BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 19 JANUARY 2021 AT 15:00 HOURS
IN ON-LINE MEETING, MICROSOFT TEAMS

A G E N D A

1 NOTICE OF RECORDING/WEBCAST

The Chairman to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

2 DECLARATIONS OF INTERESTS

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

3 APOLOGIES

To receive any apologies.

4 EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC

a) To highlight reports or appendices which officers have identified as containing exempt information within the meaning of Section 100I of the Local Government Act 1972, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report.
b) To formally pass the following resolution:-
RESOLVED – That, in accordance with Regulation 4 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of those parts of the agenda designated as exempt on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information.

5   **MINUTES AND MATTERS ARISING (15:00 - 15:05)**

To confirm the Minutes of the meeting held on the 24 November 2020.

6   **ACTION LOG (15:05 - 15:10)**

 To confirm the action log as current and correct and address any issues.

7   **CHAIR'S UPDATE**

To receive an oral update.

8   **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.
**The deadline for receipt of public questions is 5pm on 15 January 2021. Lines of questioning should be submitted via:-
https://www.birminghambeheard.org.uk/place/birmingham-health-andwellbeing-board-questions.**
(No persons may submit more than one question)
Questions will be addressed in correlation to the agenda items and within the timescale allocated. This will be included in the broadcast via the Council's Internet site (www.civico.net/birmingham).
NB: The questions and answers will not be reproduced in the minutes.

9   **CORONAVIRUS-19 POSITION STATEMENT (15:15-15:25)**

Justin Varney, Director of Public Health

10   **CORONAVIRUS-19 VACCINE UPDATE (15:25 - 15:35)**

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG

11   **BIRMINGHAM AND LEWISHAM AFRICAN CARIBBEAN HEALTH INEQUALITIES REVIEW (15:35 - 15:45)**

Justin Varney, Director of Public Health

12   **WORKING TOGETHER FOR A HEALTHIER POST COVID FUTURE (15:45 - 16:00)**

Lucy Heath, Healthy Futures, Black Country and West Birmingham

21 **OTHER URGENT BUSINESS**

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

22 **DATE, TIME AND VENUE OF NEXT MEETING**

To note that the next Birmingham Health and Wellbeing Board meeting will be held at 1500 hours on Tuesday 16 March 2021 as an online meeting.

BIRMINGHAM CITY COUNCIL

> **BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 24 NOVEMBER 2020**

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 24 NOVEMBER 2020 AT 1500 HOURS AS AN ONLINE MEETING

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Chair of Birmingham Health and Wellbeing Board
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Professor Graeme Betts, Director for Adult Social Care and Health Directorate
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Andy Cave, Chief Executive, Healthwatch Birmingham
Andy Couldrick, Chief Executive, Birmingham Children's Trust
Mark Garrick, Director of Strategy and Quality Development, UHB
Chief Superintendent Stephen Graham, West Midlands Police
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Nichola Jones, Assistant Director, Inclusion and SEND, Education and Skills
Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust
Professor Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Waheed Saleem, Birmingham and Solihull Mental Health Trust
Stan Silverman, NHS Birmingham and Solihull CCG
Gaynor Smith, Senior Employer and Partnership Leader, Birmingham and Solihull District, Department for Work and Pensions
Dr Ian Sykes, Sandwell and West Birmingham CCG
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Brian Carr, BVSC
Joanne Carney, Director of Joint Commissioning, NHS Birmingham and Solihull CCG
Andrew Dalton, Screening and Immunisation Lead, Public Health England
Carol Herity, NHS Birmingham and Solihull CCG
Elaine Kirwan, Women's and Children's NHS Foundation Trust
Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs
Patrick Nyarumbu,
John Williams, Assistant Director, Adult Social Care
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

491   The Chair advised, and the Committee noted, that this meeting would be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

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DECLARATIONS OF INTERESTS

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

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APOLOGIES

493   Apologies for absence were submitted on behalf of Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG (but Stan Silverman as substitute); Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust Peter Richmond, Chief Executive, Birmingham Social Housing Partnership; Stephen Raybould, Programmes Director, Ageing Better, BVSC (but Brian Carr as substitute).

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EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC

Members highlighted the following report and appendix which officers had identified as containing exempt information within the meaning of Section 100I of the Local Government Act 1972, and where officers considered that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report:

494   **RESOLVED:**

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

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MINUTES AND MATTERS ARISING

It was noted that Stan Silverman, NHS Birmingham and Solihull CCG was not being recorded as being present at the meeting.

495   **RESOLVED: -**

That subject to the above amendment, the Minutes of the meeting held on 22 September 2020, having been previously circulated, were confirmed.

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ACTION LOG

The following Action Log was submitted:-

(See document No. 1)

Dr Justin Varney, Director of Public Health introduced the item and advised that there were no outstanding actions on the Action Log.

496   **RESOLVED: -**

The Board noted the information.

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CHAIR'S UPDATE

497   The Chair welcomed everyone to the Health and Wellbeing Board meeting and commented that we all continue to work in unprecedented times but we had some good news on the vaccines and many of you here today will be involved in ensuring the rollout within our communities.   The pressures within the system remain and as we as a nation move out of lockdown next week, we will learn more about what Tier we will be placed in. But the message had to be we had a long way to go and we need to remain vigilant – Christmas this year definitely needed to be subdued and our message will remain that we need to remain careful and maintain social distancing.

The Chair highlighted that last week she attended a virtual Tri-city event with our partner cities in Chicago and Hamburg this year the focus was on the Impact of Social Work Practice on Mental Health and Social Justice. This year the conference would have been hosted by Chicago but instead like everything this year was hosted online via zoom.

It was interesting to hear the struggles that we have collectively been through with COVID-19 that had put an enormous strain on all social and health care structures. People have lost their loved ones; people have lost their jobs and their economic supports; people were angry and isolated. Young people have lost their parents and relatives; many have lost their jobs and their economic supports; youth are angry, socially frustrated and isolated. Our conversations had reflected the many conversations we have had here on mental health seeking to examine how social work practitioners were able to engage with

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individuals and families to support the improvement of their mental health and response to the socio/emotional crises.

Covid we sometimes could forget was a worldwide pandemic. One of the workshops also focused on something that we have been grappling with for years but following some of the events that had taken place in recent months been brought very much to the forefront - Social inequality and injustice as this had long been a feature of American and European societies. BAME communities had always been disproportionately poor and overrepresented in prison populations. We have seen a strong social movement for systemic change and racial justice worldwide. It was an interesting programme and it was always good to hear and share our different approaches and practices.

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PUBLIC QUESTIONS

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

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CORONAVIRUS-19 POSITION STATEMENT

499   Dr Justin Varney, Director of Public Health introduced the item and advised that he would not be doing an in depth briefing as there was a Local Covid Outbreak Engagement Board meeting on Thursday 26 November 2020, when he would go in detail the profile of the current data on the coronavirus situation.

Dr Varney highlighted the most recent full dataset showing that the case rate within the 7 days up to the 18th November 2020 was 368.1 cases per 100,000 population. This was a reduction of 8.2% compared to the case rate in the previous 7 days. This was the very early signs that lockdown had started to reduced case numbers but we were yet to see that sustained over several days. What we would like to see was for that pattern to continue for at least a week before we could be confident that we were on a downward trend. We had seen in terms of the pattern of the outbreak that we continued to see that the majority of cases in people aged 20 through to aged 59. As a case rate that rate was highest in our aged 30 to 44 year olds at a rate of 459 cases per 100,000 population.

Sadly we were continuing to see a slow but steady increase in the over 65s population and the case rate in that age group was now up to 302 cases per 100,000 population. As we saw case rates rose in the over 65s, that was followed by an increase in hospitalisations and sadly still by an increase in deaths. Looking at the data we had on ethnicity our white community accounted for 42% of positive cases over the last six weeks and within the last week consistently between 40 and 45%. Our second largest ethnic group was the Pakistani community which ranged between 24% and 28% over the last 6 weeks and then that was followed by our other Asian communities between 9% - 10% and our Black communities between 5% - 7%. This had been a consistent picture now over the last 6 – 8 weeks.

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In terms of the geographical distribution across the city we had seen some change in terms of case rates in different areas. Some of this reflected specific outbreaks as we had seen increases in areas like Sutton Wylde Green which linked to a cluster of cases in a care home. We persistently saw areas like Lozells, Aston, Alum Rock, Sparkhill, Bromford and Hodge Hill, Handsworth Wood and Heartlands remained in the top 10 case rates across the city. Sadly we have not seen them come down, but there were some hopeful signs that some of these areas had stopped increasing significantly. We were yet to see any of those in the top 10 group started to show a reduction. Across the majority of the city it was seen that case rates had stabilised and very few areas had started to come down significantly.

In terms of where we were going as was alluded to, we will find out on Thursday the position in relation to the national Tiering system which would depend on the data on the day. The national government was reviewing the data on a daily basis and would made a judgment on the latest possible data. We had seen the signs that the restriction the city had been under had worked and was showing that case rates had started to declined, but it was early days. In order to give the NHS the best chance of facing the winter pressures and minimising the burden of Covid we all had to play our role over the coming weeks and months to limit the spread of the virus across Birmingham and ultimately saved lives.

The Chair commented that with regard to the vaccine that it was known that there had been some apprehension amongst the ethnic minority groups people were apprehensive about taking the vaccine. The Chair enquired what the advice would be.

Dr Varney advised that vaccinations had been used over the last 100 years to eradicate serious diseases such as polio and small pox to drove down diseases that caused disability and death like Measles, Mumps and Rubella (MMR) and diseases like tetanus. As a society it was known that vaccination was safe and was probably the most successful Public Health intervention after sanitation and clean water. We needed to have confidence in it as it was an important part of trying to get back to a more normal society. The vaccines were going through and completing their clinical trials. These looked at the safety of them, the safety in different age groups and in different types of people. They also looked at their effectiveness in different age groups in different types of people and we were fortunate that several different vaccines which worked in slightly different ways were all showing to be effective.

The NHS was working to look at how to roll out those vaccines and who gets the which type of vaccine. This would depend on the Independent Regulator and some of what they had stated were conditions of the vaccine use. It was sad that people were peddling fake news when it came to vaccines and people attaching their existing conspiracy theories to vaccines. It was known that everyday across the world vaccines in different forms protected us from different diseases and fundamentally saved lives.

In Birmingham, Covid had cost us over 1500 people's lives. Dr Varney stated that he did not want to see another 1500 people because people did not want to take the vaccine that was safe. We needed to keep at the heart of that taking

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the vaccine was about protecting yourself, but it was also about protecting the people that you love. It was about stopping you from being able to carry and share this virus with other people. We all had a responsibility to step up to control the spread of Covid, not just for the city but fundamentally protecting the people that we love and care about.

Stan Silverman commented that he was in agreement with Dr Varney's comments concerning fake news and the anti-vaccine movement. We needed to be aware that the vaccination immunisation rate in Birmingham were lower than in the country as a whole. Hope was one thing, but we needed to think about what actions could be taken to reassure people about the safety and to persuade people to engage in the vaccination programme when it was rolled out. If not, as Dr Varney had stated there would be more lives lost.

Dr Manir Aslam stated that he was reflecting on how the Chair started her update which was 'this was a worldwide problem' and everybody was jostling with the same conundrum. We had the ability to look around the world to see how people were prioritising who got this vaccine. Luckily, there three vaccines that had shown to be quite efficacious. We had a robust scientific community here that enabled us to be reassured that the vaccine that came to us had gone through the appropriate process in terms of the trials and the regulatory process which people should be reassured by. We will jostle around who we needed to vaccinate and in which order and we had an idea as we had been vaccinating people for flu for many years, so we had an idea of who to vaccinate and how to get the best value out of the vaccine.

People would be anxious about a new vaccine and he understood that, but we had a good scientific community that would look at this. The Regulator would not approve a vaccine that was unsafe. Our health care community would be one of the first group of people that we would want to vaccinate to protect the NHS. Vaccinations were something we had been using in our communities for a long time as stated earlier by Dr Varney and had proven to be a great benefit.

Dr Ian Sykes stated that he fully endorsed all that had been said by Dr Varney and Dr Aslam and that he fully support the vaccine. He added that when it was his turn he would be queuing up as one of the people to have it. Dr Sykes stated that we must not forget the flu immunisation as we did not want to have a flu epidemic as it was thought that if you got Covid and flu together the outcome was likely to be much more severe. Well over 30% of our over 65s who had been vulnerable had still not yet had their flu immunisations. Dr Sykes also reminded who were eligible to get their flu immunisation as soon as possible. The GPs were probably able to do that and our pharmacies. It was important that people got the flu vaccine done as there had to be at least a week's gap between the flu vaccine and the Covid vaccine and it was important to get that done.

Paul Jennings commented that he was in agreement with everything that the doctors had said. He added that he was over 65 and had had the flu jab. He further added that he recalled that as a child he was shut in his bedroom whilst he and his sister recovered from measles. He stated that his father was affected by Small Pox. It was unimaginable to him that we could do anything other than embrace the technology and the innovation that enabled us to fight

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back against the disease. Immunisation as Dr Varney had stated after sanitation was the single strongest disarming weapon that we had in our Public Health armoury. Like Dr Sykes he would be in the right place in the queue when his turn comes.

As part of the vaccine programme, we had been preparing for some weeks, one of the things they were given were a set of priority order in which to work through with individuals. In this country we would be immunising on the basis of the risk criteria that we had used for flu as Dr Aslam had stated. We would begin by trying to protect our workforce, our health and our care workers as it was known that they could transmit it to those they were caring for and could be an important vector and we needed to slow that down. We would then move to vaccination the over 80s in the care homes and the nursing homes and working back up through the risk profile. To some extend this was dependent upon the rate at which the vaccine flow and which vaccine was available.

The Pfizer vaccine that came first was a bit more complicated to handle as it had to be stored at -70 degree Centigrade. The Oxford vaccine to come it was hoped a little later on the back of that which would be kept in the fridge one as the flu vaccine and it was easier to use. There was a massive campaign being prepared embracing Primary Care and a whole army of people that would be recruited to carry out the immunisation process, embracing secondary care and hospital providers. This was a single biggest logistic public health challenge we had ever faced. That he sat along the daily briefing call out for the vaccine programme and it was a meeting that was marked by absolute dedication and enthusiasm from a bunch of people who were going to do wonderful things.

The Chair commented that she had had her fears because when they talked about the most vulnerable groups, but for all the reasons that had been stated here today. It was important that we stopped thinking like that and start to embrace the fact that this was the gravest public health issues we have had during our life time and that it was hoped that we would not see this again. The Chair impressed on the different communities that they listen to what was being stated as the information would be clear, concise and to the point. The Chair further urged the public not to think that the vaccine was unsafe as Dr Manir had stated that there was no way anyone would give you a vaccine that was unsafe. As someone who was of a certain age she was around when people were dying from mumps and that she was hospitalised for a month with mumps. The Chair highlighted that she did not want to see anyone going through any illness that they did not have to go through.

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CHILDHOOD IMMUNISATIONS AND VACCINATIONS

Andrew Dalton, Screening and Immunisation Lead, Public Health England introduced the item and drew the attention of the Board to the information contained in the report.

(See document No. 2)

Members of the Board then commented on and raised a number of questions concerning the report.

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Dr Manir Aslam stated that the data in the pack did not include the West Birmingham data and that Pip Mayo had kindly collected some of the West Birmingham data. Just to reassure that Board.

The Chair interjected that she was told this and that she had since gone back to Public Health and enquired about this. She stated that this was not the case, but could she be told she was wrong.

Dr Aslam stated that the West Birmingham Primary Care Network (PCN) was included on page 4 of the report but that this was a small PCN and was one of the five PCNs that were in West Birmingham. He assured the Board that they were 88%, but there were 96% of the vaccination. Dr Aslam enquired what data was being used. MMR vaccinations were slightly less, but there were about 88%, but we had taken a view that we were going to prioritise this area over the next six months alongside all of the other vaccination programme including the flu and Covid vaccinations but not to take our eyes off the fact that there were 60 children within West Birmingham that had not been vaccinated with MMR.

We will focus the PCN attention on those areas. With the support of NHS England and the support they give and for all of the things raised by Councillor Bennett and about how they could prioritise and identified the children that were not getting vaccinated and the reasons for that. There was a data issue and it was hoped that colleagues from NHS England would pick up why there was a data issue. Ultimately, he believed with Councillor Bennett that if it was not known what the scale of the problem was then they could not come up with the problem to solve that. Dr Aslam assured the Board that West Birmingham was in a good place and would focus their attention on the bits that were inadequate.

The Chair referred to Mr Dalton's comments about some of the reasons Birmingham had lower levels, but compared to places like Leicester that had a high proportion of ethnic minorities in the east of the city, different parts in London and how we were in comparison to those bits of the system. The Chair commented that nationally, Birmingham was below, and enquired what these areas were doing that Birmingham was not doing. The Chair expressed shock that Northfield and Bournville were also in that hotspot. The Chair enquired what the reasons were for them to be in that hotspot, whether it was the way the coverage was done. With regard to the Oversight Group, it was noted that Public Health Birmingham was not included and whether she had misread the information.

In response to questions and comments, Mr Dalton made the following statements:-

1. Firstly the Chair's questions, in terms of other Big cities, they had broadly similar picture in some of those specific areas and in Leicester, there were similarities.
2. In terms of learning from elsewhere, it was thought that one of the schemes that we had rolled out here, which we could not take credit for inventing.

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3. The project Health Under Immunise was taken from Manchester – the inner city regions of Manchester – this was taken from there as ideas that worked well.
4. In terms of the West Birmingham PCN, Mr Dalton expressed his apologies as this was his oversight as this was data he had put together for the Board and that he could add the information to the table if it helped.
5. Concerning the data issues and its source, it was from the routinely published on the Government's website. It was not extracted but was covered data brought together.
6. In terms of the data issues we had some small geography data that was publicly available at General Practice level. Every General Practice uptake was online and that was just over a quarter and this was had for June.
7. The reason this was not presented to the Board was that a list of GPs names did not meant a lot to anybody. Mr Dalton added that this was the reason he tried to made it into a meaningful geography by PCNs.
8. There were data and there were some issues with data and how timely it was. Part of the problem with that was the nature of immunisations – a child had up to a certain age to get immunisation.
9. As there were children of the same year cohort, it was needed to wait until the end of the year to do a stock take to get the coverage in that school year to get a full cross section. This was some of the reasons there were issues with data being timely.
10. In terms of learning from other areas and what worked elsewhere and what were the underlying reasons people might not attend, Public Health England (PHE) did a national survey to find out why people were not attending. It was all well and good that a perceived type of persons were not attending, but we needed to ascertain why. We used some of that insight into GPs intervention.
11. The anti-vaccine always comes up from the last few national insight pieces of work that as a fact but it was not the biggest factor. The real biggest single thing was the physical access to a location to get vaccinated.
12. Anti-vaccine was an important thing to address and this was why in terms of getting the GPs to remind their patients of getting the vaccine that gets them to a venue and then possible some more work around availability.
13. In terms of Northfield, this was a surprised to him and it was unsure why this stood out. Perhaps there was something else going on, but there were some evidence that there were anti-vaccine which was affecting populations that we might expect which was a possibility. However more work was needed concerning this issue.
14. In terms of the Oversight Group it was uncertain why they were not included. Mr Dalton invited comments from the CCG groups concerning the issue and that he could also enquire of colleagues and then feedback the information to the Chair.

Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs made the following statements:-

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a. The data from West Birmingham PCN would be shared with Mr Dalton so that they could be added to the table. One of the things that she did this morning was that they had the breakdown at a practice level and it could be seen that there were some variance with some practices doing fairly well and a couple hitting the 100% mark whilst others were not doing so well.

b. That she had spoken to some of those who were doing well to try and work out what the difference was. Interestingly a lot of it came down to a proactive and persistent approach from the GP practice. Some were saying that instead of waiting until the child turned up for their immunisation to contact them, they were doing a forward search and inviting people to come in.

c. They were working closely with the health visiting team in the city so that if a child did not come in for their immunisation, they would inform the Health Visitor who would then pick up the conversation around it. One of the other things she had asked this morning was on the question as to the reasons people did not want to come.

d. Some of the parents who were resistant when they were contacted, we were going to see if one or two of them would like to have a more detailed conversation with us about why that was so that we could try and get behind it to understand their reasons for their reticence as it was important to get a sense of that. There were some tools that some of our practices were using around this persistent approach which was paying off and she was happy to share that information as part of the report.

Mr Richard Kirby commented that as Ms Mayo had stated about the partnership between the health visiting team and the Birmingham Forward Steps Universal Service and General Practice played an important role. The next steps on our improvement work in that area was to focus on the two year review which was important in the immunisation process. We had that in pour sight and over the next three years and six months. The Schools Immunisation Service we were responsible for were working through both this year's cohort and the backlog for the period when schools were closed during the first wave of the coronavirus. We were broadly where we said we would be at that with those cohorts actually … with that work and either teams working really hard. We will be working with the School Age Service and the Visiting and Forward Steps Team on the two years' service in partnership with GPS so that we could do our bit on this important issue.

Councillor Bennett enquired about the data – the data in the report was not necessarily the most accurate or consistent – but from what was stated it sounded like there was available quarterly to almost real time information at a practice level where they could be aggregated up to whatever geographical unit that was necessary. In terms of the Strategic Oversight Group, that had access to that information so they could see exactly how things were going. The other point was the evaluation of those two services, when the reports would be done and what the benchmark for success was.

Mr Jennings advised that Chris Baggott from Public Health, Birmingham City Council attends the group.

Mr Dalton noted Councillor Bennetts query concerning data and advised that these were publicly available data from the groups that met and the CCGs always had access to that information. This was aggregated to a different level to get something more geographically meaningful from the practice.

The Chair commented that this all sounded good, but for her sitting here perhaps she was not a novice, but it did not seem joined up. It still seemed a bit disjointed to her. If you started off with the premise that you were unsure about the data you were dealing with then everything else seemed to be built on sand. When she saw in the report that Northfield and Bournville - and she understood the reasons given that for Northfield and Bournville their figures were not where they should be, the question was what strong message was being given out by Primary Care and other to encourage people to take up the test. The Chair further questioned what joined up work was being done to ensured that people that feared was being talked about from when they first became pregnant or even before then when they were going into schools as tis appeared disjointed. If there was a couple who had strong views, if we were then waiting until they had the baby to then try to do something that they had views about since they were at school, this was a bit late.

Mr Kirby commented that it was more joined up than perhaps the impression they were giving. Between the Universal Early Years' Service, the health visitors and the teams we worked with and the GPs, the system of new birth visits and regular checks gave the right professionals the opportunity to talk to mums and dads about getting their child vaccinated alongside the work that GPs were doing backed up by the Child Health Information Scheme chasing up parents who might not have brought their children for vaccination. There was a clear model of joined up work and in some cases, there were a model work to do to ensure all of these messages result in changes in behaviour. We had the right joined up model at the PCN level that we talked about in some parts of the city where there was more to do that could help us in what we had to do next. The joining up in General Practice be those Early Years' Service and the Child Health Information Service was there and gave us the platform we need to build this on.

In terms of time scale on the one level every year they had to go at. The bit we were working at was getting the two year check that the Health Visiting Service needed up to the level it needed to be at which include the conversation about vaccination within the next three to six months. It was hoped that this would be about six months that the checks would be happening at the level that they needed to be at which should have some impact on the immunisation rate as well as a series of other things.

Mr Dalton commented that we were more joined up than he had credited us for. He apologised for this and added that with the data it may have been confusing by trying to present something a little bit more. In terms of the day to day work thee were the general practice data at the general practice level. From an operational point of view, he along with the CCGs and health visiting colleagues could work together at a practice level to with those practice that was showing concerns.

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Dr Aslam stated that West Birmingham needed to be included in those conversations around Birmingham so that it could be brought back to this Board the improvement to the immunisation service.

500   **RESOLVED: -**

The Board

    i.   Noted the work that partners are doing together to improve quality and ensure that the borough is well protected against vaccine preventable diseases.

    ii.   The Board supported the work that all partners are carrying out, where they can such as the leadership of the health promotion and community enjoyment role of the Local Authority

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IMPACT OF COVID-19 ON VULNERABLE ADULTS

John Williams, Assistant Director, Adult Social Care introduced the item and advised that the report presented to the Board was a collaboration with Adult Social Care and the CCG which was done a partnership basis. He added that a similar report was taken to the Safeguarding Board as they were keen to see was being done with our vulnerable citizens.

(See document No. 3)

Mr Williams then drew the attention of the Board to the information contained in the report.

The Chair commented that for her the issue was whether we had learnt the lessons from the first time round so that it could be ensured that people with Learning Disabilities were engaged quicker that we did the first time round. In April it was known that there was an issue in this area that she had raised at a number of different platforms but at the time it was ignored. The Chair added that going forward she would like some robust feedback about what was being done and about was being planned to ensure we identified these people early.

Professor Graeme Betts, Director for Adult Social Care and Health Directorate commented that it was more about May and June when we began to see the evidence came through about the impact of Covid-19. This was when we first began to see the data supporting the fact that the death was eleven times higher for some people with disabilities When we began to see these figures that was when we began to embarked on a process of engagement with citizens, staff and our partners to see what we could do to ensure we did not got back into that position. The way we tried to respond to that in terms of a broader strategic approach to the division where we put in place the issue of social injustice and recognising the impact both on citizens with Covid-19 and upon our staff. There was a causal relationship between the two. A lot of what Mr Williams had outlined was now trying to give that reassurance that we were working with our partners so that we did not got caught out in the way we were by some of those earlier issues not contacting people and not getting PPE out as quickly as we needed to and so forth.

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Professor Betts commented that he would never be foolish to say that they had everything sorted, but that they were in a far better position than where they were back in May. As a partner and a system we were working much closer to ensure we mitigate as far as possible the dreadful impact of the disease on people with disabilities.

Brian Carr, BVSC made the following comments: -

i. That he had recognised much of what Mr Williams had stated and that he concurred with Professor Betts. We were working in Birmingham in the voluntary sector for a number of years and obviously this was very unusual. But, the level of connectivity and collaboration between the sector and the public sector in responding to the needs as they arose at that unprecedented level.

ii. The challenge now was going to be how we kept that going as we moved into different parts of the process and the pandemic. The important thing was keeping those links going and from BVSC view point what we were doing was keeping our Covid-19 support from partnership which was the network we pulled together to help us respond to this. We were keeping this in place as it was not going anywhere and we will continue to work with our public sector partners.

iii. Mr Carr drew the attention of the Board to a new report that was published by BVSC – The State of the Sector Survey. This was a survey of the voluntary sector in Birmingham that had looked at the impact of Covid-19 on the whole for the voluntary sector and its beneficiaries.

iv. The respondents were drawn from a full range of voluntary groups in the city from the largest to the smallest. It covered all areas of the city and it covered organisations that had been in all service areas including a significant proportion who were active in health and wellbeing.

v. In line with the demographics of sector in Birmingham, most of the response was from small groups with fewer than 12 staff and an annual turnover of less that £100k as that was what most voluntary groups in Birmingham were, generally small.

vi. A significant proportion of them were of course groups that were minority ethnic led groups or serving groups. Mr Carr undertook to put a link in the chat which summarises the findings and in that would be the link to the full report.

Mr Carr highlighted that there were a couple of key messages that was relevant to this Board:-

a) The first was not surprising i.e. the voluntary sector was an essential part of the initial response to the pandemic and its ongoing response. Overall the sector had demonstrated considerable resoluteness and robustness in working with public sector partners in this initial wave.

b) What we were seeing now were some significant negative impact on the sector's infrastructure. That was going to be important to keep an eye on as we move forward in terms of collaboration as it would impact on some organisations ability to deliver their services particularly in the remote way, they had to do it at the moment.

c) 25% of our respondents were unsure if they would survive the year. 20% had already made or will be making redundancies; 56% had lost income

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directly as a result of the pandemic; 33% thought that their income was going to continue to fall into the next year.

d) We should not underestimate this and how it would reshape the landscape of community and voluntary sector in the city. Most of them were small organisations as stated earlier and these organisations were involved in preventative services, early intervention services also rehabilitation – things like home from home – hospital support etc. that fed into the theme of this meeting.

e) There were some keen health and wellbeing messages that were coming from the sector and this was what they were hearing from their beneficiaries. They were raising issues of rising mental health a detrimental impact on health more generally particularly in vulnerable and isolated communities as the very necessary restrictions were keeping people apart which had an impact on wellbeing.

f) Increases in domestic violence, potential increase in food poverty although we had not seen the kind of impact there which we might have done which speaks to the robustness of the food networks we had in the city and had been working since the beginning of the process.

g) The final issue was digital exclusion and one of the things we tried to do when Covid-19 first came to mitigate against isolation was to make sure that people were connected digitally.

h) Some people were not connected digitally and not everyone was able to access online support and we saw particularly the deaf community and, in some respect, other disabilities and learning disabilities were particularly excluded if they did not have advocacy support.

i) If those organisation that were helping support those communities were at risk, then those communities were at increased risk.

j) In Birmingham the sector was strong and resolute and, in many ways, robust but it had had the impact of Covid-19 so as things progressed, we were going to find it a different sector that we were dealing with. We needed to be mindful of that as we continue to stay connected and collaborative.

Joanne Carney, Director of Joint Commissioning, NHS Birmingham and Solihull CCG made the following statements: -

1) The points made by Mr Carr about how important the voluntary and Third sector had been. We could not have developed the offer that we had and from a mental health perspective without the support and the mobilisation from the Third Sector mental health providers.

2) They were tremendous in terms of how they mobilised. Going back to Mr Williams point in terms of the learning from that first wave, we were still learning, we were still getting to grips with and coming to terms with the impact through this period.

3) We had worked through the CCG with all of our providers to review their risk assessment frameworks and their early warning frameworks and traffic lighting around those individuals we were concerned about in the system to ensure we were getting help and support out to them.

4) The final point was how important our collective workforce was here across health and care, across primary care and across the Third sector. We had just had a successful bid through the STP in terms of establishing a mental health and wellbeing hub for our collective

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workforce, really thinking about psychological workforce as we knew that well staff provided good services for our citizens and our patients. This was something that would be welcomed across the city and Solihull.

The Chair enquired what work was being done when people became anxious especially from this Group, we were ensuring that they were picked up before it got worst, before it moved from anxiety to something else.

Ms Carney advised that there were a number of factors there not least in terms of the ongoing carers and clinicians that were involved with individuals in terms of recognising what people's triggers were, and recognising what behaviours they displayed. What we had also put in place was a 24 hour seven days per week mental health access line that had multiple facets to it. It supports people in crisis, but it also supports individuals who were feeling lonely and anxious, stressed, isolated and may require a lower lever or a higher level of psychological support. There were multiple pathways that sat behind that in terms of those that may have been impacted or affected by suicide. Pathways for children and young people specifically and bespoke culturally competent pathways for our BAME communities and also pathways for key workers as well.

Councillor Bennett commented that at one point during the pandemic we had day care centres closed but in other parts of the country they were reopening and we made provision not to. This was not saying that our decision was wrong, but if that was the correct reasons as we had been in and out of Tiers etc. Councillor Bennett stated that he just wanted to understand if that did happen in other local authorities what that experience was. Councillor Bennett stated that his second question related to page 3 of the report *The LeDeR multi agency panel highlighted four key areas of consideration* but only three were listed. He added that he did not heard how that applied or what was being done to address those things in Birmingham. It was known that this was a national report but if there were issues in Birmingham what was being done about them.

Andy Cave, Chief Executive Healthwatch Birmingham referred to page 5 of the report – the impact that Covid-19 had on carers – and what the long-term care package available for carers in addition to day services etc. and what the care package looked like.

Professor Betts noted Councillor Bennett's queries and advised that day centres were reopened across the country but this was patchy. What we did through ADASS our professional network we checked to see what was happening across the country. Generally it was places with rural areas with lower numbers and lower infection rates that were reopening the services not always the case but was generally the case. Another thing that did happen was that a number of authorities reopened their day centres and then had to closed again as infection rates rose. It was very patchy across the country. Another point was our carers and Gordon Strachan had written to members of the health and wellbeing boards about the support for carers that were in place which was a thorough approach.

Mr Williams advised that in relation to *The LeDeR* there was an impact but he did not have the figures. Mr Williams undertook to investigate the issue and get

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the figures for Birmingham, but what was recognised was the people with disabilities, learning disabilities, autism across the West Midlands was disproportionally represented in deaths during that period as a direct result of Covid-19. We had recognised with *The LeDeR* and he would send the report to the Board was that it was systemwide across the nation about how we had to improve the outcome for people with disabilities and how we had to consider the impact of our passport and the health inequalities and how as a system regardless of where you were within the country we needed to do better for people with disabilities to prevent premature deaths as a result of Covid-19.

Mr Williams echoed the comments made by Mr Carr, Ms Carney and Mr Cave and the system approach to this and all partners especially the statutory and also the voluntary sector were working together to improve our service for people with learning disability, autism and their carers. During his time in social work this was one of the best he had ever seen of all agencies coming together to make a difference.

Mr Williams noted Councillor Bennett's enquiry concerning the recommendations that were mentioned in the report and the application of the Mental Capacity Act advised that this was what would be circulated. Mr Williams added that what they had done with that was when *The LeDeR* review came and also the Local Government Association Peer Review led by the National Clinical Lead for Learning and Disabilities and Autism which considered what we were doing across Birmingham to support people with disabilities and autism. What would be helpful was if we brought this back to a future Health and Wellbeing Board to look at that scrutiny and the issues the Peer Review highlighted around good practice and areas for development. That he and colleagues were working on that at present and that then started pulling down some of the thematic work that they needed to do.

The Chair expressed thanks for a full and comprehensive report. She added that this was of interest as a result of what had happened within the BAME communities and them being disproportionately affected. This had shone a light in this area.

501 **RESOLVED: -**

The Board:

  I.   Noted the contents of the report;
  II.   Noted the update the Health and Wellbeing Board on the impact of Covid-19 on vulnerable groups and the response by Birmingham City Council and partners; and
  III.   Agreed to seek the support and engagement of the Board and its members in improving support available to vulnerable adults.

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CHILDREN'S SOCIAL CARE: AN UPDATE FROM BIRMINGHAM CHILDREN'S TRUST

Andy Couldrick, Chief Executive, Birmingham Children's Trust; Joanne Carney, Director of Joint Commissioning, NHS Birmingham and Solihull CCG and Elaine

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Kirwan, Women's and Children's NHS Foundation Trust presented the item. Mr Couldrick drew the attention of the Board to the information contained in the report.

(See document No. 4)

Joanne Carney, Director of Joint Commissioning, NHS Birmingham and Solihull CCG made the following statements:-

a. Mr Couldrick had already alluded to the partnership approach we had in place that had gotten us through the first wave and the second wave we found ourselves in currently.

b. This was a robust and a tremendous effort across the whole partnership from Police, health, care, public health and from experts with lived experiences in terms of ensuring that we had resilient oversight across mental health and the children's world to make sure that we try to do our best during this difficult period. Services had had to change rapidly in terms of the way that they were delivered.

c. It was important to note that from a children's mental health perspective no services were stopped during this period although there was a big change in terms of the way some of those services were presented and delivered.

d. There was a real blend in terms of the digital platforms and face to face work and the clinicians and our teams that we were doing. We had seen higher levels of acuity and complexities that young people and children were now starting to present with. I have already referenced some of the ways we had improved access to services in terms of the 24/7 helpline which was a life course approach.

e. We have had over 7000 calls through that helpline supporting individuals since the helpline was set up in the first wave in April 2020. We had some concerns originally back in April and the demand was increasing but since July 2020 we had seen a surge.

f. However, the good news was that our Did Not Attend (DNA) rates were low as were all cancelled appointments. This meant and signalled that young people were embracing the technology and the digital platforms that were put in place in order for them to access and support.

g. I have already referenced the point how we support our workforce through this period recognising that psychological first aid and how important it was across all sectors as it was known that this impacted on the quality and the outcome of the care that individuals received.

h. We also knew and it was referenced here that there was a disproportionate impact in terms of our BAME communities. We were doing some focussed work through our community development networks and organisations that had good links and had been to those communities with protected characteristics to understand what the impacts had been on them, what we could do to improve; what we could do to be better. There was some interesting insight recommendations coming out of that work.

i. In terms of strengthening our offer ever further - acuities and complexities - we had a consistent blended model in terms of supporting team medicine and face to face work. We were working through the

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Early Help offer that Mr Couldrick had mentioned in terms of enhancing our mental health support through the 10 localities.

j. We had previously through this meeting mentioned KOOTH which was an online digital platform supporting children and young people's mental health and wellbeing had been commissioned. There had been a staggering 17,000 logins to date from young people with over 85% of those returning for support. What was good to see was that 44% of these young people were from BAME backgrounds.

k. We had also commissioned extended capacity through our bereavement offer recognising how difficult this period had been in terms of people who had lost individuals as a direct impact of Covid-19 or other reasons. An all age pathway which went live in June 2020 was now supporting over 1,000 people with a 30% increase in terms of children and young people who were accessing that support.

l. In terms of the BAME specific pathway through the bereavement offer there was 51% increase in terms of individuals from an Asian background and 115% increase in terms of individuals from a black background.

Elaine Kirwan, Women's and Children's NHS Foundation Trust made the following statements in relation to mental health solutions that had been collaborative across the system: -

1. The integration of service models and the collaborative work across partners had been phenomenal. Many people will know that the rapid adaptation of the Mental Health Services

2. meant that we had to quickly move from face to face to tele-medicine. Our remote digital platforms became really important and communicating with our service users with how we did that was a rapid piece of work that happened across the system.

3. Our focus was about maintaining an eye on those who were most at risk and those who were most vulnerable whilst being able to provide a range of services across the system.

4. In terms of disruption the only service that we had to change because it was drop in system was the PAUSE City Centre Hub. The design gave us further opportunity and that was working with our colleagues at the Children's Trust around the acceleration of the alignment around the locality area.

5. PAUSE was now not the City Centre Hub but it was working in the locality which covered 10 localities. They were currently linked into the domestic violence, they were supporting those families in accommodations, a reach out in our Food Banks and leaflets and was able to provide additional contacts through the Food Banks. We had been working in the neighbourhood localities and reaching into the Mosques and Faith Leaders.

6. We have been running a Salvation Community Focus Group and was managing within localities matching our referrals with areas that we knew access was not as good. We had been working in the Ladywood areas and the South Teams. We had been supporting the Refugees Migrant Project so there was a young group of service users that we had been focussing on.

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7. We have also been supporting the university cohorts, not only the University of Birmingham, but bringing all the universities together as a collective so that they could think about aligning various strategies about help and support to students.
8. We had been putting extra resilience into the system through the STICK Team, which was our team that supports schools, colleges and also supports the front door of referrals and across the whole school approach.
9. STICK was our equivalent of Early Help in mental health and wellbeing and through its partnership work STICK had supported 1,200 professionals through training in environmental health.
10. We had supported 200 parents and carers through the webinars and we had offered through Forward Thinking Birmingham partners over 100k appointments since the first wave. The DNAs had been the lowest ever and we were managing to process over 500 referrals per week into the system.
11. This resilience had only been possible because of the way the system continued to work together. We had also been looking at introducing a missed campaign which was successful when schools began to reopen. This was around supporting young people who might not attend schools but also professionals in our workforce that were supported.
12. Digital platforms had allowed us to contact persons who may never approached us previously. We had support around IT facilities to ensure that our workforce had the tools to continue with their therapy and maintaining their ability for young people to remain in treatment when they were not able to and extending that to digital poverty.
13. We managed to get some care packages to young people who may not have access to their treatment due to not having devices. Through funding from partners we managed to deliver a large number of various packages to ensure there was no disconnection within care and treatment for the young people.

Ms Kirwan highlighted the following in relation to what was being done to address the inequalities caused by Covid-19:-

➢ We were taking opportunities to address these inequalities that we knew exist. We learnt from the first wave and were working with our data to understand our local population needs both needs that were there and those we knew and met. Services that supported mental health partnership around St Basil's and partnership with our colleagues.
➢ Building stronger communities and local connections particularly through our networks and the Early Help Localities and supporting early detection and interventions.
➢ We continue with the no wrong do approach and tried to make every contact points count and ensuring that every opportunity they were talking to young people around their mental health.
➢ We had been working with First Class Youth Legacy and were having conversations regarding statistics and how we get our messages out there to those who were not using digital platforms.
➢ We were talking about using radios and other platforms that got the communication and message out there. We will be doing some

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adaptation of our training modules. We had been getting and capturing feedbacks.

➢ The message was that young people wanted to see lasting change so the partnership was working together to think about those hard to reach demographics. How we moved forward as we got to the second wave around following up and having the ability to be able to manage demand and mental health coming through whilst we continue as a partnership to roll out the integration of our service models.

Councillor Kate Booth, Cabinet Member for Children's Wellbeing expressed thanks to Mr Couldrick, Ms Carney and Ms Kirwan for their presentation and commented that the social workers like health staff who had been working flat out to ensure that the most vulnerable children were protected and continue to be protected. Councillor Booth stated that whilst some agencies stopped the face to face contacts our social workers and health staff on the frontline ensured that our children were safe. They had put a robust system in place that had worked well and the support from BVSC for families who were struggling by providing hardship fund and parcels in local areas and working closely with our Food Banks and schools in providing laptops for our children in care.

Councillor Booth made reference to the Chair's comments in her earlier update and stated that as in other cities around the world like us in general our poorer communities were affected worst. One of the key things that she wanted to raise was that all of us were collectively responsible for our children and young people in care where there were Corporate Parents. We must do what we could to ensure that our children realised that and ensured that our children and young people benefitted from good care, health, good education, support, stay fit and well and to have opportunities opened to them to develop independent skills and to thrive. These were responsibilities that were mentioned by Mr Couldrick and we all shared these as Corporate Parents and that she firmly believed in the saying that It takes a village to raise a child.

Councillor Booth stated that our statutory partners and not just the Trust, Police and CCGs should all sign up to our Corporate Parenting pledge to ensured that the children in our city in need the most were supported nurtured and provided with the opportunities they needed to succeed. As partners there was more, we could all do by showing our children in care and care leaders that were identified as our top priority for receiving services by providing mainstream opportunities by offering apprenticeship and internships. Interested partners could get in touch with Mr Couldrick as being a Corporate Parent was a responsibility for us all.

Gaynor Smith, Department for Work and Pensions (DWP) commented that we should be proud of what we were doing in Birmingham to support our citizens. She stated that the DWP had launched a role that she was pleased to take part of called the Senior Safeguarding Leader. Ms Smith advised that her patch was Birmingham and Solihull and where there was not a business usual route to resolve a safeguarding issues, she would be looking at those. These could be procedural or a way they were looking at it locally. Ms Smith added that she embraced all of what was being done and requested that the DWP be involved

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in all that was being done as they were working hard to support those people who were in receipt of state aid.

Mr Couldrick stated that the description of a partnership system was working much better for now than was the case a few years ago. Our social care service was working much better too than was a few years ago. Both were still work in progress and we needed to continue to drive hard at inequalities across the system and across the city at all of those questions about which groups in our communities were underrepresented and indeed overrepresented in our services. As long as we could continue to do that in partnership and share our focus on the most vulnerable in our communities, then we would continue to progressed in a way that we had not seen in some of the very bad outcome for children that had been seen in other parts of the country. This was in no way a small part due to the way we worked together so much better than had used to be the case. If the partnership could support the recommendations in the report it would help us to grow from strength to strength.

502   **RESOLVED: -**

The Board:

1. Noted the report;
2. Continues to support and promote strong partnership safeguarding across the city for our most vulnerable children and families;
3. That members ensured that services maintain contact with vulnerable families through future periods of restriction;
4. Confirmed partners' commitment to supporting our children in care and care leavers across our services and partnerships; and
5. That the Annual Report of the Birmingham Safeguarding Children Partnership is
   formally reported to, and discussed by, the Health and Wellbeing Board each year.

NB: Information from Waheed Saleem, Birmingham and Solihull Mental Health Trust and Nichola Jones, Assistant Director Inclusion, SEND is appended to the Minutes

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INFROMATION ITEMS

503   The Chair advised that Agenda items 14 – 16 were for information only.

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OTHER URGENT BUSINESS

504   No other urgent business was submitted.

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DATE AND TIME OF NEXT MEETING

505   To note that the next Birmingham Health and Wellbeing Board meeting will be held on Tuesday 19 January 2021 at 1500 hours as an online meeting.

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The meeting ended at 1705 hours.

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CHAIRPERSON

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BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Briefing For - BIRMINGHAM HEALTH & WELLBEING BOARD
TO BE HELD ON 24 NOVEMBER 2020

<u>**SUMMARY REPORT:**</u>

- **Have you observed any changes in the presentation of needs across Birmingham in:**
  - **Adults?**
  - **Children**?

Generally referrals received into adult secondary care services have remained at 2019 levels throughout the year with the exception of April and May when initial lockdown was implemented and referrals dropped significantly to all services. Referrals to CMHT's are slightly lower, with increases in crisis services, such as inpatient services, home treatment and liaison psychiatry

BSMHFT have seen significantly higher levels of acuity in both new referrals and existing service users, particularly within the acute and urgent care pathway, with increased levels being detained and admitted under the MHA rather than informally and a significant increase in use of PICU beds, particular for male service users – the majority of these to OOA (out of area) beds, this reflects the regional picture.

With the implementation of an all age 24 hours, 7 day per week, mental health helpline managed by Birmingham Mind, in conjunction with support from BSMHFT services, the helpline has seen on average between 280/300 calls per week of which approximately 15% come into secondary services, the remaining 85% are signposted to other agencies to, the helpline activity is a previously unmet service need.

Feedback from both the helpline and the Trust safeguarding team, identifies adults are struggling with poverty, isolation and uncertainty which is increasing low level mental ill health. Many have had new stressors in family life relating to changes in circumstances with housing being particularly impacted as families face difficulties such as separation and domestic abuse.

There is an increase in substance use and significantly higher levels of domestic abuse being reported. Over the past weeks the helpline has seen increased levels of distress and suicidal thoughts from those in contact; also there have been more direct referrals to the helpline from family members/carers. Older adult referrals have been increasing as hardship and loneliness impact, causing decline in both mental and physical well-being, in addition the impact on carers due to a lack of face to face contact in care homes, is shown as a cause of much distress.

With regards to Children, although BSMHT do not treat children within Birmingham, we have via our safeguarding team, identified the changed presentation in adults, has had an impact on children's mental health, with increased safeguarding referrals due to domestic violence. Additionally, digital poverty has impacted upon education and we seeing larger numbers of children not returning to school, as expected, which has increased anxiety levels in adults.

- **How are you as a HWB partner organisation supporting the changed needs of**
  - **Adults?**
  - **Children?**

BSMHFT has looked to support the changes in referral patterns and acuity levels, by increasing support within our urgent care pathway, providing additional capacity to reduce waiting times for therapy and enhancing older people's services as part of winter pressure funding, as detailed below:

❖ Increasing staffing levels within the Psychiatric Decisions Unit (PDU) to support better flow from Emergency Departments (ED's) and improve our service user's experience.

❖ Additional Approved Mental Health Practitioner capacity both in and out of hours to support increasing demand at our S136 Place of Safety suite, PDU and ED's.

❖ Increased provision of acute male bed capacity, to support swifter admissions

❖ Increase in psychology input to Mary Seacole and Oleaster supporting service users with a diagnosis of Personality Disorder

❖ Additional crisis nurses from 23:00 to 9:00 to support out of hours crisis and helpline calls for both known and new first-time callers in crisis.

❖ Funding to develop proof of concept for Mental Health Hubs in ED's, where service users would be assessed in the hub during peak times in a more relaxed and suitable environment, supporting better flow in ED and creating an improved service user experience for people with a mental health presentation.

❖ Additional funding to increase psychology sessions in each adult CMHT to reduce waiting times for those most in need of enhanced talking therapies.

❖ Increased support within Older Adults CMHT's to extend their duty service to support their philosophy of 'home first', which reduces hospital admissions and offers support to carers. Also, to provide expert input to support our Home Treatment services to manage older people presenting in crisis.

- **What are you as a partner organisation doing to address the exacerbated health inequalities caused by Covid-19 and for the potential future waves of the pandemic?**

BSMHFT are very aware of the challenges faced by our Acute Hospital colleagues and the impact Covid-19 is having on them and subsequently we have done as much as possible to support reduced activity in to A&E departments and acute hospital beds, by increasing our capacity to divert our service user group away from these services.

Our involvement within the 24 hour all age helpline allows us to support those from all areas of Birmingham, the phone line has a freephone number and a multi-lingual chat function that allows anyone to get in touch with mental health services irrespective of ethnicity or finances, which has been an important change.

BSMHFT are working with Birmingham City Council supporting their AMHP services to increase capacity to provide more timely assessment of those potentially needing detention under the MHA, through our urgent care pathways, reducing need for police and court involvement for those who are presenting as unwell.

We are also a partner in the STPs Health Inequalities programme of work which was established during the pandemic.

Birmingham Healthy Minds are part of system wide developments related to Covid-19 rehabilitation. This will involve a pathway to Improving access to psychological therapies (IAPT) from physical health clinics that will be set up across the system.

Our staff are also our community so risk assessments have been carried out on staff who may be suffering from health inequities or specific vulnerabilities to ensure they remain safe at work.

Our future vision for community mental health services is a life-course approach improving access and breaking down barriers for service users with support close to home. We will remove the concepts of referral, transfers and discharge, replacing this with a coherent approach that flexes with service users' needs and ensures holistic input for both health and social determinants.

We will do this through establishing integrated Mental Health and Wellbeing teams across Birmingham aligned to Primary Care Networks. These will be a blended mix of providers across NHS, Social Care and the Voluntary Sector, dissolving the boundaries between primary and secondary care and ensuring our service users experience care and support for physical health, mental health and social needs that is truly joined up. Our workforce will be a combination of existing and transformative new roles.

Services will be delivered in the neighbourhood footprint, and the exact nature of the service/pathway offer and skill-mix in each locality will take account of local population demographics and need.

Additional Information
The STP People Board have led in developing bids for additional funds for. Birmingham and Solihull to support the wellbeing (including mental health wellbeing) of health and care workers, we have in recent weeks been informed our bids have been successful, securing two forms of funding, one in relation to general staff wellbeing for £2million and a second in relation to staff mental health wellbeing for £400k. (NB Graeme Betts is the BCC/social care member on the People Board and the term 'care ' in our bids means social care) We are now pulling together the implementation plans associated with delivering on these bids.

Education Wellbeing Briefing For Schools

December 2020

Birmingham City Council

INTRODUCTION

Welcome to December's wellbeing briefing. We'd like to start by sharing our gratitude with all school staff for the dedication, creativity and capability that has been shown throughout the year and particularly during the Autumn term. Because of you, a majority of students across Birmingham have made a safe and healthy return to learning and benefitted from the protective factors that come with belonging to a learning community.

We know that this has been a difficult term for all, and that you've had to adapt day to day teaching as well as providing extra wellbeing support to students and working through the many unexpected challenges that have presented. Your response has been remarkable.

SEND and Wellbeing professionals have been working closely with colleagues in schools, throughout the Autumn, to understand the developing needs of staff and students. This has helped us ensure that we can support in a way that is helpful and effective. This term, we are pleased to have provided:

Part One of the Wellbeing for Education Return programme, through which we have shared ideas and practical resources to support student and staff wellbeing.

A continuation of our 'Trauma Informed, Attachment Aware Schools' programme, which helps schools develop environments which promote positive mental health.

Targeted support from our Educational Psychology Service, to support the needs of individuals and groups of students.

We hope that the Christmas period brings an opportunity for school staff to pause and recharge. In January, our SEND and wellbeing teams will be ready to work with you once again. In particular, we are looking forward to establishing more wellbeing networks and using these to facilitate collaboration within localities; building on the Wellbeing Education Return Programme through a series of short wellbeing CPD sessions and enhancing our offer to children and young people with mental health needs and low school attendance.

If you have further ideas about how the EPS, BEP or Forward Thinking Birmingham can continue to support you, or you'd like to share a particular challenge that you're facing in your school, please do keep the conversation going with your EP, BEP and FTB professionals.

I hope you enjoy reading December's Wellbeing Briefing.

Nichola Jones, Assistant Director, Inclusion SEND and Wellbeing

Feedback from the wellbeing for Education Return Programme

November saw our local implementation of the Department for Education's 'Wellbeing for Education Return' (WER) programme. Colleagues from the Educational Psychology Service and Birmingham Education Partnership worked together to deliver webinars throughout November, reaching around 300 secondary and primary schools across the city, as well as special schools, colleges and alternative provision.

We were pleased to be able to share research-based frameworks and practical ideas for promoting wellbeing in schools, as well as offering a space for peer to peer discussion and support.

Thank you to everyone who attended the training and to those who completed the online evaluation. It was good to hear that the training

provided many of you with new ways to think about and support children and families. We also listened carefully to your feedback about how we can develop further and the request that many of you made for an ongoing, weekly programme of wellbeing CPD. In response, we are developing content for a programme which will build on the elements of the training that you found most helpful, such as the "Five R's" approach to recovery.

If you'd like more information about the topics covered during the webinars, you may wish to take a look at the Anna Freud Centre's website, which includes resources for young people, parents and professionals and which can be accessed at: https://www.annafreud.org/

Your ongoing feedback is important to us and if there are any further areas that you would like to be covered in the Spring term, please share your ideas with your link EP or BEP professional.

Wellbeing Networks

Our Wellbeing Network programme went live at the beginning of December, with our first network meeting in the Aston/Nechells Consortium and North West feeder secondary schools.

Two Network Lead Psychologists met together with Senior Leads for Mental Health and agreed ways of using action research to recognise good practice and promote wellbeing across the network. Initial feedback from those who attended was very positive and they highlighted the opportunity to work collaboratively during challenging times as a particular benefit.

Wellbeing networks will provide a great way for us to tailor our provision to needs within localities and ensure a coordinated offer from the EPS, BEP and other local partners. We've committed to increasing the number of networks throughout the new year and are already
liaising with consortia in areas of the city with a high level of mental health need.

If you'd like to learn more about wellbeing networks and how they will support locality working, please get in touch with your link Educational Psychologist.

Resources to support children who are not attending school

This term, support for students with poor mental health and low school attendance has been frequently raised as a cause for concern by school staff.

The interaction between poor mental health and low school attendance is an ongoing issue which has been magnified by the national lockdown earlier in the year and the COVID 19 pandemic. The council have worked closely with Forward Thinking Birmingham to develop guidance around the issue, which is available through the BCW website: https://bwc.nhs.uk/educational-professionals/

In addition, the Educational Psychology Service are developing a set of complementary resources to help school professionals understand the reasons that may underpin a young person's not attendance and how to intervene early. Look out for details of these resources in a future Wellbeing Briefing, alongside further information about our new Home Bridging team.

Youth Wellbeing Forum

As part of our drive to place children and young people at the centre of our city's approach to wellbeing, we have established a new 'Youth Wellbeing Forum'.

The forum will be made up of young people from secondary schools across the city. They will meet once a month and work closely with SEND and wellbeing professionals as well as senior leaders from the Council. The role involves advising the Council to deliver and review their programmes of activities, meeting with officials, councillors and other key figures such as the Director of Education and Skills.

There are still a few spaces remaining in the forum and if you know of a student who may be interested in joining, you can find out more by emailing wellbeingyouthforum@birmingham.gov.uk

Kooth – Online support for Wellbeing

Kooth is an online wellbeing platform, available free to young people living in Birmingham. It includes wellbeing related magazine articles, videos and discussion forums, as well as access to trained mental health professionals through anonymised chat and messaging services.

Content on the Kooth website is regularly updated, with recent content including 'returning to school after shielding', 'making friends at school during COVID' and 'settling back into education'. In Birmingham, the top three presenting issues for young people accessing Kooth are 'anxiety and stress', 'family relationships' and 'suicidal thoughts'.

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Throughout July, August and September, a further 1400 Birmingham young people registered to use Kooth. The majority were aged between 12 and 16 years old; 77% identified as female and 44% as BME. Over a third of new registrations came from young people living in Sutton Coldfield; Edgbaston; Aston, Handsworth and Lozells.

If you'd like to share information about Kooth with students in your school, you can find out more by accessing the Kooth website at https://www.kooth.com/ . We're particularly keen to promote Kooth to male students and to those living in the Kings Norton, Perry Barr, Bordesley, Ladywood, Sparkbrook and Balsall Heath areasNew resources have been uploaded to the #youvebeenmissed website at https://bwc.nhs.uk/youve-been-missed/ . These include Lesson plans, films and worksheets, which are all available by clicking on the "Education Professionals" tab.

BIRMINGHAM HEALTH & WELLBEING BOARD

		Action Log 2020		

Rag rating :

	Overdue
	In progress
	Complete

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

008446/2021

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

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

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

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

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

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

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

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

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

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

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19 January 2020**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney Director of Public Health**

Report Type:	Presentation

1. Purpose:	
1.1 To detail the progress of the partnership project between Birmingham City Council and Lewisham Council who are collaborating to address health inequalities faced by the African and Caribbean communities.	

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

3.   Recommendation

It is recommended that the Board:

- Acknowledge the progress made by the BLACHIR project.
- Note the new model that is being developed between the two Local Authorities.
- Agree to support the identified recommendations and promote outcomes to reduce health inequalities.

1

4.	**Report Body**

4.1   Background:

The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR) is a new partnership between Birmingham City Council and Lewisham Council to share knowledge and resources through a collaborative review process. It follows the work of both Councils as national Childhood Obesity Trailblazers.

BLACHIR will initially focus on the Black African and Black Caribbean communities, this will enable a more detailed and culturally sensitive approach. The partnership aims to jointly undertake a series of reviews to explore in-depth the inequalities experienced by Black African and Black Caribbean groups and their drivers.

An external advisory board and an academic advisory board were recruited through an open advert and structured interview process. The boards support the review process through examining the evidence with the review team and shaping the recommendations.

The main objective of the review is to produce a joint final report, that brings together the findings from the advisory board, stakeholder events, online forum, and other research. The final report will also include data analysis conducted by the review group throughout the 18 month period.

4.2   Purpose of BLACHIR:

This is the first of a planned series of reviews to be carried out jointly between Birmingham City Council and other partners, the initial review on African and Caribbean Health Inequalities is being done jointly with Lewisham Council. Further reviews for different ethnic communities and minority groups plan to be undertaken over subsequent years (potentially with different local authority partners). They will use a similar model, making necessary amendments where lessons have been learned from the initial process. The initial review will be be conducted over an 18 month period. Future reviews will be approximately 12 months, with the initial process being extended to allow for COVID-19.

The Review includes 9 topics for discussion, these are:

- Racism & discrimination role in health inequalities
- Early years, Pregnancy & Parenthood
- Children and Young People (e.g. youth violence, NEET, opportunities)
- Ageing well (e.g. Dementia & Frailty)
- Lifestyle factors (e.g. smoking, physical activity, nutrition & diet, drugs & alcohol)
- Mental health & wellbeing
- Chronic disease (e.g. diabetes, hypertension)
- Acute disease and death (e.g. hospital admissions)
- Wider determinants of health (e.g. housing, employment, education, poverty)

4.3   Objectives of the BLACHIR review

- Explore health inequalities experienced by Black African and Black Caribbean communities in Birmingham and Lewisham.
- Support the development of BLACHIR a new model growing processes and delivery of a strategic action plan to deliver a first-time impact on citizen's lives in Birmingham and Lewisham.
- Foster and develop partnership arrangements to deliver improvements in health and wellbeing for Black African and Black Caribbean communities in Birmingham and Lewisham.
- Work to the BLACHIR timeline with the External Advisory Board members to ensure all are on course to make a difference to the citizens of Birmingham and deliver on outcomes.
- Work with the External Advisory Board members who are community group and voluntary organisations members to ensure their voices are heard on matters of health inequalities.
- Support research, data collection, and monitoring

4.4   Timelines of engagement

The impact of COVID-19 has caused delays in the BLACHIR timeline. The Review intends to meet in a 6-week cycle with the External Academic and Advisory Boards to share evidence-based research and lived experienced knowledge.
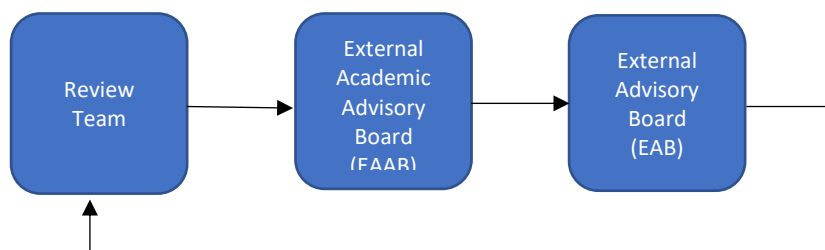
The discussions will be conducted in an ongoing cycle of meetings. These meetings will involve discussing one theme at a time. One cycle will begin with the Review Team (who are members of BCC and Lewisham council). They will collate information on the chosen theme to enable the academics to have informed discussions at the meetings. The evidence gained from the academic meetings will be put forward to inform the Advisory Board meetings. This information will be returned to the Review Team for use in producing the final report.

A written report will be produced at the end of the 18-month review process for the two Health and Wellbeing Boards. This will be a culmination of the findings from the monthly Advisory Board meetings and additional research undertaken by those involved in the review. This report will be informed and co-produced by the Public Health Divisions in Lewisham and Birmingham and members of the Advisory Board, with work being delegated appropriately between those involved. The final report will be made publicly available.

3

4.5   BLACHIR findings and outputs:

The outputs from the series of Review meetings will be recorded. Documents and information from the Review meetings will be shared with the External Board members by email. They will also be held on the networking platform Knowledge Hub. External Board members will be invited to ensure inclusivity and ensure the views and experience of the community are captured. BLACHIR is invaluable to the success of exploring health inequalities faced by the Black African and Black Caribbean communities.

The review will make recommendations to the Health and Wellbeing Boards of both Lewisham and Birmingham.

4.6   BLACHIR progress so far:

The first review meetings have taken place discussing the role "Racism & discrimination in health inequalities".

The feedback from the advisory board following discussion of the findings focused on:

- Language about racism and discrimination:
  - Ethnicity Monitoring (the use of the word "black" to identify ethnicity)
  - How we describe racism

- Adverse childhood events
  - Microaggression
  - Racism as an ACE

- Health professional's education
  - Implicit bias/cultural competency sessions review

- Role of community in tackling racism and discrimination and link to health
  - Improve public engagement
  - Address mistrust of healthcare
  - Improve access to higher education and medical/health courses.

At present, the outputs from the meetings are scheduled to be collated, analysed and to complete a thematic analysis to draw from the External Advisory Board meetings by the Review working group for both DPH's to approve as recommendations.

4.7   Next steps/Delivery:

The second pillar/theme meeting will discuss "Pregnancy, Early Years & Parenthood" on 20th January 2021.

A review of the existing processes is ongoing. The model continues to evolve based on learning to make it as effective as possible.

Walsall NHS have been commissioned to produce an evidence summary. This will be collate evidence-based research on the relevant topic to support

the Academics research. It will identify the successful interventions, barriers, and facilitators that affect the Black African and Black Caribbean communities.

A proposal for a survey of experiences of Early years, Pregnancy & Parenthood among Birmingham and Lewisham communities' part of BLACHIR review is in progress collaborating with the 'Lewisham Maternity Voices Partnership' as a target audience to collect insightful information of lived experiences.

5.	Compliance Issues

5.1	HWBB Forum Responsibility and Board Update

5.1.1 A brief update to be provided to the Health and Wellbeing Board on progress to ensure steady progress and any issue or risks highlighted that may hinder required outputs and outcomes.

5.2	Management Responsibility
	Dr Justin Varney, Director of Public Health, Birmingham City Council Dino Motti Public, Health Registrar, Birmingham City Council

6.	Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**	
The External Advisory Board members fail to deliver on their assigned actions	Medium	Medium	Robust monitoring and reporting mechanisms to ensure collaborative working to promote positive workable solutions specific to BLACHIR.	

Appendices
Appendix 1: BLACHIR – HWB Jan 2021

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

Dr Justin Varney, Director of Public Health, Birmingham City Council
Dino Motti, Public Health Registrar, Birmingham City Council
Avneet Matharu, Public Health Graduate, Birmingham City Council

The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR)

Background

Birmingham and Lewisham Public Health Divisions share a joint aspiration to address ethnic inequalities, through an increased understanding, appreciation, and engagement with Black, Asian, and Minority Ethnic (BAME) groups. This has resulted in a partnership between the two Public Health Divisions to share knowledge and resources through a collaborative review process. The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR) will initially focus on the Black African and Black Caribbean communities, this will enable a more detailed and culturally sensitive approach. The Covid19 outbreak has further highlighted the impact of these inequalities in the context of infectious disease with Black African and Black Caribbean people over-represented in the deaths from Covid19. As part of the review process, external Academic and Advisory Boards will be established to help inform the work of the review team and bring together a wide and diverse range of academics with interests in this area.

In general, England is becoming more ethnically diverse, with an increasing proportion of the population identifying as being from Black, Asian, and Minority Ethnic Groups (BAME).

There is large variation in ethnic diversity between different areas of England; eight of the ten Local Authorities (LA's) with the highest level of ethnic diversity are in London, with Lewisham being the 15th most ethnicity diverse LA in England. And outside London, Birmingham is one of the most ethnically and culturally diverse cities in the UK.

Birmingham is home to a significant proportion of the overall African and Caribbean population in England. In Lewisham, 48% of the general population are from BAME groups with the largest ethnic minority group being Black African (14%) and Black Caribbean (12%) communities.
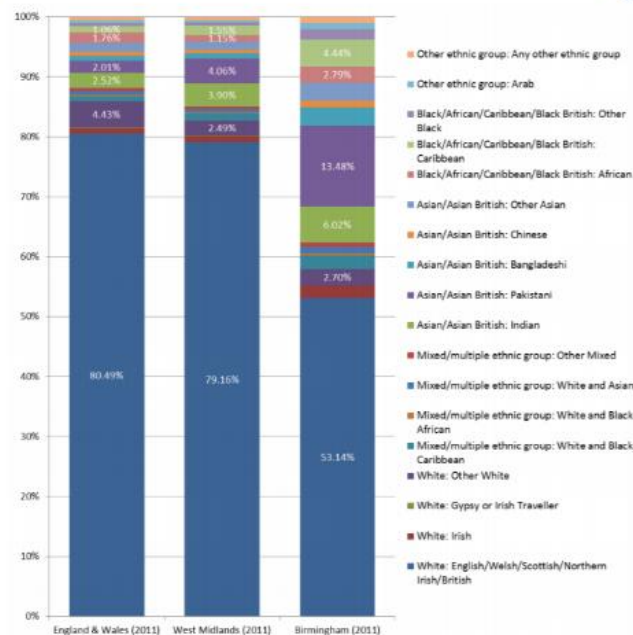
Proportion of population by ethnic groups, Birmingham 2011 (%)
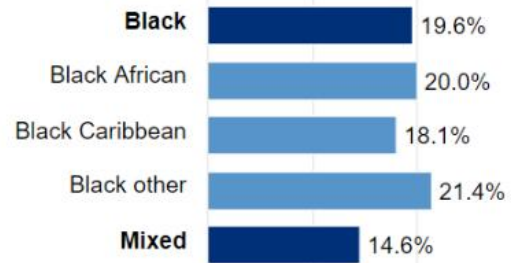
Percentage of people living in the most income-deprived neighborhoods, by ethnicity in England and Wales.

There is a link between ethnicity and levels of deprivation.

Both Lewisham and Birmingham experience high levels of deprivation; Lewisham is the 31st most deprived LA (out of 326) and Birmingham is in the top 10 most deprived LA's in England.
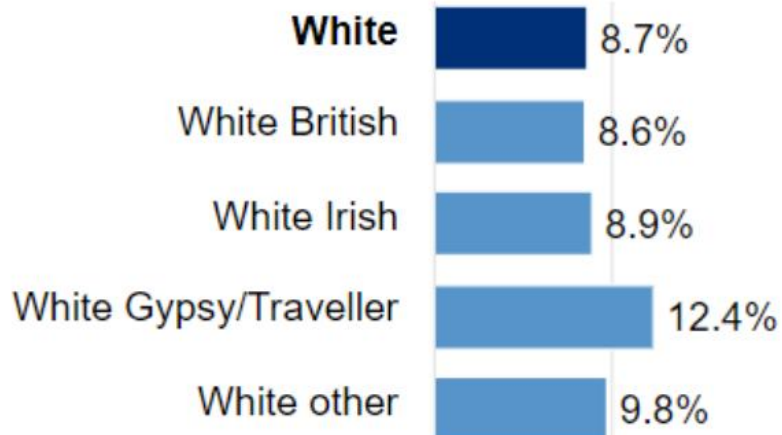
It is understood that ethnic minorities have poorer health outcomes in the UK. Both local authorities are facing these health inequalities. And therefore, Birmingham City Council and Lewisham Council are entering a partnership to improve ethnic inequalities, through an increased understanding, appreciation and engagement with BAME groups initially focusing on the Black African and black Caribbean community.

Source: England and Wales 2011 Census

Advisory Board

Purpose

The purpose of the External Advisory Board will be to provide an external group of individuals, with the aim of representing a wide range of different aspects of the Black African and Black Caribbean communities in Lewisham, Birmingham and nationally, to enable regular discussions that will inform the review process. The review will make recommendations to the Health and Wellbeing Boards of both Lewisham and Birmingham to take forward through the members of the Boards.

Academic Board

Purpose

The main purpose of the External Academic Board will be to provide a network of academics who have a research interest in African and Caribbean health inequalities to support and inform the Birmingham and Lewisham Review.

There will be an ongoing cycle of meetings, initially involving the Review Team, followed by the Academic Board and lastly the Advisory Board. A separate theme will be discussed each cycle; there may be some overlap between the cycles. This cycle is demonstrated in the diagram below:

Academic Board

15 Academics have been appointed to the board position.

They have experience and research work in:

- Media, race and social injustices

- Mental health

- Ethnic minorities in care homes

- BAME inequalities relating to housing, finance, research projects, and policy

- Research reports include African and Caribbean community

- Youth studies

- Health care research

- Youth and NEET from work experience

Advisory Board

Members of the Board have attributes of community engagement specific to Birmingham and Lewisham to collect and report lived experiences from both Local Authorities.

5 members from Lewisham and 4 members from Birmingham who are actively involved within the community and who are residents of the area have been appointed.

Collectively they have been active in community engagement encompassing and representing:

- BAME issues
- Community leaders
- Young people support
- Women representatives
- Disability issues
- Underrepresented groups
- Mental health

The 9 pillars of the review

- **Racism & discrimination role in health inequalities**

- **Early years, Pregnancy & Parenthood**

- **Children and Young People**
  - (e.g. youth violence, NEET, opportunities)

- **Ageing well**
  - (e.g. Dementia & Frailty)

- **Lifestyle factors**
  - (e.g. smoking, physical activity, nutrition & diet, drugs & alcohol)

- **Mental health & wellbeing**

- **Chronic disease**
  - (e.g. diabetes, hypertension)

- **Acute disease and death**
  - (e.g. hospital admissions)

- **Wider determinants of health**
  - (e.g. housing, employment, education, poverty)

Meeting Cycle Process

It is anticipated that there will be an ongoing cycle of meetings, initially involving the Review Team, followed by the Academic Board and lastly the Advisory Board. This cycle is demonstrated in the diagram below:

Stage 1   **Stage 2**   **Stage 3**

Review Team → External Academic Advisory Board (EAAB) → External Advisory Board (EAB)

Recruitment for Advisory board

JULY 2020

Begin official meetings

SEPT 2020

"Racism & discrimination role in health inequalities" meeting

NOV 2020

Will inform the Health and Wellbeing Board partnership and influence both Councils, NHS, academics, community and voluntary sector partners to make sustainable changes that start to address decades of inequalities

The review is first of its kind and it anticipated it will be a model for future ethnic minority groups to explore and for potentially new partnerships to form with other authorities.

JUNE 2020

AUG 2020

OCT 2020

JAN 2021

EVALUATION

FUTURE REVIEWS

Recruitment for Academic board is live

Interviews/appointed applicants chosen

External Academic and Advisory Board Welcome meeting

"Early years, Pregnancy & Parenthood" meeting

Progress so far

- The first review meetings have taken place "Racism & discrimination role in health inequalities"
- On Tuesday we have received the feedback from the advisory board on the discussion of the findings.

The discussion has been focusing on:

- Language about racism and discrimination:
  - Ethnicity Monitoring (the use of the word "black" to identify ethnicity)
  - How we describe racism
  - Language (BAME)
- Adverse childhood events
  - Microaggression
  - Racism as an ACE
- Health professionals education
  - Implicit bias/cultural competency sessions review
- Role of community in tackling racism and discrimination and link to health
  - Improve public engagement
  - Address mistrust of healthcare
  - Improve access to higher education and medical/health courses.

Next steps

Second pillar/theme meetings early next year:

- Early years, Pregnancy & Parenthood
  - Commissioned review of the evidence
  - Survey of lived experiences

- Ongoing review of processes

- https://www.birmingham.gov.uk/blachir

	Agenda Item: 12
Report to:	Birmingham Health & Wellbeing Board
Date:	18th January 2021
TITLE:	WORKING TOGETHER FOR A HEALTHIER POST-COVID FUTURE
Organisation	Birmingham City Council
Presenting Officer	Lucy Heath (Academy Director – BWCB STP)

Report Type:	Information

1.	Purpose:

1.1 The purpose of the programme is to help local partner organisations:

- better understand their local populations in terms of the interactions between the wider context of their lives and their health

- develop a set of priorities for action

- engage relevant stakeholder and community groups

- co-design, and collaboratively implement and evaluate, projects relating to the social, economic and environmental circumstances in which people live to facilitate improved population health.

2. Implications:

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

3. Recommendation

3.1 The Health and Wellbeing Board input is requested into; -

- What priority should be given to each of the target socio-economic outcomes, and why?

- Are there additional intervention mechanisms that should be considered for realising the target outcomes?

- What specific candidate interventions might be considered?

- Are there specific population cohorts that whole-system action should focus on?

3.2 Feedback from the Birmingham Health & Wellbeing Board on these key questions will be fed into a report to the Healthier Futures Partnership Board in January 2021.

4. Report Body

Background

- The Wider Determinants of Healthy Life Expectancy (WHoLE) Programme is one of the first programmes of work led by the Healthier Futures Academy.

- The programme's Phase 1 report - *Working Together for a Healthier Post-COVID Future* - is an independent overview of local experience, international evidence and bespoke, high-level analysis to generate debate and decision around collaborative whole-system action to improve population health and wellbeing in the Black Country and West Birmingham.

- The full report and executive summary are attached.

Key Points

- Population health is determined by a wide range of factors including healthcare interventions and lifestyle choices. But we know that there are wider, socio-economic determinants of health that have a greater impact on the health of the population and the resulting demand for healthcare services. BCWB has existing challenges in relation to these determinants.

- There is evidence that COVID-19 is affecting the wider determinants of health and the consequent demand for services in an adverse manner and

to a significant degree. This is in addition to the direct treatment and enduring health impacts of the disease.

- The NHS impacts population health status both directly through the care, treatment and medication it provides and indirectly through the way in which healthcare services are organised and healthcare resources invested.

- There are opportunities for the NHS, with local partners, to increase its impact as an anchor institution on the determinants of health, bringing greater benefits to local communities and limiting the adverse impacts of COVID-19.

5.	Compliance Issues

5.1	HWBB Forum Responsibility and Board Update

5.2	Management Responsibility

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

Appendices
Working Together for a Healthier Post-COVID Future Working Together for a Healthier Post-COVID Future – Exec Summary

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Working Together for a Healthier Post-COVID Future

A discussion document to promote whole-system action
on the wider determinants of healthy life expectancy
in the shadow of the COVID-19 pandemic

Black Country Consortium

Economic Intelligence Unit

The Strategy Unit.

Healthier Futures Academy
Black Country and West Birmingham

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Healthier Futures Academy
Black Country and West Birmingham

Executive Summary

In line with wider national drives towards inclusive growth and the extension of the role of 'anchor institutions', the Healthier Futures Academy has initiated the Wider Determinants of Healthy Life Expectancy (WHoLE) Programme. The purpose of the programme is to help local partner organisations:

- better understand their local populations in terms of the interactions between the wider context of their lives and their health;

- develop a set of priorities for action;

- engage relevant stakeholder and community groups; and

- co-design, and collaboratively implement and evaluate, projects relating to the social, economic and environmental circumstances in which people live to facilitate improved population health.

This discussion document and the accompanying resources represent the initial outputs of the WHoLE programme, developed for the Academy by The Strategy Unit and with additional analysis by the Black Country Consortium's Economic Intelligence Unit.

Explicitly intended to facilitate discussion with system partners and co-production with local communities, this work does not purport to offer off-the-shelf solutions to intractable social, economic and health challenges, neither does it represent the formal policy position of the Healthier Futures Partnership or any of its constituent organisations. Instead, it is an independent overview of local experience, international evidence and bespoke, high-level analysis to generate debate and decision about what an increased local focus on improving population health and wellbeing in the Black Country and West Birmingham (BCWB) should look like.
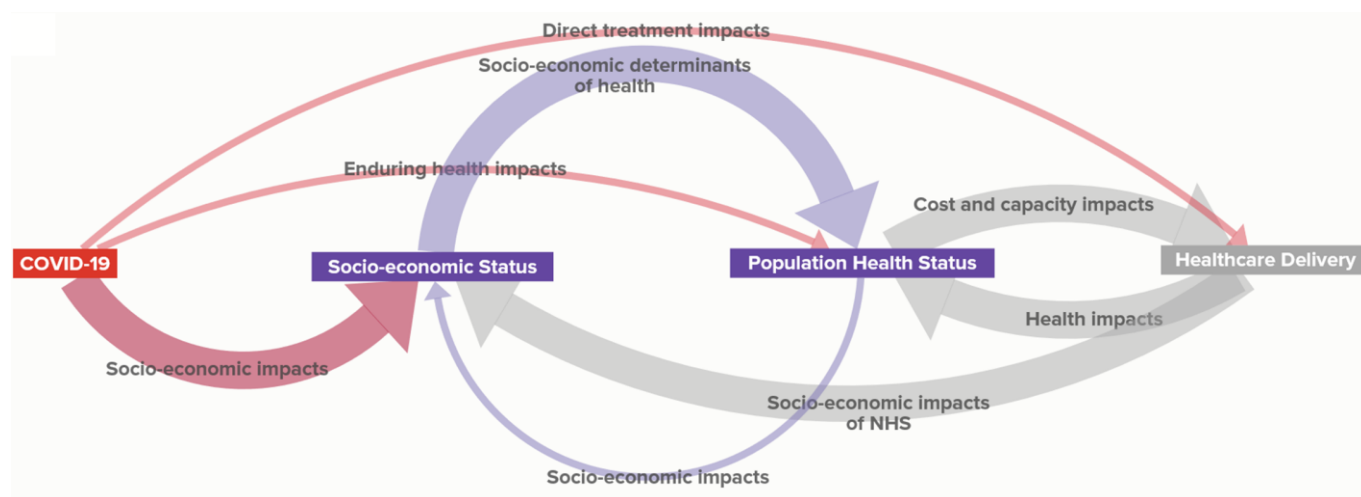

Figure 1 - Causal map

Building Healthier, Happier Communities

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<center>when the British economy sneezes, the NHS catches a cold[1]</center>

What follows is no more and no less than the launchpad for a programme of targeted and collaborative engagement and action on the economic, social and environmental forces that shape our health, even more than do the lifestyle choices we make or the healthcare services available to us. The core logic of the WHoLE programme is represented in the causal map above (Figure 1) and summarised thus:

➢ Population health is determined by a wide range of factors including healthcare interventions and lifestyle choices. But we know that there are wider, socio-economic determinants of health that have a greater impact on the health of the population and the resulting demand for healthcare services. BCWB has existing challenges in relation to these determinants.

➢ There is evidence that COVID-19 is affecting the wider determinants of health and the consequent demand for services in an adverse manner and to a significant degree. This is in addition to the direct treatment and enduring health impacts of the disease.

➢ The NHS impacts population health status both directly through the care, treatment and medication it provides and indirectly through the way in which healthcare services are organised and healthcare resources invested.

➢ There are opportunities for the NHS, with local partners, to increase its impact as an anchor institution on the determinants of health, bringing greater benefits to local communities and limiting the adverse impacts of COVID-19.

Any adverse socio-economic impacts relating to COVID-19 will affect a context in the Black Country and West Birmingham that already has structural weaknesses including:

• The relatively low average income levels across BCWB (£4k below the national average) and the constrained ability to weather an economic crisis that accompanies this;

• The high numbers of children living in poverty (17.7% live in workless households and 28% in relative low income families);

• The already high rates of unemployment especially amongst

    o mixed ethnic groups (19.3% BCWB compared to 6.2% nationally) and the Pakistani/Bangladeshi population (12.9% BCWB compared to 8.9% nationally) and

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[1] Sir Simon Stevens, Chief Executive, NHS England and NHS Improvement, speaking in 2016

Building Healthier, Happier Communities

  o 16-24 year-olds (males 15.6% compared to England 13.7%; females 13.0% compared to England 9.6%);

- The relatively low skills levels, especially in the White population;

- The relatively large proportion of 0-15 year-olds (21.5% BCWB, compared to 19.2% nationally) especially males - an age-group that will be seeking to enter the jobs market for the first time in the economic and social shadow of the COVID-19 pandemic;

- The relatively high proportion of the population that is economically inactive (i.e. neither in work nor seeking work), especially females aged 16-49 and across all ethnic groups except those of Indian ethnicity; and

- The high levels of air pollution, with 32% of neighbourhoods (LSOAs) in the 'worst' category nationally.

Illustrative, evidence-based modelling of three post-COVID scenarios undertaken by The Strategy Unit, using conservative assumptions, suggests that the unemployment rates in a COVID-related recession could lead to significant increases in healthcare activity levels during 2020-24.

- For physical health services relating to cardiovascular, musculoskeletal and respiratory conditions alone, activity levels are projected to remain above the 2019 baseline for the whole period. In the upside scenario, activity increases by 7% in 2020 before reducing to 5% then close to 2019 levels. In central and downside scenarios, the peak is in 2021 with 13% and 16% increases, respectively.

Figure 2 - Percentage change in total physical healthcare activity by scenario

The equity of access for different ethnic groups is hard to assess because of weaknesses in recording ethnicity in the activity data; there are some variations in activity level by place; and there are elevated activity levels amongst those in the lowest deprivation deciles (c.3% above the working age population proportion for those deciles).

- For mental health services, activity levels are also projected to remain above the 2019 baseline for the whole period but to a greater extent than physical health activity. In the upside scenario,

activity increases by 10% in 2020 and 2021 before reducing to 3% for the remainder of the period. In central and downside scenarios, the peak is in 2021 with 22% and 27% increases, respectively.

The equity of access for different ethnic groups is again hard to assess because of weaknesses in recording ethnicity in the activity data; there are some variations in activity level by place; and there are elevated activity levels amongst those in the lowest deprivation deciles. At 10% above the working age population proportion for those deciles, this deprivation impact is three times the level in mental healthcare activity than it is in physical healthcare activity.

In addition, a 4.45% increase would be expected in the suicide rate (4 additional deaths) along with an additional 160 suicide attempts.

Figure 3 - Percentage change in total mental healthcare activity by scenario

Whatever the nature and extent of the additional healthcare demand created by the socio-economic fallout from COVID-19, one aspect of the NHS response alongside local partners will necessarily be to make changes to the capacity of services and to the models of care that shape those services (including the skill-mix of staff). Such supply-side actions are outside the scope of this report, as are demand-side responses linked directly to lifestyle choices, and the associated prevention activities. The findings reported here may, however, additionally be used to inform supply-side planning across the system. The focus of the WHoLE programme, by contrast, is on understanding and addressing the social, economic and environmental drivers of population health that may account for 50% of the determinants of health.

> *Health is often thought of as more of a concern for the NHS than for local government, but in reality, local government has an even greater potential to influence health improvement than does the NHS. As was quoted in the recent All Parliamentary Report on longevity: "We have been caught in a false view that our national health means the NHS."[2]*

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[2] https://www.local.gov.uk/sites/default/files/documents/22.52%20Social%20Determinants%20of%20Health_05_0.pdf

What can the NHS, in a genuine and close collaboration with local government and other partners, actually do to impact these indirect drivers of population health? In fact, local NHS and other partner organisations are already acting to impact the wider determinants of health in a wide variety of ways. Examples of such action are set out below (The Opportunities for 'Anchor Institutions'), alongside evidence of effective interventions, and are linked to the five areas for potential action identified by the Health Foundation (Figure 4).

What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:

Using buildings and spaces to support communities
The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Working more closely with local partners
The NHS can learn from others, spread good ideas and model civic responsibility.

Purchasing more locally and for social benefit
In England alone, the NHS spends £27bn every year on goods and services.

Widening access to quality work
The NHS is the UK's biggest employer, with 1.6 million staff.

Reducing its environmental impact
The NHS is responsible for 40% of the public sector's carbon footprint.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

The Health Foundation

References available at www.health.org.uk/anchor-institutions
© 2019 The Health Foundation.

Figure 4 - What makes the NHS and anchor institution?

The challenge now is to redouble collaborative efforts to identify and act on opportunities to improve the circumstances that influence the health of our populations more materially than the healthcare we provide. Prior to COVID-19, the evidence and the need were already clear. In the shadow of COVID, the evidence suggests that healthcare needs will materially increase, bringing further challenge to the lives of our citizens and significant additional demand pressures on already stretched healthcare services.

Although these dynamics have long been known within the NHS, at least at a superficial level, the NHS has not yet played as full a part as it might in impacting the factors that shape population health, given

its social and economic impact in the local economy. The lead role that other bodies play in relation to this agenda, especially Local Authorities, is well recognised, as is the significance of other local anchors such as educational institutions, emergency services and other public bodies. The challenge for local NHS organisations is to better understand the socio-economic impact of their decisions (past and present) and then to use that understanding to energise and inform collaborative working with local partners. The challenge for those partners is to be open to that collaboration and to help NHS organisations discover how they can realise their potential as economic actors and become fuller partners in all aspects of inclusive local growth, thereby improving the healthy life expectancy of local populations through impacting the socioeconomic determinants of health as well as through healthcare delivery. Collaborative action at scale will have greater impact than isolated initiatives at the margins.

Figure 5 - The benefit of collaborative action

To facilitate this increased collaboration, the publication of this discussion document will be followed by two months of engagement with system partners in Local Authority Health and Wellbeing Boards, Healthier Futures partner organisations in the NHS and local government, and the local voluntary and community sector. Whilst detailed public engagement is largely intended for Phase 2, versions of this report will be made available to the public. Going forward, the governance of the programme is expected to sit with the Health Inequalities Board of the Healthier Futures Partnership. There are two aims of this engagement:

- To increase understanding of the interactions between the contexts in which citizens live (social, economic, environmental) and their health; and

- To inform the recommendation of priority areas for whole-system action in Phase 2 of the programme. These are expected to be determined by the Healthier Futures Partnership Board in January 2021, following the proposed engagement.

There are four key questions to be explored in this initial engagement. These relate to a framework for discussion and action that has been developed on the basis of the evidence and analysis presented in this report (Table 1):

	Education and Skills	Employment and Income	Community and Environment
County Health Ranking Weightings *(as % of the determinants of health)*	• 5% high school graduation (~5 GCSEs at C or above) • 5% some college education	• 10% unemployment • 10% children in poverty	• 2.5% air pollution – particulate matter • 2.5% inadequate social support
Marmot Recommendations	• Giving Every Child the Best Start in Life • Enabling all Children, Young People and Adults to Maximise their Capabilities and Have Control over their Lives	• Creating Fair Employment and Good Work for All • Ensuring a Healthy Standard of Living for All	• Create Healthy and Sustainable Places and Communities
Target Socio-economic Outcomes	• Greater school readiness • Better skills and qualifications	• Fuller employment in better jobs • Higher incomes	• Better environments (social, economic, physical and natural)
Potential Intervention Mechanisms	• Increasing early years access and support • Reducing child poverty • Increasing pay and qualification requirements for the childcare workforce • Improving pupils' physical and mental wellbeing	• Becoming living wage employers • Investing more in local procurement (including local employment and living wage jobs) under the 2012 Social Value Act • Increasing higher value apprenticeships and in-work training • Developing new roles and training paths in public sector professions	• Increasing the resilience of local communities and their economic, social and cultural assets • Improving air quality in line with national and local net zero targets • Increasing the quality and affordability of stable housing • Ensuring best value is being realised from public sector land and buildings
Available Public Sector Tools	• Adjusting public sector service models to increase wider socio-economic benefits and to reduce inequalities • Enhancing how potential and existing public sector staff (and the employees of public sector contract holders) are nurtured, recruited, trained and supported • Deriving greater socio-economic benefit from public sector financial and physical resources (including in the supply chain)		
Candidate Interventions	• *To be co-produced in Phase 2*		

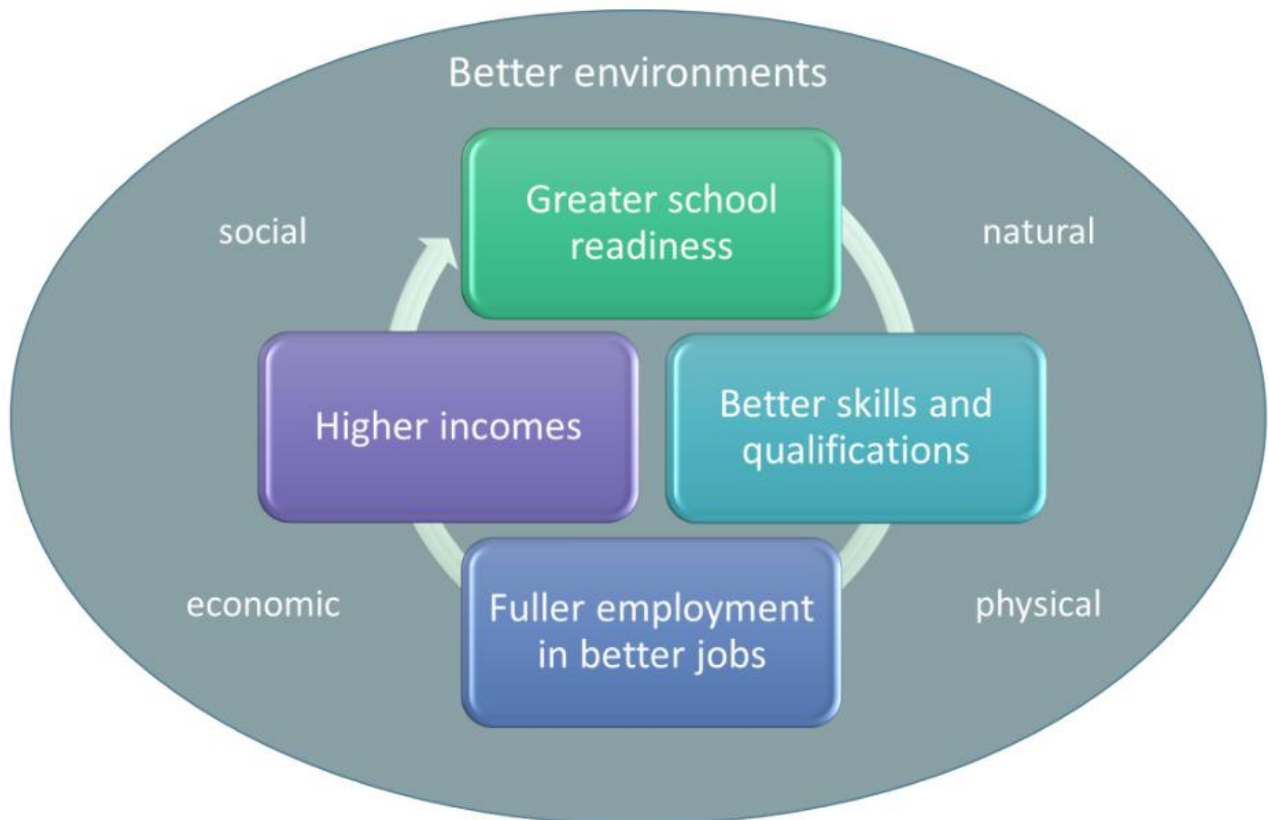*Table 1 - Framework for discussion and action*

Figure 6 - Illustration of relationship between target outcomes

1. **What priority should be given to each of the target socio-economic outcomes, and why?** Action in relation to any outcome will bring benefits in others, given how closely they are related, but some may have the potential to do this to a greater extent than others. Each also has the potential to improve healthy life expectancy. This is a question about where best to intervene in the cycle (see Figure 6).

2. **Are there additional intervention mechanisms that should be considered for realising the target outcomes?** These must be mechanisms that can be affected by the tools available to public sector organisations.

3. **What specific candidate interventions might be considered?** This is a question about the action local partners could consider taking together.

4. **Are there specific population cohorts (e.g. age groups, genders, ethnicities, deprivation quintiles, other groups) that whole-system action should focus on?** The differential needs and experiences of such groups should be considered equitably in relation to any candidate intervention, but the evidence presented above, and local experience, may suggest a case for an enhanced focus on certain cohorts.

Initial citizen engagement around these themes was conducted through the Healthier Futures Partnership's Citizen Voices Panel in September 2020 (Appendix Three – Citizen Panel Survey Data). Those who responded were largely from the Dudley and Sandwell and West Birmingham CCG areas

(84%), of White ethnicity (88%), female (66%) over 40 years of age (59%, 25% were in the 60-74 age group), and from a broad range of geo-demographic categories. The relatively unrepresentative nature of the self-selected respondents inhibits a demographic analysis of the results. The survey found that:

- The socio-economic determinants that reportedly affect respondent's **physical health** a lot (pre-COVID) are low income (22%), lack of work (16%) and poor or no housing (15%).

- Similarly, though to a greater degree, the socio-economic determinants that reportedly affect respondent's **mental health** a lot (pre-COVID) are low income (28%), lack of work (21%), crime or experience of the justice system (17%) and poor or no housing (12%).

- The aspects of life that had been significantly affected by the **COVID-19** pandemic and association policy measures were reported to be respondents' mental health (40%), close relationships (23%), education (20%) and income (20%). Only two panel members knew they had had COVID-19.

- Looking to the **future**, albeit through COVID glasses –

  o respondents' main concerns related to not being able to meet people because of COVID (26%), losing and/or not being able to find work (18%), and coping with low pay (14%), and

  o the external factors that respondents felt would most benefit their physical and mental health were income (23%), employment (23%) and skills/qualifications (8%).

These findings broadly align with the target outcomes identified above, and the evidence and analysis presented elsewhere in this report. In particular, there is a recurring focus on the significance of employment and income. The survey data also provides further evidence of the effects of COVID on mental and physical health, both directly through experience of or anxiety around the disease and indirectly through its impact on the key socio-economic determinants of health.

In addition to specific population-focused projects that are expected to emerge in Phase 2, consideration should also be given to the development of a WHoLE appraisal framework and WHoLE dashboard to inform system focus and decision-making. Operating in a manner similar to the New Zealand Treasury's *Living Standards Framework*[3], it would enable the wider determinants of health and wellbeing to be monitored and to be used alongside other established quality and financial measures in determining courses of action. This would be particularly value in a context where some of the interventions that might be considered may have higher initial costs for one or more partner organisation but which, when seen in wider perspective, offer greater longer term benefits. Effective links should also be made within Healthier Futures structures between interventions to address the wider determinants of health and those focused on carbon reduction since, in many cases, there will be significant complementarity.

Organizational and sectoral boundaries encourage siloed decision-making, and in ways that risk depriving our communities of both socio-economic and health benefits. Developing a whole-system

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[3] https://lsfdashboard.treasury.govt.nz/wellbeing/

framework, reflecting the evidence summarised in this discussion document, could enable system partners to assess the whole-system impact of their decisions and to consider more holistically what makes for the common good.

Healthier Futures Academy
Black Country and West Birmingham

Introduction

The WHoLE Programme

This report is the initial output of the Wider Determinants of Healthy Life Expectancy (WHoLE) Programme, one of the priority initiatives of the Healthier Futures Academy that has been established in the Black Country and West Birmingham (BCWB)[4] to provide population health management, service redesign and workforce transformation capacity across the Healthier Futures Partnership. The Academy has established a support partnership with The Strategy Unit to access expert advisory, research and analytical capability.

The purpose of the WHoLE programme is to significantly expand on existing initiatives (see The Opportunities for 'Anchor Institutions') by working with local citizens and public, private and charity sector bodies to:

a) establish a whole-system culture and approach that promotes greater understanding of the wider socioeconomic determinants of population health specific to BCWB;

b) establish effective collaborative action with system partners that increases the beneficial impact of those determinants; and

c) generate new learning in respect of such action that adds to the local, national and international evidence base; and

d) inform the future role and functions of the single strategic commissioner for the system.

To achieve this aim, the programme has been tasked with:

i) rapidly researching, mapping and modelling the **dynamics** likely to shape population health need in the BCWB over the medium to long term (c.1-5 years), specifically factoring in the potential impact of COVID-19 on the socioeconomic determinants of health;

ii) identifying potential **levers and areas of opportunity** in relation to which a range of interventions can be considered;

iii) engaging with **stakeholders** to create a societal conversation across the system (LA members and officers, NHS leaders and wider workforce, other public and third sector agencies, citizens, MPs, etc.), to harvest insights and ideas, and to influence understanding and action; and

iv) designing, appraising, implementing and evaluating **interventions** focused on improving the wider socioeconomic determinants of health.

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[4] The area covered by the Healthier Futures partnership and the four NHS Clinical Commissioning Groups: https://www.healthierfutures.co.uk/

This report, and the underpinning evidence, analysis and modelling tools, address the first two items above and provide a launchpad for the more practical phases of the WHoLE programme that follow.

The formal governance of the programme sits with the Healthier Futures Partnership Board, through its new Academy function. This first phase of work has been resourced through the Strategy Unit and with invaluable support from the Economic Intelligence Unit at the Black Country Consortium.[5]

An expert advisory group (see Appendix One – WHoLE Programme Expert Advisory Group) has also been established to support the aims and objectives of the programme through providing advice and guidance in relation to:

1. The validity and robustness of the **approaches** proposed for delivering programme objectives;

2. Making **connections** with relevant local issues, opportunities or organisations that could enhance programme effectiveness;

3. The form and content of programme **outputs**, to ensure maximum impact;

4. The nature and scope of **interventions** to be considered in phase 2.

The Black Country and West Birmingham

In 2018, there were 1,370,653 people living in BCWB geography, of whom 21.5% were aged between 0-15 years old (19.2% for England) and 16.3% were aged 65+ (18.2% for England). Numbers of men and women are roughly equal overall, although there is a greater proportion of males in the 0-15 age bracket and a greater proportion of females aged 65 years and over.

The 2011 Census indicates that 29.3% of the population is classed as Black, Asian and Minority Ethnic (BAME), double the England average of 14.6%. The largest single BAME population is Asian/Asian British (18.4%), followed by Black/African/Caribbean/Black British (6.1%), and Mixed/Multiple ethnic groups (3.4%).

Nearly half of the population (48.4%) lives in communities that are amongst the 20% most deprived nationally. The average life expectancy at birth in BCWB is 80.8 years for men and 84.4 years for women. Those in contact with mental health services have a life expectancy 18.4 and 15.2 years shorter, respectively, than the rest of the local population.[6]

Healthy life expectancy (HLE) - the average number of years that an individual is expected to live in a state of self-assessed good or very good health - is lower for all parts of BCWB compared to the national average (Figure 7). These low rates generally correlate with a range of other factors (Figure 8). Walsall has the lowest female HLE in BCWB, Sandwell and West Birmingham the lowest male HLE, and Dudley the greatest HLE inequity.

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[5] Particular thanks are due to Alison Turner and Anastasiia Zharinova of The Strategy Unit, and to Megan Boehm and Delma Dwight of the Black Country Consortium's Economic Intelligence Unit.

[6] http://www.strategyunitwm.nhs.uk/publications/making-case-integrating-mental-and-physical-health-care-full-report, data from 2012-2015

Figure 7 - Healthy life expectancy in the Black Country and West Birmingham

Figure 8 - Factors correlating with healthy life expectancy

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Previous analysis of Public Health England (PHE) data[7] by local teams, found that:

- Mortality from conditions considered preventable is relatively high and there is a high prevalence of long-term conditions, especially in relation to hypertension, diabetes, chronic kidney disease, chronic heart disease, depression, and dementia.

- BCWB has some of the highest infant mortality rates in the country - smoking rates in pregnancy remain high, and breast-feeding rates are low. By the time a child starts school, they are much less likely to be ready for school than in other areas. Starting school ill-prepared makes it more difficult to catch up later and has lifelong consequences.

- Both child and adult obesity rates are high, whilst physical activity levels are relatively low, and unhealthy fast food is easily available. This increases the risk of diabetes and other weight-related conditions prematurely.

- Rates of hospital admission relating to alcohol consumption or as a result of violence are high, and many users of adult social care say they feel socially isolated and experience poor health-related quality of life.

- Rates of falls and hip fractures in older people are high, as are households living in fuel poverty meaning people are exposed to the risk of cold housing in winter exacerbating long-term conditions.

The Healthier Futures Partnership across BCWB has recognised the need for collaborative action on the wider determinants of health, and individual organisations are already active in this area (see The Dual Impact of the NHS).

> *If we are to stand any chance of improving the health of our population, we have to focus at least as much attention on the factors outside the health (and social care) system that are leading to poor health as those factors within the health sector that influence health. For example a ten percent increase in unemployment is associated with a reduction in life expectancy of a year... and a ten percent increase in the rate of housing deemed unfit for habitation is associated with a reduction in life expectancy of two months.*
>
> BCWB Clinical Strategy

> *The future of healthcare in England lies in shifting our focus from responding to individual ill health to improving population health and wellbeing. This requires a collaborative approach with our wider system partners across the public and third sectors.*
>
> BCWB Draft Strategic Plan

The urgency of this need has increased materially as a result of the health and socioeconomic impacts of COVID-19, especially in areas like BCWB that already faced significant health and socioeconomic challenges and which are likely to be especially vulnerable to a post-COVID economic downturn.

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[7] https://fingertips.phe.org.uk

The Determinants of Health

Population health is determined by a wide range of factors including healthcare interventions and lifestyle choices. But we know that there are wider, socio-economic determinants of health that have a greater impact on the health of the population and the resulting demand for healthcare services. BCWB has existing challenges in relation to these determinants.

> *People with a higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus.*

Fair Society, Healthy Lives[8]

There is growing recognition of the broader factors which influence our health and wellbeing. According to the Health Foundation, the quality of, and access to, health care is estimated to account for 10-20% of what contributes to people's health.

> *Rather than being something people just get at the doctor's or at hospital, health is something that starts in families, schools, communities and workplaces. It can be found in parks and in the air people breathe. The other factors that influence health – the social determinants – affect people in different ways, according to factors like age, gender, ethnicity, sexuality and disability. And they don't operate in isolation. Rather, they are intricately woven together in a dynamic and mutually reinforcing way.[9]*

The County Health Rankings Model[10] that proposes evidence-based weightings for the influence of a range of factors assigns 50% of the influence on health outcomes to the socioeconomic and environmental factors that are the focus of the WHoLE programme.[11]

What follows is not a comprehensive analysis of all the defined wider determinants of health but a focused approach concentrating on the determinants that are likely both to be amongst the most significant of those determinants for BCWB, and to be most vulnerable to the impacts of the COVID-19 lockdown and recession. A key focus becomes the impact of unemployment and income which in the County Health Rankings model account for 20% of the determinants of health.

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[8] http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review. See also https://www.health.org.uk/funding-and-partnerships/our-partnerships/health-equity-in-england-the-marmot-review-10-years-on

[9] https://www.health.org.uk/publications/what-makes-us-healthy

[10] https://pophealthmetrics.biomedcentral.com/articles/10.1186/s12963-015-0044-2

[11] A summary of other evidence-based estimates of the relative impact of healthcare and other determinants of health can be found here: https://www.local.gov.uk/sites/default/files/documents/22.52%20Social%20Determinants%20of%20Health_05_0.pdf p.6.
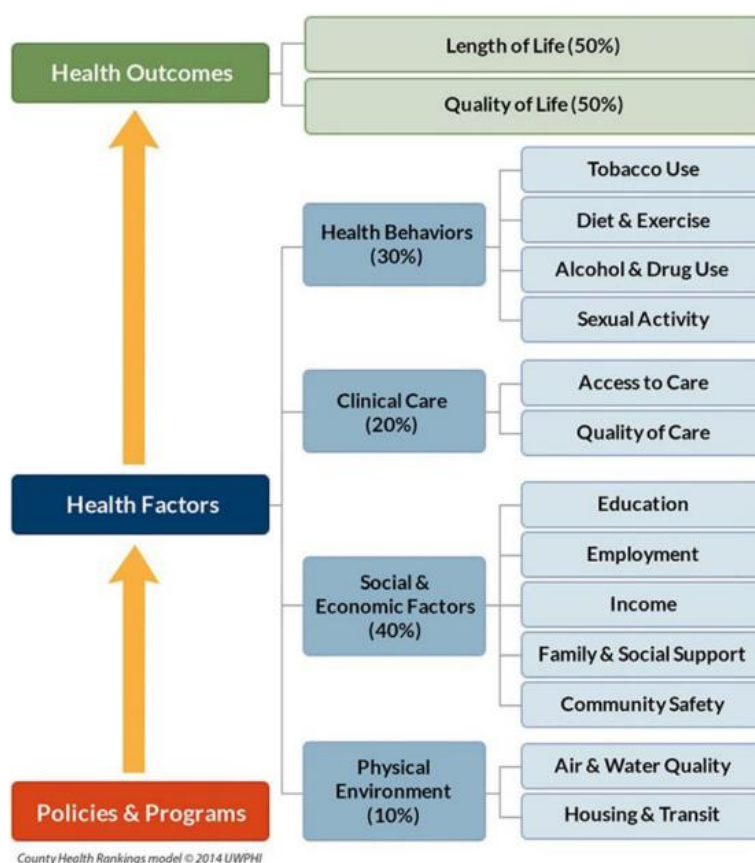
Figure 9 - County health rankings model

In what follows, we summarise relevant socio-economic data and the international evidence-base. The former is extracted from a report kindly provided by the Economic Intelligence Unit at the Black Country Consortium, and the latter from a rapid evidence analysis by The Strategy Unit. These underpinning documents are separately available. For ease of reader access, references and links in the text below are to the original sources.

Education and skills

Poor educational achievement is one of the strongest predictors of low healthy life expectancy, and a bad educational start in life fuels a trajectory of reduced educational attainment and weaker prospects. The County Health Rankings Model suggests that education accounts for a tenth of the determinants of health. Population data strongly suggests that in certain areas there is a cycle of poor educational attainment, with the associated consequences being repeated generation after generation. Low levels of school readiness are associated with low income and/or lone parent families, and high rates of teenage pregnancy, deprivation, and long term conditions, especially obesity, diabetes, coronary heart disease and depression.

Analysis by BCWB Clinical Commissioning Groups (CCGs) reveals that for every percentage point increase in children not school-ready there are decreases in key stage 2 attainment (0.7%), in the

proportion achieving 5 or more GCSEs (1.18%) and in individual achievement across 8 qualifications (0.7%), and that there is an increase in the proportion of the adult population who have no formal qualifications (1.1%). For every percentage point increase in the proportion of the adult population without formal qualifications there is a 0.5% increase in income deprivation, an increase in unemployment (2.2%), an increase in reception age obesity (1.1%) and a reduction in average HLE (8 months).

In BCWB, there is a high proportion of people with low qualifications or none, especially amongst men. For level 4 qualifications (first or higher degree, professional qualifications or equivalent) Asian and Black populations outperform while White and Mixed populations underperform, with the reverse being true at lower levels. The apprenticeship level is dominated by the White population (90% from a 70% cohort), although current apprenticeship starts are more in line with population size. The Mixed ethnic group underperforms pro rata at all levels except apprenticeship starts.

	Apprenticeship starts 2018/19	BCWB Population	No Quals	Level 1	Level 2	Apprenticeship level	Level 3	Level 4	Other quals
White	73.3%	70.7%	78.6%	73.5%	76.2%	89.4%	73.7%	67.2%	55.1%
Mixed/multiple ethnic group	5.0%	3.4%	1.6%	3.1%	3.2%	1.5%	3.0%	1.9%	1.5%
Asian/Asian British	13.9%	18.4%	14.7%	16.1%	13.0%	5.4%	15.4%	21.2%	32.8%
Black/African/Black British/ Caribbean	6.9%	6.1%	4.0%	6.2%	6.7%	3.3%	6.8%	7.9%	7.1%
Other ethnic group	0.8%	1.4%	1.2%	1.1%	0.9%	0.4%	1.1%	1.8%	3.5%

Table 2 - Qualification levels by ethnic group

Digital skills are becoming increasingly important, both for the workplace and for accessing public and commercial services. Whilst BCWB has good digital access, with 97.9% new generation broadband coverage, and the numbers of those not accessing the internet in the last three months continues to decline, the area does have digital vulnerabilities.

	Birmingham	Dudley	Sandwell	Walsall	Wolverhampton
Likelihood of digital exclusion	Medium	Medium	Medium	High	High
Not online in last 3 months	11.20%	14.20%	11.80%	13.50%	13.90%
All 5 basic digital skills	77%	77%	76%	76%	77%
Used all 5 basic skills in last 3 months	39%	42%	37%	38%	40%
Long term condition/ disability	18.40%	20.30%	20.90%	20.80%	20.50%

Table 3 - Digital literacy in BCWB, Source: British Red Cross, 2020

Digital exclusion is the inability to access online products or services or to use simple forms of digital technology. This disproportionately affects vulnerable people, low-income groups, the elderly and

marginalised communities, creating a strong correlation between digital exclusion and social exclusion.

The adverse consequences of poor educational achievement pass down the generations. Living in poverty as a child increases the risk of having low attainment at school; adults in poverty or in low-paid jobs are less likely to receive training and to progress into better jobs than those who are better paid; and young people from poorer backgrounds are around a third less likely to achieve good qualifications at age 16.

Digital Literacy Case Study

'Helen' was referred to the Integrated plus High Intensity User (HIU) project due to having multiple attendances at A&E. This was proving to be expensive for the NHS and there was no further support clinical staff could offer. She was struggling with her mental health and felt safe at the hospital. 'Helen' felt that her anxiety was taking over everything that she did, and she just wanted to feel well and enjoy life.

After being visited by a HIU Link Worker who listened to her story, it was very clear she enjoyed helping people and having a purpose. 'Helen' spoke about how much it had helped in the past when she had volunteered at different charity shops in Dudley, and she said she had always wanted to become a hospital volunteer with a view to getting back into employment in the future. The application forms were all being done online, however, and 'Helen' felt she couldn't apply because she wasn't computer literate. She felt there were a lot of opportunities she had missed out on in the past due to not being able to use a computer.

