BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 21 FEBRUARY 2023 AT 10:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

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

2 **APOLOGIES**

To receive any apologies.

3 **DECLARATIONS OF INTERESTS**

Members are reminded they must declare all relevant pecuniary and other registerable interests arising from any business to be discussed at this meeting.

If a disclosable pecuniary interest is declared a Member must not participate in any discussion or vote on the matter and must not remain in the room unless they have been granted a dispensation.

If other registerable interests are declared a Member may speak on the matter only if members of the public are allowed to speak at the meeting but otherwise must not take part in any discussion or vote on the matter and must not remain in the room unless they have been granted a dispensation.

If it is a 'sensitive interest', Members do not have to disclose the nature of the interest, just that they have an interest.

Information on the Local Government Association's Model Councillor Code of Conduct is set out via http://bit.ly/3WtGQnN. This includes, at Appendix 1, an interests flowchart which provides a simple guide to declaring interests at meetings.

5 - 12

4 **ACTION NOTES/MATTERS ARISING**

To confirm the action notes of the meeting held on 24th January 2023.
(1000-1010hrs)

13 - 118

5 **SEXUAL HEALTH TREATMENT AND PREVENTION SERVICE - UMBRELLA (UHB)**

Karl Beese, Commissioning Manager - Adults Public Health; Juliet Grainger, Public Health Service Lead (Adults); Becky Pollard, Interim Assistant Director Public Health (Adults and Older People; Maureen Black, General Manager, Umbrella; Meg Boothby, Clinical Service Lead, Umbrella and Consultant Sexual Health and HIV Medicine.
(1010-1110hrs)

119 - 140

6 **STRATEGIC OVERVIEW OF IMMUNISATIONS IN BIRMINGHAM**

Mary Orhewere, Assistant Director, Public Health; Paul Sherriff, Chief Officer for Partnerships and Integration, Integrated Care Board; Leon Mallett, Head of Immunisations and Vaccinations, NHS.
(1110-1150hrs)

141 - 160

7 **WORK PROGRAMME - FEBRUARY 2023**

For discussion.
(1150-1200hrs)

8 **DATE AND TIME OF NEXT MEETING**

To note that the next meeting is scheduled for Tuesday 14th March at 10.00am.

9 **REQUEST(S) FOR CALL IN/COUNCILLOR CALL FOR ACTION/PETITIONS RECEIVED (IF ANY)**

To consider any request for call in/councillor call for action/petitions (if received).

10 **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.

11 **AUTHORITY TO CHAIR AND OFFICERS**

Chair to move:-

'In an urgent situation between meetings, the Chair jointly with the relevant Chief Officer has authority to act on behalf of the Committee'.

BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE O&S COMMITTEE

PUBLIC MEETING

Tuesday 24 January 2023. Committee Rooms 3 & 4, Council House, Victoria Square

Action Notes

Present

Councillor Mick Brown (Chair)

Councillors: Kath Hartley, Rob Pocock, Julian Pritchard and Paul Tilsley.

Also Present:

Fiona Bottrill, Senior Overview and Scrutiny Manager (joined the meeting online)

Joanne Lowe, Head of Service, (Operations and Partnerships) Mental Health

Andrew Marsh, Head of Service, (Operations and Partnerships) Strategic Lead for Hospitals, Discharge to Assess Pathways and Integrated Hub

Gail Sadler, Scrutiny Officer

John Williams, Director – Adult Social Care (Operational and Community Services)

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1. NOTICE OF RECORDING/WEBCAST

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2. APOLOGIES

Councillors Gareth Moore and Jane Jones.

3. DECLARATIONS OF INTEREST

None.

4. ACTION NOTES/MATTERS ARISING

Actions from 19 July informal meeting

Q4 Adult Social Care Performance Monitoring Report

A further informal briefing session regarding 'Discharge to Assess Pathways' and 'Failed Discharges' with Andrew Marsh and Andrew McKirgan, Chief Officer for Out of Hospital Services, University Hospitals Birmingham NHS Foundation Trust, has been arranged for Friday 27th January 2023.

Actions from 22 November meeting:

Birmingham and Solihull Integrated Care System Ten-Year Strategy:

- That a note is provided on what long-Covid services are available in Birmingham.
- Provide a note on the membership of the ICS Partnership, ICS Board and Place Board.

The information was circulated to members on 12 January 2023.

Substance Use: Birmingham's Adult Treatment Services

- To provide information on the association between people living in Houses of Multiple Occupation (HMOs) and exempt accommodation and in treatment for drug and alcohol abuse by Wards.
- CGL to provide information regarding the training that has been given to housing providers.

Scrutiny Officer(s) have been advised that the information will be available by the end of January 2023. The Chairman requested that Scrutiny Officer(s) follow up the request.

Actions from 20th December meeting:

Adult Social Care Performance Monitoring

Members were told that the information requested in relation to the adult social care precept had been circulated via email on 5th January 2023.

5. ADULT SOCIAL CARE REFORMS

The committee received a presentation from John Williams, Director – Adult Social Care (Operational and Community Services) and Andrew Marsh, Head of Service, (Operations and Partnerships) Strategic Lead for Hospitals, Discharge to Assess Pathways and Integrated Hub, on the Governments plans to introduce Adult Social Care Reforms which were expected to be implemented in October 2023 but have now been delayed until 2025. The committee was updated on actions taken to date and key next steps for implementing the Fair Cost of Care. The following key points were highlighted:-

- The background to the Government plans to reform adult social care in England and the funding that would be used to fund the reforms.

- Key features of the Reforms include:-
    - Introducing a care cap of £86,000 on the amount anyone in England will have to spend on their personal care over their lifetime.
    - Fair Cost of Care Reforms.
- The Fair Cost of Care exercise for Birmingham is based on provider submitted data between 6 June and 4 August 2022.
    - Summary results of the Fair Cost of Care Exercise for the 65+ Care Home Market.
    - Summary results of the Fair Cost of Care Exercise for the 18+ Domiciliary Care Market.
- Progress on fair cost of care actions for the City Council and the key next steps.

In discussion, and in response to Members' questions, the following were among the main points raised:

- One challenge is that, for all local authorities, the fair cost of care needs to be funded by Government and we can only pass on those funds to our care providers. The Local Government Association and Association of Directors of Adult Social Services are working closely with Government to let them understand the impact of the fair cost of care on local authorities' budget but also on providers.
- The local authority has contracts with 236 care homes. Those that are eligible under the fair cost of care is 130 because they are providing care to the 65+ age group.
- The Hospital Social Work Discharge Team work very closely with health colleagues to maximise the number of citizens that they can help and support to leave hospital. Some of those leave without needing care and support others leave with a short-term placement and/or residential and nursing care.
- There is a very high threshold to meet for Continuing Health Care funding. Most people start with social care and then potentially move into health care funding as their physical or mental health declines.
- From a system viewpoint the number of beds is not always the issue it is having the right beds i.e., ensuring the placement is right for the person leaving hospital. An inappropriate placement could mean that person returns to hospital.
- As a system, along with University Hospitals Birmingham (UHB) and Birmingham Community Health Care (BCHC,) jointly commission a 'pathway to bed stock'. Some of this is within BCHC and some is privately commissioned. Therefore, providing jointly commissioned capacity between health and social care to enable a person to be discharged from an acute setting.
- Not aware of all self-funders as care homes do not have a requirement to notify the local authority of self-funders but commissioning colleagues are

engaging with care homes to better understand how many people are self-funded.

- At present, not in a position to know whether the Government funding is going to be enough to ensure providers can operate without cross-subsidy.
- The reported cost of 18+ domiciliary care travel time is significantly lower than national benchmarks because of the benefits of urbanisation. It costs more in rural areas.
- The BCC Director of Commissioning and Head of Service regularly meet with as many care providers as possible and do monitoring and visits to build up an operational relationship with them. From a standards point of view, 75% of providers are rated gold or silver.
- A survey based on government guidelines was sent to providers for the fair cost of care exercise.
- Worked closely with providers to understand the true costs for them. There are significant variables and data that has been used to produce the figures and how they benchmark against other local authorities.
- Regarding medium- and long-term financial planning, BCC can only pass on to providers the funding received from Government for the fair cost of care. Currently, profiling financial risk of this and financial burdens on local authorities. Also, working closely with care home providers to better understand their financial liabilities.

RESOLVED:

- The Fair Cost of Care report submitted on 14th October is circulated to the committee.
- That the committee receives a further report on the financial position regarding Fair Cost of Care early in the new municipal year.

6. APPROVED MENTAL HEALTH PROFESSIONAL

John Williams, Director – Adult Social Care (Operational and Community Services) and Joanne Lowe Joanne Lowe, Head of Service, (Operations and Partnerships) Mental Health, introduced the report which outline the role of the Approved Mental Health Professional i.e., those authorised to make certain legal decisions and applications under the Mental Health Act 1983 and highlighted the following:-

- The role of the Approved Mental Health Professional (AMHP).
- The number of Mental Health Act assessment being carried by BCC each month.
- The average time from the request for a mental health assessment to completion.
- Mental health assessment data for under 18 and over 18-year-olds over a 3-year period.

In discussion, and in response to Members' questions, the following were among the main points raised:

- AMHPs across the local authority are social workers, and they are fulfilling a dual role. Every other week they will work with the Mental Health Act HUB and they will just undertake Mental Health Act assessment work. They do undertake casework as well, so they are social workers and AMHPs.
- AMHPs are trained and skilled in working with people of all ages because there's no age limit to the Mental Health Act and work closely as social workers within Forward Thinking Birmingham as well. When assessing young people always try to get a doctor from Forward Thinking Birmingham to undertake the assessment as well.
- It is the AMHPs who ultimately decide either to detain someone or not but that's done in consultation with doctors and with the nearest relative and family members. There's a legal duty to consult with that person's nearest relative as defined under the Mental Health Act.
- It's the responsibility of the AMHP to make decisions in terms of risk. If a person is in a police cell, it may not be the most ideal place for them, but they are safe. The police will often use alternative power such as section 136, which enables them to move people out of a custody setting into the designated place of safety in Birmingham where they will be assessed with a 24-hour timeframe.
- The Mental Health Act requires the doctor to be responsible for identifying the bed and that's a function they delegate in Birmingham to bed managers. At the place of safety, which is based at the Oleaster Hospital over at the QE, they have a number of bed managers and have a bed management function and are responsible for determining who should be brought into hospital.
- Work is underway to improve AMHP workforce succession planning. Looking to approve 7 new AMHPs every year. Training takes 6 months at Wolverhampton University compared to 2 years at Birmingham University. Also encouraging BCC social workers to become AMHPs and recently set up a specialist mental health team to try and strengthen that in Birmingham.
- Concern was raised about the use of out of area placements for young people due to a lack of beds in Birmingham. Community services are not able to support younger people at an earlier stage which is impacting on the number of younger people who are presenting significantly unwell and requiring hospital admission.
- The bed management system is not managed locally. It is managed nationally by NHS England. It's not a case of allocating a bed geographically but where a bed is available, and this can be outside of the West Midlands region.
- If an individual who's been assessed, not detained, and then commits a serious assault, there will be a partner case review, that is independently done. Specialist Consultants look at what the near misses were and what could have been done to prevent that.

- Of the 4,000 annual assessments about 75-80% of those people will be detained. In Birmingham, this is a disproportionate amount of section 136s. Those are police powers where they bring people off the streets to a place of safety, and they have to be assessed within 24 hours. A high proportion of those that come in via the police won't result in detention.
- There have been instances when people, including children, have been allocated a bed with a private provider but on arrival at the hospital have been refused admission. Because they are a private provider, they have the right to refuse.
- In terms of qualitative data, it is difficult to know how many assessments were with new patients with no mental health record because there are people that have no legal right to stay, no recourse to public funds that come through requiring a Mental Health Act assessments etc. People who are picked up by the police on a section 136 and brought into custody and require a Mental Health Act assessment. They have no previous history but might be under the influence of drink and drugs and not have a mental illness.
- HR colleagues are looking at workforce planning of the service including the age profile and equality and diversity of the workforce. BCC contributes to an annual AMHP survey so has accurate data in terms of the ethnicity and age group of BCCC AMHPs.

RESOLVED:

- To provide information on how many occasions people have been refused admission to hospital from a private provider.
- To provide a report on AMHP Workforce Planning to a future meeting.
- 'Out of area bed placements' to be included in the work programme for next year in order to highlight this issue for national debate.

7. WORK PROGRAMME – JANUARY 2023

- The Senior Overview and Scrutiny Officer set out the agenda items for the next meeting on 21st February:-
    - Birmingham Sexual Health Services – Umbrella (UHB)
    - Immunisation
- Following a request for the report on Immunisation to be deferred, it was agreed that a strategic oversight paper would be requested for the 21st February meeting with a more detailed report to be presented to the 18th April meeting.
- A Task and Finish Group meeting for the Children and Young People's Mental Health Inquiry are scheduled for 31st January, 14th February and 21st February. Also, the written call for evidence has been sent to those organisations that have not been invited, at this stage, to attend a meeting. There will also be a public call for evidence that will be published on the BCC website. In addition,

trying to set up a meeting with young people on 8th February and will be linking with Healthwatch to see if they have young people who may want to join that session.

RESOLVED:

That the work programme be noted.

8. DATE AND TIME OF NEXT MEETING

The date of the next meeting is scheduled to take place on Tuesday 21st February 2023 at 10.00am.

9. REQUEST(S) FOR CALL IN/COUNCILLOR CALL FOR ACTION/PETITIONS RECEIVED (IF ANY)

None

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10. OTHER URGENT BUSINESS

None.

11. AUTHORITY TO CHAIRMAN AND OFFICERS

RESOLVED: -

That in an urgent situation between meetings the Chair, jointly with the relevant Chief Officer, has authority to act on behalf of the Committee.

The meeting ended at 1205 hours.

Birmingham City Council

Health and Social Care Overview and Scrutiny Committee

Date: 22nd November 2022

Subject:	**Sexual Health Treatment & Prevention Services delivered by Umbrella (University Hospitals Birmingham)**
Report of:	**Dr Justin Varney** **Director for Public Health** **Cllr Khan** **Cabinet Member Health & Social Care**
Report authors:	**Juliet Grainger** **Public Health Service Lead (Adults)** **Karl Beese** **Commissioning Manager, Adult Public Health Services**

1 Purpose

1.1 To provide the Health and Social Care Overview and Scrutiny Committee with an Annual overview on the performance of Birmingham Sexual Health Treatment & Prevention Services commissioned by Public Health and delivered by Umbrella (University Hospitals Birmingham).

2 Recommendations

2.1 That the Committee notes an overview of Sexual Health Treatment & Prevention Services that will be provided by Public Health, Commissioners and Umbrella on 21st February 2023 by way of the information detailed under Appendices embedded under Point 6.

3 Any Finance Implications

3.1 None, Birmingham Sexual Health Treatment & Prevention Services are funded through the Public Health Grant that is received by the Council.

4 Any Legal Implications

4.1 None, the Health and Social Care Act 2012 and associated regulations transferred the responsibility for public health from the NHS to local authorities from April 2013. Public Health are mandated to commission open access sexual

health services, including free STI testing and treatment, notification of sexual partners of infected persons and advice on, and reasonable access to, a broad range of contraception and advice on preventing unplanned pregnancy and is a condition of the Public Health Grant that is received into the Council.

5 Any Equalities Implications

5.1 None, the Birmingham Sexual Health Treatment & Prevention Service is open to anyone in Birmingham (predominantly 13+) and is not discriminatory towards any of the 9 protected characteristics detailed in the Equality Act 2010.

6 Appendices

Appendix 1: BCC Presentation to O&S Committee

BCC Sexual Health
OSC 21.02.2023 Final

Appendix 2: BCC Additional Supporting Information

SH Contextual Data
OSC 10.01.2023 Final

Appendix 3: BCC Additional Supporting Financial Information

SH OSC 21.02.2023
BCC Additional Financ

Appendix 4: Summary Profiles of Local Authority Sexual Health (SPLASH) Report

SPLASH Birmingham
01.02.2023.pdf

Appendix 5: UHB Presentation

Umbrella OSC
Presentation v3 21 Fe

Appendix 6: Umbrella Summary Report

Summary Report 21
Feb 2023 OSC Umbre

Sexual Health: Treatment and Prevention Services in Birmingham

Presentation to the Health & Social Care Overview & Scrutiny Committee

Tuesday 21st February 2023

Umbrella Sexual Health Service Overview

- Currently joint-commissioned with Solihull Metropolitan Borough Council (SMBC) and provided by University Hospitals Birmingham NHS Foundation Trust from 10th August 2015.
- Recent extension to 31st March 2024 due to impact of initial constraints of the COVID-19 pandemic and anticipation of the new national sexual health policy and national service specification, alongside commissioning and procurement guidance.
- Contract extension period to provide the necessary time to ratify the draft Sexual Health Strategy 2023-2030 and to use the consultation findings to inform the commissioning and procurement process for a new service to commence on 1st April 2024.
- Current annual block contract value of £14,038,467. Yearly spend since contract commencement is detailed in supporting information. Inflationary uplift for 2023/24 is to be agreed.

Umbrella Sexual Health Service Overview

Core City Cost Comparison 2021/22

Contract spend per head of population benchmarked against 8 core cities*:

Rank by Spending	Spend per head of population**
Highest spend: Newcastle	£18.42
6th highest spend: Birmingham	£14.38
Lowest spend: Bristol	£9.87
Mean value	£13.30

* England core cities: Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield

** Data Source: Local Authority Revenue Outturns 2021/22

Sexual Health Service Requirements

Statutory Service Mandated to Commission:

- Open access sexual health services
- Sexually transmitted infection (STI) testing and treatment
- Advice and access to a broad range of contraception and preventing unplanned pregnancy

Key Public Heath Outcome Framework & Locally Agreed Outcomes:

- Increasing the use of good quality contraception to reduce under-18 conceptions and abortions for all ages
- Reducing the late diagnosis of HIV and transmission of Sexually Transmitted Infections and Blood Borne Viruses to prevent reinfection by ensuring prompt access for earlier diagnosis and treatment
- Providing better access to services for high risk priority groups
- Improved support for people vulnerable to, and victims of, sexual coercion, sexual violence and exploitation
- Increasing the chlamydia screened diagnostic rate in the 15-24 age group

Public Health Outcomes Framework Performance 2022

1. Reducing Under 18 Conceptions

The conceptions rate per 1,000 women aged 15-17 continues to decline in line with England rates. In 2020, the rate in Birmingham was 16.1 compared to 13.0 for England and slightly above than the West Midlands rate of 15.1.

2. Prescribing Long-Acting Reversible Contraception (LARC)

In 2020, total prescribed LARC per 1,000 women aged 15-44 years was 26.5, below the rates for England (34.6) and the West Midlands (27.3).

3. Reducing the Late Diagnosis of HIV

Between 2019-2021, the percentage of late HIV diagnoses in Birmingham was 43.0% - comparable to the England average of 43.4% and West Midlands average of 42.8%.

4. New STI Diagnoses*

There were 554 all new STI diagnoses per 100,000 of the population in Birmingham in 2021. This was similar to the England rate of 551, but higher than the West Midlands rate of 429.

- **Increasing Chlamydia Diagnosis in 15-24 year-olds (per 100,000):**

  In 2021, the rate was 1,032 compared to 1,334 for England and 1,121 for the West Midlands.

(Data Source: https://fingertips.phe.org.uk/, accessed 23/01/2023)

Public Health Outcomes Framework Performance

Core City Performance Comparison

PHOF Indicator	Core City Ranking
Reducing under 18 conceptions (2020)	4th
Prescribing LARC (2020)	7th
Reducing the late diagnosis of HIV (2019-21)	5th
New STI diagnoses (2021)	3rd
Increasing chlamydia diagnoses in 15-24 year-olds (2021)	8th

* Increasing access and GP coverage through Pathway Improvement Programme

** Umbrella is undertaking a city-wide chlamydia campaign in February 2023 to improve chlamydia testing rates by promoting STI home testing and utilising 154 Umbrella pharmacies and social media.

Updates & Future Plans

Fast Track Cities+

- On 5th October 2022, Birmingham officially signed up to the Fast-Track Cities+ initiative – a worldwide drive to achieve the UN AIDS 95:95:95 HIV targets, the World Health Organisation (WHO) goals of eliminating Hepatitis B and Hepatitis C by 2030 and eliminating tuberculosis (TB) by 2035.
- Birmingham has pioneered the way by adding specific targets for viral hepatitis and TB which are informed by global and national targets.
- Birmingham is developing a jointly owned FTC+ Action Plan using the findings of an engagement and needs assessment completed in April 2022. The initiative effectiveness will be continuously monitored through the targets which have been agreed by the Steering Group.
- The FTC+ Action Plan will inform the new sexual health service specification.

Updates & Future Plans (continued)

Contract Procurement (post March 2024)

- Sexual Health Needs Assessment published.
- Draft Sexual Health Strategy 2023-30 approved by the Health & Wellbeing Board and being reviewed and refreshed prior to publication.
- Service Specification to incorporate national guidance, co-production with citizens and key partners alongside market engagement, and be developed in conjunction with procurement and commissioning strategies.
- Joint commissioning with SMBC and in line with the Integrated Care System approach.

Safeguarding Pathways for Under 13s

- Develop on-going provision as part of the wider sexual health system from 1st April 2024.

Updates & Future Plans (continued)

Pathway Improvement Programme

BCC, SMBC and UHB working collaboratively on three workstreams:

- **LARC** - increasing access, GP coverage, wider reaching comms and ease of booking.
- **Pre-Exposure Prophylaxis (PrEP)** – review of processes and awareness raising in underserved groups. PrEP is taken by someone who is HIV negative to prevent HIV transmission. Part of combination HIV prevention, alongside health promotion, condom use, regular testing and HIV treatment.
- **Business Continuity** - including building on the lessons from the COVID-19 pandemic.

Updates & Future Plans (continued)

Mpox Global Outbreak

- 3,404 confirmed cases in England in mainly gay and bisexual men who have sex with men from 06/05/22 to 19/12/22. 64 cases in Birmingham.
- Opportunistic testing and 1st and 2nd dose vaccination clinics set up in collaboration between Umbrella and BSol ICS at Whittall Street and Birmingham LGBT - including vaccinations for clinical staff.
- 1,499 vaccinations provided to 31/12/2022 (Umbrella - 601; BSol ICS - 898)
- Zero new confirmed cases in January 2023 in Birmingham but opportunistic testing and vaccinations continue (284 currently on BSol ICS waiting list).
- Vaccine cost reimbursable via NHSE, however, staffing and resources required to manage the clinics placed additional demand on the service, initially limiting access to some services.

Birmingham City Council

Report to:	**Birmingham Health and Social Care Overview and Scrutiny Committee**
Date:	**10th January 2023**
TITLE:	**SEXUAL AND REPRODUCTIVE HEALTH, CONTEXTUAL DATA**
Presenting Officer	**Becky Pollard, Interim - Public Health Assistant Director**

Report Type:	**Information Report**

1. Purpose:

To provide the Committee with a contextual briefing on sexual and reproductive health data.

2. Recommendation

The Health and Social Care Overview and Scrutiny Committee is asked to note the contents of this report.

3. Context

Sexually Transmitted Infections (STIs)

3.1 Sexually transmitted infections (STIs) are a major public health concern. If left undiagnosed and untreated common STIs may cause complications and long-term health problems, including:

- pelvic inflammatory disease, ectopic pregnancy, postpartum endometriosis, infertility, and chronic abdominal pain in women;
- adverse pregnancy outcomes - including abortion, intrauterine death, and premature delivery;
- neonatal and infant infections and blindness;
- urethral strictures and epididymitis in men;
- genital malignancies, proctitis, colitis, and enteritis in men who have sex with men (MSM); and
- cardiovascular and neurological damage.

3.2 The most commonly diagnosed STIs are chlamydia, first episode genital warts, gonorrhoea and first episode genital herpes.

3.3 The diagnosis rates of STIs remains greatest in young heterosexuals aged 15 to 24 years, black minority ethnic (BME) populations, MSM, and people residing in the most deprived areas in England.

HIV

3.4 HIV testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of HIV transmission.

3.5 Although HIV testing is increasing, the number of new HIV diagnoses has declined over the past decade, with a substantial decrease over the past 3 years. This recent reduction has been mostly driven by fewer HIV diagnoses among MSM, as a result of targeted HIV prevention, including:

- HIV testing - particularly repeat testing among higher-risk men
- improvements in the initiation of anti-retroviral therapy
- treatment as prevention (TasP)
- Pre-exposure prophylaxis (PrEP)

3.6 Late HIV diagnosis is the most important predictor of morbidity and mortality among those with a HIV infection. Those diagnosed late have a 10-fold risk of death compared to those diagnosed promptly.

3.7 Prompt treatment initiation of antiretroviral therapy (ART) reduces the risk of onward HIV infection to partners. Successful ART decreases a person's viral load and HIV transmission does not occur when the viral load is undetectable. UK British HIV Association (BHIVA) treatment guidelines recommend that all people living with a diagnosed HIV infection should be offered treatment as soon as possible after diagnosis.

3.8 Prevention is central to achieving good sexual health outcomes and entails changes that reduce the risk of poor sexual health outcomes and activities that encourage healthy behaviours. Education, condom use, diagnosis and treatment are key interventions for prevention and control.

Reproductive Health

3.9 Reproductive health is relevant for all populations regardless of gender, ethnicity, socioeconomic group or sexual preference. Public Health England's consensus statement on reproductive health aims for the population to have the ability and freedom to make choices about the aspects of their reproductive lives regardless of age, ethnicity, gender and sexuality. The consensus statement seeks for: reproductive health and access to reproductive healthcare to be free from stigma and embarrassment; the ability to make informed choices and exercise freedom of expression in all aspects of reproductive health; the ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation; the ability to optimize reproductive health, and social and psychological well-being through support and care that is proportionate to need; people to participate effectively and at every level in decisions that affect reproductive lives; and, the opportunity to experience good reproductive health and ability to access to reproductive healthcare when needed free from the wider factors that directly and indirectly impact on reproductive well-being.

3.10 Whilst there are many and varied reasons a woman may have an abortion, indicators such as total abortion rate and the proportion of repeat abortions

may be used as proxy measures for lack of access to good quality contraception services and advice and of problems with individual use of contraception. These indicators help identify maternity and contraception needs within the area.

3.11 The use of long acting reversible contraception (LARC) methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. Implants, IUS and IUD can remain in place for up to 3, 5 or 10 years depending on the type of product. An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy. It is important not to attribute 'worse'/'better' values to this indicator as the intention is to encourage choice rather than to promote LARC methods at the expense of other contraceptive methods.

Teenage Pregnancy

3.12 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. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.

3.13 Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

4. Birmingham Sexual Health Data – OHID Fingertips Data Accessed 09/01/2023

4.1 Office for Health Improvement and Disparities produces a sexual and reproductive health profile for local authority areas; this data provides useful context for sexual and reproductive health need and services within the City. Full details can be accessed via https://fingertips.phe.org.uk

4.2 Appendix A sets out local summary statistics for sexually transmitted infections; HIV; reproductive health; and, teenage pregnancy. It also provides context to the Birmingham rates, showing how Birmingham compares to the national and regional averages and against our CIPFA nearest neighbours (similar local authority areas identified for comparative and benchmarking exercises).

Sexually Transmitted Infections (STIs) (Table 1 – Appendix A). All data is for 2021.

4.3 Table 1 shows that Birmingham is consistently performing well against the Regional neighbours for Syphilis and Genital warts diagnoses.

4.4 The chlamydia diagnostic rate in Birmingham is higher than the Regional but lower than the England average (281 per 100,000 compared to 228 and 282 per 100,000, respectively) and lower than the CIPFA neighbour average of 351. For the 15-24 years old age group the chlamydia detection rate is significantly lower than the England average (1,032 per 100,000 compared to 1,334 per 100,000) and also lower than the regional average (1,121 per 100,000) and the CIPFA neighbours (1,375 per 100,000). It is also worth noting that as most chlamydia infections are asymptomatic and coverage of the National Chlamydia Screening Programme (NCSP) varies, the diagnostic rates identified nationally are very likely to underestimate the true prevalence of chlamydia in the population.

4.5 There is limited sexual and reproductive health data available at smaller geographical levels, however, Public Health England has produced a map of chlamydia detection rates in the 15-24y population at a middle super output area (MSOA). Appendix B shows this information overlaid with Birmingham's ward boundaries. Chlamydia detection rates are highest in Aston and Castle Vale and are lowest in the South East of the City.

4.6 Diagnoses for gonorrhoea in Birmingham was significantly higher compared to the England average (119.9 per 100,000 compared to 90.3). It was also higher than the regional average (72.5 per 100,000) and the CIPFA neighbours (108 per 100,000). Since 2013, the gonorrhoea rate in Birmingham was increasing steadily till it decreased in 2020 before increasing again in 2021. Unlike chlamydia, people with a gonorrhoea infection are more likely to be symptomatic and may, therefore, be more likely to seek and access sexual health services.

HIV (Table 2 – Appendix A) – All data is for 2021 unless otherwise stated

4.7 Birmingham's HIV testing coverage is 76.1%; this means that 76.1% of patients accessing at least one specialist sexual health service in a calendar year accepted a HIV test. Birmingham's HIV testing rates are significantly better than the national, CIPFA and regional averages (whose rates are 45.8%, 45.3% and 49.8%, respectively).

4.8 Birmingham's late HIV diagnosis rates average (2-year average 2019-21) were not statistically different than the England average for the heterosexual men and women, and men who have sex with men communities. Late HIV diagnosis rates can give us an indication of the populations where HIV infections are being left undiagnosed.

4.9 Prevalence of HIV in those aged 15-59 in Birmingham was 2.8 per 1,000; this was significantly higher than the regional and national values (1.9/1,000 and 2.3/1,000, respectively) but lower than the CIPFA values (2.9/1,000). Appendix C shows the diagnosed HIV prevalence by MSOA for all ages in Birmingham; this indicates that prevalence is highest in the MSOA area that

borders Edgbaston, Balsall Health West, Bordesley and Highgate and Ladywood.

4.10 Birmingham's antiretroviral therapy (ART) rates (2-year average 2019-21) in people who are newly diagnosed with HIV was significantly better than the national average and better than the CIPFA and regional averages (92.0% compared to 83.5%, 85.4% and 85.7%, respectively).

Reproductive Health (Table 3 – Appendix A) – All data is for 2020 unless otherwise stated

4.11 The abortion rate in Birmingham (21.5/1,000) is significantly higher than the national average (18.9/1,000) and slightly higher than the regional average (20.8/1,000) and CIPFA average (20.5/1,000). Repeat abortions in the under 25 population are significantly higher in Birmingham (31.8%) than the national (29.2%) average and are higher than the CIPFA average (30.0%) and the regional average (30.4%).

4.12 The proportion of long acting reversible contraception methods (LARC) prescribed in Birmingham in 2020 (26.5/1,000) is lower than the national average (34.6/1,000) the CIPFA average (30.4/1,000) and the regional average (27.3/1,000). Given the long acting nature of LARC this measure only gives an indication of the number of new prescriptions for LARC made each year – it is therefore likely to be an underestimate of LARC use in the population. LARC use is a choice and therefore it is not appropriate to attribute a better/worse value to this indicator.

4.13 Attendance of females under 25 years old in specialist contraception services in 2020 remains very low in Birmingham. Rates in Birmingham (35.6/1,000) are lower than the national, CIPFA and regional values at 97.6/1,000, 80.8/1,000 and 60.8/1,000 respectively. Reporting data from the last five years shows that this rate has steadily reduced. This suggests that there is scope to increase access of specialist contraception services in this age group.

Teenage pregnancy (Table 4 – Appendix A and Appendices D & E) – All data is for 2020 unless otherwise stated

4.14 The conception rates for those aged under 16 and under 18 are significantly higher than the national average. Birmingham's under 16s conception rate is 2.7/1,000 compared to 2.2/1,000 in the West Midlands and 2.0/1,000 in England; this rises to 16.1/1,000 conceptions in under 18s in Birmingham, West Midlands (15.1/1,000) and England (13.0/1,000).

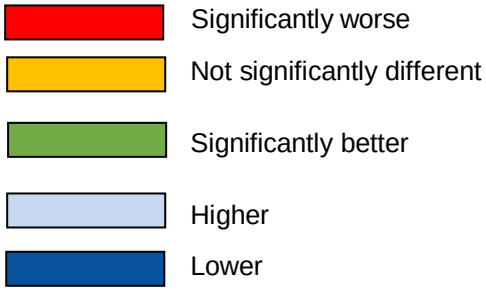
4.15 The number of births to women aged under 18 years and the proportion of teenage mothers in Birmingham in 2020/21 is significantly higher than the national average, 0.7% of mothers in Birmingham are aged between 12 and 17 compared to 0.80% in both the West Midlands and CIPFA and 0.6% in England; this may be partially explained by the younger age profile of the City.

