2020, the number of detentions under the mental health act, per 100,000 people was highest in people of Black ethnicity (321.7), followed by Mixed (214.0), Other (195.6), Asian (104.6) and people of White ethnicity (73.4).

There is very little data on wellbeing that can be analysed by ethnicity, the national adult population survey is not published routinely with ethnicity data. However, the Sport England Active Lives survey includes wellbeing questions for adults, but the sample size means that looking at this by ethnicity in Lewisham is not possible in individual years. The most recent data from the May 2020-2021[59] survey found that:

- Nationally the average anxiety score was lower for Black participants (3.19) than for White British participants (3.51). In Birmingham the gap was even more pronounced 2.10 compared to 4.02.

[57] NHS Digital (2020) *Mental health act statistics, annual figures*
[58] NHS Digital (2021). *Detentions under the mental health act*
[59] Sport England (2022) *Active Lives survey data*

- Life satisfaction scores were similar nationally between Black (6.90) and White British (6.89) participants but in Birmingham Black participants had a higher level of life satisfaction (7.74 compared to 6.51).
- The average Happiness scores were higher nationally for Black participants (7.16) than in White British (6.97) and a similar pattern was reflected in Birmingham (8.17:6.63).
- The final dimension looked at feelings of being Worthwhile. Nationally levels were similar between Black (7.28) and White British participants (7.16), but in Birmingham there were higher levels of positive responses in Black participants (8.23) than in White British(6.79).

Key findings [INFOGRAPHICS]

Headline: **29% of Black women had experienced a common mental disorder in the past week**

Headline: **Black Caribbean young men are 3 times more likely to have been in contact with mental health services before committing suicide compared to White young men**

Headline**: Black people are 4 times more likely to be detained under the Mental Health Act than White people**

Headline: **Black adults have the lowest emotional and mental health treatment rates (6.5%) compared to White adults (14.5%)**

What did we find from the community and Board engagement?

"Racism, stigma and culture play a role in the way our communities view mental health services. Sometimes, they cause more harm than good."

Birmingham community member

"Too quick to label black children as mentally disturbed" with "many ending up with the wrong diagnosis and put in inappropriate places"

Lewisham Community member

"When I step out my door, I do not see the greenery I once used to see. I see a decision made by privileged White men to surround my home with large warehouses and business. Nobody thought it would affect my mental health or wellbeing, not even gave the opportunity of consultation."

Birmingham community member

Inclusion and mental health

Structural issues, such as poverty, deprivation, and racism, must be recognised as key factors contributing to African and Caribbean communities' poor mental health. Addressing this at both institutional and societal levels will create a sense of belonging in the community. The role of urban governance, including the Integrated Care System (ICS) must be explored further and strengthened. Media coverage is largely negative and stigmatising which contributes to poorer mental health outcomes.

Cultural expertise in mental healthcare

There is a lack of or limited understanding of cultural needs and backgrounds with different Black communities. Health professionals must develop better cultural understanding in mental health services when caring for Black African and Black Caribbean patients.[60]

Community support

Grassroots and faith organisations are often unfamiliar to health professionals and for that reason they are not well engaged with community assets. We must use the assets and collaborate with mental health services to provide effective support in the communities. Working with peer, personal support networks and professional networks is essential. We can skill-up more young people and community groups in mental health first aid to reduce stigma, increasing opportunities to help.

There were concerns whether the services are appropriate and provide formal training. One individual stated that commissioned services must be "formally regulated and evaluated."

Health literacy and early intervention were addressed as being important in mental healthcare. For that reason, mental health champions could play a vital role in community inclusion improving mental health delivery.

Opportunities for action

Theme 5: Mental health and wellbeing	
Who	**Opportunities for action**
Local Public Health and Community Mental Health Trusts	1. Coproduce awareness campaigns aimed at Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Local NHS providers and Community Mental Health Trusts	2. Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
NHS Mental Health Providers and Commissioners	3. Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.
Local Health and Wellbeing Boards and NHS Integrated Care Partnerships Boards	4. Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and NHS Integrated Care Systems	5. Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

[60] Birmingham and Lewisham Black African and Black Caribbean Health Inequalities Review (BLACHIR) (2021) *Mental Health Theme: Systematic Review (sharepoint.com)*

Theme: Healthier behaviours

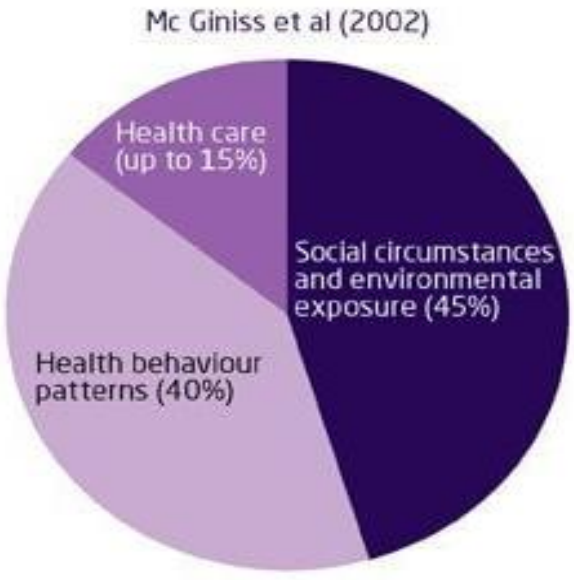
"Stop opening up fast food chains in areas of deprivation where you can get chicken and chips for £1.99 or feed a family for £9.99. Why would you sit and cook a meal for a family of five when this is on offer across the road?"

BLACHIR engagement participant

Many of the things we do each day have an impact on our health, from our diet to the amount of physical activity we take, these behaviours reduce our risk of developing conditions like diabetes and dementia and when we have illness and disease we can often improve our quality of life and reduce complications through positive health behaviours as well as clinical treatment.

Health behaviours don't happen in isolation, they are a reflection of our upbringing, our culture and heritage, our environment and social circumstances as well as our understanding of our own bodies and the health benefits of doing them. Health behaviours are a significant driver of health outcomes and the health of a population (Figure 11).

Figure 11: Broader determinants of health on population health[61]



Alternative text: McGiniss et al (2002) found that the drivers of health outcomes on population health could be broken down into the following proportions. Social circumstances and environmental exposure was the largest determinant at 45%, followed by health behaviour patterns at 40% and healthcare up to 15%.

The key behaviours that impact on the risk of death and disease are:

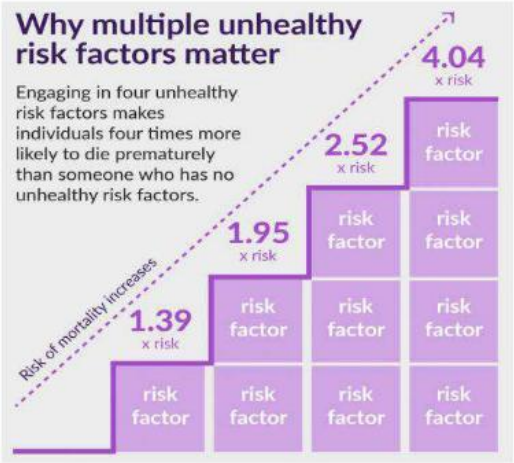
- Physical Activity
- Diet and nutrition
- Smoking, drugs and alcohol

[61] McGinnis, J. M., Williams-Russo, P. and Knickman, J.R. (2002) 'The case for more active policy attention to health promotion,' *Health Affairs* 21(2) pp 78-93.

Other behaviours such as social connection are increasingly being understood as risk factors as well through the evidence of the negative impacts of loneliness on mortality risk.

Research shows that clustering and compounding unhealthy behaviors contribute to inequalities. The number of unhealthy behaviours a person has creates a multiplier effect. After 11 years, an individual with all four risk factors had a four-fold risk of dying compared with someone who ate well, exercised and didn't smoke or drink to excess.[62]

Figure 12: The risk of mortality from engaging in unhealthy risk factors[62]



Alternative text: The risk of premature mortality increases in an upward trajectory with a higher participation in risky behaviours. Engagement in one risk factor increases the risk of premature mortality by 1.39 times compared to those who engage with no unhealthy risk factors. The risk is 1.95 times greater with engagement of two risk factors, 2.52 times at three risk factors and 4.04 times the risk in those who engage with four risk factors.

Understanding the health behaviours of Black African and Black Caribbean people in the UK, and what creates them, will help in planning effective interventions that reduce health inequalities.

Alcohol harm paradox

Disadvantaged groups can suffer greater harm with similar exposure when consuming alcohol. This has been identified as the 'Alcohol harm paradox' in a study by Alcohol research UK entitled: *Understanding the alcohol harm paradox to focus the development of intervention*.[63]

People from deprived areas who have the same or a lower level of alcohol consumption suffer greater alcohol-related harm than those from more affluent ones. Lower individual and neighbourhood socioeconomics are associated with higher rates of alcohol-related conditions and death or hospitalisation.[64]

[62] Khaw, K. T. et al (2008) 'Combined impact of health behaviours and mortality in men and women: The EPIC-Norfolk Prospective Population Study,' *PLOS Medicine*, 5(3) pp 70. doi.org/10.1371/journal.pmed.0050070
[63] Alcohol Research UK (2015) *Alcohol Research UK reports: The alcohol harm paradox, intuition school programme, social networks and alcohol identities, sight loss - Alcohol Policy UK*
[64] Bloomfield, K. (2020) 'Understanding the alcohol-harm paradox: what next?', *The Lancet Public Health*

A similar relationship can be seen in harms related to gambling where lower rates of gambling by people in poorer areas had higher rates of harm compared to people in more affluent areas.[65]

Unfair odds

"Poundland and off licences are higher in deprived areas while the healthy areas get all the fancy foods and they get the bike lanes too."
BLACHIR engagement participant

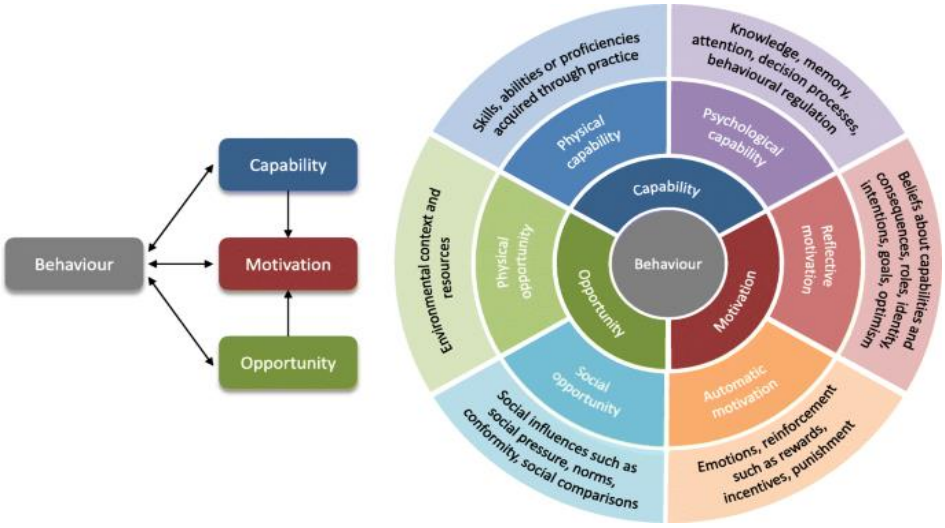
The decisions we make are often influenced by our peer group, family, social status, and the wider community. A sense of belonging is important for many people and the way we behave can be shaped by the environment in which we live.

In this analysis 'fast food' refers to energy dense food that is available quickly, covering a range of outlets that include burger bars, kebab and chicken shops, chip shops, and pizza outlets. The number of fast-food outlets in local authorities across the UK ranges from 26 to 232 per 100,000 population.[66]

The UK's most deprived areas have almost 10 times more the number of betting shops than the most affluent parts of the country.[67]

What can be done to enable behaviour change?

Figure 13: Behaviour change is a complex landscape: COM-B model of change[68]



Alternative text: The COM-B model of change proposes a bi-directional relationship between behaviour and capability, motivation and opportunity. In addition, it proposes that both capability and opportunity influence motivation.

The behavior change wheel suggests that capability includes psychological (skills, abilities or proficiencies acquired through practice) and physical capability (knowledge, memory, attention, decision processes, behavioural regulation).

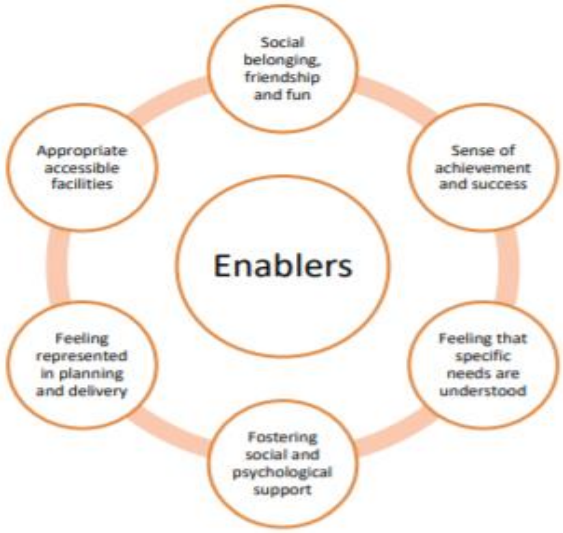
[65] Public Health England (2021) *Gambling-Related Harms: Evidence Review*
[66] Public Health England (2018) *Fast Food Outlets: Density by Local Authority in England*
[67] Russon, M-A. (2021) *Gambling: Poorer UK towns found to have the most betting shops, study shows BBC News*. BBC News
[68] Michie, S., van Stralen, M. M. and West, R. (2011) 'The behaviour change wheel: A new method for characterising and designing behaviour change interventions,' *Implementation Sci* 6(42) doi.org/10.1186/1748-5908-6-42

Opportunity includes physical opportunity (environmental context and resources) and social opportunity (social influences such as social pressure, norms, conformity, social comparisons).

Motivation includes automatic motivation (emotions, reinforcement such as rewards, incentives, punishment) and reflection motivation (beliefs about capabilities, consequences, roles, identity, intentions, goals, optimism).

For example, there is a call to address inequalities in the uptake of physical activity by tackling several enabling factors which contribute to behaviour change in relation to exercise.

Figure 14: PHE enablers of behaviour change



Alternative text: PHE enablers of behaviour change include:

- social belonging, friendship and fun
- appropriate accessible facilities
- sense of achievement and success
- feeling that specific needs are understood
- fostering social and psychological support
- feeling represented in planning and delivery

What did we find from the rapid review?

The rapid review looked at survey data across our populations and in the national data sets. Often national surveys do not present or analysis ethnicity at the level of local authorities for behavioural factors which limits our understanding.

The survey data highlighted the most significant inequalities are in physical activity and diet and nutrition behaviours whereas in many other areas Black populations have healthier behaviours.

Exercise

The evidence from national data analysis in the Active Lives Survey 2019/2020[69] revealed that physical activity is lower in the Black population than the White British population. This pattern was reflected in local data in the Nov 2019/20 survey %[70] for Birmingham but there

[69] Sport England (2021) *Active Lives Adult Survey November 2019/20 report*
[70] Sport England (2022) *Active Lives Survey Data*

were some differences for Lewisham, and overall rates of physical activity in Lewisham are higher than in Birmingham:

- Nationally the percentage of people (White British vs. Black) aged 16 years and over who were physically active between November 2019 and November 2020 were 63.1% vs. 53.3%[71].
- The percentage of Black people, aged 16yrs and over, achieving the recommended 150 minutes of physical activity every week in Birmingham was 54% compared to 53.3% nationally but in Lewisham it was much higher at 66.3%.
- The percentage of Black people achieving 30 minutes of less of physical activity, and classified as inactive, in Birmingham was 29.2% compared to 26.0% nationally but there was not a large enough sample in Lewisham to report on this.
- Nationally the percentage of physically active children and young people in Black communities (35.7%) was lower than in White British (47.7%) communities[72]. The sample of the survey is too small to provide data at a local area by ethnicity.
- Percentage of adults walking for travel at least three days per week (White British vs Black) – 14.7% vs 16.1% between 2019 and 2020[73].
- Percentage of adults cycling for travel at least three days per week (White British vs Black) – 2.2% vs 1.0% between 2019 and 2020[72].

Smoking

The national data for 2020 on smoking suggests that rates of current smoking are lower in Black communities than in White communities but are highest in those who identify with a Mixed ethnicity:[74]

- Mixed ethnicity – 17.1%
- White ethnicity – 12.6%
- Black ethnicity - 7.8%

Diet

We monitor dietary habits in population surveys through asking about the average daily consumption of five portions of fruit or vegetables, known as '5-a-day'. In 2017/18 nationally, the lowest percentages of those achieving '5-a-day' across ethnic groups was seen amongst Black adults (44.2% vs. 55.9% of White British adults).[75]

Alcohol

Data from 2014 showed nationally rates of those with hazardous, harmful or dependent alcohol levels was lower amongst people of Black ethnicity. 6.6% of Black men were featured in this category, compared to 30.8% of White British men. A similar pattern was observed amongst women (Black women = 7.4%; White British women = 14.8%)[76]

Sexually transmitted infections

The population rates of STI diagnoses is high among people of Black ethnicity nationally but varied amongst Black Caribbean and Black African ethnic groups. For example, in 2020, people of Black Caribbean ethnicity had the highest diagnosis rates of gonorrhoea and

[71] Department for Digital, Culture, Media and Sport (2022) *Ethnicity facts and figures - physical activity*
[72] Public Health England (2022) *Fingertips: Physical activity*
[73] Department for Digital, Culture, Media and Sport (2020) *Ethnicity Facts and Figures – Physical Activity*
[74] Public Health England (2022) *Fingertips: Local tobacco control profiles*
[75] Department for Digital, Culture, Media and Sport (2020) *Ethnicity Facts and Figures - Healthy Eating Amongst Adults*
[76] NHS Digital (2018) *Ethnicity Facts and Figures – Harmful and Probable Dependent Drinking in Adults*

trichomoniasis, while people of Black African ethnicity had relatively lower rates of these STIs.[77]

There are also significant differences in HIV infection between Black African and Black Caribbean communities. In the 2020 data on people newly diagnosed with HIV and accessing HIV care in England there were 526 new cases in Black African people with almost 60% of these being in women compared to only 55 in Black Caribbean and 62 in Black Other ethnic groups. In Black African (42%) and Black Other (53%) the percentage of people diagnosed with HIV late was higher than for White British (38%) but it was similar for Black Caribbean (37%), it is important to note that this difference is consistent when looking just at HIV diagnosis in people most likely exposed in the UK, suggesting that late diagnosis in Black African and Black Other communities is not just due to migration factors.[78]

Adult obesity

The percentages of adults who are overweight or obese is highest in people of Black ethnicity. In 2019/2020 the national data shows that 67.5% of Black adults were overweight/obese which is higher than White British (63.7%). The rates over excess weight in Black communities has decreased from 73.6% in 2018/19.[79]

Literature review

For this theme we were able to commission an academic provider to undertake a literature review. In the literature review, a total of 66 articles on Birmingham and 51 on London were included in research. Studies were dominated by the themes of mental health (n=77, 24.6%) and HIV/sexual health (n=53, 17%). There were 63 studies (20%) addressing the four areas of principal behavioural risk: physical activity (n=22, 7.1%), alcohol (n=17, 5.5%), smoking (n=16, 5.1%), diet/feeding practices (n=15, 4.8%).

This review has established that health behaviours result from a complex mix of individual and social factors. We often present individual behaviours in the context of the social circumstances in which they occur. Help seeking behaviour means, quite simply, admitting a need for support and relying on others for assistance. However, because of getting help from family, peers or the community this meant that health care was not being used as much.

More noticeable finding was, consistent to sociocultural factors (wider forces in cultures that affect the thoughts, feeling and behaviours), creating barriers to using health care services. These factors are obvious when looking at people being able to access mental health services. This is more heavily detailed in the mental health theme.

Cultural norms (the standards we live by) perceptions and practices among Black African and Black Caribbean people influenced behaviour risks to health. We could see this in people's choice of diet, how they fed their babies and young children, childhood weight and physical activity. Exposing parts of the body can be cultural and result in a barrier to seeking care because of feeling embarrassed.

Key findings [INFOGRAPHICS]

Headline: **Percentage of physically active adults by ethnicity**
White British – 63.1%
Black – 53.3%

[77] Public Health England (2020) *Sexually transmitted infections and screening for chlamydia in England, 2020*
[78] UK Health Security Agency (2021) *Official Statistics. HIV: Annual data tables*
[79] Sport England (2021) *Ethnicity Facts and Figures – Overweight Adults*

Headline: **Percentage of adult smokers by ethnicity**
White British – 14.4%
Black – 9.7%

Headline: **Percentage of adults achieving '5-a-day' in their diet by ethnicity**
White British – 55.9%
Black – 44.2%

Headline: **Harmful or dependent alcohol consumption by ethnicity and gender**

Black men – 6.6%
White British men – 30.8%

Black women – 7.4%
White British women – 14.8%

Headline: **Obesity in adults by ethnicity**
White British – 63.7%
Black adults – 67.5%

What did we find from the community and Board engagement?

The following quotes provide a summary of key findings from the engagement with members of the local Black African and Black Caribbean communities.

"Develop a positive health behaviours programme that does not require pharmaceutical intervention - this is fundamental".

"The 'big and Black is best' belief is very preached - trying to change the thoughts and attitudes towards being overweight and obese will require an entire cultural shift through populations - with the anti-establishment feelings/attitudes that exist I don't hold out much hope."

"Representation at the decision-making levels will not only help to create more appropriate strategies for our communities but also help to improve levels of trust in the system which is one of the fundamental issues."

The engagement highlighted the need for more culturally appropriate approaches to behaviour change in Black African and Black Caribbean communities and there were several discussions about how these need to recognise the barriers of trust and the need for recognition of culture and heritage in the approaches.

Opportunities for action

Theme 6: Healthier behaviours	
Who	**Opportunities for action**
Local Directors of Public Health	1. Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health

	behaviours, including health literacy training, social prescribing initiatives and group interventions.
Health Education England	2. Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
Local Councils and NHS Integrated Care Systems	3. Provide long-term investment for trusted Black African and Black Caribbean grass roots organisation such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Local Directors of Public Health	4. Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.
Research funding bodies such as National Institute for Health Research (NIHR)	5. Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in 'action research' to concurrently deliver and evaluate interventions.
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	6. Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

Theme: Emergency care, preventable mortality and long-term physical health conditions

"[Information]…to be in a format that is understood."
Lewisham community member

"… services just want to give out medication and I find I can't relate to the service professionals."
Lewisham community member

The important principle behind public health is the prevention of ill health through the promotion of healthy behaviours. In this review, we have established the worrying trends in health inequalities leading to lower life expectancy for some groups, especially those from Black African and Black Caribbean deprived communities. The impact of these inequalities is played out in people becoming unwell and requiring emergency care, developing long term physical health conditions and dying prematurely.

We focused on exploring research literature that reported on the inequalities in 'Emergency Care and Preventable Mortality, and Long-Term Physical Health Conditions' for men and women from these African and Caribbean communities in the UK. When considering the inequalities (access, experience and outcomes) we were focusing on evidence of differences in the results that we could measure between the community groups.

Higher rates of acute disease and emergency care were experienced by Black African and Black Caribbean communities compared to their White equals. For example, there are higher numbers of bad outcomes and preventable deaths across these groups relating to COVID-19, maternity and stroke.

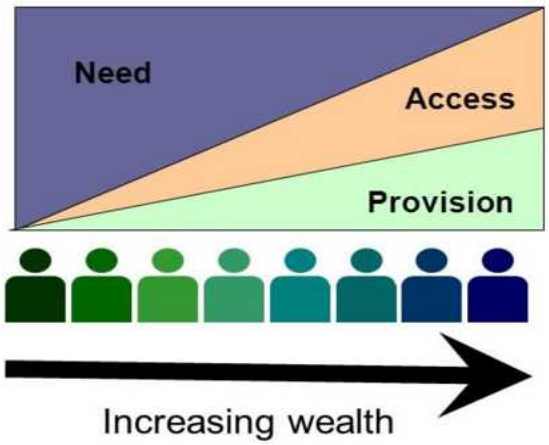
Inverse care law

The inverse care law was suggested 30 years ago by Julian Tudor Hart in a paper for *The Lancet*, to describe a relationship between the need for health care and its actual use. In other words, those who most need medical care are least likely to receive it. On the other hand, those with least need of health care tend to use health services more effectively.[80]

There is limited exploration of how this applies specifically to Black African and Black Caribbean communities but the evidence looked at by the Review strongly suggests it is applicable and needs to be addressed by services.

[80] Hart, J. T. (1971) 'The inverse care law', *The Lancet* 297(7696), pp 405-412. doi.org/10.1016/S0140-6736(71)92410-X

Figure 15: Summarising the Inverse Care Law



Alternative text: decorative (information explained above)

Reducing Premature Mortality

The pathway of someone with a disease can be complicated and there are many opportunities for intervention to reduce the risk of someone dying from the disease. Early detection is important but also improving health behaviours can make a big difference as well to premature mortality. The Vital 5 (King's Health Partners) model is used to improve the population's health and reduce health inequalities by focusing on the Vital 5 areas which can reduce premature mortality (Fig 16). In the context of this Review these Vital 5 approaches could have a major impact in reducing the inequalities in death and disease affecting Black African and Black Caribbean communities if done in culturally competent ways.

Figure 16: The Vital 5 – Addressing the Front-End of the Complete Pathway of Care

The Vital 5 – addressing the front-end of the complete pathway of care

Overall Aim: Improve the population's health and reduce health inequalities by focusing on the Vital 5 to support prevention, detection, health promotion, management and treatment wherever there is an opportunity to do so.

Vital 5	Aim	Measured through
Blood pressure	to reduce stroke and heart attack, and improve well being	BP recording
Obesity	to reduce diabetes, renal dialysis, liver transplants, amputations and other comorbidities, and improve well being	BMI from height/weight recording
Mental health score	to reduce the burden of mental illness, improve physical health, recovery and well being	GAD or PHQ-9 score
Alcohol intake	to reduce liver transplants and malignant disease, to improve well being	volume and frequency questionnaire
Smoking habits	to reduce respiratory and malignant disease, and improve well being	volume and frequency questionnaire

Alternative text: The Vital 5 have been identified as the key 5 areas which can reduce premature mortality. These 5 with the aims and measurements are as follows:

- Blood pressure – aim to reduce stroke and heart attack and improve wellbeing, measured by BP recording

- Obesity – aim to reduce diabetes, renal dialysis, liver transplants, amputations and other comorbidities and improve wellbeing, measured by body mass index measurements taken by height and weight recordings
- Mental health score – aim to reduce the burden of mental illness, improve physical health, recovery and wellbeing as measured by use of GAD or PHQ-9 questionnaires
- Alcohol intake – aim to reduce liver transplants and malignant disease and improve wellbeing, measured through volume and frequency questionnaires
- Smoking habits – aim to reduce respiratory and malignant disease and improve wellbeing as measured by use of volume and frequency questionnaires

We set out the main findings from the evidence review, community engagement and stakeholder group sessions. The opportunities for action are given to improve Black African and Black Caribbean citizens' access to support and services.

What did we find from the rapid review?

In relation to preventable death we focused on two questions:

I. What are the health inequalities associated with emergency care and preventable mortality experienced by Black African and Black Caribbean people in Birmingham, Lewisham and the UK?

II. What evidence-based approaches are effective at preventing and addressing these health inequalities?

Acute disease and emergency care prevalence

- Males with chronic obstructive pulmonary disease (COPD) in the Black African and Black Caribbean population are more likely to seek emergency care, but less likely to be prescribed medication than similar White people.[81]
- Diabetes and poor glycaemic control lead to emergency care admissions and has higher rates in this population.[82]
- Dominant endocrine disorders for these groups are sickle-cell disorders and these frequently require urgent care for acute events.[83]
- There are higher rates of asthma in UK born Black and minority ethnic groups.[84]
- There are higher rates of strokes in Black African and Black Caribbean population due to hypertension, although other risk factors (smoking, coronary heart disease) are less common.[85]

Emergency care access

- People from an ethnic minority group (excluding non-White minorities) are 25% more likely to be a casualty than White pedestrians in trauma road accidents.
- Violent crime although has uneven reporting suggests high rates of gun and knife crime in areas of deprivation often involving young Black males.[86]

[81] Gilkes, A. et al (2016) 'Does COPD risk vary by ethnicity? A retrospective cross-sectional study,' *Int J Chron Obstruct Pulmon Dis* 11, pp 739-746. doi:10.2147/COPD.S96391
[82] Haw, J. S. et al. (2021) 'Diabetes complications in racial and ethnic minority populations in the USA,' *Curr Diab Rep* 21(1) doi:10.1007/s11892-020-01369-x
[83] Petersen, J., Kandt, J. and Longley, P.A. (2021) 'Ethnic inequalities in hospital admissions in England: an observational study,' *BMC Public Health* 21, pp 862 doi.org/10.1186/s12889-021-10923-5
[84] Asthma UK (2018) *On the Edge: How Inequality Affects People with Asthma*
[85] British Heart Foundation (2022) *How African Caribbean Background Can Affect Your Heart Health*
[86] Stott C, et al (2021) *Understanding ethnic disparities in involvement in crime – a limited scope rapid evidence review, by Professor Clifford Stott et al*

- There is an increased risk of admission observed for patients of Black or Black British ethnicity linked to poor management of chronic disease.
- General practices with higher proportions of Black or Black British patients were associated with higher rates of Accident and Emergency admissions. [87]

Preventable mortality (death)

- Poor outcomes for stroke were noted in Black African and Black Caribbean populations related to a limited awareness of symptoms and reduced health literacy, causing pre -hospital delay.
- The maternal death rate among Black women in England is growing and the gap between Black and White women in terms of their mortality rate is increasing.[88]
- Mortality rates remain exceptionally high for babies of Black and Black British ethnicity: stillbirth rates are over twice of those for babies of White ethnicity and neonatal mortality rates are 43% higher.[89]
- There is a significant difference among Black and other minority ethnic communities and the White population regarding deaths from Covid-19.[90]

Disparities in healthcare services

- Where Black and minority ethnic groups live in our cities' links to poorer quality primary care[91].
- Patients often head directly to hospitals and accident and emergency departments, either because of difficulties in gaining access to general practice or a lack of understanding of the processes and systems.
- Delays in seeking treatment cause complications, poorer outcomes or avoidable mortality[92].
- Criticisms of elements of the healthcare workforce exist and relate to maintaining institutional racism, lacking cultural and religious understanding, or recognising diversity.

What is preventable mortality?

Preventable mortality can be defined as the mortality rates for causes of death which are considered preventable. These are causes where all or most deaths could potentially be prevented by public health interventions in the broadest sense (subject to age limits if appropriate).

The trends observed across the populations are described below based on the data from the Public Health Outcomes Framework, Office for Health Improvement.[93]

- There are higher rates of preventable mortality in under 75-year olds in both Lewisham and Birmingham than the England average.

- There are higher mortality rates from all cardiovascular disease per 100,000 in the under 75-year olds in both Lewisham and Birmingham compared to the England average.

---

[87] Scantlebury, R. et al (2015) 'Socioeconomic deprivation and accident and emergency attendances: Cross-sectional analysis of general practices in England', *British Journal of General Practice* 65, e649-e654. doi:10.3399/bjgp15X686893

[88] Government Equalities Office, Race Disparity Unit, and Badenoch, K. (2020) *Press Release: Government working with midwives, medical experts, and academics to investigate BAME maternal mortality*

[89] MBRRACE-UK (2021) *UK Perinatal Deaths for Births from January to December 2019*

[90] Public Health England (2020) *Beyond the data: Understanding the impact of COVID-19 on BAME groups*

[91] Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund.

[92] Gov.UK (2021) *Independent Report: Health. Commission on Race and Ethnic Disparities*

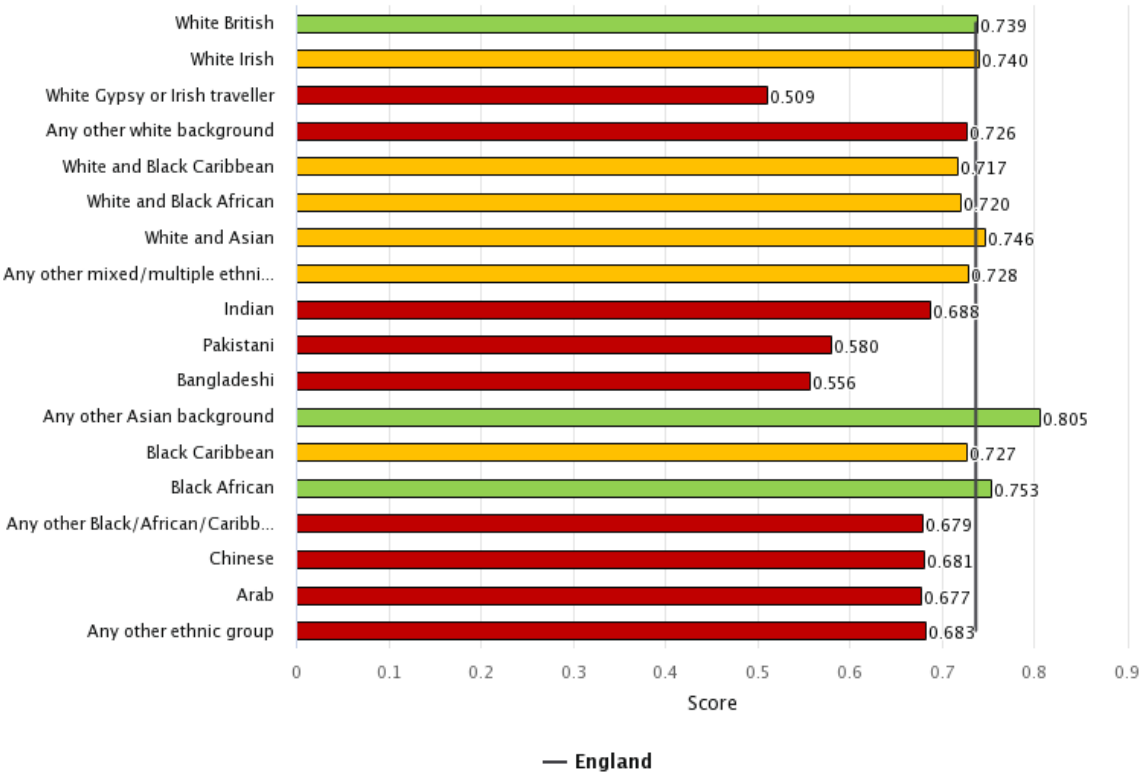
[93] Public Health England (2022) *Fingertips: Mortality Profile*

- The patterns observed in the death rates per 100,000 from ischaemic heart disease are lower in males of Black African and Black Caribbean ethnicities than White males in England and Wales.

- The patterns observed in the death rates per 100,000 from ischaemic heart disease are lower in females of Black African and Black Caribbean ethnicities than White females in England and Wales.

- The average health status score for adults aged 65 and over based on the GP Patient Survey showed similar scores reported for Black Caribbean and White older adults and better scores for Black African compared to the average score in England[94] (Figure 17).

Figure 17: Health related quality of life for older people (2016/17) – England, Ethnic Groups



Alternative text: decorative (information explained in bullet point above)

Long term conditions

According to the King's Fund,15 million people in England have at least one long-term condition. They affect wellbeing, social relationships and employment. Supporting people with long-term conditions uses 70% of the NHS budget and they are more common in older populations and those from disadvantaged backgrounds.[95]

In this review we considered the health inequalities associated with long-term physical health experienced by Black African and Black Caribbean people. We also wanted to know the evidence-based approaches that are effective at preventing health inequalities.

[94] Public Health England (2022) *Fingertips: Productive Healthy Ageing Profile*
[95] Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund

We assessed the evidence from reviewing a wide-ranging selection of published material on health conditions and multimorbidity (the presence of two or more long-term health conditions).

We found:

- Higher rates of multimorbidity, polypharmacy and earlier onset
- Increased prevalence of diabetes mellitus, poorer glucose regulation[96]
- Earlier onset of cardiovascular and chronic kidney diseases
- Higher risk and earlier onset of some cancers.[Error! Bookmark not defined.] For example, the risk of being diagnosed with prostate cancer is approximately 1 in 4 for Black men and 1 in 8 for White men, within the UK[97]
- Lower rates of COPD[98] and Multiple Sclerosis[99]
- Inequitable change in healthcare.

Some of these inequalities have been well established for many years in research but there is very little evidence of evaluated interventions or evidence-based approaches to address these inequalities.

Healthcare:

- Increased hospital use associated with long-term conditions
- Fewer admissions with Alzheimer's disease[100]
- Increased referral delays and longer period of sickness absence
- Poor patient satisfaction[101]
- Reduced access to hospice care
- Barriers to engagement with services including communication difficulties, lack of resources, cultural and family dynamics and lack of awareness

There is some encouraging data in some areas, but inequalities remain higher with the burden of long-term health conditions for our Black communities.

Key findings [INFOGRAPHICS]

Headline: **Black African and Black Caribbean populations are more likely to seek emergency care**

Headline: **There are higher rates of asthma in UK born Black and minority ethnic groups**

Headline: **There are higher rates of strokes in Black African and Black Caribbean populations**

Headline: **The risk of being diagnosed with prostate cancer is approximately 1 in 4 for Black men and 1 in 8 for White men**

Headline: **Black communities carry a bigger burden of inequalities relating to long-term conditions**

---

[96] Public Health England (2016) Diabetes *Prevalence Model*
[97] Lloyd, T. et al (2015) 'Lifetime risk of being diagnosed with, or dying from, prostate cancer by major ethnic group in England 2008–2010,' *BMC Medicine*. doi 10.1186/s12916-015-0405-5
[98] Gilkes, A. et al (2016). 'Does COPD risk vary by ethnicity? A retrospective cross-sectional study', *Int J Chron Obstruct Pulmon Dis*. 11, pp 739-746. doi:10.2147/COPD.S96391
[99] Amezcua, L. and McCauley, J. L. (2020) 'Race and ethnicity on MS presentation and disease course,' *Mult Scler*. 26(5), pp 561-567. doi:10.1177/1352458519887328
[100] Alzheimer's Society (2018) *Research suggests fewer Black men receiving dementia diagnosis*
[101] NHS Digital (2021) *Ethnicity facts and figures – patient satisfaction with hospital care*

What did we find from the community and Board engagement?

The following concerns and suggestions were shared with us by members of the local Black African and Black Caribbean communities.

"There should be more linked services within the NHS that is aimed directly at this ethnic group."

"Get a proper grasp of the barriers to accessing healthcare. Work with faith leaders to get the correct important out into the community."

"As previously stated, the environment in relation to long term physical health and preventable mortality. But to do this it exposes institutional racism and bias within areas of Authority particularly Planning Enforcement Highways and the police."

"Equality a word used by many organisations, but actions witnessed in these communities means inequality. It's just a nice word but has no meaning for many as the actions we experience does not imply Equality in Birmingham."

"Work on the locality model to ensure fairness and use organisations rooted in communities."

"Gateway receptionists need to more responsive and respectful"

"Undocumented slipping through the system", with "many die for fear of being reported"

"Social media becoming a 'source' for information and not necessarily good information 'misinformation'. Lack in confidence to 'challenge' GP's and healthcare professionals where they feel that they are not given sufficient information"

Through this engagement there was significant discussion of both structural and institutional barriers as well as issues of awareness and understanding of risk and these inequalities within communities themselves. Communities shared their frustration that solutions are often focused at patching up problems rather than addressing the root causes and were keen to see a step change in the approach.

Opportunities for action

Theme 7: Emergency care, preventable mortality and long-term physical health conditions	
Who	**Opportunities for action**
NHS England NHS Integrated Care Systems Local Councils	1. Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations. This should be supported by clear commissioning that requires data collection and analysis linked to all key relevant performance indicators. A specific example of where this can be rapidly done is through better use of the Friends and Family Test (FFT) and

	working with African and Caribbean communities so they engage with the tool and understand how it is used. There should also be better scrutiny and use of data from complaints and complements and this should be reviewed as part of contract monitoring and output data reported into system-leaders. This can also be strengthened through undertaking qualitative research to understand and overcome negative perceptions and experiences of health care for Black African and Black Caribbean communities to avoid delays in accessing care, including the influence of structural racism and discrimination. Through this better data and engagement, local areas should develop a more in depth understanding of the needs of communities in relation to emergency care, preventable mortality and long-term physical health conditions.
Local Health and Wellbeing Board and NHS ICS Partnership Board	2. Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include: • A team of community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support (e.g. social prescribing). • Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health. • Investment in grass-roots organisations to recruit volunteers who can support Black African and Black Caribbean communities that may experience structural institutional racism when accessing services.
Local Directors of Public Health and NHS Prevention Leads	3. Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include: • Services considering evidence-based ethnic differences in outcome measures (e.g. BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood and influence on life-time physical health). • Work with communities to co-develop services that are accessible for Black African and Black Caribbean communities (e.g. opening times, location of delivery).

	• Work with communities to encourage and raise awareness about how to access health services, including investment and development of multi-service hubs and pop-ups based in community locations (e.g. Youth Centres, libraries, leisure centres, faith-based sites, universities, colleges, schools) • Contractual clauses that strengthen support for Black African and Black Caribbean communities when they experience racism while accessing services and offer tiered positive approaches that address reported issues. • Meaningful measurement of change and learning from communities and grass roots organisations being captured and informing service design, monitoring, improvement, and review • Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation • Early help provision that supports communities when they do not meet statutory thresholds such as improved investment in grassroot organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

Theme: Wider determinants of health

"We can't ignore the barriers that ethnic minority communities are facing"
BLACHIR engagement participant

Where we live, how we learn, what we do and when we earn all play a part in keeping us healthy. The wider determinants term describes the factors that can influence health outcomes and include education, housing, poverty, employment and the environment in which we live. These impact on our lives both directly as we experience them but also in the longer term driving the inequalities in health outcomes we have seen throughout the Review.
This Review highlighted the evidence on inequalities caused by wider determinants of health experienced by the African and Caribbean populations. Social determinants of health are summarised in the model by Dahlgren and Whitehead[7] which is highlighted in the methodology section of this report (see Figure 2).

In 2010, The Marmot review highlighted the need to make better progress on the social determinants of health. This is because social, economic and environmental factors can impact on health, influenced by the local, national, and international distribution of power. This progress has to be invested in more for communities that experience more inequalities including the Black African and Black Caribbean communities.

What did we find from the rapid review?

We found that poverty and the wider environment has influenced Black African and Black Caribbean's health.

We identified the main causes of inequalities:

- Higher levels of deprivation, overcrowded homes, higher unemployment rates and lower education level attainment
- Racism and discrimination
- Lack of cultural expertise and sensitive methods
- Higher rates of mental health issues.

There are ten wider determinants highlighted and included as part of this review.

Housing

Within England, more Black African and Black Caribbean communities live in overcrowded homes compared to White communities (16% and 7% respectively compared with 2%).[102]

Education

National data shows that temporary exclusions across various ethnicities show differences between students: White: Gypsy/Roma (21.26%) and Irish Traveller (14.63%), Mixed White/Black Caribbean (10.69%), Black Caribbean (10.37%), Black Other (5.91%), Black African (4.13%), Mixed White/Black African (4.13%). Permanent exclusions were similar.[103] [104]

In 2019/20 the percentage of students getting 3 A Grades at A Level in England was lower amongst Black Caribbean (9.1%), Black Other (11.2%) and Black African (12.7%) students compared to White British students (20.2%).[105]

Unemployment

Black people are more likely to be unemployed compared to England average in 2019, 8% of people of Black ethnicity were unemployed which is higher than rates of White British people (4%).[106]

Income

Nationally, Black households were most likely, out of all ethnic groups, to have a weekly income under £600.[106]

Stop and search

Within England and Wales, Black people are over three times as likely to be arrested as White people.[107] In 2020, there were 54 stop and searches for every 1000 Black people, compared to six for every 1000 White people.[108]

Crime

Among juveniles sentenced in 2017 within the UK, the Black ethnic group had a high percentage of offenders sent to a young offenders institution.[109] The evidence shows the disproportionate presence of Black people in the criminal justice systems is linked with racism and discrimination, worsening the negative impact on Black people's health and wellbeing, in particular their mental health.[110]

Deprivation

---

[102] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures – Overcrowded Houses*
[103] Department for Education (2021) *Ethnicity Facts and Figures – Temporary exclusions*
[104] Department for Education (2021) Ethnicity Facts and Figures – Permanent exclusions
[105] Department for Education (2021) *Ethnicity Facts and Figures – A level grades*
[106] Department for Work and Pensions (2021) *Ethnicity Facts and Figures – Household Income*
[107] Home Office (2020) *Ethnicity Facts and Figures – Arrest Data*
[108] Home Office (2021) *Ethnicity Facts and Figures – Stop and Search Data*
[109] Ministry of Justice (2020) *Ethnicity Facts and Figures – Young People in Custody*
[110] Ministry of Justice and Youth Justice Board for England and Wales (2020) *Ethnicity Facts and Figures - Youth Justice Statistics: 2018 to 2019*

Nationally there are higher levels of deprivation among the Black African and Black Caribbean groups compared to White groups.[111]

Benefits and financial support

23% of people from Black ethnic groups within the UK receive income-related benefits such as help with the cost of housing. This is the second highest group after people of Bangladeshi origin.[112]

Cultural factors

Nationally, cultural factors such as family support, connectedness, sense of community, the influence of religion and ethnic density are viewed as protective factors. However, some research found these can also become barriers to accessing health and social care.

It is important not to assume and stereotype. While there have been a small number of faith leaders who have been against vaccination, many Christian denominations have no theological opposition to vaccines. Churches from different denominations have come together to help reassure Black members about the Covid-19 vaccine. [113]

Homelessness and fuel poverty

Lewisham has a higher percentage of homeless households from people of Black ethnicity compared to people in these groups in Birmingham and the rest of England.[114]

Figure 18: Percentage of those who live in overcrowded households and experience fuel poverty in England, Birmingham and Lewisham

	England	**Birmingham**	**Lewisham**
Overcrowded households (2011) [115]	4.8%	9.1%	12.4%
Fuel Poverty (2018) [116,117]	10.3%	14.2%	12.1%

Alternative text: The percentages of those who live in overcrowded households (2011) was higher in Lewisham (12.4%) than Birmingham (9.1%) and the England average (4.8%). The percentage of those who experience fuel poverty was higher in Birmingham (14.2%) compared to Lewisham (12.1%) and the England average (10.3%).

Key findings [INFOGRAPHICS]

Headline: **Black people in England are twice as likely to be unemployed as White people**

Headline**: Black households are more likely to have low income and live in deprivation**

[111] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures - People Living in Deprived Neighbourhoods*
[112] Department for Work and Pensions (2021) *Ethnicity Facts and Figures – State support*
[113] The Voice (2021) *UK's Black Majority Churches Want Their Congregations to Consider Taking the Covid-19 Vaccine*
[114] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures – Statutory Homelessness*
[115] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures - Overcrowded households*

[116] LG Inform (2021) *Fuel poverty in Lewisham* - *LG Inform*

[117] Department for Business, Energy & Industrial Strategy (2020) *Ethnicity Facts and Figures – Fuel Poverty*

Headline: **Black people are over 3 times as likely to be arrested as White people and 9 times more likely to be stopped and searched**

Headline: **Overcrowding, homelessness and fuel poverty are more likely to be experienced by Black households**

What did we find from the community and Board engagement?

"All black areas even were my wider family live experience the same issues that have long term implications on long term health inequalities. It's not about more access or testing it's our environments that start many of these illnesses."

BLACHIR engagement participant

Community issues

Black African and Black Caribbean people often have strong family and community networks where they live. These are positive characteristics and can provide important individual and social connections, but they can also hinder help outside of the community bubble.

Protective factors

Cultural differences, especially those in family life, may be responsible for influencing Black African and Black Caribbean communities' health and wellbeing. Culture can also impact on how they seek health advice, achieve a healthier lifestyle and access health and social care services. It is evident from the findings that social, community and familial networks act as protective factors for Black communities. Protective factors act as a buffer for those at high risk of developing health and social problems.

Social, economic and environmental factors

Wider determinants of health have major influence on the wellbeing of our communities. Therefore, it is important to understand cultural identities, health beliefs and behaviour of the UK's diverse population.

Population diversity

Population diversity is complex and understanding it can be at best uneven. Health professionals can have poor cultural expertise with lack of language, underlying racism resulting in unfair treatment that can prevent access to health and social care.

.

"They have put us in a box, and I was thinking how we get out of it?"

Council elected member

The BAME and BME terms can present a standardised view of Black and ethnic communities. According to the UK government (GOV.UK) BAME (Black, Asian and Minority Ethnic) and BME (Black and Minority Ethnic) are not helpful descriptors because they emphasise certain ethnic minority groups (Asian and Black) and exclude others (Mixed, Other, and White ethnic minority groups). The terms can also mask differences between different ethnic groups and create misleading interpretation of data.

The Office for National Statistics (ONS) will have the most up to date national and local data on population diversity for the Black African communities in Spring 2022.

Our communities have said:

"*Root cause of health in many Black communities is environmental. My blood pressure is constantly high, kids have asthma, and some have neurological conditions which many have put down to accumulation of toxic fumes of industry and pollution."*

"Healthcare workers have been exposed to risk for years long before COVID. Along with many other gig economy workers who are exposed to risk daily but keeps the wheels turning. Many of the environments we live exposes us to many risks daily. Many know friends and family who have lost their positions due to vaccine mandates. Clap when it suits and dispose of when it does not."

"Food poverty is an issue that will grow in many areas, whether to eat or heat currently."

"Councils in the deprived areas of Birmingham seem to be doing the opposite if being truthful. Development plan for this area about twelve years ago spelt out the health inequalities. Twelve years later with all the data available studies and environmental laws, many residents now have chronic illnesses due to ever increasing exposure to exceeding air and noise pollution."

"Poor housing and traffic congestion adding to people's anxiety and stress levels"

Opportunities for action

Theme 8: Wider determinants	
Who	**Opportunities for action**
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	1. Consider cultural and religious influences when developing interventions to address the wider determinants of health inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.
Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations	2. Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.
Local Health and Wellbeing Boards	3. Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	4. Take action to address employment inequalities and issues around racism and discrimination affecting in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations.

Conclusion

Out of the huts of history's shame
I rise
Up from a past that's rooted in pain
I rise
I'm a black ocean, leaping and wide,
Welling and swelling I bear in the tide.

Leaving behind nights of terror and fear
I rise
Into a daybreak that's wondrously clear
I rise
Bringing the gifts that my ancestors gave,
I am the dream and the hope of the slave.
I rise
I rise
I rise.

An excerpt from 'I Rise' by Prof. Maya Angelou

The BLACHIR process allowed us to explore the evidence using a unique compilation of rich local data and intelligence as well as co-exploration with communities to better understand the challenges of persistent inequalities affecting Black African and Black Caribbean people in Birmingham and Lewisham.

The findings from the review clearly demonstrate that the system does not take enough notice of the needs and issues affecting Black African and Black Caribbean people as communities of identity in the UK. We are publishing alongside the Review report a more detailed data pack that we hope to evolve into a dashboard to track progress and impact following this report. We have also included in Appendix 2 recommendations for research that could help to close some of the clear evidence gaps identified through the Review.

These needs include fairness, inclusion and respect, trust and transparency, better data, early interventions, health checks and campaigns, healthier behaviours and health literacy.

This deficit is against a background of historical oppression, racism and discrimination and a clear and consistent repeating pattern of inequalities. This should not be allowed to continue.

This journey to address the needs has begun in our local areas with this review, working together to coproduce opportunities for action (see Appendix 1) for each of the eight themes explored. We commit to publish in a companion document case studies that demonstrate our work so that this can be shared and learnt from by other areas.

The review is submitting these opportunities for action to the respective local Health and Wellbeing Boards for their consideration and for the two local areas to take forward this work with their communities to build a better future and to break these cycles of inequality and disadvantage for African and Caribbean communities.

Acknowledgements and Credits

We would like to express our sincere gratitude to the community representatives who were involved in this review and remained committed to its creation despite the pressures of the pandemic response.

We are grateful to the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) Advisory Board members and wider contributors involved in the community engagement, without whom this work would not have been possible.

We also thank the members of the BLACHIR Academic Board and other partners who supported the delivery of the review and were instrumental in validating the research.

Finally, the whole project would not have been accomplished without the dedication of the local Review Teams in Birmingham and Lewisham Councils. The teams worked diligently and tirelessly to develop and deliver this ground-breaking initiative contributing to the learning and legacy about health inequalities.

Cllr Paulette Hamilton (Cabinet Member for Adult Social Care and Health/ Chair of the Birmingham Health and Wellbeing Board)

Cllr Chris Best (Leader of the Council/ Chair of the Lewisham Health and Wellbeing Board)

The Review Teams

Led by Dr Justin Varney, Director of Public Health, Birmingham City Council:

Dr Modupe Omonijo
Monika Rozanski
Ricky Bhandal
Atif Ali
Lucy Bouncer
Joseph Merriman
Caroline Chioto
Janet Mahmood
Alice Spearing
Dr Frances Mason
Dr Dino Motti
Avneet Matharu
Julie Bach
Becky Haines

Led by Dr Catherine Mbema, Director of Public Health, Lewisham Council:

Michael Brannan
Pauline Cross
Patricia Duffy
Lisa Fannon
Daniel Johnson
Gemma King
Kerry Lonergan
Michael Soljak
Rachel Dunn

The Advisory Board

Tristan Johnson
Eyvonne Browne
Samantha Dias
Fola Afolabi
Sabrina Dixon
Channa Payne-Williams
Charlene Carter James
Zeid Hussein
Emmanuel Moyosola
Cllr Paulette Hamilton
Cllr Chris Best
Cllr John Cotton

The Academic Board

Shardia Briscoe-Palmer
Nadine El-Enany
Carol Webley-Brown
Karen Newbigging
Jenny Douglas
Lorna Hollowood
Nicole Andrews
Pei Kuang
Fatemeh Rabiee Khan
Geraldine Brown
Runcie Chidebe
Florbela Teixeira
Georgia Webster
Marcia Rose
Evans Asamane

Authors of evidence reviews and other contributors

Dr Angela Clifford, Prof. Rouling Chen and the Team from the University of Wolverhampton
Ginny Tyler, Dr Deepali Bhagat and the Team from Coventry University
Dr Sadiq Bhanbhro and Dr Faten Al-Salti, Sheffield Hallam University
Prof. Tracey Davenport, Dr Wendy Nicholls and the Team from the University of Wolverhampton and the Birmingham Community Healthcare NHS Foundation Trust
Ryan Walters, Birmingham City Council
Mary West from the Knowledge and Evidence Service, Public Health England
Walsall Healthcare NHS Trust
Patrick Tobi, University of Middlesex
Shola Oladipo, Food for Purpose
Naheeda Maharasingam, Lewisham
Lewisham Maternity Voices Partnership (MVP)
Lewisham Black and Minority Ethnic Carers Forum
KINARAA
360 Lifestyle Support Network
Red Ribbon
Urban Dandelion
FW Business
Lewisham Healthwatch

Lewisham Black Asian and Minority Ethnic Health Inequalities Working Group
Damien Egan - Mayor of Lewisham
Kim Wright – Lewisham Council
Tom Brown – Lewisham Council
Tony Kelly, Birmingham
Joann Bradley, Birmingham City Council
Paul Campbell, Birmingham City Council
Natalie Stewart, Birmingham City Council

Report prepared by: Local Review Teams supported by Jodie Wiltshire

Photos by: Richard Battye, River Studio

Design by: Corporate Design Team, Birmingham City Council

References

Marmot, M., Goldblatt, P. and Allen, J. (2010) *Fair Society, Healthy Lives, Strategic Review of Health Inequalities in England post 2010.* Institute of Health Equity

Marmot, M. et al (2020) *Build Back Fairer: The COVID-19 Marmot Review*. The Health Foundation

Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund

Office for National Statistics (2022) *Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 8 December 2020 to 1 December 2021*

Black Lives Matter (2022) *Home*

Dahlgren, G. and Whitehead, M. (2021) 'The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows', *Public Health* 199, pp 20-24.

Stonewall (2018) *LGBT in Britain – Home and communities*

Stonewall (2017) *LGBT in Britain - Hate crime and discrimination*

Witzel, T.C., Nutland, W. and Bourne, A. (2019) 'What are the motivations and barriers to pre-exposure prophylaxis (PrEP) use among Black men who have sex with men aged 18-45 in London? Results from a qualitative study,' *Sexually Transmitted Infections* 95(4), pp 262–266. doi: 10.1136/sextrans-2018-053773

Macpherson, W. (1999) *The Stephen Lawrence inquiry*

The Association of Directors of Public Health London (2021) *Policy position: Supporting Black, Asian and minority ethnic communities during and beyond the COVID-19 pandemic.*

Allen, G. and Zayed, Y. (2021) *Hate crime statistics*. House of Commons Library.

White, M. (2020) *What are the effects of racism on health and mental health?* Medical News Today

National Health Service (2021) *Workforce Race Equality Standard. 2020 Data analysis report for NHS Trusts and Clinical Commissioning Groups*

MBRRACE-UK (2021) *Mothers and Babies: Reducing risk through audits and confidential enquiries across the UK*

Royal College of Obstetricians and Gynaecologists (2020) *RCOG and RCM respond to UKOSS study of more than 400 pregnant women hospitalised with coronavirus*

Marmot, M. et al (2020) *Health Equity in England: The Marmot Review 10 Years on*

House of Commons Health and Social Care Committee (2019) *First 1000 days of life*

Public Health England (2016) *Infant and perinatal mortality in the West Midlands*

Office for National Statistics (2021) *Births and infant mortality by ethnicity in England and Wales: 2007 to 2019*

Public Health England (2022) *Fingertips: Public Health Profiles*

Office for National Statistics (2021) *Development goals for 4 to 5 Year Olds*

Sparrow, A. (2022) *More than half of UK's Black children live in poverty, analysis shows*. The Guardian

Bernard, D. L. et al (2021) 'Making the "C-ACE" for a culturally-informed Adverse Childhood Experiences framework to understand the pervasive mental health impact of racism on Black youth,' *Journal of Child & Adolescent Trauma* 14, pp 233-247. doi:10.1007/s40653-020-00319-9

Office for National Statistics (2020) *Overweight children*

Birmingham City Council (2022) *Supporting healthier communities*

Office for National Statistics (2021) *Births and infant mortality by ethnicity in England and Wales*

Office for National Statistics (2021) *Development goals for 4 to 5-year olds*

Powell, A. (2021) *NEET: Young people not in education, employment or training. UK Parliament: House of Commons Library*

YMCA (2020) *Young and Black. The young Black experience of institutional racism in the UK*

Office for National Statistics (2021) *Statistics: Exclusions*

Public Health England (2020) *Disparities in the risk and outcomes of Covid-19*

House of Commons. Women and Equalities Committee (2020) *Unequal impact? Coronavirus and BAME people*

Campbell, D. (2020) *Covid-19 affects BAME youth mental health more than White peers – study*. The Guardian

Centre for Ageing Better (2020) *Ethnic inequalities among over 50s revealed in new research*

Office for National Statistics (2016) *Population, People and the Community: Healthy life expectancy at birth and age 65 by upper tier local authority and area deprivation: England, 2012 to 2014*

Public Health England (2018) *Protecting and improving the nation's health*

Lewisham Health Inequalities Toolkit (2021)

Public Health England (2018) *Chapter 5: Inequalities in Health*

Office for National Statistics (2020) *People living in deprived neighbourhoods*

Public Health England (2021) *Place-based approaches for reducing health inequalities: Main repor*t

Bécares, L., Kapadia, D. and Nazroo, J. (2020) 'Neglect of older ethnic minority people in UK research and policy', *British Medical Journal* 368, doi:10.1136/bmj.m212

National Health Service (2022) *Smoking and your eyes*

Scharf, T. et al. (2002) *Growing older in socially deprived areas: Social exclusion in later life*. Help the Aged.

Victor, C. R., Burholt, V. and Martin, W. (2012) 'Loneliness and ethnic minority elders in Great Britain: an exploratory study,' *J Cross Cult Gerontol* 27(1), pp 65-78. doi: 10.1007/s10823-012-9161-6.

Adelman, S. et al (2011) 'Prevalence of dementia in African–Caribbean compared with UK-born White older people: Two-stage cross-sectional study,' *British Journal of Psychiatry*, 199(2) pp 119-125. doi:10.1192/bjp.bp.110.086405

Askari, A. et al (2015) 'Elderly, ethnic minorities and socially deprived patients at high risk of requiring emergency surgery for colorectal cancer,' *Gut*

Klop, C. et al (2017) 'The epidemiology of mortality after fracture in England: variation by age, sex, time, geographic location, and ethnicity,' *Osteoporos Int*. 28(1), pp 161-168. doi: 10.1007/s00198-016-3787-0.

Williams, E. D., Cox, A. and Cooper, R. (2020). 'Ethnic differences in functional limitations by age across the adult life course', *The Journals of Gerontology* 75(5), pp 914–921

Birmingham City Council (2021) *What is the impact of health inequalities on Black African and Black Caribbean older people in the UK?*

NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*

Lankelly Chase Foundation, Mind, The Afiya Trust and Centre for Mental Health. (2014) *Ethnic inequalities in mental health: Promoting lasting positive change*

Public Health England (2022) *Fingertips: Public Health Profiles*

NHS Digital (2020) *Mental health act statistics, annual figures*

NHS Digital (2021). *Detentions under the mental health act*

[1]Sport England (2022) *Active Lives survey data*

Birmingham and Lewisham Black African and Black Caribbean Health Inequalities Review (BLACHIR) (2021) *Mental Health Theme: Systematic Review (sharepoint.com)*

McGinnis, J. M., Williams-Russo, P. and Knickman, J.R. (2002) 'The case for more active policy attention to health promotion,' *Health Affairs* 21(2) pp 78-93.

Khaw, K. T. et al (2008) 'Combined impact of health behaviours and mortality in men and women: The EPIC-Norfolk Prospective Population Study,' *PLOS Medicine*, 5(3) pp 70. doi.org/10.1371/journal.pmed.0050070

Alcohol Research UK (2015) *Alcohol Research UK reports: The alcohol harm paradox, intuition school programme, social networks and alcohol identities, sight loss - Alcohol Policy UK*

Bloomfield, K. (2020) *Understanding the alcohol-harm paradox: what next?* - The Lancet Public Health

Public Health England (2021) *Gambling-Related Harms: Evidence Review*

Public Health England (2018) *Fast Food Outlets: Density by Local Authority in England*

Russon, M-A. (2021) *Gambling: Poorer UK towns found to have the most betting shops, study shows BBC News*. BBC News

Michie, S., van Stralen, M. M. and West, R. (2011) 'The behaviour change wheel: A new method for characterising and designing behaviour change interventions,' *Implementation Sci* 6(42) doi.org/10.1186/1748-5908-6-42

Sport England (2021) *Active Lives Adult Survey November 2019/20 report*

Sport England (2022) *Active Lives Survey Data*

Department for Digital, Culture, Media and Sport (2022) *Ethnicity facts and figures - physical activity*

Public Health England (2022) *Fingertips: Physical activity*

Department for Digital, Culture, Media and Sport (2020) *Ethnicity Facts and Figures – Physical Activity*

Public Health England (2022) *Fingertips: Local tobacco control profiles*

Department for Digital, Culture, Media and Sport (2020) *Ethnicity Facts and Figures - Healthy Eating Amongst Adults*

NHS Digital (2018) *Ethnicity Facts and Figures – Harmful and Probable Dependent Drinking in Adults*

Public Health England (2020) *Sexually transmitted infections and screening for chlamydia in England, 2020*

UK Health Security Agency (2021) *Official Statistics. HIV: Annual data tables*

Sport England (2021) *Ethnicity Facts and Figures – Overweight Adults*

Hart, J. T. (1971) 'The inverse care law', *The Lancet* 297(7696), pp 405-412. doi.org/10.1016/S0140-6736(71)92410-X

Gilkes, A. et al. (2016) 'Does COPD risk vary by ethnicity? A retrospective cross-sectional study,*' Int J Chron Obstruct Pulmon Dis* 11, pp 739-746. doi:10.2147/COPD.S96391

Haw, J. S. et al (2021) 'Diabetes complications in racial and ethnic minority populations in the USA,' *Curr Diab Rep* 21(1) doi:10.1007/s11892-020-01369-x

Petersen, J., Kandt, J. and Longley, P.A. (2021) 'Ethnic inequalities in hospital admissions in England: an observational study,' *BMC Public Health* 21, pp 862 doi.org/10.1186/s12889-021-10923-5

Asthma UK (2018) *On the Edge: How Inequality Affects People with Asthma*

British Heart Foundation (2022) *How African Caribbean Background Can Affect Your Heart Health*

Stott C, et al (2021) *Understanding ethnic disparities in involvement in crime – a limited scope rapid evidence review, by Professor Clifford Stott et al*

Scantlebury, R. et al (2015) 'Socioeconomic deprivation and accident and emergency attendances: Cross-sectional analysis of general practices in England', *British Journal of General Practice* 65, e649-e654. doi:10.3399/bjgp15X686893

Government Equalities Office, Race Disparity Unit, and Badenoch, K. (2020) *Press Release: Government working with midwives, medical experts, and academics to investigate BAME maternal mortality*

MBRRACE-UK (2021) *UK Perinatal Deaths for Births from January to December 2019*

Public Health England (2020) *Beyond the data: Understanding the impact of COVID-19 on BAME groups*

Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund.

Gov.UK (2021) *Independent Report: Health. Commission on Race and Ethnic Disparities*

Public Health England (2022) *Fingertips: Mortality Profile*

Public Health England (2022) *Fingertips: Productive Healthy Ageing Profile*

Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund.

Public Health England (2016) Diabetes *Prevalence Model*

Lloyd, T. et al (2015) 'Lifetime risk of being diagnosed with, or dying from, prostate cancer by major ethnic group in England 2008–2010,' *BMC Medicine*. doi 10.1186/s12916-015-0405-5

Gilkes, A. et al (2016). 'Does COPD risk vary by ethnicity? A retrospective cross-sectional study*', Int J Chron Obstruct Pulmon Dis*. 11, pp 739-746. doi:10.2147/COPD.S96391

Amezcua, L. and McCauley, J. L. (2020) 'Race and ethnicity on MS presentation and disease course,' *Mult Scler*. 26(5), pp 561-567. doi:10.1177/1352458519887328

Alzheimer's Society (2018) *Research suggests fewer Black men receiving dementia diagnosis*

NHS Digital (2021) *Ethnicity facts and figures – patient satisfaction with hospital care*

Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures – Overcrowded Houses*

Department for Education (2021) *Ethnicity Facts and Figures – Temporary exclusions*

Department for Education (2021) Ethnicity Facts and Figures – Permanent exclusions

Department for Education (2021) *Ethnicity Facts and Figures – A level grades*

Department for Work and Pensions (2021) *Ethnicity Facts and Figures – Household Income*

Home Office (2020) *Ethnicity Facts and Figures – Arrest Data*

Home Office (2021) *Ethnicity Facts and Figures – Stop and Search Data*

Ministry of Justice (2020) *Ethnicity Facts and Figures – Young People in Custody*

Ministry of Justice and Youth Justice Board for England and Wales (2020) *Ethnicity Facts and Figures - Youth Justice Statistics: 2018 to 2019*

Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures - People Living in Deprived Neighbourhoods*

Department for Work and Pensions (2021) *Ethnicity Facts and Figures – State support*

The Voice (2021) *UK's Black Majority Churches Want Their Congregations to Consider Taking the Covid-19 Vaccine*

Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures – Statutory Homelessness*

Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures - Overcrowded households*

LG Inform (2021) *Fuel poverty in Lewisham - LG Inform*

Department for Business, Energy & Industrial Strategy (2020) *Ethnicity Facts and Figures – Fuel Poverty*

Appendix 1: Opportunities for action

Led by research and evidence with community feedback, our review has put forward a series of detailed opportunities for action that we determined will improve the lives and experiences of Black African and Black Caribbean communities across the UK.

7 key areas that need to be addressed across the 8 themes

Fairness, Inclusion and Respect ~ Trust and Transparency ~ Better Data ~ Early Interventions ~ Health Checks and Campaigns ~ Healthier Behaviours ~ Health Literacy

Theme 1: Racism and discrimination	
Who	**Opportunities for action**
Local Councils and Health and Wellbeing Board Partners	**1.** Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.
Local Councils and Children's Trusts	**2.** Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
Local Councils and Health and Wellbeing Board Partners	**3.** Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
Local Councils and Education Partners	**4.** Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

Theme 2: Maternity, parenthood and early years	
Who	**Opportunities for action**
Local Integrated Care Systems (ICS) and NHS Trusts	**5.** Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
Local Integrated Care Systems (ICS) and NHS Trusts	**6.** Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.
Local, regional and national government, health organisations, care providers and advocates	**7.** Improve data collection by specific ethnicity considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
Local, regional and national government, health, housing, voluntary	**8.** Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through

organisations and advocates for national protocols	appropriate support and protecting them from relocation or eviction.
Local Public Health and NHS services	**9.** Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

Theme 3: Children and young people	
Who	**Opportunities for action**
Local Councils, schools, colleges, universities, community groups	**10.** Provide guidance and support for parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.
Local Integrated Care Systems (ICS), NHS Trusts	**11.** Develop culturally appropriate and accessible mental health services, including schools-based support, for young men and women to increase capability, capacity and trust to engage with services.
Local Councils, schools, regional and national government, and education organisations	**12.** Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people. This should include support on sexual and reproductive health services for young people, sexual exploitation, gender specific interventions and rape culture.
Local Councils, Local Integrated Care Systems (ICS), NHS Trusts, care providers, and advocates	**13.** Address low pay and associated poverty for frontline workers who are disproportionately of Black African and Black Caribbean heritage.
Local Councils, Health and Wellbeing Boards, community and voluntary sector organisations	**14.** Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.
Local Councils and climate change and air quality partners	**15.** Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.
NHS Integrated Care Systems	**16.** Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Theme 4: Ageing well	
Who	**Opportunities for action**
Local Public Health	**17.** Provide targeted screening services for chronic conditions in Black African and Black Caribbean older adults.
Local and national organisations, ICS, NHS Trusts	**18.** Campaign to raise awareness and increase uptake of community-based health checks in Black African and Black Caribbean older adults.

Local and national organisations, NHS Trusts, Mental Health services, First Aid England	**19.** Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.
NHS England and NHS Integrated Care System Boards	**20.** Support initiatives to improve uptake of vaccinations in older African and Caribbean people, focusing on areas of higher deprivation.
Local Councils, local, regional and national organisations and advocates	**21.** Use life course approach and consider relevant findings from this review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

Theme 5: Mental health and wellbeing	
Who	**Opportunities for action**
Local Public Health and Community Mental Health Trusts	**22.** Co-produce awareness campaigns aimed at Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Local NHS providers and Community Mental Health Trusts	**23.** Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
NHS Mental Health Providers and Commissioners	**24.** Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.
Local Health and Wellbeing Boards and NHS Integrated Care Partnerships Boards	**25.** Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and NHS Integrated Care Systems	**26.** Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

Theme 6: Healthier behaviours	
Who	**Opportunities for action**
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	**27.** Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.
Health Education England/ NHS England	**28.** Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
National Government Departments and Local Councils and NHS Integrated Care Systems	**29.** Provide long-term investment for trusted Black African and Black Caribbean grass roots organisation such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Local Directors of Public Health and	**30.** Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.

Nationally the Office of Health Improvement and Disparities (OHID)	
Department of Business, Innovation and Skills and research funding bodies such as National Institute for Health Research (NIHR)	**31.** Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in 'action research' to concurrently deliver and evaluate interventions.
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	**32.** Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

Theme 7: Emergency care, preventable mortality and long-term physical health conditions	
Who	**Opportunities for action**
NHS England NHS Integrated Care Systems Local Councils	**33.** Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations. This should be supported by clear commissioning that requires data collection and analysis linked to all key relevant performance indicators. A specific example of where this can be rapidly done is through better use of the Friends and Family Test (FFT) and working with African and Caribbean communities so they engage with the tool and understand how it is used. There should also be better scrutiny and use of data from complaints and complements and this should be reviewed as part of contract monitoring and output data reported into system-leaders. This can also be strengthened through undertaking qualitative research to understand and overcome negative perceptions and experiences of health care for Black African and Black Caribbean communities to avoid delays in accessing care, including the influence of structural racism and discrimination. Through this better data and engagement, local areas should develop a more in depth understanding of the needs of communities in relation to emergency care, preventable mortality and long-term physical health conditions.
Local Health and Wellbeing Board and NHS ICS Partnership Board	**34.** Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include:

	• A team of community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support (e.g. social prescribing). • Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health. • Investment in grass-roots organisations to recruit volunteers who can support Black African and Black Caribbean communities that may experience structural institutional racism when accessing services.
Local Directors of Public Health and NHS Prevention Leads	**35.** Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include: • Services considering evidence-based ethnic differences in outcome measures (e.g. BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood and influence on life-time physical health). • Work with communities to co-develop services that are accessible for Black African and Black Caribbean communities (e.g. opening times, location of delivery). • Work with communities to encourage and raise awareness about how to access health services, including investment and development of multi-service hubs and pop-ups based in community locations (e.g. Youth Centres, libraries, leisure centres, faith-based sites, universities, colleges, schools) • Contractual clauses that strengthen support for Black African and Black Caribbean communities when they experience racism while accessing services and offer tiered positive approaches that address reported issues. • Meaningful measurement of change and learning from communities and grass roots organisations being captured and informing service design, monitoring, improvement, and review • Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation • Early help provision that supports communities when they do not meet statutory thresholds such as improved investment in grassroot organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

Theme 8: Wider determinants	
Who	**Opportunities for action**
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**36.** Consider cultural and religious influences when developing interventions to address the wider determinants of health

	inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.
Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations	**37.** Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.
Local Health and Wellbeing Boards	**38.** Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**39.** Take action to address employment inequalities and issues around racism and discrimination affecting in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations.

Appendix 2: Research opportunities

Throughout the review there have been clear evidence gaps in the research, at times we have had to look at international evidence, which is not necessarily transferable to a UK context.

There remain significant data gaps in national collection and analysis of both NHS and Local Government data and these need to be urgently addressed in order to visualize and respond to the needs of ethnic communities. There may be a need for specific research to understand why, despite decades of policy initiatives, ethnic data collection and analysis remains so poor in the public sector.

The following are some of the research gaps that have been identified from this review's work:

- Understanding of the impact of culturally competent equality training on behaviours of professionals and on outcomes for patients/clients
- Understanding of the interventions that are most effective to improve health behaviours in different Black African and Black Caribbean communities
- Understanding of the linguistic barriers to health literacy for non-English speaking communities, especially in relation to mental health and wellbeing.

Pilots and research

Pilots and commissioned research will help to address knowledge gaps across the themes and may help identify the most effective culturally sensitive interventions to address health inequalities affecting Black African and Black Caribbean populations in Birmingham, Lewisham and the UK. In many areas the evidence is weak. Pilot schemes and small projects should guide further large-scale research and support the implementation of the opportunities of action identified as part of BLACHIR.

Birmingham Health and Wellbeing Board

	Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22nd March 2022**
TITLE:	**JOINT HEALTH AND WELLBEING STRATEGY**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney, Director of Public Health**

Report Type:	**Information / Approval**

1. Purpose:
1.1. To seek approval of the Health and Wellbeing Board's Strategy: Creating a Bolder, Healthier City 2022-2030.

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 agree to the Health and Wellbeing Strategy: 'Creating a Bolder, Healthier City 2022-2030' and publish findings from the public consultation. 3.2. To recommend the strategy for approval by Cabinet.

3.3. Background: Joint Health and Wellbeing strategy: 'Creating a Bolder, Healthier City 2022-2030'

3.3.1. The Health and Wellbeing Board is required to have a joint health and wellbeing strategy as part of its statutory functions, building upon the Joint Strategic Needs Assessment (JSNA). The proposed approach is for the strategy to coordinate and signpost to action across the health and care system.

3.3.2. 'Creating a Bolder, Healthier City' has been shaped and developed over the past three years with citizens, partner organisations and national policy changes. It sets out the Health and Wellbeing Board's ambitions for the next eight years (2022-2030), based on a series of themes and cross-cutting approaches. It includes the key actions, indicators to measure our progress, and the leadership required to achieve our ambitions.

3.3.3. The strategy has five core themes for action covering wider determinants, health protection and environmental public health. The core themes have been developed through consultation, engagement, and research. This includes the 2019 consultation on Birmingham's public health priorities and the launch of the fora alongside the existing Health Protection Forum. Four of the core themes in the strategy align with the fora.

3.3.4. The five core themes are:

- Healthy and Affordable Food
- Mental Wellness and Balance
- Active at Every Age and Ability
- Contributing to a Green and Sustainable Future
- Protect and Detect

3.3.5. The Health and Wellbeing Board supports a life course approach, reflected in the strategy. The five core themes run throughout the life course, split into three stages:

- Getting the Best Start in Life
- Living, Working, and Learning Well
- Ageing and Dying Well

3.4. Consultation

3.4.1. In September-December 2021, the Public Health Division ran a public consultation exercise on the Health and Wellbeing Strategy.

3.4.2. The public consultation process comprised an on-line questionnaire hosted on the Council's Be Heard website; virtual and in-person community-based focus groups; presentations to ward forums; webinars; and direct feedback from Healthwatch Birmingham.

3.4.3. We also obtained a review of the strategy by academics of the National Institute of Health Research (NIHR) as well as workshops with stakeholders from the various Health and Wellbeing Board Fora.

3.4.4. There were 142 responses to the public consultation, and an estimated further 100 views were collected from focus groups, presentations to ward forums and webinars. To account for the underrepresentation of some communities in the Be Heard survey, we have also undertaken a Health Impact Assessment to consider the subsequent positive and negative effects of the strategy.

3.4.5. Alongside the responses from the public consultation, the review by the academics of the NIHR also provided insight into how we could improve our evidence bases for measuring the outcomes of the strategy as well as deciding who and where targeted work is needed most.

3.4.6. This consultation feedback was then used in presentations to the officers whose work areas align with the themes to refine the strategy further. They also helped to establish the Strategy Delivery Plans for each forum, which will detail actions and partners needed for delivery.

3.4.7. Further information on the consultation can be found in the Consultation Findings report, attached in **Appendix 3** to this report.

3.5. Next Steps

3.5.1. The Health and Wellbeing Strategy will go to the Cabinet meeting on 26th April 2022 after getting approval from the Health and Wellbeing Board.

3.5.2. It is anticipated that the strategy will be published and launched officially in May/June 2022 after the period of political sensitivity.

4. Compliance Issues

4.1. HWBB Forum Responsibility and Board Update

4.1.1. The Health and Wellbeing Board will manage and oversee the joint strategy.

4.1.2. The Health and Wellbeing Board will receive an annual report which will outline the work and progress from the five fora and a wide range of partners.

4.2. Management Responsibility

4.2.1. The Birmingham Health and Wellbeing Board.

5. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Lack of stakeholder buy-in to the strategy	Low	Medium	We have already engaged with several key stakeholders regarding the strategy. We will also be working with all the fora on their delivery plans which will be guided by the ambitions and actions of the strategy.
Limited citizen engagement in the delivery phase, following publication of the 8-year strategy	Medium	Medium	The Health and Wellbeing Board will oversee and ensure further engagement and co-production on delivery plans and strategies associated with this overarching strategy. Citizen involvement is a priority of the strategy and will continue to ensure that the public is at the centre of decisions made by the Health and Wellbeing Board.

Failure to deliver the 2030 ambitions and measurable improvements to health inequalities and outcomes for citizens	Low	High	The Health and Wellbeing Board will act as the convenor to deliver the ambitious goals set out in the strategy. It will oversee the strategy, be responsible for its delivery, and ultimately be accountable for plans to achieve the 2030 ambitions.

Appendices
Appendix 1 - Creating a Bolder Healthier City 2022-2030 **Appendix 2** - Indicator Journey - Data Pack **Appendix 3** - Consultation Findings Report **Appendix 4** - Be Heard Survey Response Tables **Appendix 5** - Health Impact Assessment **Appendix 6** - Equality Impact Assessment

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

Dr Justin Varney, Director of Public Health
Dr Modupe Omonijo, Former Assistant Director of Public Health (Wider Determinants and Governance)
Dr Albert Uribe, Assistant Director of Public Health (Knowledge, Evidence and Governance)
Dr Shiraz Sheriff, Service Lead (Governance)
Luke Heslop, Service Lead (Evidence)
Aidan Hall, Senior Programme Officer (Governance)
Avneet Matharu, Senior Programme Officer (Governance)
Gurdeap Kaur, Senior Programme Officer (Knowledge)
Zoe Wright, Senior Programme Officer (Evidence)
Alexander Quarrie-Jones, Programme Officer (Governance)
Jenson Preece, Intern in Public Health (Evidence)

Birmingham Health and Wellbeing Board

Birmingham Joint Health and Wellbeing Strategy

Creating a Bolder, Healthier City 2022-2030

Our vision

To create a city where every citizen, whoever they are, wherever they live and at every stage of life, can make choices that empower them to be happy and healthy.

Contents

Foreword

Cabinet Member for Adult Health and Social Care

For far too long Birmingham has been impacted by inequalities affecting our citizens' health. Pre-pandemic Birmingham had significantly high health inequalities already with a 10-year gap in life expectancy within some of our inner-city areas compared to the more affluent outer city areas.

The devastation from the COVID-19 pandemic has only worsened our city's health. Across Birmingham, many are suffering from long Covid, bereavement and worsened outcomes for people with long-term health conditions. The economic impact of people losing their jobs has consequently limited their options to make healthier choices.

As the Cabinet Member for Health and Social Care, Chair for Birmingham Health and Wellbeing Board, and with a background in healthcare, I have worked in Local Authority to improve the unjust and preventable health differences that have left our communities with poorer health outcomes.

The way we change the unfairness is focussing primarily on the work of the Health and Wellbeing Board to reduce health inequalities. This will involve action from the board members involving political, clinical, professional and community leaders from across the care and health system to come together to improve the health and wellbeing of our local population.

So, in response to the last 18 months, previous consultation insight, including citizens, partner organisations and national policy changes, we have listened, consulted, and co-produced the Joint Health and Wellbeing Board Strategy: 'Creating a Bolder, Healthy City'.

The approach sets out our clear and bold ambitions over the next eight years (2022-2030), based on a series of core themes across the life course. It will include the key actions, indicators to measure our progress, and the leadership required to achieve our ambitions. Addressing some of the critical challenges Birmingham faces to tackle health disparities and mitigate the legacy of the COVID-19 pandemic.

The reach of this strategy will be relevant across Birmingham from members of the public, health care professionals, academics, and our voluntary sector. The way to tackle health inequalities is through a collaborative approach. It is now for us as leaders to work together through the Health and Wellbeing Boards, the new Integrated Care System Partnerships for our Birmingham communities, to deliver this ambitious 'Creating a Bolder, Healthier City' strategy.

We want Birmingham to be a city where every citizen, wherever they live and at every stage of life, to be able to make choices that empower them to be happy and healthy. We are grateful for the honesty, contribution, and insight of all of those who have shared their experiences through the development of this strategy. We must be committed to a better future for our citizens, and we must work together to seize every opportunity set out in this strategy to make Birmingham healthier for all.

Councillor Paulette A Hamilton

Cabinet Member for Adult Social Care and Health

Chair Birmingham Health and Wellbeing Board

Joint Birmingham City Health and Wellbeing Strategy on a Page

Creating a Bolder, Healthier City (2022-2030)

Our Vision

To create a city where every citizen, whoever they are, wherever they live and at every stage of life, can make choices that empower them to be happy and healthy.

Our vision is underpinned by **four key principles** that require strong partnership and collaboration across the local system. We need all stakeholder groups and their partners forging ahead together to achieve successful delivery.

- Citizen-driven and informed by citizens' lived experience
- Consciously focused on reducing inequalities through promoting equality, diversity and inclusion
- Data and evidence-informed and research-enabled action
- Impact of COVID-19 pandemic mitigated as part of our legacy work

Our five core themes within the Strategy set out our local priorities:

1. Healthy and Affordable Food
2. Mental Wellness and Balance
3. Active at Every Age and Ability
4. Contributing to a Green and Sustainable Future
5. Protect and Detect

There are three encompassing life course themes:

- Getting the Best Start in Life
- Living, Working and Learning Well
- Ageing Well and Dying Well

Introduction

People living in Birmingham experience challenges every day that directly and indirectly impact their health and may lead to far-reaching consequences that may limit their independence and autonomy. It is well understood that health and disease are predominantly the result of the wider determinants of a person's life rather than genetics or age.[1] Factors such as poverty, education, housing, employment and the environment in which we live, work and play all impact our health and wellbeing.

Health inequalities permeate our communities. The effect of social, economic, and environmental factors known as the 'causes of the causes'[2], or wider health determinants, are significant contributors to people's overall lifetime health from birth to death. Consequently, adverse events and exposures that persist in our communities from childhood may impact developmental milestones, education, employment and life chances. They remain less noticeable than disease, thereby leading to growing health inequalities.

Most health inequalities are driven by factors outside our National Health Service (NHS). By the time the health aspects of inequality reach the NHS, they are likely embedded. The challenge of rebalancing and mitigating ill health is significantly more complex than if the intervention had occurred earlier.

Creating a Bolder, Healthier City (2022 to 2030) aims to focus our local effort upstream by tackling the structural barriers and transforming our citizens' quality of life and health outcomes. In addition, reducing health inequalities experienced by those already living with chronic ill-health is paramount. It will be achieved by shaping a healthier environment and fairer opportunities for citizens to live affordable, sustainable, and enjoyable healthy lives. Birmingham will be a city that enables them to reach their potential and aspirations at every age.

Our statutory health and wellbeing strategy will be overseen through the Birmingham Health and Wellbeing Board. Working as a partnership across the city at citizen, community, local and regional levels, the Board and its partners will collaborate to create environments that enable healthier lives. This will be achieved by focusing on five core themes and the life course. The Strategy purposely addresses the urgent need to mitigate against the impact of the ongoing COVID-19 pandemic on our citizens' lives and the need to continuously create and drive a culture of equality, diversity, and inclusion. It aims to close gaps and reduce inequalities at pace and scale across the city. The Health and Wellbeing Board fora will be tasked to demonstrate progress on these priorities through their action plans.

To attain their potential, we must value our citizens by offering genuine equal opportunities across the city, such as housing, employment, and education. Communities can proactively lead the local effort to make our city bolder and healthier for all.

---

[1] Dahlgren G, Whitehead M (1993). Tackling inequalities in health: what can we learn from what has been tried? Working paper prepared for the King's Fund International Seminar on Tackling Inequalities in Health, September 1993, Ditchley Park, Oxfordshire. London, King's Fund, accessible in: Dahlgren G, Whitehead M. (2007) European strategies for tackling social inequities in health: Levelling up Part 2. Copenhagen: WHO Regional office for Europe: http://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf

[2] https://www.instituteofhealthequity.org/in-the-news/articles-by-the-institute-team-/inclusion-health-addressing-the-causes-of-the-causes---the-lancet-

Health Inequalities in Birmingham

Tackling health inequalities requires commitment and multi-agency action. Our approach must be rooted in people's lived experiences and be shaped from the onset with involvement from local communities of place, identity and interest.

Inequalities between different areas can reflect differences in assets and deficits or barriers. This can include variations in access to greenspace, quality housing, more or less comprehensive healthcare, levels of poverty and language barriers.

Some of the inequalities within the city are described below.[3]

Inequalities between Birmingham, West Midlands and England

- Males born in Birmingham can expect to live 58.5 years in good health (healthy life expectancy). This is lower than the West Midlands (61.5 years) and England (63.2 years).[4]
- Females born in Birmingham can expect to live 59.3 years in good health (healthy life expectancy). This is lower than the West Midlands (62.6 years) and England (63.5 years).[5]
- Deaths due to cardiovascular disease (2018-20) in Birmingham were 57.3 (per 100,000 population) compared to 43.4 for England and 47.0 for the West Midlands.[6]
- Deaths due to smoking in Birmingham (2018-20) were 274.8 (per 100,000 population), which is higher than England (250.2) and the West Midlands (249.3).[7]
- In 2018, in the West Midlands, the rate of new HIV diagnoses in the Black African population was 45 times that of the white population (per 100,000 population).[8]

[3] Birmingham City Council Public Health (Locally calculated rates based on ONS/NHS Digital sourced data).

[4] Public Health England (based on ONS source data): https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/4/gid/1000049/pat/6/par/E12000005/ati/102/are/E08000025/iid/90362/age/1/sex/1/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

[5] Public Health England (based on ONS source data): https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/4/gid/1000049/pat/6/par/E12000005/ati/102/are/E08000025/iid/90362/age/1/sex/2/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

[6] Public Health England (based on ONS source data). 2017-19. “Mortality Profile.” Under 75 mortality rate from all cardiovascular diseases. Accessed July 28, 2021. https://fingertips.phe.org.uk/profile/mortality-profile/data#page/3/gid/1938133009/pat/6/par/E12000005/ati/302/are/E08000025/iid/40401/age/163/sex/2/cid/4/tbm/1.