With support, 'Helen' was able to complete the online application which led to her attending an online interview with the help of the Link Worker. She was successful in securing a position as a volunteer and has continued to make progress, giving her confidence and having a positive impact on their mental health and wellbeing.

Employment and income

Guidance from Public Health England (PHE)[12] highlights four links between employment and health:

- physical work conditions

- psychosocial work conditions

- poor pay or insufficient hours

- temporary or insecure work and redundancy.

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[12] http://www.instituteofhealthequity.org/resources-reports/local-action-on-health-inequalities-promoting-good-quality-jobs-to-reduce-health-inequalities-

It estimated that, in 2014, 1.2m people in Britain, especially those in manual work, had an illness or health condition linked to historic or ongoing work experience. The most common health impacts relate to musculoskeletal disorders and mental health.

High levels of stress at work have been found to be nearly twice as high for BAME workers than amongst White workers, and the adverse impacts of poor quality work are more likely to be felt by those with a lower socioeconomic position, younger people, those in lower paid jobs and BAME citizens.[13]

Research for the Institute of Fiscal Studies has found a clear, counter-cyclical relationship between employment and health conditions, particularly in relation to mental health, musculoskeletal, cardiovascular, and respiratory conditions, and with the health condition impact taking between 1 and 5 years to reach its peak.[14]

A further review based on the 2008 recession, which also found that health impacts take many years to become fully apparent, identified the crisis as a serious threat to children's health, particularly impacting more vulnerable groups.[15] When money is short, food insecurity increases and access to healthy diets is reduced.[16] Marmot highlights how:

- *Stress, depression and anxiety associated with food insecurity affect more than half of households who are referred to food banks and a quarter of households have a member with a long-term physical condition or illness in 2018.*

- *Children who grow up in food-insecure homes are more likely to have poor health and worse educational outcomes compared with children growing up in food-secure homes.*

- *Between 2004 and 2016 food insecurity among low-income adults rose from 28% in 2004 to 46% in 2016. Between 8 and 10% of households in the UK were food-insecure between 2016 and 2018, experiencing poor physical and mental health as a result.*

- *The poorest 10% of English households would need to spend close to three-quarters of their disposable income on food to meet the guidelines in the NHS's Eatwell Guide, compared with only 6% of income for households in the richest decile shown.[17]*

Psychological problems are twice as prevalent amongst the unemployed, who also experience higher mortality. There were 1000 excess deaths by suicide in the 2 years after the financial crash.[18] Economic recessions increase vulnerability to common mental disorders, substance disorders, and suicidal behaviour, with potential long-term impacts for children and young people in families

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[13] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
[14] https://www.ifs.org.uk/publications/14807
[15] https://www.mdpi.com/1660-4601/11/6/6528
[16] https://academic.oup.com/eurpub/article/27/suppl_4/18/4430523
[17] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
[18] https://www.sciencedirect.com/science/article/abs/pii/S0140673613601026

affected by unemployment or poverty.[19] The risks of poor mental health as a result of austerity are heightened for those in the most deprived, least educated groups.

In BCWB, before COVID (2019 data), 73.4% of the population was economically active, of which 6.7% was unemployed, compared with a national rate of 4% (3.9% as of March 2020). Amongst 16-24 year olds, local rates were much higher at 15.6% for males and 13.0% for females (13.7% and 9.6%, respectively, across England). There were significant differentials in unemployment rates by ethnicity, with an extremely high figure for residents from the Mixed ethnic group:

Ethnic group	BCWB unemployment rate (%)	England unemployment rate (%)	Difference (%)
All	*6.7*	*3.9*	*2.8*
Mixed ethnic group	19.3	6.2	13.1
Pakistani/Bangladeshi	12.9	8.2	4.7
Other ethnic group	11.6	6.8	4.8
Black or Black British	9.7	8.1	1.6
White	5.5	3.5	2.0
Indian	4.5	3.9	0.6

Table 4 - Unemployment rates by ethnic group

Of the 26.6% economically inactive, 31.4% were caring for home and family and 24.3% were sick, with the remainder being students (including 16-18 year olds in education) or retired. The rate of economic inactivity is highest (52%) amongst 16-24 year old females. Economic inactivity is correlated with poor healthy life expectancy.[20]

Despite the economic challenges of the area, and the evidenced links between economic challenges and mental health prevalence, only 5% of working age adults were accessing secondary mental health services, compared with 8% nationally. The reasons for this are not clear.

The average annual earnings in BCWB were c.£4k below the England average: the gap was smaller for women but larger and deteriorating for men. Although fuel poverty was reducing at a faster rate than nationally, the BCWB rate (12.4%) still exceeded the national level (10.3%). Many local children grow up with the consequences of economic challenges: 17.7% live in workless households and 28% in relative low income families.

Retail employment is relatively high for BCWB residents as is advanced manufacturing, environmental technology, and transport technology, though on a smaller scale. Retail, public sector, health and advanced manufacturing make more of a contribution to the BCWB economy than they do nationally. The average GVA per hour for BCWB increased by 4.2% between 2017-2018 but remained significantly lower than the England average (£21,532 and £29,356, respectively). Between 46% and 62% of residents work within their home authority area, more so in the Black Country LEP (76%) than in the Birmingham LEP (61%).

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[19] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-2720-y
[20] BCWB CCG data

The top 5 BCWB sectors are:

Sector	BCWB GVA (%)	England GVA (%)	BCWB jobs (%)	England jobs (%)
Business services	31.1	42.1	24.0	25.4
Retail	12.4	10.7	17.2	15.3
Public sector	14.4	10.8	14.2	15.3
Advanced manufacturing	14.5	11.7	13.7	10.4
Health	10.6	7.4	12.7	12.9

Table 5 - GVA and jobs by sector

BCWB jobs have a higher risk of automation than nationally because skills levels are generally lower. Most regions with a low probability of automation are concentrated in the South East of England and London.[21]

Local authority	Probability of automation	Proportion of jobs at Low Risk (<30%) of automation 2017	Proportion of jobs at Medium Risk (30-70%) of automation 2017	Proportion of jobs at High Risk (>70%) of automation 2017
Birmingham	46.0%	26.7	65.9	7.5
Dudley	48.1%	19.6	71.5	8.9
Sandwell	50.3%	16.7	72.0	11.2
Walsall	47.5%	21.3	70.4	8.3
Wolverhampton	49.1%	17.5	74.3	8.2

Table 6 - Probability and risk of automation by local authority

Housing

There are two particular aspects of the impact of housing on population health that we consider here: the quality of the indoor environment and the security of housing provision.

The mechanisms through which the indoor environment of the housing stock impacts health are set out in the figure below.[22] It illustrates how indoor temperature, air quality and physical conditions affect morbidity and mortality from cancer and cardiorespiratory illness.

- 12% of new childhood asthma cases are estimated to relate to exposure to indoor mould, leading to 55,842 potentially avoidable disability-adjusted life years (DALY) and 83 potentially avoidable deaths per year.

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[21] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/theprobabilityofautomationinengland/latest#findings-from-the-office-for-national-statistics-ons-approach
[22] http://www.instituteofhealthequity.org/resources-reports/inherit-baseline-report/inherit-baseline-report.pdf

- 15% of new childhood asthma cases are estimated to relate to exposure to indoor dampness, leading to c.69,462 potentially avoidable DALYs and 103 potentially avoidable deaths per year.

- 12.8 excess deaths per 100,000 population across Europe are estimated to result from indoor cold, representing 38,200 excess winter deaths each year in 11 European countries.

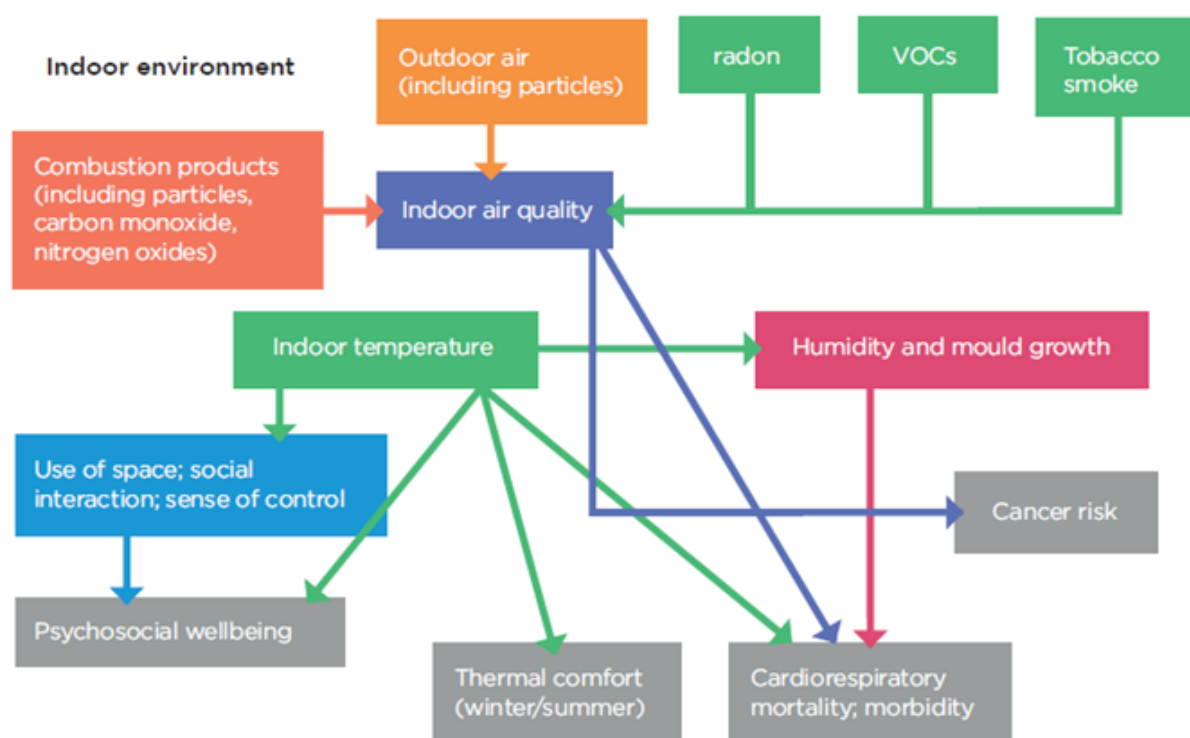- every £3 invested in reducing housing hazards would save £2 in medical costs within a year, and with a recurring impact.

Table 7 - Housing and health

In BCWB in 2018,

- 12.4% of households (67,826) were living in fuel poverty, above the national average of 10.3%.

- The overall housing affordability ratio was 5.71, below the England average of 8.68. Given its relatively low income levels, this suggests that BCWB housing costs are even lower relatively, and this may have an impact on the quality of accommodation available.

In terms of housing security, the threat of eviction is associated with both physical and mental ill health, including depression, anxiety, psychological distress and suicides, and high blood pressure

and child maltreatment.[23] The sources of stress are related to worries about safety, paying rent, and lack of control.

In BCWB, and despite the reported affordability of housing, there has been an increasing gap between housing benefit levels and actual rents. This will mean that household spending on other items is constrained. This gap has been identified as a growing cause of homelessness nationally.[24]

The total number of evictions has remained broadly steady, though since 2014/15 there has been a reduction in evictions from social housing and an increase in accelerated evictions. There were 1,600 families evicted across Birmingham and the Black Country in 2017/18. Mortgage repossessions peaked at the time of the last economic crash (c.2,000 in 2008/09) and are now at a 15-year low (200 in 2017/18), with the risk that a new recession creates a new peak.

In 2017/18 the number of those recognised as statutorily homeless was 7.8 per 1,000 households in Birmingham (57% of which were BAME in the context of a 41% BAME population) and 2.6 per 1,000 in the Black Country (42% of which were BAME in the context of a 20% BAME population). BAME homeless increases exceeded population growth in the preceding ten years. Homelessness is linked to high Emergency Department use, with evidence of attendances being five to seven times the general level, and admissions four times as high.[25]

The proportion of households that are overcrowded was 9% in Birmingham, 7% in Sandwell, 6% in Wolverhampton, 5% in Walsall and 4% in Dudley (England, 5%).

Air quality and other environmental factors

Recent research by the Environment Agency[26] highlights that:

- *Air pollution is the single biggest environmental threat to health in the UK, shortening tens of thousands of lives each year.*

- *After air pollution, noise causes the second highest pollution-related burden of disease in Europe, and is responsible for more life years lost than lead, ozone or dioxins.*

- *There is emerging evidence of health effects from lower levels of pollution, although these are not currently well understood.*

- *Antimicrobial resistant microbes are becoming more common in the environment due to contamination, meaning infectious illnesses may become harder to treat.*

[23] https://www.sciencedirect.com/science/article/abs/pii/S0277953617300102
[24] https://www.barrowcadbury.org.uk/wp-content/uploads/2019/02/NPI-The-State-of-Economic-Justice-in-Birmingham-and-the-Black-Country_lo-res-for-web.pdf
[25] https://www.rcem.ac.uk/docs/Policy/Homelessness_and_EDs.pdf
[26] https://www.gov.uk/government/publications/state-of-the-environment/state-of-the-environment-health-people-and-the-environment

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- *Mental health conditions are increasing - they are the largest single cause of disability in the UK, and can be caused or affected by pollution, flooding and climate change.*

- *Exposure to pollution, and access to the natural environment are not equally distributed across society - people living in deprived areas often have poorer quality environments with less accessible green space.*

There is an established relationship between air quality and health. Poor air quality recognised as the largest environmental risk to public health in the UK, with between 28,000 and 36,000 deaths a year attributed to long-term exposure.[27] It impacts healthy life expectancy through cardiovascular and respiratory illness, including stroke, lung cancer and asthma, as well as through low birth weight. Around 1,100 deaths annually in the Black Country and Birmingham may be attributable to particulate air pollution.

	England	West Midlands	Birmingham	Dudley	Sandwell	Walsall	Wolverhampton
Fraction of age 30+ mortality attributable to particulate air pollution	5.15	4.96	5.53	5.21	5.78	5.54	5.10
Estimate of number of deaths attributable to particulate air pollution	25,791	2,765	467	175	175	149	140
Air pollution: fine particulate matter	8.90	8.67	9.81	8.73	10.06	9.75	8.63

Table 8 - Air pollution and mortality in BCWB (PHE Fingertips data, 2018)

The major contributors to poor air quality are particulate matter (PM) and nitrogen dioxide (NO2). In BCWB, the air quality of 254 out of 804 LSOAs (32%) fell into the 'worst' category nationally. This is especially significant in Sandwell and West Birmingham. Nitrogen dioxide levels – around a quarter of which are associated with diesel vehicles (especially when moving slowly)[28] - are higher locally than across England (14.6 and 12.0, respectively). Access to Green Belt varies significantly across BCWB.[29] A report by the Royal College of Physicians found that, although air pollution is harmful to everyone, its adverse effects are especially felt by those who:

- live in deprived areas, which often have higher levels of air pollution

- live, learn or work near busy roads

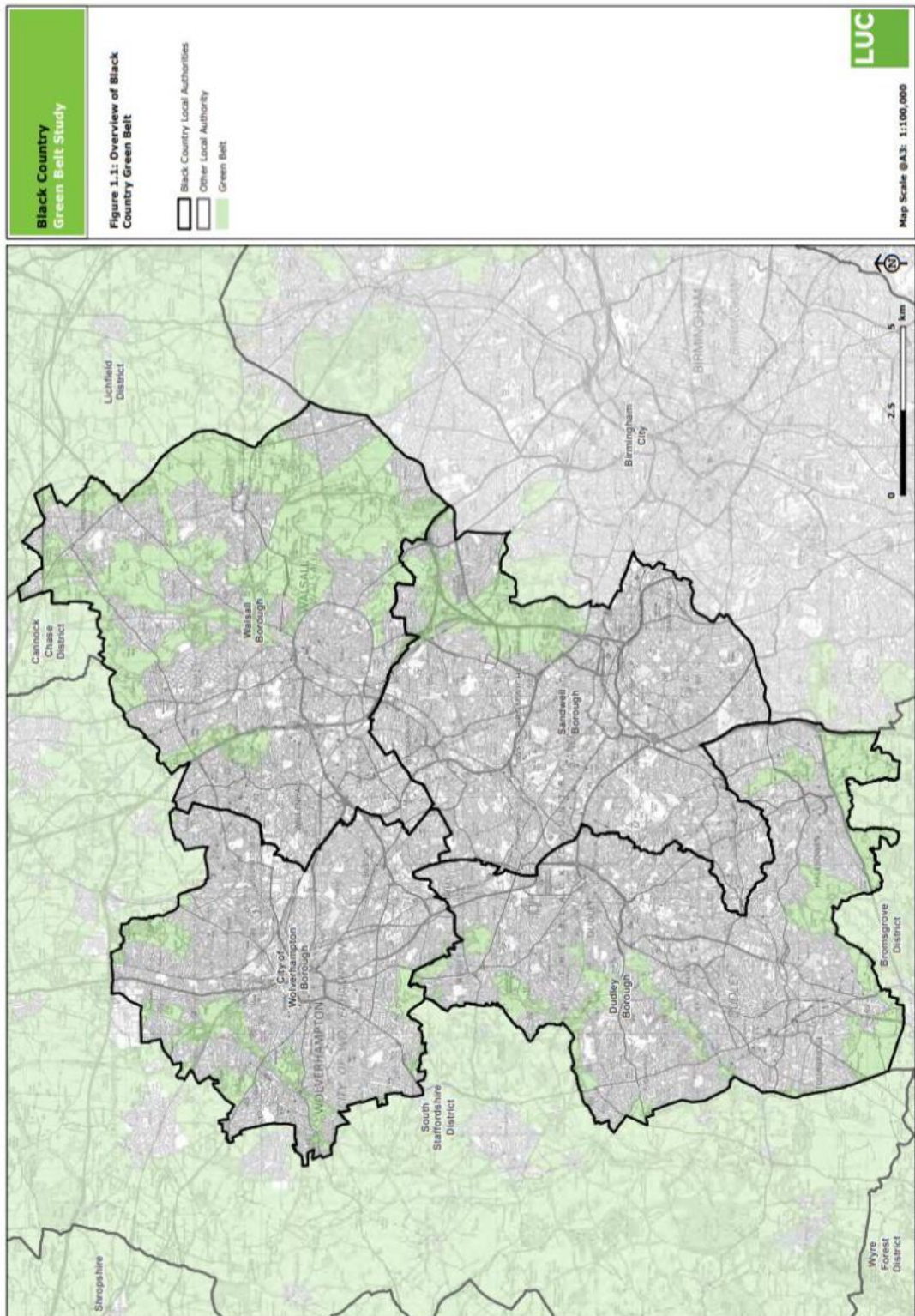- are more vulnerable because of their age or existing medical conditions.[30]

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[27] https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution ;

[28] https://uk-air.defra.gov.uk/assets/documents/reports/aqeg/nd-summary.pdf

[29] https://blackcountryplan.dudley.gov.uk/media/13882/bcgb-0919-black-country-gb-stage-1-and-2-plus-app1-final-reduced_redacted.pdf

[30] https://www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution

Black Country Green Belt Study

Figure 1.1: Overview of Black Country Green Belt

Black Country Local Authorities
Other Local Authority
Green Belt

Map Scale @A3: 1:100,000

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The Additional Impacts of COVID-19

There is evidence that COVID-19 is affecting the wider determinants of health and the consequent demand for services in an adverse manner and to a significant degree. This is in addition to the direct treatment and enduring health impacts of the disease.

Health and care services face very significant demand and supply challenges because of COVID-19.

The first wave of the disease led to enormous efforts being made in frontline and supporting health and care services to ensure that the NHS remained able to care for those affected by the disease. This necessitated the deferral of a great deal of non-COVID activity that services are now in the process of recovering. In addition, a second wave appears to be building alongside typical winter pressures, and there is emerging evidence about the long-term health needs of those more seriously affected by COVID-19.

The direct impacts of the disease have created substantial morbidity and mortality challenges, and these appear to have had a particularly severe impact on older population groups, on those with underlying conditions and on Asian and Black communities.[31]

> *The prevalence and severity of the COVID-19 pandemic is magnified because of the pre-existing epidemics of chronic disease—which are themselves socially patterned and associated with the social determinants of health. Minority ethnic groups, people living in areas of higher socio-economic deprivation, those in poverty and other marginalised groups (such as homeless people, prisoners and street-based sex workers) generally have a greater number of coexisting non-communicable diseases, which are more severe and experienced at a younger age.[32]*

Its indirect impacts, operating through the socio-economic determinants of health, are also likely to have a materially adverse impact on population health and, consequentially, on the demand for healthcare services. There is no close precedent for the current pandemic but, in terms of the economic shock and employment effects, there are lessons to be learned from the global economic crisis that followed the 2008 financial crash, and a good deal of evidence has been emerging from research during the current pandemic.

> *Our analysis shows that a recession will lead to a large rise in the prevalence of chronic ill health. During the most intense part of the financial crisis of the late 2000s in the UK, there was around a 5% fall in the employment rate, a drop that was low by international standards. Assuming a (possibly conservative) fall in the employment rate in the coming year of the same size, our analysis predicts that the prevalence of chronic conditions in the working-age population will rise by somewhere between 7% and 10%. This increase*

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[31] https://www.gov.uk/government/publications/COVID-19-understanding-the-impact-on-bame-communities
[32] https://jech.bmj.com/content/early/2020/06/13/jech-2020-214401

translates into around 900,000 more people of working age who will suffer from at least one chronic condition.[33]

Mental Health and COVID Case Study

My name is 'Donna' and I am a 22 year old carer who suffers daily with eczema, asthma, depression, anxiety, PTSD, possible MH, weakened immune system and under investigation for a heart condition and many more problems.

For as long as I can remember I have battled these conditions each day with very little understanding from those around me. Most of my conditions are triggered by my state of mentality for example my eczema is mainly affected when I am experiencing high stress levels, a PTSD attack or a change in hormones. (There are physical triggers too.) My flare ups can happen spontaneously and spread like a wildfire across all areas of my skin. Within minutes I can go from dry patches to emitting heat from large red patches of torn, weeping skin which in the past has been shredded down to muscle. It is not uncommon for my skin to flare to the point when I have to be bandaged completely and put onto rest as I am no longer able to bend my limbs due to how severe I have flared. As you can imagine this takes its toll on my mental health causing my depression to spike resulting in another flare up. It is an endless cycle with very little cures.

The scariest of my conditions is one that I do not have a formal diagnosis of as it first happened during lockdown and I have not been able to be submitted for a full investigation as of yet. My heart will jump from around 70 to over 180 plus in seconds, my chest grows tight, I then begin to hyperventilate, overheat, my body becomes numb, I lose coordination and strength, pain spreads throughout my body however I remain completely aware of everything happening without the ability to act upon it. This can happen at any given moment and as my doctor has warned me I could have a heart attack or potentially die if not treated immediately. As a young adult it feels like a death sentence and it has a massive impact on the quality of my life as I live in a perpetual state of fear which as you can guess is bad for my heart.

I have faced a lot of discrimination from health professionals, employers and people in general as they believe that because of these conditions I must be incapable when it is definitely not the case. I truly believe that with support groups and training a lot of people who are in the same boat as myself could make a difference and improve on the quality of life that we have.

Having poor health in this day and age with the Corona virus circulating people like myself who fall into a high risk category is terrifying, there is not a moment that I am not concerned for not only myself but for my disabled mother who I care for. If either of us contracted the virus there would be a much higher risk of death due to respiratory and cardiac complications.

As you can see the stress of the world and not knowing what is happening has had a massive impact on my day to day life making each moment excruciating, what makes it worse is not being able to access areas of help such as doctor surgeries and counselling due to the restrictions placed upon us so it is a battle I face alone for the time being.

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[33] https://voxeu.org/article/impact-COVID-19-chronic-health-uk

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The purpose of this section is to provide evidence of how COVID-19 is affecting, or might be expected to affect, some of the key socio-economic factors that determine the health and wellbeing of the BCWB population, and the additional demand for healthcare services that may be generated as a result. The Local Government Association (LGA) highlights that,

In the context of COVID-19 it is important to remember that it is often the effects of social determinants of health that have made people more vulnerable to the virus. Conversely the social effects of the virus on employment and the economy will have an additional impact on health.[34]

The British Red Cross' COVID-19 Vulnerability index identifies 71% (124) of BCWB's middle layer super output areas (MSOAs) as being within the most vulnerable quintile nationally, and a further 21.5% (37) within the next most vulnerable quintile. The index combines multiple sources of data to identify

- Clinical vulnerability (underlying health conditions);

- Health & wellbeing including mental health (loneliness, healthy life expectancy at 65);

- Economic vulnerability (recipients of social care benefits, employment & support allowance, disability benefits, Universal Credit); and

- Social and geographical vulnerability (barriers to housing and services, poor living environment, digital exclusion).

Education and skills

A national survey organised by the Institute for Fiscal Studies and the Institute of Education, and completed online in April and May by over 4,000 parents of children aged 4–15, found that pupils (especially those from poorer families) lost out on learning opportunities and support as a result of the pandemic:

- Primary and secondary students spent c. 5 hours a day on average on home learning, with secondary pupils more likely to have online classes

- Only 47% of secondary pupils from the poorest fifth of families were offered active help from schools, such as online teaching, compared with 64% of the richest families.

- Poorer children spent 30% less time on home learning than those from higher-income families. Assuming no school attendance prior to September this creates an access differential equivalent to fifteen full school days.

- Parents in the richest families were c.15 percentage points more likely than those in the poorest fifth to report that the provision of online and other remote support, and 58% of primary pupils from the least well-off families did not have their own study space.

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[34] https://www.local.gov.uk/sites/default/files/documents/22.52%20Social%20Determinants%20of%20Health_05_0.pdf

School closures are almost certain to increase educational inequalities. Pupils from better-off families are spending longer on home learning; they have access to more individualised resources such as private tutoring or chats with teachers; they have a better home set-up for distance learning; and their parents report feeling more able to support them. Policymakers should already be thinking about how to address the gaps in education that the crisis is widening.[35]

A recent survey for the National Foundation for Educational Research (NFER)[36] found the gap between disadvantaged pupils and their peers increasing by 46%, with the impact felt particularly in schools with the highest level of free school meals and the lowest levels of attainment. A greater need for intensive catch-up support was identified for schools with the same characteristics, as well as those with a larger share of BAME pupils. Evidence from a linked survey[37] highlighted the difficulties for some pupils of accessing IT in the home, with double the proportion of pupils in the most deprived schools having little or no access to IT than those in the least deprived schools. Teachers in the West Midlands reported lower levels of pupil engagement than in London, and the region has also received a below average increase in resources through the National Funding Formula (3.6% compared with 3.2% in London, 3.8% in the North East, 5% in the South West and 5.03% in the East of England).

The educational impact of COVID clearly risks compounding existing disadvantage, including the preparedness of students for further study and skilled employment.

Employment and income

One of the most obvious impacts of the pandemic has been on job insecurity, including the novel experience of being furloughed, uncertainty about short- and long-term employment prospects and, increasingly, redundancies. These factors clearly also affect the ability to undertake or maintain house rental or purchase, as well as other core domestic expenditure.[38]

Analysis from the Institute for Fiscal Studies[39] applies learning from other recessions to the current pandemic, suggesting that those most likely to suffer the biggest economic losses are the more vulnerable in society and therefore less resilient to economic shocks (e.g. people with lower incomes are less likely to be able to work from home or have savings to dip into), and that groups of particular concern are families with young children or where mothers are pregnant, and low-income or low-socio-economic-status individuals of all ages where health vulnerabilities and mental health problems are already prevalent.

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[35] https://www.ifs.org.uk/publications/14848
[36] https://www.nfer.ac.uk/schools-responses-to-COVID-19-the-challenges-facing-schools-and-pupils-in-september-2020/
[37] https://www.nfer.ac.uk/schools-responses-to-COVID-19-key-findings-from-the-wave-1-survey/
[38] https://www.sciencedirect.com/science/article/pii/S1743919120303162?via%3Dihub
[39] https://www.ifs.org.uk/publications/14799

A briefing from the Resolution Foundation[40] highlights the disproportionate impact in certain sectors of the workforce, reporting that those employed in shutdown sectors are over six times more likely to be in the lowest income decile than those working from home, and that under 25s are twice as likely to work in shutdown sectors than the rest of the workforce, with only 22% likely to be working from home (39% of 35- to 44-year-olds).

There is also evidence of the impact of recessions on children's health and their whole-life outcomes. Being born in a recession can reduce lifespan by c.5%; the recession-related stress experienced by pregnant mothers can lead to reduced birthweight and associated risks; and, during recessions, children's mental health outcomes can deteriorate and the use of special education services for emotional problems can increase.[41]

Economic output in the twenty most vulnerable places identified by the Centre for Progressive Policy (CPP)[42] is projected to be, on average, 18% lower after five years than the level expected pre-crisis. These are the places at particular risk of a prolonged economic downturn, and they include the five BCWB Local Authorities. The CPP further projects that average earnings in these vulnerable places will fall from £18,600 per annum to £17,300 in real terms over three years, and that parts of the Midlands face the largest initial impacts from COVID-19 and the associated economic shutdowns. Local businesses are part of internationally significant supply chains in key sectors such as advanced manufacturing, construction, and logistics. COVID-19 has forced a re-set across local businesses, as it has across Local Authorities, the NHS, and educational and other local institutions.

There were 82,040 BCWB unemployment claimants aged 16 years and over in May 2020, nearly double the figure in May 2019 (42,015). This accounts for 7.6% of the population aged 16 years and over (9.5% males, 5.8% females) and is above the national average of 5.0%. For claimants aged 16-24 years old, the BCWB figure was 10.8% compared with 7.2% nationally. Across all age BCWB groups, males have a higher number of claimants as a percentage of population (6.2%) in May 2020 compared to females (3.9%).

There are several elements of the present context that make it different from previous recessions, however. First, there have been the very significant mitigations put in place by the Treasury, including the Coronavirus Jobs Retention Scheme (resulting in a fall in average hours worked rather than in employment) and the Self-Employment Income Support Scheme (allowing the self-employed to remain in business). The OBR notes that these and other early interventions initially created

> *a contrast with the unemployment-heavy recessions of the early 1980s and early 1990s, and the more even split between unemployment, average hours and productivity that was seen during the recession that followed the financial crisis. As the support schemes come to an end, however, a more normal pattern is likely to reassert itself.*[43]

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40 https://www.resolutionfoundation.org/publications/risky-business/
41 https://www.coronavirusandtheeconomy.com/question/how-will-lockdown-and-recession-affect-childrens-health
42 https://www.progressive-policy.net/publications/back-from-the-brink
43 https://obr.uk/fsr/fiscal-sustainability-report-july-2020/

In that next phase of the crisis, secondly, it is suggested that, despite the enormous initial impact on national income (GDP), the greater sustained impact will be on jobs, and on a similar scale to the 1980s (c.12% peak nationally) rather than post-2008 (c.8% peak nationally). One expert commentator has observed that

> *Even before the crisis, corporate profitability was down 20% on levels in the first half of 2017 and at similar levels to those at the height of the 2008/09 recession. The UK had narrowly missed recession at the end of 2019, before COVID-19 struck. Now, forecasts predict that GDP is 8-10% below peak as we emerge from Lockdown in July and 4% down in the first half of next year. The absence of, or very limited, trading for some months will have pushed many firms to the edge of existence……. With no financial buffers, firms will cut jobs heavily to protect the firm until clarity emerges of their trading position after September. The risk for the firm is that holding onto too many workers will push them into to bankruptcy, so firms will err on the side of laying off workers.*

> *Further, the sectors who have and will continue to be hardest hit by Lockdown and social distancing will be the labour intensive sectors of retail, hospitality, leisure and tourism.*[44]

Linked to this, thirdly, the Resolution Foundation has argued that the defining feature of the evolving economic crises will be its sector specific impact.[45] To determine which BCWB sectors are most vulnerable to COVID-related impacts, broad sector analysis from OBR scenarios[46] has been applied to the ten main sectors. The table below highlights in red the sectors likely to be affected the most nationally, and their local 2018 scale in terms of jobs, GVA and businesses. This headline analysis suggests that the public sector (including education) and the visitor economy sector will be the sectors most impacted. The former, whilst of a similar scale locally as nationally, is relatively less productive (GVA relative to jobs); the latter is larger locally than nationally, and relatively more productive. Health may be the only sector that will be unscathed but, notably, also one of the sectors whose workforce has felt the impact of the pandemic most directly. It represents a similar proportion of the economy locally and nationally but appears to be much more productive locally.

These observations broadly align with recent analysis from City Region Economic and Development Institute (City REDI) which, although it uses a slightly different sectoral categorisation to the table below, finds that the sectors in the West Midlands most at risk of significantly reducing in size and most at risk of not bringing workers back post-furlough are advanced manufacturing and engineering, construction, retail and the cultural economy (comprising the visitor economy and sports).[47]

Although not in the highest risk sectors, the BCWB business services sector is relatively smaller and less productive than nationally, and the local retail sector represents a larger share of BCWB jobs than it does nationally. The COVID impact on retail is, of course, very mixed, appearing to increase

[44] https://blogs.ucl.ac.uk/cepeo/2020/06/17/unemployment-the-coming-storm/
[45] https://www.resolutionfoundation.org/publications/risky-business/
[46] https://cdn.obr.uk/OBR_FSR_July_2020.pdf
[47] https://blog.bham.ac.uk/cityredi/west-midlands-weekly-economic-impact-monitor-11th-september-2020/

the existing challenges for the high street but creating significant new opportunities linked to online retail, especially for groceries. How this internal sectoral change plays out is likely to be material to BCWB economic recovery. The ONS reported in September 2020 that while total sales (particularly for food and non-store retailing) had recovered, clothing sales were still 25.7% lower than in February 2020. Although footfall had increased between March and end August, it was still only c.70% or earlier levels in the high street and shopping centres and c.90% in retail parks.[48]

	Proportion of 2018 Jobs		Proportion of 2018 GVA		Proportion of 2019 Enterprises	
	BCWB	England	BCWB	England	BCWB	England
Advanced Manufacturing	13.7%	10.4%	14.5%	11.7%	10.2%	12.8%
Building Technologies	4.5%	4.6%	6.0%	6.1%	11.9%	12.7%
Business Services	24.0%	25.4%	31.1%	42.1%	34.3%	40.1%
Environmental Technologies	1.2%	1.1%	2.5%	2.5%	0.4%	0.5%
Health	12.7%	12.9%	10.6%	7.4%	4.6%	3.9%
Public Sector	14.2%	15.3%	14.4%	10.8%	2.4%	3.6%
Retail	17.2%	15.3%	12.4%	10.7%	21.2%	14.3%
Sports	1.6%	1.8%	1.2%	1.1%	0.7%	1.3%
Transport Technologies	6.1%	4.9%	4.7%	4.2%	8.1%	4.2%
Visitor Economy	4.9%	8.1%	2.5%	3.3%	6.2%	6.8%
Key:	most vulnerable sectors					least vulnerable sectors

Table 9 - Jobs, GVA and enterprises by sector

All sectors remain vulnerable to the scale of the post-COVID recession and, whatever, the scale of the risk, it will play on existing structural features including:

- The relatively low average income levels across BCWB (and the constrained ability to weather an economic crisis that accompanies this).

- The high numbers of children living in poverty (17.7% live in workless households and 28% in relative low income families).

- The already high rates of unemployment especially amongst
    - Mixed ethnic groups (19.3% BCWB compared to 6.2% nationally) and the Pakistani/Bangladeshi population (12.9% BCWB compared to 8.9% nationally) and
    - 16-24 year-olds (males 15.6% compared to England 13.7%; females 13.0% compared to England 9.6%);

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[48]

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronavirusCOVID19roundupeconomybusinessandjobs/2020-07-02

- The relatively low skills levels, especially in the White population;

- The relatively large proportion of 0-15 year-olds (21.5% BCWB, compared to 19.2% nationally) especially males - an age-group that will be seeking to enter the jobs market for the first time in the economic and social shadow of the COVID-19 pandemic; and

- The relatively high proportion of the population that is economically inactive (i.e. neither in work nor seeking work), especially females aged 16-49 and across all ethnic groups except those of Indian ethnicity; and

- The high levels of air pollution, with 32% of neighbourhoods (LSOAs) in the 'worst' category nationally.

These vulnerabilities clearly matter a great deal for the financial position of BCWB households, but they also have the potential to significantly affect BCWB population health. Janke et al (2020)[49] observe that, in England,

> *the treatment and care of people with chronic diseases accounts for an estimated 70% of total health and social care expenditure (Department of Health 2010). Around one in three of the population currently have at least one long-term health condition…….. Our analysis shows that a recession will lead to a large rise in the prevalence of chronic ill health. During the most intense part of the financial crisis of the late 2000s in the UK, there was around a 5% fall in the employment rate, a drop that was low by international standards. Assuming a (possibly conservative) fall in the employment rate in the coming year of the same size, our analysis predicts that the prevalence of chronic conditions in the working-age population will rise by somewhere between 7% and 10%. This increase translates into around 900,000 more people of working age who will suffer from at least one chronic condition.*

This evidence forms the basis of the modelling in the following section, along with analysis linking economic recession to an increase in suicide rates. That analysis[50] suggests there may have been c.8,000 excess suicides between 2007-10, and that rates remain high through economic recovering because of the perceived continuing risks around unemployment, unaffordable housing and indebtedness. The impacts of recession reduce in response to strong welfare and other support systems (such as active labour market programmes, unemployment payments and strong social capital[51]) but the unemployed have twice the risk of psychological problems and a higher mortality risk, irrespective of social groups.[52]

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[49] https://voxeu.org/article/impact-COVID-19-chronic-health-uk
[50] http://eprints.lse.ac.uk/85919/1/Austerity%20and%20health_FINAL.pdf
[51] *Ibid.*
[52] https://www.sciencedirect.com/science/article/abs/pii/S0140673613601026

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Black Country and West Birmingham

Housing

An impact on housing and homelessness is likely to follow because of changes in employment status and income. As with employment, mitigatory Government measures have sought to support houseowners and tenants to remain in their accommodation through the initial phases of the pandemic. Equally, as these measures are lifted and unemployment increases, the numbers of people experiencing housing insecurity and homelessness are likely to increase. As noted above, housing insecurity can lead to increased mental health needs, and poorer housing conditions can lead to poorer physical and mental health.

Recent research in Birmingham[53] suggests that housing quality (and air quality) are potential modulators of pneumonia presentation, and that there is a link between household overcrowding deprivation and admission to intensive care units for pneumonia patients. Patents of BAME ethnicity are more likely to be admitted from regions of highest air pollution, housing quality and household overcrowding deprivation.

The considerable numbers of employees who have been working from home and who may, to a large degree, continue to do so, also adds a pressure to the domestic environment, and may adversely affect the employment of those who residences do not easily accommodate working life, potentially by multiple occupiers. Nationally, there have been reports of increases in domestic abuse and child abuse especially during the lockdown period, with one domestic abuse helpline reporting a 25% increase in calls.[54]

Air quality and other environmental factors

Levels of nitrogen dioxide and small particle pollution are significantly lower than the levels normally seen at this time of year in most of the UK's largest cities, and emissions of carbon dioxide are expected to fall by an unprecedented 5%.[55] Despite this, the effect on population health may not be great or long-lasting, although enduring changes to travel patterns could bring material benefits. For those with existing respiratory illness, of course, COVID-19 and its after-effects are likely to have increased morbidity and mortality. Over a third of COVID-19 deaths in England before July had respiratory or cardiovascular disease as the main pre-existing health condition.[56]

The burden of coronavirus has been exacerbated and amplified by wider, deep-seated social, economic and health concerns. The right response is therefore not to duck or defer action on

[53] https://www.researchsquare.com/article/rs-35617/v1
[54] https://www.scie.org.uk/care-providers/coronavirus-COVID-19/safeguarding/domestic-violence-abuse
[55] https://warwick.ac.uk/newsandevents/knowledgecentre/science/life-sciences/air_quality_and_lockdown
[56] https://www.ons.gov.uk/economy/environmentalaccounts/articles/doesexposuretoairpollutionincreasetheriskofdyingfromthecoronavirusCOVID19/2020-08-13

these longer-term challenges even as we continue to respond to immediate pressures. It is to confront them head on.[57]

Poor air quality, especially air-borne particulates, may also have facilitated the transmission of the disease. Air pollution and housing quality deprivation are potential modulators of presentation with multi-lobar pneumonia, and household overcrowding deprivation and presentation with multi-lobar pneumonia are potential modulators of ITU admission. Patients of BAME ethnicity are more likely to be admitted in the regions with the highest air pollution, poor housing quality and household overcrowding deprivation, and this is likely to contribute an explanation towards the higher ITU admissions reported among COVID-19 BAME patients.

There is uncertainty as to when commuting levels will return, if ever, return to pre-COVID levels, due to the increase in home-working, but the air quality benefits of this will have been partially offset by increases in online retail activity and the associated delivery mechanisms. As people do return to workplaces, it may be that a higher proportion than before opt for private rather than public transport, to reduce potential exposure to COVID-19 or other diseases.

It is also the case, however, that our necessary response to the pandemic will have generated adverse environmental effects, *including increased need for personal protective equipment (PPE), cleaning products, ventilators and other associated equipment, single-use plastics and changes to patterns of prescribing and clinical interventions.*[58]

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[57] https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/
[58] https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/

The Modelled Effects of a COVID Recession on Healthcare Demand

The purpose of this section, and the modelling by The Strategy Unit that underlies it, is to illustrate the effect that a COVID-related economic recession could have on the demand for healthcare services. The full methodology is set out in Appendix Two – Methodology for Prospective Modelling of Economic Scenarios.

Methodology summary

Research undertaken for the Institute of Fiscal Studies (IFS) into the health effects of the 2008 recession that followed the global financial crash found a correlation between employment rates and prevalence rates for cardiovascular disease (CVD), musculoskeletal conditions (MSK), respiratory disease, mental health conditions and other conditions.

> *We find strong and robust counter-cyclical relationships for overall chronic health…. Chronic health conditions therefore increase in poor economic times…… The estimated effects are largest in areas with a more traditional industrial composition, older populations and populations with poorer long-term health……*[59]

The analysis was based on self-reported data captured in the UK's Quarterly Labour Force Survey that asks respondents about their chronic health conditions. For each condition, the research identified the relationship between employment and health, and how this played out over time following the initial economic shock in terms of the change in healthcare conditions associated with a percentage change in employment.

To model the effects of the emerging COVID-related recession on these same conditions, a reasonable set of assumptions about unemployment levels in BCWB over the coming 5 years needed to be established, assuming that the health impact of unemployment rate changes broadly mirror the impacts of employment rate changes. Given the extremely high levels of uncertainty around the course of the pandemic and the timing, scale and duration of its economic impacts, those assumptions were derived from the three scenarios presented in the Office for Budget Responsibility's (OBR) *Fiscal Sustainability Report, July* 2020.[60] The 2019 unemployment rate in BCWB was 2.9% higher than the national rate and, as has been noted above, its sectoral structure is particularly vulnerable to the adverse effects of a COVID-related recession. The projected annual unemployment rates in each OBR scenario have therefore been uplifted by the 2019 differential. This is a conservative adjustment given that the differential might be expected to widen but, in consultation with the Black Country Consortium, it was judged to produce a plausible range of rates. Peak Black Country unemployment after the 2008 crash

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[59] https://www.ifs.org.uk/publications/14807#:~:text=local%20area%20heterogeneity-,Macroeconomic%20conditions%20and%20health%20in%20Britain%3A%20aggregation,dynamics%20and%20local%20area%20heterogeneity&text=We%20estimate%20a%20model%20that,selection%20of%20optimal%20local%20area.
[60] https://obr.uk/fsr/fiscal-sustainability-report-july-2020/

(2010) was 13.1%, comparable to our central scenario here.[61] Those same years saw the largest increases in hospital admissions nationally for the whole of the 2008-2018 period (5.2% and 7.8%, respectively),[62] although these increases would have resulted from a number of causes beyond recession-related chronic ill health (e.g. demographic change, service capacity, changes in care models and protocols).

	2020	2021	2022	2023	2024
Upside scenario	10.8%	8.5%	6.9%	6.9%	7.0%
Central scenario	11.7%	13.0%	9.8%	8.8%	8.2%
Downside scenario	12.0%	14.5%	11.0%	9.8%	9.2%

Table 10 - BCWB unemployment rate assumptions by OBR scenario

The combined effect of these unemployment rate assumptions and the evidenced relationship between employment and health was then applied to the 2019 acute healthcare activity for BCWB residents relating to the identified conditions. The analysis was limited to the working age population (15-64 years), since this group is exposed to the direct impact of unemployment, and to NHS provider Trusts in the Black Country and Birmingham (inflows and outflows of activity are ignored, and it is assumed that services continue to be provided in the same way as in 2019, and by the same organisation). Mental health activity data is reported separately from physical health activity data due to the different activity categorisations involved, and primary and community care data is excluded since the former is not available and the latter cannot be identified by healthcare condition. The mental health data also includes two Birmingham-based provider Trusts because of the scale of services they provide to BCWB patients (and not just within West Birmingham).

To illustrate the potential impact of COVID-related unemployment in isolation, no other expected or potential changes in demography or prevalence have been assumed, including the direct and indirect healthcare activity impacts of the COVID-19 disease itself.

Summary of results

As has been noted above, the results of this modelling may usefully inform both supply-side and demand-side responses to emerging (and deteriorating) population health need. This report focuses exclusively on the latter, as it seeks to inspire further discussion and action around the socio-economic determinants of health.

Across the scenarios, the activity impact of COVID-related unemployment on physical health conditions peaks in 2020-21 with an overall increase of between 6% and 16% on the 2019 baseline (Figure 10). The scale and profile of the impact varies a little by condition, but the shape of the curves is largely determined by the assumed unemployment rate. Activity remains above baseline for the whole period but annual increases peak after 2021 for CVD (Figure 11), MSK (Figure 12) and respiratory (Figure 13).

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[61] https://www.nomisweb.co.uk/reports/lmp/lep/1925185537/subreports/ea_time_series/report.aspx?
[62] https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/quarterly-hospital-activity/qar-data/

Overall volumes for physical healthcare activity in all scenarios are summarised in Table 11, with breakdown by activity type.

Table 11 - Total physical healthcare activity by scenario

Activity Type	UPSIDE						CENTRAL						DOWNSIDE					
	2019 baseline	2020	2021	2022	2023	2024	2019 baseline	2020	2021	2022	2023	2024	2019 baseline	2020	2021	2022	2023	2024
A&E attendance	26,017	27,746	27,242	26,345	26,090	26,072	26,017	28,126	29,365	28,156	27,322	26,835	26,017	28,252	30,083	28,891	27,921	27,357
IP-Elective	16,963	18,099	17,833	17,248	17,055	17,025	16,963	18,349	19,243	18,452	17,894	17,546	16,963	18,432	19,720	19,033	18,401	18,020
IP-Emergency	12,166	12,965	12,732	12,318	12,201	12,193	12,166	13,140	13,712	13,149	12,765	12,541	12,166	13,198	14,044	13,494	13,044	12,777
OP	109,215	116,532	114,802	111,036	109,798	109,608	109,215	118,139	123,880	118,786	115,195	112,962	109,215	118,674	126,948	122,506	118,437	115,986
Grand Total	164,361	175,343	172,609	166,947	165,144	164,899	164,361	177,753	186,201	178,542	173,176	169,883	164,361	178,557	190,794	183,924	177,803	174,140
		6.7%	5.0%	1.6%	0.5%	0.3%		8.1%	13.3%	8.6%	5.4%	3.4%		8.6%	16.1%	11.9%	8.2%	5.9%
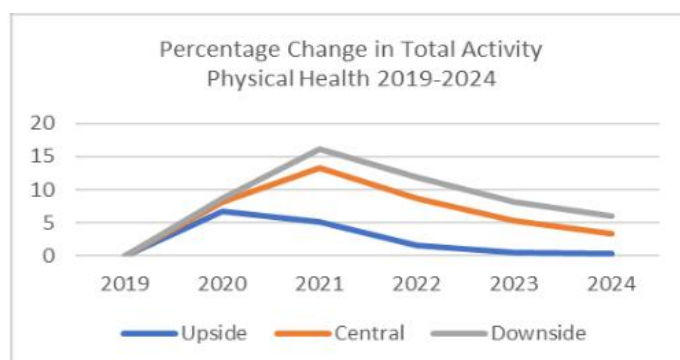
Figure 10 - Change in levels of physical healthcare activity, by scenario
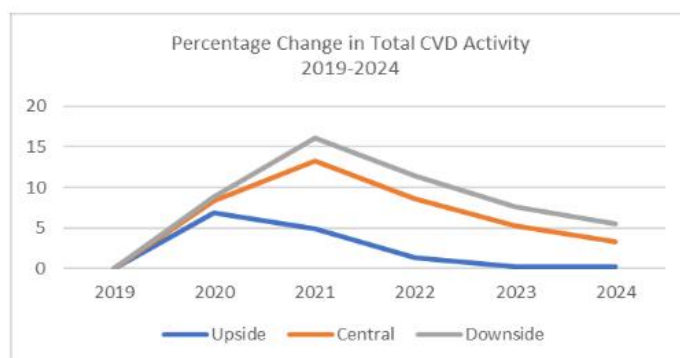
Figure 11 - Change in levels of CVD activity, by scenario
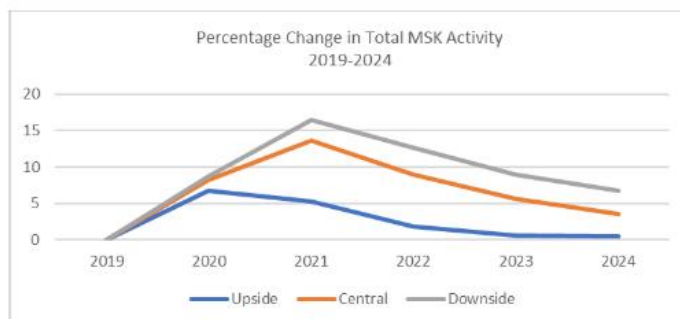
Figure 12 - Change in levels of MSK activity, by scenario
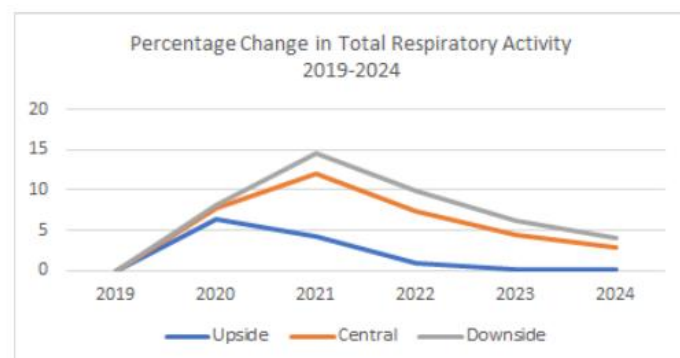
Figure 13 - Change in levels of respiratory activity, by scenario

In terms of equity of access to services for different population groups:

- Ethnicity data is missing in more than 12% of the data, roughly corresponding to apparent under-activity for White and Asian ethnic groups. It is not possible to know whether this under-activity in due to reporting issues with these groups (and, if so, why) or to issues with equity of access.

Ethnic Group	Activity		15-64 Population (2011 census)		
White	99,707	64.2%	596,138	69.9%	-5.7%
Asian/Asian British	19,492	12.5%	164,961	19.3%	-6.8%
Black/African/Caribbean/Black British	10,570	6.8%	55,109	6.5%	0.3%
Mixed/multiple ethnic	2,989	1.9%	23,895	2.8%	-0.9%
Other ethnic groups	3,042	2.0%	13,152	1.5%	0.4%
Not stated/null/blank	19,546	12.6%	0	0.0%	12.6%
Total	**155,346**	**100.0%**	**853,255**	**100.0%**	

Table 12 - Baseline physical healthcare activity by ethnic group

- There appears to be relatively low activity for Dudley patients (similarly but less so for West Birmingham patients) and relatively high activity for Wolverhampton patients. Again, it is not possible to know whether this reflects actual inequities in access or other factors (such as outflows to non-BCWB Trusts).

Place	Activity		Population (ONS mid-2019)		
Dudley	30,381	18.5%	200,787	22.7%	-4.2%
Sandwell	40,677	24.7%	211,450	23.9%	0.8%
Walsall	34,628	21.1%	179,547	20.3%	0.7%
West Birmingham	19,797	12.0%	123,066	13.9%	-1.9%
Wolverhampton	38,878	23.7%	168,518	19.1%	4.6%
Total	**164,361**	**100.0%**	**883,368**	**100.0%**	

Table 13 - Baseline physical healthcare activity by place

- Those in the two most deprived population deciles receive a proportionately higher volume of healthcare than those is less deprived deciles, but over half of the BCWB population falls into these most deprived deciles.

Deprivation Deciles	Activity		18-59/64 Population (ONS 2019)		Variance
Deciles 1-2	91,207	55.5%	455,623	52.3%	3.2%
Deciles 3-4	32,286	19.6%	171,317	19.7%	0.0%
Deciles 5-6	19,093	11.6%	112,083	12.9%	-1.3%
Deciles 7-8	12,834	7.8%	78,258	9.0%	-1.2%
Deciles 9-10	7,065	4.3%	53,646	6.2%	-1.9%
Null/blank	1,876	1.1%	0	0.0%	1.1%
Total	**164,361**	**100.0%**	**870,927**	**100.0%**	

Table 14 - Baseline physical healthcare activity by IMD decile

In line with the IFS research, the impact on mental health conditions of recession is greater than on physical health conditions. Whilst the peaks still occur in 2020-21, they range between 10% and 27% above 2019 baseline levels (Figure 14). Overall volumes for physical healthcare activity in all scenarios are summarised in Table 15, with breakdown by activity type.
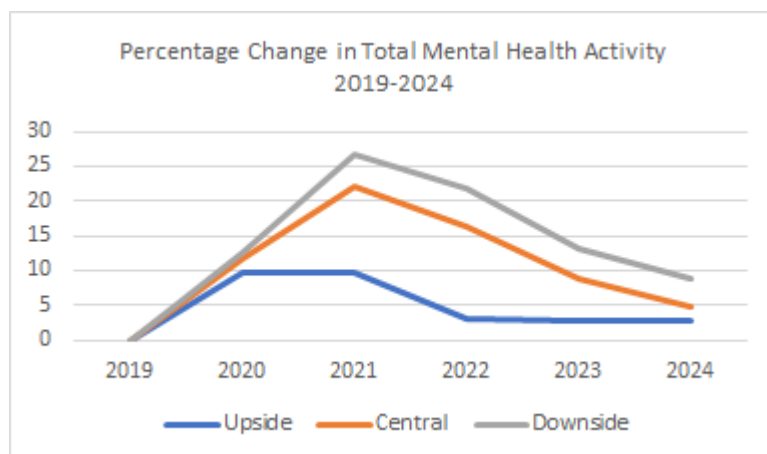

Figure 14 - Change in levels of mental healthcare activity, by scenario

Table 15 - Total mental healthcare activity by scenario

UPSIDE

Activity Type	2019 baseline	2020	2021	2022	2023	2024
Routine Referral	36,390	39,893	39,888	37,451	37,360	37,430
Urgent Referral	56,487	61,924	61,916	58,134	57,992	58,102
Stays	2,102	2,304	2,304	2,163	2,158	2,162
Contacts	294,761	323,135	323,093	303,357	302,617	303,189
Grand Total	**389,740**	**427,256**	**427,201**	**401,106**	**400,127**	**400,883**
		9.6%	9.6%	2.9%	2.7%	2.9%

CENTRAL

Activity Type	2019 baseline	2020	2021	2022	2023	2024
Routine Referral	36,390	40,662	44,393	42,287	39,560	38,155
Urgent Referral	56,487	63,118	68,910	65,641	61,408	59,226
Stays	2,102	2,349	2,564	2,443	2,285	2,204
Contacts	294,761	329,363	359,588	342,528	320,438	309,055
Grand Total	**389,740**	**435,492**	**475,456**	**452,898**	**423,691**	**408,640**
		11.7%	22.0%	16.2%	8.7%	4.8%

DOWNSIDE

Activity Type	2019 baseline	2020	2021	2022	2023	2024
Routine Referral	36,390	40,918	46,098	44,279	41,157	39,576
Urgent Referral	56,487	63,516	71,556	68,733	63,887	61,432
Stays	2,102	2,364	2,663	2,558	2,377	2,286
Contacts	294,761	331,439	373,395	358,662	333,375	320,566
Grand Total	**389,740**	**438,237**	**493,712**	**474,232**	**440,796**	**423,861**
		12.4%	26.7%	21.7%	13.1%	8.8%

In terms of equity of access to mental health services:

- Ethnicity data is missing in more than 9% of the data, with proportionately low levels of activity for White and Asian ethnic groups and high level for Black ethnic groups. It is not possible to know whether this under-activity in due to reporting issues with these groups (and, if so, why) or to issues with equitable access.

Ethnic Group	Activity		15-64 Population (2011 census)		
White	238,433	61.2%	596,138	69.9%	-8.7%
Asian/Asian British	56,680	14.5%	164,961	19.3%	-4.8%
Black/African/Black British/Caribbean	39,096	10.0%	55,109	6.5%	3.6%
Mixed/multiple ethnic	13,984	3.6%	23,895	2.8%	0.8%
Other ethnic group	5,070	1.3%	13,152	1.5%	-0.2%
Not stated/ null/blank	36,477	9.4%		0.0%	9.4%
Total	**389,740**	**100.0%**	**853,255**	**100.0%**	

Table 16 - Baseline mental healthcare activity by ethnic group

- There appears to be relatively low activity for Dudley patients (similarly but less so for Walsall patients) and relatively high activity for West Birmingham patients.

Again, it is not possible to know whether this reflects actual inequities in access or other factors (such as primary care effectiveness).

Place	Activity		Population (ONS mid-2019)		
Dudley	70,994	18.2%	200,787	22.7%	-4.5%
Sandwell	94,846	24.3%	211,450	23.9%	0.4%
Walsall	72,537	18.6%	179,547	20.3%	-1.7%
West Birmingham	74,854	19.2%	123,066	13.9%	5.3%
Wolverhampton	76,509	19.6%	168,518	19.1%	0.6%
Total	**389,740**	**100.0%**	**883,368**	**100.0%**	

Table 17 - Baseline mental healthcare activity by place

- Those in the two most deprived population deciles receive 62.5% of the activity and a proportionately higher volume than those is less deprived deciles. This differential is three times as great in mental healthcare as it is in physical healthcare.

IMD	Activity		15-59/64 Population (ONS mid-2019)		
Deciles 1-2	243,670	62.5%	455,623	52.3%	10.2%
Deciles 3-4	72,048	18.5%	171,317	19.7%	-1.2%
Deciles 5-6	36,477	9.4%	112,083	12.9%	-3.5%
Deciles 7-8	20,842	5.3%	78,258	9.0%	-3.6%
Deciles 9-10	11,949	3.1%	53,646	6.2%	-3.1%
Null/Blank	4,754	1.2%	0	0.0%	1.2%
Total	**389,740**	**100.0%**	**870,927**	**100.0%**	

Table 18 - Baseline mental healthcare activity by IMD decile

- Based on research by Stuckler et al,[63] an increase in unemployment of more than 3% would be expected to increase the number of suicides by 4.45%. Within the 0-64 age group in BCWB, this would equate to an increase from 105 to 109 suicides annually. In addition, suicide attempts are estimated to be 40 times more common than completed suicides (Borges et al[64]), suggesting that there could be as many as 160 more suicide attempts annually in BCWB, compared with 4,200 in 2019.

The above scenarios do not allow for the effects of further local or national lockdowns (though these would increase the probability of the downside scenario), nor do they make any assumptions about the effects of current or emerging government economic policy (for example, promised investment of adult education and in relation to the regeneration of high streets[65]) which, if successful, would increase the probability of the upside scenario.

It is also conceivable that the fiscal constraints associated with recession could lead to reductions in NHS and other public sector funding in the medium to long term. This would not affect the existence of

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[63] https://academic.oup.com/eurpub/article/27/suppl_4/18/4430523
[64] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3000886/
[65] https://www.gov.uk/government/news/50-million-boost-to-support-the-recovery-of-our-high-streets;
https://www.gov.uk/government/news/major-expansion-of-post-18-education-and-training-to-level-up-and-prepare-workers-for-post-covid-economy

additional healthcare demand that is associated with unemployment, although it could clearly affect the scale and/or scope of healthcare supply.

For member organisations of the BCWB Healthier Futures Partnership, two interactive modelling tools developed by The Strategy Unit are available via the Healthier Futures Academy that enable further analysis of the modelled data, including (where available) by disease group, activity type, place, ethnicity, deprivation decile, Trust, and Primary Care Network. These tools cover physical healthcare activity and mental healthcare activity, respectively. It should be noted that where there are underlying variances in treatment rates between different places and/or providers, these will simply be magnified in the projected scenarios. Further analysis and research would be required to understand the reasons for such baseline variances.

Increasing Collaborative Impact on the Wider Determinants of Health

The Dual Impact of the NHS

The NHS impacts population health status both directly through the care, treatment and medication it provides and indirectly through the way in which healthcare services are organised and healthcare resources invested.

A Strategy Unit analysis for BCWB in 2017[66] identified local spending of £2bn annually (2014/15 values), the majority of which (52%) was spent on employee benefits and the remainder on purchasing goods and services. The combined economic impact of this spending (including through multiplier effects) was estimated to be £1.5bn Gross Value Added (GVA), some 7.9% of the total sub-regional GVA. The NHS directly employed nearly 29,000 people in 24,200 full-time equivalent (FTE) jobs, not including agency staff used by the NHS. The bulk of these roles were support staff and nurses and midwives. A further 4,400 FTE jobs were directly funded as bank staff (those not permanently employed but who NHS organisations bring in to cover shifts without resorting to agency staff), and an additional 2,100 Agency jobs were supported but employed by non-NHS organisations. A total of 30,800 FTE jobs were directly supported by NHS spending on staff, representing 6.3% of the Black Country workforce. This excludes employment indirectly supported by the purchase of goods and services, and the spending of NHS staff wages. Allowing for this indirect impact, the NHS was responsible for 40,800 FTE jobs, 8.3% of the local workforce. The average annual gross wage (including value of pensions) for NHS staff in the Black Country was estimated to be £34,100, some 26% higher than the average weekly earnings locally.

The purpose of the 2017 analysis, like this present analysis, was to inform action to increase the local economic impact of the NHS. At that time, local stakeholders identified three illustrative schemes:

1. **Improving access to healthcare services for employed individuals.** Patients who are employed can find it difficult to attend healthcare appointments for themselves or for those they care for, as they typically occur during the working day. The NHS could offer services that are more convenient for employed individuals. This could be through changing forms of access (such as use of telephone or video conferencing for consultation) and /or moving services to more convenient locations. It was estimated that this could lead to an increase in economic output of £9m annually. It could also generate substantial cost savings to the NHS. The transformation of outpatient services subsequently became a focus of the NHS Long Term Plan, and significant progress has been made, of necessity, during the COVID-19 pandemic.

2. **Increasing support for employed individuals presenting common mental health problems.** Many individuals are estimated to have a mental health condition. These range from common conditions (e.g. stress and anxiety) to more complex needs. Many individuals with more

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[66] http://www.strategyunitwm.nhs.uk/publications/economic-impact-nhs-spending-black-country-full-version

common mental health conditions are either in employment or would like to return to work. By using some of the resources available within the NHS and local partner organisations , support could be provided to these individuals to ensure they can remain in employment, reducing the amount of absence individuals require, and to help support others back into work. It was estimated that this could lead to an increase in economic output of over £8m annually through limited additional expenditure.

3. **Providing support for informal carers.** The value of informal care provided in the Black Country was estimated to be over £2bn, some of which would be provided at the expense of other economic activity. Some individuals who are employed but have caring responsibilities will require time away from work to provide care and may fall out of the labour market altogether, although they do have entitlements under the Care Act 2014. Other individuals who are not in employment would like to return to work if their caring responsibilities were reduced. The NHS could use some resources to provide support to carers, to help them cope with providing care and remaining in employment. It was estimated that this could lead to increase in economic output of £8m annually through limited additional expenditure.

The combined potential impact of these illustrative schemes was £29m GVA annually, comparable to the national Growth Deal programme of government grant funding for local economies (£23m) during the same period.

> *Improving health for communities can only be done if the social determinants of health are tackled, in addition to the provision of good quality care and work to ensure behaviour change. There is little use in simply treating people for a health condition if the cause of that condition is not also addressed.*[67]

The NHS Long Term Plan has since highlighted the potential for NHS organisations to realise more fully their role as 'anchor institutions'[68] in local communities. The plan commits the NHS to working with sites across the country to identify good practice that can support wider social goals including:

- Ensuring people can maintain employment through fast, convenient access to services, including through new channels (e.g. digital appointments);

- Helping people with mental health problems to find and retain employment;

- Increasing investment in services for people experiencing a mental health crisis to help ease pressures on police services and for the most vulnerable children and young people in, or at risk of being in, contact with the youth justice system;

- Targeting early help for adults living in households with vulnerable children, and improving access to targeted support for these children, especially during transition to adult services, building on the current assessment pilots for children entering the care system;

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[67] https://www.local.gov.uk/sites/default/files/documents/22.52%20Social%20Determinants%20of%20Health_05_0.pdf
[68] https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution

- Reducing the environmental impact of NHS service provision – including waste, emissions and medicines.[69]

This commitment is echoed in the NHS Confederation's reset programme that includes a focus on the NHS's role in economic and social recovery, the focus of this local programme:

The COVID-19 health emergency is anticipated to leave a social and economic downturn in its wake. Health services have a vital role to play in the wider recovery and rebuilding of local economies and communities – driving up prosperity, population health and wellbeing.[70]

The Opportunities for 'Anchor Institutions'

There are opportunities for the NHS, with local partners, to increase its impact as an anchor institution on the determinants of health, bringing greater benefits to local communities and limiting the adverse impacts of COVID-19.

The NHS can sometimes struggle to find the best way to engage with Local Government and its priorities, and similarly with the realities of the voluntary and community sector. Given that the NHS is a significant economic actor in local communities, this is likely to mean that opportunities to collaborate on increasing economic value (as well as population health and wellbeing) are being missed. The effects of this are more likely to be felt in areas of greater deprivation, such as BCWB, where public sector spending often represents a larger proportion of the local economy. The local NHS is a very significant employer and purchaser, and there are opportunities to exploit this reality more effectively for local benefit.

A potential common frame of reference for local partners is provided by the Marmot review – *Fair Society, Healthy Lives[71]* which observes that:

People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus. Consider one measure of social position: education. People with university degrees have better health and longer lives than those without. For people aged 30 and above, if everyone without a degree had their death rate reduced to that of people with degrees, there would be 202,000 fewer premature deaths each year. Surely this is a goal worth striving for.

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[69] https://www.longtermplan.nhs.uk/online-version/appendix/the-nhs-as-an-anchor-institution/
[70] https://www.nhsconfed.org/supporting-members/nhs-reset/themes/social-and-economic-recovery
[71] http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

The review identified six priority themes, although the last is omitted in the 2020 update.[72] The remaining five themes are listed below, supported by a brief summary of Local Authority priorities across BCWB that relate to those themes:

1. Give every child the best start in life

    LA priorities range from an overarching focus on supporting a 'best start in life', through addressing wider determinants (e.g. permanent housing and household income) to improving access to services (including specialist perinatal mental health support) and health outcomes (childhood obesity, breastfeeding rates and maternal and newborn health).

2. Enable all children, young people and adults to maximise their capabilities and have control over their lives

    LA priorities include an emphasis on detecting and preventing adverse childhood experiences and increasing the capacity of children and young people to protect and safeguard themselves. There is also a common focus on enhancing emotional and mental health and wellbeing, supported by strong attachment and healthy relationship styles. Educationally, priorities include improving school readiness and outcomes, and supporting educational setting to help children and young people make healthy choices, improve health outcomes and prepare for work.

3. Create fair employment and good work for all

    LA plans not only seek to develop, attract and retain high quality staff but also to improve access to skills, training and support so that more local people are able to secure rewarding, higher quality/added value jobs, not least those with mental health conditions. There is also a focus on improving both physical and mental health and wellbeing in and through the workplace.

4. Ensure healthy standard of living for all

    LA priorities cover two main areas under this theme – improving services and improving the experience of living in local communities. In terms of services, there are priorities around joining up services (especially for frailty and end of life) and reducing unwarranted variation; increasing individual control over care; providing better support for those with mental health conditions; improving accommodation for people with learning disabilities; and improving the wellbeing of those with multiple complex needs. In terms of wider factors, priorities address the provision of affordable and appropriate housing; healthy environments with greater choice in food outlets, better air quality and that support more active lifestyles; safer communities in which offenders can rehabilitate and people are protected from extremism; and less isolated communities where, enabled by health champions, appropriate meeting places and increased volunteering, loneliness is reduced.

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[72] https://www.health.org.uk/sites/default/files/2020-03/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_executive%20summary_web.pdf

5. Create and develop healthy and sustainable places and communities

LA priorities focus on:

- Reducing obesity, especially amongst children, through improving health literacy, helping more people to be more active more often, supporting healthy choices and increasing access to healthy, affordable food.

- Increasing emotional wellbeing and resilience and adopting a zero-suicide ambition.

- Preventing the violence and exploitation that is linked to poor mental health, physical health or substance misuse.

So how do we make better use of NHS-invested resources to support the Marmot priorities across our local communities?
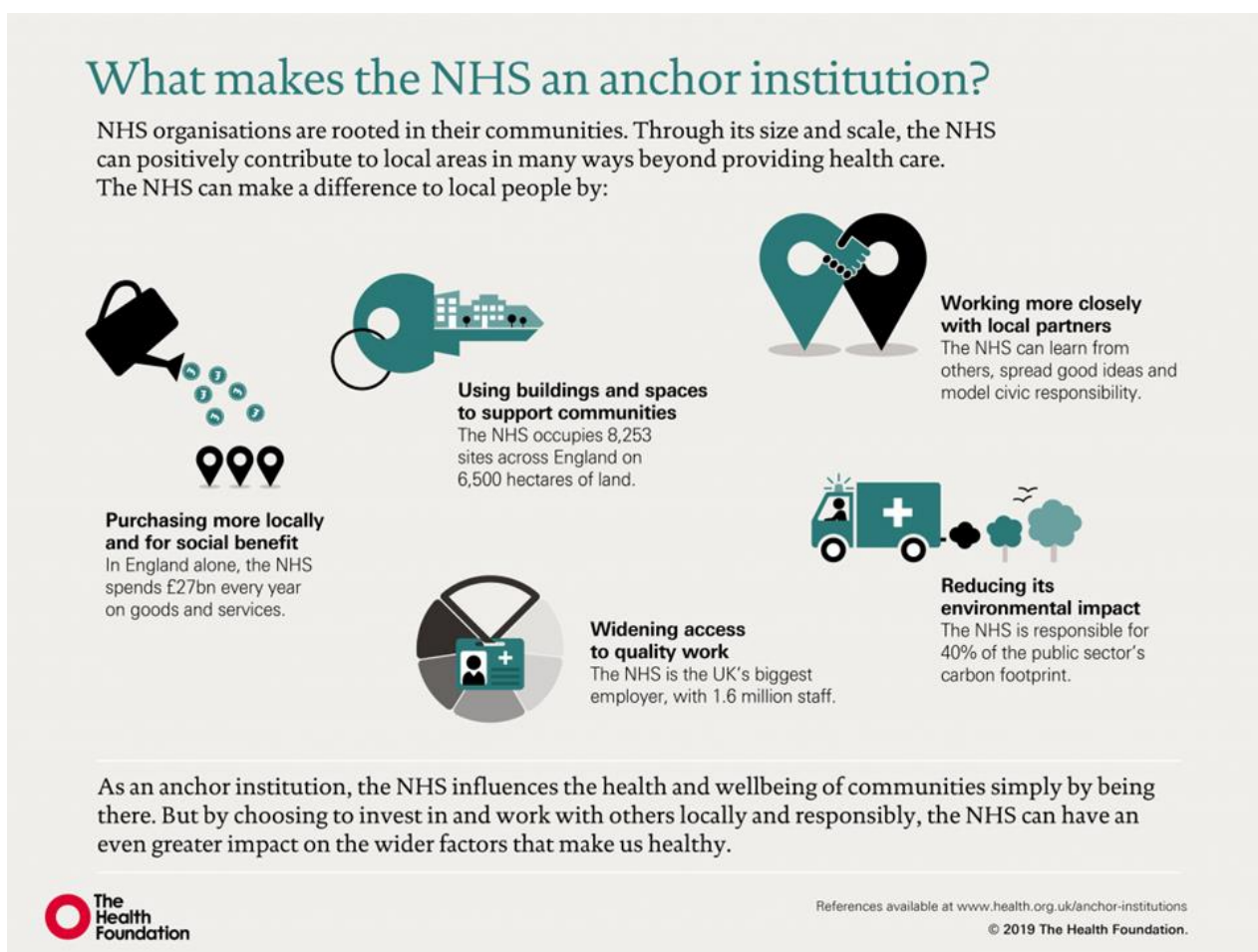
Figure 15 - What makes the NHS an anchor institution?

The Health Foundation has produced a categorisation of the ways in which NHS organisations can advance such priorities. They are set out in the figure below, and following sections describe, in relation

to each category, initiatives that are already under way in BCWB and further interventions that might be considered. [73] Other case studies from around the country are reported in the Local Government Association's report on *Social determinants of health and the role of local government*.[74]

Purchasing more locally and for social benefit

There are opportunities for NHS organisations – especially when acting in concert using their significant economic weight – to ensure that expenditure on goods and services brings the maximum benefit to local populations, including through market development activities and the inclusion of social value criteria.[75] Local businesses, especially small and medium enterprises (SME) can be proactively engaged with to enhance their readiness to understand NHS needs and to respond to NHS tenders, creating a business-base fit for a future in national and international supply chains. There is also potential for that engagement to generate innovative insights that support transformation of aspects of NHS service delivery. Embedding principles of social value in tenders and their quality assessment criteria can also bring benefits in terms of local training and employment and the reduced environmental impact of suppliers. Local purchasing can help to keep local resource in the locality and reduce unnecessary transport impacts, generating inclusive growth and a lower carbon economy.

Who did what?
Sandwell and West Birmingham NHS Trust committed to deploying a minimum of 2% of its future annual budget with local suppliers.
Why?
The NHS has significant purchasing power. Decisions about what the NHS decides to buy, and how, have ramifications on local population health and wellbeing.
What is the current or expected impact and learning?
Procuring and commissioning goods and services from local small and medium size enterprises (SMEs) and voluntary and community sector organisations can have an important economic impact, since resources spent locally have a multiplier effect and are reinvested in the local community at a faster rate than resources with national corporations. Some studies have shown an effect ranging between 1.7 and 2.1.

This theme aligns with the NHS Confederation recommendation to convene industry leaders to source potential new local supply chains and to help businesses better understand NHS needs and contribute to the design and delivery of services in new and innovative ways. Existing links with the West Midlands Academic Health Science Network and the Black Country Consortium can be used to facilitate engagement with local industry.

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[73] A large selection of case studies is also provided in the most recent Marmot review - https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

[74] https://www.local.gov.uk/sites/default/files/documents/22.52%20Social%20Determinants%20of%20Health_05_0.pdf , p.18 ff.

[75] https://www.sduhealth.org.uk/areas-of-focus/social-value.aspx

In Preston, six anchor institutions shifted local spending from £37.5m of £150m in 2012, to £135m in 2017, creating 1700 local jobs.[76] Care needs to be taken, however, that spending isn't simply transferred from one equally deprived area to another, and a regional approach may sometimes be more appropriate than a local one, to mitigate against this risk.

Using buildings and spaces to support communities

Who did what?
Walsall Together has located additional services in Blakenhall Village Centre - a community funded building which accommodates 2 GP practices, community pharmacy and children's services. These include two health and social care locality Teams, Rapid Response Team, Care and Quality Team, Intermediate Care Services and the Adult Community Management Team. It has also worked with the landlords to put on community events (e.g. learning events in the old library) and has an ambition to develop this into one of four health and wellbeing centres across Walsall.
Why?
Communities are more resilient when people are connected through social networks. Opening NHS buildings and land for community use can provide vital opportunities for social interaction.
What is the current or expected impact and learning?
The NHS influences the local economy through who it allows to operate within its facilities. By providing more opportunities for SMEs, and by working with organisations that promote social good, the NHS can further support community wealth development.

The NHS has a very substantial physical footprint, comprising some of the largest single-organisation sites in BCWB and a very varied and disparate estate. In 2014/15 there were 23 sites belong to NHS Trusts or Foundation Trusts in BCWB covering over 125 hectares of land and occupying over 500 billion square metres of floorspace. The Royal Wolverhampton NHS Trust held the largest estate, with over a quarter of the land and one third of the occupied floorspace.[77] Data on the primary care estate is less robust but 61 hectares of land were occupied by primary care organisations, representing over 179 billion square metres of occupied floorspace. GP practices in Walsall had the largest estate by site land area and occupied building space.

An 'anchor institution' approach to estates could include schemes such as developing 'One Public Estate', co-locating services across sectors wherever possible; exploring opportunities for the use of NHS land and facilities by community groups; and looking at options for developing surplus land/buildings for other purposes, such as affordable housing. Given the current shift away from office-based working, these opportunities may now be greater than ever. In doing so, the NHS could become a more active partner in local planning, contributing to fresh thinking about the future of places - the high street, commercial premises, the visitor economy and sustainable communities.

The NHS Confederation is promoting the embedding of health and care within national and local regeneration planning, ensuring a much greater alignment between health and care strategies and

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[76] https://www.progressive-policy.net/downloads/files/Beyond-NHS.pdf
[77] http://www.strategyunitwm.nhs.uk/publications/economic-impact-nhs-spending-black-country-full-version

those relating to wider economic development, and explicitly measuring the impact of NHS capital investments on the local economy.

Working more closely with local partners

The NHS Confederation is advocating for local NHS organisations to participate in the development of an anchor network across all health and care bodies within the system footprint, with a joint, data-driven vision for how they can support the local economy, engaging with other anchors to understand where the value and impact of the NHS and social care can be maximised. It also proposes the development of local 'Civic Restoration Strategies' focused on improving the vibrancy of communities in partnership with the arts and culture sector, VCSE organisations and the small independent business community, promoting sustainable, local ideas which align health and wealth.

Action on school readiness has the potential to generate very significant benefits over extended time periods. Predictors of school readiness include access to high-quality childcare; parental warmth, acceptance and responsiveness; a learning-enabling home environment; perinatal care and access to primary care; and good nutrition (linked to affordability).[78]

Who did what?
Walsall Together (WT) partnership now includes Walsall Housing Group (WHG), and the relationship has been strengthened through a common chair between **Walsall Healthcare NHS Trust** and WHG, and by the WT Managing Director joining the WHG Board. WHG is 'more than just a landlord' and had already established a Health and Wellbeing Team to support its customers. WHG housing officers have now joined each of the WT locality teams.
Why?
Good housing is the building block for health and other determinants of health (e.g. employment). Including housing officers as part of the locality teams provides opportunities to target housing support for people with specific health problems and identifying health and social care problems early as part of housing support.
What is the current or expected impact and learning?
269 customers benefited from pop up health information and advice sessions. 723 people learnt how to be more active through WHG's Family and Schools Programmes. 47 people participated in Waist Away and 80% lost weight. 285 customers aged 50+ were supported by the 'Nifty over Fifty' healthy ageing programme

Collaboration also increases the potential to address loneliness and isolation in our communities. Evidence suggests that social isolation and loneliness are associated with 50% excess risk of coronary heart disease, broadly similar to the excess risk associated with work-related stress, but that when effective interventions are in place, the return on the investment can be substantial. The Family Action 'Well Family Service', for example, reduced the number of GP consultations, demonstrating a six-fold social return on investment.[79] Care models can be

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[78] https://childandfamilyresearch.utexas.edu/evidence-base-predictors-school-readiness; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/459828/School_readiness_10_Sep_15.pdf

[79] http://www.instituteofhealthequity.org/resources-reports/local-action-on-health-inequalities-reducing-social-isolation-across-the-lifecourse

transformed, through dialogue with other providers, so that they proactively target the reduction of inequalities and respond to the real circumstances and preferences of local communities or specific population cohorts. This could be particularly relevant in relation to mental health needs given the modelled impact of COVID effects on the demand for mental health services. A 2012 review[80] highlighted the following interventions:

- Workplace-based programmes are inexpensive to introduce (c.£80 per employee per year) with savings of up to £9 for every £1 invested, accruing mostly to employers through reduced absenteeism. The programmes include a health risk appraisal, and tailored information and advice.

- Suicide awareness training for GPs and other key health professionals and cognitive behaviour therapy (CBT) for those identified as at risk can increase the detection rate of suicide risk by 20% in the short term, and generates a return of £44 from each £1 invested in training for GPs, mostly linked to employment and productivity.

- CBT for people with medically unexplained symptoms in primary care reduces NHS costs (reduced GP consultations; A&E and other hospital attendance; reduced prescriptions) and work absenteeism, generating savings of £1.75 for every £1 invested for a comprehensive programme and £7.82 for a targeted programme, mostly accruing to the NHS.

Who did what?
The Royal Wolverhampton NHS Trust formed a partnership with Wolverhampton City Council and a range of private providers (e.g. Babylon) to advance the Digital Agenda, building on the success of the joint working in their shared Population Health Unit.
Why?
Working together with the City Council makes Wolverhampton a more attractive place for investment. Better digital infrastructure will support residents to live healthier lives, book appointments at a convenient time for work and family commitments and support the NHS and LA to make a more efficient and impactful offer.
What is the current or expected impact and learning?
5G and city fibre funding has been attracted, and 50% of outpatient appointments are now digital (surpassed 30% national target). This is not simply about video-conferencing but the whole process (e.g. digital solution to sending out invites, patient-led booking).

Agencies working together can also avoid poorer outcomes for citizens. A small-scale study relating to the mental health impacts of the 2008 recession found that the specific consequences of economic hardship such as being unable to find employment, losing a job, getting into debt, housing problems or benefit sanctions could be the final straw that triggers self-harm. It suggested that interventions to mitigate such triggers should include *providing practical advice about economic issues before difficulties become insurmountable and providing appropriate psychosocial support for vulnerable individuals*.[81] A broader systematic literature review of mental health outcomes in times of economic recession found that periods of recession correlate with higher

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80 https://ebmh.bmj.com/content/ebmental/15/3/54.full.pdf
81 https://bmjopen.bmj.com/content/bmjopen/6/2/e010131.full.pdf

prevalence of common mental disorders, substance disorders, and ultimately suicidal behaviour, with key vulnerability including unemployment, having a precarious work situation, facing debts and economic strain, and having a pre-existing mental illness. Economic recession was also found to have *a severe and long-term impact on mental health in children and young people, especially if they face stress within the family as a result of economic hardship or parental unemployment*.[82]

Who did what?
Sandwell and West Birmingham NHS Trust commissioned Tribe, which combines ground-breaking technology and innovative social action, to help: 1) reduce inequalities in the care of older people and improve their health, wellbeing and inclusion by engaging, empowering and upskilling local citizens in the areas in which it operates to deliver to them personalised care and support.   2) stimulate local micro-enterprise and community activity to provide care and support, triggering economic growth (GDP per capita) particularly in areas of high inequality and giving value to paid care.   3) ensure the model is trusted by users and commissioners through assurance of services and skills.
Why?
The Tribe Project is repurposing a 'smart-cities' base technology to explore a geospatial data centred approach to care provision. At the core of the technology will be an innovative community 'need-matrix'. The matrix will be composed of a stratification of service demand and vulnerability index data consumed from Voluntary Community Sector (VCS), Local Government and Health datasets (Including Internet of things sensory systems). Public services will ultimately be able to identify the statistical probability where provision is projected to fail moves care from 'reactive' towards a 'preventative' agenda model. Focusing on these care 'dark patches' Tribe will work with Community Catalysts to stimulate community activity and development of micro-enterprises that can address the support shortfall. This model uses community need – and improved outcomes for older people - as an economic driver to facilitate the growth of micro-enterprises delivering ethical, high-impact self-employment. It uses co-design principles to ensure all stakeholders shape the implementation and validate outcomes.
What is the current or expected impact and learning?
- More carers and more care choice - Tribe will bring skilled community carers to national 'dark patches' where administrative costs are prohibitive, or no care provision currently exists facilitating a true person centred care model for individuals seeking help and support.   - Reduce the cost of care - Tribe operates on a flat rate 3% administrative fee. Councils have indicated this will bring savings of up to 50% compared with current costs where care is commissioned via traditional means in deep rural areas. As a by-product of this, the intention is to use administrative savings to increase the wages of care workers.

Conversely, it notes improved mental health can play a significant role in economic growth, suggesting a double case for targeted action on the scale, nature and accessibility of mental health services at the

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[82] https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-016-2720-y

present time. The World Health Organisation (WHO) argues that the mental health effects of a recession crisis can be mitigated through active labour market programmes, family support programmes, measures to limit alcohol consumption, the accessibility of primary care services to those at high risk of mental health problems, and support with financial debt management. To maintain mental health services through such times, WHO further recommends interventions to tackle the stigma of mental illness, building the case for investing in mental health, continuing the transformation of mental health services and ensuring universal access.[83]

In relation to collaborative action on housing, there appear to be significant benefits to be won. Analysis at EU level has identified that whilst the cost of addressing severe inadequacies in housing stock (e.g. mould, dampness and cold or structural damage) would be nearly €300bn, it could lead to healthcare savings in the first year alone of around €200bn, and therefore would provide a return on investments after just eighteen months.[84]

Widening access to quality work

Employment has been a significant focus of this report. This reflects both the expected impact of the COVID-related recession on local jobs and the pre-existing challenges around creating a greater proportion of higher skilled, higher paid jobs in BCWB.

Work by Public Health England and UCL Institute of Health Equity has identified actions that can be taken locally to promote good quality jobs and reduce health inequalities. These include local partners developing and encouraging roles in which workers are valued, receive a living wage at minimum, have opportunities for promotion, and are protected from adverse conditions. It also notes the importance in economically-deprived regions of working to improve the skills base of people in local and regional labour markets so that further skilled employment is attracted to the area.[85]

Who did what?
The Sandwell and West Birmingham NHS Trust pays all staff at or above the 'living wage'.
Why?
An important determinant of staff wellbeing is the terms and conditions of their employment, including receiving a fair wage and having a good work-life balance. Low pay can lead to financial hardship, trapping people in in-work poverty, with important implications for health and wellbeing. Being an anchor means ensuring the NHS provides secure employment and fair compensation so that all its staff can live with financial security, not least because in some areas the NHS is the largest employer.
What is the current or expected impact and learning?
On implementation, the salaries of 225 staff were increased. It is hoped that learning from this initiative will encourage system partners to follow suit.

[83] https://www.euro.who.int/__data/assets/pdf_file/0008/134999/e94837.pdf
[84] https://inherit.eu/wp-content/uploads/2017/06/INHERIT-Report-A4-Low-res_s.pdf
[85] http://www.instituteofhealthequity.org/resources-reports/local-action-on-health-inequalities-promoting-good-quality-jobs-to-reduce-health-inequalities-

Amongst the actions that NHS organisations can consider are nurturing health and care career aspirations in local schools; focusing recruitment on the local population, particularly the most deprived areas; advancing the skills of local employees; and becoming a living wage employer. There are also opportunities, as identified in the 2017 economic impact study, to do more to enabling informal carers and those with mental health or long-term conditions to remain in or get back into employment, increasing the productivity of the local economy and reducing the costs of workforce turnover. The NHS Confederation proposes making an explicit commitment to fill existing health and care vacancies with local people who are unemployed or currently economically inactive through launching targeted recruitment, focusing on making fuller use of apprenticeship schemes, establishing retraining schemes, and committing to guaranteed interviews.

Who did what?
The Royal Wolverhampton NHS Trust runs an apprenticeship programme that enhances employment prospects for young people (under 29) and creates opportunities to step into the NHS careers at levels 2-6.
Why?
There is a strong link between work and health. For work to have a positive impact on health, it must be 'good work' – providing stable employment, paying a living wage and offering fair working conditions, work-life balance and career progression. The Trust developed its apprenticeship scheme to meet workforce gaps, provide succession planning and create an entry-level route into the NHS. This can contribute to reducing unemployment.
What is the current or expected impact and learning?
274 apprenticeships have been offered to BCWB young people since 2017 (104 clinical, 180 non-clinical, 15 technical). The aim is to achieve 185 apprenticeship starts per year by 2020 (the quota set by the Modern Apprenticeship Programme). Most places are for admin roles, and the Trust is close to its target of 70% of graduating apprentices finding substantive employment in the Trust or another NHS organisation. The need for learners to be able to access pastoral support from internal trainers has been recognised.   The Trust has become a Cornerstone Employer in 2019 and works with Princes Trust to deliver packages to get young people ready for the world or work through the 'Get Into' programme; undertakes joint work with the DWP and City Council through the 'Wolves at Work' Programme; and has signed an armed forces covenant to develop a talent pipeline from resettling ex-servicemen and their families. The initiative has helped to make the Trust more representative of the community it serves.

The NHS has a number of enduring workforce challenges but has not yet fully explored the potential for a 'grow your own' approach that combines introducing new roles that draw on the characteristics and skills of the local population, with developing training pathways that enable progression from into higher skilled roles (rather than importing to those roles from other areas). Evidence from the USA relating to roles similar to UK 'health coaches', for example, highlights how *culturally competent guidance provided by navigators from a patient's own ethnic community might play a major role in overcoming barriers to healthcare*. The roles include providing culturally tailored health education,

Who did what?
Black Country Healthcare NHS FT appointed two new Senior Community Development Workers to support wider work around tackling health inequalities in BAME communities and establishing vital links with communities to improve access to and experiences of mental health services.
Why?
The Trust recognised there was a need to further strengthen the resilience of Black, Asian and Minority Ethnic (BAME) communities, and its understanding of the impact of COVID-19 on them. The combination of making links with voluntary organisations, setting up grassroots initiatives, and being able to work closely with internal colleagues provides a uniquely valuable way of supporting the COVID-19 risk assessment process and the development of equality and diversity projects across the Trust.
What is the current or expected impact and learning?
Across the area, the team has been collating data, resources and information to identify gaps and barriers to services and to improve mental health experience and outcomes of BAME communities. It is currently developing a webinar that will bring voluntary sector/stakeholder organisations together to further discuss the impact of COVID-19 on BAME communities and how that might impact service delivery and change. If you would like to find out more about the work of our senior community development workers please email nazima.esscopri1@nhs.net or Fareen.hussain1@nhs.net.

Who did what?
Six Primary Care Networks (PCNs) across the Black Country and West Birmingham have been working with professional colleagues in nursing, mental health, social care, and public health to improve the health and wellbeing of vulnerable patients and populations. The new care models created by PCNs are adapted to neighbourhood and patient context, but a common innovation adopted is a new team role for people recruited for their empathy, relational skills and lived experience within the community. They join frontline teams of GPs or other professionals at a ratio of between 3:1 and to 5:1.
Why?
These new workers increase 2- to 3-fold the amount of time patients are engaged by primary care services. This increase in time and the accompanying listening skills facilitates the use of proven engagement techniques such as shared decision making, motivational interviewing, and cognitive behavioural therapy to support people to make their choices matter for health and wellbeing. Recruiting staff from the local population with people, and supporting them with technical skills development, widens access to quality work for the local population and increases services' understanding of the context of the patient.
What is the current or expected impact and learning?
Implementation was delayed due to COVID-19. One PCN implemented earlier and has seen a reduction in reactive use of primary, community and acute care with many case studies of how the wider determinants of health have been addressed including poor housing and loneliness. Education of this new workforce will be key.

lifestyle workshops, self-care training and guidance to overcome barriers to accessing the healthcare system. In the Hispanic community, navigator activities led to significant reduction of HbA1c levels among adults with type 2 diabetes, with a cost effectiveness of $33,319 per QALY gained (interventions for diabetes control or management are considered cost-effective if they fall under the threshold of $50,000 per QALY gained).[86] Other evidence shows that people with experience of a condition (e.g. parents of children accessing intellectual disability services), also generate similar benefits.[87] There is also evidence to support the focusing of work-related initiatives on younger age groups because of the duration of the adverse health impacts of unemployment (especially mental health) both for the workers themselves and for their children.[88]

Who did what?
Black Country Healthcare NHS FT has developed an award-winning Employment Support Service that delivers: - Individual Placement Support (IPS) for users of secondary mental health services – anyone who is under the care of a psychiatrist and has a care coordinator   - Thrive into work, providing supports adults (18+) with a mental health and/or physical health condition, who are out of work and want to work.   - Thrive at work, a WMCA project that supports employees living with health conditions to stay in employment, partnering with recruitment and employment specialists to facilitate adjustments at work that provide an inclusive work environment.   - Bridges to work, supporting adults 25+ with mental health problems.   - Building Better Opportunities (BBO), providing a BAME vocational specialist and BAME-specific vocational support groups to increase engagement with BAME communities.
Why?
Being in good work is better for your health than being out of work. There is clear evidence that good work improves health and wellbeing across people's lives and protects against social exclusion. Conversely, unemployment is bad for health and wellbeing, as it is associated with an increased risk of mortality and morbidity. For many individuals, in particularly those with long term conditions such as mental health problems, musculoskeletal conditions and disabilities, health issues can be a barrier to gaining and retaining employment.
What is the current or expected impact and learning?
Between April 2019 and June 2020, 617 people were supported by IPS – c.28% were from BAME communities. In 30 months, 1,500 people have participated in Thrive into work, 450 have accessed work and 180 are currently being supported. Over 300 business across the West Midlands have signed up to the programme. Since 2017, 326 clients have been supported by BBO. 21% of participants were from BAME communities. Some participants have not felt safe continuing to access employment support during COVID-19 but the service has continued to provide a welfare role.

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86 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4714538/
87 https://onlinelibrary.wiley.com/doi/abs/10.1111/jar.12630
88 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3076863/

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Reducing environmental impact

The NHS bears a significant impact of poor quality environments, but it also contributes materially to their creation. There are significant opportunities to reduce the economic and environmental cost of service delivery, including moving to virtual appointments, electrifying the NHS fleet, home-working for office-based staff. These opportunities are clearly set out in *Delivering a 'Net Zero' National Health Service* which demonstrates the potential nationally to save over 5,700 lives every year from improved air quality.[89]

There is substantial and growing evidence for the physical and mental health benefits of spending time in the natural environment, but children are engaging less with nature. *Equality of access to, and connection with, a healthy natural environment would save billions of pounds in healthcare costs and reduced economic activity every year. There are opportunities to improve health through the choices government, regulators, businesses and individuals make in creating and contributing to healthier, greener and more accessible environments.*[90]

Who did what?
Dudley Group NHS FT, like many providers, has facilitated a very significant increase in virtual appointments (by phone or video).
Why?
The move to virtual appointments reduces the environmental impact (and others costs) of staff and patient travel, avoids the need for people to make difficult journeys on public transport (especially with COVID-associated risks) and reduces the productivity losses from time taken off work.
What is the current or expected impact and learning?
A 2018 study by the Strategy Unit for West Midlands CCGs estimated CO2 reductions of upg to 533,535kg annually through reduced patient travel, should face-to-face outpatient appointments reduce by 10% across all specialties. There were also benefits expected in productivity (£5.34m annually) and patient cost impact (£973k annually).

Who did what?
The Royal Wolverhampton NHS Trust has agreed to build a solar farm on a disused site that is too polluted for other uses. The farm will provide all the electricity needs of the Trust.
Why?
NHS organisations have a significant impact on the environment and are some of the largest contributors to climate change and air pollution. The NHS alone is responsible for 40% of public sector emissions in England.
What is the current or expected impact and learning?
By investing in solar energy, the Trust expects to significantly reduce its environmental impact.

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[89] https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/
[90] https://www.gov.uk/government/publications/state-of-the-environment/state-of-the-environment-health-people-and-the-environment

Building Healthier, Happier Communities

The *Delivering a 'Net Zero' National Health Service* report additionally sets out a broad range of mechanisms through which the NHS and its supply chain can achieve net zero carbon emissions (Figure 16).[91]
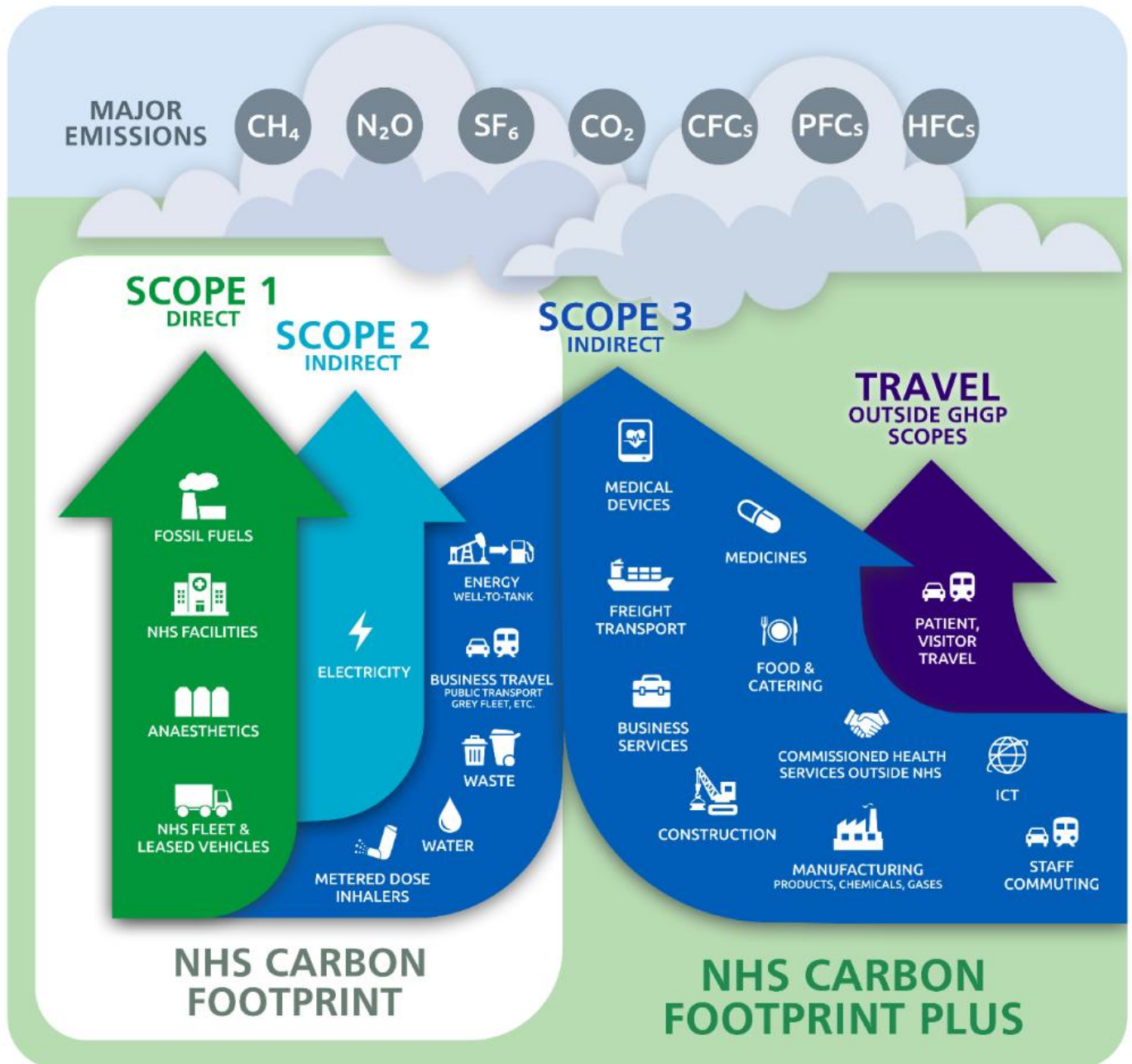

Figure 16 - Net Zero opportunities for the NHS

The report also highlights the links between climate change, sustainable development and health inequalities, such as:

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[91] https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/

- *Access to green spaces has positive mental and physical health impacts, and these beneficial effects are greatest for those from socioeconomically disadvantaged groups. However, these groups also have the least access to green spaces.*

- *Black, Asian and minority ethnic groups are disproportionately affected by high pollution levels, and children or women exposed to air pollution experience elevated risk of developing health conditions.*

- *As climate change worsens the demand for energy will increase. This may increase the price of household fuel, which is likely to make it harder for poorer families to maintain good health, particularly in poorly insulated homes.*

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Exploring System Priorities

The purpose of this final section is to provide a frame for initial stakeholder engagement around the evidence and analysis presented above. Given the breadth of the issues involved and the huge range of interventions that could be considered in relation to each issue, there is a need to co-produce a set of initial system priorities. Once these priorities have been identified, Phase 2 of the WHoLE programme can commence when further engagement, evidence and analytical work will be undertaken to support the development, initiation and evaluation of potential interventions to reduce the socio-economic impacts of COVID-19 and their health consequences.

The initial phase of high-level engagement is expected to take place in November and December 2020, and to focus on Local Authority Health and Wellbeing Boards, Healthier Futures partner organisations in the NHS and local government, and the local voluntary and community sector. Whilst detailed public engagement is largely intended for Phase 2, versions of this report will be made available to the public. Going forward, the governance of the programme is expected to sit with the Health Inequalities Board of the Healthier Futures Partnership. There are two aims of this engagement:

1. To increase understanding of the interactions between the contexts in which citizens live (social, economic, environmental) and their health; and

2. To inform the recommendation of priority areas for whole-system action in Phase 2 of the programme. These are expected to be determined by the Healthier Futures Partnership Board in January 2021, following the proposed engagement.

In relation to 2, above, an initial set of suggested target outcomes and potential intervention mechanisms has been developed and is summarised in the table overleaf (Table 19) under a defined WHoLE programme category. These categories are aligned with the proportionate impact of specific health determinants (derived from the Country Health Rankings model[92]) and the recommendations of *Health Equity in England: The Marmot Review 10 Years On*.[93]

- **Target Socio-economic Outcomes** are the suggested benefits that whole-system action might seek to achieve, leading additionally to improved healthy life expectancy (see Figure 17).

- **Potential Intervention Mechanisms**, drawn from Marmot Review recommendations and other evidence in this report, are how local partners could seek collaboratively to generate the target outcomes.

- **Available Public Sector Tools** are the high-level opportunities that public sector bodies have available for operating the potential intervention mechanisms.

- In Phase 2 of the programme, it is expected that specific **Candidate Interventions** will be identified and developed for approval that employ some combination of the available tools. This process should prioritise equality impact analysis and engagement with protected groups.

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[92] https://pophealthmetrics.biomedcentral.com/articles/10.1186/s12963-015-0044-2
[93] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

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	Education and Skills	Employment and Income	Community and Environment
County Health Ranking Weightings *(as % of the determinants of health)*	• 5% high school graduation (~5 GCSEs at C or above) • 5% some college education	• 10% unemployment • 10% children in poverty	• 2.5% air pollution – particulate matter • 2.5% inadequate social support
Marmot Recommendations	• Giving Every Child the Best Start in Life • Enabling all Children, Young People and Adults to Maximise their Capabilities and Have Control over their Lives	• Creating Fair Employment and Good Work for All • Ensuring a Healthy Standard of Living for All	• Create Healthy and Sustainable Places and Communities
Target Socio-economic Outcomes	• Greater school readiness • Better skills and qualifications	• Fuller employment in better jobs • Higher incomes	• Better environments (social, economic, physical and natural)
Potential Intervention Mechanisms	• Increasing early years access and support • Reducing child poverty • Increasing pay and qualification requirements for the childcare workforce • Improving pupils' physical and mental wellbeing	• Becoming living wage employers • Investing more in local procurement (including local employment and living wage jobs) under the 2012 Social Value Act • Increasing higher value apprenticeships and in-work training • Developing new roles and training paths in public sector professions	• Increasing the resilience of local communities and their economic, social and cultural assets • Improving air quality in line with national and local net zero targets • Increasing the quality and affordability of stable housing • Ensuring best value is being realised from public sector land and buildings
Available Public Sector Tools	• Adjusting public sector service models to increase wider socio-economic benefits and to reduce inequalities • Enhancing how potential and existing public sector staff (and the employees of public sector contract holders) are nurtured, recruited, trained and supported • Deriving greater socio-economic benefit from public sector financial and physical resources (including in the supply chain)		
Candidate Interventions	• *To be co-produced in Phase 2*		

Table 19 - Framework for collaborative discussion and action
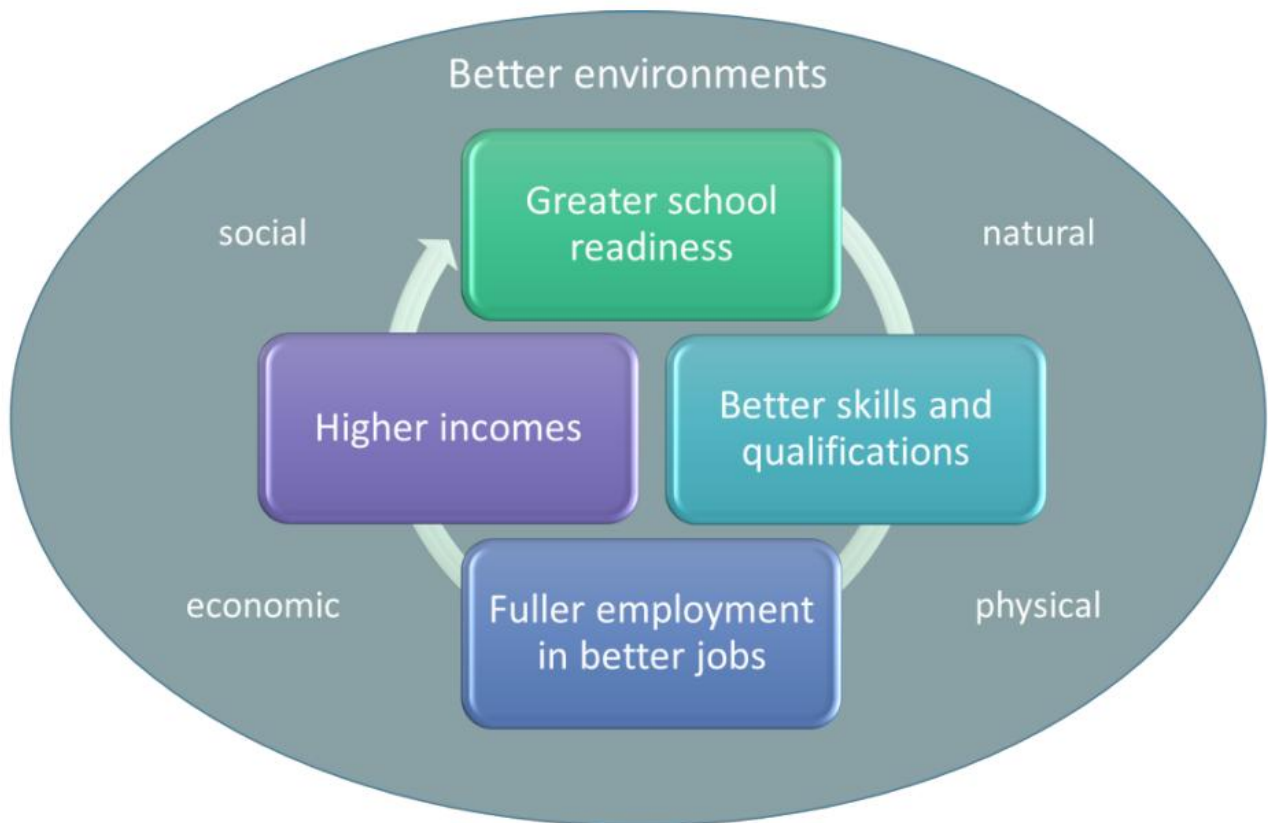
Figure 17 - Illustration of relationship between target outcomes

During the planned initial engagement period, there are four key questions to be explored in preparation for Phase 2:

1. **What priority should be given to each of the target socio-economic outcomes, and why?** Action in relation to any outcome will bring benefits in others, given how closely they are related, but some may have the potential to do this to a greater extent than others. Each also has the potential to improve healthy life expectancy. This is a question about where best to intervene in the cycle.

2. **Are there additional intervention mechanisms that should be considered for realising the target outcomes?** These must be mechanisms that can be affected by the tools available to public sector organisations.

3. **What specific candidate interventions might be considered?** This is a question about the action local partners could consider taking together.

4. **Are there specific population cohorts (e.g. age groups, genders, ethnicities, deprivation quintiles, other groups) that whole-system action should focus on?** The differential needs and experiences of such groups should be considered equitably in relation to any candidate intervention, but the evidence presented above, and local experience, may suggest a case for an enhanced focus on certain cohorts.

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Initial citizen engagement around these themes was conducted through the Healthier Futures Partnership's Citizen Voices Panel in September 2020 (Appendix Three – Citizen Panel Survey Data). Those who responded were largely from the Dudley and Sandwell and West Birmingham CCG areas (84%), of White ethnicity (88%), female (66%) over 40 years of age (59%, 25% were in the 60-74 age group), and from a broad range of geo-demographic categories. The relatively unrepresentative nature of the self-selected respondents inhibits a demographic analysis of the results.

The survey found that:

- The socio-economic determinants that reportedly affect respondent's **physical health** a lot (pre-COVID) are low income (22%), lack of work (16%) and poor or no housing (15%).

- Similarly, though to a greater degree, the socio-economic determinants that reportedly affect respondent's **mental health** a lot (pre-COVID) are low income (28%), lack of work (21%), crime or experience of the justice system (17%) and poor or no housing (12%).

- The aspects of life that had been significantly affected by the **COVID-19** pandemic and association policy measures were reported to be respondents' mental health (40%), close relationships (23%), education (20%) and income (20%). Only two panel members knew they had had COVID-19.

- Looking to the **future**, albeit through COVID glasses –

   o respondents' main concerns related to not being able to meet people because of COVID (26%), losing and/or not being able to find work (18%), and coping with low pay (14%), and

   o the external factors that respondents felt would most benefit their physical and mental health were income (23%), employment (23%) and skills/qualifications (8%).

These findings broadly align with the target outcomes identified above, and the evidence and analysis presented elsewhere in this report. In particular, there is a recurring focus on the significance of employment and income. The survey data also provides further evidence of the effects of COVID on mental and physical health, both directly through experience of or anxiety around the disease and indirectly through its impact on the key socio-economic determinants of health.