Appendices
Appendix A: Birmingham Sexual and Reproductive Health Outcomes Framework Summary Tables
Appendix B: Birmingham Chlamydia Detection Rate by Ward 2021
Appendix C: Birmingham Diagnosed HIV Prevalence by Ward 2021
Appendix D: Birmingham Teen Conceptions by Ward 2018-20 - England Comparison
Appendix E: Birmingham Teen Conceptions by Ward 2018-20 – Local Authority Comparison

Appendix A: Birmingham Sexual and Reproductive Health Profile Summary Tables

Key:

Significance compared to England average:



Change from previous:

Table 1: Sexually Transmitted Infections (STI), Birmingham, West Midlands and England averages (Reporting Period 2021)

Indicator	Age	Reporting Period	Birmingham Value	Region Value	CIPFA Value	England Value	Change from previous
Syphilis diagnostic rate per 100,000	All ages	2021	**10.7**	9.3	12	13.3	↑
Gonorrhoea diagnostic rate / 100,000	All ages	2021	**119.9**	72.5	108	90.3	↑
Chlamydia diagnostic rate / 100,000	All ages	2021	**281.3**	227.9	351	282.0	→
Chlamydia detection rate / 100,000	15-24y	2021	**1,032**	1,121	1,375	1,334	↑
Genital warts diagnostic rate / 100,000	All ages	2021	**35.3**	38.5	45.2	50.0	↑

Genital herpes rate / 100,000	All ages	2021	**25.1**	30.1	33.9	38.3	

Table 2: HIV testing, diagnoses, treatment and care, Birmingham, West Midlands and England averages (Reporting Period 2019-2021)

Indicator	Population	Reporting Period	Birmingham Value	Region Value	CIPFA Value	England Value	Change from previous
Testing							
HIV testing coverage, total (%)	All	2021	**76.1**	49.8	45.3	45.8	
Diagnoses							
New HIV diagnosis rate / 100,000	All Ages	2021	**6.6**	4.2	6.8	4.8	
Late HIV diagnosis (%)		2019-21	**43.0**	42.8	44.4	43.4	
Late HIV diagnosis in MSM (%)		2019-21	**26.7**	29.0	38.9	31.4	
Late HIV diagnosis in heterosexual men (%)		2019-21	**61.1**	55.8	59.8	58.1	
Late HIV diagnosis in heterosexual women (%)		2019-21	**37.5**	43.5	48.1	49.5	
HIV diagnosed prevalence rate / 1,000 aged 15-59		2021	**2.8**	1.9	2.9	2.3	
Treatment and care							
Prompt ART initiation in people newly diagnosed with HIV (%)	All Ages	2019-21	**92.0**	85.7	85.4	83.5	N/A

Table 3: Reproductive Health, Birmingham, West Midlands and England averages (Reporting Period 2020)

Indicator	Age	Reporting Period	Birmingham Value	Region Value	CIPFA Value	England Value	Change from previous
Total abortion rate / 1000	15-44y	2020	**21.5**	20.8	20.5	18.9	→
Under 25s repeat abortions (%)	<25y	2020	**31.8**	30.4	30.0	29.2	→
Total prescribed LARC, excluding injections, rate / 1,000		2020	**26.5**	27.3	30.4	34.6	→
Under 25s individuals attend specialist contraceptive services rate / 1000 – Females	<25y	2020	**35.6**	60.8	80.8	97.6	↓

± *Indicators not updated since last reported to Committee.*

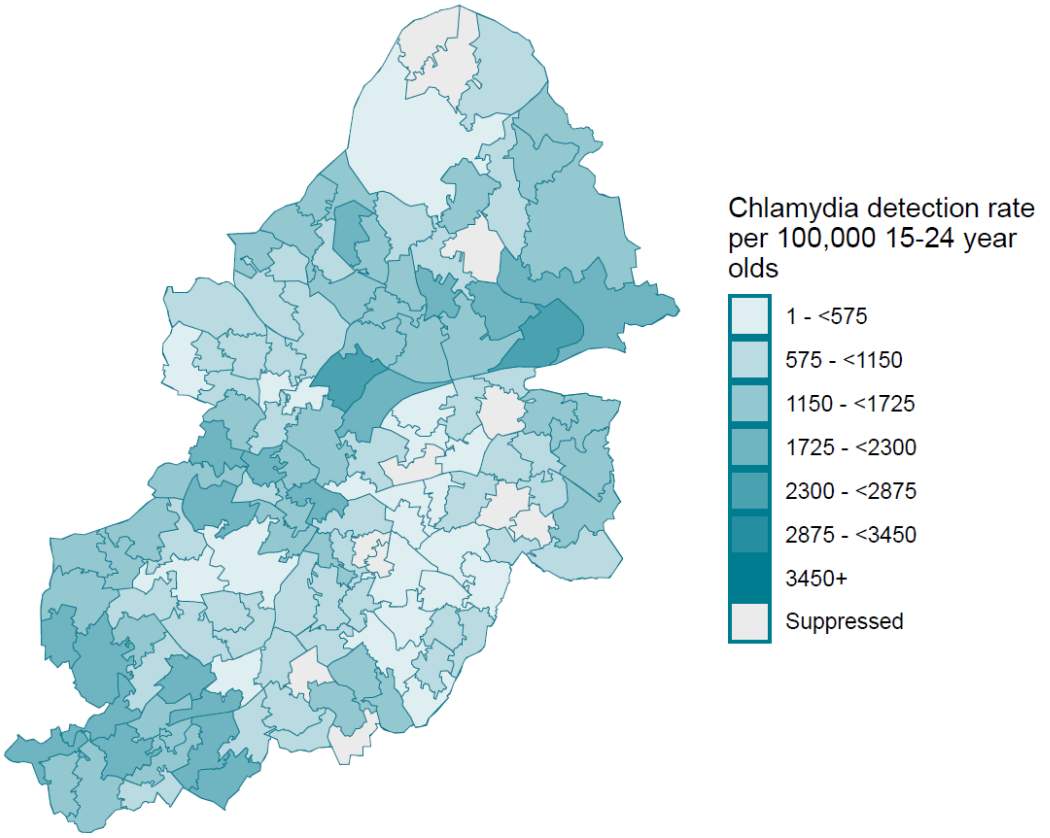
Table 4: Teenage pregnancy, Birmingham, West Midlands and England averages (Reporting Period 2020-2021)

Indicator	Age	Reporting Period	Birmingham Value	Region Value	CIPFA Value	England Value	Change from previous
Under 16s conception rate / 1,000	<16y	2020	**2.7**	2.2	2.7	2.0	→
Under 18s conception rate / 1,000	<18y	2020	**16.1**	15.1	16.3	13.0	→
Under 18s births rate / 1,000	<18y	2020	**4.7**	4.9	5.8	3.8	→
Teenage mothers (%)	12-17y	2020/21	**0.7**	0.8	0.8	0.6	→

Source: Office for Health Improvement and Disparities. Sexual and Reproductive Health Profile. [accessed 09/01/23] https://fingertips.phe.org.uk © Crown copyright 2023.

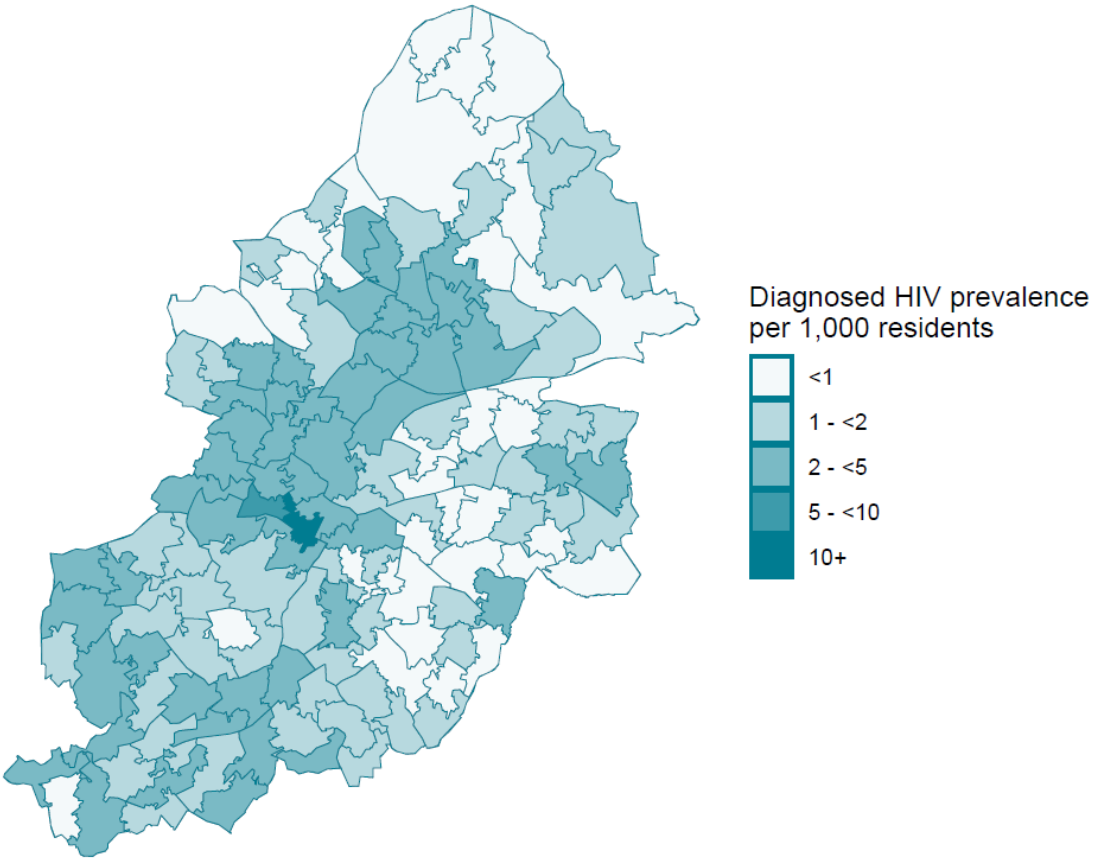
Appendix B: Map of chlamydia detection rate per 100,000 population in 15 to 24 years in Birmingham by Middle Super Output Area: 2021

Please note that this data is not available on the online Sexual and Reproductive Health Profiles. Data is sourced from the CTAD Chlamydia Surveillance System (CTAD). As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider this reconfiguration, especially when comparing with data from pre-pandemic years.



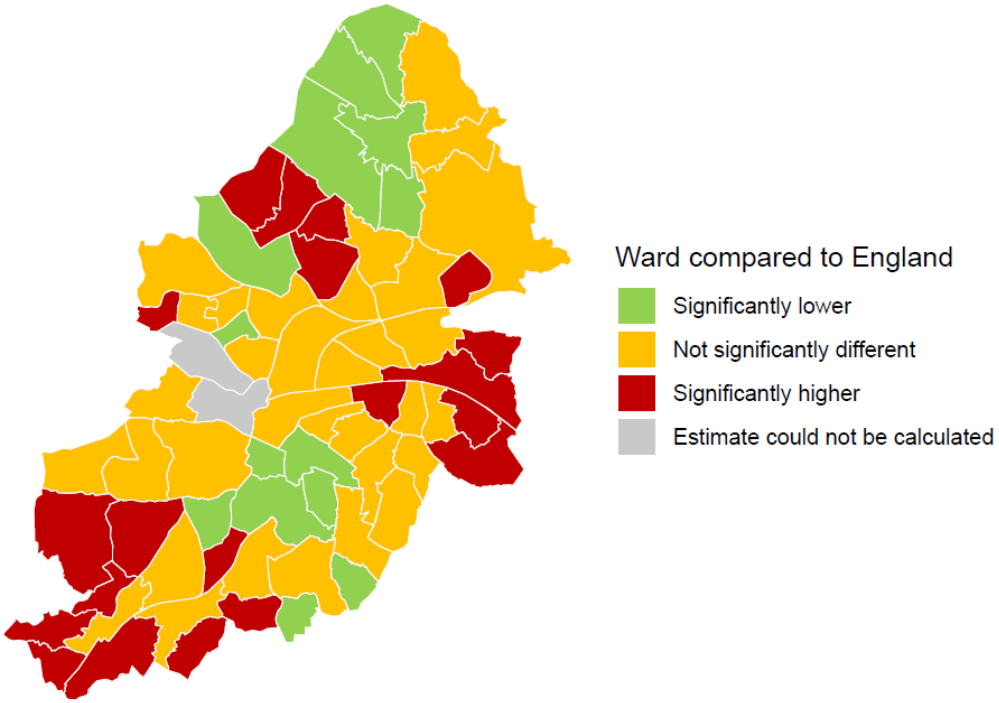
Appendix C: Map of diagnosed HIV prevalence among people of all ages in Birmingham by Middle Super Output Area: 2021

Please note that this data is not available on the online Sexual and Reproductive Health Profiles. Data is sourcec from the UKHSA HIV and AIDS Reporting System (HARS). As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measure These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.



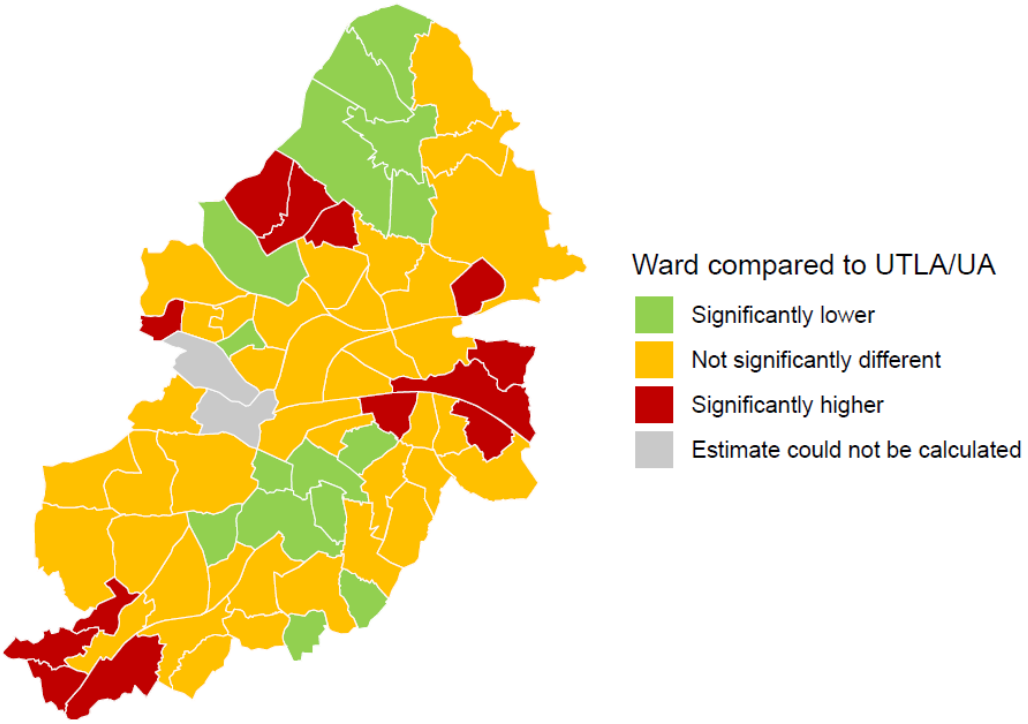
Appendix D: Under-18s conception in Birmingham by ward, compared to England: three-year period between 2018 – 20

Please note that this data is not available on the online Sexual and Reproductive Health Profiles. Data is sourced from Conception Statistics, England and Wales, ONS



Appendix E: Under-18s conception in Birmingham by ward, compared to the rate for Birmingham: three-year period between 2018 - 20

Please note that this data is not available on the online Sexual and Reproductive Health Profiles. Data is sourced fro Conception Statistics, England and Wales, ONS



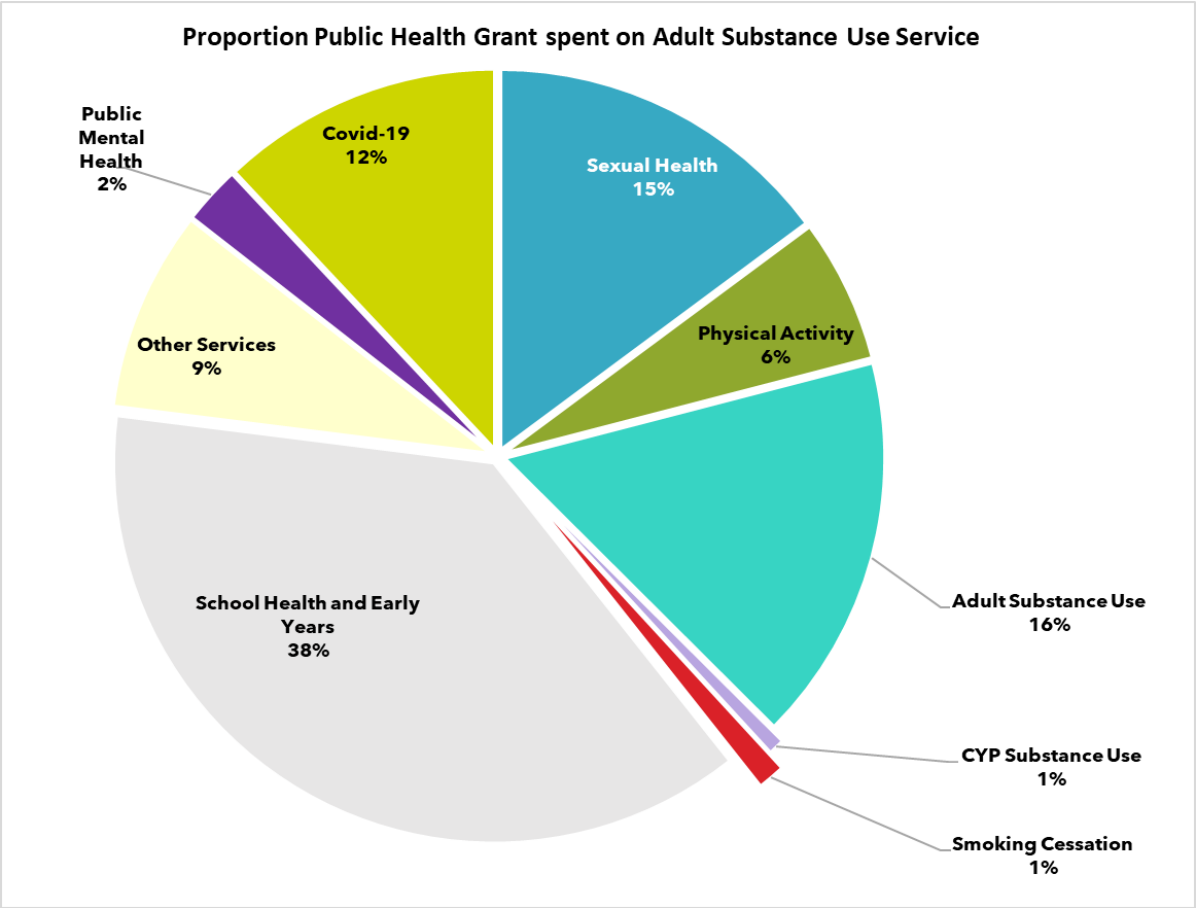
Birmingham City Council

Sexual Health: Treatment and Prevention Services

Annual Contract Spend from contract commencement on 10th August 2015 to 31st March 2024

Contract Year	Contract Value
2015/16 (10.08.2015 to 31.03.2016)	£11,229,443.74
2016/17	£14,539,844.56
2017/18	£14,754,091.29
2018/19	£14,826,147.57
2019/20	£14,777,459.98
2020/21 - 2022/23	£14,038,466.98
2023/24	£14,038,466.98 + TBA inflationary uplift

Proportion of Public Health Grant spent on the Birmingham Adults Substance Misuse Service 2022/23



In addition to the core CGL contract which is funded by the Public Health Grant, Birmingham is receiving additional funding from the Office for Health Improvement and Disparities (previously Public Health England), details of this additional grant funding is below:

Rough Sleeping Drug and Alcohol Treatment Grant

Birmingham has been allocated **£834,063** in 2022/23 and £987,600 in 2023/24 (indicative figure and yet to be confirmed formally) by OHID to fund specialist support for individuals in order for them to rapidly access and engage with drug and alcohol treatment and move towards longer-term accommodation, supporting the work of wider homelessness and rough sleeping funding.

To support the CGL team funded by the grant and more importantly to further support those people rough sleeping or homeless, CGL opened a city centre hub in early January 2022 at Lonsdale House, 52 Blucher Street, Birmingham B1 1QU. which will provide an opportunity for Change Grow Live to support vulnerable adults in a city centre location in a safe environment. The CGL teams based at Lonsdale House consist of multi-disciplinary staff, partners and volunteers with lived experience, , putting the health and well-being of service users at the heart of what they do.

This funding is managed by the Office for Health Improvement & Disparities (OHID) and is subject to annual confirmation of funding from HM Treasury. This grant is provided pursuant to section 31 of the Local Government Act 2003.

Supplemental Substance Misuse Treatment and Recovery (SSMTR) Grant

This grant is to address the aims of the treatment and recovery section of the UK Government's 2021 drug strategy (From Harm to Hope) published in December 2021. This supplemental funding is to support improvements in the quality and capacity of drug and alcohol treatment 2022/23 to 2024/25. Birmingham has been allocated **£3,018,940** in 2022/23, £4,946,496 in 2023/24 and £9,547,838 in 2024/25; the figures for 2023/24 & 2024/25 are indicative and yet to be confirmed formally.

Birmingham's detailed plan for 2022/23 has been approved by OHID and includes; Additional Commissioning and Strategic Public Health Support Capacity, Assertive outreach service that will deliver a) Brief Interventions, b) Extended Brief Interventions/Campaigns and c) Targeted Outreach, a dedicated Partnerships Lead, Increasing drug/alcohol treatment capacity by the recruitment of additional workers and increasing residential rehabilitation capacity.

From an CGL perspective, in 2022/23 this additional funding will facilitate strengthening the Criminal Justice Team, Enhancing Prison to Community Continuity of Care and recruiting additional recovery co-ordinators which will support improvements in the quality and capacity of the adult drug and alcohol treatment service in Birmingham.

This funding is managed by the Office for Health Improvement & Disparities (OHID) and is subject to annual confirmation of funding from HM Treasury. This grant is provided pursuant to section 31 of the Local Government Act 2003.

SSMTR Housing Support Grant for people in drug and alcohol treatment

The Housing Support grant is a programme to test and evaluate models of housing support for people in treatment in a targeted number of areas and is provided in *addition* to the Supplementary Substance Misuse Treatment and Recovery Grant, to deliver a programme of interventions for people in drug and alcohol treatment with a housing need. This was a commitment in the Drug Strategy in response to Dame Carol Black's recommendation that government should invest in housing support for people in treatment.

Birmingham has been allocated **£376,628** in 2022/23 and £579,428 in 2023/24 and 2024/25; the figures for 2023/24 & 2024/25 are indicative and yet to be confirmed formally.

West Midlands Inpatient Detox Consortium

This OHID funding is to increase the capacity and subsequently the uptake of residential inpatient detoxification from drugs and/or alcohol nationally. The 14 Local Authorities in the West Midlands Region have been allocated a share of £1,192,500 by OHID in order to start to commission additional inpatient alcohol and drug detoxification provision, which will increase the capacity within the treatment system.

All local authorities in the West Midlands region are part of a consortium with Staffordshire County Council acting as banker. Of the £1,192,500 Birmingham has been allocated **£285,216** for 2022/23, 2023/24 and 2024/25. The figures for 2023/24 & 2024/25 are indicative and yet to be confirmed formally.

The total amount of additional funding from OHID to Birmingham for 2022/23 is: **£4,514,847**

UK Health Security Agency

Summary profile of local authority sexual health

Birmingham

Field Service, Regions Directorate, Health Protection Operations

01 February 2023

Key findings

- This report summarises the latest available sexual and reproductive health data for Birmingham. As a response to the COVID-19 pandemic, the Government implemented national and regional lockdowns and social and physical distancing measures since March 2020. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.
- Overall, the number of new sexually transmitted infections (STIs) diagnosed among residents of Birmingham in 2021 was 6,316. The rate was 554 per 100,000 residents, similar to the rate of 551 per 100,000 in England, and lower than the average of 626 per 100,000 among its nearest neighbours.
- Birmingham ranked 47th highest out of 150 upper tier local authorities (UTLAs) and unitary authorities (UAs) for new STI diagnoses excluding chlamydia in those aged under 25 in 2021, with a rate of 387 per 100,000 residents, similar to the rate of 394 per 100,000 for England.
- The chlamydia detection rate per 100,000 young people aged 15 to 24 years in Birmingham was 1,032 in 2021, worse than the rate of 1,334 for England.
- The rank for gonorrhoea diagnoses (which can be used as an indicator of local burden of STIs in general) in Birmingham was 31st highest (out of 150 UTLAs/UAs) in 2021. The rate per 100,000 was 120, worse than the rate of 90.3 in England.
- Among specialist sexual health service (SHS) patients from Birmingham who were eligible to be tested for HIV, the percentage tested in 2021 was 76.1%, better than the 45.8% in England.
- The number of new HIV diagnoses in Birmingham was 75 in 2021. The prevalence of diagnosed HIV per 1,000 people aged 15 to 59 years in 2021 was 2.8, worse than the rate of 2.3 in England. The rank for HIV prevalence in Birmingham was 37th highest (out of 150 UTLAs/UAs).
- In Birmingham, in the three year period between 2019 - 21, the percentage of HIV diagnoses made at a late stage of infection amongst those first diagnosed in the UK (all individuals with CD4 count ≤350 cells/mm^3 within 3 months of diagnosis) was 43.0%, similar to 43.4% in England.
- The total rate of long-acting reversible contraception (LARC) (excluding injections) prescribed in primary care, specialist and non-specialist SHS per 1,000 women aged 15 to 44 years living in Birmingham was 26.5 in 2020, lower than the rate of 34.6 per 1,000 women in England. The rate prescribed in primary care was 19.1 in Birmingham, lower than the rate of 21.1 in England. The rate prescribed in the other settings was 7.5 in Birmingham, lower than the rate of 13.4 in England.
- The total abortion rate per 1,000 women aged 15 to 44 years in 2021 was 22.1 in Birmingham, higher than the England rate of 19.2 per 1,000. Of those women under 25 years who had an abortion in 2021, the proportion who had had a previous abortion was 31.8%, higher than 29.7% in England.

- In 2020, the conception rate for under-18s in Birmingham was 16.1 per 1,000 girls aged 15 to 17 years, worse than the rate of 13.0 in England.
- In 2020/21, the percentage of births to mothers under 18 years was 0.7%, worse than 0.6% in England overall.

Figure 1. Chart showing key sexual and reproductive health indicators in Birmingham compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the West Midlands UKHSA Region.

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
New STI diagnoses (excluding chlamydia aged under 25) per 100,000	2021	4,410	386.7	394.5	2,634.1	102.6
Syphilis diagnostic rate per 100,000	2021	122	10.7	13.3	145.7	0.0
Gonorrhoea diagnostic rate per 100,000	2021	1,367	119.9	90.3	1,006.2	11.2
Chlamydia detection rate per 100,000 aged 15 to 24	2021	1,904	1,031.8	1,334.2	381.5	3,063.2
Chlamydia proportion aged 15 to 24 screened	2021	17,327	9.4	14.8	5.5	40.6
STI testing rate (exclude chlamydia aged under 25) per 100,000	2021	34,492	3,024.2	3,422.4	494.8	17,622.7
New HIV diagnosis rate per 100,000	2021	75	6.6	4.8	22.2	0.0
HIV late diagnosis in people first diagnosed with HIV in the UK	2019 - 21	65	43.0	43.4	100.0	0.0
HIV diagnosed prevalence rate per 1,000 aged 15 to 59	2021	1,931	2.8	2.3	12.7	0.6
HIV testing coverage, total	2021	22,048	76.1	45.8	17.0	82.9
Total abortion rate / 1,000	2021	5,582	22.1	19.2	32.2	11.3
Abortions under 10 weeks (%)	2021	4,818	87.1	88.6	79.9	92.2
Under 18s conception rate / 1,000	2020	346	16.1	13.0	30.4	2.7
Total prescribed LARC excluding injections rate / 1,000	2020	6,705	26.5	34.6	5.3	60.9
Violent crime - sexual offences per 1,000 population	2021/22	5,053	4.4	3.0	1.4	6.3

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Introduction

Aim

This report describes sexual and reproductive health in a local area in an integrated way, including sexually transmitted infections (STIs), HIV, under-18 conceptions, abortion and Long Acting Reversible Contraception rates for women aged 15 to 44.

This is produced alongside other local HIV, sexual and reproductive health intelligence tools provided by the UK Health Security Agency (UKHSA) to help inform local Joint Strategic Needs Assessments (JSNAs) so that commissioners can effectively target service provision.

This report has been produced by the UKHSA, with support from the Office for Health Improvement and Disparities (OHID).

Information used in this report

Unless otherwise indicated this report is compiled from publicly available data on the online Sexual and Reproductive Health Profiles. Please access this tool for further data analysis and more information about the data included in this report which is described in the ‘definitions’ tab for each indicator.

Please note that City of London and Isles of Scilly are not included in the rankings in this document. Where comparisons are made to Hackney or Cornwall, please note that the data for these areas may have been combined with City of London and Isles of Scilly respectively. Please check the online Profiles.

Please note any mention of UKHSA Centre is equivalent to PHE Centres mentioned in previous versions of this report.

For an introductory guide on sexual health data sources, please access https://www.gov.uk/government/publications/sexual-and-reproductive-health-in-england-local-and-national-data.

Viewing this report and converting to PDF

This report has been developed for the best viewing experience in Google Chrome. It has also been tested with Internet Explorer 11 and Microsoft Edge, but some content may look different (for example, the table of contents is not available in Internet Explorer).

When viewed in Google Chrome, this report can be converted to a PDF through the Print menu. Select “Save as PDF” as the destination. For the best result, it is recommended to select the “background graphics” option, and deselect the “headers and footers” option.

Some other browsers also offer PDF conversion, but the formatting may not display as intended.

STIs

As STIs are often asymptomatic, frequent STI screening of groups with greater sexual health needs is important and should be conducted in line with national guidelines. Early detection and treatment can reduce important long-term consequences, such as infertility and ectopic pregnancy. Vaccination is an intervention that can be used to control genital warts, hepatitis A and hepatitis B, however, control of other STIs relies on consistent and correct condom use, behaviour change to decrease overlapping and multiple partners, ensuring prompt access to testing and treatment, and ensuring partners of cases are notified and tested.

There was an increasing trend in diagnoses of chlamydia, gonorrhoea and syphilis in England from 2010 until 2019, while diagnoses of genital warts have decreased since 2013 due to the protective effect of HPV vaccination.[1] Increasing diagnosis rates for chlamydia among people aged 15 to 24 years are largely driven by changes in testing activity through the National Chlamydia Screening Programme (NCSP), although ongoing high levels of condomless sex will have played a role. The NCSP data tables provide additional data on chlamydia testing coverage, positivity and diagnostic rates (for those aged 15 to 24 years).[2]

In March 2020, in response to the Coronavirus Disease 2019 (COVID-19) pandemic, the UK Government implemented strict non-pharmaceutical interventions (NPIs) in the form of national and regional lockdowns, as well as social and physical distancing measures including an emphasis on staying at home. Sexual health services (SHS) in England had substantially reduced capacity to deliver face-to-face consultations but underwent rapid reconfiguration to increase access to STI testing via telephone or internet consultations. STI testing and diagnoses decreased across all infections during 2020. Testing levels largely recovered during 2021, while diagnoses overall remained lower. Larger decreases in diagnoses were observed for STIs that are usually diagnosed clinically at a face-to-face consultation, such as genital warts or genital herpes, when compared to those that could be diagnosed using remote self-sampling kits such as chlamydia and gonorrhoea.[3] STIs continue to disproportionately impact gay, bisexual and other men who have sex with men (MSM), young people aged 15 to 24 years, and people of Black Caribbean ethnicity.

This report has been compiled using data from SHS and ‘community-based’ settings routine returns to the GUMCAD STI and CTAD Chlamydia surveillance systems.

‘Sexual health services’ refer to services offering specialist (level 3) STI-related care such as genitourinary medicine (GUM) and integrated GUM and sexual and reproductive health (SRH) services. They also include other services offering non-specialist (level 1 or level 2) STI-related care and community-based settings such as young people’s services, internet services, termination of pregnancy services, pharmacies, outreach, and general practice. Further details on the levels of sexual healthcare provision are provided in the BASHH Standards for the Management of STIs (Appendix B).

Burden and trend of new STIs

A total of 6,316 new STIs were diagnosed in residents of Birmingham in 2021. It should be noted that if high rates of gonorrhoea and syphilis are observed in a population, this reflects high levels of risky sexual behaviour.

When interpreting trends, please note:

- The decrease in STI testing and diagnoses in 2020 due to the reconfiguration of sexual health services during the COVID-19 pandemic response, with testing rates largely recovering during 2021, but diagnoses overall remaining lower.
- Recent decreases in genital warts diagnoses are due to the protective effect of HPV vaccination, and are particularly evident in the younger age groups (25 and younger) who have been offered the vaccine since the national programme began

Figure 2. Chart showing key STI indicators in Birmingham compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the West Midlands UKHSA Region.

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
All new STI diagnoses rate per 100,000	2021	6,316	553.8	551.0	176.2	2,980.0
New STI diagnoses (excluding chlamydia aged under 25) per 100,000	2021	4,410	386.7	394.5	2,634.1	102.6
STI testing rate (exclude chlamydia aged under 25) per 100,000	2021	34,492	3,024.2	3,422.4	494.8	17,622.7
STI testing positivity (excluding chlamydia aged under 25)	2021	2,651	7.7	6.1	2.3	13.2
Gonorrhoea diagnostic rate per 100,000	2021	1,367	119.9	90.3	1,006.2	11.2
Syphilis diagnostic rate per 100,000	2021	122	10.7	13.3	145.7	0.0
Genital warts diagnostic rate per 100,000	2021	403	35.3	50.0	170.0	5.8
Genital herpes diagnosis rate per 100,000	2021	286	25.1	38.3	138.4	5.4
Chlamydia diagnostic rate per 100,000	2021	3,208	281.3	282.0	74.7	1,156.0
Chlamydia detection rate per 100,000 aged 15 to 24 (female)	2021	1,295	1,414.0	1,762.5	547.7	3,664.1
Chlamydia detection rate per 100,000 aged 15 to 24 (male)	2021	603	648.8	859.8	212.0	2,344.8
Chlamydia detection rate per 100,000 aged 15 to 24	2021	1,904	1,031.8	1,334.2	381.5	3,063.2
Chlamydia diagnostic rate per 100,000 aged 25 years and older	2021	1,302	182.3	178.5	1,119.6	51.1
Chlamydia proportion aged 15 to 24 screened	2021	17,327	9.4	14.8	5.5	40.6
Mycoplasma genitalium diagnostic rate per 100,000	2021	79	6.9	9.0	0.4	73.6
Trichomoniasis diagnostic rate per 100,000	2021	306	26.8	10.4	0.6	105.3

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Table 1. Rates per 100,000 population of new STIs in Birmingham and England: 2020-2021

Diagnoses	2020	2021	% change 2020 to 2021*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2021‡	Value for England: 2021
New STIs	481.3	553.8	15.1%	10	45	551.0
New STIs (exc chlamydia aged <25)	318.1	386.7	21.6%	8	47	394.5
Chlamydia	270.6	281.3	4.0%	12	54	282.0
Gonorrhoea	104.1	119.9	15.2%	6	31	90.3
Syphilis	6.0	10.7	79.4%	4	54	13.3
Genital warts	24.6	35.3	43.4%	14	125	50.0
Genital herpes	17.7	25.1	41.6%	13	126	38.3
Mycoplasma genitalium[1]	8.8	6.9	-21.0%	3	62	9.0
Trichomoniasis[1]	18.3	26.8	46.4%	2	11	10.4

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.