[7] ONS mortality file, ONS LSOA single year of age population estimates and smoking status from Integrated Household Survey/Annual Population Survey, relative risks from The Information Centre for Health and Social Care, Statistics on Smoking, England 2010. 2016-18. “Local Tobacco Control Profiles.” Smoking attributable mortality. Accessed July 28, 2021. https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132885/pat/6/par/E12000005/ati/302/are/E08000025/iid/113/age/202/sex/4/cid/4/tbm/1.

[8] Public Health England. 2020. “Annual Epidemiological Spotlight on HIV in the West Midlands (2018 data).” February. Accessed July 28, 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/864734/HIV_spotlight_west_midlands_2018.pdf.

- COVID-19 mortality rates for people younger than 65 were 3.7 times higher in England's most deprived areas than the least deprived areas between March 2020 and March 2021.[9]

Inequalities within Birmingham

- There are ten-year differences in life expectancy between some of the 69 wards across the city. There is:
  - A twelve-year difference between life expectancy at birth for males in Heartlands (71.8 years) compared to Sutton Four Oaks (83.8 years).[3]
  - A nine and a half year difference between females' life expectancy at birth in Heartlands (76.9 years) compared to Sutton Reddicap (86.4 years).[3]
- In Nechells, the rate of death from coronary heart disease is over 2.5 times higher than the rate in Sutton Roughley.[3]
- The incidence of breast cancer in Rubery and Rednal is 2.8 times that of Lozells.[3]
- Rates of excess weight for children in reception class are 1.7 times higher in Kings Norton South than in Sutton Trinity. In Year 6, the rates in Handsworth are 2.2 times higher than Sutton Trinity.[3]
- Hospital stays for self-harm in Druids Heath and Monyhull are four times the rates in Sutton Wylde Green.[3]

Inequalities: Core themes

Theme 1: Healthy and Affordable Food

- Obesity (including severe obesity) in children in Year 6 (2019/2020) in Birmingham is 25.5% and in England is 21.0%.[10]
- The percentage (%) of adults regularly eating '5-a-day' (2019/20) in Birmingham is 52.60%, and in England, it is 55.40%.[11]

[9] Tinson, Adam. What geographic inequalities in COVID-19 mortality rates and health can tell us about levelling up. 2021 July. Accessed July 2021, 22. https://www.health.org.uk/news-and-comment/charts-and-infographics/what-geographic-inequalities-in-covid-19-mortality-rates-can-tell-us-about-levelling-up.

[10] Fingertips Public Health Profiles https://fingertips.phe.org.uk/search/obesity#page/4/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/90323/age/201/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

[11] Fingertips Public Health Profiles https://fingertips.phe.org.uk/search/eating#page/4/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/93077/age/164/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Statistics will be presented as infographics

Theme 2: Mental Wellness and Balance

- The percentage (%) people reporting depression and anxiety in Birmingham (2016/17) was 14.6%, while the England average was 13.7%.[12]

Theme 3: Active at Every Age and Ability

- The percentage (%) of adults who are physically inactive in Birmingham (2019/2020) is 28.90% compared to England 22.90%.[13]

Theme 4: Green and Sustainable Future

- The fraction of mortality attributable to particulate air pollution (2019) is 5.80% in Birmingham, and in England, it is 5.10%.[14]

Theme 5: Protect and Detect

- The MMR vaccine (against measles, mumps, and rubella) for 2-year-olds (one dose) in Birmingham is 85.70% compared to England at 90.60% (2019/2020).[15]
- The uptake of the national breast screening programmes (2019) in Birmingham is 68.20% compared to England at 74.50%.[16]

Inequalities: Life course

Getting the Best Start in Life

- Birmingham's infant mortality rate is 7.0 (deaths per 1,000 live birth) compared to 3.9 for England and 5.6 for the West Midlands (2017-2019).[17]
- 28.1% of Birmingham children live in low-income families, compared with 17.0% nationally (2016).[18]

---

[12] Fingertips Public Health Profiles https://fingertips.phe.org.uk/search/depression#page/4/gid/1/pat/6/ati/102/are/E08000025/iid/90647/age/168/sex/4/cid/4/tbm/1/page-options/car-do-0

[13] Fingertips Public Health Profile https://fingertips.phe.org.uk/search/physically%20inactive

[14] Fingertips Public Health Profile https://fingertips.phe.org.uk/search/pollution#page/4/gid/1/pat/6/ati/102/are/E08000025/iid/30101/age/230/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

[15] Finger tips Public Health Profile https://fingertips.phe.org.uk/search/mmr#page/4/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/30309/age/31/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

[16] Fingertips Public Health Profile https://fingertips.phe.org.uk/search/screening#page/4/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/22001/age/225/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

[17] Public Health England. 2021. “Birmingham Child Health Profile.”

[18] Gibbon and Griffith. 2020. "Infant mortality in Birmingham – the headline figures." Public Health England. December. Accessed July 30, 2021. https://bit.ly/3h6wGps.

Living, Working and Learning Well

- The percentage (%) of adults aged 40-64 years with Type 2 Diabetes (2018/19) in Birmingham and Solihull (BSol) is 47.2%, compared to England which is 43.0%[19]
- Smokers that have successfully quit at four weeks (2017/18) in Birmingham is 1,627 (per 100,000 population) compared to England which is 2,070.[20]

Ageing and Dying Well

- Women at 65 years old in Birmingham are expected to spend 8.5 years of their life in good health. This is 2.6 years less than the England average (11.1 years).[21]
- Men at 65 years old in Birmingham are expected to spend 6.9 years of their life in good health. This is 3.7 years less than the England average (10.6 years).[22]

[19] Fingertips Public Health Profile https://fingertips.phe.org.uk/search/Type%202%20Diabetes#page/1/gid/1938133107/pat/159/par/K02000001/ati/15/are/E92000001/iid/93209/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/eng-vo-1.

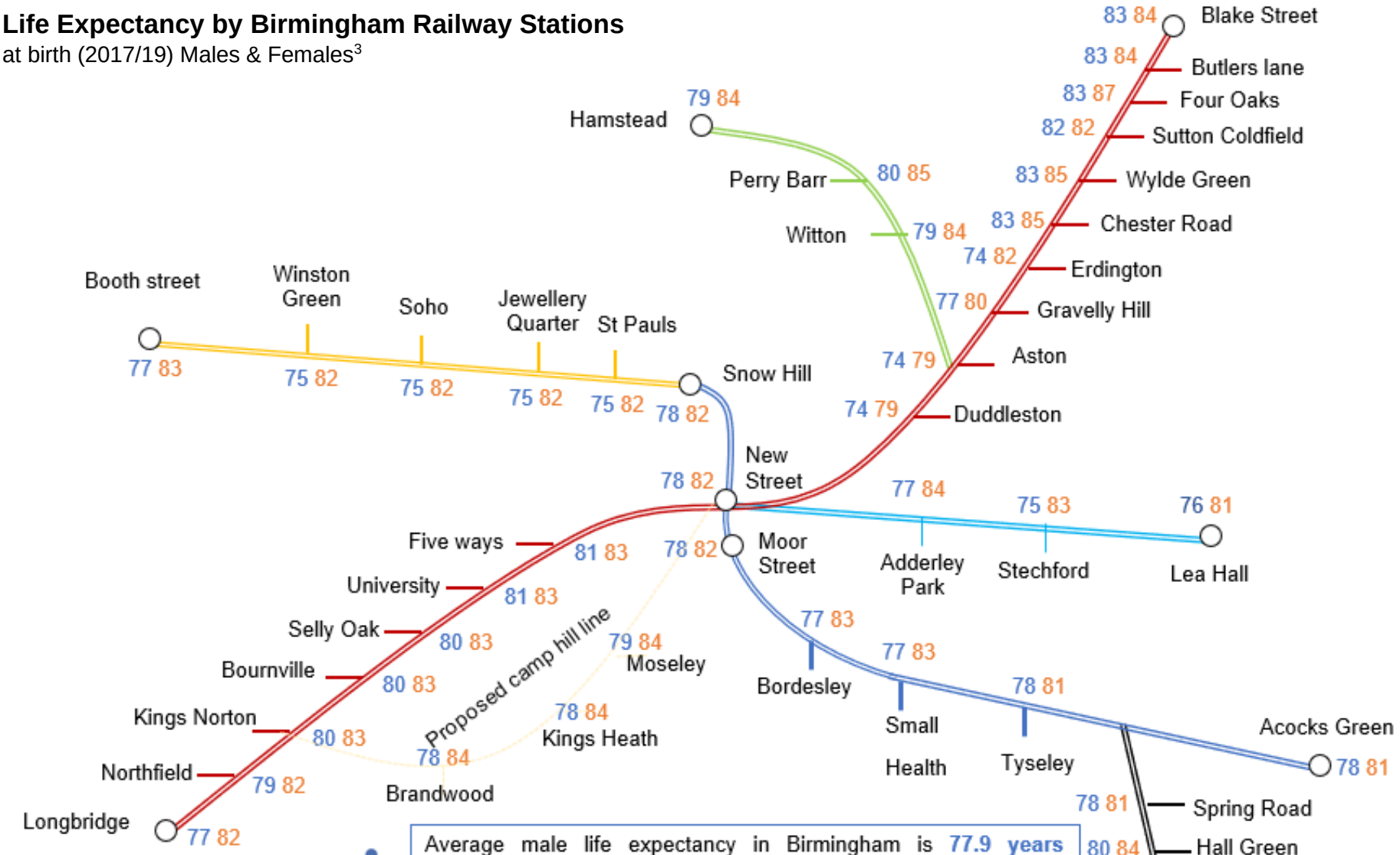
[20] Fingertips Public Health Profile https://fingertips.phe.org.uk/search/smoke#page/1/gid/1938132792/pat/159/par/K02000001/ati/15/are/E92000001/iid/1211/age/164/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/eng-vo-1

[21] Fingertips Public Health Profile https://fingertips.phe.org.uk/search/life%20expectancy#page/1/gid/1/pat/15/ati/402/are/E08000025/iid/90362/age/1/sex/1/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

[22] Fingertips Public Health Profile https://fingertips.phe.org.uk/search/life%20expectancy#page/1/gid/1/pat/15/ati/402/are/E08000025/iid/90362/age/1/sex/1/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

Life Expectancy by Birmingham Railway Stations

at birth (2017/19) Males & Females[3]



Average male life expectancy in Birmingham is **77.9 years** compared to 79.8 years for England. With only **two stops** you can shave **six years** off the average life expectancy of a male citizen.

Average female life expectancy in Birmingham is **82.4 years** compared to 83.4 years for England. With only **two stops** you can shave **six years** off the average life expectancy of a female citizen.

Source: ONS Deaths 2017/19 © Birmingham Public Health 2021

Closing the Gap

The health inequalities identified across Birmingham need to be prioritised and urgently addressed at the individual, community and local level to achieve our goal.

'Closing the gap' provides an overarching goal by highlighting specific areas of focus that cut across the city. It directs the system to focus on a principal target that brings together the priorities set out within this Strategy making this the central focus of all we do locally.

Understanding existing barriers, challenges, and people's lived experiences

Birmingham is a diverse and bold city with an ever-growing range of opportunities. Yet too often, specific groups of citizens are left behind because of marginalisation and structural barriers and challenges. We will focus on specific actions to address those health inequalities linked to poverty and marginalisation and dedicate specific resources and effort to addressing these in more detail.

The Director of Public Health Annual Report, *Complex, Lives, Fulfilling Futures*, highlighted the challenges that adults living with multiple and complex needs face. It reflects on how we can inspire action as a partnership across Birmingham to support all our citizens to thrive.[23]

There is clear evidence of significant gaps for people experiencing homelessness, care leavers, people living in poverty, carers, veterans, sex workers, people living with learning disabilities, people in contact with the justice system, and people with significant mental health

[23] Birmingham City Council Public Health. 2020. “Complex Lives, Fulfilling Futures - Director of Public Health Annual Report.”

issues. For some citizens, these experiences are intermittent or transient, and for others, these are challenges that last a lifetime.

We will support the Birmingham Levelling Up Strategy[24] to tackle disparities in our city. We recognise that we cannot '*level up'* without challenging deep and structural inequalities. The Board will support this approach to address poor health outcomes and improve the life chances of our citizens.

We will work in partnership to better understand and increase our knowledge of our communities. We will achieve this by building on existing innovations across the city, working with these communities, such as the Birmingham Poverty Truth Commission.

Mitigate the Legacy of Covid-19

The Strategy also incorporates the learning and experience from the local response to the COVID-19 pandemic and an ongoing commitment to equality, diversity, and inclusion. The Covid-19 pandemic shone a harsh and relentless light on inequalities as the pandemic disproportionately impacted our most challenged and disadvantaged communities.

As of January 2022, 1.3 million people (2.1% of the population) in the UK were experiencing self-reported long COVID.[25] In 2021, a study found that one in six middle-aged people and one in thirteen younger adults with COVID-19 report long Covid symptoms.[26] The impacts of 'long Covid' are still emerging. It will require new pathways of care and support across the health and social and community and voluntary sector, in addition to a positive and supportive response from the education and employment sector to support individuals affected.

Responding to the COVID-19 pandemic has informed the development of this strategy. We have learned from communities and partners in the private, public, academic, and voluntary sectors.

Equality, Diversity and Inclusion

The Strategy enables the Health and Wellbeing Board to maintain the values of equality, diversity and inclusion. These values are at the centre of our ambitions, actions, and leadership to tackle the inequalities in our society. Both health and disease outcomes and opportunities are often conditional on a series of factors. Our approach will focus explicitly on legally protected characteristics and specific identities of experience. There are nine protected characteristics as described in the Equality Act 2010. These are Age, Gender Identity, Sex, Race, Sexual Orientation, Religion and Belief, Disability, Pregnancy and Parenthood, Marriage and Civil Partnership.

We recognise that these do not exist in isolation. Many people possess more than one minority characteristic, making the inequalities they face even greater. The communities are woven by

[24] Birmingham City Council: https://www.birmingham.gov.uk/downloads/download/4537/birminghams_levelling_up_strategy.

[25] ONS: Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/3february2022

[26] Steves, Claire. 2021. Up to one in six people with COVID-19 report long COVID symptoms. 24 June. Accessed July 23, 2021. https://www.kcl.ac.uk/news/up-to-one-in-six-people-covid-19-long-covid-symptoms.

threads, including identities and experiences. Our communities of identity, interest and place comprise people with their lived experience.

The COVID-19 pandemic exposed and exacerbated existing inequalities, including the disproportionate impact on people from minority communities, particularly ethnic and disabled communities, and many other communities of experience. The Board will act in a cross-cutting way through the delivery of the themes set out in the Strategy. We will continue to learn from and build on specific projects which use targeted approaches to understand these inequalities and respond to them. This includes the Birmingham Poverty Truth Commission, Veterans Deep Dive, Birmingham and Lewisham African and Caribbean Health Inequalities (BLACHIR) Review. We support Birmingham City's Council's commitment to tackling inequality in Everyone's Battle Everyone's Business.[27]

Targeting Specific Health Inequalities

The Board recognises the link between this framework and the emerging priorities of the NHS Integrated Care System (ICS) and the responsibilities and strategies of the Police and Crime Commissioner. This is alongside their duty to address inequalities in consultation with other public sector, business, academic and community partners.

Each lead partnership organisation has a responsibility to address local health inequalities explicitly as part of the Strategy's implementation. This will be monitored through the Health and Wellbeing Board.

Five key areas of inequalities targeted through the development and delivery of the Strategy and chosen by the Board are;

- 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)

"Sometimes the difficulty is going to come, for example, I am Black, and I share all the experiences of Black people but am also Muslim as well. I have got two things that many people don't have. The person who is just Muslim cannot experience the Black issue, and Black people who are not Muslim will not experience the Muslim issue."

Quote from a participant in Birmingham Healthwatch report into experiences of Somali people

[27] Birmingham City **Council**. **Everyone's Battle Everyone's Business** – together we will tackle inequalities. Equality Strategy and Action Plan 2021 - 2023

Co-production Methodology

This Strategy has been shaped and formed over the last three years by drawing on input and engagement from both citizens and partner organisations and applying national policy changes.

Community Engagement

We undertook several engagement activities to help us identify the key priorities and better understand the needs of our citizens.

Community engagement and involvement of various stakeholders enabled the voices, views, and insights to be used throughout the Strategy. This joint Strategy must continually reflect and be delivered based on our learning from the lived experiences of our citizens. Recent examples of local work have reinforced the importance of engagement in the development of this Strategy.

In 2019, we held a public consultation on public health priorities for the city. We received strong support for addressing health inequalities upstream of drivers of illness and disease, in addition to reducing the inequalities affecting those already living with the burden of ill health.[28] This led to the creation of four new sub-groups of the Health and Wellbeing Board to complement the existing Health Protection Forum. They are the multi-agency and multidisciplinary Health and Wellbeing fora:

1. Creating a Healthy Food City Forum
2. Creating a Mentally Healthy City Forum
3. Creating an Active City Forum
4. Creating a City Without Inequalities Forum
5. Health Protection Forum

Thematic Approach

The Health and Wellbeing Board recognises the importance of a thematic approach with cross-cutting action throughout the life course. *Creating a Bolder, Healthier City (2022-2030)* has five core themes developed through consultation, engagement, and research. Four of the five core themes in the Strategy align with those Health and Wellbeing Board fora. The themes are:

1. Healthy and Affordable Food (Creating a Healthy Food City Forum)
2. Mental Wellness and Balance (Creating a Mentally Healthy City Forum)
3. Active at Every Age and Ability (Creating an Active City Forum)
4. Contributing to a Green and Sustainable Future (led by our partners including the City of Nature Board)
5. Protect and Detect (Health Protection Forum)

[28] Birmingham City Council Public Health. 2019. "Birmingham Public Health Green Paper." Accessed July 28, 2021. https://www.birminghambeheard.org.uk/people-1/birmingham-public-health-green-paper/supporting_documents/Birmingham%20Public%20Health%20Green%20Paper%20.pdf.

The Health and Wellbeing Board supports a life course approach, which is reflected in the Strategy. Therefore, the five core themes are complemented by the life course, split into three life stages.

- Getting the Best Start in Life
- Living, Working and Learning Well
- Ageing and Dying Well

The purpose of the Strategy is to provide a framework that the whole council, ICS and other partners will implement through subsequent strategies, commissioning and action plans. The Strategy aims to be concise and purposeful and will signpost to various examples of relevant work across the system. We have been exploring topics and themes in more depth and translating these into deliverable ambitions. We have identified clear actions which have been locally agreed.

Our Core Themes

1. Healthy and Affordable Food

Birmingham is a diverse, global, vibrant city with more than a million citizens, many of whom face challenges accessing affordable, healthy, sustainable food. Food insecurity is associated with poorer diets which can lead to negative health outcomes. Structural barriers, including poverty and deprivation, exist and prevent many people from accessing healthy food.

Unhealthy or inadequate consumption of healthy food negatively impacts physical and mental health.[29] Obesity (including severe obesity) in children in Reception in 2019/2020 was 10.9% in Birmingham, slightly higher than the national picture for England at 9.9%.[30] The pandemic has revealed how fragile food security is, as many families rely on the furlough scheme during the pandemic. In 2021, the uptake of healthy start vouchers in eligible families in Birmingham was 72%, in the West Midlands, it was 59%, and in England, it was 56.8%.[31] People have had limited access to food in the most deprived areas within the city. Some do not have a supermarket within a 15 minute walk.

Food systems contribute millions to the city's economy. The food system spans growing food, transforming food, transporting it and selling it in raw, transformed and cooked forms, in addition to recycling and waste. This system manifests itself in all our lives, from growing tomatoes in window boxes to the restaurants and takeaways on our high streets.

We want Birmingham to be a city where every citizen can eat an affordable, healthy diet and enjoy their food. Working with partners, we will focus on reducing inequalities associated with food poverty and ensure that access to good quality food choices is as equitable as possible. We also want the food we eat to be ethically, safely produced, and environmentally sustainable. The food economy is vibrant, reflecting the diversity of our communities. We want Birmingham's economy to be financially successful and sustainable. We want it to contribute to a circular economy for food that reduces waste, increases valuable employment opportunities for local people, minimises environmental harm and maximises the local assets in our city and region.

Our ambitions are to work together to:

- Increase the uptake of Healthy Start vouchers in eligible families to at least 80% by 2027
- Reduce the prevalence of obesity (including severe obesity) in children in Reception and Year 6 by 10% by 2030
- Reduce the percentage (%) of 5yr olds with visually obvious dental decay to below 20% by 2030
- Increase the percentage (%) of adults regularly eating '5 a day' to more than 55% by 2030
- Ensure that the Healthy City Planning Toolkit is utilised in 90% of developments in the City by 2030

[29] https://www.bda.uk.com/resource/food-facts-food-and-mood.html

[31] NHS Healthy Start Vouchers https://www.healthystart.nhs.uk/healthcare-professionals/

Leadership for Action

The Creating a Healthy Food City Forum and Public Health Division partners will lead this work, linking with other key partnerships such as the Birmingham Food System Strategy: Creating a Bolder, Healthier and More Sustainably Food City.

Key Actions

To achieve our ambitions, we will take the following actions:

- Implementation of the Healthy City Planning Toolkit.
- Consultation and implementation of the Birmingham Food System Strategy: Creating a Bolder, Healthier and More Sustainably Food City.
- Embed seldom-heard voices and other citizen voice into the activities of the Creating a Healthy Food City Forum.
- Strengthen and build upon local, national and international partnerships, i.e. local action groups, national Sustainable Food Places, city learning exchange partnerships, and international collaborations, including the Milan Urban Food Policy Pact (MUFPP).
- Maximise the healthy food benefits of the East Birmingham Corridor development.
- Maximise the benefits of the Food Poverty Core Group and Food Justice Network.
- Continue to develop working relationships with university partners and explore how we can better work in partnership to explore the needs of Birmingham citizens and communities.
- Understand what a healthy food system looks like and how this can be measured.

"This is what I eat at home. First of all, I eat crisps. I eat burger at night-time every day. I eat pizza, I eat fries, I watch TV, ok. Morning I eat cereal, I eat cake. I eat everything healthy."

Quote from a focus group with Primary School children of First-Generation Migrants

2. Mental Wellness and Balance

Mental wellbeing is as important as physical wellbeing: there is no good health without good mental health. However, this aspect of health can fail to get parity.

Compared to England and the West Midlands region, Birmingham is disproportionately affected by poor mental wellbeing. Currently, it has a higher than average prevalence of depression and anxiety in adults.[32] It also has a much greater proportion of people (10.4%) self-reporting a low satisfaction score compared to England (6.1%) and the West Midlands (6.5%).[33] There are further inequalities within the city with more deprived wards reporting lower resilience and poorer mental wellbeing, particularly in children.[34] Equally, there are inequalities within certain communities, such as the LGBTQ+ community, who face an increased risk of suicide and self-harm.

According to the Birmingham COVID-19 Impact Survey, by July 2020 more than half (53%) said their mental health had deteriorated since the pandemic started.[35] The impacts on mental wellbeing included bereavement, loneliness, and common mental health conditions, such as anxiety and depression. Some of these are the legacy of direct impacts of disease and illness, others due to the impacts of risk reduction restrictions and isolation. Equally, there was also an unequal impact with self-reported loneliness and anxiety being higher in older working age and respondents from ethnic minorities.[35]

Although the suicide rate in the city is relatively low, this should not lead to complacency. We must work together towards a shared ambition of zero deaths through suicide and zero admissions due to self-harm, particularly for children and young people. There are also unique challenges faced in Birmingham, such as investigating and developing the evidence of poor mental wellbeing stemming from experiences in the justice system or families affected by incarceration.

We recognise that mental wellness and balance is not the same as happiness, and that we will all experience periods of low mood and imbalance. Still, by taking a public health approach to mental wellness and balance, we can support people to navigate these times successfully and continue a positive life journey. Balance is a broad term but, in this context, we are focused on behaviours that reflect addiction, especially smoking, alcohol and drugs. Equally, the key metrics that we will measure our success include reducing the overall prevalence of anxiety and depression through improving the wellbeing indicators, triple zero and smoking rates.

---

[32] Public Health England, 'Public Health Profiles', Fingertips, Accessed: 04/02/2022 https://fingertips.phe.org.uk/search/depression#page/1/gid/1/pat/6/par/E12000005/ati/402/are/E08000025/iid/848/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/ine-ao-0_ine-yo-1:2020:-1:-1_ine-ct-39_ine-pt-0

[33] Public Health England, 'Public Health Outcomes Framework', Fingertips, Accessed: 08/02/2022, https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/3/gid/1000042/pat/6/par/E12000005/ati/402/are/E08000025/iid/22301/age/164/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-ao-0_ine-pt-1_ine-ao-0_ine-yo-1:2020:-1:-1_ine-ct-34_car-do-0

[34] Birmingham City Council, 'Birmingham Health Profile 2019', Accessed: 04/02/2022 https://www.birmingham.gov.uk/downloads/file/11845/birmingham_health_profile_2019

[35] J. Varney, "Initial findings from Covid19 Health & Wellbeing Impact Survey," August 2020. [Online]. Available: https://birmingham.cmis.uk.com/birmingham/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=yvZpCRcz3Ml85R9bK3lHnG9SpGWX9Q%2Flf3M3fXWhzdmPehkZWibWfA%3D%3D&rUzwRPf%2BZ3zd4E7Ikn8Lyw%3D%3D=pwRE6AGJFLDNlh225F5QMaQWCtPHwdhUfCZ%2FLUQzgA2uL5jNRG4jdQ%3D%3D&mCTIbCubS.

We are committed to creating a mentally healthy city where every citizen is supported to achieve good mental wellness and balance to navigate life's challenges. The new, nationally recommended Prevention Concordat for Better Mental Health will focus our partners on promoting positive mental wellbeing and reduce mental health inequalities so we can achieve a mentally healthy city.

Our ambitions are to work together to:

- Reduce the prevalence of depression and anxiety in adults to less than 12% by 2030
- Reduce our suicide rate (persons) in the city to be in the lowest ten places in England by 2030
- Reduce the emergency intentional self-harm admission rate to be within the lowest ten places in England by 2030
- Reduce the smoking prevalence in adults with a long-term mental health condition to at least the national average by 2027
- Close the gap between people with long-term health conditions, explicitly including those with severe and enduring mental health issues, and both those in employment and those without
- Achieve the ambitions of Triple Zero: i.e.to have zero deaths or overdoses linked to alcohol or drugs by 2030, and no-one living with substance addictions in the absence of support services

Leadership for Action

The Creating a Mentally Healthy City Forum will lead this theme with support from the Suicide Prevention Advisory Group and the NHS Mental Health Partnership.

Key Actions

To achieve our ambitions, we will take the following actions:

- Deliver our partnership action plans to address mental wellbeing, including the Prevention Concordat and Suicide Prevention Action Plan.
- Develop and implement evidence-based interventions to improve mental wellness and balance, including arts and culture-based interventions.
- Work with the voluntary sector and faith leaders to embed early intervention, brief advice, and signposting in all services.
- Take proactive steps to close the inequalities in employment and education for people with long term conditions, including those with severe and enduring mental health issues.
- Deliver the targets set out in the Triple Zero Strategy to tackle harm from drugs and alcohol in our city.

"I don't want to live anymore. I don't want to go on anymore. Because everything I care about has been taken away from me. Whether it's through substances, social services, police, you name it - everything I know and care about has gone from me"

Quote from a Rough Sleeper in Birmingham

3. Active at Every Age and Ability

If everyone in Birmingham moves more, we will see major improvements in health and happiness, social connectivity, resilience, and environmental benefits in our communities. Being physically active can prevent and improve long term conditions, including cardiovascular disease, diabetes and cancers, and it is also a viable part of treatment pathways.

In Birmingham during 2019/20, a higher proportion of people aged 16 and above were categorised as physically inactive (less than 30 minutes of physical activity a week) compared to both the regional and national percentages.[36] More worryingly, in 2020/21, the percentage of physically active children and young people was one of the lowest in the country (32% for Birmingham and 44.6% for England).[37]

The COVID-19 pandemic has decreased activity levels across Birmingham and changed our daily habits, often reducing travel and leading to a more sedentary way of life. The COVID-19 Impact Survey illustrated that the highest level of inactivity was in age groups 40-49 and 50-59.[35] However, beyond the pandemic, the 2022 Commonwealth Games offers a visible global celebration of sport and activity. One of its key legacy outcomes must be to inspire us all to be active every day.

Significant and visible inequalities exist when it comes to activity and we need to focus on the areas of greatest inactivity with understanding and empathy. This can be achieved through projects like the 'Active Communities Local Delivery Pilot' in partnership with The Active Wellbeing Society. This project supports physical activity in deprived communities to help close the inequality gap, focusing on deprivation, age, and ethnicity. It will be part of this wider strategy that will work on culturally competent approaches to promote physical activity.

These projects can be done together with an increased range of everyday opportunities to enjoy activity that are both accessible and affordable. These need to be based upon safe routes and the infrastructure to enable walking and cycling, local safe, affordable, and attractive sports, and activities in accessible locations and green spaces to make physical activity a viable option for everyone in our city.

Our ambitions are to work together to:

- Reduce the percentage (%) of adults who are physically inactive to less than 20% by 2030
- Increase the percentage (%) of adults walking or cycling for travel at least three days a week by at least 25% by 2030

---

[36] Public Health England (based on the Active Lives Adult Survey, Sport England). 2019/20. "Physical Activity - Percentage of physically inactive adults." Fingertips. Accessed July 28, 2021. https://fingertips.phe.org.uk/profile/physical-activity/data#page/3/gid/1938132899/pat/6/par/E12000005/ati/402/are/E08000025/iid/93015/age/298/sex/4/cid/4/tbm/1/page-options/car-do-0.

[37] Public Health England (based on the Active Lives Children and Young People Survey, 2020/21, Sport England), "Physical Activity – Percentage of physically active children and young people", Fingertips, Accessed 08/02/2022, https://fingertips.phe.org.uk/search/physical%20activity#page/3/gid/1/pat/6/par/E12000005/ati/402/are/E08000025/iid/93570/age/246/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/ine-pt-1_ine-ao-1_ine-vo-1_ine-yo-1:2020:-1:-1_ine-ct-129_car-do-0_car-ao-0.

- Increase the percentage (%) of physically active children and young people to the national average by 2030
- Reduce the inactivity gap between those living with disabilities and long-term health conditions and those without by 50% by 2030
- Reduce the inactivity gap between different ethnic communities by 50% by 2030

Leadership for Action

The work to address this theme will be led through the Creating a Physically Active City Forum, Sport Birmingham, and the Physical Activity Alliance.

Key Actions

To achieve our ambitions, we will take the following actions:

- Improve physical activity data and evidence to guide and inform practice and governance.
- Use technology, including apps and gamification, to increase inclusive physical activity participation for all including Birmingham's diverse range of communities and under-represented groups.
- Prioritise active travel in local neighbourhoods through initiatives in the Birmingham Transport Plan.
- Utilise physical activity to enhance community cohesion through targeted community events and interventions and build on previous successful projects, such as Tola Time.
- Embed physical activity as a viable part of treatment pathways for long term health conditions.

"Think Football is the anchor for my week, maintaining wellbeing in a supportive environment, while being physically active. It has quite literally saved my life."

Quote from Think Football Participant, Aston Villa Foundation

4. Contributing to a Green and Sustainable Future

The natural environment around us can both harm our health, e.g. through air pollution, and improve our physical and mental health through direct facilitation such as green gyms and exposure and nature connectedness, e.g. nature trails.

Therefore, the Health and Wellbeing Board has a vested interest in actively supporting the City in its approach in creating a green and sustainable future.

Creating this future for our green, blue (water) and white (air) environments will require action on many fronts led by several partners. This includes the City of Nature Board, the Brum Breathes Board and the Climate Action Taskforce.[38]

This theme aims to promote and protect health by improving outcomes for conditions linked to the environment and using the opportunities of a green and sustainable future to improve the health and wellbeing of citizens.

This includes taking the opportunities offered by nature and improving our environment as a pathway to wellbeing. We aim to use the green and blue spaces in our city to appreciate our environment and its value in improving the physical and mental health of our citizens.

We are blessed in this city with a huge number of natural assets. Still, there are inequalities across their geographic distribution and for those who can access them, and how they are used to benefit health.

Creating a bolder, healthier city involves seizing the opportunity to support the creation of health promoting places to live. Such places will be consciously designed to enable social interaction and be inclusive, safe, accessible; provide access and connections to nature; and support healthy lifestyles.

Our ambitions are to work together to:

- Reduce the percentage (%) of mortality attributable to particulate air pollution to less than 4.5% by 2030
- Increase the utilisation of outdoor space for exercise/health reasons to over 25% by 2028
- Increase the daily utilisation of green and blue spaces to 25% of the population by 2030
- Increase volunteering in green and blue spaces to at least 10% of the population by 2027
- Increase the proportion of our population connecting with nature to at least 35% of the population listening to birdsong by 2030

Leadership for Action

This theme will be taken forward through the work of the City of Nature Plan and Bolder Greener Birmingham.

Key Actions

To achieve our ambitions, we will take the following actions:

- Collaborate to further develop and implement the evidence base for health and wellbeing interventions which utilise the natural environment for health gain.

[38] Birmingham City Council: https://naturallybirmingham.org/birmingham-city-of-nature-delivery-framework/

- Ensure all partners play active roles as anchor organisations to support the Clean Air Strategy, Climate Change Route to Zero Strategy and City of Nature Plan.
- Work with our partners to celebrate and maximise the potential benefits to physical and mental health of our natural environment.
- Address inequalities in access and utilisation of natural space for health benefit between citizens, especially for disabled people and ethnic communities.

"The secret to using nature as a mood booster is to find activities in a green space that match the outcome you are looking for. For some, going to a quiet park to escape their daily routine will bring peace of mind and a sense of freedom. Others may use their natural landscapes to challenge themselves with activities like running or cycling. Some are intoxicated by simply interacting with animals."

Quote from Witton Lodge Community Association

5. Protect and Detect

The Protect and Detect theme is focused on the work we can do together to protect the health of citizens from infectious disease, incidents, and outbreaks. It also focuses on detecting diseases, such as cancer, at an early stage to maximise the benefits that treatment can provide.

Screening and immunisation are key to early detection and prevention for health. There are a series of national screening programmes across the life course from antenatal and pregnancy screening to cancer screening in adult and older adult life. However, these are affected by inequalities associated with barriers across the life course that include physical and communication challenges, deprivation as well as cultural and social barriers (genders, ethnicities, races, religions, or socioeconomic status).[39] Also, vaccination programmes are essential to public health and provide crucial protection against infectious diseases that can cause death and disability. This includes measles, mumps, and rubella (MMR), influenza and COVID-19. The uptake of the flu vaccine for people aged 65 and over (2020/2021) in Birmingham is 74.1%, compared to the England population coverage at 80.9%.[40] The uptake of many vaccinations is worse in Birmingham than at regional and national levels, which needs to improve. Also, the mortality rate for deaths involving COVID-19 for all ages (2020) in Birmingham was significantly higher at 224.1 (per 100,000 population) compared to the England rate of 140.1 (per 100,000 population).[41]

Birmingham has committed to becoming a Fast-Track City, an international initiative aimed at tackling blood-borne viruses (BBVs) (HIV, Hepatitis B and Hepatitis C) and tuberculosis (TB) by 2030 and 2035 respectively. By working closely with local stakeholders from across primary care, secondary care, the UK Health Security Agency (UKHSA), NHS Specialised Commissioning, industry representatives and Birmingham Public Health to meet set targets for each BBV and TB.

Protecting citizens from infectious diseases also offers opportunities for action on environmental health, sexual and reproductive health and robust cross-partnership response to local outbreaks and incidents of infectious disease.

We want Birmingham to be a city protected from infectious disease through immunisation and appropriate responses. We also want to support health and wellbeing through early detection of disease and have services available for those affected.

Our ambitions are to work together to:

- Achieve the national ambitions or targets for all national immunisation programmes by 2030
- Achieve the national targets for all national screening programmes by 2030

---

[39] UKHSA (2019) https://ukhsa.blog.gov.uk/2019/05/16/increasing-vaccine-uptake-strategies-for-addressing-barriers-in-primary-care/

[40] Fingertips Public Health Data https://fingertips.phe.org.uk/search/flu#page/4/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/30314/age/27/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

[41] Fingertip Public Health Data https://fingertips.phe.org.uk/search/covid#page/4/gid/1/pat/6/ati/102/are/E08000025/iid/93827/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

- Halve the variation in uptake (inequality) for all immunisation (children) by 2030
- Halve the variation in uptake (inequality) for all screening programmes (adults) 2030

Leadership for Action

This theme will be led by the Health Protection Forum.

Key Actions

To achieve our ambitions, we will take the following actions:

- Reduce the overall rates of new sexual health infections, including HIV, through early diagnosis and treatment to close the gap between Birmingham and national averages for adults.
- Commit to overcoming barriers that make it harder for some groups of people to engage with screening services.
- Deliver Fast-Track accreditation for Birmingham and an evidence-based approach to reduce HIV and blood-borne virus infections.
- Deliver the Sexual Health Strategy.

Life Course

Action must start before birth to close the gap in health inequalities and allow citizens to make choices that empower them to live happy and healthy lives. A life course approach supports citizens to age healthily and prevents our citizens from experiencing poor health.

Birmingham's approach will be to support our citizens in:

- Getting the Best Start in Life
- Living, Working and Learning Well
- Ageing Well and Dying Well

Getting the Best Start in Life

Giving children the best start in life is crucial to this approach and improving the life chances of our citizens. Birmingham is one of the youngest cities in Europe, with 46% of our population aged under 30.[42]

There is clear evidence that the foundations laid down for life from pre-conception through childhood and adolescence can positively or negatively impact an individual's entire life. Some of these are underpinned by poverty, and child poverty is a significant challenge for our city. Still, many are also driven by the environment and support available to children, young people and families.

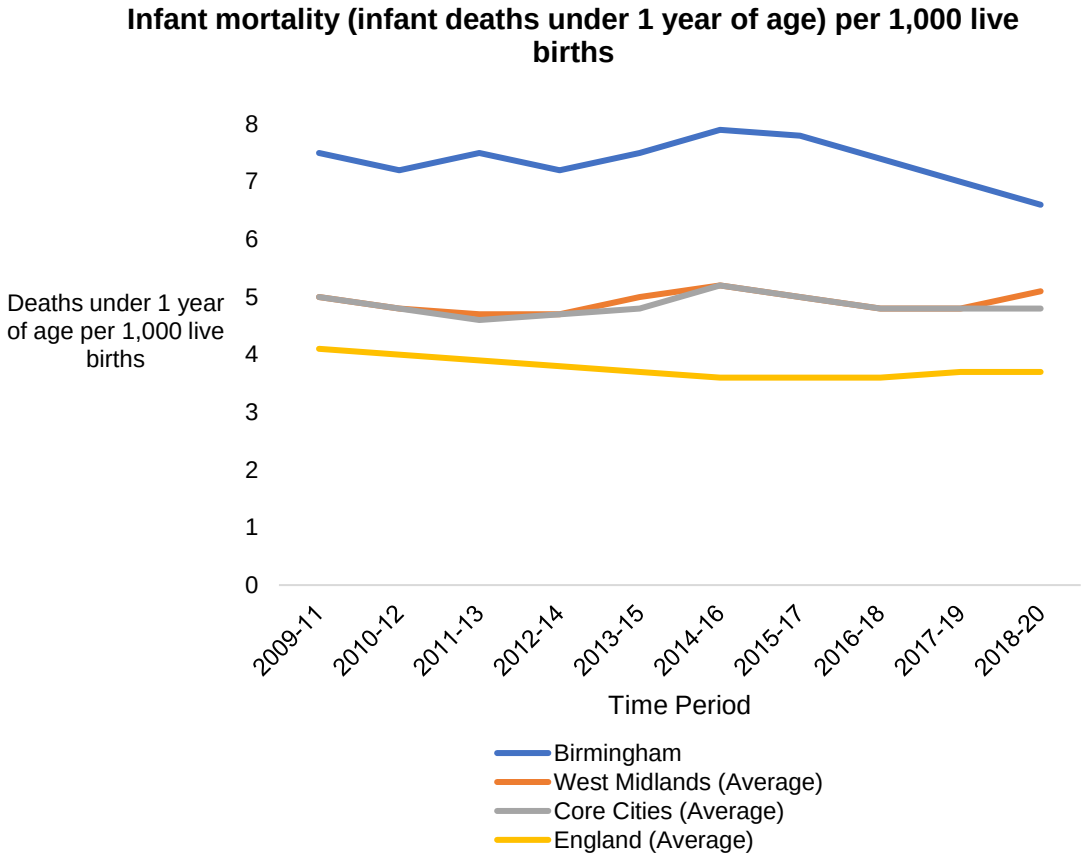
Infant mortality is highly correlated with poverty, and national rates are highest within the poorest decile of the population.[43] Birmingham continues to have a higher stillbirth and infant mortality rate than the national average. Too many babies are born with a low or very low birth weight. This highlights the need for our approach to start before conception, working with potential parents to plan parenthood safely and support them through pregnancy.

Nationally, the rate of infant mortality has been declining steadily since the 2001/03 period. Still, rates in Birmingham are higher than the national average (nearly twice the national average). Currently, out of every 1,000 births in the city, seven babies will not live until their first birthday. The multi-agency Infant Mortality Task Force, led by an Independent Chair, has been established. Our ambition is to halve the infant mortality rate in Birmingham by 2030.

As children grow, inequalities continue in primary and secondary school years. We see high levels of vulnerability emerging, undoubtedly creating more challenges for these young people to achieve their potential as they progress to adulthood. There are significant inequalities between different groups of children. We have a duty of care to children and young people with special educational needs and disabilities, as well as those who come into contact with our care system. We must strive to address these vigorously and proactively.

[42] Office for National Statistics Population estimates (2020): https://www.nomisweb.co.uk/datasets/pestnew

[43] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/7/gid/1938133228/pat/6/par/E12000005/ati/302/are/E08000025/iid/92196/age/2/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0_ine-ao-1_ine-yo-3:2018:-1:-1_ine-pt-0_ine-ct-146



There is clear evidence across a wide range of indicators for children and young people that children in Birmingham could be given a better start in life. We will work together to close the gaps between our city and the national average to enable our children to face the future on more equal terms. No single agency can take action to address these priorities (e.g. reducing infant mortality). Equally, this work is important across the five core themes of the Strategy, particularly the theme around mental wellness and balance. We will work collaboratively to achieve the step-change in outcomes for our children and young people.

Supporting people to get the best start in life includes creating the conditions for a safe community for young people and protecting them from harm. The West Midlands Violence Reduction Unit (VRU) identified three factors with the strongest correlations towards violence; deprivation affecting children, rates of mental health, lack of educational development in early years. The Health and Wellbeing Board is committed to tackling the root causes, prevention and early intervention to prevent violence. Much of the critical work in this area is led by the Children's Safeguarding Partnership and Community Safety Partnerships. We are committed to supporting this and will support work such as the Community Safety Resilience Framework.

Living, Working and Learning Well

This theme is focused on working-age adults in Birmingham. It reflects the importance of work and learning throughout our adult life, allowing us to live well. Too many adults across the city lead unhealthy lives. Although choice is a factor, so too is the environment in which we live, work and learn. We will maximise the health of our working-age citizens by treating and preventing ill health, including conditions such as cardiovascular disease. We must work together to create a city that supports all adults to be healthier at work and home.

Living well means having a safe, secure and good quality home. For example, cold housing can damage our health, and people, often those in poor health, live in a cold home. 21.2% of our citizens live in fuel poverty (2019), compared with 13.4% in England.

Working well is tackling unemployment and supporting our citizens to have meaningful, high-quality work with good wages. Poverty and poor quality employment significantly impact the physical and mental health of our citizens. Ill health and poor wellbeing can be a barrier to employment, and unemployment can create barriers to health and wellbeing. The average person will spend one-third (or 90,000 hours) of their (waking) life at work, so being healthy at work is essential. Employers across Birmingham can support their staff to lead happier and healthier lives. We must work with public sector organisations, private sector organisations, and trade unions to create healthier workplaces for all.

Similarly, ill-health can be a barrier to or result from a lack of education. Learning well is fundamental to our wellbeing, through both the content of what we learn and the act of learning itself. Creating and maintaining health literacy is an essential part of this by underpinning people's ability to make informed choices about their health and wellbeing. The challenges of health literacy in our city have been made clear by the pandemic.

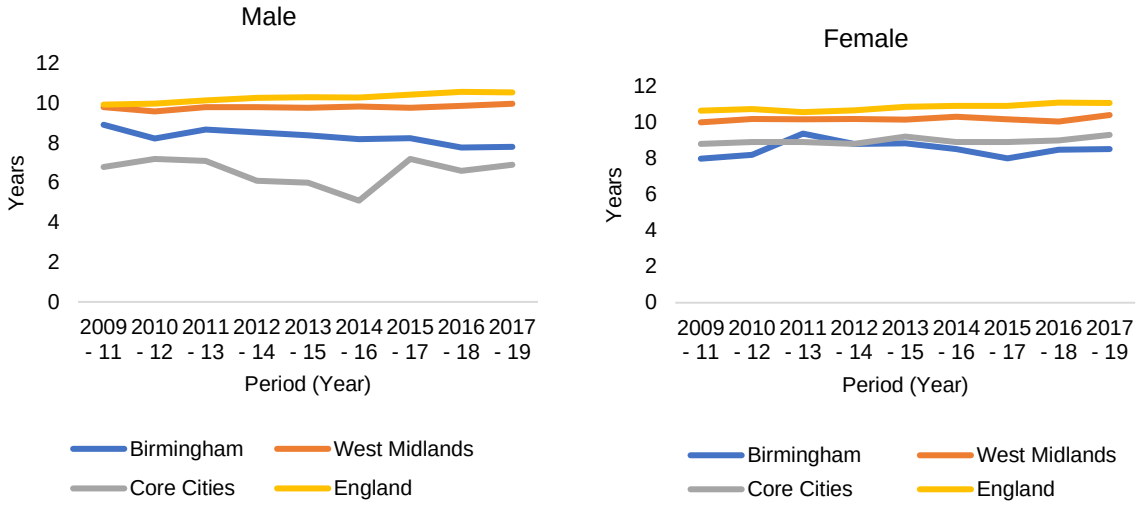
The Health and Wellbeing Board will tackle the wider determinants of health and support the city to reduce deep and ingrained structural inequalities. These inequalities are driven by poverty, education, housing, employment and the environment we live, work and learn. These factors also significantly impact our health and wellbeing. The Board will play an active role in these health determinants and support plans such as the Birmingham Levelling Up Strategy. The Levelling Up Strategy outlines an approach of early intervention and prevention and investing in 'people-powered change' with inclusive growth. We will support people to live, work and learn well through crucial partnerships, including the Integrated Care System (ICS) Inequalities Programme and the Birmingham Poverty Truth Commission.

Ageing Well and Dying Well

Birmingham is a young city, but it has a growing number of older adults traditionally defined as those above 65 years of age. Mid-year ONS estimates (2020) show approximately 13% (149,300 persons) of the Birmingham population fall in this category. This is expected to rise to up to 10.4% (166,600) in 2028 rising to 22.1% (191,600) in 2038. Many of our older adults are living with multiple health conditions. With the expected number of older people living in poor health rising, we must invest in prevention and approaches that help people age well.

On average, women in Birmingham aged 65 are predicted to live another 20.4 years and men another 17.7 years. These are below the averages for England and below the West Midlands average. Women at 65 years old in Birmingham are expected to spend 8.5 years of their life in good health (healthy life expectancy). This is 2.6 years less than the England average. Men at 65 years old in Birmingham are expected to spend 6.9 years of their life in good health. This is 3.7 years less than the England average. We need to work together to close this gap and enable our citizens to live healthier and happier lives as they age. There is also a gap in life expectancy at 65 between people living in the city's most deprived areas and those in the least deprived. People living in the most affluent parts of Birmingham are expected to live around five years longer after reaching the age of 65 than those in the most deprived areas.

Healthy Life Expectancy at 65 in Birmingham[44]



Research provides evidence of the impact of the pandemic on older people's health. It shows increased levels of anxiety (1 in 3 respondents felt more anxious) and muscle weakness (1 in 5 (2.3 million) or 18% say they feel less steady on their feet).[45]

The prevalence of conditions such as Dementia, Parkinson's Disease and Frailty increases as people age, so our ambition would be to reduce the impact of these conditions. We also understand the importance of encouraging social interaction and reducing isolation and loneliness in our older adults. We will work together to create an age-friendly city that supports older adults to fully participate in their communities and tackle We will build on the existing successes, such as our dementia-friendly communities. Through our work to become an age-friendly city, we know that older people in Birmingham want opportunities to continue their working life after 65. This can be for financial reasons, but it can also be for their physical and mental health and wellbeing. We are committed to supporting older adults in our city to continue to live, work, and learn well.

As we age, we want health and social care services to collaborate to provide integrated solutions that support citizens to remain independent and connected to communities, families, and friends. We are committed to ensuring services and support are available in the places where people live. We will support the place-based efforts in the ICS and initiatives such as the Neighbourhood Networks. We will ensure our carers feel they can cope with their caring responsibilities and have a life alongside caring. Around 1 in 5 households in Birmingham have an unpaid carer looking after a family member or friend.

We also have a responsibility to support people at the end of their life to die with dignity and as comfortably as possible, whatever their age. At the end of life, we all hope for a peaceful end. To achieve this, we must work together to support citizens, and families, to die with dignity and at a chosen place of death. We must ensure that pathways for end of life are compassionate and inclusive, and appropriate support is provided to those bereaved in addition to those who are dying.

---

44 https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1

45 https://www.ageuk.org.uk/latest-press/articles/2020/10/age-uk--research-into-the-effects-of-the-pandemic-on-the-older-populations-health/

Ambitions across the life course

To support people in getting the best start in life, we will work together to:

- Reduce infant mortality in Birmingham by 25% by 2027 and by 50% by 2030
- Improve the percentage (%) of children achieving a good level of development by age 2 to 2.5 years to over 83% by 2030
- Increase the percentage (%) of children achieving a good level of development at the end of Reception (school readiness) by 75% by 2030
- Halve the rate of children killed and seriously injured on Birmingham's roads by 2030
- Reduce the under 18 teenage conception rate to close the gap between Birmingham and the national average by 2030
- Halve the hospital admissions due to asthma in young people under 18 years by 2027
- Reduce the rate of first-time entrants (10-17 years) to the youth justice system by 25% by 2030
- Reduce the rate per 1000 of homeless young people (16-24 years) to the English average by 2030

To support our citizens to live, work and learn well, we will work together to:

- Increase the percentage (%) of the estimated individuals accessing smoking cessation services and improve the 4-week quit rate by 20% by 2030
- Reduce coronary heart disease admissions rate (all ages) by 20% by 2030
- Reduce the percentage (%) of adults from ethnic communities with Type 2 diabetes to match the demographic profile of our city by 2030
- Increase the percentage (%) of eligible citizens who took up the offer of an NHS Health Check to over 70% by 2030
- Increase the number of targeted health checks (e.g. for carers and people with learning disabilities and/or severe mental health issues) by 25% by 2027
- Achieve 50% of all medium and large businesses in Birmingham becoming part of the Thrive at Work programme in 2030
- Reduce the number of households in fuel poverty to the national average by 2030

To enable our older adults to age well and die well, we will work together to:

- Halve the gap in healthy life expectancy at 65 years between Birmingham and the national average for both men and women by 2030
- Reduce the percentage (%) of people reporting a long term Musculoskeletal (MSK) problem to 5% below the England average by 2030 by 2030
- Improve the detection of dementia by increasing the percentage (%) of people estimated to be living with dementia who are diagnosed and receiving support to over 75% by 2030
- Reduce the rate of emergency hospital admissions due to falls in people aged 65 years and over to below the national average by 2030
- Improve the carer-reported quality of life score for people caring for someone with dementia to equal or higher than the national average by 2030
- Improve the carer-reported quality of life score to equal to or above the national average by 2030
- Reduce excess winter deaths to close the gap between the actual and expected number of deaths in people aged >85years to the national average by 2030

To achieve these ambitions, we will take the following actions:

Getting the Best Start in Life

- Co-produce priorities and deliver evidence-based interventions to support our children, young people and families, e.g. Birmingham Infant Mortality Taskforce.
- Develop and support adolescent health and wellbeing, interconnecting with proven strategies on youth justice, e.g. Violence Reduction Unit (VRU).
- Work with key stakeholders in the Children and Families Directorate and the voluntary sector to increase school readiness across diverse communities, e.g. Children's Early Help Services and the Family Hubs model.
- Support the Community Safety Partnership to embed a Public Health whole-system approach to violence reduction. This includes hate crime, domestic abuse and modern slavery, e.g. Community Safety Resilience Framework.
- Develop our understanding of and respond to the health and wellbeing needs of individuals in contact with the justice and asylum systems, building on our learning during the pandemic response.

Living, Working and Learning Well

- Support the city to level up and tackle inequalities that reduce the impact on health amongst disadvantaged groups, e.g. Birmingham Levelling Up Strategy, Poverty Truth Commission and the East Birmingham Inclusive Growth Strategy.
- Build on the evidence base for understanding inequalities faced by different ethnic minority communities, e.g. Birmingham & Lewisham African & Caribbean Health Inequalities Review (BLACHIR)
- Work with the ICS to emphasise and address inequalities in healthcare access, experience and outcomes, e.g. ICS Inequalities Programme.
- Co-produce accessible and culturally appropriate services and interventions to improve health literacy e.g. weight management services targeted at specific communities of identity including ethnic and disabled communities.
- Use the leverage of anchor organisations and our evidence base to encourage employers to support employee health and wellbeing, e.g. Thrive at Work programme and the Real Living Wage.

Ageing Well and Dying Well

- Strengthen engagement and understanding of ageing in Birmingham's diverse communities, including those in inclusion groups, e.g. commissioning focus groups to understand population (and population of interest) relationships with ageing and a series of scoping reviews to understand root causes of conditions associated with ageing.
- Use clear and visible prevention and early intervention approaches to support healthy independent ageing for all citizens, e.g. Brain Health promotion for the public and professionals.
- Use community-based prevention & early intervention services to ensure support is available in the places people live, e.g. Neighbourhood Network Schemes that connect people with local opportunities and maintain health and wellbeing.
- Establish a Healthy Ageing Academic Partnership to increase the evidence base to become a recognised Age-Friendly City and Compassionate City by 2027.

- Use the Better Care Fund to support the delivery of the Birmingham Integrated Care Partnership (BICP) priorities, e.g. Early Intervention Programme.

Governance and relationships to achieve success

Creating a Bolder, Healthier City (2022-2030) will be led by the Birmingham Health and Wellbeing Board, working with local community groups, networks, and partners. The Board provides a public forum at the place (Birmingham) level for influencing, decision-making, and engagement across various areas of health and wellbeing.

The **Health and Wellbeing Board** will oversee the Strategy and receive updates on its progress against the ambition outcomes. The ambitions set out in this Strategy allow the Board to focus their action on how to achieve them and monitor progress from 2022 to 2030. Some of the actions required already exist and have been detailed in this Strategy, others are yet to be formulated. We will develop these in partnership, agreeing on clear actions and measuring our progress in the short term.

The **Health and Wellbeing Board fora** will support the ambitions and outcomes of the Birmingham Health and Wellbeing Strategy. They will create plans and strategies working in partnership. Local **partners** will deliver on the Strategy's themes and work with us and each other for Birmingham. The health and social care system will design and offer services centred around the needs of citizens, thereby aiding the overall success of the Strategy.

Birmingham's **citizens** will promote their own health and wellbeing as part of their **communities**. As they responded to the COVID-19 crisis, communities will support the most vulnerable and create connections and relationships. They will continue to be involved in decision-making and making change across the city.

Health and Wellbeing Board Partnership Fora

- Creating a Healthy Food City Forum
- Creating a Mentally Healthy City Forum
- Creating an Active City Forum
- Creating a City Without Inequalities Forum
- Health Protection Forum

NHS Strategic Partnerships

- Birmingham & Solihull Integrated Care System
- Birmingham & Solihull Provider Collaboratives
- Birmingham & Solihull Mental Health Partnership
- Birmingham & Solihull United Maternity and Newborn Partnership (BUMP) and Black Country and West Birmingham Local Maternity System

Birmingham Safeguarding Partnerships

- Children's Safeguarding Partnership Board
- Adult Safeguarding Partnership Board
- Domestic Abuse Strategy Board
- Re-offending Prevention Partnership

City Partnership Relationships

- Children's Strategic Partnership
- Community Safety Partnership
- City Board

- Youth City Board
- Financial Inclusion Partnership

Community Engagement Partnerships

- Birmingham Poverty Truth Commission
- Armed Forces Community Covenant
- Gypsy, Roma & Traveller Forum
- Birmingham Voluntary Services Council (BVSC)
- Birmingham Council of Faiths and the Birmingham Faith Leaders Group

Measuring our Success - Indicatory Journey Data Pack

Theme 1: Healthy and Affordable Food

*****_The indicators aligned with this theme are not directly about food consumption as we do not have the data._

Ambition	Indicator	Baseline				Desired Direction of Travel
		Year	Birmingham	England	Core Cities	
Increase the % of babies who are breastfed 6-8 weeks after birth to over 50% by 2027 and to over 60% by 2030	% of babies who are breastfed 6-8 weeks after birth	2019/2020	TBC	47.6%	N/A	N/A
Increase the uptake of healthy start vouchers in eligible families to at least 80% by 2030	Uptake of healthy start vouchers in eligible families	2021	72%	56.8%	N/A	Decrease
Reduce the % of 5yr olds with visually obvious dental decay to below 20% by 2030	% of 5yr olds with visually obvious dental decay	2018/19	28.6%	23.4%	29.21%	Decrease
Reduce the prevalence of obesity (including severe obesity) in children in Reception and Year 6 by 10% by 2030	Reception: Prevalence of obesity (including severe obesity)	2019/20	10.9%	9.9%	24.15%	Decrease
Reduce the prevalence of obesity (including severe obesity) in children in Reception and Year 6 by 10% by 2030	Year 6: Prevalence of obesity (including severe obesity)	2019/20	25.5%	21.0%	38.5%	Decrease
Reduce the prevalence of underweight in children in Reception to less than 1% by 2030	Reception: Prevalence of underweight	2019/20	1.4%	0.9%	1.09%	Decrease

Reduce the prevalence of underweight in children in Year 6 to less than 1% by 2030	Year 6: Prevalence of underweight	2019/20	1.6%	1.4%	1.5%	Decrease
Increase the % of adults regularly eating '5-a-day' to more than 55% by 2030	% of adults regularly eating '5-a-day'	2019/20	52.6%	55.4%	52%	Increase

Indicator	Definition	Why are we measuring this?
% of babies who are breastfed 6-8 weeks after birth	This is the percentage of infants that are totally or partially breastfed at age 6-8 weeks. Totally breastfed is defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are not receiving formula milk, any other liquids or food. Partially breastfed is defined as infants who are currently receiving breast milk at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food. Not at all breastfed is defined as infants who are not currently receiving any breast milk at 6-8 weeks of age.	The inclusion of this indicators will encourage the continued prioritisation of breastfeeding support locally. Increases in breastfeeding are expected to reduce illness in young children, have health benefits for the infant and the mother and result in cost savings to the NHS through reduced hospital admission for the treatment of infection in infants. Breast milk provides the ideal nutrition for infants in the first stages of life.
Uptake of healthy start vouchers in eligible families	Figures provided are snapshots taken at a single point during each 4-week cycle. Take-up is calculated as a percentage of entitled beneficiaries over eligible beneficiaries.	Research shows that women who are introduced to the scheme by a health professional, who takes the time to explain its public health context and health benefits, are more likely to understand the benefits and make better use of the scheme
% of 5yr olds with visually obvious dental decay	Percentage of 5-year-olds with dental decay extending to the dentine layer which can be detected by visual observation alone	Oral health is an integral part of overall health; when children are not healthy this affects their ability to learn, thrive and develop. This indicator allows benchmarking of oral health of young children across England and is an excellent proxy measure of assessing the impact of the commissioning of oral health improvement programmes on the local community. Dental caries is a synonymous term for tooth decay.

Reception: Prevalence of obesity (including severe obesity)	Prevalence of obesity (including severe obesity, BMI greater than or equal to the 95th centile of the UK90 growth reference) among children in Reception (age 4-5 years	There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older
Year 6: Prevalence of obesity (including severe obesity)	Prevalence of obesity (including severe obesity, BMI greater than or equal to the 95th centile of the UK90 growth reference) among children in Year 6 (age 10-11 years)	There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older
Reception: Prevalence of underweight	Number of children in Reception with a valid height and weight measured by the NCMP with a BMI classified as underweight.	The data can be used nationally to support local public health initiatives, and locally to inform the planning and delivery of services for children.
Year 6: Prevalence of underweight	Number of children in Reception with a valid height and weight measured by the NCMP with a BMI classified as underweight.	The data can be used nationally to support local public health initiatives, and locally to inform the planning and delivery of services for children.
% of adults regularly eating '5-a-day'	This Toolkit will aid the preparation of a Health Impact Assessment (HIA) for planning related projects, including the development of planning policy and planning applications, it provides guidance on the HIA process and demonstrates how it can be used. It identifies aspects of the built environment which have an impact upon the health of Birmingham's residents	The Healthy City Planning Toolkit supports the creation of healthy communities through health-promoting planning policies, design and development management in Birmingham

Theme 2: Mental Wellness and Balance

Ambition	Indicator	Baseline				Desired Direction of Travel
		Year	Birmingham	England	Core Cities	
Reduce the prevalence of depression and anxiety in adults to less than 12% by 2030	Prevalence of depression and anxiety in adults	2016/17	14.5%	13.7%	15.84%	Decrease
Increase the proportion of adults who have a high self-reported life satisfaction score to over 80% by 2027	% proportion of adults who have a high self-reported life satisfaction score	2015/16	78.6%	81.2%	68.6%	Increase
Increase the average happiness rating for Birmingham to the national average by 2030	Average happiness rating (0-10: 0 'not happy at all', 10 'completely happy)	2020/21	7.16	7.34	7.11	Increase
Increase the average life satisfaction rating for Birmingham to the national average by 2030	Average life satisfaction rating (0-10: 0 'not at all satisfied', 10 'completely satisfied')	2020/21	7.20	7.42	7.18	Increase
Increase the average worthwhile rating for Birmingham to the national average by 2030	Average worthwhile rating (0-10: 0 'not at all worthwhile', 10 'completely worthwhile')	2020/21	7.70	7.73	7.57	Increase
Decrease the average anxiety rating for Birmingham to the national average by 2030	Average anxiety rating (0-10: 0 'not at all anxious, 10 'completely anxious)	2020/21	3.54	3.28	3.63	Decrease
Reduce our suicide rate (persons) in the city to be in the lowest 10 UTLA in England by 2030	Suicide rate (persons) per 100,000	2017/19	8.7	10.1	10.59	Decrease

Reduce the emergency intentional self-harm admission rate to be within the lowest 10 UTLA in England by 2030	Emergency Hospital Admissions for Intentional Self-Harm per 100,000	2018/19	184.2	196	231.06	Decrease
Reduce the smoking prevalence in adults with a long-term mental health condition to at least the national average by 2027	Smoking prevalence in adults with a long-term mental health condition	2016/17	26.6%	25.8%	33%	Decrease
Reduce episodes for alcohol-related conditions (Broad definition) to below the national average by 2030	Admission episodes for alcohol-related conditions (Broad definitions) per 100,000	2017/18	2954	2367	2695.729	Decrease
Increase successful completion of drug treatment – opiate users to over 8%	Successful completion of drug treatment – opiate users	2019	4.4%	5.6%	33.6%	Increase
Increase successful completion of drug treatment – non-opiate users to over 48%	Successful completion of drug treatment – non-opiate users	2018	37.9%	34.45%	33.55%	Increase
Reduce depression & anxiety among social care users to less than 50% by 2030	Depression and anxiety among social care users	2017/18	59.1%	54.5%	N/A	Decrease

Indicator	Definition	Why are we measuring this?
Prevalence of depression and anxiety in adults	The percentage of all respondents to the question "What is the state of your health today?" who answered "moderately anxious or depressed", "severely anxious or depressed" or "extremely anxious or depressed"	This indicator gives an indication of the prevalence of anxiety and depression as reported by respondents to the GP Patient Survey. A significant proportion of people that have depression are not diagnosed. Knowledge of how many people state that they have depression contributes to building up the local

		picture of prevalence of depression. It may also highlight gaps between diagnosed and undiagnosed prevalence in a local area.
Proportion of adults who have a high self-reported life satisfaction score	The percentage of respondents scoring 7-10 to the question “Overall, how satisfied are you with your life nowadays?” in the Annual Population Survey	People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.
Average happiness rating (0-10: 0 ‘not happy at all’, 10 ‘completely happy)	This measure is the average (mean) rating to the question "Overall, how happy did you feel yesterday?" Data is derived by Office for National Statistics (ONS) from the Annual Population Survey (APS).	Well-being is a key issue for the Government and ONS are leading a programme of work to develop new measures of national well-being. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.
Average life satisfaction rating (0-10: 0 ‘not at all satisfied’, 10 ‘completely satisfied’)	This measure is the average (mean) rating to the question "Overall, how satisfied are you with your life nowadays?" Data is derived by Office for National Statistics (ONS) from the Annual Population Survey (APS).	Well-being is a key issue for the Government and ONS are leading a programme of work to develop new measures of national well-being. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.
Average worthwhile rating (0-10: 0 ‘not at all worthwhile’, 10 ‘completely worthwhile’)	This measure is the average (mean) rating to the question "Overall, to what extent do you feel the things you do in your life are worthwhile?". Data is derived by Office for National Statistics (ONS) from the Annual Population Survey (APS).	Well-being is a key issue for the Government and ONS are leading a programme of work to develop new measures of national well-being. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.
Average anxiety rating (0-10: 0 ‘not at all anxious, 10 ‘completely anxious)	This measure is the average (mean) rating to the question "Overall, how anxious did you feel yesterday?". Data is derived by Office for National Statistics (ONS) from the Annual Population Survey (APS).	Well-being is a key issue for the Government and ONS are leading a programme of work to develop new measures of national well-being. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

Suicide rate (persons) per 100,000	Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population	Suicide is a significant cause of death in young adults and is seen as an indicator of underlying rates of mental ill-health. Suicide is a major issue for society and a leading cause of years of life lost. Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.
Emergency Hospital Admissions for Intentional Self-Harm per 100,000	Emergency Hospital Admissions for Intentional Self-Harm, directly age standardised rate, all ages, Persons	To monitor public health programmes aiming to reduce the risk of self-harm. To stimulate discussion and encourage local investigation, and to lead to improvement in data quality and quality of care. To help improve the provision of services
Smoking prevalence in adults with a long-term mental health condition	Smoking prevalence in adults self-reporting moderate, extreme or severe anxiety or depression - current smokers (GPPS)	Smoking is a modifiable behavioural risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population. Studies have shown that people with mental health conditions are more likely to smoke than the general public and that smoking rates increase with the severity of illness
Admission episodes for alcohol-related conditions (Broad definitions) per 100,000	Admissions to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code.	Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually
Successful treatment of drug treatment – opiate users	Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment	Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.
Successful completion of drug treatment – non-opiate users	Number of users on non-opiates that left drug treatment	It aligns with the ambition of both public health and the Government's drug strategy of

	successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment	increasing the number of individuals recovering from addiction
Depression and anxiety among social care users	The proportion of adult respondents to the social care users survey who report that they feel moderately or extremely anxious or depressed when asked to choose a statement which describes their state of health today. This indicator relates to all adult social care users, not just those with mental health conditions	The survey seeks the opinions of service users aged 18 and over in receipt of long-term support services funded or managed by social services and is designed to help the adult social care sector understand more about how services are affecting lives to enable choice and for informing service development.

Theme 3: Active at Every Age and Ability

Ambition	Indicator	Baseline				Desired Direction of Travel
		Year	Birmingham	England	Core Cities	
Increase the % of physical activity adults to over 65% of adults by 2030	Percentage of physically active adults	2019/20	58.7%	66.4%	65.71%	Increase
Reduce the % of adults who are physically inactive to less than 20% by 2030	Percentage of physically inactive adults	2019/20	28.9%	22.9%	23.8%	Decrease
Increase the % of adults walking or cycling for travel at least three days a week by at last 25% by 2030	Percentage of adults walking for travel at least three days a week	2018/19	25.5%	22.7%	29%	Increase
Increase the % of adults walking or cycling for travel at least three days a week by at last 25% by 2030	Percentage of adults cycling for travel at least three days a week	2018/19	1.4%	3.1%	3.08%	Increase
Increase the % of young people who are regularly walking or cycling as part of their daily travel to school or other places by 50% by 2030	Percentage of young people who are regularly walking as part of their daily travel to school or other places	2018/19 Academic	34.3%	40.4%	N/A	Increase
Increase the % of young people who are regularly walking or cycling as part of their daily travel to school or other places by 50% by 2030	Percentage of young people who are regularly cycling as part of their daily travel to school or other places	2018/19 Academic	8.5%	11.2%	N/A	Increase
Increase the % of physically active children and young people to the national average by 2030	Percentage of physically active children and young people	2020/21	32.0%	44.6%	N/A	Increase

Reduce the inactivity gap between those living with disabilities and long-term health conditions and those without by 50% by 2030	Inactivity gap between those living with disabilities and long term health conditions and those without	May 19-20	15.1% gap	19% gap	N/A	Increase
Reduce the activity gap between different ethnic groups by 2030	Activity gap between different ethnic groups by 2030 (white)	May 19-20	64.6%	64%	N/A	Increase
Reduce the activity gap between different ethnic groups by 2030	Activity gap between different ethnic groups by 2030 (Black)	May 19-20	60.4%	57%	N/A	Increase
Reduce the activity gap between different ethnic groups by 2030	Activity gap between different ethnic groups by 2030 (Asian)	May 19-20	53.6%	53%	N/A	Increase

Indicator	Definition	Why are we measuring this?
Percentage of physically active adults	The number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 moderate intensity equivalent (MIE) minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 19 and over	Physical inactivity is the 4th leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle
Percentage of physically inactive adults	The percentage of adults physically inactive and is measured by the “percentage doing less than 30 mins physical activity each week”.	People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle.
Percentage of adults walking for travel at least three days a week	The number of respondents aged 16 and over, with valid responses to travel on at least twelve days in the previous 28 days	Creating an environment where people actively choose to walk as part of everyday life can have

	expressed as a percentage of the total number of respondents aged 16 and over	a significant impact on public health and may reduce inequalities in health.
Percentage of adults cycling for travel at least three days a week	The number of respondents aged 16 and over, with valid responses to cycling questions for travel on at least twelve days in the previous 28 days expressed as a percentage of the total number of respondents aged 16 and over	Creating an environment where people actively choose to cycle as part of everyday life can have a significant impact on public health and may reduce inequalities in health.
Percentage of young people who are regularly walking as part of their daily travel to school or other places	The number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 moderate intensity equivalent (MIE) minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 19 and over	Physical inactivity is the 4th leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle
Percentage of young people who are regularly cycling as part of their daily travel to school or other places	Cycling for fun or fitness Years 1-11 (ages 5-16)	Recorded from the Active Lives 2021 Academic Year Children's Survey
Percentage of physically active children and young people	Percentage of children aged 5-16 that meet the UK Chief Medical Officers' (CMOs') recommendations for physical activity (an average of at least 60 minutes moderate-vigorous intensity activity per day across the week)	Good physical activity habits established in childhood and adolescence are also likely to be carried through into adulthood. If we can help children and young people to establish and maintain high volumes of physical activity into adulthood, we will reduce the risk of morbidity and mortality from chronic non-communicable diseases later in their lives
Inactivity gap between those living with disabilities and long term health conditions and those without	Inactive is <30 minutes a week	It's still the case activity levels decrease sharply the more impairments an individual has – and just 39% of those with three or more impairments are active (Sports England, Active Lifestyle, 2021)
Activity gap between different ethnic groups by 2030 (white)	Rates and population totals for adults who have taken part in sport and physical activity	A useful measure of engagement in different sports and physical activities

	at least twice in the last 28 days in England overall and by key demographic groups	
Activity gap between different ethnic groups by 2030 (Black)	Rates and population totals for adults who have taken part in sport and physical activity at least twice in the last 28 days in England overall and by key demographic groups	A useful measure of engagement in different sports and physical activities
Activity gap between different ethnic groups by 2030 (Asian)	Rates and population totals for adults who have taken part in sport and physical activity at least twice in the last 28 days in England overall and by key demographic groups	A useful measure of engagement in different sports and physical activities

Theme 4: Green and Sustainable Future

Ambition	Indicator	Baseline				Desired Direction of Travel
		Year	Birmingham	England	Core Cities	
Reduce the fraction of mortality attributable to particulate air pollution to less than 4.5% by 2030	Fraction of mortality attributable to particulate air pollution	2019	5.8%	5.1%	7.77%	Decrease
Reduce emergency hospital admissions for respiratory disease in adults to at least the national average by 2030	Emergency hospital admissions for respiratory disease in adults per 100,000	2018/19	1637 (BSol) 1962 (SWB)	1552	N/A	Decrease
Increase the utilisation of outdoor space for exercise/health reasons to over 25% by 2028	Utilisation of outdoor space for exercise/health reasons	2015-16	17.9%	18.4%	17.15%	Increase
Increase the daily utilisation of green and blue spaces to 25% of the population by 2030	Daily utilisation of green and blue spaces	2020	14%	N/A	N/A	Increase
Increase volunteering in green and blue spaces to at least 10% of the population by 2027	Volunteering in green and blue spaces	2020	3%	N/A	N/A	Increase
Increase the proportion of our population connecting with nature to at least 35% of the population listening to birdsong by 2030	% of people listening to birdsong	2020	25.5%	N/A	N/A	Increase

Indicator	Definition	Why are we measuring this?
Fraction of mortality attributable to particulate air pollution	Background annual average PM2.5 concentrations for the year of interest are modelled on a 1km x 1km grid using an air dispersion model, and calibrated using measured concentrations taken from background sites in Defra's Automatic Urban and Rural Network (http://uk-air.defra.gov.uk/interactive-map.) Data on primary emissions from different sources and a combination of measurement data for secondary inorganic aerosol and models for sources not included in the emission inventory (including re-suspension of dusts) are used to estimate the anthropogenic (human-made) component of these concentrations. By approximating LA boundaries to the 1km by 1km grid, and using census population data, population weighted background PM2.5 concentrations for each lower tier LA are calculated. This work is completed under contract to Defra, as a small extension of its obligations under the Ambient Air Quality Directive (2008/50/EC). Concentrations of anthropogenic, rather than total, PM2.5 are used as the basis for this indicator, as burden estimates based on total PM2.5 might give a misleading impression of the scale of the potential influence of policy interventions (COMEAP, 2012)	Fraction of annual all-cause adult mortality attributable to anthropogenic (human-made) particulate air pollution (measured as fine particulate matter, PM2.5*)
Emergency hospital admissions for respiratory disease in adults per 100,000	Emergency admissions to hospital where the primary diagnosis is any respiratory disease code (ICD-10 codes J00-J99). Directly age standardised rate per 100,000 population (standardised to the European standard population).	The burden of respiratory disease on hospital activity is significant. In England in 2017/18 there are over 850,000 hospital emergency admissions and more than 4.9 million bed days for respiratory disease. Exacerbations of COPD and asthma are significant causes of respiratory admissions, yet many episodes can be prevented by improved treatment compliance, symptom control and timely treatment of acute exacerbations

Utilisation of outdoor space for exercise/health reasons	MENE Survey	The weighted estimate of the proportion of residents in each area taking a visit to the natural environment for health or exercise purposes over the previous seven days
Daily utilisation of green and blue spaces	Visiting green spaces frequency	A survey asking Birmingham residents about their use and perception of local green spaces
Volunteering in green and blue spaces	Volunteering opportunities in green spaces in Birmingham	Frequency of doing things in green spaces - Volunteering in green and blue spaces
% of people listening to birdsong	An activity measure done in green space	Frequency of doing things in green spaces - listening to birdsong

Theme 5: Protect and Detect

Ambition	Indicator	Baseline				Desired Direction of Travel
		Year	Birmingham	England	Core Cities	
Achieve the national ambitions or targets for all national immunisation programmes by 2030	MMR for one dose (2 years old)	2019/20	85.7%	90.6%	88.51%	Increase
Achieve the national ambitions or targets for all national immunisation programmes by 2030	MMR for two doses (5 years old)	2019/20	81.4%	86.6%	84.06%	Increase
Reduce transmission of HIV, Hepatitis C (HCV) and TB to reduce new cases by 50% by 2030	TB incidence (3-year rate)	2016-18	18.4	8.0	11.4	Decrease
Reduce transmission of HIV, Hepatitis C (HCV) and TB to reduce new cases by 50% by 2030	New HIV diagnosis rate per 100,000 (aged 15 years and over)	2020	6.6	5.7	8.1	Decrease
Reduce transmission of HIV, Hepatitis C (HCV) and TB to reduce new cases by 50% by 2030	Hepatitis C detection rate per 100,000	2017	35.2	18.4	30.34	Decrease
Reduce the percentage of HIV Late Diagnosis to less than 30% by 2027	HIV Late Diagnosis	2016-18	46.80%	43.10%	43.60%	Decrease
Reduce the overall prevalence of new sexually transmitted diseases through early diagnosis and treatment to close the gap between Birmingham and the national average by 2030	New STI diagnoses (exc chlamydia aged <25) / 100,000	2018	997	870	1029	Decrease

Improve the uptake of national screening programmes to close the gaps between Birmingham and the national targets	Cancer screening coverage - breast cancer	2021	57.3%	64.1%	61.4%	Increase
Improve the uptake of national screening programmes to close the gaps between Birmingham and the national targets	Cancer screening coverage - cervical cancer (aged 25 to 49 years old)	2021	59.6%	68.0%	64.1%	Increase
Improve the uptake of national screening programmes to close the gaps between Birmingham and the national targets	Cancer screening coverage – bowel cancer	2021	55.1%	65.2%	60.2%	Increase
Improve the uptake of national screening programmes to close the gaps between Birmingham and the national targets	Abdominal Aortic Aneurysm Screening - Coverage	2020-21	38.9%	55.0%	54.8%	Increase
Increase the percentage of men who have sex with men who access repeat HIV testing in the last year to over 50%	Repeat HIV testing in gay, bisexual and other men who have sex with men (%)	2020	38.2%	52.0%	50.8%	Increase

Indicator	Definition	Why are we measuring this?
MMR for one dose (2 years old)	All children for whom the local authority is responsible who received one dose of MMR on or after their first birthday and at any time up to their second birthday as a percentage	Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases.

	of all children whose second birthday falls within the time period	
MMR for two doses (5 years old)	All children for whom the local authority is responsible who received two doses of MMR on or after their first birthday and at any time up to their fifth birthday as a percentage of all children whose fifth birthday falls within the time period	MMR is the combined vaccine that protects against measles, mumps and rubella. Measles, mumps and rubella are highly infectious, common conditions that can have serious complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.
TB incidence (3-year rate)	Three-year average incidence of TB per 100,000 population.	Reducing TB incidence is a key ambition of the Collaborative Tuberculosis Strategy for England 2015-2020.
New HIV diagnosis rate per 100,000 (aged 15 years and over)	All new HIV diagnoses among adults (aged 15 years or more) in the UK, expressed as a rate per 100,000 population.	New HIV diagnosis is not synonymous with incidence; however, it provides a timely insight into the onward HIV transmission in a country and consequently allows targeting efforts to reduce transmission.
Hepatitis C detection rate per 100,000	Directly standardised rate of new diagnoses of confirmed chronic hepatitis C per 100,000 population	This indicator is designed to measure the detection of chronic hepatitis C, which reflects both the local burden of chronic hepatitis C and testing practice. Hepatitis C is an important health protection issue that increases people's risk of developing serious long term disease
HIV Late Diagnosis	Percentage of adults (aged 15 years or more) diagnosed with a CD4 cell count less than 350 cells per mm3 among all newly diagnosed adults with CD4 cell count available within 91 days of diagnosis. These include all reports of HIV diagnoses made in the UK, regardless of country of first HIV positive test (that is including people who were previously diagnosed with HIV abroad). A corrected definition of late diagnosis which excludes individuals with	A HIV key strategic priority is to decrease HIV-related mortality and morbidity through reducing the proportion and number of HIV diagnoses made at a late stage of HIV infection

	evidence of recent seroconversion can be seen in this year's annual report and web tables, though this has not yet been applied here.	
New STI diagnoses (exc chlamydia aged <25) / 100,000	Tests for syphilis, HIV, gonorrhoea and chlamydia (aged over 25) among people accessing sexual health services* in England.	Testing rates and diagnosis rates are closely linked.
Cancer screening coverage - breast cancer	The proportion of women eligible for screening who have had a test with a recorded result at least once in the previous 36 months.	Breast screening supports early detection of cancer and is estimated to save 1,400 lives in England each year.
Cancer screening coverage - cervical cancer (aged 25 to 49 years old)	The proportion of women in the resident population eligible for cervical screening aged 25 to 49 years at end of period reported who were screened adequately within the previous 3.5 years.	Cervical screening supports detection of cell abnormalities that may become cancer and is estimated to save 4,500 lives
Cancer screening coverage – bowel cancer	Bowel cancer screening supports early detection of cancer and polyps which are not cancers but may develop into cancers overtime.	Bowel cancer screening supports early detection of cancer and polyps which are not cancers but may develop into cancers overtime.
Abdominal Aortic Aneurysm Screening - Coverage	Abdominal aortic aneurysm (AAA) screening aims to reduce AAA related mortality among men aged 65 to 74	Abdominal aortic aneurysm (AAA) screening aims to reduce AAA related mortality among men aged 65 to 74
Repeat HIV testing in gay, bisexual and other men who have sex with men (%)	Number of gay, bisexual and other men who have sex with men tested for HIV at specialist SHS who have tested more than once in the year prior to their last test in each calendar year.	This indicator presents the number and proportion of gay, bisexual and other men who have sex with men (gay and bisexual men) who have tested for HIV more than once at the same clinic in the previous year. This indicator measures the NICE testing guideline which recommends that gay and bisexual men should be tested for HIV at least once a year and every 3 months if they are having unprotected sex with new or casual partners. Repeat testing facilitates prompt diagnosis of HIV and this indicator complements other HIV indicators

		presented on the Sexual and Reproductive Health Profiles such as late diagnosis rate and new HIV diagnosis rate.

Life Course Theme 1: Getting the Best Start in Life

Ambition	Indicator	Baseline				Desired Direction of Travel
		Year	Birmingham	England	Core Cities	
Reduce infant mortality in Birmingham by 25% by 2027 and by 50% by 2030	Infant mortality rate	2018-2020	6.6	3.9	4.8	Decrease
Increase the percentage of children achieving a good level of development at the end of Reception to 75% by 2030	Percentage of children achieving a good level of development at the end of Reception	2018/19	68.00%	71.80%	68.00%	Increase
Reduce the percentage of children with one or more decayed, missing or filled teeth to below the national average by 2030	Children with one or more decayed, missing or filled teeth	2018/19	28.60%	23.40%	29.21%	Decrease
Halve the rate of children killed and seriously injured (KSI) on Birmingham's roads by 2030	Rate of children killed and seriously injured (KSI) on Birmingham's roads	2019	108.8 (per billion vehicle miles)	84.4 (per billion vehicle miles)	119	Decrease
Reduce the under 18 teenage conception rate to close the gap between Birmingham and the national average by 2030	Under 18 teenage conception rate	2018	19.2 (per 1000)	16.7 (per 1000)	20.12 (per 1000)	Decrease
Halve the hospital admissions due to asthma in young people under 19yrs by 2027	Hospital admissions due to asthma in young people under 19yrs	2019/20	262.6 (per 100,000)	160.7 (per 100,000)	N/A	Decrease

Reduce the rate of first-time entrants (10-17 years) to the youth justice system by 25% by 2030	Rate of first-time entrants (10-17 years) to the youth justice system	2019	235.2	208	229.81	Decrease

Indicator	Definition	Why are we measuring this?
Infant mortality rate	Infant deaths under 1 year of age per 1000 live births	Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.
Percentage of children achieving a good level of development at the end of Reception	Children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children	A key measure of early years development across a wide range of developmental areas. Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.
Children with one or more decayed, missing or filled teeth	Percentage of 5-year olds with dental decay extending to the dentine layer which can be detected by visual observation alone	Oral health is an integral part of overall health; when children are not healthy this affects their ability to learn, thrive and develop.
Rate of children killed and seriously injured (KSI) on Birmingham's roads	Number of people reported killed or seriously injured (KSI) on the roads, all ages, per 1 billion vehicle miles travelled	Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. The vast majority of road traffic collisions are preventable and can be avoided through improved education, awareness, road infrastructure and vehicle safety.
Under 18 teenage conception rate	Conceptions in women aged under 18 per 1,000 females aged 15-17	Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS.
Hospital admissions due to asthma in young people under 19yrs	Emergency hospital admissions for asthma, crude rate per 100,000	Understanding local trends of emergency admissions of children and young people with long

		term conditions, and benchmarking against geographical and statistical neighbours will support service review and redesign.
Rate of first-time entrants (10-17 years) to the youth justice system	Children and Young people aged 10 to 17 years supervised by a youth offending team, rate per 1,000 population.	The Government strategy Preventing Suicide in England (2012) highlights that suicide is a leading cause of death among children and young people and that groups who are vulnerable include looked after children, care leavers and children and young people in the Youth Justice Service

Life Course Theme 2: Living, Working, and Learning Well

Ambition	Indicator	Baseline				Desired Direction of Travel
		Year	Birmingham	England	Core Cities	
Increasing the % of the estimated individuals who smoke accessing smoking cessation services and achieving a 4-week quit by 20% by 2030	Individuals achieving a 4-week quit smoking (per 100,000)	2017/2018	1350	2070	N/A	Increase
To reduce the percentage rate of long-term musculoskeletal problems to 5% below the England average by 2030	Rate of long-term musculoskeletal problems	2020	17.90%	18.50%	17.05%	Decrease
Reduce the number of households in fuel poverty to the national average by 2030	Fuel poverty (low income, low energy efficiency methodology)	2019	21.2%	13.4%	17.8%	Decrease
Reduce the percentage of adults aged 40-64yrs with Type 2 Diabetes by 7% by 2030	Percentage of adults aged 40-64yrs with Type 2 Diabetes (Birmingham and Solihull)	2019/20	47.4%	43.1%	N/A	Decrease
Reduce the percentage of adults aged 40-64yrs with Type 2 Diabetes by 7% by 2030	Percentage of adults aged 40-64yrs with Type 2 Diabetes (Sandwell and West Birmingham)	2018/19	50.4%	43%	N/A	Decrease
Reduce coronary heart disease mortality under 75yrs by at least 10 points in the rate of deaths per 100,000 population by 2030	Coronary heart disease mortality under 75yrs (Birmingham and Solihull)	2019/2020	48.6	39.1	48.32	Decrease

Reduce coronary heart disease mortality under 75yrs by at least 10 points in the rate of deaths per 100,000 population by 2030	Coronary heart disease mortality under 75yrs (Sandwell and West Birmingham)	2019/2020	72.1	39.1	48.32	Decrease
Reduce coronary heart disease admissions rate (all ages) by 20% by 2030	Coronary heart disease admissions rate (all ages) (Birmingham and Solihull)	2019/20	451.5	367.6	380.68	Decrease
Reduce coronary heart disease admissions rate (all ages) by 20% by 2030	Coronary heart disease admissions rate (all ages) (Sandwell and West Birmingham)	2019/20	413.2	367.6	380.68	Decrease
Reduce the percentage of adults from ethnic communities with Type 2 Diabetes to match the demographic profile of our city by 2030	Percentage of adults from ethnic communities with Type 2 Diabetes (Birmingham and Solihull)	2018/19	41.2	21.6	N/A	Decrease
Reduce the percentage of adults from ethnic communities with Type 2 Diabetes to match the demographic profile of our city by 2030	Percentage of adults from ethnic communities with Type 2 Diabetes (Sandwell and West Birmingham)	2018/19	54.6	21.6	N/A	Decrease

Indicator	Definition	Why are we measuring this?
Individuals achieving a 4-week quit smoking	Rate of successful quitters at 4-weeks per 100,000 smokers	This information is collected on NHS Stop Smoking returns in line with requirements from the Department of Health (DH)
Rate of long-term musculoskeletal problems	The percentage of people aged 16+ reporting an MSK condition, either long term back pain or long-term joint pain.	In England low back and neck pain was ranked as the top reason for years lived with disability and other musculoskeletal (MSK) conditions was ranked as number 10. MSK conditions are known to impact quality of life by increased pain, limiting range of motion and impacting the ability to take part in daily life such as attending work
Fuel poverty (low income, low energy efficiency methodology)	The percentage of households in an area that experience fuel poverty based on the "low income, low energy efficiency (LILEE)" methodology	There is compelling evidence that the drivers of fuel poverty (low income, poor energy efficiency, and energy prices) are strongly linked to cold homes. Evidence shows that living in cold homes is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups; furthermore, studies have shown that more than one in five (21.5%) excess winter deaths in England and Wales are attributable to the coldest quarter of housing.
Percentage of adults aged 40-64yrs with Type 2 Diabetes (Birmingham and Solihull)	The percentage of people with type 2 diabetes, who are 40 to 64 years old	Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over three million people in the UK having the condition. Effective control and monitoring, including monitoring the demographics of people with diabetes, can help reduce mortality and morbidity.

