BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

THURSDAY, 26 SEPTEMBER 2024 AT 10:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Public-I microsite (please click this link) 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 they must declare all relevant pecuniary and other registerable interests arising from any business to be discussed at this meeting.

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

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

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

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

3 **APOLOGIES**

To receive any apologies.

4 **DATE AND TIME OF NEXT MEETING**

To note the dates of formal meetings of the Board commencing at 1000 hours:-

Thursday 21 November 2024
Thursday 30 January 2025
Thursday 27 March 2025

5 **MINUTES AND MATTERS ARISING** **5 - 12**

To confirm and sign the Minutes of the meeting held on 18 July 2024

6 **COMMISSIONER'S REVIEW AND COMMENTS ON THE AGENDA**

To note any comments. (See the front sheet of individual reports on the agenda.

7 **ACTION LOG** **13 - 14**

To review the actions from previous meetings.

8 **CHAIR'S UPDATE**

To receive an oral update

9 **PUBLIC QUESTIONS**

(1010-1015) - Members of the Board to consider questions submitted by members of the public.
The deadline for receipt of public questions is 1500 hours on 19 September, 2024.
Questions should be sent to: HWBoard@Birmingham.gov.uk.
(No person may (submit more than one question)
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's Public-I microsite (please click this link)
NB: The questions and answers will not be reproduced in the minutes.

10 **SMOKEFREE GENERATION UPDATE** **15 - 32**

(1015-1025) - Becky Pollard (Assistant Director for Public Health, Adults and Older Adults, Birmingham City Council) will present this item.

33 - 40

11 **BIRMINGHAM DRUG AND ALCOHOL PARTNERSHIP UPDATE**

(1025 -1050) - Jo Tonkin (Deputy Director Public Health, Birmingham City Council will present this item.

41 - 66

12 **HEALTH PROTECTION FORUM ANNUAL UPDATE**

(1050 - 1115) - Funmi Worrell (Health Protection Team Service Lead, Public Health, Birmingham City Council) will present this item.

67 - 106

13 **HEALTH AND WELLBEING BOARD ANNUAL REVIEW OF STRATEGY AND GOVERNANCE REVIEW**

(1115 - 1135) - Jo Tonkin (Deputy Director, Public Health, Birmingham City Council) will present this item.

107 - 108

INFORMATION ITEMS

109 - 112

14 **HEALTH AND WELL BEING BOARD EXECUTIVE GROUP REPORT**

113 - 202

15 **BIRMINGHAM & SOLIHULL INTEGRATED CARE SYSTEM: COMMUNITY CARE COLLABORATIVE IMPLEMENTATION PLAN**

203 - 210

16 **HEALTH AND WELLBEING BOARD FORWARD PLAN**

17 **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.

211 - 392

SUPPLEMENTARY READING

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING THURSDAY, 18 JULY, 2024

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 18 JULY, 2024 AT 1030 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, BIRMINGHAM, B1 1BB

PRESENT: -

Councillor Rob Pocock Acting Cabinet Member for Health and Social Care
Dr Clara Day (Vice-Chair) Chief Medical Officer, NHS Birmingham & Solihull ICB (In the Chair)
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Justin Varney, Director of Public Health
Louise Collett, Acting Strategic Director for Adult Social Care
Andy Cave, Chief Executive Officer, Healthwatch Birmingham
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Jo Tonkin, Assistant Director (KEG), BCC
Donna Livesy on behalf of Karen Creavin, Chief Executive of TAWS
Andy Walker (on behalf of Richard Kirby), BCH NHS Foundation Trust
Professor Catherine Needham, University of Birmingham

ALSO PRESENT:-

Louisa Nisbett – Committee Services
Aidan Hall – Service Lead, Governance
Ceri Saunders - Cabinet Support Officer
Stephen Philpott, Service Director of City Housing Solutions & Support Services
Chris Jordan, AD, Neighbourhoods
Paul Langford, Strategic Director of City Housing
Philip Nell, Strat Dir Places, Prosp & Sustainability
Sal Nasreen, Assistant Director Insight, Policy and Strategy
Richard Brooks, Director of Strategy, Equalities & Partnerships

A number of Members and Officers attended the meeting online.

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NOTICE OF RECORDING/WEBCAST

1 The Chair advised that this meeting would be webcast for live or subsequent broadcast via the Council's Public-I microsite (please click this link) and that

members of the press/public may record and take photographs except where there were confidential or exempt items.

The business of the meeting and all discussions in relation to individual reports are available for public inspection via the web-stream.

APPOINTMENT OF HEALTH AND WELLBEING BOARD – FUNCTIONS, TERMS OF REFERENCE AND MEMBERSHIP 2024-2025

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

(See document attached)

DECLARATIONS OF INTERESTS

3 The Chair reminded Members that they must declare all relevant pecuniary and other registerable interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest was declared a Member must not participate in any discussion or vote on the matter and must not remain in the room unless they have been granted a dispensation.

There were no declarations made.

APOLOGIES

4 Apologies for absence were submitted on behalf of :-

Councillor Mick Brown, Cabinet Member, CYP
Councillor Saima Suleman, Cabinet Member, DCHT
Helen Ellis, Director Strategy Commissioning & Transformation
David Melbourne, NHS Birmingham and Solihull CCG
Richard Beeken, Chief Executive, Sandwell & NHS Trust

MINUTES AND MATTERS ARISING

5 The Minutes of the meeting held on 9 May, 2024, having been previously circulated, were confirmed and signed by the Chair.

COMMISSIONERS REVIEW AND COMMENTS ON THE AGENDA

6 The comments submitted by the Commissioners in relation to reports 11 and 12 on the agenda were noted as follows:-

“Commissioners note the progress that was being made in this report but were concerned that it was not presented in it’s proper context. More consideration should be given to the exceptional financial context, the governance challenges and the statutory intervention. The Council must ensure that reports were

considered in that context so that Board and Committee members were appropriately informed."

ACTION LOG

7 No outstanding actions were raised for the Action Log.

CHAIR'S UPDATE

8 Councillor Pocock, Acting Cabinet Member for Health and Social Care noted the Commissioner's comments regarding the financial situation, challenges and constraints faced by Birmingham City Council. This had led to a S114 notice being issued.

The inability of BCC to present a balanced budget was a separate issue and had led to exceptional financial support being agreed by the Government. The savings target would be delivered over a 2 year period.

PUBLIC QUESTIONS

9 The Chair advised that the Board welcomed questions, any questions should be sent to HealthyBrum@Birmingham.gov.uk.

There were no questions.

BIRMINGHAM CITY COUNCIL, DIRECTORATE SAVINGS PLANS AND POTENTIAL IMPACT ON HEALTH AND WELLBEING - DISCUSSIONS

The following report was submitted:-

(See document attached)

Councillor Pocock briefly introduced the report with the purpose to inform and brief Health and Wellbeing Board members on Birmingham City Council's agreed savings and discuss potential impacts on health and wellbeing and also to support Health and Wellbeing Board partners in discussing the implications for the Board's work programme and the delivery of the Joint Health and Wellbeing Strategy.

Public Health

Justin Varney made a presentation with the use of slides outlining savings for 2024/2025 and 2025/2026. It was clarified that Public Health was funded through a ring-fenced grant from the Department of Health and Social Care which was separate to BCC General Fund.

In response to questions Justin Varney responded that –

In most Directorates there had been significant transformation made and alternative ways to deliver services had been used. Individual Directorates had looked at the impact on citizens and had been required to think carefully what the strategy was and how to deliver it. There will be a workshop of the HWB in early October to consider the medium risk and mitigations. They had worked hard with colleagues with regard to the financial impact on the strategy.

Section 151 Officer Update on the Financial Position of the Council

Fiona Greenway, the Section 151 Officer presented some slides on the Financial Position of the Council and the Scale of the Challenge. She gave an overview of the overspend from 2022/23 to the current year and the budget gap indicating that for the current year £149.8m savings had been identified. BCC had been given permission from the Government to raise the Council Tax and had received exceptional financial support to treat day to day spend differently.

Children and Families and Birmingham Children's Trust

Sue Harrison, Strategic Director of Children and Families and James Thomas, Chief Executive, Birmingham Children's Trust both joined the meeting online. Sue Harrison made a presentation informing that the savings for Children and Families 2024/2025 had been agreed. The potential impacts on health and wellbeing were outlined. They would ensure the cuts were not having an impact on front line services. They had challenged themselves not to leave children unsafe. They recognised the extra pressures faced by families and were working with partners with this regard.

Adult Social Care

Louise Collett Strategic Director Adult Social Care attended the meeting and presented the Adult Social Care savings. There were 16 proposals that needed to deliver £23.7m in 24/25 and a further £29.1m in 25/26. A list of these savings with a brief description of each proposal was included in pages 1-2 of appendix 2. They must ensure they could still deliver the statutory duties and minimise any significant impact on citizens. There would be no impact on quality. A saving proposal had been made relating to BCC Day Centres.

City Housing

Steve Philpott, Service Director of City Housing Solutions & Support Services attended the meeting to present the City Housing savings. The directorate had 12 proposals that need to deliver £6.2m in 24/25 and a further £3.3m in 25/26. A list of these savings with a brief description were listed in the document. It was noted that the savings were general fund savings and not housing revenue funds. A housing acquisitions programme had started. Birmingham were doing relatively well compared to other cities. Presentation of homeless people were up. A strategy on homelessness would be presented to Cabinet in the autumn.

Place, Prosperity and Sustainability

David Harris, Assistant Director Corporate Landlord attended the meeting online. The directorate had 6 proposals that need to deliver £8.4m in 24/25 and a further £2.8m in 25/26 . A list of these savings with a brief description of each proposal were included in the document. He made reference in particular to the Corporate Landlord slide and the asset rationalisation and reduction workstream of the Corporate Landlord programme.

City Operations

Chris Jordan, Assistant Director Neighbourhoods attended the meeting to present the City Operations savings. The directorate had undertaken an initial review of potential H&W impacts on 45 of the proposals, with a further 31 in Street Scene still to be considered. A short presentation was given on the potential larger (11) impacts on health and wellbeing from the savings.

A discussion ensued during which comments were made by Members in particular it was noted as follows:-

- There was insufficient clarity on children's and young people. The lack of Transport for young people to college in particular was mentioned.
- On the Waste Management presentation the potential health impact from the waste collections changing to a fortnightly schedule was missing.
- When assessing cuts in one area, eg Physical & Mental Health Wellbeing, an individual may be affected by cuts in other areas. There could be wider health impact assessments.
- There was a need to work together to ensure people were aware of the services available..
- There will be grey areas regarding spend.
- Sue Harris could give a bit more assurance regarding transport budgets and how they were used.
- More detail in general was required about how things were being addressed.
- Chris Jordan was asked to comment on the street scene and to get an assessment done after the meeting.
- Louise Collett undertook to share the Health inequalities, health impact assessments
- Alternatives should be looked at for Adult Care Centres and it should be ensured that people were aware of what alternatives were available and be signposted to them.
- The possibility of changing the strategy will be discussed in the autumn.

- The Board had a responsibility to collectively own how best to work together to ensure they communicate and engage with citizens.

- The Workshop in November will reflect on the strategy and how it will be delivered. The 2025-2026 budget for May will also be discussed

- It was suggested that Members should email any questions/comments to Aidan Hall for him to arrange for officers to respond.

10 **RESOLVED**:-

That the Health and Wellbeing Board (HWB):-

i. Receive and note the presentations delivered by Directorates and comments from Members; and

ii. Commits to working in partnership to deliver the Health & Wellbeing Strategy in the context of the financial challenges facing the Council, and other system partners.

HEALTH AND WELLBEING BOARD EXECUTIVE GROUP PAPERS AND RECOMMENDATIONS

The following report was submitted:-

(See document attached)

Dr Clara Day presented this item to Members of the Health and Wellbeing Board with the recommendations from the Executive Group

11 **RESOLVED**:-

That the Health and Wellbeing Board note and approve the recommendations from the Executive Group

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HEALTH AND WELLBEING BOARD FORWARD PLAN

The following Forward Plan was submitted:-

(See document attached)

12 **RESOLVED**:-

That the Forward Plan be noted.

DATES OF FUTURE MEETINGS

13 Dates of future meetings were as follows:-

Thursdays at 1000 hours

26 September 2024
21 November 2024 (Workshop)
30 January 2025
27 March 2025

OTHER URGENT BUSINESS

14 It was noted that the Health and Wellbeing Board meeting on 21 November, 2024 had been changed to a workshop.

The meeting ended at 1226 hours.

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CHAIR

Action Log 2024/25

Rag rating:

- Overdue
- In progress
- Complete

Index no.	Date of Entry	Agenda Item	Action or Event	Named Owner	Target Date	Date Complete	Outcome/Output	Rag
1	18/07/2023	11. Children and Young People's Plan	Agree a future HWB meeting date for Children and Young People's Plan update.	Aidan Hall	26/09/2023	26/09/2023	Added to the HWB Forward Plan.	
2	18/07/2023	12. Birmingham and Solihull Joint ICB Forward Plan	Agree a future HWB meeting date for 'Joint Forward Plan' for the ICS 10-year strategy.	Aidan Hall	26/09/2023	26/09/2023	Added to the HWB Forward Plan.	
3	18/07/2023	10. Health and Wellbeing Board Development 2023-24	Defer the HWB Development item to the next meeting.	Aidan Hall	26/09/2023	26/09/2023	Item refined and brought back to the following meeting.	
4	18/07/2023	20. Exclusion of the Public	'Private' Minutes will be deferred to the next meeting and HWB will be given access	Louisa Nisbett	26/09/2023	26/09/2023	Private minutes circulated to members via email	
5	26/09/2023	9. Health and Wellbeing Board Development	Review Executive Board after 6 months.	Aidan Hall	26/03/2023			
6	26/09/2023	10. Joint Strategic Needs Assessment (JSNA) Update	Agree a future HWB meeting date for the Deep Dive Programme and JSNA update.	Aidan Hall	28/11/2023	28/11/2023	Added to the HWB Forward Plan (24/25).	

7	26/09/2023	11. Draft Birmingham and Solihull Enabling Primary Care Strategy	Agree a future HWB meeting date for the Enabling Primary Care Strategy	Aidan Hall	28/11/2023	28/11/2023	Added to the HWB Forward Plan (24/25).	

	Agenda Item: 10
Report to:	**Birmingham Health and Wellbeing Board**
Date:	**Thursday 26th September 2024**
TITLE:	**Stopping the start: our new plan to create a smokefree generation – progress update**
Organisation	**Birmingham City Council**
Presenting Officer	**Becky Pollard, Assistant Director Public Health (Adults and Older People), Birmingham City Council**

Report Type:	**Information**

1. Purpose:

1.1. The purpose of this briefing paper is to provide an update on the progress in delivering the policy on taking forward the 'Stopping the start: our new plan to create a smokefree generation'. It includes an update on proposals for the use of the Smokefree Generation Section 31 Grant of £1,676,048 awarded to Birmingham City Council in 2024/25, coordinated through the Birmingham Smoking Cessation Task Group (BSCTG).

2. Implications (tick all that apply):

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

3. Commissioner's Review:

3.1 Commissioners support the recommendations.

4. Recommendation

4.1 The Board is asked to review and note the following progress of work towards implementation of Department of Health and Social Care policy paper 'Stopping the start: our new plan to create a smokefree generation', including:

4.1.1 The Birmingham and Solihull Integrated Care Partnership Joint Position Statement which welcomed new plans to achieve a smoke-free England and Wales by 2030.

4.1.2 The establishment of a multi-agency task group, the BSCTG, chaired by the Assistant Director of Public Health (Adults and Older People) with membership made up of representatives from a range of external and internal stakeholders to coordinate local activities and the use of the £1,676,048 Smokefree Generation Section 31 grant funding in the financial year 24/25.

4.1.3 The recent invitation to partners from across the system to submit an expression of interest to the BSCTG detailing potential use of the funds and address gaps within current service provision. The primary focus will be on increasing the capacity and demand for smoking cessation services, while also addressing significant inequalities in smoking prevalence across different populations within the city.

4.2 The Board is asked to note that the BSCTG now reports to the Birmingham and Solihull Tobacco Control Alliance to oversee and coordinate efforts to deliver the grant actions.

4.3 The Board is asked to recognise that Birmingham City Council are awaiting further updates on national legislation and are requesting ongoing support of future proposals and plans set out in the briefing paper.

5. Report Body

5.1. In December 2023, Birmingham and Solihull Integrated Care Partnership welcomed new plans to achieve a smoke-free England and Wales by 2030. It produced a Joint Position Statement in which it signed up to a number of pledges to bring together local partners to renew our efforts to work together to reduce harmful tobacco use. The statement is set out at Appendix 1.

5.2. Appendix 2, sets out an overview of current activity across the Smoke free Generation landscape in Birmingham. It covers:

5.2.1 Local authority commissioned smoking cessation services across Birmingham. The aim of these services is to maximise the number of smokers accessing the service and quitting long-term, therefore contributing to the reduction of smoking prevalence in Birmingham.

5.2.2 Smoking statistics detailing a demographic breakdown for those accessing Birmingham local authority commissioned smoking cessation services.

5.2.3 A benchmarking exercise of the costs of smoking cessation services commissioned by Birmingham City Council which shows that comparatively, the council spends less per head of population on stop smoking treatment services and very little on tobacco control than the core city average and England average. The

additional non-recurrent funding (Smokefree Generation Grant £1.67m) will support very targeted cessation work at high-risk populations.

5.2.4 The purpose of the BSCTG to plan, develop and oversee the implementation of additional and advanced support to stop smoking services, including targeting inclusion groups (e.g. those with substance misuse problems and those with mental health problems) and the enhancement of existing infrastructure and local system development. Terms of reference of the group are set out at Appendix 3.

5.2.5 The Birmingham and Solihull Integrated Care System NHS Long Term Plan treatment services for tobacco dependency which includes in-patient support, services for those with severe mental health illness and support for pregnant women who smoke and are in contact with maternity services.

5.2.6 A two-year 'gold standard' community engagement project on Shisha consumption which is underway and set to end in 2026. The aims of the project are to fill gaps in knowledge around shisha consumption in Birmingham and offer recommendations to address this public health issue.

5.2.7 Youth vaping and the results of the annual Action for Smoking and Health Smokefree GB Youth Survey for 2024. Key findings show the rate of youth vaping remains high, with 18% of 11–17-year-olds (compared to 20% in 2023) having tried vaping. Since 2021, more children are vaping than smoking. Amongst 11–17-year-olds, 'once or twice' experimentation has remained the most common type of vape us amongst young people. For the second year in a row most children aged 11-17 (58%) wrongly believe that vaping is about the same or more harmful than smoking.

5.2.8 Trading Standards activity including a project funded by Birmingham City Council's Public Health to prevent illicit vape sales for the period 2024/25. Work includes inspection and advice for shops selling vapes and nicotine inhaling products, as well as targeting those premises who sell these products to underage customers. Re-visits to premises who failed inspections will take place later in the year to test compliance following advisory visits.

6. Compliance Issues
6.1. HWBB Forum Responsibility and Board Update
The Chair of the BSCTG will provide update reports on the work of the group to the Birmingham Health and Wellbeing Board and Birmingham and Solihull Tobacco Control Alliance, as and when required.
6.2. Management Responsibility
Becky Pollard, Assistant Director Public Health (Adults and Older People), Birmingham City Council Keiran Mckenzie, Service Lead (Adults), Birmingham City Council
6.3. Finance Implications
Management and administration of the Section 31 grant is managed by the Birmingham City Council Public Health Adults Team.

The Smokefree Generation Section 31 grant agreement was signed off in March 2024 between the Office for Health Improvement and Disparities (OHID) and Birmingham City Council. The council has now received the first instalment of £1,173,233 with the second instalment of £502,815 to be received in Quarter 4. If the grant is not fully spent by the end of the financial year 2024-25, or has an underspend, the local authority must notify OHID. OHID may consider reducing future grant amounts to local authorities that report significant and repeated underspends. This additional funding is contingent on the basis that there is no reduction in the core Birmingham City Council's Public Health Ringfenced Grant spend on local smoking cessation services as measured from 2022/23.
6.4. Legal Implications
A condition of the Smokefree Generation Section 31 grant is that local authorities must maintain their existing spend on stop smoking services and maintain compliance with the reporting requirements for expenditure related to the stop smoking service by submitting quarterly reports to NHS Digital. Birmingham City Council must therefore ensure that any spend of the Smokefree Generation Section 31 grant complies with the grant terms and conditions as detailed by OHID. Appendix 4. sets out the Birmingham Local Stop Smoking Services and Support Grant 2024-2025 signed terms and conditions.
6.5. Equalities Implications (Public Sector Equality Duty)
The work planned for the Smokefree Generation recognises and aim to reduce the inequalities of smoking prevalence amongst differing populations within Birmingham.

7. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Financial risks include: • Grant amount not being fully spent in year and returned to OHID • Accurate quarterly financial reporting to OHID • Ensuring successful submission of Year 1 final statement of grant usage	Medium likelihood that the Year 1 allocation of grant (£1,676,048) will not be spent before March 2025.	Delay in valuable services being implemented.	• Weekly internal meetings • Formation of project plan and risk register • Gantt chart with key dates and deadlines • Finance is informed of grant reporting and kept up to date with spending.
Legal risks include: • Ensuring spend of	Low likelihood and low risk.	Portions of grant will have to be	• Creation of the BSCTG to hold all members and

grant complies with terms and conditions		returned to OHID.	organisations accountable • BSCTG terms of reference which explicitly states the terms and conditions of grant spend

Appendices
1. Birmingham and Solihull Integrated Care Partnership: Joint Position Statement on Smokefree 2030 2. Smokefree Generation briefing paper August 2024 3. Birmingham Smoking Cessation Task Group Terms of Reference 4. Birmingham Local Stop Smoking Services and Support Grant 2024-2025 signed terms and conditions 5. Smokefree Generation Update Presentation

Background Papers
DHSC policy paper 'Stopping the start: our new plan to create a smokefree generation' Stopping the start: our new plan to create a smokefree generation - GOV.UK (www.gov.uk)

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

Becky Pollard, Assistant Director Public Health (Adults and Older People), Birmingham City Council
Keiran Mckenize, Service Lead (Public Health Adults Team), Birmingham City Council
Lynda Bradford, Service Lead (Public Health Addictions Team), Birmingham City Council
Simon Yates, Senior Public Health Officer, Birmingham City Council
Rachel Emmerich, Senior Public Health Officer, Birmingham City Council

6th December 2023

Birmingham and Solihull Integrated Care Partnership: Joint Position Statement on Smokefree 2030

Birmingham and Solihull's Integrated Care Partnership is a statutory committee jointly formed between the NHS Integrated Care Board and local authorities. We bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the 1.3 million people living in Birmingham and Solihull.

As a partnership, we are committed to delivering improvement in health outcomes for the residents of Birmingham and Solihull. Our 10 Year Strategy, supported by an outcomes framework, sets out ambitious plans to improve health and reduce health inequalities. Tackling smoking and preventing children and young people from ever becoming addicted to smoking is key to delivering this change and reducing the burden of preventable disease.

Tobacco is a uniquely lethal product which kills up to 2 in 3 long term users when used as intended. It places a significant burden on health, social care and the wider economy damaging productivity through early disease and death. Smoking is a key driver of health inequalities and causes 16 types of cancer, heart disease, COPD, strokes and a myriad of other health harms. Smoking is an addiction most start as teenagers rather than an adult choice with 4 in 5 starting before the age of 20. Among those who try smoking 70% will go on to be daily smokers.

In Birmingham, 140,652 people smoke with 18,610 smokers in Solihull. This equates to 16% of the population in Birmingham and 10.9% in Solihull. Smoking is estimated to cost £754 million in lost productivity, £45 million in healthcare costs and £13.5 million as a result of smoking related fires across Birmingham and Solihull.

As a system, we welcome new plans to achieve a smoke-free England and Wales by 2030. In 2022, we set up Birmingham and Solihull's Tobacco Control Alliance to bring together local partners to renew our efforts to work together to reduce harmful tobacco use.

There is much we can and are doing to play our part. But we are clear that we need the proposed new legislation to increase the age of sale of cigarettes to have maximum impact on local smoking prevalence. We note that raising the age of sale from 16 to 18 in 2007 in England and raising the age of sale from 18 to 21 in the US more recently both reduced rates of smoking in the relevant age group by around a third.

As a partnership we pledge to:

- Advocate for and support new legislation to increase the age of sale of cigarettes.
- Take steps to reduce smoking in our workforces and work-places
- Increase the number of patients in our hospitals who are supported to quit as in patients
- Increase the number of women supported to quit smoking in pregnancy
- Expand the reach of our community stop smoking services to reduce smoking related inequalities
- Train staff to make every contact count so they can offer patients and the public simple advice to quit
- Deploy available enforcement capacity to take illegal sales of vapes and cigarettes.
- Work with school, education and community groups to tackle youth vaping
- Monitor the impact of what we do across our partnership to reduce smoking prevalence

APPENDIX 2

Birmingham Smokefree Generation Briefing Paper August 2024

1. Purpose of paper

To inform the Birmingham Health and Wellbeing Board and the Birmingham and Solihull Tobacco Control Alliance (TCA) of the current smoke free generation landscape in Birmingham. The information provided in this briefing will be used to populate the joint Birmingham and Solihull TCA briefing paper and Birmingham Health and Wellbeing report on Smokefree Generation on 26th September 2024.

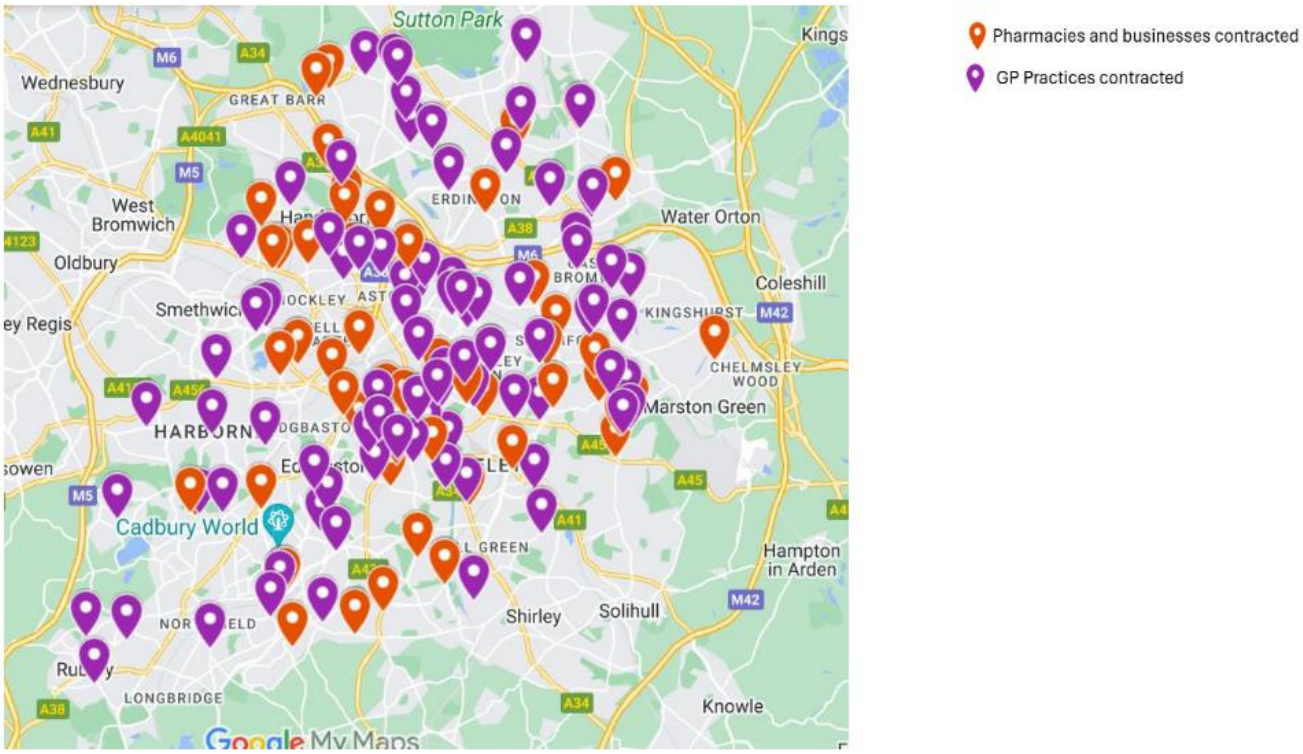
2. Legislation

The Tobacco and Vapes Bill, as introduced in the Department of Health & Social Care's policy paper in October 2023 'Stopping the start: our new plan to create a smokefree generation', will make it an offence to sell tobacco products to anyone born on or after 1 January 2009. This bill was reintroduced in the King's Speech in July 2023. It's important to note that the emphasis of the bill will be on those who sell tobacco products and will never criminalise smoking.

3. Locally commissioned smoking cessation services

The aim of Birmingham's local authority commissioned stop smoking service is to maximise the number of smokers accessing the service and quitting long-term, therefore contributing to the reduction of smoking prevalence in Birmingham. The community service is currently delivered by 165 providers citywide, including, 92 GP Practices, 2 business and 71 Pharmacies. Contracts commenced October 2023 and are in place for 4 years total with a 2-year break clause. The community service consists of 12 weeks of behavioural support alongside Nicotine Replacement Therapy (NRT) and vapes. In addition to the community service, Birmingham City Council has commissioned Solutions4Health for the provision of an Artificial Intelligence Application called 'Quit with Bella'. This is a digital tool designed to assist individuals in quitting smoking through behavioural support and interventions. The current contract terminates May 2025.

Figure 1.1. Map showing location of community service provision across Birmingham



There is good coverage of stop smoking providers across the city of Birmingham meaning good accessibility for residents. However, there are 18 postcode districts with no service provision.

Comparatively, Birmingham City Council spends less per head of population on stop smoking treatment services and very little on wider tobacco control than the core city average and England average. The additional non-recurrent funding (Smokefree Generation £1.67m) will support very targeted cessation work at high-risk populations.

There continue to be challenges in integrating smoking cessation into maternity pathways and in high-risk groups e.g. those with enduring mental health issues. In addition, improvement is needed with referral pathway from NHS tobacco treatment services and local authority commissioned services. Currently, access to local support services for Birmingham citizens looking is by self-referral by contacting a provider and making an appointment. The additional grant funding aims to address these issues and gaps although recognising it is currently only secured for one year.

The Birmingham and Solihull Integrated Care Board is also responsible for commissioning activity and services to treat tobacco dependency. It oversees tobacco treatment service for those admitted to hospital who smoke, pregnant women who smoke and are in contact with maternity services and those with severe mental health illness. It also coordinates the of the national Targeted Lung Health Check programme pilot within Birmingham.

4. Smoking statistics

Smoking prevalence:

Table 1.1 smoking prevalence of populations within Birmingham compared to England:

Population	Birmingham smoking prevalence (%)	England smoking prevalence (%)
Adults (18+) – current smokers (2022) [1]	13.6%	12.7%
Adults (18+) – never smoked (2020) [1]	61.7%	61.6%
Smoking status at time of delivery (2022/23) [1]	7.1%	8.8%
Smoking prevalence in adults (18-64) in routine and manual occupations (2022) [1]	23.5%	22.5%
Smoking prevalence in adults (18+) with a long-term mental health condition (2022/23) [1]	28.2%	25.1%
Adults (18+) identified as smoking tobacco at the start of substance misuse treatment (2021/22) [2]	86%	62%
Young people (under 18) identified as smoking tobacco at the start of substance misuse treatment (2022/23) [2]	22%	42%

Data sourced from:
1. Fingertips, Smoking Profile, Birmingham
2. National Drug Treatment Monitoring System, Commissioning report, Birmingham

The below tables and figures provide an up-to-date statistical picture of the current position in Birmingham. The below data is reported to NHS Digital on a quarterly basis and includes statistics on those accessing Birmingham City Council commissioned stop smoking services, including those accessing support via GP Practices, Pharmacies, businesses and the Quit with Bella Application. Data source for the below tables can be found Statistics on NHS Stop Smoking Services in England - NHS England Digital.

Accessing services:

310,945 individuals accessed Birmingham City Council commissioned stop smoking services and set a quit date in 2023/24. Table 1.2 shows persons setting a quit date and outcome per 100,000 smokers in 2023/24 for both Birmingham and England. Birmingham has a higher rate per 100,000 compared to England for those setting a quit date. However, England has a much higher rate per 100,000 of those successfully quitting at 4 weeks compared to Birmingham.

Table 1.2 rates per 100,000 smokers for Birmingham compared to England:

	Birmingham	England
Setting a quit date	9,025	3,346
Successful quitters (self-reported)	3,029	1,800
Not quit	3,151	914
Not known/ lost to follow up	2,846	631
Successful quitters (self- reported), confirmed by CO validation	416	363

Table 1.3 shows the number of individuals accessing Birmingham's local stop smoking service in 2023/24 by gender. The split is even as 52% service users identify as male and 48% as female.

Table 1.3 gender breakdown of those accessing the stop smoking service:

Gender	Male	Female	Total
Number of quit dates set	5,719	5,226	10,945

Table 1.4 shows the number of individuals accessing Birmingham's local stop smoking service in 2023/24 by ethnicity. 57% of individuals accessing the service are White. Black/ Black British have the lowest figure with 2.3%.

Table 1.4 ethnicity breakdown of those accessing the stop smoking service:

Ethnicity	White	Asian/ Asian British	Black/ Black British	Mixed	Other ethnic groups	Not stated	Total
Number of quit dates set	6,242	2,202	250	1,070	445	736	10,945

Table 1.5 shows the number of individuals accessing Birmingham's local stop smoking service in 2023/24 by occupation. Those in routine and manual occupations make up 26% of service users. Unfortunately, 18% of service users occupation status could not be coded, this could be because this question is optional or that they did not want to record this.

Table 1.5 occupation breakdown of those accessing the stop smoking service:

Occupation	Number of quit dates set
Managerial/ Professional	767
Intermediate occupations	151
Routine and Manual occupations	2,860
Full time students	222
Home carers (unpaid)	570
Never worked or unemployed for over 1 year	2,674
Retired	732
Sick/ disabled and unable to return to work	962
Unable to code	2,007
Total	10,945

Successful Quits:

In 2023/24 10,945 individuals set a quit date, of those 3,673 (34%) successfully quit at 4 weeks. Table 1.6 shows the number of individuals quitting smoking using Birmingham's local stop smoking services in 2023/24 by pharmacotherapy type.

Table 1.6 pharmacotherapy breakdown of those quitting smoking using the stop smoking service:

Pharmacotherapy	Single NCP only	Combination of licensed NCPs	Unlicensed NCP	Did not us any NCP	Not known	Total
Number of successful quitters	1,168 (52% success rate)	628 (27% success rate)	377 (84% success rate)	1,273 (24% success rate)	36	3,673 (34% success rate)

Table 1.7 shows a breakdown of intervention of the 3,673 successful quitters using Birmingham's local stop smoking services in 2023/24.

Table 1.7 intervention breakdown of those quitting smoking using the stop smoking service:

Intervention type	One-to-one support	Telephone support	Other	Total
Number of successful quitters	1,565 (45% success rate)	548 (49% success rate)	1,557 (24% success rate)	3,673

5. Swap to stop

The Swap to Stop scheme was introduced by Office for Health Improvement and Disparities (OHID) to improve the health of the nation and cut smoking rates by encouraging smokers to swap cigarettes for vapes. Birmingham submitted an expression of interest agreement for the swap to stop scheme which has been approved. This has been for the local substance misuse and alcohol service (Change Grow Live) whose service users have one of the highest prevalence of smoking in Birmingham.

6. Smokefree Generation Section 31 Grant funding

Background

In 2023, the government announced an additional £70 million for local authorities in England for local stop smoking services and support, delivered through a Section 31 grant. Birmingham City Council has been allocated an additional £1,676,048 to spend in financial year 2024-25 to enhance local stop smoking services and support.

A Cabinet Member Briefing paper was submitted on 1st February 2024 which outlined proposals for spend of the Section 31 grant and to highlights existing services, gaps and solutions for what the Section 31 grant could be spent on.

Table 2.1 outlines the targets for Birmingham City Council as set by Office for Health Improvement and Disparities (OHID) for the full 5 years of funding, including the percentage increase year on year.

Table 2.1 Birmingham City Council target trajectory for those setting a quit date, as set by Office for Health Improvement and Disparities (OHID)

National Goal Increase	Smoking Population Proportion	1 Year figure (Goal*Smoking Proportion)	5 Year Figure	Y1 (25%) Increase	Y2 (50%) Increase	Y3 (125%) Increase	Y4 (150%) Increase	
193,908	2.394%	4,643	23,214	1,161	2,321	5,804	6,964	6

To ensure an open and collaborative process in utilising the additional funds, the Birmingham Public Health Adults Team has set up a multi-agency task group, the Birmingham Smoking Cessation Task Group (BSCTG). Membership consists of representatives from a range of external and internal stakeholders. The purpose of the BSCTG is to plan, develop and oversee the implementation of:

- Additional services: Increasing the local ‘Swap to Stop’ offer and provision of vapes to support smokers to quit

- Advanced services: enabling referrals from a range of settings, such as acute and primary care, mental health services, substance misuse treatment services, workplaces

- Enhancement of current services: Increasing provision of pharmacotherapies (including NRT), increasing smoking cessation adviser capacity across the system by training of local healthcare and community staff to deliver smoking cessation advice and referrals

- Local system development: Strengthening existing collaborations with the NHS and other smoking cessation providers and streamline referral routes and developing new relationships with potential providers where needed

- Marketing and communication campaigns: Developing a ‘Gold’ campaign to promote awareness of local services and motivate smokers to seek support, particularly focused on Birmingham’s diverse communities.

- Evaluation: Undertaking evaluation to understand the impacts of our proposed changes and learn from what works

Recent activity

Most recently, partners from across the system have been invited to submit an expression of interest to the BSCTG detailing potential use of the funds and address gaps within current service provision. This approach has been adopted to ensure broad and inclusive engagement through the sharing and promotion of proposals and ideas. The primary focus will be on increasing the capacity and demand for smoking cessation services, while also addressing significant inequalities in smoking prevalence across different populations within the city. By doing so, we aim to enhance our efforts in reducing smoking rates and improving public health outcomes for all our residents. To date, the Task group has received 12 expressions of interest which are now being considered for funding during this financial year.

To ensure appropriate accountability and governance, the BSCTG reports to the Birmingham and Solihull Tobacco Control Alliance. In addition, progress reports will be provided to the Birmingham Health and Wellbeing Board.

Recruitment

The Birmingham City Council in currently recruiting two additional fixed-term jobs to provide additional capacity to support delivery of the Smokefree Generation Section 31 Grant. A senior programme officer is under recruitment and a communications officer has successfully been appointed.

Q1 financial reporting

As per the Local Stop Smoking Services and Support Grant 2024-2025 condition 12, Birmingham City Council must complete a financial reporting template every quarter. The total spends for Q1 totals to £19,958 and includes costings for leadership, co-ordination and commissioning and increased promotion of local stop smoking support. However, additional costs for enhanced service provision and other activities will be reflected in future financial returns.

7. Shisha

Birmingham City Council have commenced a 'gold standard' research project focused on Shisha consumption in Birmingham. This is a two-year community engagement project, to end in 2026, with various stakeholder engagement such as environmental health. The aims of the project are to fill gaps in knowledge around shisha consumption in Birmingham and will report to the Birmingham and Solihull Tobacco Control Alliance.

8. Youth Vaping

Action for Smoking and Health (ASH) has recently published their annual Smokefree GB Youth Survey for 2024:

Use of vapes

The 2024 data reveals that while the rate of youth vaping has stabilised, it remains high, with 18% of 11–17-year-olds (20% in 2023) having tried vaping. Since 2021, there have been more children vaping than smoking since 2021.

Frequency of use

Amongst 11–17-year-olds, 'once or twice' experimentation has remained the most common type of vape us amongst young people. For the first time since the survey began in 2013, regular use (more than once a week) (4.2%) has overtaken occasional use (less than once a week) (3%).

Reasons for vaping.

The most common reason for vaping, both amongst never and ever smokers is 'Just to give it a try, followed by 'Other people use them, so I join in'. 5.7% of ever smokers said they use them instead of smoking and 5.9% because they are trying to quit smoking. For the second year in a row most children aged 11-17 (58%) wrongly believe that vaping is about the same or more harmful than smoking. This also includes nearly half of those who have tried vaping (46%) and so believing vaping is harmful does not appear to be putting children off trying vaping.

Whilst youth vaping and addiction to vaping is a concern in Birmingham, commissioned support for people who want to stop vaping is not something Birmingham City Council are currently considering. This is due to the lack of evidence regarding the cost effectiveness that a vaping service would entail as highlighted in the NCSCT briefing 'Why do we not have Stop Vaping Services?'. The briefing also acknowledges that there is not strong evidence of harm from vaping.

The Smokefree GB survey carried out by YouGov has shown that vapes has become the most popular quitting aid among those who have successfully quit smoking in the last 5 years. Birmingham City Council therefore recognises the need for balance when considering vaping and support the statement by Chief Medical Officer Chris Whitty "*If you smoke, vaping is much safer; if you don't smoke, don't vape; marketing vapes to children is utterly unacceptable*."

9. Enforcement (Trading Standards)

Birmingham City Council have an internal Memorandum of Understanding (MOU) between the Public Health team and Trading Standards to deliver activity to prevent illicit vape sales for the period 2024/25. More specifically, the project is to fund work aimed at supporting the improvement of health through the inspection and advice of shops selling vapes and nicotine inhaling products as well as targeting those premises who sell these products to underage customers. The MOU provides Trading Standards with three full time employees and has the quarterly target to undertake 20 inspections on premises. In quarter one 2024/25, a total of 37 premises were visited based off intelligence and all failed the compliance test, for instance a vape tank size of over 2ml (nicotine). Advice was given by trading standards officers, which included a traders notice, leaflets, a letter from Trading Standards and an ID poster pack. Re-visits to failing premises later in the year will be conducted to test compliance following advisory visits.

Trading Standards Birmingham have highlighted the challenge of gaining young people to participate in mystery shopping activity. The BCC Public Health team are exploring options that include utilising the Bolder Healthier Youth Champions as a pool of young people for mystery shopping activity. This could act as a sustainable pool of young people moving forward; however, other sources are required to further minimise risk.

For further information please contact Rachel Emmerich, Senior Programme Officer (Smoking Cessation) Rachel.emmercih@birmingham.gov.uk or Simon Yates, Senior Programme Officer (Addictions) Simon.Yates@birmingham.gov.uk

	Agenda Item: 11
Report to:	**Birmingham Health and Wellbeing Board**
Date:	**27th September 2024**
TITLE:	**Birmingham Drug and Alcohol Partnership Update**
Organisation	**Birmingham Public Health Division**
Presenting Officer	**Jo Tonkin, Deputy Director of Public Health**

Report Type:	**Information / Discussion**

1. Purpose:

1.1. This report provides an update on the Birmingham Drug and Alcohol Partnership and its priorities.

1.2. It highlights key actions to increase the numbers of individuals in drug and alcohol treatment and key risks to the population including that presented by synthetic opioids leading to drug related deaths

2. Implications (tick all that apply):

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

3. Commissioner's Review:

3.1 Commissioners support the recommendations.

4. Recommendation

4.1. To receive the information about the Birmingham Drug and Alcohol Partnership

4.2. To note the proposal that it become a subgroup of the Health and Wellbeing Board and that reports to the Board will be brought four times a year going forward.

5. Report Body

5.1 Background

5.1.1 The Birmingham Drug and Alcohol Partnership (BDAP) brings together partners across the City including drug and alcohol treatment providers, Community Safety representatives, the NHS and those with lived experience to create transformative change in line with the recommendations of the Dame Carol Black Review 2022, the '10-year Drugs Strategy: From Harm to Hope'[1] and Birmingham's 'Triple Zero Strategy'[2].

5.1.2 The Partnership's aim is to reduce the harms of drugs and alcohol to children, young people, adults, families, and communities in Birmingham. This is achieved by ensuring there is effective strategic oversight of the drug and alcohol system of primary, secondary prevention and treatment including world class treatment and a recovery orientated system of care.

5.1.3 The ambitions of BDAP are:

1) Ensuring an effective strategic oversight of the drug and alcohol system of primary, secondary prevention and treatment including 'world class treatment and a recovery orientated system of care
2) Actively involving those with lived experience in the decision making of the Partnership
3) Increasing numbers of children, young people, and adults including parents in effective drug and alcohol treatment, with a focus on underserved populations.
4) Reducing the numbers of drug and alcohol related deaths
5) Reducing the health harms of substances including those associated with injecting and acquisition of blood born viruses and promoting health.
6) Reducing drug and alcohol crime and improving safety
7) Intervening early with targeted groups at risk of problematic use of drugs and alcohol
8) Reducing supply and exposure to illegal drugs in Birmingham, including reducing the proportion of young people being exposed to illegal drugs.

5.1.4 BDAP and its plan was reviewed in early 2024. It now has a programme of quarterly meetings and a forward plan. Its co-chair is Councillor Brennen with an independent chair to be recruited. The membership has been reviewed and partners are taking a welcome role in supporting system improvements. It has a series of

subgroups including the Drug and Alcohol Related Death (DARD) Group and the Dual Diagnosis Steering Group.

5.1.5 BDAPs work relates specifically to the Health and Wellbeing Board outcomes which are listed in Appendix 1. To note: the indicators provided are publicly available and benchmarked. The drug and alcohol system has access to a comprehensive set of administrative data which is more contemporary than that provided. This is in addition to the surveillance tools referred to below.

5.1.6 As a result of the review of the Health and Wellbeing Board, it is proposed that the BDAP will formally become a subgroup of it and will reporting progress on the partnership action plan to the Board four times a year.

5.1.7 A BDAP Data Dashboard which will expand on the current indicators the Health and Wellbeing Board are sighted on (see Appendix 1 for current Drug and Alcohol Indicators, data and commentary).

5.2 Substance Misuse Services and Increasing the Numbers of Individuals Accessing and Benefiting from Treatment

5.2.1 Public Health have the responsibility for commissioning Drug and Alcohol Services. In Birmingham the Adult Drug and Alcohol Treatment and Recovery Service is currently provided by Change, Live, Grow (CGL) and the Children and Young People's Drug and Alcohol Service is currently provided by Aquarius. These are recommended services paid from Public Health Ring Fenced Grant.

5.2.2 Noting Birmingham City Council's Section 114 and the need to reduce pressure on its statutory services, it is important to note that these services play a critical role in supporting some of the most vulnerable people in Birmingham and have a positive impact on citizens, on families, on communities and Birmingham City Council Services. Of significance is their impact on reducing the demand for specialist children and adult social care services. Adult Specialist Drug and Alcohol Services work to reduce the demand for Specialist Children's Services engaging parents who are problematically using substances in treatment. This reduces the risk of harm to children and young people in the family. They also work alongside Adult Social Care to provide comprehensive packages of care which reduce the risk of homelessness and reduce the harm for vulnerable adults with co-existing complex health and social issues.

5.2.3The cost of these services have been benchmarked against those provided by Core Cities and England. Birmingham spends slightly less than the Core City average, but more than the England average on substance misuse services. It is worth noting that the treatment system makes a significant contribution to the delivery of national policy. In July 2023-June 2024, 3% (8540) of all adults in treatment in England were in treatment in Birmingham. Data which compares the outputs and outcomes of the adult and the young people's treatment service show that the services compare well to those in Core cities and England and have improved as a result of recent investment.

5.2.4 The treatment and recovery system for adults includes a network of lived experience organisations (LEROs), which together with the treatment services ensure that the Birmingham system is recovery orientated. In addition, the system of care involves pharmacies who provide substitute prescribing and GPs who offer shared care. Scaling up an effective system requires capacity at all levels and across organisational boundaries.

5.2.5 The '10-year Drugs Strategy: From Harm to Hope'[1] resulted in £12.5 m of supplementary grants in 2024/25 (Year 3) to scale up and innovate services with a particular focus on increasing opiate users in treatment. This supplementary funding is provided on the basis that no reductions will be made in the Public Health Grant contribution to these services. Currently there is no confirmation that the grants will be continued. Currently there is no confirmation that the grants will be continued.

5.2.6 Both Adult and Children's and Young Peoples Substance misuse services have reached the end of their contract cycles and require respecifying and re-procurement. This provides an opportunity to ensure that the model of delivery is effective: in comparison to other Core Cities; is meeting the needs of Birmingham's diverse population; and integrates learning from the delivery funded through the supplementary grants.

5.2.7. A key performance indicator for the system and linked to the '10-year Drugs Strategy: From Harm to Hope'[1] is to increase the numbers of individuals accessing effective treatment. There has been a significant increase in the numbers of individuals accessing treatment for opiate use since 2020/21. However there is now some stabilisation in numbers, which suggests that to reach unmet need, innovative approaches will be required.

5.2.8. Work is underway by services supported by BDAP partners to access and make improvements to the pathways to treatment. Some of these improvements are funded through the supplementary grants. This includes work to increase the pathways: for parents affected by substance misuse; for communities of ethnicity who are underserved; for those with co-existing mental health conditions; for those in secondary care; for those in contact with the criminal justice system; and for those that are homeless.

5.2.9. The change in Standard Determinate Sentences will result in the planned release of individuals from prison, some of whom will require access to treatment and substitute prescribing. Ensuring continuity of care has highlighted pressure on pharmacy capacity in the City. This has been the focus of improvement and has been escalated nationally.

5.3 Reducing Drug Related Deaths

5.3.1 Birmingham (7.8 per 100,000 in 2020-22) has a higher rate of drug related death than England (5.3 per 100,000 in 2020-22). Current live data shows that on average in Birmingham there are 7 drug related deaths each month. These deaths are preventable and this existing unacceptable level of drug related death is further heightened by the increased presence of novel synthetic substances opioids such as nitazenes in drug supplies. They increase the risk of overdose and death due to their potency even in very small quantities. Deaths can be prevented by implementing robust surveillance, warning and informing users about novel or potent substances, ensuring that naloxone (an antidote to overdose) is widely available for use on individuals showing signs of overdose and by increasing individuals access to effective treatment. All of this is founded on good multiagency working.

5.3.2 To enhance surveillance of deaths, a Drug Related Deaths Process (DARD) has been developed. The DARD brings together real time surveillance and multiple agencies to interpret and respond to incidents and increase opportunities to take preventative action.

5.3.3. To enhance surveillance of substances in Birmingham, the Local Drug Information System (LDIS) is in operation. It receives and sends out drug alerts which

enable harm reduction information to be shared with drug users and those who come into contact with them. Since the refresh of the Birmingham LDIS, we have stood up three LDIS responses working with partners to review identified threats and taken appropriate actions. Incidents have involved synthetic cannabinoids as well as synthetic opioids. Relationships are effective and progress issues of concern in a timely way.

5.3.4 There has been an increased offer of naloxone training and provision. In addition, an overdose and naloxone administration surveillance tool is being developed. Increased presentations of individuals with overdose and increases in use of naloxone indicate an increase in risk which requires additional investigation.

5.3.5 The above evidence based and innovate approaches to preventing drug related death all inform a Synthetic Opioid Preparedness Plan, a live multiagency document which incorporates the learning from the increase in deaths in Birmingham in August 2023.

6 Compliance Issues

6.1 HWBB Forum Responsibility and Board Update

Birmingham Health and Wellbeing Board (HWBB) and Birmingham Community Safety Partnership (CSP) will be jointly responsible for, and committed to, ensuring that Birmingham's vision for substance use (alcohol and drugs) is delivered. HWBB will oversee health and treatment activity and the CSP will oversee crime and justice activity. Birmingham Public Health/Commissioning will report on the BDAP action plan and progress against its objectives.

6.2 Management Responsibility

Jo Tonkin – Deputy Director of Public Health
Candice Fairclough-Smith – Service Lead Public Health
Karl Beese – Commissioning Manager Public Health

6.3 Finance Implications

Administration of the BDAP is supported by the Addictions Team in Public Health, any costs for this activity and funding for Substance misuse contracts comes from the Public Health Ring Fenced Grant and from Supplementary Grants. Supplementary Grants for substance misuse are provided by OHID on the condition that reductions will not be made to Ring Fenced Public Health Grant contributions.

6.4 Legal Implications

Management and administration of the Section 31 supplementary grants are managed by the Birmingham City Council Public Health 's Addictions team.

The procurement of the substance misuse services for adults and children will be undertaken under the Provider Selection Regime introduced in January 2024.

6.5 Equalities Implications (Public Sector Equality Duty)
The delivery and development of the substance misuse system is undertaken based on an assessment of the relative harms of problematic substance misuse experienced by groups with protected characteristics and their access and benefit from treatment.

7 Risk Analysis:

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Risks to health:			Sythetic Opioid Preparedness Plan live plan in place.
Presence of novel synthetic opioids in drug supply	High	Increases in drug related death	DARD LDIS Action to increase and scale up the numbers of individuals in effective treatment
Inability to scale up access to pharmacological interventions in line with need	Medium	Increases in drug related death	Reorganisation of pharmacological access points across the City
Financial risks:			
Supplementary Grant amount not being fully utilised in 2024/25	Low	Loss of income and utility to Birmingham's citizens	Robust plans based on need and deliverability agreed with providers and with OHID Robust monitoring and reprofiling of spend
Supplementary grants not being available in 2025/26 with a significant reduction in the investment in the drug and alcohol system	Medium	Reduction in the capacity for the drug and alcohol system and associated harms	Strategic conversations with OHID
Accurate quarterly financial reporting to OHID	Medium	Loss of income and utility to Birmingham's citizens	Quarterly meetings with OHID
Legal risks :			
Ensuring spend of the supplementary	Medium	Loss of income and	Quarterly meetings with OHID

grants complies with terms and conditions Ensuring compliance with the Provider Selection Regime introduced in January 2024	Medium	utility to Birmingham's citizens Challenge made to Birmingham Council with financial implications	Close working with BCC Procurement

Appendices
Appendix 1: Substance Misuse Health and Wellbeing Board Indicators (September 2024 report)

Background Papers
1. From Harm to Hope National Drug Strategy From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk) 2. Birmingham Triple Zero Strategy Triple Zero Strategy | Birmingham City Council 3. Guidance for local areas on planning to deal with potent synthetic opioids - GOV.UK (www.gov.uk)

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

Jo Tonkin – Deputy Director, Public Health Division, Birmingham City Council

Lynda Bradford – Service Lead (Addictions), Public Health Division, Birmingham City Council

	Agenda Item: 12
Report to:	**Birmingham Health and Wellbeing Board**
Date:	**September 2024**
TITLE:	**Health Protection Forum Annual Report 2023-24**
Organisation	**Birmingham City Council (BCC)**
Presenting Officer	**Funmi Worrell (Service Lead, Health Protection – Public Health)**

Report Type:	Information and Approval

1. Purpose:

1.1. This report provides an update to the Board on the activities of the Health Protection Forum's (HPF) between 2023-24:

- Highlighting the HPF's wider work and activities and achievements
- Providing assurance that core Health Protection functions are being fulfilled

2. Implications (tick all that apply):

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

3. Commissioner's Review:

3.1 Commissioners support the recommendations.

4. Recommendation

4.1. The Health and Wellbeing Board is asked to note the content of the report and support the recommendations.

4.2. **Immunisations -** HWB Board should seek an assurance statement from the ICS regarding the immunisation recovery plan given the scale of the challenges of improving immunisation uptake rates.

4.3. **TB NRPF** - HWB Board members to note the complex needs of TB patients with NRPF and support the ICS via the appropriate avenues to provide a holistic approach to each patient.

5. Report Body

Background

5.1. The Health Protection Forum (HPF) is a sub-committee of the statutory Health and Wellbeing Board. It meets regularly to provide assurance to the Director of Public Health (DPH) that there are comprehensive health protection arrangements in place to protect the health of the local population. The HPF encourages the exchange of local health protection information between partners to promote a system approach to health protection in Birmingham. The last HPF Annual Report was delivered to the Health and Wellbeing board in February 2022.

5.2. This report provides an update to the Health and Wellbeing board on the HPF's work in 2023-24.

Content

5.3 The report covers the following Health Protection areas:

5.3.1 Screening and Immunisation

- Successful response to the measles outbreak that began in autumn/winter 2023 and led to ~10,000 more MMR vaccinations compared to the same period last year
- Successful roll out of the local Covid-19 and flu vaccination programmes
- Good recovery of NHS screening programmes after the COVID-19 pandemic.

5.3.2 Infection, Prevention and Control (IPC)

- A Birmingham and Solihull (BSol) Health Protection Memorandum of Understanding (MOU) has been produced and signed by BCC, SMBC, NHS BSol and UKHSA.
- This product will be a useful resource to use when dealing with outbreaks of infectious diseases across Birmingham and Solihull.

5.3.3 Non-communicable Disease and Environmental Hazards

- Every year, adverse weather leads to excess winter deaths and excess hot weather deaths in Birmingham and across the country and internationally.
- The HPF collaborated with internal and external stakeholders to develop a local Adverse Weather Plan, ensuring alignment with existing alert systems.
- This proactive approach led to successful adverse weather plan implementation, receiving positive stakeholder feedback.

- Collaborative efforts aim to enhance weather preparedness initiatives and to potentially save lives.

5.3.4 Communicable Disease

- TB No Recourse to Public Funds (NRPF) policy continues to work well, held by BSol ICB, agreed with local partners and providing appropriate accommodation for NRPF TB patients
- TB Workshops have been formalised between relevant partners to improve TB pathways for complex patients e.g. the TB Lost to Follow-Up (LTFU) pathway, where we strengthen links with partners to find TB patients lost to follow up before they develop drug resistant TB.

5.3.5 Oral Health

- An Oral Health Needs Assessment has been developed to reduce health inequalities across the city. There will be collaborative work to finalise key recommendations and facilitate the development of a local action plan.
- Funding was awarded to BCC and partners to provide oral health interventions to reduce poor oral health across Birmingham and Solihull. This resulted in toothbrush packs being supplied to education and early years settings, as well as food banks and family hubs.

5.3.6 Food safety and standards

- A Food safety and standards workstream was incorporated in the Birmingham Food Strategy launched in October 2023.
- Food borne infections are a major burden in Birmingham with over 4500 food related incidents reported in a year period, a figure that likely under-estimates the true numbers of food-related illness in the city,

Recommendations

- **5.4.1 Immunisations -** HWB Board should seek an assurance statement from the ICS regarding the immunisation recovery plan given the scale of the challenges of improving immunisation uptake rates.
- **5.4.2 TB NRPF** - HWB Board members to note the complex needs of TB patients with NRPF and support the ICS via the appropriate avenues to provide a holistic approach to each patient.

Summary

5.5 Health Protection functions returned to business-as-usual after the Covid-19 pandemic. This was challenged by the nationwide outbreak of measles in autumn 2023 which affected the West Midlands and particularly Birmingham. Despite this outbreak, health protection work has continued to tackle health inequalities across Birmingham and protect the health of its citizens. Recommendations from this report will be addressed in HPF meetings in 2024-25 and progress will be reported on in the next HPF Annual Report.

6. Compliance Issues
6.1. HWBB Forum Responsibility and Board Update

The annual report is to be approved by the HPF Chair, Cllr Nicky Brennan and disseminated to forum and board members.
6.2. Management Responsibility
Dr Mary Orhewere – Assistant Director (Health Protection); Chair, Health Protection Forum
6.3. Finance Implications
Management and administration of the forum is covered by the Public Health ringfenced grant. The Council is currently in a S114 and facing significant financial challenges. The Public Health grant which funds the majority of the health protection response is funded through the public health ring-fenced grant, although it is important to note there are key elements such as regulatory services that are funded through the general fund and are essential that these statutory functions are maintained alongside protecting the budget within the grant to respond to future challenges.
6.4. Legal Implications
N/A
6.5. Equalities Implications (Public Sector Equality Duty)
The forum aims to gain assurance that the relevant plans are in place to protect the health of the local population. This means the forum also gains assurance from its members that health inequalities have been accurately identified, and plans are in place to reduce those inequalities.

7. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Workforce challenges for all organisations in the HPF	3	4	On-going recruitment and staff training
Emerging threats, known and unknown	4	3	Preparedness

Appendices

Appx 1 - Health Protection Forum Annual Report - Final

Background Papers

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

Dr Mary Orhewere (Assistant Director, Health Protection and Environmental Public Health)
Funmi Worrell (Service Lead, Health Protection)
Helen Bissett (Senior Officer, Health Protection)
Paulius Armanavicius (Senior Officer, Health Protection)
Manuela Engelbert (Officer, Health Protection)
Onome Etim (Graduate Officer, Health Protection)

Health Protection Forum Annual Report 2023/24

Health and Wellbeing Board

September 2024

Birmingham Health Protection Team,

Birmingham City Council Public Health Division

BE BOLD BE BIRMINGHAM

Birmingham City Council

Contents

Foreword

Health Protection is one of the three domains of public health, and it is an important pillar that contributes to the improvement and maintenance of the health of everyone living in, working in and visiting Birmingham.

Birmingham is a super diverse city, and this fact provides challenges as well as opportunities for health protection. Recovery, after the COVID-19 pandemic, has been slower for some services than others e.g. NHS screening and immunisation services. The council declared section 114 in June 2023, and this has impacted significantly on the delivery of non-statutory environment health services. In autumn 23-24, there was an outbreak of measles across the country and internationally, but Birmingham was significantly impacted. There were opportunities to work across the Birmingham and Solihull Integrated Care System and deliver a fast-paced response to the measles outbreak, which has largely reduced since the Spring.

The Health Protection Forum brings together key partners from across the city who work interdependently to deliver improvements in health protection outcomes, on behalf of the Health & Wellbeing Board. The Forum monitors emerging situations and ensures that the health of the citizens of Birmingham continues to be protected. As we leave the COVID-19 pandemic and measles outbreak behind us, we continue to prepare for known threats such as Mpox whilst working through existing and on-going health protection issues like TB and adverse weather. The Forum does this work tirelessly, to ensure that the health of the population of Birmingham remains protected.

Dr Justin Varney Director of Public Health for Birmingham

Introduction

The three core domains of public health are health protection, health improvement and health care public health. Health protection focuses on the prevention and reduction of harm to population health caused by infectious diseases, chemical, biological, radiological, and nuclear incidents, and other health threats. Health protection activities include emergency planning, surveillance, response to incidents and disease outbreaks, immunisation and screening programmes.

The Health and Social Care Act (2012, updated in 2022) gives local authorities health protection duties, and the Director of Public Health (DPH) is responsible for ensuring that there are plans in place to protect the health of the population. However, most health protection functions are delivered by teams and organisations that are not part of the local authority public health division, with roles for the United Kingdom Health Security Agency (UKHSA), National Health Service (NHS) England and Integrated Care Boards (ICBs) to deliver health protection at regional and local levels. In addition, local authority environmental health and resilience teams are involved in the delivery of some health protection functions.

The Health Protection Forum (HPF) is a sub-committee of the statutory Health and Wellbeing Board. This forum focuses on facilitating the responsibility of the DPH to provide oversight and assurance of health protection. The HPF provides a link between the Health and Wellbeing (HWB) Board and partner organisations with roles in the delivery of health protection plans. The forum also provides a setting for the exchange of information, scrutiny of plans and analysis of data with all partners with a role in the delivery of health protection in Birmingham, ensuring they are acting jointly and effectively to protect the population's health.

The HPF includes membership from BCC Environmental Health, BCC Resilience, NHS BSol Infection Prevention & Control, NHS Birmingham & Solihull Immunisations & Vaccinations, NHS Birmingham & Solihull System Quality Group (SQG), UK Health Security Agency (UKHSA), Fast Track Cities Plus (FTC+) and NHS England (Midlands).

The Birmingham Health Protection Forum (HPF) has been in operation since 2013. The HPF meets regularly and provides an opportunity for partners to exchange information that is necessary to ensure that they are working together to provide comprehensive health protection services. The HPF last provided a comprehensive annual report to the HWB in February 2022.

Lessons are constantly being learned as new plans develop and incidents are responded to; this report describes and provides updates on the main health protection issues and work areas that the HPF and Public Health Team partners have been engaged with in 2023 and 2024. The report also outlines provides recommendations for the Birmingham HWB.

This report provides assurance to the DPH and the HWB that there are local plans in place to protect population health and that appropriate action plans are in place to address and closely monitor areas of health protection that require development. On behalf of the DPH, the HPF and its members address the following key concerns regarding children and young people's health: immunisation programmes, oral health, screening programmes, infection prevention and control, communicable disease, non-communicable disease and environmental hazards

1.1 Assurance statement

This report provides assurance to the DPH and the HWB that there are comprehensive local plans to protect population health and that appropriate action plans are in place to address and closely monitor areas of health protection that require development. The DPH is working through the HPF with its members to address the following key concerns: childhood vaccinations, cancer screening programs, and community infection prevention and control.

2. Actions from previous report

Table 1 Health protection actions identified in the previous HPF report (2022) and the progress that was made in 2023-24.

Area of health protection	Actions from 2022 HPF report	Progress of actions
Screening and immunisations	NHS England, LA public health and ICBs continue to work to get services back to pre-COVID levels	Measles outbreak of autumn 2023 showed that immunisation levels for NHS immunisations are below the 95% target and more work must be done to increase the uptake in Birmingham otherwise the population remains at risk of outbreaks of vaccine-preventable diseases.
Infection Prevention and Control	The COVID-19 pandemic affected the group's ability to meet and discuss a system response to IPC issues	An Health Protection MoU was agreed between relevant partners in October 2023 - this MoU provides roles and responsibilities for IPC issues across BSol.
Non-communicable diseases	On-going challenges with Environmental Health laws/powers and lack of resources to visit establishments that might be putting the public's health at risk.	HPF continues to support colleagues in Environmental Health despite continued challenges since COVID-19 but also due to section 114 which has led to only reactive and not proactive Environmental Health work being able to be done currently at BCC.
Communicable diseases	Action plans to improve working relationships are being developed, the mapping and gap analysis is being updated. This is an ongoing process. A regional TB and housing pathway for patients with no recourse to public funds (NRPF) has been adopted and implemented in Birmingham over the last 18 months. Processes to support housing and social needs of patients with recourse to public funds are being developed.	Evaluation of the TB NRPF policy has been completed and has been proven to be a strongly positive policy which helps people complete their treatment courses and where there are now fewer cases lost to follow-up. It has also been proven to be a cost-effective policy, saving much money compared to when cases where left in hospital beds when they had no appropriate accommodation whilst on treatment without being a risk to the general population.

3. Health Protection updates

This section provides an at-a-glance summary of health protection developments over the last 2 years. Further information on specific subject areas can be found in Section 4.

Positive achievements in 2023-24

- Quick, co-ordinated system response to the measles outbreak in autumn 2023
- Over 10,000 more MMR vaccinations given than at the same time period in the previous year
- HP MOU agreed across relevant partners for use during outbreaks and with clear roles and responsibilities of partners agreed
- In collaboration with Birmingham City Observatory, a HPF dashboard is in development which will include key performance indicators for Health Protection to allow the HPF to easily understand where Health Protection interventions and resources are most needed across the city.

On-going work in 2023-24

- Currently, only reactive (not proactive) work can be carried out by colleagues in Environmental Health due to restrictions caused by the section 114 declared in June 2023.
- Recruitment in EH, NHSE, BCC
- Evaluations of measles response and engagement, to be shared with system partners to influence future service provision

Areas of concern in 2023-24

- Section 114 declared by BCC in June 2023 has affected the council and its functions, including health protection functions
- Delegation of immunisation and vaccinations from NHSE to the ICB were planned for 2025 but will now be in 2026 – these changes will impact on health protection services
- Preparations for impending outbreaks and planning for resources and strategies to mitigate a potential Mpox outbreak in England.
- Uptake of immunisations across the life-course remains low, meaning residents of Birmingham are at risk of vaccine-preventable disease
- Uptake of cancer screening programmes are lower than national & regional averages
- The complex needs of TB patients with No Recourse to Public Funds (NRPF) requires collaboration between partners and a holistic approach.

Health Protection Topic Areas

NHS Screening and Immunisation programmes

NHS Screening Programmes

In the UK screening programmes exist for a range of conditions, and serve to reduce the mortality, incidence, or severity of a condition through early detection and treatment and to increase choice by identifying conditions or risk factors. The performance of all screening programmes across England reduced significantly during the COVID-19 pandemic period, 2020 onwards, particularly during the lockdown periods. The system is currently working to improve the uptake of screening programmes while achieving performance recovery in Birmingham.

AAA Programme: The local programme is running well and achieving the relevant KPIs. There is a renewed national focus on waiting time to vascular intervention. Local time frames are clinically justified but the local service will still explore any improvement opportunities. Ongoing actions will focus on working to close the gap between local coverage and Core Cities/England coverage.

Breast Screening: Data shows coverage is low compared to similar local authorities. This programme has had a particularly slow recovery from COVID-19. There are also nationally recognised workforce constraints, notably mammography but also wider radiography and radiology. IT developments/ limitations also impact the programme. The programme is projected to recover to pre-COVID-19 levels in the next year – ongoing actions will be to continue improving beyond that milestone through health promotion activities via the BSol ICB Cancer Screening and Early Diagnosis group.

Bowel Screening: The programme is entering the last year of the age extension roll out (both 50-year-olds and 52-year-olds will receive FIT kits in the next financial year). Local partners are working through the recently re-established BSol ICB Cancer Screening and Early Diagnosis group to increase uptake. National recruitment to FIT@80 pilot is underway and will require future planning of reduction in FIT threshold – colonoscopy capacity constraints remain. Coverage is increasing, but coverage in age extension cohorts is lower.

Cervical Screening: Coverage is declining across all age cohorts and is low compared to similar local authorities. Nationally, this programme has seen a long-term decline in coverage which was recognised pre-COVID-19. Increasing coverage of the programme is a key priority of regional commissioners. Actions will be complemented by the activity of the recently re-established BSol ICB Cancer Screening and Early Diagnosis group. A new call recall database was introduced in July 2024, with future programme developments to come once this has embedded. Birmingham's local sexual health service is preparing to offer opportunistic cervical cancer screening, the service is currently in the mobilisation phase of this offer.

Diabetic Eye Screening: The program is running smoothly with provider (current provider in place for ~2 years). Current efforts focus on increasing uptake and addressing equity issues, percentage of 'never screened' has subsequently decreased. Plans to increase intervals of screening appointments for low-risk individuals and adding OCT (optical coherence tomography) which may reduce pressure on DES. Antenatal and Newborn Screening: Since recent quality assurance visits at UHB sites there have been significant improvements, with most major issues addressed and governance structures enhanced – work done by the

Director of Midwifery and links into LMNS have been helpful here. Maternity services faced challenges post-pandemic but have now recovered, with staffing levels increasing and specialist roles being filled. Only community staffing continues to be impacted. Health Equity Audit is a main focus this year. Quality assurance reviews and localised pathway reviews (with SQAS) will help develop further improvements. Overall no major concerns, and performance is good.