* Percent change not provided where the value in 2020 was 0.

† These are Birmingham and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

‡ Out of 149 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

[1] Data for Mycoplasma genitalium and trichomoniasis were included for the first time in 2022. Testing for these infections is not included as part of a standard sexual health screen, but is advised for those with symptoms and the partners of those diagnosed (see BASHH guidelines for Mycoplasma genitalium and trichomoniasis).

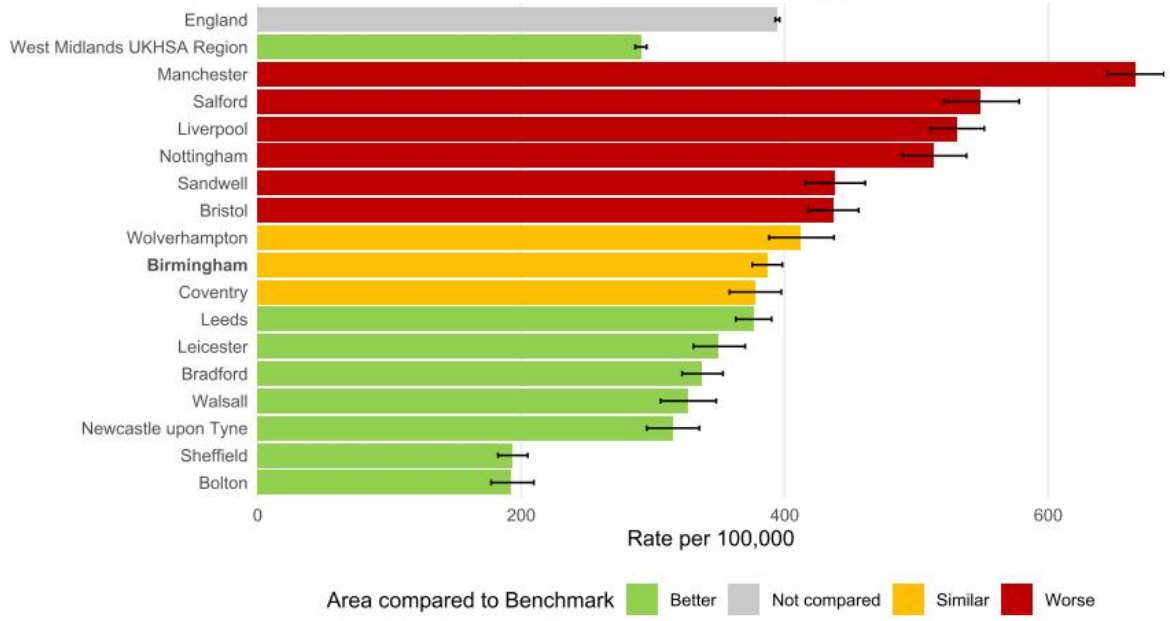
Table 2. Number of new STIs by year, Birmingham

Diagnoses	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
New STIs	11,663	11,128	10,877	10,027	10,096	10,430	10,877	11,351	5,489	6,316
New STIs (exc chlamydia aged <25)	7,539	7,225	7,194	6,979	7,023	7,188	7,500	7,961	3,628	4,410
Chlamydia	6,051	5,842	5,387	4,821	5,031	5,324	5,570	5,611	3,086	3,208
Gonorrhoea	1,027	972	1,114	1,148	1,227	1,516	1,699	2,158	1,187	1,367
Syphilis	24	48	69	101	112	112	100	108	68	122
Genital warts	1,494	1,468	1,491	1,239	1,220	1,068	1,065	943	281	403
Genital herpes	685	659	639	635	594	672	640	638	202	286
Mycoplasma genitalium[1]	-	-	-	-	-	-	-	337	100	79
Trichomoniasis[1]	586	578	496	545	600	629	611	629	209	306

[1] Data for Mycoplasma genitalium and trichomoniasis were included for the first time in 2022. Testing for these infections is not included as part of a standard sexual health screen, but is advised for those with symptoms and the partners of those diagnosed (see BASHH guidelines for Mycoplasma genitalium and trichomoniasis).

Figure 4. Rates per 100,000 population of new STIs (excluding chlamydia in under 25-year olds) in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2021

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Figure 5. Rates per 100,000 population by diagnosis by year in Birmingham compared to rates in the West Midlands UKHSA Region and England: 2012 to 2021

Please note the charts have different y axis scales.

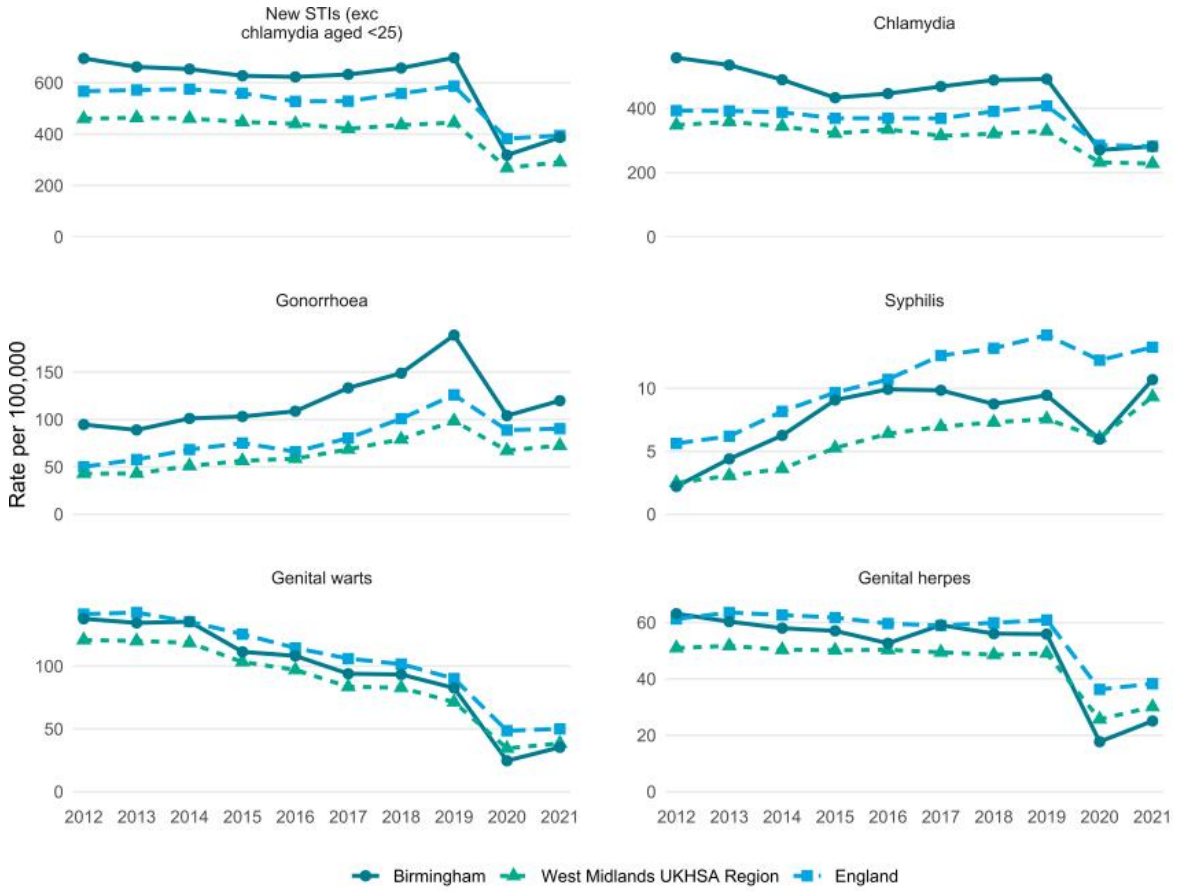


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Figure 6. Rates per 100,000 population of gonorrhoea in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2021

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model

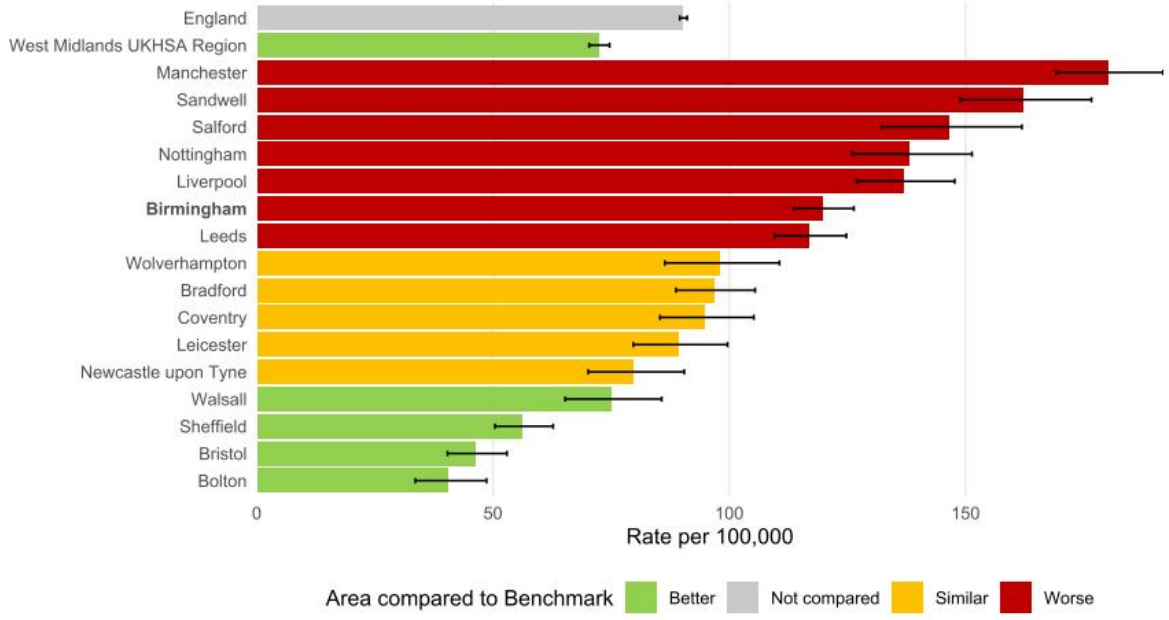

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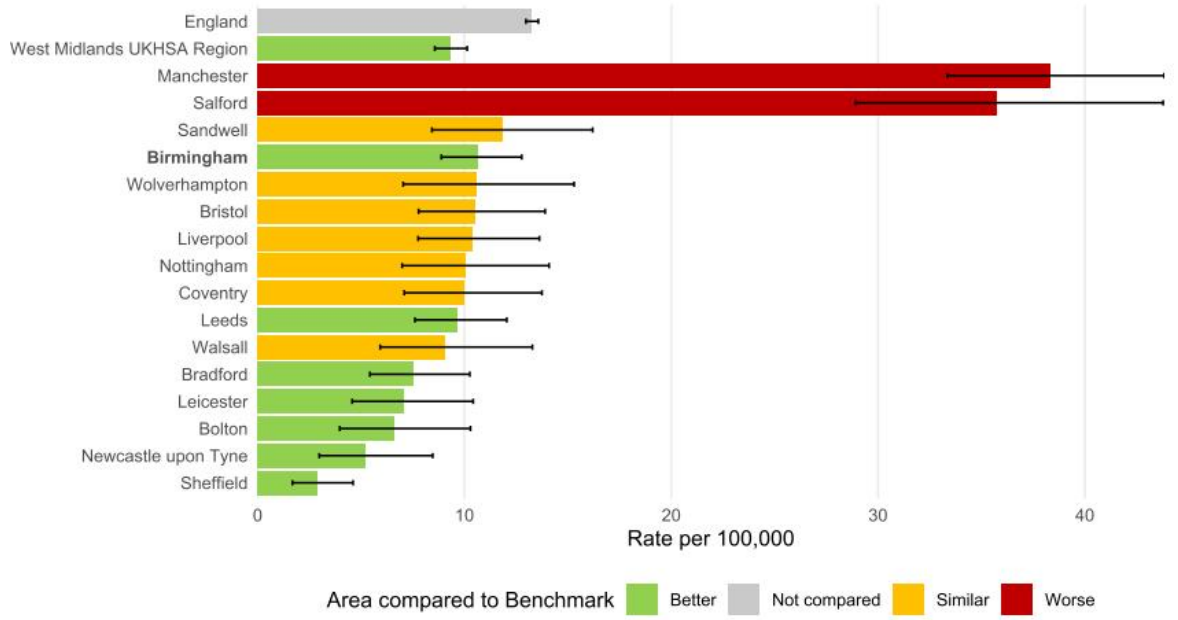
Figure 7 shows rates of syphilis per 100,000 population for Birmingham, compared to national, regional, and neighbouring rates. The UKHSA has conducted an in-depth examination of the national epidemiology of syphilis from 2010-2019,[4] in alignment with the Syphilis Action Plan (2019).[5]

Figure 7. Rates per 100,000 population of syphilis in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2021.

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



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Chlamydia detection

In June 2021, the National Chlamydia Screening Programme (NCSP) changed to focus on reducing the harms from untreated chlamydia infection.[6] These harms occur predominantly in young women and other people with a womb or ovaries - this includes transgender men, non-binary people assigned female at birth, and intersex people with a womb or ovaries. Therefore, opportunistic screening should focus on these groups, combined with reducing time to test results and treatment, strengthening partner notification and re-testing after treatment.

In practice this means that chlamydia screening in community settings (e.g. GP and Community Pharmacy) will only be proactively offered to young women and other people with a womb or ovaries. Services provided by sexual health services remain unchanged and everyone can still get tested if needed.

Given the change in programme aim, the Public Health Outcome Framework (PHOF) Detection Rate Indicator (DRI) benchmarking thresholds have been revised and will be measured against females only. A new female-only PHOF benchmark DRI will be included in the PHOF from January 2022 (to be reported in 2023).

This report covers 2021 data and benchmarks against the rate for England. Since chlamydia is most often asymptomatic, a high detection rate reflects success at

identifying infections that, if left untreated, may lead to serious reproductive health consequences.

The chlamydia detection rate in 15 to 24 year olds in 2021 in Birmingham was 1,032 per 100,000 population (1,904 positives out of 17,327 screened), lower than the 2,300 target. 9.4% of 15 to 24 year olds were tested for chlamydia, compared to 14.8% nationally. The detection rate per 100,000 and its rank among CIPFA nearest neighbours and England are shown in Table 3.

Table 3. Chlamydia detection rate per 100,000 population and percentage screened in 15 to 24 year olds in Birmingham and England: 2021

	2020	2021	% change 2020 to 2021*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2021‡	Value for England: 2021
Detection rate						
Total	1,002.0	1,031.8	3.0%	13	111	1,334.2
Women	1,386.7	1,414.0	2.0%	12	101	1,762.5
Men	617.6	648.8	5.1%	13	106	859.8
Percentage screened						
People aged 15-24	8.8	9.4	6.2%	13	134	14.8

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.
* Percent change proportional to the value in 2020, not a change in percentage points. Percent change not provided where the value in 2020 was 0.
† These are Birmingham and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.
‡ Out of 149 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Variation in rates of chlamydia detection (Figure 8) may represent differences in prevalence, but are influenced by screening coverage and whether most at risk populations are being reached (i.e. the proportion testing positive).

Figure 8. Map of chlamydia detection rate per 100,000 population in 15 to 24 years in Birmingham by Middle Super Output Area: 2021

Please note that this data is not available on the online Sexual and Reproductive Health Profiles. Data is sourced from the CTAD Chlamydia Surveillance System (CTAD). As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider this reconfiguration, especially when comparing with data from pre-pandemic years.

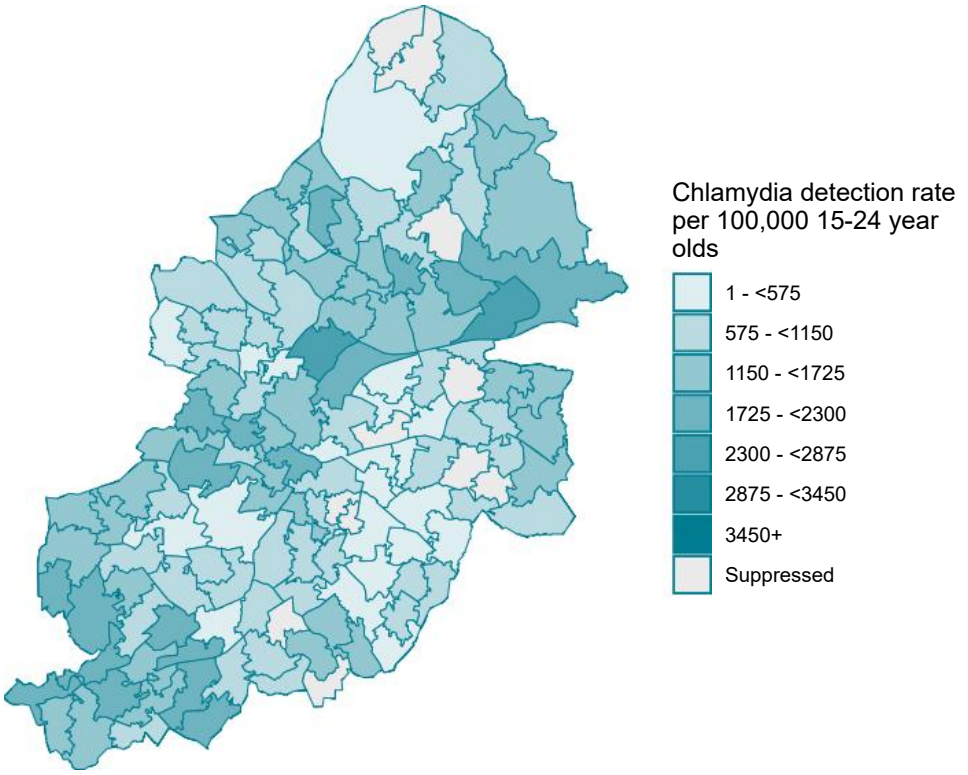
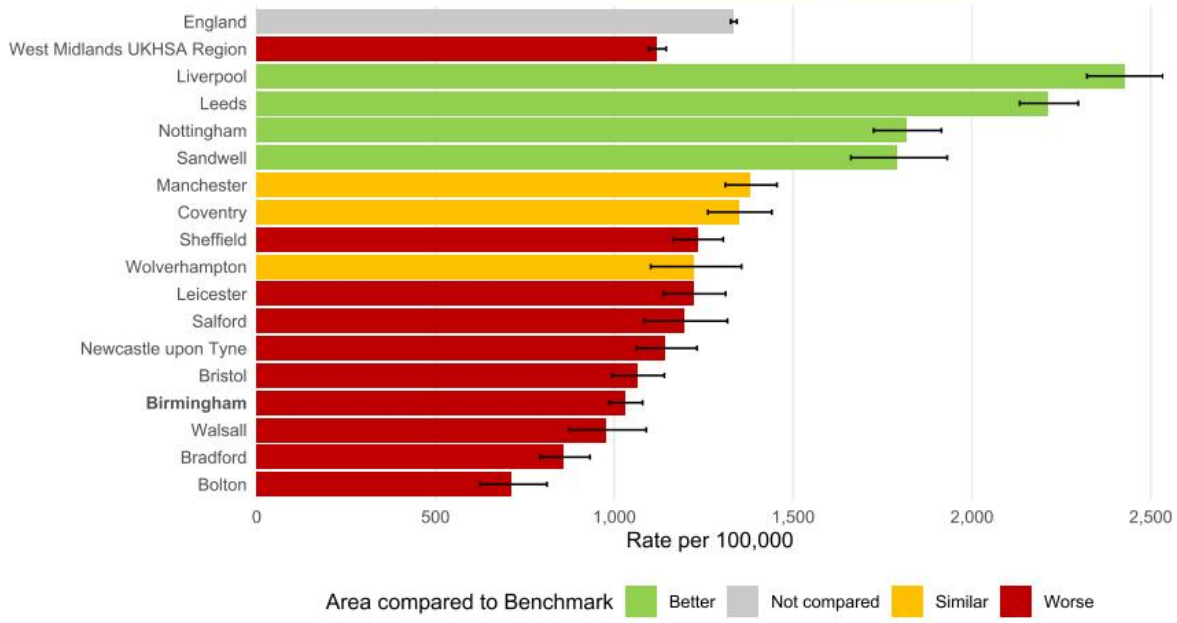


Figure 9. Chlamydia detection rate per 100,000 population in 15 to 24 year olds in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2021

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



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In the five years from 2016 to 2021, there was a 38% decrease in the chlamydia detection rate among 15 to 24 year olds in Birmingham. From 2020, the increase was 3%.

Figure 10. Chlamydia detection rate per 100,000 population in 15 to 24 year olds by year in Birmingham, the West Midlands UKHSA Region and England

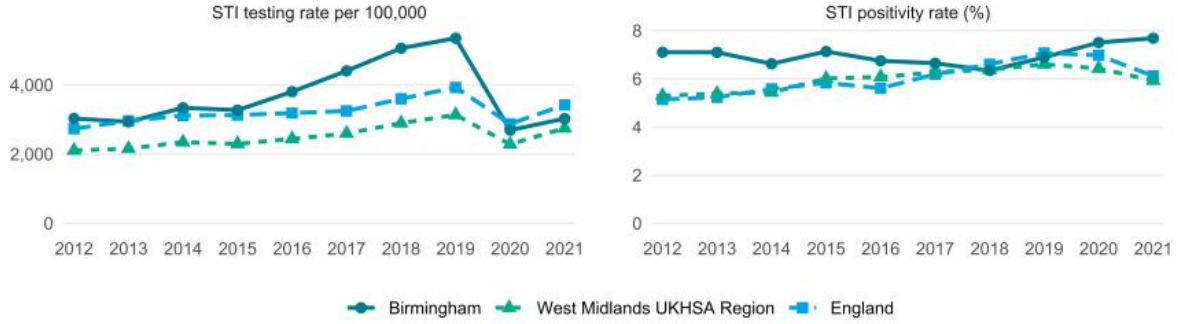
As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

STI testing in sexual health services (SHS)

In 2021 the rate of STI testing (excluding chlamydia in under 25 year individuals) in SHS in Birmingham was 3,024 per 100,000, a 12% increase compared to 2020. This is lower than the rate of 3,422 per 100,000 in England in 2021. The positivity rate in Birmingham was 7.7% in 2021, higher than 6.1% in England. Positivity rates depend both on the number of diagnoses and the offer of testing: higher positivity rates compared with previous years can represent increased burden of infection, decreases in the number of tests, or both.

The methodology to calculate the STI positivity changed in September 2021 to better reflect testing within the population accessing SHS by area. More details are available on the Sexual and Reproductive Health Profiles.[7]

Figure 11. STI testing rate and positivity rate (excluding chlamydia in under 25 year olds) per 100,000 population by year in Birmingham, the West Midlands UKHSA Region and England: 2012 to 2021



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Other infections transmitted sexually

Some bloodborne viruses can be spread through sex as well as by other routes, e.g. hepatitis B, hepatitis C. Some gastro-intestinal infections, typically linked to contaminated food or water can also be spread faecal-orally during sexual activity: these are called sexually transmissible enteric infections (STEIs) e.g. hepatitis A and *Shigella*.

Over the last decade, the number of cases of sexually-transmitted *Shigella* among MSM in England has increased,[8] with concerning increases in antimicrobial resistance. Cases of shigellosis can be severe, leading to dehydration and sepsis. Due to its presentation as an enteric illness, most symptomatic cases present to primary care (GPs, A&E) rather than SHS. Only a minority of MSM are thought to be aware of *Shigella* and how to avoid it, however, surveillance shows transmission of these infections is commonly associated with high-risk behaviours such as sexualised drug-use (including 'chemsex') and multiple casual sex partners.

Lymphogranuloma venereum (LGV), an invasive form of chlamydia, is a sexually transmitted infection which disproportionately affects MSM. In the past decade, the number of LGV diagnoses has increased substantially in England. Historically, LGV was mainly concentrated among MSM living with HIV. However, in recent years, a greater proportion of cases have been among MSM who are HIV negative.[9]

Hepatitis A vaccination is available for MSM in SHS. In 2016 an outbreak of hepatitis A was identified among MSM in England and across Europe. Between July 2016 and April 2017 266 cases associated with the outbreak had been identified in England, 74% of these among MSM.[10] This resulted in work to raise awareness of how to prevent infection through hygiene measures (e.g. washing hands after sex)[11] and recommendations around hepatitis A vaccination of MSM attending SHS. This outbreak highlights how quickly and widely an infection can become established in key populations if prevention measures such as vaccination are not undertaken.

In England, hepatitis B is most often acquired sexually. Where information on risk exposures was recorded on acute and probable acute cases of hepatitis B, the most commonly reported risk was heterosexual exposure (50%), followed by sex between men (17%).[12] Vaccination can prevent infection and is recommended for MSM, for individuals with multiple sexual partners and for individuals who place themselves at risk through sexual activity when travelling to high prevalence countries.

Most people in England acquire hepatitis C through injecting drug use.[13] However, MSM are also a risk group for hepatitis C transmission. MSM living with diagnosed HIV, especially those reporting high risk sexual practices, are disproportionately affected by hepatitis C compared to HIV-negative MSM; therefore guidance for hepatitis C testing in SHS has been targeted towards this group.

In May 2022, an international outbreak of mpox (monkeypox) was detected with cases reported concurrently from many countries where the disease is not endemic. To date, most reported cases in the outbreak have involved mainly, but not exclusively, men who have sex with men. Over 3,500 individuals have been diagnosed in England.

Vaccines developed to protect against smallpox have been approved and used for prevention of mpox and were used as part of the response. Numbers of new cases fell to very low levels by the end of 2022.

HIV

Free and effective antiretroviral therapy (ART) in the UK has transformed HIV from a fatal infection into a chronic but manageable condition. People living with HIV in the UK can now expect to have a near normal life expectancy if diagnosed promptly and they adhere to treatment. In addition, those on treatment are unable to pass on HIV, even if having unprotected sex (undetectable=untransmissible [U=U]).

In 2021, 2,692 people were newly diagnosed with HIV in England. This is a 0.7% rise from 2,673 (in 2020) and a 33% fall from 4,017 (in 2019). The impact of the COVID-19 pandemic on services and patient access means that it remains difficult to interpret the changes observed between 2019 and 2021.[14]

Among the 2,023 new diagnoses that were first made in England, men exposed through sex between men accounted for 36% (721), women exposed by heterosexual contact for 21% (429), men exposed by heterosexual contact for 18% (369), injecting drug use for 2% (45).

More than half those first diagnosed in England in 2021 were diagnosed at a late stage (with a CD4 count below 350 cells per mm^3). Median CD4 at diagnosis was especially low in men exposed by heterosexual contact, people of Black African ethnicity, and those over the age of 65, all having fallen since 2019.

Of the estimated 95,900 (credible interval (CrI) 94,700 to 97,700) people living with HIV in 2021, an estimated 4,400 (95% CrI 3,500 to 6,100) were undiagnosed. In 2021, England again achieved the UNAIDS 95-95-95 target nationally, with 95% of people living with HIV being diagnosed, 99% of those diagnosed being on treatment and 98% of those on treatment having an undetectable viral load.

For 2022, HIV surveillance data includes two new indicators on HIV Pre-exposure prophylaxis (PrEP):

- Determining PrEP need Proportion of all HIV negative individuals with estimated PrEP need who had this need identified (%)
- Initiation or continuation of PrEP among those with PrEP need: Proportion of all HIV negative individuals with estimated PrEP need who started or continued PrEP (%)

In 2021, 7% (87,828 of 1,180,923) of HIV-negative people accessing specialist SHSs in England were defined as having PrEP need. Among these, 69.6% (61,092 out of 87,828) initiated or continued PrEP.

England has set an ambition to end HIV transmission, AIDS and HIV-related deaths by 2030. The England HIV Action Plan 2022-2025 set out intermediate commitments for the next 4 years to achieve the 2030 ambition, including how HIV transmission will be reduced by 80% by 2025.[15] The monitoring and evaluation framework published in December 2022 sets out the indicators that will be used to monitor the progress towards this goal[16]

Figure 12. Chart showing key HIV indicators in Birmingham compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the West Midlands UKHSA Region.

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
HIV diagnosed prevalence rate per 1,000 aged 15 to 59	2021	1,931	2.8	2.3	12.7	0.6
HIV diagnosed prevalence rate per 1,000	2021	2,244	2.0	1.6	10.5	0.4
Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV	2019 - 21	195	92.0	83.5	60.0	100.0
Antiretroviral therapy (ART) coverage in people accessing HIV care	2021	2,234	99.6	98.4	80.9	100.0
Virological success in adults accessing HIV care	2021	2,142	97.8	97.8	91.8	100.0
New HIV diagnosis rate per 100,000	2021	75	6.6	4.8	22.2	0.0
New HIV diagnoses among persons first diagnosed in the UK rate per 100,000	2021	52	4.6	3.6	18.7	0.0
HIV late diagnosis in people first diagnosed with HIV in the UK	2019 - 21	65	43.0	43.4	100.0	0.0
HIV late diagnosis in gay, bisexual and other men who have sex with men first diagnosed with HIV in the UK	2019 - 21	16	26.7	31.4	100.0	0.0
HIV late diagnosis in heterosexual men first diagnosed with HIV in the UK	2019 - 21	33	61.1	58.1	100.0	0.0
HIV late diagnosis in heterosexual and bisexual women first diagnosed with HIV in the UK	2019 - 21	12	37.5	49.5	100.0	0.0
HIV testing coverage, total	2021	22,048	76.1	45.8	17.0	82.9
HIV testing coverage, gay, bisexual and other men who have sex with men	2021	1,434	89.9	77.8	48.9	92.1
HIV testing coverage, women	2021	12,572	73.6	36.6	8.2	81.8
HIV testing coverage, men	2021	9,350	81.0	62.8	32.5	84.5
Repeat HIV testing in gay, bisexual and other men who have sex with men	2021	637	44.5	45.3	12.3	63.6
Determining PrEP need	2021	1,074	3.7	7.4	1.2	27.3
Initiation or continuation of PrEP among those with PrEP need	2021	459	42.7	69.6	31.9	84.3

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

HIV treatment and care

In 2021, there were 1,931 Birmingham residents aged 15 to 59 years and 2,244 residents aged 15 years and over who were seen at HIV services (the prevalence of diagnosed HIV). The diagnosed prevalence per 1,000 residents aged 15 to 59 years was 2.8, worse than 2.3 per 1,000 in England. The rank of Birmingham was 37th highest (out of 150 UTLAs/UAs). Since 2020, the increase in Birmingham was 3%; in the 5 years since 2016, the decrease was 1%.

In 2021, 3.7% (1,074 out of 29,000) of HIV-negative people accessing specialist SHSs in Birmingham were defined as having PrEP need. Among these, 42.7% (459 out of 1,074) initiated or continued PrEP.

Figure 13. Diagnosed HIV prevalence per 1,000 population aged 15 to 59 years by year in Birmingham compared to rates in the West Midlands UKHSA Region and England: 2011 to 2021.