Percentage of adults aged 40-64yrs with Type 2 Diabetes (Sandwell and West Birmingham)	The percentage of people with type 2 diabetes, who are 40 to 64 years old	Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over three million people in the UK having the condition. Effective control and monitoring, including monitoring the demographics of people with diabetes, can help reduce mortality and morbidity.
Coronary heart disease mortality under 75yrs (Birmingham and Solihull)	Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years per 100,000 population.	Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment.
Coronary heart disease mortality under 75yrs (Sandwell and West Birmingham)	Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years per 100,000 population.	Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment.
Coronary heart disease admissions rate (all ages) (Birmingham and Solihull)	Trend of the rates of admissions to hospital for CHD per population (directly standardised rates) from 2003/04, for all ages	To measure trend of the rates of admissions to hospital for CHD
Coronary heart disease admissions rate (all ages) (Sandwell and West Birmingham)	Trend of the rates of admissions to hospital for CHD per population (directly standardised rates) from 2003/04, for all ages	To measure trend of the rates of admissions to hospital for CHD

Percentage of adults from ethnic communities with Type 2 Diabetes (Birmingham and Solihull)	The percentage of people with type 2 diabetes, who are of minority ethnic origin	Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over three million people in the UK having the condition. Effective control and monitoring, including monitoring the demographics of people with diabetes, can help reduce mortality and morbidity.
Percentage of adults from ethnic communities with Type 2 Diabetes (Sandwell and West Birmingham)	The percentage of people with type 2 diabetes, who are of minority ethnic origin	Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over three million people in the UK having the condition. Effective control and monitoring, including monitoring the demographics of people with diabetes, can help reduce mortality and morbidity.

Life Course Theme 3: Ageing and Dying Well

Ambition	Indicator	Baseline Year	Birmingham	England	Core Cities	Desired Direction of Travel
To halve the gap in healthy life expectancy at 65yrs between Birmingham and the national average by 2030 for both men and women	Healthy life expectancy at 65yrs	2018-2020	17.7	23.1	17.31	Increase
To halve the gap in healthy life expectancy at 65yrs between Birmingham and the national average by 2030 for both men and women	Healthy life expectancy at 65yrs	2017-2019	20.40%	21.10%	17.54%	Increase
Improve the % of adult carers who has as much social contact as they would like (>65yrs) to more than 45% by 2027	Adult carers who has as much social contact as they would like (>65yrs)	2019-2020	39.40%	43.40%	43.60%	Increase
Increase the percentage of eligible citizens offered an NHS Health Check who received it to over 70% by 2030	Percentage of eligible citizens offered an NHS Health Check who received	2020/21	44.60%	46.50%	47.00%	Increase
Improve the detection of dementia by increasing the % of people estimated to be living with dementia who are diagnosed and receiving care and support to over	Percentage of people who are diagnosed and receiving care and support (Birmingham and Solihull)	2020	57.70%	61.60%	N/A	Increase

75% by 2030 (Birmingham and Solihull)						
Improve the detection of dementia by increasing the % of people estimated to be living with dementia who are diagnosed and receiving care and support to over 75% by 2030 (Sandwell and West Birmingham)	Percentage of people estimated to be living with dementia who are diagnosed and receiving care and support (Sandwell and West Birmingham)	2020	57.90%	61.60%	N/A	Increase
Improve the carer-reported quality of life score for people caring for someone with dementia to equal to or above the national average by 2030	Carer-reported quality of life score for people caring for someone with dementia	2018/19	7.2	7.3	7.2	Increase
Improve the carer-reported quality of life score to equal to or above the national average by 2030	Carer-reported quality of life score	2018/19	6.9	7.5	7.2	Increase
Reduce the rate of emergency hospital admissions due to falls in people aged 65yrs and over to below the national average by 2030	Rate of emergency hospital admissions due to falls in people aged 65yrs	2020/21	2266	2223	2414	Decrease
Increase the uptake of the seasonal flu vaccine in people aged over 65yrs to the above 75% by 2030	Seasonal flu vaccine in people aged over 65yrs	2020/21	74.7&	71.30%	79.31%	Increase

Improve the carer-reported quality of life score for people caring for someone with dementia	Carer-reported quality of life score for people caring for someone with dementia	2018/19	7.2	7.3	7.2	Increase
Reduce the Excess Winter Deaths to close the gap between the actual and expected number of deaths in people aged >85yrs by at least 20% by 2030	Excess Winter Deaths	Aug 2019 - Jul 2020	27.80%	20.80%	18.98%	Decrease

Indicator	Definition	Why are we measuring this?
Healthy life expectancy at 65yrs	The average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years at age 65 a person would survive if he experienced the age-specific mortality rates for that area and time period throughout his or her life after that age.	This indicator gives context to healthy life expectancy figures by providing information on the estimated length of life. The two indicators are extremely important summary measures of mortality and morbidity.
Healthy life expectancy at 65yrs	The average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years at age 65 a person would survive if she experienced the age-specific mortality rates for that area and time period throughout his or her life after that age.	This indicator gives context to healthy life expectancy figures by providing information on the estimated length of life. The two indicators are extremely important summary measures of mortality and morbidity.
Adult carers who has as much social contact as they would like (>65yrs)	The percentage of respondents to the Adult Social Care Survey (service users) who responded to the question "Thinking about	There is clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social

	how much contact you've had with people you like, which of the following statements best describes your social situation?" with the answer "I have as much social contact as I want with people I like".	care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. This measure will draw on self-reported levels of social contact as an indicator of social isolation for both users of social care and carers.
Percentage of eligible citizens offered an NHS Health Check who received	Percentage of people invited for an NHS Health Check taking one up since the 1 April 2015.	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. A high take up of NHS Health Check is important to identify early signs of poor health leading to opportunities for early interventions.
Percentage of people who are diagnosed and receiving care and support (Birmingham and Solihull)	The rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia given the characteristics of the population and the age and sex specific prevalence rates of the Cognitive Function and Ageing Study II, expressed as a percentage with 95% confidence intervals.	The rationale being that a timely diagnosis enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes.
Percentage of people estimated to be living with dementia who are diagnosed and receiving care and support (Sandwell and West Birmingham)	The rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia given the characteristics of the population and the age and sex	The rationale being that a timely diagnosis enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes.

	specific prevalence rates of the Cognitive Function and Ageing Study II, expressed as a percentage with 95% confidence intervals.	
Carer-reported quality of life score for people caring for someone with dementia	Emergency hospital admissions for falls injuries in persons aged 65 and over, directly age standardised rate per 100,000.	Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care
Carer-reported quality of life score	Flu vaccine uptake (%) in adults aged 65 and over, who received the flu vaccination between 1st September to the end of February in a primary care setting (GPs)	Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Immunisation is one of the most effective healthcare interventions available and flu vaccines can prevent illness and hospital admissions among these groups of people.
Rate of emergency hospital admissions due to falls in people aged 65yrs	Emergency hospital admissions for falls injuries in persons aged 65 and over, directly age standardised rate per 100,000.	Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care
Seasonal flu vaccine in people aged over 65yrs	Flu vaccine uptake (%) in adults aged 65 and over, who received the flu vaccination between 1st September to the end of February in a primary care setting (GPs)	Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Immunisation is one of the most effective healthcare interventions available and flu vaccines can prevent illness and hospital admissions among these groups of people.
Carer-reported quality of life score for people caring for someone with dementia	The ‘Adult Social Care Outcomes Framework’ (ASCOF) measures the performance of the adult social care system as a whole.	The 'Prime Minister’s 2020 Challenge on Dementia' reports that carers of people with dementia should be made aware of and offered the opportunity for respite, education,

		training, emotional and psychological support so that they feel able to cope with their caring responsibilities and to have a life alongside caring.
Excess Winter Deaths	Excess Winter Deaths Index (EWD Index) is the excess winter deaths measured as the ratio of extra deaths from all causes that occur in all those aged 85 and over in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths in those aged 85 and over.	The number of excess winter deaths depends on the temperature and the level of disease in the population as well as other factors, such as how well equipped people are to cope with the drop in temperature. Most excess winter deaths are due to circulatory and respiratory diseases, and the majority occur amongst the elderly population

Opportunities for Innovation

Summary of issues with missing indicators

Through the development of the strategy and the indicator journey, we identified a number of indicators that we couldn't measure at the current time due to either lack of a complete data set or no reporting mechanism. Therefore, over the life course of the strategy, we will also be exploring how to innovate our evidence-gathering methods. This will allow us to utilise these indicators fully.

The indicators are:

- Number of growing spaces within Birmingham
- Reported use of Healthy City Planning Toolkit
- Percentage of children achieving a good level of development by 2/2.5 years
- Percentage of targeted health checks (e.g. for people with learning disabilities, carers, and severe mental health issues)

Health and Wellbeing Strategy 2022-2030: Consultation Findings Report

Summary

In September-December 2021 the Public Health Division ran a public consultation exercise on the Health and Wellbeing Strategy for the next 8 years. The aim of the strategy is to co-ordinate responses to health inequalities and deliver on several ambitions. The public consultation process comprised an on-line questionnaire hosted on the Council's BeHeard website; virtual and in-person community-based focus groups; presentations to ward forums; and webinars. We also obtained a review of the strategy by academic of the National Institute of Health Research (NIHR) as well as workshops with stakeholders from the various Health and Wellbeing Board Fora. In total, there were 142 responses to the public consultation and a further 100 views were collected from focus groups, presentations to ward forums, and webinars.

The headline responses from the public consultation were as follows:

- Strong agreement and support for the ambitions of the 5 core themes and the Life Course themes as well, with the greatest levels of support for Healthy and Affordable Food, Getting the Best Start in Life, and Ageing and Dying Well.
- While there was overarching agreement, there were specific concerns highlighted with how the strategy would be delivered and how achievable some of the ambitions were within the 8-year timeframe.
- The impact of the Covid-19 Pandemic has exacerbated pre-existing health inequalities and therefore actions to mitigate it should be present across the whole of the strategy, rather than an exclusive section.
- There was agreement that 'closing the gap' between health inequalities should be the central aim of the strategy, however several respondents also wanted more clarity on how this would be achieved in the short term.

Alongside the responses from the public consultation, the review by the academics of the NIHR also provided insight into how we could improve our evidence bases for measuring the outcomes of the strategy as well as deciding who and where targeted work is needed most.

This consultation feedback was then used in a series of workshops with Lead Officers from each Health and Wellbeing Board Fora, who will be responsible for the delivery of the ambitions in their theme. These workshops allowed the content of the themes, and the overall structure of the strategy, to be refined and reflect the responses from the consultation. They will also contribute to the creation of Strategy Delivery Plans for each forum which will detail actions and partners needed for delivery.

The next steps will involve the approval and endorsement of the strategy by the Health and Wellbeing Board as well as the Cabinet of Birmingham City Council. Public feedback from the consultation and its impact will be made available through a "We Asked, You Said, We Did" report, which will be published on the BeHeard website alongside a copy of this consultation findings report.

Appendix A: Birmingham Health and Wellbeing Strategy Engagement Diagram

This is a summary of the who we engaged and how we engaged them through public and professional consultation for the Health and Wellbeing Strategy.

Appendix B: Be Heard Survey Consultation Feedback Summary

The tables referred to in this summary can be found in Appendix C.

Respondents

There were 142 responses to the public consultation and a further 100 views were collected from focus groups, presentations to ward forums, and webinars.

People from a wide range of ages (20-79 years) responded to our BeHeard survey with the largest amount of responses received from those aged 45 to 59-year olds. Table 1 in Appendix B illustrates that there was under-representation of two age groups: 0-19-year olds and over 75-year olds. To address this, focus groups were commissioned to target specific groups, such as young people.

51 responses (36%) were from people reporting to have a physical or mental health condition. This was slightly lower than expected for an accurate representation of Birmingham's population, although there was a fairly good representative range of conditions within the respondents.

98 responses were received from heterosexual or straight respondents, 10* from people identifying as gay or lesbian, and 10 from those identifying as bisexual. As can be seen in Table 6, there were a further 27 respondents who preferred not to answer or declined to the answer the question.

39 respondents identified as Christian, 16 Muslim, and 52 with no religion.

Those responding to the on-line survey were mainly from a White (British) ethnic background (89 respondents).

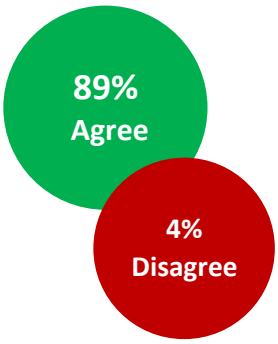
To account for groups who were estimated to be under-represented in the BeHeard survey, we commissioned several focus groups which provided us with further qualitative feedback. We also conducted a Health Impact Assessment to understand where any positive or negative impacts would arise from the strategy. Finally, we also attended several ward forums from a range of wards across the city to maximise the number of people who could contribute feedback to the strategy.

**Value suppressed*

Quantitative and Qualitative Results from Be Heard Survey

1 To what extent do you agree or disagree with the vision statement?

"*Our shared vision is to create a healthier city where every citizen, at every stage of their life, in all communities can make healthy choices that are affordable, sustainable and desirable to support them to achieve their potential for a happy, healthy life*"



Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
62.7%	**26.1%**	**4.9%**	**2.8%**	**0.7%**	**1.4%**

Key Findings

The majority (89%) agreed with the vision, including over 60% strongly agreeing.

There were just 41 comments on this question, so please take this into account when analysing trends. Most comments were either neutral or mixed (54%), with just over a third (34%) negative.

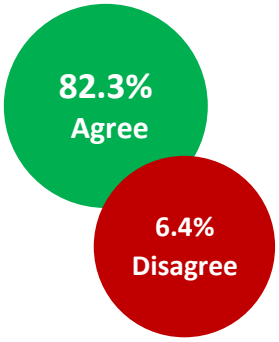
The most discussed themes were on **the delivery of the vision** (39%), particularly with scepticism over the vision's scope (27%), generally either feeling the report is **not clear enough** on how objectives will be achieved or not believing that the council can deliver the change. There were also a few comments with specific suggestions on how to improve the vision.

The main topics were around **health** (24%) **and inequality** (17%), interlinking with each other through a few comments around reducing barriers to health activities/outcomes for more vulnerable citizens, such as accessibility or cost. There was also interlinkage in with scepticism over the vision's scope, in terms of tackling complex health issues.

2 To what extent do you agree or disagree with the principles for action?

Our vision is underpinned by the following shared principles for action:

- Citizen-focussed and informed by citizens' lived experience
- Consciously focussed on reducing inequalities and promoting equality and inclusion
- Data and evidence-informed, and research-enabled action



Method	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Online only	**51.1%**	**31.2%**	**8.5%**	**2.1%**	**4.3%**	**2.1%**

Key Findings

The majority (82%) agreed with it including over 50% agreeing strongly.

There were just 42 comments on this question, so please take this into account when analysing trends.

The most discussed themes were on the role of **engaging the public or using lived experience/ citizen focus** within the principles of action (62%), generally feeling that engagement with the public is a good starting point, allowing the principles to be relevant to those they're designed to help, with many feeling this will promote inclusivity. Others feel more should be done to ensure all voices are heard and that services need to be more citizen focused. A few comments referred to co-production, linking it to the citizen focus.

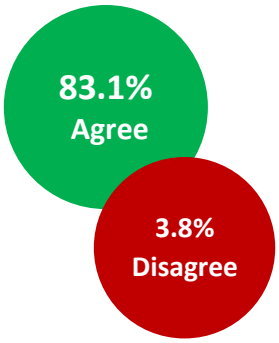
In 17% of the comments, respondents expressed **confusion over what the principles of action** would look like in practice or expressed confusion around the method of research used. This was occasionally raised alongside scepticism around the council's ability to satisfy the needs of the public.

Some respondents (17%) also mentioned that far more needed to be done to reduce **inequalities.**

3 To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy?

The Board has chosen to focus on five key areas of inequalities in the delivery of the framework:

- Inequalities linked to Deprivation
- Inequalities affecting Disabled Communities
- Inequalities affecting Inclusion Groups
- Inequalities affecting different Ethnic Communities
- Inequalities of Place



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Deprivation	58.2%	26.2%	7.1%	2.1%	1.4%	1.4%
Disabled Communities	57.7%	30.3%	4.2%	2.8%	0.0%	1.4%
Inclusion Groups	54.2%	28.9%	7.7%	2.1%	2.8%	1.4%
Ethnic Communities	54.2%	26.1%	10.6%	1.4%	3.5%	1.4%
Place	57.0%	22.5%	13.4%	1.4%	1.4%	2.1%

Key Findings

The majority of respondents agreed with the five key areas of inequalities, an average of 83.1% total agreement.

There were 56 comments on this question, so please take this into account when discussing trends.

One of the most popular themes amongst the responses was in regards the council's delivery of bridging the gap (23%). This included issues such as a **lack of clarity** for what the project would achieve and what success would look like. Other comments suggested people were **unsure of council's ability** to deliver on the aims. 7% of responses showed concern that the help on offer may not reach those who need it.

The **LGBT+ community** was also mentioned in 8.9% of responses with comments questioning why this community doesn't receive as much focus as other "inclusion groups" in the plan. There was an interlinkage over this issue and mental health concerns. 3.6% of responses made mentioned the importance of representing transgender people in the plan.

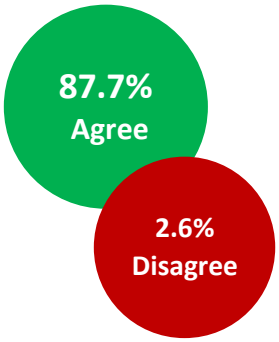
12% mentioned the wards throughout Birmingham with a few comments around improving the **consistency of access to services** throughout the wards. A few responses also indicated that vulnerable citizens who live in more affluent wards are unsure if this will make it more difficult to receive the support they need.

There were also individual mentions of other **vulnerable and marginalised groups**, such as the deaf community, migrants, people with mental health issues, and the homeless.

4 To what extent do you agree or disagree with the 5 themes in the strategy?

The five themes are:

- 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



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Theme 1	67.6%	22.5%	4.9%	0.7%	1.4%	0.7%
Theme 2	66.2%	24.6%	4.2%	0.7%	2.1%	0.7%
Theme 3	65.5%	21.8%	7.0%	1.4%	1.4%	0.7%
Theme 4	62.7%	24.6%	6.3%	1.4%	1.4%	0.7%
Theme 5	53.5%	29.6%	11.3%	1.4%	1.4%	0.7%

Key Findings

The majority of respondents agreed with the five themes, an average of 88% total agreement.

There were just 43 comments on this question, the majority of which were positive, so please take this into account when analysing trends.

One of the most talked about themes was **food**, appearing in 28% of responses. Of the responses highlighting the issue of food, a couple suggested that poor quality food in local supermarkets affected people's ability to have a healthier diet. Other comments put forward that fast-food outlets are a major contributor to poor diets, suggesting restrictions on the number of them.

Another theme often discussed is **exercise**. 26% of responses referred to exercise or fitness equipment. Of these responses 55% referred to **safety concerns preventing exercise**. Others referred to the cost of exercise equipment and clubs e.g. gym memberships preventing them leading a more active lifestyle.

Another main topic was **mental health,** in over 19% of comments. It is often mentioned linked to the other themes previously discussed. However, of the respondents who highlighted mental health, a couple mentioned busy roads negatively affecting their mental health.

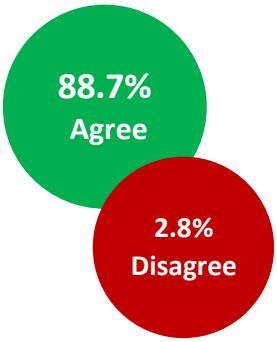
Additionally, 14% of respondents directly mentioned "**Protect and detect**" with some unsure of what was meant by it and others disapproving of the name:

There were comments with miscellaneous criticisms of the strategy's ambitions and how they will be reached (26%). This included: ensuring engagement with different communities over the strategy, that this consultation is too broad, and will be ineffective and changing anything long-term.

5 To what extent do you agree or disagree with the Life Course in the Strategy?

There are three themes covering the Life Course:

1. Getting the Best Start in Life
2. Working and Learning Well
3. Ageing and Dying Well



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Getting the Best Start	66.2%	22.5%	5.6%	1.4%	1.4%	0.7%
Working and Learning Well	58.5%	28.2%	9.2%	0.0%	1.4%	0.7%
Ageing and Dying Well	70.4%	18.3%	5.6%	0.7%	1.4%	1.4%

Key Findings

The majority of respondents agreed with the five themes, an average of 89% total agreement.

There were just 38 comments on this question, so please take this into account when analysing trends.

One of the most discussed themes (24%) was **ageing and dying well**. Many of the responses were positive, and thought it was an important area to focus on, with other responses questioning *"what can you do to make sure everyone has the chance to die with dignity?"* Some suggestions were made by those in support of the life course approach, such as:

One of the most discussed themes was education, appearing in 18% of answers. Of the responses mentioning education, some highlighted that **opportunities in education** are available, suggesting it is a choice to capitalise on these opportunities.

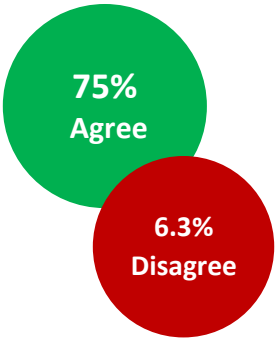
Other respondents who believed opportunities were not equally available suggested improvements:

There was also discussion around **young families**, in terms of maternity care (8%), and infant and young children's health (26%). Overall, it was about ensuring there was support for pregnant women and families and looking after the health of infants and children in early years.

6 To what extent do you agree or disagree with the cross-cutting approaches in the strategy?

There are two approaches which will cover the breadth of the strategy. These are:

1. Mitigating the legacy of COVID-19
2. Equality, Diversity, and Inclusion



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Mitigating the legacy	43.0%	28.2%	16.2%	3.5%	2.8%	4.2%
Equality, Diversity, and Inclusion	56.3%	22.5%	9.9%	4.9%	1.4%	2.8%

Key Findings

There were 139 respondents who answered this question. The average agreement was 75%.

There were only 27 comments on this question, so please be cautious when analysing trends. Most comments tended to be negative.

The main theme was around the delivery of the approach, particularly being **sceptical of the scope** (56%). This was either because they regarded it as **unrealistic/unachievable** or because they thought it was too broad/vague, with a few people unsure of what the approach was saying.

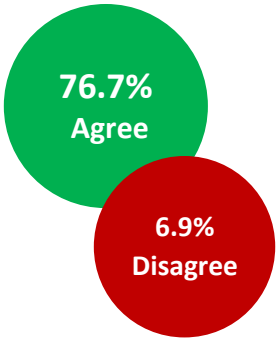
There were also comments relating to **Covid** (41%), sometimes relating to the scepticism over scope, and three comments agreeing with the cross-cutting approach's focus over Covid.

There were also a few comments around the **importance of equalities** - including a couple of issues with the local environment, health, and the inclusion of specific population groups.

7 To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme?

Eating healthily underpins so much of our physical and mental health, we celebrate and commiserate with food and the food system contributes millions to the city's economy. It is one of the most fundamental bases for a healthy life.

Ambition 1: Increase the uptake of healthy start vouchers for eligible families to at least 80% by 2027.
Ambition 2: Reduce the % of 5yr olds with visually obvious dental decay to below 20% by 2030.
Ambition 3: Reduce the prevalence of obesity (including severe obesity) in children in Reception and Year 6 by 10% by 2030.
Ambition 4: Increase the % of adults regularly eating '5-a-day' to more than 55% by 2030.
Ambition 5: Ensure that the Healthy City Planning Toolkit is utilised in 90% of developments in the City.



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Ambition 1	49.3%	17.9%	17.9%	6.0%	3.0%	0.0%
Ambition 2	55.2%	25.4%	7.5%	6.0%	0.0%	1.5%
Ambition 3	59.7%	19.4%	7.5%	6.0%	1.5%	0.0%
Ambition 4	56.7%	23.9%	9.0%	7.5%	0.0%	0.0%
Ambition 5	52.2%	23.9%	16.4%	3.0%	1.5%	0.0%

Key Findings

The majority of respondents agreed with the five ambitions, an average of 78% total agreement.

There were just 52 responses so please take this into account when analysing trends.

The most discussed comments were on the **delivery of the ambitions**, with 27% of people sceptical of how successful it can be, generally feeling that the report is not clear enough on what measures are going to be put in place, or how success will be measured.

21% of respondents suggested that the aims within the theme are **not ambitious enough**. It was also suggested that the time period over which the change will come into action, especially in regard to those affecting young children, should happen more quickly. 21% of respondents highlighted the involvement of **local shops and takeaways and other businesses** being required to help achieve healthy eating. Specific suggestions include:

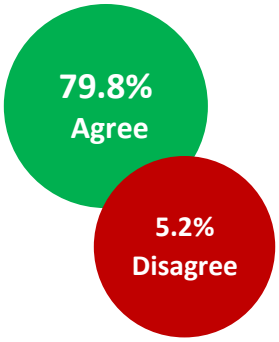
There was discussion (17%) on raising awareness and **educating families and children** on healthy eating choices. There were suggestions on how to do this, including community work, schools taking the lead for children, basic cooking classes, more information on the impact of unhealthy foods, etc.

15% of responses directly referenced **obesity**, often regarding obesity in children. Some disagreed with the aims surrounding obesity giving the following suggestion.

8 To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme?

Mental wellbeing is as important as physical wellbeing, it is often said that there is no good health without good mental health, yet this is an area that often fails to get parity.

Ambition 1: Reduce the prevalence of depression and anxiety in adults to less than 12% by 2030.
Ambition 2: Reduce our suicide rate (persons) in the city to be in the lowest 10 UTLA in England by 2030.
Ambition 3: Reduce the emergency intentional self-harm admission rate to be within the lowest 10 UTLA in England by 2030.
Ambition 4: Reduce the smoking prevalence in adults with a long-term mental health condition to at least the national average by 2027.
Ambition 5: Close the gap between people with long-term health conditions, in employment and those without.
Ambition 6: Achieve the 'Triple Zero' ambition by 2030.



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Ambition 1	62.7%	22.4%	10.4%	0.0%	3.0%	0.0%
Ambition 2	53.7%	28.4%	11.9%	3.0%	1.5%	0.0%
Ambition 3	52.2%	34.3%	9.0%	1.5%	1.5%	0.0%
Ambition 4	46.3%	25.4%	16.4%	3.0%	6.0%	0.0%
Ambition 5	47.8%	32.8%	14.9%	1.5%	1.5%	0.0%
Ambition 6	50.7%	22.4%	13.4%	6.0%	3.0%	1.5%

Key Findings

The majority of respondents agreed with the five ambitions, an average of 80% total agreement. There were 51 comments on this question, so please take this into account when analysing trends.

Among the most discussed themes included **young children, teenagers, and young adults**. 31% of respondents suggested that more needed to be done to help recognise mental illness and help support suffers from the youth of Birmingham's population.

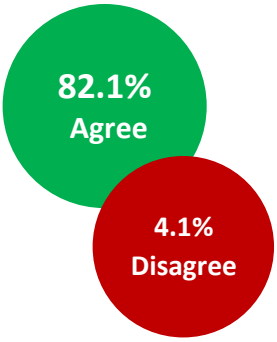
The most consistent theme raised in the responses (47%) was references to **the level of ambition** surrounding the Mental Wellness and Balance theme with the majority judging it to be "*unrealistic*" or overambitious. There were some links with reducing depression and anxiety (22%), with a mix of those saying it should be reduced entirely and others saying reducing diagnosis is unrealistic and harmful.

Ambition was also linked in with the aim of **smoking cessation**, which a few respondents believe is a "*personal choice*" so not relevant, however an equal number of people believe the goals set are not ambitious enough.

Some scepticism of the theme also refers to **poverty** with one respondent suggesting: "*You will not be able to do any of the above without taking people out of pain and poverty."* **Housing** appears as a reason for sceptics in 6% of responses. It is suggested that landlords need to be held to a higher responsibility for conditions of housing that can affect both physical and mental health.

9 To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme?

Being physically active can prevent and improve long-term conditions including cardiovascular disease, diabetes and cancers and is also a viable part of treatment pathways.
Ambition 1: Reduce the % of adults who are physically inactive to less than 20% by 2030.
Ambition 2: Increase the % of adults walking or cycling for travel at least three days a week by at least 25% by 2030.
Ambition 3: Reduce the inactivity gap between the most active 10 wards and the least active 10 wards.
Ambition 4: Reduce the inactivity gap between those living with disabilities and long-term health conditions and those without by 50% by 2030.



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Ambition 1	62.7%	26.9%	7.5%	0.0%	0.0%	0.0%
Ambition 2	65.7%	13.4%	13.4%	3.0%	1.5%	0.0%
Ambition 3	58.2%	19.4%	13.4%	7.5%	0.0%	0.0%
Ambition 4	52.2%	29.9%	10.4%	4.5%	0.0%	0.0%

Key Findings

The majority of respondents agreed with the four ambitions, an average of 82% total agreement.

There were just 47 comments on this question, so please take this into account when analysing trends. Most comments were either negative (45%) or neutral (34%).

In terms of discussion over why the ambitions need improved, the majority discussed **barriers and inequalities to activity** (62%) that needed to be properly addressed to improve activity levels.

The main barrier was around the **city's infrastructure and accessibility** (40%), mainly cycling and other transportation. This was particularly about the difficulty of being a cyclist in Birmingham due to issues with safe roads to ride on, lack of resources (cost and storage of bike), or other issues that meant cycling was not a straightforward option. Aside from cycling, other infrastructure issues including public transport and service accessibility.

Another barrier was around **health inequalities**, and that health and mobility issues weren't taken into account when encouraging cycling and other activities. For example, disabilities, older people, mobility issues, and other chronic health conditions. There was one person who was glad for the emphasis on cycling, though.

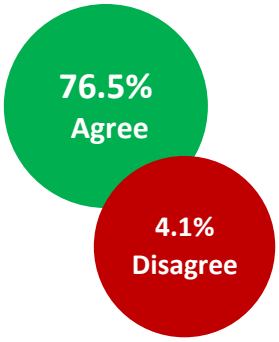
Another barrier was **not feeling safe enough** to be active in Birmingham, whether it was cyclists worrying about road safety or that the streets are increasingly not safe to walk in.

There were also a few people who gave a variety of suggestions for improvement, including advice on interventions, introducing a target for obesity, using BCHC services as part of the actions, and providing exercises and accessible facilities that would work well for specific demographic groups (such as older people or those in deprived areas).

10 To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme?

This theme aims to promote and protect health by improving outcomes for conditions linked to the environment, as well as using the opportunities of a green and sustainable future to improve the health and wellbeing of citizens.

Ambition 1: Reduce the % of mortality attributable to particulate air pollution to less than 4.5% by 2030.
Ambition 2: Increase the utilisation of outdoor space for exercise/ health reasons to over 25% by 2028.
Ambition 3: Increase the daily utilisation of green and blue spaces to 25% of the population by 2030.
Ambition 4: Increase volunteering in green and blue spaces to at least 10% of the population by 2027.



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Ambition 1	59.7%	19.4%	13.4%	3.0%	3.0%	0.0%
Ambition 2	61.2%	20.9%	9.0%	1.5%	0.0%	1.5%
Ambition 3	59.7%	20.9%	11.9%	1.5%	0.0%	0.0%
Ambition 4	46.3%	17.9%	19.4%	4.5%	3.0%	0.0%

Key Findings

The majority of respondents agreed with the four ambitions, an average of 76.5% total agreement.

There were just 43 comments on this question, so please take this into account when analysing trends. There was a mix of feelings in the comments, i.e. not just negative or neutral.

There were a variety of different topics discussed but no strong themes emerging.

Outside space, green space, and parks, was the most commented topic (30%), with a variety of issues discussed. One topic was **lack of safety in parks**, with poor maintenance (equipment, paths, litter, lighting) an issue. There were also a few comments on utilising green space more effectively to encourage people outside, such as the right equipment, better design of recreation space, use of meadows. One comment highlighted Sheffield Winter Garden as an example of best practice.

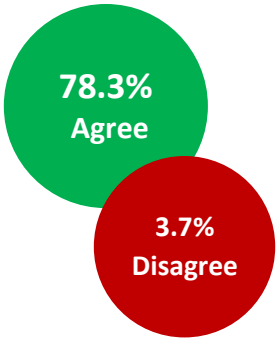
Pollution was the second most commented topic (21%), with a variety of issues discussed. It ranged from criticism of the council's road and transport strategies causing air pollution and congestion, the mortality goal not being ambitious enough, to the need for improved public transport.

There was also discussion on **volunteering** - it was regarded as a positive thing but with a few caveats. This included that this is replacing paid jobs and people should be paid for the proposed work, and that the council should be engaging with the volunteer groups already in particular parks.

11 To what extent do you agree or disagree with the ambitions in the Protect and Detect theme?

The Protect and Detect theme is focussed on the work we can do together to protect citizens from harm and detect early diseases such as cancer and HIV and from violent crime including violent crime including gang violence and domestic abuse.

Ambition 1: Achieve the national ambitions or targets for all national immunisation programmes by 2030.
Ambition 2: Achieve the national targets for all national screening programmes by 2030.
Ambition 3: Halve the variation in uptake (inequality) for all immunisation and screening programmes by 2030.
Ambition 4: Reduce the overall rates of new sexual health infections through early diagnosis and treatment to close the gap between Birmingham and the national average by 2030.



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Ambition 1	49.3%	29.9%	14.9%	4.5%	0.0%	0.0%
Ambition 2	53.7%	26.9%	13.4%	3.0%	0.0%	0.0%
Ambition 3	47.8%	23.9%	16.4%	4.5%	0.0%	0.0%
Ambition 4	58.2%	23.9%	9.0%	3.0%	0.0%	0.0%

Key Findings

The majority of respondents agreed with the four ambitions, with an average of 78% total agreement.

There were only 29 comments on this question, so please be cautious when attributing importance to trends. There was mainly a mix of negative and neutral comments.

The most comments (6) were focused on people's views on **meeting the targets**, with most thinking the targets should be more ambitious and met in a shorter timeframe.

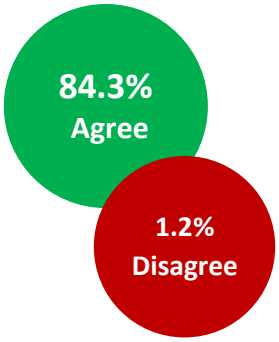
There were 5 comments around **immunisations/vaccines**, with a mix of reasons why, including a couple worried about anti-vaccination misinformation, another suggesting further education on vaccines.

There were 4 comments on the negative impact of **limited resources/services** on meeting the specific health targets, such as having no children's sure start centres, screening services being deprioritised, trouble with accessing GPs, and the lack of investment available.

There were 4 comments supporting the importance of **early detection and screening**, 4 talking about **negative behaviour around the pandemic**, and there were further miscellaneous comments around different topics, such as BCHC's offer to help achieve these ambitions and a suggestion to focus on older people.

12 To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life?

Ambition 1: Reduce infant mortality in Birmingham by 25% by 2027 and by 50% by 2030.
Ambition 2: Improve the percentage of children achieving a good level of development by 2-2.5 years to over 83% and at the end of Reception to 75% by 2030.
Ambition 3: Halve the rate of children killed and seriously injured (KSI) on Birmingham's roads by 2030.
Ambition 4: Reduce the under-18 teenage conception rate to close the gap between Birmingham and the national average by 2030.
Ambition 5: Halve the admissions due to asthma in young people under 18yrs by 2027.
Ambition 6: Reduce the rate of first-time entrants (10-17yrs) to the youth justice system by 25% by 2030.



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Ambition 1	65.7%	20.9%	10.4%	0.0%	1.5%	0.0%
Ambition 2	64.2%	19.4%	11.9%	0.0%	1.5%	1.5%
Ambition 3	73.1%	13.4%	10.4%	1.5%	0.0%	0.0%
Ambition 4	58.2%	23.9%	13.4%	0.0%	0.0%	1.5%
Ambition 5	62.7%	20.9%	14.9%	0.0%	0.0%	0.0%
Ambition 6	62.7%	20.9%	9.0%	1.5%	1.5%	1.5%

Key Findings

The majority of respondents agreed with the four ambitions, with an average of 84% total agreement.

There were just 35 comments on this question, so please be cautious when attributing importance to trends. There was mainly a mix of negative and neutral comments, with the neutral comments tending to be suggestions with no criticism or compliments about the ambitions.

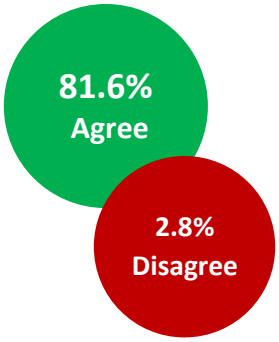
31% (11) of comments were **critical of the ambitions' scopes**, either finding them too broad in wording, unrealistic, or conversely too ambitious.

There were 9 suggestions on **how to improve or meet goals**, from funding particular services (youth services and groups/clubs, school nurse services, NCT classes, early years training), or a focus on particular issues (mental health services; Gypsy, Roma and Travellers; the credit system).

There were 6 comments on **early intervention in children's lives**, mainly emphasising the importance of it in helping to tackle inequalities, improving education and the level of development, healthy behaviours and eating, and preventing vulnerable young people from cycles of criminal behaviour.

13 To what extent do you agree or disagree with the ambitions in Working and Learning Well?

Ambition 1: Increasing the % of the estimated individuals who smoke accessing smoking cessation services and achieving a 4-week quit by 20% by 2030.
Ambition 2: To reduce the % rate of long-term musculoskeletal problems to 5% below the England average by 2030.
Ambition 3: Reduce coronary heart disease admissions rate by 20% by 2030.
Ambition 4: Reduce the % of adults from ethnic communities with Type 2 Diabetes to match the demographic profile of our city by 2030.
Ambition 5: Increase the number of targeted health checks by 25% by 2027.
Ambition 6: Reduce the rate per 1000 of homeless young people (16-24 years) to the England average.
Ambition 7: Achieve 50% of all medium and large businesses in Birmingham being part of the Thrive at Work programme.



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Ambition 1	49.3%	26.9%	13.4%	6.0%	1.5%	1.5%
Ambition 2	50.7%	26.9%	13.4%	0.0%	1.5%	0.0%
Ambition 3	59.7%	22.4%	14.9%	0.0%	1.5%	0.0%
Ambition 4	55.2%	22.4%	9.0%	1.5%	3.0%	0.0%
Ambition 5	58.2%	25.4%	10.4%	1.5%	0.0%	0.0%
Ambition 6	62.7%	26.9%	7.5%	0.0%	0.0%	1.5%
Ambition 7	46.3%	25.4%	11.9%	3.0%	0.0%	4.5%

Key Findings

The majority of respondents agreed with the four ambitions, with an average of 82% total agreement.

There were just 33 comments on this question, so please be cautious when attributing importance to trends. There was mainly a mix of negative and neutral comments, with the neutral comments tending to be suggestions with no criticism or compliments about the ambitions.

Over a third of comments were **critical of the ambitions' scopes**, either finding them unrealistic, or conversely too ambitious, or not sure how the targets were specifically decided on.

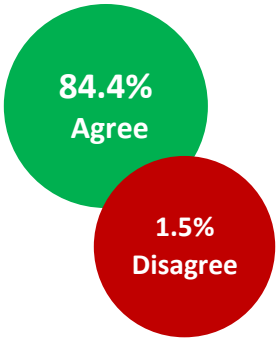
Diabetes in ethnic communities was the most discussed ambition (8 comments). Several said diabetes work should target everyone not just ethnic communities, and several discussed the link between diet and diabetes. BCHC also commented on which targets they could help with. There was also a couple of suggestions on how to help rates of diabetes.

In terms of **targeted health checks** (7 comments), people were split on whether they supported it, and a couple of people were not sure that the target was achievable.

Other ambitions discussed included a variety of comments on smoking cessation (such as a few suggestions on how to help the targets); homelessness (should aim for a higher reduction); thrive at work (issues around meeting targets); and other comments on individual topics.

14 To what extent do you agree or disagree with the ambitions in Ageing Well and Dying Well?

Ambition 1: Halve the gap in healthy life expectancy at 65 years between Birmingham and the national average for both men and women.
Ambition 2: Increase the % of eligible citizens offered an NHS Health Check who received it to over 70%.
Ambition 3: Improve the detection of dementia by increasing the % of people estimated to be living with dementia who are diagnosed and receiving care and support to over 75% by 2030.
Ambition 4: Reduce the rate of emergency hospital admissions due to falls in people aged 65yrs and over to below the national average.
Ambition 5: Improve the carer-reported quality of life score for people caring for someone with dementia to equal to or above the national average.
Average 6: Reduce the Excess Winter Deaths to close the gap between the actual and expected number of deaths in people aged >85 years by at least 20%.



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Ambition 1	52.2%	29.9%	16.4%	0.0%	0.0%	0.0%
Ambition 2	65.7%	23.9%	7.5%	0.0%	0.0%	1.5%
Ambition 3	56.7%	28.4%	10.4%	1.5%	0.0%	1.5%
Ambition 4	49.3%	32.8%	14.9%	0.0%	0.0%	1.5%
Ambition 5	61.2%	25.4%	7.5%	0.0%	0.0%	4.5%
Ambition 6	53.7%	26.9%	16.4%	1.5%	0.0%	0.0%

Key Findings

The majority of respondents agreed with the four ambitions, with an average of 84% total agreement.

There were just 34 comments on this question, so please be cautious when attributing importance to trends. There were mainly negative (44%) or neutral (32%) comments, with the neutral comments tending to be suggestions with no criticism of the survey.

As with previous ambitions, there was **criticism over the ambitions' scope** (32%), mainly finding them unmeasurable/unrealistic or set arbitrarily. Only a few (3 comments) thought they should be more ambitious.

Dementia was the main ambition discussed (7 comments), with different comments emphasising the importance of focusing on dementia, NHS issues impacting on dementia care, suggestions, and the impact on carers and families.

There was also discussion of **inequalities**, including: agreeing that there is inequality across Birmingham and it needed to be tackled, and individual comments to do with different demographics: queer and trans elders who feel excluded for not fitting into the gender binary definition; elderly Gypsy, Roma and Travellers have nowhere to go; groups with language barriers; and that training is needed for services dealing with hard-to-reach groups.

Appendix C: Demographic Profile of BeHeard respondents

Table 1. Respondents by Age

Age Group	No. of respondents*	% those that responded	% of total Birmingham population**	+/-
0-19	0	0%	29.2%	-29.2
20 – 29	13	9%	16.8%	-7.8
30 – 44	47	33%	20.8%	+12.2
45 – 59	55	39%	16.4%	+22.6
60 – 74	21	15%	10.8%	+4.2
75 – 84	0	0%	4.6%	-4.6
85+	0	0%	1.8%	-1.8
Not Answered	10	3%	N/a	N/a
Suppressed Total Respondents	**146**	**100%**	**100%**	

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Table 2. Respondents by Gender

Gender	No. of respondents*	% of respondents	% of total Birmingham population**	+/-
Male	45	32%	49.7%	-17.7%
Female	89	63%	50.3%	+12.7%
Not Answered/Prefer not to say	10	5%	N/a	N/a
Suppressed Total Respondents	**144**	**100%**	**100&**	

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Table 3. Respondents by Ethnicity

Ethnicity	No. of respondents*	% of respondents	% of total Birmingham population**	+/-
English/Welsh/Scottish/Northern Irish/British	89	63%	53.3%	+9.7
Any other White background	11	8%	2.4%	+5.6
Mixed/multiple ethnic groups	10	7%	3.8%	+3.2
Asian/ Asian British	22	16%	24.3%	-8.3
Black/ African/ Caribbean	10	6%	7.6%	-1.6
Any other ethnic group	0	0%	1.4%	-1.4
Not Answered	0	0%	N/a	N/a
Suppressed Total Respondents	**142**	**100%**	N/a	N/a

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Table 4. Respondents by Physical and Mental Health

Affected by the following long-term physical or mental health conditions or illnesses	No. of respondents*	% of all respondents
Physical or mental conditions - Yes	*51*	*36%*
Vision (e.g. blindness or partial sight)	0	0%
Hearing (e.g. deafness or partial hearing)	10	7%
Mobility (e.g. walking short distances or climbing stairs)	14	10%
Dexterity (e.g. lifting and carrying and carrying objects, using a keyboard)	10	7%
Learning or understanding or concentrating	10	7%
Memory	10	7%
Mental Health	27	19%
Stamina or breathing or fatigue	16	11%
Socially or behaviourally (e.g. associated with autism, attention deficit disorder or Asperger's syndrome)	10	7%
Other (please specify)	10	7%

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Note: percentages do not add up to 100% as respondents allowed more than one option, and this question may not apply

Table 5. Respondents by Religion or Belief

Religion or Belief	No. of respondents*	% of respondents	% of total Birmingham population**	+/-
Christian (including Church of England, Catholic, Protestant, and all other Christian denominators)	39	27%	46.1%	-19.1
Buddhism	0	1%	0.4%	+0.6
Hindu	0	2%	2.1%	-0.1
Muslim	16	11%	21.8%	-10.8
Jewish	0	0%	0.2%	-0.2
Sikhism	0	1%	3.0%	-2.0%
No Religion	52	37%	19.3%	+17.3
Any other religion (please specify)	10	4%	0.5%	+3.5
Prefer not to say	12	8%	N/a	N/a
Not Answered	10	7%	6.5%	+0.5
Blank	0	1%	N/a	N/a
Suppressed Total Respondents	**139**	**100%**		

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Table 6. Respondents by Sexual Orientation

Sexual Orientation	No. of respondents*	% of respondents
Bisexual	10	5%
Gay or Lesbian	8	6%
Heterosexual or Straight	98	69%
Other	0	0%
Prefer not to say	17	12%
Not Answered	10	6%
Blank	0	0%
Suppressed Total Respondents	**143**	**100%**

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Table 7. Respondents by Life Experiences

Do any of the following life experiences apply to your life?	No. of respondents*	% of respondents
Veteran	0	1%
Homelessness	10	4%
Care Leaver	0	3%
Refugee	0	1%
First generation migrant	10	5%
None	101	71%
Not Answered	71	50%
Suppressed Total Respondents	**192**	**134.51%**

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Note: percentages do not add up to 100% as respondents allowed more than one option

Table 8. Respondents by Caring Responsibilities

Do you have caring responsibilities? (If yes, please tick all that apply)	No. of respondents*	% of respondents
None	64	45%
Primary carer of child/children under 18	34	24%
Primary carer of disabled child/children	10	4%
Primary carer of disabled adult (18 and over)	0	1%
Primary carer of older person/people (65 and over)	10	6%
Secondary carer	24	17%
Prefer not to say	10	6%
Suppressed Total Respondents	**152**	**102.82%**

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Note: percentages do not add up to 100% as respondents allowed more than one option

**Source: Birmingham City Council, *Key Statistics on 2011 Census,* https://www.birmingham.gov.uk/downloads/download/968/census_2011_key_statistics_reports_constituency_and_wards

Appendix D: Q&A Response Table

(See separate document)

Appendix E: Focus Group Feedback

Summary

We commissioned two providers, Trueman Change and The Active Wellbeing Society, to host a series of focus group sessions with specific communities. Five of the sessions were held virtually while the rest were in-person in December 2021. Similar to the online BeHeard survey, focus group participants were provided with a copy of the draft Health and Wellbeing Strategy. They were also given a brief background on the purpose of the strategy and how their comments and feedback would be used.

There were 49 participants in all of the focus groups and a demographic breakdown can be found in Appendix E. The specific communities which attended were:

- Muslim Women's Group
- Leisure Providers
- Young People (14-19)
- Homeless/ Temporarily Accommodated
- Black, Asian, and Minority Ethnic individuals
- Adults with Learning Disabilities
- Travellers
- Healthcare Practitioners
- Adults with Physical Impairments

Key Findings

Introduction (Vision Statement, Principles for Action, Closing the Gap)

Most of the groups agreed that the Vision Statement was the right idea and it would be a huge positive if it could be achieved. Interestingly, several groups identified that affordability or limited disposable income was a barrier towards better health. This trend continued in other groups where the role of community organisations and centres was identified as essential for reducing health inequalities by being accessible to everyone.

Theme 1: Healthy and Affordable Food

In the focus groups, there were overall positive thoughts towards the take-up of healthy food vouchers; the health practitioners' group were surprised that take-up was not already at the level of 80%. It was suggested that vouchers could be better advertised through schools and GP's.

Another group identified an issue with the accessibility to junk/fast food, particularly for children. There was agreement that educating children and young people as well as facilitating healthy choices are one of the best methods for tackling obesity. Alternatively, one group wanted the council to be much more forceful and make access to fast-food restaurants more difficult. These points were agreed with by the young people's focus group who focused again on the attractiveness of low-cost fast food compared to any alternatives.

The adults with learning disabilities group highlighted that the increase in food bank use had led to people almost wholly relying on food parcels that lack any fresh food. Many of the groups said that education around options as well as healthy cooking were crucial but that behavioural change was needed for education to follow-through.

Theme 2: Mental Wellness and Balance

The health practitioners' group felt the ambitions outlined in the mental wellness and balance theme were important but too ambitious, with comments on the triple zero by 2030 ambitions not being achievable at all. This was shared by the Black, Asian, and Minority Ethnic group who felt there was an overall disconnect between each ambition and real life. It was noted in one group that the ambition to reduce the prevalence of depression and anxiety was "totally unrealistic".

There was also concern that targets around smoking, drug or alcohol addiction were tackling a symptom but not a cause of poor mental health. therefore, a preventative approach would always be preferable over a corrective one.

Finally, the adults with learning disabilities group's discussion ended on a reflection of the ambitions and a suggestion that they should have more of a continuous feel to reflect people's journeys with mental health as opposed to a start and end point of data.

Most of the focus groups agreed that the Covid-19 pandemic/ lockdowns and isolation have impacted negatively on mental health and in many cases exacerbated pre-existing issues. From this the two main points to highlight are that access to mental health services is still difficult for marginalised communities (traveller, homeless, etc). Equally, there needs to be further normalisation of open conversations about mental health, both good and bad.

Theme 3: Active at Every Age and Ability

The groups were more positive about the ambitions in this theme and considered them to be more achievable as they were accessible and tangible. There was also consensus that the link between physical and mental health could be emphasised more strongly throughout the theme. The adults with physical impairments' group was keen to see and hear of wider offers of physical activity in their local areas and touchpoints in their everyday life e.g. medical practices and volunteers. Another group highlighted the importance of making physical activity practical and affordable, linked the ambition on reducing the inactivity gap between the ten most and least active wards.

The leisure providers focus group said that they would like to see specific reference to access to physical activity regardless of ability to pay. This was echoed in several groups who said that ensuring open access was essential. The Muslim women's group also highlighted that mixed gender facilities can be negative or intimidating for them so organising activities that are for women, or women's groups, only could help.

Theme 4: Green and Sustainable Future

The young persons' group highlighted that the importance of green and blue spaces is somewhat dependent on where you live. Additionally, they noted that, on the whole, they believed their local parks were well maintained, which encouraged their use. Another group commented on this, linking safety to the enjoyment of green and blue spaces. It was agreed that maintained paths as well as lighting was necessary to deter the risk of attacks/ muggings.

Some of the groups had concerns about the ambition to increase volunteering as it was noted that the council has direct control over many parks in the city and it should be the one to employ more wardens or rubbish collectors. The focus groups also focused on how to get to green and blue spaces if you don't live within a reasonable distance and highlighted that appearance is important; i.e. if a park, canal-side or street looks unclean and rubbish-filled then people will be less inclined to go there as it suggests it is not a looked after space.

Theme 5: Protect and Detect

Many groups were pleased to see the inclusion of this theme, although there was a divergence on whether the emphasis should be on health protection or crime prevention. On the subject of health protection, the groups identified that information, education and advertisement was crucial to keep people aware and up to date (with screenings, immunisations, etc). The adults with physical impairments' group proposed that a more continuous form of health check (i.e. a lifestyle check) would help to identify problems associated with the other themes, such as poor diet or lack of physical exercise.

Some of the focus groups highlighted that the language used for the ambitions was overly technical (e.g. deliver fast-track accreditation) and whether phrases like these could be better explained.

Another common point was the growing presence of misinformation, particularly around the Covid-19 vaccine, but other health issues in general and that organisations like BCC/NHS/ etc need to be much more pro-active in identifying and tackling false information before it can spread widely.

Finally, most of the groups agreed that combining health protection and crime protection seemed like an attempt to combine two themes that should sit separately. They also highlighted that it was important to still ensure that crime prevention had a place in health and wellbeing. In particular, several groups said that domestic violence has to be addressed from all angles and 100% involves wellbeing.

Life Course 1: Getting the Best Start in Life

The Muslim women's group highlighted that children's mental health was of paramount importance but many of our ambitions/actions in Theme 2 suggested that signposting individuals to services would be primary goal, however, this is greatly reduced as children cannot be easily signposted to services.

The focus group with the traveller community highlighted the high levels of infant mortality within this community but further suggested that there could be more pro-active engagement by bereavement services in the instances of infant mortality.

The focus group with the homeless and temporarily accommodated noted that most accommodation is geared towards single-occupancy rooms which makes it harder for families to stay together in the same building if there are few rooms available.

Life Course 2: Living, Working, and Learning Well

The young people's focus group wanted a focus on the transition of information from school to home (i.e. they said they wanted to know about healthy food options so they could take this information back to their household).

The adults with learning disabilities' focus group highlighted that there is little consistency on employers adjusting work to those who need it. One participant gave an example of how an employer had been helpful in arranging an SEN assessment for them at work.

The travellers' focus group wanted to again highlight how the lifestyle of their community does not match well with the conventional approach of schools and whether an increase in online learning could be to the benefit of traveller children.

The focus group for the homeless community noted a number of points on employment. Firstly, they said offering money management skills to those in these situations would be very beneficial as it can build independence, self-confidence and further boost mental wellbeing

(remove anxiety of dependency). Equally, they noted that when in temporary accommodation, you face a choice between UC or employment, and this can be a disincentive to work.

Life Course 3: Ageing and Dying Well

The Black, Asian, and Minority Ethnic community focus group highlighted that faith is very important to older adults and faith leaders are one of most highly trusted figures. Therefore, they are very good to use with communicating key information and spreading awareness of positive health measures.

The traveller community's focus group brought up the issue of older adults in that community seeking static residential care in their older age but often struggling to arrange it through official channels.

The Muslim women's focus group highlighted the issue of age or health-related mobility being a significant barrier to engaging in any physical activity.

Appendix F: Demographic Summary of Focus Group participants

Table 9. Participants by Age Group

Age Group	No. of respondents*	% those that responded	% of total Birmingham population**	+/-
0-19	10	17%	29.2%	-12.2
20 – 29	0	7%	16.8%	-9.8
30 – 44	13	28%	20.8%	+7.2
45 – 59	12	26%	16.4%	+9.6
60 – 74	0	7%	10.8%	-3.8
75 – 84	0	2%	4.6%	-2.6
85+	0	0%	1.8%	-1.8
Not Answered	10	13%	N/a	N/a
Suppressed Total Respondents	**45**	**100%**	**100%**	

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Table 10. Participants by Gender

Gender	No. of respondents*	% of respondents	% of total Birmingham population**	+/-
Male	22	48%	49.7%	-1.7%
Female	19	41%	50.3%	-9.3%
Not Answered/Prefer not to say	10	11%	N/a	N/a
Suppressed Total Respondents	**51**	**100%**	**100%**	

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Table 11. Participants by Ethnicity

Ethnicity	No. of respondents*	% of respondents	% of total Birmingham population**	+/-
English/Welsh/Scottish/Northern Irish/British	20	43%	53.3%	-10.3
Any other White background	0	2%	2.4%	-0.4
Mixed/multiple ethnic groups	0	2%	3.8%	-1.8
Asian/ Asian British	14	24%	24.3%	-0.3
Black/ African/ Caribbean	0	9%	7.6%	+1.4
Any other ethnic group	0	2%	1.4%	+0.6
Not Answered	10	17%	N/a	N/a
Suppressed Total Respondents	**41**	**100%**	100.0%	

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Table 12. Participants by Sexual Orientation

Sexual Orientation	No. of respondents*	% of respondents
Bisexual	0	4%
Gay or Lesbian	0	4%
Heterosexual or Straight	20	43%
Other	0	0%
Prefer not to say	16	35%
Not Answered	10	13%
Blank	0	0%
Suppressed Total Respondents	**46**	**100.00%**

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

Table 13. Participants by Religion or Belief

Religion or Belief	No. of respondents*	% of respondents	% of total Birmingham population**	+/-
Christian (including Church of England, Catholic, Protestant, and all other Christian denominators)	13	28%	46.1%	-18.1
Buddhism	0	2%	0.4%	+1.6
Hindu	0	2%	2.1%	-0.1
Muslim	12	26%	21.8%	+4.2
Jewish	0	0%	0.2%	-0.2
Sikhism	0	0%	3.0%	-3.0%
No Religion	13	28%	19.3%	+8.7
Any other religion (please specify)	0	0%	0.5%	-0.5%
Prefer not to say	0	0%	N/a	N/a
Not Answered	10	13%	6.5%	+6.5
Blank	0	0%	N/a	N/a
Actual Total Respondents	**48**	**100.00%**	100.0%	

*Values less than 4 have been supressed to 0 and values between 5 and 10 have been supressed to 10. Total counts below do not match the total responses due to suppressing responses.

**Source: Birmingham City Council, *Key Statistics on 2011 Census,* https://www.birmingham.gov.uk/downloads/download/968/census_2011_key_statistics_reports_constituency_and_wards

Appendix G: Ward Forum Feedback

Summary

The Health and Wellbeing Strategy addresses some of the critical challenges Birmingham faces. Delivering this strategy requires input from many organisations across the city. It focuses on the needs of service users and communities, to tackle the factors that impact upon health and wellbeing across service boundaries.

The Birmingham Health and Wellbeing Board has recently completed a consultation period on the draft of its new strategy: Creating a Bolder, Healthier City. It contains five core themes running throughout the life course and two cross-cutting approaches. It is also underpinned by the priority of Closing the Gap, reducing health inequalities that have been highlighted and exacerbated by the COVID-19 pandemic.

Method

The consultation period for the Health and Wellbeing Strategy was opened on September 23rd, 2021 and closed on December 10th, 2021. During this period, the primary means of consultation was through a digital survey on the council's BeHeard website. This was added to by a number of other methods, including commissioned focus groups and webinars by senior council officers.

One aspect of the consultation has been to present the draft strategy at local Ward Forums. Ward forums are chaired by the local councillors for that ward and provide an opportunity for residents to discuss important local matters around crime, health, and environment.

The format of this consultation involved a Service Lead Officer from Public Health presenting a short introduction to the strategy and its different themes. They then opened up the discussion for questions and comments. Any questions that couldn't be answered during the session were followed up and the chair of the forum received an email response.

Findings

All councillors were offered the opportunity for public health officers to attend a ward forum. Those attended were all held virtually. The wards attended were: Soho and Jewellery Quarter, Stirchley, Shard End, Sutton Vesey, Nechells, Sutton Reddicap, Sparkhill, Hall Green South, and Gravelly Hill.

Attendance to the ward forum varies, with the average number in attendance being 10, including councillors and officers. Due to the varied attendance numbers, the majority of questions were from councillors. However, these questions usually provoked further discussion.

The intent of the strategy was received positively although it was expressed at multiple forum's that some of the topics have been an issue for several years, even decades now, and that previous strategies had 'come and gone' with little effect. Therefore, it was asked how this strategy would clearly have the desired impact.

Themes

Housing

- In several ward forums, quality and condition of housing was discussed as a significant factor for a person's health and wellbeing. For example, poorly insulated buildings can lead to a colder internal temperature and itself lead to pneumonia and other respiratory diseases.
- In the Sutton Vesey ward forum, it was asked how housing has been considered within the strategy. It was noted that housing, as a wider determinant of health, could certainly be given more prominence within the strategy.
- There was a suggestion that a representative from the BCC Housing Department could be invited in future to the Health and Wellbeing Board to discuss possible membership.

Air Quality

- Air pollution and air quality were also brought up in several ward forums as both a short and long-term health concern. For example, in the Gravelly Hill ward forum, it was highlighted that the negative health impacts of living on/near the Tyburn Road need to be negated through this strategy.

Social care/Carers

- There was a question from the Stirchley ward forum about the presence of carers on the Health and Wellbeing Board. While it was noted that that there are several strategic leads on the board's membership, there could be increased representation of carers (especially unpaid) on the sub-forums.
- There was a wider concern highlighted that previous strategies have fallen short when trying to integrate health and social care and how this strategy in particular would not have the same result. It was addressed by saying that there will be greater accountability built into the strategy through the fora's responsibility for delivery and the Health and Wellbeing Board's responsibility for oversight.

Health Inequalities

- Several queries were around how this strategy would help to tackle local health inequalities within specific wards.

Mental Health and Wellbeing

- It was asked in the Sutton Reddicap ward forum how mental health and wellbeing, particularly relating to children, would be factored in and which partner/s would be delivering on this. It was noted that actions in both Theme 2 and Mitigating the legacy of Covid-19 would be aimed towards children's wellbeing. It was noted though that in the ambitions for the life course, there could be a greater focus on children's mental health and wellbeing, specifically for ages 14 to 18.

Appendix H: Health Impact Assessment

Summary

A Health Impact Assessment (HIA) is a tool that seeks to improve the quality of policy decisions by evaluating the likely positive and negative health impacts from proposed programmes or policies and making recommendations to improve positive health impacts and mitigate negative ones.

As the responses from the public consultation were low (142), the HIA in addition to the focus groups and feedback from Stakeholders enabled us to identify and make recommendations to improve positive health impacts and mitigate negative ones across the strategy.

The HIA questionnaire was developed and participants were selected from different backgrounds especially from groups that did not have an active participation in the public consultation. A total of 7 HIA interviews were held with representatives from the Business Community, Sikh Community, LGBTQ Community, Pakistani Community, Academic Community, Deaf Community and Digitally Impaired Community.

The primary objective was to identify if there were any potential health gains or losses, health issues and public concerns identified from the themes? E.g. factors from the social and physical environment (i.e. housing quality, crime rates, and social networks), personal or family circumstances (i.e. diet, exercise, risk-taking behaviour, and employment), and access to public services.

It was further developed to explore who will be affected by the five strategy and life course themes and what conclusions can be drawn and recommendations made that might remove/mitigate negative impacts on health and enhance positive benefits?

A summary of the results from the Health Impact Assessment is described below.

Negative Impacts

Overall Strategy

- Review the language used to ensure it is plain English - The participants felt that the usage of jargon and data was excessive making it uneasy to comprehend a lot of the information described E.g. The Healthy Planning Toolkit, Triple Zero Strategy etc could benefit the public with explanation on what they are and what do they aim to achieve at least concisely in brackets or footnotes.
- Participants opined the Strategy was ambitious and voiced concerns over whether it was achievable as they felt there was a disconnect between stated ambitions of the Strategy and what happens on the ground, particularly around planning and implementation.
- Participants also felt that inequality was not addressed in terms of ethnicity/communities but instead were solely focussing on geographical areas.

Food Theme

- Inequality in Diets- The Strategy should explore whether people's diet and affordability changed during the pandemic.
- The Strategy has to draw focus on issues relating with food and eating disorders in the LGBTQ+ community as it is very common and Covid -19 has exacerbated that.
- Covid-19 in general has a negative impact on people's food quality, access to food, being in furlough and disadvantaged groups.

Mental Wellness and Balance

- Elderly Community- Lack of socialisation, lack of community support and deaths in the community have affected mental health.

Physical Activity

- Most participants were of the view that cost was a major barrier to participation and access in physical activity.

Protect and Detect

- Nothing explicit was there in the ambitions especially relating to domestic violence and community safety.
- Unfortunate there are groups who aren't willing to engage in vaccination.

Positive Impacts

Green Spaces

- The participants welcomed a focus on clean air in the whole city, not just the area covered by the Clean Air Zone (CAZ).

Protect and Detect

- Participants supported tackling the root causes of crime and efforts to divert young people away from criminal activity through youth provision.
- Promotion of Covid -19 vaccination have improved access to ethnic communities.

Recommendations

Overall Strategy

- Participants opined that the strategy should also be culturally sensitive and inclusive of all communities and ethnicities
- Prioritise tackling the financial barriers to health.
- Measuring Success – Annual targets should feed into the longer-term success of the Strategy for each theme indicator wherever possible.
- Infographics need to be communicating messages concisely and precisely.

Food theme

- The Strategy will need to look into what type of changes have people made in their cooking during the pandemic in terms of choice and affordability.

Mental Wellness and Balance

- There is scope to work with employers, charities and universities to design workplaces around positive wellbeing and how we work differently to tackle mental health challenges in the long term.

Physical Activity

- Include physical inactivity prevalence relationship with mental health

- Addition of inclusive spaces especially with regards to Physical activity as it affects women and groups within the LGBTQ community.

Green Spaces

- Not just clean air but volume of traffic needs to be considered in these actions. There are indirect health benefits across the themes if people are actively commuting without dependence on cars.

	To what extent do you agree or disagree with the vision statement? - Vision statement	To what extent do you agree or disagree with the vision statement? - Please use the box below for comments you wish to make. If you disagree with the vision statement, please tell us why and explain how you think it could be improved:	To what extent do you agree or disagree with the principles for action? - Principles for action	To what extent do you agree or disagree with the principles for action, please tell us why and explain how you think it could be improved:	To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - Inequalities linked to Deprivation	To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - Inequalities affecting Disabled Communities	To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - Inequalities affecting Inclusion Groups (e.g. people experiencing homelessness, sex workers, care leavers, veterans and those in contact with the justice system)	To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - Inequalities affecting different Ethnic Communities	To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - Inequalities of Place (i.e. variation/ inequalities between Wards)	To what extent do you agree or disagree with the focus on 'Closing the Gap' in the strategy? - Please use the box below for comments you wish to make. If you disagree with the approach of Closing the Gap, please tell us why and explain how you think it could be improved:
1	Strongly agree	I strongly agree with the affordable aspect as many choices are restricted by cost.	Agree	The top bullet is the relevant one as this should already encompass bullet two.	Disagree	Disagree	Disagree	Strongly disagree	Neither agree nor disagree	I think often the groups named above often have the opportunity to access better health opportunities because of where they visit, they see more adverts/signposts, often receive discounts, may have opportunities offered to them because they may access medical outlets more often. It's the people who sit at home and don't access local services that need to be targeted for improved health.
2	Disagree	Similar statements have been made for the last 50 years, but nothing in reality has changed. There continues to be disparity between rich and poor and service provisions. BAME people continue to be worse affected. There is nothing 'bolder' about your strategy	Strongly agree	No problem with headline but issue with practicality, why make a statement if you cannot deliver,	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Adequately resources service provision based on inequalities/ deprivation needs to be seriously considered going forward.
3	Don't know	You have failed on delivering so many 'visions', this will be no different. This is all talk AGAIN. You can't use local footpaths because they are so badly maintained and overgrown. Surely being able to walk locally would be an important part of the vision yet you have failed to deliver on basics. Lets face it this is not a city that treats everybody fairly	Strongly disagree	You don't listen and you make many choices that have negative effects and you either choose to ignore the issues or are incompetent at making decisions.	Strongly disagree	Agree	Strongly disagree	Strongly disagree	Strongly agree	I don't believe you trulu understand inequalities and that you are playing around the edges. What about the inequalities of threats of violence from groups in some areas. Why are you pursuing cycling measures soto the exclusion of all others when my 81 year old mom cant physically use a bike. You have done nothing for her and yet you celebrate this.
4	Strongly agree		Strongly agree		Agree	Agree	Agree	Agree	Agree	
5	Agree		Strongly agree		Neither agree nor disagree	Agree	Strongly agree	Neither agree nor disagree	Strongly agree	
6	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
7	Agree		Neither agree nor disagree	Be careful that you include all citizens and not just those who live in social housing. There are plenty of elderly in private accommodation who struggle and don't come to anyone's notice.	Agree	Agree	Agree	Agree	Agree	Make sure you 'do' rather than just 'highlighting' or 'proposing'. These things tend to reduce down to lots of words but little action.
8	Strongly agree	However, this is not a measurable goal. YOU NEED TO INCLUDE AN ACTION PLAN WITH OBJECTIVES!!!	Strongly disagree	1) Focusing on citizens isn't useful or even informing practice by their experience, you need to collaborate with the public. Same old approach, same old problems. 2) Inequality is not the end point. In fact it is a poor effort and rather unambitious. Aim to reduce inequality and promote EQUITY. You could be more innovative and strive for JUSTICE! 3) I'm keen to find out what you constitute as research-enabled action. The wording makes me think this is a quick and dirty way rather than a robust and empirical methodology	Strongly agree	Strongly agree	Strongly agree	Disagree	Disagree	There is far too much focus on marginalised groups that for sure have inequalities. Whilst these groups have problems, it is almost like a scapegoat to push the director's agenda. The BAME and LGBT communities are important but seem to be the only focus. More needs to be done around lesser heard stigmatised and disadvantaged communities/individuals.
9	Strongly agree		Strongly agree		Strongly agree	Agree	Neither agree nor disagree	Agree	Neither agree nor disagree	I have concerns about inequalities in wards-I live in an affluent ward however I am by no means affluent myself. I don't want to be penalised for living in an affluent ward.
10	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
11	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
12	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
13	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
14	Agree	Maybe the ending: and desirable to support them to achieve their potential for a happy, healthy life. Could be changed to: and desirable to support them to achieve their potential and for a happy and healthy life.	Agree	The 3rd points sounds very government policy speak. Bring it back to public level, e.g. Actions will be based on evidence and best practice	Strongly agree	Strongly agree	Agree	Agree	Strongly agree	You can't focus on everything choose one that affects Birmingham the most and focus on that.
15	Agree	Unclear where you are getting your data and research from. I would hope that health also includes mental health.	Agree	I hope data and evidence comes more from established academic research than from local research.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Greater funding for libraries and projects promoting engagement with libraries for children and adults
16	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
17	Agree	This vision stretches beyond the Health and Wellbeing directorate as not everyone is in a financial position to make healthy choices.	Neither agree nor disagree	To many buzzwords and not enough substance in these bullet points. what does 'Data and evidence-informed, and research-enabled action' even mean?	Agree	Agree	Agree	Agree	Agree	
18	Strongly agree		Strongly agree		Strongly agree	Agree	Strongly agree	Agree	Agree	Attention needs to be given to the Deaf community to have better communication. There is still a lack of BSL learning opportunities especially as funding has gone. There are still Deaf people using medical services with no interpreters. The lack of trust among the Deaf community needs to be investigated properly.
19	Strongly agree		Strongly agree		Agree	Agree	Agree	Agree	Agree	
20	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
21	Agree		Agree		Agree	Agree	Agree	Agree	Agree	
22	Strongly agree		Strongly agree		Agree	Agree	Agree	Agree	Agree	
23	Strongly agree	Exercise classes should be free and gym etc as well as subsidised healthy food so its affordable for the less well off too	Strongly agree		Strongly agree	Agree	Strongly disagree	Strongly agree	Agree	Ethnic origin is not a lifestyle choice that resulted in being disadvantaged unlike some of the other ones where drug use etc was a result of personal decisions/choices Therefore equalities as a result of ethnic origin should be prioritised above others Then deprivation and inequalities between wards as children of these families didnt choose to be born into these areas or poverty and they should be assisted to close the gap to give them a better standard of living in line with the rest of the population
24	Agree		Agree		Agree	Agree	Agree	Agree	Agree	
25	Agree	its a bit lengthy could be shortened to something like "Our shared vision is to create a healthier city where every citizen, of any age or ethnicity are supported to make healthy choices that are affordable, sustainable and desirable to help them achieve their potential for a happy, healthy life".	Strongly agree		Neither agree nor disagree	Agree	Agree	Agree	Agree	
26	Strongly agree	Personally, I see vision statements as pretty meaningless pieces of text created by PR people. Too many times, organisations churn these out and then don't follow with measurable action.	Strongly agree		Agree	Agree	Agree	Agree	Agree	
27	Neither agree nor disagree	We can all help to improve our environment however in current times and with the cost of living escalating out of control, services being cut through budget restrictions and restricted access to hospitals and doctors surgeries the vision has to have a much longer time scale as current pressures are impacting not just on physical health but far more on the mental health of the current population which is putting further pressure on restricted services. We have to be realistic in todays times and not overly optimistic.	Neither agree nor disagree		Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	In today's climate only the healthy will benefit. Those with any kind of pressure will not be able to access the help that they need through lack of resources and poor funding.
28	Strongly agree		Agree		Neither agree nor disagree	Agree	Neither agree nor disagree	Agree	Neither agree nor disagree	
29	Agree		Agree		Agree	Agree	Agree	Agree	Agree	

30	Strongly agree	I agree what are you doing to support the elderly in our communities who are not getting out and about as they used to because of covd better support is needed ring and ride communicating with GPS to locate elderly needing support	Neither agree nor disagree	More needs to be done in all communities	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Every community should be entitled to the same facilities and support where are the swimming baths and community gyms run by council why are they so expensive why aren't more swimming pools and gyms being built
31	Strongly agree	I am not sure why they word "desireable" is in the vision.	Agree	The first principles is difficult to interpret. I don't know what it means.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I think the first example of a health inequality is weak. Black Africans come from a part of the world with a high level of HIV. Why not pick an inequality between white and black people who were born in Birmingham. This will be more powerful and meaningful.
32	Strongly agree		Strongly agree		Agree	Agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	
33	Agree		Agree		Agree	Agree	Agree	Agree	Agree	You just have to look at the Birmingham the second city and the inequalities within wards just compare Handsworth to Harborne
34	Agree		Agree		Agree	Strongly agree	Strongly agree	Agree	Agree	
35	Strongly agree		Strongly agree		Disagree	Disagree	Disagree	Disagree	Disagree	
36	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	
37	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
38	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
39	Strongly agree		Agree							
40	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
41	Agree		Neither agree nor disagree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
42	Strongly agree	joined up bcc thinking (not just talk) and people come first above cars, buses and convenience of a few vocal minorities e.g. motoring lobby.	Neither agree nor disagree	people first. Example locally we want to close 2 roads to thru traffic...its like pushing jelly up hill with little support from engineers and councillor. No funds,... interesting but has anyone died? Can we do a traffic survey.. ah we havent the resources.. So how you gonna change that attitude?	Agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Don't know	how well do bcc maintain council tenant properties or create space for gypsies ?
43	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
44	Agree		Agree							There is a lot here to focus on - Whilst one cannot disagree with any, is this realistic?
45	Neither agree nor disagree		Neither agree nor disagree		Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	
46	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
47	Agree		Agree		Agree	Agree	Agree	Agree	Agree	
48	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	This needs to be joined with the city of nature vision, and needs to be a key council priority for all council directorates and partners.
49	Agree		Agree	I like the principles, although I think it needs to go beyond being informed by citizens lived experience, and provide a commitment to genuine, meaningful (and resourced) co-production	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Not quite sure what the difference is between the first and last of these points.
50	Agree		Agree		Agree	Agree	Agree	Agree	Agree	
51	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
52	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
53	Agree		Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	
54	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
55	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
56	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
57	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
58	Neither agree nor disagree		Neither agree nor disagree		Neither agree nor disagree	Agree	Agree	Agree	Agree	
59	Strongly agree		Agree	I think you should consider the principles of co-production, which is more robust than 'citizen informed'. If this is not feasible, at least consider co-design principles.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Please consider the LGBTQ+ community as part of your Inclusion Groups. There is evidence of poorer health outcomes for this group and partners such as Birmingham LGBT who are dedicated to improving this situation.
60	Neither agree nor disagree	I do not disagree, but we heard the same thing ten years ago. Inequality of health in areas is easily identified through local health records and local plans. Ten years on health in this area has declined rapidly even thou it was recognised ten years before, as having health inequalities. Due to decisions made for the area, not with the people who live here, we have experienced is decisions made in this area by Authorities, has had a significant detrimental effect on local health. The impact from the increase in Air Noise and Light pollution and polluting industries has increased the health inequalities in this area due to decisions by senior Authorities without mitigating those decisions.	Agree		Agree	Agree	Agree	Strongly agree	Strongly agree	It could be improved by equality of administration of process, law policy, and procedure. If there was equality of administration, then certain areas usually deprived areas would be protected by Air Pollution law, planning law , enforcement law, inclusion, highway law but they are not.
61	Strongly agree		Strongly agree	All too often services are not citizen focussed. The council need to take action in limiting fast food outlets in poor areas; support green food providers and caterers, (vegan, locally sourced and produced fruit & veg etc). Universal income should also be looked at	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
62	Strongly agree		Strongly agree	Coproduction is absolute key to this!	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
63	Strongly agree		Agree		Agree	Strongly agree	Agree	Strongly agree	Strongly agree	
64	Agree		Agree		Strongly agree	Agree	Agree	Neither agree nor disagree	Agree	ethnicity and deprivation - confounding each other - which makes more difference? I would guess deprivation
65	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
66	Disagree	Taxing businesses and cars with this scam caz charge achieves no such thing m	Strongly disagree	Definitely not citizen focused and just money making listening to older people when the city is almost 50% young people	Agree	Agree	Agree	Strongly agree	Agree	All wards should be equal
67	Strongly agree	I will probably not fill in all the sections I am a retired GP and also a member of the RSA -the incoming CEO is Andy Haldane former chief economist at the Bank of England. He has been seconded for 6 months to lead the "Levelling up' board He asked for suggestions so I have just copied and pasted what I sent to him So with this in mind these would be my priorities; 1.Invest heavily in creating15 minute cities so people can work play and educate locally https://www.15minutecity.com This promotes physical activity and reduces commuting but more importantly enhances social activity. Local networking takes place to find creative solutions to the locality's problems.	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	
68	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	It will also be important to address inequalities in terms of access and outcomes for LGBTQ+, and perhaps particularly trans people
69	Strongly agree		Strongly agree		Strongly agree	Agree	Agree	Strongly agree	Strongly agree	
70	Agree	Many people understand the value of life and many try and eat healthy. Health is more effected by Environment, and many living in poor environments are excluded from changes made in the area which are usually not Environmentally healthy if its a deprived area.	Agree	Citizen focus if you live in a effluent postcode of Birmingham or over the south side. You have been focused on reducing inequalities for many years but the inequalities are wider and worse than ever. As far as data is concerned waste of money ,as you have crime rates , HMO areas, drugs, pollution, speeding, Noise Pollution, 24 hr traffic noise, no enforcement, litter fly tipping. This is inequality as there is a law covering everyone of these problems but Bias and Institutional racism fail to be enforced in one area, whilst fully enforced in another.				Strongly agree	Birmingham like South Africa clear white areas and clear black areas, not saying there are no deprived white areas as there is and they experience the same inequalities. Been getting wider under this council and more identifiable by many living in communities.
71	Neither agree nor disagree		Agree		Agree	Strongly agree	Agree	Agree	Strongly agree	
72	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
73	Strongly agree	The Vision Statement, in theory, is right, however, when putting this in practice, that's where there are failures. There needs to be more integrated service delivery and a more joined-up approach with stakeholders. Inequalities need to addressed.	Strongly agree	Citizen focused and informed by citizens lived experience Consciously focused on reducing inequalities and promoting equality and inclusion Data and evidence-informed, and research-enabled action Are all important factors - lets put theory into practice	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	

74	Strongly agree		Neither agree nor disagree	A mix of both is good, needs professional input but voices heard of lived experience	Agree	Agree	Agree	Neither agree nor disagree	Neither agree nor disagree	Some things are a lottery, be it postcode or otherwise
75	Strongly agree		Agree	The action must be relevant and useful - evidence based data can often be more useful to the research than to the participant.	Strongly agree	Agree	Agree	Agree	Strongly agree	
76	Strongly agree	In order to create this vision, resources and support must be prioritised for more vulnerable groups such as BAME with pre existing health inequalities and chronic conditions compared to other citizens or groups who have a much better start in life and choices.	Agree	Recent data and evidence must be used especially coming out of the pandemic that have hit specific communities the hardest and focused in helping to enable action. You are doing great in reaching out to certain and citizen groups in engaging as many with lives experience. More could be done by working with a variety of grassroots organisations	Agree	Agree	Agree	Agree	Agree	There is no mention about closing the gap about for BAME groups with pre existing health conditions. The West Midlands BAME inquiry into COVID enquiry highlighted a number of failures, inequalities, situations and conditions that have or will be exasperated.
77	Strongly agree		Strongly agree	Promotion of equality is vital	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
78	Strongly disagree	It doesn't support Gypsy roma and travellers	Disagree	It doesn't include Gypsy romany and travellers	Disagree	Disagree	Strongly disagree	Strongly disagree	Strongly disagree	Doesn't include Gypsy romany and travellers Improve by including these groups
79	Agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
80	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	what about migrants and people waiting for Home Office decision
81	Neither agree nor disagree	I believe this statement needs to include accessibility. Many people have limitations that mean anything that could help them become healthier is inaccessible due to distance from home and travel limitations.	Strongly agree	Be sure to reach the voices of those who often go unheard	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Speak to the people from these demographics and be led by them. They know best. Create a list of all limitations and barriers fir each demographic. Work creatively with that list
82	Don't know	What does this actually mean .to me some is writing words to say nothing	Don't know	Again this has no meaning	Don't know	Don't know	Don't know	Don't know	Don't know	I am saying don't know because I fill what you are doing, going to do are not in the slightest going to achieve any of the above
83	Not Answered		Not Answered							
84	Strongly agree		Agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	By focusing on deprivation regardless of other 'areas' will ensure that those who need it get the right support.
85	Strongly agree	I think this is great, the vision should be inclusive of physical and mental health support etc. for those who need this.	Agree	I do agree - however, there are groups of people not strongly represented in data sets who additionally need help and inclusivity. I believe the data should focus on the amount of people dealing with x or y and the severity of how that impacts their life. For instance there will be a small amount of people who all have the same experience which is severely affecting their lives - just because this is say 1 to 3% of the population does not mean that they should not be given the support required because there is less of them; especially if the affect on their lives is severe.	Agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	I think that an addition should be made and this should be mental health. Not all mental health conditions fall under 'disability' and it is often difficult for those with long term or short term mental health conditions to obtain 'disability' status. There is still a stigma unfortunately around mental health and there is a large impact on people's lives which, in my opinion, is still being ignored.
86	Strongly agree		Neither agree nor disagree	Not all citizens voices are heard. Unless seldom heard groups are linked to organisations/community groups some voices will go unheard due to personal commitments (I.e. caring duties) and may not have access to or aware of the strategy proposed.	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	It's worthy to note that inequalities occur amongst all groups in society. High level of inequalities may be associated with disadvantaged groups, however people in affluent areas also experience poor health due to being asset rich, cash poor therefore affected by loneliness, dementia, etc. This most be taken in consideration when levelling up health economies.
87	Strongly agree	How are you going to measure success? What will a healthier City look like - while I really do agree with this I've not idea and I guess you may not have either of what this means in practice - how will it influence system, place and neighborhood level decision making. How does it join up with the ICS/ICB and PCN model that is now being put in place. Where does it sit with plans for developments such as road, rail and cycling changes. How will it influence planning decisions for example? How will you make sure that people live in affordable homes that are heated with clean energy? Its in danger of being hugely siloed thinking and of missing the considerable opps there are at the moment	Strongly agree	Again - what does this really mean in practice? how will this influence your design and delivery of services against a backdrop of years of underfunding and poor investment	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Again what will this mean in reality/how will anyone know whether you're making progress?
88	Agree		Agree		Agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	
89	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
90	Strongly agree		Agree		Agree	Agree	Strongly agree	Strongly agree	Neither agree nor disagree	I think inequalities of place is often encompassed within the other inequalities, therefore I am not sure whether it should stand alone.
91	Agree	It would be difficult not to agree with such a vision. However, your record of delivering your visions is appalling and I see no likelihood of improvement only talking the talk. You lack the integrity to deliver and delivery is not consistent across the geography of Birmingham.	Strongly disagree	This not about equality as much as it is about achieving certain minimum standards. In south west Birmingham accessibility (transort) is very poor and you will do nothin g to improve this and yet this is a key part o levelling up for this area.	Agree	Agree	Disagree	Strongly disagree	Strongly agree	You have a track record of investing in some areas over others and not following the principles you describe. You abandoned the Frankley Branch when this would have imroved access to jobs and other opportunities for one of the more deprived areas in Birmingham. You have not demonstrated that your 'philosophy' has improved. Birmingham does not finish at Selly Oak and yet major investment ends there. Longbridge saw the loss of 6000 jobs to be replaced witha promise of 10000 jobs. The developer has mde vast profits off this because you have let this employment site become a retail park and housing development and tSt Modwens have reaped the financial benefits. This shows poor understanding and capabilities on your part an there are many other examples including the birmingham transport plan which is terribly flawed and willstrangle the future of brum
92	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
93	Strongly agree		Strongly agree	Please focus on gross health inequalities with BAME communities. Some of these inequalities have existed for many decades.	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Inequalities amongst BAME communities are chronic. You need to look at the rise of takeaways and shisha outlets in inner city deprived neighbourhoods
94	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
95	Agree		Agree		Agree	Agree	Agree	Agree	Agree	
96	Disagree	Still too many cars around the city centre, to make the situation better make transport cheaper for members of public and more frequent service of public transport into city centre	Don't know		Neither agree nor disagree	Disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	
97	Agree		Agree		Agree	Agree	Agree	Agree	Agree	
98	Strongly agree		Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
99	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	These are all great, but don't forget the people that fall into several categories or could fall between the gaps left here.
100	Strongly agree		Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I think the long term focus should go beyond just closing the gap and should aim to improve everyone's eating behaviours.
101	Strongly agree		Neither agree nor disagree		Agree	Strongly agree	Agree	Agree	Agree	
102	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Over the years I've been let down, I feel deflated & defeated by the system & now find myself isolated with less confidence to utilise health & wellbeing services. I feel that over the years of reading the promises of improvements, it's realistically not improving & I sink further into depression mode.

