BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 17 MAY 2022 AT 15:00 HOURS
IN ON-LINE MEETING, MICROSOFT TEAMS

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

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

2 **DECLARATIONS OF INTERESTS**

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

3 **APOLOGIES**

To receive any apologies.

4 **DATES OF MEETINGS**

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

July 2022 - Development Session*
Tuesday 20 September 2022
Tuesday 29 November
2023
Tuesday 17 January
Tuesday 21 March
NB: All meetings will commence at 1500 hours unless otherwise stated.
* The date and time for the Development Session is to be agreed.

5 - 22

5 **MINUTES AND MATTERS ARISING (1500 -1510)**

To confirm and sign the Minutes of the meeting held on the 22 March 2022.

23 - 34

6 **ACTION LOG**

To review the Actions arising from previous meetings.

7 **CHAIR'S UPDATE**

To receive an oral update.

8 **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's meeting You Tube site(www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw)
NB: The questions and answers will not be reproduced in the minutes.

9 **CORONAVIRUS-19 POSITION AND VACCINE UPDATE STATEMENT (1520 - 1530)**

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

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

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

11 **ICS UPDATE (1535 - 1545)**

Karen Helliwell, Interim Accountable Officer, BSol CCG will present this item.

35 - 56

12 **SANDWELL & WEST BIRMINGHAM NHS TRUST FIVE YEAR STRATEGY**

Richard Beeken, Chief Executive Officer will present this item

57 - 76

13 **BCC EARLY INTERVENTION AND PREVENTION PROGRAMME**

Graeme Betts, Corporate Director- Adult Social Care will present this item

77 - 82

14 **BLACHIR REPORT OPPRTUNITIES FOR ACTION UPDATE**

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

15 **THE DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2021/22**

83 - 144

Dr Mary Orhewere, Assistant Director of Public Health will present this item

16 **FORWARD PLAN**

145 - 150

Item Description

17 **LINK TO MINUTES FROM THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD MEETING**

This item is for information only.
LCOEB Public Minutes 23 Feb 2022

18 **OTHER URGENT BUSINESS**

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

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING TUESDAY, 22 MARCH 2022

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 22 MARCH 2022 AT 1500 HOURS IN CHARLES DICKENS ROOM, BMI, MARGARET STREET BIRMINGHAM B3

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG,
Andy Cave, Chief Executive Officer, Healthwatch Birmingham
Karen Helliwell, Interim Accountable Officer, NHS BSol CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Richard Kirby, Birmingham Community Healthcare NHS Foundation Trust
Professor Robin Miller, PhD, Director of Global Engagement for College of Social Sciences, University of Birmingham
Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Dr Douglas Simkiss, Medical Director and Caldicott Guardian, Birmingham Community Healthcare NHS Foundation Trust
Councillor Sharon Thompson, Cabinet Member for Vulnerable Children and Families
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Aidan Hall, Programme Senior Officer – Governance, Public Health Division
Carol Herity
Alexander Quarrie-Jones, Programme Officer – Governance, Public Health Division
Monika Rozanski, Service Lead (Inequalities), Public Health Division
Dr Shiraz Sheriff, Service Lead – Governance, Public Health Division
Penny Thompson
Suman McCartney
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

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

DECLARATIONS OF INTERESTS

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

APOLOGIES

623 Apologies for absence were submitted on behalf of Councillor Paulette Hamilton, MP and Chair of Birmingham Health and Wellbeing Board
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Professor Graeme Betts, Director of Adult Social Care,
Andy Couldrick,
Mark Garrick, Director of Strategy and Quality Development, UHB
Sue Harrison, Director for Children and Families, BCC
Riaz Khan, Birmingham and Solihull District, Department for Work and Pensions
Peter Richmond, Birmingham Social Housing Partnership
Chief Superintendent Mat Shaer, West Midlands Police
Dr William Taylor, NHS Birmingham and Solihull CCG and Vice Chair for Birmingham Health and Wellbeing Board.

DATES OF MEETINGS

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

2022	2023
Tuesday 17 May	Tuesday 17 January
Tuesday 26 July	Tuesday 21 March
Tuesday 20 September	
Tuesday 29 November	

All meetings will commence at 1500 hours unless stated otherwise.

EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC

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

625 **RESOLVED:**

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

MINUTES AND MATTERS ARISING

It was noted that Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust had submitted an apology but that this had been omitted from the Minutes of the meeting held on the 8th February 2022.

626 **RESOLVED: -**

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

ACTION LOG

Aidan Hall, Programme Senior Officer – Governance, Public Health Division introduced the item and advised that there were no outstanding actions on the Action Log.

627 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

628 The Chair read the following statement from Councillor Hamilton, MP:- '*I would like to that all Health and Wellbeing Board Members for their work to improve the wellbeing of all our citizens. I really enjoyed the discussions and progress we have made. We have managed to openly discussed some key aspects of health and inequalities and the last two years responding to the pandemic have showcased how we could collectively work better together to improve our response to our citizens in our health and social care services worked better for*

them. Thanks, and I am sure that I will meet and have further discussions with many of you in my new role representing the constituents of Erdington. I wish the Health and Wellbeing Board continued success as it moved forward and the significant role it will take in the Integrated Care System (ICS). I would also like to thanked Dr Justin Varney, Director of Public Health, Dr William Taylor, Vice-Chair of the Health and Wellbeing Board and each and every one of you for your contributions throughout the year. Thank you very much'

PUBLIC QUESTIONS

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

CORONAVIRUS-19 POSITION AND VACCINE UPDATE STATEMENT

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

(See document No. 1)

Stephen Raybould, Programmes Director, Ageing Better, BVSC commented that there was a period of time reported at the end of last week where the West Midlands was the only region where cases were not rising. He enquired where Birmingham was in that picture and why that was happening.

Dr Varney made the following statements:-

- The overall the trend was that Birmingham was going up and across the West Midlands there was some fluctuation some of which were areas that went up faster.
- A few weeks ago it was Rugby that was top of the country and they were now flattening out. There was some balancing going on between different areas.
- Testing was stable and we continue to monitor wastewater which was showing that there was an increase, but it was not as dramatic as in other areas.
- Some of that was a reflection of working in patterns across the region and across the city.
- Some of this was about how hard we were hit over Christmas and the early part of this year and natural immunity providing some form of protection.
- We were not at the moment a significant out layer, we were just being a little bit slower climbing the stairs which was very much what we did throughout the whole of the pandemic - we took our time to climb.

The Chair expressed thanks to Dr Varney and team for the work they had done over the last two years concerning the pandemic.

COMMONWEALTH GAMES UPDATES UPDATE

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

(See document No. 2)

Karen Helliwell, Interim Accountable Officer, NHS BSol CCG commented that presumably the App was open to a wide geography which was good but just in terms of how we looked at the local impact.

Dr Varney made the following response:-

- What we were aiming to do was to evaluate them as a bundle of activities rather than as individuals. *Whisk* people could register so one of the things we could do was to look at people's demographics, but they did not have to, but they could.
- What we were aiming to do through that phase was the resources and the *Whisk* resources was to do a more detailed focussed group evaluations working with community organisations to ascertain how do all of this land.
- We were a nation that consumed cookery books more than any other country in the world, with the largest market for cookery books, yet that was not reflected in how much people cooked at home.
- One of the things we have been actively promoting in the *Cook Commonwealth* was affordability. This was a strong narrative in the marketing campaign and the full marketing campaign was in preparation phase and would be launched in April.

Carly Jones, Chief Executive, SIFA FIRESIDE, enquired what happened to *Whisk* post the Commonwealth Games.

In response to Ms Jones' query, Dr Varney made the following statements: -

- ✓ *Whisk* was free and we were not paying to use *Whisk* as this was part of the partnership. *Whisk* was an innovation company that spun out of Panasonic who had approached us two years ago to work collaboratively with the city. There was no money changing hands.
- ✓ From their point of view the benefit was to be able to put the *Whisk* platform in front of a big audience, but also, they were benefitting from testing it.
- ✓ There was an element if you remember pre-Covid where we were using *Whisk* with small medium sized food retailers to reformulate that menu. That was parked because of Covid, but that would be restarting now.
- ✓ Once they were on the platform they stayed there forever, and they stayed within past platforms that was clearly identified as Birmingham and Birmingham's Commonwealth activity.

Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust enquired how we could be more engaged as providers as some of our service users of mental health would want to be actively engaged with this as it was to be

launched later in the year and whether there was anything, we could do to support that.

Dr Varney advised that Public Health had just appointed a Comms and Engagement function as he did not have any resource before to support that. One of their first job is to launch in the regular newsletter that goes out to the Health and Wellbeing Board and to all our partners. As you saw each time, I present to the Board there were a number of good stuff going on, but what we struggled to do was get it out there so you could all used it. That was an important part of that, but we will also be doing some important stuff alongside the Food Strategy Consultation to help promote and raise awareness as well.

UKRAINE CRISIS UPDATE

632 The Chair introduced the item and expressed thanks to everyone. She added that health colleagues had played a key role in the last few weeks in supporting some of the children and their families that had joined us here in Birmingham and across the country. The Chair further stated that there was wide implications with that, but everyone had pulled together well which was good. The Chair expressed thanks to all our partners as we were grateful for that support and the quick action that had taken place.

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

(See document No. 3)

Dr Varney made the following statements:-

- There had be a huge amount of collaboration work between the NHS and local government particularly supporting the movement of the Ukrainian children with cancer connected to the Women's and Children's Hospital.
- It had been an amazing joint effort where clinical colleagues and local government colleagues came together particularly our colleague Monika Rozanski who was present at the meeting who had been one of the officers that helped who was asked to step up from her normal day job to support the response because of links with the communities.
- That was the first piece of collaboration, now we were moving into preparation and planning for the arrival of other refugees through the various schemes that had been established through Government.
- There was a huge amount of work that was still to come that we were prepping for now around the implications for those arrivals and how we support them through primary care, housing and through the community and voluntary sector.
- When we come back next time as a Board there will be more clarity about those next steps.
- As colleagues around the table knew this was a rapidly changing policy area and there were many questions which we were waiting for national government to give us clarity on and this changes every day very much.
- There was the Inter-agency Management Team (IMT) which was working on this and we had demonstrated through Covid how well we

came together in crisis to protect and support our citizens. This forms a mechanism that was coming into play here.

BIRMINGHAM AND LEWISHAM AFRICAN CARIBBEAN HEALTH INEQUALITIES REVIEW (BLACHIR)

The Chair introduced the item and advised that the ask was for the Board to consider coming forward to champion and to lead on any of the opportunities for the actions that were identified and report back to the Board of what we could do collectively to build a better future and to break the cycle of inequality and disadvantages for African and Caribbean communities. The Chair highlighted that Councillor John Cotton had requested that the fact be urged that this was also about *Everyone's Battle, Everyone's Business* and this was the reason we were pushing for that collaborative piece. The Chair added that this was something that Councillor Hamilton, MP was passionate about too.

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

(See document No. 3)

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG commented that the approach to the report and its recommendations were fascinating. He added that Dr Varney alluded to the fact that he had a conversation with Mr Kirby about how we implement some of these. There was quite a lot that required cross-organisational work which was great as we were in the business of integration. Dr Aslam enquired how this was going to work practically, as we would need to resourced these things if we wanted them to work. But they will have such a significant impact. Dr Aslam further enquired what the strategy was, what success and good looked like and how will we know.

Dr Varney made the following statements:-

a. The Plan would be submitted in May after the local elections (we have brought this to the Board in order to get the report published before the elections). The Action Plan comes after the elections and some of the process given the political sensitivity, we had to respect that.
b. We were now building a team to work in Birmingham on how we implement this and how we do that working across the different partnerships that we have. This was the next phase with the view that we have a date towards the end of May.
c. The plan was that by the end of May we would have the event that would bring together the Academic Board and the Advisory Board to look at what we started to form as the Action Plan to see if was good enough.
d. One of the things we were quite keen on was to maintain that community co-production and involvement in creating the Action Plan. If not, the organisations take it away and adjust it with that co-production to play through.

e. We have had some initial discussions around the resources from Public Health towards that and because of political sensitivity we had to be careful how we phrased it.

Dr Aslam commented that we had health checks that was built in and successfully do them on a large scale, but there were communities that were missed and to their detriment. We talked about diagnostic centres and all of these conversations were happening in separate places. The role of the Integrated Care Partnership was to coordinate that conversation. Ultimately, we probably have enough resources within our system to do this, but it was in different places.

Dr Varney gave the following response:-

- That this was what he and Mr Kirby was talking about from the ICS viewpoint and the Inequalities Board being the kind of nexus for some of the NHS pieces of work.
- Health checks was a good example as we were already starting a journey towards what he called Health Checks 2.0 and the team had been working up a timeline between now and December for how we might change the way we commissioned.
- Health checks could also helped to remind the data because on the dashboard for health checks we could not see them by ethnicity.
- That he was aware that at individual practice level this could be seen, but at the system level we could not so we needed to do that piece of work.
- There was some good work that was being done by the maternity system looking at an equity audit which reflected good practice.
- The question was how we could test whether our services were really reaching our communities properly and we did not do that routinely enough.
- What we will see was across a range of services this will prompt the question. We all need to share the good practice learning, so we do not try to continue to reinvent the wheel.
- For Primary Care it was going to be an important part of the PCN inequality lead roles. Someone explaining how you extracted the data on *EMIS* for this then all the other *EMIS* practices could do it the same way, so we did not kept starting from a blank sheet of paper.
- This he believed was where the ICS system would become helpful in sharing the practice and the learning.

Richard Kirby, Birmingham Community Healthcare NHS Foundation Trust made the following statements:-

1. This was an interesting piece of work much for the way it had been done as for what it stated. Hopefully it will give what it tells us. We needed to do greater power and an opportunity to see it through. There was a couple of reasons why the timing for this was helpful.
2. Firstly, the ICS was in the process of setting out its strategy for inequalities and there was a clear opportunity to take these recommendations which needed the ICS to lean on and put them in the right place with the right level of prioritisation around that. It was hoped that this report would come to the ICS and the Inequalities Programme

Board in a few weeks' time. We should be able to see the big NHS recommendations from here appearing in that work.

3. Secondly, we were in effect thinking what the change model for the various things we needed to do. Some of these things were best for the individual NHS Provider Institutions were best tasked with doing them well for their own services and cracking on in that spirit.
4. Some models will need some (possibly Birmingham and Solihull wide) collaboration as it made sense to do one piece across the bit. But the other bit in other places was clearly for some of our localities (this was a big issue) and particularly in some of the communities in West Birmingham needed us to respond sensibly to these recommendations.
5. There was also a role particularly for the West Birmingham Locality Partnership which was the best developed at the moment of the various partnerships to be asked to work through what it thought was its contribution to this directly.
6. We had a range of ways in and the ICS inequalities strategy document will set out which were the actions which would apply to which. There was a big reflection doing this well and taking this seriously and giving it the response it deserved was a big job.
7. Mr Kirby undertook to speak with Dr Varney more about the NHS side and the Council side about resourcing it properly and seeing it through and all of the things that was talked about.

Professor Robin Miller, Head of Department, Social Work and Social Care, University of Birmingham applauded Dr Varney and the team, City Council and the wider partners who kept this work going through Covid which was an incredibly task and report. This was an important landmark for the city.

In terms of universities he could see three contributions that universities could make:-

- Firstly there was the research and we also train a lot of the future health and social care professionals and some important messages in this report about cultural appreciation.
- Secondly, the ability to engaged with different communities that was highlighted that we could do something about.
- Thirdly, one thing we had not came across before was the educational opportunity was an access to employment and different career routes to universities.

At the University of Birmingham we have been doing a lot of work recently to try and understand how we could make such opportunities more accessible to Black and African Caribbean communities. Professor Miller enquired what the best way was of having a conversation offline to try and coordinate this response of universities in the city to ensure we engaged with this and look at those three issues of research, training students and also in terms of opening up educational opportunities and to African and Black communities.

Dr Varney undertook to pick up with Professor Miller offline as he was going to send the information to the Vice Chancellors to prompt their thinking. The point on those pipelines were important particularly in the mental health and wellbeing section. We had two individuals from the communities who were clinically trained psychologists who were saying how hard it was to progress.

This also chimed with several academics who felt strongly that their progression was being halted because of their ethnicity and that they were struggling to break through. It was an important point raise by Professor Miller regarding the third point which came out in the detail of the report about career progression and career opportunities, something we all needed to reflect on.

Andy Cave, Chief Executive, Healthwatch Birmingham commented that he welcomed the report coming before the elections. Mr Cave stated that what came through for him was the continuous co-production which was important and a lot of the opportunities that will happen. He added that he was happy that the potential relaunching of that, but equally with the ICS system and elective resource with engagement the involved groups was a real opportunity to come together. It was an opportunity to develop the principles of co-production involved.

Mr Cave enquired whether there was anything that came through in addition to what was in the opportunities that suggested alternative ways of doing co-production that would help us to engage with the African Caribbean communities. There were three areas that came through that echoed some of the learning through Covid that was community advocates, workplace and investment in organisations and whether there was anything else that could be highlighted in good co-production.

Dr Varney made the following statements:-

a. The two things that stood out for him was recognising firstly that African Caribbean communities were not the same community which was important and within African communities there were some significant differences. This came out through the co-production.
b. The engagement was we needed to be better as public sector organisations in understanding that the heritage, culture and identity of a Ghanaian person was different from a South African from an Egyptian and we called them all African because they happened to be on the same continent. Yet, we would be quite affronted if we were called French or Italian as we did not think of ourselves as Europeans. This was the first thing that came out strongly.
c. The second thing was Faith and business and recognising that Faith gets us far but was not the totality and the assumptions of Faith. Again, that came out clearly. We have a large Somalian Muslim population in the city and often with these communities that was Evangelical Church and Christianity was the predominant Faith. So really challenging ourselves to think about who was not being heard and that was where the business network became useful.
d. Another thing we had done through this was working closely with community media and radio stations like New Star Radio have been really supportive. There was more we could do to engage with social media content producers and other routes and mechanisms for co-production and engagement.
e. When we started this journey, we knew it was going to be big, but I am not sure that we quite realised how complexing and big it was going to be, particularly in understanding the African diaspora. This was one of the areas where the review had highlighted the need to dig deeper and

do more and to not assume that someone represented the totality of the community.

Mr Cave referred to health education and enquired whether it was too early to ask what the action plan for that could look like for us as a city.

Dr Varney responded that some of this was being tested with the Commonwealth Games Legacy Project. He reminded the Board of the Community Health Profiles that was launched – the Sikh and Bangladeshi profiles. We have commissioned a range of different African countries to profile linked to the Commonwealth part of which was a test of how much we were able to draw out in difference and understanding with the work we were doing around the physical guidelines. You could consider this as an overkill, but it was part of understanding the languages aligned with the differences in communities within south Asia.

We were starting to test that and there was a recognition from the people we developed the review with that there was not an easy solution. No one was able to say here was an intervention that would solve the problem. What they were able to do was to say quite clearly here was what was not working. There has been mandatory quality training since he qualified in the NHS, yet we failed to closed the discrimination gap in the NHS as long as he had been working in it. This was the kind of stuff they were challenging us on – look at what you were doing and why you were doing it, what was the evidence that made the difference.

Karen Helliwell, Interim Accountable Officer, NHS BSol CCG commented that she welcomed the report and that the new organisation of the ICP, the Commissioner this will very much play around how we prioritised commissioning and resources which covers the regional services. Hopefully this will help on the screening of Sickle Cell and the more specialist areas which she had known from her previous roles in the past which was important to get right. Ms Helliwell stated that she was happy to help in that respect and enquired whether in terms of Lewisham whether the twinning of the comparing and contrasting the learning with Lewisham would be kept as it always helped if it worked as a partnership.

Dr Varney stated that we had decided to move from being siblings to being cousins in this in the next phase with Lewisham partly because we were in quite different stages of the process and partly because the ICS structure were quite different. He added that he along with the Director of Public Health in Lewisham felt that now was the time to part ways, but we would continue to communicate on learning. Some of that also in relation to the emphasis and the data pack which was still being produced that will go alongside this for the May launch which we hoped will be an interactive data pack on Power BI demonstrated that there were quite some significant differences between ourselves and Lewisham.

Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust echoed Dr Varney's earlier statements in reference to the identification of African and Caribbean communities and made the following comments:-

- We needed to be more specific with our interventions as Africa was a continent of 54 countries. The broad brush of Africans we needed to start being more specific by our interventions as this relates to how people experience of services. If we were not specific, we constantly keep it at a high level. There was a level of fatigue out there about the number of reports we produced the route into any difference in terms of the day to day challenges that people faced. We needed to think about how we were going to really focussed on how this makes a difference. This report had tapped into some things that was recorded in our systems as we talked about the recording of ethnicity.
- We had seen a very high prevalence in terms of the use of the Mental Health Act something that we were currently focussing on and will be taking some of these recommendations to our providers as we have a number of pledges that speaks to the same things. This was another point of frustration that we had reviewed and tells us the same things, but what were we doing about it.
- We needed to ensure that we get into the details behind some of the inequality that we did not get consumed into the wider machinery of what we were talking about. These were some of the challenges that could get consumed into the big machinery and we lose sight of what we were trying to deliver.
- That he was committed to supporting this and to act as a champion from a mental health perspective.

Stephen Raybould, Programmes Director, Ageing Better, BVSC commented that he welcomed the report and the inclusion of the contributions that the community organisations could make. He added that as a general point he was more confident about resourcing communities of place than we had been about resourcing organisations for communities of interests. This was the reason for the change. What we had done previously was try to make everyone inclusive rather than trying to be specific about what we needed and what was capable of reaching out to the groups. It was a challenge back to the whole system to be brave and welcome the report.

Dr Varney commented that Mr Raybould's point was a powerful one. He stated that we found through Covid whereas a public health team we tried to commissioned partners to work with us for communities of identity. There were lots of gaps and the communities of place organisations did not have the cultural engagement and were not trusted by the communities to engage with them. This was something that as we go through this year of living safely with Covid that the team that had been leading that were now looking at how we transition that into some community partners to work with specific communities of identity as we already had good strategies with neighbourhood networks and communities of place but were weaker on communities of identity and communities of experience. For a city of this size it was disappointing that we had not been able to maintain those, and it was not known whether in our history it existed or not. They were not there as we came into the pandemic and we needed them there for the next one as well as for addressing these inequalities.

Dr Aslam stated that for the next paper that we have how as a strategy from now until 2030 it was not going to take us this long to address these issues in

this document. If it was not how will we judge whether this was going well and how will we comeback to it to hold each other to account to say that this has not gone as well as we would have liked. We needed to change tact.
Dr Varney gave the following response:-

a. This will come through in May's report with the Action Plan and the Data Pack. One of the challenges in this was that we did not routinely collect data on ethnicity on a whole load of outcomes.
b. It may be in the computer, but it was not extracted – example talking therapies the IAP service so the data on ethnicity was absolutely in the system but the IAP dashboard only allows access of ethnic data on one of the nine indicators of IAP. This was not routinely extracted.
c. There were some short-term things that we would expect to see in that Action Plan as a milestone within the next 18 months across the ICS and the Council services that were committed to analysing and reporting on our data publicly and transparently so we start to move to a way where we could track progress.
d. It was hard at this point to say here were the three indicators that would show success as the three indicators I could see in the data were probably the one that we would necessarily choose to track.
e. An important part of this was getting the data management right and through that setting milestones.
f. As we have been going through this, we had not sat on our hands particularly in the maternity area where there was damming evidence and the local maternity system had been proactive and responding to the initial findings.
g. They had already starting to commission culturally competent materials for maternity staff to better understand different ethnicities and cultural practices around birthing, weaning and breastfeeding. This was already a good example of things where we were moving fast.
h. There were some other areas where we needed to take this report to our national and NHS colleagues. Some of this was about the way the computers were built to make it hard to get stuff out.
i. It was hoped that when we come back to the Board in May there will be an Action Plan and a milestone alongside that for the Board to be able to clearly see and it was one of the recommendations for us to seek the Board's approval to bring this back on a regular basis so the Board could hold us to account.

Carly Jones, Chief Executive, SIFA FIRESIDE enquired about commissioning frameworks coming into the programme and whether there was a vision for voluntary sector organisation to be commissioned i.e. that this will be built into commissioning frameworks. She further enquired whether contractual obligations were being created for them to support and whether this extends beyond the big players such as the NHS bodies but filters down to the whole of our system and whether this was the intent for what would happen.

Dr Varney stated that it was thought that this was something particularly in the Inequalities Forum that we needed to work through. As much as we had done this for the African and Caribbean communities, we could have equally done it for our visually impaired communities or for other ethnic communities and it would have probably came out with very similar issues. As commissioners we needed to be smarter to understand and reflect the differences and the work on

maternity was a good example of that where there was a specific difference affecting African and Caribbean women. A specific taskforce was now established to focussed on those inequalities and what it was that we needed to do differently in the maternity system. It was about balancing that – progressive universalism which was a term we used in Children's Commissioning a lot - meaning that we expected everyone to be inclusive and competent. We expected to see targeted services where the need demands it and the evidence drives us. We needed a more robust approach to communities identity in a much smarter way.

The Chair commented that there was a strong need for collaboration and co-production and ensuring that the Third Sector was involved at the different levels. A great opportunity in terms of help with the NHS and what happened with the ICS.

633 **RESOLVED: -**

The Health and Wellbeing Board:-

1. Approve the content of the report from the Birmingham and Lewisham Black African and Caribbean Health Inequalities Review (BLACHIR);

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

3. The Board considered nominating a champion who will be responsible to ensure the Board partners respond to the review; and

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

BIRMINGHAM JOINT HEALTH AND WELLBEING STRATEGY

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

(See document No. 4)

Stephen Raybould, Programmes Director, Ageing Better, BVSC enquired about progress in relation to the joint Health and Wellbeing Strategy. He referred to the map showing life expectancy and queried why that could not be done around ethnicity before. He added that there was a challenge around the way that the way that the information systems were constructed to enabled that to be produced. It was known that it was better n the Covid crisis but there were still limitations. Mr Raybould further enquired whether there was enough progress to get good visibility going forward around life expectancy.