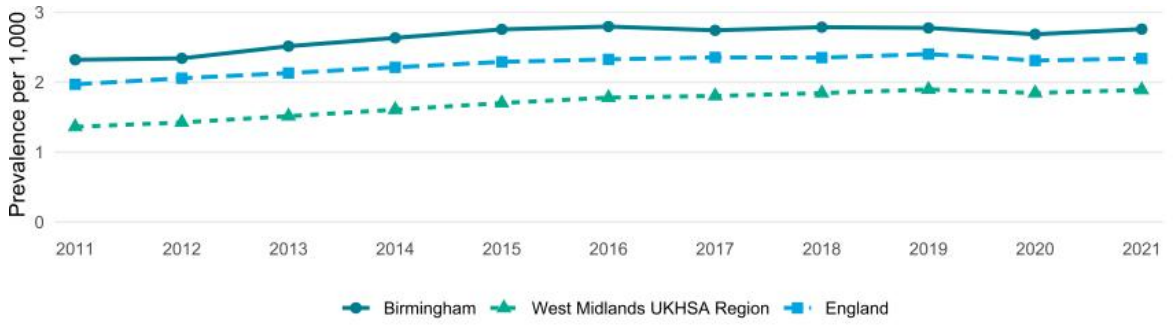

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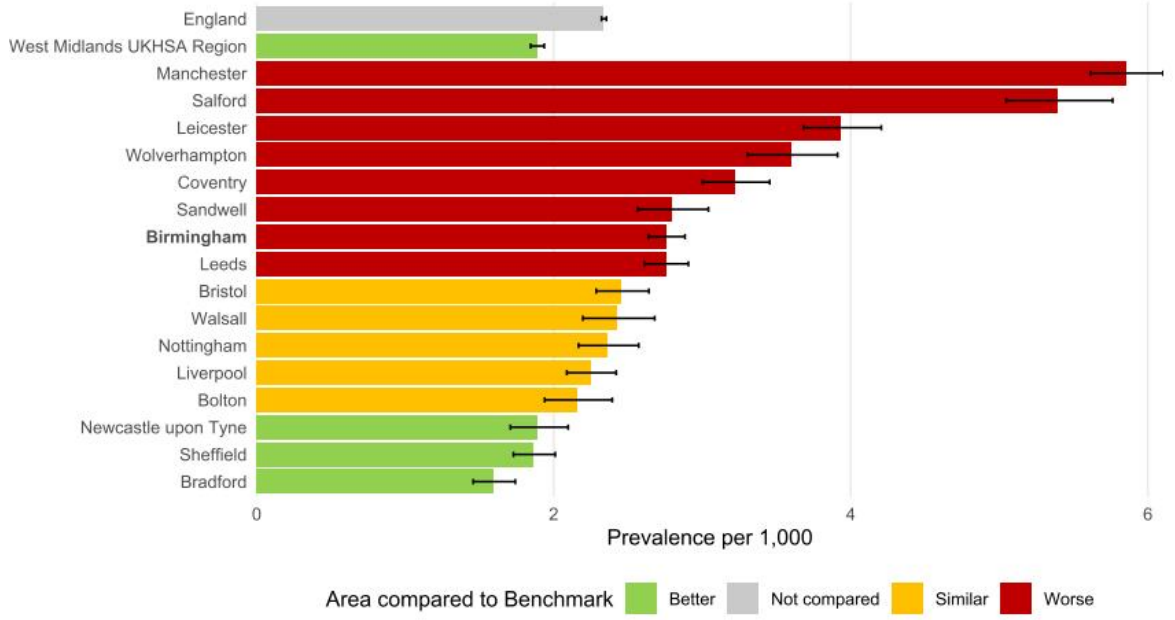
Figure 14. Diagnosed HIV prevalence per 1,000 population aged 15 to 59 years in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2021

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



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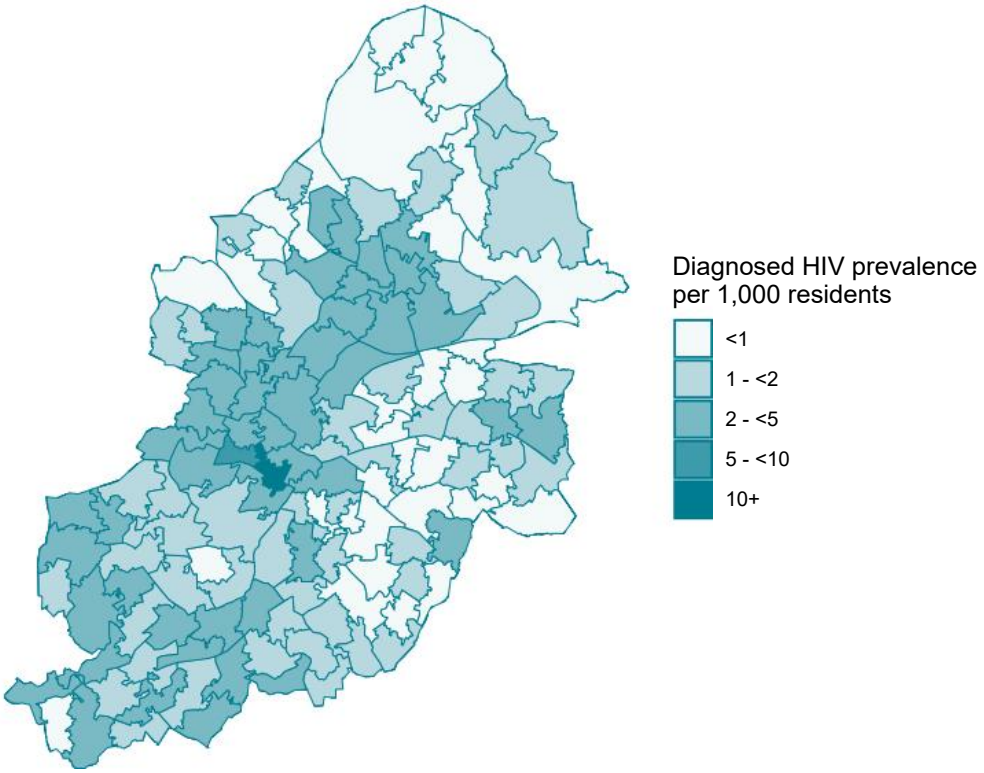
The percentage of people (aged 15 years and over) in Birmingham accessing HIV care who were prescribed ART in 2021 was 99.6%, better than 98.4% in England. The percentage of people in Birmingham newly diagnosed with HIV in the three-year period between 2019 - 21 who started antiretroviral therapy (ART) promptly (within 91 days of their diagnosis) was 92.0%, better than 83.5% in England.

The percentage of adults in Birmingham accessing HIV care in 2021 who were virally suppressed (undetectable viral load) was 97.8%, similar to 97.8% in England.

The Sexual and Reproductive Health Profiles also provides these data at lower tier local authority geographies.

Figure 15. Map of diagnosed HIV prevalence among people of all ages in Birmingham by Middle Super Output Area: 2021

Please note that this data is not available on the online Sexual and Reproductive Health Profiles. Data is sourced from the UKHSA HIV and AIDS Reporting System (HARS). As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.

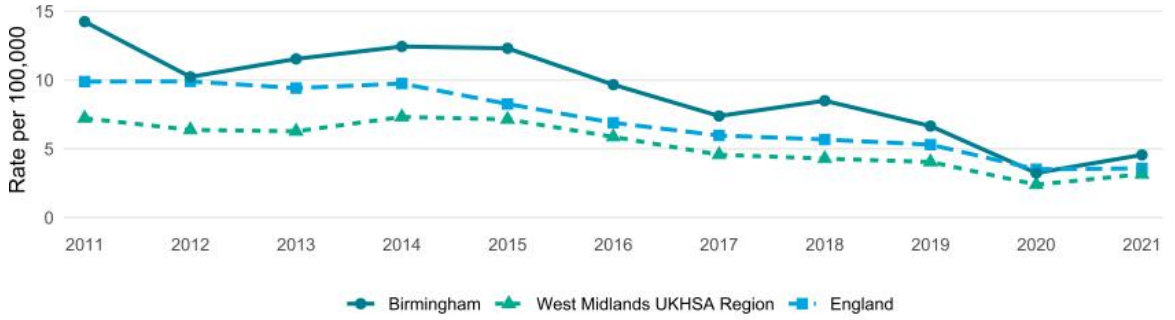


New HIV diagnoses among persons first diagnosed in the UK

To measure HIV transmission in the UK more accurately, diagnoses where the first HIV positive test occurred in the UK are considered in this section. All reports of new HIV diagnoses, regardless of country of first HIV positive test, are presented in Figure 12.

In 2021, the number of Birmingham residents aged 15 years and older who were newly diagnosed with HIV in the UK was 52. The rate of new diagnoses per 100,000 residents was 4.6, similar to the rate of 3.6 per 100,000 in England. This represented a 41% increase since 2020 and a 53% decrease in the 5 years since 2016. The rank of Birmingham for the rate of new HIV diagnoses was 48th highest (out of 150 UTLAs/UAs).

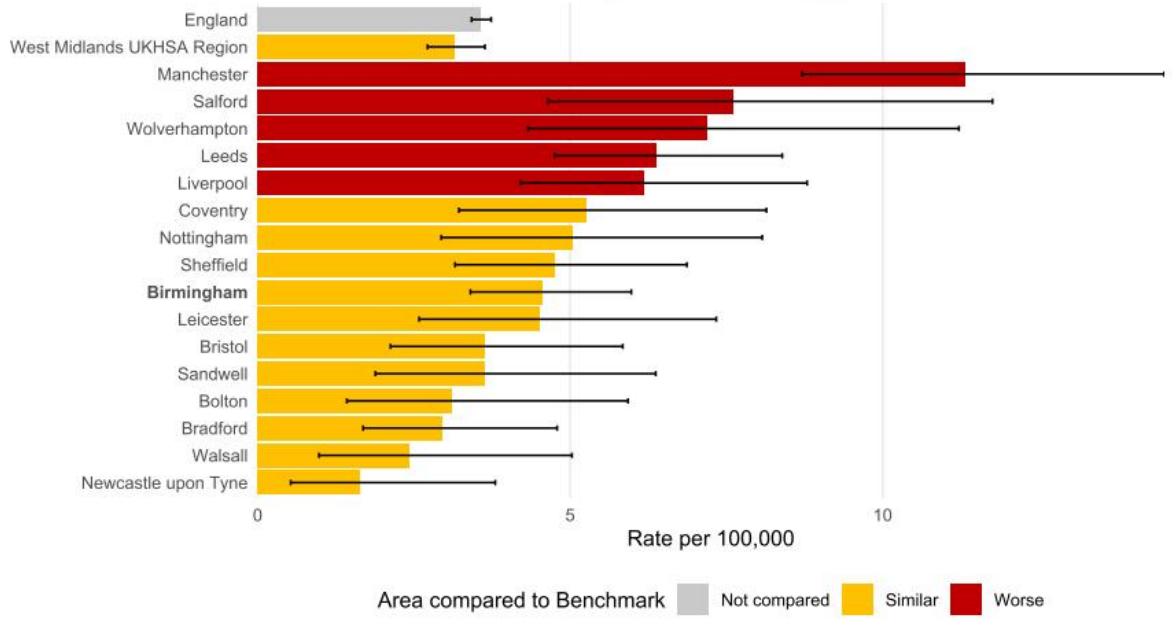
Figure 16. Rate of new HIV diagnoses per 100,000 population among people aged 15 years or above first diagnosed in the UK by year in Birmingham compared to rates in the West Midlands UKHSA Region and England: 2011 to 2021.



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Figure 17. New HIV diagnoses among persons first diagnosed in the UK rate per 100,000 population aged 15 years and above in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2021

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



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Late HIV diagnosis

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a PHOF indicator, and monitoring is essential to evaluate the success of local HIV testing efforts. Late diagnosis is defined here as having a CD4 count <350 cells/mm^3 within 91 days of first HIV diagnosis in the UK. An updated definition of late HIV diagnosis which incorporates evidence of recent seroconversion has also been published in other outputs.

In Birmingham, the percentage of HIV diagnoses made at a late stage of infection in the three-year period between 2019 - 21 was 43.0%, similar to 43.4% in England.

Figure 18. Percentage of late HIV diagnoses (all CD4<350) in 16 similar local authorities and West Midlands UKHSA Region, compared to England: 2019 - 21

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model

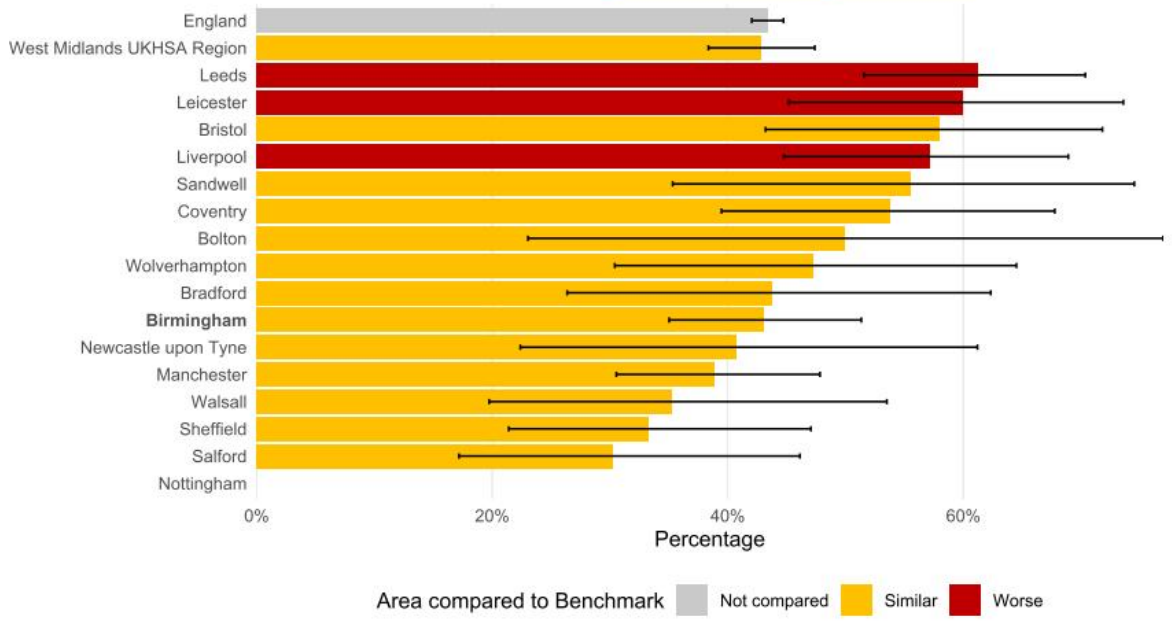

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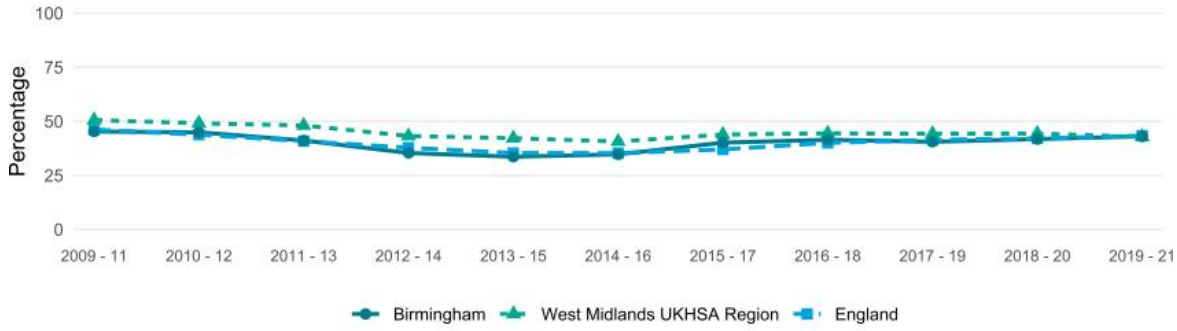
Figure 19. Percentage of late HIV diagnoses (all CD4<350) in Birmingham compared to the West Midlands UKHSA Region and England: 2009-11 to 2019-21



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

For Birmingham residents, the percentage of HIV diagnoses made at a late stage of infection for different risk groups in the three-year period between 2019 - 21 was as follows: MSM - 26.7%, similar to 31.4% in England; heterosexual men - 61.1%, similar to 58.1% in England; heterosexual women - 37.5%, similar to 49.5% in England.

HIV testing

In 2021, among Birmingham residents, the percentage of eligible SHS attendees who received an HIV test was 76.1%, better than 45.8% for England. This represented a 17% increase since 2020, and a 9% increase since 2016. For 2021, the percentage of MSM in Birmingham who had tested more than once in the previous year was 44.5%, similar to 45.3% in England.

Table 4. Coverage of HIV testing among eligible patients at specialist SHSs for Birmingham and England: 2021

	2020	2021	% change 2020 to 2021*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2021‡	Value for England: 2021
Total	65.3	76.1	16.6%	1	4	45.8
Women	62.2	73.6	18.2%	1	5	36.6
Men	71.0	81.0	14.0%	1	3	62.8
MSM	77.0	89.9	16.7%	2	6	77.8

When calculating these rates, eligibility for HIV testing is determined by reviewing previous HIV diagnosis and testing history for each patient. Those who are known to be HIV positive, based on their GUMCAD history, are not considered eligible for testing. Those who have been tested already are not considered eligible to be tested again until six weeks have passed (i.e. eligibility for testing occurs only once every six weeks).
As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.
* Percent change proportional to the value in 2020, not a change in percentage points. Percent change not provided where the value in 2020 was 0.
† These are Birmingham and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.
‡ Out of 149 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Reproductive health

The COVID-19 pandemic and reproductive health

In 2020 the government responded to the COVID-19 pandemic with national lockdowns which directly impacted SRH provision in England. Many contraception services, such as Long Acting Reversible Contraception (LARC), were impacted by the restrictions due to the requirement for face-to-face interactions. Other areas of Reproductive Health, such as abortion, have seen a change in service delivery with the option of home abortion. The long term impact of lockdown measures on sexual behaviour and health service provision continues to be reviewed and is reflected in sexual and reproductive health indicator data. The ongoing impact and the changes to service delivery should be acknowledged when interpreting the data, especially when comparing with data from pre-pandemic years.

Unplanned pregnancy

Unplanned pregnancies can end in maternity, miscarriage or abortion. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures, negative health impacts and have impacts on existing children. Restricting access to contraceptive provision can therefore be counterproductive and ultimately increase costs.

The Third National Survey of Sexual Attitudes and Lifestyles (NATSAL-3), which was carried out in Britain in 2010-12, found that 16.2% of all pregnancies in the year before the study interview were unplanned. This survey found that:

- Pregnancies among 16 to 19 year old individuals accounted for 7.5% of the total number of pregnancies, but 21.2% of the total number that were unplanned.
- The highest numbers of unplanned pregnancies occur in the 20 to 34 year age group.

The survey included a pregnancy analysis of 5,686 women aged 16 to 44 years. The survey used a psychometrically-validated London Measure of Unplanned Pregnancy (LMUP), which assigned a score to each multiple choice answer, to questions on contraceptive use and intention of getting pregnant. The total score of 0-3 is categorised as unplanned, 4-9 as ambivalent and 10-12 as planned. The survey estimated that 54.8% (95% CI 50.3-59.2) of pregnancies were planned. The remaining 45.2% of pregnancies were described as 29.0% (95% CI 25.2-33.2) ambivalent and 16.2% (95% CI 13.1-19.9) unplanned.

Unplanned pregnancy is also strongly associated with lower educational attainment, current smoking, recent drug use, lack of sexual competence at first sex and with receiving sex education mainly from sources other than school, supporting the importance of the recent statutory RSHE requirement for all schools in England.

Abortion

The total abortion rate, under 25 years repeat abortion rate, under 25 years abortions after a birth, and over 25 years abortion rates may be indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method.

In Birmingham the total number of abortions in 2021 was 5,582. The total abortion rate per 1,000 female population aged 15 to 44 years was 22.1, higher than the rate in England of 19.2 per 1,000. The rank (out of 150 UTLAs/UAs) within England for the total abortion rate was 45th highest.

Figure 20. Chart showing key abortion indicators in Birmingham UTLAs/UAs compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the West Midlands UKHSA Region.

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
Total abortion rate / 1,000	2021	5,582	22.1	19.2	32.2	11.3
Under 18s abortions rate / 1,000	2021	133	6.2	6.5	2.0	14.6
Over 25s abortion rate / 1,000	2021	3,547	22.0	17.9	29.4	10.2
Under 25s repeat abortions (%)	2021	647	31.8	29.7	39.8	17.3
Under 25s abortion after a birth (%)	2021	541	26.6	26.0	47.2	8.2

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Table 5. Abortion figures in Birmingham and England: 2021

	2020	2021	% change 2020 to 2021*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2021‡	Value for England: 2021
Rates						
Total abortion rate / 1,000	21.5	22.1	2.8%	8	45	19.2
Under 18s abortions rate / 1,000	7.0	6.2	-11.4%	14	82	6.5
Over 25s abortion rate / 1,000	21.6	22.0	1.9%	8	32	17.9
Percentages						
Under 25s repeat abortions (%)	31.8	31.8	0.0%	7	48	29.7
Under 25s abortion after a birth (%)	27.6	26.6	-3.6%	6	68	26.0

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.

* Percent change proportional to the value in 2020, not a change in percentage points. Percent change not provided where the value in 2020 was 0.

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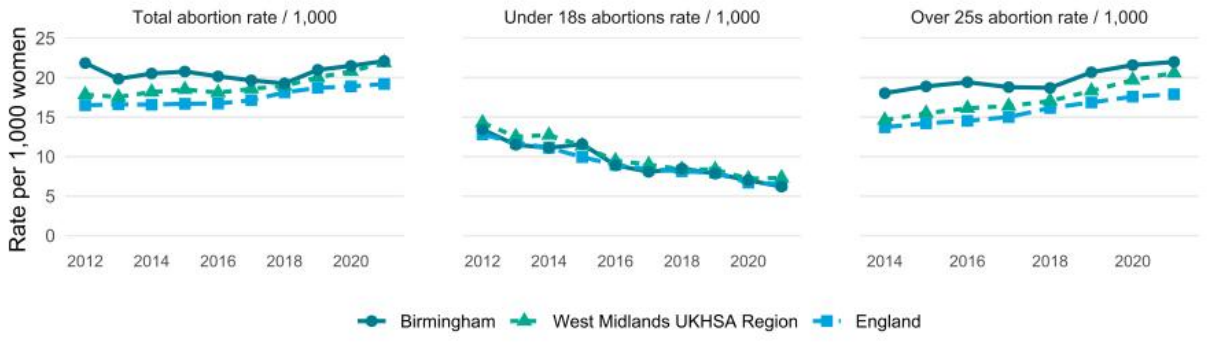
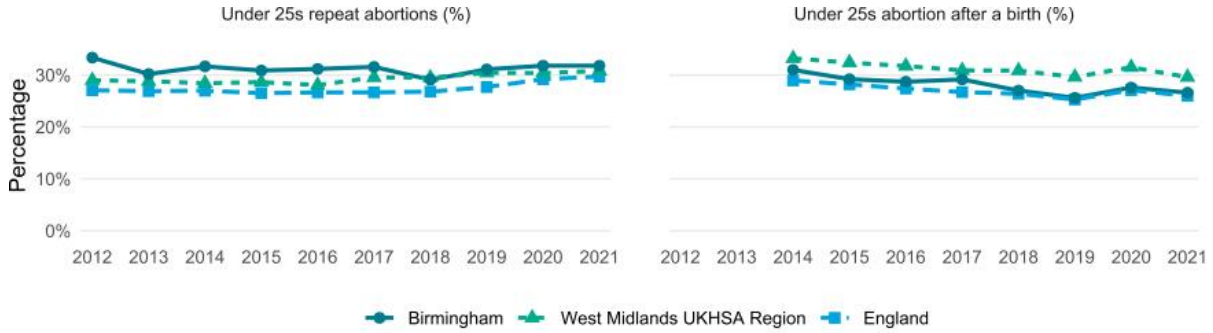
Figure 21. Abortion rates per 1,000 women by age in Birmingham compared to the West Midlands UKHSA Region and England: 2012 to 2021



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

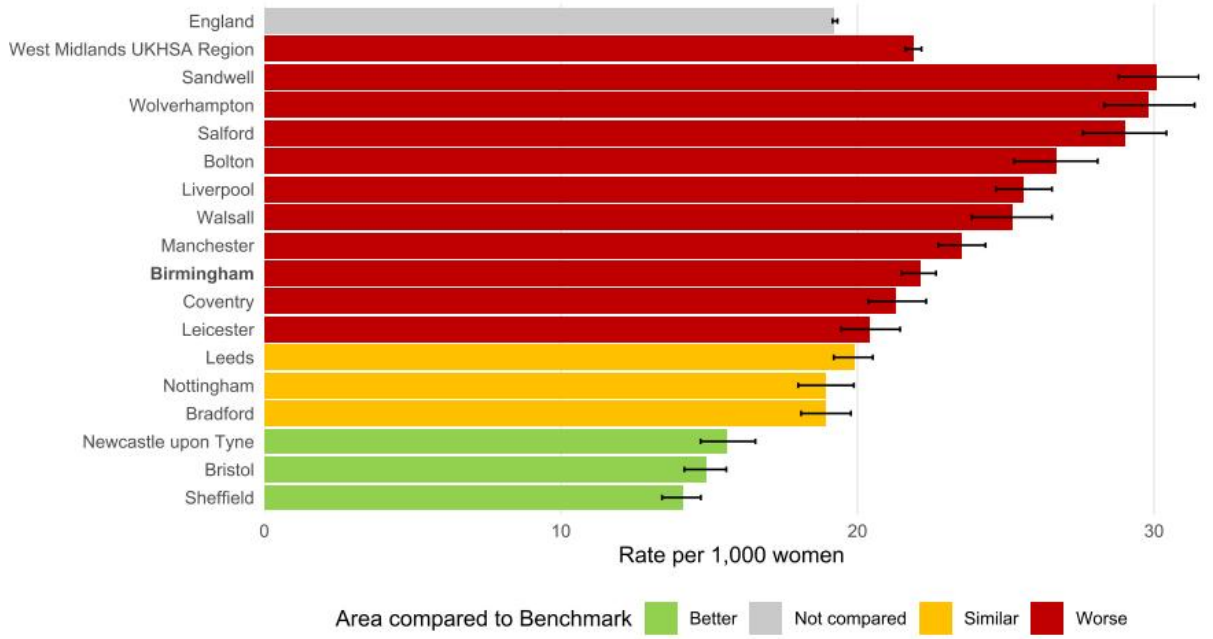
Figure 22. Characteristics of abortions over time in Birmingham compared to the West Midlands UKHSA Region and England: 2012 to 2021



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Figure 23. Abortion rate per 1,000 women in 16 similar local authorities and West Midlands UKHSA Region, compared to England: 2021

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

The earlier abortions are performed, the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality.

In Birmingham, the percentage of NHS-funded abortions that were under 10 weeks was 87.1% in 2021, worse than the percentage in England of 88.6. The rank within England for this indicator was 126th highest (out of 150 UTLAs/UAs).

Over the last ten years, there has been an increase in the overall percentage of abortions performed at under 10 weeks gestation in England. Early medical abortion is less invasive than a surgical procedure as it does not involve instrumentation or the use of anaesthetics.

However, women may prefer a surgical abortion under local or general anaesthesia/conscious sedation for a variety of reasons, including wishing to avoid the experience of going through an induced pregnancy loss and wanting to have the procedure carried out during a single visit.

Ensuring women have access to a method of contraception of their choice after an abortion is recommended practice. Provision of LARC methods post-abortion has been shown to lower subsequent unintended pregnancy rates.[17]

The following indicator relating to the use of medical procedures helps to improve transparency at a local level on the extent of medical and surgical services available to women and could thus be an indicator of patient choice. A very low or a very high percentage of medical abortions compared to other areas could be an issue for concern.

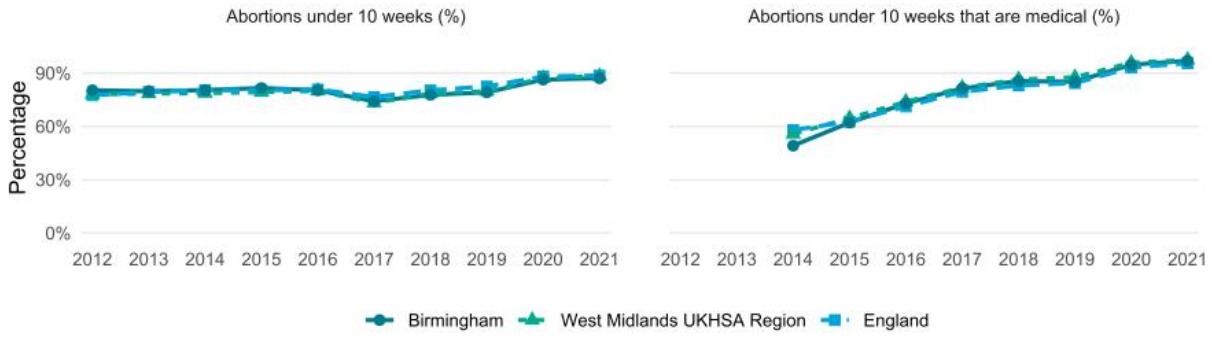
Among NHS-funded abortions in Birmingham, the percentage of those under 10 weeks gestation that were performed using a medical procedure in 2021 was 96.9%, higher than the percentage in England of 95.5%. The rank within England for this indicator was 54th highest (out of 150 UTLAs/UAs).

Table 6. Abortion figures for Birmingham and England: 2021

	2020	2021	% change 2020 to 2021*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2021‡	Value for England: 2021
Abortions under 10 weeks (%)	86.3	87.1	0.9%	11	126	88.6
Abortions under 10 weeks that are medical (%)	94.7	96.9	2.3%	9	51	95.5

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.
* Percent change not provided where the value in 2020 was 0.
† These are Birmingham and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.
‡ Out of 149 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Figure 24. Early abortion over time in Birmingham compared to the West Midlands UKHSA Region and England: 2012 to 2021



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

In April 2022, Parliament made the decision to legislate to allow the remote delivery of early medical abortion (EMA) services in England and Wales. This was in line with the temporary arrangements introduced at the start of the COVID-19 pandemic to reduce the risk of transmission and ensure continued access to abortion services. The Abortion Act has been amended to allow eligible girls and women in the first 10 weeks of pregnancy (9 weeks and 6 days) to take both pills required to induce an abortion at home, without the need to first attend a hospital or clinic.

Under-18s Conception

Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Babies born to mothers under 20 years consistently have higher rates of stillbirth, infant mortality and low birthweight than average, though the difference fluctuates from year to year due to relatively low numbers. The inequality in low birthweight increased from 2012-2016 and has remained similar from 2016-2019.[18] The rates of low birthweight in younger mothers is 30% higher than average, and this inequality is increasing. Children born to teenage mothers have a 63% higher risk of living in poverty.[19] Teenage mothers are more likely than other young people to not be in education, employment or training; and by the age of 30 years,[20] are 22% more likely to be living in poverty than mothers giving birth aged 24 years or over.[21] Young fathers are twice as likely to be unemployed aged 30 years, even after taking account of deprivation.[22]

Since the introduction of the Teenage Pregnancy Strategy in 1999, England has achieved a 72.1% reduction in the under-18 conception rate between 1998 and 2020. The success of the Strategy's approach has been recognised by the World Health Organization with the lessons being shared internationally with countries seeking to address high rates.[23] However, despite the significant progress, England's teenage birth rate remains higher than comparable Western countries,[24] and inequalities in the under-18 conception rate persist between and within local areas. Over a quarter of local authorities have an under-18s conception rate significantly higher than the England average and 80% have at least one high rate ward. Further progress in both reducing the under-18s conception rate and improving the outcomes for young parents is central to improving young people's sexual health and narrowing the health and educational inequalities experienced by young parents and their children.

Maintaining the downward trend is a priority in the Department of Health Framework for Sexual Health Improvement in England[25] and addresses a number of key public health priorities including reducing health inequalities, ensuring every child gets the best start in life, and improving sexual and reproductive health. The Public Health Outcomes Framework (PHOF) includes the under-18 conception rate and a number of other indicators disproportionately affecting young parents and their children.

International evidence identifies the provision of high quality, comprehensive relationships and sex education (RSE) linked to improved use of contraception as the areas where the strongest empirical evidence exists on impact on teenage pregnancy rates.[26] [27] [28] In September 2020, Statutory Guidance was introduced that requires all primary schools to provide relationships education, all secondary schools to provide

relationships and sex education and both primary and secondary schools to provide health education, including puberty.[29] This includes specific reference to ensuring all secondary school pupils know about local services providing confidential SRH advice and care.

Contraceptive services need to be accessible and youth friendly to encourage early uptake of advice, with consultations that recognise and address any knowledge gaps about fertility and concerns about side effects and support young people to choose and use their preferred method. Some young people will be at greater risk of early pregnancy and require more intensive RSE and contraceptive support, combined with programmes to build resilience and aspiration, providing the means and the motivation to prevent early pregnancy.

Reaching young people most in need involves looking at area and individual level associated risk factors. Child poverty and unemployment are the two area deprivation indicators with the strongest influence on under-18 conception rates.[30] At an individual level, the strongest associated factors for pregnancy before 18 years are free school meal eligibility, persistent school absence by age 14 years, poorer than expected academic progress between ages 11-14 years, and being looked after or a care leaver.[31] [32] [33]

Teenagers are more likely to present late for abortion and to book late for antenatal care.[34] The higher risk of unplanned pregnancy, late confirmation of pregnancy and fear of disclosure, all contribute to delays in accessing abortion and maternity services.[35] Early pregnancy diagnosis, unbiased advice on pregnancy options and swift referral to maternity or abortion services are required to minimise delays.[36] Young people who have experienced pregnancy are also at higher risk of subsequent unplanned conceptions.[37]

Between 2020-21 there was a greater decrease in teenage conceptions rates in England and Wales compared to pre-pandemic rates. This is believed to be linked to the nationwide lockdown restrictions and the changes to sexual behaviours during the COVID-19 pandemic and remains under review.

Figure 25. Chart showing under-18s conception indicators in Birmingham compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the West Midlands UKHSA Region.

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
Under 18s conception rate / 1,000	2020	346	16.1	13.0	30.4	2.7
Under 16s conception rate / 1,000	2020	61	2.7	2.0	5.7	0.5
Under 18s births rate / 1,000	2020	102	4.7	3.8	12.8	0.0
Teenage mothers	2020/21	100	0.7	0.6	1.8	0.0
Under 18s conceptions leading to abortion (%)	2020	157	45.4	53.0	24.3	82.9

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

In 2020, the under-18s conception rate per 1,000 females aged 15 to 17 years in Birmingham was 16.1, worse than the rate of 13.0 per 1,000 in England. The decrease from 2019 was 10%. The rank within England for the under-18s conception rate was 41st highest (out of 150 UTLAs/UAs). Between 1998 and 2020, the decrease in the under-18s conception rate in Birmingham was 72%, compared to a 66% decrease in England.