103	Strongly agree	Word soup with not much tangible action promised. Sounds like an election campaign full of empty promises. HOW are you planning to achieve this? Huge change at central government level is needed to accomplish this. CMS, DWP, UC, NHS, the care system, SEN provision, CJS, legal aid, housing standards, and the education sector would need entirely overhauling to achieve this. Is that in your plan?	Strongly agree	statement. The issues are extremely clear, constantly asking the same questions isn't going to move anyone further forwards. The CMS needs completely overhauling. CMS debt needs to be more aggressively chased and enforced, wait times need to be significantly cut down, fees for resident parents must be scrapped entirely, DWP sanctions need to be overhauled with regulations that NO family with children under the age of 18 are ever left destitute for any reason. Education system needs to be brought into the 21st century with children being taught coding, financial, life, and healthy relationship skills from primary school. Children leaving secondary school should all be able to understand how interest works, mortgages, basic economy, budgeting skills, how credit reports	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	There's no explanation of how you propose to address these issues
104	Neither agree nor disagree	Its far too nebulous and management babble. It means nothing	Strongly disagree	Not specific	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	The difference between wards is a shocker. The provision of cheap or free classes for example in Bournville is great, plenty of people offer their services. Less so elsewhere
105	Strongly agree		Agree		Agree	Agree	Agree	Agree	Neither agree nor disagree	Keeping authentic village structure of historic Birmingham while giving opportunities to improve areas at the same time as keeping the character of an area too.
106	Agree		Agree		Agree	Strongly agree	Agree	Agree	Neither agree nor disagree	
107	Strongly agree	I agree,but with reservations as to how "their potential" can be judged and by whom. It doesn't sound like a measurable aim.	Agree	Agree, but unsure what age groups are encompassed by the tem "citizen" Are young people included and how will their lived experience be judged?	Strongly agree	Agree	Agree	Agree	Strongly agree	Although I have agreed I think these inequalities were well recognised twenty years ago, and have worsened partly due to withdrawal of services locally, so am unconvinced that the actions needed to achieve these aspirations have been understood or acted on in policies since.
108	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
109	Agree	Citizen makes me question who is left out: eg rough sleepers, refugees, transient populations? We should also recognise that desirable choices will be different for everybody	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I don't disagree with any of the areas of focus but I would question how they were selected. For example, we know that queer people, espeically bi and trans people, experience worse health outcomes across the board, especially in the area of mental health. Why was that population not considered?
110	Agree		Don't know		Don't know	Don't know	Don't know	Don't know	Don't know	Poorly worded question. This is very difficult to understand. I agree money should be spent on the most vulnerable in society. Inequality for disabled and ethnic health issues should be funded by the NHS investing more in their rehabilitation/treatment. Investment in deprived areas rather than paying for the broken Metro again would be a better use of money.
111	Agree	I find 'happy' vague and inadequate. 'Fulfilling' seems more appropriate	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	It's important to link this strand to people's aspirations as well as safety nets. Working with schools, colleges and the universities to promote initiatives that support people throughout education and training to ensure they can complete courses to gain skills and qualifications; and promote awareness, robust policies and initiatives in those institutions that cater for diverse learners.
112	Strongly agree		Strongly agree		Strongly agree	Agree	Strongly agree	Agree	Agree	I couldn't read Closing the Gap!! Perhaps that is an inequality -- I am old and my sight is not very good for small print, even with glasses. But I have answered the questions.
113	Agree	Citizens should be able to make these choices safely. For example, many women do not feel that they can go for a run when it suits them due to safety issues	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
114	Agree	"Desirable" from whose point of view? IME, what governmental bodies/the "healthcare" sector think I should find desirable can be radically different from what I actually need or think is important...	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	The over-representation of HMOs in the Erdington ward is causing huge problems - a massive rise in deprivation and antisocial behaviour, overcrowding, community disruption, and overloading of healthcare and other social facilities in the area. Proper regulation of the companies running HMOs, while not on the surface a healthcare action in itself, would improve not only the health and wellbeing of their tenants, but everyone in the wider community affected by the preponderance of these facilities.
115	Strongly agree	I THINK YOU NEED TO PRIORITISE CLEAN AIR ABOVE ALL ELSE -- all other things will consequently be improved if we get that right! Less traffic -- more community interaction -- less health-related problems. Never forget Ella Kisi Debra who died tragically far too young because of the polluted air she was breathing in Lewisham. So improving air quality by reducing traffic and improving and promoting public transport should be one of your action principles!	Strongly agree		Strongly agree	Agree	Agree	Agree	Neither agree nor disagree	
116	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
117	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
118	Strongly agree	It supports equality for all, no matter who someone is.	Strongly agree	Citizen-focused will make it more relevant to the people actually needing the initiatives, instead of someone at the top who may not know what the challenges are prescribing something that ends up not working and ending up wasting resources. Evidence-based is also useful to avoid wasting resources on something that might not work.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	The idea of prevention before someone reaches a point of crisis is always a good one.
119	Strongly agree		Strongly agree	We applaud the focus of the	Agree	Agree	Agree	Agree	Agree	
120	Strongly agree	This response has been prepared by the Centre for Economics of Obesity, University of Birmingham. Our research measures the economic value of interventions that target the spectrum of factors that affect population obesity. It is from this perspective that we have written our response. We strongly support the vision statement. We are particularly supportive of the emphasis on tackling inequalities and addressing the wider determinants of health and wellbeing.	Agree	principles of action on reducing inequalities and promoting equality and inclusion, and the need for it to be citizen focused. The importance of citizen participation in policy-making has been highlighted in the recent OECD report (Government at a Glance 2017). A citizen-based approach to action can also promote social inclusion for individuals and communities experiencing marginalisation by considering the role of local communities and civic associations in improving people's health and wellbeing. However, we feel that the principles for action should also include a statement alluding to the roles and responsibilities of the multiple stakeholders and the need for accountability to deliver on the actions. Furthermore, a comprehensive citizen participation strategy could help promote the involvement of citizens in policy-	Strongly agree	Agree	Agree	Agree	Strongly agree	We strongly support the focus on inequalities of deprivation and inequalities of place. Action must be taken to address the disproportionate rates of chronic ill-health such as obesity within some population subgroups. It is important that the strategy not only acknowledges this but that it includes specific actions to address it. System-wide actions are required across sectors to level-up and measures focused on deprivation, environment and system changes need to be prioritised. We also recommend the strategy must prioritise actions that will have sustainable impact. Evidence shows that action that focus solely on education and behaviour change are likely to have a negative impact on equity, so policies that change the structural conditions and daily living conditions should be prioritised. Local places where people live, work
121	Agree		Agree		Agree	Agree	Agree	Agree	Agree	
122	Agree		Strongly agree			Strongly agree	Strongly agree	Strongly agree	Strongly agree	
123	Strongly agree		Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	

124	Strongly agree	At the moment, this is not achievable because it is too difficult to get a GP's appointment for acute issues let alone basic issues. The waiting lists for counselling or any other long term mental health support are too long.	Strongly agree	How will you get this information, and how much money will it cost? The current needs are not being met so why waste money on finding out what the needs are when we already know what they are and what needs to be done?	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	
125	Strongly agree	I agree with this whole heartedly	Agree	I think the use of lived experience to guide decision is of particular importance. I am happy to see work being done to promote a more inclusive society.	Agree	Agree	Agree	Agree	Agree	Agree with points for development
126	Agree		Neither agree nor disagree		Agree	Agree	Neither agree nor disagree	Agree	Neither agree nor disagree	
127	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	
128	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	
129	Strongly agree		Strongly agree	The best principles/actions are those taken from normal peoples real-life experiences	Agree	Strongly agree	Agree	Agree	Strongly agree	Targeting the health and well-being of the homeless, sex workers etc would require extra special attention, requiring help in educating, housing and fully changing these people's lives so that their health does not suffer. Does Birmingham City council have the funding and resources to provide a specific task force to help these marginalised groups?
130	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
131	Disagree	How are you going to achieve this?	Strongly disagree	Birmingham Council never listen to members of the public. What makes this any different? For example knocking down the flyover in Perry Barr - the majority were against it but it happened. The CAZ - people highlighted how you're pushing traffic from the centre with low numbers of people residing there to areas that are much higher populated. Again this was ignored.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Many people were made redundant during the pandemic, but as some own homes or have a partner that has savings they aren't entitled to anything. How about you help everyone.
132	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	Agree	
133	Strongly agree		Don't know	This is a very abstract survey and it is not possible to give a decent response to this question. Birmingham needs more investment and London does not, that's for sure!	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I think it is important that trans groups do not get left behind
134	Agree		Disagree		Strongly disagree	Neither agree nor disagree	Strongly disagree	Strongly disagree	Strongly disagree	
135	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
136	Strongly agree		Agree		Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
137	Strongly agree		Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
138	Agree		Strongly agree		Agree	Agree	Strongly agree	Strongly agree	Agree	
139	Strongly agree		Agree		Agree	Agree	Agree	Agree	Neither agree nor disagree	
140	Agree	the only word I worry about is 'happy'. I just wonder how that chimes with the what many communities have had to endure over the last couple of years would something like 'fulfilled' be better? (accepting the need for language to be accessible)	Strongly agree	Can't disagree with this at all; an applaud the obvious consultation with many that has gone on during the process of putting this strategy together	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Hugely important to address in a way that is meaningful to the 'unequal' communities
141	Agree		Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
142	Not Answered		Disagree	"Citizen focused and informed by citizens lived experience" and "Data and evidence-informed, and research-enabled action" are to opposite engrangent research inform practices. How are you ensuring that you're not unethically 'mining' data from seldom engaged with community groups? Additionally data and evidence is very deficit based approach - no a citizen focused one? Seems like these two points are complete opposite and need to be more clear/ transparent about why/what you're action plan is	Neither agree nor disagree	Agree	Agree	Neither agree nor disagree	Agree	

	To what extent do you agree or disagree with the 5 themes in the strategy? - To what extent do you agree or disagree with the 5 themes in the strategy? - Theme 1: Healthy and Affordable Food	To what extent do you agree or disagree with the 5 themes in the strategy? - To what extent do you agree or disagree with the 5 themes in the strategy? - Theme 2: Mental Wellness and Balance	To what extent do you agree or disagree with the 5 themes in the strategy? - To what extent do you agree or disagree with the 5 themes in the strategy? - Theme 3: Active at Every Age and Ability	To what extent do you agree or disagree with the 5 themes in the strategy? - To what extent do you agree or disagree with the 5 themes in the strategy? - Theme 4: Contributing to a Green and Sustainable Future	To what extent do you agree or disagree with the 5 themes in the strategy? - To what extent do you agree or disagree with the 5 themes in the strategy? - Theme 5: Protect and Detect	To what extent do you agree or disagree with the 5 themes in the strategy? - Please use the box below for comments you wish to make. If you disagree with the thematic approach, please tell us why and explain how you think it could be improved:	To what extent do you agree or disagree with the Life Course in the strategy? - To what extent do you agree or disagree with the Life Course in the strategy? - 1. Getting the Best Start in Life	To what extent do you agree or disagree with the Life Course in the strategy? - To what extent do you agree or disagree with the Life Course in the strategy? - 2. Working and Learning Well	To what extent do you agree or disagree with the Life Course in the strategy? - To what extent do you agree or disagree with the Life Course in the strategy? - 3. Ageing and Dying Well	To what extent do you agree or disagree with the Life Course in the strategy? - Please use the box below for comments you wish to make. If you disagree with the life course approach, please tell us why and explain how you think it could be improved:	To what extent do you agree or disagree with the cross-cutting approaches in the strategy? - To what extent do you agree or disagree with the cross-cutting approaches in the strategy? - Mitigate the Legacy of COVID-19	To what extent do you agree or disagree with the cross-cutting approaches in the strategy? - To what extent do you agree or disagree with the cross-cutting approaches in the strategy? - Equality, Diversity and Inclusion	To what extent do you agree or disagree with the cross-cutting approaches in the strategy? - Please use the box below for comments you wish to make. If you disagree with the cross-cutting approaches, please tell us why and explain how you think it could be improved:
1	Agree	Agree	Strongly agree	Agree	Strongly agree	If Protect and Detect is about protecting our older folk and detecting health issues to keep them well then this is a positive.	Agree	Neither agree nor disagree	Strongly agree	I think we do give everyone the same start in life. I think working and learning well is down the individual and people do have a choice in how they grasp opportunities. I believe the services and support we offer about ageing and dying well is very restrictive. There are not enough hospices or hospice in the home support in Birmingham. Everyone in Birmingham should have the opportunity to access hospice support in a timely fashion. Also I don't believe we offer the best options for our ageing generation again in terms of keeping them safe and healthy. There needs to be more affordable social care, not just for those on benefits but for those who have worked all their life and contributed to society but then have to pay extortionate care fees and their is a gap in support from the council in making choices for this group.	Strongly agree	Disagree	
2	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree		Strongly agree	Strongly agree	Strongly agree	We area filling with infant mortality We are failing in Education We are failing in Hospitals And then we charge inflated prices for burials How is this helping the average person?	Strongly agree	Strongly agree	The Covid disparity has been due to historical bias policies and provisions, these last words needs resources and infrastructure to put right. Wheres the investment coming from?
3	Agree	Neither agree nor disagree	Agree	Neither agree nor disagree	Strongly agree	There is so much food waste because the products in the shop are so poor. The vegetables on sale in supermarkets can be in a worse condition than the food I throw out. Also, a lot of food goes off before thje dates on the labels. Bordering on criminal activity which trading standards should bbe on top of	Disagree	Agree	Strongly agree	There are a lot of people that are not interested in a good start. They want to doss about at school and just do what they like. You can see this in the people coming forward for jobs and how poor their attitude is. Their are consequences for decisions (BCC dont seem to get that) so they are not setting a good exampple. Bullshit is not a specialism but it seems to be valued highly by many including BCC	Disagree	Disagree	You are trying to mitigate what you dint understand. In the words of Covey, seek first to understand then to be understood. You should also be looking at the works of Deming so that you should understand what needs to be 'fixed'. Can you honestly say you understand the dynamics of what has happened with Covid and more importantly what will naturally happen and what requires intervention
4	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Agree	Agree	
5	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Strongly agree	
6	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
7	Agree	Agree	Agree	Agree	Agree	Make sure your 'active at every age and ability' is not just trying to get people on bicycles and scooters and causing a danger to everyone. Don't just create opportunities in the City Centre, it needs to be city wide and aimed at everyone. Just because someone has a job and a house, doesn't mean they can afford the gym or pool or other activity. Make sure you really do include all citizens in your consultation. Often these things are put on the Council website and no one is aware of them. Market your stuff.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	I do think your target of nine years in the future is too far away, what about now. Some of the targets are unambitious. Bit of a pat on the back exercise.	Neither agree nor disagree	Neither agree nor disagree	Too wishy washy - 'work on' - what does that mean? Another project set up by the council, lots of unnecessary meetings to decide how often you should meet and who should be involved and meetings about the meetings? Lots of consultants at great expense and a comment "we are working on it". This really needs to be more precise and more proactive.
8	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I like these themes. Please ensure ridiculous ventures (e.g. VOI scooters) are not promoted to achieve the goals of corresponding themes.	Strongly agree	Strongly agree	Strongly agree	I would like to see something here that bridges the gaps between childhood, adulthood and older age	Neither agree nor disagree	Disagree	1) I think COVID-19 widened many inequality gaps. Whilst this should be reduced, the problems are systemic and need a more innovative approach than "lets mitigate the legacy of COVID-19" 2) Stop using the word equality. It does not benefit everyone equally nor does it ensure equity. Aim to provide JUSTICE! Provide services that remove systemic barriers
9	Strongly agree	Strongly agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Agree		Neither agree nor disagree	Agree	
10	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
11	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	
12	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	
13	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
14	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	All priorities but needs to be opportunities at all community levels to work towards these themes.	Strongly agree	Strongly agree	Strongly agree	All very important.	Agree	Strongly agree	
15	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Free bicycles for residents could get the whole city cycling. Improved access to library services and enhanced projects promoting library use. More microgardens and meadows around the city for citizens to enjoy and participate in. Fill every green space and abandon grass (along with that the cost to the council of maintaining grass)	Strongly agree	Strongly agree	Strongly agree	More gardening and library projects	Strongly agree	Neither agree nor disagree	
16	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
17	Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Some of these focuses fall outside of health and wellbeing's remit. How are you going to measure and change issues you have no power over to change?	Agree	Agree	Neither agree nor disagree	Ageing and Dying Well sounds like a very strange statement. I am not sure about this as it seams to be very aspirational but am not sure how much impact you will be able to have on this.	Neither agree nor disagree	Agree	There seams to be a group missing from this list. Single people mainly single old people should be a protected group as they can become easily isolated and need more help from the state as they may not have relatives to look after them.
18	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Activities need to be affordable and safe. The previous affordability for children's gym activity at Northfield baths was destroyed by the new set up when BCC pulled out.	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Mitigate: verb make (something bad) less severe, serious, or painful. Why use words that a lot of people don't understand? Should be in readable English.
19	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree		Agree	Agree	
20	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	
21	Agree	Agree	Neither agree nor disagree	Agree	Strongly agree		Agree	Agree	Agree		Neither agree nor disagree	Strongly agree	
22	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Agree	Agree	
23	Strongly agree	Strongly agree	Agree	Neither agree nor disagree	Disagree	Mental well being and affordable food is a basic need for every human and should be prioritised above all else. I feel you should ask people from different backgrounds socially, ethnically etc for their views as their priorities will differ from those of maybe a middle-class white person who would possibly put a Green and sustainable future above else as they arent affected by food poverty or lack of access to help with mental health. Also a white person surveyed may not see the injustices and deprivation felt by ethnic minorities daily so they wont prioritise them. Please ensure you have a poll reflective of the community or this survey is no good	Strongly agree	Agree	Agree	Very important to detect dementia early Excellent strategies	Disagree	Agree	
24	Agree	Agree	Agree	Agree	Agree		Strongly agree	Agree	Agree		Agree	Agree	
25	Agree	Agree	Strongly agree	Agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Agree	Agree	
26	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Strongly agree	Neither agree nor disagree	"Protect and detect"? I think most people will struggle to understand what this means - too vague.	Neither agree nor disagree	Neither agree nor disagree	Strongly agree		Neither agree nor disagree	Neither agree nor disagree	
27	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Set a realistic time frame for the themes. In todays climate they are not achievable. More funding and support and more jobs for NHS, social care, mental health and a decent living wage. No further job cuts in these industries as they are already under pressure and cannot continue to provide the current level of support to a rapidly increasing client list.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	A much higher level of support is required to assist the elderly in prolonging a happy healthy life. Millions has been spent of research to provide life saving and life prolonging treatment/medicines that our medical system can no longer afford to buy and do not have enough staff to provide and administer the use of. Let the elderly have as much right to treatment as they have had throughout their lives.	Neither agree nor disagree	Neither agree nor disagree	
28	Agree	Agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree		Agree	Agree	
29	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Strongly agree		Strongly agree	Strongly agree	
30	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Make it compulsory for all children to have swim lessons talk to GPS about elderly, GPS should be working with communities they have all the information, put positive body image on curriculum for schools ,reduce the cost of gyms so expensive	Strongly agree	Strongly agree	Strongly agree	Services for all ages need improvement all the money that goes into the NHS reduce GP Salaries reduce NHS DIRECTOR salaries	Strongly agree	Strongly agree	Free health support for all from infants to elderly , reduce the price of fruit and veg why is all the healthy food so expensive
31	Strongly agree	Agree	Agree	Strongly agree	Agree	I can't see anything to explain HOW these changes will be brought about. I do not believe that people choose to eat poor quality food because they want it - they have other reasons to make these choices. How can we tackle the real problems? Wealth inequality is an elephant in the room. People KNOW what proper food looks like. They can struggle to access it for a wide range of reasons.	Strongly agree	Agree	Agree	The numbers look as if they have been plucked from the air. Are they achievable...and if so...why stop there...couldn't we do more?	Neither agree nor disagree	Neither agree nor disagree	
32	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Neither agree nor disagree	
33	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree		Agree	Agree	
34	Strongly agree	Agree	Neither agree nor disagree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
35	Agree	Agree	Strongly agree	Agree	Strongly agree		Agree	Agree	Strongly agree		Agree	Strongly agree	
36	Agree	Strongly agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Whilst not within Birmingham CC's gift, I support the Dignity in Dying campaign and would like to see this form part of the "ageing and dying well" limb of this strategy.	Agree	Strongly agree	
37	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
38	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
39													
40	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
41	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Neither agree nor disagree	

42	Agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	theme 4 means looking after parks and support services e.g rangers...cotton nurseries are a key part too selling plants to residents>enhanced well being. More proper cycle ways not just painted lines and more bus only lanes. Also bus lanes and cycle ways must be swept and maintained!!! bins cuz de says etc must be prompted and one way systems to.... many ways to reduce traffic. Buses must be marketed better/ people need security/must be timely/ must be seen as not the transport of chavs and school children...clean frequent timely and air conditioned... quite a challenge... get me out my car and onto a bus?? how are you going to do that.i havent a clue which bus to catch, how much or how to pay or routes and times... how you going to educate /help me???	Neither agree nor disagree	Neither agree nor disagree	Strongly agree		Don't know	Don't know	
43	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Strongly agree	
44	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	How does this address drugs and alcohol abuse and domestic abuse?	Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Agree	
45	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Poor diet - restrict number of fast food outlets Include exercise as part of the educational curriculum Do not sell off school playing fields Improve cycling infrastructure Encourage walking to school/ restrict school parking	Agree	Agree	Agree		Strongly disagree	Strongly disagree	
46	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
47	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree		Agree	Agree	
48	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	You need to include a healthy place to live. Many BCC properties are of poor quality, lacking in investment, and this is contributing to poor outcomes for tenants living in these properties. The private rented sector also has terrible landlords who are contributing to this issue.	Strongly agree	Strongly agree	Strongly agree	Living well needs to include the property/accommodation residents live in. Without a safe, secure, well repaired place to live the health outcomes will be compromised.	Strongly agree	Strongly agree	
49	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	I am not sure what Protect and Detect refers to.	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
50	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree		Agree	Agree	
51	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
52	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
53	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Neither agree nor disagree	Strongly agree	Wonder how far mid-life is reflect for those not able to work or engage in education.	Strongly agree	Strongly agree	
54	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
55	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
56	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	The strategy is correct that each of these cornerstones are essential and without which we can't achieve better more equal health outcomes.	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
57	Strongly agree	Strongly agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
58	Neither agree nor disagree	Agree	Disagree	Neither agree nor disagree	Neither agree nor disagree		Neither agree nor disagree	Agree	Neither agree nor disagree		Agree	Neither agree nor disagree	
59	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
60	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Environment is key to a equal start in life. Those living near main roads suffer long term damage to health. Including mental health anxieties due to speeding cars and collisions witnessed along here. Being exposed to twenty four hours of noise daily.	Strongly agree	Agree	Strongly agree		Neither agree nor disagree	Strongly agree	Pollution has been killing people in roadside deprived communities a long time before covid. But no one seem that concerned as the focus was CAZ ,which has never had 2700 HGV passing within 20 feet of homes or five feet if walking. For BCC to attend a residents forum and tell us pollution levels have fallen when we have been unable to open windows for the last four years due to the yearly increase of traffic. We may live in a deprived area but we can read and are educated and understand the effects of pollution. Covid has not really exposed inequalities they have been there for a long time.Its just that the people exposed to them are not presented with the same channels to be heard.
61	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Work makes most people ill. Work killed my mother at 46 and it darn near killed me at 48, so I want Universal Basic Income so that people like me (Black female postgrad from the inner city with 30+ employment history) can pursue freelance cultural work that contributes to personal and community wellbeing. Instead of being forced into depressing jobs where my gender, ethnicity and neurodiversity go against me in the workplace.	Strongly agree	Strongly agree	
62	Neither agree nor disagree	Strongly agree	Agree	Strongly agree	Neither agree nor disagree		Strongly agree	Neither agree nor disagree	Strongly agree		Strongly agree	Strongly agree	
63	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree		Agree	Strongly agree	
64	Agree	Agree	Strongly agree	Strongly agree	Neither agree nor disagree		Strongly agree	Agree	Strongly agree		Agree	Agree	
65	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Strongly agree	
66	Agree	Agree	Agree	Disagree	Agree		Agree	Agree	Neither agree nor disagree		Agree	Agree	
67	Agree	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Neither agree nor disagree	
68	Strongly agree	Agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Strongly agree	
69	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	Strongly agree		Neither agree nor disagree	Agree	
70	Strongly agree					My children have been greatly effected because we live by a main road on the Northside of the city. Being a few feet from the road my children are faced with noise 24 hours a day, this is exceeding traffic noise. They walk a mere four to five feet from polluting vehicles on there way to school. Children along here, not just mine suffer anxiety from the collisions witnessed and the speed of vehicles. As I said previously many children are being damaged by the environment built round them and parents cannot change.				In areas that exceed safe pollution levels, the first day you bring your baby home you are damaging their health as many of us are aware of the impact of pollution and fumes get strong at times. My children have been effected by pollution quite badly and the levels have increased yearly, we also get fumes blowing in from the asphalt factory which is terrifying as parents have no control.	Disagree		Covid did highlight some inequalities but they were already their but council have failed to aknowledge them. Public Health advert made residents laugh, open your windows get fresh air into your homes. Families living here have not opened windows for years due to noise and fumes and it has got worse yearly. Such simple advice, but we fear pollution more than covid as we have seen the damage it does to our children.
71	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	
72	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
73	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Getting the best start in life enables children to get a good head start in life. It is important that pregnancy is also factored in.	Strongly agree	Strongly agree	Equality, Diversity and Inclusion is very important for the people of Birmingham and the workforce.
74	Strongly agree	Agree	Agree	Agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Strongly agree	
75	Strongly agree	Agree	Strongly agree	Strongly agree	Agree		Strongly agree	Agree	Strongly agree		Agree	Agree	
76	Strongly agree	Strongly agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
77	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Don't know what this is? I feel safety is missing form this - safety to walk and cycle especially, and especially as a female. Protect and detect - early, innovative intervention is key.	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Safety missing in my view
78	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Doesn't include Gypsy romany and travellers Include us to improve	Strongly disagree	Strongly disagree	Strongly disagree	Doesn't include Gypsy romany and travellers We have the highest rate of infant mortality and suicide	Strongly disagree	Strongly disagree	Doesn't include Gypsy romany and travellers
79	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
80	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
81	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	So many consultations, so many great big lines that look like key and current issues are being addressed. Nothing of substance ever comes from these and nothing ever changes. It just get worse. Make sure that these themes have something of substance happen behind them	Strongly agree	Agree	Strongly agree	These issues are much more complex than stated here. Where is the focus on parents? The mid-ages of those who don't work in paid employment for one reason or another?		Strongly agree	
82	Don't know	Don't know	Don't know	Don't know	Don't know	Do people really listen to what you have to say and do something about it.i don't think so	Don't know	Don't know	Don't know	?	Don't know	Don't know	What does this mean in simple term?
83													
84	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	Agree	Mental Health is important but by addressing the other themes the MH of many citizen will automatically improve.	Strongly agree	Neither agree nor disagree	Strongly agree	The early years is so important. More help needs to be provided to pregnant women and families with children under 5's- this includes childcare. Everyone deserves dignity in death.	Neither agree nor disagree	Strongly agree	
85	Agree	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
86	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	
87	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Its hard to disagree it's all a bit motherhood and apple pie tell me what will be different for example in a sustainable and green future what does that mean for me? My children's?- their children?	Strongly agree	Strongly agree	Strongly agree	In terms of aging and dying well what can you do to make sure everyone has the chance to die with dignity?	Strongly agree	Strongly agree	So again - what on earth does this mean on the day to day operations of the LA/NHS/etc? What are you going to do - the extracts on all of these set out WHAT YOU KNOW NOT WHAT YOU'RE GOING to do DIFFERENTLY
88	Neither agree nor disagree	Agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	Agree		Agree	Agree	
89	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	It is difficult to do anything but strongly agree to all questions in this section. They are all of key importance.
90	Strongly agree	Agree	Strongly agree	Strongly agree	Agree		Agree	Strongly agree	Agree		Agree	Strongly agree	
91	Strongly agree	Agree	Neither agree nor disagree	Agree	Neither agree nor disagree	On the food front, the supermarkets seem to sell food that I would have thrown out in that condition and does not keep long enough to cook. How can people be active when the footways around here can't even be walked on because they are so overgrown and you have yto walk in the road. Refuse collections result in litter i the streets where your operatives are 'clumsy' and on recycling days you can see piles of broken glass outside each property where they spill stuff. Complaining about this has been a waste of time so until your services are 'honest' things will never get better. Portect and detect = dont make me laugh. We have people breaking in to our properties and violence all over the place so dont pretend that we are not far short of the wild west. You only have to look at the news to look at the violent crimes being perpetrated. I can send loads of photos of how shitty our streets are and that is just purely a minority to	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Talk is cheap. All these statements are great but realistically they will not be achieved. Every criminal went to school and was given opportunities and did not take them. Why focus efforts on people that would be a waste awhen you should support those who do make the effort. BCC pay poor wages so are not walking the walk.	Disagree	Disagree	one legacy of covid 19 is that bcc have put in or are going to put in a load of very poor traffic schemes. these have not been porperly consulted on using covid as an excuse and are ill conceived and ill implemented schemes. You alve not taken on board what people want yet this exercise says you will but it is obvious ypou wont
92	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree		Strongly agree	Agree	
93	Strongly agree	Strongly agree	Agree	Agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	We need bold and practical actions for equality, diversity and inclusion. Health services make up and use needs to be fully examined.
94	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
95	Strongly agree	Agree	Strongly agree	Agree	Agree		Strongly agree	Agree	Strongly agree		Agree	Neither agree nor disagree	
96	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		Neither agree nor disagree	Neither agree nor disagree	Don't know		Don't know	Don't know	
97	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Strongly agree		Strongly agree	Agree	
98	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Protect and Detect sounds like policing and will definitely not be trusted by marginalised communities that are often targeted by police strategies. Please change the name of this theme - it is awful!	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	

99	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Adult social care needs particular attention here.	Agree	Strongly agree	COVID was a big deal, but there has to be some realism here as mitigation may not actually be possible in all areas.
100	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Coupled with making healthy eating affordable and attractive and equipping people with the necessary food preparation/cooking skills, I think it is also necessary to educate people on disease rates considered to be caused by factors such as poor diet and encourage everyone to take responsibility for their and their children's health.	Strongly agree	Strongly agree	
101	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	
102	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Neither agree nor disagree	
103	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Completely missed the mark with everything here. All that will happen is you'll line the pockets of third sector companies who make big promises and deliver marginal (if any) returns that're overinflated for reporting. None of this will address the issues at their core. Real, meaningful, structural change is required.	Strongly disagree	Strongly disagree	Strongly disagree	Who is in charge of this?? The issues for the large part aren't stemming from individuals but from the systems causing inequality. The focus needs to be on changing the structures causing the damage first and foremost. You're looking at all the wrong places but I guess it's a good way to keep profiting from the poor so...	Neither agree nor disagree	Neither agree nor disagree	I don't think whoever wrote this really understand the issues well enough. It's nice words and I'm sure the people involved are well-meaning but this is beyond tone deaf.
104	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	You've got no chance. I work in town and by the bus stops at Dale End the schoolkids pile in to Awesome Chips, German Doner kebab, Dessert place, Scary Maccies and the like. The council allow it, these places make a fortune off the kids and pay rent to the council. No way the council are brave enough to turn them down. How about using disused buildings or empty shops as pop up fitness studios if you serious	Strongly agree	Strongly agree	Strongly agree		Strongly disagree	Strongly agree	Covid 19 is a national issue not a local one, the legacy is simply that most eople are selfish and the extent of their largesse was clapping on a Thursday night then partying on a Friday. My wife is a nurse, she saw it all and still does, it isn't a legacy issue, nor will it be for years
105	Agree	Agree	Agree	Agree	Neither agree nor disagree		Agree	Agree	Agree		Agree	Agree	
106	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree		Disagree	Disagree	
107	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I do not think the target date of 2030 is ambitious enough and such a long timescale may lead to lack of momentum. The extra needs that have accumulated during the pandemic make action more urgent	Strongly agree	Strongly agree	Strongly agree	But at present very little in planning decisions, certainly in the ward in which I live,have taken any of this into account over the last five years. What was once a supportive area with opportunities for children from very diverse backgrounds and low once households is becoming unrecognisable as the area of opportunity it once was. The provision of support for the elderly has similarly vanished.	Strongly agree	Strongly agree	
108	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	A ban on placing vulnerable and adults with leaning difficulties in unregulated accommodation	Agree	Strongly agree	
109	Strongly agree	Strongly agree	Agree	Agree	Strongly agree	I think the themes are all needed, but that there is little that can be done for some of them without massive investment and change. For example, "active travel" sounds great but is harder for people with disabilities and often harder for parents of young children. Women generally won't want to walk or cycle alone late at night, especially with the lack of trust in the criminal justice system that the streets will be safe. I do note some areas of work that are not evidence-based. For example, the 5 a day number for vegetables isn't backed up by a lot of evidence, it was essentially plucked out of the air. Using obesity as a rough measure of health outcomes is also less specific than look at other issues. For example, if you are using it as a proxy for cholesterol, you can just test that. There is a lot of evidence that fat people avoid going to the dr and get sub-par support when they do go. A focus on childhood obesity is just as [illegible]	Strongly agree	Neither agree nor disagree	Strongly agree	I don't think our health should be defined by our ability to work. Work often makes us sick. Educational inequalities are a huge area of concern, but they will persist as long as Birmingham has a grammer school/King Edwards system. A test you take at 11 shouldn't determine the outcome of your life but for lots of children it still does. It entrenches inequality in the city.	Agree	Agree	
110	Disagree	Disagree	Disagree	Disagree	Disagree	Theme 1: free school meals for all children and a magic breakfast for all children. Vouchers are inconvenient and under used. Theme 2: taking more action for Birmingham Pride/gay/trans rights would lower the incidence of suicide and self harm in the community. Theme 3: reinstate the Couch to 5k at Cotteridge Park/Kings Norton Park. No running groups are active anymore. I have stopped running. Do not feel safe running alone especially after recent stabbings in my area. There is no outdoor gym equipment either. The high crime rate along the canal means I do not cycle along the towpath. Theme 4: Cotteridge Park had its parkkeeper taken away. Since then the play equipment has been damaged and not replaced. No baby swings, no overhead zip wire.	Disagree	Neither agree nor disagree	Disagree	1. During maternity care the NCT classes should be available to all parents. They are best placed to avoid issues. Nursery places should be free so that infants are regularly assessed and parents given support when required. Including health checks/dental treatment and healthy eating. By the time children begin school. It is too late for these early interventions. 3. Dementia care is awful in the City. Staff shortages are already a problem and the new Covid vaccine requirement will mean even fewer staff to care for those with dementia. The Care system/NHS need to be overhauled. It is not fit for purpose.	Don't know	Don't know	This question is very vague. There is not a clear action plan on the cross-cutting approach. It appears to be - lump several problems together in order to lower the number of projects to be undertaken? Long covid is too general an issue and I do not think it is on a par with the level of importance for issues such as Child Poverty or homelessness in Birmingham.
111	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Tackling nutrition knowledge has to be a top priority. The emphasis on low fat and calorie counting to address the obesity epidemic is completely misplaced. Fat is a fundamental requirement of our diet and promotes satiety. Low fat has little taste which has to be compensated by sugar in processed food products. Sugar is addictive and needs to be treated as a drug. Until this issue is addressed obesity and diabetes will continue to increase. Access to fresh produce locally for all citizens is crucial. https://www.aafp.org/afp/2015/0501/p634.html The Board needs to work with the NHS to persuade them to change their nutrition guidelines which currently promote low fat/calorie counting for weight loss. Citizens have little chance of understanding healthy diet unless they understand how to research and weigh up evidence themselves. There is a vital need for a change in [illegible]	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
112	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree	Again – I could only read part of it!	Don't know	Agree	
113	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Theme 3. Older citizens are often forgotten so it's good to see this theme. A lot of older people are restricted from doing the simple activity of going for a walk due to the uneven nature of a number of pavements across the city which leads to the risk of falls. If these were repaired, older people would have more freedom to go for a walk	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	
114	Strongly agree	Agree	Neither agree nor disagree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
115	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	bring in recycling FOOD WASTE, B IRMINGHAM, what are you waiting for.	Strongly agree	Agree	Agree		Neither agree nor disagree	Agree	
116	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
117	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	
118	Agree	Strongly agree	Agree	Agree	Agree	"Arts and culture based interventions" are mentioned in this document to improve mental wellness. If resources are provided to facilitate reading groups in libraries, this can improve both literacy and wellbeing. As you are promising to base interventions on evidence-based initiatives, you might be interested to know that a 2015 Reading Agency report found that "95% of respondents report that members feel happy because of being part of the group." Also related to mental wellbeing: "Many respondents describe the close bond they have developed with the people in their reading group, referring to the support the group provides through major life events. A number state that the meetings are therapeutic or like counselling sessions, in part because the act of discussing books enables them to talk about deep and difficult issues in a [illegible]"	Agree	Agree	Agree	More can be done to reduce feelings of loneliness in older adults, which leads to physical and mental decline. If the age for free bus passes is raised, many older adults will simply stop going out which will result in worse physical and cognitive outcomes. Having the option of travel via a free bus pass enables many to participate in regular walking groups where they connect with other people, or a trip to the local library where they can access a heated and safe building and some friendly faces. Connecting young and old could help reduce loneliness. Initiatives such as this one in our local area would help: https://www.ageuk.org.uk/sutton/get-involved/letters-of-joy/	Strongly agree	Strongly agree	Again, the heavy drinking culture in England automatically excludes some people when many activities are based around this.
119	Agree	Agree	Neither agree nor disagree	Neither agree nor disagree	Agree		Agree	Agree	Neither agree nor disagree		Agree	Agree	
120	Strongly agree	Agree	Strongly agree	Strongly agree	Agree	All five themes are important to consider for developing a comprehensive health and well-being strategy for the city. Furthermore, research suggests a strong relationship between these domains. Therefore, it would be important to consider whether synergies can be created by addressing these themes not only individually, but also collectively as part of more comprehensive interventions. An example of such an initiative is a school-based health promotion intervention combining healthy eating and physical activity that has been shown to be effective in lowering children's Body Mass Index scores (Bartelink et al., 2019). This positive effect was noted across all subgroups. Another example would be the use of vouchers and food stamps. These aids can help the purchase of food, reduce food insecurity, and provide better calorie balance for population. [illegible]	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
121	Strongly agree	Agree	Agree	Strongly agree	Strongly agree		Neither agree nor disagree	Agree	Strongly agree		Agree	Agree	
122	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree		Agree	Strongly agree	Strongly agree		Agree	Strongly agree	
123	Strongly agree	Agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	
124	Agree	Strongly agree	Agree	Agree	Agree	Mental health should be the number one priority. It affects everything: crime, all sectors, marriages and family break down. It doesn't matter how many nurses, police etc you recruit, if their mental wellbeing is not prioritised, they will not be able to perform properly or will be on sick leave or will leave. All of society suffers. A person can it focus on healthy eating if their mental wellbeing is not good. Mental health (or ill- health) is a factor in nearly all terrorist related incidents.	Agree	Agree	Agree	Again there needs to be more emphasis on mental wellbeing. Also on more jobs and training courses and back into work schemes for the 50 years plus age range.	Agree	Agree	

125	Agree	Strongly agree	Agree	Strongly agree	Agree	Happy to see progress being made already to secure a more sustainable future. e.g. introduction of clean air act Would like to see preservation/ creation of green spaces in city centre for this and to aid mental health	Agree	Agree	Agree	Agree	Agree	Agree	Happy to see the effects of covid on mental health as well as physical health being made a priority.
126	Aeree	Aeree	Aeree	Aeree	Aeree		Aeree	Stronely aeree	Stronely aeree		Aeree	Stronely aeree	
127	Stronely aeree	Stronely aeree	Aeree	Aeree	Aeree		Stronely aeree	Stronely aeree	Stronely aeree		Aeree	Stronely aeree	
128	Stronely aeree	Stronely aeree	Stronely aeree	Stronely aeree	Stronely aeree		Stronely aeree	Stronely aeree	Stronely aeree		Stronely aeree	Stronely aeree	
129	Agree	Strongly agree	Neither agree nor disagree	Agree	Agree		Agree	Agree	Neither agree nor disagree		Strongly agree	Strongly agree	COVID has left a big hole in our society, addressing its repercussions is key.
130	Stronely aeree	Stronely aeree	Stronely aeree	Stronely aeree	Aeree		Stronely aeree	Stronely aeree	Stronely aeree		Stronely aeree	Stronely aeree	
131	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Can't see how you can implement these.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Can't see how these can be implemented. You can't even implement a bus lane on Bristol Road without reversing the decision and causing bottle necking of traffic by the Train Station now.	Strongly disagree	Neither agree nor disagree	I'm immunocompromised. I have had zero support from the Council. I've also been forced to send my child to school in an environment that isn't exactly safe with covid rife and children in school with positive family members. You are already causing issues to mental health by not allowing people to home teach their children to keep them and themselves safe.
132	Stronely aeree	Stronely aeree	Aeree	Stronely aeree	Aeree		Stronely aeree	Stronely aeree	Stronely aeree		Stronely aeree	Stronely aeree	
133	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	equal opportunities for tertiary education	Agree	Agree	Agree	would be helpful to see what areas have been removed to make an informed choice	Don't know	Strongly agree	Not sure what this means: what is missing, etc?
134	Aeree	Stronely disaeree	Neither aeree nor disaeree	Aeree	Aeree		Aeree	Aeree	Aeree		Aeree	Disaeree	
135	Stronely aeree	Stronely aeree	Stronely aeree	Stronely aeree	Stronely aeree		Stronely aeree	Stronely aeree	Stronely aeree		Stronely aeree	Stronely aeree	
136	Stronely aeree	Stronely aeree	Stronely aeree	Stronely aeree	Stronely aeree		Aeree	Stronely aeree	Stronely aeree		Stronely aeree	Stronely aeree	
137	Stronely aeree	Stronely aeree	Stronely aeree	Stronely aeree	Stronely aeree		Stronely aeree	Stronely aeree	Stronely aeree		Stronely aeree	Stronely aeree	
138	Aeree	Stronely aeree	Stronely aeree	Aeree	Neither aeree nor disaeree		Aeree	Stronely aeree	Stronely aeree		Aeree	Aeree	
139	Stronely aeree	Stronely aeree	Aeree	Aeree	Neither aeree nor disaeree		Aeree	Aeree	Aeree		Stronely aeree	Aeree	
140	Agree	Strongly agree	Strongly agree	Agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	I like the matrix approach of addressing citizen's life and experience from several different angles. the key will be being able to join up the different work streams where there is overlap (which there will be with this approach, quite correctly) to ensure consistency	Strongly agree	Strongly agree	COVID legacy enormous and rightly addressed head on
141	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	
142	Agree	Agree	Agree	Neither agree nor disagree	Neither agree nor disagree		Agree	Agree	Agree		Agree	Neither agree nor disagree	

	To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - Increase the uptake of healthy start vouchers for eligible families to at least 80% by 2027	To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - Reduce the % of 5yr olds with visually obvious dental decay to below 20% by 2030	To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - Reduce the prevalence of obesity (including severe obesity) in children in Reception and Year 6 by 10% by 2030	To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - Increase the % of adults regularly eating '5-a-day' to more than 50% by 2030	To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - Ensure that the Healthy City Planning Toolkit is utilised in 90% of developments in the City	To what extent do you agree or disagree with the ambitions in the Healthy and Affordable Food theme? - Please use the box below for comments you wish to make, if you disagree with the ambitions in the Healthy and Affordable Food theme, please tell us why and explain how you think it could be improved:	To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - Reduce the prevalence of depression and anxiety in adults to less than 11% by 2030	To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - Reduce our suicide rate (persons) in the city to be in the lowest 10 UTLA in England by 2030	To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - Reduce the emergency intentional self-harm admission rate to be within the lowest 10 UTLA in England by 2030	To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - Reduce the smoking prevalence in adults with a long term mental health condition to at least the national average by 2027	To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - Close the gap between people with long term health conditions, including explicitly those with severe and enduring mental health issues, in employment and those without	To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - Achieve the ambitions of triple zero, to have zero deaths or overdoses linked to alcohol or drugs by 2030 and have no people living with substance addictions without support services	To what extent do you agree or disagree with the ambitions in the Mental Wellness and Balance theme? - Please use the box below for comments you wish to make, if you disagree with the ambitions in the Mental Wellness and Balance theme, please tell us why and explain how you think it could be improved:	
1	Agree	Disagree	Agree	Strongly agree	Strongly agree	This is all around educating people about healthy choices - starting at school age up to those in care and how their food choices can be supported. Not aware of the healthy city planning toolkit so this needs more publicity	Agree	Agree	Agree	Strongly disagree	Agree	Disagree	I think many of the above are interlinked and should be seen as such. Early intervention when there is mental ill health would minimise suicide and self harm. Don't agree with a focus on smoking, this is a personal choice.	
2	Neither agree nor disagree	Strongly agree	Strongly agree	Agree	Strongly agree	Families just over the 'means testing' will miss out, but suffer the most because of financial commitments. How will you achieve the other targets - seem to be a pie in the sky statements	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	How will this be achieved - its been said for so long[illegible]	
3	Strongly disagree	Don't know	Neither agree nor disagree	Disagree	Neither agree nor disagree	Targets are fine but it is how you go about augmenting them that is the concern. Will it be a punitive approach and tax certain foods or will you stop junk food outlets setting up near schools. I doubt it will be the latter as your approach to planning is dire and is effectively a waste of time	Neither agree nor disagree	Disagree	Agree	Strongly agree	Neither agree nor disagree	Disagree		
4	Strongly agree	Agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Strongly agree		
5	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree		
6	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
7	Disagree	Disagree	Disagree	Disagree	Disagree	Sorry but this is not ambitious enough - in 9 years down the line and too little too late.	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Not ambitious enough - pretty disgraceful. Mental health needs addressing now and the figures need to be far more ambitious, 9 years time is too late, particularly where suicide is concerned. What are you doing now to help children? They can't access mental health services because they get told the waiting list is 18 to 24 months time - tell that to the grieving parents - " we couldn't help your child but we could if it had been 9 years in the future". Please don't use acronyms - what is "UTLA" if you are consulting with people about the strategy don't assume people know what you are talking about.	
8	Disagree	Disagree	Disagree	Disagree	Strongly disagree	1) why can this not be 100% or at least make 100% of eligible people aware of the scheme? 2) Sort out wording, change % for proportion 3) can obesity prevalence not be below the national average? why 10%? what does this figure mean and how was it chosen? Feels lazy 4) Again, why 52%? again don't use %, use full written English 5) why not 100%? Are the 10% of residents going to be part of a new inequality due to housing? You state you want to reduce inequality then purposefully ensure 10% experience it	Strongly disagree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly disagree	1) again, why 12%? These numbers sound ridiculous without context 2) better and more achievable 3) same as above 4) not sure why this is chosen. What is the psychophysiological mechanism for this? 5) could do with a % here and not an arbitrary one 6) utter nonsense. Come up with achievable ambitions. This should be looked at but by sensible people (i.e. academics and service workers) and not people who want snappy slogans	
9	Strongly agree	Agree	Strongly agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree		
10	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree		
11	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree		Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Strongly agree		
12	Neither agree nor disagree	Agree	Agree	Agree	Agree	A proper living/minimum wage would go a long way to alleviating a lot of ill health	Agree	Agree	Agree	Agree	Agree	Agree		
13	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
14	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree	Strongly agree	Strongly agree	Don't know	The last point is ridiculous and is set to fail, you cannot achieve zero death rate from overdose/addiction. Overambitious and unrealistic	
15	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Plant more fruit trees accompanied by signs instructing residents to share the fruit with their families.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Encourage and fund more projects like Martineau Gardens to help individuals with mental health [illegible]	
16	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I agree with this theme and I feel one of the ways this can be improved is to provide adequate support and we must also realise that these issues can only be resolved with effective long term [illegible]	
17	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	You cannot tackle this alone as there are many factors out of your control - I think you should look at some more realistic targets.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Disagree	These are admirable targets not I honestly can not see you being able to achieve these targets - again you should concentrate on things you [illegible]	
18	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	These target dates are too late. Needs to be done now.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Need to take the drugs off the streets now and remove the dealers [illegible]	
19	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree		
20	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	Agree	Agree	Agree	Neither agree nor disagree		
21	Agree	Agree	Agree	Agree	Agree		Strongly agree	Agree	Agree	Agree	Neither agree nor disagree	Agree		
22	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
23	Disagree	Strongly agree	Agree	Strongly agree	Neither agree nor disagree	Very important to have access to dental care. So many dentists not taking new patients or just fob you off. They need to be educated to educate youngsters and parents need to be taught the importance of brushing babies teeth as soon as they appear. People from deprived backgrounds may not know this so by the time their child starts school they have decay etc	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Disagree	Disagree		
24	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
25	Agree	Strongly agree	Strongly agree	Agree	Agree		Strongly agree	Agree	Agree	Strongly agree	Strongly agree	Neither agree nor disagree	I don't feel having unrealistic ambitions which are clearly unachievable are useful or helpful Targets should be achievable [illegible] and timely	
26	Disagree	Agree	Strongly agree	Strongly agree	Strongly agree	These are all laudable goals, but I struggle to see how they will be achieved. They also imply learned helplessness - people don't need a governing agency to ensure they eat healthily. In this age of information, failure to eat healthily is a personal choice, not the result of failure at the governmental or agency level.	Agree	Agree	Agree	Disagree	Neither agree nor disagree	Neither agree nor disagree		
27	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		
28	Neither agree nor disagree	Agree	Strongly agree	Agree	Agree		Agree	Agree	Agree	Strongly agree	Agree	Neither agree nor disagree		
29	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree		
30	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Not just people on benefits I've been single parent I've always been proud not entitled to any support really difficult to keep children healthy paying for swim lessons and healthy food and same with elderly supporting my parents now there is no help everything so expensive	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	The nhs go on about every mind matters but do not put it in to practice I know several people suffered through our covid and before all age groups but there was no support again GPS need a good shake up and the NHS yes they did a great job during pandemic but They also neglected a lot of people and are still doing so we need better traing for people in the hospitals and NHS who are there as a caring profession but they really are not caring at all shoddy attitudes towards elderly and infirm it's supposed to be a caring profession train them how to speak to people and use customer care	
31	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	The numbers look as if they are plucked from the air. They do not represent enough change. 5-A-Day knowledge is absolute minimum - we need to be talking about 10 a day. We need 100% of people to be eating 5 portions of fruit and veg a day. Similarly, the other figures don't obviously to relate to anything.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Again, some of these targets are shocking. Why do want 12% of adults with anxiety and depression? Surely 0% is the correct target. We have a decade to get there.	
32	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
33	Neither agree nor disagree	Agree	Agree	Agree	Agree		Agree	Neither agree nor disagree	Agree	Agree	Agree	Agree		
34	Agree	Agree	Strongly disagree	Agree	Agree	I disagree with the obesity ambition. Any focus on healthy food should be focused on availability, behaviours, skills and affordability, and not on the physical characteristics or health conditions of individuals. "Obesity" is an ill defined, unquantifiable condition of being. It's diagnosis is based on BMI which in itself is hugely problematic, based on anthropological studies, with random parameters set by organisations with no evidence base. BMI and obesity easily obscure health and healthy behaviours, and are stigmatising concepts which have been proven to increase stress, depression and anxiety, and using obesity as a public health focus has been shown to increase bullying and isolation. Using obesity and BMI as a diagnostic has been proven to increase risk of misdiagnosis of health conditions, because it is far	Agree	Agree	Agree	Agree	Agree	Strongly agree	The current support services for substance misuse are inadequate and do not cater for people with complex needs, mobility problems and over 50s. The model used at CGL is based on group work. Our older people particularly need support in this area as alcohol use is a major factor in many cancers, dementia, organ damage and infectious illnesses. The ravers of the 90s are growing up now and need support.	
35	Strongly disagree	Agree	Agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Agree		
36	Agree	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	I don't know what the "Healthy City Planning Toolkit" is.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	I don't approve of the inclusion of the anti-smoking rhetoric in this section. You are blurring the lines here. If someone has severe mental health issues and smoking gives them some comfort, let them crack on and do it.	
37	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Can only be done with the involvement of the third sector in planning as well as implementation	
38	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
39	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Strongly agree		
40	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
41	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree		
42	Neither agree nor disagree	Agree	Strongly agree	Disagree	Neither agree nor disagree	adult eating isn't the role of bcc.. its nhs etc.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	not BCC roles unless you cause the issues in the first place!	
43	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree	Strongly agree	Strongly agree	Strongly agree		
44	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree		
45	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree	Agree	Agree	Agree		
46	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
47	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree		
48	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
49	Agree	Agree	Agree	Agree	Neither agree nor disagree		Agree	Agree	Agree	Agree	Agree	Agree	Would like to see something around children and adolescents mental health be consistent	
50	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree		
51	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
52	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
53	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
54	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
55	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
56	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Access to healthy food which is affordable is vital as well as knowing how to prepare and having confidence. Shift working and larger families makes preparing fresh food difficult. Could takeaways be encouraged to offer healthier options?	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
57	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
58	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree		
59	Strongly agree	Agree	Strongly agree	Agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree		
60						food is a need, but clean air is essential, and can damage a child in a mothers belly and that's were life begins.	Strongly agree	Agree	Agree	Neither agree nor disagree	Agree		The environment that the Authorities have changed from a safe vibrate community into one of a industrialised crime scene from C19 has added to the mental health of elderly and disabled in this [illegible]	

61	Disagree	Disagree	Disagree	Disagree	Disagree	No you need to be more ambitious. Has Covid not taught this system that half measures are not enough?	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	You will not be able to do any of the above without taking people out of pain and poverty. It is the system that messes people up so we need systemic change and we have a Tory Government for the foreseeable future.	
62	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree		Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree		
63	Agree	Agree	Strongly agree	Agree	Strongly agree		Strongly agree	Strongly agree	Agree	Agree	Agree	Agree		
64	Agree	Strongly agree	Agree	Agree	Strongly agree		Strongly agree	Agree	Agree	Agree	Strongly agree	Agree		
65	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	Agree	Agree	Agree	Agree		
66	Neither agree nor disagree	Neither agree nor disagree	Disagree	Neither agree nor disagree	Neither agree nor disagree		Neither agree nor disagree	Disagree	Disagree	Disagree	Agree	Agree		
67														
68	Neither agree nor disagree	Agree	Strongly agree	Agree	Strongly agree		Agree	Agree	Agree	Agree	Agree	Agree		
69	Agree	Strongly agree	Agree	Strongly agree	Neither agree nor disagree		Strongly agree	Strongly agree	Strongly agree	Agree	Neither agree nor disagree	I can't know		
70						Food is important, but your overall mental and physical well being is more important. When you step outside your front door and the first thing you see is clean and green safety your day starts positive. When we step outside we immediately step into fear from the road from people who have been moved here who have support needs. Stinking air blocked footpaths needles & bleak for children, i can feed my children but cannot change their environment					Agree		Should look at damage done to children in deprived environments as this then leads to the above issues. prevention better than cure	
71	[illegible]	[illegible]	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
72	Agree	Strongly agree	Strongly agree	Strongly disagree	Disagree	Respondents need to know some examples of what constitutes in five a day as given in the questionnaire. A brief concise version of the healthy city planning toolkit would be good to be added in this questionnaire so respondents know what it is	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
73	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Individuals also have a responsibility. However, engagement with citizens should be at a very early stage. Better engagement is needed. Ensure that the Healthy City Planning Toolkit is utilised in 50% of developments in the City - is this really achievable??!?!?	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Achieve the ambitions of triple zero, to have zero deaths or overdoses linked to alcohol or drugs by 2030 and have no people living with substance addictions without support services You are setting yourself up to fail - this is unrealistic!	
74	Neither agree nor disagree	Strongly agree	Agree	Strongly agree	Agree		Strongly agree	Strongly agree	Agree	Agree	Strongly agree	Strongly agree		
75	Agree	Agree	Strongly agree	Strongly agree	Agree		Agree	Strongly agree	Agree	Agree	Strongly agree	Agree		
76	Strongly agree	Agree	Agree	Strongly agree	Agree		Strongly agree	Strongly agree	Agree	Agree	Strongly agree	Agree		
77	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Ideas around parents and childrens basic cooking skills ness to support the above strategy. Tax on fried food shops and fines for littering for shops that sell unhealthy food to help towards these schemes.	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Work with children and up in schools using innovative methods e.g. theatre in education to get across the 5 ways of wellbeing. Work with adultson these themes too. To get 5 ways advertised in city	
78	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Doesn't include Gypsy romany and travellers We struggle to get somewhere to live and can't get medical support	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Included the most marginalised communities who need this support	
79	Strongly agree	Strongly agree	Disagree	Strongly agree	Strongly agree	There should be a bolder ambition to reduce obesity in reception and yr 6 - target of 10% is too low.	Disagree	Strongly agree	Strongly agree	Disagree	Strongly agree	Strongly agree	12% reduction target too low And should also be more ambitious re smoking cessation - should be aiming for above average	
80	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
81	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Eating healthy starts in the home. Energy costs factor in too. Have a safe and affordable to run home and healthier cooking will follow for many. Along with being over worked, try cooking a healthy meal for children everyday when your exhausted, unwell etc. even sourcing the fruit and veggies regularly enough is costly, online minimum spends, traveling to affordable stores. So many limitations all start with having a home that works for you. Enough income and enough time. People are poor in most of these areas if not one or two	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	This will only be solved by hc using a cultural change. Change the narrative surrounding those who are most vulnerable or in minority. Creating a caring and understanding narrative. Be real about these peoples limitations and barriers. Plus more funding to children's mental health services. There should be counsellors in every town not just in the city centre Pause service. Make it accessible! BPI needs a complete overhaul and much more funding. Stop turning children away with no help! A bit of exercise and some veggies will not fix trauma of living in poverty. Trauma of abusive families. Trauma from uncaring and disconnected systems. Stop relying on schools to fill all the gaps in our society. Create a SEND provision to be proud of not one that repeatedly traumatises carers and children by failing them to work out deserving. Create safe affordable homes, take	
82	Don't know	Don't know	Don't know	Don't know	Don't know	Active lifestyle is awesome	Don't know	Don't know	Don't know	Don't know	Don't know	Don't know	[illegible]	
83														
84	Agree	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Young people must be the priority with food. Teach healthy habits young to prove the future.	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Agree	Neither agree nor disagree		
85	Disagree	Neither agree nor disagree	Disagree	Neither agree nor disagree	Strongly agree	I agree the healthy planning toolkit will be very helpful. Even with access to better foods/vegetables and vouchers etc., families often make a choice to eat unhealthily and I don't believe this will help.	Agree	Strongly agree	Strongly agree	Disagree	Strongly agree	Neither agree nor disagree	1. 'Depression and anxiety' are seen to be the most common mental health disorders, however there are many people living with eating disorders, dissociative disorders etc. who are not treated as they should be and not supported by GPs either. More education is needed on other mental health conditions - not just pushing people to CBT which often doesn't work long term for other disorders and means more admissions to A & E etc. for those in the other groups - dissociative disorders etc. 4. Again, I believe smoking is a personal choice. 6. I think it is difficult to have zero overdoses - unfortunately young people do tend to experiment with drugs and the small statistics regarding this sort of overdose cannot be mitigated - therefore, we'd be setting ourselves up for failure.	
86	Strongly agree	Strongly agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Strongly agree	Agree		
87	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	HOW - and where is this going to happen? How are you going for example to get more people to eat 5 a day - what can you act on in this research?	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Where will the invest come from to achieve this?	
88	Neither agree nor disagree	Agree	Agree	Agree	Strongly agree		Agree	Agree	Agree	Strongly agree	I can't know	I can't know		
89	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
90	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree		Agree	Agree	Agree	Agree	Agree	Agree		
91	Strongly disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Kids eat crap because parents take he easy route and give them crap. Why do yous sponsor so many junk food outlets and fast food crap - you are part of the problem so need to get your own house in order	Neither agree nor disagree	Agree	Agree	Strongly agree	Neither agree nor disagree	Disagree		
92	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
93	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	Agree	Agree	Strongly agree	Agree		
94	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
95	Strongly agree	Strongly agree	Strongly agree	Agree	Agree		Neither agree nor disagree	Strongly agree	Strongly agree	Agree	Agree	Agree		
96	Agree	Agree	Strongly agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
97	Agree	Strongly agree	Agree	Strongly agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree		
98	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	These are extremely ambitious targets given the complete defunding and deprioritisation of mental health services during the Tory government, and the lack of GP awareness and understanding of mental health issues. But good luck	
99	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Neither agree nor disagree	Strongly agree	Agree	These all sound like great ideas, but not sure how realistic they are when the mental health services are almost non-existent currently. Never mind addiction services.	
100	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree	The targets (whilst challenging) don't go far enough. No child should ever been obese. I am horrified at the number of children under 10 who are seriously obese. The attention on 'fat shaming' isn't helping people to understand that being seriously overweight should never be considered an acceptable healthy choice. More emphasis, funding and trained staff/nutritionists needs to be provided for schools to promote food growing and healthy eating. I've always liked the idea of having free fruit and veg shops in socially deprived areas funded by Government which are complemented with community social activities and cooking apps/lessons.	Strongly disagree	Agree	Agree	Strongly disagree	Strongly agree	Strongly agree	Targets don't go far enough. Having 12% of a population suffering from depression and/or anxiety is unacceptable. Similarly, we should be aiming higher than merely reducing smoking levels among this group to the national average.	
101	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I think the triple zero ambition may be over ambitious given the fact there are drug dealers on almost every street in Birmingham and not enough police to do anything about it.	
102	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	I hope these are not empty promises, it's all well n good laying out strategies etc but actions speak louder than words	Neither agree nor disagree	Neither agree nor disagree	Agree	Agree	Agree	Agree	No comment.	
103	Disagree	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Consider cycling opportunities. We get no one further forward. To tackle health issues you must start with education and that needs to be delivered respectfully, not by forcing 'the poor' to use vouchers like some post-war rationing state. Less division and more inclusion. Marketing healthier events towards families and as socially acceptable things for adults to be occasionally do instead of activities involving alcohol. Banning junk food companies from being able to advertise their foods and encouraging fruit and veg producers to market their foods. Working with respected chefs to market their healthier recipes and selling the idea that healthy food tastes good. Changing attitudes in the proven ways. Put more funding into sports, science, and the arts to get the community more involved and engaged in healthier, more productive activities away from pubs. Making these activities more	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Disagree	Disagree	These are largely unrealistic goals. You will not abolish addiction but you can get better at understanding it and training our front line workers to identify issues upstream to take preventative action. I am absolutely against trying to reduce the number of people with diagnosed mental health conditions. Our societal attitude still has a long way to go, not to mention our scientific understanding of mental health issues. Having a mental health issue is not in and of itself always a 'bad' thing and having a diagnosis is absolutely a positive thing for so many. These people need understanding and legal protection in the workforce and the stigma demonstrated in your wording above is what needs working on.	
104	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	See above re: selfishness and the rubbish food council allows near kids	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
105	Neither agree nor disagree	Agree	Agree	Neither agree nor disagree	Agree		Agree	Agree	Agree	Agree	Agree	Agree		
106	Neither agree nor disagree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree		
107	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Disagree	Why is the last aim only 90 per cent and when is this to be achieved by. 7 I think that 2030 is too distant a target especially when you are talking about young children. It is not bold enough	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	Agree	Neither agree nor disagree	Not sure about the first as unsure if we currently have really robust measures of the prevalence or the wherewithal to establish these and monitor them, especially with the on-going procedures in primary care.	
108	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	I believe you need to be much more ambitious in the drive in this area. This is what I would say Increase the uptake of healthy start vouchers for eligible families to 100% by 2025 Reduce the % of 5yr olds with visually obvious dental decay to below 15% by 2025 Increase the % of adults regularly eating '5-a-day' to more than 75% by 2025 Ensure that the Healthy City Planning Toolkit is utilised in all of developments in the City immediately	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Need to see clear proposals on how you propose achieving these goals as I feel some are highly unrealistic	

109	Strongly agree	Agree	Disagree	Agree	Agree	Again, there is little solid evidence for the 5 a day fruit and vegetable target. Overall, we should aim to eat a variety of food, including fruit and vegetables, but 5-a-in't a magic number. Again, there is very little evidence that school focuses on childhood obesity reduces obesity. There is very strong evidence that it increases bullying, eating disorders, and distrust of doctors and other healthcare professionals- all of which lead to negative health outcomes.	Strongly agree	Strongly agree	Strongly agree	Agree	Neither agree nor disagree	Agree	I would like recognition that reducing mental health issues in different communities needs different solutions, and that mental health issues are explicitly linked to poverty. If we can't reduce poverty, they will continue to exist. I see no poverty-reduction ideas in this report. Reducing poverty and inequalities are public health goals.	
110	Strongly disagree	Agree	Agree	Agree	Don't know	Reduce the % of 5yr olds with visually obvious dental decay to below 20% by 2030 Have children in free Nursery places from 2 years old. To promote healthy eating. Provide all children free school meals/healthy breakfast for healthy eating/ Increase the % of adults regularly eating '5-a-day' to more than 55% by 2030 Reduce the number of unhealthy take away outlets in the high street.	Don't know	Agree		Don't know	Don't know	Don't know	Promoting gay/trans rights would help this community deal with suicide and self harm	
111	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Cross-cutting with sustainability - "everyone has access to locally produced healthy food" - should be an ambition throughout this strand. 5-a-day is a start but citizens need to know that eating a low fat (sweetened) fruit yoghurt or sweetened fruit juice is actually detrimental to their health. The guidance needs to move away from processed to raw produce.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
112	Strongly agree	Agree	Strongly agree	Agree	Agree		Agree	Agree	Agree	Agree	Strongly agree	Agree	would be great if we could do it....i but I am not entirely convinced this is possible. I think it might be helped if there were more PLACES TO LIVE for homeless people, and if there were some form of compensation for the Bedroom Tax -- or a lot more 1 bedroom flats than there used to be. And just a lot more HOMES and fewer high rise buildings for businesses. Also -- some community meeting venues have appeared because of the closure of shops during the pandemic -- we need to KEEP THEM (or replace them with other venues) if we want to support people after the pandemic finishes. Anxiety is partially caused by the complexity of our lives these days, and I'm not sure we can change that.	
113	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	Agree	Agree	Agree	Strongly agree	More needs to be done to stop the prevalence of drugs. The city centre is particularly bad. More support needed for those in HMO's. Landlords need to be more accountable for their HMO's and what goes on in them	
114	Strongly agree	Strongly agree	Strongly disagree	Agree	Neither agree nor disagree	Healthcare initiatives aimed at "obesity" tend strongly towards harsh sweeping measures and victim-blaming. Fatness is a body size, not an illness, and much of the medical basis for fatness causing ill-health is overstated and poorly researched (correlation is not causation), and many studies on "obesity" are funded by the diet industry). While I would support healthy-eating initiatives, I am concerned by the usual devolvement of obesity-reduction schemes into the realm of "eat less, hate your body, your weight is your own fault", which is immensely harmful for any person of size, but doubly so for impressionable children. Working to decrease poverty, and improve food access and nutritional education would have more impact on children's health than the usual bullying "obesity" measures.	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree		
115	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Agree		
116	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
117	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
118	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Please be aware of differing dietary needs within this. Some people will be vegetarian or vegan for example so any advice needs to be tailored to meet these needs. People with specific dietary needs won't connect with advice unless it is something they can do.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Apart from the first one that states common mental health issues (depression and anxiety), this list of outcomes focuses mainly on crisis. It would be good to focus on prevention as well in this area.	
119	Neither agree nor disagree	Agree	Agree	Agree	Agree		Agree	Disagree	Agree	Agree	Agree	Agree		
120	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Theme 1 Actions: We strongly agree with the actions listed within theme 1 (healthy and affordable food) and would like to recommend the following additional actions: • To complement the action to create a healthier food environment this should also include an explicit additional action to reduce the availability of unhealthy drinks and foods in all environments. See Nakayiki et al (2015) for a review of measures. •An additional action that encompasses the responsibilities of the commercial sector to support the 'co-development and implementation of a new Birmingham Food strategy to create a healthier, affordable, safe and sustainable food system for the city'. Nutritionally deficient yet calorie dense foods are aggressively promoted especially to vulnerable subpopulations like children. The	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	We agree that mental health is strongly linked to other aspects of health including physical and emotional health. While the strategies outlined in this theme are broad, the selected indicators focus primarily on the adult population. The majority of mental health problems begin to develop during childhood and adolescence (Kessler et al., 2007). Therefore, we believe that there should be stronger emphasis on prevention, identification and treatment of mental health conditions in the population of children and adolescents. References: Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: a review of recent literature. Current opinion in psychiatry, 20(4), 359.	
121	Agree	Agree	Agree	Agree	Don't know		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
122	Agree	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Neither agree nor disagree	Agree	Agree	Strongly agree	Strongly agree		
123	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
124	Agree	Agree	Agree	Agree	Agree	You need to make vegetables and fruit (especially organic) cheaper and more accessible to achieve these objectives. Also make packets smaller in supermarkets so that they don't get spoilt sooner. Packets of veg and fruit are too large if you are single or a couple.	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Absolutely this should be the highest priority. Birmingham has an opportunity to be a leader in dealing with the mental health crisis we are facing. There's no point investing in other areas of society if the mental wellbeing of Birmingham residents is not tackled. This needs to be the number one focus, and then everything else will fall into place.	
125	Agree	Agree	Agree	Agree	Agree	Working in a school I see first hand the importance of FSM provision - I am glad to see healthy vouchers being included in this.	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	All priorities which I'm glad are being addressed. The focus on mental well being is particularly important post covid and I feel this is being focussed well.	
126	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Agree	Agree	Strongly agree	Agree		
127	Strongly agree	Strongly agree	Strongly agree	Agree	Agree	The above could be more ambitious, particularly in regards to children	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree		
128	Strongly agree	Strongly agree	Agree	Neither agree nor disagree	Neither agree nor disagree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
129	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I agree with these the most- healthy body healthy mind! Kids shouldn't be starting life as a disadvantage just because of the price of healthy food	Agree	Agree	Agree	Neither agree nor disagree	Strongly agree	Agree	Really important but I think helping adults, as a whole, improve their mental health would prove very difficult	
130	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	BCHC is represented on the Creating a Healthy Food City Forum by the dietetic service. There are a number of indicators in this theme that relate directly to our services and may need to be reflected in our KPI's. These are: 1.Increasing uptake of healthy start vouchers by 80% by 2027 2.Reducing percentage of 5 year olds with visibly obvious dental decay to less than 20% by 2030 3.Reducing obesity in reception and Year 6 by 10% by 2030.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	BCHC could be represented on the Creating a Mentally Healthy City Forum by the Head of Psychology in this theme there is an ambition to close the gap between people with a long term condition in employment. This is rightly focused on those with a mental illness as a long term condition; a question would be whether mental ill-health as the cause of unemployment for BCHC physical health long term conditions patients could be included too. BCHC has a suicide prevention policy and could be involved in the Suicide Prevention Action Plan. BCHC would like to embed the early intervention, brief advice and signposting described in this theme into all relevant BCHC service pathways. This includes the arts and culture based interventions to promote mental wellbeing.	
131	Disagree	Disagree	Disagree	Disagree	Strongly disagree	How will you be implementing this? Have you seen school meals these days? Curry or a wrap for infant school children? Not all children eat curry so don't benefit from a hot meal at school. How will you enforce Developers to do this? I very unfortunately live on a new development by Persimmon and you are allowing the developers to walk away without completing as per your approved plans. So you have zero chance of enforcing this.	Strongly disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Again how will you implement these? Impossible.	
132	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Don't know	Neither agree nor disagree	One of the best ways to improve mental health is to do more PE in schools and it doesn't need to be competitive e.g dancing, walking in parks or skipping. Being in nature has been proven to improve mental health maybe a tree planting program of a free tree for every house in Birmingham.	
133	Agree	Agree	Agree	Agree	Don't know	no idea what the toolkit involves? It could be a complete waste of time and resources if not correctly administered	Agree	Agree	Agree	Agree	Agree	Agree	there needs to be investment in the professional support provided to people with mental health conditions	
134	Agree	Agree	Agree	Agree	Agree		Disagree	Strongly disagree	Disagree	Neither agree nor disagree	Strongly disagree	Strongly disagree		
135	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
136	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree		
137	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
138	Agree	Agree	Strongly agree	Strongly agree	Neither agree nor disagree		Strongly agree	Agree	Agree	Neither agree nor disagree	Agree	Neither agree nor disagree		
139	Agree	Agree	Disagree	Neither agree nor disagree	Agree	Need a reduction in healthier food at supermarkets. Also more healthier takeaways and no hot food	Strongly agree	Strongly agree	Agree	Agree	Agree	Neither agree nor disagree		

140						I cannot comment directly on each ambition as i dont know enough of the details behind each of these proposals. The challenge will be is that 1. are they measurable? 2. is the lag in measurement / and indeed change in outcome such that can be meaningful during the relevant time scale? I think many are ambitious, which i will not criticise, but the key will be how to manage if data change is not as wished for either because of data lag, of the expected lag of outcome after intervention and thus management of morale and momentum							as above	
141	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
142	Agree	Agree	Agree	Neither agree nor disagree	Disagree									

	To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme? - To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme? - Reduce the % of adults who are physically inactive to less than 20% by 2030	To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme? - To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme? - Increase the % of adults walking or cycling for travel at least three days a week by at least 25% by 2030	To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme? - To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme? - Reduce the inactivity gap between the most active 10 wards and the least active 10 wards	To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme? - To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme? - Reduce the inactivity gap between those living with disabilities and long-term health conditions and those without by 50% by 2030	To what extent do you agree or disagree with the ambitions in the Active at Every Age and Ability theme? - Please use the box below for comments you wish to make. If you disagree with the ambitions in the Active at Every Age and Ability theme, please tell us why and explain how you think it could be improved:	To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme? - To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme? - Reduce the % of mortality attributable to particulate air pollution to less than 4.5% by 2030	To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme? - To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme? - Increase the utilization of outdoor space for exercise/health reasons to over 25% by 2028	To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme? - To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme? - Increase the daily utilization of green and blue spaces to 25% of the population by 2030	To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme? - To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme? - Increase volunteering in green and blue spaces to at least 10% of the population by 2027	To what extent do you agree or disagree with the ambitions in the Contributing to a Green and Sustainable Future theme? - Please use the box below for comments you wish to make. If you disagree with the ambitions in the Contributing to a Green and Sustainable Future theme, please tell us why and explain how you think it could be improved:
1	Strongly agree	Agree	Disagree	Agree		Neither agree nor disagree	Strongly agree	Strongly agree	Neither agree nor disagree	
2	Strongly agree	Strongly agree	Strongly agree	Strongly agree	How - who - when	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	
3	Agree	Strongly disagree	Disagree	Agree	as stated the footways locally are not fit to walk on so you have caused some of these problems. Do you plan to ban obese people from cars. Cyclists are a nightmare and have no regard for other userrs or the rules. They come charging at peds and expect them to get out of gtheir way on the footway. In town I watched a number of cyclists ride past the cyclists dismount signs where the footway had been narrowwed for roadworks. They are an ignorant blinkered bunch that BCC pander to. Where is the equality in that	Neither agree nor disagree	Neither agree nor disagree	Agree	Strongly disagree	BCC decision making is responsible for increasing congestion which increasing the air quality issues but BCC are so ignorant of theis connection. You have demonstrated institutionalised incompetence when it comes to the roads and road schemes. Youa re creating issues that will take massive amounts of time, money and effort to get nack to previousm levels. You only have to look at the debacles that were the measures you put in under Covid and the levels of incompetence that demonstrated. yet youare still pursuing half baked schemes based on wishes and hoping it works out - it wont. Your ignorance knows no bounds on thee matters. You built a 40 million pound schemne at selly oak yet the quesue are worse than ever. How on earth did replacing 4 lane road with a 2 lane road get considered as as a good option
4	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	Agree	Agree	
5	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
6	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
7	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Again it's not ambitious enough - 9 years too late.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Disagree	why 2030 why not now. Not sure what volunteering has to do with anything in the strategy.
8	Neither agree nor disagree	Neither agree nor disagree	Agree	Neither agree nor disagree	1) again, why 20%? These numbers have no context 2) same as above 3) how is the activity gap being measured? 4) again, why 50%? and when were these data collected? Surely activity levels have changed over the pandemic so how confident are you in this statement and will your results be valid?	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	1) again, context for numbers needed 2) again 3) again 4) again
9	Agree	Disagree	Neither agree nor disagree	Neither agree nor disagree	I will never cycle so am a bit fed up of all the emphasis being placed on cycling!	Strongly agree	Agree	Agree	Neither agree nor disagree	
10	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
11	Strongly agree	Strongly agree	Neither agree nor disagree	Agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	
12	Agree	Strongly agree	Agree	Agree		Agree	Agree	Agree	Neither agree nor disagree	
13	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
14	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	Strongly agree	Neither agree nor disagree	Nice point about volunteering but maybe over ambitious
15	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Increase green spaces by abandoning grass and adding meadows across the city along with more planters etc that local community groups can care for instead of the costly grasscutting of the council
16	Strongly agree	Strongly agree	Strongly agree	Strongly agree	We must make council run gym more accessible and possibly think offering concessionary rates to those who require this type of treatment to improve their physical health.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
17	Strongly agree	Neither agree nor disagree	Disagree	Disagree	Reducing the inactivity gap for people with disabilities is a huge task.	Disagree	Strongly agree	Strongly agree	Strongly disagree	
18	Strongly agree	Neither agree nor disagree	Strongly agree	Agree	Need to look at the practicalities of some of these ideas which were no doubt thought up by people who have good incomes and abilities to cycle to work.	Agree	Strongly agree	Strongly agree	Strongly agree	Don't build housing in a city centre. Put decent transport into the city centre.
19	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	
20	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
21	Agree	Neither agree nor disagree	Agree	Agree		Agree	Neither agree nor disagree	Neither agree nor disagree	Agree	
22	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
23	Agree	Disagree	Strongly agree	Agree	Have safer outdoor walking areas for women only Better lit for evening walks especially in inner city areas	Strongly agree	Strongly agree	Agree	Neither agree nor disagree	Please prioritise cleaning the streets first. In my local area in Sparkhill the roads are filthy Rubbish is left on the streets, bins overflowing no one collects it. It feels like a 3rd world country with bad sanitation systems. I don't mind helping clean up, residents should get involved but we should be given litter pickers, bags, gloves a place to dispose of all the waste safely. The focus should be organised community initiatives to clean their areas. Not just making green belt areas and parks all nice and green when the streets we live on are filthy and rats running everywhere that we feel grossed out having to walk or exercise outdoors.
24	Strongly agree	Strongly agree	Strongly agree			Strongly agree	Strongly agree	Strongly agree	Strongly agree	
25	Strongly agree	Strongly agree	Strongly agree	Agree		Agree	Agree	Agree	Agree	
26	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	
27	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Many of those who are inactive are still waiting for medical treatment that could improve their ability to be active, stop budget cuts and increase funding. Bring back maintenance of recreational areas where people used to use bikes rather than putting them in potential danger with other road users and increasing demand on hospital resources.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		Increase funding and bring back jobs in areas where a high volume of volunteers are needed. people are working longer hours to increase their income to be able to live the best they can and have less time to devote to family life already.
28	Strongly agree	Strongly agree	Agree	Agree		Strongly agree	Agree	Agree	Agree	
29	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	
30	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Let's hope it happens	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
31	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Reducing the inactivity gap could be achieved by making the most active wards less active - is this wording deliberate??	Neither agree nor disagree	Don't know	Neither agree nor disagree	Strongly agree	
32	Strongly agree	Strongly agree	Strongly agree	Strongly agree	create more cycle lanes. create safe spaces for people to run cycle walk	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
33	Agree	Agree	Agree	Agree		Agree	Agree	Neither agree nor disagree	Neither agree nor disagree	
34	Agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
35	Strongly agree	Strongly agree	Disagree	Disagree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
36	Strongly agree	Strongly agree	Neither agree nor disagree	Agree	I am very much in favour of initiatives that get Brummies out of their cars and on to other means of travel	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
37	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
38	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
39	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Agree	Strongly agree	Strongly agree	
40	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
41	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Agree	Strongly agree	Strongly agree	
42	Agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree		Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	10% of population volunteering is 100000 people... really!I gonna be crowded in those green spaces.. BCC can enable and help locally via parks service staff also city wide by advertising how people can volunteer... but dont forget there are green groups out there already working hard ..you had better engage with them.
43	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Although I believe volunteering is plaudable this should be at the expense of paid work
44	Strongly agree	Agree	Strongly agree	Strongly agree		Disagree	Strongly agree	Agree	Agree	
45	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	
46	Strongly agree	Strongly agree	Strongly agree	Strongly agree	It would be usefull to have an obesity target in relation to adults.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
47	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	
48	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
49	Agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
50	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	
51	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
52	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly disagree	Strongly agree	Strongly agree	Disagree	
53	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	
54	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
55	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	

56	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Greener active travel and health all go hand in hand. Cycling and walking needs to be much safer. Threats from vehicles and threats of violence from people. Volunteering can help to reclaim a space and grass roots groups do great work here. Increase of parkruns puts more events closer to more people and opportunities to get active, involved in community and volunteer.
57	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Neither agree nor disagree	
58	Agree	Strongly agree	Agree	Agree		Neither agree nor disagree	Agree	Neither agree nor disagree	Agree	
59	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
60			Agree	Strongly agree	We ask you take a look at fixmystreet typing in postcode B24 8EH it high lights the obstacles put in the way especially for children, elderly and disabled residents living in the area. It has isolated many disabled/elderly residents it is not a area for activity.	Strongly agree	Strongly agree	Strongly agree		Green Clean and Safe has never really reached deprived areas in Birmingham. Its quite bad when you can just name the black areas of birmingham , and the white posh areas its just become that obvious. So yes Green brings wellness health and peace of mind all missing from tese areas.
61	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		Agree	Strongly agree	Strongly agree	Neither agree nor disagree	Volunteering replaces jobs. Provide people with a basic income and volunteering would increase
62	Agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	
63	Agree	Agree	Strongly agree	Agree		Agree	Agree	Strongly agree	Agree	
64	Strongly agree	Neither agree nor disagree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Agree	
65	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
66	Agree	Neither agree nor disagree	Disagree	Disagree		Strongly disagree	Disagree	Disagree	Disagree	
67										
68	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
69	Agree	Agree	Strongly agree	Agree		Strongly agree	Strongly agree	Agree	Neither agree nor disagree	
70				Strongly agree	I have seen the isolation of elderly and disabled before covid, due to environmental changes. Our local gym is based on the road our children have to jog between large motorway lorries cars and vehicles parked on the pavement. Only two weeks ago one short sighted resident with stick crashed into the back of one of several lorries parked on pavement its so unsafe for pedestrians. Its areas like this that physical activity is needed but the environment does not allow it.	Strongly agree				My family live in a area that suffers exceeding levels of air noise and light pollution. We have experienced first hand the damage it is doing to us and how it has effected neighbours. But in areas such as this pollution has not only been ignored but increased,
71	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	
72	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
73	Strongly agree	Strongly agree	Strongly agree	Strongly agree	All Birmingham parks need excercise equipement - including gymnastic and calisthenics equipment. Swimmming should be free for everyone. Free gym/exercise should be given to diabetics on a measured programme - where exercise reduces diabetic levels and therefore cost on medication. In return healthier people and cost saving in medication.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree - green spaces should be better untilised. Add gym equipment - check the American parks and free gym equipment.
74	Agree	Agree	Agree	Strongly agree		Agree	Strongly agree	Strongly agree	Strongly agree	
75	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
76	Agree	Agree	Agree	Strongly agree		Agree	Agree	Agree	Neither agree nor disagree	
77	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Yes definetely getting people walking and cycling. I am unclear how city rental scooters comeinto this s too fast, ridden dangerously and not getting anyone fit. Need more cycle awareness, more speed cameras working, a crack down on dangerous driving including racing, on kerb driving and dangerous parking....needs sorting as is so dangerous and stops people cycling and even walking.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Less cars everywhere inthe city and not just LTN that seems to be pushinig cars to a few now very, very busy polluted roads. Train stations - local ones open.
78	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Include Gypsy romany and travellers	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Gypsies romanies and travellers have rec icled for years
79	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Disagree	Strongly agree	Strongly agree	Strongly agree	Should have bolder target than 4.5 per cent mortality. Knock on effect will be felt for those may not die but suffer debilitating physical ill health as a consequence of poor air quality which is avoidable if we take right steps
80	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
81	Strongly agree	Strongly agree	Strongly agree	Strongly agree	You must focus on carers too. I care for someone who's mobility issues limit me. You will not get people walking until the streets are safe again. Knife crime, muggings etc. No police on the streets anymore. It's not safe to go out so people don't.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
82	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Don't know	Difficult to achieve		Don't know	Don't know	Don't know	I think this will be to expensive to achieve
83										
84	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	
85	Agree	Agree	Agree	Agree	Again, these are good goals but I think they are unachievable. You can push schemes until the end of time but exercise is a personal choice in most cases.	Strongly agree	Agree	Agree	Agree	
86	Agree	Agree	Strongly agree	Neither agree nor disagree		Agree	Agree	Agree	Agree	
87	Strongly agree	Strongly agree	Strongly agree	Strongly agree	What are you going to actually do????	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
88	Strongly agree	Strongly agree	Strongly agree	Don't know		Strongly agree	Strongly agree	Strongly agree	Agree	
89	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
90	Strongly agree	Strongly agree	Agree	Strongly agree		Agree	Strongly agree	Don't know	Agree	Increase the daily utilization of green and blue spaces to 25% of the population by 2030 - I do not understand this ambition.
91	Agree	Strongly disagree	Disagree	Agree	the transport plan is all stick and focuses on cycling too much. I cant expect my 82 year old mom to cycle to the shops or other facilites and public transporr is a very dehumanising experience. is the inactivity gap between wards down to the topography of those wards, sw birmingham is hilly and has poor roads so cycling is not an option I have the national cycle route by muy house and I see more motorbikes (unlicensed) on it than I have seen cyclists	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	the transport plan will increase congestion and therefore increase pollution from vehicles so you are scuppering your own targets. the footpaths on the local green space by me floods when it rains so I have to walk through puddles and the grass just becomes mud. The footways by me are already green - they are overgrown from the planting alongside it and the the footways arecoveredin green moss and very slippy. How safe is it having walk in the road?
92	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
93	Strongly agree	Agree	Strongly agree	Agree		Strongly agree	Agree	Agree	Agree	
94	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
95	Agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		Neither agree nor disagree	Agree	Agree	Agree	
96	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
97	Agree	Agree	Agree	Agree		Agree	Agree	Neither agree nor disagree	Neither agree nor disagree	
98	Agree	Agree	Agree	Disagree	This needs to recognise that many people with LTCs experience fatigue, and increase in activity may not be appropriate for them and can actually worsen their condition. Please recognise the individual in this strategy	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I agree with these but why aren't the % targets higher
99	Agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Agree	
100	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	not ambitious enough and two targets aren't quantified	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	All targets seem low
101	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Again very ambitious, how will you do this?	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
102	Agree	Agree	Agree	Neither agree nor disagree	No comment	Agree	Neither agree nor disagree	Agree	Strongly agree	
103	Agree	Agree	Agree	Agree	Marketing. Marketing. Marketing. In a respectful and encouraging way. No virtue signalling, alienating, or condescension or you will lose your audience. I advise speaking to a top notch marketing/PR firm about this. 'This girl can' and all that disaster is definitely not the way to do it. Grassroots clubs and quirky, innovative dating and social experiences are a good route to go in my opinion.	Disagree	Strongly agree	Strongly agree	Neither agree nor disagree	That clean air goal is too low. Increasing volunteering in an age where we already expect so much of so many is too much of an ask too imo. Community service is a good thing for rehabilitating offenders.
104	Strongly agree	Strongly disagree	Strongly agree	Strongly agree	Cycling costs money, in buying a bike and putting it somewhere. You can't say in one chapter that we have overcrowded housing, then suggest a family store a load of bikes in the kitchen or something	Disagree	Strongly agree	Strongly agree	Strongly agree	The volunteering would be massive. People can't afford the gym sometimes, don't know the exercises or most likely, feel self conscious about their ability or image as they begin exercise from an unhealthy start point
105	Agree	Strongly agree	Agree	Neither agree nor disagree		Strongly agree	Strongly agree	Strongly agree	Agree	
106	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	

