BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 31 JANUARY 2023 AT 10:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA
SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1   **NOTICE OF RECORDING/WEBCAST**

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

2   **DECLARATIONS OF INTERESTS**

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

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

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

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

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

3 **APOLOGIES**

To receive any apologies.

4 **DATE AND TIME OF NEXT MEETING**

To note the date of the next meeting of the Board commencing at 1000 hours Tuesday, 28 March 2023.

5 **MINUTES - 29 NOVEMBER, 2022**

To confirm and sign the minutes of the last meeting on 29 November, 2022.

6 **ACTION LOG**

(1010-1015) - To review the actions arising from previous meetings.

7 **CHAIR'S UPDATE**

To receive an oral update.

8 **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.

The deadline for receipt of public questions is 3:00pm on 24th January 2023.

Questions should be sent to: HealthyBrum@Birmingham.gov.uk.

(No person may (submit more than one question)

Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's You Tube site: www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw

NB: The questions and answers will not be reproduced in the minutes.

9 **COST OF LIVING CRISIS - VERBAL UPDATE ON BIRMINGHAM CITY COUNCIL'S RESPONSE**

(1025-1030) - *Greg Ward (Levelling Up Programme Lead, Birmingham City Council) will present this item*

10 **COST OF LIVING CRISIS - VCSFE INSIGHTS REPORT**

(1030-1050) - Stephen Raybould (Programmes Director, Birmingham Voluntary Services Council (BVSC)) will present this item.

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

BIRMINGHAM CITY COUNCIL

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BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING TUESDAY, 29 NOVEMBER, 2022

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MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 29 NOVEMBER, 2022 AT 1000 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, BIRMINGHAM, B1 1BB

PRESENT: -

Councillor Mariam Khan, Cabinet Member for Health and Social Care and Chair for the Birmingham Health and Wellbeing Board in the Chair

Natalie Allen Chief Executive SIFA FIRESIDE
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Andy Cave, Chief Executive Officer, Healthwatch Birmingham
Andy Couldrick – Children's Trust
Dr Anne Coufopoulous. University College, Birmingham
Councillor Karen McCarthy, Cabinet Member for Children Young People and Families
David Melbourne, NHS Birmingham and Solihull CCG
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Peter Richmond, Birmingham Social Housing Partnership
Jo Tonkin, Assistant Director (KEG), BCC
Dr Justin Varney, Director of Public Health

ALSO PRESENT:-

Aidan Hall, Service Lead, Programme Senior Officer
Louisa Nisbett, Committee Services
Helen Price (in place of Sue Harrison)
Sarah Pullen, Street Food Systems
Monika Rozanski, Service Lead Health Equalities
Ceri Saunders, Cabinet Support Officer
Marina Soltan, NHS
Greg Ward, Levelling up Programme

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NOTICE OF RECORDING/WEBCAST

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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

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Information on the Local Government Association's Model Councillor Code of Conduct is set out via http://bit.ly/3WtGQnN

This includes, at Appendix 1, an interests flowchart which provides a simple guide to declaring interests at meetings.

There were no declarations made.

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APOLOGIES

Apologies for absence were submitted on behalf of
Richard Beeken – Sandwell & West Birmingham Hospitals
Professor Graeme Betts, Director of Adult Social Care
Suzanne Cleary, BC Healthcare, NHS Foundation Trust
Dr Clara Day (Vice-Chair) Chief Medical Officer, NHS Birmingham & Solihull ICB
Mark Garrick, Director of Strategy and Quality Development, UHB
Sue Harrison, Director for Children and Families, BCC
Riaz Khan, Dept. Work and Pensions
Dr Robin Miller UCB
Patrick Nyarumbu, Birmingham & Slihull Mental Health Trust

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DATES OF MEETINGS

677   The Board noted the following meeting dates for the remainder of the Municipal Year 2022/23:-

Tuesday 31 January 2023
Tuesday 28 March 2023

All meetings will commence at 1000 hours unless stated otherwise.

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MINUTES AND MATTERS ARISING

678 The Minutes of the meeting held on 27 September, 2022, having been previously circulated, were confirmed and signed by the Chair.

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ACTION LOG

679 Aiden Hall, Programme Senior Officer (Governance) advised that there were no outstanding actions on the Action Log.

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CHAIR'S UPDATE

680 Councillor Mariam Khan, Cabinet Member for Health and Social Care welcomed Aiden Hall, Programme Senior Officer (Governance) who had replaced Dr Shiraz Sheriff, Service Lead – Governance, Public Health Division to support the Board. She placed on record thanks to Dr Shiraz Sheriff for his work.

- The Chair advised that she had sent a letter as Chair of the Creating a Healthy Food City Forum., which had also been signed off by the Leader of the Council to the Government regarding the Cost of Living Crisis calling for urgent national action. She undertook to circulate the letter to Committee Members. The 6 main themes were:-

1. Appoint an independent commissioner for food security and a cross party and inter-agency taskforce to advise national and local government on rapid action to address the growing food security crisis.
2. Extend Free School Meals to all children whose families are in receipt of Universal Credit
3. Increase the value of Healthy Start Vouchers in line with inflation and extend eligibility.
4. Require the Department of Work and Pensions to issue pre-sanction warnings and instigate direct verbal contact before benefits sanctions are enacted.
5. Promote healthy and nutritious food by committing to keep all anti-obesity measures.
6. Introduce income support measures for those on benefits and strengthen the welfare system longer term.

Maintaining local government funding in line with inflation and ensuring the ring-fenced public health grant remains protected.

- The Chair announced that as it was her birthday there was some doughnuts and a healthy option available. .

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PUBLIC QUESTIONS

681 The Chair advised that there were no public questions for this meeting.   The Board welcomed questions, any questions should be sent to HealthyBrum@Birmingham.gov.uk.

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COST OF LIVING CRISIS- MEASURES & RESPONSES UNDERTAKEN BY BIRMINGHAM CITY COUNCIL 010836/2022

Greg Ward, Levelling Up Programme Lead- Birmingham City Council gave an online presentation on the cost of living emergency using some slides. During the discussion that ensued Councillor Karen McCarthy spoke about the good work being carried out including the contribution from health colleagues and the sharing of ideas and experiences and with the right interventions to support families. Greg Ward welcomed any advice and a follow up discussion with Dr Anne Coufopoulous. University College, Birmingham.

The Chair referred to the Leader declaring a cost of living emergency and the hard work on a response. She mentioned that there were different types of warm spaces. In reply to her request for an update on support for foodbanks, Justin Varney reported that they were waiting on the proposal for additional funding for foodbanks to be approved. Sarah Pullen advised that her team was leading on food provision to support a lot of people in the City. They were finalising an application form to enable 100 foodbanks to receive £800 per month for a period.

Greg Ward said there were smaller grants to purchase things such as microwaves, kettles etc. to make spaces as accessible as possible. There was a more detailed application for larger spaces for furniture etc. The Chair thanked everyone for their joint up work.

682   **RESOLVED**

That the presentation be noted and a copy of the application form be sent to Members.

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COST OF LIVING CRISIS- BIRMINGHAM SOCIAL HOUSING PARTNERSHIP

The following document was submitted:-

(See document no. 1)

Peter Richmond, Chief Executive- Birmingham Village Trust presented the item and responded to questions.

David Melbourne noted that Birmingham had not been asked to be involved in the pilot which included Gloucestershire and 2 other areas. He understood that the NHS had put some resources aside for some small grants over the winter and undertook to follow this up outside of the meeting.

683   **RESOLVED**:-

That the report be noted.

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HWB STRATEGY DELIVERY PLAN AND INDICATOR DASHBOARD

The following report was submitted:-

(See document no. 2)

Jo Tonkin AD (KEG) gave an update to the Health and Wellbeing Board (HWB) on the Joint Health and Wellbeing Strategy (JHWS) and the approach to delivering its 2030 ambitions. A dashboard had been created to bring together all of the indicators. An annual review will be submitted to the Board. Members were urged to explore the dashboard and giv   e feedback.

684 **RESOLVED**:-

i)   That the update on the strategy and indicator dashboard be noted; and

ii)   That the approach to support the delivery of the strategy be agreed.

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CREATING A HEALTHY FOOD CITY FORUM- ANNUAL UPDATE

The following document was submitted:-

(See document no. 3)

Sarah Pullen, Service Lead, Food Systems gave a summary of the report and an update on delivery to date, and current and planned activity on selected workstreams within the context of the Creating a Healthy Food City Forum and wider food portfolio of work. During the discussion she requested feedback from the Board with regard to the resources needed and made reference to the Commonwealth Games website where there was a link to a lot of Community events across the City. The Creative dinner event attended by students was highlighted.

685 **RESOLVED**:-

That the Board note the past and ongoing work by the Creating a Healthy Food City Forum.

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CREATING A CITY WITHOUT INEQUALITIES FORUM- ToR's APPROVAL

The following report was submitted::-

(See document no. 4)

Monika Rozanski, Service Lead, Health Inequalities presented the Terms of reference (TOR) for the CCWIF and newly formed BLACHIR implementation Board.

686   <u>**RESOLVED**</u>:-

     i)   That the Committee approve the terms of reference for Creating a City Without Inequalities Forum; and

     ii)   That the Committee approve the terms of reference for the BLACHIR implementation Board.

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Information Items

<u>**FORWARD PLAN**</u>

687   Aidan Hall presented the Forward Plan which was noted.

   (See document no. 5)

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<u>**WRITTEN UPDATES**</u>

The following written updates were on the Agenda for information only.

 (See document nos. 6 to 8)

<u>**Joint Strategic Meeds Assesment (JSNA)**</u>

<u>**Creating a Physically Active City Forum (CPACF) Report**</u>

<u>**Health Protection Forum (HPF) Report**</u>

688   <u>**RESOLVED**</u>:-

That the written updates be noted.
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<u>**OTHER URGENT BUSINESS**</u>

689   The Chairman agreed that the following item could be considered as a matter of urgent business.

<u>**Service Pressure**</u>

David Melbourne reported as follows::-

-   GP and ambulance turnaround times had improved in all areas but was not where they wanted them to be. Industrial action was planned for December. They would work to ensure that it had minimum impact.

-   Free breakfast – They hoped to use some money from the NHS towards a prevention strategy.

-   They had continued to deliver planned services during the winter.

- Staffing vacancy rates – Only a 3rd of staff had taken the booster vaccine. Primary Care needed help and support. A third of calls to GP's were not from people needing a GP. It needed to be ensured that people could navigate the system.

- Justin Varney said that people could reduce the pressure by practicing self care and healthy eating. Pressure on the NHS through accidents was huge.

- People were going to PALS because they were not getting information from GPs. David Melbourne was working with Secondary Care Colleagues on how to decompress the system. Justin Varney spoke about the importance of understanding the cultural shift which was a long journey.

- Councillor Matt Bennett commented that Vaccine, MRI jabs etc were not on the forward plan and this was noted.

- The work of the HWB was commended. GP patients were more likely to present to the NHS. It was suggested that the warm spaces be used to give injections to people and that there should be a move towards generalist skills. Patients needed to be educated about healthcare.

The meeting ended at 1140 hours

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CHAIR

BIRMINGHAM HEALTH & WELLBEING BOARD

Action Log 2021

Rag rating :

	Overdue
	In progress
	Complete

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

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

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

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

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

	24/09/2019	SUICIDE 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.	

BIRMINGHAM HEALTH AND WELLBEING BOARD

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**31st January 2023**
TITLE:	**COST LIVING INSIGHTS REPORT**
Organisation	**BVSC**
Presenting Officer	**Stephen Raybould**

Report Type:	**Report Presented for Information**

1. Purpose:

1.1. Update Health and Wellbeing Board on VCFSE activity in relation to the cost-of-living crisis.

2. Implications (tick all that apply):

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

3. Recommendation

3.1. To note the recommendations of the attached report.

3.2. To support the development of a holistic, sustainable VCSFE.

3.3. To work with VCSFE to give Birmingham more of a presence at national level.

A BOLDER HEALTHIER BIRMINGHAM

4. Report Body

Background

On the 5th September 2022, the Leader of Birmingham City Council announced a city-wide emergency regarding the cost of living (COL) crisis. This means that there is now a city-wide strategic group who have been brought together to address the crisis. BVSC is part of this group, representing the VCFSE sector, and supporting discussions about how our sector can contribute to wider strategies, and what we need from our partners across the private and public sector, to respond effectively to this crisis.

Birmingham is a city that's particularly at risk to the COL crisis. Our city is on average poorer than the rest of the UK, we have higher level of unemployment and a notably poorer quality housing stock. We know that poorer households, living in unstable housing are likely to be most affected by the crisis.

We also know that whilst the COL crisis is happening right now, for many communities the current crisis has simply compounded existing inequalities, there remains an urgent need for a long-term focus. Many of our communities were struggling *before* Covid and the COL crisis, so as a city, we need to consider what can be done to bring those communities out of poverty, permanently.

5. Compliance Issues

5.1. HWBB Forum Responsibility and Board Update

5.2. Management Responsibility

Actions put forward in the report will be taken forward by BVSC

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
VCFSE capacity reduces as crisis progresses	Medium	High	Improved Commissioning approach
Focus on short term impact of crisis without addressing	Medium	High	Cost of living strategic response groups.

A BOLDER HEALTHIER BIRMINGHAM

underlying causes of poverty			
Services overwhelmed by demand	High	High	Capacity building activity across VCFSE.

Appendices
Appendix 1 - Cost of Living Crisis – VCSFE Insights report

2023 State of the Sector
Insight Report #1
Cost Of Living

CONTENTS

INTRODUCTION

In our 2021 State of the Sector survey - click here to read - partners from across the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector told us that when looking to the future, one of their biggest concerns was the rising cost of living (COL). We know that since this report was published the COL crisis has significantly deepened, with rising inflation, energy and food costs impacting communities across the UK.

In order to gain a fuller understanding of the issues facing the sector and the communities we serve, BVSC and the Barrow Cadbury Trust held a Cost of Living event on 1st November 2022. The event was attended by over 140 people.

This Insight Report (the first of five such reports based on issues raised in the 2021 State of the Sector) provides a summary of the key themes that emerged from the 12 workshops delivered throughout the day.

To view the agenda from the day, the speaker presentations and biographies, and to access a variety of toolkits, please visit https://www.bvsc.org/cost-of-living.

Our sincere thanks to Barrow Cadbury Trust who funded the event and to all who participated.

CONTEXT

On the 5th September 2022, the Leader of Birmingham City Council announced a city-wide emergency regarding the COL crisis. This means that there is now a city-wide strategic group who have been brought together to address the crisis. BVSC is part of this group, representing the VCFSE sector, supporting discussions about how our sector can contribute to wider strategies and exploring what we, as a sector, need from our partners across the private and public sector to respond effectively to this crisis.

Birmingham is a city that is particularly at risk to the COL crisis. Our city is on average poorer than the rest of the UK, we have a higher level of unemployment and a notably poorer quality housing stock. We know that poorer households, living in unstable housing are likely to be most affected by the crisis.

We also know that whilst the COL crisis is happening right now, for many communities the current crisis has simply compounded existing inequalities. There remains an urgent need for a long-term focus that addresses these inequalities. Many of our communities were struggling before Covid and the COL crisis, so as a city, we need to consider what can be done to bring those communities out of poverty, permanently.

Although the COL crisis has impacted communities across Birmingham, it is important to highlight the invaluable work already being done by the VCFSE sector. Organisations within the sector have already played a major role in supporting Birmingham's many communities and will continue doing so. The staff and volunteers working within the sector were highlighted throughout the event as a true strength for the city.

> "
> **Whatever challenges we face, always remember why we're doing this, and the differences we're making to so many vulnerable people. We're helping transform society**
> "

HOUSEHOLDS HAVE SEEN A
45% INCREASE
IN PRIORITY DEBT
FROM SEPTEMBER 21
TO SEPTEMBER 22

BVSC | 2023 State of the Sector Insight Report #1

POVERTY RATES IN BIRMINGHAM ARE MUCH HIGHER THAN THE NATIONAL AVERAGE: ALMOST DOUBLE THE NATIONAL RATE FOR CHILDREN. THAT'S OVER 100,000 CHILDREN AND WELL OVER 300,000 PEOPLE.

1. ORGANISATIONS & COMMUNICATION

Clear communication and access to information is crucial. Ensuring Birmingham's citizens access all of the benefits they're entitled to, as well as general advice related to COL, is more important than ever. For example, it is thought that 15,000 children currently entitled to free school meals are not accessing them, and 30% of overall benefits are going unclaimed. Birmingham's citizens have a variety of requirements that must be considered, such as language barriers, varying levels of digital literacy and the potential stigma faced by claiming benefits and visiting food and warmth banks.

We therefore must consider new and innovative methods to engage with our citizens to ensure they have access to timely, accurate and useful information.

What we know:
- Although there is a great deal of useful intelligence and information held within the sector, it is not always easily accessible to staff and citizens. Certain organisations hold information on their specific area of expertise, but organisations must work together to share information if citizens are to be supported holistically.
- The benefit system is complex and eligibility criteria is confusing. Support staff attempt to navigate through the systems with clients but it's difficult even for those professionals.
- Employment advice is difficult to provide particularly when there seems little advantage for citizens to finding low paid employment and sacrificing the benefits they may be collecting. The security of benefits can be seen as safer than starting a new job. For example, social housing tenants spoke of feeling trapped within the benefits system, wanting a job but concerned about low wages and paying for housing.

Good practice we can build on:
- Some organisations have started to think and act differently about effectively engaging citizens. They are beginning to establish networks to link in via local, neighbourhood level community groups. For citizens who can't afford to travel to the city centre, we heard that some city-centre based organisations are beginning to provide outreach services by providing advice in local community spaces.
- Other organisations told us that they are linking in with community groups who are already established within the community, upskilling staff who already have relationships with local communities in their locality. This approach has been found to be a more effective manner of engaging people than attempting to engage with communities independently.
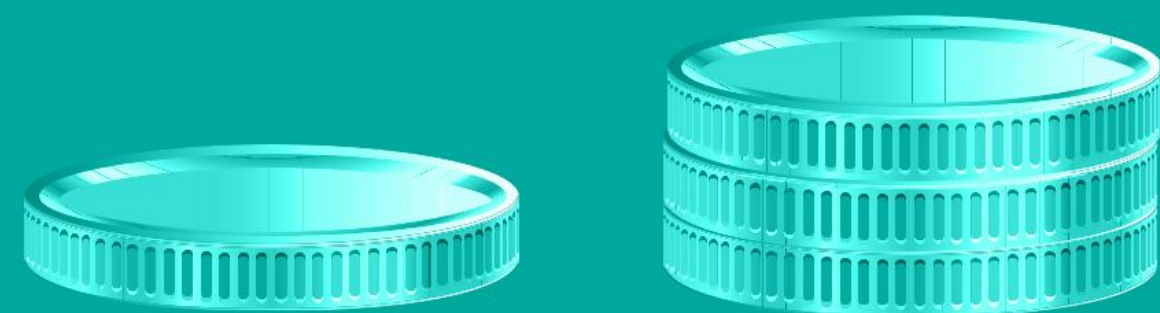
THE AVERAGE LOW-INCOME FAMILY WILL PAY AROUND THREE TIMES MORE FOR ENERGY IN 2023-24 COMPARED TO 2021-22.
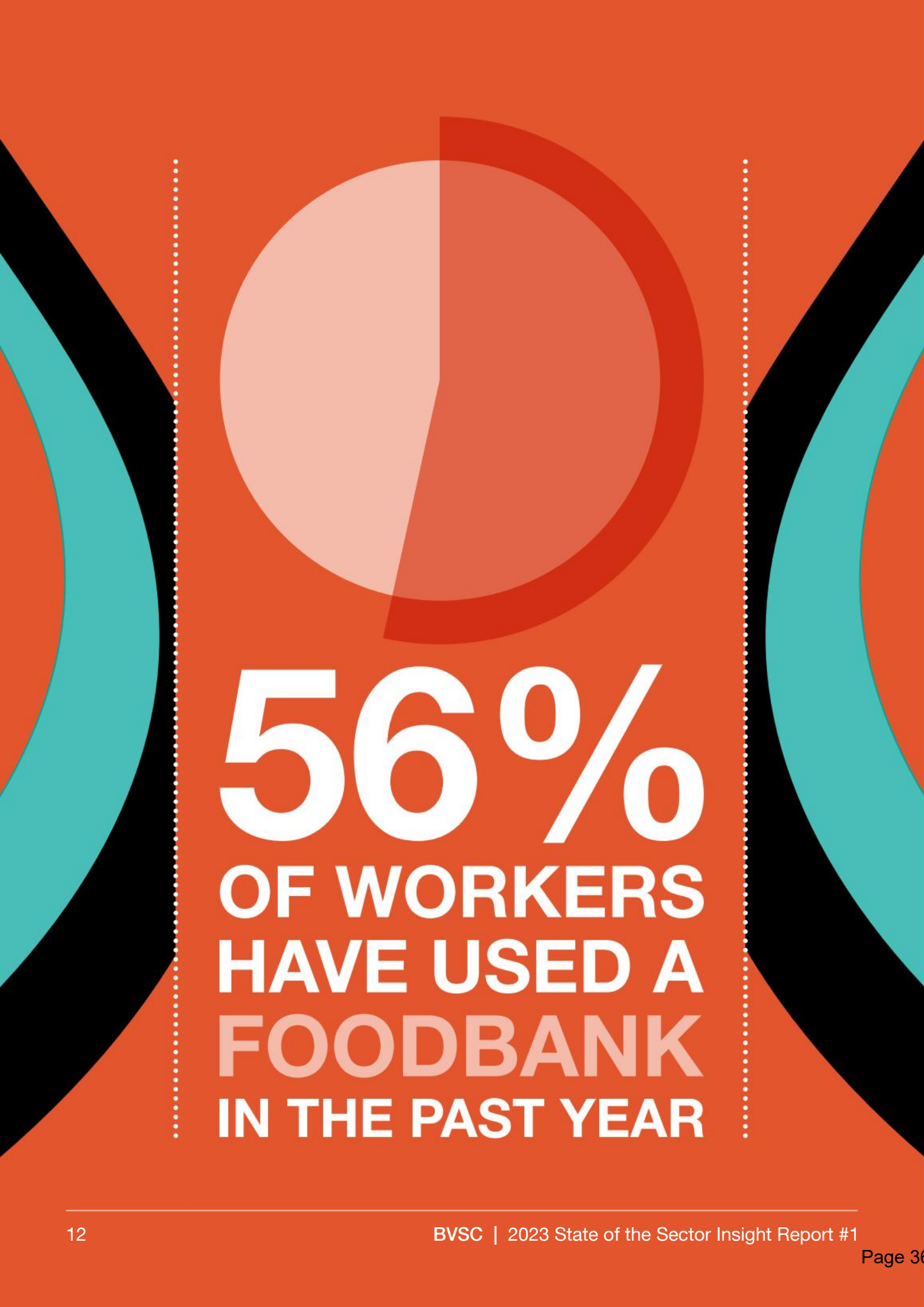
2. PREVENTION & INTERVENTIONS

It was generally agreed that focussing on the here and now is important given the scale of the current crisis. However, organisations stressed that we should not lose sight of the longer-term implications, emphasising how interventions aimed at 'prevention' will help in the sustainability of actions being taken today. The COL crisis is occurring at a time in Birmingham where other areas of support have been put under significant pressure due to an increase in complexity and intensity of support needs (many that were exacerbated during the pandemic). It was also identified that certain groups and communities are affected more severely by COL, and therefore broader, more holistic and longer-term solutions would need to be implemented to ensure these groups truly benefit from any action.

What we know:

- Organisations reported that the intensity of needs of their clients are increasing. It is not just about more people needing support, it is about individual clients presenting with more intensive and complicated needs.
- The support that is available is limited and sometimes staff felt that they may overwhelm organisations by referring lots of people to them.
- It was highlighted that desperation, poverty, hunger, profound anxiety, homelessness and the interrelation of several other aspects has the potential to lead to increased criminality in the city. This vulnerability was also seen to lead to a growing risk of people turning to loan sharks and illegal moneylenders.
- It was agreed that nobody in the city should be evicted from their home due to poverty. Birmingham needs to consider ways to keep people in their homes prior to crisis being reached. The difficulties within the social housing sector were also discussed. There was an agreement that rents need to be affordable, but maintenance and repairs also need to happen to keep the housing stock at an acceptable standard.
- Attendees also raised concern about the exempt housing sector (an area BVSC is reviewing within its Quality Standards work).
- The most deprived communities are being hit the hardest and those already below the poverty line will feel the increase in cost of living most acutely.
- People from Black, Asian and other ethnic minority communities are being, and will be, disproportionately affected by the COL crisis compared to white people due to a number of factors which place these groups in positions of greater financial difficulty.
- When food banks are in place, there is the need to consider diversity and diets (e.g., halal etc) so as not to exclude groups.

56%
OF WORKERS HAVE USED A FOODBANK IN THE PAST YEAR

Good practice we can build on:

- The wraparound, holistic, person-centred, asset-based support often offered by the VCFSE sector is seen as pivotal to providing support to individuals struggling with the COL. This will be especially important with those citizens presenting with more complex needs.
- Working in partnership with organisations and communities collaboratively is key. The voice of people who are experiencing poverty need to be heard, and this can be supported by

DATA SHOWS THE NUMBER OF HOUSEHOLDS WHO CAN'T TOP UP PREPAYMENT METERS EXCEEDS THE LAST THREE YEARS ADDED TOGETHER.

ITS ESTIMATED THAT 30% OF PEOPLE ENTITLED TO GOVERNMENT BENEFITS ARE NOT CLAIMING THEM.

3. STAFF WELLBEING & THE IMPORTANCE OF EMPLOYMENT & VOLUNTEERS

It is undeniable that the COL crisis has directly affected the VCFSE workforce, as well as those that they are trying to support. People spoke of the stress that staff are under due to increased capacity and the complexity of issues their clients face, as well as the difficulties organisations have experienced in recruiting and retaining both paid staff and volunteers.

Wellbeing:

- Organisations spoke about how, when complexity of client need increases, so does the pressure on staff dealing with those clients, impacting on mental health and levels of work-related stress. People spoke of the requirement for further support for staff including suicide training.
- Capacity is at breaking point, with staff facing an unprecedented level of need from individuals and communities.
- Numerous staffing challenges were discussed including the difficulties of retaining staff as well as the competition in recruitment across the sector.
- The resilience piece was seen as extremely important and relevant both for staff and for volunteers.
- Organisations are having to consider how to make limited resource go further, whilst also ensuring that their staff and volunteers feel valued and supported.

Volunteers:

- Organisations are seeing a reduction in volunteers returning following the lifting of Covid restrictions. People aren't returning to volunteering, so organisations need to refocus towards being staff-led and being innovative with their volunteer recruitment.
- We heard that there was often a lack of organisational resource to successfully recruit, train and support volunteers – with this 'role' often being an add-on to existing roles within a staff team.
- People spoke of the lack of professionalisation of volunteers and the importance of a route to work through volunteering.
- When organisations were able to recruit volunteers, more volunteers were now needing to claim the expenses they were due (parking, travel etc), adding to organisational costs that weren't previously seen. This, in turn, impacts on the VCFSE sector who may not have those costs built into projects.

PEOPLE FROM BLACK
AND MINORITY ETHNIC BACKGROUNDS
IN THE WEST MIDLANDS,
ARE ON AVERAGE,
PAID 9.5% LESS
THAN WHITE EMPLOYEES
ACROSS ALL SECTORS.
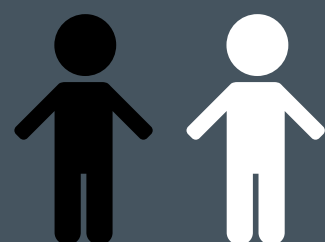
PEOPLE FROM BLACK
AND MINORITY ETHNIC BACKGROUNDS
ARE 2.5 TIMES MORE LIKELY
TO BE IN POVERTY
THAN WHITE PEOPLE

Employment:

- One in seven (14.5%) of VCFSE organisations across Birmingham employ staff paid less than a Real Living Wage. Therefore, the question of who can afford to work in the sector was asked. People spoke about the importance of employment and the Real Living Wage as a factor to tackle the COL crisis.
- This has the knock-on effect of potentially exacerbating inequality in the sector. It raised concerns about the sector workforce not being representative of the communities we serve and lacking in diversity.
- It was felt that more progressive and innovative approaches to employment were required.
- The resilience, respect and endurance of people living with poverty every day was seen as something to be harnessed. The skills and ideas people have to share should be used for co-production, co-design and participation. Understanding and connecting people and listening to resident's ideas could help to build a better city for the long term.

4. VOICE

It was recognised that the voice of the VCFSE sector, and that of BVSC, is now more important than ever. However, it was felt that we do not currently have the influence we should have. There is an urgent need for the 'sector' to collectively adopt a campaigning role that advocates on behalf of the communities we serve.

5. STEPPING IN & STEPPING UP

There was a view that the VCFSE sector is often seen as a cheaper means of service provision. There is a risk that this can be taken advantage of, weakening the sectors position. Our ability to "Step-In and Step-Up" during times of crisis, demonstrated throughout the pandemic, should not be taken for granted. If we are to be part of the solution, we too need adequate financial and structural support.

6. FUNDING

Future funding for the VCFSE sector was highlighted as a concern. Existing funding was simply not stretching as far as it once did due to rising costs that had to be met. There was also a concern that in the current funding landscape, there was a propensity to focus solely on the current crisis rather than longer-term, sustainable solutions.

This issue related closely to the many neighbourhood organisations who started up during Covid. Some lacked the underlying infrastructure and then needed to close, so there should be learning about maximizing the value of organisations that grow in response to a crisis.

ALMOST ALL OF BIRMINGHAM'S WARDS ARE MORE DEPRIVED THAN THE ENGLAND AVERAGE – MOST ARE IN THE BOTTOM 20% NATIONALLY

Collaboration

- Research into issues such as the COL crisis needs to be shared, linked and publicised. It was felt that good work is happening, but it can be difficult to find the results, so it's unclear what the city is focussing on.
- We must avoid working in silos. The VCFSE sector isn't a homogenous sector. There are lots of different parts of it. We must build connections both amongst ourselves but also across the public and private sectors.

Funding

- Funders need to connect with BVSC, Birmingham City Council (BCC) and other stakeholders in understanding who is doing what, and what funders can contribute to more targeted immediate, medium and longer-term solutions.
- We need to work together smarter. Our response to the COL crisis must be about using local expertise that's already there. So, for the VCFSE sector, it's about creating a list of funders who give out individual grants and how to access them.

Workforce & Volunteering

- We need a workforce strategy for the city, focussing on the vacancies in social care especially, but also highlighting the difficulties in finding staff across the VCFSE sector.
- The Let's make Birmingham a Living Wage City, supported by BCC and BVSC, and a range of other corporate employers should be promoted across the sector.
- There needs to be a renewed focus on employment, and in particular youth unemployment.
- Any Vision for Volunteering for Birmingham needs to highlight and promote the impact that volunteers have made. This will make a real difference to volunteer recruitment and will also help us understand the motivations for volunteering.
- Management of volunteers needs to be robust. Organisations should be provided with support so that they know where they can find more information about best practice in volunteer management.

Information & Communication

- The VCFSE sector holds a vast amount of critical information and expertise. The sector needs to consider an approach to share that information centrally, ensuring that both staff and citizens can access the information easily and effectively.
- The energy crisis may have an impact on behaviour and create change and is an opportunity to educate. We need to help people alleviate the immediate crisis but also think about how to manage energy consumption for longer term.

Strategy

- It is crucial that the VCFSE sector plays a central role in the strategies being developed to address inequalities. The current recognition by the Local Authority of the importance and influence of the sector must be maintained and built upon.
- The sector should play an active and integral role across the four identified target areas of action for Birmingham identified by Birmingham City Council (click here to view BCC presentation from the event)
- The city needs to consider a strategy for supporting those who are denied recourse to public funds. Currently, this support is falling on the VCFSE sector with little structural support from the government.
- The sector should be supporting a long-term green investment strategy that tackles rising bills along with a long-term agricultural strategy to see an end to recurring crises around energy and food poverty.
- A strategy to better harness the skills and experience within communities was also called for. Numerous examples of codesign and coproduction were discussed and the benefits these had within, and external to, the sector. The voice of lived experience needs to be heard if services are to be designed in ways that meet the needs of communities.

Crime & the Community

- The PCC will be raising awareness of loan sharks and the existence of community credit unions (affordable social lenders). Whilst community policing is at the heart of rebuilding compassionate policing, the VCFSE sector must be central to communications around this issue for these plans to be effective. The sector already has relationships and trust with those that are most effected and can support community policing to benefit those that most need it.
- We need a renewed focus on recreational/diversionary/engagement activities. Sports and arts clubs in the community, for example, are often pivotal to developing a sense of self-worth and purpose, reducing social isolation and tackling anti-social behaviour. The VCFSE sector are often best placed to provide these activities.

> **"We need to share information from this event with colleagues and friends. Knowledge is power!"**

Research and Consultancy
Conducting research to inform and support the voluntary and community sector and its public sector partners in response to identified needs; consultancy support in a range of areas including strategic planning and values-based approaches.

Evaluation
Providing evaluation of service and delivery models that support innovation and development across sectors and ensures that service provision is evidence-based.

Analysis
Providing analysis and briefings to the third sector around policy developments in the City; increasing the sector's capacity to inform and influence policy.

Learning
Sharing learning with the VCS, providing 'space to think' facilitating dialogue and debate; upskilling the sector to respond to complex issues; sharing resources, intelligence and information from partners to ensure these are circulated to as wide an audience as possible.

The work of BVSC Research is led and coordinated by our Director of Research, Sophie Wilson. Sophie has worked in the third sector for over twenty five years and has extensive experience in areas including volunteering, social action, criminal justice, homelessness, mental health and substance misuse.

BVSC Research is keen to work in partnership with others and will enlist the support of external partners, consultants and independent researchers as appropriate. If you are interested in becoming an associate of BVSC Research please contact Sophie directly.

BVSC Research is a directorate within BVSC core service provision.

Contact
Sophie Wilson, Director of BVSC Research
Email: SophieW@bvsc.org or Tel: 07765 867869
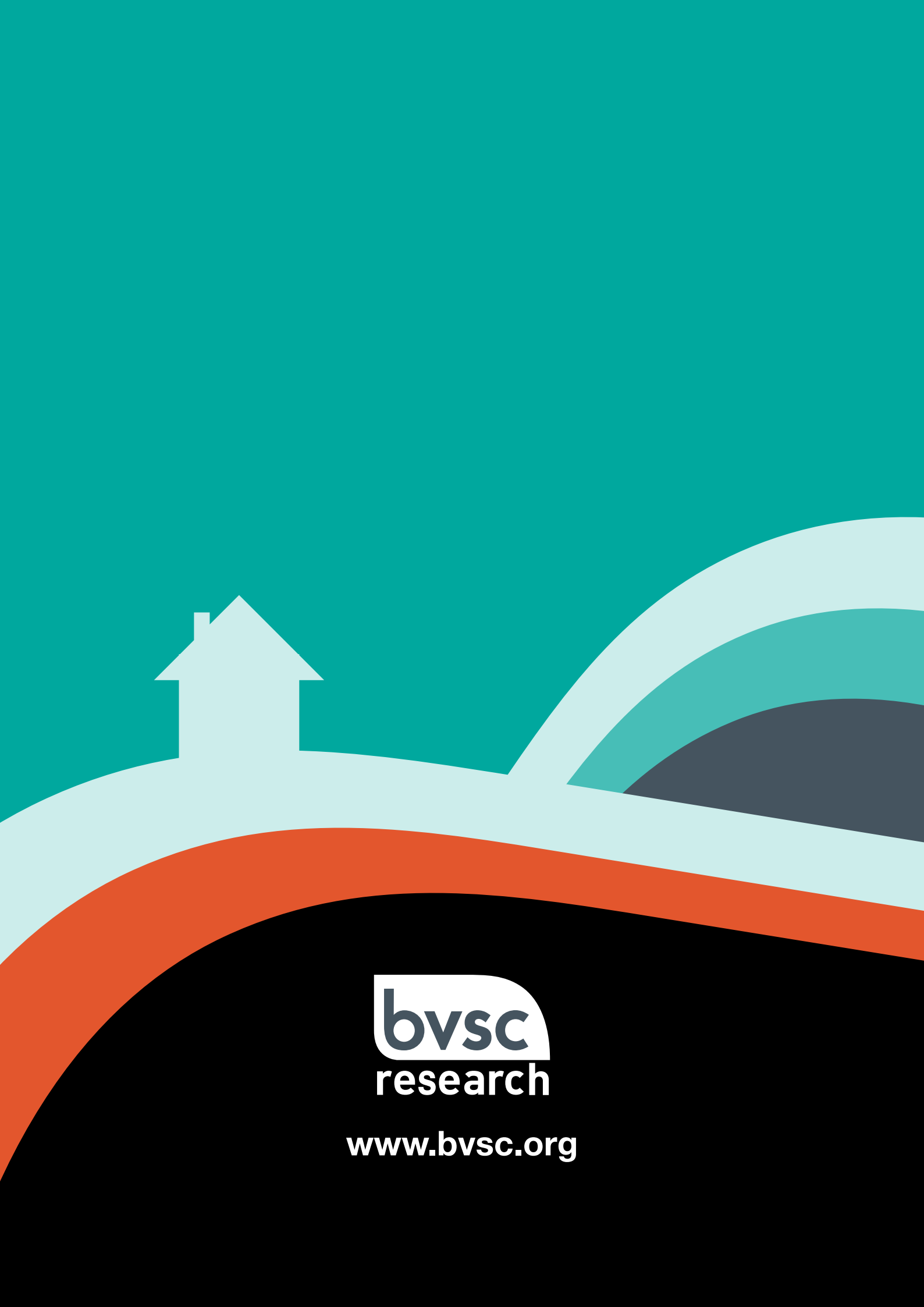
	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**31ˢᵗ January 2023**
TITLE:	**BCF ADULT SOCIAL CARE DISCHARGE FUND**
Organisation	**Birmingham City Council/Integrated Care Board**
Presenting Officer	**Michael Walsh, Head of Service – Commissioning, ASC, BCC**

Report Type:	**Approval**

1. Purpose:

1.1. To seek retrospective approval from the Health and Well-being Board for the Addendum Better Care Fund Plan: Adult Social Care Discharge Fund.

1.2. To update the board on the use and implementation of the fund.

2. Implications (tick all that apply):

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

3. Recommendation

3.1. H&WBB is recommended to approve the attached ASC Discharge Fund BCF Addendum Plan.

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4. Report Body

Background & Key Issues

4.1. In September 2002 the Government announced a £500m fund to support discharge from acute to social care over the winter period. The details of the fund were published in late November with a requirement for a plan to be submitted on 16ᵗʰ December 2022. This timetable did not allow for approval to be gained from the Health and Well-being Board.

4.2. Funding is being allocated in 2 tranches. The first tranche (40%) has been paid on receipt of a jointly agreed (ICB & BCC) plan. The second tranche (60%) will be paid subject to satisfactory implementation of the plan and system performance; to be determined at a review stage in late January. The funding is split into allocations to the ICB and to BCC – which are then pooled into the Better Care Fund. The total value of funding for Birmingham is £8,890,913.

4.3. The fund is being provided in order to directly support or enable the discharge from acute care of people who no longer have a reason to stay. Typically, this will be people who have an ongoing care need who are unable to return home without support or who need another form of on-going care in a community setting. Action in support of discharge from acute mental health care is also explicitly encouraged.

4.4. A condition of the fund is that an Addendum Plan for the Better Care Fund is developed and agreed by the ICB and BCC. The submitted plan is attached as **Appendix A.**

4.5. The key intervention outlined in the plan is to provide £6,040,193 of funding to support recruitment and retention in the independent care sector. This will be distributed to care providers to make retention and recruitment payments to existing and new staff in order to both maintain and increase capacity within the care sector. This is viewed as the most effective use of the resource as it can be rapidly deployed at scale and addresses the greatest risk to the provision of ongoing care and therefore discharge. The systemic issues of low pay in the care sector is a root cause in respect of difficulties in securing out-of-hospital home, nursing and residential care.

4.6. Other interventions in the plan include funding to purchase additional home care – although this is constrained by capacity in the market; to support retention and recruitment of BCC social care staff; to provide a joint budget for bespoke care packages for people with complex care needs and a number of initiatives to improve the experience of people being discharged from acute mental health care. This includes support for a new mental health out-of-hospital homeless pathway alongside enhanced mental health support for pathway 2 step-down beds.

4.7. Implementation of the plan has commenced alongside a fortnightly reporting schedule to the national Better Care Fund Team at NHS England. The key activity is to develop a mechanism for distributing funds to the independent care sector via an application process that will enable evaluation of the impact of funding in respect of additional care hours provided over the winter period.

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5. Compliance Issues
5.1. HWBB Forum Responsibility and Board Update
5.1.1. As an Addendum to the BCF plan the H&WBB has responsibility for approval. The Chair of the H&WBB was consulted on the plan prior to the submission on 16th December 2022.
5.2. Management Responsibility
5.2.1. Fortnightly reporting to the Better Care Fund national team and full implementation and spend against the Discharge Fund Plan.

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Failure to fully mobilize all elements of the plan	Medium	Loss of potential capacity to support discharge	Fortnightly ICB/BCC meetings to monitor implementation. Reporting through to ICB Strategic Oversight Group. Ability to flex resources between schemes in response to demand and capacity for implementation.

Appendices
Appendix 1: BCF ASC Discharge Fund Plan

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Discharge fund 2022-23 Funding Template
2. Cover

HM Government

NHS

Version 1.0.0

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- This template has been produced for areas to confirm how the additional funding to support discharge from hospital and bolster the social care workforce will be spent in each area. The government has also produced guidance on the conditions attached to this funding, that you should ensure has been followed.

- This template collects detailed data on how the funding allocated to each area will be spent. The portion of the funding that is allocated via Integrated Care Boards (ICBs) does not have a centrally set distribution to individual HWBs. ICBs should agree with local authority partners how this funding will be distributed and confirm this distribution in a separate template. The amount pooled into the BCF plan for this HWB from each ICB should also be entered in the expenditure worksheet of this template (cell N31) (The use of all funding should be agreed in each HWB area between health and social care partners.

Health and Wellbeing Board:	Birmingham
Completed by:	Sarah Feeley
E-mail:	sarah.feeley@birmingham.gov.uk
Contact number:	7704538632

Please confirm that the planned use of the funding has been agreed between the local authority and the ICB and indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Confirm that use of the funding has been agreed (Yes/No)	Yes
Job Title:	Strategic Director Adult Social Care
Name:	Professor Graeme Betts

If the following contacts have changed since your main BCF plan was submitted, please update the details.

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
*Area Assurance Contact Details:	Health and Wellbeing Board Chair	Cllr	Mariam	Khan	mariam.khan@birmingham.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Paul	Athey	paul.athey@nhs.net
	Local Authority Chief Executive		Deborah	Cadman	deborah.cadman@birmingham.gov.uk
	LA Section 151 Officer		Rebecca	Hellard	rebecca.hellard@birmingham.gov.uk
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

When all yellow sections have been completed, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net
saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Discharge fund 2022-23 Funding Template

5. Expenditure

Selected Health and Wellbeing Board: | Birmingham

Source of funding		Amount pooled	Planned spend
LA allocation		£4,666,913	£4,666,193
ICB allocation	NHS Birmingham and Solihull ICB	4244000	
		Please enter amount pooled from ICB	
		Please enter amount pooled from ICB	

Yellow sections indicate required input

Scheme ID	Scheme Name	Brief Description of Scheme (including impact on reducing delayed discharges).	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Estimated number of packages/beneficiaries	Setting	Spend Area	Commissioner	Source of Funding	Planned Expenditure (£)
1	P1 Capacity	Purchasing additional P1 capacity to meet increased demand over the winter	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		396 citizens with 6 weeks of initial care (1.5 hours		Social Care	Birmingham	Local authority grant	£500,000
2	Mental Health Wraparound P2	Mental Health Homeless Pathway	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)		15 beds and 40 citizens		Mental Health	NHS Birmingham and Solihull ICB	ICB allocation	£200,000
3	Care Provider Workforce - Recruitment and	Direct funding to independent care providers to pay recruitment and	Improve retention of existing workforce	Incentive payments			Both	Social Care	Birmingham	ICB allocation	£3,024,000
4	Care Provider Workforce - Recruitment and	Direct funding to independent care providers to pay recruitment and	Improve retention of existing workforce	Incentive payments			Both	Social Care	Birmingham	Local authority grant	£3,016,193
5	Care Home High Intensity	Additional support to enable Care Homes to accept existing residents	Bed Based Intermediate Care Services	Other	Providing enhanced healthcare at			Social Care	Birmingham	ICB allocation	£300,000
6	Mental Health Homeless Pathway	Step-down provision for homeless citizens from acute mental health care	Other		Capacity to ensure homeless complex mental			Mental Health	Birmingham	Local authority grant	£300,000
7	Discharges outside of existing pathways	Bespoke care packages for citizens with complex needs that cannot be met through	Other		Bespoke packages for citizens who		Both	Social Care	NHS Birmingham and Solihull ICB	ICB allocation	£300,000
8	BCC Assessment and Coordination Capacity	Provide additional capacity for social woker assessment and brokerage functions	Increase hours worked by existing workforce	Overtime for existing staff.				Social Care	Birmingham	Local authority grant	£500,000

9	BCC Assessment and Coordination Capacity	Maintain assessment and co-ordination capacity by payment of retention	Improve retention of existing workforce	Retention bonuses for existing care staff				Social Care	Birmingham	Local authority grant	£250,000
10	Contingency	Contingency	Contingency					Social Care	Birmingham	Local authority grant	£100,000
11	Mental Health Step-down provision	Step - down provision for MFFD mental health patients	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		20-30 at any one time		Mental Health	NHS Birmingham and Solihull ICB	ICB allocation	£420,000

Scheme types and guidance

This guidance should be read alongside the addendum to the 202

The scheme types below are based on the BCF scheme types in ma
been added that relate to activity to retain or recruit social care w
select 'other' as a main scheme type. That option should <u>only</u> be u

The conditions for use of the funding (as set out in the addendum
funding. Funding should be pooled into local BCF agreements as an
between ICBs and local government on the planned spend.

The relevant Area of Spend (Social Care/Primary Care/Community

The expenditure sheet can be used to indicate whether spending is

This funding is being allocated via:
 - a grant to local government - (40% of the fund)
 - an allocation to ICBs - (60% of the fund)

Both elements of funding should be pooled into local BCF section

Once the HWB is selected on the cover sheet, the local authority a
BCF pool will also appear on the expenditure sheet. The amount th
template that confirms the distribution of the funding across HWB

When completing the expenditure plan, the two elements of fundi
with the second tranche dependent on an area submitting a spenc
funding. Further reporting is also expected, and this should detail
end of year reporting, will be circulated separately)

Local areas may use up to 1% of their total allocation (LA and ICB)

For the scheme types listed below, the number of people that will
is being purchased with part of the funding, it should be indicated

Assistive Technologies and Equipment
Home Care or Domiciliary Care
Bed Based Intermediate Care Services
Reablement in a Person's Own Home
Residential Placements

Scheme types/services
Assistive Technologies and Equipment

Home Care or Domiciliary Care
Bed Based Intermediate Care Services
Reablement in a Person's Own Home
Residential Placements
Increase hours worked by existing workforce
Improve retention of existing workforce
Additional or redeployed capacity from current care workers
Local recruitment initiatives
Other

Administration

2-23 BCF Policy Framework and Planning Requirements.

ain BCF plans, but have been amended to reflect the scope of the funding. Additional scheme types have
orkforce. The most appropriate description should be chosen for each scheme. There is an option to
sed when none of the specific categories are appropriate.

to the 2022-23 BCF Policy Framework and Planning Requirements) confirm expectations for use of this
n addition to existing section 75 arrangements. Local areas should ensure that there is agreement

Health/Mental Health/Acute Care) should be selected

s commissioned by the local authority or the ICB.

75 agreements.

llocation will pre populate on the expenditure sheet. The names of all ICBs that contribute to the HWB's
hat each ICB will pool into each HWB's BCF must be specified. ICBs are required to submit a separate
s in their system. (Template to be circulated separately).

ing that is being used for each line of spend, should be selected. The funding will be paid in two tranches,
ling plan 4 weeks after allocation of funding. The plan should cover expected use of both tranches of
the actual spend over the duration of the fund. (An amended reporting template for fortnightly basis and

for reasonable administrative costs associated with distributing and reporting on this funding.

benefit from the increased capacity should be indicated - for example where additional domiciliary care
how many more packages of care are expected to be purchased with this funding.

Sub type
1.   Telecare
2.   Community based equipment
3.   Other

1. Domiciliary care packages
2. Domiciliary care to support hospital discharge
3. Domiciliary care workforce development
4. Other

1. Step down (discharge to assess pathway 2)
2. Other

1. Reablement to support to discharge – step down
2. Reablement service accepting community and discharge
3. Other

1. Care home
2. Nursing home
3. Discharge from hospital (with reablement) to long term care
4. Other

1. Childcare costs
2. Overtime for existing staff.

1. Retention bonuses for existing care staff
2. Incentive payments
3. Wellbeing measures

4. Bringing forward planned pay increases

1. Costs of agency staff

2. Local staff banks

3. Redeploy other local authority staff

Notes	home care?
You should include an expected number of beneficiaries for expenditure under this category	Y

You should include an expected number of beneficiaries for expenditure under this category	Y
You should include an expected number of beneficiaries for expenditure under this category	N
You should include an expected number of beneficiaries for expenditure under this category	Y
You should include an expected number of beneficiaries for expenditure under this category	N
You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
You should minimise spend under this category and use the standard scheme types wherever possible.	Area to indicate setting

Areas can use up to 1% of their spend to cover the costs of administering this funding. This must reflect actual costs and be no more than 1% of the total amount that is pooled in each HWB area	NA

		Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**	
Date:	**31st January 2023**	
TITLE:	**TRIPLE ZERO DRUG AND ALCOHOL STRATEGY BUNDLE**	
Organisation	**Birmingham Public Health**	
Presenting Officer	**Chris Baggott**	

Report Type:	**Information and Approval**

1.   Purpose:
1.1.   To present the contents of the Triple Zero Drug and Alcohol Strategy document pack and seek approval for continuation through the governance process to Cabinet before publication.

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

3.   Recommendation
3.1.   To note the documents contained in the bundle as outlined in section 4.
3.2.   To agree to HWB responsibility for oversight of delivery of actions supporting the strategy (health and treatment activity)
3.3.   To approve continuation through the governance process and request to Cabinet for publication

A BOLDER HEALTHIER BIRMINGHAM

4. Report Body

4.1 Background

The first draft of the Triple Zero Drug and Alcohol Strategy was produced in early 2020 but public consultation was delayed due to the Covid-19 pandemic. The public consultation ran for 12 weeks over the summer of 2021 and received approximately 900 responses. A team of analysts worked on the qualitative and quantitative feedback and produced a summary report. Following consultation, amendments were made to the strategy and these are presented in a 'You Said ….We Did' document which makes it clear to citizens, how we have responded to their views. In addition, a substance use needs assessment was carried out in the Autumn of 2021 to support the development of the final strategy.

There are 5 documents which form the Triple Zero Drug and Alcohol Strategy pack. They are:

- Triple Zero Strategy (**Appendix 1**)
- Needs Assessment Executive Summary (**Appendix 2**)
- Full Needs Assessment (**Appendix 3**)
- Consultation Analysis (**Appendix 4**)
- 'You said…we did' summary of findings and actions taken (**Appendix 5**)

4.2 Purpose of the Triple Zero Strategy

The strategy provides our high-level vision, aims and direction for tackling drug and alcohol addiction. This strategy isn't a detailed action plan, nor a list of performance measures and targets. As we progress through the strategy period detailed action plans will be developed to support and deliver our ambitions and themes.

4.3 Key Points in the Strategy

We have three ambitions for Birmingham:

- Zero deaths due to drug or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people unable to receive support for their addiction when they need it

One of the main criticisms from the public was that these 'targets' are impossible to achieve. However, in this draft we have made it clear that these are our ambitions and state that 'they represent what we should be aiming for. Aiming for anything less would be a disservice to our citizens, families, friends, and communities affected by addiction'.

There are 5 themes in the strategy with example actions:

a.   Prevention and Early Intervention
b.   Treatment Support and Recovery
c.   Children and Young People
d.   Additional Challenges and Complex Needs

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e.   Data and Evidence

The themes are underpinned by 5 principles:

a.   Citizen First
b.   Regulation and Enforcement
c.   Diversity and Inclusion
d.   Quality and Quantity
e.   Learning and Listening

In recent months the Government has published 'From Harm to Hope: A 10-year drugs plan to cut crime and save lives'. Local work to plan for the delivery of the targets in the plan is ongoing and this Birmingham Strategy will sit alongside that at an important time as we deliver a world-class drug and alcohol treatment system in Birmingham.

4.4 Triple Zero Strategy Governance

Monitoring Progress

A Triple Zero Action Plan will be developed and implemented to facilitate the delivery of the Strategy.

A multi-agency partnership Birmingham Combatting Drugs and Alcohol Partnership group (BCDAP) will be established and will be chaired by an Independent Chair. The BCDAP will monitor progress towards the Strategy ambitions and progress against the Triple Zero Action Plan. The Birmingham City Council Public Health Division will facilitate the action plan, commissioning of treatment services, monitoring of delivery, and report into the BCDAP

Strategic oversight

Birmingham Health and Wellbeing Board (HWB) and Birmingham Community Safety Partnership (CSP) will be jointly responsible for, and committed to, ensuring that Birmingham's vision for substance use (alcohol and drugs) is delivered.

Strategic assurance

The Birmingham Combatting Drugs and Alcohol Partnership, with its Independent Chair will provide assurance (through the respective governance structures of the partnership members) on the implementation of the TZ Action Plan to the West Midlands Combatting Drugs and Alcohol Partnership (Chaired by WM Police and Crime Commissioner)

The Birmingham partnership will bring together relevant local statutory and voluntary and community sector organisations with a role or interest in the implementation of the Triple Zero Strategy.

4.5 Key findings from the Needs Assessment

- Capturing true prevalence of drug and alcohol misuse in the population is challenging and is likely to be much higher than is currently captured.

3

- Evidence around the impact of the pandemic on substance use is still emerging and the longer-term impact on health and service demand is yet to be realised, however it is an important consideration in planning for future service and resource planning

- 1,140 individuals are in treatment at specialist alcohol misuse services in Birmingham (2019/20), which is almost a 42% reduction since 2016/17

- There are 10,525 problem drug users of opiate and/or crack cocaine (OCU) in Birmingham, of which 8,799 are opiate users and 6,817 are crack cocaine users. The rate of OCU was 14.2 per 1000 people which is significantly higher than the England (8.9) and the West Midlands (9.6) rates

- White men aged 30-49 years made up the highest proportion of CGL clients in treatment for opiate, non-opiate and alcohol problems

- In Birmingham there are an estimated 13,442 dependent drinkers, which represents 1.58% of the adult population (2019/20). This is higher than the England average (1.37%)

- The number of individuals not in contact with drug treatment services for an opiate problem in Birmingham (n = 4,114) has increased by 42.8% since its lowest number in 2012/13. This represents an unmet need of 46.9%, which is comparable to the national figure (46.3%)

- The number of individuals not in contact with drug treatment services for an OCU problem in Birmingham (n = 5,728) has increased by 53.6% since its lowest number in 2012/13. The unmet need (54.4%) is comparable to the national figure (53.4%)

- The number of individuals not in contact with drug treatment services for a crack cocaine problem in Birmingham (n = 3,887) has increased by 14.3% since its lowest number in 2012/13. The unmet need (57.0%) is lower than the national figure (61.3%)

- The number of individuals not in contact with treatment services for an alcohol problem in Birmingham (n = 11,830) has increased by 10.1% since its lowest number in 2014/15. This represent a large unmet need of 88.0%, which is higher than the national figure (83.0%)

- There are several inequalities that predispose marginalised groups to substance misuse. Therefore, there is a need to acknowledge intersectionality in the context of substance misuse to better understand diverse and complex treatment needs.

- Social return on investment is very high in terms of monetary value and reduction in crime

- For every £1 spent on drug and alcohol treatment services in Birmingham, there was an estimated social return on investment of £5.60 for individuals in treatment and £27.10 for individuals in treatment and recovery. The gross benefit per person was £9,640 (in treatment) and £46,761 for long-term gross benefit per person

- Substance misuse treatment is estimated to have prevented about 149,000 (a reduction of 29%) crimes committed by drug users and about 2,700 (a reduction of 45%) crimes by alcohol users

5.	Compliance Issues

5.1.	**HWBB Forum Responsibility and Board Update**

Birmingham Health and Wellbeing Board (HWB) and Birmingham Community Safety Partnership (CSP) will be jointly responsible for, and committed to, ensuring that Birmingham's vision for substance use (alcohol and drugs) is delivered. HWB will oversee health and treatment activity and the CSP will oversee crime and justice activity.

Birmingham Public Health/Commissioning will report on the action plan and progress.

5.2.	**Management Responsibility**

Mary Orhewere – Assistant Director of Public Health

Chris Baggott – Service Lead Public Health

Karl Beese – Commissioning Manager Public Health

6.	Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
If the Strategy and supporting information isn't published there may be a failure to deliver progress against the 2032 ambitions and measurable improvements to health inequalities and outcomes for citizens	Low	High	The Strategy and supporting information have been consulted on, and has been approved by Public Health SMT, Council Leadership Team and the Cabinet Member so it is expected to be suitable for publication. Work will continue to delivery against all relevant national and local targets. The Health and Wellbeing Board will oversee the delivery of health and treatment activity against the ambitions set out in the strategy, supported by a multi-level regional and local governance process and to guide and enable us to deliver a world-class drug and alcohol treatment system in Birmingham.

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Appendices

- **Appendix 1** - Triple Zero Strategy

- **Appendix 2** - Needs Assessment Executive Summary

- **Appendix 3** - Full Needs Assessment

- **Appendix 4** - Consultation Analysis

- **Appendix 5** - 'You said…we did' summary of findings and actions taken

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

Chris Baggott – Service Lead, Birmingham Public Health

Jenny Riley – Senior Officer, Birmingham Public Health

One death is one too many.
One overdose is one too many.
One unsupported person is one too many.

2022-2032

BIRMINGHAM
TRIPLE ZERO DRUG
AND ALCOHOL STRATEGY

A BOLDER HEALTHIER BIRMINGHAM

FOREWORD

Drug and alcohol addiction ruins lives for those caught up in active addiction and their family and friends, and for communities affected by crime and disorder. In Birmingham as well as premature deaths, illness and disability caused by addiction, we see childhoods and futures damaged by parental substance use, that could have been prevented with the right support, prevention and intervention.

Our Triple Zero Strategy sets out three ambitions to drive our work forward on drug and alcohol;

**Councillor
Mariam Khan**

- Zero deaths due to drug or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people unable to receive support for their addiction when they need it

We know that the strategy is incredibly ambitious and feedback from citizen consultation told us that you thought it was impossible to achieve, but how can we aim for anything less? What number of deaths, overdoses or unsupported people are acceptable? Which lives do not matter? My answer is none. Aiming for the triple zero ambitions is what the citizens of this City deserve.

Our strategy provides a high-level overview of our direction over the next ten years and what we can do to make change. We will work with other organizations, communities, and people with valuable lived experience to turn this strategy into reality and publish action plans to show how we will get there. We have listened to your consultation feedback and I hope that this strategy shows you clearly, where we want to be.

To get anywhere near to zero needs bravery, transformation and true partnership. No one organization can make the changes we need to effectively support individuals and communities and change lives.

As the largest Local Authority all eyes are on the city. Following the Dame Carol Black Review and the new Government Strategy: From Harm to Hope, drug and alcohol addiction is getting the attention nationally that it has long deserved. We are entering a period of government investment in the form of new grants, the formation of Local Drug and Alcohol Partnerships, new commissioning and monitoring frameworks and above all new opportunities to improve the lives of those blighted by addiction.

Now is the time for real and lasting change.

**Cabinet member for health and social care
Chair of Birmingham health and well being board**

CONTENTS

1 CONTEXT AND PURPOSE OF THE STRATEGY

Why is a Drug and Alcohol Strategy Important for Birmingham?

Drug and alcohol misuse is a major public health concern and socioeconomic burden responsible for considerable healthcare expenditure in the United Kingdom (UK)[1]. The annual estimated cost to the NHS of treating drug misuse is approximately £500m[2], whilst the healthcare cost of alcohol misuse is estimated to be as much as £3.5bn per year[3]. The total direct cost to society including treatment and support, crime, and costs to the economy is estimated to be around £21bn for Alcohol[4] and £20bn for drugs[5]. We must not forget the human cost associated with crime, illness, disability and death. There were 4,561 deaths related to drug poisoning recorded in England and Wales in 2020[6] and 8,974 deaths from alcohol specific causes.

Given the complexity of drug and alcohol addiction and the increasing need to combat endemic substance misuse in Birmingham and indeed nationally, this strategy sets out our ambitions, vision and priorities for drug and alcohol services and wider community and system level intervention. It provides a framework to guide the planning, commissioning and delivery of services.

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Under the HSC Act 2012, local authorities have the duty to reduce health inequalities and improve the health of their local population by ensuring that there are public health services aimed at reducing drug and alcohol misuse and have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services.

Scope of the Strategy

This strategy provides our high-level vision, aims and direction for tackling drug and alcohol addiction. Substance use impacts communities and individuals. It effects physical and mental health, relationships, education and career prospects, financial status, housing and criminal involvement, but these can also be what drive people to addiction. This strategy is not the answer to everything but is complementary with other Birmingham level strategies, needs assessments and reports where some of these wider interdependencies are addressed further.

Examples include;

- Birmingham and Solihull Joint Sexual Health Strategy
- Birmingham Domestic Violence Strategy
- Birmingham Homelessness Strategy
- Rough Sleeping Action Plan 2020-23
- DPH Annual Report – Complex Lives Fulfilling Futures
- ICS inequalities strategy
- Mental Health Commissioning Plan

This strategy focuses on drugs and alcohol because we are in the process of recommissioning drug and alcohol treatment services. We recognise that there are individuals and their loved ones suffering the consequences of behavioural addictions such as gambling or gaming. A list of support organisations that you can contact is contained at the rear of this document.

Our strategy is based on the most up to date intelligence we have on drug and alcohol use, underpinned by the Substance Use Needs Assessment (2021), where detailed data and analysis can be found to support this strategy as well as definitions of drugs and alcohol use and policy drivers.

This strategy isn't a detailed action plan, nor a list of performance measures and targets. As we progress through the strategy period detailed action plans will be developed to support our ambitions and themes.

2 THE CURRENT LANDSCAPE

For detailed data and evidence on substance use and service provision, please refer to the 2021 Substance Use Needs Assessment.

The Local Evidence Base

13,443
dependent drinkers in Birmingham

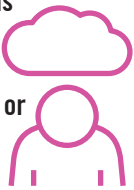**OVER 7,000**
adults admitted to hospital due to alcohol

20%
of all adults with alcohol dependence are parents

Deaths related to drug misuse have increased by **211.4%**

280
admissions for all types of substance use among young people aged 15-24

384
deaths due to conditions which have been wholly caused by alcohol consumption

370
deaths where alcohol was an underlying cause

2,015
admissions where there is a primary or secondary diagnosis of drug related mental and behavioural disorders

10,525
problem drug users of opiate and/or crack cocaine (OCU) in Birmingham

Current Service Provision

In 2020, Birmingham City Council invested £14.8m in drug and alcohol treatment and support for all ages funded by the public health grant. A single system with a matrix of partnership providers has been commissioned to deliver these services. GP and pharmacy primary care, as well as the third sector, are part of the provider matrix. There is a range of services provided through this partnership including specific service elements focused on mental health, prison release, employment, criminal justice, blood-borne viruses, domestic abuse, acute sector, child protection and homelessness.

Birmingham City Council commissions two service providers to support substance misuse services in the city: Aquarius (Young People) and Change Grow Live (Adults).

Numbers in Treatment

1,470
individuals (18+) in treatment at specialist alcohol misuse services in 2020/21

111,830
dependent drinkers NOT in treatment which represents unmet need

5,742
individuals (aged 18+) were in treatment at specialist drug misuse services in 2020/21

4,797 were Crack and/or Opiate users
5,728 Crack and/or Opiate users NOT in treatment

Key Findings from the Substance Use Needs Assessment

- Capturing true prevalence of drug and alcohol misuse in the population is challenging and is likely to be much higher than is currently captured.
- Evidence around the impact of the pandemic on substance use is still emerging and the longer-term impact on health and service demand is yet to be realised, however it is an important consideration in planning for future service and resource planning.
- There are many inequalities that predispose marginalised groups to substance misuse. Therefore, there is a need to acknowledge intersectionality in the context of substance misuse to better understand diverse and complex treatment needs.
- Social return on investment is very high in terms of monetary value and reduction in crime.
- For every £1 spent on drug and alcohol treatment services in Birmingham, there was an estimated social return on investment of £5.60 for individuals in treatment and £27.10 for individuals in long term recovery following treatment. The gross benefit per person was £9,640 (in treatment) and £46,761 for long-term gross benefit per person.
- Substance misuse treatment is estimated to have prevented about 149,000 (a reduction of 29%) crimes committed by drug users and about 2,700 (a reduction of 45%) crimes by alcohol users.

£5.60
social return on investment for every £1 spent on individuals in treatment

£27.10
social return on investment for every £1 spent on individuals in long term recovery following treatment

£9,640
gross benefit per person in treatment

£46,761
long-term gross benefit per person

SUBSTANCE MISUSE TREATMENT is estimated to have prevented about
149,000
crimes committed by DRUG USERS (a reduction of 29%)

SUBSTANCE MISUSE TREATMENT is estimated to have prevented about
2,700
(a reduction of 45%) crimes by ALCOHOL USERS

The Dame Carol Black Review

In 2019, Professor Dame Carol Black was appointed to undertake an independent review of drugs[7][8]. This was to inform the government's approach to tackling harm caused by drugs. The review examined the challenges posed by drug supply and demand in a £10 billion a year market, with 3 million users, serious violence, harm and exploitation. It also highlighted the declining quality and capacity of drug treatment services, with disproportionate premature death and entrenched drug use associated with deprivation.

The second part of the review[9] commissioned by the Department for Health and Social Care, focuses on prevention, treatment and recovery. The report's aim is to make sure that vulnerable people with substance misuse problems get the support they need. It makes a series of 32 recommendations for Government, Local Government and other organisations around key themes:

- Radical reform of leadership, funding and commissioning
- Rebuilding services
- Increased focus on primary prevention and early intervention
- Improvements to research and how science informs policy, commissioning and practice

The review has major implication for future responsibilities and service delivery. We are keeping track of national and regional responses to the recommendations to ensure that local plans and responses are updated at the earliest opportunity including this strategy.

3 OUR VISION

We want Birmingham to be a city where drugs and alcohol addiction do not cause preventable deaths and damage lives through overdose and crime.

We want Birmingham to be a city where young people grow up without addiction and where adults who are living with addiction to substances can access treatment and support and regain control of their lives.

Our Triple Zero Ambitions

We have three ambitions for our City:

- Zero deaths due to drug or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people unable to receive support for their addiction when they need it

We know they are very ambitious, and many would argue impossible to achieve. However, they are not targets, they represent what we should be aiming for. Aiming for anything less would be a disservice to our citizens and individuals, family and friends affected by addiction.

Put simply one death is one too many, one overdose is one too many and one person unable to received support when they need it…. is one too many.

Key Aims and Objectives

These three ambitions are underpinned by a series of aims and objectives:

- Reduce access to, and the affordability of, illegal drugs in Birmingham
- Reduce the proportion of young people being exposed to, and trying illegal drugs
- Reduce the number of harmful and hazardous drinkers
- Increase the proportion of people with drug and alcohol addiction in treatment
- Explore new models of treatment, care and support to minimise the risk of overdose and death
- Improve access to Naloxone and other interventions that can improve outcomes of overdose
- Improve access to employment support for people accessing treatment and support for drug and alcohol addiction
- Improve access to healthcare services for people accessing treatment support for drug and alcohol addiction
- Work in partnership with citizens, businesses, and organisations across the city towards our vision

Realising Our Vision

To work towards our vision, we will focus on delivery through five themed workstreams that will work together to create a safer, healthier city.

THE FIVE THEMES ARE:				
THEME ONE	**THEME TWO**	**THEME THREE**	**THEME FOUR**	**THEME FIVE**
Prevention and Early Intervention	Treatment, Support & Recovery	Children and young people	Additional challenges and Complex Needs	Data and Evidence
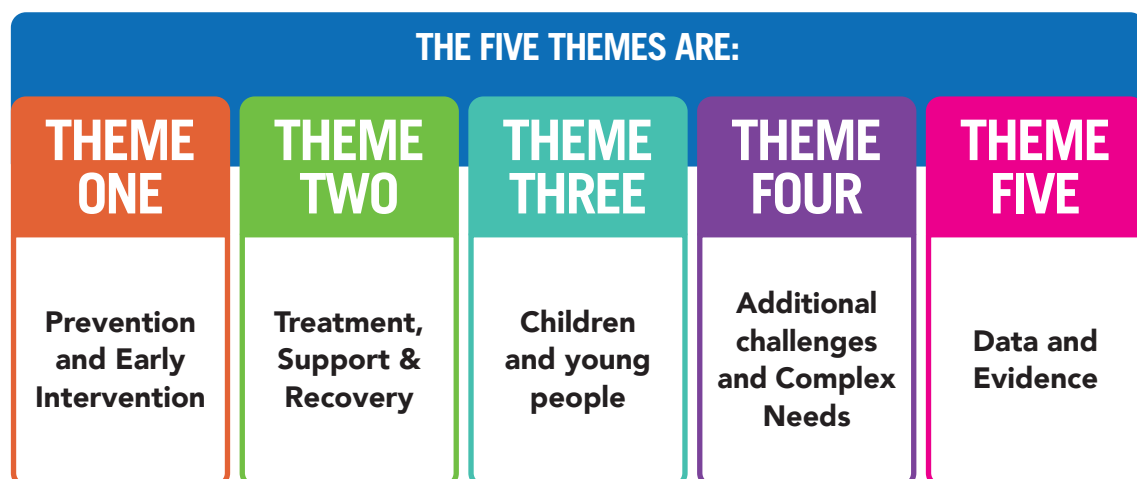
Through the five themes there are five principles which weave across all the themes:

Citizen First

We will put the citizen at the heart of our approach, working with citizens across the city to deliver our vision.
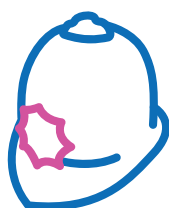
Regulation & Enforcement

We want to support businesses to be sustainable and make the most of the everyday contact between regulation and enforcement authorities to enable working towards a city in which people enjoy alcohol responsibly and without it causing harm.