Dr Varney advised not on life expectancy yet, but this was a conversation he had with the Chair at the beginning of the pandemic concerning death certificates which did not record ethnicity. Although the government had made a commitment as far as he was aware this still had not happened yet as they have not changed, he books. The death certificate was a handwritten bit of paper.

Until that happens it was very difficult to get life expectancy by ethnicity. The only way it was done in Covid was the Office for National Statistics (ONS) was able to connect people's death certificate with their NHS number and from their NHS number they were able to identified their ethnicity, and this was how it was done. It was a huge piece of resource and was not something that we could mimic at a local level unfortunately, let alone the mass of life expectancy which was a complicated piece of calculation.

Aside from that until government changed the death certificate to explicitly include ethnicity, we would not be able to create that kind of roadmap for inequalities in a robust enough way. Where we had progress and it had reflected to some extent in the strategy was that there were more indications now that we could get different data not just for ethnicity but for other dimensions in identity and we needed to do more to continue to build that because the code sat within the NHS system, we just did not extract the analysis.

The maternity piece of work was a good example of we could start to do that moving forward. We need to build across that into looking at example – hospital admissions for acute heart attacks. Public Health cannot access this at the moment. The population data by ethnicity for the local level was within the system – through our population health management programme we could start to develop that, so it become a routine report. This was a key part of the underpinning foundational change that we had to make.

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG commented that things will happen quickly and enquired whether this was one of the things that will happen quickly. He added that he did not bought into the issues that we had to wait for the death certificate as we could use the same information the ONS used. We could pull out the clinical data from the system as one of the population management tools that could facilitate that bit. Dr Aslam stated that he was keen that we avoid delay waiting for something to happen.

Dr Varney advised that in terms of population management stuff the first piece of work was on infant mortality and two further pieces of work that were happening on diabetes and Covid vaccinations. Part of that was matching data across the various bits of primary and secondary care to bring those together which for colleagues who were not in the NHS you would think was relatively straightforward. In reality this was horrendously complex and although there were quite rapid movement with things like integrated care records which would make it easier, that was still going to be a while before it became available.

Life expectancy was not as straightforward as just pulling the age at which someone dies, there was a whole piece of maths which sat behind and was not

easy which was why we were reluctant to try and calculate it locally without significant university support. There were stuff that we absolutely could do much to look at the preventative causes of death and cardiovascular disease now which across the NHS we recognised and across the system was one of the largest drivers of early death in the city. There was a lot of data we could pull by ethnicity and by other dimensions of identifying that and faster and to driver the action that we needed to.

Dr Aslam referred to the number of universities within Birmingham and that we had Aston University, which was sitting in West Birmingham, but we did not have direct conversations with them. He enquired whether Dr Varney has had that conversation with the universities.

Dr Varney responded that through Covid he had expanded his contact with the universities. He added that he had contacts with the five large universities, but less so with the four specialist, example, Birmingham University of Law which was a small specialist university with about 400 students. With the four specialist ones generally they were not public health focussed. With the five they have got different levels of engagement and one of the things outside of the meeting he had being doing was working with the Vice-Chancellors on how we flex the academic capital of the city more to support the work we needed to do on inequalities and think beyond the medical schools. Medical schools were important, and we did some really great stuff, but we needed the support of Social Sciences to be working with us on this.

Dr Varney highlighted that he was due to meet the University of Birmingham's Head of School for Social Science next week to talk through that point and would then mirrored that with the other four universities.

Th Chair commented that we could tell by the strategy that it had pulled together the ambitions of the Health and Wellbeing Board. The Chair expressed thanks to every that had contributed to the consultations, the engagements, research and the huge amount of work that had been put into this and also those that had collated all of the evidence and pulled the strategy together. This had taken a lot of work in the background. Thanks to everyone who were involved in that piece of work.

634 **RESOLVED: -**

The Health and Wellbeing Board:-

I. Agreed the Health and Wellbeing Strategy: 'Creating a Bolder, Healthier City 2022-2030' and publish findings from the public consultation; and
II. Recommended the strategy for approval by Cabinet.

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

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

(See document No. 5)

The Chair commented that she found the report incredibly useful and a good reflection which would be useful moving forward at we addressed some of the health inequalities and the things it had flagged up that we did not realised that was there. The Chair expressed thanks to Dr Varney and officers for the work that had been done in this area.

635 **RESOLVED: -**

The Health and Wellbeing Board:-

a. Noted the contents of this report;
b. Provided feedback on this report;
c. Agreed to support the identified recommendations of the report; and
d. Approved the Annual Report for publication.

PERINATAL AND INFANT MORTALITY TASKFORCE

Dr Justin Varney, Director of Public Health presented the item and drew the attention of the Board to the information contained in the slide presentation highlighting paragraph 4.8 of the report - identifying the three workstreams that came through the co-production approach. At the heart of the Task Force had been a strong approach co-production.

(See document No. 6)

Dr Varney stated that one of the powerful things of the Task Force was the voices of women with the lived experience of infant mortality and how passionate they were to act as part of the solution to prevent other parents going through that loss. They had made some strong recommendations about things that we needed to do in the short term to improve support for families affected by infant mortality.

636 **RESOLVED: -**

The Health and Wellbeing Board noted the contents of the report.

AGENDA ITEMS 16 - 17

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

The Chair reminded the Board that anyone wishing to be Champions within their organisations to please get back to Dr Varney on any of the things they had volunteered for as this would be most appreciated.

The Chair expressed thanks to Councillor Paulette Hamilton, MP who had chaired the Board meetings for a long time and for all her work and dedication to the Board.

OTHER URGENT BUSINESS

638 There was no other urgent business for this meeting.

The meeting ended at 1628 hours.

……
CHAIRPERSON

BIRMINGHAM HEALTH & WELLBEING BOARD

Action Log 2021

Rag rating :
- Overdue
- In progress
- Complete

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

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

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

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

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

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

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

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

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

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

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

NHS
Sandwell and
West Birmingham
NHS Trust




THE TRUST STRATEGY 2022– 2027

PATIENTS
PEOPLE
POPULATION

Contents

Sir David Nicholson
Chairman

Richard Beeken
Chief Executive

Background

At the heart of our 2015 to 2020 strategy, we wanted to be the best integrated care organisation in the NHS.

In that time, we have made huge strides working together on areas such as end of life care, specialised care when leaving hospital (complex discharge) and, of course, vaccination. In 2020, we integrated with a General Practice group, Your Health Partnership, meaning that we now hold direct responsibility for primary, community and secondary care needs for 10% of our population.

Our efforts to implement seamless and best value, quality care across the Black Country and West Birmingham have been supported by changes in national policy. 2022 will see the introduction of Integrated Care Systems (ICS), Place Based Partnerships (PBP) and Provider Collaboratives (PC). These policies formalise how and where partnership working can assist in the delivery of our strategic objectives.

Our vision for 2020 focused on the development of our new hospital, now named the Midland Metropolitan University Hospital (MMUH). It has been a challenging construction journey, but we move closer each day to opening its doors. MMUH will offer maternity, children's and inpatient adult services to half a million people in a state of the art facility. MMUH's location in Smethwick leads the way in social and economic regeneration for our communities, supporting a better quality of life. MMUH presents a once in a generation opportunity to transform care delivery and our workforce.

Within and beyond the walls of our new hospital, we are transforming how we deliver care. We have already implemented our new electronic patient record, Unity. Our next five years will see more investment into Community Care as part of our big picture approach to delivering care, known as the Acute Care Model, as well as more investment into our own Clinical Research to benefit our local population.

However, we still have a long way to go if we are to build an organisation that achieves our aspirations. We remain rated as "Requires Improvement" by the Care Quality Commission, who regulate health and care services. For staff and patient satisfaction we are in the bottom 25% of all NHS Trusts.

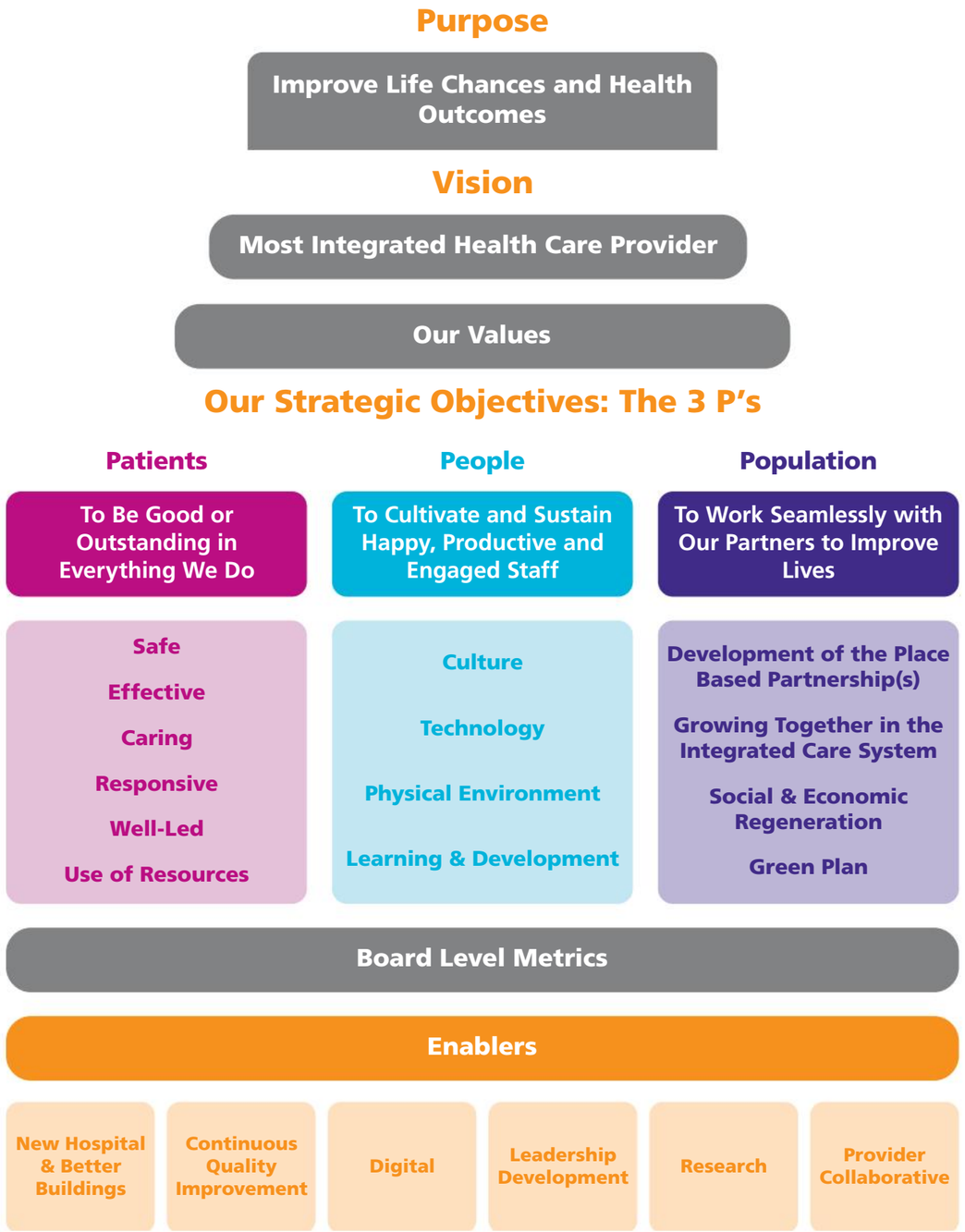
Our five year strategy is set in the context of:

- **completing and opening a new hospital with both supply chain and workforce challenges;**
- **meeting the changing demands of COVID including vaccination;**
- **recovery and restoration of our services, in particular our planned care waiting lists;**
- **worsening health in our population, exacerbated further through inequalities;**
- **a workforce that is burnt-out and suffering physical and mental health impacts of COVID;**
- **integrating with other organisations in our region; and**
- **finite resources in a health system that requires end to end transformation.**

As the world around us continues to change we must stay focussed on why we do what we do, how we conduct ourselves, and what we want to deliver.

Strategic Framework

To deliver our strategy we need to be clear about five areas: purpose, vision, values, strategic objectives and board level metrics. These five fundamentals are underpinned by six 'enablers' – the areas that will support achievement of our strategy: our new hospital and better buildings; continuous quality improvement; improved use of digital; leadership development; research; and our provider collaborative. These are visualised in the diagram below.



Purpose

Our Trust has always aspired to be more than a hospital. In fact, we have always aspired to be more than a healthcare provider.

Our vision has been to become renowned as the best integrated care organisation in the NHS. This is because we have always believed that by working seamlessly with our population, our people, and our partners we could "Improve the Life Chances and Health Outcomes of our Population". This is our purpose.

Vision

Our Vision is retained with one small amendment from "best" to "most" integrated care organisation in the NHS". This small change responds to feedback received so that it reads as collaborative rather than competitive.

Our vision remains underpinned by the National Voices (2013) definition for person-centred coordinated care:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

Values

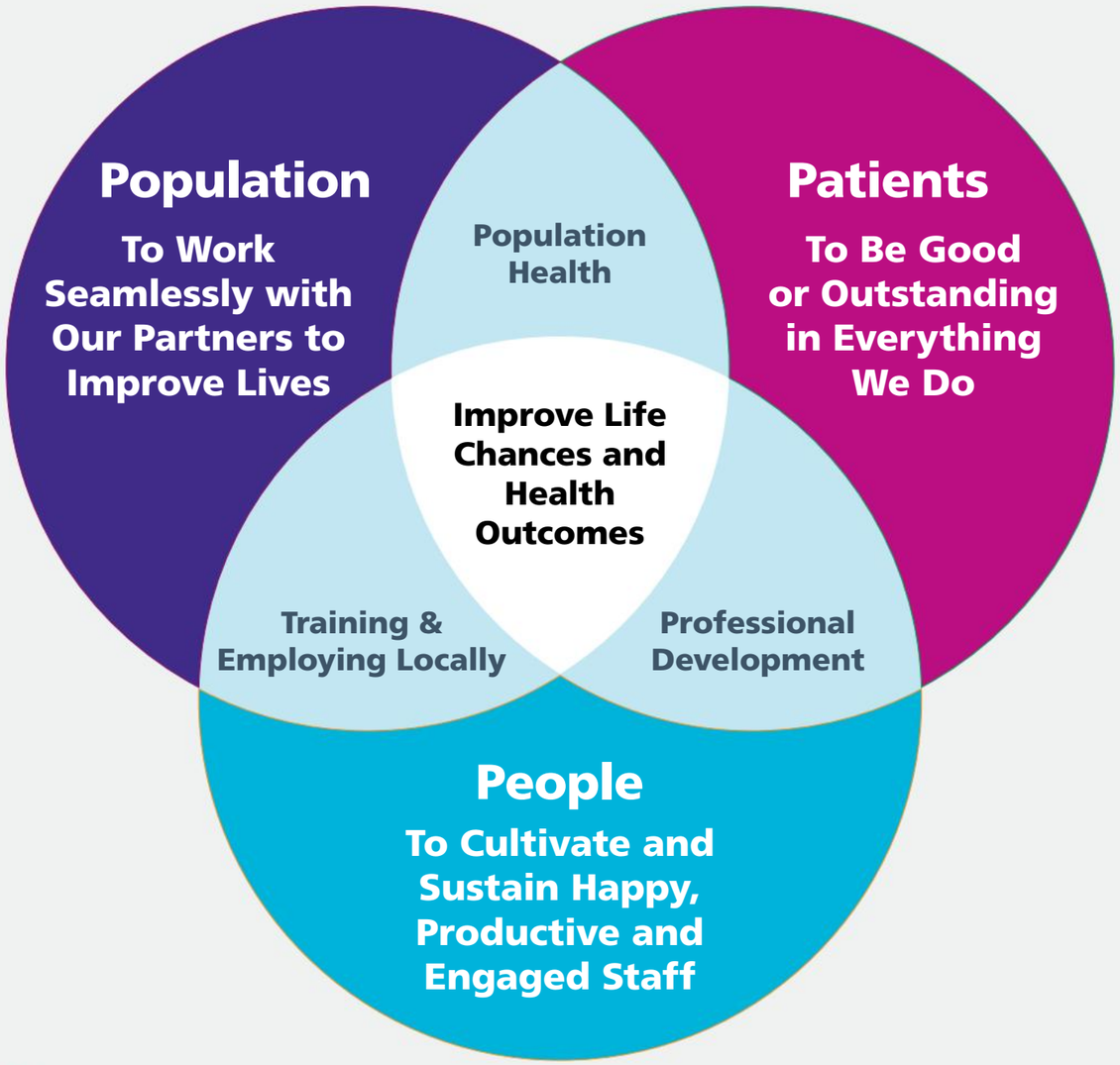
Since 2009 the Trust lived by nine care standards, or promises, developed by frontline staff. In Spring 2022, we will consult with our People, our Patients, our Population and our Partners and agree a new set of values that reflect our inclusive, collaborative and compassionate community. These will be practiced through a new behavioural framework which will be fundamental to who we are, who we recruit, how we work and how we treat those that we work with and care for.

Strategic Objectives

Over the next five years we will have three strategic objectives:

1. **Our People** – to cultivate and sustain happy, productive and engaged staff
2. **Our Patients** – to be good or outstanding in everything we do
3. **Our Population** – to work seamlessly with our partners to improve lives

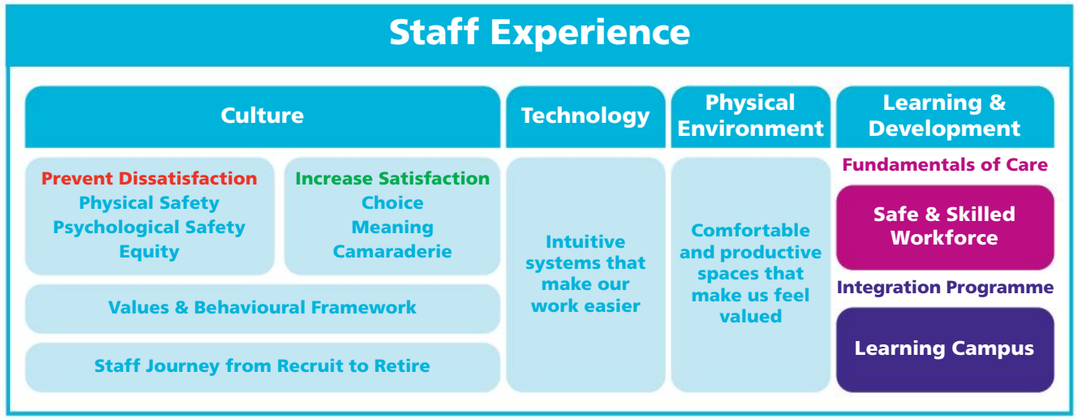
In setting our strategic objectives we have considered how they are linked together. We must deliver improvements in all three objectives if we are to be successful in delivering our purpose. This is shown in the diagram below.



Our People

Delivering great care starts with great people; people who are happy, productive and engaged in their work. Our staff survey results tell us that we must do better as an organisation in creating a workplace where people can thrive.

Over the next five years, we will improve staff experience to be in the top 25% of NHS Trusts through four means: culture, technology, physical environment, and learning and development.



Growing our culture together is a key part of improving staff experience, and we will focus on six domains to do this.

- **Physical Safety** – Our staff feel free from physical harm during their daily work and are assured that the right measures are in place to protect them;
- **Psychological Safety** – Our staff feel free to express thoughts and feelings about work and speak up about how things could be better without fear of negative consequences;
- **Equity** – Our staff can truly be themselves, are treated fairly, and are given the right support to meet their individual needs;
- **Camaraderie** – We nurture trusting relationships and community at work so that wherever we work, we feel like a team;
- **Choice** – Our staff feel that they have choice and flexibility in their daily lives and the way in which things are done;
- **Staff find Meaning** in their work and feel that what they do makes a difference.

These domains have been formulated through best practice within healthcare and aligned to the NHS staff survey. We will develop these domains so they are felt by every member of staff in their journey with us from recruitment to retirement, and practiced every day through our Values and Behavioural Framework.

In addition to culture, we will strive to make our technology easy for our people, patients and population to use and in MMUH and across all sites, we will develop work spaces that our staff are proud of.

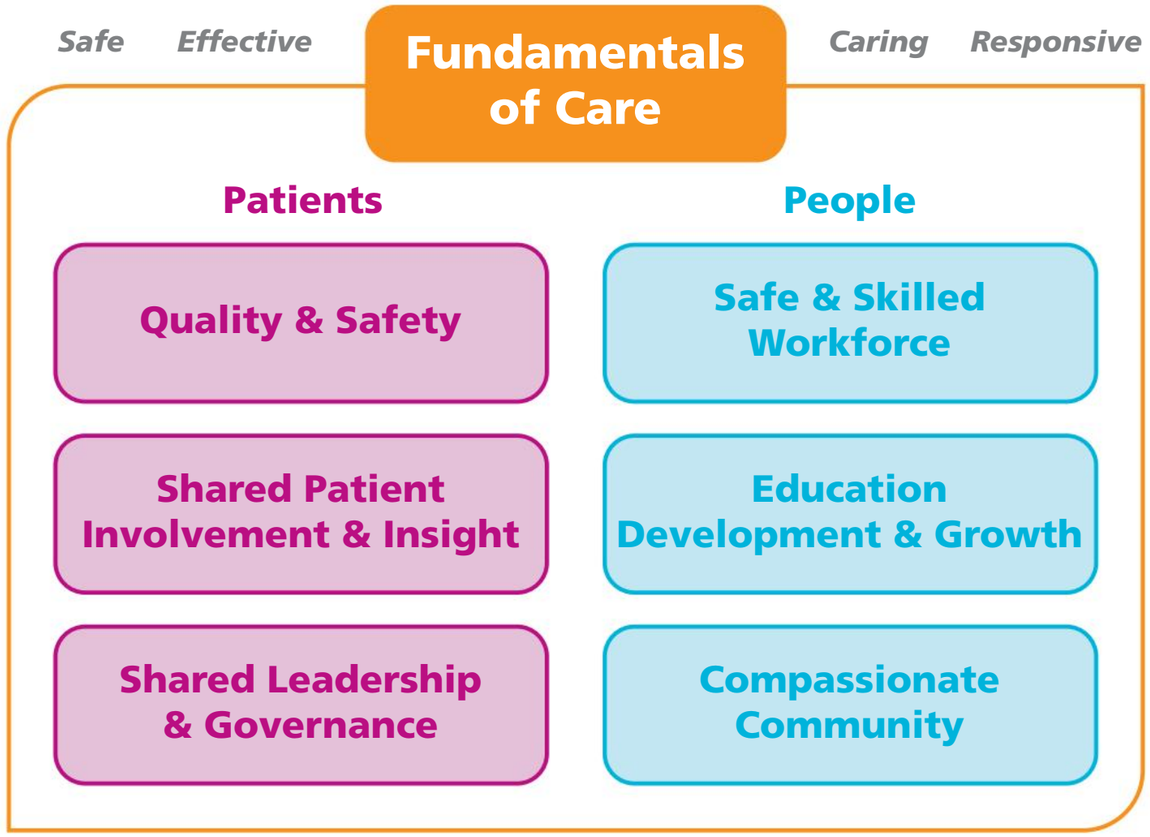
In developing our strategy, we have heard how passionate staff are to develop, and to support their colleagues to grow too. Learning and development will be another key part of the People Plan and the Fundamentals of Care programme while working with our partner Universities and other education institutions to develop and grow the training programmes that we deliver. The construction of a learning campus on our MMUH site will see further investment in developing our People and our Population.

Our Patients

We want to deliver better care to our patients. This means being seen in a timely and convenient way, feeling respected and listened to, and achieving the best clinical outcome possible for the best value. Over the next five years, we want to take our focus back to basics and get the fundamentals of care right for every patient.

We are commencing a new care improvement programme across the Trust. The Fundamentals of Care programme will bring together our Doctors, our Nurses and Allied Health Professionals and our Operational Leaders in a joint improvement programme for the first time. Fundamentals of Care is a Trust-wide initiative; it will empower our five Clinical Groups to work on what issues matter most to their patients and staff, supported by our Corporate Group. The Fundamentals of Care Programme has six components:

- **Quality and Safety including quality assurance and improvement across Safe, Caring, Effective and Responsive domains.**
- **Shared Patient Involvement and Insight, which develops person and population focused care including advocacy, co-production and experience.**
- **Shared Leadership and Governance to develop and embed inclusive leadership at all levels, including the creation of shared decision making committees.**
- **Safe and Skilled Workforce looks at the '3 R's' of Recruitment, Retention and Resilience to ensure we have appropriate staff with the right skills to care for our patients.**
- **Education, Development and Growth will create a 'University on the floor' with development pathways for all professions through the Fundamentals of Care Academy.**
- **Compassionate Community develops recovery and restoration in our workforce including wellbeing, teamwork, belonging and meaning.**



Together with the Clinical Groups we will set priority metrics so that we can see if we are improving in each part of the organisation. Our work with our teams and our patients will be underpinned by our focus at Board level to become recognised as being Well-Led.

The end goal will be a Good or Outstanding CQC rating across the five domains and in all areas of the Trust along with patient experience scores in the top 25% of NHS Trusts.

In addition to the Fundamentals of Care and Well Led Programmes, our Better Value, Quality Care Programme will explore how we can deliver care that uses our resources effectively and ensures that we are financially sustainable.

Our Population

Throughout the last 20 years, life expectancy in the population we serve has remained lower than the national average. As an organisation with primary, secondary and community care services, we are in a unique position to affect the health of our Population.

Over the next five years, there are two areas of focus in our Population strategic objective: Seamless Care, and Health and Wealth.

Seamless Care

Development of the Place Based Partnership(s) ***Locality Level***

Growing Together in the Integrated Care System

Population

To Work Seamlessly with Partners to Improve Lives

Health & Wealth

Social and Economic Regeneration as an Anchor Institution

Green Plan to Reduce Our Impact on Our Environment

Seamless Care

2022 sees policy change in the way the health and care sector is structured. This means that we are encouraged to collaborate more with other partners in health and care so that we can deliver services in a more seamless and impactful way. The policy creates three formal collaborative groups:

- **The Place Based Partnership (PBP) which affects communities at a Town and Neighbourhood level;**
- **The Provider Collaborative (PC), which brings together the Black Country hospital Trusts into a peer network;**
- **The Integrated Care System (ICS), which coordinates system working across the Black Country.**

At Place level (town and neighbourhood), the focus is upon managing demand more effectively by providing better support in community and primary care. At a System level (Black Country), focus is upon solving inequalities in service capacity and workforce challenges through collaboration.