107	Strongly agree	Strongly agree	Strongly agree	Strongly agree	But much in planning decisions that are now irreversible has mitigated against these improvements over the last 20 years and the costs to clubs of using council parks to promote activities has priced many of them out of the market.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	The reduction in green spaces is going to make this difficult. The wear and tear on our local green spaces during the pandemic shows just how difficult maintenance of safety and standards will be if we reach this goal. The presence of drug dealing and use in many of the spaces available for recreation also puts people off.
108	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Promotion of Birmingham's great parks on your doorsteps may be one area to explore. Among many others	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	I would say Reduce the % of mortality attributable to particulate air pollution to zero by 2030 Increase the utilization of outdoor space for exercise/health reasons to over 50% by 2028. I walk from Birmingham New Street station to my of place of work in Nechells occasionally instead of getting off at Duddeston Station. I hardly ever see people on foot walking from Duddeston to Birmingham city centre. In Bristol, where I previously lived, it was far more common. I would walk from my home in the Whitehall area to Bristol city centre. I would feel safer as more people walk there.
109	Neither agree nor disagree	Agree	Agree	Disagree	We need to recognise that physical activity is hard for mutiple and complex reasons, and that fixing it takes money. Where is that money coming from? For example, short winter days mean that outside activity at night or in the morning is going to happen in the dark. Many people don't feel safe running or jogging in the dark- how can that be changed? Cramped shared housing mean at home workouts aren't possible, and yet a gym is expensive and can often be unwelcoming. How can that be changed? Even if a person does want to walk or cycle frequently, the state of Birmingham roads means this isn't always a safe option. There's no recognition here of the infrastructure projects that would make more active travel possible and pleasant	Strongly agree	Strongly agree	Strongly agree	Strongly agree	I agree with all of this, but there has been massive and consistent underinvestment in Birmingham's parks for at least a decade. Will this be reversed? Will new parks be created in parts of the city lacking them? Will there be investment to keep those parks clean, safe, and pleasant? My local park is always full of fly tipping and often broken glass, there's no way I'd take a child or a dog there. I shouldn't have to drive to a park in a more affluent area of the city just to have a pleasant green space.
110	Disagree	Disagree	Agree	Agree	Funding has been cut to local running couch to 5k. There are no classes available since Covid. The canal bike route is unsafe. Lots of crime, do not feel safe cycling along the canal. Pershore rd is too busy to cycle along,	Agree	Disagree	Disagree	Disagree	More funding is required for the green spaces. Cotteridge park has no park keeper. The play equipment is damaged. No lighting in park. Can not exercise after dark as it is too dangerous. Volunteers already formed a working party with gardening, art classes. The council do not contribute enough towards Cotteridge Park.
111	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
112	Strongly agree	Strongly agree	Strongly agree	Agree	I am pleased that cycling is being supported in Birmingham -- a good many people with disabilities can cycle more easily than walk (this is ignored by the DWP and Capita....)	Strongly agree	Neither agree nor disagree	Agree	Strongly agree	not sure what is meant by the 25% in the second question!
113	Agree	Agree	Agree	Agree	Citizens need to feel safe when walking or cycling. This isn't so in many wards in they city. Until you address this robustly, many will feel that walking and cycling isn't safe for them to do	Agree	Strongly agree	Strongly agree	Agree	Safety in wards needs to be improved. There are a lot of parks etc. across the city but few where you can feel safe To improve air quality you need to address public transport issues. Not only green buses etc. but safety on public transport. The amount of rubbish lying around also needs to be addressed both by clearing and prevention. Rubbish encourages vermin which in turn puts people off of exercising
114	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	The ability to be active is hugely impacted by working hours, caring responsibilities, access to safe outdoor space, and underlying physical and mental health. People struggling with grinding poverty and disability really don't need added pressure to "exercise more" as if that's some magical bullet that will make their lives all better. The ability and time to live an "active life" is a massive privilege, and in many if not most cases entirely the luck of the draw.	Strongly agree	Agree	Neither agree nor disagree	Neither agree nor disagree	Usage of green and blue spaces is dependent on time and access, with the poorest sectors of the population having neither...
115	Strongly agree	Strongly agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
116	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
117	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
118	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	Please ensure physical activities on offer are culturally sensitive. Some groups may prefer female only spaces or a group that isn't overly reliant on the pub being a main source of socialisation before/during/after the activity. Other people may be nervously starting their physical activity journey and may want to start with non competitive sports to build confidence. So please don't make this about competitive sports only as that may end up putting off the very types of people you wish to encourage.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Parks could be made safer and more welcome space for people by installing cafes/visitor centres and covered outdoor seating. If they are busier due to these facilities, this will also help women feel safer using them. These buildings would also offer toilet facilities for women because don't forget younger women menstruate and that could put them off exercising outdoors if there are no facilities. Birmingham doesn't have much in the way of covered, well ventilated outdoor space. There is the lovely Winter Garden in Sheffield for inspiration. These types of spaces would also be considered safe and be well-used in the event of another airborne pandemic due to the well ventilated shelter they would provide. Simpler constructions than the Sheffield Winter Garden could be made if cost is an issue, but it just needs to be
119	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	
120	Strongly agree	Strongly agree	Strongly agree	Strongly agree	We welcome the focus on physical activity as a means to promote population health and wellbeing, however as well as an overarching aim to reduce physically inactivity by 2030, shorter- and medium-term achievable targets need to be set. A recent report showed that the current % of physically inactive adults in Birmingham is at around 30%. In practice, reducing that proportion to 20% would mean a shift upwards of 150,000 adults to a 'non-inactive' status within a 9-year time span. This is an ambitious goal. Targeted and tailored strategies need to be carefully designed to ensure that changes in physical behaviours are sustainable, both from a behavioural (e.g., activities that fit into people's daily lives) and an economic perspective (affordability and cost-effectiveness). There are some considerations to make in this	Strongly agree	Strongly agree	Strongly agree	Strongly agree	We strongly agree with the actions set out within theme 4. They are broad overarching ambitions but it is not clear how tangible these actions are and who will be responsible and accountable with delivering on them. We would argue that there is a need for a whole system taking responsibility rather than placing responsibility on individuals or families to create change. An upstream approach to prevention is needed, where more financial support would be given to multidisciplinary teams within local authorities to create a dialogue with communities and target interventions/services to disadvantaged population groups. Furthermore, we recommend an additional action to: -Work with our partners to understand the value of our green and blue space as assets within an
121	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
122	Strongly agree	Strongly agree	Strongly agree	Agree		Agree	Strongly agree	Neither agree nor disagree	Strongly agree	
123	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree		Strongly agree	

124	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Physical activity is not always possible for those with mental health issues and those recovering from cancer. And it has been proven recently that it can make things worse for those with Chronic fatigue syndrome and ME. It should be more patient centred and the focus being around what is achievable and best especially given the fatigue levels the person may be feeling. Other forms of moves like pilates tailored to those recovering from cancer treatment and those on strong medication for mental health issues should be considered.	Neither agree nor disagree	Neither agree nor disagree	Agree	Neither agree nor disagree	Recycling is more important. There is not enough recycling in Birmingham compared to other parts of England.
125	Agree	Neither agree nor disagree	Neither agree nor disagree	Agree	More provision of low cost or free facilities to encourage active lifestyles. Particularly for deprived areas. Increase in provision of free extra curricular sporting activities in schools. Promotion of commonwealth games.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	So important in the current climate
126	Strongly agree	Strongly agree	Agree	Agree		Agree	Agree	Agree	Agree	
127	Agree	Agree	Agree	Agree	This is an important area, but there is more of a el of personal responsibility. Also practicalities need to be considered when targeting walking or cycling to work, due to commute distance - this would not be practical for a number of people.	Strongly agree	Neither agree nor disagree	Agree	Neither agree nor disagree	Utilisation of outdoor spaces is very lifestyle and schedule dependant, so a prescriptive approach may be of putting for many people. Similarly, the exercise aspect would need to be communicated carefully so as not to put people off all together.
128	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
129	Agree	Agree	Agree	Strongly agree		Neither agree nor disagree	Agree	Neither agree nor disagree	Neither agree nor disagree	
130	Strongly agree	Strongly agree	Strongly agree	Strongly agree	BCHC could be represented in this work stream; the Therapy App could have a role in key action 3 and the Musculo-skeletal service could have a role in key action 6. There are 'inactive wards' and BCHC could have a role in promoting activity through Making Every Contact Count in these areas and BCHC provides care to some groups at risk of inactivity such as those with a disability and other long term conditions.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Is there a role for the Safeguarding Children Board on the Future Parks Accelerator Board, as safety in parks has been one of the issues raised by children in the city in recent years? BCHC is developing a Green Plan which links us to the Clean Air Strategy and the Climate Change Route to Zero Strategy.
131	Neither agree nor disagree	Strongly disagree	Neither agree nor disagree	Strongly disagree	How can you make a disabled person more active? Has a disabled person been asked about this stage? Public transport in the city is disgusting and riddled with crime. No way would ai travel on public transport in Birmingham. Maybe you should increase electric car chargers in the city. It's embarrassing how few you have.	Strongly disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	You are pushing cars to disadvantaged areas. How is this all going to be done? You can't force people to do anything.
132	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Plant more trees please!
133	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	stop selling off space to unscrupulous private car park owners
134	Neither agree nor disagree	Neither agree nor disagree	Disagree	Neither agree nor disagree		Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	
135	Stronely agree	Stronely agree	Stronely agree	Stronely agree		Stronely agree	Stronely agree	Stronely agree	Stronely agree	
136	Agree	Neither agree nor disagree	Strongly agree	Strongly agree		Strongly agree	Agree	Strongly agree	Strongly agree	
137	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
138	Agree	Agree	Strongly agree	Agree		Strongly agree	Agree	Strongly agree	Neither agree nor disagree	
139	Agree	Neither agree nor disagree	Agree	Agree	Elderly sports equipment for physiotherapy like in Holland in outdoor spaces. Not full gyms	Neither agree nor disagree	Agree	Neither agree nor disagree	Neither agree nor disagree	Encourage more recycling in poorer Parts of city Closing roads to allow cyclists like kings Heath just moves traffic elsewhere causing jams which crests more pollution. Keep roads flowing so cars aren't stationary.
140					as above					as above
141	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	
142										

	To what extent do you agree or disagree with the ambitions in the Protect and Detect theme? - To what extent do you agree or disagree with the ambitions in the Protect and Detect theme? - Achieve the national ambitions or targets for all national immunisation programmes by 2030	To what extent do you agree or disagree with the ambitions in the Protect and Detect theme? - To what extent do you agree or disagree with the ambitions in the Protect and Detect theme? - Achieve the national targets for all national screening programmes by 2030	To what extent do you agree or disagree with the ambitions in the Protect and Detect theme? - To what extent do you agree or disagree with the ambitions in the Protect and Detect theme? - Halve the variation in uptake (inequality) for all immunisation and screening programmes by 2030	To what extent do you agree or disagree with the ambitions in the Protect and Detect theme? - To what extent do you agree or disagree with the ambitions in the Protect and Detect theme? - Reduce the overall rates of new sexual health infections, including HIV, through early diagnosis and treatment to close the gap between Birmingham and the national average by 2030	To what extent do you agree or disagree with the ambitions in the Protect and Detect theme? - Please use the box below for comments you wish to make. If you disagree with the ambitions in the Protect and Detect theme, please tell us why and explain how you think this could be improved:	To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - Reduce infant mortality in Birmingham by 25% by 2027 and by 50% by 2030	To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - Improve the percentage of children achieving a good level of development by 2-2.5yrs to over 83% and at the end of Reception to 75% by 2030	To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - Halve the rate of children killed and seriously injured (KSI) on Birmingham's roads by 2030	To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - Reduce the under 18 teenage conception rate to close the gap between Birmingham and the national average by 2030	To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - Halve the hospital admissions due to asthma in young people under 18yrs by 2027	To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - Reduce the rate of first-time entrants (10-17yrs) to the youth justice system by 25% by 2030	To what extent do you agree or disagree with the ambitions in Getting the Best Start in Life? - Please use the box below for comments you wish to make. If you disagree with the ambitions in Getting the Best Start in Life, please tell us why and explain how you think it could be improved:
1	Strongly agree	Strongly agree	Neither agree nor disagree	Agree	The focus needs to be on older folk who may not necessarily be able to access health care easily.	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	
2	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
3	Agree	Agree	Agree	Agree	There are certain groups that will not change and you could see people walkig around without masks in lockdown. What did you do - nothing more than talk again. They behave likre children but you treat them as adults	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	stop enabling some of these groups
4	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
5	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
6	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
7	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	2030 is 9 years away - what about now	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Should be more ambitious in both percentage terms and numbers of year
8	Strongly agree	Strongly agree		Strongly agree	1) good 2) good 3) why half? Is that a significant reduction? 4) good Much better section. Provides. context and a good level of ambition	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Agree	Neither agree nor disagree	Neither agree nor disagree	1) why 25 and 50 %? Are these meaningful? 2) same as above 3) why half? is half a good outcome? surely eliminating this is not unachievable? 4) much better statement and provides context nationally, but needs to include by how much and needs to not be arbitrary...MEANINGFUL!!! 5) WHY HALF??!!!! Half means nothing. 6) again
9	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
10	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
11	Agree	Strongly agree	Strongly agree	Neither agree nor disagree		Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
12	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
13	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
14	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Agree	Agree	Strongly agree	Agree	
15	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Promote vaccines in mothers groups. Many mothers groups spread vaccine conspiracy theories.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Fund more youth groups like the Stonehouse Gang
16	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		
17	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	You should be hitting national targets already. This should be a huge priority and achieved well before 2030.	Agree	Agree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Strongly agree	yet again there are several ambitions which you will be able to have very limited impact on. You should be concentrating on things you can directly impact at set 'wouldn't it be good if' targets.
18	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
19	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
20	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
21	Agree	Agree	Agree	Agree		Agree	Neither agree nor disagree	Agree	Neither agree nor disagree	Neither agree nor disagree	Agree	
22	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
23	Disagree	Agree	Strongly agree	Agree		Agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	Roads need to be made safer There are too many speeding drivers All side residential roads should have speed ramps on them to slow cars down
24	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
25	Strongly agree	Strongly agree	Agree	Strongly agree		Agree	Agree	Strongly agree	Strongly agree	Agree	Strongly agree	
26	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	
27	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	
28	Agree	Agree	Neither agree nor disagree	Neither agree nor disagree		Neither agree nor disagree	Agree	Strongly agree	Neither agree nor disagree	Agree	Agree	
29	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
30	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Again it all begins with GPS they need to be overhauled its a disgrace the way they are treating people at the moment	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Support services for miscarriage also need improvement
31	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree		Strongly agree	Don't know	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Some of the wording is too open e.g. reducing teenage pregnancies could be acheived by locking every under-18 in a cell. I am not proposing this idea...just pointing out that it may well acheive the objective.
32	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
33	Agree	Agree	Strongly agree	Strongly agree		Agree	Agree	Agree	Agree	Agree	Agree	
34	Agree	Agree	Agree	Agree		Agree	Agree	Strongly agree	Agree	Agree	Agree	
35	Agree	Agree	Agree	Disagree		Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	
36	Agree	Strongly agree	Agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Again - massive issue with traffic in the city that needs to feed in to a larger strategy to make the city safer and pedestrian-friendly.
37	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	School nurse service needs [illegible]
38	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
39	Agree	Strongly agree	Agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
40	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
41	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	Neither agree nor disagree	Strongly agree	
42	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree		Strongly disagree	Strongly disagree	Strongly agree	Don't know	Strongly agree	Don't know	
43	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	
44	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
45	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Disagree	
46	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
47	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
48	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
49	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Agree	Agree	Agree	Strongly agree	Again, I think there needs to be a focus on CYP mental health
50	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
51	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
52	Disagree	Disagree	Disagree	Disagree		Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly disagree	
53	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
54	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
55	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
56	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Birmingham sexual health clinics are currently not treating patients (over the phone is not a treatment) and so this increases prevelance.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
57	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
58	Agree	Agree	Agree	Agree		Agree	Agree	Strongly agree	Agree	Agree	Strongly agree	
59	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
60	Disagree	Neither agree nor disagree	Disagree	Agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Agree	My children no longer cross round here as it is to dangerous, more dangerous at crossings due to jumping of red lights. My children and neighbours have increased the use of inhalers over the last four years , which is a concern. So anything that makes roads safer and helps with asthma reduction would be welcome in these areas.
61	Neither agree nor disagree	Agree	Neither agree nor disagree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	
62	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree		Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	
63	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Agree	
64	Agree	Neither agree nor disagree	Neither agree nor disagree	Agree		Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
65	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
66	Neither agree nor disagree	Disagree	Disagree	Agree		Neither agree nor disagree	Neither agree nor disagree	Disagree	Agree	Agree	Agree	
67												
68	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Strongly agree	Agree	Agree	Strongly agree	
69	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Agree	Agree	Strongly agree	Agree	
70								Strongly agree		Strongly agree		Live by a road and you understand the long term damage it does mentally and physically. Anxiety is common in children as many has witnessed traumatic accidents along here, along with adults. I see my kids tense when they hear brakes outside and as soon as fumes build up the inhalers come out. So two things effect children in your list if they live by a road
71	Agree	Agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
72	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
73	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Children are very important, especially in deprived areas and where there are inequalities. Let's help children to get the best out of life
74	Agree	Agree	Agree	Strongly agree		Agree	Agree	Strongly agree	Strongly agree	Agree	Strongly agree	
75	Agree	Neither agree nor disagree	Neither agree nor disagree	Agree		Agree	Agree	Strongly agree	Agree	Strongly agree	Strongly agree	
76	Agree	Strongly agree	Agree	Agree		Strongly agree	Strongly agree	Agree	Agree	Agree	Neither agree nor disagree	
77	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Again early intervention is key about what makes a healthy, equal and positve relationship.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	The Birmingham roads are a killer and really need ot be tackled. The dangerous driving and parking makes it hard for people to walk and cycle and to be safe generally.
78	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	My people don't even discuss some of these issues and it needs to be discussed	Strongly disagree	Strongly disagree	Strongly disagree	Don't know	Strongly disagree	Strongly disagree	Gypsy romany and travellers need included our children matter
79	Strongly agree	Strongly agree	Disagree	Strongly agree	Should aim to have eliminated the variation in 9 years, not just half it.	Strongly disagree	Strongly disagree	Strongly agree	Strongly agree	Agree	Strongly disagree	Ambitions too low: Infant mortality should be halved in next 3 years (as other systems have committed to) Targets of good development should be 90 per cent by 2030 - or we will be writing off a huge number of young people in coming generation, and creating pressures on system further down the line Similarly with criminal justice system - need to prevent young people entering that as cycles for life set up. Given large number of cared for young people and those vulnerable to mental ill health who end up in CJS, this is a particularly vulnerable group of young people who should be better supported in formative years - and who are more reliant on system getting things right as dont have family support to fall back on.
80	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
81	Strongly agree	Strongly agree	Strongly agree	Strongly agree	So much of this could've been stopped or delivered by our children's sure start centres.. anyone regret taking them away yet?	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
82	Don't know	Don't know	Don't know	Don't know		Strongly agree	Strongly agree	Strongly agree	Don't know	Don't know	Strongly agree	Avain difficult to achieve
83												

84	Agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Improve the percentage of children achieving a good level of development by 2-2.5yrs to over 83% and at the end of Reception to 75% by 2030- it is wrong to be aiming for this. 100% of our young children deserver the best start in life.
85	Neither agree nor disagree	Agree	Neither agree nor disagree	Agree		Agree	Agree	Strongly agree	Agree	Agree	Agree	Unfortunately there are many side effects of contraception pushed on females. More research needs to be done into other forms of contraception - especially those for men.
86	Agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Starting well is very important in life and addressing socio economic factors (i.e. wider determinants) . If the city can get the right provisions in place at the right time and apply targeted interventions based on data intel then this will create a more resilient, cohesive and flourishing communities which instils hope for better neighbourhood and its people.
87	Strongly agree	Strongly agree	Strongly agree	Strongly agree	This is going to require investment in services that have been cut to the bone and then cut some more where is that investment going to come from	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
88	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
89	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
90	Agree	Agree	Strongly agree	Strongly agree		Agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	
91	Strongly agree	Agree	Disagree	Neither agree nor disagree	what about violence - no question on hat. The news is full of violent crime and that is just the tip of the iceberg. What are you doing about knife culture and its prevalence amongst immigrants. you cant get to see a GP because they are generally lazy moneygrabbing people and this leads to so much suffering and that goes against the oath they swore. I have seen first hand many examples of this and I am sure others have as well. The misdiagnosis by GPs because they want to consult by phone is shocking and not acceptable the inequality in uptake for immunisation is merely a reflection of what was happening earlier in he crisis when the majority of people not wearing a mask when one was required were from minorities. Friday prayers were carried out in shops with 30 people crowder in to a corbner shop illegally	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Agree	Neither agree nor disagree	Agree	
92	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
93	Agree	Agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Agree	
94	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
95	Neither agree nor disagree	Agree	Neither agree nor disagree	Strongly agree		Agree	Agree		Agree	Agree	Strongly agree	
96	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree	Strongly agree	Strongly agree	Strongly agree	
97	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
98	Strongly agree	Strongly agree	Strongly agree	Strongly agree	As with mental health, sexual health services and reproductive screening has been deprioritised and defunded during the Tory government. How can you expect to meet these targets when there is very little funding and the NHS is overstretched?	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
99	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	Strongly agree	Agree	Strongly agree	Agree	
100	Strongly agree	Strongly agree	Disagree	Strongly agree	Again the targets seem too low.	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Targets seem too low.
101	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
102	Agree	Agree	Strongly agree	Strongly agree		Agree	Strongly agree	Agree	Agree	Agree	Strongly agree	
103	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Education. Marketing. Education.	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Education, cleaner air, more economic opportunity, social mobility, social hope, and higher quality healthcare. Completely redo the credit system. It's an expensive business being poor. That needs to change. Charging someone for going into overdrafts, higher interest rates for the poor, higher rent than mortgages - its perverse.
104	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
105	Agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree		Agree	Agree	Agree	Agree	Strongly agree	Agree	
106	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
107	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Again I think 2030 is not ambitious enough. And the improvement in infant mortality should be more ambitious, given what we now know about the gross racial inequalities in this area.
108	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree but by 2025	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	
109	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	To reduce the entrants to the youth justice system (such a euphamism) we need to address the often racist nature of the justice system. What plans are there for that? Give that by some estimates over half of young people identify as queer (and many as trans) what consideration has been given to that? We know that the real, persistent atmosphere of transphobia in British media discourse has real health effects- what will this plan do to mitigate that affect on queer and trans youth?
110	Disagree	Don't know	Don't know	Don't know	With all the anti vax online dogma I think more accountability from social media companies is required.	Disagree	Disagree	Don't know	Don't know	Don't know	Don't know	More antenatal care is required e.g. NCT classes for all. Free access to Nursery places from age 2 would ensure infants get the best start.
111	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
112	Neither agree nor disagree	Agree	Agree	Agree	I don't really know enough about this	Agree	Strongly agree	Agree	Agree	Strongly agree	Strongly agree	Children's and youth services were reduced and closed throughout the austerity (and even before that). Both need to be increased to achieve the fourth and sixth goal in this question. There are some local voluntary sector services for this and they need better support.
113	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Strongly agree	Strongly agree	Strongly agree	Agree	Agree	
114	Strongly agree	Agree	Agree	Agree	Care should be taken to remember the importance of consent and avoid undue pressure to comply. The NHS in recent years has developed an unpleasant habit of referring people for screening and making appointments for them without their knowledge and consent, rather than offering them screening and respecting their own agency, and it's obnoxious.	Strongly agree	Agree	Agree	Agree	Agree	Agree	
115	Strongly agree	Strongly agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	
116	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
117	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
118	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
119	Neither agree nor disagree	Agree	Agree	Neither agree nor disagree		Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Agree	Agree	
120	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Screening and early detection is instrumental in protecting and improving the health of the population. In addition to the action points listed, we recommend that the actions are expanded to incorporate strategies to detect chronic physical and mental health conditions. This is particularly relevant given the immense burden and costs for society associated with these conditions (Vigo et al., 2016; Kessler et al., 2016; Newton et al., 2015; Department of Health and Social Care, 2012). Furthermore, timely detection can contribute to the reduction of health inequalities as chronic conditions are more prevalent among deprived population groups (Department of Health and Social Care, 2012). References: Vigo, D., Thornicroft, G., & Atun, R. (2016). Estimating the true global burden of mental illness. The Lancet	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	There is strong evidence around the health and economic benefit of early intervention, particularly the first 2000 days (Hayes, 2016) so we applaud the focus on improving the percentage of children achieving a good level of development by 2 years. Furthermore, we believe that the role of schools in prevention and health promotion during childhood and adolescence should be highlighted more. Schools have an important role in health promotion and health education, in particular in relation to obesity. According to the World Health Organization, "schools offer an important opportunity to address childhood obesity by improving children's and adolescents' nutrition through providing healthy food and drink options, promoting physical activity and providing health education." (WHO, 2018) We recommend that the actions include: -Implementation of evidence-based
121	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	
122	Strongly agree	Agree	Agree	Strongly agree		Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	
123	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
124	Agree	Strongly agree	Strongly agree	Agree	Screening for cancer would save a lot of money on the long run.	Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Strongly agree	I don't know how these figures are going to be achieved but they are all admirable objectives.
125	Agree	Agree	Agree	Strongly agree	A positive step to overcome the effect of covid on treatment time and recognition of other illnesses	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	To provide the best future for our children.
126	Agree	Agree	Agree	Agree		Neither agree nor disagree	Agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	
127	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
128	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
129	Agree	Agree	Agree	Strongly agree		Strongly agree	Agree	Strongly agree	Strongly agree	Agree	Agree	

130	Strongly agree	Strongly agree	Strongly agree	Strongly agree	There are significant linkages for BCHC with this theme. BCHC is a member of the Children's Safeguarding Partnership, the Adult Safeguarding Partnership and the Community Safety Partnerships. The latter has a focus on park safety and BCHC will play what role it can to reduce domestic and gang violence. BCHC plays an important role in the city's vaccination work and is happy to contribute to open, respectful and responsible conversations with communities. BCHC leads the Long COVID pathway and finally, would like to be a member of the Creating a City Without Inequality Forum, though we would frame that positively as Creating an Equitable City Forum.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	The Hweb draft strategy takes a life course approach too and segments life into three phases; Getting the Best Start in Life, Working and Learning Well and Aging Well and Dying Well. BCHC provides services across all three of these phases of life. We are involved with Low Birth Weight and Very Low Birth Weight babies in the Health Visiting and broader Birmingham Forward Steps service. When these, and other children, have additional needs we see them in the Therapy Services, Child Development Centres, Community Paediatric Services and Special school provision as part of our Special Educational Needs and Disability Services. The school nursing service monitors weight in Reception and Year 6 and we would be keen to be part of a broad obesity reduction programme. We note Birmingham Children's Partnership as the vehicle for delivering the ambitions on school readiness, asthma and infant mortality as
131	Agree	Agree	Neither agree nor disagree	Neither agree nor disagree	You need more Doctors Surgeries. It took me 106 times to get through to my GP last week ! You need to educate people about vaccinations and why it's important.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Agree	Neither agree nor disagree	Again how will you do this? You don't have the staff and support. We rarely saw the health visitor as they never had appointments when our child was a baby.
132	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	More youth clubs please.
133	Agree	Don't know	Don't know	Agree	immunisation should be a choice	Strongly agree	Don't know	Strongly agree	Don't know	Strongly agree	Don't know	Some people need support so reducing uptake is not necessarily a good thing. Not sure about the morals and approach for reducing the conception rate?
134	Agree	Agree	Neither agree nor disagree	Neither agree nor disagree		Agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	
135	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
136	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	
137	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
138	Strongly agree	Neither agree nor disagree	Agree	Agree		Agree	Agree	Strongly agree	Agree	Agree		
139	Strongly agree	Strongly agree	Agree	Strongly agree	Standard Screening / mris to look for secondary cancers. Not just treat primary.	Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Agree	
140					as above							as above
141	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
142												

	To what extent do you agree or disagree with the ambitions in Working and Learning Well? - To what extent do you agree or disagree with the ambition in Working and Learning Well? - Increasing the % of the estimated individuals who smoke accessing smoking cessation services and achieving a 6-week quit by 30% by 2020	To what extent do you agree or disagree with the ambitions in Working and Learning Well? - To what extent do you agree or disagree with the ambition in Working and Learning Well? - To reduce the % rate of long-term musculoskeletal problems to 5% below the England average by 2020	To what extent do you agree or disagree with the ambitions in Working and Learning Well? - To what extent do you agree or disagree with the ambition in Working and Learning Well? - Reduce coronary heart disease admissions rate (all ages) by 20% by 2030	To what extent do you agree or disagree with the ambitions in Working and Learning Well? - To what extent do you agree or disagree with the ambition in Working and Learning Well? - Reduce the % of adults from ethnic communities with Type 2 Diabetes to match the demographic profile of our city by 2030	To what extent do you agree or disagree with the ambitions in Working and Learning Well? - To what extent do you agree or disagree with the ambition in Working and Learning Well? - Increase the number of targeted health checks (e.g., for people with learning disabilities, carers and severe mental health issues) by 15% by 2022	To what extent do you agree or disagree with the ambitions in Working and Learning Well? - To what extent do you agree or disagree with the ambition in Working and Learning Well? - Reduce the rate per 1000 of homeless young people (16-24 years) to the England Average	To what extent do you agree or disagree with the ambitions in Working and Learning Well? - To what extent do you agree or disagree with the ambition in Working and Learning Well? - Achieve 50% of all medium and large businesses in Birmingham being part of the Thrive at Work programme	To what extent do you agree or disagree with the ambitions in Working and Learning Well? - To what extent do you agree or disagree with the ambition in Working and Learning Well? - If you agree with the ambitions in Working and Learning Well, please tell us why and explain how you think this could be improved.	To what extent do you agree or disagree with the ambitions in Ageing Well and Dying Well? - To what extent do you agree or disagree with the ambition in Ageing Well and Dying Well? - Improve the gap in healthy life expectancy at 65yrs between Birmingham and the national average for both men and women	To what extent do you agree or disagree with the ambitions in Ageing Well and Dying Well? - To what extent do you agree or disagree with the ambition in Ageing Well and Dying Well? - Increase the % of eligible citizens offered an NHS Health Check who received it to over 70%	To what extent do you agree or disagree with the ambitions in Ageing Well and Dying Well? - To what extent do you agree or disagree with the ambition in Ageing Well and Dying Well? - Improve the detection of dementia by increasing the % of people estimated to be living with dementia who are diagnosed and receiving care and support to over [illegible]	To what extent do you agree or disagree with the ambitions in Ageing Well and Dying Well? - To what extent do you agree or disagree with the ambition in Ageing Well and Dying Well? - Reduce the rate of emergency hospital admissions due to falls in people aged 65yrs and over to below the national average	To what extent do you agree or disagree with the ambitions in Ageing Well and Dying Well? - To what extent do you agree or disagree with the ambition in Ageing Well and Dying Well? - Improve the carer-reported quality of life score for people caring for someone with dementia to equal to or above the national average	To what extent do you agree or disagree with the ambitions in Ageing Well and Dying Well? - To what extent do you agree or disagree with the ambition in Ageing Well and Dying Well? - Reduce the Excess Winter Deaths to close the gap between the actual and expected number of deaths in people aged >65yrs by at least 20%	To what extent do you agree or disagree with the ambitions in Ageing Well and Dying Well? - To what extent do you agree or disagree with the ambition in Ageing Well and Dying Well? - Please use the box below for comments you wish to make. If you disagree with the ambitions in Ageing Well and Dying Well, please tell us why and explain how you think this could be improved.
1	Disagree	Strongly agree	Strongly agree	Disagree	Strongly agree	Strongly agree	Strongly agree	I think the focus should be on the homelessness. Everyone with diabetes should be targetted to get healthier rather than just ethnic minority groups - target all.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	Needs to be much better awareness and positive support for people or carers for Dementia. Having been through this families are reliant on charities and I think there is a gap where the Council could be doing more to support people living with dementia.
2	Disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly disagree	Disagree	Neither agree nor disagree	Neither agree nor disagree	are you going to change the diets of ethnic communities if that is what is causing the diabetes. Birmingham will be a target for homelessbecause the pickings are better for begging.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	GPs are not interested in patients, they are now just businesses and people are seen as a product. Hpe about stopping all these 'tourists' coming and using the service and overloading it
4	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
5	Disagree	Disagree	Strongly disagree	Strongly disagree	Disagree	Strongly disagree	Strongly disagree		Neither agree nor disagree	Agree	Don't know	Neither agree nor disagree	Strongly disagree	Strongly disagree	
6	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
7	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Not ambitious enough - Reduce the % of adults from ethnic communities with Type 2 Diabetes to match the demographic profile of our city by 2030 - why only ethnic communities? This should be everyone not just some otherwise you will fail another group. What is the demographic profile and why 2030. None of the figures are particularly ambitious.	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Pathetic figures- "by at least 20%" these figures should be much higher.
8	Neither agree nor disagree	Agree	Neither agree nor disagree	Strongly disagree	Neither agree nor disagree	Agree	Agree	1) why estimated? can you not collect data for it/can I? I thought you said evidence-informed practice earlier on 2) why 1% below though? is this number magical? 3) yes but why 2030? Also, does this include congenital conditions? 4) what does this even mean? Are you saying non-White people are more likely to develop diabetes? and if so, this is massively tied into culture. Sounds stupid. Why not reduce it for all ethnic groups? One minute you say you want to reduce inequality then you target specific communities, which emphasises inequality (i.e. unequal treatment) 5) same problem again! 6) Much better. You don't need to state "per 1000". A rate is a rate. Use proportion instead. 7) why 10%?	Neither agree nor disagree	Neither agree nor disagree	Disagree	Strongly agree	Strongly agree	Neither agree nor disagree	1) WHY HALF??? Is this come magical threshold I'm unaware of? 2) 70% sounds arbitrary again 3) stop using % when you can using a full word. Also, this is too complex. Make it simpler to understand on first read. 4) GOOD! 5) good again. How is this being standardised? 6) why 20% for this one? is this meaningful in the context of winter deaths?
9	Agree	Agree	Agree	Agree	Agree	Strongly agree	Neither agree nor disagree	obviously agree with all of the targets but cant help wonder how much personal choice is involved here and how can these changes be made without removing personal [illegible]	Neither agree nor disagree	Strongly agree	Agree	Agree	Strongly agree	Agree	do think some of these factors are to be expected such as falls in the elderly group and not sure if these can be improved or rather are you wasting efforts in trying to improve [illegible]
10	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		[illegible]	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
11	Neither agree nor disagree	Strongly agree	Agree	Agree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree		Neither agree nor disagree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	
12	Agree	Agree	Agree	Agree	Agree	Strongly agree	Agree		Agree	Strongly agree	Agree	Agree	Strongly agree	Agree	
13	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
14	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	All great points BUT the investment city wide to reduce MSK issues will be large - need to increase knowledge of citywide workforce in health and beyond and provide places for engagement. With the increased health checks that is also great but I foresee workforce issues in doing this.	Strongly agree	Strongly agree	Agree	Strongly agree	Agree	Agree	All good ambitions but will the increase in health checks be funded at GP level? What is your plans for workforce? To reduce falls you need to a community wide approach and services that can reach frail homebound patients. Again, I feel a lot of investment in healthcare is needed and wonder what the plans are for this?
15	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
16	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
17	Disagree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Disagree	The smoking target is way to broad - remove the word 'estimated' if you want to actually tackle the problem. Also vaping has been of huge benefit to reducing the number of smokers and this should be encouraged by ACC - Please speak to some industry bodies to find out how the council can help people switch. I would suggest the IBVTA or even look within your own organization for people who have knowledge of the benefits of vaping.	Agree	Agree	Strongly agree	Agree	Agree	Strongly agree	to tackle the falls problem you should be adding single people to the protected list. again there are to many ambitions that you as a service can reasonably affect. More focus is needed in your ambitions.
18	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
19	Agree	Agree	Agree	Strongly agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
20	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
21	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
22	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
23	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Quit smoking aids should be free and available at pharmacies to collect like you have the lateral flow tests freely available. This should be the same and will make it simple for people to quit.	Agree	Strongly agree	Strongly agree	Agree	Strongly agree	Disagree	
24	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
25	Agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree	Agree	Agree	Agree	
26	Neither agree nor disagree	Neither agree nor disagree	Agree	Strongly agree	Strongly agree	Strongly agree	Agree	I'm not entirely sure how the musculoskeletal problems target can be achieved? Is this to do with the way people work and move - poor posture of working habits [illegible]	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Agree	Again, not entirely sure how you plan to address hospital admissions due to falls. Seems like something out of the sphere of influence of BCC to be honest.
27	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
28	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
29	Agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Agree	Agree	Agree	Agree	Agree	Agree	
30	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
41	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
42	Strongly disagree	Strongly disagree	Strongly disagree	Neither agree nor disagree	Agree	Don't know	Strongly agree		Neither agree nor disagree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	
43	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Agree	
44	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	what about advance care plans and dying well? this would reduce unnecessary hospital admissions. need more focus on palliative care
45	Agree	Agree	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
46	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
47	Agree	Agree	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
48	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
49	Strongly agree	Neither agree nor disagree	Agree	Agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
50	Agree	Agree	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
51	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
52	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
53	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
54	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
55	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
56	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
57	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
58	Strongly agree	Agree	Agree	Strongly agree	Strongly agree	Strongly agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
59	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	This area we lose a average of eight years just by living in this area. Two miles up the road Sutton Coldfield were they lose no years. Health inequality is very black and white [illegible]
60	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Agree	Agree	Agree		Agree	Strongly agree	Agree	Agree	Strongly agree	Strongly agree		
61	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Agree	Agree	Neither agree nor disagree	Neither agree nor disagree	Agree	Agree	Neither agree nor disagree	Agree	Strongly agree	Agree	Neither agree nor disagree	
62	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Strongly agree	
63	Agree	Agree	Agree	Neither agree nor disagree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Strongly agree	Agree	
64	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	
65	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
66	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	
67															
68	Agree	Agree	Agree	Agree	Agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Agree	Agree	Agree	Agree	
69	Agree	Agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Strongly agree	Disagree	Agree	Agree	Strongly agree	Neither agree nor disagree	Disagree	Agree		I think that the health and well being of society would be vastly improved if older people had the informed choice to end their life, or if we made a collective decision not to prolong life. Living with dementia has decimated my mum and dad, compromised their relationship and has day to day impact on our whole family. Frankly it would be better if my mum were allowed to die with [illegible]
70			Strongly agree												Probably will not see old age living here just like my neighbour
71	Agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
72	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree all very important - especially diabetes control. Help reduce rates by providing free exercise for all diabetics, in a measured programme where exercise suits no children's health	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Are elderly people need this support. Inequalities need to be reduced sooner rather than latter. We bang on about inequalities, but we don't see any reduction.
73	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
74	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
75	Agree	Agree	Agree	Agree	Agree	Agree	Agree		[illegible]	Agree	[illegible]	[illegible]	Agree	[illegible]	
76	Agree	Agree	Agree	Agree	Agree	Agree	Agree		[illegible]	Agree	Agree	Agree	Agree	[illegible]	
77	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
78	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Again we are not included and struggle to find somewhere to live and to get medical attention read my report done with cog British Red Cross on accessing gps in [illegible]	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Lots of our old people have no sites to go on
79	Disagree	Strongly agree	Disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree	Overall need bolder ambitions for the ones I have disagreed on	Disagree	Disagree	Strongly agree	Disagree	Disagree	Disagree	I agree with the aims - but have disagreed where no timelines have been given - too open ended so risk little progress being made.
80	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
81	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Make sure everyone of these demographics receives targeted health checks, no one left behind. We need to aim to reduce the rate of homelessness to below the national average. This is something that should not be happening and is easily avoidable!	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
82															
83															
84	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
85	Neither agree nor disagree	Agree	Agree	Neither agree nor disagree	Strongly agree	Agree	Strongly agree	Again, I believe there is fairly good support for smoking - then again I don't smoke.	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Agree	
86	Agree	Agree	Agree	Agree	Strongly agree	Strongly agree	Strongly agree	Smoking cessation programmes needs to be more accessible to those who smoke and not just primary providers. Evidence suggests that people in manual jobs and low socio economic groups smoke the most therefore more targeted intervention is required and better marketing/promotion.	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Make every contact count training should be rolled out to all front line staff who are likely to have access to vulnerable/ at need groups and their families and be able to make a positive impact. Organisations/employers should also be more included with local initiatives and promote it to their employees such as Thrive at Work, dying matters, mental health first aid etc
87	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
88	Agree	Agree	Agree	Neither agree nor disagree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	
89	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Again it is hard to argue that any of the questions in this section are anything other than strongly [illegible]
90	Strongly agree	Agree	Strongly agree	Agree	Strongly agree	Agree	Agree		Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Agree	
91	Agree	Agree	Agree	Strongly disagree	Neither agree nor disagree	Disagree	Neither agree nor disagree	the diet for ethnic minorities leads to health issues and realistically there will be no changes to these diets so the effort required to make these changes will not make enough change so effort would be best used where it can be most effective	Agree	Neither agree nor disagree	Neither agree nor disagree	Agree	Neither agree nor disagree	Agree	
92	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
93	Agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
94	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
95	Agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Strongly agree	Neither agree nor disagree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	
96	Neither agree nor disagree	Agree	Strongly agree	Agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
97	Agree	Agree	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Agree	

98	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
99	Agree	Agree	Agree	Strongly agree	Strongly agree	Strongly agree	Agree	I think we can probably aim higher regarding homeless youth and we need to look at the root causes of child and young people's homelessness and deal with these and not see these people as a problem to be solved but a group to be aided back into society.	Agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	We need to look at the conditions our elderly are living in and encouraged more fuel poverty allowances as well as easy access to GP/pharmacies and flu jabs, etc.
100	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree	Targets seem too low. I like the idea of free healthy food coupled with education/social events and financial incentives as well as price increases and stricter regulation/banning of some food products.	Strongly disagree	Strongly disagree	Agree	Agree	Strongly disagree	Strongly disagree	Targets seem too low.
101	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
102	Strongly agree	Agree	Agree	Agree	Strongly agree	Strongly agree	Agree		Agree	Agree	Agree	Agree	Strongly agree	Strongly agree	
103	Disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	I don't know a lot about these issues	Neither agree nor disagree	Neither agree nor disagree	Agree	Neither agree nor disagree	Neither agree nor disagree	Agree	I worry a lot of this would result in fudging of numbers, rather than [redacted]
104	Don't know	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Neither agree nor disagree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
105	Agree	Agree	Agree	Agree	Neither agree nor disagree	Agree	Agree		Agree	Agree	Agree	Agree	Strongly agree	Agree	
106	Agree	Agree	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
107	Strongly agree	Don't know	Strongly agree	Strongly agree	Disagree	Strongly agree	Strongly agree	Don't think 2027 target ambitious enough. Unclear from what year the England average measurements are to be drawn, surely this is a moving target. Unsure about the musculoskeletal target as surely much of this is related to previous industrial/ work injuries, wear and tear, and exposure. Because much industry has now gone I think this target should maybe be age- delineated because otherwise it may simply be achieved by the death from old age of those with the industrially-related conditions	Strongly agree	Neither agree nor disagree	Disagree	Strongly agree	Strongly agree	Strongly agree	Disagreed on dementia target as do not think 2030 is ambitious enough
108	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	Strongly disagree	Strongly agree	Don't know	Think it should be increase the number of targeted health checks (eg., for people with learning disabilities, carers and severe mental health issues) by 100% immediately Achieve 100% of all businesses in Birmingham being part of the [redacted]	Strongly agree	Strongly disagree	Strongly agree	Strongly agree		Strongly agree	I believe that you need to: Increase the % of eligible citizens offered an NHS Health Check who received it to 100%
109	Strongly agree		Strongly agree	Strongly agree	Agree	Strongly agree	Neither agree nor disagree	For health checks to be taken up, it must be easy to access the health service. It often isn't, even before covid. How will this be addressed?	Strongly agree	Neither agree nor disagree	Strongly agree	Agree	Strongly agree	Agree	End of life care cannot simply fall on families. What plans are there to extend the network of high-quality, paid carers? Again, the binary focus on men and women ignores the end-of-life inequalities for queer and trans elders, who can sometimes find they are forced back into the closet because elder care is not affirming or supportive. I would have liked to see consideration of this.
110	Don't know	Don't know	Don't know	Don't know	Don't know	Don't know	Don't know		Don't know	Don't know	Disagree	Don't know	Disagree	Don't know	Dementia need to be further up the agenda. The care homes struggle to staff there homes and staff do not have relevant dementia training. Having family using the NHS then being discharged from hospital highlighted the awful discharging system. Care plan being divided up, in rather a piece-meal manner with family having to read and understand the gaps in provision and spend hours on the telephone dealing with care companies, pharmacies and equipment hire firms. With no-one checking things were in place and ready at discharge. Our local Care home has an awful reputation with dementia care.
111	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
112	Agree	Strongly agree	Strongly agree	Strongly agree	Agree	Neither agree nor disagree	Strongly agree	Can we please reduce homelessness below the England [redacted]	Agree	Neither agree nor disagree	Agree	Agree	Agree	Agree	I don't know what the Health Check is, haven't had it (I'm 74!)
113	Strongly agree	Agree	Agree	Agree	Agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Agree	Strongly agree	Agree	Agree	If you repair pavements across the city, you would reduce the number of falls and thus emergency admissions to hospital
114	Neither agree nor disagree	Agree	Agree	Agree	Agree	Agree	Strongly disagree	I strongly object to workplaces sticking their noses into employees' healthcare and wellbeing, and pushing healthcare initiatives on them. Companies should stay in their damn lane, and the Council shouldn't be encouraging them to overstep into their employees' private lives. If they want to help their employees' wellbeing, fair livable wages, reasonable working weeks and commitment to diversity and equality should be their main input.	Strongly agree	Strongly agree	Don't know	Strongly agree	Strongly agree	Strongly agree	The detection of dementia item doesn't make logical sense. How do you improve detection by increasing diagnosis? Isn't that a circular argument - we'll do the thing by doing the thing??
115	Agree	Agree	Strongly agree	Agree	Agree	Strongly agree	Neither agree nor disagree		Strongly agree	Agree	Agree	Agree	Agree	Agree	
116	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
117	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
118	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	There needs to be something about literacy and libraries in here. Learning Well requires access to a safe and quiet space to learn in (which not all members of the community have at home) and learning materials (such as books and computers). Resourcing libraries so they are not part time would help with accessibility for the most vulnerable members of our community.	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Detection of dementia will need to focus on communities that may not be receiving the current messages due to language barriers.
119	Agree	Agree	Agree	Agree	Agree	Agree	Agree		Agree	Agree	Agree	Agree	Agree	Neither agree nor disagree	
120	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
121	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Agree	
122	Strongly agree	Agree	Strongly agree	Strongly agree	Agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
123	Agree	Agree	Agree	Agree	Agree	Strongly agree	Strongly agree	There should be more schemes for returning to work for those who have been out of work due to ill-health especially if they are over 45 years old. There should be more part-time and home working jobs available for people in this [redacted]	Agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	More carers and more affordable private carers need to be made available for those who are ill, disabled or old.
124	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Happy to see the elderly being prioritised - particularly with the improvement in detection of [redacted]
125	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	
126	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree		Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	
127	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
128	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
129	Strongly agree	Agree	Agree	Agree	Strongly agree	Strongly agree	Neither agree nor disagree		Agree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Neither agree nor disagree	
130	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	In the Working and Learning Well element of the life course, this strategy has a number of Key Performance Indicators where BCHC can contribute. These include •Increasing those who access smoking cessation services and achieving a four week quit by 20% by 2030 •Reducing the percentage of long term MSK problems to 5% below the England average by 2030 •Reducing type 2 diabetes in ethnic communities to match demographic profile of Birmingham by 2030 •Increasing targeted health checks for people with Learning Disability by 25% by 2030	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	In the Aging Well and Dying Well, BCHC is working with partners in this work. There is BCHC led engagement with diverse communities on dying well and we are involved in the End of Life Coordination Group, the Neighbourhood Scheme and the Birmingham and Solihull Dementia Interface Pathway Group. We are actively working with the West Midlands Ambulance Service to reduce the rate of emergency hospital admissions due to falls in people aged 65 and over to below the national average. On the Healthy Aging Academic Partnership, there is already a group called ARCHA (Aston Research Centre for Healthy Ageing) which may serve as this [redacted]
131	Disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	You can't force people to change nor have these checks.	Agree	Agree	Agree	Agree	Agree	Agree	How? You need more GPs and staff to encourage people to attend. Huge waiting lists or having to call back puts people off.
132	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree		Neither agree nor disagree	Strongly agree	Strongly agree	Neither agree nor disagree	Strongly agree	Agree	
133	Agree	Agree	Strongly agree	Strongly agree	Don't know	Strongly agree	Don't know	I don't know about the Thrive at work programme? Increased checks on people with disabilities could be stressful?	Strongly agree	Strongly agree	Strongly agree	Strongly disagree	Strongly agree	Don't know	I have responded 'don't know' to responses here as data could drive inappropriate behaviours. Caring for people in the right way is most important
134	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree	Disagree	Disagree	Neither agree nor disagree	Agree		Agree	Agree	Agree	Neither agree nor disagree	Neither agree nor disagree	Agree	
135	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
136	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
137	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
138	Agree	Agree	Agree	Strongly agree	Strongly agree	Agree	Don't know		Agree	Neither agree nor disagree	Strongly agree	Strongly agree	Strongly agree	Agree	
139	Neither agree nor disagree	Agree	Agree	Agree	Neither agree nor disagree	Agree	Neither agree nor disagree		Agree	Agree	Agree	Agree	Agree	Agree	
140	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	as above	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	as above
141															
142															

Rapid Health Impact Assessment (HIA) For Birmingham City Council's Health and Wellbeing Strategy

"Creating a Bolder, Healthier City 2022 to 2030"

Our vision

To create a city where every citizen, whoever they are, wherever they live and at every stage of life, can make choices that empower them to be happy and healthy.

February 2022

Background

The Birmingham City Joint Health and Wellbeing Strategy, *Creating a Bolder, Healthier City 2022-2030,* sets out the overarching proposals across the city's health and social care system to tackle growing inequalities which have been exacerbated by the ongoing COVID-19 pandemic. The strategy development has been delayed due to the pandemic. Hence it has been developed over three years with input from key individuals, stakeholder organisations and community groups who helped the public health division of the council collate areas identified as main priority themes.

The strategy is a proposal comprising of the key priority themes and their associated ambitions and actions which are anticipated to be led by the local health and social care system. These themes illustrate the complexity and diversity of the local population needs and each theme comprises of ambitions, actions, and measurable outcome to enable ownership and clear deliverables for measuring success. An overview of the strategy is in **Appendix 1**.

This Health Impact Assessment (HIA) will assist the local decision makers under the leadership Health and Wellbeing Board (HWB) to better understand and assess the health impacts on local communities and services, from the strategy's proposed ambitions and actions. The HIA can be a valuable resource in anticipating the health effects of these proposals within the strategy in the short, medium, and long-term and the results have been collated to offer recommendations for improving the local planning of services and help in managing the expectations across the system of the strategy's proposals.

The vision of the local strategy is underpinned by four key guiding principles which require strong partnership and collaboration across the local system to achieve successful delivery of the local priorities to address health inequalities across the city. These principles are;

1. Citizen driven and informed by citizens' lived experience
2. Consciously focused on reducing inequalities through promoting equality, diversity, and inclusion
3. Data and evidence informed and research-enabled action
4. Impact of COVID-19 pandemic mitigated as part of legacy work

Our Birmingham City Health and Wellbeing Board holds the strategic leadership that enables the health and care system to work together to improve the health and wellbeing of our local population and reduce health inequalities. The Board is comprised of local elected members and leaders from across the local health and social care system. The Board is tasked with safeguarding the health of all citizens across the city and to advocate for communities ensuring their voices shape the planning and delivery of services. The strategy enables the Board to fulfil its statutory functions as set out in the Health and Social Care Act 2012 as follows;

- promoting the reduction in health inequalities across the City through the commissioning decisions of member organisations
- reporting the progress of reducing health inequalities to the Cabinet and the various Clinical Commissioning Group Boards
- being the responsible body for delivering the Joint Strategic Needs Assessment for Birmingham (including the Pharmaceutical Needs Assessment)
- delivering and implementing the Joint Health and Wellbeing Strategy for Birmingham
- participating in the annual assessment process to support Clinical Commissioning Group authorisation
- identifying opportunities for effective joint commissioning arrangements and pooled budget arrangements
- providing a forum to promote greater service integration across health and social care.

Birmingham is a diverse and vibrant city with a population of 1.14 million people living across 69 wards. Birmingham is the seventh most deprived local authority in England. One in four people are aged under 18yrs old and 46% of citizens are from Non-White ethnicities and although Birmingham is a young city, the number of older adults in the city is significant. There are health inequalities within the city between many wards and population groups and between Birmingham and the rest of the West Midlands and England. For example, the mortality rate in women for deaths under 75years due to cardiovascular disease in Birmingham was 57.3 deaths per 100,000 compared to 43.4 for England and 47.0 for the West Midlands in 2017-2019).[1] Smoking attributable death rates in Birmingham were 274.8 deaths per 100,000 population compared to 250.2 for England and 249.3 for the West Midlands in 2016 and 2018).[2]

During the pandemic, COVID-19 deaths were highest among the most deprived quintile and people from ethnic minority backgrounds had a higher risk of death from COVID-19 compared with the White ethnic groups. Certain risk factors were and still are associated with an increased likelihood of severe illness and death. Prior to the pandemic, the city already had significant challenges in many of the clinical conditions that were and still are risk factors (Table 1).

Table 1. Health Risk Factors Comparing Birmingham and England

Health Risk Factors	Birmingham	England
Population 65+ yrs (%) 2020	13.1%	18.7%
Smoking Prevalence in adults (18+ yrs) 2019	14.8%	13.9%
Overweight or obese adults (18+ yrs) 2019/20	65.2%	62.8%
Birmingham Diabetes prevalence (17+ yrs) 2019/20	9.0%	7.1%
Diabetes prevalence (17+ yrs) 2019/20 Birmingham and Solihull CCG	8.7%	7.1%
People with type 2 diabetes who achieved all three treatment targets 2018/19 (Birmingham and Solihull CCG)	8.7%	7.1%
New cancer cases (per 100,000 population) 2018/19 Birmingham and Solihull CCG	436	529

This report documents the HIA as it was conducted including why it was conducted and the main findings which will form the recommendations to the HWB to enable successful delivery and help to mitigate against any negative health impacts.

1 Public Health England (based on ONS source data). 2017-19. “Mortality Profile.” Under 75 mortality rate from all cardiovascular diseases. Accessed July 28, 2021. https://fingertips.phe.org.uk/profile/mortality-profile/data#page/3/gid/1938133009/pat/6/par/E12000005/ati/302/are/E08000025/iid/40401/age/163/sex/2/cid/4/tbm/1.

2 ONS mortality file, ONS LSOA single year of age population estimates and smoking status from Integrated Household Survey/Annual Population Survey, relative risks from The Information Centre for Health and Social Care, Statistics on Smoking, England 2010. 2016-18. “Local Tobacco Control Profiles.” Smoking attributable mortality. Accessed July 28, 2021. https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132885/pat/6/par/E12000005/ati/302/are/E08000025/iid/113/age/202/sex/4/cid/4/tbm/1.

Why was the HIA performed?

The strategy public consultation was via an online 'BeHeard' survey shared across the city from 23 September 2021 to 10 December 2021. This only produced 142 responses from people aged 20 to 79 years with the highest number of responses received from those aged 45 to 59 years. Those responding to the on-line survey were largely from the White (British) ethnic background (89 respondents). Fifty-one responses (36%) were from people reporting to have a physical or mental health condition.

These figures were lower than expected compared to previous local surveys to assure us that we had adequate representation across Birmingham's population.

There was also under-representation of 0-19-year olds, over 75-year olds and other groups including non-White ethic groups. To address this poor engagement with the consultation and to ensure any potential health impact of the strategy's proposals have been comprehensively captured, focus groups were commissioned to target specific underrepresented groups and provide further qualitative feedback. This ensured we had accounted for groups who were estimated to be underrepresented in these initial consultations.

However, more than 50% of the additional planned engagement following the initial public consultation did not hold. Therefore, the HIA was conducted to understand where any positive or negative impacts would arise from the strategy and targeting specific groups who had not so far engaged.

The HIA is a decision-support tool to assist the HWB with vital information to aid evidence-based decision making and insight that drives community-led initiatives as well as building trust with our citizens. Many of our communities have expressed historic and rapidly growing mistrust of the system and apathy towards local policies and strategies which they feel do not result in any lasting change or promote sustainable and healthy communities.

Due to the new proposals consisting of the ambitions and associated actions within the strategy, we considered the need to subject the strategy to some sort of review on health impact. The HIA provides a framework and procedure for estimating the impact of a proposed programme or policy action on a defined population.[3]

We also considered the following important factors in deciding to conduct the HIA;

- The potential for the strategy's proposals to harm or improve human health and any associated consequences since the HIA can be used to predict the likely impacts of the strategy on all affected populations and population sub-groups.
- Policies rarely serve all interests equally; typically, some values are prioritised over others hence the need to seek further assurance based on the lower than expected engagement.

The HIA would broaden the local approach and could be used to not only show how the proposed strategy could impact health directly, but also indirectly through various health determinants considering the existing health inequalities within Birmingham.

The Health and Wellbeing Board is keen for the new local strategy to provide system leadership in tackling the health inequalities that existed before the COVID-19 pandemic including those that have been exacerbated as a result of the pandemic. This will mean that the system should work in partnership to identify, mitigate any consequences or potential risks from the proposed strategy proposals.

3 https://www.who.int/tools/health-impact-assessments

There are five core themes within the strategy that set out our local priorities:

1. Healthy and Affordable Food
2. Mental Wellness and Balance
3. Active at Every Age and Ability
4. Contributing to a Green and Sustainable Future
5. Protect and Detect

There are three encompassing life course themes

- Getting the Best Start in Life
- Living, Working and Learning Well
- Ageing Well and Dying Well

There are actions across these themes that have been identified, reviewed and mitigation jointly agreed to safeguard the future of the local health economy through the lifespan of the strategy from 2022 to 2030.

Who performed this HIA?

The team completing the HIA was led by the local public health team including a consultant in public health and several public health service leads supported by other council departments, academics, analysts, social researchers, voluntary organisations and other community-based organisation. The group was multidisciplinary to ensure the assessment was drawing in expertise from a range of subject specialists where needed.

The timing of the decision was key as the HIA should be started at the beginning of the strategy development process, with adequate time and resources available to support it. However, due to the constraints from the pandemic which had already delayed the strategy development, it was agreed that undertaking the HIA after the public consultation ended in December would be beneficial to the development of the strategy. This was because the consultation did not have sufficient responses and some of the responses reflected a lack of clarity and confidence about the strategy's proposals.

The strategy was still in development phase and the HIA was developed from the point when the consultation was identified as being inadequate and continued from December 2021 to February 2022 over the course of the strategy cycle. The feedback from the limited public consultation were used to scope the HIA and informed the need for changes which may be required to reassure the system and provide clarity about the strategy's proposals.

Some of the feedback has resulted in some change and others are being taken to the leadership team for their input.

The HIA process continued with some elements of it commissioned to a provider who works with seldom heard groups including those people from non-White ethnic backgrounds to ensure a wide range of perspectives were considered.

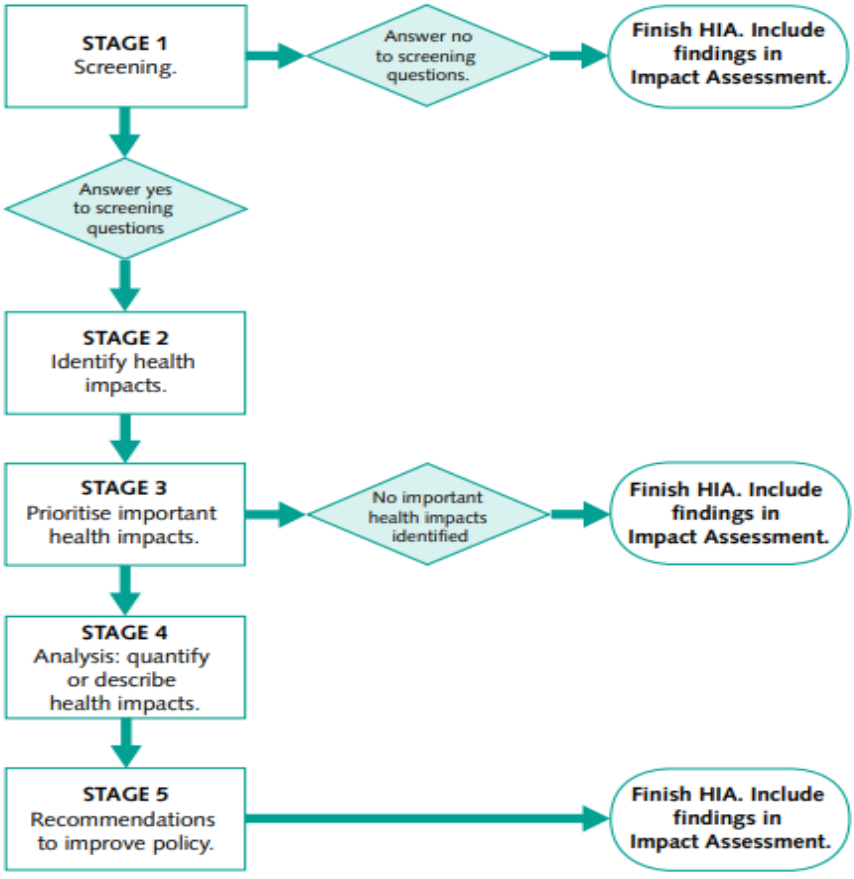
The HIA will need to be revisited with each iteration of the strategy as the strategy development progresses, to ensure that significant changes have been assessed and that these changes relate to the final strategy document.

What methods were used for the HIA?

The HIA was completed as a prospective assessment of the strategy before its implementation. The team gathered opinions and concerns regarding the proposed strategy based on the ambitions and the actions proposed to determine the expected impacts of the proposed strategy particularly on the most vulnerable and disadvantaged populations.

Participants were encouraged to describe both quantitative and qualitative health impacts as appropriate and an open and honest participatory approach was adopted. Recommendations were produced for decision-makers and stakeholders, with the aim of maximising the strategy's positive health impacts and minimising its negative health impacts. The consequences for health of all the options can then be fully considered, and the HIA can have a genuine influence on the chosen option.

The method[4] used is described below



Screening
During the screening stage, based on the feedback and outputs from the strategy online consultation survey, a HWB strategy working group was established. This group was led by the local public health governance team. The group held several meetings to discuss the strategy and agreed that the HIA would be beneficial to support the quality of the strategy and provide assurance that any potential effects on the determinants of health, health outcome and population groups had been identified. The screening resulted in a decision that the HIA was needed based on the responses to key considerations below.

4 Health Impact Assessment Tools: Simple tools for recording the results of the Health Impact Assessment (publishing.service.gov.uk)

1. Will the strategy have a direct impact on health, mental health and wellbeing?
    a. **Yes**
2. Will the strategy have an impact on social, economic and environmental living conditions that would indirectly affect health?
    a. **Yes, in particular the Contributing to a Green and Sustainable Future Theme**
3. Will the strategy proposals affect an individual's ability to improve their own health and wellbeing?
    a. **Yes, it will affect their ability to be physically active, choose healthy food, reduce drinking.**

Scoping
The second step was the planning of the HIA and identifying what health risks and benefits to consider. The HWB strategy working group developed and adopted the terms of reference for the HIA (see **Appendix 2**)**.** Scoping involved bringing together the major stakeholders of the strategy proposals led by the working group to develop the HIA. The group aimed to reduce the risk of presenting only one side of the evidence by being systematic. As the responses to the consultation were low, this HIA in addition to the focus groups will enable us to identify and make recommendations to improve positive health impacts and mitigate negative ones. The themes within the strategy were agreed and further streamlined to be used to systematically work with target groups and individuals to carry out the appraisals which are the next stage in the HIA process.

Appraisal
An appraisal is the main process for the HIA activity and due to the expectations that the strategy would be finalised within two months, we conducted a rapid appraisal rather than a comprehensive one. The appraisals were based on the HWB strategy's 5 themes and questions were developed based on the initial consultation feedback. We developed a template (see **Appendix 3**) for gathering the data and evidence, held meetings with key stakeholders involved with the communities affected. We also requested the commissioned provider to use the template at focus groups organised for the groups who had been under-represented during our initial consultations. The collated templates were analysed, and results summarised into a spreadsheet for thematic analysis. We analysed the data collected already, identified affected populations and estimated health impacts. These estimates helped us to develop recommendations for actions that promote positive health impacts and minimise negative health impacts of the proposals within the strategy.

Reporting
The results obtained are within this report to be presented to the decision-makers although some changes have already been made to the strategy based on the results and details are contained in the analysis sheet. The contents of the report include a description of the scope, the priorities identified at the beginning of the process, the views expressed by the stakeholders and the evidence available from the various sources, the overall findings and any recommendations.

Monitoring
This final step of the HIA process allows the team to evaluate the process and effectiveness of the HIA in meeting its purpose. The discussions have already begun at the working group meetings and monitoring will continue until the strategy is launched. It will involve evaluating whether the HIA has influenced the decision-making process and how this led to any changes in the strategy proposals to help us assess if the HIA has worked. The HWB may also monitor longer term to see if the predictions made during the appraisals were accurate, and to see if the health, or health-promoting behaviours of the community have improved.

What was the scope of the HIA?

The evidence gathered during the strategy development were incorporated and used to determine the scope of the HIA.

Following an initial public consultation process which had very limited engagement, it was agreed to scope the usefulness of an HIA to provide further understanding of the potential health impacts of the strategy's proposals and enable the opportunity for the local system to consider any options as recommendations to address any potential negative impacts or enhance the positive impacts from the strategy.

The HIA was agreed to be limited to the following

1. **Groups missed by focus groups:**
    - LGBT+ Groups
    - Business (any)
    - Food Business (supermarkets, restaurants, etc)

2. **Under-represented groups from online BeHeard Survey:**
    - 0-19 years olds
    - 75+ year olds
    - Asian/Asian British community
    - Black/ African/ Caribbean community
    - Vision-impaired persons
    - Muslim community

3. **Groups who required a more targeted approach for the Health and Wellbeing Strategy Consultation.**

Due to the limitations of the consultations, the HIA was focussed at addressing any potential to miss key issues including the impacts of the ambitions and actions within the strategy on the population's health.

It was agreed that the HIA could support the leadership team who had already seen the strategy in draft form and the HWB, and enable informed decision making required from across the system when the HWB strategy is eventually presented and launched.

Quality Assurance

The rapid HIA for the Health and Wellbeing strategy seeks to improve the quality of policy decisions by evaluating the likely positive and negative health impacts from the strategy's proposals and making recommendations to improve positive health impacts and mitigate negative ones. The process followed has adhered to the recognised available frameworks and our approach stresses the participation of public stakeholders and provides for a social model of health and wellbeing in which there is an explicit focus on equity, sustainability and social justice. The HIA is in line with the council's commitment to openness, public scrutiny and involvement.

Main Findings of the HIA and recommendations

Negative health impacts

Overall Strategy

- Use of a lot of jargon and too much data makes it uneasy to comprehend a lot of the information described. For example, The Healthy Planning Toolkit, Triple Zero Strategy should have some explanation on what they are and what they aim to achieve at least concisely in brackets or footnotes.
- Participants felt the strategy was ambitious and raised concerns about whether it was achievable. They felt that this may result in a negative health impact on the key priority health needs of the population, as the system may become overwhelmed.
- Participants felt there was a disconnect between some of the ambitions stated within the strategy and the reality on the ground, particularly around planning services and this may deter the use of existing resources judiciously.
- Participants felt that health inequalities were not explicitly addressed for specific ethnic groups and communities but instead were solely focussing on geographical areas across the city which could increase the inequalities gap.

Healthy and Affordable Food Theme

- Lack of emphasis on the need to determine whether people's diet changed during the pandemic or how their food affordability or food choices changed can impact negatively on behaviours towards food.

Mental Wellness and Balance Theme

- Reference to signposting for self-referral to mental health support services can create a barrier which delays uptake of support as it assumes all patients can make an informed choice.
- Lack of emphasis on the mental health of specific groups which have worsened during the pandemic may mean these groups experience deteriorating outcomes.

Active at Every Age and Ability Theme

- The cost of taking up physical activity interventions paid for by individuals themselves creates stigma and can be a major barrier to participation in physical activity which can result in poor mental and physical health.

Green Spaces Contributing to a Green and Sustainable Future Theme

- Lack of consideration for housing within the strategy. It was noted that housing, as a wider determinant of health, could certainly be given more prominence within the strategy to ensure it did not create more inequality.
- Focus on only clean air without consideration for the volume of traffic may not reduce risks to health such as increased respiratory disease from city's traffic congestion.

.

Protect and Detect Theme

- Nothing explicit was there in the ambitions especially relating to domestic violence and community safety.
- The strategy assumes vaccines are acceptable to everyone which may result in masking of the underlying variations in vaccine confidence across the city.
- Theme lacked coherence and the language was inaccessible which may result in no real health benefit and worsening of the health of the target groups particularly young people who already suffer with violence.

Positives health impacts

Overall Strategy

- Ambitions and actions offer many wide-ranging opportunities to work with communities to increase health gains particularly where there are growing inequalities due to the pandemic.
- Useful information sharing with communities to enable them consider options to support making an informed choice.
- Enables a spotlight on the impact of covid and the need to reverse the adverse health impacts on populations including most vulnerable, people with addictive behaviours who have struggled more.

Healthy and Affordable Food Theme

- Participants welcomed a focus on food literacy and basic cooking skills at a young age to reverse the negative impact of COVID-19 which has resulted in changing eating habits fuelled by isolation and dependence on takeaways and high calorific meals.
- Participants felt the strategy would improve access and affordability which are known barriers alongside people making the wrong choices.

Active at Every Age and Ability Theme

- Participants were supportive of exercise on prescription as they felt the respect felt for doctors, particularly among the older population, would encourage take up.
- Positive impact on health through reducing air pollution from the traffic on the roads Valuable that green and blue spaces became important during the pandemic

Green Spaces Contributing to a Green and Sustainable Future Theme

- The participants welcomed a focus on clean air in the whole city, not just the area covered by the Ultra-Low Emissions Zone.
- The idea of community activities and community events provides opportunity for community empowerment.
- Offer opportunity to maximise and maintain people's engagement with green and blue spaces building on from the pandemic.

Protect and Detect Theme

- Participants supported tackling the root causes of crime and efforts to divert young people away from criminal activity through youth provision.
- Promotion of COVID-19 vaccination has improved access to ethnic communities.

Recommendations

Overall Strategy

- Ensure the strategy is culturally sensitive and inclusive of all communities and ethnicities to achieve success.
- Prioritise tackling the financial barriers to health.
- Review language used to ensure it is plain English
- Involve people with lived experience from the beginning of policy and strategy development.
- Prioritise children, women, healthcare workers, people who suffer with their mental health and geographical areas with the greatest need.
- Measure success continuously as this is key by embedding annual targets into the longer-term success indicators/ambitions of the strategy wherever possible.
- Infographics need to be communicating messages concisely and precisely.
- Focus not only on geographical areas in the city and socioeconomic status, but also on the impact of prejudice and discrimination on health and wellbeing.
- Education within schools should be a priority.

Healthy and Affordable Food Theme

- Learning from social norms is key to success and requires more to understand; What type of changes have people made to their cooking? What has changed, why has it changed and how can you take changes, learn from them and adapt something new?
- Improve understanding and awareness about any issues relating to food within LGBTQ community with possible increase in eating disorders due to the isolation and mental health impact of COVID-19.

Mental Wellness and Balance Theme

- Consider support for self-referral to mental health services or tailor more training for GPs and other key professionals who signpost people to these services.
- There is scope to work with employers, charities, and universities to design workplaces around how human brains work differently in order to tackle mental health challenges in the long term.
- Educating employers about different mental health conditions could aid reduction in employment inequalities.
- Focus on increased actions to improve availability and uptake of Talking Therapies.

Active at Every Age and Ability Theme

- Include the relationship between prevalence of physical inactivity and mental health
- Incorporate inclusive spaces, for example, for physical activity to address barriers which affect groups such as woman and some groups within the LGBTQ community.
- Participants also felt that exercising as a family should be emphasised.

Green Spaces Contributing to a Green and Sustainable Future Theme

- Incorporate volume of traffic not just clean air to ensure indirect health benefits are gained.

Protect and Detect Theme

- Consider restructuring the Protect and Detect theme to separate out the unrelated topics (i.e. infectious disease, screening and violence reduction) to enable more emphasis on real change, such as stronger action needed to prevent the supply of drugs within the city and enforcement of other drug laws.
- Families and carers should be much more involved in supporting treatment plans for patients who struggle with drug and alcohol misuse.

Appendix 1

Joint Birmingham City Health and Wellbeing Strategy at a glance: 'Creating a Bolder, Healthier City (2022-2030)'

Our Shared Vision: *To create a city where every citizen, whoever they are, wherever they live and at every stage of life, can make choices that empower them to be happy and healthy.*

The vision is underpinned by four key guiding principles which require strong partnership and collaboration across the local system, with all stakeholder groups and their partners forging ahead together to achieve successful delivery.

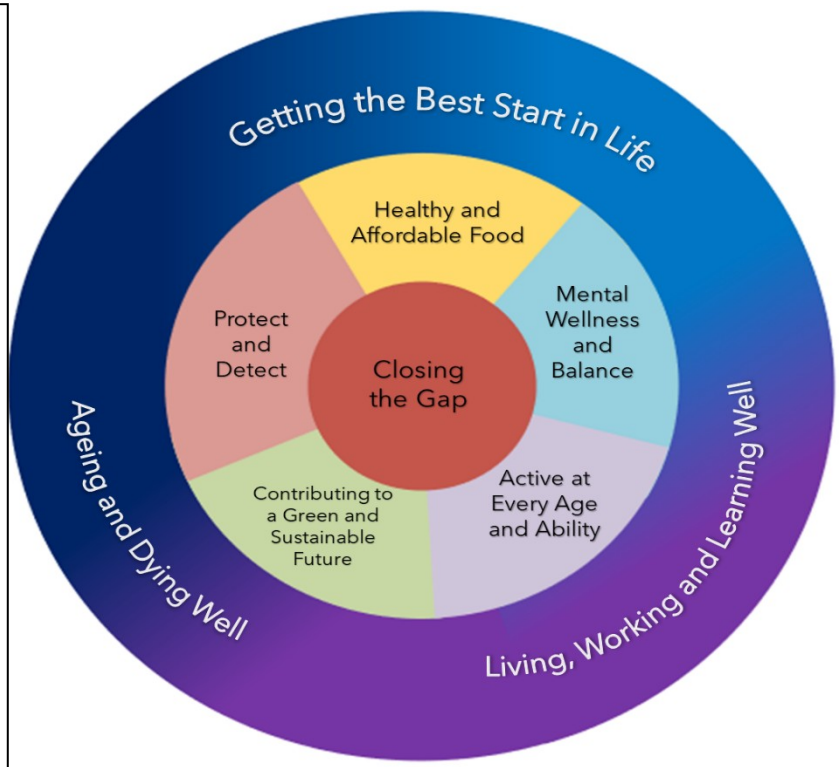
- Citizen driven and informed by citizens' lived experience
- Consciously focused on reducing inequalities through promoting equality, diversity and inclusion
- Data and evidence informed and research-enabled action
- Impact of COVID-19 pandemic mitigated as part of legacy work

There are five core themes within the strategy that set out our local priorities:

1. Healthy and Affordable Food
2. Mental Wellness and Balance
3. Active at Every Age and Ability
4. Contributing to a Green and Sustainable Future
5. Protect and Detect

There are three encompassing life course themes

- Getting the Best Start in Life
- Living, Working and Learning Well
- Ageing Well and Dying Well



Appendix 2

Scoping and Terms of Reference

Rationale
As the responses to the online consultation were low, the Health Impact Assessment in addition to the further focus groups will enable us to identify and make recommendations to improve positive health impacts and mitigate negative ones.

Health Impact Assessment Working Group
The working group comprises of the Public Health Governance Team led by the Assistant Director of Public Health and working alongside key individuals and stakeholders working across the five core themes and life course themes within the strategy. These professionals may not attend meetings however their views are sought using emails and one-to-one meetings to ensure the scope of the HIA is reinforced with as many [professional and public perspectives as possible.

Objectives

1. To capture any health issues and public health concerns identified from our consultations including factors such as the social and physical environment (i.e. housing quality, crime rates, and social networks), personal or family circumstances (i.e. diet, exercise, risk-taking behaviour, and employment), and access to public services.
2. To gather data on health impacts and analyse them within the five core and three life course themes to estimate the potential for positive or negative health impacts.
3. To determine who will be affected by the strategy proposals within each theme and assess the need for further review of baseline data on current population health need.
4. To make predictions where possible, about any likely changes in health status of the affected groups, as a result of the strategy.
5. To agree any changes or update to the strategy proposals that would support positive health impacts and mitigate negative health impacts and present to decision makers.
6. To consider the use of rapid or in-depth assessment procedures depending on limitations of time, budget and epidemiological/quantitative evidence.
7. To agree conclusions which can be drawn from available data, and recommendations made that might remove/mitigate negative impacts on environment and health and enhance positive benefits.
8. To decide any action, where appropriate, that can be taken to monitor the actual impacts on health and enhance the existing evidence base regarding impacts.

Timescale: 2 months

Key Outputs: Rapid Health Impact Assessment Report and Updated Health and Wellbeing Strategy

Appendix 3

Rapid Health Impact Assessment Questionnaire used for each theme of the Health and Wellbeing Strategy (*'Creating a Bolder, Healthier City')*

Questions	Comments
THEME: **IDENTIFY THE HEALTH IMPACTS** • *Describe any potential impacts on health from this theme?* • *In your opinion what impact has COVID-19 had on this theme?*	
THEME AMBITIONS • *Are there any potential positive health impacts?* • *Are there any potential negative health impacts?* • *If yes to both positive and negative impacts, which population groups will be impacted and how?* • *Do you feel that the negative impacts can be mitigated? If yes, what suggestions do you have to mitigate these?*	
THEME ACTIONS • *Are these actions relevant to the ambitions?* • *Will these actions help to address the existing health inequalities and address any negative health impacts?* • *Is there clarity within the actions about WHO, WHEN and WHAT is to be achieved?*	
Measuring Success • *In your opinion would it be beneficial for the strategy to focus on long-term or short-term goals to achieve success?* • *Do you have any other suggestions / comments about other priorities to include in the Strategy?*	

Title of proposed EIA	Birmingham Joint Health and Wellbeing Strategy: Creating a Bolder, Healthier City (2022-2030)
Reference No	EQUA863
EA is in support of	New Strategy
Review Frequency	Annually
Date of first review	21/02/2023
Directorate	PIP
Division	Public Health
Service Area	Governance
Responsible Officer(s)	☐ Aidan Hall
Quality Control Officer(s)	☐ Shiraz Sheriff
Accountable Officer(s)	☐ Albert Uribe
Purpose of proposal	Health and Wellbeing Boards must publish a Joint Health & Wellbeing Strategy under the Health and Social Care Act 2012. This proposal assesses the new Strategy; Creating a Bolder, Healthier City (2022-2030), against the legally protected characteristics.
Data sources	Survey(s); Consultation Results; Interviews; relevant reports/strategies; Statistical Database (please specify); relevant research
Please include any other sources of data	Fingertips, LG Inform

ASSESS THE IMPACT AGAINST THE PROTECTED CHARACTERISTICS

Protected characteristic: Age	Service Users / Stakeholders; Wider Community
Age details:	The overall impact of the Strategy is likely to be positive for all age groups. The life course recognises it is appropriate to ensure children get the best start in life and age healthily. The Strategy outlines 22 ambitions within the life course themes and a series of actions to deliver better outcomes for all ages. Certain age groups may be more affected by some of the five core themes, for example young people and Creating a Green and Sustainable Future (theme 4). However, the ambitions and associated actions (e.g. reducing air pollution) will positively impact this group. Respondents to the

impact this group. Respondents to the consultation varied by age, and an additional focus group with young people (aged 14-19) was commissioned to understand the views of this population. The survey and focus groups found no adverse impact on this protected characteristic.

Protected characteristic: Disability	Service Users / Stakeholders; Wider Community
Disability details:	A disability is 'a physical or mental impairment which has a long-term and substantial adverse effect on the ability to carry out normal day-to-day activities'. Many people in Birmingham have a disability or long-term condition. This Strategy will focus on 'Closing the Gap' and reducing inequalities and should therefore deliver benefits for people with a disability. One of the five areas of focus for the Board is to reduce inequalities experienced by the disabled community. There are also specific ambitions that will positively impact this characteristic. This includes reducing the inactivity gap between those living with disabilities and long-term health conditions and those without and increasing the number of targeted health checks (e.g. for people with learning disabilities and/or severe mental health issues). The various methods of consultation found no adverse impact on this protected characteristic.
Protected characteristic: Sex	Service Users / Stakeholders; Wider Community
Gender details:	We expect the overarching goal of '*Closing the Gap*' will address inequalities based on this characteristic. Women make up a disproportionate amount of our carers, and men make up a disproportionate amount of those experiencing homelessness in Birmingham. In tackling these inequalities, improving the social determinants of health, and

	supporting those communities of identity and experience, we can positively impact this characteristic through this Strategy.
Protected characteristics: Gender Reassignment	Service Users / Stakeholders; Wider Community
Gender reassignment details:	Data on the transgender population in England is limited because the subject is not included in the 2011 Census. The 2021 Census (results not published at the time of completing this assessment) does include a question asking: "*Is the gender you identify with the same as your sex registered at birth*?". The best current estimate is that around 1% of the population might identify as transgender, including people who identify as non-binary. We know that this community face significant health inequalities throughout their lives, and this Strategy's mission to close the gap will have a positive impact. This includes furthering the understanding of these inequalities and addressing them as a partnership. Our consultation included a Health Impact Assessment (HIA) to understand the potential health effects of the Strategy on the LGBT+ community. The HIA, alongside our survey, found no adverse impact on this protected characteristic.
Protected characteristics: Marriage and Civil Partnership	Not Applicable
Marriage and civil partnership details:	
Protected characteristics: Pregnancy and Maternity	Service Users / Stakeholders; Wider Community
Pregnancy and maternity details:	The Strategy is likely to have a positive impact on this group. The life course approach recognises the importance of upstream factors to support people from pre-conception to age healthily. This starts before birth; therefore supporting people in this group will help us close the gap in health inequalities such as infant mortality.
Protected characteristics: Race	Service Users / Stakeholders; Wider

Community

Race details:

According to the 2011 Census, the Black and Minority Ethnic (BME) Population (population whose ethnicity is not White) was 42.1%. The same value for England is 14.6%. There is a range of national evidence on the health and wider inequalities affecting ethnically diverse groups. For example, people from ethnic minority groups are more likely than those from the White British group to report having long-term illnesses and poor health. This Strategy commits to tackling inequalities between ethnic communities and will positively impact this characteristic. Our Strategy signposts to work such as the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) project. In addition to our Be Heard Survey, we commissioned focus groups to ensure we had views from minority ethnic communities. The survey and focus groups found no adverse impact on this protected characteristic. This Strategy will improve our understanding and evidence of inequalities and respond to them.

Protected characteristics: Religion or Beliefs

Service Users / Stakeholders; Wider Community

Religion or beliefs details:

The interaction between faith, religion, and health is complex, reflecting the role that faith plays in our health beliefs and behaviours and the impact of religious rules on aspects of our lives, such as food and physical activity. There is limited evidence on inequalities linked to faith and religion. In addition to our Be Heard Survey, we commissioned focus groups to ensure we had views from faith communities. We also conducted a Health Impact Assessment to understand the potential health effects of the Strategy on a particular faith community. The survey and focus groups found no adverse impact on this protected

	characteristic. This Strategy will improve our understanding and evidence of inequalities and respond to them.
Protected characteristics: Sexual Orientation	Service Users / Stakeholders; Wider Community
Sexual orientation details:	The Birmingham Public Health Division estimate the LGBT+ population of Birmingham to be approximately 45,000 adults. There is strong epidemiological evidence that members of the community face significant health inequalities throughout their lives. Our consultation included a Health Impact Assessment (HIA) to understand the potential health effects of the Strategy on the LGBT+ community. The survey and HIA found no adverse impact on this protected characteristic. This Strategy will improve our understanding of these inequalities and address them as a partnership.
Socio-economic impacts	
	This Strategy will tackle the wider determinants of health and therefore have a positive socio-economic impact. It is well understood that health and disease are predominantly the result of the wider determinants of a person's life, rather than their genetics or age. Factors such as poverty, education, housing, employment and the environment in which we live, work and play all impact on our health and wellbeing.
Please indicate any actions arising from completing this screening exercise.	
Please indicate whether a full impact assessment is recommended	NO
What data has been collected to facilitate the assessment of this policy/proposal?	
Consultation analysis	
Adverse impact on any people with protected characteristics.	
Could the policy/proposal be modified to reduce or eliminate any adverse impact?	

Could the policy/proposal be modified to reduce or eliminate any adverse impact?	
How will the effect(s) of this policy/proposal on equality be monitored?	
What data is required in the future?	
Are there any adverse impacts on any particular group(s)	No
If yes, please explain your reasons for going ahead.	
Initial equality impact assessment of your proposal	
Consulted People or Groups	
Informed People or Groups	
Summary and evidence of findings from your EIA	*Creating a Bolder, Healthier City (2022-2030)* is expected to have a strong positive impact on inequalities through the aim of '*Closing the Gap*'. Through the findings from the consultation and developing the Strategy with professionals and the public, we do not predict adverse impacts on any of the protected characteristics. The Strategy is a commitment of the Health and Wellbeing Board to equality, diversity and inclusion. These values are at the centre of our ambitions, actions and leadership across the five core themes and life course.
QUALITY CONTORL SECTION	
Submit to the Quality Control Officer for reviewing?	No
Quality Control Officer comments	The EIA carried out has looked into all aspects that will not adversely impact the protected characteristics of the aforementioned groups and hence can proceed forward.
Decision by Quality Control Officer	Proceed for final approval
Submit draft to Accountable Officer?	No
Decision by Accountable Officer	Approve
Date approved / rejected by the Accountable Officer	24/02/2022
Reasons for approval or rejection	
Please print and save a PDF copy for your records	Yes

Content Type: Item
Version: 28.0
Created at 21/02/2022 02:08 PM by Aidan Hall
Last modified at 24/02/2022 05:12 PM by Workflow on behalf of Albert Uribe

Close

Birmingham Health and Wellbeing Board

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22nd March 2022**
TITLE:	**THE DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2020/21**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney**

Report Type:	**Information / Approval**

1. Purpose:

1.1 The Director of Public Health (DPH) has a duty to write an independent evidence-based annual report detailing the health and wellbeing of our local population.

1.2 The Annual Director of Public Health Report for 2020/21 reflects the journey of Birmingham City through the COVID-19 pandemic, providing insights and recommendations for the health of the population.

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 It is recommended that the Health and Wellbeing Board:

- Note the contents of this report.
- Provides feedback on this report.
- Agrees to support the identified recommendations of the report.
- Approves the Annual Report for publication.

4. Report Body

4.1 Background

The report builds a narrative to show case the context of COVID-19 on the lives of the people in Birmingham City impinging upon their health, relationships and society utilising data from

- Hospital admissions and deaths
- The COVD-19 Health and Wellbeing Impact Survey
- Ethnographic research with 12 Birmingham residents
- Highlight reports from the Public Health Data Cell and Birmingham Test and Trace

4.2 Summary of Key Issues

The report draws attention on how the impact was uneven, affecting people differently and recommends why it is important to acknowledge pre-existing health inequalities in closing the gap when planning our recovery from the pandemic.

Mitigation strategies should also focus upon mental wellbeing, long- term impacts of COVID-19 and reducing the drivers of inequality in COVID-19 case rates and mortality.

4.3 Recommendations

The recommendations from this report will be used alongside the Joint Strategic Needs Assessment (JSNA) and local intelligence to inform local policymaking that can influence the wider determinants of health.

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

5.2	Management Responsibility
	Dr Justin Varney, The Director of Public Health Dr Shiraz Sheriff, Service Lead in Governance

6.	Risk Analysis		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Partners do not implement the report recommendations	Medium	Medium	Ensure recommendations are embedded into the action plans underpinning the themes in the Health and Wellbeing Board Strategy as part of mitigating the legacy of Covid-19.

Appendices	
Appendix 1	The Director of Public Health Annual Report for 2020/21 – 'The Year I Stopped Dancing'

The following people have been involved in the preparation of this board paper:
Dr Justin Varney, Director or Public Health
Dr Julia Duke-Mcrae, Consultant in Public Health
Dr Mary Orhewere, Assistant Director in Public Health
Dr Remi Omotoye, Service Lead (Test and Trace)
Dr Shiraz Sheriff, Service Lead (Governance)
Aidan Hall, Senior Programme Officer (Governance)
Avneet Matharu, Senior Programme Officer (Governance)
Alexander Quarrie-Jones, Programme Officer (Governance)
Dawn Hannigan, Support Officer (Governance)

Director of Public Health

Annual Report 2021

COVID-2019: 'The Year I Stopped Dancing'

December 2021

Making a positive difference every day to people's lives

Birmingham City Council

Contents

1. Foreword

Cabinet Member for Adult Health and Social Care

It has truly been a difficult 18 months as we have all battled with the impact and devastation of the Covid-19 pandemic. We are still battling to protect our citizens, specifically our older citizens and those with underlying health conditions which leave them more susceptible to hospitalisation.

Birmingham pre-Covid19 already had significantly high health inequalities, with a 10-year gap in life expectancy in some of our inner-city areas compared to our more affluent outer city areas. During the early stages of initial lockdown, we were not aware that some of our communities had higher risk rates, which made them more vulnerable to the virus and therefore at a higher risk of serious illness and death than other communities. Many of these communities worked in our frontline services health, social care, education and the hospitality sector and some lived in intergenerational households which contributed to the spread of the virus.

In response to the concerns being raised in our black and minority ethnic local communities, I organised a Health and Wellbeing Board. There was an overwhelming number of questions and worries that came in for consideration which our local health professionals and Director of Public Health responded too. Following this, a letter was sent to the Health Minister and shortly afterwards a national review took place to investigate the effects of Covid on our BAME communities.

There are many lessons the Government, our health service and local authorities need to learn from. In the event of there being a similar virus threat in the future; we need to ensure we are able to quickly and effectively respond to crucially save lives. We will continue to deal with the effects of this pandemic for some time. Our health professionals are still grappling with the consequences and health implications of long Covid, post-traumatic stress and a rise in mental health issues. There is also the impact on education, the economy and those who are struggling financially continues to increase. Evidence has shown that an increase in physical inactivity which needs to be addressed.

The Covid-19 vaccine was a very positive step forward to respond to the pandemic and the booster vaccine rollout is going well. However, vaccine hesitancy and new variants emerging which are more transmissible and deadly pose a significant risk to recovery. There is a need for Government, the NHS and local authorities to identify social media strategies to effectively

respond to those spreading misinformation and mistruths on vaccinations which has significantly contributed to vaccine hesitancy. I would like to urge everyone who is eligible to take the vaccine to protect themselves, their loved ones and their communities.