Figure 26. Under-18s conception rate per 1,000 women in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2020

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model

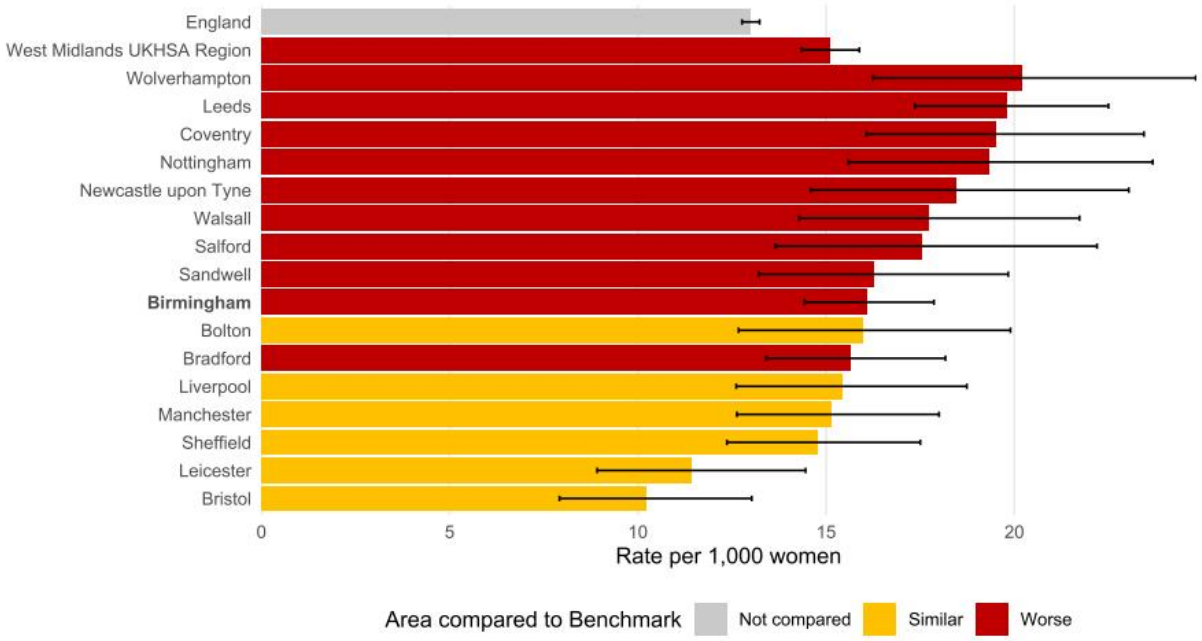


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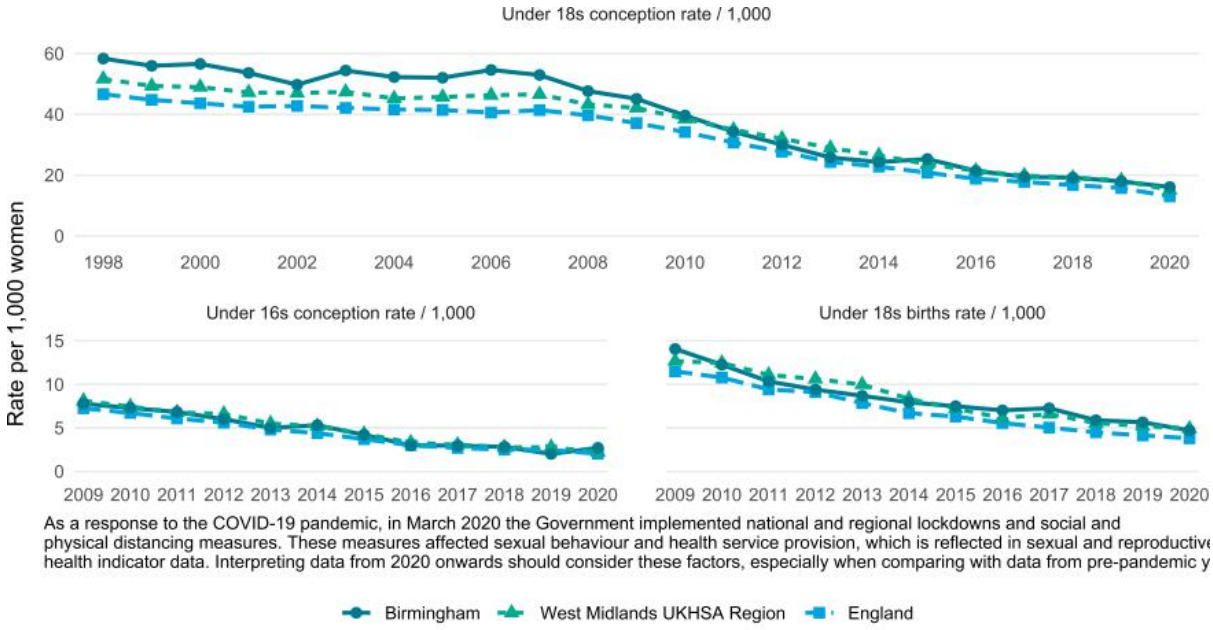
Figure 27. Rates of under-18s conception and births over time in Birmingham compared to the West Midlands UKHSA Region and England

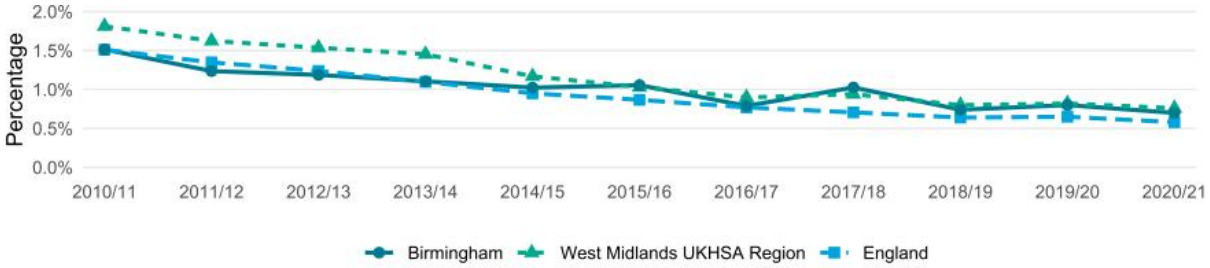


Among the under-18 conceptions in Birmingham, the percentage of those leading to abortion in 2020 was 45.4%, lower than the percentage in England of 53.0%. The rank for the percentage of conceptions leading to abortion in Birmingham was 120th highest (out of 150 UTLAs/UAs). A lower than average percentage may indicate a higher proportion of young women choosing to continue the pregnancy, but can also reflect barriers to accessing abortion care.

Figure 28. Percentage of under-18 conceptions leading to abortion, over time in Birmingham compared to the West Midlands UKHSA Region and England: 1998 to 2020

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Figure 29. Percentage of births where the mother is aged under 18 years, over time in Birmingham compared to the West Midlands UKHSA Region and England: 2010/11 to 2020/21



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Table 7. Under-18s conception and birth figures in Birmingham and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Under 18s conception rate / 1,000	17.9	16.1	-10.3%	9	41	13
Under 16s conception rate / 1,000	2.0	2.7	35.0%	9	42	2
Under 18s conceptions leading to abortion (%)	48.0	45.4	-5.4%	10	120	53

Please note that under-18 conceptions data has not yet been published for 2020, so data in this section does not show the impact of the COVID-19 pandemic.

* Percent change not provided where the value in 2019 was 0.

† These are Birmingham and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

‡ Out of 149 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Figure 30. Under-18s conception in Birmingham by ward, compared to England: three-year period between 2018 - 20

Please note that this data is not available on the online Sexual and Reproductive Health Profiles. Data is sourced from Conception Statistics, England and Wales, ONS

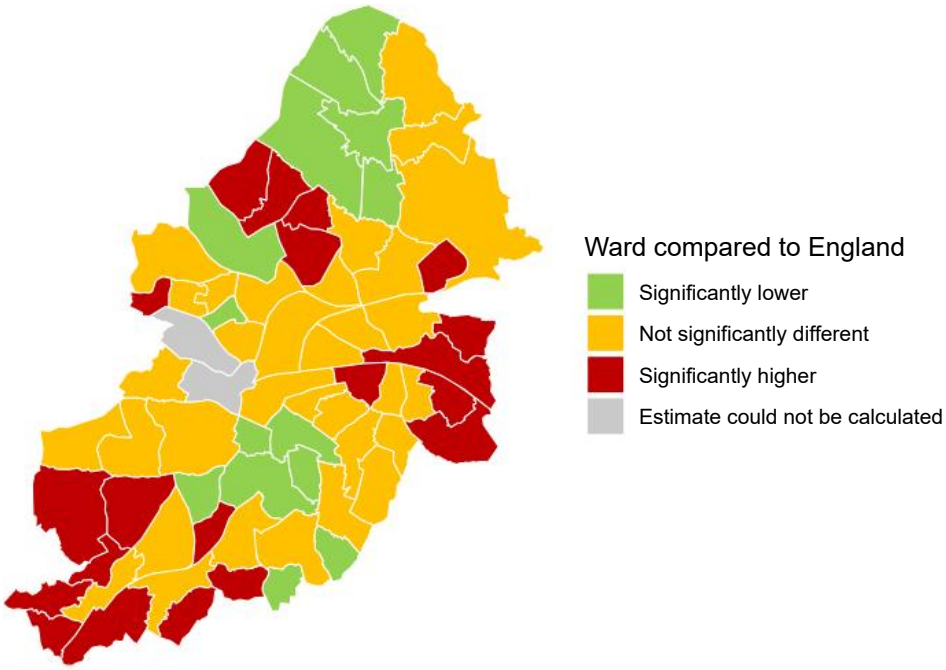
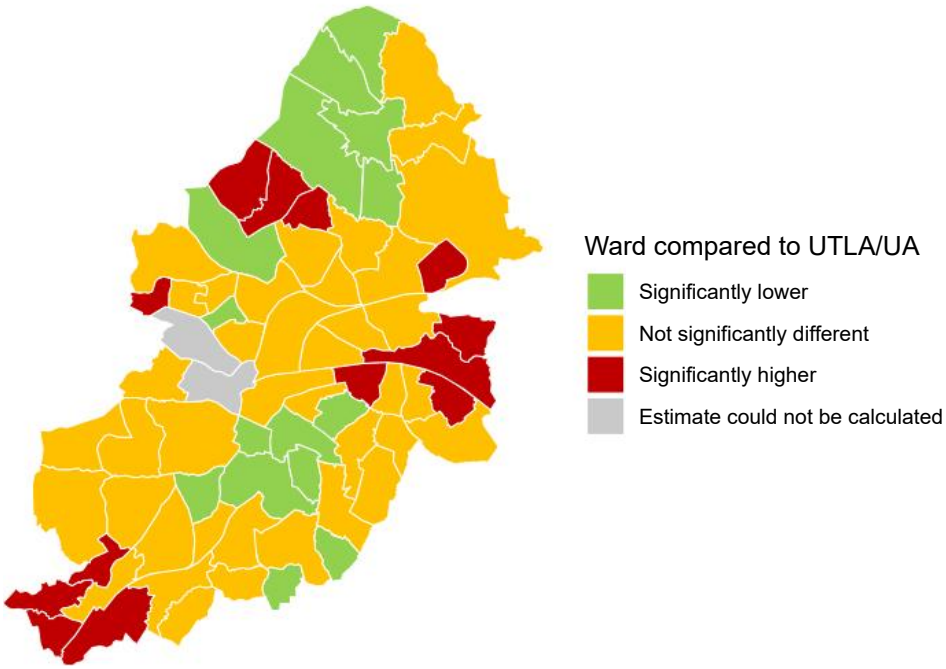


Figure 31. Under-18s conception in Birmingham by ward, compared to the rate for Birmingham: three-year period between 2018 - 20

Please note that this data is not available on the online Sexual and Reproductive Health Profiles. Data is sourced from Conception Statistics, England and Wales, ONS



Contraception

This section has not been updated in the January 2023 refresh because most of the indicators are rates which use population estimates as the denominator. Updating of these indicators has been affected by the update of population estimates following the 2021 census. A 2021 population estimate has been released by the Office for National Statistics (ONS) which is not comparable to previous population estimates. Revised population estimates for previous years will be published later in 2023. 2021 data can be seen on Fingertips. This section will be updated when the full time series for these indicators is available.

The government and the Faculty of Sexual and Reproductive Healthcare (FSRH) both highlight the importance of knowledge, access and choice for all women and men to all methods of contraception to help reduce unwanted pregnancies. Good contraception services have been shown to lower rates of teenage conceptions.

Contraception is widely available in the UK from a number of sources and is provided free by the NHS for people of all ages. Contraception is available free of charge from: general practices, level 2 sexual and reproductive health (SRH) services, young person's clinics, NHS walk-in centres (emergency contraception only), integrated SHS, some specialist SHS (emergency contraception and male condoms) and some pharmacists under a Patient Group Direction. Provision of contraception at the time of abortion is recommended practice and is almost always commissioned as part of this service; a significant proportion of this is thought to be the most effective long-acting reversible contraception (LARC) methods (implants, intra-uterine systems [IUS] and intrauterine devices [IUD] but not injections).

Condoms are free at SHS as well as for young people through local condom distribution schemes. Around 85% of local authorities provide a c-card or other condom distribution scheme. Condoms can also be purchased from pharmacies, supermarkets, and other retailers. Emergency hormonal contraception (levonorgestrel and ulipristal acetate) may be provided for free via; GP surgeries, sexual health service (SHS), and from pharmacies (depending on local commissioning arrangements). It is also available for over-the-counter purchase at some pharmacies and online.

Currently, data on contraception provision are only centrally collected from specialist SHS, level 2 SRH services and some young person's clinics through the Sexual and Reproductive Health Activity Dataset (SRHAD) and from NHS prescription forms within primary care. Data sources used in this report are SRHAD and Prescribing Analysis Cost Tabulation (ePACT2). ePACT2 data is available by number of prescriptions and is therefore a more useful indicator of use for LARC than short acting methods that require repeated prescription. However, there is no way of measuring method continuation, so the LARC data reflects method initiation only. The way in which this report presents total amount of contraception used in England should therefore be interpreted with care.

Attendance indicators provide a measure of young people's access to specialist contraceptive services. The indicators are split by sex and unique attendances because there are different patterns of service access and recording relating to each sex. Females access services more than males and make more repeated visits in a year.

Attendance and service provision at SRH services is likely to be reflective of local service models and local geography e.g. more urban areas may have greater attendance at specialist SRH services as they may be easier to access, whereas in more rural areas it may be easier to attend general practice than travel to a specialist clinic.

Figure 32. Chart showing key contraception indicators in Birmingham compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the West Midlands UKHSA Region.

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Females	2020	3,260	35.6	97.6	6.0	312.2
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Males	2020	215	2.3	13.0	0.3	53.8
Women choose injections at SRH Services (%)	2020	465	6.4	8.1	1.6	25.7
Women choose user-dependent methods at SRH Services (%)	2020	3,935	54.1	54.9	34.2	72.4
Women choose hormonal short-acting contraceptives at SRH Services (%)	2020	2,190	30.1	41.7	20.3	66.4
Under 25s choose LARC excluding injections at SRH Services (%)	2020	835	29.1	28.8	11.2	46.8
Over 25s choose LARC excluding injections at SRH Services (%)	2020	2,040	46.3	43.5	19.8	72.7
Total prescribed LARC excluding injections rate / 1,000	2020	6,705	26.5	34.6	5.3	60.9
GP prescribed LARC excluding injections rate / 1,000	2020	4,819	19.1	21.1	0.0	51.5
SRH Services prescribed LARC excluding injections rate / 1,000	2020	1,885	7.5	13.4	0.8	32.0

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

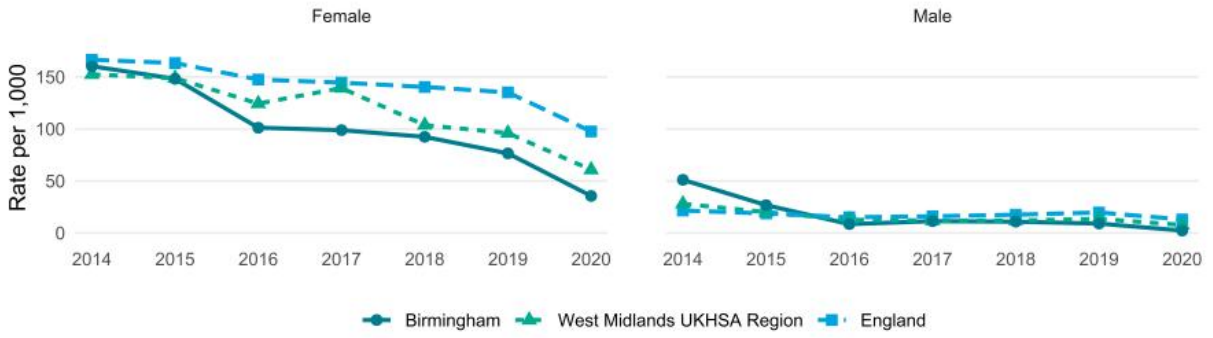
Attendance and service provision at sexual and reproductive health (SRH) clinics

Table 8. Attendance at specialist contraceptive services per 1,000 residents under 25 by gender, in Birmingham and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Females	76.6	35.6	-53.5%	14	146	97.6
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Males	9.0	2.3	-74.4%	11	110	13.0

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.
* Percent change not provided where the value in 2019 was 0.
† These are Birmingham and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.
‡ Out of 149 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Figure 33. Attendance at specialist contraceptive services among under 25s by gender, in Birmingham compared to the West Midlands UKHSA Region and England: 2014 to 2020



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Contraceptive care

Table 9. Women's choice of contraception at SRH services in Birmingham and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Women choose injections at SRH Services (%)	6.6	6.4	-3.5%	11	83	8.1
Women choose user-dependent methods at SRH Services (%)	60.9	54.1	-11.2%	5	66	54.9
Women choose hormonal short-acting contraceptives at SRH Services (%)	31.5	30.1	-4.5%	12	137	41.7
Under 25s choose LARC excluding injections at SRH Services (%)	23.8	29.1	22.3%	11	82	28.8
Over 25s choose LARC excluding injections at SRH Services (%)	38.6	46.3	20.0%	9	70	43.5

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.

* Percent change proportional to the value in 2019, not a change in percentage points. Percent change not provided where the value in 2019 was 0.

† These are Birmingham and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

‡ Out of 149 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Focus on long-acting reversible contraceptives (LARCs)

In 2020, National GP and SRH Long Acting Reversible Contraception prescribing data[38] shows that there was a significant drop in prescribing of IUD, IUS and implants from April 2020 with significant national recovery in prescribing by December 2020. However, prescribing did not exceed 2019 baseline rates in any month in 2020, so significant backlogs in provision likely remain. It is also important to note that national recovery can mask significant regional and local variation.

The total rate of long-acting reversible contraception (LARC) (excluding injections) prescribed in Birmingham primary care, specialist and non-specialist SHS was 26.5 per 1,000 women aged 15 to 44 years in 2020, lower than the rate of 34.6 per 1,000 women in England.

LARC provision is likely to reflect local geography and service models e.g. there may be more provision in primary care in more rural and semi-rural areas. In Birmingham, the rate prescribed in primary care was 19.1 in 2020, lower than the rate of 21.1 in England. The rate prescribed in the other settings was 7.5 in 2020, lower than the rate of 13.4 in England.

Table 10. Rate of LARCs (excluding injections) prescribed per 1,000 women aged 15-44 years by setting, Birmingham and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Total prescribed LARC excluding injections rate / 1,000	42.1	26.5	-37.1%	9	106	34.6
GP prescribed LARC excluding injections rate / 1,000	28.2	19.1	-32.4%	7	75	21.1
SRH Services prescribed LARC excluding injections rate / 1,000	13.9	7.5	-46.5%	14	131	13.4

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years.

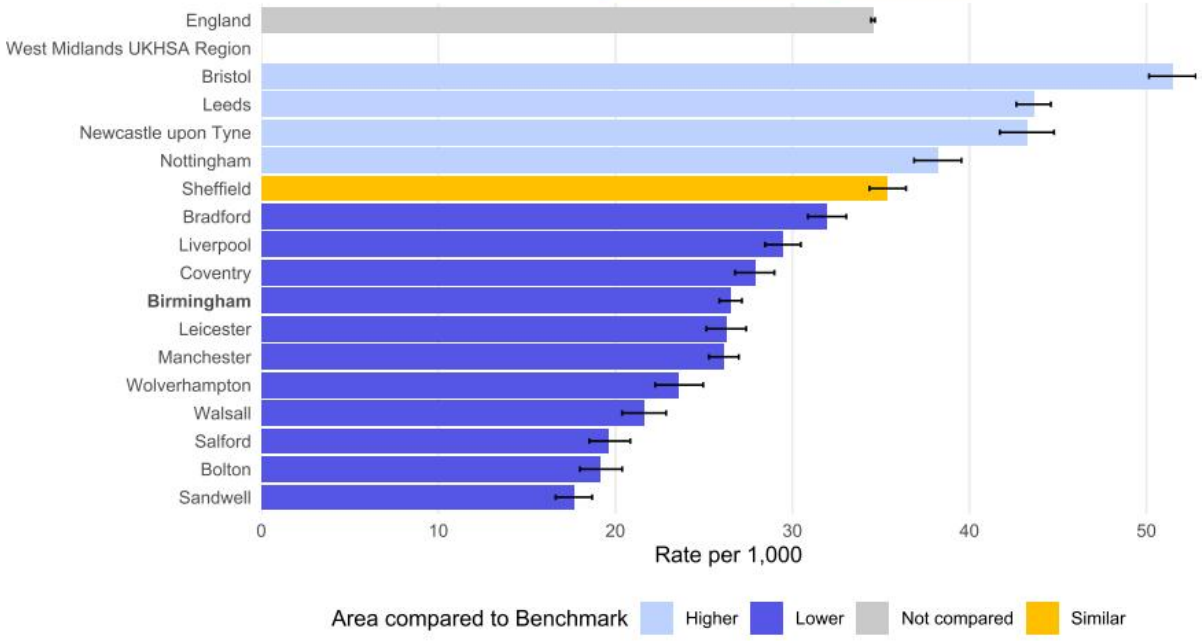
* Percent change not provided where the value in 2019 was 0.

† These are Birmingham and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

‡ Out of 149 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Figure 34. Total rate of LARC (excluding injections) prescribed in primary care and in SRH services per 1,000 women aged 15 to 44 years in 16 similar local authorities and the West Midlands UKHSA Region, compared to England: 2020

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

Data sources

- Abortions under 10 weeks (%). Data source: Department of Health based on data from abortion clinics
- Abortions under 10 weeks that are medical (%). Data source: Department of Health based on data from abortion clinics
- All new STI diagnoses rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- Antiretroviral therapy (ART) coverage in people accessing HIV care. Data source: UK Health Security Agency (UKHSA)
- Chlamydia detection rate per 100,000 aged 15 to 24. Data source: UK Health Security Agency (UKHSA)
- Chlamydia detection rate per 100,000 aged 15 to 24. Data source: UK Health Security Agency (UKHSA)
- Chlamydia diagnostic rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- Chlamydia diagnostic rate per 100,000 aged 25 years and older. Data source: UK Health Security Agency (UKHSA)
- Chlamydia proportion aged 15 to 24 screened. Data source: UK Health Security Agency (UKHSA)
- Determining PrEP need. Data source: UK Health Security Agency (UKHSA)
- Genital herpes diagnosis rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- Genital warts diagnostic rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- Gonorrhoea diagnostic rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- GP prescribed LARC excluding injections rate / 1,000. Data source: OHID based on NHS Business Services Authority ePACT2 prescribing data and Office for National Statistics mid-year population estimates
- HIV diagnosed prevalence rate per 1,000. Data source: UK Health Security Agency (UKHSA)
- HIV diagnosed prevalence rate per 1,000 aged 15 to 59. Data source: UK Health Security Agency (UKHSA)
- HIV late diagnosis in gay, bisexual and other men who have sex with men first diagnosed with HIV in the UK. Data source: UK Health Security Agency (UKHSA)
- HIV late diagnosis in heterosexual and bisexual women first diagnosed with HIV in the UK. Data source: UK Health Security Agency (UKHSA)
- HIV late diagnosis in heterosexual men first diagnosed with HIV in the UK. Data source: UK Health Security Agency (UKHSA)
- HIV late diagnosis in people first diagnosed with HIV in the UK. Data source: UK Health Security Agency (UKHSA)
- HIV testing coverage, gay, bisexual and other men who have sex with men. Data source: UK Health Security Agency (UKHSA)
- HIV testing coverage, men. Data source: UK Health Security Agency (UKHSA)
- HIV testing coverage, total. Data source: UK Health Security Agency (UKHSA)
- HIV testing coverage, women. Data source: UK Health Security Agency (UKHSA)
- Initiation or continuation of PrEP among those with PrEP need. Data source: UK Health Security Agency (UKHSA)
- Mycoplasma genitalium diagnostic rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- New HIV diagnoses among persons first diagnosed in the UK rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- New HIV diagnosis rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- New STI diagnoses (excluding chlamydia aged under 25) per 100,000. Data source: UK Health Security Agency (UKHSA)
- Over 25s choose LARC excluding injections at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data
- Over 25s abortion rate / 1000. Data source: Department of Health based on data from abortion clinics
- Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV. Data source: UK Health Security Agency (UKHSA)
- Repeat HIV testing in gay, bisexual and other men who have sex with men. Data source: UK Health Security Agency (UKHSA)

- SRH Services prescribed LARC excluding injections rate / 1,000. Data source: OHID based on NHS Digital SRHAD data and Office for National Statistics mid-year population estimates
- STI testing positivity (excluding chlamydia aged under 25). Data source: UK Health Security Agency (UKHSA)
- STI testing rate (exclude chlamydia aged under 25) per 100,000. Data source: UK Health Security Agency (UKHSA)
- Syphilis diagnostic rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- Teenage mothers. Data source: Hospital Episode Statistics (HES)
- Total abortion rate / 1000. Data source: Department of Health based on data from abortion clinics
- Total prescribed LARC excluding injections rate / 1,000. Data source: OHID based on NHS Digital SRHAD data, NHS Business Services Authority ePACT2 prescribing data and Office for National Statistics mid-year population estimates
- Trichomoniasis diagnostic rate per 100,000. Data source: UK Health Security Agency (UKHSA)
- Under 16s conception rate / 1,000. Data source: Office for National Statistics (ONS)
- Under 18s abortions rate / 1,000. Data source: Department of Health
- Under 18s births rate / 1,000. Data source: Office for National Statistics (ONS)
- Under 18s conception rate / 1,000. Data source: Office for National Statistics (ONS)
- Under 18s conceptions leading to abortion (%). Data source: Office for National Statistics (ONS)
- Under 25s abortion after a birth (%). Data source: Department of Health
- Under 25s choose LARC excluding injections at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data
- Under 25s individuals attend specialist contraceptive services rate / 1000 - Females. Data source: OHID based on NHS Digital SRHAD data and Office for National Statistics mid-year population estimates
- Under 25s individuals attend specialist contraceptive services rate / 1000 - Males. Data source: OHID based on NHS Digital SRHAD data and Office for National Statistics mid-year population estimates
- Under 25s repeat abortions (%). Data source: Department of Health
- Violent crime - sexual offences per 1,000 population. Data source: OHID's Population Health Analysis Team using Home Office crime data and ONS population data
- Virological success in adults accessing HIV care. Data source: UK Health Security Agency (UKHSA)
- Women choose hormonal short-acting contraceptives at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data
- Women choose injections at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data and Office for National Statistics mid-year population estimates
- Women choose user-dependent methods at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data

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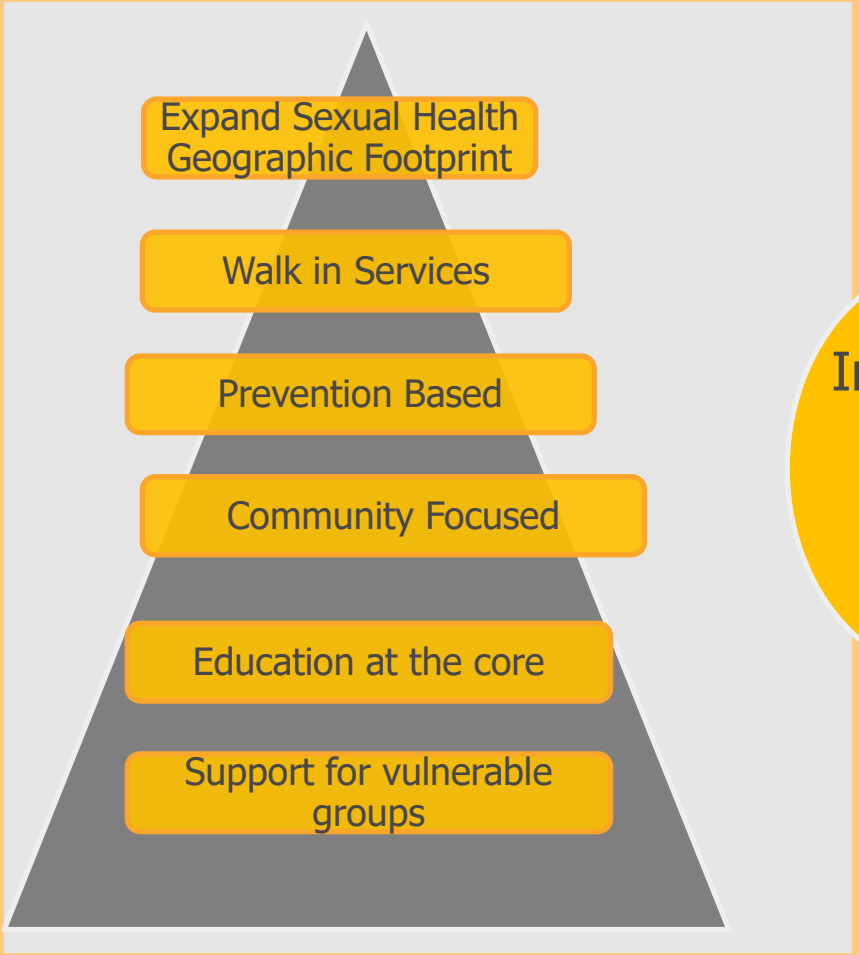
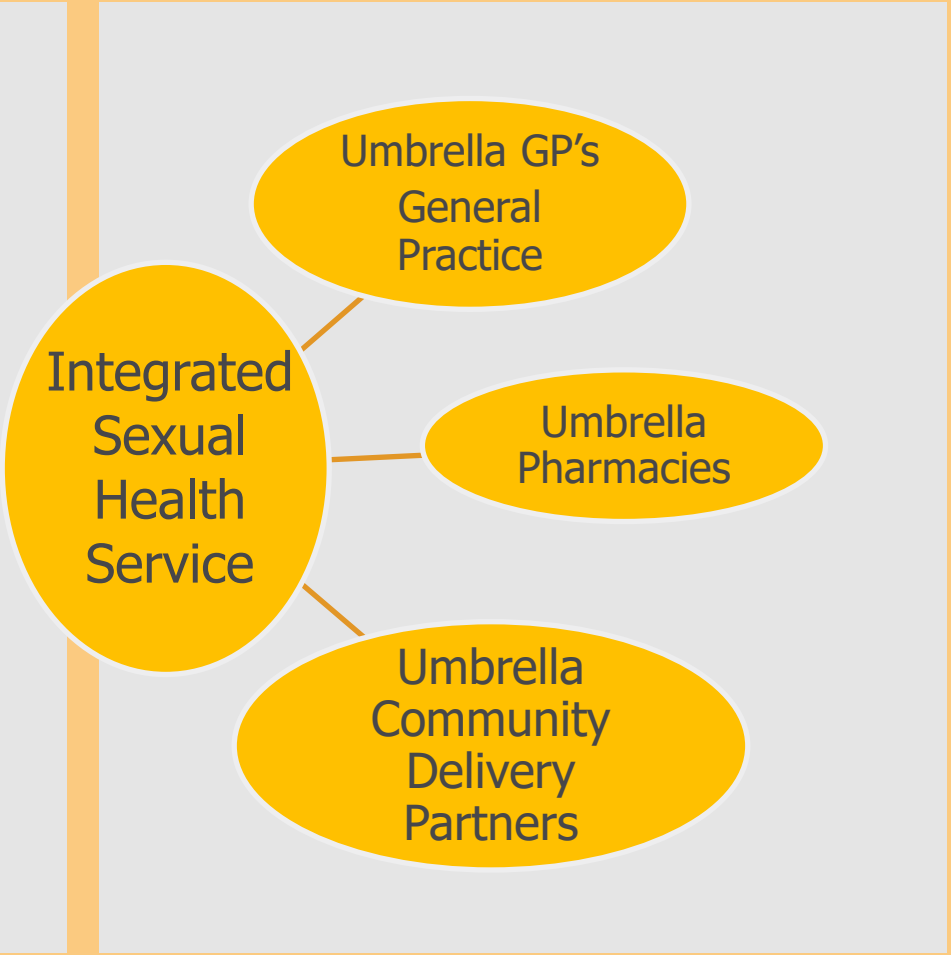
Oversight and Scrutiny Committee
Tuesday 21st February 2023

umbrella

Umbrella Pledge in 2015





A New Landscape Umbrella focus 2021/2022

Increase activity

Resilience training. Staff Engagement Sessions

GP, Pharmacy forums, Young Persons meeting

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Year 7 - In Numbers
Increases in all areas

01 August 2021 – 31st July 2022

- **83,670 Total clinic attendances 14% increase**
- **55,376 Self testing kits 26% increase**
- **51,964 all age contraceptives 31% increase**
- **3,661 ≤ 18 years contraceptives 23% increase**
- **9,636 LARC fittings 11% increase**
- **23,209 chlamydia screens age 15 -24 yrs increase of 44%**
- **38,193 HIV tests 58% increase**
- **913 new PrEP patients 17% increase**
- **9 Umbrella Campaigns**
- **1000 patients accessing CHAThealth, since launch in November 2022.**
- **407,393 hits on the Umbrella Website**

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Umbrella Support for Monkeypox (Mpox)

July 2022 – December 2022

- 597

Vaccines administered

- 130

130

MPV tests undertaken

- Ongoing Opportunistic Testing

Continued support

Umbrella in Numbers – Delivery Partners

- Birmingham Youth Service 10,999 Clinical Interventions
- BLGBT 5,267 Clinical Interventions
- Birmingham & Solihull Women's Aid 291 contacts
- Rape and Sexual Violence Project 3,818 Interventions
- Loudmouth 139 Group sessions (17,281 attendees)
- 6, 431 GP LARC Attendances
- 57, 631 Pharmacy contacts 28% increase

Vision for 2023
A New Landscape

Apps, telemedicine, telehealth at scale in communities

YP one stop clinic

Focus on older people 40+ yrs

ChatHealth

Increase LARC

Umbrella Research

umbrella
Birmingham and Solihull Sexual Health

Umbrella Summary Report

Period: 01 August 2021 to 31 July 2022

Table of contents

1) Executive summary and background

In August 2015, Birmingham City Council (BCC) and Solihull Metropolitan Borough Council (SMBC) commissioned Umbrella to provide a new, unique, outcomes-based sexual health service that would enable greater access to sexual health services for all Birmingham and Solihull residents.