We are the host organisation for Sandwell PBP as part of our ICS which covers the Black Country. We also participate in the Ladywood and Perry Barr PBP in West Birmingham, which will become part of the Birmingham and Solihull ICS.

These Groups will focus on delivering four National 'purposes':

1. **Improving Population Health and Healthcare**
2. **Tackling Unequal Outcomes and Access**
3. **Enhancing Productivity and Value for Money**
4. **Supporting Social and Economic Development**

Working closer with other providers will bring many benefits to our People, Patients and Population. The Sandwell Place Based Partnership will focus on four areas shown below in driving seamless and holistic care in our community.

Sandwell Place Based Partnership

RESILIENT COMMUNITIES	INTEGRATED PRIMARY CARE	INTERMEDIATE AND SPECIALIST CARE	INTEGRATED PATHWAYS
Prevent ill-heath by addressing inequalities and living conditions, hosted in six new well-being centres	Develop locality hubs to deliver integrated and co-located well-being, primary and community services	Specialist teams that support primary care to prevent worsening health including 'step-up' and 'step-down' care	Embed seamless, end to end care across different providers with care navigation

As we work with partners to improve life chances and health outcomes we will monitor our rate of improvement as well as how we compare to other systems like us.

Health & Wealth

Research tells us that the care that healthcare organisations give only accounts for up to 25% of health outcomes, and other factors such as living and working conditions have a greater impact. As a large organisation that will always be rooted in Sandwell and West Birmingham, we have purchasing and employing power. We can choose to spend our budget and employ locally, which will positively impact our community and its economy. This is known as being an 'Anchor Institution'. Over the next five years, we will use our economic power locally to positively affect the lives of our population.

The development of our new hospital, Midland Metropolitan University Hospital (MMUH), is a great example of how we are using our organisational power as a force for community good.

Environmental issues such as global warming and air quality also affect the quality of life in our communities. Our award winning sustainability team have developed a new Green Plan which will tackle our impact on our environment as part of the national NHS objective to deliver net zero emissions by 2040.

Board Level Metrics

In 2021/22, we started the journey to make our way of measuring and managing our performance simpler and more focused. The first step has seen us reduce the volume of targets we monitor at Board Level by 80% to focus on the top 25 metrics which matter the most, known as our 'Board Level Metrics'.

We have made sure to align these to national requirements such as the Care Quality Commission and national targets, as well as local targets that we need to improve. We have adopted Statistical Process Control (SPC) charts to monitor whether we are making a meaningful difference and we benchmark our performance against other NHS Trusts.

Enablers

Our strategy is underpinned by six 'enablers' – the areas that will help us to deliver it. These are: our new hospital and better buildings; continuous quality improvement, improved use of digital; leadership development; research and our provider collaborative.

Midland Metropolitan University Hospital (MMUH) and Better Buildings

The single biggest change to our organisation in the next five years will be the opening of our new hospital, Midland Metropolitan University Hospital (MMUH). MMUH is a once in a generation opportunity to transform care delivery and our workforce.

MIDLAND METROPOLITAN UNIVERSITY HOSPITAL

Patients

- Transformed Acute Care Model
- Smart Hospital Design & Equipment
- 50% Single & En-suite Rooms
- Increased Frailty Capacity
- 7 Day Senior Decision Making

People

- One Team for Emergency & Acute Care
- Partnered with Universities to Develop Our People
- Flexible & Remote Working
- Simulation & Virtual Learning Environments

Population

- Regeneration of Smethwick & Ladywood
- More Green Spaces and Public Transport
- Pop-up Shops & Community Led Spaces
- Housing Development

For many of our people it creates a new environment to learn and to work on a single site and as a single team for acute care. Consolidation of staffing and the ability to attract new staff will help to create and sustain our workforce, develop our teams, and improve our efficiency.

For our inpatients, infection control and privacy will be improved with 50% of the rooms being single and en-suite. Critical areas such as theatres and intensive care will benefit from the latest design thinking and technology. There will be more seven-day decision making, same day emergency care and day case procedures provided from our treatment centres at Sandwell and City hospitals. More care will be provided in places other than hospitals with an enhanced community services provision in most specialties to keep people well and to return them home more quickly.

For our population, MMUH's location in Smethwick leads the way in social and economic regeneration for our communities, supporting a better quality of life. There will be inspiring urban design, more green spaces, public transport and housing, as well as opportunities for local businesses. Co-located with the hospital will be a new Learning Campus, helping to raise and realise the ambitions of not only our staff and students on placement but also our communities. This could provide a blueprint for other organisations like us and future regenerations in the West Midlands.

MMUH will be the most significant development within an estates plan which will have as much of a focus on community services as acute hospital services. The improved facilities, consolidation of teams and new pathways that come with the new hospital and our estates plan will underpin shifts in our Board Level Metrics around Quality, Safety, Efficiency and Experience.

Continuous Quality Improvement

The best healthcare organisations have been shown to have a culture of continuous quality improvement. This means that our People, as well as our Patients and Population, have the time, ability, and the means to make positive changes in our services.

Over the next five years we will adopt a clear and inclusive approach to continuous quality improvement. Staff across all levels of the organisation will be trained in quality improvement skills so that we have a shared way of doing things, making it easier to work together and have a positive impact on care delivery.

Digital

Delivering our Digital Ambitions is as fundamental to our People Plan as it is to our plans to improve the life chances and health outcomes of our Patients and Population.

Over the next five years we plan to:

- **Implement technologies that are easy to use and help our people to do their jobs more easily;**
- **Make the most of digital technologies to transform the delivery of care and patient outcomes, helping to understand our population and their needs, and keep them in the best possible health;**
- **Achieve a core level of digitisation in every service to make our work easier and safer;**
- **Support our partnerships in linking our information together so that we can all see a full picture of health and reduce inefficiencies.**

Leadership Development

Over the next five years we will set a tone of compassionate and inclusive leadership. Whilst the Board and the Executive are our formal leaders, we need leaders at all levels of the organisation. We will develop all our leaders: clinical and corporate; junior and senior; aspiring and established. Leadership development is an essential component in making our strategy a reality in our everyday work.

Research

Research advances all aspects of the care and wellbeing of our population, be it by: identifying gaps in treatment options; testing new services, models of care or new treatments; collecting samples for future use; or bringing evidence informed practice into everything that we do.

Evidence shows that research active organisations have better patient outcomes and that patients want to be active contributors to improving care by taking part. Increasing research knowledge and experience across all staff groups will help to expand this opportunity to more of our patients and local population, provide opportunities for individual staff development, enable clinical role and service development and improve staff experience.

Over the next five years we will work closely with our Clinical Groups to focus our research on what our population needs the most. In doing so, we will embed research into the heart of the organisation.

Provider Collaborative

Across the Black Country system, we have started to work more closely with our counterparts in our Black Country ICS, through a 'Provider Collaborative' (PC), in line with national guidance. This approach brings together the other NHS Trusts to explore how we can reduce differences in access, experience and outcome for our patients by working together.

Collaborating means that we can bring more benefits to our People, Patients and Population, including how we might bolster our specialised services by bringing them into one team, or improve our poorer services by learning from where it is working well elsewhere. Any proposed changes to service, workforce or organisational form, will be tested against our strategic objectives to establish whether they will help us to achieve them faster or more easily.

Priorities

We cannot do everything at once, so if we are to make meaningful progress on what is most important we must prioritise our key actions. We will therefore plan our strategy in actions before opening our new hospital, and afterwards.

Our Trust Priorities

Before MMUH

- Launch our Strategy and co-develop the plans e.g. Fundamentals of Care
- Value and Behavioural Framework
- Prepare for and open MMUH
- Staff journey from recruit to retire
- Budget reset and cost control
- Place Base Partnership Development
- Agree a Continuous Quality Improvement approach

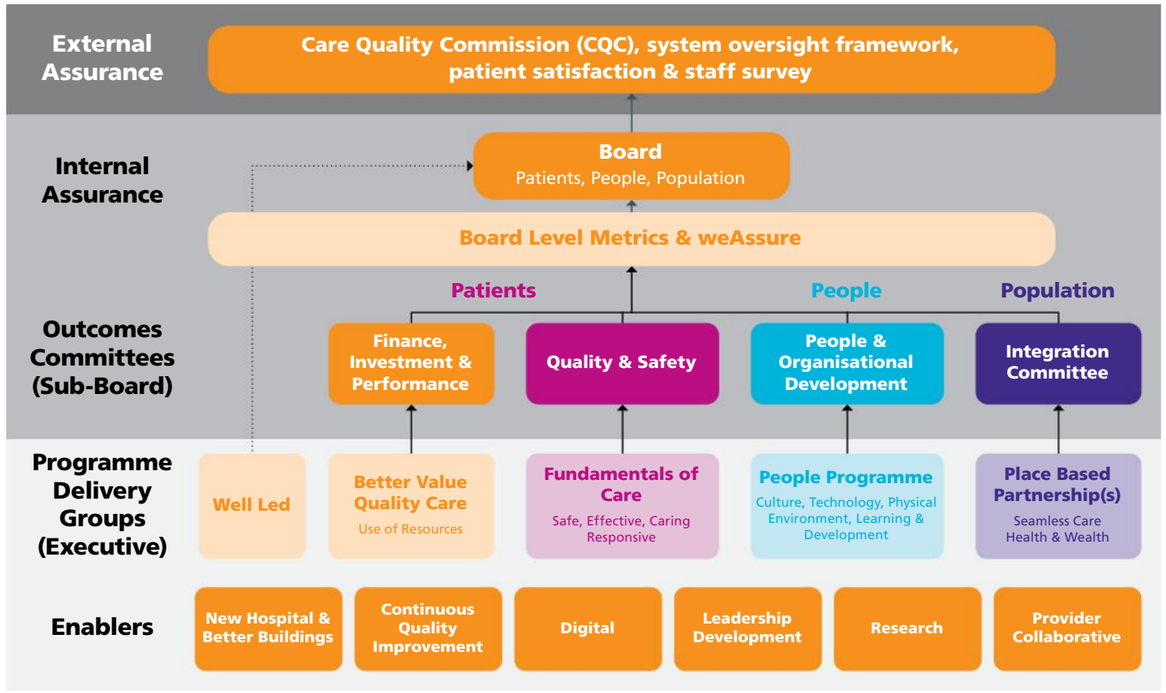
MIDLAND METROPOLITAN UNIVERSITY HOSPITAL

After MMUH

- Embed new ways of working and Continuous Quality Improvement
- Make significant improvement in our Board Level Metrics, Staff Survey and Patient Experience
- Develop a Learning Campus
- Work closer with partners in the Integrated Care System

Governance

It is our governance that sets out and underpins 'how' we will deliver the strategy. Our governance flows from the external assurance mechanisms, such as the Care Quality Commission reviews or NHS England's System Oversight Framework, to our internal assurance mechanisms such as our Board, our Outcome Committees and our Board Level Metrics, and through into our key Programmes. It will be the role of our Outcome Committees to scrutinise the journeys that the Programmes are making. This structure will drive our improvement against our People, Patient and Population objectives with support from our strategic enablers.



Find out more

@SWBHnhs SWBHnhs SWBHnhs

PATIENTS PEOPLE POPULATION

NHS
Sandwell and West Birmingham
NHS Trust

THE TRUST STRATEGY 2022 – 2027

Context

Looking back

- Integrated with a GP Group, Your Health Partnership
- Implemented new EPR, Unity
- Construction setbacks for our new hospital
- Collaborated with partners eg vaccination and complex discharge

Looking ahead

- Opening and operating the Midland Metropolitan University Hospital
- Post-Covid world service design
- Recovery and restoration of services and workforce
- Delivery of place-based care in line with the white paper
- Integration at a system level as outlined in new integrating care white paper

PATIENTS PEOPLE POPULATION

NHS Sandwell and West Birmingham NHS Trust

Purpose

Improve Life Chances and Health Outcomes

Vision

Most Integrated Health Care Provider

Our Values

Our Strategic Objectives: The 3 P's

Patients	People	Population
To Be Good or Outstanding in Everything We Do	To Cultivate and Sustain Happy, Productive and Engaged Staff	To Work Seamlessly with Our Partners to Improve Lives
Safe Effective Caring Responsive Well-Led Use of Resources	Culture Technology Physical Environment Learning & Development	Development of the Place Based Partnership(s) Growing Together in the Integrated Care System Social & Economic Regeneration Green Plan

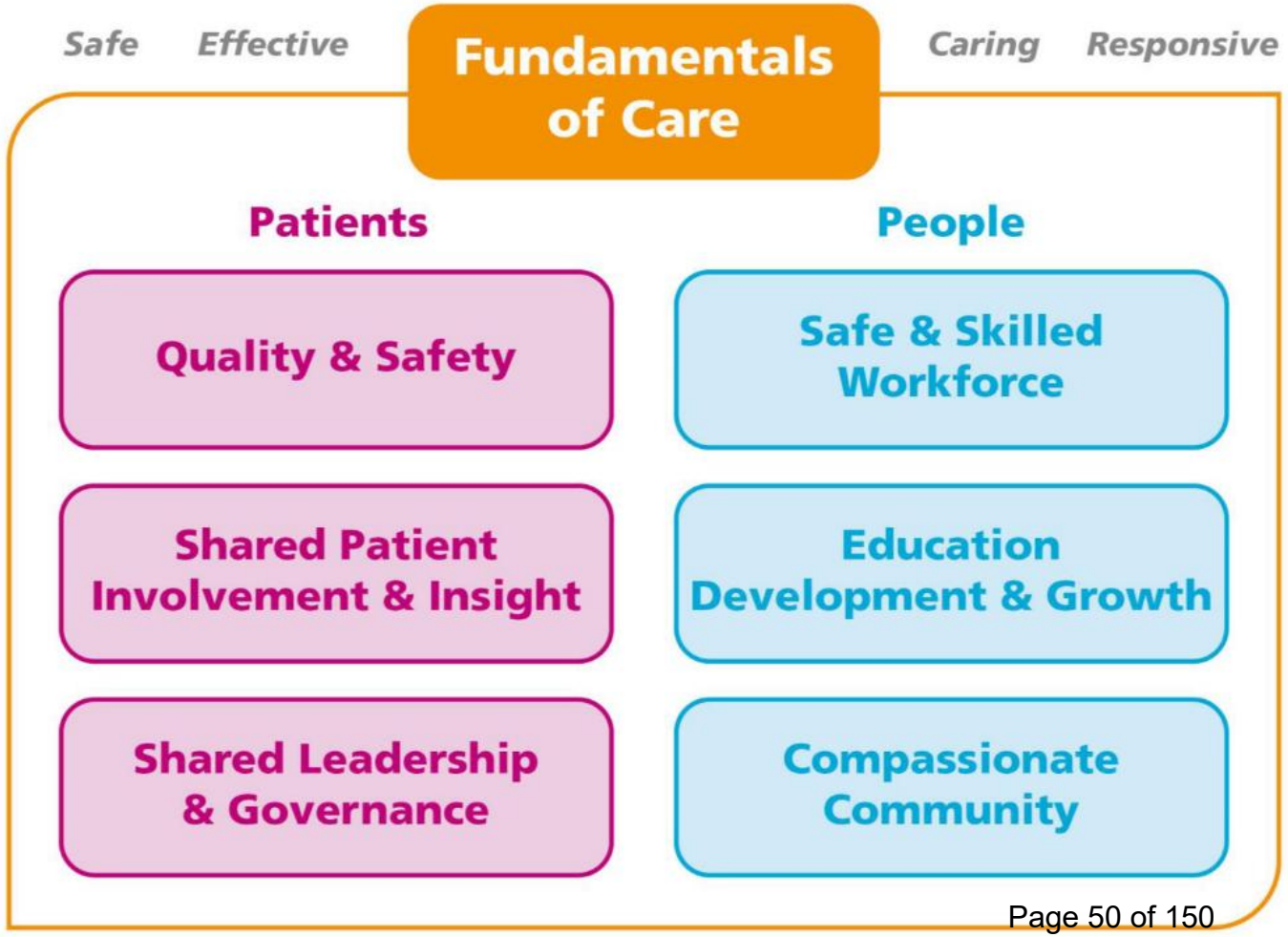
Board Level Metrics

Enablers

New Hospital & Better Buildings | Continuous Quality Improvement | Digital | Leadership Development | Research | Provider Collaborative

Our Patients

To Be Good or Outstanding in Everything We Do



Better Value, Quality Care

Well Led

Our People

To Cultivate and Sustain Happy, Productive and Engaged Staff

Staff Experience

Culture

Prevent Dissatisfaction
Physical Safety
Psychological Safety
Equity

Increase Satisfaction
Choice
Meaning
Camaraderie

Values & Behavioural Framework

Staff Journey from Recruit to Retire

Technology

Intuitive systems that make our work easier

Physical Environment

Comfortable and productive spaces that make us feel valued

Learning & Development

Fundamentals of Care

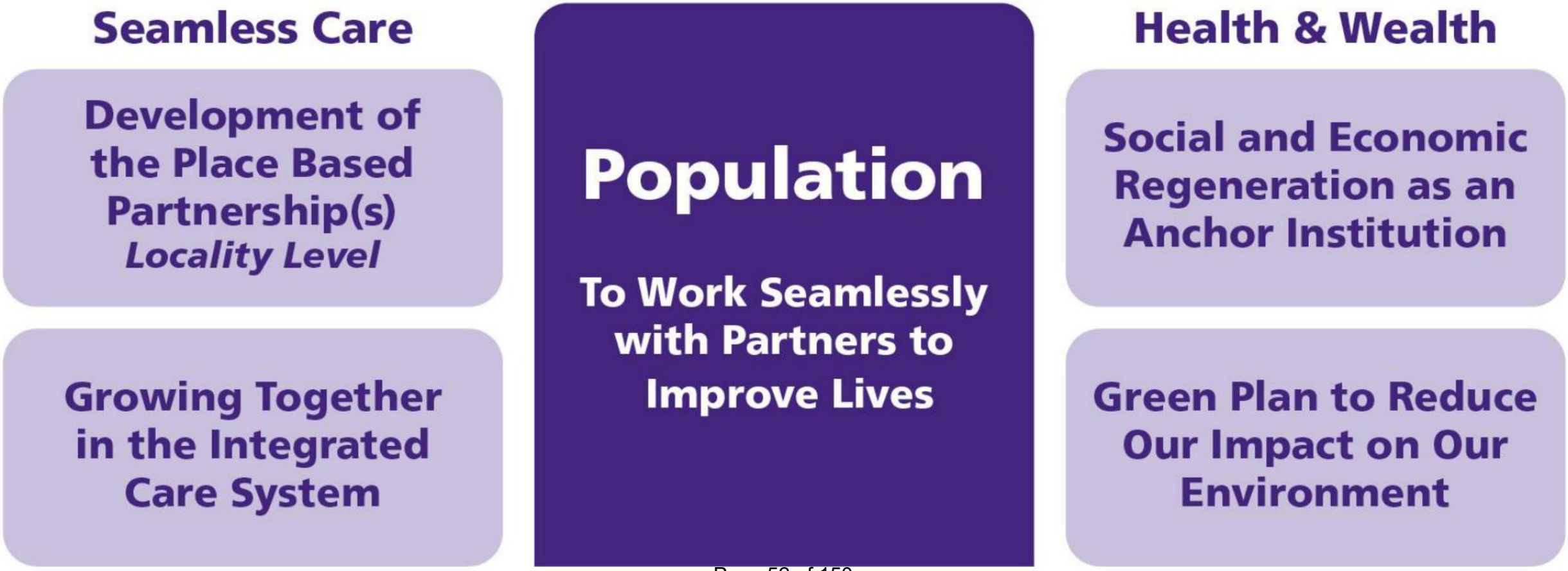
Safe & Skilled Workforce

Integration Programme

Learning Campus

Our Population

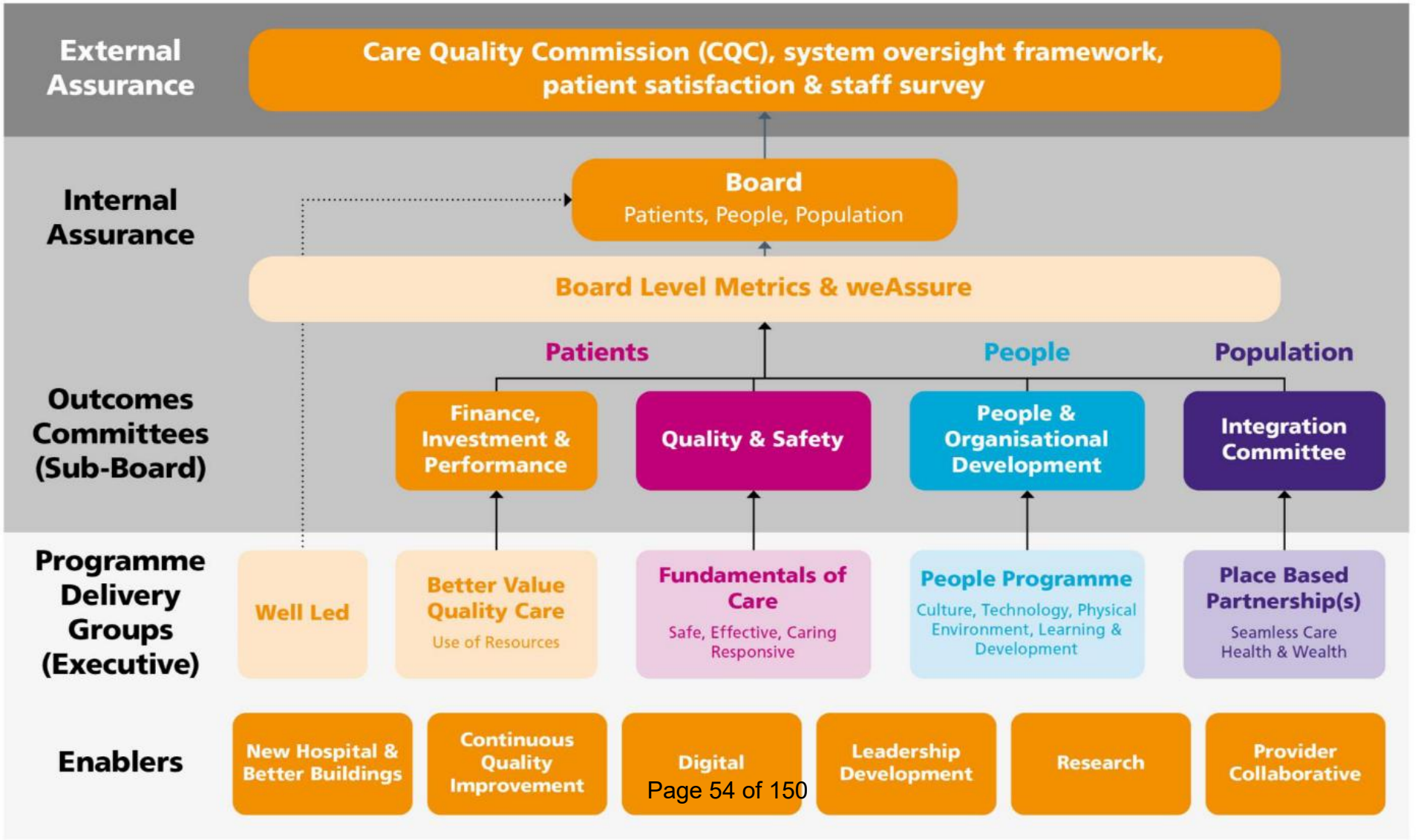
To work seamlessly with Partners to Improve Lives



Enablers

New Hospital & Better Buildings	Continuous Quality Improvement	Digital	Leadership Development	Research	Provider Collaborative
• Midland Metropolitan University Hospital • Acute Care Model • Upgrading our Existing Estate	• Create the capability and environment for Continuous Quality Improvement	• Easy to use • Transform delivery of care • Core level of digitisation • Link more systems together	• Compassionate, inclusive and aligned leadership at all levels of the organisation	• Advance our research maturity • Do more research for our local population	• Reduce differences access, experience and outcomes by working together

Our Governance



Our Trust Priorities

Before MMUH

- Launch our Strategy and co-develop the plans e.g. Fundamentals of Care
- Value and Behavioural Framework
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MIDLAND METROPOLITAN UNIVERSITY HOSPITAL

After MMUH

- Embed new ways of working and Continuous Quality Improvement
- Make significant improvement in our Board Level Metrics, Staff Survey and Patient Experience
- Develop a Learning Campus
- Work closer with partners in the Integrated Care System

Birmingham Health and Wellbeing Board

	Agenda Item:13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**17th May 2022**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES - BCC EARLY INTERVENTION AND PREVENTION PROGRAMME**
Organisation	**Birmingham City Council**
Presenting Officer	**Professor Graeme Betts, CBE**

Report Type:	**Information**

1. Purpose:

- To increase awareness and understanding of the Early Intervention and Prevention Programme
- To provide an overview and update on the programme
- Identify opportunities to align and collaborate on key elements of the programme

2. Implications:

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

3. Recommendation

3.1 To be mindful of EI&P programme and to help identify alignment opportunities with BHWB strategies and current priorities – implications of EI&P across BHWB strategic priorities and programmes, as detailed above

3.2	Identify any additional stakeholders, including staff, citizens and partners, to be involved in research and codesign for EI&P
3.3	Help identify appropriate SMEs (internal and external)
3.4	Define cadence of board appearances, receive reports or how best to work moving forward – to keep both parties aware and aligned of programme developments

4. Report Body

4.1 Birmingham City Council has recognised as part of its draft Corporate Delivery Plan 2022-2026 that shifting our focus from crisis to prevention is fundamental to improving citizen outcomes by supporting individuals and families at the early stages of an issue or crisis in their lives, before it becomes an acute problem. This is reinforced by Birmingham's Levelling Up strategy, which places early intervention and prevention (EI&P) as one of the five 'Levelling Up Accelerators' to enable prosperity and opportunity for all.