I would like to thank all our front-line workers, our faith and third sector communities and volunteers who have all stepped up to support our most vulnerable citizens to ensure they were safe, had access to food and were supported. During the dark times, they really emerged as our true heroes.

Paulette Hamilton

Councillor Paulette A Hamilton
Cabinet member for Adult Social Care and Health
Chair Birmingham Health and Wellbeing Board

Director of Public Health

In December 2019 I was called to an urgent briefing by Public Health England to be told about the first signs of a new strain of coronavirus in China. By February 2020 this new virus had spread to large outbreaks in Iran**,** Italy, and large regions of China and then in March the first case was confirmed in Birmingham.

What followed has been perhaps the most significant challenge to Birmingham since the World Wars. We have lost more citizens to Covid in the last year than to the World War 2 blitz bombing of the city. The impact of Covid has fallen hardest on our most disadvantaged communities through a combination of employment-related exposure, poor baseline health and more challenging living circumstances. Over the last year we have experienced a roller coaster of rising and falling case rates, hospitalisation, and death. The pressure on communities, businesses, education settings, the voluntary and public sector has been immense. It is only because of the strength of partnership and collaboration across the City that we have avoided an even greater loss of life.

Through this report are woven the voices and images of citizens and their lived experiences during the pandemic. It has been important to capture these experiences as we went through the pandemic so they could inform and shape our response. We have used creative arts as well as surveys and community researchers to capture these experiences and I hope they will provide a lasting history of the pandemic as well as their value in real-time as they shaped our response.

I am humbled to have stood alongside so many leaders in our communities working together to protect citizens from the pandemic. There have been many moments where humanity and compassion have been at the heart of our response. Examples such as the universities who came to our aid in the Spring 2020 manufacturing field hand sanitiser for social care, the Council working with the food banks of the City and BCVS to supplement food stocks and coordinate supplies between different parts of the city, to the faith leaders from our Masjids, Temples, Gurdwaras and Churches who have co-produced guidelines and supported the spiritual resilience of the city, Environmental Health Officers and members of West Midlands Fire Service who went door to door offering support and advice to those isolating to ensure they were safe and supported, and our elected members and politicians who set aside political differences to jointly lobby to the support and help as a City we needed. I am also grateful to the hundreds of Covid Community Champions and our Community Engagement Partners who answered our call to volunteer and help us raise understanding and awareness in

communities, their wisdom and advice have helped keep us authentic in our response and approach to support citizens.

I want to pay a special note of thanks to the Public Health Teams of Birmingham City Council and West Midlands Public Health England, it has been a privilege to work alongside these teams who have battled day and night over the last 18 months to support our response. From developing local guidelines, attending hundreds of community meetings to answer questions and share information, contact tracing and following up with citizens to ensure they have the information to protect themselves and their families, producing detailed daily data reports, supporting schools and universities to manage outbreaks and working with care homes to protect their residents. They have been every bit as important as the doctors and nurses in our pandemic response, and I am grateful for their professionalism and their fortitude.

The list of those who should be thanked is long and many will be invisible to most of us as they worked quietly and diligently to protect us. To them, as citizens of Birmingham, we all owe a huge debt of gratitude.

Now, as we move into a world in which we live with Covid-19 with the benefit of safe and effective vaccines, we must reflect on the journey we have taken and respond to the legacy of Covid.

The impact of the deaths and disability caused by the disease itself and the impacts of the restrictions that have saved lives but have also affected mental wellbeing, education and employment.

We must address the inequalities that disadvantage so many communities across the City. Coming into the pandemic we had a 10-year life expectancy gap within the City, high levels of diabetes, cardiovascular disease, obesity and low levels of health literacy, these all made our communities more vulnerable to the threat of infectious disease and we must reduce these vulnerabilities for the future.

So we must learn from the challenges and experiences of the pandemic and our response, we must move forward and rebuild better, being bold in our ambition to address the inequalities that disadvantaged so many of our citizens in the face of the pandemic, and we must prepare because sadly another pandemic will come at some point again and we must be ready.

Dr Justin Varney

Director of Public Health

Birmingham City Council

2. Purpose

The core purpose of the role of the Director of Public Health (DPH) is independent advocacy for the health of the population and system leadership for its improvement and protection".[1] The DPH annual report provides insight and recommendations on the health of a population. It is used alongside the Joint Strategic Needs Assessment (JSNA) and local intelligence to inform local policymaking that can influence the wider determinants of health. The 2020/21 DPH annual report reflects on the journey of Birmingham through the coronavirus (COVID-19) pandemic.

Quantitative and qualitative data from research conducted throughout the pandemic tell the story of the crisis. There is a focus on the experiences of Birmingham's citizens, the inequalities that have been exposed and exacerbated, as well as the overall impact on the city's population.

There are four main sources for the data used to inform and produce this report:

1. **COVID-19 cases, hospital admissions, deaths, and vaccinations.**

   This includes data from NHS England, the UK Government Coronavirus Dashboard[2], Public Health England Covid-19 Situational Awareness Explorer[3], Birmingham and Solihull (BSol) Clinical Commissioning Group (CCG), Birmingham Community Healthcare NHS Foundation Trust, Birmingham Women's and Children's NHS Foundation Trust, Sandwell and West Birmingham Hospital NHS Trust and University Hospital Birmingham NHS Foundation.

[1] ADPH, "Current Directors of Public Health," September 2021. [Online]. Available: https://www.adph.org.uk/current-directors-of-public-health/. (Accessed: 15 November 2021).

[2] Official Coronavirus (COVID-19) disease situation dashboard: Vaccinations. [Online]. Available: https://coronavirus.data.gov.uk/ (Accessed: 17 November 2021).

[3] PHE COVID-19 Situational Awareness Explorer. [Online] (Downloaded: 18 November 2021).

2. COVID-19 Health and Wellbeing Impact Survey (22nd May until 31st July 2020). [4]

The COVID-19 Impact Survey had 3,095 respondents. Compared with the city's census-based profiles[5], respondents were more likely to be older, white, female and report no religion. Compared with national estimates, there was a slightly higher representation of lesbian, gay and bisexual respondents, and disabled respondents. The geographical distribution of responses across Birmingham was varied. The highest participation was from the following wards: Longbridge and West Health, Brandwood and Kings Heath, and Bournville and Cotteridge. The lowest participation was in the following wards: Tyseley and Hay Mills, Lozells, and Bordesley Green (See Appendix B, Table 17).

3. Ethnographic research with 12 Birmingham residents.[6]

This commissioned study was completed by Humankind Research. Focusing on the stories of 12 citizens, it describes their unique experience of the pandemic in Birmingham, highlighting inequalities, support needs and engagement with public services. More information on the participants can be found on the following page. All identifiable information has been changed, including the names of participants.

4. Highlight Reports from the Public Health Data Cell and Birmingham Test and Trace.[7]

The Public Health Division has prepared regular reports highlighting the various COVID-19 related indicators and tracking the pandemic. This includes daily and weekly reporting on cases, deaths and associated health inequalities.

[4] J. Varney, "Initial findings from Covid19 Health & Wellbeing Impact Survey," August 2020. [Online]. Available: https://birmingham.cmis.uk.com/birmingham/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=yvZpCRcz3Ml85R9bK3lHnG9SpGWX9Q%2Flf3M3fXWhzdmPehkZWibWfA%3D%3D&rUzwRPf%2BZ3zd4E7Ikn8Lyw%3D%3D=pwRE6AGJFLDNlh225F5QMaQWCtPHwdhUfCZ%2FLUQzgA2uL5jNRG4jdQ%3D%3D&mCTIbCubS. (Accessed 15 November 2021).

[5] Office of National Statistics/Birmingham City Council. [Online]. Available: https://www.birmingham.gov.uk/downloads/file/4564/2011_census_birmingham_population_and_migration_report pdf (Accessed: 15 November 2021).

[6] Humankind Research, "Ethnographic research into the impact of COVID-19 on Birmingham," 2020.

[7] Public Health Data Cell and Birmingham Test and Trace Reports.

Ethnographic Research Participants[6]

Claire

25 years old

Unemployed since Dec. 2019, seeking career in graphic design

Lives with parents

Uses Universal Credit

John

34 years old

Sexual health nurse Deployed to Covid ward

Has had Covid

Lives with parents

Family in Zimbabwe

Guy

18 years old

Finished A-levels during first lockdown

Started uni in Sept.

Mum recently diagnosed with brain tumour

Barbara

83 years old

Lives alone

Has age-related macular degeneration & rheumatoid arthritis

Dee

41 years old

Credit controller

Single, lives alone

Contracted Covid in March 2020

Kim

17 years old

Lives with parents, sister and grandma

At school: started year 13 in Sept 2020

Flo

45 years old

Separated from husband but still lives with him for financial reasons

Has 20-year-old daughter

Beautician – was furloughed

Sami

49 years old

Algerian

Self-employed delivery driver

Lives with wife (has adult child)

Uses Universal Credit

Nadhiya

39 years old

Unemployed

Single parent of 4

Youngest son has major health issues and was required to shield

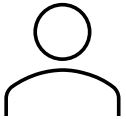
Joy

56 years old

Diagnosed 2018 with CLL and has neuropathy

On shielding list

Married to NHS logistics worker; 3 adult children



Greg

42 years old

In a relationship but lives alone

Was furloughed from job in travel March onwards

Leanne

27 years old

Project manager in clinical investigations

Lives with partner

Spanish

3. COVID-19: A global crisis with a local impact

The National and International Context

COVID-19 was identified in China in December 2019. The World Health Organisation (WHO) declared a global health emergency at the end of January 2020 because of the rapid escalation of case numbers in China.

The outbreak spread to Italy and Iran in the early part of 2020 and then across Europe, Africa, and South America.

The first cases of UK transmission were reported in England in February 2020. Case rates increased quickly in England.

In early March 2020, the UK Government started to issue advice to stop non-essential travel and contact. At the end of March, the first lockdown was announced. The Coronavirus Act 2020 was published, bringing into law on the 26th March the national lockdown measures to stay at home and protect the NHS from overwhelming demand.

In the following 12 months, society re-opened and then lockdown measures were re-introduced, locally, regionally and nationally. Restrictions were primarily driven by the need to contain the spread of new variants of the virus (Figure 2).

Testing technology evolved through the pandemic, and there was limited access to diagnostic testing in the first wave. It was likely that the data reflected the tip of the pandemic iceberg, which was later evidenced by the number of excess deaths during this period (Figure 13) and the impact on care homes (Figure 15). By the summer of 2020, testing for symptomatic individuals was expanded and accessible to more people. Still, only in 2021, the large-scale role out of asymptomatic testing was possible with rapid home testing kits.

As scientific understanding of virus transmission improved, guidelines were updated on measures to reduce spread. This included the introduction of face coverings in public enclosed spaces and on public transport. In the early days of the pandemic, there was little evidence of

transmission from asymptomatic people (people who do not have symptoms).[8] However, it became clear that those without symptoms could transmit the virus.[9]

From the start of the pandemic, it was clear that the restrictions introduced to prevent the spread of COVID-19 and protect us also had implications for daily life. Support was required to help workplaces, services, and communities operate within the restrictions to limit the spread of the virus. The restrictions also had financial, relational and health implications on individuals. By early summer 2020, evidence emerged to support our understanding of this impact, including mental health. This included the Centre for Mental Health report on understanding inequalities and mental health during the pandemic.[10] The evidence and recommendations influenced the commissioned ethnographic research to understand the impact on Birmingham's citizens.

In December 2020, the first vaccines were released in the UK, and the national vaccination programme started in earnest. The vaccines offer safe and effective protection from severe illness and death from COVID-19. The vaccination programme allowed the UK Government to create the road map out of lockdown, which reached its final stage on the 19th July 2021. Many of the legislative restrictions were removed at this stage.

The learning from the COVID-19 pandemic is ongoing. What we know now has been highlighted through the impact of inequalities on health outcomes in the UK. All ethnic minority groups (other than Chinese) had a higher rate of COVID-19 cases than the White ethnic population for both males and females.[11] Despite making up less than 14% of the UK

[8] UK Research and Innovation. Can infected people without symptoms transmit coronavirus [Online]. Available: https://coronavirusexplained.ukri.org/en/article/und0006/ (Accessed 17 November 2021).

[9] Nature. What the data say about asymptomatic COVID infections. [Online]. Available: https://www.nature.com/articles/d41586-020-03141-3 (Accessed: 17 November 2021).

[10] L. Allwood and A. Bell, "Centre for Mental Health: Covid-19: understanding inequalities in mental health during the pandemic," June 2020. [Online]. Available: https://www.centreformentalhealth.org.uk/sites/default/files/2020-06/CentreforMentalHealth_CovidInequalities_0.pdf. (Accessed 16 November 2021).

[11] Office of National Statistics. Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England and Wales: deaths occurring 2 March to 28 July 2020. [Online]. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/deathsoccurring2marchto28july2020 (Accessed 29 November 2021).

population, Black, Asian, and minority ethnic groups accounted for 19% of deaths in hospitals and 35% of critical care admissions following COVID-19.[12]

Individuals from ethnic minority groups are more likely to work in occupations with a higher risk of COVID-19 exposure, including frontline workers, and are more likely to use public transportation to travel to their essential work.[13] In England, due to underlying pre-existing health conditions, people of South Asian ethnic backgrounds had a higher prevalence of cardiovascular diseases and diabetes which are associated with increased COVID-19 mortality.[13] The risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members from ethnic minority groups, including living in multigenerational households.[11]

The findings mentioned above reveal the COVID-19 impact on health outcomes at a national level. Birmingham follows a similar pattern as the city faces high levels of deprivation and rich ethnic minority populations.

In the summer of 2021, the nation moved into a period of learning to live with coronavirus. This focused efforts on increasing the protection of citizens through vaccination to prevent further loss of life and protect essential services such as the NHS and children's education.

The Birmingham Context

Birmingham's first case was confirmed on 5th March 2020, and case numbers in the city rapidly escalated. The peak of cases, hospitalisations, and deaths in the first wave came in Easter 2020. However, there have been several subsequent peaks and troughs as the pandemic has surged again and again throughout our city.

Entering the pandemic, Birmingham already had significant health inequalities. Although it was less understood at the start, many of our communities had high rates of the risk factors for exposure and a higher risk of death and severe illness.

A more significant proportion of our population worked in roles that remained frontline and active during the pandemic. In 2019, 15.7% of all employees in Birmingham worked in human

[12] Department of Health and Social Care (DHSC) and the Office for National Statistics (ONS) 2020. (COVID-19 Daily Deaths.) [Online]. Available: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/ (Accessed 29 November 2021).

health and social care activities, compared with 13.1% nationally. Furthermore, 10.3% worked in education, compared to 8.7% nationally.[13]

Living conditions, particularly overcrowding, played a significant role in transmission. We often saw households rapidly become infected once one case was confirmed. In the 2011 Census, Birmingham had 9.1% of households classified as overcrowded compared to 4.8% across England and 4.6% across the West Midlands region.[14]

Certain risk factors were and still are associated with an increased likelihood of severe illness and death. Although Birmingham is a young city, the number of older adults is significant. The city already had significant challenges in many of the clinical conditions that were and still are risk factors (Table 1).

At the start of the pandemic, it was predicted that in the worst-case scenario, there could be as many as 9,000 lives lost in Birmingham in the first wave. Up until the 1st October 2021, the total number of deaths (people whose death certificate mentioned COVID-19 as one of the causes) was 3,020. This is a significant loss to the city and one that will resonate for years to come. It is also a testament to the hard work of many in keeping this loss far lower than predicted.

[13]Office of National Statistics. [Online]. Available: https://www.nomisweb.co.uk/reports/lmp/la/1946157186/report.aspx#tabempocc (Accessed: 17 November 2021).

[14] Office of National Statistics/Birmingham City Council. [Online]. Available: https://www.birmingham.gov.uk/downloads/file/9752/2018_ks403_rooms_bedrooms_and_central_heating (Accessed: 17 November 2021).

Table 1. Health Risk Factors Comparing Birmingham and England[15]

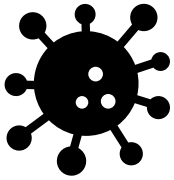
Health Risk Factors	Birmingham	England
Population 65+ years (Count) 2020	149,412	12,508,638
Population 65+ years (%) 2020	13.1%	18.7%
Smoking Prevalence in adults (18+ years) 2019	14.8%	13.9%
Overweight or Obese adults (18+ years) 2019/20	65.2%	62.8%
Birmingham Diabetes prevalence (17+ years) 2019/20	9.0%	7.1%
Diabetes prevalence (17+ years) 2019/20 Birmingham and Solihull CCG	8.7%	7.1%
People with Type 2 Diabetes who achieved all three treatment targets 2018/19 Birmingham and Solihull CCG	8.7%	7.1%
Coronary Heart Disease prevalence (all ages) 2019/20	2.7%	3.1%
Chronic kidney disease (CKD) prevalence (18+ years) 2019/20	3.8%	4.0%
New cancer cases (per 100,000 population) 2018/19 Birmingham and Solihull CCG	436	529

[15] PHE Fingertips. [Online]. Available: https://fingertips.phe.org.uk/ (Accessed: 17 November 2021).

Birmingham's Pandemic on a Page

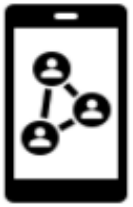
887,745

People tested for COVID-19 up to 30th September 2021.[7]



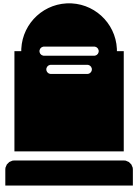
159,273

Confirmed cases of COVID-19 up to 30th September 2021.[2]



18,782

Cases followed up by Birmingham City Council contract tracing teams.[7]

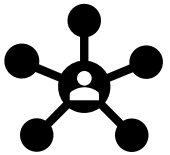


3,020

Deaths where COVID -19 was recorded on the death certificate up to 1st October 2021.[12]

681,788

First doses of COVID-19 vaccine given to Birmingham residents aged 16+ (67.5% of the eligible population), with 622,731 (61.7%) of second doses up to 23/12/2021.[2]



795

Covid Community Champions and 19 community engagement partners working with over 30 different targeted communities.[7]

The Numbers

The COVID-19 pandemic has highlighted the need for accurate and timely intelligence, enabling the response to save lives. The first wave saw a peak of cases in April 2020, the second in January 2021, and the third in July 2021. Sadly, some people were admitted to the hospital, and many tragically lost their life. This section outlines the impact of the pandemic with a focus on testing, cases, hospital admissions and deaths.

Testing

Access to testing evolved throughout the pandemic as new testing kits became available. National policy on testing was developed to respond to the emerging science around transmission between asymptomatic people. There was an initial focus on testing individuals in hospital with symptoms in March 2020. This was then expanded to healthcare professionals over spring 2020 and then, as laboratory capacity expanded (to process the swabs), to symptomatic people using PCR (polymerase chain reaction) testing kits by the summer of 2020.

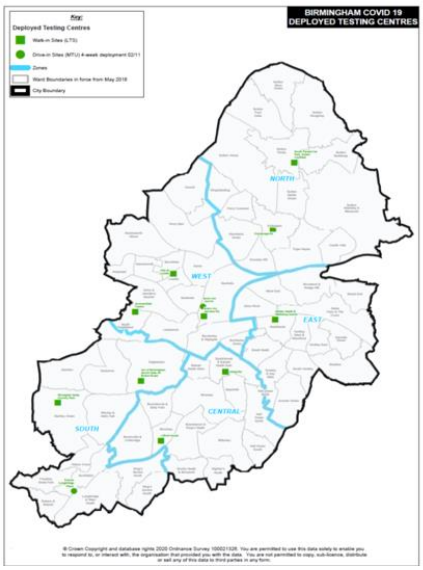
Birmingham established its first PCR testing site in December 2020. It worked with the Department of Health and Social Care (DHSC) to create a network of a further nine walk-through sites and two drive-through locations (Figure 1). Sites were spread across the city to ensure most of the population were within easy reach of testing. In the autumn of 2020, the new LFD (lateral flow device) became available in large numbers. This enabled rapid results for the testing of asymptomatic people.

These tests were obtained through drive-in/walk-in stationary and mobile testing sites and subsequently via a national postal kit service.

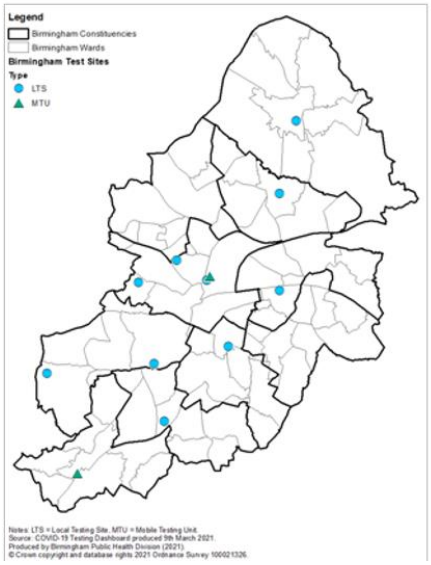
This shift in testing reduced the need for static PCR testing sites. Over the summer of 2021, many of these sites were stood down as the national postal testing service could not cope with demand. However, a contingency of mobile sites remains for deployment into hot spots of outbreaks, such as Operation Eagle.

Figure 1. Deployed Testing Centres in Birmingham (2020-2021)[7]

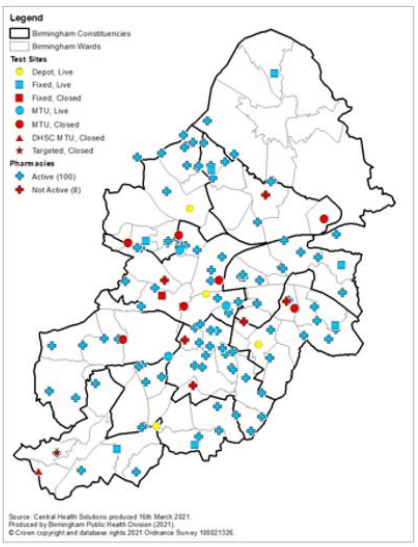
Test sites by Status and Type as at 7th December 2020



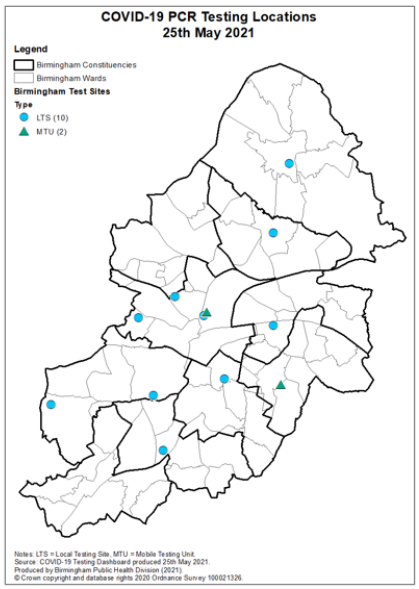
PCR Testing Locations at 16th March 2021



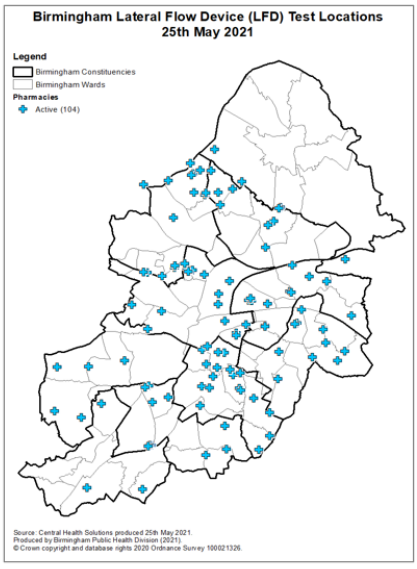
LFD Testing Locations at 16 March 2021



PCR Testing Locations at 25th May 2021



LFD Testing Locations at 25th May 2021



LFD Testing Locations at 28th Sep 2021

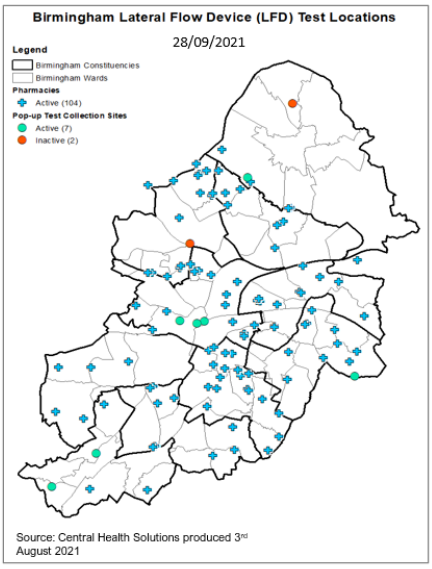
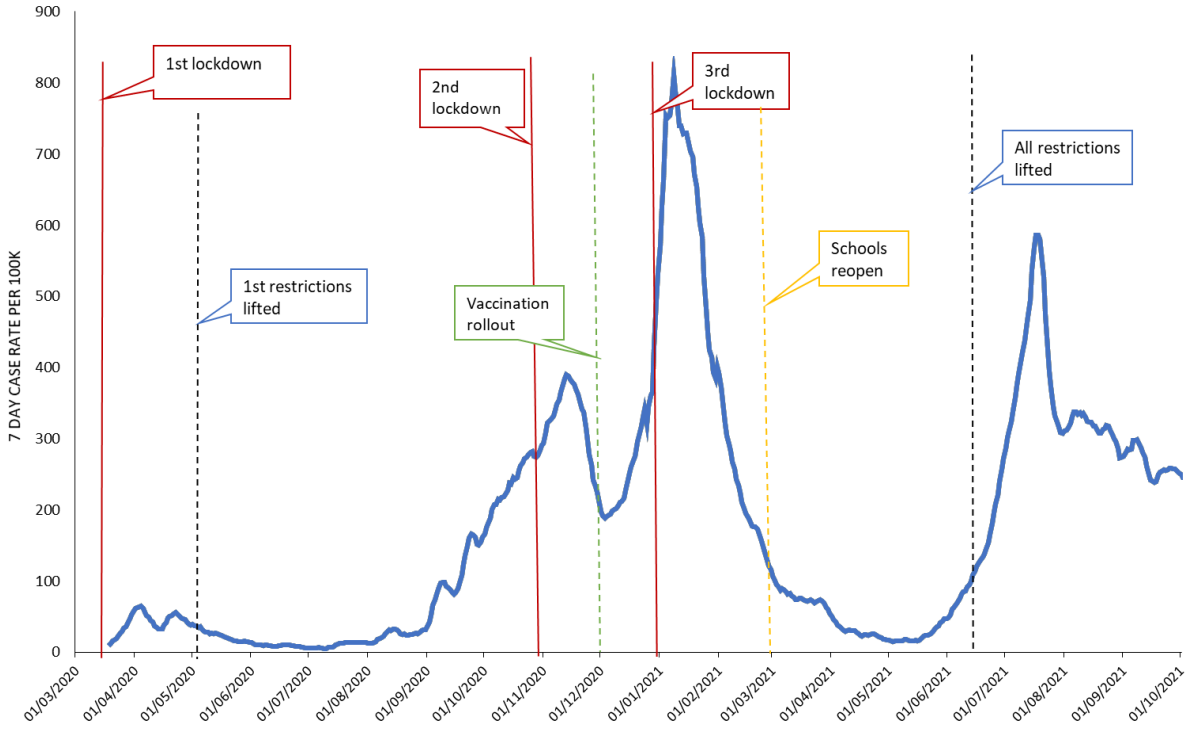


Figure 2. COVID-19 Case Rate (7-day rolling) and alert level thresholds[2]

1st March 2020 – 30th September 2021



Covid's impact on citizens in Birmingham, affecting aspects of identity and geography, is yet to be fully understood due to the limitation in inequalities data on different communities. A breakdown of cases by age, gender, ethnicity and geography emerged over the first wave. By the summer of 2020, this data was routinely reported by Public Health England West Midlands and analysed and reported on locally by the Council's Public Health team.

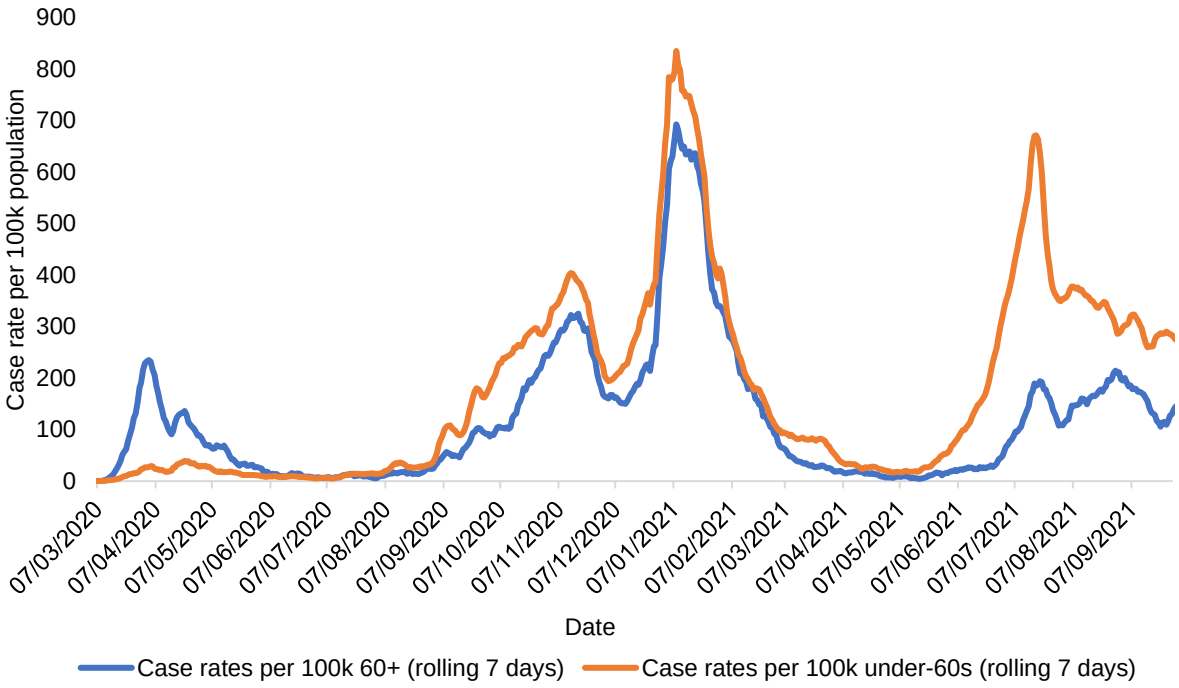
Age

Much of the focus has been on the impact of COVID-19 on older adults. In general, they are more susceptible to severe illness and death due to COVID-19. In the first wave, the case rate in those aged 60+ was higher than those under 60 (Figure 3). This reflects the fact that wider population access to testing only became available in the summer of 2020 as before this testing was only done on symptomatic individuals. There may have been much higher rates in younger age groups, but we were unable to identify them. In the peaks in November 2020, January 2021 and the summer of 2021, the pattern of cases in the same age groups was higher in those aged under 60 but followed a similar trend to those aged over 60 (Figure 3).

This highlighted that many of our older adults live in intergenerational households and are not isolated from wider community trends.

Figure 3. COVID-19 Case rates in under-60s compared to 60+[3]

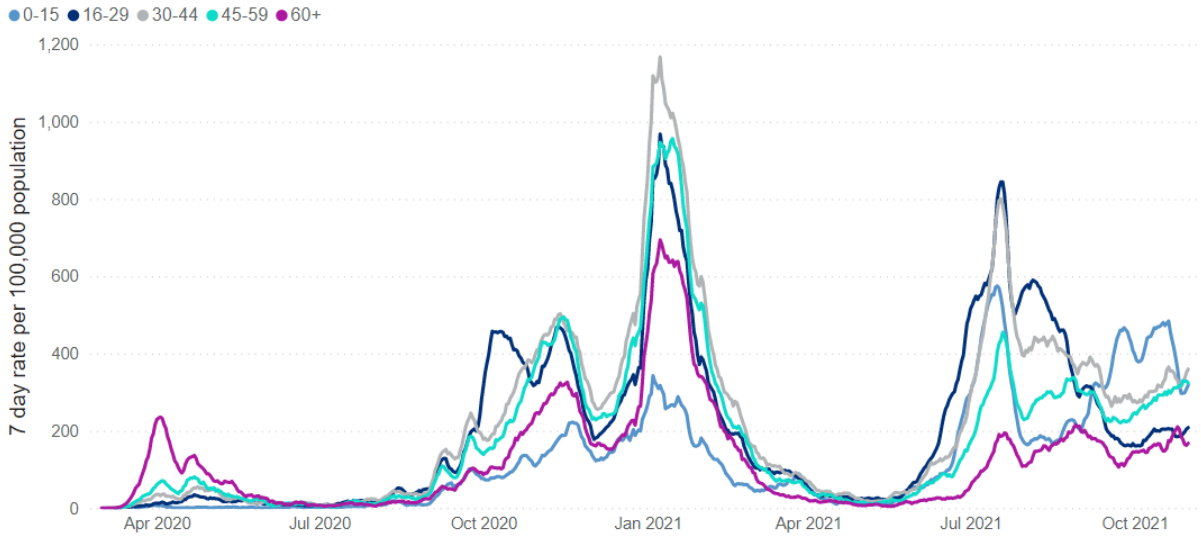
March 2020 – September 2021



As the data improved, we obtained a more granular understanding of case rates in smaller age cohorts (Figure 4). This highlighted spikes in specific age groups, e.g., when students returned to education in autumn 2020. Since the introduction of population-level testing in the summer of 2020, there have been consistently higher case rates in working-age adults (aged 30-44yrs). This is likely to reflect occupational exposure and the impact of intergenerational households.

Figure 4. COVID-19 Case rates by age[3]

1st March 2020 – 30th September 2021



Early in the pandemic, case rates per 100,000 of the population increased in the 60+ age group, peaking in early April and remaining higher than the rest of the population until July 2020. Subsequently, the over-60s followed similar trends to the under-60s but were consistently lower. High rates were seen in November 2020, with peaks in the over and under-60s age group. This dropped dramatically until early December 2020 and rose again in early January 2021, peaking at 834.7 (per 100,000 population) for under-60s and 692.4 among over-60s. Following a fall in early 2021, case rates rose to a peak in July 2021, with higher rates in school-age groups and the working-age population, a reversal in pattern compared to that in the early period of the pandemic. Higher case rates in younger age groups, though fluctuating, has been the pattern up to the end of September 2021.

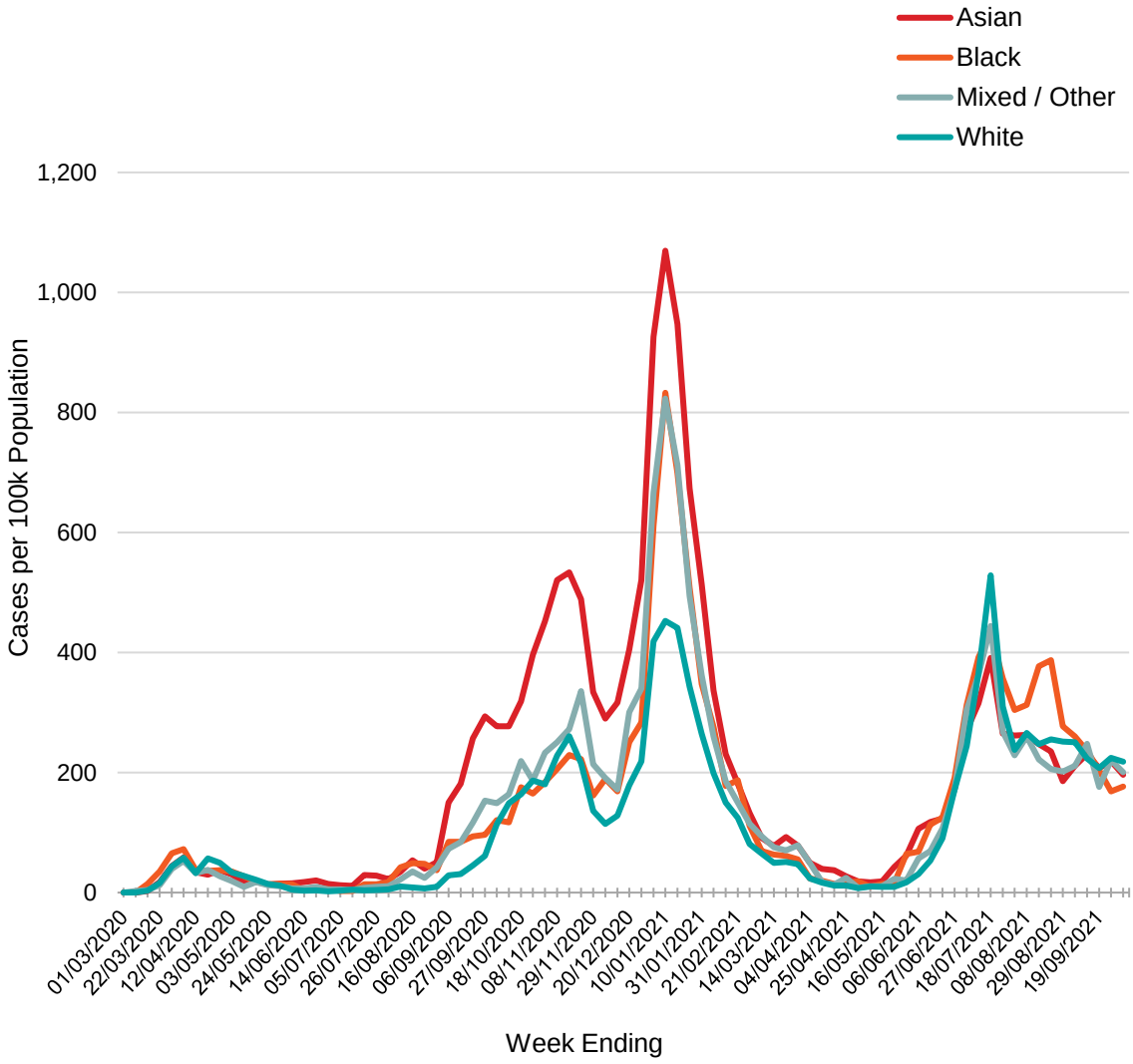
Ethnicity

There have been consistently higher case rates in South Asian ethnic groups, especially Pakistani, Bangladeshi and Indian. This may reflect several factors, including occupational exposure. These communities often work in health and social care, education and hospitality sectors. They may also be part of larger intergenerational households where multiple members of the same household became infected. There may also be an impact of variable testing uptake in different communities.

The pattern of higher case rates in the Asian groups was temporarily reversed around the peak periods in the summer of 2021, when rates were higher in the White ethnic groups and

Mixed/other ethnic groups. However, in August, this reverted to the earlier established patterns (of high rates in the Asian groups). This is shown in Figure 5.

Figure 5. COVID-19 Case Rate per 100,000 Population by Week and Ethnic Group[3]

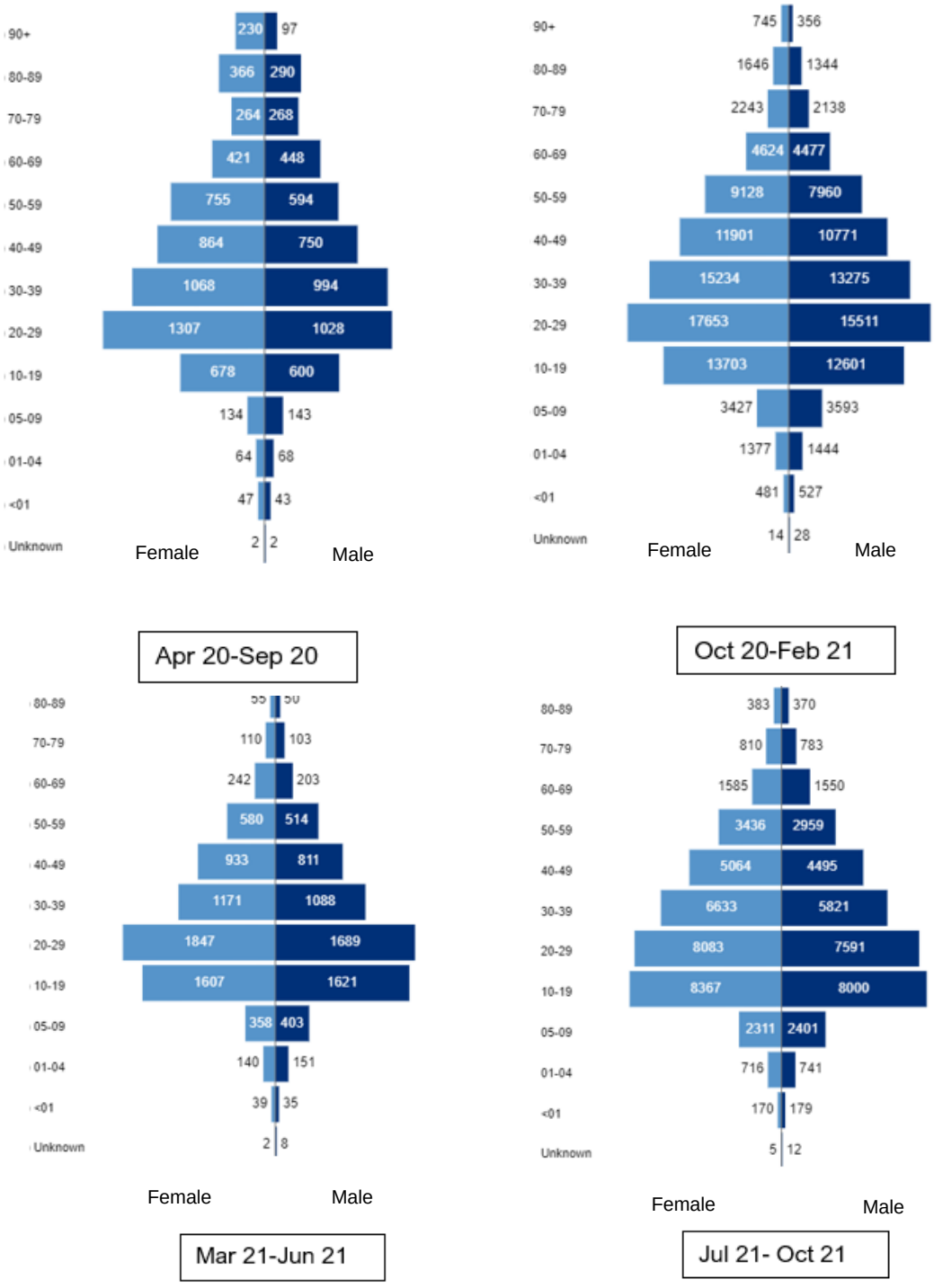


Age and Gender

Case rates were reported by gender from early on, although this has not included transgender people or non-binary genders. Throughout the pandemic, case rates were around 10% higher in women than in men. Between 1st March 2020 and 31st March 2021, for women there were 8,986 cases per 100,000 of the population, compared to 8,057 cases per 100,000 of the

population for men (Figure 6). This may reflect occupational exposure in health and social care, or potentially more household exposure to women if they are in a primary caring role in the house for sick members of the family. It may also reflect a bias in testing uptake as, in general, women are more likely to access healthcare than men.

Figure 6. Confirmed cases by age (years) and gender[3]



In the first half of the pandemic, the number of cases in the older age groups (65+) was significantly higher than in other groups. By the second half, cases had increased in all age groups except the 80+ age group, with a significant rise in cases in children and young adults. The highest rates were in the 20-29 age group, and cases almost doubled in the second half of the pandemic. The 30-49 and 10-19 age groups followed a similar pattern.

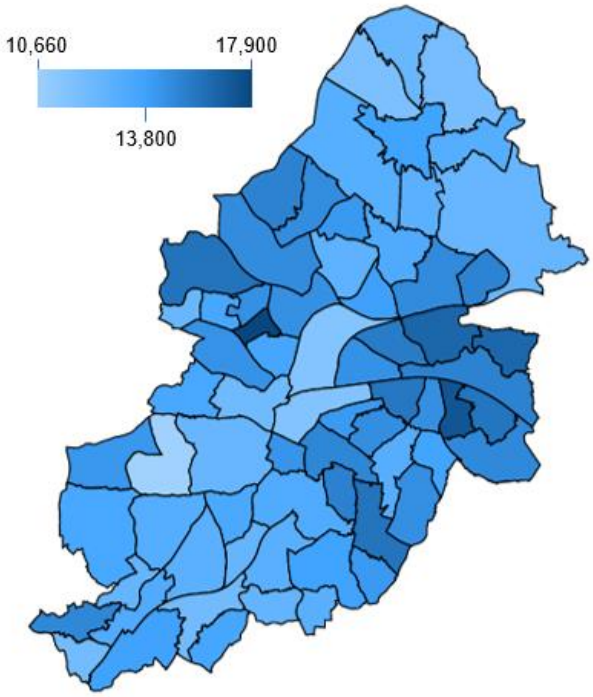
Place

The city's 69 wards have been used to monitor case rates and analyse patterns following the impact of the pandemic. Although we cannot attribute causality, we can use the geographical distribution of case rates to map over deprivation and other risk factors such as overcrowding to identify trends. Case rates by ward have been highest in the most deprived and ethnically diverse of the city's wards (Figure 7).

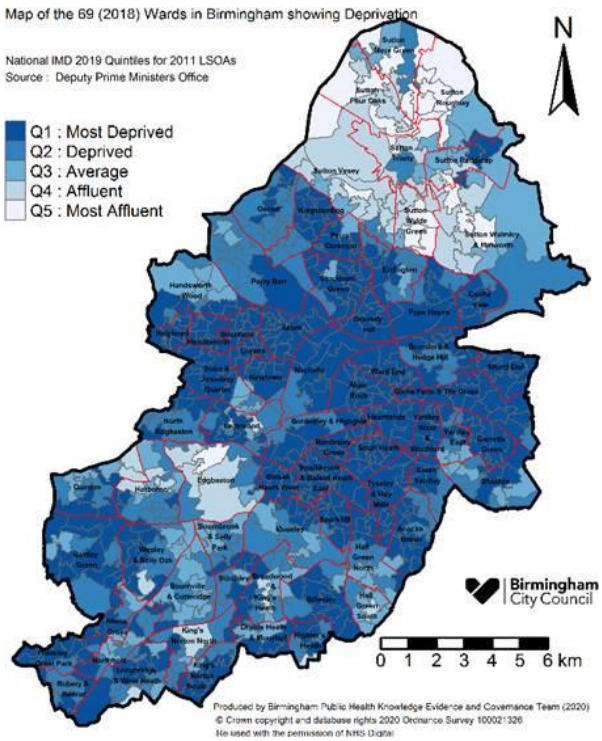
Figure 7. Ward Inequalities in COVID-19 Case Rates[3]

Confirmed Cases (Pillar 1 and 2) of COVID-19 by Ward 1st March 2020-30th September 2021

(per 100,000 population)



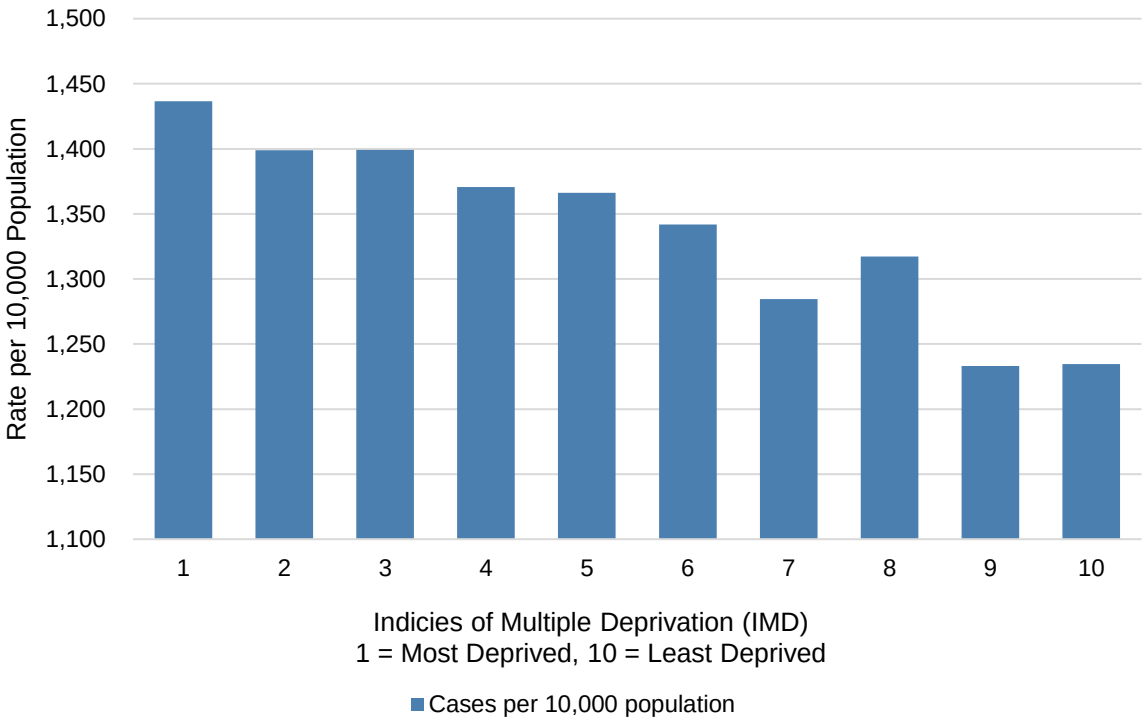
Index of Multiple Deprivation (IMD) by Ward (2019)



Measuring the relationship between COVID-19 case rates and poverty is achieved through the postcode of residence and the Index of Multiple Deprivation (IMD). From 1st March 2020 to 30th September 2021, the rate of cases was 16% higher (per 10,000 of the population) in the most deprived decile compared to the least deprived decile (Figure 8). There was an over-representation of COVID-19 cases in the most deprived areas of the population. The general trend suggests that the lower the IMD score (most deprived), the higher the case rate.

Figure 8. Rate of COVID-19 Cases per Population by IMD National Decile in Birmingham[3]

1st March 2020 to 30th September 2021



Occupation

Inequalities in COVID-19 case rates by profession have primarily been reflected in the impact on healthcare professionals, social care professionals, and 'other' professional groups. Despite data on case rates categorised by professional groups not being routinely reported, there have been significant concerns raised around occupational exposure. As mentioned, data on case rates based on the profession is not routinely collected. However, according to the Office for National Statistics (ONS), some ethnic groups are more likely to work in jobs

with higher COVID-19 death rates. The ONS has also found that Black and Asian men are more likely to have a job that is linked to higher death rates of COVID-19, including transport. Other services such as security and cleaning also have a relatively high proportion of employment for ethnic minorities.[16]

The largest employment sector in Birmingham. People of minority ethnic groups make up a high proportion of some healthcare professions, just over a quarter of dental practitioners, medical practitioners, and opticians. These professions and others where the proportion is high, including nursing and medical radiographers, involve regular contact with people and disease (see Table 2).

These occupations cannot be carried out from home and may have contributed to inequalities by profession (excluding periods of legislative restrictions on workplaces).

Table 2. Profession (2020) and Concern of Exposure to COVID-19[17]

Profession	**Birmingham (2020) Jobs**	**Birmingham (2020) (%)**	**Great Britain (2020) (%)**
Human Health and Social Work Activities	82,000	15.9	13.6
Wholesale and Retail Trade	71,000	13.8	14.9
Education	54,000	10.5	9.0
Manufacturing	33,000	6.4	7.9

[16] Office for National Statistics, "Why have Black and South Asian people been hit hardest by COVID-19?," 14 12 2020. [Online]. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/whyhaveblackandsouthasianpeoplebeenhithardestbycovid19/2020-12-14. (Accessed 10 12 2021).

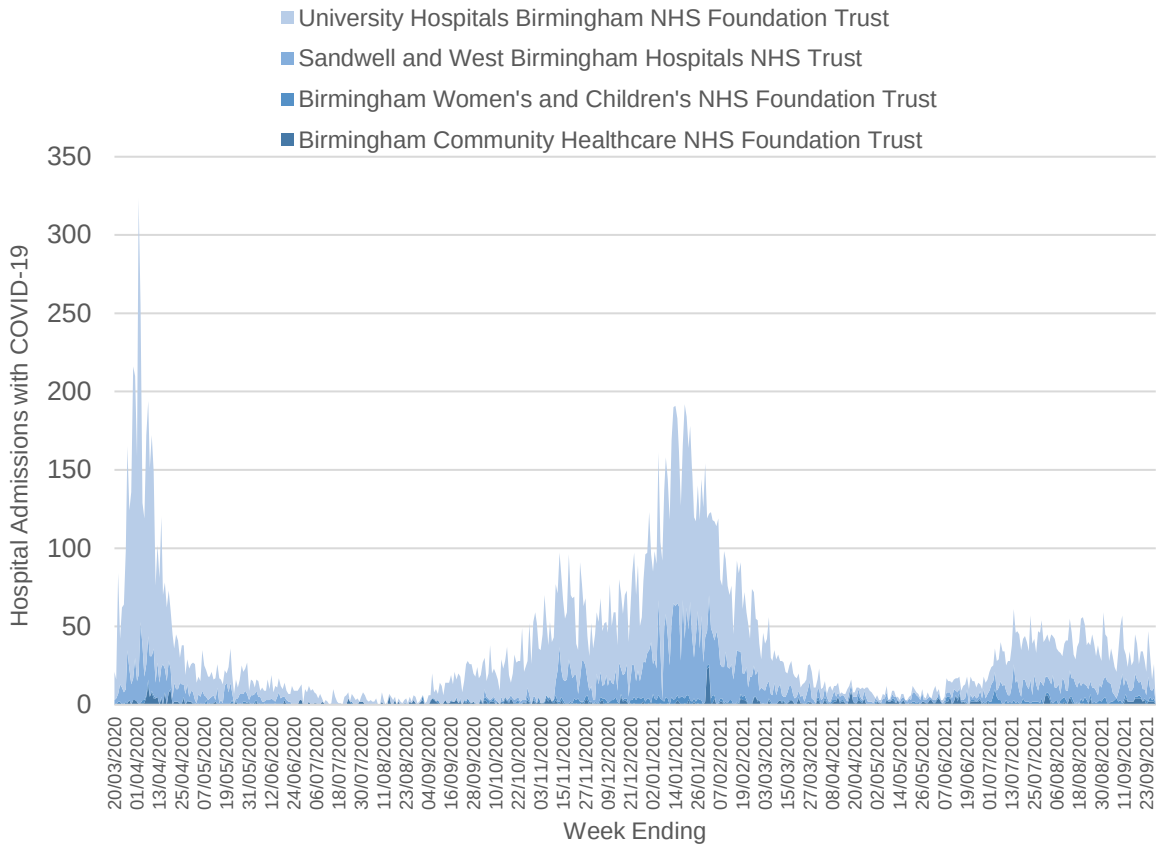
[17] Office of National Statistics, Labour Market Profile – Birmingham Employee jobs (2020)

https://www.nomisweb.co.uk/reports/lmp/la/1946157186/report.aspx#tabempocc (Accessed: 17/11/2021)

Hospital Admissions

The introduction of social distancing measures and restrictions played a vital role in reducing the number of cases and therefore the number of hospital admissions with COVID-19. Hospital admissions indicated the severity of the virus on our health and the activity and capacity of the NHS. 'Protect the NHS' was aimed to communicate the importance of reducing hospital admissions by staying at home. Hospital admissions with COVID-19 did increase in each wave (Figure 9) and following the rise in cases (Figure 2) between March 2020 and September 2021. In total, during the period until the end of September 2021, there were 22,185 hospital admissions due to COVID-19.

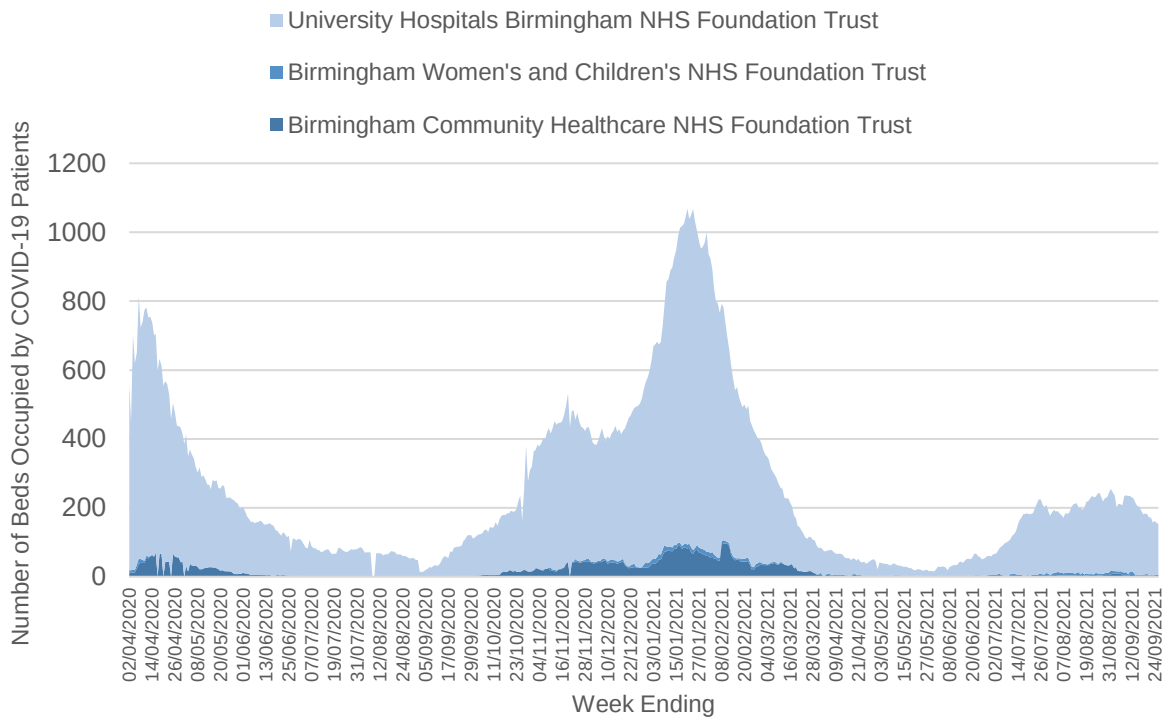
Figure 9. Total Number of Hospital Admissions with COVID-19 by Trust[18]



[18] NHS England Hospital Admissions by Birmingham Trusts (Accessed: 25 November 2021)

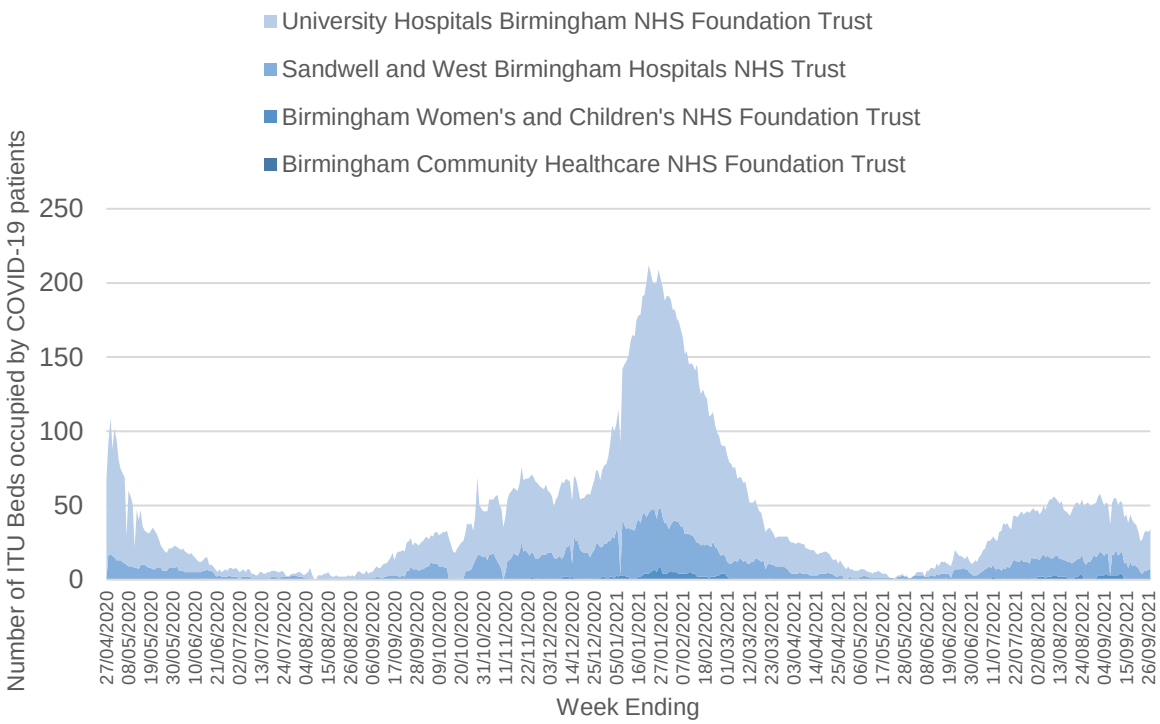
The number of beds occupied was higher in the second wave (December 2020 to January 2021), with an average of 927 beds, compared to 285 beds in other periods of the pandemic up to end September 2021 (Figure 10).

Figure 10: Number of beds occupied by COVID-19 patients (by Trust) since outbreak[18]



The pattern was similar with intensive therapy unit (ITU) beds, which had an average of 113 occupied during the second wave peak periods of December 2020 to January 2021. This is compared to an average of 34 ITU bed occupancy in other periods of the pandemic up to September 2021 (Figure 11).

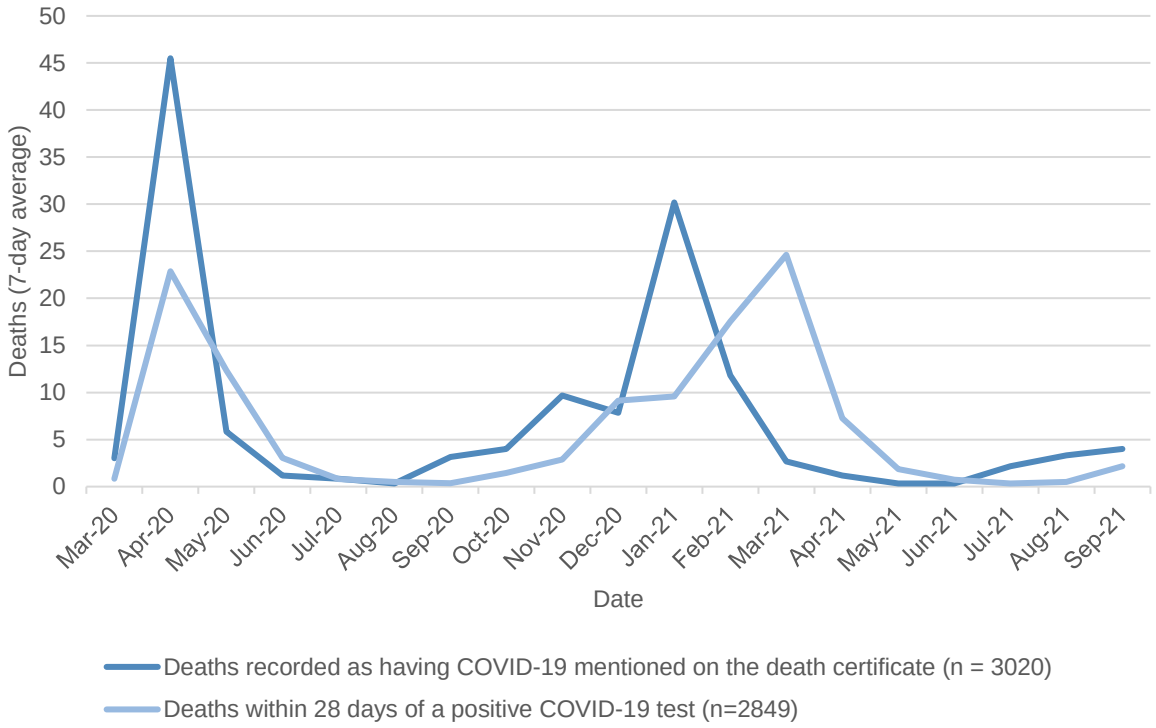
Figure 11: Number of ITU Beds occupied by COVID-19 patients by Trust since outbreak[18]



Deaths

The number of deaths with COVID-19 confirmed on the death certificate up until October 1st 2021 was 3,020. The highest number of registered deaths from COVID-19 in a week was in the week ending the 17th April when 273 deaths were recorded (Figure 12). There is a slight lag between the reported deaths occurring 28 days after a positive COVID-19 test and the ONS data, which shows the number of deaths with COVID-19 mentioned on the death certificate. There are slightly more deaths (9.5%) recorded as having COVID-19 mentioned on the death certificate than those that occurred within 28 days of a positive COVID-19 test.

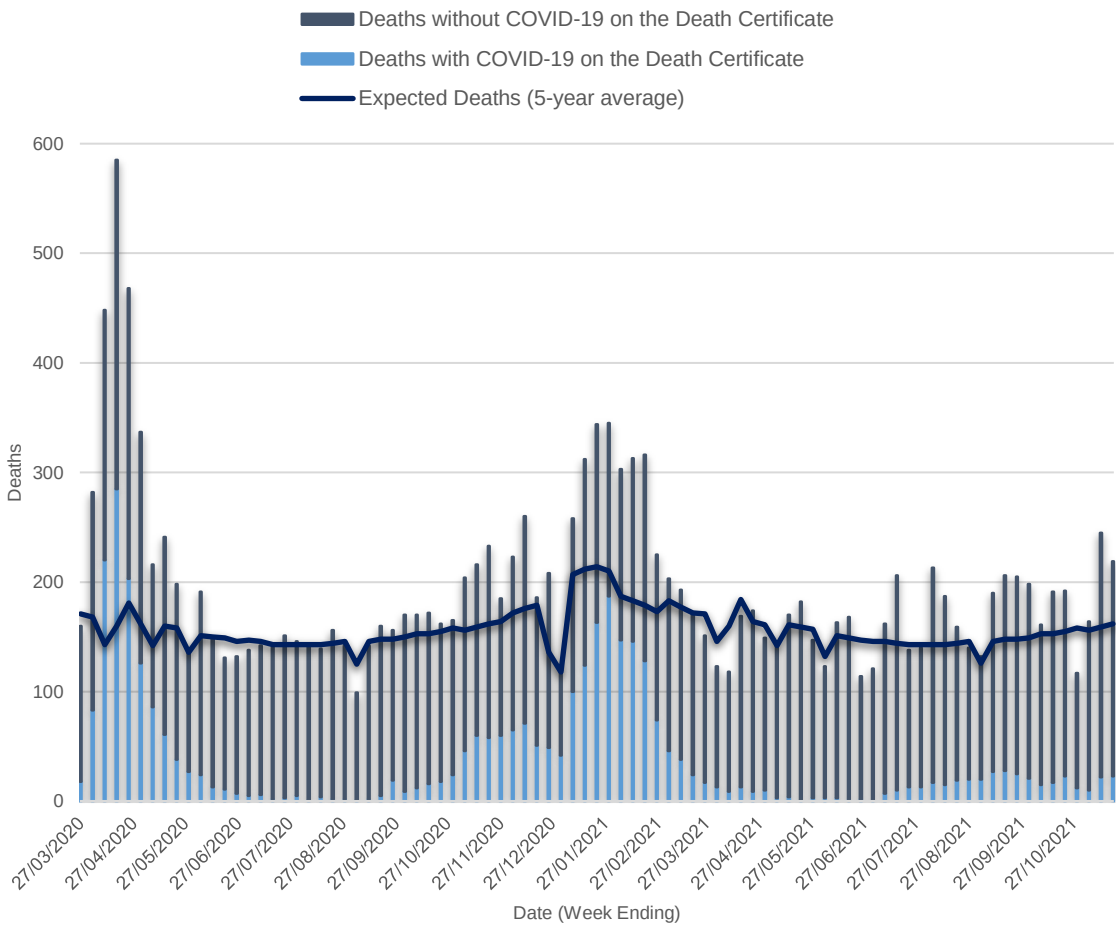
Figure 12. 7-day average daily deaths in Birmingham from COVID-19[12]



Excess Deaths

Excess deaths are the additional number of people who died from all causes when compared with the five-year average during the same time in the year. Excess deaths (Figure 13) illustrates the impact of the first wave, with 1,162 more people dying in April 2020 than the average of the previous five years for the same month. Excess deaths in the autumn and winter were more spread out, with the highest number of excess deaths in Birmingham for that period falling in February 2021 with 373 additional deaths.

Figure 13. Weekly deaths above the 5-year average (excess deaths)[19]

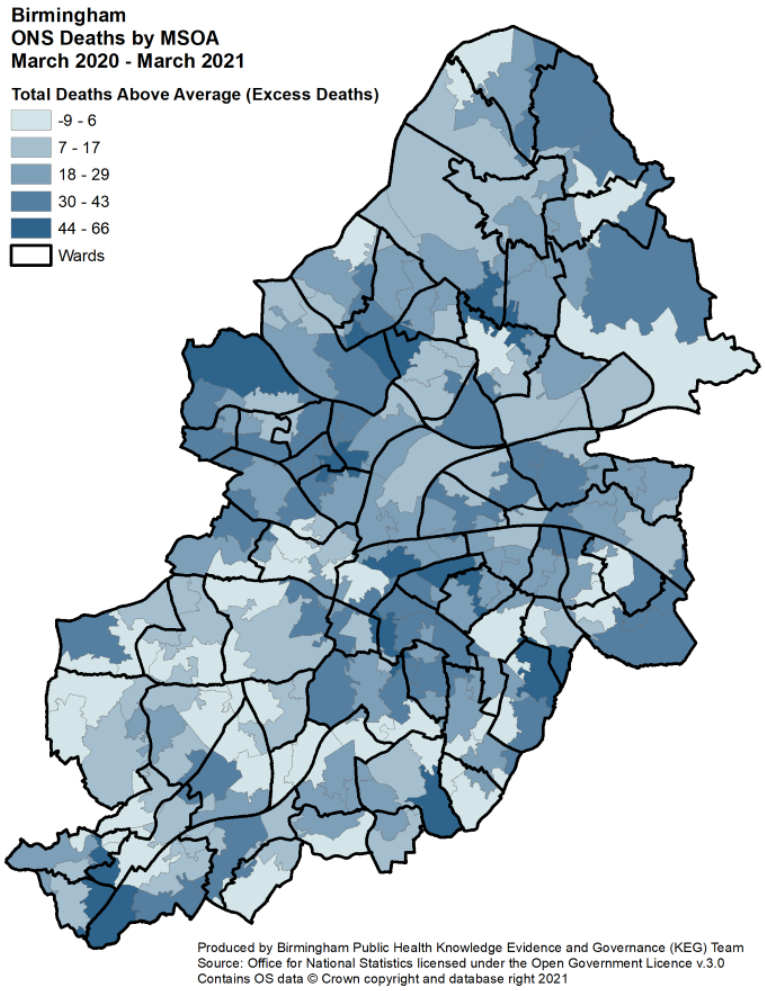


Some of Birmingham's neighbourhoods saw more people die than expected for the time of year, particularly to the east and west of the city (Figure 14). Complete ward-level data for excess deaths is only available from March 2020 to March 2021.

[19] Office of National Statistics, 'Excess deaths in your neighbourhood during the coronavirus (COVID-19) pandemic', https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/excessdeathsinyourneighbourhoodduringthecoronaviruscovid19pandemic/2021-08-03, (Accessed: 1 December 2021)

Figure 14. Map of deaths in Birmingham above the 5-year average[19]

1st March 2020 to 31st March 2021



There were differences between places regarding deaths and excess deaths (Figure 15). Care homes saw a high number of deaths during the first wave (April 2020). Many of these deaths did not mention COVID-19 on the death certificate, and this is likely to reflect the limited access to testing in the first wave. Deaths at home and at hospital followed a similar trend to that seen in Figure 13, with excess deaths in April 2020 and February 2021.

Figure 15. Place Inequalities in COVID-19 Death Rates: Trends[11]

Vaccinations

The vaccination programme began on 8th December 2020 with people receiving the vaccine developed by Pfizer/BioNTech. People began receiving the Oxford University/AstraZeneca vaccine from 4th January 2021, and the Moderna vaccine from 7th April 2021.[20] Initially, the vaccines were prioritised to be administered to the over-80s, care home residents and workers, and NHS staff.[21] Data on vaccination uptake, extracted on the 23rd November 2021, can provide us with a snapshot of the health inequalities that the pandemic has highlighted. For example, in Tables 3, 4 and 5, the percentage uptake between male and female residents is generally equal with a small divergence as you descend the age groups. It also includes those who are clinically extremely vulnerable (CEV) and those who are at risk.

75% or more of the ward have been vaccinated	**75% or more of the ward have been vaccinated**

Table 3. Vaccination uptake (1st dose) by age and gender (up to 23/11/21)[22]

Gender	80+yrs	75-79yrs	70-74yrs	65-69yrs	60-64yrs	55-59yrs	50-54yrs	40-49yrs	30-39yrs	18-29yrs	16-17yrs	12-15yrs	CEV	COVID At Risk
Female	93.2	93.9	92.6	90.2	88.3	86.1	84.9	78.5	66.2	58.2	45.3	31.1	87.4	82.2
Male	92.7	93.7	92.1	88.3	85.2	81.1	77.5	66.8	56.1	53.0	40.3	29.9	88.3	80.4

Table 4. Vaccination uptake (2nd dose) by age and gender (up to 23/11/21)[22]

Gender	80+yrs	75-79yrs	70-74yrs	65-69yrs	60-64yrs	55-59yrs	50-54yrs	40-49yrs	30-39yrs	18-29yrs	16-17yrs	12-15yrs	CEV	COVID At Risk
Female	92.1	93.0	91.6	88.8	86.5	84.0	81.9	74.1	59.7	49.6	10.6	0.0	83.7	77.5
Male	91.8	92.8	91.3	87.0	83.5	78.9	74.6	62.4	50.2	44.1	9.3	0.0	85.8	76.0

[20] Office of National Statistics https://www.nomisweb.co.uk/reports/lmp/la/1946157186/report.aspx#tabempocc (Accessed: 17/11/2021)https://coronavirus.data.gov.uk/details/vaccinations?areaType=ltla&areaName=Birmingham (Accessed: 17 November 2021).

[21]UK Health Security Agency https://coronavirus.data.gov.uk/details/vaccinations?areaType=ltla&areaName=Birmingham (Accessed: 17 November 2021).

[22] National Immunisation Management System (NIMS). [Online] (Downloaded: 23 November 2021).

Table 5. Vaccination uptake (booster dose) by age and gender (up to 23/11/21)[22]

Gender	80+yrs	75-79yrs	70-74yrs	65-69yrs	60-64yrs	55-59yrs	50-54yrs	40-49yrs	30-39yrs	18-29yrs	16-17yrs	12-15yrs	CEV	COVID At Risk
Female	79.5	84.8	80.7	69.8	58.3	56.2	53.3	41.0	59.0	60.5	37.6	0.0	61.1	49.7
Male	84.3	87.5	83.5	69.5	54.9	51.4	48.3	36.9	56.9	47.3	37.4	0.0	65.3	47.9

However, Tables 6, 7 and 8 demonstrate a lower uptake in more deprived communities than in affluent areas, which is more pronounced among younger age groups. For example, there is an 8.4% gap between the most affluent residents and the most deprived residents in terms of % uptake of the 1st dose for those over 80-years old, and this difference is 39.6% in the 16-17 age group. This pattern is seen for 1st, 2nd, and booster doses. Therefore, those living in more deprived areas were less likely to have been vaccinated than those living in less deprived areas.

Uneven uptake of 1st, 2nd and booster doses of the COVID-19 vaccine is also shown in Tables 9, 10 and 11 across ethnic groups. Across the priority groups, uptake of the 1st and 2nd doses of the vaccine are lower in African, Caribbean and Black communities and then Pakistani and Bangladeshi. Booster uptake is lowest amongst Arab, Pakistani and Bangladeshi communities. Still, there is a significant difference in the size of different ethnic groups in different priority groups. For example, the total eligible population of those >80 years from a Pakistani ethnic group is 3,552, compared to 402 from an African ethnic group.

75% or more of the ward have been vaccinated

75% or more of the ward have been vaccinated

Table 6. Vaccination Uptake (1st dose) by age and Indices of Multiple Deprivation (up to 23/11/21)[22]

IMD Deprivation Quintile	80+yrs	75-79yrs	70-74yrs	65-69yrs	60-64yrs	55-59yrs	50-54yrs	40-49yrs	30-39yrs	18-29yrs	16-17yrs	12-15yrs	CEV	COVID-19 At Risk
Deprived (DQ1)	88.9	91.1	88.9	85.2	82.0	78.2	75.9	67.2	55.5	48.8	33.7	23.9	85.1	77.3
Moderately Deprived (DQ2)	94.1	93.7	92.8	89.7	88.1	84.7	82.4	73.7	63.2	58.6	47.7	33.4	90.0	83.6
Average (DQ3)	95.8	95.7	95.1	93.4	91.1	89.3	87.2	78.0	68.3	64.2	55.9	41.4	93.1	87.7
Moderately Affluent (DQ4)	96.5	96.0	96.0	94.4	93.0	91.0	89.0	81.2	71.8	66.1	64.5	47.3	94.9	91.3
Affluent (DQ5)	97.3	97.6	96.7	95.8	94.8	93.6	92.0	88.2	81.2	79.5	73.3	53.3	96.9	93.5

Table 7. Vaccination Uptake (1st dose) by age and Indices of Multiple Deprivation (up to 23/11/21)[22]Error! Bookmark not defined.

IMD Deprivation Quintile	80+yrs	75-79yrs	70-74yrs	65-69yrs	60-64yrs	55-59yrs	50-54yrs	40-49yrs	30-39yrs	18-29yrs	16-17yrs	12-15yrs	CEV	COVID-19 At Risk
Deprived (DQ1)	87.4	89.5	87.4	83.2	79.6	75.2	72.0	61.6	48.2	38.8	7.3	0.0	81.2	71.8
Moderately Deprived (DQ2)	93.1	93.0	92.0	88.6	86.5	82.8	79.8	69.8	57.6	50.2	11.7	0.0	87.5	79.7
Average (DQ3)	95.3	95.3	94.6	92.7	90.0	87.9	85.0	74.9	63.5	57.3	13.2	0.0	91.2	84.5
Moderately Affluent (DQ4)	96.0	95.5	95.7	93.8	92.0	90.0	87.5	78.8	67.6	60.3	16.1	0.0	93.5	88.6
Affluent (DQ5)	97.0	97.2	96.4	95.3	94.4	92.9	91.1	86.5	77.7	73.1	19.2	0.0	96.2	91.7

Table 8. Vaccination Uptake (booster dose) by age and Indices of Multiple Deprivation (up to 23/11/21)[22]

IMD Deprivation Quintile	80+yrs	75-79yrs	70-74yrs	65-69yrs	60-64yrs	55-59yrs	50-54yrs	40-49yrs	30-39yrs	18-29yrs	16-17yrs	12-15yrs	CEV	COVID-19 At Risk
Deprived (DQ1)	72.9	78.8	74.9	62.6	52.2	50.3	46.0	34.5	45.5	43.3	35.2	0.0	55.7	44.3
Moderately Deprived (DQ2)	82.5	87.0	83.0	72.7	59.0	57.1	54.2	41.8	63.5	58.4	39.2	0.0	67.5	52.3
Average (DQ3)	85.3	89.5	85.8	75.0	59.8	56.7	55.0	42.3	71.3	68.1	47.1	0.0	72.5	53.6
Moderately Affluent (DQ4)	88.6	91.9	88.3	77.1	61.2	58.0	57.2	46.9	81.3	72.0	32.5	0.0	79.4	55.9
Affluent (DQ5)	91.7	94.2	90.7	74.7	60.0	54.6	56.0	47.2	80.9	69.0	35.3	0.0	83.3	54.0

Table 9. Vaccination Uptake (1st dose) by cohort and ethnic group (up to 23/11/21)[22]

Ethnic Group	80+yrs	75-79yrs	70-74yrs	65-69yrs	60-64yrs	55-59yrs	50-54yrs	40-49yrs	30-39yrs	18-29yrs	16-17yrs	12-15yrs	CEV	COVID-19 At Risk
Not recorded	71.8	79.2	77.6	70.4	65.5	57.9	54.1	39.9	37.0	39.4	28.6	20.6	82.0	73.7
African	70.6	69.7	71.6	73.5	73.2	71.6	71.4	68.0	54.2	43.4	25.7	18.6	77.3	71.1
Any other Asian background	84.0	85.5	83.8	83.8	82.5	81.4	79.6	74.6	61.9	56.1	39.7	31.5	85.2	79.2
Any other Black background	78.4	72.6	69.2	70.4	66.1	63.9	63.2	55.5	39.5	35.6	20.0	11.4	69.5	60.3
Any other ethnic group	77.2	79.3	77.9	76.5	75.0	71.7	71.5	63.9	53.0	42.7	29.8	21.9	77.0	68.5
Any other mixed background	86.6	88.8	78.4	77.5	75.8	74.0	71.9	65.6	49.1	45.2	35.4	25.4	75.4	64.5
Any other White background	94.1	92.1	87.2	81.3	76.6	75.2	69.1	57.8	46.2	45.2	37.6	23.6	82.5	70.6
Arab	78.6	66.7	69.6	74.4	63.2	73.4	71.4	63.2	47.8	34.0	27.0	16.4	64.9	67.3
Bangladeshi or British Bangladeshi	82.9	86.3	86.6	89.3	89.3	90.3	89.7	84.0	71.0	62.2	46.0	36.1	90.9	86.4
British, Mixed British	97.3	97.3	96.7	95.4	94.2	92.6	90.9	85.9	75.1	71.7	59.8	43.1	94.5	88.2
Caribbean	78.0	78.3	73.8	68.4	64.3	60.2	56.9	43.7	28.8	27.2	14.6	9.4	69.2	56.4
Chinese	85.2	70.9	69.4	73.1	73.3	73.3	73.6	69.3	42.3	24.7	64.4	52.7	89.6	81.3
Indian or British Indian	91.4	90.1	90.6	90.2	89.9	88.6	87.2	82.2	71.8	71.1	61.0	43.6	93.2	89.6
Irish	95.9	95.4	92.1	91.8	90.9	86.5	84.6	73.6	59.4	60.6	60.4	37.9	94.9	83.9
Pakistani or British Pakistani	83.2	85.5	83.7	83.2	83.6	81.4	80.3	74.1	63.0	50.9	32.1	21.3	83.1	76.6
Traveller	0.0	50.0	0.0	0.0	20.0	38.5	26.7	16.3	12.7	6.8	0.0	1.0	15.4	17.6
White and Asian	76.9	83.8	89.1	78.7	87.6	87.4	81.8	71.7	60.9	59.8	43.2	34.2	80.0	77.2
White and Black African	76.2	72.0	62.0	68.4	77.3	70.4	72.5	68.3	55.9	48.9	36.0	23.2	79.4	72.2
White and Black Caribbean	75.7	76.5	76.9	76.0	71.2	68.7	66.6	54.9	39.0	37.3	24.4	16.6	69.4	57.7

Table 10. Vaccination Uptake (2nd dose) by cohort and ethnic group (up to 23/11/21)[22]

Ethnic Group	80+yrs	75-79yrs	70-74yrs	65-69yrs	60-64yrs	55-59yrs	50-54yrs	40-49yrs	30-39yrs	18-29yrs	16-17yrs	CEV	COVID-19 At Risk
Not recorded	71.0	78.5	76.8	68.9	64.1	56.2	52.2	37.5	33.4	32.9	5.8	79.9	69.7
African	69.4	68.0	68.2	71.0	70.3	68.2	66.8	61.3	45.3	30.7	4.7	72.7	64.9
Any other Asian background	81.5	83.2	82.8	82.2	79.7	79.2	76.1	69.8	55.0	45.6	9.6	81.1	73.7
Any other Black background	74.2	69.5	65.8	67.5	61.8	59.3	57.8	48.6	32.4	26.3	2.9	63.9	53.9
Any other ethnic group	75.2	78.1	76.6	74.2	72.7	69.2	67.7	59.4	47.1	33.9	6.5	72.2	63.0
Any other mixed background	86.6	88.8	76.3	74.2	73.5	69.9	68.7	60.9	43.5	36.0	6.4	70.6	57.8
Any other White background	93.6	91.5	86.4	80.2	75.0	73.2	66.3	54.6	41.9	38.9	8.2	80.3	66.7
Arab	75.0	53.3	69.6	67.4	63.2	72.3	63.9	59.3	43.9	26.3	8.0	59.6	63.9
Bangladeshi or British Bangladeshi	79.9	82.5	84.4	87.2	87.0	88.3	87.1	79.6	63.4	49.9	9.1	87.3	81.4
British, Mixed British	96.7	96.6	96.1	94.5	92.8	90.8	88.6	82.0	69.2	63.6	15.1	92.5	84.5
Caribbean	75.8	76.2	71.5	65.9	61.4	56.7	52.6	38.6	23.8	20.6	3.7	65.6	52.0
Chinese	83.4	69.2	68.7	71.6	72.1	71.6	72.3	67.2	40.4	22.3	18.4	87.2	79.2
Indian or British Indian	90.2	89.6	89.3	89.0	88.5	86.8	84.8	78.7	66.0	60.4	14.6	90.6	86.2
Irish	95.1	94.8	91.3	90.3	88.4	84.1	82.5	70.3	55.5	53.1	20.7	93.3	80.8
Pakistani or British Pakistani	79.2	80.9	80.3	79.5	79.9	76.8	74.4	66.1	52.5	38.3	6.6	76.8	68.8
Traveller	0.0	50.0	0.0	0.0	20.0	38.5	26.7	13.5	10.2	3.7	0.0	15.4	13.7
White and Asian	74.4	83.8	82.8	75.3	85.7	83.1	78.7	69.0	54.2	51.4	10.1	74.2	71.1
White and Black African	76.2	72.0	58.0	66.3	71.4	68.8	68.2	62.8	48.1	38.2	5.2	75.3	66.3
White and Black Caribbean	74.5	76.5	75.4	72.6	68.1	64.2	62.3	49.5	33.5	29.3	5.8	65.7	52.0

Table 11. Vaccination Uptake (booster dose) by cohort and ethnic group (up to 23/11/21)[22]

Ethnic Group	80+yrs	75-79yrs	70-74yrs	65-69yrs	60-64yrs	55-59yrs	50-54yrs	40-49yrs	30-39yrs	18-29yrs	16-17yrs	CEV	COVID-19 At Risk
Not recorded	85.9	89.4	83.0	68.7	56.1	55.4	53.4	41.1	71.1	68.0	27.8	70.0	50.3
African	63.6	66.3	66.2	58.9	47.3	46.3	40.5	28.5	48.5	38.8	25.0	42.3	37.8
Any other Asian background	69.3	66.0	74.7	60.7	53.3	50.9	51.0	42.0	69.7	60.5	40.0	49.1	45.0
Any other Black background	62.8	73.0	61.7	55.8	43.7	44.2	41.4	31.0	41.4	39.6	0.0	46.8	40.3
Any other ethnic group	71.0	70.0	75.8	61.7	54.4	47.3	54.2	40.7	52.9	61.5	25.0	48.1	42.7
Any other mixed background	73.6	79.4	72.7	62.7	54.2	55.6	49.3	39.5	65.7	54.6	33.3	49.7	46.2
Any other White background	82.1	86.4	82.8	69.5	56.0	55.3	54.3	40.2	60.6	52.9	33.3	66.3	49.2
Arab	35.0	0.0	70.0	35.3	23.1	21.1	46.2	29.2	44.0	20.0	0.0	29.4	28.6
Bangladeshi or British Bangladeshi	49.9	54.1	49.2	39.8	32.9	37.6	36.8	28.3	30.2	33.0	8.3	30.5	30.6
British, Mixed British	84.7	88.6	85.3	73.8	59.5	56.5	54.1	42.7	60.9	56.7	42.3	72.5	53.2
Caribbean	61.9	65.2	59.5	53.7	44.5	45.1	43.9	31.3	40.8	31.7	20.0	54.7	43.5
Chinese	84.4	81.4	81.1	69.1	51.7	51.1	53.4	50.4	84.6	100.0	0.0	67.1	49.5
Indian or British Indian	75.9	79.8	75.2	65.5	54.6	53.8	53.0	44.1	70.9	74.4	40.0	57.7	48.6
Irish	84.0	85.0	81.6	73.6	64.3	59.6	55.4	46.9	61.8	75.9	20.0	77.8	57.6
Pakistani or British Pakistani	44.1	50.1	44.5	41.0	36.7	35.3	31.7	25.0	38.2	35.4	32.5	33.5	29.9
Traveller	0.0	100.0	0.0	0.0	0.0	100.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0
White and Asian	77.8	80.6	64.0	75.0	55.2	47.1	53.8	38.4	67.0	61.6	28.6	52.5	43.8
White and Black African	80.0	64.3	70.8	66.7	40.9	56.8	47.6	33.9	43.5	38.6	0.0	57.0	47.3
White and Black Caribbean	66.1	76.1	63.3	53.8	49.6	47.2	43.8	33.4	42.6	37.3	50.0	48.1	40.9

4. The Local Impact of COVID-19

Our Health

Physical Health

The direct impact of COVID-19 infection was seen in the case rates, hospital admissions and fatalities. However, behind these numbers were people experiencing a new disease that healthcare professionals and scientists knew little about.