NHS Immunisation Programmes

Key Points

- Birmingham has the lowest vaccination coverage in the West Midlands for many childhood and adult vaccinations, falling below the national target of 95% for children. This low coverage poses a risk of increasing vaccine-preventable diseases.
- Birmingham faced challenges in 2023-2024, including low uptake of COVID-19, influenza and recently pertussis vaccines. The city's response to a measles outbreak in early 2024 highlighted the strain on resources and the need for immediate, coordinated action to manage the situation effectively.
- The Integrated Care System (ICS) Immunisation & Vaccination Programme Board aims to improve vaccination uptake across Birmingham by coordinating efforts among various partners. The board addresses multiple vaccination programs, including COVID-19, influenza, and childhood immunisations.

The UK national immunisation programmes aim to protect children and adults against preventable infectious diseases to reduce the risk of avoidable diseases and death. Immunisation programmes delivered in Birmingham are nationally specified, co-ordinated and commissioned locally by the NHS England West Midlands Team.

High vaccine coverage has meant that vaccine-preventable diseases rare in the UK. These diseases can become more prevalent if vaccine coverage falls as seen with the 2017 and 2023 Measles outbreaks. Vaccination coverage in Birmingham is the lowest in the West Midlands for many childhood and adult vaccinations and is below the 95% national target for all in children. Coverage falls as children get older – recent data shows that only 78% of children aged 5 have had the required two doses of the MMR vaccine (to protect against measles, mumps, and rubella).

An Integrated Care System (ICS) Immunisation & Vaccination Programme Board was established in late 2021 to tackle the uptake of influenza and Coronavirus Disease (COVID-19). In 2022 it has also included all other national vaccination programmes by bringing together partners across the immunisation system to work together to improve vaccination uptake across the city. Several sub-groups feed into the programme board, including a Childhood and Adolescent Immunisations & Vaccinations sub-group.

In response to the COVID-19 variant BA.2.86, the vaccination campaign in Birmingham and Solihull (BSol) was moved up from October to September 11, 2023, resulting in over 11,000 vaccinations by mid-September. However, by December, vaccine uptake rates were lagging behind targets, with BSol ranking low among West Midlands systems. Both COVID-19 and influenza vaccine uptake were below national targets, with low engagement among healthcare and adult social care staff. This low uptake prompted concerns about potential waning protection by January 2024, and the possibility of a spring booster campaign was raised.

By January 2024, Birmingham faced community transmission of measles, prompting discussions around declaring a major incident. The ICB was under pressure due to inadequate resources for managing the outbreak, especially for contact tracing. Plans to escalate the

situation were discussed, including seeking additional resources and coordinating with national and local partners. The timing of the national MMR catch-up campaign was deemed too late for Birmingham, highlighting the need for immediate action to allocate resources effectively. Efforts to strengthen outreach and vaccination initiatives were crucial, with plans to engage schools and headteachers through webinars.

In June and July 2024, the health system continued to grapple with various challenges, including low MMR uptake among young children, a decline in prenatal pertussis vaccinations, and ongoing efforts to improve COVID-19 and RSV vaccination rates. Although COVID-19 vaccination targets were met, concerns persisted about immunosuppressed individuals and the uptake among health and social care workers. The need for additional appointments and staff to manage RSV and prenatal vaccination campaigns was highlighted, with potential risks to other vaccination programs due to overlapping priorities. Community engagement efforts focused on addressing complacency and vaccine hesitancy to prevent future outbreaks.

Recommendation:

- HWB Board should seek an assurance statement from the ICS regarding the immunisation recovery plan given the scale of the challenges of improving immunisation uptake rates.

Infection Prevention and Control (IPC)

Health Protection MOU

Key points

- A BSol Health Protection Memorandum of Understanding (MOU) has been produced and signed by BCC, SMBC, NHS BSol and UKHSA
- This MOU agrees a joint collaborative and co-ordinated all hazards approach to health protection incidents and plugs previously identified gaps around incident management between different agencies.
- The MOU will be reviewed bi-annually to ensure system learning continually improves Birmingham's health protection response.

The BCC Health Protection team has developed a Memorandum of Understanding (MOU) in collaboration with the BCC Environmental Health team, Solihull Metropolitan Borough Council (SMBC) Health Protection and Regulatory Services teams, UKHSA West Midlands, and Birmingham and Solihull Integrated Care Board (BSol ICB).

The purpose of the MOU is to agree on a joint collaborative and co-ordinated all hazards approach to health protection incidents, ensuring a joined-up health protection service for the Birmingham and Solihull population covering both prevention and response measures.

Although local partners have historically worked well together in responding to health protection incidents, there was no formal agreed approach explicitly outlining roles and responsibilities alongside system-wide guiding principles to incident response. This gap sometimes led to avoidable delays in incident responses, especially when identifying lead agencies to deliver on specific elements of a response. It also reduced consistency in incident responses across the patch, thereby opening up health protection risks for citizens through potentially delayed, illogical, or inconsistent responses.

From June 2023, lead agencies set out their roles and responsibilities in the MOU. The MOU has been agreed in principle by each of the above lead agencies. Once all formal signatures have been collected BCC and SMBC Health Protection teams will stand up the MOU review schedule, which includes a routine regular review of the document.

Non-Communicable Diseases

Adverse Weather Preparedness

Key Points

- Every year, adverse weather leads to excess winter deaths and excess hot weather deaths in Birmingham and across the country and internationally.
- The HPF collaborated with internal and external stakeholders to develop a local Adverse Weather Plan, ensuring alignment with existing alert systems.
- This proactive approach led to successful adverse weather plan implementation, receiving positive stakeholder feedback.
- Collaborative efforts aim to enhance weather preparedness initiatives and to potentially save lives.

The Health Protection Team develops a comprehensive Adverse Weather Plan each year, aligning with Birmingham City Council's Weather Preparedness Plan and the Met Office's alert systems. This strategy involves monitoring weather alerts, distributing messages and resources to stakeholders, including General Practitioners and community organisations, and collaborating with the Public Health Communications team to inform Birmingham residents. A new Weather-Health Alert (WHA) system, developed with the UK Health Security Agency (UKHSA) and the Met Office, was launched on June 1, 2023, enhancing preparedness for extreme weather conditions.

The HPT's implementation of the adverse weather plan has been successful, focusing on health implications of extreme weather and positively impacting vulnerable patients. Weather alerts and resources, such as UKHSA’s "Beat the Heat" and "Keep Warm and Well" posters, were well-received. Social media campaigns and collaborations with various council teams extended the reach of these messages, ensuring widespread community preparedness.

Collaboration with the Emergency Preparedness and Resilience Team has been essential for refining heatwave and cold weather plans. Moving forward, the HPT aims to enhance this collaboration to improve the alerting system and support vulnerable groups more effectively. Evaluations of weather preparedness initiatives will help refine future engagement activities.

The next steps include focusing on heatwave preparedness and planning for cold weather preparedness for the upcoming winter period. Future plans include structuring this work into a formal program.

Environmental Hazards

Key Points:

- The Environmental Health team at BCC investigates and enforces a wide range of statutory provisions including animal cruelty, drainage, filthy and verminous premises, unauthorised encampments and intruder alarms.
- A 90% timely response rate have been recorded for planning applications in Birmingham.

KPIs have been developed for each environmental health service to monitor service workload and response time.

BCC's Environmental Health Team ensures compliance with Health and Safety legislation through inspections and investigations of accidents and complaints in over 25,000 business in Birmingham. A Health and Safety Law Enforcement Plan is produced every year to set out the activity for the coming year.

Monitoring of development planning applications have been successful, with 2500+ consultations responded to annually. The target for timely responses (21 days of receipt of the consultation) is 85%. This KPI was developed to monitor the workloads and demands on the service and to identify any future concerns early.

The 'Statutory Nuisance and Ombudsman complaints against service' has been crucial in investigating and resolving statutory nuisances including noise, odour and light complaints.
where complaints are triaged to gather further information and tailor the investigation for the specific issues being complained of. The sports ground legislation has 6 certificated sports grounds (whole stadiums/regulated stands) and ensures all aspects of spectator safety, installations and emergency procedures.

The Pest Control service receives over 12,000 requests for assistance for rat treatments each year and whilst the team currently has vacancies priority is given to Rat enquires over work such as insects. The mortuary currently undertakes over 1600 post-mortems each year. This is an increasing number and heading towards 1800 from 1400 pre covid due to changes in legislation and increases in population.
Moving forward, the environmental health team will pay closer attention to close contact services like the beauty industry, to ensure that they are well regulated.

Communicable Diseases

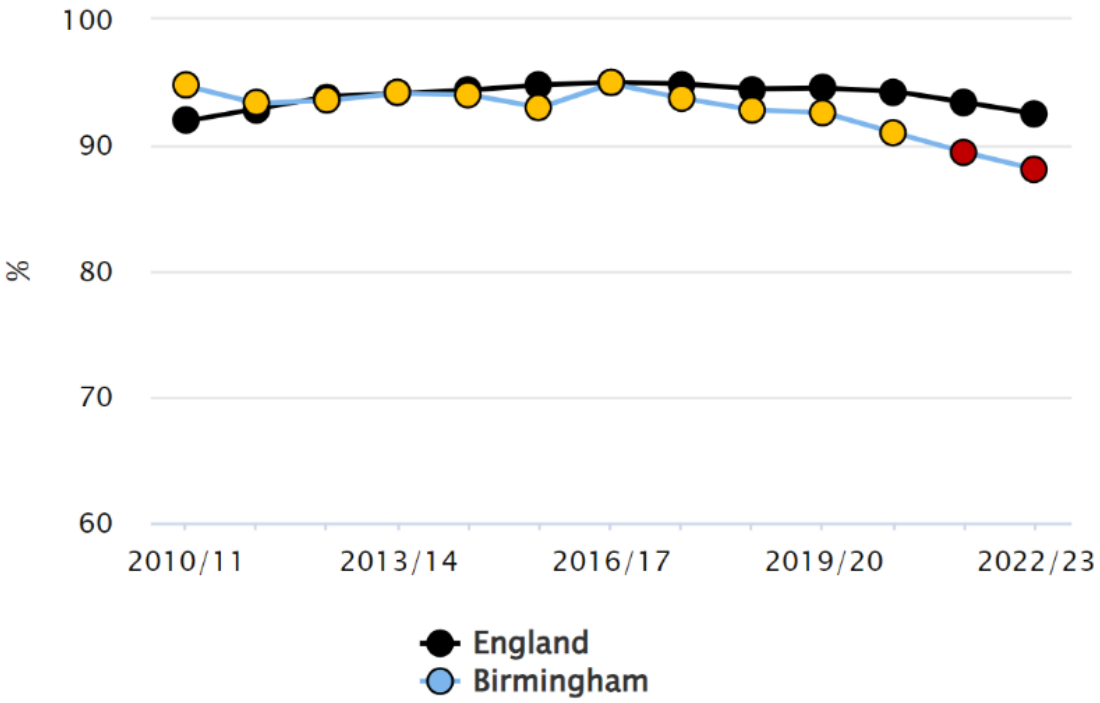
Measles, Mumps and Rubella (MMR)/ Measles outbreak response

Key points

- Birmingham residents are at-risk of future measles outbreaks as city-wide uptake levels of MMR immunisation are low
- A measles outbreak was declared in the West Midlands in January 2024 by UKHSA; the majority of cases were Birmingham residents
- BSol ICS worked rapidly in partnership to deliver a comprehensive system response – with focuses on primary care, community engagement and communications
- Whole system action is needed to remove the risk of measles to Birmingham residents, by rapidly increasing the city's MMR uptake rate.

The UK lost its measles free status in 2019, regained it in 2021 but is at risk of losing it again. (World Health Organisation, 2024). A population is protected against measles if uptake of the Measles, Mumps and Rubella (MMR) immunisation reaches 95% ((World Health Organisation, 2019). However, Birmingham has had low uptake of the Measles, Mumps and Rubella (MMR) vaccine for many years. From 2010/11 to 2022/23 Birmingham did not reach this 95% target, and in recent years this uptake has been reducing (OHID, 2023). This low MMR uptake rate has meant that Birmingham citizens have been at risk of a measles outbreak for some time.

Figure 1: Population vaccination coverage: MMR1 at (5 years old)



Source: OHID, 2023

In summer 2023, measles cases started increasing in London, and UKHSA warned that London was at risk of a major outbreak. It was recognised that this posed a risk to Birmingham, as another major city in the UK with similarly low MMR uptake rates. This was discussed regularly at Birmingham's Health Protection Forum, with members from UKHSA regularly

updating on regional/national measles cases and the changing risk to Birmingham, and members from NHS BSol sharing plans for potential measles cases.

In October 2023 cases started to appear in Birmingham and increased steadily over the following months. By January 2024 the outbreak of measles across the country was declared a national incident by UKHSA. Cases are linked mainly by deprivation (the majority of cases being in Index of Multiple Deprivation decile 1) and most cases were in children aged under 10 years. A summary of the system measles response is outlined in Table 1.

Table 1: BSol Measles Response, October 2023 – April 2024

Measles Response Activity	Work delivered
Communications	Social media adverts with 417,000 impressions over 9 weeks 170 screens across Central Birmingham with 3.5 million impressions over 6 weeks 441 spots on Free Radio with 270,000 reach (Jan-Feb) 432 spots on Free Radio with 364,000 reach (April-May) 96 media appearances (including international, national and regional outlets
Community Engagement	BCC-led 'Supportive Conversations' Measles and MMR training delivered to local communities – 588 attendees across 39 sessions Bespoke webinars delivered to key communities, e.g. Council of Faiths Collaboration with UKHSA to test national measles/MMR leaflets with Birmingham residents Community soft intelligence captured ready for thematic analysis
Primary Care	An additional 10,000 immunisations delivered to Birmingham residents by primary care Engagement with GPs through quarterly Quality Improvement Forums
Education settings	Immunisations delivered in schools to those most at risk of a measles outbreak NHS BSol-led engagement with school staff/parents at school gates Sharing communications and guidance on how to manage measles outbreaks in schools via School Noticeboard and Headteacher webinars

Source: BCC HPT July 2024

As the outbreak has continued, the response shifted to more targeted and proactive engagement based on data indicating populations most at risk of a measles outbreak. This approach began with targeting schools and GP practice with MMR vaccination clinics, based on numbers of unvaccinated children and patients at those settings. An incident cell structure was established to support with continued incident response (with sub-cells dedicated to contact tracing, vaccination, community engagement, education, and communications).

The risk to Birmingham residents from measles will continue even after the end of the current outbreak unless MMR vaccination rates increase across the city. Innovative partnership working during this outbreak has been key to rapidly increasing awareness of the importance of the MMR vaccine and ultimately working to increase uptake. However, it will be essential to maintain the same urgency across the system to increase MMR uptake in the long-term. The HP Team will look to harness the current scale and pace of the measles outbreak response to continue leading work on meaningful community engagement around the MMR vaccine, and to continue working to improve vaccine uptake across all ages, to ensure Birmingham residents are protected against vaccine preventable diseases.

Recommendation:

- HWB Board should seek an assurance statement from the ICS regarding the immunisation recovery plan given the scale of the challenges of improving immunisation uptake rates.

Tuberculosis (TB)

Key Points

- In the UK, Birmingham has the second highest rates of pulmonary Tuberculosis (TB), after London.
- Pulmonary TB is most common amongst those born in the UK compared with non-UK born people
- The highest risk factor for contracting pulmonary TB in the UK is being an asylum seeker.
- In Birmingham and other areas in the West Midlands, the 'No Recourse to Public Funds' (NRPF)TB pathway is an efficient and cost-effective tool in managing complex TB cases who have a NRPF status.

Tuberculosis Overview

Tuberculosis (TB) remains a leading cause of death globally, with the World Health Organization (WHO) reporting 10.6 million new cases in 2022. Without treatment, 50% of those affected risk death. Factors complicating TB cases include HIV status, social determinants, and mental health conditions. In England, there were 5,092 TB notifications in the past year, with Birmingham reporting the highest number of cases outside London. According to ONS 2021 census and official government figures on TB notifications, TB rates in Birmingham are estimated to be nearly 3 times larger than the UK average with Birmingham having an estimated 20.8/100,000 TB rate and the national average being 7.75/100,000.

TB treatment is lengthy and requires strict adherence to medication regimes, often spanning a minimum of six months. Non-compliance can lead to increased symptom severity, greater infectiousness, and the emergence of drug-resistant strains, demanding more resources from healthcare systems.

TB and Migrant Health

Asylum seekers are the group at highest risk for TB in the UK, closely followed by the homeless, people who use drugs, those who have spent time in detained estates and those who have suffered mental ill health. Migrants from high TB prevalence countries often have higher levels of latent TB. Asylum seekers often lack access to public funds and comprehensive health checks due to immigration control regulations, complicating TB management further.

NRPF Pathway for TB Management

To manage complex TB cases among those with No Recourse to Public Funds (NRPF), a policy was developed in the West Midlands, involving supervised treatment in separate housing. This initiative ensures compliance through daily monitoring and has significantly improved treatment outcomes.

Key Findings from NRPF Policy Evaluation (2024):

- Social Risk Factors: 70% of those accessing the pathway had multiple social risk factors; 35% had drug-resistant TB.
- Completion Rates: The pathway achieved a 100% treatment completion rate, compared to a 57% follow-up loss rate previously.
- Cost Savings: Significant savings were realized, with over £44,000 saved per case over six months compared to hospital stays. Savings accrued within 2.5 weeks of pathway implementation.

Outcomes

The NRPF pathway resulted in:

- Reduced TB treatment costs
- Higher treatment completion rates
- Fewer cases lost to follow-up
- Reduced instances of interrupted or prolonged treatment
- Lower risk of drug resistance
- Improved health outcomes for patients

Recommendations

- HWB Board members to note the complex needs of TB patients with NRPF and support the ICS via the appropriate avenues to provide a holistic approach to each patient.

Oral Health

Key points

- More children in Birmingham have enamel/dentinal decay than regional and national averages
- The Oral Health Improvement Network leads on evidence-based oral health improvement interventions across Birmingham and Solihull
- Future work will be informed by recommendations from an upcoming Oral Health Needs Assessment

Oral health is an integral part of general health and wellbeing. Poor oral health can affect a child's ability to sleep, eat, speak, play, and socialise. It may also result, in toothache and other related pains, causing school absenteeism and parents to take time off work to handle their children's illness. Dental extraction is the most common factor in hospital admission for under-18-year-olds in England. Individuals living in more affluent areas show considerably better oral health compared to those living in the most deprived areas.

33.7% of children surveyed in Birmingham had experience of enamel or dentinal decay, according to the National Oral Health Survey of 5-year-old children. This is higher than the regional and national average. The average number of missing (extracted due to decay) teeth among surveyed children with a history of missing teeth was 4 (OHID, 2023). Although Birmingham has a fluoridated water supply which has been attributed to relatively low levels of poor oral health given deprivation in the city (Cotton *et al.*, 2014), these data show there are still a large amount of children in Birmingham living with poor oral health, and of those a large number experiencing severe tooth decay admitted to hospital under general anaesthetic for avoidable tooth extractions.

An Oral Health Improvement Network (OHIN) has been established to bring together relevant stakeholders, map out current work, identify gaps and draw up an action plan. The inaugural meeting took place in August 2022, with subsequent meetings focussing on preparing for an upcoming supervised toothbrushing scheme for Early Years, planning for local data collection for the National Dental Epidemiology Programme survey of 5-year-old children, and responding to recommendations from the Oral Health Needs Assessment (OHNA).
Non-recurrent grants were also secured to fund several separate oral health projects for children and vulnerable adults' groups between years 2022 and 2023. The majority of funding was used to purchase toothbrush packs (containing a toothbrush, toothpaste and oral health advice leaflets) and distribute them to local communities most at-risk of poor oral health.

Table 2 – Grant funded BCC-led oral health projects and associated activity

Project	Activity	Details
Oral Health Promotion – Children and Vulnerable Adults	53,705 toothbrush packs purchased and distributed	Distributed in 3 phases (vulnerable adults, nurseries, school) to the following organisations: • Year 1 & Year 2 school children (All) • SEN school children (All primary) • Early years Startwell • Offender Hub • SIFA single adults' hub • Domestic abuse hub

		• Emergency provision • St Basils • Youth Hub • Refugee and Migrant Centre • Temporary Accommodation
Oral Health Promotion – Foodbanks	Approximately 280,000 packs purchased and distributed	Distributed in 2 phases (West Midlands foodbanks, and Birmingham Children's Centres/Family Hubs)
NHSE Fund 1 – Oral Health Presenters	Oral Health Presenters for nursery resources purchased	Oral Health Presenters for nursery resources used by NHS BCHC Startwell for Early Years Oral Health promotion activities
NHSE Fund 1 – Health Visitors Pilot project	1,268 toothbrush packs purchased	Toothbrush packs for distribution by Health Visiting Teams as part of innovative pilot project
NHSE Fund 1 – Oral Health Needs Assessment	Fixed-term GR4 officer recruited	Fixed term GR4 officer to be recruited to deliver agreed recommendations from Birmingham Oral Health Needs Assessment
NHSE Fund 2 – Toothbrushes for Schools EYFS (Nursery and Reception)	Approximately 36,600 toothbrush packs purchased and distributed	Distributed to all EYFS pupils in Birmingham

Source: BCC HP Team, 2024

Birmingham residents are experiencing challenges when attempting to access dental care, reflecting issues with access to dental services reported regionally and nationally (Healthwatch Birmingham, 2023). It is therefore extremely important to ensure all residents have the right knowledge and capability to take the recommended preventative measures to ensure good oral health. BCC-led toothbrush distribution initiatives have supported with this ambition, encouraging regular toothbrushing habits and providing quick information to upskill adults and children. The publication of the Oral Health Needs Assessment (anticipated Autumn 2024) will inform recommendations to best improve, maintain and protect the oral health of Birmingham residents. BCC HP team will conduct evaluations of previous oral health activity, to help inform actions to meet those recommendations. The team will also continue working with and supporting the activity of the NHS BCHC Oral Health Improvement team, and ensure future activity is evidence-based and directly responding to the needs of local citizens.

Food Safety and Hygiene

Key Points

- The Food Standards Agency (FSA) estimates that food poisoning costs the UK £9 billion annually of which £ billion is a result of unknown causes.

- Food borne infections are a major burden in Birmingham with over 4500 food related incidents reported in a 4-year period, a figure that likely under-estimates the true numbers of food related illness in the city
- Awareness and understanding of food hygiene rating and the scheme itself are essential to improving food hygiene compliance within Birmingham.

The Birmingham Food Strategy, launched in late 2023, aims to create a sustainable and healthy food system in the city to enhance residents' health. A key focus is on food safety and standards, managed by the HPT in partnership with other BCC. From January 2019 to November 2023, 4543 cases of food poisoning were reported in Birmingham, likely an underestimate. Nationally, the Food Standards Agency (FSA) estimates 2.4 million annual cases of foodborne illness, costing the UK £9 billion, with Birmingham's share in the tens of millions.

The HPT, along with the Environmental Health Team, identified wards with high concentrations of non-compliant food businesses. In this report, a non-compliant business refers to businesses that are rated between 0 and 2, with 2 meaning improvement necessary and 0 meaning urgent improvement necessary. The wards include Soho & Jewellery Quarter, Ladywood, Nechells, Alum Rock, Ward End, Bordesley, and Highgate. These areas, marked by high deprivation and low home cooking rates, face negative health outcomes.

An FSA survey in 2021 revealed 89% awareness of the Food Hygiene Rating Scheme, but only 43% considered it when choosing takeaways. Efforts to improve food hygiene understanding include the Healthy School Programme and developing training resources for non-compliant businesses. Inspections in non-compliant businesses showed a lack of safety culture. Some restaurants were found to not provide sufficient training and in some cases reliance on different languages among staff was also noted. To address this, the HPT recommends creating easy-to-understand, multilingual training resources to overcome cultural and language barriers, thereby enhancing food safety standards citywide.

Communications

Key points

- The Health Protection Team (HPT) collaborates with stakeholders to ensure timely and accurate information sharing, as demonstrated during the measles outbreak response and hot weather preparedness efforts.
- HPT hosts webinars and partners with local advocates to promote health protection messages, including Black History and LGBT Month and the 'Bolder Healthier Champions' program.
- HPT recommends continued coordinated efforts and face-to-face interactions during urgent incidents and the creation of an annual communications calendar for effective outreach.

The Health Protection Team (HPT) prioritises effective communication with partners, stakeholders, and communities to ensure accurate and timely information sharing. This was crucial during the measles outbreak, where HPT engaged schools and community partners to amplify messages. Continuous communication efforts, including hot weather preparedness sessions with Chinese and faith community groups, uphold standards and educate the public.

HPT hosted webinars during Black History and LGBT Month to address health inequalities, focusing on vaccination rates and access to health services. Collaborating with the Addictions team, they emphasized health protection and addiction issues. Additionally, HPT worked with the 'Bolder Healthier Champions' program, empowering local advocates to promote screening and immunization programs within their communities, addressing mistrust in authorities.

HPT's engagement with diverse communities highlighted the need for coordinated efforts and effective in-person interactions. Future operations will blend face-to-face and digital communications to maximize impact.

The HPT is currently compiling information from engagement during the measles outbreak into a qualitative report. This report aims to support future initiatives targeting deprived and vulnerable communities to reduce health inequalities in Birmingham. Additionally, a comprehensive year-long communications schedule is being developed to help the HPT track communication needs and provide timely support when necessary.

Conclusion

In the last year there has been much work across various health protection workstreams. There has been significant outreach work done including engagement with schools, early years institutions and various under-served communities. This includes sending out tailored communicable disease guidance and communications to schools, early years and educational institutions regarding measles and carrying out oral health promotional activities with schools. This work has allowed for the building of relationships with schools and educational institutions to improve engagement and partnership work across Birmingham.

The establishment of multi-agency groups has allowed for cross-system and collaborative work to develop solutions and start work to improve health protection within the city. This partnership work during the 2023/24 measles outbreak in Birmingham.

In the coming year, there will be a focus on developing approaches to work collaboratively across the network and engage with under-served communities to improve health outcomes and work to reduce health inequalities in these communities. The upscaling of public health intelligence and evidence to provide a representative view of the Birmingham child population and the identification of gaps within and across the system will aid in moving forward in the right direction.

Glossary

Acronym	Term
BCC	Birmingham City Council
BSol	Birmingham and Solihull
COVID-19	Coronavirus Disease
DPH	Director of Public Health
EH	Environmental Health
FTC+	Fast Track Cities Plus
HPT	Health Protection Team
HPF	Health Protection Forum
ICB	Integrated Care Board
ICS	Integrated Care Systems
MMR	Measles, Mumps and Rubella
MOU	Memorandum of Understanding
NHS	National Health Service
TB	Tuberculosis
UKHSA	UK Health Security Agency

Contributors

Birmingham City Council Public Health - Health Protection Team

- Dr Mary Orhewere
- Funmi Worrell
- Helen Bissett
- Paulius Armanavicius
- Manuela Engelbert
- Onome Etim

Partners

BCC Environment Health team, BCC Resilience team,
ICB partners: IPC team, ICB immunisation and vaccination team,
UKHSA – West Midlands team.

	Agenda Item: 13
Report to:	**Birmingham Health and Wellbeing Board**
Date:	**26th September 2024**
TITLE:	**Health and Wellbeing Board Annual Review of Strategy and Governance Review**
Organisation	**Birmingham City Council**
Presenting Officer	**Jo Tonkin (Deputy Director, Public Health)**

Report Type:	Discussion and Approval

1. Purpose:

1.1. To share the Annual Review of the Joint Health and Wellbeing Strategy for 2023-24 with Board members for approval.

1.2. To inform Health and Wellbeing Board members about the proposed structure for new and existing forums/partnerships of the Health and Wellbeing Board.

1.3. To ask for HWB members' endorsement of this proposed structure and operating practices.

2. Implications (tick all that apply):

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

3. Commissioner's Review:

3.1 Commissioners support the recommendations.

4. Recommendation

Accept the Annual Review 2023-24 and note any considerations around indicator viability.

4.1. To approve the proposal for the HWB Forums Refresh, subject to any comments from Health and Wellbeing Board members.

4.2. To ask permission to take the HWB Forums Refresh Proposal to the next available Birmingham Place Committee to present there and strengthen NHS provider collaborative representation.

5. Report Body

5.1. This item is split between the Annual Review of the JHWB Strategy for 2023-24 (and associated indicator update pack) and the proposal for the HWB Forums structure following on from the Refresh Survey.

5.2. As both papers relate to the governance of the Health and Wellbeing Board as well as the delivery of the JHWB Strategy, they have been submitted for consideration as one item by the Board.

5.3. All papers attached are summarised below:

Annual Review 2023-24

5.4. The Annual Review of the Joint Health and Wellbeing Strategy is an overview of the progress made against each theme in the strategy, including highlights from the last annual period and an update on any governance changes.

5.5. This year's review covers the period approximately from May 2023 to May 2024 and also includes a link to all papers and items submitted to the Health and Wellbeing Board during this period.

5.6. The Annual Review is also accompanied by an Indicator Update Pack which provides a comprehensive commentary on each indicator used to measure progress for the strategy. It can also be used to provide context to the RAG ratings in the review.

5.7. It should be noted though that the majority of indicators in the Joint Health and Wellbeing Strategy are lag indicators and will not show the progress made in each of the strategy's themes until approximately 2 years after implementation.

5.8. To ensure that real-time progress is measured, individual strategies and action plans for each theme will contain lead indicators that measure activity and

immediate impact. These will be included in updates to the Health and Wellbeing Board by those forums and partnerships that are responsible for delivery.

Health and Wellbeing Board Forums Refresh Survey

5.9. To assess the effectiveness of the current HWB Forums structure in delivering the ambitions of the Joint Health and Wellbeing Strategy, Public Health undertook as assessment of the current structure using a BeHeard survey and engagement sessions with forum members.

5.10. This survey was open from 7th May to 6th June 2024 and open to be completed by any forum members, Health and Wellbeing Board members, and key stakeholders from the wider health and care system.

5.11. The survey was designed using an NHS framework on committee effectiveness and broadly asked about the themes of leadership, organisation, effectiveness and collaboration. Most questions were measured on a scale of 0-10 (0 = poor, 10 = best) and had free text boxes for respondents to provide context or detail to their response.

5.12. The survey itself was intended to understand perspectives on how the forums were operating and where improvements could be made. It was also intended to determine if there were gaps in the current structure relating to the ambitions of the Joint Health and Wellbeing Strategy.

5.13. The survey received 52 responses in total, with 35 of these responses from either a member of a forum or the Health and Wellbeing Board. The results from the survey can be found in Appendix 2.

5.14. The responses to the survey and individual engagement with forums has informed a proposal to the Health and Wellbeing Board on a refreshed structure for the forums, including the adoption of existing partnerships and the establishment of two new partnerships.

Health and Wellbeing Board Forums Refresh Proposal

5.15. The overall proposal for the refreshed structure is to have ten partnerships that would comprise of the current forums, pre-existing partnerships that would now report into the Health and Wellbeing Board, and new partnerships.

5.16. These partnerships would all have broadly standardised features. These would be:

5.16.1. A co-chair model, consisting of an Elected Member or Senior Director from Birmingham City Council alongside a representative from a partner organisation.

5.16.2. Consistent naming for each partnership as the 'Birmingham XXXX Partnership'.

5.16.3. Quarterly meetings, with preferably at least two meetings to be held in-person.

5.16.4. Three written updates (short paragraph with agreed template) and one annual update presentation (with agreed template) to the Health and Wellbeing Board.

5.16.5. Full Terms of Reference to be published online and reviewed on an annual basis.

5.16.6. Partnerships will have their own discretion to form sub-groups, but their work should be included in any updates and reporting to the Health and Wellbeing Board.

5.16.7. Independent expert members and those representing citizen voice may be added to partnerships through agreement of existing members through a standardised open process.

5.17. The proposal sets out a revised structure for each partnership within the Health and Wellbeing Board structure.

5.18. It also sets out a provisional reporting calendar for 2025 that would allow each partnership to fulfil its requirement to meet quarterly and provide an annual update to the Health and Wellbeing Board.

5.19. More detail on the specifics of the proposal can be found in the Refresh Proposal slides in Appendix 1 and draft Terms of References in Appendix 5.

6. Compliance Issues
6.1. HWBB Forum Responsibility and Board Update
All new and existing partnerships will be responsible for taking ownership of delivery relating to their subject area/ theme of the Joint Health and Wellbeing Strategy. As specified, all partnerships must provide an annual update to the HWB via a presentation and opportunity for members to ask questions.
6.2. Management Responsibility
Each partnership will be managed by a lead officer from BCC Public Health, who will act as the point of contact for any queries or requests. The Service Lead (Governance) in BCC Public Health will coordinate the relationships between the HWB and each partnership.
6.3. Finance Implications
Strategic support for the Health and Wellbeing Board and the delivery of proposed actions is supported by Public Health staff and the ring-fenced grant. Membership of partnerships will be on a voluntary basis.
6.4. Legal Implications
N/A

6.5. Equalities Implications (Public Sector Equality Duty)
N/A

7. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
An increased number of partnerships creates a higher workload and coordination for the HWB.	Medium	Low	A clear and consistent reporting schedule for partnership meetings and annual updates to the HWB will balance the increased need for coordination between each partnership.
Partnerships that have overlapping focuses either duplicate work or work exclusive to each other.	Low	Medium	Once all partnerships have been established, there will be a regular forum for the lead officers to coordinate their forward plans and suggest inter-partnership working.

Appendices
Appendix 1 – HWB Forums Refresh Proposal Appendix 2 – JHWS Annual Review 2023-24 Appendix 3 – Indicator Update Pack 2023-24 Appendix 4 – HWB Refresh Survey Results Appendix 5 – Draft Terms of References for HWB Partnerships

Background Papers
2019 Proposal - Development of Health & Wellbeing Board Sub-Committee Structure

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

Aidan Hall (Service Lead, Governance, Public Health)

Alex Quarrie-Jones (Senior Programme Officer, Governance, Public Health)

HWB Forums Refresh Proposal

Health and Wellbeing Board

26th September 2024

RESET RESHAPE RESTART

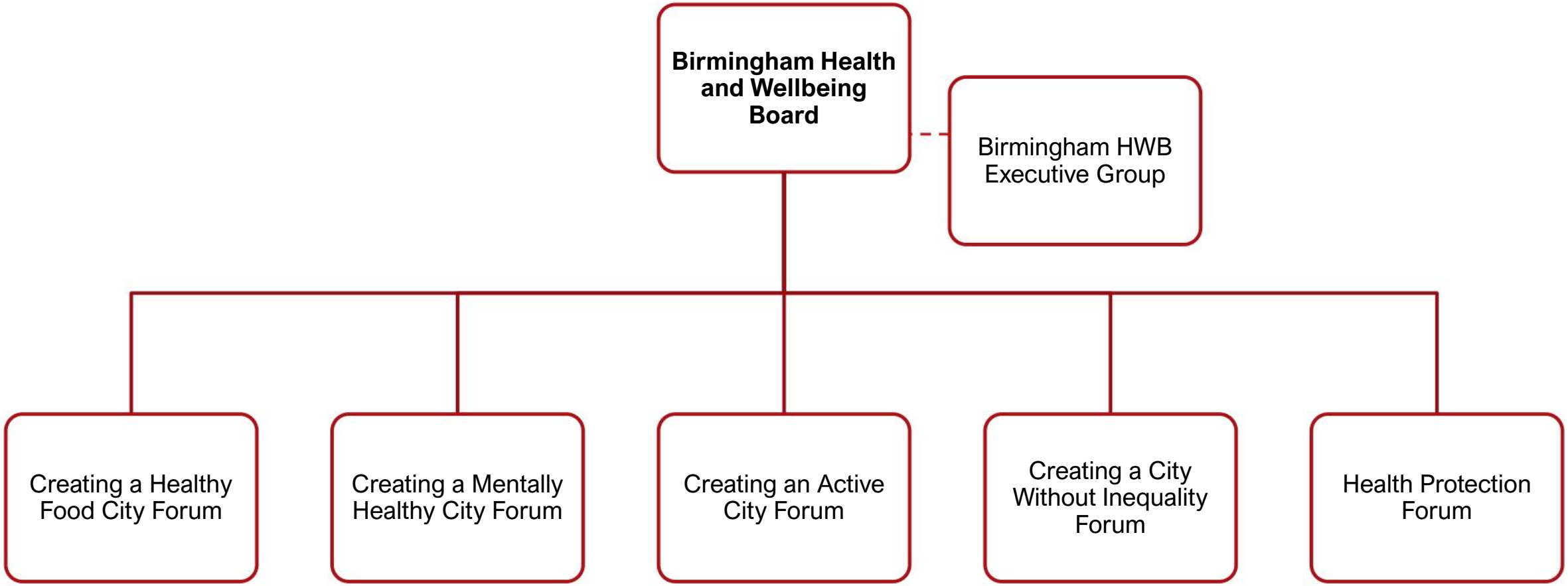
Background

Birmingham Health and Wellbeing Board (HWB) is a statutory committee of Cabinet for Birmingham City Council. Currently, there are five forums of the HWB with a topical focus. Each of these forums constitutes a sub-group of the HWB. These are:

- Creating a Healthy Food City Forum
- Creating a Mentally Healthy City Forum
- Creating an Active City Forum
- Creating a City without Inequalities Forum
- Health Protection Forum

It has been five years since the establishment of the forums. Each forum has developed significantly during this time, with activities evolving from their original remit.

Current Structure



HWB Forums Refresh Survey (June-July 2024)

Approach

We sought the views of members of the Health and Wellbeing Board, members of the forums and any other relevant partners to provide their perspectives on how the forums are currently operating and where improvements could be made.

The purpose of this survey was to:

- obtain views from Forum members on the effectiveness and functioning of individual forums and the overall sub-group structure
- obtain views from Health and Wellbeing Board members and wider partners on the overall sub-group structure and governance
- support a refresh of the sub-group structure to deliver the ambitions in the Joint Health and Wellbeing Strategy

In addition to this there has been a review of membership and participation of existing forums, their terms of reference, progress against partnership delivery plans and evidence of impact.

Overall Summary

- There is good practice across the forums, but areas for improvement. The most mature forums (e.g. Creating a Healthy Food City Forum) have achieved successful multi-agency matrix working and distributed leadership for delivery across the system as well as clear escalation to the HWB for strategic issue resolution.

- There should be additional value for individual forums and Health and Wellbeing Board where there are gaps in existing partnership and matrix working for delivering the strategy. These have been explored with key individuals in shaping the proposals e.g. ‘Ageing Well Partnership’ proposal has been discussed with the Director of Adult Social Care and addresses a current gap in partnership work on prevention and healthy ageing which cannot be addressed in existing partnerships and also helps provide stronger links between some of the disparate older people partnerships groups.

- New forums have been suggested, alongside the need for Health and Wellbeing Board to oversee work on tackling inequalities (5 areas in joint strategy) with the Inequalities forum transitioning to focus on Inclusion Health.

- Where Health and Wellbeing Board does not have direct oversight of a group (e.g. life course, sustainability), it should have a mechanism for overseeing or influencing work that supports the ambitions in the Joint Health and Wellbeing Strategy, e.g. Children's Transformation Partnership.

- With new groups and additional meetings and increasing workload for elected members, an alternative chairing model will be considered.

Proposals for HWB Forums

Emerging Partnership Structure

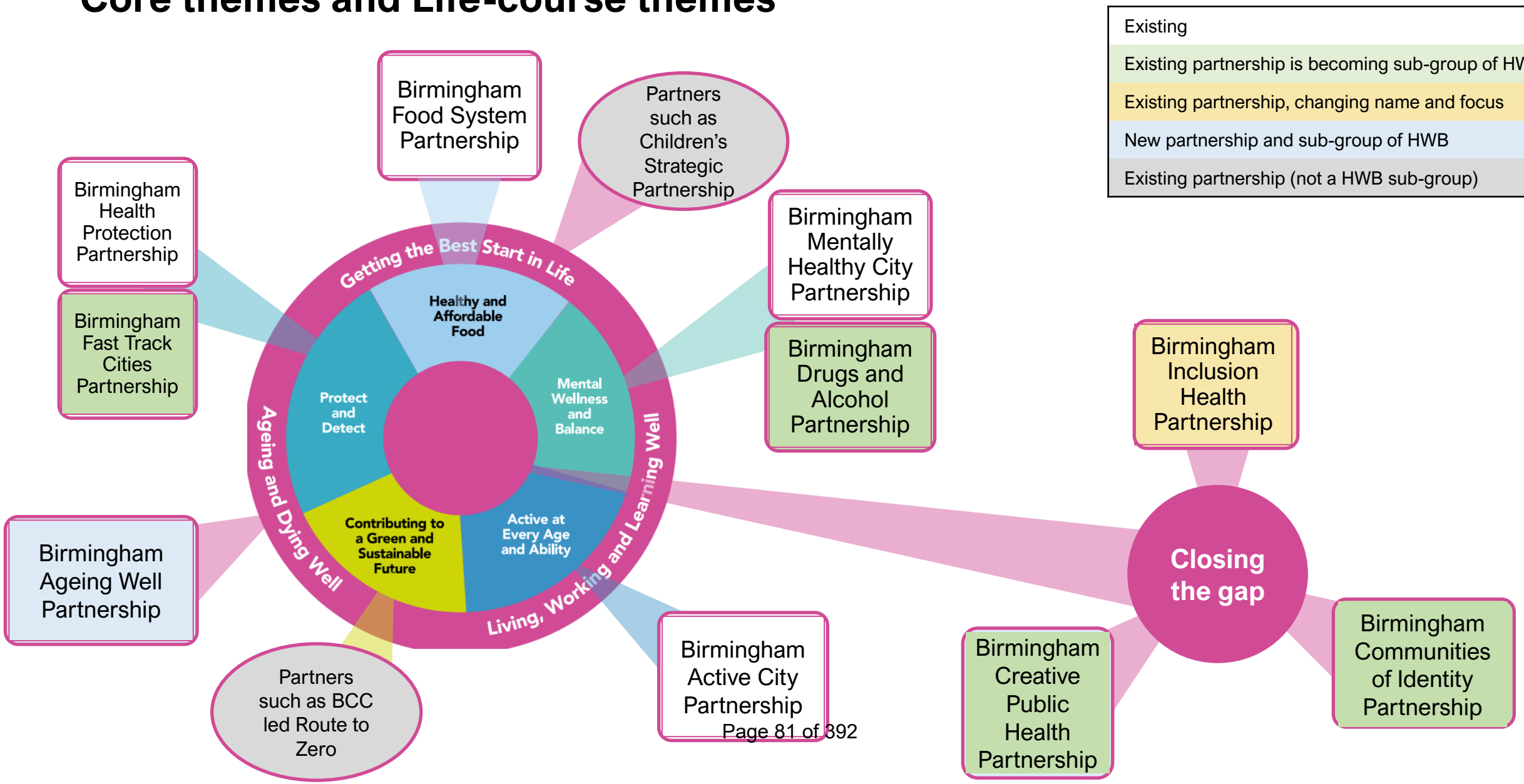
- Retain the current 5 forums (see next slide for maximising impact)
  - *Rename these forums and re-focus the 'Creating a City without Inequalities' Forum*

- Formalise the relationship with the HWB of 4 existing partnerships which currently do not have strong governance arrangements but are responsible for delivery against the themes of the Joint Health & Wellbeing Strategy
  - *Drug & Alcohol Partnership, Fast-track Cities, Creative Public Health and BLACHIR Board (renamed as Communities of Identity Partnership) to become sub-groups of the HWB*

- Create one new partnership, Ageing Well, for which there is a system gap and no existing partnership in place.

- Retain existing arrangements for Children's Strategic Partnership and Route to Net Zero Board i.e. not a formal sub-group of HWB but continue to report into the HWB on annual basis.

Emerging Partnership Structure and Joint Health and Wellbeing Strategy – Core themes and Life-course themes



Partnership	Purpose	Partners
Food System	**To work together to apply a whole system approach to understanding the food landscape of the city and improving the food behaviours at a population level** across Birmingham by ensuring that a joint action plan is co-produced and delivered. This will be achieved through the delivery of the Food System Strategy.	• The Food Foundation • Healthy Futures • Birmingham Food Council • Trussell Trust • University of Birmingham • University College Birmingham • Birmingham City University
Mentally Healthy City	**To develop a public health approach to mental health and wellbeing in the City**, delivering upon the Prevention Concordat for Better Mental Health which is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health is a valuable contribution to achieving a fairer and more level society. This will be completed through creation and implementation of the Creating a Mentally Healthy City Strategy.	• Birmingham & Solihull Mental Health NHS Foundation Trust • Birmingham MIND • Washwood Health Multi-Academy Trust • Newman University • University of Birmingham • Birmingham Voluntary Service Council • Birmingham Children's Trust
Drugs and Alcohol	**To reduce the harms of drugs and alcohol to children, young people, adults, families, and communities in Birmingham.** It brings together partners across the City to create transformative change in line with the recommendations of the Dame Carol Black Review 2022, the '10 year Drugs Strategy: From Harm to Hope' and Birmingham's 'Triple Zero Strategy'.	• West Midlands Police • Birmingham Youth Offending Service • West Midlands Ambluance Service • Birmingham City Council Housing Options • Change Grow Live (CGL) • Aquarius • Birmingham Children's Trust
Active City	**To work collaboratively to increase physical activity (PA) at a population level across Birmingham.** It will enable residents to be physically active and to reduce inequalities between geographies, communities and abilities. It will achieve this through the delivery of the Creating an Active Birmingham Strategy.	• Sport Birmingham • Canal and River Trust • Sustrans • The Active Wellbeing Society • West Midlands Combined Authority • Children & Families Directorate, BCC
Inclusion Health	**To deliver the strategic aims of the Health and Wellbeing Board and Integrated Care System with a specific focus on inclusion health groups within our population. It will** deliver its purpose through the co-production and co-delivery of an action plan. The partnership is based on the principle of collaboration and shared leadership for delivery, maximising the potential of our partnership to achieve impact. It will have three core functions for shaping the inclusion health agenda: supporting programme delivery, shining the light through data and evidence, and enabling and empowering voices.	• Crisis • SIFA Fireside • Citizens Advice Bureau Birmingham • Anawim • Birmingham Children's Trust • Birmingham & Solihull Mental Health NHS Foundation Trust • Birmingham Women's & Children Hospital NHS Trust • Department for Work & Pensions • Birmingham Community Healthcare NHS Foundation Trust

Partnership	Purpose	Partners
Health Protection	**To facilitate the Director of Public Health's responsibility to provide oversight and assurance of local health protection plans.** It will provide the link between the Health and Wellbeing Board and partner organisations with roles in the delivery of health protection plans. It will also provide a setting for the exchange and analysis of information and data relevant to the plans.	• Environmental Health, BCC • Birmingham & Solihull Integrated Care Board • NHS England • UK Healthy Security Agency
Fast Track Cities	**To bring together expertise from the organisations and communities involved in and affected by the prevention, diagnosis, treatment and support of people living with and at risk of HIV, Viral Hepatitis and TB in Birmingham.** It will also ensure an inclusive and transparent whole-city approach by developing, delivering, monitoring and evaluating the FTC+ Action Plan.	• Birmingham & Solihull Integrated Care Board • Local Pharmaceutical Committee • University Hospitals Birmingham NHS Foundation Trust • UK Health Security Agency • Change Grow Live (CGL)
Creative Public Health	**To develop and implement a shared vision that maximises the potential of creative public health activity at community and population level to support the vision and aims of the Health and Wellbeing Strategy.** This will be achieved by implementing a strategic framework for how arts, culture and heritage can contribute to better public health, including by enabling equitable access for all residents and widening the available evidence base.	• Birmingham Museums Trust • Ikon Gallery • Birmingham Hippodrome • Midlands Art Centre • University of Birmingham • Birmingham & Solihull Integrated Care Board • Arts Council England • Culture Central • National Centre for Creative Health
Communities of Identity	**To work together with different communities of identity to address health inequalities across Birmingham, and to empower community partners to lead community-based programmes with support from the wider system to improve health.** It will also ensure that voices from communities of identity are shaping public health services and strategies. It will continue the successes and lessons learned from the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR).	• Birmingham & Solihull Integrated Care Board (BLACHIR Taskforce) • Newman University • Chinese Community Centre Birmingham • Ashiana Community Project • Birmingham LGBT Centre • Focus Birmingham • BID Services
Ageing Well	**To plan, develop and oversee the implementation of a Birmingham Ageing Well Strategy which focuses on those approaching or entering retirement age (50 – 70 years old).** The core pillars of the strategy will be: dementia and neuro-degenerative diseases, prevention of frailty, loneliness/ living alone, preparation for older age, end of life, and the wider determinants of health for older adults (unemployment/retirement, caring responsibilities, mobility and travel).	• Adult Social Care, BCC • Birmingham & Solihull Integrated Care Board • Age UK • Cruse Bereavement Support • Compassionate Cities UK

Proposed reporting to HWB

- To enable the necessary oversight and provide opportunities to discuss their work, all partnerships will present an annual update to the Health and Wellbeing Board.

- These updates will be distributed throughout the year with 1 to 2 updates at each Board meeting.

- Where applicable, updates will be grouped thematically (e.g. Health Protection Partnership & Fast Track Cities+ Partnership).

Proposal features for every partnership

1. A co-chair model, consisting of an Elected Member or Senior Director from Birmingham City Council alongside a representative from a partner organisation.

2. Consistent naming for each partnership as the '*Birmingham XXXX Partnership'.*

3. Quarterly meetings, with preferably at least two meetings to be held in-person.

4. Three written updates (short paragraph with agreed template) and one annual update presentation (with agreed template) to the Health and Wellbeing Board.

5. Full Terms of Reference to be published online and reviewed on an annual basis.

6. Partnerships will have their own discretion to form sub-groups, but their work should be included in any updates and reporting to the Health and Wellbeing Board.

7. Independent expert members and those representing citizen voice may be added to partnerships through agreement of existing members through a standardised open process.

Chairing Model

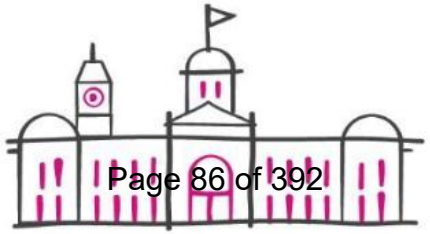
With new partnerships and concerns over the workload for Cabinet Members, different options for chairing the forums have been considered.

The proposed approach is to adopt a model consisting of:

Elected Member **or** Senior Director from Birmingham City Council **and** a representative from a partner organisation.

We consider this option to be the most viable.

A report to Health and Wellbeing Board in September will outline the role of the co-chairs. Decisions in the partnership will be made collectively and accountability will sit with Health and Wellbeing Board.



Indicative approach

*Existing forum/partnership within HWB structure

Elected Members

1. Birmingham Food System Partnership*
2. Birmingham Mentally Healthy City Partnership*
3. Birmingham Active City Partnership*
4. Birmingham Inclusion Health Partnership*
5. Birmingham Creative Public Health Partnership
6. Birmingham Ageing Well Partnership
7. Birmingham Communities of Identity (formerly BLACHIR Board) Partnership
8. Birmingham Drugs and Alcohol Partnership
9. Birmingham Fast Track Cities Partnership

BCC Director

1. Birmingham Health Protection Partnership*

Birmingham City Council

Questions?

RESET RESHAPE RESTART

DRAFT

Birmingham Joint Local Health and Wellbeing Strategy

Creating a Bolder, Healthier City 2022-2030

Annual Review 2023-2024

Date approved by Health and Wellbeing Board	

Contents

Introduction

Chair's Statement

It has been excellent to see all the progress made in this year's review of the Joint Health and Wellbeing Strategy, and equally all the contributions from our many partners and collaborators. It is clear that the work of all the organisations responsible for the delivery of our ambitions is rapidly gathering pace and I look forward to seeing how this progresses.

While I have only been the Acting Chair of the Health and Wellbeing Board for this year, I have been incredibly heartened to see the strong bonds of partnership working that the Board fosters for its members, and across the city. I have also been impressed by the depth of different topics that the Board discusses, from pharmaceutical needs to an Active City strategy to discussions around being a Compassionate City. I believe that these breadth of projects and services are reflected in this Annual Review.

The most recent Health and Wellbeing Board meeting in July was also an important reminder that we still face a variety of challenges in order to reduce health inequalities across the city and improve our citizens' happiness and health. It was vital to see the current savings proposals for Birmingham City Council considered through the lens of health and wellbeing. I thank those directors who made themselves available and Board members who contributed thoroughly to the discussion.

I am also hopeful that at the next Health and Wellbeing Board workshop in November we can continue to have these constructive discussions and channel the partnership working ethic of the Board for further solutions.

Cllr Rob Pocock
Cabinet Member for Health and Social Care
Acting Chair of the Birmingham Health and Wellbeing Board

What is the Birmingham Health and Wellbeing Board?

The Health and Wellbeing Board (HWB) is a group of senior representatives from organisations across Birmingham, including Birmingham City Council, the NHS, the community sector and Healthwatch, which represents views of the public. There is cross-party political representation, with meetings chaired by the Cabinet Member for Health and Social Care.

The Health and Wellbeing Board's vision for Birmingham is to "create a city where every citizen, whoever they are, wherever they live and at every state of life, can make choices that empower them to be happy and healthy". The Health and Wellbeing Board works collectively, with the strengths and assets of Birmingham people, to oversee, influence and shape action to ensure Birmingham is a healthy city with high quality services.

About this review

This review covers the second full year of delivery for the Joint Local Health and Wellbeing Strategy. The review is not a comprehensive examination of all the activity that has happened in the past year but seeks to highlight significant progress against each theme. The main content of the review looks at the progress of each theme in the strategy. This is split into five core themes and three life-course themes. For themes with strategic indicators, a summary of their direction since the last Annual Review has been provided through a RAG rating. The table below provides an explanation of the rating for each colour:

RAG Rating	Explanation
	≥ 1 percentage point movement in the correct direction
	≤ 1 percentage point movement in either direction (e.g. no change)
	≥ 1 percentage point movement in the incorrect direction
	Indicator has not updated or is no longer measured

For the majority of indicators, the data are referring to the **2022/23 annual period**. This means that these indicators will not reflect any recent interventions, initiatives, services or projects. It is advised that indicators are utilised to highlight the trend and the progress towards the intended ambition within each theme. Equally, there are a minority of indicators that have not updated since the publication of the Joint Health and Wellbeing Strategy or are no longer measured and accessible.

More information on specific indicators, as well as commentary on their direction, is provided in the Indicator Update Pack of this review. All the data is also available on the Joint Health and Wellbeing Strategy Dashboard. A summary of activity relating to each Health and Wellbeing Board meeting over the past annual period can be found in Appendix 1 of this review.

Further information on each item can be found at the attached link: CMIS > Committee > Health and Wellbeing > Birmingham Health and Wellbeing Board. If you have any queries about this review, please contact this email: hwboard@birmingham.gov.uk

Creating a Bolder, Healthier City 2022-2030: Strategy on a page

Our Vision

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

Our Principles

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

Our Themes

The strategy has five core themes for action covering the wider determinants of health, health protection and environmental public health. These are:

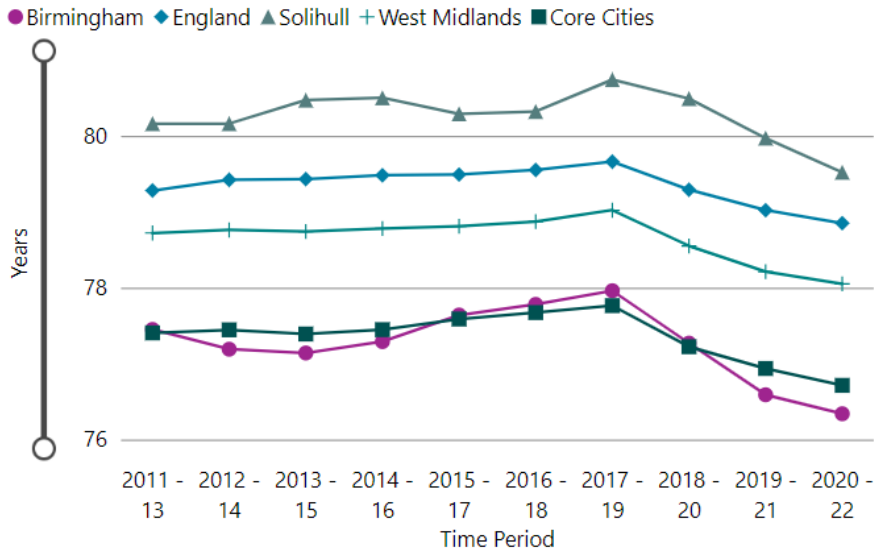
1. Healthy and Affordable Food
2. Mental Wellness and Balance
3. Active at Every Age and Ability
4. Contributing to a Green and Sustainable Future
5. Protect and Detect

The five core themes run throughout the life course, which is split into three stages:

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

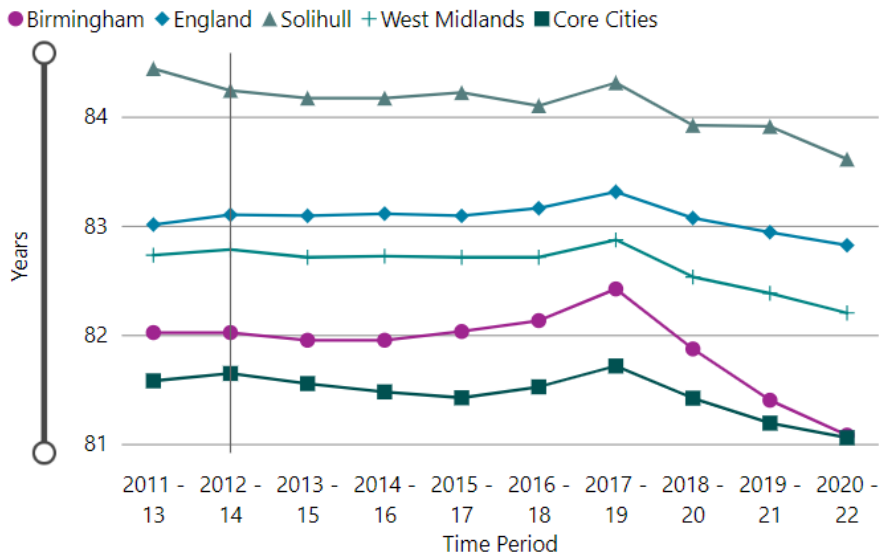
Headline Indicators

Life expectancy at birth (Male) Updated 19 Apr 2024



The above indicator shows life expectancy at birth for males in Birmingham over the last ten years. During this period, life expectancy remained lower than the national and regional averages and generally mirrored that of the Core Cities average. The decline starting in the 2018-20 period and continuing to the 2020-22 period is attributable to an increased mortality rate from the COVID-19 pandemic. Birmingham's decrease mirrors national and regional trends but exhibits a greater drop from its relative peak in the 2017-19 period. It is expected that as post-pandemic births and mortality data is included, the trend will either plateau or begin to increase.

Life expectancy at birth (Female) Updated 19 Apr 2024



The above indicator shows life expectancy at birth for females in Birmingham over the last ten years. During this period, life expectancy remained lower than the national and regional averages but above the Core Cities average (until the 2020-22 period). The decline starting in the 2018-20 period and continuing to 2020-22 is attributable to an increased mortality rate from COVID-19 pandemic. The decrease in Birmingham mirrors national and regional trends but exhibits a greater drop from its relative peak in the 2017-19 period. It is also a more pronounced drop compared to the life expectancy rate for males as it is probably that there were a greater proportion of females aged 80 years and above compared to males.

Progress towards delivering the Birmingham Health and Wellbeing Strategy

Core Themes

Theme 1: Healthy and Affordable Food

Highlights

- Official launch of the Birmingham Food System Strategy in October 2023, which included six workstreams and four cross-cutting themes.
- Action plan workshops for each individual workstream and theme of the Food System Strategy have also been held in October 2023.
- Local Food Legend Grant was delivered to 44 organisations across the city.
- 'Full of Beans' campaign to encourage more consumption of beans, pulses and lentils was delivered to 70 Holiday, Activity and Food (HAF) clubs in Summer 2023.
- Birmingham won the Bronze Award in the Sustainable Food Places Awards in November 2023.
- The UK Urban Food Forum, chaired by Birmingham, hosted its first meeting in December 2023.
- Through the Food Provision Group, 116 community projects received £480,000 to support with emergency food aid in the city.
- Launch of the Centre for Urban Food at University College Birmingham, in co-ordination with Birmingham Public

Indicator Name	Bham Value	Rating
Uptake of healthy start vouchers in eligible families (%)	71.4	
Percentage of adults meeting the '5-a-day' fruit and vegetable consumption recommendations (%)	23.2	
Obesity: QOF prevalence (18+)(%)	11.5	
Reception: Prevalence of underweight (Persons, 4-5 yrs)(%)	1.9	
Reception: Prevalence of obesity (including severe obesity) (Persons, 4-5 yrs)(%)	10.2	
Year 6: Prevalence of underweight (Persons, 10-11 yrs)(%)	2.4	
Year 6: Prevalence of obesity (including severe obesity) (Persons, 10-11 yrs)(%)	27.0	
Breastfeeding prevalence at 6-8 weeks after birth - current method (%)	46.3	
Percentage of 5-year-olds with experience of dental decay (Persons, 5 yrs)(%)	23.8	

Governance

- The Creating a Healthy Food City (CHFC) Forum has responsibility for the delivery of this theme.
- Their last report to the Health and Wellbeing Board was in November 2023.
- Specific action groups are responsible for each workstream of the Food System Strategy and report to the Forum.

Theme 2: Mental Wellness and Balance

Highlights

- Development of a new Suicide Prevention Action Plan from October 2023 to October 2024.
- Full evaluation in June 2023 of 16 community projects funded through the 'Better Mental Health Fund'.
- 3,143 people were directly engaged through these projects, with a further 14,062 indirectly supported. Over half of those engaged were aged between 5 and 17 years old. 6 projects have also received legacy funding to continue delivering through 2023/24.
- Commencement of 1st phase of the development of the 'Creating a Mentally Healthy City' Strategy in May 2024.
- Completion of real-time community listening research through 'The price we can't pay' in March 2024. This engaged a sample of 20 Birmingham residents over 3 months to provide video diaries on how the Cost-of-Living crisis affected residents' mental health and wellbeing.
- Creation of the Birmingham Drugs and Alcohol Partnership (BDAP) to deliver the Triple Zero Strategy.

Governance

- The Creating a Mentally Healthy City (CMHC) forum has responsibility for the delivery of this theme.
- The Suicide Prevention Advisory Group (SPAG) is a sub-group of the forum.
- Responsibility is also shared by the Birmingham Drugs and Alcohol Partnership (BDAP).

Indicator Name	Bham Value	Rating
Depression and anxiety among social care users: % of social care users (%)	51.7	
Prevalence of depression and anxiety in adults (%)	14.5	
Admission episodes for alcohol-related conditions (Broad definitions) per 100,000	2127.0	
Suicide rate (persons) per 100,000	8.5	
Emergency Hospital Admissions for Intentional Self-Harm per 100,000	134.8	
Proportion of adults who have a high self-reported life satisfaction score (%)	61.9	
Average worthwhile rating (0-10: 0 'not at all worthwhile', 10 'completely worthwhile')	7.7	
Average happiness rating (0-10: 0 'not happy at all', 10 'completely happy)	7.2	
Average life satisfaction rating (0-10: 0 'not at all satisfied', 10 'completely satisfied')	7.2	
Average anxiety rating (0-10: 0 'not at all anxious, 10 'completely anxious)	3.4	
Successful treatment of drug treatment – opiate users (%)	4.0	
Successful completion of drug treatment – non-opiate users (%)	31.3	
Smoking prevalence in adults with a long term mental health condition (18+)(%)	28.2	

Theme 3: Active at Every Age and Ability

Highlights

- Public consultation for the 'Creating an Active Birmingham Strategy' from November 2023 to January 2023.
- Over 1000 residents were directly engaged on the draft strategy, either through a BeHeard questionnaire or in face-to-face consultation sessions.
- Out of the respondents, a citizens panel is also being formed to provide an improvement perspective on the implementation of the strategy.
- Publication of the Creating an Active Birmingham Strategy in April 2024.
- Launch of the Physical Activity Clinical Champion (PACC) pilot in Birmingham in May 2024.
- Creation of an 'Active Birmingham' steering Group to help co-ordinate community project opportunities from an underspend on the 2022 Commonwealth Games Legacy funding. This steering group will help to identify projects that will have a positive impact on sport and physical activity in the city.
- Development of an indicator dashboard for the Creating an Active Birmingham Strategy in partnership with the Birmingham City Observatory.

Indicator Name	Bham Value	Rating
Percentage of adults walking for travel at least three days a week	16.8	
Percentage of adults cycling for travel at least three days a week	2.0	
Percentage of young people who are regularly walking as part of their daily travel to school or other places	42.1	
Percentage of young people who are regularly cycling as part of their daily travel to school or other places	7.3	
Inactivity gap between those living with disabilities and long term health conditions and those without	20.3	
Activity gap between ethnic groups: White British and Asian (excluding Chinese)	11.4	
Activity gap between ethnic groups: White British and Black	10.3	
Activity gap between ethnic groups: White British and Chinese	N/A	
Percentage of physically active children and young people	34.2	
Percentage of physically inactive adults	27.9	
Percentage of physically active adults	60.4	

Governance

- The Active City Forum (ACF) has the primary responsibility for the delivery of this theme.
- Key projects are also delivered by partner organisations, such as The Active Wellbeing Society and Sport Birmingham.
- The Health and Wellbeing Board has received items on the development of the Creating an Active Birmingham Strategy in November 2023 and March 2024.

Theme 4: Contributing to a Green and Sustainable Future

Highlights

- Creation of the City of Nature Alliance in July 2023 to co-ordinate key organisations in Birmingham who are responsible for achieving the City of Nature Plan.
- Development of new green spaces in Birmingham that comply with the Future Parks Standard.
- Completion of pilot project in Bordesley and Highgate with installation of new pathways, facilities and safety features.
- Commencing initial works on next five priority wards (Castle Vale, Gravelly Hill, Nechells, Balsall Health West, and Pype Hays).
- Recruitment of Green Champions to engage communities in areas where new green spaces are being developed.
- Reduction of non-compliant vehicles driving within the Birmingham Clean Air Zone (CAZ) to 6.0% by June 2023.

Indicator Name	Bham Value	Rating
Utilisation of outdoor space for exercise/health reasons (Persons, 16+ yrs)	18.4	
Daily utilisation of green and blue spaces (%)	14.0	
Volunteering in green and blue spaces (%)	3.3	
Percentage of people listening to birdsong	25.5	
Emergency hospital admissions for respiratory disease in adults per 100,000	2018.7	
Fraction of mortality attributable to particulate air pollution (Persons, 30+ yrs)(%)	6.2	

Governance

- This theme is delivered in part by the City of Nature Alliance's works programme.
- The alliance contains organisations like the Birmingham Open Spaces Forum, the Birmingham and Black Country Wildlife Trust, and The Active Wellbeing Society.
- This programme also reports into Birmingham City Council's Climate Change, Nature, and Net Zero Board.

Theme 5: Protect and Detect

Highlights

- Supporting eligible Birmingham TB patients through the No Recourse to Public Funds (TB NRPF) pathway, delivering large cost-savings to NHS by freeing up bed space and protecting the health of local residents.
- Managing and contributing to health protection incident responses, e.g. high-profile strychnine incident in Autumn 2023.
- Birmingham & Solihull Health Protection Memorandum of Understanding (MOU) agreed for collaboration on all-hazards approach to health protection incidents.
- Major response to Measles outbreak in January 2024, including targeted school vaccination clinics and media campaigns to encourage take-up of the MRR vaccine.
- Formed the Measles Engagement Cell and hosted 588 attendees across 39 sessions to build trust and start dialogue with residents on vaccinations.
- Increasing referrals into treatment pathways for Blood Borne Viruses (BBV) through the 'Fast Track Cities +' programme.
- Delivery of awareness campaign to at-risk communities to encourage testing for BBV's and TB.
- Running a pilot for Emergency Department Opt-Out testing.

Indicator Name	Bham Value	Rating
Hepatitis C detection rate/100,000 (Persons, 1+ yrs)	41.7	
Repeat HIV testing in gay, bisexual and other men who have sex with men (%) (Male, All ages)	53.5	
MMR for one dose (2 years old)	82.1	
MMR for two doses (5 years old)	75.1	
HIV late diagnosis (all CD4 less than 350) (%) (Persons, 15+ yrs)	46.4	
New HIV diagnosis rate per 100,000 aged 15 years and over (Persons, 15+ yrs)	6.7	
Cancer screening coverage - bowel cancer (Persons, 60-74 yrs)	62.0	
Cancer screening coverage - cervical cancer (aged 25 to 49 years old) (Female, 25-49 yrs)	56.6	
Abdominal Aortic Aneurysm Screening - Coverage (Male, 65)	69.2	
Cancer screening coverage - breast cancer (Female, 53-70 yrs)	56.3	
TB incidence (three-year average) (Persons, All ages)	17.0	
New STI diagnoses (excluding chlamydia aged under 25) per 100,000 (All ages)	468.2	

Governance

- The Health Protection Forum has the primary responsibility for the delivery of this theme.
- This forum provides oversight on any key health protection programmes as well as co-ordinating and managing incident responses.
- The Fast Track Cities programme is also operated through the FTC+ Project Board and Steering Group.

Life-course Themes

Getting the Best Start in Life

Highlights

- Birmingham Children and Young People's Partnership launched their five-year plan in July 2023.
- The strategic goals for the five-year plan are: to create an inclusive city, join up the offer of services for children and young people, and build a safe environment for them in the city.
- The plan is also aligned with Birmingham & Solihull ICS' Ten-year Masterplan and the Birmingham SEND Strategy 2023-2028.
- Infant Feeding Strategy was co-produced by the Local Maternity and Neonatal System in May 2024.
- Family Hubs launched in March 2024 in all ten Birmingham localities. These hubs are a one-stop shop for providing advice and guidance on infants, parenting, schooling and finances.
- Infant Mortality Action Committee stood up and led by Birmingham & Solihull ICB, with priority in the 10-year ICS Strategy.
- Launch of the Birmingham Healthy Schools Programme to co-design a framework with schools on improving health and wellbeing in education settings.

Indicator Name	Bham Value	Rating
Children aged 11-15 killed or seriously injured in road traffic accidents (Persons, 11-15 yrs)	31.5	
Rate of first-time entrants (10-17 years) to the youth justice system (per 100,000)	132.5	
Percentage of children achieving a good level of development at the end of Reception	65.1	
Homelessness (aged 16-24) - households owed a duty under the Homelessness Reduction Act (per 1,000)	2.3	
Infant mortality rate (per 1,000)	7.2	
Hospital admissions due to asthma in young people under 19yrs (per 100,000)	214.6	
Child development: percentage of children achieving a good level of development at 2 to 2½ years	80.7	
Under 18 teenage conception rate (per 1,000)	13.4	

Governance

- The Birmingham Children and Young People's Partnership has the primary responsibility for the delivery of this theme, alongside the Birmingham Safeguarding Children Partnership for specific projects.
- The Birmingham & Solihull United Maternity and Newborn Partnership (BUMP) also represents the wider system for infant and maternal healthcare, including the Local Maternity and Neo-natal System.
- The Children and Young People's Partnership provided an annual update to the Health and Wellbeing Board, including the five-year plan, in July 2023.