4.2 In March 2022, Cabinet approved funding to proceed to design and deploy a new EI&P service or Directorate that will bring together a multi-disciplinary, integrated, and inclusive offer that leverages the strengths of the Council and its partners to truly drive better outcomes for citizens. Our ambition is to bring our universal and targeted services together in one place, with the technology, tools, and ways of working that are fundamental to transforming how we work and think differently around working with our citizens EI&P.

4.3 Progress to date:

- Presented overview of the programme to **Housing** and **Digital & CS DMTs**
- **Cabinet report** and high level Target Operating Model **approved** on 22nd March – approval to move to detailed design phase and associated investment to resource the team
- Continued with **detailed design planning**, for example programme plan, project one-page overviews, resource requirements, stakeholder and engagement plan
- **'Accelerator project' options** continue to develop, projects prioritised and leads being identified
- **Design working group** session 4 – 10th May

4.4 Key points:

- We consider the EI&P programme will have implications for and be implicated by the strategic priorities and programmes associated with the board, as highlighted in section 2, due to the scale and scope of programmes. We hope to work in partnerships to align and collaborate

- Awareness of pathway approach developed by strategic partners based on existing best practice from the City – strategic partners from across the city have engaged with the programme so far; Police, BVCS, ICS leads, Citizen reps

- Health inequalities – aware that the ICS and Public Health have a number of programmes in this space, BHWB has oversight of these – research, learning, thinking is aligned to what we are doing as part of EI&P e.g. using libraries as accelerator projects use to share information regarding health, wellbeing, GP surgeries to be used as / alongside Community Hubs or to improve proliferation of IAG

4.5 Next steps:

- Secure strategic partner for phase 1 of the programme; June 2022 – February 2023

- Identify and onboard internal resource for key roles, including accelerator project leads, programme manager

- CLT workshop – 24th May

5. Compliance Issues
5.1 HWBB Forum Responsibility and Board Update
5.1.1 Health and Wellbeing Board will be updated periodically on the progress

5.2 Management Responsibility
• Help identify stakeholders, groups, SMEs, partners of interest for EI&P • Support of the partnership approach, including ISC, voluntary and community sector, BVSC strategic partner organisation, public health • Awareness – Strategic Sponsor (Graeme Betts) – engaged in the ICS governance structure

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Availability of appropriate resources to deliver the detailed design phase, starting June 2022 and subsequent accelerator projects.	2	4	Resource requirements articulated by end of February Investment ask included in March Cabinet paper to get a team mobilised from June 2022

Impact: Inability to deliver programme & target outcomes at pace, loss of momentum due to multiple paper submissions and approvals			Ongoing monitoring: via Corporate PMO Engaged with relevant stakeholders to identify if suitable resources are available. Internal resourcing of these key roles is prioritised
Staff not aware of potential changes before Cabinet paper produced in December 2022 **Impact:** Frustrated and angered staff	2	4	Brief CLT on changes prior to release of report, to informally feedback to teams Wider stakeholder engagement across the Council
Culture change required of BCC staff, partners and citizens does not land well or have desired effect **Impact:** Groups or individuals feel ostracised, pushed further away by the organisation. They do not feel as though they belong or align to the values and morals of the organisation. Decision to leave the organisation, stop working partnerships, disengage with council services.	3	4	Considered and thoughtful approach to culture change. External communications and change resource considered in addition to the strategic partner.
There are numerous change programmes underway across BCC and dependencies need to be understood to ensure there is not duplication **Impact:** Members and staff may 'perceive failure' if programmes do not appear to be integrated and / or expectations are not effectively managed.	3	3	Linking in with CPMO reporting, engagement with directors to understand programme change in their areas Engagement with relevant boards

Appendices
Cabinet report – March 2022 High level TOM – March 2022

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

Kalvinder Kohli, Chess Dennis and Charlie Hyland

Birmingham Health and Wellbeing Board

Early Intervention & Prevention (EI&P)

17th May 2022

Introduction

Purpose: to share a progress update, and request HWB's continued support for, the Early Intervention & Prevention programme as we move into detailed design.

Agenda:

- Programme overview
- Progress to date
- Risks & mitigating actions
- Accelerator projects
- Next steps
- Asks and recommendations

Early Intervention & Prevention - overview

Problem statement:

Many Birmingham citizens are not consistently empowered to or equipped with the necessary tools to live healthy, fulfilling lives independently. This is resulting in more citizens reaching crisis before they are supported, which is expensive for BCC, and leads to worse outcomes for individuals and families.

Our vision:

Enable everyone in Birmingham to become, and to be, ***independent***, socially and ***economically active*** and ***resilient citizens***, starting from when they are children and continuing ***throughout their lives***

How we will do this:

- Taking a **citizen-centric approach** that supports individuals to build **independence** and **resilience**
- Empowering officers to help citizens the **first time** by focusing on a **strengths-based** approach underpinned by **data**
- Adopting a **digital-first** approach where possible, with **options** to support a diverse range of needs
- Develop a **multi-disciplinary, integrated offer** that leverages the strengths of the Council and its partners (e.g. ComVol sector, health, police)
- Using **data** in a secure, ethical and compliant way to drive **improved decision-making**
- Driving improved **efficiency & effectiveness** (quality) by transforming the way we deliver our services

Value this will deliver:

Our citizens:
- ✓ I have built supportive local networks
- ✓ I am independent & resilience
- ✓ I have a positive first experience when engaging with services I need

Our staff:
- ✓ I am able to work collaboratively internally and with partners
- ✓ I feel engaged with my organisation
- ✓ I am satisfied with my job

Our council:
- ✓ We have a reduction in re-referrals
- ✓ We have reduced statutory demand
- ✓ We have positive interactions with citizens and partners

Early Intervention & Prevention – progress to date

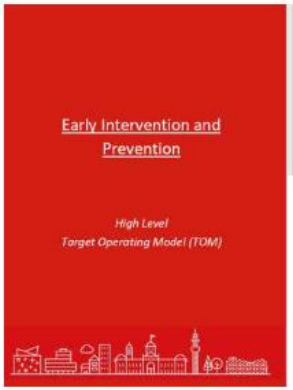
Following Cabinet approval for the EI&P high-level target operating model, we are now building a team for detailed design and prioritising capabilities or services for phase one of the transformation.

Progress to date

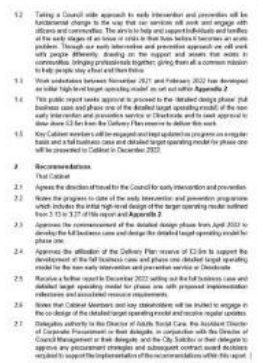
- Presented overview of the programme to **Housing** and **Digital & CS DMTs**
- **Cabinet report** and high level Target Operating Model **approved** on 22nd March – approval to move to detailed design phase and associated investment to resource the team
- Continued with **detailed design planning**, for example programme plan, project one-page overviews, resource requirements, stakeholder and engagement plan
- **'Accelerator project' options** continue to develop, projects prioritised and leads being identified

Risks & issues

Risk / Issue	Mitigations
• **Risk:** Availability of appropriate resources to deliver the detailed design phase	• Utilise a blended team of internal & external expertise and capacity to deliver
• **Risk:** Complex technology architecture across multiple services that will support delivery of EI&P	• Collaborative working with Digital & Customer Services directorate to map and understand required platforms



Output – Cabinet Papers



Output – Draft Research & Insight Brief

Accelerator project summary*

Our accelerator projects are those we want to take forward at pace as part of phase one to build the foundations for our EI&P service ('enablers') and create momentum with citizens for the new approach ('universal capabilities').

Universal capabilities

Homes & Money Advice

Lead: tbc (joint with Comm Hubs)

Dedicated Homes & Money Hub (physical and virtual) that supports citizens to become financially stable, able to maximise their income, reduce arrears, and avoid evictions. This will include universal services accessible to all citizens and a targeted service to support those who are at high risk of re-entry to the hub or require specialist support as their case is complex.

Libraries Experience

Lead: HoS (tbd – May 2022)

Re-think how our libraries become physical and virtual hubs for learning, discovery and culture for our communities that offer a range of shared and creative resources, activities and collaborative spaces for people to come together, work together, and learn together in addition to being able to access wider public services in the universal space through co-location.

Enablers

Information, Advice & Guidance

Lead: tbc

Curate a single source of truth for citizens and staff that is timely, accurate and relevant to support 'better, active and independent lives for Birmingham's citizens with lower demand for reactive crisis support'.

Community Hubs

Lead: tbc (joint with Homes & Money Advice)

Co-located, multi-disciplinary hubs with multiple services available there (internal and external) to encourage self-navigation and where staff are able to have strength based conversations offering navigation and direct support where required.

Contact Centre

Lead: tbc

Create streamlined points of contact (telephone and instant messaging) where citizens can receive advice from staff who are able to have strength based conversations and navigate them to the appropriate universal and targeted services as required.

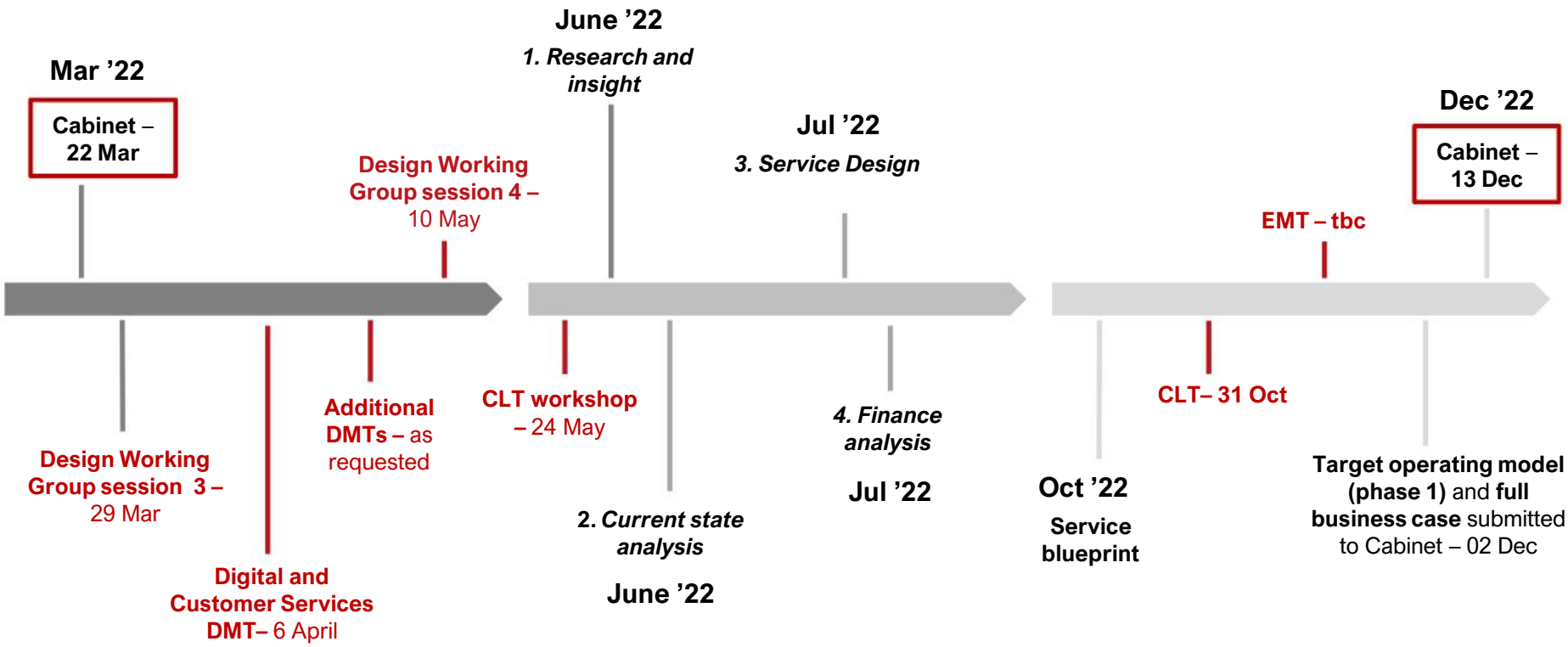
Data: single view of citizen

Lead: tbc

Design and implement a data and analytics tool that brings together key service data sets from across BCC and partner organisations to inform service development and in turn support service delivery as well as use data as a tool to identify those at risk of statutory support.

**there are several interdependencies between these projects and with wider strategies / programmes across BCC*

Early Intervention & Prevention – next steps



Key

Activity

Key engagement

** Not exhaustive*

Asks of and recommendations for BHWB

1. To be mindful of the EI&P programme and to help identify alignment opportunities with BHWB strategies and current priorities. **Support for the accelerator projects** and consideration of interdependencies across related programmes and strategies

2. Identify any additional stakeholders, including staff, citizens and partners, to be involved in research and co-design for EI&P

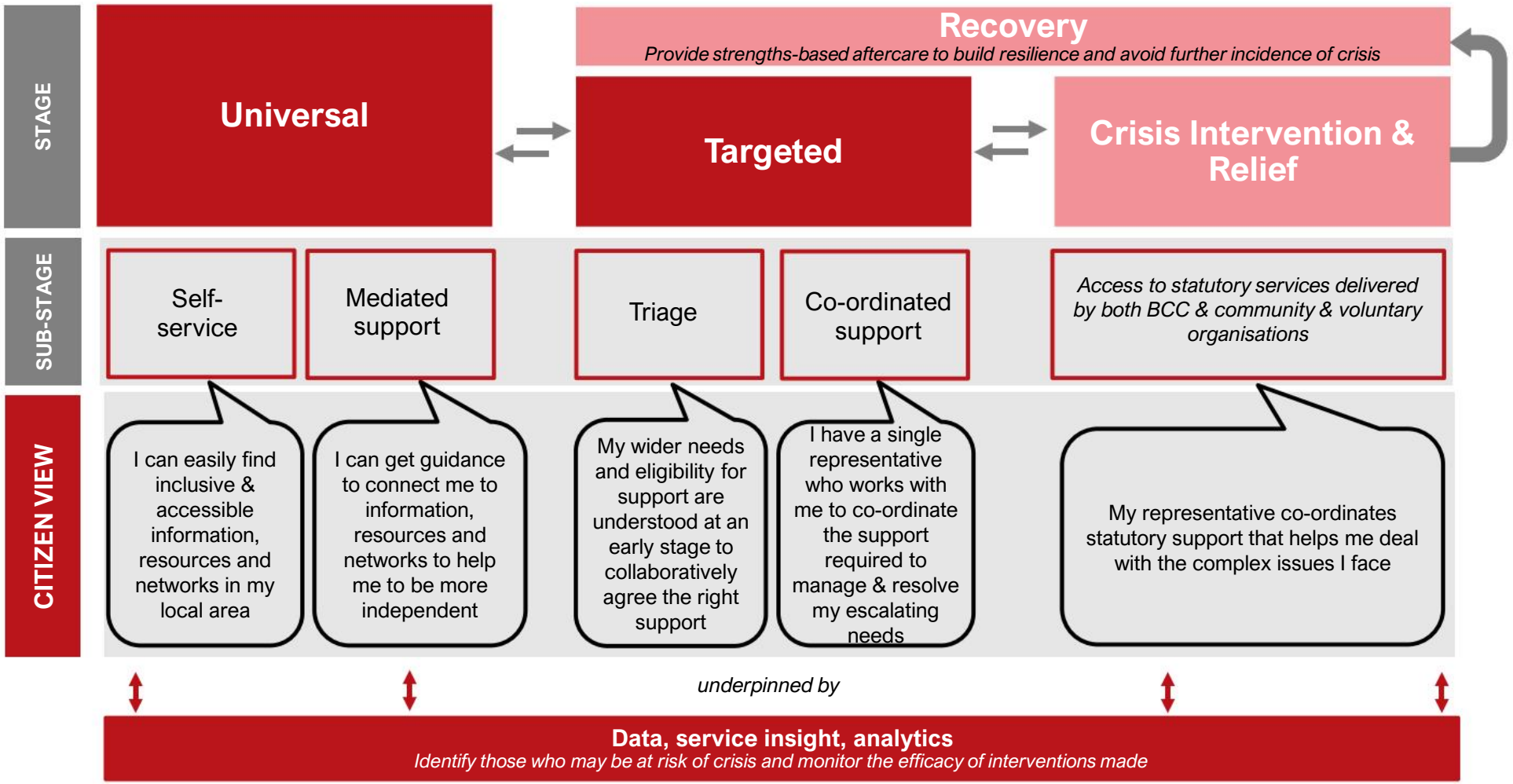
3. Help identify appropriate SMEs (internal and external). We are building a blended full-time team to deliver but will also require support from **Subject Matter Experts** across the Council for all in-scope services for phase one (tbd)

4. Define cadence of board appearances or how best to work moving forward – to keep both parties aware and aligned of programme developments

If you would like more details, please contact Kalvinder Kohli: Kalvinder.Kohli@birmingham.gov.uk

APPENDIX

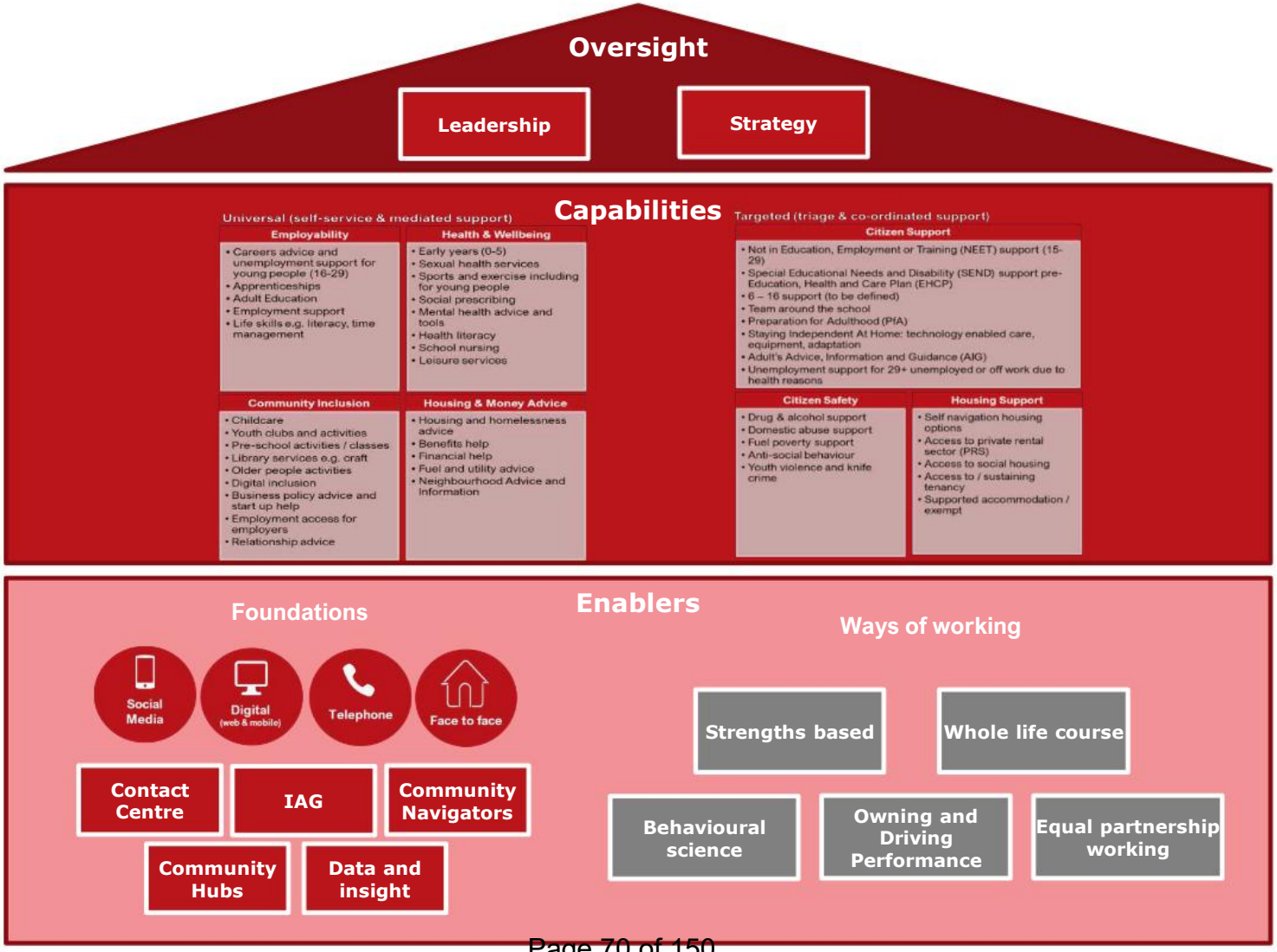
Prevention pathway



Key
- Focus for EI&P
- Outside of EI&P
- Transition

N.B: this is not a linear model - people will come in and move between different stages. The visual is simply designed to articulate what we mean by each of the stages and the key transitions, and is based on learnings from existing prevention models.

High level target operating model (TOM)



EI&P services & capabilities (future state?) *

Employability

- Careers advice and unemployment support for young people (16-29)
- Apprenticeships
- Adult Education
- Employment support
- Life skills e.g. literacy, time management

Health & Wellbeing

- Early years (0-5)
- Sexual health services
- Sports and exercise including for young people
- Social prescribing
- Mental health advice and tools
- Health literacy
- School nursing
- Leisure services

Citizen Support

- Not in Education, Employment or Training (NEET) support (15-29)
- Special Educational Needs and Disability (SEND) support pre-Education, Health and Care Plan (EHCP)
- 6 – 16 support (to be defined)
- Team around the school
- Preparation for Adulthood (PfA)
- Staying Independent At Home: technology enabled care, equipment, adaptation
- Adult's Advice, Information and Guidance (AIG)
- Unemployment support for 29+ unemployed or off work due to health reasons

Community Inclusion

- Childcare
- Youth clubs and activities
- Pre-school activities / classes
- Library services e.g. craft
- Older people activities
- Digital inclusion
- Business policy advice and start up help
- Employment access for employers
- Relationship advice

Housing & Money Advice

- Housing and homelessness advice
- Benefits help
- Financial help
- Fuel and utility advice
- Neighbourhood Advice and Information

Citizen Safety

- Drug & alcohol support
- Domestic abuse support
- Fuel poverty support
- Anti-social behaviour
- Youth violence and knife crime

Housing Support

- Self navigation housing options
- Access to private rental sector (PRS)
- Access to social housing
- Access to / sustaining tenancy
- Supported accommodation / exempt

Data, service insight and analytics - *overarching data & insight capability to gain insight into individual / household risk factors & inform intervention / resource commissioning*

* the capabilities above will be tailored based on the needs of different cohorts to be identified during detailed design

*these hypotheses will be tested with citizens during detailed design

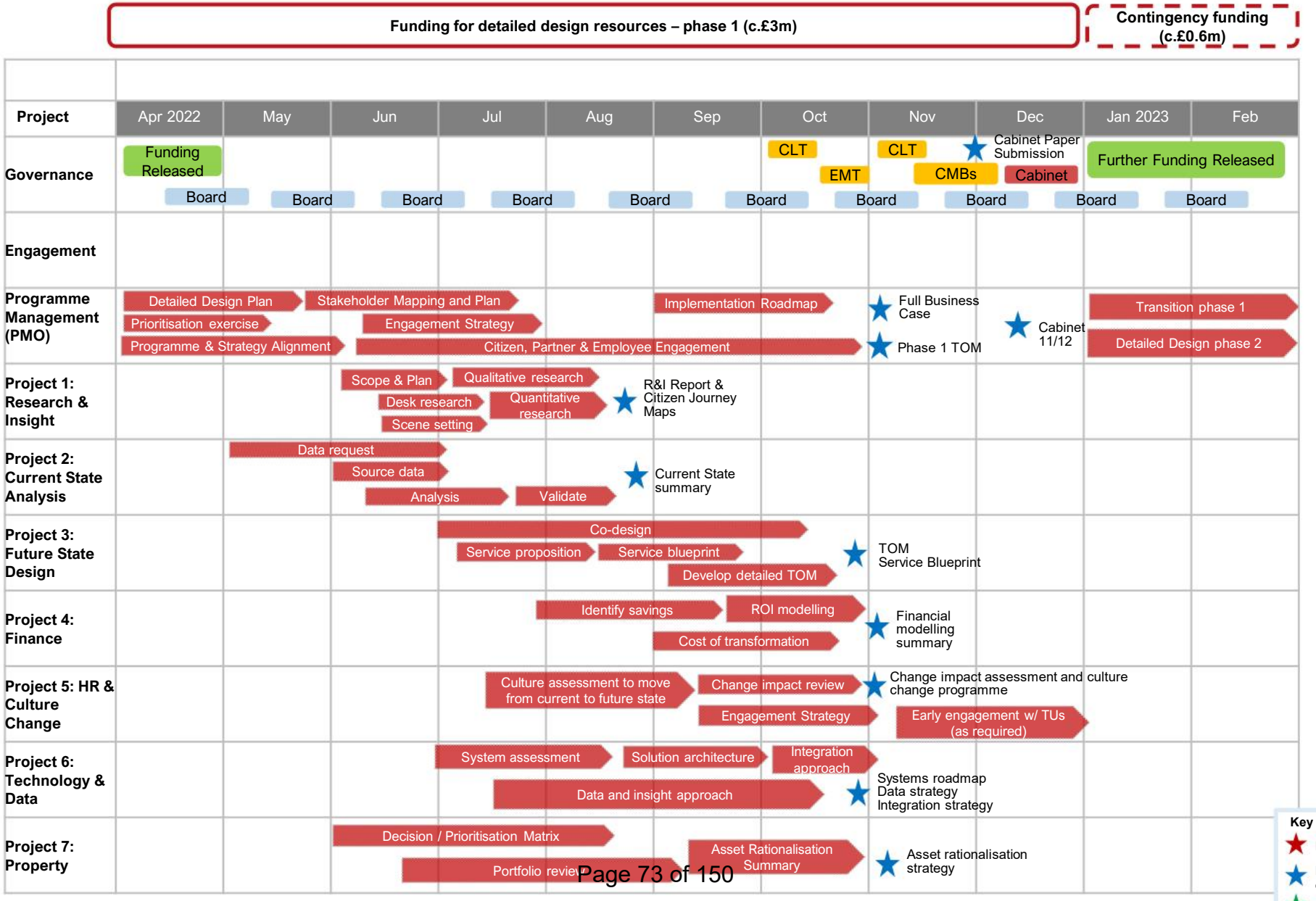
Review: Detailed design – citizen view

Our citizens want…*	Our EI&P service will…
 *I can easily find information and advice about local services on the web*	**Digital** (web & mobile) • Have one main website as the **single source of truth** for citizens and carers that contains **up-to-date information** and is **intuitive** to navigate • Have a website that uses **simple, easy to understand** with no jargon • Example: Use the **BRUM account** (customer portal) as the single online account to access personalised information, status updates, self-assessments • Provide access to **self assessment tools** for example housing options, integrated benefits calculator, income/ expenditure tools • Receive information **via text, email, and social media** on issues that are important
 *I can find out about local activities and community events on social media*	**Social Media** • Use trusted information from the main website to **share updates and information around local issues** and activities • **Promote activities** happening in the local community to encourage attendance • **Use data to identify what citizens are accessing services for** and how can we proactively push out information around these areas

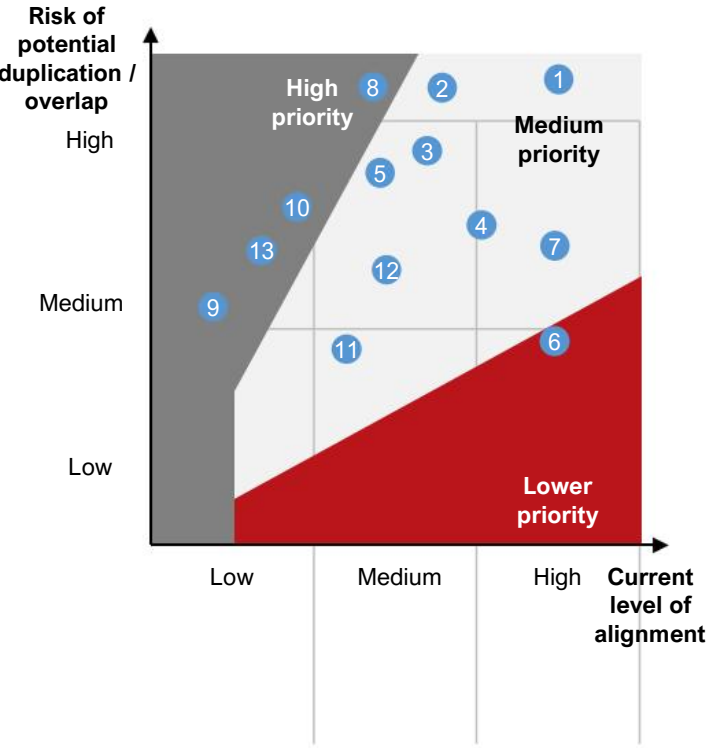
 *We know where we can pop in to speak to someone for information or advice about local services*	**Face to face**
	• Have co-located, multi-disciplinary services (internal and external) **across each of the 10 constituencies set within, for example:**
	  • **Community Hubs/Library Experience/Money and Advice** – multiple services under one roof for example health and wellbeing, employment and education support, activities in the local area alongside touch screens to encourage self-navigation
	  • **Partner locations** - places citizens already access and feel comfortable in for example GP surgeries, leisure centres, places of worship, commissioned providers
	  • **Outreach** - focused sessions for example on money advice in locations where citizens already meet for example faith settings, adult education sites, schools
	  • Staff are able to have **strength based conversations** offering navigation and direct support where required.