The different experiences of some of our citizens captured through the ethnographic research demonstrated how the disease affected people differently in terms of symptoms and their overall health (Table 12). Some of the respondents reported having relatively short-term effects and quicker recovery times, but they were yet to fully gain overall fitness and stamina. For others, it was more debilitating with long-term effects of the infection still lingering on physically and psychologically.

Table 12. The stories of the impact of COVID-19 on physical and mental health[6]

Dee	***Flo***	***John***
• Very unwell for a week • Being home alone was a challenge • Lasting post-viral fatigue for weeks after	• Poorly for a short period with no care from an ex at home • Recovered quickly • Long term effects on fitness	• Contracted COVID-19 in the COVID-19 ward • Acute illness • Fear of infecting his parents • Long term psychological anxiety

Stories from those who contracted the virus experienced both short-term and long-term effects. Initially, it was debilitating for some. Longer-term impacts included a perceived reduction in stamina and an increase in anxiety.

"I felt absolutely horrible, I couldn't eat properly, constant headaches, joints absolutely aching, I had to self-isolate. I really didn't want to go back into hospital. No one knew if you could get it again once you had gone into hospital once. Everyone had their eyes closed, so many unknowns. There were lots of ethnic minorities getting it which made me worried."

John, 34, individual interview (October 2020)[6]

In addition, the imposed restrictions and deferral of health interventions had impacts on physical health. Citizens reported worsening of physical conditions, particularly among those who were more isolated due to limited mobility, including older adults and those who were shielding. People also reported issues in accessing treatment for existing issues for themselves or dependents.

The NHS faced multiple overlapping challenges during the pandemic. It protected patients already in hospital from further infection by reducing visitors whilst providing an acute response service to those who were sick and needed help. Staff were diverted from routine care to respond to the pressures of coronavirus. In addition, the NHS had to manage sickness absence and caring responsibilities as its staff were directly impacted themselves.

Many 'non-urgent' and non-COVID-19 services were closed for large parts of the year as the NHS tried to navigate an unprecedented assault from the pandemic and its impacts. Patients also changed their behaviour, and many services moved to virtual and telephone assessments whilst GPs maintained face to face appointments for those that clinically needed it. Some chose to stay at home rather than face the risk of contamination in a health setting or for fear of 'being a burden'.

The NHS is now facing a large backlog of care unrelated to COVID-19. The total BSol CCG system waiting list increased by 59% between February 2020 and April 2021 (Table 13).

Table 13. Birmingham and Solihull (BSol) Referral to Treatment Change During Pandemic

February 2020 to April 2021[23]

Referral to Treatment (patients waiting on elective care pathway)	February 2020	April 2021	Change
Total BSol system waiting list	121,309	192,819	+ 71,510
% waiting for treatment < 18 weeks	81.4%	53.6%	-27.8%
52+ week waiters	2	21,588	+ 21,586
Longest Waiter Inpatient	57 weeks	118 weeks	61-week increase
Longest Waiter Outpatient	52 weeks	113 weeks	61-week increase
Mean length of wait Diagnostics	2-3 weeks	3-4 weeks	+ 1-2 weeks

Cancer waiting times also increased compared with pre-pandemic levels. In the BSol CCG system, fewer people were seen following a referral with suspected cancer. 85% of patients were seen within two weeks in February 2020, compared to 62% in March 2021 (Table 14).

[23] NHS England. [Online]. Available: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2020-21/ (Accessed: 29 November 2021).

Table 14. Cancer referrals change during the pandemic

February 2020 to March 2021[23]

	February 2020 Inside timescale	February 2020 Outside timescale	February 2020 Total seen	March 2021 Inside timescale	March 2021 Outside timescale	March 2021 Total seen
Two weeks wait (patients who are referred with suspected cancer on a 2-week wait pathway)	3428	598	4026	2649	1638	4287
62 days (patients waiting for their first definitive cancer treatment and should be treated within 62 days)	73.5	91.5	165	116	175	291

Table 15. Cancer referrals change during the pandemic – 104-day breaches

February 2020 to March 2021[23]

	February 2020	March 2021
104-day breaches (patients who have waited more than 104 days for their first treatment)	34.5	78.5

Mental Health

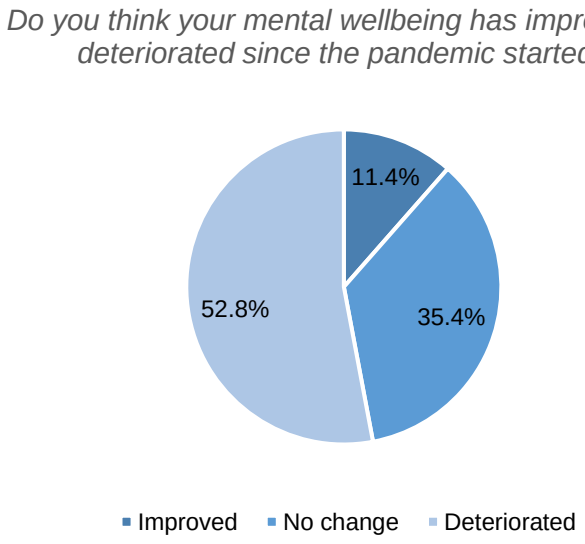
The pandemic has been a unique challenge for all of us, and there have been moments for everyone where we have felt isolated, overwhelmed, and depressed. The important restrictions that saved lives also impacted heavily on social contact, accessing support, and seeking help. Alongside this, there were pressures on people's mental wellbeing from financial insecurity and disruption to education and care provision.

"Going back to school in September, I don't deal well with change but I was impressed how I got back into it after so many months and it felt really good. But now I have to self-isolate because someone in my year tested positive, and I feel so low and sad and down, just in my room."

Kim, 17, individual interview (October 2020)[6]

The COVID-19 Impact Survey conducted during the first six months of the pandemic showed that citizens felt that their mental wellbeing had deteriorated (Figure 16).

Figure 16. Mental wellbeing during the first six months of the crisis[4]

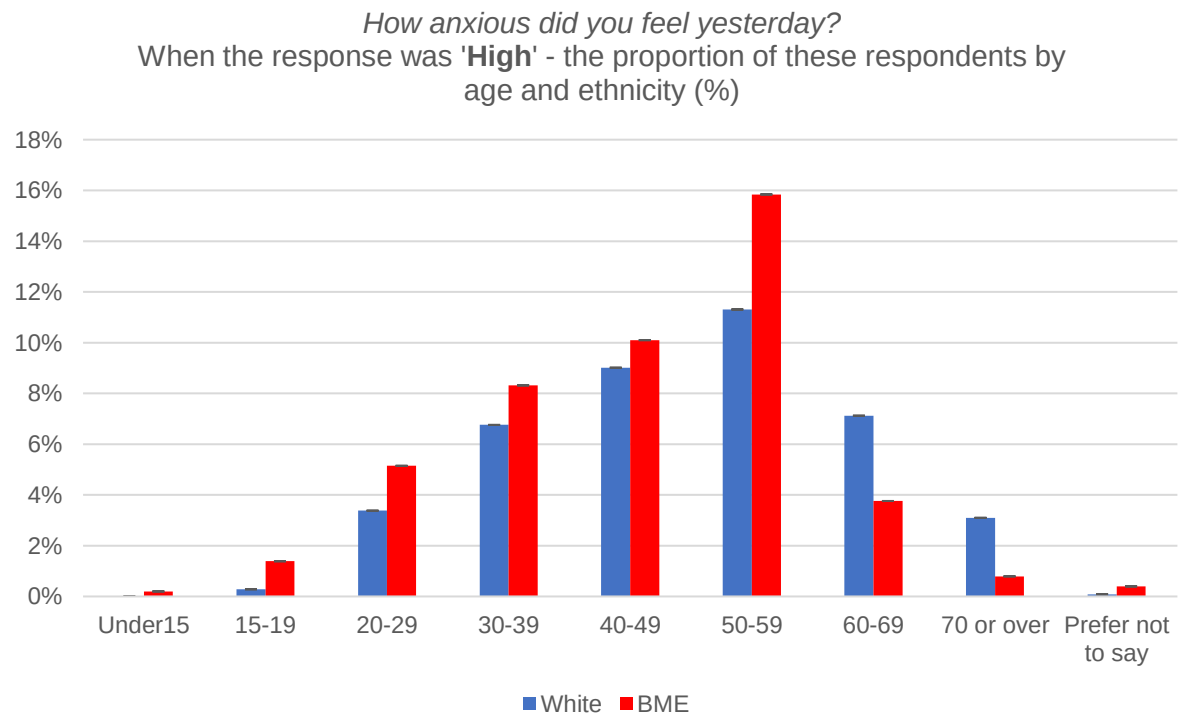


The results from the COVID-19 Impact Survey highlighted increasing levels of concern, anxiety and worry across age groups and different segments of our population. These include:

- Overall uncertainty
- Worry about health
- Separation from loved ones / relational tension
- Economic impact
- Loss of opportunity
- Disruption of routines and rhythms

Many of us suffered from anxiety and loneliness due to the pandemic. Still, there is evidence from the local COVID-19 Impact Survey that this didn't affect everyone in the same way. Rates of self-reported anxiety were the highest for those between 50-59 years old. This difference was more significant in ethnic minority (excluding White minority) communities (Figure 17).

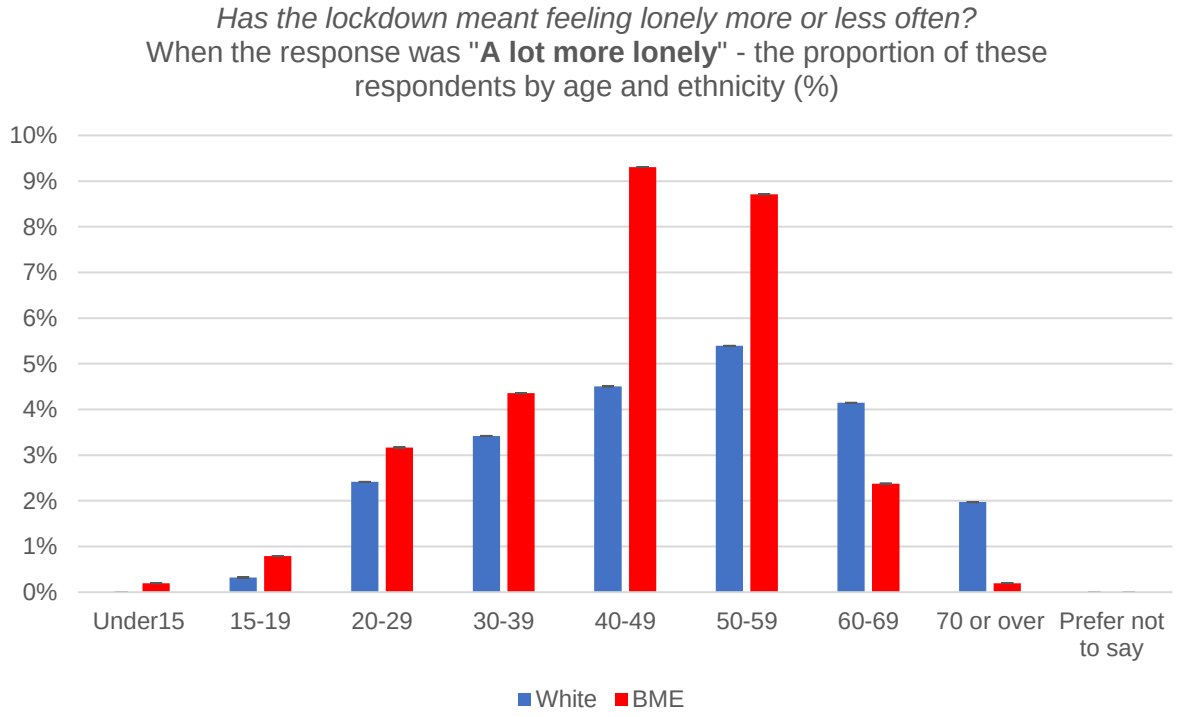
Figure 17. Rates of Self-Reported Anxiety by Age and Ethnicity[4]



Women were also more likely to report higher levels of anxiety. Non-white ethnic males had higher rates of reported anxiety than White males, but this was still lower than their female counterparts (See Appendix B, Figure 48). Many people experienced loneliness throughout

the crisis. There were higher levels of self-reported loneliness for people aged between 40-59 years. This is more significant in non-white ethnic groups (Figure 18).

Figure 18. Rates of Self-Reported Loneliness by Age and Ethnicity[4]



Females were more likely to report feeling a lot lonelier than males. Non-white ethnic groups had higher levels of self-reported loneliness in both genders than White counterparts, but this may not be a significant difference for females (See Appendix B, Figure 49).

The mental health impact upon children and young people continued beyond the first lockdown as they suffered several disruptions to usual education patterns. This was explored by a report from the Birmingham Youth City Board in February 2021 which asked children aged 11 to 18 similar questions to the original Impact Survey. For example, when asked 'has Coronavirus/lockdowns had an impact on how you are feeling?', 52% answered that they felt worse, with 31% feeling the same and only 17% feeling better.[24] When asked to provide comments, 26% of respondents said they felt stressed, anxious, and worried. A further 26% said their feelings had impacted their sleep and subsequent progress with learning.[24]

[24] Birmingham City Council, "Education in the Pandemic", February 2021

Figure 19. Factors Affecting Coping with the Mental Health Crisis[6]

The Well Equipped

- Often younger
- Often with pre-existing mental health conditions/treatment
- Mental health literacy and fluency on issues
- Ability to prioritise own mental health
- Coping strategies developed in some that have previously suffered
- Ability to take part in activities that allow them to self-actualise and slow down (e.g. gardening, creating, spending time with their family)
- Found purpose by caring for others

The Less Well Equipped

- Often older
- Often with limited coping strategies
- Had a limited understanding of mental health
- Did not normally prioritise mental health
- Not developed any coping strategies
- Might have struggled to meet own needs
- Did not manage to slow down, self-actualise, and reflect
- Needs were often overshadowed by caring for others

The Triggered

- Could impact either of the other two categories
- Triggered by traumatic or difficult experiences during the crisis
- Examples include
    - Contracting COVID-19
    - Working on a COVID-19 ward
    - Isolation
    - Death of a loved one
    - Economic insecurity
    - Challenges in the home
    - Impact of COVID-19 on our lives

Bereavement

Through our community partnerships and engagement sessions during the pandemic, there has been significant discussion of the impact of the restrictions on families and friends of people who were severely ill or dying. The NHS tried its best to be compassionate and use virtual calls and text updates to keep people informed and connected. However, this wasn't the same as being physically able to hold the hand of someone you love who is passing.

One specific element that came through these discussions was the issue of 'conversations unsaid', especially for lesbian, gay, bisexual and trans people. People described that the

distance and limitations meant they hadn't been able to have the difficult or 'closure' conversations they needed to have with the dying individual. These couldn't be done over the phone or through a virtual call. This lack of closure to relationships was described as adding to the grief and made grieving more difficult.

With over 3,000 deaths due to COVID-19 during the pandemic, many individuals, families, and communities were touched by death in this difficult period.

Resilience

As with physical health, some factors can make individuals more or less susceptible to worse mental health and wellbeing and how well an individual can respond to the crisis. It is hard to assess how much of the population were already in the less well-equipped or triggered groups entering the pandemic. This reflects a lack of data on mental wellbeing in our population, which has to improve moving forward.

Support

In the Spring of 2020, the NHS and the Council worked together to expand bereavement counselling support and worked with community organisations to support additional capacity in mental wellbeing support services.

The Council commissioned a series of interventions to try and support the mental wellbeing of citizens including launching the Be Healthy toolkit and a suite of YouTube videos from local people focused on wellbeing and self-care.

It was also recognised that children's and young people's mental health had been acutely affected. Forward Thinking Birmingham, the local partnership of mental health service providers for 0 to 25 year-olds, moved rapidly to adapt access so that residents could still reach their services and access support, including face to face support for those who were in the most clinical need.

Many of us reflected heavily on our mental wellbeing during the pandemic. We used coping strategies to deal with this mental health crisis that included finding different ways to connect through telephone calls, letters and online quiz nights. Some of us developed new routines which brought together physical activity and mindfulness to find balance. Through this difficult year, we have perhaps grown in our understanding of our mental wellness, which we have to build on for the future.

Health Behaviours

Physical Activity

Being active every day is important to prevent disease and reduce complications in people living with long term conditions. Moderate to vigorous physical activity not only benefits our physical health but also improves lung capacity and has a positive impact on mental health and wellbeing as well. The Chief Medical Officers recommend a minimum of 150 minutes a week of moderate physical activity and muscle-strengthening exercise two days a week for adults to improve health.

According to the COVID-19 Impact Survey in Birmingham, physical inactivity was the highest for those between 50-59 years (Figure 20). However, there were inequalities in the levels of inactivity by ethnicity. There were significantly higher levels of inactivity in non-white minorities in several adult age groups (20-29 years, 30-39 years and 40-49 years). Women were more inactive than men overall, but there did not appear to be any significant difference between White and other ethnic groups combined (Figure 21).

Figure 20. Levels of physical activity by age and ethnicity[4]

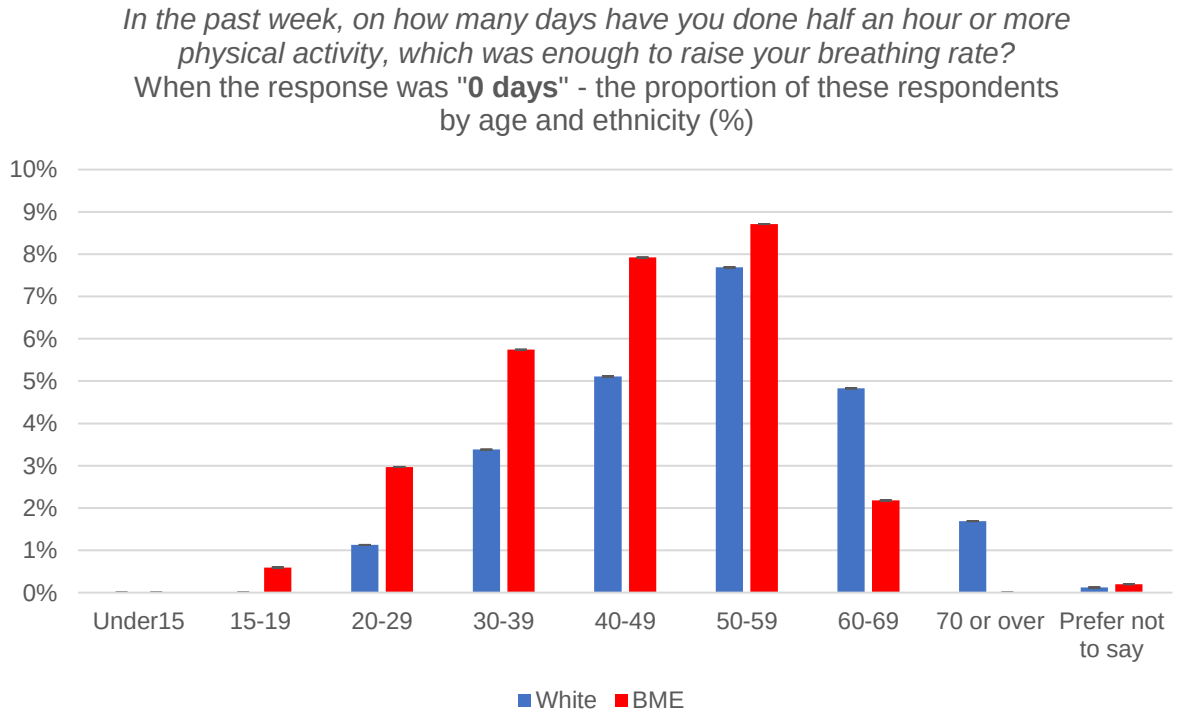
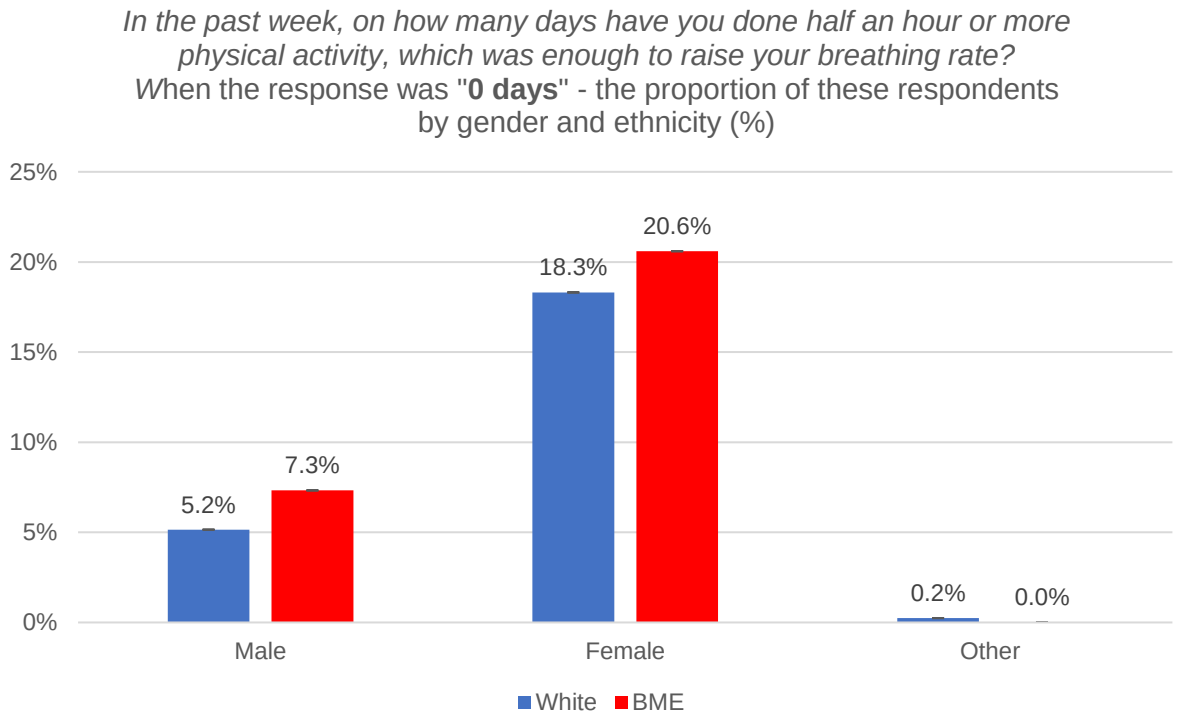


Figure 21. Levels of physical activity by gender and ethnicity[4]



People enjoy the outdoors for their physical and mental wellbeing. The use of green and open spaces increased during this time, helping them pursue some form of physical activity and offer a change of surroundings away from the confines of their homes. But a report commissioned by the National Trust in June 2020 highlighted that despite a considerable surge in utilising green spaces during the pandemic, inequalities existed in access to nature in many neighbourhoods, towns and cities. The study[25] found that Black and Asian people visit natural settings 60% less than White people. In the poorest 20% of households, 46% did not own a car and so urban parks and green spaces are their only opportunity to have contact with nature.

[25] National Trust. [Online]. Available: https://www.nationaltrust.org.uk/features/new-research-shows-the-need-for-urban-green-space (Accessed: 3rd December 2021).

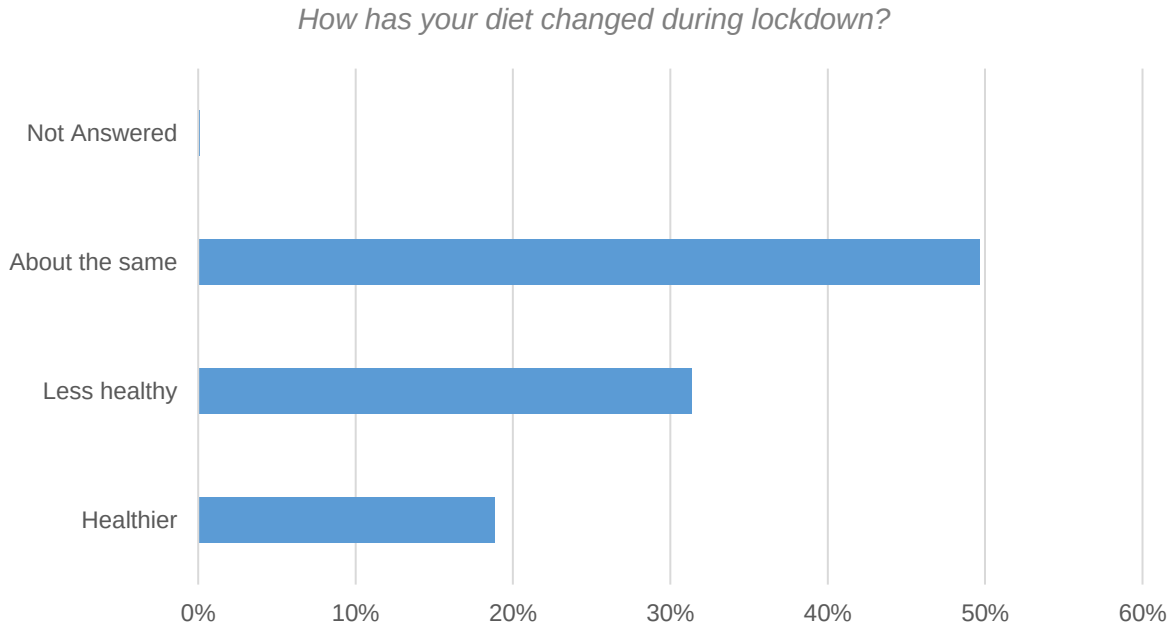
Although Birmingham has 600 blue and green spaces[26], we need to address the inequity of access and increase the number of publicly accessible green spaces, supporting the recovery from the pandemic.

Diet and Nutrition

The COVID-19 Impact Survey findings uncovered diet and nutrition were affected during the lockdown. Over 31% of participants felt their diet was less healthy since lockdown started. (Figure 22). More findings revealed the proportion of adults reporting meeting the recommended 5 portions of fruit/veg a day was only 24.4% compared to 48% in 2018/19. Also, 4.9% reported using a food bank for the first time and a total of 6.8% reported using food banks during lockdown (212 people). Additionally, just under 16% of participants reported ordering hot food deliveries at least once a week during the lockdown. In contrast, 52% reported doing so less than once a month. During the pandemic, the Council has supported a range of initiatives to support food security for citizens, including working with the Active Wellbeing Society to develop emergency food packages. This involved incorporating fresh produce and culturally appropriate contents, supporting additional food supplies to the food banks, enabling coordination between them to ensure that they remained stocked, and supporting citizens with new learning resources on home cooking on a budget and creating interesting, healthy meals.

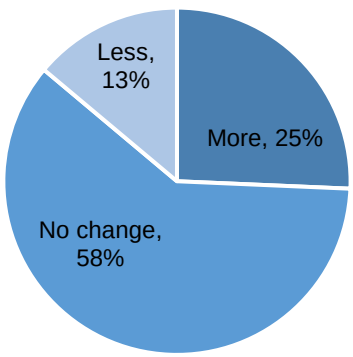
[26] Birmingham City Council," City of Nature", Executive Summary. [Online]. Available: https://naturallybirmingham.files.wordpress.com/2021/11/birmingham-city-of-nature-development-framework-summary.pdf (Accessed: 3rd December 2021).

Figure 22: How diet has changed during lockdown[4]



Further insight from citizen responses showed just over 25% of participants reported increased alcohol consumption during the lockdown (Figure 23). In the matter of water intake, there was an increase in water consumption, with more than 21% of participants stating they drink more water now than before lockdown. Around 15% reported drinking less water, and 13% reported drinking no water in the previous day.

Figure 23: Alcohol consumption change during lockdown[4]



Addiction

Respondents from the COVID-19 Impact Survey were also asked if the lockdown had affected any addictive behaviours they might have had. Starting with smoking, just under 82% of respondents were non-smokers and just under 16% reported smoking, vaping or using shisha, approximately 495 of the respondents. Within this, only 24 participants reported quitting smoking during lockdown and 16 reported switching from cigarettes to vaping. Unfortunately, 18 reported starting smoking and 1 reported starting using Shisha. Of those using tobacco products, just over 6.9% reported using more frequently compared to only 1.4% using less.[4]

The Impact Survey also asked if respondents used recreational drugs and whether the lockdown had affected this use. The survey did not ask about the type of drug being used. Only 128 participants disclosed using recreational drugs. Of these 29 reported using more drugs during the lockdown, 11 reported using less and 10 reported stopping completely. 67 people did not answer this question which was the largest 'no response' in the questionnaire.[4]

Substance misuse services rapidly adapted during the first wave of the pandemic to ensure that people in need of crisis support and access to treatment continued to receive the help they needed. We also brought online new app-based support for smoking cessation as an innovation pilot to provide additional support for people wanting to quit.[4]

Case Study: Joy, a story of shielding[4]

"In February I had a chest infection and went to my GP. He was worried because I have chronic lymphatic leukaemia, but he gave me antibiotics and it cleared up. I didn't think I had corona at the time, but when it all came to light afterwards, I have to think that maybe I had some kind of mild form of it. Then sometime in March I got my shielding letter from my GP and thought ok I won't be able to go out as much as normal. My daughter was still going to work, and my husband started doing all the shopping. I was shocked seeing the pictures in the news of shelves in shops with nothing on them. Luckily my husband didn't have to queue because he works for the NHS. Every time he or my daughter came back to the house, they would get undressed and put everything straight in the washing machine to make sure it was safe."

"It wasn't until they started to give out the figures of how many people were in the hospital that I realised how bad it was; I thought they might have something like vaccination or a better way to deal with it. I found it very unbelievable to be honest, who would have predicted 2020 would have been such a horrible year? It was hard being in lockdown. Even though I've been ill I still

try and get out a bit, but I haven't been able to see my friends as I normally would, and I miss that kind of contact. We do keep up on WhatsApp and over the phone. If I think about someone, I just drop them a text and ask how they are; those bits of interaction make people know you are there."

"Visiting my Mum over the summer was strange as well… she stood by her car and I stood by the front gate. I kept thinking if something happened to them, would this by my last memory. The worst thing though is not sleeping in the bed with my husband which has been right since the start, when we were advised not to because he works for the NHS and I'm in the shielding category. It makes me feel alone and I worry imagining if something happens to one of us. I don't know when we'll share a bed again, I guess once they have a vaccine. I don't know anyone directly who has got corona, but I'm on a Facebook group called Shine a Light and you do see how much different people are struggling with it. Especially when people haven't been able to be with their families in hospital. I was in hospital a lot last year because of my condition and I just feel so lucky that I am not going through that now. I was always waiting for my husband to come and visit me. I can't imagine not having those visits."

"When I was having my main treatment in 2018, I was going into hospital twice a week getting blood transfusions. I'm thankful that now I don't need to go in as much. I actually had a call from the hospital in May when they said there was no need for me to come for a test. I know they've said some cancer care has been delayed, but luckily mine at the moment is just monitoring. The next time I went in was in August and the hospital was totally dead, and everything went so smoothly. I actually felt really comfortable there, it just felt well managed and like they had it under control. And my GP has been brilliant. He was the one who suggested I take some time off work when the virus was first starting to spread, because I would be in contact with a lot of people. He also gave me a number for mental health support. I really felt looked after. He always discusses things with me, like if my prescriptions need reviewing, it never feels like he is rushing me."

Our Relationships

Many people experienced strain on their relationships during the crisis. One of the reasons for this was the nature of their home and its impact on their everyday life. The research identified two contrasting experiences of the home which took on disproportionate importance. Some were happy and saw their home as a 'sanctuary', and some were unhappy and saw it as a 'prison'. A sanctuary was a comforting space where relationships could be nurtured at home. It was a place where activities could take place (gardening, creating or family time). Those who saw their home as a sanctuary had coping strategies and lifelines in the home, including routines, activities, and people. It was also somewhere that was perceived to be safe from the virus. A prison was usually a limited space and sometimes included challenging relationships. When problematic relationships were present, it was difficult to escape, and there was limited access to lifelines outside the home in the same way that was in someone's sanctuary. Many people in this situation felt trapped and afraid.

"At times it got horrible and awkward, living with my ex during lockdown. I had to go and stay with a friend for a few days. I found out I could do that in lockdown – mentally I was going round the twist. Looking back, it was quite difficult, but I had to think about my daughter as well, protecting her. She stayed with her boyfriend for a few days, to get out of the toxic background we had. It's been very difficult."

Flo, 45, individual interview (October 2020)[4]

Some have experienced significant strain on relationships. Lockdown caused people to spend more time at home, and for some, this was too much. Differences in views on the crisis and the restrictions imposed also led to a strain on relationships. For most, the crisis has emphasized the importance of interpersonal relationships and face to face contact.

The pandemic has had an extraordinary impact on interacting, supporting, and connecting. The effects of the virus and the necessary restrictions came at a cost of our relationships with one another. Our needs have been to continue to ensure our contact with each other goes beyond the functional. Our contact with each other has to actively nurture the relationships we build and maintain. We have coped with this relational crisis by 'creative interpretation' of

bubbles, connecting digitally, and making the most of meeting physically when allowed to do so. Our assets have been those strong existing relationships we have relied upon, living close to loved ones, and meeting people in outdoor spaces. The ability to utilise digital communications and the presence of community has been vital for our relationships. Support has come from family, friends and community. It includes both online and offline contact, but it must be meaningful. Those with unmet needs had fewer or geographically more distant relationships. Sometimes this meant people lacked 'someone to turn to'. Occasionally, further communicating the importance of social connection was required, and some went without secure spaces for social interactions. Volunteers and professionals could help build positive relationships that may be lacking, which can help build community and minimise relational costs.

"Family are the people who should help us in a crisis. But all my family are in America and my wife's family is in Hungary. No one in the community here really knows each other or helps each other. I speak to my family a bit on WhatsApp, but here there is no one we can turn to for help."

Sami, 49, individual interview (October 2020)[4]

People have varying levels of responsibility and vulnerable people that depend on them, which has impacted people's experience of the crisis. Those with more vulnerable dependents have experienced greater anxiety and complexity. Their actions and the decisions they make also have greater consequences. However, the act of caring for the people that depend on them gives them purpose and distracts them from the uncertainty caused by the crisis and, at times, boosts their mental health. Those with fewer or less vulnerable dependent people have greater freedom and can make those personal decisions without worrying about the consequences of involving vulnerable loved ones. Some, however, have experienced the feeling of separation from their loved ones.

Figure 24. Relational needs and support during the crisis[4]

Needs

- Contact with others that actively nurtures relationships
- Copying strategies
- Interpretative Creation of Bubbles
- Digital Connection
- Making the most of physical meeting
- Making quality time count

Assets

- Strong existing relationships
- Living near loved ones
- Outside space to meet people
- Less vulnerability in bubble
- Being part of community
- Ability to use digital communications

Support

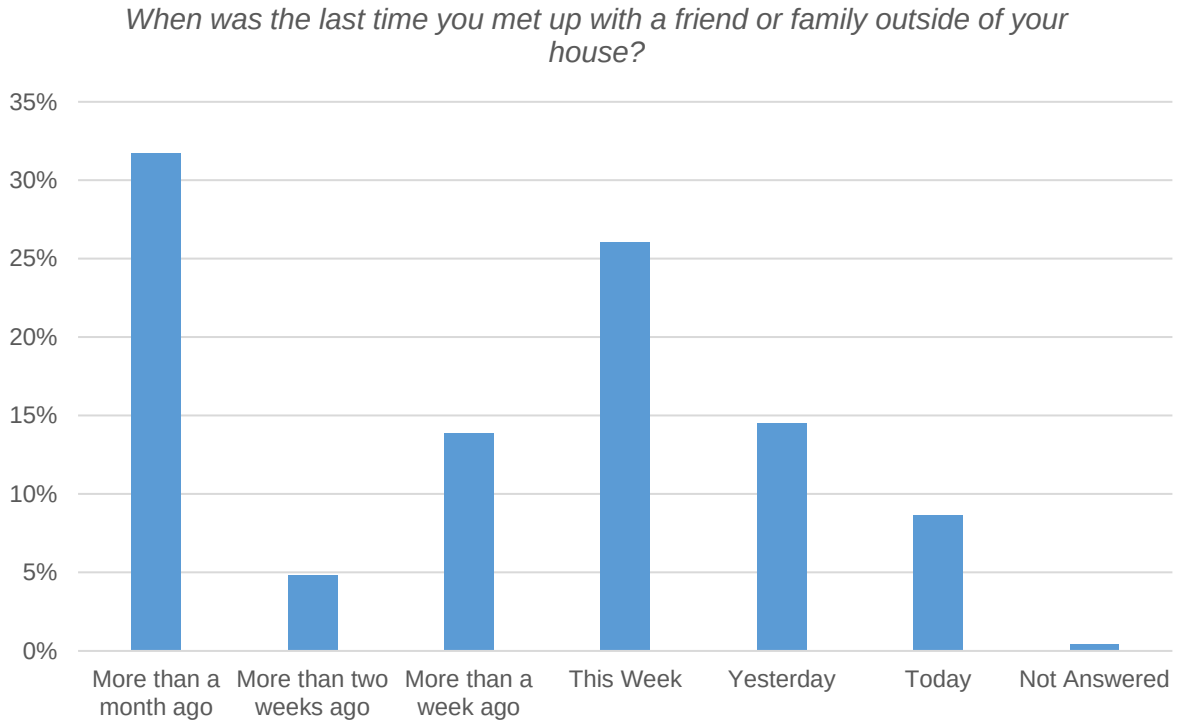
- Meaningful online and offline contact
- Friends
- Family
- Community

Unmet Needs

- Lacking ‘someone to turn to’
- Communicate importance of social connection
- COVID-19 secure spaces for interactions
- Volunteers and professionals to befriend those lacking positive relationships
- Community-building

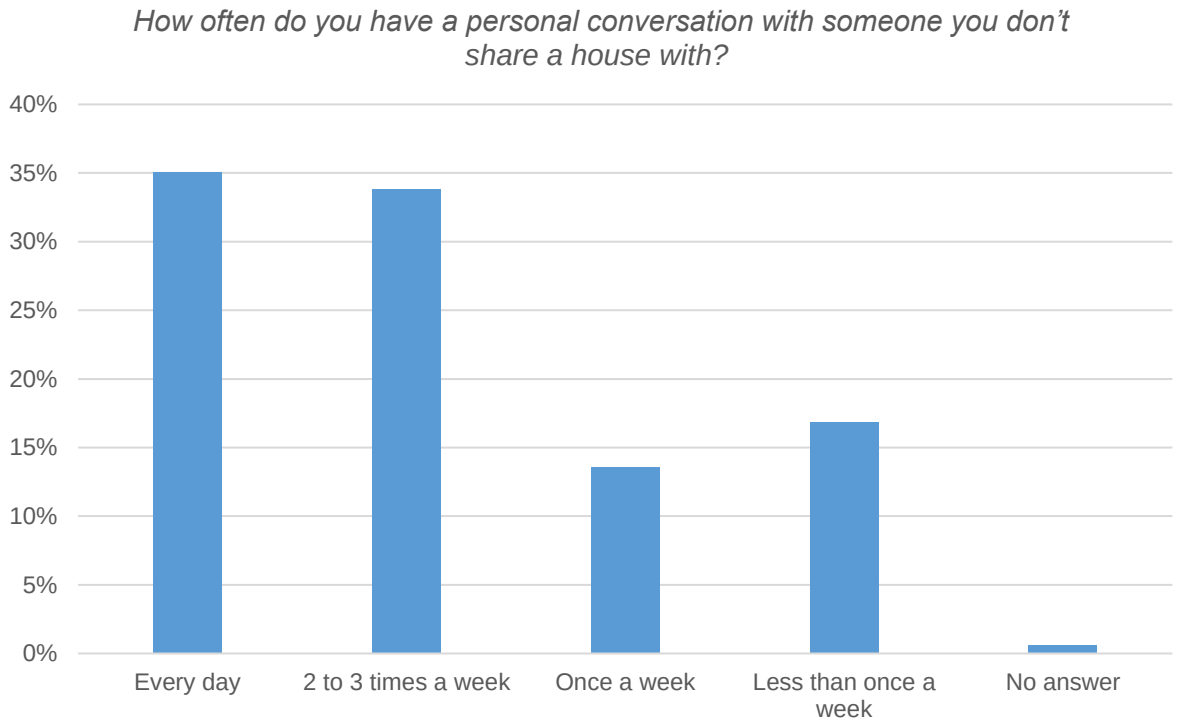
The impact of the pandemic on relationships was also seen in survey responses relating to the frequency that people were able to meet with family and friends outside of their house. During the first set of restrictions, at the time of their response, almost one-third of people (32%) had only done so more than a month previously (Figure 25).

Figure 25. Meeting with family and friends outside the home[4]



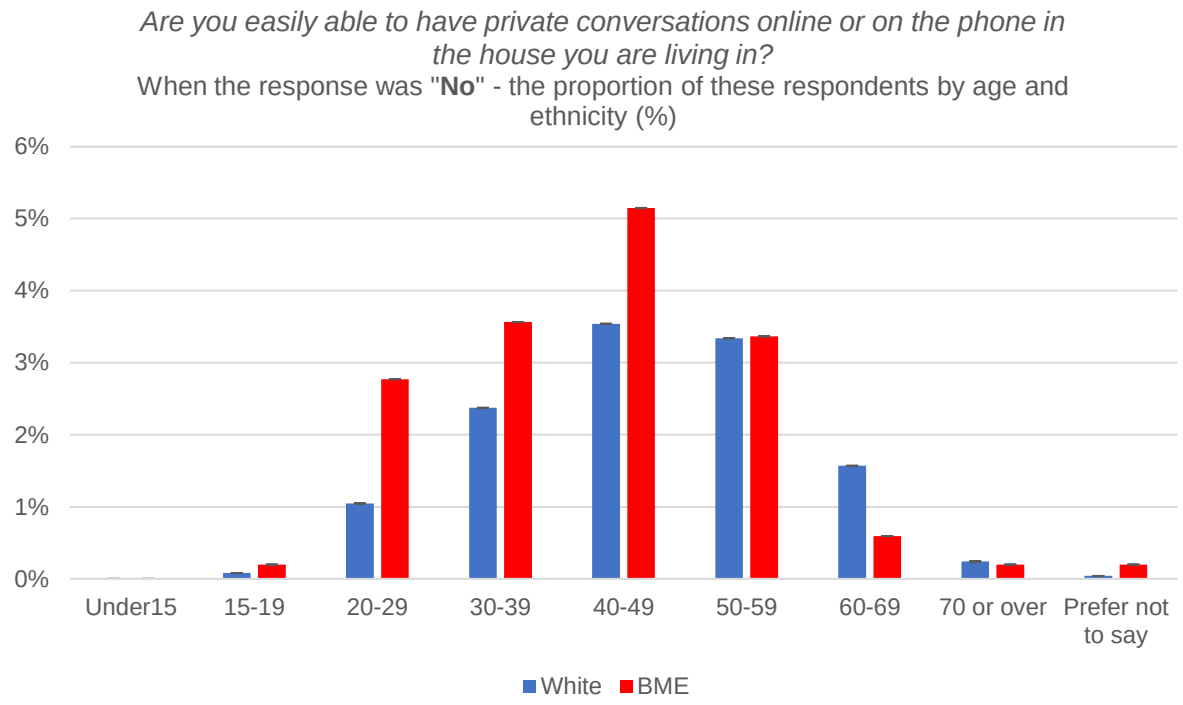
Despite the impact of restrictions on the pandemic, according to the COVID-19 Impact Survey, most people were still able to have personal conversations with someone they did not share a house with (Figure 26). Over one-third of respondents (35%) said they did so every day, and a similar figure (34%) did so two to three times per week. However, 1 in 6 people (17%) said that they were having personal conversations with someone they didn't share a house with less than once a week.

Figure 26. Personal conversations with those outside the home[4]



However, maintaining relationships and maintaining privacy became an issue for many people when restricted to their homes. Many people struggled to have private conversations when at home. Figure 27 demonstrates that a slightly higher proportion of non-white respondents around the working age were affected by this compared to white respondents. However, the confidence intervals suggest the most significant difference between ethnic groups is those between 20-29 years.

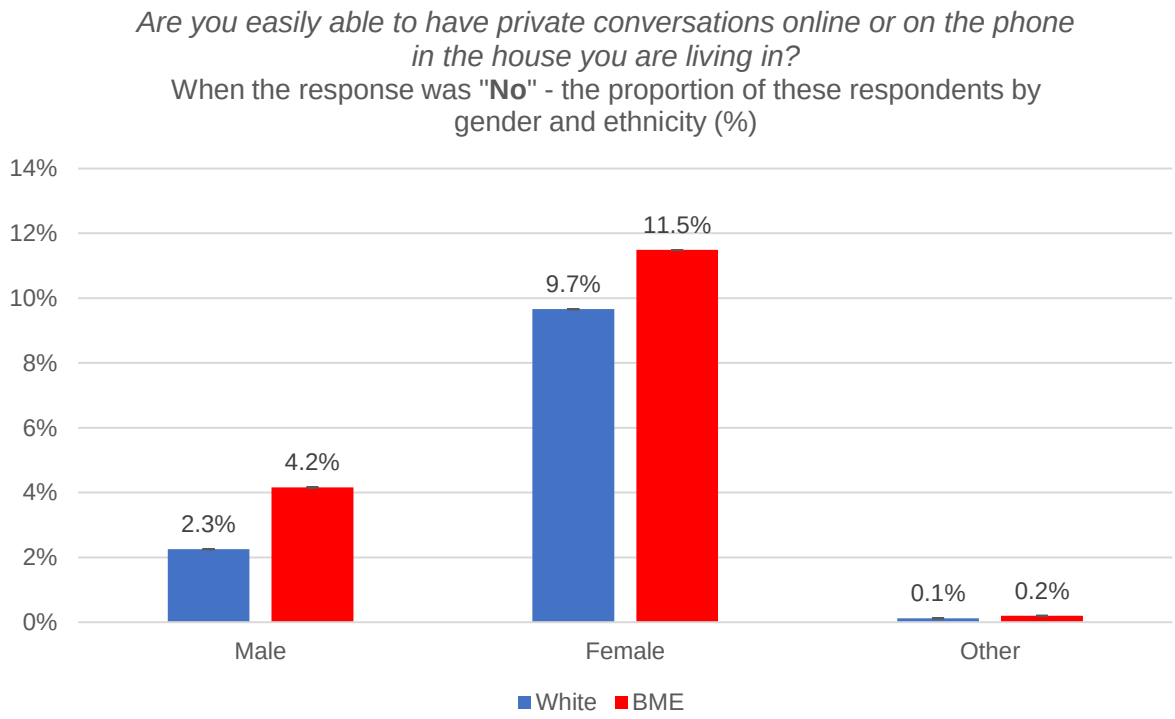
Figure 27. Private conversations within the house, by age and ethnicity[4]



Women were a lot less likely to report having privacy at home. Still, the data suggests that there did not appear to be a significant difference between ethnic groups (see Appendix B, Figure 42).

The survey also suggested that family relationships have deteriorated more in age groups 40-49 years and 50-59 years for those with a White ethnicity group. However, this difference is not as clear in non-white ethnic groups because of overlapping confidence intervals (Figure 28). Again, women were more likely to report family deterioration than men, but there did not appear to be significant differences between ethnic groups (see Appendix B, Figure 43). Personal relationships (with partners) were also impacted differently. According to the COVID-19 Impact Survey, they appeared to deteriorate more with increasing age up to 59 years. This was significantly higher in non-white ethnic groups aged between 40-49 years and 50-59 years (see Appendix B, Figure 44).

Figure 28. Relationship changes with children/family since lockdown by gender and ethnicity[4]



Females were more likely to report that their relationships with their partners had changed than males. And while there did not appear to be significant differences between White and non-white ethnic groups for females, it was significantly higher for men among non-white ethnic groups compared to White groups (see Appendix B, Figure 44).

Case Study: Leanne, a story of isolation[6]

At first, things didn't feel that different for me. I work as a project manager in clinical investigations and often worked from home anyway. The biggest change was not being able to go into hospitals. My fiancé works for his family business and they went back to the office quite quickly, so it didn't feel too cramped working from home for too long!"

"I'd say I've been pretty lucky when it's come to lockdown and Covid. My fiancé and I are both in secure and stable jobs, and to be honest I've really appreciated the opportunity to spend more quality time together: going out for lots of walks and runs; having more time to cook together at home; spending time in the garden. We had to cancel our wedding which was planned for June, but that feels a small sacrifice compared to what I know other people have experienced over the last year. And all our families have been healthy, which I'm very grateful for."

"Perhaps because I work in the world of healthcare, I've always taken quite a scientific view of restrictions. I was happy when they made face coverings mandatory because I do believe they significantly slow transmission of the virus. And I agreed with pubs closing at 10pm, because alcohol definitely limits inhibitions! But I've often wondered if there could have possibly been a more nuanced response to the pandemic – shielding vulnerable groups and letting others live their lives safely. I thought it was good that schools weren't totally closed like they were in Spain: the children of key workers and kids who need extra support could still go."

"And I've been unimpressed with testing: you go online to find out about local capacity, and hear there's nothing available, but then when you go to a testing site it's empty. My fiancé had that experience in Wolverhampton. It feels so disorganised and the government should be doing better. But I know this situation is unprecedented and they have a tough job."

"By far the hardest thing for me has been not seeing my family who live in the south of Spain. We're very close and I typically see them every 5 or 6 weeks. Maybe it's a Spanish thing, but family are really important, having them all close to you. I really missed them at the beginning of all this when I couldn't see them at all. Now we can travel, but quarantine makes it more complicated. Digital contact helped, but it's not the same. We drove to Spain in July and it was so so lovely to see them after all that time. I gave them all hugs – I'm not sure if that was allowed but it was just so wonderful to finally be together again! And we're only human. I enjoyed seeing my fiancé's family (who live locally) during summer when that was allowed – of course it's not the same as seeing your own family but it was always lovely to see them, and I was sad when Birmingham went into local lockdown in September and that wasn't allowed anymore. It's all definitely affected my mood – not to the extent that I need to seek help, I guess just as much as you'd expect during a time like this."

"Overall, I haven't interacted with many people over this time. I didn't have a huge social life here to begin with, and now it's even harder to meet people. In Spain I was always a very sociable person, so this has felt like a big change for me. So, I guess it would be good if there was a service that provided opportunities to meet likeminded people in a safe environment. Like organised sport – but safely! I'd definitely really appreciate that."

Our Society

The pandemic has had a profound impact on our society. Trust in the public authorities has fluctuated through the pandemic and some have noted a lack of deference to authorities. Many have turned to alternative sources of support and information.

For some, the restrictions imposed were not enough whereas others felt they were too much and impacted on personal choice. For others, there has been a lack of logic in what the guidance means. Many have viewed the restrictions with suspicion, particularly those who will pay a higher price. Misinformation has featured during the pandemic and at times, conspiracy theories have entered the mainstream. Whilst this has been present throughout the pandemic, it has featured heavily in the rollout of the vaccination programme. There is a pressing need to restore trust and togetherness in our society as we emerge from this crisis.

The cost of the COVID-19 pandemic has been felt individually and as a society. As we entered the crisis, we needed clarity on messaging and a sense of connection and solidarity with local leaders. People also wanted to feel heard and understood, as well as understand the restrictions that were imposed on society. To cope, we often looked for alternative messengers and narratives, which in some cases led to more conspiratorial theories and disobeying the rules. We used a wider engagement with news sources as an asset and received support from news providers who simplified messaging. Initially, the press conferences provided support alongside the countries' leading experts in the Scientific Advisory Group for Emergencies (SAGE). In entering this societal crisis, people have felt there is a gap in a local representative that is vocal and makes the people of Birmingham feel their needs are heard and represented.

Figure 29. Societal needs and support during the crisis[6]

Needs

- Clarity of messaging
- Sense of connection and solidarity with (local) leaders
- Feeling heard, feeling understood, and understanding of restrictions

Coping Strategies

- Looking for alternative messengers/narrative
- Resorting to conspiracy theories
- Disobeying the rules

Assets

- Wider engagement with news sources

Support

- News providers who clarify and simply messaging
- Press conferences (initially) and SAGE

Unmet Needs

- More vocal local representative/voice that makes people of Birmingham feel their needs are heard and represented

Authorities and Restrictions

The pandemic has impacted our lives in different ways and our journeys are unique. However, there were some patterns identified in the ethnographic research.[6] As time progressed throughout 2020, there was a growing sense of anxiety, depletion and confusion. There was also a growth in autonomy too. As the pandemic went on, people became anxious about their health, money and opportunities. They became anxious about daily rhythms arising from the "everyday crisis". People's reserves became depleted, including financial resources and their emotional resilience. This reduced people's ability to cope and occurred after 6 months after the onset of the crisis in March 2020. There was also growing confusion with new restrictions, rules and guidelines. In some cases, there was a perceived lack of communication on a local level, with authority and leadership becoming increasingly unclear. For some, this led to a growing mistrust in authority. Despite the diminishing of resilience, we found new ways to adapt to changing circumstances and became more autonomous. Many people suffered during the crisis and felt it was better to take control of their own decisions, doing what they feel is the right thing, rather than what they have been told to do.

Many believed that following the rules meant that they had a price to pay. Many used this cognitive dissonance to develop their philosophy of adhering to the rules imposed. There were situations where the price was high when choosing whether to follow the rules:

"Whilst I had Covid, a friend alerted me that my daughter was writing worrying things on her Facebook wall. My mother's instinct told me I had to drive to pick her up immediately, even though I had Covid and was meant to be staying at home and isolating."

Flo, 45, individual interview, October 2020[6]

People's internal commitment to following guidelines started to falter as time progressed. There were situations where the perceived pain if they were to adhere to the rules changed, and therefore so did their behaviour:

Different Rules for Different Relationships[6]

"When I went to Spain [after lockdown], I was living in the same house as my family [and hugged them], you are a human being as well, but for example my [my fiancé's] family I haven't hugged them since lockdown."

Drawing Tighter Boundaries around Certain Dependents[6]

"It's tough as my mum isn't very well and I would like to see my parents […] I know I wouldn't be at much risk myself but I don't want to put my family at risk so I would get tested before I go."

Bending the rules for special moments[6]

"There would be 11 of us here for Christmas, so I'm not sure what we will do this year […] I'll be very sad if I can't do Christmas […] I'm not sure I'll stick to the rules that rigidly."

People's personal philosophies contributed to how they perceived the handling of restrictions. Those who did not adhere to the rules were more likely to say the rules were confusing, illogical or impossible to understand. They were also more likely to feel that the price to pay was too high and not sustainable. Their growing mistrust and scepticism of government became a justification for themselves to make those decisions. Those who have a philosophy of adhering to the rules to a greater extent are more likely to feel like they are not in control. They felt like they had to go beyond the guidance to protect themselves further and became uneasy and worried about others not following restrictions. Some were even relieved when restrictions were tightened for this reason and were critical of the Government for not enforcing restrictions to the pace or the extent that they felt they were required. These opposing views created huge challenges for authorities to manage expectations and maintain credibility, trust and support.

"I don't even know what exactly the rules are anymore. I always would have done the things I am doing anyway. People want to meet people, it is a human need. That is why solitary confinement is a punishment. I don't know anyone my age who is sticking to the rules. In the beginning, everyone was. But now everyone thinks it's over now and that was long enough…"

Guy, 18, individual interview (October 2020)[6]

Messaging

Regarding the ethnographic research[6], many agree that communication from authority at a national level has been confusing. Despite the sympathy offered due to the circumstances, many were critical of the lack of clarity and U-turns (e.g. face masks policy). Public trust has also been impacted by the perceived notion that the elites are not following the rules that they were involved in creating and enforcing. For example, when the Prime Minister's advisor Dominic Cummings did not comply with restrictions. As the pandemic went on, the frequency of national communication declined. People were appreciative of the press conferences that started in March 2020 and the updates from SAGE and its technical and scientific experts. These updates and more regular communication made people feel more informed and in control. The lack of messaging in this context increased the feeling of uncertainty. More communication from national politicians and civil servants can help build trust in the government's response to the virus and enable people following the restrictions to better understand the rationale behind them.

"It would have been good for local councils to send out leaflets to people, saying what is available to people, whether a phone number to call, for families struggling financially and food-wise. There could be pamphlets or booklets with information on websites."

Joy, 56, individual interview (October 2020)[6]

Research suggests that people have a low awareness of the role of local government during the pandemic.[6] There was an appreciation of "marking" in public spaces and reminders to wear a face mask, keep a distance from one another and use hand sanitiser. However, this

was not attributed to local authorities. Within the research conducted, there was little awareness of communications from Birmingham City Council, apart from initial contact for those who were shielding. Overall, people felt increasingly isolated and without direction during the year.

The focus on COVID-19, the restrictions, and our response to it meant the news was fixated on a single topic. This can expose it to disinformation and conspiracy theories which became a bigger part of the mainstream discourse. Disinformation was able to spread when there is a vacuum in understanding or when people became frustrated with the restrictions and looked for alternatives. Examples of ideas that have gone beyond fringe thinking are around the origins of the virus, the Government using restrictions as a method of social control and the anti-vaccine messages.

Figure 30. Perceptions on authorities and messaging[6]

National Government

- Initially trusted and appreciated for efforts
- Now increasing mistrust as people find:
- the strategy less clear
- the restrictions less effective
- that the price paid for pandemic feels increasingly heavy

SAGE

- Appreciated as medical authority
- Initially trusted more than the Government
- Now feels more in the background

Local Government

- Notably absent
- Opportunity for local government to speak out more frequently and clearly
- To make people of Birmingham feel their needs are being addressed on a more local level

Alternative Messengers

- Particularly younger people are turning to alternative messengers e.g. meme accounts for their news
- Opportunity to use a wider range of messengers to make messages more resonant across target groups

There are similarities in the perceptions of authorities from the stories from citizens and the research which asked survey respondents which sources of information they trusted to a low, medium or high extent. Despite initially trusting the national government, survey respondents trusted them the least of any of the institutions that were asked (Figure 31). NHS organisations and Public Health England (PHE) were the most trusted, which was followed by Birmingham City Council (BCC). According to the survey, social media platforms were the least likely to be trusted, with word of mouth seen as a slightly more trustworthy source. However, the research did suggest that more people, particularly young people, were turning to alternative messengers for information.

Figure 31. Trust in the information people received from various sources[4]

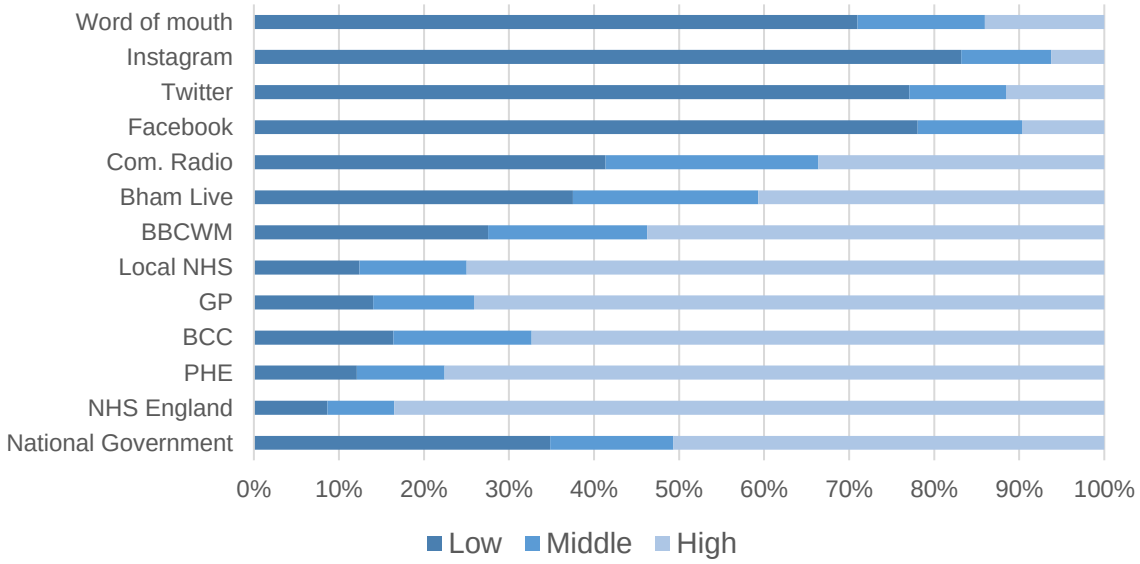
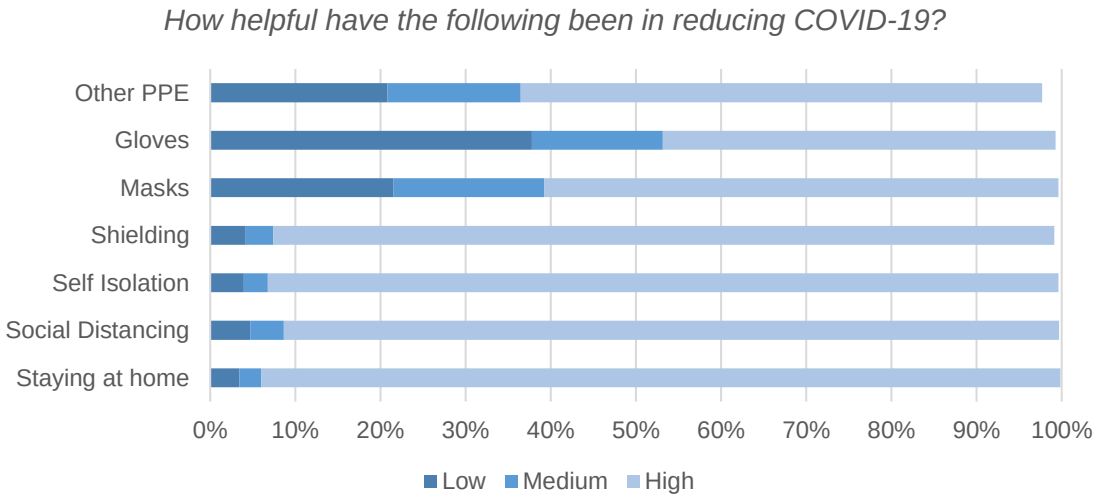


Figure 32. Perceptions of the success of protective measures against COVID-19[4]

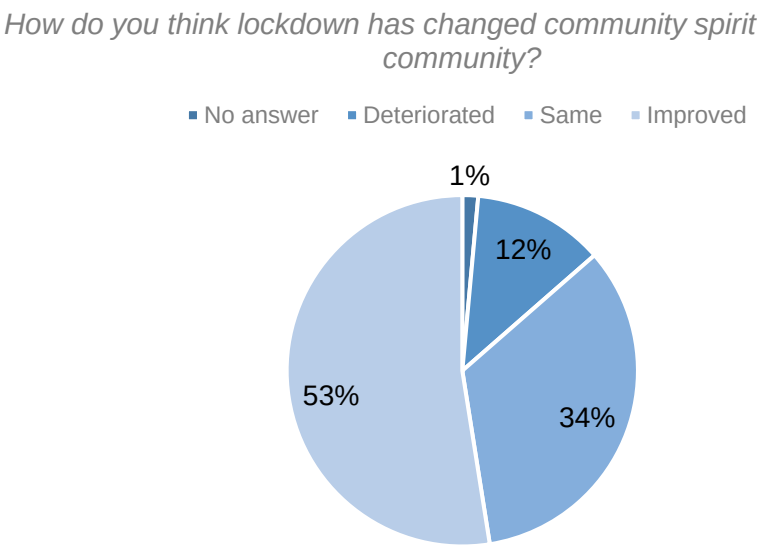


Communities

Linked to messaging and communication, was the impact that lockdown/s had on community spirit. The connection people have with their community played a role in their response to mitigate the impacts of the crisis. Some experienced their support network through their community, with neighbours helping with activities such as shopping, plumbing and check-ins. Others did not experience this and did not have a community around them and therefore did not have this local safety net.

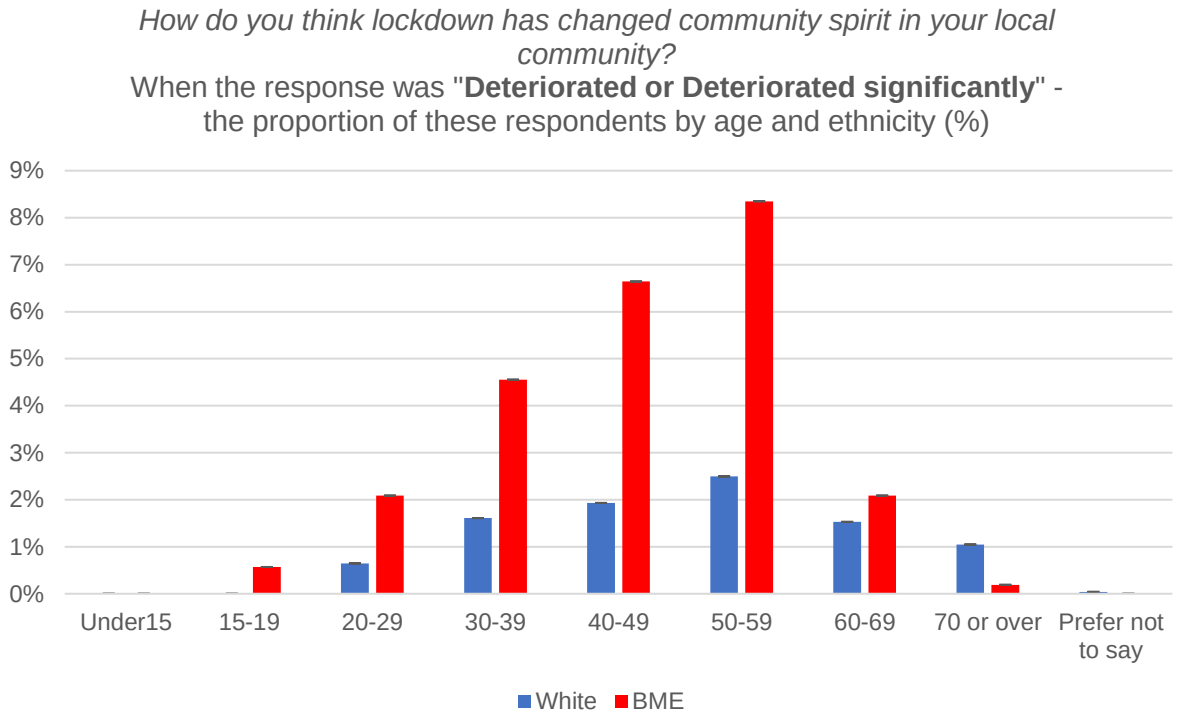
The survey responses illustrate that a majority of respondents believed that lockdown/s had improved community spirit in their local area (Figure 33).

Figure 33. The impact of lockdown on community spirit in the local community[4]



However, there were inequalities present in people's perception of community spirit. In general, non-white ethnic communities were more likely to report that they felt that community spirit in their local community has deteriorated during the crisis. This figure was also higher in the working-age groups (Figure 34). A similar pattern was seen for perceptions of community spirit in local communities and across the city as a whole (see Appendix B, Figure 45).

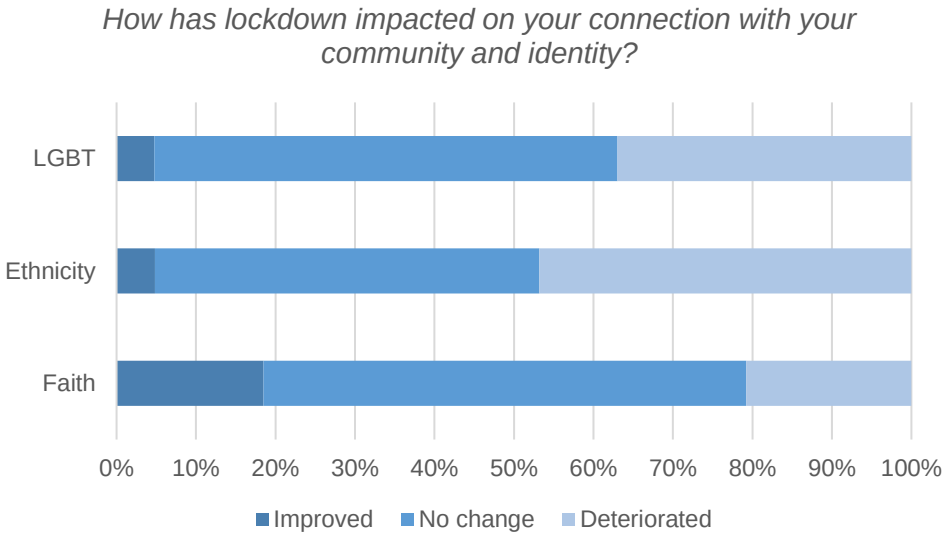
Figure 34. The negative impact of lockdown on community spirit in the local community, by age and ethnicity[4]



This pattern continues with people's relationships with their local geographical community, where non-white ethnic groups were more likely to report that this had deteriorated during the lockdown/s. Again, this increased across the working-age groups (see Appendix B, Figure 46). Equally, females were more likely to report that their relationship with their local community had deteriorated compared to males. This was true in both White and non-white ethnic groups and more significant for non-white ethnic groups in both genders (see Appendix B, Figure 47).

In general, communities of identity have also felt their relationship with these communities has deteriorated during lockdown (Figure 35). This is except for faith, where almost as many thought it had improved as deteriorated. Ethnic minority communities were the most negative about how their relationship with their community had changed during the pandemic.

Figure 35. The impact of lockdown on connection to community and identity[4]



Finally, a significant community; children and young people in education also reported the mixed impacts that lockdowns had on their learning. For example, when asked how well they thought they had adjusted to home learning, just over 61% answered that they had adjusted well while 39% said they hadn't. The difference is even slimmer when asked if they clearly understood what was happening with their school or college work. For this question, just over half (53%) said that they did understand what was happening.[24]

The impact of the first lockdown, in particular, provokes a negative response from the survey respondents. When asked if they were given a good standard of education in the first lockdown, 57% answered 'no'. When a similar question was asked about concerns they had about the delivery of their education at the time of the survey (February 2021), a significant majority (45%) still reported that they were concerned, with reasons for this concern ranging from a lower standard of teaching and less 1:1 interaction with teachers.[24]

The knock-on effect of disruptions to children's and young people's education has been a loss of confidence in their preparedness for the next steps of education. When asked how prepared they felt, only 7% felt 'very prepared' with a further 30% answering that they felt 'prepared'. However, 33% said they only felt 'a little prepared' and another 30% said they didn't feel 'prepared at all'.[24] The concern that these results illustrate is that it is difficult to find any answer where the respondents gave overwhelmingly positive responses. While on aggregate, just over half do seem to have adjusted and feel prepared enough to continue, a significant minority have only felt the negative impacts of the disruptions. They have lost confidence in their education as a result.

Case Study: Guy, a story of frustration[6]

"They started announcing they were closing schools around March. I thought it might be a month and a half that schools would be closed, but then they said exams were cancelled and our work basically just stopped. We never went back to school and people just didn't bother to do the stuff online because we knew we wouldn't have exams. It did feel really weird. We just got an email at 7am on results day, and that was it. They could have done that better. I then went through clearing as I messed up my UCAS choices, and it was all a bit stressful, but the school didn't really help at all with that."

"My last exam would have been June, and me and my mates were planning to go to Magaluf a few days after that to celebrate, but it all got cancelled. At the start of lockdown, me and my friends did loads of group calls on that House Party app, just messing around, but we got bored of that. Then April and May were pretty quiet months. I would wake up, do a workout, do nothing until the evening, then go for a walk to get outside. It just felt like a long and boring summer holiday. I missed sitting around with friends and messing around, and those random conversations that you just don't get on Zoom or texting. And the gym!"

"Towards the end of lockdown, I started meeting up with friends a bit in the park. We just felt bored and knew there was such a low chance of having the virus. Then by mid-June I went to the first house party, with maybe 20 people. It felt so great. We were mainly outside, but it just felt good to be back. In the summer I had some friends over and we would go to the pub a bit, which my parents were fine with because they knew everyone I was meeting up with."

"It was really nice to get to uni and meet people. I think being inside for so long during lockdown made me feel like I had to make the most of it, it's made me more sociable. I've been going out every single night since I got here. There are a lot of flat parties because the clubs and bars are all closed. It's a bit annoying because there is security everywhere, but they can't be everywhere all the time. You get messages from friends around 9 or 10pm saying come here or there, and if security comes you just have to dodge them. We still go to the pub and things, they have no way to check who is in your household, as long as you go in a group smaller than 6. I think we're in Tier 2, but I don't really know what that means. I didn't watch Boris Johnson's announcement, I just follow a lot of Instagram pages and it will say Boris has said x, y, z about the restrictions, or there will be a meme about couples in tier 2 not being able to meet inside. That filters out most of what I don't need to hear."

“There are 12 people in my flat and those who want to go out just go out, it wasn’t like we had a group discussion or anything about it. Everyone just does what they want. There are three people who are never in the shared space, they just grab a pot noodle and then are back to their room. You have to wear a mask in all of the lectures, and you have to shout through the mask to be able to say anything, but actually most stuff has been online. I don’t mind that too much, I can play the lectures at double speed as they are all pre-recorded. What they haven’t done at uni is anything to deal with people’s desire to socialise, so people have just met anyway. People want to meet people; it’s a human need. That’s why solitary confinement is a punishment. I don’t know anyone my age who is sticking to the rules, whereas at the beginning everyone was. But now everyone thinks it’s over and that it was long enough.”

“I think at the start people sacrificed their need to socialise, but now not anymore. It comes down to common sense for me, you can be sensible. Like I’ve seen people who have been in mosh pits in a tiny kitchen rammed full of people, and that kind of thing obviously isn’t sensible. But me sitting around a living room with 10 other people doesn’t feel that risky. I’m not a big worrier, but I sometimes think about how things might change long term, like festivals and things. I don’t think they will ever really go back to normal, there will always be a remnant of this. There will always be people wearing masks. You are always going to be reminded of how that all started.”

Our Economy

The economic and financial impact has been felt differently across the city, and it has not been an economic crisis for all. Some have experienced short-term impacts, whilst others feared their financial future.

The Impact on our City

The city has experienced its highest levels of unemployment since the 1980s. In 2021, the total number of unemployed people claiming job seekers allowance or other unemployment-related benefits was higher than before the first lockdown, which has also affected young people (18-24 years old) (Table 16).

Table 16. Increase in Claimant Count Unemployment

February 2020 to March 2021[27]

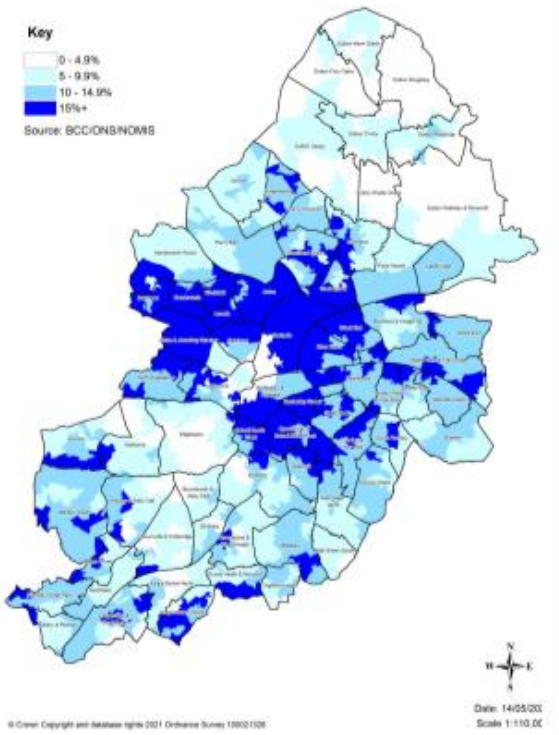
Month	Total Claimants (Count)	Total Claimants (% of total)	Youth Claimants (Count)	Youth Claimants (% of total)
February 2020	48,560	36.7%	8,840	35.2%
March 2021	83,920	63.3%	16,305	64.8%
Increase	**+35,360**	+26.6%	**+7,456**	+29.6%

Wards in Birmingham that have high levels of deprivation were associated with high levels of unemployment (Figure 36). Individuals who can do remotely and work from home were less likely to experience job loss. Those in jobs that require physical presence were more likely to be furloughed, have a reduction in working hours, or be laid off.

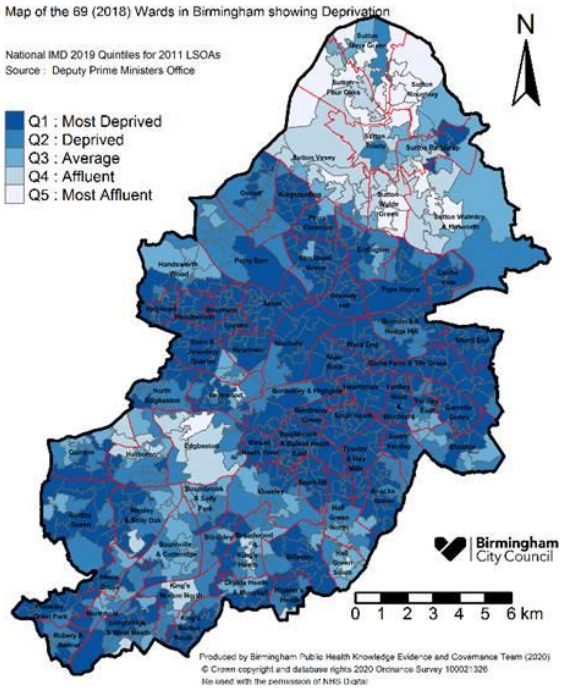
[27] Birmingham City Council. Economic information and statistics. [Online]. Available https://www.birmingham.gov.uk/info/20164/economic_information/521/economic_information_and_statistics/4 (Accessed 2021 November 15).

Figure 36. Claimant Count Unemployment (2020/21) and Deprivation (2019)[27]

Increase in Claimant Count Unemployment by Ward (February 2020 to March 2021)



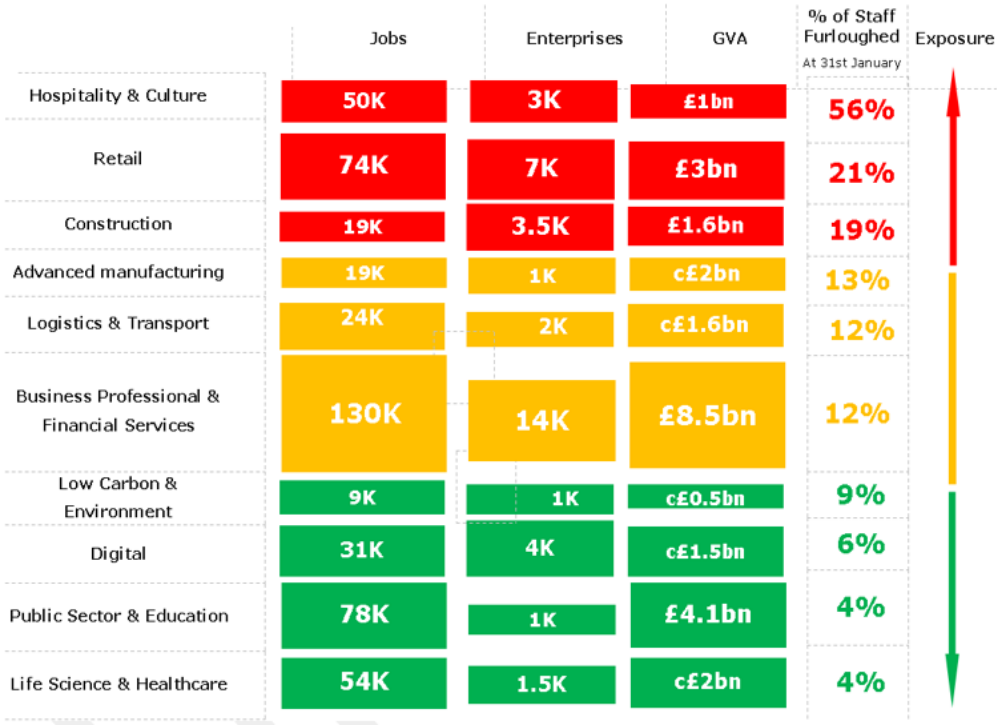
Index of Multiple Deprivation (IMD) by Ward (2019)



The acute impacts were experienced by those who were unable to find work, working fewer hours and because of the period between becoming unemployed and receiving their first Universal Credit payment. Whilst people did experience short term impacts, it is important to recognise that many had a limited ability to address their basic needs, including food and housing costs. There was a sense in some of our citizens that, in addition to the losses now, the worst was not experienced during the pandemic but that it is still to come. Many feared losing their job in the future, and others were concerned about their career prospects, particularly our young people. The economic crisis created a need for job stability, support in finding new jobs, and even for changing careers.

The 'Hospitality and Culture' sector became exposed as a result of the necessary restrictions. As of 31st January 2021, 56% of its estimated 50,000 staff were furloughed. As expected, the least exposed sectors as a result of the restrictions were 'Public Sector and Education' and 'Life Science and Healthcare' (Figure 37).

Figure 37. Sector Exposure and Resilience in Birmingham[27]



The Impact of Economic Shock on Health and Wellbeing

The closing of businesses and the introduction of living with restrictions affecting social interactions led to an immediate shock to Birmingham's Economy. Employment, income, and financial insecurity can result in negative impacts on the health and wellbeing of a population. Unemployment is associated with poor health and an increased risk of mental and physical illness. Job loss can result in losing regular income, work relationships, daily structure and a sense of self-purpose. On average, individuals are twice as likely to develop symptoms of anxiety and depression. Associated feelings and stress can be like any other major loss.

In England, those aged between 25–34 experienced a 57% increase in high anxiety in 2019/20. Among the 65–74-year-olds, there was an 89% increase. In Birmingham, this would represent more than 23,800 younger aged citizens and more than 11,500 older-aged citizens. The effects of the pandemic on the mental health of young generations are greater than on older generations, and Birmingham has a much younger population than the rest of the West Midlands and England.

Negative behaviours can be associated with those experiencing financial insecurity, including increased use of alcohol, cannabis, and other drugs. Heavy drinking is estimated to be a 50% higher risk when unemployed and is associated with excess alcohol-related deaths in

those under 65. The impact of losing a job for current smokers who do not obtain new employment is that they are more likely to smoke more cigarettes on average. Domestic abuse (DA) support providers reported an increase in visits to DA websites and calls to helpline during the lockdown. Unemployment increases the likelihood of violent behaviour compared to those who remain in employment. Evidence suggests that an increase in the male unemployment rate causes a decline in the incidence of physical abuse against women; conversely, an increase in the female unemployment rate has the opposite effect. There is also an increased likelihood of children being hospitalised for abuse and neglect. Also, unemployment or low employment may be associated with increased rates of low birth weight or very low birth weight. Increasing infant mortality rates are associated with increasing unemployment rates.

Loss of income from a job loss can also lead to a decline in the standard of living which can influence both the physical and mental health of the unemployed. The severity of the decline in the standard of living depends on factors such as the unemployed person's assets, unemployment benefits available, income and assets of other household members, and the duration of unemployment.

Unemployment significantly impacts an individual's diet which is influenced by the duration of unemployment. In the short term, the increased use of discount stores, food spending, and food consumption of animal-based foods, saturated fat, total fat and protein are higher. In comparison, a medium length of unemployment can decrease food expenditure and the consumption of fresh animal-based foods, saturated fat, total fat and protein. During long-term unemployment, nutrients are substituted by carbohydrates and added sugar. The worst impact on diets is seen in households that include children, pensioners, and single-parent households who experience greater decline than other households.

Income and employment are key social determinants of population health and health inequalities. Being out of work can lead to poor health while being in good employment is protective of health.

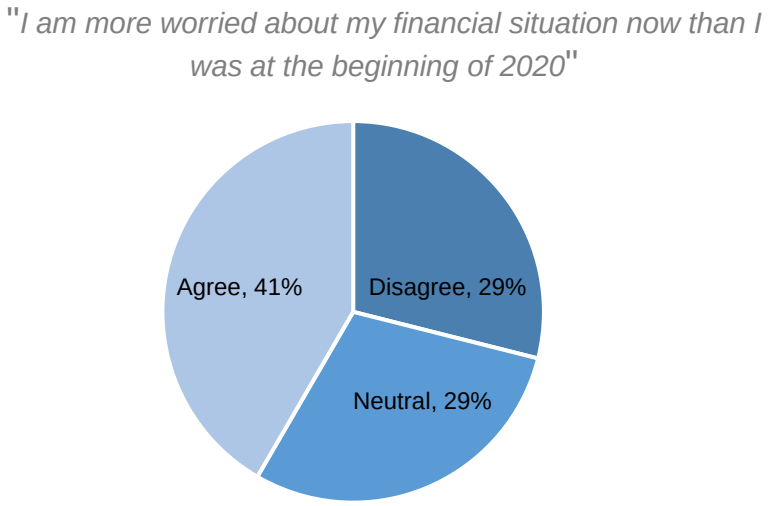
Experience and perceptions of financial impact

The impact on the economy was felt individually across the city. Acute crises, related to gaps between losing jobs and delays in the first Universal Credit payment, led to worry and limits on basic needs (foods and rent). For many, there was a further worry that losing opportunities in the future would limit career prospects (especially for younger age groups). For example, when 11 to 18-year olds were surveyed about missing out on opportunities because of the

pandemic, 45% responded that they had missed out.[24] Within this, when asked to specify, 40% mentioned missing out on work experience or placements that would help them with future employment.[24]

When surveying people about their financial situation, 41% agreed that they were more worried during the early stages of the pandemic than they were at the beginning of 2020. Almost 30% reported that their household income had fallen since the start of lockdown (Figure 38).

Figure 38. Perceptions of financial situation[4]



The economic shock of the pandemic meant many people required financial support, support for basic needs and a supportive landlord or mortgage provider. Support for basic needs was often accessed discreetly to reduce feelings of shame. Research identified a key unmet need regarding emergency support to bridge the gap for those who experienced sudden unemployment and their first Universal Credit payment. There is also a need for the city to provide longer-term employment support for insecure industries badly affected by or because of the pandemic.

"You have to wait 5 weeks to get the first Universal Credit payment. If you lose your job, the income would just stop like that. UC is not enough on its own. We saw so many food banks, rows in food banks, charities, just to help. Especially businesses should do more, supermarkets, they should get all the remaining unsold things, near expiry, they should give to charity."

Sami, 49 individual interview, October 2020[6]

Figure 39. Financial needs and support during the crisis[6]

Needs

- Job stability
- Supporting and shaping careers
- Finding new jobs
- Access to financial support
- Access to discreet support for basic needs
- Supportive landlord or mortgage providers

Coping Strategies

- Entrepreneurialism
- Taking on additional jobs
- Reducing outgoings
- Living more simply

Assets

- Savings
- Pensions
- Partner or another family member in a stable job
- Space, time, and ideas to create business

Support

- Universal Credit
- Government support schemes
- Jobcentres Plus
- Flexible employers

Unmet Needs

- Emergency support to bridge the gap between sudden unemployment and support
- Longer-term jo support for insecure industries

Financial Inequalities

Many were vulnerable to the physical effects of the virus due to pre-existing health inequality. However, some people were more exposed to the physical impact of COVID-19 because of their profession and responsibilities. This is predominantly, but not always, linked to socio-economic status.

This is reflected in the stories of those who were suggested to be at risk. Many were in roles with exposure to the virus, including key worker roles such as working on a COVID-19 ward, being a delivery driver and working at a supermarket. These people were anxious about catching the virus and aware of the risk they were taking daily. Some also felt insufficiently supported and appreciated by their managers. The stories of those with low exposure were different; they felt safer and more removed and usually were on the furlough scheme, working from home or retired.

Financial inequality is linked to the stability of people's income during the pandemic. Many people struggled (and continue to do so) because their outgoings were greater than their income. This includes those who were struggling financially before the pandemic, those who lost their job or were at risk of doing so, and those who were not sufficiently supported by Universal Credit or the furlough scheme.

This is in contrast with those who were able to save during the pandemic. Usually, they lived comfortably before the pandemic began. It is likely their job continued, or the furlough scheme sufficiently supported them. This group were also likely to see their expenditure reduce during the lockdown. The pandemic has had an unequal and lasting impact on different sectors, which will contribute to inequality in the future.

Public support to mitigate the impact of inequality has also been impacted by inequalities in people's skills to navigate that support and guidance. Those who are less skilled in navigating that support may be less fluent in English or less informed of what is on offer to them. They may also be less connected to their community of friends and family who are local and may have shown them where to go and how to access help. Many of those who were less skilled were less able to navigate financial support and support for basic needs, much of which was online. Those who were more skilled were usually more fluent in English and more informed about what was on offer. They relied on a network of relationships that could signpost them to support what was available and had a greater ability to navigate the financial support (e.g. using JobCentre Plus).