Diversity & Inclusion

We know that there are significantly different relationships with drugs and alcohol in different cultures, communities and marginalised and vulnerable groups across the city and as we progress this work, we want to work with them to find solutions and approaches that work.
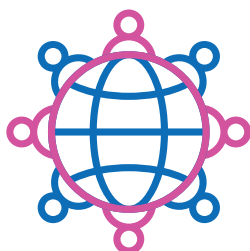
Quality and Quantity

Birmingham is a large city with a diverse population and it is important that we find ways to support citizens across the whole city without sacrificing quality of services and interventions.

Learning & Listening

We also know we need to listen and be humble in our approach, 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.

Our Partners in Delivery

A central circle labelled "PREVENTION AND EARLY INTERVENTION" with arrows pointing to it from the following partners: Secondary care, Primary care, Police and Crime Commissioner, OHID and UKHSA, Blue Light Services, Service providers, Education, NHSE/I, Voluntary and Community Sector, BSol CCG/IGS, Commissioned services.

4 THEMES

THEME ONE: PREVENTION AND EARLY INTERVENTION

Why is this Important?

Health harming behaviours such as the use of drugs and alcohol can be easier to tackle before they become part of life for individuals and communities. By preventing or making harmful choices more difficult, or educating people to make better choices, we can change the path towards addiction.

Prevention requires action on multiple levels across the city to reduce the supply of drugs and saturation of alcohol and raising awareness through education of all people of all ages.

Early intervention is about providing support to prevent addiction forming and providing alternative ways of managing the stress and pressures that are pushing people towards misuse.

What can we do?

Challenge the saturation of low-cost alcohol sales.

Education and awareness raising, especially with communities most at risk.

Exploring opportunities to tackle sales of steroids and nitrous oxide in the city.

Targeted social marketing and awareness work with communities at highest risk.

Medicine monitoring and support in healthcare settings to tackle prescription and over the counter medicine misuse.

Work with key settings such as workplaces, schools and universities to support organisational approaches to reducing drug and alcohol misuse.

Promoting access to peer support and self-care early interventions including support for family and friends.

Increasing training and awareness among professionals working with communities most at risk.

Work with community and performance gyms to raise awareness of steroid abuse risks and impacts.

Continue to strengthen the collaboration between homelessness, mental health and substance misuse services.

THEME TWO: TREATMENT SUPPORT AND RECOVERY

Why is this Important?

The right treatment and support very can lead to huge improvements in mental and physical health for people living with addiction such as heart and liver health, serious mental illness such as psychosis and prevention of premature death. Programmes such as needle exchange can reduce transmission of blood-borne viruses and use of Naloxone can reduce fatalities from accidental overdose.

Treatment aims to help people to manage their addiction, ideally with the ambition to achieve a life free of drugs or alcohol misuse, or where this is not possible to achieve a level of maintenance which enables them to actively participate in society. We know that there are far more people with problematic use of alcohol and other drugs than those receiving treatment. We need to ensure that effective treatment is available to those who need it, providing them with support to improve health and reduce individual and societal harm. We also need to ensure that support is also available for friends and family who affected. Interventions must be provided in a way that is sensitive to culture, vulnerability and wider complex needs such as homelessness, domestic abuse and mental health.

What can we do?

Continue to support drug and alcohol treatment services in line with national commissioning guidelines and national provided funding resources.

Continue to review the models of care provided against the emerging pattern of usage.

Employment support for people accessing drug or alcohol treatment services and work with employers to encourage provision of job opportunities.

Explore innovative models of risk minimisation such as heroin assisted treatment, safer injecting facilities and widespread use of Naloxone.

Increase connectivity between commissioned professional treatment services and community based mutual aid groups such as Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous.

Improve awareness and knowledge of substance misuse and service availability in frontline (non-substance misuse) services by providing specialist training to staff.

Increase the number of people engaging with support through clearer promotion of where and how to find help.

Destigmatise seeking support by utilising the voices of people with lived experience.

Embed service user voice in treatment planning, evaluation and service designnboration between homelessness, mental health and substance misuse services.

THEME THREE: CHILDREN AND YOUNG PEOPLE

Why is this Important?

Birmingham has a larger proportion of children and young people than the UK average and if we are going to address drug and alcohol misuse fully, we must explicitly consider how to work with them to change the city and their future.

Drug and alcohol misuse impacts on children and young people in many ways, either because they are themselves using alcohol or drugs, or their parents or other family members are, or because they are pawns in organised crime or victims of crime. The impact of drugs and alcohol on children and young people can last a lifetime.

Young people receiving interventions for substance misuse have a range of vulnerabilities that require specialist support and intervention. Those in treatment often say they:

- are/were victims of domestic violence
- have contracted a sexually transmitted infection
- have experienced sexual exploitation and are more likely to:
- are not in education, employment or training and
- are in contact with the youth justice systems

Over two thirds of these Children and Young People accessing service have more than one complexity or vulnerability.

Dependent parental alcohol and drug use has an adverse impact on children, particularly regarding their physical health, psychosocial wellbeing and personal alcohol and drug use.

There is increasing evidence that adverse childhood experiences (ACEs) such as living in a household with problem alcohol use can contribute to long term harms. If a child experiences four or more risk factors during childhood they have a substantially higher risk of developing health-harming behaviours, such as smoking, heavy drinking and cannabis use.

What can we do?

Address youth gang violence and crime and particularly tackle organised crime's use of children and young people in drug trafficking.

Integrate drug and alcohol prevention and early intervention into other services concerned with reducing risky behaviours in children and young people such as sexual health or truancy.

Support schools to deliver high quality evidence-based education on personal resilience in all educational settings including schools, and universities.

Promote access for young people to accurate information about drugs to allow them to make informed choices.

Increased screening and referral of young people at risk of substance misuse through mainstream services working with higher risk groups.

Ensure that drug and alcohol treatment services have strong relationships with social care and safeguarding support to ensure children and young people in families where there is substance misuse are safe and protected.

Ensure that support for children and young people is closely joined up to support for adults so that young people get the support they need as they get older and transition between services.

Specific work with the Birmingham Children's Trust to strengthen links and support for families where a parent or family member is misusing alcohol or drugs.

Specific work with Birmingham United Maternity Partnership (BUMP) to ensure interconnected pathways of care and support for mothers with addiction issues.

THEME FOUR: ADDITIONAL CHALLENGES AND COMPLEX NEEDS

Why is this Important?

Many individuals who are struggling with addiction face additional challenges, these include those who are homeless or have insecure housing, people living with mental health issues or people experiencing violence, coercion, abuse or involved in the criminal justice system or sex work.

There is often a vicious cycle of using substances to cope difficult and complex lives and motivation to stop using substances can be low when survival is more important than seeking support and recovery. Many are at high risk of social exclusion and multiple health problems as well as substance misuse. Substance use can often lead to homelessness when addiction disrupt relationships with family and friends or causes job loss. But in many situations, substance abuse is a result of homelessness rather than a cause.

The co-occurrence of a substance use disorder and a mental health disorder is known as dual diagnosis and it is often under-diagnosed, underestimated and poorly treated throughout the world. Dual diagnosis is a serious and prevalent problem, particularly within homelessness which presents its own multitude of barriers when accessing services including mental health support.

What can we do?

Additional targeted training and awareness to support engagement and referral for people accessing mental health or housing services.
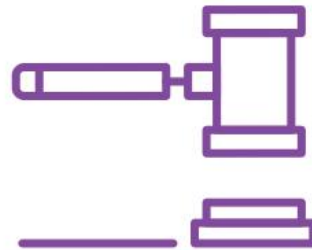
Specific work with the criminal justice health system to address drug and alcohol issues within custody and through probation and youth justice services.

Include substance use in future inclusion health (inequalities team) needs assessments and deep dives to highlight inequalities and intersectionality in vulnerable groups. For example: sex workers, mental health. This will lead to increased understanding and awareness of the challenges faced by these vulnerable groups.

Conduct a deep dive focusing on mental health in relation to substance abuse (dual diagnosis).

Create/enhance pathways between substance misuse services and other services such as the secondary mental health services, CJS and primary care.

Data sharing to prevent duplication and more efficient progression through concurrent treatment services.

Promote client recovery through holistic treatment services that address wider determinants of health concerns (e.g. employment, housing).

THEME FIVE:
DATA AND EVIDENCE

Why is this Important?

Through the work to deliver this strategy we aim to increase the understanding of the picture of drug and alcohol misuse and addiction in the city and strengthen the evidence base for what works and to understand our population. More representative data is needed to understand the behaviours associated with and the prevalence of substance misuse and we must learn from existing evidence and best practice.

What can we do?

Develop a more detailed local data set of indicators to track progress and impact.

Explore potential for economic indicators and metrics to look at impact of low-cost alcohol.

Research into steroids, nitrous oxide, club drug and NPA to better understand patterns of use and supply chains.

Research to better understand the cultural context of alcohol and substance misuse and the inequalities within the city.

Development of routine data collection in education settings (young people) to gather information on early substance use, which could improve the effectiveness of preventative programmes.

More research in and engagement with hard-to-reach communities.

Targeted research on prevalence of drugs for which the prevalence is not well established (e.g. opiates, crack cocaine, GBL, cannabis and crystal meth).

Undertake robust research on effectiveness of treatment interventions.

Develop a working group between relevant bodies (e.g. commissioners, subject experts, service professionals, service users) to develop an action plan for the routine collection of specific data.

5 GOVERNANCE

Monitoring Progress

A Triple Zero Action Plan will be developed to implement delivery of the Strategy.

A Birmingham Combatting drugs and alcohol partnership group (BCDAP) will be established – which is a multi-agency partnership chaired by an Independent Chair. The BCDAP will monitor progress towards the Strategy ambitions and progress against the Triple Zero Action Plan. The Birmingham City Council Public Health Division will facilitate the action plan, commissioning of treatment services, monitoring of delivery, and report into the BCDAP.

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Birmingham Health and Wellbeing Board (HWB) and Birmingham Community Safety Partnership (CSP) will be jointly responsible for, and committed to, ensuring that Birmingham's vision for substance use (alcohol and drugs) is delivered.

Strategic assurance

The Birmingham Combatting Drugs and Alcohol Partnership, with its Independent Chair will provide assurance (through the respective governance structures of the partnership members) on the implementation of the TZ Action Plan to the West Midlands Combatting Drug and Alcohol Partnership (Chaired by WM Police and Crime Commissioner).

The Birmingham partnership will bring together relevant local statutory and voluntary and community sector organisations with a role or interest in the implementation of the Triple Zero Strategy.

REFERENCES

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Birmingham Substance Use Needs Assessment

Executive Summary

December 2021

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Birmingham City Council

1 Introduction

The aim of this needs assessment is to establish an evidence base to support the treatment planning process, including identifying the level of need in the population, and gaps and barriers in service provision prior to re-commissioning substance misuse treatment services.

To achieve the aims, specific objectives were to:

- use epidemiological approaches and a broad range of quantitative and qualitative data sources to comprehensively and comparatively assess the needs of the population of Birmingham in relation to alcohol and drug use,
- identify gaps in service provision and areas of unmet need and inequalities, and
- make recommendations to address the needs of Birmingham in future service commissioning.

With the effects of substance abuse pervading society, the challenges posed are increasingly great at the individual, societal and clinical levels. Substance abuse impacts on physical and mental health, emotional well-being, familial and other relationships, education and career prospects, financial status, and criminal involvement.

The causes and consequences of substance misuse behaviours are complex and interrelated to such a large extent that they are almost impossible to separate.
Given the complexity of drug and alcohol addiction and the increasing need to combat endemic substance misuse in Birmingham and indeed nationally, this needs assessment provides a necessary update to the last needs assessment in 2013/14

2 Background & Policy[1]

From Harm to Home 2021 was published in December 2021 to combat illegal drugs by cutting off the supply of drugs by criminal gangs and giving people with a drug addiction a route to a productive and drug-free life. The strategy is underpinned by investment of over £3 billion over the next three years.

In 2019, Professor Dame Carol Black was appointed to undertake an independent review of drugs. This was to inform the government's approach to tackling harm caused by drugs. The review examined the challenges posed by drug supply and demand in a £10 billion a year market, with 3 million users, serious violence, harm, and exploitation. It also highlighted the declining quality and capacity of drug treatment services, with disproportionate premature death and entrenched drug use associated with deprivation.

The second part of the review, commissioned by the Department for Health and Social Care, focuses on prevention, treatment, and recovery. The report's aim is to make sure that vulnerable people with substance misuse problems get the support they need. It makes a series of 32 recommendations for Government, Local Government, and other organisations around key themes:

•   Radical reform of leadership, funding, and commissioning

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[1] Section 2 of full Birmingham Substance Use Needs Assessment 2021

- Rebuilding services
- Increased focus on primary prevention and early intervention
- Improvements to research and how science informs policy, commissioning, and practice

The review has major implication for future responsibilities and service delivery.

3   Key Findings from the Needs Assessment[2]

- Capturing true prevalence of drug and alcohol misuse in the population is challenging and is likely to be much higher than is currently captured.
- Evidence around the impact of the pandemic on substance use is still emerging and the longer-term impact on health and service demand is yet to be realised, however it is an important consideration in planning for future service and resource planning
- 1,140 individuals are in treatment at specialist alcohol misuse services in Birmingham (2019/20), which is almost a 42% reduction since 2016/17
- There are 10,525 problem drug users of opiate and/or crack cocaine (OCU) in Birmingham, of which 8,799 are opiate users and 6,817 are crack cocaine users. The rate of OCU was 14.2 per 1000 people which is significantly higher than the England (8.9) and the West Midlands (9.6) rates
- White men aged 30-49 years made up the highest proportion of CGL clients in treatment for opiate, non-opiate and alcohol problems
- In Birmingham there are an estimated 13,442 dependent drinkers, which represents 1.58% of the adult population (2019/20). This is higher than the England average (1.37%)
- The number of individuals not in contact with drug treatment services for an opiate problem in Birmingham (n = 4,114) has increased by 42.8% since its lowest number in 2012/13. This represents an unmet need of 46.9%, which is comparable to the national figure (46.3%)
- The number of individuals not in contact with drug treatment services for an OCU problem in Birmingham (n = 5,728) has increased by 53.6% since its lowest number in 2012/13. The unmet need (54.4%) is comparable to the national figure (53.4%)
- The number of individuals not in contact with drug treatment services for a crack cocaine problem in Birmingham (n = 3,887) has increased by 14.3% since its lowest number in 2012/13. The unmet need (57.0%) is lower than the national figure (61.3%)
- The number of individuals not in contact with treatment services for an alcohol problem in Birmingham (n = 11,830) has increased by 10.1% since its lowest number in 2014/15. This represent a large unmet need of 88.0%, which is higher than the national figure (83.0%)
- There are several inequalities that predispose marginalised groups to substance misuse. Therefore, there is a need to acknowledge intersectionality in the context of substance misuse to better understand diverse and complex treatment needs.
- Social return on investment is very high in terms of monetary value and reduction in crime
- For every £1 spent on drug and alcohol treatment services in Birmingham, there was an estimated social return on investment of £5.60 for individuals in treatment and £27.10 for individuals in treatment and recovery. The gross benefit per person was £9,640 (in treatment) and £46,761 for long-term gross benefit per person

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[2] Section 11 of full Birmingham Substance Use Needs Assessment 2021

- Substance misuse treatment is estimated to have prevented about 149,000 (a reduction of 29%) crimes committed by drug users and about 2,700 (a reduction of 45%) crimes by alcohol users

4 Service Provision in Birmingham[3]

In 2020, Birmingham City Council invested £14.8m in drug and alcohol treatment and support for all ages funded by the public health grant. A single system with a matrix of partnership providers has been commissioned to deliver these services. GP and pharmacy primary care, as well as the third sector, are part of the provider matrix. There is a range of services provided through this partnership including specific service elements focused on mental health, prison release, employment, criminal justice, blood-borne viruses, domestic abuse, acute sector, child protection and homelessness.

Birmingham City Council commissions two service providers to support substance misuse services in the city: Aquarius (Young People) and Change Grow Live (Adults).

4.1 Aquarius Young Persons Service

The Young People's Service is delivered by Aquarius. An original 5-year contract ran from March 2015 – February 2020, with the option to extend for additional 1+1 years exercised, to align with re-procurement of the Adult Services.

Aquarius' head office is in Edgbaston. They work with young people aged under 18 years affected by substance misuse; either young people who are drinking or using drugs themselves OR who have a family member who drinks or uses drugs. Types of support can include:
- Information and advice about drinking and drug use
- A drop-in service
- 1:1 advice and interventions for children and young people using or at risking of using substances
- Structured, evidence-based psychological and psychosocial interventions and support
- Group work

Aquarius works in partnership with other organisations to deliver support including:

Forward Thinking Birmingham – consisting of a consultant psychiatrist, a clinical nurse specialist, and an assistant psychologist to assess and provide specialist support, including opiate substitute prescribing.
St Basil's – to work with young people who are affected by both substance use and homelessness.
Barnardo's – Child Sexual Exploitation worker in the Aquarius team for if there are concerns around both substance use and sexual exploitation
Youth Offending Team – there's an Aquarius Practitioner based in each of the Youth Offending Teams across Birmingham who work with young people if there are concerns around substance use (even if the offending isn't related to substance use).

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[3] Section 6 of full Birmingham Substance Use Needs Assessment 2021

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4.2 Change Grow Live

Adult services are commissioned by Birmingham Public Health through a single provider: Change, Grow, Live (CGL). This was originally a 5-year contract March 2015 – February 2020, and a 2-year option to extend via delegated authority was exercised. In February 2021, Cabinet also approved a further 13-month extension due to Public Health supporting the Birmingham City Council COVID-19 response. The new contract end date is 31st March 2023, which aligns with the end of the Young People's contract for joint commissioning to take place.

The service is for adults (aged 18 years and above) experiencing difficulties with drugs or alcohol in Birmingham and has four community hubs across the city:
•   South Hub, Bournville
•   Central and West Hub, Newtown
•   East Hub, Stechford
•   North Hub, Great Barr
A further City Centre location – Lonsdale House - is due to open January 2022.

Change Grow Live have the following specialist teams:
•   Homeless and Rough Sleeper Team working in partnership with the Rough Sleepers Initiative
•   Women and Families Team based in Ladywood, female only access
•   Hospital Team working across UHB Hospital Sites and City Hospital
•   Criminal Justice Team based within CRC
•   Criminal Justice Project
•   Programmes and Throughcare Team based in all of the hubs and community venues

Needle Exchange

Needle Exchange was first introduced in England in 1985 in response to the HIV/AIDS epidemic. It is a facility where injecting drug users can obtain sterile injecting equipment and dispose of used needles in a responsible, hygienic, and safe manner.

5 Inequalities and Vulnerable Groups[4]

Institutionalised and cultural norms predispose many groups of people to higher rates of substance abuse, poorer health outcomes and social stigma. The bidirectional nature of the impact of substance abuse further complicates the issue. The consequences of substance misuse may be exacerbated by socioeconomic inequalities whilst psychosocial and environmental consequences may increase vulnerability to inequalities in social determinants of health. The full needs assessment considers demographic differences and vulnerable groups separately to highlight their individual inequalities before drawing together the evidence through an intersectional lens, providing a holistic view across social-structural dimensions.

A review of available evidence showed clear inequalities in sex, age, ethnicity and deprivation, which suggested that services should look to understand the underlying social context for substance misuse, focusing on the role of community social norms in driving behaviours.

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[4] Section 8 of full Birmingham Substance Use Needs Assessment 2021

Children and Young People

There is increasing evidence that adverse childhood experiences (ACEs) such as living in a household with problem alcohol use can contribute to long-term harms. If a child experiences four or more risk factors during childhood they have a substantially higher risk of developing health-harming behaviors, such as smoking, heavy drinking and cannabis use. Identifying and minimizing risk early on is key to prevention and substance use services should be delivered holistically in partnership with key agencies, addressing wider vulnerabilities as well as misuse.

Stigma, Discrimination and Complex Needs

The full needs assessment explores the interrelationship between substance misuse and mental health, disability, sexual orientation and gender identity, rough sleeping, sex work and modern slavery. From what we know there are clear inequalities in substance use which also reflect wider health inequalities. However, in most cases epidemiological data is limited which presents a major barrier when establishing health policy priority interventions. What is clear is that one size does not fit all when it comes to service provision, and perceived stigma and discrimination is often a major barrier to engagement with services. Services need to understand complexity and be specialised and accessible with early prevention and joined-up social support.

6 Service User Perspective[5]

As part of the needs assessment the voice of services users and people with lived experience is a crucial part of truly understanding need. A user group of past and current service users, facilitated by CGL was held to understand some of the barriers to support and recovery, and what works, and its findings were captured. This exercise revealed some of the barriers to support and recovery which should be explored when developing services.

Source: Change Grow Live Service User Group

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[5] Section 9 of full Birmingham Substance Use Needs Assessment 2021

7 Recommendations[6]

7.1 Recommendations to promote a partnership approach

- Increase engagement with drug and alcohol users through targeted activity (e.g., women less likely to be picked up by services than men)
- Create/enhance pathways between substance misuse services and other services such as the secondary mental health services, CJS and primary care
- Continuation of specific pathways from police custody (e.g., from police healthcare)
- Data sharing to prevent duplication and more efficient progression through concurrent treatment services
- Continuation of a centralised service that links into related services so that clients with complex needs are offered treatment in a timely and orderly manner
- Specialist services should engage with mainstream treatment providers to encourage engagements and successful completions in treatment
- Embed service user voice in treatment planning, evaluation, and service design
- Substance misuse should be included in future inclusion health (inequalities team) needs assessments and deep dives to highlight inequalities and intersectionality in vulnerable groups. For example: sex workers, mental health. This will lead to increased understanding and awareness of the challenges faced by these vulnerable groups

7.2 Recommendations to improve access to services

- A single case-management system that is used by all service providers across Birmingham. This would improve staff efficiencies, reduce administrative inefficiencies, enhance client engagement, and experience, and improve access to services for potential clients
- Outreach programmes should be developed jointly by service providers, public health officers and substance misuse treatment service commissioners and coordinated between them to maximise contact with hard-to-reach communities
- Promote the presence and involvement of recovery champions across partnership organisations/services
- Locality based service provision for hot spots in the city

7.3 Recommendations to reduce harms and improve recovery

- Person centred approach offering individualised and flexible treatment, whilst acknowledging the socioenvironmental and demographic factors that cause inequalities related to substance misuse
- Promote client recovery through holistic treatment services that address wider determinants of health concerns (e.g., employment, housing)
- Harm reduction, maintenance and palliative care has been the focus within treatment services. More focus on recovery needs to be adopted within treatment services in Birmingham, in line with the National Drug strategy 2010 [234]
- More focus on prevention is needed, specifically on gateway drugs and alcohol in younger people and opiates in adults
- Improve awareness and knowledge of substance misuse in frontline (non-substance misuse) services by providing specialist training to staff

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[6] Section 12 of full Birmingham Substance Use Needs Assessment 2021

- Diversity and inclusion training to be a requirement for all staff in substance use service provision
- Ensure resources are distributed according to the level and specificity of substance misuse needs
- Focus on improving health-related outcomes. Spend per head is relatively low in Birmingham for substance misuse services but relatively poor for outcomes in comparison to statistical neighbours and core cities

7.4 Recommendations to improve knowledge and understanding of client base and local prevalence

- Data collection and quality needs to improve. This could be achieved by working with academic partners to collect qualitative and quantitative data on treatment interventions, outcome monitoring, recovery, and unmet need
- Data should be routinely collected in education settings (young people) to gather information on early substance use, which could improve the effectiveness of preventative programmes
- More representative data are needed to understand the behaviours associated with and the prevalence of substance misuse. The sample nationally and regionally is not representative of the clients in treatment. More research in and engagement with hard-to-reach communities is warranted, as well as in the general population
- More granular data needed on drug types other than opiate and crack cocaine. Targeted research on prevalence of drugs for which the prevalence is not well established (e.g., opiates, crack cocaine, GBL, cannabis and crystal meth)
- A working group should be formed between relevant bodies (e.g., commissioners, subject experts, service professionals, service users) to develop an action plan for the routine collection of specific data
- Undertake robust research on effectiveness of treatment interventions
- Undertake robust research on efficacy of prevalence and substance use monitoring in different settings (e.g., schools)
- Research should be conducted by independent organisations (e.g., academic and 3rd sector) to detach from institutions that are perceived negatively by respondents and therefore influence the validity of data (i.e., research should not contain words like "crime" that could have an influence on participants)
- Conduct a deep dive focusing on mental health in relation to substance abuse (dual diagnosis)
- Substance misuse should be included in future inclusion health (inequalities team) needs assessments and deep dives to highlight inequalities and intersectionality in vulnerable groups. For example: sex workers, mental health. This will lead to increased understanding and awareness of the challenges faced by these vulnerable groups

8 Limitations[7]

- Prevalence estimates at local authority level for drug types other than opiate, non-opiate and crack cocaine are not currently captured. More granular data are needed on a wider range of drug types
- NDTMS data are not always consistent with Fingertip's data, which leads to ambiguity and potential reporting errors
- High fidelity data are unavailable at a local and national level for prevalence by drug type across all ages
- Readers should be cautious when making generalisations based on the data and evidence in this needs assessment. Some of the data are not representative of the general population. Furthermore, the data were largely derived from PHE fingertips and NDTMS, precluding secondary analysis of the data
- The scale of the problem on substance misuse is likely an underestimate. Unmet need represents the proportion of individuals in need of treatment but who are not currently receiving specialist treatment for substance misuse compared to prevalence. Given the propensity for surveys on substance use prevalence to introduce sources of error and provide underestimates, this would result in a greater unmet need than currently reported
- Unmet need may also be influenced by temporal lag in reporting. NDTMS data for prevalence after 2016/17 is not available. Therefore, estimated prevalence of OCU and alcohol users beyond this year has been based on the 2016/17 prevalence estimate. Adults in treatment is however reported on till 2020/21. The paucity of up-to-date available data may contribute to an underestimated unmet need

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[7] Section 14 of full Birmingham Substance Use Needs Assessment 2021

Birmingham Substance Use Needs Assessment

December 2021

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Acknowledgements

Contents

1   Introduction

Drug and alcohol misuse is a major public health concern and socioeconomic burden, responsible for considerable healthcare expenditure in the United Kingdom (UK) [1]. The annual estimated cost to the NHS of treating drug misuse is approximately £500m [2], whilst the healthcare cost of alcohol misuse is estimated to be as much as £3.5bn per year [3]. The adverse impact on health is equally large, with 4,561 deaths (79.5 deaths per million) related to drug poisoning recorded in England and Wales in 2020 [4]. The impact also appears to be greater in the UK compared to other counties. In Europe, the UK ranked 11th highest for the number of years lost due to ill-health, disability or early death due to a substance use disorder and has the highest rate of people living with disability due to substance misuse.

With the effects of substance abuse pervading society, the challenges posed are increasingly great at the individual, societal and clinical levels [5]. Substance abuse impacts on physical and mental health, emotional well-being, familial and other relationships, education and career prospects, financial status, and criminal involvement.

The causes and consequences of substance misuse behaviours are complex and interrelated to such a large extent that they are almost impossible to separate. However, it is important to note that institutionalised and cultural norms predispose marginalised groups to higher rates of substance abuse, poorer health outcomes and social stigma [6–9]. The bidirectional nature of the impact of substance abuse further complicates the issue. The consequences of substance misuse may be exacerbated by socioeconomic inequalities whilst psychosocial and environmental consequences may increase vulnerability to inequalities in social determinants of health [10].

Given the complexity of drug and alcohol addiction and the increasing need to combat endemic substance misuse in Birmingham and indeed nationally, this needs assessment provides a necessary update to the 2013/14 publication [11].

1.1 Aims and Objectives

The aim of this needs assessment is to establish an evidence base to support the 2021/22 treatment planning process, including identifying the level of need in the population, and gaps and barriers in service provision prior to re-commissioning substance misuse treatment services. In order to achieve the aims, the specific objectives were to:

1) use epidemiological approaches and a broad range of quantitative and qualitative data sources to comprehensively and comparatively assess the needs of the population of Birmingham in relation to alcohol and drug use
2) Identify gaps in service provision and areas of unmet need and inequalities, and
3) Make recommendations to address the needs of Birmingham in future service commissioning.

1.2 Drug type descriptions and impact on health

1.2.1 Club drugs

Club drugs refer to Methylenedioxymethamphetamine (MDMA also known as ecstasy), Methamphetamine, Lysergic Acid Diethylamide (LSD), Ketamine, Gamma-hydroxybutyrate (GHB) and Flunitrazepam.

These substances, primarily used in recreational settings such as night clubs, have diverse psychotropic effects with varying levels of toxicity, dependence and adverse health outcomes [12]. Whilst these substances are collectively known as "club drugs", their pharmacological classifications vary giving rise to their distinct pharmacokinetic and pharmacodynamic properties [13–15]. Broadly these drugs can be categorised as having hallucinogenic properties (e.g. ketamine, LSD and GHB), stimulant properties (e.g. methamphetamine) or both (e.g. ecstasy). Previous research suggests that the stimulant and hallucinogenic effects enhance the "rave" experience by increasing sensory perceptions and the ability to dance all night [13]. Drugs such as GHB, Rohypnol® and ketamine also have anaesthetic properties in high doses [16], which can lead to loss of consciousness and short-term memory loss [17]. The sedative properties of these substances make them dangerous "date rape" drugs.

Despite the risk of severe adverse health outcomes and even death, individuals continue to use club drugs due to social and cultural factors and poses a considerable public health problem. Club drugs are relatively inexpensive and accessible, and their ability to enhance the rave experience together with their social acceptability and perceived benign nature appear to be the key reasons for their continued popularity [18–20].

1.2.2 Cannabis

Since the mid-1990s, cannabis has been the most commonly used illicit drug in England and Wales [21]. Whilst the evidence for cannabis offering a range of medical benefits is growing [22], it is still seen as a particularly dangerous drug [23] due to its harmful characteristics, risks of abuse and limited therapeutic value [24].

Cannabis is rapidly absorbed, typically through inhalation, and its acute toxicity brings about mood changes from anxiety and arousal to calmness, detachment and diminished levels of consciousness and motivation. Psychotic symptoms are also common, such as irrational panic, fear of dying, and paranoia [25,26]. The dangers of cannabis are made worse through inhalation as the constituents of cannabis smoke carry cardiovascular and respiratory health risks similar to those of tobacco smoke [27]. Cannabis can also be ingested, although absorption may be erratic which can delay the onset and prolong the effects of its main psychoactive ingredient, tetrahydrocannabinol (THC). Overwhelming evidence now shows that prolonged and long-term use leads to both physical and behavioural cannabis dependence in 7-10% of users [28]. Given that early onset of use is a strong predictor of future dependence [28], it is a major public health concern that cannabis use amongst adolescents and younger adults continues to increase [21].

1.2.3 Cocaine

Cocaine has a long history of being used as an anaesthetic in medicine [29]. However, its use as a recreational stimulant predisposes users to serious heart conditions and blood disorders as 'street cocaine' may be contaminated with other local anaesthetic agents [30]. Its addictive properties also makes it the second most abused drug in England and Wales [21].

Recreational doses of cocaine lead to temporary increases in noradrenaline and dopamine with levels then dropping below normal concentration values. Initially, users experience euphoria after taking cocaine before entering a state of depression. These mood states are related to the rise and subsequent decline in neurotransmitters [31].

The consequences of cocaine use are not confined to mood states. Cocaine adversely affects several biological systems, including the sympathetic nervous system, cardiovascular system, endocrine system and triggers neurological episodes such as anxiety, paranoia and psychosis [30,32].

Cocaine is consumed mainly in one of two forms. The powder form is inhaled through the nose "snorted" or injected and is absorbed slowly producing prolonged effects. Crack cocaine, a more potent crystalline form of cocaine, is typically smoked allowing it to be absorbed more rapidly resulting in intense yet transient highs [31]. Whilst the use of crack cocaine appears to be negligible, powder cocaine continues to be a commonly used drug in England and Wales [21], likely due to its relative low cost and reputation as a fashionable social drug.

1.2.4   Opioids

Opioids are a broad class of pain-relieving drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and legally available prescription pain relievers such as oxycodone. When opioids travel through your blood and attach to opioid receptors in your brain cells, users experience muffled perceptions of pain and elevated levels of pleasure [33]. However, these effects that make opioids effective medications for treating pain also make them dangerous when used recreationally. At lower doses, opioids have a profound sedative effect and cause nausea, vomiting and constipation, and at higher doses they can inhibit respiratory structures and induce respiratory depression leading to potentially fatal breathing complications [34,35].

Heroin, the most popular illicit opioid, can be administered in several ways (e.g. injected, snorted, smoked and consumed orally). It is an extremely addictive substance that is synthesized from the opium poppy plant. Recent research has indicated that heroin abuse has increased at an alarming rate due to its accessibility and more permissive societal views as an initiating opioid (i.e. heroin used as the first opioid). This increase amongst inexperienced opioid users could lead to increased rates and risks of overdose [36].

Consequently, opioid abuse, including the abuse of prescription opioids and illicit substances like heroin, presents a major public health challenge and substantial economic burden in the UK and Europe [1].

1.2.5   Anabolic steroids

Developed initially as a performance-enhancing drug for athletes, anabolic steroids have become increasingly popular in the general population. There has been greater interest, availability and usage of performance-enhancing drugs over the past twenty years due to advancements in technology and pharmacology as well as the expansion of the internet [37,38]. Anabolic steroids are used illicitly to enhance muscle growth and strength, physical activity and sport performance, and for aesthetic purposes [39].

However, there are adverse health impacts of anabolic steroid use ranging from cosmetic (e.g. acne, striae, gynaecomastia) to life-threatening (e.g. organ failure) [40]. Expert statements have recently highlighted the harmful effects of anabolic steroids on various

organs and biological systems [41], however, the greatest health impacts appear to be on the cardiovascular system [42]. Given that anabolic steroids are typically administered through injection, users also have an additional risk of contracting blood borne viruses, although the risk of transmission amongst steroid injectors is low due to hygienic practices and low levels of sharing [43].

The causes and drivers of illicit anabolic steroid use in the UK are complex and not fully understood, resulting in a growing issue for public health departments [44].

1.2.6   New Psychoactive Substances

New psychoactive substances (NPS) are newly available synthetic substances that mimic the effects of existing drugs [45]. As a means to circumvent the law, they were originally known as "legal highs" but their supply, production and import have since been made illegal under the Psychoactive Substances Act 2016.

The full extent of bodily damage caused by NPSs is still to be determined as many of these drugs have unknown effects in addition to their intended effect. The risk to users is therefore unpredictable and extremely dangerous [46].

Synthetic cannabinoids (Spice/Mamba) act on the same brain cell receptors as the mind-altering ingredient in marijuana (THC) and are the most commonly used NPS. Some of them are known to bind more strongly to the cell receptors affected by THC and can produce much stronger and unpredictable effects. Cannabinoids are the most common cause of drug related admissions for mental and behavioural disorders [47].

NPSs continue to present a public health concern as they are deliberately misbranded in attempts to evade regulatory frameworks. Users are therefore susceptible to considerable health and criminal justice harms and, despite efforts to restrict supply, NPSs are still available through illicit means [48].

1.2.7   Prescription Medication

A prescription medicine or Prescription Only Medicine (POM) is a drug that requires a medical prescription in order to be legally dispensed by a medical practitioner, dentist or by qualified nurses or pharmacists [49]. The use of POM is essential for the treatment of various conditions such as diabetes, epilepsy, neurological disorders, and pain management. Using POMS without prescription, for longer/in greater amounts than instructed or in any other way not directed by healthcare professional is considered misuse [50]. The Human Medicines Regulations 2012, regulation 62(3) for drug classification, sets out the criteria used to classify drugs. This includes criteria addressing danger to human health if drugs are used incorrectly. Drugs can be re-classified if there is new evidence to support changes to classification, especially if there is a risk to human health which may lead to death if misused. In the UK, Diclofenac was re-classified upwards from non-prescription to POM due to a newfound cardiovascular risk being identified that made it unsafe for self-medication [51].

In 2018/19, 6.4% of adults in England and Wales aged 16 to 59 misused prescription-only painkillers for medical reasons while 0.2% used it solely for the feeling or experience it gave them. Painkiller misuse is more common in 16 to 25 year-olds and is associated to alcohol misuse [52] . Evidence suggests that being prescribed prescription-only opioids during adolescence is associated to future opioid misuse in adults with little or no previous history of misuse [53]. This may be due to the addictive neurological qualities of some of the opioid based POM's. People with long-standing illnesses or disabilities are more likely to have misused prescription-only painkillers for medical reasons [52]. The 2015 National Survey on

Drug Use and Health (NSDUH) showed a similar trend: among adults who misused POM pain reliver at least once a year, 63.4% did so to relieve physical pain. Other reasons for prescription-only pain killer misuse include to feel good or to relax and relieve tension [50].

1.2.8 Alcohol

Illicit drug use has well-known harmful effects; however, alcohol has a greater detrimental impact on health globally. Alcohol contributes to 5% of disability adjusted life years, which is comparably larger than the impact of illicit drug use on global disease burden; illicit drugs add 1.4% disability-adjusted life years [54]. This highlights the considerable influence of alcohol on health at a population level, which continues to be a major public health concern and socioeconomic burden [55].

Whilst the adverse health outcomes associated with alcohol abuse are well known, the last thirty years of research has revealed that alcohol has a more severe and complex influence on health that previously thought. This has led to policy changes in the UK, when in 2016 the government updated alcohol consumption guidelines and reduced the recommended maximum number of units per week to 14 for men and women [56].

Unlike illicit drugs, alcohol can be consumed safely in small doses, although it is important to note that it can directly and indirectly affect virtually every organ system in the body and it is detrimental to health in higher doses [57].

Specific harmful effects of alcohol include damage to the heart and elevated blood pressure and increased risk for heart failure and stroke. Excessive alcohol consumption can cause damage to various tissues, bring about negative physiological changes, and impair hormonal and biochemical regulation of a variety of cellular and metabolic functions. High alcohol intake over a longer period of time can also increase risk for developing alcohol dependency syndrome [57]. Alcohol exposure over a longer period also increases the risk for certain cancers. Finally, acute and chronic alcohol use significantly increases the risk for accidental injuries and impairs the recovery from those injuries [58].

Despite stricter policy changes, and medical and scientific advances, alcohol abuse continues to challenge public health services. This may in part be due to the approaches taken, whereby individuals have typically received palliative care rather than preventative treatment, and population-based public health approaches have largely been neglected [55].

2 Background & Policy

2.1 National & International Drug Policy Overview

From Harm to Home 2021 [59] was published in December 2021 to combat illegal drugs by cutting off the supply of drugs by criminal gangs and giving people with a drug addiction a route to a productive and drug-free life. The strategy is underpinned by investment of over £3 billion over the next three years.

National policy places the responsibility for the commissioning of drug treatment services as part of the recommended services commissioned through the local authority public health grant, however it is not a statutory service. Local authorities have responsibilities with regards to the NHS Constitution, under the 2012 legislation, to deliver drug and alcohol recovery services and are required to fund appropriate interventions as recommended by National Institute of Health and Care Excellence (NICE).

NICE have published guidelines on drug treatment and made recommendations about interventions at a system level that can influence drug misuse, but these are not government policy.

The World Health Organisation (WHO) identifies the world drug problem as both a public health issue and a safety and security issue, with different countries responding with their own balance between these two domains. The WHO recommends that drug use disorders are managed within the public health system, as the evidence shows this is what works best. In some countries the idea of including treatment of drug use disorders still meets resistance –partly owing to a delay in transferring science to policy. The WHO advocates a life course approach for prevention on the basis that intervention in the early years has most impact. The UK has taken a less liberal approach to drug decriminalisation. Spain, Italy, Portugal, and Luxembourg, there has been decriminalisation 'by law', meaning that the law does not foresee possession for personal consumption of some, or of any drugs (Portugal) as criminal offences.

There are some areas of substance use intervention and practice where there has been significant innovation internationally, especially in relation to heroin assisted treatment such as "safer injecting facilities". Drug consumption rooms, where illicit drugs can be used under the supervision of trained staff, have been operating for the last three decades and are now found in 11 European countries; Belgium, Finland, Switzerland, Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Portugal and France [60]. The benefits of providing supervised drug consumption facilities may include improvements in safe, hygienic drug use, especially among regular clients, increased access to health and social services, and reduced public drug use and associated nuisance. There is no evidence to suggest that the availability of safer injecting facilities increases drug use or frequency of injecting. These services facilitate rather than delay treatment entry and do not result in higher rates of local drug-related crime [61].

A national outcomes framework is being put together, which will endeavour to set out a clear set of measurable goals, to deliver drugs programmes across the country (DHSC,2021).

2.2 The Dame Carol Black Review

"Government faces an unavoidable choice: invest in tackling the problem or keep paying for the consequences"

In 2019, Professor Dame Carol Black was appointed to undertake an independent review of drugs. This was to inform the government's approach to tackling harm caused by drugs. The review [62] examined the challenges posed by drug supply and demand in a £10 billion a year market, with 3 million users, serious violence, harm and exploitation. It also highlighted the declining quality and capacity of drug treatment services, with disproportionate premature death and entrenched drug use associated with deprivation.

The second part of the review [63], commissioned by the Department for Health and Social Care, focuses on prevention, treatment and recovery. The report's aim is to make sure that vulnerable people with substance misuse problems get the support they need. It makes a series of 32 recommendations for Government, Local Government and other organisations around key themes:

- Radical reform of leadership, funding, and commissioning
- Rebuilding services
- Increased focus on primary prevention and early intervention
- Improvements to research and how science informs policy, commissioning, and practice

The review has major implication for future responsibilities and service delivery. A Government response to the review and its recommendations has not yet been published but the BCC public health team working on drug and alcohol support is keeping track of national and regional responses to the recommendations to ensure that local plans and responses are updated at the earliest opportunity.

2.3 National & International Alcohol Policy Overview

The World Health Organisation published their Global strategy to reduce the harmful use of alcohol in 2010 [64] and at the World Health Assembly in 2019 it was agreed that the WHO would report on its implementation during the first decade of its endorsement. The WHO provides a Global Status Report [65] on Alcohol Policy, through the Global Alcohol Policy Alliance.

In 2018 PHE published guidance: "Alcohol: applying All Our Health" [66]. This focuses on work to reduce alcohol harm in professional practice and action that can be taken by front-line health and care professionals. It also outlines actions that can be taken by both management and strategic leaders. The primary measures of the impact of alcohol harm are found in the Public Health Outcomes Framework Indicators (alcohol-related admissions to hospital and successful completion of alcohol treatment).

The most recent National Institute for Clinical Excellence public health guidance (NICE PH24) provides guidelines on prevention and identification of alcohol use disorders among people over 10 years old. It includes recommendations on price availability and marketing, support, screening and referral.

The UK Government Alcohol Strategy [67] was published in 2012. The strategy announced minimum unit pricing; however, this was subject to a U-turn in 2013 and there has been no alcohol specific strategy since. The strategy promotes measurable, evidence-based prevention activities at a local level, and national ambitions to reduce harm.

3 Local Geographical Area and Population Demographics

To understand need, we must first understand our population. Birmingham is the largest local authority in Europe, with a resident population of 1,140,525 as of 2020 (an increase of 67,480 [6.3%] since 2011) (Figure 1).
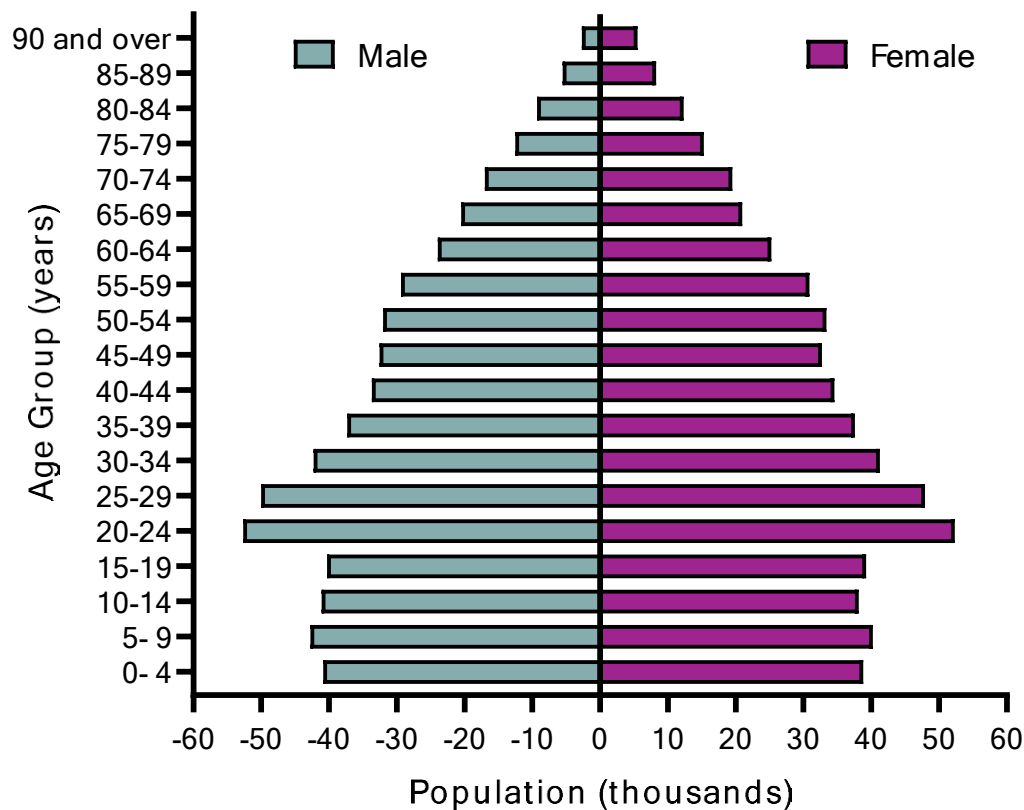
Figure 1: Birmingham population pyramid by age (ONS mid-year population estimates 2020)

Birmingham is made up of 69 Wards, 10 constituencies and 5 localities. It is a young and an ethnically diverse city, which presents many unique opportunities. However, Birmingham has higher than average levels of deprivation compared to the rest of England: 40% of Birmingham's population live in the most deprived decile areas in England (IMD 2019).

Birmingham Demographics

Population Growth

3.7% to 1,199,533 in 2031
8.2% to 1,251,689 by 2043

15,208 Births + 9,883 Deaths

5,325 more Births than Deaths

Biggest Growth of 15%

Growth in 80's and over

Youngest city in Europe

40% Aged Under 25yrs

Median Age 32.7yrs

Population Size
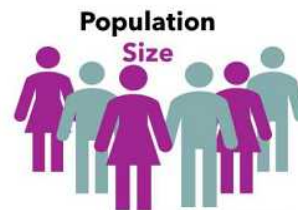
Estimated 1,140,525 Residents

White	570,217
Mixed	47,605
Asian	285,640
Black	96,360
Other	21,804

Census 2011 Population Estimates

0   200,000   400,000   600,000
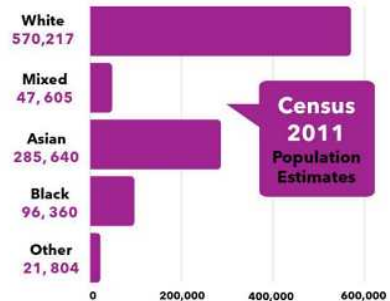
4 National Prevalence estimates

4.1 Client Classification

4.1.1 Drugs

For prevalence data, individuals presenting to adult alcohol and drug treatment services are categorised by the substances they cite as problematic at the start of treatment [68]. They are categorised by the following hierarchal criteria:

- any mention of opiate use in any episode would result in the client being categorised as an OPIATE client (irrespective of what other substances are cited)
- clients who present with non-opiate substances (and not opiates or alcohol) will be classified as NON-OPIATE ONLY
- clients who present with a non-opiate substance and alcohol (but not opiates) recorded in any drug in any episode in their treatment journeys will be classified as NON-OPIATE AND ALCOHOL
- clients who present with alcohol and no other substances will be categorised as ALCOHOL ONLY

The classification method is illustrated in Figure 2.
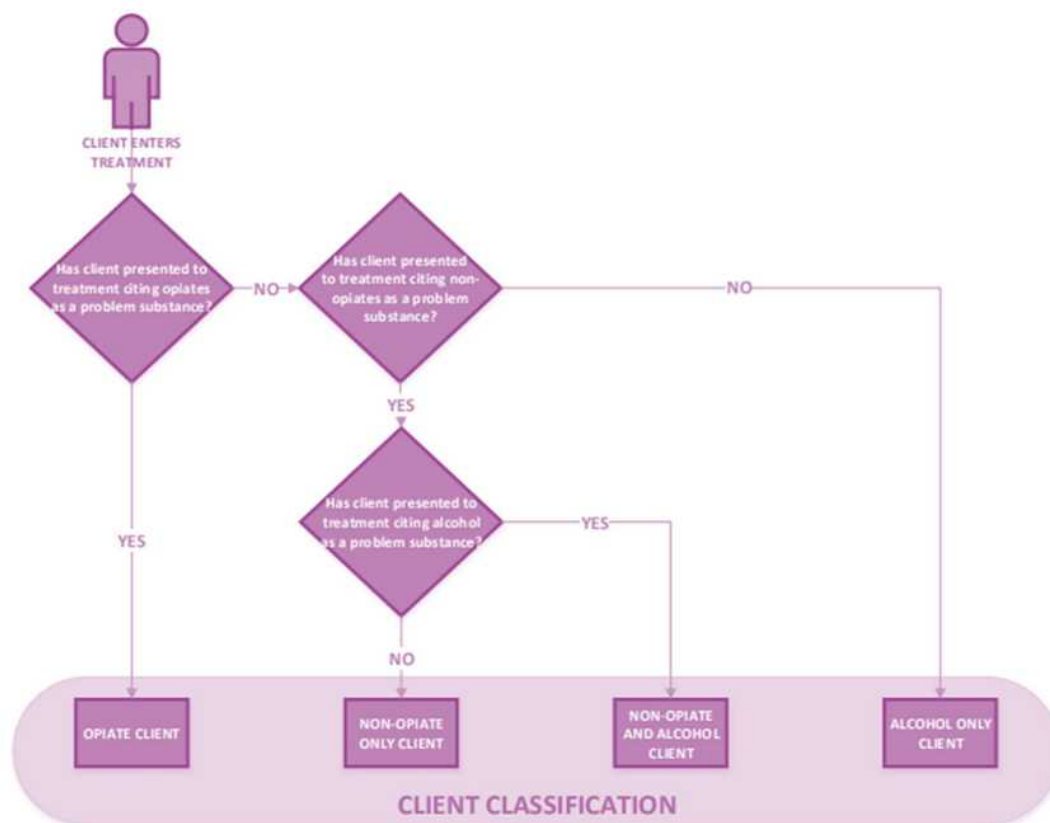
Figure 2: Classification Method for Clients Entering Drugs and Alcohol Treatment [68]

4.1.2 Alcohol

Harmful drinking (high-risk drinking) is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. Alcohol dependence is characterised by craving,

tolerance, a preoccupation with alcohol and continued drinking despite harmful consequences (e.g. liver disease or depression caused by drinking) (NICE CG115).

4.2 Alcohol misuse in the general population

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society £21 billion annually [69].

There are around 600,000 dependent drinkers in England [70] despite a 17% decrease in prevalence between 2014/15 and 2019/20 [71]. Of these, most (82.3%) are not in treatment at a specialist alcohol service [72].

Of the 74,213 people in treatment in 2019, around 39% (28,902 people) [73] successfully completed their treatment. Successful completions are users that complete alcohol treatment in a year and who do not re-present to treatment within 6 months.

Alcohol is responsible for a large proportion of hospital admissions. In 2018/19 there were 1.26 million hospital admissions for alcohol related conditions in England, which equates to 23.7 admissions per 1000 people in England [74]. This includes those solely caused by alcohol consumption such as alcoholic liver disease and acute alcohol intoxication, as well as conditions where it is known that a proportion of the cases are caused by alcohol consumption such as circulatory diseases and certain cancers.

There have been significant increases in the rate of alcohol-specific deaths in people aged 55 to 79 years since 2001[75]. Between 2017 and 2019 there were 17,357 recorded deaths from alcohol-specific conditions which is 10.9 deaths per 100,000 people (directly age-standardised rate[1]). Alcohol specific conditions are those where alcohol is the sole known cause, such as alcoholic liver disease. The rate of alcohol-specific deaths in males (14.9 per 100,000) is significantly higher and more than double the rate for females (7.1 per 100,000) [76].

These statistics show the significant and wide-ranging impact of alcohol consumption and alcoholism across England. It is negatively impacting on NHS resources and on the population's health, particularly in terms of life expectancy and quality of life due to serious alcohol-related health conditions.

4.3 Drug use in the general population

The UK is ranked within the top 10 European countries with the highest rates of any drug use, problem drug use and overdose deaths [77]. The total cost of harms related to illicit drug use in England was £19.3 billion for 2017-18, with drug-related crime being the main driver of total costs. There are also substantial social and economic costs associated with people with drug problems such as homelessness, unemployment, mental health and social care support provided to children and young people who are affected by drug use, including looked after children and safeguarding [78].

Additionally, the needs of people with drug dependence are often more complex than just the dependency itself. Almost a third starting treatment for problems with opiate use have housing needs and half have a mental health need [79]. Despite this, the capacity and quality of the treatment system has been in decline since 2013. More than half of people with the most harmful opiate and crack cocaine addictions are not engaged in treatment [80].

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[1] Directly standardized rates (DSRs) adjust for different age distributions in different populations and enable, the rates of disease or death between the populations to be directly compared

An estimated 1 in 11 adults aged 16 to 59 years had taken an illicit drug in the last year (9.4%; approximately 3.2 million people) [21]. This is higher for young adults with 1 in 5 people aged 16 to 24 having taken a drug in the last year, which is around 1.3 million people [52].

Cannabis is the most widely used illicit drug in the UK. 7.6% of adults said that they had used cannabis in the last year. It is the most reported drug in school surveys with 22% of 15-year-olds in England saying they had used cannabis [81].

There are an estimated 313,971 opiate and crack cocaine user (OCU) in England. At a national level, the combined numbers of people who take crack cocaine on its own, illicit opiates on their own and those who take both drugs, has risen by 4.4% between 2014-15 and 2016-17. Despite this, new incidences of heroin use have actually fallen continuously since 2005, while crack cocaine prevalence, has increased [82].

In England there are almost 200,000 people in treatment at specialist drug misuse services, a rate of 4.5 per 100,000 persons. The number of people coming into treatment for crack cocaine problems (without heroin) increased by 49% between 2014 -15 and 2017-18 [83]. There are clear differences in successful completion of treatment depending on the type of addiction. For non-opiates this is around 33.1% but for opiate users this is only 4.4%. Successful completions are users that left drug treatment free of drug(s) of dependence and who do not then re-present to treatment again within 6 months [84].

In 2019/20, there was a 5% decrease in admissions (7,027) for drug-related mental and behavioural disorders compared to 2018/19 (7,736), with a rate of 12.5 admissions per 100,000 people. There was also a 6% decrease in 2019/20 admissions (16,994) for poisoning by drug use compared to 2018/19 (18,053), with a rate of 30.5 admissions per 100,000.

Drug misuse is also a significant cause of premature mortality. Between 2018- 2020, 8,185 deaths from drug misuse were recorded in England, a directly standardised rate of 5.0 per 100,000. Deaths in males are significantly higher than that of females [85].

Drug use disorders are the fourth ranked cause of death in the 15–49 age group in the United Kingdom after cancers, cardiovascular disease, and suicide [86]. In 2020, the highest rate of drug misuse deaths was found in those aged 45 to 49 years, closely followed by those aged 40 to 44 years. Those born between 1970 and 1979, often referred to as 'Generation X', have consistently had the highest rates of drug misuse deaths for the past 25 years [87]. However, they are not the only age group affected, and nearly one in nine deaths registered among people in their 20s and 30s in England and Wales were related to drug misuse 2020 [88,89].

4.4 The Impact of the Pandemic

During the COVID-19 public health crisis, stressors such as social isolation, physical and financial insecurity, economic crisis, education, and job limitations (including redundancies) have occurred simultaneously [90,91]. These factors are traumatic and can potentially trigger psychological problems and changes in health behaviours, which can result in addiction and harmful alcohol consumption [91,92].

High-risk consumption of alcohol and the misuse of drugs are lifestyle factors can lead to detrimental health effects. For instance, harmful alcohol consumption can result in individuals becoming more susceptible to COVID-19 due to its effects on immunity and other health issues such as liver disease and cancer which may increase the likelihood of severe symptoms [93].

The use of high doses of opioids, whether illicit or prescription only, may cause respiratory depression, which can leave habitual users at a high risk of mortality from chronic respiratory diseases and COVID-19 [94]. Methamphetamine can reduce the production of antibodies and efficiency of white blood cells, which are essential for adequate immune responses [95]. People Who Inject Drugs (PWID) are a high-risk group for the transmission of COVID-19 due to factors such as poor hygiene and communal drug use, and produce lower levels of COVID-19 antibodies after infection [96].

During the national lockdowns alcohol was classified as an 'essential good' and available for purchase at alcohol retailers throughout the UK, making it relatively easy to purchase and evidence shows that harmful alcohol consumption at home has increased significantly [97,98]. From 2019/2020 to 2020/2021 there was a 24.4% increase in sales volume of alcoholic beverages drunk in places other than the place of sale [97]. The increase was sustained and consistent throughout 2020. Those who were already buying large quantities of alcohol before the pandemic were purchasing even more, 5.3 million litres more (14.3%) [97]. Subsequently there has been a 21% increase in alcoholic liver deaths with rates having accelerated rapidly across the duration of the pandemic [97].

In contrast, the flow of illicit drugs into the UK drug market may have been halted due to sudden temporary border closures during lockdowns [99]. This may have reduced the availability of street drugs to drug users. Preliminary data shows that there was a decline in the use of some drug during the first three month of the pandemic throughout Europe [99]. The closure of common recreational settings such as night clubs where club drugs are commonly in circulation and the social isolation and boredom resulting from national lockdowns and government guidance to 'stay home' may also contributed to this decline in drug circulation [99]. However, this reduction in supply may have also led drug users to alternative harder and/or more widely available drugs instead; for example, the use of prescription-only medication rose in Europe during the pandemic [99].

Research suggests that those who were already using drugs more frequently increased their consumption [99] with COVID-19 related anxiety contributing in part to this increase [100]. Anxieties and stressors such as worrying about the dangers of COVID-19, coming in contact with contaminated surfaces/objects, COVID-19 related compulsive checking and reassurance seeking, and a worry about the socioeconomic impacts of the pandemic were all associated with drug abuse [100].

In May 2021, it was reported that there was a 16.6% increase in the number of people in treatment for opiate use and a 77.5% increase in the number of deaths in treatment for the use of opiates during the pandemic [101]. A study of PWID during the pandemic showed that while they were appreciative of the effort services made to continue supporting them during the pandemic (such as relaxation of rules on taking opiate substitutes under supervision and home delivery of sterile injecting equipment), they also highlighted difficulties engaging with services which were not in-person, and with limited in person support, addictions may have worsened as a result [98]. However, Opioid Substitution Therapy (OST) services and home delivery needle and syringe programmes (NSP) were all viewed positively [98].

Evidence around the impact of the pandemic on substance use is still emerging and the longer-term impact on health and service demand is yet to be realised, however it is an important consideration in planning for future service and resource planning.

5 Local Prevalence and Health Burden

5.1 Prevalence

5.1.1 Alcohol

In Birmingham, the estimated number of dependent drinkers was 13,443 (95% CI: 10,654, 17,887) in 2018/19, which represents 1.58% (95% CI: 1.25%, 2.10%) of the adult population. This is higher than the England average (1.37%) [102].

An estimated 20% of all adults with alcohol dependence are parents [103], which would equate to around 2,700 alcohol dependent parents in Birmingham.

The proportion of people regularly drinking more than 14 units of alcohol per week (maximum recommended limit) was 12.2% in Birmingham, which was significantly lower than both the West Midlands (22.2%) and England (22.8%). Almost 11% of adults reported binge drinking in Birmingham compared to 15.1% in the West Midlands and 15.4% in England [104].

In the 28 days before entering treatment, 15% of people entering treatment had been drinking over 1000 units of alcohol. The highest proportion (20%) were drinking up to up to 199 units. 12% reported drinking no units in the 28 days prior to entering treatment [105].

Source: National Drug Treatment Monitoring System 2021
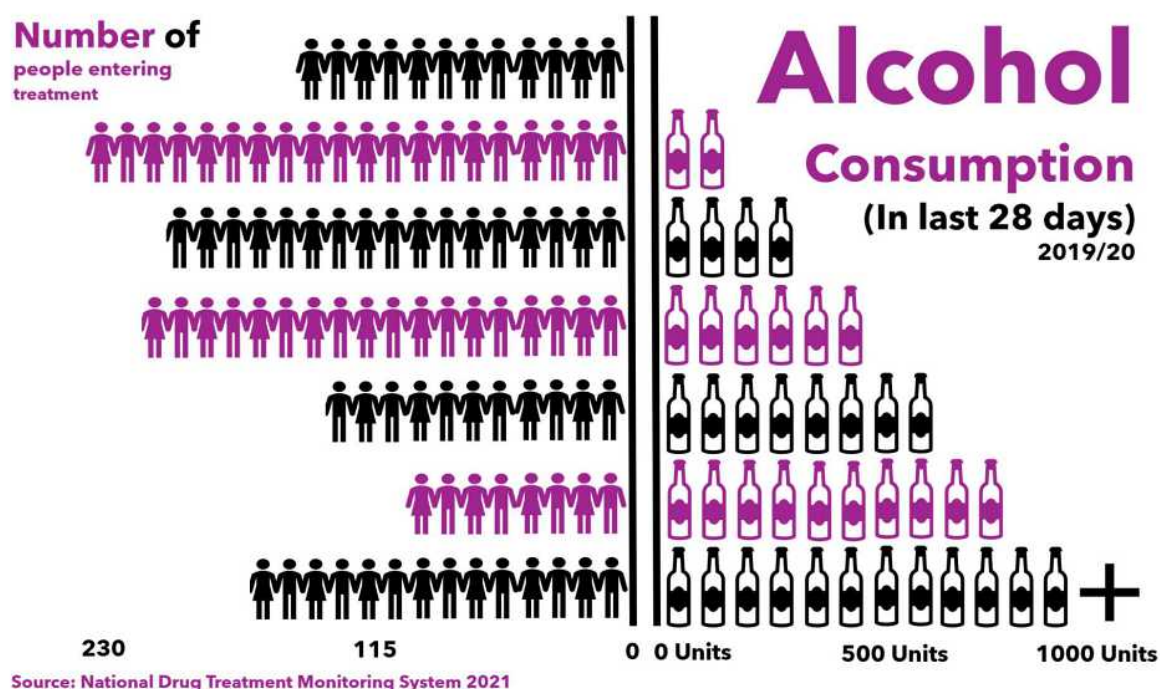
5.1.2 Drugs

The most recent estimate from 2016/17 indicates that there are around 10,525 problem drug users of opiate and/or crack cocaine (OCU) in Birmingham, of which there are an estimated 8,799 (opiate users and 6,817 crack cocaine users. The rate of OCU was 14.2 per 1000 people which is significantly higher compared to a rate of 8.85 for England and 9.61 for the West Midlands (Figure 3) [106]. Prevalence estimates at local authority level for other drug types is not currently captured nationally.

5.2 Hospital Admissions

	England	West Midlands	Birmingham
Hospital Admissions due to Alcohol (<18yrs)			
Hospital Admissions due to Alcohol (Adults)			
Hospital admissions due to substance misuse (15-24 years)			
Hospital admissions due to drug poisoning (Adults)			

Source: PHE: Knowledge and Intelligence Team and National Drug Treatment Monitoring System 2021
Values display the Age-Standardised Mortality rate per 100,000

Figure 3: Hospital Admissions due to Alcohol Consumption and Substance Misuse

5.2.1   Hospital Admissions due to Alcohol – Under 18s

Between 2017/18-2019/20, there were 150 admissions for alcohol-related disease, injury, or condition among underage drinkers. This equates 17.4 admissions per 100,000 people under 18 (13.5 in males and 21.5 in females). This is a lower rate than both the West Midlands (25.8) and England (30.7) [107].

5.2.2   Hospital Admissions due to Alcohol

In 2019/20, there were over 7,000 adult admissions to hospital due to alcohol. This is a rate of 763 admissions per 100,000 people (directly standardised rate). This was almost 3 times higher for males (1,117 per 100,000) than females (377 per 100,000). The overall rate for Birmingham was higher than the West Midlands region (622) and England (644) [108].

5.2.3   Hospital Admissions due to Substance Use - 15–24-year-olds

There were 280 admissions for all types of substance use among young people aged 15-24. This is 50.6 admissions per 100,000 people of that age. This is significantly lower than England (84.7) and the West Midlands (70.5).

5.2.4   Hospital Admissions due to Drugs - Adults

In Birmingham in 2019/20, there were 365 admissions with a primary of poisoning or drug misuse [109] (32 per 100,000 people). This is higher than the West Midlands and England averages of 29 and 30 per 100,000, respectively. There were 2,015 admissions where there is a primary or secondary diagnosis of drug related mental and behavioural disorders (181 per 100,000 people). This is also higher than the West Midlands (143) but similar to the England average (180.5). On average, men account for three quarters of these types of admission.

5.3 Deaths

5.3.1   Alcohol Deaths

Between 2017 and 2019, the alcohol specific mortality rate for Birmingham was 14.5 per 100,000 people (21.9 for males, 7.5 for females), which was higher than the rates for the West Midlands (12.9) and England (10.9). This equates to 384 deaths due to conditions which have been wholly caused by alcohol consumption.

In 2019, there were 370 deaths with alcohol recorded as an underlying cause of alcohol
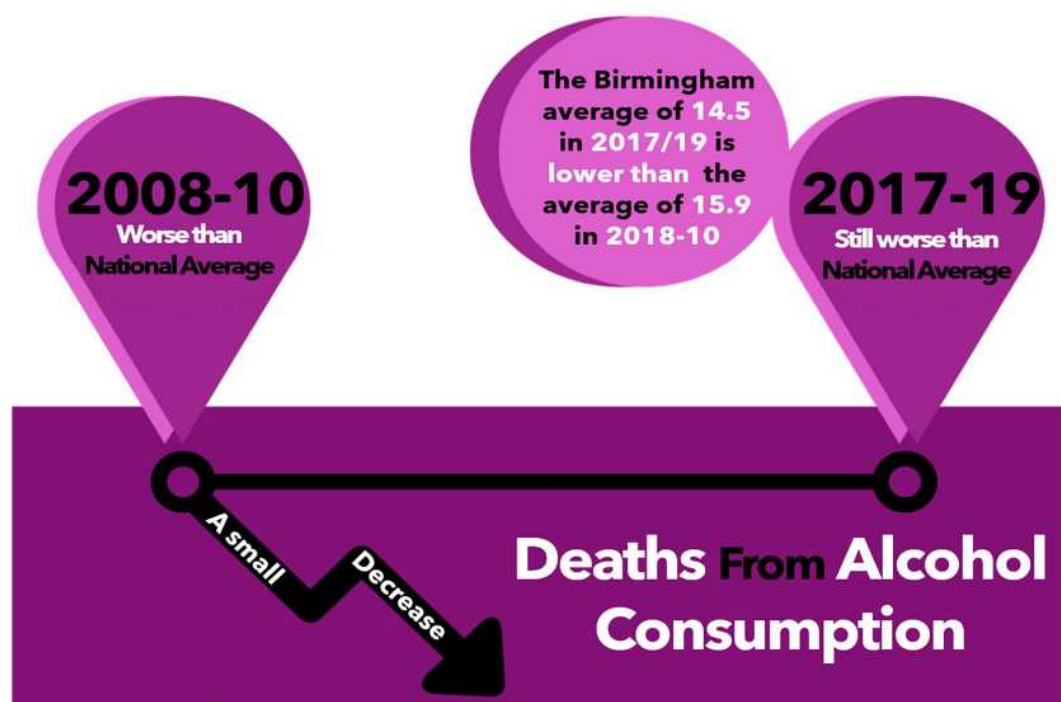
2008-10
Worse than National Average

The Birmingham average of **14.5** in 2017/19 is lower than the average of **15.9** in 2018-10

2017-19
Still worse than National Average

A small Decrease

Deaths From **Alcohol Consumption**

Source: Office of National Statistics (ONS) 2021
Values display the Age-Standardised Mortality rate per 100,000

poisoning. The rate for Birmingham (43.5 per 100,000) was higher than the rates for the West Midlands (38.6) and England (35.7) [110].

In 2018, there were a total of 7,386 years of life lost prematurely due to alcohol and the situation in Birmingham (815 years per 100,000 people) is worse than the West Midlands

(708) and England (637). The situation for years of life lost is worse for men (1,186 years per 100,000 men) than women (454 years per 100,000 women) [111].

5.3.2 Death from Drug Misuse

Between 2018 – 2020, there were 246 deaths recorded in Birmingham from drug misuse (80.0% were males, 20.0% were females). This equates to a rate of 7.8 deaths related to drug misuse per 100,000 people. The Birmingham rate is significantly worse than for England (5.0) and the West Midlands (5.3) [112]. Deaths related to drug misuse have increased by 211.4% (167 deaths) from its lowest point in 2010 – 2012.

Deaths have more than doubled since form 2010 to 2020

2010 Similar to National Average

Increasing since 2015

2020 Worse than National Average

Deaths from Drug Misuse

Source: Office of National Statistics (ONS) 2021

5.3.3 Deaths Related to Drug Poisoning

Between 2018 – 2020, there were 287 deaths recorded in Birmingham related to drug poisoning (78% were males and 22% were females). This equates to 9.2 deaths related to drug poisoning per 100,000 people: higher than the national average of 7.6 deaths per 100,000. Deaths related to drug poisoning have increased by 61.7% (177 deaths) from its lowest point in 2010 – 2012.