Living, Working and Learning Well

Highlights

- BCC Public Health team recommissioned NHS health checks and local smoking cessation services delivered through general practice and community pharmacies.
- The 'Million Hearts' project provided cardiovascular disease (CVD) health checks via local community settings from April to August 2024 for any residents aged 40 years and above.
- Establishment of a Birmingham Smoking Cessation Task Group to oversee the utilisation of the Smokefree Generation Grant of £1.67 million to enhance local support to stop smoking services.
- Launch of awareness raising campaigns with community partners on the risks associated with cardiovascular disease (CVD).
- Design and Build Phases of a Community Care Collaborative by the Birmingham & Solihull Integrated System. This will integrate care for all-ages at neighbourhood and locality levels. This Collaborative will be launched in April 2025 with an initial five-year plan.

Indicator Name	Bham Value	Rating
Proportion of eligible adults with a learning disability having a GP health check (%)	46.4	
Smokers that have successfully quit at 4 weeks	261.9	
Emergency hospital admissions for coronary heart disease, standardised admission ratio (per 100,00)	462.1	
Fuel poverty (low income, low energy efficiency methodology)(%)	24.0	
Percentage of people with type 2 diabetes aged 40 to 64	49.5	
Percentage of adults from ethnic communities with Type 2 Diabetes	52.0	
Under 75 mortality rate from heart disease (Persons, 3 year range, per 100,00)	54.1	
Rate of long-term musculoskeletal problems (%)	17.7	

Governance

- Due to the broad scope of this theme, there is not a single partnership with delivery responsibility. Responsibility is held across several partnerships and groups including:
    - Birmingham & Solihull CVD Programme Board
    - Birmingham & Solihull Tobacco Control Alliance
    - Birmingham Smoking Cessation Task Group
    - National Diabetes Prevention Programme Board

Ageing and Dying Well

Highlights

- Continued progress on delivery of the Compassionate Cities Charter with a city-wide Steering Committee, including a Compassionate Cities Conference in July 2023.
- Development of a Death Literacy Index (DLI) by Compassionate Cities UK to understand levels of awareness around death, end of life care and bereavement in the city.
- Delivered webinars in January 2024 on brain health and dementia prevention in co-ordination with the Birmingham & Solihull Dementia Interface Pathway Group.
- Healthy Ageing survey conducted across the city to identify key priorities to help shape and citywide Ageing Well strategy currently underway.
- A Wellbeing Zone was established in September 2023 within the Library of Birmingham to provide information on health and wellbeing and a space to hold meetings and talks.
- Creative Arts and Health workshops run once a month with focus on bereavement and arts activities.

Indicator Name	Bham Value	Rating
Carer-reported quality of life score for people caring for someone with dementia	N/A	
Population vaccination coverage - Flu (aged 65+)(%)	67.9	
Estimated dementia diagnosis rate (aged 65 and over)(%)	62.7	
Carer-reported quality of life score (out of 12)	6.7	
Percentage of adult carers who have as much social contact as they would like (65+ yrs)(%)	23.3	
Emergency hospital admissions due to falls in people aged 65 and over (Persons, 65+ yrs)(per 100,000)	2,136.9	
Excess winter deaths index (Persons, All ages)(%)	9.0	
Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check (%)	43.6	

Governance

- At present, there is not a single partnership with primary responsibility for the delivery of this theme. However, an Ageing Well Partnership is currently being developed and it is planned to be functional by November 2024.
- Delivery of this theme is supported by various groups which will become sub-groups of the newly established partnership. These groups are:
    - Falls Prevention Steering Group
    - Dementia Interface Pathway Group
- Delivery of this theme is also supported by the Neighbourhood Network Schemes and the Compassionate Cities Steering Committee.

Conclusion and looking ahead to next year

The second full year of the Joint Health and Wellbeing Strategy's delivery has seen multiple positive developments, primarily through the launch of thematic-based strategies. These are providing greater focus on how the ambitions of each theme can be practically delivered alongside co-ordinating the right people, organisations, and resources towards these ambitions.

Similarly, actions originating from the Health and Wellbeing Board Development Day in May 2023 have allowed for the establishment of an Executive Group to better streamline items and reporting to the full Board. This has allowed more time at each meeting to have more detailed and comprehensive discussions on key items. These actions have also encouraged greater clarity of the relationship the Health and Wellbeing Board has with other strategic and/or statutory bodies in the health and care system. These relationships have been formalised through a Ways of Working Agreement which will be presented to the Board in late 2024.

Another major action has been to assess the current structure of the Health and Wellbeing Board Forums and refresh this structure to better align to the themes and ambitions of the Joint Health and Wellbeing Strategy. This has been achieved so far through a survey and engagement with forum members, HWB members and other relevant stakeholders. The findings from this survey and Forums Refresh Proposal will be presented to the Board in late 2024 for comment and approval.

Finally, there are a number of internal and external issues which the Board will need to consider moving forward. With the Joint HWB Strategy, there will need to be a consideration of how progress is measured with indicators that are no longer suitable (particularly in Theme 4). There will also need to be a reflection on how the Health and Wellbeing Board can adopt greater oversight over delivery in the life course themes, although the refreshed structure should assist in that. Finally, there are external considerations for delivery including a new UK government, which may alter the national context, and locally there are significant ramifications from Birmingham City Council's financial situation. Both of these considerations will be discussed at the next Health and Wellbeing Board workshop in November 2024.

BIRMINGHAM HEALTH AND WELLBEING BOARD

Appendix 1: Summary of Health and Wellbeing Board Activity

July 2023

Full Health and Wellbeing Board Meeting (Link to agenda & papers)

- *Birmingham Children and Young People's Plan*
- *Birmingham and Solihull ICB Joint Forward Plan*
- *West Midlands Police: 'Right Care, Right Person' Model*
- *Better Care Fund – End of Year Return 2022/23*
- *Better Care Fund Plan 2023-25*
- *Birmingham and Solihull Child Death Review Team and Child Death Overview Panel Annual Report 2021-22*
- *Birmingham and Solihull ICB Joint Capital Plan 2023-24*

September 2023

Full Health and Wellbeing Board Meeting (Link to agenda & papers)

- *Health and Wellbeing Board Development 2023-24*
- *Joint Strategic Needs Assessment Update*
- *Draft Birmingham and Solihull ICB Enabling Primary Care Strategy*
- *Fast Track Cities+ Update and Action Plan*

November 2023

Full Health and Wellbeing Board Meeting (Link to agenda & papers)

- *Birmingham and Solihull Winter Pressures Update*
- *Midlands Metropolitan Hospital Update*
- *Creating an Active City Strategy Consultation*
- *Creating a Healthy Food City Forum Annual Update*
- *Birmingham Children and Young People's Partnership Update*

December 2023

HWB Executive Group Meeting (Non-public meeting)

March 2024

Full Health and Wellbeing Board Meeting (Link to agenda & papers)

- *Director of Public Health Annual Report 2023-24*
- *Birmingham & Solihull ICB Joint Forward Plan Update*
- *Creating an Active Birmingham Strategy – Consultation Findings and Final Strategy*
- *Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) Progress Update*
- *Pharmaceutical Needs Assessment (PNA) Update – Supplementary Statement*
- *Health and Wellbeing Board – Executive Board Papers (Dec 2023)*

May 2024

Full Health and Wellbeing Board Meeting (Link to agenda & papers)

- *'Creating a City without Inequality' Forum Annual Update*
- *Learning Disabilities Deep Dive Report*
- *Compassionate Cities Update*
- *Birmingham Place Committee Update*
- *Better Care Fund Quarter 3 Report*

BIRMINGHAM HEALTH AND WELLBEING BOARD

Information Items

	Agenda Item: 14
Report to:	**Birmingham Health and Wellbeing Board**
Date:	**26th September 2024**
TITLE:	**HEALTH AND WELLBEING BOARD EXECUTIVE GROUP SUMMARY REPORT**
Organisation	**Executive Group of Birmingham HWB**
Presenting Officer	**Dr Clara Day**

Report Type:	Information

1. Purpose:

1.1. For members of the Health and Wellbeing Board to note items that were discussed at the Executive Group meeting on 19th August 2024.

2. Implications (tick all that apply):

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

3. Commissioner's Review:

3.1. *This report is from The HWB Executive Group and therefore is not subject to review by the Commissioners.*

4. Recommendation

4.1. To note the items discussed at the HWB Executive Group meeting (there are no formal recommendations from the Executive Group from this meeting)

5. Report Body

5.1. **Background**

To better facilitate the responsibilities of the Health and Wellbeing Board, an Executive Group has been established to support the streamlining of decision making by the Health and Wellbeing Board.

The Executive Group met virtually on the 19th August 2024. The agenda, attendance list and discussion summary can be found below.

5.2. **Agenda**

Items that were discussed at the Executive Group are as follows:

- Birmingham & Solihull Community Care Collaborative
- Annual Review of JHW Strategy & HWB Governance
- Planning for HWB Discussion on BCC Savings Plan 2025/26

5.3. **Attendance**

Name	Role	Organisation
Dr Clara Day (Chair)	Chief Medical Officer	NHS Birmingham and Solihull Integrated Care Board (ICB)
Jo Tonkin (on behalf of Dr Justin Varney)	Deputy Director of Public Health	Birmingham City Council
Andy Cave	Chief Executive	Birmingham Healthwatch
Michael Walsh (on behalf of Louise Collett)	Head of Service – Commissioning, Adult Social Care	Birmingham City Council
James Thomas	Chief Executive	Birmingham Children's Trust

5.4. **Recommendations**

There were no formal recommendations from the Executive Group to the full Health and Wellbeing Board.

Item	Recommendation	Rationale	Members present
Community Care Collaborative Implementation Plan	Note the item from Birmingham & Solihull ICs and ask that the HWB receives annual updates on progress.	The Integrated Care Board and the Birmingham Place Committee have approved the Implementation Plan so this item is to inform HWB members.	Dr Clara Day (Chair) Andy Cave Michael Walsh James Thomas Jo Tonkin
Annual Review of JHW Strategy & HWB Governance	Note both the Annual Review and HWB Forums Proposal for discussion at full HWB.	Both item relate directly to the Board's strategy and the delivery of it via forums. Therefore, it warrants a full discussion at HWB.	Dr Clara Day (Chair) Andy Cave Michael Walsh James Thomas Jo Tonkin
Planning for HWB Discussion on BCC Savings Plan 2025/26	Request Directorates at Birmingham City Council to attend HWB workshop in November 2024.	The November workshop will focus on how health and wellbeing implications can be fully considered as part of BCC Savings Plan for 2025/26.	Dr Clara Day (Chair) Andy Cave Michael Walsh James Thomas Jo Tonkin

6. Compliance Issues
6.1. HWBB Forum Responsibility and Board Update
The Executive Group will submit a summary of its recommendations to every Health and Wellbeing Board that follows its meeting.
6.2. Management Responsibility
Each report outlines the relevant management responsibility.
6.3. Finance Implications

The Executive Group is supported by officers in Public Health and is part of overall support for Health and Wellbeing Board. The financial implications of each paper are considered in each report to HWB.
6.4. Legal Implications
The legal implications of each paper are considered in each report to HWB.
6.5. Equalities Implications (Public Sector Equality Duty)
The equalities implications of each paper are considered in each report to HWB.

7. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
N/a	N/a	N/a	N/a

Appendices
None

Background Papers
None

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

Alex Quarrie-Jones, Senior Programme Officer (Governance), Public Health, Birmingham City Council

	Agenda Item: 15
Report to:	**Birmingham Health and Wellbeing Board**
Date:	**26th September 2024**
TITLE:	**ICS Community Care Collaborative Implementation Plan**
Organisation	**Birmingham Community Healthcare NHS Foundation Trust, on behalf of the Community Care Collaborative**
Presenting Officer	**Michael Walsh, Head of Service – Commissioning**

Report Type:	Information

1. Purpose:

1.1. To present the Implementation Plan, which describes the expected outcomes of the Collaborative, and lays out a Plan for the Collaborative's models of care and work programmes, their implementation and development.

2. Implications (tick all that apply):

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

3. Commissioner's Review:

3.1. *This report is from Birmingham Community Healthcare NHS Foundation Trust and therefore is not subject to review by the Commissioners.*

4. Recommendation

4.1. To note the implementation plan which sets out the plan for the Collaborative and to give consideration to future reporting arrangements.

5. Report Body

5.1. The vision for the Birmingham and Solihull Integrated Care System is that 'the people of Birmingham and Solihull will live longer, healthier and happier lives'. In order to achieve this vision, an important priority is the integration in local places of health and care services, to better meet the needs of individuals and local communities.

5.2. The Birmingham and Solihull Community Care Collaborative will be a key vehicle for the delivery of more holistic, integrated care, at place, locality and neighbourhood level.

5.3. The Implementation Plan builds on the Strategic Outline Case which was approved in November 2023 to set out the expected benefits and outcomes from the Collaborative's work. It describes the models of care, including the role of Localities, and the priorities of the five work programmes:

- **Integrated Teams in Neighbourhoods and Localities**
- **Intermediate Care**
- **Long Term Conditions**
- **Supporting Primary Care Development**
- **Children's Community Services.**

5.4. It should be noted that work programme 5 is not yet live, as the strategic view across CYP services has not yet been clarified by the Children and Young People's Partnership Board.

5.5. The Implementation Plan describes the scope of the Collaborative, identifying which services will be included. Where services are defined as 'out of scope', the Collaborative will not be responsible for the coordination and delivery of services but will still work closely with other services where appropriate, including with other provider collaboratives.

5.6. The Plan sets out the role that the Collaborative will take across the portfolio of services, and that in 2025/26, the Collaborative will be the Lead Provider for

- Adult Community Services (Birmingham)
- Localities and INTs
- Intermediate Care (NHS services)
- GP Provider Support Unit (pending separate Case for Change)

5.7. To enable this, there is a formal process to follow to transfer responsibilities to the Collaborative, that takes a minimum of six months.

5.8. The Implementation Plan details the current governance arrangements, and how we will ensure quality of services and quality improvement. It describes the key enabling functions, and identifies where resource will need to be identified in order to support delivery of the ambitious aims of the Collaborative.

5.9. The Plan has been developed collaboratively over the last six months, including with the Community Care Collaborative Steering Group and the ICB.

6. Compliance Issues
6.1. HWBB Forum Responsibility and Board Update
N/a
6.2. Management Responsibility
The delivery of the Implementation Plan will be managed through a multi-agency Community Care Collaborative Steering Group. Executive responsibility is with Birmingham Community Healthcare NHS Trust as the lead for the collaborative.
6.3. Finance Implications
It is anticipated that there will be a delegation of financial and commissioning responsibilities from the ICB to the Collaborative as it develops and matures.
6.4. Legal Implications
The legal framework of Integrated Care Systems is set out in the Health and Care Acct 2022. This includes a duty to collaborate.
6.5. Equalities Implications (Public Sector Equality Duty)
N/a

7. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
N/a			

Appendices
Appendix 1 - Community Care Collaborative Implementation Plan Appendix 2 – Implementation Plan Overview for Partners

Background Papers
None

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

Mike Walsh – Head of Service (Commissioning), Adult Social Care, Birmingham City Council

Community Care Collaborative

Right care, right time, right place
for the people of Birmingham and Solihull

Birmingham and Solihull Community Care Collaborative

Implementation Plan 2024/5 - 2026/7

June 2024

	Date	Changes
Version 0.1	30/05/24	First draft
Version 0.2	04/06/24	Additional sections included
Version 0.3	10/06/24	Edits and amendments for SG
Version 0.4	17/06/24	Amendments following Steering Group
Version 0.5	18/06/24	Further amendments following Steering Group
Version 0.6	26/06/24	Feedback from partners
Version 0.7		

Partners

- NHS Organisations
  - Birmingham Community Healthcare NHS Foundation Trust
  - University Hospitals Birmingham NHS Foundation Trust
  - Sandwell and West Birmingham NHS Trust
  - Birmingham Women's and Children's NHS Foundation Trust
  - Birmingham and Solihull Mental Health NHS Foundation Trust
  - Royal Orthopaedic Hospital NHS Foundation Trust
- General Practice
- Local Authorities
  - Birmingham City Council
  - Solihull Metropolitan Borough Council
- Birmingham Children's Trust
- Voluntary, Community, Faith and Social Enterprise (VCFSE) sector
  - Birmingham Voluntary Service Council
  - Community and Voluntary Action Solihull

Consultation and Approval Process

Community Care Collaborative Steering Group	13th June 2024
Birmingham and Solihull Place Committees	21st June 2024
GP Partnership Board	26th June 2024
BCHC Community Care Collaborative Committee	27th June 2024
BSol Integrated Care Board	8th July 2024
BCHC Trust Board	1st August 2024

Partner Consultation

ICB executive team	24th June 2024
BCHC Trust Leadership Team	25th June 2024
Solihull Metropolitan Borough Council – Corporate Leadership Team	25th June 2024
University Hospitals Birmingham Executive Team Trust Board	25th June July
ROH Executive Meeting ROH Trust Board	25th June 2024 1st July 2024
Birmingham City Council – Adult Social Care Management Team Children's Transformation Leadership Team	26th June 2024 Via email
SWBH Integration Committee	27th June 2024
BSMHFT Senior Leadership Meeting	1st July 2024
BVSC and CAVA - BSol VCFSE Leadership Alliance	Via email
BWCH – Chief Officers Meeting	w/c 25th June 2024
Birmingham Children's Trust Leadership Team	June 2024

Contents

Foreword from Richard Kirby, Senior Responsible Officer

Community Care Collaborative

Welcome to the Birmingham and Solihull Community Care Collaborative's Implementation Plan.

The Collaborative is the system-wide partnership of primary care, community services, mental health services, social care and the community and voluntary sector. We exist to deliver integrated care in neighbourhoods and localities that helps people to stay as healthy as possible in their own homes. This Plan sets out how we intend to deliver this mission over the next three years.

"A Bolder Healthier Future for the People of Birmingham & Solihull", the 10-year strategy for our Integrated Care System, sets out an ambition to increase healthy life expectancy for our citizens. Our "Joint Forward Plan" describes how we will work together based on two Place Committees and three Provider Collaboratives. The Community Care Collaborative is one of those collaboratives.

Our Strategic Outline Case, approved in 2023, outlined our purpose. This Implementation Plan describes how we will approach this task. It sets out our model of care based on integrated primary and community care services, early intervention and prevention and partnerships with the community and voluntary sector. We will bring this to life through five work programmes:

- integrated care in neighbourhoods and localities;
- intermediate care transformation;
- long-term condition pathways;
- supporting primary care development;
- community children's services.

These will be supported by three enabling programmes – estates, digital and workforce – to build the infrastructure that we need to support integrated care.

We are not starting from scratch and as we take forward our work programmes, we will learn from the work that we have already done with our partners. We have already established five Integrated Neighbourhood Teams, one in each of Birmingham's localities with well-advanced

plans to launch a sixth in Solihull, and each of our six localities have the core elements of a Locality Hub in place.

We recognise that we work within a diverse and complex system in which one size will definitely not fit all. It is for this reason that we have committed to support six Locality Delivery Partnerships. This will enable us to bring together local services to deliver the Collaborative's model of care in a way that makes sense to the communities they serve and to build the local relationships between clinical and professional teams that will be at the heart of a more integrated approach to care.

The Locality Delivery Partnerships will also be central to the contribution that we can make to reducing inequalities in health outcomes within Birmingham and Solihull. We will aim to understand the issues that most effect health outcomes for citizens in each locality and tailor our approach to reflect these through local partnerships. The work of the "Flourish" voluntary and community sector collaboration in West Birmingham is a good example of this approach already in action.

Developing integrated care in neighbourhoods and localities is not a "quick fix" and the approach that we set out in this plan is designed to build sustainable foundations for the future. We are committed to learning as we go and have described our approach to evaluation and outlined the measures that we will use to track our impact. I trust that, in this Implementation Plan, you will see how as a Collaborative we intend to approach integrated care in neighbourhoods and localities for the people of Birmingham and Solihull.

Richard Kirby

Senior Responsible Officer – Birmingham & Solihull Community Care Collaborative

Chief Executive Officer – Birmingham Community Healthcare NHS Foundation Trust

June 2024

1. Introduction and Context

The Birmingham and Solihull Community Care Collaborative (the Collaborative) provides a historic opportunity for our Integrated Care System to ensure that everyone has the chance to live a longer, healthier and happier life. To tackle the long-standing inequalities in health and care provision, in terms of access, experience and outcomes, it is essential that local services are better integrated and coordinated within local places.

The Collaborative is a key vehicle for the delivery of more holistic, integrated care, at place, locality and neighbourhood level. At the heart of the Collaborative is the drive to make it easier for citizens to access the care and support they need when they need it, to support more people to live well in their homes and communities, and to create space and time for clinicians and professionals to provide better care and to have a greater focus on prevention and addressing inequalities.

The Collaborative will address the holistic needs of local people in neighbourhoods, localities and places, through our C.A.R.E. approach (Appendix 1 – C.A.R.E Approach. By working together we will be more:-

- Connected – removing barriers, working together in local places;
- Accessible – making it easier for people to access the care they need, when and where they need it;
- Responsive – providing proactive, personalised care;
- Empowering – supporting everyone to live a happy, healthy life.

The Collaborative will enable us to create clarity and visibility about shared needs and responses, to act as an influential voice on behalf of community care within the system and to foster strong connections and a climate of trust between a wide range of service providers.

In November 2023 the Integrated Care Board approved the Strategic Outline Case (SOC) for the Collaborative[1]. The SOC set out a vision for the Collaborative as an all-age partnership focused on the development of integrated care in neighbourhoods and localities that enables people to live well in their homes and local communities. The Collaborative will develop models of care that promote early intervention and prevention with more timely access to the right care and support as local to where people live as possible, and reduce health inequalities.

The Collaborative brings together a wide range of health and care providers from primary medical care, community physical and mental health services, social care, acute care and the voluntary, faith, community and social enterprise sector. Hosted by BCHC, we are developing the Collaborative as an inclusive partnership of all providers, with community involvement and participation running through everything we do. A summary of our purpose and approach is included in the infographic below.

[1] Strategic Outline Case (2023) available at https://www.bhamcommunity.nhs.uk/download.cfm?doc=docm93jijm4n6339

Community Care Collaborative

Providing the **right care** at the **right time** in the **right place** for the people of Birmingham & Solihull

The Vision

To deliver integrated care in localities and neighbourhoods to support people to live well for longer in their own homes

C **CONNECTED** removing barriers and working together in local places

A **ACCESSIBLE** making it easier for people to access the care they need when they need it

R **RESPONSIVE** providing proactive and personalised care

E **EMPOWERING** supporting everyone to live a happy and healthy life

Integrated teams in localities and neighbourhoods	Intermediate care transformation	Long term condition pathways	Supporting primary care development	Community children's services

Birmingham and Solihull Integrated Care System
Caring about healthier lives

www.birminghamandsolihullics.org.uk

The national and local context was set out in the SOC as well in the ICP's Ten Year Strategy so is not repeated in any detail in this Implementation Plan. However, it is important to reference the diverse communities and population within Birmingham and Solihull, noting that these include areas of high deprivation, where people have significantly lower life expectancy and lower healthy life expectancy than the national average, and experience significant health inequalities. As we develop the Collaborative, focusing our support on the areas that need us most, to address and reduce the inequalities that exist, is a core aim.

The infographic above also shows the five key work programmes, agreed through the SOC, that the Collaborative will deliver over the next three years.

1. Integrated Teams in Localities and Neighbourhoods
2. Intermediate Care Transformation
3. Long Term Conditions Pathways
4. Supporting Primary Care
5. Community Children's Services

This Implementation Plan will build on the SOC, to set out

- **Why the Collaborative exists** - the expected and desired outcomes and benefits of the Collaborative, and how we will demonstrate impact and effectiveness
- **What the Collaborative will do** - the scope of the Collaborative, and what existing and new services will be in its remit
- **How and when** –
    - Plans, where known, for each of the five work programmes for the next three years, along with current and developing models of care
    - The role of Locality Delivery Partnerships in the Collaborative and the System including the developing Locality Operating Model
    - How resources and responsibility will be transferred to the Collaborative to enable the agreed work programmes.

1.1 National Context

As we develop the Collaborative further, it is worth recognising that a number of national organisations have recently published reports on integrated care. These reports help build the evidence-base for our approach and identify some of the key issues that we will need to address in order to ensure that we succeed. Additionally the publication Next Steps for Integrating Primary Care (2022) has helped to shape our work over the past year.

In 2023, the NHS Confederation published Unlocking the Power of Health Beyond the Hospital which showed that systems with well-developed primary and community services experience reduced pressure on acute care. More recently, the King's Fund published Making Care Closer to Home a Reality setting out key changes to support the NHS to become more primary and community care based and in 2024 the Nuffield Trust published Integrated Neighbourhood Teams: Lessons from a Decade of Integration All of these reports provide useful insights into the evidence-base for

effective primary and community care that we care building into the development of integrated care through the Collaborative.

1.2 Establishing the Collaborative

The development of the Collaborative will happen largely in three broad phases:-

- **Phase 1 (Design)** – concluded December 2023. This phase concentrated on establishing a system-wide Steering Group, developing the Collaborative SOC, launching the first two work programmes, and determining and agreeing our approach for locality Delivery Partnerships.
- **Phase 2 (Build)** – this phase is expected to run through to March 2025 and includes approval of this Implementation Plan, establishing Locality Delivery Partnerships and strengthening our primary care partnership through work with the GP Provider Support Unit;
- **Phase 3 (Operate)** – this phase will run from April 2025 and will see the Collaborative progress our work programmes and support locally integrated care through Locality Delivery Partnerships and a Locality Operating Model.

2. Benefits and Outcomes of the Community Care Collaborative

Through our work so far, we believe that benefits will be delivered across a range of areas:

- Addressing historic inequities in service provision by improving access, experience and care outcomes
- Positive impact on demand to services, through the focus on prevention and early invention
- Addressing workforce challenges, through building new roles and skills and developing new careers, increasing flexibility and opportunities for our staff, and widening participation
- Improved productivity and efficiency, through reducing duplication of services and joining up care

The Birmingham and Solihull Integrated Care Board (BSol ICB) Clinical Outcomes Framework[2] described the priority areas for improvement over the next 10 years. We have mapped the five key work programmes for the Collaborative against this outcome framework. Table 1 below shows how the work of the Collaborative will contribute to and influence all of the system level ambitions.

[2] Birmingham_and_Solihull_Joint_Forward_Plan.pdf (icb.nhs.uk)

		Work programme				
System level ambition		1	2	3	4	5
Prevention	*Reduced prevalence of Smoking*	•	•	•	•	
	Increased prevalence of Physical activity	•	•	•	•	
	Reduced prevalence of Obesity	•	•	•	•	
Cancer, Frailty End of Life	*Reduced Under 75yrs mortality rate from cancer*	•	•		•	
	Increased healthy life expectancy at 65yrs	•	•	•	•	
	Increase the number of patients with End of Life Personalised Care Plans	•	•	•	•	
Mental Health	*Reduced prevalence of depression and anxiety in adults*	•			•	
	Reduced excess under 75 mortality rates in adults with serious mental illness	•			•	
	Substance misuse	•			•	
Early Years	*Reduced Infant Mortality Rate*	•			•	•
	Reduced Child / early years Mortality Rate	•			•	•
	Substance misuse	•			•	•
Respiratory Health	*Reduced prevalence of COPD*	•			•	•
	Reduced prevalence of Asthma (6yrs+)	•			•	•
Cardiovascular Health	*Cardiovascular Health (e.g. stroke, heart failure, atrial fibrillation, hypertension)*	•		•	•	
	Reduced under 75yrs mortality from acute myocardial infarction, stroke	•		•	•	
	Reduced prevalence of Diabetes	•		•	•	
Other	*Improved Patient experience*	•	•	•		

Table 1 – ICB Outcomes Framework

Table 2 below builds on the expected impact of the Community Care Collaborative work programmes as set out in our Strategic Outline Case and proposes a set of initial measures of impact for the Collaborative over the period 2024/5 to 2026/7.

- Our measures of impact will continue to evolve as the Collaborative itself develops. We will commission specific further work on our approach to outcomes and impact for citizens across our partnership.
- The initial measures aim to take account of the outcome framework in the ICS 10-year strategy and relevant existing metrics such as those associated with the Better Care Fund (BCF) and the Primary Care Right Access First Time (RAFT) metrics. The framework also seeks to take account of the priorities and outcomes frameworks of our Place Committees in Birmingham and Solihull where these are relevant to the work of the Collaborative. Finally, It reflects existing system-wide priorities relevant to the Collaborative including a commitment to improve end of life care pathways, wound care pathways and the detection and management of hypertension as our circulatory disease priority.

In developing this initial set of impact measures for the Collaborative, we recognise that there are more measures that could be included over time as the work of the Collaborative develops. These could include, for example, uptake of annual healthchecks by those eligible for these, vaccination coverage in adults and children, an expanded range of long-term condition measures, measures of oral health or measures of the effectiveness of stroke and neurological rehabilitation pathways. Whilst we have had to be selective and concentrate on measures relating to our current “live” priorities, we expect that this will continue to develop in the period covered by this Implementation Plan.

MEASURES OF IMPACT 2024/5 – 2026/7

WORK PROGRAMME	EXPECTED IMPACT (FROM OUR STRATEGIC OUTLINE CASE)	INITIAL MEASURES OF IMPACT 2024/5 – 2026/7
1. Integrated Teams in Neighbourhoods & Localities	• Improved support for high users of health and care – reducing reliance on Emergency Departments (ED) and acute admission. • Improved early intervention and prevention reducing the chances of people becoming high users. • More people supported safely and effectively in their own homes at the end of their lives.	1. People on the caseload for Integrated Neighbourhood Teams (i.e. existing high users of health and care services). 2. Emergency admissions to acute hospital for people on the caseload of the Integrated Neighbourhood Team. 3. GP consultations for people on the caseload of the Integrated Neighbourhood Team. 4. Rate of admission to residential or nursing care homes (BCF metric).
2. Intermediate Care Transformation	• Increased admission avoidance – more patients cared for at home instead of ED or admission. • Improved discharge – patients discharged home earlier with improved rehabilitation support. • Improved healthcare support for people living in care homes reducing the need for ED / acute admission for this group.	5. Urgent Community Response referrals, response time and percentage of people managed at home. 6. Time from “discharge ready” to discharge from acute hospital for Pathway 1 and Pathway 2 referrals. 7. Emergency admissions to acute care for people resident in nursing care homes. 8. Older people still at home 91 days after discharge from hospital into reablement or rehabilitation services (BCF metric). 9. Emergency admission to acute hospital following a fall for older people (BCF metric).
3. Long Term Conditions	• More people living with long-term conditions are well-supported in their community.	10. Patients with registered smoking status and proportion referred to Stop Smoking Services

WORK PROGRAMME	EXPECTED IMPACT (FROM OUR STRATEGIC OUTLINE CASE)	INITIAL MEASURES OF IMPACT 2024/5 – 2026/7
	• Reduced use of ED and acute admission by people with long-term conditions. • More people supported safely and effectively in their own homes at the end of their lives.	11. Number of people on primary care hypertension registers compared to expected incidence. 12. Proportion of people with hypertension with blood pressure and cholesterol within clinically appropriate ranges. 13. [As part of our next steps, we will develop indicators of the identification and community management of diabetes similar to those included for hypertension] 14. Percentage of deaths that occur at home or in a care home (i.e. outside of acute hospital). 15. [As part of our next steps, we will develop a measure of the quality of end of life care as well as its location]. 16. Unplanned admissions to acute hospital for ambulatory sensitive chronic conditions (BCF metric).
4. Supporting Primary Care Development	• Improving access to primary care in line with the system's Primary Care strategy. • Improved resilience in primary care workforce, estate and digital systems. • Improved interface between general practice and other providers	17. Improved wound care pathway: Urgent Treatment Centre consultations for wound care and GP prescribing of wound care related products. 18. GP appointments per 1,000 patients. (RAFT metric) 19. GP appointments: percentage offered on same day and within 14 days (RAFT metric). 20. [A measure of the sustainability of the primary care workforce to be developed]
5. Community Children's Services	• To be scoped as the programme is developed but expected to include long-term conditions and intermediate care impact for children.	21. [To be scoped as part of the future development of the Collaborative.]

Table 2 – Collaborative measures of impact

Health Inequalities

Addressing the significant health inequalities that exist across our System is a core aim of the ICS. The Collaborative's work programmes reflect the importance of reducing inequalities in health outcomes set out in the ICS 10-year strategy, the Birmingham and Solihull Joint Strategic Needs Assessments (JSNAs) and Public Health priorities and the national "Core20Plus5" approach.

The measures set out above in Table 2 will be reviewed through different lenses, and we will view access, outcomes and experience across a range of factors including

- socio-economic factors,
- geography, within and between Locality and Place. The 'system-designed, locality-delivery' model will ensure equity of offer across the System, whilst allowing for localisation to take account of local health needs.
- specific characteristics including those protected in law, such as sex, ethnicity or disability
- socially excluded groups, for example, people experiencing homelessness.

In tracking our impact we will keep a focus on our impact on inequalities. Our approach will strengthen as the Collaborative develops but in the first instance we would expect:

- to understand the characteristics of the people who make up the caseloads for our Integrated Neighbourhood Teams, ensuring that these include people for whom access to and outcomes from health and care are worst in our current model of care;
- to use a targeted approach to specific at-risk groups through our neighbourhood-level integrated teams as part of a wider population health management approach
- in developing working on smoking and the detection and management of hypertension, to concentrate on showing greatest improvement for people who the worst outcomes currently;
- in supporting improved access to primary care, to seek to ensure that access is improving for all communities and that we can show improved access to appropriate care for those communities with the poorest health outcomes.

2.1 Evidence

There is a significant body of evidence regarding the impact of integrated care models to support the expectations above. Whilst the results are mixed, there is a general trend towards positive outcomes[3; 4] (see also National Context). Measures include both performance outputs (emergency department attendances, length of stay etc.) and more specific clinical outcomes (patient experience, hypertension and diabetes control, mortality etc.).

[3] Evelien S. van Hoorn et al. Value-Based Integrated Care: A Systematic Literature Review *Int J Health Policy Manag* 2024; 13: 8038
[4] Dorling G et al (for McKinsey). The evidence for integrated care. *Healthcare Practice*. March 2015

It is important to note that evaluation of UK integrated care models[5; 6] have suggested that changes to unscheduled care activity may take between two to six years to become apparent. However, more local data has demonstrated that focused effort may produce much more rapid benefit, although these may be more resource dependant.

A summary of the available evidence is included at Appendix 2 – Collaborative Outcomes – Evidence Base.

The pilot phase of the work to date on Integrated Neighbourhood Teams has been evaluated and the early impact of the initial INTs along with more integrated working across the locality in East Birmingham is set out in the box below. Although small scale, these interventions have shown a positive impact and the Collaborative will build on our 'test and learn' approach and to scale up these successful initiatives.

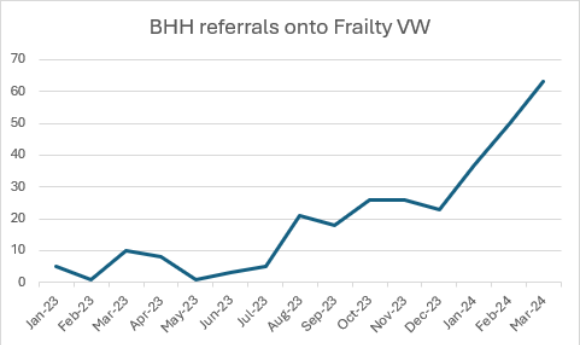
[5] The long-term impacts of new care models on hospital use. An evaluation of the Integrated Care Transformation Programme in Mid-Nottinghamshire. *Health Foundation.* September 2020
[6] Evaluation of the Dudley Multidisciplinary Teams (MDTs). *The Strategy Unit*. May 2017

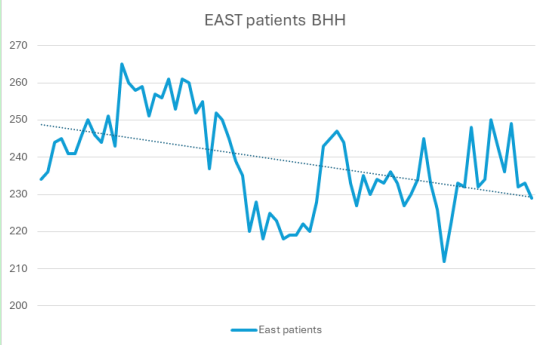
Early Impact - Birmingham

- The Case for Change for Integrated Neighbourhood Teams[1] identified that a small group (10%) of citizens are receiving up to 71% of the total system care provision across specific services, and that 45% of these individuals could benefit from support from an Integrated Neighbourhood Team.
- An initial diagnostic of our INT pilot teams[1] supported this, and further found that 80% of interventions required were medication reviews, social and mental health support, and social prescribing services, and thus demonstrating the importance of a multidisciplinary approach.
- Very early analysis is beginning to demonstrate that for those individuals supported by the INT, the number of service interventions needed has begun to significantly reduce compared with equivalent periods pre-involvement of the INT. Whilst further analysis is underway, these initial findings are very encouraging..

		GP APPOINTMENTS	A&E ATTENDANCES	INPATIENT SPELLS	OUTPATIENTS & COMMUNITY CONTACTS	CARE PACKAGES
EAST INT	PRE-INT INTERVENTION	2110	370	87	3262	8
	POST INT INTERVENTION	1372	56	31	2257	3
	VARIANCE	-738	-314	-56	-1005	-5
WEST INT	PRE-INT INTERVENTION	2951	783	145	4855	17
	POST INT INTERVENTION	2108	188	58	3597	5
	VARIANCE	-843	-595	-87	-1258	-12
TOTAL	PRE-INT INTERVENTION	5061	1153	232	8117	25
	POST INT INTERVENTION	3480	244	89	5854	8
	VARIANCE	-1581	-909	-143	-2263	-17

- During winter 2023, the system undertook a “perfect week” initiative in the East locality, which provided the locality team with far greater visibility on where and how their locality citizens were accessing urgent and emergency care, and therefore how to join teams and services up to better support this demand.
- The results saw improvement across a number of settings including those frequently attending the Emergency Department, the number waiting in acute assessment facilities as well as the number of patients staying in hospital for over seven days.
- Coordinating teams and services better also saw a substantial increase in referrals to the frailty Virtual Ward and therefore allowing more people to be receiving their care at home
- Underpinning the initiatives above was therefore a reduction in the overall number of citizens from the East locality residing in a hospital bed, by providing integrated care closer, or at home





3. Community Care Collaborative Model of Care

The Birmingham & Solihull Community Care Collaborative is the system-wide, all-age partnership of primary care, social care, mental health services, community health services and the community and voluntary sector. It exists to deliver integrated care in localities and neighbourhoods to support people to live well for longer in their own homes.

In developing our plans for the Collaborative, we have worked with partners and stakeholders on the principles that will guide our model of care. These are set out in our C.A.R.E. approach.

- **C**onnected – removing barriers and working together in local places;
- **A**ccessible – making it easier for people to access the care they need when they need it;
- **R**esponsive – providing proactive and personalised care;
- **E**mpowering – supporting everyone to live a happy and healthy life.

As we have developed the Collaborative we have designed a "model of care" based on these principles to support us to deliver our ambition. This section of the plan sets out that model of care. The Collaborative model of care is based on the following elements.

1. Focusing on a "whole person" approach that brings together the physical and mental health needs of our citizens and seeks to design services that bring a bio-psycho-social approach to the understanding of people's strengths and needs for support. (**Empowering**)

2. Developing easy access to appropriate care and advice from primary care and community services when people need it. This will build on existing work to improve access to multi-disciplinary teams in primary and community care including appropriate access to same-day and urgent care and support for those who need it. (**Accessible**)

3. Developing pro-active, personalised care from multi-disciplinary and multi-organisational teams for people with complex needs including long-term conditions. Our model of care aims to identify those with the most complex needs making greatest use of health and social care services and use our integrated neighbourhood teams to provide care that better supports them to live well in their communities. (**Responsive**)

4. Strengthening our approach to community-based prevention and early intervention in ways that support people to stay well at home. This approach will build on local partnerships to understand the needs of the neighbourhoods and localities that we serve and design local approaches to prevention and early intervention. It will include work to develop models of self-care empowering people to look after their own health (learning from the experience of the BCHC supported self-care team in community nursing) (**Empowering**).

5. Bringing together intermediate care services to avoid emergency admissions to hospital, support early discharge and promote rehabilitation and recovery. We will build a co-ordinated, locality-based approach to intermediate care based on a “home first” approach and a focus on maintaining independence, rehabilitation and recovery (**Responsive**).

6. Building partnerships with the community, voluntary, faith and social enterprise sector to deliver support in ways that work with local groups who know and understand the people who live in their community (**Connected**).

7. Focussing on those citizens and communities who most need support as we play our part in the wider work of the Integrated Care System to reduce inequalities in health outcomes in Birmingham and Solihull. As the Collaborative develops we will aim to focus our efforts on those communities that most need our support (**Empowering**).

3.1 Locality Operating Model

To enable us to deliver this model of care in practice we have developed a “Locality Operating Model” (LOM) for our system. It is based on the following levels of provision.

- **General Practice**. The GP practice is the core unit for primary and community care services working together to meet the needs of our patients and citizens. Through the GP Provider Support Unit and our Primary Care work programme we will work to support the sustainability and effectiveness of practices.

- **Neighbourhood**. Neighbourhoods of 30,000 – 50,000 people form the next level of our model. We will increasingly align neighbourhoods and Primary Care Networks and each neighbourhood will be supported by an Integrated Neighbourhood Team approach. Voluntary and community organisations and services providers will be linked to our neighbourhood teams. Whilst we will develop neighbourhoods with some flexibility to local circumstances, we expect that there will be c. 35 neighbourhoods across Birmingham and Solihull.

- **Locality**. Localities of c. 250,000 – 300,000 people are the third level of our model. Localities will support neighbourhoods to operate effectively (there will be 5-6 neighbourhoods in each locality) and will be the level at which we deliver more specialist services including intermediate care services working closely with the local acute hospital. Our system will have six localities each of which will be supported by the development of a locality hub. Each locality will also develop a dedicated local voluntary and community sector partnership.

Our LOM builds upon the principles within the Fuller Stocktake to deliver an offer for episodic or same day urgent care built around our neighbourhoods and localities as well as increasing our capacity for continuity of care and prevention. It will include all system partners across primary, secondary and community care, mental health, local

authorities and the voluntary sector (VCFSE), to provide care closer to the neighbourhoods and communities we serve and support the move towards more localised coordination and decision making. An emerging LOM has been developed with system partners (Figure 3) and it is anticipated that there will be further iterations of the model, with various elements being refined or added as the work programme progresses.

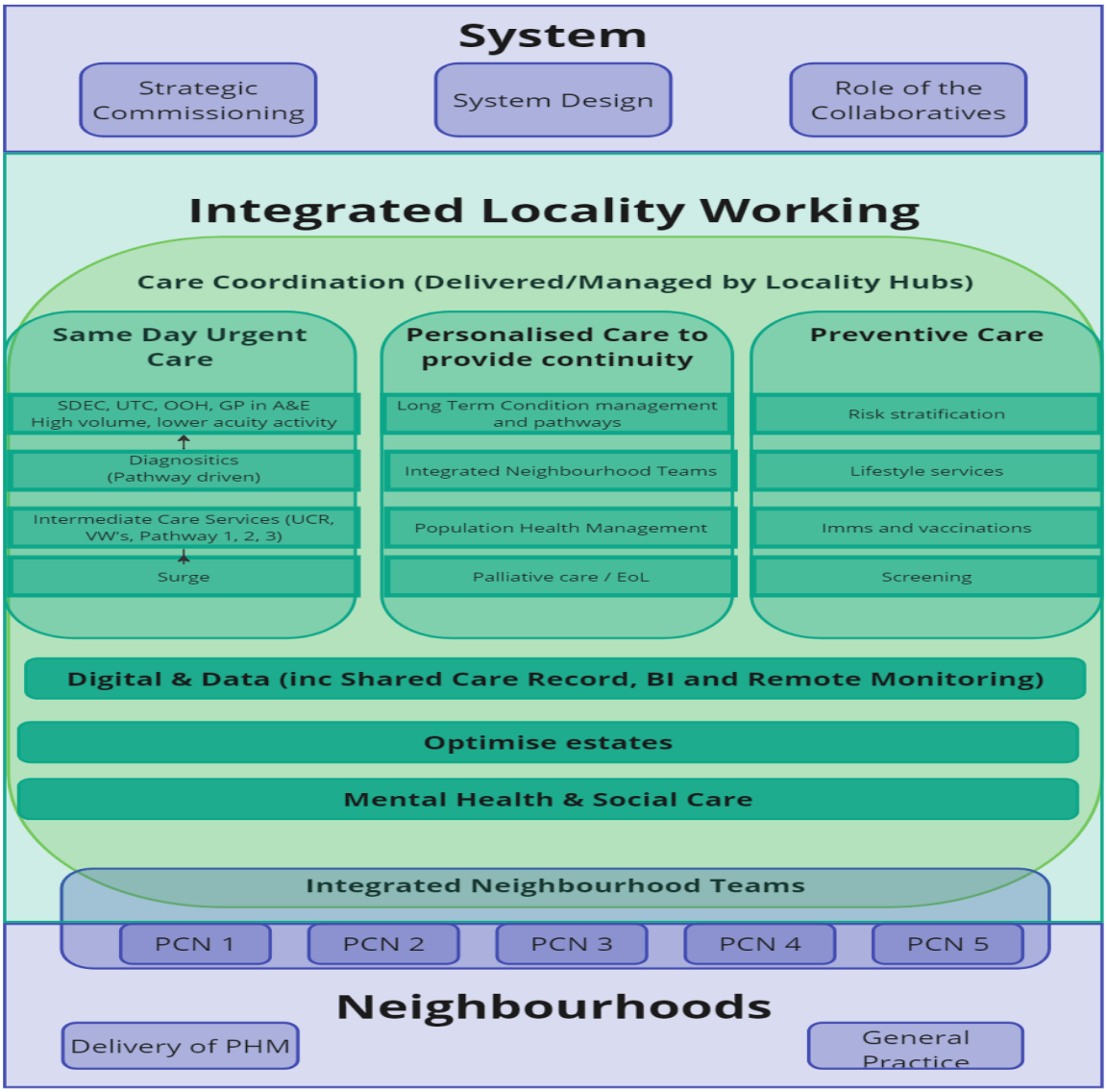


Figure 3 – Locality Operating Model April 2024

The Locality Operating Model will also be key to tackling health inequalities, with our Integrated Neighbourhood Teams evolving to be the 'delivery arm for targeted Population Health Management (PHM)'.

Locality Hubs

An important feature of the Locality Operating Model is the **locality hub**, with one planned for each of the six localities across Birmingham Solihull. A locality hub system design group is working to develop and oversee a standardised approach to the hubs including how the hubs can better co-ordinate care across each locality

taking account of existing provision locally, e.g. in general practice. It is envisaged that, as a core offer, they will deliver:

- A care coordination function across the locality (including the provision of an interface for general practice and acute hospital sites).
- A physical location for locality based long term condition management, whilst also providing oversight from supporting satellite sites.
- Same-day urgent treatment capacity for the Locality.
- The ability to mobilise surge capacity for the locality based on increases in hospital and primary care demand.
- A potential base to act as the locality 'HQ'.

The locality hub infrastructure will enable neighbourhood-level integrated teams to target specific at-risk groups as part of a wider population health management approach, which is a fundamental enabler for the Collaborative's role in addressing health inequalities.

3.2 Locality Delivery Partnerships

The vision for integrated working at a population level of 250,000 – 300,000 was set out by NHS England back in 2019[7] and has been part of the Birmingham and Solihull system operating model since the inception of the Integrated Care System (see figure 4 below; note – the term 'integrator' has been superseded by 'Collaborative'.)

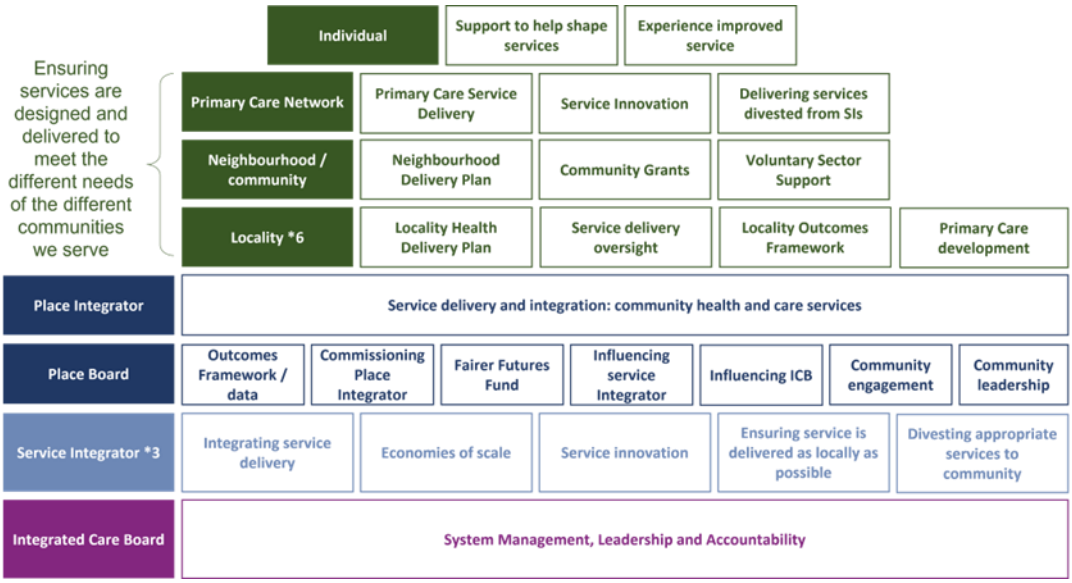


Figure 4 – ICS Operating Model

The Birmingham and Solihull Integrated Care Board Joint Forward Plan (2023)[8] set out the role of the Community Care Collaborative in 'bringing together services run by multiple organisations to work together as one team to support the delivery of services' working at this 250,000 – 300,000 population level.

[7] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf

[8] Birmingham_and_Solihull_Joint_Forward_Plan.pdf (icb.nhs.uk) https://www.birminghamsolihull.icb.nhs.uk/application/files/9516/9176/8128/Birmingham_and_Solihull_Joint_Forward_Plan.pdf

The Community Care Collaborative has established six Locality Delivery Partnerships that are accountable to the Collaborative Steering Group. The Locality Delivery Partnerships (LDPs) also have a strong link to the Birmingham and Solihull Place Committees and to the GP Partnership Board.

Whilst the LDPs are at different stages of maturity across the BSol system, they are bringing together providers of primary care, social care, community physical and mental healthcare, the voluntary, community, faith & social enterprise sector, and secondary care where care coordination across providers is key for patients, service users, their families and wider citizens.

The purpose of the LDP as per their terms of reference is to:

- Focus on delivery and be a “unit of action”; with each LDP developing an annual delivery plan linked to the Collaborative key Delivery Priorities and taking into account local population demographics.
- Have an outcome focus and encourage a preventative and proactive approach.
- Drive integration and quality improvement.

Establishing the Collaborative model of care across Birmingham and Solihull to improve the care we provide to support people to stay well at home, is a significant task that we expect will take the full three-year period of this Implementation Plan.

The LDPs will also be a place where the different system Collaboratives (Mental Health Provider Collaborative and Acute Provider Collaborative) can come together. As key members from each will be included in the LDPs this will be an opportunity for coordination with out-of-scope programmes of work, and visibility of the work of other collaboratives.

Starting from our C.A.R.E. approach designed with partners, building on the principles for our model of care described in this section and developing the Locality Operating Model and Locality Delivery Partnerships will, we believe, enable us to deliver the ambitious shift in the way we deliver care in our system that is the ambition of the Collaborative.

4. What the Collaborative Will Do

4.1 Scope

The Collaborative’s five programmes of work were agreed in the Strategic Outline Case, and are described in greater detail in section 5. We expect this to continue to evolve as the Collaborative develops through the period covered by this Plan.

This section therefore describes what current services are in and out of scope for the Collaborative, for delegation of commissioning responsibilities from the ICB, and what roles we anticipate the Collaborative and BCHC will play in each case over the next three years as the Collaborative continues to mature and system confidence grows in the Collaborative’s ability to deliver benefits for citizens, patients and service users. It should be recognised that a wider range of services than those that

"in scope" for delegation are covered by the partnership and transformation work of the Collaborative. Community mental heath services, for example, will not be directly commissioned by the Collaborative but are a vital part of our integrated neighbourhood and locality teams.

In Scope	Out of Scope
• Integrated Teams in Neighbourhoods and Localities • Intermediate Care (NHS-funded) • Intermediate Care (council-funded) • Urgent care* • Primary Medical Care development (GPPSU) • Adult Community Services • Long Term Conditions • Children's Community Services	• Children's Community Services where jointly commissioned with LA • Mental Health Services • Primary Care Contracting & Performance • Continuing Healthcare (CHC) Packages of care • Learning Disability and Autism Services (these will sit in the MH Collaborative) • Services outside of BSol footprint

See table 7

Figure 5 - Scope of Collaborative

*subject to UEC review

Where services are included in 'out of scope' above – the Collaborative will not be responsible for the delivery or coordination of these services. However, Collaborative partners and services will still be working closely with other services (for example mental health practitioners are a key part of the INT).

It should be noted that there are naturally interdependencies with the other provider collaboratives in the system (Acute Provider Collaborative and Mental Health Provider Collaborative) and with other programmes of work in the system. As the governance around LDPs and the Collaboratives develops it will be important to consider how these are managed in a pragmatic and effective way.

4.2 Role of the Collaborative

As described in the Strategic Outline Case, the Collaborative may take a variety of roles, dependent on factors such as where and how existing services are commissioned, the number of providers involved, and the benefits that a single provider might bring. Of the four potential models described in the SOC, we have identified that two of these will be applicable for the Collaborative over the next three years.

The role of the Collaborative will evolve over time as the Collaborative matures. The Collaborative will play two key roles as **Lead Provider** (taking responsibility for the budget and tactical commissioning and contracts of a portfolio) and **Programme**

Enabler (coordinating operational integration across system-partners at a local level).

The intentions are depicted in Table 6; with dates subject to confirmation.

Table 6 – proposed role of Collaborative

Portfolio Area	24/25	25/26 (TBC)	26/27 (TBC)
Localities and INTs			
Intermediate care: NHS services	100 Day Challenge, UEC Review (ICB led)		
Intermediate care: council-commissioned services			
Urgent care	100 Day Challenge, UEC Review (ICB led)		
Primary Medical care development	Pending separate case for change	April 25	
Adult community services (Bham)*		April 2025	
Adult community services (Solihull)*		April 2025	
LTC programme			
Children's community services**		To be decided	

Key	Position	Descriptor
	Lead provider – responsible for services	Receiving transferred responsibility from the ICB for the tactical commissioning, contracting, quality assurance and financial management of a specified portfolio.
	Programme Enabler – oversight and coordination	The Collaborative plays a convening role that better enables stakeholders to align their own decision making and delivery activities. Budgets, resources, accountability remains with individual organisations
	Status quo	Providers to work as active partners in commissioner-led programmes

*The ICB is leading a review of Community services, including future arrangements for commissioning and provision. The Collaborative will work with the ICB to determine the most effective and appropriate models of commissioning and delivery of services and to include the outcome of this review in our future development.

**As shown above (and detailed in section 5.5), the long-term vision is that Children and Young People's (CYP) community services will, ultimately, be in scope for the Collaborative. However, the ICB's Children and Young People Partnership Board is currently being established and will provide a strategic view on CYP services and the role of the Collaborative. CYP services are therefore not being brought into the Collaborative at this point; plans will be developed and approved through the Collaborative Steering Group.

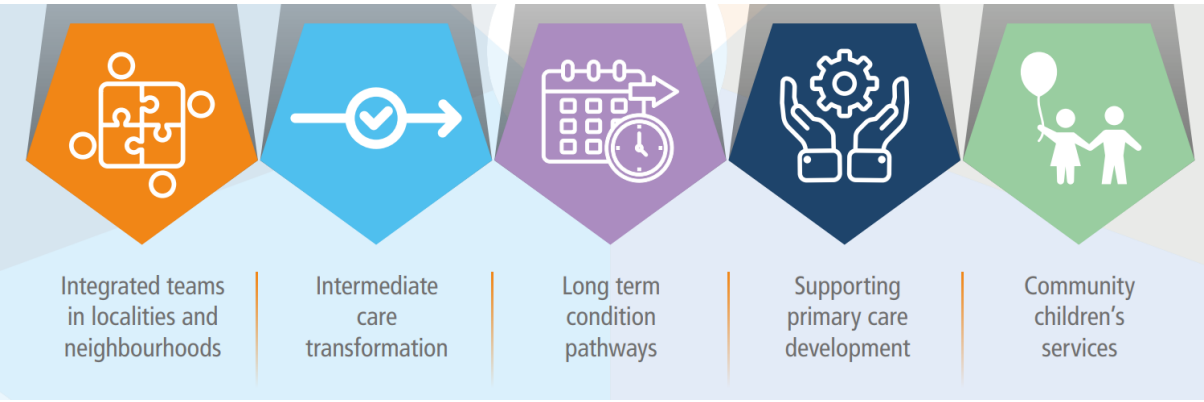
Table 7 shows in more detail which services are included under the high-level headings in Figure 5, and where commissioning and provision responsibilities for these services currently sit.

	Localities and INT	Intermediate Care	Urgent Care	Supporting Primary Care Development	Adult Community Services		Long Term Conditions	Children's Community Services
					Birmingham	Solihull		
Services included	• Non-recurrent INT • Non-recurrent Locality Hubs • Place Support Teams	• P1 Home Care (NHS/council-commissioned) • P2 Intermediate Care Beds • Care Home Support (Solihull) • Discharge Outside Pathway • Virtual wards • UCR • Care Coordination Centre	• UTCs • GP OOH • GP streaming at EDs	• GP Provider Support Unit • ARRS coordination	• Community Nursing • Specialist Nursing • Therapies • Community In-patient • Early Intervention Team • Long Covid	• Community Nursing • Specialist Nursing • Therapies • Community Inpatient	• CVD / Stroke • Diabetes • Respiratory • End of Life	• *Detail of portfolio TBC*
	Aligned VCFSE Contracts							
Commissioners	ICB BCF	ICB Local Authorities BCF	ICB	ICB	ICB	ICB	ICB	ICB Joint commissioning Local Authorities
Providers	BCHC General Practice VCFSE	BCHC UHB VCFSE	BCHC Various Independent	ICB (currently)	BCHC VCFSE	 UHB VCFSE	BCHC General Practice UHB VCFSE	BCHC UHB VCFSE

Table 7 – Portfolio overview

5. Work Programmes

As agreed through the SOC, there are five work programmes currently in the Collaborative as shown below. The aim of each work programme, intended models of care, and current stage of development are set out in this section. The detail of the work programmes over the next three years is laid out in detail in section 7.



As shown in the Introduction, overall the Collaborative is in the 'build' phase. However, our work programmes are at different stages of development, as is shown in this section, with a summary below.

Work Programmes		Design	Build	Operate
Integrated Teams in Neighbourhoods and Localities			✓	
Intermediate Care			✓	
Long Term conditions		✓		
Supporting Primary care Development			✓	
Children's Community Services		✓		
Enabling Programmes	**Estates**	✓		
	Digital	✓		
	Workforce	✓		

Table 8 – Stages of the Collaborative Work Programmes

5.1 Integrated Teams in Neighbourhoods and Localities - Work Programme 1

5.1.1 Delivering the Locality Operating Model

The Locality Operating Model (Section 3.1) will bring health and care services together at neighbourhood and locality level, across all sectors, to better meet the needs and preferences of the diverse communities within Birmingham and Solihull.

Work Programme One will build Integrated Neighbourhood Teams and Locality Hubs along with their supporting infrastructure, coordinating health and care services to provide care more effectively and efficiently, supporting better access, experience and outcomes for citizens.

The initial phase will focus on bringing together services for adults, based on the concept that existing services and importantly the people working in them will be better connected and will feel like one locality team. Core to this model will be the design, development and delivery of Locality Hubs and Integrated Neighbourhood Teams.

Work Programme One will also co-ordinate better utilisation, and flexible use of, public estate, with a focus on primary care centres and community care bases. This will include the re-development of Sutton Cottage Hospital as a hub for services for older people (in the North Birmingham locality) and the planned 'Kingshurst Integrated Community, Health and Wellness Hub' in north Solihull (See Section 8.3.6).

5.1.2 Integrated Neighbourhood Teams

Fundamental to delivery of the LOM will be the development and mobilisation of our Integrated Neighbourhood Teams (INTs).

With support from Newton Europe and extensive engagement from clinical colleagues we have developed a model for Integrated Neighbourhood Teams. Our INTs are broadly aligned to Primary Care Networks and bring together GPs, community health services, community mental health services, social care and links to the community and voluntary sector. Our prototype teams have started by reviewing the care we provide for those people who make the greatest use of health and social care in each neighbourhood currently. Our design work has demonstrated the potential to make an impact by better integrated care including more joined up work with community and voluntary sector partners,

There is currently one INT across each of the five Localities in Birmingham and work is underway to mobilise an INT in Solihull (expected mobilisation Summer 2024). The INT model works on the basis that there will be aligned resource within an INT which will deliver expertise and intervention(s) at a Neighbourhood/PCN level.

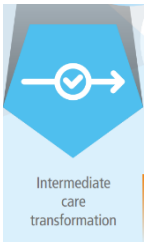
- For the future roll out of the model, system partners are in agreement that realigning existing resource for social care, mental health, GP and community health services will deliver the core roles of an INT. Neighbourhood experts

and neighbourhood coordinators could be delivered through locality-wide arrangements with the voluntary sector or hosted by a partner organisation within the community care collaborative.

- There are two crucial roles within the model which will require recurrent investment to support further roll-out; the Neighbourhood Expert and Neighbourhood Co-Ordinator roles. A summary of all the roles within the INT (including the new roles referenced above) is included in Appendix 3.

As detailed in Section 2, the development of integrated teams must be aligned to improving outcomes for patients and citizens, and the initial focus will be on supporting those High Intensity Service Users with complex care needs who are making the greatest current use of health and social care services.

5.2 Intermediate Care - Work Programme 2



As part of the system-wide Urgent and Emergency Care (UEC) programme, overseen by the UEC Board, the Collaborative will deliver Intermediate Care across BSol. System partners have developed a vision for Intermediate Care across BSol, as below:

To offer a consistent Intermediate Care service across Birmingham and Solihull, which is locality led in its delivery and supported by Place and System infrastructure.

Services will be designed to ensure that they reflect the needs of their local community and support people to receive the appropriate care and rehabilitation they need, in a seamless way, that will deliver the best possible outcomes and help people return to or remain in their own home.

It will have the following features:

- A single, integrated Intermediate Care model across Birmingham and Solihull, which is locality-led in its delivery, supported by Place and System infrastructure.
- A single point of access and referral into the service, which is responsive and simple to navigate.
- A workforce that can work flexibly across intermediate care, following the person from hospital to community bed and/or directly home, with a locality focus, and independent of organisational setting.
- An inclusive model which does not exclude individuals based on whether they have a particular condition, are a certain age or live in a particular environment.
- A service based upon professional trusted principles between teams to minimise assessment and duplication and ensure information.
- A service that drives a reduction in health inequalities by ensuring equity of access and provision across a locality footprint.

- A service that sets, agrees and delivers consistent standards, performance and objectives across the BSol System.

5.2.1 Model of Delivery

The vision of a system-wide Intermediate Care service that is locality delivered, is something that system partners have been working towards since 2023/24. As shown in section 4.2, to deliver the Intermediate Care programme, it is proposed that BCHC (on behalf of the Community Care Collaborative) will become the Lead Provider for all NHS-funded elements of Intermediate Care services.

The future model will be intrinsically linked to locality hubs and Integrated Neighbourhood Teams (INTs), as outlined under work programme 1. It will ensure alignment with other models of care e.g. community nursing, primary care, community mental health, by delivering a cohesive set of services across the locality geographical footprint.

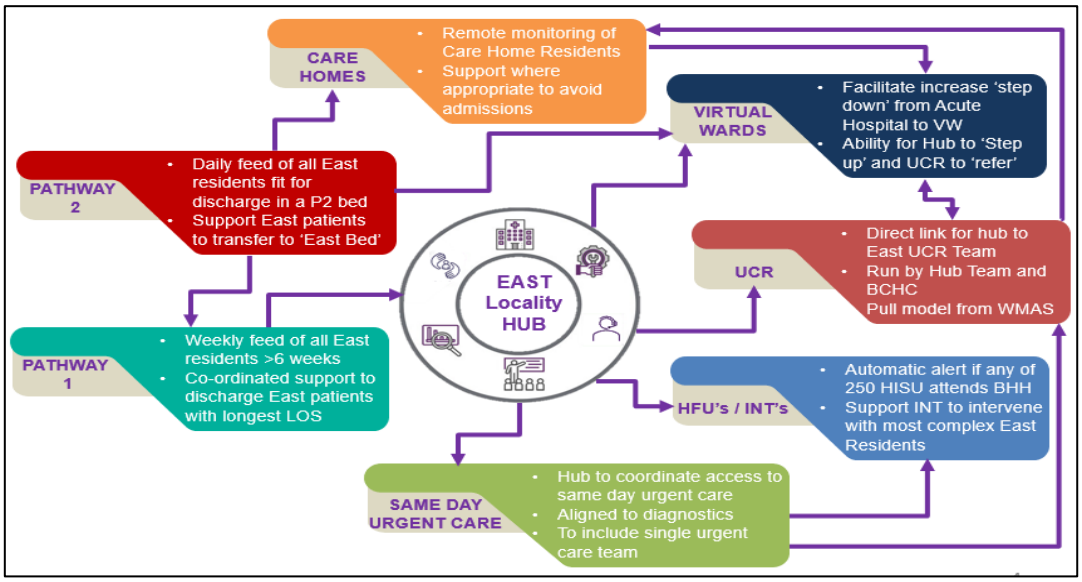


Figure 9 – Intermediate Care Services

Figure 9 provides a representation of the range of intermediate care services that will come together to form the Intermediate Care Team within each locality. Our intermediate care vision includes improved care and support for people living in care homes to reduce their need for emergency admission to acute care.

5.2.2 Focus in 2024/25

The aim is to have Intermediate Care services which are system-designed and locality-delivered. As part of the development of the Locality Operating Model, the Collaborative will pilot a locality-based Intermediate Care Team in one area, working in partnership with the local acute hospital, with the aim of improving patient outcomes and locality-level patient flow over winter 2024/25.

The table below provides an overview of progress towards this approach and identifies that further work is required to support a system-design model for pathway 1 (home discharge services) and pathway 2 (intermediate care beds):

Services	System Designed	Locality Delivered
Pathway 1 – Home discharge	✖	The proposed locality operating model will aim to bring the different services together to deliver a single, locality-based service.
Pathway 2 – Intermediate care beds	✖	
Care Coordination Centre	✖	
Virtual Wards	✓	
Urgent Community Response	✓	
Single Transfer of Care	✓	

Table 10 – Intermediate Care status

For 2024/25, the priorities and scope for the Intermediate Care work programme encompasses four components (Table 11)

Pathway 1 - Home Discharge	Pathway 2 - Intermediate Care Beds*	Locality Operating Model	Remote Monitoring
•To develop a consistent service model for Pathway 1 discharges and 'step up' support for patients across Birmingham & Solihull •To develop an Operational delivery model which is Locality based, across all relevant providers	•To progress P2 bed strategy for circa 480 beds (inc mobilisation of Solihull P2 beds) •Initial focus on Care Centre model and developing a consistent model & approach •Future phases to incorporate Sub-Acute and Specialist step down beds	•Create a single, consolidated 'Unplanned' team across a Locality (UCR, VW's, EICT, P2) •Integrate wider Collaborative components e.g. Locality Hub, INT etc	•Utilise West Mids Regional funding for RM •Roll out Docobo to 80% of Care Homes in E,W &Sol •Develop tech anabled support for P2 bed model

Table 11 – Priorities for Intermediate Care

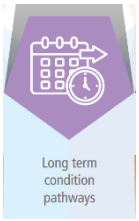
5.2.3 Intermediate Care Beds

A key priority for the work programme is the better organisation and provision of the Intermediate Care beds across BSol. The table below outlines the 3 phases to undertake this work.

	Beds / Units	What	Facilities	No. of beds	Approach
Phase 1	**Rehabilitation & further assessment (via Care Centres)**	Patients / citizens who we aim to get home but require a period of rehabilitation / recovery to maximise independence or require further assessment of care needs	• Anne-Marie Howes • Perry Trees • Norman Power • Kenrick Centre • CU27	156 beds (B)	Initial area of focus for Intermediate Care Programme – P2 Beds Predominantly Care Centre provision, working with BCC
	EAB / Nursing	Assessing longer term care and support for citizens who require nursing	• Abbey Rose • Aran Court • Solihull (Various)	22 beds (B) ~60 beds (Sol)	Short-medium term solution in Solihull at Solihull Hospital
Phase 2	**Generic sub-acute / Specialist**	• Sub-acute care for patients medically stable, but requiring ongoing observation / support • Specialist care e.g. INRU, Stroke • EOL / Palliative care	• Mosely Hall Hospital • West Heath Hospital	171 beds (B)	Focus for 2025/26 in terms of role and use of MHH and WHH Potential to enhance specialist care provision e.g. INRU
Phase 3	**Nursing / Complex Dementia**	Assessment of longer-term care for patients with nursing needs & complex dementia & require a physical setting / layout that can support this.	• Bromford Lane • Anne-Marie Howes	68 beds	Independent-sector provided beds for more complex nursing / dementia care. Potential to work with BSMHFT.
				~ 480 beds	

The alignment of the budgets across the c. 480 community-based beds is considered a key enabler for the Community Care Collaborative to deliver a more consistent, sustainable solution and drive better productivity and efficiency. It is anticipated that oversight of the full suite of intermediate care beds will form part of the lead provider arrangements (as per section 4.2).

5.3 Long Term Conditions - Work Programme 3



Long Term Conditions (LTCs or chronic diseases) are conditions for which there is currently no cure, and which are managed with drugs and other treatments, for example: diabetes, hypertension, cardiovascular disease, chronic kidney disease, cerebrovascular disease, dementia, chronic obstructive pulmonary disease, arthritis. They are managed across service providers as shown in table 7 (section 4) with a large element delivered by general practice.

Inequalities in health outcomes are overwhelming and most of these inequalities are associated with the development and progression of LTCs. Birmingham and Solihull has the highest proportion of citizens within the most deprived sections of the population in England. There are major differences in LTCs between demographic groups; for example, one in three people of South Asian ethnicity over the age of 35 has diabetes or pre-diabetes; hypertension has a very high presence in people of Black ethnicity.