In addition to specific population-focused projects that are expected to emerge in Phase 2, consideration should also be given to the development of a WHoLE appraisal framework and WHoLE dashboard to inform system focus and decision-making. Operating like the New Zealand Treasury's *Living Standards Framework*[94], it would enable the wider determinants of health and wellbeing to be monitored and to be used alongside other established quality and financial measures in determining courses of action. This would be particularly value in a context where some of the interventions that might be considered may have higher initial costs for one or more partner organisation but which, when seen in wider perspective, offer greater longer term benefits.

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[94] https://lsfdashboard.treasury.govt.nz/wellbeing/

Effective links should also be made within Healthier Futures structures between interventions to address the wider determinants of health and those focused on carbon reduction since, in many cases, there will be significant complementarity.

Organizational and sectoral boundaries encourage siloed decision-making, and in ways that risk depriving our communities of both socio-economic and health benefits. Developing a whole-system framework, reflecting the evidence summarised in this discussion document, could enable system partners to assess the whole-system impact of their decisions and to consider more holistically what makes for the common good.

Appendix One – WHoLE Programme Expert Advisory Group

The membership of the programme's advisory group is as follows:

- Lucy Heath, Healthier Futures Academy Director – Chair

- Ian Carey for Sarah Middleton, CEO Black Country Consortium

- Sean Russell, WMCA Director of Implementation

- Marion Gibbon for Justin Varney, DPH Birmingham City Council (for BCWB DsPH)

- Dr Jonathan Odum, MD Royal Wolverhampton NHS Trust and BCWB CLG Lead

- Dr Chris Weiner, MD Dudley Integrated Health and Care NHS Trust

- Kuli Kaur-Wilson for Mark Axcell, CEO Black Country Healthcare NHS FT

- Julian Hobbs, MD DGFT, for Dame Yve Buckland, Chair DGFT, Pro-Chancellor Aston University

- Daren Fradgley, Director of Integration, Walsall Healthcare NHS Trust

- Ian Darch, CEO Wolverhampton Voluntary Sector Council (linking to other BCWB VSCs)

- Chris Handy, CEO Accord Housing Group, NED Dudley CCG, BC LEP Board Member

- Matt Hartland, Deputy Accountable Officer CCGs and STP planning lead

- Anthony Nicholls, Head of Intelligence, Dudley CCG

- David Frith, Principal Consultant, The Strategy Unit (Programme Director, Phase 1)

Additional thanks are due to Delma Dwight and Megan Boehm of the Black Country Consortium's Economic Intelligence Unit and to Alison Turner and Anastasiia Zharinova of The Strategy Unit.

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Appendix Two – Methodology for Prospective Modelling of Economic Scenarios

Methodology

The prospective modelling included in this report is derived from two interactive tools developed for the WHoLE Programme by The Strategy Unit. These tools illustrate how both mental healthcare activity and physical healthcare activity within the NHS in the Black Country and West Birmingham could increase in the period 2020-2024 due to COVID-related changes in the unemployment rate.

The tools are based on evidence from the 2008 recession that demonstrates the link between employment and the prevalence of long-term conditions.[95] This evidence suggests that for every 1% change in the unemployment rate there will be a larger percentage change in the prevalence rates of certain disease groups. Changes in prevalence rates would naturally lead to an increase in demand for healthcare services.

The four disease areas considered are musculoskeletal, cardiovascular, respiratory and mental health:

Disease group	Conditions
Musculoskeletal	Problems or disabilities (including arthritis or rheumatism) connected with … arms or hands; … legs or feet; … back or neck
Cardiovascular	Heart, blood pressure or blood circulation problems
Respiratory	Chest or breathing problems, asthma, bronchitis
Mental health	Depression, bad nerves or anxiety; Mental illness, or suffer from phobia, panics or other nervous disorders

Calculating potential demand pressures on local healthcare services involved the following four steps:

1. Like the study by Janke et al, prevalence rates for long-term conditions in 2019 were calculated using data from the Labour Force Survey. The proportion of respondents in the Black Country and West Birmingham STP having a condition within one of the above disease groups was established by dividing the number of respondents in the area confirming that they have a certain health condition by the total number of respondents in the area.

2. Changes in prevalence rates were calculated based on the changes in unemployment rate and long-run employment elasticity. Employment elasticities show how the prevalence rate of certain long-term conditions will change if employment changes by 1 percentage point. For example, a 1 percentage point increase in unemployment in 2020 will increase the prevalence of common mental health conditions by 2.3% in 2020 and by a further 1.4% in 2021. Janke et al provide quarterly elasticities for each disease group. To convert this to an annual effect, the mid-year point was used. Employment elasticities to prevalence are presented in the table below. To

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[95] Janke, Katharina, et al. "Macroeconomic Conditions and Health in Britain: Aggregation, Dynamics and Local Area Heterogeneity." (2020)

identify the impact of unemployment (rather than employment) on the prevalence, we have changed the sign of the elasticity.

	Year1	Year2	Year3	Year4	Year5
Mental health conditions	-0.023	-0.014	-0.003	-0.001	0.000
Cardiovascular disease	-0.017	-0.005	-0.001	0.000	0.000
Respiratory disease	-0.015	-0.004	-0.001	0.000	0.000
Musculoskeletal conditions	-0.016	-0.006	-0.002	-0.001	-0.001

3. The evidence suggests that the effect of a change in employment rate on health lasts for approximately 5 years and slowly decreases over those 20 quarters. So, each year of the five years considered initiates a new cycle based on the unemployment rate at the beginning of each cycle. Changes in prevalence rates for each scenario and each disease group are presented below.

Mental Health					
Upside scenario					
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	9.6%	5.9%	1.1%	0.4%	0.2%
2021		-5%	-3%	-1%	0%
2022			-4%	0%	0%
2023				0%	0%
2024					0%
Central scenario					
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	12%	7%	1%	0%	0%
2021		3%	2%	0%	0%
2022			-8%	-5%	-1%
2023				-2%	-1%
2024					-1%
Downside scenario					
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	12%	8%	1%	1%	0%
2021		6%	4%	1%	0%
2022			-8%	-5%	-1%
2023				-3%	-2%
2024					-1%

Physical Health - cardiovascular					
Upside scenario					
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	7%	2%	1%	0%	0%
2021		-4%	-1%	0%	0%
2022			-3%	-1%	0%
2023				0%	0%
2024					0%
Central scenario					
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	8%	3%	1%	0%	0%
2021		2%	1%	0%	0%
2022			-5%	-2%	0%
2023				-2%	-1%
2024					-1%
Downside scenario					
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	9%	3%	1%	0%	0%
2021		4%	1%	0%	0%
2022			-6%	2%	0%
2023				-2%	-1%
2024					-1%

Physical Health - respiratory				
Upside scenario				
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	6%	2%	0%	0%	0%
2021		-4%	-1%	0%	0%
2022			-2%	-1%	0%
2023				0%	0%
2024					0%
Central scenario				
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	8%	2%	0%	0%	0%
2021		2%	1%	0%	0%
2022			-5%	-1%	0%
2023				-2%	0%
2024					-1%
Downside scenario				
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	8%	2%	0%	0%	0%
2021		4%	1%	0%	0%
2022			-5%	-1%	0%
2023				-2%	0%
2024					-1%

Physical Health - musculoskeletal				
Upside scenario				
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	7%	3%	1%	0%	0%
2021		-4%	-1%	0%	0%
2022			-3%	-1%	0%
2023				0%	0%
2024					0%
Central scenario				
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	8%	3%	1%	0%	0%
2021		2%	1%	0%	0%
2022			-5%	-2%	-1%
2023				-2%	-1%
2024					-1%
Downside scenario				
Year to year	*2020*	*2021*	*2022*	*2023*	*2024*
2020	9%	3%	1%	1%	0%
2021		4%	2%	1%	0%
2022			-6%	-2%	-1%
2023				-2%	-1%
2024					-1%

4. An increase in the prevalence rate will increase the demand on healthcare services. It is assumed that the prevalence to service use ratio remains constant as prevalence increases. For example, if 1,000 people had a respiratory condition and used 2,000 appointments, when prevalence increases to 1,100 people, 2,200 appointments will be utilised.

In addition to service use, the research identified a potential increase in the number of suicides. Stuckler et al (2011) identified that an increase in unemployment of 3% will increase the suicide rate by 4.45%.[96] According to Office for Budget Responsibility forecasts, in 2020 the unemployment rate will increase by more than 3%. This means that the suicide rate in the Black Country and West Birmingham STP would be expected to increase by 4.45%.

Assumptions

The following assumptions have been made:

1. The research considered the residents of the Black Country and West Birmingham STP only. Activity in BCWB organisations for non-BCWB patients has been excluded but might be expected to increase by very similar proportions given the socioeconomic similarities in surrounding areas.

2. To illustrate the impact of unemployment rate changes alone, demographic change over the period has been excluded from the analysis but should be considered if the tools are used for planning purposes. Population estimates for mid 2019 from Office for National Statistics (ONS) were used for all following years.

3. Only activity provided to those of working age (15-64 years) has been included on the basis that this is the cohort most likely to be exposed to the direct impact of unemployment. Similar to the work by Janke et al, the cohort was not adjusted by proportion of economic active population due to data limitations.

4. Changes in unemployment rate over the modelled period are based on the Office for Budget Responsibility (OBR) forecasts and have been adjusted for the Black Country and West Birmingham STP by assuming the 2019 differential between local and notional rates neither increases nor decreases.

5. Only local providers were included in the model. For the mental health services, Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham Community Healthcare NHS Trust, Dudley and Walsall Mental Health Partnership NHS Trust and Black Country Partnership NHS Trust were included. For the physical health, Sandwell and West Birmingham Hospitals NHS Trust, the Dudley Group NHS Foundation Trust, the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust were included.

6. Different service categories were considered for different disease groups. For physical health, we have included A&E, outpatient appointments and inpatient admissions (elective and non-

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[96] Stuckler, D., Basu, S., Suhrcke, M., Coutts, A. and McKee, M., 2011. Effects of the 2008 recession on health: a first look at European data. The Lancet, 378(9786), pp.124-125.

elective). For mental health activity, referrals, attended care contacts and hospital stays were considered. Primary and community care data is excluded since the former is not available and the latter cannot be identified by healthcare condition.

7. To identify the area of residence and Primary Care Network (PCN), each record was matched by a GP Code. However, it was impossible to identify PCN for the Mental Health services. Instead of GP code, the Local Authority of residence field was used for these services.

8. In practice, service use will likely to be constrained due to limits in staff and available resources (especially for elective inpatient admissions and outpatient appointments). Equally, changes to services models may affect the efficiency of delivery. The modelling assumes no supply side changes from the 2019 baseline period, including the effects of organisational mergers or other changes.

Data

The main data sources are presented in the table below:

Data element	Source
Population Estimates	Office for National Statistics
Prevalence rate of long-term conditions in 2019	Labour Force Survey (2019)
Dynamics of unemployment rates	Based on the Office for Budget Responsibility (OBR) forecast
Activity estimates: physical health	Secondary Uses Service (SUS) data
Activity estimates: mental health	Mental Health Services Data Set (MHDS)
Suicides rate in the area	Public Health England, average of 4 CCGs

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Appendix Three – Citizen Panel Survey Data

The survey was completed by fifty-six members of the panel during the second half of September 2020. Of those responding, two reported having had COVID-19 and fifteen said they did not know whether they had had the disease.

Responses were as follows. The survey also asked about access to mental health support but those findings are not included here.

1. Thinking about before the Covid-19 pandemic, to what extent have the following things affected your physical health at any time in your life?

	A lot	A little	Not at all	Don't know
Lack of qualifications/skills	7.4%	25.9%	57.4%	9.3%
Lack of work	16.4%	9.1%	67.3%	7.3%
Low income	22.2%	24.1%	51.9%	1.9%
Poor or no housing	15.1%	7.5%	75.5%	1.9%
Local environment/air quality	3.8%	37.7%	47.2%	11.3%
Crime or experience of the justice system	5.6%	18.5%	66.7%	9.3%

2. Thinking about before the Covid-19 pandemic, to what extent have the following things affected your mental health at any time in your life?

	A lot	A little	Not at all	Don't know
Lack of qualifications/skills	9.6%	28.8%	53.8%	7.7%
Lack of work	20.8%	18.9%	54.7%	5.7%
Low income	28.3%	26.4%	43.4%	1.9%
Poor or no housing	11.8%	17.6%	70.6%	0.0%
Local environment/air quality	7.5%	22.6%	60.4%	9.4%
Crime or experience of the justice system	17.3%	25.0%	53.8%	3.8%

3. Has the Covid pandemic/lockdown led to difficulties with your:

	A lot	A little	Not at all	Don't know
Income	20.0%	27.3%	50.9%	1.8%
Physical health	13.0%	42.6%	44.4%	0.0%
Mental health	40.4%	40.4%	19.2%	0.0%
Close relationships	22.6%	41.5%	35.8%	0.0%
Education	20.4%	18.5%	61.1%	0.0%
Housing	9.3%	1.9%	87.0%	1.9%
Other	8.0%	6.0%	70.0%	16.0%

'Other' responses included:

- *My child's mental health*
- *Getting the correct help from my doctor's practice*
- *Getting essential goods and shopping.*
- *Primarily massive disagreements with long-time friends about how to slow down the pandemic. It is serious how intense disagreements can become and friends of decades have chose to adopt a careless denial about the need to maintain safe habits.*
- *Father's cancer being diagnosed too late and now terminal.*
- *Not being able to go and see family and friends.*
- *"The lack of contact with family members when you have no sign of c19 or a temperature*
- *Not being able to use your own judgement with your families health. I can understand the need to isolate from strangers But family your not going to put your children in danger."*
- *Found it very hard to be shielded and felt like I'd been put there then no body bother just left me to get on with it. Now I can get out I'm finding it hard to get motivated and to get my weight under control*
- *Future plans*
- *Freedom to do things, especially dropping in to see family and friends when we want to. Struggled with that aspect a lot*

4. What are you most concerned about for the future?

Not having the right qualifications/skills	7.8%
Losing my job/struggling to find work	18.4%
Coping with low pay	13.5%
Problems with getting/keeping decent housing	7.1%
The effects of pollution or other problems in my local environment	8.5%
Being a victim of crime	9.9%
Having a bad experience of being in the justice system	2.1%
Not being able to meet people because of Covid	26.2%
Other (please specify)	6.4%

'Other' responses included:

- *losing my disability benefits and family members*
- *Future work opportunities for my family*
- *Unfairness*

5. What 3 changes in things outside your control (e.g. work, income, environment, education and skills) would make the greatest different to your mental and/or physical health?

Income	23.3%
Employment	23.3%
Skills/qualifications	8.2%
Better personal/community relations/support	5.5%
Emotional and mental health support	4.1%
Access to physical activity opportunities	4.1%
Better health	4.1%
Better access to healthcare	4.1%
Environment	2.7%
Housing	2.7%
COVID-related:	17.8%
end to pandemic	
ability to see people/get around	
impact on schools/universities	

6. What do you do in your life that helps your mental wellbeing?

Socialising (including virtually) with family, friends and others	32.1%
Exercise (including walking)	29.5%
Hobbies and interests	16.7%
Relaxation, quietness and meditation	12.8%
Working	5.1%
Other: being alone/without pain and good diet	3.8%

7. Demographic profile of respondents

Age group	Count
17-21	7
22-29	7
30-39	9
40-49	10
50-59	8
60-74	14
75+	1
Grand Total	**56**

Clinical Commissioning Group	Count
NHS Dudley CCG	24
NHS Sandwell and West Birmingham CCG	23
NHS Walsall CCG	7
NHS Wolverhampton CCG	2
Grand Total	**56**

Gender	Count
Female	37
Male	19
Grand Total	**56**

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Ethnic group	Count
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	2
Black or Black British - Caribbean	1
Mixed - White and Asian	1
Not stated	2
White - English, Welsh, Scottish, Northern Irish, British	47
White - Other	2
Grand Total	**56**

Acorn group	Count
Career Climbers [E]	1
Countryside Communities [F]	2
Difficult Circumstances [Q]	8
Executive Wealth [B]	1
Mature Money [C]	1
Modest Means [L]	5
Poorer Pensioners [N]	2
Starting Out [J]	3
Steady Neighbourhoods [H]	7
Striving Families [M]	10
Struggling Estates [P]	5
Successful Suburbs [G]	4
Young Hardship [O]	7
Grand Total	**56**

Disability	Count
A learning disability	1
A mental health problem	5
A mental health problem, A learning disability	2
A physical disability	4
A physical disability, A mental health problem, A learning disability	1
A physical disability, A sensory disability	1
A sensory disability, A physical disability, Any other special need	1
Any other special need (please list in the 'Notes' section)	1
No disability	40
Grand Total	**56**

Healthier Futures Academy
Black Country and West Birmingham

Working Together for a Healthier Post-COVID Future

Executive Summary

Black Country Consortium
Economic Intelligence Unit

The Strategy Unit.

008451/2021

Healthier Futures Academy
Black Country and West Birmingham

Executive Summary

In line with wider national drives towards inclusive growth and the extension of the role of 'anchor institutions', the Healthier Futures Academy has initiated the Wider Determinants of Healthy Life Expectancy (WHoLE) Programme. The purpose of the programme is to help local partner organisations:

- Better understand their local populations in terms of the interactions between the wider context of their lives and their health;

- Develop a set of priorities for action;

- Engage relevant stakeholder and community groups; and

- Co-design, and collaboratively implement and evaluate, projects relating to the social, economic and environmental circumstances in which people live to facilitate improved population health.

This discussion document and the accompanying resources represent the initial outputs of the WHoLE programme, developed for the Academy by The Strategy Unit and with additional analysis by the Black Country Consortium's Economic Intelligence Unit.

Explicitly intended to facilitate discussion with system partners and co-production with local communities, this work does not purport to offer off-the-shelf solutions to intractable social, economic and health challenges, neither does it represent the formal policy position of the Healthier Futures Partnership or any of its constituent organisations. Instead, it is an independent overview of local experience, international evidence and bespoke, high-level analysis to generate debate and decision about what an increased local focus on improving population health and wellbeing in the Black Country and West Birmingham (BCWB) should look like.

Figure 1 - Causal map

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when the British economy sneezes, the NHS catches a cold[1]

What follows is no more and no less than the launchpad for a programme of targeted and collaborative engagement and action on the economic, social and environmental forces that shape our health, even more than do the lifestyle choices we make or the healthcare services available to us. The core logic of the WHoLE programme is represented in the causal map above (Figure 1) and summarised thus:

➢ Population health is determined by a wide range of factors including healthcare interventions and lifestyle choices. But we know that there are wider, socio-economic determinants of health that have a greater impact on the health of the population and the resulting demand for healthcare services. BCWB has existing challenges in relation to these determinants.

➢ There is evidence that COVID-19 is affecting the wider determinants of health and the consequent demand for services in an adverse manner and to a significant degree. This is in addition to the direct treatment and enduring health impacts of the disease.

➢ The NHS impacts population health status both directly through the care, treatment and medication it provides and indirectly through the way in which healthcare services are organised and healthcare resources invested.

➢ There are opportunities for the NHS, with local partners, to increase its impact as an anchor institution on the determinants of health, bringing greater benefits to local communities and limiting the adverse impacts of COVID-19.

Any adverse socio-economic impacts relating to COVID-19 will affect a context in the Black Country and West Birmingham that already has structural weaknesses including:

- The relatively low average income levels across BCWB (£4k below the national average) and the constrained ability to weather an economic crisis that accompanies this.

- The high numbers of children living in poverty (17.7% live in workless households and 28% in relative low income families).

- The already high rates of unemployment especially amongst

  - mixed ethnic groups (19.3% BCWB compared to 6.2% nationally) and the Pakistani/Bangladeshi population (12.9% BCWB compared to 8.9% nationally) and

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[1] Sir Simon Stevens, Chief Executive, NHS England and NHS Improvement, speaking in 2016

- 16-24 year-olds (males 15.6% compared to England 13.7%; females 13.0% compared to England 9.6%);

- The relatively low skills levels, especially in the White population.

- The relatively large proportion of 0-15 year-olds (21.5% BCWB, compared to 19.2% nationally) especially males - an age-group that will be seeking to enter the jobs market for the first time in the economic and social shadow of the COVID-19 pandemic.

- The relatively high proportion of the population that is economically inactive (i.e. neither in work nor seeking work), especially females aged 16-49 and across all ethnic groups except those of Indian ethnicity.

- The high levels of air pollution, with 32% of neighbourhoods (LSOAs) in the 'worst' category nationally.

Illustrative, evidence-based modelling of three post-COVID scenarios undertaken by The Strategy Unit, using conservative assumptions, suggests that the unemployment rates in a COVID-related recession could lead to significant increases in healthcare activity levels during 2020-24.

- For physical health services relating to cardiovascular, musculoskeletal and respiratory conditions alone, activity levels are projected to remain above the 2019 baseline for the whole period. In the upside scenario, activity increases by 7% in 2020 before reducing to 5% then close to 2019 levels. In central and downside scenarios, the peak is in 2021 with 13% and 16% increases, respectively.

Figure 2 - Percentage change in total physical healthcare activity by scenario

The equity of access for different ethnic groups is hard to assess because of weaknesses in recording ethnicity in the activity data; there are some variations in activity level by place; and there are elevated activity levels amongst those in the lowest deprivation deciles (c.3% above the working age population proportion for those deciles).

- For mental health services, activity levels are also projected to remain above the 2019 baseline for the whole period but to a greater extent than physical health activity. In the upside scenario, activity increases by 10% in 2020 and 2021 before reducing to 3% for the remainder of the period. In central and downside scenarios, the peak is in 2021 with 22% and 27% increases, respectively.

The equity of access for different ethnic groups is again hard to assess because of weaknesses in recording ethnicity in the activity data; there are some variations in activity level by place; and there are elevated activity levels amongst those in the lowest deprivation deciles. At 10% above the working age population proportion for those deciles, this deprivation impact is three times the level in mental healthcare activity than it is in physical healthcare activity.

In addition, a 4.45% increase would be expected in the suicide rate (4 additional deaths) along with an additional 160 suicide attempts.

Figure 3 - Percentage change in total mental healthcare activity by scenario

Whatever the nature and extent of the additional healthcare demand created by the socio-economic fallout from COVID-19, one aspect of the NHS response alongside local partners will necessarily be to make changes to the capacity of services and to the models of care that shape those services (including the skill-mix of staff). Such supply-side actions are outside the scope of this report, as are demand-side responses linked directly to lifestyle choices, and the associated prevention activities. The findings reported here may, however, additionally be used to inform supply-side planning across the system. The focus of the WHoLE programme, by contrast, is on understanding and addressing the social, economic and environmental drivers of population health that may account for 50% of the determinants of health.

> *Health is often thought of as more of a concern for the NHS than for local government, but in reality, local government has an even greater potential to influence health improvement than does the NHS. As was quoted in the recent All Parliamentary Report on longevity: "We have been caught in a false view that our national health means the NHS."[2]*

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[2] https://www.local.gov.uk/sites/default/files/documents/22.52%20Social%20Determinants%20of%20Health_05_0.pdf

What can the NHS, in a genuine and close collaboration with local government and other partners, actually do to impact these indirect drivers of population health? In fact, local NHS and other partner organisations are already acting to impact the wider determinants of health in a wide variety of ways which the Health Foundation categorises as five areas for potential action (Figure 4).

Figure 4 - What makes the NHS and anchor institution?

The challenge now is to redouble collaborative efforts to identify and act on opportunities to improve the circumstances that influence the health of our populations more materially than the healthcare we provide. Prior to COVID-19, the evidence and the need were already clear. In the shadow of COVID, the evidence suggests that healthcare needs will materially increase, bringing further challenge to the lives of our citizens and significant additional demand pressures on already stretched healthcare services.

Although these dynamics have long been known within the NHS, at least at a superficial level, the NHS has not yet played as full a part as it might in impacting the factors that shape population health, given its social and economic impact in the local economy. The lead role that other bodies play in relation to this agenda, especially Local Authorities, is well recognised, as is the significance of other local anchors

such as educational institutions, emergency services and other public bodies. The challenge for local NHS organisations is to better understand the socio-economic impact of their decisions (past and present) and then to use that understanding to energise and inform collaborative working with local partners. The challenge for those partners is to be open to that collaboration and to help NHS organisations discover how they can realise their potential as economic actors and become fuller partners in all aspects of inclusive local growth, thereby improving the healthy life expectancy of local populations through impacting the socioeconomic determinants of health as well as through healthcare delivery. Collaborative action at scale will have greater impact than isolated initiatives at the margins.

Figure 5 - The benefit of collaborative action

To facilitate this increased collaboration, the publication of this discussion document will be followed by two months of engagement with system partners in Local Authority Health and Wellbeing Boards, Healthier Futures partner organisations in the NHS and local government, and the local voluntary and community sector. Whilst detailed public engagement is largely intended for Phase 2, versions of this report will be made available to the public. Going forward, the governance of the programme is expected to sit with the Health Inequalities Board of the Healthier Futures Partnership. There are two aims of this engagement:

- To increase understanding of the interactions between the contexts in which citizens live (social, economic, environmental) and their health; and

- To inform the recommendation of priority areas for whole-system action in Phase 2 of the programme. These are expected to be determined by the Healthier Futures Partnership Board in January 2021, following the proposed engagement.

There are four key questions to be explored in this initial engagement. These relate to a framework for discussion and action that has been developed on the basis of the evidence and analysis presented in this report (Table 1):

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	Education and Skills	Employment and Income	Community and Environment
County Health Ranking Weightings *(as % of the determinants of health)*	• 5% high school graduation (~5 GCSEs at C or above) • 5% some college education	• 10% unemployment • 10% children in poverty	• 2.5% air pollution – particulate matter • 2.5% inadequate social support
Marmot Recommendations	• Giving Every Child the Best Start in Life • Enabling all Children, Young People and Adults to Maximise their Capabilities and Have Control over their Lives	• Creating Fair Employment and Good Work for All • Ensuring a Healthy Standard of Living for All	• Create Healthy and Sustainable Places and Communities
Target Socio-economic Outcomes	• Greater school readiness • Better skills and qualifications	• Fuller employment in better jobs • Higher incomes	• Better environments (social, economic, physical and natural)
Potential Intervention Mechanisms	• Increasing early years access and support • Reducing child poverty • Increasing pay and qualification requirements for the childcare workforce • Improving pupils' physical and mental wellbeing	• Becoming living wage employers • Investing more in local procurement (including local employment and living wage jobs) under the 2012 Social Value Act • Increasing higher value apprenticeships and in-work training • Developing new roles and training paths in public sector professions	• Increasing the resilience of local communities and their economic, social and cultural assets • Improving air quality in line with national and local net zero targets • Increasing the quality and affordability of stable housing • Ensuring best value is being realised from public sector land and buildings
Available Public Sector Tools	• Adjusting public sector service models to increase wider socio-economic benefits and to reduce inequalities • Enhancing how potential and existing public sector staff (and the employees of public sector contract holders) are nurtured, recruited, trained and supported • Deriving greater socio-economic benefit from public sector financial and physical resources (including in the supply chain)		
Candidate Interventions	• *To be co-produced in Phase 2*		

Table 1 - Framework for discussion and action

Building Healthier, Happier Communities

Figure 6 - Illustration of relationship between target outcomes

1. **What priority should be given to each of the target socio-economic outcomes, and why?** Action in relation to any outcome will bring benefits in others, given how closely they are related, but some may have the potential to do this to a greater extent than others. Each also has the potential to improve healthy life expectancy. This is a question about where best to intervene in the cycle (see Figure 6).

2. **Are there additional intervention mechanisms that should be considered for realising the target outcomes?** These must be mechanisms that can be affected by the tools available to public sector organisations.

3. **What specific candidate interventions might be considered?** This is a question about the action local partners could consider taking together.

4. **Are there specific population cohorts (e.g. age groups, genders, ethnicities, deprivation quintiles, other groups) that whole-system action should focus on?** The differential needs and experiences of such groups should be considered equitably in relation to any candidate intervention, but the evidence presented above, and local experience, may suggest a case for an enhanced focus on certain cohorts.

Initial citizen engagement around these themes was conducted through the Healthier Futures Partnership's Citizen Voices Panel in September 2020. Those who responded were largely from the Dudley and Sandwell and West Birmingham CCG areas (84%), of White ethnicity (88%), female (66%) over 40 years of age (59%, 25% were in the 60-74 age group), and from a broad range of geo-

demographic categories. The relatively unrepresentative nature of the self-selected respondents inhibits a demographic analysis of the results.

The survey found that:

- The socio-economic determinants that reportedly affect respondent's **physical health** a lot (pre-COVID) are low income (22%), lack of work (16%) and poor or no housing (15%).

- Similarly, though to a greater degree, the socio-economic determinants that reportedly affect respondent's **mental health** a lot (pre-COVID) are low income (28%), lack of work (21%), crime or experience of the justice system (17%) and poor or no housing (12%).

- The aspects of life that had been significantly affected by the **COVID-19** pandemic and association policy measures were reported to be respondents' mental health (40%), close relationships (23%), education (20%) and income (20%). Only two panel members knew they had had COVID-19.

- Looking to the **future**, albeit through COVID glasses –

  o respondents' main concerns related to not being able to meet people because of COVID (26%), losing and/or not being able to find work (18%), and coping with low pay (14%), and

  o the external factors that respondents felt would most benefit their physical and mental health were income (23%), employment (23%) and skills/qualifications (8%).

These findings broadly align with the target outcomes identified above, and the evidence and analysis presented elsewhere in this report. In particular, there is a recurring focus on the significance of employment and income. The survey data also provides further evidence of the effects of COVID on mental and physical health, both directly through experience of or anxiety around the disease and indirectly through its impact on the key socio-economic determinants of health.

In addition to specific population-focused projects that are expected to emerge in Phase 2, consideration should also be given to the development of a WHoLE appraisal framework and WHoLE dashboard to inform system focus and decision-making. Operating in a manner similar to the New Zealand Treasury's *Living Standards Framework*[3], it would enable the wider determinants of health and wellbeing to be monitored and to be used alongside other established quality and financial measures in determining courses of action. This would be particularly value in a context where some of the interventions that might be considered may have higher initial costs for one or more partner organisation but which, when seen in wider perspective, offer greater longer term benefits. Effective links should also be made within Healthier Futures structures between interventions to address the wider determinants of health and those focused on carbon reduction since, in many cases, there will be significant complementarity.

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[3] https://lsfdashboard.treasury.govt.nz/wellbeing/

Organizational and sectoral boundaries encourage siloed decision-making, and in ways that risk depriving our communities of both socio-economic and health benefits. Developing a whole-system framework, reflecting the evidence summarised in this discussion document, could enable system partners to assess the whole-system impact of their decisions and to consider more holistically what makes for the common good.

Birmingham Health and Wellbeing Board

	Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th January 2021**
TITLE:	**IMPACT OF ECONOMIC SHOCK ON HEALTH AND WELLBEING**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Marion Gibbon, Interim Assistant Director of Public Health, Damilola Agbato, Programme Senior Officer**

Report Type:	**Presentation**

1. Purpose:	
1.1 To inform the Board of the progress of the work on the impact of economic shock on health and wellbeing	

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

3. Recommendation	
3.1 The Board is asked to note the progress detailed in the report.	

1

4.	Report Body

Background

The rapid and unexpected closure of businesses and restrictions in social interactions was a significant and ongoing shock to the economy of the UK and Birmingham. This directly affected employment, income, and financial security with knock-on effect on the health and wellbeing of the population.

4.1 The paper summarises the progress made to date on the impact of economic shock on the health and wellbeing. Key themes covered include:

- Evidence on the impact of unemployment/job loss

- Mechanisms and processes that lead to negative health and wellbeing outcomes following economic shock

- Developing a framework for intervention

- Working collaboratively to quantify the impacts on service demand and estimate future prevalence of poor health and wellbeing.

4.2 The following partners have contributed to the report:

- Birmingham City Council
- NHS Birmingham and Solihull Clinical Commissioning Group

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**

5.1.1 The impact and mitigation of the risk of negative health and wellbeing outcomes on citizens of Birmingham.

5.2	**Management Responsibility**

Dr Marion Gibbon, Interim Assistant Director of Public Health
Dr Justin Varney, Director of Public Health, Birmingham City Council

6.	Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Board member organisations cease to mitigate the risk and support	Low	High	Continue to facilitate discussions.

communities from the economic shock leading to poor health outcomes and further increase in inequalities.		3	

Appendices
Appendix 1 – Presentation: Impact of Economic Shock on Health and Wellbeing to follow Jan 4th

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

Dr Marion Gibbon, Interim Assistant Director of Public Health,
Damilola Agbato, Programme Senior Officer

Impact of economic shock on health and wellbeing

Brexit

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Focus

- Identify and describe what is know about unemployment/financial insecurity, caused by economic shock, and its implications for health and wellbeing.

- Produce a tool kit that helps plan services in context of economic shock.

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Content

- Evidence of impact

- Theory of Causation

- Framework for intervention

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What is known

EVIDENCE REVIEW

Income, employment and health

- Income and employment are key social determinants of population health and health inequalities[1].

- Unemployment contributes to poor health while being in good employment is protective of health.

- The greater one's income the less likelihood of disease and premature death[2].

1 Fair Society Healthy Lives, the Marmot Review
2 How are Income and Wealth Linked to Health and Longevity?

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Initial findings

EVIDENCE REVIEW

Economic shock health and wellbeing
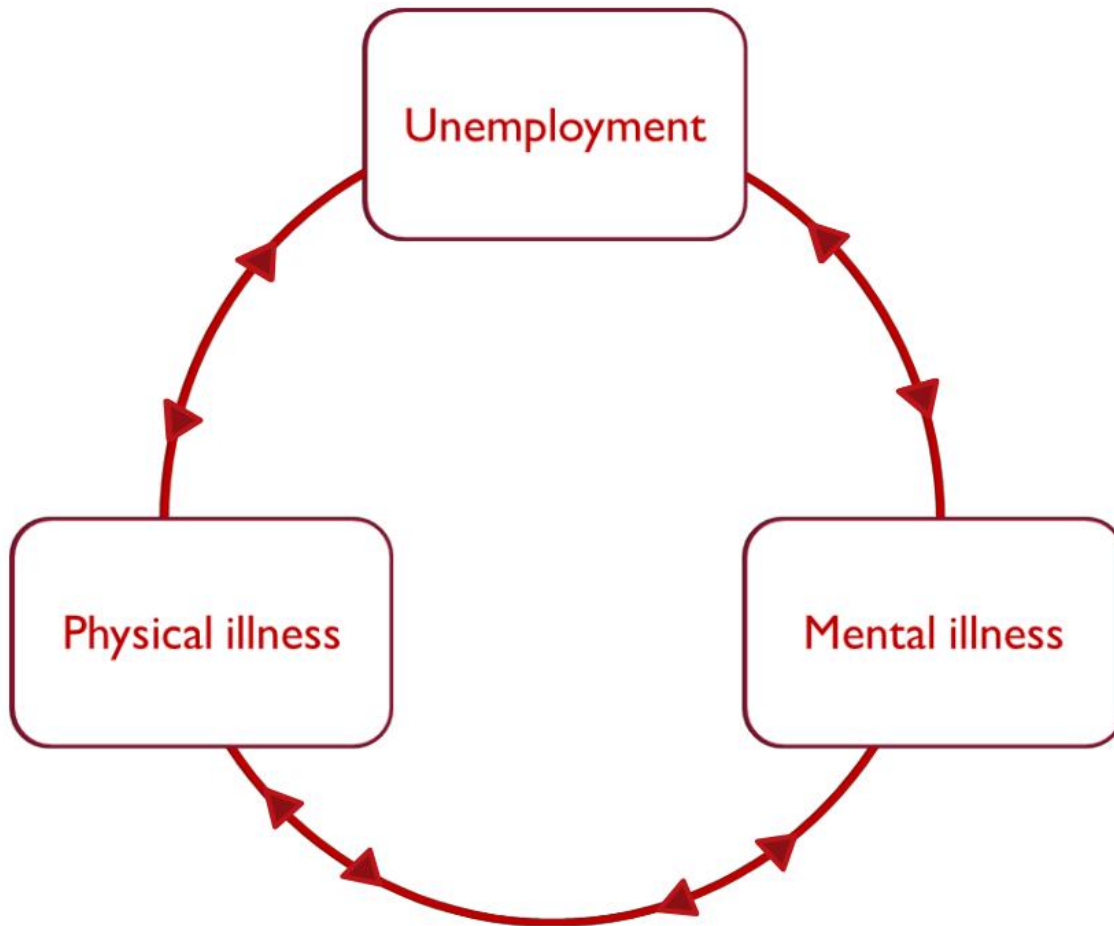
Unemployment

Physical illness

Mental illness

- Unemployment increases risk for mental illness
- Unemployment increases risk for physical illness

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Anxiety and Depression

- In the event of job loss, individuals are on average twice as likely to develop symptoms of anxiety and depression[3].

- Transitions to inadequate employment, insecure or temporary employment, and income loss, are reported to all increase symptoms of anxiety and depression. Although the effect is less than that seen in involuntary job loss[3].

- Reemployment in the previously unemployed reduces symptoms of depression and reduces the risk of experiencing severe symptoms of depression requiring the need for professional intervention[4].

- Unemployment and loss of investment income is associated with population level increase in rates of depression[5].

3 The Health Effects of Economic Decline
4 Unemployment, Reemployment, and Emotional Functioning in a Community Sample
5 Evidence for the 2008 economic crisis exacerbating depression in Hong Kong

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Substance Use and Abuse

- Unemployment increases the use of alcohol, cannabis, and other drugs[3].

- Long-term unemployment increases the risk of heavy drinking by about 50%[6].

- Increased unemployment is associated with excess alcohol related deaths in those under 65[7].

6 Is the duration of poverty and unemployment a risk factor for heavy drinking?

7 The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis

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Violent behaviour and domestic violence

- Unemployment increases the likelihood of violent behaviour among those laid-off compared to the those remaining in employment[8].

- Unemployment increase the likelihood of children being hospitalized for abuse and neglect[9].

- Evidence suggests that increase in male unemployment rate causes a decline in the incidence of physical abuse against women, conversely an increase in the female unemployment rate has the opposite effect[10].

- Domestic abuse (DA) support providers report increase in visits to DA websites and calls to helpline during lockdown.

8 Using ECA Survey Data to Examine the Effect of Job Layoffs on Violent Behavior

9 Growing Up with Unemployment: A Study of Parental Unemployment and Children's Risk of Abuse and Neglect Based on National Longitudinal 1973 Birth Cohorts in Denmark

10 Unemployment and Domestic Violence: Theory and Evidence

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Suicide

- Being unemployed is associated with a two to three-fold increase in suicide compared with the employed[11].

- Suicide rates increase as unemployment rises within the population[12].

11 Unemployment and suicide. Evidence for a causal association?
12 Why are suicide rates rising in young men but falling in the elderly? —a time-series analysis of trends in England and Wales 1950–1998

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Cardiovascular disease

- Evidence on association between cardiovascular disease and unemployment varies between Europe and the U.S[13].

- In Northern European studies job loss is not associated with coronary heart disease mortality. U.S cohorts however demonstrate that involuntary job loss later in life predicts increase risk of heart attack in subsequent years[14].

[13] The effects of workplace downsizing on cause-specific mortality: a register-based follow-up study of Finnish men and women remaining in employment

[14] The impact of late career job loss on myocardial infarction and stroke: a 10 year follow up using the health and retirement survey

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Birth weight and Infant mortality

- Unemployment or low employment may be associated with increased rates of low birth weight or very low birth weight[15].

- Increasing infant mortality rates is associated with increasing unemployment rates[3].

15 The Ecological Effect of Unemployment on the Incidence of Very Low Birthweight in Norway and Sweden

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General morbidity and mortality

- Unemployment is associated with increased risk of hospitalization due to alcohol related problems, road traffic accidents, and in men only, self-harm and mental health problems[16].

- Job loss is associated with an increased risk of mortality[17].

16 Job loss is bad for your health – Swedish evidence on cause-specific hospitalization following involuntary job loss

17 High local unemployment and increased mortality in Danish adults; results from a prospective multilevel study

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Diet

- Unemployment significantly impacts diet composition; effect varies with duration of unemployment[18].
  - Short term
    - Favour discount stores, increase in food expenditure, consumption of animal-based foods, saturated fat, total fat, protein.
  - Medium
    - Decreased food expenditure, consumption of fresh animal-based foods, saturated fat, total fat, protein.
  - Long term
    - Nutrient substituted by carbohydrates and added sugar.

- Impact varies by household: households with children, pensioners, and single parent households experienced greater decline than other households[19]
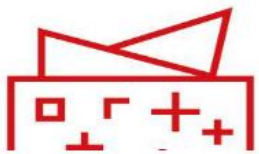
18 The consequences of unemployment on diet composition and purchase behaviour: a longitudinal study from Denmark

19 Food expenditure and nutritional quality over the Great Recession

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Smoking

- Those who are unemployed are more likely to be current smokers or to have ever smoked than those in employment[20].

- Older workers who are former smokers have over twice the odds of relapse following job loss than those who remain in employment. current smokers who do not obtain new employment are more likely to smoke more cigarettes on average following job loss[21].

- Smokers have a lower likelihood to be reemployed at 1 year and are paid significantly less relative to non-smokers when reemployed[22].

20 Cigarette smoking and employment status
21 The effect of involuntary job loss on smoking intensity and relapse
22 Likelihood of Unemployed Smokers vs Nonsmokers Attaining Reemployment in a One-Year Observational Study

to people's lives

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THEORY OF CAUSATION

Theory of Causation

- Unemployment can be a shock to the whole system. Its loss…
  - Loss of usual source of income
  - Personal work relationships
  - Daily structures
  - Sense of self-purpose

- Experience feelings and stresses similar to any other major loss.

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Causation

Decline in living standard	Income insecurity	Stigma and loss of self-esteem	Loss of social contacts
Stress			
Effect budgeting		Frustration aggression	
	Anxiety	Depression, suicide	
Diet	Cardiovascular morbidity	Anti-social, violent behaviour	Domestic abuse
	Gestational and infant mortality		Alcohol and substance misuse

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Duration of unemployment

Existing assets, unemployment benefits, income and assets of other household members

Stress; Frustration-aggression; Effect budgeting

Economic shock → Unemployment → Loss of Income

Decline in living standards

Insecurity of Income

Stigma/ Loss of self esteem

Loss of Social contacts

Anxiety: length of income loss, risk of future decline in living standards, feelings of life not being under control

Loss of status amongst friends and family. Loss of contact with work colleagues and shrinking social networks, loss of engagement and social capital

Anxiety and Depression

Substance use and abuse

Violent behaviour

Suicide

Cardiovascular disease

General morbidity and mortality

Gestational mortality and morbidity

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Framework

Overview

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Pre-unemployment

Employment

Economic shock

Stress

Anxiety

Develop individual and community assets for wellbeing

Physical/mental health and wellbeing

Job loss

Short term

Loss of income

Insecurity of income, decline n living standards

Anxiety, loss of sleep, sub-clinical depression

Poor nutrition

Active labour market programs

Mental health selfcare and telephone support

Benefit and income support, housing support

Food parcels and nutrition advise

Mid term

Stigma/ Loss of self esteem, Loss o social contact

Clinical depression, Suicide,

Substance use and abuse

Domestic abuse and violent behaviour

Cardiovascular disease,

Gestational and infant morbidity/mortility

Job retraining and skills development , employability

Outpatient and inpatient mental health services

Alcohol and substance misuse programs

DA victim services, police and crime prevention services

Long term

Antenatal and maternal health

Health checks and screening

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Economic shock, job loss and primary effects

Interventions

Stress	Loneliness	Frustration-aggression	Effect budgeting

• Talking therapies
  • CBT
  • Mindfulness-based stress reduction
• Ecotherapy
• Complimentary and alternative therapies
  • Yoga and meditation
  • Acupuncture
  • Aromatherapy
  • Massage
	• Groups or classes focused on activities of interest
	• Volunteering
		• Assertiveness training
		• Anger management classes
			• Income support
			• Benefit and welfare awareness and advise
			• Re-employment: employability skills development and training

Anxiety, depression, suicide
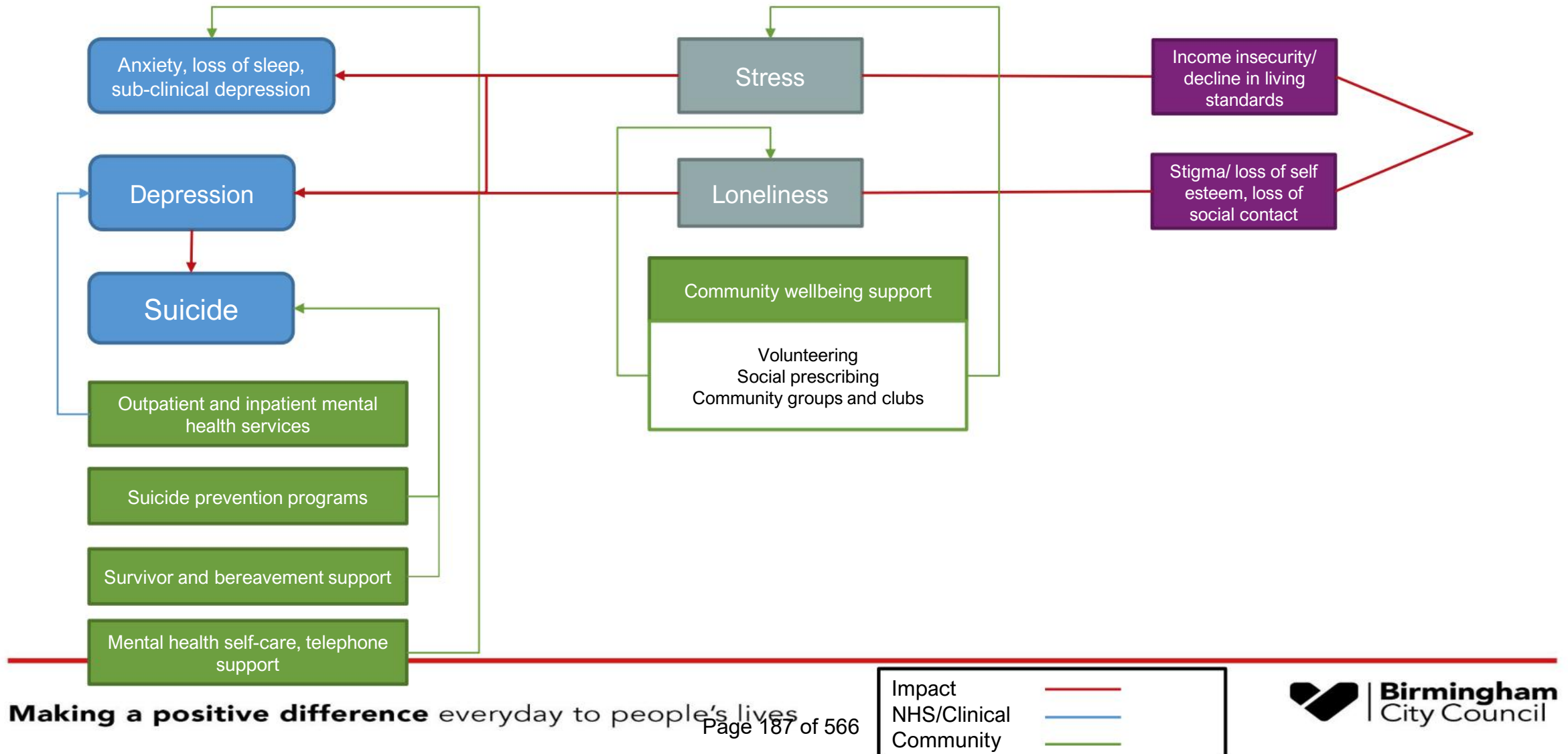
Psychological Interventions

- Anxiety
  - Individual non-facilitated self-help[1]
  - Individual guided self-help[1,2]
    - Workbooks based on CBT - [Reading Well website](#)
    - Computer based CBT programme and app-based CBT courses - [the NHS apps library](#)
  - Psychoeducational groups[1]
  - Applied relaxation[2]

- Depression
  - Mild to moderate[3]
    - Self help
      - Individual guided self-help book or online based on CBT
      - Self-help groups for people with depression
    - Structured group physical activity programme
  - Moderate to severe
    - Medication

1. [Generalised anxiety disorder and panic disorder in adults: management](#)
2. [Generalized anxiety disorder in adults](#)
3. [Clinical depression: treatment](#)

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Suicide prevention

- Suicide prevention partnerships, strategies and action plans[1]
- Suicide prevention strategies[2]
  - Strengthen economic supports
  - Strengthen access and delivery of mental healthcare
  - Create protective environments
  - Promote connectedness
  - Teach coping and problem solving skills
  - Identify and support people at risk
  - Lessen harms and prevent future risk

1. Preventing suicide in community and custodial settings NICE guideline [NG105]
2. Suicide: Prevention Strategies

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Domestic abuse, violent behaviour, alcohol and substance misuse
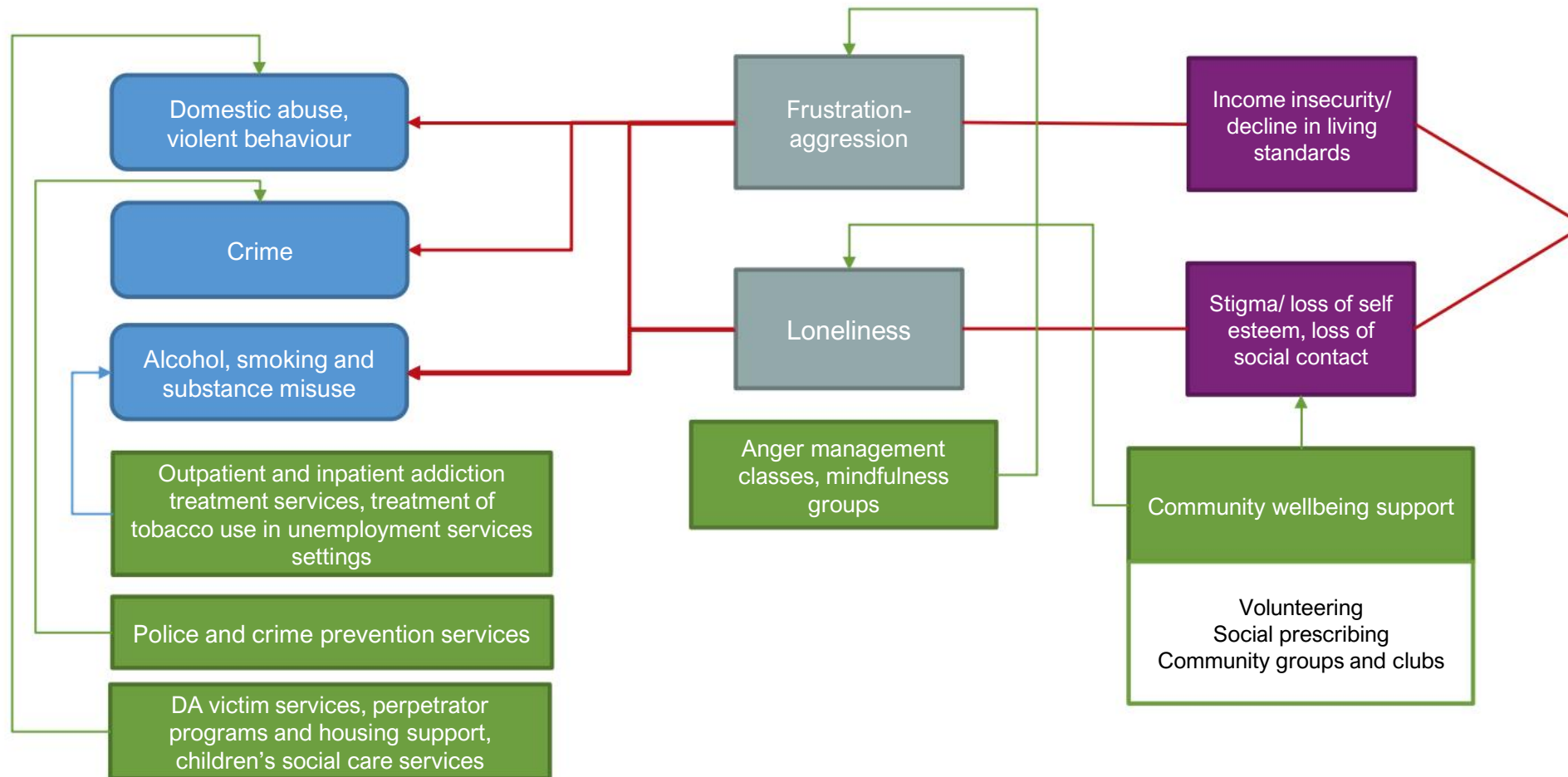
Domestic abuse - Interventions

- Victims
  - Birmingham Domestic Abuse Prevention Strategy 2018-2023[1]
  - Victim services provided
  - Intimate Partner Violence Prevention Strategies[2]

- Programs for perpetrator of domestic violence[3]
  - Experimental
  - Based on CBT or Duluth model
  - Lack of clear evidence of effectiveness, most research from North America
  - More likely to be effective if they are delivered as intended, they contribute to a wider multi-agency approach to risk management; and they apply the principles of Risk, Need and Responsivity.

1 Birmingham DAP
2 Intimate partner violence prevention strategies
3 Intimate partner violence – domestic abuse programmes

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At risk groups

- Risk factors for perpetration[1]
- Societal Factors
  - Traditional gender norms and gender inequality (for example, the idea women should stay at home, not enter the workforce, and be submissive; men should support the family and make the decisions)
  - Cultural norms that support aggression toward others
  - Societal income inequality
  - Weak health, educational, economic, and social policies/laws

Current services

- Commissioned
  - Domestic Abuse Health and Wellbeing Hub
  - Housing Health and Wellbeing Hub
  - Emergency Accommodation
  - Dispersed Refuge
  - Navigator Support
  - Singles' complex needs provision
- Direct
  - Sanctuary measures (injunctions, panic alarms etc.)
  - Bharosa (support service for south Asian women)

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Alcohol, substance misuse and crime - Interventions

- **Alcohol and substance misuse**
  - Preventing alcohol misuse[1,2]
  - Electronic screening and brief intervention
  - Prevention[3] : Skills training – children and young people
  - Counselling
  - Talking therapies – CBT
  - Medication
  - Detoxification
  - Self-help – Narcotics Anonymous.
  - Harm reduction – HIV, Hepatitis testing and treatment

- **Crime**

[1] Alcohol-use disorders: prevention
[2] Preventing excessive alcohol use
[3] Drug misuse prevention: targeted interventions

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At risk groups

- Alcohol and substance misuse[1]
  - Groups at risk of drug misuse, including:
  - people who have mental health problems
  - people who are being sexually exploited or sexually assaulted
  - people involved in commercial sex work
  - people who are lesbian, gay, bisexual or transgender
  - people not in employment, education or training (including children and young people who are excluded from school or who truant regularly)
  - children and young people whose carers or families use drugs
  - children and young people who are looked after or care leavers
  - children and young people who are in contact with young offender teams but not in secure environments (prisons and young offender institutions)
  - people who are considered homeless
  - people who attend nightclubs and festivals
  - people who are known to use drugs occasionally or recreationally.

- Crime

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Poor nutrition, cardiovascular disease, gestational and infant morbidity/ mortality

Intervention

- Poor nutrition and Obesity
  - Eating a balanced diet[1]
  - Food parcels, nutrition advise, cooking classes
  - Lifestyle and behavioural interventions[2]
  - NHS weight management programme[3]
    - Diet
    - Exercise
    - Medicines
    - Surgery

- Cardiovascular disease[4]
  - Policy
    - Reducing salt, fat, trans fat
    - Marketing and promotion aimed at children and young people
    - Product labelling
    - Physically active travel
    - Public sector catering guidelines
    - Take-away and other food outlets
  - CVD prevention programmes
    - NHS health checks
    - Physical activity

1 Eating a balanced diet
2 Obesity: identification, assessment and management
3 Healthy weight
4 Cardiovascular disease prevention

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Interventions

- Gestational and infant morbidity and mortality

Quantitative estimates

ECONOMIC SHOCK - HEALTH AND WELLBEING IMPACT

Wider economic environment - UK

- Employment
  - Rising unemployment
  - Large decrease in young people in employment, and increased unemployment.
  - >5M still temporarily away from work (including furlough)
- Claimant count more than doubled since March 2020
- GDP contracted by 19.8% in Quarter 2 of 2020.

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- ## In employment

  - 64.6% of the resident population of Birmingham were in employment April 2019 – Mar 2020. A decrease of 0.9pp when compared to April 2018 – Mar2019 (difference of over 6000 people)[1].

- ## Unemployment rate

  - 9.0%, April 2019 – Mar 2020 increase of 1.8pp compared to April 2018 – Mar 2019. Translates to about 10,000 people unemployed[2].

- ## Claimant count

  - August 2020 – 11.1%. Almost double August 2019 – 6.3%, and significantly rising since March 2020. Another significant rise could be seen in Oct/Nov as the Coronavirus Jobs Retention Scheme closes[3].

1 All people – Economically active – In employment Birmingham
2 All people – Economically active – Unemployed (model based) Birmingham
3 Claimant count by sex time series – All claimants Birmingham

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Macroeconomic conditions and health[1]

- Evidence of a counter cyclical effect of economic performance on health outcomes.

- A 5 percent fall in employment could lead to 7-10% rise in prevalence of chronic conditions.

- Translating to about 900,000 more people of working age with chronic diseases

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Data sources

Service	Contact	Data source	External source
Alcohol and Substance misuse	Karl Beese, KEG	CGL	PHE - Finger tips
Sexual Health	Karl Beese, KEG	UHB	PHE - Finger tips
Mental Health			
primary care - Anxiety, depression		PHE - Finger tips, dx prevalence sources, GP practice data	
secondary care		hospital admissions data, CCG - monitor MH during pandemic	
Domestic Abuse	Kalvinder Kholi		
Smoking cessation	Bhavna Taank	Pharmacies, GP	
Violent behaviour		crime data	
Physical activity	Kyle Stott		
Employment and skills	Kam Hundal, Tara Verrelle		

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	Unemployment	Claimant count	Public health	Mental health	Alcohol misuse treatment	Drug misuse	Adult services
%	9.0	11.1			12	43	
Population	48,200	81,525			1400	4700	
Financial					15M		
Employment							
7-10% rise							

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Economic shock, job loss and primary effects

Economic Shock: Impact on health and wellbeing

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Economic shock → Job loss

100% → Loss of income
100% → Loss of daily routine
Loss of purpose

Loss of income → Income insecurity / Decline in living standards — **50%[1]**

Income insecurity + Decline in living standards → Effect budgeting

Loss of daily routine / Loss of purpose → Stigma/ loss of self esteem, → Stress
loss of social contact → Frustration-aggression / Loneliness

Effect budgeting → Gestational and infant mortality and morbidity / Poor nutrition, obesity / Cardiovascular disease

Stress → **15-30%[2]** → Anxiety / Depression **7-10%** / Suicide

Frustration-aggression → Domestic abuse, violent behaviour / Crime

Loneliness → Alcohol, smoking and drug abuse

[1] Individuals with formal savings and investment - Great Britain.
[2] Towards a better estimation of the effect of job loss on health
[3] Social determinants of health and population health – rapid evidence scan, Strategy Unit West Midlands NHS.
[4] Working Together for a Healthier Post-COVID Future

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Approach

- Quantitative evidence of changes in employment levels and impact on prevalence of chronic diseases and in turn on demand for services.

- Based on framework for intervention, identify data sources required to estimate change in disease prevalence and service demand.