Case Study: Claire, a story of struggling[6]

"The hardest moment in all this was the day my dad found my grandad dead. Our immediate thought was that it could be from Covid. My mum had just gone back to work and then quit her job there and then, as she was worried, she would be exposed and was still caring for my gran. We all got tests done because we had been in contact with him, and the results came back unclear which just didn't help the situation at all. It wasn't until we got the coroner's report that we knew it wasn't Covid. We were all just really relieved he hadn't died of Covid, to be honest. But the funeral was hard; we all had to wear masks and we weren't allowed to touch the coffin. It just felt very unnatural."

"And then not having work has been hard. I left my job in retail last December; I worked at a clothing retailer and I hated it. I thought I would spend two months getting my graphic design portfolio together and then get a graphic design job, which is what I really want to do. And then Covid came. It went from 14 pages of graphic designer jobs on LinkedIn to 2. So I haven't been able to get a job since, which made me wish I had never left my old job. I'm hoping next year it will all come around. I can't live like this forever you know… it feels like I have put everything on hold. I know I'm sounding very dramatic but it's just things like buying a flat with my boyfriend we had talked about doing, as we both still live with our parents, but I can't get a mortgage without a job so I just feel like I'm holding us back. I've been feeling more and more alone in a sense because all my other friends have been in work and have stuff going on and I'm just at home. Luckily, I get on really well with my parents and do love it at home."

"I was using the Universal Credit Journal… the dreaded journal and the Jobcentre were good in the fact that they were sending me jobs, like working on the HS2 line or construction jobs, but I would have liked them to send something more specific to me, more like a recruitment agency. I also sent them my CV for feedback a few weeks ago, which they asked me to do, but I still haven't heard anything back so that's been a bit de-motivating."

"I went back to my old employer last week and asked for my old job back. That was a low point really. They gave it to me, and I am grateful for that, but I didn't want it to come to this. I feel like I am taking a step backwards. I didn't realise Covid was going to make things this hard. But it's good that I'll make some money and the Christmas hours are normally really good. Thank god for over time though because if I just got the basic pay it would be a pound less than I was getting on Universal Credit! I nearly thought I'm better off doing nothing, but the overtime is making up the hours. And it does make me feel better that at least I have a job now."

“And I have got some other work which is exciting. My boyfriend put me in touch with someone who is paying me to do a small graphic design job. I also started doing lino printing over the summer just as something to do, and then my friends and family where like you should sell your stuff, so I made an account on Etsy and have been selling through Instagram too. It’s been amazing seeing people actually buy it and making money from it! So, in a way Covid has made me try these new things which I wouldn’t have got round to before.”

Our ‘Everyday’

This chapter explores the experiences and behaviours of Birmingham residents during the first year of coronavirus. It brings together ethnographic research and self-reported survey data to understand its impact.

Research suggested citizens felt a new phenomenon of tension in doing ordinary or everyday activities. Many have appreciated the focus on hygiene, but others have felt tension when it comes to public space. There was a suggestion that public spaces that were normally vibrant became ‘dead zones’ during the pandemic. Many referred to the inter-personal suspicion and policing between strangers. Routines have altered quickly, and many have been subject to multiple changes (e.g. the opening of schools followed by a period of self-isolation). It has been an unprecedented period that has universally but disproportionately impacted the infrastructure of people’s lives.

The uncertainty surrounding the pandemic brought a desire for a sense of stability and structure. Some of us yearned for routine, while others wanted confidence and comfort in public spaces and a sense of normality. Many coped with the pandemic by sticking to routines, and in some cases, re-imagining routines that existed previously. We coped by adhering to the rules and some were understanding of the approach that others took. Our assets, alongside those existing routines and structures, were a supportive community and loved ones that lived close by. Similarly, to our relational and societal crises, our family, friends and neighbourhoods helped us with those everyday activities where we needed them. This included helping us with groceries and pill prescriptions. Supportive workplaces helped us and some were supported by specific services such as the Age UK Transport Service. Despite this support, our structures and systems could have made people and the fabric of every day feel more stable. In some cases, we also lacked support in making workplaces safe and viable—for example, more personal protective equipment and childcare support.

“We went into Birmingham shopping after the funeral to cheer ourselves up and it was horrible – all the restrictions and how people behave. Some people don’t care, others are too extreme. I think all of this brings out the worst in people. It’s not pleasant, I don’t like it, I try to keep away. I don’t like the vibe anymore, how people behave. Some people bump into you – others are afraid to go near you in gloves and mask.”

Claire, 25, individual interview (October 2020)[6]

Figure 40. Everyday needs and support[6]

Needs

- Routine
- Structure
- Sense of stability
- Confidence and comfort in public spaces
- Coping Strategies Sticking to or reimagining pre-existing routines
- Adhering to guidance on e.g. mask-wearing and hand washing
- Being understanding of other people's approaches

Assets

- Strong existing routines
- Discipline and structure
- Supportive community
- Loved ones who live close by

Support

- Family/neighbours/friends providing support (e.g. groceries and pill prescriptions)
- Supportive workplace
- Age UK transport service

Unmet Needs Greater solidarity

- Structures and systems to make people and the fabric of every day feel more stable
- More support to make workplaces safe and viable e.g. PPE and childcare
- More comfortable public spaces despite the restrictions

It was evident that there was a need to reinforce measures that would transform how we went about with our everyday life despite the pandemic. Our city rose to meet these challenges and are detailed in the next chapter.

Case Study: Nadiya, a story of worry[6]

"When I first heard about Coronavirus, I thought it wouldn't affect us so much, like Ebola or Swine Flu. I thought it might just be a couple of months and then disappear. But this has gone wild! When we went into national lockdown it was a big shock. We had never done anything like this before, never gone into isolation. I was very afraid. You heard of all these people picking up Covid and dying. My youngest son has always had a bad immune system, skin condition, allergies. He has been in and out of the doctor's his whole life and picks stuff up really easily. This whole time my biggest worry is that one of us catches it and gives it to him"

"I didn't like the panic buying, but to tell you the truth I was panic buying too. Because my son can't eat certain things because he is gluten free and dairy free, and I knew it would be hard to get out of the house. The first couple of weeks were ok. It was nice to spend time with the kids. I got a trampoline and a paddling pool. And for about a month they were quite happy in the garden. It was good to spend time with my two eldest children, as normally they are out the house all the time. But then they started to get a bit bored, and I only have one TV between the four. It was a struggle keeping them entertained without being able to go and meet up with people. It became quite boring and depressing for the kids so they became quite difficult. And so it all just got too much for me. Normally I have my mum and my family and friends to see and to help me out. I think I just really missed them."

"Then some of the rules started easing which was good in some ways but also made me worried that people were too relaxed. I think the eating out scheme was a mistake. People were going mad – not obeying the regulations, crowding outside restaurants. A lot of gathering, nobody was bothered. It wasn't the old people but the youngsters. They don't really understand how bad it could get."

"School started again but then my kids had to isolate for two weeks because someone at school had the virus. Those weeks were hard work. I had a leak and no plumber would come because we were isolating. Luckily, I was able to call a neighbour who is a plumber, and overall my community have been very helpful."

"When my children were finally able to go back to school, I got a bit of a break for myself, which was nice. But my youngest son is still at home. His health has been so much better at home. As soon as he gets out the house, he just picks things up immediately. But I'm worried he is getting behind on his schoolwork. The teachers don't have time to really support his learning at home. My priority is his health, but I still worry about his long-term development and not being able to socialise. He's always asking after his friends and teachers."

"The GP has been great. He hadn't heard from us for a while, so he called especially to see if my son is doing ok, and ask us if we need help with anything. That's so much better than having to go into hospital and mixing with people."

"I am worried about the economic situation in the UK, with both my eldest children entering the job market. My daughter found a job as teacher, but my son hasn't found a job as a

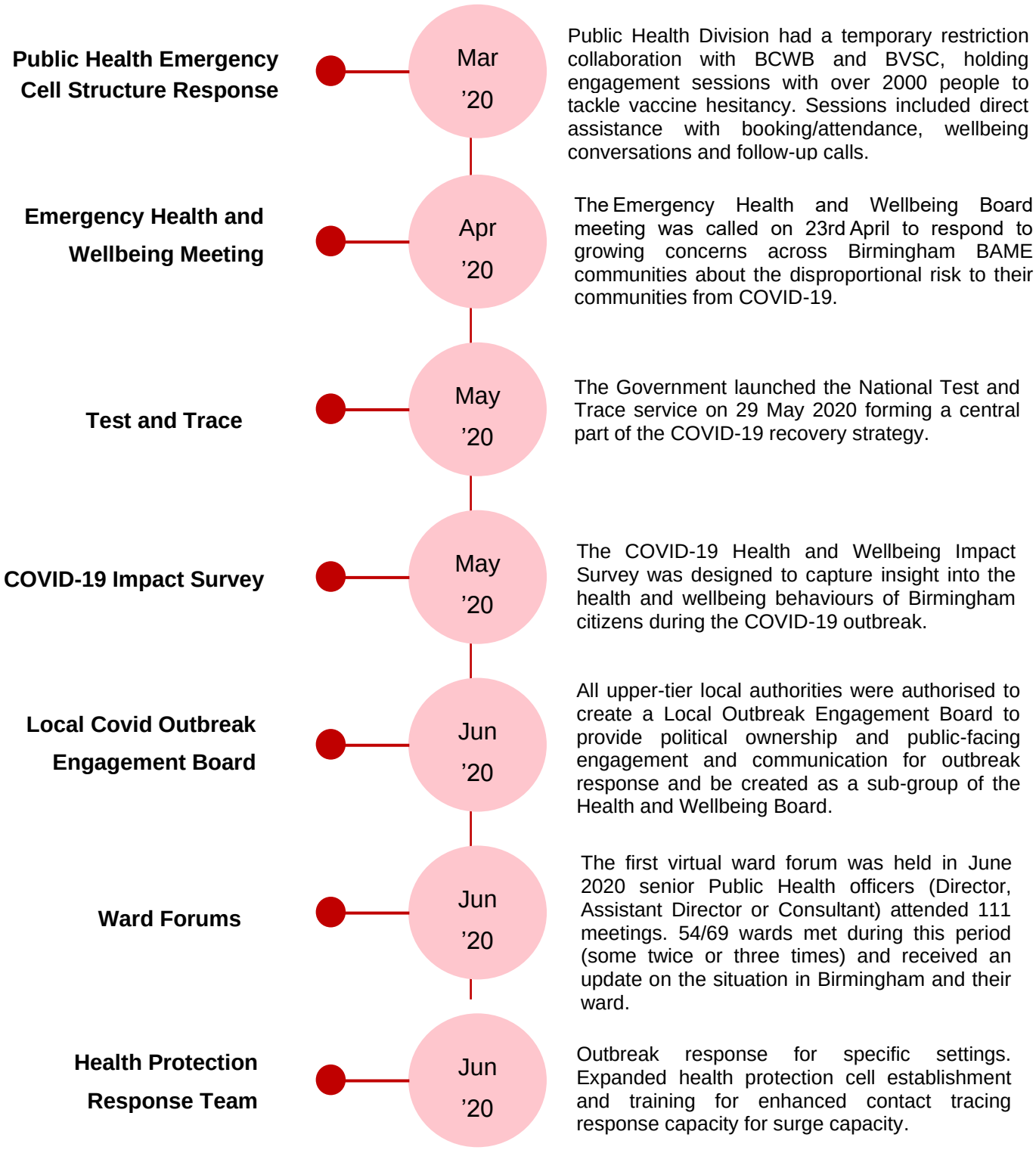
barber. I helped him apply for Universal Credit to help with the mortgage, and that worked well."

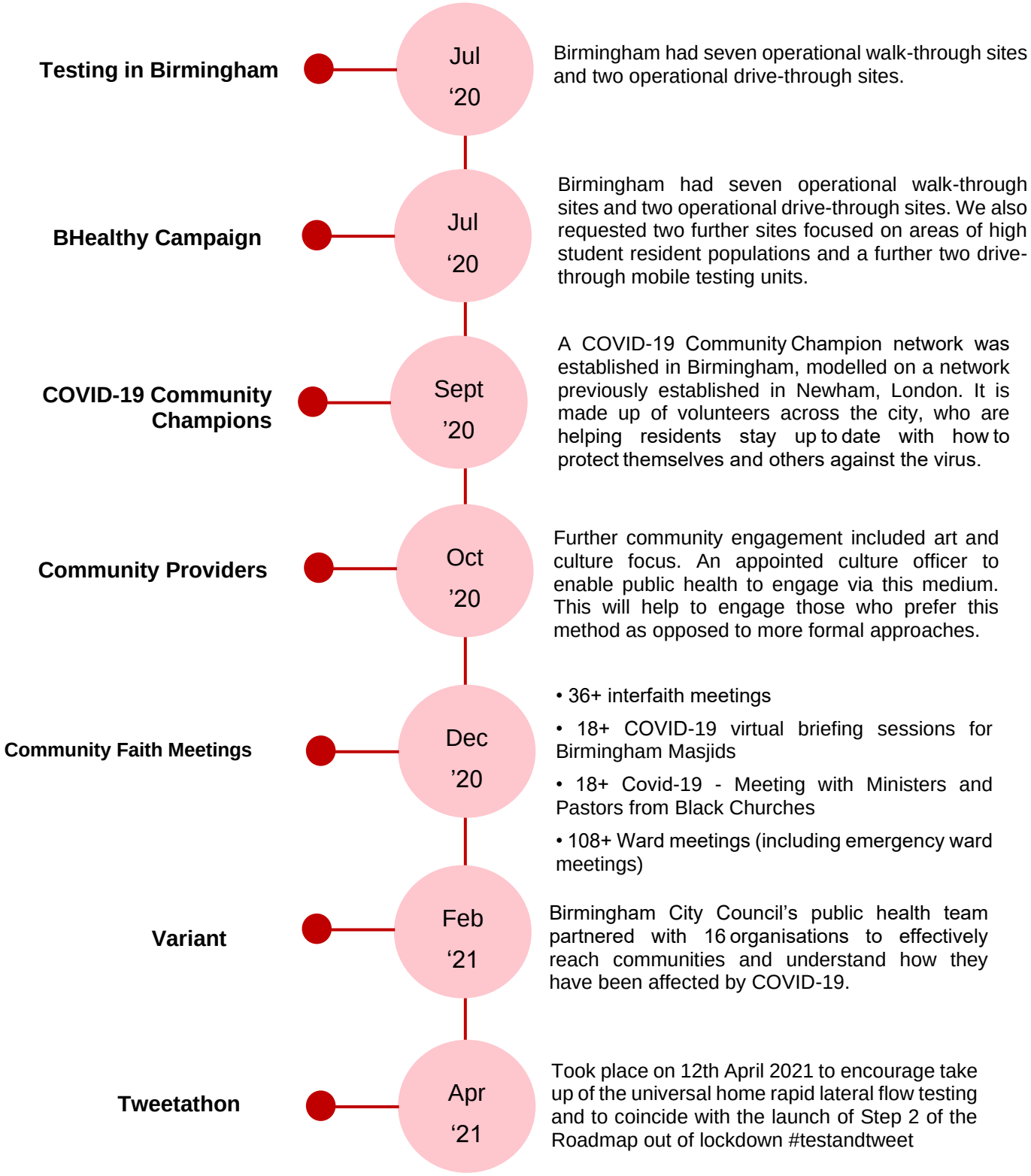
"The recent rules have been confusing. The virus is out of hand and increasing – they should stop letting people out to restaurants and things for now. It's nice meeting your friends but you don't know who has Covid and who doesn't. You could pick it up and pass it on to family. When we had the full lockdown things were clearer, and for now they need to keep the rules simple and straightforward so we can get the virus under control."

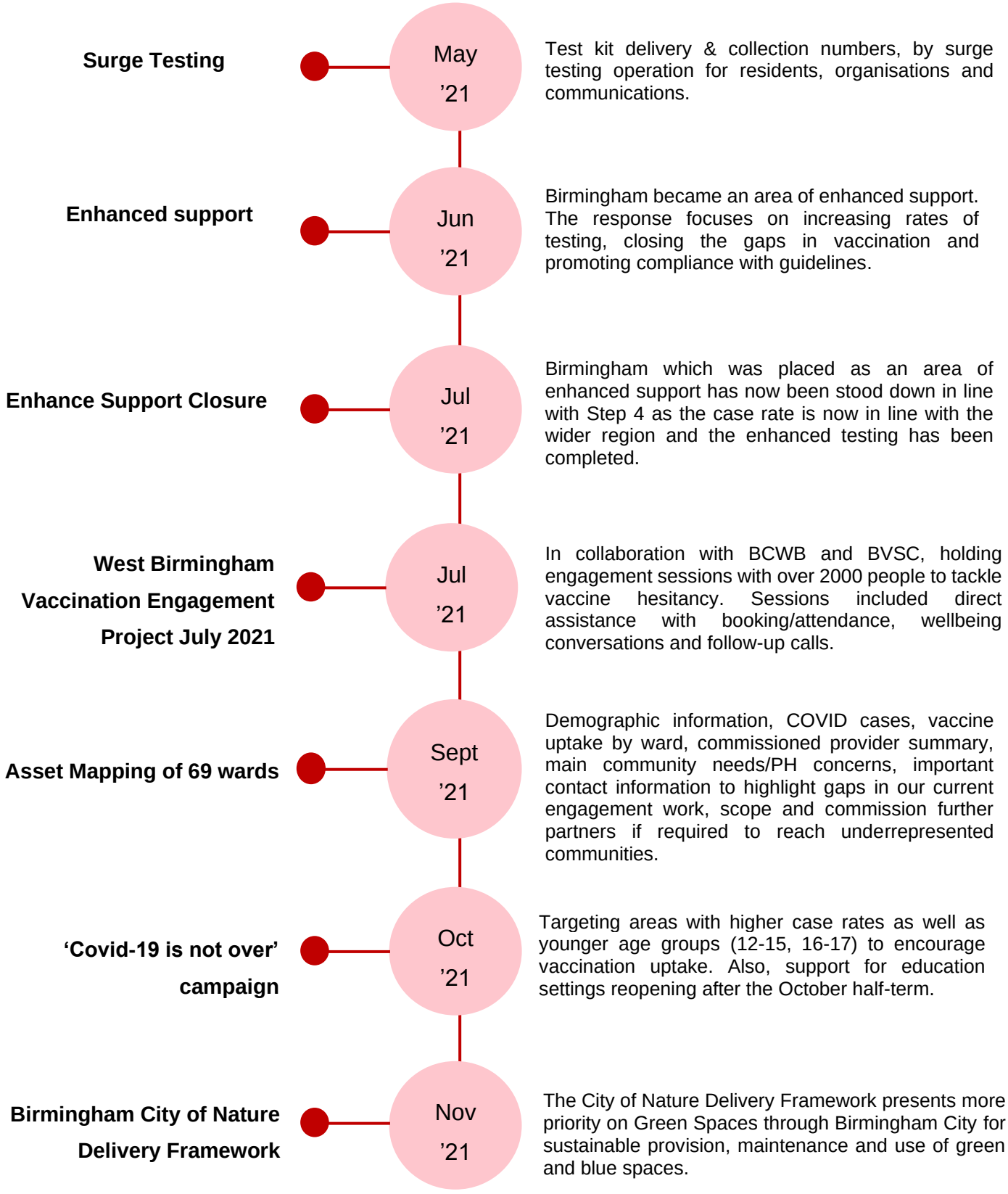
5. COVID-19: Our Response

Birmingham City Council's Public Health Division's response to the COVID-19 pandemic started in March 2020 and continues to be focused on supporting future work to support Birmingham citizens (Figure 41). Communications and social media have been active throughout the pandemic (see Appendix C).

Figure 41. Birmingham City Council's Public Health Response Timeline




Testing in Birmingham
Jul '20
Birmingham had seven operational walk-through sites and two operational drive-through sites.
BHealthy Campaign
Jul '20
Birmingham had seven operational walk-through sites and two operational drive-through sites. We also requested two further sites focused on areas of high student resident populations and a further two drive-through mobile testing units.
COVID-19 Community Champions
Sept '20
A COVID-19 Community Champion network was established in Birmingham, modelled on a network previously established in Newham, London. It is made up of volunteers across the city, who are helping residents stay up to date with how to protect themselves and others against the virus.
Community Providers
Oct '20
Further community engagement included art and culture focus. An appointed culture officer to enable public health to engage via this medium. This will help to engage those who prefer this method as opposed to more formal approaches.
Community Faith Meetings
Dec '20
• 36+ interfaith meetings
• 18+ COVID-19 virtual briefing sessions for Birmingham Masjids
• 18+ Covid-19 - Meeting with Ministers and Pastors from Black Churches
• 108+ Ward meetings (including emergency ward meetings)
Variant
Feb '21
Birmingham City Council's public health team partnered with 16 organisations to effectively reach communities and understand how they have been affected by COVID-19.
Tweetathon
Apr '21
Took place on 12th April 2021 to encourage take up of the universal home rapid lateral flow testing and to coincide with the launch of Step 2 of the Roadmap out of lockdown #testandtweet


Surge Testing
May ’21
Test kit delivery & collection numbers, by surge testing operation for residents, organisations and communications.
Enhanced support
Jun ’21
Birmingham became an area of enhanced support. The response focuses on increasing rates of testing, closing the gaps in vaccination and promoting compliance with guidelines.
Enhance Support Closure
Jul ’21
Birmingham which was placed as an area of enhanced support has now been stood down in line with Step 4 as the case rate is now in line with the wider region and the enhanced testing has been completed.
West Birmingham Vaccination Engagement Project July 2021
Jul ’21
In collaboration with BCWB and BVSC, holding engagement sessions with over 2000 people to tackle vaccine hesitancy. Sessions included direct assistance with booking/attendance, wellbeing conversations and follow-up calls.
Asset Mapping of 69 wards
Sept ’21
Demographic information, COVID cases, vaccine uptake by ward, commissioned provider summary, main community needs/PH concerns, important contact information to highlight gaps in our current engagement work, scope and commission further partners if required to reach underrepresented communities.
‘Covid-19 is not over’ campaign
Oct ’21
Targeting areas with higher case rates as well as younger age groups (12-15, 16-17) to encourage vaccination uptake. Also, support for education settings reopening after the October half-term.
Birmingham City of Nature Delivery Framework
Nov ’21
The City of Nature Delivery Framework presents more priority on Green Spaces through Birmingham City for sustainable provision, maintenance and use of green and blue spaces.

6. What Next: Living with COVID-19 and Creating a Bolder, Healthier City

Conclusions

This report, the ethnographic research, and the results of the COVID-19 Impact Survey have highlighted many significant issues that need to be addressed as part of our recovery from the pandemic. Firstly, and possibly the most widely recognised, pre-pandemic health inequalities have been exposed and exacerbated across the city, with a significantly uneven impact. Wards with high levels of deprivation have consistently reported higher case numbers than those more affluent wards, as seen in Figure 7, mirroring the trend across England. Equally, residents from Black, Asian and Minority Ethnic backgrounds have been impacted harder than residents from a white background despite being a smaller part of the population. This is exemplified through the statistic that at one time the case rate in the Pakistani population was 591 times higher than that of the White British population.

More widely, beyond the direct health impacts of the pandemic, there has been a series of crises that have affected every aspect of residents' lives, from daily mood to financial security to community spirit. Lockdowns and social isolation have caused a spike in mental health issues. Once again though, the impact was uneven as women, older working-aged residents, and Black and Minority Ethnic residents reported higher levels of anxiety and loneliness. The restrictions on businesses have led to the highest level of unemployment in Birmingham for decades and a significant increase in youth unemployment, as the retail and hospitality sector was one of the largest employers of 18-24-year olds in the city.

Finally, there have been significant societal impacts since these events have been unprecedented in many residents' lives. Lockdowns, coronavirus restrictions and emergency powers meant that residents had to trust central and local governments with their safety and rely on them for information. There have been varying levels of trust in information sources regarding the pandemic, and as it has progressed, there has been a growing discontentment with sources of authority. Central to this has been messaging around the pandemic. Responses from the ethnographic research and the impact survey illustrate that message at a national level was appreciated in the early stages because it was frequent and consistent. However, towards the end of the year, attempts to make restrictions more localised resulted in confusion and frustration. Messaging and representation at a local level were positive overall, with higher levels of trust being recorded in local authority compared to the central government. However, this could have been stronger and made up for the confusion felt at the later stages.

Closing the Gap

Why were there inequalities in the impact of Covid?

When planning our recovery from the pandemic, we must consider why it was the case that the impact was so uneven and how to 'close the gaps' that the pandemic has exposed. As the report identifies, the most significant gap was the pre-existing health inequality in our population. For example, the higher than national average health risk factors, such as obesity and diabetes, lead to a high number of direct deaths from COVID-19, as seen in Table 1. Therefore, one of the first gaps to address will be significantly reducing the rates of these risk factors through Public Health and NHS interventions to prevent these conditions from occurring and improve the management and support for people living with them.

The gaps that illustrate inequality are not isolated to physical health resilience. The proportion of residents that were 'well-equipped to deal with the mental health impacts of the pandemic was much smaller than either the 'less well equipped or the 'triggered'. This is clear in Figure 16, where over half of respondents reported a deterioration in their mental health in the first six months of the pandemic. Significantly related to this is the increase in financial insecurity. This has been particularly acute among younger residents as they were more likely to be employed in a sector that closed during the lockdowns. This insecurity was aggravated for many residents as they found themselves accessing Universal Credit or welfare support for the first time and lacked the understanding about how to access the service properly and understand the process (e.g. the 5-week wait for the first Universal Credit payment).

Equally, by almost every metric measured on the Impact Survey, ethnic communities were disproportionately affected by the crises that the pandemic precipitated. For example, a higher proportion of ethnic citizens reported relationship breakdowns, be that with partners or family, as well as a deterioration in community spirit, than among White citizens. A further breakdown of the results shows that these wider unequal impacts were most likely to centre around working-age adults and almost entirely on females.

Who has a responsibility to close the gap?

Birmingham City Council, as the local authority and one of the largest organisations across the city, should take a driving role in addressing the gaps identified by the report and the research. Similarly, the NHS, and incoming Integrated Care System, have the responsibility to consider how they can address the health inequalities that the pandemic has exacerbated. This is true for the legacy physical health effects, such as 'Long Covid' or reduction in healthy

activity, but even more so for the continuing mental health crisis that cuts across all parts of the city's population.

The Health and Wellbeing Board, and the organisations that sit on it, must coordinate to deliver outcomes that "close the gap" on inequalities by considering the wider determinants that affect health. This can be spearheaded through programmes that reduce food poverty, encourage regular physical activity and alleviate social isolation. Alongside large organisations, the voluntary and community sector is best placed to lead or support these programmes because its groups can focus on the prevention of issues rather than intervention by local services. They also cover a wide range of activities, from food parcels to outdoor excursions to mental health support groups and career advice.

Finally, businesses have a role to play in supporting the economic recovery from the pandemic, which is where some of the gaps are most acute. Levels of unemployment, especially youth unemployment, have increased. When the furlough scheme ends, there will need to be coordination on how to prevent even further job losses. Specific businesses, such as supermarkets could also take on a more proactive role in tackling food insecurity by providing greater levels of surplus stock to food banks. It is essential that as we rebuild our economy, we do so by creating good jobs and healthy workplaces.

How will it be achieved?

To address the gaps that the pandemic has exposed, the responsible organisations will need to use a range of approaches unified around one goal. That is why the Health and Wellbeing Board's emerging strategy will be underpinned by 'closing the gap' over the length of the strategy. It will ensure a specific plan for mitigating the legacy of COVID-19 in the next few years. This will be focused on addressing gaps in three areas exposed by the pandemic:

1. **Mitigating the impact of Covid on Mental Wellbeing**

   By July 2020, more than half of respondents (53%) said their mental health had deteriorated since the pandemic had started.[4] The impacts on mental wellbeing include bereavement, loneliness and common mental health conditions such as anxiety and depression. Some are a legacy of the direct impact of disease and illness, and others are due to the effects of risk reduction restrictions and isolation. The Creating a Mentally Healthy City Forum will lead on this work and has an explicit focus on the mental well-being of Birmingham citizens, emphasising upstream prevention and promotion of better

mental health. This includes the Better Mental Health Fund (~£800,000 allocated) to support and improve the mental health of Birmingham citizens.

2. Addressing the long-term impacts of Covid on health

One in 6 middle-aged people and one in 13 younger adults with COVID-19 report long Covid symptoms.[28] The impacts of 'Long Covid' are still emerging. It will require new pathways of care and support across the health and social care and community and voluntary sector. It will also require a positive and supportive response from the education and employment sector to support individuals affected.

3. Reducing the drivers of inequality in Covid case rates and mortality

COVID-19 mortality rates for people younger than 65 were 3.7 times higher in England's most deprived areas than the least deprived areas between March 2020 and March 2021. [29] The background to these inequalities is complex, layering employment, deprivation, ethnicity and baseline health. We need to explore how this drove the inequalities in infection and death during the pandemic to prevent it from happening again. A complete understanding of the impact on our citizens affecting aspects of identity and geography is yet to be wholly understood due to the limitation in inequalities data on different communities. The Public Health Division is developing a series of evidence-based community health profiles to understand, improve and reduce health inequalities in Birmingham.[30] They will enable us to better understand and be aware of communities and their needs.

---

[28] Steves, Claire. 2021. Up to one in six people with COVID-19 report long COVID symptoms. 24 June. [Online]. Available. https://www.kcl.ac.uk/news/up-to-one-in-six-people-covid-19-long-covid-symptoms. (Accessed 23 July 2021).

[29] Tinson, Adam. What geographic inequalities in COVID-19 mortality rates and health can tell us about levelling up. [Online]. Available: https://www.health.org.uk/news-and-comment/charts-andinfographics/what-geographic-inequalities-in-covid-19-mortality-rates-can-tell-us-about-levelling-up (Accessed 22 July 2021).

[30] Birmingham Public Health, “Community health profiles Overview,” 2021. [Online]. Available: https://www.birmingham.gov.uk/info/50265/supporting_healthier_communities/2463/community_health_profiles. (Accessed 15 November 2021)

7. Review of Annual Report 2019/20 - Complex Lives, Fulfilling Futures

Background

The Director of Public Health (DPH) Annual Report 2019-20: Complex Lives Fulfilling Futures was produced and completed (March 2020) to explore and understand the health and wellbeing needs of local people experiencing multiple complex needs (MCN), such as homelessness, substance misuse, mental health issues and offending. The report explored a range of evidence-based interventions and services for people with MCN, identifying what matters to them, what is on offer locally, and what gaps and barriers exist. Supported by ethnographic research, the report concluded by presenting a case for change and made several recommendations for a city-wide partnership work going forward.

The final stage of the development of the report coincided with the start of the coronavirus pandemic, whereby Public Health priority went into coronavirus response. The extensive evidence produced and consolidated within the report highlighted the risks and further reinforced the need to protect those with MCN from COVID-19 and the longer-term health and social impacts of the virus.

Progress to date

Covid-19 Response

- A city-wide partnership enabled a coordinated and coherent approach to prevent and contain COVID-19 infections amongst homeless people in the city.
- As part of the ‘Everyone-in’ initiative, the city council mobilised additional accommodation for the homeless that extended beyond the criteria of the national project and with an offer of wider multi-agency support. Access to accommodation and subsistence was secured for over 165 street homeless individuals and enabled progress towards a sustainable future.
- HealthNow Alliance (an alliance between the public sector and the community and voluntary organisations led by Groundswell and Crisis), through their initiative involving peer advocates with lived experience, developed the Birmingham Homeless Vaccination Model and have led on engagement and communication with individuals with MCN.
- The Public Health Division in Birmingham City Council developed a Symptomatic Homeless Pathway as guidance for professionals and volunteers. The pathway provides:

    - clarity on access to diagnosis, treatment and support for the infected statutorily homeless individuals (often with other complex needs)
    - protection of longer-term health and wellbeing of the statutorily homeless citizens
    - prevention of further transmission of the virus amongst the homeless population in all types of settings.
- The pathway was shared widely across agencies and settings and contributed to preventing high infection rates and complications from COVID-19, minimising the risk of being admitted to hospital and of mortality amongst the statutorily homeless population, and has been used as an example of good practice and guidance by Public Health England.
- The Public Health Division commissioned a range of local 'grassroots' organisations to deliver a series of engagement activities with the most vulnerable groups in the city throughout the pandemic to ensure ongoing person-centred support that is trauma-informed.

HealthNow Alliance

HealthNow Alliance is a partnership led by Groundswell, partnered with national charities Crisis and Shelter working towards:

- Tackling barriers to registration and difficulty in accessing primary care services by the homeless. This includes but is not limited to the provision of training to practice staff and healthcare workers, reinforcement of the duty to provide free primary care services and incentivisation for practices to register patients with MCN;
- Raising awareness and providing training around Mental Health and Substance Misuse through the development of multiagency hubs;
- Establishing links between hospital discharges and peer advocates;
- Creating housing and navigator roles building into a specialist integrated homeless team;
- Providing training for clinical and non-clinical staff on interpreting needs and in lived experiences of homelessness.

Changing Futures Together

Birmingham Changing Futures Together is a **project** funded by the National Lottery Community Fund to provide better support to those with MCN. The project has been

pioneering new ways of working, with services led by those with lived experience, using innovative technology and close partnerships with specialist agencies across the city to provide a faster, better informed and more unified approach to support. Achievements so far include:

- Development of a suite of resources aimed at encouraging organisations to embed the approach within their services.
- Working closely with the West Midlands Police, coaching on how to better engage with people with MCNs and assisting them with the right support whilst in custody.
- Development of a training package on how services with clients facing MCN can bring the 'No Wrong Door' approach into their support.
- Worked with over 350 clients to ensure they didn't fall through the gaps between services, with over a quarter of the clients having all four MCN.
- The team are now working with services in the region to pass on their learning around multi-agency meetings and the skills required to keep clients facing multiple disadvantages engaged in their support.
- Worked with BCC to create and roll out the Supported Exempt Accommodation Quality Standards and with WMCA to create and roll out the Commitment to Collaborate Toolkit.

Commissioned services

A new strategy to recommission Vulnerable Adults Housing and Wellbeing Support Services has been approved for implementation. It includes a clear pathway built around four key elements: Universal Prevention, Early Targeted Help, Crisis Support and Transition Services.

These services are vital in delivering against several recommendations in the DPH Annual Report 2019-20. They include improvements in the corporate parenting system, creating sustainable housing options for the most vulnerable and addressing some of the drivers of homelessness, such as domestic abuse:

- The Housing Options Service has formally launched its new operating model – and, since 2 August 2021, has been called the Housing Solutions and Support Service. The new model supports the council's investing in our future agenda by shifting the service focus from crisis to homeless prevention work. This will result in better supporting households at the early stages of a housing crisis before it manifests into a statutory need. This significant investment will enable the new service to:

    - Deliver increased prevention work that enables people at-risk of homelessness households to remain in their existing home, or secure alternative accommodation, before they are homeless.
    - Implement temporary accommodation move-on plans to ensure households in temporary accommodation get the required level of support to sustain a new tenancy and ensure that their stay in temporary accommodation is as short as possible.
    - Improve accessibility and availability of alternative housing solutions – such as the private rented sector.
- Online housing and wellbeing support service has been put in place for individuals to self-navigate, also for use by professionals, practitioners and carers;
- Client-specific housing and wellbeing prevention hubs are available providing face to face support and access to services and transitional support through Health & Wellbeing Centres is also available;
- Multi-agency outreach street intervention team for substance misuse, mental and physical health is in operation;
- Domestic abuse refuge supported accommodation and 24/7 emergency supported accommodation for singles aged 25+ are available.

Recently, a city-wide rough sleeper substance misuse model has been established. As part of the model, services will proactively seek to identify, assess and support rough sleepers wherever they may be in the city (the current model is city centre-based) to include:

- Frontline capacity increased through funding programmes (Rough Sleeper Initiative, Protect Programme).
- Accommodation and support offer increased through Housing First (over 160 rough sleepers accommodated over a pilot period), Rough Sleeper Accommodation Programme (further 40 flats in 2021-22) and Transition Centre (11 units for most complex requirements).
- Additional programmes of help and support – Hospital Discharge Programme; Domestic Abuse Respite Programme; PHE Substance Misuse Programme; Mental Health Transformation Programme
- Delivery coordinated through daily outreach tasking, weekly rough sleeper partnership review meeting, bi-weekly liaison meeting with West Midlands Police and Community Safety, monthly Rough Sleeper Action Group oversight and reporting into Homeless Partnership Board and working in conjunction with the WMCA Homeless Taskforce.

The Council's Health and Homelessness Partnership (a working group reporting to the Birmingham Homelessness Partnership Board) have led the development of the Homeless Out of Hospital Care Model. The pilot paid for through funding awarded by the DHSC, will test out the sensitivities of the hospital discharge to assess a model for citizens who are rough sleeping / homeless so that no one is discharged to the streets. It will establish a homeless nursing team working across primary/secondary care (acute and mental health services) to discharge the homeless into appropriate step down medical respite, with substance misuse support that will wrap floating support around citizens whilst their housing needs are being assessed by dedicated housing officers. The service will support the citizens whilst in accommodation to establish goals and plans, pulling in relevant support. The support will continue as the individuals are moved on into stable accommodation and until there is satisfactory handover to the vulnerable adults and other support services. This model builds on the DHSC High Impact Change Model, a supporting tool & research by King's College London. The project will be evaluated to generate evidence of the effectiveness of the model.

Creating a Mentally Healthy City Partnership

- Covid-19 and the restrictions have significantly impacted people's mental and emotional health and wellbeing. The Creating a Mentally Healthy City Forum partners are currently working to:
    - Understand local needs and assets ensuring commissioning is robust and directed to areas of greatest need when tackling mental health and inequality;
    - Measure outcomes to define success on any actions taken on prevention and promotion of better mental health across the life-course;
    - Develop a bespoke model of mental wellbeing support for women with MCN, working with Anawim, Birmingham's Centre for Women;
    - Develop training initiatives on how to support young people with MCN;
    - Promote Psychologically Informed Environment (PIE) training and practice across all relevant sectors and services.

Also, work to implement the Prevention Concordat for Better Mental Health and Public Mental Health Delivery Plan continues.

Creating a City without Inequality Forum

This Health and Wellbeing Board's sub-group is now developing strategic action underpinned by Sir Marmot's recommendations published in his reviews into health inequalities. The Forum uses the life-course approach to ensure a focus on prevention and early intervention at every

stage of life and that health inequalities are being addressed before the gaps widen and needs become more complex.

By focusing on each of the priority objectives identified by Marmot, the CCwI Forum can link projects and programmes to each area, reporting on the outcomes and identifying gaps and developing associated actions. This will give the forum a sharper focus and encourage real joined-up working across organisations and systems.

Appendices

Appendix A: List of Figures and Tables

Figures

Tables

Appendix B: Supplementary Tables and Figures

Table 17. Confirmed Cases of COVID-19 by Ward (Pillar 1 and Pillar 2 Tests)[3]

1st March 2020 – 30th September 2021

Ward Name	Cases	Population	Rate per 100,000	Rank
Lozells	1756	9,809	17,901.93	1
Yardley East	1785	10,362	17,226.40	2
Bromford & Hodge Hill	3584	21,679	16,532.13	3
Shard End	2024	12,311	16,440.58	4
Handsworth Wood	3286	20,610	15,943.72	5
Hall Green North	3632	22,832	15,907.50	6
Garretts Green	1694	10,701	15,830.30	7
Heartlands	2111	13,392	15,763.14	8
Ward End	2119	13,617	15,561.43	9
Sparkhill	3330	21,722	15,330.08	10
Oscott	3074	20,139	15,263.92	11
Glebe Farm & Tile Cross	3664	24,031	15,246.97	12
Castle Vale	1492	9,812	15,205.87	13
Sparkbrook & Balsall Heath East	3937	26,089	15,090.65	14
Frankley Great Park	1781	11,836	15,047.31	15
Sheldon	2979	19,895	14,973.61	16
Pype Hayes	1611	10,816	14,894.60	17
Perry Barr	3063	20,620	14,854.51	18
Kingstanding	3115	21,052	14,796.69	19
Small Heath	3115	21,114	14,753.24	20
Yardley West & Stechford	1867	12,701	14,699.63	21
Acocks Green	3564	24,279	14,679.35	22
Birchfield	1839	12,556	14,646.38	23
Aston	3535	24,142	14,642.53	24
Alum Rock	3992	27,311	14,616.82	25
Soho & Jewellery Quarter	3951	27,132	14,562.14	26
Balsall Heath West	1768	12,233	14,452.71	27
Quinton	2924	20,407	14,328.42	28
Perry Common	1665	11,645	14,297.98	29
Hall Green South	1490	10,467	14,235.22	30
Bordesley Green	1808	12,701	14,235.10	31
Gravelly Hill	1508	10,821	13,935.87	32
Longbridge & West Heath	2815	20,362	13,824.77	33
Sutton Trinity	1278	9,257	13,805.77	34
Billesley	2745	19,889	13,801.60	35
South Yardley	1471	10,725	13,715.62	36
Newtown	1991	14,621	13,617.40	37
King's Norton South	1540	11,311	13,615.06	38
Handsworth	1722	12,703	13,555.85	39
North Edgbaston	3334	24,600	13,552.85	40
Bartley Green	3095	22,858	13,540.12	41
Bournbrook & Selly Park	3311	24,598	13,460.44	42

Ward Name	Cases	Population	Rate per 100,000	Rank
Erdington	2757	20,715	13,309.20	43
Northfield	1383	10,412	13,282.75	44
Moseley	2887	21,774	13,258.93	45
Weoley & Selly Oak	3153	24,008	13,133.12	46
Sutton Reddicap	1311	10,004	13,104.76	47
Tyseley & Hay Mills	1615	12,352	13,074.81	48
Sutton Vesey	2568	19,656	13,064.71	49
Highter's Heath	1463	11,267	12,984.82	50
Brandwood & King's Heath	2464	18,991	12,974.57	51
Bournville & Cotteridge	2313	17,863	12,948.55	52
Sutton Wylde Green	1151	8,900	12,932.58	53
Stockland Green	3106	24,168	12,851.70	54
Druids Heath & Monyhull	1487	11,753	12,652.09	55
Allens Cross	1360	10,778	12,618.30	56
Stirchley	1272	10,103	12,590.32	57
Sutton Walmley & Minworth	2004	15,975	12,544.60	58
Edgbaston	2765	22,092	12,515.84	59
Sutton Mere Green	1232	9,856	12,500.00	60
Holyhead	1553	12,454	12,469.89	61
Ladywood	3480	28,415	12,247.05	62
King's Norton North	1438	11,803	12,183.34	63
Rubery & Rednal	1318	10,841	12,157.55	64
Sutton Roughley	1394	11,591	12,026.57	65
Sutton Four Oaks	1085	9,156	11,850.15	66
Bordesley & Highgate	1830	15,763	11,609.47	67
Nechells	1948	16,813	11,586.27	68
Harborne	2571	24,113	10,662.30	69
Birmingham	**159,273**	**1,141,374**	**13,954.50**	

Figure 42. Private conversations within the house, by gender and ethnicity[4]

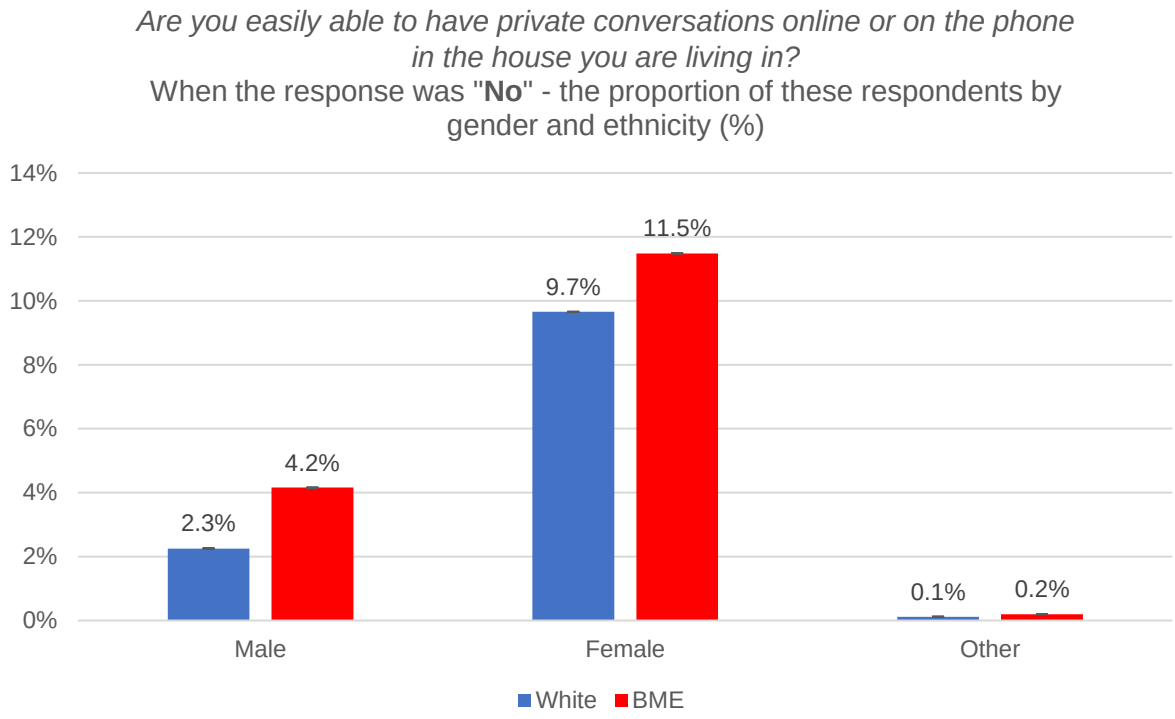


Figure 43. Relationship changes with children/family since lockdown, by gender and ethnicity[4]

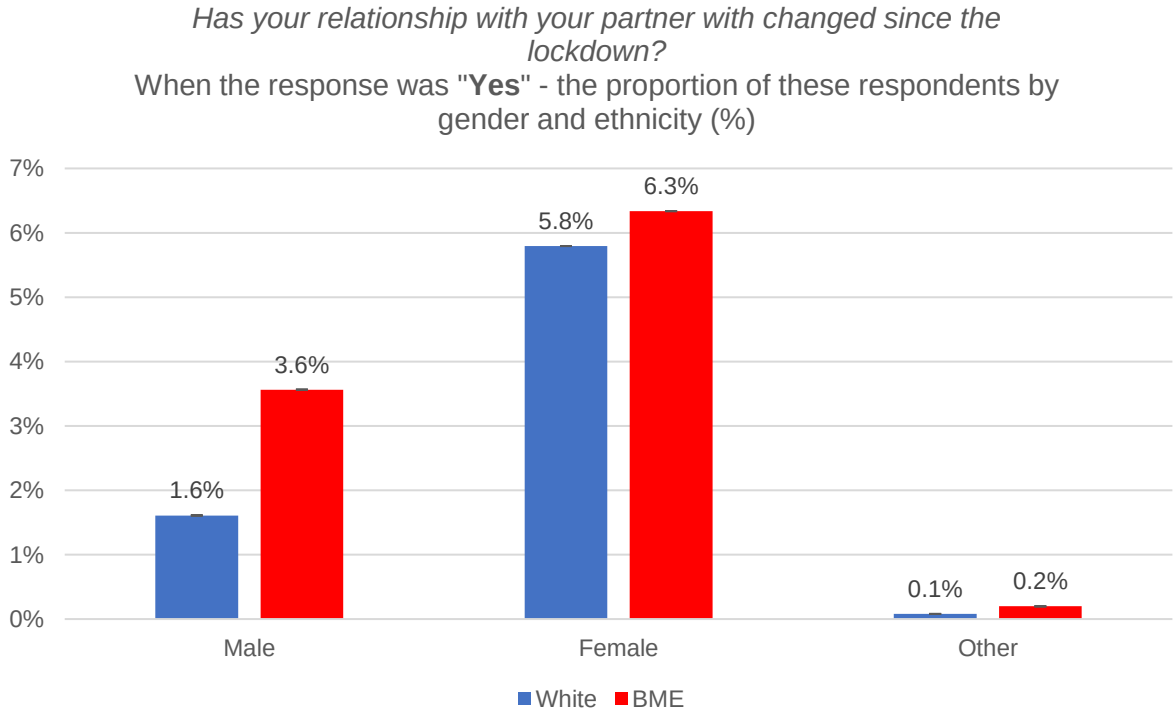


Figure 44. Relationship changes with partner since lockdown, by age and ethnicity[4]

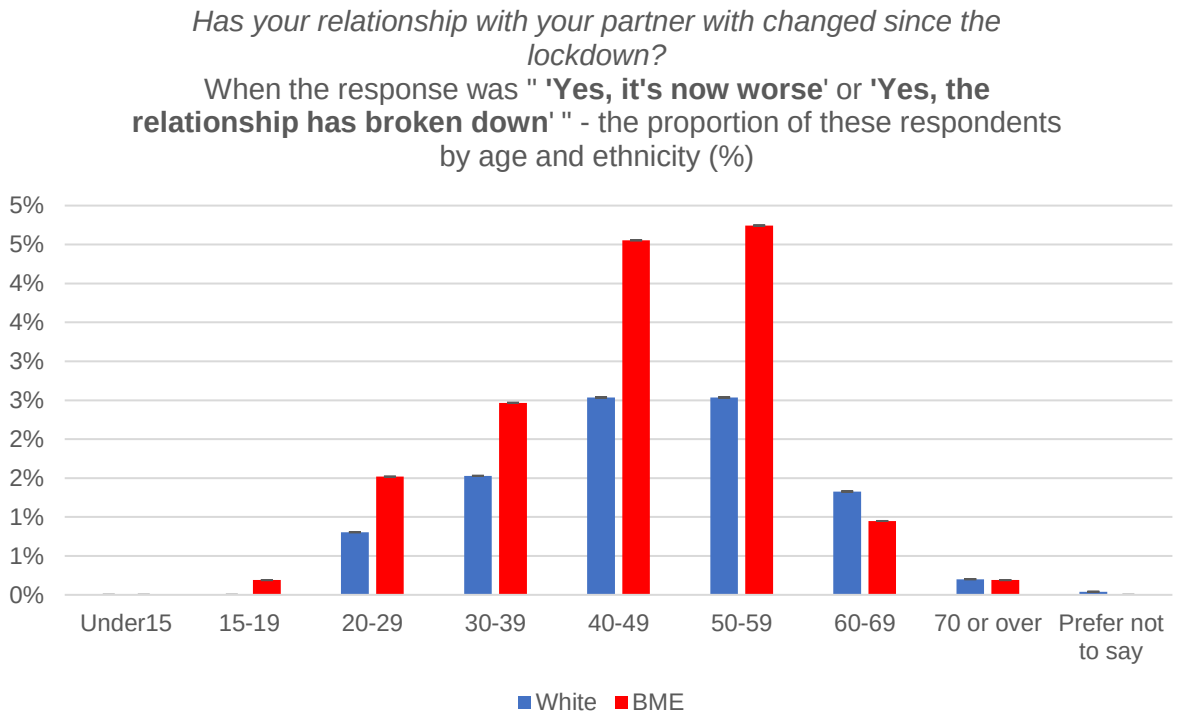


Figure 45. The negative impact of lockdown on community spirit across Birmingham, by age and ethnicity[4]

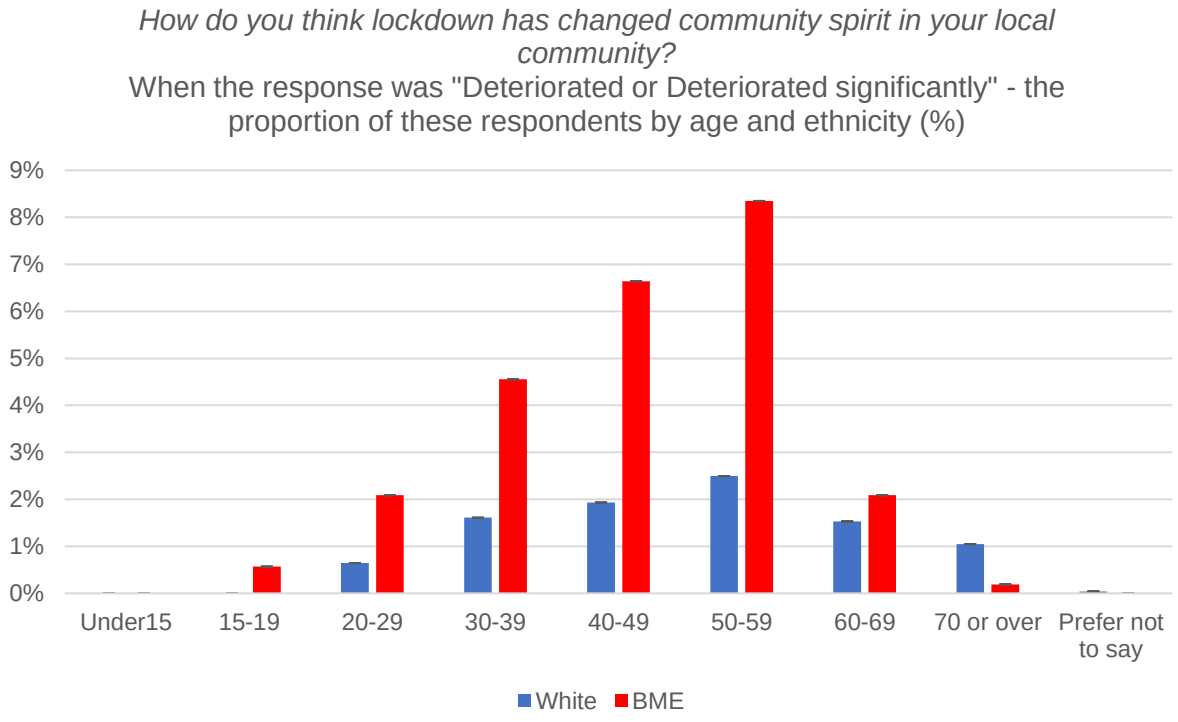


Figure 46. The impact of lockdown on links to local geographic communities, by age and ethnicity[4]

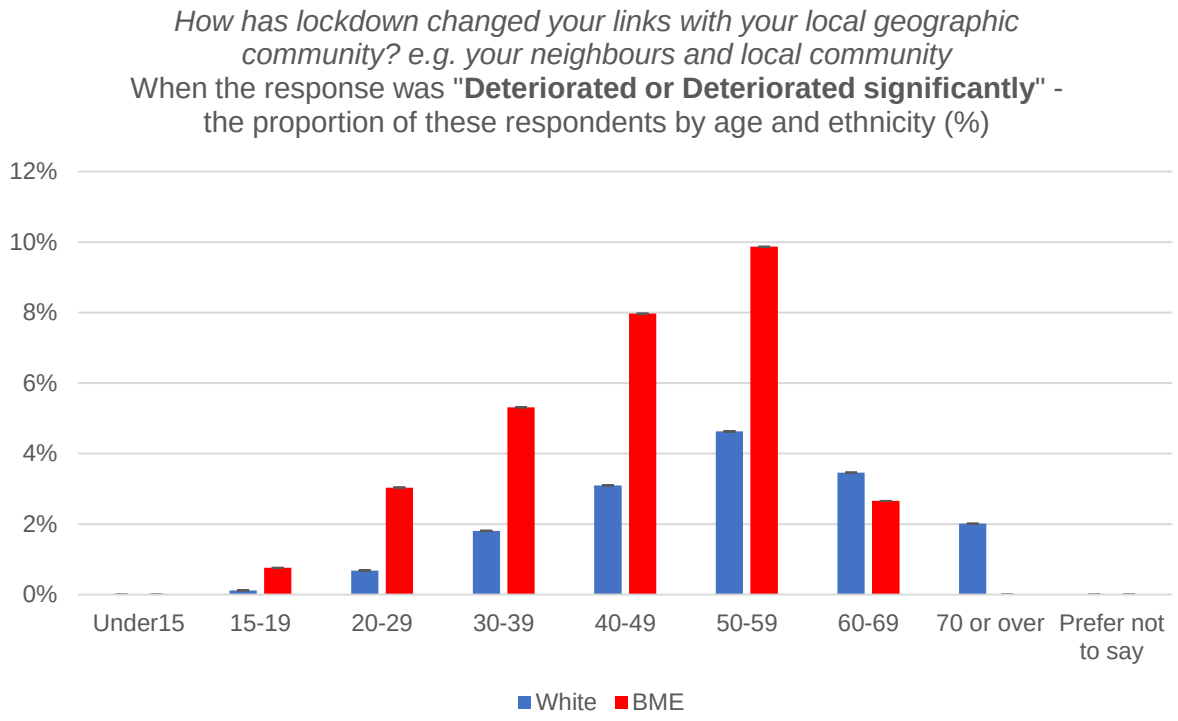


Figure 47. The impact of lockdown on links to local geographic communities, by gender and ethnicity[4]

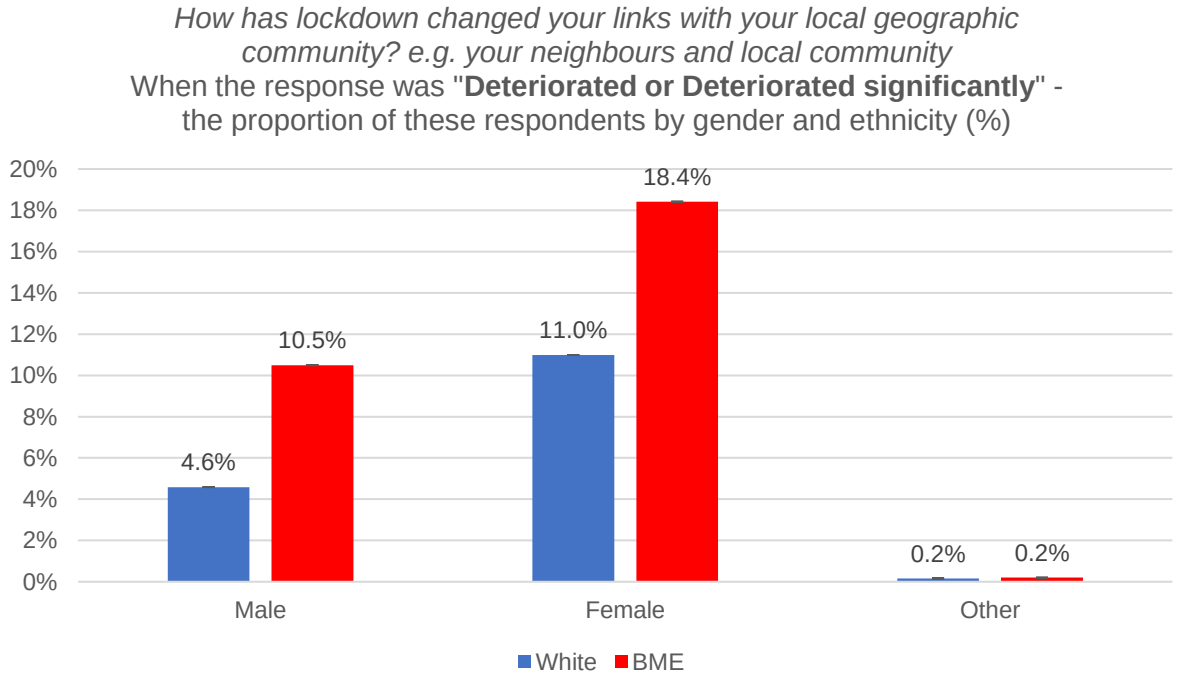


Figure 48. The impact of lockdown on anxiety, by gender and ethnicity[4]

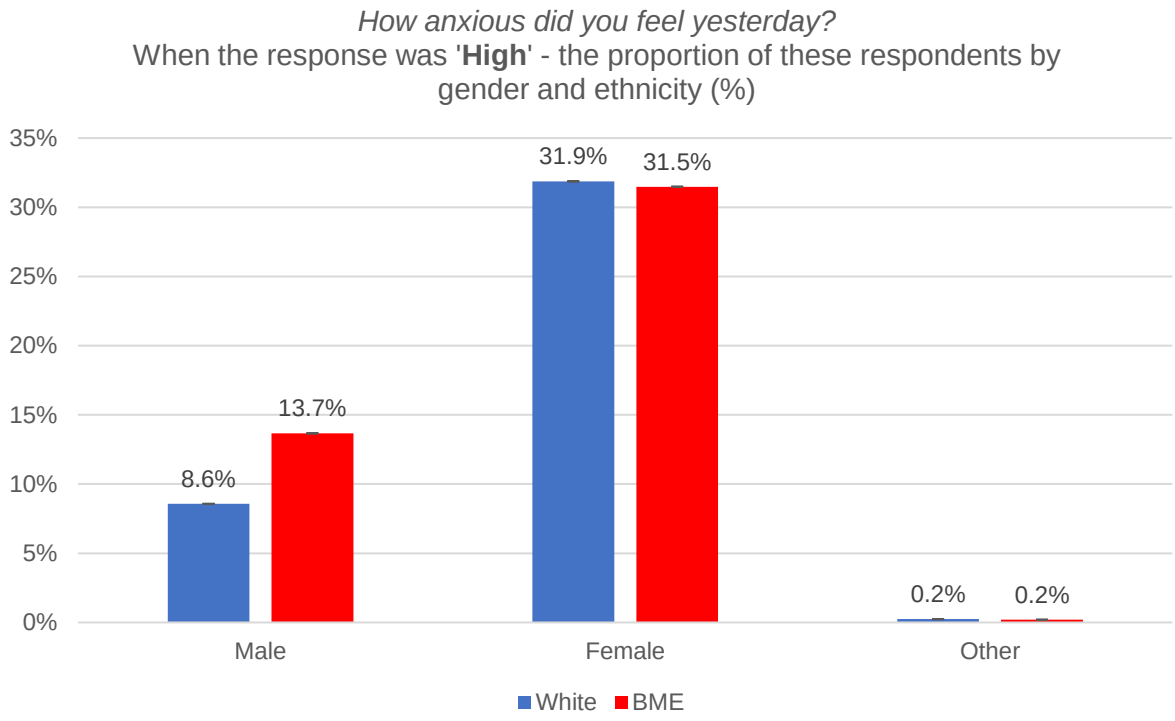


Figure 49. The impact of lockdown on loneliness, by gender and ethnicity[4]

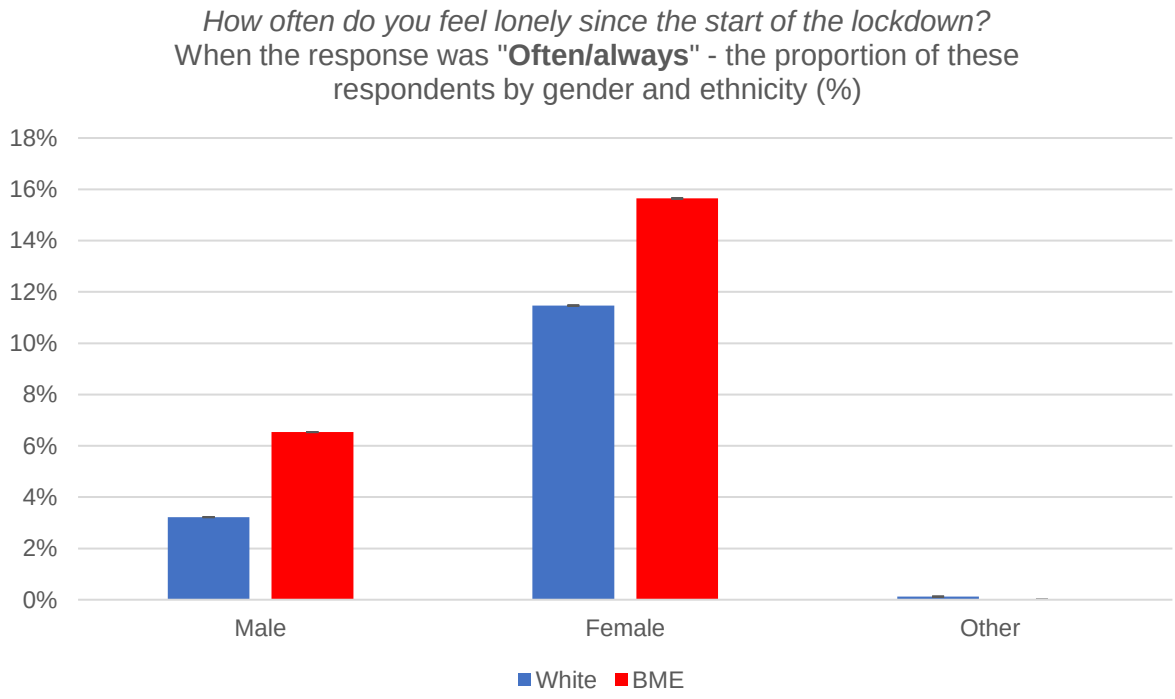


Table 18. COVID-19 Impact Survey: Participant's Gender[4]

Gender	Total
Female	71.5%
Male	26.1%
Other	0.5%
Prefer not to say	1.2%
Not Stated	0.8%
Grand Total	100.0%

Table 19. COVID-19 Impact Survey: Participant's Age Group[4]

Age Group	Total
< 15	0.1%
15-19	0.7%
20-29	6.8%
30-39	14.3%
40-49	22.1%
50-59	29.6%
60-69	17.6%
> 70	8.0%
Prefer not to say	0.6%
Not Stated	0.2%
Grand Total	100.0%

Table 20. COVID-19 Impact Survey: Participant's Ethnicity[4]

Ethnicity	Total
African	0.7%
Any other Asian background	0.4%
Any other Black / African / Caribbean background	1.1%
Any other ethnic group	0.4%
Any other Mixed / Multiple ethnic background	0.9%
Any other White background	3.7%
Arab	0.3%

Ethnicity	Total
Bangladeshi	0.7%
Caribbean	2.9%
Chinese	0.4%
English / Welsh / Scottish / Northern Irish / British	74.5%
Gypsy or Irish Traveller	0.2%
Indian	3.4%
Irish	1.9%
Pakistani	3.9%
Prefer not to say	2.3%
White and Asian	0.6%
White and Black African	0.1%
White and Black Caribbean	1.2%
Not Stated	0.4%
Grand Total	100.0%

Appendix C: Communications and Social Media Engagement

This section contains a summary of social media, communications and engagement and website updates from December 2020 to September 2021.

Social media engagement through @HealthyBrum and Birmingham City Council Twitter, Facebook, Instagram, and YouTube accounts.

Key Messages:

- **Safety measures**
  - Increased focus on face-coverings, test & trace and handwashing to keep members of the public updated on staying safe for their daily commutes and whilst at work
  - Returning to school settings
  - Continued caution with relaxing of lockdown restrictions
  - Community videos on COVID-19 risks
  - Safety measures - continued caution with relaxing of lockdown restrictions, Ventilation when indoors (Euro 2021)
  - Enhanced support plans
  - Ventilation when indoors (Euro 2021)
  - Roadmap out of lockdown
- **Vaccinations**
  - Vaccines access for 18yrs+ and continued caution with relaxing of lockdown restrictions
  - Vaccination (safety, pregnancy, 16-17 years, 18+ and survey about reasons for not getting vaccinated)
  - Mobile Vaccination Units
  - Home and door-to-door LFD testing
  - Testing (LFD, PCR)
  - Encourage take up of the universal home rapid lateral flow testing
- **Wider Topics**
  - NHS App
  - Mental health awareness – all ages
  - Creating a Bolder, Healthier City Strategy
  - BeHealthy Campaign

Media, Press and Advertising

- **Cross cutting communications**

  - Weekly hour-long Q&A with BCC Staff by Director of Public Health, similar targeted Q&A and awareness sessions have been held through the BHealthy Seminars.

    - Update COVID-19 items at Cabinet and Health and Wellbeing Board and to each of the Health and Wellbeing Forums.
    - NHS Test and Trace App launched on 24th September 2020 – messaging has been pushed out through all communication channels.
    - Community Update meetings
    - Staff weekly updates

- **Online and Community Q&As, Radio, Podcasts & TV: COVID-19**
    - BBC WM Q&A on the latest COVID news
    - BBC WM interview on the drive time show about COVID-19 rates and return to education
    - Weekly Q&A with Jane Haynes from Birmingham Live about return to education and COVID-19 updates
- **Online and Community Q&As, Radio, Podcasts & TV: Vaccinations**
    - Q&A with Bahu Trust about vaccines within the Muslim community
    - Vaccine Q&A with Trident staff about upcoming care staff vaccine deadline and misinformation
    - Vaccine Q&A with St Basil's charity and Tamzin Reynolds-Rosser about young peoples' vaccines
    - Vaccine Q&A on Facebook Live with Birmingham Live
    - Vaccine Q&A with First Class Legacy
- **Emails & Newsletters**
    - Vaccines offer to various age groups
    - Locations/sites for vaccine access
    - Birmingham vaccine survey
    - Vaccine toolkit
    - Testing
    - New guidance and isolation rules
    - Long COVID-19 and any health priorities for communities
    - Step 4 RoadMap rules
    - Mobile vaccination vans
    - Enhanced support including links to materials such as Isolation pack
    - Vaccination toolkit
    - Travel rules
- **Verbal** – (word of mouth communication via communities)
    - 'COVID-19 is not over': Personal responsibility
    - 16-17 and 18+ vaccination
    - Testing
    - New isolation rules and support for education settings reopening in September 2021
    - Enhanced support testing

Birmingham City Council Public Health website

- **Website content updates** (over 500,000 visits to COVID-19 pages)
    - Translated Vaccine toolkit and slides
    - Accessible BSL resources
    - Champions COVID-19 dashboard
    - Latest COVID-19 guidance and updates
    - New Education guidance for reopening in September
    - Roadmap guidance and other related COVID-19 updates
    - Vaccine slide deck in multiple languages
    - New LFT sites
    - New LFT map
    - New guidance (roadmap)

Targeted Media Adverts

- **Radio advertising in the multi-languages to publicise NHS App, COVID champion recruitment**:
    - Ambur Radio: 200,000 listeners
    - Switch Radio: 22,000 – 28,000 listeners
    - Raaj FM: 40,000 listeners
    - New Style Radio: no listener figures available
    - Big City Radio: no listener figures available
    - Unity Radio: 90,000 listeners
    - Vaccine resources in multiple languages
    - Over 70s vaccine resources
    - Mayor vaccine video
- **General Public (Birmingham)**
    - BBC WM Radio
    - Birmingham Live – Facebook
    - BBC Midlands Today
    - Capital FM
    - Free Radio
    - ITV Central
- **General public National**
    - BBC Radio 4
    - Sky News
    - Daily Record
    - BBC Radio 5 Live
    - Channel 4
    - The MJ
    - Smooth Radio
    - BBC News Online
- **General Public Trade**
    - Health Service Journal

    - The Doctor
- **Community Groups**
    - First Class Legacy Radio
    - Brit Asia TV
    - Mosque Leaders Forum/Interfaith Forum/Black Churches Forum
    - Live Ape Podcast
    - Sikh Channel TV
    - China Daily, Young Chinese People Forum, Chinese Carers Support project
    - BeatFreaks
    - Birmingham Institute for the Deaf

Birmingham Health and Wellbeing Board

	Agenda Item: 15
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22 March 2022**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES - PERI-NATAL AND INFANT MORTALITY TASK FORCE**
Organisation	**Birmingham City Council**
Presenting Officer	**Justin Varney, Marion Gibbon, Sushma Acquilla**

Report Type:	**Information**

1.	**Purpose:**
1.1	The purpose of this report is to update the board of progress made to date by the Birmingham Peri-natal and Infant Mortality Task force. The main report is a video presentation.

2. **Implications:**		
BHWB Strategy Priorities	Reducing Perinatal and Infant Mortality in Birmingham and Solihull	Y
	Reducing Health Inequalities	Y
Joint Strategic Needs Assessment		
Creating a Healthy Food City		
Creating a Mentally Healthy City		
Creating an Active City		
Creating a City without Inequality		Y
Health Protection		

3.	**Recommendation**
3.1	The board to note the contents of this report.

4. Background

4.1 A report was prepared for Birmingham Health Overview and Scrutiny in 2020 and a request for an in-depth piece of work to consider the figures for infant mortality in Birmingham and the contributing factors which was presented to HOSC in December 2020.

4.2 A series of recommendations were posed which consisted of:

1. To work with partners to establish a multi-agency 'Reducing Infant Mortality in Birmingham' Task Force to oversee a concerted effort by all relevant agencies to achieve a substantial reduction in infant mortality in the city. The Task Force should include the existing Local Maternity System, Clinical Genetics representation, commissioners and other maternity services such as BCHC, plus BCC Public Health, representatives of the CVS sector and elected Member, with a brief to bring the threads of all related interventions together in a concerted and mutually reinforcing programme. It should also identify and address any factors that may discourage some parents from engaging with their maternity service professionals.

2. To set an ambitious goal to reduce infant mortality by 50% in Birmingham by 2025 (from 2015 figures, matching the national target) but to then go further and eliminate the gap between infant mortality rates in Birmingham and the England average by this date. This should be accompanied by a delivery plan that can plausibly demonstrate how these targets can be met, identifying both the structural and modifiable factors underlying the infant mortality within the City.

3. To develop a strong community awareness strand within the Task Force work programme, led by respected and trusted community groups, local community and faith leaders, and other influencers who are engaged in social media. This should be targeted at improved health behaviours, identifying and supporting families facing material hardship and adverse stressful circumstances, early detection of poor baby growth, and empowering people to make healthy life choices that minimise their infant mortality risk factors. This will include ensuring up to date information is available, including current and likely future trends in consanguineous unions in Birmingham.

4. The work of the Task Force should be tasked to consider and adapt the 'four strands' approach put to us by Professor Salway and access any resource and support available nationally.

5. Progress towards achievement of these recommendations should be reported to the HOSC no later than 30th October 2021. Subsequent progress reports will be scheduled by the Committee thereafter, until all recommendations are implemented.

4.3 A tracking report was provided for HOSC on the progress of each of the recommendations in October 2021 detailing the progress of the recommendations (see **Appendix 1**).

4.4 As part of shaping the approach to creating a positive discussion, regarding both desire and preparation for pregnancy, Birmingham City Council commissioned qualitative research targeting 'seldom heard' communities across Birmingham. The groups included: Bangladeshi and Pakistani, Chinese, Eastern European, Black African and Caribbean and women with particular needs, including learning disabilities. A report was written which captures the findings and recommendations from these conversations. It is currently being finalised.

4.5 In response to Recommendation 1 of the HOSC report, a Task Force was established, and an Independent Chair was appointed by Birmingham City Council on 23rd August 2021. The Task Force has been established for a period of time to take an accelerated evidence-based and data-driven approach with organisational partners and communities to reduce perinatal and infant mortality across the city.

4.6 The membership of the task force was selected and agreed by the Infant Mortality Task and Finish Group that was established to report on Infant Mortality in Birmingham for the HOSC.

4.7 Their first workshop was held on 21st September 2021 involving over 30 stakeholders and representing professionals from 12 different organisations. The first meeting of the task force was held in January 2022 where the terms of reference were agreed and suggestions to expand the membership were discussed and agreed.

4.8 It was agreed that:

- The Task force will work in 3 work streams led by the designated members of the task force, leading each stream. Work stream leaders can choose to include individuals that may not be members of the task force and report progress at the Task force meeting. Following were agreed as the three groups:

- **Research Group: to be established** by Richard Kennedy. It will create research evidence build on previous work and draw on the national and international evidence base. Research questions on belief and attitude should be included**.**

- **Innovation and co-production of possible solutions: to be led by Marion Gibbon.** To draw on lived experience of citizens and professionals to shape its thinking and will connect with a broad base of academic resources across the city from different disciplines.

- **Implementation of Key actions:** in the short, medium and long term, that will reduce the rate of perinatal and infant mortality in Birmingham and will provide advice and monitor implementation of these actions. It will also look at the quality improvement in the existing service and identify gaps.

- In addition to the three agreed workstreams, the appointed chair – Sushma Aquila - decided to have 1 to 1 meetings with the individuals who had experience of the topic and were interested in making a difference. This included not only the members of the task force but also the individuals identified by those who were interested but not the members of the task force.

The findings from these interviews will in turn provide the input for action into three workstreams.

- It has been agreed with the DPH and the members of the Task Force, items that can be implemented in the service as follows:

  1. Ethnicity to be recorded in near 100% maternity patients
  2. Those at risk should be flagged and monitored carefully.
  3. All pregnant women advised re obesity, diabetes and smoking risk factors. To add vaccination as current requirement.
  4. Any women with having a stillbirth / infant loss referred for bereavement and future pregnancy planning at 6-8 weeks and not at 3 months. Ideally this visit should be with partner accompanying the women.
  5. Pre-Pregnancy health/ consanguinity/ genetic test availability should be taught in the school and not wait till later.
  6. Complicated premature delivery should only be done in the level 3 main hospital with good neonatal facility.
  7. Treatment pathway should be developed and followed in the maternity hospitals.
  8. Community facility to be provided where minority women can meet and discuss their issues openly.

- **For constitution of task force** (see **Appendix 2.)**
- **Accountabilities**

  1. The task force will be accountable to the Creating a City without Health Inequalities Forum.
  2. The Task force will help determine, shape and implement key priorities to deliver improved perinatal and infant mortality and reduce inequalities, during the next year

5.	**Compliance Issues**
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	This report is to update the board on the progress being made by the Birmingham Perinatal and Infant Mortality Task force set up in September 2021 by the Birmingham Council.

5.2	Management Responsibility
	The task force is accountable to the Health and wellbeing Board through the Director of Public Health.

6.	Risk Analysis		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Lack of engagement from partners	Low	High	Ensure are partners informed and involved throughout
Lack of involvement from women and families	Low	High	Ensure co-production throughout
Task force does not complete actions within agreed time frame	Medium	Medium	Close monitoring of agreed actions by task force and subgroups

Appendices
Appendix 1 - Infant Mortality Tracking Report **Appendix 2** - Membership of the Taskforce **Appendix 3** - Draft Development Plan

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

Sushma Acquilla, Marion Gibbon.

Appendix

Appendix 1.

Infant Mortality Tracking Report October 2021.pdf

Appendix 2.

Task Force Membership:

- Independent Chair
- Chair of Child Death Overview Panel
- Birmingham City Council (secretariat)
    - Public Health Children & Young People's Lead
    - Children's Commissioning Lead
- NHS Birmingham & Solihull
    - Children & Maternity Commissioning Lead
    - Local Maternity System
- Maternity & Paediatric Providers
    - Birmingham Women's and Children's NHS Foundation Trust (Obstetrician or foetal medicine Paediatrician)
    - University Hospital Birmingham NHS FT (Obstetrician or Paediatrician)
    - Sandwell and West Birmingham (obstetrician or paediatrician)
    - Genetics department of BWCNFT
    - Midwifery Services Lead
- Birmingham Voluntary & Community Sector
- Academic representatives
- Elected Member
- It has been suggested that Bereavement Nurse/ HV should be invited.

Appendix 3.

Draft Development Plan:

1. Research and innovation
2. Co-production and community engagement
3. Implementation

Priority themes, objectives and actions

1. Quality, safety and access to services

Objectives	Themes from discussion 1:1
Improving access to the system	Best care for women knowing How and what to do Plenty of good guidance is available but problem with implementation of guidance Move towards "Package of care"

Strengthen preconception care services and engagement	Vitamin D and Folic acid deficiency Non invasive prenatal screening. Holistic support and care for next pregnancy Implementation of good practice Reducing preterm births: pre pregnancy Counselling Pre-conception panel genetics Advice re losing weight before next pregnancy / poverty issue Community side of the care is missing sometimes, hence pre-pregnancy/ pre conception advice is not available.
Increase engagement with antenatal services and promote the benefits of antenatal care	Services are better for high alert patients Care drops after 2nd delivery in hospital Risk assessment best done by Fetal medicine nurse /HV Improving access to the system HBA1C needs to be introduced as routine test in pregnancy. Quality standards in antenatal care are important factors.
Increase awareness regarding genetic services	More education is required in school on preventable causes Rare conditions recorded at delivery but may not be seen as problem – prompt referral Difficult to change as 90% of Consanguineous couples may produce normal child
Training of health care workers and clinicians in cultural compassion	Women feel that there is structural racism and lack of trust and respect. There are superstitions and cultural behaviours that do not help Holistic support and care for next pregnancy get a group of women and arrange meeting to educate them and empower women in decision making
Training regarding postpartum contraception	Implementation of good practice Move towards “Package of care” Need to improve maternal post partum care/ postnatal checks.

Appropriate assessment and referral during pregnancy and support during birth	Services are better for high alert patients Care drops after 2nd delivery in hospital Risk assessment best done by Fetal medicine nurse /HV Non invasive prenatal screening. Risk assessment and risk management
Develop excellence in reducing injury in premature Births	Use literature from other areas like Manchester. Plenty of good guidance is available but problem with implementation of guidance Adverse outcome if born in separate local unit without adequate neonatal support. Adverse outcome for hypothermia in babies at the time of resuscitation. Both can be avoided by complicated/ premature deliveries to be done in Level 3 women's hospital and Transthermot heating pack cover the baby and avoid hypothermia. Monitor breathing cycle during "golden hour" Midwives have an important role for those who have had premature delivery before.

2. Maternal and infant wellbeing

Objectives	Theme group
Support women to stop smoking and promote smoke free homes	Smoking cessation Immediate action could be taken on major risk factors in women i.e. Obesity/ smoking/ diabetes/ socio economic factors Main causes on Infant deaths Obese mothers with high BMI, From deprived area, smoking, Housing issues: overcrowding
Support maternal mental health and wellbeing	Re establish women's centre for exchange of information/ education Re establish children's/ women's Centres like Sure start get a group of women and arrange meeting to educate them and empower women in decision making
Reduce maternal obesity and improve nutrition	More education is required in school on preventable causes Immediate action could be taken on major risk factors in women i.e. Obesity/ smoking/ diabetes/ socio economic factors Main causes on Infant deaths Obese mothers with high BMI, From deprived area, smoking, Housing issues: overcrowding

Encourage and support breastfeeding	
Support families in health and genetic literacy	More education is required in school on preventable causes get a group of women and arrange meeting to educate them and empower women in decision making Service providers need to change attitude Families are now coming forward for tests and new generations are changing. Access to information for young couples Intervention not accepted due to religion and get judged on the decision Adoption and milk bank not accepted in religion Rare conditions recorded at delivery but may not be seen as problem – prompt referral
Alcohol and substance-misuse support during pregnancy and postnatally	

3. Addressing the wider determinants of health

Objectives	Theme group
Support efforts to reduce and mitigate the impact of poverty	Wider public health determinants to be addressed i.e. pollution and Poverty Income poverty and quality standards in antenatal care are important factors.
Housing	Wider public health determinants to be addressed i.e. pollution and Poverty Main causes on Infant deaths Obese mothers with high BMI, From deprived area, smoking, Hosing issues: overcrowding
Identify and address poor environments	Wider public health determinants to be addressed i.e. pollution and Poverty
Working with homeless team to support vulnerable mothers and infants	

4. Safeguarding and keeping infants safe from harm

Objectives	Actions
Safe sleeping	More education is required in school on preventable causes
Safe home environments	More education is required in school on preventable causes
Prevention of injuries	More education is required in school on preventable causes
Reduction in domestic abuse during pregnancy and motherhood	More education is required in school on preventable causes "I can cope" not shaking the baby

5. Providing support for those bereaved and affected by baby loss

Objectives	Theme group
A system-wide approach to making things as easy as possible for bereaved families	counselling for those who have lost a baby-(3 months after)
Strengthen pathways to ensure people who have had a loss receive enhanced support for their next pregnancy	Holistic support and care for next pregnancy Timing for postnatal bereavement 5-6 wks Late loss in pregnancy and stillbirths should be one of the research priorities
Increase the skills and confidence of the wider workforce to talk about bereavement	Timing for postnatal bereavement 5-6 wks

Birmingham Health and Wellbeing Board
Draft Forward Work Programme and Board Membership:
July 2021-22

Board Members:

Name	Position	Organisation
Councillor Paulette Hamilton (Board Chair)	Cabinet member for Adult Social Care and Health	Birmingham City Council
William Taylor (Vice Chair)	Chair	NHS Birmingham and Solihull CCG
Councillor Sharon Thompson	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
Karen Helliwell	Interim Accountable Officer	NHS Birmingham and Solihull CCG
Paul Maubach	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
Richard Kirby	Chief Executive	Birmingham Community Healthcare
Mark Garrick	Director or Strategy and Quality Development	University Hospitals Birmingham NHS Foundation Trust

Chief Superintendent Stephen Graham	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
Waheed Saleem	Executive Director Strategic Partnership	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

Committee Board Manager
Landline: 0121 675 0955
Email: errol.wilson@birmingham.gov.uk

Business Support Manager for Governance & Compliance
Landline:0121 303 4843
Mobile : 07912793832
Email : Tony.G.Lloyd@birmingham.gov.uk

Forward Plan:

	27th July 2021	**21st September 2021**	**30th November 2021**	**18th January 2022**	**8th February 2022**	**22nd March 2022**
Draft Papers Deadline	7th July 2021	25th August 2021	3rd November 2021	22nd December 2021	19th January 2022	23rd February 2022
Final Papers Deadline	15th July 2021	9th September 2021	18th November 2021	6th January 2022		10th March 2022
Standing items	Covid-19 position statement -Dr Justin Varney Vaccination update -Paul Jennings ICS Update - Yve Buckland	Covid-19 position statement - Dr Justin Varney Vaccination (Flu and Covid) update - Paul Jennings ICS Update - Yve Buckland CWG Legacy Update	Covid-19 position statement -Dr Justin Varney Vaccination update - Karen Helliwell ICS Update - Karen Helliwell CWG Legacy Update	Covid-19 position statement -Dr Justin Varney Vaccination update - Karen Helliwell ICS Update - Karen Helliwell CWG Legacy Update	Covid-19 position statement -Dr Justin Varney Vaccination update - Karen Helliwell CWG Legacy Update	Covid-19 position statement -Dr Justin Varney Vaccination update - Karen Helliwell ICS Update - Karen Helliwell CWG Legacy Update
Theme	**Business Meeting**	**Equity of access to health services/care**	**System Strategies**	**Inequalities**	**ICS**	**Business Meeting**

Items	Appointment of Health and Wellbeing Board – Functions, Terms of Reference, and Membership of the Board Schedule of HWB Meetings for 2021/22 **JSNA deep drive** -Luke Heslop, Service Lead **PH Commissioned Services** -Bhavna Taank/Karl Beese, Service Lead **HWB Creating a Healthier City Framework** -Dr Justin Varney, Director of Public Health **Creating a Mentally Healthy City Forum** -MH bid Natalie Stewart, Service Lead **Ofsted Report** -Kevin Crompton, Director of Children's Services	**Population Health Management** opportunity -What's the system doing to improve uptake in services. -TBC PH/ICS inequalities board **Screening and Immunisations** -CCG	**Creating a Healthy Food City Forum** -Birmingham Food Strategy -Seldom Heard Voices report - Maria Rivas, Interim Director of Public Health		**ICS Transition update -** Anna Hammond, BSol Place Development Director **BSol ICS Finances Update –** Paul Athey, Chief Finance Officer, NHS Birmingham and Solihull CCG **BSol System Recovery Plan** – Rachel O'Connor, Chief Operating Officer / Harvir Lawrence, Director of Planning and Delivery	**BLACHIR Final report –** Dr Justin Varney, Director of Public Health **Health and Wellbeing Board Strategy**- Dr Justin Varney, Director of Public Health **ADPH Report 2020//21** - Dr Justin Varney, Director of Public Health
Nonthematic items		**JSNA Deep Dives** - Luke Heslop, Evidence Service Lead	**Better Care Fund** - Mike Walsh, Service Lead, Adult Social Care **Social Prescribing** - CCG/BVSC		**Better Care Fund** - Mike Walsh, Service Lead, Adult Social Care	

			Birmingham Children and Young People Local Transformation Plan - CCG, Carol McCauley Lead Strategic Commissioner			
Written updates	BLACHIR Forums ISC Inequalities Board LCOEB	Forums BLACHIR ISC Inequalities Board LCOEB	BLACHIR Forums ISC Inequalities Board LCOEB	Forums BLACHIR LCOEB	**Health Protection Forum** - Annual report Chris Baggot, PH Service Lead **JSNA End of Life**- Luke Heslop, PH Service Lead **The City of Nature Vision** - Hamira Sultan, Public Health Consultant **Draft Sexual Health Strategy**- Karl Beese – Commissioning Manager, Adult Public Health Services	**Infant Mortality Task Force** update/feedback - Dr Marion Gibbon, Assistant Director of Public Health LCOEB

					Birmingham Integrated Care Partnership (BICP) Annual Report- Mike Walsh, Service Lead, Adult Social Care FORUMS BLACHIR LCOEB	

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.