Deaths related to
Drug Poisoning
2018-2020

Birmingham is the
Worst out of the
West Midlands
Metropolitan County
Local Authorities
and **second best**
out of the Core Cities

Significant increase
in deaths in the last
ten years from 5.0
in 2008 to 2010 to
9.2 in 2018 to 2020

England
7.6

West Midlands
6.7

Core Cities
12.1

Birmingham
9.2

Source: Office of National Statistics (ONS) 2021
Values display the Age-Standardised Mortality rate per 100,000
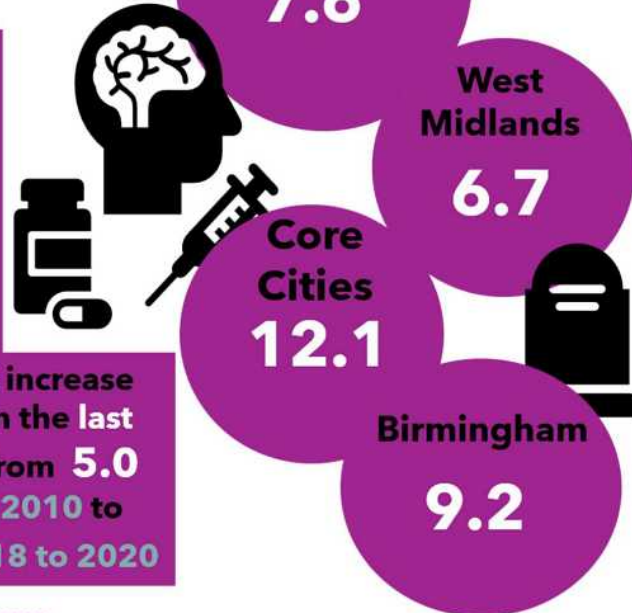
Birmingham has one of the lowest rates of death related to drug poisoning (9.2) between the period 2018 – 2020 when compared to Core Cities[2] in England. Newcastle (15.6), Liverpool (15.6) and Manchester (11.3) have the highest rates amongst the Core Cities, and most Core Cities exhibit similar upward trends to Birmingham over the past 10 years.

However, when Birmingham is compared to other West Midlands Metropolitan local authorities (regional average: 6.7), the city has one of the highest rates of deaths related to drug poisoning [113].

5.3.4 Deaths from drug use - under the age of 25

There were fewer than 15 deaths reported in Birmingham between 2017 - 2019 for persons aged under 25 years. Deaths in males were six times higher than that of females. Caution should be taken when interpreting these data as absolute numbers are low.

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[2] Core Cities is an association of 11 large UK cities: Belfast, Birmingham, Bristol, Cardiff, Glasgow, Leeds, Liverpool, Manchester, Newcastle, Nottingham. This analysis refers to English Core Cities as the data is for England.

6 Treatment and Recovery

6.1 Birmingham Commissioned Service Providers

In 2020, Birmingham City Council invested £14.8m in drug and alcohol treatment and support for all ages funded by the public health grant. A single system with a matrix of partnership providers has been commissioned to deliver these services. GP and pharmacy primary care, as well as the third sector, are part of the provider matrix. There is a range of services provided through this partnership including specific service elements focused on mental health, prison release, employment, criminal justice, blood-borne viruses, domestic abuse, acute sector, child protection and homelessness.

Birmingham City Council commissions two service providers to support substance misuse services in the city: Aquarius (Young People) and Change Grow Live (Adults). The Birmingham Substance Misuse Providers are displayed in *Figure 4*.

6.1.1 Provider Locations
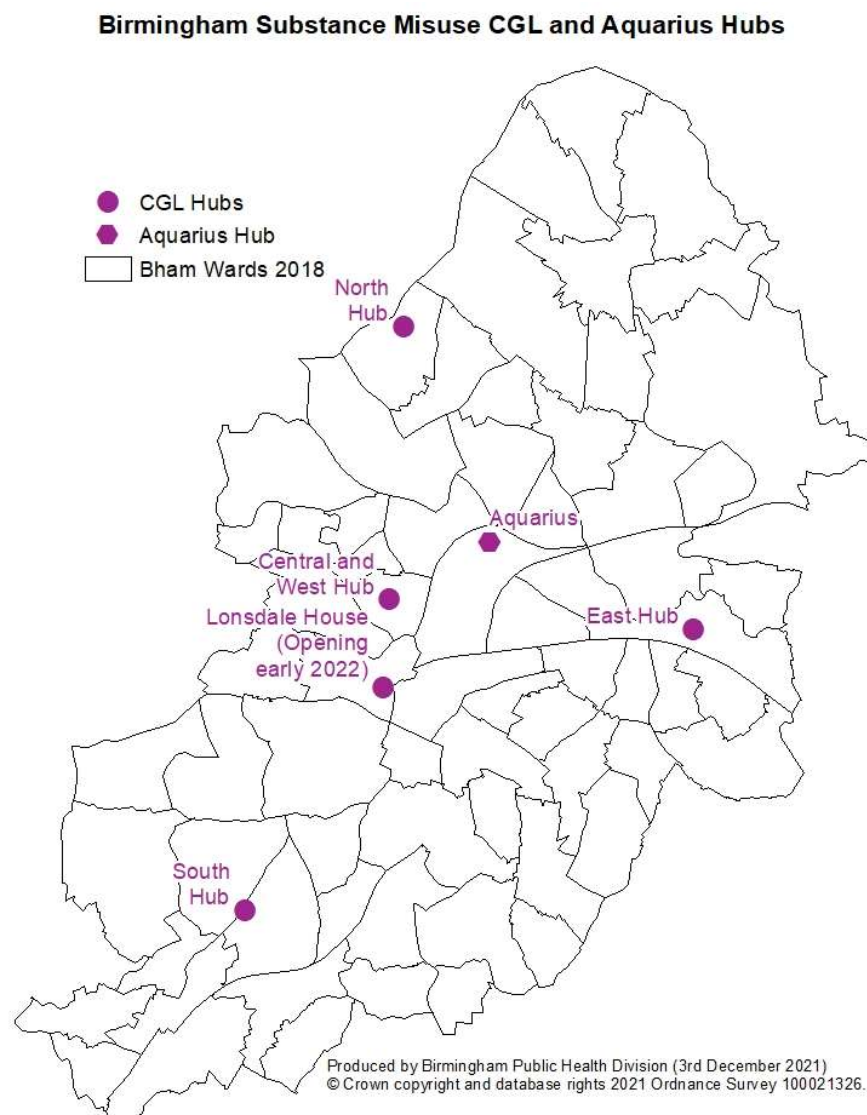
Figure 4: Birmingham Substance Misuse Provider Map

6.1.2 Aquarius Young Persons Service

The Young People's Service is delivered by Aquarius. An original 5-year contract ran from March 2015 – February 2020, with the option to extend for additional 1+1 years exercised, to align with re-procurement of the Adult Services.

Aquarius' head office is in Edgbaston. They work with young people aged under 18 years affected by substance misuse; either young people who are drinking or using drugs themselves OR who have a family member who drinks or uses drugs. Types of support can include:

- Information and advice about drinking and drug use
- A drop-in service
- 1:1 advice and interventions for children and young people using or at risking of using substances
- Structured, evidence-based psychological and psychosocial interventions and support
- Group work

Aquarius works in partnership with other organisations to deliver support including:

Forward Thinking Birmingham – consisting of a consultant psychiatrist, a clinical nurse specialist, and an assistant psychologist to assess and provide specialist support, including opiate substitute prescribing.
St Basil's – to work with young people who are affected by both substance use and homelessness.
Barnardo's – Child Sexual Exploitation worker in the Aquarius team for if there are concerns around both substance use and sexual exploitation
Youth Offending Team – there's an Aquarius Practitioner based in each of the Youth Offending Teams across Birmingham who work with young people if there are concerns around substance use (even if the offending isn't related to substance use).

6.1.3 Change Grow Live

Adult services are commissioned by Birmingham Public Health through a single provider: Change, Grow, Live (CGL). This was originally a 5-year contract March 2015 – February 2020, and a 2-year option to extend via delegated authority was exercised. In February 2021, Cabinet also approved a further 13-month extension due to Public Health supporting the Birmingham City Council COVID-19 response. The new contract end date is 31st March 2023, which aligns with the end of the Young People's contract in order for joint commissioning to take place.

The service is for adults (aged 18 years and above) experiencing difficulties with drugs or alcohol in Birmingham and has four community hubs across the city:
- South Hub, Bournville
- Central and West Hub, Newtown
- East Hub, Stechford
- North Hub, Great Barr
A further City Centre location – Lonsdale House - is due to open January 2022.

Change Grow Live have the following specialist teams:
- Homeless and Rough Sleeper Team working in partnership with the Rough Sleepers Initiative
- Women and Families Team based in Ladywood, female only access
- Hospital Team working across UHB Hospital Sites and City Hospital
- Criminal Justice Team based within CRC
- Criminal Justice Project

- Programmes and Throughcare Team based in all of the hubs and community venues

6.1.4 Needle Exchange

Needle Exchange was first introduced in England in 1985 in response to the HIV/AIDS epidemic. It is a facility where injecting drug users can obtain sterile injecting equipment and dispose of used needles in a responsible, hygienic, and safe manner.

Needle Exchange is a harm reduction method that is offered by many pharmacies in Birmingham. The needle exchange scheme also offers the opportunity for users to learn about safe injecting practises, equipment disposal, access into treatment services and education on drug use in general. This scheme is an opportunity for substance users, not currently in treatment to engage with someone who can provide advice and information.

Birmingham Public Health are supporting the efforts to educate injecting drug users as well as improving services that continue to prevent HIV infections. There is currently an extensive network of 85 pharmacy-based and 4 CGL locality hubs across Birmingham. For individuals who continue to inject, the needle exchanges provide a safe and confidential route for disposal of used works and provision of clean equipment. These services are having a recognisable impact in reducing the risk of spreading blood-borne viruses such as hepatitis and HIV. These services are also available to steroid users.

As well as safer injecting information, advice and general healthcare assessments, specialist needle exchange programmes are available to provide access to confidential Hepatitis B, Hepatitis C and HIV testing along with Hepatitis B vaccination. They also offer referral to prescribing and other health services including Hepatitis C and HIV treatment together with wound care advice and treatment [114].

Between January 2016 to September 2021, 7,138,340 needles have been distributed by pharmacies. There are three different types of packs:

1ml packs: contain 10 fixed needle syringes – these are usually 29G by 12mm and used directly into the vein (arms, feet, in between toes and fingers). Overall, 538,146 packs and 5,381,460 needles have been distributed, an average of 7,799 packs each month.
Deep vein packs: contain 10 x 2ml syringes. Steroid needles need to be thick as they are going through muscle and tissue (groins, thighs, buttocks). Overall, 122,957 packs and 1,229,570 needles have been distributed, an average of 1,781 packs each month.
Steroid packs: contain 10 x 2ml Low dead space (reduces the risk of BBV's) syringe barrels, 10 x green needles (21G x 1.5") and 10 x blue needles (23g x 1.25"). The longer needle 1.5" will be used for drawing up (getting the liquid out of the vial) and the shorter needle (1.25") to inject so in effect there are 10 needles in a pack. Overall, 52,721 packs and 527,210 needles have been distributed, an average of 764 packs per month.

6.2 Alcohol Treatment

6.2.1 Number in treatment

There were 1,470 individuals in treatment at specialist alcohol misuse services in 2020/21 in Birmingham, which is a 40% reduction since the peak number in 2013/14 [101].

6.2.2 Demographics of Alcohol Treatment Clients in Birmingham [115]

- Men accounted for 64% of the client base
- 51% were aged 30-49 years, 39% were over 50 years and 10% were 18-29 years of age
- Individuals from a white ethnic background made up the majority of clients (78%), followed by Asian (12%), Black (5%), Mixed (4%) and Other ethnic backgrounds (1%)
- The most reported disability was behaviour and emotional (27%)
- The majority stated no faith (47%), with Christianity making up 21%, Unknown 18%, Muslim 5%, Sikh 4% and Hindu 1%
- 90% identified as heterosexual, 7% not stated, 2% identified as gay/lesbian and 1% identified as bisexual
- 26% reported being in regular employment, 53% were unemployed, 19% had long-term sickness or disability, 1% in education and 1% other
- 7% reported housing problems and 1% had urgent housing issues
- 18% reported being a parent that lived with children, 21% were parents that did not live with children and 4% were not parents but lived with children
- Half of referrals for alcohol treatment were either self-referral or through family/friends, 30% were from health services and social care, and 11% were from the criminal justice services

6.2.3 Service User Geography

There is geographical variation in the numbers of clients accessing alcohol treatment across the City which may reflect variation in need and possible association with deprivation (see section 10.4) or other demographic variation such as ethnicity (see section 10.2).

As a number per 10,000 of the population, there are significantly more service users from Bartley Green, Lozells, Perry Barr, Stockland Green and Gravelly Hill (Figure 5).

Change Grow Live Alcohol Clients per 10,000
Source: CGL
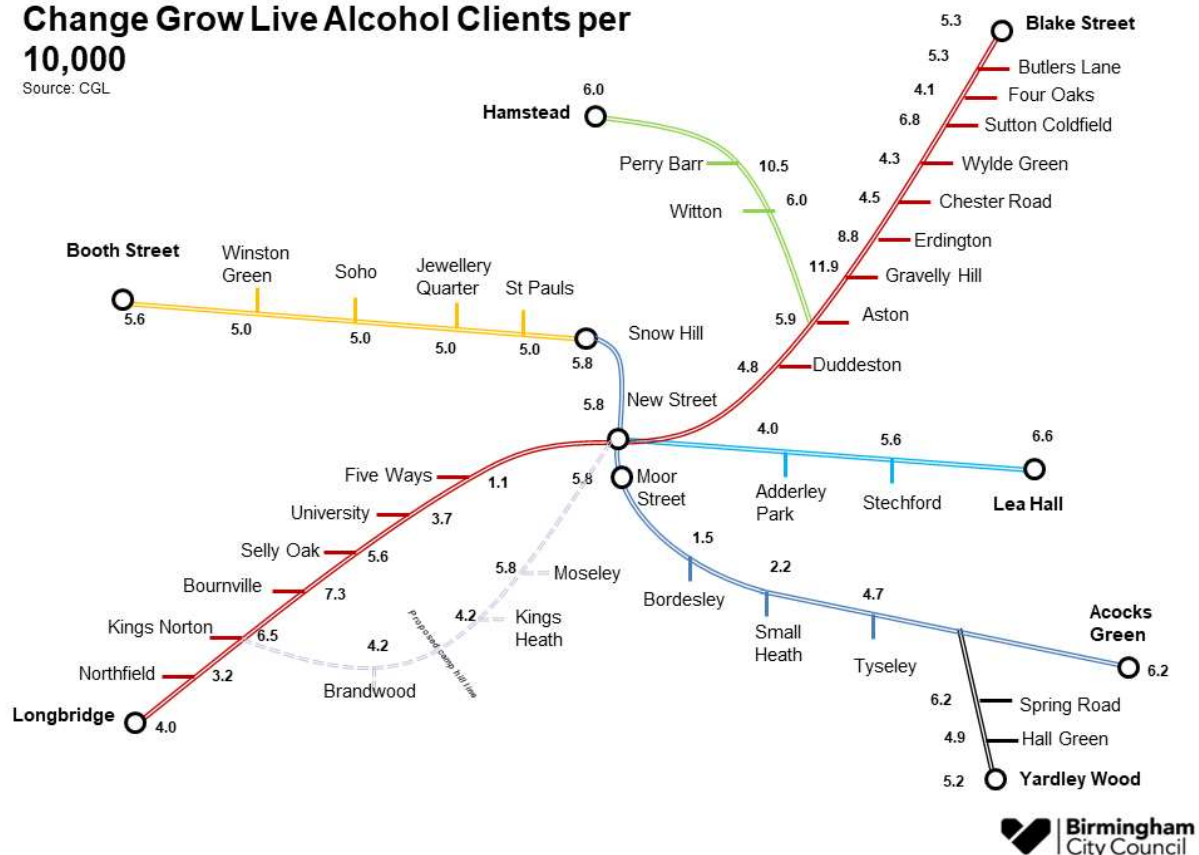
Figure 5: Alcohol Clients Train Map

6.2.4 Treatment Pathways and Service Provision

For the 1,100 people in treatment (with intervention recorded), the intervention provided is either psychosocial (e.g. talking therapy) or pharmacological (e.g. prescribed medication). 98% received psychosocial treatment either on its own or combined with pharmacological, and 11% for pharmacological treatment either on its own or combined with psychosocial.
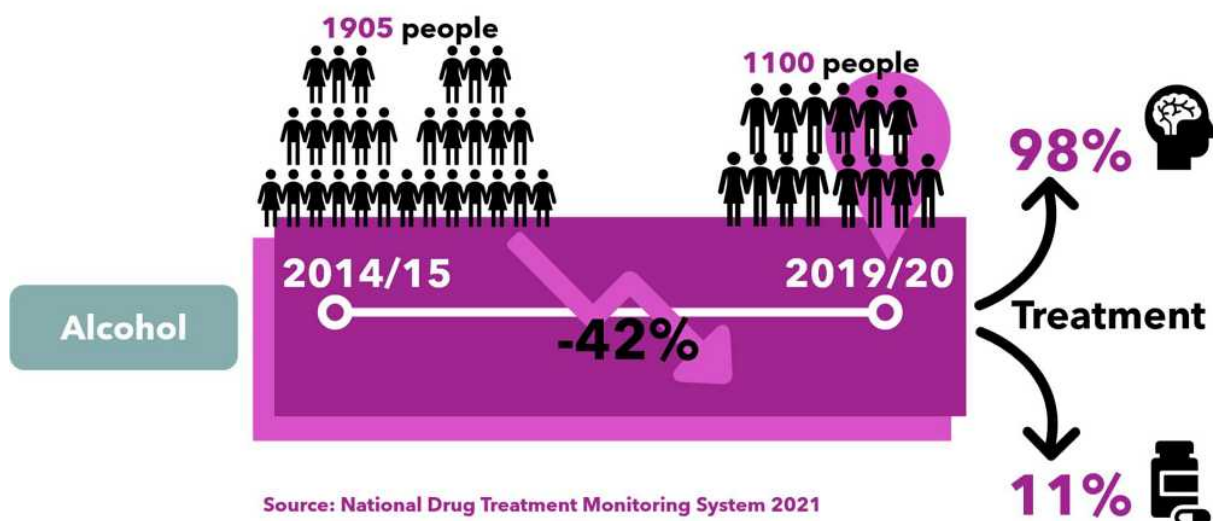
1,030 people were treated in the community, 30 in primary care, 40 in a residential setting and 55 were treated as inpatients. Of the inpatients, all 55 were receiving pharmacological

interventions and 45 also received psychosocial treatment. No one has received treatment in a recovery house since 2015/16 [116].

In 2019/20, 12.1% of those with alcohol dependence in Birmingham were in treatment but only 0.8% had to wait for more than 3 weeks for treatment [117].

6.2.5   Time in Treatment

According to the most recent data (2019/20) [118], 90.4% of alcohol users in Birmingham (n = 1140) are in treatment for less than 1 year . According to the most recent data (2019/20) [118]. 7.9% receive treatment for 1 to 2 years, and 1.8% for 2 to 4 years. None receive treatment for longer than 4 years.
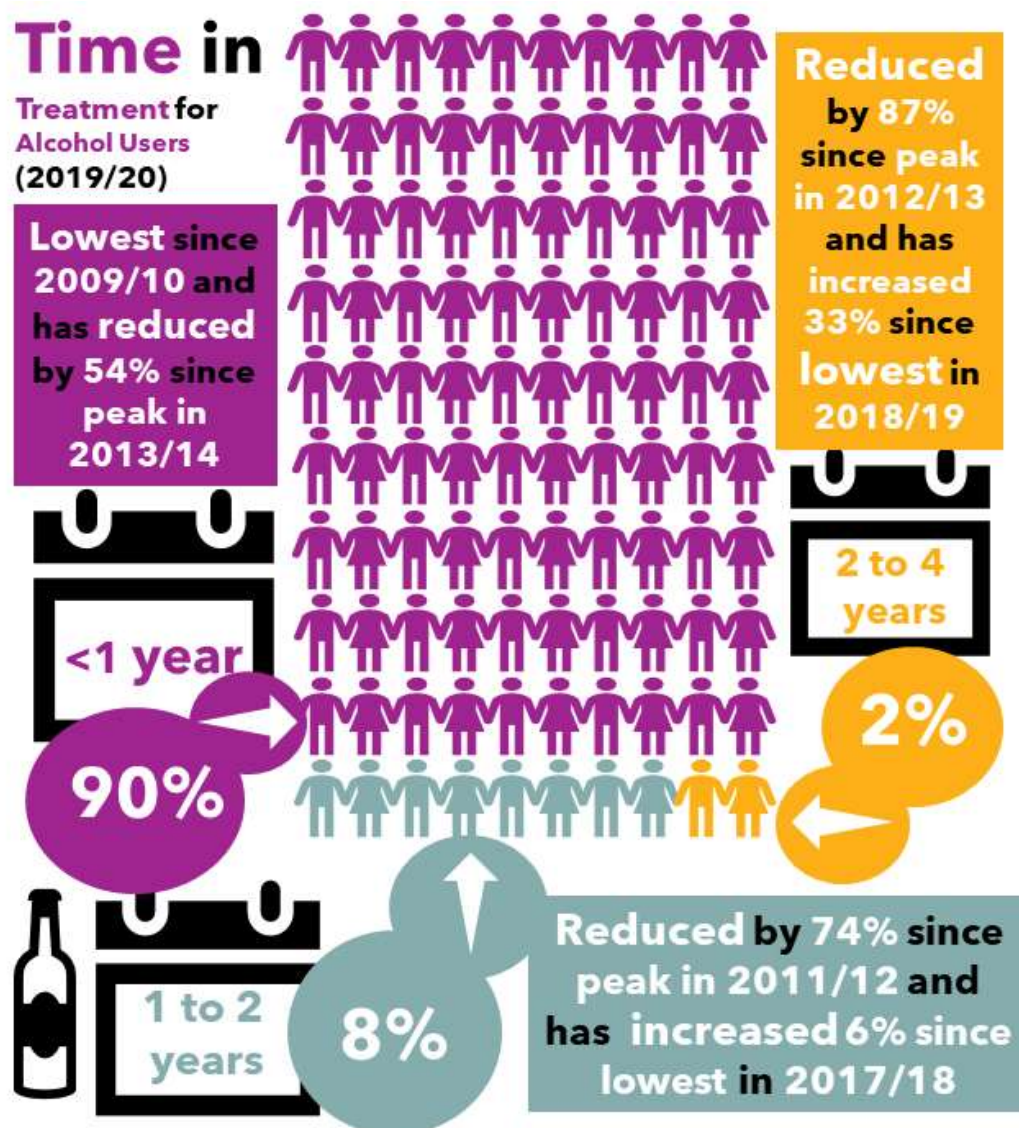
6.2.6   Successful Completions

Successful completion rate of alcohol treatment was lower for Birmingham (33.5%) than for the West Midlands (38.0%) and England (37.8%). 89% of completions were receiving treatment for under 1 year, 10% for 1 to 2 years, and 1% for 2 to 4 years [118]. For the successful completion of alcohol treatment ratio, where observed number is compared with expected (taking different variables such gender, age etc. into account), Birmingham was

similar to the expected ratio (0.90; 95% CI: 0.81 – 1.01) which was down from the 2018 ratio (1.15; 95% CI: 1.02 – 1.30) [119].

6.2.7 Deaths in alcohol treatment:

Between 2017-18 and 2019-20, there were 36 deaths in Birmingham for those aged 18 years and over and receiving alcohol treatment from a specialist misuse service. This represents a mortality ratio of 0.95; lower than the previous 3-year average ratio of 1.17 [120] and comparable to the national ratio (1.00).

6.2.8 Mental Health

In 2016/17, 47.0% of adults in specialist alcohol misuse treatment services were also receiving mental health treatment in Birmingham, a significantly higher proportion than both the West Midlands (25.0%) and England (22.7%) (*Figure 6*) [121].
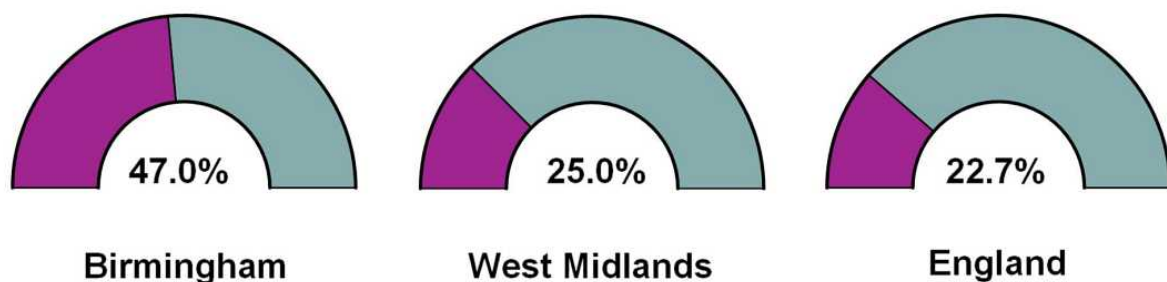
Figure 6: Percentage of Adults in Specialist Alcohol Misuse Treatment Services also receiving Mental Health Treatment

6.3 Drug Treatment
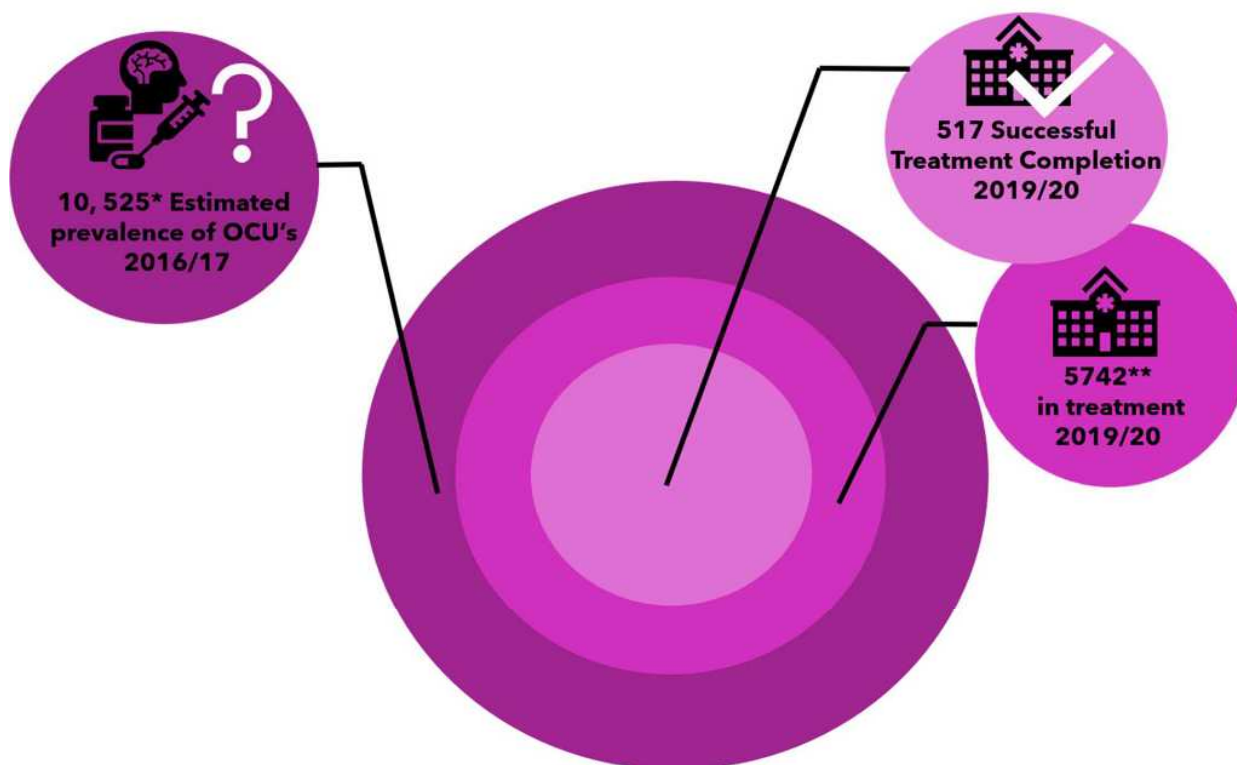
Source: National Drug Treatment Monitoring System 2021 and Adult Misuse Treatment Statistics
*most up to date data available
**all drug users

6.3.1 Number in treatment

6,388 individuals (aged 18+) were in treatment at specialist drug misuse services in 2020/21 in Birmingham. This represents a 19.3% (n = 1,370) reduction in number in treatment at a specialist misuse service in comparison to 2013/14 [122]. The number of clients in treatment by substance category were 4820 for opiates, 470 for non-opiate only and 450 for non-opiate and alcohol [118].

6.3.2 Demographics of Opiate Drug Treatment Clients in Birmingham[115]

- Men accounted for 76% of the opiate client base
- 78% of the opiate client base were aged 30-49 years, 16% were over 50 years and 6% were 18-29 years of age
- Clients from a white ethnic background formed the majority of the client base (75%), followed by Asian (15%), Mixed (5%), Black (3%), and Other ethnic backgrounds (2%)
- Over half (57%) reported a behaviour and emotional disability
- 48% stated no religion, with Christianity making up 19%, Unknown 16%, and Muslim 9%, other 3% and Sikh 1%
- 90% identified as heterosexual, 7% not stated, 2% as gay/lesbian and 1% as bisexual
- 8% reported being in regular employment, with one in three (75%) reported being unemployed, 16% had long-term sickness or disability, and 1% in other
- 10% reported housing problems and 6% had urgent housing problems

6.3.3   Demographics of Non-opiate Drug Treatment Clients in Birmingham[115]

- Men accounted for 74% of non-opiate service users
- 54% were aged 30-49 years, 39% were aged 18-29 years and 8% were over 50 years
- 68% of non-opiate users were from a white ethnic background, followed by Asian (13%), Black (11%), Mixed (7%), and Other ethnic backgrounds (1%)
- 57% reported a behaviour and emotional disability
- 53% reported no religion, Christians made up the next highest proportion of users (15%) alongside those who reported unknown (15%), then Muslim (10%) and other (3%)
- 87% identified as heterosexual, 6% not stated, 3% gay/lesbian and 2% as bisexual and other
- 33% reported being in regular employment, 54% reported being unemployed, 11% had long-term sickness or disability, and 2% in education
- 7% reported housing problems and 1% had urgent housing issues

6.3.4   Service User Geography

The residential location of CGL service users in drug treatment shows significant variation across the City which may reflect variation in need and possible association with deprivation (see section 10.4) or other demographic variation such as ethnicity (see section 10.2).

As a number per 10,000 of the population, there are significantly more non-opiate service users from Perry Common, Erdington, Lozells, Shard End and Garratt's Green wards than the average for Birmingham (*Figure 7*).

Figure 7: Non-opiate Clients Train Map

For opiate clients, the neighbouring wards of Holyhead, Handsworth, Birchfield, Lozells, Aston, Stockland Green and Gravelly Hill Ladywood, and Sparkbrook and Balsall Heath East have the significantly more service users per 10,000 of the population than the Birmingham average (*Figure 8*).
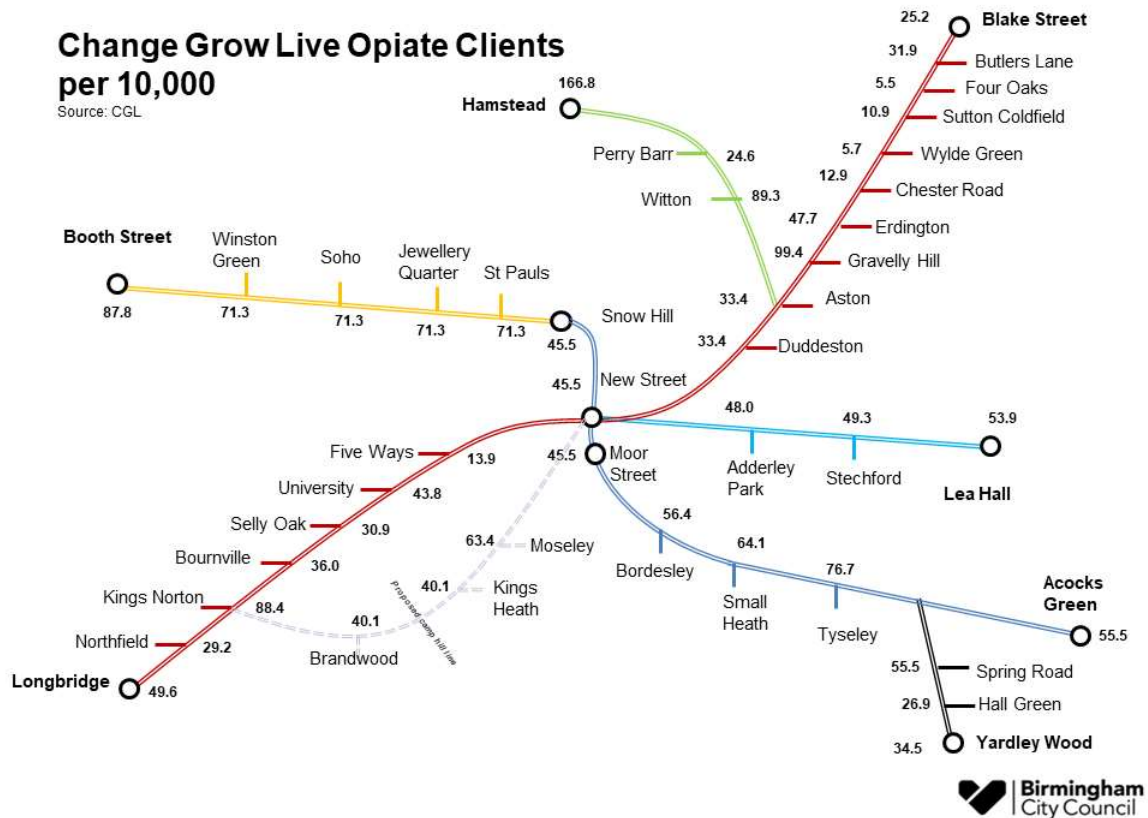
Figure 8: Opiate Clients Train Map

6.3.5 Treatment Pathways and Service Provision [123]

6.3.5.1 Opiate Users

For the people in treatment, most clients received both pharmacological (96%) and psychosocial (98%) treatment interventions.

5,090 people

4,795 people

Opiates

2016/17 — 2019/20

-6%

98% Treatment

96%

Source: National Drug Treatment Monitoring System 2021
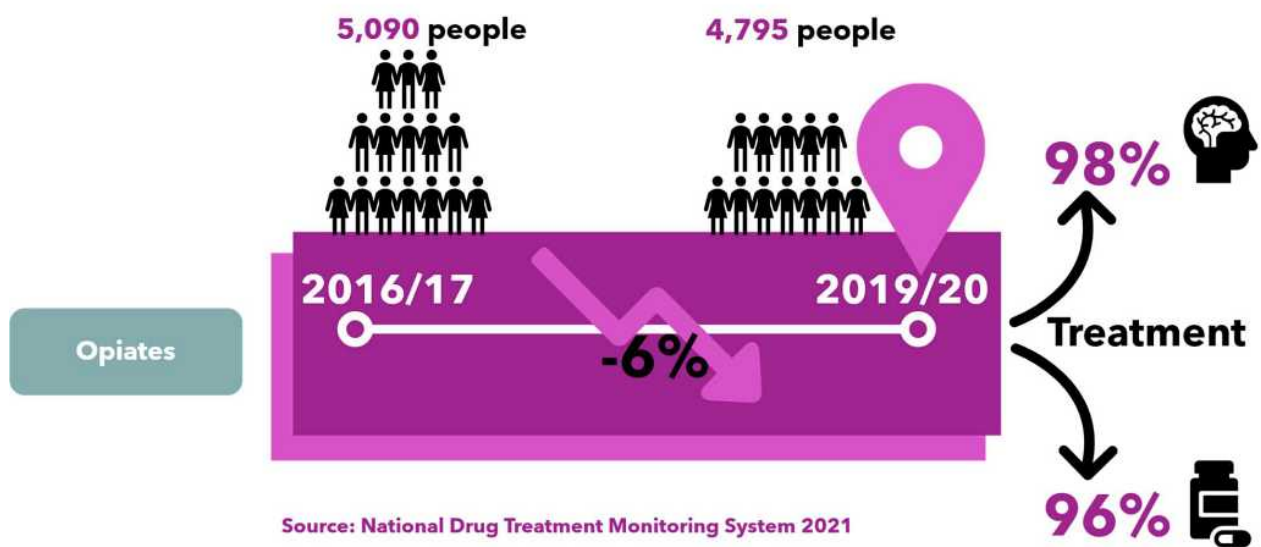
Out of the 4,795 clients, 4,110 were treated in the community, 1,080 in primary care, 115 in a residential setting and 165 were treated as inpatients.

10 individuals were waiting more than three weeks to commence treatment in 2019/20, which is proportionately better than the national figure (0.4% vs 1.2%, respectively). The number waiting over 3 weeks to commence treatment has fallen by 90% since its peak in 2010/11.

6.3.5.2 Non-opiate Users

99% of non-opiate users received psychosocial intervention (with or without pharmacological intervention) and 10% received pharmacological interventions (with or without psychosocial interventions).

715 people

460 people

Non-Opiates

2016/17 — 2019/20

-36%

99% Treatment

10%

Source: National Drug Treatment Monitoring System 2021
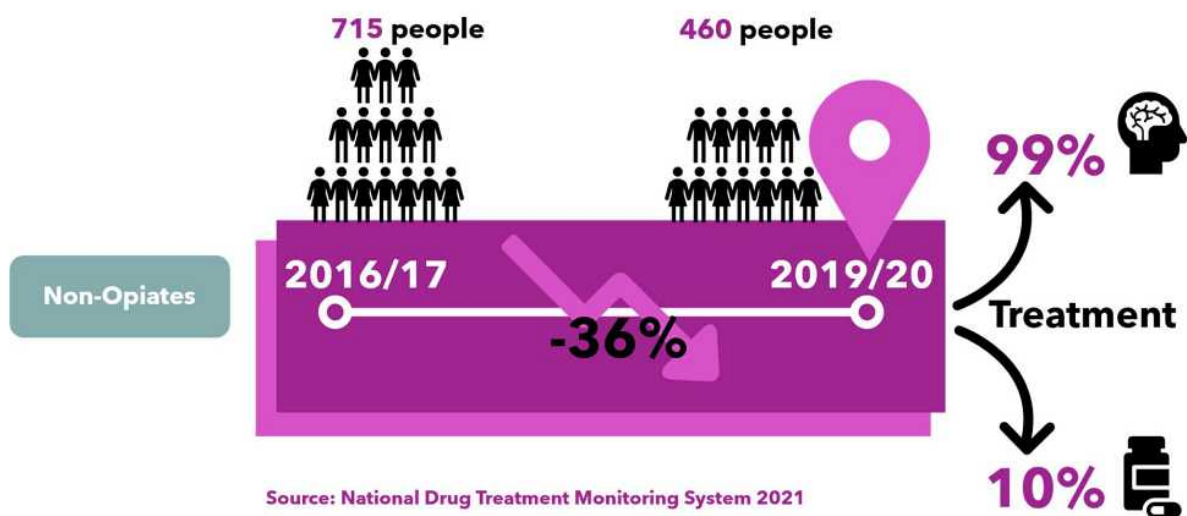
Out of the 460 clients, 445 were treated in the community, 15 in a residential setting and 5 were treated as inpatients. None were treated in a primary care setting.

Five individuals were waiting more than three weeks to commence treatment in 2019/20, which is proportionately better than the national figure (1.1% vs 1.6%, respectively). The number waiting over 3 weeks to commence treatment has fallen by 83% since its peak in 2012/13.

6.3.6 Time in treatment

6.3.6.1 Opiate Users

According to the most recent data (2019/20) [118], 34.9% of opiate users in Birmingham (n = 4820) are in treatment for less than 1 year. 24.7% receive treatment for over 6 years. The number receiving treatment for over 6 years has increased by 125% since its lowest in 2009/10 but reduced by 12% since its highest in 2016/17.
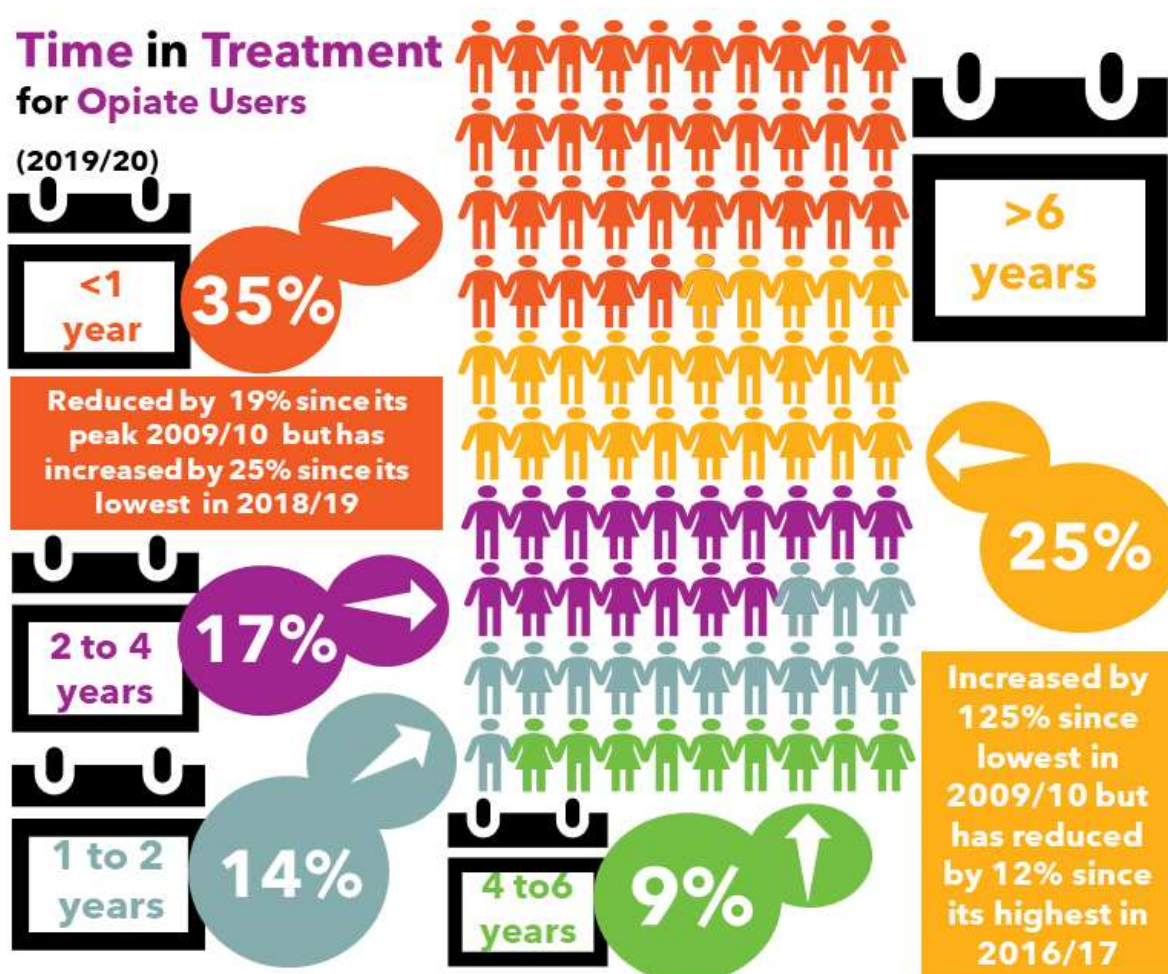
6.3.6.2 Non-opiate Users

95.7% of non-opiate users in Birmingham (n = 470) are in treatment for less than 1 year, according to recent estimates (2019/20) [118]. The next highest proportion of non-opiate users in treatment (3.2%) receive treatment for 1 to 2 years, followed by 1.1% for 2 to 4 years. None receive treatment for longer than 4 years.

Time in Treatment for Non-opiate Users (2019/20)

96%
<1 year

Reduced by 63% since its peak in 2013/14 but increased by 2% since its lowest in 2018/19

2 to 4 years   1%   3%   1 to 2 years
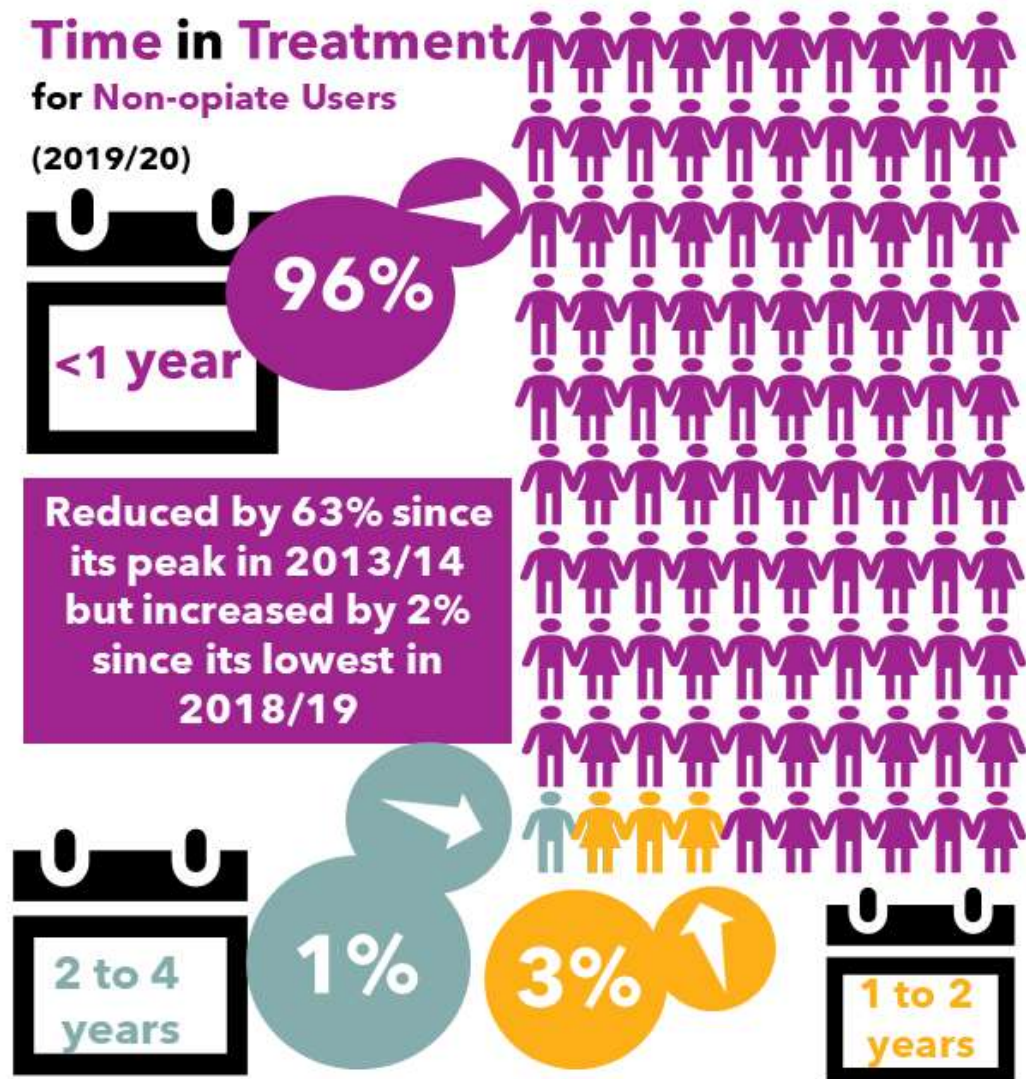
6.3.6.3 Non-opiate and Alcohol Users (concurrent use)

Based on the most recent data [118], 85.7% of concurrent non-opiate and alcohol users in Birmingham (n = 450) are in treatment for less than 1 year. 9.9% receive treatment for 1 to 2 years and 2.2% for 2 to 4 years. 1.1% are in treatment for 4 to 6 years, and the same proportion receive treatment for over 6 years.

Time in Treatment for Non-opiate and Alcohol Users (2019/20)

<1 year — 86%

Reduced by 37% since peak in 2014/15 and has increased 3% since its lowest in 2018/19

1 to 2 years — 10%

Reduced 53% since its peak in 2012/13 but has increased 50% since its lowest in 2017/18

2 to 4 years — 2%

4 to 6 years — 1%

> 6 years — 1%

The number of those in treatment for 2 to 4, 4 to 6 and >6 years has reduced overall since 2009/10
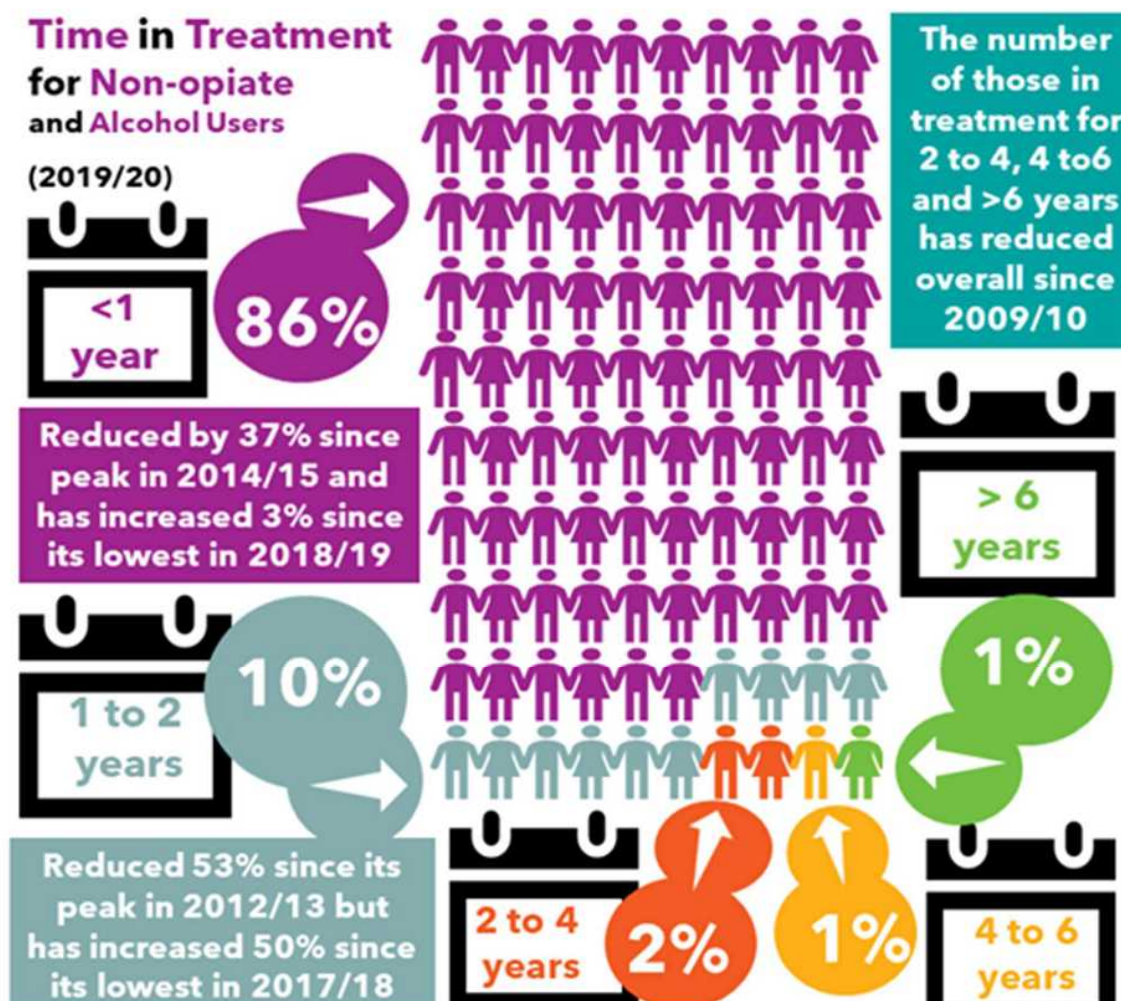
6.3.7 Successful Completions

6.3.7.1 Opiate Treatment

Successful completion rate of opiate treatment was lower for Birmingham (20.5%) than for the West Midlands (20.9%) and England (24.4%). 51% of completions were receiving treatment for under 1 year, 16% for 1 to 2 years, 14% for 2 to 4 years, 6% for 4 to 6 years, and 13% for over 6 years [118].

6.3.7.2 Non-opiate Treatment

Successful completion rate of non-opiate treatment was lower for Birmingham (39.7%) than for the West Midlands (49.3%) and England (53.4%). 97% of completions were receiving treatment for under 1 year [118].

6.3.8 Deaths in drug treatment:

Between 2017-18 and 2019-20, there were 131 deaths in Birmingham for those aged 18 years and over and receiving drug treatment from a specialist misuse service. This represents a mortality ratio of 0.74, which is significantly better than the national figure (1.00) [124].

6.3.9 Mental Health

According to the most recent data (2016/17) [125], 39.5% of adults in specialist drug misuse treatment services were concurrently in contact with mental health services in Birmingham; a significantly higher proportion than both the West Midlands (25.8%) and England (24.3%) (*Figure 9*).
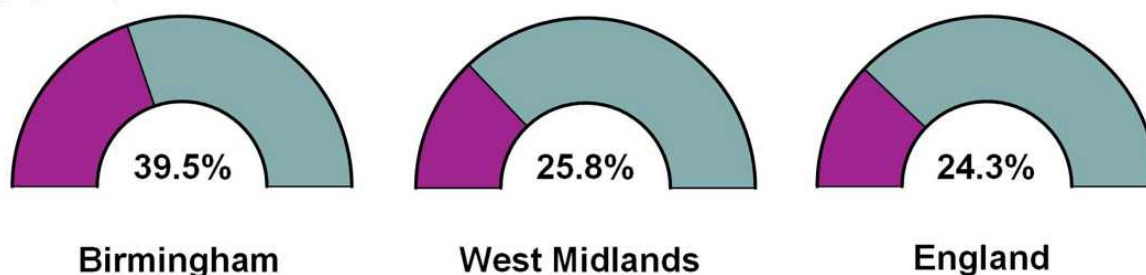
Figure 9: Percentage of Adults in Specialist Drug Misuse Treatment Services also receiving Mental Health Treatment

6.3.10 Hepatitis Testing and Vaccination

Individuals who inject drugs are at higher risk of contracting hepatitis B and C. Hepatitis C virus is mainly transmitted through contact with infected blood. Injecting drug use is the most important risk factor for infection within the UK. Hepatitis left untreated can lead to cirrhosis, a progressive deterioration and malfunction of the liver, and can also lead to liver cancer. People accessing drug treatment services are offered testing and referral for treatment for hepatitis B hepatitis C, and vaccination for hepatitis B.

In 2016/17,109 eligible people entering drug misuse treatment completed a course of Hepatitis B vaccination.

Birmingham had a significantly lower percentage of eligible people completing a course of hepatitis B vaccination (5.2%) compared to England (8.1%) and the West Midlands (7.0%) (*Figure 10*) [126].
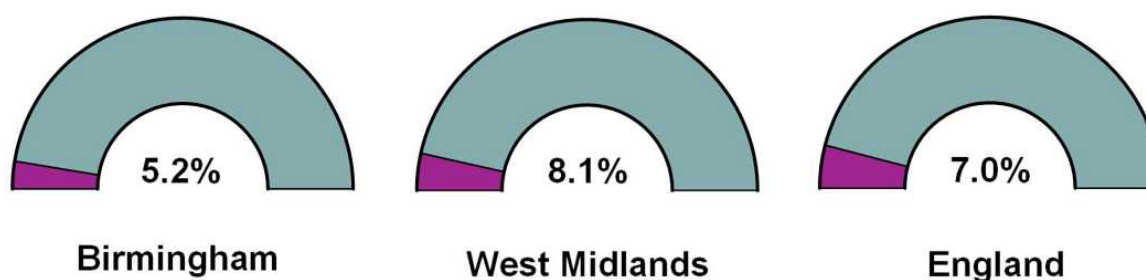
Figure 10: Drug Misuse Treatment - percentage of eligible people completing a course of hepatitis B vaccination

In 2017/18, 1,533 eligible people in drug misuse treatment who inject drugs received a Hepatitis C test.

Birmingham had a significantly lower percentage of eligible people receiving a hepatitis C test (76.0%) compared to England (84.2%) and the West Midlands (79.4%) (*Figure 11*) [127].
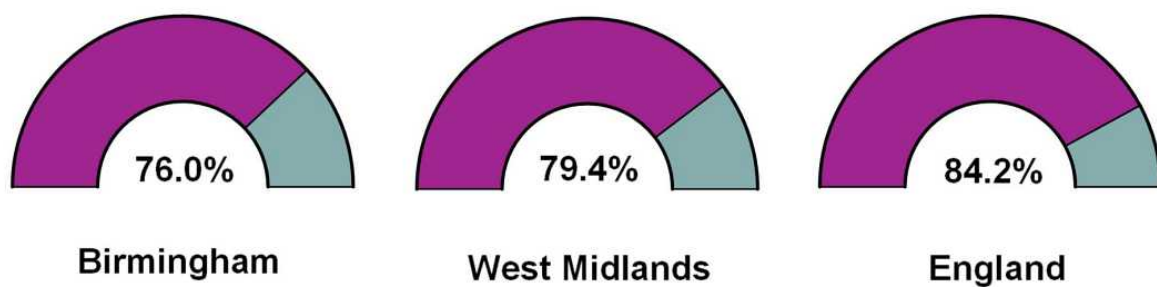
Figure 11: Drug Misuse Treatment - percentage eligible persons who have received a hepatitis C test

6.3.11 Criminal Justice and Prison Release

One of the priorities for the National Partnership Agreement (NPA) for prison healthcare in England (2018) is to reduce the impact of substance misuse, address the risks and harms of misuse, and ensuring the right help is available at the right time [128].
 This indicator measures the proportion of adults released from prison (into the Local Authority Area) with substance misuse treatment need who go on to engage in structured treatment interventions in the community within 3 weeks of release.
In Birmingham, 250 adults (aged 18 years+) with substance misuse treatment need successfully engaged in community-based structured treatment following release from prison. This places Birmingham (29.4%) lower than the national (38.1%) and regional (36.2%) figures when expressed as the proportion of adults (*Figure 12*) [129] .
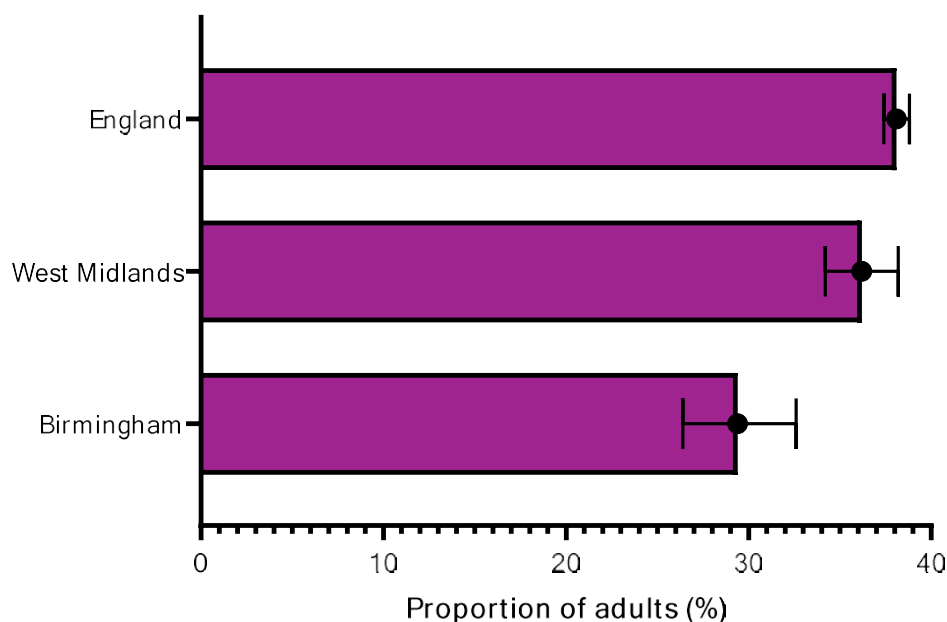
Figure 12: Proportion of adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison [129]

7 Unmet Need in Birmingham [130]

7.1 Opiate Users

According to the most recent data in 2017/18, the number of individuals <u>not</u> in contact with drug treatment services for an opiate problem in Birmingham (n = 4,114) has increased by 42.8% since its lowest number in 2012/13. As a proportion of opiate prevalence (46.9%), this represents an 11.4%-point increase. The proportion of individuals <u>not</u> in treatment is comparable to the national figure (46.3%).
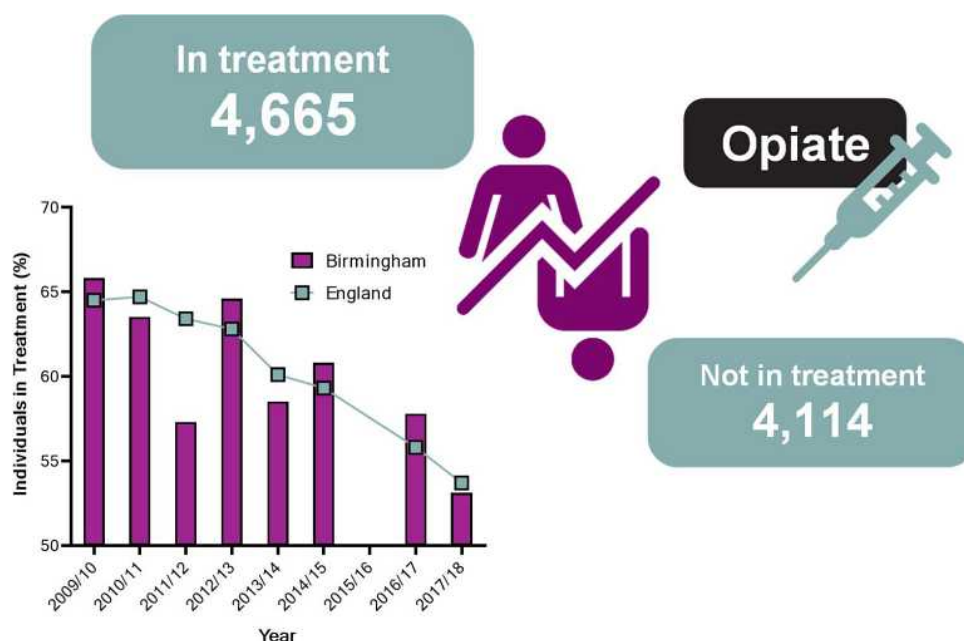
7.2 Opiate and/or Crack cocaine Users (OCU)

Based on recent estimates from 2017/18, the number of individuals <u>not</u> in contact with drug treatment services for an OCU problem in Birmingham (n = 5,728) has increased by 53.6% since its lowest number in 2012/13. As a proportion of OCU prevalence (54.4%), this represents a 13.6%-point increase. The proportion of individuals <u>not</u> in treatment is comparable to the national figure (53.4%).

In treatment
4,797

OCU

Not in treatment
5,728
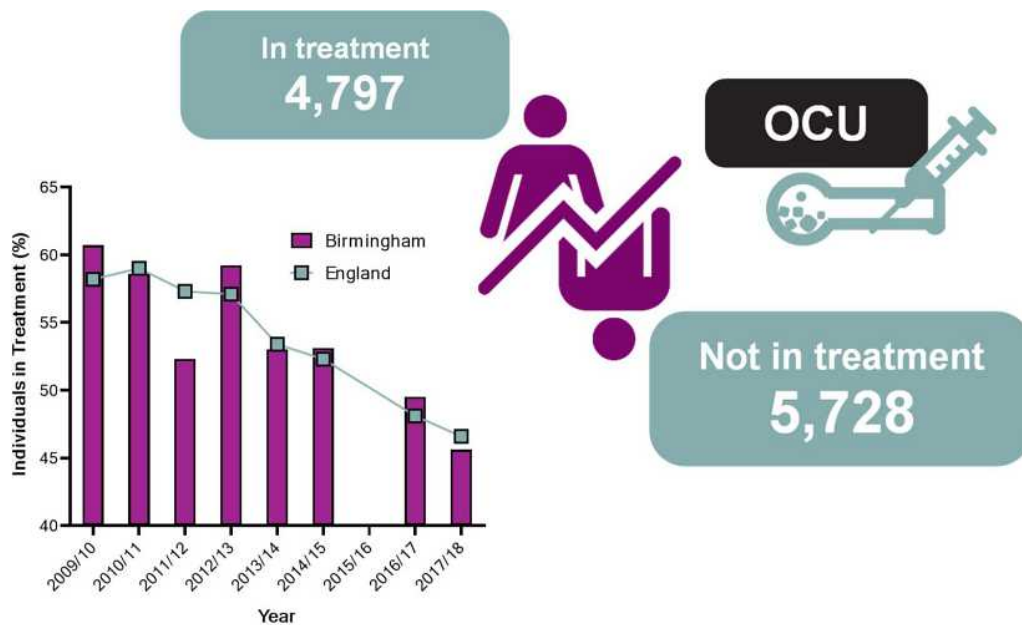
7.3 Crack cocaine Users

In 2017/18, the number of individuals not in contact with drug treatment services for a crack cocaine problem in Birmingham (n = 3,887) has increased by 14.3% since its lowest number in 2012/13. As a proportion of crack cocaine prevalence (57.0%), this represents a 4.9%-point increase. The proportion of individuals not in treatment is lower than the national figure (61.3%).

In treatment
2,930

Crack cocaine

Not in treatment
3,887
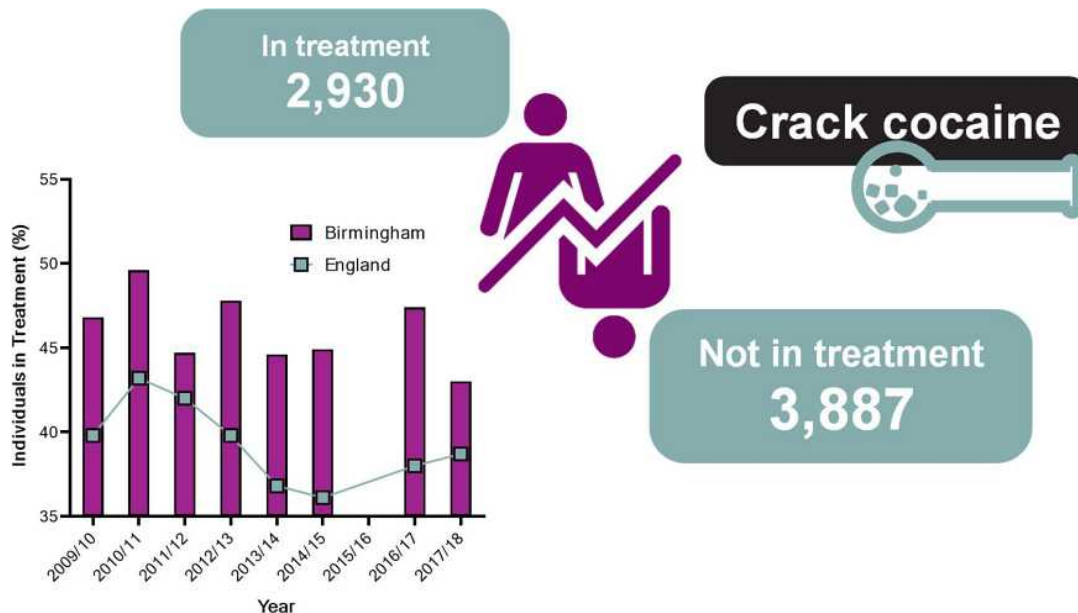
7.4 Alcohol Users

The most recent data in 2018/19 indicate that the number of individuals not in contact with treatment services for an alcohol problem in Birmingham (n = 11,830) has increased by 10.1% since its lowest number in 2014/15. As a proportion of alcohol dependency prevalence (88.0%), this represents a 9.0%-point increase. The proportion of individuals not in treatment is higher than the national figure (83.0%).

8 Inequalities and Vulnerable Groups

Conceptual models that examine the production of risk and harm in substance use research have been crucial in emphasising the wider environmental and societal factors that influence health outcomes for people who use drugs. The risk environment framework promotes an understanding of harm and harm reduction in the form of contingent causation. Put simply, harm is dependent on social context, involving interactions between individuals and their environments [131].

Whilst such models have been valuable in emphasising key factors associated with substance misuse, they have not been able to fully highlight the nuances and complexities that exist between commonly selected social positions (e.g. sex, ethnicity, gender) and social-structural factors (e.g. deprivation, policy). Therefore, there is a need to acknowledge intersectionality in the context of substance misuse to better understand diverse and complex treatment needs.

For the purposes of this needs assessment, each sociodemographic factor will be considered separately to highlight their individual inequalities before drawing together the evidence through an intersectional lens, providing a holistic view across social-structural dimensions.

8.1 Sex

Traditionally, drug and alcohol abuse were considered to be problems specific to men. Because women were poorly represented in early studies, the majority of drug abuse research has focused on men. However, sex-specific drug and alcohol abuse differences have been now been identified [132]. Whilst men are more likely to use illicit drugs [21], when women develop substance misuse problems it is typically faster than men [133]. Men have typically reported higher rates of cannabis and alcohol abuse, whilst women more often reported use of other narcotics and mild sedatives [134].

Furthermore, women differ from men in their subjective and biological response to drugs and alcohol [135]. The clinical literature indicates that women initiate cocaine use sooner, experience greater intoxication after comparable amounts of alcohol intake, and become addicted to cocaine, opioids and alcohol sooner after initiation than males [136,137].