 *I know what number to call to get information or advice about local services*	**Telephone** • Have **one phone number** for citizens to access the contact centre • Staff are able to have **strength based conversations** offering navigation and direct support where required.

EI&P Detailed Design POAP – Phase 1 (Apr 22 – Feb 23)



EI&P – alignment with programmes and strategies *



	Programme	Lead contact	Scope alignment	Resource	Current Phase	Approach	Next steps
1	**Levelling Up** programme	Unknown	High	Unknown	Deliver	Monitoring	
2	**Customer Service**	Sheraz Yaqub / Nikki Spencer	High	Delivery resource to Jan 2023	Design & Deliver	Monthly alignment held in Feb and Mar, milestones/timelines shared, ad-hoc sessions also being held	Monthly session, opportunities to collaborate to be formalized, additional alignment sessions
3	**IAG**	Mike Davis	High	Unknown	Discover	Number of 1:1 conversations, part of Design Working Group (DWG)	Developing accelerator project approach, opportunities to collaborate being identified
4	**Digital Inclusion**	Sameena Asmat	Medium	Fully for 2 years	Design	Number of 1:1 conversations, accelerator project potential	Ad-hoc sessions
5	**Children and Families Transformation**	Deborah Brooks	Medium	Unknown	Discover	Monthly alignment, first 1:1 held in Feb	Reconnect end of April following service review
6	**Comm. Recovery Framework**	Jamila Mensah	High	One lead	Design	1:1 engagement with Jamila as required	
7	**Locality working/ Community Hubs**	Robin Burton	Medium	One lead	Discover	Call held, follow-up required	Lead to be identified, accelerator project potential
8	**Data & analytics** solution	Peter Bishop	Medium	Fully resourced	Design	Monthly call established, held Jan, Feb, Mar, Apr, key enabler	Monthly data and digital session
9	**Homelessness prevention re-design**	Julie Griffin	Medium	Fully resourced	Design	Number of 1:1 conversations, part of DWG	TOM review tender, engage with team when onboard
10	**Family Hubs**	Brianne Thomas	Medium	Unknown	Discover	Initial call in Jan, part of DWG	Hubs to be accelerator project, identify if suited
11	**Children's Trust**	Jenny Turncross	Low	Unknown	Deliver	Initial call in Jan	Increase involvement at DWG
12	**Libraries**	Ilgun Yusuf	Medium	None currently	Design	Number of 1:1 conversations, part of DWG, accelerator project	Establish relationship with new Head of Service
13	**Community Resilience**	Waqar Ahmed	Medium	Paper being written	Discover	Regular 1:1 to be established	Call planned April 25th

** As of April 2022*

RAID log escalations

Type	Ref #	Category	Description	Impact (1-5)	Probability (1-5)	Total score (I *P)	Mitigation	Updates	Mitigation Owner	Review date
Issue	I02	Resource	• Internal recruitment process and external procurement of strategic partner/ interims to ensure team is in place by 1 June 2022 **Impact:** Unlikely to achieve December 2022 return to Cabinet with Full Business Case and detailed TOM	5	3	**15**	• Prioritise recruitment and procurement processes and ensure appropriate team in place (service, procurement, HR etc) to achieve 1 June deadline	• Internal; engaging with HR to assist with internal recruitment, job specifications for roles required internally are being developed • External; specification for strategic partner was released 12th April	Kalvinder Kohli	23/05/22 (weekly)
Risk	R01	Scope	• Housing transformation - overlaps with potential scope of this programme • **Impact:** Duplication of effort, mixed messages for teams	4	4	**16**	• Strategic discussions around timings/ potential overlap • Director alignment session planned 18th May	• Presented at Housing DMT 17th February • Senior stakeholder update 25th April	Kalvinder Kohli	28/05/22 (monthly)
Risk	R12	Technology	• Complex technology architecture across multiple services that will support delivery of EI&P • **Impact:** Siloed service approach and disparate working continues, not taking an intelligence led or targeted approach	4	3	**12**	• Collaborative working with Digital & Customer Services directorate to map and streamline required platforms • Consider additional resource or suppliers who may be able to assist		Kalvinder Kohli	24/05/22
Risk	R15	Resource	• Strategic partner award replaces current external support • **Impact:** Lost knowledge, understanding and working relationships	4	3	**12**	• Knowledge transfer and off / on-boarding built into current contractual arrangement • Materials and assets created are high quality, usable	• Contract awarded this week, 16/05/22	Kalvinder Kohli	16/05/22
Risk	R16	Communication	• Culture change required of BCC staff, partners and citizens does not land well or have desired effect • **Impact:** Groups or individuals feel ostracised, pushed further away by the organisation	4	3	**12**	• Considered and thoughtful approach to culture change • External, local communications and change resource considered in addition to the strategic partner	• Reviewed monthly, approach to be determined – support from strategic partner possibility	Kalvinder Kohli	30/05/22
Risk	R18	Resource	• Availability of appropriate resource to lead the 'Accelerator projects' • **Impact:** Inability to deliver projects and target outcomes at pace, loss of momentum with projects that are key enablers to the wider programme	5	3	**15**	• Engaged with relevant stakeholders to identify if suitable resource are available • Internal resourcing of these key roles is prioritised	• Weekly review along with other resource requests	Kalvinder Kohli	23/05/22 (weekly)

Birmingham Health and Wellbeing Board

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**17th May 2022**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES - BLACHIR REPORT OPPORTUNITIES FOR ACTION UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney, Director of Public Health**

Report Type:	**Information and endorsement**

1. Purpose:
The purpose of this report is to provide an update on the plans to implement the BLACHIR opportunities for action

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

3. Recommendation	
3.1	The Board are requested to consider and endorse the approach to implementing BLACHIR recommendations in Birmingham.

4. Report Body

Background

The Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) was launched in 2020 as a partnership between Birmingham and Lewisham to explore and better understand the inequalities affecting African and Caribbean communities in our areas and co-produce with communities, opportunities for action to break structural inequalities.

The review was a new approach methodology working with an external community advisory board and an academic advisory board to develop recommended opportunities for action to achieve systemic change.

A thematic approach was taken to considering the inequalities drawing on the life-course model and the recognised wider determinants of health.

Eight themes were explored in detail and for each theme there was a rapid evidence review undertaken by one of the Public Health teams, either directly or commissioned out. These were then discussed with the academic board to identify potential evidence-based recommendations that were then discussed with the community advisory board to reflect on lived experience and practical application.

There was then public consultation to review the identified opportunities for action, including specific workshops with young people.

The review was completed on 31 January 2022 and the draft was report was shared with and endorsed by the health and wellbeing boards in both localities in March 2022. The report is currently being designed by the Birmingham City Council's design team into a fully accessible format. It is expected that it will be available for publication by end of May 2022.

BLACHIR findings

Findings from the review were presented to the Board in March 2022 summarised as follows:

1. **Fairness, inclusion and respect**

   The Review calls for the Health and Wellbeing Board and NHS Integrated Care Systems to explicitly recognise structural racism and discrimination as drivers of ill health, systematically identify and address discrimination within systems and practices, and engage with Black African and Black Caribbean individuals and organisations to ensure community voice and their leadership in driving this work.

2. **Trust and transparency**

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

3. **Better data**

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

4. **Early interventions**

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

5. Health checks and campaigns

The Review calls for the Health and Wellbeing Board to act across their partnerships to promote health checks through public campaigns to increase the uptake of 8 community-based health checks in easy to access locations. This should also include specific work on mental health and wellbeing, working with community organisations and partners to increase peoples' understanding of the different types of mental illness and to encourage self-help, early intervention and self-referral to the NHS mental health services.

6. Healthier behaviours

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

7. Health literacy

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

There are 39 opportunities for action across the seven finding themes. In some areas these opportunities are suggested as pilots of approaches as the evidence base and live experience supports action but there is limited evidence on effectiveness.

Launch and Implementation

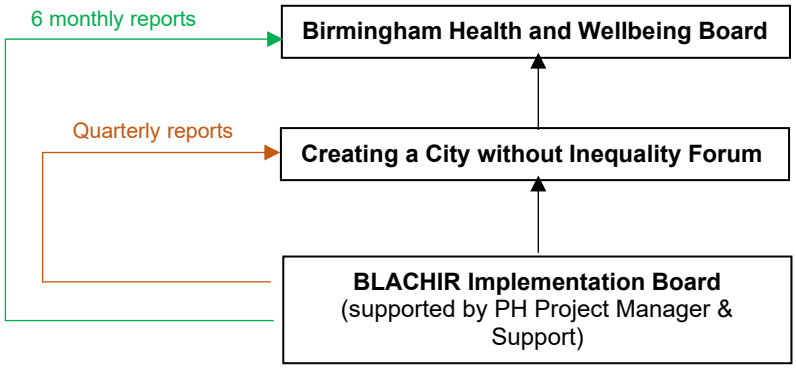
The Public Health Teams in both localities are supporting complimentary launch events. There will be bespoke events foreach locality within the week of 6 June 2022. In Birmingham, our launch will take place on 9 June 2022, starting at 4pm (venue within the community to be confirmed shortly). The launch will involve communities and partners who will share the findings of the report and plans to address the opportunities for action.

It is paramount that the project remains engaged with the local communities in the city and continues to learn from lived experience as the opportunities for action are taken up. To support this, the Public Health Team are commissioning 4 engagement partners to link with local African and Caribbean communities and facilitate action to address the issues described in the report.

The Creating a City without Inequality Forum has overseen the BLACHIR work on behalf of the Health & Wellbeing Board and is proposing the establishment of a

project board sub-group to embed the opportunities for action across our health and care system. The work will be supported by a dedicated public health senior officer within the PH Inequalities Team that we are currently in the process of recruiting.

A detailed implementation plan will be developed jointly with the project board in June 2022 and will be shared with the health and wellbeing board for ratification.



Conclusion and Recommendation

The Board are requested to consider and endorse the approach to the implementation of BLACHIR opportunities for action as detailed above. This approach will provide the assurance and transparency required for this project.

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
	We will provide an update to the Health and Wellbeing Board every 6 months throughout the duration of the implementation project. The update will include information on progress and will highlight any issues or risks that may hinder required outputs and outcomes that the health and wellbeing board may be able to help to address.

5.2	**Management Responsibility**
	Dr Justin Varney, Director of Public Health, Birmingham City Council Dr Tessa Lindfield – Interim Assistant Director, Birmingham City Council Monika Rozanski – Service Lead - Inequalities

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
There are no significant risks identified at present			

Appendices
None

Birmingham Health and Wellbeing Board

	Agenda Item:
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**17th May 2022**
TITLE:	**Director of Public Health Annual Report 2021-22: Creating a built environment that makes Birmingham a healthier place to live**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Mary Orhewere**

Report Type:	**Information/Approval**

1. Purpose:	
1.1	To present the Director of Public Health Annual Report 2021-22 and seek approval for publication.

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

3. Recommendation

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

3.2 To agree to support the identified recommendations of the report.

4. Report Body

3.3 The Director of Public Health (DPH) has a statutory duty to write an independent, evidence-based annual report detailing the health and wellbeing of our local population. The DPH report is an opportunity to provide advice and recommendations on population health to both professionals and the public. The report includes a selected, specific issue that the DPH wishes to discuss within the report.

3.4 Birmingham City Council has to publish the DPH Annual Report (under sections 73B (5) & (6) of the NHS 2006 Act, inserted by section 31 of the Health and Social Care Act 2012).

3.5 The content and structure of the report are decided locally based on current evidence-based health priorities. Previous year's reports in Birmingham have focused on various topics, including adults with multiple complex needs (2019/20) and the impact of the coronavirus (COVID-19) pandemic (2020/21).

3.6 The Director of Public Health Annual Report 2021/22 is focused on the built environment and its role in making Birmingham a healthier place to live.

3.7 The importance of the built environment in shaping health outcomes is widely acknowledged. The built environment can encourage and support healthy behaviours, such as active travel (walking or cycling) as part of people's daily routine. Settings that provide access to parks and public spaces have been shown to reduce obesity and non-communicable diseases (e.g. diabetes).

3.8 This report examines four key built environment factors as contributors to health and wellbeing:

- Housing
- Neighbourhood and Community Spaces
- Local Economy
- Movement and Access

3.9 The report draws on perceptions of commuting patterns, the quality of neighbourhood spaces, homemaking in Birmingham, local policies and measures, and future actions.

3.10 A digital ethnography was commissioned to expand the knowledge presented in this report and depict daily life and travel for residents. Forty Birmingham residents participated, and case studies were presented, observing their journeys and daily routines moving through the built environment.

3.11 The recommendations from this report will be used alongside the Joint Strategic Needs Assessment (JSNA) and local intelligence to inform local policymaking that will influence the wider determinants of health.

5. Compliance Issues
5.1 HWBB Forum Responsibility and Board Update
N/A

5.2 Management Responsibility
Dr Mary Orhewere, Assistant Director, Environmental Public Health, Health Protection & Place Dr Shiraz Sheriff, Service Lead (Governance)

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
The system does not support the report's recommendations.	Medium	Medium	The recommendations will be formalised into an action plan. This will be used to ensure partners can support the opportunities for action. This report will be presented to Cabinet.

Appendices
Appendix 1 Director of Public Health Annual Report 2021-22: Creating a built environment that makes Birmingham a healthier place to live

The following people have been involved in the preparation of this board paper:
Built Environment Team, Public Health
Governance Team, Public Health

BE BOLD BE BIRMINGHAM

Draft Director of Public Health Annual Report 2022

Creating a built environment that makes Birmingham a healthier place to live

Contents

1 Introduction

This year's annual DPH report focuses on health and the built environment. The built environment includes physical spaces where we live, work and play as well as the places that connect them. They can all contribute to a healthy life. For example, environments conducive to walking or cycling as part of the daily routine can improve our fitness and reduce car journeys. The use of parks and public spaces can improve mental wellbeing and reduce isolation, help reduce obesity and chronic disease.

The core purpose of the Director of Public Health (DPH) is independent advocacy for the health of the population and system leadership for its improvement and protection.[1] This report highlights the major health implications and opportunities of our built environment in the context of housing, neighbourhood and community, local economy, and movement and access. It includes some inspiring examples of work being done locally to support residents' health.

It explores insight from evidence gathered from direct observation of Birmingham citizens in their natural environment (a digital ethnography study). This describes daily life and travel for locals, explores views about commuting patterns, the quality of neighbourhood spaces and homemaking in Birmingham.

Birmingham has a rich history of public health policy and practice which has been influenced, directly and indirectly, by living and working conditions of residents, and their health. This relationship between the built environment and public health outcomes is shown in **Figure 1**. This shows some of the major public health milestones and developments, globally and in Birmingham, from the 1800s to the 21st century. It illustrates how major progress in population health has occurred by improving general social conditions such as housing, food supply and quality, water, and sanitation. These have been underpinned by evolving standards of land use, planning and design .

Increased population and poor environmental conditions accompanied the industrial revolution, resulting in poorer health for the workers and, as a result, a higher incidence of diseases. The average life expectancy was about 40 years. Efforts to better understand, prevent and cure disease have continued. The field of epidemiology (the mid to late 1800s) emerged from England's efforts to control a cholera epidemic which cost thousands of lives.

Furthermore, factors beyond than 'the absence of sickness' have had a positive impact on public health. Birmingham was named a town around the time of the cholera epidemics (mid-1800s). The back-to-back slums were demolished (also mid-1800s) to develop better housing and stimulate economic development. The Birmingham New Street Station, which now serves as a national transport hubs, has created thousands of jobs. The Edgbaston and Bartley Green reservoirs were major developments of that era (mid to late 1800s).

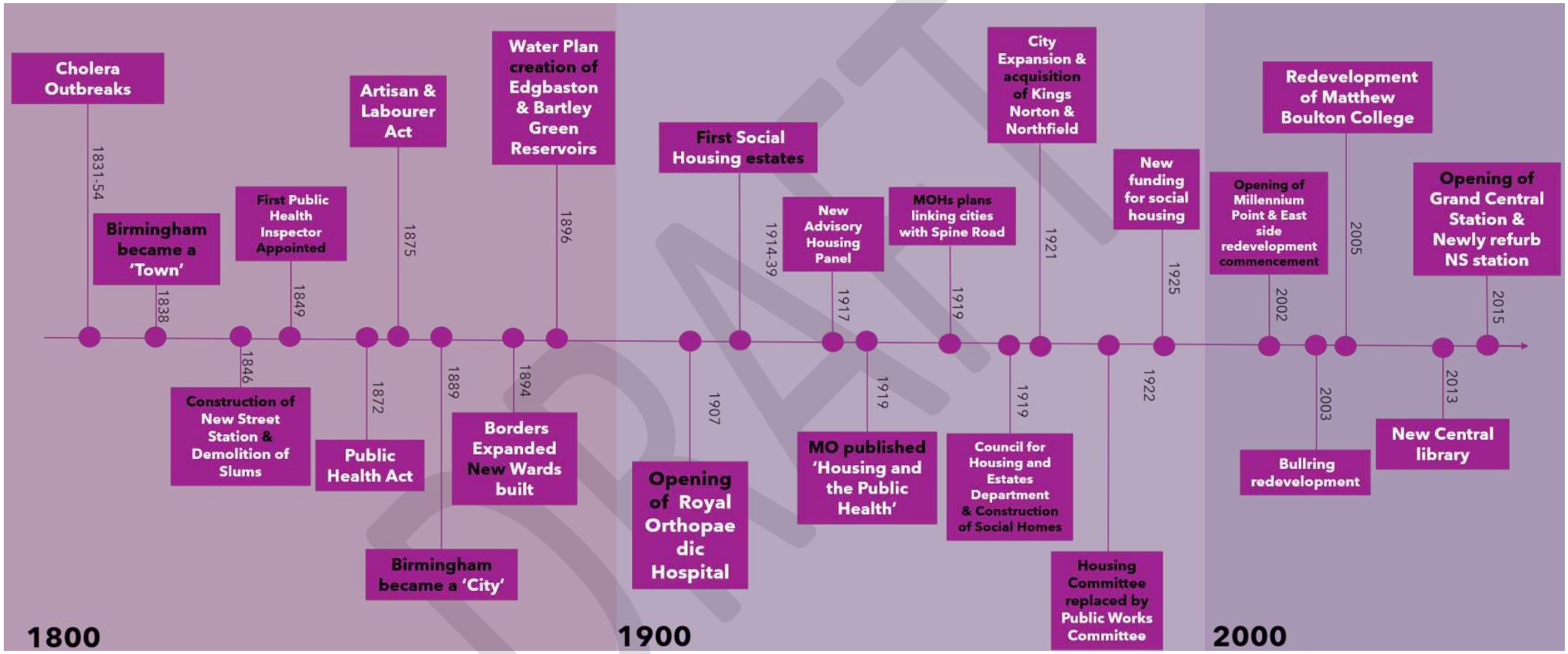
The sanitary movement, which heralded the passing of the Sanitation and new Public Health Acts (mid to late 1800s) was followed by with social concerns which reformers exploited to push for mandatory schooling for children as a strategy to end child labour in factories (mid-

1800s), and concern for nutritious food are just a few examples (late 1800s). These improvements were only possible with government intervention. Following the Public Health Act, local health boards were established, and a Medical Officer of Health was appointed (MOH)

Even greater progress was made in England's public health in the early 1900s. Concern for improving the lives of mothers and children resulted in new local responsibilities for maternal and child welfare, health visiting, school medicine and learning disabilities. Major improvements were made to mental institutions in this period. The first group of social housing estates was constructed in Birmingham following Hill's notion that community cohesion, access to open spaces, and good quality housing supported health and well-being. The National Health Service (NHS) was launched in 1948, and some of these responsibilities shifted from local authorities.

While significant strides have been made in public health throughout the last century, major issues remain. Long-standing health inequalities have worsened. As Britain has become wealthier, for many people diets have become less healthy and their lives less active, resulting in a significant increase in obesity and related illnesses, such as diabetes. Poverty and poor housing continue to harm health. And despite the considerable public health effort, many people smoke, some consume large quantities of alcohol, and social isolation is rife.

Figure 1: The evolution of the built environment and its association with public health



2 The built environment as wider determinants of health

2.1 Defining the built environment

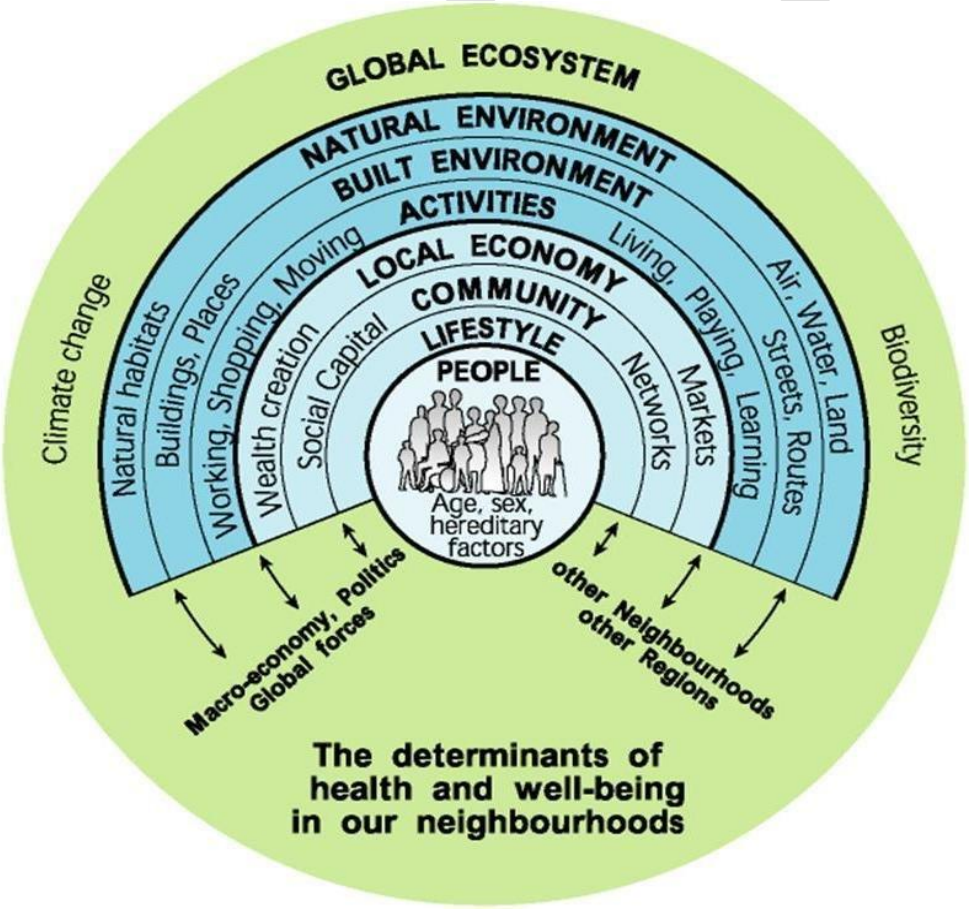
Where we play, live, learn and work has a significant impact on our health and well-being. Previous research has emphasised the relationship between the built environment and individual health outcomes.[2] The built environment refers to buildings and other built forms such as parks and infrastructure that supports human activity, including transport networks. The built environment consists of six key elements: neighbourhood and community, public and green space, buildings and houses, movement and access, local economy, and the food system (see **Figure 2**).