People with Long-Term Conditions comprise most cases of hospital outpatient and primary care appointments, inpatient bed days, acute hospitalisation, re-admissions, and health care costs. People with Long-Term Conditions are those who progress to dementia, frailty, and end-of life care. In BSOL there are over 300,000 people with Cardiovascular disease, 200,000 people with chronic kidney disease and over 140,000 with Type 2 Diabetes.

The Integrated Care Partnership strategy[9] identified five key clinical condition areas which, through sustained improvements in prevention and outcomes, offer the greatest opportunity increase to life expectancy and reduce premature deaths across Birmingham and Solihull. The Long Term Conditions work programme covers two of these (circulatory disease and respiratory disease) as well as other long term conditions, as detailed in section 4.2.

- Respiratory
- Cardiovascular disease / Stroke / Diabetes
- Palliative & End of Life care

Established core principles for LTC care in BSoL comprise:

- Equality of outcomes; clinical and patient reported
- Locality enabled, locality delivered
- Integrated LTC teams (primary, community specialty, secondary care)
- Empowered workforce development
- Based on measurables for interventions with an evidence base
- Maximising partnerships: charity; industry; academic; social care

Key areas of focus within the overarching programme are

1. **The development of an integrated framework to identify those with or at risk of LTCs;** ensuring primary care data is used to identify patients with, or at risk of developing, a LTC; ensuring all health-care professionals can access and enter information on LTC onto the primary care electronic record; linking and using primary and secondary care data to enhance care for admissions for patients with a LTC (section 8.3.7)
2. **Workforce configuration and development;** defining the skill-mix and models for Locality-based teams, understanding the current workforce, and developing a programme of evolution from a specialist to an enhanced generalist model
3. **Delivery of care**; integrated patient information and patient reported experience measurement framework; BSol evidence and implementation hub for LTC (multi-partnership), including a secondary prevention framework; Locality-based models of care
4. **Research, development and innovation**; developing criteria for service pilots, and appropriate generalizable evaluation framework; establishing a framework for clinical trials, research, development and innovation with partners.

Core measurements for circulatory and respiratory disease are being finalised as well as the development of a single core dataset that identifies, for each major long term condition, numbers, demographics, including localities and combinations of conditions. The starting data set will

(i) Identify, by locality, the number of individuals with long-term conditions both singly and in combination, weighted for demography.

(ii) Measure core primary and secondary prevention interventions

[9] A Bolder, Healthier Future for the People of Birmingham and Solihull (icb.nhs.uk)

This will allow the mapping of numbers to system design, workforce skills and distribution, infrastructure, interventions.

5.3.1 Respiratory

In Birmingham and Solihull more than 23,000 mainly older adults suffer from COPD, while over 88,000 people – including children – suffer from asthma. Emergency admissions for COPD, admission rates for children from asthma, and under-75 mortality rates from respiratory disease are both significantly higher than the England average. There is considerable variation in both the availability and quality of care provided within primary medical and community services, including variation in diagnosis rates and waiting times. Respiratory virtual wards are not being utilised effectively and joint working between secondary care at a neighbourhood/locality level with primary medical care and community specialist services is limited. Several providers are commissioned to provide components of the current respiratory pathway however these are often delivered in isolation and there is no overarching system respiratory oversight. More needs to be done to reduce smoking prevalence and increase vaccination rates within high-risk groups.

The Collaborative will bring together providers from across the system to develop an integrated end-to-end respiratory pathway which is evidence-based and outcomes focused, starting from primary prevention right through to end of life care.

5.3.1.1 Focus in 2024/25

Currently led by the ICB, a Respiratory Programme Board was established in May 2024 to take this work forward. The Board includes clinical and operational representatives from all partners and comprises 4 work streams:

1. Integrated community respiratory model
2. Community respiratory diagnostics
3. Pulmonary Rehabilitation
4. Home Oxygen Treatment

The Board will bring together current strands of respiratory activity across providers and work effectively with interdependent work programmes. A significant amount of work in this area was undertaken at a system level pre COVID; although an overarching model was not implemented across BSOL as originally proposed in 2019 there are a number of elements that are in operation (some non-recurrently), but are being managed in separate programmes:

a) Virtual wards
b) Same Day Emergency Care
c) Community Diagnostic Centres

The initial focus for the Respiratory Programme Board is the development of an integrated care model, utilising a multi-disciplinary approach, to improve the management of adults with existing chronic respiratory conditions; mainly Chronic Obstructive Pulmonary Disease (COPD) and asthma. The model aims to provide

four key levels of intervention to support patients that require advanced clinical expertise beyond what is ordinarily provided by Primary Medical Care professionals.

Figure 12 – Respiratory Model

Multi-disciplinary teams will bring together existing clinicians and care professionals from different health and care sectors, working at neighbourhood or locality level. It is envisaged that these teams will support primary medical care practitioners to improve their skills and knowledge through direct involvement in multi-disciplinary working, combined with educational programmes. The teams will work across the community and acute hospitals to identify patients who can safely be cared for at home through Early Supported Discharge and virtual wards, with escalation to specialist intervention where required (Appendix 5).

5.3.2 Circulatory Disease

Circulatory disease includes a range of clinical conditions such as hypertension, diabetes, ischaemic heart disease and stroke. A significant amount of work is already happening across the BSol system to drive a reduction of harm related to circulatory disease. Primary prevention is the root to widespread reduction of cardiovascular disease; although the Collaborative may have limited influence on primary prevention as it relates to “macro” public policy, a priority will be to improve secondary prevention where existing risk factors are treated more effectively, specifically for hypertension and diabetes.

Similar to the respiratory pathway, current activity is often fragmented across different organisations and needs aligning through the development of a single end-to-end, system wide circulatory model. Inclusion in the remit of the Collaborative will ensure that interdependencies with other agreed Collaborative priorities, for example INTs and the LOM, are identified and addressed.

5.3.2.1 Focus in 2024/25

The workstream will be led initially in 2024/25 by the ICB through a Circulatory Board with membership from secondary, community and primary medical care health providers, public health and the VCFSE. The priority for 2024/25 will be the creation of a single, integrated approach to hypertension which is the most common circulatory disease in BSol, affecting over 300,000 people.

The workstream will work to improve outcomes by implementing evidence-based primary prevention, targeted earlier detection within at-risk communities and intervention to treat known risk factors, as well as effective and prompt treatment of acute disease. The workstream will include effective interventions to reduce obesity and smoking, increased uptake of NHS health checks, treatment to guidelines of high blood pressure and cholesterol, structured stroke care (including mechanical thrombectomy) and primary coronary angioplasty for myocardial infarction (heart attack).

Four workstreams will be established:-

1. **Optimising condition management in primary medical care** through the 2024/25 Enhanced Support Offer (ESO) to General Practice through pathway-based management, educational support and a single service directory for healthy lifestyle support services available to citizens.
2. **Tackling Health Inequalities** there is a specific ask to increase hypertension case finding within the Core20PLUS5[10] NHS England Health Inequalities approach and the ICS Health Inequalities Strategy. The programme will include innovative approaches, for example through training community advocates / third sector to screen their neighbourhood population through the use of Blood Pressure Monitors and / or mini health checks. Locations include barbers, hairdressers, libraries and faith settings.
3. **Patient Platform & Engagement** - The co-design and delivery of a single patient information platform for circulatory diseases, including local adaptation for approaches to lifestyle support as well as linkages to clinical management pathways.
4. **Innovation & Improvement Hub** - In partnership with Health Innovation West Midlands (HIWM):
   a) create a single framework for evaluating the value of any intervention for the population that we serve and ensuring we are clear what we are asking for from any stakeholder (see section 2.2).
   b) create a single system framework to identify and maximise all funding opportunities including those from industry. At present engagement with industry is fragmented across the system hindering the ability of BSol to attract at-scale collaborators with significant investment.
   c) Scope the potential for a single team approach to continuous improvement in the circulatory space, in line with the Collaborative's agreed Quality Improvement approach (section 9.4.1).

Whilst the programme will in time be housed within the Community Care Collaborative, both the acute and mental health collaboratives will play an important

[10] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

role in the development and effective implementation of new long term condition models. This includes ensuring there is a multi-disciplinary team framework for those who need specialist care and that identified secondary care specialists are embedded within locality-based teams.

5.3.3 Palliative and End of Life Care

People of all ages who face progressive, life-limiting illnesses, need a variety of health and care support at different points in their lives. In addition, most people are likely to need Palliative and/or End of Life Care (PEoLC), as they approach the last year(s) of their lives.

Currently, many Birmingham and Solihull residents do not die in their preferred place of death, with hospital deaths higher than the national average, and low numbers of care home deaths. Between April 22 and March 23, of the **11,868** recorded deaths, 5,792 of these people died in hospital. On average, each person attended ED 3 times in the 90 days prior to their death.

The Birmingham Joint Service Needs Assessment (JSNA) Deep Dive report[11] (2022) identified areas for service improvement to improve experience for those approaching end of life:

- Services could be more coordinated.
- Care plans are not routinely offered to patients in need of palliative care and their carers.
- People have difficulty discussing what they want when they die.

Similarly, the Solihull report[12] identified that around a half of older people who died in Solihull in 2016 did so in hospital.

Inequalities exist in both access to and experience of all palliative / end of life care services[13]. The current model across Birmingham and Solihull is fragmented with multiple providers commissioned separately to provide elements of palliative / end of life care pathway, including charitable hospices. Without considering the best use of investment, gaps in funded services and inequalities will likely worsen over time. As the population ages and more people die outside hospital, it will be important to consider how to meet projected increased demand and ensure a more sustainable and resilient model.

5.3.3.1 Model of Care

By bringing end of life care within the remit of the Collaborative, we will be able to take a more holistic view, focusing less on specific diseases or conditions, and instead developing an integrated, person-centred and personalised model of care.

We want to

[11] Joint Strategic Needs Assessment (JSNA) | Birmingham City Council
[12] Joint Strategic Needs Assessment: Evidence Summary (solihull.gov.uk)
[13] ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)

- Improve identification of those nearing the end of their life for better coordinated care, allowing for preferred place of death.
- Improve experience: the Integrated Palliative care Outcome Scale (IPOS) has been used to measure how well a patient's needs are met at this time. This, or similar, should be implemented to allow for quantitative assessment of patient experience.

Over the past three years extensive work has sought to align with the National Ambitions for Palliative & EoL Life Care Framework 2021 – 2026[14]. Underpinning these ambitions are 8 foundation principles, which have been agreed as BSol priorities.

1. **Personalised Care Planning** – more patients having personalised care plans
2. **Shared Records** – centralisation of work relating to 'identification' of patients; agreed community dataset.
3. **Evidence and Information** – improved recording end of life priorities through the shared care record
4. **Those important to the dying person** – increasing Preferred Priorities of Care (PCC) discussions
5. **Education & Training** – increasing workforce knowledge and confidence, through a shared resource web-based platform
6. **24/7 access** – to ensure equality of access across 24/7. A submitted bid to Macmillan (outcome to be determined) proposed that by developing an OOH service could reduce the number of hospital admissions and calls to 999 and increase the number of patients who die in their place of choice
7. **Co–design** – involving patients, carers and citizens in designing services
8. **Leadership** – providing strong and integrated leadership across providers.

5.3.3.2 Focus in 2024/25

The workstream will be led initially in 2024/25 by the ICB as part of the Long Term Conditions programme through an End of Life Board with membership from secondary, community and primary medical care health providers, public health and the VCFSE. The priority for 2024/25 will be to develop a system wide strategy and dashboard around End of Life Care.

5.4 Supporting Primary Care Development - Work Programme 4

This work programme will initially focus on General Practice; it will not initially include a focus on wider primary care services, though these may be included in time.

General Practice is considered the bedrock of the NHS[15]. It provides a large proportion of NHS care and is the anchor for integration across primary care, community and acute physical and mental health and social care at neighbourhood level. It is critical that General Practice are equal partners in the Collaborative and

[14] NHS England » Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026
[15] NHS England » Next steps for integrating primary care: Fuller stocktake report

there is an explicit aspiration that the Collaborative will support the development and resilience of the sector.

General Practice is currently experiencing some of its most challenging times with increased demand, workforce challenges and resilience. Despite these issues, General Practice in BSol has continued to deliver, offering more activity than ever (16% more compared to pre-covid levels) and working to modernise the model of care in line with local and national aspirations.

The work programme will support General Practice development in line with BSol's Enabling Primary Care strategy[16]. There are many inefficient systems, processes and referral pathways between General Practice and other providers that add burden to health and care professionals and add no value to patient care. The work programme will enhance interface working between General Practice, community and acute physical and mental health services, social care and the VCFSE, to build trust and practical working relationships.

The work programme will aim to

- Promote functional working relationships between teams at practice, PCN and locality levels
- Support general practice delivery, in particularly enhancing pathways and processes that add value to the patient journey and reduce bureaucracy for General Practice (e.g. self-referrals)
- Deliver joint working to address health inequalities
- Deliver closer practical interfaces across health and care providers.

A separate Case for Change is being considered to move the hosting of the GP Provider Support Unit (GP PSU) to BCHC, as the lead provider organisation for the Collaborative. This would further enhance the potential benefits of closer and more integrated working between general practice and other providers.

5.4.1 Model of Delivery

The ethos and purpose of the Collaborative is to drive integration and improve interfaces between providers, and to provide integrated services which promote early intervention and prevention. General Practice will be an essential part of each work programme, and is referenced throughout this Plan.

Interfaces

This work programme will support specific deliverables around redesign of processes between general practice and other providers, to reduce bureaucracy and improve pathways of care for patients. These will include

[16] Birmingham and Solihull ICB (2023). *Enabling Primary Care - A strategy for enabling primary care across BSOL ICB*

- Developing an integrated practical model of preventive care, which includes targeting those people who do not ordinarily present at primary care e.g. links to immunisations and vaccinations
- Initiating a systematic joint communication programme (see section 8.3.4) to describe offers of care/support, how they can be accessed and where they are delivered
- Co-producing and developing a workforce model which designs and implements solutions to attract and retain staff to help deliver general practice and community care. This will be part of the overall workforce plan for the Collaborative (section 8.3.5).
- Reviewing and redesigning interface processes to reduce bureaucracy on GPs and other providers, and improve pathways of care for patients. As per the NHS England Delivery Plan for Recovering Access to Primary Care this will include a focus initially on the main recommendations from the Academy of Medical Royal Collages and the RCGP[17] to streamline and agree an approach to
    - onward referrals
    - complete care (fit notes and discharge letters)
    - call and recall
    - a point of contact for clinicians.

Infrastructure - GP Provider Support Unit

The GP PSU is the delivery arm of the GP Partnership Board which provides essential leadership on behalf of General Practice across BSol. The PSU was set up in 2022 to provide dedicated infrastructure to support General Practice, with the three main aims to

- support **sustainability** of general practice;
- increase **standardisation** to meet and exceed quality service standards;
- achieve overall **improvement** of general practice service delivery.

5.4.2 Focus in 2024/25

The work programme will be led initially in 2024/25 by the ICB which currently hosts the GP PSU.

The priority for 2024/25 will be to

- Support the transition of the GP PSU to the lead organisation for the Collaborative (BCHC), if agreed through the separate Case for Change.
- To work with partners to identify specific objectives and deliverables to begin to deliver the aims outlined in 5.4.1, focusing on wound care and community nursing.

[17] Policy areas (rcgp.org.uk); GPSC_Working_better_together_0323.pdf (aomrc.org.uk)

5.5 Children's Community Services - Work Programme 5

The Collaborative remains committed to being 'all age' and to cover the full life course. Since the Strategic Outline Case was approved by the ICB in November 2023, there has been limited progress in determining which NHS-commissioned community services for babies, children, young people and their families might be included within the remit of the Collaborative.

We recognise that the place-based partnership arrangements for services for children and young people are different from those for adults and that there are well-established programmes of work in both Birmingham and Solihull seeking to improve services for children with Special Education Needs and Disabilities (SEND) and to develop integrated local care for children and young people through Family Hubs and 0 – 19 years pathways. The Collaborative does not want to disrupt this existing work.

The ICB is looking to establish a Children and Young People's Health Partnership Board. The terms of reference have been drafted and, whilst not yet ratified, it is expected that the Partnership Board will provide a strategic view across the numerous programmes of work in relationship to Children and Young People which meet the following criteria:

- The programme involves clinical care
- The programme exists within the ICS
- The programme requires both horizontal and vertical integration.

Through involvement in this new Health Partnership Board, the role of the Community Care Collaborative in relation to NHS-commissioned community services for babies, children, young people and their families will become clear.

As our understanding of the how the Collaborative can best support the delivery of local integrated care for children and young people, it is possible that the following services could form part of this work programme:

- Intermediate care services for children and young people;
- managing long-term conditions for children and young people;
- supporting the delivery of locally integrated care working closely with the place-based partnerships in Birmingham and Solihull.

In 2024/25 the above will be taken forward to identify what is in scope for the Collaborative in this work programme, and what the delivery plan will be for 2025/26 and beyond.

6. Locality Delivery Partnerships

The Locality Delivery Partnerships described in Section 3.2 will focus first on integrating physical and mental health and care for adults. In time, the emerging Family Hub networks within Birmingham and Solihull will connect into the developing Locality Operating Model and membership of the Locality Delivery Partnerships will evolve accordingly.

The functions of the Locality Delivery Partnerships to deliver the vision set out in section 3.2 are set out below:-

- To bring local partners together to build and continue to develop an inclusive and active Locality Delivery Partnership
- To understand locality demographics, population health needs and key performance / delivery pressures linked to the Community Care collaborative's Outcomes Framework
- Initial operational focus in 2024/25 will be on the development and delivery within the locality of:
    - Integrated Neighbourhood Teams and establishing a 'Locality Operating Model'
    - Local Intermediate Care pathway
    - Development and operation of physical Locality Hubs for same day urgent community care
    - Oversight of the allocation of Fairer Futures Locality Funds targeted to local health needs and monitoring delivery of schemes / projects.

During quarter two of 2024/25, each LDP will develop a delivery plan and align delivery capacity to agreed system/place priorities.

Each LDP is chaired by a Locality GP who is a representative on the GP Partnership Board who will work closely with a named senior system leader, working on behalf of the Community Care Collaborative to deliver the Collaboratives objectives. The system leader will act as the Senior Responsible Officer (SRO) and is a member of the Community Care Collaborative Steering Group; the chair and the SRO are accountable to the Steering Group for the performance of the Locality Delivery Partnership. They will also play a key role in representing the views and priorities of the Locality Delivery Partnership within the Collaborative

The Locality Delivery Partnerships will be supported by a Locality Manager employed by the Community Care Collaborative. Core membership is set out in Box 13 below. As the Community Care Collaborative takes on additional responsibilities in future, the functions and membership of LDPs will be reviewed.

- **NHS Community Healthcare Provider**
- **General Practice** (in addition to GP Chair)
- **Local Authority Adult Social Care**
- **Local Authority Children's Social Care / Birmingham Children's Trust**
- **Voluntary, Faith, Community & Social Enterprise Sector**
- **Local Authority Public Health**
- **NHS Community Mental Health Provider**
- **NHS Acute Provider**
- **Neighbourhood Network Scheme lead** (Birmingham)
- **Experts by experience / citizen reps** (To be developed)
- **Family Hub Network lead provider** (in time)

Box 13 – Core Membership of Locality Delivery Partnerships

7. Phasing of Delivery

	2024/25	2025/26	2026/27
Development of the Collaborative	• Develop, agree and implement Quality Improvement approach • Models for VCFSE, citizens and Experts by Experience (EbE) involvement designed and implemented • Establish LDPs in all localities • Develop workforce, digital and estates delivery plans • Develop Locality Operating Model dashboard • Appraisal and procurement of system data extraction tool • Embed robust governance and risk management approaches across the Collaborative	• Quality Improvement approach embedded across all work programmes • Locality-level VCFSE collaboratives established and working in partnership with the LDPs • Citizens and EbE involved in decision making at all levels • LDPs take on responsibility for locality-level delivery and performance • Collaborative governance and risk management systems fully matured	• Quality Improvement used routinely in all change programmes • LDPs take on increased delegated responsibility from the Collaborative and Place Committees • Sustainability of Locality Fairer Futures Fund schemes post-evaluation addressed • Audit of Collaborative governance and risk systems and processes to ensure fit for purpose
Overarching deliverables	• Initiate a joint communications plan for staff and the public • Produce and implement a combined community and general practice winter plan	•	•
Integrated Teams in Neighbourhoods and Localities	• Sustainable, integrated digital solution in place for ongoing identification of INT caseload(s). • Locality hub 'case for change' agreed.	• Integrated Neighbourhood Team coverage across all 35 Neighbourhoods/PCN's in BSOL	• Population Health Management approach mobilised within all INT's across BSol (funding dependent)

	• Integrated locality operating model tested and evaluated in one locality. • Digital and Estates enabling strategies agreed	• Locality hubs mobilised and operational across all five Birmingham localities and Solihull (subject to agreed funding). • Locality operating model mobilisation underway. • Sutton Cottage refurbishment completed.	• Kingshurst Health & Wellness Hub completed
Intermediate Care	• Locality-based Intermediate Care service tested and evaluated in one Locality • Recommissioning of P1 Pathway (Birmingham) agreed. • Full Business Case on provision of Phase 2 of Pathway 2 beds agreed (Birmingham & Solihull). • Process for transfer of commissioning responsibilities for NHS services	• Roll-out of locality-based Intermediate Care teams. • Implementation of Pathway 2 provision (Phase 1) across BSol underway to plan. • Full Business Case for Phase 2 of Pathway 2 beds. • Collaborative lead Provider for Intermediate Care. • Locality operating model mobilisation underway (re. Intermediate Care)	• Implementation of Pathway 2 provision (Phase 2) across BSol underway to plan. • Locality operating model mobilisation completed (re. Intermediate Care)
Long Term Conditions	• Establish BSOL Respiratory Board • Appoint BSOL clinical lead for respiratory. • Bring together existing programmes comprising respiratory elements. • Refine and test integrated community team model aligned to an acute hospital and its localities during winter 24/25.	• Develop and roll out (subject to approval) an integrated community respiratory model. • Develop and roll out (subject to approval) a future community diagnostic model. • Bring forward proposals for Pulmonary Rehabilitation & Home Oxygen	•

	• Develop future community diagnostic model for BSOL. • Establish single respiratory clinical dashboard for BSOL. • Complete review of Pulmonary Rehabilitation and Home Oxygen services • Establish single BSOL circulatory board with underlying workstreams • Create a single set of system hypertension metrics to form part of system circulatory dashboard • Embed hypertension measures in the ESO 24/25 with appropriate support offer to primary care • Map current activity focusing on detection and primary prevention across partners and agree system priority work programme. Work with HIWM/Aston University on evaluation methodology • Scope opportunity to develop a single patient platform across all circulatory conditions • Scope potential for launch of integrated PEoLC life OOH service across Bsol • Delivery on improved identification metrics • Develop Bsol PEoLC Dashboard	• Focus on develop PEoLC strategic (focusing on future commissioning) • Integrated PEoLC and LTC workstreams	• Deliver Bsol PEoLC strategy

	• Set planning for Bsol system PEoLC Strategy • Web based platform launch	• Post identification support pathways • 24/7 PEoLC service review	
Supporting Primary Care Development	• Design and implement wound care model • Redesign process for joint working between general practice and community nursing • Launch ICBs *transfer of commissioning responsibilities* (September) to move the PSU to BCHC	• Mobilisation of the transfer of GP PSU to BCHC • Include alignment to community teams in a target operating model for general practice • First year of PSU within BCHC – stabilisation phase • Improve the community mental health and general practice interface • Promote social care and general practice interface • Identify further ambulatory pathway design and implementation based on PHM • Develop robust general practice and community workforce plans • Design a joint preventative approach	• Develop and implement a comprehensive community and general practice strategy • Flexible employment models in place for nursing staff • Implementation of further pathways of care • Fully implement the preventative approach
Children's Community Services	• Define scope of the work programme and prioritise areas for inclusion • Develop delivery plan for 2025/26 and beyond	SUBJECT TO WORK IN 2024/25	

8. What is Needed to Achieve this?

8.1 Resources

Appropriate resourcing of the Collaborative, and the risk to delivery if this is not adequate, is recognised as a significant risk (rating 15) on the Collaborative's risk register. In view of the current financial situation, it is understood by partners that in large part improvement and transformation will need to come from a realignment of existing resources, rather than the ability to expand the workforce. However, there are significant requirements in some areas, which are summarised below and in table 14.

- **Delivery Team**

There has been some investment in the overarching architecture of the Collaborative, in recognition of the need to invest in resource to drive forward change and transformation. £1.2m of funding has been agreed to support this work as per Table 14. This provides sufficient capacity to make the progress that we aim to make in 2024/5.

- **Collaborative Infrastructure**

Additional capacity in some key corporate areas is crucial if we are to realise the potential benefits of the Collaborative. These include

- **Business Intelligence** – to develop the tools to integrate data from partners, and display this in a useful way for those providing care directly, and for those designing and managing pathways of care. To analyse the data in a way that informs and drives change in an evidence-based way. If appropriate technology is invested in, this may be largely a pump priming investment rather than ongoing.
- **Information Governance** – to ensure information governance and information security across the system, to manage and streamline the current situation of multiple agreements and assessments, and to negotiate the reduction and integration of patient records and administration systems.
- **Digital** – to support the development of digital interoperability and integration interoperability between partners; investment in equipment and technology.
- **Communications** – as resource is non recurrently funded
- **Experts by Experience** - to realise our ambition to include meaningful participation and coproduction with citizens and experts be experience (as per section 8.3.1).

As the delegation process is worked through, identification of existing resource in the ICB may support these corporate areas and the shift in resource.

- **Work Programmes**

Individual work programmes will be subject to business cases where appropriate if changes are being made to services, or investment sought.

- **Locality Hubs.** The current Locality Hubs in Birmingham are being funded non-recurrently from the Birmingham Better Care Fund. The future funding

arrangements for the locality hubs will be, in some part, linked to the BSOL ICS 'UEC Reform' programme, with opportunities to potentially better co-ordinate existing funding arrangements on a locality footprint. It is important to note therefore that the existing current funding arrangements for locality hubs are non-recurrent only cover 2024/25.

- Solihull Locality Hub – We have identified non-recurrent funding to get the Solihull locality hub and running; the recently submitted Solihull Better Care Fund plan includes a budget of £365k towards the cost of a Locality Hub in Solihull from the ICB's element of the Social Care Discharge Fund. Access to this funding is contingent on the delivery of a clear business case setting out the proposed operating model, costs & benefits etc for the Locality Hub.
- We recognise that we need to agree a sustainable approach to funding for Solihull and the Collaborative and ICB are working with Solihull Council to identify how this can be done from within the resources available to us.
- **Work programme 1: Integrated Neighbourhood Teams**. The Business case for INTs is being written - whilst the majority of the Integrated Neighbourhood Teams model is based upon re-organisation, focus and co-ordination of existing services and teams, there are two crucial roles within the model which will require recurrent investment to support further roll-out; the Neighbourhood Expert and Neighbourhood Co-Ordinator roles, as per table 14. A summary of all the roles within the INT (including the new roles referenced above) is included in Appendix 3.
- In Birmingham, there is c£1m ringfenced within the 24/25 Better Care Fund plan to fund core roles in the existing INT, whilst the business case is being written and assessed.

Programme	Value (£)	BSOL Agreed (Y/N)	Rec / Non Rec	Source of Funding
Community Integrator - Project Team to deliver the CCC Pla	1,186,089	Y	Rec	BSOL
INT - Five existing Teams	984,612	Y	Non Rec	Better Care Fund (BCF)
INT - Roll Out - 20 Teams	2,079,840	N	Rec	BSOL
Hubs - For East and West	3,119,000	Y	Non Rec	Better Care Fund (BCF)
Hub - Solihull	1,043,208	Part	Non Rec	Social Care Discharge Fund (BCF)

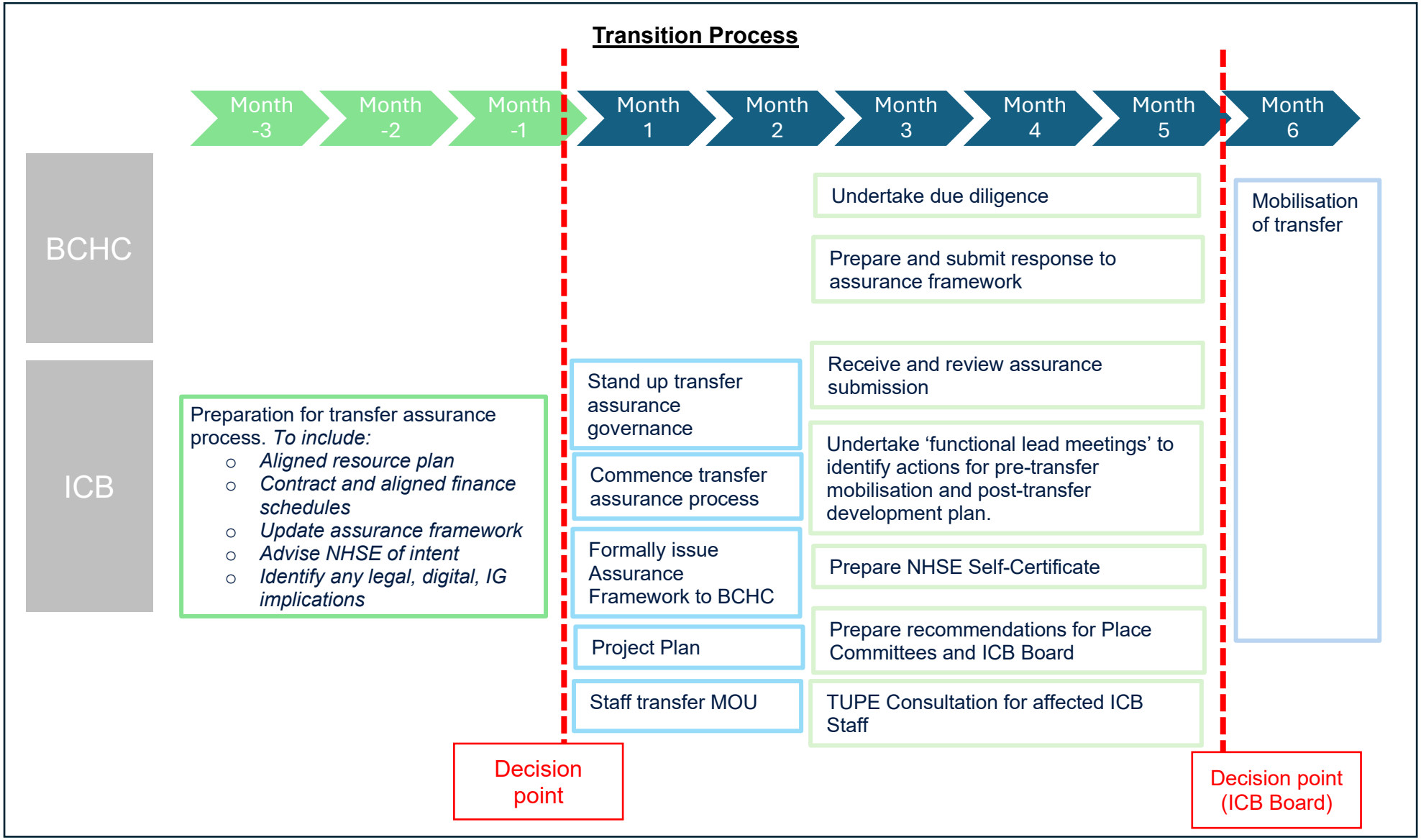
Table 14 – Collaborative funding streams

As noted above historic differences mean that we are fortunate to have more flexibility to use the Better Care Fund to support integrated neighbourhood teams and locality hubs in Birmingham than we do in Solihull. The ICB and the Collaborative are committed to working with Solihull Council to agree how we can resource these developments in Solihull in 2024/5 so that we have a shared agreed approach by September 2024. We recognise that this approach will have to work within the resources already available to each of the partners.

8.2 Transfer of Responsibilities

As shown in section 4.2, there will be a move to bring some services under the umbrella of the Collaborative – i.e. when status moves to Collaborative as **Programme Enabler**. There will be a decision point here; this decision will be taken by the Collaborative Steering Group, and where applicable, by associated partner governance.

In order for the lead organisation for the Collaborative (BCHC) to assume **Lead Provider** status there will be a formal process as shown below. This will take a minimum of six months (based on learning from the MHPC).



The Transition will be informed by the Approach taken with the MHPC, and the assurance framework developed, proportionally and thematically adjusted:

- **Shared Vision, Collaboration** and **Leadership**
- **Governance**
- **Financial management, commissioning and contracting**
- **Quality monitoring and assurance**

8.3 Enabling Functions

8.3.1 Participation and Co-production

The Birmingham and Solihull Integrated Care System is committed to ensuring citizens have a real voice in shaping the way services are planned and delivered.

"We are ambitious to ensure that there is not only effective participation of residents, patients, service users, carers and partners in the design, delivery and evaluation of our ICS ambition but also that future participation enables true power-sharing with our communities and encompasses all ICS activity, including governance arrangements, the development of strategy and informing decision making and prioritisation."

Taken from the Birmingham and Solihull Integrated Care System Operating Framework (2022)

"Birmingham and Solihull ICS will seize the opportunity to reshape citizen engagement…. We want to ensure that citizen and patient voices are at the heart of future service development and delivery, and that we are engaging our communities in a coherent and coordinated way…. In doing so, we will seek to systematically drive improvement in health outcomes and tackle health inequalities."

Taken from the Birmingham and Solihull Integrated Care Board 'Working with People and Communities Strategy' (2022)

In the Community Care Collaborative C.A.R.E. approach, set out in Section 1, the 'E' stands for Empowering:-

Empowering - helping everyone to live a healthy, happy life, with better and easier-to-find information about healthy choices and local activities that support a healthy lifestyle.

Being **Empowering** also includes our commitment to engage and involve people and communities.

'We will engage and involve citizen representatives and Experts by Experience in every decision-making group, at all levels of our Collaborative. Through our VCFSE partners, we will actively engage with all local communities, with a particular focus on the marginalised, minoritized and so-called 'seldom heard', to ensure we are working on the issues that matter most to local people. We will work together with our super-diverse communities across Birmingham and Solihull to co-produce services that most effectively meet local needs**.'**

Taken from the Birmingham and Solihull Community Care Collaborative Strategic Outline Case, approved by BSol Integrated Care Board November 2023

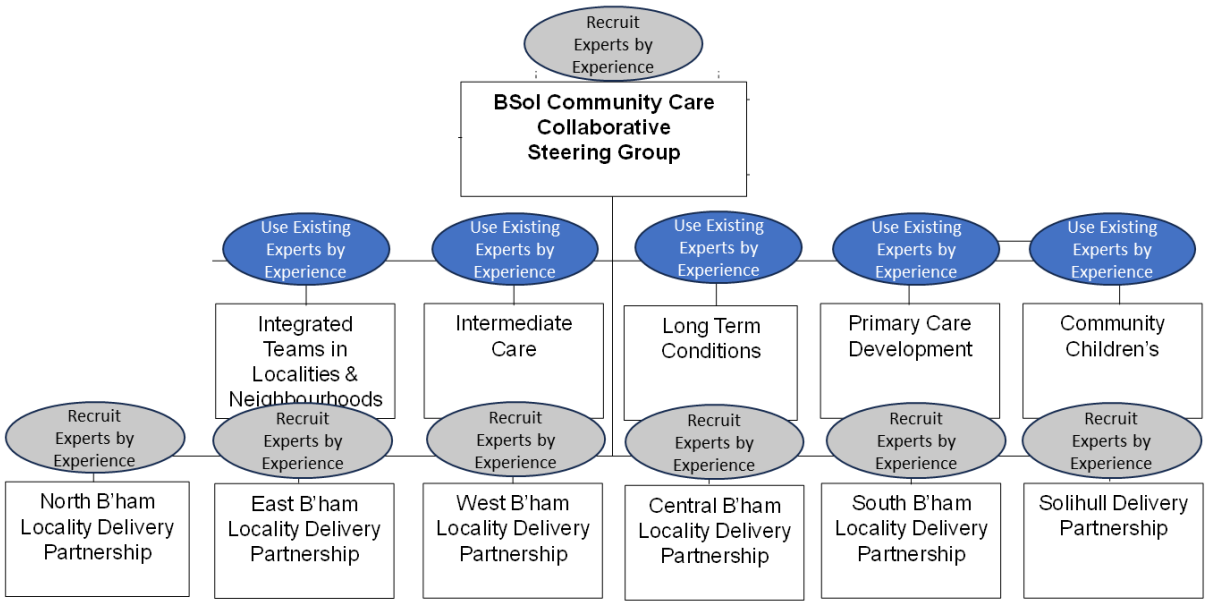
The Community Care Collaborative has developed and agreed the following principles for engaging citizens and 'experts by experience'[18] in the work of the Collaborative based on a review of national best practice models

- Experts by Experience and citizens should be involved in decision making at every level of the Community Care Collaborative
- These roles should be recognised as having equal voice and value
- People should be given the support they need to feel fully included and to be able to actively participate
- People should be recognised for the expertise they bring and paid for their time. This creates greater equity with employed staff who also attend these meetings

The Collaborative recognises that an approach with varied and wide-ranging engagement with citizens and service users will provide the richest input, and will be looking to utilise a range of methods of engaging with our communities and experts by experience.

8.3.2 Proposed Engagement Model

The proposed model is to have citizens and 'experts by experience' involved in all levels of decision-making within the Collaborative:-



Where these already exist, we will ensure that we engage with patient, service user and carer forums and networks across Birmingham and Solihull. The Collaborative will look to recruit Experts by Experience for each of the five work programmes and ensure that they have appropriate ongoing support.

The involvement of citizens in the six Locality Delivery Partnership and the wider Collaborative decision-making groups will require a different approach. These citizen representatives (who may also be Experts by Experience) will be recruited through

[18] Experts by Experience are people who have lived experience of using or caring for someone who has used health and / or social care services recently.

an open process, receive some basic training on how the health and care system operates and be provided with ongoing support to undertake their roles on the various groups. These individuals will be well connected within their local community to represent the views of the wider community, rather than simply their own views.

The Collaborative will need to identify resources, in particular funding, to enable our ambition for inclusion through participation and coproduction to be realised in a range of ways. Preferred options being explored include increasing existing capacity and capability in one of the Collaborative partner organisations or to commission this as a discrete service. This could include utilising and build on the existing expertise of Community Connexions [19], funded by the Clinical Research Network West Midlands and led by BCHC and Black Country Healthcare NHS Foundation Trust with Aston University. Community Connexions collaborate with a broad spectrum of community and voluntary organisations from faith organisations, local charities groups, mutual aid groups and community forums to better understand the needs and priorities of local communities, Health behaviours and barriers that lead to poor engagement with health services and/or research. This helps to adapt our services to better meet local needs, inform future health research and develop understanding for prevailing health inequalities and how these can be addressed.

8.3.3 VCFSE Collaboration

BCHC as the lead for the Collaborative has an established relationship with the VCFSE. We have worked closely with BVSC in Birmingham for a number of years and are building links with CAVA in Solihull.

Supported by funding from the former Black Country and West Birmingham Clinical Commissioning Group, we enabled the development of Flourish, the West Birmingham Community Health Collaborative[20] as an open group of third sector organisations working in partnership with the NHS and other care providers to reduce health inequalities across West Birmingham.

This partnership between the NHS, Local Authority and VCFSE sector has already shown impact, winning the Health Service Journal NHS Race Equality Award in 2023[21]. Flourish are already part of the Locality Delivery Partnership for West Birmingham and we want to replicate this model across Birmingham and Solihull.

In Birmingham, we have supported BVSC to develop a proposal to establish similar collaboratives across the VCFSE sector in each of the five localities. These

[19] https://www.bhamcommunity.nhs.uk/community-connexions/
[20] https://flourish-health.net/
[21] https://flourish-health.net/winner-flourish-and-the-ladywood-perry-barr-locality-partnership-walk-away-the-nhs-race-equality-award-at-the-hsj-awards/

collaboratives will play a key role in working with statutory sector partners to develop proposals for the Locality element of the Birmingham Fairer Futures Fund.
We will look to work in a similar way with CAVA and the VCFSE sector within Solihull.

8.3.4 Communications

A communications strategy was developed in December 2023. It includes the development of a Collaborative brand identity which, launched in March 2024. With multiple system stakeholders, and a large workforce involved both directly and indirectly in the work of the Collaborative, it is important to ensure that communications are well managed to ensure a consistent 'single story' approach. This will help to avoid any confusion or speculation as the Collaborative continues to develop.

As a first step we have established "Connect" as our monthly newsletter for partners and stakeholders.

The Collaborative will continue to develop effective tools and assets for stakeholders and disseminate via established neighbourhood, locality, place and system-level communication and engagement channels.

It will be important to communicate with citizens and patients around the offers of care and support, what these means and how to access them.

8.3.5 Workforce

Having enough people, with the right skills and values, in the right place is clearly fundamental to the realisation of the Collaborative's aims. In addition to the resources referred to in 5.1, we will also be looking to work differently across our collective workforce, to promote integrated teams and leadership, and support new ways of working.

The opportunities offered by integrated working to address the many workforce challenges faced by the members of the Collaborative – including high vacancy rates and turnover and low levels of staff satisfaction – were identified in the Strategic Outline Case[22]. They include building new capabilities, developing fulfilling careers, widening participation, sharing good practice, and supporting development.

The Collaborative will develop a workforce model which attracts and retains staff to primary and community services, to improve the delivery of care and services.

BSol Workforce Programme

This workforce plan should be seen in the system context, and the Collaborative is connected to the wider system workforce programme. In 2023 a 'workforce diagnostic' was carried out across the ICS, which highlighted that BSOL was

[22] Strategic Outline Case 2023 - https://www.bhamcommunity.nhs.uk/download.cfm?doc=docm93jijm4n6339

struggling to achieve net growth in some professions, more people were leaving than joining, increasingly any growth was coming from International Recruitment (163% increase since 17/18) and agency, and that 93% of our workforce was still within the acute sector.

It was recognised that unless trend-breaking actions were taken, in the short term, BSOL would not achieve in-year operational plans in terms of activity and finance, and in the medium term, were likely to lose more staff with an impact on the quality of care, and in the longer term, fail to achieve JFP objectives of improved quality and reduced inequalities.

In response a system wide action plan was agreed under a '4 R's' Workforce Programme, which member organisations are involved in.

- Reconnecting with our staff
- Recovering net growth through recruitment and retention
- Resilience - Reducing reliance on contingent actions (agency and IR)
- Redistributing growth and new skills to redesigned future (community/NHTs)

Reform

Under the 4th priority a Reform Workstream was established to understand the workforce requirements of the new models of care and develop resources to support them. The workstream is of particular importance to the Collaborative as it will support the delivery of local plans and strategies[23] through redesigning the model of care and ensuring we have enough people with the right skills and values in the right place to deliver it.

The Community Care Collaborative has been actively involved in the initial work of the Reform workstream in developing and testing a range of tools and resources to support workforce planning and development, and identify initial workforce risks and challenges.

The vision of the Reform approach is to see a redistribution of skills and people to support the longer-term model of care; key enablers of that will be to influence a shift in education placements and training and enhance the experience of staff working within primary care and community settings.

Collaborative workforce leads will not work in isolation but will work with other collaboratives to share and learn in terms of workforce transformation good practice.

Wellbeing

We should also recognize the significance of some of the shifts and changes on our workforce, and the need to support our colleagues through HR and OD offers, to understand, embed, and make the most of the opportunities from the Collaborative.

23

8.3.6 Estates

To deliver on our commitment to integration, reducing duplication, and providing connected, accessible services, we will need to ensure that we have the right Estate. We recognise, collectively, that our current estate is not always fit for purpose, or in the best place for our service users and for delivery of efficient services, and that there is a limit to suitable estate in the system. Our estates needs will be affected by the new ways that we are and will be working together: teams will be working across organisational and professional boundaries, and our services will be increasingly organised around Neighbourhoods and Localities.

Working together with our partners, through the Collaborative, gives us huge opportunity to

- Connect our services better, through co-location of teams, e.g. our Primary Care Centres to co-locate teams from across health and care organisations and ensure the development of new models of care utilise this space e.g. integrated locality hubs.
- Understand what estate we have available to us as a Collaborative, and how that might be better used, to minimise waste and duplication including for travel of our workforce.
- Use community-based assets in delivery of our services.
- Review where services are best provided across the System, and flex how partners' estate might be used.
- Challenging cultures and actively pursuing and investing in agile working.
- Utilising digital technologies to avoid over reliance on the estate and create flexibility

Estate is an area which challenges all Collaborative partner organisations, and is a prime example of how working together in the Collaborative will allow us to address longstanding issues. A holistic approach to department budgets will be required to facilitate implementation of shared estate use. As in so many areas of collaboration, trust and openness will be key to realising potential benefits.

8.3.7 Digital, Information and Information Governance

As with our ambitions around estates, the same is true of how we use and embrace digital technology and information as a critical enabler in the delivery of our overall agenda.

Having the right systems, information and data will be an important part in realising the potential benefits of the Collaborative, to support direct patient care, population health management and the reduction in health inequalities. Learning from other Collaboratives such as Leeds Health and Care Partnership[24] has shown that being able to input and access information and data, in real time, is a key enabler of change.

[24] Innovation is key: early learnings from NHS England's discharge frontrunner sites (nhsproviders.org)
Breakfast session - How enhanced system visibility is enabling transformation and improved in Leeds (youtube.com)

The Collaborative will work towards minimising duplication and ensuring secure and appropriate access to systems and information. Our commitment to improving the availability and use of information will be at differing levels:

A. unhindered confidential patient information (CPI) data flow to individual professionals, and integrated teams (to deliver direct patient care),
B. pseudonymised data flow at locality and system level (population health management, reducing health inequality),
C. anonymised data flow to levels system and national level (reporting requirements, service and resource planning), and
D. citizen / patient autonomy through national NHS App – appointments, prescriptions, medical records

Confidential patient information – if we are to deliver the promise of being **CONNECTED**, and people only telling their story once, we will need to ensure all those who are providing support across the care pathway can see the relevant information to support care and improve outcomes.

Pseudonymised and Anonymised data
Being able to see information, in real time, at individual, team, neighbourhood, locality, place and system level, will enable us to be **CONNECTED** and **RESPONSIVE**; to effect changes and respond to demand, to see the impact on outcomes, to understand system performance, and identify people most at risk and identify health and service inequalities.

Citizen/patient autonomy
We will share information with citizens, **EMPOWERING** and enabling people to join in conversations about their health and well-being and shape their care and support. People will be able to access care more easily, using the full potential of the NHS App to book appointments online, check test results and access information on their own care

Digital and technology

The Collaborative will identify opportunities for Digital, Data and Technological innovation, and play an active role in driving integration and development through the ICS-wide digital programme of change.

This will be done through building upon progress being made in critical areas and developing opportunities, this will include:

- Delivering upon the ambition to present a single care record which will allow our health and social care professionals to easily and accurately establish a holistic picture of an citizens care needs and the various interactions they are having with our collective services. We will do this through the increasing expansion of the Digital eco system of which the Shared Care Record sits centrally to ensure this is available and accessible to all of our teams.
- Ensuing that the right equipment and networking is in place so all professionals working across BSol are able to connect with an appropriate, fit for purpose device, no matter what facility they are working from.
- Joining up our data across all providers to allow us to release the potential of a data-driven approach to care. The advantages of such an approach have already been identified in the work undertaken with the integrated

neighbourhood teams. The development of sustainable data streams, which are continually refreshed and supporting teams to identify and support the right citizens, through a more detailed population-health management approach is critical
    - Expanding the use of home-based remote monitoring technologies to support people to better manage their condition from the comfort of their own home
    - Developing digitally enabled integrated care pathways that offer clearer advice and guidance for how to access online health promotion, self-management support materials, e-therapeutic platforms, community service signposting, self-assessment services, self-referral options and wellbeing apps.
    - Giving greater choice to empower service users and carers to make better decisions and make it easier to interact with our services and access information about them.

Reducing inequalities is a central aim of the Collaborative, and we are committed to addressing inequalities from a digital perspective, moving digital exclusion to digital inclusion and addressing digital poverty

We will develop a digital delivery plan through 2024/25 that will outline our approach and those areas of identified focus.

8.3.8 Research and Evaluation

The principles of research and innovation (R&I) will be embedded within the Collaborative, evaluating the transformational change. This will support us to understand and demonstrate the Collaborative's impact, against the agreed metrics and across a range of balancing and other measures. It will also support our workforce, contributing to job satisfaction, enhancing skills, and recruitment and retention.

We will do this through existing research capacity within the Collaborative's membership, and through collaboration with the University of Birmingham, Aston University, and wider population health analytics in the BSol system.

The Collaborative's research and innovation programme will be:

- **Focused on our communities** – knowing our communities and their needs in relation to research and innovation; ensuring R&I is accessible and meaningful to our communities; supporting support our communities to participate in all aspects of research and innovation.
- **Driven by a confident and capable workforce** – ensuring that R&I is accessible and meaningful to our workforce, embedding R&I in workforce strategies, supporting a culture of continuous improvement
- **Collaborative and coordinated** – working together to facilitate R&I, and ensure collaboration, coordination and communication in R&I
- **Embedded in everything we do** – our work programmes and services will incorporate research and innovation into their design, planning and delivery.

9. Governance and assurance

9.1 Governance

Our governance continues to develop as the Collaborative matures, and since the SOC was approved the structure has responded to need and evolved. As shown in the diagram below, the Collaborative is accountable to the ICB through the BCHC Trust Board and the BCHC Community Care Collaborative Committee (chaired by BCHC Chair Prof David Sallah). The Collaborative Steering Group (chaired by BCHC CEO Richard Kirby) is the governing body for the Community Care Collaborative, and is well-established, with members from all partners in the Collaborative. The Steering Group is supported by the Collaborative Executive Group and the Collaborative Professional Advisory Group.

The Collaborative is represented at both Place Committees to ensure their close alignment and reports regularly to the Place Committees in Birmingham and Solihull as well as the GP Partnership Board.

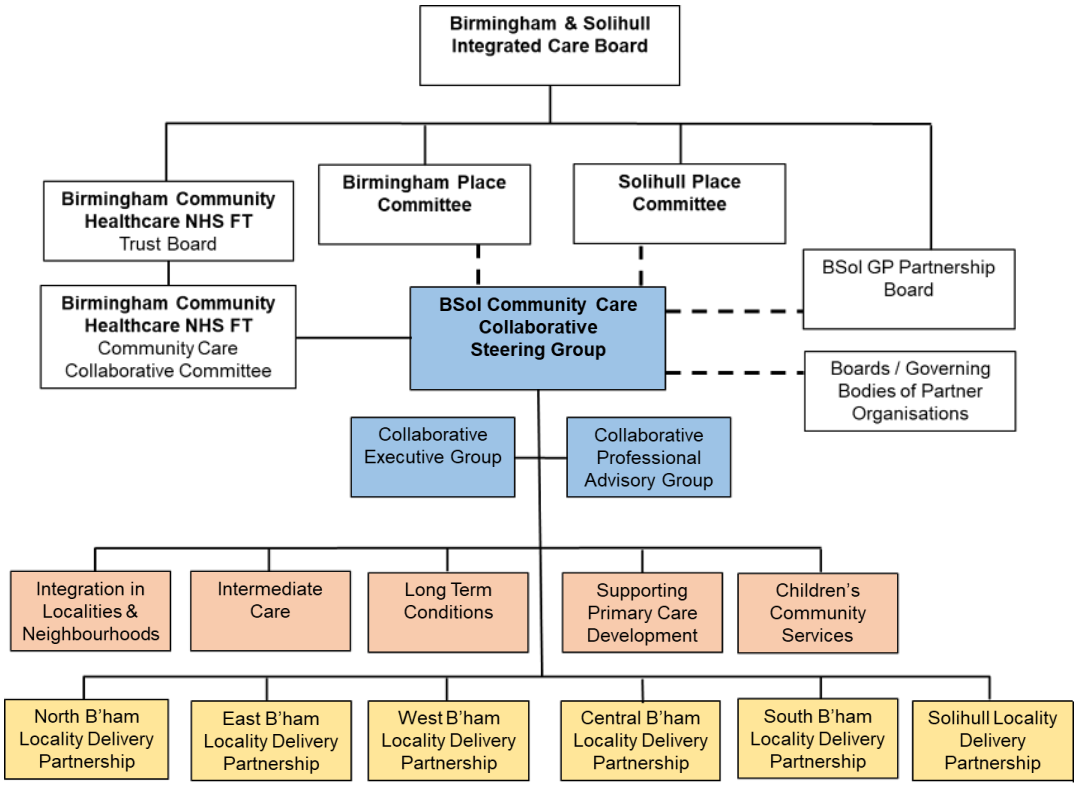


Figure 15 – Collaborative Governance Framework June 2024

The above diagram shows how the Collaborative works through

- **Locality Delivery Partnerships** – to deliver the Collaborative's commitment to integrated care through Localities, taking into account local population demographics (see section 6)
- **System work programmes** – system-wide design groups leading work on new models of integrated care and the redesign of care pathways (see section 5)

- **Collaborative-wide groups** - To agree the priorities and plans for the Collaborative, to hold programmes to account, to provide assurance to the ICB.

The Locality Delivery Partnerships are accountable to the Collaborative Steering Group and responsible to the Birmingham and Solihull Place Committees. The Place Committees may choose to delegate responsibilities to the LDPs and will want to ensure that local priorities are reflected in the LDPs Annual Delivery Plans and are being delivered.

As described earlier in this Plan, not all of the work programmes and not all the LDPs are 'live'; they will report into the Collaborative Steering Group and Place Committees once established.

As detailed in section 5.4, there is a separate Case for Change which proposes that the GP PSU is transferred to BCHC. If this is approved, it is likely that a Joint Committee would be established, with delegated functions of decision-making powers in respect of the ICB and BCHC. This would enable collective decisions in a more streamlined and efficient manner, as there will areas of joint concern given contracting and commissioning functions for primary medical care would remain with the ICB.

As the work programmes develop, there will be appropriate governance implemented to oversee the delivery. Given the interdependencies, it is proposed to have appropriate governance in place which aligns work programmes 1 and 2 around the development of the locality operating model. This is represented in Appendix 4. Further, relationships between the Collaborative and other Collaboratives will need to be considered to promote cross-collaborative working and identify interdependencies.

We also recognise that the Community Care Collaborative has important links to other system-wide work programmes. These include the system-wide Urgent & Emergency Care Board. The Collaborative's intermediate care work programme makes an important contribution to our system-wide urgent and emergency care pathway improvement as well as to the delivery of our Collaborative locality operating model.

9.2 Risk Management

In a complex system, with multiple partners and cross-cutting programmes of work, we need to be clear where and how risks are identified, owned and managed, and how assurance is given to the Steering Group and ultimately to BCHC Trust Board, which is accountable for the delivery of the Collaborative's work. Effective risk management will support the Collaborative and the partners to deliver the plans set out in this document, and to minimise the risk of harm to patients, citizens and our organisations[25].

[25] Provider Collaboration: A practical guide to lawful, well-governed collaboratives (nhsproviders.org)

There are a variety of ‘types’ of risks for the Collaborative. These include service-related risks both regarding transformation (e.g. identification of suitable estate for new services) and once services are up and running (for example the risk of partners moving staff away from INTs to staff other areas). It also includes broader risks such as inadequate resourcing of the Collaborative overall.

The principles of risk management that the Collaborative will work to are

- Any risk to the Collaborative, or to the delivery of programmes of work covered by the Collaborative, should be visible (at the appropriate level) through the governance structures shown above
- The Steering Group and Collaborative Committee will see significant risks and these will be held on BCHC’s risk management tool Datix
- The Steering Group, the Collaborative Committee, and BCHC Board will seek assurance that they are aware of the key risks, and that these are being appropriately managed.
- Lower-level risks will be held on project/LDP risk and issues logs, and/or managed through local organisations’ existing structures and reporting mechanisms
- Individual organisations/services, LDPs, or work programmes will own and manage the risks, as appropriate.

The Collaborative will frequently review the effectiveness of the risk management arrangements during 2024/25. As the arrangements become embedded and established, the frequency of review will reduce.

9.3 Role of Birmingham and Solihull Local Authorities

As shown in section 4.2, council-funded services are not currently in scope for inclusion in the lead provider portfolio for the Collaborative.

There may however be some elements of the Collaborative’s work programmes that are funded through the Better Care Funds in Birmingham and Solihull, which will require approval from Local Authority partners. This is identified in section 8.1 as a potential risk if there are differences in funding arrangements in the two Places within the Birmingham and Solihull Integrated Care System.

Both local Authorities are key partners in the work of the Collaborative, and commit to support the implementation and operation of the Birmingham and Solihull Community Care Collaborative:

- To work in partnership with Collaborative member organisations with the aim of improving services delivered by individual organisations within the partnership, or jointly as organisations working together.
- To provide appropriate representation at the relevant Collaborative forums and participate as per the Terms of Reference of those forums (e.g. Steering Group, Locality Delivery Partnership).

9.4 Quality

As the Collaborative takes on greater responsibility for the delivery of services, ensuring that these services are safe and of high quality will be essential. The Collaborative will establish a quality management system that incorporates quality planning, quality control, quality improvement and quality assurance. These elements are shown in Figure 16 below

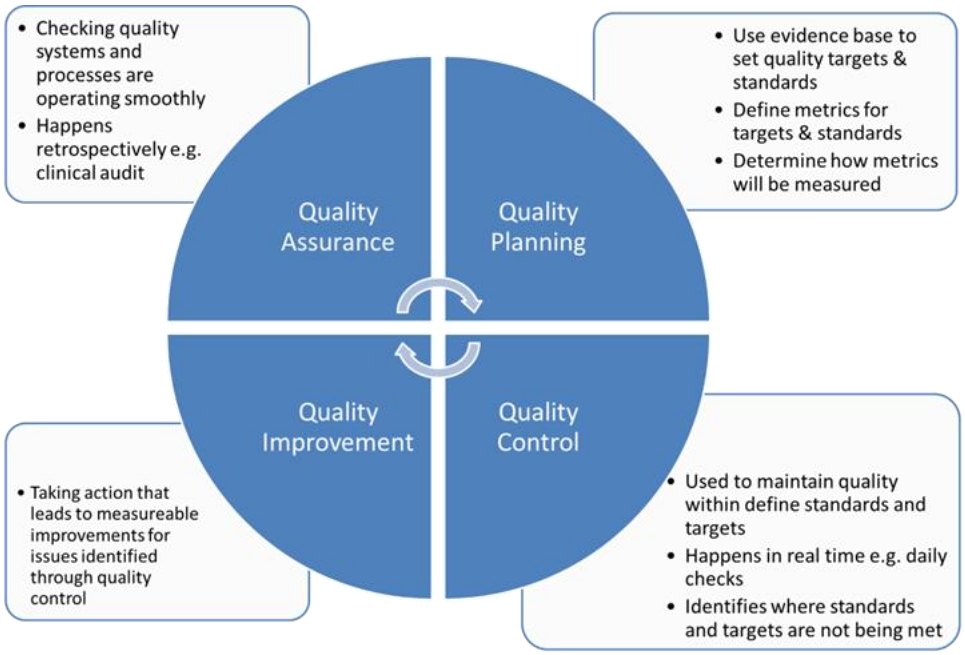


Figure 16: Quality Approach

Initially, the quality management system will be included as part of the existing BCHC governance framework. This will incorporate BCHC's Patient Experience team, and connection of the service-user's voice in the quality system including via the complaints system. The use of BCHC's existing framework is largely for pragmatic reasons and as we anticipate that there will be minimal additional resource transferred to the Collaborative to undertake quality management. As the Collaborative matures and takes on additional responsibilities, it may be necessary to establish management systems for a range of quality and corporate functions for the Collaborative itself.

9.4.1 Quality Improvement

BCHC has established itself as a leader in Quality Improvement (QI) across the local health system so is well placed to embed quality improvement as part of the culture of those whose work is linked to the Collaborative. Literature highlights positive associations between good improvement cultures and the experiences of both people accessing services and those who provide services. The Collaborative will establish systems and processes to ensure information is available to frontline teams (see section 8.3.7) so that they can identify where improvement is needed in quality or productivity, where there are inequalities in care provision and to equip those working within the Collaborative to have the skills and knowledge about improvement

science tools to be able to improve the quality and productivity of service delivery to address the holistic needs of local people in neighbourhoods, localities and places.

Recognising that continuous improvement approaches will vary across sectors and methodologies are similar but not the same, the Collaborative will adopt the key principles of the NHS Impact[26] approach, which are recognised as good evidence-based practice.

1. **Building a shared purpose and vision** which are widely spread and guide all improvement effort.
2. **Investing in people and culture** and building an improvement focused culture.
3. **Developing leadership behaviours** - Leaders at every level who understand improvement and practise it in their daily work.
4. **Building improvement capability and capacity** - The consistent use of an appropriate suite of improvement methods and tools.
5. **Embedding improvement into management systems and processes** so that it becomes the way in which we lead and run our organisations and systems.

As the Collaborative is a diverse and varied group of organisations and sectors, through 2024/25 we will develop and agree our shared approach to quality improvement. This will encompass how we

- Establish and start to embed the agreed improvement model across the Collaborative
- Embed the citizen and service user voice in the quality improvement approach including identification of areas for improvement
- Invest in and support the development of QI capability and capacity (tools and approaches) and how the QI resource is used across organisations and sectors
- Build in local initiatives where teams highlight areas for improvement to resolve local issues (e.g. QI Huddles)
- Apply QI tools and improvement science thinking to the major projects within the five Collaborative work programmes
- Ensure the improvement is data-driven and evidence-based
- Create a community of practice and associates' model that enables us to more successfully share and deploy resources across the system
- Role model the right behaviours whilst sharing and learning from each other the impact of our efforts.

10. Conclusion

The Community Care Collaborative, working together to connect and coordinate services around our citizens and neighbourhoods, gives us a real opportunity to improve outcomes for citizens and patients. We will do this via our five work programmes, and through our six Locality Delivery Partnerships.

[26] NHS England » NHS IMPACT

As noted in section 2, improved integration has been shown elsewhere to reduce the burden of non-elective work in acute trusts, and improve care and outcomes, although sustained changes may not be apparent for several years. Across a number of areas, early evidence of the impact of improved integration can be demonstrated, leading to longer-term fall in mortality and morbidity rates.

As demonstrated throughout this Implementation Plan, realising the potential benefits and changing the way that services are set up and delivered will necessitate a shift in resources and focus. In the main we will transform our services through a realignment of existing resources. However, it should be recognised that there is also a need to fund the Collaborative's infrastructure if we want to make meaningful, lasting, and efficient change. For example, investment in

- Communications resource – to work with our staff and communities so that they understand how and why we are working differently
- Experts by experience – to bring meaningful and inclusive voices to the Collaborative and its programmes of work,
- Digital, information, information governance experts and technology, to enable integration and visibility of data and information at the appropriate level, to inform service design, and delivery of connected direct patient care
- Locality managers, to facilitate the emerging LDPs and see them develop as the delivery arm of the Collaborative.

This Implementation Plan has laid out the intentions for the Collaborative over the next three years, and how we will deliver these plans in a well-managed and planned way. We fully anticipate that the Collaborative and its work programmes will need to change, adapt, and be flexible given the political and economic context in which we are working. The governance processes laid out in section 9 will ensure that any decisions are made openly and according to the principles of the Collaborative laid out in the SOC.

Our partnership is committed to making our services **Connected** and **Accessible**, so that people have access to and can navigate our health and care services; to providing more **Responsive** and proactive care, and to **Empowering** our communities, and helping everyone to live a healthy, happy life. Working as needed at system, Place, Locality and Neighbourhood level, in a 'system-designed, locality-delivered' model, will enable us to localise services and address health inequalities, within a framework set by the Collaborative.

We believe that the Birmingham and Solihull Community Care Collaborative provides a historic opportunity to better meet the diverse needs of all communities across our Integrated Care System and we are all fully committed to ensure that, as the Collaborative, we play our part in realising the vision for the 'people of Birmingham and Solihull to live longer, healthier and happier lives'.

Appendix 1 – C.A.R.E Approach

Our C.A.R.E. approach (see boxes below for more details) includes being better able to identify and take action to address inequalities in the provision of existing services in terms of access, experience and outcomes for the people of Birmingham and Solihull. We will also be able to make better use of our collective resources, both financial and our workforce, by working in more integrated and innovative ways involving all partners in our Community Care Collaborative – the NHS, Local Authorities, Voluntary, Community, Faith and Social Enterprise sectors.

The Community Care Collaborative will be CONNECTED – working better together in local places

As a Community Care Collaborative, we will work together to ensure the NHS, Local Authorities and voluntary, community, faith and social enterprise (VCFSE) organisations understand and are better able to meet the needs of local people.

We will work together to make it easier for all people to understand and navigate health and care services, removing barriers between different services and service providers to make care person-centred and as connected as possible.

We will make greater use of digital technology to share information, including enhancing Personalised Care and Support Planning, enabling people to join in conversations about their health and well-being and shape their care and support. With appropriate safeguards and consent, everyone involved in providing care will know what people need and want and involve people in making decisions about their care. This will prevent people having to repeat information about themselves and remove duplication – and potential gaps – between care providers. We will adopt the Shared Care Record as the digital tool to provide better joined-up visibility of digital care plans.

We will work together to co-locate services where possible and appropriate, to provide the best connected care. We will adopt a 'think prevention' approach and will work together effectively to enable this.

The Community Care Collaborative will be ACCESSIBLE - helping everyone to more easily access the care they need, when and where they need it

As a Community Care Collaborative, we will make it simpler for everyone to access the information and services they need, when they need it and where they need it.

Prevention

Our 'think prevention' approach will mean that information and advice is accessible in a co-ordinated and joined up way.

When people need care quickly but don't need to go to hospital – we will make it easier for people to get the care they need by developing an integrated urgent community care model across primary care, community care and social care. This could include a same day appointment at an Integrated Care Hub , a visit to a person's home from our Urgent Community Response service, a short stay in one of our community intermediate care centres or additional monitoring and support on a 'virtual ward'.

When people have longer-term or more complex needs – we will provide more proactive, responsive and personalised care with support from interdisciplinary teams of care professionals (see Responsive)

When people have been in hospital and need additional support – we will work with each person, based on their individual needs and circumstances, to better support them to go home through a service like our virtual wards and our Early Intervention Community Teams, or to have further treatment in one of our community intermediate care centres

The Community Care Collaborative will be RESPONSIVE - providing more proactive, personalised care

As a Community Care Collaborative, we will provide more **proactive**, personalised care with support from multi-disciplinary and multi-organisational teams of care professionals. Our Integrated Teams and multi-organisational teams working within Neighbourhoods / Localities / Places will be able to make better use of information, through shared care records and by working closely together, to identify those people most at risk of deteriorating health and wellbeing, enabling teams to take earlier, preventative action to support people with the appropriate help and care

Where possible, the health and care professionals working in these teams will be physically based together, making it as easy as possible for them to work together, across professional disciplines and organisations to feel like one team – a 'team of teams'

We will expand the use of home-based technologies to support people to better manage their condition(s) from the comfort of their own home. While this won't suit everyone, where people want to be trained to use technology to support their care we will make it accessible to them.

The Community Care Collaborative will be EMPOWERING - helping everyone to live a healthy, happy life

As a Community Care Collaborative, we will work together in local communities to develop and make it easier to find, and get access to better information about living a healthy, happy life, including how to get advice on other important services like employment, housing and benefits. We will focus on the 'Big 5' causes of the gap in life expectancy between those living in the least deprived areas and the most deprived areas:

- Circulatory Disease, including heart disease and diabetes

- Infant Mortality
- Respiratory Disease, including asthma
- Cancer
- Mental Health, including addressing social isolation and loneliness

We will prioritise prevention, and make it easier for people to find out what activities are available in their local area and how to access these. This may be through a physical building also known as a ‘hub’ and also information available online. We will also provide support to help people work out what you need through the Neighbourhood Networks Scheme in Birmingham and similar in Solihull, Social Prescribers, Care Connectors, Early Help and other existing mechanisms to connect people and their families to the support they want.

We will expand the 'Healthy Schools' programme, including the 'health hack' model developed in Ladywood & Perry Barr to provide children, young people and their families with information about specific topics. We will also look to expand the 'community researchers' programme giving young people opportunities and experience.

We will engage and involve citizen representatives and Experts by Experience in every decision-making group, at all levels of our Collaborative. Through our VCFSE partners, we will actively engage with all local communities, with a particular focus on the marginalised, minoritized and so-called ‘seldom heard’, to ensure we are working on the issues that matter most to local people. We will work together with our super-diverse communities across Birmingham and Solihull to co-produce services that most effectively meet local needs.

Appendix 2 – Collaborative Outcomes – Evidence Base

High-intensity service users

Several programmes have been implemented and evaluated elsewhere to work with this population[27]. These service users often have a range of complaints including social issues, mental health, loneliness, addiction, complex medical presentations, or a combination of any of these factors. Through the multi-agency support programmes, a reduction in ED attendances of up to 59% and up to 67% reduction in admissions has been demonstrated, with associated financial savings.

Virtual wards

The current virtual ward (VW) provision across Birmingham provides predominantly step-down care for respiratory and frailty and is relatively new in its implementation. The service is under review, but with a recognition that the occupancy for the respiratory ward is low. However, despite Birmingham having not yet seen a significant impact, a recently published evaluation of more mature services across the South-East of England[28] analysing data from 22,000 admissions suggest that VWs can achieve a 1:1 association between the 'avoided' non-elective admissions and VW activity, with a strong return on investment. Providing a stronger virtual ward model will particularly support those with long-term conditions (LTCs); we would expect to see impact on improved patient experience, and overall reduction in overall healthcare use, including acute hospital care.

Long Terms Conditions

Cardiovascular disease (CVD) secondary prevention

The prevalence of hypertension in Bsol is much lower than the national average (c12.5% v 15%) which, given the demographics suggests under-reporting - 86% of GP-registered patients over the age of 45 have had a blood pressure reading in the last five years. This is why we expect to see increased identification of disease through the Collaborative's work. In terms of outcomes, only 65% of under 80's have a lower blood pressure than recommended. Diabetes prevalence is higher than the national average, only two-thirds are receiving optimal therapy with acceptable control achieved in only one-third of Type 1 diabetics.

Measurable improvement in blood pressure and diabetes will be through a combination of identification, and then optimal management. Much of this will be GP-led and through contractual mechanisms, however the evidence does suggest that the wider input from integrated care systems will also provide benefit by reducing blood pressure, HbA1C levels and subsequently hospital admission**Error! Bookmark not defined.**. With improved care, diabetic ketoacidosis (DKA) and hypoglycaemia should reduce. Whilst it will be outside the scope of the Collaborative in the short-term, such secondary prevention should correlate with longer-term reduction in CVD and its associated mortality and morbidity.