In England and Wales, drug use is nearly twice as prevalent in men as in women (*Figure 13*). Whilst prevalence by sex data is not available for Birmingham, the proportion of male clients (72%) receiving treatment in Birmingham for drug and alcohol misuse is far greater than women (28%).
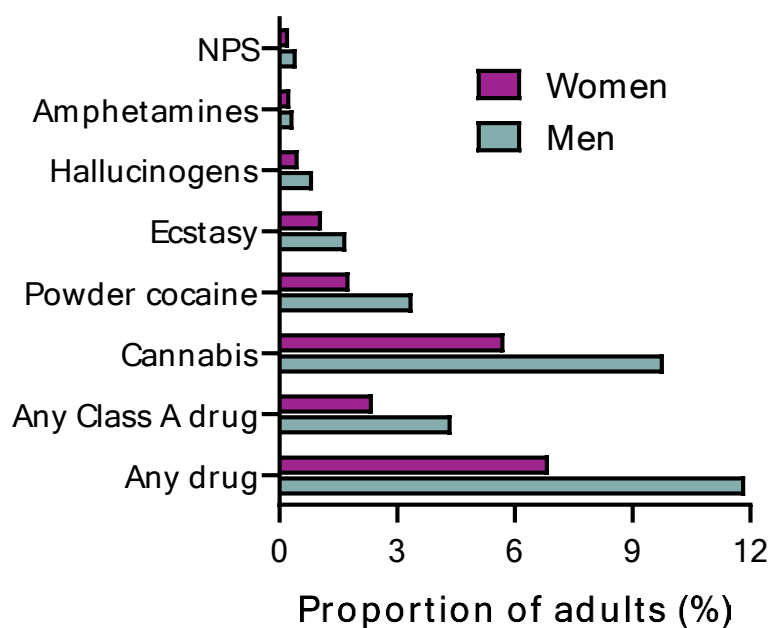
Figure 13: Proportion of adults aged 16 to 59 years who reported using a drug in the last year by sex, England and Wales, year ending March 2020[21]

Given that the experiences of female drug users are often very different to their male counterparts (e.g. women suffer greater societal stigma, more severe addiction, and physical and psychological reactions than men), sex-specific differences related to drug and alcohol abuse present unique challenges to service provision. Health services should consider the sex-specific differences in drug treatment by 1) addressing sex-specific risk factors for reduced treatment initiation, continuation, and treatment outcomes, 2) identifying subgroups of women and men who would benefit from sex-specific interventions, and 3) improving the care and referral pathways into specialised addiction treatment for men and women who seek help in primary care or mental health settings [138,139].

8.2 Ethnicity

The role of ethnicity in substance abuse has been a source of interest for over 30 years [140]. Ethnicity itself is a complex concept, encompassing inherited characteristics (e.g. race) and learned aspects (e.g. religion, language, cultural attitudes, values and customs). Despite the recognised context-dependent and fluid nature of ethnic identity, substance misuse research has tended to analyse ethnicity as something static and discrete with little consideration of the sociocultural decisions that shape drug users' choices to abuse illicit substances [141].

National level data shows that adults of mixed/multiple ethnicities are most likely to use illicit drugs whilst Asian adults are least likely (*Figure 14*). The higher rate of drug use among mixed/multiple ethnicity adults can be explained by relatively higher rates of cannabis use in this (22.1%) compared to White (8.2%), Asian/Asian British (2.9%), Black/African/Caribbean/Black British (4.8%) and other (4.2%) ethnic groups [21].

Sex also plays a considerable role in illicit drug use when categorised by ethnicity – across all ethnicities men are more likely to abuse drugs and alcohol [142]. Different patterns of drug use (i.e. types of drugs, mode of administration and user history) may also differ between ethnic groups as well as the contexts in which drug abuse occurs. For example, fatal cases attributed

to mephedrone (stimulant drug related to amphetamine) use in the UK amongst 16-24 year olds between 2009-2013 were all of white ethnicity [143].
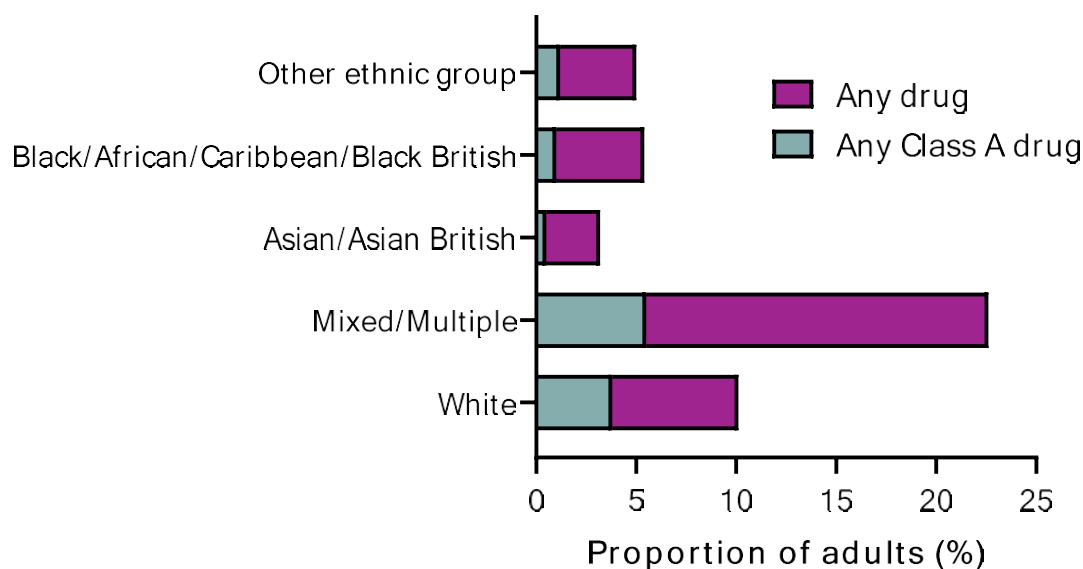
Figure 14: Percentage of adults who used illicit drugs by ethnicity and drug type[21]. Bars are superimposed

In Birmingham, there are ethnicity-specific differences in drug use. The number of CGL clients currently receiving treatment in Birmingham (at 30/06/21) grouped by ethnicity are shown in *Figure 15*. White British represent the majority of clients, accounting for 65.6% of all clients in Birmingham. Pakistani/Pakistani-British make up the second largest client base (6.5%) whilst Chinese represent the smallest ethnic CGL client base (< 0.1%) in Birmingham.
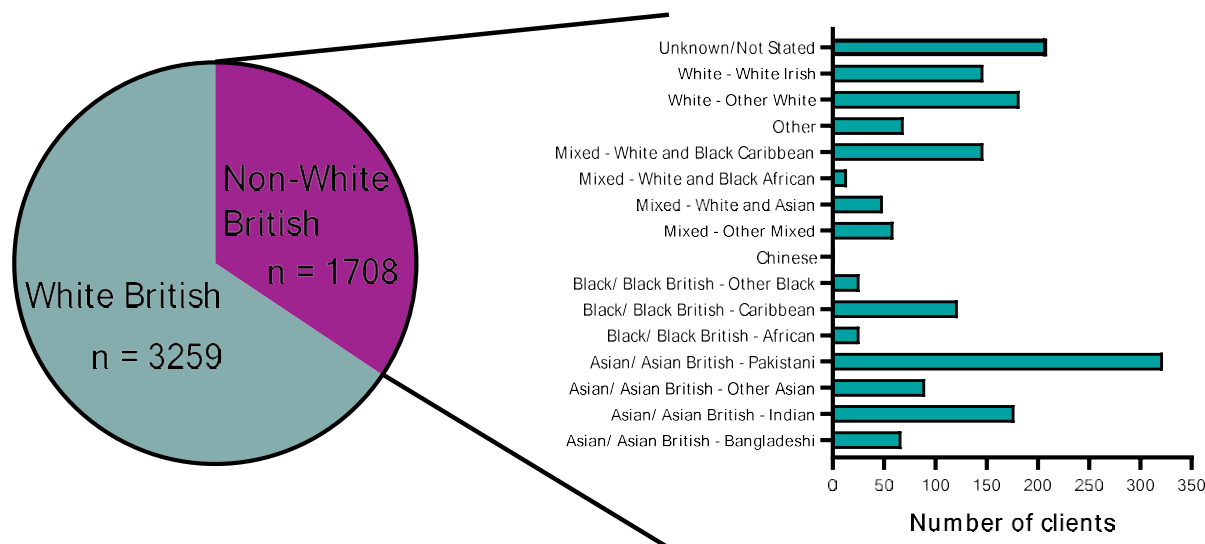
Figure 15: CGL Birmingham current clients by ethnicity at 30/06/21

To fully understand the ethnic-specific differences in illicit drug use, further information is needed on the variation in drug use within specific ethnic communities to identify the role and relative importance of related factors such as personal, social, economic, cultural, geographical. These factors may increase the risk of or provide protection against drug use. Furthermore, as many minority communities reside in more deprived and disadvantaged areas, where drug markets thrive, this may predispose them to future risks and increased prevalence of illicit drug use.

8.3 Age

Age presents a complex social issue with respect to substance abuse. Evidence shows that drug use is more prevalent in younger age groups (*Figure 16*) [21] and that adolescents who use cannabis, either regularly or occasionally, are more likely to graduate on to harmful substance use behaviours in early adulthood [144]. This early-onset of cannabis use may be particularly problematic, as it is not only associated with other drug use but with several adverse health outcomes including substance and cannabis use disorders [145–147].

Conversely, alcohol is the most commonly misused substance among older people in England, with 55-64 year olds representing the age group with the highest proportion of men and women drinking over 14 units per week [148]. Whilst the number of people aged over 50 experiencing problems from substance abuse is rising rapidly [149], alcohol is still the most common substance misused among older people. This is highlighted by a decline in risky drinking (over 14 units per week) in the UK except in people aged 50 years or older [150].

According to experts in this field [151], alcohol misuse in older populations may increase further as "baby boomers" grow older. This is because they typically exhibit more liberal views towards and consume greater levels of alcohol. There is also an upward trend for episodic heavy drinking in this age group [150].

Nationally, illicit drug use and risky drinking varies depending on age. Whilst younger adults aged 20-29 years were more likely to have taken drugs in the last year (*Figure 16*), older adults aged 45-74 years were more likely to exhibit riskier drinking behaviours (*Figure 17*). Sex does not appear to influence this pattern, although the proportions of both drug users and risky drinkers were greater for men than women.
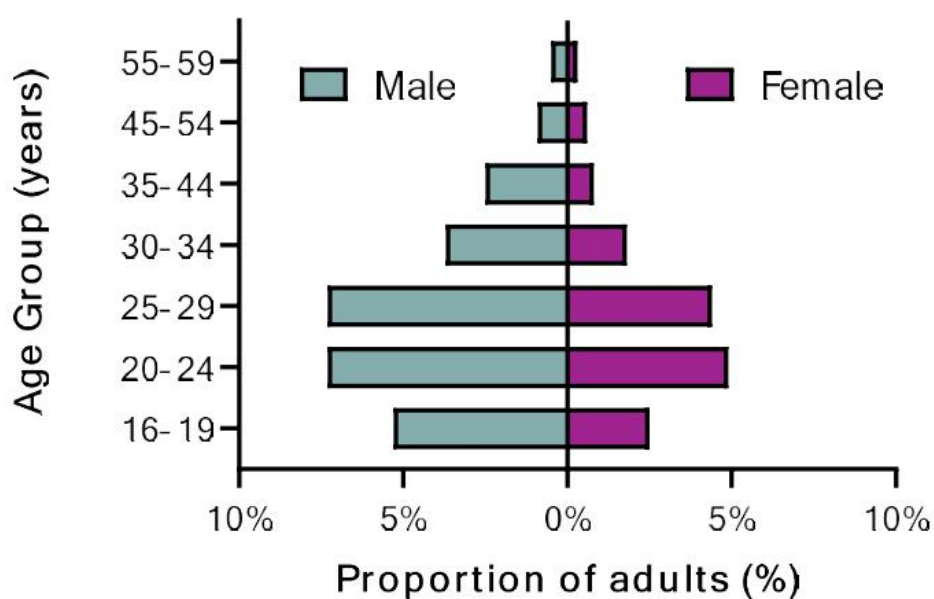
Figure 16: Proportion of 16 to 59 year olds reporting use of illicit drugs in the last year by age and sex (ONS 2020)
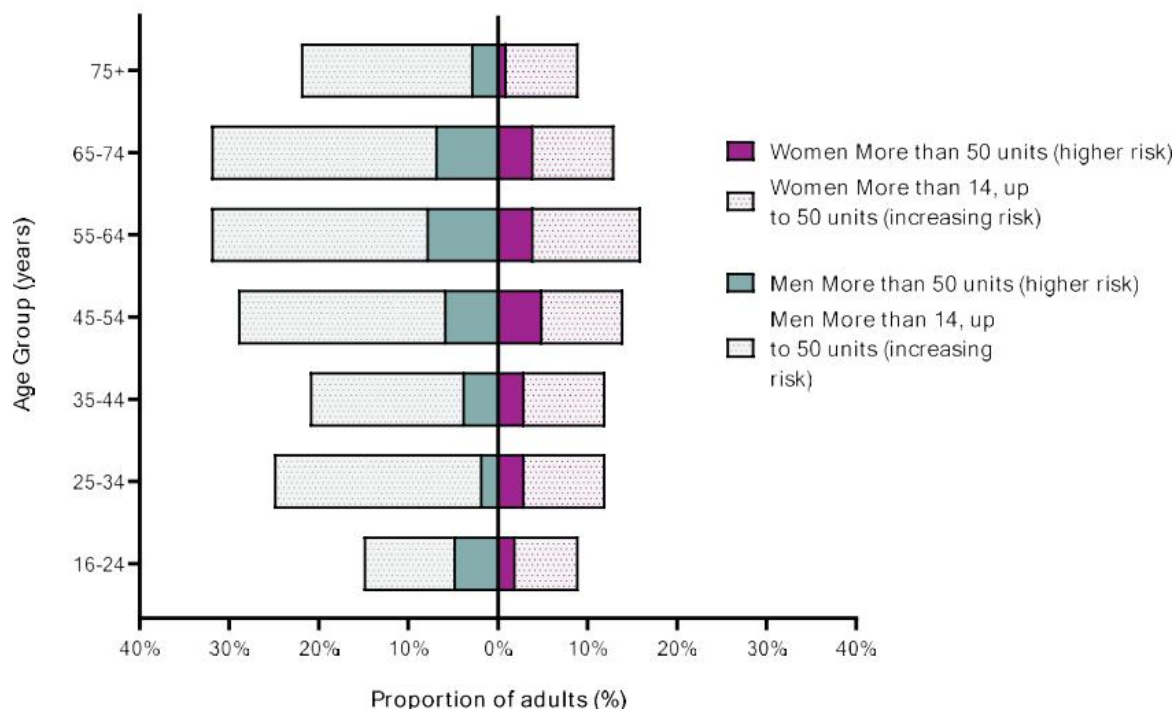
Figure 17: Proportion of adults drinking over 14 units a week (at increased or higher risk of harm), by age and sex[152].

Whilst data on drug use and risky drinking prevalence are unavailable for Birmingham, the number of clients in treatment for drug and alcohol abuse shows that adults aged 40-44 years make up the highest proportion of clients (22.8%) (*Figure 18*). Those aged 35-39 years make up the second highest proportion of clients (16.2%), and those aged 45-49 years are the third most represented (15.6%). These data for clients in treatment in Birmingham conflict somewhat with national prevalence data, suggesting that younger and older adults are less likely to access treatment than middle-aged adults.
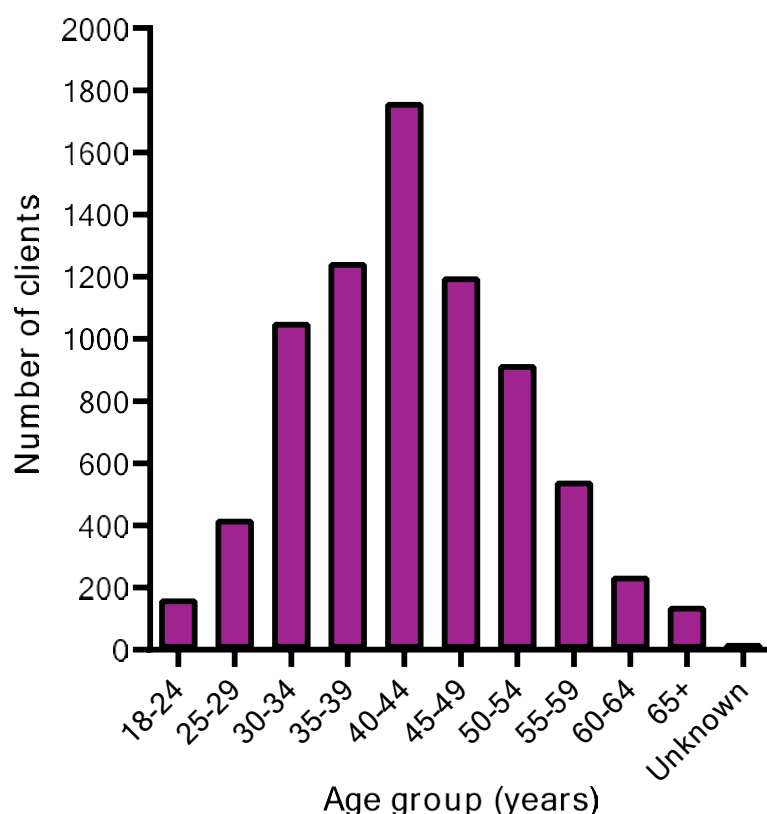
Figure 18: CGL data for clients in treatment by age 01/04/20 to 31/03/21

Younger people are usually perceived as the perpetrators of illicit drug use and heavy episodic drinking; however, evidence shows that it is in older age groups where drug use rates have risen the most and alcohol misuse behaviours are most prevalent. This is possibly the consequence of effective treatment and harm minimisation initiatives, together with medical advances, which has increased the life expectancy of people dependent on drugs [153].

Early intervention is imperative to prevent adolescents who first take drugs or abuse alcohol from progressing onto more harmful drugs and developing drug misuse behaviours and dependency [144,154]. This is highlighted by adolescents/younger adults, particularly males with lower educational levels, being more likely to use cannabis and be at greater risk of cannabis use disorder [146]. Given that younger adolescents face greater societal pressures, early intervention is imperative to prevent adolescents who first take drugs or abuse alcohol from progressing onto more harmful drugs and developing drug misuse behaviours and dependency [144,154]. This is highlighted by adolescents/younger adults, particularly males with lower educational levels, being more likely to use cannabis and being at greater risk of cannabis use disorder [146]. Stigma is a barrier to treatment, however, reduced stigma may encourage greater substance use in younger groups [155]. Given that younger adolescents

face greater societal stigma than older age groups, this presents a complicated public health challenge.

Conversely, with alcohol being the most common substance of misuse among older people, under detection of alcohol problems is of immediate concern in this age group [151]. The challenges posed by different age groups with regards to substance misuse emphasises their disparate needs for treatment and prevention. Services should look to understand the underlying social context for substance misuse, focusing on the role of community social norms in driving an age group's behaviours rather than providing brief counselling on individuals' behaviours[156].

8.4 Deprivation

Deprivation and poverty have been linked to problematic drug use and higher prevalence of substance abuse, with those at the "margins" of society most at risk (e.g. in care, in the criminal justice system, in mental health services and homeless people) [157]. Whilst good quality evidence on drug and alcohol misuse is sparse, available data indicate that substance abuse is a serious problem for those at the "extremes" who face socio-economic barriers such as unemployment and social exclusion [158].

To compound the issue, users who abuse substances and live in deprivation are often less likely to seek care and treatment as well as being less likely to overcome drugs and alcohol misuse problems [159]. Reasons for this are complex and according to Buchanan [160] problematic drug use is a socially constructed phenomenon that is influenced by an individual's structural disadvantages, limited opportunities and lack of alternatives and resources (e.g. access to meaningful employment and housing) rather than personal choice or physical dependence. Deprived areas with high unemployment can also provide an environment for drug dealing to become an established means of earning money. Whilst this may present a societal issue nationally, it is particularly difficult to tackle drug abuse problems at the community level [161].

Nationally, adults living in the lowest income households were more likely to have taken any drug, whilst the use of class A drugs in adults was comparable for lower-, middle- and higher-income households (*Figure 19*).
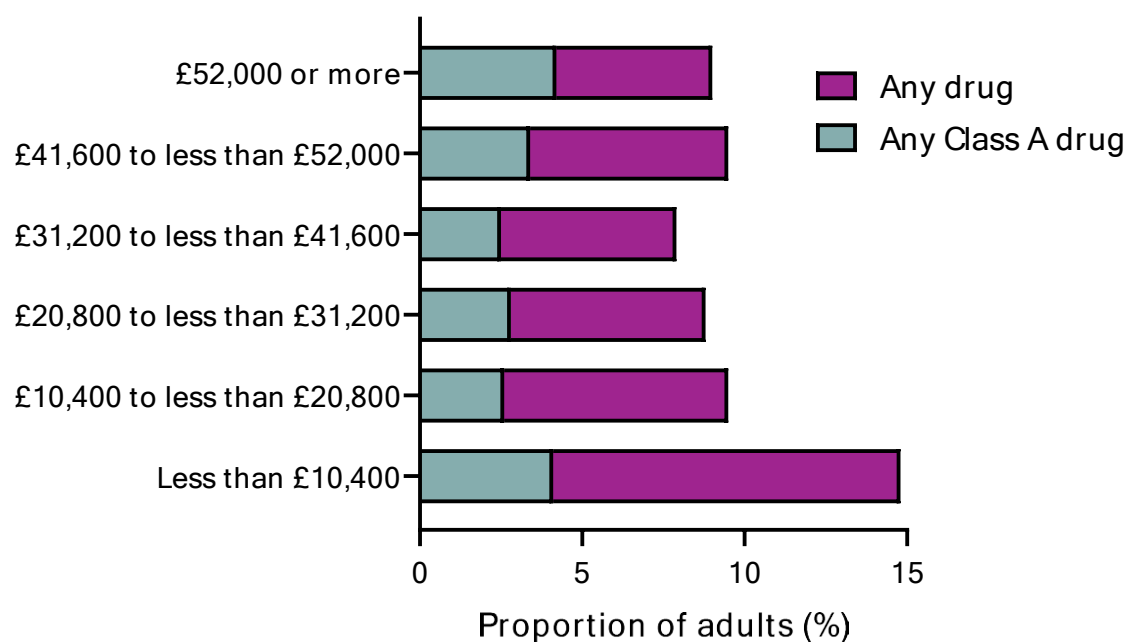
Figure 19: Proportion of adults aged 16 to 59 years who reported using a drug in the last year by total household income, England and Wales, year ending March 2020 [21]. Bars are superimposed

The greater prevalence of any drug in the lowest income households can partly attributed to cannabis use. Those in the lowest income households (13.2%) were more likely to have taken cannabis than those in higher income households (6.3% – 8%). However, the prevalence of powder cocaine was greater in adults from the highest income households (*Figure 20*).
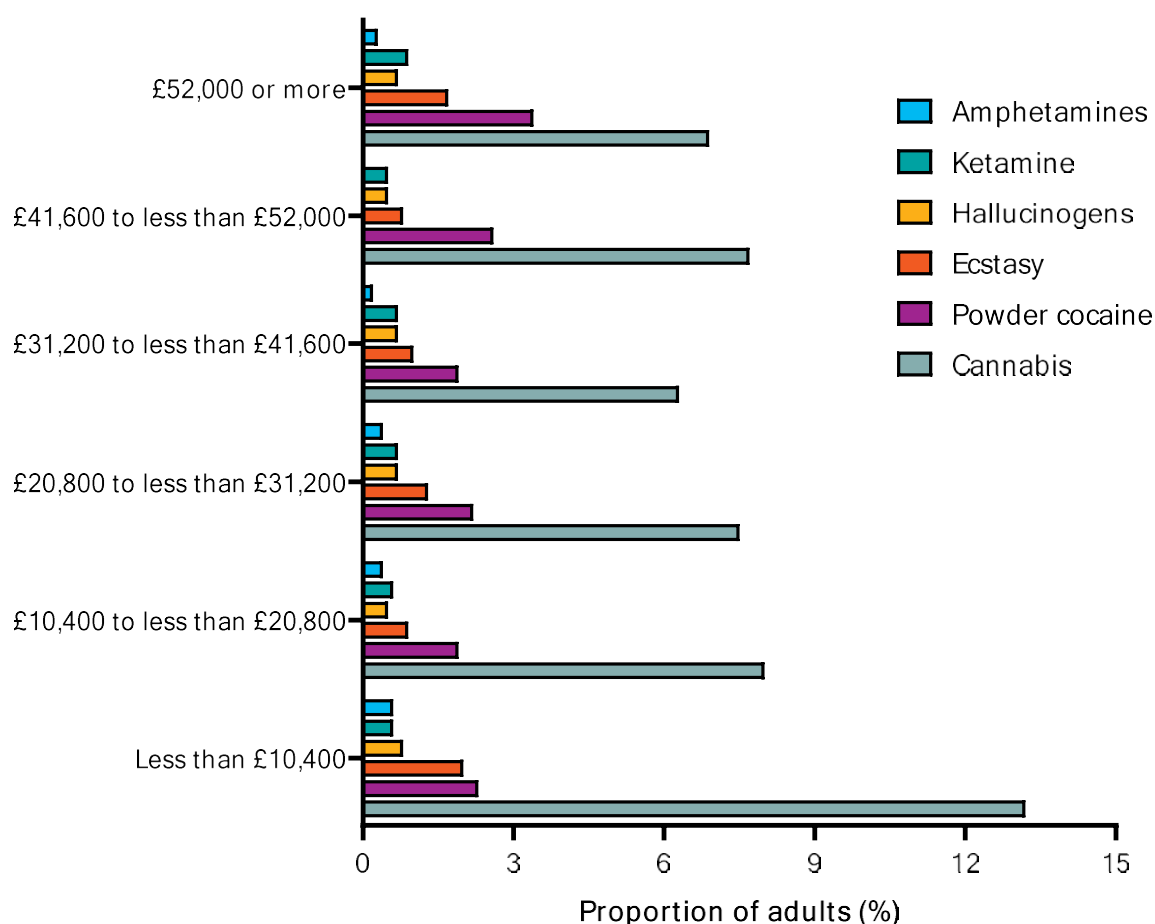
Figure 20: Proportion of adults aged 16 to 59 years who reported using a drug in the last year by total household income and drug type, England and Wales, year ending March 2020 [21].

Some research suggests that the general patterns of drug use and alcohol abuse exhibit little correlation with poverty or social class [158]. However, such observations fail to acknowledge the extremes of problematic substance abuse and the complex socioenvironmental factors that influence these behaviours. For example, deprivation has greater associations with extremes of problematic use and weaker associations with casual, recreational, or intermittent drug use. Deprivation is also related to a lower age of first use, progression to dependence, injecting drug use, risky use, health and social complications from use and to criminal involvement; rather than simply being related to whether people have ever taken drugs [162].

In agreement with previous suggestions [160,163], service provision should focus on reducing social deprivation in order to lower the prevalence of the most damaging drugs. Adopting a more holistic approach for drug and alcohol treatment services will move towards adequately addressing the social context, nature, and underlying causes of problematic drug use in deprived communities.

8.5 Children, Young People and Families

Rates of substance use are lower among children and young people compared to the adult population. However, like all estimates of substance use, there is likely to be underreporting

of the true prevalence. The What About Youth (WAY) Survey [164] of 15 year olds found that Birmingham prevalence of substance use was lower than the England average however there were clear inequalities in sex and ethnicity.

Table 1 Key findings from the What About Youth (WAY) survey regarding drug and alcohol use behaviours

Drug and alcohol use behaviour	Main findings
Getting drunk in the last 4 weeks	Rates were lower in Birmingham than in England (5.9% vs 14.3%) Within Birmingham, rates were higher for girls than boys; highest for white ethnicity amongst girls and mixed ethnicity amongst boys
Ever trying cannabis	A lower proportion of Birmingham children reported ever trying cannabis (6.5%) than in England (10.5%) Within Birmingham, mixed ethnicity had the highest rates.
Taking cannabis in the last month	A lower proportion of Birmingham children reported taking cannabis in the last month (2.0%) than in England (4.55) Within Birmingham, rates were highest for black boys and mixed ethnicity girls.
Ever trying drugs other than cannabis	A lower proportion of Birmingham children reported ever trying drugs other than cannabis (1.4%) than in England (2.4%) Within Birmingham, rates were higher for girls; highest for white girls and black boys
Taking drugs other than cannabis in the last month	A very low proportion of Birmingham children reported taking drugs other than cannabis in the last month (0.2% vs 0.8% in England)

Of those in service, the proportion of opiate users is far smaller than adults in treatment (<1% compared to 68% for adults) (Figure 21). Almost 70 % of young people presented initially with non opiate drug use, the most prevalent being cannabis use. However following referral for cannabis use, interventions with young people can often result in poly use disclosure such as alcohol, nitrous oxide, vaping, THC or cocaine use.
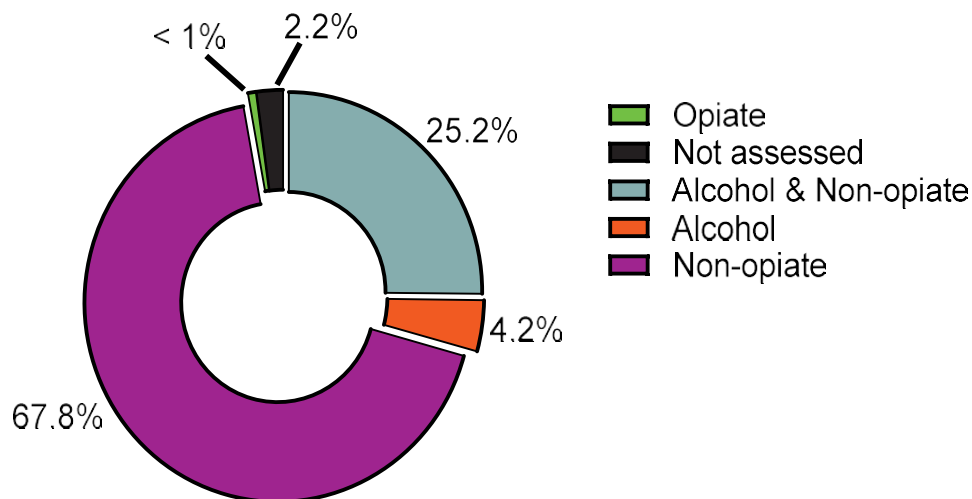
Figure 21: Substances used by Young People presenting to Aquarius.

Although the proportion of young people who are using alcohol and drugs (and in particular opiates and crack cocaine) is much smaller than adults, this is a highly vulnerable group. There is evidence to suggest that young people who use recreational drugs run the risk of damage to mental health including suicide, depression, and disruptive behaviour disorders. Regular use of cannabis or other drugs may also lead to dependence. Among 10 to 15 year olds, an increased likelihood of drug use is linked to a range of adverse experiences and behaviour, including truancy, exclusion from school, homelessness, time in care, and serious or frequent offending.

Young people receiving interventions for substance misuse often have a range of vulnerabilities that require specialist support and intervention. Data from the current service provider, Aquarius[3] shows that;

- 89% of young people currently accessing services identify substance misuse amongst family members
- 22% of young people accessing services are open to children's services under a Child Protection Plan
- 70% of young people accessing services have been risk assessed as High & Medium Risk
- 37% of young people referred to services are open to the youth offending team.
- 18% of young people accessing support have identified mental health as a need.
- 14% of young people currently accessing support have been identified as involved in exploitation

Over two thirds of these Children and Young People accessing service have more than one complexity or vulnerability.

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[3] Report to Overview and Scrutiny committee November 2021
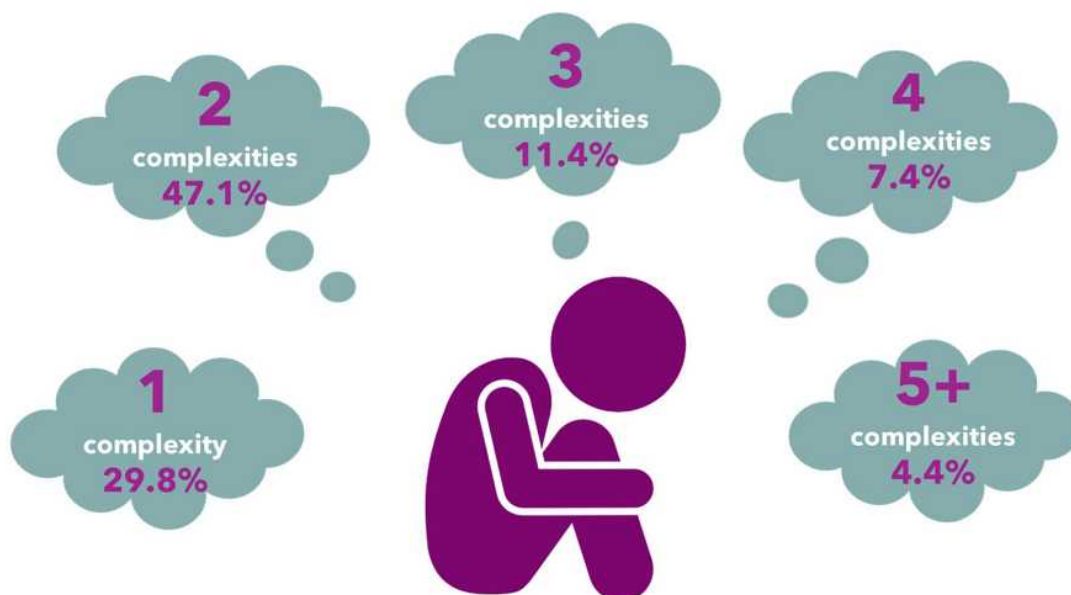
Drug and alcohol misuse impacts children and young people in many ways, either because they are themselves using alcohol or drugs, or their parents or other family members are, or because they are pawns in organised crime or victims of crime. Dependent parental alcohol and drug use has an adverse impact on children, particularly regarding their physical health, psychosocial wellbeing and personal alcohol and drug use.

Findings from the Children's Commissioner applied to the Birmingham population showed [165]:

- 30,000 children and young people aged under 18 in Birmingham are living with an adult who has reported substance misuse
- Of these, over 11,000 are living with an adult who is dependent on drugs or alcohol
- Of these, 2,500 are living with an adult who also has severe mental health problems and has experienced DV

There is increasing evidence that adverse childhood experiences (ACEs) such as living in a household with problem alcohol use can contribute to long-term harms. If a child experiences four or more risk factors during childhood they have a substantially higher risk of developing health-harming behaviors, such as smoking, heavy drinking and cannabis use. Identifying and minimizing risk early on is key to prevention and substance use services should be delivered holistically in partnership with key agencies, addressing wider vulnerabilities as well as misuse.

8.5.1   Demographics of Young People in Service

459 Young People in Treatment

Female 24%
Male 76%

White British 40.7%

Caribbean 19.7%

White & Black Caribbean 4.6%

Pakistani 9.6%

NOTE: Ethnicity unknown 6.8%, African 3.9%, White and Asian 2.8%, Other mixed 2.6%. All other ethnic groups contribute less than 2% of clients. 2.2% were not assessed regarding treatment pathway
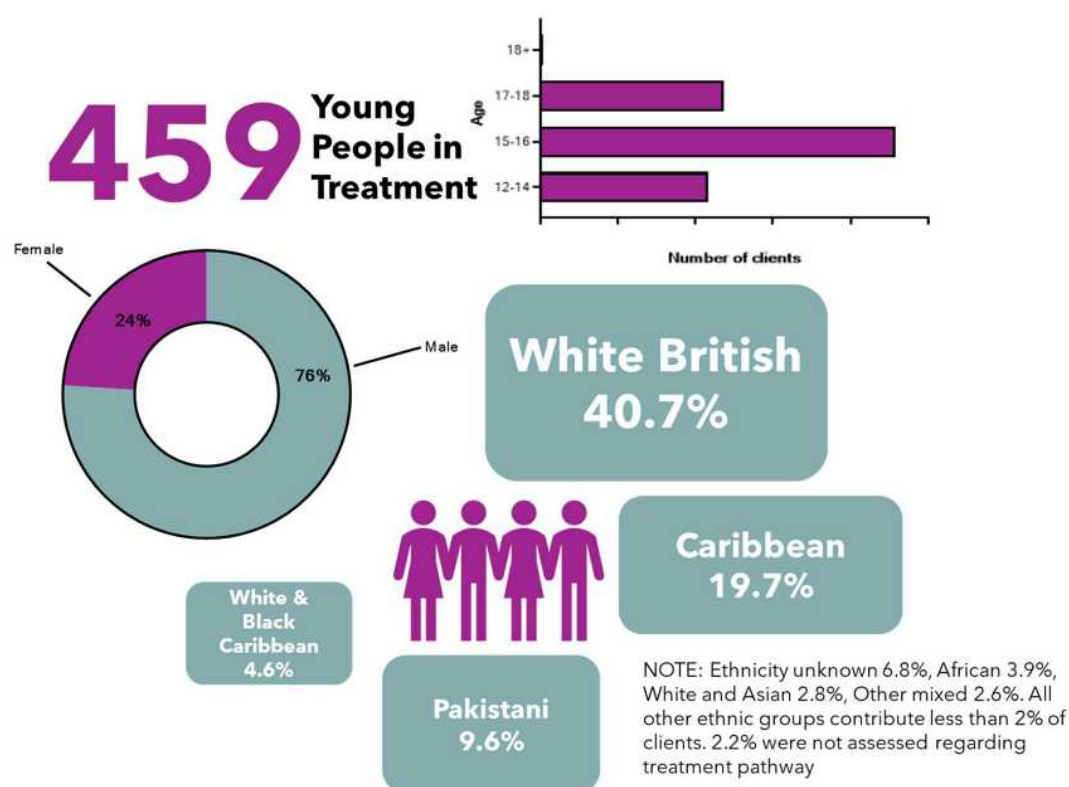
8.6 Mental Health

Research has shown that comorbidity between mental and substance use disorders is highly prevalent [166] with strong links between cognitive and behavioural disorders and substance use disorders [167]. The co-occurrence of a substance use disorder and a mental health disorder is known as dual diagnosis and it is often under-diagnosed, underestimated and poorly treated throughout the world [168].

People with negative mood states (e.g. depression and anxiety) are more likely to use alcohol [169] and those who suffer psychological distress or social anxiety and rely on alcohol to relieve symptoms are more susceptible to alcohol dependency [170–173]. Anxiety disorders are also associated with cannabis use [174] as well as cocaine although the latter may be influenced by social situation [175].

It is difficult however to understand the relationship and pathways between mental health and substance misuse as they differ across substances and disorders. For example, alcohol abuse likely follows a causal model (i.e. alcohol abuse leads to depression) rather than a self-medication model (i.e. depression leads to increased risk of alcohol abuse) [176]. Conversely, psychoactive substances are likely used as a self-regulation strategy to alleviate distress, which supports the theory of self-medication [177]. Despite the known concerns regarding this issue, it has been acknowledged in the United Kingdom that people with comorbidity often receive poor health care and gaps in service provision are likely due to ambivalence towards the problem (i.e. health professionals hold stereotypical preconceptions about drug users, which may be contrary to those who work within mental health services) [178].

Nationally, 59% of adults starting substance misuse treatment declared having a mental health treatment need [179]; an increase of 6 percentage points from the previous year. In

Birmingham, the number of clients in treatment with a mental health issue is high (n = 1507) (*Figure 22*). Furthermore, a large number are recorded as having a "behavioural and emotional" main disability, which is the most prevalent disability recorded. "Mobility and gross motor" disability is second (3.4%). It appears that dual diagnosis has sex-specific influences and is also related to homelessness based on CGL data. The dedicated "Women's Team" and "Homeless Team" recorded that 29% and 31% of clients had mental health issues, respectively.
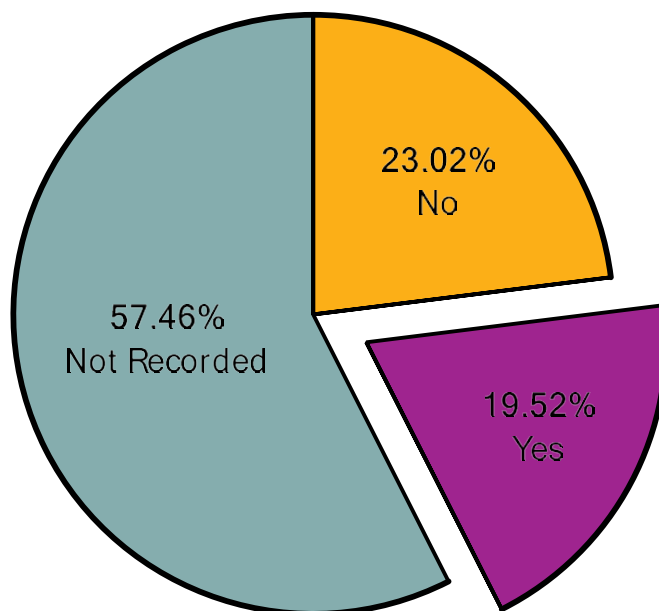
Total number of clients =7719

Figure 22: CGL clients 01/04/20 to 21/03/21: with mental health issues recorded

Diagnosing and treating individuals who misuse drugs and alcohol and have a mental health problem is important as these clients often have the most complex needs. However, optimal treatment pathways are ambiguous with regards to dual diagnosis, likely due to its complex nature. This is reflected in policy where it is unclear whether treating mental health issues as the antecedent or consequence of substance misuse behaviour is more effective. For example, policies that reduce the use of substances are likely to reduce the prevalence of mental disorders [166] whilst accessing mental health services in adolescence may reduce the likelihood of using drugs in older adolescence and in adulthood [156].

Understanding the user's experience is imperative in providing effective dual diagnosis treatment. Therefore, treatment should be available in an integrated fashion for both mental and substance use disorders [166]. Such an approach could also enable identification of self-medication or causal models that are related to substance misuse and mental health issues.

8.7 Disability and Long-term Conditions

Long-term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment. Over 18m people in the UK live with long-term health conditions [180].

Given that substance abuse among persons living with a disability (40%) is purportedly more prevalent than in persons without a disability (34%) [181], the absolute number of individuals living with a disability/long term condition and also misusing drugs and or alcohol in the UK is considerable and presents a major public health challenge. Research has consistently shown that individuals with a disability are at increased odds of drug misuse [182,183] and those with physical disabilities may be at particular risk of alcohol and drug abuse [184]. This is reflected in the CGL client base in Birmingham, where mobility and gross motor (n = 262) and physical (n = 119) disabilities are the second and third most reported disabilities, respectively.

Individuals living with a disability battle unique stressors, such as social pressure and stigma, low self-esteem and low self-efficacy amongst other adverse socioeconomic and quality of life outcomes [185,186]. These can contribute to feelings of unhappiness, depression and a lack of purpose. It is reasonable to assume that individuals with disability who abuse substances to cope with impairments related to physical disability have not psychosocially adjusted, although empirical evidence to support this assertion is lacking [185].

It is important to note that disability or a long-term health condition may lead to pain medication addiction, where individuals become addicted to prescription opioids and later develop abusive behaviours for illicit drugs (e.g. heroin) [187–189]. Those with a disability who abuse substances such as opioids are also less likely to enter treatment due to experiencing greater barriers [189].

The available evidence suggests that drug treatment services are often unable to offer effective treatment to individuals with a disability [186]. It has been recommended that national government and local commissioners meet the variable and disparate needs of individuals with a disability by 1) building the capacity and competences of specialist generic disability bodies and support networks regarding drug issues; and 2) enhancing the capacity of existing drug service providers to respond to the needs of people with disabilities [186].

Ultimately, disability further complicates an already complicated phenomenon. Concerns are being raised regarding the specificity (i.e. differences with mainstream addiction) of disability substance abuse treatment services, which is likely due to a lack of integrated service provision.

8.8 Sexual Orientation and Gender Identity

People who identify as lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) often face social stigma and discrimination, and a greater risk of harassment and violence not encountered by people who identify as heterosexual. Together with other stressors (e.g. internalised stigma), these factors predispose sexual minorities to an increased risk of behavioural health issues [190]. As a consequence, the proportion of adults (aged 16-59 years) using illicit drugs is higher in those who identify as gay/lesbian (8.8%), bisexual (31.4%) and other (9.0%), than straight/heterosexual (8.8%) (*Figure 23*) [21].

In the UK, mephedrone and crystal meth (stimulants) are particularly used in sexual minority communities to trigger euphoria and sexual arousal. GHB/GBL and ketamine is also used to reduce inhibition and increase sexual pleasure. Intentional sex under the influence of these psychoactive drugs has given rise to the term "chemsex" in recent years [191,192] and it is estimated that 10% of men who have sex with men in England have engaged in chemsex within the past year [193]. However, this estimate may be conservative as other research indicates chemsex prevalence in men who have sex with men is 18.7% in HIV-negative and 41.7% in HIV-positive individuals [194]. This suggests that chemsex is associated with engagement in HIV risk behaviours [194]. In Birmingham specialist chemsex support is provided by Birmingham LGBT, supported by Umbrella Sexual Health.

Whilst chemsex drugs are of particular concern in the LGBTQ community due to increased potential for transmission of sexually transmitted infections (STIs), HIV and other bloodborne viruses [195], cannabis is still the most commonly used drug amongst gay/lesbian and bisexual adults nationally, and is proportionally the most used drug across all genders [21].
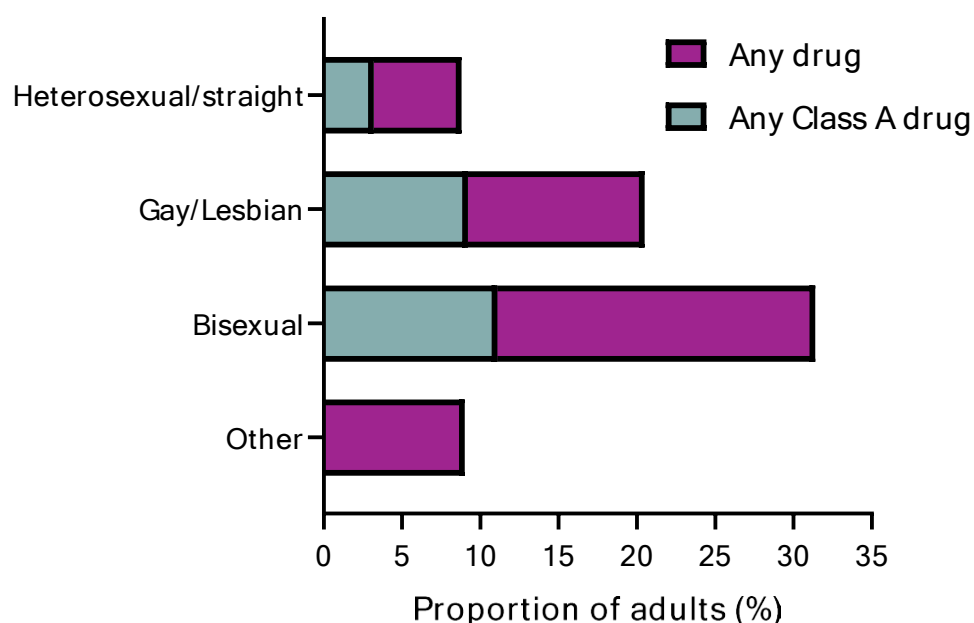
Figure 23: Proportion of 16 to 59 year olds reporting use of illicit drugs in the last year by sexual orientation, year ending March 2020 [21]. Bars are superimposed

For both heterosexual and sexual minority groups, new clients were mainly being treated for alcohol and opiate abuse. A considerable proportion (6.9%) of new clients in Birmingham preferred not to state their sexual orientation. Amongst the new LGBT clients in 2019/20, opiates were the main substance being treated for in adults identifying as bisexual or lesbian, whilst alcohol abuse was the main substance being treated for in gay men (*Figure 24*).
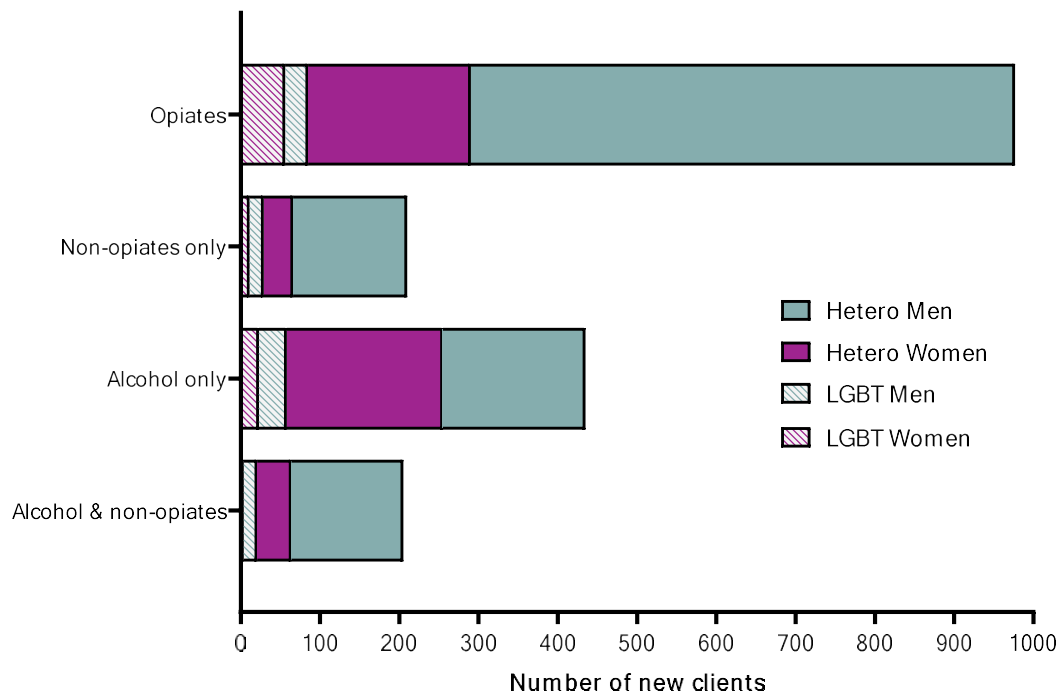
Figure 24: New clients in Birmingham in treatment by drug type and sexual orientation

Epidemiological data on drug and alcohol abuse in sexual minorities are lacking, which presents a major barrier when establishing health policy priority interventions. Furthermore, the complex sociocultural decisions and actions that lead to drug and alcohol abuse in the LGBT community warrant further investigation. Understanding the barriers that prevent LGBT drug users from accessing treatment services (e.g. social stigma) is critical in providing tailored and effective interventions. Societal stigma contributes to minority stress processes and is likely a catalyst for minority stress, which is thought to be a major driver of health inequalities in sexual minority communities [196]. Finally, the high prevalence of drug and alcohol abuse and increased risk of behavioural health issues in this community makes them particularly vulnerable to a range of health, socioeconomic, and criminal justice harms.

While there is an established evidence base around addiction and treatment, the experiences of transgender people have been excluded entirely or grouped with those of sexual minority groups [197]. This is even more the case for non-binary and genderqueer research.

Although an emerging field of research, gender minority groups experience many stressors which drive reliance on substances to cope psychologically [198] including discrimination, gender dysphoria [199] internalised transphobia [200], and higher prevalence of mental health problems.

Evidence, although limited, suggests that transgender individuals have significantly higher use of nicotine, alcohol and drugs compared to cisgender individuals [198]. And experience of any drug use disorder almost 4 times higher than the cisgender population. Non-binary people who used drugs appear to be more likely to report problematic substance use; may require more support with reducing substance use than people of other genders and may be at increased risk of experiencing sexual abuse when under the influence of substances, relative to cis and binary trans people [201].

Service providers should be aware of the multiple, complex drivers of substance use for these groups and ensure non -discriminatory delivery. Given the high prevalence of trauma experienced by gender minority people, trauma-informed psychosocial interventions may be useful in the management of problematic substance

8.9 Sex Workers

There is a strong association between substance use and sex work with research consistently indicating higher prevalence of alcohol and drug misuse than the general population.

Addiction can push individuals into sex work, or sex work can be the catalyst for addiction. It has been suggested that around 55% enter into prostitution with existing addiction, with the remaining 45% commencing drug use at the same time or after [202].

There is often a vicious cycle of using substances to cope with selling sex, violence and abuse, then needing to sell sex specifically to fund problematic addiction [203]. Unlike other substances, research suggests alcohol is less of a driver for entry into prostitution, with alcohol predominantly used as self-medication [204].

Street-based work remains the most visible aspect of the industry and is where the relationship with substance misuse is most prevalent. Evidence consistently demonstrates a high proportion of women involved in street-based prostitution have substance use problems. This group are more like to use class A drugs than indoor workers [205], in particular opiate use, but also frequently injecting and polydrug use [206]. Estimates are as high as 95% of street prostitutes in the UK using crack cocaine or heroin [207]. The Drug Treatment Outcomes Research Study (DTORS) found that 10% of women commencing drug treatment said that they had exchanged sex for money, drugs or something else in the past four weeks and sex workers on the whole have far higher rates of lifetime use of all drugs [208]. (Figure 25)
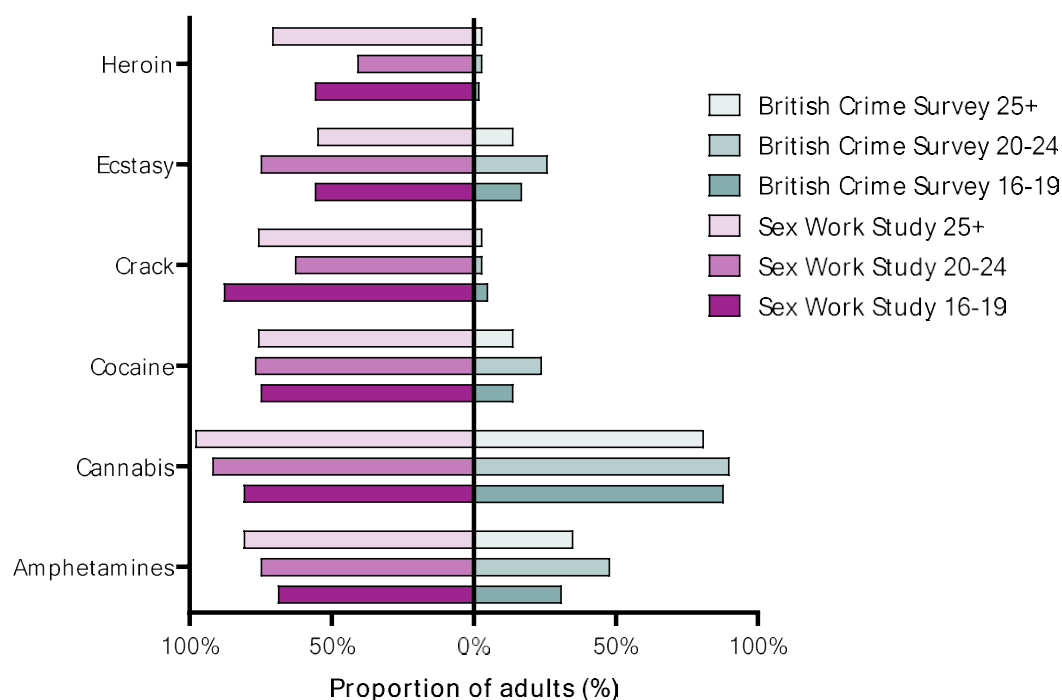
Figure 25: Percentage of Sex Workers who use different types of Drugs compared to the general population.

This is however an extremely vulnerable group often with multiple and complex needs such as homelessness, criminal behaviour, and mental health, with the double stigma of prostitution and addiction often preventing users from seeking support [209]. Addiction also presents additional risks to sexual health through riskier sexual behaviour, mental health, experience of violence, abuse and increased risk of incarceration.

Due to the nature of sex work, there are no comprehensive estimates of the number of people involved in the UK. Estimates range from between 60,000 and 80,000 and up to 5,000 are believed to be under 18 [210] for the UK as a whole. Using these estimates this means there may be 1,250 sex workers in Birmingham, however this could be much higher due to its hidden nature and typically poor engagement with services and research projects due to stigma [211]. Given the high prevalence of problem substance misuse in an already complex cohort of vulnerable individuals, services need to provide a holistic approach which addresses the root cause of substance misuse and the often-complex web of support needs, not just addressing addiction.

8.10 Homeless and Rough Sleepers

Homeless individuals and especially rough sleepers are at high risk of social exclusion, multiple health problems and substance misuse. Substance use can often lead to homelessness when addiction disrupt relationships with family and friends or causes job loss. But in many situations, substance abuse is a result of homelessness rather than a cause. It becomes a means of coping in a difficult situation, to get temporary relief, or even to be accepted. Motivation to stop using substances can be low when survival is more important than seeking support and recovery [212].

UK research shows that almost three quarters of people who had slept rough had had a drug or alcohol need during their life, either historically or still actively using or dependent on them [213]. 'Need' refers to those who consider themselves dependent, have been in treatment, or have high levels of use. 60% had a current need and 12% were defined as having both drug and alcohol needs. Cannabis, crack cocaine and opiates are the most used (Figure 26). Problematic substance use is perhaps most visible in this vulnerable group of citizens.
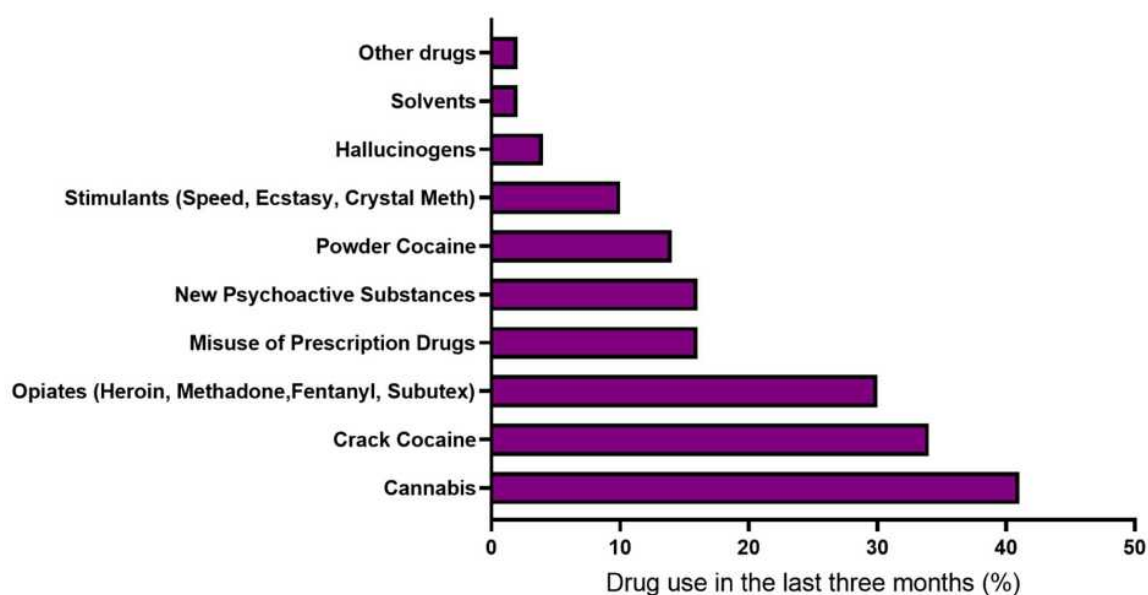
Figure 26: Percentage of rough sleeping respondents using drugs by drug type within the last three months

Dual diagnosis (co-morbidity of substance abuse and mental health issues) is a serious and prevalent problem, particularly within homelessness which presents its own multitude of

barriers when accessing services including mental health support (see section 9.6). Evidence suggests that around 10-20% of the homeless population would fulfil the criteria for dual diagnosis and they are nearly five times more likely to die than the equivalent age group in the general population [214]. The effects of drug and alcohol use also have an extremely detrimental effect on the physical health of homeless people. It causes early alcoholic liver disease and is often also associated with Hepatitis C, both of which often result in severe liver disease and early death.

Statistics show that 37% of all deaths among homeless people in England were a result of drug poisoning compared to 1% for the general population. Around 10% of estimated deaths are from alcohol-specific conditions [215]. This is due in part to higher prevalence of OCU use, however evidence also suggests that the excess deaths we see associated with considerable social exclusion is extreme [216]. They are likely to present a high level of health needs, but at the same time are not accessing health services which exacerbates vulnerability and exclusion.

In Birmingham, 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 [217].

A local study of patients registered to Birmingham Homeless Healthcare Centre in Birmingham city centre found that nearly one in eight had been offered support for substance dependence and one in five had been offered support for alcohol misuse [218]. In November 2020, there were 217 known people in the city with an alcohol or drugs problem who are either sleeping rough or in danger of doing so in the future. This includes rough sleepers, people in emergency and temporary accommodation, and people who recently moved into other accommodation. However, true estimates are potentially much higher. The Hard Edges Report [219] estimates that as many as 2.8 people in every 1,000 Birmingham Citizens experience coexisting homelessness AND substance misuse problems, which equates to 1,880 people (this definition of homeless includes those in temporary and emergency accommodation as well as rough sleepers). 31% of these individuals also have mental health problems.

Despite suffering worse health than the general population, homeless people often struggle to access healthcare and support services or maintain engagement. Services should be specialised and accessible with early prevention and treatment of mental health and substance dependence with joined-up social support if the cycle of homelessness is to be broken. The Advisory Council on the Misuse of Drugs (ACDM) recommend [220]:

- local services adopt a tailored approach to tackling the specific needs of homeless drug users in their area
- Integrated and targeted services, outreach, and peer mentors to engage and retain homeless people in proven treatments
- raising awareness among service providers of the levels of stigma experienced by homeless individuals who use drugs and ensure they are treated with respect
- involving people with experience of homelessness and substance use in the design and delivery of the service provision for substance use and homelessness services

8.11 Modern Slavery

Modern slavery is a public health concern due to its major implications on the physical, mental, psychological, and developmental health of the victims [221]. Modern slavery includes sexual exploitation, forced labour, organ harvesting, forced begging and gang related criminality. A large a proportion of modern slaves had unstable lives at home, mental or physical issues and drugs and/or alcohol dependencies prior to being recruited [222]. Victims

with addictions are often supplied alcohol, drugs and gifts as an incentive to partake in criminal activity. This lifestyle is glamorised by offenders to manipulate and exploit victims [222,223]. Drug coercion is a known recruitment tactic; some traffickers target individuals who have recently come out of rehab or detoxification programs or may recruit directly from drug treatment facilities and services [224]. Perpetrators may entrap victims using existing or newly initiated dependencies and use the threat of drug withdrawal for control, this method may cause extreme mental and physical trauma [224]. Opioids are an extremely effective coercion tool due to their pain numbing qualities [225]. Drugs may also be used by victims in order to deal with the trauma captive and abused by traffickers [226].

The report 'A Few Doors Down' commissioned by the Salvation Army and Black Country Women's Aid made links between substance misuse and modern slavery and states that victims are often negatively stigmatised [227]. Childhood abuse, such as that experienced by victims of child modern slavery has been associated with poor adult mental health, which may lead to drug and alcohol misuse [228]. The Independent Anti-Slavery Commissioner estimated that there were 136,000 victims of modern slavery and human trafficking in the UK in 2019 [229]. Furthermore, Birmingham Police service recorded that there was a total of 615 reports of modern slavery offences from March 2019 till March 2021. It is essential that survivors are referred to safe and trauma-informed services and facilities and secure housing when identified [224]. Trauma-informed care prevents re-traumatisation and increases chances of long-term recovery, providing training to healthcare professionals for ethical trauma-informed care is therefore essential [224]. Coordination between drug and alcohol services and healthcare professionals to identify victims with substance use issues could prevent preparators from gaining further access to victims.

9 Service User Perspective

The voice of services users and people with lived experience is a crucial part of understanding need. A user group of past and current service users, facilitated by CGL was held to understand some of the barriers to support and recovery, and what works, and its findings were captured. We have tried to retain the user voice as much as possible while protecting identity.

Source: Change Grow Live Service User Group
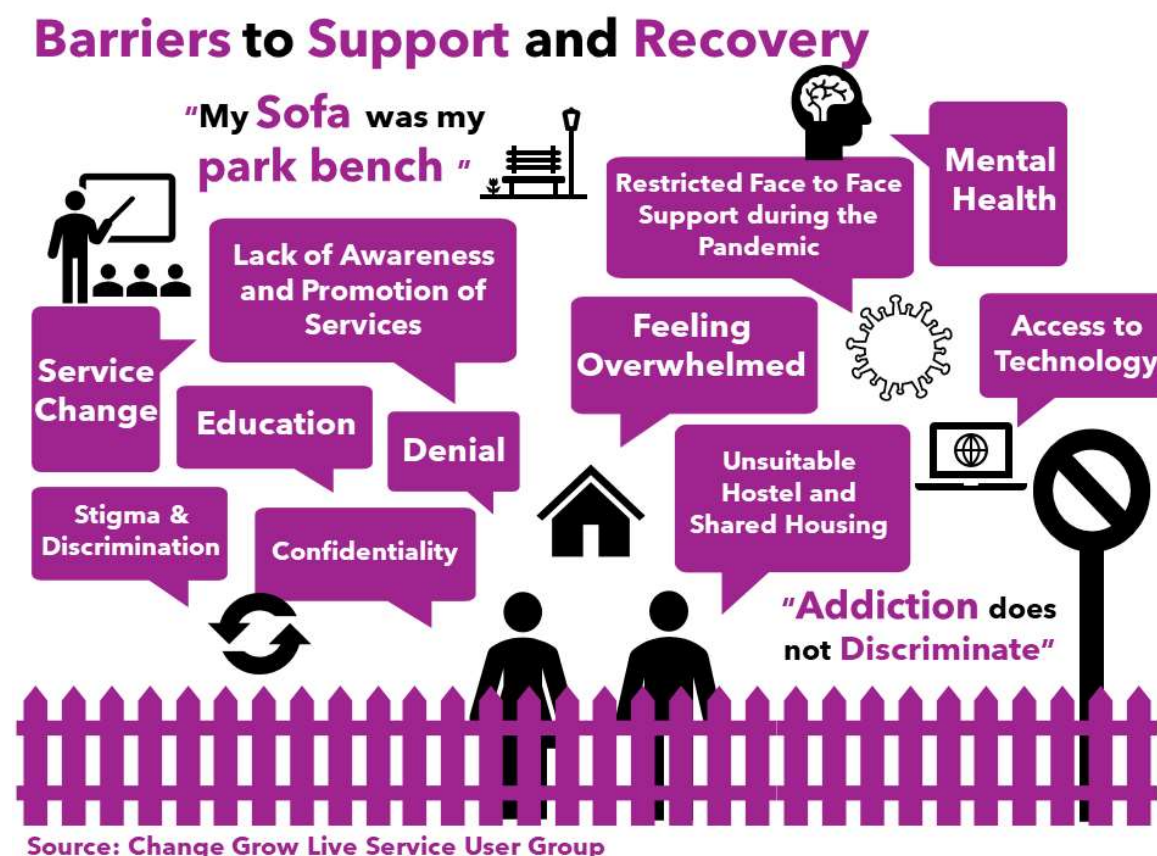
- There is sometimes too much of an assumption that people have access to technology and can access support and information online. Many people still rely on face to face or telephone contact to get the right support and have conversations with the right people, because they've lost or did not have technology skills in the first place. There always needs to be a non-online option available to people when they're trying to access any service, otherwise you're at risk of people just giving up.

- Support networks either closed completely or totally changed the way they operated during the pandemic.

- Unmet mental health needs fuel people's addiction, which often lead down the road to novel psychoactive substances like spice and mamba. Once those drugs get a hold of you, you're in trouble. You're likely to end up homeless and in need of accommodation

- When you then try to get support, you are given accommodation in settings that will set you back further in your recovery, i.e. hostels/shared housing. Or people are given flats and because they've lost their ability to cope with daily living tasks, they cannot cope with holding down their tenancies, so they just stay stuck as they are.

- People need consistency with services, so that they can build up relationships with the staff and support that is available and learn to trust them. Changing service name, contact details, locations every 3-5 years doesn't help with this. People feel this should stay the same regardless of which provider is responsible for delivering services.

- Members of the public and professionals need to know who the substance misuse provider is, where they are based and how people can access their support. All too often people attend their GP surgery and are met by professionals who themselves have no idea who the drug and alcohol services are and how they can be accessed. And very simply, there is rarely even any posters/information up in GP surgeries for people to read/learn about services in reception areas.

- Lots of people can feel very nervous about seeking support for drug and alcohol issues because they are concerned key people in their lives, i.e. employers/family will be told about their engagement. Service providers need to do a better job at the point of advertising their services, of assuring services are free and, importantly, are confidential!

- People who feel overwhelmed with addiction and their situations will have little to no belief that change is possible and that recovery is attainable. As a result, people don't reach out for support as they don't feel like there is a way out. Service providers need to do a better job of promoting success stories and showing people that recovery is real and is possible with the right support.

- Providers need to do a better of job of helping people to realise they may have an issue that requires support. People are often in denial or have absolutely no idea about how their alcohol or drug use is impacting on them or others around them. They need information and advice delivered in a way that will help them to recognise where they are at with their substance use and how they need to spend some time considering the benefits of making changes.

- Some people reach a point in their addictions where it can feel to the individual person, like society has completely given up on them...

"Services need to attract people by showing them why that service will improve their lives and why it's important. It needs to be more than just simply promoting the support and what's on offer."

- There is still a huge amount of stigma around alcohol and drug issues. People don't understand or acknowledge that drugs and alcohol problems can affect anyone, and people don't see it as an illness There needs to be more publicity about drugs and alcohol that helps the public to understand why people are affected by drugs and alcohol and how they or somebody else they know may need some support.

"Addiction does not discriminate….people assume that you're classed as an alcoholic when you've hit rock bottom and you're

homeless and drinking on a park bench. My sofa in my living room was my park bench"

- There needs to be stronger advertising campaigns about the harm alcohol does to people's health and lives. People feel like the often very discrete "drink aware" messages that are heard on TV, do not carry a strong enough message and that they need to be more serious/improved when it comes to highlighting the harms of drinking alcohol excessively.

- There is an age-old problem with attitudes within mental health services when it comes to drug and alcohol issues. Mental health services need to stop turning people away from support, because they learn about a drug or alcohol issue, and instead recognise that people drink or use drugs because of an underlying mental health issue. Some people feel like there needs to speciality services available to people who have co-existing drug and alcohol, and mental health issues, where individuals will be taken seriously and will be supported for both conditions.

- There needs to be better education amongst the general public about addictions and why people develop them, with information how people can cope / address their issues. This goes for the individual people who have addictions themselves, their children, family members and employers. Everyone involved needs a better understanding and better access to support that will help them through it.

- People need support to recognise they may be developing an addiction sooner, so they can prevent reaching rock bottom.

"Addiction is a progressive illness. I used to look down on those people who sat on park benches or friends who I'd see drinking too much. And back then, I was drinking at levels at which I could have stopped. I wasn't aware of what was happening with my alcohol use, why I was drinking and how this was actually getting out of hand."

What helped / prompted people to get into recovery

- Finally finding the courage to be honest about their drug and alcohol issue with themselves and other people
- Building confidence by getting involved in activities that helped them to realise they could achieve things in life, i.e. courses at college
- Working on their attitudes towards themselves and developing their self-worth
- Breaking old connections and finding support networks where they don't feel judged
- The realisation that their addiction was impacting significantly on their health

"I realised I was killing myself. My drinking was a form of self-abuse. I'd pretty much given up. But then I had a realised I still had a lot to offer in this world. I could still contribute something positive. So, I reached out for support."