Figure 2: Elements of the Built Environment

2.2 The importance of the built environment for health

The Barton and Grant health map shown in **Figure 3** highlights the relationship between the built environment (wider determinant) and health. The six elements of the built environment are good examples of the social determinants of health including income and education. These broader factors have a 'knock-on' effect on other wider determinants affecting people's health in various ways. They influence our physical and social environments (weather conditions, air quality, civic participation, community capacity and local economy) and so our health and quality of life. According to the World Health Organisation (WHO), "the social determinants of health are mostly responsible for health inequities; the unfair and avoidable differences in health status seen within and between countries". [3]

Figure 3: The broader social and economic determinants of health and well-being



We want to create a constructive process where we work jointly with planning, transportation, housing, and other council departments to create conditions for healthier lifestyles.

In Birmingham, a social gradient (inequities that runs from top to bottom affecting everyone) across negative environmental conditions contributes to health outcomes, with disadvantage communities experiencing worse outcomes than better off people.

The choice and range of built environment interventions must equal the disadvantage which our residents face. People who live in deprived areas are more likely to be affected by poor housing, high crime rates, poor air quality, unsafe traffic, and a lack of green areas with children's play spaces. They are also likely to experience the negative effects from climate change.

HOUSING

(Quality, design, tenure, affordability)

3 Housing

3.1 Why is housing an important determinant of health?

We are estimated to spend 90% of our time indoors, with 65% of that time spent at home before COVID-19.[4] If we want to improve individuals, families, and the community's health and well-being, practitioners need to start in the home where most people spend their lives.

Although the relationship between housing and health is complex, providing a physical environment where people can live healthier lives is vital to reducing health inequalities. Good building design encourages physical activity; hence 'active designs' promote health in their developments and create surroundings that are accessible and encourage physical activity. These include, safe, attractive, and labelled stairwells, bike racks, public open spaces, and water features. [5]

There are several housing characteristics that can affect our health and well-being. Poorly designed houses are linked to various physical and mental health conditions.[6] Housing conditions, such as dampness, mould, cold, and overcrowding are related to respiratory infections, severe asthma, and poor mental health. Inadequate heating is also closely linked to increased excess winter deaths.[7] [8] Poor housing conditions negatively impact children's well-being. Children who live in cold, damp housing miss more school days, suffer from longer-term health problems and disabilities, and are more likely to perform poorly in school. [9]

Those who live in substandard housing often face one or more other disadvantages, including low income, high unemployment rates, and social isolation. On the other hand, age-appropriate, affordable, and safe housing promotes physical and mental health and better life chances.

There is a rich body of evidence linking poor living and housing conditions to human health, from Friedrich Engels and Rudolf Virchow to more recent WHO reports and Marmot reviews of health inequalities. These have added to our understanding of the determinants of health.[10] [11] [12]

The disproportionate number of deaths from COVID-19 in ethnic minority communities are often explained partially by the conditions in which people live and work. COVID-19 has highlighted the link between housing and health in two ways: some poor housing conditions, such as overcrowding and poor indoor air quality, have resulted in increased virus transmission; and so, the lockdown measures used to control the virus have resulted in those living in poor housing being exposed to conditions that worsen their health. For some, the measures adopted to contain the virus have meant spending more time in damp, mould-infested, physically dangerous, and inappropriate dwellings. [13]

Housing also has indirect impacts on health, the UK's housing accounts for about a quarter of the country's total carbon emissions. This places housing at the heart of government's commitment to the climate change agenda and have resulted in increased local and national

efforts to improve the quality of existing homes through retrofitting projects. However, retrofitting efforts have not kept pace with need. So, increased investment in upgrading the existing housing stock can generate a variety of co-benefits such as climates change adaptation, fuel poverty reduction and wider public health improvements.

3.2 Housing conditions

3.2.1 Indoor air quality

Indoor air quality is critical for good health due to the amount of time we spend inside. People who can't heat their homes due to high fuel costs are particularly vulnerable to moisture and mould, which can occur regardless of the age of the building (old, recently upgraded, or new residences). Some people are more sensitive to mould than others, including babies and children, the elderly, and those with pre-existing skin and health conditions.

3.2.2 Fuel poverty

Even though it is well acknowledged that upgrading the quality of UK housing stock can result in significant health benefits, the number of homes in fuel poverty continues to increase year on year.

Poor energy efficiency in existing homes, combined with rapidly rising fuel costs, makes it unaffordable for low-income households to heat and ventilate their homes adequately. This can compromise their health and quality of life increasing financial difficulties. Cold homes can have harmful effects on physical and mental health, putting extra strain on the NHS, local councils' social care budgets and the Department of Work and Pensions supplementary benefits budget (Winter Fuel Payments and Cold Weather Payments). It also contributes to higher winter mortality rate and long-term health conditions, which are associated with a threefold increase in healthcare costs.[14] According to the Committee on Fuel Poverty (2021) report 46% of the people in the fuel poverty were excluded from getting assistance from existing fuel poverty alleviation programmes as they did not receive any qualifying benefits.

3.2.3 Housing tenure and affordability

Another aspect of housing vital for health and well-being is feeling secure in your home. Insecure housing tenure or the threat of eviction can have a significant emotional impact on mental health, sense of belonging and community connection. People who live in insecure housing are three times more likely than those who live in secure housing to experience mental distress. Children have been reported to suffer from behavioural issues, educational delays, depression, low birth weights, and other health concerns because of housing instability.[15]

Insecure housing tenure restricts 'home making' for those living in the private rented sector, and tenure insecurity has made it difficult to feel settled.[16] The affordability of housing has clear health implications. The shortage of affordable housing limits families' and individuals'

choices about where they live, resulting in lower-income families living in substandard or overcrowded homes.

Young people on low incomes in private rented accommodation generally live in low-rent accommodation and houses in multiple occupations (HMOs). [17] This raises concerns about privacy, control and choice, and various environmental problems.[18] An Australian study of low-income rental households found housing insecurity linked to a lack of privacy, belonging, physical comfort, housing mobility, housing instability, and feeling unsafe.[19]

3.2.4 Health impacts of housing

Our home, the location, and the physical structure itself impact practically every aspect of our lives, from how well we sleep how often we see friends to how safe and secure we feel.[20]

Housing affordability and health have been shown to have a bi-directional relationship, implying that your physical and mental health affects the type of housing you can afford and vice versa. People living in good quality, secure, affordable housing have fewer health problems. The reverse is true for people living in substandard, insecure, and unaffordable housing. These consequences are more evident for more vulnerable populations, such as single parents and low-income households.

Indeed, housing affordability is likely to affect people's health and well-being in at least two ways:

1. People with restricted budgets and resources may choose between housing affordability. This includes location and access to jobs, education, and daily life services, such as schools, recreation, shopping, and food availability. The amount of time spent travelling increases sedentary behaviour while reducing the time available for local physical and social activities.

2. Individuals with less money could find that the suitability of available housing may be limited. They could live in lower-quality residences or neighbourhoods (high crime and incivilities) and overcrowding. A wide body of research suggests that poor housing quality (insufficient insulation, lack of heating) and overcrowding are linked to lower housing satisfaction, poor mental health, greater risk of contracting infectious diseases, respiratory illnesses, and injuries. These effects may be increased for people who live in unsafe neighbourhoods because they could feel restricted when going about their daily lives.

3.3 Local context

Birmingham City Council has a housing stock of 60,673 units and many of these properties are in good condition. In 2021, the total housing stock in Birmingham was 445,276 with an estimated 89,000 new homes need by 2023. Housing occupations across Birmingham are broken down as follows: private sector 75% (owner-occupied and private landlords), council 13% and other housing associations 12%.[21] The poor housing quality is spread across council

blocks, the private rented sector, HMOs, and temporary accommodation. A recent listening campaign by the homeless charity Shelter revealed many families currently living in sub-standard housing.[22]

The private rental sector satisfies the needs of a diverse group of people, but it does have some problems. This is because the number of people renting their homes from private landlords has increased, and the trend is expected to continue. Private landlords mostly provide decent quality housing. But there are concerns about high rental cost, security of tenure, and house condition which continues to be a problem for individuals. In the 'Home Truths' campaign, 17% of private renters report in the study housing insecurity and instability.

Overcrowding is a major concern for the city, with 9% of homes in Birmingham classed as overcrowded. Outside London, Ladywood has the highest rates of overcrowding (15%). The 'Home Truths' campaign found that 22% of people lived in unsuitable homes for their household size, and 19% of people in temporary accommodation reported overcrowding.

Birmingham residents have poorer health outcomes than the national average. The city has unusually high rates of homelessness: over three out of every 100,000 households were homeless in 2019, which is more than 50% higher than the national average. [23] [24]

There are several disadvantaged neighbourhoods, especially in the city's inner sections. This is geographically related to other social issues such as overcrowding (worst in western areas), poor health and poverty. These areas often have lower levels of tree canopy cover and green space. Unemployment is a serious problem, and the employment rate is well below the national average.

An estimated 8,000 houses in Birmingham lack central heating and can't heat their homes to the temperature required to be healthy and warm. In the latest estimates (2019), around 69.692 (16%) households in Birmingham were fuel poor.

3.4 What is already underway?

3.4.1 Public realm projects

The city's growth strategy will deliver 51,000 new homes by 2031, and much of this work is already underway. Perry Barr will have the 1000 homes residential scheme, and the Eastside and Langley Sustainable Urban Extension (SUE) will consist of approximately 6000 homes. Improvement on council-owned houses is underway, including a £4.5 million retrofitting of 80 fuel poor council-owned properties and a £67 million independent living adaptation programme with more regeneration work to come.

3.5 Recommendations

Future development on brown sites will deliver sustainable compact communities that will create local jobs for local people, encourage active travel and reduce reliance on cars.

3.5.1 Lifetime homes

Birmingham's current commitment to lifetime homes is critical for future high-quality housing provision (BMHT). All new homes will have accessibility features and will be energy efficient. These changes will aid Birmingham's ageing population by allowing more individuals to 'age in place,' lessening the need for residential care.

3.5.2 Ensure enough affordable homes in regenerated areas

According to the Birmingham Housing Strategy 2019-2029, individuals will be able to access and maintain affordable housing that meets their needs. As more people find it difficult to acquire a home, private renting has increased. Rents are increasingly rising beyond the means of low-income families. As a result, it's critical to create a diverse selection of affordable housing to fulfil the demands of households across the economic scale.

Support the city's effort to help those experiencing homelessness and connect residents to the issue. Our findings suggest that this can generate a wider sense of safety and pride in local neighbourhoods.

3.5.3 Recognise the possible impact of affordable schemes on overcrowding

Housing affordability is reflected in the extent of overcrowding in the private rented sector. We recommend that the council expand permitted developments rights to allow private landlords to extend rented properties allowing renters more room as their family grows. Affordable schemes under housing regeneration must target those most vulnerable to overcrowding, particularly those with children.

3.5.4 Support families and housing improvements through the winter fuel payments

Winter fuel payments are available to all adults 65 and over regardless of need (10% of beneficiaries. We recommend that the council realign the Winter Fuel Payment budget to assist people who are most in need with their energy costs and use the remaining funds to improve the energy efficiency of fuel-poor homes.

3.5.5 Ensure safe and affordable housing for private renters

We recommend that the council put better regulation and enforcement standards for private rented landlords in place.

3.5.6 Ensure warmth for all

We recommend a city-wide retrofitting programme of existing housing across all sectors to reduce fuel poverty and a commitment to build low carbon social housing that is efficient.

Investigate and promote insulation incentives and regulations to help increase the number of properties that can get insulated to improve residents' health and well-being.

3.6 Policy reference

Birmingham Design Guide[25]
Birmingham Development Plan[26]
BHMT housing Plan[27]
Langley SUE[28]
WMCA: Zero Carbon Neighbourhoods

NEIGHBOURHOOD and COMMUNITY SPACES

(social & community infrastructure, land use, public open spaces)

4 Neighbourhoods and Community Spaces

4.1 Why are neighbourhoods and communities a determinant of health?

While the conditions in our homes have important implications for our health, wider determinants (conditions) in the neighbourhood, community, and 'place' surrounding our homes can also significantly impact our health. The neighbourhoods design surrounding a home is crucial because it allows for social contact, access to nature, exercise, schools, and local facilities. Also so are the policies that make access to a healthy and affordable home possible for everyone. All these factors influence how much a person enjoys living in their neighbourhood, but also their health and well-being too.

Well-being in neighbourhoods is strongly linked to the ecological dimensions, including physical (air), built (housing), services (educational), socio-cultural and reputation. Well-designed and appealing neighbourhoods with more people on the streets promote natural surveillance, making the neighbourhood appear and feel safer while encouraging social interactions (create social capital). Poorly designed neighbourhoods can make it difficult for vulnerable people to leave their homes, leading to social isolation and premature mortality.[29]

Attractive neighbourhood places support physical, psychosocial, and emotional well-being. Better street lighting, less noise pollution, well-kept pavements, green spaces, and streetscaping have all been shown to boost residents' sense of safety and civic pride.[30]

4.2 Land use (planning)

Research shows that in comparison to residential areas separated from local services (segregated use planning) mixed-use spatial planning is more likely to produce healthy settings. The use of mixed land often includes high-density residential areas where people can live locally and meet their daily needs. Such as, for example, access to work, schools, grocery shopping, and places to socialise, child and medical care, and exercise.[31] This arrangement allows for more compact communities that enable people to access services within 15-minutes of their homes by walking or cycling, encouraging non-intentional physical activity.[32] The ability to 'live locally in this way reduces both the number and length of journeys made daily, reducing carbon emissions. It also creates conditions for healthier, happier communities.[33] Mixed-used development also encourages social engagement, reducing social isolation.[34]

The concept of the 15-minute neighbourhood (also called the 15-minute city) was visible during the COVID-19 pandemic. Neighbourhood amenities were significant when more people worked from home, and fewer people went out owing to public health measures (lockdowns). Local shopping for basic items and active transportation became more important. There were areas that applied outdoor hospitality, slow roadway initiatives and temporary cycle lanes. Some residents may continue to value local life more moving forward because of the shift toward working from home and discovering their neighbourhoods.

4.3 Health and non-health benefits of the 15-minute neighbourhood

Walking and cycling become the natural choice for short trips, enabled by redesigned streets and space around, between and within buildings that are publicly accessible (public realm). Increased levels of walking and cycling contribute to better physical outcomes[35]and improved mental health[36] while providing more opportunities to spend time in green spaces, reducing the risk of anxiety and depression.[37] The ability to access everyday needs within the local area also contributes to being more inclusive by removing the transport barriers to jobs and services faced by people without access to a car and who often live far from the services on which they rely. [38] [39]

4.4 Roads, streets, pavements (public spaces)

"If you plan cities for cars and traffic, you get cars and traffic. If you plan for people and places, you get people and places." —Fred Kent, Project for Public Spaces

Streets account for over 80% of all public space in most cities worldwide. When properly built, they provide commerce, cultural energy, a safe place to meet people, stay, or simply pleasant to travel through. However, our streets have often become dangerous places dominated by cars, noise, air pollution, and danger to active users.[40]

Vehicular traffic is the main source of health-harming noise and air pollutants such as nitrogen dioxide (NO2) and Particulate Matter (PM). Living near major or high-density traffic has been associated with short and long-term health outcomes, including asthma and other respiratory illnesses, adverse birth outcomes, and cardiovascular diseases.[41] The West Midlands Air Quality Improvement Programme (WM-Air) estimates that about 2.8 million people in the region are affected by air pollution-reducing life expectancy by up to 6 months.[42] [38]

Likewise, people living in disadvantaged areas tend to live in more dangerous environments, with higher levels of on-street parking and higher volumes of fast-moving traffic. This implies they are more vulnerable to the dangers of road traffic. In 2019, there were 470 pedestrian fatalities and 21,770 pedestrian casualties of all severity in the UK.[43]

4.5 Open spaces

Open spaces such as parks and green spaces are important built environment settings for promoting and improving health and well-being. Living close to good quality green spaces is associated with increased physical activity and good health.[44] Conversely, those with limited access to good quality outdoor spaces are more likely to have fewer social connections and poorer Health, including cardiovascular disease, obesity, type 2 diabetes, and mental health.[45] [46]

It's becoming evident that spending time in 'blue space,' or near water, can benefit our mental and physical well-being.[47] Blue spaces should be considered when developing and planning green space, parks, and other natural environment components.

In addition to green and blue spaces, children need play areas to maintain healthy lifestyles. Informal play burns calories and has substantial benefits in maintaining a healthy weight. Green and blue spaces and play areas need to be accessible, safe, of good quality to deliver effective physical and social benefits. [48] [49]

4.6 Health and non-health benefits of open spaces and community infrastructure

"Public spaces are especially good arenas for creativity and collaboration between governments, the private sector, and citizens for creating vibrant and inclusive neighbourhoods and districts." – John Kaw, The Hidden Wealth of Cities: Creating, Financing, and Managing Public Spaces

One in six deaths in the UK is attributed to physical inactivity, and obesity rates are increasing for both adults and children. Compact and connected street networks with fewer lanes on major roads (pedestrianised streets) encourage walking and cycling and reduce morbidity for lifestyle diseases. In addition, street network design has a significant impact on road safety.[50]

Surface transport is a significant source of greenhouse gas (GHG) emissions (22% in the UK). Cities that promote walkability and cycling over car use can help to mitigate climate change by reducing carbon emissions.[51]

Parks and green spaces are not only important for recreation but contribute to good health through improved air quality, enhanced physical activity, stress reduction and better social cohesion. [52] The Glover review also emphasised the importance of connecting people and nature. The WHO estimates that 3.3% of global deaths are linked to lack of recreational areas and poor walkability.[53]

Parks and green spaces are also crucial for buffering the effects of climate change, such as stormwater management and cooling the urban heat island effects. They also host diverse species of birds, animals, and plants.

Libraries, community, and leisure centres are examples of public facilities and amenities that serve as services for communities and create a feeling of placemaking and social cohesion. Research indicates that people who live near high-quality public places and amenities trust others and feel less socially isolated. [54]

4.7 Local context

Birmingham has over 1.1 million people spread over 26,777 hectares, and this figure is predicted to increase by about 3.7% by 2031. This will boost housing demand and create new opportunities to develop good quality affordable mixed-use sustainable neighbourhoods that provide access to jobs and services. Birmingham's house stock comprises mostly low-rise terraces and semi-detached housing, even in areas close to transport links. **Figure 4** display the land use in Birmingham including major development sites, leisure, education establishments, conservation areas, railway lines and station as well as mixed use centres.

Due to its car-centric development history, Birmingham has high-density residential land use at about 4,300 persons per square kilometre (2018 data).[55] The high population density in the city has increased productivity, overcrowding and material deprivation.

We depend greatly on the natural environment for our well-being and quality of life. Green, blue open spaces play an important role in promoting and encouraging outdoor recreation, exercise, and relaxation and addressing health issues, including obesity and mental health problems.

Birmingham is the third most deprived core city in England and is among the least prosperous 10% of local authorities in the UK. The city has one of the highest child poverty rates in England (40%) and is ranked fourteenth for income deprivation affecting older adults. 90% of wards in Birmingham are ranked among the most deprived areas in England.

The gap in life expectancy between Birmingham's least and most deprived areas is 6.2 years for women and 9.9 years for men. It is estimated that 68% of Birmingham adults are obese or overweight, and 26% of children in year 6 (age 10-11 years) are classed as overweight or obese, which is worse than the England average.[56]

Figure 5: Life expectancy rates in Birmingham

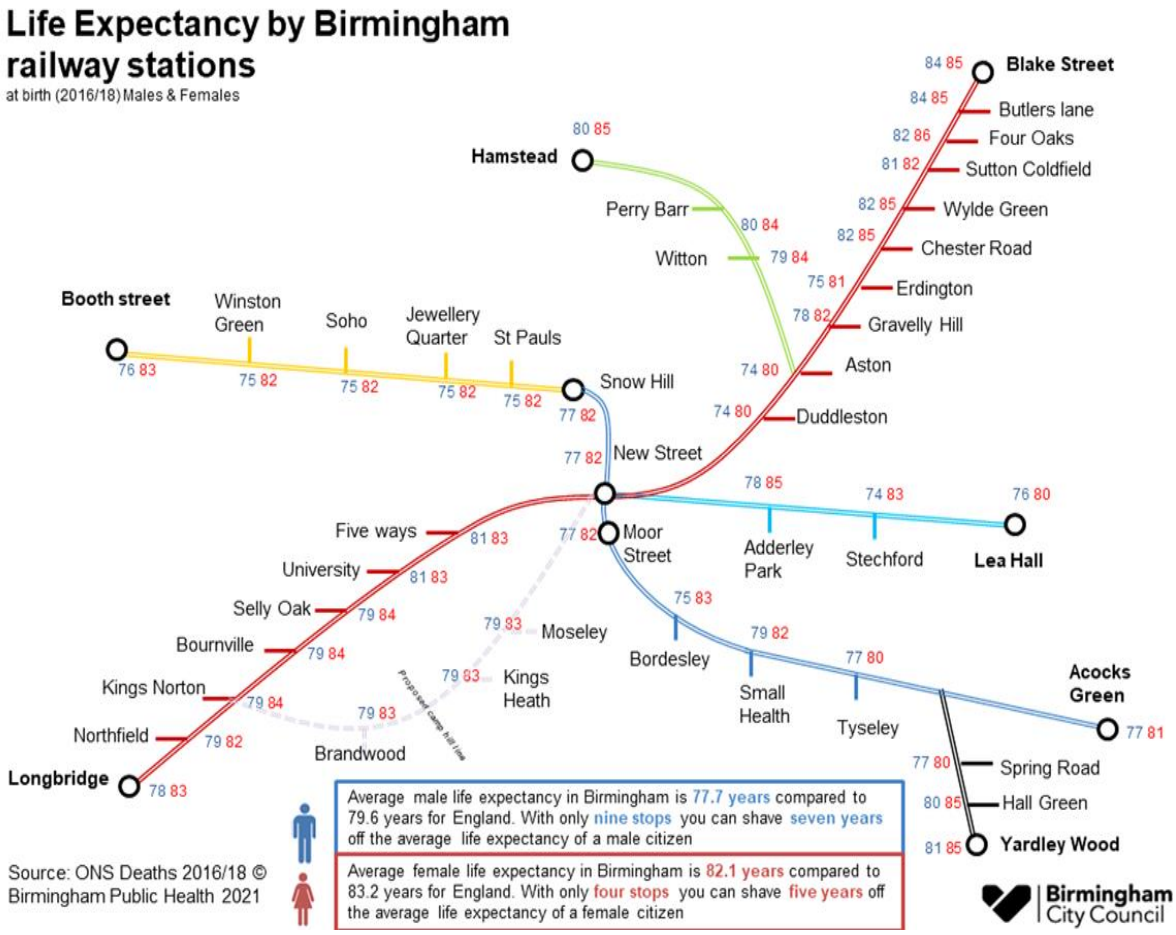
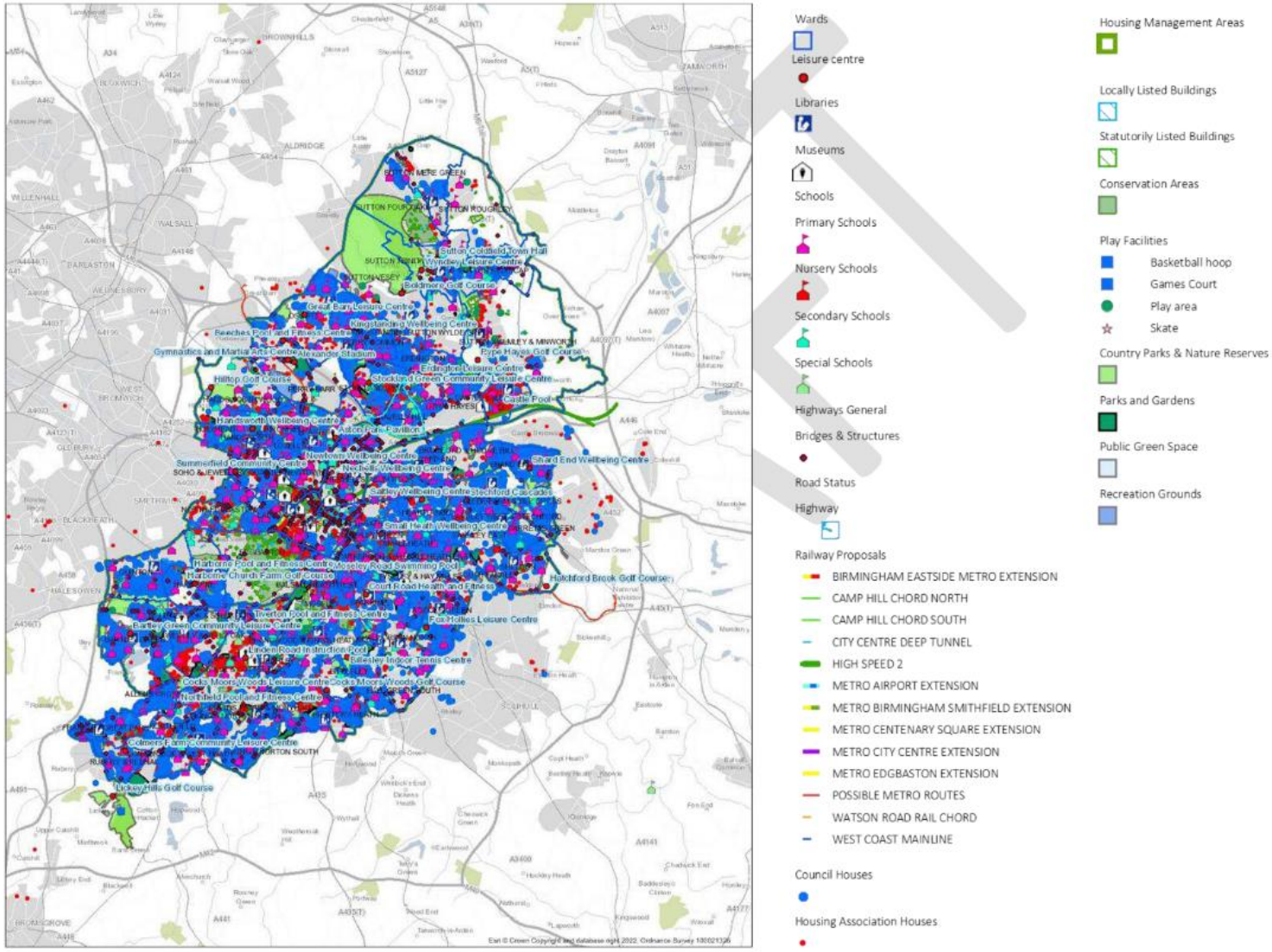