Respiratory disease

[27] Sillero-Rejon C et al. Supporting High impact useRs in Emergency Departments (SHarED) quality improvement: a mixed method evaluation. *BMJ Open Qual.* 2023 Dec 19;12(4); Teams working with high intensity users of health services in BSW report positive results - BSW Together

[28] Summary of South East region virtual wards evaluation. NHS England. 16th May 2024

The NHS Right Care pathway for COPD sets out the necessary components for early identification, diagnosis and optimal management. QOF data suggests our population has a relatively low rate of COPD, which may represent under-recognition. With increased access to place-based diagnostics (spirometry etc.) there should be an initial increase in recorded prevalence. Improving access to pulmonary rehabilitation, in addition to broader measures such as medicines optimisation, discharge bundles, improved self-management and personalised reviews would be anticipated to reduce system performance metrics, but equally important will be to identify patient related experience measures that are not widely captured at present.

Smoking cessation
An important risk factor for both CVD and respiratory disease is smoking. Whilst recent legislation seeks to prevent people form starting, this will not impact on long-term outcomes for many years. Approximately 15% of the BSol population smokes. Dedicated smoking cessation programmes have been demonstrated to reduce hospital admission and 1-year mortality rates compared to controls[29]. Whilst the evidence is primarily related to programmes commenced in hospital, there is no reason these pathways cannot be extended to the community. With the data available we should be able to measure an overall reduction in smoking prevalence, and (together with other Collaborative measures) early reduction in admission/readmission for respiratory related diseases.

Wound care
The National Wound Care Strategy Programme (NWCSP) has been commissioned by NHS England to improve the care of pressure ulcers, lower limb wounds and surgical wounds. In England, there is considerable variation in leg ulcer practice and outcomes which increases care costs and extends healing times. This unwarranted variation offers major opportunities to improve healing rates and reduce recurrence rates and thus reduce individual suffering, spend on inappropriate and ineffective treatments and the amount of clinical time spent on care.

There are an estimated 739,000 leg ulcers in England with estimated associated healthcare costs of £3.1 billion per year, placing a significant burden on NHS services. There is robust evidence that demonstrates that ensuring equitable and accessible services for people with leg ulcers would reduce unwarranted variation of care, increase the use of evidence-based care and discourage the over-use of therapies for which there is insufficient evidence, resulting in higher healing rates and lower recurrence rates.

Locality based specialist lower limb clinic would provide centres of expert clinical assessment and treatment with better use of prescribing resources and efficient use of clinical time. It is anticipated that a standardised approach would improve healing rates and this could be readily demonstrated through measurable outcomes.

Health inequalities and wider impacts

[29] Mullen KA, et al. Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare outcomes. *Tob Control*. 2017 May; 26(3): 293-299

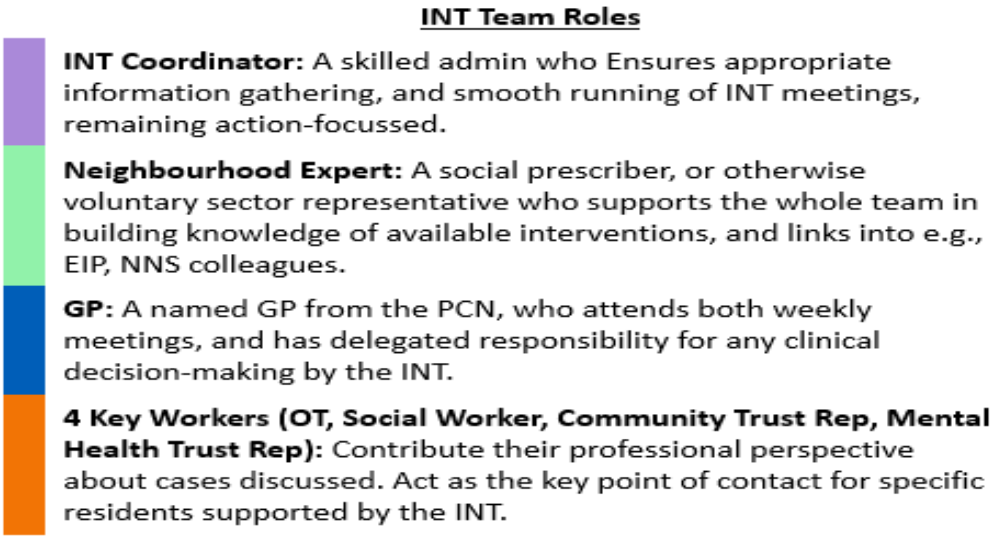
It will be vital that the Collaborative acts to reduce health inequalities, addressing the Core20PLUS5 principles. In terms of the five programmes for accelerated work, the Collaborative will be vital as part of the hypertension and chronic respiratory disease pathway improvement (previously described), but also for increased cancer screening uptake. BSol has some of the lowest screening coverage within England:

Indicator	Period	Birmingham and Solihull ICB - QHL			NHS regions (since ICB setup) England	England		England	
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Proportion of GP registered populations by age group (65+ yrs)	2023	→	217,557	13.6%	18.5%	17.7%	9.3%		25.0%
Deprivation score (IMD 2019)	2019	–	-	-	-	21.7	-	*Insufficient number of values for a spine chart*	-
New cancer cases (Crude incidence rate)	2021/22	–	-	418	-	540	320		716
Breast screening coverage: aged 53 to 70 years old	2022/23	–	81,025	59.4%	67.2%*	66.6%	51.0%		75.7%
Cervical screening coverage: aged 25 to 49 years old	2022/23	↓	167,529	60.8%	67.6%*	67.0%	55.3%		73.5%
Cervical screening coverage, aged 50 to 64 years old	2022/23	↓	85,989	72.2%	75.4%*	74.9%	68.7%		78.1%
Bowel cancer screening coverage: aged 60 to 74 years old	2022/23	↑	123,285	64.8%	71.8%*	72.0%	61.0%		76.5%

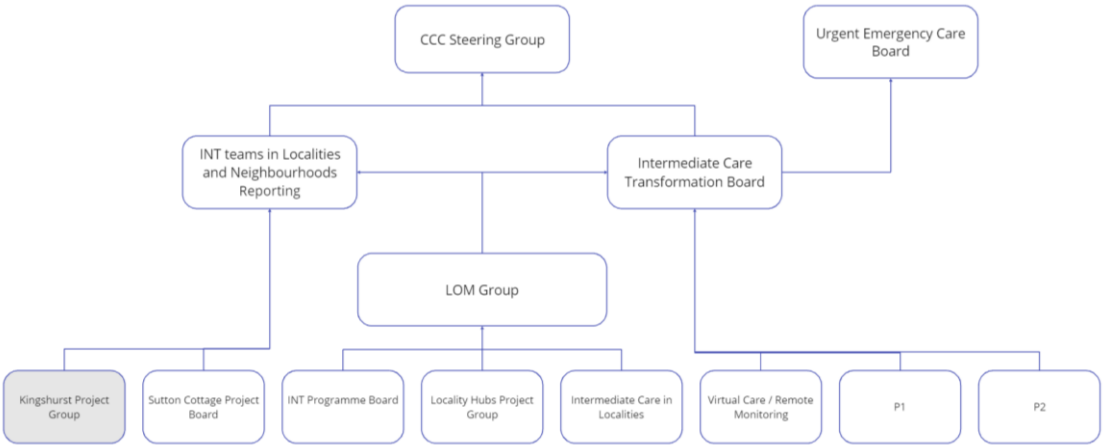
Following recent pilots using “Community Health and Well-being Workers” in London**Error! Bookmark not defined.** cancer screening and NHS Health Checks was 82% higher than previously matched time period. Without necessarily replicating this exact model, it is a proof of concept for better in-reach to underserved communities, using local population understanding and data. In addition to measuring cancer screening coverage, immunisation uptake was also increased by 47%. It is through these surrogate measures that one could assess the impact of the work at integrated and primary care level.

Using a data-driven approach, and targeted action, neighbourhood and Locality teams will identify and address health inequalities. Working well with our communities should identify underserved populations and reduce health inequalities measured through surrogate markers.

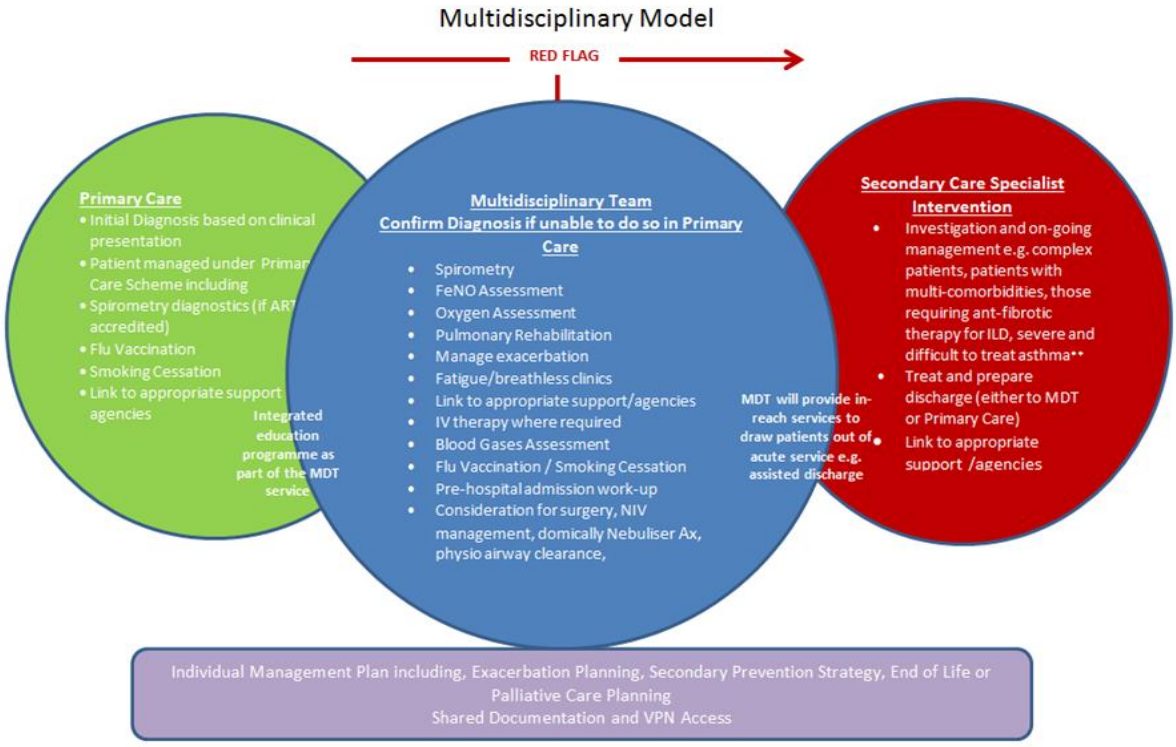
Appendix 3 – Integrated Neighbourhood Team Roles



Appendix 4 – Governance for Locality Operating Model



Appendix 5 –Respiratory Multidisciplinary Model



**https://www.brit-thoracic.org.uk/document-library/clinical-information/specialist-referral/bts-statement-on-criteria-for-specialist-referral/

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Developing the Birmingham and Solihull Community Care Collaborative

Overview of Implementation Plan for Partners

June 2024

Community Care Collaborative on a page

Community Care Collaborative

Providing the **right care** at the **right time** in the **right place** for the people of Birmingham & Solihull

The Strategic Outline Case (SOC) was approved by the ICB in November 2023. This laid out the vision, the C.A.R.E. approach and the five work programmes for the Collaborative, which are shown in this infographic.

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

www.birminghamsolihullics.org.uk

Benefits and outcomes of the Collaborative

Work Programme	2024/25 Key Metrics
Integrated Teams in Neighbourhoods & Localities	• Reduced GP attendances for HISUs • Reduced GP attendances for non-clinical issues e.g. lifestyle support • Reduced ED attendances and admissions for HISUs
Intermediate Care	• Reduced ED attendance, admissions and length of stay for intermediate care amenable conditions • Increased use of frailty virtual wards • 2h Urgent Community Response performance target • Increased uptake of ‘call before convey’

Long term conditions	• Increased identification of people with hypertension
	• Improved clinical outcomes –
	  ○ Increase in people supported to die in place of choice outside acute settings
	  ○ Reduction in smoking prevalence
	  ○ Treatment optimisation for high blood pressure and cholesterol within general practice
	  ○ Increased immunisation uptake for ‘flu and pneumonia
	• Improved system outcomes –
	  ○ reduced ED attendances, acute admissions and length of stay for COPD, asthma, cardiovascular disease and end of life care; Increased use of respiratory virtual wards

Supporting Primary Care Development	• Reduced attendance at Urgent Treatment Centres for wound care • Reduced follow-up attendances in general practices for wound care • Increase in proportion of self-referrals to other services

Collaborative Model of Care

The Collaborative model of care is based on our C.A.R.E. approach (Connected, Accessible, Responsive, Empowering)

1. Focus on a “whole person” approach that brings together the physical and mental health needs of our citizens and seeks to design services that bring a bio-psycho-social approach to the understanding of people’s strengths and needs for support. (**Empowering**)
2. Developing easy access to appropriate care and advice from primary care and community services when people need it. (**Accessible**)
3. Developing pro-active, personalised care from multi-disciplinary and multi-organisational teams for people with complex needs including long-term conditions. (**Responsive**)
4. Strengthening our approach to community-based prevention and early intervention in ways that support people to stay well at home. (**Empowering**).
5. Bringing together intermediate care services to build a co-ordinated, locality-based approach to intermediate care based on a “home first” approach and a focus on maintaining independence, rehabilitation and recovery (**Responsive**).
6. Building partnerships with the community, voluntary, faith and social enterprise sector to deliver support in ways that work with local groups who know and understand the people who live in their community (**Connected**).
7. Focussing on those citizens and communities who most need support as we play our part in the wider work of the Integrated Care System to reduce inequalities in health outcomes in Birmingham and Solihull. (**Empowering**).

The work will be overseen by the Locality delivery Partnerships, through an agreed, system-designed, Locality Operating Model.

Locality Delivery Partnerships

The Community Care Collaborative has established six Locality Delivery Partnerships (LDPs) that are accountable to the Collaborative Steering Group, with a link to the Birmingham and Solihull Place Committees and to the GP Partnership Board. Each LDP is chaired by a Locality GP, who is a representative on the GP Partnership Board, who will work closely with a named senior system leader.

The LDPs are bringing together providers of primary care, social care, community physical and mental healthcare, the voluntary, community, faith & social enterprise sector, and secondary care. They are at different stages of maturity across the BSol system.

The purpose of the LDPs is to:

- Focus on delivery and be a “unit of action”; with each LDP developing an annual delivery plan linked to the Collaborative key Delivery Priorities, taking into account local population demographics.
- Have an outcome focus and encourage a preventative and proactive approach.
- Drive integration and quality improvement

The LDPs will focus first on integrating physical and mental health and care for adults. Initial operational focus in 2024/25 will be on the development and delivery within the locality of:

- Integrated Neighbourhood Teams and establishing a ‘Locality Operating Model’
- Local Intermediate Care pathway
- Development and operation of physical Locality Hubs for same day urgent community care
- Oversight of the allocation of Fairer Futures Locality Funds targeted to local health needs, and monitoring delivery
- .

Locality Operating Model

The shift to more joined up care will be facilitated by the development of an all-age system Locality Operating Model (LOM), based on provision at the following levels:

- General Practice
- Neighbourhood
- Locality

It will include all system partners, to provide care closer to neighbourhoods and communities and support the move towards more localised coordination and decision making. The LOM will

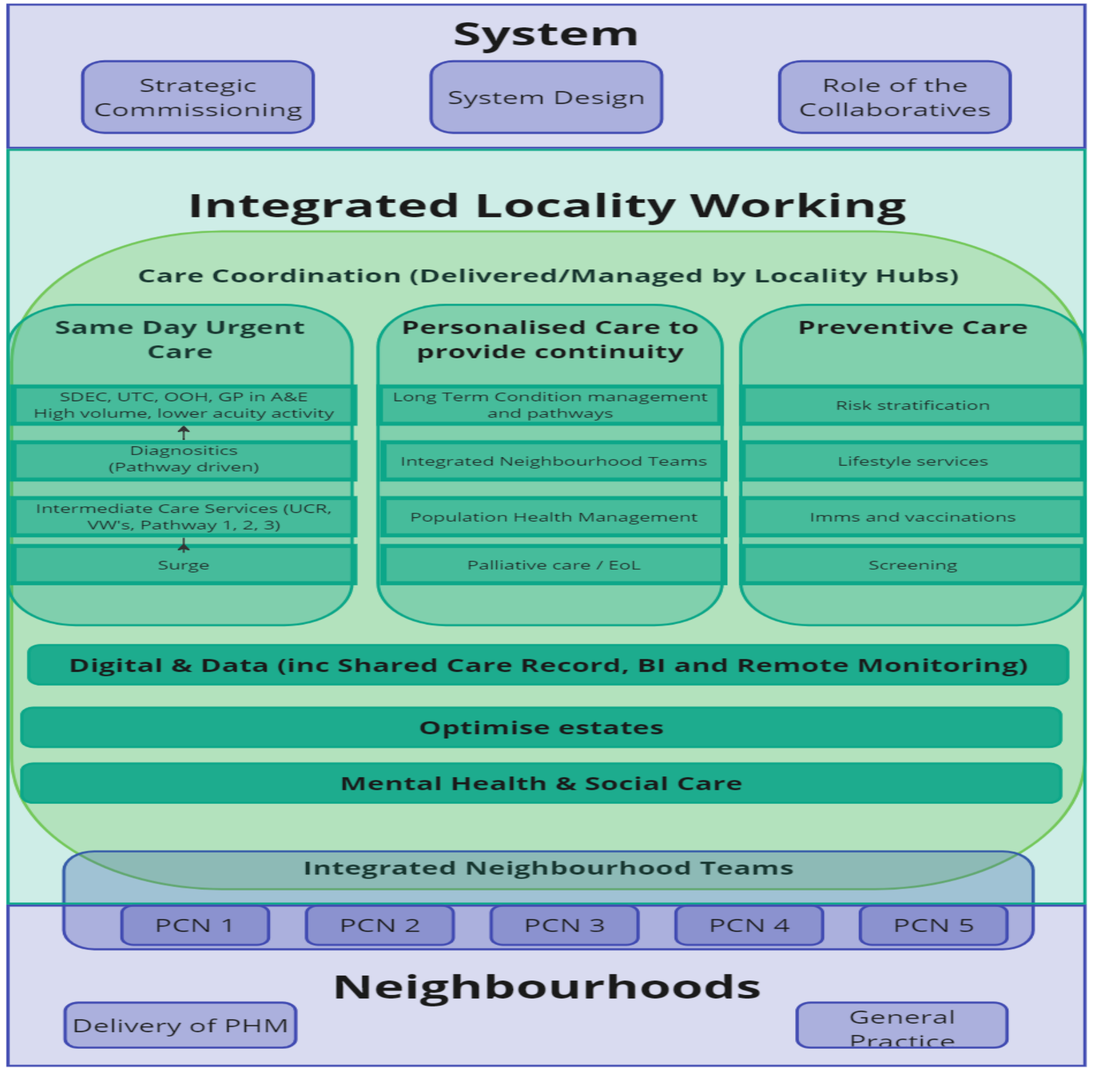
- deliver an offer for episodic or same day urgent care built around our neighbourhoods and localities as well as
- increase our capacity for continuity of care and prevention.

An emerging LOM has been developed with system partners (Figure 3) and it is anticipated that this will continue to develop.

Locality Hubs

A key feature of the Locality Operating Model is the locality hub, with one planned for each of the six localities. These will deliver

- a care coordination function,
- a physical location for locality based long term condition management,
- Same-day urgent treatment capacity for the Locality,
- the ability to mobilise surge capacity for the locality,
- a potential base to act as the locality 'HQ'.



Scope of the Community Care Collaborative

In Scope

- Integrated Teams in Neighbourhoods and Localities
- Intermediate Care (NHS-funded)
- Intermediate Care (council-funded
- Urgent care bundle
- Primary Medical Care development (GPPSU)
- Adult Community Services
- Long Term Conditions
- Children's Community NHS Services

Out of Scope*

- Children's Community Services where jointly commissioned with LA
- Mental Health Services
- Primary Care Contracting & Performance
- Continuing Healthcare (CHC) Packages of care
- Learning Disability and Autism Services (these will sit in the MH Collaborative)
- Services outside of BSol footprint

*Where services are included in 'out of scope' – the Collaborative will not be responsible for the delivery or coordination of these services. However, Collaborative partners and services will still be working closely with other services (for example mental health practitioners are a key part of the INT).

Birmingham and Solihull Integrated Care System
Caring about healthier lives

ICB Community Services Portfolio Overview – Current State

	Localities and INT	Intermediate Care	Urgent Care	Supporting Primary Care	Adult Community Services		Long Term Conditions	Children's Community Services
					Birmingham	Solihull		
Services included	• Non-recurrent INT • Non-recurrent Locality Hubs • Place Support Teams	• P1 Home Care (NHS/council-commissioned) • P2 • Care Home Support (Solihull) • Discharge Outside Pathway • Virtual wards • UCR • Care Coordination Centre	• UTCs • GP OOH • GP streaming at EDs	• GP Provider Support Unit • ARRS coordination	• Community Nursing • Specialist Nursing • Therapies • Community In-patient • Early Intervention Team • Long Covid	• Community Nursing • Specialist Nursing • Therapies • Community Inpatient	• CVD / Stroke • Diabetes • Respiratory • End of Life	• Detail of portfolio TBC
	Aligned VCFSE Contracts							
Commissioners	ICB Better Care Fund	ICB Local Authorities Better Care Fund	ICB	ICB	ICB	ICB	ICB	ICB Joint commissioning Local Authorities
Providers	BCHC Primary Medical Care VCFSE	BCHC UHB VCFSE	BCHC Various Independent	ICB (currently)	BCHC VCFSE	UHB VCFSE	BCHC UHB VCFSE	BCHC UHB VCFSE

Role of the Community Care Collaborative

The role of the Collaborative will evolve over time as the Collaborative matures and the Collaborative may take different approaches in different scenarios. These roles may vary dependent on where and how existing services are commissioned, the number of providers involved, and the benefits that a system-wide provider might bring.

	24/25	25/26	26/27
Localities and INTs			
Intermediate care: NHS services			
Intermediate care: council-commissioned services			
Urgent care	Subject to UTC review		
Primary Medical care development		(pending separate case for change) from Apr 25	
Adult community services (Bham)*			
Adult community services (Solihull)*			
LTC programme			
Children's community services**			To be decided

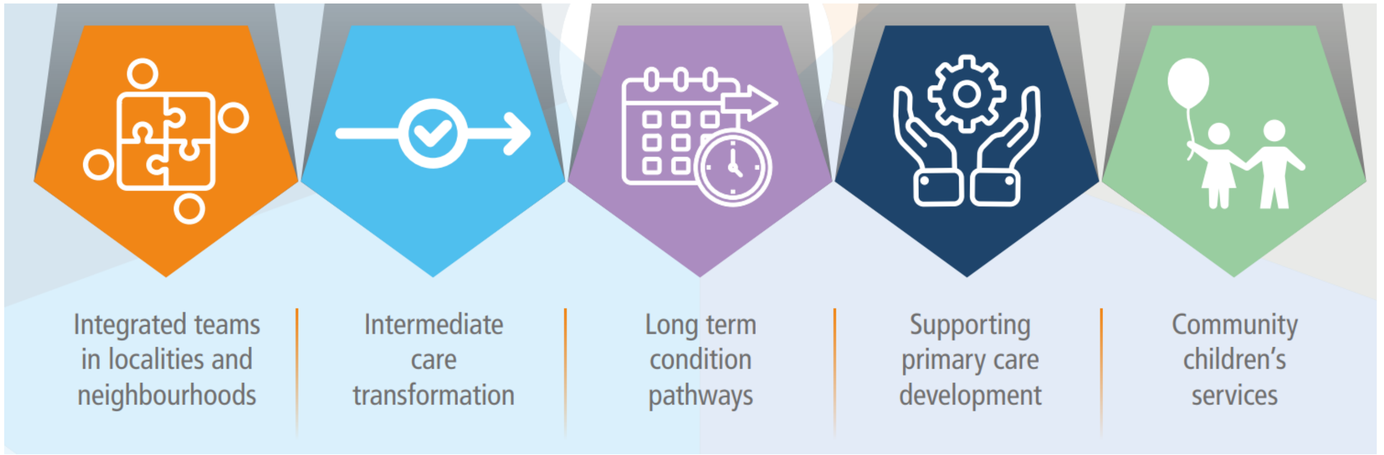
	Lead provider – responsible for services	Some or all functions and resources within scope of the Collaborative transfer to the lead organisation with resource channelled through the Lead or Sole Provider to deliver the functions required.
	Programme Enabler – oversight and coordination	The Collaborative plays a convening role that better enables stakeholders to align their own decision making and delivery activities. Budgets, resources, accountability remains with individual organisations
	Status quo	Providers to work as active partners in commissioner-led programmes

*The ICB is leading a review of Community services, including future arrangements for commissioning and provision. The Collaborative will work with the ICB to determine the most effective and appropriate models of commissioning and delivery of services and to include the outcome of this review in our future development

**The long-term vision is that Children and Young People's (CYP) community services will, ultimately, be in scope for the Collaborative. However, the ICB's Children and Young People Partnership Board is currently being established and will provide a strategic view on CYP services and the role of the Collaborative. CYP services are therefore not being brought into the Collaborative at this point; plans will be developed and approved through the CCC Steering Group.

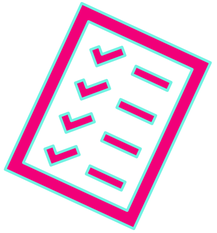
What will the Community Care Collaborative do?

There are five programmes of work, which are at differing stages of development.



Work Programmes		Design	Build	Operate
Integrated Teams in Neighbourhoods and Localities			√	
Intermediate Care			√	
Long Term conditions		√		
Supporting Primary care Development			√	
Children's Community Services		√		
Enabling Programmes	Estates	√		
	Digital	√		
	Workforce	√		

Collaborative Delivery Plan for 2024/25



Development of the Collaborative	Integrated Teams in Neighbourhoods and Localities	Intermediate Care	Long Term Conditions	Supporting Primary Care Development	Children's Community Services
• Develop, agree and implement Quality Improvement approach • Models for VCFSE, citizens and Experts by Experience (EbE) involvement designed and implemented • Develop workforce, digital and estates delivery plans • Develop Locality Operating Model dashboard • Establish LDPs in all localities • Embed robust governance and risk management approaches across the Collaborative	• Sustainable, integrated digital solution in place for ongoing identification of INT caseload(s). • Locality hub 'case for change' agreed. • Integrated locality operating model tested and evaluated in one locality. • Digital and Estates enabling strategies agreed	• Locality-based Intermediate Care service tested and evaluated in one Locality • Recommissioning of P1 Pathway (Birmingham) agreed. • Full Business Case on provision of Phase 2 of Pathway 2 beds agreed (Birmingham & Solihull). • Process for transfer of commissioning responsibilities for NHS services	• Establish BSOL Respiratory Board • Appoint BSOL clinical lead for respiratory. • Bring together existing respiratory programmes. Refine and test integrated community team model aligned to an acute hospital and its localities during winter 24/25. • Develop future community diagnostic model for BSOL. • Establish single respiratory clinical dashboard for BSOL. • Complete review of Pulmonary Rehabilitation and Home Oxygen services • Map currently commissioned and provided circulatory activity • Create a single set of system hypertension metrics to form part of system circulatory dashboard • Launch integrated EoL life OOH service across Bsol • Delivery on improved identification metrics • Develop Bsol EoL Dashboard • Set planning for Bsol system EoL Strategy • Web based platform launch	• Design and implement wound care model • Redesign process for joint working between general practice and community nursing • Launch ICBs transfer of commissioning responsibilities (September) to move the PSU to BCHC	**SUBJECT TO FURTHER WORK ACROSS THE SYSTEM TO DETERMINE THE ROLE OF THE COMMUNITY CARE COLLABORATIVE**
Overarching Deliverables					
• Initiate a joint communications plan for staff and the public • Produce and implement a combined community and general practice winter plan					

Resources

Appropriate resourcing of the Collaborative, and the risk to delivery if this is not adequate, is recognised as a significant risk (rating 15) on the Collaborative's risk register. In view of the current financial situation, it is understood by partners that in large part improvement and transformation will need to come from a realignment of existing resources, rather than the ability to expand the workforce. However, there are significant requirements in some areas:

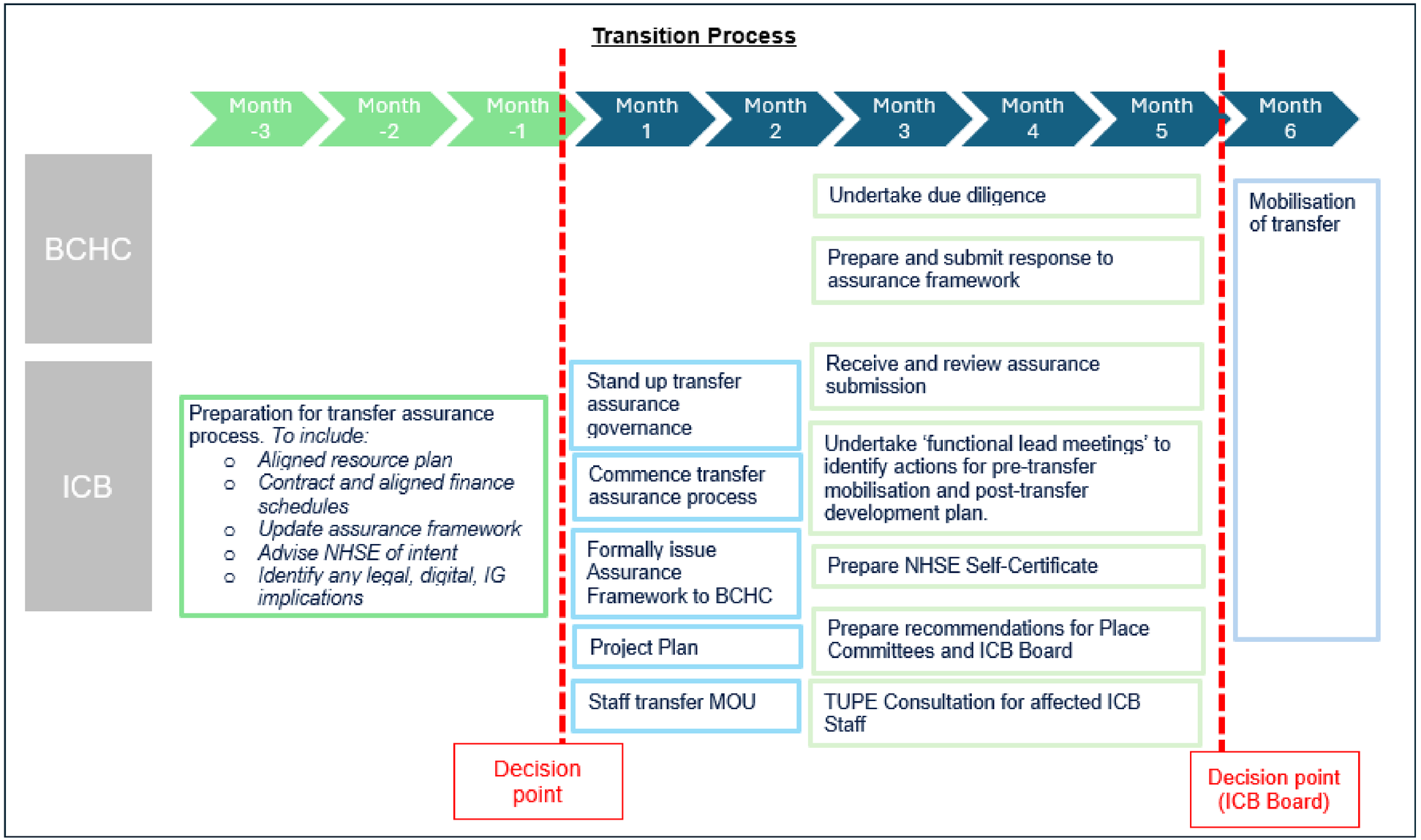
- **Delivery Team** - There has been some investment in the overarching architecture of the Collaborative, in recognition of the need to invest in resource to drive forward change and transformation. This provides sufficient capacity to make the progress that we aim to make in 2024/25.

- **Collaborative Infrastructure** – additional capacity in some key corporate areas will be crucial if we are to realise the potential benefits of the Collaborative. These include
  - Business Intelligence
  - Information Governance
  - Digital
  - Communications
  - Experts by Experience

- **Work Programmes** – though individual work programmes will be subject to business cases where appropriate, investment will be sought for
  - Locality Hubs – to recurrently fund the hubs
  - Integrated Neighbourhood Teams – to support new roles in rolling out the programme

Standard Process for Transfer of Commissioning Responsibilities from the ICB to Provider Collaboratives

In order for the lead organisation for the Collaborative (BCHC) to assume Lead Provider status, there will be a formal process followed as shown, led by the ICB. This will take a minimum of six months.



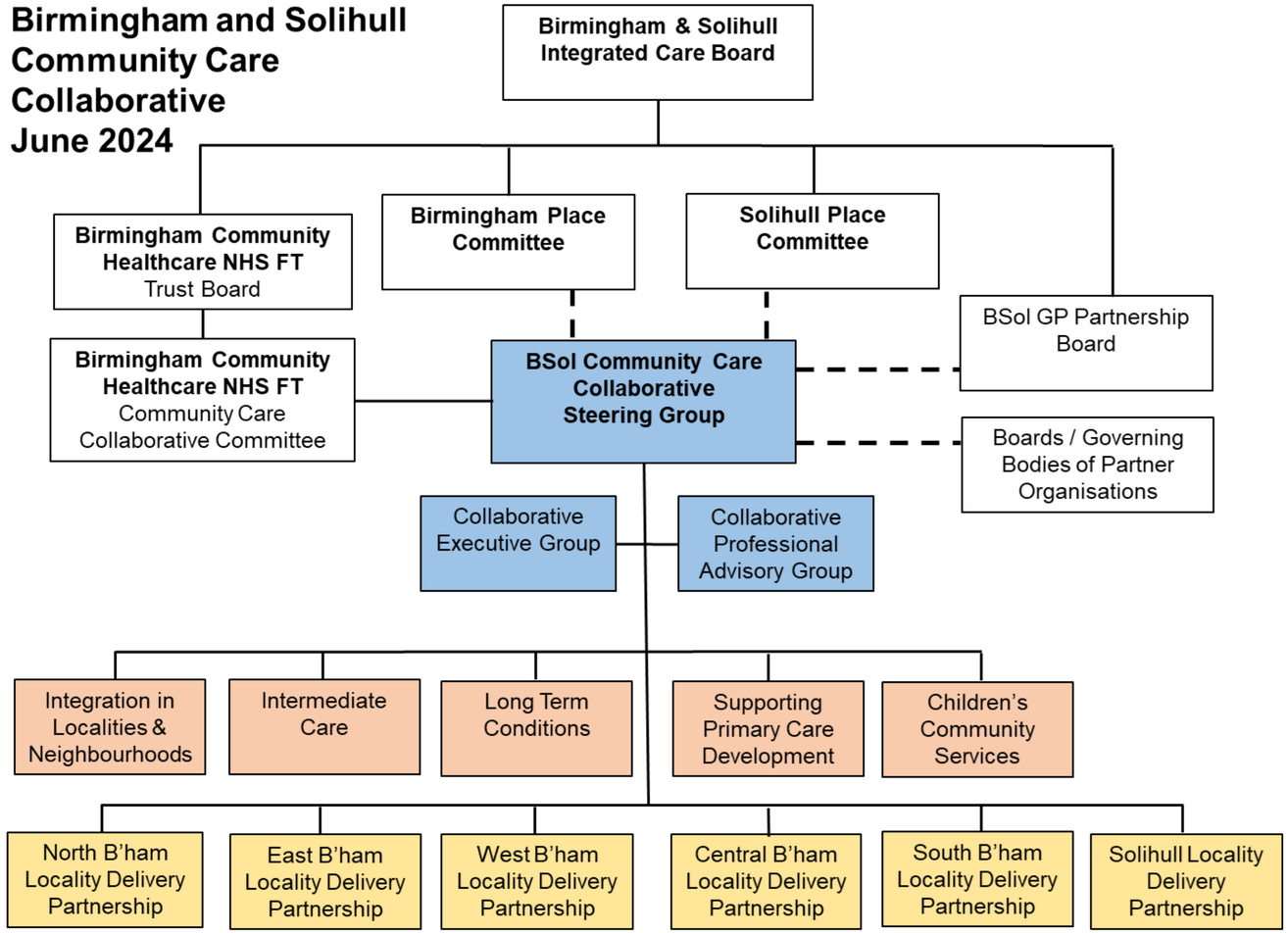
Governance of the Collaborative

The Collaborative Steering Group is the governing body for the Collaborative and provides assurance to the Integrated Care Board via the BCHC Community Care Collaborative Committee and BCHC Trust Board.

The Collaborative works in two ways:

- **System work programmes** system-wide design groups leading work on new models of integrated care and the redesign of care pathways;
- **Locality Delivery Partnerships** – to deliver the Collaborative's commitment to integrated care through Localities, taking into account local population demographics

The Collaborative reports regularly to the Place Committees in Birmingham and Solihull as well as the GP Partnership Board. The Collaborative is represented at both Place Committees
Locality Delivery Partnerships are accountable to the Collaborative and have a responsibility to the local Place Committee to have due regard for Place priorities



Next Steps

This Implementation Plan has been developed for submission to the ICB Board in July 2024 for approval.

All partners are asked to consider the Implementation Plan in June/July and to confirm endorsement by end July 2024.

For comments and feedback please email Suzanne.cleary@nhs.net or Pippa.Pollard@nhs.net

Birmingham Health and Wellbeing Board
Board Membership and Work Programme 2024-25

Board Members:

Name	Position	Organisation
Councillor Mariam Khan (Board Chair) Councillor Rob Pocock (Acting Chair)	Cabinet Member for Adult Social Care and Health Cabinet Member for Transformation, Governance and HR	Birmingham City Council
Dr Clara Day (Vice Chair)	Chief Medical Officer	NHS Birmingham and Solihull Integrated Care Board (ICB)
Councillor Mick Brown	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
Louise Collett	Acting Strategic Director for Adult Social Care	Birmingham City Council
Helen Ellis	Director - Strategy, Commissioning and Transformation Children and Families	Birmingham City Council
David Melbourne	Chief Executive	NHS Birmingham and Solihull Integrated Care Board (ICB)
Richard Beeken	Chief Executive	Sandwell and West Birmingham NHS Trust
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
James A Thomas	Chief Executive of Birmingham Children's Trust	Birmingham Children's Trust
Anne Coufopoulos	Executive Dean (School of Health, Sport and Food)	University College Birmingham

Professor Catherine Needham	Professor of Public Policy and Public Management	University of Birmingham
Richard Kirby	Chief Executive	Birmingham Community Healthcare NHS Foundation Trust
Mo Hussain	Chief Executive	University Hospitals Birmingham NHS Foundation Trust
Chief Superintendent Richard North	Chief Superintendent	West Midlands Police
TBC	TBC	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust	Birmingham Social Housing Partnership
TBC	TBC	Birmingham Chamber of Commerce
Co-optee		
Natalie Allen	Chief Executive of SIFA Fireside	SIFA Fireside
Patrick Nyarumbu	Executive Director Strategic Partnership	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council
Karen Creavin	Chief Executive of TAWS	The Active Wellbeing Society (TAWS)

Committee Board Manager
Landline: 0121 303 9844
Email: Louisa.Nisbett@birmingham.gov.uk

Forward Plan: 2024/25

Date	Item	Lead	Purpose	Format	HWB Lead
<u>July</u> Thursday 18th July 2024	**Appointment of Health and Wellbeing Board - Functions, Terms of Reference and Membership**	Chair	Information	Report	Chair
	Birmingham City Council: Directorate Savings Plans and Impact on Health and Wellbeing - Discussion	All	Discussion	Presentation	Chair
	Health and Wellbeing Board Executive Group papers	Chair	Approval	Report	Chair
<u>August</u> (Executive Board) Monday 19th August 2024	**Dual Diagnosis Deep Dive**	Luke Heslop	Approval	Report	Dr Justin Varney
	Community Care Collaborative Implementation Plan	Michael Walsh	Information	Presentation	Dr Clara Day
	Health and Wellbeing Board Annual Review of Strategy and Governance Review	Aidan Hall	Approval	Report	Dr Justin Varney

Date	Item	Lead	Purpose	Format	HWB Lead
September Thursday 26th September 2024	**Health Protection Forum Annual Update**	Dr Mary Orherwere	Information	Presentation	Dr Justin Varney
	Smokefree Generation Update	Becky Pollard	Information	Presentation	Dr Justin Varney
	Triple Zero update and Drugs/Alcohol re-procurement	Jo Tonkin	Information	Presentation	Dr Justin Varney
	Health and Wellbeing Board Annual Review of Strategy and Governance Review	Dr Justin Varney	Approval	Report	Dr Justin Varney
	Health and Wellbeing Board Executive Group papers	Chair	Approval	Report	Chair

Date	Item	Lead	Purpose	Format	HWB Lead
October (Executive Board) Monday 21st October 2024					
November Thursday 21st November 2024					
December (Executive Board) Thursday 19th December 2024					
January Thursday 30th January 2025					

Date	Item	Lead	Purpose	Format	HWB Lead
February (Executive Board) (TBC)					
March Thursday 27th March 2025					
April (Executive Board) (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).

Public Questions

Public questions are to be submitted in advance of the meeting. Questions should be sent to: HWBoard@birmingham.gov.uk

BIRMINGHAM HEALTH AND WELLBEING BOARD

Supplementary Reading

Appendix 3.

Birmingham Smoking Cessation Task Group

Terms of Reference

Version	**V4**
Last review date	**02/08/2024**
Next review date	**30/05/2025**

1. Background

In October 2023 the Government published the Stopping the Start command paper outlining a series of legislative and funding programmes to tackle smoking. This included a commitment to provide an additional £70m per year for local stop smoking services (LSSS) in England. The Government has committed to support LSSS with £70m additional funding for five years (2024/25 to 2028/29).

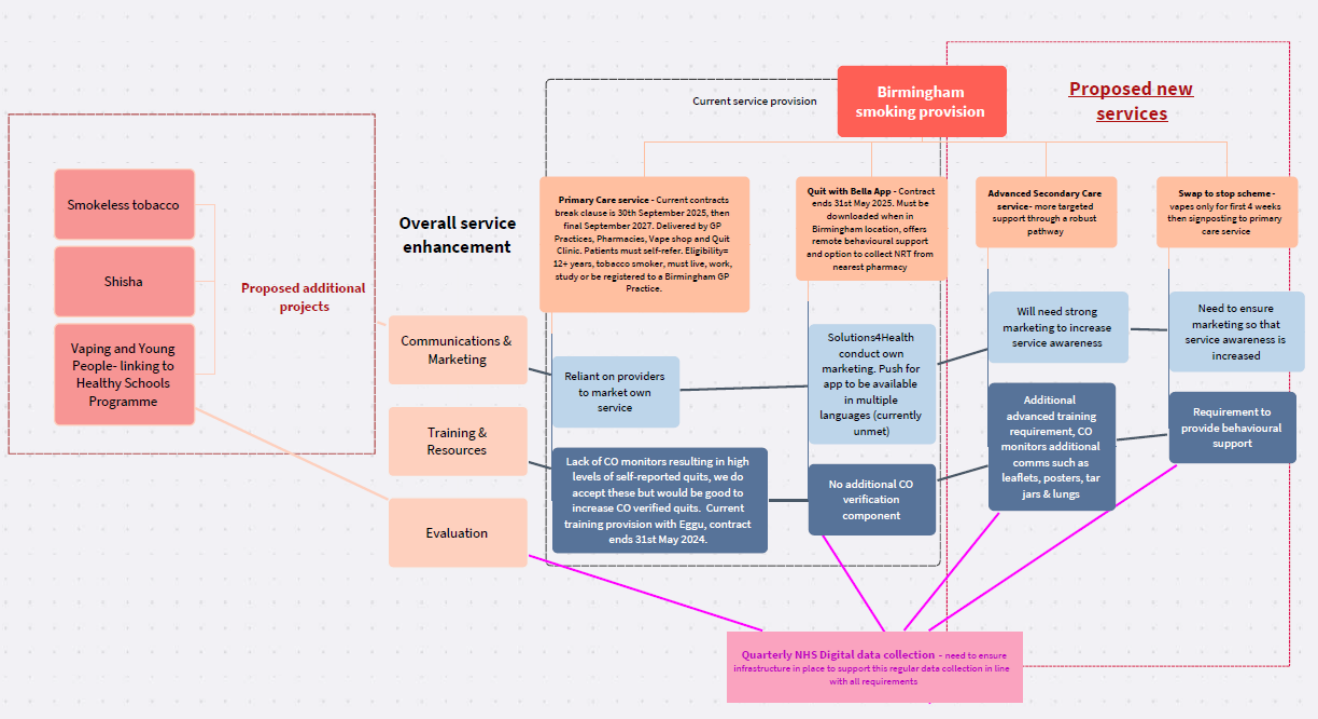
The purpose of this investment is to support existing smokers to quit through evidence based behavioural support to quit. A Section 31 grant agreement covers the first 12 months of the programme. The funding allocation was calculated by multiplying the total £70m pot by the percentage of England's smokers who live in Birmingham City Council.

The Section 31 grant agreement for Birmingham City Council for Year One funding of £1,676,048 was signed and returned to OHID on 8th March 2024. The grant will be ringfenced for use on LSSS and support.

The condition of the grant is that funding will be used for

- Enhancing local authority commissioners stop smoking services and support, in addition to and while maintain existing spend on these services and support from the public health grant. It should not replace other/existing smoking cessation programmes.
- Build capacity to deliver expanded local stop smoking services and support
- Build demand for local stop smoking services and support
- Deliver increases in the number of people setting a quit date and 4 week quit outcomes, reporting outcomes in the Stop Smoking Services Collection.

A flowchart of current and prospective future services is set out below:



2. Purpose

The purpose of the Smoking Cessation Task Group is to plan, develop and oversee the implementation of:

2.1 Additional services: Increasing the local ‘Swap to Stop’ offer and provision of vapes to support smokers to quit

2.2 Advanced services: Increasing referrals from a range of settings, such as acute and primary care, mental health services, substance misuse treatment services, workplaces

2.3 Enhancement of current services: Increasing provision of pharmacotherapies (including NRT), increasing smoking cessation adviser capacity across the system by training of local healthcare and community staff to deliver smoking cessation advice and referrals

2.4 Local system development: Strengthening existing collaborations with the NHS and other smoking cessation providers and streamline referral routes and developing new relationships with potential providers where needed

2.5 Marketing and communication campaigns: Developing a ‘Gold’ campaign to promote awareness of local services and motivate smokers to seek support, particularly focused on Birmingham’s diverse communities

2.6 Evaluation: Undertaking evaluation to understand the impacts of our proposed changes and learn from what works

3. Task Group Objectives

Medium term – addressing system gaps. This will include commissioning targeted interventions for 2024 25 to engage populations with the highest prevalence as well as a specialist, community smoking support offer to align with MH & LD pathways, the Targeted Lung health check programme as well as preoperative support.

Long term - strengthen the current smoking support offer by modelling services for the next 2-3 years to align with and create an integrated Healthy lifestyle offer. These services will lay the foundation for any future healthy lifestyle services.

- Review current local stop smoking service provision
- Identify gaps and areas for further development
- Improve pathways for citizens to access evidence-based services
- Engage with citizens and high-risk target groups to improve service provision
- Develop and coordinate public awareness and communication campaigns

4. Membership

The following organisations will be represented on the Task Group:

- Birmingham City Council (Public Health)
- BSol ICS
- Birmingham Community and Voluntary Sector
- Birmingham Healthwatch
- Locality delivery partnership representation /Primary Care Networks
- LMC
- LPC
- University Hospitals Birmingham NHS Foundation Trust
- Birmingham Community Health Services NHS Trust
- Birmingham Women's Hospital – Maternity
- Birmingham Mental Health NHS Trust
- CGL
- Targeted Lung Health Check Programme
- NHS England and NHS Improvement
- OHID
- University of Birmingham

Name	Position	Organisation
Becky Pollard (Chair)	Assistant Director of Public Health	Birmingham City Council
Keiran McKenzie	Service Lead (Adults)	Birmingham City Council

TBC	Senior Programme Officer (Smokefree Generation)	Birmingham City Council
Lynda Bradford	Service Lead (Addictions)	Birmingham City Council
Thomas Harwood	Head of Office (Comms)	Birmingham City Council
Sophiya Begum	Project Officer for Tobacco Dependency Program	NHS Birmingham and Solihull Integrated Care System
Wendy Loveridge	Director of Practice Support/Committee Secretary	Local Medical Committee (LMC)
Jeff Blankley	Chief Officer	Local Pharmaceutical Committee (LPC)
Sophiya Begum	Project Officer for Tobacco Dependency Program	NHS Birmingham and Solihull Integrated Care System
TBC		University Hospitals Birmingham NHS Foundation Trust
TBC		Birmingham Community Health Services NHS Trust
Heena Jabbar	Smoke free pregnancy Lead and Team Manager	Birmingham Women's Hospital – Maternity
Hanan Khan	Tobacco Dependency Lead	Birmingham and Solihull Mental Health Trust
Dorcas Abioye	Cluster Lead Nurse	Change Grow Live (CGL)
Dr Babu Naidu (Theresa Earle if BN unavailable) Tracy Jones (Lorrenda Waite as TJ on maternity leave) Kevin Wright (Ruby Hughes until KW replacement)	Consultant Thoracic Surgeon Programme Manager Service Evaluation Officer	Targeted Lung Health Check Programme
TBC		NHS England and NHS Improvement
Dmitri Nepogodiev	Interim Smoking & Tobacco Programme Lead	OHID

Dr Amanda Farley	Head of Postgraduate Research (PGR) for IAHR	University of Birmingham
Simon Hall (Louise Bown if SH unavailable)	Senior Delivery Manager - Wellbeing and Prevention	West Midlands Combined Authority
Andy Cave (tbc)	Chief Executive Officer	HealthWatch
Stephanie Bloxham	Health and Social Care Business Unit Manager	Birmingham Community Voluntary Sector

For information: Ben Murphy – Public Health Comms
Simon Yates – Senior Programme Officer (Addictions)
John Forde – Public Health Consultant, Solihull Council

Membership to be reviewed at regular interval.

Other representatives to be invited on an ad hoc basis, as required.

Sub-groups may be established to take forward specific pieces of work, as identified by the Task Group. These will be led by and directed by the Task Group and report back to it at regular intervals. Membership of the subgroups may include a wider representation according to the objectives of each group.

5. Task Group Requirements

- Each representative will nominate a suitable deputy in the event of unavoidable absence.
- Each representative will establish mechanisms to work with their own organisation to ensure that there is a two-way flow of communication. They will represent the views and needs of that organisation as well as keep them informed of the activities of the Task Group.
- Members will declare any outside interests on joining the Task Group. The Register of Interests will be held and regularly reviewed by the chair.
- The Task Group creates a forum where members can advocate internally between partner organisations. Members should use their access to strategic forums and to senior regional and national leadership for upward advocacy.

6. Meeting Frequency & Arrangements

- Frequency of meetings will be determined by the group (dates and locations to be confirmed by Birmingham Public Health).
- The expectation that these will be on a six-weekly basis unless otherwise stated.
- Meetings to follow an agenda as agreed by the group.
- Birmingham Public Health to lead on the coordination of the meeting.
- The group will be chaired either by the Assistant Director of Public Health (Adults and Older People) or by the Service Lead for Adults from Birmingham Public Health.
- A co-chair may be nominated from a different stakeholder organisation.
- Group membership and group meetings will be managed by the group, new additions to the group invited and recruited in agreement with the group.

Dates of Next Meetings:

- Thursday 5 September 2024, 11.30 – 13.00
- Thursday 17 October 2024, 11.30 – 13.00
- Thursday 28 November 2024, 11.30 – 13.00
- Thursday 6 January 2025, 11.30 – 13.00

7. Governance and Reporting

The Birmingham Smoking Cessation Task Group will report to the Birmingham and Solihull Tobacco Control Alliance.

Any subgroups will report to the Task Group.

8. Resources

The Task Group will generate ideas and proposals on how to utilise the Section 31 Smokefree Generation Grant and any other financial resources generated to enhance capacity and build demand for Local Stop Smoking Services within Birmingham (e.g. research grants or other potential funders).

9. Links to other Groups

Birmingham Public Health will share progress with the relevant councillors via their briefing meetings.

The Task Group will link with other existing groups, including:

- BSol CVD Prevention Board
- BSol Stroke Board
- Operational Tobacco Group
- Cancer Group
- Creating A Mental Health City Forum

Office for Health Improvement & Disparities

Office for Health Improvement & Disparities
Department of Health & Social Care
39 Victoria Street
London SW1H 0EU

27th February 2024

To: Justin Varney, Birmingham City Council

cc. Dmitri Nepogodiev; Karen Saunders, OHID Tobacco Control Regional Lead(s)

Dear Colleagues

Re: Local Stop Smoking Services and Support Grant 2024-2025

This letter sets out:

- allocations of the local stop smoking services and support grant for 2024 to 2025
- the conditions that will apply to that grant
- guidance intended to assist local authorities
- signature panel to accept the grant and its conditions

Background

The government has announced additional funding for local stop smoking services and support over the next five financial years, starting from 2024-25 until 2028-29. This circular pertains to the first year, with funding for subsequent years subject to spending review settlements, following the routine practice for all government expenditure.

The Secretary of State for Health and Social Care has determined that the grant will be paid based on the understanding that the funding will be used to:

- Invest in enhancing local authority commissioned stop smoking services and support, in addition to and while maintaining existing spend on these services and support from the public health grant. This should not replace other/existing programmes which support smokers to quit, for example the tobacco dependency programme delivered within the NHS Long Term Plan;

- Build capacity to deliver expanded local stop smoking services and support;

- Build demand for local stop smoking services and support; and

- Deliver increases in the number of people setting a quit date and 4 week quit outcomes, reporting outcomes in the Stop Smoking Services Collection.

Office for Health Improvement & Disparities

The grant will be ring-fenced for use on local stop smoking services and support.

The Secretary of State has determined, pursuant to section 31 of the Local Government Act 2003, to pay grants to relevant authorities in the amounts indicated for the financial year 2024 to 2025.

This letter is accompanied by 4 annexes:

Annex A: local stop smoking services and support ring-fenced grant determination including;

Appendix 1 - Local Authority Allocations 2024/25; and

Appendix 2 - Grant conditions

Annex B: Project Summary

Annex C: Payment Arrangements

Annex D: Statement of Grant Usage (SOGU) Assurance Template example

The grant

The 2023 to 2024 grant will be paid in bi-annual instalments (see Annex C).

Pursuant to section 31(4) of the Local Government Act 2003 the Secretary of State has attached conditions to the payment of the grant, which are set out at Annex A.

The department's presumption is that the grant will be spent in-year. The grant recipient will notify the department as soon as is reasonably practicable should an underspend be forecast. The department may consider reducing future grant amounts to local authorities that report significant and repeated underspends.

Enquires about this agreement should be addressed to stopsmokinggrant@dhsc.gov.uk

To accept the funding and conditions, please sign on page 19 and return to stopsmokinggrant@dhsc.gov.uk by 24th April 2024 for payment on 24th May. However, if the signed agreement is returned by 27th March, payment will be made on 26th April 2024.

Yours sincerely

Natasha Burgon

Director | Health Improvement | Global and Public Health Group

Office for Health Improvement and Disparities

Office for Health Improvement & Disparities

Annex A: Revenue grant determination (ringfenced)

Section 31 local authority grants for local stop smoking services and support
GRANT DETERMINATION 2024-2025: No 31/7043

The Minister of State for Health and Social Care ("the Minister of State"), in exercise of the powers conferred by section 31 of the Local Government Act 2003, makes the following determination:

Citation

This determination may be cited as the 'local stop smoking services and support' Grant Scheme Determination (2024-2025) [No31/7043]

Purpose of the grant

The purpose of the grant is to provide support to local authorities in England towards expenditure lawfully incurred or to be incurred by them in connection with the provision of local stop smoking services and support.

Determination

The Minister of State determines as the authorities to which grant is to be paid and the amount of grant to be paid in the financial year 2024 to 2025, the authorities and the amounts for the financial year 2024 to 2025 set out in Appendix 1.

Treasury consent

Before making this determination in relation to local authorities in England, the Minister of State obtained the consent of the Treasury.

Grant conditions

Pursuant to section 31(3) and section 31(4) of the Local Government Act 2003, the Minister of State determines that the grant will be paid subject to the conditions in Appendix 2.

UK Government Branding

The grant recipient shall at all times during and following the end of the funding period:

- comply with requirements of the Branding Manual in relation to the Funded Activities; and
- cease use of the Funded by UK Government logo on demand if directed to do so by the Authority.

Office for Health Improvement & Disparities

Branding Manual means the HM Government of the United Kingdom of Great Britain and Northern Ireland 'Funded by UK Government branding manual' first published by the Cabinet Office in November 2022 and is available at https://gcs.civilservice.gov.uk/guidance/marketing/branding-guidelines/ including any subsequent updates from time to time.

Signed by authority of the Minister of State for Health and Social Care

Natasha Burgon

Director | Health Improvement | Global and Public Health Group

Office for Health Improvement and Disparities

Department of Health and Social Care

[26/02/2024]

Office for Health Improvement & Disparities

Appendix 1

Local Authority Allocations 2024/25

Authorities to which grant is to be paid	Amount of grant to be paid
Barking and Dagenham London Borough	254,178
Barnet London Borough	333,217
Barnsley Metropolitan Borough Council	378,504
Bath and North East Somerset Council	202,171
Bedford UA	219,025
Bexley London Borough	303,247
Birmingham City Council	1,676,048
Blackburn with Darwen Borough Council	237,341
Blackpool Borough Council	281,362
Bolton Metropolitan Borough Council	438,537
Bournemouth, Christchurch and Poole Council	422,313
Bracknell Forest Borough Council	141,728
Brent London Borough	354,624
Brighton and Hove Council	402,084
Bristol Council	742,043
Bromley London Borough	272,889
Buckinghamshire Council	541,832
Bury Metropolitan Borough Council	207,932
Calderdale Metropolitan Borough Council	263,562
Cambridgeshire County Council	885,734
Camden London Borough	171,504
Central Bedfordshire UA	379,284
Cheshire East UA	432,331
Cheshire West and Chester UA	356,235
City of Bradford Metropolitan District Council	762,108
City of London	12,087
City of York Council	196,542
Cornwall County UA	643,620
Coventry City Council	520,304
Croydon London Borough	436,814
Cumberland Council	398,216
Darlington Borough Council	122,336
Derby City Council	374,638
Derbyshire County Council	1,083,451
Devon County Council	949,746

Doncaster Metropolitan Borough Council	499,326
Dorset Council	368,335
Dudley Metropolitan Borough Council	406,558
Durham County UA	806,023
Ealing London Borough	425,784
East Riding of Yorkshire Council	349,603
East Sussex County Council	700,148
Enfield London Borough	445,959
Essex County Council	1,870,699
Gateshead Metropolitan Borough Council	251,686
Gloucestershire County Council	787,301
Greenwich London Borough	353,049
Hackney London Borough	327,891
Halton Borough Council	159,432
Hammersmith and Fulham London Borough	191,033
Hampshire County Council	1,381,823
Haringey London Borough	332,932
Harrow London Borough	191,828
Hartlepool Council	142,389
Havering London Borough	307,543
Herefordshire Council	226,799
Hertfordshire County Council	1,283,608
Hillingdon London Borough	281,393
Hounslow London Borough	361,119
Isle of Wight Council	169,296
Isles of Scilly Council	2,918
Islington London Borough	287,152
Kensington and Chelsea Royal Borough	180,653
Kent County Council	1,944,823
Hull City Council	506,386
Kingston upon Thames Royal Borough	135,792
Kirklees Metropolitan Borough Council	552,549
Knowsley Metropolitan Borough Council	219,024
Lambeth London Borough	407,371
Lancashire County Council	1,673,989
Leeds City Council	985,430
Leicester City Council	456,669
Leicestershire County Council	716,153
Lewisham London Borough	364,953
Lincolnshire County Council	1,076,632
Liverpool City Council	831,826

London Borough of Richmond upon Thames	125,059
Luton Borough Council	344,835
Manchester City Council	929,359
Medway Council	326,025
Merton London Borough	269,532
Middlesbrough Borough	219,929
Milton Keynes Council	375,145
Newcastle City Council	411,496
Newham London Borough	430,093
Norfolk County Council	1,300,766
North East Lincolnshire Council	279,508
North Lincolnshire Council	223,471
North Northamptonshire	487,696
North Somerset Council	244,475
North Tyneside Metropolitan Borough Council	278,293
North Yorkshire	632,698
Northumberland County UA	366,759
Nottingham City Council	545,215
Nottinghamshire County Council	1,039,463
Oldham Metropolitan Borough Council	321,524
Oxfordshire County Council	795,255
Peterborough City Council	272,376
Plymouth City Council	415,628
Portsmouth City Council	294,830
Reading Borough Council	240,006
Redbridge London Borough	334,777
Redcar and Cleveland Borough Council	191,493
Rochdale Metropolitan Borough Council	327,431
Rotherham Metropolitan Borough Council	384,845
Rutland County Council District Council	43,358
Salford City Council	367,204
Sandwell Metropolitan Borough Council	548,413
Sefton	231,529
Sheffield City Council	650,694
Shropshire County UA	359,568
Slough Borough Council	211,394
Solihull Metropolitan Borough Council	221,767
Somerset	743,908
South Gloucestershire Council	318,377
South Tyneside Metropolitan Borough Council	232,311
Southampton City Council	314,430

Southend on Sea City Council	227,889
Southwark London Borough	393,832
St Helens Metropolitan Borough Council	207,251
Staffordshire County Council	938,554
Stockport Metropolitan Borough Council	360,808
Stockton-on-Tees Borough Council	236,760
Stoke-on-Trent City Council	396,370
Suffolk County Council	1,012,764
Sunderland City Council	407,965
Surrey County Council	1,131,204
Sutton London Borough	195,780
Swindon Borough Council	257,699
Tameside Metropolitan Borough Council	412,776
Telford and Wrekin Council	264,278
Thurrock Council	225,920
Torbay Borough Council	216,975
Tower Hamlets London Borough	375,067
Trafford Metropolitan Borough Council	208,410
Wakefield Metropolitan District Council	536,886
Walsall Metropolitan Borough Council	367,927
Waltham Forest London Borough	297,307
Wandsworth London Borough	338,067
Warrington Borough Council	199,598
Warwickshire County Council	786,180
West Berkshire District Council	181,670
West Northamptonshire	478,149
West Sussex County Council	1,075,586
Westminster City Council	284,971
Westmorland and Furness Council	259,242
Wigan Metropolitan Borough Council	475,110
Wiltshire County UA	581,930
Windsor and Maidenhead Royal Borough Council	152,132
Wirral Metropolitan Borough Council	360,729
Wokingham District Council	102,358
Wolverhampton Metropolitan Borough Council	322,613
Worcestershire County Council	716,845

Appendix 2

Grant conditions

1. In this Appendix:

- ‘an authority’ means an upper tier or unitary local authority identified in Appendix 1
- ‘the Department’ means the Department of Health and Social Care
- ‘Financial Year’ means a period of 12 months commencing on 1 April 2024 and ending 31 March 2025
- ‘grant’ means the amounts set out in the ‘Ring-fenced local stop smoking services and support grant determination 2024 to 2025’
- ‘upper tier and unitary local authorities’ means:
  - a county council in England
  - a district council in England, other than a council for a district in a county for which there is a county council
  - a London borough council
  - the Council of the Isles of Scilly
  - the Common Council of the City of London
- “the Project” means those outputs, activities, milestones and targets identified in the project summary (attached at Annex B)
- “the Secretary of State” means the Minister of State for Health and Social Care

Use of the grant

2. Pursuant to section 31 of the Local Government Act 2003, the Secretary of State hereby determines that the local stop smoking services and support grant shall be paid towards expenditure incurred, or to be incurred, by upper tier and unitary local authorities in the financial year 2024 to 2025.

3. Subject to paragraph 4, the grant must be used only for meeting eligible expenditure incurred or to be incurred by authorities for the purposes of providing local stop smoking services and support.

4. An authority must, in using the grant:

- Invest in enhancing local authority commissioned stop smoking services and support, in addition to and while maintaining existing spend on these services and support from the public health grant. This should not replace other/existing programmes which

support smokers to quit, for example the tobacco dependency programme delivered within the NHS Long Term Plan;

- Build capacity to deliver expanded local stop smoking services and support;
- Build demand for local stop smoking services and support; and
- Deliver increases in the number of people setting a quit date and 4 week quit outcomes, reporting outcomes in the Stop Smoking Services Collection.

Eligible expenditure

5. Eligible expenditure means expenditure incurred by an authority or any person acting on behalf of an authority, between 1 April 2024 and 31 March 2025, for the purposes of carrying out stop smoking services and support functions referred to in paragraph 4.

6. If an authority incurs any of the following costs, those costs must be excluded from eligible expenditure:

a) contributions in kind

b) payments for activities of a political or exclusively religious nature

c) depreciation, amortisation or impairment of fixed assets owned by the authority

d) input VAT reclaimable by the authority from HM Revenue and Customs

e) interest payments or service charge payments for finance leases

f) gifts, other than promotional items, with a value of no more than £10 in a year to any one-person

g) entertaining (entertaining for this purpose means anything that would be a taxable benefit to the person being entertained, according to current UK tax regulations)

h) statutory fines, criminal fines or penalties

7. An authority must not deliberately incur liabilities for eligible expenditure before there is an operational need for it to do so.

8. For the purpose of defining the time of payments, an authority shall account for its spend from the grant using the accrual basis of accounting (for an explanation of accrual accounting please refer to the CIPFA Code of Practice on Local Authority Accounting in the United Kingdom).

Payment arrangements

9. Payments will be made during the Financial Year in Q1 and Q4 (as further detailed in Annex C). The Q4 payment made may cover forecast spend in Q4, up to the end of the Financial Year.

10. The authority will notify the Department as soon as is reasonably practicable should an underspend be forecast. The Department reserves the right to alter the timing or amount of grants payments accordingly.

Reporting

11. The authority will work with the Department to provide the necessary information and data to monitor and evaluate progress against the aims and outcomes of the Project.

12. The reporting will take place through these delivery mechanisms:

- Stop Smoking Services Collection, an existing data collection and reporting system used to monitor the delivery of local stop smoking interventions. NHS England collects the data from local authorities and there is a requirement to submit activity for each quarter. NHS England publishes submission dates and local authorities can return activity and outcome data associated with quit support provided. The collection requires local authorities to submit cumulative counts of activity using a template, which you can request from the Strategic Data Collection Service;

- The Department will financially monitor the grants provided to authorities on a quarterly basis using the supplied financial reporting template. This financial monitoring will ask authorities to provide a breakdown of the payments to service providers and a breakdown by budget line of spend within the project delivery. (Note this reporting mechanism has been added since the gov.uk guidance 'Expected reporting mechanisms' section was published on gov.uk in November 2023); and

- A final statement of grant usage (being in the form set out at Annex D) must be submitted to the Department (stopsmokinggrant@dhsc.gov.uk) on the 21st day of the month following the expiry of the Financial Year. The final statement of grant usage must be certified by the authority's Chief Executive/s Officer that, to the best of their knowledge, the amounts shown on the statement are all eligible expenditure and that the grant has been used for the purposes intended.

13. An authority must notify the Department immediately in writing should it become aware of any circumstances that may cause delay in the delivery of the Project.

14. The Secretary of State may require a further external validation to be carried out by an appropriately qualified independent accountant or auditor of the use of the grant where the return referred to in paragraph 12 above fails to provide sufficient assurance to the Secretary of State that the grant has been used in accordance with these conditions.

Financial management

15. The authority must maintain a robust system of internal financial controls and inform the department promptly of any significant financial control issues raised by its internal auditors in relation to the use of the grant.

16. If an authority identifies any overpayment of the grant, the authority must repay this amount within 30 days of it coming to their attention.

17. If an authority has any grounds for suspecting financial irregularity in the use of any grant paid under this determination, it must notify the Department immediately, explain what steps are being taken to investigate the suspicion and keep the department informed about the progress of the investigation. For these purposes 'financial irregularity' includes fraud or other impropriety, mismanagement, and the use of the grant for purposes other than those for which it was provided.

External audit arrangements

18. Appointed auditors are responsible for auditing the financial statements of the authority and for reaching a conclusion on an authority's overall arrangements for securing economy, efficiency and effectiveness in the use of resources. The use of, and accounting for, this grant and the arrangements for securing economy, efficiency and effectiveness in doing so fall within the scope of the work that appointed auditors may plan to carry out, having regard to the risk of material error in the authority's accounts and significance.

Records to be kept

19. The authority must maintain reliable, accessible and up to date accounting records with an adequate audit trail for all expenditure funded by grant monies under this determination.

20. The authority and any person acting on behalf of an authority must allow a) the Comptroller and Auditor General or appointed representatives and b) the Secretary of State or appointed representatives free access at all reasonable times to all documents (including computerised documents and data) and other information as is connected to the grant payable under this determination, or to the purposes for which the grant was used, subject to the provisions in paragraph 22.

21. The documents, data and information referred to in paragraph 20 are such as the Secretary of State or the Comptroller and Auditor General may reasonably require for the purposes of the Secretary of State's or the Comptroller and Auditor General's financial audit or that any department or other public body may reasonably require for the purposes of carrying out examinations into the economy, efficiency and effectiveness with which any department or other public body has used its resources. An authority must provide such further explanations as are reasonably required for these purposes.

22. Paragraphs 19 and 20 do not constitute a requirement for the examination, certification or inspection of the accounts of an authority by the Comptroller and Auditor General under section 6(3) of the National Audit Act 1983. The Comptroller and Auditor General will seek access in a measured manner to minimise any burden on the authority and will avoid duplication of effort by seeking and sharing information with the Audit Commission.

Breach of conditions and recovery of grant

23. If the authority fails to comply with any of these conditions, or if any overpayment is made under this grant or any amount is paid in error, or if any of the events set out in paragraph 24 occurs, the Secretary of State may reduce, suspend or withhold grant payments or require the repayment of the whole or any part of the grant monies paid, as may be determined by the Secretary of State and notified in writing to the authority. Such sum as has been notified will immediately become repayable to the Secretary of State who may set off the sum against any future amount due to the authority from central government.

24. The events referred to in paragraph 23 are:

a) the authority purports to transfer or assign any rights, interests or obligations arising under this determination without the prior agreement of the Secretary of State;

b) any information provided in any application for grant monies payable under this determination, or in any subsequent supporting correspondence is found to be significantly incorrect or incomplete in the opinion of the Secretary of State;

c) it appears to the Secretary of State that other circumstances have arisen or events have occurred that are likely to significantly affect the authority's ability to achieve the outputs, activities, milestones and targets set out in the bid;

d) the authority 's chief internal auditor is unable to provide reasonable assurance that the Statement of Grant Usage, in all material respects, fairly presents the eligible expenditure in the period 1 April 2024 to 31 March 2025 in accordance with the definitions and conditions in this determination.