10   Health Economics

Health economics is about using resources efficiently and effectively to improve the population's health. This part of the needs assessment looks at what financial resources are available for substance use in the City, and value for money when we consider outcomes using some of the national tools, it is recognised that this does not includes charitable and privately funded services and support.

10.1 Adult's Service

The total expenditure (adults) for substance misuse in Birmingham was £16,388,000 in 2020/21. Total expenditure for alcohol misuse treatment in adults was £2,800,000. Total expenditure for drug misuse treatment in adults was £8,316,000. These are the summative expenditures for all associated service provision.

Other funding sources include the Office for Health Improvement and Disparities (OHID, previously Public Health England), with additional funding from:

Alcohol Capital Grant

The Public Health Division in partnership with CGL successfully bid for and received **£749,971** in April 2019 for the Birmingham Substance Use Service to refurbish and set up four new locality-based Recovery Hubs. These new Recovery Hubs underpin a transformed service model, which will deliver improved access to alcohol treatment for Birmingham citizens.

Rough Sleeping Drug and Alcohol Treatment Grant Scheme

The Public Health Division in partnership with CGL successfully bid for and received **£1,012,683** in March 2021 to fund specialist support for individuals in 2021/22 to access and engage with drug and alcohol treatment and move towards longer-term accommodation, supporting the work of wider homelessness and rough sleeping funding. BCC is currently awaiting confirmation that a similar amount of funding will be available for 2022/23.

Section 31 local authority grants for additional drug treatment crime and harm reduction activity in 2021/22 – Universal funding component

Birmingham was allocated **£1,209,000** in April 2021 by OHID to help local areas drive down the crime associated with the drug market, particularly acquisitive crime and violent crime, and the rise in drug-related deaths. At this juncture it is not known if this funding will be extended to cover 2022/23.

Additional drug treatment crime and harm reduction activity funding in 2021/22

The 14 local authorities in the West Midlands region have been allocated a share of **£1,192,500** by OHID to start commissioning additional inpatient alcohol and drug detoxification provision, which will increase the capacity within the treatment system. Birmingham's share of the **£1,192,500** is **£285,216** (24%) and all 14 local authorities are working in partnership via a Consortium. At this juncture, it is not known if this funding will be extended to cover 2022/23.

Total amount of additional funding from PHE/OHID is: **£3,256,870**

10.2 Children and Young People's Service

The total expenditure for specialist drug and alcohol misuse services for children and young people was £738,000 in 2020/21 for Birmingham. Young people's provision and funding is not split with regards to drugs and alcohol; frontline practitioners work with any presenting substance.

10.3 Spend and Outcomes

The Spend and Outcomes Tool (SPOT) provides a broad overview of spend and outcomes on a range of public health interventions (*Figure 27*). SPOT aims to help local commissioners improve people's health and wellbeing and reduce health inequalities through better information about value for money.

To enable comparison between different indicators, SPOT includes Interquartile Range (IR) scores. An IR-score between 1.5 and 3 signifies a potential outlier, whilst an IR-score above 3 indicates a probable outlier. These values are effectively equivalent to 1 and 2 standard deviations, respectively. Spend figures are based on spend per head per annum and calculated by dividing total spend by total resident population.

For further information on the methodology used for SPOT visit PHE SPOT Methodology and Interpretation [230].
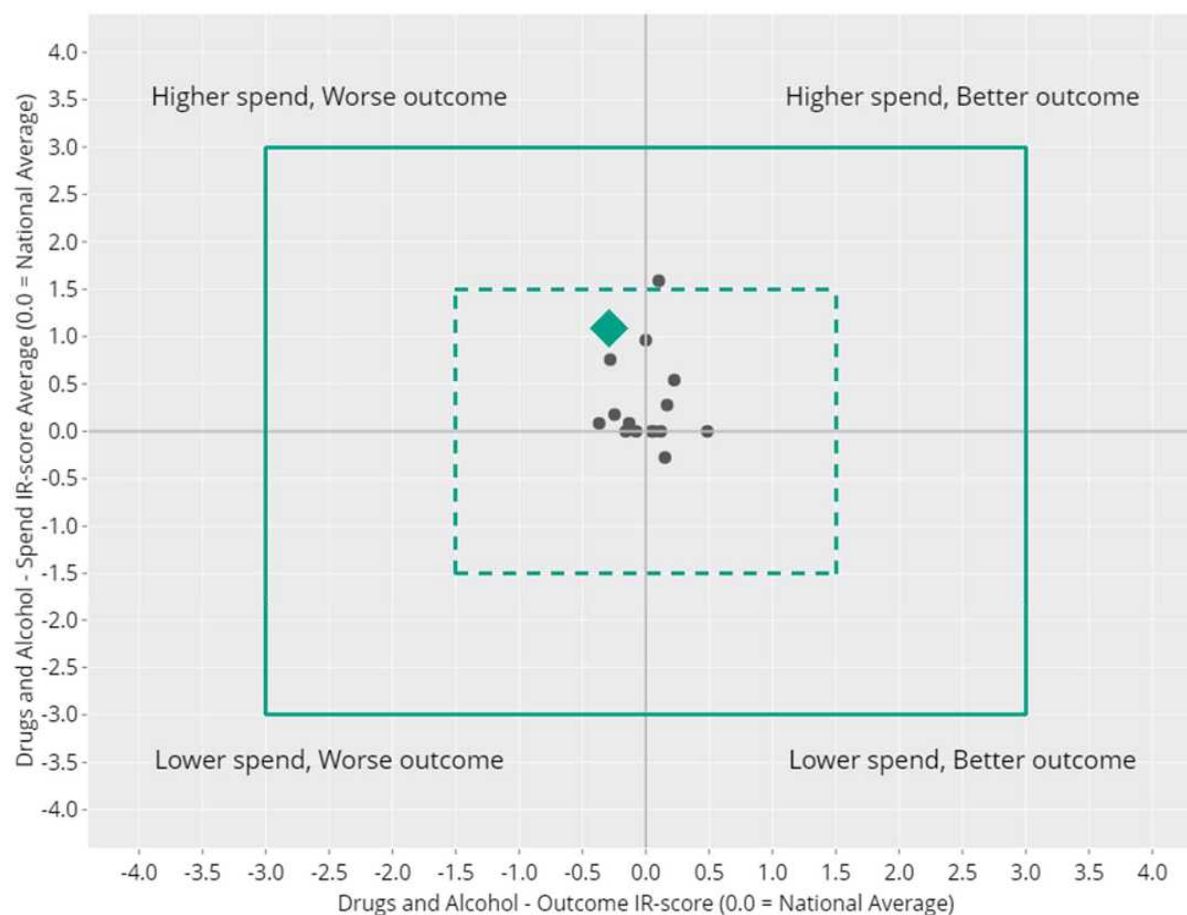
Figure 27: Birmingham Spend vs Outcomes against statistical neighbours (CIPFA)

Birmingham is placed in the upper left quadrant. This indicates that Birmingham has higher spend and worse outcomes compared to the national average.

Interestingly, SPOT results are contradictory to local benchmarking data. As of 2020/21, Birmingham has a spend of £12.44 per head for adult substance misuse services, which is the lowest of all English core cities. The highest is Liverpool with a spend of £26.83 per head; more than double the spend of Birmingham. However, Birmingham ranks relatively poorly for successful opiate, non-opiate and alcohol completion rates compared to English core cities (5th out of 8 for each). When Birmingham is compared to statistical neighbours a similar pattern emerges whereby Birmingham's rank for spend (6th out of 11) is better relative to its outcomes (9th out of 11 for opiate and non-opiate successful completions; 11th out of 11 for successful alcohol completions).

A plausible explanation for higher spend in Birmingham, based on SPOT, is due to Opioid Substitution Treatment (OST). OST is defined as the administration of a prescribed (daily) dosage of opioid medicines to patients with opioid dependence problems. The medications used for OST are methadone and buprenorphine and are recommended by the National Institute for Health and Care Excellence (NICE) guidelines for opioid substitution treatment [NICE TA114]. There are several costs associated with the prescribing of OST (e.g. prescribing, dispensing, pharmacy and GP costs)[4]. In Birmingham, as of November 2021, there were approximately 3,300 service users within the CGL service receiving OST with an estimated cost of £200 - £250k per month.

10.4 Social Return on Investment

Social Return on Investment (SROI) is a framework to measure and account for the broader impact of environmental and social values in order to 1) reduce inequalities and environmental degradation, and 2) increase wellbeing by taking into account the social and environmental costs and benefits alongside the economic costs and benefits (A guide to Social Return on Investments; the SROI Network). This tool allows commissioners and policy makers to make informed decision when commissioning services.

According to the most recent estimates in 2016-17, for every £1 spent on drug and alcohol treatment services in Birmingham, there was an estimated social return on investment of £5.60 for individuals in treatment and £27.10 for individuals in treatment and recovery. The gross benefit per person was £9,640 (in treatment) and £46,761 for long-term gross benefit per person. Table 2 displays the benefits gained from Investment into drug and alcohol treatment in Birmingham.

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[4] Pharmacy costs are for supervised consumption whereby the pharmacist or registered technician supervises the consumption of methadone or buprenorphine at the point of dispensing in the pharmacy. GP costs relate to Shared Care GPs who see clients on a 12-week cycle and carry out medication reviews.

Table 2: Estimated benefits gained from investment into drug and alcohol treatment in 2016/17

Offence Type	Estimated Crimes committed before treatment	
	Drug users	Alcohol Only
Shoplifting	245412	5405
Theft of a vehicle	3307	15
Theft from a vehicle	9922	25
Domestic Burglary	1984	78
Non-domestic burglary	12568	44
Robbery	3969	28
Fraud	5292	15
Criminal damage and arson	225	36
Violence against the person	583	128
Sexual Offences	90	30
Begging	31090	1
Drink/Drug driving	49	43
Other Theft	25137	82
Drug offences	140897	13
Prostitution	32413	0
Breach Offences	590	52
Public Order	87	18
Other Theft	428	45
Total	*514055*	*6059*

Estimated Crimes after starting treatment	Drug Users	Alcohol Only
% Change	-29%	-45%
Number of crimes prevented	148,941	2735

Average crime-related cost	Drug Users		Alcohol Only	
	Before starting treatment (£) →	After starting treatment (£)	Before starting treatment (£) →	After starting treatment (£)
Social costs	3616 →	2568	772 →	423
Economic costs	23836 →	16929	1367 →	750
Social and Economic costs	*27451 → 19498*		*2139 → 1173*	

Gross Benefits	Drug Users (£)	Alcohol Only (£)
Social Return	6,640,103	652,941
Economic Return	43,771,520	1,156,863
Total	**50,411,623**	**1,809,804**

For every £1 spent on drug treatment services, there was an estimated social return on investment of £6.50 for individuals in treatment, and £30.00 for individuals in treatment and recovery. The gross benefit per person was £11,670 (in treatment) and long-term benefit per person was £53,665.

For every £1 spent on alcohol treatment services in Birmingham, there was an estimated social return on investment of £1.80 for individuals in treatment, and £15.50 for individuals in treatment and recovery. The gross benefit per person was £2,780 (in treatment) and £23,424 for long-term benefit per person.

In 2016-17, an estimated 514,044 crimes were committed by drug users and 6,059 crimes by alcohol (only) dependent users, before treatment. Shoplifting (47.7%), drug offences (27.4%) and prostitution (6.3%) were the most reported offences committed by drug users and shoplifting (89.2%) was the main offence for those with alcohol only problems. Substance misuse treatment is estimated to have prevented about 149,000 (a reduction of 29%) crimes committed by drug users and about 2,700 (a reduction of 45%) crimes by alcohol users.

The social and economic costs before starting treatment for drug users was £27,450. This reduced by about 29% to £19,498 after the start of treatment. The social and economic costs before treatment for alcohol only was £2,139, which reduced by about 45% to £1,173 after starting treatment.

10.4.1 Children and Young people

School-based prevention interventions, including those delivered as part of the curriculum, derive cost-benefits for society. For example, interventions to tackle emotional learning save money in the first year by reducing costs for social services, the NHS and criminal justice system, and have recouped £50 for every £1 spent [231].

Specialist interventions for young people's substance misuse are effective and provide value for money. A Department for Education cost-benefit analysis found that every £1 invested saved £1.93 within two years and up to £8.38 in the long
Term [232].

11 Key Findings

- Capturing true prevalence of drug and alcohol misuse in the population is challenging and is likely to be much higher than is currently captured.
- Evidence around the impact of the pandemic on substance use is still emerging and the longer-term impact on health and service demand is yet to be realised, however it is an important consideration in planning for future service and resource planning
- 1,140 individuals are in treatment at specialist alcohol misuse services in Birmingham (2019/20), which is almost a 42% reduction since 2016/17
- There are 10,525 problem drug users of opiate and/or crack cocaine (OCU) in Birmingham, of which 8,799 are opiate users and 6,817 are crack cocaine users. The rate of OCU was 14.2 per 1000 people which is significantly higher than the England (8.9) and the West Midlands (9.6) rates
- White men aged 30-49 years made up the highest proportion of CGL clients in treatment for opiate, non-opiate and alcohol problems
- In Birmingham there are an estimated 13,442 dependent drinkers, which represents 1.58% of the adult population (2019/20). This is higher than the England average (1.37%)
- The number of individuals not in contact with drug treatment services for an opiate problem in Birmingham (n = 4,114) has increased by 42.8% since its lowest number in 2012/13. This represents an unmet need of 46.9%, which is comparable to the national figure (46.3%)
- The number of individuals not in contact with drug treatment services for an OCU problem in Birmingham (n = 5,728) has increased by 53.6% since its lowest number in 2012/13. The unmet need (54.4%) is comparable to the national figure (53.4%)
- The number of individuals not in contact with drug treatment services for a crack cocaine problem in Birmingham (n = 3,887) has increased by 14.3% since its lowest number in 2012/13. The unmet need (57.0%) is lower than the national figure (61.3%)
- The number of individuals not in contact with treatment services for an alcohol problem in Birmingham (n = 11,830) has increased by 10.1% since its lowest number in 2014/15. This represent a large unmet need of 88.0%, which is higher than the national figure (83.0%)
- There are several inequalities that predispose marginalised groups to substance misuse. Therefore, there is a need to acknowledge intersectionality in the context of substance misuse to better understand diverse and complex treatment needs.
- Social return on investment is very high in terms of monetary value and reduction in crime
- For every £1 spent on drug and alcohol treatment services in Birmingham, there was an estimated social return on investment of £5.60 for individuals in treatment and £27.10 for individuals in treatment and recovery. The gross benefit per person was £9,640 (in treatment) and £46,761 for long-term gross benefit per person
- Substance misuse treatment is estimated to have prevented about 149,000 (a reduction of 29%) crimes committed by drug users and about 2,700 (a reduction of 45%) crimes by alcohol users

12 Recommendations

12.1 Recommendations to promote a partnership approach

- Increase engagement with drug and alcohol users through targeted activity (e.g. women less likely to be picked up by services than men)
- Create/enhance pathways between substance misuse services and other services such as the secondary mental health services, CJS and primary care
- Continuation of specific pathways from police custody (e.g. from police healthcare)
- Data sharing to prevent duplication and more efficient progression through concurrent treatment services
- Continuation of a centralised service that links into related services so that clients with complex needs are offered treatment in a timely and orderly manner
- Specialist services should engage with mainstream treatment providers to encourage engagements and successful completions in treatment
- Embed service user voice in treatment planning, evaluation, and service design
- Substance misuse should be included in future inclusion health (inequalities team) needs assessments and deep dives to highlight inequalities and intersectionality in vulnerable groups. For example: sex workers, mental health. This will lead to increased understanding and awareness of the challenges faced by these vulnerable groups

12.2 Recommendations to improve access to services

- A single case-management system that is used by all service providers across Birmingham. This would improve staff efficiencies, reduce administrative inefficiencies, enhance client engagement and experience, and improve access to services for potential clients
- Outreach programmes should be developed jointly by service providers, public health officers and substance misuse treatment service commissioners and coordinated between them to maximise contact with hard-to-reach communities
- Promote the presence and involvement of recovery champions across partnership organisations/services
- Locality based service provision for hot spots in the city

12.3 Recommendations to reduce harms and improve recovery

- Person centred approach offering individualised and flexible treatment, whilst acknowledging the socioenvironmental and demographic factors that cause inequalities related to substance misuse
- Promote client recovery through holistic treatment services that address wider determinants of health concerns (e.g. employment, housing)
- Harm reduction, maintenance and palliative care has been the focus within treatment services. More focus on recovery needs to be adopted within treatment services in Birmingham, in line with the National Drug strategy 2010 [234]
- More focus on prevention is needed, specifically on gateway drugs and alcohol in younger people and opiates in adults
- Improve awareness and knowledge of substance misuse in frontline (non-substance misuse) services by providing specialist training to staff
- Diversity and inclusion training to be a requirement for all staff in substance use service provision

- Ensure resources are distributed according to the level and specificity of substance misuse needs
- Focus on improving health-related outcomes. Spend per head is relatively low in Birmingham for substance misuse services but relatively poor for outcomes in comparison to statistical neighbours and core cities

12.4 Recommendations to improve knowledge and understanding of client base and local prevalence

- Data collection and quality needs to improve. This could be achieved by working with academic partners to collect qualitative and quantitative data on treatment interventions, outcome monitoring, recovery and unmet need
- Data should be routinely collected in education settings (young people) to gather information on early substance use, which could improve the effectiveness of preventative programmes
- More representative data are needed to understand the behaviours associated with and the prevalence of substance misuse. The sample nationally and regionally is not representative of the clients in treatment. More research in and engagement with hard-to-reach communities is warranted, as well as in the general population
- More granular data needed on drug types other than opiate and crack cocaine. Targeted research on prevalence of drugs for which the prevalence is not well established (e.g. opiates, crack cocaine, GBL, cannabis and crystal meth)
- A working group should be formed between relevant bodies (e.g. commissioners, subject experts, service professionals, service users) to develop an action plan for the routine collection of specific data
- Undertake robust research on effectiveness of treatment interventions
- Undertake robust research on efficacy of prevalence and substance use monitoring in different settings (e.g. schools)
- Research should be conducted by independent organisations (e.g. academic and 3rd sector) to detach from institutions that are perceived negatively by respondents and therefore influence the validity of data (i.e. research should not contain words like "crime" that could have an influence on participants)
- Conduct a deep dive focusing on mental health in relation to substance abuse (dual diagnosis)
- Substance misuse should be included in future inclusion health (inequalities team) needs assessments and deep dives to highlight inequalities and intersectionality in vulnerable groups. For example: sex workers, mental health. This will lead to increased understanding and awareness of the challenges faced by these vulnerable groups

13 Limitations

- Prevalence estimates at local authority level for drug types other than opiate, non-opiate and crack cocaine are not currently captured. More granular data are needed on a wider range of drug types
- NDTMS data are not always consistent with Fingertips data, which leads to ambiguity and potential reporting errors
- High fidelity data are unavailable at a local and national level for prevalence by drug type across all ages
- Readers should be cautious when making generalisations based on the data and evidence in this needs assessment. Some of the data are not representative of the general population. Furthermore, the data were largely derived from PHE fingertips and NDTMS, precluding secondary analysis of the data
- The scale of the problem on substance misuse is likely an underestimate. Unmet need represents the proportion of individuals in need of treatment but who are not currently receiving specialist treatment for substance misuse compared to prevalence. Given the propensity for surveys on substance use prevalence to introduce sources of error and provide underestimates [233], this would result in a greater unmet need than currently reported
- Unmet need may also be influenced by temporal lag in reporting. NDTMS data for prevalence after 2016/17 is not available. Therefore, estimated prevalence of OCU and alcohol users beyond this year has been based on the 2016/17 prevalence estimate. Adults in treatment is however reported on till 2020/21. The paucity of up-to-date available data may contribute to an underestimated unmet need

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Triple Zero City Consultation

Citizen Views and Analysis

October 2021

BE BOLD BE BIRMINGHAM

Birmingham City Council

Background

The Triple Zero City Strategy is a new approach aiming to reduce deaths, overdoses and addiction linked to drug and alcohol misuse. This work is overseen by the Health Protection Forum sub-group of the Health and Wellbeing Board and is managed by the Health Protection Team. Birmingham City Council asked the people of Birmingham, strategic partners and key agencies to give their view on the strategy. The questionnaire went out to public consultation on 10th May 2021, closing on 2nd August. Responses and views were sought via an online questionnaire hosted on the City Council consultation hub, 'Be Heard', (https://www.birminghambeheard.org.uk). The consultation was online only due to the impact of COVID-19.

Methods

The questionnaire asked 22 questions relating to the different parts of the strategy using a 5 point Likert scale (Strongly Agree to Strongly Disagree) alongside free text boxes, to capture opinion on the proposed strategy for tackling substance misuse, addiction and associated harms. Responses using the scales were captured numerically and associated percentages calculated.

The questionnaire included a section to capture the demographics of respondents. This was a voluntary part of the questionnaire and was analysed to understand the characteristics of those responding and whether they were representative of the population.

Free text, qualitative responses were analysed independently by a team of analysts. An inductive thematic coding approach was used to allow key themes to emerge. This approach included open coding whereby anchors were identified, and key data points gathered, consistent with Grounded Theory. Higher order themes were then established as the data grew richer.

This meant examining each text response to identify common themes (topics, ideas and patterns of meaning) that come up repeatedly. Instances of each theme were counted with the most common themes reported on, and where necessary sub-themes to provide additional context. Quotes were selected to represent the balance of feedback. The supplementary written responses received from individuals and organisations via the Triple Zero mailbox, were included in the overall analysis.

Results

894 responses were received overall with between 208 and 454 written responses per question that included a free text field. Emergent themes from written responses are presented for each question in the consultation.

Whilst each question comprised subject-specific responses that lead to specific themes, some themes were consistent across questions. For example, thematic

analysis of multiple questions revealed that respondents generally felt that the "Zero" target was unrealistic and overly ambitious but it was the right thing to aim for.

Conclusion

The quantitative results from the consultation showed that respondents agree with the strategy overall. At the same time many of the people who provided a written response expressed concerns with the details of the strategy such as wording, implementation and recognising the interconnections and the wider determinants of addiction in delivering the strategy.

We recognise that not everyone provided a written response in addition to their selection on the scale, and research shows that those with strong positive or negative views are the more likely to provide additional context to their responses.

Given the valuable contribution of respondents' voices, the final strategy should incorporate the themes that emerged from this consultation

Respondent Characteristics

- A typical respondent who provided their demographic information was a white male or female member of the public aged 50 – 74 years; identifying as Christian or no religion and heterosexual, without a disability but with a condition that affects everyday activities.
- **77.6% of respondents were a member of the public** and 14.3% were health or care professionals; the remaining 8.1% comprised public health specialists, academics and people who preferred not to answer.
- **The age of respondents was very different to the population.** Over half (56.1%) of respondents fell within the age group 50 – 74 years compared to the 22% in the general population. Only 4% of responses were from people in their 20s, compared to 21% of the population.
- **People from non-white ethnic groups were under-represented in the cohort responding to the consultation.** Most notably the number of responses from Asian or Asian-British individuals was less than a third of what the background population suggests it should have been (8% compared to 27%). 84% of those that gave their ethnicity were white, compared to 58% of the population. 13% did not answer this question or preferred not to say.
- **Slightly more people identifying as female responded to the consultation.** Of those providing their gender 55% identified as female. 6.6% did not or preferred not to answer. We acknowledge that the consultation design only offered Male or Female as options and this will be changed in future consultation.
- **The most represented religious group was Christianity (46.0% of those stating their religion).** This is the same as the population (46.1%). However more people responding stated they had no religion (43%) compared to the population (19%) and some other faiths were under-represented. The most notable ones being Islam – only 5% compared to 25% and Sikhism (1% compared to 3%). 19% preferred not to or did not answer.
- **More people stated they had a disability than population data suggests.** 18% of respondents choosing to answer this question said they had a long-term condition or disability compared to 9% in census data. 7.3% preferred not to answer and 1.6% did not provide a response.
- **Of those that gave their sexual orientation 91% were heterosexual/straight** The other respondents who provided an answer were bisexual (5.0%), gay (3%), lesbian (1%), 13.4% preferred not to say or did not answer (17%).
- **Health conditions** that affect every day activities were relatively equally shared amongst the different types of conditions with respondents stating that **mobility (15.8%) and mental health (15.0%) were most common.** Other conditions reported included breathing/fatigue (13.1%), dexterity (10.4%), hearing (10.1%), memory/concentration (6.1%), neurological (4.3%), vision (4.2%) and learning (4.0%).

While the population is likely to have changed since the 2011 census data we are comparing to, we recognise that participant demographics are in many cases still not representative of the Birmingham population. This is despite there being targeted

promotion activity to capture the views of specific demographic groups and this is something we can learn from for future consultation. We did not ask if people had lived experience of drug or alcohol addiction as either individuals, or their family and friends. This would have been valuable information to obtain.

Do you think / To what extent do you agree

Some of the questions in the survey had two parts. Part 1 looked like **"Do you think that including ……… is a good idea?"** whilst part 2 looked like **"To what extent do you agree or disagree that these actions on ……… should be included in our framework for action?"**

Although these questions appear similar they highlight the difference between concept and practicality. The 6 questions comprising two parts with corresponding responses are shown below.

Do you think that including ……… is a good idea?

To what extent do you agree or disagree that these actions on ……… should be included in our framework for action?

Prevention	
Early Intervention	
Treatment, Support and Recovery	
Children and Young People	
Additional Challenges	
Data and Evidence	

Legend:
- Strongly agree
- Agree
- Don't know
- Disagree
- Strongly disagree
- Not answered

More respondents strongly agreed that including each subject was a good idea than the actions being included in the framework for action. This demonstrates that **respondents are in favour of including all of the proposed subjects conceptually.** However, when it came to the practicality of including these in the framework for action, fewer people were as strongly in agreement.

Analysis of the written responses allows us to understand these discrepancies and **take action to strengthen the strategy.**

Shared Ambition

To what extent do you agree or disagree with having this as a shared ambition for Birmingham?

Over 99% of respondents answered this question using the scale. 87% agree or strongly agree with the ambition.
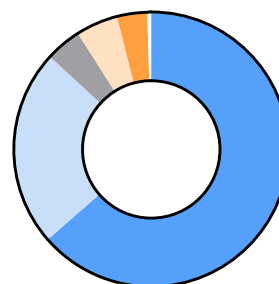
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	568	63.6%	207	23.2%	38	4.3%	44	4.9%	32	3.6%	4	0.4%

Top themes from free text responses and what they are saying

444/894 respondents provided a written response. Of those:

- **123** felt that the shared ambition was **unrealistic** or had **concerns over the practicality of delivery and resourcing, wording, measurement, and accountability.** However of these, the majority (109) still felt it was **commendable** or **worth aiming for**.
- **55** respondents raised **concerns about the current state of service provision** and the substance misuse situation in Birmingham, whilst **47** felt the ambition needed to **consider other factors that contribute to drug and alcohol abuse** (e.g. homelessness, crime, unemployment). It was generally felt that better support is needed to overcome failing services, and education and prevention is needed rather than responding to emergencies.
- Respondents generally felt that substance misuse should be seen as a **health problem and not a criminal justice issue**, with **22** calling for **more care and support** making Birmingham a **place of shared community**. This contrasted with 21 others who stated that the criminal justice system should take a harsher stance with tougher penalties for perpetrators of drug related crimes.

The following comments are typical of points raised.

"Agree. However having a vision must be obtainable and a target of zero is a very stretching one for a city the size of Birmingham. This city has many social problems that need to be dealt with first as these problems feed the drugs and alcohol that people become addicted to."

"The plan needs far more emphasis on the corollaries of drug and drink misuse. As I read it your plan says nothing about poverty, poor housing, 'sink estates' all of which contribute to the problems you seek to address. Without significant change in these areas your an will be ineffective in my view."

"Don't know what shared ambition means."

"the 'shared ambition' is very woolly and enables non-measurement of actual achievement."

"The ambition is excellent but the devil is in the detail which seems lacking"

"I strongly support safe consumption rooms and hope that Birmingham will pioneer this. I've been involved in community litterpicks for years and years - and have had to deal with discarded needles far too often. Time for some radical action to make life safer for those with addictions - and for the rest of us."

Zero Deaths

To what extent do you agree or disagree with the ambition: Zero deaths due to drugs or alcohol addiction?

99% of respondents answered this question using the scale and **over 80% agree or strongly agree with the ambition.**
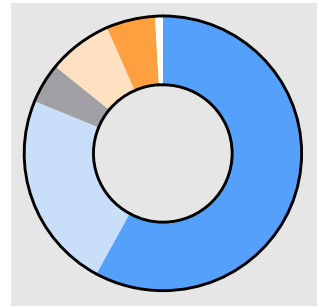
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	518	57.9%	208	23.2%	42	4.7%	67	7.5%	51	5.7%	8	0.9%

Top Themes from free text responses and what they are saying

387/894 respondents provided a written response. Of those:

- 165 felt that the zero deaths outcome was **unrealistic, over ambitious or difficult to achieve** but at the same time the majority of those (96) felt it was **commendable or the right thing** to aim for in principle. There were questions raised around **measurement** and criticism of **wording**. The effect of **personal choice** was also spoken about, with respondents citing this a one of the reasons zero could not be achieved, as some people will always choose to consume substances or not want help.

- 133 commented on **Services**, calling for **better support and resourcing** in the face of failing services, and a need for **education and prevention**.

- 33 talked about the impact of **wider determinants** such as housing and homelessness, crime and environment and the importance of addressing these to prevent deaths.

The following comments are typical of points raised.

"It is our public and social and moral duty to do whatever we can to achieve this. We have neglected this group of society for far too long".

"In a city of this size, I doubt I'm alone in thinking that zero deaths in a year is an unachievable goal, but I support the target as to strive for anything less is letting people down.

"you are holding yourself accountable for somebody else's choices. Not everybody is ready for change."

"I agree with the ambition, but also think given the nature of addiction, it might not be possible. I think the phrasing of "zero preventable deaths" was better."

"This needs to be a real strive for change and not just lip service.."

"You're dreaming if you actually think you can achieve what no other city (IN THE WORLD) has managed."

Zero Overdoses

To what extent do you agree or disagree with the following ambition: "Zero overdoses due to drug or alcohol addiction"?

Over 95% of respondents answered this question using the scale. Three quarters agree or strongly agree with the ambition.
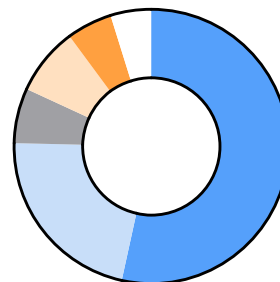
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	478	53.5%	196	21.9%	58	6.5%	71	7.9%	48	5.4%	43	4.8%

Top Themes from free text responses and what they are saying

323/894 respondents provided a written response. Of those:

- **118** felt that zero overdoses due to drug or alcohol addiction was **unrealistic**, although **1 in 6 of these** felt it was a **laudable ambition** and were happy to support the proposed outcome.
- **78** had **concerns over delivery and resourcing**, but the majority of these agreed with the zero overdoses outcome.
- **40** respondents raised **concerns about clarity**, indicating that measurement and wording were not clear
- **Considering broader factors** that contribute to overdosing due to drug and alcohol addiction was a common theme, with 17 out of the **31** written responses being accompanied by a positive response.
- **35** felt that the **current system is failing** with **5 of these** and **24 others** stating that it is impossible to help everyone particularly as **some may not want support or treatment**.
- **21** respondents indicated that there is a **greater need for education and awareness** whilst a comparable number (22) suggested that the criminal justice system should take a harsher stance on drug/alcohol users who overdose.
- Improving control and administration of drugs was another key theme, with **22** calling for more people trained to **administer Naloxone or medically control drugs**, and **14** asking for **safer injection sites** with trained professionals.

The following comments are typical of points raised.

"It is a great aim but not sure how realistic it is."

"I think this should read "Zero drug and alcohol overdoses" - clear English is important."

"Great ambition, may be hampered by people's readiness to address their addictions but it is something we should be aiming for."

"This is really only achievable if drugs are legalised for use within certain facilities to keep an eye on dosage."

"Overdoses can be prevented by the right education and adequate access to medications in case of emergency."

"allowing safe places for drug users to consume, buy and test the substances they are taking would help achieve this target."

Zero people living with addiction to drugs or alcohol not receiving support to manage and overcome their addiction

To what extent do you agree or disagree with the ambition: Zero people living with addiction to drugs or alcohol not receiving support to manage and overcome their addiction

98% of respondents answered this question using the scale. **Over three quarters agree or strongly agree with the ambition.**
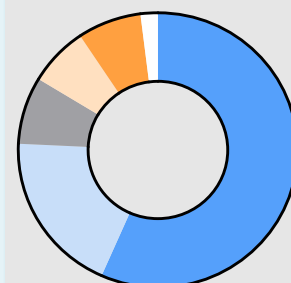
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	506	56.6%	171	19.1%	71	7.9%	62	6.9%%	66	7.3%	18	2.0%

Top Themes from free text responses and what they are saying

454/876 provided a written response. Of those:

- 129 provided additional comments supporting their **agreement with the ambition in principle.** However some of these felt it was **unrealistic, over ambitious or impossible to achieve (93)**. This ambition was cited as underpinning achievement of the other ambitions (zero death and overdoses). As with other ambitions there were concerns with **wording** with some respondents stating they did not understand either the question, or the ambition itself.

- For this question 94 respondents talked about **personal choice** in seeking support, with mention of **denial, engagement and refusal** affecting achievement of this ambition, and suggestions that the ambition should be changed to include 'those who want support'

- 204 commented on **Services**, calling for **better support and resourcing** in the face of failing services, and a need for **education and prevention**.

The following comments are typical of points raised.

Zero again the problem! You cannot force people without their consent! Look at how people react against lockdown!

some people will always choose to decline support as is their human right

People need care and support and money shouldn't come into it I see no difference in needing support to fix a broken leg and fixing an addiction

The very nature of the culture of alcohol usage in this country differs widely from drug usage. As such the two should be delineated with a different strategy for both including separate commissioned providers.

not all people living with addiction disclose it. The statement should include a few words around those wanting the help

These are good aspirational ideas but to make them a measurable goal is unrealistic in terms of both human and financial costs. It would be far better to see these as aspirations but to have a more realistic goal such as to reduce as far as possible these issues.

Addiction Definition

To what extent do you agree or disagree that we should use this broad definition of addiction in the strategy?

98% of respondents answered this question using the scale. **Over 80% agree or strongly agree with the definition.**
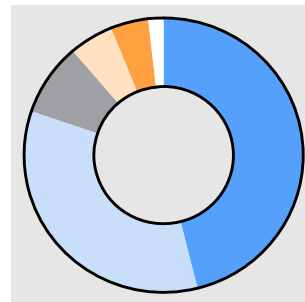
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	412	46.1%	305	34.1%	76	8.5%	46	5.2%	39	4.4%	16	1.8%

Top Themes from free text responses and what they are saying

299/894 respondents provided a written response. Of those:

- There was a mix of subjects, with no singular theme dominating discussion.
- The largest theme (75 people, 25% of responses) was around the proposed definition **not being broad enough or capturing the relevant detail**. Comments included expanding the list of addictions - such as non-drug addictions like gambling - or that the list was **out of date** and not keeping up with trends.
- There were also suggestions that focusing on a list of drugs was limiting, and the definition should **consider other aspects of addiction**, such as cause, behaviours, and predicted outcomes.
- There was a small number (14, 5%) who thought the **definition should instead be narrowed** to the most harmful, addictive substances so that limited resources are focused on the most urgent areas.
- Other themes included: general agreement with definition; prescription medication issues; service issues and suggestions for improvement; concern that the strategy/definition is not achievable.

The following comments are typical of many points raised.

"This is just a list of drugs. The element that is important is "harmful use" .... This needs to be from a mental health perspective not a war on drugs perspective - it's been tried it doesn't work. Why people use drugs and how they become addictive and harmful is what needs to be understood."

"Will there be sufficient resources to respond to all forms of drug use, particularly prescription and over the counter medications. This would require significant investment. If this is not possible perhaps there should be priority on which drugs are causing most harm."

"Need to be aware that usage and addiction are NOT the same."

"Far too broad in particular the prescription drugs subheading. If you potentially make people feel like criminals because they are taking antidepressants or anti-anxiety medication etc you risk people not seeking the required support they need."

"What about other addictions that are not related to substance abuse such as gambling"

Prevention

To what extent do you agree or disagree that these actions on Prevention should be included in our framework for action?

95% of respondents answered this question using the scale, **8 in every 10 people agreeing or strongly agreeing** with the actions on prevention being included in the framework for action.
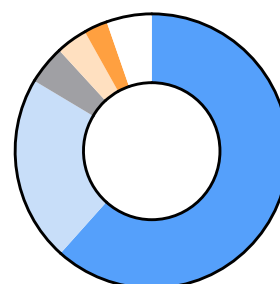
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	551	61.6%	196	21.9%	41	4.6%	33	3.7%	25	2.8%	48	5.4%

Top themes from free text responses and what they are saying

339/894 respondents provided a written response. Of those:

- A large number (176) expressed **concerns over the illicit drugs trade** and the **relative availability and affordability of alcohol and drugs**. These responses generally called for greater focus on **tackling drug supply and distribution** as well as **depowering drug dealers**. However, views were ambiguous regarding the sale of low-cost alcohol.
- Strong themes emerged around **supporting communities and people (50)**. However, **43** respondents felt that **preventative support should be more holistic and consider wider factors** that lead people to substance misuse.
- **Health concerns** were raised, particularly **mental health** in **24** respondents, calling for preventative measures to consider this as a priority.
- **16** raised **concerns around organised crime**, indicating that **stronger wording and tougher stances** may be required to tackle the problem. Others suggested that substance misuse is not only affected by organised crime.

The following comments are typical of many points raised.

"Closing down the organised crime that underpins the drugs trade feels like a huge task that will require vast increases in resources, e.g. in Policing."

"It should start in primary schools, be a prime objective in secondary schools, with opportunities to take it further after 18 (sport training areas, youth club leaders etc)."

"I think there needs to be the addition of a focus on diverting people particularly young people from criminal exploitation and being drawn into the drugs trade."

"I would exercise caution when it comes to challenging low cost alcohol as this is official interference in private commercial transactions freely entered into between adults."

"It's a systemic issue with numerous society levers in play … the prevention piece requires many other social matters to change not least poverty and racism"

"Agree but prevention should also include reducing mental health issues and poverty in order to prevent drug and alcohol addiction."

Early Intervention

To what extent do you agree or disagree that these actions on Early Intervention should be included in our framework for action? 94% of respondents answered this question using the scale. Over **87% of respondents agree or strongly agree** with the actions on early intervention being included in the framework for action.
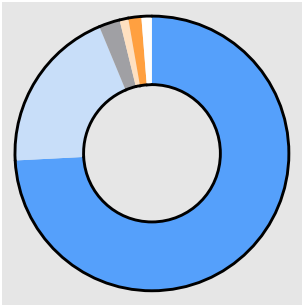
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Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	598	66.9%	180	20.1%	31	3.5%	15	1.7%	19	2.1%	51	5.7%

Top Themes from free text responses and what they are saying

248/894 respondents provided a written response. Of those:

- **73** people indicated that they were **supportive of the early intervention approach**
- **40** people discussed **doubts/possible limitations**, including concerns that actions/goals were unrealistic, difficulties in engaging people, challenges in changing professional culture, a lack of acknowledgement of the root causes of addiction and poor integration/communication between organisations.
- **Funding and resources** was a regular theme. The main points raised were **lack of adequate resources** for early intervention and the **need for substantial investment**, specialised staff, dedicated facilities and monitoring of cost-effectiveness.
- A total of **39** people discussed the need for **education and awareness** for children, young people, adults and/or professionals as part of the early intervention approach.

The following comments are typical of points raised.

"Definitely a good approach"

"Early intervention is correct and necessary to deter further problems arising which may be costly to the authorities if kept unchecked for a long period of time"

"Agree but I think the problems are a lot larger than you think and would be unachievable"

"Tip of the iceberg, this is needed but wouldn't make a dent"

"Where is the funding? If it was this easy, there wouldn't be a problem"

"Education is the only way. This should be across the board leaving no one out including OAP"

"Professionals within the NHS sector require training around drug and alcohol addiction so that they are equipped with the right tools to support the patient and… signpost patients to appropriate services based on early signs"

Actions on Treatment

To what extent do you agree or disagree that these actions on Treatment, Support and Recovery should be included in our framework for action?
96% respondents answered the question using the scale. **87% of respondents agreed or strongly agree** with the actions on Treatment, Support, and recovery being included in the framework for action.
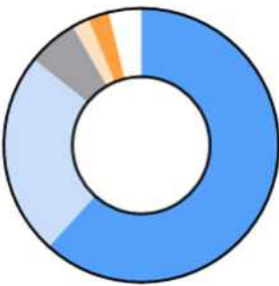
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	552	61.74%	215	24.05%	53	5.93%	18	2.01%	22	2.46%	34	3.80%

Top themes from written responses and what they are saying

281/894 respondents provided written responses. Of those:

- **14%** of respondents where **happy with the inclusion of treatment, support, and recovery in the framework**. Whereas **10%** suggested that existing services either needed evaluation and strengthening or the new framework needed reviewing and strengthening.
- **53%** of respondents (**149** respondents) suggested that there should be **changes to services and provisions**. The largest majority within this theme suggested that there should be changes in funding to accommodate the proposed strategy or were concerned about funding not being adequate (including for the previous strategy).
- There were also themes around **resources, staffing and training provided to employees as well as changes to management and the involvement of more stakeholders**.

The following comments are typical of points raised.

"Individuals will only progress if they have a desire to move forward. Need to support with mental well-being where individuals can see a positive outcome and can become independent individuals contributing to society. High quality is key, rather than numbers through the door."

"To bring people into a good and supportive work environment gives a sense of self-worth."

"These are essential if the main objectives are to be achieved."

"If you're relying on government funding, then it will fail. The level of funding will not be constant and will be outsourced and will be seen less as a social issue than a fiscal one. It needs to be ring fenced through the council budget."

Children and Young People

To what extent do you agree or disagree that these actions on Children and Young People should be included in our framework for action?

96% of respondents answered this question using the scale. **9 in every 10 people agree or strongly agree** with the actions on being included in the framework for action. This question had the highest percentage agreement in the framework for action section
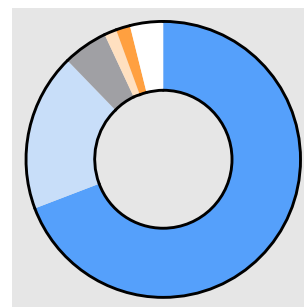
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	619	69.24%	165	18.46%	47	5.26%	13	1.45%	15	1.68%	35	3.91%

Top themes from written responses and what they are saying

281/894 respondents provided written responses. Of those

- For this question there were very few comments directly regarding whether people were or were not in agreement and instead the majority of comments were around what was needed in terms of interventions and services or the problems people saw.
- 199 respondents spoke about services and a need for better support and early intervention. The **vital role of Social Services** was also raised, but this also came with comments about poor performance and under-resourcing
- **7% of responses mentioned lack of opportunities for children and young people**, calling for sports and youth clubs and the importance of **youth workers** in prevention, alongside 13% of responses about **Education**
- 11% talked about the impact of **Adverse Childhood Experiences and Parental substance misuse**, and a need for additional support for these particularly vulnerable children.
- 55 talked about crime, county lines and the role of policing

The following comments are typical of points raised.

"Youth workers are trained to work with young people and can offer the early prevention and intervention work around risky behaviour and resilience building"

"Systemic approach and inter-generational substance misuse is again missing. You can't patch up the problem without looking at the wider picture to prevent reoccurring patterns within family units"

"most problematic use in young people is linked to trauma and abuse, so a work force who are trauma informed and do not victim blame is needed"

"Again obviously the right approach but this cannot just be achieved by targeting those most at risk. There needs to be investment in a range of services like youth work, youth centres, schools and especially further education to produce a much more nurturing environment for our young people. In many areas this was better in the past. E.g. youth services and Sure Start"

I am concerned that you have still not mentioned anything about recognition of the factors that drive children down these pathways i.e. their abuse. Services need to be trauma informed. Schools play a key role. You need to invest in Education.

Additional Challenges

To what extent do you agree or disagree that these actions on Additional Challenges should be included in our framework for action?

95% of respondents answered this question using the scale. Over **80% agree or strongly agree with the actions** on additional challenges being included in the framework for action.
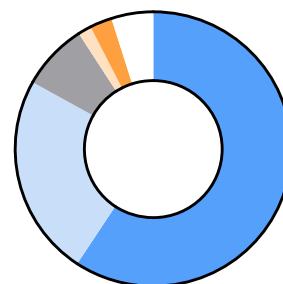
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	530	59.3%	213	23.8%	70	7.8%	14	1.6%	23	2.6%	44	4.9%

Top themes from written responses and what they are saying

256/894 respondents provided a written response. Of those

- **Concerns over the practicality of delivering the proposed strategy** was the main theme that emerged (**168**), with **resourcing and funding**, **current services not functioning well**, more effective **partnership working**, clearer **focus** and strong **leadership** forming the majority of concerns (159)
- A large number (**86**) called for **more attention** to be paid to **social issues**, **mental health** and **wider determinants** that contribute to substance misuse. A considerable number also felt that **additional challenges shouldn't be seen as additional**, rather an **integral component of action** to redress substance misuse issues
- **58** respondents were **unhappy with the proposed actions**, indicating that they risk **overpromising** and they're **unrealistic** or do not consider the root causes of substance abuse and addiction, they **only tackle the symptoms** and won't bring about lasting change
- **42** called for a more **targeted approach to support young people, vulnerable adults and families**, whilst **34** commented on the **lack of safe and affordable housing**, and problematic HMOs and landlords
- **18** suggested taking a **harsher stance** such as enforcing tougher penalties for drug users, however, a greater number (**60**) wanted a more **supportive approach** whereby people are offered more **support in the criminal justice system** and **services are empathetic**, offering **security** and **empowerment** rather than stigma and viewing illicit substance use as a criminal issue

The following comments are typical of points raised.

"It is very important to include strategies to facilitate treatment to homeless and hostel-dwellers and other high-risk groups such as pregnant drug users and those entering or existing the criminal justice system."

"You need a holistic approach to addiction. The causes of the issue have to be addressed and supported for a person to find their way forward."

"A public health approach to address the broad individual, environmental, and societal factors that influence drug and alcohol addiction and misuse and the consequences is necessary. If we are to improve the health, safety, and well-being of Birmingham's citizens, we need to both understand and address the wide range of interacting factors that influence drug and alcohol misuse and coordinate efforts across a whole range of stakeholders."

"Currently all these services are under-resourced so fail to have a big impact. We need more investment here."

"I think that in many cases, these issues are the trigger for addictions, as away to escape the difficulties being experienced. Thus I feel that the Additional Challenges need to be addressed first and foremost."

Data and Evidence

To what extent do you agree or disagree that these actions on Data and Evidence should be included in our framework for action?

96% of respondents answered this question using the scale. **8 in every 10 people agree or strongly agree with the actions** on data and evidence being included in the framework for action.
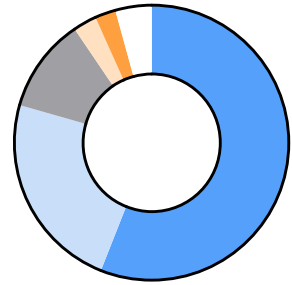
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	501	56.0%	209	23.4%	99	11.1%	25	2.8%	22	2.5%	38	4.3%

Top themes from written responses and what they are saying

285/894 respondents provided a written response. Of those

- **152** responses talked about **governance**. Within this broad theme respondents voiced that **robust data is needed (93)** particularly to enable **targeted support (40)**. **23** also called for **data transparency**, indicating that it is vital to make statistics and data unbiased and ideally collected independently.
- **57** responses referred to a **lack of action** stating that any **data and evidence needs to be put into action**
- **Negative themes** emerged **(43)** where respondents generally said that **data should already be available** or that actions on data and evidence were a **waste of time and money** .
- However, these were in contrast to **positive responses (31)** indicating that these actions will **improve understanding to shape action (18)** and that using data and evidence is crucial to improve services and they are a **good inclusion (12)**.
- **Funding** was also raised as a concern **(17)** as well as **effective management (11)**, suggesting that the **experts are required** to access the data and evidence in order to deal with these complex issues.

The following comments are typical of points raised.

"Good data can help define the issues clearly both in location and scope, and can indicate what approaches/action work and to what extent."

"We absolutely need to know what is working and the impact/value of treatment and support. We should not be slaves to what we have always done and look at the value data brings."

"you can prove anything with statistics. All depends on what the data you are collecting is and what using for. Needs to be balanced and population wide, not cherry picking to prove an agenda."

"Data is only important and effective if it helps people."

"As long as it doesn't get in the way of actually working with these people."

"This data will improve our local understanding of addiction, and shape actions around citizens' needs."

"You should be using data and evidence to formulate the strategy- not as part of the strategy."

Citizen First

Question: To what extent do you agree or disagree that Citizen First should be a principle of our framework for action?

97% of respondents answered this question using the scale. **84% either agree or strongly agree** with the including Citizen First as a principle in the framework.
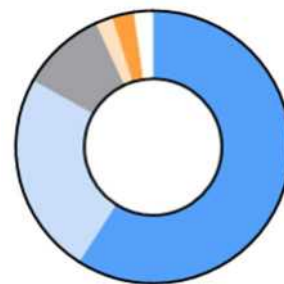
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	528	59.06%	215	24.05%	90	10.07%	23	2.57%	23	2.57%	20	2.24%

Top themes from written responses and what they are saying

226/894 respondents provided written responses. Of those:

- **40.7%** of respondents (**92** respondents) made **positive comments**. 15.5% (**35**) were **happy** with including 'Citizen First' as a principle in the framework and thought it was an **equitable approach**.
- A common theme (**9.2%** of respondents) was that the term Citizen First' needed to **include all people** for example: those indirectly affected by drug users (e.g. family and friends) and also a consideration of the employees who are helping the drug users.
- **21.7%** of respondents (**49** respondents) made **negative comments**. Some thought that there needed to be some **clarifications and improvements**. 35 respondents though that the term citizen first was **vague and needed defining or redefining**.
- Many of the themes were associated to wanting an **equitable approach** with many answers including an element on treating all service users equally and letting the voice of both the minority and majority be heard. For instance, **13.7%** of respondents (**31**) thought that listening to the users or the communities in which those users are found in should be listened to and that their voices should be incorporated in the implementation of policies.

The following comments are typical of many points raised.

"This would need to be all citizens, including those who most often don't have a voice - i.e the end user of the services."

"I have a degree yet I don't know what that means - it is too broad a definition."

"Citizen first has to be a goal, but how does this work when you have people with entrenched addictions and behaviours who do not wish to change as they do not see their lifestyle as an issue?"

"This should be a requirement for any changes impacting peoples existing rights. Difficult to achieve as there is a wide range of options, so difficult to impose an unelected set of new rules. The citizens are the expected population for compliance so their engagement is vital before moving on with the changes."

Diversity and Inclusion

To what extent do you agree or disagree that Diversity and Inclusion should be a principle of our framework for action?

98% of respondents answered this question using the scale, with nearly 83% agreeing or strongly agreeing that Diversity and Inclusion should be a principle.
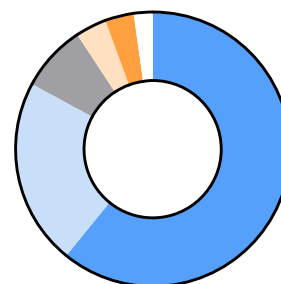
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	544	60.9%	197	22.0%	70	7.8%	33	3.7%	30	3.4%	20	2.2%

Top themes from written responses and what they are saying

217/894 respondents provided a written response. Of those:

- Almost half (100) felt that including the principle for diversity and inclusion inherently goes against embracing diversity and inclusivity and perpetuates differences rather than seeing people as individuals with unique needs.
- 21 said it is critical to include diversity and inclusion as a principle.
- 69 said we should stop labelling individuals and stereotyping and 21 said no one should be left behind as we are all equal regardless of sociodemographic status, lifestyle choices, identity, and background.
- 39 responses focused on the lack of action and that previous approaches have not worked.
- 19 identified potential barriers that may affect diversity and inclusion, namely that not everyone wants to receive treatment and that prejudice will be difficult to stamp out .

The following comments are typical of many points raised.

"All citizens should be equally served and no preconceived notions of culture should impact on the service provided."

"When you continually push differences between cultures, race and creed you create division, were still defining people by these factors, yes heritage is important and cultural beliefs but we are all humans, stop separating and start embracing,"

"Inclusion is great but spending more money on Diversity is waste of resources and causes more division"

"This does not need to be 'woke'. It needs to be relevant to all people."

"It's important to understand how and why people become addicted no matter what colour, creed, culture or religion. That can be difficult in some cultures who are "closed shop" and offer little in the way of help. That said, the drivers for change must go past that and encourage the whole community to be as one."

"Diversity is a big part of Birmingham, cannot respond to this issue without understanding the diversity implications"

"To be included is everyone no matter what age or background. Working together is the key."

Learning and Listening

To what extent do you agree or disagree that Learning and Listening should be a principle of our framework for action?

Over 98% of respondents answered this question using the scale, with **9 in every 10 people agree or strongly agree** with Learning and Listening being a principle of our framework for action.
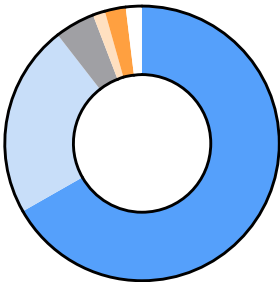
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	597	66.8%	203	22.7%	42	4.7%	13	1.5%	22	2.5%	17	1.9%

Top themes from written responses and what they are saying

226/894 respondents provided a written response. Of those:

- A strong theme was centred around listening to those who are and have been **affected by drug and alcohol abuse (96)** , **addicts and service users (36)**, **communities and all citizens** in Birmingham **(37)**, **front line service providers (9)**, and not to **listen to** the loudest voices or those who think they know best, rather the ones that are most relevant with **lived experience (14)**.
- People **don't feel heard (63)**
- **92** highlighted that **action is needed**. Respondents felt that learning and listening needs to include **effective action (32)**, frequent and robust **evaluation and planning (25)**, **not using preconceptions (18)**, and **learning from previous successful and unsuccessful approaches (17)**.
- **32** felt it is a must to have Learning and Listening as a principle of our framework for action.
- **52** called for **changes to the strategy wording** .**11** indicated that **communication should be the focus** rather than listening and **5** thought learning and listening should be reversed so that **learning happens after listening**.

The following comments are typical of points raised.

"You should also involve the client and not assume that the professional knows more."

"It should be made clear that you'll listen to the people who are the subject of each stage and not just those with a view on it."

"Most people have opinions, but who decides which opinions are correct? If some opinions do not align with yours, are they to be ignored?"

"The learning and listening may highlight where work is needed to change attitudes among sections of society who do not understand addiction .including some alcohol addicts who do not recognise they have a problem"

"Yes implementing best practice and trialled methods is the best way. Continuous feedback loops are important"

Scale and Pace

To what extent do you agree or disagree that Scale and Pace should be a principle of our framework for action?

97% of respondents answered this question using the scale, with **79% agree or strongly agree** that Scale and Pace should be a principle of our framework for action.
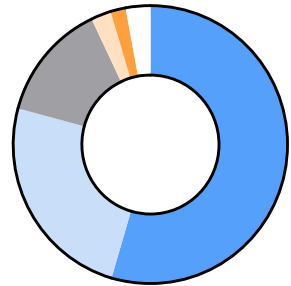
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	488	54.6%	220	24.6%	123	13.8%	21	2.4%	16	1.8%	26	2.9%

Top themes from written responses and what they are saying

208/894 respondents provided a written response. Of those

- **137** raised **concerns over** the **delivery** of this principle even though they were positive about it (92). They felt **resourcing and funding is an issue (29)**, and any **service delivery or intervention** should be done carefully and **piloted first** to assess efficacy and effectiveness **(29)**.
- Similarly **scale and pace is good as long as quality doesn't deteriorate** as a consequence **(17)**.
- **Programmes should focus on need** and should be targeted rather than a one size fits all approach **(22)**.
- **46** responses stated that the **principle was confusing, too vague and worded poorly**.
- **11** called for **greater consideration of long-term outcomes** and consequences for this principle
- **21** responses were **strongly in favour** suggesting it is a **vital inclusion**.

The following comments are typical of points raised.

"This principle seems unclear. I agree that it's important to work on a big scale so the benefit is felt by as many people in the city as possible. However, it's also important not to rush processes. Quality over quantity could be key in creating strategies and/or interventions that work. Localising interventions could also be very important, rather than rapidly applying a "one size fits all" approach."

"Although Pace is important, it is also important to recognise that some issues like substance use need years/decades to overcome, particularly if long-lasting change is to be achieved."

"What is scale and pace?"

"Pushing too much in terms of timescale might be jeopardising the project in the long term and preventing sustainability."

"I think that your statement on moving quickly is right as Birmingham is the second city and this is the right bold approach."

Regulation and Enforcement

To what extent do you agree or disagree that Regulation and Enforcement should be a principle of our framework for action?

98% of respondents answered this question using the scale, with **8 in every 10 people agreeing or strongly agreeing with the actions** on regulation and enforcement being a principle in the framework for action.
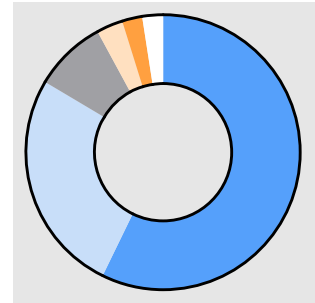
Method	Strongly Agree		Agree		Don't Know		Disagree		Strongly Disagree		Not Answered	
Online only	512	57.3%	235	26.2%	76	8.5%	28	3.1%	21	2.4%	22	2.5%

Top themes from written responses and what they are saying

360/894 respondents provided a written response. Of those:

- Respondents who expressed concerns around the regulation and enforcement content of the strategy felt it was **too ambitious (30), too bureaucratic (9) , or too narrow (12)** with suggestions for inclusions such as **gambling** and **anabolic steroids** . There was criticism of the **wording (42)** and the **lack of plans or actions (19)**. 63 respondents wrote comments **in support** of the principle.
- There was some contrast in responses regarding the general approach to Regulation and Enforcement with 57 advocating a **supportive, person centred, lighter touch** approach before enforcement, and **43** calling for much **harsher** regulation and enforcement, or the need for a balanced approach.
- 28 spoke about the need for **businesses** (especially small local shops) to be **better regulated** around the sale of alcohol and that a joint approach with was needed
- As with previous questions there were concerns around availability of **funding** and other **resources** (30), including **policing** (36)

The following comments are typical of many points raised.

"Actions speak louder than words. Having a bunch of nice slogans won't achieve anything, so be careful not to waste time/money on semantics"

"Enforcement with businesses is perfectly reasonable. Enforcement with those addicted is different and goals need to be realistic and supported to positive outcome."

"I have reservations about having the police involved in social and health issues, and the criminalising of people struggling with addiction."

"Thank you for making this a priority for our city."

"Sensible This is HUGE! I'd love to believe this is not just another bit of rhetoric. If you're going to do it, then REALLY do it!"

"A carrot/stick analogy springs to mind - getting the balance is key."

Recommendations

1. Consider changing the wording of the title of the strategy and the ambitions. Many felt the current strategy and associated wording were unrealistic and overly ambitious.

2. Consider a single zero - "Zero deaths" would be a more realistic and clearer message, which the other zeros (more support for those who need it, and reduction in overdoses) would feed into.

3. If Triple Zero is to remain, consider making it clearer in plain English that the title is what we should aim for and not a measurable target (e.g. Triple zero is not a *target* ….this is our *ambition* and aiming for anything less is a disservice).

4. Consider including a clear purpose statement on what a strategy is and its requirements so that citizens are not expecting an action plan or metrics. This should include the specific scope of the current strategy as this is not currently stated (i.e. drugs and alcohol – not other addictions). Whilst there is information included within the draft strategy, consider including clearer narrative that links the strategy to action planning and removing options for delivery as this confuses the purpose of a strategy, and respondents were concerned by the lack of clarity and detail around the practicalities of delivery.

5. Consider reducing the length of the strategy.

6. Reduce data on need to avoid confusion on strategy purpose and reduce length. This content can be used in the needs assessment.

7. The current format of the objectives and outcomes were not well received by respondents who provided written comments. Many felt it was confusing and too vague. Consider the following:
    o changing the ambitious outcomes to ambitions.
    o including robust aims and objectives with associated outputs and outcomes.

8. Consider changing phrases and language throughout to be clearer and more understandable. The general consensus was that a lot of "phraseology" was used, and people felt alienated by certain terminology (e.g. scale and pace).

9. Consider including more information around intersectionality and the wider determinants that influence substance misuse (e.g. homelessness, crime Adverse Childhood Experiences, unemployment) etc. Many felt this aspect was lacking and the strategy didn't fully consider the comprehensive nature of drug and alcohol addiction/abuse. This section should direct to other strategies (for example Domestic Abuse Strategy) and recommend strategy formulation if they aren't there.

10. Consider learning from other published BCC strategies such as the Domestic Abuse Strategy with regards length, structure and clarity around scope

You Said …. We Did

Summary of Changes to the Triple Zero Strategy in Response to Consultation Feedback

October 2021

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Birmingham City Council

You said……   # We did……

You said……	We did……
You didn't like 'Triple Zero' or the term 'ambitious outcome' – it was unrealistic and wordy and shouldn't be a target	We have made it clear that this is our ambition and not a target and explained our reasons why this is something we should aspire to. 'Ambitious outcome' has been removed
That you didn't understand the purpose of the strategy and there was confusion about what should and shouldn't be in there. Other addictions such as gambling are missing	We have included a clear purpose statement and described what is and isn't in the strategy. This strategy is only for drugs and alcohol, but the impact of gambling addiction is noted, and list of support organisations included
Addiction should be seen as a health problem and not a criminal issue	We have reduced references to crime except where it is absolutely necessary
The Third ambitious outcome ' Zero people living with addiction to drugs or alcohol not receiving support to manage and overcome their addiction' was flawed due to personal choice and consent.	Wording changed to 'Zero people unable to received support for their addiction when they need it'
The strategy is too long with too much data, and it isn't clear	Length reduced considerably including data. Only summary statistics included and readers are directed to the accompanying Needs Assessment if they wish to explore in more detail. The format has also been completely changed to include infographics to make it more visually appealing. Clearer headings have been used throughout.
The current format with ambitious outcomes and objectives was confusing and vague	Wording changed to improve clarity and statement that action plans will be developed during the period of this strategy
There are too many fancy phrases and you felt alienated by certain terminology such as 'scale and pace'	Phrases and language changed throughout to be in clearer English. 'Scale and Pace' is now Quality and Quantity
There isn't enough consideration of the wider determinants of substance misuse	Clearer statement on interdependencies (1.2) , increased narrative in themes 3 and 4 and direction to other relevant strategies and reports.
You were concern that including Diversity and Inclusion as a principle was divisive and perpetuates discrimination and racism	Diversity and Inclusion has remained in the strategy as health inequalities are at the heart of Public Health. The wording which accompanies this point has been amended to make sure that we are not just talking about different cultures, but also any vulnerable and marginalised group of people.

		Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**	
Date:	**31ˢᵗ January 2023**	
TITLE:	**Update on the work of the Perinatal and Infant Mortality Taskforce**	
Organisation	**Birmingham City Council**	
Presenting Officer	**Dr Marion Gibbon**	

Report Type:	**Information**

1. Purpose:

1.1. To update the Health and Wellbeing Board on the work of the Perinatal and Infant Mortality Taskforce.

2. Implications (tick all that apply):

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

3. Recommendation

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3.1. To note the report.

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4. Report Body

4.1 Background - Update on the work of the Infant Mortality Taskforce

4.1.1 A report was prepared for Birmingham Health Overview and Scrutiny in 2020 and a request for an in-depth piece of work to consider the figures for infant mortality in Birmingham and the contributing factors which was presented to HOSC (Health Overview and Scrutiny Committee) in December 2020.

4.1.2 A series of recommendations were posed which consisted of:

1. To work with partners to establish a multi-agency 'Reducing Infant Mortality in Birmingham' Task Force to oversee a concerted effort by all relevant agencies to achieve a substantial reduction in infant mortality in the city. The Task Force should include the existing Local Maternity System, Clinical Genetics representation, commissioners, and other maternity services such as BCHC (Birmingham Community Health Care), plus BCC (Birmingham City Council) Public Health, representatives of the CVS sector and elected Member, with a brief to bring the threads of all related interventions together in a concerted and mutually reinforcing programme. It should also identify and address any factors that may discourage some parents from engaging with their maternity service professionals.

2. To set an ambitious goal to reduce infant mortality by 50% in Birmingham by 2025 (from 2015 figures, matching the national target) but to then go further and eliminate the gap between infant mortality rates in Birmingham and the England average by this date. This should be accompanied by a delivery plan that can plausibly demonstrate how these targets can be met, identifying both the structural and modifiable factors underlying the infant mortality within the City.

3. To develop a strong community awareness strand within the Task Force work programme, led by respected and trusted community groups, local community and faith leaders, and other influencers who are engaged in social media. This should be targeted at improved health behaviours, identifying, and supporting families facing material hardship and adverse stressful circumstances, early detection of poor baby growth, and empowering people to make healthy life choices that minimise their infant mortality risk factors. This will include ensuring up to date information is available, including current and likely future trends in consanguineous unions in Birmingham.

4. The work of the Task Force should be tasked to consider and adapt the 'four strands' approach of Professor Salway and access any resource and support available nationally.

4.1.3 A tracking report was provided for HOSC on the progress of each of the recommendations in October 2021 detailing the progress of the recommendations. A further report to HOSC was presented on 18th October 2022 (Appendix 1).

4.2 Achievements

4.2.1 The Perinatal and Infant Mortality taskforce has been established and has been meeting on a regular basis. Three streams of work have been established to take the work forward, which consist of:

1. Research – this group is chaired by Jo Garstang, the Designated Doctor for Childhood Death, she has received funding to establish research that develops an approach to understand the impact of infant loss on mothers and their families. Part of this is also looking at how these women can be supported.

2. Co-production and innovation - led by Dr Marion Gibbon. She is working with the Ladywood and Perry Barr Partnership Development Lead for Maternity and Children, Amy Maclean on a pilot project that is developing work with schools on the "Best Start in Life." This has been extremely successful, and this work will be taken forward by a partnership between Birmingham Education Partnership and Youth People's Education Community (YPEC). During the pilot, year 11 students in 2 secondary schools have participated in a Health Hack where they engage with health professionals and information about causes of infant mortality but framed as ways, they can enable a best start in life for themselves, their peers, families, and communities. Feedback from students has been positive, including gratitude for learning about such topics at this point in their lives.

3. Implementation – this was to be chaired by Marcia Perry, Birmingham Community Healthcare Trust once she retired. The majority of implementation relating to infant mortality is through the LMNS. One aspect that the development plan has highlighted is the need to look at the pathway from maternity into health visiting. As Marcia has now left this chair is vacant and we are hoping that someone from the Birmingham and Solihull (BSol) ICB (Integrated Care Board) will take on this role. It has been agreed that the taskforce will sit under the LMNS (Local Maternity and Neonatal System) BUMP (BSol United and neonatal Maternity Partnership) board. This will ensure greater accountability and traction for the work of the taskforce.

4.2.2 The Task Force includes members of the local maternity neonatal system (LMNS), clinical genetics, BSol ICS (Integrated Care System), BCC Public Health, representatives from the voluntary sector and elected Members. There is ongoing work to enable parents to engage effectively with their maternity service professionals. Members of the group have been working with the BSol (BUMP) to

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review the working of the Maternity Voices Partnership (MVP) and establish its new arrangements to ensure women's voices and experiences underpin the work.

4.3 The Perinatal and Infant Mortality goal and workplan

4.3.1 The Development Plan was presented at the last Health and Wellbeing Board when an update was requested on 22nd March 2022 (CMIS (Committee Management Information System) > Meetings Appendix 3 pp384-388).

4.3.2 The development plan is not a static document; it is dynamic and changes considering findings from the work being undertaken by the group. The latest version of the development plan is attached (Appendix 2). A significant amount of work has occurred since October 2022 with the consolidation of national and local policy documents by Barnes, J (SpR) and a discussion with the LMNS concerning leadership and priorities for the future.

4.4 Community awareness strand

4.4.1 Seldom Heard Report:
4.4.1.1 Birmingham Public Health commissioned providers to facilitate target focus group conversations to capture the voices of women about pregnancy and its interlinking topics. This offered insight into personal thoughts and experiences and based on those discussions, developed recommendations on how to improve the system.

4.4.1.2 It was thought that the findings from the groups would help influence the development of the Infant Mortality Action Plan. Written reports of the key findings were produced by each individual researcher and have since been consolidated into one report.

4.4.1.3 Helpful resources are being collated alongside a comms plan for sharing the report on a wider footprint which might help address some of the issues raised in the report. The report has recently been published (Appendix 3) and highlights the work of the Birmingham and Lewisham Health Inequalities Review. Work on cultural compassion is an area that is highlighted in both reports.

4.4.2 Community Researchers:
4.4.2.1 Birmingham Public Health commissioned Community Research training, women were recruited and trained from seldom heard communities (Black African, Polish & Eastern European, South Asian, and Chinese communities).

4.4.2.2 The training was to enhance the skills and abilities of women, enabling them to further develop trusting relationships with women in their communities. This gave them a good understanding of ways of engaging with individuals and communities through conversations around the topic of pregnancy, maternity services, language barriers, cultural and religious beliefs.

4.4.2.3 The training provided confidence and understanding of ways to highlight key issues with Public Health. Public Health have now agreed host organisations

and are finalising terms and conditions for them to support and develop the trained Community Researchers, in order that they can be confident in engaging in research practice with topics identified by Public Health and other partners.

4.4.3 Pilot Population Health Management (PHM):
A population health management approach is being piloted by Public Health aimed at identifying risk factors for low birth weight. This approach accesses standardised and linked data sets. It applies statistical techniques to identify and assess risk.

4.4.4 School Project:
4.4.4.1 There are two strands to this. The first is the development of PHSE materials that support the discussion of genetics and cousin marriage within the school curriculum. Several schools have been involved in this and a package is currently in development. A PowerPoint slide set has been developed (Appendix 4).

4.4.4.2 The second strand is the co-production of an approach with schools called "Best Start in Life" which aims to enable young adults in schools (young women in the first instance) to discuss what factors can lead to better health outcomes in babies. This event focused on developing action to improve health behaviours, identifying, and discussing early detection of problems, and empowered young women to make healthier life choices that minimise their infant mortality risk factors.