- Required
  - Disease prevalence measures
  - Services activity levels

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```
Stress ──15-30%[1]──┐
                    ├──→ Anxiety ──────→ Mental health self-care, telephone support
          7-10%[2]  │
                    ├──→ Depression ───→ Outpatient and inpatient mental health services
                    │
                    └──→ Suicide ──────→ Suicide prevention programs
                                   └────→ Survivor and bereavement support
```

Anxiety

Depression

Suicide

Mental health self-care, telephone support

Outpatient and inpatient mental health services

Suicide prevention programs

Survivor and bereavement support

3.8% increase in mental health services provision[3]

1 Towards a better estimation of the effect of job loss on health

2 Social determinants of health and population health – rapid evidence scan, Strategy Unit West Midlands NHS

3 Working Together for a Healthier Post-COVID Future

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Anxiety and depression	Estimated prevalence of common mental disorders: % of population aged 16 & over	21.1	2017	
	Depression and anxiety among social care users: % of social care users 2017	59.1	2017/18	
Depression	Depression: Recorded prevalence (aged 18+)	9.2	2017/18	
	ESA claimants for mental and behavioural disorders: rate per 1,000 working age population	36.0	2018	
Suicide	Suicide registrations in England and Wales by local authority	74	2018	

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Mental health

- Modelled service activity levels expected to increase by 10%, 21% and 27% in upside, central and downside scenarios respectively.

- A 4.45% increase in suicides rates is expected as well as increase in suicide attempts.

- 1 percentage point drop in employment growth leads to a 4.2% increase in mental health conditions.

- At Mar 2020, there has been a 0.9 percentage point drop in employment which could lead to a 3.8% increase in prevalence of mental health conditions.

- 2019 levels – actual numbers.

- Projections based on scenarios

- Data sources – PHE fingertips, others

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Frustration-aggression		Domestic abuse, violent behaviour		DA victim services, perpetrator programs and housing support, children's social care services
Isolation		Crime		Police and crime prevention services
		Alcohol, smoking and drug abuse		Outpatient and inpatient addiction treatment services, treatment of tobacco use in unemployment services settings

Alcohol and substance misuse	CGL Birmingham Current Clients & Drug Category by Ward at 31/03/20	3813		Users/dependent 2019	Cause specific deaths	% in treatment of users/dependent	% change due to unemployment
Alcohol		330		13,300	373	12	50
Non-opiates		90		10,500	173	43	8-17
Opiates		3310					
Domestic abuse, violent behaviour							
Crime							

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Alcohol and substance misuse

- Adult services
  - CGL: 5 year contract up to 2022
  - 2018/19 contract value - £15M
  - Spend per head population - £13.79
- Young people's services
  - Aquarius: 2year contract to 2021
  - 2019/2020 contract value - £673,000

- 50% increased risk of alcohol use in the unemployed – increased spend by over £400K for adult services.

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┌─────────────┐                    ┌──────────────┐         ┌────────────────────────┐
│   Effect    │────┐            ┌──▶│ Gestational  │────────▶│                        │
│  budgeting  │    │            │   │ and infant   │         │                        │
└─────────────┘    │            │   │ mortality and│         │                        │
                   │            │   │  morbidity   │         │                        │
                   │            │   └──────────────┘         └────────────────────────┘
                   ├────────────┤
                   │            │   ┌──────────────┐         ┌────────────────────────┐
                   │            ├──▶│Poor nutrition,│────────▶│ Food parcels and       │
                   │            │   │   obesity    │         │ nutrition advise       │
                   │            │   └──────────────┘         │ and cooking classes    │
┌─────────────┐    │            │                            └────────────────────────┘
│   Stress    │────┘            │   ┌──────────────┐         ┌────────────────────────┐
└─────────────┘                 └──▶│Cardiovascular│────────▶│ Health checks and      │
                                    │   disease    │         │ screening,             │
                                    └──────────────┘         │ physical activity      │
                                                             └────────────────────────┘
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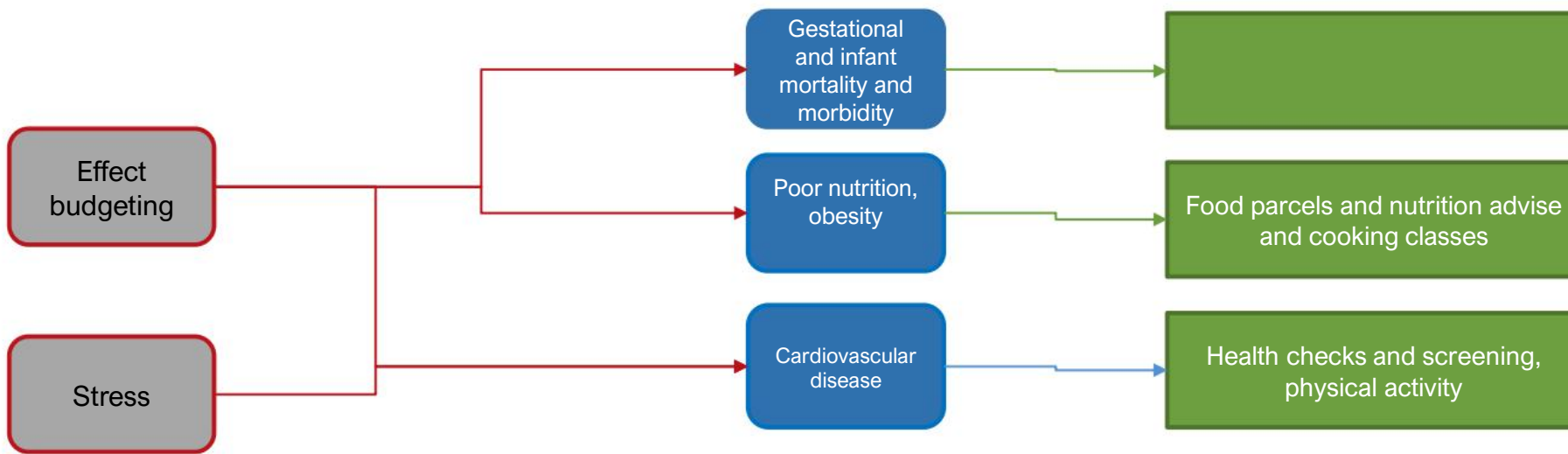
	Indicator	Year	Prevalence	Count	% increase in prevalence	Increased count
Cardiovascular disease	CHD: QOF prevalence (all ages) %	2018/19	2.9	38,496	2.16	831
	CHD admissions (all ages) per 100,000	2018/19	526.3	4,940		106
Obesity	Obesity: QOF prevalence (18+) %	2018/19	10.3	104,382		

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Cardiovascular disease

- 1pp drop in employment is modelled to lead to a 2.4% increase in prevalence of Cardiovascular disease. 0.9pp drop in employment at March 2020 could lead to a 2.16% increase in prevalence of CVD.

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Impact of the Economic Shock on Health & Wellbeing

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PROGRAMME SENIOR OFFICER, PUBLIC HEALTH

008452/2021

About this briefing

This briefing summarizes evidence from literature on the health effects of unemployment and financial security due to economic decline.

Key points

- Income and employment are key social determinants of population health and health inequalities. Unemployment contributes to poor health while being in good employment is protective of health[1].
- The greater one's income the less likelihood of disease and premature death[2].
- Unemployment increases risk for mental illness
- Unemployment increases risk for physical illness

Background

On March 23rd, 2020, the UK government instituted a lockdown to slow the spread of the novel Coronavirus. The rapid and unexpected closure of businesses and restrictions in social interactions was a significant shock to the economy of the region and Birmingham directly affects employment, income, and financial security with impacts on the health and wellbeing of the population.

Birmingham has the highest claimant unemployment rate at 15.3% of the UK core cities (November 2020[3].

A package of economic support was introduced by the UK government, these have mitigated some of the immediate effects of the economic shock by acting as a safety net for businesses and individuals.

In the current economic shock due to the Coronavirus pandemic, individuals with jobs that can be done remotely are able to work from home and are less likely to experience job loss. Individuals in jobs that require physical presence are more likely to experience being furloughed, reduction in working hours or being laid off. This presents a risk of widening inequalities in employment and income. As employers introduce new ways to get work done some jobs may never return.

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[1] Fair Society Healthy Lives, the Marmot Review
[2] How are Income and Wealth Linked to Health and Longevity?
[3] Claimant Count Unemployment Monthly Update - November 2020 Data

Economic shock health and wellbeing
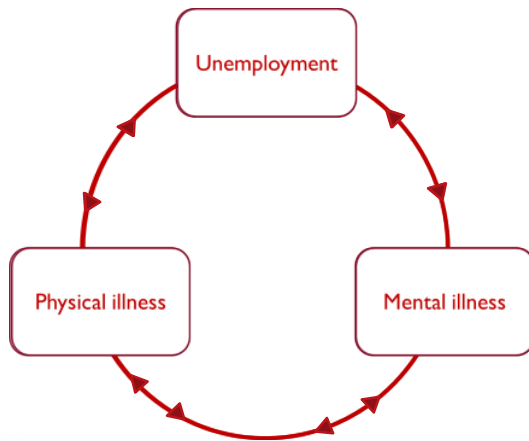
- Unemployment increases risk for mental illness
- Unemployment increases risk for physical illness

Anxiety and Depression

- In the event of job loss, individuals are on average twice as likely to develop symptoms of anxiety and depression[4].
- Transitions to inadequate employment, insecure or temporary employment, and income loss, are reported to all increase symptoms of anxiety and depression. Although the effect is less than that seen in involuntary job loss[4].
- Reemployment in the previously unemployed reduces symptoms of depression and reduces the risk of experiencing severe symptoms of depression requiring the need for professional intervention[5].
- Unemployment and loss of investment income is associated with population level increase in rates of depression.[6]

Substance Use and Abuse

- Unemployment increases the use of alcohol, cannabis, and other drugs[4].
- Long-term unemployment increases the risk of heavy drinking by about 50%[7].
- Increased unemployment is associated with excess alcohol related deaths in those under 65[8].

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[4] The Health Effects of Economic Decline
[5] Unemployment, Reemployment, and Emotional Functioning in a Community Sample
[6] Evidence for the 2008 economic crisis exacerbating depression in Hong Kong
[7] Is the duration of poverty and unemployment a risk factor for heavy drinking?
[8] The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis

Violent behaviour and domestic violence

- Unemployment increases the likelihood of violent behaviour among those laid-off compared to the those remaining in employment[9].
- Unemployment increase the likelihood of children being hospitalized for abuse and neglect[10].
- Evidence suggests that increase in male unemployment rate causes a decline in the incidence of physical abuse against women, conversely an increase in the female unemployment rate has the opposite effect[11].

Suicide

- Being Unemployed is associated with a two to three-fold increase in suicide compared with the employed[12].
- Suicide rates increase as unemployment rises within the population[13].

Cardiovascular disease

- Evidence on association between cardiovascular disease and unemployment varies between Europe and the U.S. In Northern European studies job loss is not associated with coronary heart disease mortality[14]. U.S cohorts however demonstrate that involuntary job loss later in life predicts increase risk of heart attack in subsequent years[15].

Birth weight

- Unemployment or low employment may be associated with increased rates of low birth weight or very low birth weight[16].

Infant mortality

- Increasing infant mortality rate is associated with increasing unemployment rates[4].

General morbidity

- Unemployment is associated with increased risk of hospitalization due to alcohol related problems, road traffic accidents, and in men only, self-harm and mental health problems[17].

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[9] Using ECA Survey Data to Examine the Effect of Job Layoffs on Violent Behavior

[10] Growing Up with Unemployment: A Study of Parental Unemployment and Children's Risk of Abuse and Neglect Based on National Longitudinal 1973 Birth Cohorts in Denmark

[11] Unemployment and Domestic Violence: Theory and Evidence

[12] Unemployment and suicide. Evidence for a causal association?

[13] Why are suicide rates rising in young men but falling in the elderly? —a time-series analysis of trends in England and Wales 1950–1998

[14] The effects of workplace downsizing on cause-specific mortality: a register-based follow-up study of Finnish men and women remaining in employment

[15] The impact of late career job loss on myocardial infarction and stroke: a 10 year follow up using the health and retirement survey

[16] The Ecological Effect of Unemployment on the Incidence of Very Low Birthweight in Norway and Sweden

[17] Job loss is bad for your health – Swedish evidence on cause-specific hospitalization following involuntary job loss

General mortality

- Job loss is associated with an increased risk of mortality[18].

Diet

- Unemployment significantly impacts on diet composition; effect varies with duration of unemployment [19].

  - Short term

    - Increase use of discount stores, increase in food expenditure, consumption of animal-based foods, saturated fat, total fat, protein.

  - Medium

    - Decreased food expenditure, consumption of fresh animal-based foods, saturated fat, total fat, protein.

  - Long term

    - Nutrient substituted by carbohydrates and added sugar.

- Decline in nutritional quality and food expenditure during economic recession varies by household type[20]. Households with children, pensioners, and single parent households experienced greater decline than other households. Showing greater substitution away from fruits and vegetables to processed foods.

Smoking

- Those who are unemployed are more likely to be current smokers or to have ever smoked than those in employment[21].

- Older workers who are former smokers have over twice the odds of relapse following job loss than those who remain in employment. current smokers who do not obtain new employment are more likely to smoke more cigarettes on average following job loss[22.]

- Smokers have a lower likelihood to be reemployed at 1 year and are paid significantly less relative to non-smokers when reemployed[23].

---

[18] High local unemployment and increased mortality in Danish adults; results from a prospective multilevel study

[19] The consequences of unemployment on diet composition and purchase behaviour: a longitudinal study from Denmark

[20] Food expenditure and nutritional quality over the Great Recession

[21] Cigarette smoking and employment status

[22] The effect of involuntary job loss on smoking intensity and relapse

[23] Likelihood of Unemployed Smokers vs Non-smokers Attaining Reemployment in a One-Year Observational Study

Equity statement

Health inequalities are unfair and avoidable differences in people's health across social groups and between different population groups. Health inequalities can occur by gender, income, social class, deprivation, educational status, ethnicity, and geography[24].

Ethnic inequalities in labour market participation have remained persistent over time. There are considerable differences in unemployment rates between ethnic groups demonstrating continuing disadvantage. Employed people in certain minority ethnic groups are over-represented in certain occupations[25].

Theory of Causation

Unemployment presents a shock to the whole system. It is a loss of not only the usual source of income, but also of your personal work relationships, daily structures, and sense of self-purpose. It is not uncommon to experience some of the same feelings and stresses as from serious injury, divorce, or the loss of a loved one[26].

Economic shock leads to unemployment and there are several ways unemployment could lead to worsening health and wellbeing.

Decline in standard of living

Loss of income from job loss could lead to a decline in standard of living which could influence both physical and mental health of the unemployed. The severity of decline in standard of living depends on factors such as the unemployed persons assets, unemployment benefits available, income and assets of other household members, and the duration of unemployment[27].

Income insecurity

Being unemployed could lead to anxiety about the length of income loss and the risk of future drop in standard of living. Joblessness can generate a feeling that life is not under one's control[27,28].

Stigma and loss of self-esteem

Becoming unemployed can result in a drop in status among friends, family, and community at large[27].

Loss of social contacts

Job loss typically results in a loss of contact with work colleagues and a shrinking of social networks. The loss of engagement and social capital can bring about a decline in personal wellbeing[29].

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[24] Health inequalities - what are they and how do we reduce them?
[25] Ethnic minority disadvantage in the labour market
[26] https://cmha.ca/unemployment
[27] Unemployment and mental health
[28] Social Psychology, Unemployment and Macroeconomics
[29] The social context of well-being

Declining economies affects physical and mental health and wellbeing through three broadly defined mechanisms.

Stress

declining economies increase the incidence of stressful job and financial events and that these events increase the likelihood of experiencing other stressors not intuitively associated with the economy (such as marital difficulties). There are reports of economic decline increasing the anticipation of stressful experiences, including job loss and difficulty meeting financial obligations[4].

Frustration-aggression

This mechanism suggests that individuals denied an expected reward may experience psychosomatic precursors of aggression. Some exhibit antisocial behaviours, whereas others cope by using alcohol or drugs. The literature argues that contracting economies increase the perception of unfair loss of earned rewards, and thereby increase the incidence of intrafamily and workplace violence as well as substance abuse[4].

Effect budgeting

This mechanism assume that we have limited time, energy, and money to manage our environments and experiences and we budget these resources in ways that reflect expected costs and benefits. It asserts that following job loss individuals will allocate available resources away from existing investments if it ranks relatively low in in the hierarchy. (e.g., exercise, socially supportive behaviour, medication, good nutrition, surveillance of one's own or others' biology or behaviour) and thereby increase his or her risk of illness[4].

Economic Shock: Impact on health and wellbeing
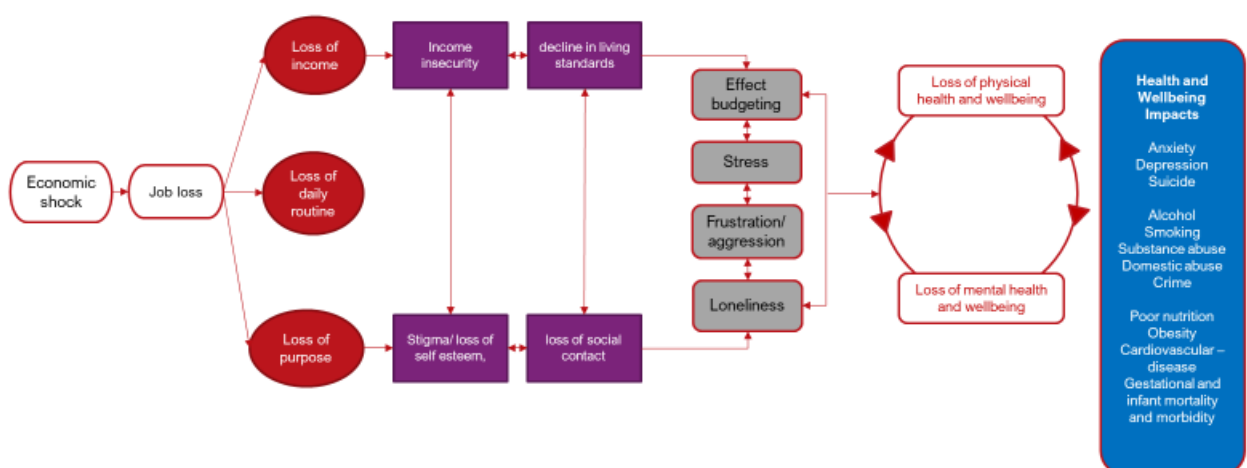
Framework for intervention

A framework for intervention was developed based on the theory of causation.

Economic shock, job loss and primary effects
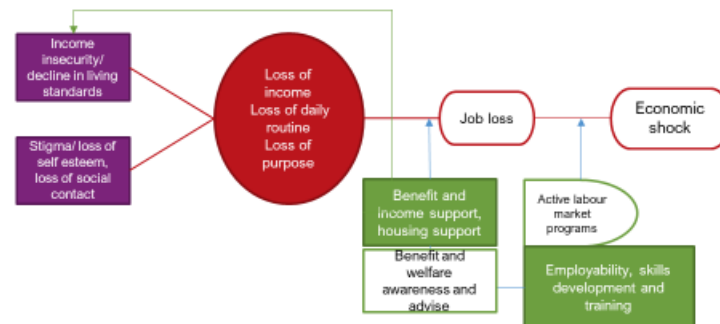
Primary effects

Stress, lonliness, frustration-aggression, and effect budgeting could be addressed through interventions designed to prevent further progression towards decline of health and wellbeing. Interventions preventing or delaying job loss, or speeding up reemployment will prevent material depravation.

Stress	Lonliness	Frustration-aggression	Effect budgeting
Talking therapies • CBT • Mindfulness-based stress reduction • Ecotherapy Complimentary and alternative therapies • Yoga and meditation • Acupuncture • Aromatherapy • Massage	Groups or classes focused on activities of interest. Volunteering	Assertiveness training. Anger management classes.	Income support and Benefits, housing support, and welfare awareness and advise. Re-employment: employability skills development and training.

When primary effects progress to decline in physical or mental health and wellbeing, various Clinical/NHS, and community/third sector interventions will aid recovery.

Anxiety, depression, suicide
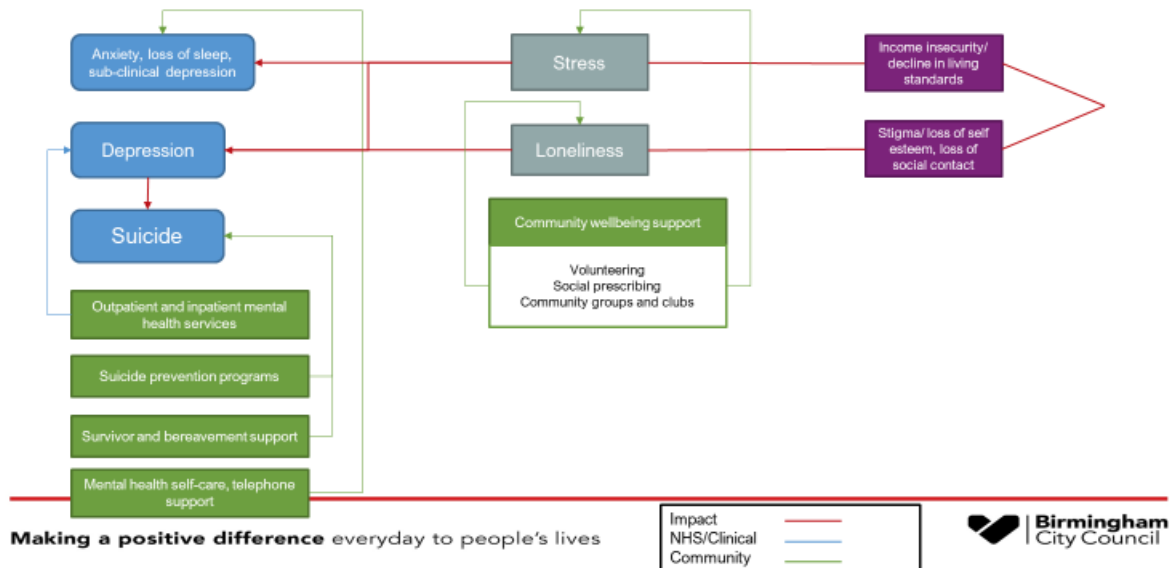
Domestic abuse, violent behaviour, alcohol and substance misuse
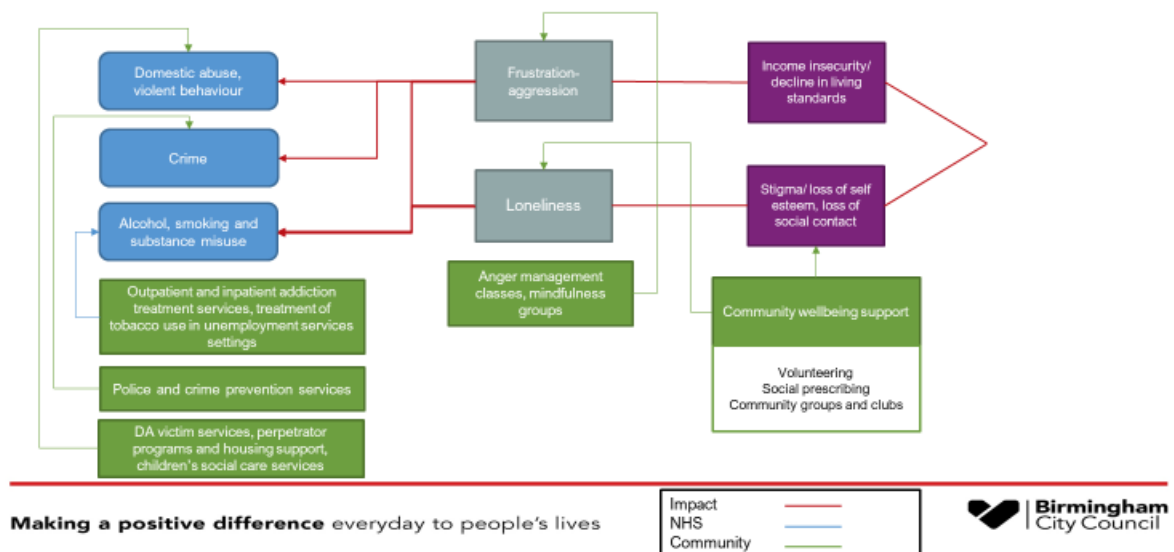
Poor nutrition, cardiovascular disease, gestational and infant morbidity/mortality

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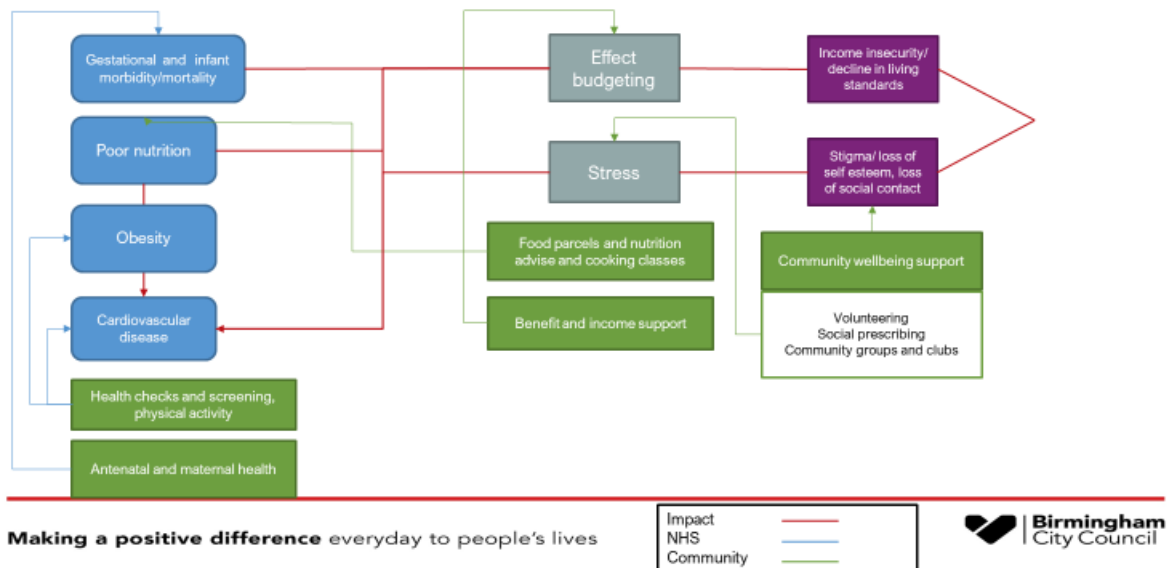
Quantitative estimates

Macroeconomic conditions and health

There is evidence of an inverse relationship between economic performance and health outcomes[30].

- A 5 percent fall in employment could lead to 7-10% rise in prevalence of chronic conditions.
- Translating to about 900,000 more people of working age with chronic diseases.

Approach

Utilize quantitative evidence of changes in employment levels and impact on prevalence of chronic diseases and in turn on demand for services.

- Based on framework for intervention, identify data sources required to model change in disease prevalence and service demand.
- Required
  - Disease prevalence measures
  - Services activity levels
- Modelling to carried out in by BI team.

Outputs

- A modelling tool quantitative estimates of changes to economic indicators and effect on disease prevalence and service demand.
- A planning tool kit to support population health and wellbeing in the context of a significant economic shock within the city.

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[30] Macroeconomic conditions and health

Birmingham
Health and Wellbeing
Board

	Agenda Item: 14
Report to:	Birmingham Health & Wellbeing Board
Date:	19 January 2021
TITLE:	CREATING A HEALTHY FOOD CITY FORUM UPDATE
Organisation	Birmingham City Council
Presenting Officer	Paul Campbell, Service Lead (Wider Determinants), Public Health

Report Type:	Presentation

1.	Purpose:

- To provide an update on delivery to date, and current and planned activity on selected work streams within the context Creating a Healthy Food City Forum and wider food portfolio of work.

- To seek approval and input from the Board where noted within the report and as summarised in section 3. Recommendations.

2. Implications: # Please indicate Y or N as appropriate]

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

3.	Recommendation

- Endorse the inclusion of the resilience theme into the Draft Food Strategy.

- To participate (or nominate representatives to participate) in a workshop on the Emergency Food Plan. It is suggested this approach should include representation from multiple levels / sectors (the Board, one or more Fora, the Food Justice Network and possible more), to enable moving forward at pace.

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4.	Report Body

4.1 **Context**

The main purpose of the Forum is to work together to apply a whole system approach to understanding the food landscape of the city and improving the food behaviours at a population level across Birmingham by ensuring that a joint action plan is developed and delivered.

The forum has met 14 January 2021 for the first time since June 2020. The Forum meetings were placed on hold due to the need for Public Health to focus resources on the various being taken against COVID-19 in Birmingham. Whilst the Forum itself has been on hold various projects have been progressed and this report will provide updates to the Board as requested on:

Food Strategy
Emergency Food Plan
Birmingham Food Conversation
Food Poverty
International Partnerships
Sustainable Food Places Application
Childhood Obesity Trailblazer Project

The full agenda of the recent Creating a Healthy Food City can be seen as **Appendix 1.**

4.2 **Current Circumstance**

4.2.1 **Food Strategy**

During late 2019 and early 2020 there were multiple rounds of consultation with partners on the Birmingham Food Strategy, with the intention of public consultation shortly thereafter. The COVID-19 response placed these conversations and the strategy itself on hold, however the input of partners was captured and can be seen in **Appendix 2.**

The most notable update to the strategy since the previous draft is the inclusion of a resilience workstream. This has become more important than ever considering the upcoming COVID-19 recovery phase, and the potential implications of the exit from the European Union. Please see recommendations above and next steps below.

4.2.2 **Emergency Food Plan**

There have been some preliminary discussion on creating an Emergency Food Plan as an interim measure during the ongoing COVID-19 response to ensure that parts of the Birmingham Food Strategy that have been placed in hold, but would be of assistance to the response, can be strategically shaped and implemented. Initial thoughts are that the plan would focus on communications around eating well and healthily despite current restrictions, the resilience of the food system, and food transport logistics. An initial skeleton draft of some thoughts on this can be seen in **Appendix 3.** It is accepted that there is more activity that may have been missed, please see

recommendations above and next steps below.

4.2.3 Birmingham Food Conversation

The Birmingham Food Conversation consisted of **two substantial pieces of primary data collection**.

Firstly, the Birmingham Food Survey; although this was cut short to prevent the bias inherent on continuing the survey during the COVID-19 response there were 394 responses received. The full summary of results is available to view in **Appendix 4**, although headline findings include:

- 40% of respondents feeling the single biggest intervention could be making fruit and vegetables more affordable / accessible.
- 31% highlighted the need for locally grown / sourced food.
- 28% felt there should be restrictions on takeaway advertising.
- 47% described their diet as healthy, and a further 48% as average.
- 40% stated that they never drank fizzy drinks.
- Over four fifths felt they had been taught to cook, although the vast majority of these were self taught.

We are currently developing internally how the findings of this report can better inform the food systems approach to multiple strands of work.

Secondly, thirty-one different organisations were commissioned to **deliver 'Seldom Heard Food Voices' research**. The groups were facilitated by community research consultants, employees of organisations serving the needs of specific target groups, and occasionally a combination of organisations matching research expertise with organisational reach.

All organisations reported details of scripts and resources used as well as the structure focus group. All groups covered the questions highlighted in the tender specification. The facilitators delivered these questions in a range of ways, adapting them where appropriate for the groups they were working with.

We have completed draft version of the final report and are in the process of finalising recommendations around the consensus opinions on what is required to create a healthy city, as well as some unexpected and unsolicited comments on how to engage better as part of future consultation processes.

4.2.4 Food Poverty

In November 2020 Birmingham City Council re-established the Food Poverty Core Group to better understand the systems level responses we can put in place across the local systems in Birmingham to ensure a robust and coordinated response to the various issues around food poverty.
The three themes we need to focus on; 1) prevention of people going into food poverty 2) crisis management – how do we get them out of it 3) recovery – moving forward, long term impact.
A rapid evidence review will be completed on each theme for action / discussion by the group.

4.2.5 International Partnerships

The Food Foundation Partnership contract was finalised to assist with implementation of national and international food policies and guidelines, and specialist advice, support and management of Birmingham's international relationships launched on 01 July 2020 and will be effective for two years. The partners have been in ongoing conversations to discuss:

Key project deliverables by quarter over the life of the contract

Milan Urban Food Policy Pact's Milan Pact Talks event took place on 17 December and showcased the videos that Birmingham City Council and other partners submitted to highlight food strategy work. The key common themes of focus were food aid in the COVID-19 response, healthy diet, and shaping food economies. Birmingham has been invited to share learning around our wide approach to the inequalities highlighted by COVID-19 surveys and data collection.

· The BINDI project (Birmingham Public Health partnership with Pune, India). How we can maximise sharing knowledge on food systems and work together towards Commonwealth 2022 legacy. The December 2020 update was cancelled and we are awaiting a rescheduled update for January 2021.

4.2.6 Sustainable Food Places Application

The Sustainable Food Places Award is designed to recognise and celebrate the success of those places taking a joined-up, holistic approach to food and that have achieved significant positive change across six key food issues. We have held discussions with the awarding body to finalise the application and be accredited as a food partnership that is making healthy and sustainable food a defining characteristic of Birmingham. The deadline for final submission has now been extended to 15 April 2021.

There are ongoing conversations regarding which the food system partners in Birmingham who can assist with finalising the application which will be led by Birmingham City Council.

4.2.7 Childhood Obesity Trailblazer Project

The Childhood Obesity Trailblazer is a national project to encourage Local Authorities to focus their efforts on becoming healthy food places. In Birmingham we have three workstreams to enable this ambition.

Workstream 1 - Creating a health food planning and economic climate through creation and implementation of a developer toolkit. The content of the toolkit is for the most part created, and we will shortly enter the design phase. The substantive delivery of this work has been moved to the Place Service Lead within the Wider Determinants Team of Public Health to enable better resource capacity to deliver, and to ensure that benefits of the toolkit are maximised by considering as many Public Health place based development outcomes as possible and also be complementary to a healthy food city environment. The developer toolkit will be signed-off by the end of

January 2021.

Workstream 2 - Creating a better understanding of food in the city through the Birmingham Basket. Through initial market scoping we have identified at least one supplier capable of delivering the required data, information and insight to understand how the people of Birmingham purchase food. However, we have decided a full competitive tender process should be utilised to ensure we commission the most innovative, and value for money solution. The full tender process will be initiated before the end of December 2020 for delivery of baseline data by end of February 2020.

Workstream 3 - Creating a healthy apprenticeship workforce that understands health, healthy eating and can support a healthier food economy. We are using our leverage through the corporate management team and health and wellbeing board to ensure that commissioning specifications for employment, skills and apprenticeships services for Birmingham City Council employees carry a health and wellbeing spiral curriculum. A spiral curriculum is an approach to education that involves regularly re-visiting the same educational topics over the course of a student's education. Each time the content is re-visited, the student gains deeper knowledge of the topic.

Base line data collection commenced 12 October 2020 having agreed the evaluation process and methodology.

As part of a workshop with employment, skills and apprenticeship providers on 15 October 2020 we gauged interest of providers and on the whole engagement was positive amongst the 15 organisations who attended. Issues were identified as part of the workshop that meant the initial approach was deemed unworkable in practice, however the project delivery has been reframed. A new draft of the operational implementation has been drafted for review by the key partners.

4.3   Next Steps / Delivery

4.3.1   Food Strategy

- To ask that the Board endorse the inclusion of the resilience theme into the Draft Food Strategy today.

- To finalise the Draft Food Strategy with agreement from partners by March 2021 Creating a Healthy Food City Forum.

- To enter full public consultation with a view to finalising and publishing the Food Strategy in September / October 2021.

4.3.2   Emergency Food Plan

- To hold a workshop as soon as possible to co-develop the plan with all stakeholders and sign-up to actions.

- To deliver on the actions at pace and ensure regular shared updates to relevant Fora and the Board on progress.

4.3.3 Birmingham Food Conversation

- Finalise the results of both the survey and Seldom Heard Voices reports and utilise these to inform the wider portfolio.

4.3.4 Food Poverty

- Complete rapid evidence reviews around the three core strategic areas and develop these into action plans for the Food Poverty Core Group over the next six months. It is envisaged this will be closely aligned with the Emergency Food Plan work.

4.3.5 International Partnerships

- Finalise Food Foundation partnership project deliverables by March 2021.

- Continue to engage with national and international partners.

- Share best practice with MUFPP partners in line with agreed governance on sign-off of sharing.

4.3.6 Sustainable Food Places Application

- Finalise partners to contribute to systems level application in February 2021.

- Submit redrafted application in early March 2021 for final comments ahead of April 2021 deadline.

4.2.7 Childhood Obesity Trailblazer Project

- Obtain final governance around implementation of developer toolkit.

- Initiate tender process for Birmingham Basket.

- Finalise the reframed delivery of Spiral Curriculum.

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5.   Compliance Issues

5.1   HWBB Forum Responsibility and Board Update

All work within the remit of the Forum will be reported to the Board as either a presentation (similar to today) or as part of the information updates detailing all Forum activity as per current governance arrangements.

Day to day responsibilities are managed:

- Internally via regular food programme huddle meetings in line with Agile project management principles (monthly updates as a minimum), and regular updates to the Cabinet Member for Health and Wellbeing through the Public Health Cabinet Member Briefing sessions (as requested).

- With partners through the Creating a Healthy Food City Forum itself, as well as multiple interfaces on shared work packages, objectives, and outcomes.

5.2   Management Responsibility

Paul Campbell, Service Lead (Wider Determinants), Public Health, Birmingham City Council
Elizabeth Griffiths, Assistant Director of Public Health, Birmingham City Council

6.   Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
To follow CMB and CHFC Forum	#	#	#
#	#	#	#
#	#	#	#

Appendices

See attached 4 Appendices.   Subject to change on final submission to the board.

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

Paul Campbell, Service Lead (Wider Determinants), Public Health, Birmingham City Council
e-mail: paul.campbell@birmingham.gov.uk

Creating a Healthy Food City Forum
Virtual Forum, Teams Meeting
Wednesday 14th January 2021
10:00 – 12:00

Agenda Item	Owner	Time
1. **Welcome, apologies and introductions**	Councillor Hamilton (Cabinet member for Adult Social Care and Health)	5 mins
2. **Partner Mini-Update Presentations**		
TBC	TBC	5 mins
TBC	TBC	5 mins
TBC	TBC	5 mins
3. **GBSLEP – Food and Drink Manufacturing**	Ellen Peacock	20 mins
4. **Food Trails**	Karolina Medwecka	20 mins
5. **Food Poverty / Emergency Food Plan**	Paul Campbell	20 mins
6. **Draft Food Strategy**	Paul Campbell	20 mins
7. **Information Items**		10 mins
International partnerships	Shaleen Meelu	
Whisk	Paul Campbell	
Community Obesity Trailblazer	Paul Campbell	
Sustainable Food Places Application	Shaleen Meelu	
Food Survey	Paul Campbell	
Fizz Free February	Paul Campbell	
8. **Review of Actions**		5 mins
a. **AOB**	All	5 mins
9. **Date/time of next meeting**		

TBC
Virtual Forum, Teams Meeting

008453/2021

Creating a Healthy Food City Strategy

Birmingham

2020-2030

Early working draft for discussion v0.2

Our Shared Ambition

We want Birmingham to be a city where every citizen can eat an affordable, healthy diet, and enjoys their food. Working with partners focused on inequality in relation to poverty we want to ensure that access to good quality food choices is as equitable as possible. We also want the food they eat to be ethically and safely produced, and environmentally sustainable (including attempting to reduce single use plastics and micro-plastics where possible).

We want Birmingham to be a city where the food economy is vibrant; reflects the diversity of our communities; and is financially successful and sustainable contributing to a circular economy for food which reduces waste, increases valuable employment opportunities for local people, minimises environmental harm and maximises the local assets of the city and West Midlands region.

Key Objectives

- Improve the access to safe, environmentally sustainable, and ethically produced, and healthy food within their budgetary constraints, across Birmingham in every community for every citizen;
- Develop a financially and environmentally sustainable food system in the city;
- Reduce the systemic structural inequalities in food access and nutritional intake across the city;
- Work in partnership with citizens, businesses, and organisations across the city to achieve our shared ambition to create a healthy food city in Birmingham.
- Improve the skills and knowledge regarding healthy, environmentally, and ethically sustainable food across the city.
- Influence the supply chain of food within the city and minimise the journey from farm gate to supermarket shelf to enable improved consumer knowledge of food sources and minimise carbon emissions in the supply chain logistics.

Context

Birmingham is a diverse, global, vibrant city with over a million citizens, however too many of our citizens face challenges accessing affordable, healthy, sustainable food.

Eating healthily underpins so much of our physical and mental health, we celebrate and commiserate with food and the food system contributes millions to the city economy.

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The food system spans growing food, transforming food, transporting it and selling it in raw, transformed and cooked forms as well as recycling and waste. This system exists in all of our lives, from growing tomatoes in window boxes to the restaurants and take-aways in our high streets.

Policy Context

National

England is undergoing the first independent review in 75 years, of its entire food system.[1] The evidence-based analysis of the current system is expected in early 2020, paving the way for a new national food strategy in Summer 2020. The National Food Strategy will set out the transformation from the food system we have now, to a system better suited to the many needs and challenges faced now and in the future.

Placeholder: Food Foundation Policy audit

Placeholder: International policy summary

Context of Food in Birmingham

There is limited data currently available on the food system in Birmingham and this is one of the key work streams for action through this strategy.

The food economy in Birmingham is estimated to be worth circa £XX and approximately XXX people in the city are employed in a trade connected to the food system, whether in hospitality, food retail or food production or logistics.

In December 2019[2] there were 98 businesses registered with the Food Standards Agency involved in food production or transformation, including processing plants for meat, fish and dairy products.

There are 114 allotment sites, with over 7000 plot holders, in the city enabling citizens to grow fruit and vegetables in the heart of the city if they don't have their own garden.

In January 2020[3] there were over 8,500 food businesses registered with the Council and on the FSA national database for food hygiene rating in Birmingham. There is significant turnover in the food system and Birmingham City Council Environmental Health inspect about XXX new businesses every year.

Food consumption

When surveyed, 54.1% of Birmingham's 15 year olds reported that they eat five portions or more of fruit and veg a day, compared to the England average of 52.4% (2014/15).
Five a day habits by adults are not measured at a local level, but we know from the Health Survey for England that nationally only 29% of adults eat the recommended five a day.

The majority of adults in England in 2017 were overweight or obese (64%) (Health Survey for England). Prevalence for Birmingham citizens is unknown.

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[1] https://www.nationalfoodstrategy.org/
[2] Food Standards Agency. Approved Food Establishments as at 1st December 2019.
[3] Food Standards Agency. West Midlands Food Hygiene Ratings

In 2017/18 the percentage of obese Birmingham children at reception and year six is above the England average and among the highest in the West Midlands. In reception 11.3% are classified as obese (9.5% England); in year six 25.6% are classified as obese (20.1% England).

In 2016/17 26.1 % of the city's 5 year olds had decayed, missing or filled teeth. Although higher than the England figure of 23.3% it was not significantly higher. This is a reduced over time for Birmingham children, with the figure being 32.5% in 2011/12.

Intelligence on salt and sugar consumption is unknown at a local level, but a YouGov sample survey tells us that Birmingham residents are concerned about certain food content. When asked if they were concerned about the following food contents: fat, sugar, salt or calories, 41% of respondents in the city said they were concerned with sugar in food.

Food waste

Analysis of waste taken to city's Tyseley Energy Recovery Facility in April 2019 identified 25.1% as food waste. This approximates to 60,600 tonnes of food waste within the total residual waste from households.

Placeholder: Food Conversation findings

Our Framework for Creating a Healthy Food City

The Framework for Action is focused on delivery through eight themed work streams, based on the international evidence base and learning from networks such as the Milan Urban Food Policy Pact. The eight themed work streams are:

1. Food Production
2. Food Transformation
3. Food Logistics/Supply Chains
4. Food Retail – Home
5. Food Retail – Out of Home
6. Recycling & Waste
7. Food beliefs & behaviours
8. Data and Evidence

Through the eight work streams there are six 'golden threads' which weave across all of the Forum frameworks for action:

Citizen First

We will put the citizen at the heart of our approach, working with citizens across the city to help co-produce a healthy, sustainable, economically viable food environment that is accessible to everyone.

Regulation & Enforcement

We want to support businesses to be financially and environmentally sustainable and make the most of the everyday contact between food regulation and enforcement authorities in the city and the

region to support businesses to work towards our shared ambition of a healthy, safe and affordable food system in Birmingham.

Diversity & Inclusion

We know that there are significantly different relationships with food in different cultures and communities across the city and as we progress this work we want to work with these communities to find solutions and approaches that work in the context of celebrating this diversity.

Scale & Pace

Birmingham is a large city with a diverse community and it is important that we keep a focus on moving at pace and scaling to reach every part of Birmingham with our work, building on success and finding ways to scale across the whole city to ensure every citizen benefits.

Learning & Listening

We know we need to listen and be humble in our approach, learning in true partnership with cities, in the UK and across the world, learning from research and practice-based evidence and from our citizens. We will be open and honest in our conversations about the challenges as well as the opportunities and successes.

Risk & Resilience

The food system is subject to potential significant challenges nationally, due to the as yet unknown long-term impacts of COVID-19 and the upcoming exit from the European Union. We need to ensure that the impact of these risks are understood and that Birmingham is prepared.

Work Streams of Action

The eight work streams of action will create a framework for delivering the vision and ambition of the strategy.

1.Food Production

Both domestic and commercial food production have a role to play in creating a healthier food city, whether growing plants in the garden or hydroponically raising fish in a warehouse. Empowering and enabling people to grow their own through increased focus on potentially under-utilised allotment resources, becoming more self-sufficient in their food needs, while acknowledging this is a micro-level intervention. We would encourage retail at smaller, specialised outlets (including farmers markets) rather than supermarkets to support this at a commercial level.

2.Food Transformation

Just 12 crops and five animal species provide 75 per cent of the world's energy intake[4]. To increase resilience in the local food system by promoting new plant based, nutrient-rich alternatives to businesses, which will reduce reliance on traditional food growing and production.

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[4] https://www.unenvironment.org/news-and-stories/story/towards-great-food-transformation

Placeholder - Shaleen can provide info on healthier businesses / recipes.

3.Food Logistics/Supply Chains

Movement of food throughout local supply chains, both retail and catering, and working towards being an exemplar to influence regional, national, perhaps even global attitudes towards supply chain management. We need to better understand the issues in this area and the profit implications for retailers and businesses. Consider local employment opportunities within the supply chain and the associated economic benefits.

Placeholder – partners to consider which businesses they may be able to engage with and influence.

4.Food Retail – Home

Understanding what drives our choices about what we buy to consume at home is important; accessibility, availability, convenience, time, knowledge and mood are some of the things that impact upon these choices. We also need to consider the impact of financial inequality, and how this drives food behaviours and choices.

Placeholder – partners to consider which businesses they may be able to engage with and influence.

Placeholder – BU / LIDL pilots on promoting veg?

5.Food Retail – Out of Home

Birmingham has a wide-ranging food retail offer; our ambition is to have an affordable, safe, healthy sustainable food offering across the city, both in commercial and social settings. We also need to consider the provision of meals in non-retail settings (e.g. – schools). We also need to consider the impact of financial inequality, and how this drives food behaviours and choices.

Placeholder – Chamber of Commerce insight into policy implications for businesses.

Placeholder – flexibility of licences etc. for healthier food businesses. Or restrictions on promotions as part of standard licencing conditions.

6.Recycling & Waste

How we dispose of our waste needs to be considered; minimising packaging and food waste, maximising recycling and reuse will help create a sustainable food system. Ensure that businesses are committed to reducing food waste at source. Need to ensure dignity of those accessing food systems while subject to financial inequality. We need to engage with Birmingham City Council recycling and waste disposal to promote better behaviours within the home towards recycling food and food packaging.

Placeholder – engage with system modellers for financial return – e.g. circular economy.

7.Food beliefs & behaviours

Understanding citizens food beliefs and behaviours is integral to changing the food environment in the city. This is reflected in the 'golden threads'. We would also look to improve knowledge and skills around healthy, ethically sourced, environmentally friendly foods, and how food waste can be reduced or recycled as part of this work stream.

The Birmingham Food Conversation, launched in October 2019, provides an avenue for citizens to talk about their food experiences and habits, their needs and thoughts. We would look to expand this work into focusing on shared beliefs across different communities in Birmingham and how we could use these to drive healthier behaviours.

Investigate the cause and effect relationship between food provision and food purchase to better understand the root cause driver(s).

Placeholder – offers of understanding formation and stability of preferences / behviours.

Placeholder – HealthWatch engagement and data collection.

8.Data and Evidence

Data on the food system is Birmingham, and also nationally is limited. Work streams such as the Birmingham Basket, through the Childhood Obesity Trailblazer and the Birmingham Food Conversation aim to provide more insight.

Placeholder – identifying gaps in evidence

Place holder - emerging local evidence

Place holder - learning from international partnerships

Place holder – Food Foundation introduction to PEAT

Measuring Success

Place holder - evaluation metrics TBC once work stream finalised

Governance

The Creating A Healthy Food City Strategy will be overseen by the Health and Wellbeing Board, as a statutory committee of Cabinet.

The Framework will be delivered through the Creating a Healthy Food City Forum, which reports to the Health and Wellbeing Board, under the leadership of the Cabinet Member for Adult Health and Social Care.

Draft Action Plan

	Initial Actions	Lead	Partners	Timescale	Notes
Priority 1: Communications on how to eat healthily under current restrictions					
1a	YouTube Food Videos — Creation of a suite of YouTube videos by local chefs to provide a variety of practical examples of recipes to meet diversified food needs, cultural preferences, and budgets.	Birmingham City Council Public Health	Local Chefs	First tranche of videos has gone live.	Depending on the engagement potential to create more content on specific themes.
1b	BHealthy — As part of the COVID response a simple checklist with practical tools and tips to help improve your health and wellbeing and reduce risk of becoming seriously ill from Covid-19 was produced. These resources including healthy eating and can be reused as part of ongoing citizen engagement.	Birmingham City Council Public Health	Various	TBC	The resources are available and have been heavily promoted already. Consideration needs to be given to a future comms plan through alternative routes.
1c	Whisk project — The overall aim of this pilot is to understand if giving businesses access to a platform that can simply express the "healthiness" of their food offer make them more aware of their food offer and does this change their behaviour? This pilot will enable a small collection of businesses to: • Evaluate their food offer - providing a healthy menu score. • Help customers make informed choice about the food they are eating and the establishments they purchase from, focussing on the potential impact on their health. • Focus on switching to healthier ingredients and cooking practices.	Birmingham City Council Public Health	Whisk (Samsung), others TBC by March 2021	Pilot Phase: January – December 2021 (TBC) Expansion / Roll-out phase: TBD following quarterly evaluations commencing June / July 2021.	This will help BCC to understand: • If this increases the healthy options provided. • If the businesses will restructure their menus to achieve healthier scores

	Initial Actions	Lead	Partners	Timescale	Notes
Priority 2: Food system resilience					
2a	Community Growing — The potential health and social benefits of gardening and community food growing warrant the attention of health professionals and policy makers. Whilst local authorities and planning departments are well placed to enable people to participate in horticultural activities in their community.	The Active Wellbeing Society	Birmingham City Council Adults Social Care, Birmingham City Council Neighbourhoods, Birmingham City Council Parks.	Initial activity has focused on feasibility. During January 2021 the group will focus on potential bids funding streams,	

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		Jointly this group is working towards freeing up parcels of land held by Birmingham City Council and others that can be repurposed as community growing spaces.			and then operational implementation.	
2b	Lead Food Poverty Core Group	In November 2020 Birmingham City Council re-established the Food Poverty Core Group to better understand the systems level responses we can put in place across the local systems in Birmingham to ensure a robust and coordinated response to the various issues around food poverty. The three themes we need to focus on; 1) prevention of people going into food poverty 2) crisis management – how do we get them out of it 3) recovery – moving forward, long term impact. A rapid evidence review will be completed on each theme for action / discussion by the group.	Birmingham City Council Public Health	The Active Wellbeing Society, Birmingham City Council Adults Social Care, Birmingham City Council Neighbourhoods, Birmingham Children's Partnership.		
2c	Engagement with Food Justice Network	The Food Justice Network is a partnership to co-ordinate the work on food justice within Birmingham across multiple partners and sectors. It has a number of sub-groups focused on direct, practical action including: • Street feeding • Community Cafes and Cooked Food • Growing • Barriers and Opportunities • Funding • Campaigning • Emergency Food Distribution	The Active Wellbeing Society	Multiple	Monthly meetings by sub-groups and core groups at varying frequencies.	While Birmingham City Council Public Health is not able to attend all meetings, it is sighted on most minutes.

	Initial Actions		**Lead**	**Partners**	**Timescale**	**Notes**
Priority 3: Food transport systems						
3a	Food Systems Vulnerabilities Mapping	WMCA led project on the commissioning of a piece of research to understand the vulnerabilities of the West Midlands food system and potential challenges to food security in relation to the end of the transition period, the impact of COVID, and the future impact of climate change.	WMCA	WMCA, Birmingham City Council, Solihull MBC, Health education partners (TBC), LEPs (TBC)	This project will seek to complete tender process by February 2020.	Whilst this comes after the official departure date in the event of a no deal (Jan 1st) there are still several benefits to the research: - Food stocks and interim arrangements will likely mean the full impact to the food system will not be felt until after the end of the

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						transition - The researchers can examine our food system in 'real time' as it responds to the immediate pressures of EU exit - Even If recommendations are not able to be adopted in time, they will prepare us for future shocks (in terms of further pandemics or the impact of climate change and a growing global population).
3b	Buffer Contingency Stocks	Birmingham Food Council has produced a model to address buffer contingency stock systems, that would enable the UK to be better prepared for future food system shocks.	Birmingham Food Council	TBC	Meeting between BCC and BFC (date TBC)	
3c	Food and Drink Manufacturing Recovery Plan	Birmingham City Council Public Health has been sighted on an early version of the plan, which includes objectives to: • Support food and drink manufacturing businesses to adapt their organisation for survival now and their business models to thrive and be sustainable long-term. • Assess and overcome food and drink manufacturing skills gaps both now and in the future.	GBSLEP	TBC	Presentation to Creating a Healthy Food City in January 2021 and then TBC.	

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Creating a Healthy Food City

Birmingham Food Survey Report

394 Responses Collected

Collected pre-Covid-19, measures baseline position

Lydia Carter

Public Health Officer

Lydia.Carter@birmingham.gov.uk

Making a positive difference everyday to people's lives

Birmingham City Council

008453/2021

Birmingham Food Survey Results

The survey finished on the 16th April 2020

394 SURVEYS COMPLETED
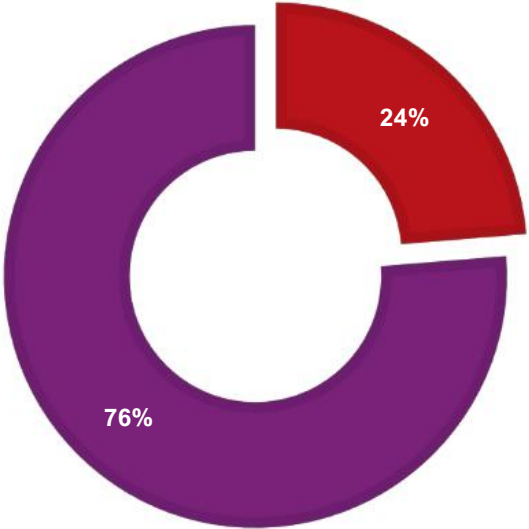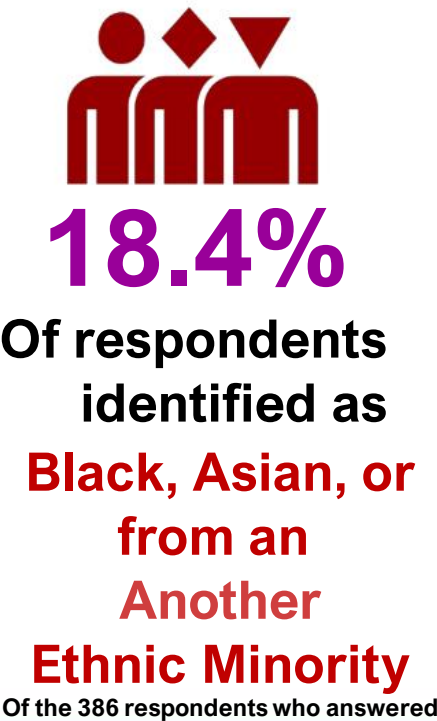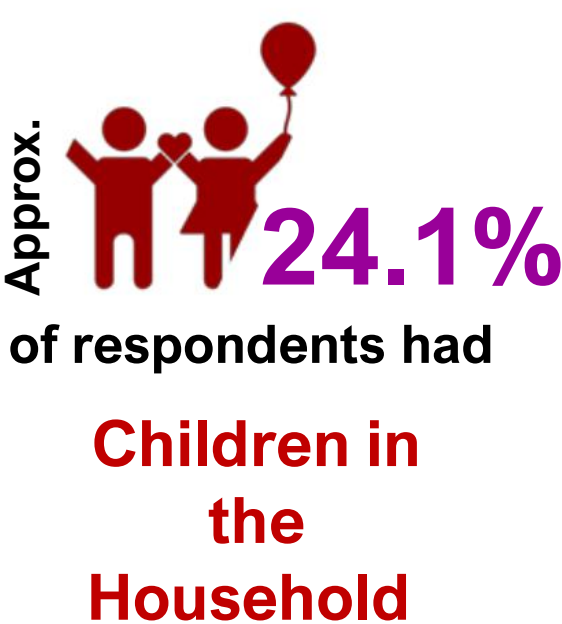
Gender

Of the 367 respondents who answered

■ Male ■ Female

24%

76%

Approx. **24.1%** of respondents had **Children in the Household**

18.4% Of respondents identified as **Black, Asian, or from an Another Ethnic Minority**

Of the 386 respondents who answered
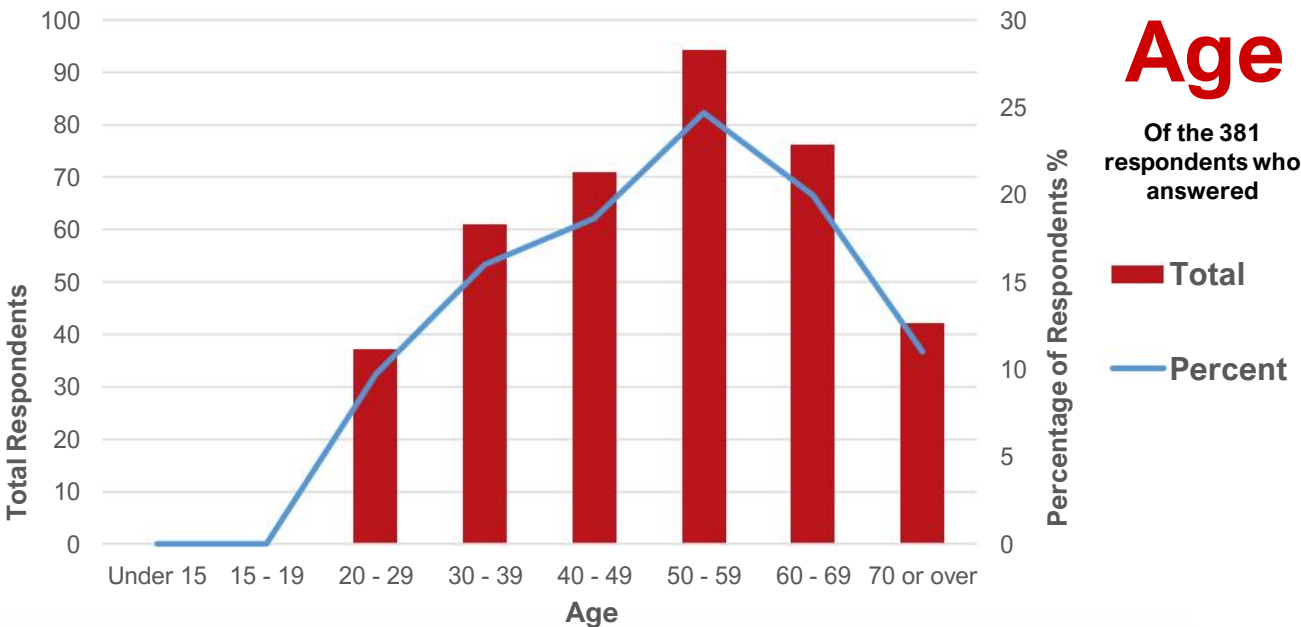
Age

Of the 381 respondents who answered

■ Total
— Percent

Total Respondents

Percentage of Respondents %

Age: Under 15, 15 - 19, 20 - 29, 30 - 39, 40 - 49, 50 - 59, 60 - 69, 70 or over

Making a positive difference everyday to people's lives

PAGE 2

Birmingham City Council

Section 1: Your Food Experiences

Birmingham citizens share their best and worst food experiences to help us understand the experiences that are influencing their food choices.

Question: Tell us about your most memorable food experience.

Qualitative Feedback - Key codes identified
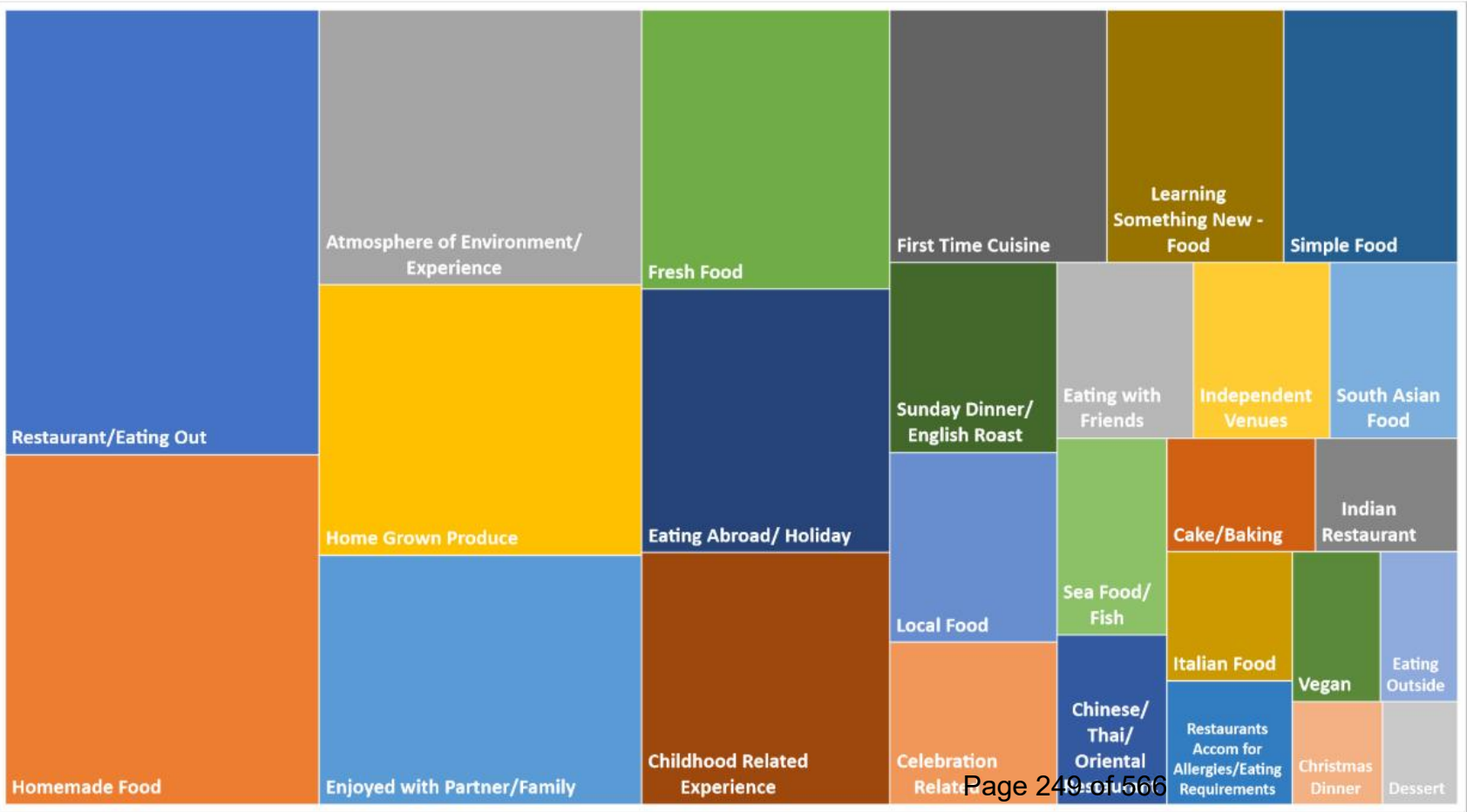
362

Of respondents chose to provide a comment

Section 1: Your Food Experiences

Birmingham citizens share their best and worst food experiences to help us understand the experiences that are influencing their food choices.

Question: Tell us about your most memorable food experience.

Qualitative Feedback - Key themes identified

Eating Out

'I've had 2 fantastic food experiences in the past year that have really shaped how I view food. I had a tasting menu at Harbourne Kitchen and another at Little Blackwood in Moseley and I view those 2 experiences as some of the top highlights of my year - the different flavours that I wouldn't normally cook myself and the way they paired the food with the various drinks was especially memorable..."

Self-Sufficient and Homely Food Experiences

"Coming from a Caribbean background food has always been important. Watching my mother as a young child create delicious healthy meals daily on a low budget. Utilising ingredients grown in our own garden ..."

Food & Experience

"Sometimes the enjoyment comes from new experiences, sometimes from revisiting familiar dishes or familiar places"

"Eating a delicious seafood couscous on a balmy summer evening outside a small backstreet restaurant in Trapani, Sicily"

Food & Company

'Cooking my favourite Sunday roast for my family and seeing my little girl who was 6 months old at the time, eat food for the first time. It was lovely to be able to eat as a family and share my love of food and cooking with her"

'My most memorable food experiences are times when I enjoy home cooked food with family or friends. They are social and culinary experiences and don't have to be exotic- simple food is just as good'

Section 1: Your Food Experiences

Birmingham citizens share their best and worst food experiences to help us understand the experiences that are influencing their food choices.

Question: What was your least favourite food experience?

Qualitative Feedback - Key codes identified

Takeaway/Fast food

Poor quality food

Unwell

Childhood memories

Restaurant

Specific ingredients

Eating out

School dinners

Poorly cooked/prepared

Abroad

Forced to eat

Greasy food

Macdonalds

Vegan/Vegetarian

Burger

Vegetables/Fruit

Poor service

Chicken

Cold food

Sea food

Overpriced

Offal products

Curry

Pub/Bar

Chipshop
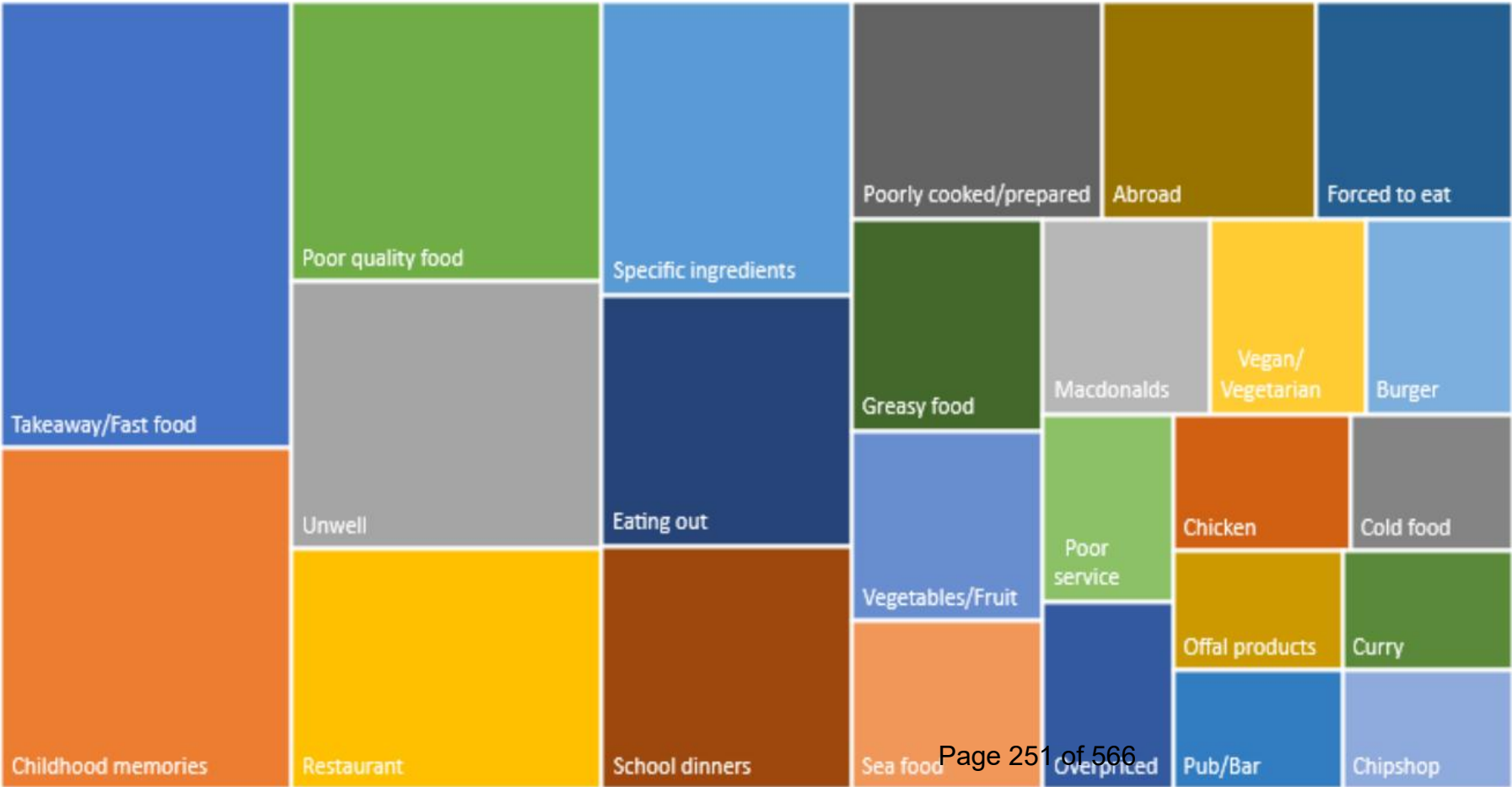
357

Of respondents chose to provide a comment

Section 1: Your Food Experiences

Birmingham citizens share their best and worst food experiences to help us understand the experiences that are influencing their food choices.

Question: What was your least favourite food experience?

Qualitative Feedback – Key themes identified

Takeaways and Fast food

"Greasy, stodgy takeaways, my first ever McDonald's, a donna kebab"

"Being served raw chicken on a meal at a restaurant, it has made me very hesitant about eating chicken when out now"

Poor food

"In hospital I have been served 3 coloured splodge - a mound of splodge in brown, cream and grey, supposed to be mince, mash and vegetables but smelling so foul it was left untouched…"

"Poor quality, tasteless food such as fast or mass-produced food."

Memories

"Did not like school lumpy mash yucky I use to vomit when I was forced to eat it at school."

"Having to clear my plate of food I hated"

Being unwell

"Food poisoning after eating in a restaurant."

Eating out

Asda Café. Ordered 2 mega breakfasts at over £6 each. Was appalling. Dry rubbery meat, cold small portions. Egg was rock hard. Beans dry and cold. How the manager could serve that to customers is beyond me.

"I got food poisoning after eating at KFC as a child and I haven't been able to go back to a KFC since - even the thought of it makes me feel nauseous"

Section 2: Healthy Food City

Birmingham citizens tell us which food related policies they believe we should prioritise on our journey to make Birmingham a Healthy Food City.

Knowledge & Skills

Increase food hygiene skills and knowledge
11%

Run city wide marketing campaigns to promote healthy food
17%

Adult education programmes
15%

Cookery classes for adults
19%

Cookery classes for children
38%

Of the 390 respondents who answered
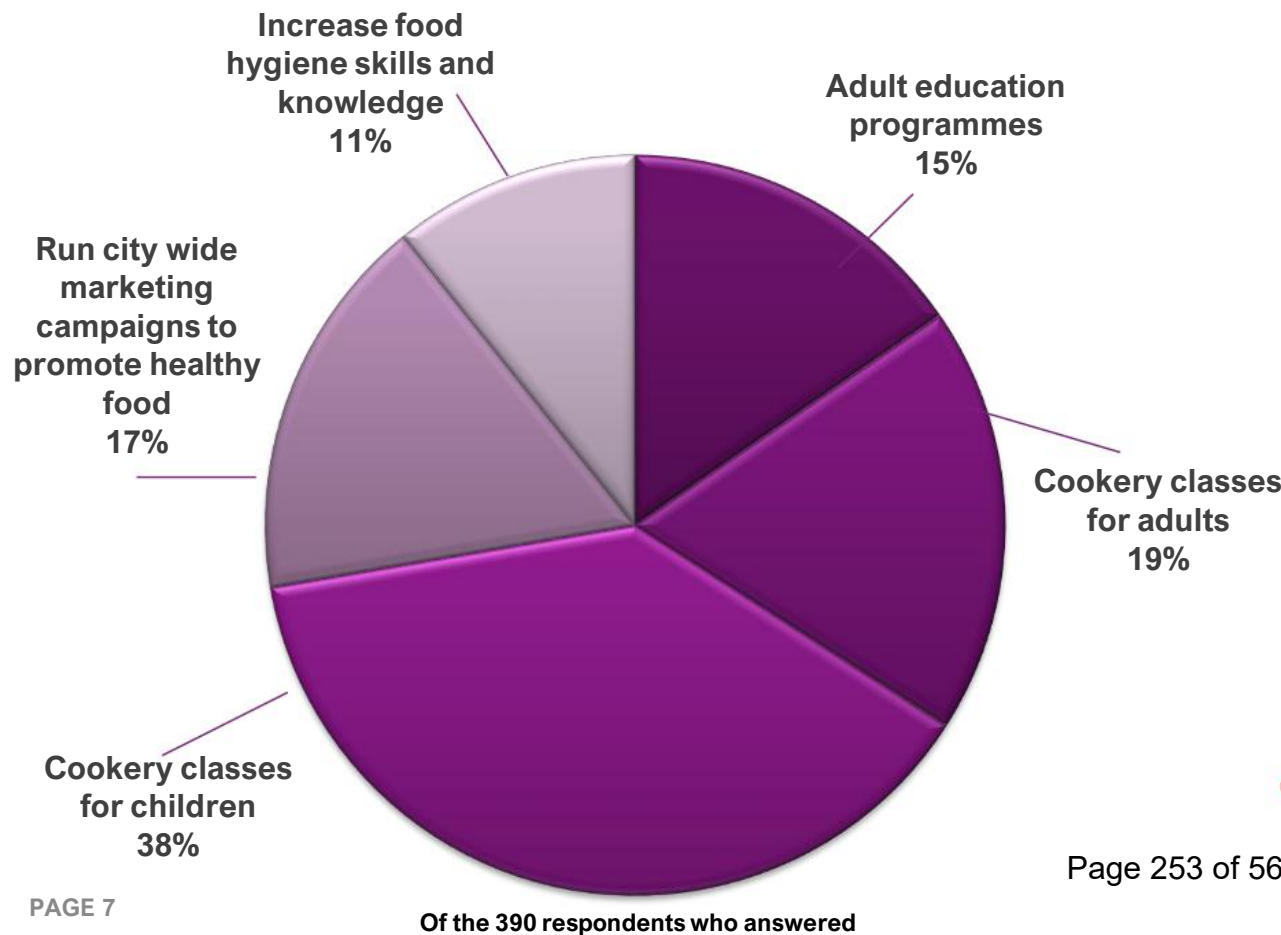
Access & Availability

With no more than 28.7% favouring other measures suggested

40.1% **Make fruit and vegetables more affordable and accessible**

31.3% **Increase the availability and affordability of locally grown food**

Of the 387 respondents who answered

Birmingham City Council

Section 2: Healthy Food City

Birmingham citizens tell us which food related policies they believe we should prioritise on our journey to make Birmingham a Healthy Food City.

Licensing & Regulation

Of the 390 respondents who answered

Percentage of Respondents %

- **28%** Restrict advertising of unhealthy food
- **26%** Only provide healthy food in public sector organisation spaces e.g. hospitals, leisure centres
- **22%** Require public sector funded business to offer healthy food to public and staff
- **13%** Restrict unhealthy street food vending
- **12%** Restrict unhealthy vending machines in public spaces
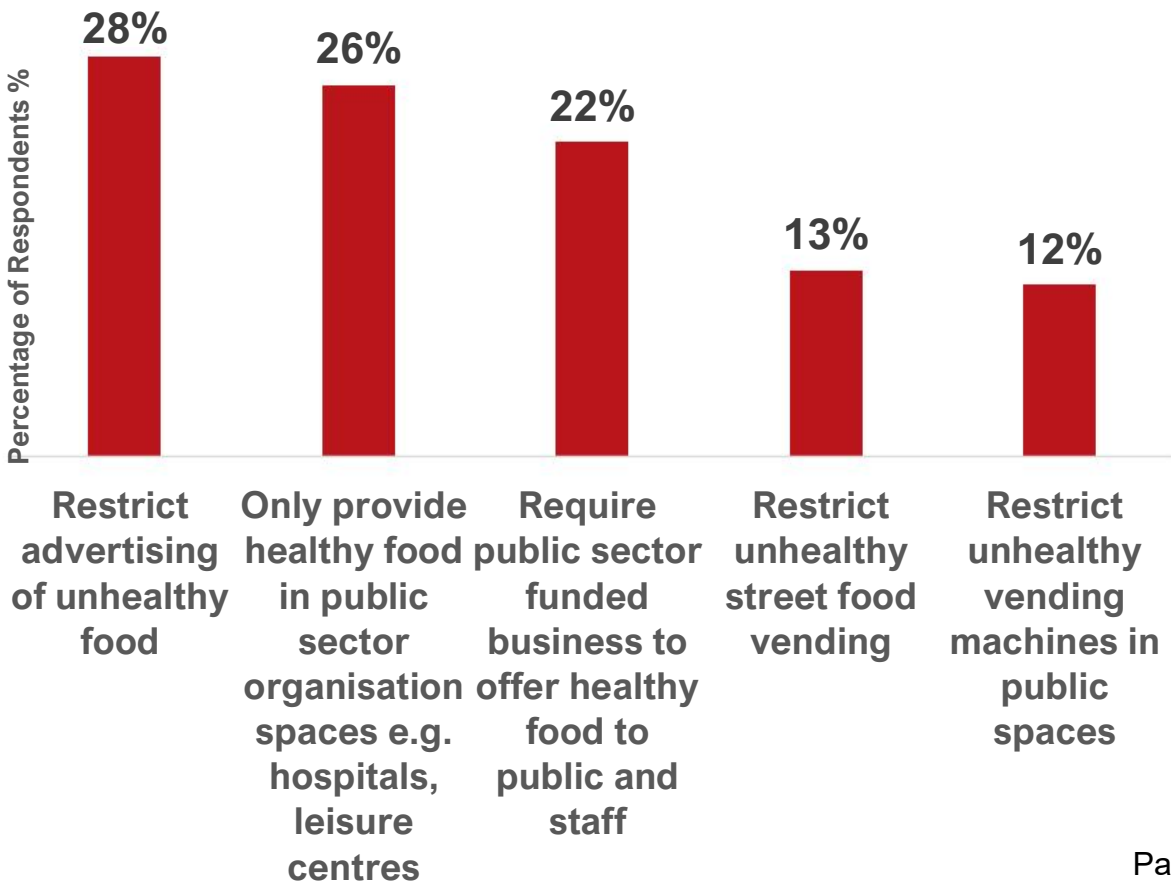
Restaurants & Take-Away Policy

Of the 390 respondents who answered

- Licensing regulation to require minimum % healthier food offer
- Require food hygiene rating public display as part of licence
- Require food nutrition labelling of food as part of licence
- Require calorie labelling on menus
- Prevent school time discounting
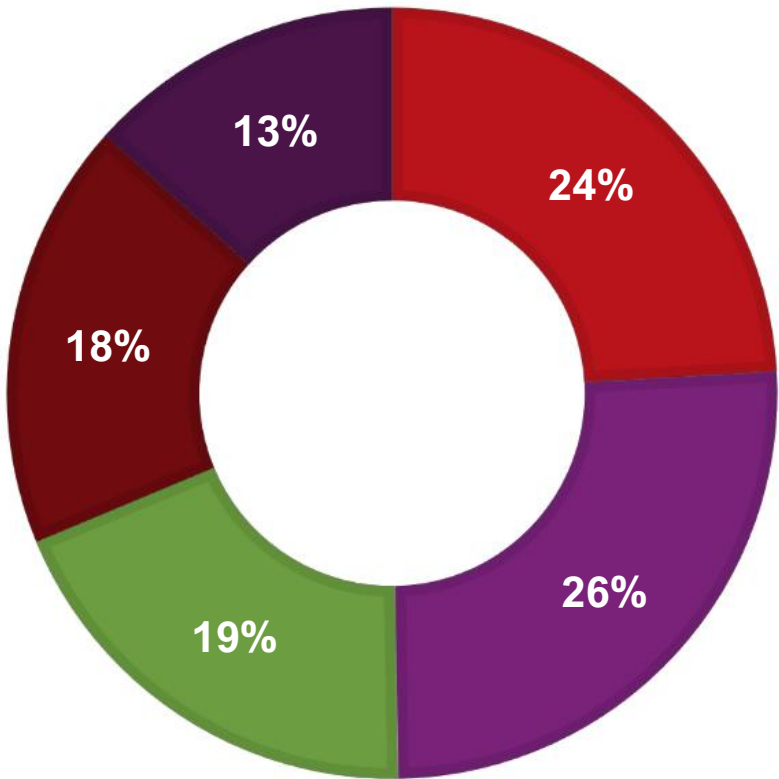
24% — 26% — 19% — 18% — 13%

PAG

Public Response to Healthy Eating Licensing and Regulation

Section 2: Healthy Food City

Birmingham citizens tell us which food related policies they believe we should prioritise on our journey to make Birmingham a Healthy Food City.

Question - Do you think there are any other specific policy options we should be considering as a council?

Qualitative Feedback - Key codes identified

277

Of respondents chose to provide a comment

Section 2: Healthy Food City

Birmingham citizens tell us which food related policies they believe we should prioritise on our journey to make Birmingham a Healthy Food City.

Question - Do you think there are any other specific policy options we should be considering as a council?

Qualitative Feedback - Key themes identified

Reducing Food Swamps

"The food environment in which we live dictates how we eat. In our area there are several fast food outlets (Chinese, pizza, fish & chips, fried chicken). It makes it easy for people to access and eat this food because it is there on the doorstep. Surely some sort of licensing or planning laws can be enacted in order to restrict the number of outlets in a given location or ward."

"Too many take away shops restaurants opened near schools to target school children"

Affordable Healthy Food

"In Stirchley you can get good veg on one end of the high street but on the other end the only option is the co-op which is expensive and unreliable…When the alternatives are cheap frozen pizzas from the local convenience shop, you can see why people make less healthy choices."

"Increase the amount of fresh, healthy food available locally"

Environmental Impact

"Promote sustainable and environmentally-friendly food choices: educating people on what food is seasonal, on how to reduce food waste, on how to grow your own, how to eat less meat and more vegetables etc. Health and environment go hand-in-hand…"

Enhance Education

"Schools could offer cookery days for both pupils and parents, cooking as a family but make if enjoyable. Introduce some healthy tips like eating more vegetables"

"Teaching young adults to plan, budget and cook for themselves and in a healthy way."

"Making sure allotments are readily available across the city. They encourage people to grow healthy food, reduce food miles…"

Section 3: The Last Meal You Ate

Birmingham citizens tell us about the last meal they had eaten so we can understand the different types of meals consumed in Birmingham.

What was your last meal?
What time did you eat that meal?

% Response At This Meal	Meal	Most Common Time For Meal
16.8%	Breakfast	06:00-8:00
30.0%	Lunch	12:00-14:00
17.8%	Dinner	18:00-20:00

69.5% Stated their last meal had been 'Eaten At Home'

30.8% Stated their last meal was 'Eaten Outside The Home'

Of the 394 respondents who answered

Of the 383 respondents who answered

Section 3: The Last Meal You Ate

Birmingham citizens tell us about the last meal they had eaten so we can understand the different types of meals consumed in Birmingham.

What kind of meal did you eat outside the home?

- Restaurant
- Independent fast food retailer
- Large chain fast food retailer (e.g. KFC, McDonalds, etc.)
- Workplace canteen
- Supermarket
- Corner shop
- Street vendor/food truck
- Place of worship
- Other

11%

4%

2%

54%

14%

11%

1%

1%

2%
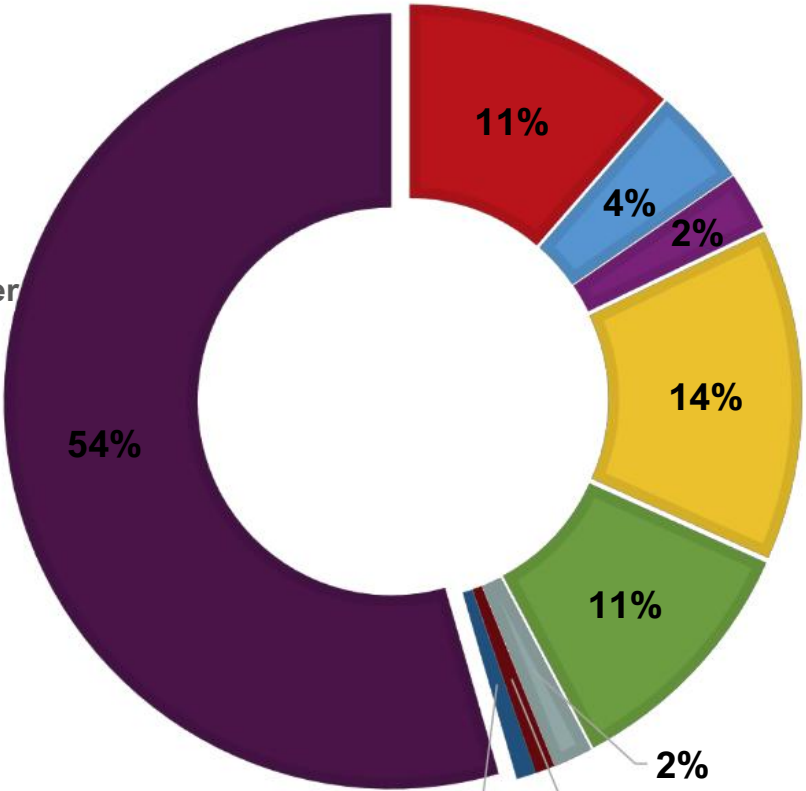
Of the 123 respondents who answered

How satisfied were you with your 'Outside the home' meal?

Of the 177 respondents who answered

Happy 94%

Unhappy 6%

Was your 'Outside the home' meal value for money?

Of the 74 respondents who answered

Good Value 42%

Poor Value 11%

Section 4: Fluid Intake

Birmingham citizens tell us about their fluid intake, their healthy and unhealthy drinking behaviours.

How many glasses of water did you drink in the last 24hrs?
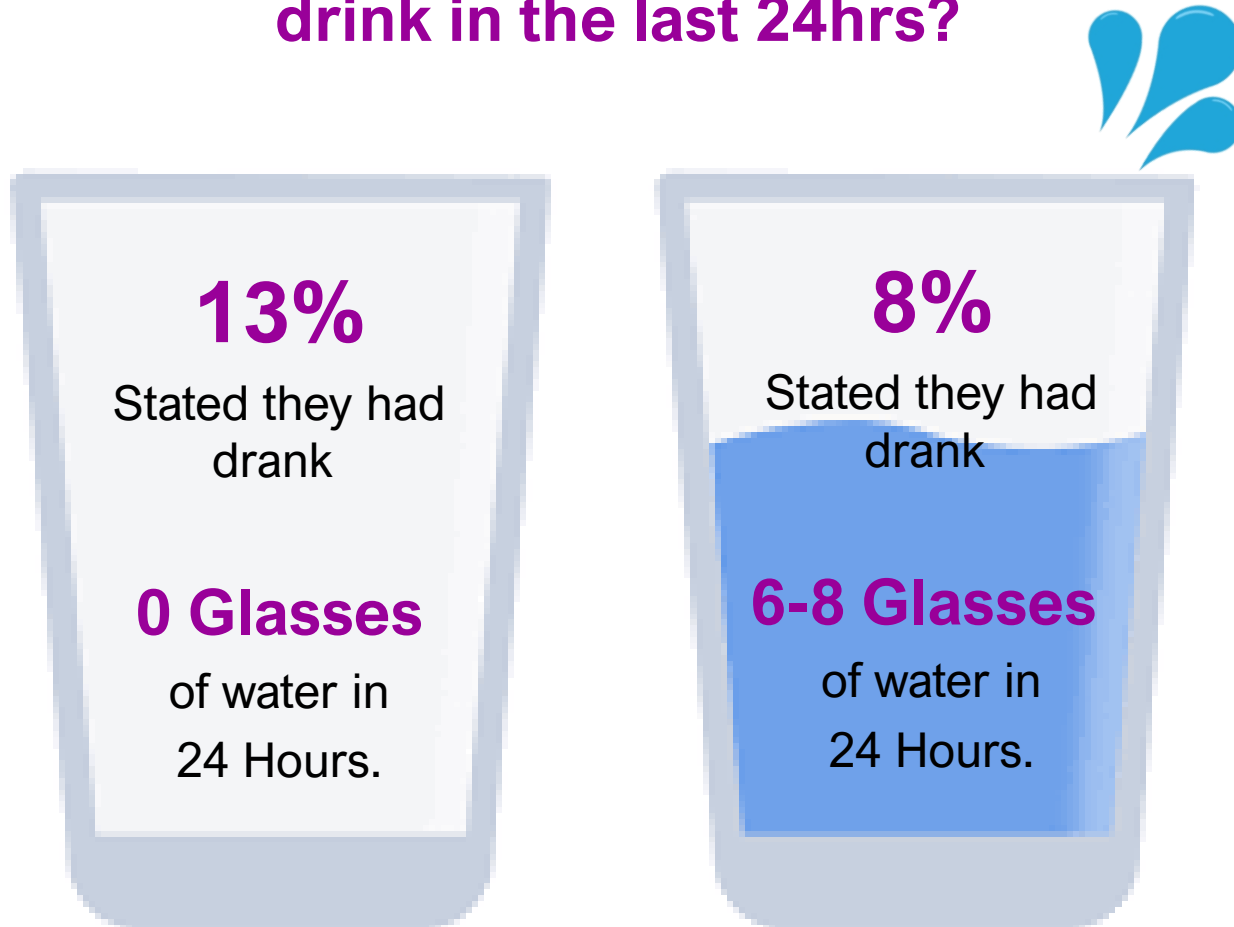
The most popular drinks consumed in the last 24 hours

13%

Stated they had drank

0 Glasses

of water in 24 Hours.

8%

Stated they had drank

6-8 Glasses

of water in 24 Hours.

Tea
69%

Coffee
62%

Wine or Fruit juice
19%

Of the 391 respondents who answered
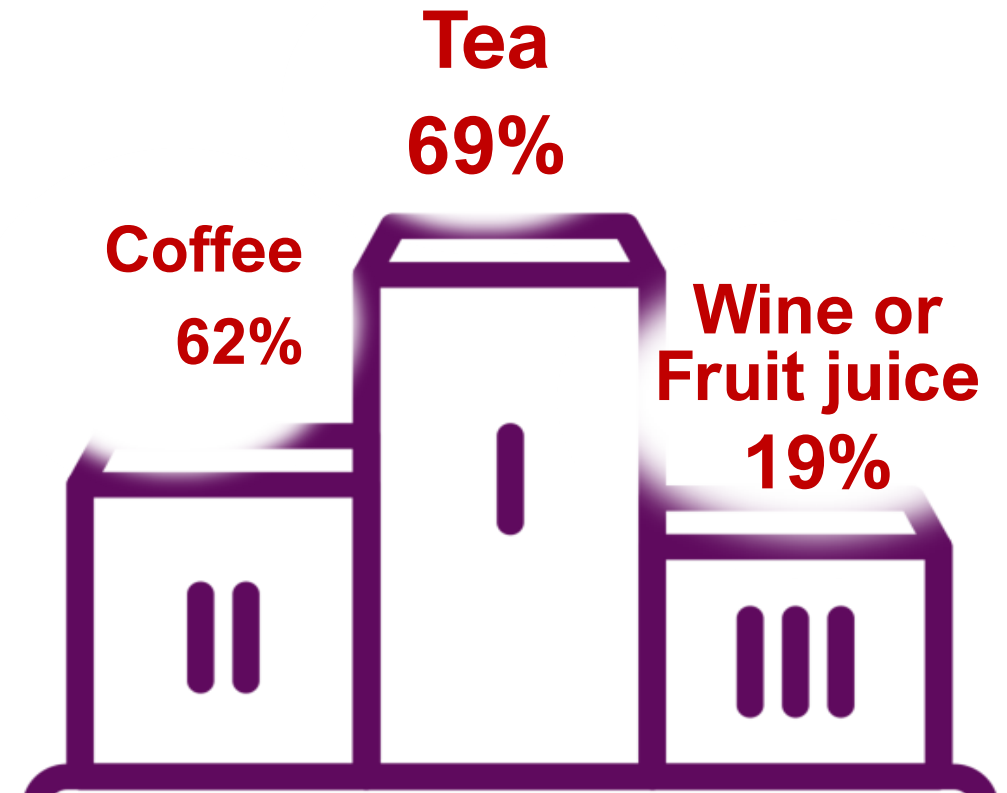
Of the 384 respondents who answered

How often do you have a fizzy (non-alcoholic) drink?
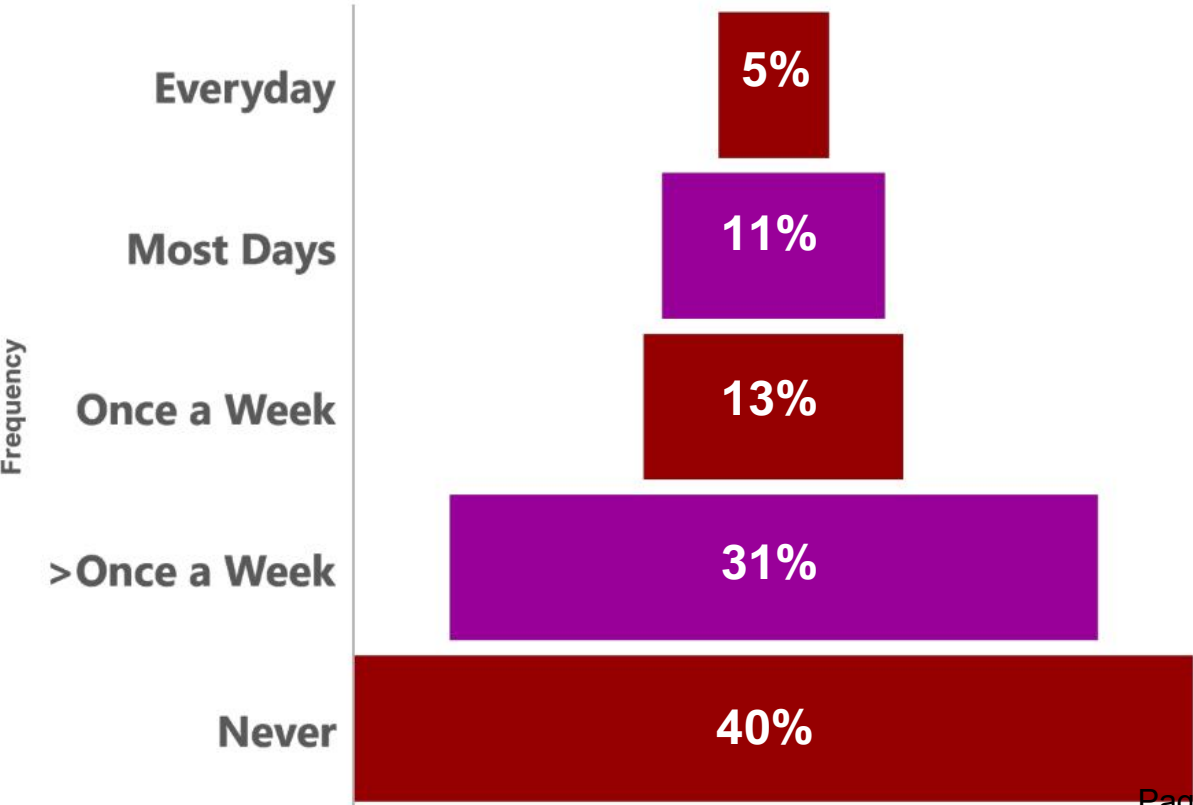
If 'everyday' or 'most days', how many fizzy drink servings do you usually consume?

Everyday — 5%
Most Days — 11%
Once a Week — 13%
>Once a Week — 31%
Never — 40%

Frequency

Legend:
- 1 to 2 Drinks
- 3 to 4 Drinks
- 5 to 6 Drinks
- 7 to 9 Drinks
- 10 or more Drinks

1%
1%
8%
4%
86%

Page 260 of 566

Of the 392 respondents who answered
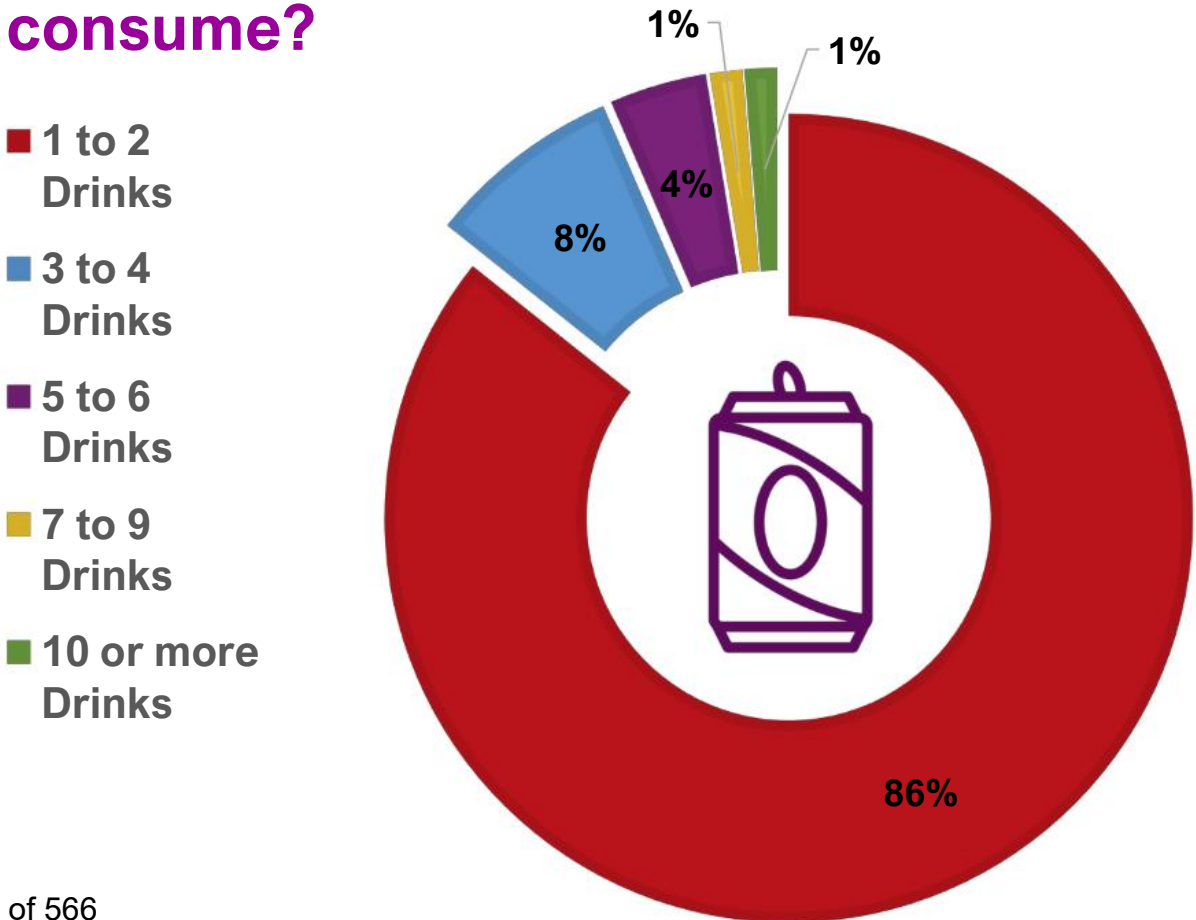
Of the 77 respondents who answered

Section 4: Fluid Intake

Birmingham citizens tell us about their fluid intake, their healthy and unhealthy drinking behaviours.

How often do you have a drink containing alcohol?

Of the 390 respondents who answered

Never — 17%
>Once a Week — 30%
Once a Week — 31%
Most Days — 19%
Everyday — 2%

Frequency (y-axis)
Percentage of Respondents % (x-axis): 0% 10% 20% 30% 40%
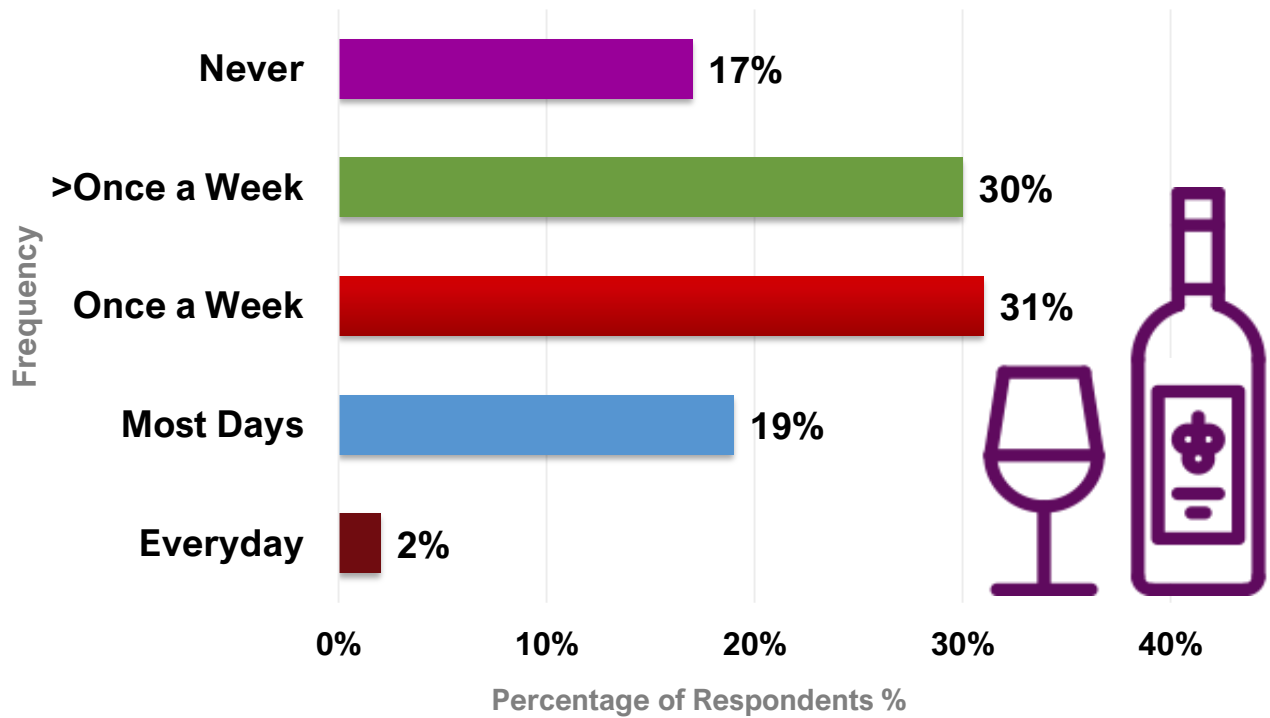
How many alcoholic drinks a day do you have?

Of the 327 respondents who answered
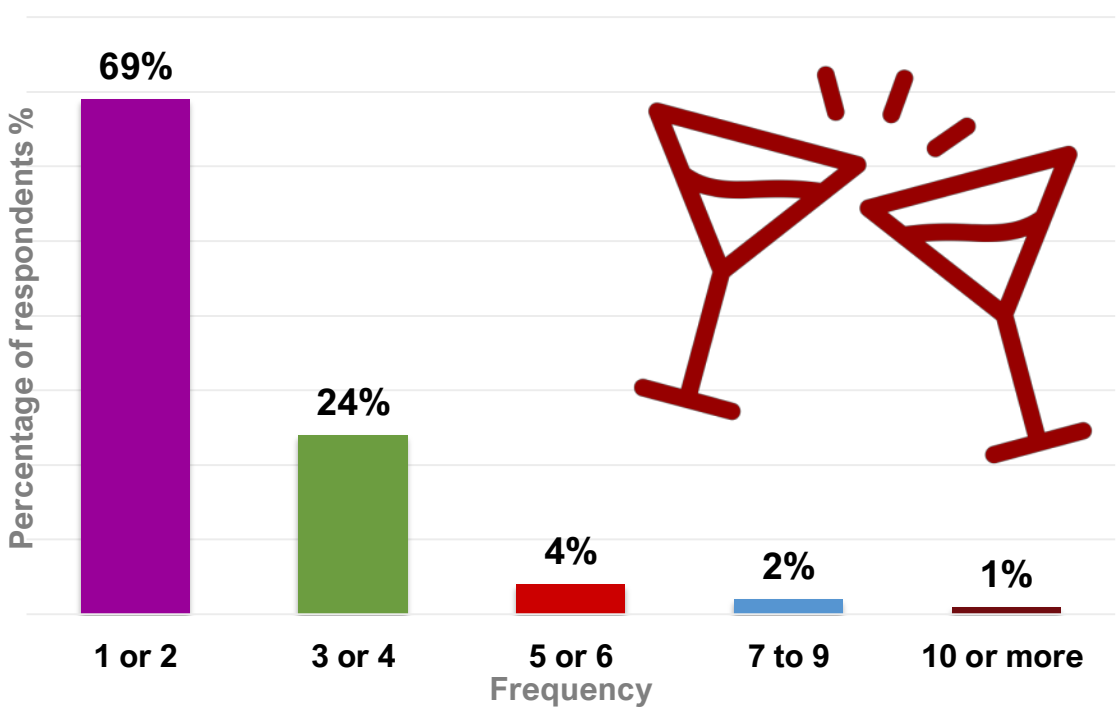
1 or 2 — 69%
3 or 4 — 24%
5 or 6 — 4%
7 to 9 — 2%
10 or more — 1%

Percentage of respondents % (y-axis)
Frequency (x-axis)

Section 5: Diet & Cooking Behaviours

Birmingham citizens tell us about their diet and cooking behaviours at home.

How would you describe your diet?

- Healthy: 47.70%
- Average: 48.50%
- Unhealthy: 3.80%

Type of Diet

Percentage of respondents %
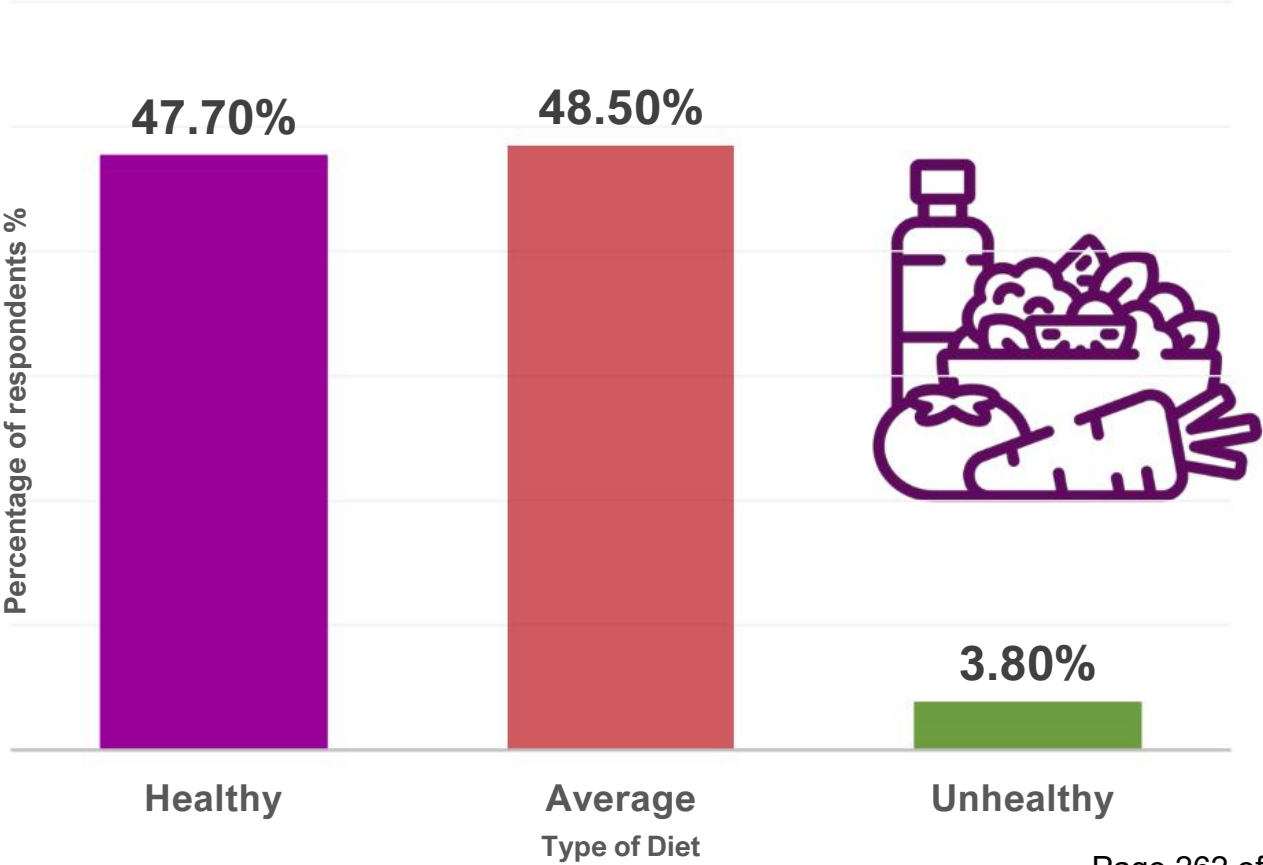
Of the 394 respondents who answered

The Eatwell Guide? Have you seen this guide?
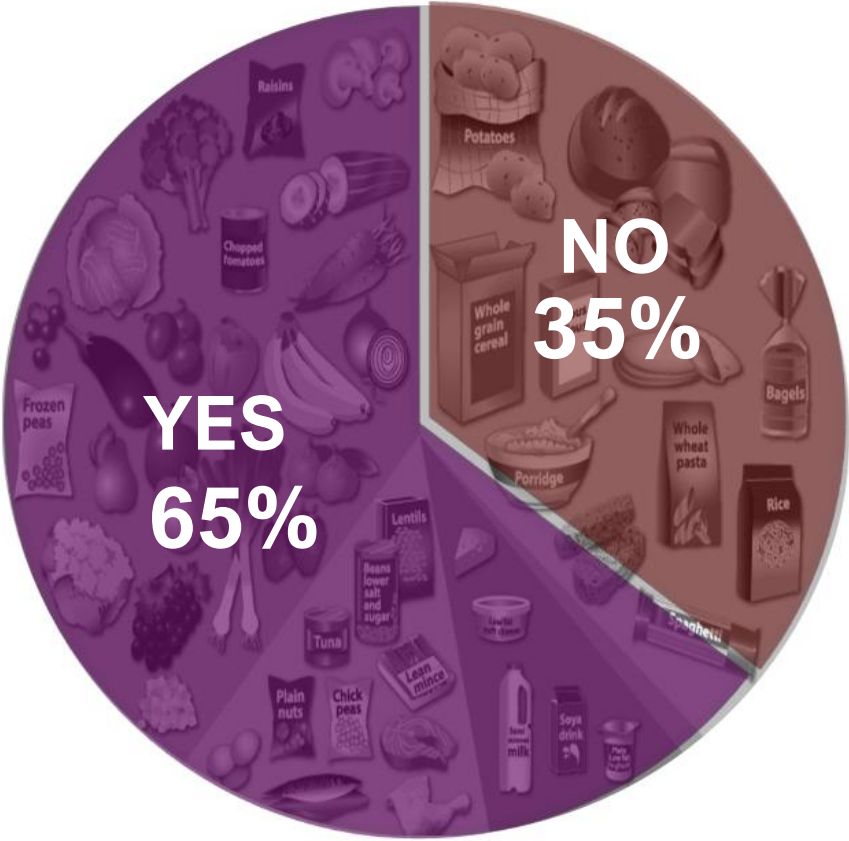
YES 65%

NO 35%

Of the 393 respondents who answered

Section 5: Diet & Cooking Behaviours
Birmingham citizens tell us about their diet and cooking behaviours at home.

Have you been taught to cook?

NO 19%

YES 81%
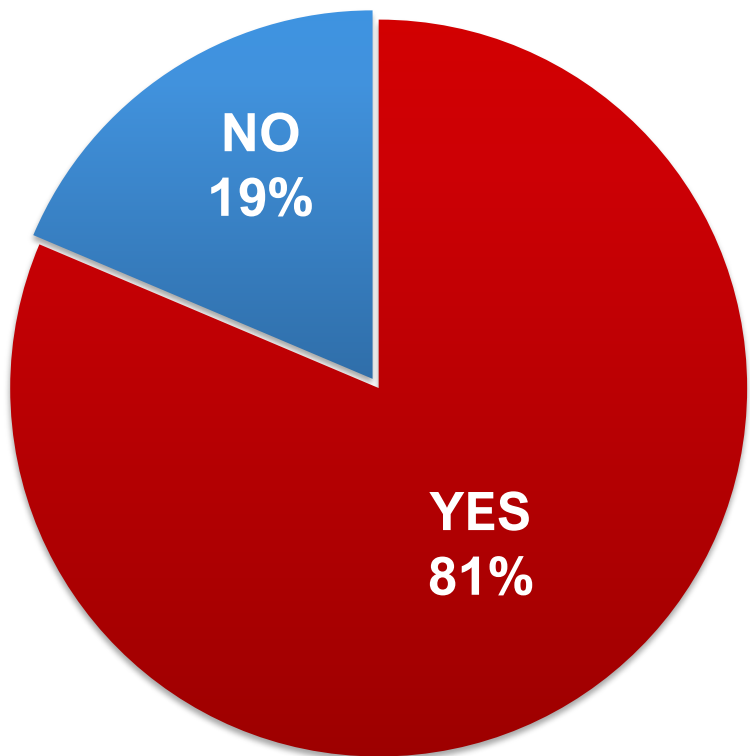
Of the 392 respondents who answered

Who taught you to cook?

Category	Percentage
Adult cooking classes/further education	9%
YouTube /Social Media	20%
School	59%
Parents	78%
Self taught	82%
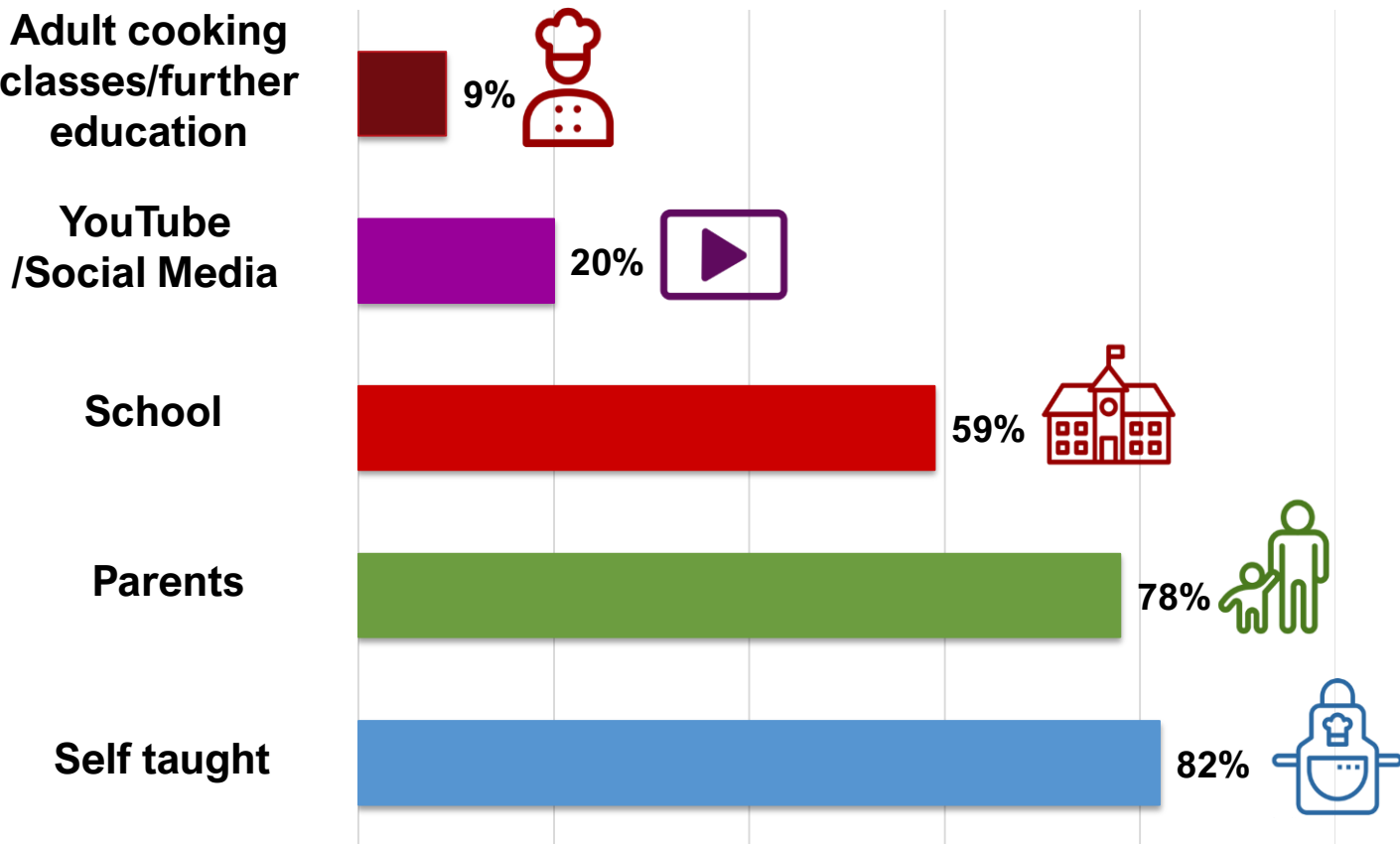
Percentage of Respondents %

Of the 358 respondents who answered

Section 5: Diet & Cooking Behaviours

Birmingham citizens tell us about their diet and cooking behaviours at home.

What's the biggest influence on your food choices?

Nutritious 61.0%

Availability 56.7%

Price 56.4%

Ease/speed of preparation 55.6%

56.4% Habit/usual purchases
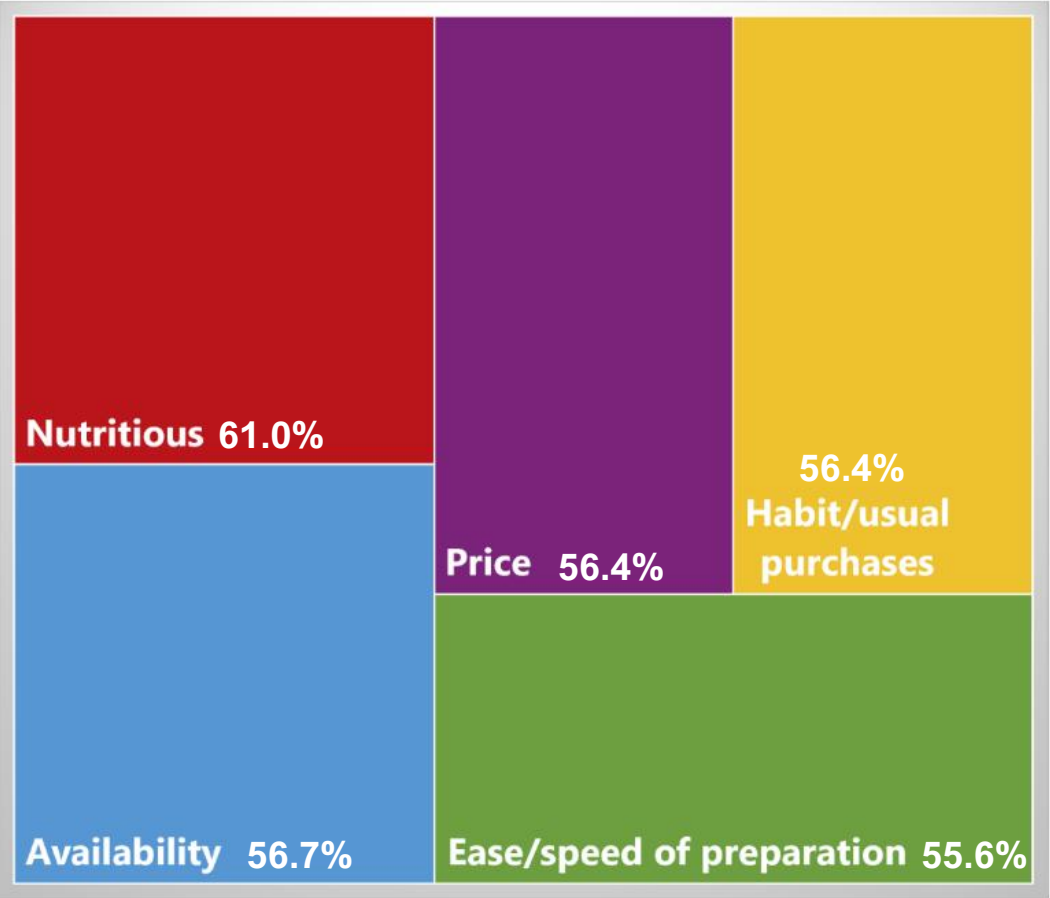
Of the 390 respondents who answered

Which of the following types of food do you eat more than once a week?
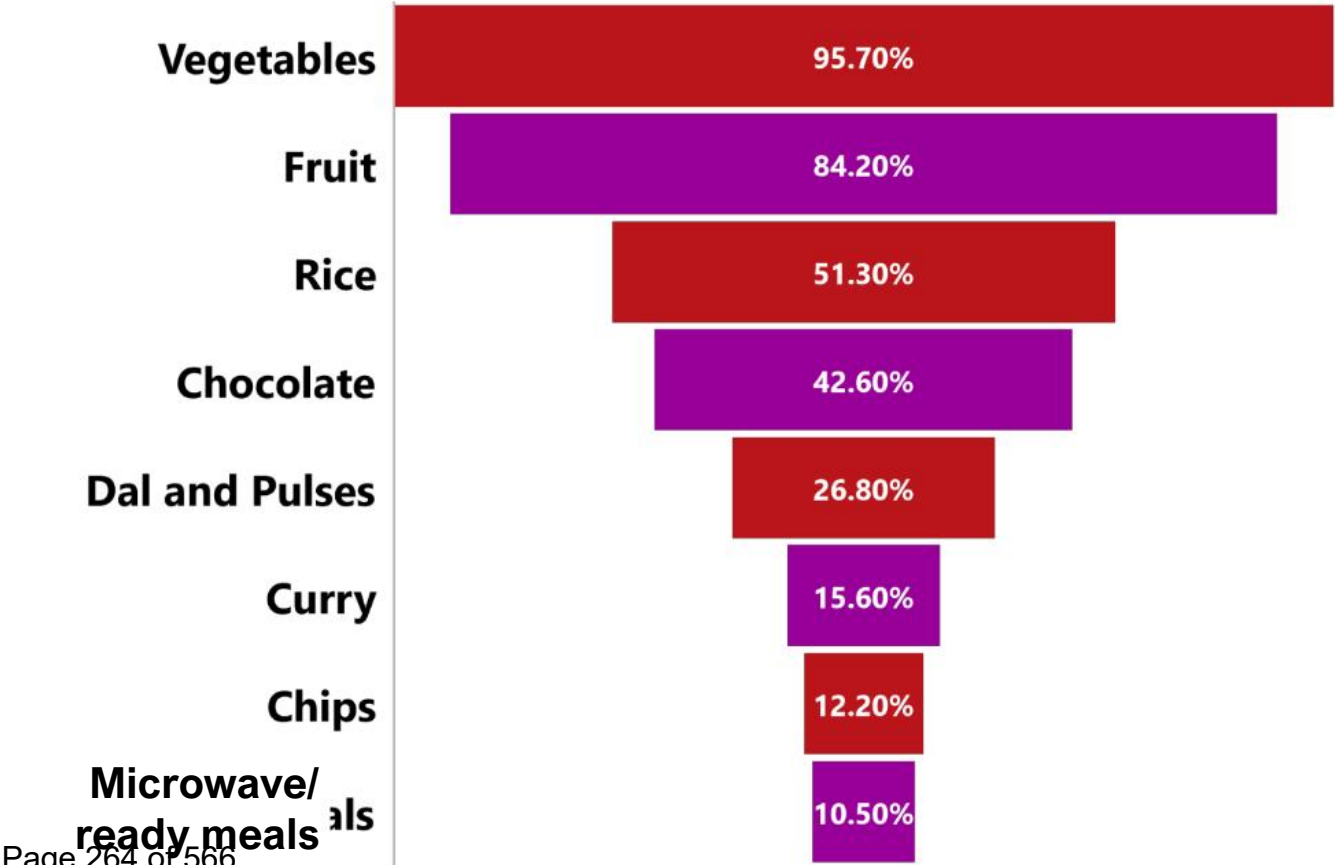
Food	Percentage
Vegetables	95.70%
Fruit	84.20%
Rice	51.30%
Chocolate	42.60%
Dal and Pulses	26.80%
Curry	15.60%
Chips	12.20%
Microwave/ ready meals	10.50%

Of the 392 respondents who answered

Section 6: Hot Food Take-Away

Birmingham citizens tell us about their choices when ordering Hot Food Take-Away and behaviour when ordering food from 'Outside of the Home'.

Which of the food delivery services have you used, in the last month?

Deliveroo
6%

Just Eat
14%

I do not use online delivery services
60%

Local takeaway delivery
13%

Uber Eats
5%

Other
2%
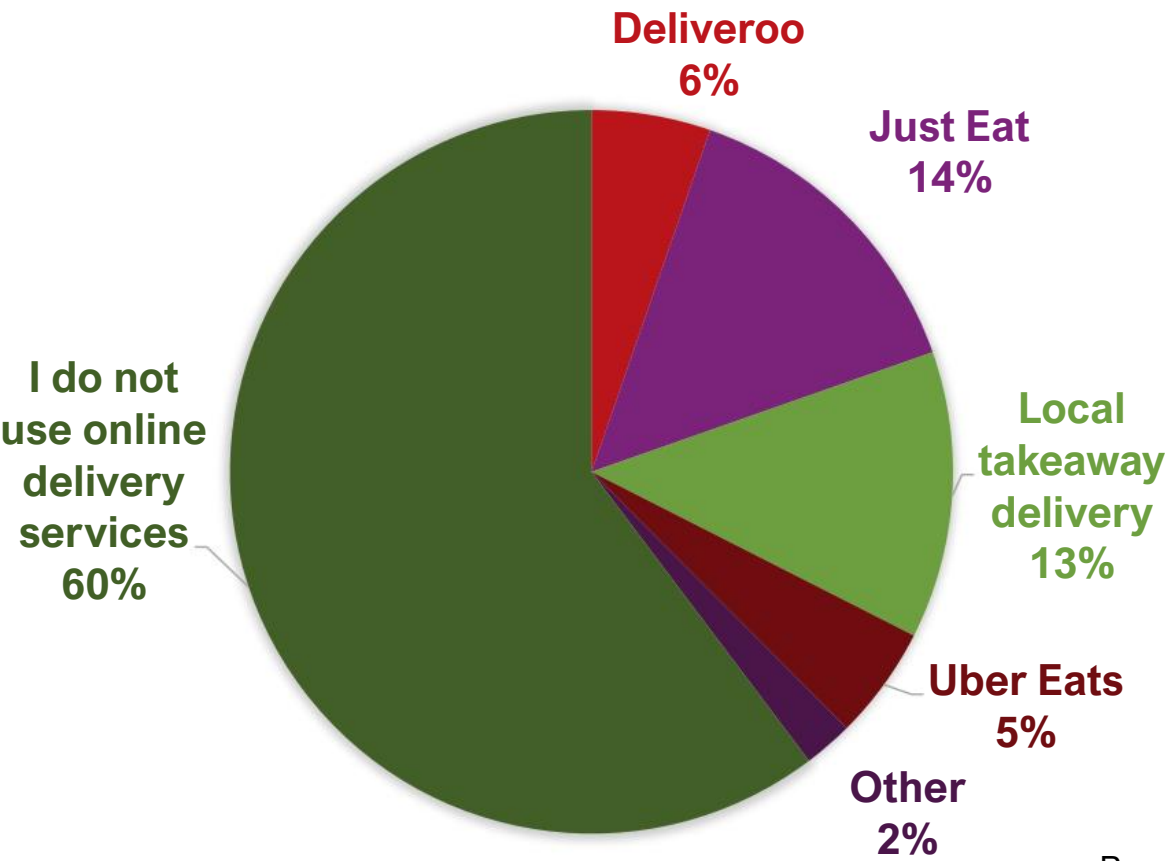
Of the 379 respondents who answered

On average, how often do you order hot food to be delivered to your home?

1-3 Times a Week
16%

Once a Fortnight
16%

>Once a Month
50%

Once a Month
18%
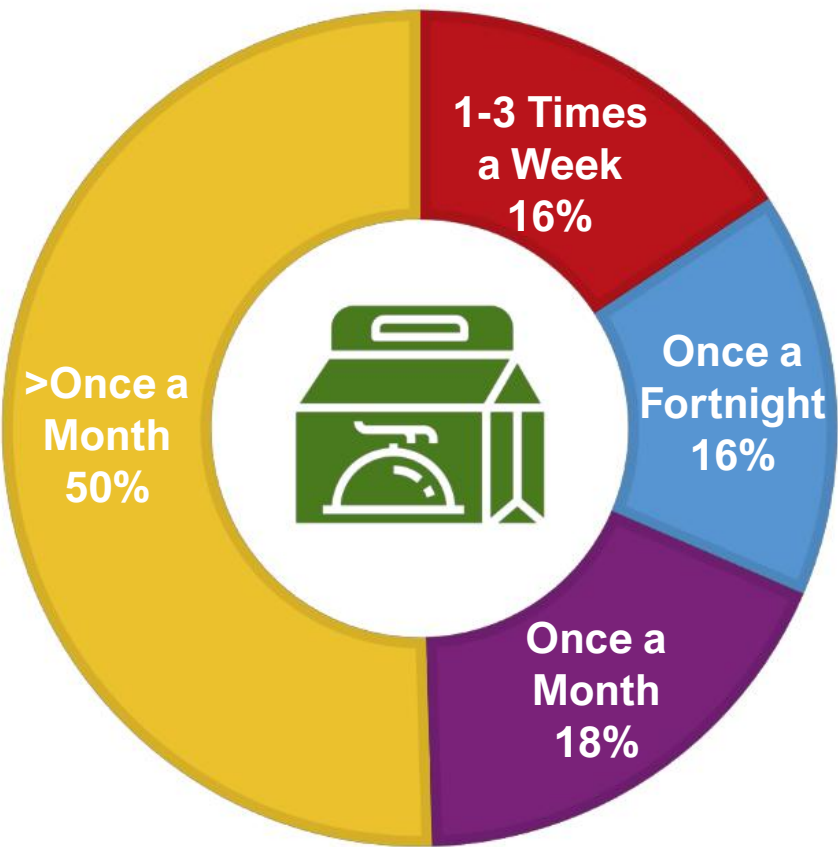
Of the 216 respondents who answered

Section 6: Hot Food Take-Away

Birmingham citizens tell us about their choices when ordering Hot Food Take-Away and behaviour when ordering food from 'Outside of the Home'.

Most popular hot food take-away choices

Of the 203 respondents who answered

Indian
35.5%

Chinese
26.1%

Pizza
20.7%

Vegetarian
8.4%
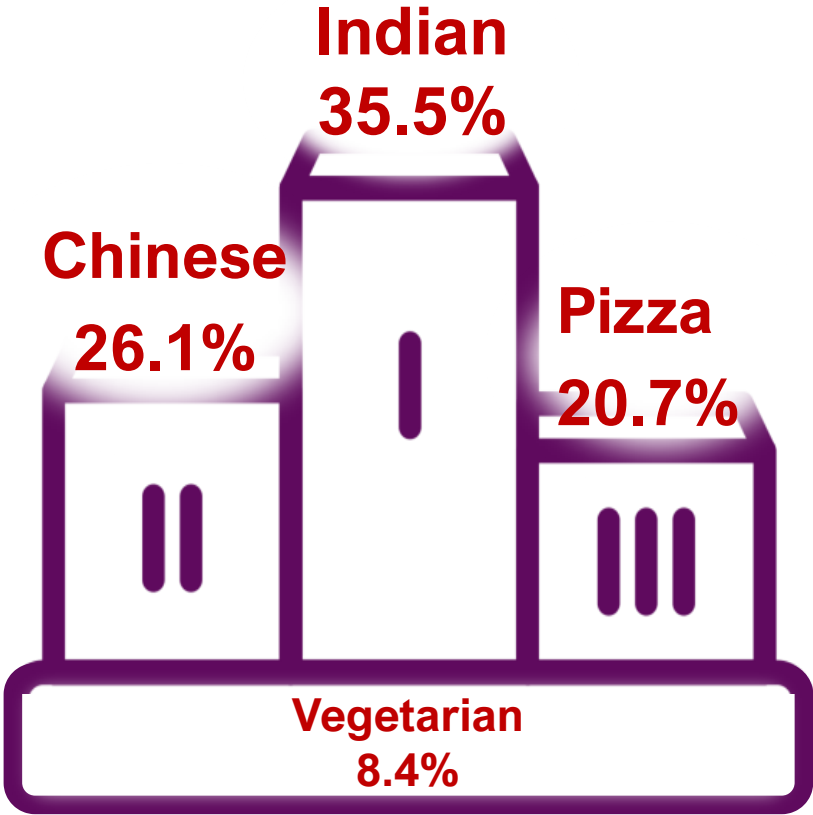
Roughly, how much did your last takeaway cost?

Of the 205 respondents who answered
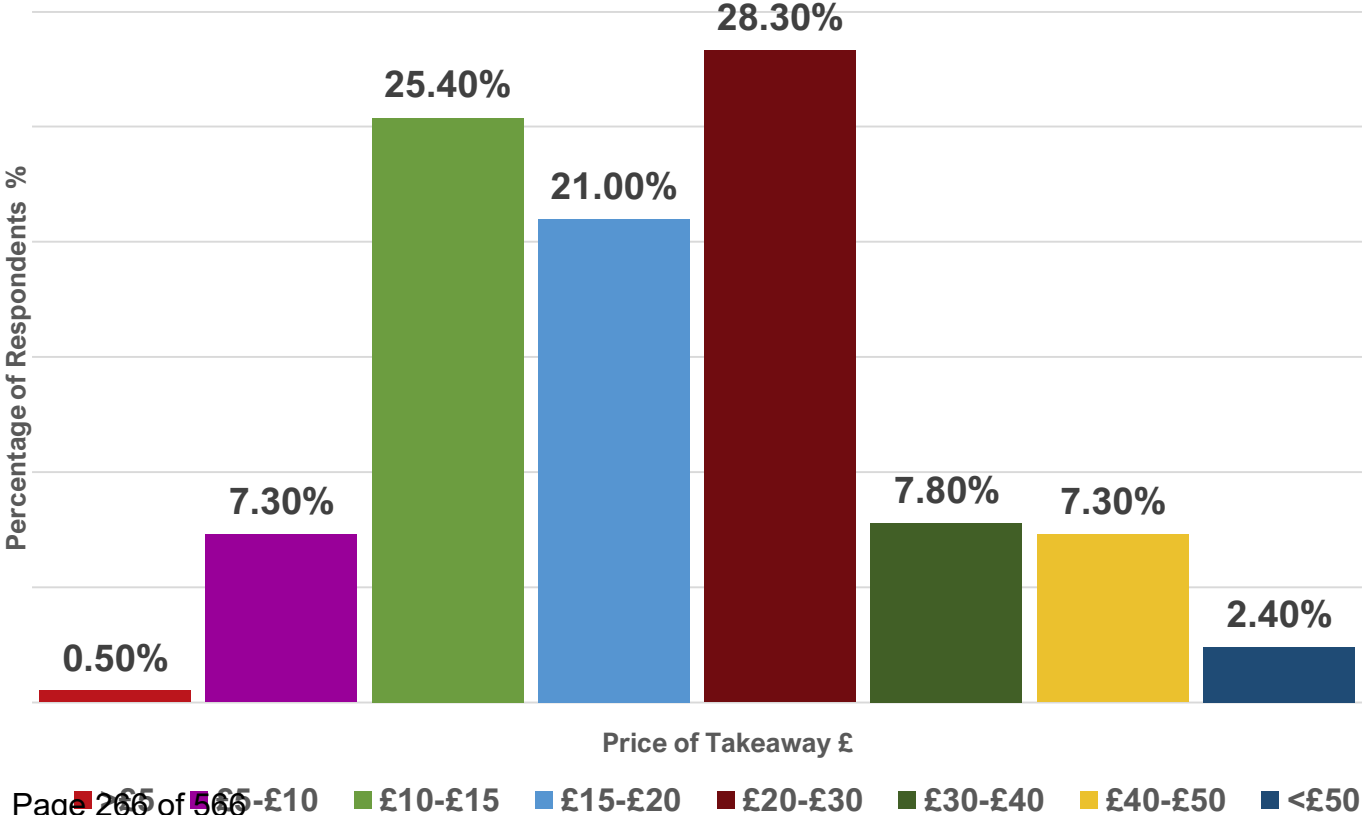
28.30%
25.40%
21.00%
7.30%
7.80%
7.30%
0.50%
2.40%

Percentage of Respondents %

Price of Takeaway £

<£5 — £5-£10 — £10-£15 — £15-£20 — £20-£30 — £30-£40 — £40-£50 — <£50

Section 7: Buying Food

Birmingham citizens tell us where, why and how they buy food for themselves, or their households.

On average, how much do you spend on food each week for the household?

Of the 389 respondents who answered

Approx. Average amount of money spent per person given the number of people in the household

Average Spend Per Person £

People Per Houshold

Data points: 40.33, 33.42, 28.01, 23.65, 20, 13.69, 17.86, 21.88
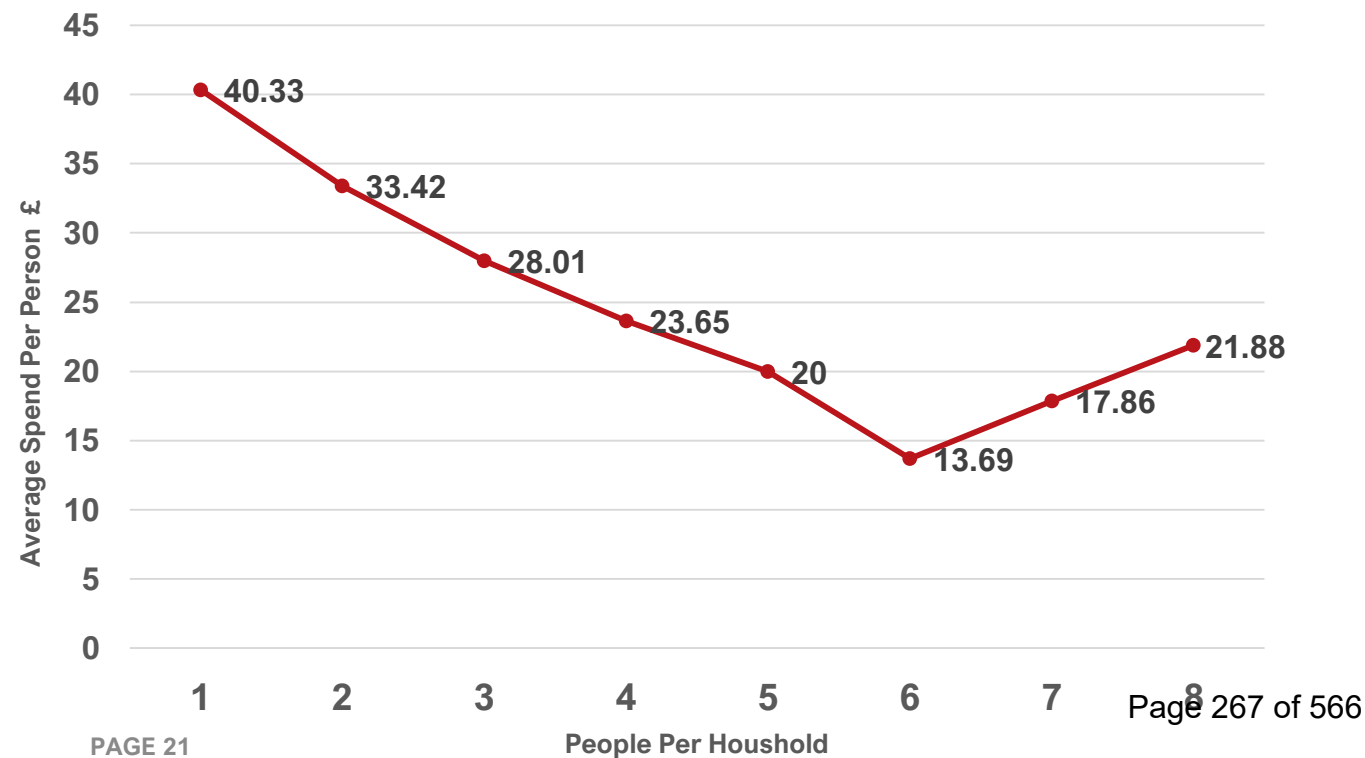
On average per person per household, respondents spent
Approx. £28.59

Section 7: Buying Food

Birmingham citizens tell us where, why and how they buy food for themselves, or their households.

Of respondents

1%

had used a food bank in the last six months

Of the 391 respondents who answered

In the last week where has the majority of the food eaten in the house been bought?
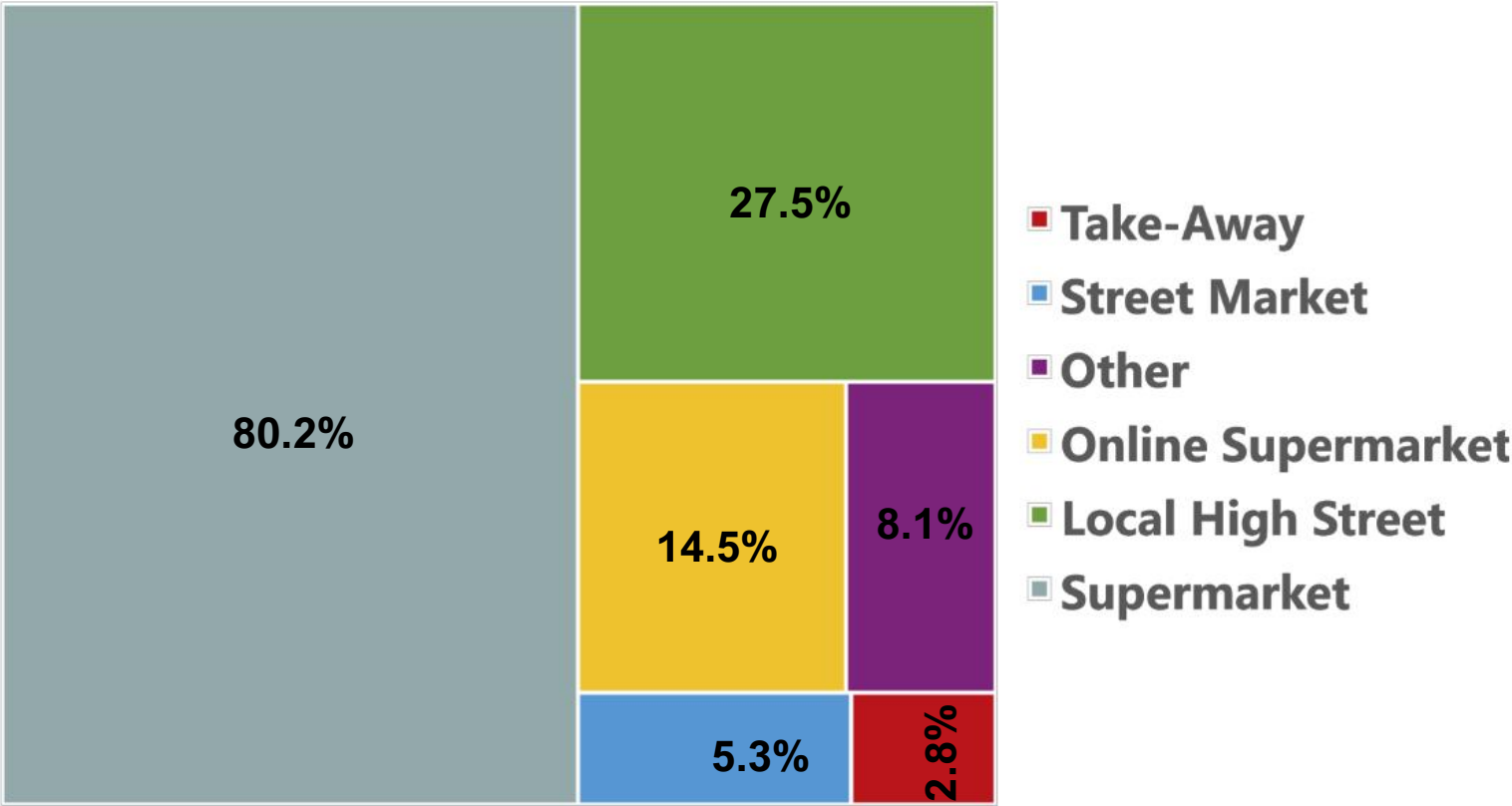
80.2%

27.5%

14.5%

8.1%

5.3%

2.8%

- ■ Take-Away
- ■ Street Market
- ■ Other
- ■ Online Supermarket
- ■ Local High Street
- ■ Supermarket

Of the 393 respondents who answered

Section 7: Buying Food

Birmingham citizens tell us where, why and how they buy food for themselves, or their households.

Roughly how long is your regular journey to do the main food shop?

Of the 390 respondents who answered

■ >15 Min ■ 15Min-30Min ■ <30Min ■ Don't Travel

- 67%
- 25%
- 3%
- 5%
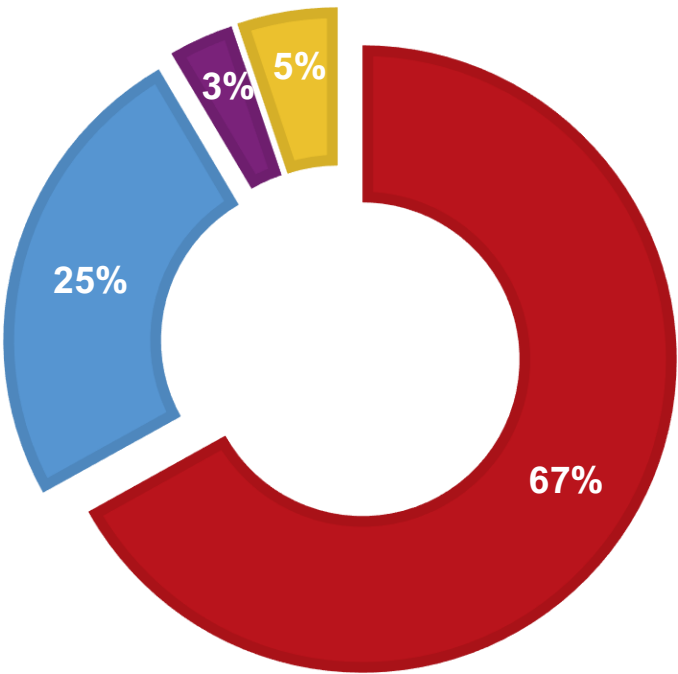
What mode of transport do you use to do the main household food shop?

Of the 390 respondents who answered

- 0%
- 2%
- 6%
- 8%
- 16%
- 68%

Mode of Travel

Percentage of Respondents %

Birmingham Health and Wellbeing Board
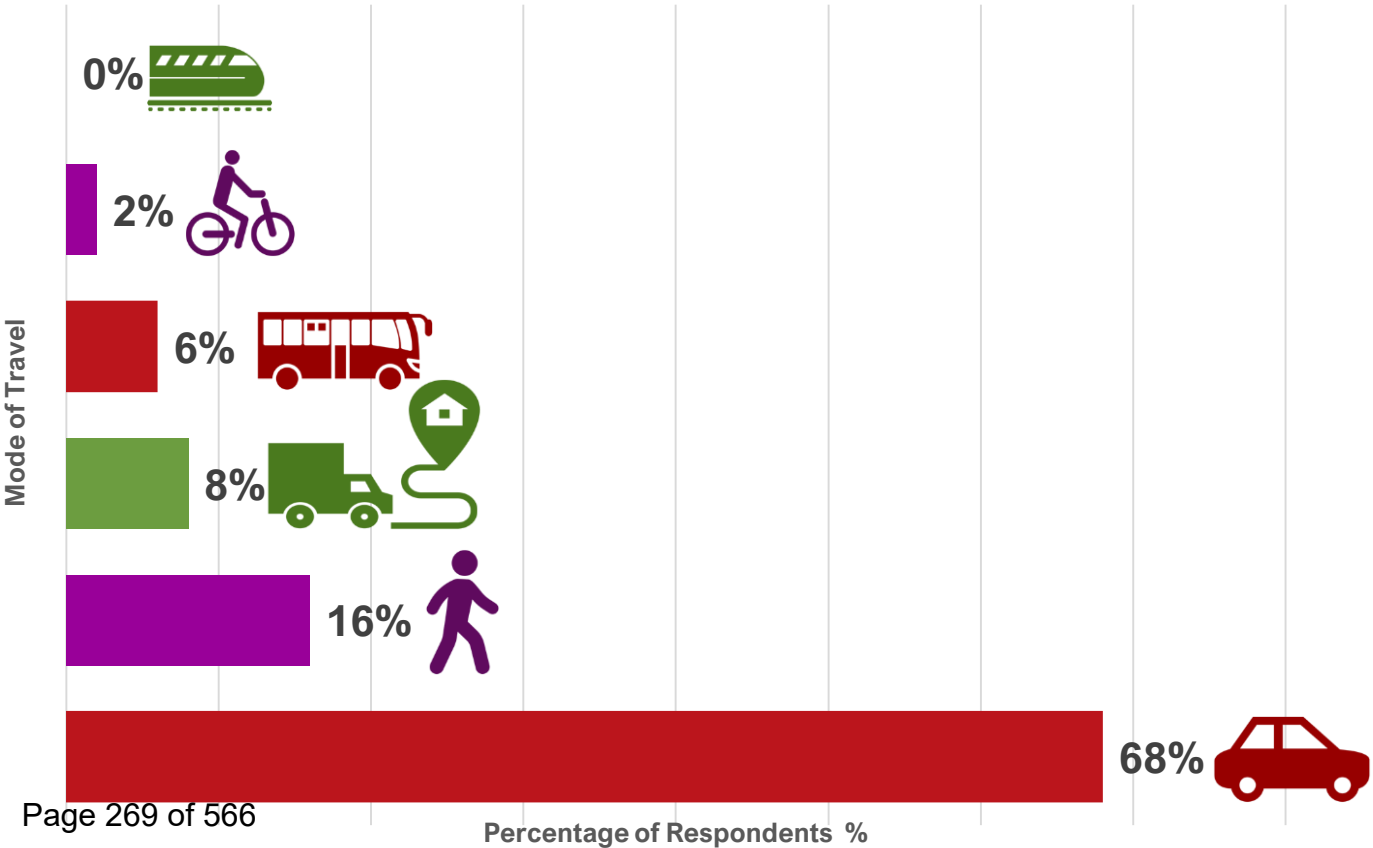
	Agenda Item: 15
Report to:	Birmingham Health & Wellbeing Board
Date:	19 January 2021
TITLE:	COMPLEX LIVES, FULFILLING FUTURES DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2019/20
Organisation	Public Health Division
Presenting Officer	Dr Justin Varney

Report Type:	Presentation

1.	Purpose:
	To update the Health and Wellbeing Board on the DPH Annual Report.

2.	Implications: # Please indicate Y or N as appropriate]	
BHWB Strategy Priorities	Childhood Obesity	Y
	Health Inequalities	Y
Joint Strategic Needs Assessment		Y
Creating a Healthy Food City		Y
Creating a Mentally Healthy City		Y
Creating an Active City		Y
Creating a City without Inequality		Y
Health Protection		Y

3.	Recommendation
	It is recommended that the Health and Wellbeing Board:
3.1	Note the contents of the report
3.2	Agrees to support the identified recommendations of the report

1

4.	**Report Body**

4.1   Context

The Director of Public Health (DPH) has a duty to write an independent evidence-based annual report detailing the health and wellbeing of our local population. The report includes a selected, specific issue that the Director of Public Health wishes to discuss within the report and provide recommendations for it. Birmingham City Council has a duty to publish the DPH Annual Report (under section 73B (5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act).

The content and structure of the report is decided locally based on current evidence-based health priorities for Birmingham City.

4.2   Current Circumstance

In Dr Justin Varney's first annual report as Director of Public Health for Birmingham City Council, the DPH report highlights the challenges that adults living with multiple and complex needs face and reflects on how we, as a city partnership can inspire action across Birmingham to support all our citizens to thrive.

The report sets out robust data and evidence, including ethnographic research, of the extent of multiple and complex needs that affect the lives of adults in Birmingham. It aims to raise awareness of what really matters when it comes to preventing and tackling many of these problems and emphasises learning from individuals with lived experience towards service design.

The report recommends that all partner organisations consider their approach when working with adults with multiple complex needs ensuring that their approach is underpinned by the principles of Making Every Contact Count and Making Every Adult Matter (MEAM). It advocates for an inclusive coordinated approach to work that is person centred, culturally sensitive and trauma informed.

The recommendations can be applied across the life course and potentially benefit all ages.

The content of the report was presented to Cabinet on 21 April 2020 and recommendations were endorsed unanimously.

4.3   Next Steps / Delivery

There are plans to submit this report alongside the new one, which is currently being worked on, to The Association of Directors of Public Health Annual Report competition. Delays in design brought on by the pressures associated with the pandemic in March 2020 meant we were not able to meet the deadlines of the last competition.

5.	Compliance Issues
5.1	*HWBB Forum Responsibility and Board Update*
5.2	*Management Responsibility*
	Monika Rozanski (Service Manager – Inequalities; currently on secondment to Test & Trace, Health Protection Response)

6.	Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**	
Partners do not implement the report recommendations	Medium	Medium	Ensure recommendations are embedded into the action plan underpinning the Creating a City without Inequality Forum.	

Appendices
• DPH Annual Report 2019/2020: Complex Lives, Fulfilling Futures

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

Monika Rozanski – Service Manager, Health Protection Response
Surinder Jassi - Senior Officer, Inequalities

2019/20

Complex Lives, Fulfilling Futures
Director of Public Health Annual Report

birmingham.gov.uk/publichealth

Birmingham City Council

Contents

Foreword

All of us experience challenges at some point in our life, many are short-lived, and we move forward, but for some of us these challenges persist and become baggage that can weigh down our lives and make it hard to achieve our potential.

Some individuals face multiple challenges such as mental health issues, substance misuse and homelessness. Each one is significant, but when added together they magnify the impact making even simple tasks seem overwhelming and unachievable.

Sadly, it is easy to slip into an approach that responds only to the specific need that brought a person to the front door and not see the complexities that surround that individual and challenge them every day.

In my first annual report as a Director of Public Health for Birmingham City Council, I want to highlight the challenges that adults living with multiple and complex needs face and reflect on how we, as a city partnership, can make every adult matter.

The report sets out the data and evidence of the extent multiple and complex needs affect the lives of adults in Birmingham and aims to raise awareness of what really matters when it comes to preventing and tackling many of these problems. Through the shared stories of Bee and Dion, I encourage readers to reflect on how we can help individuals facing multiple complex needs to live fulfilling lives.

I hope that this report inspires action across the city to make every adult matter in Birmingham and support all citizens to thrive.

Dr Justin Varney
Director of Public Health
Birmingham City Council

I am really pleased that this year's Director of Public Health Annual Report focuses on the most vulnerable adults in our city who may have 'fallen through the cracks' of our care system. We need to use this report to reflect on our work in this area and learn how to continue to improve our services to achieve better outcomes for those most at need.

Whilst many of us might experience complex needs at some point of our lives, none of us should struggle on their own. As the Portfolio Holder for Health and Social Care and as the first Mental Health Champion for the City Council, I am keen to ensure that every person who lives in our city has the opportunity to achieve their full potential.

It is important to acknowledge the effort and investment that has already been made to support our citizens with multiple complex needs to transform their lives. We have seen a significant reduction in our rough sleeping population since the previous count through greater partnership work and targeted support and intervention. We are working more closely together across the wider health and care system to prevent crisis through our joint strategies and service models, but we know that more can and must be done.

The challenges of working across a multifaceted system to address complex needs of vulnerable individuals remain considerable. Therefore, it is important that together with all our stakeholders, community and voluntary groups, commissioned services and with health partners we are able to identify issues early and avoid a high cost to people's health and wellbeing, their lives as well as the public purse.

I hope that this report will provide the opportunity through system partnership to develop a joint upstream action. I hope it will stimulate further a commitment to work collaboratively and act on the Director of Public Health recommendations as well as work towards turning the complex lives of many of our citizens into fulfilling futures.

P. A Hamilton

Cllr Paulette Hamilton
Chair of the Birmingham Health and Wellbeing Board
Portfolio Holder for Health and Social Care
Birmingham City Council

1. Introduction

"The core purpose of the DPH (Director of Public Health) is independent advocacy for the health of the population and system leadership for its improvement and protection" (Association of Directors of Public Health, Faculty of Public Health 2016).

The DPH annual report is a way for providing advice and recommendations on population health to both professionals and public, complementing information available within the Joint Strategic Needs Assessment (JSNA) and local health profiles. Its purpose is to influence local policies defining the wider determinants of health.

Findings and recommendations in this report have been based on a thorough study of the journeys of those with multiple complex needs as well as success and gaps in support available across the wider health and care system in Birmingham.

The focus of the study was the consolidation and analysis of all available statistical and service use data across four main disadvantage domains:
- homelessness
- substance misuse
- mental health
- offending.

The latter has been based to a large extent on information shared by the probation service, as it had been difficult to obtain the police data within the study's time constraints. Therefore, it must be acknowledged that whilst the themes and trends that have emerged from analysis may be similar, the findings may be incomplete.

The study is complemented by qualitative research, which includes a wide-ranging literature and policy review as well as findings from three focus groups and a rapid ethnographic research.

The semi-structured focus groups were carried out by the Birmingham Public Health' Inequalities Team with three distinctive cohorts of participants to gather city specific insight into multiple complex needs. Focus groups were conducted with:

- Department for Work and Pensions (DWP) front-line staff from across Birmingham in order to determine the challenges they face as a result of an introduction of the Government's work and health policy[1] and the Universal Credit. Both place more responsibility on DWP to carry out health and wellbeing assessments and provide tailored wellbeing and coaching support to facilitate a higher number of people with complex needs into becoming economically active;
- female service users with multiple complex needs in order to understand the challenges that specifically women with multiple complex needs face and how their experiences may differ from those of men;
- peer mentors from Birmingham Changing Futures programme[2] who provide a lead worker support to the most entrenched individuals experiencing multiple complex needs, including rough sleepers.

The three focus groups were structured by six topics: family composition, common crisis points and vulnerabilities, access to services, service successes, service failures, gaps in service provision. Findings were analysed by the Knowledge, Evidence and Governance Team (Birmingham Public Health) to identify key themes as well as compare the service user and professional perspectives on gaps and needs.

Rapid ethnography was commissioned to develop the insight presented in this report further and to illustrate what daily life and struggle with multiple complex needs is like.

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1 Department for Work and Pensions, Department of Health (2017), Improving Lives - The Future of Work, Health and Disability

2 Birmingham Changing Futures Together, https://changingfuturesbham.co.uk/

2. Understanding Multiple Complex Needs

2a. Defining Multiple Complex Needs

> *'I don't want to live anymore. I don't want to go on anymore. Because everything I care about has been taken away from me. Whether it's through substances, social services, police, you name it – everything I know and care about has gone from me.'*
> *(Rough Sleeper in Birmingham)*

The above quote pretty much defines what life with multiple complex needs, including mental health, substance misuse and homelessness, is like from the perspective of personal experience of the deepest crisis.

Looking through a professional lens, multiple and complex needs (MCN) describe interrelated health and social care needs of disadvantaged individuals which are often enduring and highly problematic, effecting day to day living, life chances and social functioning as well as resulting in economic and social costs where support is inadequate. In many cases the problems develop from trauma and those facing multiple needs often live in poverty and experience stigma and discrimination.

Several terms are used to describe multiple and complex needs in published literature. Terms such as 'Severe and Multiple Disadvantage' (SMD) [3] and 'Multiple and Chronic Exclusion'[4] are also used to describe similar cohorts of individuals, though the main areas of need or disadvantage are broadly consistent. They are most commonly:
- homelessness
- mental ill health
- substance misuse and
- contact with the criminal justice system (offending).

In some cases, this definition is wider as factors of worklessness and mental health can also add to the complexity and challenge of addressing MCN. Also, it is recognised that experience of domestic abuse and violence, separation from children and social inequalities often contribute to women's severe and multiple disadvantage[5].

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3 Lankelly Chase Foundation (2015), Hard Edges: Mapping severe and multiple disadvantage, England.

4   Fitzpatrick, Bramley, Johnsen (2013), Pathways into multiple exclusion homelessness in seven UK cities. Urban Studies, Jan 2013, 50(1):148-68.

5   McNeish and Scott (2014), Women and Girls at Risk, Evidence Across the Life Course, DKMS Research.

MCN relate to both the multiplicity of need (more than one interconnected need) and depth of need (profound, severe or intense needs)[6].

Making Every Adult Matter (MEAM) approach[7] details three criteria to identify people facing multiple needs and exclusions:

- Ineffective contact with services: Despite often looking for help, people with multiple needs face challenges when services are designed to only meet one need, or they fail to meet individual service thresholds and no single organisation takes overall responsibility.
- Chaotic Lives: One need may lead to another and often become a downward spiral especially where they are interlinked, and individuals become trapped in chaotic lives, often since early childhood, and are unsupported.
- Experiencing several problems at the same time: One main need may be complicated by others or multiple lower level needs may become problematic together.

Based on research underpinning the Fulfilling Lives[8] programme and its many evaluations, MCN can be associated with lifelong disadvantage and inequalities that impact on the individual, their interactions with services as well as their interactions with others, often starting from early on in life and escalating throughout the life course up to the point of crisis.

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6 Rankin and Regan (2004), Meeting Complex Needs: The Future of Social Care, London: Turning Point and IPPR.

7 Battrick, Hilbery, Holloway (2013), Findings from the Making Every Adult Matter (MEAM) service pilots: a summary paper, Advances in Dual Diagnosis, 2013 May, 17;6(2):66-75.

8 Funded by the National Lottery Community Fund, the nationwide Fulfilling Lives programme has been developed to improve services for people with multiple and complex needs; http://www.goldenkeybristol.org.uk/about-us/fulfilling-lives-supporting-people-complex-needs .

2b. What is the bigger picture?

"The house of children whose parents are addicted to crack-cocaine: Dad has passed out on the mattress in his own vomit, mum is crouched over a table, preparing her fix. What you don't see is the child hidden in the corner crying."

This quote opens the Coalition Government's strategy from 2012, Social Justice: Transforming Lives, developed following the Marmot's Review 2010[9] and setting out "an ambitious new vision for supporting the most disadvantaged individuals and families in the UK". That vision was based on two principles: **prevention throughout a person's life**, with carefully designed interventions to stop people falling off track and into difficult circumstances, and **a 'second chance society'**, in which anybody who needs a second chance should be able to access the support and tools they need to transform their lives.

Following this strategy, initiatives for families affected by MCN were prioritised with the Troubled Families[10] programme being one of the more successful ones. What appeared to be given less of a priority at the time was the support to single adults without dependents.

Despite a considerable focus on tackling multiple disadvantage in the past decade across the UK and in Birmingham, inequalities appear to be increasing. A follow-up report by Sir Marmot has now been published and examines further health inequalities and their cost to the society and to public services. Sadly, it reports that health inequalities in the country are widening and calls for a system-wide action to address inequity of support through effective prevention and early intervention that will reduce future costs[11].

Whilst estimating the scale and true cost of MCN is difficult, a national study suggests that average public expenditure for a person with MCN is £19,000 (of which £6,020 is welfare benefits) per annum; more than four times the cost of £4,600 for an average individual[12].

COST TO PUBLIC PURSE

Average benefits claimant **£1**

Benefits claimant with MCN **£4**

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9   Marmot (2010), Fair Society, Healthy Lives, Strategic Review of Health Inequalities in England post-2010.

10   The Troubled Families programme is a UK Government scheme under the Department for Communities and Local Government with the stated aim of helping troubled families turn their lives around (https://www.gov.uk/government/publications/national-evaluation-of-the-troubled-families-programme-2015-to-2020-findings).

11   Marmot (2020), Health Equity in England: The Marmot Review 10 Years On.

12   Lankelly Chase Foundation (2015), Hard Edges: mapping severe and multiple disadvantage, England.

The Lankelly Chase Foundation estimates that over a quarter of a million people in England experience at least two out of three of the homelessness, substance misuse and offending which equals 4.2 people per one thousand.

UK POPULATION	With 2 MCN	With 3 MCN
c. 67m	c. 280k	c. 100k

ENGLAND'S POPULATION	With 2 MCN	With 3 MCN
c. 54m	c. 227k	c. 81k

BIRMINGHAM'S POPULATION	With 2 MCN	With 3 MCN
c. 1.1m	c. 4.6k	c. 1.65k
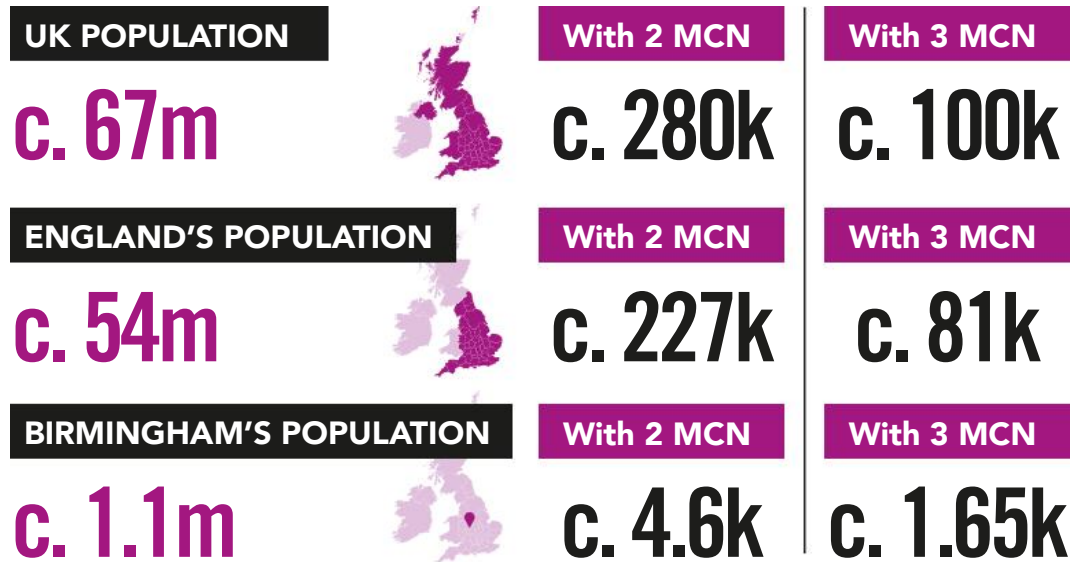
Source: Proportion of persons experiencing two complex needs using the estimate above
(based on ONS population estimates from 2019)

The research also estimates that 1.5 per one thousand people of working age are likely to experience all three of the complex needs.

The study, which focused to a large extent on the rough sleeping population, also found that those experiencing MCN were predominantly white males, aged 25-44 years with history of marginalisation and childhood trauma. 90% of the homeless population are likely to be single homeless rather than family homeless.

8 OUT OF 10

people facing MCN are men

Though note street sex work, marginalisation and childhood trauma closely interrelated with some of these more extreme manifestations of MCN, is dominated by women (Fitzpatrick et al, 2013).

We have found out that even amongst people with the most complex needs (all three), almost 60% either live with or have ongoing contact with children.

3. The Story In Birmingham
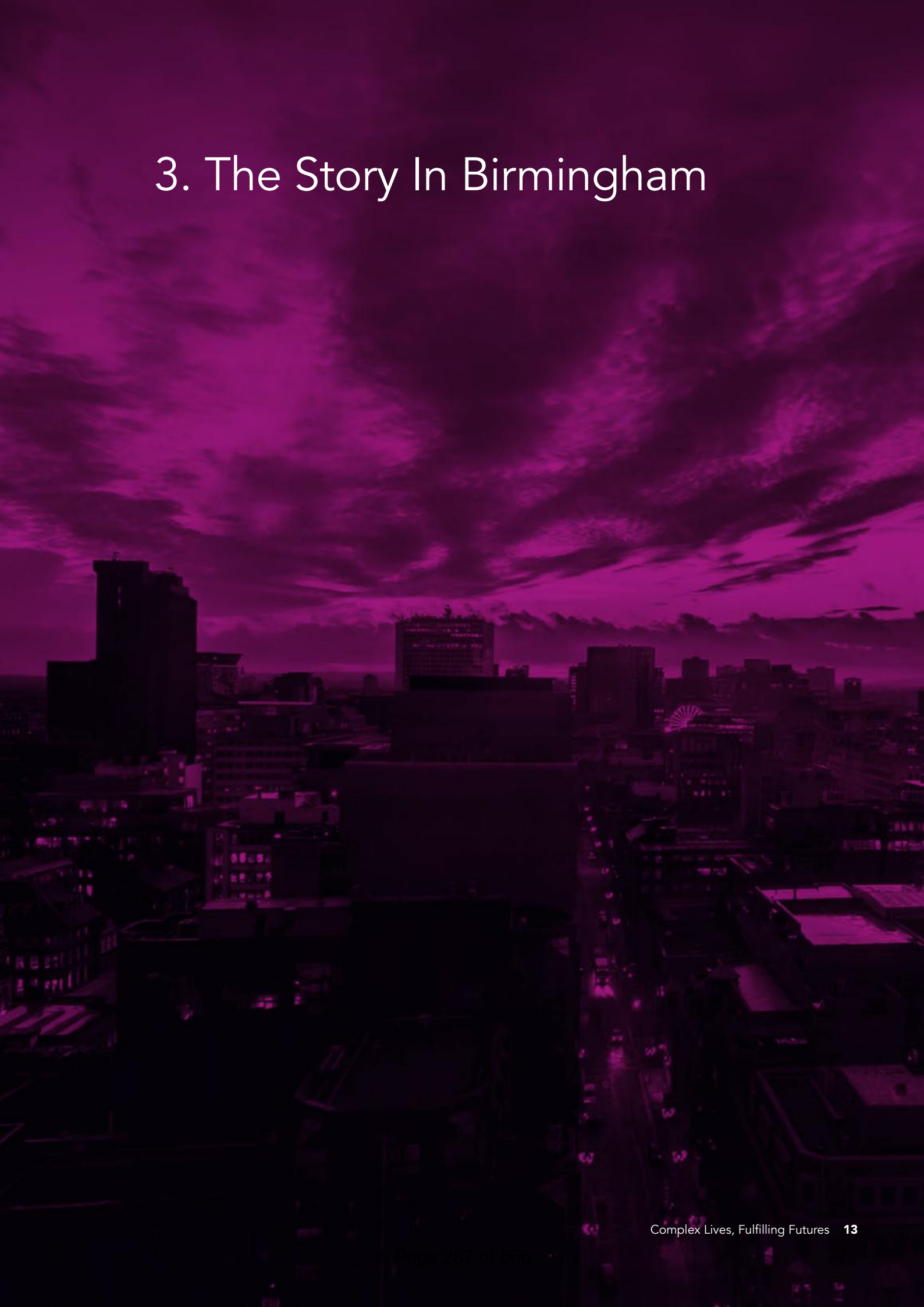
3a. How do we compare nationally?

According to research carried out by Lankelly Chase Foundation[13], Birmingham belongs to a group of 24 Local Authority areas with the highest prevalence of MCN and takes 18th place in the ranking[14].

Table 1: Index of Local Authorities with the highest prevalence of SMD based on data for England 2010/11 (where 100 is the national average)

Source: Hard Edges, Lankelly Chase Foundation 2015

Local Authority (SS)	SP	OASys	NDTMS	Combined
1. Blackpool	378	299	244	306
2. Middlesbrough	152	306	387	281
3. Liverpool	265	200	249	238
4. Rochdale	310	183	184	226
5. Manchester	245	212	217	225
6. Kingston upon Hull	251	191	232	224
7. Bournemouth	266	177	218	220
8. Nottingham	260	199	181	213
9. Stoke-on-Trent	193	215	224	210
10. Newcastle upon Tyne	271	186	167	208
11. Leicester	219	196	187	200
12. Knowsley	179	143	271	197
13. Derby	323	159	110	197
14. North East Lincolnshire	227	140	208	191
15. Blackburn with Darwe	122	235	216	191
16. Camden	239	125	199	188
17. Islington	174	175	205	185
18. Birmingham	**171**	**162**	**217**	**183**
19. Coventry	216	165	161	181
20. Tower Hamlets	188	140	210	179
21. Westminster	193	96	236	175
22. Plymouth	262	101	162	174
23. South Tyneside	123	157	238	173
24. Bristol	187	159	162	169

Based on the same research, we would estimate that in Birmingham around 7,100 people meet the criteria of at least one complex need and a mental health issue, and overall, just over 19,700 people have at least one category of MCN.

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13 Lankelly Chase Foundation (2015), Hard Edges: Mapping severe and multiple disadvantage, England.

14 The ranking is based on three national data sources from 2010-11: Offender Assessment System, National Drug System Monitoring System and the Supporting People Client Record and Outcomes for Short-Term Service data. Other evidence and measures are available which could or could not result in the same ranking.

ESTIMATED

19,700

people in B'ham have **at least one complex need**

ESTIMATED

7,100

people in B'ham have **one complex need and a mental health issue**

Based on Lankelly Chase research applied to Birmingham population

Table 2: *Estimates of MCN (referred to as SMD) in Birmingham*

Source: Hard Edges, Lankelly Chase Foundation 2015

Severe Multiple Disadvantage Category	Rate per 1,000 population		Estimated Numbers of People		
	Birmingham	National Average	Overall	With Mental Health Problems	% with Mental Health Problems
SMD1: Homeless Only	5.3	1.9	3,640	480	13%
SMD1: Offender Only	5.8	4.4	3,950	960	24%
SMD1: Sustance Misuse Only	6	5.4	4,070	2,350	58%
SMD2: Offender & Substance Misuse	4.8	3	3,290	1,440	44%
SMD2: Homeless & Substance Misuse	2.8	1.4	1,880	590	31%
SMD2: Homeless & Offender	1.4	0.8	960	340	35%
SMD3: (Based on Supporting People data)	3.6	1.7	2,450	1,150	47%
SMD3: (Based on Offender Assesment data)	2.1	1.4	1,410	750	53%
SMD 1-3	29	17.4	19,720	7,110	36%

3b. How do we measure locally?

Homelessness

Homeless households often contain some of the most vulnerable people in the city that have higher health and social needs than the general population.

Complex Lives, Fulfilling Futures **15**

In 2018-19, almost one household in every one thousand in the city was not in priority need and therefore not eligible to be housed. Individuals in such households may not present formally to local housing authorities as homeless and having MCN, and as a result have a high risk of rough sleeping and developing associated problems.

The introduction of the Homelessness Reduction Act 2017 provided a further safety net for single homeless who were entitled to have a personal housing plan completed to assist in preventing or relieving their homelessness. The challenge is to create the paradigm shift required to ensure that single homeless with MCN are supported and made aware of their entitlement to receive support around their homelessness when they declare their complex needs. Birmingham has maintained investment in supporting single homeless predominantly through the voluntary and third sector, and the development of the system of joint statutory and third sector support for single homeless is one of the aims of the Birmingham Homelessness Prevention Strategy.

Figure 1: *Statutory homelessness - Eligible homeless people not in priority need 2017/18*

Source: Public Health England[15]
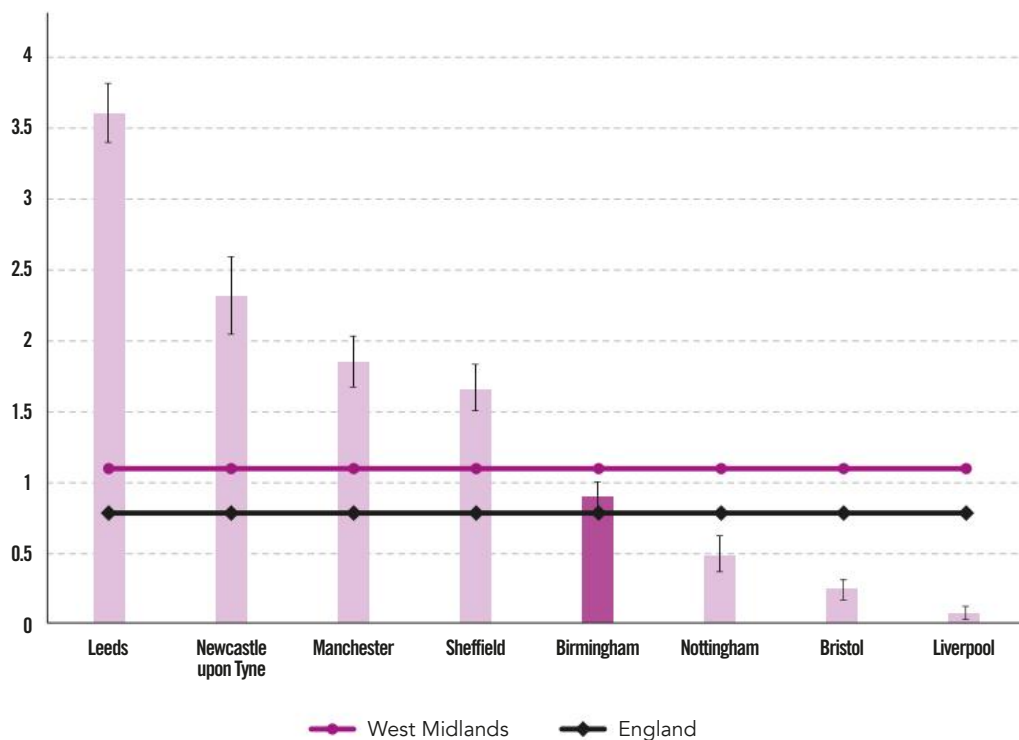
15 Public Health England, Public Health Profiles. - August 2019; https://fingertips.phe.org.uk © Crown copyright [2019]

In addition, Birmingham has one of the highest of the core cities number of households in temporary accommodation as a rate per 1,000.

2,058

households in temporary accommodation.

Source: PHE/Ministry of Housing, Communities & Local Government 2017/18

Figure 2: *Statutory homelessness - households in temporary accommodation (2017/18)*

Source: Public Health England and Ministry of Housing, Communities & Local Government[16]

— West Midlands — England
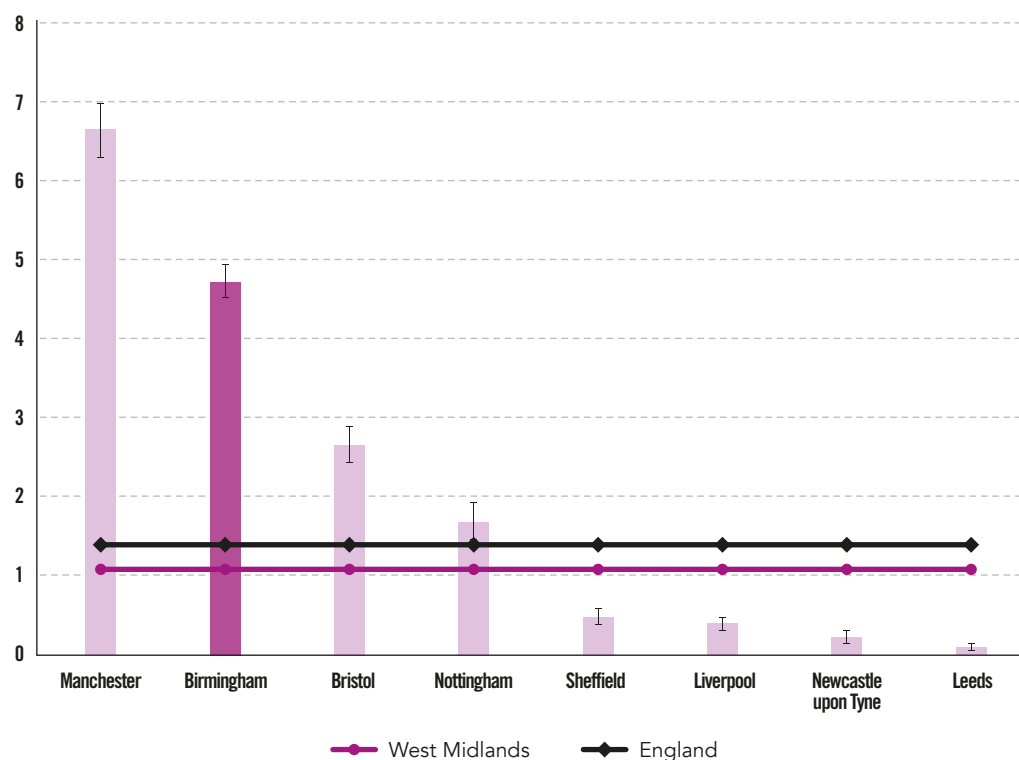
Between 2009 and 2015, 24,562 persons presented to Birmingham City Council as homeless or at risk of being homeless within the next eight weeks. The only recording available to indicate whether these persons may have had MCN was the Homeless Priority Reason recorded within their application (it should be noted that

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16 Public Health England. Public Health Profiles. - August 2019; https://fingertips.phe.org.uk © Crown copyright [2019]

only one reason used to be recorded and as such this may have resulted in under-recording of additional presenting needs[17]).

The main priority reasons recorded through homeless applications included having dependent children, overall these accounted for 41% (10,099) of applications.

BETWEEN 2009-15

over 24,500

persons made a homeless application to Birmingham City Council.

41%

of those had dependent children.
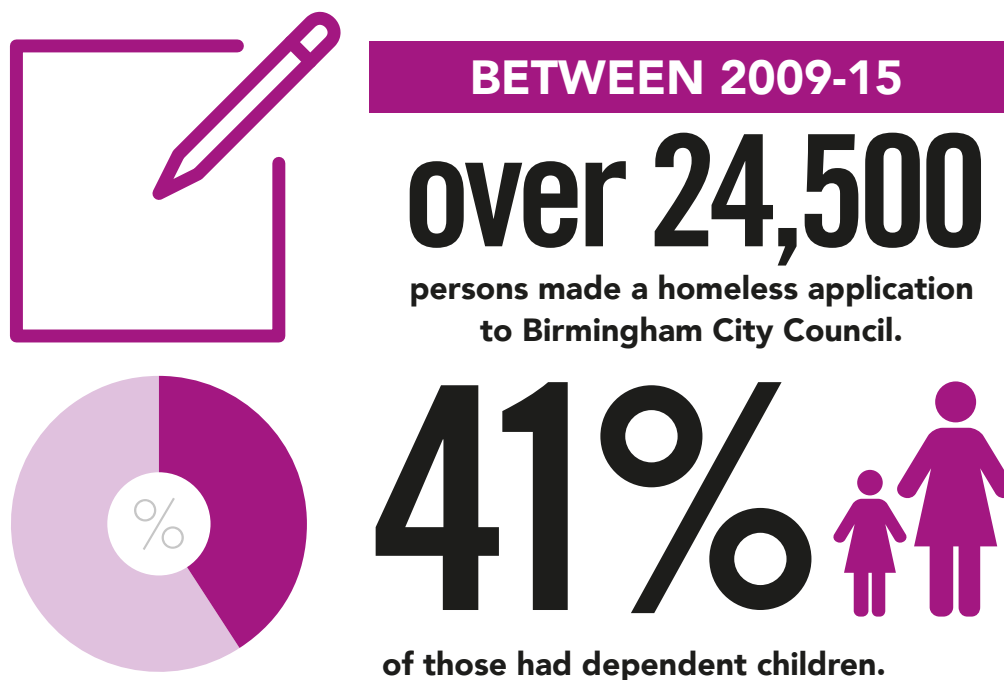
Source: Birmingham City Council

Substance misuse accounted for less than 5% of the recorded homeless priority reasons, and mental disability accounted for 4% (970) of all applications. Again, if these issues are not identified in the homeless applications to the local authority, the individuals are not assessed to have that priority need, and this may result in under-recording of the true prevalence.

Drugs and alcohol are the leading cause of death for people sleeping rough or staying in an emergency accommodation in the city. Between 2013 and 2018 this accounted for 19 deaths[18].

It is worth pointing out that many homeless people may not be visible to the care system. Anawim, a Birmingham charity supporting women with MCN, reported some of their clients, who may have not presented as experiencing MCN to the local authority, were using friends' accommodation or squats.

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17 Analysis of data recorded by the new HCLIC system, which captures information on those presenting as homeless, needs to be undertaken, as will provide information on wider needs of the homeless population.

18 ONS - Deaths of homeless people (identified) by underlying cause of death, Birmingham, 2013 to 2018 (bespoke mortality reporting).

Substance Misuse

It is estimated that 14 per every 1000 people between ages 15 and 64 in Birmingham are opiate and/ or crack cocaine users.

ESTIMATED
over 10,500
people aged 15-64 in B'ham use opiates or crack cocaine

Source: PHE: Public Health Profiles 2016/17
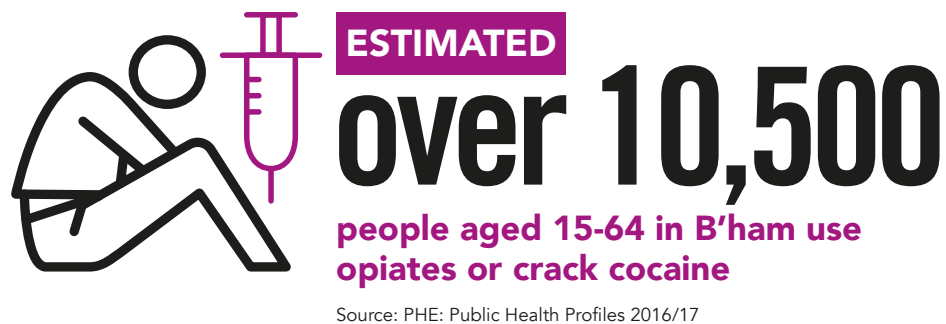
Opiates refer to heroin and painkillers such as morphine. Around 40% of opiate users are not in treatment and therefore may not have any contact with services. Based on evidence, treatment is completed by around 40% of non-opiate users, but only by 6% of opiate users[19].

AROUND
40%
of drug addicts in treatment receive mental health treatment

Around 40% of individuals, who entered treatment at a specialist drug misuse service, were in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment. This is significantly higher than England, the West Midlands and the other 'core cities' and may reflect better recording in Birmingham and/ or higher prevalence.

It is important to note that the prevalence data is only available for opiates and alcohol, and it is recognised that substance misuse is much broader and includes other drugs such as cannabis, synthetic cannabinoids, prescription medication, steroids and "club" drugs.

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19 Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

Figure 3: Concurrent contact with mental health and substance misuse services for drug misuse (%) - 2016/17

Source: Public Health England / National Drug Treatment Monitoring System 2016/17[20]

━●━ West Midlands   ━◆━ England
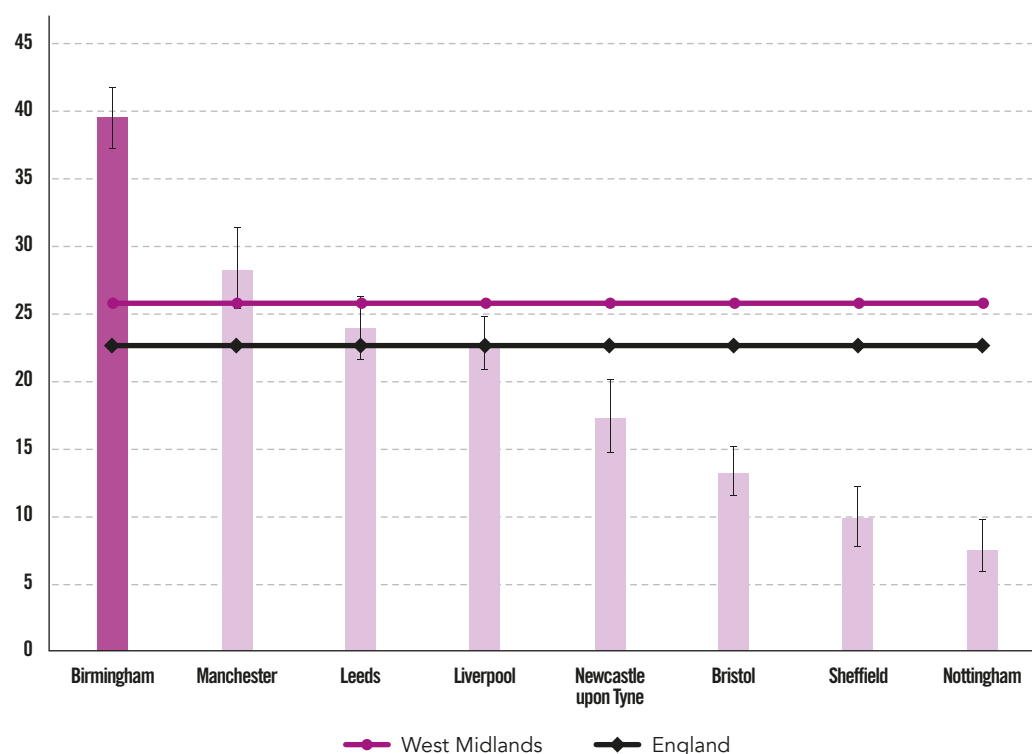
Alcohol can have equally devastating consequences as drug misuse. There were 25,875 admissions in Birmingham in 2018-19 for alcohol related conditions.

c. 26,000
hospital admissions in B'ham for alcohol related conditions (2017-18)
Source: Public Health England
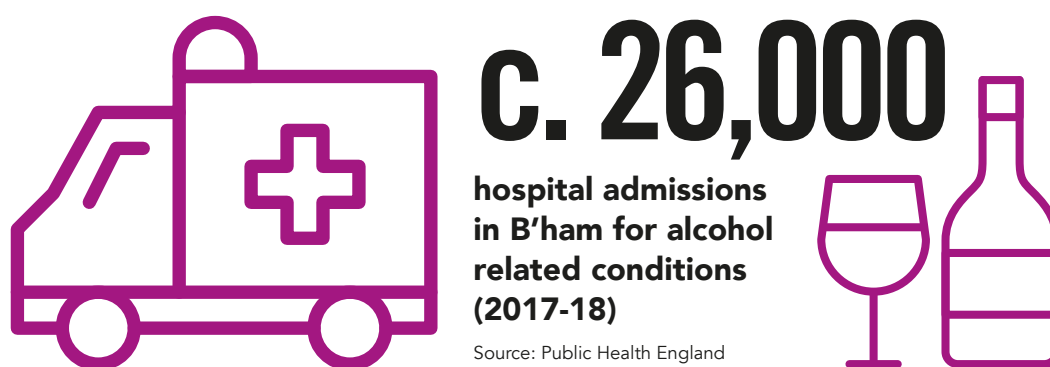
It is estimated that over 80% of dependent drinkers are not in treatment and only 43% of those entering treatment complete it successfully[21].

In 2018-19 almost 7,000 assessments were undertaken by the local substance misuse service provider Change Grow Live (CGL). The majority (75%) were for

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20 Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

21 Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

male service users between the ages of 35 and 44 (44%). As a rate per 1,000, the most prevalent ethnic groups were white and mixed (8 per 1,000 for each group). Half of service users did not have children. Of those that had children, the majority did not live with them[22].

Figure 4: *CGL Client Parental Status – 2018/19*

A. Not a parent 50%
B. None of the children live with the client 33%
C. All the children live with the client 13%
D. Some of the children live with the client 4%
E. Client declined to answer 0%
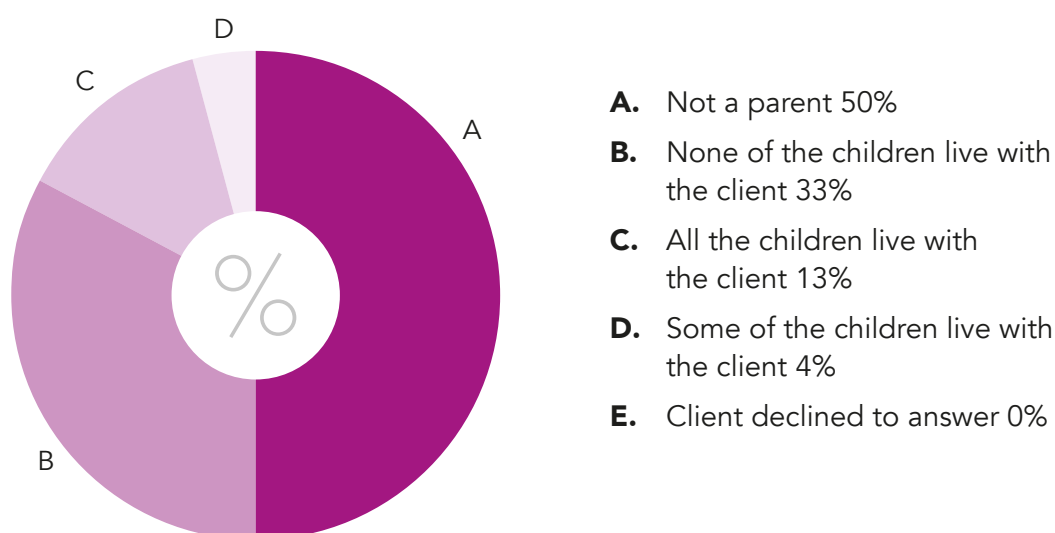
In terms of multiple needs, almost 2,000 referrals to CGL came from criminal justice - 35% (this may be related to the Criminal Justice System's duty to refer), 19% had housing problems and over a third of people had mental health needs. Though it was not possible to cross-tabulate needs, we can assume that as an absolute minimum around third have at least one need additional to substance misuse problems, though this is likely to be higher. Applying the 'Hard Edges' research estimates, around 55% would have one additional need (either offending or homelessness).

7000 referrals into CGL in 2018/19:

35% from criminal justice
19% had a housing problem
34% had mental health issues

Source: CGL

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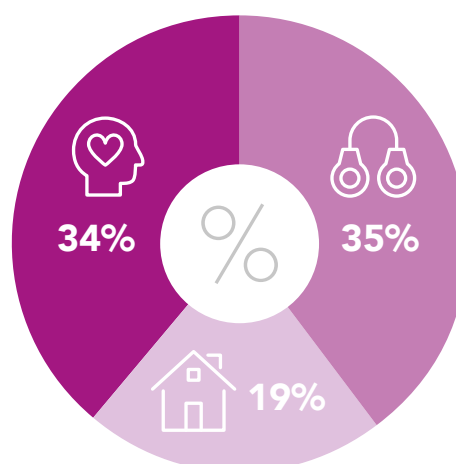
22 Open Recovery Assessments between 01/04/2018 and 31/03/2019 - data provided by CGL.

Mental Health

We know that 1.19% of people in Birmingham have serious mental illness such as schizophrenia, bipolar affective disorder and other psychoses, and 10% are diagnosed with depression.

OVER **16,000** people (all ages) in Birmingham have **serious mental illness**

NEARLY **100,000** people in Birmingham (18+) have a diagnosis of depression
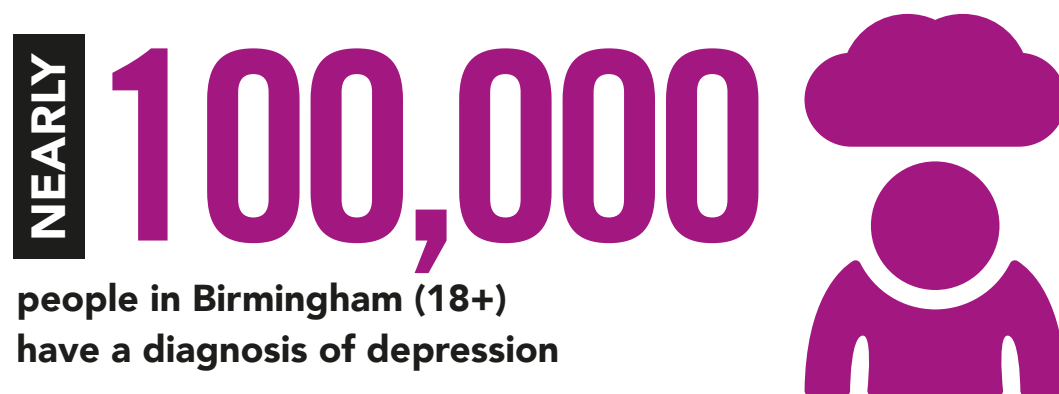
Source: QoF- NHS Digital 2018/19

This only captures those people who are registered with a GP and who have a recorded diagnosis which again highlights the complexity of capturing data on the more isolated populations such as the homeless and new migrants.

ONLY **64%** of adults accessing mental health services **live in stable accommodation**

Source: NHS Digital & Adult and Social Care Outcomes Framework 2018/19

In 2018-19, only 64% of adults in contact with secondary mental health services lived in stable accommodation. This is slightly better for females than males and may potentially be linked to family composition or housing eligibility.

In 2018-19 the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) received 43,337 referrals[23] (including sub-referrals when a patient has been referred to more than one service or team type) for adults aged 18+ living in Birmingham. 51% of referrals were for female patients and 55% of referrals were for patients from a white ethnic group. The largest groups as a rate were Black/ Black British (39 per 1,000) and White/ White British (38 per 1,000). 24% of people were 25-34 and 21% were 35-44 years old.

Only around 2% had a recorded substance misuse issue. This has been assessed by commissioners (Adult Social Care and Clinical Commissioning Groups) as very low and a likely underestimation, which may reflect issues with referrals being accepted for clients with dual (addiction and mental health) diagnosis. Only 3% of BSMHFT patients had a recorded status of non-settled accommodation. It is also important to note that there are recognised limitations with data quality in the Mental Health Service Dataset.[24]

Criminal Justice

Offending behaviour is often linked to mental health and substance misuse issues, and offenders experience significant health inequalities.

Around 12,000 offences were recorded in the city in 2017-18. There were approximately 2,600 first time offenders in 2018, and it is estimated that of all offenders around a third go on to reoffend[25].

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23 The number of referrals excludes those that were not accepted.

24 The latest national Data Quality Maturity Index (DQMI) score for MHSDS (NHS England) was 71.9%, hence there are still data quality issues with the dataset.
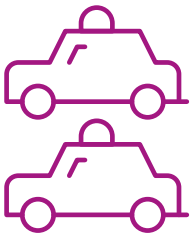
25 Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

Figure 5: Rate of first-time offenders based on recorded (via Police National Computer) crime data per 100,000 population aged 10+

Source: Public Health England /Ministry of Justice 2018[26]
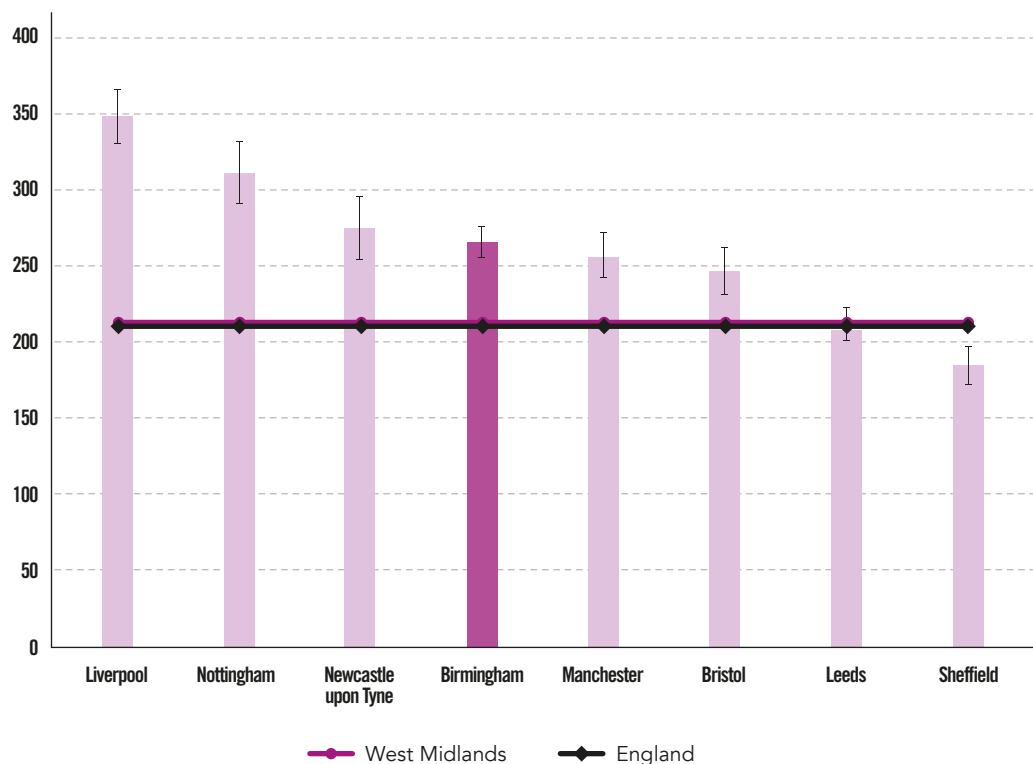
West Midlands Police estimate that approximately 95% of referrals to the Force's Vulnerability Team received through the online portal[27] were for people with MCN living in Birmingham. This equates to almost 4,950 out of 5,200 referrals in 2019 and does not include incidents reported through alternative referral methods. Data relates to those who gave consent to be referred for support into a partner organisation.

4,950

online Police referrals for adults with MCN living in B'ham

Source: West Midlands Police estimates for 2019

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26 Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

27 This system captures cases where concerns around the vulnerability of individuals are reported by other departments of the police force or members of the public.

There were 1,185 cases managed by the National Probation Service' Birmingham Local Delivery Unit as at 7 January 2020[28]. These consist of offenders in three categories: (a) community – an individual with community order or suspended sentence order; (b) post-release – offenders on licence; (c) pre-release – offenders currently in custody. Of the 1,185 records 36% (421) had a register description of mental health issues and/ or a description of a mentally disordered offender. An additional field indicated that 9% (111) persons were recorded as having no fixed abode.

MCN specific service data

In 2019, Anawim received 1,025 referrals. They estimated that 76% of women referred to their service presented with five needs or more, 39% presented with 7-10 needs each and the most common need was mental health. Anawim use more need categories than the standard definition and include domestic violence amongst others.

Around 42% of their service users have children and around a quarter of those who stated their ethnicity were White British. The majority of Anawim service users were 26-35 (31%) followed by 36-45 years of age (27%)[29].

1,025 WOMEN REFERRED TO ANAWIM, 76% with 5 or more complex needs

Source: Anawim 2019

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28 Data provided by National Probation Service Birmingham Local Delivery Unit.

29 Data provided by ANAWIM.

Figure 6: *Percentage of service users by need for a period of 12 months to November 2019*

Source: Anawim
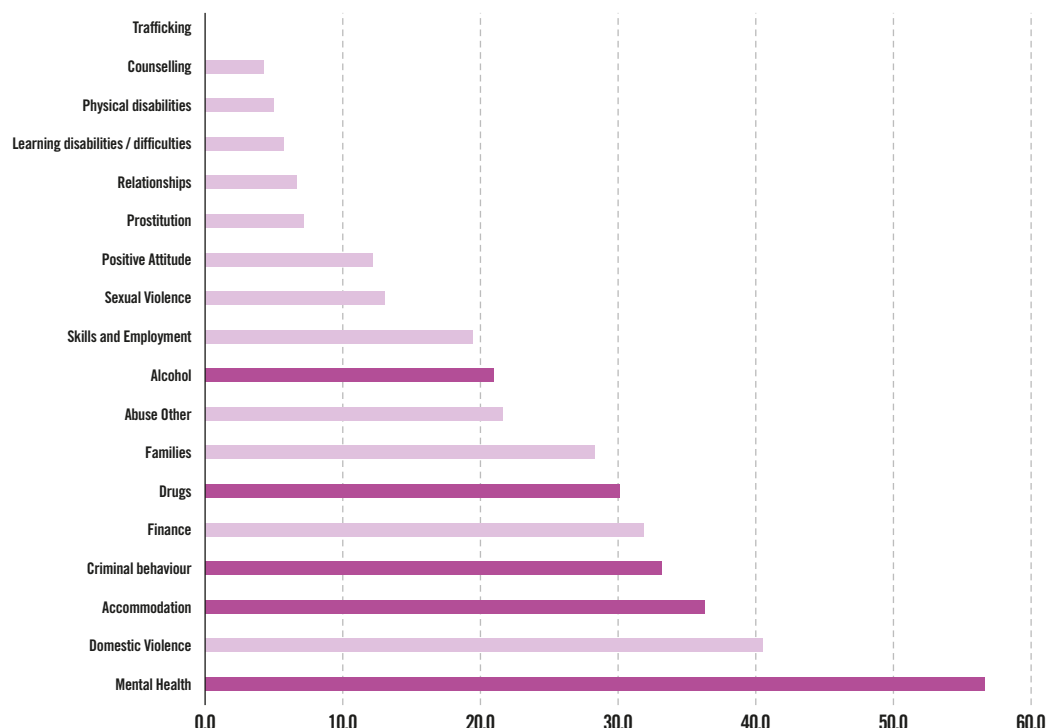
Source: Anawim 2019

Data provided by the Birmingham Voluntary Service Council (BVSC), who lead on the Changing Futures Together programme[30], suggests there is a higher level of MCN in Birmingham than it had been anticipated by the organisation originally. It was estimated that 156 of the most entrenched individuals (with three or more of homelessness, problematic substance misuse, reoffending and mental ill health needs) would receive support from the programme between December 2014 and June 2019. This figure was exceeded in the first two years and continues to grow.

2018-19 data from their Lead Worker Peer Mentor Programme (LWPM), which provides a one to one support by a trained mentor with lived experience, shows that 130 people accessed the service. Of these 64% were male. The largest proportion of service users were 35 to 44 years old (34%), followed by 25 to 34-year-olds (20%), and majority of service users were of white ethnicity.

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30   Data extract from Birmingham Changing Futures LWPM cost benefit report 2018/19.

PROFILE OF LWPM SERVICE USERS

64% MALE

34% 35 - 44 YEARS OLD

20% 25 - 34 YEARS OLD
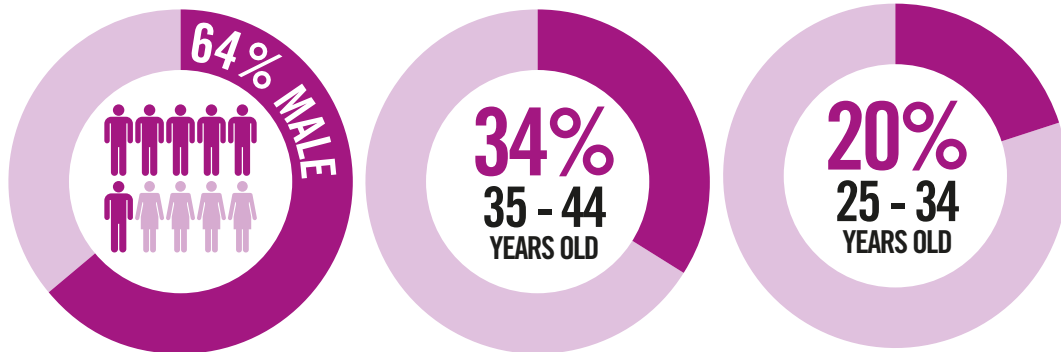
Source: BVSC – Changing Futures Together

Changing Futures captures data on specific need domains. Over two thirds of service users had needs in all four domains, though this was more common in males than females with 74% of males having needs in all four areas compared to 57% of females. This suggests a potentially different pattern of need and intervention required for different genders which is supported by published research[31].

Figure 7: *Birmingham Changing Futures' percentage of service users by need category*

Source: BVSC

A. All four domains 68%

B. Homelessness, substance misuse, mental health 18%

C. Offending, substance misuse, mental health 7%

D. Homelessness, offending, substance misuse 6%

E. Homelessness, offending, mental health 1%
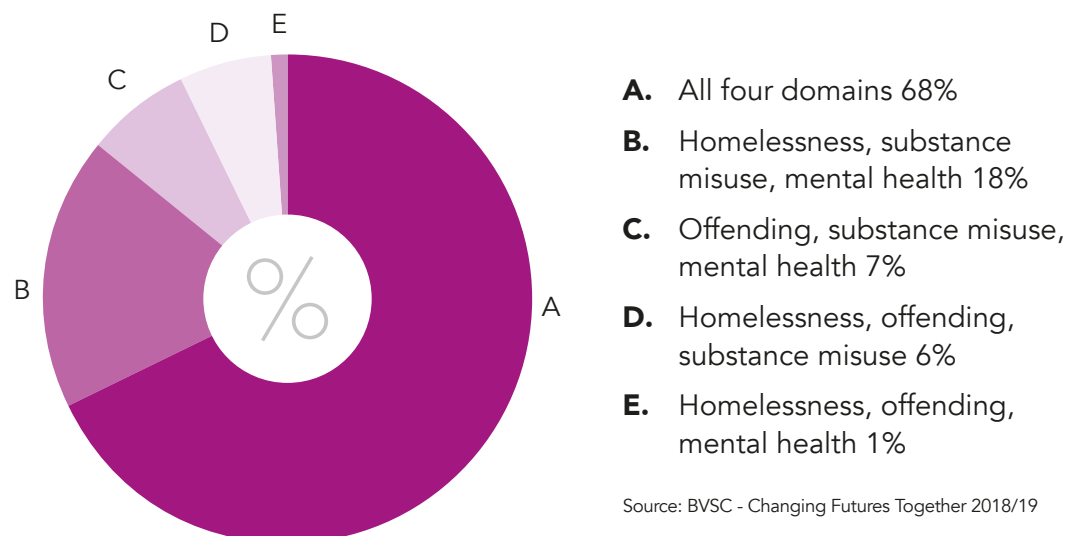
Source: BVSC - Changing Futures Together 2018/19

31   Agenda, AVA and Burrow Cadbury Trust (2014), Mapping The Maze: Services for women experiencing multiple disadvantage in England and Wales.

Hospital episodes statistics data collected during inpatient visits in 2018-19 shows we had 6,845 admissions of Birmingham residents with MCN (classified in this instance as two or more of mental ill health, homelessness or substance misuse needs) out of a total of 391,172 general admissions - this equates to 1.7%. Over the past 10 years, the MCN rate has been mostly static at 1.6 or 1.7%. Such recording would in some instances be reliant on the person declaring these diagnoses or the diagnoses being relevant to that admission.

ALMOST

7,000

HOSPITAL ADMISSIONS

of patients with MCN in Birmingham in 2018/19

Source: NHS Digital – Hospital Episode Statistics

4. Meet Bee And Dion

To complement the findings from data analysis and develop a greater understanding of what life of a person experiencing multiple complex needs living in Birmingham looks like, two case studies have been developed using an ethnographic research methodology.

In January 2020, an experienced ethnographer worked with two people in Birmingham who fell into the category of having MCN. Below are the written accounts of that work. The stories have been anonymised as far as is possible whilst retaining the critical features of the places in which the work was carried out. While reading them, it is worth remembering that no individual story need match a macro picture, and that no individual will perfectly reflect statistical trends. Furthermore, ethnographic work like this can yield rich pictures, but also coarse ones. For that we make no apology.

It is also worth remembering that these two accounts alone should not be used as evidencing the full extent of a 'system' or any particular service, or a population of certain kinds of people. In the sense that they rely to some extent on self-reporting, and on self-confessed unreliable witnesses, they should also not be seen as being unfailingly 'true'. What they are, are honest accounts of a day in the life of two people living and trying to get on, in Birmingham.

Bee, 45 years old

"It's like they *wish* I was being abused!" "What do you mean?" "It's like if I was being abused, they would know which form to pull out. They don't want to hear that I'm fine. I'm in a relationship. With a man. And he doesn't abuse me." Bee is talking about a women's outreach centre that she has been attending for years.