Prior to Umbrella, the sexual health service model had been fragmented, treatment-based and predominantly delivered in specialist clinical centres. Umbrella transformed the model into a prevention-based, community-focused service with education, empowerment and self-care at its core.

Umbrella achieved this greater access through an innovative combination of training, education, health promotion and partnership working, building the most integrated sexual health service for all of its service users. Umbrella is now in its seventh year and this year 7 summary report focuses on the service's 5 key outcomes from 1 August 2021 to 31 July 2022.

2) Contractual Arrangements

The 2015 contract award was for 5+ 2 years. The two year option to extend was initiated with a further contract amendment on 8th July 2021. The two councils planned to tender the service in 2021 with a completion date of March 2022.

However, instead of going out to tender the commissioners recommended three Quality Improvement (QI) programmes to be undertaken over a 6 month period, from October 2022 to March 2023. The service is in the process of working with the councils to take the recommendations forward. The three QI areas are outlined below.

QI AREA	AIM
LARC (Long Lasting Reproductive Contraception)	Improving the provision of LARC across Birmingham and Solihull.
PrEP (Pre-Exposure Prophylaxis)	Ensuring the service is engaging everyone.

Business Continuity	Review of clinic provision , communication, website and delivery partners

Outcome 1: Reducing under-18 conceptions

Why this outcome is important

It is widely understood that teenage pregnancy and early motherhood can be associated with poor educational achievement, poor physical and mental health, social isolation, poverty and related factors. There is also a growing recognition that socio-economic disadvantage can be both a cause and a consequence of teenage motherhood.

Ensuring that under-18 year olds are aware of Umbrella services and are provided with access to services is an essential aim for Umbrella.

Figure 1 identifies emergency hormonal contraception (EHC) as the most frequently used form of contraception in Birmingham at 67% (a marginal decrease from year 6 at 69%).

Figure 1: *Period: 01-Aug 21 to 31-Jul 2022*

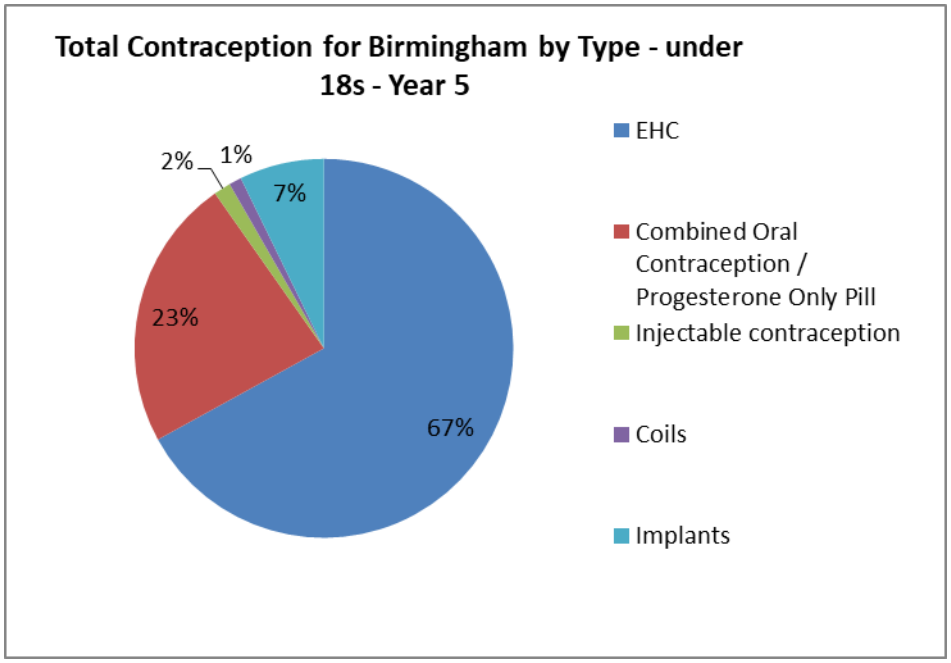
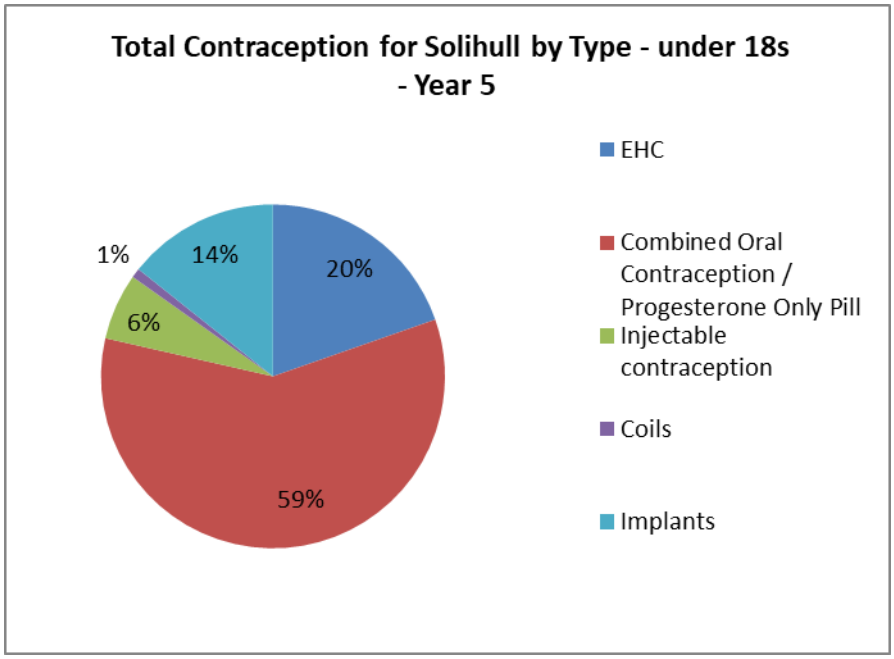


Figure 2 indicates that in Solihull the most widely used contraception is the Progestogen - only pill (POP)/Combined Oral Contraception at 59 % of the total in year 7. This is a marginal reduction in the number of the Progesterone only Pill from

year 6 which recorded an uptake of 64%. The rate of uptake of EHC in Solihull is significantly lower at 20% than in Birmingham, this is in part due to the fact that Solihull Council does not commission Umbrella GP's and Pharmacies.

Figure 2: *Period: 01-Aug 2021 to 31-Jul 2022*



All age Contraception. Year 7: Period: 01 Aug 21 to 31 Jul 22

Umbrella will work to increase the use of reliable forms of contraception for all age groups, including LARCs and oral contraception in both Birmingham and Solihull as one of our key Quality Improvement objectives. This will include a focus on a combination of health promotion campaigns and increased activity within clinics.

In year 7 a total of 51.964 contraceptions were administered cross Birmingham and representing a 31% increase compared to Year 6.

Table -2- overall Umbrella contraception

	Umbrella			
	Clinic	Pharmacy	GP	**total**
LARC Total Fittings (Coil,Implant,Injectable)	2,828	377	6,431	**9,636**
EHC Provided	998	29,958	-	**30,956**
POP/COC	3,282	8,090	-	**11,372**
Total	**7,108**	**38,425**	**6,431**	**51,964**

Table 3 outlines the number of contraception delivered in Solihull within Umbrella clinics. Solihull does not commission Umbrella services within Pharmacies and GPs

Table -3- Contraception Solihull

Solihull			
Clinic	Pharmacy	GP	**Total**
340	-	-	**340**
89	-	-	**89**
378	-	-	**378**
807	**0**	**0**	**807**

Figure 1 – Contraception by type Birmingham.

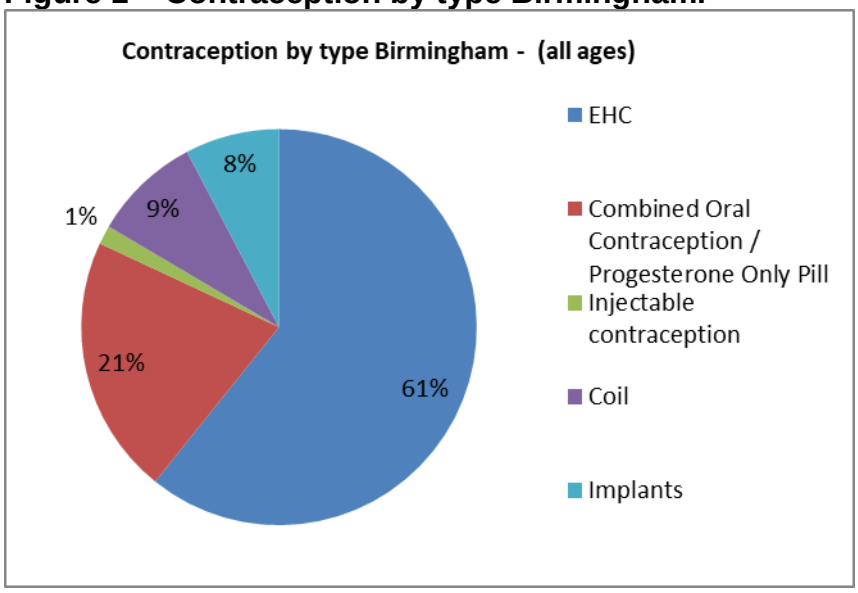
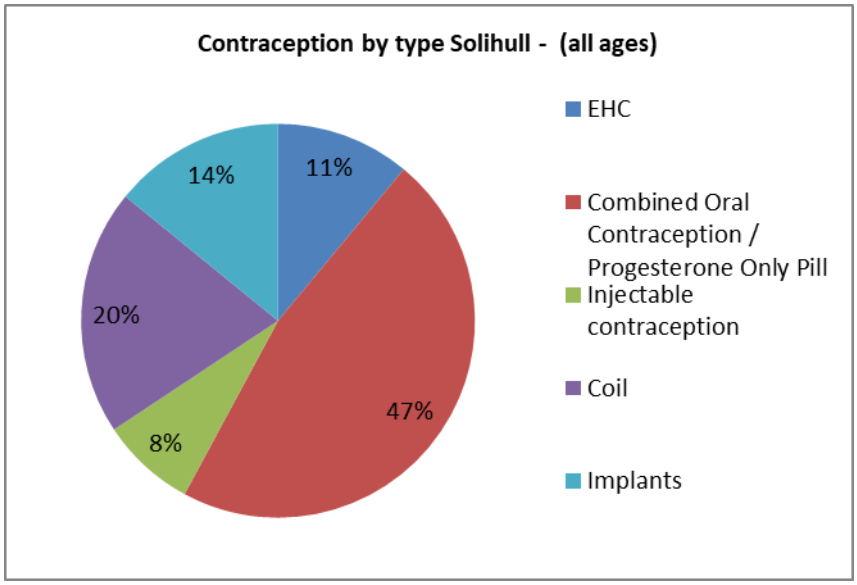


Figure 2 Contraception by type Solihull.



Outcome 2: Increasing chlamydia diagnoses in the 15-24 age group

Why this outcome is important

The prevalence of chlamydia infection is highest in young sexually active adults (15–24 year olds). The aim is to reduce the infection rate across Birmingham and Solihull through early detection and treatment, particularly of asymptomatic patients in order to prevent further transmission of the infection.

As can be seen in Figure 1 and 2 below, the majority of screening takes place through home sampling STI testing kits 58% for Birmingham City and 61% for Solihull.

Figure 1: *Birmingham chlamydia screening 15-24 year old*

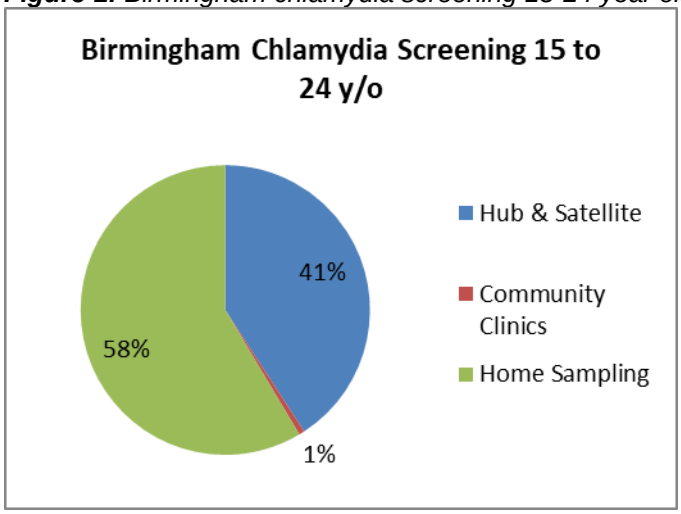


Figure 2: Solihull chlamydia screening 15-24 year olds

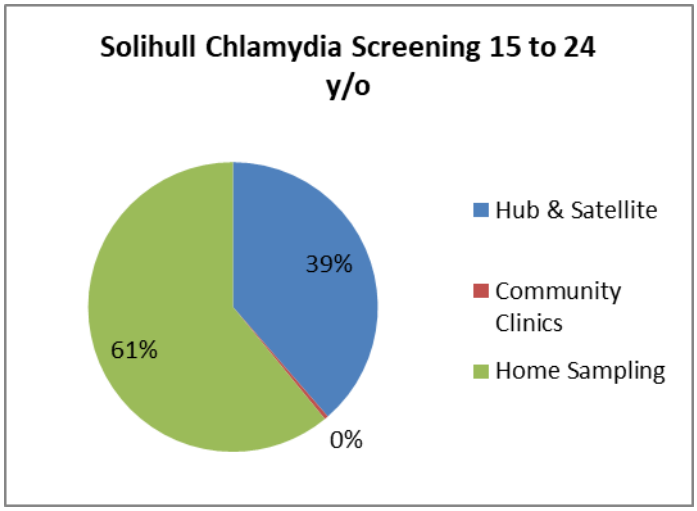
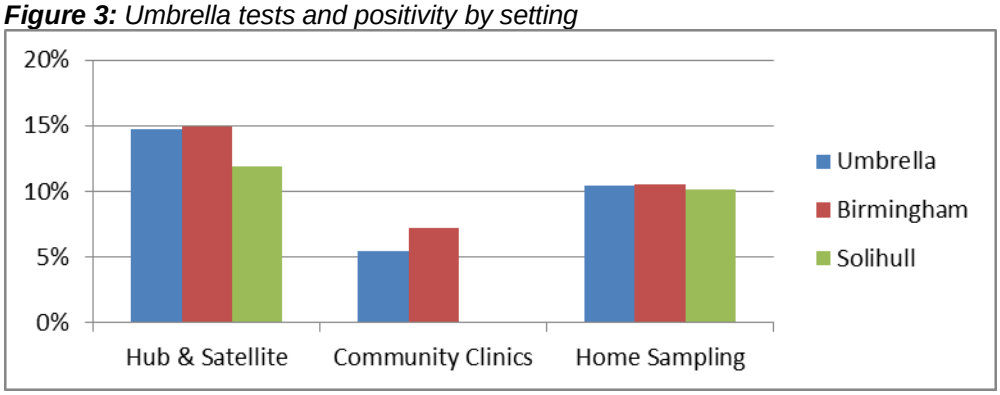


Figure 3 below outlines the positivity rates for all Umbrella chlamydia activity across Birmingham and Solihull based on where the test was initiated. There was a 7% positivity rate within the Birmingham community clinics. The Birmingham and Solihull hub and satellite clinics saw a 15 % and 12% positivity rate with a 10% positivity rate for STI self-sampling screening for Birmingham and Solihull.

The overall positivity rate for Birmingham was 12% and 11% for Solihull. This high level of positivity indicates that our health promotion campaigns are targeting the right people and encouraging those with the highest need to get tested.

Figure 3: *Umbrella tests and positivity by setting*



Umbrella Chlamydia Tests and Positivity by Gender

Figures 4 and 5 below highlight the gender spilt for chlamydia testing in Birmingham and Solihull to be approximately two thirds female, and one third male.

Of those tested in Birmingham, 13,559 were female with a 12% positivity rate. This represents a 37% increase in the number of females tested compared to year 6.

The number of males tested in Birmingham increased by 33% compared to Year 6 with a corresponding increase in the positivity rate of 14% compared to 12.25% in year 6.

In Solihull, 1,315 females were tested for Chlamydia representing an increase of 25% compared to Year 6 with a positivity rate of 10%.

There was an increase of 35% for Males tested in Solihull compared to year 6. The male positivity rate remains the same at 12%.

Figure 4: **Birmingham positivity by gender**

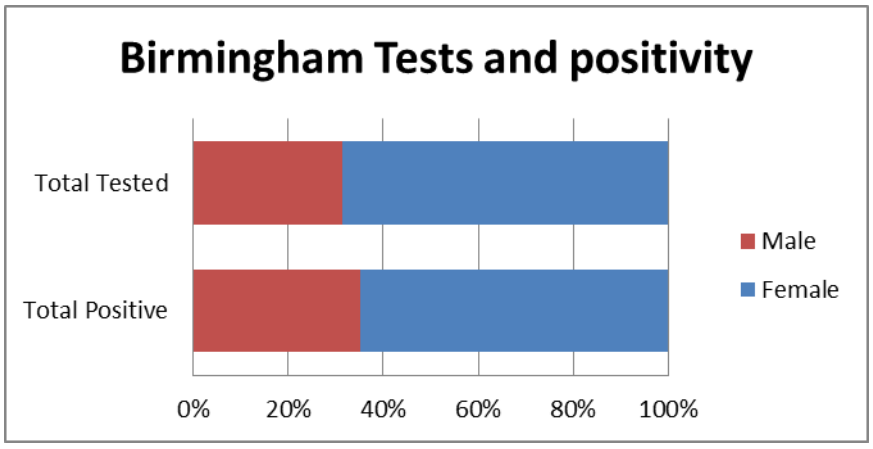
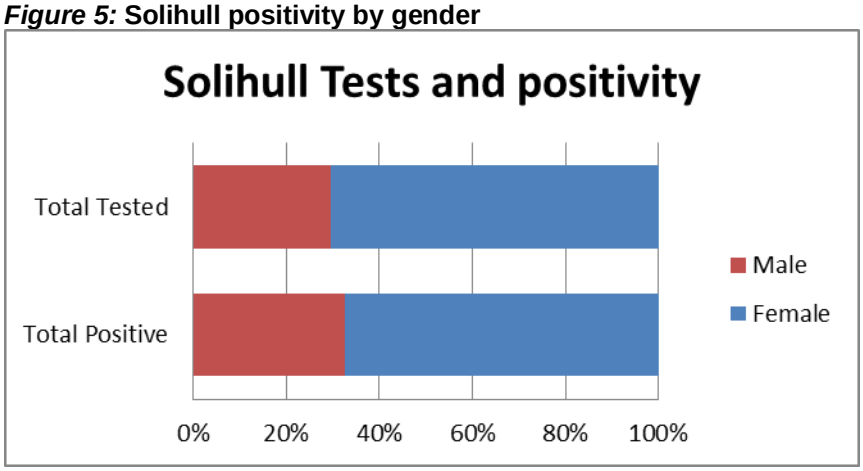


Figure 5: **Solihull positivity by gender**



Outcome 3: Reducing the late diagnosis of HIV

Why this outcome is important

A late diagnosis is made at a point in time after which HIV treatment should have been started. Reducing late diagnosis is important, because not taking treatment until the immune system is severely weakened increases the chances of developing serious, life-threatening illnesses.

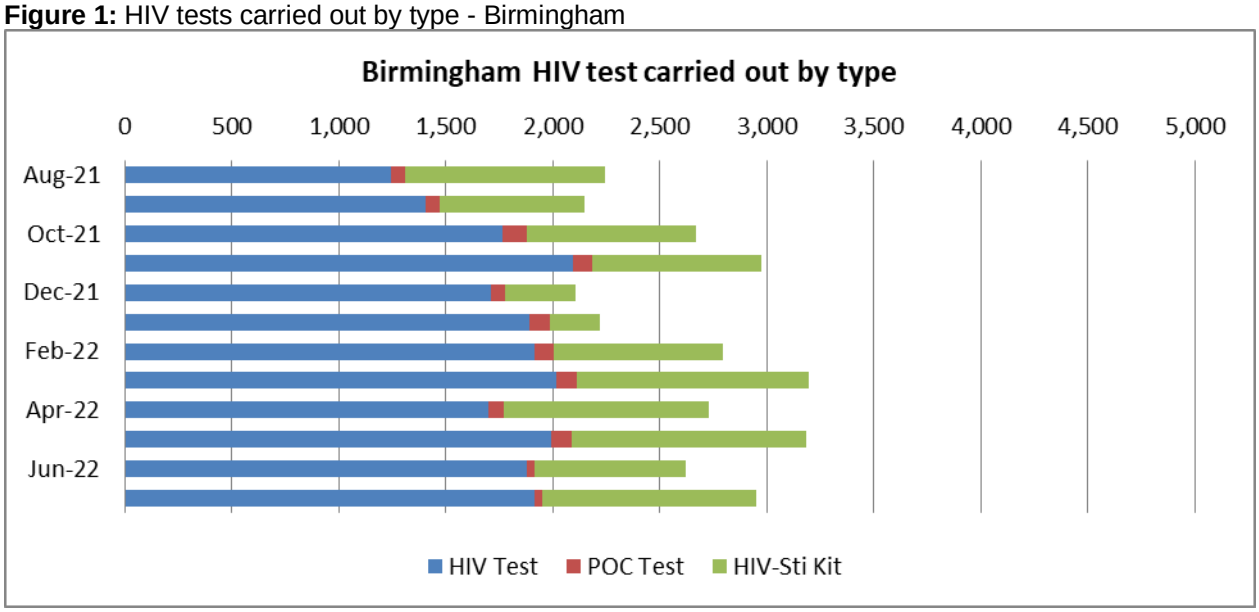
HIV treatments have seen significant improvements over the past few years and one of the key messages that Umbrella is seeking to communicate is that HIV is now a chronic disease that can be managed and that the medication now available, if accessed early enough, can enable an infected individual to achieve a near-normal life expectancy.

Umbrella carried out a total of 38,193 HIV tests in year 7.This is an increase of 58% compared to year 6.

Figures 1 & 2 below outlines the route of testing within Birmingham and Solihull. The majority of testing for Birmingham takes place within Umbrella clinics (21,519) However, a significant proportion is also carried out through self-sampling STI kits (9,394). There was also 935 Point of Care Tests (POCT) undertaken. These take place in a small number of high-risk outreach settings and provide an immediate result, rather than the sample needing to be sent back to the laboratories.

There were 31 confirmed positive test results within Birmingham and 5 within Solihull

Figure 1: HIV tests carried out by type - Birmingham



Within Solihull a total of 2,107 tests were carried out in Umbrella clinics, 64 POC tests and 1,065 HIV STI tests

Figure 2: HIV tests carried out by type – Solihull

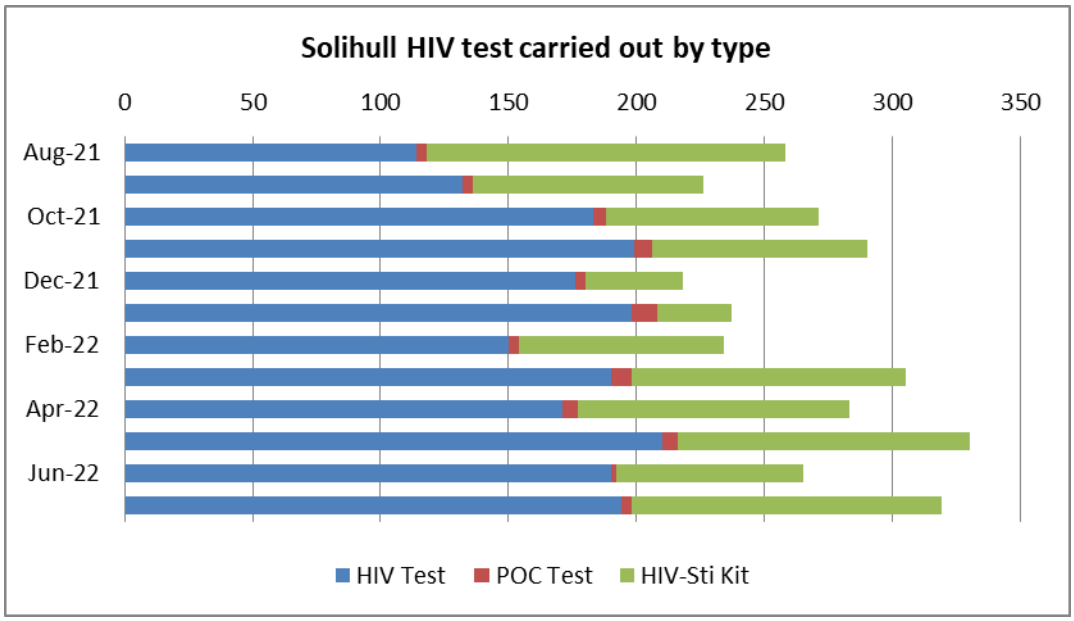
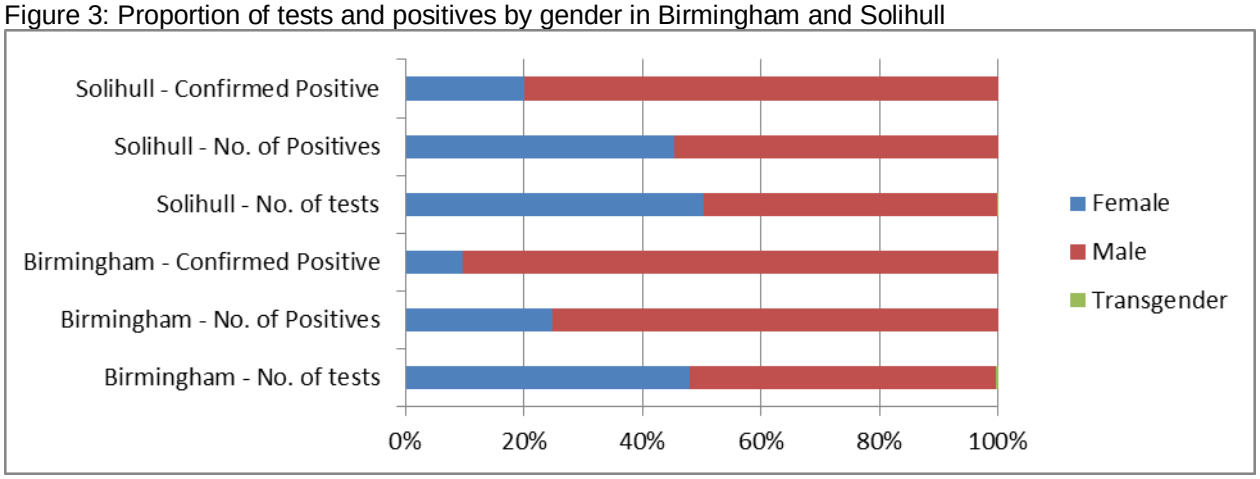


Figure 3 below outlines the number of female and male HIV tests carried out in year 7. There is an almost even split between both male and females testing in both Birmingham and Solihull. Within Birmingham 15,276 females were tested, 16,414 males and 141 transgender patients. In Solihull 1,627 female and 1,602 males were tested and 6 transgender patients

Figure 3: Proportion of tests and positives by gender in Birmingham and Solihull



HIV Pre-Exposure Prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) is a form of HIV prevention that uses anti-HIV drugs to protect HIV-negative people from acquiring HIV.

Umbrella introduced PrEP as part of mainstream service delivery in October 2020. This followed Umbrella's successful involvement in the national PrEP Impact Trial from March 2018 to March 2020. In year 7 a total of 913 new patients were started on PrEP (August 2021 July 2022) representing an increase of 17% from Year 6.

Outcome 4: Improving support for people vulnerable to, and victims of, sexual coercion, sexual violence and exploitation

Why this outcome is important

Sexual violence covers a wide range of abusive acts directed towards an individual's sexuality, including sexual assault, rape, sexual coercion, honour-based marriage, human trafficking and female genital mutilation.

One of the settings in which the first disclosure of rape or sexual assault occurs is often an NHS sexual health clinic.

Umbrella, in partnership with the Rape and Sexual Violence Project (RSVP), and Birmingham Lesbian, Bisexual and Transgender (LGBT) have developed improved support for survivors of sexual violence.

All patients who attend Umbrella clinics regardless of the reason are routinely asked to complete a self-assessment to assess whether they have experienced sexual violence and abuse, as well as domestic abuse, and if so, whether they would like to access support on the day that they are attending.

During 2021-2022, 3,818 interventions were carried out by Umbrella's Independent Sexual Violence Advisors (ISVA).

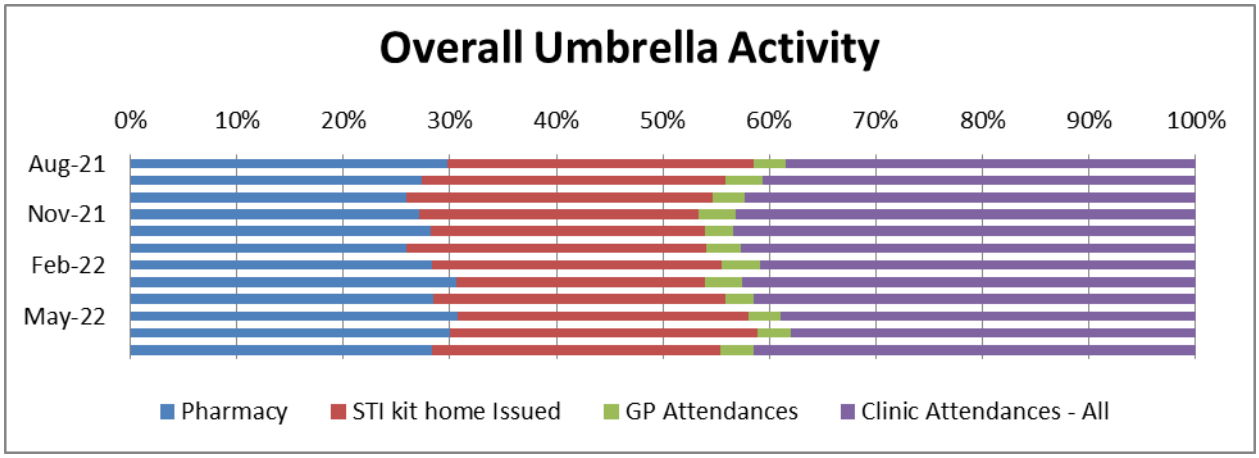
Umbrella's partnership with Birmingham and Solihull Women's Aid (BSWAID) provides Umbrella with an Independent Domestic Violence Advisor (IDVA) to support victims of domestic abuse. From August 2021 to July 2022, the Umbrella IDVA had 291 contacts. The inter-relation with RSVP and BSWAID as key delivery partners provides a complementary and integrated service for patients who have experienced sexual or domestic violence.

Outcome 5: Providing better access to services for high-risk communities

Why this outcome is important

This outcome will help to reduce the stigma associated with STIs by 'normalising' testing among sexually active people. To do this, services need to be easily accessible. Umbrella see this outcome as central to increasing the rate of testing and reducing the risk of transmission. To deliver on this outcome, we engage with partners across the system as well as providing access within Umbrella clinics.
As seen in **figure 1 below** the overall activity for year 7 broken down by various access points was 203,108, representing a 13% increase from year 6

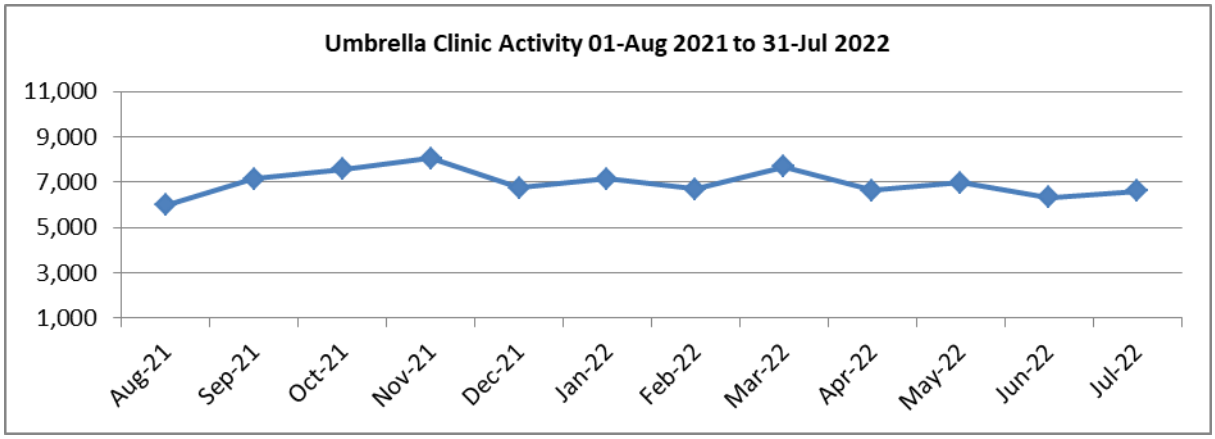
Figure 1 below outlines overall Umbrella activity 01-Aug 21 to 31-Jul 22



Clinic Activity

Within Umbrella clinics there were 83,670 attendances which is a 14% increase from year 6.