4.4.4.3 Presentations from health professionals provided up-to-date information about infant mortality, and information on the current scale and genetic problems caused by social and cultural factors in Birmingham. The first event was held on Friday 9th September at Handsworth Girls Academy. A report from this event is being produced.

4.4.5 Developing Workforce Cultural Compassion:
BUMP has commissioned a training programme called "5 times more", which focuses on developing workforce cultural compassion in the workforce. To date two sessions have been held with more planned.

4.4.6 Immediate Post-Natal Contraception:
A pilot has been completed and the findings presented to the BUMP board. Public Health has met with the Clinical Director of the local maternity partnership system to discuss the next phase of implementation. A further update will be produced on this project.

4.4.7 The Economic Cost of Genetic Conditions:
A report has been completed and presented to the Perinatal and Infant Mortality Taskforce. Several recommendations were posed which will feed into the development of culturally compassionate materials for families which is being led by the EDI (Equality, Diversity, and Inclusion) lead for BUMP.

4.4.8 LMNS Culturally Competent Genetics Service

4.4.8.1 The LMNS Culturally Competent Genetics Service has established a working group which will be monitored by the Maternal Quality Committee. The LMNS will be responsible for reporting progress made by the group to NHSEI (NHS England and Improvement) and Maternity Transformation Programme (MTP) on a regular basis.

4.4.8.2 The first national strategy for England to improve access to high quality genetics services for underserved groups will give families opportunities to make informed reproductive decisions, while respecting their culture, values, and beliefs. The NHSE strategy was coproduced with parents, clinicians, and academics. The strategy is informed by research evidence and national consensus on how this unmet health need should be addressed (Salway et al., 2019). It has four strands, illustrated below and which the service will be developed on:

Strand 1 raise genetic literacy at community level	Strand 2 educate and equip healthcare professionals
	Culturally competent genetic services	
Strand 3 improve access to genomics services for underserved groups	Strand 4 continuously improve with national support

4.4.8.3 As per the MTP bid process the LMNS have a financial package including national support to help implement Culturally Competent Genetic Service for the identified underserved groups in areas of high need for Birmingham, ringfenced to Birmingham North & East and Heart of Birmingham (based on the old PCT boundaries) where two separate bid applications required approval.
As part of the offer the LMNS are committed to rolling out a Culturally Competent Genetics Service for consanguineous couples in Birmingham North and East and Birmingham Central and West to aligned to the old Heart of Birmingham boundaries with the aim to develop work to:
- Improve access to genomics services for underserved groups; and
- Give families the opportunity to make informed reproductive decisions

4.4.8.4 The project funding is for 3 years and will be subject to confirmation in line with NHS England planning processes. As part of the 1st year allocation a "Genomics Associate x 1.0 WTE to the Regional Service will be appointed who will part support Midwifery resource locally (0.4 WTE Band 6 x 2 posts) to cover BSOL LMNS high need areas focusing on Birmingham North & East, Central & West localities—they will lead training, education, and information sharing; the recruitment process is taking place.

4.4.9 Child Death Overview Panel
Each year a report is written on the child deaths that have occurred in Birmingham. The current report was agreed for publication on 13th January 2023 (See Appendix 6) 2022 Annual Report of the Birmingham and Solihull Child Death Review Team and Child Death Overview Panel. The recommendations from the report will be implemented in 2023. These are:

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1. To ensure BCH implement joint child death review meetings for all deaths
2. To continue to catch up on cases delayed due to the Covid-19 pandemic
3. Ensure that all lessons learnt from the whole death review process are captured on the eCDOP Analysis form
4. Ensure that all Child Death Review Meetings are multi-agency and external professionals are invited
5. To provide Joint Agency Response (JAR) training for health, police and coroner's staff
6. Closer working with public health.
   a. Consanguinity
   b. Deaths compared to social deprivation
   c. Perinatal deaths and maternal health

4.4.10 Linking to the Children and Young People's Plan

The Children and Families Directorate is collaborating with partners in preparing our five-year Children and Young People's Plan 2023-2028. During 2022, strategic workshops were held to engage partners in developing strategic priorities for the plan. One workshop focused on infant mortality, preventable deaths, and early intervention. It is crucial to consider how we support children, young people, and families to have healthy relationships, pregnancies, and good health outcomes. The plan is due to be published in April 2023 and includes collective strategic action on joining up our offer in local places so families can connect with support they trust. This includes interventions that minimise the impact of child poverty, which is vital for decreasing infant mortality.

The new role that the Children and Families Division have instituted will ensure that links between public health and other parts of the council have a lasting impact on the health of our communities. Further links are to be developed between Council Services, the Integrated Care System and the NHS Trust Hospitals through the recommissioning of Public Health Nursing (0-19) Services. This will include the pathway between Hospital Maternity Services and Public Health Nursing to support infant health at home and in the community in the first weeks and months of life.

Governance arrangements have been strengthened to make sure that children and young people are at the heart of the work of the Health and Wellbeing Board. Birmingham Children and Young People's Partnership Board will meet quarterly to provide oversight and scrutiny of the progress against the plan. This Board will send regular reports to Health and Wellbeing Board to provide assurance on delivery of strategic actions on infant mortality. The performance framework for the plan will include infant mortality rates as a headline indicator to measure progress, alongside further recognised health and wellbeing indicators.

4.4.11 Update on the numbers

The Office of National Statistics are yet to publish overall infant deaths for 2021. However, via NOMIS they have published England higher level numbers of deaths for 2021, but not the rates. The following update on infant death rates for Birmingham are based on data currently available to the Birmingham Public Health Intelligence team. The update only includes England comparisons where

the information was available via NOMIS. This means that whilst we have rates for Birmingham between 2019 and 2021 it is not possible to include England comparators. We anticipate that it will be available in March 2023 before we would be able to do so. Appendix 5 also gives a year-to-date graph of information the team currently hold.

What follows is a summary.

- 2021 saw an increase of 21 infant deaths registration. The England rate also rose in 2021.
- Three-year rates have increased Birmingham to 7.6 per 1,000 but England has remained static at 3.9 per 1,000 live births.
- Perinatal single year rates have decreased in 2020 to 9.1 The 3 year rolling rates for 2018/20 have also decreased slightly on to 9.8 per 1,000 births locally (Please note data is not available for 2021 currently).
- Early neonatal deaths in 2021 increased by 14 in Birmingham which meant the rate increased by 1.5 deaths per 1,000 live births. England data is unavailable.
- Early neonatal 3-year rates 2019/21 for Birmingham increased by 0.3 per 1,000 live births. England data is unavailable.
- Late neonatal single year death rates have slightly increased in Birmingham in 2021. England data is unavailable.
- Neonatal deaths increased during 2021 by 1.9 per 1,000 live births in Birmingham. England data is unavailable.
- 2019/21 Neonatal rates have increased slightly. England rates are currently unavailable.
- Post neonatal death rates have increase for Birmingham, England 3-year rates are currently unavailable.
- Live births dropped across the city by an estimated 1,000 – stillbirths remained static.
- Currently England Stillbirths for 2019/21 and 2021/22 are unavailable. In Birmingham, locally calculated rates for both years have increased with 20 more stillbirths than 2018/20. Meaning Perinatal mortality has also increased.

5. Compliance Issues
5.1. HWBB Forum Responsibility and Board Update
5.1.1.   This report is to update the board on the progress being made by the Birmingham Perinatal and Infant Mortality Task force set up in September 2021 by the Birmingham Council.
5.2. Management Responsibility

5.2.1.   The task force is accountable to the Health and wellbeing Board through the Director of Public Health. In future it will also report into the LMNS BUMP Board. The link with delivery through the LMNS is important, as is the appointment of Dr Deepthi Jyothi as clinical Senior Responsible Officer with dedicated sessions to focus on leadership. Infant Mortality is seen as the number one priority in the ICS reducing health inequalities strategy,

6.   Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Lack of engagement from partners	Low	High	Ensure are partners informed and involved throughout
Lack of involvement from women and families	Low	High	Ensure co-production throughout
Task force does not complete actions within agreed time frame	Medium	Medium	Close monitoring of agreed actions by task force and subgroups

Appendices

Appendix 1 – HOSC infant mortality tracking report
Appendix 2 – Perinatal and Infant Mortality Development Plan
Appendix 3 – Seldom Heard Report
Appendix 4 - PowerPoint Presentation on Infant Mortality for School Curriculum
Appendix 5 – INFANT MORTALITY UPDATE – January 2023
Appendix 6 – Annual report of the Child Death Overview Panel 2022

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

Author: Dr Marion Gibbon – Assistant Director of Public Health – Children and Young People, BCC
Jeanette Davis – Public Health Officer Evidence – Public Health Knowledge, Evidence and Governance, BCC
Amy Maclean – Maternity and Children Development Lead – Ladywood and Perry Barr Locality Partnership
Colin Michel – Interim Strategy & Partnerships Lead Birmingham Children's Partnership
Lisa Stalley-Green – Deputy Chief Executive and Chief Nursing Officer BSol ICB

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Jo Tonkin – Interim Assistant Director of Public Health – Knowledge, Governance and Intelligence, BCC

Sushma Acquilla – Independent Chair of the Perinatal and Infant Mortality Taskforce

	Agenda Item:14
Report to:	Birmingham Health & Wellbeing Board
Date:	31st January 2023
TITLE:	UPDATE ON THE WORK OF THE PERINATAL AND INFANT MORTALITY TASKFORCE
Organisation	Birmingham City Council
Presenting Officer	Dr Marion Gibbon

Report Type:	Information/Approval

1. Purpose:
1.1. To update the Health and Wellbeing Board on the work of the Perinatal and Infant Mortality Taskforce.

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

3. Recommendation
3.1. To note the report.

4.   Report Body

4.1   Background - Update on the work of the Infant Mortality Taskforce

4.1.1   A report was prepared for Birmingham Health Overview and Scrutiny in 2020 and a request for an in-depth piece of work to consider the figures for infant mortality in Birmingham and the contributing factors which was presented to HOSC (Health Overview and Scrutiny Committee) in December 2020.

4.1.2   A series of recommendations were posed which consisted of:

1.   To work with partners to establish a multi-agency 'Reducing Infant Mortality in Birmingham' Task Force to oversee a concerted effort by all relevant agencies to achieve a substantial reduction in infant mortality in the city. The Task Force should include the existing Local Maternity System, Clinical Genetics representation, commissioners, and other maternity services such as BCHC (Birmingham Community Health Care), plus BCC (Birmingham City Council) Public Health, representatives of the CVS sector and elected Member, with a brief to bring the threads of all related interventions together in a concerted and mutually reinforcing programme. It should also identify and address any factors that may discourage some parents from engaging with their maternity service professionals.

2.   To set an ambitious goal to reduce infant mortality by 50% in Birmingham by 2025 (from 2015 figures, matching the national target) but to then go further and eliminate the gap between infant mortality rates in Birmingham and the England average by this date. This should be accompanied by a delivery plan that can plausibly demonstrate how these targets can be met, identifying both the structural and modifiable factors underlying the infant mortality within the City.

3.   To develop a strong community awareness strand within the Task Force work programme, led by respected and trusted community groups, local community and faith leaders, and other influencers who are engaged in social media. This should be targeted at improved health behaviours, identifying, and supporting families facing material hardship and adverse stressful circumstances, early detection of poor baby growth, and empowering people to make healthy life choices that minimise their infant mortality risk factors. This will include ensuring up to date information is available, including current and likely future trends in consanguineous unions in Birmingham.

4.   The work of the Task Force should be tasked to consider and adapt the 'four strands' approach of Professor Salway and access any resource and support available nationally.

4.1.3 A tracking report was provided for HOSC on the progress of each of the recommendations in October 2021 detailing the progress of the recommendations. A further report to HOSC was presented on 18th October 2022 (**Appendix 1**).

4.2   Achievements

4.2.1 The Perinatal and Infant Mortality taskforce has been established and has been meeting on a regular basis. Three streams of work have been established to take the work forward, which consist of:

1. Research – this group is chaired by Jo Garstang, the Designated Doctor for Childhood Death, she has received funding to establish research that develops an approach to understand the impact of infant loss on mothers and their families. Part of this is also looking at how these women can be supported.

2. Co-production and innovation - led by Dr Marion Gibbon. She is working with the Ladywood and Perry Barr Partnership Development Lead for Maternity and Children, Amy Maclean on a pilot project that is developing work with schools on the "Best Start in Life." This has been extremely successful, and this work will be taken forward by a partnership between Birmingham Education Partnership and Youth People's Education Community (YPEC). During the pilot, year 11 students in 2 secondary schools have participated in a Health Hack where they engage with health professionals and information about causes of infant mortality but framed as ways, they can enable a best start in life for themselves, their peers, families, and communities. Feedback from students has been positive, including gratitude for learning about such topics at this point in their lives.

3. Implementation – this was to be chaired by Marcia Perry, Birmingham Community Healthcare Trust once she retired. The majority of implementation relating to infant mortality is through the LMNS. One aspect that the development plan has highlighted is the need to look at the pathway from maternity into health visiting. As Marcia has now left this chair is vacant and we are hoping that someone from the Birmingham and Solihull (BSol) ICB (Integrated Care Board) will take on this role. It has been agreed that the taskforce will sit under the LMNS (Local Maternity and Neonatal System) BUMP (BSol United and neonatal Maternity Partnership) board. This will ensure greater accountability and traction for the work of the taskforce.

4.2.2 The Task Force includes members of the local maternity neonatal system (LMNS), clinical genetics, BSol ICS (Integrated Care System), BCC Public Health, representatives from the voluntary sector and elected Members.

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There is ongoing work to enable parents to engage effectively with their maternity service professionals. Members of the group have been working with the BSol (BUMP) to review the working of the Maternity Voices Partnership (MVP) and establish its new arrangements to ensure women's voices and experiences underpin the work.

4.3   The Perinatal and Infant Mortality goal and workplan

4.3.1   The Development Plan was presented at the last Health and Wellbeing Board when an update was requested on 22nd March 2022 ([CMIS (Committee Management Information System) > Meetings](#) **Appendix 3 pp384-388).**

4.3.2   The development plan is not a static document; it is dynamic and changes considering findings from the work being undertaken by the group. The latest version of the development plan is attached (**Appendix 2**). A significant amount of work has occurred since October 2022 with the consolidation of national and local policy documents by Barnes, J (SpR) and a discussion with the LMNS concerning leadership and priorities for the future.

4.4   Community awareness strand

4.4.1   Seldom Heard Report:

4.4.1.1   Birmingham Public Health commissioned providers to facilitate target focus group conversations to capture the voices of women about pregnancy and its interlinking topics. This offered insight into personal thoughts and experiences and based on those discussions, developed recommendations on how to improve the system.

4.4.1.2   It was thought that the findings from the groups would help influence the development of the Infant Mortality Action Plan. Written reports of the key findings were produced by each individual researcher and have since been consolidated into one report.

4.4.1.3   Helpful resources are being collated alongside a comms plan for sharing the report on a wider footprint which might help address some of the issues raised in the report. The report has recently been published (**Appendix 3**) and highlights the work of the Birmingham and Lewisham Health Inequalities Review. Work on cultural compassion is an area that is highlighted in both reports.

4.4.2   Community Researchers:

4.4.2.1   Birmingham Public Health commissioned Community Research training, women were recruited and trained from seldom heard communities (Black African, Polish & Eastern European, South Asian, and Chinese communities).

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4.4.2.2   The training was to enhance the skills and abilities of women, enabling them to further develop trusting relationships with women in their communities. This gave them a good understanding of ways of engaging with individuals and communities through conversations around the topic of pregnancy, maternity services, language barriers, cultural and religious beliefs.

4.4.2.3 The training provided confidence and understanding of ways to highlight key issues with Public Health. Public Health have now agreed host organisations and are finalising terms and conditions for them to support and develop the trained Community Researchers, in order that they can be confident in engaging in research practice with topics identified by Public Health and other partners.

4.4.3   Pilot Population Health Management (PHM):

A population health management approach is being piloted by Public Health aimed at identifying risk factors for low birth weight. This approach accesses standardised and linked data sets. It applies statistical techniques to identify and assess risk.

4.4.4   School Project:

4.4.4.1   There are two strands to this. The first is the development of PHSE materials that support the discussion of genetics and cousin marriage within the school curriculum. Several schools have been involved in this and a package is currently in development. A PowerPoint slide set has been developed (**Appendix 4**).

4.4.4.2   The second strand is the co-production of an approach with schools called "Best Start in Life" which aims to enable young adults in schools (young women in the first instance) to discuss what factors can lead to better health outcomes in babies. This event focused on developing action to improve health behaviours, identifying, and discussing early detection of problems, and empowered young women to make healthier life choices that minimise their infant mortality risk factors.

4.4.4.3 Presentations from health professionals provided up-to-date information about infant mortality, and information on the current scale and genetic problems caused by social and cultural factors in Birmingham. The first event was held on Friday 9th September at Handsworth Girls Academy. A report from this event is being produced.

4.4.5   Developing Workforce Cultural Compassion:

BUMP has commissioned a training programme called "5 times more", which focuses on developing workforce cultural compassion in the workforce. To date two sessions have been held with more planned.

4.4.6 Immediate Post-Natal Contraception:

A pilot has been completed and the findings presented to the BUMP board. Public Health has met with the Clinical Director of the local maternity partnership system to discuss the next phase of implementation. A further update will be produced on this project.

4.4.7 The Economic Cost of Genetic Conditions:

A report has been completed and presented to the Perinatal and Infant Mortality Taskforce. Several recommendations were posed which will feed into the development of culturally compassionate materials for families which is being led by the EDI (Equality, Diversity, and Inclusion) lead for BUMP.

4.4.8 LMNS Culturally Competent Genetics Service

4.4.8.1 The LMNS Culturally Competent Genetics Service has established a working group which will be monitored by the Maternal Quality Committee. The LMNS will be responsible for reporting progress made by the group to NHSEI (NHS England and Improvement) and Maternity Transformation Programme (MTP) on a regular basis.

4.4.8.2 The first national strategy for England to improve access to high quality genetics services for underserved groups will give families opportunities to make informed reproductive decisions, while respecting their culture, values, and beliefs. The NHSE strategy was coproduced with parents, clinicians, and academics. The strategy is informed by research evidence and national consensus on how this unmet health need should be addressed (Salway et al., 2019). It has four strands, illustrated below and which the service will be developed on:

Strand 1 raise genetic literacy at community level	Strand 2 educate and equip healthcare professionals
	Culturally competent genetic services	
Strand 3 improve access to genomics services for underserved groups	Strand 4 continuously improve with national support

4.4.8.3 As per the MTP bid process the LMNS have a financial package including national support to help implement Culturally Competent Genetic Service for the identified underserved groups in areas of high need for Birmingham, ringfenced to Birmingham North & East and Heart of Birmingham (based on the old PCT boundaries) where two separate bid applications required approval.

As part of the offer the LMNS are committed to rolling out a Culturally Competent Genetics Service for consanguineous couples in Birmingham North and East and Birmingham Central and West to aligned to the old Heart of Birmingham boundaries with the aim to develop work to:

- Improve access to genomics services for underserved groups; and

- Give families the opportunity to make informed reproductive decisions

4.4.8.4 The project funding is for 3 years and will be subject to confirmation in line with NHS England planning processes. As part of the 1st year allocation a "Genomics Associate x 1.0 WTE to the Regional Service will be appointed who will part support Midwifery resource locally (0.4 WTE Band 6 x 2 posts) to cover BSOL LMNS high need areas focusing on Birmingham North & East, Central & West localities—they will lead training, education, and information sharing; the recruitment process is taking place.

4.4.10 Child Death Overview Panel

Each year a report is written on the child deaths that have occurred in Birmingham. The current report was agreed for publication on 13th January 2023 (See **Appendix 6**) 2022 Annual Report of the Birmingham and Solihull Child Death Review Team and Child Death Overview Panel. The recommendations from the report will be implemented in 2023. These are:

1. To ensure BCH implement joint child death review meetings for all deaths

2. To continue to catch up on cases delayed due to the Covid-19 pandemic

3. Ensure that all lessons learnt from the whole death review process are captured on the eCDOP Analysis form

4. Ensure that all Child Death Review Meetings are multi-agency and external professionals are invited

5. To provide Joint Agency Response (JAR) training for health, police and coroner's staff

6. Closer working with public health.

    a. Consanguinity
    b. Deaths compared to social deprivation
    c. Perinatal deaths and maternal health

4.4.9 Linking to the Children and Young People's Plan

Currently the Children and Families Division is preparing the Birmingham Children and Young People's Plan. Part of this was a series of Think Tanks one of which focused on Infant Mortality and Early Intervention. It is crucial to consider how we support families and young people to have healthy

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relationships, pregnancies, and good health outcomes. Ensuring that our families are well supported and that we have interventions that minimise the impact of child poverty are crucial in decreasing infant mortality. The new role that the Children and Families Division have instituted will ensure that links between public health and other parts of the council have a lasting impact on the health of our communities is crucial.

4.4.10 Update on the numbers

The Office of National Statistics are yet to publish overall infant deaths for 2021. However, via NOMIS they have published England higher level numbers of deaths for 2021, but not the rates. The following update on infant death rates for Birmingham are based on data currently available to the Birmingham Public Health Intelligence team. The update only includes England comparisons where the information was available via NOMIS. This means that whilst we have rates for Birmingham between 2019 and 2021 it is not possible to include England comparators. We anticipate that it will be available in March 2023 before we would be able to do so. **Appendix 5** also gives a year-to-date graph of information the team currently hold.

What follows is a summary.

- 2021 saw an increase of 21 infant deaths registration. The England rate also rose in 2021.

- Three-year rates have increased Birmingham to 7.6 per 1,000 but England has remained static at 3.9 per 1,000 live births.

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- Neonatal deaths increased during 2021 by 1.9 per 1,000 live births in Birmingham. England data is unavailable.

- 2019/21 Neonatal rates have increased slightly. England rates are currently unavailable.

- Post neonatal death rates have increase for Birmingham, England 3-year rates are currently unavailable.

- Live births dropped across the city by an estimated 1,000 – stillbirths remained static.

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6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Lack of engagement from partners	Low	High	Ensure are partners informed and involved throughout
Lack of involvement from women and families	Low	High	Ensure co-production throughout

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Task force does not complete actions within agreed time frame	Medium	Medium	Close monitoring of agreed actions by task force and subgroups

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

Author: Dr Marion Gibbon – Assistant Director of Public Health – Children and Young People, BCC

Jeanette Davis – Public Health Officer Evidence – Public Health Knowledge, Evidence and Governance, BCC

Amy Maclean – Maternity and Children Development Lead – Ladywood and Perry Barr Locality Partnership

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Jo Tonkin – Interim Assistant Director of Public Health – Knowledge, Governance and Intelligence, BCC

Sushma Acquilla – Independent Chair of the Perinatal and Infant Mortality Taskforce

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Report of:	Cabinet Member for Health and Social Care
To:	Health and Social Care Overview and Scrutiny Committee
Date:	18th October 2022

Progress Report on Implementation: Infant Mortality

Review Information

Date approved at City Council:	13th April 2021
Member who led the original review:	Councillor Rob Pocock
Lead Officer for the review:	Emma Williamson
Date progress last tracked:	N/A

1. In approving this Review the City Council asked me, as the appropriate Cabinet Member for Health and Social Care, to report on progress towards these recommendations to this Overview and Scrutiny Committee.

2. Details of progress with the remaining recommendations are shown in Appendix 2.

3. Members are therefore asked to consider progress against the recommendations and give their view as to how progress is categorized for each.

Appendices

1	Scrutiny Office guidance on the tracking process
2	Recommendations you are tracking today
3	Recommendations tracked previously and concluded

For more information about this report, please contact

Contact Officer:	Dr Marion Gibbon
Title:	Interim Assistant Director of Public Health
Telephone:	
E-Mail:	marion.gibbon@birmingham.gov.uk

Appendix ◯: The Tracking Process

In making its assessment, the Committee may wish to consider:
- What progress/ key actions have been made against each recommendation?
- Are these actions pertinent to the measures required in the recommendation?
- Have the actions been undertaken within the time scale allocated?
- Are there any matters in the recommendation where progress is outstanding?
- Is the Committee satisfied that sufficient progress has been made and that the recommendation has been achieved?

Category	Criteria
1: Achieved (Fully)	The evidence provided shows that the recommendation has been fully implemented within the timescale specified.
2: Achieved (Late)	The evidence provided shows that the recommendation has been fully implemented but not within the timescale specified.
3: Not Achieved (Progress Made)	The evidence provided shows that the recommendation has not been fully achieved, but there has been significant progress made towards full achievement. **An anticipated date by which the recommendation is expected to become achieved must be advised.**
4: Not Achieved (Obstacle)	The evidence provided shows that the recommendation has not been fully achieved, but all possible action has been taken. Outstanding actions are prevented by obstacles beyond the control of the Council (such as passage of enabling legislation).
5: Not Achieved (Insufficient Progress)	The evidence provided shows that the recommendation has not been fully achieved and there has been insufficient progress made towards full achievement. **An anticipated date by which the recommendation is expected to become achieved must be advised.**
6: In Progress	It is not appropriate to monitor achievement of the recommendation at this time because the timescale specified has not yet expired.

Appendix ◯: Progress with Recommendations

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R01	To work with partners to establish a multi-agency 'Reducing Infant Mortality in Birmingham' Task Force to oversee a concerted effort by all relevant agencies to achieve a substantial and reduction in Infant Mortality in the City. The Task Force should include the existing Local Maternity System, Clinical Genetics representation, commissioners and other maternity services such as BCHC, plus BCC Public Health, representatives of the CVS sector and elected Members, with a brief to bring the threads of all related interventions together in a concerted and mutually reinforcing programme. It should also identify and address any factors that may discourage some parents from engaging effectively with their maternity service professionals.	Cabinet Member, Health and Social Care	July 2021	

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

The Perinatal and Infant Mortality taskforce has been established and has been meeting on a regular basis. There are three streams of work which consist of:

1. Implementation – this is chaired by Marcia Perry, Birmingham Community Health Trust. This group is looking at the pathway from maternity into health visiting.
2. Research – this group was to be chaired by Richard Kennedy. Jo Garstang the Designated Doctor for Childhood Death has received funding to establish research that develops an approach to understand the impact of infant loss on mothers and their families. Part of this is also looking at how these women can be supported.
3. Co-production and innovation this strand is led by Dr Marion Gibbon. She is working with the Development Lead for Maternity and Children, Amy Maclean on a pilot project that is developing work with schools on the "Best Start in Life".

The Task Force includes members of the local maternity system, clinical genetics, BSol ICS, BCC Public Health, representatives of the voluntary sector and elected Members. There is ongoing work to enable parents to engage effectively with their maternity service professionals. Members of the group have been working with the BSol United Maternity Partnership (BUMP) to review the working of the Maternity Voices Partnership (MVP) and establish its new arrangements.

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R02	To set an ambitious goal to reduce infant mortality by 50% in Birmingham by 2025 (from 2015 figures, matching the national target) but to then go further and eliminate	Cabinet Member, Health and Social Care	July 2021	

| | the gap between infant mortality rates in Birmingham and the England average by this date.

This should be accompanied by a delivery plan that can plausibly demonstrate how these targets can be met, identifying both the structural and modifiable factors underlying the inequalities in infant mortality within the City. | | October 2021 | |

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

The group now has a development plan which was presented at the last Health and Wellbeing Board when an update was requested. The development plan is not a static document it is dynamic and changes in light of findings from the work being undertaken by the group.

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R03	To develop a strong community awareness strand within the Task Force work programme, led by respected and trusted community groups, local community and faith leaders, and other influencers who are engaged in social media. This should be targeted at improved health behaviours, identifying and supporting families facing material hardship and adverse stressful circumstances, early detection of poor baby growth, and empowering people to make healthy life choices that minimise their infant mortality risk factors. This will include ensuring up to date information is available, including the current scale and likely future trends in consanguineous unions in Birmingham.	Cabinet Member, Health and Social Care	February 2022	

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

Seldom Heard Report:
Birmingham Public Health commissioned providers to facilitate target focus group conversations to capture the voices of women about pregnancy and its interlinking topics. This offered insight into personal thoughts and experiences and based on those discussions, developed recommendations on how to improve the system.

It was thought that the findings from the groups would help influence the development of the Infant Mortality Action Plan. Written reports of the key findings were produced by each individual researcher and have since been consolidated into one report.

Helpful resources are being collated alongside a comms plan for sharing the report on a wider footprint which might help address some of the issues raised in the report.

Community Researchers:
Birmingham Public Health commissioned Community Research training, women were recruited and trained from seldom heard communities (Black African, Polish & Eastern European, South Asian, and Chinese communities).

The training was to enhance the skills and abilities of women, enabling them to further develop trusting relationships with women in their communities. This gave them a good understanding of ways of engaging with individuals and communities through conversations around the topic of pregnancy, maternity services, language barriers, cultural and religious beliefs.

The training provided confidence and understanding of ways to highlight key issues with Public Health. Public Health have now agreed host organisations and are finalising terms and conditions for them to support and develop the trained Community Researchers, in order that they can be confident in engaging in research practice with topics identified by Public Health and other partners.

- Pilot Population Health Management (PHM) - work is being developed by the PHM lead in public health with partners
- School Project – there are two strands to this. The first is the development of PHSE materials that support the discussion of genetics and cousin marriage within the school curriculum. Several schools have been involved in this and a package is currently in development. The second strand is the co-production of an approach with schools called "Best Start in Life" which aims to enable school aged children (girls in the first instance) to discuss what factors can lead to better health outcomes in babies. This event focused on developing action to improve health behaviours, identifying and discussed early detection of problems, and was to empower young women to make healthy life choices that minimise their infant mortality risk factors. Presentations from health professionals provided up-to-date information about infant mortality, and information on the current scale and likely future trends genetic problems caused by social and cultural factors in Birmingham. The first event was held on Friday 9th September at Handsworth Girls Academy. A report from this event will be produced.
- Developing Workforce Cultural Compassion – BUMP has commissioned a training programme called "5 times more", which focuses on developing workforce cultural compassion in the workforce. To date two sessions have been held and there are more planned.
- Immediate Post-Natal Contraception – a pilot has been completed and the findings presented to the BUMP board. Public Health is meeting with the Clinical Director of the local maternity partnership system to discuss the next phase of implementation
- The Economic Cost of Genetic Conditions – a report has been completed and presented to the Perinatal and Infant Mortality Taskforce. Several recommendations were posed which will feed into the development of culturally compassionate materials for families which is being led by the EDI lead for BUMP.

| No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R04	The work of the Task Force should be tasked to consider and adapt the 'four strands' approach put to us by Professor	Cabinet Member, Health and Social Care	March 2022	

	Salway (outlined above) and access any resource and support available nationally.			

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

Building on from the Delphi exercise (which brought about professor Salway's recommended 'four strands' approach), there has been a national strategy being funded by NHSEI in response to increased genetic risk associated with close relative marriage.

- In order to deliver against the four strands (fig.1) the programme is aiming to work with 8 areas of high need based on infant mortality data of which North & East Birmingham have been identified as one.

Fig.1
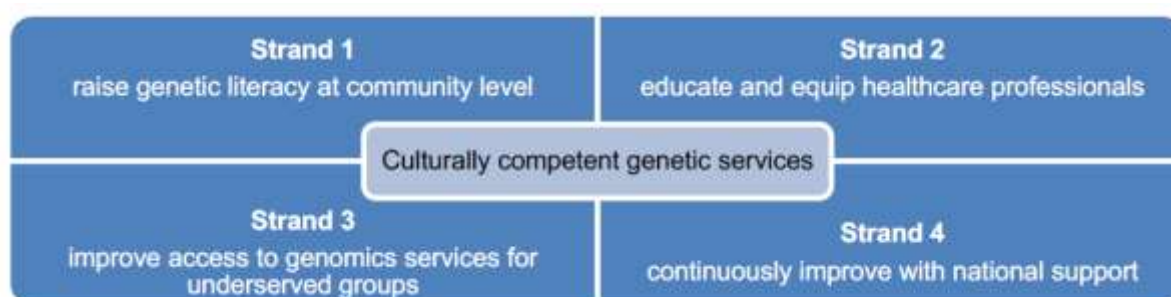
The Equity & Equality: guidance for Local Maternity Systems (pp. 26, 29-30), made a commitment to roll out culturally competent genetics services for consanguineous couples. There are two aims of this work to:
  1. improve access to genomics services for underserved groups; and
  2. give families the opportunity to make informed reproductive decisions

NHSEI has offered financial and national support to help implement these culturally competent genetic services for underserved groups in Birmingham. Birmingham LMNS can access this extra support, including funding for local genetic literacy programmes; funding for a close relative marriage midwife (band 6, 0.4WTE); dedicated support in the regional genomics service; and a clinically led national support offer.

In order to oversee this work, a Culturally Competent Genetics Service – Relative Marriages Working Group has been convened, Terms of Reference are available on request. The group will apply for the available funding, £334,000 per annum over 3 years and work together to deliver and monitor expected and agreed outcomes.

The Group will address the areas of work outlined in the four strands below:

Strand 1: raise genetic literacy at community level
Will develop a genetic literacy programme to raise awareness of genetic risk and improve access to NHS Services to support informed reproductive decision-making. Alongside ensuring there is a process for sharing health promotion materials provided by NHSE to support face-to-face conversations between families and a health or social care worker for the population of North and East Birmingham respecting their cultural values and belief.

Strand 2: educate and equip healthcare professionals
Will carry out recruitment process to appoint a 'Close Relative Marriage Midwife (band 6 at least 0.4wte per high need area), based within the provider trust's screening team. With development of online training and

follow-up webinars to midwives, maternity support workers, neonatal staff, GPs, health visitors, paediatricians, social workers, and others by incorporating emphasis on respect of the cultural values and belief of the population of North and East Birmingham – *detail to be worked through.*

Strand 3: Improve access to genomic services for underserved groups
- Will develop and improve local pathways for counselling to improve access to services for families at increased genetic risk associated with close relative marriage, from primary and secondary care to ensure high quality referrals to the regional genomics service, with a focus on underserved groups within North & East Bham – for those practising close relative marriage, particularly couples from Pakistani ethnic groups.

- Will monitor local metrics evidencing an increase in high quality referrals to the Regional Genomics Service from underserved groups across North & East Bham by increasing face to face contacts for families in the North and East Birmingham areas when interventions are developed.

Strand 4: Continuously improve with national support
- Will be commitment from the appointed Close relative marriage midwife and a public health representative to attend the all-day events to share learning and receive training.
- LMNS leads, public health, ICS and members of the local, multi-agency working group(s) to attend and contribute to the annual event. To provide quarterly highlight reports on progress and spend against plan, risks, etc, using template provided by MTP.
- Will provide anonymous data every month for quality improvement purposes, in line with reporting cycles; these data will be shared with other organisations, e.g., the NHS, ICBs, local authorities, national steering group members.
- Will participate in qualitative and quantitative surveys and facilitate access to staff and service users

The timeline for applying for the funding:
- **1 August Process for bid submission is issued to LMNS**
- 6 September Virtual workshop about the application process (from 2-4pm)
- **23 September Deadline to submit applications and supporting documents**
- 5 October Assessment of applications
- **7 October Notification of decision sent to successful applicants**
- October 2022 Funding transferred to the LMNS' host ICB

Appendix ○: Concluded Recommendations

These recommendations have been tracked previously and concluded.
They are presented here for information only.

Concluded

No.	Recommendation	Responsibility	Date Concluded by Overview and Scrutiny Committee	Tracking Assessment
R05	Progress towards achievement of these recommendations should be reported to the Health and Social Care Overview and Scrutiny Committee no later than 31 October 2021. Subsequent progress reports will be scheduled by the Committee thereafter, until all recommendations are implemented.	Cabinet Member, Health and Social Care	October 2021	1

DRAFT: Recommendations on tackling Perinatal/Infant Mortality

Prof Sushma Acquilla FRCP, FFPH
Independent Chair Birmingham Perinatal and Infant Mortality Task force

Introduction

The overlap between Perinatal and infant mortality, maternal mortality and the maternity services cannot be ignored and a whole system approach is required. These draft recommendations have arisen from the following meetings;

- 1:1 meetings with various stakeholders and key players (28 to date since Oct 21, some outstanding)*

Task Force meetings (8) and other group meetings attended

- Maternity Action Group for West B'ham
- BUMP / LMNS program Board
- Culturally Competent Genetics Services - Funding Bid opportunity BSOL LMNS
- Genetic Risk: Close relative marriage Interactive workshop on the application process
- Culturally Competent Genetics Service Working Group/for bid
- Preventable Deaths Think tank
- Birmingham Solihull CEDOP Strategic meeting
- BSiL subgroup/MAG merged meeting
- Birmingham Children's Partnership Away Day

    - **So far I have had no success in meeting the Muslim Males and the faith leaders. In process of rearranging these meetings with faith leaders from Birmingham.*

A separate report in tabular form at Annex A summarises the recommendations from the following significant national and local reports:

1) *Seldom Heard; Conversations about Pregnancy,* Birmingham City Council, July 2022
2) *INVISIBLE; Maternity Experiences of Muslim Women from Racialised Minority Communities. A Summary Report*, Shaista Gohir OBE, July 2022
3) *Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR),* March 2022
4) *Women's Health Strategy for England*, Department for Health and Social Care 20 July 2022
5) FIVEXMORE: The Black Maternity Experiences Survey: A Nationwide Study of Black Women's Experiences of Maternity Services in the United Kingdom; Peter and Wheeler, 2022.

~~* PS So far I have had no success in meeting the Muslim Males and the faith leaders. In process of rearranging these meetings with faith leaders from Birmingham.~~

Priority themes, objectives and actions

Below are the broad objectives to improving better care.

1. Research and innovation
2. Co-production and community engagement
3. Implementation

1. Quality, safety and access to services

Objectives	Themes from discussion 1:1
Improving access to the system	Best care for women knowing How and what to do Plenty of good guidance is available but problem with implementation of guidance Move towards "Package of care"
Strengthen preconception care services and engagement	Vitamin D and Folic acid deficiency Non invasive prenatal screening. Holistic support and care for next pregnancy Implementation of good practice Reducing preterm births: pre pregnancy Counselling Pre-conception panel genetics Advice re losing weight before next pregnancy / poverty issue Community side of the care is missing sometimes, hence pre-pregnancy/ pre conception advice is not available.
Increase engagement with antenatal services and promote the benefits of antenatal care	Services are better for high alert patients Care drops after 2nd delivery in hospital Risk assessment best done by Fetal medicine nurse /HV Improving access to the system HBA1C needs to be introduced as routine test in pregnancy. Quality standards in antenatal care are important factors.
Increase awareness regarding genetic services	More education is required in school on preventable causes Rare conditions recorded at delivery but may not be seen as problem – prompt referral Difficult to change as 90% of Consanguineous couples may produce normal child
Training of health care workers and clinicians in cultural compassion	Women feel that there is structural racism and lack of trust and respect. There are superstitions and cultural behaviours that do not help Holistic support and care for next pregnancy get a group of women and arrange meeting to educate them and empower women in decision making
Training regarding postpartum contraception	Implementation of good practice Move towards "Package of care" Need to improve maternal post partum care/ postnatal checks.

Appropriate assessment and referral during pregnancy and support during birth	Services are better for high alert patients Care drops after 2nd delivery in hospital Risk assessment best done by Fetal medicine nurse /HV Non invasive prenatal screening. Risk assessment and risk management
Develop excellence in reducing injury in premature Births[GJ(CHNFT1]	Use literature from other areas like Manchester. Plenty of good guidance is available but problem with implementation of guidance Adverse outcome if born in separate local unit without adequate neonatal support. Adverse outcome for hypothermia in babies at the time of resuscitation. Both can be avoided by complicated/ premature deliveries to be done in Level 3 women's hospital and Transthermot heating pack cover the baby and avoid hypothermia. Monitor breathing cycle during "golden hour" Midwives have an important role for those who have had premature delivery before.

2. Maternal and infant wellbeing

Objectives	Theme group
Support women to stop smoking and promote smoke free homes	Smoking cessation Immediate action could be taken on major risk factors in women i.e. Obesity/ smoking/ diabetes/ socio economic factors Main causes on Infant deaths Obese mothers with high BMI, From deprived area, smoking, Housing issues: overcrowding
Support maternal mental health and wellbeing	Re establish women's centre for exchange of information/ education Re establish children's/ women's Centres like Sure start get a group of women and arrange meeting to educate them and empower women in decision making
Reduce maternal obesity and improve nutrition	More education is required in school on preventable causes Immediate action could be taken on major risk factors in women i.e. Obesity/ smoking/ diabetes/ socio economic factors Main causes on Infant deaths Obese mothers with high BMI, From deprived area, smoking, Housing issues: overcrowding
Encourage and support breastfeeding	What about Health Visitors/ children centres support?

	More education is required in school on preventable causes
	get a group of women and arrange meeting to educate them and empower women in decision making
	Service providers need to change attitude
Support families in health and genetic literacy	==Families are now coming forward for tests and new generations are changing.== Access to information for young couples
	==Intervention not accepted due to religion and get judged on the decision==
	Adoption and milk bank not accepted in religion
	Rare conditions recorded at delivery but may not be seen as problem – prompt referral
Alcohol and substance-misuse support during pregnancy and postnatally	

3. Addressing the wider determinants of health

Objectives	Theme group
Support efforts to reduce and mitigate the impact of poverty	Wider public health determinants to be addressed i.e. pollution and Poverty Income poverty and quality standards in antenatal care are important factors.
Housing	Wider public health determinants to be addressed i.e. pollution and Poverty Main causes on Infant deaths Obese mothers with high BMI, From deprived area, smoking, Hosing issues: overcrowding
Identify and address poor environments	Wider public health determinants to be addressed i.e. pollution and Poverty
Working with homeless team to support vulnerable mothers and infants	

4. Safeguarding and keeping infants safe from harm

Objectives	Actions
Safe sleeping	More education is required in school[GJ(CHNFT2] on preventable causes
Safe home environments	More education is required in school[GJ(CHNFT3] on preventable causes

Prevention of injuries	More education is required in school on preventable causes
Reduction in domestic abuse during pregnancy and motherhood	More education is required in school on preventable causes "I can cope" not shaking the baby[GJ(CHNFT4]

5. Providing support for those bereaved and affected by baby loss

Objectives	Theme group
A system-wide approach to making things as easy as possible for bereaved families	counselling for those who have lost a baby-(3 months after)[GJ(CHNFT5]
Strengthen pathways to ensure people who have had a loss receive enhanced support for their next pregnancy	Holistic support and care for next pregnancy Timing for postnatal bereavement 5-6 wks Late loss in pregnancy and stillbirths should be one of the research priorities
Increase the skills and confidence of the wider workforce to talk about bereavement	Timing for postnatal bereavement 5-6 wks

Recommendations

Although the draft recommendations have been circulated earlier to various individuals/ groups, they were discussed fully on 14th October at the Infant mortality and inequality Group. It was decided that these recommendations should be presented in the priority order that can be implemented as soon as possible with appropriate policy and protocols. It was also agreed that these should be presented in tabular form and there should names attached to each of the recommendation, who would take a lead on implementation. The recommendations were reviewed again on 11th Nov.

Recommendation	Lead person	Progress
Ambulance services should convey premature labour cases to a tertiary centre as per national guidance, rather than to the place of booking. Where there are barriers to this happening this should be addressed.	Lisa Stalley-Green/Bump (?WMAS input requested)	Maternity pathway issue *'Ambulances are alerted by hospital leaders if there is a need to divert women away from their original place of booking. Information is also sent out in the daily SitRep based on the Operational Pressures Escalation Levels framework (OPEL) via email across the region. If a hospital is in escalation this is communicated, and alternative arrangements for other tertiary units are found. This may be out of the region, depending on whether the unit is in escalation due to maternal beds or neonatal cots'* Issue appears to be one primarily of bed-space. Meeting to be had with WMAS to gain their thoughts.
Ante-natal steroid use has been shown to be effective in improving perinatal outcomes. This should continue to be tracked and delivery maximised.	Lisa Stalley-Green/Bump	Maternity pathway issue *This is already a standardised antenatal pathway, and is measured on the LMNS monthly dashboard.* Could there be a role for PeriPREM or similar to maximise? (JB)
Thermal Management: Optimal temperature management has been shown to improve outcomes: how are we monitoring effective use?	Lisa Stalley-Green/Bump	Maternity pathway issue *Already in guidelines, (needs to be measured to take up with NN team*)
CDOP enquiry has highlighted delayed cord clamping as involved in a number of it's cases. There should		(Helen Chaplin)

be a review of the policy on this.		
All CDOP problems identified should be followed by identified actions for all preventable deaths. There should be a mechanism to 'close the loop'	CDOP Coordinator – Marion should be able to action through CDOP	*This already happens. After each CDOP meeting letters are written to the appropriate organisation/officer. These are recorded on the minutes and are followed up.*
Data monitoring to be more granular with accurate mapping of causes of deaths, with geographical mapping. This would help identify the preventable and other causes due to congenital abnormalities and population/ areas to focus upon.	As above	*Work with Deepthi Jo Garstang and Marion. Marion to link in with Jo Tonkin the AD in PH with responsibility for data, insight and intelligence.*
Improved access to genetic screening services for those at particular risk (consanguinity) or those who have the history of perinatal loss.	ICS – Lisa in first instance	*Successful bid for a culturally competent genetics service has been awarded, therefore a service will be implemented in the coming months*
Improve delivery and access to Preterm Baby clinics to encourage early booking and approachable parenting. Specific targeting at parts of the community that are less likely to access services should be delivered	Lisa/BUMP	Maternity Pathway *There are already preterm clinics led by consultants within the system for those who have/are at risk of preterm delivery. Liaison with external stakeholders will be sought to help reach a wider audience (KRN) ?Use of local radio was made at initial meeting (JB)*
Additional funds have been announced for 6-8 highest PNM and IM areas. Need to make appropriate bid, ideally in collaboration with other areas to get synergistic effect of any action.	ICS – Lisa S-G	To speak with Kathleen Roche - Nagi
There has been an introduction of nationally funded pilot in 8 areas with Culturally Competent Genetic Service. There should be collaboration with 7 additional sites to enable joint learning.	As above	*Sylvia to follow up*
Consideration of monthly outreach clinics to help consultants working with GPs and reach hard to get community. Connecting with ICS and PCNs is important to get the priorities listed.	ICS – L S-G/BUMP	*Link workers are doing this work already, although there is no specific outreach clinics due to estate, link workers are community based to reach MWs and linking in with GPs, (although work with GPs could*

		be explored further).
Engage with midwives from the clinics where initial booking is happening. Introduce Black companion service to help facilitator role within existing services; Significant legacies need to be tackled as parts of the community feel left behind and frustrated. Implementation of BLACHIR recs is key.	Lisa S/G/BUMP	BLACHIR work being implemented (reword recommendation)
Establishing maternal medicine network. This may include use of Independent midwives	BUMP	MMN established
Need for establishment of Peri-natal Psychology services to help those bereaved with loss of the baby but also to support with the major risk factors identified, where the larger partners from LA should be involved, like poverty/ overcrowding/ smoking.	commissioner leads for MH & Maternity Bereavement midwife leads Cassie	Bereavement pathway is in draft, due for sign off Dec '22 Childrens' plan (link) colin.michel@birmingham.gov.uk
Engagement with Faith and community leaders. This should be broad, not just focussed on e.g. local Imams	Salma Yaqoob has offered to help with this problem working with Kathleen	In progress
Cultural competency training, starting with leadership would be important. Level of cultural competency with an individualised rather than homogenised approach to black communities. Major awareness campaign to be introduced	Need to unpack and discuss, if just in maternity then BUMP, if not then BLACHIR ICS group for NHS and BLACHIR implementation board	Sylvia BLACHIR *Commissioned Culturally competent work is taking place within the trust providers, Sylvia working with a group of parent leaders to find out the specific needs for black women in the community*
Need to have a meeting with appropriate individuals who can bring about a positive change,		Planned meetings with Neonatologists and WMAS

Perinatal Care for Women in minority groups; information brief

Dr J Barnes, GPST1

Introduction

This Annex forms part of the context of the task force set up in Birmingham to address the higher rate of perinatal mortality in the region. At the time of writing (Autumn 2022), a number of reports had been commissioned both nationally and regionally which each shone light on different aspects of perinatal care for pregnant women from a number of backgrounds. This brief aims to summarise these reports to establish a grounding.

Sources:

1) *Seldom Heard; Conversations about Pregnancy,* Birmingham City Council, July 2022
   2) *INVISIBLE; Maternity Experiences of Muslim Women from Racialised Minority Communities. A Summary Report*, Shaista Gohir OBE, July 2022
   3) *Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR),* March 2022
   4) *Women's Health Strategy for England*, Department for Health and Social Care 20 July 2022
   5) *FIVEXMORE: The Black Maternity Experiences Survey: A Nationwide Study of Black Women's Experiences of Maternity Services in the United Kingdom*; Peter and Wheeler, 2022.

Theme	Seldom Heard Voices	Invisible	BLACHIR	Womens PLAN	FIVEXMORE
Access to Healthcare	Access to healthcare generally worse than population as a whole, but difficulty especially in accessing resources related to sexual and reproductive health (SRH). Particular barriers are social (stigma of attending services, linguistic (not having resources translated, or translations being out of date), and digital exclusion (with limited access to internet) being an issue.	Despite increased population risks of certain maternal complications, the report felt that 'additional screening is not being offered' (p18). Where screening was offered, it wasn't specific to individual risk for their ethnic group.	"Women were not provided with sufficient antenatal education" (p18)- Significant barriers such as under-resourcing of services and difficulty in accessing midwives impacted women's health. Recommendation: 'Promote health checks through public campaigns to increase the uptake of community-based health checks in easy to access locations' (p10)	"Fragmented commissioning and delivery of (SRH) negatively impacts women's access to services." (p25) Not specific to Birmingham, but having to attend multiple different services negatively impact outcomes. Strategy Goal: 'Women are supported through high quality information and education to make informed decisions about their reproductive health, including if and when to have a child' p68	Although few barriers to accessing healthcare were identified, the quality of advice was a drawback. Many felt uninformed about risks, and felt a sense of 'dismissiveness' about their concerns. Concerns were raised about access to screening eg for sickle trait, and generally for accessing pain relief.
Cultural Differences	Some Muslims view problems in pregnancy being 'the will of Allah' was seen, with similar approaches to contraception. Conversely, when things went wrong with a pregnancy, some felt that they were blamed, and felt unsupported emotionally by partners and family. On male partners, some identified contraception as the 'woman's job', and poor understanding of pregnancy meant a lack of support for mothers. Cultural factors such as religion, beliefs and values played a significant amount for some, with the view of elders being held in high regard. Often this was poorly understood by HCPs and not reflected in their causing an extra barrier.	Significant concerns were raised about unconscious bias of merging all of the various Muslim communities under one label, causing a barrier to effective healthcare. Of note, less than 40% of staff were reported as having good or very good 'knowledge of the culture of the women they served' (p17).	Maternity Care Processes do not recognise cultural differences between black African and Black Caribbean women' (P38).		A lack of sensitivity towards cultural experiences of pain seemed to be a common theme. Broadly, recommendations for addressing unconscious bias were made, with concerns about instances of inappropriate jokes made.
Health Communication	Barrier to communication from lack of information in own language, or language that isn't up to date. Poor access to interpreters can also be a significant issue. Also some issues with the ways in which HCPs present information, with some 'feeling judged for wanting more children'	Women "were not provided with sufficient antenatal education", putting them and their babies at risk (p15). Women felt pressured to 'accept interventions' such as induction of labour (p21). Throughout report not being listened to was a recurrent theme.		"84% of (Women report) instances in which they had not been listened to by healthcare professionals." (p15)	Although there seemed to be good access to antenatal advice re: physical health, there was limited Mental Health input- 40% weren't asked about their mental wellbeing. Women in the study wanted HCPs to 'listen…without making assumptions'

Sources of Information	Significant amount of peer and community teaching, often different to NHS advice. Some felt that they would only need information about contraception later on in life and would seek it out then. Lack of access to internet services and 'digital exclusion' was particulary prevalent in some communities. Suggestions for the kind of service that would be beneficial was the option for pre-conception clinics, especially ones embedded within the communities involved.	56% using Friends and family for source of info (p15)	Suggestion: 'develop targeted programmes on health literacy for 'Black african and Black caribbean communities' (p10)	Family and friends main source of information (74%) (p21)	60% of women surveyed had accessed e.g. the NHS website as a source of information.
Outcomes		Significant Gaps in data because of lack of ethnicity data and no disaggregation into smaller groups. (p32)	Black women 5* more likely to die in pregnancy or childbirth than white women (p34) Highest infant mortality rates... in the Carribbean and Central Afric(an)' communities. Concerns about significant lack of data on these communities, lack of 'lived experience'		27% felt that their overall care was either poor or very poor. One key recommendation was for more community-based midwifery input.

SELDOM HEARD

Conversations about pregnancy

**Birmingham
City Council**

CONTENTS

SELDOM HEARD

Conversations about pregnancy

INTRODUCTION

Infant mortality is a key public health indicator of the health of the general population as well as standards of clinical care. Nationally the rate of infant mortality has been declining since 2001/03 but in Birmingham infant mortality rates have been statistically high for many years, nearly twice the national average.

As recommended in 'Better Births' to improve outcomes for maternity services there is a need to understand our 'seldom heard' community's perspective around pregnancy. Having relevant information and being supported to make healthier choices is known to make a positive difference in the pregnancy journey for most women. Therefore, as part of shaping the approach to creating a positive discussion regarding both desire and preparation for pregnancy, Birmingham City Council Public Health Team commissioned qualitative research targeting 'seldom heard' communities across Birmingham. These conversations took place January 2021 through to June 2021. The findings from these conversations will help influence the development of the Reducing Perinatal and Infant Mortality action plan and its overall aim to reduce infant deaths in Birmingham.

Key findings
- Women repeatedly stated they were not listened to and their concerns not taken seriously or valued.
- Participants from the Black, Asian and minority ethnicities and deaf and hard of hearing groups commented on how they felt invisible when health professionals would speak directly to family, friends or interpreters who accompanied them.
- Asylum seekers and refugee women felt unheard and wanted a voice in their care. They shared that things were 'done to them' rather than asking what it is they need not what their husband, family or nurse feels they need.
- Deaf and hard of hearing women told of the impact on their confidence, independence and mental health when they do not have access to an interpreter.
- Participants felt there were gaps in information and help when things didn't go as planned for example miscarriage or loss of a baby.
- Participants from Black, Asian and minority ethnic groups discussed how they didn't know what to expect in their first pregnancy, what signs to look for and how they wanted to be better informed about risks.
- Deaf and hard of hearing women felt it important to know interpreters will be available prior to appointments and that additional time will be allocated to allow time for a three-way conversation.

- Women identified how accessing emergency contraception through pharmacies can lack privacy.
- All focus groups expressed concerns around not being treated with dignity and respect from healthcare service providers. It was felt that personal interactions needed to be more of a positive experience.
- Delivering services, support and information using technology can create an additional barrier for women and families who don't have access to the internet and/or don't have the right equipment.
- Women from Black, Asian and minority ethnic focus groups identified their feelings of distress and low moods after experiencing stillbirths/miscarriages, was not getting picked up by their doctors or their communities.
- During conversations, women placed a strong emphasis on the importance of culture and how it impacts on the woman's pregnancy and parental journey.
- Women from the South Asian group strongly felt access to health services and treatment is not on par with pregnant women who are more proficient with English.
- Bangladeshi women discussed how they were unsure of what not to eat and had very little knowledge of any recommended vitamins etc to take during pregnancy.
- A number of participants across groups were not aware of how weight can impact on becoming pregnant.
- Participants shared the influence of others on their pregnancy journey and how this conflicting information often left them finding it difficult to know which advice to follow.
- Women spoken to were generally comfortable being asked 'one key question' by health professionals. A small number suggested they would be happy to be asked by other support agencies.
- There was a general feeling mother and baby support had been cut so there was less support on offer.

Key Recommendations
- Ask women what they need and give them options and choices.
- Health professionals to give women time to talk about their concerns and frustrations without reprimand from family or communities.
- Ensure accessible, timely and appropriate information in order for women to make decisions and choices about their care. This should be available in a range of translated formats including leaflets, digital platforms, videos and workshops to talk through the information.
- Services should be personal and focussed around their women's needs, culture and beliefs.
- Sexual health services should be delivered in different settings, including education and the workplace, making them more accessible.

- Interpreter support should be available not only for planned appointments but for emergency appointments as well.
- Ensure new parents are knowledgeable about the 'system', their rights and how they can meet their own needs with the resources available.
- More support for those who experience multiple pregnancies.
- Translators, in all languages, need to develop a repour with the pregnant women they are working with to build trust.
- Translators should understand the culture and traditions of the person they are translating for.
- Where the option exists, an opportunity to talk to a female doctor should be offered.
- Medical professionals should ask more probing questions and always check on the woman's mental health.
- Improvements to the cultural compassion of health professionals need to be made through appropriate training.
- There needs to be clear information on access to maternity services for new families to Birmingham and for women with literacy and language barriers.
- Opportunities for parent education in appropriate languages should be provided.
- Help and support for new fathers should be provided and should include education on being both a new father and a supportive partner.
- There should be opportunities for social network building and encouragement for movement and participation in green spaces, both during pregnancy and for establishing familiarity for life with a new baby.
- Information on pregnancy and parenthood for parents and their extended family, including why recommendations are made, needs to come from a reliable source.
- More information is needed on sexual health, contraception and pregnancy at universities, ensuring it meets the needs of international students.
- There needs to be personalised, empathic care with enough time for a curious conversation.

Targeted communities ('the seldom heard')

Public Health commissioned four providers to recruit at least 10 people from each 'seldom heard' community identified below (focusing on women but not to the exclusion of men), capturing their views and experiences in response to a set of questions/themes provided by Public Health (Appendix A).

a. Refugee and asylum seekers;

b. People with sensory impairments;

c. People of working age with mental health conditions;

d. People of working age with long term health conditions e.g. diabetes, COPD;

e. First/Second Year University students;

f. Teenagers (14-18yrs);

g. Care Leavers;

h. Young women (18-25yrs);

i. Black and minority ethnic communities, specifically the following separate focus groups:

   – Polish and eastern European

   – Chinese/Vietnamese/Korean

   – Black African (including Somali, Eritrean, Ugandan)

   – South Asian (including Indian, Pakistani and Bangladeshi)

Methodology

Public Health identified targeted (seldom heard) groups and developed questions/themes to aid discussion. Questions were simplified to enable British Sign Language (BSL) interpreters to translate effectively. During sessions with Asylum Seekers and Refugees, the provider introduced additional questions to gain greater insight.

We commissioned relevant providers able to undertake appropriate qualitative research with our identified groups. Research recruitment methods included: online survey's, Twitter, LinkedIn, WhatsApp, local networks, voluntary organisations, newsletters. There were 112 participants: 105 females and seven males (see Appendix B for demographics). A number of engagement methods were used including virtual focus groups, face to face focus groups, WhatsApp, mobile phones, Zoom, Mentimeter, JotForm and individual interviews. Public Health collated and summarised key findings and themes from individual reports into this final report.

TOPICS DISCUSSED

The importance of relationships, sex and health education (RSHE) was discussed in several focus groups. Participants thought information about exploring the difficulties of getting pregnant, being pregnant including physical and emotional aspects, what a good pregnancy looks like and being a good parent should be included as part of RSHE in schools.

In addition to understanding more about pregnancy and parenthood, it was clear that participants felt education on understanding and improving self-worth and self-respect were key. Positive role models were identified as helpful. Relationships were discussed and there was support for ensuring an understanding of domestic abuse, the signs and where help can be sought.

When asked who they could speak to about relationships and sexual health the young people spoken to reported that they didn't feel like they could talk to parents/carers. They did say however, they would feel more comfortable sharing and discussing these topics amongst peers as conversations with friends were typically more open.

The young people highlighted that at University, whilst there was a lot of information about mental health, they thought more was needed around sexual health, contraception, pregnancy and appropriate support services. It was suggested that international students may benefit from this the most, helping to improve their knowledge of sexual health risks and services available in the UK.

AS A MALE, WHO LEFT SCHOOL AT YEAR 8, I DEFINITELY FEEL THERE SHOULD BE MORE INFORMATION AROUND PREGNANCY FROM A MALE PERSPECTIVE AND RESPONSIBILITIES NOT JUST IN SCHOOL BUT FROM OTHER SOURCES.

QUOTE FROM EXPECTANT FATHER

Whilst the young people spoken to were confident in identifying places, they could access sexual health information including Internet, children centres and local provider Umbrella, they suggested sexual health services could be made more accessible by delivering them in different settings, including education and the workplace. They also felt there should be a choice in the gender of the sexual health professional.

Across the young people's groups there was agreement that women do not know enough about anatomy. It was felt that there is stigma and judgement when talking about their reproductive organs and any issues or concerns they might be having. They were aware this might prevent some people, in certain cultures, discussing any issues or accessing services during their pregnancy if they had a problem.

The young people shared their thoughts on the impact of porn on relationships and sex and how they felt it distorted young people's views and makes it seem as if there are no consequences. They felt more education around this topic would be beneficial.

Some of the young people participating thought that the roles between same sex couples were more equal than roles held between heterosexual couples. They went on to discuss how they view society as 'still very traditional', with dad at work and mum at home.

ALL WOMEN CAN'T GET PREGNANT THE FIRST TIME THEY HAVE SEX.

QUOTE FROM 1ST YEAR STUDENT
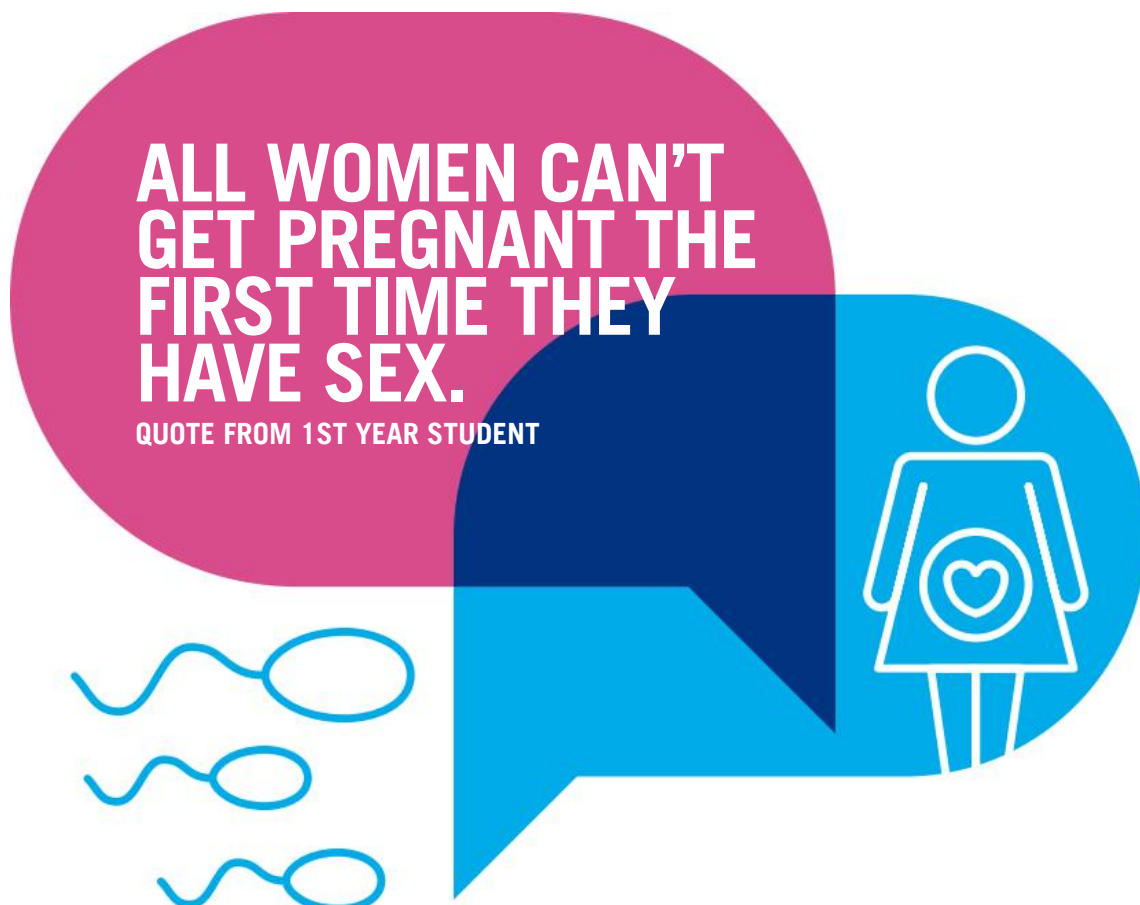
CONTRACEPTION

In all the groups spoken to, women were aware that contraception was widely available with the oral contraceptive pill identified as the most commonly used. Some groups discussed preferences for accessing contraception with pharmacies, GPs and sexual health clinics coming out on top.

Young people spoken to said they preferred to access contraception from sexual health clinics rather than GPs, due to waiting times, confidentiality and they felt staff were more approachable. In addition, they said they would not go to the GP if they thought they were pregnant because they have no relationship with them.

It was suggested that further training may be required to help healthcare professionals have conversations about contraception in a respectful/approachable manner. Women shared that they often felt judged for wanting more children. One woman shared, "My GP kept insisting on the Coil for family planning. My GP was intrusive, looking down on me, because I already had two kids with a two-year gap."

EVERY GP PRACTICE SHOULD HAVE SOMEONE AVAILABLE TO TALK TO AND HELP SUPPORT WITH EMERGENCY CONTRACEPTION/ MORNING AFTER PILL.
QUOTE FROM WOMAN FROM BLACK ASIAN AND MINORITY ETHNICITIES FOCUS GROUP

An expectant dad shared how he thought most contraception didn't work and he viewed contraception as a 'woman's job'. Other dads also felt that contraception was not always 100% reliable.

There was some discussion about a male contraceptive pill and the participants believed this method was already available and people didn't know about it.

For the single Black, Asian and minority ethnic women, they felt their limited knowledge around contraception choices was acceptable at this stage in their lives and fitted with their spiritual and faith beliefs. However, if they did need to know, they would consider researching their options/choices and/or approaching health professionals.

When discussing emergency contraception participants said, it was readily available through multiple routes however, not everyone could identify what those where. For the women who could identify access points some shared that they felt access to emergency contraception through pharmacies, lacked privacy and other women felt that a direct point of contact in their GP practice would be helpful to provide support and advice around emergency contraception.

Whilst a comment was made that, "even 11/12 year olds can now access contraception", a number of barriers to use were identified by the focus groups including embarrassment, fear of being judged by health professional and others, language, stigma, religious, spiritual and personal beliefs and lack of knowledge.

PREPARING FOR PREGNANCY

Discussions were focused around the health and wellbeing of the mother when exploring preparations for pregnancy. There were some thoughts shared about how eating a healthy diet, keeping active, not smoking and taking vitamins/supplements were all positive preparations.

The women from the asylum seekers and refugees group however were unaware of how weight can impact on becoming pregnant and agreed that more education was needed to bring this to people's attention. Consideration of pre-conception clinics delivered within communities to educate on "what to expect" was put forward.

Expectant fathers spoken to mentioned the internet as a key place for them to find information on contraception and pregnancy.

NEED TO BE RESPONSIBLE – NEED TO BE READY TO BE A MUM TO CARE FOR A NEW LIFE, TO HAVE GOOD HEALTH TO HAVE BABY AND CAN'T JUST SAY YOU DON'T WANT IT ANYMORE

QUOTE FROM A YOUNG WOMAN

STAYING WELL AND HEALTHY DURING PREGNANCY

Across the different focus groups, it was discussed how there can often be conflict between what families/communities/culture says should be done whilst preparing for and during pregnancy and what official NHS guidance says.

Nearly all deaf and hard of hearing participants looked to their family and friends, alongside health professionals for advice around planning for pregnancy and being pregnant. Participants said that whilst their families and friends shared their own experiences and advised them to eat healthily, avoid smoking, alcohol and drugs and take vitamins. they preferred to speak with deaf friends who could tell them more about what it is like for a deaf woman to be pregnant.

Across all of the focus groups with women from Black, Asian and minority ethnicities, there was a strong emphasis placed on the importance of their culture and the influence and impacts it has upon the women before, during and after their pregnancy. They discussed how their culture can cause constraints on mature pregnant women and confusion for the younger mothers.

Some of the Bangladeshi women spoken to, discussed their knowledge of what to eat during pregnancy but were unsure of what not to eat and had very little knowledge of any recommended vitamins to take during pregnancy.

The majority of women in the South Asian focus group however, had a good understanding of what a healthy pregnancy was, identifying daily exercise, healthy diet, taking vitamins (most specified folic acid) and not smoking although a few had smoked during their pregnancy. There was little understanding of why exercise was important. Participants identified some conflict with elders who thought exercise could harm the baby and they should conserve their energy and rest. In addition to the culture/NHS information conflict, it was identified that there was a lack of trust in health information. To address this, it was felt that information needs to be translated for all members of the family from elders to younger.

Based on their experience, some women thought a clear understanding of the possible consequences of not following NHS pregnancy guidelines would be helpful. One woman in her 20s of African Caribbean background commented how she followed all the guidelines in her first pregnancy and had a healthy pregnancy; however, she became more "relaxed and lazier" in her second, as a result became overweight and had a problematic pregnancy. Deaf and hard of hearing participants highlighted that they wished they'd understood more about why they should take the vitamins and iron supplements recommended and how/if they might interact with other prescribed medication. One participant shared that with her first pregnancy she did not take the supplements until she was feeling weak. It was only at this point did the midwife explain why she needed them. She proactively took supplements with her second child and felt much stronger.

Overall, it was identified that participant knowledge on staying well and healthy during pregnancy had limitations and was full of conflicting information, advice and myths, which was a concern. Pregnancy myths shared from across the groups showed how they can influence thoughts on staying well and healthy e.g. 'If you eat loads of pineapple, you will have a soft cervix', 'Baby weight depends on how big the mother is so if you are small, you will have a small baby.'

UNSURE ON WHAT TYPE OF EXERCISES TO DO OR NOT. WORRIED END UP IN HOSPITAL, PUT SELF AND BABY AT RISK.

QUOTE FROM WOMAN FROM BLACK, ASIAN AND MINORITY ETHNICITIES FOCUS GROUP

For the women aware of the importance of exercise during pregnancy they felt it was necessary for them to have access to green spaces which they knew would support their mental wellbeing as well as their physical wellbeing.