25**.** Details for correspondence

The Authority (the Grant Recipient) to complete this section
Name:
Position:
Address:
Email:

Office for Health Improvement & Disparities

Annex B: Project Summary

PROJECT TITLE: Supporting people to quit smoking

In October 2023 the Prime Minster announced a comprehensive plan to create a smokefree generation. The plan acknowledged harms smoking causes to our society and evidence-based measures to reduce smoking prevalence. As part of a wide package of measures, the Prime Minster announced an extra £70 million per year over the next 5 years to increase support available for smokers to quit. This extra ringfenced investment is available for local authorities who maintain existing spend on stop smoking services and support from the public health grant, and report outcomes in the stop smoking services collection.

The purpose of this investment is to support existing smokers to quit in England. As a result of the investment the Government wants to increase access to evidence-based behavioural support to quit and targeted support to people more likely to smoke, to reduce health inequalities. 'Local stop smoking services and support: guidance for local authorities' published on gov.uk on 8 November 2023 sets out a framework for delivering services and support in line with this aim. This investment should not replace activity delivered as part of the NHS Long Term Plan or the public health grant. It is intended to allow local authorities to deliver more or enhanced stop smoking support provision. For example, the new funding can support building capacity to support smokers to quit and increase referrals from a range of community settings, such as primary care or mental health services. The funding can also be used to train more local healthcare staff to deliver smoking cessation advice and referrals. It should not be used for tobacco enforcement activity.

The provision of stop smoking services and support in England varies. In recognition of this, targets linked to funding will not be set for the first year of this investment. This position will be kept under review for subsequent years. The Government's ambition for this investment is to see 360,000 people set quit dates, with 198,000 successful quits (measured as 4-week quits) in England each year. It is understood that local authorities will need time to commission and upscale local offers and generate demand for stop smoking support over time.

A methodology has been applied to support understanding of what this ambition means for local areas. This approach has:

- Taken the total number of additional quit dates needed to be set in England
- Distributed them as a proportion across each local authority area, based on the share of the smoking population in that local authority area
- This expected increase in activity is added to the local authority's most recent year's performance to provide a new ambition for the locality, which incorporates historic performance and expected uplift from the new funding.
- For local authorities that have no submitted performance data in the most recent year, a baseline level of activity has been calculated based on national average performance of the local authority's expected contribution to the 360,000 new quit dates per year for England.
- Factored in a gradual increase of set quit dates with an expectation of what these numbers will look like throughout the full five years of investment.

- These figures are for local authorities to measure their performance against, whilst scaling up services and delivering quits needed to meet the ambition over the next 5 years.

For Birmingham City Council, this is modelled into the following trajectory of set quit dates.

National Goal Increase	Smoking Population Proportion	1 Year figure (Goal*Smoking Proportion)	5 Year Figure	Y1 (25%) Increase	Y2 (50%) Increase	Y3 (125%) Increase	Y4 (150%) Increase	Y5 (150%) Increase
193,908	2.394%	4,643	23,214	1,161	2,321	5,804	6,964	6,964

Current Rate (as reported in SSS)	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total
798	1,959	3,119	6,602	7,762	7,762

For Birmingham City Council, reported spend in 2022/23 was £0 - No Data Submitted.

Office for Health Improvement & Disparities

Annex C: Payment Arrangements

Your maximum funding allocation is £1,676,048 to be spent in financial year 2024 - 2025.

Payment Dates	Payment Amount
Quarter 1 – April to June 2024	**£1,173,233**
Quarter 4 – Jan to March 2025	**£502,815**
Total	**£1,676,048**

Office for Health Improvement & Disparities

Annex D: Statement of Grant Usage (SOGU) Assurance Template (NOT FOR COMPLETION)

YEAR 1: FINANCIAL YEAR PERIOD - ENDING DD MM YYYY

Project Name: Local Stop Smoking Services and Support Grant 2024-2025

Please use this form to provide a statement of grant usage.

This Statement should be submitted to Office for Health Improvement & Disparities by [dd mmm 20yy]

Contact Details

Name of authority	
Authority Address	
	Postcode:
Name and telephone number of person to whom queries about this Statement can be made	Name: Tel: Email:

Grant Reference Number: [XXXXXXX]

Please complete the following table, to the nearest £1.

Office for Health Improvement & Disparities

Amount of funding received (£)	Actual eligible expenditure from [DD/MM/YYYY] to [DD/MM/YYYY]	Reason for any difference
Revenue	**Revenue**	
£xxxxxx	£xxxxxxx	

Complete the certification before returning.

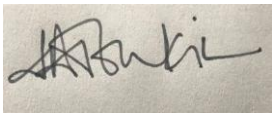
Certification

I certify that to the best of my knowledge and belief the above information gives a complete and accurate record of the eligible expenditure as stated in the determination in relation to funding received from the Department of Health and Social Care for the above project and that we have taken steps to ensure that we would be in a position to repay the grant if we breach the grant conditions for the provision of Local Stop Smoking Services and Support for the financial year 2024 – 2025.

Signed by the authority Finance Director or equivalent.

Signature:	
Name: (BLOCK CAPITALS):	
Job Title:	
Date:	

Office for Health Improvement & Disparities

Signed by the LOCAL AUTHORITY (Grant Recipient)	
	…….
	Authorised Signatory
	Jo Tonkin
PRINT NAME:	…..…….….
	08/03/2024
DATE	……..…….
	Deputy Director (Public Health)
POSITION:	……..…….

Smoke Free Generation Update: Health and Wellbeing Board

26 September 2024

Becky Pollard, Assistant Director - Adults & Older People
Birmingham Public Health

Purpose of the paper

To update Board members on progress towards:

- delivering the ‘Stopping the start: our new plan to create a smokefree generation’ policy
- the use of the Smokefree Generation Section 31 Grant (£1,676,048) awarded to Birmingham City Council in 2024/25
- Ask for ongoing support to this work

‘Stopping the Start: our new Plan to create a Smokefree Generation’

- Legislation to create a smokefree generation
- Supporting people to quit smoking
- Addressing Youth Vaping
- Enforcement– underage sales, point of sale, age restrictions and spot fines

Tobacco and Vape Bill

- The Tobacco and Vapes Bill was introduced in the Department of Health & Social Care's policy paper in October 2023 'Stopping the start: our new plan to create a smokefree generation'.

- The bill:
  - Will make it an offence to sell tobacco products to anyone born on or after 1 January 2009 and was reintroduced in the King's Speech in July 2024.
  - Will give government powers to curb youth vaping while ensuring adult smokers can still use vapes to quit, such as regulations on vape branding, flavours and advertising.

Smoking prevalence

Smoking prevalence of populations within Birmingham compared to England

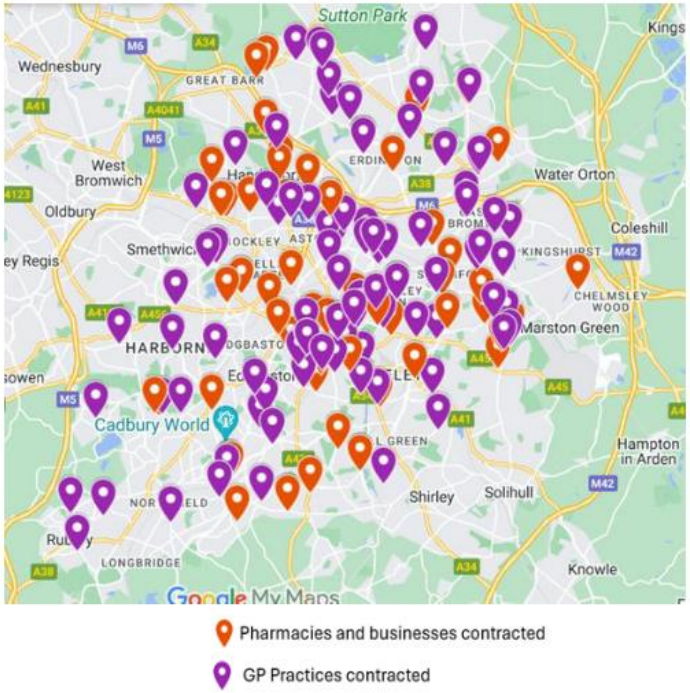
Population	Birmingham smoking prevalence (%)	England smoking prevalence (%)
Adults (18+) – current smokers (2022) [1]	13.6%	12.7%
Adults (18+) – never smoked (2020) [1]	61.7%	61.6%
Smoking status at time of delivery (2022/23) [1]	7.1%	8.8%
Smoking prevalence in adults (18-64) in routine and manual occupations (2022) [1]	23.5%	22.5%
Smoking prevalence in adults (18+) with a long-term mental health condition (2022/23) [1]	28.2%	25.1%
Adults (18+) identified as smoking tobacco at the start of substance misuse treatment (2021/22) [2]	86%	62%
Young people (under 18) identified as smoking tobacco at the start of substance misuse treatment (2022/23) [2]	22%	42%

Key achievements

- Birmingham and Solihull Integrated Care Partnership - Joint Position Statement in support of the plan setting out pledges to bring together local partners to renew our efforts to work together to reduce harmful tobacco use
- Set up of the BSol Tobacco Control Alliance
- Establishment of the Birmingham Smoking Cessation Task Group to manage the additional Smokefree Generation Grant (£1,676,048 in 2024/25)

Current Smoking Cessation Services

- The current community service commissioned by Birmingham City Council is being delivered by 165 providers citywide, including:
  - 92 GP Practices
  - 71 Pharmacies
  - 2 Businesses
- The community service consists of 12 weeks of behavioural support alongside Nicotine Replacement Therapy (NRT) and vapes.
- In addition, the council has commissioned Solutions4Health for the provision of an AI app called ‘Quit with Bella’. It is designed to assist individuals in quitting smoking through behavioural support and interventions.



Stop Smoking Service performance

Rates per 100,000 smokers for Birmingham compared to England:

	Birmingham	England
Setting a quit date	9,025	3,346
Successful quitters (self-reported)	3,029	1,800
Not quit	3,151	914
Not known/ lost to follow up	2,846	631
Successful quitters (self- reported), confirmed by CO validation	416	363

NHS Long Term Plan Treating Tobacco Dependency Programme

- Acute in-patient support services
- Services for those with severe mental health illness
- Support for pregnant women who smoke and are in contact with maternity services
- Coordination of the National Targeted Lung Health Check programme pilot in Birmingham

Smoke Free Generation Grant

- Additional funding for local stop smoking services and support over the next five financial years, starting 2024/25 until 2028/29.
- Birmingham City Council allocated £1,676,048 in financial year 2024-25.
- Local authorities must maintain spend on existing services, must not use the fund to replace existing services and must adhere to quarterly reporting requirements.
- The condition of the grant is that funding will be exclusively used to:
  - Build capacity to deliver expanded local stop smoking services and support.
  - Build demand for local stop smoking services and support.
  - Increases the number of people setting a quit date and 4 week quit outcomes.
  - Report outcomes quarterly to NHS Digital against expenditure.

Shisha

- A two-year ‘gold standard’ community engagement project focused on Shisha consumption is underway, set to end in 2026.
- The aims of the project are to fill gaps in knowledge around shisha consumption in Birmingham and offer recommendations to address this public health issue.
- The project will report to the Birmingham and Solihull Tobacco Control Alliance.

Youth Vaping

- Action for Smoking and Health (ASH) has recently published their annual Smokefree GB Youth Survey for 2024:
  - The 2024 data reveals that the rate of youth vaping remains high, with 18% of 11–17-year-olds (20% in 2023) having tried vaping. Since 2021, there have been more children vaping than smoking.
  - Amongst 11–17-year-olds, ‘once or twice’ experimentation has remained the most common type of vaping amongst young people.
  - For the second year in a row most children aged 11-17 (58%) wrongly believe that vaping is about the same or more harmful than smoking.
- Commissioned support for people who want to stop vaping is not something Birmingham City Council are currently considering.

Enforcement

- Birmingham City Council Public Health have an internal Memorandum of Understanding (MOU) with Trading Standards to deliver activity to prevent illicit vape sales for the period 2024/25.
- The project funds the inspection and advice for shops selling vapes and nicotine inhaling products as well as targeting those premises who sell these products to underage customers.
- In quarter one of 2024/25, a total of 37 premises were visited based off intelligence and all failed the compliance test. An example of a failure is due to the presence of illicit vapes.
- Re-visits to failing premises later in the year will be conducted to test compliance following advisory visits.

Recommendations to the Board

- Note progress to date and offer any feedback
- Note that further updates on national legislation awaited
- Board members provide ongoing support of future proposals and plans set out in the briefing paper

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Appendix 1: Substance Misuse Health and Wellbeing Board Indicators (September 2024 report)

Indicator	Admission episodes for alcohol-related conditions per 100,000 (Broad)				
2030 Ambition	Reduce episodes for alcohol-related conditions to below the national average by 2030				
Date updated	05/01/2024	Time Period	2022/23		
Birmingham (previous date 2021/22)	**Birmingham (current)**	**Solihull**	**West Midlands**	**Core Cities**	**England**
2066	2171	1734	1959	2017	1705
The current admissions episodes in Birmingham are higher than the England average by 27% and higher than the core cities by 8%. **Since last update (2021/22), Birmingham has seen an increase in admissions by 5%.** This translates in Birmingham to a rate of alcohol related admissions of 2171 which is much higher than the current national average of 1705. Birmingham, like the rest of England has a higher rate of unmet treatment need for dependent drinkers. Recent Office for Health Inequalities and Disparities 'Harm to Hope' Drug Strategy supplementary grant funding has enabled us to commission activity that aims to reduce this unmet need and support the aspiration to achieve the 2030 ambition stated above.					

Indicator	Successful treatment of drug treatment – opiate users (%)				
2030 Ambition	Increase successful completion of drug treatment – opiate users to over 8%				
Date updated	25th October 2023	Time Period	2022		
Birmingham (previous date 2021)	**Birmingham (current)**	**Solihull**	**West Midlands**	**Core Cities**	**England**
3.5	4.0	5.7	4.6	4.3	5.0
Birmingham has a lower percentage of successful completion (opiate users) compared to the England average and Core Cities. **Since last update, Birmingham has seen a 0.5 percentage point increase in successful treatment completions**.					

The number of opiate users in treatment in Birmingham has risen due to the increased capacity of the local substance misuse service. It is positive that the increased numbers in treatment have coexisted with an increase in successful treatment, however there is a long way to go to realise the 2030 ambition stated above.
New treatments have been introduced in Birmingham, such as prescription of Buvidal. This long-acting buprenorphine treatment is administered via subcutaneous injection, and effectively reduces cravings and withdrawal symptoms, over a longer period. Advantages include reduced risk of a missed dose, increased independence due to the reduced frequency of administration compared to other pharmacotherapies. The numbers of individuals able to benefit from Buvidal prescribing is increasing monthly and could be an intervention which will improve the data for this indicator.

Indicator	Successful completion of drug treatment – non-opiate users (%)				
2030 Ambition	Increase successful completion of drug treatment – non-opiate users to over 48%				
Date updated	25th October 2023	Time Period	2022		
Birmingham (previous date 2021)	**Birmingham (current)**	**Solihull**	**West Midlands**	**Core Cities**	**England**
34.6	31.3	44.3	30.4	33.7	31.4

Birmingham has the same percentage of successful completion (non-opiate users) as the England average but slightly lower than the Core Cities.
Since last update, Birmingham has seen a decrease of 3.3 percentage points in successful treatment completions.
National Drug Strategy policy 'Harm to Hope' funding has seen an increase in Drug workers in both Adult and Children Substance Misuse services in Birmingham. This additional capacity is allowing more individuals to come into treatment, many of which are non-opiate users. As the numbers of non-opiate users in treatment in Birmingham has gone up, it is possible that there is a data lag in successful completions for new clients.

Annual Review 2023-2024: Indicator Updates

Theme 1: Healthy and Affordable Food

Indicator	**Breastfeeding prevalence at 6-8 weeks after birth - current method**
2030 Ambition	Increase the % of babies who are breastfed 6-8wks after birth to over 50 & by 2027 and over 60% by 2030
Date updated	25/07/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
46.8	**46.3**	46.9	N/a	54.7	49.2

Birmingham's percentage (%) is lower than the average in England and the Core Cities. This slight decrease could be attributed to the shortage of infant feeding staff to support breastfeeding initiation and the offer of continued support once the family is back in the community. From this year, Family Hubs will be focusing on increasing infant breastfeeding across the city and supporting families. This will include: grants to purchase breast pumps for maternity infant feeding teams and extra funding to support the employment of additional infant feeding staff. Additionally, the New Baby Network have been commissioned to develop peer support groups across the city. These initiatives should help to increase the prevalence by the time of the next Annual Review.

Indicator	**Obesity: QOF prevalence (18+)**
2030 Ambition	Reduce the prevalence of adult obesity (18+) to the national average by 2030
Date updated	15/04/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
9.8	**11.5**	10.5	12.9	10.8	11.4

The prevalence of obesity in Birmingham is similar to the national and Core Cities average. There has been an increase since the last update, similar to the national picture. Obesity is a complex interaction of many factors. Tackling the root causes of obesity requires a systems and partnership approach. Partners also deliver support for citizens. Birmingham City Council commissions two Tier 2 Adult Weight Management Services to support overweight citizens lose weight in a healthy and sustainable way. These are an App Service provided by Healum and is available to all Birmingham citizens that meet the eligibility criteria and a Disability Service for disabled Birmingham citizens. Tier 3 obesity services are commissioned by NHS commissioners.

Microsoft Power BI Dashboard

Indicator	**Percentage of 5-year olds with experience of dental decay (Persons, 5 yrs)**
2030 Ambition	Reduce the % of 5yr olds with experience of dental decay to below 20% by 2030
Date updated	13/12/2023 **Time Period** 2021/2022

Birmingham (2018/2019)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
28.6	**23.8**	16.4	23.8	30.5	23.7

The percentage of 5-year-olds with experience of dental decay in Birmingham is similar to the national average and lower than the Core Cities average. Since Birmingham's previous update, there has been a decrease. Birmingham City Council has led on distributing toothbrush packs to families at risk of poor oral health over the past 12 months – this has provided resources to these families. Staff have also led on educating families & professionals on key oral health messages. A Birmingham and Solihull Oral Health Needs Assessment (OHNA) has been produced, and a public health officer recruited to deliver the recommendations. An Oral Health Improvement strategy has been developed locally, with a newly recruited team of NHS BCHC Oral Health Improvement nurses delivering this locally, including:

- Workforce development training - training delivered by BCHC Dietetic Team to early years settings as part of Startwell. Training delivered to Health Visiting teams in 4 localities and 10,500 toothbrush packs provided as part of a pilot to increase attendance at 1 year development check)
- Supervised toothbrushing programmes in early years settings (Brilliant Brushers) - target settings for first wave of programme identified based on need and in collaboration with Oral Health Improvement Network.

Indicator	**Proportion of the population meeting the recommended '5-a'day' on a 'usual day' (adults)(Persons, 16+ yrs)**
2030 Ambition	Increase the % of adults regularly eating '5-a-day' to more than 55% by 2030
Date updated	25/04/2024 **Time Period** 2019/2020

Birmingham (2018/2019)	Birmingham (2019/2020)	Solihull	West Midlands	Core Cities	England
23.9	**23.2**	31.5	28.8	27.3	31.0

The Birmingham percentage is lower than both the England and Core Cities average. Since Birmingham's previous update, there has been a slight decrease. Under the Food System strategy, we have undertaken work to increase consumption of fruits, vegetables, beans and pulses (which all contribute to 5-a-day). This work includes:

- A campaign to increase beans and pulses consumption in young people, delivered through the Bring it on Brum programme (Holidays, Activities and Food)
- Hakuna Fruitata consists of activities to increase fruit and vegetable consumption, also delivered through Bring it on Brum
- Continuing to work on the Diverse Eating Guidance to help people make sense of healthy eating messages and how they can achieve dietary recommendations in nutritious and culturally appropriate ways
- An emphasis on nutritious food in Birmingham's Cost of Living Food Provision response
- Funding food skills workshops and activities through the Birmingham Food Legends Fund

It is worth noting that the Cost-of-Living crisis and increasing poverty levels will likely lead to decreases in 5-a-day consumption as healthy foods (especially fruits and vegetables) are more expensive than unhealthy foods (especially foods high in fat, salt and sugar).

Indicator	**Reception: Prevalence of obesity (including severe obesity) (Persons, 4-5 yrs)**		
2030 Ambition	Reduce the prevalence of obesity (including severe obesity) in children in Reception and Year 6 by 10% by 2030		
Date updated	10/10/2023	**Time Period**	2021/2022

Birmingham (2019/2020)	Birmingham (2021/2022)	*Solihull*	*West Midlands*	*Core Cities*	*England*
12.2	**10.2**	8.4	10.1	10.9	9.2

The prevalence in Birmingham is slightly higher than the average in England and lower than the Core Cities average. Since Birmingham's previous update, there has been a decrease. Childhood obesity is a complex interaction of many factors. Tackling the root causes of childhood obesity requires a systems and partnership approach. New weight management service has been commissioned in Birmingham, specifically for ages 5 to 12. Birmingham commissioned a new Tier 2 children, young people and families weight management offer in July 2021. As this was a new service, with nothing similar offered previously, it took some time to mobilise and set up referral pathways. The children in this cohort would have been previously impacted by the COVID-10 Pandemic restrictions, reducing ability to socialise and engage in informal physical activity opportunities.

Microsoft Power BI Dashboard

Indicator	**Reception: Prevalence of underweight (Persons, 4-5 yrs)**
2030 Ambition	Reduce the prevalence of underweight children in Reception to less than 1% by 2030
Date updated	10/10/2023 **Time Period** 2021/2022

Birmingham (2019/2020)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
1.8	**1.9**	1.5	1.3	1.3	1.2

The prevalence of underweight children in Reception is higher in Birmingham than the averages of both England and Core Cities. Since Birmingham's previous update, there has been a slight increase. There could be several reasons why a child is underweight. Underweight in a child may reflect undernutrition (a form of malnutrition) but may also reflect a small build (UK Parliament, 2020). Children must get the right amount of calories, nutrients and minerals to support healthy growth.

Indicator	**Uptake of healthy start vouchers in eligible families (%)**
2030 Ambition	Increase the uptake of healthy start vouchers in eligible families to at least 80% by 2027
Date updated	01/03/2022 **Time Period** 2022

Birmingham (2021)	Birmingham (2022)	Solihull	West Midlands	Core Cities	England
68.6	**71.4**	70.7	65.2	70.2	64.7

The Birmingham percentage is higher than the averages of both England and Core Cities. Since Birmingham's previous update, there has been an increase in uptake. Current data on the uptake of Healthy Start in Birmingham reflects the national picture. The number of people on the scheme has increased due to benefits and tax credits ending and being replaced by Universal Credit. As Universal Credit is one of the main qualifying benefits for the scheme, we have seen a significant increase in the eligible cohort. Between March and April 2024, the eligible cohort increased by 11,021. Department for Work and Pensions estimate that this will likely continue as more people move to Universal Credit, one consequence of which may be a lower percentage in uptake. Birmingham is above the national average in families registering for Healthy Start, and uptake is spread evenly across the city, ranging between 47% and 100%.

Microsoft Power BI Dashboard

Indicator	**Year 6: Prevalence of obesity (including severe obesity) (Persons, 10-11 yrs)**
2030 Ambition	Reduce the prevalence of obesity (including severe obesity) in children in Reception and Year 6 by 10% by 2030
Date updated	10/10/2023 **Time Period** 2021/2022

Birmingham (2019/2020)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
27.9	**27.0**	19.4	25.2	26.5	22.7

The prevalence in Birmingham is higher than the national average and slightly higher than the Core Cities average. Since Birmingham's previous update, there has been a slight decrease. Childhood obesity is a complex interaction of many factors. Tackling the root causes of childhood obesity requires a systems and partnership approach. Birmingham commissioned a new Tier 2 children, young people and families weight management offer in July 2021. As this was a new service, with nothing similar offered previously, it took some time to mobilise and set up referral pathways. The children in this cohort would have been previously impacted by the COVID-10 Pandemic restrictions, reducing their ability to socialise and engage in informal physical activity opportunities.

Indicator	**Year 6: Prevalence of underweight (Persons, 10-11 yrs)**
2030 Ambition	Reduce the prevalence of underweight in children in Year 6 to less than 1% by 2030
Date updated	10/10/2023 **Time Period** 2021/2022

Birmingham (2019/2020)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
2.1	**2.4**	2.1	1.7	1.5	1.6

The prevalence of underweight children in Year 6 is higher in Birmingham than both the England and Core Cities average. Since Birmingham's previous update, there has been a slight increase. There could be several reasons why a child is underweight. Underweight in a child may reflect undernutrition (a form of malnutrition) but may also reflect a small build (UK Parliament, 2020). Children must get the right amount of calories, nutrients and minerals to support healthy growth.

Theme 2: Mental Wellness and Balance

Indicator	**Admission episodes for alcohol-related conditions (Broad definitions) per 100,000**
2030 Ambition	Reduce episodes for alcohol-related conditions (Broad definitions) to below the national average by 2030
Date updated	05/01/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/23)	Solihull	West Midlands	Core Cities	England
2066.2	**2171.2**	1733.7	1958.7	2087.5	1704.6

Since the last update (2021/22), Birmingham has seen an increase in admissions by 5%. This translates in Birmingham to a rate of alcohol-related admissions of 2,171, which is much higher than the current national average of 1,705. Birmingham, like the rest of England, has a high rate of unmet treatment need for dependent drinkers. Recent Office for Health Inequalities and Disparities' Harm to Hope' Drug Strategy grant funding has enabled us to commission activity that aims to reduce this unmet need and support the aspiration to achieve the 2030 ambition stated above.

Indicator	**Average anxiety rating (0-10: 0 'not at all anxious', 10 'completely anxious')**
2030 Ambition	Ensure our personal well-being scores are equal to or better than the national average by 2030
Date updated	16/11/2023 **Time Period** 2021/2022

Birmingham (2020/2021)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
3.2	**3.4**	3.0	3.2	3.4	3.2

Birmingham's average anxiety rating is slightly higher than the England average and the same rate as for the Core Cities. Since Birmingham's previous update there has been a slight increase. This data is taken from the ONS measures of wellbeing through the Annual Population Survey. Alongside the Creating a Mentally Healthy City Strategy, the Director of Public Health Annual Report 2024/25 will focus on exploring wellbeing and will provide further information and depth on these indicators.

Microsoft Power BI Dashboard

Indicator	**Average happiness rating (0-10: 0 'not happy at all', 10 'completely happy')**
2030 Ambition	Ensure our personal well-being scores are equal to or better than the national average by 2030
Date updated	16/11/2023 **Time Period** 2021/2022

Birmingham (2020/2021)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
7.3	**7.2**	7.6	7.4	7.2	7.4

Birmingham's' average happiness rating is slightly lower than the England average and the same rate as the Core Cities. Since Birmingham's previous update there has been a slight decrease. This data is taken from the ONS measures of wellbeing through the Annual Population Survey. Alongside the Creating a Mentally Healthy City Strategy, the Director of Public Health Annual Report 2024/25 will focus on exploring wellbeing and will provide further information and depth on these indicators.

Indicator	**Average life satisfaction rating (0-10: 0 'not at all satisfied', 10 'completely satisfied')**
2030 Ambition	Ensure our personal well-being scores are equal to or better than the national average by 2030
Date updated	16/11/2023 **Time Period** 2021/2022

Birmingham (2020/2021)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
7.5	**7.2**	7.6	7.4	7.3	7.4

The Birmingham rate is almost the same as both the England and Core Cities average. Since Birmingham's previous update there has been a slight decrease. This data is taken from the ONS measures of wellbeing through the Annual Population Survey. Alongside the Creating a Mentally Healthy City Strategy, the Director of Public Health Annual Report 2024/25 will focus on exploring wellbeing and will provide further information and depth on these indicators.

Microsoft Power BI Dashboard

Indicator	**Average worthwhile rating (0-10: 0 'not at all worthwhile', 10 'completely worthwhile')**
2030 Ambition	Ensure our personal well-being scores are equal to or better than the national average by 2030
Date updated	16/11/2023 **Time Period** 2021/2022

Birmingham (2020/2021)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
7.7	**7.7**	7.8	7.8	7.5	7.7

The rate for Birmingham is the same as the England average and slightly higher than the Core Cities. Since Birmingham's previous update there has been no change. This data is taken from the ONS measures of wellbeing through the Annual Population Survey. Alongside the Creating a Mentally Healthy City Strategy, the Director of Public Health Annual Report 2024/25 will focus on exploring wellbeing and will provide further information and depth on these indicators.

Indicator	**Emergency hospital admissions for intentional self-harm per 100,000**
2030 Ambition	Reduce the emergency intentional self-harm admission rate to be within the lowest 10 UTLA in England by 2030
Date updated	16/04/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
162.7	**134.8**	111.9	120.2	139.3	126.3

Emergency hospital admissions for intentional self-harm are higher in Birmingham than the average for England but lower than that of the core cities. Since Birmingham's previous update there has been a decrease.

Microsoft Power BI Dashboard

Indicator	**Prevalence of depression and anxiety in adults**
2030 Ambition	Reduce the prevalence of depression and anxiety in adults to less than 12% by 2030
Date updated	03/10/2020
Time Period	2016/2017

Birmingham (2015/2016)	Birmingham (2016/2017)	Solihull	West Midlands	Core Cities	England
14.6	**14.5**	11.9	N/A	16.8	13.7

The prevalence of depression and anxiety has been previously higher in Birmingham than the national average, but similar to the core cities. This data is pre-pandemic, and more recent and local (sub-city) data is required to understand this indicator and ambition. The Creating a Mentally Healthy City Strategy will build on and support the HW&B Strategy aims and recommendations. One of the key objectives is to reduce depression and anxiety across the city. There will be a focus on early intervention and prevention as this approach recognises the importance of identifying and addressing mental health concerns at an early stage to prevent them from escalating into more severe conditions.

Indicator	**Proportion of adults who have a high self-reported life satisfaction score**
2030 Ambition	Ensure our personal well-being scores are equal to or better than the national average by 2030
Date updated	16/11/2023
Time Period	2021/2022

Birmingham (2020/2021)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
54.0	**61.9**	54.4	54.1	56.2	53.9

The proportion of adults who have a high self-reported life satisfaction score is higher in Birmingham than the national and core cities average. Since Birmingham's previous update there has been an increase. This data is taken from the ONS measures of wellbeing through the Annual Population Survey. Alongside the Creating a Mentally Healthy City Strategy, the Director of Public Health Annual Report 2024/25 will focus on exploring wellbeing and will provide further information and depth on these indicators.

Microsoft Power BI Dashboard

Indicator	**Smoking prevalence in adults with a long-term mental health condition (18+)**
2030 Ambition	Reduce the smoking prevalence in adults with a long-term mental health condition to at least the national average by 2027
Date updated	28/02/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
28.7	**28.2**	17.9	24.6	27.5	25.1

Smoking prevalence in adults with a long-term mental health condition is higher than the national average and the core cities average. Since Birmingham's previous update, there has been a slight decrease. Whilst this is a positive direction of travel, further work is underway to reduce prevalence rates in this high-risk group. BSol Mental Health Foundation Trust runs an in-patient programme to support patients to quit smoking, and work is underway to strengthen this offer within their community mental health services and provide better continuity of smoking cessation support for those patients who are discharged from in-patient care. This work is being supported through Birmingham's Smokefree - Smoking Cessation Task Group.

Indicator	**Successful completion of drug treatment – non-opiate users**
2030 Ambition	Increase successful completion of drug treatment – non-opiate users to over 48%
Date updated	30/07/2024 **Time Period** 2022

Birmingham (2021)	Birmingham (2022)	Solihull	West Midlands	Core Cities	England
34.6	**31.3**	44.3	30.4	33.7	31.4

The percentage in Birmingham is almost equal to the average in England and slightly lower than the core cities average. Since the last update, Birmingham has seen a decrease of 3.3 percentage points in successful treatment completions. The National Drug Strategy policy 'Harm to Hope' funding has seen more workers in both Adult and Children Substance Misuse services in Birmingham. This additional capacity is allowing more individuals to come into treatment, many of whom are non-opiate users. As the number of non-opiate users in treatment in Birmingham has gone up, there may be a data lag in successful completions for new clients.

Microsoft Power BI Dashboard

Indicator	**Successful treatment of drug treatment – opiate users to over 8%**		
2030 Ambition	Increase successful completion of drug treatment – opiate users to over 8%		
Date updated	30/07/2024	**Time Period**	2022

Birmingham (2021)	Birmingham (2022)	Solihull	West Midlands	Core Cities	England
3.5	**4.0**	5.7	4.6	4.3	5.0

The percentage in Birmingham is lower than the averages for England and the Core Cities. Since the last update, Birmingham has seen a 0.5 percentage point increase in successful treatment completions. The number of opiate users in treatment in Birmingham has risen due to the increased capacity of the local substance misuse service. It is positive that the increased numbers in treatment have coexisted with an increase in successful treatment. However, there is a long way to go to realise the 2030 ambition stated above. New treatments have been introduced in Birmingham, such as Buvidal prescriptions. This long-acting buprenorphine treatment is administered via subcutaneous injection and effectively reduces cravings and withdrawal symptoms over a longer period. Advantages include reduced risk of a missed dose and increased independence due to the reduced frequency of administration compared to other pharmacotherapies. The number of individuals able to benefit from Buvidal prescribing is increasing monthly, and this could be an intervention that will improve the data for this indicator.

Microsoft Power BI Dashboard

Indicator	**Suicide rate (persons) per 100,000**
2030 Ambition	Reduce our suicide rate (persons) in the city to be in the lowest 10 UTLA in England by 2030
Date updated	01/02/2024 **Time Period** 2020/2022

Birmingham (2019/2021)	Birmingham (2020/2022)	Solihull	West Midlands	Core Cities	England
8.5	**8.5**	10.6	10.7	10.9	10.3

Birmingham's suicide rate is lower than the England average and Core Cities average. Since Birmingham's previous update, there has been no change. Actions being taken to address suicide rates:

- Formulation of a new suicide prevention strategy and action plan – this will include analysis of current suicide rates, define which groups are at risk and what actions PH and its partners need to take to reduce the risk of suicide
- Coronial audit (analysing suicides from 2017-2021) is in the process of being signed off – this will help us to understand trends within BSOL and be able to focus resources and public health interventions for people highlighted as being at risk based on the data
- Development of a real-time suspected suicide surveillance system to give us real-time data on deaths, be able to identify clusters/trends and respond accordingly
- Orange Button Scheme – creating a network of trained individuals who are identifiable by the public as someone trained to talk about suicide
- Monitoring of national data basis (e.g. Fingertips and national RTSSS) to identify trends and respond accordingly

Theme 3: Active at Every Age and Ability

Indicator	**Activity gap between ethnic groups: White British and Asian (excluding Chinese)**
2030 Ambition	Close the activity gap between different ethnic groups by 2030
Date updated	20/04/2023
Time Period	2020/2021 (Nov)

Birmingham (2020/2021 May)	Birmingham (2020/2021 Nov)	Solihull	West Midlands	Core Cities	England
19.3	**11.4**	3.4	11.5	11.3	11.5

The gap is similar to the core cities average and England's average. Since Birmingham's previous update, there has been a decrease. Closing the gap is a key priority in the published Creating an Active Birmingham Strategy. Work includes the development of a culturally competent PA toolkit to increase people's knowledge of the Chief Medical Officer's guidance amongst communities. Other parts of the strategy include working in partnership through the Active City Forum to ensure localised coordination of assets and interventions that are relevant to communities.

Indicator	**Activity gap between ethnic groups: White British and Black**
2030 Ambition	Close the activity gap between different ethnic groups by 2030
Date updated	20/04/2023
Time Period	2020/2021 (Nov)

Birmingham (2020/2021 May)	Birmingham (2020/2021 Nov)	Solihull	West Midlands	Core Cities	England
9.6	**10.3**	N/A	12.1	6.4	10.2

The gap is similar to the national average but higher than the core cities. Since Birmingham's previous update, there has been an increase. Closing the gap is a key priority in the published Creating an Active Birmingham Strategy. Work includes the development of a culturally competent PA toolkit to increase people's knowledge of the Chief Medical Officer's guidance amongst communities. Other parts of the strategy include working in partnership through the Active City Forum to ensure localised coordination of assets and interventions that are relevant to communities.

Indicator	**Activity gap between ethnic groups: White British and Chinese**
2030 Ambition	Close the activity gap between different ethnic groups by 2030
Date updated	20/04/2023
Time Period	2020/2021 (Nov)

Birmingham (2020/2021 May)	Birmingham (2020/2021 Nov)	Solihull	West Midlands	Core Cities	England
N/A	**N/A**	N/A	1.3	1.1	5.3

There is insufficient data in the Active Lives Survey to report on this indicator.

Indicator	**Inactivity gap between those living with disabilities and long-term health conditions and those without**
2030 Ambition	Reduce the inactivity gap between those living with disabilities and long-term health conditions and those without by 50% by 2030
Date updated	20/04/2023
Time Period	2020/2021 (Nov)

Birmingham (2020/2021 May)	Birmingham (2020/2021 Nov)	Solihull	West Midlands	Core Cities	England
16.6	**20.3**	24.5	21.5	18.1	20.1

The inactivity gap between those living with disabilities and long-term health conditions and those without is similar to England and bigger than the core cities. Since Birmingham's previous update, there has been an increase in the gap. Co-produced work has focused on hearing seldom-heard voices and understanding barriers, which was used as evidence in the Physical Activity Needs Assessment. This work has informed the Closing the Gap priority in the Creating an Active Birmingham Strategy. Working with the Active City Forum will also ensure we can provide better, more suitable opportunities for citizens with learning disabilities to be active.

Indicator	**Percentage of adults cycling for travel at least three days a week**
2030 Ambition	Increase the % of adults walking or cycling for travel at least three days a week by at least 25% by 2030
Date updated	19/10/2021 **Time Period** 2019/2020

Birmingham (2018/2019)	Birmingham (2019/2020)	Solihull	West Midlands	Core Cities	England
1.4	**2.0**	1.3	1.4	3.0	2.3

The percentage of adults cycling for travel is lower than both the England average and the Core Cities average. Since Birmingham's previous update, there has been an increase. Active People and Active environments priorities of the Creating an Active Birmingham strategy to increase safe infrastructure and encourage individual behaviour change. Collaboration with transport team to evaluate Places for People Programme to better deliver subsequent phases to promote walking and cycling behaviours within communities and for travel

Indicator	**Percentage of adults walking for travel at least three days a week**
2030 Ambition	Increase the % of adults walking or cycling for travel at least three days a week by at least 25% by 2030
Date updated	19/10/2021 **Time Period** 2019/2020

Birmingham (2018/2019)	Birmingham (2019/2020)	Solihull	West Midlands	Core Cities	England
25.5	**16.8**	14.0	12.6	19.5	15.1

The Birmingham % is higher than England but lower than the Core Cities average. Since Birmingham's previous update there has been a decrease. Active People and Active environments priorities of the Creating an Active Birmingham strategy to increase safe infrastructure and encourage individual behaviour change.

Microsoft Power BI Dashboard

Indicator	**Percentage of physically active children and young people**
2030 Ambition	Increase the % of physically active children and young people to the national average by 2030
Date updated	29/04/2024 **Time Period** 2020/2021

Birmingham (2019/2020)	Birmingham (2020/2021)	Solihull	West Midlands	Core Cities	England
41.6	**34.2**	40.2	43.9	45.6	47.0

The Birmingham % is lower than both the England and Core Cities average. Since Birmingham's previous update there has been a decrease. To improve the percentage of physically active children, the Physical Activity team and partners are working with the Healthy Schools Programme to identify new projects to collaborate together on. Similarly, a better data quality approach is being explored by investigating proxy measures and boosting completion of the Active Lives Survey.

Indicator	**Percentage of physically inactive adults**
2030 Ambition	Reduce the % of adults who are physically inactive to less than 20% by 2030
Date updated	25/04/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
29.4	**27.9**	21.8	25.1	22.4	22.6

The Birmingham % is higher than both the England and Core Cities average. Since Birmingham's previous update there has been a decrease. There are currently projects underway that are focusing on individual behaviour change around physical inactivity and breaking sedentary lifestyles.

Microsoft Power BI Dashboard

Indicator	**Percentage of physically active adults**		
2030 Ambition	Increase the % of physically active adults to over 65% by 2030		
Date updated	25/04/2024	**Time Period**	2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
58.1	**60.4**	68.7	64.0	67.9	67.1

The Birmingham % is lower than both the England and Core Cities average. Since Birmingham's previous update there has been an increase. A major strand of the Creating an Active Birmingham Strategy will be focusing on how to achieve 'active people, active environments, and active societies'. These will be facilitated through an publicly accessible online activity finder, a culturally competent toolkit and a drive for better data collection and reporting.

Indicator	**Percentage of young people who are regularly cycling as part of their daily travel to school or other places**		
2030 Ambition	Increase the % of young people who are regularly walking or cycling as part of their daily travel to school or other places by 50% by 2030		
Date updated	15/01/2024	**Time Period**	2021/2022

Birmingham (2020/2021)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
5.9	**7.3**	12.9	9.3	9.0	10.8

The Birmingham % is lower than both the England and Core Cities average. Since Birmingham's previous update there has been an increase. Additionally, proxy measures will be looked into to be commissioned to obtain more representative data for Birmingham.

Microsoft Power BI Dashboard

Indicator	**Percentage of young people who are regularly walking as part of their daily travel to school and other places**
2030 Ambition	Increase the % of young people who are regularly walking or cycling as part of their daily travel to school or other places by 50% by 2030
Date updated	15/01/2024
Time Period	2021/2022

Birmingham (2020/2021)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
41.3	**42.1**	40.1	50.4	50.8	51.3

The Birmingham % is lower than both the England and Core Cities average. Since Birmingham's previous update there has been a slight increase. The Active Systems strand of the Creating an Active Birmingham Strategy will ensure adequate representation from the Healthy Schools Programme towards the active travel agenda for young people.

Theme 4: Contributing to a Green and Sustainable Future

Indicator	**Fraction of mortality attributable to particulate air pollution (Persons, 30+ yrs)**		
2030 Ambition	Reduce the fraction of mortality attributable to particulate air pollution to less than 4.5% by 2030		
Date updated	01/10/2023	**Time Period**	2021

Birmingham (2019)	Birmingham (2021)	Solihull	West Midlands	Core Cities	England
5.8	**6.2**	5.7	5.5	5.7	5.5

The Birmingham % is slightly higher for both the England and Core Cities average. Since the Birmingham's previous update there has been a slight increase. It is important to note that the term 'Particulate Matter' (PM) includes everything in the air that is not a gas and as such it is made up of a huge variety of chemical compounds and material, some of which are toxic. Around half of the concentrations of PM that people in the UK are exposed to from either naturally occurring sources, such as pollen and sea spray, or are transported to the UK. The remaining half come from human activities, such as wood burning, various industrial processes and vehicle tyre and brake wear.

DEFRA's Environmental Improvement Plan (2023) sets out actions that will drive continued improvements to air quality and to meet the new national interim and long-term targets for PM2.5. Similarly, the Government's National Air Quality strategy (2023) sets out roles and responsibilities for local authorities to work towards the new targets. This work builds on the Road to Zero strategy which details the approach to reducing exhaust emissions (Nitrogen dioxide) from road transport through a number of mechanisms. In Birmingham, the single biggest intervention to reduce the levels of nitrogen dioxide in the city, has been the Clean Air Zone. This scheme has proven effective in reducing the levels of this air pollutant in a relatively short period of time.

Microsoft Power BI Dashboard

Indicator	**Emergency hospital admissions for respiratory disease in adults per 100,000**
2030 Ambition	Reduce emergency hospital admissions for respiratory disease in adults to at least the national average by 2030
Date updated	11/06/2024 **Time Period** 2022/23

Birmingham (2019)	Birmingham (2021)	Solihull	West Midlands	Core Cities	England
1611.9	**2018.7**	1433.9	N/A	1709.4	1384.7

The Birmingham % is higher than the rate for England and the Core Cities average. Since the previous update there has been an increase , although the current figure represents a decrease on the pre-COVID-19 pandemic rate.

Theme 5: Protect and Detect

Indicator	**Abdominal Aortic Aneurysm Screening – Coverage (Male, 65)**
2030 Ambition	Improve the uptake of national screening programmes (close the gaps between Birmingham and the national targets)
Date updated	29/04/2024 **Time Period** 2022/23

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
65.7	**69.2**	83.6	80.2	74.2	78.3

The Birmingham % is lower for both the England and Core Cities average. Since Birmingham's previous update there has been an increase. The local programme is running well and achieving the relevant KPIs. Renewed national focus on waiting time to vascular intervention. Local time frames are clinically justified but will still explore any improvement opportunities. Ongoing actions will focus on working to close the gap between local coverage and Core Cities/England coverage.

Indicator	**Cancer screening coverage – Bowel cancer (Persons, 60-74 yrs)**
2030 Ambition	Improve the uptake of national screening programmes (close the gaps between Birmingham and the national targets)
Date updated	29/04/2024 **Time Period** 2023

Birmingham (2022)	Birmingham (2023)	Solihull	West Midlands	Core Cities	England
60.3	**62.0**	74.6	70.4	67.8	72.0

The Birmingham % is lower than both the England average and Core Cities. Since Birmingham's previous update there has been an increase. The programme is entering the last year of the age extension roll out (both 50-year-olds and 52-year-olds will receive FIT kits in the next financial year). Local partners are working through the recently re-established BSol ICB Cancer Screening and Early Diagnosis group to increase uptake. National recruitment to FIT@80 pilot is underway and will require future planning of reduction in FIT threshold – colonoscopy capacity constraints remain.

Microsoft Power BI Dashboard

Indicator **Cancer screening coverage – Breast cancer (Female, 53-70 yrs)**

2030 Ambition Improve the uptake of national screening programmes to close the gaps between Birmingham and the national targets

Date updated 29/04/2024 **Time Period** 2023

Birmingham (2022)	Birmingham (2023)	Solihull	West Midlands	Core Cities	England
55.6	**56.3**	66.7	65.5	60.3	66.2

The Birmingham % is lower than both the England and Core Cities average. Since Birmingham's previous update there has been a slight increase. This programme has had a particularly slow recovery from COVID-19. There are also nationally recognised workforce constraints, notably mammography but also wider radiography and radiology. IT developments/ limitations also impact the programme. The programme is projected to recover to pre-COVID-19 levels in the next year – ongoing actions will be to continue improving beyond that milestone through health promotion activities via the BSol ICB Cancer Screening and Early Diagnosis group.

Indicator **Cancer screening coverage – Cervical cancer (Female, 25-49 yrs)**

2030 Ambition Improve the uptake of national screening programmes to close the gaps between Birmingham and the national targets

Date updated 29/04/2024 **Time Period** 2023

Birmingham (2022)	Birmingham (2023)	Solihull	West Midlands	Core Cities	England
58.7	**56.6**	70.2	65.1	60.7	65.8

The Birmingham % is lower for both the England and Core Cities average. Since Birmingham's previous update there has been a decrease. Nationally, this programme has seen a long-term decline in coverage which was recognised pre-COVID-19. Increasing coverage of the programme is a key priority of regional commissioners. Actions will be complemented by the activity of the recently re-established BSol ICB Cancer Screening and Early Diagnosis group. Introduction of new call recall database in July 2024, with future programme developments to come once this has embedded. Birmingham's local sexual health service is preparing to offer opportunistic cervical cancer screening, the service is currently in the mobilisation phase of this offer.

Indicator	**HIV late diagnosis (all CD4 less than 350)(%) (Persons, 15+ yrs)**
2030 Ambition	Reduce the percentage of HIV Late Diagnosis to less than 30% by 2027
Date updated	25/09/2023 **Time Period** 2019/2021

Birmingham (2018/2020)	Birmingham (2019/2021)	Solihull	West Midlands	Core Cities	England
43.3	**46.4**	37.5	45.9	44.9	43.3

The % in Birmingham is higher than the England and Core Cities average. Since Birmingham's previous update there has been an increase. The recently recommissioned sexual health services across Birmingham provides an opportunity to strengthen efforts to increase repeat testing within this target group through the Umbrella Service delivered by University Hospital NHS Trust. A key aim for the Birmingham's Fast Track Cities+ programme is to increase testing for all blood-borne viruses (including HIV). It is planning an engagement and communications campaign 'Know Your Status' through the year and into 2025 to encourage citizens to come forward for testing for those in specific high risk groups. The roll out of the national pilot 'opt out testing scheme' in emergency departments for blood-borne viruses aims to increase identification of those who are HIV positive.

Indicator	**Hepatitis C detection rate/100,000**
2030 Ambition	Reduce transmission of HIV, Hepatitis C (HCV) and TB to reduce new cases by 50% by 2030
Date updated	29/07/2024 **Time Period** 2021

Birmingham (2020)	Birmingham (2021)	Solihull	West Midlands	Core Cities	England
21.6	**41.7**	3.2	22.3	41.6	27.8

The rate is higher in Birmingham than the national and regional average, but similar to the Core Cities average. The rate has significantly increased since the previous update but there is a time lag. Rates have increased nationally and across the Core Cities. The recently recommissioned sexual health services across Birmingham

provides an opportunity to strengthen efforts to increase repeat testing through the Umbrella Service delivered by University Hospital NHS Trust. A key aim for the Birmingham's Fast Track Cities+ programme is to increase testing for all blood-borne viruses (including Hep C). It is planning an engagement and communications campaign 'Know Your Status' through the year and into 2025 to encourage citizens to come forward for testing for those in high risk groups. The roll out of the national pilot 'opt out testing scheme' in emergency departments for bloodborne viruses aims to increase identification of those who test positive for Hep C.

Indicator	**MMR for one dose (2 yrs old)**		
2030 Ambition	Achieve the national ambitions or targets for all national immunisation programmes by 2030		
Date updated	25/04/2024	**Time Period**	2022/23

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
82.5	**82.1**	91.8	88.9	86.4	89.3

The Birmingham % is lower than both the England and Core Cities average. Since Birmingham's previous update there has been a slight decrease. In response to the 2023-24 measles outbreak, a system-wide response was mobilised to increase immunisation rates of the local population. Immunisation numbers increased during this time, which will be reflected in data releases. The 1 to under-5's cohort is a priority, and is being targeted through partnership working with Children's Centres, the Local Maternity Network Service (LMNS), and GP practices/primary care. The BSol Immunisations & Vaccinations Programme Board continues to work across the ICS to improve local uptake and reduce inequalities across the programme.

Indicator	**MMR for two doses (5 yrs old)**		
2030 Ambition	Achieve the national ambitions or targets for all national immunisation programmes by 2030		
Date updated	25/04/2024	**Time Period**	2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
76.7	**75.1**	85.8	83.7	79.6	84.5

The % for Birmingham is lower than the averages for both England and the Core Cities. Since Birmingham's previous update there has been a slight decrease. In response to the 2023-24 measles outbreak, a system-wide response was mobilised to increase immunisation rates of the local population. Immunisation numbers increased during this time, which will be reflected in data releases. The 1 to under-5's cohort is a priority and is being targeted through partnership working with Children's Centres, the Local Maternity Network Service (LMNS), and GP practices/primary care. The BSol Immunisations & Vaccinations Programme Board continues to work across the ICS to improve local uptake and reduce inequalities across the programme.

Indicator	**New HIV diagnosis rate per 100,000 (Persons, 15+ yrs)**		
2030 Ambition	Reduce transmission of HIV, Hepatitis C (HCV) and TB to reduce new cases by 50% by 2030		
Date updated	27/09/2023	**Time Period**	2021

Birmingham (2020)	Birmingham (2021)	Solihull	West Midlands	Core Cities	England
6.7	**6.7**	5.1	4.9	10.2	6.7

The rate for Birmingham is the same as the England average and lower for the Core Cities. Since Birmingham's previous update there has been no change. The recently recommissioned sexual health services across Birmingham provides an opportunity to strengthen efforts to increase repeat testing through the Umbrella Service delivered by University Hospital NHS Trust. A key aim for the Birmingham's Fast Track Cities+ programme is to increase testing for all blood-borne viruses (including HIV). It is planning an engagement and communications campaign 'Know Your Status' through the year and into 2025 to encourage citizens to come forward for testing for those in high risk groups. Birmingham City Council has commissioned a pilot enhanced community TB outreach service in partnership with University Hospital NHS Trust and Saving Lives to test for blood-borne viruses and increase access to treatment and prevention services. The roll out of the national pilot 'opt out testing scheme' in emergency departments for bloodborne viruses aims to increase identification of those who test positive for HIV.

Microsoft Power BI Dashboard

Indicator	**New STI diagnoses (excluding chlamydia aged under 25) per 100,000 (All ages)**
2030 Ambition	Reduce the overall prevalence of new sexually transmitted diseases to close the gap between Birmingham and the national average by 2030
Date updated	29/05/2024
Time Period	2023

Birmingham (2022)	Birmingham (2023)	Solihull	West Midlands	Core Cities	England
396.6	**468.2**	222.8	349.7	673.6	519.9

The rate for Birmingham is both lower than the England and Core Cities average. Since Birmingham's previous update there has been an increase. The recently recommissioned sexual health services across Birmingham provides an opportunity to strengthen efforts to increase identification and treatment of all sexually transmitted diseases through the Umbrella Service delivered by University Hospital NHS Trust. This includes access to sexual health clinics across the city as well as outreach prevention and treatment services

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Indicator	**Repeat HIV testing in gay, bisexual and other men who have sex with men (%) (Male, All ages)**
2030 Ambition	Increase the percentage of men who have sex with men who access repeat HIV testing in the last year to over 50%
Date updated	27/09/2023
Time Period	2021

Birmingham (2020)	Birmingham (2021)	Solihull	West Midlands	Core Cities	England
43.7	**53.5**	52.2	49.0	49.3	47.3

The % in Birmingham is higher than the England and Core Cities average. Since Birmingham's previous update there has been an increase. The recently recommissioned sexual health services across Birmingham provides an opportunity to strengthen efforts to increase repeat testing within this target group through the Umbrella Service delivered by University Hospital NHS Trust. A key aim for the Birmingham's Fast Track Cities+ partnership is to increase testing for all blood-borne viruses (including HIV). It is planning an engagement and communications campaign 'Know Your Status' through the year and into 2025 to encourage citizens to come forward for testing specifically targeting high risk groups.

Indicator	**TB incidence (three year average) (Persons, All ages)**
2030 Ambition	Reduce transmission of HIV, Hepatitis C (HCV) and TB to reduce new cases by 50% by 2030
Date updated	25/03/2024 **Time Period** 2020/2022

Birmingham (2019/2021)	Birmingham (2020/2022)	Solihull	West Midlands	Core Cities	England
17.8	**17.0**	3.1	9.2	10.9	7.6

The incidence in Birmingham is significantly higher than both the England and Core Cities average. Since Birmingham's previous update there has been a slight decrease. Birmingham has had higher tuberculosis (TB) rates than most areas of the UK for many years (second only to London). At least a third of all cases are attributable to social risk factors such as being an asylum seeker, drug addiction, alcohol abuse, mental health conditions, homelessness and having spent time in detained estates.

The majority of actions taken to address TB in Birmingham are reactive in nature. Each confirmed TB case has a nurse specialist assigned to them to support their compliance to the treatment. ICS partners such as UKHSA provide support for TB cases. BCC in collaboration with BSOL ICB supports cases who have a no recourse to public funds (NRPF) status as well as helping with cases that are lost to follow up. The Fast Track Cities Plus (FTC+) initiative. Launched in Birmingham in 2022, aims to decrease the incidence of TB by 50% by 2030.

Life Course: Getting the Best Start in Life

Indicator	**Child development: percentage of children achieving a good level of development at 2 to 2 ½ years**
2030 Ambition	Increase the percentage of children achieving a good level of development by age 2 to 2 ½ years to over 83% by 2030
Date updated	27/11/2023 **Time Period** 2021/2022

Birmingham (2020/2021)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
82.5	**80.7**	82.1	76.3	79.5	79.2

The Birmingham % is slightly higher for both the England and Core Cities average. Since Birmingham's previous update there has been a slight decrease. The children included in the data for 2022/23, would have been the children born during the Covid Pandemic and so they and their families would have been impacted by the restrictions, reducing ability to socialise and develop as they might otherwise have.

Indicator	**Children aged 11-15 killed or seriously injured in road traffic accidents (Persons, 11-15 yrs, per 100,000)**
2030 Ambition	Halve the rate of children killed and seriously injured (KSI) on Birmingham's roads by 2030
Date updated	27/02/2024 **Time Period** 2020-2022

Birmingham (2018/2020)	Birmingham (2020/2022)	Solihull	West Midlands	Core Cities	England
N/A	**31.5**	19.5	27.7	38.2	30.6

The % in Birmingham is higher than the England average but lower than the Core Cities. There is no Birmingham previous data. Birmingham is prioritising investment in a reduction of incidents through the Road Harm Reduction Strategy which will be published in 2024. In particular, the Healthy Streets Approach will ensure that local streets are made safer and more accessible to facilitate walking and cycling as well as an overall reduction in road traffic.

Microsoft Power BI Dashboard

Indicator	**Homelessness (aged 16-24) – households owed a duty under the Homelessness Reduction Act**
2030 Ambition	Reduce the rate of homeless young people (16-24 years) to the English average by 2030
Date updated	26/01/2023 **Time Period** 2021/2022

Birmingham (2020/2021)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
1.7	**2.3**	2.6	2.5	3.3	2.4

The Birmingham % is similar to England and lower than the core cities. Since Birmingham's previous update there has been an increase. This increase is reflective of a national trend, post COVID-19 pandemic after the 'Everybody-In' initiative ended. There are also local challenges relating to the current financial situation of Birmingham City Council, which will impact upon current homelessness provisions.

In order combat these forthcoming challenges, Birmingham City Council have developed a new Homelessness Prevention Strategy 2024-29, which aims to deliver realistic change, to help mitigate the current homelessness climate. Additionally, the strategy also commits to working closely with Birmingham Children's trust to develop protocols (that reflect the Council's financial position) to proactively ensure no children are made homeless on their 18th birthday, and therefore build on the positive pathway approach to ensure underreached groups have the right tailored support when things go wrong.

Indicator	**Hospital admissions due to asthma in young people under 19 yrs**
2030 Ambition	Halve the hospital admissions due to asthma in young people under 19 yrs by 2027
Date updated	28/02/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
230.9	**214.6**	119.4	157.4	133.7	122.2

Microsoft Power BI Dashboard

The number of admissions in Birmingham is significantly higher than both the England and Core Cities average. Since Birmingham's previous update there has been a decrease. Most attributable factor leading to hospitalisation due to asthma in children is smoking. Children who live in households where the adult is a smoker are twice as likely to pick up smoking themselves. Taking this into account a local decrease correlates with a decrease in overall smoking rates in the UK.

The Birmingham Joint Health and Wellbeing Strategy plans to tackle smoking by ensuring: the reduction of the smoking prevalence in adults with a long-term mental health condition to at least the national average by 2027, increase the percentage (%) of the estimated individuals accessing smoking cessation services and improve the 4-week quit rate by 20% by 2030. The Birmingham and Solihull NHS 10-year plan called "A Bolder, Healthier Future for the People of Birmingham and Solihull' sets out a local 5–10-year commitment that all health and social care professionals will complete basic e-learning for behaviour change, and those in clinical contact roles completing additional training on brief advice for smoking cessation.

Indicator	**Infant mortality rate**		
2030 Ambition	Reduce infant mortality in Birmingham by 25% by 2027 and by 50% by 2030		
Date updated	22/02/2024	**Time Period**	2020/2022

Birmingham (2019/2021)	Birmingham (2020/2022)	Solihull	West Midlands	Core Cities	England
7.0	**7.2**	4.6	5.6	5.2	3.9

The rate in Birmingham is higher than both the England and Core Cities average. Since Birmingham's previous update there has been a very slight increase. A change in the infant mortality rate from 7/1000 births to 7.2/1000 live births is difficult to contextualise as a small change in infant deaths influences the figures. It only requires an increase of 1 death to increase the infant mortality rate. Most infant deaths occur in the first four weeks with leading causes of death relating to prematurity or congenital anomalies. Health inequalities exist and are worsening with higher rates observed in our most deprived communities and disproportionately affecting Black African, Caribbean and South Asian communities.

Many infant deaths are preventable yet, despite efforts at local and system-level, high rates have persisted. To improve this a sustained focus on improving pre-conception health, targeted interventions to improve living conditions (relating to housing/income maximisation) and improving maternal and neonatal care pathways are required. Intervention should be informed by robust data and local intelligence surveillance. Intervention should be culturally informed, and efforts should be made to ensure it is informed by the voices of women and their families and those communities that experience barriers of access to preventive intervention.

Microsoft Power BI Dashboard

Indicator	**Percentage of children achieving a good level of development at the end of Reception**
2030 Ambition	Increase the percentage of children achieving a good level of development at the end of Reception to 75% by 2030
Date updated	29/04/2024 **Time Period** 2022/23

Birmingham (2021/22)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
62.7	**65.1**	69.0	66.0	63.3	67.2

The % in Birmingham is lower for the England average and higher for the Core Cities. Since Birmingham's previous update there has been an increase.

What is going well:-

- Gap to national has reduced to 2.1% from 2.5% for children's outcomes at end of EYFS
- Birmingham's GLD percentage is higher than both the core cities and statistical neighbours average (currently ranked 2nd and 4th respectively which is an improvement)
- The percentage of Free School Meals pupils that achieve a GLD in Birmingham is 6.8% points higher than the England average
- 75.8% of children reached expected level in Communication and Language (an increase of 0.4%)
- 67% of children reached expected level in Literacy (an increase of 1.9%)

Ongoing actions to improve:

- Drive-up the take-up of the early years entitlements – children who access early education are far more likely than those who did not to achieve a good level of development
- Continue our focus on Speech, Language and Communication (SLC) development with the city-wide WellComm toolkit and the Early Talk Boost programme through Family Hubs
- Introduction of the "Flexible Funding" to allow additional points of funded admissions when headcount/census has been missed so we get children in earlier
- Development of an Early Years data tool that can be used within the City Observatory and will enable us to target and address barriers to take-up within specific communities/areas of the city
- Early Years Developing Local Provision (Phase 2) programme with a focus on improving take-up and supporting transition for children with SEND from Nursery to Reception with targeted support for children where placement breakdown is likely.

Indicator	**Rate of first-time entrants (10-17 years) to the youth justice system**
2030 Ambition	Reduce the rate of first-time entrants (10-17 years) to the youth justice system by 25% by 2030
Date updated	09/07/2024 **Time Period** 2023

Birmingham (2022)	Birmingham (2023)	Solihull	West Midlands	Core Cities	England
116.5	**132.5**	68.4	127.4	215.7	143.4

The Birmingham rate is lower than the England average and significantly lower for the Core Cities. Since Birmingham's previous update there has been an increase.

Indicator	**Under 18 teenage conception rate**
2030 Ambition	Reduce the under 18 teenage conception rate to close the gap between Birmingham and the national average by 2030
Date updated	30/04/2024 **Time Period** 2021

Birmingham (2020)	Birmingham (2021)	Solihull	West Midlands	Core Cities	England
15.1	**13.4**	11.4	15.2	16.8	13.1

The rate in Birmingham is slightly higher than the England average and lower than the Core Cities. Since Birmingham's previous update there has been a decrease. The recently recommissioned sexual health services through the Umbrella service provided by University Hospital NHS Trust across Birmingham provides an opportunity to strengthen efforts to increase uptake of contraception services (including long acting reversible contraception). The School Health Support Service commissioned by Birmingham City Council and the Healthy Schools programme recently launched provide sexual and reproductive health education to reduce unwanted teenage pregnancies.

Life Course: Living, Working and Learning Well

Indicator	**Emergency hospital admissions for coronary heart disease, standardised admission ratio**
2030 Ambition	Reduce coronary heart disease admissions rate (all ages) by 20% by 2030
Date updated	15/02/2024 **Time Period** 2016/17 – 20/21

Birmingham (previous)	Birmingham (2016/17 – 2020/21)	Solihull	West Midlands	Core Cities	England
461.2	**462.1**	317.6	N/A	384.1	387.1

The rate for Birmingham is higher then the England and Core Cities average. Since Birmingham's previous update there has been a slight increase. The Birmingham & Solihull CVD Programme Board has recently delivered the 'Million Hearts' project which increased CVD health checks in community settings for any residents aged 40 years and above.

Indicator	**Fuel poverty (low income, low efficiency methodology)**
2030 Ambition	Reduce the number of households in fuel poverty to the national average by 2030
Date updated	03/07/2024 **Time Period** 2022

Birmingham (2021)	Birmingham (2022)	Solihull	West Midlands	Core Cities	England
23.2	**24.0**	14.1	19.6	16.9	13.1

The percentage of people living in fuel poverty in Birmingham is higher than the England and Core Cities average. Since the previous update there has been a slight increase. This is likely to continue to increase due to the energy crisis has been gripping the UK since autumn 2021. In Birmingham, the Council is working to help residents reduce fuel bills and maintain warmth and well-being. It continues to work closely with partners to develop and deliver interventions that provide maximum support within available resources. Interventions are focusing on low-income and vulnerable households with cold homes, including the terminally ill.

Indicator	**Percentage of adults from ethnic communities with Type 2 Diabetes**
2030 Ambition	Reduce the percentage of adults from ethnic communities with Type 2 Diabetes to match the demographic profile of our city by 2030
Date updated	28/02/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
49.5	**52.0**	21.0	27.7	31.5	24.0

The % in Birmingham is significantly higher than the England and Core Cities average. Since Birmingham's previous update there has been a slight increase. To NHS is offering a structured education course to all those diagnosed as diabetic, within 12 months of the diagnosis. The local Oviva Diabetes Support Programme co-ordinates this course and has a focus on improving the engagement rate with patients from an ethnically diverse community. The Integrated Care Board are also facilitating Diabetes Patient Ambassador events which are community-based and raise awareness about the risks of diabetes as well as how to manage a diagnosis.

Indicator	**Percentage of people with Type 2 Diabetes aged 40 to 64**
2030 Ambition	Reduce the percentage of adults aged 40-64 yrs with Type 2 Diabetes by 7 percentage points by 2030
Date updated	28/02/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
49.0	**49.5**	39.5	43.5	46.2	43.9

The % in Birmingham is higher than England and Core Cities average. Since Birmingham's previous update there has been a slight increase. The nationally commissioned NHS type 2 diabetes remission programme. This is a yearlong programme covering total diet replacement, weight loss and lifestyle support for individuals diagnosed in the last 6 years with type 2 diabetes and BMI over 25 kg/m2. Birmingham & Solihull target is 250 starts over 12 months which is on target. In Q1 24 25, 46% of programme starts were individuals from ethnically diverse communities.

Microsoft Power BI Dashboard

Indicator	**Proportion of eligible adults with a learning disability having a GP health check (%)**
2030 Ambition	Increase the number of targeted health checks (e.g. for people with learning disabilities and/or severe mental health issues) by 25% by 2027
Date updated	26/05/2020 **Time Period** 2018/2019

Birmingham (previous)	Birmingham (2018/2019)	Solihull	West Midlands	Core Cities	England
N/A	**46.4**	52.2	46.1	49.5	52.3

There is insufficient data on this indicator as it has not been updated by NHS Digital for several years due to a data quality issue.

Indicator	**Rate of long-term musculoskeletal problems**
2030 Ambition	Reduce the percentage rate of long-term musculoskeletal problems to 5% below the England average by 2030
Date updated	27/12/2023 **Time Period** 2022

Birmingham (2021)	Birmingham (2022)	Solihull	West Midlands	Core Cities	England
17.0	**17.7**	21.9	20.5	17.2	18.4

The rate in Birmingham is slightly lower than the England average and slightly higher than the Core Cities. Since Birmingham's previous update there has been a slight increase.

Microsoft Power BI Dashboard

Indicator	**Smokers that have successfully quit at 4 weeks**
2030 Ambition	Increase the rate of the estimated individuals who smoke achieving a 4-week quit by 2030
Date updated	23/02/2024 **Time Period** 2022/2023

Birmingham (2017/2018)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
1350.3	**261.9**	1593.1	889.6	1769.7	1620.1

The rate in Birmingham is lower than England and Core Cities. Since Birmingham's previous update there is a decrease. Although the number of smokers who set a quit date is higher than the national rate, more work is needed to increase the rate of those who remain quit at 4-weeks. As part of the national Smokefree Generation programme, the Birmingham Smoking Cessation Group is mapping current provision and identifying ways to increase numbers quitting and quit rates through providing enhanced and targeted local support to stop services, provision of pharmacotherapies and the Swap to Stop scheme

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Indicator	**Under 75 mortality rate from heart disease (Persons, 3 year range)**
2030 Ambition	Reduce coronary heart disease mortality under 75 yrs by at least 10 points in the rate of deaths per 100,000 population by 2030
Date updated	25/03/2024 **Time Period** 2020/2022

Birmingham (2019/2021)	Birmingham (2020/2022)	Solihull	West Midlands	Core Cities	England
50.9	**54.1**	31.6	47.0	54.7	40.6

The % in Birmingham is higher than the England and slightly lower than the Core Cities average. Since Birmingham's previous update there has been an increase.

Microsoft Power BI Dashboard

Life Course: Ageing and Dying Well

Indicator	**Carer-reported quality of life score**
2030 Ambition	Improve the carer-reported quality of life score to equal to or above the national average by 2030
Date updated	08/12/2023 **Time Period** 2021/2022

Birmingham (2018/2019)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England
6.9	**6.7**	7.0	7.2	7.0	7.3

The score in Birmingham is lower than the averages of both England and Core Cities. Since Birmingham's previous update there has been a slight decrease. The Birmingham Carers Strategy has recently completed consultation and is scheduled to be implemented later this year. This is currently being driven by the Carer's Steering Group, led by Adult Social Care within Birmingham City Council. An in-depth refresh of the Carer's Needs Assessment has also been completed to inform the strategy.

Indicator	**Cumulative percentage of the eligible population aged 40-74 who have received an NHS Health Check**
2030 Ambition	Increase the percentage of eligible citizens offered an NHS Health Check who received it to over 70% by 2030
Date updated	15/06/2023 **Time Period** 2019/2020 – 2023/2024

Birmingham (2018/19 – 22/23)	Birmingham (2019/2020 – 2023/2024)	Solihull	West Midlands	Core Cities	England
46.1	**43.6**	35.5	25.9	22.5	28.1

The % in Birmingham is significantly higher than England and Core Cities average. Since Birmingham's previous update there has been a slight increase. Birmingham City Council has recently increased local service provision for NHS health checks through general practices. Plans are underway to pilot the provision of CVD checks within workplaces across the city.

Indicator	**Emergency hospital admissions due to falls in people aged 65 and over (Persons, 65+ yrs)**
2030 Ambition	Reduce the rate of emergency hospital admissions due to falls in people aged 65 yrs and over to below the national average by 2030
Date updated	16/04/2024 **Time Period** 2022/2023

Birmingham (2021/2022)	Birmingham (2022/2023)	Solihull	West Midlands	Core Cities	England
2,357.5	**2,136.9**	1,981.5	1951.6	2,282.4	1,932.8

The rate in Birmingham lower than the Core Cities average and higher than the England. Since Birmingham's previous update there has been a significant decrease. The programme of work around falls prevention is co-ordinated through the Fall Prevention Steering Group. This is currently led by the BSol ICB but has significant Public Health input to ensure that a preventative approach is embedded. There is also a series of campaigns planned to improve risks around falls through awareness raising projects. This particular topic will also be explored in comprehensive depth through the Mobility Impairment Deep Dive.