Figure 6: Birmingham Land Use Map



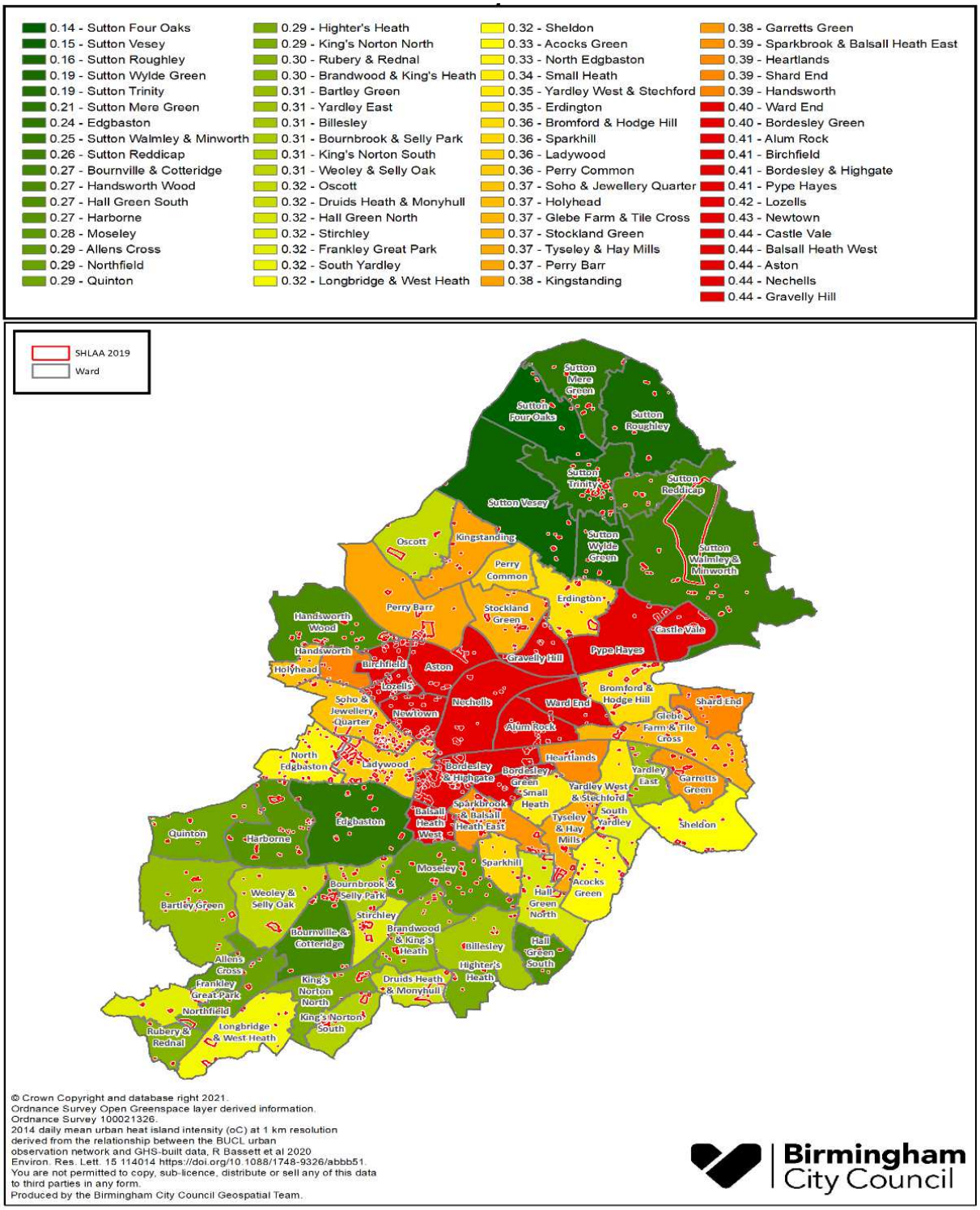
Birmingham is one of the greenest cities in the UK, with over 600 (4,700 ha) public parks and green spaces, many of which are linked by over 160 miles of canals and waterways. The city's parks and green spaces are mostly used for leisure and recreation, with an estimated 58-million visits annually. About 96% of residents have access to green space within 15 minutes of their home. But levels vary between wards (see **Figure 6**); areas with the least green space, as measured by 'canopy cover', the area of leaves, branches and tree trunks are among the most deprived.

For instance, the ten wards with the least canopy cover are all among the poorest 10th of wards. An additional 400 green space provision is needed to meet the national required standard for green spaces and play areas in the city.

Birmingham's parks and greenspace provide a net benefit to society of approximately £600 million each year, including £192 million in health benefits. [57] [58] There are several other benefits that green spaces provide to the city's wider ecosystem that contribute to health. For example, through carbon capture (350 tonnes each year), quality-adjusted life-years (3,300 per year)[59] and biodiversity.

Birmingham aspires to become carbon-neutral by 2030, with the main goal of requiring about 80% of all trips to be made on foot, bike, or public transportation. The city's road network is quite complex, with around 12 major radial routes, two ring roads, and a stretch of the A38M running through it. In addition, the city is encircled by four heavily travelled motorways, M5, M6, M6 Toll, and M42. The average congestion level in 2021 was 24%. This means a 30-minute drive took 7 minutes longer. [60]

Figure 7: Environmental justice map displaying the mean value for the combined index by Birmingham ward



4.8 What is already underway?

4.8.1 Our Future City Plan 2021-2040

The Our Future City Plan (OFCP) outlines Birmingham's commitment to 'lifetime neighbourhoods' within regenerated areas (Port Loop) towards becoming a bolder, greener city. Achieving net-zero is embedded in the plan and all regeneration and new developments will be sustainable. Mixed land use will make housing, transportation, public services, civic spaces, and amenities more accessible to residents, allowing people of all ages and abilities to participate in their community.

4.8.2 Birmingham Transport Plan

The Birmingham Transport Plan (BTP) sets out plans to reclaim Birmingham streets as public spaces and reduce car use. These plans sit within the OFCP and will rebalance the use of streets so that pedestrian and cyclists have their equal share of the street. Communities will recover the full use as means of social engagement.

4.8.3 Urban Forest Master Plan[61]

The Urban Forest Master Plan takes a 'green approach to public health' that will safeguard our treescape for the long-term protection and advancement of the city's biodiversity and the health and well-being of residents.

4.8.4 Green spaces and play areas

Birmingham falls short of the recommended open space per person (2.05 ha per 1000), and the provision for an additional 400 spaces is built into the City of Nature Plan. Additionally, there is 123,971 square metres of play provision for children.

4.8.5 Public Realm projects

Investments and improvements under Legacy 22 is helping to make Birmingham into a city to grow, live, work and age well with further work commencing on Colmore Row, Waterloo Street and Victoria Square. The East and Southside of the city are transforming with the construction of the Eastside metro extension and the 42-acre Digbeth development, and high street revamp. Improvement works in the Southside will change walking and cycling connections from New Streets station to the Southside. Other big projects include the Perry Barr plan, £1.9 billion Smithfield development, Peddimore, and the Birmingham Health Innovation centre. HS2 is already delivering investment and jobs to the city, but it will provide a massive economic boost and set the city on a long-term positive path when it is completed.

Birmingham now has over one million trees, including 76,000 street trees. This creates a more appealing atmosphere for residents encouraging them to spend more time outdoors. But safety in the public realm is a key concern for residents. This was highlighted in the

commissioned ethnographic research, where poor street lighting was a major concern for pedestrians and drivers.[43]

4.9 Recommendations

4.9.1 Nature-based solutions

- Continue to support citizen involvement in tree planting activities to enhance and conserve the natural environment
- Promote nature positive built environment design (green roofs), maximise future opportunities to improve, enhance or add to greenway networks and create compact lifetime communities through Planning and Development
- Multifunctional uses of green spaces (food growing)
- Addressing flood risk and low levels of biodiversity quality in parts of the city.

4.9.2 Mixed-use buildings

Denser urban composition with more mixed-use buildings and mid-rise apartments allows people to live closer to public transport links. Implement local development orders to plan for mid-rise housing near current and new transport links.

4.9.3 Provide online resources to encourage the use of public spaces and recreational activities

Although Birmingham has many parks and blue and green spaces, residents need to be more aware of these spaces and what activities can be accessed. We recommend creating an online directory of these spaces, including play areas, parks with public toilets, picnic areas, bike and walking paths, exercise equipment, parking, and cafes.

4.9.4 Increase the quantity of play provision

To improve the physical activity of Birmingham's children, we recommend increasing opportunities for informal play. Enforcing the Birmingham Development Plan's development requirements, which compel all developers to assess need and offer (or help fund) play provision, will assist in achieving the necessary increase.

4.9.5 Outdoor sports provision

We recommend that the council increase provision and quality of outdoor sports fields, including outdoor gyms.

4.9.6 Create healthier communities

Advocate for the 15-minute neighbourhood to empower communities to make healthy choices, build community spirit, connect with others, and grow the local economy.

Design and promote initiatives and campaigns to counter fly-tipping and demonstrate the Council is aware of and cares about this issue.

Use messaging to increase awareness and knowledge of what Birmingham City Council is already doing to improve neighbourhood and community spaces. This will increase visibility and counteract the perception that the Council cares more about affluent areas.

4.10 Policy reference

National and Regional context
25 Year Environment Plan[62]
Transport for West Midlands Transport Plan[63]
Healthy High Street: Good placemaking in an urban setting.[52]

Local policy context
The City of Nature (in consultation)
Urban Forest Master Plan[64]
The Climate Action Plan[65]
The Green Living Spaces Plan[66]
The Parks and Open Spaces Strategy[67]
The Birmingham Tree Policy[68]
Birmingham Design Guide[23]
Birmingham Development Plan (BDP)[24]
Langley SUE[69]
BHMT housing Plan[25]

LOCAL ECONOMY

(High street, employment, education, and services)

5 Local Economy

"Ultimately, we must ensure town centres and high streets are tasked with the role of lifting communities, not draining them. The proliferation of fast-food takeaways, vape shops, payday lenders, betting shops and off licences have damaged communities and become a catalyst for public health, debt and addiction problems." Bill Grimsey

5.1 Why is the local economy a determinant of health?

The COVID-19 pandemic has raised concerns about job security and the critical link between the economy and health. It has drawn attention to the large number of people in the UK who are in poverty or at risk. We need prospering communities and for this to happen people must be financially secure. The local economy must provide services that encourage rather than deter people from healthier habits.

Employment opportunities significantly affect population health. Unemployment is linked to poor physical and mental health in the short and long term due to fewer financial resources to live a healthy life, stress associated with job loss and financial difficulty, and higher levels of fuel poverty and homelessness.[70] Also, the quality of available local jobs directly affects health. To lead healthy lives, people must earn a living wage. Insufficient income means that people cannot afford good quality housing, healthy food, or leisure services. Developing regional employment and investing in human capital is essential to improving long-term local health.

The local economy impacts on health since it determines the services that are provided. The Royal Society for Public Health used the prevalence of fast-food outlets, bookmakers, tanning salons, and payday lenders to indicate poor health on the High Street in their Health on the High Street report.[71] In contrast, community pharmacies, health services, leisure centres, libraries, pubs, and bars indicated good health. All these services impact on health by influencing lifestyle.

The level of education a person achieves has a direct impact on general health and well-being but also the economy. The Human Capital Theory conceptualises education as an investment into the economy by increasing people's productivity. [72] The level of education a person has can influence their abilities to promote health, including skills, reasoning and effectiveness. [73] A lower education level is associated with poor health outcomes, chronic conditions, functional limitations and disability.

The pathways in which education leads to better health can be grouped into four categories: economic, health-behavioural, social-psychological, and access to health care. A higher education level enables people to have more stable jobs with higher incomes. [72] Health harming behaviours such as smoking, excess alcohol consumption, inactivity and unhealthy dieting are linked to lower education levels. [74] [75] The neighbourhoods where people live also affect their socio-economic opportunities and vice versa. [76]

Neighbourhood poverty creates social disorganisation and disorder among neighbours. A neighbourhood with fewer opportunities for employment or neighbourhood facilities may nurture a hostile environment between residents. [77] This behaviour can limit social cohesion and may leave residents unable to control deviant behaviour or enforce positive attitudes towards education. [76]

Carbon emissions impact people's health through air pollution, climate change, and more. Economic activity is one of the main causes of carbon emissions. With local authorities' commitment to reach zero carbon by 2050, we are likely to be seeing a shift by UK business and industry toward 'green' sectors, which will have significant implications for health, education and skill and the wider economy.

5.2 The High Street

Around 80% of the UK population currently lives in cities,[78] and the high street is just one aspect of the urban environment. Its architecture and design influence how we use our high streets, whether they are somewhere we enjoy being or avoid, if they nurture community and social connections or encourage us to walk away quickly with our eyes down. The amount of traffic, how accessible it is for pedestrians, and how safe we feel affect whether we visit a local high street or prefer to shop online from the comfort of our own home.

The high street is largely a transactional environment where we can spend time relaxing with friends or shopping. We can also gain cultural experience or a sense of well-being from engaging in a dance or exercise class. But this exchange is not always beneficial to our health. The high street enables and supports unhealthy behaviour when our time and money are converted into a loss at the bookmaker, a tan from a sunbed, a high-cost loan, or a cone of fish and chips. On the other hand, healthy high streets promote good health, provide easy and inclusive access to many users. Health-promoting high streets are clean, safe, walkable and promote active participation contributing to social inclusion and cohesiveness and the growth of sustainable urban communities (greenscape and blue infrastructure reduces pollution). [79] [80]

The different approaches outlined above have pathways to improve health. For example, diversifying retail offers can lead to behavioural changes, leading to positive dietary habits or regular exercise in the community. Furthermore, preventing crime and safety initiatives can provide opportunities for social interaction, access to services and community activities, and social cohesion.[70]

Many high streets are saturated with fast food outlets. They do not offer fresh produce or a variety of healthy or suitable food options for all communities, e.g. vegetarian, vegan, religious diets. Fast food is easily accessible as it is cheap and quick; however, consuming unhealthy food regularly can increase obesity, high blood pressure and diabetes. Research has established that those living in the most deprived areas have a disproportional number of fast-food outlets close to them compared to those in more affluent areas. [81] [82]

5.3 Local Economy and Employment

A healthy and flourishing high street impacts the economy while indirectly influencing health. A thriving high street will provide its inhabitants with employment opportunities and improved living standards. **Figure 7** highlights the factors that directly and indirectly impact health outcomes in the high street-built environment.

Figure 8: Approaches to improving the Built Environment in High Streets. Adapted (Source PHE, 2018)

5.4 Local context

Despite showing strong resilience, the local economy has been severely disrupted. The footfall in Birmingham City Centre decreased by 46% from June 2020 to June 2021, which has impacted the economy and the ability of businesses to thrive.[83] The regional Gross Value Added (GVA) dropped by 13%, with overcast recovery not expected till 2022 at the earliest. The GVA measures the contribution made to an economy by one individual producer, industry, sector, or region and directly reflects the economy.

Birmingham has a strong economic centre in the 'financial district' where most high-paying jobs are concentrated. The financial district consists of business, finance, and professional service sectors. It is worth 17.2bn and with 206,200 jobs.[83] The city's most deprived areas are east and west; the most affluent areas are north. **Figure 8** displays the distribution of deprivation in Birmingham by LSOAs (Lower-layer Super Output Areas). LSOAs are small areas designed to be of a similar population size. 41.3% of Birmingham's LSOAs are living in the 10% most deprived LSOAs in England. This includes Hodge Hill, Ladywood, and Erdington

constituencies. Communities of ethnic minorities tend to be concentrated in the less well-off and under-resourced neighbourhoods.

On the other hand, Birmingham's population is relatively young, with about 38% of the population being aged 25 years and below and so has a strong pool for the workforce. Youth unemployment rose to 13.8% in Birmingham in 2020, and young people also had a higher instance of furlough resulting from the closure of various venues and sectors due to COVID-19 pandemic restrictions. The skills gap also restricted business growth significantly. Of 57% of firms in Greater Birmingham that attempted to recruit in quarter 3 of 2021, 62% had great difficulty in doing so.[83] As a result, Birmingham has low productivity compared to the rest of the nation.

Figure 9: Distribution of Deprivation in Birmingham by IMD Decile, (1 (10% most deprived) to 10 (10% least deprived). Adapted (Source PHE 2021)

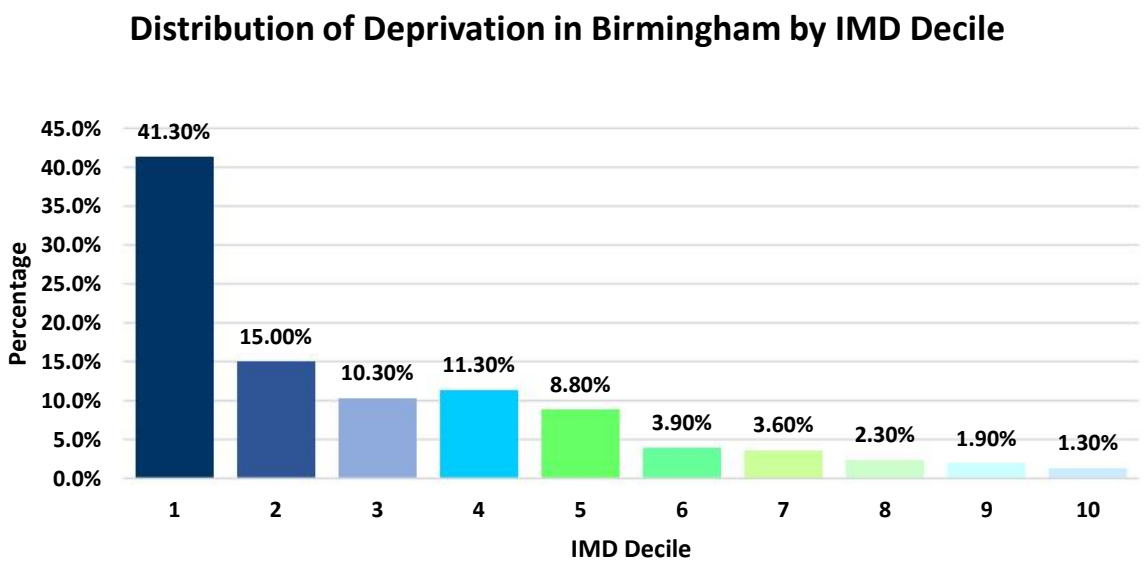
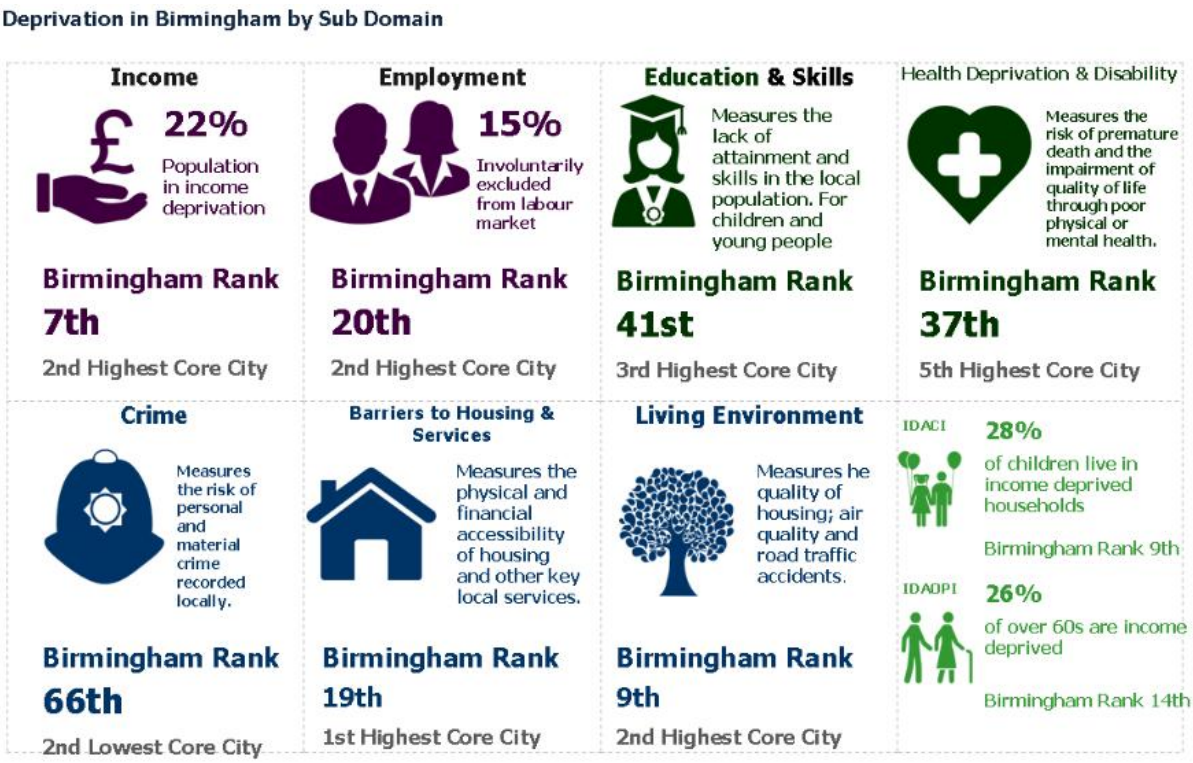


Figure 10: Deprivation by sub-domain



5.5 What is already underway?

Despite the economic disruption caused by COVID-19, the Birmingham economy is on a steady path to recovery. [83] Birmingham is predicted to have the 7th fastest employment growth rate by the end of 2022, increasing year-on-year by 2.2 % and adding almost 14,100 new positions filled. Furthermore, the GVA is expected to have increased year on year by 7.5%, with a 3.9% increase in the number of people in employment. Several projects are currently underway to strengthen the local economy and recover the economy.

5.5.1 Economic Recovery Strategy

Birmingham's Economic Recovery Strategy sits alongside the plans set out by the Combined Authority and the Local Enterprise Partnership[84]. The strategy draws together actions and priorities under six recovery themes:

1. Develop a city recovery vision built on collaborative public services.
2. Inclusive Economic Recovery, tackling existing and new inequalities to leave no one behind.
3. Community Capacity, Community Power, infrastructure, and support platforms to VCFSE organisations.
4. Social Recovery, prevention, early intervention, and whole life course approaches change our relationships with citizens.
5. Localisation working in neighbourhoods.

6. Service Integration across organisations to achieve an effective system for recovery

The economic recovery strategy aims to deliver 100,000 new jobs, 350,000 square metres of new retail space, and 745,000 square metres of new office space by 2031. Much of this work is underway. [84] For example, Paradise and Arena Central developments in the Westside area of the city and the Perry Barr district centre developments.

Furthermore, six Economic Zones have been created to cluster economic activity within high-quality business environments. Delivering high-quality office accommodation for growth in business, financial and professional services and supporting digital media and creative industries

Hot Food Takeaway Policy

To prevent the oversaturation of hot food takeaways in Birmingham highstreets, the Hot Food Takeaway policy was introduced [85]. The Shopping and Local Centres Supplementary Planning Document was adopted in March 2012 and was produced to help address issues affecting the vibrancy and vitality of Birmingham's largest 73 shopping centres. [85] One of the policies outlined in this was to avoid an overconcentration of hot food takeaway uses by restricting their number to no more than 10% of the total units in a centre or individual parade. This prevents any new establishments from being built if going over the 10% threshold. This is monitored yearly to ensure that local centres and primary shopping areas remain diverse. [85]

Levelling up Strategy

The Levelling Up Strategy promises prosperity and opportunity for all residents. The vision is to accelerate growth and harness it for a more equitable city. The Commonwealth Games will add energy to this process, creating jobs, and community participation and pride. The strategy aims to delivery equity across education, skills, jobs, and housing. The TEED project is an example of what is possible delivering the aims within the strategy.

5.6 Recommendations

5.6.1 Edible Landscapes

We recommend the implementation of edible landscapes to complement work already underway to create a greener city. Edible landscaping incorporates edible food plants into the design of landscapes. As well as serving an aesthetic purpose, the plants can be consumed by users of such spaces [86]. Edible landscapes encompass a variety of garden types and scales but do not include food items produced for sale. Incorporating this feature into recreational areas and local high streets would be beneficial. [86] Projects such as this have already been introduced to some major cities, including London via the Edible Landscapes London non-profit community education project. [87] This has enabled a food growing designing system to mimic a natural ecosystem in urban areas, creating 'Urban Food Forests'. This project specialises in forest gardening and has produced the first-ever accredited forest gardening course in the UK, which could be used as good practice. [87]

5.6.2 Mixed-Use Neighbourhoods'

Another recommendation would be to create more mixed-use neighbourhoods near major high streets. Research shows that urban design policies which allow the mixed-use of neighbourhoods and give opportunities to residents to live closer to their workplace are beneficial to health and economic growth. [88] Therefore, urban policy development frameworks should support access to a higher density of shops, services, and recreational facilities. Promoting the mixed-use of neighbourhoods, including local high streets, could promote healthy behaviours such as active walking and cycling to work. [88] Therefore, it is important that high streets and urban areas are accessible to people who use them most often. A longer distance from workplace to home and access to car parking is positively associated with transport-related sedentary behaviour (i.e., car driving). [88]

5.6.3 Increase accessible childcare

We recommend that developers include childcare in mixed-use developments to reduce travel time and distance for parents who live and work there.