But Bee *has* been abused. She has worked in the sex industry where abuse, she says, was the norm: "When other women [who did the work she did] tell me they've been raped, I just tell them to get over it. Get on with it. That's what I did. Move on. It's normal. You can't let it get you down."

The abuse that Bee has suffered isn't the root cause of all the problems she now faces. It doesn't dictate all the decisions, good and bad, that she makes. It is a bitter part in a life of peaks and troughs; one of many traumas that may one day be properly dealt with or may not. Bee is also often fierce like this: about other people that can't keep up with her, about services that she feels don't properly listen, about the 'nana heads' on [the] road, and with herself and her own struggles with addiction and the legacies of bad choices and bad luck.

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Bee drinks. She starts early in the day with a can of beer and then drinks slowly throughout. Sometimes she will be out of her house early, on others she may never leave, spending the day laying on her sofa and watching Netflix. When the weather is cold, she says, there are fewer people out ('on road'). There's less going on. Less happening.

This is the SAFE waiting room. Bee has been a regular attendee for many years.

Nonetheless, today, cold though it is, she has a doctor's appointment. "Pills are easy. I always get lots of pills. I have manic dep… [correcting herself] bi-polar. They changed the name, but it's the same." The clinic she attends is clean and welcoming, a friendly, if institutional, space. The only sign that this is not an everyday GP's surgery is the prominent security guard sitting behind a desk at the entrance. The staff are friendly even as Bee barks requests and instructions to them from the back of a short queue. It's 10 minutes before the start of her appointment: "Am I early? Don't say I am early. I can't wait. I can't wait in here." Bee is visibly uncomfortable. She sits. Stands. Sits again. The staff say that the doctor won't be a moment. It's too much for Bee. She walks out. It's not the place specifically, she says, it's all queues. She tells a story about how she had been physically forced to leave a shop only the day before because she looked like she was going to hit someone in a queue. She says she wouldn't have.

This is where SAFE is.

On the way back to her house, she stops to buy a second can of beer from a grocer's. There is a man standing outside. She knows him. He is impassive as she asks him if he is ok or needs her help. On her way out she gives him enough money to buy a can for himself. He thanks her and goes in behind her. "I used to drink with his brother. I loved him. But he died last year."

Her home is not far away but she opts to ride the bus. After a stop or two, another woman gets on, close in age to Bee but her clothes are shabby compared to Bee's ostentatious long-coat and beads, and her mouth is toothless when she smiles, unlike Bee's confident grin. They know each other. The new passenger sits on the opposite side of the aisle and loudly recounts lurid tales of a couple, each heroin addicts, that she and Bee both know. Some other passengers turn their

heads away pretending not to hear. Bee joins in the banter, but later confides that she seems to attract 'all the crazies' and that the woman on the bus shouldn't be considered a friend. She also, privately, confides that she herself has bit of an addiction problem beyond drink, but to keep this quiet, as the people around her in her life don't know.

Back at her house, Bee introduces her housemates. They drink too. Bee gives them some money for beers, and they go out. Bee thinks that one of them sometimes steals from her when she is not there and points to padlocks crudely fixed to her kitchen cupboards. But she also cares for them. She is better with money, and better at avoiding trouble, and this puts her in a slightly authoritative role: "Queen Bee". She tries to settle down when they have gone, but she is antsy. Today is not one of her 'staying in' days. She wants to get back on the street, to 'hustle', and she has a plan to go and see a friend.

Changing Futures is in here, which Bee speaks well of.

The plan is convoluted. Bee has a friend who helps her out. He's older and retired and has time for her. Bee has asked him to come around in his car and to take her to see another friend, Alice, which he happily agrees to. The plan involves going into a formal place of work, so Bee stashes her fresh beer can under her coat. At the front desk reception, she listens with wide eyes to the directions she is given to find Alice. It quickly becomes apparent that she couldn't take them in and has to ask almost everyone she passes for more directions ("I have such a bad memory you know. I'm not even joking. It was the drugs. Before."). She has to journey through the building in small increments. Eventually, she gives up and calls Alice on her phone. Alice emerges from a corridor and rushes over to greet Bee. Bee gives her a £5 note and asks if Alice will cook dinner for her the next day. Alice agrees with a smile and rushes back to work. The whole encounter is over in seconds. And then Bee turns to try and find her way out of the labyrinth, and back to the car that is waiting for her in a no-parking zone…

On the way home, Bee asks to be dropped on the main road instead. She wants to find people. She warns that some of them could be dangerous. Not too long ago she had received a number of death threat letters to her home, though is not sure why, or who they might have been from. In the event, she finds lots of people. The road, a busy shopping street packed with charity shops, takeaway restaurants, cheap supermarkets and newsagents, is full of people that call out

to her. None of them are using the shops and services. They are all drinkers, and many are also addicts, she says. They are just moving up and down the street, as if on conveyor belts, finding each other and looking for *opportunities*. Bee exchanges pleasantries, sometimes ostentatiously, sometimes cautiously. But she is looking for another kind of person, someone who might have just got 'paid' in fact. Someone from whom she might be able to call in a favour: a bit of money, or a drink. This is 'hustling'.

The bar near the drinkers' park, where Bee was allowed to sit.

Avoiding a pub that she sometimes goes to because there is no one in there she knows she can trust; she moves to find somewhere quieter and emptier. Eventually she tries a bar she often goes to. She thinks some of her better acquaintances might come into the bar on their way there. The staff know her and turn a blind eye to the can of beer she is already carrying. Once in the bar, there is little else for her to do. Bee slumps and waits, but the bar is empty and it's not clear exactly what she is waiting for.

She is also getting tired. The previous night had been disturbed when a 'gang of kids' broke into the house opposite her own. Bee and her housemates suspected that it had been to do with drugs and claimed to have seen this with their own eyes ("The police never even came! They still haven't come." "Did any of you call the police?" "No way!"). Certainly, there was plenty of evidence for what had happened visible to the naked eye, but Bee says that the gangs are dangerous. She points out several places in the streets near her house where they seem to act with impunity and warns not to take pictures. She tells a story of a friend who was stabbed and almost died, 'for nothing', when he was just walking past them on his way home, and then, shockingly, of how she and another friend of hers had recently been car-jacked by some young boys with a machete. The gang had taken the car and left her and her friend shivering with fright in the street.

Despite all of this, Bee insists that her life is not currently at a low ebb. In fact, she has the opportunity to move to a new home, which she will do initially on her own. She has plans to make it how she wants it before inviting anyone else (including her boyfriend) to come and stay with her. She has been desperate to escape from the area she currently lives in ("It's not safe!"), so this chance is a good one. She is also reasonably stable mentally, she says, and has been able to rekindle some relationships with family members, and maintain friendships with people like Alice, who live 'like normal'. She has a plan to kick her more recent drug addiction too

and has already told a local service provider about it in order to start this process off ("… but they need to give me respite. I've had it before. It's amazing! I need to be sent away for like a couple of weeks and use, you know, the substitute. To get it together and then get on …").

The troughs were worse. Bee says that she had been good at school, outgoing and reasonably successful, but at 16 had suffered a mental breakdown: "That's when things started going wrong." Since then, she says, she has suffered some 15 or 16 similar breakdowns. Each one has involved significant memory loss, long stays in hospital, and some kind of traumatic consequence. It is the breakdowns, she says, that ruin everything. In the past, such breakdowns have led to her having a child removed from her (and from whom she is now permanently estranged), a trauma from which she says she cannot entirely recover. She has lost housing because of things she has done during breakdowns. And she has lost work (which she would love to get back to but recognises that this seems a long shot now).

She has also lived on the streets, including a long period living behind some industrial bins with a partner she had met ("having a man can keep you safer you know?"). This relationship kept her out of housing for a long time as she felt she couldn't leave him even when she was offered more permanent accommodation. It also meant that she prolonged an addiction to crack cocaine ("That's bad stuff. I have no memory anymore. I can forget things that have only just happened"). Living on the streets, she says, was the worst time of her life.

This is Bee: peaks and troughs. As the day draws to a close, she reflects on her own personality. Is it a good thing that she is such a character? That people know her? Does that attract trouble? Or does it keep her safe, and give her a network to draw on? Probably both, she decides, but she also knows that it means that every day is unpredictable. Staying at home is safe, but not realistic. And the more she is out, the more she accumulates colourful pieces in her jigsaw life. Her parting remarks reflect the danger: "You should have visited me in the summer. There is so much more going on then. [She winks] It would have been like an all-day party!"

Dion

Dion is frustrated. He lost his phone a week ago and it is beginning to cause him problems. He has a new phone, but it has a new number, and he has lost his contacts. He explains that he had lent his previous phone to a friend, another homeless man in Birmingham, and had been due to get it back a couple of days later. Unfortunately, the other man had committed a serious crime the very night that Dion had lent him the phone, and had been taken away by the police, with Dion's phone. Dion didn't expect to get it back.

Not having his phone means that there are a couple of trips, outside of his usual routine, that he must make. He is dressed for the cold weather: a thick winter jacket, tightly woven trousers with multiple pockets, a woollen hat, and a good pair of boots. He is in his late 50s, and still physically strong, though his face attests to the ageing properties of too much alcohol and years of living outdoors, and he has underlying health problems that are likely to become more visible in the near future than they are today.

At around the same time that he lost his phone, Dion had managed to secure a bed in a small house run by a registered social landlord. There is a spare room at the house and the landlord has given Dion a week to find someone to fill it before he finds someone else (a potential risk for Dion who has had bad experiences with unexpected housemates in the past). Dion has told a friend about it, but that friend now has the wrong phone number, so Dion must go and find him where he lives in supported housing. Dion describes his friend as a 'couple of slices short of a loaf', but he's also 'safe', and Dion has known him a long time.
The building where his friend lives has a reception desk and Dion is told that he can't go in, and that they can't tell Dion whether his friend is in or out. So, Dion leaves a note with his new phone number and a message asking his friend to call him back or to meet him at his 'pitch'.

His 'pitch' is the place where Dion stands to sell copies of the Big Issue magazine. The walk from the dilapidated supported accommodation building and Big Issue distribution office to the centre of the city is marked by a jarring shift in wealth and affluence with each road crossed. Dion's demeanour changes as he transitions from safe anonymity in one, to interloper in another. As soon as he approaches the city centre, Dion becomes animated and witty. He needs to be a cheery vendor working the crowds to entice a sale. He has a ready quip for almost every passer-by, some are stock ("Buy a Big Issue? No? A small one for half the price?") others are off-the-cuff. Dion is an alcoholic but describes himself as a friendly and mellow drunk ("I get funnier throughout the day.").

At his pitch, Dion occupies the space in a different way to the shoppers and businesspeople passing by. Whilst most offer smiles as Dion offers his magazines, or chat on phones and in groups whilst on the move, Dion's world is more permanent. A constant cast of characters who also live on the streets come past. They all know Dion and Dion knows them all. One man comes by struggling with crutches and a cast. Another man, bare-chested despite the cold, and with a constant patter about football clubs, stands and talks at Dion for 10 minutes. A young girl with a hooded jacket tight round her face and carrying a massive backpack trudges up. Dion offers a wave and a smile and explains that she is only recently arrived, homeless and from London ("She needs help now or she'll get stuck."). A street musician whom Dion likes comes over to see how he is doing. Dion offers the spare room in his house to the man (in case his other friend never gets his note), and this prompts a flurry of phone calls to the landlord, but it won't work because the musician does not have the security of a state provided income. And finally, a man and a woman with some news. They know where Dion's phone is. The friend he had lent it to hadn't taken it with him to the police station. Dion can go and collect it from the woman's mother's house later that day. It was a complicated story.

The food van that gave Dion the sandwiches.

All the while Dion breaks up the time with trips away from the busy shopping street (first carefully removing his red Big Issue bib), down side alleys or behind bins for a piss ("The shops often don't let me in"), or to take a drink from a bottle of vodka that he has secreted in one of his deep jacket pockets. At 3 o'clock Dion can also make a trip to a nearby food van where they will give him a free sandwich. He had once gone to them at the end of a long cold day around Christmas and had begged for some food, and they had taken pity. Now it's a regular thing. For the most part however, Dion does not eat in the day ("It gets in the way of my drinking"), which is strange, he reflects, since he is a fully trained chef.

When he was young, still a teenager, Dion had joined the army as a way of getting out of a rough South London life. He served two tours. He doesn't want to recall everything he did or what it was like, but he is clear that the time left him scarred mentally ("How can anybody see those things and be ok?"). When he left, he was determined to do something different and studied catering at a college in the North of England, during which time he met a woman with whom he had a

child. When she was still young however, he says that out of the blue, he was sent a letter by a lawyer saying that his girlfriend and daughter had left him and never wanted to see him again. It pains him now to recount this, and tears are visible as he says definitively that his life fell apart that day. In retrospect, of course, he had already faced a great many difficulties before then: violence on the streets of London, a children's home, active duty in the army, and of course, drinking had already become a habit. But on that day, he says, he suffered a breakdown. He doesn't remember exactly what happened, but he woke up in hospital a week later, and has taken prescribed medication to pacify and calm his mind ever since.

From then on, he says, he used the skills that the army taught him to survive. He claims to have travelled all over Europe, taking jobs in restaurants or living wild in forests whilst taking odd building jobs. Sure enough, he demonstrates that he is near fluent in Italian and can get by in German. He is proud, he says, that he can live anywhere. He can build shelters, skin animals, make a fire ("Survival. That's what I am good at. As long as I have a mission. And I have one right now!" "What is your mission?" "Survival!"). This is not to say that he always made good choices of course. He met another woman, and had another child, but he no longer knows where they are. He spent time in prison after getting caught up in the midst of some deals that went wrong and that had turned violent. And all of the time, he was drinking.

When he came back to England, he reunited with family, from whom he was long 'ex-communicated', and who now lived in the North of England. But the relationships broke down acrimoniously, and he was soon on the streets again. He says that he has since slept in every doorway, carpark and alley that homeless people sleep in, along with finding beds in "every proverbial shithole that some people call 'housing'". That's how he knows everybody on the streets.

But he is beginning to feel his age. His body is slowing down. In fact, his body is *breaking* down. He missed his last doctor's appointment that was arranged for him at the Homeless People's Health Xchange, but he knows there is something seriously wrong. He has lost strength in one of his arms, and he shakes involuntarily. He rejects help though insisting that he has the skills to look after himself, and besides, he says, he can't handle structure. "You mean like AA? No way. I don't like that. Meetings. God. And anyway, I don't want to stop." "Veterans stuff? Yeah, they have offered me help now and then. But there's too many rules. I don't need that. I know how to survive." "Even the Big Issue is a bit like that. So many rules. But at least I can make some money."

Today, he says, is "like Groundhog Day … but not in a bad way. I get up, have my

'breakfast' [beer], maybe go and get some Big Issues if I have run out. Make some money – I can survive on a tenner – then go to Tesco, buy some food, my vodka – it calms my mind – and something for 'breakfast' – then start it all again." The vodka, he says, calms his mind enough to leave the house: "Without it, I wouldn't leave. The medication makes me confused and forget things. But the vodka gets me out of the house, and I need to get out to get the money." He also tops up with his income from ESA, which he has recently used to buy a computer. The landlord has also agreed to provide internet in the house. And this is important, because with his contacts back and an internet connection, he can get back in contact with his mother. His mother lives separately from the rest of his family, but also far away from Birmingham. She is old, and confused, he says, and probably doesn't have long to live. But he wants to speak to her still, until she dies.

As he leaves, Dion reminds me "I'm sorted now. I have a good landlord. A house. I am getting the internet. I can survive." He has been in this new situation for ten days.

5. What Matters

Complex Lives, Fulfilling Futures **39**

Whilst the ethnographic study highlights the uniqueness of the life journey, experiences and choices of each of the individuals experiencing MCN, focus group discussions with those with lived experience as well as front-line practitioners helped us develop an understanding of the feelings and perceptions that are frequently reported or may be common to the most vulnerable people in the city. Below is a summary of what, in general, matters most to people with MCN, particularly when it comes to accessing support.

5a. What people with multiple complex needs think

"The easiest thing to give in my opinion is love and care, but it's the hardest thing that they find."
(Anawim service user about statutory sector provision)

"If we could see people when they are younger and help them and explain things to them because we have been through it and we have got understanding, I think they might not get to where we are now. They might be helped before they get to this age."

"I will pick the phone up to ring to put a complaint in about housing or mental health or even just to access some help with it. And they just read a script, there is no humanity there anymore."

"In the mental health now, a few do care. But the majority of them, it's just, onto the next one, onto the next one. No understanding, no compassion, none of it."

"Yeah so every time it's been a huge amount of time. But it's priceless. It's 24-26 weeks whereas I think now, the way they treat you, you get six weeks mate. If you're lucky I will give you an extra three. If you're lucky, you know what I mean? And you better be fixed by then, get back to work."

To develop a good understanding of what really matters to individuals experiencing MCN to be able to transform their lives and what the common drivers for the inequality they face are, we talked to them through a series of focus groups. Here is what they value most when it comes to contact with services:

- Understanding, compassion and humanity from professionals responding to requests for help or providing support;
- "Personal touch" when providing support, such as a follow up letter or telephone call;
- Opportunity to build trust and relationships with key workers to be able to fully engage with treatment and therapy without the fear of the possibility of being abandoned or let down later;
- Tenacity of professionals who will persistently encourage engagement with services and offer support all the way through;
- Being seen or provided support immediately or shortly after a referral, so that the window of opportunity is not missed, and the daily chaos does not hinder the chance to transform their lives;
- Prevention and early intervention, starting from early childhood when neglect, abandonment and abuse are first being experienced;
- Same easy access to support regardless of age, gender, disability or family circumstances (i.e. marital status and dependents);
- Knowledge of where to find appropriate services and support;
- Continuity of key worker;
- Time to recover before support is abruptly ended when it reaches the maximum target time;
- Peer support throughout the journey.

5b. What professionals think

There is a strong perception amongst the professionals that the escalation of complex needs is associated with limited, insufficient or no access to welfare support. We chose to interview a group of job centre front-line staff from across Birmingham who, according to the latest state of welfare reports produced by the Department for Work and Pensions (DWP), routinely come into contact and support individuals with MCN, many of whom are single and without dependents with them.

> "We get a lot of homeless people, people which are in supported accommodation. Majority of those tend to be ex-offenders, things like that. So, if there are single people with children then they are usually not with the parents that we see."

Here are the things that the practitioners stated they believed were of the greatest importance for their clients:

- Stable and safe environment (i.e. being away from the relatives and networks who had a negative impact on their lives, or caused harm);
- Stable and suitable accommodation (e.g. appropriate support, guidance, presence of support workers in supported accommodation);
- Presence of role models or mentors who genuinely have the best interest of the person with MCN at heart;
- Front-line staff being appropriately trained to be able to provide support more effectively;
- Trust to encourage engagement with the service followed by the service being able to provide the help required for the duration that is needed in order to secure the long term best possible outcome;
- Planned upstream provision for those at risk of having MCN or their escalation, e.g. planned prison releases into appropriate accommodation and/ or treatment;
- Communication and robust handovers between services and organisations for wraparound seamless support;
- Multi-agency working and co-location of services for easy access and timely provision.

"That is the critical issue. The type of housing. If they are in a more stable environment a lot of this wouldn't be able to happen. They would be safer and less exposed to the wrong kind of people."

"You'll find a lot of these landlords take up these properties just so they can take the vulnerable people in and go mishap with them" (about unregulated supported accommodation).

"We keep using the word supported accommodation, but it is only supported financially, there is no such thing as workers and guidance."

"In an ideal world, they should be some sort of plan where we are moving you to this cos you've just come out of prison or you were homeless, this is our plan with you over the next 6 months. We are going to do this in a phased way and if you meet these criteria we are going to do (next phase), there is none of that. So, you're asking people to fix multiple aspects of their life in one go. It is too much for anyone, no one can do that."

"It's important that we have more access to each other's services at the right level, so we know where one finishes and the next one starts."

6. What Works

Successful interventions save the public purse significant sums:
"The research identified three broad categories of experience in women with multiple needs using the women's centres[32], with varying levels of support need. The model shows that a successful intervention, costing between £1,151 and £2,302 per woman per year can save the public purse between £47,000 and £264,000 per woman over five years, depending upon the level of support needed" (Revolving Doors Agency, 2011).

Below is a compilation of best practice when working with people with complex needs based on available research literature and evaluation of local, national and international initiatives.

The National Institute for Health and Care Excellence (NICE) recommends that people with mental illness and substance misuse problems should not be excluded from secondary mental health services because of their substance misuse, and should have a coordinator to support with social care, housing, physical and mental health needs, as well as their substance misuse problems[33]. In addition, there is a need for effective identification, assessment, coordination and delivery of care for all people with a mental health problem in contact with the criminal justice system, including those on probation[34].

The Advisory Council on the Misuse of Drugs[35] provided advice to the government on the factors that make the homeless population vulnerable to substance misuse harms and how these risks can be reduced. It recommended that:
1. Housing policies, strategies and plans should specifically address the needs of people who use drugs and are experiencing homelessness.
2. Services at a local level must be tailored to meet the specific needs of substance users who are currently experiencing, or have recently experienced, homelessness. and need to consider people who are experiencing multiple and complex needs.
3. Substance use, mental health and homelessness services should use evidence-based approaches such as integrated and targeted services, outreach, and peer mentors to engage and retain homeless people in proven treatments, such as the opiate substitution treatment.

The guidelines above are incorporated into the Birmingham Homelessness Prevention Strategy and the commissioning strategies for substance misuse. Dual

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32 Centres or hubs where support was provided specifically to women experiencing complex needs that were subject of the study carried out by the Revolving Doors Agency in 2011 - Counting the Cost – Findings from women-specific Financial Analysis model.

33 National Institute for Health and Care Excellence (2016), Coexisting severe mental illness and substance misuse: community health and social care services. NICE guideline [NG58].

34 NICE (2017), Mental health of adults in contact with the criminal justice system guideline [NG66].

35 Advisory Council on the Misuse of Drugs (2019), Drug-related Harms in Homeless Populations.

diagnosis services have also been established, but there are still challenges to be addressed in order to ensure their full capability.

Research generated by the third sector organisations working with people with MCN focuses more on their individual experiences, best approaches to their recovery and transforming their complex lives. It sets out 10 principles for effective services[36]. They also reflect findings from many evaluations of national and local schemes, such as Anawim and Changing Futures Together.

Here are the 10 principles[37] for effective MCN services:
1. **'Someone on your side':** Opportunity to build consistent, positive and trusting relationships.
2. **Assertive and persistent approach** to engagement that does not give up on people. Continuous and consistent support over a prolonged period, responding positively and constructively to setbacks.
3. **Tailored support:** A personalised approach which addresses the full gambit of an individual's needs and is psychologically and culturally sensitive to particular needs of specific groups including women, people of black and minority ethnic backgrounds and young adults.
4. **Building on strengths:** Supporting the client to recognise and develop their personal strengths, recognising more than a 'bundle of needs and problems'.
5. **Coordinated and seamless support** that understands and links with other services, pulls services together around the client, helps clients to access and navigate support through brokerage and advocacy. It ensures continuous support across key transitions, avoiding gaps in care.
6. **Flexible and responsive approach** to support and an ability to react quickly in a crisis.
7. **'No wrong door':** If a service cannot provide support, they take responsibility for connecting the client with someone who can.
8. **Trauma informed environment:** Services understand the emotional and behavioural impact of traumatic childhood and life experiences on clients and vicarious trauma on staff, avoid re-traumatisation, facilitate reflective practice, build resilience and support recovery.
9. **Co-production:** Support designed in partnership with service users.
10. **Strategic support:** There is a buy-in of senior, strategic stakeholders and services are adequately resourced.

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36 These principles are based on a combination of desistance and recovery theory as well as Revolving Doors Agency research: Comprehensive Services for Complex Needs: A summary of the evidence, Adding Value? Reflections on payment by results for people with multiple complex needs.

37 http://www.russellwebster.com/10-principles-for-working-with-people-with-complex-needs/

Research on multiple complex needs is wide in scope and much of the published evidence comes from evaluations of specific interventions, or research around the benefits of prevention and early intervention. There are several approaches and models, which, through evaluation and review, seem to be showing positive results[38].

Prevention and early intervention

"Why should you have to get to the rock bottom before someone comes in? if they catch you then, then you won't hit there."
Focus group participant

"Effective early intervention works to prevent problems occurring, or to tackle them head-on when they do, before problems get worse. It also helps to foster a whole set of personal strengths and skills that prepare a child for adult life. We have a good understanding of the risk actors that can threaten children's development, limit future social and economic opportunities, and increase the likelihood of mental and physical health problems, criminal involvement, substance misuse, or exploitation or abuse in later life." (Early Intervention Foundation)

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38 Revolving Doors Agency (2015), Comprehensive services for complex needs: assessing the evidence for three approaches.

Figure 8: *Factors impacting on child's life*
Source: Early Intervention Foundation
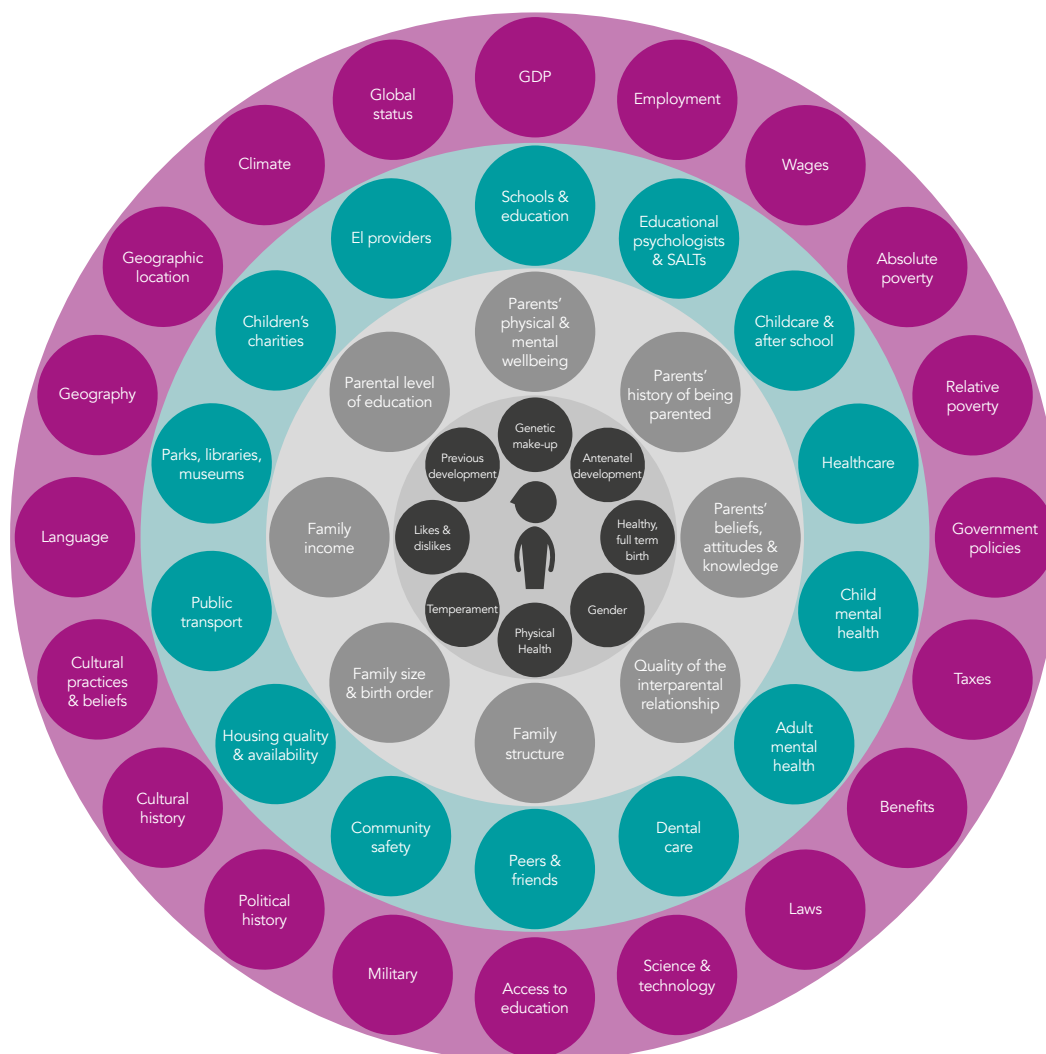
Source: Early Intervention Foundation

Adverse childhood experiences (ACEs) are an indicator of the child, if they are not helped, being at risk of developing multiple complex needs later in life. These risk factors cannot tell us exactly which child or young person will need help, but they can help us identify children who are vulnerable and who may need extra support. Studies show that early intervention works best when it is made available based on pre-identified risks. This links with Prof. Michael Marmot's Life Course approach to tackling health inequalities through prevention.

Figure 9: *Action across the life course model*

Source: Fair Society, Healthy Lives. The Marmot Review 2010

Areas of Action

Sustainable communities and places
Healthy standard of living

| Early Years | Skills Development | Employment and Work | Prevention |

Life Course

Accumulation of positive and negative effects on health and wellbeing

| Prenatal | Pre-School | School | Training | Employment | Retirement |
| Family Building |

Life course stages
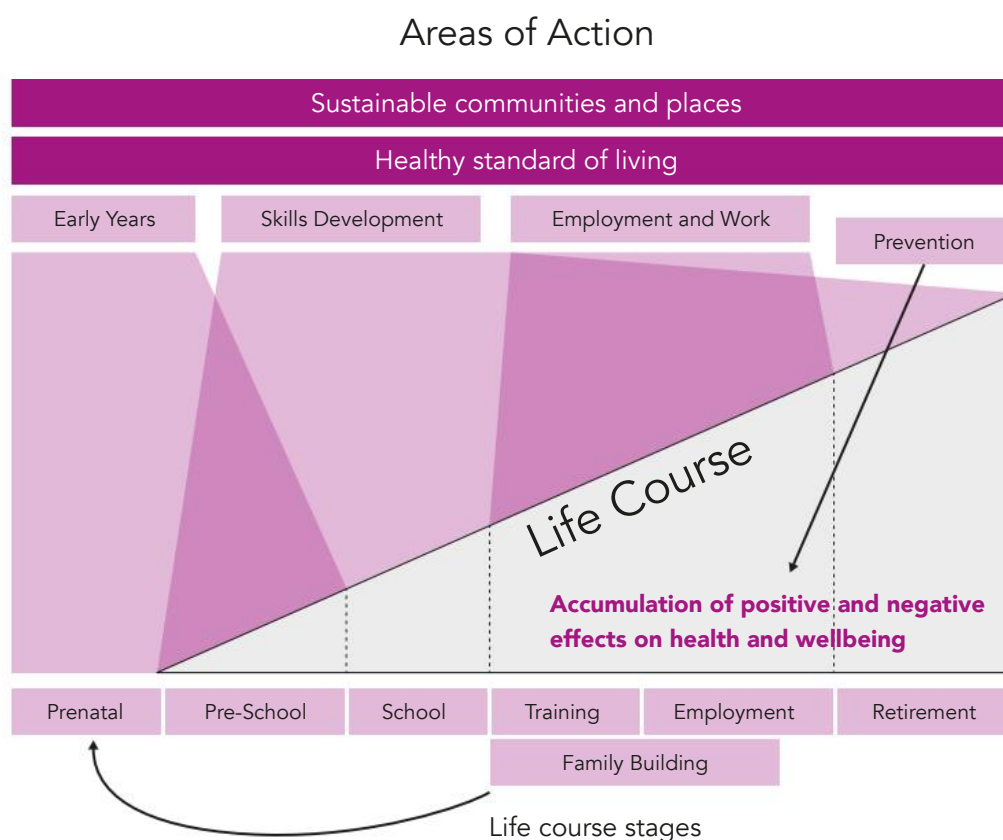
Social isolation is also one of the risk factors that may lead to the escalation of need and developing MCN. The new Marmot Review highlights the huge impact it has on people declining. In some cases, reduction of social isolation could prevent complex needs.

Not all complex needs can be prevented, but there are interventions and approaches that can be put in place to prevent their escalation and crisis. Those, for example, include:

- **Multisystemic Therapy**[39] - an intensive psychological treatment programme which takes place in the family home. Therapists work closely with young people and their families to address the different areas which influence behaviour.
- **Wraparound support**[40] - a process of co-ordinating professional and

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39 Revolving Doors Agency (2015), Comprehensive Services for Complex Needs: A summary of evidence.

40 Revolving Doors Agency (2015), Comprehensive Services for Complex Needs: A summary of evidence.

community-based support for young people, underpinned by a focus on family strengths and the 'voice and choice' of young people and their families.

- **Comprehensive leaving care plans and interventions** for young people, including life skills training and preparedness for independent living and adulthood, starting well in advance of leaving care. One of many such interventions is the House Project[41], but there are other opportunities much earlier on in the child's journey through care.

- **Support for veterans** experiencing complex needs, such as substance misuse, post-traumatic stress, family breakdown, right from the start of leaving service or medical care through fast-tracking into appropriate local support.

- **Planned prison releases** where a **coordinated plan and care** are established and available from the moment of release. For example, the Through the Gate Resettlement Service being provided by the probation service theoretically is such intervention, but we know from evaluations that not all service objectives are being met consistently across the country[42]. An improved model is being introduced by the Community Rehabilitation Company operating in Birmingham.

- **Planned hospital discharge** where a coordinated plan and care are in place and available from the moment of discharge. Birmingham's Adult Social Care commissioners are exploring a partnership pilot which includes a multi-disciplinary team delivering the service within the University Hospitals Birmingham (UHB), and there is a plan to replicate it within the Sandwell and West Birmingham NHS Trust in an attempt to ensure that nobody is discharged into homelessness.

Recovery and transformation

Many people with MCN struggle to recover and transform their lives through support from mainstream services. They may be excluded for disruptive behaviour or they do not meet the rigid and complicated thresholds for access. This means they often disengage and come into contact with the system at crisis point, and so repeatedly attend A&E or end up in custody. Many are repeatedly imprisoned for short periods of time; many are unable to sustain stable housing and end up homeless. Families with complex needs and a chaotic environment often have their children taken into care.

Here is a list of the interventions that have proved to be effective when it comes to

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41 https://thehouseproject.org/a-local-house-project/

42 https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2016/09/Through-the-Gate.pdf

recovery and transformation:

- **Lead or Link Workers and Service Navigators:** The model aims to provide support from a worker who helps people who are not receiving the support they need, through linking them in with services, providing advocacy and emotional support, providing consistency and stability. The evidence base is limited and largely from consultancy evaluations such as Fulfilling Lives and Revolving Doors and is for the most part qualitative. However, evaluations show promising results in terms of outcomes for service users such as reductions in hospital admissions and criminal behaviour.

- **Peer mentoring** is a form of mentorship between a person who has lived through a specific experience and a person who is relatively new to that experience. Peer mentors can be role models to show that change is possible. The peer mentor role also provides positive development and opportunity for the mentors themselves. Evidence behind the effectiveness of peer mentoring specifically for MCN is still emerging. This type of model has a Randomised Controlled Trial (RCT) evidence base in other support areas such as HIV, substance misuse and parenting. However, local evaluations show the value of this type of support in transforming people's lives and securing longer term outcomes.

- **Psychologically informed / trauma informed environments** are services where the day-to-day running has been designed around psychological theory or grounded in complete understanding of the effects of trauma exposure, considering the psychological and emotional needs of people with vulnerabilities and trauma history. There is an absence of RCT evidence, though findings from the Liverpool Wavers of Hope service indicate that their psychologically informed accommodation service had a much higher rate of successful move-on (93%) compared to general accommodation services.[43]

- **Housing First** is designed to help people who need a home, but also need extra help to address their complex needs. The model is intended to provide suitable housing solutions quickly to those in need and, crucially, is not conditional on abstinence from alcohol or drugs. There are established Housing First projects in North America and Scandinavia, but the model is relatively new in the UK and has been promoted by the Government through the national Rough Sleeping Strategy 2018. This approach has been quite successful abroad and there are several evaluations available to support this. The evidence in the UK is still limited, however, it is being reported that people in the Housing First intervention groups experience significantly fewer episodes of hospitalisation and shorter hospital stays, and are more likely to remain housed at 18-24 months compared to the rest of the population experiencing rough sleeping.

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43   Liverpool Waves of Hope (2017), Accommodation Based Service: Lessons from a Psychologically Informed Approach.

- **Coordination and integration:** The Making Every Adult Matter (MEAM) helps local areas design and deliver better coordinated services for people experiencing multiple disadvantage. The MEAM coalition supported three pilots in Cambridgeshire, Derby and Somerset in 2011 to coordinate and integrate the delivery of existing local services for people facing MCN and exclusions. Each pilot area employed a coordinator to engage with clients and ensure the best possible route through services, for example by helping clients to gain access to housing, treatment for substance misuse or mental health assessments in a timely manner that best works for the client to sustain their recovery. The findings 44 showed statistically significant improvements in wellbeing for nearly all clients across all quantitative measures45. Some of the associated costs to local services decreased in the first year of the pilot. Cambridgeshire saw a 31% reduction in crime costs. Other services experienced a temporary surge in usage as access to them had been enabled through the coordinators. The MEAM approach is currently being used by partnerships of statutory and voluntary agencies in 27 local areas in England. MEAM areas consider seven principles, which they adapt to local needs and circumstances.

Figure 10: *Seven principles of MEAM*

Source: meam.org.uk
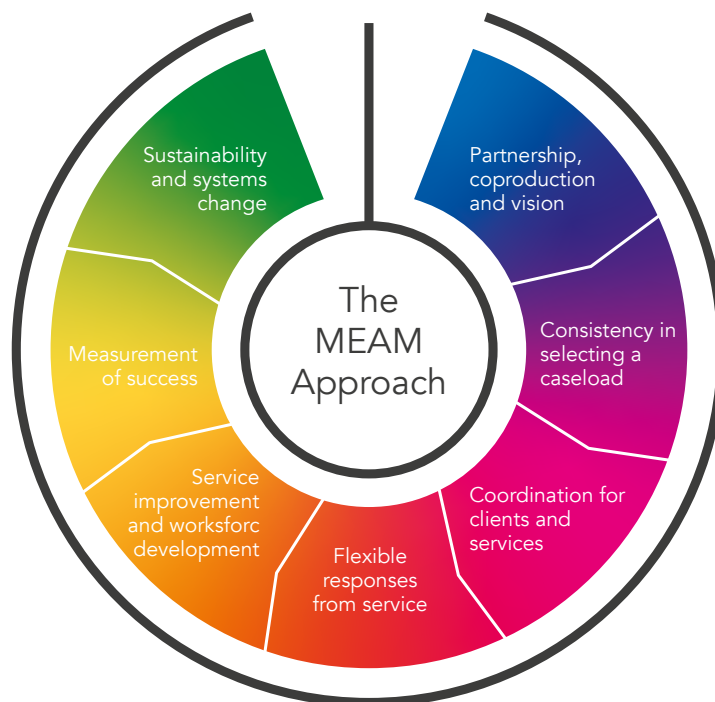
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44   Battrick, Hilbery, Holloway (2013), Findings from the Making Every Adult Matter (MEAM) service pilots: a summary paper. Advances in Dual Diagnosis. May 2013 17;6(2):66-75.).

45   The quantitative measures include the New Directions Team (NDT) Assessment, the Warwick-Edinburgh Mental Well-Being Scale and the Homelessness Outcomes Star.

- **Bespoke person-centred solutions:** Fulfilling Lives is a national £112 million investment over 8 years via the Big Lottery Community Fund supporting people who are experiencing some of the most entrenched complex needs. It funds voluntary sector-led partnerships in 12 areas of England, of which Birmingham's Changing Futures is one. They are working to provide person-centered and coordinated services for people with MCN, engaging individuals who are not currently engaged with services and are routinely excluded from other support. An independent evaluation of 12 of the Fulfilling Lives partnerships carried out by CFE Research and the University of Sheffield showed that up until the end of September 2017, almost 3,000 people had used the programme of which a large number were found to have at least three of the four needs (95%) and just over half (51%) had all four. Individuals who remained engaged with the programme for approximately two years showed a clear reduction in risk and need, though people with the most complex needs may require extended periods of engagement with services (12 months or more) in order to build trust[46].

- **A stepped approach to addressing complex needs** which locally has been used by Anawim, has proved to be effective when addressing MCN of women. It is based on the Maslow's theory of the Hierarchy of Needs[47] and demonstrates how safe and secure accommodation facilitates the process of engagement with services and that it is crucial before a woman is able to address her health and social needs[48]. We also know that being able to make own choices and being in control of our lives has a positive impact on recovery, so access to accommodation in itself may not lead to addressing MCN, but access to suitable accommodation of **choice** may be more helpful.

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46   CFE Research (2017), Fulfilling Lives: supporting people with multiple needs. Annual report 2017 - Key insights from the past year.

47   Maslow (1943), A Theory of Human Motivation, Psychological Review, Issue 50, p.370-396.

48   McDonald et al (2014), Women with Multiple Needs: Breaking the Cycle- Summary Report.

Figure 11: *Hierarchy of needs – women with MCN*

Source: Anawim

Education &
Employment

Family
reunification:
Return of children

Esteem:
Tackling low self-esteem,
abuse, sexual exploitation and
creating healthy relationships

Social:
Practical: finance, debt,
benefits & budgeting
Health: addiction, mental health,
self harm, PTSD

Safe and secure environment:
Providing accessible, appropriate,
safe and affordable accomodation
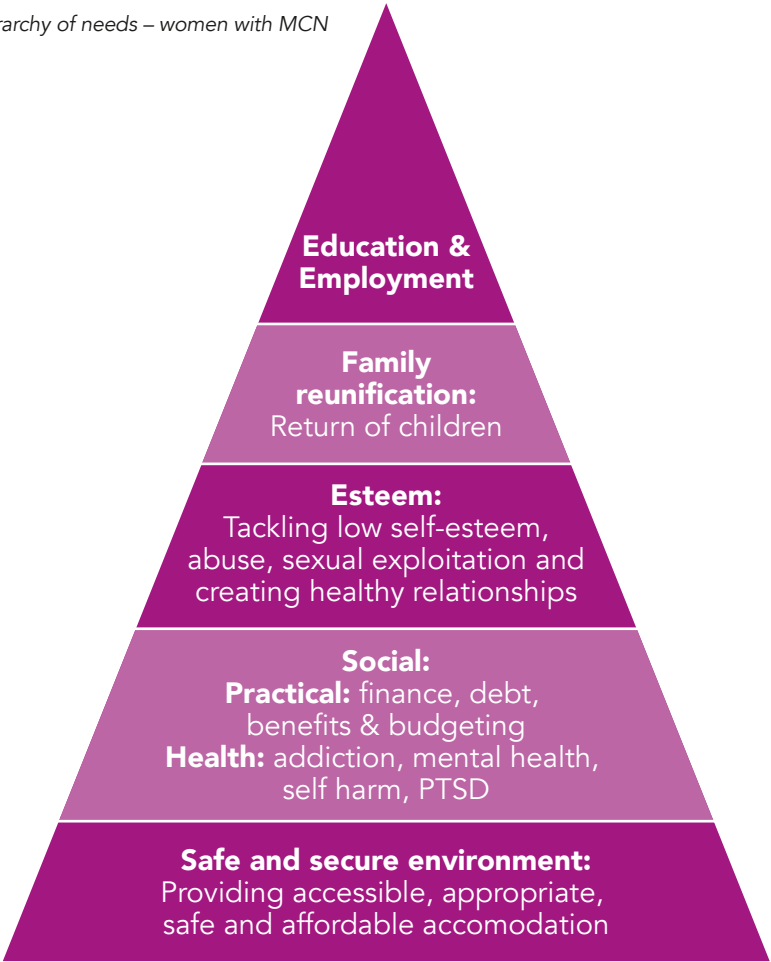
7. What's On Offer

7a. Local strategies and approaches

Below is a list of key local strategies and approaches developed to address specific complex needs of the most vulnerable residents of Birmingham. Those stem from, are linked to or complement the sub-regional and regional work being undertaken by:

- The West Midlands Combined Authority's Homelessness Taskforce
- The West Midlands Combined Authority's Public Sector Reform Board
- The Birmingham and Solihull Sustainability and Transformation Partnership
- The Black Country and West Birmingham Sustainability and Transformation Partnership and other.

Birmingham Homelessness Prevention Strategy 2017+

This multi-sector cross-agency strategy focuses on preventing people from becoming homeless in the first place and supporting those who are homeless to build a more positive future in good health, sustainable accommodation and long-lasting employment. It aims to do so by implementing a robust pathway from prevention, through early intervention to recovery.

BIRMINGHAM

Homelessness Prevention Strategy 2017+

Working together to end homelessness

Making a positive difference everyday to people's lives

Birmingham City Council

Figure 12: *The Positive Pathway*

Source: Birmingham Homelessness Prevention Strategy 2017+
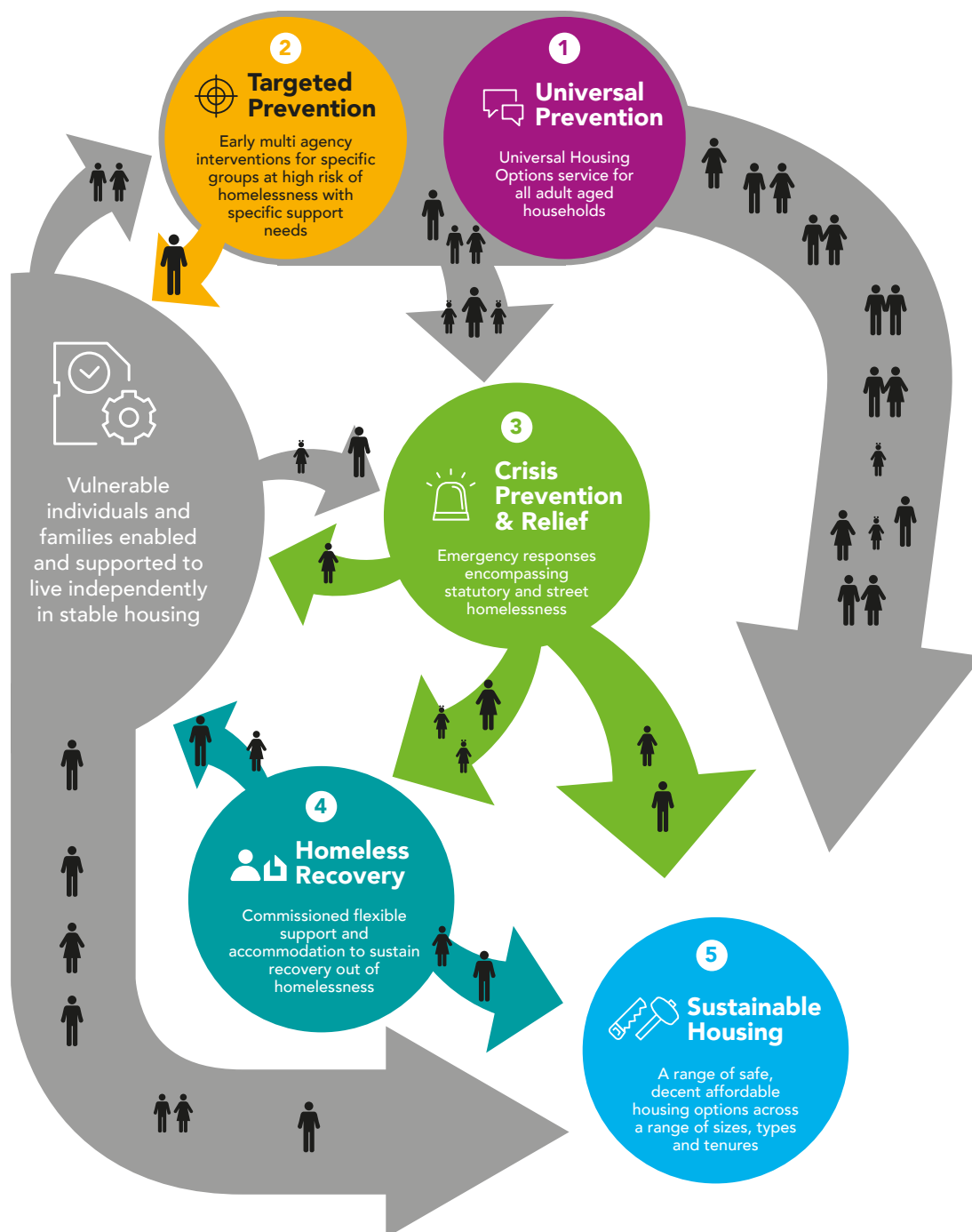
Birmingham Domestic Abuse Prevention Strategy 2018-2023

In 2017 domestic abuse was the second highest reason for homelessness in Birmingham. Whilst 90% of victims who applied for housing as homeless were accepted, only 32% of women and children seeking refuge in an emergency were able to access accommodation. The impact of domestic abuse on the mental health of victims, including children, is severe. Dealing emotionally with the abuse and trauma they have experienced often results in depression, anxiety and post-traumatic stress disorders. Women experiencing significant domestic abuse are more than twice as likely to have an alcohol problem and eight times more likely to be drug dependent than others. Children being exposed to or witnessing domestic abuse experience it, too. So, they too need appropriate support to prevent them developing MCN in the future.

For perpetrators of domestic abuse that are held accountable through the justice system, the resulting impacts can be of the breakdown of family connections and diminishing of wider community networks as well as the ending of relationships and loss of a place to live in. These in combination can result in a spiralling complexity of health, financial and social decline and disadvantage; leading to multiple complex needs, i.e. poor mental and physical health, having no fixed abode, rough sleeping.

Therefore, the Birmingham Domestic Abuse Prevention Strategy focuses on adults (predominantly women), children and young people experiencing domestic abuse, children that are exposed to or witness domestic abuse as well as domestic abuse perpetrators. It outlines a layered prevention model and three key priorities.

Figure 13: *Domestic Abuse Prevention Model*

Source: Birmingham Domestic Abuse Prevention Strategy 2018-2023
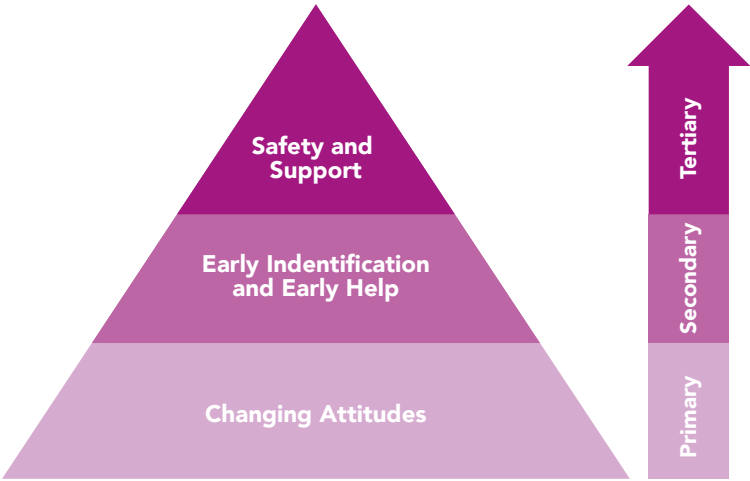
Birmingham Armed Forces Community Covenant

In Birmingham there are an estimated 93,000[49] veterans, many of whom are at risk or experiencing MCN, including mental health issues which are often associated with service-related trauma and may lead to substance misuse and homelessness.

The Council and many partner organisations are signatories to the Armed Forces Community Covenant, which sets out a commitment to support veterans and presents an opportunity to specifically focus on complex issues affecting their lives.

It is important to note that very few ex armed forces personnel in Birmingham are amongst the known service users with MCN. Also, service user experience suggests that many of the existing support agencies for veterans struggle to deal with MCN and the support available focuses mainly on immediate discharge form service.

Creating a Mentally Healthy City

The Birmingham Health and Wellbeing Board created a sub-forum that focuses specifically on mental health and wellbeing. The forum is a partnership of strategic stakeholders who are committed to making Birmingham a mentally healthy city.

There is ongoing work to improve access to mental health services for the most vulnerable and disadvantaged groups through the Joint Strategic Needs Assessment (JSNA) work and our recent Suicide Prevention Strategy as well as emerging work towards addressing health inequalities through the health and wellbeing board's Creating a City without Inequalities Forum.

There is a commitment to develop a comprehensive public health approach to measure our achievement in reaching disadvantaged and vulnerable people and effectiveness of our work with these communities, which include Black and Minority Ethnic groups, migrant groups, people who identify as Lesbian, Gay, Bisexual or Transgender (LGBT) and people that are homeless.

Birmingham Suicide Prevention Strategy 2019-2024

The Birmingham Suicide Prevention Strategy sets out priorities for action and a shared ambition for the city to reduce deaths through suicide as part of our wider ambition to become a mentally healthy city.

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49 2011 Census estimate (ONS).

Individuals experiencing MCN are at a higher risk of suicide. Preventing or tackling MCN leads to preventing suicide deaths.

MARITAL BREAK DOWN

12.5% of adults are living in single person households (2011)

LOW HAPPINESS SCORE

8.8% of adults have a low happines score

4.2% report a low level of life satisfaction

19.0% report a high anxiety score

(2017/18)

CRIME & VIOLENCE

6.4 young people (10-18yrs) per 1,000 in the youth justice system

24.2 domestic abuse-related crimes and incidents per 1,000 adults recorded by the police

(2017/18)

SEVERE MENTAL ILLNESS

1.19% of GP patients have a severe mental health illness (2017/18)

HOMELESSNESS

4.7 households per 1,000 households in Birmingham are in temporary accomodation (17/18)

MARITAL BREAK DOWN

10.7% of adults are divorced or separated (2011)

Source: Public Health England Suicide Fingertips Tool

7b. Local services

There is a wide range of services, statutory and non-statutory, available in Birmingham for those experiencing complex needs. Most of them focus on intervention and recovery through a series of carefully designed criteria and pathways.

This report highlights the main provision and acknowledges that the list is not exhaustive.

Prevention and early intervention

There are several universal and early intervention services being commissioned by Birmingham Public Health and the Children's Trust that aim to prevent and tackle the early indicators of complex needs in children and young people. The key services are:

- Health visiting and early years provision
- School health and wellbeing service
- Early help and family support.

Birmingham's **Think Family Strategy**[50] complements and provides a response to families with additional needs captured within the **Right Help, Right Time** framework and the **Strategy for Early Help in Birmingham 2019-2022**[51] adopted by the Birmingham Safeguarding Children Partnership.

The family support service trained a number of staff in the **Adverse Childhood Experiences (ACE) recovery toolkit** and the Children's Trust now deliver the toolkit citywide to parents and children. The Trust are also looking to implement trauma-Informed approaches and are exploring what this may look like operationally in line with their **Relationship-based practice** model.

There are other services in the city (e.g. Birmingham and Solihull Mental Health Foundation NHS Trust, Women's Aid) that already use such approaches which may also be known as **Psychologically Informed Environment** (PIE) models. Others (e.g. Housing) are working towards their implementation.

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50 https://www.birminghamchildrenstrust.co.uk/info/4/information_for_families_and_carers/60/additional_help_for_families_think_family

51 http://www.lscpbirmingham.org.uk/early-help

Homelessness

Birmingham City Council commissions a variety of services for rough sleepers as part of its new **Street Intervention** model which, since recently, is coordinated by the Trident Reach outreach service.

Figure 14: Street Outreach Service Model

Source: Birmingham City Council

Intervention Model: Rough Sleeping Services
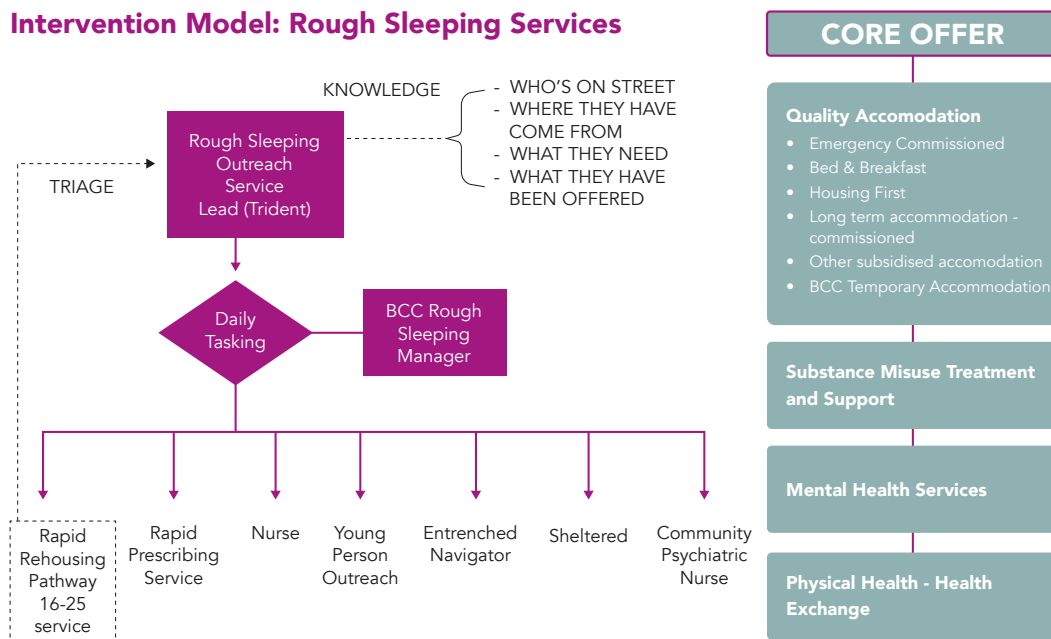
Referral Routes: Hubs

Referral Sources
Self, Voluntary & Community Sector, Health, & Statutory Agencies

Referral

HOUSING AND WELLBEING HUB SUPPORT SERVICE

Referral Routes: Lead Worker

Employment & Training Needs

Substance Misuse Services

Housing Needs

Health Needs

Mental Health Needs

Vulnerable Clients with needs

Support Needs

Referral Sources
Statutory housing options service, Vulnerable Adults Team & other agreed referral agencies (all sectors)

LEAD WORKER SUPPORT SERVICE

The partner organisations meet regularly and decide on user centred approaches that can include single and joint contact, depending on level and complexity of presenting need. **The Housing First** service accepts referrals from the Street Intervention service and provides a named system navigator for those who require more intense support and are known to be rough sleepers or at risk of becoming

a rough sleeper. Housing First **i**nitiative has been funded since 2018 via a £9.6 million central government's grant and represents a new in the UK approach to addressing homelessness with Birmingham being one of the first cities in the West Midlands to trial this service over 3 years. It relies on joint working between the council, housing associations, private rented sector and a variety of support groups to help rough sleepers to break the cycle of decline and multiple deprivation that has led them to living on the streets. It starts by putting homeless people into a home before building a support network around them. Housing First provides wraparound support for the multiple needs of the persons referred and this support continues even if they are rehoused.

In terms of the substance misuse offer, the interface with CGL supports persons who are rough sleeping, those in homeless hostels as well as their ongoing community-based treatment, should they find accommodation. Working in partnership with the BVSC, CGL also offer rapid on street opiate substitute prescribing as part of the national Rough Sleeping Initiative[52].

Health Xchange is Birmingham and Solihull Mental Health Foundation Trust's primary care service specifically for the homeless population. They offer a full general practice service to those who are homeless or vulnerably housed aged 16 and over and not pregnant. As well as GP access, nurse prescribing drop-ins and nurse clinics are provided offering a range of services, i.e. sexual health, screening, chronic illness support, blood and HIV testing. A counselling service is also provided by community psychiatric nurses who triage a person's mental health problems and will refer to secondary services where appropriate.

Mental health

The Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) provides a range of community based, day, inpatient and specialist mental health services.

The **Community Mental Health Team** provide a statutory mental health NHS service in Birmingham and Solihull for people who are homeless and experiencing mental health problems. The service includes assessment and treatment of mental health problems, management of complex psychological and social needs, risk assessment, community nursing support, physical health monitoring, social assessment, access to vocational training and occupational activity and resettlement advice. It is a city-wide service and see people with mental health problems that are sleeping rough, living in squats, hostels or otherwise homeless. This includes patients that are not registered with a GP.

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52 https://www.gov.uk/government/news/boost-to-successful-government-rough-sleeping-programme

In January 2020, a new **Street Psychology** service was commissioned for five years to explicitly support homeless persons sleeping rough who experience mental health issues. They undertake street-based assessments and link rough sleepers with appropriate services, and in any instance where the persons are housed, there is a handover to the Community Mental Health Team to ensure continuity of care.

The **NHS Veterans' Mental Health Complex Treatment Service** (VMH CTS) is a specialist community mental health service for armed forces veterans. It is for those experiencing complex mental illness related to their time in the military and to help veterans regardless of when they left the armed forces.

BSMHFT also provides low and medium secure mental health services for adults, as well as forensic services for children and young people, addictions services and dual diagnosis.

Substance Misuse

Change Grow Live (CGL) supports all persons with substance misuse issues over the age of 18 through a variety of services.

CGL's core approach to working alongside vulnerable people includes delivering treatment and recovery actions that integrate with the city's wider multi-agency approach to tackling substance misuse and commonly associated conditions, such as homelessness and mental health.

The **CGL homeless offer** was rated as an outstanding area of practice by the Care Quality Commission in April 2019 and is delivered in partnership with the Street Intervention Model and incorporates the agreed protocol for the mental health co-provision, as detailed below.

In terms of offenders, CGL work to the requirements of the Probation National Standards in order to provide **drug rehabilitation** and **alcohol treatment** requirements where these are set out as terms of probation. Such work is undertaken in partnership with probation service providers and the Integrated Offender Management system to identify and work with offenders including those categorised as PPOs (prolific and priority offenders).

Dual diagnosis approach

CGL has an agreed protocol with Birmingham Solihull Mental Health Trust that details the treatment pathway for those with co-existing mental health and substance misuse problems. When a referral received fits the pathway criteria

then a joint assessment should be completed within one week, and a care plan co-produced with input from the service user that includes details of all relevant partner agencies.

Offending

In addition to the interfaces laid out above as well as other provision available through the **Vulnerable Adults Housing and Wellbeing Support**, there is number of hubs across the city, including one specifically focused on ex-offenders. The other hubs are focused on young people aged between 18 and 24, single adults, childless couples and victims of domestic abuse.

The work of all these hubs is likely to bring them into contact and provide services to persons with MCN. They concentrate on coordinating and networking services in a person-centred manner by providing a named lead worker to facilitate such multi-agency working for a period of two years. This is especially relevant in terms of ex-offenders with MCN, as they can have up to five appointments in the first day of being released from prison with the aim to avoid re-incarceration, aid reintegration into society, and speed up recovery.

Voluntary sector

<u>**BVSC: Birmingham Changing Futures Together**</u> is one of twelve Fulfilling Lives sites across the country supporting people with MCN. The National Lottery Community Fund has invested £9,950,000 in this Birmingham project, which started in June 2014.

At the heart of the project is a strong focus on working in partnership with "experts by experience". The project aims to improve the collaboration and integration of agencies to improve the service user journey, striving to ensure:
- Seamless and integrated services through better signposting and referral pathways
- Earlier identification and diagnosis of complex needs to ensure a response is triggered sooner
- Tracking and monitoring of progress and outcomes
- Data sharing between providers so that service users are not repeatedly required to "tell their story"
- Intensive and more 'guided' support for service users
- Support and guidance to partner agencies
- Co-production with service users in service design and system change.

It has several workstreams ranging from a *Virtual Hub* that provides information, data and expertise to the programme and specific streams of work:

- *Lead Workers and Peer Mentors* helping people with MCN to navigate services to access appropriate recovery and support,
- *No Wrong Door* ensuring collaborative working through a network of organisations, so that individuals can easily access help
- *Every Step of the Way –* a co-design initiative ensuring service users are involved and integral towards developing and monitoring the programme
- *Intelligent Common Assessment Tool (iCAT)* – a system which enables sharing information and records between agencies
- *Improved Outreach/ In- reach and Beyond the Basics* support towards connections with friendship groups for building resilience and sustaining recovery, and ultimately breaking the cycle of intense service use.

The programme promotes practice and training that is guided by the Psychologically Informed Environments approach**.**

Anawim, based in Birmingham, provides a holistic service through caseworker and criminal justice solutions to women with MCN aged over 18 and their children, and anyone that identifies as a woman resident in Birmingham. Their work aims to:

- Increase self-worth and keep families together (where appropriate)
- Empower each woman and child towards independence, regular employment and dignity
- Raise each woman's self-awareness, trust and responsibility towards herself, her children and the wider community
- Ensure the wider community are better informed about issues affecting this client group.

Anawim work with other agencies specifically supporting those vulnerable to exploitation including prostitution and substance misuse. They support women who may have offended and those vulnerable to crime as well as victims of domestic violence. They offer intervention, support, rehabilitation, prison in-reach, drop-ins and outreach in the community, including to homeless women and street workers.

Shelter is a national charity that helps people struggling with inappropriate housing or homelessness through advice, support and legal services. They offer face to face and online advice, legal support and a national helpline.

SIFA Fireside is a charity enabling homeless and vulnerable people to take control towards achieving healthier, fulfilling lives. They work to provide inclusion,

engagement and equal access to services for people that are disadvantaged or experiencing homelessness, aiming to reduce homelessness and offending, increase social inclusion and life skills, improving health and employment potential.

Partnership agencies work alongside SIFA to provide health and wellbeing services to clients. The access point for all services is their Drop-in Centre. They also deliver the Adult Support Hub aimed at early intervention for individuals with multiple needs living in precarious housing.

St. Basil's works with young people to enable them to find and keep a home, grow their confidence, develop skills, increase opportunities and prevent homelessness.

They aim to:
- Meet the needs and raise the aspirations of young people through provision of good quality accommodation
- Support services to meet the diverse needs of young people and prevent homelessness
- Ensure young people are involved in setting standards, identifying priorities and monitoring services
- Challenge discrimination and promote diversity and cohesion through employment, service delivery and community engagement.

Birmingham Mind is part of a national mental health charity providing services in and beyond Birmingham's boundaries, increasing service provision to those most affected by poor mental health as well as increasing preventative and community-based services.

Other services and initiatives
The PURE (Placing Vulnerable Urban Residents into Employment) project is part-funded by the European Social Fund and delivered by Birmingham City Council's Adult Social Care. It brings together a range of coordinated interventions which assist citizens with complex needs experiencing barriers with access to employment. The project participants gain an intensive level of support to address their needs to be able to access either employment or training.
The Preventing Crisis Project is an initiative developed and delivered by Birmingham City Council and voluntary sector partners, including ASIRT, Refugee and Migrant Centre and Central England Law Centre. It works with organisations supporting individuals with MCN, such as Women's Aid and SIFA to provide them with legal, immigration and welfare advice.

8. Gaps And Barriers
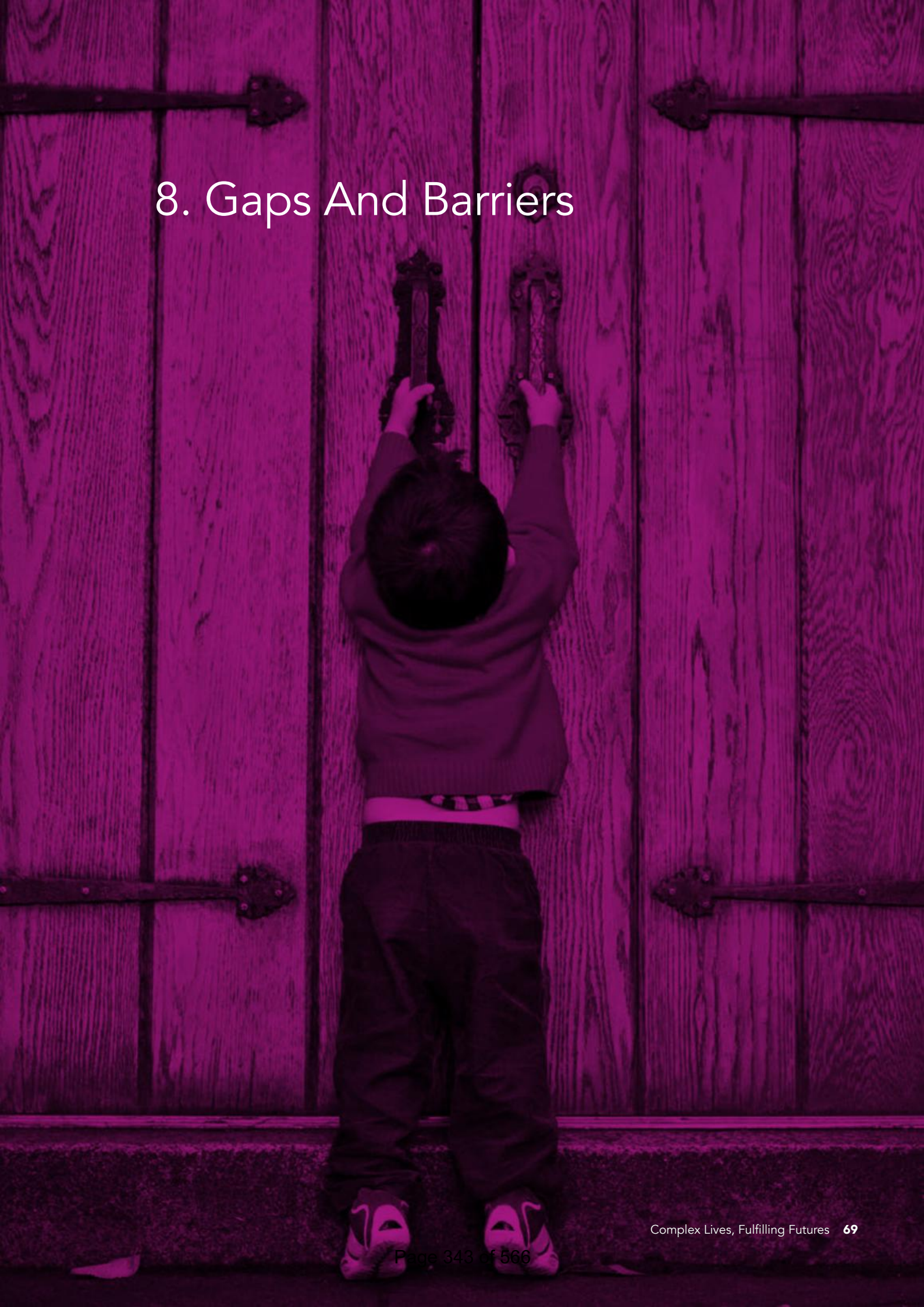
8a. Lived experience perspective

> "I just think if I knocked on the door of services and I just said I had two kids and a disability I would get more."
>
> *(Focus group participant with MCN)*

The research that was conducted to underpin this report through a series of focus groups and a rapid ethnography suggests that **not having dependents poses a significant barrier** to accessing the right services at the right time. Not having dependents and **being in a relationship** can further hinder the opportunity to receive support.

Through past experiences, many individuals with complex needs are unable to manage relationships whether at a family, personal level or with professionals. This affects engagement as well as coping mechanisms. The peer mentors from one of the focus groups reported that most people they see are single, though a small minority are in unhealthy relationships, and confirmed that it is easier for the single people to get support.

> "I think it's actually easier for a single person to get help. Because they are only focusing on themselves. We see it so often, people… if you looked at like growing up, they are just looking for a fix. They are just looking for somebody to validate them."
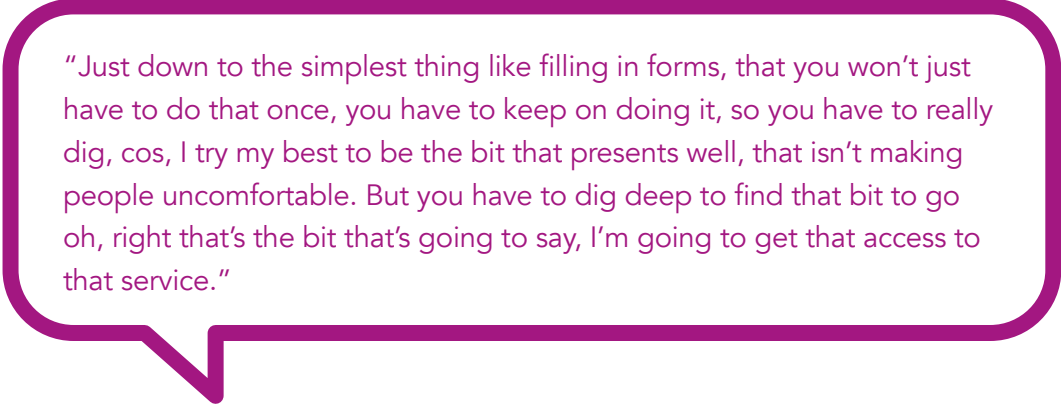
Substance misuse was discussed a major complicating factor in accessing services such as mental health assessments or accommodation.

> "So, it's like a vicious cycle, it's like trying to get accommodation but you also need to get quick to get them straight into other services to get them on scripts, to get their mental health looked at. They can't, you can't, treat mental health when there is substance misuse happening."

In addition, **substance misuse treatment was considered too limited** in terms of capacity and a scope of substances, with perceived absence of a pathway for new psychoactive substances which are a big problem.
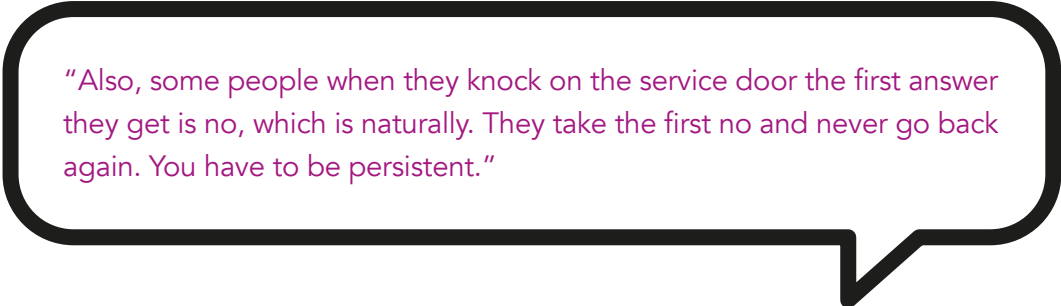
Most experiences that were shared with us were around how difficult it is to access services due to **lack of IT skills** as well as the **high thresholds, rigidity of eligibility and complicated pathways into services** posing a significant barrier. The service users felt that they have to repeatedly expose the worst and most painful parts of themselves in order to be considered for support, which in itself can make them more vulnerable.

"Just down to the simplest thing like filling in forms, that you won't just have to do that once, you have to keep on doing it, so you have to really dig, cos, I try my best to be the bit that presents well, that isn't making people uncomfortable. But you have to dig deep to find that bit to go oh, right that's the bit that's going to say, I'm going to get that access to that service."
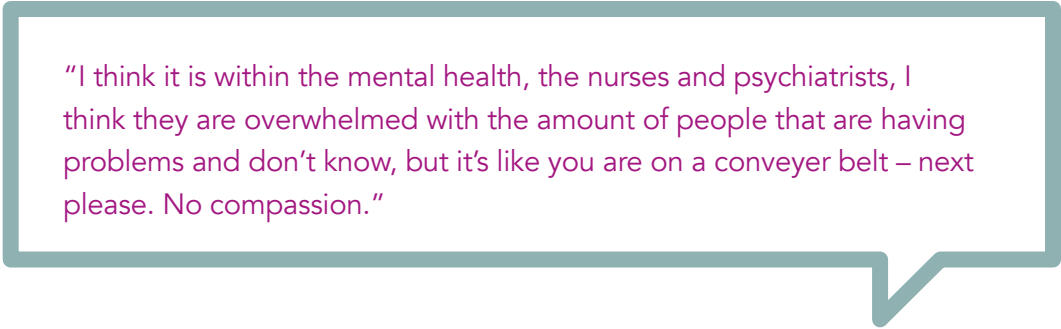
"One barrier is lack of awareness, lack of knowledge. Some people don't know how to get, to go on the internet and navigate the web to find services necessarily. You have to be quite savvy to do that."

Additionally, comments were made that the services themselves can discourage people from engaging, even where there is a valid need for support.

"Also, some people when they knock on the service door the first answer they get is no, which is naturally. They take the first no and never go back again. You have to be persistent."
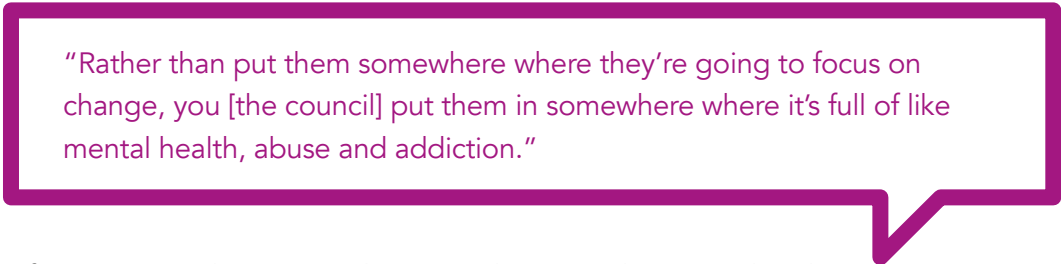
The theme of humanity (or lack thereof) in persons delivering services was revisited, and a perceived lack of care from professionals. It was apparent that the group took this quite personally and felt that improvements in this were important but also difficult to achieve. There was some concession made that **the burden of need on services** was driving this due to **professionals being under pressure** to deliver quick services, and the resultant sacrifice of quality of service.

> "I think it is within the mental health, the nurses and psychiatrists, I think they are overwhelmed with the amount of people that are having problems and don't know, but it's like you are on a conveyer belt – next please. No compassion."
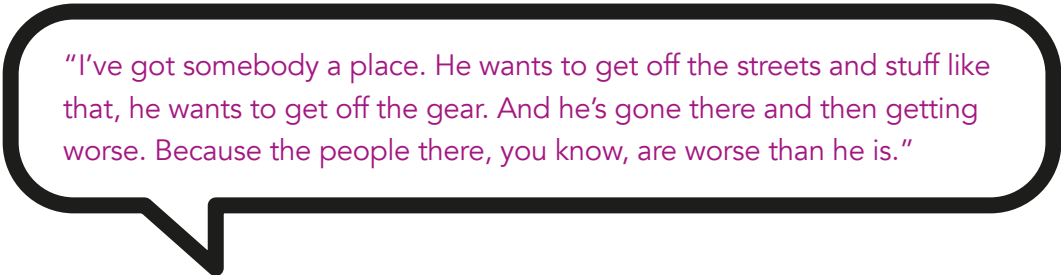
The **waiting times and time limited aspect of mental health services** was criticised as those waiting for services can sometimes deteriorate, and those within services are sometimes not fully recovered when treatment ends.

It would be fair to say that one of the gaps and barriers that the focus groups' participants felt most passionately about was **the suitability of temporary supported accommodation**. While it was viewed as relatively straightforward to find someone somewhere to stay, specific criticism was pointed at the non-commissioned exempt supported housing sector viewed as inappropriate and unsafe, as not regulated or monitored in terms of standards. It was stressed that people often feel safer in the streets rather than in that accommodation.

> "Rather than put them somewhere where they're going to focus on change, you [the council] put them in somewhere where it's full of like mental health, abuse and addiction."

Often supported accommodation can be more detrimental and was seen as wasted money when alternative types of support would be better.

> "I've got somebody a place. He wants to get off the streets and stuff like that, he wants to get off the gear. And he's gone there and then getting worse. Because the people there, you know, are worse than he is."

"The city council are spending millions and it's all wasted. They could be putting it into another service that actually helps."

The evaluation of the service user experience conducted by the Changing Futures Together programme confirms that majority of those who reported trying access

support (housing and rehabilitation) complained that **short term /temporary accommodation put them at risk** and or led to relapse. Many did not re-engage with specific services if they had a poor experience.

All of the above can lead to another frequently fed back barrier to engagement with services and support: **mistrust of services**.

"A lot of people, they don't trust services. I didn't trust services, I wanted to do everything on my own. So yeah. But I think on the plus side if you do keep an open mind the support is there.'

8b. Service perspective
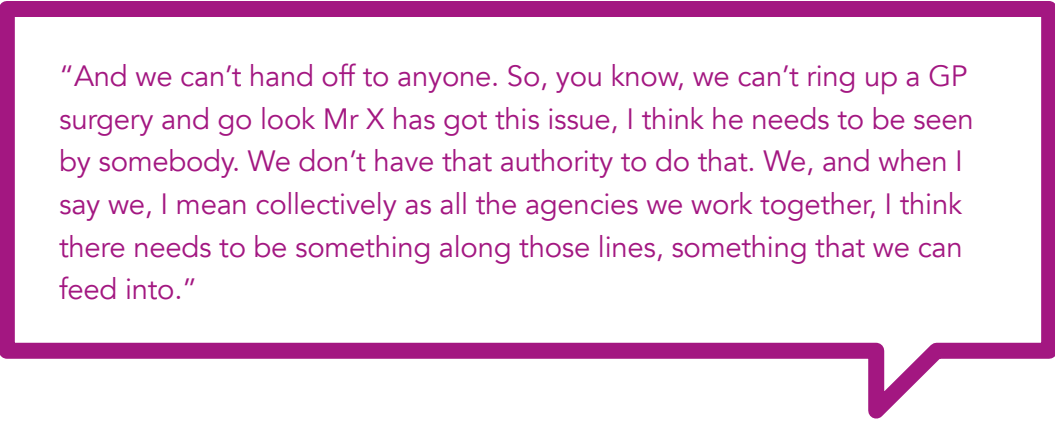
Our research suggests that professionals view lack of services and specifically those services concerned with **financial support,** creating or exacerbating other pre-existing conditions and pushing people to crisis point.

"And when universal credit came in, that's what it did to them. It threw money at them and left them out there. And now they are in crisis, they are coming back for help but there are not that many places we can send them for help cos everywhere is shutting down, closing down."

Other issues seemed to be centred on there being a **lack of coordinated or integrated services** or the **inappropriateness of services relative to the needs** of clients. There were barriers identified in reference to being unable to refer on behalf of clients and a **lack of a feedback mechanism or information sharing** around services that are suggested to clients.
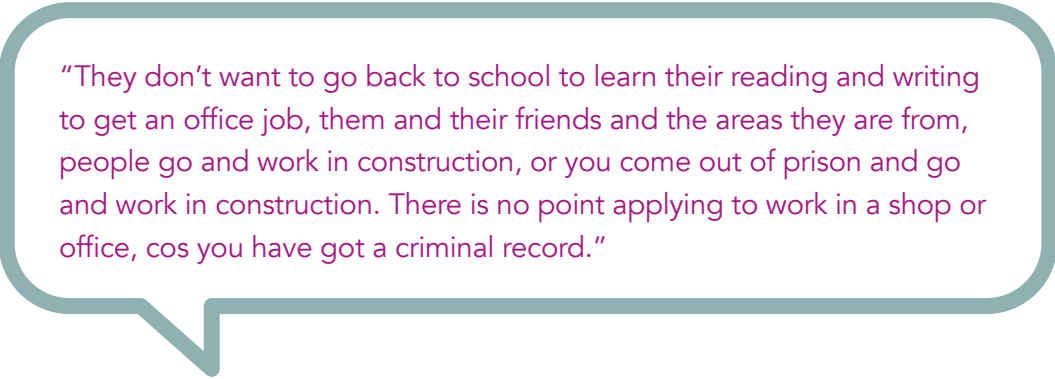
"Everyone is so scared of GDPR."

"What you are saying is you get people at crisis point, whether they are suicidal, and you get people who have some mental health and anxiety issues who could do with some support and they are either one or two. But where is the middle?"

"And we can't hand off to anyone. So, you know, we can't ring up a GP surgery and go look Mr X has got this issue, I think he needs to be seen by somebody. We don't have that authority to do that. We, and when I say we, I mean collectively as all the agencies we work together, I think there needs to be something along those lines, something that we can feed into."

There were concerns that **lack of education and skills** within the client group meant they were unable to access some of the support services available or seek employment in a meaningful way. It was felt that clients would potentially not be receptive to training if it were made available, mostly due to peer groups and employer **attitudes towards criminal history**.

"They don't want to go back to school to learn their reading and writing to get an office job, them and their friends and the areas they are from, people go and work in construction, or you come out of prison and go and work in construction. There is no point applying to work in a shop or office, cos you have got a criminal record."

Two particular client groups were perceived as being failed by the current systems more than others; **ex-offenders** and more specifically **those subject to multi-agency public protection arrangements** (MAPPAs) to ensure the successful management of violent and sexual offenders. It was highlighted that these persons are often vulnerable and likely to have been a victim of similar offences themselves but are only treated as perpetrators often experiencing a limited access to appropriate support and services.

"So this is customers, yeah the MAPPAs, where they have had, you know they have restrictions placed on them for whatever – it tends to be sex offenders and things like that but you know, they automatically get, you know, if that is one of those customers they get exited from our programme- they can't be sent to things, they can't do, because of those restrictions…. They are just as vulnerable as everybody else, as it has been proven 9 times out of 10 that if they have done it, it's happened to them at some point and things like that."

Particular problems were highlighted with the **need for self-advocacy** (which some clients struggle with), **continuity of contact with named persons** within services**,** and **communication between services.**

"People establishing a good rapport with a probation officer but then because of circumstances leaving prison and being put in touch with probation in another area, which staggers the appointments – you lose the contact, you lose the continuity."

Practitioners we spoke to also mentioned the risk that **No Recourse to Public Funds** (NRPF) poses when it comes to developing MCN and how it may hinder their recovery and transformation. Although the study that underpins this report did not come into a direct contact with individuals with NRPF, we are aware through reports from a range of services that there are perceived significant **gaps in understanding the eligibility** for support and stressed the importance of free and competent legal advice to enable access to appropriate level of support.

9. A Case For Change

People with multiple complex needs (MCN) often suffer from physical and mental health problems, unemployment, family breakdown and exclusion. These are the common symptoms of MCN, but the pathways that lead to developing those needs are unique to each person. It is important to recognise the number and range of services and innovative approaches serving the most vulnerable citizens in Birmingham. In fact, the scale of the statutory and non-statutory provision landscape is significant. However, current services are organised to respond to the common symptoms well, but they are not flexible enough to adapt and support the complex needs and unique journeys of vulnerable people, leading to unfulfilled lives and high service and social costs. Finding a balance between equity and equality is not easy.

We know that problems of MCN start young and require early intervention. By the time we start identifying, assessing and planning interventions we are often years too late increasing significantly the cost to society and economy.

As the cost of late intervention increases, there is less chance for a positive outcome. Extrapolated across Birmingham and Solihull, a total of over £127 million is spent per annum on services for people with at least two needs out of homelessness, offending and substance misuse. There is a high overlap between people in this cohort and those who are unemployed; only about 6% of those with three complex needs are currently employed (60% are unemployed).

As can be seen from the stories of Bee and Dion as well as our focus groups' participants, the diversity of organisations required to support people with MCN may work in separate divisions, but people do not. Dealing with mental health issues, substance misuse, homelessness and offending involves contact through numerous different departments and teams. These can collectively contribute and represent the daily trials and tribulations of one person with several needs. When services are not working together effectively to provide a wraparound care, people just slip through the cracks and organisations are then perceived to be out of touch with the real complexity of people's lives.

The data, research and feedback from those affected by MCN tell us that much more can and should be done to improve the life chances of children and young people in Birmingham and help those already experiencing crisis to transform their lives. This is with a full acknowledgement that Birmingham has already built solid foundations and public services are working in times of financial constraint. When working well and in true collaboration, they are able to serve as a pillar and a guide, removing barriers and bridging many gaps.

10. Working Together

This report has highlighted many examples of good practice and collaboration when it comes to tackling some of the most complex needs and inequalities in Birmingham. But there are still significant gaps and as a City Partnership, working alongside the national policy and locally with the health and wellbeing board, safeguarding children and adults partnerships and the Housing Birmingham board, we have the potential to do more.

I. Through genuine commitment to work together we can develop:

1. A clear offer of support that is evidence based, coherent, cost-effective and sustainable; this includes an offer of safe and suitable supported accommodation;
2. A system that is prevention and early intervention driven through understanding where the critical intervention points are and acting upon them quickly;
3. Recovery and transformation mainstream support that is timely and flexible enough to meet the unique support needs of individuals with complex lives, where they can build on their strengths in an environment of trust and do not experience any unintended consequences of the rigidity of the system;
4. A coordinated approach to the management and delivery of multiagency support and robust information recording and sharing to ensure a seamless provision without duplication and delay.

II. We must ensure that:

1. Support is person centred, trauma informed, culturally sensitive and accessible to all when it is needed most;
2. Support is holistic and MCN are not approached in isolation from key risk factors such as adverse childhood experiences and poverty;
3. Activity of all front-line professionals working with people with MCN is underpinned by the principles of Making Every Contact Count (MECC) and Making Every Adult Matter (MEAM);
4. We share best practice and learn from individuals with lived experience of MCN and design services together.

III. To enable change, system leaders are asked to:

1. Endorse the principles of the MEAM approach across the health and care system in Birmingham;
2. Consider MCN in partner work programmes to develop a shared understanding and ownership of the problems with the current system and a

clear vision and action for change;

3. Provide strategic support to develop integrated data sharing and intelligence around those who have MCN that cuts across organisational boundaries;

4. Support a sustainable system and culture change that will enable a greater flexibility and better coordination of services for those with multiple complex needs and create more opportunities for prevention and early intervention;

5. Influence partner organisations to ensure their commitment, shared responsibility and accountability.

By working together with energy and purpose, we can influence change across the system for people like **Bee** and **Dion**, to support and empower them and many others in our city to build fulfilling futures.

ACKNOWLEDGEMENTS

GLOSSARY

Adverse Childhood Experiences (ACEs) are stressful events occurring in childhood including domestic violence, parental abandonment through separation or divorce, being the victim of abuse or neglect, a member of the household being in prison.

Children's trust: Children's trusts are there to support and coordinate the delivery of children's services in a locality and to act as a focal point for decision-making about local children, based on local considerations.

Clinical Commissioning Group (CCG): They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

Commissioned services: It means care, support or supervision that has been arranged and paid for on a client's behalf by a public authority such as: In the case of personal care, a local authority adult social care department.

Core cities: The Core Cities Group is a self-selected advocacy group of large regional cities in the United Kingdom and outside Greater London. It is a partnership of eight city councils: Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham, and Sheffield.

Cross-tabulation is a method to quantitatively analyse the relationship between multiple variables.

Dual diagnosis: If you have severe mental health problems and problematic substance misuse, you may be given what is known as a 'dual diagnosis' – when both problems are diagnosed.

Early intervention: It means identifying and providing effective early support to children and young people who are at risk of poor outcomes. Effective early intervention works to prevent problems occurring, or to tackle them head-on when they do, before problems get worse.

Eligibility means having the right to receive something (e.g. service, support) through satisfaction of the appropriate criteria that determines whether a person qualifies to receive it.

Ethnography: It is an in-depth qualitative research method based on the recording and analysis of a culture, society, or a population group, usually involving participant-observation and resulting in a written account.

Focus group: It is a qualitative research method which involves gathering of deliberately selected people who participate in a facilitated discussion intended to elicit perceptions about a particular subject matter or issue.

General Data Protection Regulation: GDPR is EU law on data protection and privacy.

Health Inequalities: These are differences in health status or in the distribution of health determinants between different population groups, for example, differences in mortality rates between people from different social classes.

Homelessness is defined as living in housing that is below the minimum standard or lacks secure tenure. People can be categorized as homeless if they are: living on the streets (rough sleeping), moving between temporary shelters, including houses of friends, family and emergency accommodation, living in private boarding houses without a private bathroom or security of tenure.

Homeless Priority Reason: It is one of priority need categories in homeless applications. The definition of priority need is contained in Part 7 of the Housing Act 1996. The categories include pregnant women, households with dependent children and vulnerable people, as defined within the Act.

iCAT (Intelligent Common Assessment Tool): iCAT is all-in-one database, referral and case management tool for supporting clients with MCN, providing a platform for easy communication and information sharing across many specialist services.

Joint Strategic Needs Assessment: A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.

Making Every Adult Matter: MEAM is a coalition of national charities representing over 1,300 frontline organisations across England. Working together they support local areas across the country to develop effective, coordinated services that directly improve the lives of people facing multiple disadvantage.

Making Every Contact Count: MECC is an approach to behaviour change that uses day to day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing.

Multi-Agency Public Protection Arrangements (MAPPA): The Criminal Justice Act 2003 provides for the establishment of MAPPA in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership to ensure that the appropriate resources are available to manage risks posed by sexual, violent and other dangerous offenders in the community and that the public are protected as far as possible.

Maslow's hierarchy of needs: It is a motivational theory in psychology introduced in 1943 by an American psychologist Abraham Maslow. The theory comprises a five-tier model of human needs, often depicted as hierarchical levels within a pyramid. Needs lower down in the hierarchy must be satisfied before individuals can attend to needs higher up. From the bottom of the hierarchy upwards, the needs are: physiological, safety, love and belonging, esteem, and self-actualisation.

Multi-Agency Public Protection Arrangements: In the jurisdiction of England and Wales, a Multi-Agency Public Protection Arrangement (MAPPA) is an arrangement for the «responsible authorities» tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.

Multiple Complex Needs: MCN are persistent, problematic and interrelated health and social care needs which impact an individual's life and their ability to function in society. They are likely to include homelessness, mental, psychological and physical health problems, drug and/or alcohol dependency, and offending behaviour.

New Directions Team (NDT) Assessment also known as the Chaos Index is a way of measuring multiple exclusion and complex needs in order to establish eligibility for services and support. The assessment was developed by the New Directions Team in the London Borough of Merton as part of the Adults Facing Chronic Exclusion national programme.

No Recourse to Public Funds: NRPF is a condition imposed on someone due to their immigration status. Section 115 Immigration and Asylum Act 1999 states that a person will have no recourse to public funds if they are subject to immigration control. This prohibition only applies to certain specified public funds, so a person with this condition is not prevented from accessing other publicly funded services, including support from social care.

Outcomes Star: It describes a family of evidence-based tools for measuring and supporting change when working with people.

Peer mentor is a person who has lived through a specific experience and is able to guide and support another person, who is new to that experience.

Psychologically Informed Environment (PIE) is one that considers the psychological makeup – the thinking, emotions, personalities and past experience - of its participants in the way that it operates. It's an approach to supporting people out of homelessness, in particular those who have experienced complex trauma or are diagnosed with a personality disorder. It also considers the psychological needs of staff: developing skills and knowledge, increasing motivation, job satisfaction and resilience.

Prevalence: It is the number of disease cases present in a particular population at a given time.

Prevention: It is an action of stopping something (in the context of this report – health inequalities, multiple complex needs or crisis) from happening.

Qualitative research: It is primarily exploratory research. It is used to gain an understanding of underlying reasons, opinions, and motivations. It provides insights into the problem or helps to develop ideas or hypotheses for potential quantitative research.

Quantitative measures are measures that rely on numbers. The goal of quantitative measurement is to run statistical analysis, so data has to be in numerical form.

Quantitative research is used to quantify the problem by way of generating numerical data or data that can be transformed into usable statistics. It is used to quantify attitudes, opinions, behaviours, and other defined variables – and generalise results from a larger sample population.

Randomised Controlled Trial: RCT is a quantitative study in which people are allocated at random to receive one of several clinical interventions to measure and compare their outcomes. RCTs are quantitative, comparative, controlled experiments in which investigators study two or more interventions.

Relationship-based practice model: The central characteristic of relationship-based practice is the emphasis it places on the professional relationship as the medium through which the practitioner/ social worker can engage with and intervene in the complexity of an individual's internal and external worlds in order to support them to achieve positive outcomes and improve their lives.

Social determinants of health: These are conditions in which people are born, grow, live, work and age, and which are shaped by the distribution of money, power and resources at global, national and local levels.

Statistical neighbours: These are local authorities with similar demographic characteristics, e.g. age distribution, levels of deprivation.

Statutorily homeless: These are households or individuals whom the local authority has a legal duty to assist on the basis that they are unintentionally homeless and fall within a specified priority need group.

Supported housing: It describes is any housing scheme where housing, support and sometimes care services are provided as an integrated package. Supported housing services include homelessness hostels, refuges, sheltered housing and long-term accommodation for people with ongoing support needs.

Sustainability and Transformation Partnership (STP) is a collaboration of public NHS, council social care commissioners and providers across a local area (of between 300,000 and 3,000,000 population) working together with partners in the voluntary, community and independent sectors to find the most effective ways to manage the health and care needs of the population within available resources and provide high quality, sustainable care for the future. There are 44 STPs across England.

Universal Credit is a benefit payment for people in or out of work. It replaces some of the previous benefits and tax credits:
- Housing Benefit
- Child Tax Credit
- Income Support
- Working Tax Credit
- Income-based Jobseeker's Allowance
- Income-related Employment and Support Allowance.

Warwickshire-Edinburgh Wellbeing Scale: These were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The 14-item scale WEMWBS has 5 response categories, summed to provide a single score. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing, thereby making the concept more accessible.
The scale has been widely used nationally and internationally for monitoring, evaluating projects and programmes and investigating the determinants of mental wellbeing.

APPENDIX I

Update on actions recommended in the Director of Public Health Annual Report 2018: Fulfilling Lives for Under Fives.

Domain	Recommendations	Progress to date	What next
1. Overarching – fulfilling lives for under fives	1. Commissioners and providers of Early Years services within Birmingham take account of the demographic makeup and distribution of the under-fives population across the city (specifically in Central and Eastern areas) and target efforts and resources accordingly.	Birmingham Forward Steps (BFS) is contracted to provide a city-wide service, which meets the needs of different parts of the city, e.g. children's centres remain operational in areas, where the need is greater.	We will continue to support the provider to implement the targeted approach. Ensure that the findings in the JSNA help inform this approach.
	2. Commissioners and providers have in place robust data collection systems to monitor health needs and outcomes for children under five and their families, including the Ages and Stages Questionnaire (ASQ) and breastfeeding rates.	Performance indicators for BFS contract include ASQ and breastfeeding rates, they are monitored monthly. Commissioners of services and their providers have worked closely to improve data collection systems to ensure they meet data quality requirements.	We will continue to support the provider to deliver robust data collection and reporting systems.
	3. Local Sustainable Transformation Partnerships (STP) across the city encourage commissioners and service providers to strengthen the prevention offer from preconception through to early years for the citizens of Birmingham, particularly through the Local Maternity System (LMS) and Birmingham Forward Steps.	Birmingham and Solihull STP has a specific children and maternity portfolio. A subgroup of this is CHIP (children's health improvement programme), this is where work is being done to improve the prevention offer with a particular focus on the LMS and BFS.	We will develop and implement specific action plans for prevention under the STP. This currently includes increasing uptake of children's vaccinations.
	4. Inclusive growth and economic development programmes across the city and those led by the West Midlands Combined Authority, maximise opportunities to promote the wellbeing of young children and their families, particularly those in poverty and in the greatest need.	The city has been successful in being part of the Local Government Association's Childhood Obesity Trailblazer programme which is focused on upstream interventions to improve the food environment for families.	We will continue to implement the Childhood Obesity Trailblazer programme in the city.
	5. The Birmingham Health and Wellbeing Board encourages and facilitates strong strategic partnership working and ensures robust governance arrangements are in place between statutory and non-statutory bodies to monitor and promote the health and wellbeing of under five-year olds.	Four new sub-groups have been created which report to the health and wellbeing: Creating a Physically Active City Forum Creating a Mentally Healthy City Forum Creating a City without Inequality Forum Creating a Healthy Food City Forum The needs of 0-5-year olds and their families are included in all these delivery forums.	The Children and Young People chapter of the JSNA has been developed and will inform the agenda further.

2. Conception, pregnancy, neonatal	1. The Birmingham and Solihull United Maternity Programme (BUMP), as it develops into the Local Maternity System, must be explicit about the arrangements for supporting women with additional needs described in this section.	Current work on supporting women with additional needs is being undertaken. Service capacity and demand are being reviewed in Birmingham and Solihull to ensure needs can be met.	Qualitative work on pre-conception will be carried out to inform future service provision.
	2. The Birmingham and Solihull United Maternity Programme, as it develops into the Local Maternity System, must be explicit about the arrangements for identifying women who smoke, motivating them to stop, and the referral arrangements with the Birmingham and Solihull Smoking Cessation providers.	The ante-natal smoking cessation model is delivered by 2 trained midwifery support workers in Erdington community midwifery team, offering specialist clinics embedded into maternity services. The pilot has proved to be successful leading to higher patient engagement and chances of quitting smoking.	The BUMP programme board has extended the model to prevent a gap in provision, until a similar model can be rolled out to Birmingham maternity services.
	3. The Birmingham and Solihull United Maternity Programme, as it develops into the Local Maternity System, must ensure robust delivery of the NHS Saving Babies' Lives Care Bundle.	The BUMP programme is focusing on the delivery of the NHS Saving Babies Lives Care Bundle and progress is overseen through the programme board. Over the last year there has been a significant progress, including a new pathway for the management of pre-term labour, a joint peer to peer perinatal mortality review process and a successful pilot of the Single Point of Access model across 16 GP surgeries. Funding has been secured from Health Education England to support a roll out of a Saving Babies Lives training programme, starting in 2020.	The BUMP programme will continue to progress delivery of NHS Saving Babies Lives Care Bundle to complete implementation in line with the national guidelines.
	4. Birmingham Forward Steps must establish a systematic approach to supporting women's nutrition and physical activity in the postnatal period, particularly those who are overweight or obese.	BFS are commissioned to deliver the healthy child programme, which includes providing lifestyles advice to women in the postnatal period.	We will continue to monitor the outcomes from the healthy child programme and ensure ongoing improvement, as required.
3a. Early years health and care: health service use	1. The work on increasing the uptake and use of the Healthy Start vouchers should continue and report to the Health and Wellbeing Board and Overview and Scrutiny Committee on progress and impact in June 2019.	The baseline uptake of Healthy Start vouchers in March 2018 was 70%. Through a programme of targeted action working with agencies we increased the uptake to 75% and maintained the uptake at 75% through to February 2019. In February 2019 the DWP and NHS adjusted their databases of eligible beneficiaries and uncovered a significant number of people who were eligible for HSV that were previously unknown. This resulted in all local authority rates dropping, in Birmingham it dropped to 60% in March 2019, an additional 2,824 extra beneficiaries were identified. Work to increase uptake is under way and it is overseen by the Financial Inclusion Partnership as well as the Creating a City without Inequality Forum.	We are now working to sign up the additional families and have increased our rate to 62%. As well as front line health visiting and children centre staff we are working with: DWP, early years education community groups, debt advice agencies, GPs and primary care to sign up the additional eligible beneficiaries.

	2. The Birmingham and Solihull United Maternity Programme, as it develops into the Local Maternity System, should collaborate with the City Forward Steps to establish a robust and sustainable offer of breast-feeding support to improve breast-feeding rates at initiation, 6-8 weeks and beyond.	The infant feeding sub-group of the BUMP includes representation from maternity service providers and Birmingham Forward Steps. The aim of this group is to develop a robust, consistent, systematic offer across the early years system to increase breast-feeding initiation and duration rates.	We will continue to develop the offer and monitor outcomes.
	3. Birmingham City Council should work with the commissioned Early Years Service – Birmingham Forward Steps (BFS) to address data quality issues, particularly in relation to breast-feeding rates.	BCC has worked with BFS and Public Health England colleagues to improve breast-feeding data quality. BFS data collection systems are being modified to ensure that data generated in future meets quality criteria.	We will continue to monitor and evaluate the data.
	4. Birmingham City Council (BCC) and partner organisations should develop an offer of enhanced nutritional and physical activity opportunities to optimise weight and fitness for life, based on a whole systems approach to obesity.	BCC is working with partners through the health and wellbeing board's forums (physically active city and healthy food city) on a whole systems approach to obesity which involves re-focusing work upstream.	We will develop action plans through the Creating a Physically Active City Forum and the Creating a Healthy Food City Forum.
3b. **Early years health and care: vaccinations**	1. NHS England works with partners to develop action plans in areas, communities or populations with low uptake to deliver increased uptake. This will reduce levels of inequality in uptake. 2. NHS England and Clinical Commissioning Groups to produce and implement plans to target the lowest performing 10% of GPs and deliver increased uptake in Practices with the very lowest performance.	Birmingham and Solihull STP has identified improving childhood vaccination uptake as a priority, and action plans are being developed with stakeholders, including NHS England (NHSE), to take this forward. West Midlands Immunisation Partnership meetings are in place for planning between NHSE, Local Authorities and CCGs. NHSE and CCG leads have worked together on flu vaccine ordering and performance.	We will continue to work in partnership to improve vaccination uptake. MMR tail-gunning has been planned for Birmingham and Coventry from April 2020.
3c. **Early years health and care: Oral health**	1. Public Health England to publish the results of Children's Oral Health Needs Assessment to identify areas or communities with the worst oral health inequalities. 2. Birmingham Forward Steps to adopt NICE and Public Health England oral health improvement recommendations.	BFS have worked with PHE colleagues to adopt best practice in relation to oral health improvement recommendations.	We are currently awaiting publication of 2019 survey of 5-year olds by PHE and will plan action in response to its findings.

4. **Early years education and development**	1. Birmingham Forward Steps should develop locality links with the local private, voluntary, or independent providers of Early Years Education to enhance and enable the uptake of the Early Years 2-2.5-year assessment and educational entitlement offers.	Education and Development BFS representatives engage in regular early years forum meetings which provides an opportunity to develop links with early years education providers in the private, independent and voluntary sectors. Children's centre staff are working to develop good links with early education providers.	We will continue to develop collaborations and monitor impact of joint action.
	2. Birmingham Forward Steps and Birmingham City Council should work together to address data quality issues identified in relation to the Ages and Stages questionnaire (ASQ-3) collected at the 2-2.5-year health visitor assessment.	BFS, BCC and PHE colleagues have worked closely together to address data issues in relation to the ASQ-3 collected at the 2-2.5-year health visitor assessment. BFS systems have now been adapted to incorporate necessary changes and anticipate seeing considerable improvements in data quality within the current financial year.	We will continue to monitor and evaluate the data.
5a. **Family and social environment**	1. The reduction in the impact of family poverty on children should become the outcome measure for the economic developments in the City by all partners collectively. The principles of the Inclusive Growth Commission and WMCA Inclusive Growth Unit should be explicitly explored for their implications in Birmingham by Birmingham Financial Inclusion Partnership and Birmingham Child Poverty Action Forum.	Birmingham's Child Poverty Action Forum (CPAF) has inclusive growth as a key policy area of focus. The CPAF alongside the Financial Inclusion Partnership is supporting cross-sector plans to make Birmingham a living wage city. A cross-sector group, led by the Council, has been established. This group is working up plans to submit to the Living Wage Foundation.	We will continue to work in partnership to tackle child and family poverty in the city and continue to promote a living wage approach.
	2. The poor health of deprived areas is a symptom of, and barrier to, inclusive growth. The Joint Strategic Needs Assessment (JSNA) must describe these patterns of impacts and should be used to support decisions to reduce family poverty by Birmingham Health and Wellbeing Board and Birmingham Financial Inclusion Partnership.	The CYP chapter of the JSNA includes patterns of deprivation and its impact on outcomes. This will be used to inform the work of the fora set up under the health and wellbeing board, including the Creating a City Without Inequality Forum as well as the Financial Inclusion Partnership, which the Forum is linked with.	We will develop a joint upstream action as part of the Creating a City without Inequality Forum's and the Financial Inclusion Partnership's work.
	3. Evaluation of schemes using 106 funding in Longbridge should be shared widely with recommendations and next steps to start further innovative schemes along these principles by Birmingham Health and Wellbeing Board and Child Poverty Action Forum.	The Longbridge scheme has not been evaluated. As part of the Longbridge project, an RCT was conducted on Run a Mile. Findings were published. https://research.birmingham.ac.uk/portal/files/46440038/Breheny_et_al_Cluster_Randomised_BMC_Public_Health.pdf	

5b. **Adverse Childhood Experiences**	1. Opportunities for tertiary prevention should be developed with adult mental health clients (including personality disorder, complex family presentations), children's social care (Child Protection and Child in Need) and Primary Care. 2. Opportunities for secondary prevention should be developed into an early emotional help system framework for primary schools. This should be a partnership of schools, the voluntary sector and NHS, which responds to children with difficult and concerning behaviour. This should include the introduction of enquiry into the adverse experiences in the child and family. 3. Opportunities for primary prevention should be sought in sharing the understanding of impacts of adverse experiences with parents during the antenatal period by the Local Maternity System and Forward Thinking Birmingham.	Opportunities to develop an ACEs informed approach across the system, at a strategic level, are being explored by senior Public Health staff in collaboration with the Children's Trust, who have been implementing relevant training. This will provide an opportunity to build on the existing Framework of Preventing the Impact of ACEs in Childhood in Birmingham at primary, secondary and tertiary levels. Commissioners and providers with an interest in emotional health and wellbeing regularly meet as part of the Education Emotional Wellbeing Steering Group and help to shape emotional health and wellbeing services around schools through links with the CYP Local Mental Health Transformation Board. Enquiry into adverse childhood experiences is an implicit aspect of this work. Primary prevention opportunities arise across the LMS and early years settings providers.	We will continue to develop a joint action with partners, taking a public health approach to addressing ACEs and their impact.
	4. Opportunities to develop locality understanding and responses in wider linked communities such as extended families, faith or social groups and neighbourhoods to the evidence of harmful impact of these experiences should build upon the experiences of the pilots in Castle Vale and Kings Norton (Dr Andrew Coward, Area Early Help Hubs and Forward Thinking Birmingham).	At the time of producing the report the West Midlands Combined Authority Adverse Childhood Experiences lead, Dr Andrew Coward, was proposing a community-based development of awareness of the impact of these experiences in Castle Vale and Kings Norton. This would, of course, be evaluated before more widespread adoption.	We will continue to work with partners to build greater understanding of ACEs at a locality level in order to address these issues more effectively.
5c. **Child homelessness**	1. The Joint Strategic Needs Assessment should focus on supporting the evaluation of the Birmingham Homelessness Prevention Strategy by Adult Social Care, Birmingham Public Health, and Birmingham Forward Steps.	The 2019-20 JSNA chapter on children and young people includes a specific section on homelessness and how it affects children and young people to help inform the local approach.	We will continue to collaborate with the Housing and CCG partners to improve support to children and young people living in temporary accommodation.

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Birmingham
Health and Wellbeing
Board

	Agenda Item: 16
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19 January 2021**
TITLE:	**JSNA Core Data Set – Working Age Adults**
Organisation	**Birmingham City Council**
Presenting Officer	**Ralph Smith, Service Lead, Knowledge Evidence and Governance**

Report Type:	Presentation

1.	**Purpose:**
	To update the Board on the progress of the core Birmingham Joint Strategic Needs Assessment (JSNA) Working Age Adults Chapter.

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

3.	**Recommendation**

It is recommended that the Health and Wellbeing Board:

- Approve the publication of the Working Age Adults Chapter of the Birmingham Core JSNA.

- The Board are also asked to note the document was written in the pre-Covid era. The content will be refreshed in 2021/22 to include Covid data/impact.

4.	Report Body

4.1	**Context**
	The approval of Birmingham JSNA 2020/21 chapters came to a halt in March 2020 due to the start of the pandemic. The Working Age Adults chapter was very near completion and is presented today for comment and approval for publication.
4.2	**Current Circumstance**
	Following the writing of a draft version by Public Health Knowledge, Evidence and Governance team, the document has been distributed widely to critical friends throughout the Council. The document has also been tabled at the Corporate leadership Team and at the Cabinet Member's briefing. Comments and suggestions have been incorporated.
4.3	**Next Steps / Delivery**
	The document will be published on the Public health website and advertised widely amongst stakeholders.
	The final chapter of the 2020/21 Birmingham JSNA *'Older adults'* is undergoing a refresh of data. The draft document will be circulated to internal and external partners for comment. The chapter will be presented at the March 2021 HWBB meeting.

5.	Compliance Issues

5.1	*HWBB Forum Responsibility and Board Update*
	The development of the JSNA, both core and deep dives, is managed by the JSNA steering group.