Figure 1: Umbrella clinic activity



Umbrella serves an ethnically diverse population and recognises the need to ensure that all groups within our community feel that Umbrella is a service that is there for them.

Attendance in clinic is monitored to help understand which population groups are accessing services and to evaluate which communication messages are working with which groups, and target campaigns more effectively.

Figure 1: Birmingham attendances by ethnicity

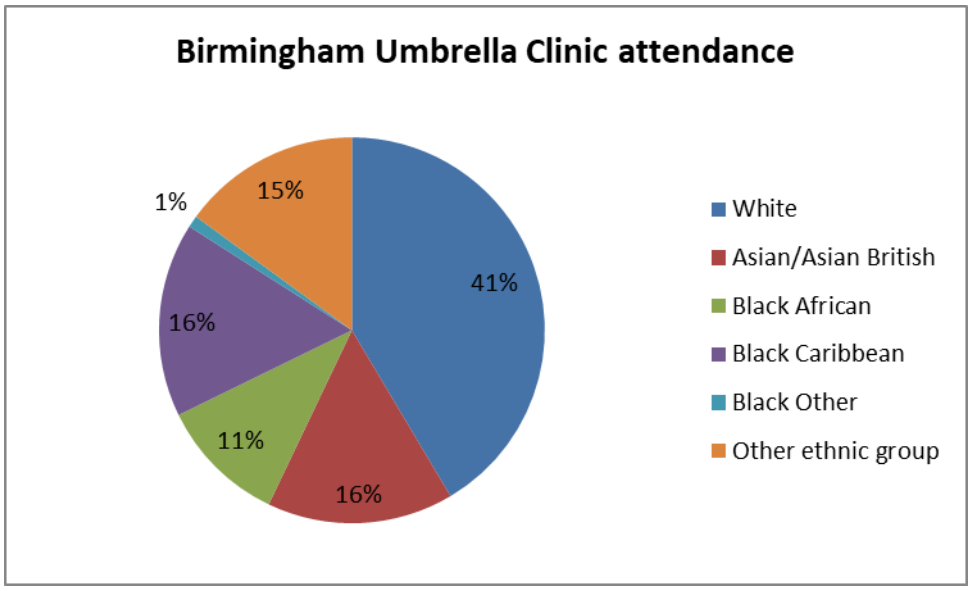


Figure 2: Birmingham attendances by ethnicity per 100,000

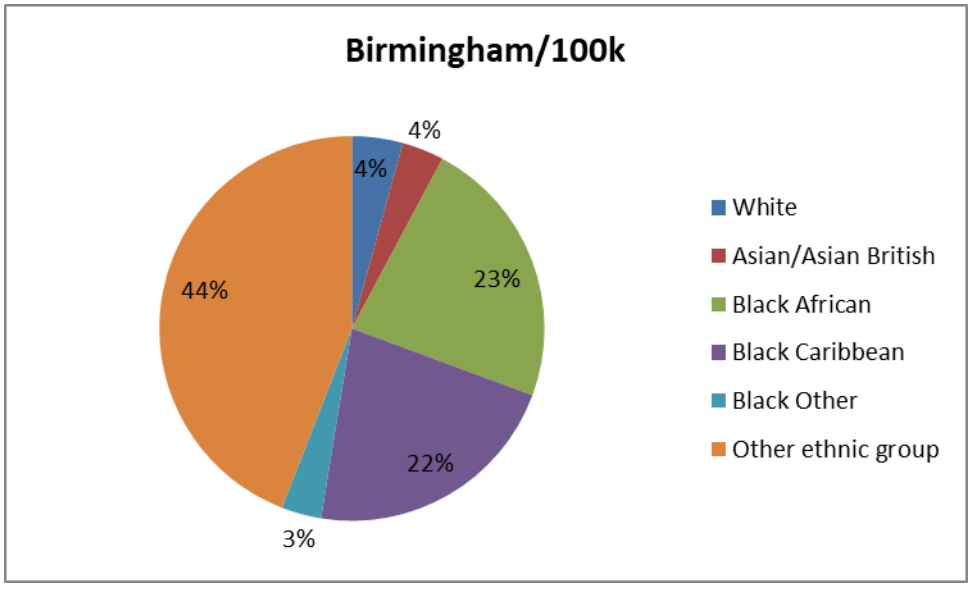


Figure 3: Solihull attendances by ethnicity

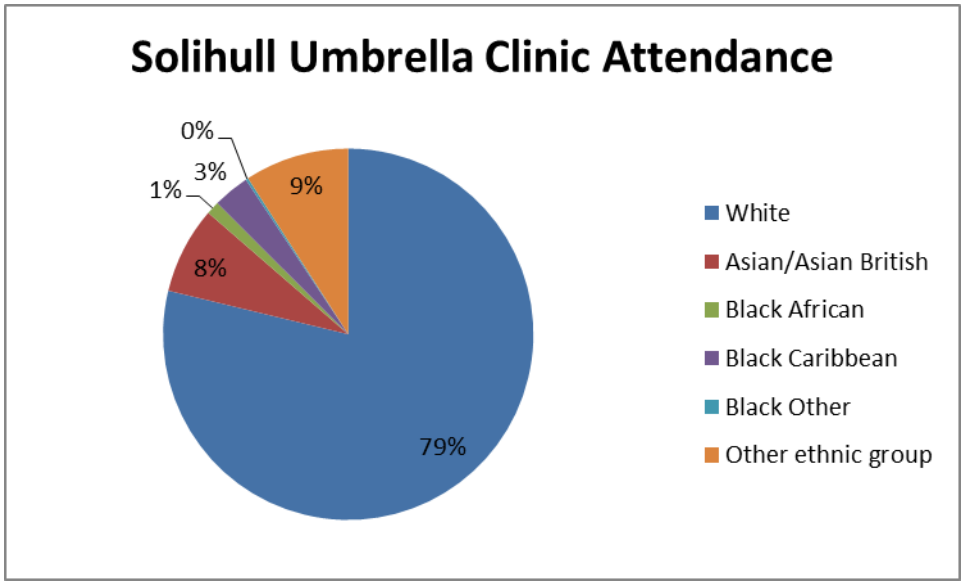
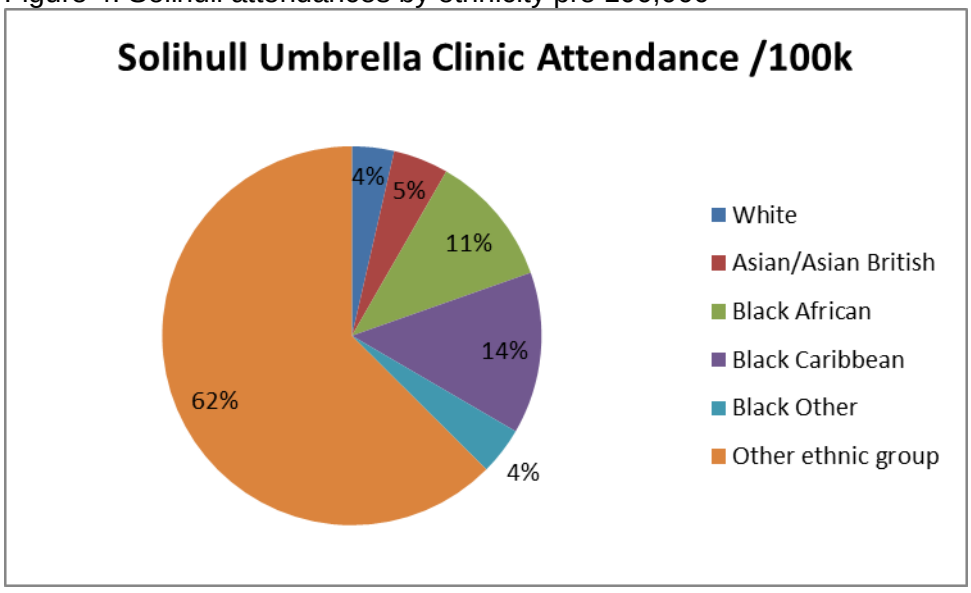


Figure 4: Solihull attendances by ethnicity pre 100,000



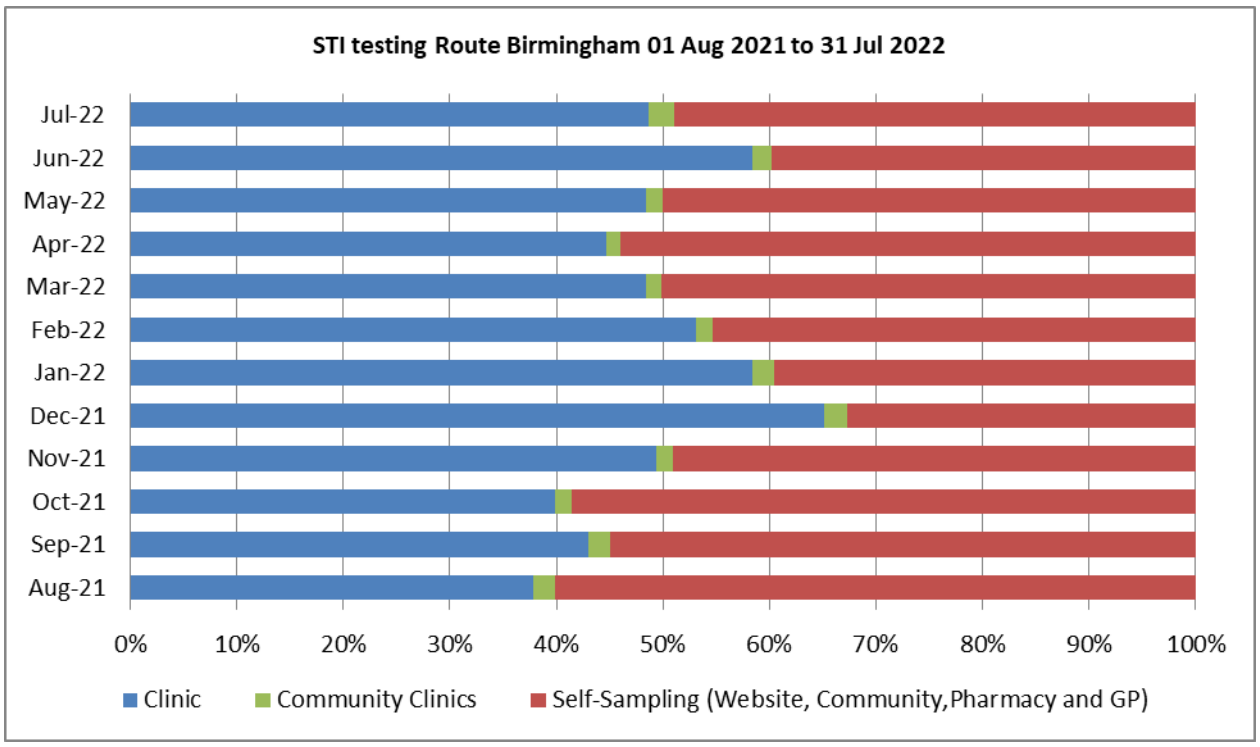
Reducing the number of people repeatedly treated for STI's.

By encouraging more people to be tested via all Umbrella access routes, we can reduce the number of people repeatedly treated for STI's.

Figure 1outlines the various access points in which patients are tested for Sexually Transmitted Infections (STI's). The Umbrella clinics continue to test the highest number of patients. As indicated below, in year 7, 24,307 patients were tested within Umbrella clinics, representing an increase of102% compared to year 6.

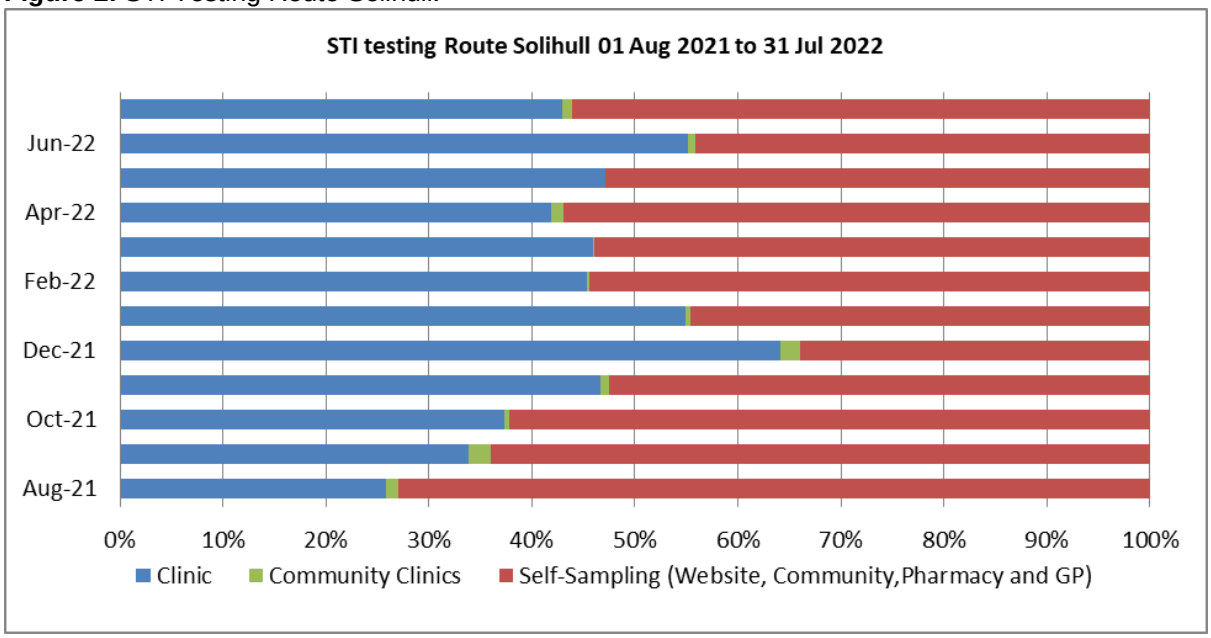
Patients also use the STI self testing kits as an accessible method of testing. Throughout year 7, there were 24, 346 tests carried out via the home sampling STI Kit ordering route, representing an increase of 32% compared to year 6

Figure 1: STI Testing Route Birmingham



There were 5,704 tests carried out within Solihull across all testing routes, representing an increase of 56% compared to year 6. When broken down by testing access routes 3,133 comprised kits ordered via the Umbrella website indicating an increase of 24% compared to year 6 and 2,526 were tested within Umbrella clinics, representing an increase of 129% compared to year 6.

Figure 2: STI Testing Route Solihull.



Figures 3 and 4 below outline the type of tests carried out for Birmingham and Solihull.

Figure 3: Type of *Tests* - Birmingham

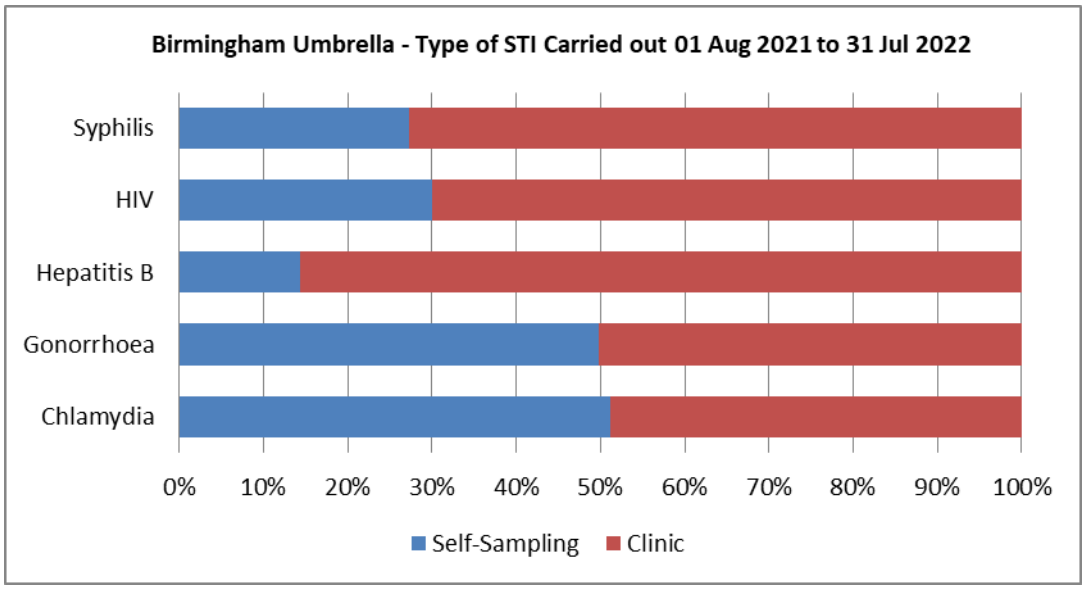
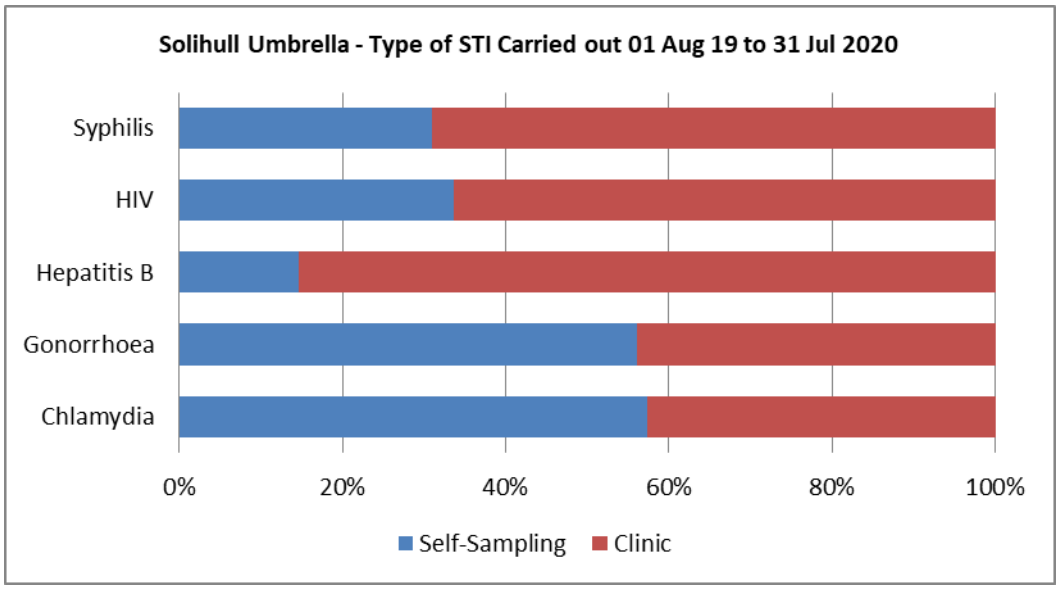


Figure 4: Type of Tests – Solihull



Umbrella Highlights Year 7

The Umbrella service has been through a number of changes throughout the past 7 years, mainly due to the impact of the COVID-19 pandemic, and to a lesser degree MonkeyPox, but also as a result of reflecting on what has worked well and introducing improvements, for example mainstreaming the provision of PrEP and the introduction of CHATHealth.

Some of the Year 7 highlights are detailed below:

Mainstream introduction of PrEP

Following the success of the PrEP Impact Trial from March 2018 to March 2020. PrEP became embedded within Umbrella's mainstream service delivery.
From March 2020 to July 2022, the service provided PrEP to 1,694 new patients.
In year 7, there were 913, new PrEP patients, all of whom continue to have follow up monitoring and prescriptions.

Partnership with Birmingham and Solihull Women's Aid.

The partnership with Birmingham and Solihull Women's Aid (BSWAID) and appointment of an Independent Domestic Violence Advisor (IDVA) working alongside the clinical Health Advisor team is a further highlight. The IDVA compliments the work undertaken by the Independent Sexual Health Advisor (ISVA) in securing support for patients affected by domestic and sexual abuse.

ChatHealth

More recently Umbrella has implemented CHATHealth, a digitally safe platform in which Clinicians can send and receive SMS messages from patients.

This service supports under 18 year old patients and other service users with advice on any of the issues listed below.

- Sexual assault
- Domestic abuse
- Untreated Gonorrhoea, Chlamydia, Syphilis and Mycoplasma Genitalium
- Trichomonas (TV)
- PEPSE

Since the launch in November 2022, the Umbrella Health Advising (HA) team has had 1000 service users with 627 messages received, and 1076 messages sent by the team. This is an excellent outcome with the system currently managed solely by Umbrella HA support staff. Umbrella is keen to harness the opportunities Digital Health can provide without losing the connection and insight that follows face to face interactions.

Older adults 40+ accessing Sexual Health Services.

Although the Umbrella service engages with a large percentage of young people a recent report carried out by the Local Government Association (LGA) has highlighted an increasing number of older adults who are accessing sexual health services.

The report states:

> The number of over-65s who caught common STIs rose from 2,280 in 2017 to 2,748 in 2019, an increase of 20%. Latest official data also showed that the age group accounted for the biggest proportional increases in cases of gonorrhoea and chlamydia.

This research signals the importance of reaching out to all age demographics when promoting safe sexual health. We have taken this knowledge on board and included a campaign specifically focused on the over 40 age group in May 2023. The campaign will run for 4 weeks as part of Umbrella's well-established Campaign schedule for 2023.

Monkeypox (MPVX)

The Umbrella service provided opportunistic testing and vaccinations for patients attending clinics who met the MPVX criteria. From July 2022 to December 2022 597 MPVX vaccines where administered, and 130 tests carried out.

Umbrella continues to provide ongoing testing and support to those patients who are eligible.

Year 7 overall increase in activity

The service has demonstrated increases in activity throughout year 7 compared to Year 6. As outlined below.

- 83,670 Total clinic attendances 14% increase
- 55,376 Self testing kits issued 26% increase
- 51,964 all age contraceptives 31% increase
- 3,661 ≤ 18 year contraceptives 23% increase
- 23,209 chlamydia screens age 15 -24 yrs 44% increase
- 38,193 HIV tests 58% increase
- 913 new PrEP patients 17% increase

Conclusion

A Renewed Umbrella Vision 2023.

The focus throughout 2022 has been to recover the service to pre-Covid levels of activity and ensure the support and well-being of staff who provided so much support throughout the pandemic.

The increases in key activity areas demonstrate the progress made in Year 7 to bridge the 18% gap in clinical activity and 7% gap in overall Umbrella contacts. The latter includes GP's Pharmacies and STI home issued testing kits.

The Umbrella service recognises that the landscape has significantly changed since the service began in 2015. As a service we aim to adapt to the changing profile of sexual health. For example by introducing enhanced digital options, such as ChatHealth and responding to the recent LGA report on the age demographics of older adults accessing sexual health service.

We will also aim to improve the delivery of high quality sexual and reproductive healthcare through Umbrella's program of health care services research.

Umbrella's partnerships play a key role in supporting our outcomes. However, we are keen to extend our reach into groups who find it hard to access sexual health services. For example, the Birmingham Institute for the Deaf (BID) and Birmingham and Solihull Mental Health Trust Services are two community partners we intend to work with in the coming year.

In conclusion, the Umbrella vision has evolved over the past 7 years. As we move forward there will be a renewed focus that reflects the learning accumulated from our experience in providing a fully integrated sexual health service.

Within an ever changing landscape, Umbrella will be adaptive, make quality improvements, listen to our patients and focus on providing an enhanced sexual health service for the population of Birmingham and Solihull.

Birmingham City Council

Health and Social Care Overview and Scrutiny Committee

09.02.23

Subject:	Strategic Overview of Immunisations in Birmingham
Report of:	Kate Woolley (Director of Immunisations & Vaccinations, BSol ICB) Mary Orhewere (Assistant Director, Public Health, Birmingham City Council)
Report author:	Kate Woolley (Director of Immunisations & Vaccinations, BSol ICB) Mary Orhewere (Assistant Director, Public Health, Birmingham City Council) Helen Bissett (Senior Officer, Public Health, Birmingham City Council)

1 Purpose

1.1 The purpose of the paper is to provide information to committee members about what immunisation uptake looks like in Birmingham, local immunisation system roles and an indication of local challenges faced when working to improve immunisation uptake across the city.

1.2 This paper gives a broad overview of the immunisations in Birmingham in advance of a more detailed paper (which will be presented at April's HOSC meeting). Any discussion and feedback from committee members will influence the focus of this April paper.

2 Recommendations

2.1 To note the contents of this report.

2.2 This strategic overview paper, the upcoming April paper and any discussion and recommendations from HOSC committee members will be shared with all immunisation system partners to influence future work and planning.

3 Any Finance Implications

3.1 None.

4 Any Legal Implications

4.1 None.

5 Any Equalities Implications

5.1 There is high variation and inequity of vaccination uptake across Birmingham. This means that behind Birmingham's low uptake rate, there will be specific communities that experience even lower rates. Improving uptake while reducing this inequity is essential to ensure all citizens in Birmingham receive equitable benefit from vaccination programmes.

6 Appendices

6.1 Strategic Overview of Immunisations in Birmingham

6.2 Strategic Overview of Immunisations in Birmingham (slides)

Strategic Overview of Immunisations in Birmingham

BACKGROUND

Immunisation prevents disease and protects the health of the local population. Immunisations and vaccinations are delivered to people who are well as an ongoing protective and preventative healthcare strategy, from birth to older age, as part of a basic foundation of good health and wellbeing.

Immunisation is one of the most effective and evidence based public health measures after clean water and has a huge impact on reducing infectious disease and death due to vaccine preventable disease, especially in children. Immunisations and vaccinations are also given in response to emerging infectious diseases, providing protection against significant outbreaks and pandemics. It is one of the most cost-effective public health interventions and reduces people getting avoidable disease and therefore saves expenditure in other areas of healthcare.[i]

The complete routine immunisation schedule is published by the UK Health Security Agency (UKHSA).

The purpose of this paper is to give the Health Overview & Scrutiny Committee a brief strategic overview of immunisations and vaccinations in Birmingham, and associated challenges with uptake. This paper will be followed up with two more detailed papers to be presented at the April committee meeting. The two papers will be authored by the ICB and Public Health respectively.

SYSTEM ROLES

Immunisation and vaccination services are commissioned by NHS England. The primary responsibility for uptake improvement in the different immunisation programmes sits with NHS England's local screening and immunisation teams (SITs).

The Birmingham & Solihull (BSol) Integrated Care Board (ICB) take a systems lead role in immunisation. The ICB has oversight of the programme deliverables and are held accountable for performance. The ICB runs an all-age Immunisations and Vaccinations programme board, under which sit several project boards and further working groups dedicated to all aspects of the national immunisation programme. Partners are drawn from across the Integrated Care System (ICS), and strategic plans for these programmes are agreed at the board.

The Director of Public Health has a responsibility to be assured that there are sufficient plans in place to protect the health of the local population. As part of this, the Director of Public Health (DPH) is required to be assured that there are sufficient plans in place to ensure all citizens in Birmingham are receiving the vaccinations they are eligible for. This assurance is obtained through Birmingham's Health Protection Forum (HPF). The role of Public Health is to scrutinise, challenge and where appropriate support the NHS.

The diagram in Figure 1 illustrates the statutory roles and responsibilities within England's Immunisation System[ii]. It demonstrates the complexity of the strategic landscape at the national, regional, and local levels.

It is important to note that the immunisation system also involves other groups that are not recognised below. This includes media channels, employers, and citizens. Citizens interact with the immunisations system through their contact with service providers (including maternity services, GPs, school aged immunisation service, community pharmacies and other providers). This interaction with the immunisation system will usually be limited to vaccination appointments, but in some cases, it can be in the form of short conversations encouraging citizens to take up the offer of vaccinations (e.g. maternity services talking to parents, or GPs talking to vulnerable adults) in advance of these appointments.

Although these groups play essential roles in the immunisation system, there is no systematic or defined route through which they interact with this system, which is why they are absent from this diagram. This absence contributes to system-wide issues with wider partnership working to improve immunisation uptake.

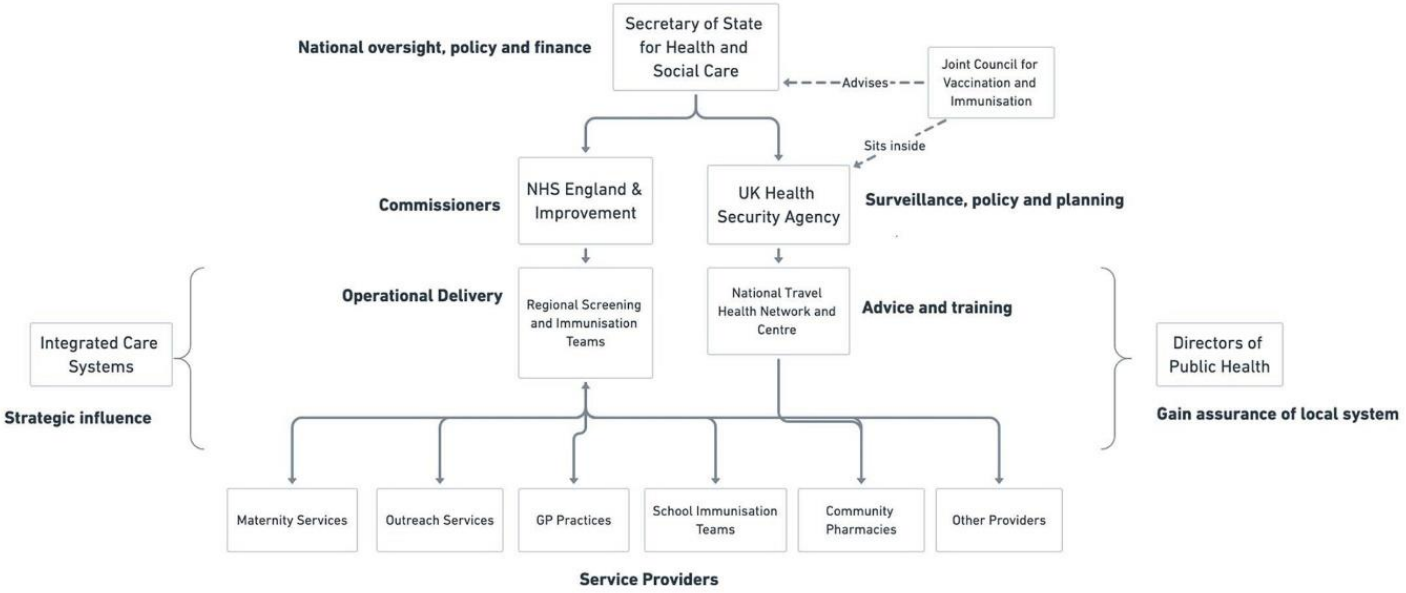


Figure 1. Statutory Roles and Responsibilities within England's Immunisation System [ii]

IMMUNISATIONS IN BIRMINGHAM

Immunisation uptake across Birmingham is challenging for all ages and below expected targets for most vaccinations. The level of protection for the entire population is therefore also reduced. In most programmes, uptake has decreased over time, with uptake rates falling year on year for the last three years. Although immunisation provision remained in place during the pandemic, disruption and the associated recovery from this period is evident in uptake data. There is high inequality and variation across the programmes, meaning that there are some groups and communities who have less protection against disease than others. This is an important consideration for communities where there are higher levels of deprivation for example, as these communities proportionately need more effort and resource to offer them protection that would be achieved through vaccinations. National uptake rates do not make these issues visible. This means there will be some communities with significantly lower uptake rates compared to Birmingham's overall rate.

A system priority is focused on rapidly improve childhood immunisation uptake, in order to prevent harm to citizens through a disease outbreak. There is a particular focus on improving the uptake of the MMR vaccine, to ensure Birmingham is protected against future outbreaks of measles. At age 5 the uptake for children has fallen over the last three years to 78.7% compared to the optimum protection level of 95%. Birmingham also ranks near the bottom compared to MMR uptake rates of its nearest neighbours and ranks last compared to other areas within the West Midlands. Birmingham's unvaccinated population is much larger than its nearest neighbours and other areas in the West Midlands, meaning there are more unvaccinated children in Birmingham than in other poorly performing areas such as Nottingham, Liverpool, and Wolverhampton[iii,iv]. Although low uptake is an issue in other cities, there is a larger scale to this issue in Birmingham that demands serious attention. The level of children living in poverty in Birmingham elevates this risk.

There is also a system priority to improve the uptake of winter vaccinations (COVID-19 and flu). For COVID-19, the number of unvaccinated people across BSol from a population of 1.5m is currently over a third of the population at 542,000. High uptake of both vaccines is important to prevent hospitalisation and death in more vulnerable adults. It is also important to ensure that Birmingham's working age adults remain well throughout winter, ensuring that workforces (especially health and social care workforces) are maintained for the protection of more vulnerable citizens. Behaviour has changed significantly since the first COVID vaccination was delivered at University Hospitals Coventry and Warwickshire on 2nd December 2021, with people now regarding COVID and flu infections as unimportant factors in their daily struggles, low risk and not a threat to life.

STRATEGIC CHALLENGES

There are several strategic challenges that the immunisation system faces. These challenges have been grouped into six broad themes and represent issues that impact all system partners.

Ongoing work and future strategic planning are aiming to resolve, or reduce the impact, of these issues with the ultimate aim of improving Birmingham's immunisation uptake rate and ensuring citizens are protected against vaccine preventable disease. Further details of the ongoing work and future planning will be provided in April's papers.