Indicator	**Estimated dementia diagnosis rate (aged 65 and over)**
2030 Ambition	Improve the dementia diagnosis rate to over 75% by 2030
Date updated	02/07/2024 **Time Period** 2024

Birmingham (2023)	Birmingham (2024)	Solihull	West Midlands	Core Cities	England
60.8	**62.7**	54.6	62.1	71.4	64.8

The % in Birmingham is lower than both the England average and Core Cities. Since Birmingham's previous update there has been an increase. There was a significant drop across all areas as a result of the COVID-19 pandemic and there has been marginal improvement since. Birmingham mirrors the national trend and it is expected that the dementia diagnosis rate will continue to improve. Additionally, there is currently a refresh of the ICS Dementia Strategy and Action Plan, with a specific focus on improving the diagnosis rate and ensuring that more training is available for key workers, such as ambulance-based paramedics.

Indicator	**Excess winter deaths index (Persons, all ages)**		
2030 Ambition	Reduce the excess winter deaths to the national average by 2030		
Date updated	31/01/2024	**Time Period**	Aug 2021 – Jul 2022

Birmingham (Aug 2020 – Jul 2021)	Birmingham (Aug 2021 – Jul 2022)	Solihull	West Midlands	Core Cities	England
40.6	**9.0**	8.0	8.8	9.6	8.1

The % in Birmingham is slightly higher than the England average and slightly lower than the Core Cities. Since Birmingham's previous update there has been a large decrease. The increase in the August 2020 to July 2021 period can be mostly attributed to deaths relating to the COVID-19 pandemic, which has created a large spike in the overall data trend. Local plans to reduce excess winter deaths are informed by the UK Health Security Agency's Cold Weather Plan for England, including messaging and information.

Indicator	**Percentage of adult carers who have as much social contact as they would like (65+ yrs)**		
2030 Ambition	Improve the % of adult carers who has as much social contact as they would like (>65 yrs) to more than 45% by 2027		
Date updated	23/01/2024	**Time Period**	2021/2022

Birmingham (2018/2019)	Birmingham (2021/2022)	Solihull	West Midlands	Core Cities	England

Microsoft Power BI Dashboard

25.1	**23.3**	25.7	29.4	26.7	28.0

The Birmingham % is lower than both the England and Core Cities average. Since Birmingham's previous update there has been a decrease. The Birmingham Carers Strategy has recently completed consultation and is scheduled to be implemented later this year. This is currently being driven by the Carer's Steering Group, led by Adult Social Care within Birmingham City Council. An in-depth refresh of the Carer's Needs Assessment has also been completed to inform the strategy.

Indicator	**Population vaccination coverage – Flu (aged 65+)**		
2030 Ambition	Increase the uptake of the seasonal flu vaccine in people aged 65 yrs to above 75% by 2030		
Date updated	08/07/2024	**Time Period**	2023/24

Birmingham (2022/2023)	Birmingham (2023/2024)	Solihull	West Midlands	Core Cities	England
70.5	**67.9**	79.2	76.8	74.7	77.8

The Birmingham % is lower than both the England and Core Cities average. Since Birmingham's previous update there has been a decrease. Birmingham has had low flu uptake for many years in specific cohorts (e.g. pregnant women, 5-65-year-olds at risk are cohorts with historically low uptake). The BSol Immunisations & Vaccinations Programme Board works across the ICS to improve local uptake and reduce inequalities across the programme.

The 'Flu and Covid working group' is a sub-group of the BSol Immunisations & Vaccinations programme board. This is stood up every year to prepare for the seasonal flu programmes and monitor issues during its delivery. In support of the seasonal flu programme, system partners engage with GPs, care homes and community leaders. A local communications campaign is delivered, and flexible delivery models are used, where appropriate.

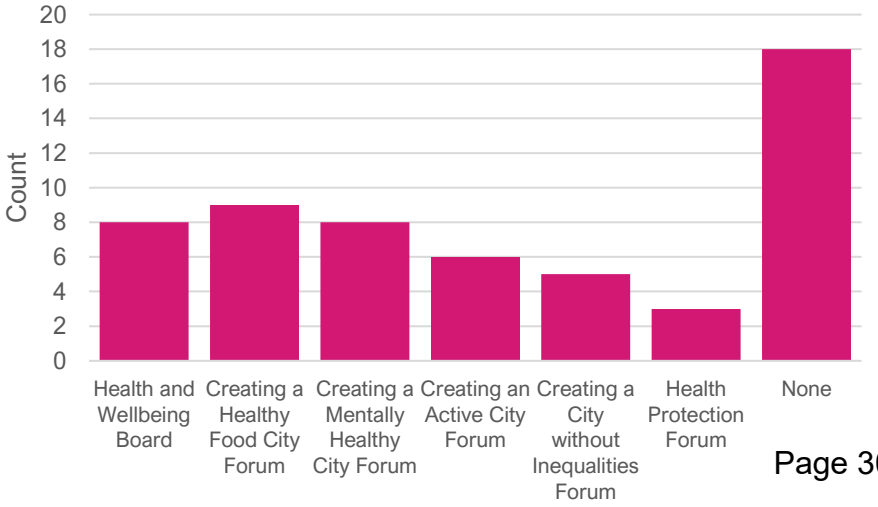
Health and Wellbeing Forums Refresh – Survey 2024

Summary of responses – July 2024

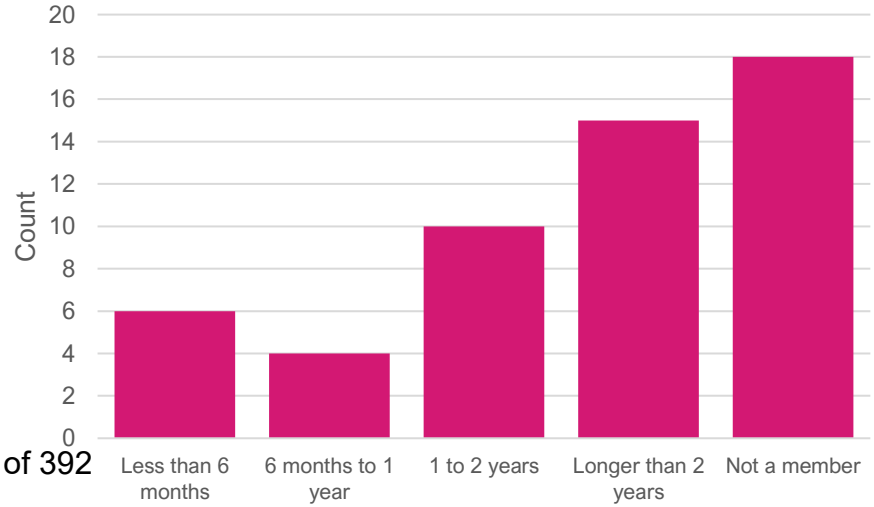
Summary of Respondents

- **52** responses in total
- **67.3%** of respondents (n=35) were either a member of a forum or Health and Wellbeing Board
- **32.7%** of respondents (n=17) were not a member of a forum or Health and Wellbeing Board
- **3** respondents were a member of >1 forum

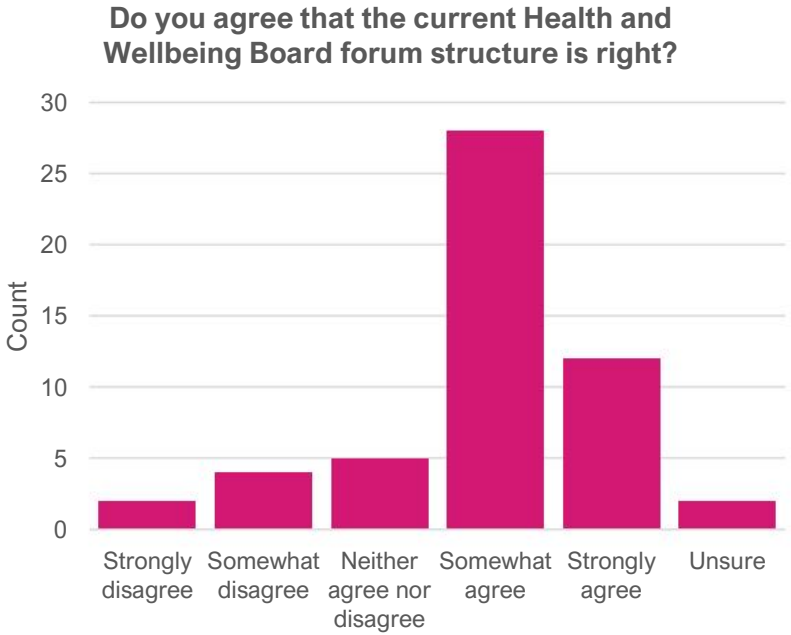
Are you a member of any of the following forums (or the Health and Wellbeing Board)?

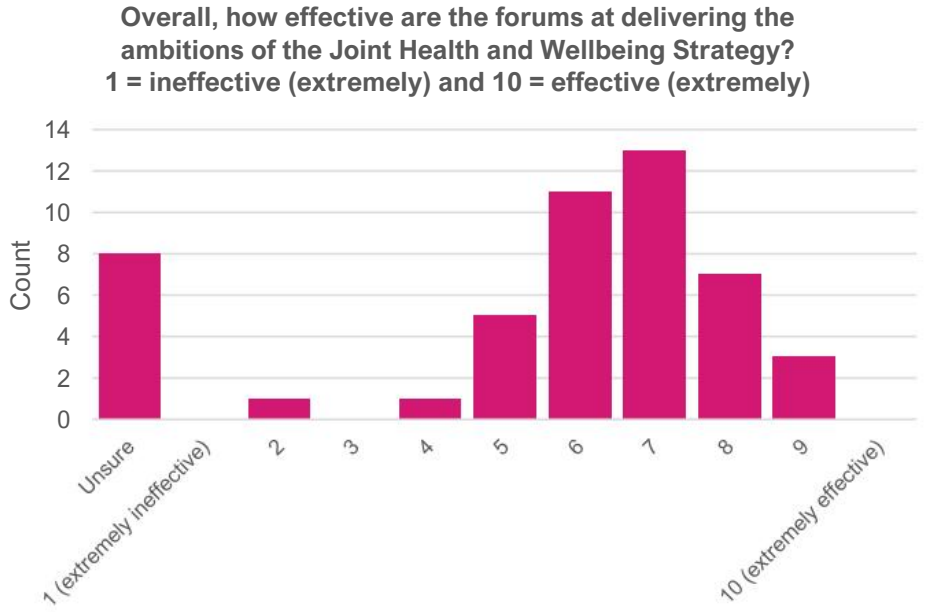


How long have you been a member of any forum (or the Health and Wellbeing Board)?

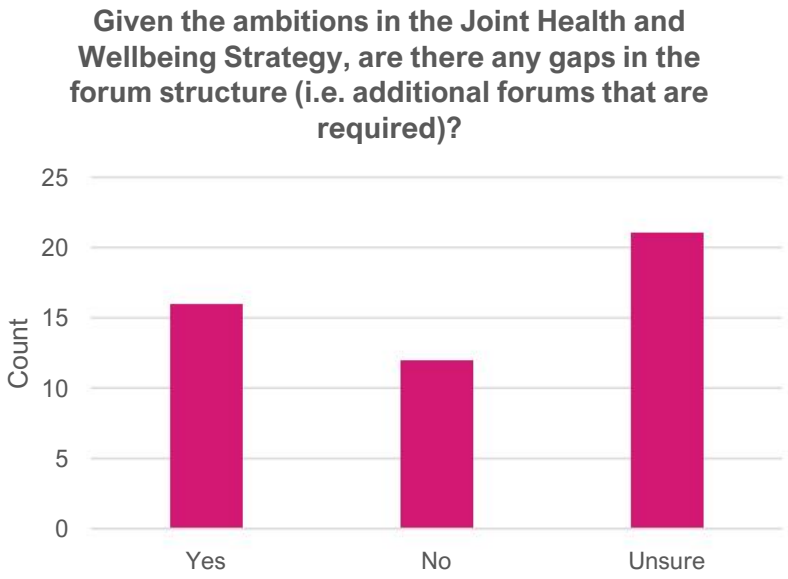


Overarching questions





Overarching questions



Summary of comments and themes

New forums were suggested based on identified gaps based on the Joint Health and Wellbeing Strategy, these included:

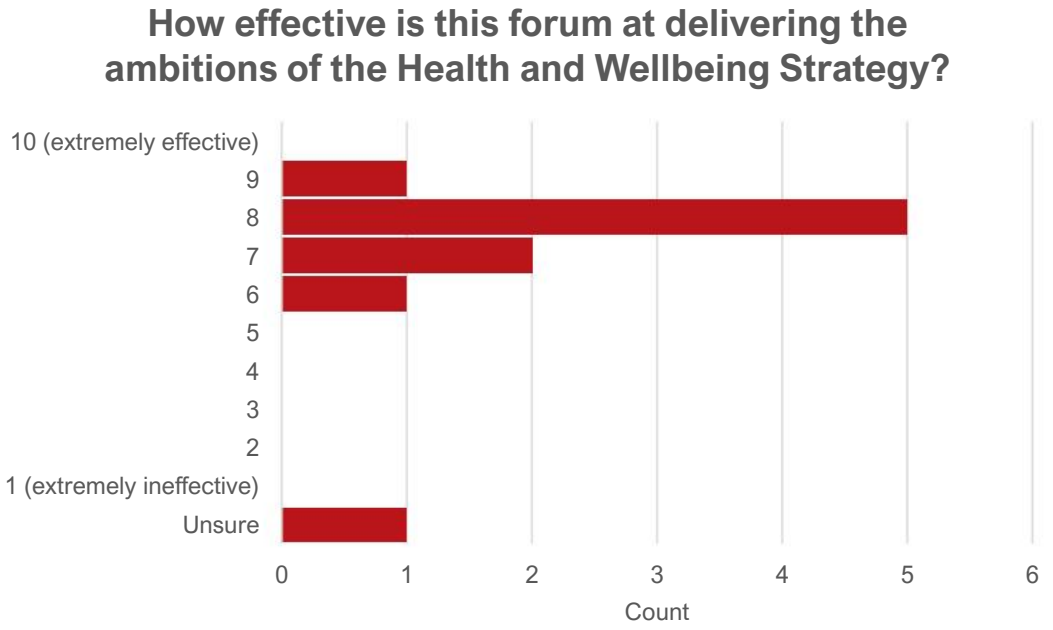
- Addictions and substance misuse forum, namely Birmingham Drug and Alcohol Partnership
- Life course forums, including children and young people and ageing well
- Targeted action for people with disabilities
- Health & Work
- Culture & Health
- Communities of Identity
- Income inequalities and health or city without poverty
- Environmental aspects/sustainability

General comments included an ask to consider the place-based agenda and the linkages with the provider collaboratives.
Some asked for further clarity on reporting governance to Health and Wellbeing Board for new and existing forums.
In the absence of a forum, clear lines of accountability and where the work is being reported back to Health and Wellbeing Board should be understood, an example being the environmental/sustainability agenda.

Creating a Healthy Food City Forum

10 respondents

Creating a Healthy Food City Forum: Effectiveness



It is a complex system with multiple stakeholders, but I believe the work completed so far is on the right track

We could include more of a focus on how education and empowerment can be used to access healthy food

Creating a Healthy Food City: Summary and Proposed Next Steps

Summary

- Overall positive response from forum members, with structure, function and effectiveness all well-regarded.
- A rotating chair model was proposed to enhance ownership of the forum.
- Food business representatives (producers and vendors) could be included on the forum's membership.

Proposed Next Steps for Forum

- Change the name of the forum as requested by forum members.
- Propose candidates for alternative chairing models (see slide 35).
- Review membership and identify opportunities for inviting guest members (e.g. food businesses).
- Continue with current approach to reporting and delivery, including supporting sub-groups aligned to the Food System Strategy.

Creating a Mentally Healthy City Forum

10 respondents

RESET RESHAPE RESTART

Creating a Mentally Healthy City Forum: Effectiveness

Forum hasn't progressed a strategy or action framework beyond suicide work

Engage with the broader membership, not just defer to those in senior positions and ICB structures

The strategy is a key part of the effectiveness of the forum

Creating a Mentally Healthy City: Summary and Proposed Next Steps

Summary

- Some positive feedback from forum members regarding collaboration and process.
- Some provided suggestions to improve the membership and effectiveness of the forum.
- There was a clear consensus on establishing sub-groups to support the forum, building on the Suicide Prevention approach.
- Respondents said the emerging strategy will support the forum to have more clarity and be more effective.
- Feedback suggests an alternative chairing model should be considered.

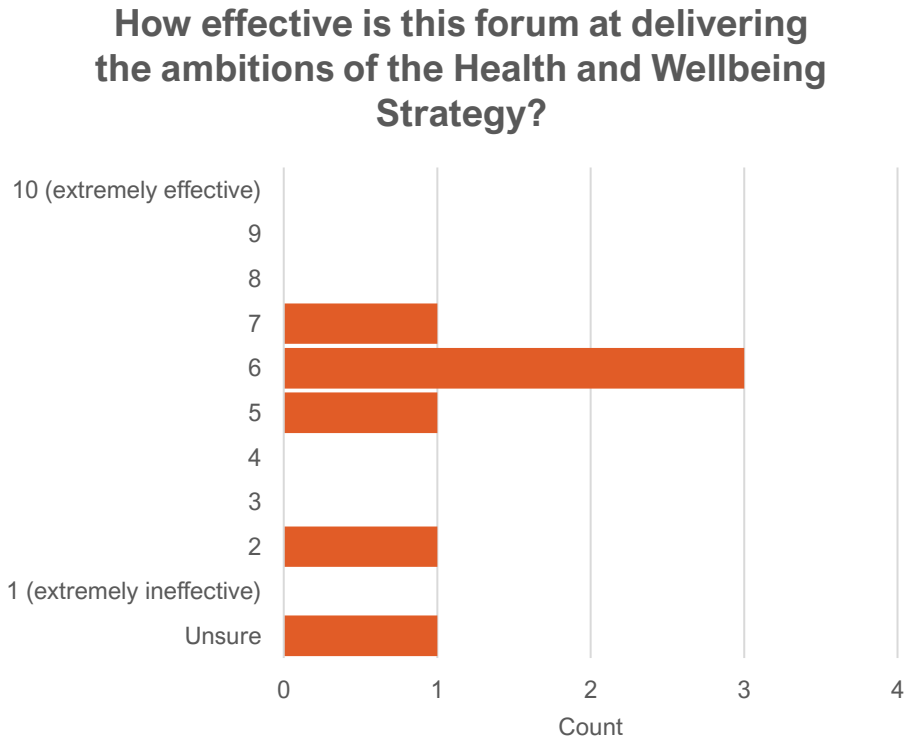
Proposed Next Steps for Forum

- Continue co-producing the strategy, updating the forum's terms of reference (including membership) and establishing sub-groups after publication.
- Agree to report to Health and Wellbeing Board on an annual basis and by exception. This should be included in the current and any updated terms of reference.
- Propose candidates for alternative chairing models (see slide 35).
- Work closely with the Birmingham Drug and Alcohol Partnership, an emerging forum.

Creating an Active City Forum

7 respondents

Creating an Active City Forum: Effectiveness



With a clear governance framework for accountability to the HWB, the forum could be more precise in its objectives resulting in increased effectiveness

The ToR and PA and HWB strategies now provide a framework for collaboration. As referenced, we believe the forum should focus more on facilitating a whole system approach to physical activity in Birmingham, acting as the strategic representative and oversight group for PA in the city

Creating an Active City Forum: Summary and Proposed Next Steps

Summary

- Overall positive response from forum members on the functioning and leadership of the forum.
- There was some agreement without a clear consensus on the introduction of sub-groups. There was agreement that if used, they would need to have a specific remit.
- Some members think that the forum could look at other aspects of the physical activity agenda, alongside active travel.
- Members suggested including more community representatives in the forum alongside representation from the BSol ICS.
- Most members identified that the publication of the Physical Activity Strategy will help to shape the forum's future agenda and direction.

Proposed Next Steps for Forum

- Obtain agreement from the forum and subsequently introduce sub-groups in the form of Locality Active Partnerships (LAPs).
- Agree to report to Health and Wellbeing Board on an annual basis and by exception. This should be included in the current and any updated terms of reference.
- Review membership and identify opportunities to inviting guest members (e.g. community representatives and BSol ICS).
- Propose candidates for alternative chairing models (see slide 35).

Creating a City without Inequalities Forum

10 respondents

RESET RESHAPE RESTART

Creating a City without Inequalities Forum: Effectiveness

I think as this forum sits across the whole strategy, it should be focussed around the inclusion groups on pg. 11 of the strategy. There may need to be a subgroup for each of the 5 key areas of inequalities

Yes. Transition into a BSol footprint Inclusion Health Forum that co-produces its own inclusion health strategy and delivers it (similarly to the food system strategy and forum).

Creating a City without Inequalities: Summary and Proposed Next Steps

Summary

- Some positive feedback from forum members regarding collaboration and process.
- There was agreement that the current terms of reference is not fit for purpose for this particular forum.
- There was a lack of clarity from respondents on the focus for this forum (inclusion health or health inequalities).
- It was felt that this forum should focus on inclusion health and inequalities should run across all forums as it does across the joint health and wellbeing strategy.
- Feedback suggests the leadership would benefit from an alternative chairing model.

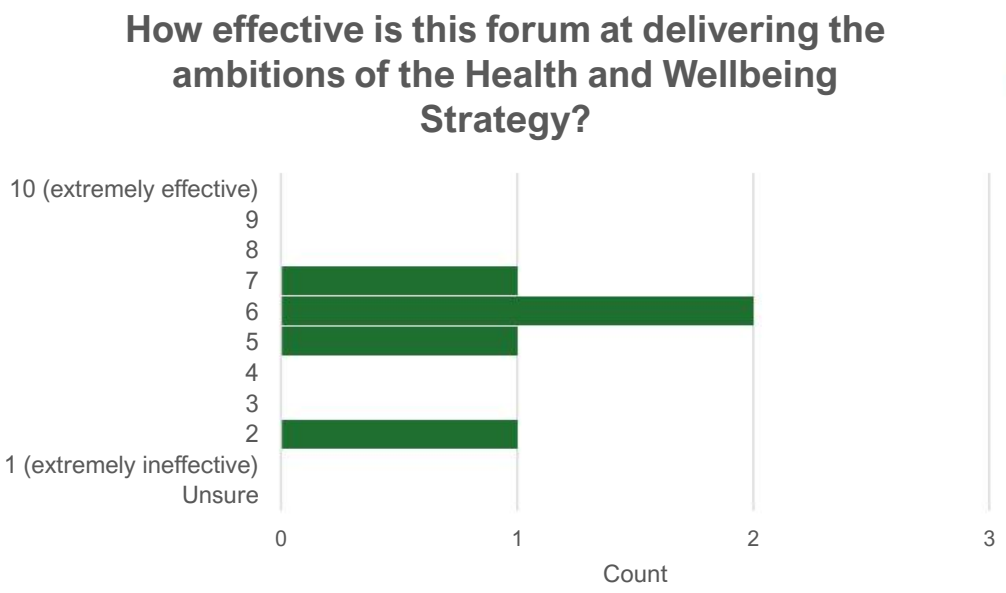
Proposed Next Steps for Forum

- Change name to ‘Inclusion Health Forum or Partnership’ as requested by forum members.
- Review the current purpose and membership, then share an updated terms of reference with Health and Wellbeing Board. Agree to report to Health and Wellbeing Board on an annual basis and by exception.
- Agree a level of collaboration and ways of working with Solihull and outline clearly in the terms of reference.
- Propose candidates for alternative chairing models (see slide 35).

Health Protection Forum

5 respondents

Health Protection Forum: Effectiveness



Some of the ambitions of the HWB Strategy are beyond the scope of the HPF e.g. sexual health and adults content that is not within the "gift" of Public Health's Health Protection team or HPF.

I would say the forum rarely discusses the shared ambitions explicitly, although topics are covered on the agendas because they are important/timely HP issues. It may be that for 2 meetings a year for example, we start to have an agenda item on reviewing delivery of the shared ambitions.

Health Protection Forum: Summary and Proposed Next Steps

Summary

- Positive feedback from forum members on the functioning of the forum.
- There was no clear consensus on whether the forum should have sub-groups.
- There was a lack of clarity regarding the Joint Health and Wellbeing Strategy and HPF's responsibilities (e.g. Addictions, Sexual Health).
- Feedback on the leadership of the forum was positive. Feedback suggests the meetings would benefit from an alternative chairing model.

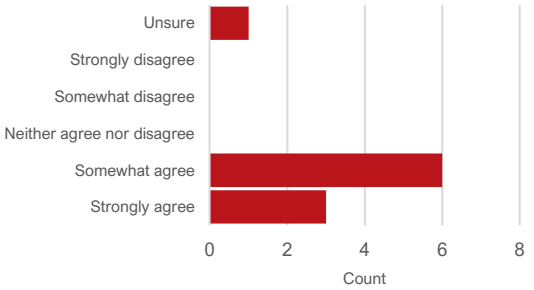
Proposed Next Steps for Forum

- Update the terms of reference to reflect feedback from members, including an ask for longer, less frequent meetings. Review membership in the updated ToR.
- Agree to report to Health and Wellbeing Board on an annual basis and by exception. This should be included in the current and any updated terms of reference.
- Identify BSol ICB groups and establish ways of working (e.g. NHS Vaccinations and Immunisations Board).
- Review relevant workstreams in Health and Wellbeing Strategy (Protect and Detect priority) and relationship with HPF (e.g. Fast Track Cities, Addictions).
- Propose candidates for alternative chairing models (see slide 35).

Additional result slides

Creating a Healthy Food City Forum: Structure

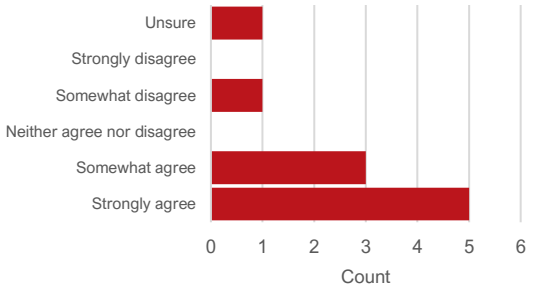
Do you agree that this forum's current terms of reference are appropriate?



The membership could include representatives from the catering sector or primary producers

There could be greater reference to the Birmingham Food System Strategy

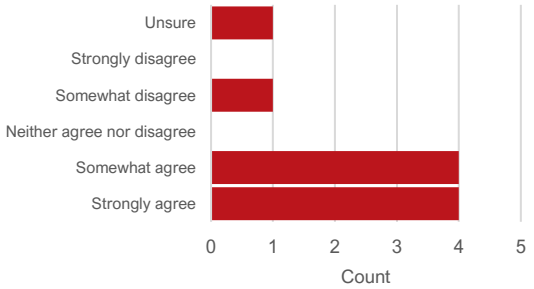
Do you agree that the frequency at which this forum meets is appropriate?



Quarterly may work better

I think current frequency works well

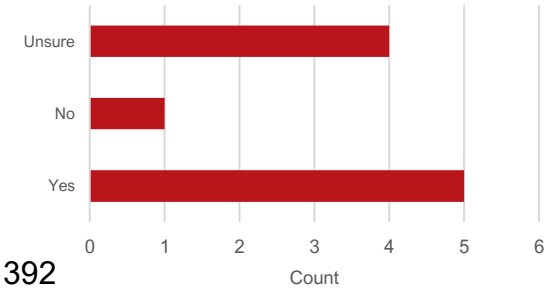
Do you agree that membership of this forum is appropriate?



We could have stronger representation from the food business sector

The membership is good and encourages joined up working

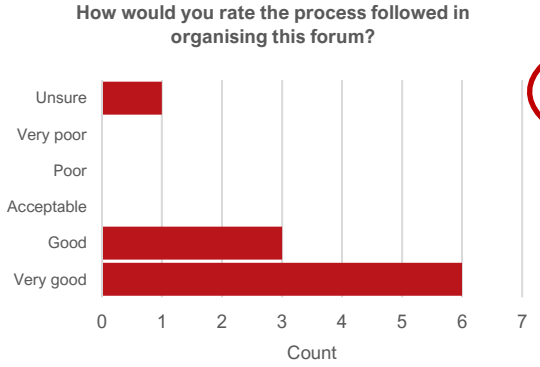
Do you think this forum should have sub-groups (i.e. locality, action or delivery groups)?



Locality-based sub-groups could be useful

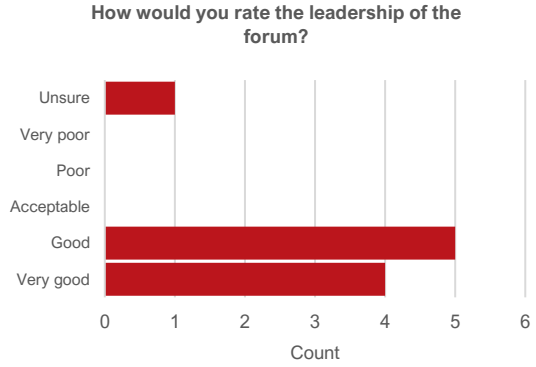
The pre-existing action groups for strategy workstreams are working well

Creating a Healthy Food City Forum: Functioning



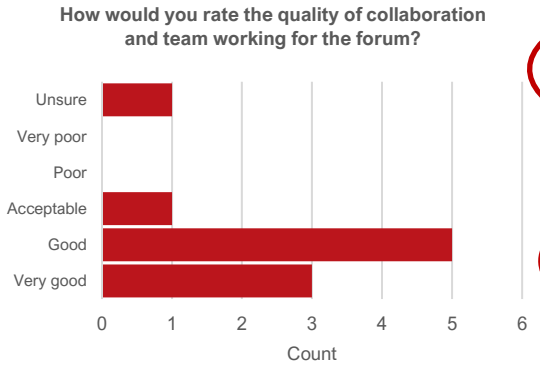
Better reviewing of past and present milestones could help

More opportunities for input from forum members ahead of time



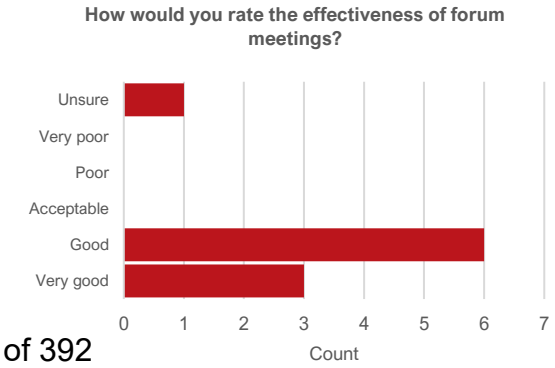
The Chair has been excellent and giving them a briefing before the meeting is a good move

Rotating chairs could help to broaden the partnership and make it feel less council-led



Collaboration has improved with smaller action group meetings

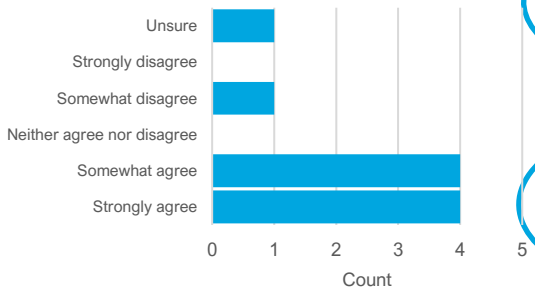
There is good engagement by members between meetings



It's a busy but well-managed agenda

Creating a Mentally Healthy City Forum: Structure

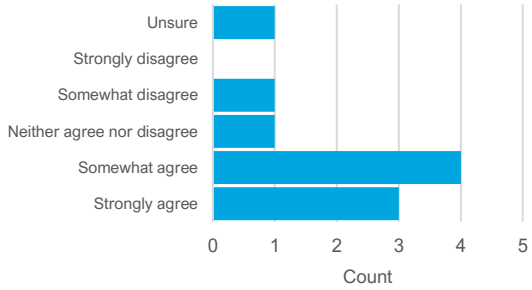
Do you agree that this forum's current terms of reference are appropriate?



The ToR could be more specific and focus on upstream interventions

We could update it to reflect the coproduction of the Creating a Mentally Healthy City strategy

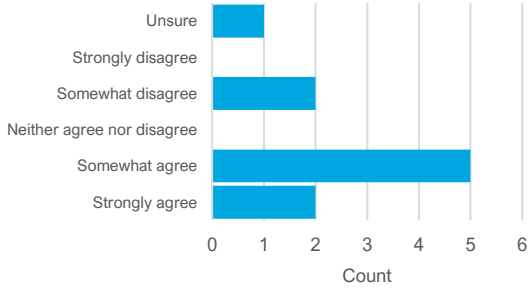
Do you agree that the frequency at which this forum meets is appropriate?



Frequency is good but potentially we should meet in early evenings to allow for those who can't commit time in the workday to attend

Meetings should be monthly given the goals and targets to achieve

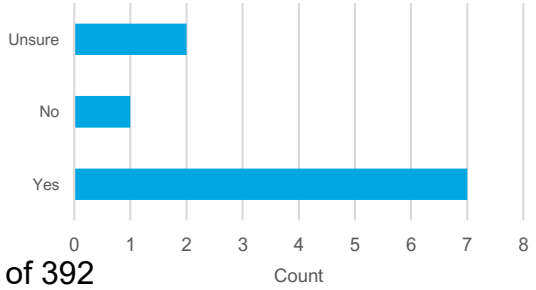
Do you agree that membership of this forum is appropriate?



We need representation from the business community and large employers in Birmingham

More inclusion of people with lived experience of mental illness, including families and carers

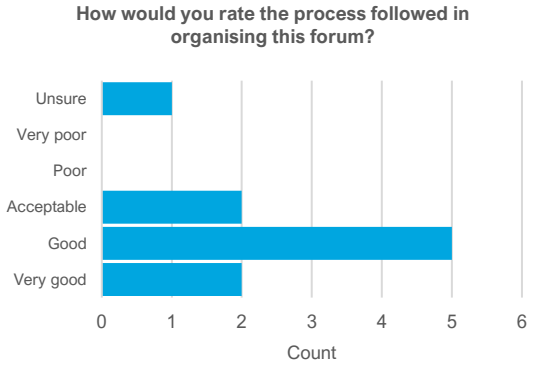
Do you think this forum should have sub-groups (i.e. locality, action or delivery groups)?



Sub-groups should build of the SPAG example and be topic specific

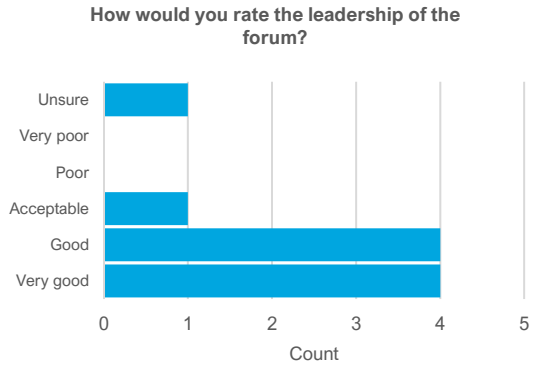
Action groups should be created for each of the themes from the strategy

Creating a Mentally Healthy City Forum: Functioning



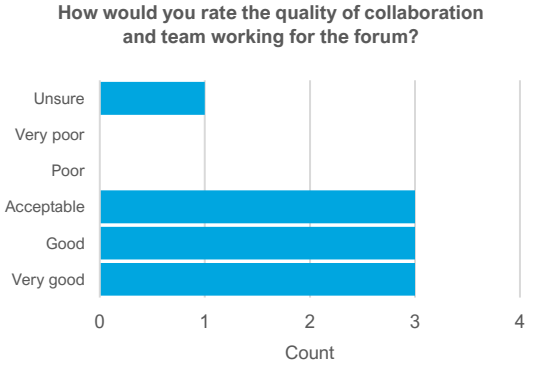
Monthly meetings would allow members to keep on track

Agendas and papers could be sent out further in advance for reading



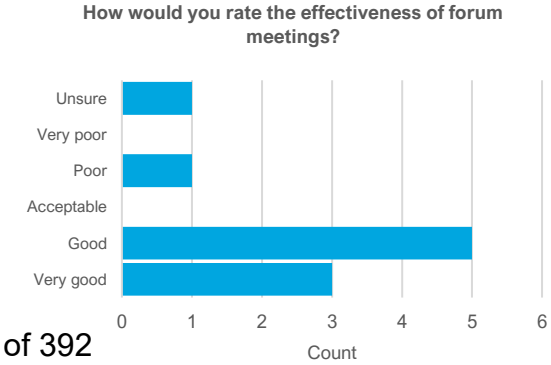
Need to consider co-chairs as cabinet members are not always available

Inconsistency with chairing has sometimes led to slower progress



Generally positive and collaborative atmosphere

Engagement is good but representation is wide so smaller groups would help to focus on topics

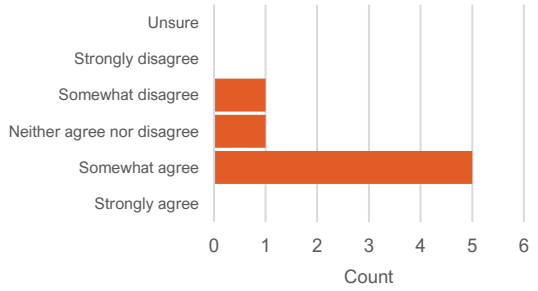


Can sometimes feel too much to navigate in one meeting

Smaller task and finish groups would be good

Creating an Active City Forum: Structure

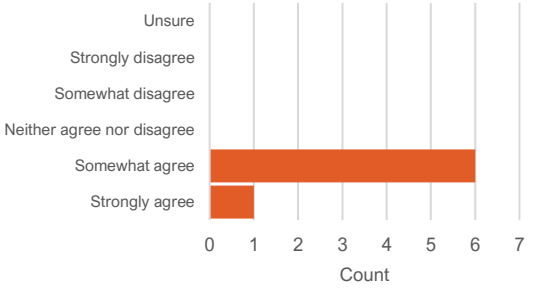
Do you agree that this forum's current terms of reference are appropriate?



More emphasis on the principles and behaviours that underpin effective place-based systemic working

Needs to have greater focus on local delivery

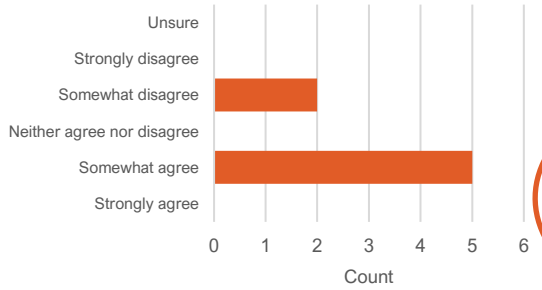
Do you agree that the frequency at which this forum meets is appropriate?



Frequency is good but we could have a clearer framework for reporting and progress

Meeting frequency generally OK, but limited activity or progress on anything between meetings

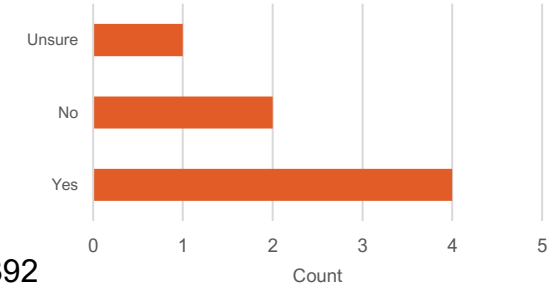
Do you agree that membership of this forum is appropriate?



We could have different community representatives at each meeting

We should review the membership now that that the Physical Activity Strategy has been published to ensure that the group can achieve its ambitions

Do you think this forum should have sub-groups (i.e. locality, action or delivery groups)?

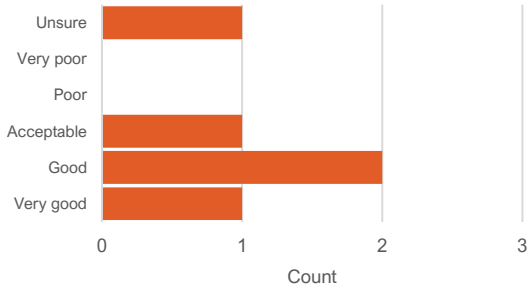


Only if done on a 'task and finish' basis to best progress an identified need

Localities and task and finish groups for specific projects/pieces of work

Creating an Active City Forum: Functioning

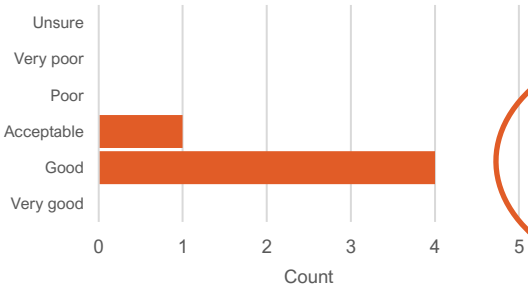
How would you rate the process followed in organising this forum?



Process currently works well as the right level of information is shared in advance of the meetings

Process works but it does take a great deal of capacity off of the PA team

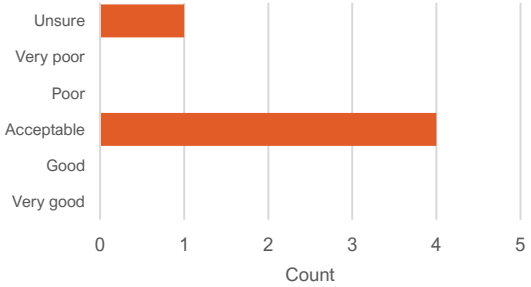
How would you rate the leadership of the forum?



Previous Cabinet Member (Cllr Clements) has been very good for the forum

It has been great to have the Cabinet Member engaged in the forum, although I think it may be beneficial to investigate an independent chair/co-chair

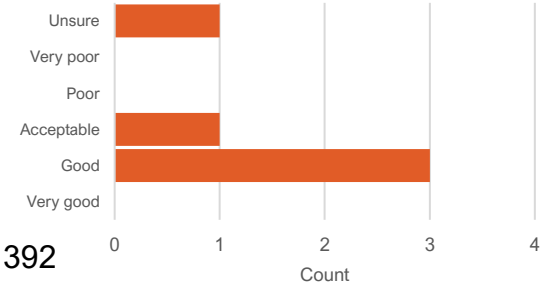
How would you rate the quality of collaboration and team working for the forum?



This could be better as it currently seems like the council vs others rather than a city-wide forum

I haven't seen much interaction/ collaboration with the ICB so I think there is an opportunity there

How would you rate the effectiveness of forum meetings?

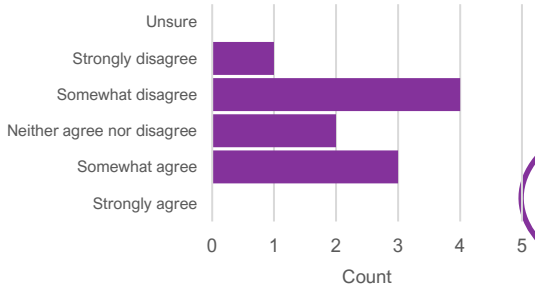


More variety of agenda items rather than just updates from partners

I think the agenda is often too broad and focussed on 'projects'. I think we should have a more topical focus for each meeting (e.g. cycling)

Creating a City without Inequalities Forum: Structure

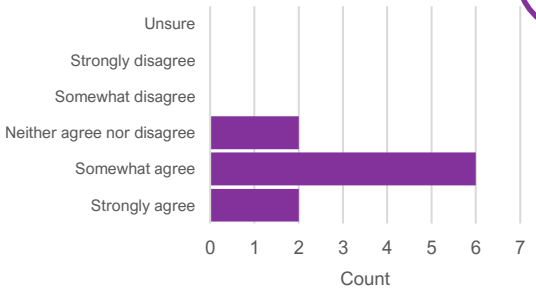
Do you agree that this forum's current terms of reference are appropriate?



This needs to be an inclusion health forum that focuses on a smaller number of key priorities

Need to tighten focus in on inclusion health groups and communities of experience rather than trying to be too broad

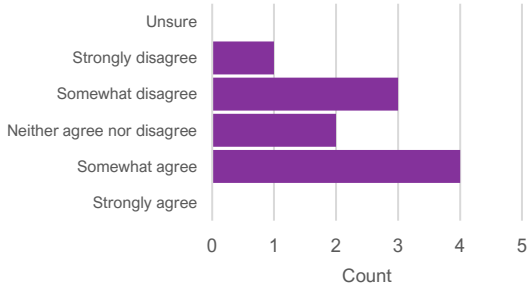
Do you agree that the frequency at which this forum meets is appropriate?



Every two months is often enough and I would suggest that 2 hour meeting is too long

It depends on how the scope of this work is narrowed down or split, at the minute it covers too much

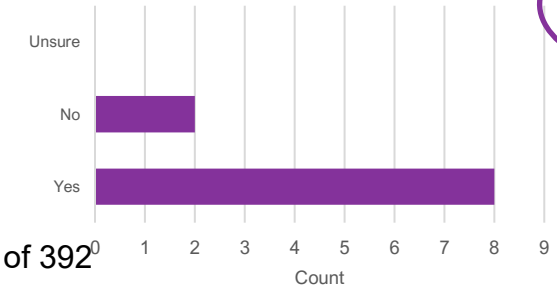
Do you agree that membership of this forum is appropriate?



Review VCS leads, does this representation cover the areas needed to progress the work?

The membership of the forum is broad, but without clear priority areas, its impact over time may not be as great as it could be

Do you think this forum should have sub-groups (i.e. locality, action or delivery groups)?

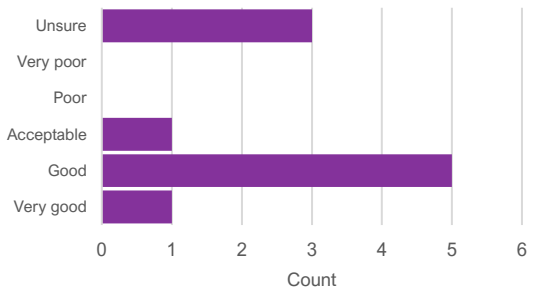


We need to co-produce an inclusion health strategy that will link to the existing priorities

If the group became action focussed there could be a need for smaller task and finish groups to lead

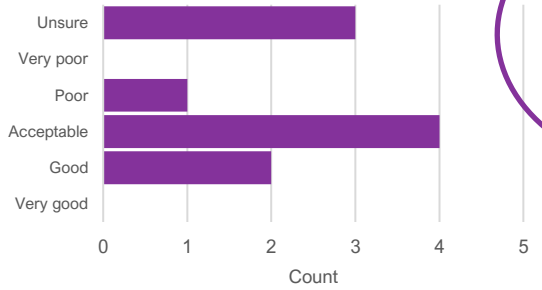
Creating a City without Inequalities Forum: Functioning

How would you rate the process followed in organising this forum?



Smaller, focused remit will enable for the agendas to be more focussed

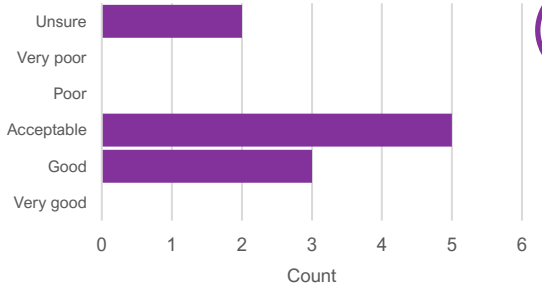
How would you rate the leadership of the forum?



The leadership needs to demonstrate a dedicated interest in this agenda and engage with the briefing and discussion process in order to facilitate debate, appropriate input and impact

Co-chair model would help this

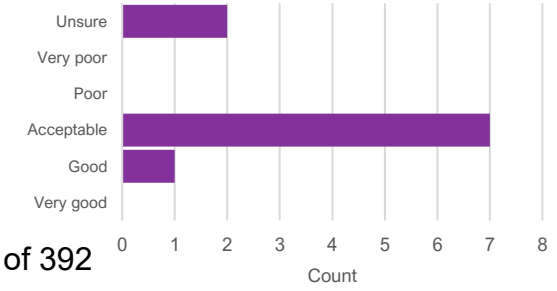
How would you rate the quality of collaboration and team working for the forum?



Participation is limited to a relatively small group of members and stakeholders.

Don't necessarily have the right people at this group

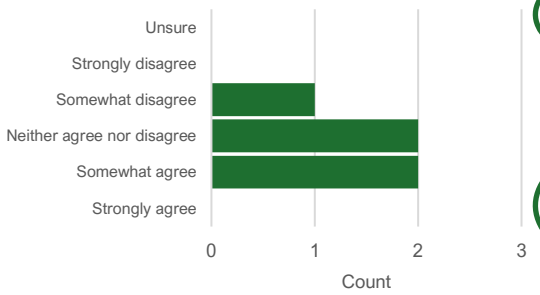
How would you rate the effectiveness of forum meetings?



Tighter focus, clear commitment and collaborative action.

Health Protection Forum: Structure

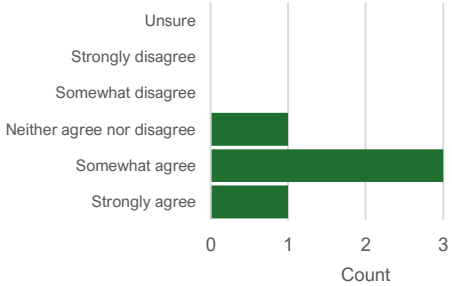
Do you agree that this forum's current terms of reference are appropriate?



Too big a focus on the annual report and less focus on purpose and delivery

Suggested changes are being covered in the current review of the ToR (to structure and membership etc)

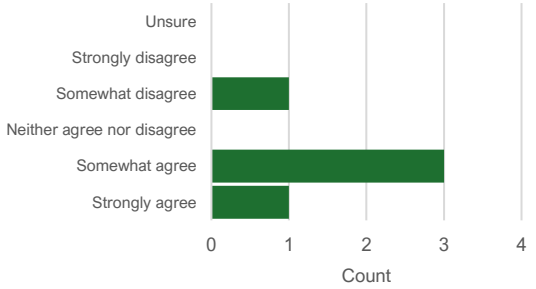
Do you agree that the frequency at which this forum meets is appropriate?



The membership is currently considering changing the frequency to minimum 8 sessions a year, with themes

Members have suggested meeting for longer but less frequently - current hourly monthly structure is probably too frequent and a bit short

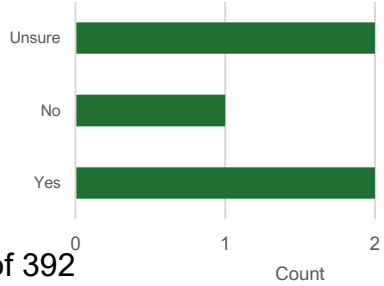
Do you agree that membership of this forum is appropriate?



Feels weak on non-UKHSA areas of responsibility e.g. screening and substance misuse

Members tend to be engaged during meetings but attendance can be poor/other meetings prioritised

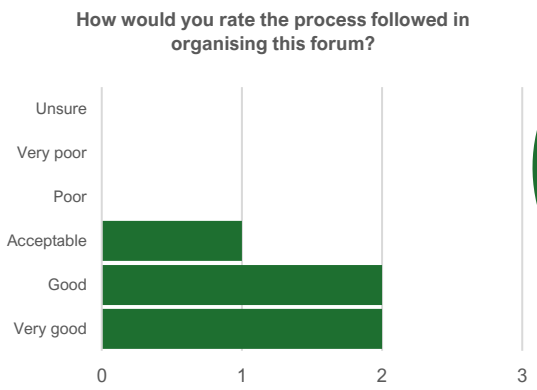
Do you think this forum should have sub-groups (i.e. locality, action or delivery groups)?



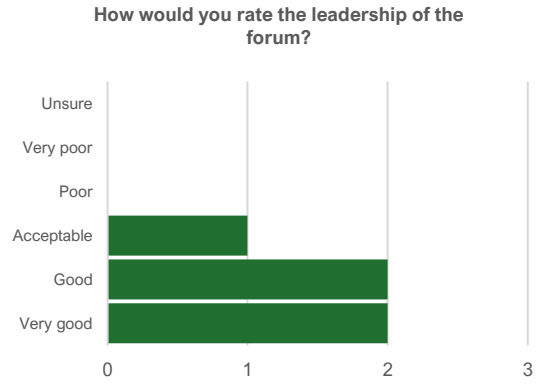
Possibly linked to delivery of shared ambitions but only where not covered in other meetings (e.g. NHS imms and vacc board)

May need some task and finish working groups on specific areas and be clear if addictions sits here

Health Protection Forum: Functioning

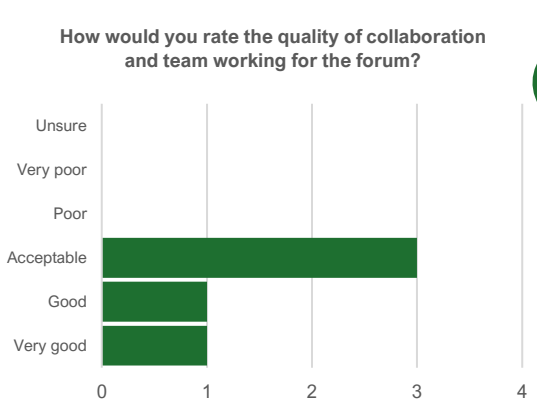


Agendas are usually clear and meetings well organised - the short meetings mean sometimes other agenda items have to be prioritised over revisiting actions



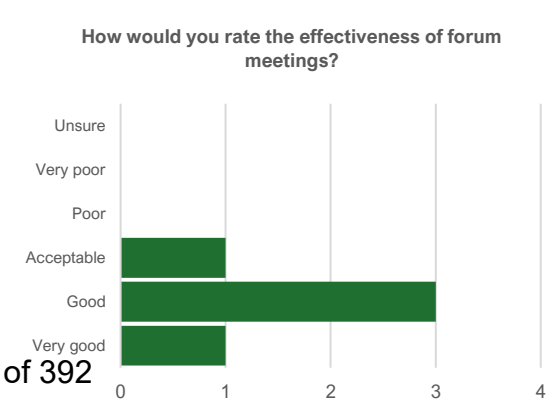
The chair is usually good at ensuring all members speak, and encouraging participation in all agenda items

Formal Co-chair would help



Some issues discussed may not need collaboration between partners at the Board

Attendance of forum meetings has been poor recently, we need to work on ensuring HPF is a priority for its members



Meetings stay on topic, and usually clear actions are agreed on in each agenda item

TERMS OF REFERENCE

Birmingham Food System Partnership

1. Purpose

1.1. The Birmingham Food System Partnership (BFSP) is a sub-committee of the Birmingham Health and Wellbeing Board. The purpose of the Forum is to work together to apply a whole system approach to understanding the food landscape of the city and improving the food behaviours at a population level across Birmingham by ensuring that a joint action plan is co-produced and delivered.

1.2. The Birmingham Food System Partnership participated in the formation of the Birmingham Food System Strategy, which set the strategic direction for the city of Birmingham until 2030. The Forum will be responsible for the strategic delivery of the Birmingham Food System Strategy, including the creation and ongoing management of the Birmingham Food System Strategic Action Plan in partnership with the Food System Strategy Action Groups.

2. Objectives

2.1. The Forum has the following overarching objectives:

a) To deliver a joint vision for addressing current healthy, affordable food levels in the city and to exploit opportunities for joint working.

b) To co-produce the Strategic Action Plan for the Birmingham Food System Strategy which will underpin the delivery of the Health & Wellbeing Board's priorities and indicators and oversee its delivery.

c) To co-produce an informed, accessible city-wide Birmingham Food System Strategic Action Plan that will outline key actions for all with the focus of delivering the objectives of the Birmingham Food System Strategy. The action plan will also embed research at every opportunity to improve the food system and reach our objectives for 2030.

d) To provide a strategic direction and seek alignment with the work being undertaken through a range of other relevant work programmes and boards.

e) To contribute to the development of the Joint Strategic Needs Assessment (JSNA) and other relevant works as required.

f) To contribute to informing the commissioning intentions as required.

g) To promote and facilitate coordination between partners and partnerships and to consider what agendas and resources might be shared more effectively, where appropriate.

h) To report to and support the activities of the Health and Wellbeing Board.

i) To support the activities of the Birmingham Food System.

j) To promote communication and engagement with the stakeholders and residents of Birmingham relating to the healthy food agenda as required.

k) To promote best practice and sharing of ideas including collaboration that may lead to maximisation of external funding opportunities.

l) The BFSP will oversee performance and address areas for future development and improvement.

3. Principles

3.1. The Forum expects all partner agencies to:

a) Engage, co-produce, and own the Birmingham Food System Strategic Action Plan for the Birmingham Food System Strategy.
b) Embrace the aims and objectives of the BFSP.
c) Consult and/or inform the Forum over organisational changes (including any changes in representation) that may impact on collective working.
d) Follow and work within the performance management framework agreed by BFSP partners.
e) Proactively manage risk and acknowledge the principle of shared risk in the context of partnership working.
f) Own the Food System Strategy through promoting and driving service transformation and improvement within their respective services and organisations.
g) Report on progress on mutually agreed actions.
h) Share relevant information and promote collaborative and innovative work.

4. Membership

4.1. The BFSP will have a core group of organisations that will play a key role and will have the responsibility to improve the specific aspect/focus of the BFSP in relation to levering change to the Birmingham Food System at levels for the population of Birmingham.

4.2. Each Lead officer has the responsibility for theme areas and items in the BFSP action plan and to report on these to the BFSP.

4.3 The BFSP requires its members to:

a) have the authority to make decisions in relation to the Food System on behalf of their organisation or be able to seek and secure them within timescales agreed by the BFSP.
b) attend all meetings, or in exceptional circumstances to arrange for a suitable named delegate to attend in their place. In case of delegating, the nominee should be appropriately briefed prior to attending the meeting and able to make decisions on behalf of the organisation they represent.
c) represent the views of their nominating organisation, to keep their nominating organisation informed about progress and to communicate the outcomes of the BFSP meetings to their organisations.
d) ensure that there is prompt progress and delivery by their nominating body on any actions and strategies agreed by the BFSP.
e) to engage in positive and constructive discussions between members in order to achieve workable solutions to common issues.

Membership of the BFSP is as follows:

4.4 The membership of the BFSP may be reviewed from time to time as necessary. New members may be admitted provided always that:
   a) any such new member is able to demonstrate to the satisfaction of the BFSP the contribution that they can make to the overriding aims and objectives; and
   b) in deciding whether or not to admit any such new member, the Chair shall have, regard to the current size and composition of the BFSP, whether the new member is to be admitted.

4.5 Other persons may attend meetings of the BFSP with the agreement of the Chair/ Deputy Chair.

4.6 The Co-Chairing approach of the BFSP will consist of a Birmingham City Council Cabinet Member/Elected Official/Senior Public Health Manager and a BFSP Member.

5 Meetings

5.1 The Forum will meet every three months for no more than 2 hours. Such other meetings may be held as necessary at the discretion of the Chair or should commissioning decisions drive the agenda.

5.2 Partners may be requested to contribute to a forward plan which will be used to develop the agenda for meetings.

5.3 The agenda for meetings, agreed by the Chair, and all accompanying papers and discussion points will be sent to members at least 3 working days before the meeting. Late agenda items and/or papers may be accepted in exceptional circumstances at the discretion of the Chair.

5.4 Minutes of all meetings of the BFSP (including a record of attendance and any conflicts of interest) will be approved and circulated within 10 working days and submitted for approval to the next appropriate meeting.

5.5 The BFSP may establish task and finish groups as agreed by the Chair.

5.6 The BFSP administrative support will be provided by the Public Health Division, and they will be responsible for arranging and minuting meetings and disseminating supporting information to BFSP members.

5.7 The BFSP will be monitored and accountable to Health and Wellbeing Board through the agreed reporting arrangements.

6 Decisions

6.1 Recommendations and decisions will be arrived at by consensus and recorded in the minutes and a decision log.

7 Conflicts of interest

7.1 Whenever a representative has a conflict of interest in a matter to be decided at a meeting of the BFSP Forum, the representative concerned shall declare such interest at or before

discussions begin on the matter, the Chair shall record the interest in the minutes of the meeting and unless otherwise agreed by the BFSP that representative shall take no part in the decision-making process.

8 Review

8.1 These terms of reference will be reviewed annually, taking into account views expressed by relevant partner agencies.

Version 1.0

Date: 08.08.24

Author: Niamh Mellerick

Approved on:

TERMS OF REFERENCE

Creating a Mentally Healthy City Forum

1. PURPOSE

1.1 The 'Creating a Mentally Healthy City' Forum is a statutory Health and Wellbeing Board sub-committee. This Forum will focus on developing a public health approach to mental health and wellbeing in the City, delivering upon the Prevention Concordat for Better Mental Health which is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health is a valuable contribution to achieving a fairer and more level society. The Concordat promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. This will be completed through creation and implementation of the Creating a Mentally Healthy City Strategy.

1.2 The 'Creating A Mentally Healthy City' Forum will provide a link between the Health and Wellbeing Board and the Mental Health Provider Collaborative.

1.3 Its purpose is to enable local partnership between the Local Authority, NHS, third and voluntary sector organisations, faith groups, the business community, and the wider Public Health sector. These organisations will collectively deliver specific characteristics of the Health and Wellbeing Strategy, the Creating a Bolder, Healthier City for Birmingham 2022-2030. Notably, the Creating a Mentally Healthy City Forum will respond to priorities under the Mental Wellness and Balance theme and priorities identified within the Creating a Mentally Healthy City Strategy.

2. OBJECTIVES

The overarching objectives of this sub-group, 'Creating a Mentally Healthy City', are:

2.1 To finalise the Creating a Mentally Healthy City Strategy and following Framework for Action that will be the focus of the sub-group, enabling the measurement of impact and improvement in local communities in relation to prevention, and the promotion of mental wellbeing.

2.2 To work in partnership to implement the evidence-based approaches which create positive mental health and wellbeing, working upstream to increase mental wellness and reduce the need for clinical interventions

2.3 To provide a strategic direction and seek alignment with the work being undertaken through a range of other relevant work programmes and Boards

2.4 To encourage collaboration with other Health and Wellbeing Board forums to share learning and promote positive mental wellbeing through other existing partnerships

2.5 To contribute to the development of the Joint Strategic Needs Assessment (JSNA)

2.6 To agree on the level of partnership engagement that will measure the impact and improvements in how we work in promoting mental wellbeing

2.7 To progress the delivery of a Report on the activities of the Forum to the Health and Wellbeing Board on an annual basis

2.8 To promote best practices and sharing of ideas including collaboration that leads to maximising external funding opportunities

2.9 To collaborate and share local information and intelligence between partners and stakeholders that will lead to better relationships with local communities

3. PRINCIPLES

The Forum expects all partner agencies to:

3.1 Embrace the aims and objectives of the Forum

3.2 Embrace coproduction as a key element of the Forum

3.3 Consult and/or inform the Forum about organisational changes (including any changes in representation) that may impact collective working

3.4 Follow and work within the performance management framework agreed by Forum partners

3.5 Proactively manage risk and acknowledge the principle of shared risk in the context of partnership working

3.6 Own the health and wellbeing inequalities agenda through promoting and driving service transformation and improvement within their respective services and organisations

3.7 Report on progress on mutually agreed actions

3.8 Share relevant information to support the effective use of evidence-based practice and to promote collaborative and innovative work

4. MEMBERSHIP

4.1 The Chair of the Board will be the Birmingham City Council Cabinet Member with a portfolio for Health and Social Care

4.2 The Forum will have a core group of organisations that will play a key role and will have the responsibility to improve the specific aspects/focus of the Forum in relation to the health and wellbeing of the population of Birmingham.

4.3 Forum Members will have the responsibility for communicating the Group's business through their respective organisation communication channels

4.4 A Lead Officer will be designated against thematic areas agreed upon by the Creating a Mentally Healthy City Forum and will be responsible for reporting these to the sub-committee.

4.5 Membership will be continuously reviewed, and the Forum reserves the right to co-opt individuals for specific areas as necessary

4.6 If a member of the group misses three consecutive meetings without giving notice their membership on the sub-committee will be reviewed

4.7 The Forum requires its members to:

4.7.1 Have the authority to make decisions on behalf of their organisation about mental wellbeing, or to be able to seek and secure decisions within a given timescale as agreed by the Forum

4.7.2 Attend all meetings or, in exceptional circumstances, arrange for a suitable named delegate to attend as a representative. Delegated representative should be suitably briefed before the meeting and have the authority to make decisions in the same capacity as a core member

4.7.3 Have responsibility for representing the views of their nominating organisations and keep their nominating organisation apprised of any actions taken, and decisions and progress made by the Forum

4.7.4 Ensure that actions on delivery and progress are carried out promptly on any actions and strategies agreed by the Forum

4.7.5 Have positive and constructive discussions to achieve workable solutions to common issues

4.8 Other persons may attend meetings of the Board with the agreement of the Chair and/or Deputy Chair

4.9 The core membership of the Forum can be seen in APPENDIX A. The membership list of other invited participants can be seen in APPENDIX B:

5. MEETINGS AND WORKING ARRANGEMENTS

5.1 The Forum will meet quarterly from 2025, scheduled for two hours. One of these meetings per annum will be an in-person workshop with an invitation to members from the other Health and Wellbeing Forums. Additional meetings may be held as necessary at the discretion of the Chair should commissioning decisions drive the Agenda. It will be explored with the Forum members on the timing of the meetings, following feedback from Forum members that some evening slots may be appropriate for some members.

5.2 A forward plan will be created with members of the Forum for the year 2025. This will run with themes that arise from the Creating a Mentally Healthy City Strategy, with each Forum meeting being focused on one theme.

5.3 Chairing arrangements will be agreed by the Chair of the Health and Wellbeing Board

5.4 The Agenda for meetings, agreed by the Chair, and all accompanying papers will be sent to members at least five working days before the meeting. Late agenda items and/or papers may be accepted in exceptional circumstances at the discretion of the Chair

5.5 Action Notes of all meetings of the Forum (including a record of attendance and any conflict of interest) will be approved by the Chair and circulated within 10 working days before the next meeting

5.6 The Forum administrative support will be provided by the Public Health Division and will have responsibility for arranging meetings, note-taking, and disseminating supporting information to the Forum Members

5.7 The Forum will be monitored and accountable to the Health and Wellbeing Board through the agreed reporting arrangements

5.8 Forum Members will be requested to contribute to a Forward Plan that will be used to develop the Agenda for the meeting

5.9 The Forum may establish 'Task and Finish' Groups against the thematic areas developed from the Strategy as agreed by the Forum Co-Chairs. The proposal is that the 'Task and Finish Groups' report into a 'Steering Group,' which in turn reports into the Creating a Mentally Healthy City Forum.

6. DECISIONS

6.1 Recommendations and decisions will be arrived at by consensus, and these will be recorded in the action notes and on the Action Log.

7. CONFLICTS OF INTEREST

7.1 If a representative has a conflict of interest in a matter to be decided at a meeting of the Forum, the representative concerned shall declare such interest at or before discussions begin on the matter. The Chair shall ask for this conflict to be recorded in the actions notes and unless otherwise agreed by the Forum that representative shall take no part in the decision-making process.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually for updating purposes and to express the views of relevant partner agencies.

Version 0.6 Final
19th of August 2024

Dr Justin Varney
Director of Public Health
Public Health Division
Partnership, Insight and Prevention
Birmingham City Council

APPENDIX A:

Core Membership

	NAME	ROLE/ORGANISATION
Chair	Cllr Mariam Khan	Cabinet Member for Health and Social Care, Birmingham City Council
Deputy Chair	Helen Harrison	Assistant Director for Healthy Behaviours and Communities, Public Health, Birmingham City Council
Public Health	Joe Merriman	Service Lead, Mental Wellbeing Team, Healthy Behaviours and Communities, Public Health, Birmingham City Council
NHS Commissioner Representative	Joanne Carney	Associate Director Joint Commissioning, Birmingham and Solihull Clinical Commissioning Group
Academic Representatives	Dr Adam Benkwitz Dr Karen Newbigging Dr Adam Walsh	Head of Sport and Health, and Social Care, Newman University Director of Impact & Knowledge Exchange; Lecturer Health Service Management Centre; and Director of Institute for Mental Health UoB Head of Health and Life Science, BCU
BVSC Representative	Helen Wadley	Chief Executive Officer, Birmingham MIND
Schools Forum	Dr Bev Mabey	Washwood Heath Multi Academy Trust

APPENDIX B:

Other Essential Members – representatives from the following organisations:

Local Councillors	Office for Health Improvement and Disparities (OHID)
NHS Providers	Faith Group
NHS Commissioners	West Midlands Combined Authority
Voluntary Sector	Youth City Board
Charity Sector	Office of the West Midlands Police and Crime Commissioner
Birmingham Education Partnership	Department of Work and Pensions
Adult Social Care	

Birmingham Drugs and Alcohol Partnership (BDAP)

Terms of Reference

1. Aim:

This Partnership's aim is **to reduce the harms of drugs and alcohol to children, young people, adults, families, and communities in Birmingham.**

It brings together partners across the City including drug and alcohol treatment providers and those with lived experience to create transformative change in line with the recommendations of the Dame Carol Black Review 2022, the '10 year Drugs Strategy: From Harm to Hope' and Birmingham's 'Triple Zero Strategy'.

Partners will work with Citywide and Regional fora as well as within their own organization to maximize impact.

2. Objectives:

The Partnership will achieve its aims by:

1) Ensuring an effective strategic oversight of the drug and alcohol system of primary, secondary prevention and treatment including 'world class' treatment and a recovery orientated system of care
2) Actively involving those with lived experience in the decision making of the Partnership
3) Increasing numbers of children, young people, and adults including parents in **effective** drug and alcohol treatment, with a focus on underserved populations.
4) Reducing the numbers of drug and alcohol related deaths
5) Reducing the health harms of substances including those associated with injecting and acquisition of blood born virus and promoting health.
6) Reducing drug and alcohol crime and improving safety
7) Intervening early with targeted groups at risk of problematic use of drugs and alcohol
8) Reducing supply and exposure to illegal drugs in Birmingham, including reducing the proportion of young people being exposed to illegal drugs.

3. How the Partnership will work

Comprehensive Approach: The Partnership will seek assurance that the system is addressing drug and alcohol availability, use, and related harms, in line with the national strategy 'From Harm to Hope' and JCDU guidance that emphasises the importance of tackling both illegal drugs and alcohol issues comprehensively.

Vision and National Alignment: The Partnership will work as a unified system to realise our vision for Birmingham, supporting the Birmingham Triple Zero Strategy, to improve outcomes for the Birmingham population.

Evidence-Based Approach: The Partnership will prioritise the use of evidence-based strategies and best practices in our efforts to address drug and alcohol-related issues, ensuring that our actions are effective and rooted in research.