It was agreed that more information was required on what a healthy pregnancy actually means, both physically and mentally. Women identified additional information they would find of use:

• What to expect during pregnancy and birth.
• Foods they could and could not eat when pregnant.
• What appointments they needed.
• Having a healthy lifestyle.
• What causes diabetes in pregnancy and what to do to avoid it.
• Points of contact.
• Information on baby classes.
• And one person said genetic support.
• Financial stability.
• Positive environment.
• Regular check-ups.
• Detailed advice on diet and exercise.

When it came to preparation to be a parent, participants in the deaf and hard of hearing focus group thought it was very important to know if their baby would be born deaf. They did not mind if the baby would be deaf but they would want to be prepared and get the right support in place, if needed.

To help them manage as deaf mothers, participants highlighted they would have liked more information during the antenatal period, on what practical equipment and support is available to deaf mother's following baby's birth and where they could access these resources.

When discussing what options were used to know when baby cries, one deaf woman of East European background was told to "tie a bit of string to the baby so you'd get a tug on the string when they cried". She reported that she now knows she can connect a device to her watch that will vibrate when baby cries. Another woman reported that she gets her husband to wake her as they did not use the 'modern device.'

Participants felt they would have benefitted from discussions about BSL signing with their baby.

MENTAL HEALTH AND WELLBEING

The South Asian women suggested that more education was needed for male partners to help them understand the pregnancy journey and postnatal period for women alongside the difficulties they faced. They wanted men to understand the pressure and stress they experienced during this time coupled by expectations that they cannot continue to complete daily household/childcare chores without support. Despite requests for help, some of the women spoken to felt they were not seen as important and were not listened to. They felt there was an imbalance in the roles and responsibilities within the household.

These women expressed how they would like their partners to understand that they would value some support, both practical and emotional, especially following a miscarriage or loss of a child. Women went on to share how expectations and pressures from their partners to continue life as 'normal' was causing poor mental health during their pregnancy. The ongoing pressures for some women to produce a male child was also acknowledged.

The women spoke about how they felt they had needed more emotional support during their pregnancy, knowing that their wellbeing and happiness would lead to healthier and happier relationships for all and especially for the growth of their baby in the womb.

CHILDCARE IS SO EXPENSIVE SO WOMEN LOOK AFTER CHILDREN RATHER THAN MEN, AS THEY GO TO WORK CAN CAUSE ANXIETY AND TENSION.

QUOTE FROM 1ST YEAR STUDENT

The South Asian group also discussed the stigma that exists within some communities around family history, cousin/blood relations and miscarriages. They shared that this feeds a reluctance to speak about these subjects openly.

The asylum seeking and refugee women also identified how poor mental health during their pregnancy has an impact on them and their friends/relatives. One participant shared how a pregnant relative with other children, was made homeless whilst pregnant and found it put additional stress on their mental and physical health.

Participants talked about feeling isolated whilst pregnant with the expectation they should just get on with things. In most situations, the women knew no different, so did as they were told, not reaching out for help or support.

All of the groups spoken to touched upon infant mortality in their discussions. It was felt there should be more counselling support services to address the diversity of mothers/partners guilt, grief, and loss from infant death.

In the focus group for Black, Asian and minority ethnic women, there were discussions around feelings of distress and low moods after experiencing loss through stillbirths and miscarriages. They felt this was not getting picked up by their doctors or their communities. One woman said, "The faith is strong to accept, but the suffering of women is still evident but ignored." Across all the focus groups it was discussed how medical professionals should ask more probing questions and always check on the woman's mental health.

A participant from the same focus group shared that when a woman loses a baby through miscarriage, the men didn't understand or support them emotionally, there is a 'blame' culture and guilt would often be placed on the woman. When these negative experiences mounted up, the women tended to withdraw and living in fear was considered the norm. They felt that the support from the family and the community is not there and so if they are suffering, they keep it to themselves and try and manage as best they can. The women did not feel in control of their destinies and that their culture and the belief systems within their society and religions, drove the 'blueprint' that they were destined to follow.

Deaf and hard of hearing women also talked about feelings of isolation through not being able to communicate with others. One participant described how alone she felt "I don't know anyone, no-one can do BSL sign with me". Deaf people in hearing families can be very isolated, especially if their families do not learn how to sign, and their access to general family advice and conversation can be limited.

WOMEN WHO ARE DEPRESSED HAVE TO HIDE IT, AS WORRIED KIDS WILL BE TAKEN OFF THEM.

QUOTE FROM PREGNANT WOMAN

Mental Health was a strong concern in the young people groups. One expectant mother shared, "I was told by GPs I have to come off my mental health medication but I have since found that I could take alternative medications. I was not offered alternative therapy/support". When asked what concerns they might have when/if raising a baby, mental health was in the foreground for one young woman:

"…there is a big stigma, which has only recently begun to be talked about, about once you give birth that you're supposed to be 'the happiest woman alive' – in reality, this may not be the case. Having a child can be exhausting, and there are diverse issues that women can experience afterwards.

Finally, I think the loneliness element scares me to be honest. I am excited to be a parent one day, (I think anyway!) but spending so much time alone in the daytime on maternity leave with the baby, could be quite a lonely experience. I think it's important for support to be put in place for mothers, no matter their family circumstance, to ensure they still feel 'emerged in society'."

The care leavers who participated felt that their experiences of being in care had impacted on their views on pregnancy, as they don't want their children to grow up without parents.

SOMETIMES… IF THERE IS NO ACCESS TO AN INTERPRETER… MY LEVEL OF CONFIDENCE DIPS.

QUOTE FROM DEAF AND HARD OF HEARING FOCUS GROUP

HAVING A VOICE

Across the South Asian and Refugee and Asylum Seeker groups, women commented about the need for an advocacy/maternity forum in order for their voices to be heard, especially where there is fear of a 'backlash' for speaking up. It was clear from some of the comments, that the women spoken to were unaware of the Maternity Voices Partnership and the support they could offer.

It was discussed how women's voices need to be heard and opportunities created so they have the confidence to speak up about their needs. Some of the women spoken to on this topic wanted to cry. They did not understand their basic rights and how to exercise them. They felt that the doctors they interacted with did not have the time to listen and were concerned they would not understand their experiences. In some instances, the women felt their pregnancy journey had been traumatic and that their need for help and support for this was neglected.
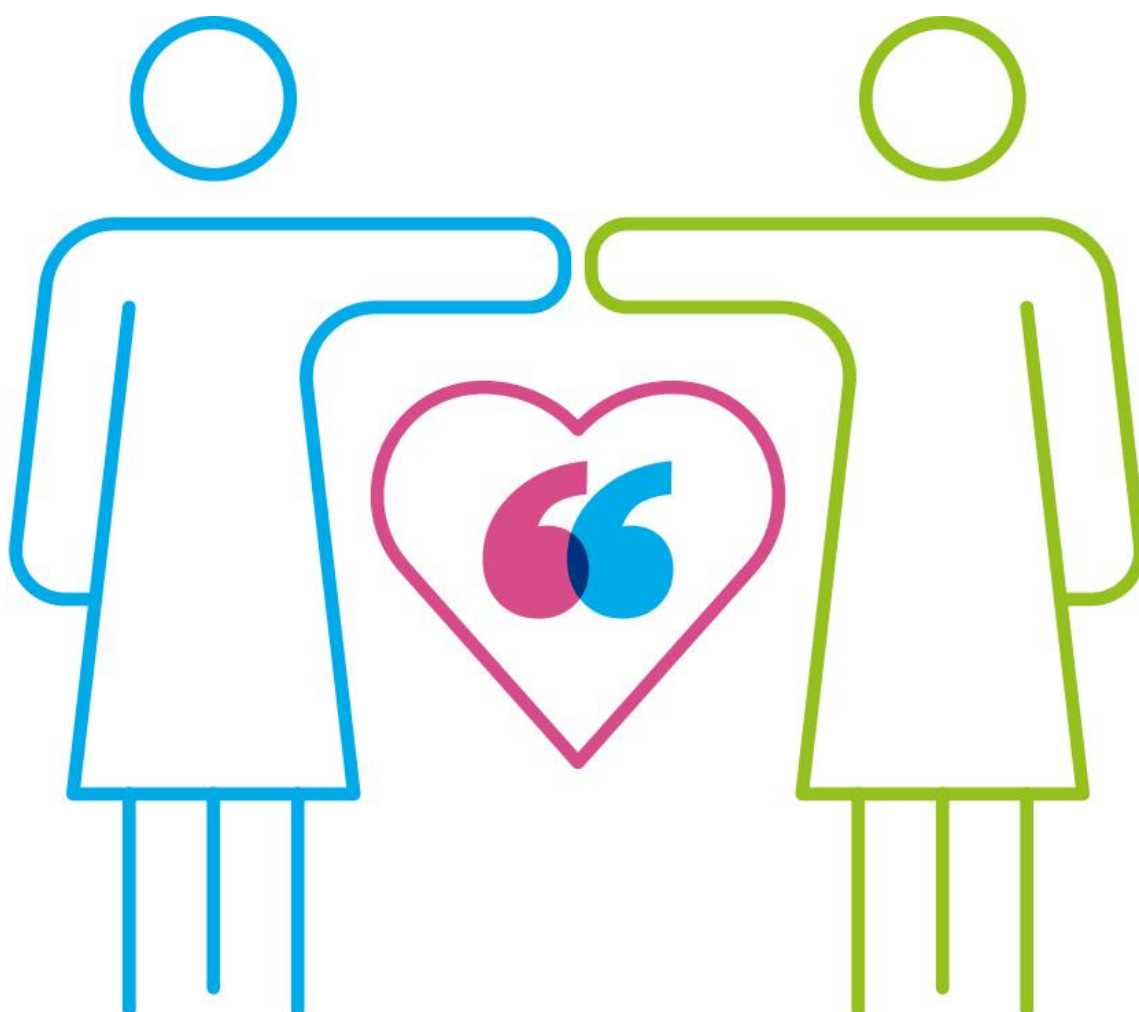
Women shared that they thought a peer-to-peer intervention would be useful so those who had gone through similar experiences could walk and talk others through the process, creating a 'buddy system'. They felt this approach would enable them to get advice and guidance from people who would believe them, were impartial and who understood the health system, including the language used. It was suggested by these groups that in having their voices heard, their culture would be understood and services would be appropriate to meet their needs. The participants were clear that they needed to share their experiences so that the 'younger ones' didn't have similar negative experiences.

WHO WILL HELP ME? ARE THERE DEAF MIDWIVES?

QUOTE FROM DEAF AND HARD OF HEARING FOCUS GROUP
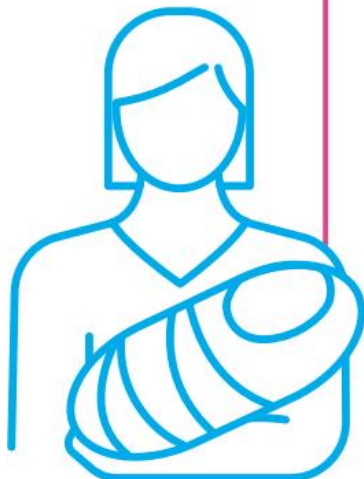
WITH REGARDS TO BREAST FEEDING, I COULD REALLY HAVE USED AN INTERPRETER. IT WAS AWFUL REALLY AND IT WOULD HAVE BEEN GREAT TO HAVE SOME HELP WITH THAT. IT'S HARDER WHEN YOU'RE USING GESTURES AND WRITING, AND MY WRITTEN ENGLISH ISN'T GREAT ...IT WOULD HAVE BEEN SO MUCH EASIER IF I COULD HAVE JUST TALKED TO SOMEONE ABOUT THE DIFFICULTIES I WAS HAVING.

QUOTE FROM DEAF AND HARD OF HEARING FOCUS GROUP

> **I DON'T MIND, HOWEVER I WOULD LIKE FURTHER ADVICE (OR) ASSISTANCE HOW TO HELP COMMUNICATE WITH MY CHILD. I WANT MY CHILD TO HAVE A BETTER LIFESTYLE THAN ME.**
>
> **QUOTE FROM DEAF AND HARD OF HEARING FOCUS GROUP**

> **FOR MY FIRST BABY, WHICH I HAD IN LONDON, I GOT INTERPRETERS TO SUPPORT ME AND I WAS ABLE TO UNDERSTAND EVERYTHING AND TO CHECK EVERYTHING AND I WAS VERY HAPPY... WITH MY SECOND BABY NOW I'VE MOVED TO BIRMINGHAM, I'VE NO ACCESS TO INTERPRETERS AND THAT ISN'T MAKING ME HAPPY.**
>
> **QUOTE FROM DEAF AND HARD OF HEARING FOCUS GROUP**

AWARENESS OF SERVICES

It was felt that access to support and information was an equality issue across several groups, they talked about their rights and access to information. South Asian women identified that whilst they do not generally talk about pregnancy, young women from their communities, tend to have better knowledge and understanding of where to get information and advice linked to pregnancy and support services.
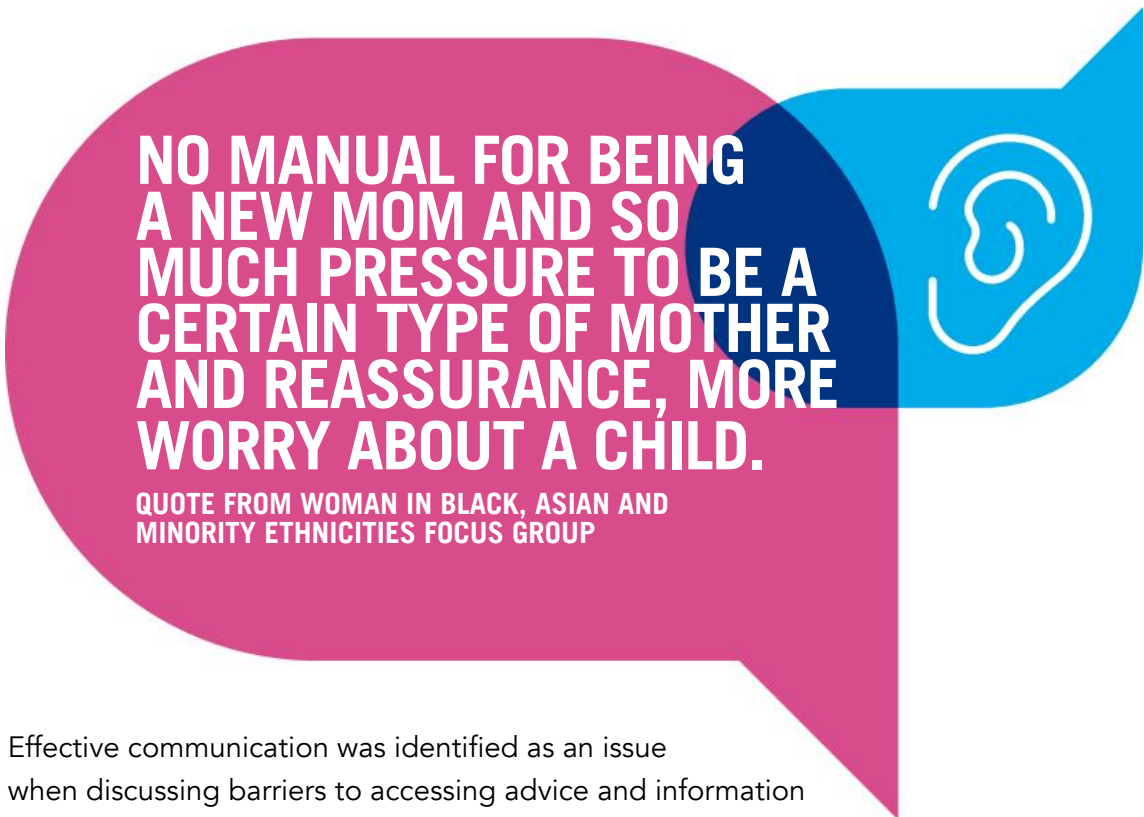
It was highlighted that education was needed and awareness raised of all the pre and post pregnancy support services being offered. Some women were unclear if any information around pregnancy was available as they did not have access to the internet, with some only recently coming from Pakistan and Bangladesh before becoming pregnant. Others said they thought access to information was limited and wanted more information in their own language so they can have better understanding.

Participants from the asylum seekers and refugees group shared how they did not know how to access services, so they don't and worried this could have a negative impact on their health and wellbeing. It was identified that Covid had further contributed to the negative impact on their access to the right information and health services at the right time for their pregnancy. Identifying that their treatment was not on par with pregnant women from other cultures or who are more proficient with English, had led to them feeling isolated, ignored and undermined.

Participants also wanted more information to help them understand where to access maternity services. It was agreed that more consideration needed to be given to how new families into the city and women with literacy and language barriers could access this information and the services available.

People were able to recall some negative experiences where the support information and resources offered were out of date.

COMMUNICATION

NO MANUAL FOR BEING A NEW MOM AND SO MUCH PRESSURE TO BE A CERTAIN TYPE OF MOTHER AND REASSURANCE, MORE WORRY ABOUT A CHILD.

QUOTE FROM WOMAN IN BLACK, ASIAN AND MINORITY ETHNICITIES FOCUS GROUP

Effective communication was identified as an issue when discussing barriers to accessing advice and information about pregnancy. Access to an interpreter was identified as the crucial factor for a number of women.

The deaf and hard of hearing women spoken to highlighted how Birmingham is a multicultural city where there are lots of people with differing international sign languages rather than BSL, not to mention, regional differences and shorthand signing. It was suggested the use of deaf relay interpreters would help. They are experienced deaf people, who work alongside BSL interpreters to assist understanding.

The deaf and hard of hearing women, identified that it was important to know interpreters would be available prior to maternity appointments and that additional time would be allocated to allow for a three-way conversation. Whilst interpreter support was often available for planned appointments this was not necessarily so for emergency appointments. When a woman is in labour, the women felt that the woman and midwife need to be able to communicate effectively in terms of mother and baby's safety. One woman described her experience of having an emergency Caesarean section. She woke up with abdominal pain, wondering where her baby was. She felt very scared and isolated as she did not have access to interpreting support at that time.

The deaf and hard of hearing group went on to discuss how communicating using pen and paper is not a solution when interpreters are not available. They identified that many deaf people have poor literacy skills and often English is not their first language. This causes additional difficulties when trying to understand medical terminology. Confidence grew for the women we spoke to but only with additional pregnancies, knowing what to expect and when to request an interpreter.

For the women where understanding English was a barrier, they felt their voices were not being heard or worse, ignored. During medical appointments the health professional would often speak directly to the interpreter, who may be their partner or mother-in-law. They stated that the 'doctors made them feel invisible' and they felt that 'things were being done to them', but not with their consent or with understanding of their needs. As a result, women said their feelings and emotions of what they were going through were never shared. They want to be communicated with directly.

There is a need for translators in all languages to develop a rapport with the pregnant woman building trust to make them feel comfortable. Women would prefer someone who understands their culture and traditions if possible.

What was clearly expressed by the deaf/hard of hearing women, was the impact on their confidence, independence and mental health when they do not have access to an interpreter during, what they felt was, one of the most emotional and potentially uncertain times in a woman's life. It can be frightening and isolating for women in situations where they do not understand what is happening, in the way it would be for people who communicate with a different spoken language.

I DON'T WANT TO RELY ON MY FAMILY, I WANT INTERPRETER TO DISCUSS THIS. I DON'T WANT TO SHARE (UNKNOWN) THING WITH FAMILY AS INFORMATION ALWAYS GET LOST IN TRANSLATION.

QUOTE FROM DEAF AND HARD OF HEARING FOCUS GROUP

Digital exclusion was highlighted as an issue for some of the ethnically diverse women who were spoken to. They felt that delivering services, support and information using technology can create an additional barrier for them as they either don't have access to the internet and/or don't have the right equipment e.g. smart phones, computers, laptops, tablets etc. This left them not knowing how to access the resources they needed and with language barriers as well, they identified isolation and feeling that they were being deprived of services which could help them to have better pregnancies and care.

There was an understanding amongst some of the women that if you are pregnant, information automatically comes to your home address telling you what you do or don't need to do.

FEELING 'INVISIBLE' WHEN ATTENDING A DOCTOR'S CONSULTATION.

QUOTE FROM WOMAN IN ASYLUM SEEKER & REFUGEE FOCUS GROUP

FEEDBACK TO PROFESSIONALS

There was discussion across all the focus groups on being repeatedly asked for the same basic information. The women spoken to said they would like to provide information once and this be shared across the relevant service areas.

Sensitivity, confidentiality, trust, the need to be understood and not feeling rushed was key for the women from the ethnically diverse groups spoken to. They felt this considerate approach would then enable them to discuss their concerns and needs, especially how they feel mentally and emotionally. In addition, they highlighted that they felt religion and culture could be given more consideration by health professionals when developing their pregnancy plans.

> I HAVE A NEGATIVE BLOOD AND I WAS ASKED TO TAKE A VACCINE IN CASE THE BABY'S BLOOD WAS POSITIVE AS I COULD BE MADE INFERTILE, HOWEVER IF MY HUSBAND HAS POSITIVE BLOOD, I DO NOT NEED TO TAKE A VACCINE. I WOULD HAVE FELT BETTER IF THEY HAD ALLOWED MY HUSBAND TO HAVE A BLOOD TEST. IN THE END HE GAVE BLOOD TO KNOW HIS BLOOD GROUP AND I HAD A VACCINE.
>
> **QUOTE FROM WOMAN IN BLACK, ASIAN AND MINORITY ETHNICITIES FOCUS GROUP**

EVERY WOMAN TO BE TREATED SPECIAL NOT LIKE A MACHINE. CULTURALLY MORE SUPPORT AND FAMILY – A VILLAGE NO MATTER BACKGROUND.

QUOTE FROM WOMAN IN BLACK, ASIAN AND MINORITY ETHNICITIES FOCUS GROUP

The South Asian women went on to share they felt their pregnancy care plans were inconsistent and inadequate because they did not fully take into consideration their particular needs. This was put down to poor communication by the health professionals they had contact with. This lack of consistency caused them a lot of anxiety. It was agreed that continuity of carer could have improved their pregnancy and birth experience. One woman said "I did not know I had a plan and rights and choices. I had no guidance and was not involved in my birth plan. I had no idea on pain relief."

Participants of the focus groups wanted to ensure that clinicians understand every pregnancy is different, even for women having more than one pregnancy. Taking a 'one size fits all' approach, they felt could lead to inappropriate services and lack of care and attention to detail.

Young people discussed how they felt adults would often talk down them, telling them what to do, when discussing pregnancy options. They also felt there was a lack of appropriate support for them during their pregnancy and after baby was born. They said they were often told how not to do things but never told how best to do things. They talked about experiencing pressure from health professionals to have certain procedures, an example was given where a woman, was told by the midwife during her pregnancy, to have stronger drugs when she wanted just gas and air.

The care leavers, who were also parents, from their experience felt that Children's Social Care staff were very judgemental. They felt they did not provide the support needed, particularly where a parent maybe struggling and needed some emotional support or help with parenting skills.

In the young people's group, it was felt that there is still stigma around single parents which was preventing some women from accessing services. It was suggested that healthcare workers needed to be more alert to the situation and signs of domestic abuse.

> I KNOW THIS MASK THING IS ONLY TEMPORARY, BUT I WISH THE NURSE AND DOCTOR WOULD UNDERSTAND THE DIFFICULTY DEAF AND HARD OF HEARING FACE TO UNDERSTAND (WHEN THEY ARE WEARING MASKS).
>
> THEY ARE IN PROFESSIONAL LINE AND THEIR ROLE IS TO UNDERSTAND DIFFERENT DISABILITY. WITH DEAF AND HARD OF HEARING SITUATION THEY TURN BLIND (EYE), OFFER NO SOLUTIONS OR FIND A WAY. THE FRUSTRATION IS REAL. THERE SHOULD BE AWARENESS.
>
> **QUOTE FROM DEAF AND HARD OF HEARING FOCUS GROUP**

CULTURAL COMPASSION

It was strongly felt, by the women from the Black, Asian and minority ethnicities focus group, that Doctors/health professionals must have a better understanding of the woman's culture and beliefs. This would in turn improve the impact on her access and understanding of medical information/advice/guidance, especially around culturally acceptable options for contraception and family planning.

There were many cases of stillborn and miscarriages reported within the same focus group. They felt little exploration was carried out as to why these things were happening. The Muslim women said that in their culture it was accepted that it is the 'Will of Allah' and the real causes of the situation were not discussed. The lack of conversation around this matter was just accepted, rather than exploring what should be done differently next time for better health and a healthy pregnancy. There was also a degree of resistance in talking about the pregnancy, especially around the possibility of infant mortality. It was felt that you were 'tempting fate' if you talk about negative outcomes.

These women also expressed that they would like more help from health professionals

to tackle some of the old cultural practices that are having a negative impact on them during and following their pregnancies. It was felt however, that professionals didn't try to understand the cultural differences to be able to help/support the women.

The Somalian women's group pointed out the misconception that they are very tough and can take anything. They explained that they too are suffering from poor mental and physical health and it was felt that very little care is offered to them in the community. When it came to the delivery and pain management whilst giving birth, they experienced the same misconception with Doctors thinking they are strong and can take the pain.

This group also spoke about how Somalian women are circumcised. They shared how they were too shy to talk about what they have been through and how this continued to impact on them. The lack of communication and language barriers meant they were unable to communicate with doctors about their specific needs.

> ## STOP ACCEPTING THAT 'THIS IS HOW IT IS IN THEIR CULTURE' AND HELP WOMEN SUPPORT THE CHANGE NEEDED TO MAKE A BETTER LIFE FOR WOMEN.
> **QUOTE FROM WOMAN IN ASYLUM SEEKER & REFUGEE FOCUS GROUP**

The South Asian women talked about how there were often 'rifts' within their families where it is felt that the young mothers are not listening to the wise elders of the family. The women spoken to were keen to advise that, health professionals need to be mindful that it is accepted whatever the elder says will go and if it does not then there is disharmony between the family. There are many 'unwritten rules in the Indian culture' which can have a negative impact on the women in society, and especially when pregnant. There are high expectations placed upon the women, so even though they may be ill there is an expectation that they will still visit or socialise when they really do not want to or cannot.

They also discussed how genetic predispositions are considered and dealt with pre-marriage to ensure that there is no relationship connections of cousins or distance cousins as in this community, they are seen to be your brothers and sisters, and therefore marriage cannot take place. If there are similar names, the background of the mother's family is investigated to check and confirm that there are no

> **I SEE A LOT OF WOMEN EXPERIENCING MISCARRIAGES BECAUSE OF STRESS AND DEPRESSION IN OUR ASIAN COMMUNITY.**
>
> **QUOTE FROM WOMAN IN BLACK, ASIAN AND MINORITY ETHNICITIES FOCUS GROUP**

cross-linkage or overlap, if this is the case then serious consideration is given as to whether a marriage can take place or not.

Some of the young people talked about how their older relatives have more views on pregnancy and how they too also held similar views, such as pregnancy should only take place when two people are married. They talked about how they felt there is still stigma surrounding young people getting pregnant but agreed that having children young is difficult and some people are not emotionally mature enough to handle the responsibility.

The young women shared that they felt judged by some health professionals for accessing contraception or being pregnant and not being married.
Some comments on how pregnancy is viewed in the cultures of the participants was shared during the focus groups:

- **Asian Culture** – Pregnancy should be in marriage and should have structure, needs to be planned and conversations had around wanting kids.
- **Arabic Culture** – If a pregnancy goes wrong, the man does not have anything to do with it. The woman will speak to another woman, mother, or friend.
- **Nigerian Culture** – It is a community thing, raising a baby, whereas in the UK, there is less family/ community so it can be a lonelier experience. There is a need for more mother and toddler groups so Nigerian women do not feel as isolated.
- **Buddhism Religion** – Parents must be married first, it is a disgrace if not married first, dishonour to religion and family, stigma from communities. Religion does not support abortion.
- **Chinese Culture** – Young people will be forced to get married first and raise the child together. Participants felt that this can affect the mental health of baby.
- **Malaysian Culture** – Does not support use of the contraceptive pill as it can have side effects on the body but does support the use of condoms.

ONE KEY QUESTION

WOULD YOU BE HAPPY TO BECOME PREGNANT WITHIN THE NEXT YEAR?

In the main, women were comfortable being asked the 'one key question' by health professionals. A smaller number of women spoken to said they would be happy to be asked by other support workers e.g. housing officers, benefits office, social worker or support worker. One person said the question was irrelevant as she believes the decision to become pregnant is left to Allah. It was highlighted that asking the question would need to depend on the situation. Sensitivity is key taking into consideration those women who may have difficulty conceiving or those that may have lost a child.

Whilst most were comfortable with being asked the question, there were some concerns about how it would be phrased. Participants were able to suggest alternatives, including broadening it out so it was more inclusive and relative to men as well. Suggestions included:

- "Do you have any ideas / plans of when you might want to get pregnant"?
- "When are you planning on getting pregnant?"
- "How would you feel if you got pregnant in the next year?"
- "How would you feel if you had a child in the next year?"

HEALTH LITERACY

I GET MY INFORMATION FROM GOOGLE.
QUOTE FROM EXPECTANT FATHER

It was agreed that information needs to come from a reliable source, with clear explanations as to why recommendations are being made and why they are important for mother and baby. It was suggested throughout the focus groups however, that health professionals pay consideration to the terminology they use. For those with English as a second language or where there are communication barriers, it can be difficult to translate some medical terms and this can have a negative impact on the woman's understanding of what was happening with their pregnancy and any action that may need to be taken.

Some of the deaf and hard of hearing women spoken to, identified that written information or leaflets provided on all topics discussed in appointments would be useful to take away. However, they also identified how literacy is an issue for them, and how receiving letters can be difficult as they needed support to understand them, especially medical letters.

A variety of information in accessible formats was suggested including where to go for pregnancy activities, deaf clubs, accessible pregnancy information sessions and mum and baby activities post-pregnancy. It was highlighted that the use of video can be key when communicating with the deaf community: "Videos is where I'm getting most of my information… I have to ask family members to relay what is said on a letter, it is very difficult English not being my first language, I find that a real barrier and if I am showing it to my father, he is not proficient in sign language so it is not even clear when relayed from a family member."

It was suggested that it would be useful if healthcare professionals could provide workshops/spaces where women could talk through information contained in booklets etc offering face to face information as well. This approach could also help with the issue raised by the refugee and asylum-seeking women who shared that the majority of them had not been to school, so did not understand the importance of the pregnancy information shared with them.

SPECIFIC FEEDBACK FROM FOCUS GROUPS

The feedback below, pulled and collated from the individual reports, was used to shape the key recommendations at the front of the report (p5).

Identified across all groups:
- Ensure appropriate information on vitamins and supplements is offered early on in the pregnancy journey.
- Ensure awareness and education on which vitamins can be obtained from food sources.
- Ensure basic English is used for communicating and avoid using 'medical terminologies or jargon' where possible.
- Consideration of health literacy is essential when sharing information.
- Ensure antenatal classes are inviting/accessible to men.
- MVP to engage with seldom heard groups, like those taking part in the focus groups.
- Ensure the use of 'advocates' for women to air their views, concerns and issues.
- Specialist groups to offer 'peer to peer' community mentoring or 'buddy' system for soon to be mums.
- Develop information specifically for dads on pregnancy and how best to support pregnant partners through their pregnancy journey.
- Women are given a 'voice', options, and choices, regarding the service offered to them.
- Help parents to understand the impact of unhealthy relationships on mother and baby.
- Deliver 'Active and Empathic Listening' training for all clinical staff.
- Special support programmes for mothers who have lost their babies to create resilience and where appropriate, prevention strategies for the future.
- Clear explanation of processes during birth to expectant mothers and fathers. This will help to relieve stress anxiety.
- An identified contact in GP practices to provide support and advice for emergency contraception.
- Training for healthcare professionals including GPs, on how to have conversations about contraception in a respectful, culturally appropriate and approachable manner.
- Communicate changes to pregnancy plans clearly and with reasons.

- Provide new mothers with more information, especially on community support services and wellbeing.
- Raise awareness of the role and function of health visitors.
- Improve communication amongst health care professionals during transitions from one team to another/one area of the system to another.
- Ensure midwife continuity.
- Promote and ensure access to green space for women who are expecting, to support mother's mental wellbeing and physical exercise.
- Ensure more support for those who experience multiple pregnancies.
- Make it easier to book. Not just online, more localised options needed.
- Offer counselling and support services for mothers/partners to address guilt, grief, and loss from infant death.
- Offer more support for young women/mothers.
- Ensure support groups for fathers.

Identified across Black, Asian and other minority ethnicities focus groups including refugees and asylum-seeking women:

- Ensure interpreters are briefed so appropriate translation can take place.
- Structure awareness raising sessions focusing on sensitivity and cultural influences that cover the whole journey of pregnancy for men, women, and families.
- Targeted advice and guidance delivered within the community settings.
- Consider developing interpreters with specialism in health.
- Non-digital communication strategies be deployed to engage with women within their communities.
- Ensure women know where to access digital devices and have access to the help and support to use them.
- Effective Antenatal/parenting programmes be delivered within the community.
- Clinicians to review their communication styles.
- Create short videos around the contraception offer.
- Develop a sexual health out-reach service ensuring more awareness/promotion of emergency contraception.
- Where possible, choice is given re gender of doctor.
- Holistic programmes for pre-pregnancy health are promoted in all communities
- Health professionals make effective use of community links to capture the real 'voices and concerns'.
- Health materials/information are translated into various languages either into pictorial or basic video clips.
- Increase awareness about domestic abuse during pregnancy.
- More religious and cultural awareness to be considered.
- Consider a single point of access (SPA) for pregnancy related information, advice, and guidance. Not just digital offer.

- Greater level of awareness from clinicians of the culture and tradition of Refugees and Asylum seekers so they are not to be seen through a tarnished lens.
- Ensure health professionals are aware of referral routes into help and support for women who have experienced FGM.
- Improve accessibility of GUM clinics for Muslim women to access.

Identified by deaf and hard of hearing women:
- BSL interpreters should be available at all stages of pregnancy/parenting journey from pre-conception through to breastfeeding support and beyond.
- Deaf women should be clearly informed of all their options at each stage including how to access complaints processes. Understanding should be confirmed.
- Information should be available in accessible forms, such as short, signed videos.
- Upskill staff in primary care, midwifery and health visiting teams to include at least one person who can communicate with Level 2 BSL signing ability rather than relaying though a relative.
- Recognise the need for deaf relay interpreters, as well as BSL interpreters, in Birmingham as a multicultural city and put funding and systems in place to make them accessible.
- Staff should offer deaf and hard of hearing patients longer appointment times, rather than rushing the conversation through an interpreter.
- Co-design information on contraception, pre-conception health and pregnancy planning in accessible forms for deaf and hard of hearing women, such as short, signed videos in BSL.
- Translation into sign language is not as straightforward as direct translation into other spoken languages. Therefore, it is so important to brief interpreters in advance.

Identified across young people's focus groups:
- Increase in information and awareness of sexual health, in particular contraception, pregnancy, birth process, parenting skills and emotional aspects of pregnancy and being a parent. Ensure this includes a SEND offer.
- More information around sexual health for international students
- Develop Sexual Health champions, using peer on peer education approach.
- Develop parent advocates, to talk about their experiences and raise awareness.
- Increase signposting to services.
- Increase local sexual health promotions related to target audiences.
- Increase information for 'friends' so that they understand where a young parent might be struggling and what they could do to support.
- Increase access and awareness of local parenting groups
- Reduce stigma around asking for support from services, addressing fear of being labelled 'a bad parent' or concern of social care involvement.
- Ensure pregnancy information packs are relevant, in date and complete.

ACKNOWLEDGEMENTS

Acacia
ACCESS Information and Guidance team
Ashley Community Housing
Aston University Student Officers
BID Services
Birmingham Children Centres
Birmingham Children's Trust – Care Leavers and Young Parent Forums
Birmingham First Steps
Birmingham Forward Steps
Birmingham Youth Council
BSL interpreters
BVSC
Deaf Cultural Centre
Enigma Consulting
Gateway Family Services
Golden Ethics Company Limited
Malaysian University Society
Merida Associates
Mosely Exchange
Orbita CX Limited trading as Insight Now
Paddy Stanley Associates
Parent Forums/networks
Sexual Health Youth Council
Unity Streets

APPENDICES

Appendix A: Focus group questions/themes.
Appendix B: Participant demographics.

Appendix A: Focus group questions/themes

Research questions for discussion:

1. Birth Control Beliefs & Choices
a. Emergency contraception/'morning after pill'.
b. Access to emergency contraception.

2. Attitude to the 'One Key Question' – Would you be happy to become pregnant within the next year?
a. The possible responses (yes, no and maybe).

3. Pregnancy Beliefs & Choices
a. Beliefs about what facilitates a healthy pregnancy.

4. Access to pregnancy related advice
a. Exploration of where they access pregnancy related information.
b. Exploration of who provides information and how reliable it is.
c. What influences the way pregnancy related information is provided?
d. How secure do participants feel about their access to advice? This might reflect challenges with cost of accessing services, accessibility or lack of facilities where they can find acceptable trustworthy information.

5. Understanding and Practice about Pre-pregnancy behaviours and choices
a. Folate and prenatal vitamins.
b. Health conditions – like asthma, diabetes.
c. Medications.
d. Vaccinations.
e. Smoking.
f. Alcohol.
g. Healthy weight.
h. Physical activity.
i. Genetic pre-dispositions (consanguinity).

Appendix B: Participant Demographics

The research focussed on participants from Seldom Heard groups across Birmingham. We aimed for a diverse sample to gain a broader range of experiences, including people of different age groups, ethnic backgrounds etc. Demographic breakdown from 112 participants below:

Gender
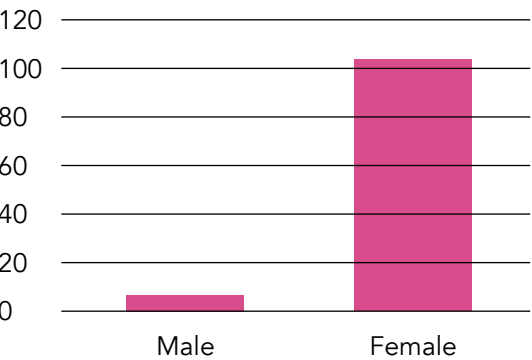
Age
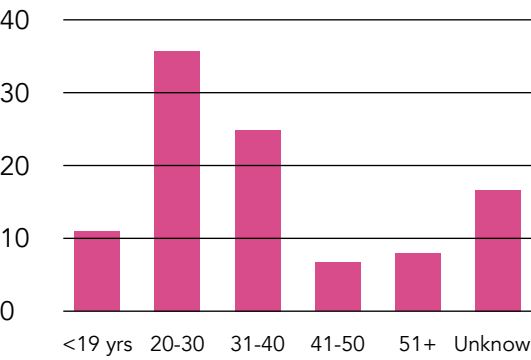
Ethnic Groups
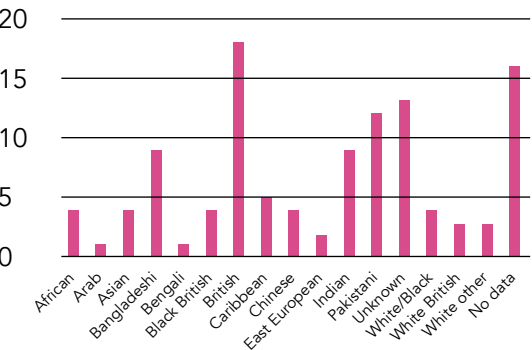
Religion
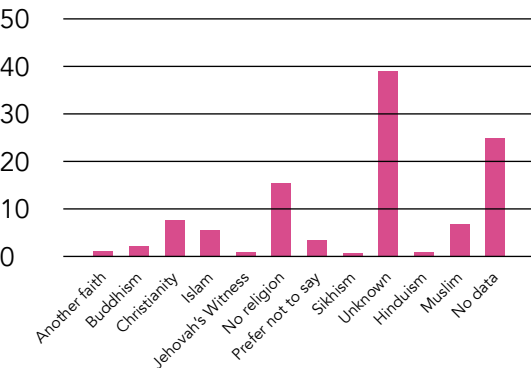
Disability
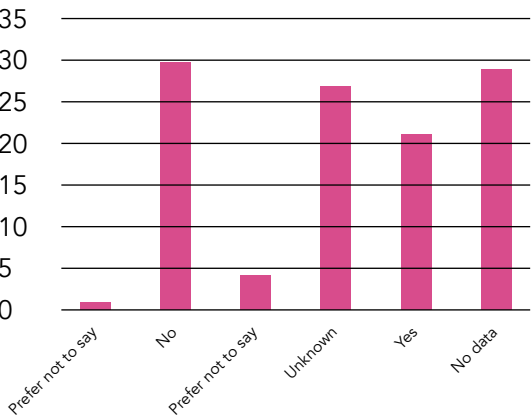
Sexuality
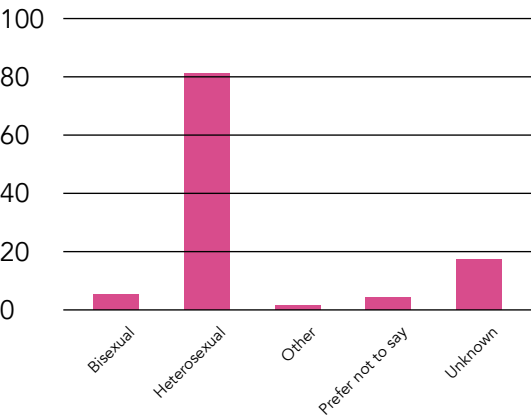
Infant Mortality and Early Years in Birmingham

Dr Marion Gibbon – Assistant Director of Public Health

Contents

1. Background
2. Modifiable factors
3. Child poverty
4. Teenage pregnancy
5. Access to antenatal care
6. Smoking in pregnancy
7. Maternal and infant nutrition
8. Sudden unexpected death in infancy
9. Vaccinations
10. Acknowledgements

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PAGE 2

Birmingham City Council

Background

Aims:

- Provide a descriptive analysis of infant mortality and early years in Birmingham
- Highlight the importance of investment in IM and Early Years
- Highlight the known risk factors for infant mortality
- Describe what can facilitate improvements in service planning and delivery

Background (2)

Infant Mortality is the term used to describe the number of babies who are born alive but die before their 1st Birthday.

The Infant Mortality Rate (IMR) is defined as the number of deaths under the age of one year, per 1,000 live births. It consists of two components:

- the neonatal mortality rate: The number of neonatal deaths (those occurring during the first 28 days of life)
- the post-neonatal mortality rate: The number of infants who die between 28 days and less than one year

Mortality during the neonatal period is a good indicator of maternal and newborn health and care.

In 2020 in Birmingham **90** babies did not live to see their first birthday

This means that at least **1.5** babies die each week before their first birthday.

This is over **2X** the number of children killed on our roads each year.

**On average
1 in 165
babies die in B'ham each year**

In Birmingham there are 3 main causes of death:

Being Born Too Early - Immaturity-related conditions

38%

Babies born with disabilities - Congenital anomalies

18%

All other causes – this does not include SUID or infections

16%

Mortality is linked to deprivation and is greater in more deprived areas

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PAGE4

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Infant mortality in Birmingham (2018-20) is higher than England and the other Core Cities

Core City Infant Mortality 2018-20
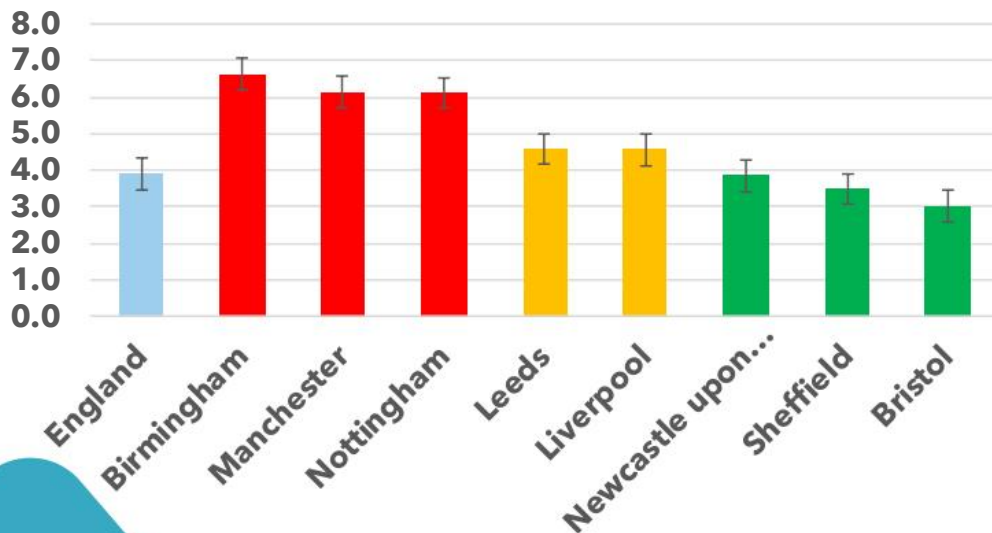
IMRs have reduced from 2001-03 to 2018-20

England
5.3 (2001 - 03)
⬇
3.8 (2018 - 20)

Birmingham
9.3 (2001 - 03)
⬇
6.6 (2018-20)

The infant mortality rate (IMR) in Birmingham in 2020, 6.6 per 1,000 live births, is **nearly double** that of England

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Infant mortality in Birmingham (2001 – 2020 3 year rolling average) compared to West Midlands and England

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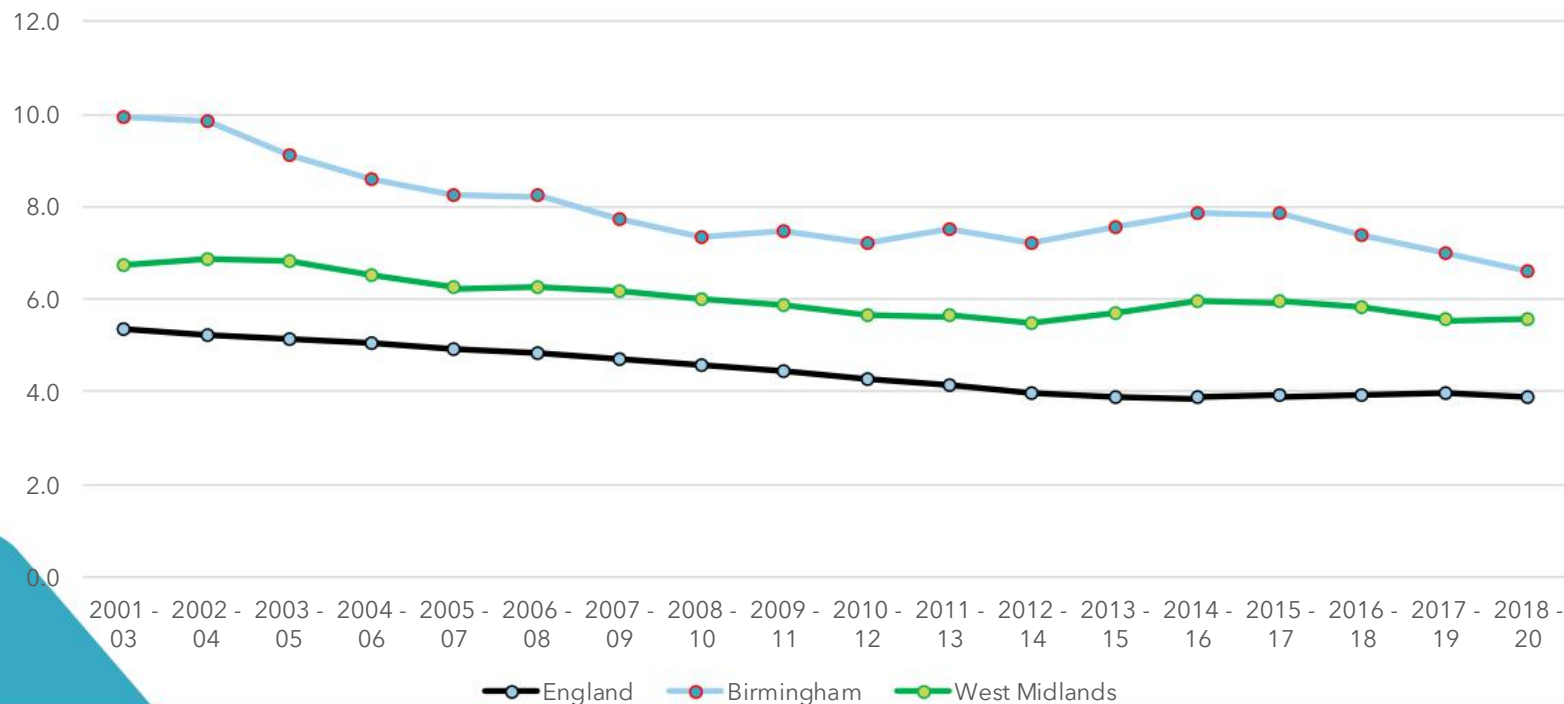
Risk factors for infant mortality

The infant mortality rate for babies born to teenage mothers is **44% higher** than mothers aged 20-39

Low birth weight babies are **27x more likely** to die before the age of 1 year than babies of normal birth weight

The infant mortality rate for babies of mothers born in the Caribbean is **almost 2x higher** than for mothers born inside the UK

Babies born to mothers in the routine and manual group have a **4x** higher infant mortality rate than those born to mothers in higher managerial and professional groups

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Economics of Infant Mortality

There are no current estimates of the total cost or economic impact of infant mortality at a regional or national level. Most direct costs can be attributed to the cost of treating preterm and low birth weight babies in hospital, but there are also indirect costs due to bereavement and the wider impact on families and communities.

Evidence demonstrates that spending on reducing teenage pregnancy is cost effective:
For every £1 spent on contraception, £11 is saved in other healthcare costs

Smoking in pregnancy accounts for 5-8% of preterm births.

The wider societal cost of smoking in pregnancy in Birmingham is estimated to be between £2 million and £5.4 million

The total annual cost to the public sector in **England** associated with children born preterm until age 18 is around **£1.24 billion**, total societal costs (including parental costs and lost productivity) are about **£2.48 billion.**

Reducing the rate of preterm birth, and through this infant mortality, even by a small amount, will have a significant impact on reducing these costs.

Every **£1** spent on prenatal care for low-income women saves **£3.38** on infant medical care during the first year of life

Investment to increase and sustain breastfeeding rates has been shown to provide a rapid financial return on investment

Modifiable factors

Central node: Modifiable factors

- Lack of antenatal care
- Maternal obesity
- Maternal smoking
- Household smoking
- Home conditions and living environment
- Unsafe sleeping arrangements
- Parental alcohol/substance misuse
- Teenage pregnancy
- Cousin marriage
- Lack of infant supervision
- Service provision

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Reducing infant mortality – what needs to be done?

1

Co-ordination and leadership
Strong local leadership is vital for an effective cross agency approach to improving maternity and early years services and reducing infant mortality and to ensure that governance arrangements are in place so local areas can work together to deliver reductions in infant mortality

2

Commissioning
Integrated commissioning will ensure a whole systems approach to tackling infant mortality and improving infant and maternal health. Local authorities have to work closely with colleagues in ICBs, OHID, UKHSA and NHS England to ensure a seamless care pathway for families between services

3

Communication
Community engagement and understanding the preferences and needs of the local population is essential in developing flexible, responsive, acceptable services for the use of those who need them

4

Care pathways
The development of clear care pathways is vital to support sustained improvements in service delivery and quality

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Child poverty

4 in **10** of children in Birmingham live in poverty

Mothers living in poverty are more likely to:
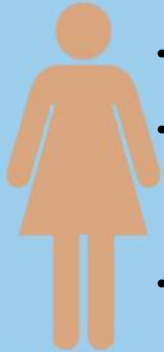
- be in poor health
- have more psychological problems in pregnancy
- smoke more

Babies born into poor families are:
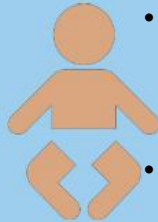
- more likely to be born prematurely and have low birth weights
- 2x more likely to die within one year of birth than those born to affluent families

Addressing child poverty needs a long-term approach underpinned by:
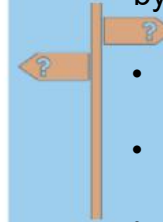
- early intervention and prevention
- building on the assets of individuals and communities
- ensuring that children's and families' needs and abilities are at the centre of service design and delivery

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Teenage pregnancy

Why it matters

1 in 45

teenage girls aged 15-17 years in Birmingham become pregnant every year

The impact of teenage pregnancy

44% higher risk of infant mortality

25% higher risk of low birth weight babies at term

63% higher risk of child poverty

6x higher rate of maternal smoking

1/3 lower rate of breastfeeding initiation

Recommended actions

10 factors for an effective local strategy

Strategic leadership and accountability

- SRE in schools and colleges
- Youth friendly contraceptive/ SH services and condom schemes
- Targeted prevention for young people at risk
- Support for parents to discuss relationships and sexual health
- Training on relationships and sexual health for health and non-health professionals
- Advice and access to contraception in non-health youth settings
- Consistent messages to young people, parents and practitioners
- Dedicated support for teenage parents - including SRE and contraception
- Strong use of data for commissioning and monitoring of progress

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Access to antenatal care

Early booking is essential to ensure early engagement and assessment for informed choice and screening in early maternal care

Pregnant women should be supported to access antenatal care, ideally by 10 weeks. In Birmingham **1** in **4** women book after 12 week's gestation

Risk factors for late booking:
- Your age (<20 years)
- High parity
- Mother from a minority community
- Mother in temporary accommodation

16% of all pregnant women delay seeking maternity care until they are 5 months or more pregnant

Late booking and poor attendance for antenatal care are associated with poor outcomes for mothers and babies

1 in **20** women who dies on or after pregnancy booked after 20 weeks

Booking for maternity after 12 weeks is a risk factor for still births and neonatal deaths

Promoting early antenatal booking includes:
- Proactively providing clear information
- Identifying barriers to early booking
- Providing accessible services
- Working with other providers

Smoking in pregnancy

Smoking in pregnancy accounts for:

1 in 12
Premature births

1 in 5
Cases of low birth weight in babies carried to full term

1 in 14
Pre-term-related deaths

1 in 3
SUDI (Sudden Unexpected Death in Infants)

Pregnant women from unskilled occupations are **5x** more likely to smoke than professionals
Teenagers in England are **6x** more likely to smoke than older mothers aged 30-34

0.8 in 10 women smoke during pregnancy in Birmingham...**fewer than** that of England (1 in 10 women)

Reducing smoking in pregnancy includes:

- identification and referral of pregnant women who smoke
- sufficient expertise in local stop smoking services to meet the needs of pregnant women
- smoking cessation training for all health professionals working with pregnant women
- effective communication with women and their families
- effective communication between health professionals
- implementation of NICE guidelines

Smoking is the **single most important modifiable risk factor** in pregnancy

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Maternal and infant nutrition

Breastfeeding is ....

☐ best nourishment for infants   vital to improving maternal health   FREE and readily available

Breastfeeding in the first year of a baby's life for the period indicated reduces disease risk by:

3 months
- Childhood Asthma — 27%
- Type 1 Diabetes — 23%
- Childhood Obesity — 7%

6 months
- LRTI Admissions — 72%
- Gastroenteritis — 64%

4-6 months EXCLUSIVE breastfeeding
- SUDI — 36%

Mothers who breastfeed benefit from a **faster** return to pre-pregnancy weight and possible **lower** risk of breast and ovarian cancer

Barriers to breastfeeding include:

- Mother's ill-health
- Influence of sociocultural factors
- Inadequate information and support
- Lack of conducive surroundings outside the home

In Birmingham
7 out of 10 mothers breastfeed their babies in the first 48hrs after delivery

This falls to about **4 out of 10** mothers continuing at 6-8 weeks

Increasing breastfeeding is **crucial** to **improving** infant outcomes. **Actions** to increase breastfeeding include:

- Expanding the baby friendly hospital initiative in health care systems
- Provision of education and support during pregnancy and postnatally
- Limiting the marketing of breastmilk substitutes

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Maternal and infant nutrition (2)

In Birmingham , **2 in 5** women aged 16+ years are obese

- age **over 35 years** is a predictive factor for maternal obesity
- **84.6%** of obese mothers are white Caucasian
- **1 in 3** pregnant women with BMI ≥35 kg/m^2 live in the **most deprived** quintile

Health impacts of maternal obesity
Poorer maternal health, including:

- cardiac disease
- spontaneous and recurrent miscarriage
- pre-eclampsia
- gestational diabetes

Poorer babies' health, including:

- macrosomia (weight more than 4.5kg)
- growth restriction
- congenital anomalies e.g. cleft lip and palate
- pre term or post date

Mortality and maternal obesity:

Maternal deaths, including:

- **1 in 5** maternal deaths from 2003 to 2005
- **1 in 2** maternal deaths from thromboembolism and heart disease

Stillbirths and infant deaths, including:

- **1 in 3** stillbirths
- **1 in 4** late foetal deaths
- **1 in 3** neonatal deaths

Women who are obese are grouped as high risk during pregnancy and require additional antenatal screening, intervention and monitoring.

Additional healthcare resources are essential due to pregnancy complications and increased use of neonatal intensive care.

In France, healthcare costs both pre- and postnatally were **higher** in women with BMI greater than 29kg/m^2 due to longer hospital admissions.

Addressing maternal obesity requires seamless collaboration between professionals incorporating community-based public health services starting from preconception. Interventions should include:

- provision of health education on weight management, healthy eating, physical activity and ongoing support before, during and after pregnancy
- modifying lifestyle and environmental factors through behaviour change techniques focusing health education and weight control interventions at maternity care units within neighbourhoods most at risk

SUDI

For each baby who dies from a SUDI, risk factors include:

Deprivation
3.5x
higher risk

Low birth weight
5 x
higher risk

Mothers aged under 20 yrs.
X 2 higher risk

Bed sharing
X 2
higher risk

Smoking
X 5
higher risk

What works to reduce Sudden Unexpected Deaths in Infancy (SUDI)

| Ensuring that infants sleep in the supine position – 'back to sleep' | Keeping the baby's head uncovered by placing the baby in the 'feet to foot' position | Ensuring that infants sleep in a separate cot | Ensuring that infants sleep in the same room as their parents | Reducing parental smoking | Encouraging and supporting mothers to breastfeed their baby |

Changing knowledge and behaviour through clear communication about the risk factors for SUDI

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Vaccination

VACCINES

Timely and complete immunisation of children is one of the **most important** aspects of prevention

There are infant deaths that could be **prevented** if a vaccine had been given on time

SAVE

DTaP/IPV/HiB coverage in Birmingham in 2018-19 was the **worse than** in England

1.2 in 10 children in Birmingham did not complete the primary immunisation course by their first birthday

LIVES

Actions to improve uptake include:
- improving **data collection** and reporting
- a **comprehensive commissioning** approach
- **staff engagement** to promote uptake
- **Effective communication** to families

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Perinatal and infant mortality task force
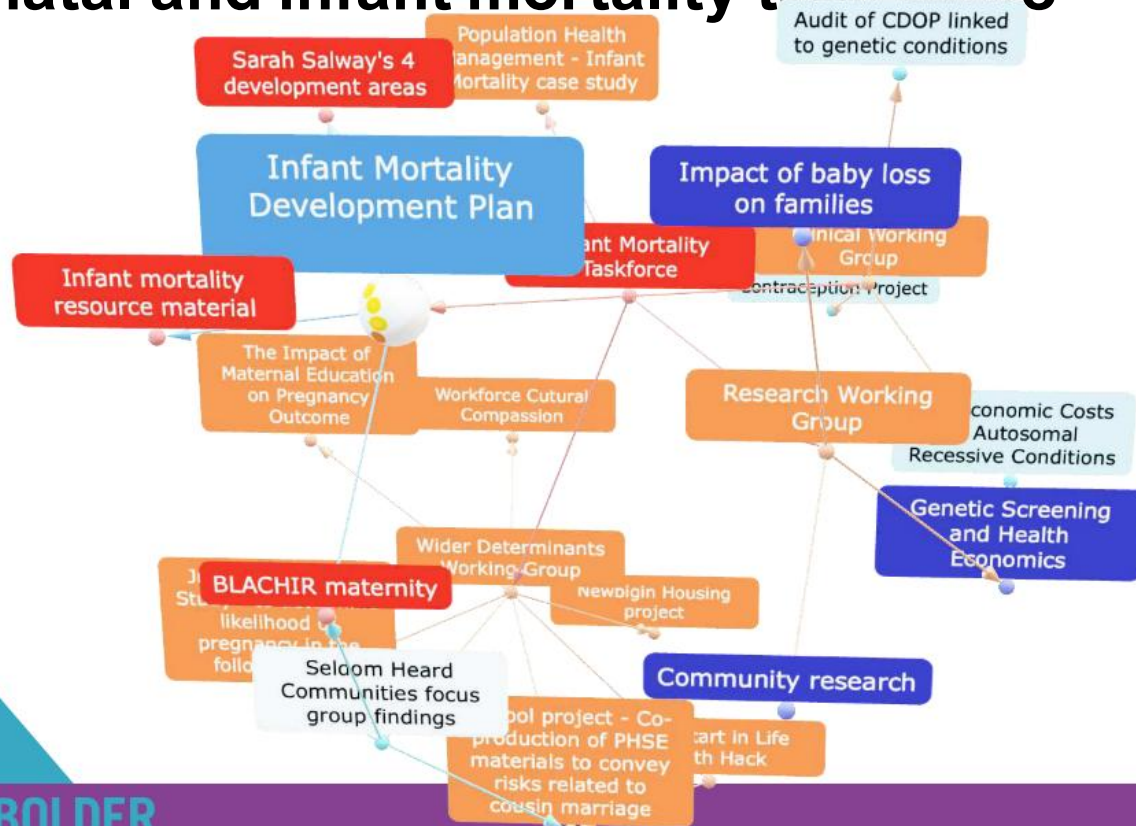
Acknowledgements

- Adapted, with permission, from PHE London Resource originally developed by Dr Marilena Korkodilos and Modupe Omonijo
- With input from the BCC Knowledge, Evidence and Governance team particularly Jeanette Davis
- All resources are available from the public health team including references

INFANT MORTALITY UPDATE — January 2023

Key Facts

- 2021 saw an increase of 21 infant deaths registration. The England rate also rose in 2021.
- Three-year rates have increased Birmingham to 7.6 per 1,000 but England has remained static at 3.9 per 1,000
- Perinatal single year rates have decreased in 2020 to 9.1 The 3 year rolling rates for 2018/20 have also decreased slightly on to 9.8 per 1,000 births locally (Please note this is not currently available for 2021).
- Early neonatal deaths in 2021 increased by 14 in Birmingham which meant the rate increased by 1.5 deaths per 1,000 live births. England data is currently unavailable.
- Early neonatal 3-year rates 2019/21 for Birmingham increased by 0.3 per 1,000 live births. England data is currently unavailable.
- Late neonatal single year death rates have slightly increased in Birmingham in 2021. England data is not currently available.
- Neonatal death increased during 2021 by 1.9 per 1,000 live births in Birmingham. England data is currently unavailable.
- 2019/21 Neonatal rates have increased slightly. England rates are currently unavailable.
- Post neonatal death rates have increased for Birmingham, England 3-year rates are currently unavailable.
- Live births dropped across the city by an estimated 1,000 – stillbirths remained static.
- Currently for England Stillbirths for 2019/21 or 2021 are not available. In Birmingham, locally calculated rates for both years have increased with 20 more stillbirths than 2018/20. Meaning Perinatal mortality has also increased.
- **NB.** *Perinatal and stillbirths are calculated per 1,000 total births, whilst all other rates are calculated per 1,000 live births*
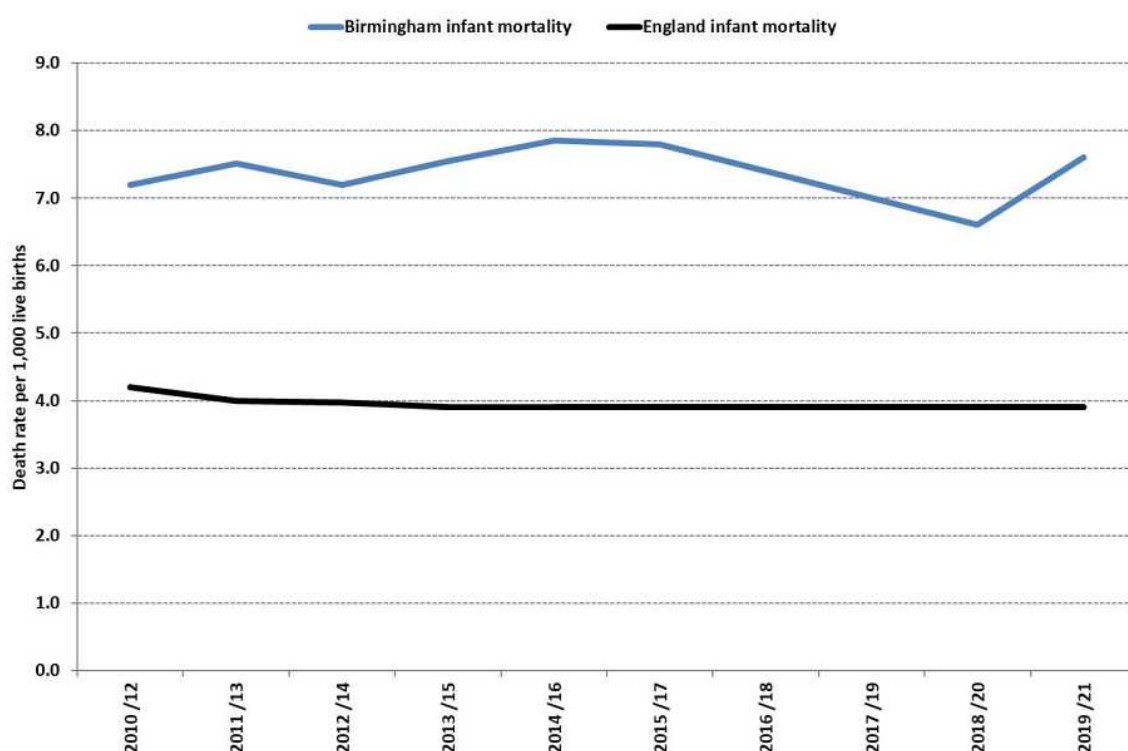
Key rates	Birmingham	England
Infant mortality 2021	8.0	4.0
Infant mortality 3 year rate 2019/2021	7.6	3.9
Early Neonatal Rate 2021	5.0	NA
Early neonatal 3 year rate 2019/2021	4.3	NA
Late Neonatal rate 2021	1.3	NA
Late neonatal 3 year rate 2019/2021	1.2	NA
Neonatal rate 2021	6.3	NA
Neonatal 3 year rate 2019/2021	5.6	NA
Post neonatal 2021	1.7	NA
Post neonatal 3 year rate 2019/2021	1.5	NA
Perinatal rate 2021	8.8	NA
Perinatal 3 year rate 2019/2021	9.9	NA
Still birth rate 2021	5.4	NA
Stillbirth 3 year rate 2019/2021	5.5	NA

1

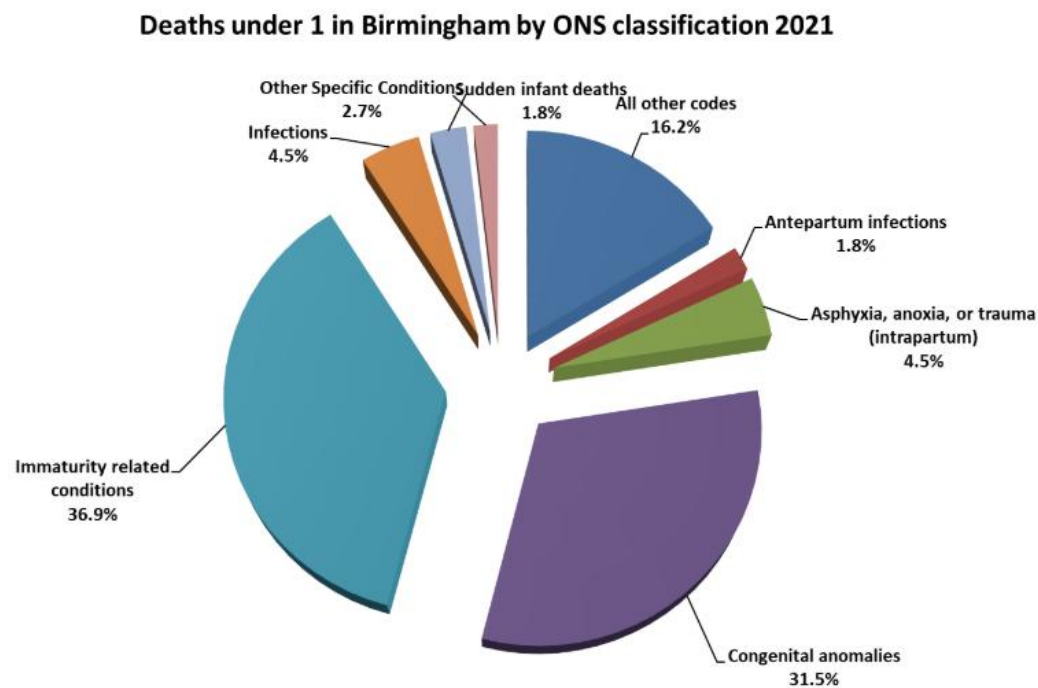**Figure 1 : Single year infant mortality 2010 – 2021**
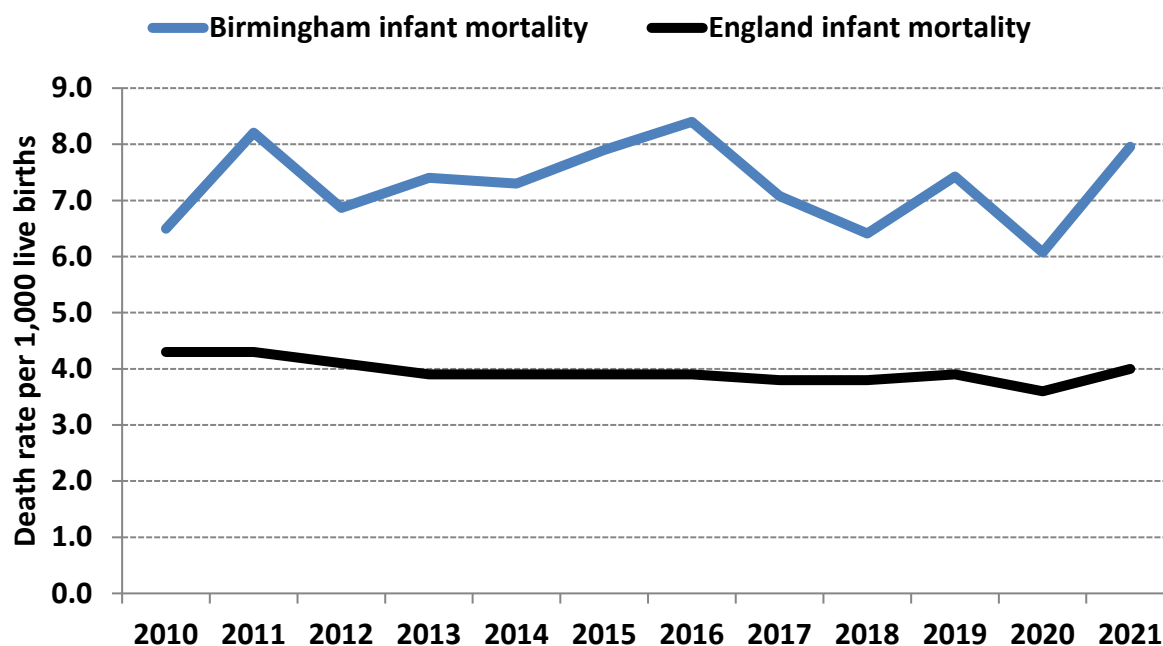
Source: ONS Deaths/Births

Figure 2 : Three year infant mortality 2010 - 2021
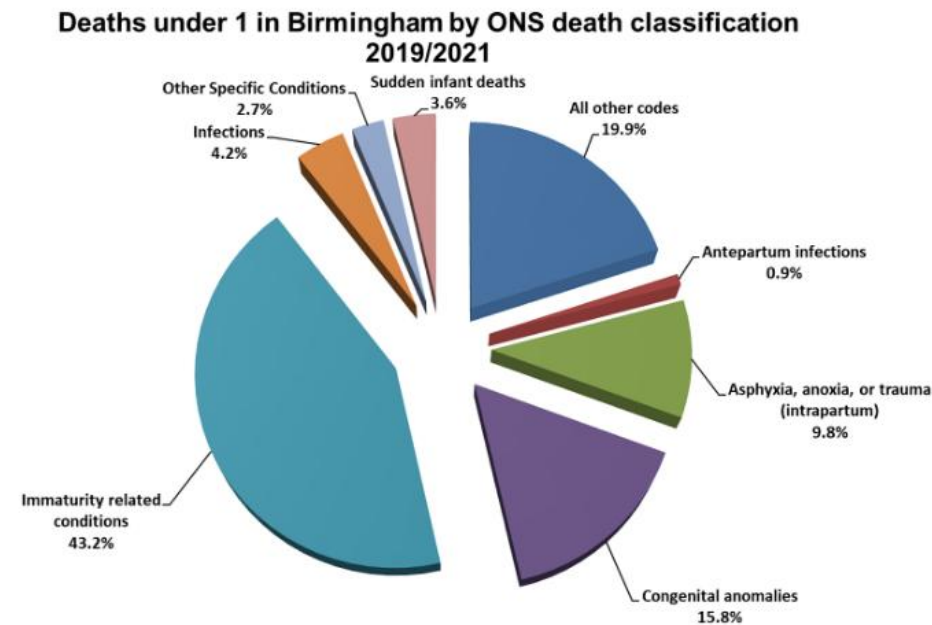

Source: ONS Deaths/Births

CAUSAL FACTORS
Figures 3 Breakdown of causes of death 2021

Deaths under 1 in Birmingham by ONS classification 2021

- Other Specific Conditions 2.7%
- Sudden infant deaths 1.8%
- Infections 4.5%
- All other codes 16.2%
- Antepartum infections 1.8%
- Asphyxia, anoxia, or trauma (intrapartum) 4.5%
- Immaturity related conditions 36.9%
- Congenital anomalies 31.5%

Source: ONS Deaths

Figure 4 Breakdown of causes of death 2019-2021

Deaths under 1 in Birmingham by ONS death classification 2019/2021

- Other Specific Conditions 2.7%
- Sudden infant deaths 3.6%
- Infections 4.2%
- All other codes 19.9%
- Antepartum infections 0.9%
- Asphyxia, anoxia, or trauma (intrapartum) 9.8%
- Immaturity related conditions 43.2%
- Congenital anomalies 15.8%

Source: ONS Deaths

3

Figure 5 gives a breakdown of the early neonatal deaths by year by gestation age at birth of infant from 2018 to 2021. Whilst those born 23 weeks and under has always been high 2021 saw an increase of 6 deaths on that of 2018. In 2018, 23 weeks and under was 57% of total early neonatal deaths (i.e., those babies dying in their first week of birth). In 2021, it was 61% of early neonatal deaths.