5.6.4 Integrate healthier catering assurances into pre-planning applications

Healthy food access should be included in the new BDP and SPD. Pre-planning applications for hot meal takeaways (A3-A5), for example, could demand a commitment to healthy catering. In addition, a tax on hot food takeaway operators should be imposed to support obesity prevention programmes.

5.6.5 Use third sector organisations as a vehicle to drive food growing initiatives

We recommend strengthening the collaboration with third sector organisations and allotment societies already involved in promoting food growing to expand this to individual gardens and innovative ways of growing food at home.

5.6.6 Invest in lifelong education and skills development

The pandemic has demonstrated the unequal impact of employment loss, especially among young people. This means that there must be a greater focus on employment support and career advice for young people entering the workforce, those working in financially unstable areas, and those who may need to change jobs owing to COVID-19 complications.

5.6.7 The economic determinants of health

There have been many missed opportunities to use economic development to improve health and reduce inequalities because public health and economic development strategies are usually developed in silo. The COVID recovery plan and Levelling Up strategy is an opportunity to create a more inclusive economy. We recommend closer working between public health and economic development specialists.

5.7 Policy reference

Birmingham Development Plan (BDP)[24]
Shopping and Local Centres Supplementary Planning Document (SPD)[89]
Birmingham's Economic Recovery Strategy 2021[90]
Healthy High Street: good placemaking in an urban setting[52]
Licensing

MOVEMENT AND ACCESS

(Pedestrian, vehicle, public transport)

6 Movement and Access

6.1 Why is movement and access a determinant of health?

The most important function transportation plays in community health is walking or cycling for physical activity (alone or part of public transport journeys). Physically active people have less risk of stroke, dementia, cancer, and type 2 diabetes. Also, active transportation reduces road traffic injuries and air pollution and significantly decreases respiratory illnesses such as asthma.

Traffic calming measures have proven to save lives. While the most significant health benefits come from active transport, vehicle speeds also impact health outcomes. The risk of a fatal accident at 20km for children is less than one-fifth of the risk at 30km

Travel is necessary for connecting people to employment, education, health care, recreation, and other community services. Every day, most people travel somehow, making it a part of their daily lives and thus a factor that can significantly impact their health.[91] [43]

The success of cities and the quality of living is inextricably linked to how people move around within them. The average commuting time in the United Kingdom was roughly 30 minutes, compared to 25 minutes in the European Union. According to Eurostat, 60% of UK workers commuted for less than 30 minutes, and 80% commuted for less than 45 minutes in 2019.[92]

Research found shorter commuting time to be a consistent determinant of an individual's ability to escape poverty.[93] The COVID-19 pandemic has highlighted the disparity across UK communities living in areas with limited transport access who were disproportionately vulnerable to the virus. They could not get tested regularly or take advantage of early vaccine rollouts due to their distance from COVID facilities and lack of transportation. Vaccine penetration was slowest in areas with the most limited transportation networks.[30]

6.2 How health is impacted

The way we design and build our roadways (transportation network) and how people choose to move through their communities has an impact on health, including exposure to harmful emissions, physical activity, and access to services, amenities, employment, education, and social networks, among other things.

Walking, riding, and taking public transportation are more difficult for some populations. Older people, for example, are more vulnerable to road accidents. The safety and comfort of older persons who use active transportation is affected by factors such as sidewalk design, traffic, rest spaces, and aesthetics.

The difficulties to getting to school securely and conveniently are one of the reasons for the decline in children who walk and bike to school. Community design that encourages high traffic volume and speed while lacking pedestrian and cycling facilities, for example, might result in more injuries and fatalities.

6.3 Local context

Birmingham's transportation network covers large physical areas where residents can access the city in 30 minutes. While the city boasts a large public transportation system, including a local bus network, a metro line, a suburban rail system, cycling and walking routes, including the canal network, Birmingham is highly car-centric, with vehicles accounting for nearly 70% of surface transportation activities. With an average of 80 hours lost annually per driver at an individual cost of £264 and £323 million to the wider city.[94] In addition to the financial costs to drivers, traffic congestion delays public transportation. It limits the flow of freight and commercial vehicles, all of which are essential to Birmingham's day-to-day retail operations.

Birmingham ranks as the third most transportation-congested city in the UK for commuting.[95] Public transportation accounts for 58 per cent of morning peak trips in Birmingham city centre alone. In commuting to Birmingham is mainly from Southeast Staffordshire, South Warwickshire, Solihull, and North Worcestershire.[96]

However, its wide-ranging geography results in vastly different transportation experiences and pain points for those who live and work here, with infrastructure and funding discrepancies resulting in worse service for poorer, underserved communities. In addition, area coverage depends on public transportation network capacity, journey times and infrastructure investment.

Over-reliance on private cars has a significant and negative influence on individuals living and working in Birmingham and visitors. Restoring the balance allows placemaking to prioritise people, and travel is enjoyable rather than frustrating.

6.4 What is already underway?

6.4.1 Transport plan

Birmingham's current long-term transportation plan will shift travel priority following typical large European city regions. Car use accounts for 40 per cent of all travels, compared to 70 per cent in Birmingham. In addition, the West Midlands Combined Authority (WMCA) Cycle Charter sets a goal for 10% of all journeys in the West Midlands Metropolitan Area to be made by bike by 2033. The plan outlines large scope investments in active and public transport. Additionally, it outlines plans to reclaim much of the streets for pedestrian and bike use, mobile and sustainable transport modes.

6.4.2 Public realm improvements

Much is happening across Birmingham to work toward a first-class transport system that meets the need of residents and visitors and Birmingham's goal to become a net-zero carbon city. Birmingham is investing in a mix of transport systems, including active travel that encourages cycling and walking, Sprint Bus networks, new and renovated rail stations, and the Midland Metro tram network.

Work is underway to deliver 150 miles of new metro (8 new lines) and rail (Eastside metro), connecting more people to employment, leisure, and services. Passenger services will be re-introduced at Camp Hill, and three stations are currently under refurbishment with plans to build 18 new stations.

Sprint services will provide high-frequency service on major commuter routes, with predictable travel times and schedules. Sprint's first phase will be completed for the 2022 Commonwealth Games on the A34 Walsall Road and A45 Coventry Road corridors. Additionally, Active Travel Fund schemes are delivering extensive reallocation of road space for cycling and walking schemes.

6.5 Recommendations

6.5.1 Active travel (see the transport plan)

Walking and bicycling are most associated with active transportation but skateboarding, scootering, and rollerblading count. These methods of travel can increase levels of physical activity while reducing pollution levels.

Examples of strategies within the Birmingham transport plan to support active transportation include infrastructure design like connected bicycle networks or multi-use trails or policies that provide sidewalks, bicycle lanes, and share-the-road signs to provide safe and convenient travel for all roadway users.

Other proposed initiatives include a workplace parking levy to reduce car use, cross-city bus routes to reduce wait times, sprint rapid transit buses (to be launched in July 2022), an increase in rail freight and the re-opening of train routes and stations. Streetscape amenities such as benches, landscaping, lighting, and public art encourage active transportation.

A proposal to increase public transport subsidy from 10% to 30% may encourage uptake in public transport usage.

6.5.2 Encourage uptake of active travel through communication campaigns and online resources

Basic online walking and bicycle route guides should be developed to boost active travel adoption. We also believe that disclosing actual (as opposed to perceived) levels of safety for walking and cycling could enhance attitudes and, as a result, active travel uptake.

Raise awareness of the quality and availability of public transport (particularly buses) to help alter perceptions and discourage the use of cars.

6.6 Policy reference

WMCA transport strategy – TfWM Draft Transport Plan (in consultation till Apr 22)[52]
WMCA Walking and Cycling Strategy
Birmingham Cycling and Walking Infrastructure Plan[97]

15 Minute Cities
Birmingham Transport Plan[98]
Clean Air Strategy
OFCP
COVID-19 Economic Recovery Plan

ETHNOGRAPHIC RESEARCH

Experiencing the built environment: citizens stories

7 Experiencing the built environment: Citizens stories

Everyone in Birmingham has their own experience of interacting with the built environment. This ethnographic research provides us with an understanding of residents' lived experiences of the built environment. The aim was to gain insight into their daily lives, their interactions with the built environment, and its potential and perceived impact on health and well-being. The research was commissioned by Birmingham City Council and completed by Shift Insight between November 2021 and March 2022.[1]

Forty participants from across Birmingham took part (see Appendix X for a full breakdown of participant profiles), and their stories are woven through this section. Ten case studies were developed from journeys citizens made through the built environment in their daily lives. The findings and case studies should not be used to evidence the entire system but rather a snapshot of experience in the built environment. Citizens took all the photos in this section as part of the digital ethnography.

The summary of information gathered from the research is split by subject (housing, neighbourhood and community, local economy and movement and access) while also identifying the origin of these comments.

7.1 Housing

The experiences of the Covid-19 lockdowns led to acute acknowledgements that a person's housing situation, whether positive or negative, deeply affected their experience during the pandemic.

> ***I'm not going to lie, it's been really hard, especially these last two years, the fact that I couldn't go out when we were in lockdown. That was really, really hard mentally to basically be stuck indoors."***
> **Handsworth (Indian, Private rental)**

> ***"If I look out of the balcony, I've got a really nice view of Sutton Park. It was actually a pretty big factor in why I liked this flat so much, because it's a nice view that I have from the balcony, and yeah, I don't want to live in a dungeon."***
>
> **Sutton Trinity**

More widely, participants often formed aesthetic judgements of where they lived. Visual cues played a big role in how individuals felt about their surroundings, especially their immediate home environment. Residents mentioned clean, visibly thriving neighbourhoods with calming views.

7.1.1 Housing Quality

A consistent theme emerged here, with participants emphasising the necessity of maintaining a safe and comfortable temperature in the home and how this relates to the quality and design. Highlighting the importance of materials (tile and stone are more difficult to heat), orientation (see lighting below), and floor level (temperature on the bottom floor and top floor more difficult to maintain). The ability to stay warm in the winter and cool in the summer. When it's hot outside, have windows that restrict or boost their ability to keep warm or adjust for ventilation and natural lighting.

"Being a ground floor flat, and concrete as well, obviously you get the elements because it's only PVC and it's quite dated – the windows, the frames. The frames actually go to the floor so yes it can be very cold unless the heating is on, and then, of course, that's costly."

Participants expressed concerns about living in a cold environment. Improvements are frequently insufficient to maintain a comfortable temperature or are too expensive. The use of Economy 7 heaters, a lack of insulation, and residences with high ceilings are not energy efficient and add more to the bills. Residents were aware of moisture and mould forming in their homes because of the constant insufficient temperature.

"Because it hasn't got a window in [the bathroom] and it doesn't circulate air very well, you have to ventilate it quite well, so it doesn't like gather mould and all the rest of it … I have to ventilate it really well, the air vents and opening my bedroom windows quite a lot. It can seem quite cold."

Erdington (Flat)

"All the windows seem to be getting damp around them and getting like mould on the walls and stuff. It's not major, but you can tell it's been painted over before I moved in. Because our bed is right by the window and it's got obviously damp around it, I think it does make us a little bit poorly. Not poorly … me and my [partner] have realised that we feel a bit bunged up of a night and a bit of a sore throat in the morning."

Oscott (Flat)

This was especially true for those living in rented homes, and it brought up a crucial topic. Residents who do not own their homes sometimes feel powerless over these decisions. They also stated that these decisions are frequently made so that the landlord will incur a lower direct cost than the expense of heating the house.

Respondents frequently link their mental health to lighting quality in their homes. Their favourite rooms in the house were those with more light. Those with accessibility needs would normally make the necessary changes to their homes to meet their requirements. However, common building accessibility (flats without lifts and a stairwell without a handrail) and parking availability in residential areas were also of concern.

When discussing housing and health, it's important to include a discussion of homelessness, as it's a major predictor of a person's health. Health difficulties disproportionately affect homeless or rough sleeping individuals. According to participants, homelessness is a major issue in Birmingham, and it can contribute to larger crime problems in some locations. On the other hand, several participants perceived homelessness as a tragic aspect of their journeys rather than a problematic issue.

> *"This (homelessness) is probably the biggest thing in the city that makes me feel sad. The amount of homeless people you see dotted around the city, either along the roads or along the streets begging for money"*
>
> **Kings Heath**

7.1.2 Green and blue spaces

Access to nature and green places was quite important, and they appeared in various aspects of the data. Many emotional accounts about how a shortage of green space during COVID had trapped individuals in cramped dwellings or was being eased by access to a garden or a park. It demonstrated the importance of spending time in green space for mental and physical well-being.

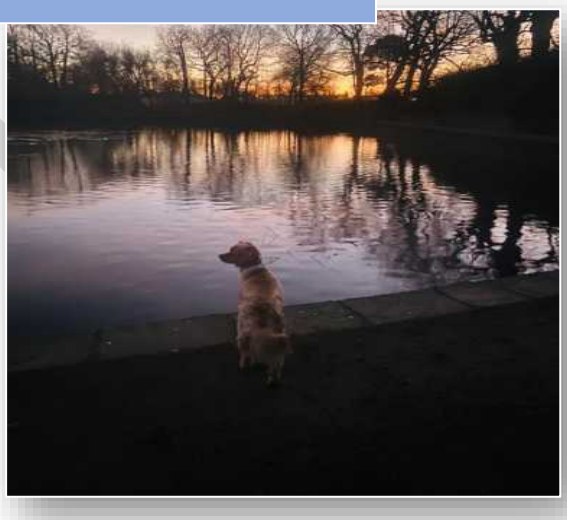
Access to these spaces within their 15-minutes neighbourhood was highly valued, and the research highlighted some green areas throughout the city that were not always consistently well-kept with evidence of litter or substance abuse which could lead to their avoiding and not using them at all.

"This is one of my favourite places in Birmingham and near my house. I love that, although you're in the city, you feel like you're in the countryside. There is no road noise, it's beautiful in the winter and the summer. Having this on my doorstep makes me happy!"

"I believe that harmony is where you find it and I am with one in my own backyard as they say! I am not a great gardener but take peace and tranquillity sitting out on the decking with a nice cup of coffee and just let the world go by … It is my safe place."

"The little spaces we do have are polluted and not policed or cared for like other parts of Birmingham where it's evident the council are present. "

"I feel the water adds to a calmer mood"



7.2 Neighbourhood and Community Spaces

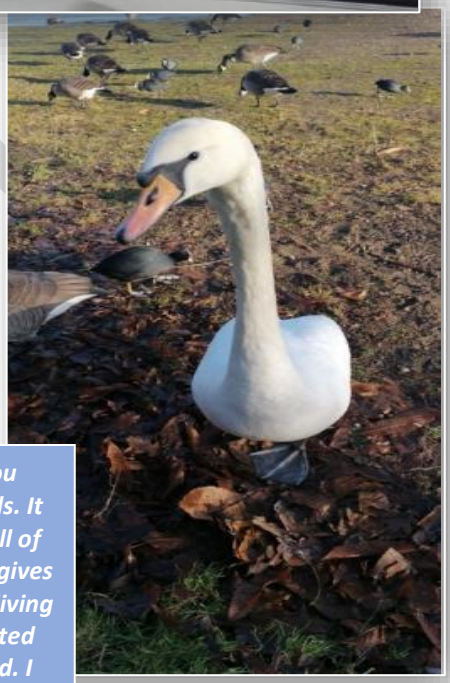
People spoke about social cohesion and pride in their community, often pointing out the lack of these qualities. Although they made suggestions for change, they were proud to call themselves Brummies. People's hometown and local neighbourhoods needed to have aesthetic appeal. The level of pride people felt was down to maintenance, congestion and pedestrianisation, boarded up or lively shops and restaurants, access to green spaces and seeing less homeless people on the street.

"If you go ... the library way, you've got some old buildings, and then Grand Central way you've got all these modern things coming up, so you go 'Wow, this is nice!' I like this. I like a mixture of things so it's not all the same thing. You don't walk and find the same thing everywhere."

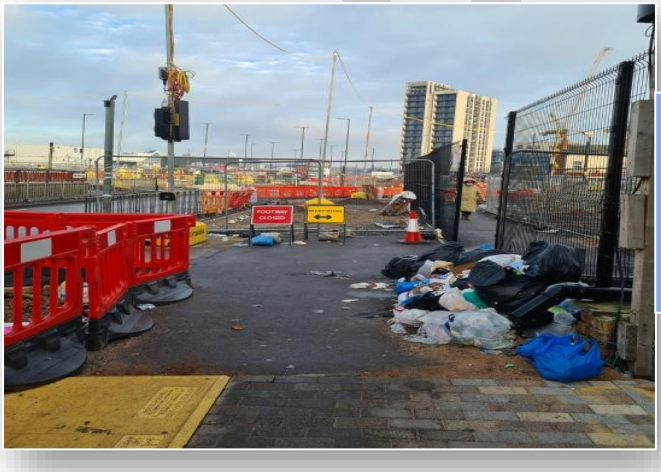
"This photo makes me happy and proud – it's the Birmingham brass bull and it's iconic to Birmingham and the city centre. You only have to show someone this photo and, if they have knowledge of Birmingham or have been, I can assure you they will know straightaway where this photo was taken and what it is, I'm a proud Brummie!"

This is a Gurdwara in Handsworth. It's one of the biggest landmarks in Birmingham. Amazing to look at ... Brings back warm happy memories from my childhood. It's nice to see a multi-cultural Birmingham. I feel safe in a mixed area."

"[This photo] shows how people find it easy to fly-tip. There are no consequences for people who do this. I feel the council should introduce collection days for all household items to overcome these scenes … The fly-tipping needs to be tackled. People need to take pride in their areas."



"It is so big that once you walk through you wouldn't even know you were near any roads. It is peaceful, the grass is well looked after. Full of trees and even has access to an allotment. It gives that green space that you need when you're living in and around the city. There are plants dotted around the edges and plenty of trees around. I really enjoy this park and how easy it is to access it. I can even walk there from my house so, whether I walk or drive, I enjoy this park being on my doorstep."



"This is general waste and recycling that hasn't been picked up for weeks… every road in this area is like this. It makes us not want to exercise in the area"

7.2.1 Lighting

Participants were frequently asked to consider how various circumstances made them feel comfortable or unsafe. We wanted to know whether the environment impacted on their mental health daily and influenced travel decisions. These could be whether to drive, avoid going out in the dark and exercising outdoors. The feeling of safety extended to driving as well, providing insight into drivers' perceptions of city streetlights on well-being.

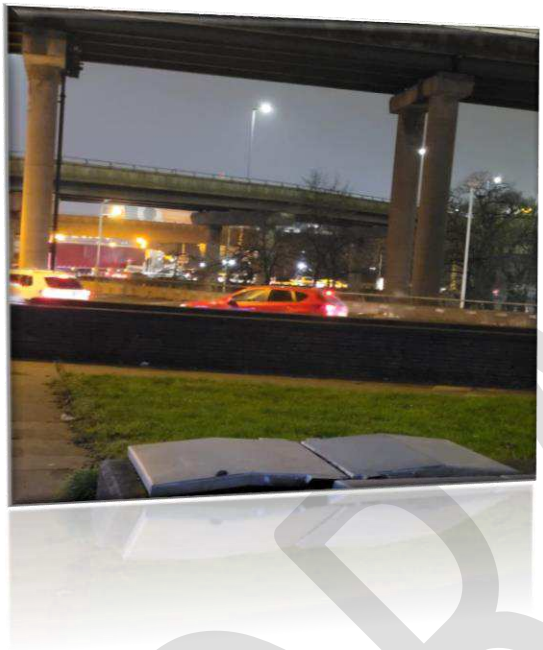
"I would say the street lighting can be improved and this in turn would allow better visibility, safer driving conditions."

"Lift [is in] the dark … it was not bright enough for wheelchair users or buggy carriers, which may cause some concern for using the lift, especially in winter season."

"A photo in our local park [that] we use to walk the dog. It's a clean park, nice walking paths, [but] would be nice to have more night-time lights."

7.3 Movement and access

The recurring theme from people is that the city was intended for cars so harder to navigate for those on foot. In terms of sustainability, this was linked to participants' impressions of Clean Air Zones and their belief that traffic had been diverted to different parts of the city. The statistics revealed how multiple roadworks negatively influenced healthy behaviours such as walking, cycling, and exercising. It revealed inconsistencies in behaviour, such as respondents preferred to drive since it stopped them from having to navigate streets as a pedestrian. But they were actually adding to air pollution and congestion by doing so.



"This is probably my worst photo and sums up Birmingham city centre perfectly! … The area is full of pollution and all you can ever smell is fumes from exhausts or the smell from factories or the builders."

7.3.1 Public transportation

The citizen journeys represent that many residents have access to a local train station and numerous bus stops. Trains were thought to be a good way to avoid traffic and roadworks.

There was a notion that buses were unreliable, vulnerable to congestion, and that bus stops were more likely to be filthy or cluttered. Many of these negative comments were from people who rarely take the bus. Despite the amount of bus routes and stops available, several participants refused to take the bus.

7.4 Local Economy

The city centre was a popular destination for most participants. However, on the other hand, participants' neighbourhoods were strongly featured, which might often highlight the disparity between visible investment in various parts of the city and more suburban areas.

These photographs show participants highlighting areas of the city that appear to be neglected or well-kept.

This image depicts dilapidated or boarded-up shops, which have been linked to feelings of depression, anxiety, and a sense of being 'left behind.' As a result, negative behaviours such as littering, or fly-tipping have become more frequent and accepted as the standard and resistance to walking and exercise.

Highstreets like Boldmere and Sutton was cited as ideal example of what residents want their high street to look like.

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Birmingham Health and Wellbeing Board
Draft Forward Work Programme and Board Membership:
May 2022-23

Board Members:

Name	Position	Organisation
Councillor Paulette Hamilton (Board Chair)	Cabinet member for Adult Social Care and Health	Birmingham City Council
William Taylor (Vice Chair)	Chair	NHS Birmingham and Solihull CCG
Councillor Sharon Thompson	Cabinet Member for Vulnerable Children and Families	Birmingham City Council
Councillor Matt Bennett	Opposition Spokesperson on Health and Social Care	Birmingham City Council
Dr Justin Varney	Director of Public Health	Birmingham City Council
Dr Graeme Betts	Director for Adult Social Care and Health Directorate	Birmingham City Council
Kevin Crompton	Director of Education and Skills	Birmingham City Council
Karen Helliwell	Interim Accountable Officer	NHS Birmingham and Solihull CCG
Paul Maubach	Chair, Sandwell and West Birmingham CCG	Sandwell and West Birmingham CCG
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Children's Trust
Dr Robin Miller	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham Education Sector
Richard Kirby	Chief Executive	Birmingham Community Healthcare
Mark Garrick	Director or Strategy and Quality Development	University Hospitals Birmingham NHS Foundation Trust

Chief Superintendent Stephen Graham	Chief Superintendent	West Midlands Police
Riaz Khan	Senior and Employer Partnership Leader	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust	Birmingham Social Housing Partnership
Doug Simkiss	Medical Director and Deputy Chief Executive of Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Yve Buckland	Chair	Birmingham and Solihull Integrated Care System
tbc	tbc	Birmingham Chamber of Commerce
Co – optees		
Carly Jones	Chief Executive of SIFA FIRESIDE	SIFA FIRESIDE
Waheed Saleem	Executive Director Strategic Partnership	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

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Forward Plan: 2022/23

	17th May 2022	**July (HWB Development Day TBC)**	**20th September 2022**	**29th November 2022**	**17th January 2023**	**21st March 2023**
Draft Papers Deadline	27th April 2022	TBC	31st August 2022	9th November 2022	28th December 2023	1st March 2023
Final Papers Deadline	05th May 2022	TBC	9th September 2022	18th November 2022	6th January 2023	10th March 2023
Standing items	Covid-19 position statement & Vaccination update- Justin Varney Commonwealth Games update- Justin Varney ICS Update – Karen Helliwell	TBC	TBC	TBC	TBC	TBC
Theme	**Business Meeting**	**Business Meeting**	**TBC**	**TBC**	**TBC**	**TBC**
Items	**Sandwell and West Birmingham NHS Trust Five year Strategy** – Richard Beeken, CEO **BCC Early Intervention and Prevention Programme** – Graeme Betts, Corporate Director **DPH Annual Report 21/22, Built Environment** – Dr Mary Orhewere, Additional Director	TBC	TBC	TBC	TBC	TBC

	BLACHIR Opportunities for Action Update – Dr Justin Varney					
Nonthematic items						
Written updates	LCOEB	TBC	TBC	TBC	TBC	TBC

Standard Agenda

1. Notice of Recording
2. Notice of Potential for Public Exclusions
3. Declaration of Interests
4. Apologies
5. Minutes and Matters Arising
6. Action Log
7. Chair's Update
8. Public Questions
9. Presentation Items (see detail above)
10. Information Items (see detail above)
11. Forward Plan Review
12. Finalise Agenda for next Meeting
13. Date, Time and Venue of next Meeting
14. Notice of Recording Ceased
15. Private Items (see detail above)

Notes

Any agenda change request must form part of prior HWBB information item with as much lead in as possible but no later than the HWBB immediately prior to the agenda change request, including requests from sub-groups (see below).

Health Inequality Focus and Childhood Obesity Focus agenda presentations can be several items if appropriate, but all must include decision(s) and / or action(s) for the Board.

Health and Wellbeing Board Fora will provide a written update to each Board meeting; each will have an annual formal presentation to the Board on a rotational basis.

Public Questions

Public questions are to be submitted in advance of the meeting via the Birmingham Health and Wellbeing Board public question portal.