5.2	*Management Responsibility*
	Ralph Smith, Service Lead, Knowledge Evidence and Governance

6.	Risk Analysis
	Further delay in publication. Changes suggested at presentations.

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Further delay in publication	Low	Medium	Any changes/updates will have a high priority in officer's work programmes.

Changes suggested at presentations	Low	Low	Any changes/updates will have a high priority in officer's work programmes.

Appendices
The Birmingham Core JSNA Working Age Adults Chapter

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

Ralph Smith, Service Lead, Knowledge Evidence and Governance

Working Age Adults
2019/20 Joint Strategic Needs Assessment

V6.4 – December 2020

Version Control	Date	Amendments	Lead Authors
V3	25/10/2019	Draft version following sprint	Mohan Singh and Ralph Smith, Public Health Knowledge Evidence and Governance Team, BCC
V5	27-01-2020	First two sections draft read	Ralph Smith
V6.1	29-01-2020	All sections draft read by RS: First 2 sections commented on by RC	Ralph Smith and Rachel Chapman
V6.2	10-02-2020	Comments from PH critical friends. Distributed to external critical friends 11-02-2020	Ralph Smith
V6.2a		Sent to March 2020 pre agenda meeting.	Ralph Smith
V6.3		Sent to HWBB March 17 for private session	Ralph Smith, Paul Campbell
V6.4		Sent to CMB	Ralph Smith

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		25/11/2020 Sent to CLT 07/12/2020 Sent to HWBB pre agenda meeting 23/12/2020	

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Executive Summary

One of the Council's priorities for working age adults is that we have a city that is an entrepreneurial city to learn, work and invest in. The Birmingham and Solihull Sustainable and Transformation Partnership (STP) also have adulthood and work as a priority, achievable through breaking the cycle of deprivation.

Adult lifestyle outcomes remain a problem in Birmingham. Smoking is still the biggest cause of premature mortality in England, with the adult smoking prevalence in the city at 16.2 % (fifth of the eight Core Cities), higher than the England average of 14.4%.

Alcohol consumption and drug misuse are contributing factors to hospital admissions and deaths from a wide range of conditions. Birmingham's (2017/18) hospital admissions for alcohol related conditions are significantly higher than England, with the city also having a higher prevalence of adult dependent drinkers in treatment compared to England.

Estimated prevalence of opiate and/or crack cocaine use in Birmingham residents (5-64 years old) has been nearly twice the national rate in recent years, with the percentage successfully completing their treatment (6%) comparable with the England figure (6.5%) and ranking 3rd out of the core cites.

Most recent figures show 61% of Birmingham adults aged 19 years and above were classified as being physically active and 26% were as inactive, these figures are worse than England which had 66% active and 22% inactive.

49% of Birmingham adults aged 16+ years eat the recommended 5 a day on a usual day, compared to the England average of 55%. Birmingham is also likely to follow similar trends to the national average when it comes to nutrient consumption: with adults not meeting the recommended intake for things like sugar, saturated fat and salt.

Long term health conditions continue to contribute to premature mortality (under 75 years), the city's mortality rate of cardiovascular disease, prevalence of diabetes and common mental disorders being significantly higher than the national average.

Employment status and educational attainment remain important determinants of health in Birmingham, as does crime and violence. Reported crime saw an increase over the last two reporting periods. Domestic violence accounted for 11% of total crime (5,540 incidents).

The evidence shows that certain groups of working age adults facing additional challenges consistently have worse health outcomes, whether they are adults with disabilities, migrant and refugee adults or homeless adults with families. Little is known about the health status of some of the groups locally.

Based on current trends Birmingham will need to remain focused on improving adult's lifestyles, promoting health and wellbeing and managing chronic diseases. Addressing the wider determinants of health will help improve overall health. Adulthood is an important time for building assets, reducing risks and intervening early to prevent ill-health.

Contents

4

Working age Black Asian & Minority Ethnic population

Birmingham 40.9%

England 14.9%

Source-https://www.nomisweb.co.uk/census/2011/dc2101ew
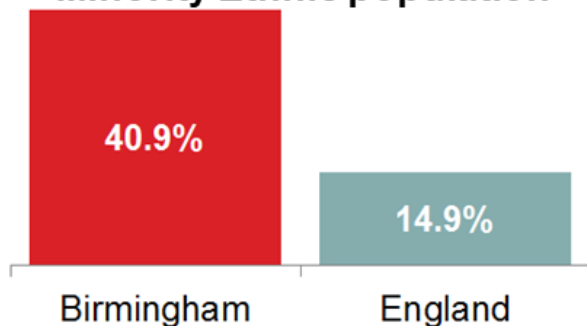
Employment trend (calendar years)

England

Birmingham

11.3% GAP

10.1% GAP

Source-_Nomis Annual population survey
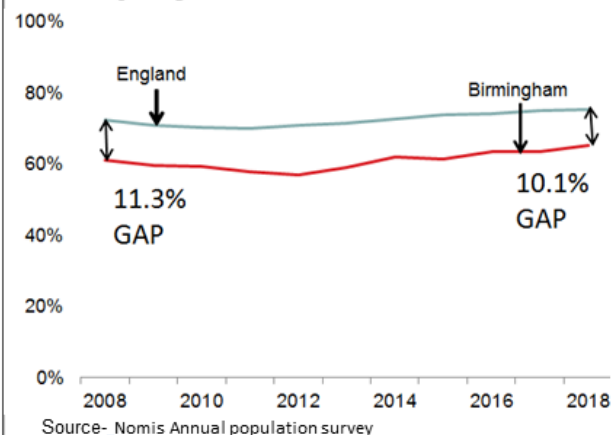
Economic inactivity by reason
% (Jul 2018 to Jun 2019)

	Student	Looking after family/home	Long-term sick	Retired	Other
England	27.2	24.5	22.1	12.5	13.7
Birmingham	40.0	28.6	16.5	5.1	9.3

■ Birmingham ── England
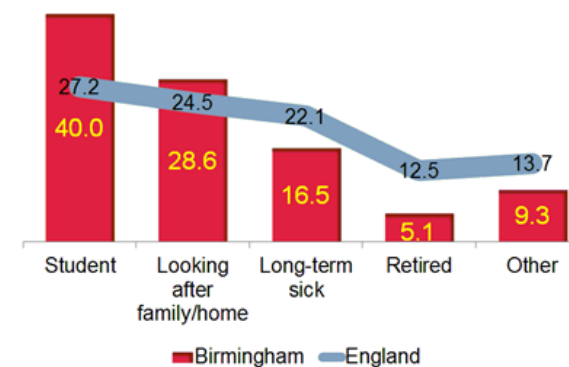
Cancer deaths (2015-17)

Birmingham 148.2 DSR
England 134.6 DSR

1,475 people died from lung cancer

Created by karina from Noun Project

Physical inactivity (2015-17)

Birmingham 26%
England 22%
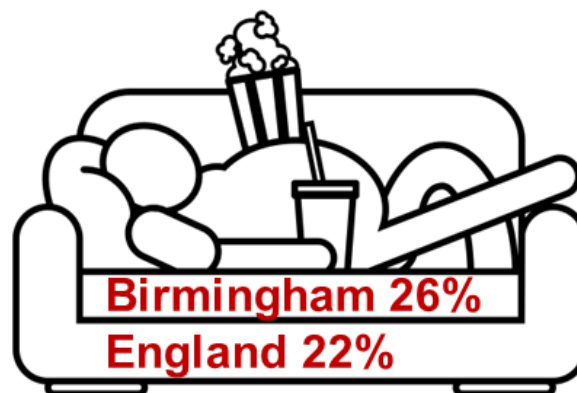
Nil or maximum NVQ level 1 qualification (2018)

23%
(Birmingham)

5% higher than England average

5
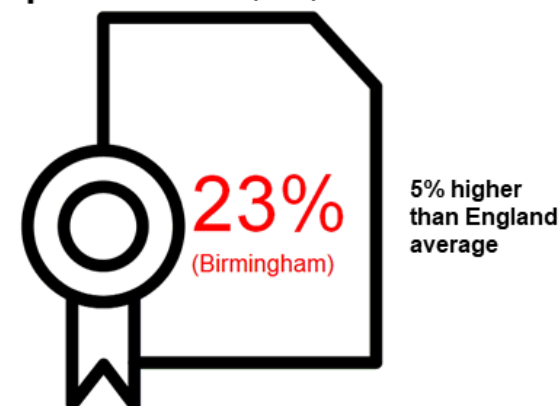
Section 1: Lifestyle Behaviours

Smoking

Key statistics

Smoking is the leading cause of premature death, killing 78,000 people in England each year. In 2017/18, the Birmingham rate of smoking related admissions to hospital for those aged 35 years and over was 1,632 per 100,000 which is significantly higher compared to the England average of 1,530 per 100,000[1], although second lowest of the eight Core Cities. One in 4 patients in hospital beds are smokers. Smokers also see their GP 35% more than non-smokers.[2]

Prevalence

In 2018, 16.2% of adults in Birmingham were current smokers (fifth highest of the eight Core Cities) compared to the England average of 14.4% (Source: Annual Population Survey). The rate for Birmingham men (19.2%) was higher than women (13.3%). Birmingham's males and females are above the England average which are (16.4%) and (12.6%) respectively. Routine or manual workers are most likely to be current smokers (23.7%) compared to individuals in managerial and professional occupations (9.4%). The England figures for these employment groups respectively are 25.4% and 10.3%. [1] There is a strong association between smoking and mental health conditions, with smoking rates among people with a mental health condition significantly higher than in the general population. This association becomes stronger relative to the severity of the mental health condition, with the highest levels of smoking found in psychiatric in-patients. It is estimated that around 30% of smokers in the UK have a mental health condition, and more than 40% of adults with a serious mental illness smoke. [3]

Diversity and inclusion

There is variation in smoking rates in different ethnic groups. People in Mixed (20.4%), Other (15.5%) and White (15%) ethnic groups had the highest smoking prevalence (age 18+) in 2018. The Unknown ethnic group had the lowest prevalence at 5.8% [1].

A 2011 survey revealed that Birmingham's LGBT community have a higher smoking prevalence (24.1%) compared to England general population (19.2%) [4] In 2017,

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[1] 'Public Health England. Local Tobacco Control Profiles. [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]
[2] Public Health England: Smoking and tobacco: applying All Our Health
[3] ASH: Fact sheet No. 12: Smoking and Mental Health
[4] Birmingham LGB survey downloaded 7th November 2019

smoking prevalence was 1.5 times higher in lesbian, gay and bisexual people than heterosexual or straight people for UK residents. [5]

Amongst mothers, smoking at time of delivery was 8.6% and 10.6% for Birmingham and England respectively (2018/19), with the Core Cities average at 11.1%. The prevalence has decreased for both areas over the last 8 years. The gap between the two areas has increased in this time period from 1 % to 2% respectively with England having a higher rate. These figures need to be treated with caution, as there were a lot of mothers whose smoking status is unknown.[1]

Service Model

A stop smoking service is commissioned by Birmingham City Council (BCC). This is a universal service accessible via GPs and pharmacies. Patients are offered behavioural and pharmacotherapy support with the service aiming to maximise the number of smokers accessing the service and increasing long-term quit rates. The programme is looking to expand the services to accommodate target groups who are known to have a higher prevalence; such as people with poor mental health, those in contact with drug and alcohol services, pregnant women and groups in hospital acute settings.

Service data

The smoking cessation service is offered to smokers aged 12+. Providers must ensure the system meets the patient's age, culture, disability and gender sensitivity needs. Providers demonstrate evidence of this through the equality assessment processes. The service targets areas of high prevalence for smoking and high deprivation.

Number quitting for the period 1st April 2019 - 31st Dec 2019 for Pharmacies and GP practices is 2664, with 498 of those successfully sustaining being smoke free (18.7%).

Table 1 Successful 4 and 12 week quitters, 1st April 2019 - 31st Dec 2019 for Pharmacies and GP practices

4 week successful quit	Pharmacies	GP practices	Total
Quarter 1	283	232	515
Q 2	305	1491	1796
Q 3	353	0	353

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[5] ONS: Adult smoking habits in the UK: 2018

Q 4	N/A	N/A	0
Total	**941**	**1723**	**2664**

12 week successful quit	Pharmacies	GP practices	Total
Quarter 1	124	146	270
Q 2	102	0	102
Q 3	126	0	126
Q 4	N/A	N/a	0
Total	**352**	**146**	**498**

Trends and Future Analysis

The current smoking service has started to offer e-Cigarettes as a method of quitting. The data is still currently not robust enough to understand future trends, which should be available soon, once the offer has been available for more than 12 months. In addition, there should be increases in quits for target groups as we are moving forward to develop specialist smoking provision within targeted service across Birmingham including workplace offers.

Alcohol

Key statistics

Alcohol consumption is a contributing factor to hospital admissions and deaths from a wide range of conditions which costs the NHS about £3.5 billion per year and society £21 billion annually[6].

Prevalence

Based on national prevalence rates (2014/15) it was estimated that there were around 13,603 adults in Birmingham with alcohol dependence in need of specialist treatment[7].

In 2016/17, Birmingham had 1,895 dependent drinkers in alcohol treatment of which males were estimated to be 79% of the cohort[7]. As a percentage of the total population, Birmingham had a higher prevalence of adults (1.7%) in this cohort group when compared to England (1.4%) for 2014/15. There is a large gap between those in treatment and those identified as having alcohol dependence.

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[6] Alcohol Change UK: The Alcohol Change Report
[7] 'Public Health England. Local Alcohol Profiles. [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]

Diversity and inclusion

There are variations in rates of harmful drinking in different ethnic groups. The percentage of adults nationally, by ethnic group, who drank at harmful or dependent levels are

- White 5.2%
- Mixed 3.9%
- Black 3.5%
- White- Other 1.9%
- Asian - 1.0%. (2014) [8]

However, these overall figures may mask higher rates of drinking in some communities. There is also variation depending on deprivation; of adults in the most deprived deciles 2.1% were dependant drinkers, compared to 0.9% in the least deprived [9].

Impact

Whilst the overall drinking rates in England have decreased from 2011 to 2016 (from 34% to 31% for males and 18% to 16% of women), Birmingham's (2017/18) hospital admissions for alcohol related conditions are significantly higher than England. For males admissions it was 3,553 per 100,000 (England 3,051) and for female's 1,762 (England 1,513) [9]. In relation to the Core Cities, Birmingham has the sixth highest rate per 100,000 admissions for alcohol related conditions for both males and females.

The Birmingham rate for alcohol specific and alcohol related mortality is significantly higher than the England average and has been over recent years. The latest period 2015/17, has the alcohol *specific* mortality rate for Birmingham at 14.4 deaths per 100,000 population, which is sixth highest of the eight Core Cities (England, 10.6 deaths). Similarly, the 2015/17 alcohol *related* mortality rate for Birmingham is 53.3, also sixth highest of the eight Core Cities, deaths per 100,000 population compared to the England rate of 46.2 deaths per 100,000 population[9].

Service Model

Birmingham City Council Public Health commissions a single system treatment and recovery service for patients experiencing the harms associated with drug and alcohol use. The service is provided by Change, Grow, Live (CGL) as of 2019 and supports approximately 7,000 service users in Birmingham. As a recovery-focused delivery model it provides users with advice and support delivered via a 5-tiered model.

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[8] GOV.UK: Harmful and probable dependent drinking in adults: 2018
[9] 'Public Health England. Public Health Alcohol Profiles. [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]

Tier 1: Advice & Information; including signposting to other services which include advocacy and mutual aid.

Tier 2: Non-dependent drug and alcohol use – Group / 1:1 work up to 12 weeks

Tier 3: Dependent alcohol use, opiate use, heavy crack cocaine/synthetic cannabinoids etc. – Group/1:1 work, longer term, structured support

Tier 4: In-patient specialist unit (Park House in Hockley) which delivers detoxification and stabilisation

Tier 5: Aftercare provision – Group/1:1 work

Service data

The demand on the substance misuse service continues to increase due to prevalence of individuals who use illegal drugs and alcohol. The complexity of service users is also increasing citywide. Alcohol treatment services recorded 18,890 patients for Birmingham of which 75% are male.

The ethnic breakdown for service users were White (69%), Asian (14%), Other (8%), Mixed (5%) and Black (4%).

Trends and Future Analysis

Tier 3 is key as 87% of clients in treatment are in receipt of opioid substitute treatment (OST), this is an ageing cohort and brings with it other health related issues. Managing the OST cohort means that less prevention work is undertaken resulting in a large alcohol unmet need.

Drugs

Key statistics

Nationally, nearly one in nine deaths registered among people in their 20s and 30s in England and Wales in 2014 were related to drug misuse, with the deaths from drug misuse increasing substantially since 2011/13 [10]. The main substances that Birmingham residents present to treatment services continue to be alcohol, opiates, cocaine, and cannabis.

Prevalence

Estimated prevalence of opiate and/or crack cocaine use in Birmingham residents (5-64 years old) has been nearly twice the national rate in recent years. In 2011/12 the rate was 15.2 per 1000 population (England 8.4 and Core Cities average 13.7). In 2016/17 Birmingham and Core Cities average rates decreased to 14.2 and 12.8 respectively, while nationally it has increased to 8.9 per 1,000 population.

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[10] Public Health England. Public Health Outcomes Framework 2.15iv. [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]

The city's recorded number of drug users (opiate and/or crack cocaine use measured by various organisations, including drug treatment, probation, police and prison data) fluctuates over time: with cases at a peak of 10,743 (2011/12), then decreasing to 9,705 (2014/15) and rising again to 10,525 (2016/17) [11].

The latest percentage (2017) of "opiate clients successfully completing their treatment" is slightly lower for Birmingham (6%) when compared to England (6.5%) [12]. From 2010-2017 this has been a consistent trend (except 2013 when Birmingham was higher). Birmingham ranks 3rd highest out of the Core Cites, which have an average of 4.8%

The latest percentage (2017) for "successful completion of drug treatment - non-opiate users" is higher for Birmingham (41.5%) compared to England (36.9%). However, these figures do fluctuate year on year[13].

Diversity and inclusion

The LGBT community has a higher than average use of recreational drugs. A 2011 survey highlighted that 50% of respondents had used drugs for recreational purposes.

At a national level, communities that are most deprived have nearly three times the prevalence rate than the least deprived areas for opiate and/or crack cocaine use[11].

Impact

The latest period for '2016-2018' has the Birmingham drug misuse death rate at 6.3 per 100,000 individuals which is significantly higher than the corresponding national drug misuse death rate of 4.5, although is ranked sixth out of the eight Core Cities.[14]

Service Model

Birmingham City Council Public Health commissions a single system treatment and recovery service for Birmingham citizens experiencing the harms associated with drug and alcohol use. The service is provided by Change, Grow, Live (CGL) and supports approximately 7000 service users (2019) in Birmingham delivered via four CGL hubs city-wide which are fully integrated with partner organisations that deliver relevant health and social care services.

The Birmingham service delivery outcomes are measured by increasing employment for patients, reducing re-offending, improving housing and assisting users with their social and health needs. Specific targeted support is provided to homeless rough sleepers through an outreach team.

Service data

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[11] Public Health England. Public Health Mental Health and Wellbing Profiles. [09-12-2019]
https://fingertips.phe.org.uk © Crown copyright [2019]
[12] Public Health England. Public Health Outcomes Framework C19a. [09-12-2019]
https://fingertips.phe.org.uk © Crown copyright [2019]
[13] Public Health England. Public Health Outcomes Framework C19b. [09-12-2019]
https://fingertips.phe.org.uk © Crown copyright [2019]
[14] 'Public Health England. Public Health Outcome Framework [09-12-2019]
https://fingertips.phe.org.uk © Crown copyright [2019]

Opiate clients in treatment have reduced; like the national picture where in 2009/10 there were 170,032 clients in treatment, compared to 141,189 in 2017/18.

Non opiate clients in treatment have seen a small reduction; like the national picture where from its peak of 25,570 clients in 2013/14, by 2017/18 the figure had reduced to 23,780.

Alcohol clients in treatment have reduced. The national picture shows a peak of 91,651 clients in 2013/14: by 2017/18 the figure had reduced to 75,787.

Non-opiate and alcohol clients in treatment have seen little change from 2015 – 2018, which is reflective of the national picture whereby in 2009/10 there were 28,992 clients in treatment nationally compared to 27,684 in 2017/18 (see table 2).

Table 2 Clients in Treatment - Birmingham

Clients in treatment - Birmingham - All in Treatment - Count									
Drug Group	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Opiate	5702	5797	5392	5252	5096	5017	4920	5091	4691
Non-opiate only	812	925	953	1160	1288	936	674	717	615
Alcohol only	1559	2236	2250	2364	2463	2105	1824	1895	1413
Non-opiate & alcohol	509	541	508	645	728	713	590	584	461
Totals	**8582**	**9499**	**9103**	**9421**	**9575**	**8771**	**8008**	**8287**	**7180**

Trends & Future Analysis

Treatment of opiate substitute treatment clients, as an ageing cohort, bring with it other health related issues. This results in less prevention work and a large unmet alcohol need as previously mentioned. Increasing dual diagnosis (mental health and substance misuse) will impact on services and outcomes.

The city's Triple Zero City Strategy, 2020- 2030 has three key ambitious outcomes

- Zero deaths due to drugs or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people living with addiction to drugs or alcohol not receiving support to manage their addiction

These are deliberately ambitious as we need to keep pace and focus to drive change at scale and truly impact on the challenge of drug and alcohol addiction in the city. Led by Birmingham City Council, in partnership with the West Midlands Police and Crime Commissioner, the Triple Zero Strategy sets out a refreshed approach to creating a healthier and safer city for all the residents of Birmingham.

Physical Activity
Key statistics

People who lead a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and improved mental

health. In older adults' physical activity is associated with increased functional capacities[15].

Prevalence

In 2017/18, 61% of Birmingham adults aged 19 years and above were classified as being physically active and 26% were as inactive, these figures are worse than all other Core Cities and worse than England which had 66% active and 22% inactive.[16]

Diversity and inclusion

Fewer women (64%) across England are physically active compared to men (68%). Asian (57%) and Black (56%) residents are less active than the general population. Activity decreases in people age 75 and over. People living in the most deprived 10% of neighbourhoods in England are the least likely to be physically active compared with those in the least deprived areas (57% compared to 72%). Nationally people are significantly more active in the managerial professions compared with the routine and manual occupation and unemployed category[17].

Over 700,000 attendances were seen across BCC/TAWS physical (and social for TAWS) activities in the year April 2018 – March 2019. Of these,
- 79% of these were people from the most deprived 40% of areas (IMD Quintiles 1 & 2)
- 62% were by participants from BAME backgrounds
- 51% were by female participants

Service Model

Birmingham Public Health commissions a Health and Wellbeing Service to ensure that communities have access to facilities, infrastructure and support to engage in active, healthy lifestyles that will support improvement in their social, physical and mental wellbeing. A Wellbeing Service will enable residents to be physically and socially active and involved in their local community within Wellbeing and Leisure Centres, Parks and Green Spaces and Community Settings. The service is provided by The Council's Place Directorate through the services Be Active and Be Active Plus; as well as The Active Wellbeing Society (TAWS) [18] which contributes to Active parks, Active Bikes and Active Streets.

The Birmingham Wellbeing Service does not just focus on facilities, but involve an element of community activities delivered by third sector organisations such as Age UK who deliver Tai Chi in community settings and Moseley Baths CIC who deliver Be Active

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[15] https://fingertips.phe.org.uk/profile/physical-activity
[16] Public Health England. Public Health Outcome Framework [09-12-2019]
https://fingertips.phe.org.uk © Crown copyright [2019]
[17] 'Public Health England. Public Health Physical Activity Profile [09-12-2019]
https://fingertips.phe.org.uk © Crown copyright [2019]
[18] The Active Wellbeing Society

There are many Friends of Parks groups around the city that organise events that can help support a physically active lifestyle. [19]

Service data

For the Be Active services, for the period April 2018 – March 2019, there were 609,733 visits by 57,697 unique users which give a mean average of 11 visits per user per year.
- 19,106 (33.1%) attended once in the 12 month period
- 17,412 (30.1%) attended twice in the 12 month period
- 2,242 (3.9%) attended 50 plus times in the 12 month period

Considering visits rather than unique users, there were,

- 620,000 attendances across BCC leisure centres
- 85,000 attendances across outdoor (TAWS) activity

Trends & Future Analysis

The last three years data covering adults who are physically active shows that there is a trend for the percentage to decrease.

Birmingham Public Health are leading the Partnership for Healthy Cities/Bloomberg work across Birmingham; an internationally funded campaign to encourage a shift in knowledge, attitudes and behaviours around walking, cycling and active travel among the diverse populations.

Diet and Nutrition

Diet refers to the food and drink people regularly consume.

Nutrition is a process that involves an adequate consumption of nutrients, vitamins, and minerals to live a healthy and prosperous life.

Poor diet and nutrition, plus obesity, are leading causes of premature death and mortality [20] , and are associated with a wide range of diseases including cardiovascular disease and some cancers, which can have a significant impact on an individual's physical and mental health and wellbeing.

The costs of diet related chronic diseases to the NHS, and more broadly to society are considerable. Average intakes of saturated fat, sugar, and salt are above recommendations nationally, while intakes of fruit and vegetables, oily fish, fibre and some vitamins and minerals in some groups are below national recommendations.

On average, the population consumes too much saturated fat, salt, and sugar and

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[19] Birmingham Open Spaces Forum
[20] Global Burden of Disease, 2017

eats too little fibre, fruit and vegetables and oily fish than recommended. We also know that some sections of the population have intakes of some vitamins and minerals below recommended levels.

The government recommends that everyone:

- eats at least five portions of a variety of fruit and vegetables every day
- base meals on potatoes, bread, rice, pasta or other starchy carbohydrates choosing wholegrain versions where possible
- have some dairy or dairy alternatives (such as calcium fortified soya drinks) :choosing lower fat and lower sugar options
- eats some beans, pulses, fish, eggs, meat and other proteins. This includes two portions of fish every week, one of which should be oily. If consuming more than 90g of red or processed meat per day, try to cut down to no more than 70g on average
- choose unsaturated oils and spreads and eat in small amounts
- drink six to eight cups/glasses of fluid every day [21]

Key statistics

49% of Birmingham adults aged 16+ years eat the recommended 5 a day on a usual day, compared to the England average of 55%. Figure 1 shows Birmingham in comparison to other Core Cities. Nationally, more women eat the recommended 5 a day than men (59% compared to 50%). The proportion rises with age, particularly among over 55s. People living in the most deprived 10% of neighbourhoods in England are the least likely to eat the recommended 5 a day and those in the least deprived areas most likely (46% compared to 60%) [22].

Figure 1 Percent of Adults Aged 16+ Eating Recommended 5 a Day on a Usual Day in 2017/18

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[21] Public health England: Healthier and more sustainable catering: Nutrition principles

[22] Public Health England : Public Health Outcomes Framework 2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)

Source: Public Health England

The National Diet and Nutritional Survey (NDNS) gives national figures on nutritional intake [23]

Free sugars [24]

It is recommended that these make up no more than 5% of energy intake.
The average intake nationally for 19-64year olds was 11% (both men and women).
The main sources of free sugars in adults aged 19 to 64 years were 'sugar, preserves and confectionery' (25%), 'cereal and cereal products' (24%) and 'non-alcoholic beverages' (21%).

Fibre

Fibre is measured using a method developed by the American Association of Analytical Chemists (AOAC); so AOAC fibre is often referred to. Using this, the

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[23] [Results of the National Diet and Nutrition Survey (NDNS) rolling programme for 2014 to 2015 and 2015 to 2016](#)

[24] Free sugars includes all added sugars in any form; all sugars naturally present in fruit and vegetable juices, purees and pastes, and similar products in which the structure has been broken down; all sugars in drinks (except for dairy-based drinks) and lactose and galactose added as ingredients

recommended intake is 30g/day for adults – From the national survey of 19-64 year olds, only 13% of men met the recommended daily intake, and 4% of women.

Saturated fat

Saturated fat recommended consumption is 12.5% for adults aged 19-64 years – the national survey showed the following consumption - men 27%, women 23%.

Fruit and vegetables

The survey revealed 31% of adults achieving 5-a-day (compared to 55% from Active Lives, which is a self-reported figure).

Red and processed meat

Adults are advised to eat no more than 70g/day. The survey reported men eating 77g and women 47g.

Oily fish

The recommended intake is 140g/day. In the survey adults reported eating 8g/day.

Micronutrients

Table 3 Proportion of males and females aged 19-64 in the UK with intakes of micronutrients (from food sources) below the lower reference nutrient intake (LRNI)*

	Calcium	Folate**	Iodine	Iron	Potassium	Zinc
Men	7	3	9	2	11	7
Women	11	5 ***	15	27	23	8

*Intakes below the LRNI are inadequate for most individuals.
**also includes supplements
*** 7% of women aged 19-49 y (defined by NDNS as 'childbearing age') were reported to have intakes below LRNI

The Global Nutrition Report is the world's leading report on the state of global nutrition [25]. In the 2018 report it noted that the United Kingdom is off course to meet the global targets for anaemia in women of reproductive age. This is echoed by the low folate intake by women shown in table 3.

Salt

The NDNS did an in-depth report on salt intake in 2014 [26] for adults in England. The average intake of salt per day for adults was 8g/day. This was 33% higher

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[25] 2018 Global Nutrition Report
[26] National Diet and Nutrition Survey: assessment of dietary sodium

than the recommended intake. Intake was 9.1g/day for men and 6.8g/day for women.

Almost 20% of deaths worldwide are attributable to an unhealthy diet[27]. Since 2008, the price of food has risen 10% more than other goods making low income households particularly susceptible to consuming unhealthy diets. Excluding food bought out of the home, the average household spends 11% of their income on food. This is 16% for low-income households, who now spend 23% more on food than they did in 2007, compared to the average increase of 18%.

Single pregnant mothers are also in the risk group for poor dietary habits as it is estimated a healthy diet costs £30.34 per week, which is 57% of Jobseeker's Allowance for those under 25. Price is the most important feature in buying food for over a third of customers and is a commonly cited barrier to consuming a healthier diet. Research suggests that healthier foods are up to three times the cost per calorie of unhealthier food and it has been estimated that spending per calorie has dropped 5% since 2008. In addition to this whilst the number of those living with food insecurity is likely to be higher than the number accessing food banks, in 2013, an estimated 500,000 people relied on emergency food aid [28].

Diversity and inclusion

There is sparse data to inform us of food and nutrition differences in the diverse groups that make up the city's population. The Birmingham Creating a Healthy City Forum is conducting an online survey of food habits and behaviour which should shed light on the local situation.

Service Model

Birmingham City Council is creating a Health Food City strategy that will,

- Improve the access to affordable healthy sustainable food across Birmingham in every community for every citizen
- Develop a sustainable food city approach across the food system in the city
- Reduce the inequalities in food access and nutritional intake across the city
- Work in partnership with citizens and organisations across the city to achieve the shared ambition to create a healthy food city in Birmingham

Trends & Future Analysis

The National Diet and Nutrition Survey rolling programme has reported findings for a 9 year period, 2008/09 – 2016/17.[29]

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[27] Global Burden of Disease, 2017
[28] Barriers to Healthy food – Houses of Parliament
[29] National Diet and Nutrition Survey: Years 1 to 9 of the Rolling Programme (2008/2009 – 2016/2017): Time trend and income analyses

The trends for food were that there was little change in intake of fruit and vegetables, with all age/sex groups having a mean intake below the 5 a day recommendation. There was a downward trend in consumption of fruit juice and little change in the intake of oily fish. Red and processed meat consumption showed a downwards trend.

The trends for nutrients were that adults showed a reduction in the intake of free sugars, but still exceeded the current recommended intake. Adults showed a reduction in trans fatty acids intake (with trans fats produced artificially through food processing), although no trend was seen in the consumption of total fat or saturated fatty acid intakes as a percentage of food energy. Men aged 19-64 showed a significant increase in fibre intake; although average intakes for fibre for all groups remained below recommendations. There was a downward trend in intakes of most vitamins and minerals over the 9-year period for many age/sex groups.

Section 2: Disease Conditions

Excess Weight

Definition

The term obese describes a person who is very overweight, with a lot of body fat. The most widely used method to check if you're a healthy weight is body mass index (BMI). BMI is a measure of whether you're a healthy weight for your height. [30]

For most adults, a BMI of:
- 18.5 to 24.9 means you're a healthy weight
- 25 to 29.9 means you're overweight
- 30 to 39.9 means you're obese
- 40 or above means you're severely obese

Key statistics

In 2017/18, just over 65% of Birmingham adults aged 18 and over have excess weight (overweight or obese) compared to the England average of 62% (see figure 2). Nationally, men are more likely to have excess weight than women (68% compared to 56%), with the proportion rising with age (53% 25-34 years, 71% 65-74 years).

Figure 2 Percent Adults with Excess Weight in 2017/18

Source : Public Health England

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[30] https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-call-to-action-on-obesity-in-england

20
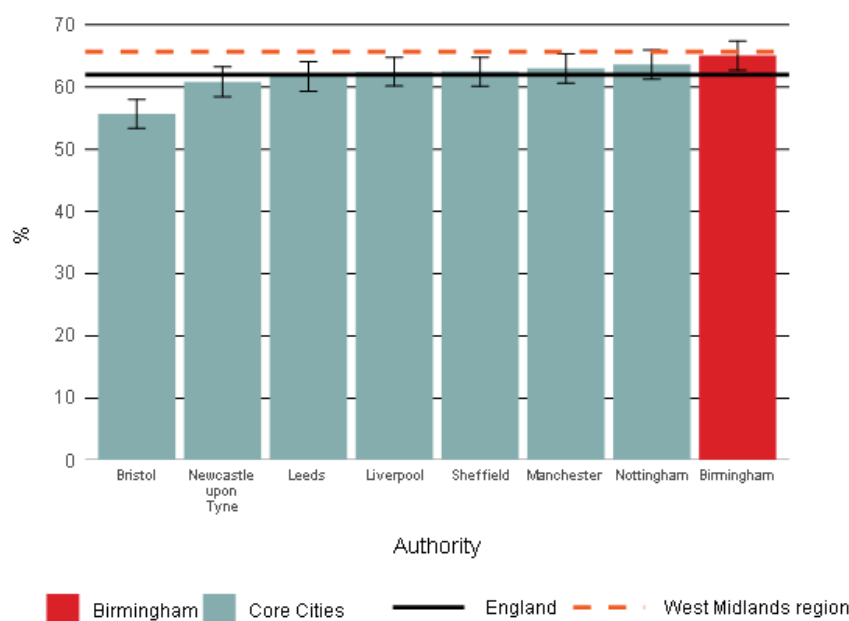
Diversity and inclusion

Sport England's recent survey (July 2019) showed that Black adults were the most likely ethnic group to be overweight or obese, with a prevalence of 72.8%. The Chinese ethnic group were least likely to have excess weight, at 34.5%. Unfortunately, the report is only done nationally, so no local data exists.[31]

Analysis has shown that nationally lesbian and bisexual women were more likely to be overweight or obese compared with heterosexual women, and gay men were less likely to be overweight or obese compared with heterosexual men.[32] Whilst the UK does not record sexual orientation systematically as part of the general health services offered there are some theories on why this inequality may exist such as increased stress or discrimination, or that the body-size standards adopted by heterosexuals are in fact rejected by LGBT+ communities.[33]

It is estimated that weight gain during pregnancy varies with the BMI of the mother at the time of conception. A woman with normal BMI can expect to gain between 11 to 40 pounds, most of which should be lost quickly after birth. NICE guidance [34] suggests that for those wanting to conceive, health officials should offer advice on weight loss or explain the health implications and how important it is for them to monitor their weight and do light exercise to maintain a healthy pregnancy and positive birth outcome.

People living in the 10% most deprived neighbourhoods in England are also more likely to have excess weight than those in the least deprived areas (67% compared to 56%)[35].

Nationally people belonging to a routine or manual socioeconomic class are more likely to be overweight compared with other socioeconomic groups (66% in the recent 2017/18 data). However, other groupings for intermediate occupations and unemployed are also significantly worse than the England average, with 65.1% and 64.3% respectively in the latest 2017/18 data[36].

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[31] GOV.UK: Ethnicity facts and figures Obese adults
[32] Why body mass index and sexual orientation study raises health concerns for lesbian and gay
[33] Bisexual Women and Beauty Norms
[34] NICE: Weight management before, during and after pregnancy 2010
[35] Public Health England: Public Health Outcomes Framework 2.12 - % of adults classified as overweight or obese
[36] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/7/gid/1000042/pat/6/par/E12000005/ati/102/are/E08000025/iid/93088/age/168/sex/4

Figure 3 Percent of adults (18+) classified as overweight or obese by socio-economic class (2017/18)

C16 – Percentage of adults (aged 18+) classified as overweight or obese (2017/18) – England Socioeconomic class

Socioeconomic class	%
Managerial and professional oc...	61.2
Intermediate occupations	65.1
Routine and manual occupations	66.0
Never worked and long term une...	64.3
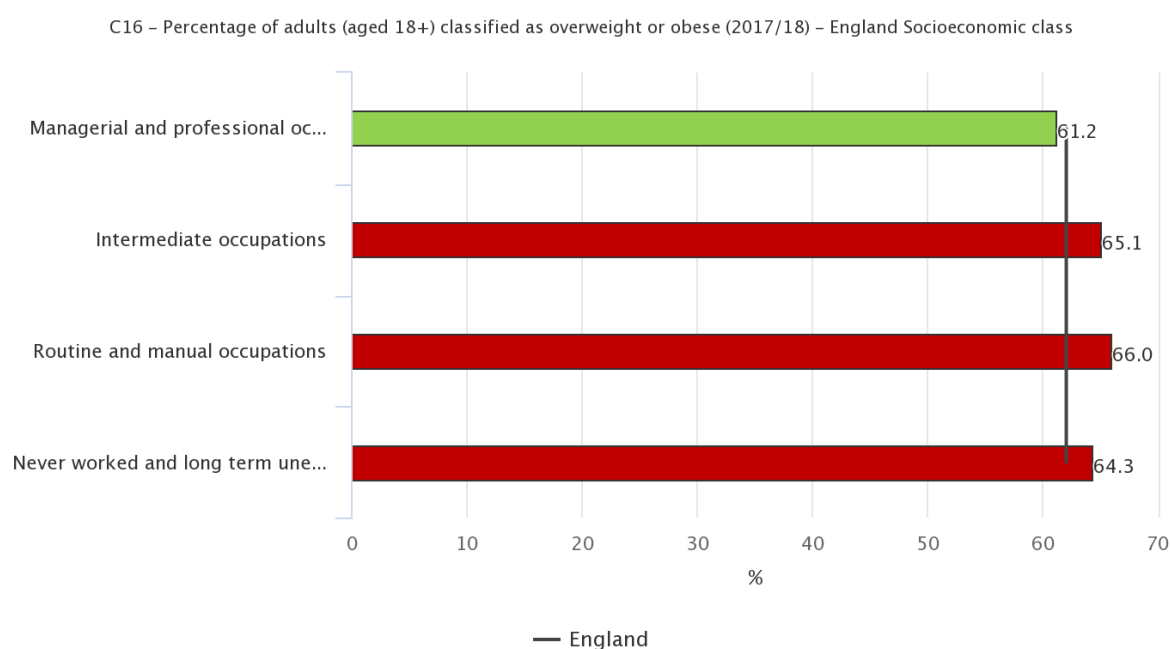
— England

Source: Public Health England

Service Model

The Active Wellbeing Society [37] (TAWS) provide a wide range of free activities for Birmingham residents of all levels from absolute beginners, through to advanced practitioners (the BeActive scheme), in partnership with Birmingham Public Health. Residents are offered free swimming, group exercise classes and gym sessions at certain times of the day at various leisure centres and parks. They are also creating safe, active, healthy spaces within communities through their Active Streets and Active Communities initiatives. Additionally TAWS provide Be Active Plus, which is a GP referral exercise programme for people with specific medical conditions that can benefit from being more active, such as obesity.
The Specialist Weight Management Service at Birmingham Community Healthcare Trust is for people who have struggled with their weight for a long period of time. The service offers a more intensive approach to weight management, when other interventions have not worked, making sure that all options have been tried before someone is considered for obesity surgery. Access to bariatric surgery is currently only considered when previous conventional weight management has failed.
Move More Eat Well[38] in the South of the city provides community focused food growing and cooking programmes.

More broadly, the Creating a Healthy Food City Forum is taking a system wide approach to work such as Birmingham's role in the Milan Urban Food Policy Pact, the BINDI partnership and the Childhood Obesity Trailblazer, which are all concerned with developing and delivering a robust action plan that will underpin Health and Wellbeing Board healthier food and obesity priorities.

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[37] https://theaws.co.uk/
[38] https://movemoreeatwell.com/

22

Trends & Future Analysis

Nationally, data from the NHS Health Survey for England shows that the percentage of adults classified as obese increased from 24% in 2006 to 26% in 2016, with the upward trend evident amongst both men and women[39].

Figure 4 National trends in Obese Adults

Trends in Adults Aged 16+ in England Classified as % Obese

Source : NHS Health Survey for England 2016
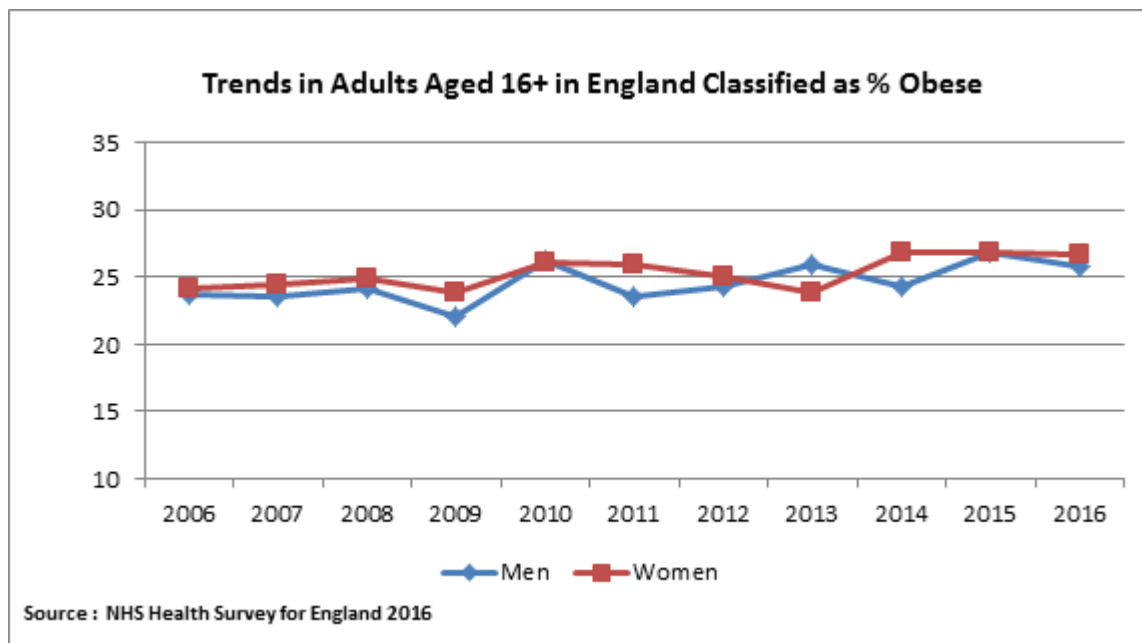
Cardiovascular Health

Definition

Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels and is currently the major cause of death and disability in the UK. It includes coronary artery diseases such as angina and myocardial infarction (heart attack) and stroke amongst others. The NHS focus is on ABC (Atrial fibrillation (AF), blood pressure and cholesterol).

Key statistics

The early mortality (under 75 years) death rate from coronary heart disease (CHD) for Birmingham and Solihull (BSOL) CCG is 63.3 per 100,000: significantly higher than England (38.2) [40]. CHD is the commonest underlying cause of AF. Prevalence of AF (1.6%) and stroke (1.4%) is lower in Birmingham compared to England (2% and 1.8% respectively). This could be due to underdiagnoses of the condition, but

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[39] NHS Digital: Health Survey for England 2016
[40] Public Health England. Heart Disease Profile [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]

also because it mostly affects those aged 65+.[41] Approximately 13.9% of people within the CCG area have diagnosed hypertension, a key risk factor for CVD [42].

Diversity and inclusion

- Men generally develop CVD at a younger age and have a higher risk of CHD than women. Women, in contrast, are at a higher risk of stroke, which often occurs at older age [43]
- South Asians are at a highest risk of developing Coronary Heart Diseases (CHD) and strokes especially in 65+ age groups. African Caribbean are more likely to have higher blood pressure [44].
- CVD is strongly associated with deprivation due to higher prevalence of lifestyle risk factors such as smoking, alcohol and lack of physical activity.
- Research suggests LGBT groups are more likely to experience adverse cardiovascular outcomes relative to heterosexuals [45].
- Women have a relatively low risk of CVD events during pregnancy. However, the biggest causes of maternal deaths are due to heart disease due to the extra exertion experienced on the heart by women during the first trimester [46].

Service Model

Early detection of the risks of CVD and changes in lifestyle or treatment can reduce the risks. NHS Health Checks programme is designed for adults aged 40-74 years old [47] to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. Lifestyle support to prevent CVD is designed around stop smoking services, maintaining a healthy weight, encouraging individuals to exercise and consuming a balanced diet [48]. For patients with existing heart conditions, Birmingham has the Community Heart Failure Specialist and the Community Cardiac Rehabilitation Team [49].

Service data

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[41] Public Health England. Stroke Profile [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]

[42] Public Health England. Cardiovascular Disease Profile [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]

[43] Bots SH, Peters SA, Woodward M. Sex differences in coronary heart disease and stroke mortality: a global assessment of the effect of ageing between 1980 and 2010. BMJ global health. 2017 Mar 1;2(2):e000298.

[44] https://www.bhf.org.uk/informationsupport/support/your-ethnicity-and-heart-disease

[45] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3659331/

[46] https://www.bhf.org.uk/informationsupport/heart-matters-magazine/medical/women/pregnancy-and-heart-disease

[47] https://www.nhs.uk/conditions/nhs-health-check/?tabname=menu

[48] https://www.nhs.uk/conditions/cardiovascular-disease/

[49] https://www.bhamcommunity.nhs.uk/patients-public/adults/cardiac-services/

24

From 2013/14 to 2017/18, 56.7% of Birmingham's eligible population received a health check, compared to the England average of 44.3% and a Core Cities average 41.8%[50].

Trends & Future Analysis

Birmingham, being similar to England, has seen the halving of CVD rates for under 75s from 2001/03 to 2016/18, dropping from 178.4 deaths per 100,000 population to 95.5. England's rate decreased from 138.0 to 71.7. There has been variable change across the Core Cities with some showing increase and other decreases across the same time period, as of 2016/18 Birmingham is fourth out of the eight Core Cities and Birmingham's mortality rate remains significantly higher than England.[51]

Diabetes

Definition

Diabetes Mellitus is a chronic metabolic disorder where the pancreas does not produce the hormone insulin or fails to produce or use it effectively. In the case of type 1 diabetes, insulin is not produced due to the immune system destroying the insulin producing cells of the pancreas. With type 2, the body does not respond to insulin effectively. This is often referred to as insulin resistance and in the long term this can lead to less insulin being produced by the pancreas. Type 2 diabetes accounts for around 90% of cases.

Key statistics

Diabetes is major cause of premature death and disability; people with type 1 diabetes are 129% more likely to die prematurely than those without, whilst those with Type 2 are at 34.5% additional risk[52].

Diabetes prevalence for Birmingham is higher than England. The figures are only available by NHS area; with Birmingham and Solihull (BSoL) CCG having a rate of 8.4% (England 6.9%) for adults 17+ in 2018/19. A proportion of Birmingham's residents are counted in the data for Sandwell and West Birmingham CCG: this CCG has the highest diabetes prevalence in the West Midlands at 9.3%.

In 2018, the estimated diabetes diagnosis rate in Birmingham for adults was 80.4%, which was second highest of the Core Cities.[53] While the diagnosis rate is slightly higher than England there are still around 1 in 5 people with diabetes who are undiagnosed and these individuals may be at higher risk of life changing complications such as retinopathy, neuropathy, kidney disease, amputation and CVD events because their condition is unmanaged.

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[50] Public Health Outcomes Framework 2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check
[51] Public Health England. Mortality Profile [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]
[52] Public Health England Public Health Matters Blog
[53] Public Health England: Public Health Outcomes Framework 2.17 - Estimated diabetes diagnosis rate

Diversity and inclusion

- Nationally, people living in the most deprived 10% of neighbourhoods in England are more likely to have diabetes than those in the least deprived areas (7.5% compared to 5.6%)[54] 52% of referrals for an initial assessment for diabetes were from Decile 1 (most deprived) for 2019 in Birmingham
- Type 2 diabetes is up to 6 times more likely in people of South Asian descent and up to three times more likely in African and Africa-Caribbean people[55].
- Evidence from Birmingham suggests that prevalence in the LGBT community is similar to the general population.[56].
- Of women who have diabetes during pregnancy, it is estimated that approximately 87.5% have gestational diabetes (which may or may not resolve after pregnancy), 7.5% have type 1 diabetes and the remaining 5% have type 2 diabetes[57].

Service Model

BSol CCG has received funding from NHSE to transform diabetes care and reduce variation in outcomes, experience and spend. Multidisciplinary diabetes teams will support patients with diabetes to achieve the 3 NICE recommended treatment targets (HbA1c, blood pressure, cholesterol).

The Diabetes Inpatient Specialist Nursing service now operates 7 days a week and has improved referral processes to the DISN service. Policy has been developed and implemented to ensure eligible patients can access real-time continuous glucose monitoring (CGM) and flash glucose scanning (FGS). These new technologies are available to support management of type 1 diabetes, helping patients to better manage their blood glucose levels.[58].

Under the Universal Offer agreement with Primary Care, practices are asked to identify those at risk of developing type 2 diabetes and offer eligible patients a referral into the NHS Diabetes Prevention Programme (NDPP) Between July 2016 and June 2019 Birmingham referred 26,699 individuals into the service.

Trends & Future Analysis

Prevalence of type 2 diabetes continues to rise and evidence suggest this can be attributed to increasing levels of obesity and other lifestyle risk factors that are considered modifiable.

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[54]   Public Health England. Diabetes Profile [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]

[55] Association of glycaemia with macrovascular and microvascular complications of Type 2 diabetes: prospective observational study British Medical Journal 2000; 321: 405-412

[56] LGBT Birmingham (2011) Out and about in Birmingham

[57] https://www.nice.org.uk/guidance/ng3/chapter/Introduction

[58]NHS Birmingham and Solihull CCG (Commissioning Department)

Liver Disease

Definition

The liver is the largest gland, and the largest solid organ in the body, holding approximately 13% of total blood supply and has over 500 functions. There are many different types of liver disease. The most common are alcohol-related liver disease, non-alcoholic fatty liver disease, hepatitis, haemochromatosis and primary biliary cirrhosis. Liver disease is largely preventable.[59] Hepatitis is an inflammatory condition of the liver, commonly caused by a viral infection, but there are other possible causes of hepatitis. These include autoimmune hepatitis and hepatitis that occurs as a secondary result of medications, drugs, toxins, and alcohol.

Key statistics

Alcoholic liver disease is one of the top three causes of premature mortality in Birmingham. In the period 2014-16 this disease accounted for 1,552 excess years of life lost (YLL) for those aged under 75. [60] YLL is a summary measure of premature mortality. YLL estimates the years of potential life lost due to premature deaths

Prevalence

The rate for Birmingham hospital admissions due to liver disease in 2016/17 was 130 per 100,000, fourth highest of the seven Core Cites who submitted data for this period across all persons. The rate is higher for males (173) and is like the England rate. The rate for females (90.7) is significantly lower than the national rate.[61] All Core Cities who submitted data also showed higher prevalence in males compared to females.

The Birmingham rate for hospital admissions for *alcoholic* liver disease for males in 2016/17 was 66.9 per 100,000, significantly higher than the national average. The rate for females (27.7) is similar to the national rate.

Diversity and inclusion

- Prevalence of liver disease is higher for males than females
- The association of poor health with deprivation is well established. The 10% most deprived areas in England have a hospital admissions rate of 167.3 per 100,000 for liver disease, compared to only 97.2 in the least deprived
- The LGBT community have a higher than average alcohol consumption, mainly because social occasions for this community tend to centre on venues providing it. 10.8% of those who took part in a local survey [62] had digestive, liver and kidney problems indirectly or directly linked to their consumption.

Service Model and data

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[59] https://www.nhs.uk/conditions/liver-disease/
[60] Birmingham Public Health: Birmingham Health Profile 2019
[61] Public Health England, Liver Disease Profiles, https://fingertips.phe.org.uk/profile/liver-disease
[62] Out and About In Birmingham, Birmingham LGBT

Most liver disease can be prevented by maintaining a healthy weight and staying within the recommended alcohol limits. There are vaccines available for hepatitis A and hepatitis B. A liver transplant may be required in severe cases.

University Hospitals Birmingham NHS Foundation Trust Liver and Hepato-Pancreato-Bilary Unit [63] is one of the largest in the UK. The unit treats all types of liver diseases.

Social care and support may be required for support with day-to-day living. Respite care and support to carers who are looking after those living with the condition.

Trends & Future Analysis

In Birmingham premature deaths relating to liver disease in males are rising (figure 5).[64] However, deaths for women have fallen since 2013-2015.

Figure 5 Under 75 mortality trend for liver disease
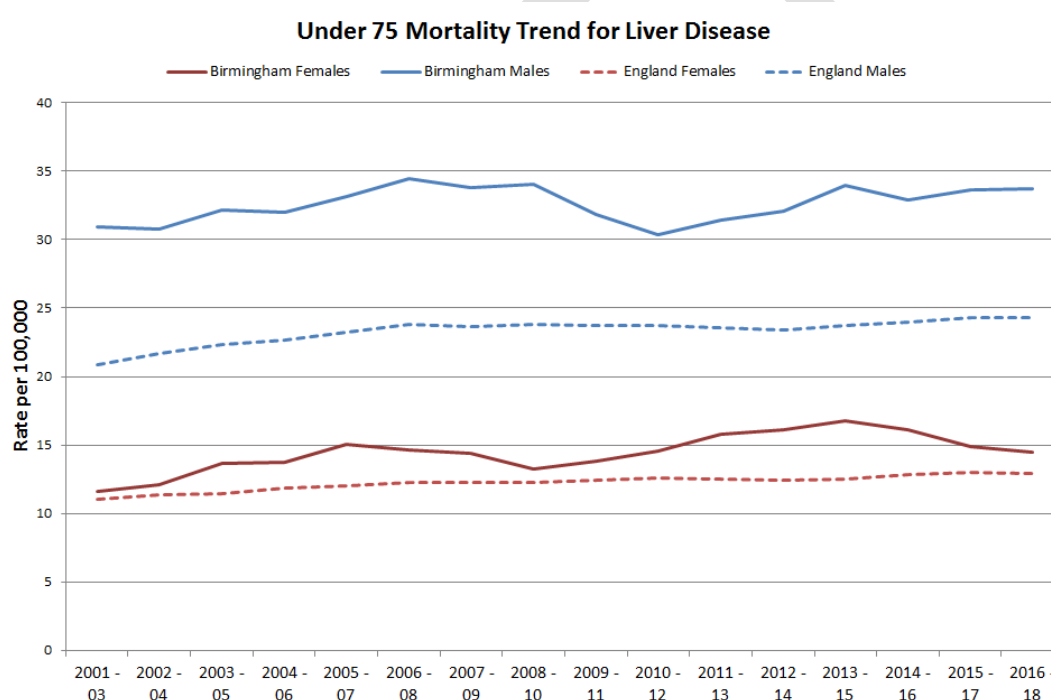
Source: Office for National Statistics: Public Health England Annual Mortality Extracts

Kidney Disease

Definition

The kidneys are a pair of bean-shaped organs on either side of the spine, filtering blood, removing waste, controlling the body's fluid balance, and keeping the right levels of electrolytes. All of the blood in your body passes through them several times a day. Chronic kidney disease (CKD) is a long-term condition where the

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[63] University Hospitals Birmingham https://www.uhb.nhs.uk/liver-unit.htm
[64] Office for National Statistics: Public Health England Annual Mortality Extracts

kidneys don't work as well as they should and is commonly associated with getting older. CKD can get worse over time and eventually the kidneys may stop working altogether. However, many people with CKD can live long lives with the condition. CKD is usually caused by conditions that put a strain on the kidneys and is often the result of a combination of different problems e.g. high blood pressure, diabetes, high cholesterol and kidney infections. Cardiovascular disease is one of the main causes of death in people with kidney disease, although healthy lifestyle changes and medicine can help reduce this risk.

Key Statistics

- 50% of people aged 75 and over have some form of kidney disease.[65]
- CKD only progresses to kidney failure in around 1 in 50 people with the condition.
- Survival rates for kidney transplants are very good. About 90% of transplants still function after 5 years and many work usefully after 10 years or more.

Prevalence

The diagnosed prevalence of CKD within Birmingham and Solihull STP area was 4.2% which is similar to the national average. However, it is estimated the prevalence may be 5.9%.[66]

Diversity and inclusion

- CKD occurs earlier and more frequently in Asian and Black African ethnicities.[67]
- 10% of the Birmingham LGBT community who took part in a local survey [68] had digestive, liver and kidney problems indirectly or directly linked to their consumption.

Service Model

CKD can be prevented by maintaining a healthy lifestyle and ensuring any underlying conditions are well controlled. Lifestyle changes include stopping smoking, eating a healthy diet, restricting salt intake, regular exercise, recommended alcohol intake and losing weight.

Early diagnosis means patients benefit from early treatment, usually medicine to control associated problems such as high blood pressure and high cholesterol. Most people with CKD will be able to control their condition with medicine and regular check-ups.

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[65] Kidney Care UK, https://www.kidneycareuk.org/about-kidney-health/conditions/ckd/
[66] NHS Digital, Quality and Outcomes Framework (QOF) 2018-19
[67] Mathur et al, 2018, Ethnic differences in the progression of chronic kidney disease and risk of death in a UK diabetic population: an observational cohort study, BMJ 8;3 https://bmjopen.bmj.com/content/8/3/e020145
[68] Out and About In Birmingham, Birmingham LGBT

Think Kidneys is a national programme led by the renal community and supported by NHS England and the UK Renal Registry and is the NHS campaign to improve the care of people at risk of, or with acute kidney injury.[69]

For a small proportion of people, the kidneys will stop working. In these cases, dialysis treatment to replicate some of the kidney's functions may be necessary. Haemodialysis is usually done about 3 times a week, either at hospital or at home. Peritoneal dialysis is normally done at home several times a day, or overnight. Treatment with dialysis will usually need to be lifelong unless there is a kidney transplant.

Kidney transplant is often the most effective treatment for advanced kidney disease but involves major surgery and taking medicines (immunosuppressants) for the rest of the recipient's life. Supportive treatment is offered for those who decide not to have dialysis or a transplant or are not suitable for these treatments. The aim is to treat and control the symptoms of kidney failure. It includes medical, psychological and practical care for both the person with kidney failure and their family, including planning for the end of life.

Social care and support may be required for support with day-to-day living. Respite care and support to carers who are looking after those living with the condition.

Service data

CKD is one of the QOF disease registers. GPs are required to maintain a register of patients aged 18 and over with the condition. There are three treatment indicators relating to blood pressure, treatment for hypertension and proteinuria, and urine ablumin:creatinin ratio. Birmingham and Solihull GPs perform better than the national average for these.

Trends & Future Analysis

Prevalence for the City has remained at a similar level to the national rate since 2012/13. As the numbers of older residents increases, the numbers with CKD will rise.

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[69] Think Kidneys https://www.thinkkidneys.nhs.uk/aki/aki-data/

Respiratory Illness

Respiratory Illness effects the lungs and other parts of the respiratory system. The most common chronic diagnosed diseases are Asthma and Chronic Obstructive Pulmonary Disease (COPD). COPD defines a group of lung diseases which cause breathing difficulties including emphysema (which damages the air sacs in the lungs) and chronic bronchitis (which is the long-term inflammation of the airways).

The biggest risk groups for COPD are middle-aged or older adults who smoke. Untreated, COPD can cause breathing problems which tend to get worse resulting in limitations of everyday activities. Treatment for COPD can help keep it under control.

Key statistics

Respiratory disease affects one in five people and is the third biggest cause of death in England (after cancer and cardiovascular disease)[70] and UK prevalence has increased by around 27% in the last decade[71]

The combined QOF prevalence estimates of Birmingham's two CCGs suggest in 2018/19 that around 1.7% of the adult population have a COPD diagnosis in comparison to a QOF prevalence of 1.9% nationally[72]. During 2017/18, Birmingham hospitals had nearly 27,000 [73] inpatient admissions for COPD symptoms.

Diversity and inclusion

Many inequalities related to COPD can be attributed to different patterns of smoking.

- There is some evidence that ethnicity is related to risk of COPD. However, it is suggested that much of this could be due to smoking and deprivation and more likely to be related to severity than incidence. [74]
- The LGBT community have a higher than average smoking prevalence. This was reflected in a report by LGBT Birmingham that showed 24.3% of those suffered from long term chest / breathing conditions associated with COPD and asthma.
- Incidence and mortality rates from respiratory disease are higher in disadvantaged groups and areas of social deprivation. The most deprived communities have a higher smoking rates, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards
- Pregnancy – the side effects of COPD or asthma can be exacerbated during pregnancy, making breathing more difficult particularly during the first trimester when inhalers or any other type of steroid is not recommended. However, these can be used later and so assist pregnant women with the condition.
- Employment - initial diagnosis of COPD varies but generally manifests around middle age. Initially, this can lead to short periods of absence from work whilst

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[70]

[71] Nell N, Strachan D, Hubbard R, *et al* S32 Epidemiology of chronic obstructive pulmonary disease (COPD) in the uk: findings from the british lung foundation's 'respiratory health of the nation' project. *Thorax* 2016;**71:**A20.

[72] https://qof.digital.nhs.uk/

[73] 2017/18 HES Inpatients data from NHS Digital

[74] PHE: COPD prevalence model for small populations

undergoing treatment if required but as the condition worsens, absence increases and leads to many taking early retirement.

Service Model

Respiratory Admission Avoidance and Assisted Discharge Service is available for North, East, Central and West Birmingham adult patients aged 35 or over who have a confirmed diagnosis of COPD and other conditions. Central and West Birmingham primary care respiratory clinic is led by a GP. The Pulmonary rehabilitation programme is offered to Central and West Birmingham adult patients aged 35 years and over with a suspected/confirmed diagnosis of COPD or any other respiratory disease. The Admission Avoidance and Assisted Discharge Service provides access for adults with chronic asthma, COPD and bronchiectasis to deliver active care management when their condition is unstable[75].

Trends & Future Analysis

Similar to national trends and those in other Core Cities, the under 75 mortality rates for respiratory diseases for Birmingham residents in 2016/18 is less than in 2001/03. However, the rate is currently fifth amongst the Core Cities, and has always been significantly greater than the national average and we have not seen a decline in the city's rate since 2009/11.[76]

Mental Health
Definition

'Mental health' and 'mental illness' are often used interchangeably, although mental health is more than simply an absence of mental illness. Everyone has mental health, just like everyone has health, and the state of that health is on a continuum. Not all people will experience a mental illness, but most will at some point struggle with their mental well-being (i.e. their mental health) just like we all have challenges with our physical well-being.[77]

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices.[78]

Common conditions that effect mental health include depression, anxiety, stress, panic disorders, obsessive-compulsive behaviours, and various phobias.[79] Severe

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[75] https://www.bhamcommunity.nhs.uk/patients-public/adults/respiratory-services/
[76] https://fingertips.phe.org.uk/search/respiratory#page/4/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/40701/age/163/sex/4
[77] https://www.heretohelp.bc.ca/q-and-a/whats-the-difference-between-mental-health-and-mental-illness
[78] https://www.mentalhealth.gov/basics/what-is-mental-health
[79] https://www.nice.org.uk/guidance/cg123/ifp/chapter/Common-mental-health-problems

and enduring mental illness is mainly used about long term experiences of schizophrenia and psychosis.[80]

Key statistics

Key statistics on wellbeing are fewer than those for mental illness. The Annual Population Survey asks respondents "Overall, how satisfied are you with your life nowadays?" 78.6% of Birmingham respondent rated themselves as highly satisfied (positioned fifth of the eight Core Cities), compared to 81.2% nationally. They were then asked "Overall, how happy did you feel yesterday?" 73% had a high happiness score (again fifth of the eight Core Cities), compared the England at 74.7%. [81]

In England, at any one time, about one in six people aged 16-64 will have experienced a common mental health condition such as anxiety or depression in the past week, with this being more prevalent in women (22%) than men (14%).

It is estimated that in 2019 there were nearly 134,755 Birmingham adults aged 18-64 with Common Mental Disorder (CMD), representing 18% of the age group population. CMDs include depression, generalised anxiety disorder, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder.

Diversity and Inclusion

- The LGBT community have a higher than average rate of mental health issues. This was reflected in the Outandabout in Birmingham survey that reported 31% of those who took part had mood (affective) disorders, 19.5% anxiety disorders, 9.7% adjustment disorders and 5.5% eating disorders.
- Pregnant women can experience various mental health issues, either during or post pregnancy. It is estimated by PHE that approximately 20% of pregnant women experience Perinatal mental health issues, of varying intensity. In addition, some research has suggested an association with increased risk of childhood injury.[82]
- The links between Adverse Childhood Experiences (ACEs) and poor mental health in adult life are well established, with 75% of mental illness in adult life starting by the age 18.[83]
- People who have been unemployed for more than 12 weeks show between four and ten times the prevalence of depression and anxiety than the general population.[84]
- The prevalence of common mental health disorders among homeless people is twice as high as the general population with psychosis between 4-15 times higher.[85]

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[80] https://oxfordmedicine.com/view/10.1093/med/9780199644957.001.0001/med-9780199644957-chapter-48

[81] Public Health England. Mental Health and Wellbeing JSNA Profile [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]

[82] https://adc.bmj.com/content/104/3/268?rss=1

[83] Mental Health Foundation: Mental Health statistics children and young people

[84] Waddell, G. and Burton, K. (2006) is work good for your health and wellbeing? London: TSO

- 72% of carers in the UK reported that they have suffered mental ill health because of caring.[86]
- At a national level, 17% of people living in the most deprived communities reported that they were suffering from anxiety or depression compared to 11% of people from the least deprived areas.[87]

Service Model
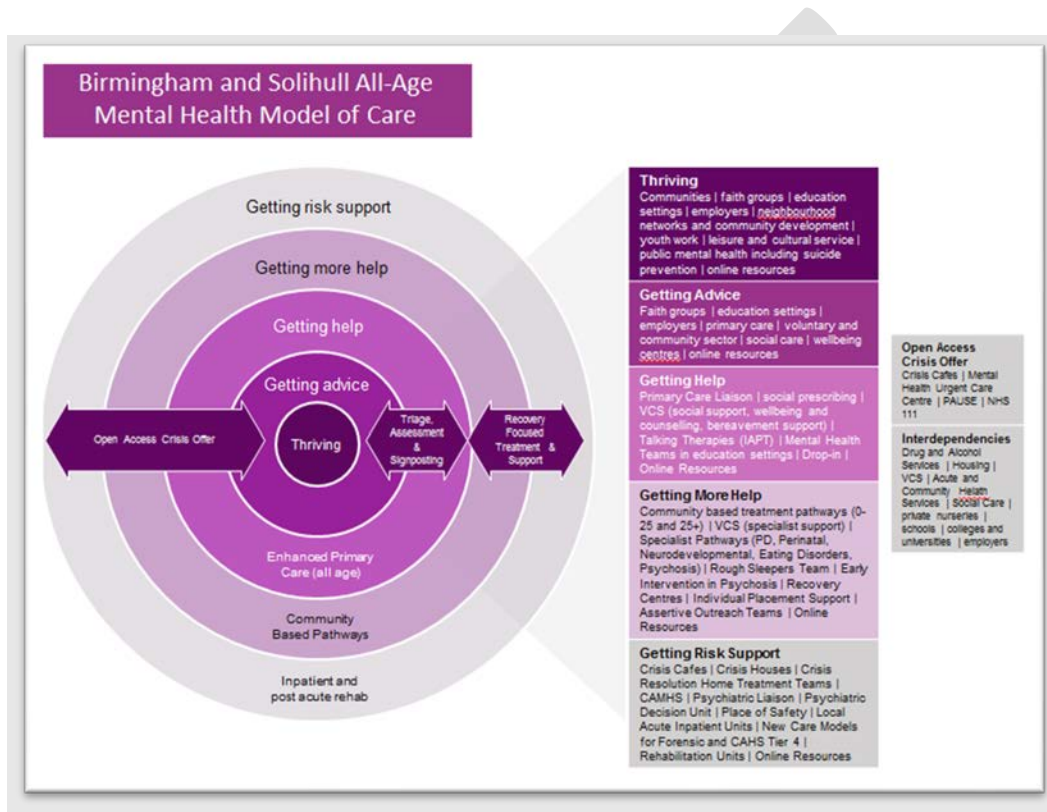
Birmingham and Solihull CCG[88] operate a proportionate universalism style model for mental health and mental illness service provision, meaning that the intensity of service increases in line with the intensity of need. On the right of the figure there is a list of the service areas contained within each 'tier' of care. The top box is not necessarily CCG commissioned but represents those community and Council driven services that can contribute to better mental health.

Birmingham City Council has now established a Creating a Mentally Healthy City Forum as a sub-committee of the Health and Wellbeing Board. This forum will ensure that the work of the Board partners, as well as the NHS Mental Health Pathways Programme Board and the Mental Health Partnership Stakeholder Board,

[85] Homeless Link: The Unhealthy State of Homelessness. Health Audit Results 2014
[86] Carers UK: The State of Caring 2018
[87] Public Health England : Mental Health and Wellbeing JSNA :- Long-term mental health problems (GP Patient Survey): % of respondents (aged 18+)
[88] https://www.birminghamandsolihullccg.nhs.uk/

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is aligned and coordinated. Current key pieces of work are the Prevention Concordat, and the Suicide Prevention Strategy and Action Plan.

The Prevention Concordat is an alliance of organisations that have committed to working together to prevent mental health problems and promote good mental health through local and national action. The Suicide Prevention Strategy acknowledges that suicide requires partnership working across the breadth of society and builds on the 2012 national strategy. This strategy has been developed through a co-production partnership between the Council and a wide range of organisations; including strategic partners, stakeholders, Third, Voluntary, and Faith organisations, who have committed to working together as a shared approach to reducing deaths through suicide.

Service Data

On average, on a monthly basis, there were just over 41,000 open referrals to NHS Adult Mental Health Services in the Birmingham and Solihull Mental Health NHS Trust in the period April 2018 to March 2019: an increase of 8% compared with the same period in 2017/18 (from 38,032 in April-March 2017/18 to 41,055 in April to March 2018/19). A similar upward trend is in the number of contacts with NHS Adult Mental Health Services is evident[89].

Figure 6 Birmingham and Solihull Mental Health Trust: Adult Mental Health Services - Number of Open Referrals and Contacts

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[89] NHS Digital: Mental Health services monthly statistics
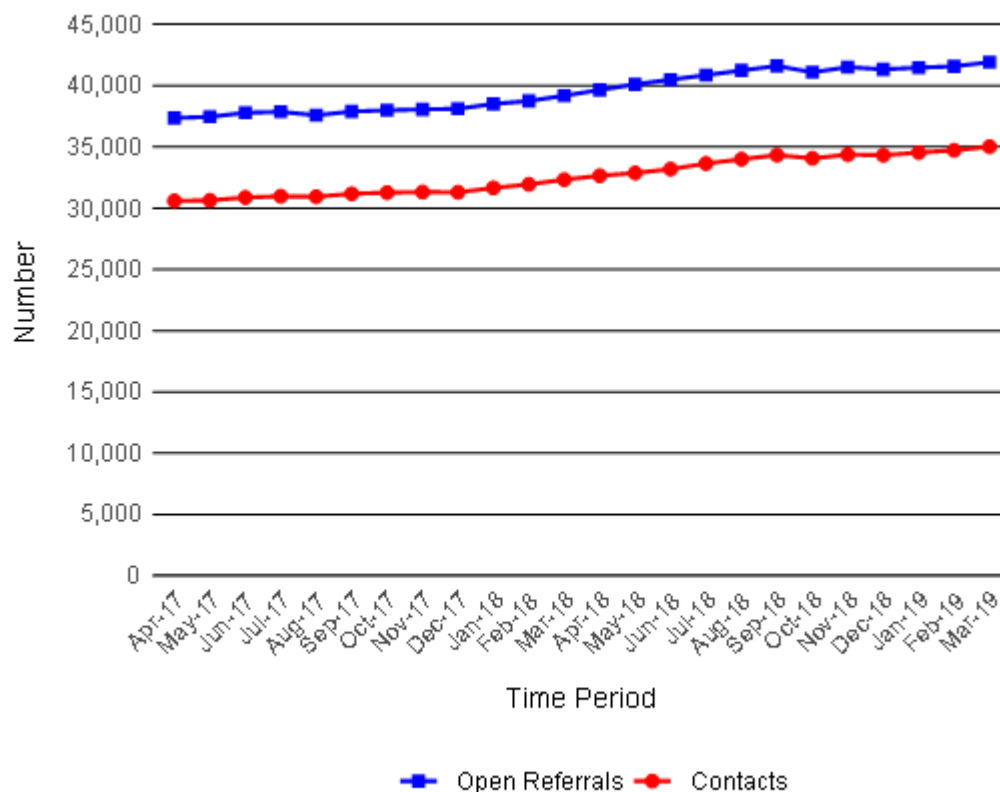
Source : NHS Digital

In Q4 2018/19, 38.5% of people in contact with substance misuse services for alcohol problems were also in contact with Birmingham community mental health services. Additionally, 30.4% of opiate users in treatment also were in contact with Birmingham community mental health services.[90]

At the end of 2017/18, 64% of Birmingham adults in contact with secondary mental health services were living independently with or without support, this is the fourth highest prevalence of the eight Core Cities and above the England Average of 57%.[91]

At the end of 2017/18, 4% of Birmingham adults in contact with secondary mental health services were in paid employment, this is the second lowest prevalence amongst the eight Core Cities and below the England average of 7%.[92]

Severe mental illness such as schizophrenia or bipolar disorder is relatively rare. For instance, 1.2% of patients registered with a Birmingham GP were recorded as have a severe mental illness, compared to 0.9% across England as a whole. Nationally, the prevalence rate for severe mental ill health is higher in the most deprived 10% of communities (1.1%) compared to the least deprived (0.8%). This is

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[90] NDTMS
[91] NHS Digital :- Adult Social Care Outcomes Framework
[92] NHS Digital :- Adult Social Care Outcomes Framework

consistent with local GP data that shows the highest prevalence rates are recorded at practices within the most deprived localities.[93]

Like England as a whole, people in Birmingham with severe mental illness are far more likely to die prematurely than the general population. In 2014/15 the excess mortality under the age of 75 for people in contact with secondary mental health services in Birmingham was 487 compared to the England average of 370, and is the third highest amongst the Core Cities. This means that people in Birmingham with a severe mental illness were 4.9 times more likely than the general population to die before 75 years of age.[94]

Trends & Future Analysis

In the 2017/18 GP Patient Survey, 9.5% of adults aged 18 and over registered with a Birmingham practice indicated that they had long-term mental health problems, in-line with the England average of 9.1%. Notwithstanding a reduction in 2016/17, the number reporting long-term mental health problems in Birmingham has, like in England as a whole, been trending upwards since 2011/12.[95]

The number of adults with Common Mental Disorder in Birmingham is predicted to increase by 5% between 2019 and 2030 (6,884 individuals, which is higher with ONS population projections [96]

This is also reflected in ONS projections which estimate there are currently just over 51,000 persons aged 18-64 in Birmingham with two or more psychiatric disorders and this is expected to increase to 55,000 by 2035.[97]

Cancer
Definition

Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. The cancerous cells can invade and destroy surrounding healthy tissue, including organs**.** Cancer sometimes begins in one part of the body before spreading to other areas. This process is known as metastasis. In the UK, the four most common types of cancer are:

- breast cancer
- lung cancer
- prostate cancer
- bowel cancer

There are up to 200 known cancers [98]

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[93] http://www.gp-patient.co.uk/surveysandreports-10-16
[94] Public Health England: Public Health Outcomes Framework 4.09i - Premature mortality in adults with severe mental illness
[95] Public Health England : Mental Health and Wellbeing JSNA :- Long-term mental health problems (GP Patient Survey): % of respondents (aged 18+)
[96] Institute of Public Care: Projecting Adult Needs and Service Information (PANSI)
[97] https://www.pansi.org.uk/
[98] https://www.nhs.uk/conditions/cancer/

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Key statistics

Prevalence

More than one in three people will develop some form of cancer during their lifetime. The 2018/19 Quality Outcomes Framework gives a prevalence of those receiving treatment by GPs across CCG, but not by local authority and as Birmingham patients fall within two CCGs we can only estimate prevalence. Latest estimates are 2.1% for Birmingham in comparison to 3.0% nationally (2018/19).

Cancer is the second largest killer in Birmingham for all ages, during 2015/17 with 1,548 people 16 to 64 died from the disease. One of the main causes of cancer is smoking and it is estimated that it accounts for 26% of cancer deaths. This means that approximately 400 of the 2015/17 cancer deaths can be attributed to smoking. Obesity has also been highlighted as a cause of the disease.[99]

In 2016 the number of new cases of cancer in Birmingham (cancer incidence rate) was in-line with the England average (612 compared to 602 per 100,000). Like England as a whole, the rate among Birmingham males is higher than among females (692 compared to 531 per 100,000).

Diversity and inclusion

- Ethnicity - During 2017/18 Birmingham had approximately 14,000 cancer hospital inpatients admissions. Of these 64% where White, 14% Asian, 5% not known or refuse to state their ethnicity, 1% were of Mixed race, 9% were Black and the remaining 3% were from other ethnicities not previously identified.
- The LGBT community have a higher than average smoking prevalence. LGBT Birmingham highlighted in a report written in 2011 that 2% of those who took part in the survey were currently suffering from cancer which was higher than the prevalence of the general population at the time.
- Pregnancy – any type of cancer can develop during pregnancy but the most common one is breast cancer approx. 1 in 6,000. Research has shown that pregnancy does not cause a cancer to grow faster, however; how you are treated for your cancer during pregnancy varies between cancers because of evasive forms that exist for some cancer. A lot will also depend on how long in the pregnancy you are [100]
- Cancer Research UK highlight that those living in most deprived quintiles are more likely to develop cancer than those living in more affluent quintiles.[101] 2015/17 cancer mortality rates for deprivation confirmed this in Birmingham with a most deprived rate of 105.3 per 100,000 and a most affluent rate of 60.9 per 100,000.

Service Model

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[99] [1] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2018/part-1-smoking-related-ill-health-and-mortality
[100] https://www.macmillan.org.uk/information-and-support/audience/cancer-and-pregnancy
[101] https://www.cancerresearchuk.org/health-professional/cancer-statistics/mortality/deprivation-gradient

Cervical cancer, breast cancer, and bowel cancer are covered by national cancer screening programmes commissioned by NHS England. Screening programmes aim to identify all people within a specified age group who may have the condition before the presentation of symptoms. These screening programmes have been shown to be effective in identifying asymptomatic individuals in the early stages of the cancer. It allows for early treatment, which has been shown to increase survival rates, and increase disability free life expectancy in comparison with people who are not screened; who present with symptoms of the disease at a later stage. GPs also offer the facility for men to be screened for prostate cancer from 60+. Additionally, many lifestyle choices can contribute to patients developing cancer; there are numerous Public Health campaigns that try to get patients to stop smoking, exercise more and eat well.

Service data

In 2017/18 cancer screening rates in Birmingham and Solihull CCG were lower than the England average.

- 68% of women aged 25-64 years have attended cervical screening within the target period (72% England)
- 68% of women aged 50-70 years have been screened for breast cancer in last 3 years (72% England)
- 52% of people aged 60-74 years have been screened for bowel cancer in last 30 months (60% England)

Trends & Future Analysis

Between 2012 and 2016 the cancer incidence rate in Birmingham fell by 4% compared to the England average reduction of 2%. The Birmingham male cancer incidence rate fell by 5% in this period and the corresponding Birmingham female rate fell by 3%. These are on a par with the England national rates which saw a reduction in males of 4% and the female's rate which remained constant for the period 2012 to 2016. Additionally, cancer has for many years either been the main cause of death in the city or the second most common cause. In 2015/17 it accounted for 34% of all deaths 16 to 64 in Birmingham.

Section 3: Wider Determinants of Health

Employment

Definition - The ONS classify an individual as employed if they are 16 or over and work at least one hour a work[102] . For most people, employment means having an integrated job in the community.

Key statistics

The seasonally adjusted unemployment count for Birmingham was 46,972 in September 2019 (an increase of 934 from quarter 2). The total prevalence of unemployed was 8.9% (an increase of 0.2% from quarter 2). Youth employment (seasonally adjusted) was 8,492, an increase of 93 (prevalence of 11.7% an increase of 0.2% from quarter 2).

The total working age residents in employment was 473,700 a decrease of 4000 from the previous quarter, (65% in total employment, 0.5% decrease from Q2).

Economic inactivity refers to the cohort of the working age population which is not in employment and is not actively seeking employment [103] thus, not part of the working population. This includes individuals such as students, homemakers, the long-term sick or retired. For Birmingham in Q3 this was 210,100 a decrease of 1,500 from Q2. The total prevalence was 28.8% (a decrease of 0.2% from Q2).

Birmingham has a well-balanced labour market with particular strengths in manufacturing, engineering, transport and storage, business administration, support services, higher education, accommodation, food, information and communication. However, unemployment remains higher in the City than in England. (See Section on Unemployed Adults).

Diversity and inclusion

- The employment rate for the city as a whole is 65.5% (Q3 2019). For BAME groups the rate is lower at 57.6%, however this difference is not statistically significant. The Equality and Human Rights Commission's report "Healing a Divided Britain" highlights that ethnic minorities also have a higher presence in uncertain employment than white workers, and this contributes to low earnings and growing inequality. The higher unemployment rates among ethnic minority groups may be the result of low educational outcomes and socio-cultural factors that limit labour market participation. The Joseph Rowntree Foundation's report on poverty and ethnicity in the labour market found that African and Bangladeshi graduates tend to be over-qualified for the positions they hold in the labour market. This implies that there are other barriers (beyond qualifications) that limit the labour market outcomes of these groups.
- LGBT - it is difficult to estimate an accurate figure of members of this community who are employed, as this is not recorded systematically. In the

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[102]

https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/definitionofemployed
[103] https://www.tutor2u.net/economics/reference/economic-inactivity

national LGBT survey, 80% of respondents aged 16-64 had been in employment at some point in the 12 months preceding the survey. Trans people were less likely to have had a paid job in the 12 months preceding the survey (65% of trans women and 57% of trans men had one)[104].

- The highest levels of unemployment (September 2019) [105] are largely concentrated in the inner-city areas of Birmingham with some pockets in outer city areas. The top five wards by unemployment are Handsworth (13.3%), Birchfield and Lozells (13.0%), Newtown (11.5%), Aston (11.4%). These wards also in the most deprived deprivation decile in the whole of England (IMD 2015).
- Pregnant employees have four main legal rights: Paid time off for antenatal care, maternity leave, maternity pay or allowance and protection against unfair treatment, discrimination or dismissal. Whilst there is nothing locally, the latest government quarterly report on those receiving maternity allowance showed that 14.5% were in employment nationally and in the West Midlands this was 4.8%
- Employment outcomes for people classified as Equalities Act (EA) or work-limiting disabled are less favourable than the population as a whole. In 2018, a lower proportion of disabled Birmingham residents were in work than across the UK as a whole (49% compared to 53%), and also unemployment rates were higher (12% compared to 8%)[106]. In addition people with health conditions or illness lasting for more than 12 months are also less likely to be in employment than the rest of the population with an employment rate of 41%, which is also lower than the UK average of 46%[107].

Service Model

The East Birmingham Board has been established to ensure that the necessary leadership, collaboration and communication are in place to co-ordinate the development and delivery of interventions across East Birmingham.
The key objectives of the Board are:
- to deliver growth;
- to bring forward the key interventions to enable local residents to benefit from the jobs and opportunities created.

The East Birmingham Board will be overseeing the development of a strategy. This is a shared statement of vision and approach, and each of the partners will commit to working in close collaboration to address the persistent issues of poverty, deprivation and inequality which were identified by the Baseline Report. Birmingham City Council has a social value policy. The Birmingham Business Charter for Social Responsibility and the Birmingham Living Wage policy are the mechanisms for implementing the social value described in this policy. It has become an integral part of the Council's procurement process and contractual arrangements.

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[104] National LGBT Survey Summary Report (2018) Government Equalities Office
[105]

https://www.birmingham.gov.uk/download/downloads/id/12673/labour_market_update_q3_2019.pdf

[106] Nomis :- ONS Annual Population Survey
[107] Nomis :- ONS Annual Population Survey

The approach to inclusive growth can apply to other parts of the city and lessons around the partnership approach will be taken and applied.

Trends & Future Analysis

Over the eight years 2010-2017 Birmingham has one of the fastest growing labour markets in England and Wales. However, the average annual increase in total employment in Birmingham (1.1%) is lower than the England and Wales average (1.45%)[108].
The number of new business starts in Birmingham fell quite sharply in 2017 (-2430 businesses, -26.4%), following four consecutive annual increases. However, this trend is consistent with the UK as a whole. New businesses in Birmingham are less likely to survive for 5 years than across the UK as a whole (39.7% vs 43.2%)[109].

Education

Background

The impact of educational attainment by young people on long term health and wellbeing outcomes is well understood. Whilst the impact of adult education on health and wellbeing is less documented, there is a growing evidence base for the links between adult learning and health and wellbeing outcomes. A 2014 Public Health England (PHE) review of adult learning concluded that it can have indirect health benefits by improving social capital and connectedness, health behaviours, skills, and employment outcomes.[110] There is also some evidence that adult learning has direct positive effects on mental health.
The PHE review of adult learning concluded that a life course approach to learning is important as groups at different stages will benefit from different learning methods. The review also highlighted the barriers to participating such as financial costs and lack of confidence in potential participants.

Key Statistics

In 2018, proportionally fewer 16-64 year olds in Birmingham had the equivalent of a degree level qualification (NVQ4+) than the England average (33% compared to 39%).[111] At the other end of the spectrum the proportion of Birmingham 16-64 year olds with low skills (either no formal qualifications or a maximum of NVQ level 1) is, at 23%, higher than the England average of 18%.
Residents (aged 16+) in the central part of the city are far less likely to have a higher-level qualification (NVQ L4 and above) than those living elsewhere in the local authority. A major difference can be seen in the proportion of qualified residents between wards such as Sutton Four Oaks, Sutton Vesey and Sutton Trinity which

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[108] NOMIS :- ONS Annual Population Survey
[109] ONS :- UK Business Demography 2017

[110] Public Health England, UCL Institute of Health Equity, Local action on health inequalities: Adult learning services
[111] ONS/Nomis: Annual Population Survey

have respectively 42.0%, 40.1%, 37%, compared to Aston, Bordesley Green and Washwood Heath (16.5%, 14.6% and 12.8%).[112]

People with higher level qualifications have far more favorable employment outcomes than those with lower level qualifications. This is particularly evident if the employment rate between those with degree level qualifications are compared to those with no qualifications (42% compared to 7%).[113]

Figure 7 Employment rates by level of qualification for Birmingham 16-64 year olds at 2018

Source : Annual Population Survey
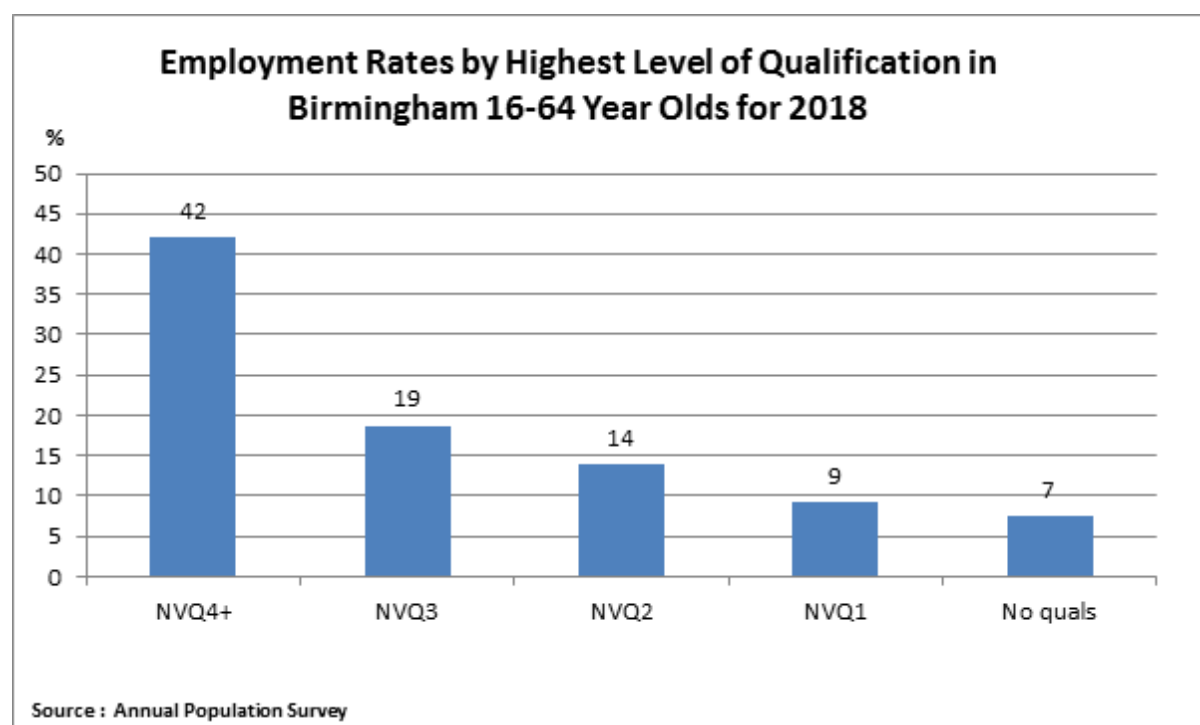
Diversity and inclusion

- Whilst adult education might have the potential to reduce health inequalities, people who are more disadvantaged tend to have lower levels of educational attainment but are also less likely to engage in adult education. However, there is some evidence that Birmingham has a better track record for adult education with deprived and minority groups.
- The 2017 Equality Report by the Birmingham Adult Education Service (BAES)[114] found that participants were more likely to be from ethnic minority groups and live in more deprived areas.

Service Model & Service Data

Birmingham Adult Education Service (BAES) has developed a wide range of partnerships across Birmingham including community and voluntary organisations,

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[112] ONS/Nomis Census 2011 Local characteristics table LC5102EW
[113] ONS/Nomis: Annual Population Survey
[114] Birmingham Adult Education Service, Equality Report 2017

libraries, schools, children's centres and employers to maximise reach into areas of disadvantage. A key focus of these partnerships is to engage with people who have been out of education for a significant time and those who are seeking work and wishing to upskill and gain employment.

During the 2015/16 academic year BAES worked in partnership with Colleges, Jobcentre Plus, The Best Network, JTL, and the National Careers Service (NCS) supporting over 2000 adults. Furthermore, BAES engaged with over 247 unemployed adults with a view to offer bespoke pre-employment training opportunities in retail, hospitality and Adult Social Care and finance securing 41 job outcomes. BAES worked in partnership with Springhill High School, Employment Access Team and YMCA for the purpose of employment referral and recruitment. In addition, some 325 unemployed adults were supported through BAES bespoke English for Speakers of Other Languages programme.

Whilst the highest proportion of enrolments on BAES courses in 2015/16 were in the 30 – 39 age group, there were significant numbers across all adult age groups.

Table 4 BAES enrolments by age group, 2015/16

Age	Enrolments	%
16-18	453	1.6%
19-29	5,948	21.4%
30-39	8,974	32.3%
40-49	5,694	20.5%
50-59	3,455	12.4%
60+	3,262	11.7%
Not recorded	7	0.0%
Total	**27,793**	**100.0%**

Women are disproportionately represented amongst learners accessing BAES courses in 2015/16 and accounted for 74% of enrolments in 2015/16. BAES continue to promote increased male participation though the use of role models and case studies.

In 2015/16 17% of learners accessing BAES courses declared they had a disability. This is higher than the prevalence of disability amongst the Birmingham population. Adult education for people with disabilities could help to address some of the inequalities experienced by individuals with disability in Birmingham such as the low rates of employment.

In 2015/16 ethnic minority groups made up a bigger proportion amongst BAES learners than they do to the population as a whole. This is influenced by the extensive work undertaken by BAES in the inner-city wards of Birmingham.

Table 5 BAES enrolments by ethnic group, 2015/16

Ethnic Group	Enrolments	%	Census 2011
Asian/Asian	9,257	33.3%	26%

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British/Other Asian			
Black/African/Caribbean/Black British/Other	4,657	16.8%	9%
Mixed/Multiple Ethnic Groups	844	3.0%	4%
White/White British	11,286	40.6%	58%
Other Ethnic Group	1,461	5.3%	2%
Not known/not provided	288	1.0%	<1%
Total	**27,793**	**100.0%**	**100%**

Family Learning

BAES provide family learning for children and their family members with the aim of helping "…families from Birmingham's disadvantaged areas learn, work and grow together."[115] Courses are provided in children's centres, early years settings, primary and secondary schools, community venues and hostels across Birmingham. The family learning provision focusses on raising achievement, aspirations and social cohesion through parental engagement. The programme is targeted towards areas of deprivation and participants who are unemployed, on benefits or have few qualifications. In 2015-16 the programme engaged 2028 parents and more than 2000 children in 81 schools and children's centres.

Family English, maths and language courses help parents to develop new skills for themselves and to support their children. Other family learning courses support learning around health and wellbeing.

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[115] http://www.learnbaes.ac.uk/family-learning

Crime and Violence

Definition

Crime and violence, in relation to community safety, is how crime and anti-social behavior affects a community. When taking a public health approach to community safety it is valuable to consider victims and vulnerability, as well as violence and reoffending.

Public mental health approaches (such as improving mental wellbeing, improving resilience, reducing risk and impact of mental ill-health) can impact on crime reduction, preventing offending and victimisation, and the rehabilitation of people who offend.

Key statistics

Key statistics on this topic are reported annually by the Local Partnership Delivery Group's Strategic Assessment. The latest edition is for 2019.

Reported crime

In the period October 1 2017 to September 30 2018 there were 104,974 crimes recorded in Birmingham. This means the city has a crime rate of 92 crimes per 1000 residents. Although this rate is above that of the West Midlands Force area (84 per 1000); when compared to the average of similar Local Authorities (rate 123/1000) Birmingham rate is lower. Compared to the same period ending September 2017 Total Recorded Crime has increased by 8,116 crimes (8%).

Victims and repeat victimisation

Of those reporting offences in Birmingham (46,557 individuals; 4.1% of the population) in the period up to September 2018, just under ¾ were Birmingham residents. 51% of offences were committed at the home address of the victim; of these 21% were categorized as domestic violence.

People experiencing repeat victimisation are those most acutely affected by crime and disorder. The risk of being a victim rises as the number of crimes experienced increases, with this risk being at its greatest immediately after a crime taking place.

Although there are concerns with data quality when it comes to examining repeat victimisation, the following is reported in the Strategic Assessment for year ending Sept.2018.

- 4,372 repeat victims accounted for 9.5% of all victims
- 1 in 10 victims are victimized more than once (1 in 7 in previous reporting period)
- Repeat victims account for 10% of all recorded crime but only make up 0.4% of the city's population
- Domestic violence accounts for 34% of repeat victims

- Of crimes committed against repeat victims – 58% were committed in the victim's home with the top five offence being
  - Actual bodily harm
  - Common assault
  - Residential burglary
  - Criminal damage to a dwelling
  - Sending communications conveying a threatening message

Offenders

Although there are intelligence gaps in understanding the profile of offenders who commit crime in Birmingham, the Strategic Assessment tells us that of the 12,436 detected offences, which were attributable to 7,589 offenders, male defendants (offenders) made up 84% of these. The peak age group for offending is 26-35 years old. Of the 12,436 detected offences, repeat offenders accounted for 7,045 of them (56%).

Domestic violence

In the strategic assessment reporting period, the year up to Sept. 2018, domestic violence accounted for 11% of total recorded crime. This is equal to 11,992 crimes and 5,540 incidents of domestic violence. This is equivalent to 16 incidents and crimes per 1,000 population in the city – compared to 19/1,000 for the West Midlands Police force area [116] Females who are aged 26-35 are particularly vulnerable – accounting for 28% of domestic violence victims.

Diversity and inclusion

Robust analysis is limited due to categories in which defendants are characterised. 53.9% of defendants were classed as 'White North European', 17.82% as 'Black', 17.15% as 'Asian', 8.94% were 'Unknown/Other/blank', 1.14% as 'White south European', 0.83% as 'Middle Eastern', 0.21% 'Chinese/Japanese/South East Asian' and 0.02% as Bangladeshi.

70% of homophobic hate crime victims were White North European. Equally LGBT Birmingham estimated in 2017 that 41% of their community had been the subject of hate crime but less likely to report it.

Service Model

Each local authority has a statutory duty to have a Community Safety Partnership. The partnership is made up of the host, Birmingham City Council, and four other authorities: Police, Fire Service, Probation Trust and Birmingham and Solihull Clinical Commissioning Group.

The Birmingham Community Safety Partnership (BCSP) has the follow statutory duties,

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116 ONS data, Year ending March 2018 – Domestic Abuse in England and Wales data tool

- To set up a strategic group to direct the work of the partnership and produce a delivery plan
- To consult and engage with the community about their priorities
- Set up information sharing protocols
- Analyse a wide range of data and produce an annual strategic assessment
- Produce a strategy to reduce reoffending
- Commission Domestic Homicide Reviews
- Community Trigger Process
- Reduce serious violence

To ensure that all the BCSP obligations are met, the following strategic themes have been established,

- Violence and reoffending theme
- Victims and vulnerability theme
- Place theme (which include anti-social behaviour and crime and the community)

Working Age Adults Facing Additional Challenges

Disabled Working Age Adults

Background

The Equality Act 2010 defines a disability as 'a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities'.

Often such disabilities are split into two areas; physical and learning disabilities. People with a disability are often vulnerable and can suffer from poorer health than the general population. They can also experience worse outcomes when the wider determinants of health are considered.

The disabilities covered in this chapter include, whether they be from birth, progressive or acquired, physical disabilities, mental disabilities, learning disabilities (distinct from learning difficulties), and autism. Long term health conditions are discussed in detail elsewhere in more detail.

Key statistics summary

On average, the life expectancy of people with a learning disability is shorter than the general population (women 18 years, men 14 years less). People with a learning disability died from an avoidable cause, compared to 9% in a comparison population of people without a learning disability [117]

A substantially higher proportion of individuals who live in families with disabled members live in poverty, compared to individuals who live in families where no one is disabled. Although disabled people are now more likely to be employed than they were in 2002, disabled people remain significantly less likely to be in employment than non-disabled people. Disabled people are around 3 times as likely not to hold any qualifications compared to non-disabled people, and around half as likely to hold a degree-level qualification. Disabled people are significantly more likely to experience unfair treatment at work than non-disabled people and remain significantly less likely to participate in cultural, leisure and sporting activities. Disabled people are half as likely as non-disabled people to be active [118] Only one in four people with learning difficulties take part in physical activity each month compared to over half of those without a disability' [119]

The latest family resources survey [120] reports that 18% of working age adults in Great Britain reported a disability. This would equate to 131,660 of the Birmingham population. The top 4 specific impairments reported by all ages were mobility, stamina/breathing/fatigue, dexterity and mental health.

Learning disabilities (LD)

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[117] Learning Disabilities Mortality Review (LeDeR)
[118] Sports England (2014) Active People Survey 8 (2013/14)
[119] Sport England Active People Survey December 2013 (sport once a month, any sport, any duration)
[120] Family Resources Survey 2017/18

Baseline estimates of the prevalence of people with LD in Birmingham in 2019 put the figure at 2.5% (17,556) which is projected to remain the same up to 2035. The prevalence of those with *moderate or severe* LD was 0.6% [121]

Physical disabilities

It is estimated that in 2019 around 50,860 adults aged 18-64 in Birmingham have a moderate disability and a further 14,287 have a serious physical disability, representing 7.1% and 2% respectively of the age group. The number of adults with a moderate or serious physical disability is expected to increase by around 7% between 2019 and 2035 (4,736 individuals). It is estimated that of the 65,147 adults with either a moderate or serious physical disability around 29,300 have a personal care disability (45% of all with a physical disability). These are adults who require assistance to undertake personal care tasks such as getting in and out of bed, getting in and out of a chair, dressing, washing, feeding, and using the toilet [122]

Service model & data

Learning disabilities services are provided by BCC Adult Social Care and Health (ASC&H) under a Section 75 agreement. The latter is a mechanism designed to enable integrated commissioning for health and social care, in this case between Birmingham City Council and Birmingham and Solihull CCG. The service includes placements, home support and supported living, provision of day services and direct payments. In 2017/18 ASC&H spent £103,860,000 on care for adults with learning disabilities. Services commissioned included day services; direct payments / home support and supported living and placements through third parties. £28,690,000 was spent on adults with physical disabilities. [123]

BCC supports the use of 'blue badges' which help with parking - in 2018 32,600 individual valid blue badges were held by Birmingham citizens, 2.9% of the population (England 4.2%) [124]

Birmingham Community Healthcare Trust teams provide healthcare for people with learning disabilities living in the community. The service aims to provide high quality care through multidisciplinary working and close collaboration with other agencies. People aged 19 and over with a learning disability can access specialist support to help with complex needs such as epilepsy, challenging behaviour, forensic needs and mental health conditions.

[121] Institute of Public Care: Projecting adult need and service information
[122] Institute of Public Care: Projecting Adult Needs and Service Information (PANSI)
[123] The Local Account for Adult Social Care Services 1 April 2017 – 31 March 2018
[124] National Statistics: Blue badge scheme statistics: 2018

Lesbian, Gay, Bisexual and Trans Adults
Background

There is strong international[125] and UK evidence[126] that lesbian, gay, bisexual and trans adult face significant health inequalities including:

- Increased risk of suicide and self-harm
- Increased depression and anxiety – the community has higher rates than their heterosexual and cisgender counterparts
- Increased rates of smoking
- Increased rates of sexually transmitted diseases
- A risk of domestic violence and injury but on a par with heterosexual females
- Less likely to report crimes because of reaction of services involved
- Eating disorders and substance misuse

The evidence base suggests that there are also inequalities within the LGBT population and bisexual and trans people experience poorer health outcomes than their lesbian and gay counterparts, and LGBT people who are from ethnic minorities or disabled also experience higher levels of inequalities, but all four groups face significantly worse health than their heterosexual and cis-gender counterparts. Many of the LGBT community have difficulties accessing culturally competent mental health services that meet their needs.

Key statistics summary

Whilst there is no accurate prevalence of the numbers of the LGBT community in either Birmingham or nationally, many official documents produced by Stonewall, Birmingham LGBT, Public Health England (PHE) and ONS (via the Annual Population Surveys) suggest that the numbers are between 2% to 6%.[127] The PHE survey highlighted that older members of the LGBT community are less likely to 'out' based on historical laws that made homosexuality illegal. Based on the various available reports we have estimated the LGBT population of Birmingham to be approximately 45,000 adults. This does not however include practising homosexual men who continue to see themselves as heterosexual whilst having sexual contact with other men.

Over the last few years there have been many surveys done to identify estimated population, demographics and health issues of the LGBT community, alongside many done by Stonewall (LGBT in Britain and Over the Rainbow); these have included a national survey by PHE in 2015 and one by LGBT Birmingham[128] in 2011, that tried to establish health disparities among the LGBT community in Birmingham.

[125] https://fra.europa.eu/en/publication/2013/eu-lgbt-survey-european-union-lesbian-gay-bisexual-and-transgender-survey-results downloaded 7th November 2019
[126] https://fra.europa.eu/en/publication/2013/eu-lgbt-survey-european-union-lesbian-gay-bisexual-and-transgender-survey-results downloaded 7th November 2019
[127] [1] https://www.stonewall.org.uk/ Downloaded 8th November 2019

[128] https://blgbt.org/about/ (accessed 7th November 2019)

The Birmingham survey was produced following a systematic review in 2011. Stonewall's report tends to show what it's like to be LGBT and particularly Trans in society whilst the LGBT Birmingham concentrates on the key issues such as the demographics, health issues and ability to access services. Importantly, all the reports highlight a need for change and the lack of sustained measurements of population and performance indicators around these changes.

Service model & data

Birmingham has a dedicated centre called Birmingham LGBT which is a local charity providing support, information and advice to the local lesbian, gay, bisexual and trans community, and those who identify under a variety of other sexual orientations and genders. In 2015 they produced their strategy document – Strategic Priorities 2015-2020 which includes some specific provision for LGBT adults and young people:

- Sexual health services
- Wellbeing support service
- Counselling and psychotherapy
- Improved health and wellbeing amongst its community

Further approaches could be modelled on existing practice in contracts, such as Umbrella Health Sexual Health Service & Support that make specific provision for LGBT groups within their services delivered through Umbrella, and the Birmingham LGBT are actively involved in recruitment to the PrEP Impact Trial. PrEP (Pre-exposure Prophylaxis) is a precautionary drug to limit the risk of contracting HIV / AIDs during unprotected sex, and as such would address a health inequality that impacts in reference to men who have sex with men.

Across the NHS and other large employers within the city there is a commitment to mandatory equality and diversity training which includes awareness of LGBT inclusion , however this tends to be via e-learning, and not revisited, therefore there is a need for a more consistent approach to targeted LGBT awareness training such as intersectionality and health inequalities that should be regularly updated.

Headline Analysis

There is insufficient routine data collection on sexual orientation and gender identity in adults service data to identify whether there are different inequalities affecting those living in Birmingham from the national and international evidence.

There is a growing body of best practice work to support LGBT adults:

- Preventing Suicide: LGB youth and trans youth and extending this to adults
- Promising Practice model and RCGP LGBT Care guidelines
- Improving Health and Wellbeing of Gay and Bisexual Men and other Men who Have Sex with Men
- Improving the Health and Wellbeing of Lesbian and Bisexual Women and other Women who have sex with women

The published evidence would suggest that LGBT adults will experience significant health inequalities that may underpin the wider inequalities in the city; however their

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smoking prevalence and suicide rates are higher; as are the rates of mental health in general, one example is eating disorders particularly amongst the male population.

Migrant and Refugee Adults

There is evidence that many migrants are relatively healthy upon arrival compared with the native population, but good health can deteriorate over time in the receiving society[129] , with rates of morbidity and mortality becoming worse than those of the UK born population. The health of migrants is influenced by many complex factors. A PHE report into migrant health in the West Midlands[130] grouped factors affecting migrant health into 4 categories:

- Country of origin – factors around disease epidemiology, socioeconomic and environmental conditions, healthcare. These factors influence outcomes such as infection (for example tuberculosis), nutritional deficiency and toxic exposures.
- Migration – the reason and circumstances for migrating and the legal status in the receiving country. Influence on mental health, access to healthcare and health inequalities.
- Ethnicity – disease susceptibility and genetic disorders. Linked to diseases such as cardiovascular disease, diabetes and haemoglobinopathies (for instance sickle cell)
- Culture – practices such as female genital mutilation.

Health issues specifically identified as affecting working age migrants include poor working conditions and inadequate safety practices in some industries employing migrants.

Key statistics summary

In 2018 ONS estimate that 25.5% (approximately 290,000) of the Birmingham population were born overseas. Net long-term international migration[131] in Birmingham is estimated to have increased from approximately 13,000 in 2009 to approximately 16,000 in 2018.

GP registration data shows 15,970 new registrations in Birmingham by people aged between 18 and 64 and born overseas in 2017. This was an increase from 13,556 in 2014 but a decrease from 17,341 in 2016. Of the new registrations in 2017, the majority were for younger people: 53% were by people aged between 20 and 29 and 84% were by people aged between 18 and 39.

The top 10 countries of birth for new GP registrations in 2017 are detailed below.

Table 6   Top 10 countries of birth for new Birmingham GP registrations

Country of Birth	New GP Registrations
Romania	2,477
China	2,010
Pakistan	1,321

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[129] Rechel, B., P. Mladowsky et al. "Migration and health in an increasingly diverse Europe." Lancet 381 (2013)
[130] PHE Migrant Health in the West Midlands
[131] A long-term international migrant, is someone who does not change his or her usual residence for a period of at least a year.

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India	955
Poland	646
Bangladesh	455
Italy	334
Spain (Except Canary Islands)	329
Nigeria	293
France	270

Source: NHS Digital Open Exeter GP Registration Data

Service model & data

Birmingham has two Asylum Seeker Initial Accommodation (IA) centres. There are approximately 370 beds for adults and families. Whilst in the IA, people are able to access universal health services, but they are not expected to register with a GP, so separate health services are provided to deal with minor health issues, manage any long-term issues, and refer on to hospital if that is needed.

Current services in Birmingham include the Refugee and Migrant Centre who work to assist "… refugees and migrants through crisis and disadvantage, by removing barriers to their integration and enabling them to become equal citizens." Their services include free welfare and benefits advice and support as well as co-hosting some specific health support services such as latent TB screening for new arrivals.

Birmingham has made commitments to the needs of asylum seekers, refugees and migrants through the Birmingham City of Sanctuary Policy Statement 2018[132] and the Migration Friendly Cites project (2017/18 – 2020/21).[133] In July 2019 Birmingham was also awarded £1.2m of additional government funding towards projects aimed at helping asylum seekers, refugees and migrants integrate into the cities communities.

Headline analysis

A Migrants Health Needs Assessment for Birmingham was completed by Doctors of the World in 2017.[134] The report identified mental health as the single most prevalent health need amongst vulnerable migrants, along with issues around barriers to healthcare and GP registration. Whilst services that support migrants were identified as connected and working collaboratively, gaps were identified in healthcare commissioning to support the specific needs of migrants.

In the immediate future, emerging issues around modern slavery and human trafficking are expected to come to the fore and demand the attention of policy makers. The hidden nature of these problems makes identifying their scale

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[132] Birmingham City of Sanctuary Policy Statement 2018-22
[133] MiFriendly Cities – Migration Friendly Cities Birmingham, Coventry and Wolverhampton 2017/18-2020/21
[134] Doctors of the World. Migrant Health Needs Assessment Birmingham 2017

problematic, but the impacts on the mental and physical health of victims of these activities are severe.[135,136,137]

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[135] Such Elizabeth, Walton Elizabeth, Bonvoisin Toby, Stoklosa Hanni. Modern slavery: a global public health concern *BMJ* 2019; 364 :l838
[136] European Union Human Trafficking - Medical effects on victims
[137] International Organisation for Migration. Caring for Trafficked Persons: Guidance for Health Providers