**Figure 5 Early neo natal deaths gestation at birth 2018 to 2021**

Source: ONS Deaths

4
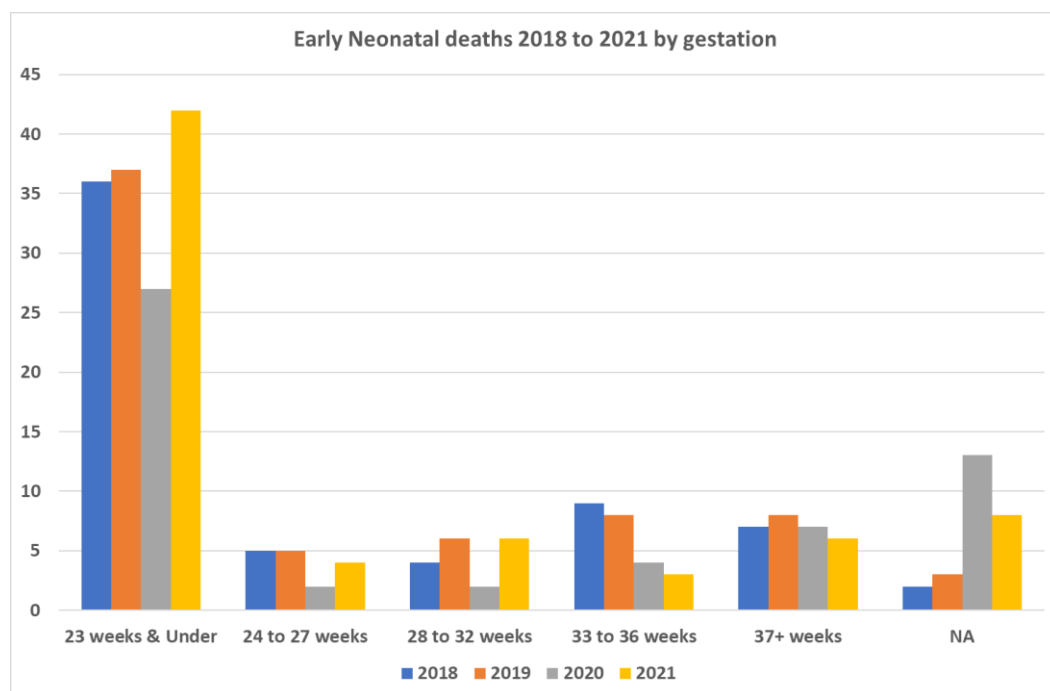
INFANT MORTALITY REGISTRATIONS 2022

Figure 6 gives a breakdown by age of infant at time of death, the majority of the 70 (82.9%) death registrations to the end of September 2022 are in the early neonatal stage (under 7 days). Currently, due to the way we received our registrations – more detailed analysis on these deaths can only be done on 63 of these deaths. Based on the numbers so far there is a likelihood overall 2022 registrations may equal 2021 (110 registrations).

Figures 6 Infant Death registrations up to end September 2022
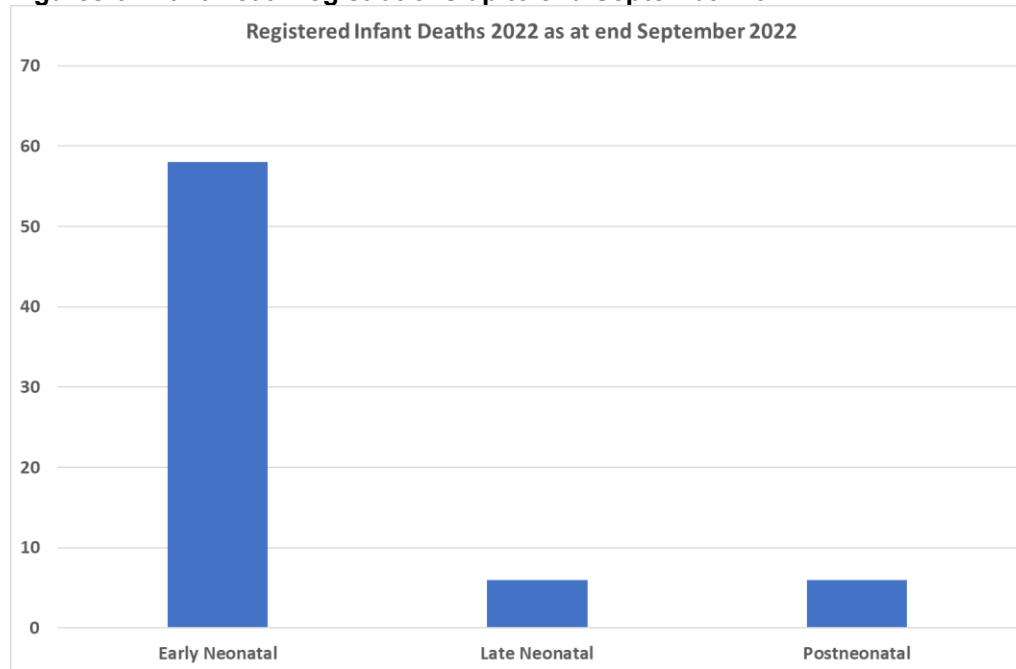
Source: ONS Deaths/Births

2022 Annual Report of the Birmingham and Solihull Child Death Review Team and Child Death Overview Panel

Terminology
CDOP – Child Death Overview Panel
CDRT – Child Death Review Team
CDRM – Child Death Review Meeting
PMRT – Perinatal Mortality Review Tool
SUDIC – Sudden and Unexpected Death in Childhood
JAR – Joint Agency Response
NCMD – National Child Mortality Database
HSIB – Healthcare Safety Investigation Branch

1.0 Introduction
Working Together to Safeguard Children (2018)[1] outlines the governance arrangements of the statutory duty to review deaths of children resident in the City Council's area or resident elsewhere but Looked After by the City Council. The Child Death Review Partners during 2021-22 were Birmingham and Solihull CCG and Birmingham City Council (local authority). Following the Health and Care Act 2022 the Birmingham and Solihull CCG was succeeded by NHS Birmingham and Solihull Integrated Care Board in July 2022.

The Statutory and Operational Child Death Review guidance [2] set out the responsibilities of the Child Death partners and details explicit operational guidance. The Flow Chart in the guidance (Figure 1) illustrates the full process of a child death review. It identifies the responsibility of the local review by professionals involved in the care of the child (Child Death Review Meeting) and the review of an independent multi-agency panel (Child Death Overview Panel - CDOP) organised by the Child Death review Partners. These processes were implemented during the CDOP year 2019-20.

Figure 1 Child Death Review Processes, 2018
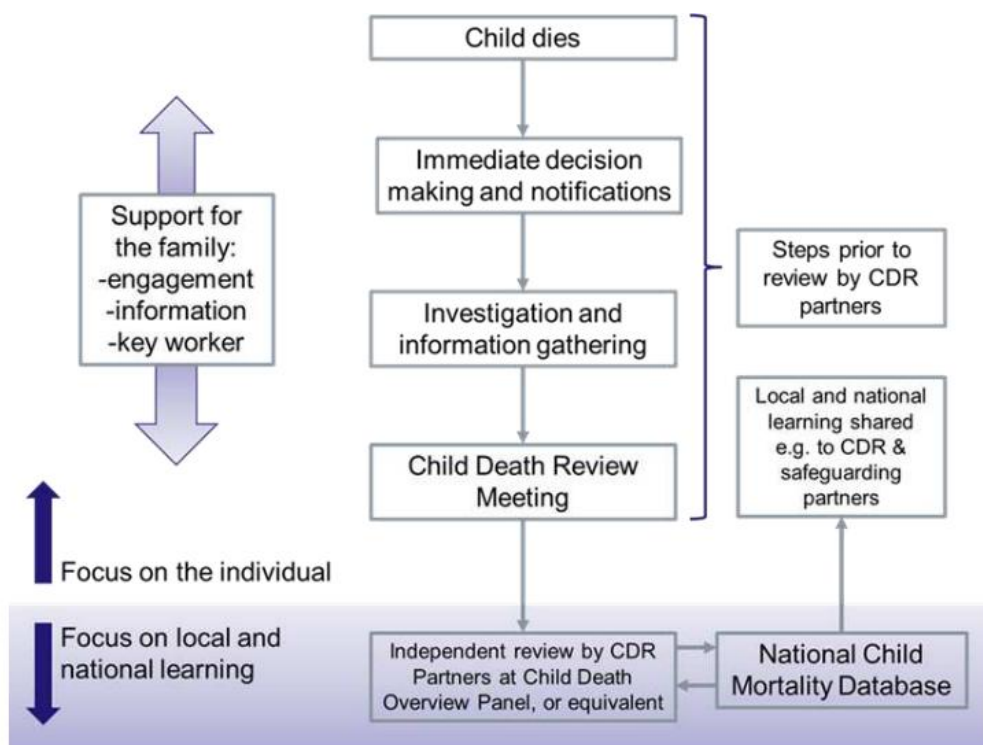
1.1 Time period

The CDOP year follows the financial year reporting period. This annual report covers the period from 01 April 2021 to 31 March 2022.

2.0 The Birmingham and Solihull Child Death Review Team

The multi-professional Child Death Review Team (CDRT) is part of the Safeguarding Team at NHS Birmingham and Solihull Integrated Care Board (ICB). Birmingham and Solihull CDOP is managed by the CDRT. The offices for the CDRT are at the Wesleyan Building in Birmingham. The meetings were a mixture of virtual and face to face; the Neonatal Panel meetings were all virtual and the General/SUDIC meetings were face to face/hybrid meetings where possible.

Birmingham CDOP took over the responsibility for reviewing Solihull child deaths from 01 April 2021, so cases reviewed include children resident in either Birmingham or Solihull.

The CDRT are directly responsible for the co-ordination of the Joint Agency Response (JAR) to unexpected child deaths (SUDIC – Sudden Unexpected Death In Childhood) for both Birmingham and Solihull resident children. The CDRT oversees CDR services provided by NHS Trusts.

Terms of reference for the CDRT are available here:
https://www.birminghamsolihull.icb.nhs.uk/application/files/3616/6791/8309/Terms_of_Reference_for_BSol_Child_Death_Review_Team_2021.pdf

2.1 CDRT staff

Dr Joanna Garstang	Designated Doctor for Child Death
Dr Helen Chaplin	Designated Doctor for Safeguarding – Lead for Neonatal Deaths
Sarah Hunt & Sue Cope	Lead Nurses for Child Death Review
Melisha McKenzie	Administrator until Sept 2021 then CDRT manager from Sept 2021

Joanne Fox   Administrator

There was a vacancy in Administrator role from Sept 2021 until June 2022.

CDOP membership
Di Rhoden   CCG Head of Safeguarding, Chair
Dr Joanna Garstang   Designated Doctor for Child Death
Dr Helen Chaplin   Designated Doctor for Safeguarding – Lead for Neonatal Deaths
Sarah Hunt   Lead Nurse for Child Death Review
Sue Cope   Lead Nurse for Child Death Review
Melisha McKenzie   Administrator until Sept 2021 then CDRT manager from September 2021
Detective Inspector Joseph Davenport, Ladywood Public Protection Unit, West Midlands Police
Dr Yasmin Hussain, Named GP for Safeguarding, BSol CCG

Birmingham:
Dr Marion Gibbon, Interim Assistant Director of Public Health
Judith Beddow, Head of Child Protection Review, Birmingham Children's Trust
Paul Nash, Head of Service, Independent Review, Birmingham Children's Trust
Micho Moyo, Head of Safeguarding Education, Birmingham City Council
Dr Michael Plunkett, Named Doctor for Safeguarding, General Paediatrician, University Hospital Birmingham

Solihull:
Dr Rob Davies, Consultant in Public Health, Solihull Metropolitan Borough Council
Hasina Miah, Independent Reviewing Officer, Children's Services, Solihull Metropolitan Borough Council
Natasha Chamberlain, Senior Education Improvement Adviser, Solihull Metropolitan Borough Council

Neonatal Meetings:
Dr Vikki Fradd, Consultant Neonatologist, University Hospitals Birmingham
Joselle Wright, Consultant Midwife, University Hospitals Birmingham (left position in October 2021 and was not replaced during rest of 2021-22 year)
Dr Matt Cawsey, Consultant Neonatologist, Birmingham Women's and Children's Hospital
Louisa Davidson, Consultant Midwife, Birmingham Women's and Children's Hospital

3.0 Local Child Death Review Meetings
The statutory guidance requires that all child deaths should be reviewed at a local child death review meeting (CDRM). With the exception of deaths requiring a Joint Agency Response (JAR), which are directly managed by the CDRT, it is the responsibility of the health care trust caring for the child at the time of death to hold the CDRM.

Birmingham Community Healthcare Trust holds CDRM for children who die under their palliative care team; Acorns hospice contributes to these reviews.

University Hospitals Birmingham holds CDRM for children dying on the paediatric wards, and for neonatal deaths in addition to using the Perinatal Mortality Review Tool (PMRT).

Birmingham Women and Children's Hospitals are using the PMRT for neonatal deaths. They have an established mortality review programme for deaths at Birmingham Children's Hospital but this

only considers provision of care during recent treatment within the hospital; these meetings are not compliant with the Working Together to Safeguard Children (2018) Statutory Guidance. They have received substantial support from the CDRT to commence holding CDRM and started doing so in April 2022 so outside of the time frame of this report.

City and Sandwell Hospitals are using the PMRT for neonatal deaths.

For neonatal deaths where the baby was transferred antenatally or postnatally, a joint PMRT between both Hospital Trusts has been established.

All trusts have found challenges in having primary care and other agencies join CDRM. The CDRT are reminding trusts of this requirement and supporting them to invite the appropriate professionals.

4.0 Joint Agency Response (JAR)

The CDRT provides oversight and administrative support for any death which requires a JAR. The JAR should be started if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (incl. SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural;
- in the case of a stillbirth where no healthcare professional was in attendance

There is a consultant Paediatrician from either Birmingham Community Healthcare NHS Trust or University Hospitals Birmingham NHS Trust on call 24 hours per day to support the JAR and ensure that joint home visits with the police can take place as soon as possible. This on-call duty is alongside existing clinical commitments so although the Paediatrician is always available for advice they may not be immediately able for home visits. Other neighbouring areas have much more limited JAR cover. During working hours, the lead nurse on-call from the CDRT will accompany the Paediatrician.

Each SUDIC case has an allocated lead nurse from the CDRT who supports parents/carers and attends the initial and final multi-agency meetings. The CDRT nurses also lead on homicide cases and deaths that occur abroad.

All agencies follow the 2016 Kennedy Guidelines[3] for investigation of SUDIC. A local Birmingham multi-agency guideline was agreed between West Midlands Police, the Birmingham Coroner and BSol CCG in May 2021. National multi-agency guidance for the JAR during the COVID-19 pandemic was issued in April 2020, and this was followed when necessary.

4.1 JAR audit

Joint Agency Response Audit

Audit of JAR for children dying between 01 April 2021 and 31 March 2022

The JAR is audited annually to provide assurance compliance with national standards. A summary of the audit is presented here. It takes a minimum of 4 months (and often much longer) to complete a JAR due to the length of time needed for post-mortem reports to be completed, therefore few cases will have completed the JAR process yet. At present there is only one paediatric pathologist in the West Midlands able to undertake infant post-mortems with older children sent out of region, and a national shortage of paediatric pathologists.

There were 28 deaths subject to JAR; 2 additional cases started the JAR process but were promptly stepped down following the initial JAR meeting as medical causes of death were confirmed. 23 children were Birmingham residents and 5 Solihull, 15 were female and 13 male. The median age at death was 7 years with a range of birth to 17 years.

Table 1 Performance against JAR audit standards

Audit standard	Number of eligible cases	Number of cases achieving standard (%)
Joint home visit by police and paediatrician	21 (7 in public place/ out of region)	16 (76%) (all same day, 5 police only)
Initial multi-agency sharing meeting	26 (1 complex strategy meeting held instead and 1 meeting not required)	26 (100%) (Mean 4 days after death)
Final case discussion to review cause of death	22 (6 not required)	5 (72%) (mean 5 months after death – others still waiting post-mortem result)
Parents offered feedback from final case discussion	11	7(64%) 2 additional cases supported by police 4 families accepted feedback meeting
Final case discussion prior to Inquest (if held)	4	3 (75%)

Audit of JAR cases finalised at CDOP between 01 April 2021 and 31 March 2022

There were 27 JAR cases finalised in this time period: 24 from Birmingham and 3 from Solihull. The year of death is shown in figure 1, 15/27 cases died in 2020-21.

Figure 1 Year of death for cases finalised at CDOP 2021-2
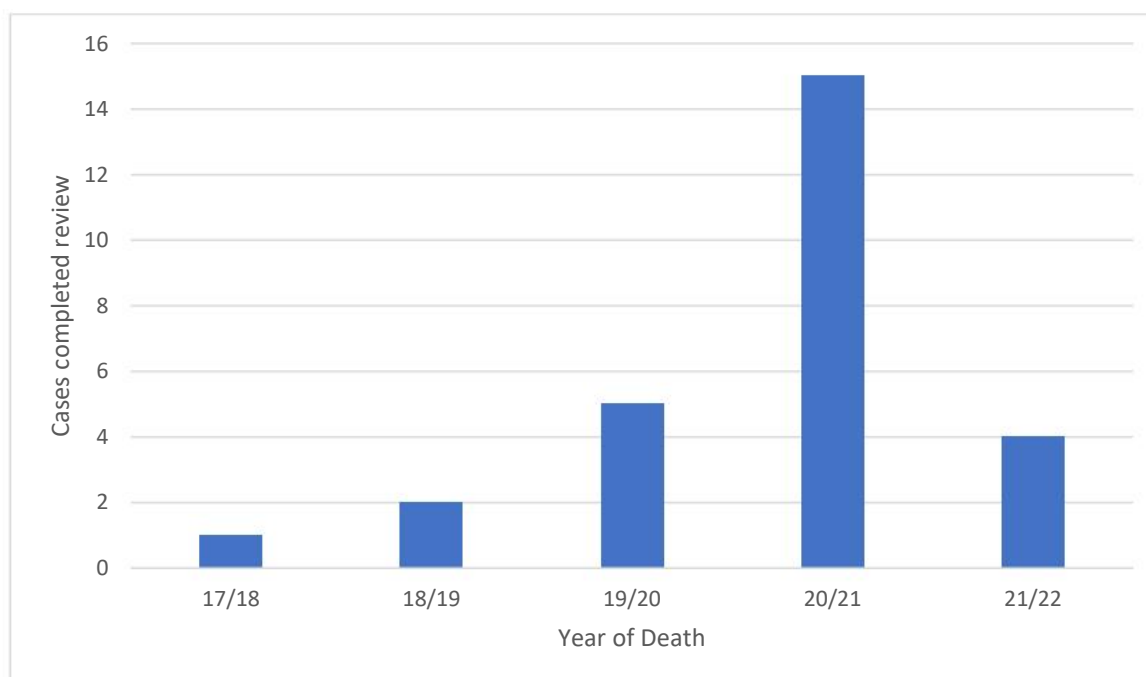
There was good attendance at initial and final multi-agency meetings from all agencies. Coroner's investigators attended 20/27 initial JAR meetings compared to none in the previous year. Coroner's investigators do not attend Final Case Discussions to ensure independence although all documents are shared with them.

Final case discussions took place for 16 cases at a mean of 5.3 months. Final case discussions were not required in 11 cases mainly because complete information on the child, cause of death and potential modifiable factors was available at initial information sharing meeting.

All families were offered follow-up following the conclusion of the JAR. The Child Death Review team offered this to 22 families, 14 families accepted and 8 declined. Of the remaining 5 cases; 4 families had a follow-up visit from police or other healthcare professionals and 1 family was offered follow-up from another CDOP as the SUDIC process had commenced in their area.

The final CDOP category of death is shown in figure 2. The most common category was trauma and external factors; this includes Road Traffic Collisions, drowning and accidental asphyxia of infants.

There were four unexpected and unexplained sleep related deaths of infants under the age of one year. Risk factors included co-sleeping and smoking, babies sleeping on their fronts, overheating and hazardous items in the bedspace.

Figure 2 Final Category of Death JAR cases reviewed 2021-2
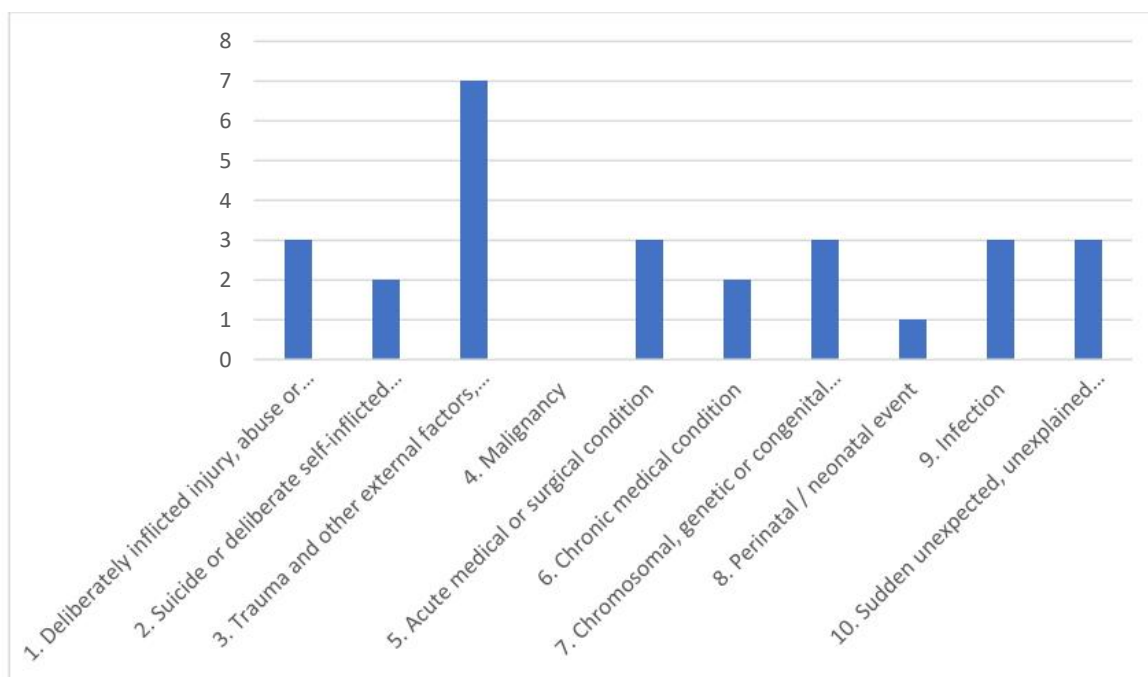
In 4 cases, children had significant pre-existing medical conditions and in all of these children their death was directly due to this condition. This is in direct contrast to last year where 15 children with a life limiting illness died unexpectedly and 9 of these deaths were not due to underlying conditions.

The JAR identified child protection concerns in five families.

Modifiable factors were identified in 16/27 deaths, these included;

Factors intrinsic to the child:
- undiagnosed mental health conditions in children and the influence of social media upon children's mental health,
-denied/concealed pregnancy

Factors in social environment including family and parenting capacity:
- carers not recognising signs and symptoms of deteriorating illness
-Co-sleeping, babies not sleeping on their backs
-school exclusion
-gang affiliation
-smoking-antenatally and postnatally
-asthma management

Factors in the physical environment:
-unsafe sleep for infants: over heating or hazardous items in bedspace
-home safety
-dangerous driving

Factors in service provision:
 -inadequate triage by healthcare professionals
-lack of written information for parents/carers in relation to deteriorating illness in child
-Inadequate discharge planning from acute trusts
-delays in elective surgery
-asthma management by professionals
-Emergency Department provision for teenage trauma patients
-language barriers

A Local Child Safeguarding Practice Review was held in 3 cases. Most families were not known to social care prior to the death, social care status is shown in figure 4.

Figure 3 Social care status at time of death

Legend: ■ Current case open ■ CIN plan ■ Previously known ■ Never known
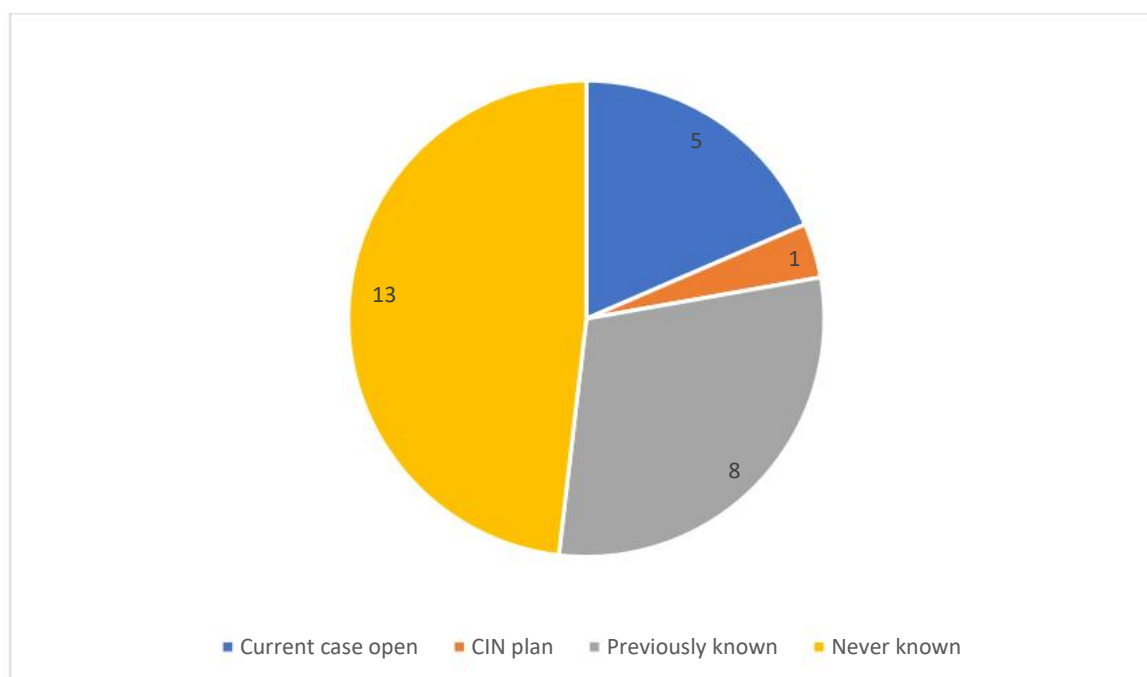
5.0 Deaths Reviewed by Birmingham CDOP

179 deaths were reviewed by Birmingham CDOP, compared to 62 in 2020-21 and 180 in 2019-20. COVID was the reason for the reduction in reviews in 2020-21, with several CDOP meetings cancelled and delays in getting the information required from acute hospitals. The number of cases that have been reviewed in 2021-22 is back similar to pre-COVID figures. There were 161 deaths in 2021-22, and 120 in 2020-21. Therefore there has been some catch up of the backlog of cases not able to be reviewed in 2020-21 due to COVID.

The majority of deaths are in infants under the age of 1 year. The breakdown of ages is shown in figure 2 with data for 2019-20 and 2020-21 shown for comparison.

Figure 4 Age of children reviewed at CDOP 2021-22 with 2019-20 and 2020-21 for comparison
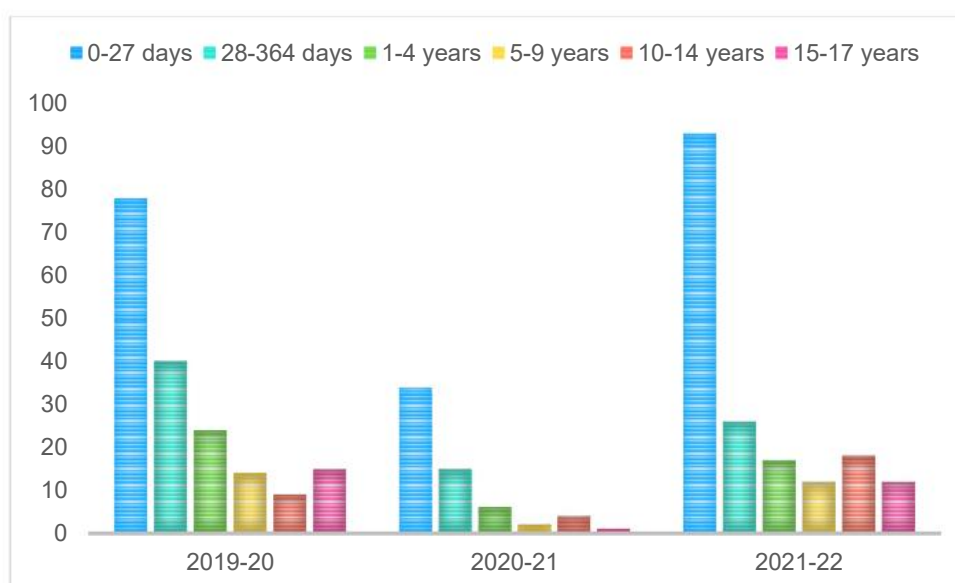
The median time for a review to be completed was 360 days (range 91-1472). This compares to 235 days (range 42 to 908) in 2021-22. There are often lengthy delays while CDOP wait to receive information from hospitals, particularly for mortality reviews to be completed at Birmingham Children's Hospital, in part due to their multi-layered mortality review process. Further delays are also unavoidable if there are criminal investigations, prosecutions or Safeguarding Practice Reviews. However, the increase in time compared to 2020-21 is likely to be due to the backlog of cases delayed due to COVID with more complex cases having longer delays than before COVID.

5.1 Place of death

The majority of the deaths occurred in hospital (80%) or at home (15%). Most of the hospital deaths occurred on labour ward, the neonatal unit or PICU. This is illustrated in figure 3.
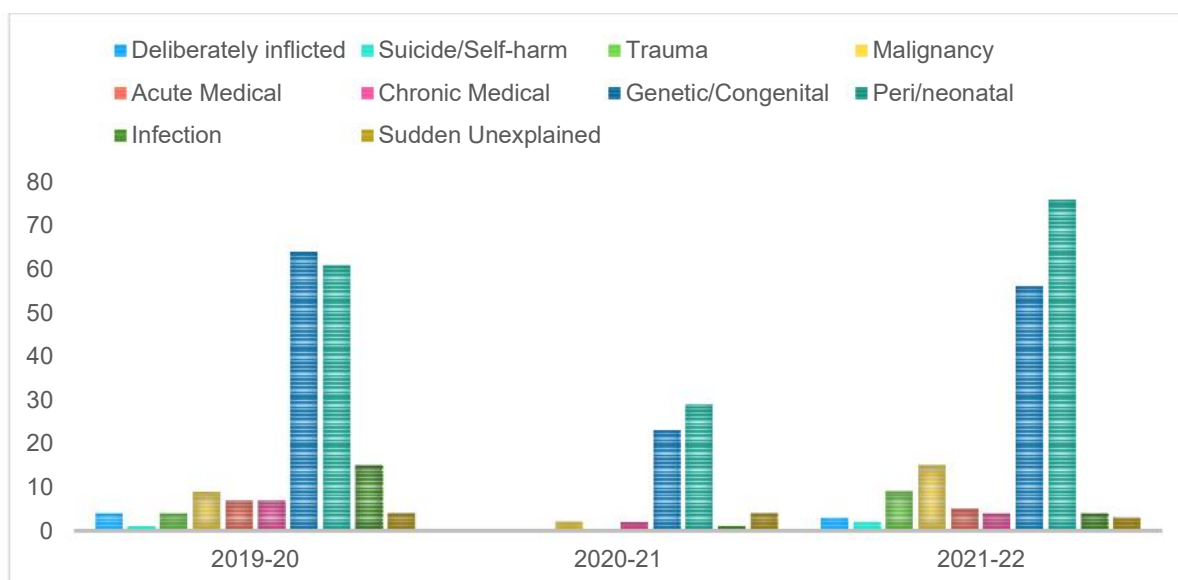
Figure 3 Location of death 2021-22
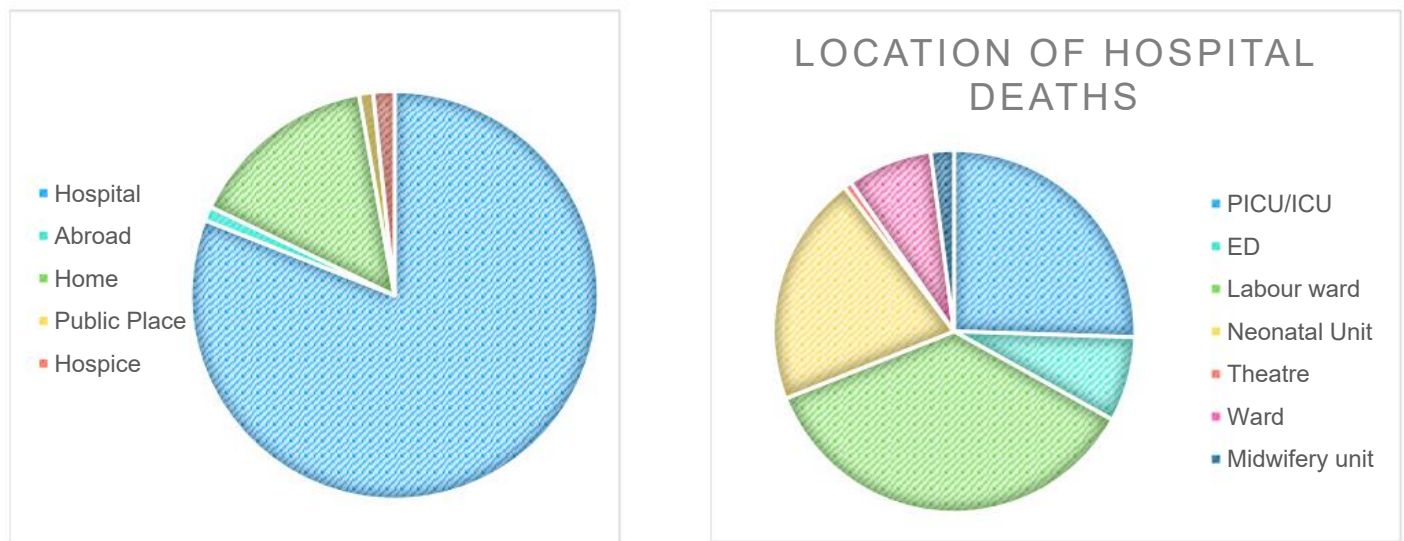
5.2 Causes for death and modifiable factors

CDOP categorises deaths into broad categories, the frequency of deaths in each category varies with age as shown in figure 4. As with 2020-21, there were no deaths directly due to COVID.

Figure 4 Causes for death 2021-22, with 2019-20 and 2020-21 for comparison

CDOP consider whether each death is preventable based on the presence of modifiable factors. These are defined as '… factors in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.' In total 59/179 (33%) of deaths had modifiable factors, which is similar to 2020-21 (34%). The modifiability per category of death is illustrated in figure 5.

Figure 5 Modifiable factors and category of death 2021-2022
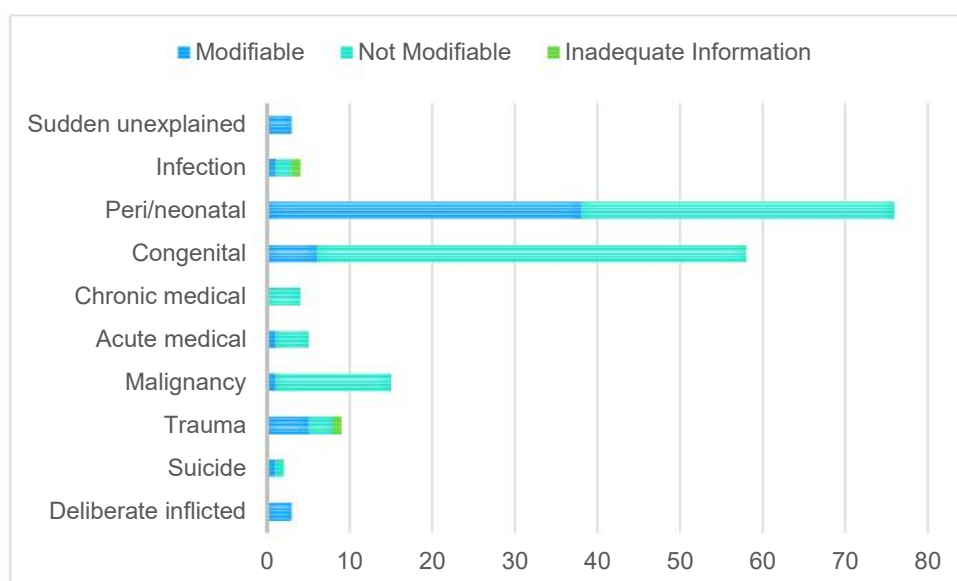
5.3 Modifiable factors for Perinatal and Neonatal Deaths

Notably, 50% (38/76) of our perinatal/neonatal deaths had one or more modifiable factor recognised. This has been an increase over the last 2 years, from 13% in 2019-20 and 42% in 2020-21. We now receive high quality information in the form of the hospital completed Perinatal Mortality Review Tool (PMRT)[4], which is an evidence based template for reviewing stillbirths and neonatal deaths born after 22 weeks gestation. In addition to this, deaths of term babies (over 37 weeks gestation) who

died within the first week of life were also reviewed by the Healthcare Safety Investigation Branch (HSIB)[5] and these reports were also reviewed as part of the CDOP process.

We hold specialist neonatal CDOPs, with consultant neonatologists and specialist midwives present enabling clinical experts to contribute to reviews. In Birmingham, there are three NHS Trusts with maternity hospitals: Birmingham Women's Hospital, Heartlands Hospital (University Hospitals Birmingham) and City Hospital. We hold separate CDOP meetings for cases from each hospital, with clinicians from the other hospital attending to review cases; this ensures both clinical expertise and a high degree of scrutiny with independent experts.

The majority of modifiable factors identified in perinatal and neonatal deaths were related to suboptimal maternal health, namely maternal smoking (increasing risk of premature delivery and low birth weight) and maternal weight (obesity or underweight). There were some modifiable factors with service provision regarding antenatal care (e.g. booking delays, not optimising management of other medical issues during pregnancy), intrapartum care (around the time of birth, e.g. incorrect monitoring/misinterpretation of cardiotocography monitoring/delay in giving antibiotics) and with neonatal care (e.g. delay in surfactant administration). The modifiable factors for perinatal and neonatal deaths are shown in figure 6.

Figure 6 Modifiable factors for perinatal and neonatal deaths
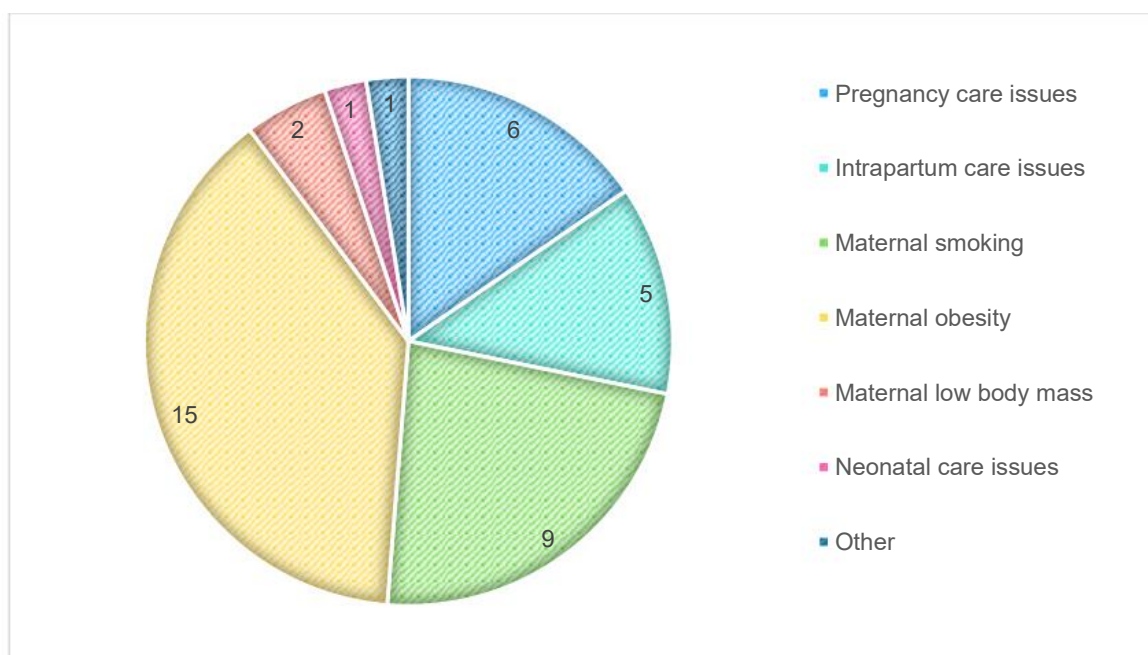
5.4 Modifiable factors in other deaths (excluding perinatal and neonatal deaths)

There were five sleep-related sudden unexpected infant deaths. Three remained unexplained following full investigation with modifiable factors of co-sleeping in two, parental smoking in one, and a hot sleeping environment in one. Two deaths were categorised by CDOP as trauma these involved accidental suffocation due to unsafe sleeping environments.

Parental smoking was also noted in a death from a respiratory illness. Modifiable factors in health service provision were also identified in two deaths related to staffing issues and waiting times; these issues caused poor communication of results within hospital and delays in gastrostomy surgery.
Parental consanguinity was not noted as a modifiable factor in any of the genetic or congenital deaths, compared to 4 deaths in 2020-21. This is because the National Child Mortality Database (NCMD)

gave interim advice to CDOP: to determine if consanguinity was contributory to the death but not to mark it as modifiable. NCMD are currently developing guidelines regarding how CDOPs should determine modifiability of various factors; it is hoped that this will establish a uniformed approach across the country. There were 10 deaths of children from genetic syndromes, whose parents were blood relatives.

5.5 Learning from deaths

63/179 reviews identified relevant learning, even though in most cases this would have made no difference to the outcome for that child. Much of the learning was identified by provider trusts at internal CDRM or through the Healthcare Safety Investigation Branch. It was felt by the CDRT that most cases discussed have some learning and so perhaps lessons identified at CDRM level are not being captured fully enough on the eCDOP Analysis Form (see recommendations Section 7 below).

Learning themes for peri-neonatal deaths included the need for better processes for management of mothers who are book late for antenatal care (5 cases), improving intrapartum care, such as giving steroids and magnesium in a timely way for mothers in preterm labour (4 cases), and better interpretation of Cardiotocography Monitoring to identify fetal distress (4 cases). There was also learning regarding the early management of neonates; giving correct adrenaline dose (2 cases), and ensuring timely stabilisation of the baby on the Neonatal Unit (golden hour) is met (3 cases).

There was also learning regarding management after death;

- Ensuring the Joint Agency Review process is followed correctly (5 cases)
  - E.g. Remembering to consider as a SUDIC when child is 'expected' to die several days after an 'unexpected' collapse
- Ensuring adequate post-mortem tests (2 cases)
  - E.g. Ensuring post-mortems that are carried out by adult pathologists (on older teenagers) still follow SUDIC Kennedy Guidelines 2016[3], with appropriate histology and ancillary samples being taken.
- Ensuring admission of twins in SUDIC cases (2 cases)
  - SUDIC Kennedy Guidelines 2016[3] advises that if a twin dies suddenly and unexpectedly that the surviving twin should be admitted as an inpatient paediatric unit for close monitoring for at least 24 hours.
- More sensitive communication of post-mortem results to family (3 cases)
  - E.g. Ensuring the CDR team is notified immediately when post-mortem results are available so that they can support the family.

Other themes included communication between healthcare professionals (3 cases) and issues with IT systems, for example, difficulty sharing results/information across different services, trusts or agencies (6 cases). Learning included the importance of good communication with families and patients (4 cases) such as involving young people in their care planning and the use of interpreters. The importance of timely referral to palliative care services was also highlighted (3 cases).

One of the deaths highlighted the confusion regarding where West Midland Ambulance Service should take teenagers with severe trauma with older teenagers being diverted from the regional trauma centre Birmingham Children's Hospital purely due to age. Birmingham Children's Hospital only take up to 16 years, with Heartlands Hospital (UHB) and City Hospital accepting any age and Queen Elizabeth Hospital only accepting over 16 years. The Integrated Care Board will be working

with hospitals and West Midlands Ambulance Service to ensure that young people with critical injuries are taken to the Emergency Department (ED) best equipped to deal with their clinical presentation rather than selecting the ED based on age alone.

One death identified lessons to be learnt regarding management of developmental delay. As a result a training package regarding developmental delay, arrest and regression was produced by the CDRT and rolled out to primary care staff.

5.6 Learning from what went well

As well as learning from what went wrong, it is also and important role of CDOP to review and highlight positive factors in provision and examples of best practice. 54/175 deaths reviewed had examples of positive service provision or best practice. Examples included members of staff coming to work on their days off to help, good joint working with hospital teams and palliative care, support from primary care providers such as GPs and Health Visitors, and support from school for families both before and after children had died.

5.7 Learning Disability Mortality Review (LeDeR)

The Birmingham and Solihull (BSOL) Child Death Overview Panel (CDOP) reports deaths of children with a learning disability to LeDeR via the online referral form and provides core information about the child. Additional CDOP documentation containing details regarding the circumstances leading to death is submitted following the comprehensive review at CDOP. This analysis form is then uploaded to the LeDeR database. The analysis form lists any common contributory factors leading to deaths:

- Factors that may have contributed to the vulnerability, ill health or death of the child
- Modifiable factors that may reduce the risk of future child deaths
- Learning points and issues identified in the review
- Recommendations and actions that may inform and support local, regional or national learning

This information is submitted to the LeDeR platform and themes and trends are collated for the city.

The LeDeR representative has recently started attending CDOP at which the death is reviewed.

During the CDOP meeting, the LeDeR representative may offer advice and expertise about learning disabilities (if appropriate) and ensure that the CDOP provides sufficient core data to support the LeDeR programme.

Total number of deaths in 2021-22 were 161 (Note these refer to deaths during 2021-22, rather than completed reviews, as in figure 2).

Number of LeDeR referrals was 9 (5.5%)

7 of these deaths were expected 2 were sudden and unexplained (SUDIC).

Reviews completed so far are 5 (4 are still waiting to be reviewed by CDOP)

Age range		Gender	

8 - 10	3	Male – 33%	
11 - 13	5	Female – 66%	
14 - 17	1		

Ethnicity	
White British	4
Black or Black British African	1
Asian/Asian British – Pakistani	3
Black or Black British - Caribbean	1

Classification of death at CDOP	
Chromosomal, genetic or congenital anomaly.	4
Infection	1
Cases not yet reviewed at CDOP	4

Modifiable factors	
Modifiable factors	1
No modifiable factors	4
Not yet reviewed at CDOP	4

Modifiable factors Modifiable are defined as 'those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'

Of the 9 cases that have been referred 6 had appropriate advanced care plans (ACP) in place. Themes throughout the cases are good working relationships and good communication between all teams involved with the child and family. Including a child being able to stay at home for end of life care as the cardiac consultant and nurse supported complex medications usually only used in hospital to mange difficult symptoms and ensure that the child was able to remain at home as per the families wishes.

Covid featured in the cases and in one case the child hadn't been seen face to face in clinic due to the pandemic for over 12 months.

6.0 Progress towards targets
In our last annual report we stated the following targets for this year as:

1. To address the backlog of deaths needing review at CDOP
   This has been addressed somewhat (see section 5.0) but it is expected there will be the need for some further catch up during 2021-22.

2. To support Birmingham Women's and Children's Hospital (BWCH) to implement effective Child Death Review Meetings

Significant support has been given to assist implementation. Some joint CDR meetings have occurred, and the benefit has been acknowledged. BCWH have made a business case for a co-ordinator to assist in implementation. BCWH have committed that all deaths from 1 April 2022 are to be subject to CDR meetings.

3. To review the provision of SUDIC services for Solihull, given the retirement of the current consultant providing 24/7 cover.
This has been addressed by combining the rota for Birmingham and Solihull. An additional Acute Paediatrician from UHB has joined the SUDIC rota to help support this.

4. To disseminate learning from deaths promptly by the use of tools such as 7 minute briefings
7 minute briefings have been produced for CDOP, SUDIC, Safer sleep, CONI and Bereavement support. A 10 minute training video has been produced regarding learning from a case of Arrested Development.

5. To continue to support the Infant Mortality Task Force
The CDRT and in particular Dr Garstang (Designated Doctor for Child Death) works closely with the newly established Birmingham Infant Mortality Task Force.

7.0 Recommendations for 2022-23
1. To ensure BCH implement joint CDRM for all deaths
2. To continue to catch up on cases delayed due to the Covid-19 pandemic
3. Ensure that all lessons learnt from the whole death review process are captured on eCDOP Analysis Form.
4. Ensure all CDRM are multi-agency and external professionals invited
5. To provide Joint Agency Response (JAR) training for health, police and coroners staff
6. Closer working with public health. Completing thematic analysis of deaths:
   a. Consanguinity
   b. Deaths compared to social deprivation
   c. Perinatal deaths and maternal health

8.0 Conclusion
The year 2021-22 has been busy as there were a backlog of cases due to the pandemic. The quality of information has improved significantly, which has led to better recognition of modifiable factors and more learning arising from deaths. However, this rich information also in turn has associated challenges as CDOP meetings and the associated preparation takes much more time. We aim to continue working closely with the Birmingham Infant Mortality Task Force and hope to contribute to further themed CDOP meetings over the next year.

References
1. HM Government. Working Together to Safeguard Children. London: Department for Education, 2018
2. HM Government. Child Death Review Statutory and Operational Guidance (England). In: Department for Health and Social Care, ed. London, 2018.
3. Sudden unexpected death in infancy and childhood, 2nd Edition, November 2016, The Baroness Helena Kennedy QC
4. National Perinatal Epidemiology Unit. Perinatal Mortality Review Tool / Parent Engagement Tools 2020 [Available from: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials.
5. Healthcare Safety Investigation Branch, Maternity Investigations. https://www.hsib.org.uk.

Birmingham Health and Wellbeing Board
Work Programme and Board Membership 2022-23

Board Members:

Name	Position	Organisation
Councillor Mariam Khan (Board Chair)	Cabinet Member for Adult Social Care and Health	Birmingham City Council
Dr Clara Day (Vice Chair)	Chief Medical Officer	NHS Birmingham and Solihull
Councillor Karen McCarthy	Cabinet Member for Vulnerable Children and Families	Birmingham City Council
Councillor Matt Bennett	Opposition Spokesperson on Health and Social Care	Birmingham City Council
Dr Justin Varney	Director of Public Health	Birmingham City Council
Professor Graeme Betts	Director for Adult Social Care	Birmingham City Council
Sue Harrison	Director of Education and Skills	Birmingham City Council
David Melbourne	Chief Executive	NHS Birmingham and Solihull
Richard Beeken	Chief Executive	Sandwell and West Birmingham NHS Trust
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Birmingham Children's Trust
Professor Robin Miller, PhD	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham
Richard Kirby	Chief Executive	Birmingham Community Healthcare NHS Foundation Trust

Douglas Simkiss	Medical Director and Deputy Chief Executive of Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Mark Garrick	Director or Strategy and Quality Development	University Hospitals Birmingham NHS Foundation Trust
Chief Superintendent Matt Shaer	Chief Superintendent	West Midlands Police
Riaz Khan	Senior and Employer Partnership Leader	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust	Birmingham Social Housing Partnership
tbc	tbc	Birmingham Chamber of Commerce
Co-optee		
Natalie Allen	Chief Executive of SIFA Fireside	SIFA Fireside
Patrick Nyarumbu	Executive Director Strategic Partnership	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

Committee Board Manager
Landline: 0121 303 9844
Email: Louisa.Nisbett@birmingham.gov.uk

Business Support Manager for Governance & Compliance
Landline:0121 303 4843
Mobile: 07912793832
Email: Tony.G.Lloyd@birmingham.gov.uk

Forward Plan: 2022/23

HWB Meeting Dates	27th September 2022	29th November 2022	31st January 2023	28th March 2023
Draft Papers Deadline	31st August 2022	9th November 2022	28th December 2023	1st March 2023
Final Papers Deadline	16th September 2022	18th November 2022	20th January 2023	17th March 2023
Standing items		**Cost of Living** **Cost of Living Crisis- Measures and Responses by BCC-** Greg Ward, Levelling Up Lead BCC **Cost of Living Crisis-** Peter Richmond, B'ham Social Housing Partnership	**Cost of Living** **Cost of Living Crisis – Update on Measures and Response -** Greg Ward, Levelling Up Lead, Birmingham City Council '**Cost of Living Crisis - system challenges and longer-term approaches to tackling poverty'-** Stephen Raybould, Programmes Director, BVSC **Cost of Living Emergency -** Andy Cave, Chief Executive, Birmingham Healthwatch	**Cost of Living** **Cost of Living response: Food Provision** Sarah Pullen, Food Systems Service Lead, Public Health
Items	**Approval of HWB ToR and membership 2022/23 -** Cllr Mariam Khan, Chair of the Health and Wellbeing Board	**HWB Strategy Update/Delivery Plan and Indicator Dashboard –** Jo Tonkin, Assistant Director, Public Health	**Triple Zero Drug and Alcohol Strategy –** Dr Mary Orhewere (Assistant Director, Public Health)	**Birmingham and Solihull Integrated Care System Ten-Year Strategy,** David Melbourne, BSol ICS **Birmingham and Lewisham African**

Joint BSOL PNA approval and delegation of sign off authority to the Steering Group - Jo Tonkin, Assistant Director, Public Health **BCF: End of Year Plan -** Michael Walsh, Head of Service - Commissioning, Adult Social Care **Early Intervention Programme Completion Report -** Michael Walsh, Head of Service - Commissioning, Adult Social Care **Sign off of the BCF Plan for 22/23 –** Michael Walsh, Head of Service - Commissioning, Adult Social Care **ICS Inequalities Strategy Update –** Lisa Stalley- Green, NHS Birmingham and Solihull (BSol) Integrated Care Board (ICB) **Birmingham and Solihull (Draft) Sexual Health Strategy 2023 – 2030 Public Consultation Report -**	**CHFC Annual Update -** Sarah Pullen, Food Systems Service Lead, Public Health **CCWIF- ToR Approval -** Monika Rozanski, Health Inequalities Service Lead, Public Health	**Infant Mortality Update** – Dr Marion Gibbon, Assistant Director, Public Health	**Caribbean Health Inequalities Review (BLACHIR) Progress Update –** Monika Rozanski, Inequalities Team Service Lead, Public Health **DPH Annual Report 2022/23 (Digital Technology) -** Dr Justin Varney, Director of Public Health **Birmingham Food System Strategy 2022-2030 –** Sarah Pullen, Food Systems Service Lead, Public Health **Adult Social Care Update** – Prof Graeme Betts, Director for Adult Social Care **Deep Dive Evidence Review - Learning Disabilities –** Luke Heslop, Evidence Service Lead, Public Health **Health Protection Forum Annual Report –** Chris Baggot, Health Protection Service Lead, Public Health

	Juliet Grainger, Adults Service Lead, Public Health **CCWIF -Progress update and future direction of the forum –** Tessa Lindfield, Assistant Director, Public Health			**Creating a City without Inequalities Forum Annual Report –** Monika Rozanski, Inequalities Team Service Lead, Public Health **Creating a Mentally Healthy City Annual Report -** Stacey Gunther, People Team Service Lead, Public Health
Written updates	Forum Updates	**JSNA** - Information Update Forum Updates	Forum Updates	**Joint Birmingham and Solihull PNA Final Report** Forum Updates

Standard Agenda

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

Notes

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

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

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

Public Questions

Public questions are to be submitted in advance of the meeting. Questions should be sent to: HealthyBrum@Birmingham.gov.uk.

	Agenda Item: 16
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**31st January 2023**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham Public Health**
Presenting Officer	**Aidan Hall**
Report Type:	**Information**

1. Purpose:
1.1. This update report details recent, current and future work related to: • Creating a Physically Active City Forum • Creating a Mentally Healthy City Forum • Health Protection Forum 1.2. The Creating a City without Inequalities Forum recently presented an updated terms of reference and outlined the future direction of the forum (November 2022). 1.3. The Creating a Healthy Food City Forum recently presented their annual substantive update (November 2022).

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

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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.   The Creating a Healthy Food City Forum is presenting at the November 2021 Board meeting, with the remaining forums providing a written update. Forums will continue to present on a rota basis, with each theme presenting at least annually.

4.3.   This report is formed of three written updates. Further detail specific to each Forum can be found in **Appendices 1-3.**

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**

5.2.1. Aidan Hall, Service Lead, Public Health
Stacey Gunther, Service Lead, Public Health
Kyle Stott, Service Lead, Public Health
Chris Baggott, Service Lead, 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	Medium	Medium	Robust monitoring and regular update reports via the relevant forum.

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required to enable the forums work.			

Appendices
Appendix 1 – Creating a Mentally Healthy City Forum Appendix 2 – Creating a Physically Active City Forum Appendix 3 – Health Protection Forum

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**Appendix 1 – Creating a Mentally Healthy City Forum Highlight Report**

1.   Context

1.1   The 'Creating a Mentally Health City Forum' (CMHC) has an explicit focus on the mental wellbeing of citizens in Birmingham, with an emphasis on upstream prevention and promotion of better mental health. It encompasses Suicide Prevention which has its own Advisory Group, Strategy and Action Plan. It is one of five partnership Fora supported by the Public Health Division with reporting responsibility to the Health and Wellbeing Board. These reports are based on the activities set out in the Forum Delivery Plan.

1.2   The aim of the CMHC Forum is to work with partners, stakeholders, academics, voluntary and third sector organisations, faith groups, and most importantly, our local communities to ensure that we are creating a City where all our citizens have opportunities to thrive and build a life that will enable them to achieve their potential and prosper.

2.   Current Circumstance

2.1   The November CMHC Forum commenced with a review of the Terms of Reference and agreement to update the membership of the forum.

2.2   The forum build on discussions from the September meeting and work of the framework for action taskforce group. Plans for the development of the framework for action were discussed and further volunteers welcomed to join the taskforce. The framework aims:

- To focus the efforts of the forum where it adds value by understanding need in the community
- To guide the work of the form towards a set of agreed priorities detailed in its action plan
- To enable work of the forum via collection of members of the forum and the wider community

Framework for action with underpinning action plan
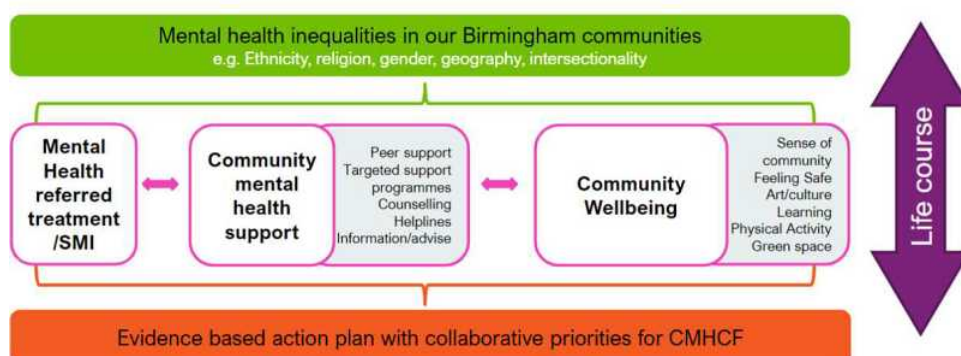
2.4   Forward Thinking Birmingham presented on Breathe Education, focusing on the Birmingham level dashboard.

2.5 CMHCF have responsibility for the Mental Wellness and Balance of the Health and Wellbeing Board Strategy. The new indicator dashboard was presented to the meeting and relevant indicators discussed.

2.6 The Cost-of-Living Crisis focus continued from the September meeting. A presentation was delivered on the Price we Can't Pay, a proposed Birmingham City Council Public Health Division project to understand the impact of the Cost-of-Living Crisis on mental health and wellbeing and to shape action. The tender has been released and closes on 5th January.

2.7 The Better Mental Health Fund projects have continued to address mental health inequalities in Birmingham. Nine projects have now been completed with the remaining projects ongoing to maximise the impact of the investment. An independent evaluation of the Birmingham project is currently being commissioned, 20 applications were received, contract award is expected to take place early in 2023.

2.8 Action has been taken to continue the legacy of the BMHF and six projects have been allocated further funding. Projects were allocated funding based on evidence of initial project success, clear need, and an ability to increase understanding of what works well for different communities.

2.5 The Suicide Prevention Advisory Group (SPAG) took place on the 25th of October 2022. The focus was to understand progress against the action plan. The SPAG is actively collecting information from our providers on progress on the Suicide Prevention Action Plan. The group supported the progress being made.

2.7 To address inequalities in mental health and create stronger relationships between Birmingham City Council and our Polish and Eastern European we have advertised for a partner organisation to support us in recruiting and managing an Engagement Officer for these communities. The contract is expected to be awarded early in 2023 with work commencing shortly afterwards.

3. Next Steps and Delivery

- The development of the Framework for Action

- Completion of the Better Mental Health Fund external evaluation

Appendix 2 – Creating a Physically Active City (CPAC) Forum Highlight Report

1.1   Context

The Forum last met on Wednesday 14th December 2022.

1.2   Current Circumstance

1. Cllr Liz Clements has been appointed as the new chair and this forum was her first meeting in the role. Cllr Clements had been briefed on the role and the forum's operation in advance of the meeting and provided with biographies of members to familiarise herself with attendees.

2. An item was presented to remind the new chair and the members of the targets and ambitions of the CPAC and that these are underpinned by Priority 3 of the JBHWS - Active at Every Age and Ability. Cllr Clements requested information about performance monitoring and this will be provided to all members for the next meeting.

3. An update on the progress with the Physical Activity Needs Assessment was presented. A review of existing evidence is underway and is due to be completed by the end of December and will be followed by mapping of current provision and identification of any gaps is due .

4. An evidence review of physical activity interventions that work is taking place - what's most effective and what the barriers might be. Learning points have been identified and a full written report will be available next year.

5. The development of a Physical Activity Strategy for Birmingham is in progress. Pre-consultation workshops will be taking place in January with a draft strategy to follow. CPAC members have been asked to contribute their support to this. Work has been taking place to align the Physical Activity Strategy to the Sport Strategy.

6. Updates were provided about the current work programmes, including the Daily Mile, The Safe and Active Mobility Campaign, Health Literacy Toolkits, and the outcome of the Tola Time campaign which concluded earlier this year. Members have been asked to look out for and share further information on these campaigns.

1.3   Next Steps

The next meeting of the forum will take place on Wednesday 8th February 2023.

Item 16 - Appx 3 – Health Protection Forum Highlight Report (January 2023)

1.1 Context

The Health Protection Forum (HPF) meets monthly to discuss and seek assurance on health protection arrangements from local health protection system stakeholders. The HPF discusses screening, immunisation, oral health, infection control, communicable and non-communicable diseases.

1.2 Current Circumstance

The HPF has set a plan for meeting topics for the 2022 meetings, alternating general meetings with subject-specific meetings on a bi-monthly cycle:

HPF meeting	Content
July 2022	Focused – Oral Health
August 2022	General HPF meeting
September 2022	Focused – Environmental Health & Non-Communicable Disease
October 2022	General HPF meeting
November 2022	Focused – Infection Prevention & Control
December 2022	General HPF meeting
January 2023	Focused – Communicable Disease

Recent discussions at the HPF have included:

a. The content, focus and key section of the annual report from the HPF to the Health and Wellbeing Board
b. Possible changes to the commissioning roles relating to the National Immunisation Programmes that are delivered locally, and currently commissioned by NHS England
c. Updates on the recovery of the cancer screening programmes following the unexpected changes put in place temporarily during the CoVid-19 social restrictions
d. Updates on the Group A Streptococcal incidents that occurred in November and December 2022 – particularly how the local support to Birmingham schools was facilitated by the Health Protection team supporting the Education and Schools support team, with support from UKHSA
e. Future options for the delivery of infection prevention and control services across the Birmingham and Solihull (ICS) footprint after the two existing covid-focussed commissioned service contracts conclude are still being discussed with the ICB and Solihull Public Health, using a business case jointly developed to support commissioning decisions
f. Flu and covid case rates and infection prevention and control activity
g. Cold weather resilience and planning, and integration of public messages with the council's cost of living messages
h. Investigations being led by UKHSA into rates of infectious diseases to determine any patterns or actions required

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1.3   Next Steps and Delivery

    a. Final draft of the health protection report for the March 2023 Health and Wellbeing Board meeting.

    b. Monitoring and assurance of the seasonal flu and SARS-CoV2 (Covid-19) vaccination programmes (led by the Immunisation Programme Board).

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Item 17 - Creating a Bolder Healthier City (2022-2030): Indicator Updates

The Health and Wellbeing Strategy has a series of ambitious targets for 2030. Each ambition is linked to an indicator that will be used to monitor progress and measure our impact. This update informs the Health and Wellbeing Board (HWB) of data that has been recently updated (since the previous HWB). The Power BI dashboard, which contains data for all indicators (including trends) can be viewed by clicking on the image below.

Click to view the dashboard

Recent Updates: 23rd November 2022 – 19th January 2022

Indicator	Theme	Date updated
Percentage of people with type 2 diabetes aged 40 to 64	Living, Learning and Working Well	03 January 2023
Percentage of people with type 2 diabetes who are of minority ethnic origin	Living, Learning and Working Well	03 January 2023
HIV late diagnosis (all CD4 less than 350) (%) (Persons, 15+ yrs)	Theme 5: Protect and Detect	30 November 2022
New HIV diagnosis rate per 100,000 aged 15 years and over (Persons, 15+ yrs)	Theme 5: Protect and Detect	30 November 2022
Year 6: Prevalence of obesity (including severe obesity) (Persons, 10-11 yrs)	Theme 1: Healthy and Affordable Food	29 November 2022
Reception: Prevalence of obesity (including severe obesity) (Persons, 4-5 yrs)	Theme 1: Healthy and Affordable Food	29 November 2022
Reception: Prevalence of underweight (Persons, 4-5 yrs)	Theme 1: Healthy and Affordable Food	23 November 2022
Year 6: Prevalence of underweight (Persons, 10-11 yrs)	Theme 1: Healthy and Affordable Food	23 November 2022