- **Data**

Access to quality data is an ongoing national issue, for both Public Health and the ICB. Nationally there will be new systems commissioned although the results of this procurement will not be available until 2024 for Children's data. Locally, and to compensate for these challenges we are working on and innovative digital solution to pull patient data for all practices. This will allow us to see directly which patients remain unvaccinated. This work is important, as it allows a more accurate and swift diagnosis of the scale of the issue and allows direct patient contact for follow up. This is particularly important in gaining intelligence from people about why they may not have had their vaccination. Partners can then target the root causes in discrete and very local locations to improve how we engage with citizens and thereby vaccination uptake.

- **Community links**

It is essential to ensure effective engagement links with Birmingham communities to promote immunisation. Much local learning has been acquired about the most effective ways to increase uptake in communities where vaccination rates are low. Positive working with communities has built on BCC approaches and a well-established 'hyperlocal' approach works flexibly in community settings to deliver a bespoke service to citizens. Vaccination vans continue outreach into low-uptake wards to offer residents the opportunity to receive a Covid-19 vaccination. Community centres and local meeting places that people gather in have afforded the vaccination team the opportunity to get to know people who spend time there, engage on a one-to-one level, and support all-age general health and wellbeing conversations. A low-key vaccination offer in a safe space from a small trolley after trusted conversations have proved successful. Embedding this way of working across all immunisation programmes would also enable engagement to create long-term cultural changes on attitudes towards vaccinations in Birmingham. The approach to gentle myth busting and how parents and relatives can protect their families aims to create a demand for vaccinations beyond COVID. Inter-generational influence appears to be a powerful factor – from younger citizens to their older relatives, where people are dissuaded from getting the protection they need. The ICB and its partners are working hard to ensure the right information is available and that every individual practitioner conversation with a citizen can consistently and confidently explain the benefits of uptake. The focus on good early years uptake is to create an environment where having available vaccinations is the norm and embedded into our local culture.

- **Access to services**

The ICB through the all-age Immunisations & Vaccinations programme board has recently considered bold and innovative ways to improve the vaccination offer in Birmingham in order to significantly improve uptake across the city. Alternative provision to the current vaccination delivery model has begun – looking outside a clinical environment and replicating a more flexible offer for parents and their children in places within their community which are

familiar. Learning from the roving COVID vaccination offer we know that access for citizens is a key factor to encourage uptake, showing that the move to a locally accessible service within a ten-minute walk improved a convenience response to uptake. The local community offer would enable conversations with a trusted healthcare professional in confidence to resolve any concerns, feeding back into the 'tailored communications' challenge. An understanding of issues around access to services is now understood, and alternative provision for example at weekends and community locations will enable us to see parents who previously and repeatedly have not attended when called for their child's vaccinations. This approach to alternative provision also offers the opportunity to adopt a MECC and direct intervention approach, ensuring communities are supported and directed to all relevant onward health services through direct links to an appointment with another healthcare professional. This is part of the ICB's broader commitment to work with public health and its partners to improve health and wellbeing for citizens in Birmingham.

- **Vaccine hesitancy**

Acquired evidence through the delivery of a range of community engagement services highlights the high levels of vaccine hesitancy in Birmingham, and a shift in patient behaviour since the inception of the COVID-19 vaccination programme. The level of vaccine hesitancy varies, ranging from a lack of knowledge and or confidence about the safety of the vaccine to entrenched beliefs or previous experiences that influence behaviours and attitudes to vaccinations. The SAGE working group developed the 3 C's model of vaccine hesitancy: confidence (does the group believe the vaccination is safe/effective?), complacency (does the group understand the risks of the disease vaccinated against) and convenience (can the group easily make an informed decision, and easily receive their vaccine?)[v]. Community providers in low uptake Birmingham wards reported that many individuals were hesitant about accepting the offer of vaccination but emphasised that the hesitancy they encountered was on a spectrum, and rarely extreme in nature. This indicates that there is room for encouragement and discussion that would be welcomed by some citizens. The ICB vaccinations team has been facilitating and promoting open discussions in low uptake cohorts and their experience echoes these findings. There are many examples of the team securing vaccine uptake following positive conversations that listen to and respond calmy to these concerns. In a specialist piece of work called 'The Big Push' the approach for pregnant women enabled proactive conversations with healthcare professionals. Of 300+ women around 100+ vaccinations were achieved antenatally.

Pandemic fatigue has also impacted on population attitudes to vaccinations. The WHO defines pandemic fatigue as '…demotivation to follow recommended behaviours emerging gradually over time'[vi]. In Birmingham, residents in low-uptake wards have reported negative attitudes towards Covid-19 vaccinations, and some have reported this negative feeling has impacted on previously positive or neutral attitudes to other routine vaccinations.

- **Partnership working**

In order to improve immunisation uptake across Birmingham, effectively engagement and partnership working is essential to increasing vaccination uptake for all ages. All partners would need to embed the principles and practice that routinely vaccinating our population is part of everyone's core agenda and practice. Long-term, this wider support and engagement would promote immunisations and vaccinations as a civic right and responsibility. BSol's Immunisations and Vaccinations programme board provides a group for partners from across the ICS to form and contribute to strategic plans to improve

immunisation uptake. Support and buy-in from non-health partners will help to address the work needed to create behavioural change within communities to ensure there is a demand for vaccination (linking to the 'Community Links' challenge).

Frontline Health and Care and Social worker uptake in Birmingham is poor compared to the rest of the West Midlands. A sub group to look a how the system works together to encourage our own staff to role model good vaccination behaviour is a vital piece of work to which all partners can contribute.

- **Communications and marketing**

It is important to ensure effective immunisations communications and marketing are in place and effective. To be effective, system efforts are focused on tailoring information as far as possible to Birmingham's large & diverse population. Language issues present barriers to immunisation uptake, including being unable to access information about the vaccine, and feeling uncomfortable with potential communication issues when attending appointments held in English.[vii] As Birmingham is an ethnically diverse city, it is likely that this issue will affect our residents. Although the Vaccinations team produce information in locally prevalent languages and dialects, more can be achieved to ensure we are all consistent with a common narrative and use of information. Using staff who are multilingual has proven how effective a conversation can be through people who live and work locally. The breadth of languages available and in a range of formats, for all ages is key to improving health literacy.

We know that the route to having a good conversation about vaccinations is by initiating a general wellbeing conversation and exploring other matters later in the conversation. Residents have reported exposure to vaccine misinformation which is trusted above more traditional sources of information. Moreover, community engagement groups have also reported a generally low level of vaccine literacy (understanding how vaccines work, what they are used for and why they are being offered). This suggests that some citizens do not have the necessary information to challenge misinformation they are exposed to, with this messaging especially powerful on social media[viii].

The ICB regularly engages with key community groups to distribute tailored communication materials. They are also working towards developing a better-quality communications strategy for the all age immunisation and vaccinations programme. Co-production with practitioners and residents will be essential to tailored future communications to Birmingham audiences. This strategy should also consider the need for constant marketing as an ongoing and long-term approach to vaccination promotion, considering the importance of vaccinations in ensuring good health across the life course. All partners including vaccine information in their own marketing information is a prerequisite to consistent messaging to the public.

NEXT STEPS

The upcoming April papers will present a more detailed look into the current immunisation picture in Birmingham and will provide further information on the challenges mentioned above, as well as the ongoing system work in place aiming to resolve these issues. The papers will also discuss future opportunities to improve and expand existing uptake improvement efforts, and recommendations for how to best progress this work.

The ICB paper will present a more detailed look at immunisation & vaccination delivery, planning, and uptake. The Public Health paper will focus on the division's assurance work related to immunisations & vaccinations.

These papers and subsequent discussion and recommendations from HOSC committee members will be shared with all immunisation system partners to influence future work and planning.

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Item 6

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Strategic Overview of Immunisations in Birmingham

February 2023

Kate Woolley – Director of Immunisations & Vaccinations, NHS Birmingham & Solihull ICB

Mary Orhewere – Assistant Director, Public Health, Birmingham City Council

Background

- Immunisations and vaccinations are delivered to people who are **well,** as an ongoing protective and preventative healthcare strategy from birth to older age, as part of a life-long basic foundation of good health and wellbeing

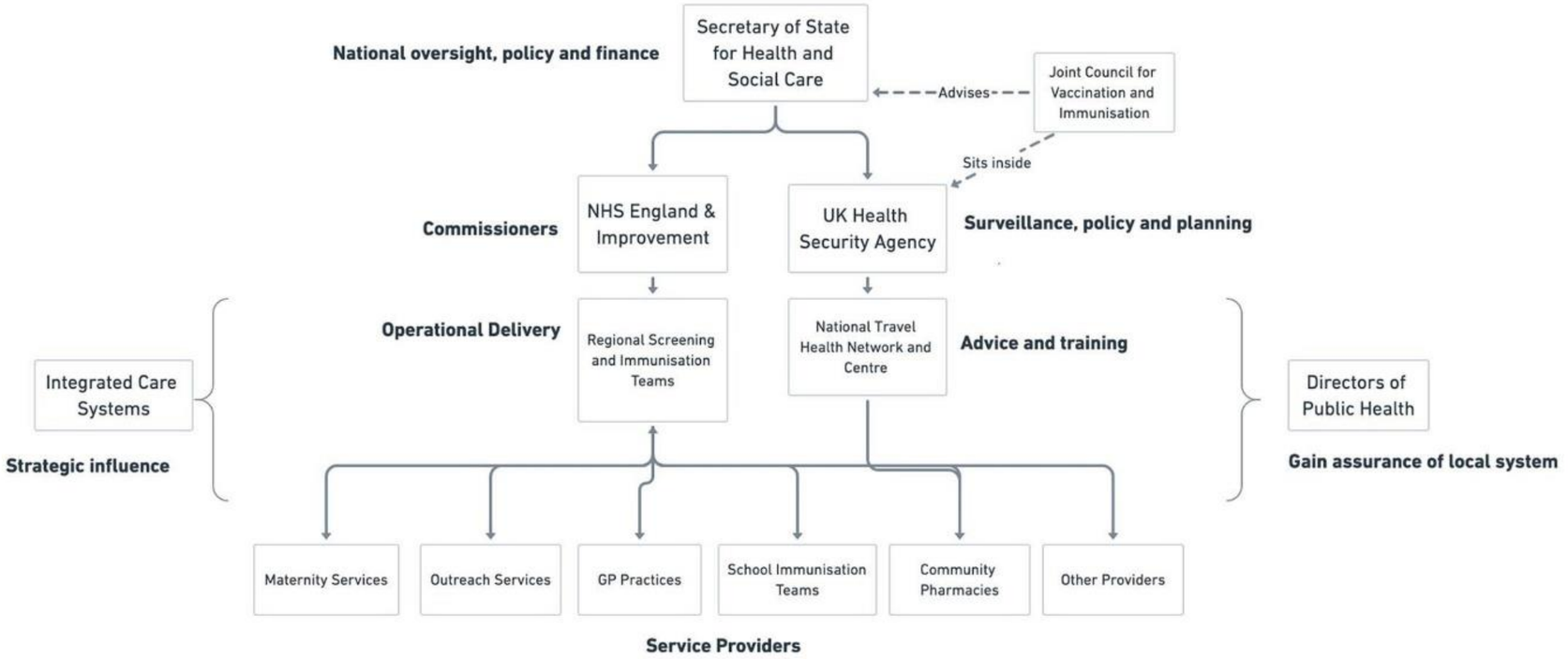
- It is one of the most effective and evidence based public health measures and has a key role in reducing sickness and death due to vaccine preventable diseases, especially in children

Purpose

- The purpose of this paper is to give the Health and Social Care Overview & Scrutiny Committee a brief strategic overview of the challenges associated with immunisations and vaccinations in Birmingham

- This overview will be followed by two more detailed papers (authored by BSol ICB and Public Health respectively) that will be presented at April's HOSC meeting

System Roles



Statutory Roles and Responsibilities within England's Immunisation System (from Royal Society of Public Health)

System roles - NHS

The NHS leads Birmingham's local immunisations system

- Immunisation services are commissioned by NHS England. The primary responsibility for uptake improvement in the different immunisation programmes sits with NHS England's local screening and immunisation teams (SITs)
- The ICB has oversight of the programme deliverables and are held accountable for performance and leads the all-age Immunisations & Vaccinations programme board with representatives across the system partners to make key decisions about the programmes

System roles - Public Health

- The Director of Public Health has a responsibility to be assured that there are sufficient plans in place to protect the health of the local population

- The role of Public Health is to scrutinise, challenge and where appropriate support the NHS

Immunisations in Birmingham

- Immunisation uptake across Birmingham is challenging for all ages and **below expected targets** for most vaccinations. The level of protection for the Birmingham population specifically is reduced.

- In most Childhood and Adolescent programmes **uptake has decreased** year on year for the last three years. Uptake for flu and COVID this Autumn/Winter is around 20% below expected levels

- There is **high inequality and uptake variation** across the programmes, with some groups and communities who have less protection and are therefore more vulnerable to avoidable illnesses and disease than others

Children and young people's immunisations

- A system priority is to rapidly improve childhood immunisation uptake, in order to prevent harm to citizens through a disease outbreak

- Improving MMR uptake is a focus, to ensure Birmingham is protected against future outbreaks of measles. At age 5 uptake has **fallen over the last three years to 78.7%** compared to the optimum protection level of 95%

- Birmingham’s unvaccinated population is much larger than its nearest neighbours and other areas in the West Midlands. There are **more unvaccinated children in Birmingham** than in areas such as Nottingham, Liverpool, and Wolverhampton. The level of children living in poverty in Birmingham elevates this risk.

Immunisations in Birmingham - adults

- There is also a system priority to improve the uptake of winter vaccinations (COVID-19 and flu)
- For COVID-19, the number of **unvaccinated** people across BSol from a population of 1.5m is currently over a third of the population at **542,000. Those 49 and below are the least vaccinated**
- High uptake of both vaccines is important to **prevent hospitalisation and death** in more vulnerable adults
- It is also important to ensure that Birmingham's **working age adults remain well** throughout winter, ensuring that workforces (especially health and social care workforces) are maintained for the protection of more vulnerable citizens. Uptake in **50-64** year olds this autumn/winter is only 36 and 46% respectively.

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Strategic challenges

1. Access to high quality **data**
2. Establishing effective links with **communities**
3. Ensuring easy **access** to vaccination services

4. **Vaccine hesitancy** in the local population
5. **Partnership working** outside of traditional health partners
6. Tailored and effective **communications & marketing**

Next Steps

- The ICB April paper will present a more detailed look at immunisation & vaccination delivery, planning, and uptake
- The Public Health April paper will focus on the division's assurance work related to immunisations & vaccinations
- Papers will discuss future opportunities to improve and expand existing uptake improvement efforts with recommendations on progressing this work

These papers and subsequent discussion and recommendations from HOSC committee members will be shared with all immunisation system partners to influence future work and planning

Health and Social Care O&S Committee: Work Programme 2022/23

Chair:	Cllr Mick Brown
Deputy Chair:	Cllr Rob Pocock
Committee Members:	Cllrs: Kath Hartley, Jane Jones, Kirsten Kurt-Elli, Gareth Moore, Julian Pritchard and Paul Tilsley.
Officer Support:	Senior Overview and Scrutiny Manager: Fiona Bottrill (07395 884487) Scrutiny Officer: Gail Sadler (303 1901) Committee Manager: Sofia Mirza (675 0216)

1 Introduction

1.1 The Health and Social Care Overview and Scrutiny Committee's remit is to fulfil the functions of an Overview and Scrutiny Committee as they relate to any policies, services and activities concerning adult safeguarding, social care and public health; and to discharge the relevant overview and scrutiny role set out in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012, including: The appointment of Joint Overview and Scrutiny Committees with neighbouring authorities; and the exercise of the power to make referrals of contested service reconfigurations to the Secretary of State as previously delegated to the Health and Social Care Overview and Scrutiny Committee by the Council.

1.2 This report provides details of the proposed scrutiny work programme for 2022/23.

2 Recommendation

2.1 That the Committee considers its work programme, attached at Appendix 1, and agrees any amendments required.

3 Background

3.1 "Scrutiny is based on the principle that someone who makes a decision…should not be the only one to review or challenge it. Overview is founded on the belief that an open, inclusive, member-led approach to policy review…results in better policies in the long run." (Jessica Crowe, former Executive Director, Centre for Governance and Scrutiny).

3.2 Developing an effective work programme is the bedrock of an effective scrutiny function. Done well, it can help lay the foundations for targeted, inclusive and timely work on issues of local

importance, where scrutiny can add value. Done poorly, scrutiny can end up wasting time and resources on issues where the impact of any scrutiny work done is likely to be minimal.

3.3 As a result, the careful selection and prioritisation of work is essential if the scrutiny function is to be successful, add value and retain credibility.

4 Work Programme

4.1 Appendix 1 sets out the future work programme for this Committee. This provides information on the aims and objectives, together with lead officers and witnesses, for each item. The attached work programme also includes items to be programmed where dates are still to be confirmed, and any outstanding items including the tracking of previous recommendations.

5 Joint Working Across Committee Work Programmes 2022/23

5.1 As the work programmes for the Committees have developed a number of cross cutting issues have been identified. To avoid duplication Members will be invited to attend different Overview and Scrutiny Committee meetings for relevant reports as set out below:-

Lead Committee	**Meeting and Agenda Item**	**Members to be invited and reason**
Education and Children's Social Care O&SC	22 February 2023 Report from Birmingham Safeguarding Children's Partnership (BSCP)	Members of the CYP Mental Health Inquiry from the Health and Adult Care O&SC Information from the BSCP will inform the CYP mental health inquiry.
Commonwealth Games, Culture and Physical Activity O&SC	Meeting: TBC Report on employment and skills Legacy of the Commonwealth Games	Members of the Economy and Skills OSC At the meeting on the 8th July Co-ordinating O&SC decided that this issue falls within the remit of the CWG, Culture and Physical Activity OSC, and as it has been identified during the work planning for the Economy and Skills O&SC as an issue of interest Members of this Committee would be invited to the relevant meeting.

6 Inquiry

6.1 Evidence gathering meetings for the inquiry on children and young people's mental health have been arranged during February and March 2023.

7 Other Meetings

7.1 The Birmingham/Solihull Joint Health Scrutiny Committee will meet on Wednesday 15th February at 6.00pm in the Civic Suite, Solihull.

Call in Meetings:

None scheduled

Petitions

None scheduled

Councillor Call for Action requests

None scheduled

The Committee approved Tuesday at 10.00am as a suitable day and time each week for any additional meetings required to consider 'requests for call in' which may be lodged in respect of Executive decisions

8 Forward Plan for Cabinet Decisions

8.1 Since the implementation of the Local Government Act and the introduction of the Forward Plan, scrutiny members have found the Plan to be a useful tool in identifying potential agenda items.

8.2 The following decisions, extracted from the CMIS Forward Plan of Decisions, are likely to be relevant to the Health and Social Care O&S Committee's remit. The Panel may wish to consider whether any of these issues require further investigation or monitoring via scrutiny. The Forward Plan can be viewed in full via Forward Plans (cmis.uk.com).

ID Number	Title	Proposed Date of Decision
010749/2023	Grant Funding Extension to The Active Wellbeing Society for Future Physical Interventions	14 Feb 2023
010912/2023	Prevention and Communities Grants Programme Recommissioning	14 Feb 2023
010985/2023	Distribution of the Market Sustainability and Fair Cost of Care Grant to Adult Social Care Providers and Approval of the Market Sustainability Plan	14 Feb 2023

9 Legal Implications

9.1 There are no immediate legal implications arising from this report.

10 Financial Implications

10.1 There are no financial implications arising from the recommendations set out in this report.

11 Public Sector Equality Duty

11.1 The Council has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

11.2 The Committee should ensure that it addresses these duties by considering them during work programme development, the scoping of work, evidence gathering and making recommendations. This should include considering: How policy issues impact on different groups within the community, particularly those that share a relevant protected characteristic; Whether the impact on particular groups is fair and proportionate; Whether there is equality of access to services and fair representation of all groups within Birmingham; Whether any positive opportunities to advance equality of opportunity and/or good relations between people are being realised.

11.3 The Committee should ensure that equalities comments, and any recommendations, are based on evidence. This should include demographic and service level data and evidence of residents/service-users views gathered through consultation.

12 Use of Appendices

12.1 Appendix 1 – Work Programme for 2022/2023

APPENDIX 1

HEALTH & SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE 2022-23 WORK PROGRAMME

Date of Meeting: 19th July 2022

Item/ Topic	Type of Scrutiny	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information (Including joint working / links with other O&S Committees)
Q4 Adult Social Care Performance Monitoring	*Agenda item*	*Report on red rated performance indicators; 5 performance indicators chosen by HOSC for in-depth examination and the complete set of Adult Social Care performance indicators.*	*Maria Gavin*	*N/A*	*None identified*	*Maria to include any performance information on Delayed Transfers of Care.*
Healthwatch Birmingham Annual Report 2021/22	*Agenda item*	*Reporting on investigations completed in the previous year.*	*Andy Cave, CEO, Healthwatch Birmingham*	*N/A*	*None identified*	• *Access to NHS Dentistry* • *Investigation about people's experiences of Day Services* • *Access to GP Services*

Final Deadline: Thursday 7th July 2022

Publication: Monday 11th July 2022

Date of Meeting: **Tuesday 20th September 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Election of Deputy Chair	*Agenda item*	*To elect a Deputy Chair. Deferred from 19th July informal meeting.*				
Action Notes/ Matters Arising	*Agenda item*	*To approve the action notes of the meeting held on 29th March 2022.* *To note the action notes of the informal meeting held on 19th July 2022.*				
Report of the Cabinet Member for Health and Social Care	*Agenda Item*	*To set out the Cabinet Member's priorities for the coming year.*	*Ceri Saunders*	*N/A*	*None identified*	*Councillor Mariam Khan*
Period Poverty and Raising Period Awareness	*Tracking Recommendations*	*To track progress against implementation of recommendations.*	*Monika Rozanski* *Rokneddin Shariat*	*N/A*	*None identified*	

Final Deadline: Thursday 8th September 2022

Publication: Monday 12th September 2022

Date of Meeting: **Tuesday 18th October 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Forward Thinking Birmingham	*Agenda item*	*To present the annual report.*	*Fiona Reynolds Chief Medical Officer Birmingham Women's and Children's NHS Foundation Trust (FTB)*	*N/A*	*None identified*	It was agreed at Co-ordinating OSC on the 8 July 2022 that the Health and Social Care O&SC undertakes scrutiny of children's mental health (under the overview and scrutiny role set out in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012) and members of the Education and Children's Social Care Committee will be invited to attend as mental health is included within the Committee's terms of reference.
Infant Mortality – Tracking Report	*Tracking Recommendations*	*To track progress against implementation of recommendations.*	*Dr Marion Gibbon*	*N/A*	*None identified*	

Q1 Adult Social Care Performance Monitoring	*Agenda item*	*Report on red rated performance indicators; 5 performance indicators chosen by HOSC for in-depth examination and the complete set of Adult Social Care performance indicators.(Deferred to 20 December 2022)*	*Maria Gavin John Williams Merryn Tate*	*N/A*	*None identified*	*The Q1 Performance data had been deferred to the meeting on 20 December. An update will be provided to the October meeting on the future arrangements for Adult Social Care Performance Monitoring data.*
Children and Young People's Mental Health Inquiry	*Agenda item*	*Terms of Reference*	*Fiona Bottrill*	*N/A*	*None identified*	

Final Deadline: Thursday 6th October 2022

Publication: Monday 10th October 2022

Date of Meeting: **Tuesday 22nd November 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Birmingham Substance Misuse Recovery System (CGL)	*Agenda item*	*Annual report on performance against public health contract.*	*Karl Beese*	*N/A*	*None identified*	
Birmingham and Solihull Integrated Care System Ten-Year Strategy	*Agenda item*	*Report setting out the plan for health and care services for Birmingham and Solihull*	*David Melbourne Chief Executive, Birmingham and Solihull ICS*	*N/A*	*None identified*	

Final Deadline: Thursday 10th November 2022

Publication: Monday 14th November 2022

Date of Meeting: **Tuesday 20th December 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Birmingham Safeguarding Adults Board Annual Report	*Agenda item*	*Reporting on outcomes against priorities in the previous year.*	*Asif Manzoor Dr Carolyn Kus, Independent Chair*	*N/A*	*None identified*	
Birmingham and Lewisham African Health Inequalities Review (BLACHIR)	*Agenda item*	*Reporting on progress against actions in the report*	*Monika Rozanski; Jo Tonkin; Modupe Omonijo; Marcia Wynter; Ceri Saunders*	*N/A*	*None identified*	*Councillor Mariam Khan, Cabinet Member for Health and Social Care.*
Q2 Adult Social Care Performance Monitoring	*Agenda item*	*Report on red rated performance indicators; 5 performance indicators chosen by HOSC for in-depth examination and the complete set of Adult Social Care performance indicators.*	*Maria Gavin*	*N/A*	*None identified*	*Reporting Q1 and Q2.*

Final Deadline: Thursday 8th December 2022

Publication: Monday 12th December 2022

Date of Meeting: **Tuesday 24th January 2023**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Adult Social Care Reforms	*Agenda item*	*To inform the committee on reforms to Adult Social Care.*	*John Williams*	*N/A*	*None identified*	
Approved Mental Health Professional	*Agenda item*	*Evidence gathering for the Children and Young People's Mental Health Inquiry*	*John Williams / Joanne Lowe*	*N/A*	*None identified*	

Final Deadline: Thursday 12th January 2023

Publication: Monday 16th January 2023

Date of Meeting: **Tuesday 21st February 2023**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Birmingham Sexual Health Services – Umbrella (UHB)	*Agenda item*	*Annual report on performance against public health contract.*	*Karl Beese*	*N/A*	*None identified*	
Strategic Overview of Immunisations in Birmingham	*Agenda item*	*Report to set out the strategic oversight.*	*Mary Orhewere / Paul Sherriff / Leon Mallett*	*N/A*	*None identified*	

Final Deadline: Thursday 9th February 2023

Publication: Monday 13th February 2023

Date of Meeting: **Tuesday 14th March 2023**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Cabinet Member Update Report	*Agenda item*	*Cabinet Member to report progress against portfolio priorities*	*Ceri Saunders*	*N/A*	*None identified*	*Councillor Mariam Khan, Cabinet Member for Health and Social Care.*
Day Opportunities Co-Production Review	*Agenda item*	*Findings of the independent co-produced review of day opportunity services.*	*Dr Temitope Ademosu / John Williams / Saba Rai / John Freeman*	*N/A*	*None identified*	*Also attending are representatives from the Empowering Peoples Team.*
Q3 Adult Social Care Performance Monitoring	*Agenda item*	*Report on red rated performance indicators; 5 performance indicators chosen by HOSC for in-depth examination and the complete set of Adult Social Care performance indicators.*	*Maria Gavin*	*N/A*	*None identified*	

Final Deadline: Thursday 2nd March 2023

Publication: Monday 6th March 2023

Date of Meeting: **Tuesday 18th April 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
ICB Update	*Agenda item*		*Paul Sherriff and Karen Kelly*	*N/A*	*N/A*	
Immunisation	*Agenda item*	*Report to set out the challenges with the take up of immunisations.*	*Mary Orhewere / Kate Woolley, Director of Immunisation and Vaccinations*	*N/A*	*None identified*	*Report to be presented as a scoping paper for a possible future inquiry based on previous scoping paper for Infant Mortality.*

Final Deadline: Thursday 6th April 2023

Publication: Monday 10th April 2023

INFORMAL BRIEFINGS (TO BE ARRANGED)
Engaging with third sector providers of Adult Social Care (Louise Collett)
City Observatory Data (Richard Brooks)

TO BE SCHEDULED:

1. Public Health Horizon Scanning / JSNA
2. Primary Care Networks
3. Mental Health and Wellbeing Post-COVID
4. Visit to UHB NHS Foundation Trust Hospital sites.
5. Visit to Early Intervention Community Team, Norman Power Centre

BIRMINGHAM/SANDWELL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **29th November @ 2.00pm**

Venue: **Birmingham**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Committee Terms of Reference	*Agenda item*	*To update the committee terms of reference*	*Fiona Bottrill*	*N/A*	*None identified*	
Acute Care Model	*Agenda item*	*To report on the model for acute care.*	*Liam Kennedy, Midland Metropolitan Hospital Delivery Director*	*N/A*	*None identified*	
Feedback on proposed changes to Day Case Surgery	*Agenda item*	*To report on feedback regarding proposed changed to Day Case Surgery.*	*Liam Kennedy, Midland Metropolitan Hospital Delivery Director*	*N/A*	*None identified*	

Final Deadline: 17th November 2022

Publication: 21st November 2022

BIRMINGHAM/SOLIHULL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **13th October – 1800-2000 hrs – Solihull Civic Suite**

Venue: **Solihull**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Draft BSoL Strategic Vision for Autism and the Draft BSoL Strategic Vision for Learning Difficulties and Disabilities	*Agenda item*		*TBC*	*N/A*	*None identified*	
Birmingham and Solihull ICS Financial Planning Update	*Agenda item*	*To report on the financial plan for the ICS.*	*Paul Athey, ICS Finance Lead*	*N/A*	*None identified*	
Update on the recovery and proposed configuration of surgical services across University Hospitals Birmingham – ICB and UHB and Preparation for Winter Pressures	*Agenda item*	*To report on the current status of services and waiting lists.*	*Jonathan Brotherton, Chief Operating Officer, UHB*	*N/A*	*None identified*	

Final Deadline:

Publication: **5th October 2022**

BIRMINGHAM/SOLIHULL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **19th January 2023 at 2.00pm, Committee Room 3&4, Council House**

Venue: **Birmingham**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Committee Terms of Reference	*Agenda item*	*To update the committee terms of reference*	*Fiona Bottrill*	*N/A*	*None identified*	
Healthwatch Ground Rules for Reviews announced by NHS Birmingham and Solihull	*Agenda item*	*To seek endorsement from the committee on the ground rules*	*Fiona Bottrill / Andy Cave, Healthwatch Birmingham*	*N/A*	*None identified*	
ICS/UHB Update	*Agenda item*	*To respond to concerns raised by the BBC Newsnight investigations.*	*Jonathan Brotherton, UHB; David Melbourne, BSol ICS*	*N/A*	*None identified*	
West Midlands Ambulance Service Update	*Agenda item*	*To respond to concerns raised by the BBC Newsnight investigations*	*Vivek Khashu and Mark Docherty, WMAS; David Melbourne, BSol, ICS*	*N/A*	*None identified*	
BSol ICS update on performance against finance and recovery plans	*Agenda item*	*To update on the current status regarding finance and recovery plans*	*Paul Athey, ICS Finance Lead*	*N/A*	*None identified*	

Final Deadline: 10th January 2023

Publication: **11th January 2023**

BIRMINGHAM/SOLIHULL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **15th February 2023 at 6.00pm, Civic Suite**

Venue: **Solihull**

Dementia Strategy	*Agenda item*	*Following consultation seeking approval for the strategy*	*Revinder Johal, Commissioning Manager – Strategy and Integration, ASC* *Anna Walker, Commissioning Manager for Strategy and Planning, Solihull MBC*	*N/A*	*None identified*	
Primary Care Enabling Strategy	*Agenda item*		*Paul Sherriff*	*N/A*	*None identified*	
ICS/UHB Update	*Agenda item*	*To receive an update on the 3 reviews being undertaken at UHB.*	*TBC*	*N/A*	*None identified*	
Proposed configuration of services across UHB – engagement outcomes	*Agenda item*		*TBC*	*N/A*	*None identified*	

Final Deadline: 6th February 2023

Publication: **7th February 2023**

BIRMINGHAM/SOLIHULL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **13th March 2023 at 2.00pm, Committee Rooms 3 and 4, Council House**

Venue: **Birmingham**

ICS/UHB Update	*Agenda item*	*Update on the 3 reviews being undertaken at UHB. Findings of the 1st review.*	*Jonathan Brotherton, UHB; David Melbourne, BSol ICS*	*N/A*	*None identified*	*Representatives for UHB and BSol ICS TBC.*
West Midlands Ambulance Service Update	*Agenda item*	*Update on actions taken to respond to concerns raised at the January meeting.*	*Vivek Khashu and Mark Docherty, WMAS; David Melbourne, BSol, ICS*	*N/A*	*None identified*	
BSol ICS update on performance against finance and recovery plans	*Agenda item*	*To update on the current status regarding finance and recovery plans*	*Paul Athey, ICS Finance Lead*	*N/A*	*None identified*	*Representative for Paul Athey TBC.*

Final Deadline: 2nd March 2023

Publication: **3rd March 2023**

TO BE SCHEDULED

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Integrated Care System and the Role of Scrutiny	*Agenda item*	*To determine future arrangements and reporting*	*David Melbourne, BSol ICS*	*N/A*	*None identified*	
ICS Joint Forward Plan	*Agenda item*	*Report on health planning for the system including commissioning intentions.*	*Carol Herity to confirm Lead Officer*	*N/A*	*None identified*	*To be scheduled early in the new municipal year*
ICS Quality Assurance Update	*Agenda item*	*Update on Quality Assurance to every JHOSC*	*Carol Herity to confirm Lead Officer*	*N/A*	*None identified*	*To be scheduled early in the new municipal year*
Update on Post-COVID Syndrome ('Long COVID') Rehabilitation	*Agenda item*	*Update on previous report presented to JHOSC on 29th September 2021*	*Ben Richards, Chief Operating Officer, Birmingham Community Healthcare NHS Foundation Trust*	*N/A*	*None identified*	*Report to include Long COVID implications on health and long-term employment.*
Phase 2, Musculoskeletal Redesign Programme	*Agenda item*	*To report on the current status of the programme*	*Marie Peplow, Chief Operating Officer, The ROH*	*N/A*	*None identified*	