Gypsy and Traveller (GT) Adults

Background

GTs face some of the most severe health inequalities and poorer life outcomes when compared to other demographic groups. GTs are estimated to have life expectancies 10 to 25 years shorter than the general population[138] and often face horrific levels of discriminatory attitudes [139]. Qualitative evidence [140] shows this group suffering from misconceptions around health issues along with discrimination and significant barriers when accessing the health service [141].

Key statistics summary

There were 58,000 GT in England and Wales recorded in the 2011 Census. Birmingham had 408 individuals who identified themselves as GT of which 291 were adults. Recent statistics from Birmingham and Solihull's (BSoL) 2018 health inequalities strategy estimates more than 1,000 GT people living in Birmingham with a planned traveller site located in Aston[142].

GT working life shows disturbed working patterns with 40% in employment compared to 70% of the national population with GTs (22%) more likely to work in elementary occupations [143] compared to the national population (11%) [144].

Service model & data

There is a lack of specific data on existing service models for working age GTs. The BSoL CCG inequalities strategy (2018-2021) outlines proposals to work with representatives of "seldom heard" communities such as the GTs. The strategy calls for partner organisations to work jointly across all levels of organisations and to develop a staff culture which fosters inclusion, wellbeing and diversity. The strategy also calls upon local GTs and health providers to jointly develop a locality development plan around the most pressing and unmet health needs for GT groups.

GTs face major barriers when accessing GP services often due to lack of appropriate paperwork. Suggested models [145] will allow GPs to apply for an " enhanced status " when treating GTs and thus ensure appropriate reimbursement for rendered health services[146].

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[138] https://www.gypsy-traveller.org/wp-content/uploads/2019/03/No-room-at-the-inn-findings-from-mystery-shopping-GP-practices.pdf

[139] https://travellermovement.org.uk/news/49-new-yougov-poll-finds-shocking-racism-toward-gypsies-and-travellers

[140] http://www.gypsy-traveller.org/wp-content/uploads/health-brief.pdf

[141] https://www.gypsy-traveller.org/wp-content/uploads/2019/07/Experiences-of-Gypsies-and-Travellers-in-primary-care-GP-services-FINAL-1.docx

[142] BSoL CCG: Equality Objectives and Health Inequalities Strategy 2018 - 2021

[143] https://www.ilo.org/public/english/bureau/stat/isco/isco88/9.htm

[144] https://researchbriefings.files.parliament.uk/documents/CBP-8083/CBP-8083.pdf

[145] https://www.birminghamandsolihullccg.nhs.uk/publications/strategic/44-equality-objectives-health-inequalities-strategy-2018-2021/file

[146] https://www.birminghamandsolihullccg.nhs.uk/publications/strategic/44-equality-objectives-health-inequalities-strategy-2018-2021/file

Poor housing has long been associated with poor health outcomes [147] and as part of the Housing Act 2004, Birmingham has completed an accommodation study projecting GT housing needs until 2031 thus meeting its statutory obligations[148].

Headline analysis

More work is required to determine the unmet health needs of GT groups to ensure any obstacles they face, particularly in accessing primary care services are tackled using a systematic approach.

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[147] https://www.gov.uk/government/publications/gypsy-and-traveller-health-accommodation-and-living-environment

[148]

https://www.birmingham.gov.uk/download/downloads/id/1175/gypsy_and_traveller_accommodation_assessment_2014.pdf

Homeless Adults and Families

The causes of homelessness are typically described as either structural or individual and can be interrelated and reinforced by one another.[149] Structural factors that can contribute include poverty, housing supply and affordability (exacerbated by issues within private rented sector specifically), and insecure employment[150]. Individual factors may include physical or mental health problems, experience or exposure to violence, drug and alcohol misuse, or life crisis points such as bereavement or the breakdown of a key relationship.[151]

Not having a home or stable accommodation can impact on health, work prospects and relationships. It can also lead to the later manifestation of the individual factors that lead to homelessness (as detailed above) and cause a spiral of repeated episodes of homelessness. There is also evidence that the longer the period(s) of homelessness the more difficult it becomes to recover. Because of these amongst other issues it is estimated that nationally homelessness costs the tax payer £1billion per year, with each homeless person costing an average of £26,000.[152]

The Homelessness Reduction Act 2017 came into force on 03 April 2018. Some of the key measures within the act are duties to prevent / relieve homelessness for all eligible applicants threatened with homelessness.

Birmingham's 'Homeless Prevention Strategy 2017+' recognises that addressing homelessness necessitates a partnership approach and a change in focus from crisis to upstream prevention, both targeted and universal.

Key statistics summary

Figure 8 Statutory Homeless, rate per 1,000 Households

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[149] https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

[150] https://www.voicemag.uk/blog/4740/how-do-people-end-up-homeless?gclid=CjwKCAiAqgTuBRBAEiwA7B66hcr9v4YEtHTOBPrg01N4BY5YR0YXae3QLH1VF0RQ9HgfVX8QFI15hBoCD0QQAvD_BwE

[151] https://www.dashorg.co.uk/causes-of-homelessness?gclid=CjwKCAiAqgTuBRBAEiwA7B66hf4xE7bGiP0es57B6RrhLhCtn1_Kp2xkWd6TKSonScYXqAftwOjIyBoCybIQAvD_BwE

[152] https://www.homeless.org.uk/facts/understanding-homelessness/impact-of-homelessness
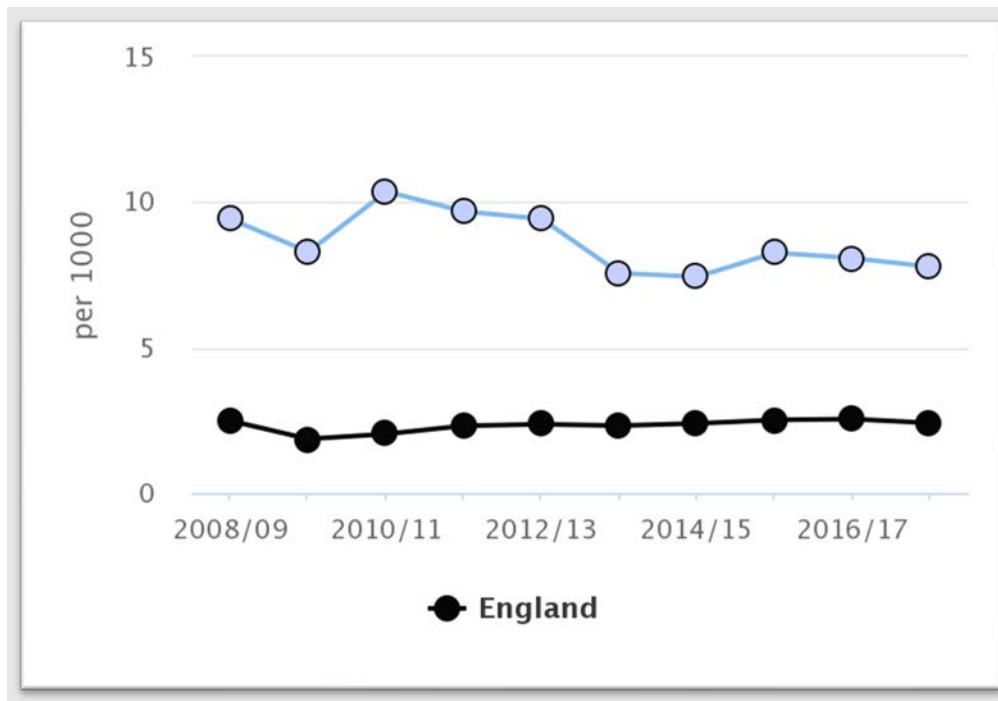
Source: PHE Fingertips

Homeless households are classified as households who are unintentionally homeless and in priority need, and that the local authority accepts as eligible for support into accommodation. In 2017/18 there were 3,386 households in Birmingham who were statutory homeless. As a rate per household, this figure equates to 7.8 per 1000. This is considerably higher than the rate for England (2.4) and West Midlands (3.3) and is the highest out of the Core Cities, which had an average of 3.6 per 1000.[153]

Many homeless adults and families have issues caused by drug-taking and chaotic lifestyles, but homeless patients registered at special GP practices also have issues similar to people seen in mainstream GP practices. These are exacerbated by late presentation to services (often only once crisis or danger point has been reached) which are not as easy to access for this population.

The Homeless Health Exchange, located just outside Birmingham city centre, has just over 1,000 patients on its register, more than double the number it had when it opened 16 years ago. Typically, patients are aged in their 30s or 40s, although they present themselves with symptoms comparable to people in their 70s.[172]

The average age of death for a homeless man is 47 (compared to 77 for general male population in Birmingham). For women, it is 43 (compared to 82).[154] In 2017, over half of all deaths of people experiencing homelessness were due to 3 factors[155]:

- accidents, including drug poisoning, accounted for 40%
- suicides accounted for 13%
- diseases of the liver accounted for 9%

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[153] PHE Fingertips
[154] https://www.bbc.co.uk/news/uk-england-birmingham-46946182
[155] https://publichealthmatters.blog.gov.uk/2019/09/30/health-matters-rough-sleeping/

Service model & data

Serious steps have already been taken to address homelessness issues and reduce rough sleeping in the city. The BCC Homelessness Prevention Strategy[156] was launched in 2018 and a strategic partnership board established to take a whole system approach and ownership to its delivery. The strategy promotes the Positive Pathway which is built on collaboration, best practice and service integration. The Positive Pathway was first developed by St Basils and implemented locally with young people at risk of experiencing homelessness. The pathway has seen much success. It comprises of 5 key areas:

- Universal Prevention
- Targeted Prevention
- Crisis Prevention and Relief
- Homeless Recovery
- Sustainable Housing

However, it requires a commitment and collaboration by all partners from across the system of a wide-ranging provision for the most vulnerable citizens and a development of a much more integrated infrastructure that will enable its implementation and application.

In 2018 a cross-sectional analysis was undertaken of 2,300 households in Birmingham City Council funded temporary accommodation. Headline results were:

- The largest populations in terms of Age Band were aged 25-29, 30-34, and 35-39 (18.3%, 18.3%, and 19.5% of temporary accommodated main applicants respectively).
- 58.5% were single applicants as opposed to joint.
- 25.6% did not have children, 24.9% had one child,19.6% had two children, and the remaining 30% had 3 or more children.
- In terms of the three main homeless reasons (excluding Other) these were; Expiry of Assured Short Hold Tenancy (22.0%), Breakdown of Relationship Partner Domestic Violence (10.7%), and Other Relative/Friends Not Accommodate (9.2%).
- White British (19.5%), Black African (18.3%), and Pakistani (12.9%) were the most prevalent ethnicities of the main applicant. No other group accounted for more than 6.3%.
- Over two fifths (42.2%) of applicants were lone female parents, and a further third (28.1%) couples with dependents.

It is immediately obvious that both the persons who present as homeless, their household compositions, and the underlying reasons for presentation are both diverse and complex. However, this issue is most prevalent in those at the lower age end of the working age adults group.

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https://www.birmingham.gov.uk/downloads/file/2531/birmingham_homelessness_prevention_strategy_2017

Veterans

A veteran is defined as: "*anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve), or Merchant Mariners who have seen duty on legally defined military operations.*" Personnel and their families experience unique factors as a result of their time in service, including the risks of injury or death, and the disruption of frequent moves. The 2018 Veterans Strategy[157] and Armed Forces Covenant[158] reinforce our moral obligation to those who serve or have served in the Armed Forces, their families and the bereaved.

Key statistics summary

Armed Forces recruitment in Birmingham is one of the highest in the UK. There is a careers office in the city centre and the Army and Royal Navy have Reserve bases here. Most data on veterans are available only at a national level and are not wholly reliable; the question is not always asked and younger veterans do not always identify as being a veteran, preferring the term 'ex-service'. Using national data we estimate there are 31,800 veterans living in Birmingham.[159] Approximately half of current veterans are aged over 75 but this cohort is decreasing and the percentage of veterans of working age is projected to rise. The percentage of female veterans is projected to increase.[160]

Service model & data

No reliable evidence exists as to the long-term health effects of military service. Ministry Of Defense reviews suggest ex-personnel are likely to suffer the same issues as the general population and most are robust people who make a successful transition to civilian life.[161] However, a minority struggle, experiencing complex mental and physical issues that are often compounded by wider determinants of health such as social isolation, crime, housing and income.

A physically active job, regular balanced meals, and regular health checks mean a healthier lifestyle than many experience in civilian life.[162] However, personnel are exposed to extreme conditions and trauma. The main health issues of veterans relate to the back and neck, cardio-vascular and legs and feet.[163] For elderly veterans, health problems are likely to be age-related. For younger veterans, it is difficult to unpick whether military service has contributed to ill-health. Recruitment is often from those with deprived backgrounds and poor educational achievement. Both these factors are independently associated with poor health.

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[157] HM Government, The Strategy for Our Veterans, 2018
[158] Armed Forces Covenant, https://www.armedforcescovenant.gov.uk/
[159] Annual Population Survey: UK Armed Forces Veterans residing in Great Britain, 2016 and Office for National Statistics, 2017 mid-year estimates (APS)
[160] Ministry of Defence UK, Population Projections: UK Armed Forces Veterans residing in Great Britain, 2016-2018 (2019)
[161] NHS Advancing Quality Alliance, North West Military Veterans Mental Health Mapping Project, 2012
[162] House of Lords, Veterans Strategy: Background to the Government Policy Debate on 15 November 2018
[163] APS 2017

The recent Defence Committee on mental health[164] heard that certain groups may be at higher risk of difficulties and called for more evidence to support these claims. The groups were: those that served in Iraq and Afghanistan; early service leavers; younger recruits; those who suffered physical injury; and female personnel. Evidence regarding social isolation amongst veterans is limited and conflicting. A key finding of the Defence Committee was the sense of community within the Armed Forces may have improved mental health or delayed the onset of conditions. However, a 2018 survey found that one in four feel lonely and socially isolated 'always' or 'often'.[165]

A large proportion of personnel join aged 16-19 years[166] and therefore are less likely to have a degree and more likely to obtain qualifications through work. Military service is a unique experience and it can be difficult to translate experiences to civilian employment. Some employers have a limited understanding of the skills that veterans can offer and employment options are sometimes restricted to stereotypical roles e.g. blue light services, security and prison service.

Veterans' support services[167] report that finance is a key area of need. Military life, often starting in very early adulthood, can leave veterans unprepared for balancing the financial demands of civilian life. However, veterans are just as likely to own their own home as the non-veteran population.[168] There is no evidence to suggest that veterans are overrepresented in the homeless population but the public perception is that there is a significant problem with homelessness.

Veterans are 30% less likely to be in prison in England and Wales than the general population.[169] West Midlands Police custody data for 2018-2019 shows a total of 362 Birmingham residents identified as veterans following their arrests. 64% of those arrested served in the British Forces, 30% had served elsewhere. The most common offence was assault (27%). Little is known about veterans of foreign forces living in the city.

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[164] House of Commons Defence Committee, Mental Health and the Armed Forces, Part One: The Scale of Mental Health Issues, 25 July 2018, HC 813 of session 2017, p30
[165] Royal British Legion, Loneliness and Isolation in the Armed Forces Community 2018
[166] Royal British Legion, Deployment to Employment 2016, pp12-19
[167] Veterans' Gateway https://www.veteransgateway.org.uk/
[168] APS 2017
[169] Ministry of Justice, Experimental Statistics Ex-service personnel in the prison population, England and Wales (2018)

Unemployed Adults

Employment is a primary determinant of health, impacting both directly and indirectly on the individual, their families and communities. The negative health effects of unemployment can be linked to both psychological factors and the financial problems it brings – especially the consequences of debt and poverty which may affect food choices, quality of housing, lifestyle behaviours and social networks among others. However unemployed people face numerous health challenges beyond loss of income with evidence consistently suggesting a strong association between unemployment and adverse mental and physical health outcomes such as higher rates of overall mortality, common mental disorders, cardiovascular disease and poorer health related quality of life[170]. This effect on health is still demonstrable when social class, poverty, age and pre-existing morbidity are adjusted for[171]. Evidence suggests around 20% of suicides may be linked to unemployment and job insecurity[172].

While becoming unemployed can affect an individual's health, there are others whose worsening health *becomes the cause* of unemployment or restricts the opportunity work. Research suggests that around one third of those leaving work because of ill-health or injury were living in poverty within a year[173].

In today's climate of uncertainty in the economy and labour market, unemployment is becoming a bigger challenge to public health. Measures to support people in financial crisis; and to gain and keep employment are becoming more important to protecting the physical and mental health of our working age population.

Key statistics summary

Both the unemployment rate and economic inactivity rates are higher in Birmingham than the West Midlands Region and England as a whole. Nearly 9% are unemployed, compared to 3.6% in England. Around 47,000 are unemployed in the City with a further 210,000 who are economically inactive[174]. Almost two thirds of people who have a health condition which lasted more than 12 months are unemployed or economically inactive[175] compared to just over a third of the general population.

Service model & data

There are many services which aim to help unemployed adults gain employment or support them when out of work provided by partners such as the Department for Works and Pensions, as well as City Council Services.

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[170] Norström, F., Waenerlund, A., Lindholm, L. *et al.* Does unemployment contribute to poorer health-related quality of life among Swedish adults?. *BMC Public Health* 19, 457 (2019) doi:10.1186/s12889-019-6825-y

[171] Wilson SH, Walker GM. Unemployment and health: a review. Public Health. 1993 May;107(3):153-62.

[172] Nordt C, Warnke I, Seifritz E, Kawohl W. Modelling suicide and unemployment: a longitudinal analysis covering 63 countries, 2000–11. The Lancet Psychiatry. 2015 Mar 1;2(3):239-45.

[174] Birmingham City Council – Labour Market Update Q3 2019

[175] Nomis :- ONS Annual Population Survey

The Birmingham Employment Access Team works with employers and developers to understand their recruitment requirements, then find the right skilled unemployed people, or train people to get them 'fit for the job'. As part of the council, the team is in a unique position to know when certain construction jobs may be available, as they get to know what developers will be building over the coming months as part of the planning application process. It is often made a legal requirement linked to planning permission that developers work with the service to fill vacancies when building in the city. The team is currently delivering two European Union funded projects helping to connect local unemployed citizens into employment: World of Work (WOW) aims to engage with long term unemployed people across Birmingham and provide support with training and linkages to work within key growth sectors. Youth Promise plus provides job support, training, education and mentoring for people under 30.

Schemes such as Project Search, Remploy and Ambition for Autism all provide specific support for employers around placements and job opportunities for people with learning disabilities and mental health conditions. Within the council Shelforce is a supported business dedicated to the assistance of disabled people looking to enter employment. It actively recruits and supports severely disabled people within its own factory, and other businesses in the wider community.

Safeguarding Adults

The Care Act 2014 statutory guidance defines adult safeguarding as:

'Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.'[176]

Adult safeguarding concerns can be varied and sometimes occur concurrently, such concerns include domestic violence, self-neglect, neglect of others, and financial abuse. Those with dementia, learning disabilities, mental ill-health or substance abuse issues, or care and support needs may be more vulnerable to such abuse or neglect and as such the Council has a statutory responsibility to address these concerns.[177]

In Birmingham this is delivered through the Birmingham Adults Safeguarding Board, which has three core duties; to deliver a strategic plan for the board and partners, publish an annual report on how effective it has been, and the commissioning of Adult Safeguarding Reviews (retrospective reviews of how adult safeguarding processes could have worked better in a given instance).[178]

Referrals for Adults Safeguarding are reviewed in the first instance by Birmingham City Council to understand if the criteria for an enquiry has been met. The Care Act 2014 requires enquiries must be made by Birmingham City Council, or cause others to do so, if they reasonably suspect an adult:

- has needs for care and support (regardless of whether the Council is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

These are known as statutory Safeguarding Adult, or "Section 42" Enquiries.[179]

In addition, the Council and other organisations support people who do not meet the full adult safeguarding criteria, but who may be being abused and are unsure where to go next.

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[176] The Care Act 2014 Act
[177] Highlights: Safeguarding Adults - September 2017 (Social Care Institute for Excellence)
[178] Birmingham Safeguarding Adults Board
[179] Guidance for Managing Officers and Enquiry Officers responsible for conducting Adult Safeguarding Enquiries under Section 42 of the Care Act 2014

Wherever someone is being harmed, or at risk if harm, there are agencies that can help, even if a formal adult safeguarding response is not triggered. These include:

- the police
- domestic abuse services
- the National Referral Mechanism[180] for victims of modern slavery
- community and support groups
- other social services teams.[181]

Key statistics summary

In 2018-19 Birmingham had 10,805 adult safeguarding concerns raised (a rate of 1,267 per 100,000 adults) out of a total of 415,050 nationally (943 per 100,000 adults). This seems high however it should be noted that in terms of the percentage of concerns that initiate full enquiries Birmingham has 20% compared to the national average of 39%, meaning that 2,150 enquiries were held in Birmingham, which equate to 252 per 100,000 adults as compared to 368 per 100,000 nationally.[182]

Adult safeguarding rates vary by age and the risk increases as people get older, within Birmingham there are 140 enquiries per 100,000 persons aged 18-64 compared with over 10 times that rate for persons aged 85+, nationally the picture is markedly different with 125 enquiries per 100,000 persons aged 18-64 and over 20 times that rate in persons aged 85+.[183] There is the potential this is an artefact of the unusually young population within Birmingham but could warrant further investigation to understand what is driving these trends.

Additionally, there are two outcome measures that are used as a proxy for levels of potential adult safeguarding concern within the Adult Social Care Outcome Framework. Firstly, the *proportion of people who use services who feel safe*; 65.3% of respondents for Birmingham City Council aged 18-64 indicated that they felt safe using services in 2018-19, which is the fourth highest of the eight Core Cities, and broadly comparable to the England average of 68.3%.[184] Secondly, the *proportion of people who use services who say that those services have made them feel safe and secure*; 88.6% of respondents for Birmingham City Council aged 18-64 indicated that the services provided made them feel safe and secure, the fifth highest amongst the eight Core Cities, and in line with the England average of 88.0%.[185]

Service model and data

Birmingham City Council, in partnership with health, commissioned services, third sector, and others has a clear vision and strategy for Adult Social Care and Health, which includes as one of its eight key elements the need to "make (adult)

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[180] National Referral Mechanism
[181] Highlights: Safeguarding Adults - September 2017 (Social Care Institute for Excellence)
[182] NHS Digital Safeguarding Adults, England 2018-19 – Interactive Report
[183] NHS Digital Safeguarding Adults, England 2018-19 – Interactive Report
[184] Adult Social Care Outcomes Framework Measure 4A - Proportion of people who use services who feel safe
[185] Adults Social Care Outcomes Framework Measure 4B - Proportion of people who use services who say that those services have made them feel safe and secure

safeguarding personal". While it is essential that along with ensuring that people of all ages are safe and free from any form of abuse or neglect, that adult safeguarding is undertaken in a person-centred manner that places their desired outcomes as the core of the enquiries and actions that may be undertaken.[186]

This approach seeks to achieve,[187]

- A personalised approach that enables adult safeguarding to be done with, not to, people.
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'.
- An approach that utilises social work skills rather than just 'putting people through a process'.
- An approach that enables practitioners, families, teams and Safeguarding Adults Boards to know what difference has been made.

2017-18 was the second year of "making (adult) safeguarding personal" for Birmingham City Council. Of the 1,663 adult safeguarding enquiries 90% were asked what their desired outcomes were before or during the enquiries, of these 93% expressed that their desired outcomes had been met by the end of the enquiry (64% fully achieved, 29% partially achieved).[188]

In addition, Birmingham City Council Domestic Abuse Prevention Strategy 2018-2023[189] details the Council's commitment to ensuring that stop domestic abusers stop being invisible to services and the need to control and manage them more effectively. Over the 5 years leading up to 2016 there was a 57% increase in reports of domestic abuse to West Midlands Police but only a 19% increase in convictions of abusers through the criminal justice system, despite such abuse leading directly to 21 women being killed.[190]

The vision is that domestic abuse should become everyone's business and concentrates those resources on pro-active preventative measures, while recognising the need for response to acute crisis situations. As the Strategy is jointly monitored by the Health and Wellbeing Board and Community Safety Partnership a true multi-agency response has been adopted and a detailed action plan developed to ensure delivery.

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[186] Birmingham City Council – Vision and Strategy for Adult Social Care and Health
[187] Birmingham City Council Adult Social Care and Health Local Performance Account Reports
[188] Birmingham City Council Adult Social Care and Health Local Performance Account Reports
[189] Birmingham City Council Domestic Abuse Prevention Strategy 2018 - 2023
[190] Domestic Abuse Needs Analysis Update 2016

	Agenda Item: 17
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th January 2021**
TITLE:	**DEVELOPER TOOLKIT**
Organisation	**Birmingham City Council**
Presenting Officer	**Kyle Stott**

Report Type:	**Presentation**

1. Purpose:

1.1. The environment we live in has a huge impact on our health. By creating healthier built and natural environments we can prevent premature death and disease, enhance social cohesion and encourage physical activity. Conversely, a poorly designed built environment can adversely impact upon the health of the population and lead to inequalities in both health and wellbeing. Designing for health does not have to be onerous. If done well we will be able to achieve measurable improvements for the environment, 'environmental net gains', while ensuring economic growth and reducing costs, complexity and delays for developers.

1.2. Birmingham Public Health has created a toolkit to address the above issues. This toolkit has been designed with several prompts to help developers, architects and planners to consider and assess the impact new developments have on the health and wellbeing of the population.

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

1

3.	Recommendation

3.1   The board is asked to note the role of the toolkit

3.2   The board is asked to endorse the toolkit, and to offer support to the embedding of the toolkit throughout Birmingham City Council processes*

     *At this early stage it is envisaged that the toolkit will supplement planning guidance and be routinely considered by applicants seeking planning consent and their associates, for example architects and developers.

     *The toolkit has been endorsed by the Corporate Leadership Team (CLT) on the 30th November 2020, and it has been endorsed by the Creating a Physically Active City Forum of the Health and Wellbeing Board on the 16th December 2020.

4.	Report Body
4.1	**Background**

     Simply put, health is not a material consideration for planning. However, it is implicit within the National Planning Policy Framework (2019), that planning policies and decisions should aim to achieve healthy, inclusive and safe places which:

    a)   Promote social interaction
    b)   Are safe and accessible
    c)   Enable and support healthy lifestyles
    d)   Provide social, recreational and cultural facilities and services that the community needs
    e)   Consider the social, economic and environmental benefits of estate regeneration

     The toolkit is designed to ensure that health and wellbeing is considered at the earliest opportunity in the planning and development process – where possible at the pre-application stage. The toolkit is also designed to be used to test emerging local authority policies, plans and documents that provide the shaping of planning, regenerating and developing the city, specifically in the context of sustainable health and wellbeing outcomes.

     The toolkit was developed by Birmingham Public Health and has been tested on Birmingham City Council Supplementary Planning Documents and Planning Applications for several years, it has proven to be successful in influencing positive health outcomes. It is currently being used in the development of the Perry Barr Masterplan.

     The toolkit consists of 14 specific domains. Each one of these domains has been developed and supported by experts within Birmingham City Council and wider partners.

The toolkit has the support of the West Midlands Planning and Health Group, this includes the lead for Planning and Health for Public Health England and is seen as a model of good practice.

It follows the principles of the NHS Healthy Urban Development Unit, which implemented the principles to develop a healthier London.

Health is not a material consideration for planning, this is Birmingham's response to addressing this issue.

The toolkit is not currently used routinely in the planning process. To adopt it formally into planning processes would provide the mechanism for its routine use.

The toolkit is not exclusively for use with planning applications. It can, and has been used as a rapid way to assess the health impact of policies documents and plans that influence the development of the city, and to shape the content to elicit health gain

4.2 Next Steps and Delivery

- To seek Cabinet support for the adoption of the toolkit into planning processes and policy in Birmingham.

- To develop a framework of activity designed to raise the profile of and land the toolkit with major developers associated with the city, and to also consider the wider planning and development community, including those who support applicants in the design and development phases.

- To use the endorsements received to encourage embedding of the toolkit into suitable planning policies and/or processes within Birmingham City Council (in its role as a Planning Authority).

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

5.1.1 Regular updates will be reported to the Director and Assistant Director of Public Health. Regular updates will be reported to the Health and Wellbeing Board via update reports in this format.

5.2 Management Responsibility

Kyle Stott, Service Lead, Public Health
Elizabeth Griffiths, Assistant Director of Public Health
Dr Justin Varney, Director of Public Health

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Other divisions, especially planning, not adopting the toolkit into their routine processes	medium	high	Support from HWBB Support from CLT Support from Planning Committee

Appendices
Appendix 1 – Draft Developer Toolkit

The following people have been involved in the preparation of this board paper:
Kyle Stott, Public Health Service Lead

Birmingham

Healthy City Planning Toolkit

November 2020

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Healthy City Planning Toolkit

Overview and Summary 2020

1   Introduction

The environment we live in has a huge impact on our health. By creating healthier built and natural environments we can prevent premature death and disease, enhance social cohesion and encourage physical activity. Conversely, a poorly designed built environment can adversely impact upon the health of the population and lead to inequalities in both health and wellbeing.

Designing for health does not have to be onerous. If done well we will be able to achieve measurable improvements for the environment, 'environmental net gains', while ensuring economic growth and reducing costs, complexity and delays for developers.

This toolkit has been designed with a number of prompts to help developers, architects and planners to consider and assess the impact new developments have on the health and wellbeing of the population.

2   Purpose of the Toolkit

The Healthy City Planning Toolkit supports the creation of healthy communities through health-promoting planning policies, design and development management in Birmingham.

This Toolkit will aid the preparation of a Health Impact Assessment (HIA) for planning related projects, including the development of planning policy and planning applications, it provides guidance on the HIA process and demonstrates how it can be used. It identifies aspects of the built environment which have an impact upon the health of Birmingham's residents.

Included with the toolkit is a HIA template for completion, and guide to aid completion – this is based on the London Healthy Urban Development Unit (HUDU) assessment tool and related documents. The toolkit reflects the World Health Organisation publication Healthy Urban Planning (by Hugh Barton and Catherine Tsourou).

3   Who is the Toolkit for?

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This toolkit will support:

- Planning professionals including planning policy and development management officers in helping them to identify and, where necessary, respond to the health impact issues of development proposals through Local Plans and development management techniques
- Architects, Developers and planning agents, to screen and scope the health impact of their development proposals and assessing the health impacts of a subsequent planning application
- Other professionals who are involved in scrutinising and commenting on health-related issues in Local Plans and development proposals.

4   Toolkit contents

Healthy City Planning Toolkit includes:

- **Overview**
- **Preliminary Checklist**
- **Rapid Health Impact Assessment (HIA) Tool**
  A Health Impact Assessment (HIA) ensures that the effect of the development on both health and health inequalities are considered and responded to during the planning process. The toolkit includes a rapid Health Impact Assessment for completion, setting out key questions and areas for consideration during the planning process to support the creation of healthy communities through health-promoting planning policies in Birmingham.
- **Guide and Appendices**
  To be read in conjunction with the HIA, this guide provides links to national and local policy by themed areas, impacts of risk, additional considerations and information.

5   Using this Toolkit

This toolkit is most effective when used within the initial stages of design planning; it can provide you with a framework to identify risks and impacts to health, throughout the development process.

Contact the assigned Planning Officer at Birmingham City Council and also set up a meeting with the person responsible for health and the built environment within the Public Health Division. This will ensure that we can engage with you at the earliest opportunity and start process.

5.1   Development Zones

Each development can be divided into three zones:

- **the core zone** - the area of your development up to and including the boundary as defined on the plans.
- **the walkable zone** – the area that your development will have an immediate impact upon outside of the core zone for example local communities, these are usually within a ten to 20-minute walking distance (up to 1 mile away)
- **the buffer zone** – the area that your development will have the potential to influence, for example is there a lack of certain facilities in the wider area that your development will be providing? If so, this may encourage external usage or opportunity for provision

The distances provided above for each zoned area is a suggestion – it is up the developer to decide the breadth and scope of each zone and apply reasonable adjustments to ensure developments are accessible, flexible and considerate. The HIA can help identify gaps or provide additional considerations to assist with mitigation.

5.2 Preliminary Checklist

Carry out an initial assessment by using the checklist below prior to your scoping meeting with the assigned Planning Officer; this will enable all parties to quickly establish what the main objectives of the development are and where the opportunities for maximising public health impacts will be.

The checklist provides you with an 'at-a-glance' summary of the 14 criteria that will form the basis of your initial discussions with the Duty Planning Officer and the areas that will be scrutinised as part of the assessment of the final planning document.

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PRELIMINARY CHECKLIST			
Criteria	**Is this a consideration for your proposal?**		
	Yes	**No**	**NA**
1 Housing quality and design	☐	☐	☐
2 Access to healthcare services and other social infrastructure	☐	☐	☐
3 Access to open space and nature	☐	☐	☐
4 Air quality, noise and neighbourhood amenity	☐	☐	☐
5 Accessibility and active travel	☐	☐	☐
6 Crime reduction and community safety	☐	☐	☐
7 Access to healthy food (e.g. green grocers, supermarkets)	☐	☐	☐
8 Access to work and training	☐	☐	☐
9 Social cohesion and lifetime neighbourhoods	☐	☐	☐
10 Minimising the use of resources	☐	☐	☐
11 Climate change	☐	☐	☐
12 Digital and Technology	☐	☐	☐
13 Child friendly development	☐	☐	☐
14 Impact upon equalities: protected characteristics	☐	☐	☐

5.3 Scoping meeting

This is where you will be able to discuss your proposals with the Duty Planning Officer to comment on the outcomes of preliminary checklist. This will also be the time to agree a series of follow-up meetings and actions that will take your proposals through the more detailed assessment stage and planning process to ensure that the final plans are submitted to the planning authority with as much detail as possible reflecting where public health impact of the development can be maximised.

5.4   Rapid Health Impact Assessment (HIA)

The detailed assessment is the next phase of the process; this will take your plans through a set of up-to 14 pre-existing planning and health criteria. What emerges are a set of priorities that offer positive health impacts where possible, and where there is a negative impact, offers sound opportunities for mitigation, and support throughout this process.

6   Health Impact Assessment Template and Guidance

6.1   Health Impact Assessment

A health impact assessment (HIA) helps ensure that health and wellbeing are being properly considered in planning policies and proposals. HIAs can be done at any stage in the development process but are best done at the earliest stage possible. HIAs can be done as stand-alone assessments or as part of a wider Sustainability Appraisal, Environmental Impact Assessment, or Integrated Impact Assessment.

The process looks at the positive and negative impacts of a development as well as assessing the indirect implications for the wider community. The aim is to identify the main impacts and prompt discussion about the best ways of dealing with them to maximise the benefits and avoid any potential adverse impacts.

6.2   Who should complete a HIA?

Completing a HIA should be collaborative; we encourage different stakeholders to work together to address the health impacts of plans and development proposals. As such, the Guide could be used by:

- Architects and Developers, to screen and scope the health impacts of development proposals and designs;
- Planning officers, to help identify and address the health impacts of plans and development proposals;
- Public health and environmental health professionals, to comment and scrutinise plans and development proposals;
- Neighbourhood forums, community groups and housing associations to comment on major planning applications to help foster community engagement

To create and develop healthy and sustainable places and communities, the Marmot Review of Health Inequalities in England 'Fair Society Healthy Lives' recommends that the planning system should be fully integrated within transport, housing, environmental and health policy.

Therefore, this planning toolkit, and following HIA, will also be of interest to environmental health officers concerned with environmental impacts and risks, transport planners concerned with promoting active travel and housing officers seeking to ensure that new housing is affordable and accessible.

6.3 How to use the Health Impact Assessment template and guidance

This Health Impact Assessment is designed to be used at the earliest opportunity to inform design, layout and composition of a development proposal. The assessment will include arrangements for monitoring and evaluating the impacts and mitigation and enhancement measures.

Developers should complete the HIA as fully as possible, linking to additional policies, processes and information to demonstrate all areas have been considered and mitigation is appropriate. This may include **a planning statement, design and access statement, or an environmental statement** as appropriate. In some cases, there may be a lack of information and/or data about certain aspects of the proposal. In this case, the impact is likely to be uncertain and more information will be requested.

Where an impact is identified, recommendations to mitigate a negative impact or enhance / secure a positive impact must be included. Recommended actions on development proposals may require design layout changes, closer adherence to policy requirements or standards or planning conditions or obligations. In some cases, it may be helpful to identify non-planning measures, such as licensing controls or maintenance agreements.

The accompanying guides and appendix provide additional information, considerations and policy references to aid developers in the completion of the HIA.

7   Useful Public Health Information and Resources

7.1 Public Health Support

If you require Public Health assistance with a Planning query, or if your development is classed as a major development (more than 10 homes or more than 10,000m^2 of commercial) please email publichealth@birmingham.gov.uk

7.2 Health profiles and data

- Local Health: Produced by Public Health England via Local View, these profiles provide key data on each of the wards including population, access to services and health indicators.
- Fingertips: Public Health England also provides a wide range of health-related data via its Fingertips tool
- Birmingham Local Area Health Profiles: These profiles contain demographics and data relating to the health and wellbeing of the citizens of Birmingham at citywide and smaller local area levels.

7.3 Other Resources

- London Healthy Urban Design Unit Model
- World Health Organisation: Healthy Urban Design
- Town and Country Planning Association: Healthy Place Making
- National Planning Policy Framework

8 Health Impact Assessment template and guidance

1 Housing Quality and Design - Guide

Potential Health Impacts
Affordable housing; housing quality; noise insulation; energy efficiency; accessible; adaptable; well orientated; sufficient range of housing tenures; good basic services; adaptable buildings for community use such as health, education and leisure to create sustainable communities
Providing lifetime homes which allow residents to remain in their home despite changing accommodation requirements, creating adaptable housing to more easily permit care to be provided in the community

Overview	**Issues for consideration –** see appendix for associated policies and documents
Access to decent and adequate housing is critically important for health and wellbeing, especially for the very young and very old. Environmental factors, overcrowding and sanitation in buildings as well as unhealthy urban spaces have been widely recognised as causing illness since urban planning was formally introduced. Post-construction management also has impact on community welfare, cohesion and mental wellbeing.	Does the proposal meet the National Technical Standards? • Accessibility and wheelchair housing standards • Water efficiency standards • Internal space standards
	Does the proposal address change in housing needs across the life course? i.e. Lifetime homes - adaptability to support independent living for older and disabled people.
	Does the proposal promote good design through layout and orientation, meeting internal space standards?
	Does the proposal include a range of housing types and sizes, including affordable housing responding to local housing needs?
	Does the proposal contain homes that are highly energy efficient (e.g. a high SAP rating)?

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1.1   Housing Quality and Design HIA - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal meet the National Technical Standards?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal address changes in housing needs across the life course? i.e. Lifetime homes - adaptability to support independent living for older and disabled people.	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal promote good design through layout and orientation, meeting internal space standards?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal include a range of housing types and sizes, including affordable housing responding to local housing needs?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal contain homes that are highly energy efficient (e.g. a high SAP rating)?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

2   **Access to healthcare services and other social infrastructure - Guide**

Potential Health Impacts
Provision of accessible healthcare services and other social infrastructure – supporting population growth and change to create sustainable, healthy communities; modernise and improve quality of facilities and services; co-locating some services – improving effectiveness and efficiency of service delivery – e.g. primary health, social care, dentistry and pharmacies. Siting facilities locally allows for active travel and reduce car travel – bringing health benefits from increased activity and improved air quality.

Overview	Issues for consideration – see appendix for associated policies and documents
Strong, vibrant, sustainable and cohesive communities require good quality, accessible public services and infrastructure. Encouraging the use of local services is influenced by accessibility, in terms of transport and access into a building, and the range and quality of services offered. Access to good quality health & social care, education (primary, secondary and post-19) and community facilities has a direct positive effect on human health. Opportunities for the community to authentically and ethically participate in the planning of these services has the potential to impact positively on mental health and wellbeing and can lead to greater community cohesion.	Does the proposal retain or re-provide existing social infrastructure? Social Infrastructure is made up of three dimensions: 1. Buildings, facilities and the built environment 2. Services and organisations 3. Communities
	Does the proposal assess the demand for healthcare services and identify requirements and costs using the HUDU model?
	Does the proposal provide for healthcare services either in the form of a financial contribution or in-kind?
	Does the proposal enhance accessibility (by foot, bicycle and public transport) of other social infrastructure, e.g. schools, social care and community facilities?
	Does the proposal explore opportunities for shared community use and co-location of services?
	Does the proposal contribute to meeting primary, secondary and post 19 education needs?

2.1 Access to healthcare services and other social infrastructure - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal retain or re-provide existing social infrastructure?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal assess the demand for healthcare services and identify requirements and costs using the HUDU model?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal provide for healthcare services either in the form of a financial contribution or in-kind?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal assess the capacity, location and accessibility (by foot, bicycle and public transport) of other social infrastructure, e.g. schools, social care and community facilities?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal explore opportunities for shared community use and co-location of services?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal contribute to meeting primary, secondary and post 19 education needs?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

3 Access to open space and nature, heritage and culture - Guide

Potential Health Impacts
Publicly accessible green space and play spaces can encourage physical activity and maintain or improve positive mental health. A range of formal and informal play spaces and equipment will need to reflect growing populations, particularly an increase in children. Natural spaces and tree cover provide areas of shade and can improve air quality. Opportunities to integrate space with other related health and environmental programmes such as food growing and biodiversity. Improving connectivity between green space and the public realm, allows greater access to both spaces and adds value for residents and wildlife. Arts and heritage trails are effective ways in which to encourage interaction and learning about a place. Opportunities to integrate arts, culture and heritage with other related health and environmental programmes such as food growing and biodiversity.

Overview	Issues for consideration – see appendix for associated policies and documents
Providing secure, convenient and attractive open/green space can lead to more physical activity and reduce levels of ill-health problems that are associated with both sedentary occupations and stressful lifestyles. There is growing evidence that access to parks and open spaces and nature can help to maintain or improve mental health.	Does the proposal protect existing open and natural spaces, and key heritage assets, referencing local culture and features?
	Does the proposal improve the provision, quality and access to green infrastructure of the city, in line with the expectations of the 25-year environment plan?
The patterns of physical activity established in childhood are perceived to be a key determinant of adult behaviour; a growing number of children are missing out on regular exercise, and an increasing number of children are being diagnosed as obese. There is a strong correlation between the quality of open space and the frequency of use for physical activity, social interaction or relaxation. Discovering and developing interests and learning through taking note of the natural and designed environment such as rivers, canals, landscaping, art and heritage assets.	In areas of deficiency, does the proposal provide new open or natural space, or improve access (by foot, bicycle and public transport) to existing spaces?
	Does the proposal provide safe, walkable links between open and natural spaces and the public realm? E.g. to transport links
	Are the existing and new open and natural spaces, culture and heritage sites welcoming, safe and accessible for all?
	Does the proposal set out how new open space and assets will be managed and maintained?
	Does the proposal connect people with nature through play, activity, food, school grounds or local restoration?

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3.1   Access to open space and nature, heritage and culture - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal protect existing open and natural spaces, and key heritage assets, referencing local culture and features?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal improve the provision, quality and access to green infrastructure of the city, in line with the expectations of the 25-year environment plan?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
In areas of deficiency, does the proposal provide new open or natural space, or improve access (by foot, bicycle and public transport) to existing spaces?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal provide safe, walkable links between open and natural spaces and the public realm? E.g. to transport links	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Are the existing and new open and natural spaces, culture and heritage sites welcoming, safe and accessible for all?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal set out how new open space and assets will be managed and maintained?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

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Does the proposal connect people with nature through play, activity, food, school grounds or local restoration?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

4 Air quality, noise and neighbourhood amenity - Guide

Potential Health Impacts
The use of construction management plans can lessen construction impacts, particularly hours of working and construction traffic movements. Reduced levels of car parking and travel plans which encourage the use of public transport, cycling and walking will result in better local environmental conditions. Good design and the sensitive location and orientation of residential units can lessen noise impacts, contribute to improved air quality and neighbourhood amenity and reduce noise pollution. Natural spaces and trees can improve the air quality in urban areas.

Overview	Issues for consideration – see appendix for associated policies and documents
The quality of the local environment can have a significant impact on physical and mental health. Pollution caused by construction, traffic and commercial activity can result in poor air quality, noise nuisance and vibration. Poor air quality is linked to incidence of chronic lung disease (chronic bronchitis or emphysema) and heart conditions and asthma levels of among children. Noise pollution can have a detrimental impact on health resulting in sleep disturbance, cardiovascular and psycho-physiological effects. Good design and the separation of land uses can lessen noise impacts.	Does the proposal minimise construction impacts such as construction traffic, dust, noise, vibration and odours? (Where appropriate a construction management plan should be produced)
	Does the proposal minimise air pollution caused by traffic, industrial uses and energy facilities (by provided ULEV infrastructure, for example)?
	Does the proposal minimise noise pollution caused by traffic and commercial uses through insulation, engineering, site layout, landscaping and cycling and walking infrastructure?
	Does the proposal consider how green infrastructure could assist in mitigating poor air, noise or light pollution?

4.1 Air quality, noise and neighbourhood amenity - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions

Does the proposal minimise construction impacts such as construction traffic, dust, noise, vibration and odours? (Where appropriate a construction management plan should be produced)	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal minimise air pollution caused by traffic, industrial uses and energy facilities (by provided ULEV infrastructure, for example)?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal minimise noise pollution caused by traffic and commercial uses through insulation, engineering, site layout, landscaping and cycling and walking infrastructure?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal consider how green infrastructure could assist in mitigating poor air, noise or light pollution?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

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5 Accessibility and active travel - Guide

Potential Health Impacts
Combining active travel and public transport options can help people achieve recommended daily physical activity levels. Inclusive design, access, orientation and streetscape planners can make it easier for people to access facilities using public transport, walking or cycling. Reduced levels of car parking and travel plans encourage the use of public transport, cycling and walking will result in increased active travel. Planning can promote cycling and walking by connecting routes and public to wider networks, providing safe junctions and calming traffic and providing secure cycle parking spaces. Improved accessibility and walking spaces supports the principles of Walkability outlined in the Birmingham Connected Report (Placing Pedestrians at the Top of the Transport Hierarchy).

Overview	Issues for consideration – see appendix for associated policies and documents
Convenient access to a range of services and facilities minimises the need to travel and provides greater opportunities for social interaction. Buildings and spaces that are easily accessible and safe also encourage all groups, including older people and people with a disability, to use them. Discouraging car use and providing opportunities for walking and cycling can increase physical activity and help prevent chronic diseases, reduce risk of premature death and improve mental health	Does the proposal prioritise and encourage walking (such as through shared and natural spaces, good crossing facilitates well-lit and direct walking routes)?
	Does the proposal prioritise and encourage cycling (for example by providing secure, visible cycle parking, showers, cycling infrastructure, crossing facilities and good signposting)?
	Does the proposal connect public realm and internal routes to local and strategic cycle and walking networks and provide streets with permeable access for cyclists and pedestrians?
	Does the proposal include traffic management and speed reduction measures to help reduce and minimise road injuries (for example crossing facilities, speed limits, etc.)?
	Is the proposal well connected to public transport, local services and facilities?
	Does the proposal minimise transport emissions and discourage car use through parking management measures, provision of sustainable transport infrastructure, ULEV charging provision, car clubs, service and delivery plans and construction management plans?
	Does the proposal provide parking/charging facilities for low emissions?

	Does the proposal allow people with mobility problems or a disability to access buildings and places?

5.1 Accessibility and active travel - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal prioritise and encourage walking (such as through shared and natural spaces, good crossing facilitates well-lit and direct walking routes)?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal prioritise and encourage cycling (for example by providing secure, visible cycle parking, showers, cycling infrastructure, crossing facilities and good signposting)?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal connect public realm and internal routes to local and strategic cycle and walking networks and provide streets with permeable access for cyclists and pedestrians?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal include traffic management and speed reduction measures to help reduce and minimise road injuries (for example crossing facilities, speed limits, etc.)?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Is the proposal well connected to public transport, local services and facilities?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

Does the proposal minimise transport emissions and discourage car use through parking management measures, provision of sustainable transport infrastructure, ULEV charging provision, car clubs, service and delivery plans and construction management plans?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal provide parking/charging facilities for low emissions?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal allow people with mobility problems or a disability to access buildings and places?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

6   Crime reduction and community safety - Guide

Potential Health Impacts
The detailed design and layout of residential and commercial areas can ensure natural surveillance over public space. This can be assisted by creating places which enable possibilities for community interaction and avoiding social exclusion. Active use of streets and public spaces, combined with effective lighting and greenery, is likely to decrease opportunities for anti-social behaviour or criminal activity. Planners to work with the Designing Out Crime Officers to obtain their advice on making development proposals follow the principles within the Secure by Design guides. They can also involve communities to foster a sense of ownership and empowerment, which can also help to enhance community safety. An arts and culture plan can outline the opportunities for artists and community collaborations to activate spaces and its implementation enable collective consideration of a range of appropriate uses and innovative creative approaches.

Overview	Issues for consideration – see appendix for associated policies and documents
Thoughtful planning and urban design that promotes natural surveillance and social interaction can help to reduce crime and the 'fear of crime', both of which impacts on the mental wellbeing of residents. As well as the immediate physical and psychological impact of being a victim of crime, people can also suffer indirect long-term health consequences including disability, victimisation and isolation because of fear. Community engagement in development proposals can lessen fears and concerns	Does the proposal follow the five underlying principles of Crime Prevention Through Environmental Design (CPTED)? i) physical security ii) surveillance; iii) movement control; iv) management and maintenance and v) defensible space
	Does the proposal incorporate other elements to help design out crime? E.g. well-lit spaces and natural surveillance)?
	Does the proposal incorporate design techniques to help people feel secure and connected?
	Does the proposal include well designed, multi-use public spaces and buildings with clear indications of intended use?
	Does the proposal clearly indicate the intended use of any public spaces or buildings?
	Does the proposal create any areas of ambiguous space where conflicting interests might occur?
	Has or will authentic engagement and consultation been/be carried out with the local community?

6.1   Crime reduction and community safety - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal follow the five underlying principles of Crime Prevention Through Environmental Design (CPTED)? i) physical security ii) surveillance; iii) movement control; iv) management and maintenance and v) defensible space	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal incorporate other elements to help design out crime? E.g. well-lit spaces and natural surveillance)?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal incorporate design techniques to help people feel secure and connected?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal include well designed, multi-use public spaces and buildings with clear indications of intended use?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal clearly indicate the intended use of any public spaces or buildings?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal create any areas of ambiguous space where conflicting interests might occur?	Yes ☐ No ☐ N/A ☐	Page 465 of 566	Positive ☐ Negative ☐ Neutral ☐	

			Uncertain ☐	
Has or will authentic engagement and consultation been/be carried out with the local community?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

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7   Access to healthy food - Guide

Potential Health Impacts

Consider food access, location and how to facilitate social enterprises planners can help to create the conditions that enable low income people to have better and affordable access to nutritious food. Planning can preserve and protect areas for small-scale community projects/local food production, including allotments. Planning can increase the diversity of shopping facilities in local centres, restrict large supermarkets, and limit concentrations of hot food takeaways.

Overview	Issues for consideration – see appendix for associated policies and documents
Access to healthy and nutritious food can improve diet and prevent chronic diseases related to obesity. People on low incomes, including young families, older people are the least able to eat well because of lack of access to nutritious food. They are more likely to have access to food that is high in salt, oil, energy-dense fat and sugar. Opportunities to grow and purchase local healthy food and limiting concentrations of hot food takeaways can change eating behaviour and improve physical and mental health.	Does the proposal facilitate the supply, delivery and self-sufficiency growing of local food, within a safe and sustainable environment (allotments, community gardens and farms, access to water, compost, and farmers' markets, for example)?
	Is there a range of retail uses, including food stores and smaller affordable shops for social enterprises?
	Does the proposal avoid contributing towards an over-concentration of hot food takeaways in the local area in line with Birmingham policy?
	Does the proposal allow for large vehicle access to properties for the purpose of home deliveries and accessibility?

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7.1 Access to healthy food - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal facilitate the supply, delivery and self-sufficiency growing of local food, within a safe and sustainable environment? E.g. allotments, community gardens and farms, access to water, compost, and farmers' markets	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Is there a range of retail uses, including food stores and smaller affordable shops for social enterprises?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal avoid contributing towards an over-concentration of hot food takeaways in the local area in line with Birmingham policy?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal allow for large vehicle access to properties for the purpose of home deliveries and accessibility?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

8   Access to work and training - Guide

Potential Health Impacts
Urban planning linked to clear strategies for economic regeneration, allocation of appropriate sites and coordination of infrastructure provision can help to facilitate attractive opportunities for businesses, encourage diversity in employment and ensure that local jobs are created and retained. Equitable transport strategies can play an important part in providing access to job opportunities. The provision of local work can encourage shorter trip lengths, reduce emissions from transport and enable people to walk or cycle. Access to other support services, notably childcare, work experience and training can make employment opportunities easier to access.

Overview	Issues for consideration – see appendix for associated policies and documents
Employment and income is a key determinant of health and wellbeing. Unemployment generally leads to poverty, illness and a reduction in personal and social esteem. Works aids recovery from physical and mental illnesses. Locating training and access to work experience, jobs and apprenticeships in inaccessible locations or failing to provide a diversity of local jobs or training opportunities can negatively affect health and mental wellbeing both directly and indirectly.	Does the proposal provide access (by foot, bicycle or public transport) to local employment, training, work experience and apprenticeship opportunities, including temporary construction delivery phase and 'end-use' jobs?
	Does the proposal link skills development with technology and services that will help manage our relationship with the natural environment into the future?
	Does the proposal include managed and affordable workspace for local businesses?
	Does the proposal include access to training, work experience, apprenticeships and jobs for local people via local procurement arrangements?

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8.1   Access to work and training - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal provide access (by foot, bicycle or public transport) to local employment, training, work experience and apprenticeship opportunities, including temporary construction delivery phase and 'end-use' jobs?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal link skills development with technology and services that will help manage our relationship with the natural environment into the future?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal include managed and affordable workspace for local businesses?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal include access to training, work experience, apprenticeships and jobs for local people via local procurement arrangements?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

9   Social cohesion and lifetime neighbourhoods - Guide

Potential Health Impacts

Urban planning can help to facilitate social cohesion by creating safe and permeable environments with places where people can meet informally. Mixed-use developments in town centres and residential neighbourhoods can help to widen social options for people. The provision of a range of diverse local employment opportunities (paid and unpaid) can also improve mental health, social cohesion and the creation of lifetime neighbourhoods.

Overview	Issues for consideration – see appendix for associated policies and documents
Friendship and supportive networks in a community can reduce depression/ levels of chronic illness as well as speed recovery after illness and improve wellbeing. Fragmentation of social structures can lead to communities demarcated by socio-economic status, age and/or ethnicity. Building networks for people who are isolated and disconnected, and to provide meaningful interaction to improve mental wellbeing. Lifetime Neighbourhoods places the design criteria of Lifetime Homes into a wider context, creating environments that people of all ages and abilities can access and enjoy, facilitating communities that people can participate in, interact and feel safe.	Does the design of the public realm maximise opportunities for social interaction and connect the proposal with neighbouring communities by promoting physical activity (walking/cycling etc.), the use of public transport, social interactions, community activity and the use of public nature or green and blue spaces?
	Does the proposal include a mix of uses and a range of community facilities appropriate to demographic need?
	Does the proposal include provision of communal areas facilities within multi-dwelling buildings? E.g. apartments, student accommodations, mixed dwellings, etc.
	Does the proposal provide opportunities for the arts, culture, sport, voluntary and community sectors?
	Does the proposal address the principles of Lifetime Neighbourhoods?

9.1   Social cohesion and lifetime neighbourhoods - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the design of the public realm maximise opportunities for social interaction and connect the proposal with neighbouring communities by promoting physical activity (walking/cycling etc.), the use of public transport, social interactions, community activity and the use of public nature or green and blue spaces?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal include a mix of uses and a range of community facilities appropriate to demographic need?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal include provision of communal areas facilities within multi-dwelling buildings? E.g. apartments, student accommodations, mixed dwellings, etc.	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal provide opportunities for the arts, culture, sport, voluntary and community sectors?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal address the principles of Lifetime Neighbourhoods?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

10 Minimising the use of resources - Guide

Potential Health Impacts

Planning can impose standards and criteria on hazardous waste disposal, recycling and domestic waste and that linked to development. It can ensure that hazardous waste is disposed of correctly, as well as ensure that local recycled and renewable materials are used whenever possible in the building construction process. Redevelopment on brownfield sites or derelict urban land also ensures that land is effectively used, recycled and enhanced. Through encouraging reduction, reuse and recycling, resource minimisation can be better realised and contribute towards a better environment. For larger scale developments, the impact on natural capital and its related health benefits can be measured through the National Capital Tool.

Overview	Issues for consideration – see appendix for associated policies and documents
Reducing or minimising waste including disposal, processes for construction as well as encouraging recycling at all levels can improve human health directly and indirectly by minimising environmental impact, such as air pollution.	Does the proposal make best use of existing land, green and natural spaces, waterways and natural resources? If so, is it also complimentary to the heritage of the area?
	Does the proposal encourage recycling, including building materials and food waste?
	Does the proposal allow for future waste collection and promote minimisation on site?
	Does the proposal incorporate sustainable design and construction techniques?
	Does the proposal make effective use of water minimisation techniques, infrastructure and materials to reduce water waste during the development and into the future?

10.1 Minimising the use of resources - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal make best use of existing land, green and natural spaces, waterways and natural resources? If so, is it also complimentary to the heritage of the area?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal encourage recycling, including building materials and food waste?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal allow for future waste collection and promote minimisation on site?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal incorporate sustainable design and construction techniques?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal make effective use of water minimisation techniques, infrastructure and materials to reduce water waste during the development and into the future?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

Potential Health Impacts

Urban planning can help to reduce greenhouse gas emissions by requiring lower energy use in buildings and transport, and by encouraging renewable energy sources, contributing to the climate change mitigation. Planning can address sustainability and environmental considerations through the use of standards such as the Code for Sustainable Homes will help to reduce energy demands and increase the amount of renewable energy. For larger scale developments, the impact on natural capital and its related health benefits can be measured through the National Capital Tool.

Overview	Issues for consideration – see appendix for associated policies and documents
There is a clear link between climate change and health. The Marmot Review is clear that local areas should prioritise policies and interventions that 'reduce both health inequalities and mitigate climate change' because of the likelihood that people with the poorest health would be hit hardest by the impacts of climate change.	Does the proposal incorporate renewable energy and encourage climate change mitigation measures (safe walking routes, cycling, public transport infrastructure, Ultra Low Emission Vehicles (ULEV) provision, for example)?
	Does the proposal ensure that buildings and public spaces are designed to respond to winter and summer temperatures, i.e. ventilation, shading and landscaping?
Planning is at the forefront of both trying to reduce carbon emissions and to adapt urban environments. Poorly designed homes can lead to fuel poverty in winter and overheating in summer contributing to excess winter and summer deaths. Developments also have the potential to contribute towards mental wellbeing of residents	Does the proposal maintain or enhance nature conservation and biodiversity? e.g. an uninterrupted green corridor
	Does the proposal reduce surface water flood risk through sustainable urban drainage systems?

11.1 Climate change - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal incorporate renewable energy and encourage climate change mitigation measures (safe walking routes, cycling, public transport infrastructure, Ultra Low Emission Vehicles (ULEV) provision, for example)?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal ensure that buildings and public spaces are designed to respond to winter and summer temperatures, i.e. ventilation, shading and landscaping?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal maintain or enhance nature conservation and biodiversity? e.g. an uninterrupted green corridor	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal reduce surface water flood risk through sustainable urban drainage systems?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

Potential Health Impacts

Future planning for telecom infrastructure within the initial stages of planning can encourage the development of new technologies, promote competition and offer greater consumer choice, and ensure greater connectivity for those who work flexibility and those most vulnerable. Strategies such as the Future Telecoms Infrastructure Review offer insight on how planning now, through simple measures such as additional ducting or multi-purpose fibre cabling, can allow developments to evolve with technology into sustainable housing, with minimal disruptions to the public and encouraging communities to grow.

Overview	Issues for consideration – see appendix for associated policies and documents
Understanding the role digital and technology have in the planning process is instrumental to ensure developments can adapt and evolve with changing technologies and digital advancements. As well as providing greater connectively for a growing flexible workforce who are required to work from home or on the move, technology advancements also allow for improved healthcare provision at home via telecare, ability to introduce smart home adaptions to better regulate environments, improved information points for transport infrastructure, and the opportunity to harness new energy provision and work smarter using existing infrastructure. The ability to move flexibly and stay connected is paramount to maintain both physical and mental health well-being.	Is there a telecommunication/connectivity plan submitted as part of the proposals in a similar way as with other utilities, including robust coverage of telecommunication cellular networks?
	Does the proposal provide for a digital model or 3D visualisation of the development as part of the consultation, review and user engagement process?
	Is there adequate provision of internet and broadband available within the proposal from multiple providers, encouraging consumer choice and preventing provider monopolies? This would include additional ducting to the premises to enable new telecommunication entrants to deliver competitive services and facilitate upgrading of technology through the lifespan of the building to avoid retrospective civil works.
	Does the proposal make provisions for digital assets, enablement and legacy? For example: • Digital signage, information points and messaging (e.g. bus shelters and public displays) • Smart lighting that can maximise use of natural light, and use sustainable, low energy, low glare lighting • Sensor and monitoring equipment to improve carbon savings, air quality and promote sustainable travel (including electric charging points) • Telecare and enablement technology
	Does the proposal ensure that the build design minimised barriers to cellular network penetration?

	Does the technology embedded in this proposal enable users to control their environmental quality and are there sufficient electrical and digital points within the buildings to enable easy deployment of IoT, other sensors and other digital devices for health and social care monitoring? (Smart buildings: ventilation, light, air quality etc)
	There are provisions for free public Wi-Fi in communal areas or in open spaces across the development

12.1 Digital and Technology - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Is there a telecommunication/connectivity plan submitted as part of the proposals in a similar way as with other utilities, including robust coverage of telecommunication cellular networks?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal provide for a digital model or 3D visualisation of the development as part of the consultation, review and user engagement process?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Is there adequate provision of internet and broadband available within the proposal from multiple providers, encouraging consumer choice and preventing provider monopolies? This would include additional ducting to the premises to enable new telecommunication entrants to deliver competitive services and facilitate upgrading of technology through the lifespan of the building to avoid retrospective civil works.	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

Does the proposal make provisions for digital assets, enablement and legacy? For example: • Digital signage, information points and messaging (e.g. bus shelters and public displays) • Smart lighting that can maximise use of natural light, and use sustainable, low energy, low glare lighting • Sensor and monitoring equipment to improve carbon savings, air quality and promote sustainable travel (including electric charging points) Telecare and enablement technology	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal ensure that the build design minimised barriers to cellular network penetration?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the technology embedded in this proposal enable users to control their environmental quality and are there sufficient electrical and digital points within the buildings to enable easy deployment of IoT, other sensors and other digital devices for health and social care monitoring? (Smart buildings: ventilation, light, air quality etc)	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
There are provisions for free public Wi-Fi in communal areas or in open spaces across the development	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

13 Child friendly development - Guide

Potential Health Impacts

Whether or not a person is well and has good health is largely determined by the environment in which they live. This is particularly true for children and young people, who have little choice about where they reside. People living in the most deprived areas face worse health inequalities. These are caused by a mix of environmental and social factors linked to a local area. These health and social inequalities are completely avoidable. Considering and addressing them alongside the wider determinants of health will help improve not only the futures of the next generation but the burden and cost of related non-communicable disease on health services.

Overview	Issues for consideration – see appendix for associated policies and documents
All developments should aim to be child friendly; emphasising the wellbeing of future generations. The amount of time children play outdoors, their ability to get around independently, and their level of contact with nature are strong indicators of how a city is performing, not just for children but for all generations. If cities fail to address the needs of children, they risk economic and cultural impacts as families move away. An integrated child-friendly approach reverses the idea that children's space should be discreet areas, such as playgrounds, and excluded from other parts of the public realm. Creating a 'children's infrastructure' network of spaces, streets, nature and design interventions provides an opportunity to create better cities and better outcomes for all generations.	Does the development promote the rights of children to gather, play and participate?
	Does the development recognising children as a distinct group of inhabitants of the development? N.B. The development needs to explicitly acknowledge the differences amongst children and young people.
	Does the development focus on achieving child friendly outcomes?
	Does the proposal enhance links between the development and early years, childcare, play and education?
	Does the proposal provide affordable childcare and training facilities?

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13.1 Child friendly development - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the development promote the rights of children to gather, play and participate?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the development recognising children as a distinct group of inhabitants of the development? N.B. The development needs to explicitly acknowledge the differences amongst children and young people.	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the development focus on achieving child friendly outcomes?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal enhance links between the development and early years, childcare, play and education?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

14 Impact upon equalities: protected characteristics - Guide

Potential Health Impacts
Many different groups can experience health inequalities. The way in which places are designed can either help to close those gaps or worsen them. The built environment can contribute to a more equal, inclusive and cohesive society if places, facilities and neighbourhoods are designed to be accessible and inclusive for all. Inclusive design aims to remove the barriers that create undue effort and separation. It enables everyone to participate confidently and independently in everyday activities.1

Overview	Issues for consideration – see appendix for associated policies and documents
The Equalities Act sets out nine protected characteristics: Age, Race and Ethnicity; Disability; Religion or belief; Sexual orientation; Gender; Gender reassignment; pregnancy and maternity; marriage and civil partnership. Developments should work for everyone. To achieve this, inclusive design should be considered through all stages of a project. Taking time to consider different user needs and how those might change will allow solutions to be designed in that evolve with the project, helping to reduce the risk of costly alterations and retro fitting. Utilising best practise and working with local service users and ambassadors to understand additional needs and discussion solutions will ensure the development is inclusive to all, across the lifetime.	Does the proposal foster good relations between persons who share a relevant protected characteristic and persons who do not share it?
	Does the proposal contribute to inequalities of access to the development between persons who share a relevant protected characteristic and persons who do not share it?
	Does the proposal advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it?

1 https://www.designcouncil.org.uk/sites/default/files/asset/document/Inclusive%20Environments%20Action%20Plan1.pdf

14.1 Impact upon equalities: protected characteristics - Assessment Template

Assessment criteria	Relevant?	Details/evidence/policy compliance (where relevant)	Potential health impact?	Recommended mitigation or enhancement actions
Does the proposal foster good relations between persons who share a relevant protected characteristic and persons who do not share it?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal contribute to inequalities of access to the development between persons who share a relevant protected characteristic and persons who do not share it?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	
Does the proposal advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it?	Yes ☐ No ☐ N/A ☐		Positive ☐ Negative ☐ Neutral ☐ Uncertain ☐	

10 **Appendix**

	National Policies and Documents	Regional and local Policies
1 Housing Quality and Design	• Office of the Deputy Prime Minister (2004) The Impact of Overcrowding on Health and Education • BRE Trust (2010) The Real Cost of Poor Housing • World Health Organization (2011) Environmental burden of disease associated with inadequate housing • Report of the Marmot Review Built Environment Task Group (2010) • Marmot Review Team (2011) The Health Impacts of Cold Homes and Fuel Poverty • Department for Communities and Local Government Code for Sustainable Homes • Department for Communities and Local Government (2012) Investigation into overheating in homes: Literature review and Analysis of gaps and recommendations • Lifetime Homes Foundation, Lifetime Homes Standards Department for Communities and Local Government (2008) Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society	• National technical Standards • National Planning Policy Framework • BDP: policy PG3, policy TP27, TP30 • Supplementary planning documents and guidance: • Places for Living: pg. 8, pg. 9, • Places for All: pg. 7, pg. 8pg 27, pg. 28 • Specific Needs Residential Uses: Supplementary Planning Guidance: paragraph 4, paragraph 5 • SPD SUDS guide for Birmingham (2016) Birmingham Green Living Spaces Plan (2013); 7 principles

2 Access to healthcare services and other social infrastructure	- National Planning Policy Framework (March 2012) - Promoting healthy communities - Paragraph 162 Infrastructure planning - Paragraph 204 Planning obligations - Report of the Marmot Review Social Inclusion and Social Mobility Task Group (2010) - NHS London Healthy Urban Development Unit Planning Contributions Tool (the HUDU Model) - Institute of Public Health in Ireland (2008) Health Impacts of Education: a review - Environmental Audit Committee inquiry into Transport and the Accessibility of Public Services - Building Research Establishment Environmental Assessment Method (BREEAM) Sport England, Accessing schools for community use	- BDP, policy TP37, policy TP28, TP45 - Non-policy- BDP, section 9.60 - Supplementary planning documents and guidance: - Access for People with Disabilities SPD 2006: paragraph - Working Together in Neighbourhoods White Paper - Community Cohesion White Paper - Imagination, Creativity and Enterprise: Birmingham Cultural Strategy *(to be refreshed in 2019/2020)* Collaborations in Place-based Practice: Birmingham Public Art Strategy *(to be refreshed in 2019/2020)*

3 Access to open space and nature/ heritage / culture	• National Planning Policy Framework (March 2012) • Promoting healthy communities; 9 Protecting Green Belt land; 11 Conserving and enhancing the natural environment • Department of Health (2011) Healthy Lives, Healthy People: A Call to Action on Obesity in England • Department for Environment Food and Rural Affairs (2011) Natural Environment White Paper: Natural Choice securing the value of nature • UK National Ecosystem Assessment (2011) • Foresight Report (2007) Tackling Obesities: future choices • NICE (2008) Guidance on the promotion and creation of physical environments that support increased levels of physical activity (PH8) • Report of the Marmot Review Built Environment Task Group (2010) • Faculty of Public Health (2010) Great Outdoors: How Our Natural Health Service Uses Green Space To Improve Wellbeing • Sustainable Development Commission (2008) Health, Place and Nature • Sport England Active Design • HM Government, Greener Space 25 year environment plan 2018 • Natural England, Access to Green Spaces standards (2014) • NIA Ecological Strategy • LNP State of the Environment dashboard • LNP Health & Wellbeing Progress Report • Green Cities Good Global evidence archive • Natural England (20090, Our Natural Health Service role of the natural environment in maintaining healthy lives	• BDP: policy TP7, TP8, TP9, T1, T2, T27, T39, T40 • Supplementary planning documents and guidance: • Access for People with Disabilities SPD 2006: paragraph 9.4,9.6, 9.7, 9.10, 9.14, 9.15, • Public Open Space in New Residential Development 2007: paragraph 3.2, paragraph 3.3 • Places for living 2001, pg. 11 • Birmingham and Black Country Nature Improvement Area Strategy 2017-2022 • Natural Capital Tool • Birmingham and Black Country Biodiversity Action Plan (2010) • Birmingham City Council Green Living Spaces Plan • Birmingham Green Commission Carbon Roadmap • Imagination, Creativity and Enterprise: Birmingham Cultural Strategy *(to be refreshed in 2019/2020)* Collaborations in Place-based Practice: Birmingham Public Art Strategy *(to be refreshed in 2019/2020)*

	• Biodiversity 2020: A strategy for England Wildlife and Ecosystem Services	

4 Air quality, noise and neighbourhood amenity	• National Planning Policy Framework (March 2012)
	  • Protecting Green Belt land
	  • Conserving and enhancing the natural environment
	• Paragraph 200 Tailoring planning controls to local circumstances
	• Supporting information
	• Report of the Marmot Review Built Environment Task Group (2010)
	• Environmental Protection UK (2010) Development Control: Planning for Air Quality
	• British Medical Association (July 2012) Healthy transport = Healthy lives
	• Health Protection Agency (2010) Environmental Noise and Health in the UK
	• European Environment Agency (2010) Good practice guide on noise exposure and potential health effects, EEA Technical report No 11/2010
	• HM Government, Greener Space 25 year environment plan 2018
	
	Trees Design Action Group: First steps in urban air quality (2018
		• BDP: Policy PG3, TP1, TP7, TP8, TP9, TP15, TP27, TP28, TP37, TP38, TP43, TP44, TP45
		• Supplementary planning documents and guidance:
		• UDP: paragraph 8.27 8.29, 8.32
		• Places for worship SPD may 2011: paragraph 5.6.1
		• Birmingham and Black Country Nature Improvement Area Strategy 2017-2022
		• Natural Capital Tool
		• Planning consultation guidance note noise and vibration (?source)
		• Birmingham City Council guidance on mitigating the impact from construction activities
		
		Air Quality Plan??

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5 Accessibility and active travel	- National Planning Policy Framework (March 2012) - Promoting sustainable transport; 7 Requiring good design; 8 Promoting healthy communities - WHO (2011) Health economic assessment tools (HEAT) for walking and for cycling - Marmot Review Built Environment Task Group (2010) - Bristol Essential evidence – benefits of cycling & walking - Chartered Institution of Highways and Transportation (2010) Manual for Streets 2 - Department for Transport (2012) Guidance on the Appraisal of Walking and Cycling Schemes - DfT Local Transport Note 1/11: Shared Space - DfT (2012) Investigating the potential health benefits of increasing cycling in the Cycling City and Towns - The City of New York Active (2010) Design Guidelines – Promoting physical activity and health in design - Transport for London (2011) Transport planning for healthier lifestyles: A best practice guide - HM Government, Greener Space 25 year environment plan 2018 - Transport for London Health Streets Guide - DfT DH, January 2011, Transport and Health Resource: Delivering Healthy Local Transport Plans British Medical Association (July 2012) Healthy transport = Healthy lives	- BDP: Policy TP7, TP21, TP22, TP24 TP27, TP28, TP38, TP39, TP40, TP41, TP44, TP45 - Non-policy- BDP, section 9.60, 9.61, 9.62 - UDP: paragraph 8.7 - Supplementary planning documents and guidance: - Access for People with Disabilities SPD 2006: paragraph 9.4,9.6, 9.7, 9.8, 9.9, 9.10, 9.1, 9.14, 9.15, 9.16, 9.18 - Places for worship SPD may 2011: paragraph 5.2.1 , 5.2.2 - Places for living 2001, pg. 8, pg. 13, pg. 16, pg. 18 - Places for All: pg. 7, pg. 10, pg. 11, pg. 13, pg. 14 - Birmingham and Black Country Nature Improvement Area Strategy 2017-2022 - Natural Capital Tool - Birmingham Connected - Birmingham Road Safety Strategy - West Midlands Movement for Growth - West Midlands Health and Transport Strategy West Midlands Cycle Design Guidance's

6 Crime reduction and community safety	- National Planning Policy Framework (March 2012) - Requiring good design - Promoting healthy communities - Supporting information - Report of the Marmot Review Built Environment Task Group (2010) - Department of Health (2012) No health without mental health: implementation framework - ODPM (2004) Safer Places – the planning system and crime prevention - Secured By Design' Design Guides for; Homes, Commercial, Schools and Hospitals ~~Secured By Design, Design Guides~~ Design Council Guides: Design out Crime - CABE (2009) This Way to Better Residential Streets - Lighting Against Crime: A Guide for Crime Reduction Professionals - Crime Prevention through Environmental Design (CPTED) and Housing in the UK - Armitage, Rachel (2017) - Town & Country Planning Act	- BDP: policy PG3, TP11, TP27, TP37, TP39, UDP: paragraph 8.7 - Supplementary planning documents and guidance: - Places for living 2001, pg. 20, pg. 21, pg. 25, pg. 27, - Places for All: pg. 16, pg. 18

| 7 Access to healthy food | National Planning Policy Framework (March 2012)

• Ensuring the vitality of town centres
• Requiring good design
• Promoting healthy communities

Supporting information

• Department of Health (2011) Healthy Lives, Healthy People: A Call to Action on Obesity in England
• Mayor of London (2006) London Food Strategy - Healthy & Sustainable Food for London
• Foresight Report (2007) Tackling Obesities: future choices
• Report of the Marmot Sustainable Development Task Group (2010)
• Sustain (2011) Good planning for good food - using planning policy for local and sustainable food

HM Government 25 year Environment Plan | • BDP, policy TP9, TP24, TP27,
• Non-policy- BDP, section 9.60
• Supplementary planning documents and guidance:
• Shopping and Local Centres Supplementary Planning Guidance: policy 4, policy 6
• Natural Capital Tool

Birmingham Green Living Spaces |

8 Access to work and training	• National Planning Policy Framework (March 2012)
	  • Building a strong, competitive economy
	  • Ensuring the vitality of town centres
	  • Supporting a prosperous rural economy
	• Supporting information
	  • Department for Work and Pensions Cross-Government initiative 'Health, Work and Well-being'
	  • Report of the Marmot Review Social Inclusion and Social Mobility Task Group (2010)
	  • Report of Marmot Review Employment and Work Task Group (2010)
	  • Leeds Metropolitan University (2010) Mental Health and Employment review
	  • Inclusive Growth strategy
	  • Industrial Strategy
	  • Government skills strategy
	  • HM Government 25 year environment plan
	
	Social Value Act 2012
		• BDP: policy TP26, TP27, TP28, TP34,
		• Birmingham Skills and Investment plan
		• Greater Birmingham LEP skills for Growth Strategy
		• Mental health commission: WMCA
		• Skills and Productivity Commission. WMCA
		• Birmingham Connected (Placing Pedestrians at the Top of the Transport Hierarchy)(2014)
		• Birmingham Business Charter for Social Resposibility
		• Birmingham Procurement Policy Framework for jobs and skills
		• Birmingham Planning Protocol for jobs and skills

9 Social cohesion and lifetime neighbourhoods	- National Planning Policy Framework (March 2012) 8 Promoting healthy communities - NICE (2004) Social capital for health: Issues of definition, measurement and links to health - Marmot Review Social Inclusion and Social Mobility Task Group (2010) - Marmot Review Employment and Work Task Group (2010) - Department for Communities and Local Government (2011) Lifetime Neighbourhoods - National MWAH Collaborative (England) (2011) Mental Health Wellbeing Impact Assessment: A Toolkit for Well-being - UK National Statistics: societal wellbeing theme Young Foundation (2010) Cohesive Communities	- BDP: policy PG3, TP27, TP30, UDP: Paragraph 3.14 - Supplementary planning documents and guidance: - Birmingham Green Living Spaces Plan (2013) - Places for living 2001, pg. 8, pg. 9 - THRIVE, West Midlands combined Authority - Places for All - Working Together in Neighbourhoods White Paper - Community Cohesion White Paper - Imagination, Creativity and Enterprise: Birmingham Cultural Strategy *(to be refreshed in 2019/2020)* Collaborations in Place-based Practice: Birmingham Public Art Strategy *(to be refreshed in 2019/2020)*

10 Minimising the use of resources	• National Planning Policy Framework (March 2012)
	
	  • Meeting the challenge of climate change, flooding and coastal change
	
	  • Conserving and enhancing the natural environment
	
	  • Facilitating the sustainable use of minerals
	
	• Supporting information
	
	  • Report of the Marmot Sustainable Development Task Group (2010)
	
	  • Mayor of London and London Councils (2006) The Control of Dust and Emissions from Construction and Demolition: Best Practice Guidance
	
	  • Building Research Establishment Environmental Assessment Method (BREEAM)
	
	HM Government, Greener Space 25 year environment plan 2018
	
	BRE Green Code
	
	BRE BES6001:2008 Part G Building regulations
	
	WRAP guidance on designing out waster
		• BDP, policy TP3, TP5, TP13, TP14, TP27,
		
		• Supplementary planning documents and guidance:
		
		• Access for People with Disabilities SPD 2006: paragraph 9.4,9.6, 9.7, 9.8, 9.9, 9.10, 9.1, 9.14, 9.15, 9.16, 9.18
		
		• Public Open Space in New Residential Development 2007: paragraph 3.2, paragraph 3.3
		
		• Places for living 2001, pg. 31, pg. 34
		
		• Places for All: pg. 23
		
		• Birmingham and Black Country Nature Improvement Area Strategy 2017-2022
		
		• Natural Capital Tool

11 Climate change	- National Planning Policy Framework (March 2012) 10 Meeting the challenge of climate change, flooding and coastal change - Department for Communities and Local Government (2012) Investigation into overheating in homes: Literature review - Department for Communities and Local Government Code for Sustainable Homes - Assessment Method (BREEAM) - Marmot Sustainable Development Task Group (2010) - Green and Blue Space Adaptation for Urban Areas and Eco Towns (GRaBS) project - NHS Sustainable Development Unit (2009) Saving Carbon, Improving Health – NHS Carbon Reduction Strategy for England - Lancet (2009) Health benefits of tackling climate change: evidence - Department for Environment, Food and Rural Affairs (2012) UK Climate Change Risk Assessment HM Government, Greener Space 25 year environment plan 2018	- TP5, TP6, TP7, TP8, TP27, TP38, TP39, TP40, TP41 - Supplementary planning documents and guidance: - Places for Living: pg. 30, - Places for All: pg. 22, pg. 25 - BDP, policy TP1, TP2, TP3, TP4, TP13, - Birmingham and Black Country Nature Improvement Area Strategy 2017-2022 - Natural Capital Tool - SPD SUDS guide for Birmingham (2016) - Birmingham Green Living Spaces Plan (2013) Air Quality Plan
12 Digital and Technology	- Future Telecoms Infrastructure Review, Department for Digital, Culture, Media & Sport, July 2018. - BS ISO 37106:2018, Sustainable cities and communities. Guidance on establishing smart city operating models for sustainable communities PAS 2016:2010: next generation access for new build homes guide	

13 Child friendly development	• UN Convention on the Rights of the Child (UNCRC). • ARUP: Child-centred Urban Resilience Framework UNICEF Handbook for Child-responsive Urban Planning	The Review of Child Friendly Planning in the UK three key human rights as stipulated in the UN Convention on the Rights of the Child (UNCRC). These are the right to participate in decision-making (Article 12); to gather in public space (Article 15); and to play, rest leisure, and access cultural life (Article 31).
14 Impact upon equalities: protected characteristics		• Equalities Act Public Sector Equalities Duty Any planning guidance around equalities

Birmingham
Health and Wellbeing
Board

	Agenda Item: 18
Report to:	Birmingham Health & Wellbeing Board
Date:	19 January 2020
TITLE:	LOCAL COVID OUTBREAK ENGAGEMENT BOARD
Organisation	Birmingham City Council
Presenting Officer	Elizabeth Griffiths, Assistant Director of Public Health

Report Type:	Information

1.	Purpose:
	To inform the Board of Governance and purpose of the new sub-Group of the Health and Wellbeing Board, the Local Covid Outbreak Engagement Board.

2. Implications:

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

3.	Recommendation
3.1	The Board is asked to note this update of the Local Covid Outbreak Engagement Board.

4.	Report Body
4.1	The Local Covid Outbreak Engagement Board is a new sub-committee of the Birmingham Health and Wellbeing Board. The Board is required by national guidelines for each upper tier local Authority's response to the Covid 19 outbreak.

4.2 The purpose of the Board is to provide political ownership and public-facing engagement and communication for outbreak response to Covid19 in Birmingham.

4.3 The Board has been set up to:

- Take an overview of the progress of the local implementation of Test and Trace.

- Ensure that the Test and Trace response in Birmingham is delivering the right interventions to protect the health and wellbeing of citizens

- To influence the development of the local Test and Trace programme.

- To promote communication and engagement with stakeholders and residents of Birmingham related to Covid 19 and the Test and Trace programme.

4.4 The Board is chaired by the Leader of the Council; membership comprises five elected Members, the Director of Public Health, Assistant Director of Public Health, the Birmingham and Solihull and the Sandwell and West Birmingham Clinical Commissioning Groups, WM Police, BVSC and Birmingham Healthwatch.

4.5 The first meeting of the Local Covid Outbreak Engagement Board (LCOEB) was held on 24 June 2020, with meetings held on a monthly basis.

4.6 The LCOEB receives a regular Covid19 situation update – both at the monthly meeting and on a weekly basis to members of the Board. These updates include the latest position in relation to Covid19 cases across the city, testing uptake, the proportion of tests taken that return a positive result. As the this is a rapidly changing situation the latest epidemiology is presented to the Board.

4.7 Appended to this report are the minutes of the LCOEB.

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**

5.1.1 Whilst Birmingham's emergency plan is activated, the Test and Trace Cell will form part of the "Silver" command structure as a cell of the Tactical Cell. In parallel, the Test and Trace Cell feeds into the Birmingham Health Protection Forum, chaired by the Director of Public Health, which is a sub-group of the Health and Wellbeing Board.

5.1.2 Recognising that Test and Trace is likely to extend beyond twelve months, at such a time as the emergency response structures are stood down, formal governance of the Test and Trace Cell will be via the Health Protection Forum.

5.1.3   The Local Covid Outbreak Engagement Board will provide democratic oversight to the Test and Trace response.

5.2	**Management Responsibility**
	The Director of Public Health is responsible for publishing the Local Outbreak Response Plan for the City and Chairs the Health Protection Forum. The Assistant Director of Public Health chairs the Test and Trace Cell and is responsible for the local operational delivery of Test and Trace in Birmingham.

Appendices
Appendix 1 - Local Covid Outbreak Engagement Board Minutes - 26.11.20 Appendix 2 - Local Covid Outbreak Engagement Board Minutes - 27.10.20 Appendix 3 - Local Covid Outbreak Engagement Board Minutes - 01.10.20

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

Elizabeth Griffiths, Assistant Director of Public Health

BIRMINGHAM CITY COUNCIL

**LOCAL COVID OUTBREAK
ENGAGEMENT BOARD
THURSDAY,
26 NOVEMBER 2020**

**MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK
ENGAGEMENT BOARD HELD ON THURSDAY 26 NOVEMBER 2020 AT
1500 HOURS ON-LINE**

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Andy Cave, Chief Executive, Healthwatch Birmingham
Chief Superintendent Stephen Graham, West Midlands Police
Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and
Deputy Chair of the LCOEB
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Councillor Brigid Jones, Deputy Leader of Birmingham City Council;
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Councillor Paul Tilsley
Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the
LCOEB

ALSO PRESENT:-

Mark Croxford, Head of Environmental Health, Neighbourhoods, BCC
Elizabeth Griffiths, Assistant Director of Public Health
Dr Mary Orhewere, Interim Assistant Director of Public Health
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

77   The Chair advised, and the Committee noted, that this meeting would be
        webcast for live or subsequent broadcast via the Council's Internet site
        (www.civico.net/birmingham) and that members of the press/public may
        record and take photographs except where there are confidential or exempt
        items.

        The Chair advised that the private part of this meeting will not be needed.
        _____

APOLOGIES

78   An apology for absence was submitted on behalf of Pip Mayo, Managing Director – West Birmingham, Black Country and West Birmingham CCGs. An apology for lateness was received from Councillor Paulette Hamilton as she had a prior engagement.

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DECLARATIONS OF INTERESTS

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

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WELCOME AND INTRODUCTIONS

80   The Chair welcomed everyone to the Local Covid Outbreak Engagement Board meeting.

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CHANGE TO ORDER OF BUSINESS

81   The Chair advised that he would take agenda item 7 ahead of the remaining reports.

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ENFORCEMENT UPDATE