Empowerment and Inclusivity: The Partnership will empower and engage local communities, including vulnerable populations, ensuring their voices are heard and their unique needs are addressed in our initiatives.

Resource Efficiency: The Partnership will maximise the efficient allocation of resources, including financial and human resources, to achieve our goals and deliver cost-effective solutions that benefit the community.

Monitoring and Accountability: The Partnership will monitor and evaluate the outcomes of our initiatives, regularly reporting on progress and results to seek assurance targets are being met.

Emerging Trends: The Partnership will recommend proportionate responses to emerging local substance use trends and their impact on the population, which will require updates on progress and outcomes.

4. Governance, Monitoring and Accountability:

The Partnership will report to Birmingham's Health and Wellbeing Board and to Birmingham's Community Safety Partnership. It will link into and contribute to the Regional Combatting Drugs Strategy.

It is proposed that the Partnership will be a Subgroup of the Health and Wellbeing Board. This is pending confirmation from the Board.

The Drug and Alcohol Related Death Panel (DARD) will be formed as a subgroup to the Partnership.

The Partnership will receive a regular update of system outputs and outcomes linked to the ambition of the Triple Zero Strategy and '' From Harm to Hope' and work together to identify actions aimed at their improvement.

The Partnership will agree and monitor a Partnership Action Plan.

The Partnership will collaborate in projects delivered through task and finish groups linked to the Action Plan and described in Delivery Plans.

The Partnership will hold Partners to account for their actions.

4 Membership

4.1 The Partnership will be Co-Chaired by the Elected Member for Social Justice and an Independent Chair (recruitment pending).

The Deputy Chair will be the Deputy Director of Public Health.

It will operate at a senior level. Members will have a strategic role, which permits them to comment, feedback, initiate action, and answer on behalf of their organisation/department, in relation to their response to alcohol and drug use.

The Public Health Addictions team will provide administration for the Partnership.

4.2 Representation:

- Local Authority (Public Health, Housing, Education)
- Health (mental health, primary care, secondary care, commissioners)
- West Midlands Police and the OPCC
- West Midlands Ambulance Service
- Children and younger people's services
- Treatment providers and service users

- Criminal Justice (probation, YOS, prisons)
- Voluntary and Community Sector (VCS).
- Consideration will be given to how to incorporate people with lived experience and the views of health & social care service users.

4.3 Other attendees may be invited as required if approved by the Chair.

5 Frequency

5.1 The 'Birmingham Drugs and Alcohol Partnership' will meet quarterly.

5.2 The frequency of meetings will be reviewed in early 2025.

TERMS OF REFERENCE – DRAFT

Active City Forum

1. Purpose

1.1 The Active City Forum (formerly known as the Creating a Physically Active City Forum) is a sub-committee of the Birmingham Health and Wellbeing Board (HWBB). The purpose of the Forum and its members is to work together to increase physical activity (PA) at a population level across Birmingham.

2. Objective

2.1 The key objective of the Forum is to create a Birmingham that enables its residents to be physically active.

3. Principles

3.1 The ways of working for Forum members is set out in the following principles:

- The Forum will be more than an information sharing group – one that supports co-ordinated action to tackle issues around physical inactivity in Birmingham.
- The Forum will take recommendations both to and from the HWBB, with clear feedback from the HWBB regarding their actions to tackle physical inactivity.
- Provide commitment to embedding physical activity into policy to ensure multiple outcomes are met around health, climate change, and air quality through strong strategic collaboration.
- Take a targeted approach to interventions to increase physical activity throughout the life course by using data, intelligence, and insight to focus on geographies and communities with unmet needs or where inequalities exist.
- Support a community centred approach to increasing physical activity and empower local people to lead, embedding the voice and influence of local people across the work of the forum.
- Support activities that focus on early help and prevention and ensure interventions are tailored and person-centred.

  Support a more sustainable, strategic, and joined up approach to the areas of evaluation, communication and funding opportunities.

4. MEMBERSHIP

4.1 The Forum will have a core group of organisations to enable increasing physical activity levels for the population of Birmingham.

4.2 The Forum requires its members to:

- Attend all meetings, or in exceptional circumstances to arrange for a suitable named delegate to attend in his/her place. In case of delegating, the nominee should be appropriately briefed prior to attending the meeting and able to make decisions on behalf of the organisation they represent.

- Represent the views of their organisation, to keep their organisation informed about progress and to communicate the outcomes of the Forum meetings to their organisations.

- Ensure that there is prompt progress and delivery by their nominating body on any actions and strategies agreed by the Forum.

4.5 The membership of the Forum will be reviewed as necessary. New members may be admitted provided that:

(i) any such new member is able to demonstrate to the satisfaction of the Forum the contribution that they can make to the overriding aims and objectives; and

(ii) in deciding whether or not to admit any such new member the Board shall have regard to the resulting size and composition of the Board were the new member to be admitted.

(iii) They are temporary members and are co-opted at times for specific outcomes, tasks and capacity.

4.5 Other persons may attend meetings of the Forum with the agreement of the Chair/ Deputy Chair.

4.6 The Chair of the Forum will be the Birmingham City Council Cabinet Member with a portfolio for Transport.

4.7 Current Membership of the Forum is listed in the Table found in Appendix 1.

4.8 Community voice will be brought in via the Physical Activity Citizen's Panel and managed by the Public Health PA team in BCC.

5 MEETINGS

5.1 The Forum will meet every two months for one and a half hours. Such other meetings may be held as necessary at the discretion of the Chair or should commissioning decisions drive the agenda.

5.2 Members will be requested to contribute to a forward plan which will be used to develop the agenda for meeting.

5.3 The agenda for meetings, agreed by the Chair, and all accompanying papers will be sent to members at least 5 working days before the meeting. Late agenda items and/or papers may be accepted in exceptional circumstances at the discretion of the Chair.

5.4 Action notes of all meetings of the Forum (including a record of attendance and any conflicts of interest) will be approved and circulated within 10 working days and submitted for approval to the next appropriate meeting. i

5.5 The Forum may establish task and finish groups as agreed by the Forum Chairs.

5.6 The Forum's administrative support will be provided by the Public Health Division and they will be responsible for arranging and writing action for the meetings and disseminating supporting information to Forum Members.

5.7 The Forum will be monitored through a data dashboard (currently in development and will be co-designed by the Forum) and accountable to the Health and Wellbeing Board through the agreed reporting arrangements.

6. DECISIONS

6.1 Recommendations and decisions will be arrived at by consensus and recorded in the action notes and a decision log.

7. CONFLICTS OF INTEREST

7.1 Whenever a representative has a conflict of interest in a matter to be decided at a meeting of the Forum, the representative concerned shall declare such interest at or before discussions begin on the matter, the Chair shall record the interest in the minutes of the meeting and unless otherwise agreed by the Forum that representative shall take no part in the decision making process.

7. REVIEW

7.1 These terms of reference will be reviewed annually, considering views expressed by members.

Appendix 1: Creating an Active City Forum Membership Table

Role within the Forum	Organisation/Team	Name
Chair	Birmingham City Council (BCC)	Cllr Clements – Cabinet Member with portfolio For Transport
Deputy Chair and Director of Public Health	Public Health Division, BCC	Dr Justin Varney
Strategic Physical Activity Lead	Public Health Division, BCC	Mary Orhewere
Deputy Strategic Physical Activity Lead	Public Health Division, BCC	Humera Sultan
Physical Activity Service Lead	Public Health Division, BCC	Ibrahim Subdurally-Plon
Strategic Lead for Sport	Sport and Physical Activity Team, BCC	Dave Wagg
Strategic Lead for BCC Inhouse Leisure Services	Wellbeing Service, BCC	Lesley Poulton
Strategic Lead for Sports Partnership	Sport Birmingham	Mike Chamberlain
Strategic Lead Strategic Lead for CWG Legacy/ Sport England Extended Workforce	Sport Birmingham	Dean Hill
Strategic Lead for the Canal and River Trust	Canal and River Trust	Ian Lane
Strategic Lead for Transport	Travel Demand Management Team, BCC	Joe Green
Physical Activity Policy and Delivery	West Midlands Combined Authority	Simon Hall
Strategic Lead for the Children and Young People	Children and Families Directorate, BCC	Hannah Redfern
Strategic Lead for Postgraduate Education	Birmingham Newman University	Dr Lorayne Woodfield
National Strategic Representative for Physical Activity	Office of Health Improvement and Disparities	Danny Kemp
Strategic Lead for Planning	Planning Team BCC	Martin Dando
Cycling Representative	Sustrans	Hannah Chivers
NHS Strategic Lead for Physical Activity	Birmingham and Solihull ICS	Fiona Alexander
Strategic Lead Holiday Activity Fund	Holiday Activity Fund	Jenny Carter
Strategic Lead The Active Wellbeing Society (TAWS)	The Active Wellbeing Society (TAWS)	Erica Martin
Physical Activity Champion		Dr Ewan Hamnett
Voluntary Sector Lead	Saheli	Naseem Akhtar

TERMS OF REFERENCE
Birmingham and Solihull Inclusion Health Partnership (BSIHP)

The Birmingham and Solihull Inclusion Health Partnership (BSIHP) is a multi-agency partnership group focused on delivering the strategic aims of the Health and Wellbeing Board and the Integrated Care System 10yr Strategy with a specific focus on inclusion health groups within our population.

The BSIHP is a formally constituted sub-group of the Birmingham Health and Wellbeing Board with links to the Solihull Health and Wellbeing and the ICS Health Inequalities BoardS, with which it will collaborate on areas of common interest/ priority.

1. Definitions

1.1 **Inclusion health** is an umbrella term used to describe people who are socially excluded, who typically experience multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence, and complex trauma. People in inclusion health groups tend to have poor experiences of healthcare services because of barriers created by service design. These negative experiences can lead to people in inclusion health groups avoiding future contact with NHS services and being least likely to receive healthcare despite have high needs. This can result in significantly poorer health outcomes and earlier death among people in inclusion health groups compared with the general population.

1.2 People in inclusion health groups include:

- People who experience homelessness
- People with drug and alcohol dependence
- Vulnerable migrants and refugees
- Gypsy, Roma, and Traveller communities
- People in contact with the justice system
- Victims of modern slavery
- Sex workers
- Other defined marginalised groups, in Birmingham & Solihull this has been expanded to include:
  - Veterans
  - Carers
  - People with experience of the state care systems (care leavers).

2. Purpose

2.1 The purpose of the BSIHP is to:

2.1.1 Support delivery, through partnership working, of the ambitions and objectives of the Birmingham Health and Wellbeing Board's Strategy and the BSol ICS 10yr Strategy in relation to inclusion health groups.

2.1.2 In doing this the Partnership will improve health outcomes of inclusion health populations in the Birmingham and Solihull area.

2.2. The BSIHP delivers its purpose through the co-production and co-delivery of an action plan. The forum is based on the principle of collaboration and shared leadership for delivery, maximising the potential of our partnership to achieve impact.

2.3. The forum delivers its purpose and strategy through its three core functions:

Amplifying and Supporting Programme Delivery
Actions and projects we drive/ oversee for the Health and Wellbeing Board(s) and the BSol Integrated Care System (*Creating a Bolder, Healthier City 2022-2030, A Bolder, Healthier Future for the People of Birmingham and Solihull 2023-2033*) as well as contribution to other relevant strategies and work programmes, e.g.:

- Making Every Adult Matter (MEAM) Programme
- 'Safe Surgeries' initiative
- Poverty Proofing Project, etc.

Shining the light through data and evidence
The forum aims to shine the light on:

- Issues arising from needs assessments, deep dives, community health profiles relevant to inclusion health groups.
- Best practice from reviews of evidence and needs analyses conducted as well as effective / impactful local services, initiatives and solutions.
- Emerging challenges and barriers experienced by inclusion health groups.

Enabling and empowering voices
The forum operates to enable the following:

- Engagement with, and input from, inclusion health communities
- Sharing emerging practice on enabling and empowering voices and experiences of inclusion health groups to influence practice and policy.
- Collaboration and networking opportunities among members to foster partnerships and collective action
- Effective communication channels to ensure transparent and timely information sharing among partners who work in the inclusion health space.

2. Objectives:

2.1 To work collaboratively with partners and communities to respond to the challenges, opportunities and ambitions set out in the Health and Wellbeing Boards Strategies and the ICS 10yr Strategy, through the BSIHP Action Plan.

2.2 Draw on the learning and evidence base of the NHS Action on Inclusion Health Framework and use its principles as a framework for the development of the BSIHP Action Plan.

2.3 To gain a comprehensive understanding of the characteristics and needs of different inclusion health populations as well as evidence based effective solutions in order to inform action to improve the health outcomes for these groups.

2.4 To actively contribute to the development of the Joint Strategic Needs Assessments (JSNA), ensuring that the health needs of inclusion health groups are accurately identified and addressed. This includes addressing data gaps, collecting and disseminating intelligence, and utilising data-driven approaches to gain insights into the challenges faced by inclusion health groups.

2.5 To commit as a partnership to identifying and taking tangible and meaningful actions to meet the needs of inclusion health populations, including removing systemic barriers and improving access to health and care services.

2.6 To oversee and support specific projects focused on improving the health outcomes of inclusion health groups in Birmingham and Solihull, on behalf of the Health and Wellbeing Boards (HWB), ensuring their successful implementation.

2.7 To actively collaborate with and influence partner organisations and partnerships to foster a shared commitment, responsibility, and accountability toward addressing the needs of inclusion health groups, with a strong emphasis on prevention and early intervention.

2.8 To promote and facilitate community engagement, co-production, and other participatory approaches that empower inclusion health groups and support collective action in addressing health inequalities across the healthcare system.

2.9 To actively gather and share case studies, patient experiences, and lived experiences to identify areas for improvement and inform the development of effective interventions and services for inclusion health groups.

2.10 To advocate for the collection and analysis of data on the impact of interventions, tracking outcomes, and evaluating the effectiveness of initiatives, with the aim of driving evidence-based approaches, informing decision-making, and continuously improving the health outcomes of inclusion health groups.

3. Principles

3.1 All members are expected to fully support and align with the aims and objectives of the Birmingham and Solihull Inclusion Health Forum.

3.2 Members should consult with and inform the Partnership of any organisational changes, including changes in representation, that may impact collective working. They should actively engage in the agreed framework to review and monitor activities led by the BSIHP.

3.3 Members are expected to share relevant information and promote collaborative and innovative work within the Forum. This includes sharing best practices, research findings, and resources that contribute to advancing inclusion health.

3.4 The Forum emphasises the importance of involving individuals with lived experience and other relevant stakeholders in decision-making processes. Their perspectives and expertise should be valued and incorporated into the Forum's initiatives and actions.

3.5 Members are encouraged to create an environment of openness and transparency within the Forum. This includes sharing information, insights, challenges, and successes openly, fostering trust, and promoting a culture of constructive dialogue.

3.6 Members are expected to contribute to assessing the BSHIP's maturity and identifying areas for improvement. This involves actively participating in evaluation processes, providing feedback, and proposing strategies to enhance the effectiveness and impact of the Forum's work.

3.7 Members should leverage the broad network of participants within the group to collectively address system-level challenges and social issues impacting inclusion health groups. This may involve advocating for policy changes, implementing systemic reforms, and collaborating with other relevant organisations and stakeholders.

3.8 Members are expected to report on progress related to mutually agreed actions promptly. This includes providing updates, sharing outcomes and demonstrating accountability for the commitments made within the Forum.

4. Membership

4.1 The BSIHP will consist of senior representatives from stakeholders from all sectors, including people leading the policy and work that impacts directly the health and wellbeing of inclusion health groups as well as community representatives.

4.2 The Partnership will be co-chaired by an elected member from Birmingham City Council and a senior representative from a partner organisation/ BSol ICS.

4.3 The group may invite external experts or guest speakers to contribute to specific discussions or provide insights on relevant topics. Regular feedback and input from individuals with lived experience will be sought and valued, as their insights and perspectives are crucial in shaping the forum's initiatives, policies and recommendations.

4.4 The Partnership will strive to create a safe and inclusive space where all members, including those with lived experience, feel respected, valued, and heard. Measures will be taken to foster an environment that encourages open dialogue and understanding.

5. Roles and Responsibilities:

5.1 Members should have the authority to make decisions regarding the inclusion health agenda on behalf of their organisation or have the ability to seek and secure such authority within agreed timescales.

5.2 Attendance at the majority of meetings is expected. In exceptional circumstances, members may arrange for a suitable delegate to attend in their place. If delegation occurs, the nominee should be appropriately briefed and have the necessary authority to make decisions on behalf of their organisation.

5.3 Members are responsible for representing the views of their nominating organisation, keeping their organisation informed, driving progress against the agreed actions within their organisations/ services, and communicating the outcomes of BSIHP meetings.

5.4 It is essential that members ensure prompt progress and delivery by their nominating body on any actions and strategies agreed upon by the Partnership.

5.5 Members are expected to engage in positive and constructive discussions with other members to achieve workable solutions to common issues.

5.6 Members may be nominated to lead/ form/ join smaller task and finish groups to drive specific actions or work programmes on behalf of the Partnership.

6. Meetings

6.1 The BSIHP will convene regular meetings quarterly, with each meeting lasting for 2 hours. Additionally, the Co-chairs may call for special meetings as necessary.

6.2 Partners will be invited to contribute to a forward plan, which will serve as the basis for developing the agenda for each meeting.

6.3 The Partnership may establish task and finish groups to drive the delivery of agreed actions with equitable secretariat support between partners for these groups.

6.4 The Chair(s) will finalise the meeting agenda, and along with all relevant supporting documents, it will be distributed to members at least 5 working days prior to the scheduled meeting. In exceptional circumstances, the Co-chairs may consider accepting late agenda items and/or papers at their discretion.

6.5 Following each meeting, the Co-chairs will review and approve the minutes/action notes. These approved minutes/action notes will then be circulated to all attendees within 10 working days. The final approval of minutes/action notes will take place during the subsequent Forum meeting.

6.6 The administrative support for the Partnership will be provided by the Public Health Inclusion Health team. Their responsibilities will include organising the meetings, taking minutes/action notes, and disseminating relevant information to Forum members. Furthermore, they will ensure the accuracy of membership records.

6.7 The BSIHP will maintain accountability to the Birmingham Health and Wellbeing Board through the established arrangements with links to the Solihull Health and Wellbeing Board and the BSol ICS relevant governance board (arrangements are to be agreed with the two boards).

7. Decisions and Information Sharing

7.1 Recommendations and decisions will be arrived at by consensus and recorded in the minutes and a decision log. If a consensus cannot be reached the Co-chair will call for a vote. The Co-chairs will have a joint casting vote in the case of equality of votes.

7.2 Members will support work on appropriate data sharing and development of protocols where appropriate.

8. Conflicts of Interest

8.1 Whenever a representative has a conflict of interest in a matter to be decided at a meeting of the Partnership, the representative concerned shall declare such interest at or before discussions begin on the matter, the Chair shall record the interest in the minutes of the meeting and unless otherwise agreed by the Partnership that representative shall take no part in the decision-making process.

9. Review and Amendments

9.1 The terms of reference will be reviewed periodically to ensure its continued relevance and effectiveness. Amendments may be proposed and approved by the BSIHP members during meetings.

Appendix 1

Birmingham and Solihull Inclusion Health Partnership membership

Role	Organisation
Cabinet Member for Social Justice, Community, Safety and Equalities (Chair)	Birmingham City Council
Director for Health Inequalities/ Inclusion Health or equivalent (Co-Chair)	Birmingham and Solihull Integrated Care System
Assistant Director of Public Health with relevant portfolio	Birmingham City Council
Experts by experience from inclusion health communities – number tbc	Communities of experience
Head of Multiple Disadvantage	Birmingham Voluntary Service Council (BVSC)
Director	Crisis
Chief Executive Officer	SIFA Fireside
Chief Executive Officer	St Basils
Chief Executive Officer	Citizens Advice Bureau Birmingham
Chief Executive Officer	Anawim
Director/ Head of Service	PACT
Director/ Deputy Director of Public Health	Solihull Metropolitan Borough Council
Inclusion Health/ Health Inequalities Lead	Solihull Metropolitan Borough Council
Service Lead (Inclusion Health)	Public Health, Birmingham City Council
Service Lead – Addictions	Public Health, Birmingham City Council
Assistant Director - Early Intervention & Prevention	Birmingham City Council
Head of Adult Social Care Commissioning (Prevention/ Public Health/ Vulnerable Adults services)	Birmingham City Council
Director of City Housing Solutions & Support Services	Birmingham City Council

Assistant Director for Community Safety and Cohesion	Birmingham City Council
Director/ Assistant Director of Education Services	Birmingham City Council
Head of Youth Services	Birmingham City Council
Assistant Director – Safeguarding	Birmingham Children's Trust
Head of Service Care Leavers Service, Un-accompanied Asylum Seeking Children and Homelessness	Birmingham's Children's Trust
Head of Service Youth Offending Services	Birmingham's Children's Trust
Programme Manager – Health Inequalities (Inclusion Health)	NHS Birmingham and Solihull (Integrated Care Board)
Director of Nursing – Safeguarding & Children in Care	NHS Birmingham and Solihull (Integrated Care Board)
PCN Health Inequality Champions	
Associate Director of Equality, Diversity, Inclusion and Organisational Development	Birmingham and Solihull Mental Health NHS Foundation Trust
TBC	NHS Birmingham Community Healthcare NHS Foundation Trust
TBC	University Hospitals Birmingham NHS Foundation Trust
TBC	Birmingham Women's and Children Hospital NHS Trust
Programme Lead – Inclusion Health	Office for Health Improvement and Disparities, Department of Health and Social Care
Health and Justice Programme Manager – Healthcare Public Health	NHS England – Midlands (West)
Inclusion and Engagement Partnership Manager	Department for Work and Pensions
Head of Birmingham Courts and Centralised Functions	National Probation Service – West Midlands/ Birmingham and Solihull
TBC	West Midlands Police
TBC	West Midlands Police and Crime Commissioner

Health Protection Forum (HPF)

Terms of Reference

Document name	Terms of Reference
Programme	Health Protection
Chair	Dr Mary Orhewere
Service Lead	Funmi Oluboyede (Interim)
Version 0.3	Date: September 2023

Document management/Revison history:

0.1	April 2021	Redraft in new format
0.2	August 2023	Redraft (Mary Orhewere, Funmi Oluboyede, Helen Bissett, Manuela Englebert)
0.3	September 2023	Final (Mary Orhewere, Funmi Oluboyede)

Approved by:

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Dr Mary Orhewere		Assistant Director of Public Health	September 2023	0.3

Document control

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1. PURPOSE

1.1 The Health Protection Forum (HPF) is a sub-committee of the statutory Health and Wellbeing Board. The Director of Public Health (DPH) has a responsibility to provide oversight and assurance of health protection plans. This forum will focus on facilitating that responsibility.

1.2 The HPF will provide a link between the Health and Wellbeing Board and partner organisations with roles in the delivery of health protection plans.

1.3 The HPF will provide a setting for the exchange of information, scrutiny of plans and analysis of data with all partners with a role in the delivery of health protection in Birmingham, ensuring they are acting jointly and effectively to protect the population's health.

2. OBJECTIVES

2.1 Provide assurance to the DPH that plans are in place to protect the population's health (mandated function, Health and Social Care Act 2012 & 2022).

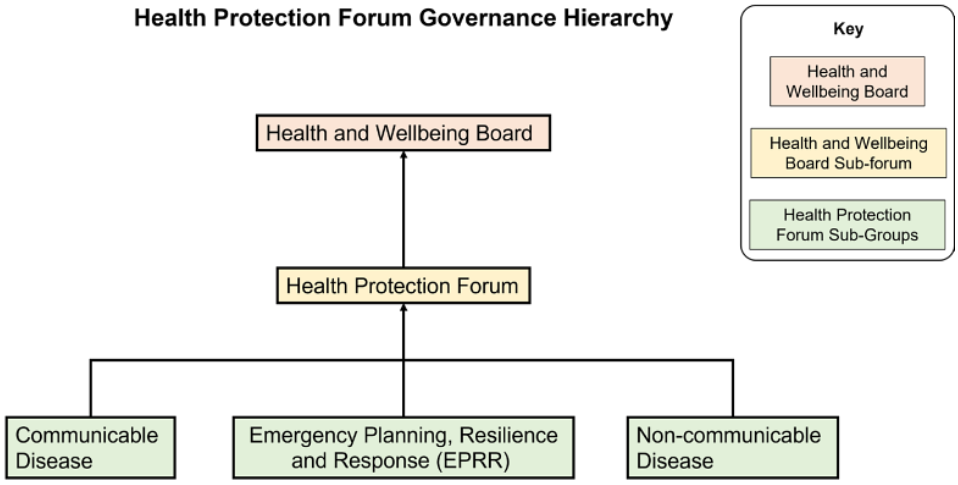
2.2 Provide regular updates to the Birmingham Health and Wellbeing Board (including short information updates and annual reports).

2.3 To provide a governance and accountability framework for existing member groups with a health protection remit and support the establishment of new groups where appropriate; to initially include the following (sub) groups:

2.3.1 Communicable Diseases

2.3.2 Non-Communicable Diseases

2.3.3 Emergency Planning, Resilience and Response (EPRR)



2.4 To receive reports from HPF members on appropriate plans and progress made as appropriate.

2.5 To receive regular reports at least annually and more frequently by exception.

2.6 To note:

2.6.1 Significant incidents

2.6.2 Outbreaks

2.7 To make recommendations to:

2.7.1 HPF members

2.7.2 Commissioners

2.7.3 Providers

2.7.4 Health and Wellbeing Board

2.8 To provide health protection input into the Joint Strategic Needs Assessment processes as required.

2.9 To support the DPH in providing information for scrutiny on any Health Protection-related matter

2.10 To receive reports on any other issue that would enable the DPH to undertake their assurance role in relation to health protection.

3. PRINCIPLES

The Forum expects all partner agencies to:

3.1 Support the aims and objectives of the Forum

3.2 Consult and/or inform the Forum on organisational changes (including any changes in representation) that may impact collective working.

3.3 Proactively manage risk and acknowledge the principle of shared risk in the context of partnership working.

3.4 Own the health and wellbeing inequalities agenda through promoting and driving service transformation and improvement within their respective services and organisations.

3.5 Report progress on mutually agreed actions.

3.6 Share relevant information and promote collaborative and innovative work.

4. MEMBERSHIP

Membership will be continuously reviewed, and the Forum reserves the right to co-opt individuals for specific areas as necessary provided that:

4.1 Any such new member can demonstrate to the satisfaction of the Forum the contribution that they can make to the overriding aims and objectives; and

4.2 In deciding whether to admit any such new member the Board shall have regard to the resulting size and composition of the Board were the new member to be admitted

The Core Membership of the group will be as listed below (Table 1). One decision-maker representative of each subgroup will form the membership of the Health Protection Forum, alongside other stakeholder members.

Table 1. Health Protection Forum Membership

Name	Job Title	Organisation
Dr Mary Orhewere*	Assistant Director, Public Health	Birmingham City Council
Becky Pollard	Assistant Director, Public Health (FTC+)	Birmingham City Council
Funmi Worrell	Interim Service Lead, Health Protection	Birmingham City Council
Helen Bissett**	Senior Programme Officer, Health Protection	Birmingham City Council
Mark Croxford	Head of Environmental Health	Birmingham City Council
Janet Bradley**	Operations Manager, Environmental Health	Birmingham City Council
Michael Enderby	Head of Resilience and Operations	Birmingham City Council
David Jones	Senior Infection Prevention and Control Nurse	BSol ICB
Kate Woolley	Director of Immunisation and Vaccinations	BSol ICB
Leon Mallett	Head of Immunisation and Vaccinations	BSol ICB

Andrew Dalton	Screening and Immunisation Lead	NSH England
Dr Roger Gajraj	Consultant in Communicable Disease Control	UKHSA

*Deputy Chair to the Director of Public Health, Birmingham City Council

**In Attendance Only

5. Quorum

One Forum member from each of the following named agencies will constitute a quorum: NHS England, Birmingham City Council and UKHSA (with the Chair or their appointed deputy always present). If the named member or deputy cannot attend, a designated substitute may attend the Forum with the prior agreement of the Chair.

6. Communication of Decisions to Partners

All members will be responsible for communicating actions and decisions to appropriate colleagues within their own organisation following each meeting.

7. Frequency of Meetings

The group will meet once every month and at other times as required by the DPH.

8. Committee Chair

Meetings will be chaired by the DPH or their appointed deputy.

Minutes will be produced by the administrative team of the Director of Public Health. Meeting papers will be circulated 5 working days ahead of meetings, with minutes also circulated in a timely fashion to Forum members following each meeting.

9. Reports

Short reports for discussion at the Health Protection Forum will be submitted by each subgroup at least 5 working days ahead of the meeting date to allow time for collation and circulation to the group. Verbal reports will be accepted if organisational capacity is limited with the expectation of a short written report to follow.

10. Standing Agenda Items

Standing agenda items will include (for each sub-group):

- current status summary for each member organisation

11. Review

Terms of Reference will be fully reviewed at least every two years. The Terms of Reference will be amended every time an organisation becomes or ceases to be a member.

Next review by **September 2025**.

Fast-Track Cities+ Initiative Steering Group

Terms of Reference

Version	**V4**
Last review date	**13/04/2023**
Next review date	**15/04/2024**

Context of Fast-Track Cities+ Initiative (FTC+ Initiative)

The Fast-Track Cities initiative is a global partnership between a network of cities and four core partners:

- the International Association of Providers of AIDS Care (IAPAC),
- the Joint United Nations Programme on HIV/AIDS (UNAIDS)
- the United Nations Human Settlements Programme (UN-Habitat), and
- the city of Paris.

The aim of the initiative is to strengthen existing programmes and focus resources to accelerate locally coordinated, city-wide responses to end HIV/AIDS by 2030.

The initiative requires cities to sign the Paris Declaration, which pledges to attain the following targets by 2030:

- 95% of people living with HIV (PLHIV) knowing their HIV status
- 95% of people who know their HIV-positive status on HIV treatment
- 95% of PLHIV on HIV treatment being virally suppressed
- Zero stigma and discrimination

Birmingham signed the Paris Declaration on the 5th October 2022 pledging to seven commitments, which will be included in the Birmingham FTC+ Action Plan, to achieve the FTC vision. IAPAC have developed evidence-based guidelines to support these cities in attaining the targets. To date, FTC programmes operate in over 150 countries worldwide.

Originally the initiative just aimed to target and eliminate HIV but since initiation in Birmingham viral hepatitis (Hep B and Hep C) and tuberculosis (TB) were added to the initiative as they could be co-targeted with HIV, leading to the Fast-Track Cities+ initiative (with '+' indicating the addition of viral hepatitis and TB). The Steering Group and Project Board will have responsibility for the additional targets, attached in Appendix 1.

The FTC+ Birmingham Action Plan will set out the actions required to meet the initiatives targets. The Summary Action Plan for the initiative is attached in Appendix 2.

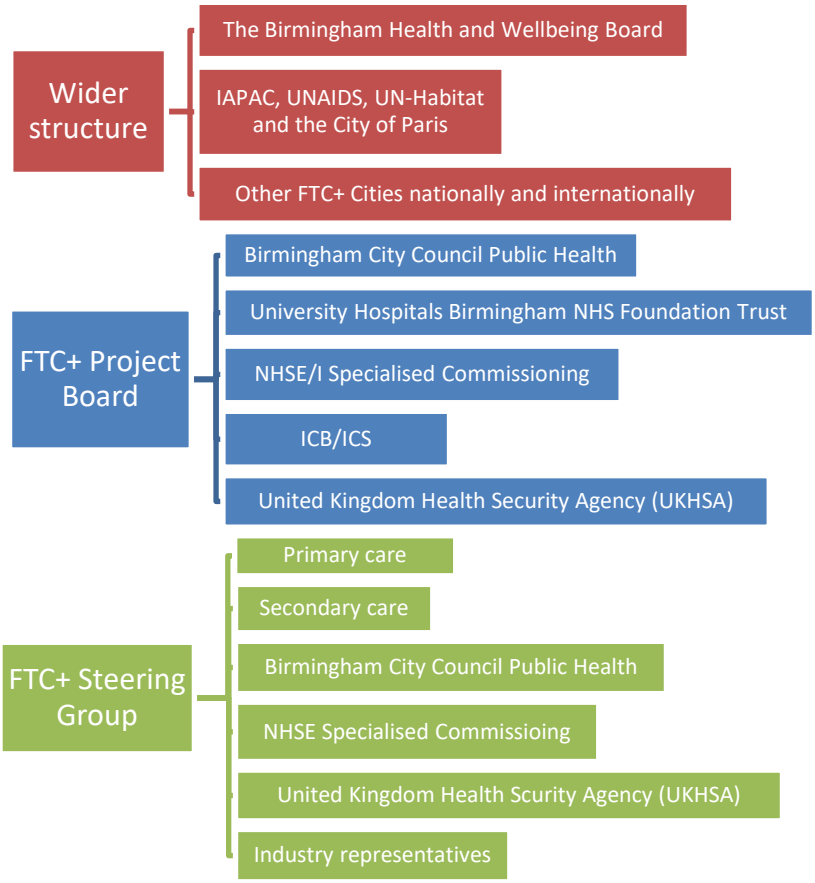
The Vision for Birmingham FTC+

The delivery of FTC+ in Birmingham will fall in line with the international initiative's vision. It will, therefore, incorporate any future additions or changes, without having to re-issue the Terms of Reference.

The key stakeholders in the Birmingham FTC+ initiative will have a proactive approach to reducing HIV, viral hepatitis and TB in Birmingham. These conditions

have implications for all parts of the system, not just clinical treatment or testing services. There is significant need to address stigma and discrimination as well as improve the response and support from mainstream services. We want to collaborate on this programme of work to achieve our shared vision. We are aiming to achieve the elimination of new transmissions of all three Blood Borne Viruses (BBVs) by 2030 and TB by 2035.

1. The Structure of Birmingham FTC+



2. Purpose

The Fast-Track Cities+ initiative Steering Group (FTC+ SG) brings together expertise from the organisations and communities involved in and affected by the prevention, diagnosis, treatment and support of people living with and at risk of HIV, Viral Hepatitis and TB in Birmingham and to ensure an inclusive and transparent whole-city approach.

The FTC+ SG is a pan-Birmingham working group which will facilitate the development, delivery, monitoring and evaluation of the Birmingham FTC+ Action Plan.

2.1. Steering Group Objectives

- The focus of the SG is to provide strategic and operational input to ensure that the initiative meets it's agreed objectives and targets as an FTC+
- The SG may form subgroups to undertake work on specific work streams within the programme.

3. Steering Group Membership

The following organisations will be represented on the steering group:

- Birmingham Public Health
- Integrated Care Board (ICB)
- Drug and Alcohol Services
- Local Charities
- Local Pharmaceutical Committee (LPC)
- Primary Care
- UK Health Security Agency West Midlands (UKHSA WM)
- Third Sector Organisations
- University Hospitals Birmingham NHS Foundation Trust – Umbrella
- University Hospitals Birmingham NHS Foundation Trust **i.e.**
    - HIV Lead
    - Hepatitis Lead
    - Tuberculosis Lead

4. Steering Group (SG) requirements

- Use the available and most recent data to define the city's current epidemiology and response to HIV, Viral Hepatitis and TB.
- Prepare and take joint ownership of the FTC+ Action Plan to ensure the needs of Birmingham are met.
- Ensure actions are delivered from the FTC+ Action Plan.
- Agree metrics which demonstrate the effectiveness of the initiative and will be reported to the Global Fast-Track Cities Web Portal.
- Produce an FTC+ Annual Report.
- Collaborate with other UK and international Fast-Track Cities (FTC) to facilitate shared learning and improve outcomes.
- Develop a communication plan to inform and promote the work of FTC+ to stakeholders.
- Decide how resources will be utilised to achieve these objectives.

5. Meeting Arrangements

- The frequency of meetings is to be determined by the group (dates and locations to be confirmed by Birmingham Public Health).
- The expectation for the Steering Group is that these will be on a 6-8 week basis unless otherwise stated.
- Meetings to follow an agenda as agreed by the group.
- Birmingham Public Health to lead on the coordination of the meeting.

- The group will be chaired by a Service Lead from Birmingham Public Health.
- A co-chair may be nominated from a different stakeholder constituency of the membership.
- Group membership and group meetings will be managed by the group, new additions to the group invited and recruited in agreement with the group.

6. Governance and Reporting

- The Steering Group will report to the Project Board
- Each Project Board member will have their own organisations governing body to report to and they must ensure that this is done in a timely manner
- Project Board will report to Birmingham Health and Wellbeing Board and IAPAC
- In addition, the Birmingham FTC+ will report to:
    - Any potential new governance structures that emerge throughout the life of the initiative
    - Residents of Birmingham in line with the communications plan

7. Quoracy

The leadership will be quorate if the following are present:

- A representative of each of the FTC+ SG signatory organisations (Birmingham Public Health, UHB, UKHSA)
- 50% membership plus 1.

8. Resources

Decisions on how to utilise any financial resources generated for FTC+ (e.g. research grants or other potential funders) will be reviewed by the FTC+ SG and recommended for agreement by the FTC+ PB.

9. Links to Other Groups

Birmingham FTC+ Public Health Officers will report to the public health contracts board and will share progress with the relevant councillors via their briefing meetings. Additionally, they will ensure that the Health and Wellbeing Board is kept updated and make the requisite links with Birmingham sexual health services.

Agreement to Terms of Reference

By signing this, you are agreeing to being a member of the Steering Group for the Fast-Track Cities+ initiative and the Terms of Reference listed above.

Name:
Role:
Signature:
Date:

Glossary

AIDS	- Acquired immune deficiency syndrome
BBV	- Blood borne virus
FTC	- Fast Track Cities
FTC+	- Fast-Track Cities Plus
IAPAC	- International Association of Providers of AIDS Care
ICB	- Integrated Care Board
ICS	- Integrated Care System
Hep B	- Hepatis B Virus
Hep C	- Hepatitis C Virus
HIV	- Human immunodeficiency virus
PB	- Project Board
PLWHIV	- People living with HIV
PWID	- People who inject drugs
SG	- Steering Group
TB	- Tuberculosis
UKHSA	- UK Health Security Agency
UHB	- University Hospital Birmingham
UNAIDS	- Joint United Nations Programme on HIV/AIDS
UN-Habitat	- United Nations Human Settlements Programme

Appendix 1

Birmingham FTC+ Additional Targets

The following targets have been set to ensure the reduction/eradication of viral hepatitis in Birmingham[1];

Hep B:

- 90% reduction in new cases of chronic Hep B infections by 2030 (compared to 2015)
- 65% reduction in deaths from Hep B by 2030 (compared to 2015)
- 90% childhood Hep B virus vaccination coverage (3rd dose coverage)
- 100% Hep B virus birth-dose vaccination coverage or other approach to prevent mother-to-child transmission
- 90% coverage of vaccination in prisoners, sexual health clinic clients, homeless individuals, sex workers, contacts of Hep B infected cases, asylum seekers, new migrants and people who inject drugs (PWID)

Hep C:

- 90% reduction in new cases of chronic Hep C infections by 2025 (compared to 2015)
- 65% reduction in deaths from Hep C deaths by 2025 (compared to 2015)
- 100% of injecting drug users report adequate needle and syringe provision for their needs
- 90% of the those living with Hep C diagnosed
- 80% of eligible persons with current Hep C infection started treatment

The following targets have been set to ensure the reduction/eradication of **TB** in Birmingham[2];

- 90% reduction in TB incidence compared to 2015
- 95% reduction in TB deaths compared to 2015
- Decrease annually, by 5% the proportion of people who develop active TB within 5 years of post UK entry using the 3-year average, 2017 to 2019, as a baseline
- Achieve 1358 LTBI Tests per year in Birmingham
- Achieve 90% treatment completion rates (12-month outcome) by 2026
- 80% BCG vaccination coverage for all children eligible in the Birmingham LA
- Reduce the average delay in diagnosis in people with pulmonary TB by 5% per year
- 100% of TB cases offered a HIV test

[1] http://apps.who.int/iris/bitstream/handle/10665/246177/WHO-HIV-2016.06-eng.pdf;jsessionid=4C75CEB88C637A88274135577126159B?sequence=1
[2] file:///C:/Users/TMPdcedy/Downloads/9789240037021-eng.pdf

Appendix 2

FTC+ Summary Action Plan

Theme 1: New Ways of Working

Increase collaborative working across services

- Create multi-disciplinary teams supported by ICSs and ICBs to provide a comprehensive service to end-users.
- New partnerships and pathways e.g. with sexual health and substance misuse services.
- Ensure all providers have consistent contracting arrangements.
- Build pathways around the service user, including the voice of service users in designing interventions.

Improve system leadership and unity

- Set out an inclusion commitment for all LGBT groups.
- Make new links with and engage community leaders/champions in BBV and TB education.
- Reduce inequalities by targeting underserved communities and ensuring culturally appropriate service provision.

Improve communication

- Promote referral pathways.
- Offer communication training to different groups e.g. professionals, volunteers, community leaders.
- Work with affected communities to co-develop communications.

Improve confidentiality and information sharing

- Improve communication between primary and secondary care.
- Confidentiality training for healthcare professionals.
- Address patients' privacy concerns e.g. by requesting communication preferences.

Improve technology use

- Make technology and language for online testing and appointment booking accessible to all communities.

Improve data monitoring

- Develop a Fast-Track Cities+ dashboard.

Closer alignment with national policies

- Align Fast-Track Cities+ with national elimination strategies and clinical guidance.

Theme 2: Prevention

Increase information and awareness amongst public and healthcare workforce

Across the public:

- Age-appropriate education and awareness campaigns and workshops.
- Utilise a peer-to-peer approach and patient voices.

At-risk communities:

- Use 'Champions' to raise awareness.
- Utilise a peer-to-peer approach.
- Educate via established pathways using culturally competent health promotion interventions.

- Free and easy to access education and training.

Across the healthcare workforce:

- Improve education in health services e.g. on key groups at higher risk, common misconceptions.
- Provide cultural competence training.

Develop targeted promotional campaigns

- Target different ages, physical locations and those at greater risk.
- Social media campaigns.
- Promote other relevant support services.
- Community involvement in design, delivery and evaluation of campaigns.

Increase prevention activities

- Improve information on prevention strategies e.g. vaccinations, condoms, PrEP, PEP and needle and syringe programmes.
- Maintain and maximise the delivery of Hep B and BCG vaccination uptake.
- Use best practice from other countries.
- Further understand needs of at-risk groups e.g. sex workers, MSM and black African heterosexuals.

Theme 3: Testing and Diagnosis

Increase awareness of the importance of testing

- Promote testing at large events, via the media and advertisements in physical locations.
- Promote testing using sexual health and substance misuse services.

Increase testing as part of current community outreach services

- Increase testing and treatment in services already supporting at-risk groups.
- Increase testing and test kits available via GPs, pharmacies, home delivery, prisons, abortion services and substance misuse services.
- Provide services in accessible venues, increase opening hours and use technology to ease test booking.
- Maintain and improve uptake of LTBI screening in primary care (National LTBI Screening Programme).

Increase testing as part of an opt-out system

- Expand routine blood tests in primary care to include BBVs.
- Expand testing in primary care, A&E, hospitals and community pharmacy, ensuring NICE recommendations are fully implemented.
- Discuss testing at cervical screening and LARC fitting appointments.
- Consider Hepatitis C testing as part of routine antenatal screening.

Theme 4: Treatment

Increase access to treatment

- Increase numbers of support workers and volunteers.
- Ensure a fluid treatment pathway with prison services.
- Educate everyone on the treatment options available.
- Offer multiple touchpoints, appointments, and provision at venues patients want.

Theme 5: Support Services

Reduce stigma and discrimination

- Education and awareness campaigns e.g. for U=U and TasP.
- Educating universal services about the needs to people living with HIV, TB and Hepatitis.
- All relevant health providers to encourage testing and treatment.

Improve after care and health and wellbeing support

- Expand mental health and support services for patients.
- Improve access to peer mentors and volunteers.
- Make effective use of community networks and be sensitive to the needs of diverse communities.

Improve social support and accommodation

- Address social and health inequalities affecting groups at higher risk.
- Provide suitable accommodation/allowance for asylum seekers living with BBVs and TB.

TERMS OF REFERENCE – DRAFT

Creative Public Health Forum (CPHF)

1. Background

1.1. Birmingham's Creative Public Health Programme is focused on exploring the value arts, culture and heritage can have in improving population health. This is in response to a growing body of evidence demonstrating where the arts have been successfully utilised to facilitate health behaviour change; to improve health literacy; to reduce social isolation and to improve mental wellbeing. The arts is also valuable in facilitating the expression of people's experiences and perspectives on health and health services in a manner than can be heard, understood and empathised with.

1.2. During the last year, Public Health has worked to create the structures and partnerships to enable the impact of a strategic approach to utilising the wealth of art, culture and heritage in the City to improve public health to be realised and measured.

1.3. To date, Public Health has created City Level Partnerships with Birmingham Museums Trust, Birmingham Hippodrome, Ikon Gallery, and Midlands Arts Centre via our Research Officers in residence programme as well as Hyper Local Partnerships with Zawiya Trust, Roundhouse, Number 11 arts, and Flatpack via our Creative Public Health Innovation, Partnership and Impact Fund.

1.4. This is the first time formative strategic action in the City has been made in this thematic area and is demonstrating the pivotal role of creativity in facilitating equitable health outcomes, we have also been instrumental in sharing our approach nationally.

1.5. The proposed CPHF will bring together our City Level and hyperlocal arts, culture and heritage partnerships with BCC and the NHS to develop and realise a shared vision for a creative public health approach. This will be a life-course approach, aligned to the themes in the Birmingham Health and Wellbeing Board Strategy 2022-2030. that will maximise opportunities for the prevention, promotion, management, and treatment given to Birmingham citizens.

1.6. We also want to ensure all citizens can benefit from the opportunities the arts afford to empower citizens to be happy and healthy, enabling culture and heritage to contribute to the vision of Health and Wellbeing Board Strategy

2. Purpose

2.1. The Culture and Health Partnership will be a sub-committee of the Birmingham Health and Wellbeing Board (HWBB). The purpose of the Forum to develop and implement a shared vision that maximises the potential of creative public health activity at community and population level to support the vision and aims of the HWB Strategy.

3. Objective

3.1. To develop and implement a strategic framework for how arts, culture and heritage can support the aims of the HWB strategy across the life-course

3.2. To enable residents to have equitable access to quality creative activities that contribute to better public health, e.g. helping map, build and collectively sustain creative public health activity at a local and hyper local level

3.3. To contribute to the evidence base for Creative Public Health through the implementation of evaluated projects, e.g. co-creating a Creative Public Health Evaluation toolkit to be adopted when undertaking projects and/or initiatives

3.4. To work with the other HWB Sub-Forums to support them to utilise the Creative arts in achieving their health priorities, e.g. sharing, presenting and contributing to other relevant forums when necessary

3.5. To oversee the work of the Researchers in Residents and the Innovation, Partnership and Impact Fund, e.g. to provide effective insight guidance and challenges where necessary to enable the continuous improvement of these initiatives, as well as assurance.

3.6. To facilitate collaboration between cultural/creative and health sectors to realise shared goals, e.g. to support on-going and new relationships, collaborations and partnerships that incorporate input from the public and communities in an innovative manner to protect the public's health

4. Principles

4.1. The ways of working for Forum members is set out in the following principles:

- The Forum will be more than an information sharing group – one that supports co-ordinated action to work towards better interconnectedness of creative public health in Birmingham.

- The Forum will take recommendations both to and from the HWBB, with clear feedback from the HWBB regarding their actions to better creative public health provision across Birmingham.
- Provide commitment to embedding a creative public health approach into policy to ensure multiple outcomes are met around arts, culture, heritage and health through strong, multi-sector strategic collaboration.
- Ensure improvements to the public realm are central to our mission for allowing all to be creative for the betterment of their health.
- Take a targeted approach to interventions to increase creative health activity throughout the life course by using data, intelligence, and insight to focus on geographies and communities with unmet needs or where inequalities exist.
- Support a community centred approach to increasing creative health and empower local people to lead, embedding the voice and influence of local people across the work of the forum.
- Support activities that focus on early help and prevention and ensure interventions are tailored and person-centred.
- Support a more sustainable, strategic, and joined up approach to the areas of evaluation, communication and funding opportunities.

5. Membership

5.1. The Forum will have a core group of organisations to enable that enables its residents to have accessible, available, adequate and sustainable creative activities that contribute to better public health.

5.2. The Forum requires its members to:

- Attend all meetings, or in exceptional circumstances to arrange for a suitable named delegate to attend in his/her place. In case of delegating, the nominee should be appropriately briefed prior to attending the meeting and able to make decisions on behalf of the organisation they represent.
- Represent the views of their organisation, to keep their organisation informed about progress and to communicate the outcomes of the Forum meetings to their organisations.
- Ensure that there is prompt progress and delivery by their nominating body on any actions and strategies agreed by the Forum.

5.3. The membership of the Forum will be reviewed as necessary. New members may be admitted provided that:

(i) any such new member is able to demonstrate to the satisfaction of the Forum the contribution that they can make to the overriding aims and objectives; and

(ii) in deciding whether or not to admit any such new member the Board shall have regard to the resulting size and composition of the Board were the new member to be admitted.

(iii) They are temporary members and are co-opted at times for specific outcomes, tasks and capacity.

5.4. Other persons may attend meetings of the Forum with the agreement of the Chair/ Deputy Chair.

5.5. The Chair of the Forum will be the Birmingham City Council Cabinet Member for Digital, Culture, Heritage & Tourism.

5.6. Current Membership of the Forum is listed in the Table found in Appendix 1.

5.7. Community voice will be brought in via the re-development of the Arts and Health Working Group into a Creative Health Working Group and managed by the Public Health Communities team in BCC.

6. Meetings

6.1. The Forum will meet every three months for one and a half hours. Such other meetings may be held as necessary at the discretion of the Chair or should commissioning decisions drive the agenda.

6.2. Members will be requested to contribute to a forward plan which will be used to develop the agenda for meeting.

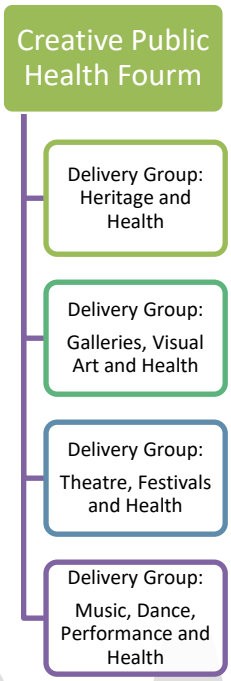
6.3. The agenda for meetings, agreed by the Chair, and all accompanying papers will be sent to members at least 5 working days before the meeting. Late agenda items and/or papers may be accepted in exceptional circumstances at the discretion of the Chair.

6.4. Action notes of all meetings of the Forum (including a record of attendance and any conflicts of interest) will be approved and circulated within 10 working days and submitted for approval to the next appropriate meeting.

6.5. The Forum may establish task and finish groups as agreed by the Forum Chairs.

6.6. The Forum's administrative support will be provided by the Public Health Division and they will be responsible for arranging and writing action for the meetings and disseminating supporting information to Forum Members.

6.7. The Forum will be monitored through a data dashboard (currently in development and will be co-designed by the Forum) and accountable to the Health and Wellbeing Board through the agreed reporting arrangements.



7. Delivery Groups

7.1. To support this new forum, it is proposed that we establish dedicated thematic delivery groups who will be supported by our partner organisations, public health research officers and specific sector leads with the purpose of:

- Creating a community of practice, thematic aligned towards their creative practice and underpinned by a public heath approach
- Development of action plans – signed off by forum
- Collection and development of local evidence-base in relation to creative health

8. Decisions

8.1. Recommendations and decisions will be arrived at by consensus and recorded in the action notes and a decision log.

8.2. Significant decisions and risks impacting on the progress of the Forum will be escalated to the HWBB.

9. Conflicts of Interest

9.1. Whenever a representative has a conflict of interest in a matter to be decided at a meeting of the Forum, the representative concerned shall declare such interest at or before discussions begin on the matter, the Chair shall record the interest in the minutes of the meeting and unless otherwise agreed by the Forum that representative shall take no part in the decision making process.

10. Review

10.1. These terms of reference will be reviewed annually, considering views expressed by members.

Appendix 1: Creating an Active City Forum Membership Table

Role within the Forum	Organisation/Team	Name
Chair	TBC	TBC
Deputy Chair	TBC	TBC
Director of Public Health	Public Health Division, BCC	Dr Justin Varney
Assistant Director of Public Health	Public Health Division, BCC	Helen Harrison
Deputy Lead	Public Health Division, BCC	Rhys Boyer
Delivery Group Lead (Heritage and Health)	Birmingham Museums Trust	TBC
Delivery Group Lead (Galleries, Visual Art and Health)	Ikon Gallery	TBC
Delivery Group Lead (Theatre, Festivals and Health)	Birmingham Hippodrome	TBC
Delivery Group Lead (Music, Dance performance and Health)	Midlands Art Centre	TBC
Clinical Representative	Birmingham and Solihull ICS	Satish Rao
Academic Representative	University of Birmingham	Ewan Fernie
National Culture Representative	Department for Digital, Culture, Media and Sport	TBC
National Health Representative	Department for Health and Social Care	TBC
National Arts Representative	Arts Council England	TBC
Regional Voluntary, Community, Faith and Social Enterprise Representative	BVSC	Stephanie Bloxham
Regional Community Representative	West Midlands Combined Authority	Mubasshir Ajaz
Regional Voluntary, Community, Faith and Social Enterprise Representative	Culture Central	Erica Love
	National Lottery Heritage	Liz Shaw
National Creative Health Representatives	National Centre for Creative Health	Alex Coulter
National Creative Health Representatives	Culture, Health and Wellbeing Alliance	Victoria Hume

Head of Culture Development and Tourism, BCC	City Operations, BCC	Symon Easton
Libraries Services Manager, BCC	Adults Social Care, BCC	Dawn Beaumont

TERMS OF REFERENCE – DRAFT

Communities of Identity Health Inequalities Forum (CIHIF)

1. BACKGROUND

1.1 The proposal for a **Communities of Identity Health Inequalities Forum** under the Health and Wellbeing Board has been borne out of the success and lessons learnt from the Birmingham and Lewisham Health Inequalities Review implementation board (BLACHIRIB) which was set up in November 2022 to provide system wide oversight of the implementation of recommendations from the Birmingham and Lewisham Health Inequalities Review (BLACHIR). The review highlighted systemic racial inequalities that impacted health outcomes and set out actionable opportunities to address these inequities.

1.2 Key to the approach of the BLACHIR Governance was working alongside community partners for the purposes of both accountability and delivery. This approach has evolved into the Deep Engagement Partner (DEP) programme where 17 communities of identity will be actively involved in a medium-term project with BCC focusing on improving health inequalities aligned to the Health and Wellbeing Board and integrating community organisations into Council and ICS governance structures.

1.3 Feedback from the Board and wider partners demonstrated a need to take the learning from BLACHIR and evolve the Board to support a wider range of communities of identity who are experiencing discrimination and systematic barriers to achieving good health and wellbeing. This aligns with the Vision and Principles of the Health and Wellbeing Board strategy, Creating a Bolder, Healthier City 2022-2030:

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

- Citizen-driven and informed by citizens' lived experience
- Consciously focused on reducing inequalities through promoting equality, diversity and inclusion

2. PURPOSE

2.1 The Communities and Health Partnership will be a new sub-committee of the of the Birmingham Health and Wellbeing Board (HWBB).

2.2 The purpose of the Forum and its members is to work together with different communities of identity to address health inequalities across Birmingham, and to empower community partners to lead community-based programmes with support from the wider system to improve health and ensure communities of identity voices are shaping public health services and strategies.

3. OBJECTIVES

The Forum will have the following overarching objectives:

3.1 Advocate for system-wide action to reduce inequalities and discrimination that affects communities of identity in our policies, structures and services.

3.2 To sustain the momentum and build on the progress made by the BLACHIB by continuing to oversee the implementation of the BLACHIR 7 key areas for action and interface with the BLACHIR ICS Taskforce to support the ongoing implementation of the 39 opportunities for action.

3.3 Embed learning from the BLACHIR programme work with community partners to move towards equal power sharing of health decisions impacting different communities of identity.

3.4 Build capacity and capability within the system and local communities to work together to improve population health.

3.5 Oversee and provide support to specific community lead projects delivered by the Deep Engagement partners via community collaboratives.

3.6 Build connections between different communities of identity to build social cohesion and cultural competence.

3.7 Actively work towards improving our collective understanding of the impacts of intersectionality on health.

3.8 Champion cultural competence and equity across the health and care system.

4. PRINCIPLES

The ways of working for Forum members is set out in the following principles:

4.1 The Forum will be more than an information sharing group – one that supports co-ordinated action to work towards better interconnectedness of communities to the health and care system in Birmingham.

4.2 The Forum will take recommendations both to and from the HWBB, with clear feedback from the HWBB regarding their actions to better creative public health provision across Birmingham.

4.3 Provide a Psychological safety blanket for community partners to facilitate the issues raised to be heard by HWB leaders.

4.4 Provide ongoing commitment to the ongoing implementation of BLACHIR by embedding learnings from the BLACHIR into policy to ensure multiple outcomes are met around tackling health inequalities among different communities of identity through strong, multi-sector strategic collaboration.

4.5 Consult and/or inform the Forum of organisational changes (including any changes in community representation) which may impact on collective working.

4.6 Ensure improvements to the public realm are central to our mission for minimising disparities in experienced health inequalities by different communities of identity.

4.7 Take a targeted approach to interventions throughout the life course by using data, intelligence, and insight to focus on geographies and communities with unmet needs or where inequalities exist.

4.8 Support a community centred approach to minimising disparities in experienced health inequalities and empower local people to lead, embedding the voice and influence of local people across the work of the forum.

4.9 Support activities that focus on early help and prevention and ensure interventions are tailored and person-centred.

4.10 Proactively manage risk and acknowledge the principle of shared risk in the context of partnership working.

4.11 Support a more sustainable, strategic, and joined up approach to the areas of evaluation, communication and funding opportunities.

5. MEMBERSHIP

5.1 The Forum will have a core group of organisations to enable that enables its residents to have accessible, available, adequate and sustainable creative activities that contribute to better public health.

5.2 The Forum requires its members to:

5.2.1 Attend all meetings, or in exceptional circumstances to arrange for a suitable named delegate to attend in their place. In case of delegating, the nominee should be appropriately briefed prior to attending the meeting and able to make decisions on behalf of the organisation they represent.

5.2.2 Represent the views of their organisation, to keep their organisation informed about progress and to communicate the outcomes of the Forum meetings to their organisations.

5.2.3 Ensure that there is prompt progress and delivery by their nominating body on any actions and strategies agreed by the Forum.

5.2.4 Have sufficient delegated authority to make decisions in relation to the implementation of BLACHIR on behalf of their organisation, where relevant, or be able to seek and secure them within timescales agreed by the Forum.

5.3 The membership of the Forum will be reviewed as necessary. New members may be admitted provided that:

5.3.1 Any such new member is able to demonstrate to the satisfaction of the Forum the contribution that they can make to the overriding aims and objectives; and

5.3.2 in deciding whether or not to admit any such new member the Board shall have regard to the resulting size and composition of the Board were the new member to be admitted.

5.3.3 They are temporary members and are co-opted at times for specific outcomes, tasks and capacity.

5.4 Other persons may attend meetings of the Forum with the agreement of the co-Chairs/ Deputy Chair.

5.5 The Chair(s) of the Forum will be the Birmingham City Council Cabinet Member for TBC and a community representative from one of the DEPs. The DEP co-chairing the Forum will be decided by:

5.5.1 Member of community volunteering to co-chair all Communities of Identity Forums in a given year, and

5.5.2 Community organisations who have received suitable community leadership training to ensure they possess the appropriate skillset necessary

5.6 Current Membership of the Forum is listed in the Table found in Appendix 1.

6. MEETINGS

6.1 The Forum will meet every three months for one and a half hours. Such other meetings may be held as necessary at the discretion of the co-Chairs or should commissioning decisions drive the agenda.

Commented [JF1]: Can we keep at 2 hours for continuity of BLACHIRIB?

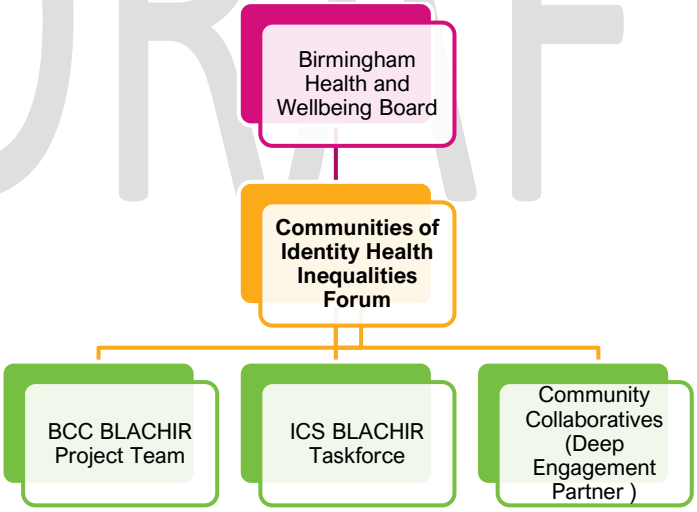
6.2 Members will be requested to contribute to a forward plan which will be used to develop the agenda for meeting.

6.3 The agenda for meetings, agreed by the co-Chairs, and all accompanying papers will be sent to members at least 5 working days before the meeting. Late agenda items and/or papers may be accepted in exceptional circumstances at the discretion of the co-Chairs.

6.4 Action notes of all meetings of the Forum (including a record of attendance and any conflicts of interest) will be approved and circulated within 10 working days and submitted for approval to the next appropriate meeting.

6.5 The Forum may establish task and finish groups and/or community collaboratives as agreed by the Forum Chairs.

6.6 The Forum's administrative support will be provided by the Public Health Division and they will be responsible for arranging and writing action for the meetings and disseminating supporting information to Forum Members.



7. COMMUNITY COLLABORATIVES

To support this the new forum, it is proposed to have delivery groups led by the deep engagement partners, supported by a commissioned academic partner and relevant health and care professionals to focus on community priorities within specific communities of identity (agreed between DEP, local communities and system partners).

Proposed purpose and objectives of these collaboratives:

- Working with local community and using Community Health Profiles to identify key health priorities for action
- Development of project plans – signed off by forum
- Co-design of interventions with local community of identity
- Implementation of projects
- Collect evidence to measure outputs and impacts of projects
- Support learning – capacity building of local community and health and care professionals.

8. DECISIONS

8.1 Recommendations and decisions will be arrived at by consensus and recorded in the action notes and a decision log.

8.2 Significant decisions and risks impacting on the progress of the Forum will be escalated to the HWBB.

9. CONFLICTS OF INTEREST

9.1 Whenever a representative has a conflict of interest in a matter to be decided at a meeting of the Forum, the representative concerned shall declare such interest at or before discussions begin on the matter, the co-Chairs shall record the interest in the minutes of the meeting and unless otherwise agreed by the Forum that representative shall take no part in the decision making process.

10. REVIEW

10.1 These terms of reference will be reviewed annually, considering views expressed by members.

Appendix 1: Communities of Identity Health Inequalities Forum Membership Table

Role within the Forum	Organisation/Team	Name
Co-Chair	Cllr, BCC	TBC
Co-Chair	Deep Engagement Partner, TBC	TBC
Deputy Chair	TBC	TBC
Director of Public Health	Public Health Division, BCC	Dr Justin Varney
Assistant Director of Public Health	Public Health Division, BCC	Helen Harrison
Public Health Service Lead	Public Health Division, BCC	Ricky Bhandal
Deputy Lead	Public Health Division, BCC	Jordan Francis
Delivery Group Lead (Caribbean Deep Engagement Partner)	Mindseye Development CIC	Michael Brown
Delivery Group Lead (African Deep Engagement Partner)	Ilera Health	Tunde Awe
Delivery Group Lead (Somali Deep Engagement Partner)	TBC	TBC
Delivery Group Lead (Pakistani Deep Engagement Partner)	TBC	TBC
Delivery Group Lead (Indian Deep Engagement Partner)	TBC	TBC
Delivery Group Lead (Bangladeshi Deep Engagement Partner)	TBC	TBC
Delivery Group Lead (Chinese Deep Engagement Partner)	Chinese Community Centre Birmingham	TBC
Delivery Group Lead (Polish Deep Engagement Partner)	TBC	TBC
Delivery Group Lead (Romanian Deep Engagement Partner)	TBC	TBC
Delivery Group Lead (Sikh and Christian Deep Engagement Partner)	Lifeline Community Project	TBC
Delivery Group Lead (Muslim Deep Engagement Partner)	Ashiana Community Project	TBC
Delivery Group Lead (Sexual Orientation and Gender Identity Deep Engagement Partner)	Birmingham LGBT Centre	TBC
Delivery Group Lead (d/Deaf Deep Engagement Partner)	BID Services	TBC

Delivery Group Lead (Sight Loss and Complex Disabilities Deep Engagement Partner)	Focus Birmingham	TBC
Clinical Representative	Birmingham and Solihull ICS BLACHIR Taskforce	TBC
Academic Representative		TBC
Academic Representative (BLACHIR PhD)	Newman University	TBC
National Health Representative	Department for Health and Social Care	TBC
National Equalities Representative	TBC	TBC
Other National Representatives (TBC)		TBC
Regional Voluntary, Community, Faith and Social Enterprise Representative	TBC	TBC
Regional Community Representative	TBC (West Midlands Combined Authority?)	TBC
Regional Community Representative	Faith Alliance Network	TBC
Regional Community Representative	Proud Rainbow City Partnership	TBC
Regional Community Representative	Birmingham North Locality Lead	
Regional Community Representative	Birmingham West Locality Lead	
Regional Community Representative	Birmingham Central Locality Lead	
Regional Community Representative	Birmingham South Locality Lead	
Regional Community Representative	ICS Lead	
Regional Community Representative	BVSC (role TBC)	TBC
Head of Adults Social Care	Adults Social Care, BCC	TBC
Regional Equalities Representatives	Asian and Allies Network, BCC	TBC
Regional Equalities Representatives	Corporate Black Workers' Support Group, BCC	TBC

Commented [HH2]: bvsc, locality leads, ICS lead

Commented [JF3R2]: Added, also feedback from new DEP to include Bolder Healthier Champions rep in membership

Regional Equalities Representatives	Disability Advisory Network, BCC	TBC
Regional Equalities Representatives	LGBT and Allies' Network, BCC	TBC
Community Engagement Representative	Lead Officer for the Bolder, Healthier, Champions Programme	TBC
Other (TBC)	TBC	TBC

Birmingham Ageing Well Strategy Steering Group

Terms of Reference

Version	**V0.1**
Last review date	
Next review date	

1. Background

This group has been established oversee delivery of a systemwide Birmingham Ageing Well Strategy, which will be led and chaired by the Service Lead for the Older People Team within Public Health.

The initial drivers for the creation of a strategy are twofold.

1. The publication of the Chief Medical Officer (CMO)'s Annual Report 2023: Health in an Ageing Society. The focus of the report by the CMO, Professor Chris Whitty, is how to maximise the independence, and minimise the time in ill health, between people in England reaching older age and the end of their life.

   The report detailed 13 core areas from a national perspective, which the Older People team reviewed through a local lens to better understand if and how they are applicable to Birmingham, and what actions could be taken against the recommendations at a city level.

2. The findings of the DPH Annual Report to be published in 2024, which focused on the differences between demographics captured in 2011 census data and 2021 census data, particularly within the city of Birmingham.

   The report clearly highlights that, while Birmingham is still considered a "young" city by population proportionate measures, that the size of the Birmingham population as a whole means that the count of older people within the city is substantial. It also highlighted that the city is, overall, older between the two censuses, and that this trend is likely to increase. Most notably there is a pronounced bulge in the population pyramids presented around those approaching retirement age.

2. Purpose

The purpose of the Ageing Well Strategy Steering Group is to plan, develop and oversee the implementation a Birmingham Ageing Well Strategy focuses on the following six core pillars, each with a chapter devoted to them:

- Dementias and Neuro-degenerative Diseases (e.g. – Parkinsons)
- Prevention of frailty
- Loneliness / Living Alone
- Preparation for older age / retirement
- End of Life
- Wider Determinants of Health

The core of the strategy will fall within these six pillars and be targeted at 50-70 year old populations (those approaching or entering retirement age) as this will allow for primary upstream Public Health interventions to take place.

The Wider Determinants of Health pillar will include factors more associated with the older demographic such as underoccupancy, unemployment / retirement, caring responsibilities (including working carers), mobility and travel, financial security,

There will also be a section on "Additional factors for older people". This will touch on those areas that, whilst important, are not the main focus in the strategy as they are associated with the full life course. This is being included as there can be some unique challenges for older demographics. Initial suggestions for this inclusion under this heading are (not an exhaustive list) – mental health, sexual health and physical activity.

The proposed structure would include:

- A brief introduction to the strategy
- A chapter on each of the core pillars indicating the current position, the intended future position, evidence base, and opportunities for action to move from one state to the other and key outcome or success measures.
- Smaller chapters on the "additional factors for older people", potentially combined where appropriate if the wider determinant drivers and / or opportunities for action are the same.

A summary and a call to action for those within the system able to deliver on the opportunities for action.

3. Steering Group Objectives

Immediate Priority - Create task and finish groups based around the pillars of the strategy.

Short Term - Task and finish groups to populate framework for collation by Steering Group by end of October 2024.

Medium Term – to consult with wider stakeholders and citizens by end of December 2024.

Long Term – to steer the strategy through the necessary governance to enable delivery by end of March 2025.

4. Membership

The following organisations will be represented on the Steering Group:

- Birmingham City Council (Public Health)
- BSol ICS
- Birmingham City Council (Adult Social Care)

- TBC?

Name	Position	Organisation

5. Steering Group Requirements

- Each representative will nominate a suitable deputy in the event of unavoidable absence.
- Each representative will establish mechanisms to work with their own organisation to ensure that there is a two-way flow of communication. They will represent the views and needs of that organisation as well as keep them informed of the activities of the Steering Group.
- Members will declare any outside interests on joining the Steering Group. The Register of Interests will be held and regularly reviewed by the chair.
- The Steering Group creates a forum where members can advocate internally between partner organisations. Members should use their access to strategic forums and to senior regional and national leadership for upward advocacy.

6. Meeting Frequency & Arrangements

- Frequency of meetings will be determined by the group (dates and locations to be confirmed by Birmingham Public Health).
- The expectation that these will be on a monthly basis unless otherwise stated.
- Meetings to follow an agenda as agreed by the group.
- Birmingham Public Health to lead on the coordination of the meeting.
- The group will be chaired either by the Service Lead for Older People from Birmingham Public Health or the Assistant Director of Public Health (Adults and Older People) or by
- A co-chair may be nominated from a different stakeholder organisation.
- Group membership and group meetings will be managed by the group, new additions to the group invited and recruited in agreement with the group.

7. Governance and Reporting

The Steering Group will report to <?? HWBB, ASC / PH SMT??>