Mark Croxford, Head of Environmental Health, Neighbourhoods, BCC introduced the item and drew the attention of the Board to the information contained in the report and the slide presentation entitled *Covid Proactive Patrol Statistics*.

(See document No. 1)

Chief Superintendent Stephen Graham, West Midlands Police then drew the attention of the Board to the information contained in his report.

(See document No. 2)

Chief Superintendent Graham advised that since the first lockdown there had been 198 changes to the rules and regulations which had been a challenge to Mr Croxford and colleagues as well as his officers to try and keep on top of these regulations. Chief Superintendent Graham highlighted paragraph 3.8 of the report in relation to Directions to Leave (DTL).

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Local Covid Outbreak Engagement Board – 27 October 2020

The Chair commented that in his view the West Midlands Police (WMP) response to the current crisis was appropriate, balanced and proportionate which was to the credit of the WMP force.

In response to questions and comments, Chief Superintendent Graham made the following statements:-

a. Chief Superintendent Graham noted Councillor Brigid Jones' query concerning the number of regulations and the amount of notice the Police received regarding new notice coming in and advised that there were 198 regulations, but looking at the law it spoke of the Health Protection Covid Regulations No.4 so people might think that there were only four regulations. Within those four regulations there was just under 200 variations.

b. In terms of the notice the Police received, the Police usually found out the information from Sky News and they were given a couple of days' notice before the rules were implemented so that when this was cascaded out the Police service nationally could see how it was going to be implemented. The Police got next to no notice.

c. Chief Superintendent Graham noted Mr Raybould's comment in relation to the data the Board was presented with concerning the high prevalence of the virus amongst the Asian and the Black communities and his request for more articulation as to why the DTL was so heavily levied against the Black community in Birmingham and advised that the Police were not targeting any communities.

d. Chief Superintendent Graham highlighted that what the Police was targeting was the areas that had a high level of infections, and that what was seen amongst members of the Black and Asian communities was that there were mass gatherings such as weddings whether they were impromptu or otherwise music events. What was happening was that one or two interventions had led to 150 – 300 DTL being issued which generates from one incident from weddings at banqueting centres.

e. Chief Superintendent Graham emphasised that the Police was not targeting any communities disproportionately but were targeting the places where there were higher levels of infections.

f. Chief Superintendent Graham noted Councillor Tilsley's comment concerning support and advised that there was a decent level of support from a number of the News networks that had seen the sort of things they were facing. One of the things the Police was doing was to follow up on the blatant breaches and would publicise the Police going into a public house as detailed in Mr Croxford's report.

At this juncture, Councillor Paulette Hamilton made the following comments: -

1 That this had been an issue that had been developing gradually before summer. The Police did a wonderful job as they could have handed out fines from May/June because within the African/Caribbean community

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and part of the Asian community there were people who refused to believe.

2   There were sections of these communities that believed that there was some conspiracy and the level of disbelief and distrust even though they saw the number of deaths, they did not believe these were Covid deaths. They also believed that people were being classed as having Covid when they did not. They also believed that people's rights were impeded. The information within these communities had become *legendary.*

3   Councillor Hamilton highlighted that she had undertaken a number of interviews over the last months speaking with a large number of her community in different ways, but they were refusing to listen. That she was of the view that the only way they will listen was by what was happening now. Unfortunately, this was what was needed to be done as it was a small core of people that did not want to change and so they were having wakes and other events as stated by Chief Superintendent Graham that they were wilfully breaking the rules.

4   The rules were being obeyed until the Dominic Cummins episode as people were saying *there was one rule for some and one rule for another.* Since the Cummings issue something broke at that point and there was the view that certain groups of society were getting away with breaking the rules and they were just locked in their homes to develop mental health issues. There was a level of distrust of what was being said by politicians and the Police.

5   A lot of people from the community respect what the Police and Army were trying to do but there was a level of distrust. It was important to get the message into communities, but it was not that people did not know, but it had gotten to the stage where people were choosing to break the rules. It was about the constant messages that we keep reinforcing to tell the community that when the Government had to do what it had to do to get through the pandemic when economically it was causing devastation in this country and across the world.

6   That, if people thought it was being targeted against certain communities they were being misled. In the first wave of the virus it was affecting certain communities disproportionately, but in this wave of the virus, it was proportionate to the communities. She was not saying certain communities were not being disproportionately affected, but what she was saying was people had to start following the rules.

The Chair commented that we all had to continue to follow the rules i.e. the NHS, Police, local authority and any other organisation had to reinforce the message that people have to follow all of the guidance around the rules as the virus was out there and it does kill. This was the case as the virus was deadly if you happen to get it. There was a need to keep people safe and to build this bridge through to the roll out of the vaccination.

82   **RESOLVED: -**

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That the Board noted the report.

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MINUTES

83   ### RESOLVED:-

The Minutes of the meeting held on 27 October 2020, having been previously circulated, were confirmed by the Chair.

Councillor Bennett referred to the Test and Trace incident with the used swabs and stated that on the radio this morning one of the students that was affected stated that the Council had not apologised. Councillor Bennett stated that he had heard the Chair apologised for the incident in one or two meetings. He enquired whether a personal apology had been given to the persons affected.

The Chair advised that his understanding was that the Interim Chief Executive had written a letter of apology to the students concerned. Dr Justin Varney corroborated that there was an explicit apology to the student in the letter from the Interim Chief Executive.

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COVID-19 SITUATION UPDATE

84   Dr Justin Varney, Director of Public Health introduced the item and drew the attention of the Board to the key points in the slide presentation.

(See document No. 3)

The Leader commented that it was not a surprise that Birmingham had ended up in Tier 3 as the data was not showing enough movement in the right direction.

Councillor Paulette Hamilton stated that Adult Social Care had been under a level of pressure that had not been seen before. Although there had not been the level of death that there was in the first wave of the virus, the pressure in Adult Social care was immense. The pressure that was developing in our nursing homes due to the number of people that were developing Covid-19 was also quite high at the moment. Councillor Hamilton further stated that due to an announcement made by the Government to say that they will now be testing people who were in domiciliary care. For carers who goes into people's homes there will be a level of pressure that would develop in this area. At present, just like the hospitals that stated that they were *creaking* and could be at breaking point (not that we were at breaking point), but across the social care system it was *creaking*. It was expected that a large number of carers will go off sick with Covid-19 when testing in that area commence.

The Chair commented that this was a group of staff that were working for the last 7 months plus in a very stressful situation. He added that it was not surprising that that service area was creaking.

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Stephen Raybould welcomed Councillor Hamilton's comment around the testing of domiciliary care workers as this was something in the sector that people were pushing for, for quite some time now despite the workforce changes that that would create. He added that it was equally welcomed the prioritisation of the vaccination of that workforce. Mr Raybould further stated that there were a number of different issues that would feed into the infection rate for Birmingham – contact tracing was different from the regional average and the different forms of non-compliance. He enquired which of these would make the most significant difference if it was increased.

Dr Varney advised that it would make a huge difference with contact tracing if people engaged with the contact tracing system more. What was seen was a mixture of people putting in the wrong information when they registered for a test, the wrong telephone number of the wrong email and people just not responding or answering the phone when they were called. It was known that there were some issues with the national system particularly around children as children was treated exactly the same way as an adult.

Dr Varney stated that understand adults that got fed up by having multiple calls when both children and parents had Covid and they each had an individual call as the computer did not understand that this was a family and the parent cannot answer on behalf of the child. This was one of the things that would be updated and improved, but it was important to emphasised that this was one of the key bits. If we could get better information about everyone who was exposed to a positive case of Covid, we could get them the right information to protect themselves and their families and stop the spread. This virus spread from person to person. We need to break the chain and the contact tracing was a fundamental part of this process. It was hopeful that the national changes to test and trace would improve that contact tracing as it was the key bit of the jigsaw that at the moment was not doing as well as it could.

The Board noted the slide presentation.

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UPDATE FROM THE NHS

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Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG and Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG presented the item.

Mr Jennings drew the attention of the Board to the information contained in the slide presentation.

(See document No. 4)

Dr Aslam made the following statements:-

1. That there were was some reasonably good news and they were cautiously optimistic about the vaccine. That Mr Jennings had highlighted the great work that had been happening in terms of the logistics behind the vaccination programme. We were waiting for the

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regulators to give their approval of the vaccination and then working with NHS England about how we deploy the vaccination programme.

2. This will be a logistical nightmare but it was something that we were able to do and it was important we pursue that as vigorously as we could. There was some optimism as our system had been challenged in much the way as Dr Varney had highlighted the community spread. We have seen a decrease in community spread – example, in Sandwell last week we had around 500 case per 100,000, but today this was about 400 cases per 100,000 which was a significant reduction. The two week lag with community infection and hospitalisation was quite apparent.

3. There were 60 people in critical care and almost 700people in inpatient bed and almost 250 patients in Sandwell which makes up a quarter of the inpatients we have as sitting Covid patients. We had a significant number of deaths and an increasing number of care home outbreaks.

4. Although the lockdown has helped, we need to be cautious about the opportunities about relaxing and moving into Tier 3 as the Covid will only be increasing in that period if people were not careful so we needed to be mindful about that. We have been progressing as Mr Jennings had mentioned about the flu vaccination. We have been progressing through the vaccination and had relaxed some of the commissioning to general practice so that they could focus on the flu vaccination for urgent care patient and immunisation for children and then whatever the endeavour for Covid going forward.

5. We had recently been given some advice by NHS England about vaccinating the 50 – 64 year olds which was on top of the vaccinations that we would ordinarily be doing for our vaccination programme. This will start at the beginning of next week which will be a gargantuan task. Nationally, we were around 64% of the 65s o be vaccinated.

6. In Sandwell and West Birmingham we were 52% and across Birmingham and Solihull we were only 60%. The numbers were less when you look at vaccinating the under 65 year olds that were at the at risk categories with Sandwell being around 24% and nationally being 30%. These numbers were challenging and we have a month or so to get on top of those vaccination numbers which was important as we cannot afford to have a flu outbreak alongside the Covid outbreak.

7. The likelihood of dying if you have both at the same time was twice as high so it was imperative for people to have the flu vaccine as much as we could encourage people to get vaccinated. It was also known that with the flu vaccination people will need to have the flu vaccination at least a week before they could have the Covid vaccination, but the regulator will give us some more information going forward as people will not be able to have the two at the same time.

8. Depending on the type of Covid vaccine these needed to be based on a month apart so it was important to get the flu vaccination out of the way now so that there was a chance to vaccinate people once the Covid

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vaccination is approved. We were running our health system – our hospitals, general practices and our community services on empty. There was a need to reinvigorate the community to think on the best way to avoid having a complication with Covid and not to have Covid in the first place by taking all the measures alluded to by Dr Varney earlier.

The Chair commented that he would amplify that as the NHS was at the crucible end of this but it was also the frontline care workers operated by local authorities under extreme stress.

The Chair stated that it had been reported in the press that there were three vaccines for Covid that might become available in the near future – the Pfizer vaccine which had to be kept at a very low temperature; hopefully the Astra Zeneca vaccine may become available subsequent to that. The Chair enquired when it was likely that we would see these vaccines become available. In terms of the differences between the two and the Moderna vaccine what the difference in logistics might be in rolling these out and how this might occur and how he privatisation might work around them.

Mr Jennings and Dr Aslam made the following statements:-

i.   The first vaccine that will be available was the Pfizer vaccine which relied on an extremely cold chain and has to be held at -70 degrees and was relatively fragile. It had to be used for immunisation at the point to which it was delivered. When it comes to Public Health England it had to be used in that place.

ii.   In the first instance we would be seeing that vaccine deployed for the mass vaccination sites where we could have the -70 degree with the pharmacies supporting to ensure everything was good. Hopefully the Oxford vaccine will not be very long after that – in a matter of two to three weeks – as this vaccine was more like the flu vaccine as it could be kept on the fridge as opposed to the deep freezer.

iii. It can be ported about easily and this might be that one that would tend to be used more commonly in the Primary Care setting and also taking it out into the care homes and the nursing homes and patients' own homes.

iv.   The Pfizer vaccine was an RNA vaccine. In terms of vaccines there were live vaccines and non-live vaccines. The RNA vaccines were not a live vaccine and the Oxford vaccine would be similar to what was used around the flu vaccine in terms of the logistics of it. The efficacy data was seen for both vaccines over the last few weeks and they were waiting for the regulator to give more information concerning the efficacy and where we could deploy.

v.   The Pfizer vaccine had the logistical challenge of having to be refrigerated between -70 and -80 degrees which was a logistical problem whereas the other vaccines could be stored at 68 degrees.

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vi. In terms of the prioritisation we prioritise giving the flu vaccine on a yearly basis so the prioritisation for this would be along similar lines. Who was vaccinated and at what time we were working with NHS England to give us that information, but essentially it would be as described by Mr Jennings – over 85s, care home residents care home staff and healthcare workers.

vii. Maintaining our health system would be a priority and it was likely that the vaccination of healthcare staff and care home workers and some patients who would be able to get the mass vaccination would be better suited to that because of the nature of the vaccine. Once the vaccine is defrosted it had to be used within four days and it had a thousand vaccine per defrosting or per bulk. Once it has been constituted each vaccine needed to be used within four hours.

viii. Dr Aslam noted Mr Raybould's enquiry concerning whether there had been any move to look at whether a place based vaccination programme could be instigated and advised that the way this was structured at present there would be mass vaccination sites, with Primary Care delivery of the vaccine when it was appropriate. This would be network based which would be place based with each of the network having an allocated place where they would be vaccinating the population of people that sat within that area.

ix. There will be a rolling team that would be able to go to care homes and places where patients were vulnerable but were not likely to be easily moved such as care homes and facilities for learning disabilities and other places. There will be the three Tiers and the networks were working together to see the best and most efficient way for us to manage the population.

x. In terms of the Tiers and the age groups that was probably the most effective way to start the process. It was not thought that this was just age related, but it was age within area. We had breakdowns of age profile within each of the areas.

Councillor Hamilton referred to Mr Jennings statement and stated that they had worked closely with the Council to ensure that even though the vaccinations were led by the Health Service and Primary Care, the Council had been involved as already the Council had everything in place that when the vaccine is rolled out our care home residents will be vaccinated quickly by Primary Care and the GPs. Everything that they were doing they ensured that the Council and Adult Social Care was not left out.

Councillor Hamilton stated that the only issue she foresaw was that a number of care home residents lacked capacity and for speed sometimes some of the residents did not have the immediate family members with that authority and it was needed to ensured that the vaccinations was administered quickly. She enquired whether any thoughts had been given as to how we would ensure that as many of the residents that lacked capacity was given the vaccine as quickly as possible.

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Dr Aslam advised that this was an important point and what they were able to learn through the flu vaccination programme and vaccinating care homes in bulk was exactly that challenge. The issue was who they needed to speak to when the patient lacked capacity and how could they get the consent from those people so that they could vaccinate as there was a process to go through. What they were able to do during this period with the flu vaccine this year was to understand that process better so that when the Covid vaccine became available then we could hit the ground running as we know who those people were.

The Chair commented that there were some fantastic team work being done throughout this period and we needed to keep that going and get the vaccine rolled out which was a huge logistical task as was being indicated. It provides us with a hope that there could be an end to this, but it was not the vaccine becoming available it was getting it rolled out and getting people inoculated. We were not out of the woods with this virus yet and this underlined why we all needed to continue following the rules that applied to Tier 3 that the city was going into next week.

The Chair highlighted that we all needed to take care and take precautions over the Christmas release period and to ensure that we keep as many people safe right the way through to the position where sufficient people were inoculated against the virus, then we could begin to ease things off again .

The Board noted the report.
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TEST AND TRACE IMPLEMENTATION AND ENGAGEMENT PLAN UPDATE

Elizabeth Griffiths, Assistant Director of Public Health presented the item and drew the attention of the Board to the information in the report.

(See document No. 5)

86   **RESOLVED: -**

That the Board noted the report.
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COVID-19 IMPACT SURVEY REPORT

Elizabeth Griffiths, Assistant Director of Public Health presented the item and drew the attention of the Board to the information in the report.

(See document No. 6)

Dr Aslam enquired about the economic impacts of the pandemic as there would be job losses, people with loss of income which could lead to a deterioration in their mental health. Dr Aslam further enquired whether there was a sense of what the impact might be or was there a working group that we could linked in with as the economic impact would impact the Health Service.

The Chair advised that there was a sense of this happening and that everybody had agreed that unemployment was going to be a problem going forward particularly given the number of people who were currently furloughed and the situations some businesses were in. The Chair highlighted that the City Council had prepared an Economic Recovery Plan and would be more than happy to share this with Dr Aslam to ensure that others were cited on that document.

Ms Griffiths stated that this had been recognised within the emergency service structure and there were some detailed work looking at the economic impact. Public Health also recognised the impact that people's financial situation was having on their ability to respond in adhering to some of the Covid restrictions in particular isolation. There were mechanisms in place to be able to provide financial support to some of those individuals – example the £500 that was available.

The Chair commented that as we emerge from the pandemic, we will need to make an effort to improve our health and wellbeing, become more active and return our diets to the healthier conditions than before we entered the first lockdown in March 2020.

87 **RESOLVED: -**

    i.   That the Board noted the report; and
   ii.   The Board agreed to use the intelligence in the report to shape services and public communication.

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PUBLIC QUESTIONS SUBMITTED IN ADVANCE

88 The Chair introduced the item and advised that there was no public question submitted for this meeting.

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TEST AND TRACE BUDGET OVERVIEW

Elizabeth Griffiths, Assistant Director of Public Health presented the item and drew the attention of the Board to the information contained in the report.

(See document No. 6)

89 **RESOLVED: -**

That the Board noted the report.

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OTHER URGENT BUSINESS

90 No items of urgent business were raised.

DATE AND TIME OF NEXT MEETING

91   It was noted that the next Local Covid Outbreak Engagement Board meeting would be held on Monday 14 December 2020 at 1500 hours as an online meeting.

The Chair reiterated that there were no private items for this meeting and that the private part of the agenda will not be needed.

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The meeting ended at 1636 hours.

CHAIRMAN

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BIRMINGHAM CITY COUNCIL

> **LOCAL COVID OUTBREAK ENGAGEMENT BOARD THURSDAY, 27 OCTOBER 2020**

MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON TUESDAY 27 OCTOBER 2020 AT 1400 HOURS ON-LINE

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Andy Cave, Chief Executive, Healthwatch Birmingham
Chief Superintendent Stephen Graham, West Midlands Police
Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Councillor Paul Tilsley
Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the LCOEB

ALSO PRESENT:-

Carol Chatt, Public Health England
Louise Collett, Assistant Director, Adult Social Care
Mark Croxford, Head of Environmental Health, Neighbourhoods, BCC
Robert James, Acting Director of Neighbourhoods
Alison Malik, Service Lead, CCoE, Adult Social Care
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

61   The Chair advised, and the Committee noted, that this meeting would be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

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APOLOGIES

62   Apologies for absence was submitted on behalf of Councillor Brigid Jones, Deputy Leader of Birmingham City Council; Elizabeth Griffiths, Assistant Director of Public Health; Pip Mayo, Managing Director – West Birmingham, Black Country and West Birmingham CCGs and Dr Mary Orhewere, Interim Assistant Director of Public Health

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DECLARATIONS OF INTERESTS

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

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WELCOME AND INTRODUCTIONS

64   The Chair welcomed everyone to the Local Covid Outbreak Engagement Board meeting.

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MINUTES

65   **RESOLVED:-**

The Minutes of the meeting held on 1 October 2020, having been previously circulated, were confirmed by the Chair.

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UPDATE FROM THE NHS

66   Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG introduced the item and made the following statements:-

   a. The hospital numbers since the 19 October 2020 had continued to rise and as of this morning there were 291 inpatients in the UHB hospitals who had Covid. Of those 242 were considered still to be active because they were within 14 days of their diagnosis compared to 200. There were 33 people this morning in the intensive care units.

   b. That it was important for the NHS to be open and transparent about these numbers although some people were uncomfortable about sharing numbers. He added that it was important as a system as it was one of the clearest ways of expressing the pressure that the NHS finds itself under.

   c. It was important to remember that the hospital sat at the pinnacle/peak of a massive healthcare system – 90% of interventions in healthcare were

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in the primary care system. This was a busy time of the year and the NHS was expected to be busier around now as the general run of the mill viruses and illnesses would be starting to appear and this year was no exception. This year life was more complicated as the NHS was now operating in a world that includes Covid-19.

d. In March 2020 and April 2020 life was a bit simpler as everything was turned off except the response to coronavirus. The NHS was now operating in a more complicated world where we were trying to deal with coronavirus and with all the issues the NHS normally dealt with. We were also trying to deal with those services and those patients that had to be passed over during the first wave/peak of coronavirus.

e. As the number of patients with coronavirus cases rises it places more demands on the system which makes it more difficult to deliver the other services that the NHS was trying to put in place to offer to people. Primary Care did not lack numbers in quite the same way. It was not simple to describe how busy Primary Care was but they were dealing with all the things they normally dealt with.

f. Primary Care was also dealing with one of the well-advertised and serious flu vaccination campaigns as it would be disastrous if the flu was running through the community as well as coronavirus running through simultaneously. Primary Care was busy, Accident and Emergency was busy and the hospital beds were busy.

g. In terms of the NHS, a lot was said at the beginning of the coronavirus about protecting the NHS and this was a message the Director of Public Health would amplify. This was not just about protecting the NHS but about protecting our self and protecting each other.

h. What was seen in terms of in the hospitals were that two or three weeks on from when someone acquires the infection – it was not until people had the infection that they were required to be hospitalised – the numbers were steadily rising in terms of the case rate. The numbers were steadily rising in terms of patients in our hospitals and patients reporting with symptoms to Primary Care. They needed to do everything they could in terms of our behaviour and persuade each other to behave in a way that minimised the terrible impact that it would have on our society and community.

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG stated that:-

1. It was worth reflecting on what Mr Jennings had stated as they had a responsibility in Primary Care to ensure that there was access to the care that people need, but we also had a responsibility to protect our staff. The conundrum of making sure we see the people that we needed to see in the most appropriate time frame at the most appropriate location was a conundrum for them this winter.

2. There were more viruses around with children back at school (although it was half-term now) and this perpetuated the viruses around this time of

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year and increase the demand on general practice. It was a difficult time but Primary Care were managing as there was capacity and the red sites had been set up.

3. In Birmingham the site in Aston Pride was busier now and the complexity of the patients it was seeing were more complex and people were more sick when they came to the red sites and were more likely to be referred into hospitals.

4. Dr Manir highlighted that there was capacity and that he did not want people watching the meeting to think that Primary Care did not have capacity, but that they needed people to understand that the way they would be seen would be different. This was something that needed to be embedded into people's psychic as there was a significant amount in the press recently about the face to face appointments.

5. Dr Manir stated that we just needed to be realistic as the face to face appointments were going to be by exception and they had to see some people on occasions for examinations that were necessary – to take blood test and provide immunisation.

6. There were situations where people needed to be seen face to face and staff were geared up with the appropriate PPE for that, but they needed to be realistic about the volume of people that were seen in general practice not just to protect people coming because if they were coming to see us there was a level of vulnerability and we needed to protect our staff.

7. We had a significant BAME population with their contribution that made up a significant proportion of our staff. Whilst there was capacity and we were seeing people it did not necessarily meant the kind of care people got would be as good if not better than before but would be delivered differently.

In response to questions and comments, Mr Jennings made the following statements:-

i. Mr Jennings noted Councillor Hamilton's query as to whether there was enough flu vaccine and how people could obtain the flu vaccine and what people who were vulnerable could do if they were not contacted about getting the flu jab and advised that if people were in one of the vulnerable groups – over 65 year old or suffer from a number of health conditions and were under 65 years old people would hopefully be identified by their GP Practice.

ii. That if people believed they were within one of those groups but had not been identified they will need to speak with their Practice. That whilst orders had been placed for sufficient vaccine to vaccinate everybody that needed a vaccine in the first instance, there was mechanism for us to draw down extra supply if they were needed.

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iii. Conversations were being had in Primary Care with our practices those who were starting to believe they were going to use up all their stock to get some more. There was arrangement in place to be able to make this happen. We were relevantly competent that those who fit the criteria would be able to have their vaccine. Mr Jennings stated that he was aware that some of the pharmacies were struggling and a lot of people who attend the pharmacies were people who were choosing to have the vaccine and were choosing to do that privately.

iv. In terms of those who had a clinical need for the vaccine there was enough vaccine in the system to be able to meet those needs through our Primary Care system.

v. Mr Jennings noted Councillor Bennett's enquiry concerning the opening of the Nightingale Hospitals; the conflicting reports about the coronavirus rates within hospitals and advised that the hospitals were careful about how they manage this for the sake of the patients but also for the sake of their staff as well.

vi. One of the lessons that was learnt from Italy was that we have to protect our staff. If we did not have the staff to do the work then we would be in a dreadful place. What we had been doing over the last couple of weeks was that we were having testing of staff who had symptoms and this had happened across a number of hospitals both in Birmingham and across the Midlands and has identified a small number of individuals who were asymptomatic and were positive.

vii. If a person was positive and they had no symptoms at all there was no way of knowing unless the person was tested and they were starting to do that. Although they had found some, reassuringly they were small numbers (single figures) after thousands of tests. There was a small associated possibility of a coronavirus with someone in hospital who did not knew they had it as they did not have symptoms but this was a small number.

viii. Decisions to open any of the Nightingale Hospitals were national decisions and would be taken by NHS England as they had the command structure for doing so. The way this worked locally was that the first ward which was 28 patients would be staffed by either University Hospitals Birmingham, then after that a ward at a time would be opened if they were instructed to do so which would be by drawing down resources from hospitals within 60 minutes of the Nightingale Hospital. This was the way it would work.

ix. Everybody within 60 minutes of the Nightingale Hospital would be contributing patients and staff. But we were nowhere near being in a position when we would need to be thinking about taking that decision. What we had done locally was to escalate this so that we were now able to open the Nightingale Hospital at 72 hours' notice.

Dr Manir advised that despite all the planning that was done, the supply chain for flu vaccination had being sporadic. At the beginning of September we had

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received some of our nasal flu for under 2 years old and a small stock for over 65 years old at the end of September. We were yet to receive our stock for under 65 years old. We ordered a year ago, but we have not received the stock yet. This did not mean that we were not going to receive it as it was anticipated that we were going to receive it. If you have not received a message from your GP advising to come and have your flu vaccination, it maybe that their stocks were arriving in accordance with the supply chain. It was awkward, considering all the planning that had been done that the pharmacies had received theirs first. Lots of Practice had been proactive and had sent their patients who were at risk to their pharmacies to have their vaccination. If you have not received a message from your Practice, do not give up, it will come or contact them to find out when their stock will arrive

The Board noted the presentation.

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COVID-19 SITUATION UPDATE

67   Dr Justin Varney, Director of Public Health introduced the item and drew the attention of the Board to the key points in the slide presentation.

(See document No. 1)

In response to questions and comments, Dr Varney made the following statements:-

a) Dr Varney noted Councillor Bennett's queries concerning the fall in testing rates; the rise in Covid-19 amongst the over 80s age group and the Asian population and the extent that this had to do with drop and collect service and advised that by pausing the drop and collect service it had had an impact in terms of testing in areas where Public Health had concerns.

b) Drop and collect was being targeted to take testing out on the street in areas where we had a high number of cases but not enough testing. This helped to boost testing rate in some of those communities that had not been well engaged with testing. What was seen was that when drop and collect left the testing rate stayed up and was a kind of legacy effect of drop and collect which was positive. We were not seeing at the moment any area of the city really dropping down in testing. It was just what had been lost, the additional level of enhance testing.

c) As the investigation goes on, Public health were looking at alternative models that could be used to set up quickly to try and plug that gap. The approach with drop and collect had identified people who had very mild symptoms and identified them as being positive. This had enabled Public Health to stop the spread and we had seen evidence in some of the wards where drop and collect was focussed. Their case numbers had come down and continued to stay down which suggest that it was successfully breaking that chain of transmission.

d) In terms of the over 80s this was the reason he had presented some of the analysis today that Public Health was doing to try and delve into that a bit more. What was interesting was that there were two things there that was different – a) The ethnic profile suggested that the over 60s and particularly the over 80s were predominantly white than from our other ethnic communities.

e) This changes some of our hypothesis about whether this was about intergenerational households, was this about large families. What was seen when this was looked at in more detail was that it was seen that more couples were becoming infected. We had quite a lot of elderly couples who lived together independently and sadly they both became infected.

f) The next stage of this was to do a little bit more work to find out how they caught it, whether it was about people coming into their home, elderly people meeting up for cups of tea - but this was not yet known as we do not have this information. The younger age group – the 60-69 year olds - strong links to work could be seen and was an important reminder to employers watching the meeting to really think through Covid with safety and protecting the more elderly staff and ensuring that they were Covid risk management was taken.

g) In relation to the point on positivity as our testing rate was staying reasonably flat, we had gone down a little bit and came back up, but we were staying roughly the same. Drop and collect had not had a significant change in our positivity rate and the people we found trough drop and collect we found earlier in their disease that had fewer symptoms and had not thought to get a test yet. Had Public Health not gone and tested them then in about a week's time, they would have had symptoms as they were positive. Their disease probably would have progressed but we have caught it earlier. We will see over the next week or two how this played out.

h) What Public Health was seeing was a real rise in the community, particularly a marked rise in our white British community and a particular rise in our elderly community over the age of 60. This was an important warning for all of us to take action to protect the people we love and care for. This was about doing things to protect people we care about. The collateral benefit was that it would protect the city, but it starts with what you do and how that impacted on the people you care for.

i) Dr Varney noted Councillor Bennett's enquiry in relation to the percentage of people being picked up through drop and collect that went on to have symptoms and advised that public Health did not have this information at the local level but there was some national research being done to look at this issue. One interesting thing was also some of the batch testing that was being done in care homes particularly with staff.

j) Where most asymptomatic cases were being diagnosed was in care home staff and to some extent in NHS professionals when more batch testing was being done of them rather than in the community. What was

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interesting from the drop and collect point of view was quite often when the information was seen coming through or where the contact tracers were having calls after people had been found, by the time they had that conversation they were asymptomatic.

k) There were people that were asymptomatic with Covid, but it did not appear that they were as good at spreading it which made sense as the more virus you had the more symptoms you were expected to have. Therefore you were more likely to spread it if you had symptoms as there was a lot of virus in the throat and nose. Someone who was asymptomatic would not have the coughing symptoms for example which would project the virus further. We have not seen from the national work those clusters linking back to asymptomatic people.

l) Although there were people who were asymptomatic, and we had found some through the batch testing Public Health was doing, these were mild symptoms. The challenge was helping people reached out for a test as soon as the symptoms developed. The sooner you test the sooner you have the result as to whether it was Covid or not and if it was Covid the more under control it would be.

m) Dr Varney noted Dr Manir's query concerning the number of people who were asymptomatic and getting tested versus those people who had symptoms and were not getting tested and advised that Public Health did not have the numbers at present. Dr Varney stated that a national research was being done to look at what could be understood about people who were not getting tested who were positive.

n) The issue Public Health had was that people did not know they were positive unless they took a test and Public Health had to find a way of identifying them to do the research in that way. The national surveillance samples were all kept for people who opted in to do testing as there were people who did not have symptoms but opted to do test every month. This did not really help us.

o) It was thought that where Public Health was drawing this from was two things –

Firstly, where there had been general research at national level about what people felt about testing, this was what was telling Public Health that people were saying that they were not booking a test as they did not want to isolate or they could not afford to isolate. It was important to remind people that there was financial aid for those people who were on low income. This information was on the City Council's website if people needed to isolate.

Secondly, the feedback Public Health was getting from our community engagement where people were telling us directly that people were not wanting to test because of the implications of a positive test.

p) It was important to remind people that the implications of a positive test meant that you needed to isolate for 10 days and the people you live

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with had to isolate for 14 days. This stops people from spreading the virus to someone they care about who may not be able to defend themselves in the way you could. This could end up with the person going into hospital and ultimately with them dying. This was the point about getting a test. Dr Varney reiterated that people should get a test to find out if they had Covid and you will not put the people you love at risk of getting Covid.

Councillor Hamilton referred to the marked rise in the over 80's age group and in the white community and also that care home staff seemed to be non-asymptomatic or were carrying the virus. That it had been proven that many of these persons who work in care homes and the health service a large proportion of these persons were from the BAME community and questioned why these figures were not showing in the families as a lot of families were large families. Councillor Hamilton further question whether it could be that the over 80's in the white community proportionately were testing more than the other communities.

q) Dr Varney stated that what could be seen looking at a month's data for the over 60's increase, but Public Health had not looked at all age group in terms of staff that worked in care homes. As care home staff were testing on a regular basis Public Health was able to pick up people with a mild symptom or no symptoms but this was because they were tested every month. What was not seen in care home staff was more or less likely to be asymptomatic with Covid. We find them because we were routinely testing them which was unique as no one else got tested in that way.

r) Looking at the over 60s age group and the staff who work in care homes it was similar as there were only 34 people that had Covid in the last month that were over aged 60 and was working in a care home. 14 of those identified with white ethnicity, 5 from an Asian ethnicity and 7 from a black ethnicity. There was a balanced picture with the people that worked in care homes in terms of ethnicity. We know that many of our ethnic communities were the backbone for our health and social care system.

s) As they were being tested more frequently cases were being picked up much earlier and it was hoped that people were able to limit the spread in their households and use resources like the Germs Defence Website to think through how they could protect the people they were living with.

t) It was hard to stop household transmissions and a lot of households were seen where everyone in the house ended up catching the virus. This was the reason it was important to ascertain whether it was Covid soon. The sooner it was known, the more you could try to protect the relative you live with. If they did become sick then it helps the GP and other healthcare professionals make the diagnosis faster and make the right treatment decisions. It was important to get tested quickly if you have symptoms.

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u) In terms of the over 80s testing rates Public Health was looking at some of the analysis of that at the moment. No evidence was seen that the over 80s testing rate had changed as batch testing was being done in care homes for several months and it was not thought that that was behind it, partially because Public Health was not seeing the rise in cases being mainly in care homes. It was mainly in the community.

v) What was thought to have changed was that there was more walk through testing site that were opened. The map of the city shown in the slides earlier showing more of it going dark purple showed high levels of testing particularly in areas like Sutton Vesey for example where they had the walk through site at Sutton Coldfield Town Centre. This had improved in the uptake of testing for people who did not have cars. This may be helping to find cases earlier, but it was not thought given the analysis that was done that this was driven by the care homes. There was concerns about what the wider community was doing as we should not be visiting each other houses. The question was how was this getting in the elderly houses and more work would be done to try and explore this over the coming days and weeks.

The Board noted the slide presentation.

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ENFORCEMENT UPDATE

Mark Croxford, Head of Environmental Health, Neighbourhoods, BCC presented the item and drew the attention of the Board to the information contained in the report.

(See document No. 3)

Chief Superintendent Stephen Graham, West Midlands Police advised that:-

1. The Police had issued a couple of the £10,000.00 fines for the flagrant breaches. These were not technicalities for people to say that they did not know what they were doing. This was normally where people had taken active steps to try and deceive the Police or our colleagues by closing shutters up but were doing something else.

2. There were extreme moments but, on the whole, given the size of our city it was still the exception rather than the rule when people breach the various rules to regulations. When they do so we give people the chance to modify their behaviour and the Police go through enforcement as a last resort. Albeit it was now fair to say the Police was reaching that last resort sooner than they were doing six months ago as people could not say that they did not knew this or that they did non knew that. There were some technical breaches but there were people who actively knew the rule and took steps to try and deceive the Police.

3. In terms of enforcements, the Prime Minister had spoken some time ago about the military backfilling the Police's roles in time of extremist. Chief

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Superintendent Graham reiterated that if the military or service personnel was seen on the streets of Birmingham they were solely assisting in the drop and collect exercise and there was no enforcement activity being taken by the military. The request for that was purely out of the drop and collect service and was not linked to any enforcement. The work of the service personnel was purely to look after the health and welfare of the residents of this city.

4. £30m of Government funding which was made available nationally to sustain Covid surge in force activity. It was expected that £800,000 to £1m to spend on Birmingham based on a prorate basis. The Police had not carved it up via each local authority, but this was the level of extra activity the city would see from policing in the coming months.

At this juncture the Chair, commented that the point made by Chief Superintendent Graham about the armed forces assisting us in order to keep people safe here in Birmingham was well worth making particularly given the unfortunate and unnecessary incident that was seen last month.

Mr Croxford stated that they had some money coming through to the Council but as this would be reported through the Cabinet structure, he did not go through any detail concerning the issue. This was a significant amount of money coming through for compliance and enforcement and they were trying to share that out with colleagues not just regulatory services. He added that a report on that would be submitted at a future meeting.

Councillor Hamilton enquired whether there had been any feedback concerning the incident referred to by the Chair as this had taken place in her Ward. She added that as a Council they deplored what had taken place and that she was embarrassed and ashamed of the incident that took place.

Chief Superintendent Graham advised that the Police had not gotten to the bottom to identify the person whose behaviour had embarrassed themselves and the city. He further stated that he did not want Councillor Hamilton to take personal as he was aware that she was deeply passionate about the area. Chief Superintendent Graham stated that it was important to point out as Councillor Hamilton implied that this was very much an isolated incident and that he had spoken to a couple of the senior officers from the military and that Cornel Chambers had stated that the service of the personnel did not in any way shape or form on a day to day basis reflected that one off incident. That on a whole they were broadly welcomed by the people of the city and in the area in which the incident took place the backlash against the *idiot* on social media spoke greater volume for the city and Councillor Hamilton's Ward.

The Chair commented that the population of 1.1m people, one *idiot* was not representative of this city and that he had sent a message to give thanks to the armed service personnel for their help with the drop and collect service

68   **RESOLVED: -**

That the Board noted the report.

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TEST AND TRACE IMPLEMENTATION AND ENGAGEMENT PLAN UPDATE

Dr Justin Varney, Director of Public Health presented the item and drew the attention of the Board to the information in the report.

(See document No. 6)

The Chair commented that it was clear from the report that a large amount of work was being undertaken and we could not do enough around communication. There was increasing evidence that the public was becoming fatigued about the rules and what they had to do and the more information we could give it was clear from the report that we were doing just that.

Dr Varney noted Councillor Hamilton's request for clarity concerning the retesting request for Covid from pupils and schools and advised that if you had tested positive for Covid there was no point in retesting within six weeks as you will stay positive for six weeks. If you tested positive there was no need to retest as the test result would not change anytime soon. It was a waste of a test and did not change whether you could go back to work or not. Similarly it does not change if you could go back to school. Schools should not be requiring students to take test before they return after the half-term break. You should only be getting a test if you have one of the three symptoms – high temperature; new persistent cough or a loss of sense of smell or taste or if asked to by a Public Health professional in Public Health Birmingham City Council or Public Health England

69   **RESOLVED: -**

That the Board noted the report.

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PUBLIC QUESTIONS SUBMITTED IN ADVANCE

70   The Chair introduced the item and advised that there was no public question submitted for this meeting.

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TEST AND TRACE BUDGET OVERVIEW

Dr Justin Varney, Director of Public Health introduced the item and highlighted that from the budget report Public Health had not yet reconciled a lot of the spend over the last month or two.

(See document No. 10)

Dr Varney advised that the major contract for the swabbing provision with the Community Trust was the first invoice for the first quarter of activity comes in November 2020. One of the reason the budget looked like it was underspent was some of the external commissions and the internal recharge has not yet happened as it was done on a quarterly basis and would not come into effect until the next report.

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Dr Varney highlighted that there was a reduction in the remaining budget to be spent and that Public Health was in the process of expanding slightly the capacity in the Test and Trace team to reflect that there was increasing pressure on that team. The modelling that they were previously being working to underestimated the scale of support that was needed to provide it. A significant proportion of that support which Public Health England previously supplied they were no longer able to do so.

Public Health will be expanding the Test and Trace team slightly which would consume some of the remaining non-allocated budget. However, a healthy contingency was retained on the basis that the government was yet to clarify if this grant was for the financial year or whether it was a 12 month grant running from the end of July 2020 to July 2021. Until this issue was resolved Public Health was reluctant to relax that contingency budget until clarity was had for how long the money was to be used for.

The Chair commented that this was wise as clarity was being sought from the government for several months and one would hope that someone from government would give us an answer.

71   **RESOLVED: -**

That the Board noted the report.

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OTHER URGENT BUSINESS

72   No items of urgent business were raised.

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DATE AND TIME OF NEXT MEETING

73   It was noted that the next Local Covid Outbreak Engagement Board meeting would be held on Thursday 26 November 2020 at 1500 hours as an online meeting.

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EXCLUSION OF THE PUBLIC

74   **RESOLVED: -**

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

Exempt Paragraph 3 of Schedule 12A.

BIRMINGHAM CITY COUNCIL

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LOCAL COVID OUTBREAK ENGAGEMENT BOARD THURSDAY, 1 OCTOBER 2020

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MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON THURSDAY 1 OCTOBER 2020 AT 1400 HOURS ON-LINE

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Andy Cave, Chief Executive, Healthwatch Birmingham
Chief Superintendent Stephen Graham, West Midlands Police
Elizabeth Griffiths, Assistant Director of Public Health
Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Councillor Brigid Jones, Deputy Leader of the City Council;
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Councillor Paul Tilsley
Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the LCOEB

ALSO PRESENT:-

Mark Croxford, Head of Environmental Health, Neighbourhoods, BCC
Suzanne Dodd, Assistant Director and Solicitor – Legal Services (Deputy Monitoring Officer)
Pip Mayo, Managing Director – West Birmingham, Black Country and West Birmingham CCGs
Dr Mary Orhewere, Interim Assistant Director of Public Health
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

43   The Chair advised, and the Committee noted, that this meeting would be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

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008457/2021

Local Covid Outbreak Engagement Board – 1 October 2020

APOLOGIES

44   An apology for absence was submitted on behalf of Dr Justin Varney, Director of Public Health, Birmingham City Council. An apology for lateness was submitted by Councillor Paulette Hamilton.

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DECLARATIONS OF INTERESTS

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

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WELCOME AND INTRODUCTIONS

46   The Chair welcomed everyone to the Local Covid Outbreak Engagement Board meeting.

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MINUTES

47   **RESOLVED:-**

The Minutes of the meeting held on 27 August 2020, having been previously circulated, were confirmed by the Chair.

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CHANGE TO ORDER OF BUSINESS

48   The Chair advised that he would take agenda item 10 ahead of the remaining reports.

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UPDATE FROM THE NHS

49   Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG stated that in Birmingham and Solihull they were seeing the consequences of admissions in terms of intensive care that were consequent upon the rising numbers of cases in the population. There was a 14 day incubation period for the virus and a 10 day period usually after the first manifestation of symptoms for Covid for people appearing in hospital. What was seen in our hospitals tells us what was happening three to five week ago in the system. The number of patients in ICU had remained at a fairly constant level over the last couple of days with the number of in-patients gently rising.

The NHS was seeing in terms of Accident and Emergency (A&E), the activities were now back to the level it was before Covid started, but they were seeing increasing levels of Covid in A&E attenders which was significant in trying to manage the front as they were trying to keep social distancing going and to

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keep the Covid potential patients away from the non-Covid patients which was creating some significant issues.

Mr Jennings stated that it was important to note that the last few months was incredibly hard work particularly for the keyworkers on the frontline. The prospect of going into a winter (winter was harder work as there was more illness about), that also includes Covid was quite concerning. Mr Jennings reiterated the absolute significance and importance of everyone doing their best to adhere to the rules that were in place in terms of our behaviour to avoid a second wave and to minimise the spread of the virus and to improve our current situation as winter could be difficult otherwise.

The Chair expressed the Board's thanks and admiration for all of the hard work NHS staff and other key workers had done over the last six months which had been a particularly difficult time and we had the next six months of winter to come and would be relying again on staff in the NHS and key workers to keep us all going and as safe as we could be over the next six months period.

Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs advised that Mr Jennings had covered most of the things on her presentation, but there were a couple of issues to be added. She stated that Mr Jennings had also set out the challenges they had at the moment to try and restore and recover a lot of services that was stood down during Wave 1 of the virus to prepare for a second surge and to deal with the coming winter. Two particular points to be added to the overview were – planning for the flu vaccinations which was a key strand of their work alongside Covid. The message was being promoted that one of the things people could do if they were in one of the target groups were to help to protect themselves through the winter was to take the flu vaccination and to ensure they had received it.

Another key issue that had arisen was access to Primary Care. As a reassurance Primary Care was open and were seeing a lot of people digitally but if there was a need to seek GP support, people were encouraged to do that rather than turning up in triage by general practice. General practice was busy at the moment and were dealing with a lot of enquiries. General Practice was also mindful of the fact that through the first stage of Covid there were many people who did not attend their GP when there was a need for them to do so. Ms Mayo reiterated that General practice was still open but people needed to ring first before attending.

Councillor Tilsley commented that he had a telephone call from his pharmacy a month ago inviting him to attend for his flu jab, but unfortunately the pharmacy had run out. He added that the GP would be sending letters out in mid-October and yet Boots were offering virtually on site vaccinations. It appeared desperate at the moment and whether there was any explanation concerning the issue.

Mr Jennings advised that the GPs ordered their vaccines nearly a year in advance and the vaccine supplier scheduled them as to when they would arrive. For reasons unknown the supplier let the pharmacies had their supply first before the GP vaccines arrived. What appeared to be happening this year was that there was a high level request for the flu vaccines understandably so

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pharmacies were starting to ran out whereas some of the GP practices had barely started to administer their supply. This was down to the vaccine suppliers as it arrived in several deliveries.

In terms of the future supplies, the NHS had been briefed that there was a centrally held stock the Department of Health Social Care and that GPs could have access to that through a mechanism yet to be described to us should they need it in the future. If we were going to get anywhere the levels of immunisations that was given to us as targets, we will need to have more vaccine available than was currently sitting either in the fridges or the delivery chains.

Stephen Raybould commented that they were picking up a lot of uncertainty around the potential arrival of Covid vaccine and whilst talk of the possibility of the Oxford vaccine being signed off for the autumn period, there was now a radio silence. Mr Raybould enquired whether there was any early intelligence from the NHS around planning and implementation should it be signed off.

Mr Jennings advised that the planning process had begun for immunisation which will be a huge exercise. It was understood that the target groups would be the over 65s and vulnerable; the 50 to 64s who had some other feature than their age and anyone with a BAME background and over 18 years old. This was a massive population for them to be thinking about. He added that as he understands it all of the Covid vaccines that were in development were the ones that were potentially purchased by the government for us. These were two stage vaccines so people were required to have two immunisations to be protected from the impact of the virus. The planning was started in terms of how we would think about delivering or perhaps scale up which was unprecedented overwork. It was unprecedented for us to carryout probably for our population 1.6m immunisation in the space of over four weeks difference between the dates – 800,000 of them.

In terms of the actual arrival of the vaccine, the understanding was that there was still some possibility that this could begin before Christmas. However, people would have heard on the news that there was an issue with the Oxford vaccine where it was slowed down because of someone becoming ill. If someone became ill because of the vaccine trials, then it was obvious why they had to go through a very complex series of analysis to understand whether it was the impact of the vaccine that did that. It was thought that there was still some hope that this would be available before Christmas. Even if it was available, again there would be a huge use of supply depending how quickly it flows through the system and how quickly we could manage to carry out the vaccinations.

The Chair commented that he was convinced that science would come up with an answer to this pandemic. He added that we needed to be hopeful that we got a vaccine on the timeline that Mr Jennings indicated might be possible.

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG stated that the Red site situated in Aston Pride and were seeing an increase in the number of Covid within Sandwell and West Birmingham. This was predominantly in West Birmingham and was spilling over into Sandwell and Smethwick and into

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West Bromwich. They were not seeing the same level of activities in the other areas, but this was increasing across the entire Black Country areas. The advice they wanted to give was if people had symptoms, they should call 111 or your GP who will direct you rather than attending an A&E Department and walking in which then exposes everybody to a risk of potential Covid. People could get tested the way the testing system was set up but they should not go to A&E without having contacted someone first.

In terms of the flu vaccine, these were ordered a year in advance and they could not have anticipated the demand this year. They have had some of the nasal flu vaccines in his practice and they have had some of the over 65s that was likely to be delivered at the beginning of next week. It was a phased order and what they had tried to do with the pharmacies that had been receiving the vaccine was to direct the patients they would ordinarily have vaccinated to them rather than having people that they would not include on their high risk categories which was the people they would accept later in the year subject to the vaccine being available. There were processes in place and testing and there was a Red site that was based at Aston Pride in Aston that was seeing patients from both Solihull, Sandwell and West Birmingham. It was thought that people could use the facilities that were set up appropriately as this was the best way to protect all the people around us.

The Board noted the presentation.

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COVID-19 SITUATION UPDATE

50   Elizabeth Griffiths, Assistant Director of Public Health introduced the item and drew the attention of the Board to the key points in the slide presentation.

(See document No. 1)

In response to questions and comments, Ms Griffiths made the following statements:-

    a) Ms Griffiths noted Councillor Bennetts query concerning the stories in the press in relation to schools and advise that Public Health was looking at the data as best they could but there were some limitations with how the data was presented. Ms Griffiths advised that she was unable to provide this information at present and undertook to provide the information following the meeting.

    b) Ms Griffiths highlighted that Public Health had undertaken some analysis of the contact cases and that the way the information came through from the National Contact Tracing Service had detailed where cases have been; where people had been and what environment they had been in as a sample.

    c) Public Health had undertaken an analysis of that and what this showed was that the contacts were largely through a household spread. 83% of contacts had been confirmed cases were in a household; 9% were visiting other households with 2% being through education. This was not

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to say that they had not seen through school's transmission, Public Health had seen within schools' transmissions within Birmingham Schools. Public Health had not seen any real significant information of that transmission being between the children within those bubbles. Some slight cluster was seen between teachers where that transmission may have happened within the school and it appeared that it had been out of that school context within a social setting whether it's through siblings or whether it was by linked activities such as people going to birthday parties etc. with a friendship group.

d) Public Health was continuing to monitor this daily and was trying to understand this and were working closely with schools to understand the picture.

e) Ms Griffiths noted the Chair's comment that the commute to and from school, particularly the pupils walking to and from school. advised that Public Health did not have enough information concerning this issue and undertook to get the information for the Chair.

Dr Manir enquired about testing and commented that there were a number of instances where people have had a test and whilst they were awaiting the results had in some instances turned up at the surgery and then subsequently had positive results. This makes it difficult for them to safeguard staff and other patients. He questioned whether the message was clear enough and whether they could reiterate that it needed to be clear that if you are having a test, it was more than likely that you had symptoms which meant that you had to isolate until that test result came back. The period of time was a tricky time for people, but the result was the indication which decides whether they continue to isolate or not.

f) Ms Griffiths concurred with Dr Manir's comments and stated that isolation meant to be strengthened and that Public Health England had launched a campaign on exactly that point. Public Health had robust communications and were keen to do more and were looking to have detailed engagement. Public Health were doing the Champions network where the information could be pushed to communities regarding behaviours.

g) The messages regarding the latest guidance and the latest legislations that came out so people could get those views into the communities and capture where this was not working in communities, where it was not being understood and where Public Health could make that message stronger.

Dr Manir advised that he was a Covid Champion and had been receiving the information. He added that this was useful and that he had been sending this out to all patients by text messages and encouraging them about the mis-communication, the uncertainty around the communication about what they could and could not do.

h) Ms Griffiths noted Mr Raybould's questions concerning containment and multiple generational families and advised that the per centages around

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households' spreads was the identified contacts of cases. Ms Griffiths advised that she took onboard the point concerning multiple generational houses and blended families and undertook to take this back so they could be included on the frequently asked questions and to ensure that this was addressed in the guidance.

The Board noted the slide presentation.

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THE LEGAL POSITION

Suzanne Dodd, Assistant Director and Solicitor – Legal Services (Deputy Monitoring Officer) introduced the item and drew the Board's attention to the information contained in the report.

(See document No. 2)

Ms Dodd noted Councillor Tilsley' s enquiry concerning the number of times the City Council had used legal powers and issued notices. Ms Dodd advised that she did not have the information to hand, but that Mark Croxford, Head of Environmental Health, Neighbourhoods, BCC will provide the information when he presents the next item on the agenda concerning *Enforcement Update.*

51   **RESOLVED: -**

That the Board noted the report.

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ENFORCEMENT UPDATE

Mark Croxford, Head of Environmental Health, Neighbourhoods, BCC and Chief Superintendent Stephen Graham, West Midlands Police presented the item.

Mr Croxford advised that he would be referring to a report that was taken to the Licensing and Public Protection Committee on the 30 September 2020 - *Coronavirus and Enforcement* as an Appendix to the report before the Board.

(See document No. 3)

Mr Croxford then highlighted the key points in the Appendix to the report at paragraphs 3.1; 3.3; 3.5 and 4.1.

Chief Superintendent Stephen Graham drew the attention of the Board to the information contained in the report – *West Midlands Police Enforcement Update*

(See document No. 4)

The Chair commented that it was seen at the end of March beginning of April 2020 the criticisms of forces elsewhere in the country for what was considered a heavy handed approach. The Chair paid tribute and thanked West Midlands Police (WMP) for the common-sense approach they had taken in dealing with

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this matter and the issues over the last six months. He added that the way the WMP had behaved and performed during that period was not only a credit to the force but was also one of the reasons of high level of confidence by WMP across the entirety of the West Midlands

52   **RESOLVED**: -

That the Board noted the report.

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VULNERABLE GROUPS

Elizabeth Griffiths, Assistant Director of Public Health introduced the item and drew the attention of the Board to the information contained in the slide presentation.

(See document No. 5)

The Chair commented that the outbreak at one of the hotels in the city was in no way the fault of the asylum seekers who had been housed there. They were victims of the pandemic the same as others who had been in this country and all the more so given that they were fleeing from wars and persecutions from elsewhere in the world.

Ms Griffiths noted Mr Raybould's enquiry as to whether the learning from the outbreak in the residential setting that was housing asylum seekers could be shared across other areas and advised that there was much learning to be had from that particular outbreak. Ms Griffiths undertook to progress this with Public Health England (PHE).

53   **RESOLVED**: -

That the Board noted the report.

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TEST AND TRACE IMPLEMENTATION UPDATE

Dr Mary Orhewere, Interim Assistant Director of Public Health (Test and Trace) presented the item and highlighted the main points in the report to the Board.

(See document No. 6)

In response to questions and comments, Dr Orhewere made the following statements:-

1. Dr Orhewere noted Councillor Brigid Jones, Deputy Leader, BCC enquiries in relation to how many of the City Council's staff were doing the drop and collect exercise and whether there were any gaps between what the Council currently had testing wise and advised that in relation to testing, more testing was needed that was accessible by people who did no have cars.

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2. More testing was needed overall, but in particular by those who did not have cars as Public Health was asking people who were symptomatic to go for testing. Public Health did not want them to go on public transport. If people did not have access to a car they would be stuck at home.

3. People could order a home kit but this takes a little longer, but this meant additional working and breaking that chain of transmission takes a bit longer. Access to walk through testing would be better.

4. Public Health was keen to get a drive through testing facility for key workers across the whole of the public sector but was not successful in achieving this so Public Health was looking at how they could support this in other ways.

5. In terms of the drop and collect exercise, Dr Orhewere advised that she did not have the figures for the number of staff involved at hand and undertook to bring this information back to the Board.

The Chair commented that the issue concerning the testing site for key workers was important and wondered whether the Council could do some political lobbying to try and bring that about as over the next six months – dark evenings, cold weather – we needed to take every care that we could for our key workers across the city.

6. In terms of the number of BCC staff doing the drop and collect exercise, there were 467 in various roles as of the 28 September 2020 and externally, there was 104. External include external volunteers, Birmingham Children's Trust and agency staffing. This did not include the armed forces – there were 30 per shift. Public Health had received some funding through the Test and Trace Budget but wee looking for additional funding for this.

7. Dr Orhewere noted Dr Manir's query concerning rapid Antigen testing and advised that this was a good question and that it needed to be known whether the test these companies were offering were sufficiently valid to be used. The other issue was understanding how the result of that test plugged into the national system so that it could be linked back to the patterns and trends. Dr Orhewere undertook to make some enquiries and to give a response to the Board.

Councillor Tilsley referred to the issue of key workers and stated that looking at the distribution of testing sites whether it would be possible – there was Aston University Car Park, Brewery Street Car Park – these were in a couple hundred yards of each other. He questioned whether it was possible for the City Council to designate one of those sites specifically for key workers.

8. Dr Orhewere advised that Public Health got weekly updates on the utilisation on the Council's testing capacity and all were at the maximum level. What was needed was additional testing capacity and if Public Health had surplus capacity, we may not meet the key tester service at all. Additional capacity was needed.

The Chair undertook to write to the Government concerning the issue. The Chair also noted Mr Raybould's comments concerning the anxiety from citizens about the experience of the armed forces around the testing system and advised that his understanding was that the armed forces personnel were not in uniform so they did not look like the armed forces being deployed on the street.

9. Dr Orhewere stated that there was considerable debate as to whether the armed forces should be in uniform or not. Dr Orhewere stated her understanding was that they should be in uniform but without head dress. They would be recognisable as being armed forces personnel but would always have a BCC colleague working with them. The armed forces would also have some identification stating that they were working for and with BCC and would not be going out on their own and would not be unarmed. It was further noted that the armed forces were in uniform but with a BCC tabard over the uniform.

54   **RESOLVED: -**

That the Board noted the report.
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TEST AND TRACE ENGAGEMENT PLAN UPDATE

Dr Mary Orhewere, Interim Assistant Director of Public Health (Test and Trace) presented the item and drew the attention of the Board to information contained in the report.

(See document No. 7)

55   **RESOLVED: -**

That the Board noted the report.
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PUBLIC QUESTIONS SUBMITTED IN ADVANCE

56   The Chair introduced the item and advised that the following question was submitted by # HealthNow Alliance.

(See document No. 8)

Elizabeth Griffiths, Assistant Director of Public Health gave the following response to the question:-

i.   In terms of test kits Public Health was working with the Department of Health and Social Care and so they could allocate some reserved tests for service providers to be able to have that rapid response to access testing for this particular vulnerable community.

ii.   In addition the Birmingham Community Health Care Trust (BCHCT) swabbing so if we were in the unfortunate event that there was an outbreak within a homelessness accommodation setting Public Health would be able to rapidly deploy testing to that facility.

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iii. In terms of training Public Health had within our Memorandum of Understanding with BCHCT to train people up to swab and we will be working with homelessness accommodations providers so that we could identify people to get that training.

iv. In terms of capturing the views of the community, it was felt that this was the reason the Community Champions were appointed for that. Finally, Public Health approach had already been outlined in the presentation in the PowerPoint on vulnerable groups.

v. The limitations for this group was recognised and the national testing relied on people having communication to receive those results whether this was through emails or through a mobile phone.

vi. It was agreed with Saba Rai, Behaviour Service Integration Manager, Adult Social Care, BCC to explore that pathway with the Health and Homelessness Sub-Group to find out what those barriers were and what could be done to better support them so that they could come back to us with some recommendations of how to improve that process for them.

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TEST AND TRACE BUDGET OVERVIEW

Elizabeth Griffiths, Assistant Director of Public Health introduced the item and advised that this was part of the regular update to the Board. Ms Griffiths then drew the Board's attention to the information contained in the report.

(See document No. 9)

Ms Griffiths advised that there was a delay with projected spends coming through due to the fact Public Health was currently recruiting people into posts. She added that a lot of the services that were in place would be invoiced on a quarterly basis. Public Health knew what was projected and what they had committed to but the spend to date had not come through yet. Ms Griffiths highlighted that they were still getting more and more coming through and they had to evolve and adapt to be able to respond to different situations. Enhanced contact tracing with schools and universities the wider Public Health group was now stretched concerning this. Public Health had committed the funding that it currently had but as Councillor Brigid Jones also mentioned there was a need for additional funding to be able to support the work they were asked to do.

Ms Griffiths advised that the other thing that as not clear was the funding available for the next financial year and Public Health was pushing to understanding what would come forward.

The Chair commented that the Council had written to the government to ask for clarity when this particular budget either comes to an end or will be replenished. Councillor Brigid Jones commented that it was not know how long this budget was going to last and that information was needed from the government. The Chair advised that this will be chased up with the government so that a response and clarity could be had. He added that Birmingham was not the only local authority that was looking for a response to this question.

57 **RESOLVED**: -

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That the Board noted the report.

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BIRMINGHAM UNIVERSITIES COVID RESPONSE OVERVIEW

Dr Mary Orhewere, Interim Assistant Director of Public Health (Test and Trace) presented the item and drew the attention of the Board to the information in the slide presentation.

(See document No. 10)

Councillor Brigid Jones stated that she represents BournBrook and Selly Oak Ward with a high concentration of University of Birmingham students living there. She stated that there were concerns about this, but that she was pleased with the amount of work that had gone on. Councillor Brigid Jones enquired whether there was anything that was not being done due to resources, that we wished we had the resources to do in this area.

Dr Orhewere advised that her wish list would be more walk-up testing sites. She added that there were some in the pipeline, but where there was a concentration of people who typically did not have cars who mixed in ways and whose lives were such that they may be at increased risk of getting the virus, there needed to be a system whereby once people become symptomatic they could get testing rapidly. More testing was needed, it was not in our personal gift if we could do what we could alongside key worker testing, more testing for universities. Councillor Jones enquired whether this was asked of the government. Dr Orhewere advised that this was asked of the government and there were some coming on stream but she did not have this information to hand, but it was not coming fast enough. The rate of progress was determined by the national system, but the request was there.

58   **RESOLVED: -**

That the Board noted the report.

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OTHER URGENT BUSINESS

59   No items of urgent business were raised.

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DATE AND TIME OF NEXT MEETING

60   It was noted that the next Local Covid Outbreak Engagement Board meeting would be held on Tuesday 27 October 2020 at 1400 hours as an online meeting.

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The meeting ended at 1554 hours.

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CHAIRMAN

Birmingham Health and Wellbeing Board

Draft Forward Work Programme

April 2020-21

Board Members:

Councillor Paulette Hamilton (Board Chair)	Cabinet member for Adult Social Care and Health	Birmingham City Council
Dr Peter Ingham (Vice Chair)	Clinical Chair	NHS Birmingham and Solihull CCG
Councillor Kate Booth	Cabinet Member for Children's Wellbeing	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
Professor Graeme Betts	Corporate Director for Adult Social Care and Health Directorate	Birmingham City Council
Dr Tim O'Neil (Nichola Jones as substitute)	Director of Education and Skills (Assistant Director, Inclusion and SEND, Education and Skills)	Birmingham City Council
Paul Jennings	Chief Executive	NHS Birmingham and Solihull Clinical Commissioning Group
Ian Sykes	Chair, Sandwell and West Birmingham CCG.	Sandwell and West Birmingham CCG.
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Children's Trust
Dr Robin Miller	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham Education Sector

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Chief Superintendent Stephen Graham	Chief Superintendent	West Midlands Police
Gaynor Smith	Senior and Employer Partnership Leader	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust.	Birmingham Social Housing Partnership
Richard Kirby	Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Mark Garrick		University Hospitals Birmingham NHS Foundation Trust
Co – optees		
Carly Jones	Chief Executive of SIFA FIRESIDE.	SIFA FIRESIDE
Waheed Saleem	Executive Director Strategic Partnership.	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

Board Support:

Committee Board Manager
Landline: 0121 675 0955
Email: errol.wilson@birmingham.gov.uk

Business Support Manager for Governance & Compliance
Landline:0121 303 4843
Mobile : 07912793832
Email : Tony.G.Lloyd@birmingham.gov.uk

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Schedule of work April 2020-21

Formal Meeting		Presentation Items	
17th March 2020 ==CANCELLED== ==Replaced with 23 April – BAME Covid update meeting== Venue : Rooms 3 & 4, Council House – 3pm -5pm Peter Ingham to Chair	Draft Report Deadline for Pre- agenda : 19th February 2020 Pre – agenda meeting : 24th February 2020 Final Report Deadline: 5th March 2020 Agenda and Reports Dispatch Date: 6th March 2020	Better Care Fund 2019/20 Plan	Mike Walsh
		Creating a Mentally Healthy City Forum Update	Elizabeth Griffiths
		JSNA Core Data Set – Children and Young People Chapter	Ralph Smith
		Pre-Conception Conversation	Marion Gibbon
		Birmingham Forward Steps / Early Years Contract	Richard Kirby
		Families in Temporary Accommodation	Saba Rai
		East Birmingham Corridor Consultation	Mark Gamble
		Triple Zero	Chris Baggott
		Coronavirus Update	Justin Varney
		Information Items	
		Health and Wellbeing Board Fora updates	
		Sustainability and Transformation Plan Update	
		Delayed Transfers of Care workshop Feedback	
		Private Items	
		Director of Public Health Annual Report	Justin Varney
		JSNA Core Data Set – Working Age Adults Chapter	Ralph Smith

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Development Day			
28th April 2020 Venue: TBC <mark>CANCELLED due to covid response</mark>	Draft Report Deadline for Pre- agenda : 1th April 2020 Pre – agenda meeting : 6th April 2020 Final Report Deadline: 16th March 2020 Agenda and Reports Dispatch Date: 17th March 2020	TBC	TBC

Formal Meeting		Presentation Items	
July 2020	Draft Report Deadline for Pre- agenda: 1st July 2020	Appointment and Terms of Reference	TBC
		Social Prescribing	Pip Mayo
	Pre – agenda meeting: 8th July 2020	Birmingham Community Safety Partnership Consultation	Amelia Murray
	Final Report Deadline: 14th July 2020	Creating an Active City Forum Update	Kyle Stott
		JSNA Core Data Set – Working Age Adults Chapter	Ralph Smith
	Agenda and Reports Dispatch Date: 15th July 2020	JSNA Core Data Set – Needs of Older People Chapter	Ralph Smith
		JSNA Core Data Set – Wider Determinants Chapter	Ralph Smith
		JSNA Deep Dives – H&WB of Armed Forces Veterans in Birmingham(TBC)	Susan Lowe
		JSNA Deep Dives – Death and Dying in Birmingham (TBC)	Susan Lowe
		JSNA Deep Dive – H&WB of Public Sector Workforce in Birmingham (TBC)	Susan Lowe
		JSNA Deep Dive – Diversity and Inclusion (TBC)	Susan Lowe
		Information Items	
		Health and Wellbeing Board Fora updates	TBC
		Sustainability and Transformation Plan Update	Paul Jennings
		Healthwatch Birmingham Annual Report	Andy Cave

Formal Meeting		Presentation Items	
September 2020	Draft Report Deadline for Pre- agenda: 26th August 2020	Chairs update	
		COVID position statement	Justin Varney
		LOCEB – written update	Elizabeth Griffiths
	Pre – agenda meeting: 2nd September 2020	Flu Plan update 30 mins – Bsol	Rachel O'Connor (BSol CCG)
		Screening, Imms	PHE/NHS England
	Final Report Deadline: 11th September 2020	Commissioned services	BCC
		Information Items	
	Agenda and Reports Dispatch Date: 12th September 2020	BCF	Michael Walsh
		Health and Wellbeing Board Fora updates	Stacey Gunther

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Formal Meeting		Presentation Items	
November 2020	Draft Report Deadline for Pre- agenda: 28th October 2020	Chairs Update	
		Childhood immunisations and vaccinations	Ash Banerjee/Andrew Dalton PHE
	Pre – agenda meeting: 4th November 2020	Impact of Covid on vulnerable adults	John Williams BCC ASC
	Final Report Deadline: 13th November 2020	Children's Social Care	Andy Couldrick Birmingham Children's Trust
	Agenda and Reports Dispatch Date: 16th November 2020	**Information Items** HWB Forward Plan	Stacey Gunther
		Local COVID Outbreak Engagement Board	Elizabeth Griffiths
		Health and Wellbeing Board Fora updates	Stacey Gunther
		Sustainability and Transformation Plan Update	Paul Jennings

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Formal Meeting		Presentation Items	
January 2021	Draft Report Deadline for Pre- agenda: 23rd December 2020	Chairs Update	
		BLACHIR	Justin
	Pre – agenda meeting: 4th January 2020	-Birmingham Food strategy/food conversation -Food poverty -International Partnerships update Childhood obesity trail blazer data/update -Sustainable food partnerships	Paul Campbell
	Final Report Deadline: 8th January 2021		
	Agenda and Reports Dispatch Date: 11th January 2021	JSNA Adult Chapter	Ralph Smith
		Public Health Annual Report	Justin Varney
		Developer Toolkit	Kyle Stott
		Information Items	
		HWB forward plan	Stacey Gunther
		Local COVID Outbreak Engagement board	Elizabeth Griffiths
		Health and Wellbeing Board Fora updates	Stacey Gunther

Formal Meeting		Presentation Items	
March 2021		Social Prescribing	Rachel O'Conner BSol/Pip Mayo West Birmingham
		Birmingham Integrated Care Partnership	Graeme Betts, Director, Adult Social Care
		Creating a Mentally Healthy City Forum Update Suicide prevention strategy Waiting Room Cultural update Employee wellness	Mo Phillips
		JSNA Older Adults	Ralph Smith
		Public Health Annual Report	Justin Varney
		Information Items	
		HWB forward plan	Stacey Gunther
		Local COVID Outbreak Engagement board	Elizabeth Griffiths
		Health and Wellbeing Board Fora updates	Stacey Gunther
Development Day			
April 2021		Health and Wellbeing Board Priorities – Review and Refresh	TBC
Formal Meeting		**Presentation Items**	
July 2021			
Formal Meeting		**Presentation Items**	
September 2021			
Formal Meeting		**Presentation Items**	
November 2021			

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Formal Meeting January 2022		Presentation Items	
Formal Meeting March 2022		Presentation Items	
Development Day April 2022		Health and Wellbeing Board Priorities – Review and Refresh	

Standard Agenda

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

Notes

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

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

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

Any decisions and actions shall be subject to providing an update to the Board on the substantive outcomes, either via presentation or information item as deemed appropriate by the Board, at a future date to be agreed as part of said decision or action.

Supporting Documents Requiring Development

Agenda change request form

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Report draft template
Report final template
Action / Decision request form
Action / Decision update report template

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Birmingham
Health and Wellbeing
Board

	Agenda Item: 20
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19 January 2021**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham City Council**
Presenting Officer	**Stacey Gunther, Service Lead, Public Health**

Report Type:	Information

1. Purpose:	

1.1   This update report details recent, current and future work related to:

- Creating a Healthy Food City
- Creating a Physically Active City Forum
- Creating a Mentally Healthy City Forum
- Creating a City Without Inequalities Forum
- Health Protection Forum Update

1.2   Sub forum meetings, excluding the Health Protection Forum, were initially paused as the Public Health Division diverted resource to support Covid-19 response. Forums are currently working online with partners or holding meetings online via Teams to move Covid-19 related items forward. It is anticipated that forums meetings will restart in early 2021.

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

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3.	Recommendation

3.1   It is recommended that the board note the contents of the report.

4.	Report Body

Background

4.1   The Birmingham Health and Wellbeing Board has five thematic forums. The forums oversee the development and delivery of shared action to drive city-wide improvement. The forums are: Creating a Mentally Healthy City, Creating a Healthy Food City, Creating an Active City, Creating a City Without Inequality, and the Health Protection Forum.

4.2   At each Birmingham Health and Wellbeing Board meeting, a presentation will be given from 1 of the thematic forums for discussion. The other forums will provide written update reports. The themes will be present on a rota basis, with each theme presenting at least annually.

4.3   This report is formed of 4 written updates. Further detail specific to each Forum can be found in **Appendices 1-4.**

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**

5.1.1   Regular updates will be reported to the Health and Wellbeing Board via a joint update report in this format, with each forum providing a presentation item rather than an information item update at least annually.

5.1.2   Action logs of the forums shall be recorded and reviewed at every forum to ensure actions are delivered.

5.2	**Management Responsibility**

Stacey Gunther, Service Lead, Public Health
Mo Phillips, Service Lead, Public Health
Kyle Stott, Service Lead, Public Health
Frances Mason, Service Lead, Public Health
Chris Baggott, Service Lead, Public Health
Elizabeth Griffiths, Acting Assistant Director, Public Health
Dr Justin Varney, Director of Public Health

6.	Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**	
Partners not delivering on the assigned actions required to enable the forums work.	Medium	Medium	Robust monitoring and regular update reports via the relevant forum	

Appendices
Appendix 1 - Creating a Physically Active City Forum Appendix 2 - Creating a Mentally Healthy City Forum Appendix 3 – Creating a City Without Inequalities Forum Appendix 4 – Health Protection Forum

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

Stacey Gunther, Service Lead, Public Health
Mo Phillips, Service Lead, Public Health
Chris Baggot, Service Lead, Public Health
Kyle Stott, Service Lead, Public Health
Frances Mason, Service Lead, Public Health
Elizabeth Griffiths, Assistant Director, Public Health

Birmingham
Health and Wellbeing
Board

Appendix 1 – Creating a Physically Active City Forum Highlight Report

1.1 Context

The forum met virtually on 16th December 2020, the fourth meeting since business as usual activity had paused following the COVID-19 emergency response. The forum specifically requested an agenda to cover the following items:

- An update on Active Travel work in the city
- An update from WMCA/Sport Birmingham with reference to CWG
- A presentation of the Healthy City Planning Toolkit (for endorsement)

1.2 Current Circumstance

The December meeting of the Forum was chaired by Cllr Waseem Zaffar, Cabinet Member for Transport and the Environment. It was attended by 17 participants. The meeting acknowledged the continued focus on the impact of COVID-19, and once again discussed the impact on participation, impact on programme delivery, the Emergency Transport Plan and the Emergency Travel Fund. The agenda covered the following:

Updates

- An update on the progress of the Emergency Active Travel Fund (EATF) tranche 2 funding bid was given, this included confirmation that Birmingham has been successful in being awarded funding from tranche 2 of the Department for Transport Active Travel fund. This includes circa £55k for a walking and cycling social prescribing model to be piloted in the city, and approximately another 1,000 free bikes for the city. The bid was worked up by BCC Travel Demand Management and Public Health in conjunction with WMCA.
- An update on the Bloomberg/Partnership for Healthy Cities project was given, highlighting progress against the milestones of the work plan. This included the completion of the Seldom Heard Voices surveys, future insight work, and the commissioning conclusions to appoint a marketing and communications provider to develop the campaigns and social media messages that will underpin the project; a preferred provider has now been identified and a contract is being drawn up for them to start work in January 2021
- The Healthy City Planning toolkit was presented by Public Health, this was to seek endorsement of the toolkit and to support next steps to it being embedded into Local Authority planning policy and/or guidance. Support and endorsement was unanimous; it was also communicated that CLT provided similar endorsement and support on the 30th November.

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1.3 Next Steps and Delivery

- Consider the guidance on next steps for ensuring that the toolkit is embedded into Local Authority planning policy and/or guidance.

- Consider the opportunities put forward by WMCA and Sport Birmingham to embed the toolkit into CWG legacy work and WMCA wider determinants work.

- Work with providers to produce delivery plans to enable the next tranche of EATF funding projects to start.

- Consider an agenda that focuses on resilience and recovery for the next meeting in February.

Appendix 2 – Creating a Mentally Healthy City Forum Highlight Report

1.1   Context
The Forum 'Creating a Mentally Healthy City' (CMHC) aims to build strong working relationships with strategic partners, stakeholders, Third and Voluntary sector organisations, Academics, Faith Groups and local communities. Our purpose is to improve mental wellbeing, including access to mental health services, for the most vulnerable and disadvantaged groups and to address inequalities in our communities through the programmes mentioned in the Joint Strategic Needs Assessment (JSNA), the call to action in the Prevention Concordat, and the Suicide Prevention Strategy, and to work jointly with other HWBB Forums.

1.2   Current Circumstance
The Creating a Mentally Healthy City Forum was suspended for a second time in August 2020. The final Forum meeting took place in June 2020 when we had a record number of participants due to the interest from local citizens and requests to get involved in mental wellbeing issues during the pandemic. The decision to step down was made to enable the Wellbeing Cell to focus on getting vital information such as guidances on keeping safe and well, videos to help maintain mental wellbeing, as well as 16 webinars from the Public Health BHealthy series delivered by sector experts focusing on long-term conditions including mental health and wellbeing. These webinars were aimed at community and frontline workers who were tasked to take the messages to their local communities. They aimed to prepare Birmingham residents for the coming months, manage mental wellbeing and stem the spread of COVID-19. These webinars were widely publicised on various social media platforms, via emails, and on the Creating a Mentally Health City LinkedIn page.

1.3   Next Steps and Delivery

- Stepping up the Creating a Mentally Healthy City Forum to resume in February 2021 with bi-monthly meetings.

- The Prevention Concordat has been relaunched by Public Health England. We have amended to include our work in tackling inequalities through the life course. Our objective is to work more closely with our Forum members who are experienced in working with people in our local communities and build on relationships that were forged during the lockdown.

- As a result of the service mapping carried out during the first lockdown, we identified there was a gap of available mental wellbeing services for young people 16-25. We have been granted funding to address this and will be working to provide peer-to-peer mentoring with mental health first aid to young people with disabilities, LGBT, BAME, schools, and universities. This is currently a work in progress and will be reported on as the project develops.

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- We will be creating a 'Directory of Services' available to local people and will work with Forum members to publish on various social media platforms and members' websites so information on where to get help for mental wellbeing is easily assessible to all. The list will be organic; members will be encouraged to let us know of any new services that they are aware of via this document so they can be added to the list.

- We will continue to use the Creating a Mentally Health City LinkedIn platform to disseminate information on mental wellbeing and also further encourage our Forum and LinkedIn Group members to use this medium to publicise services that are available to Birmingham people.

- Stepping up the Suicide Prevention Advisory Group to resume early in the New Year with bi-monthly meetings.

- Aarti Kumari has been appointed to the role of Suicide Prevention Coordinator and officially took up post on 7th December. Aarti will be working two days a week for Solihull MBC and three days a week for Birmingham City Council and has already started looking at the Birmingham Suicide Prevention Strategy and Action Plan in readiness for a post-Covid-19 refresh.

- Elaine Woodward, Regional Suicide Prevention Coordinator, is currently sharing research on the economic impact of Covid-19 and Brexit with Suicide Prevention leads across the region which will require prevention strategies focused on multiple domains. Work is underway with Local Authority colleagues on the Real Time Surveillance System and learning from best practice in Coventry & Warwickshire. In early 2021 West Midlands Combined Authority and the Zero Suicide Alliance will launch suicide prevention training and awareness which has been based on the THRIVE model. Funding for Elaine's post has come from the Association of Directors of Public Health for the remainder of this financial year 2020/21.

Appendix 3 – Creating a City without Inequality Forum Highlight Report

1.1   Context

The Public Health Division are refocusing capacity to support the health protection response to Covid-19. As such, on the 21st September the decision was taken to postpone future meetings of the forum until the new year. Communication with the forum has continued in the interim via the LinkedIn group, with several projects continuing virtually.

1.2   Current Circumstance

Positions within the Inequalities team have recently been filled.

Whilst resources have been diverted to support the health protection response, the team are continuing to maintain momentum of the forum by communicating with members using the dedicated LinkedIn page, where relevant updates are posted. Recent updates include:

- Equalities team live event
- Birmingham consultation on tackling inequalities
- Connecting families project

1.3   Next Steps and Delivery

- Forum Terms of Reference to be revisited in line with 2021 business plans. Forum to be re-established 2021.
- The inequalities team are working to set objectives and will develop a proposal for the focus on the forum for its restart in 2021.
- The complete Health and Wellbeing Impact analysis including the qualitative data analysis will be shared with Creating a City Without Inequality (CCWIF) members. This will bring context to the quantitative data and further inform wider work
- The Locality Director (West Birmingham) & Head of Partnership for BSol CCG will share the STPs response to implementing phase 3 of the NHS response to the COVID-19 pandemic with Forum
- Progress actions resulting from sharing of the life course document and continuation of mapping the challenges, gaps, best practice, assets and opportunities for more effective action.

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**Birmingham
Health and Wellbeing
Board**

Appendix 4 – Health Protection Forum Highlight Report

1.1 **Context**

Due to the covid outbreak the Health Protection Forum (HPF) have been meeting every 2 weeks since the 30ᵗʰ June 2020. Approximately 80% of each meeting is devoted to discussing the current coronavirus situation and response, with the remainder covering other health protection concerns.

1.2 **Current Circumstance**

The HPF coronavirus discussions include:
1. The coronavirus outbreak plan
2. Testing – drop and collect programme
3. Mobile testing logistics
4. Outbreak summaries and learning
5. Testing results – trends, patterns, rates of change
6. Development of plans in response to 1-5 above
7. Infection prevention and control plans and issues
8. Vaccination plans and updates
9. Review of activity from the working groups
    a. Residential and clinical settings (including care homes, hospitals, primary care, children's' residential settings)
    b. Education settings
    c. Other settings (including homeless settings, workplaces etc)
Non-coronavirus discussions include:
1. Challenging health protection cases
    a. TB and blood-borne viruses
2. Vaccination and screening programme plans and delivery (including flu, MMR and other childhood vaccinations)
    a. CCGs/STPs have produced detailed local delivery plans with all local providers (incl. GPs); plans address limitations due to coronavirus, higher uptake targets, additional target cohorts and expected higher demand for vaccination of particular vaccines.

1.3 **Next Steps and Delivery**

- The short- and medium-term focus is on the delivery of the NHS seasonal flu programme that is commissioned by NHSE&I and delivered by GPs, pharmacies, hospitals and vaccination service providers. Planning is led by BSol STP (and includes the West Birmingham area) and uptake activity will be reported into the HPF

- Planning for the delivery of the SARS-CoV2 (known as covid) vaccination programme is ongoing and will report into the HPF. This is being led by the NHS.

- The Forum will also be seeking assurance on plans for catch-up child vaccination programmes that have been impacted by the pandemic.

- Monitoring of covid case/contact data, outbreaks, intelligence will continue and be used to inform the response.

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