

Childhood
Obesity
Trailblazer
Programme

Final Evaluation Report

2019-2022





Executive Summary Introduction

The overarching aim of the Childhood Obesity Trailblazer Programme (COTP) was to create a city which enables all citizens to eat healthily and be active every day, including supporting children and families to achieve a healthy weight. The COTP project was designed to act as a catalyst to address the complex food system in Birmingham, driving forward change in the city.

This aligns with our Birmingham Food System Strategy, which is the city's ambitious eight-year approach to creating a bold, sustainable, healthy and thriving food system. This strategy is the outcome of three years of collaboration with partners and citizens; with the key aim of creating a whole-system strategy that demonstrates what

we need to enable radical change locally, and shape a food system for all.

We aimed to achieve the overarching aims of the COTP through three work streams. Work Stream 1 considered how to integrate public health into built environment processes, Work Stream 2 explored how to capture food system insights and data, and Work Stream 3 looked at health literacy development and identified barriers and enablers to implementation and practice.

The COTP enabled highly influential pieces of work for Birmingham City Council. Three work streams were developed to create a lasting legacy in Birmingham influencing how future projects are carried out. This has involved supporting the creation of a whole system approach to achieving these objectives and strengthening partnership and coordinated working. In addition, it has involved integrating the COTP projects and outputs with other work and initiatives happening within the council and across the city.

The shift from initially seeing the COTP work streams as a collection of single projects, to working towards broader objectives, has been instrumental in enabling a whole system approach and a joint vision across the council.

COTP Leadership

The COTP work streams have been led by the Public Health Division at Birmingham City Council. Initially led by the Place Team, and then the Food System Team post COVID-19 lockdowns. The University of Birmingham led the evaluation of Work Stream 3



Executive Summary Work Stream 1- Integrate Public Health into Built Environment **Processes**

About this Work Stream: Our aim was to create a planning and development system that routinely maximises opportunities for creating salutogenic environments, through the adoption of specific policies, practices and frameworks. We also wanted to maximise the opportunities to change planning and development policy that routinely offer improvement to the health and wellbeing of the population. We created a Healthy City Planning Toolkit Health Impact Assessment tool and explored how to embed a whole system approach to public health and planning.

Successes: Created a Healthy City Planning Toolkit to support with the Health Impact Assessment of planning processes, and designed it as a living document that can be built on in the future. Birmingham's approach goes beyond those recommended in national toolkits, and includes protected characteristics and digital technology. We have also developed an action plan to support the future embedding of public health in planning processes as part of a whole system approach. In addition, we have looked at how planning and land use can be considered from other angles, including from a community growing perspective.

Challenges: The Public Health Division's role in the emergency response to the COVID-19 pandemic, together with staff changes and sickness, meant that progress with this work stream was slowed.

Conclusion: This work stream has instigated projects and relationships across Birmingham City Council that will drive forward the public health and planning agenda. We are still on the start of this journey.

Lessons learned: It is essential that planning and public health colleagues work together collaboratively from the start. This ensures that the solutions produced are suitable for how corporate processes work in reality. Also, it is important to map out the existing planning processes in order to identify opportunities and potential challenges. A document that does not fit with existing processes will not be adopted. Finally, any resource should be a living document. Planning and public health guidance and policy are continuously developing, so any solution needs to be designed to evolve, too. No solutions should be static.

Test and Learn

Our approach evolved over time and rather than focusing on a single toolkit, we are now developing a whole system approach and closer working relationship between public health and planning colleagues.

Executive Summary Work Stream 2 - Capture Food System Insights and Data

About this Work Stream: Our aim was to develop tools, metrics and techniques to enable the effective capturing of insights and data across the food system to identify priorities and measure impact of actions. Our initial plan was to create a Birmingham Basket tool with consumer panel data to capture food purchasing habits in Birmingham, but our stakeholder and partner engagement activities led to us exploring many other tools to support with capturing food system insights. These included: a food affordability toolkit, asset mapping, community researchers, youth researchers, focus groups and surveys and questionnaires.

Successes: We have developed strong relationships with a wide variety of stakeholders and partners across Birmingham which has reduced duplication in tools and has increased innovation and solutions. The conversations that took place as part of the initial scoping of this work stream led to the Mandala Consortium focusing their food system research project on

Birmingham. We have ongoing project with community researchers and young people which will have impacts for years to come as we are developing tools that will be shared.

impacts for years to come as we are developing tools that will be shared.

Challenges: Communication and collaboration between diverse partners is challenging. Existing data collection across the food system is limited and GDPR and data laws mean that even when data is collected, it often cannot be shared between partners. Many data insight tools will require significant technology and software investment.

Conclusion: This is an exciting work stream that is embedded into the innovative food system work taking place in Birmingham. There are many conversations taking place with partners to explore solutions.

Lessons learned: It is necessary to ensure a variety of people are involved with the development of insight tools. This includes scientific and theoretical experts as well as those who are experienced in practical applications in real world settings. This will ensure any tools are scientifically robust, and logistically feasible to use. Also, it is important to develop strong relationships and communication with stakeholders and partners. Many solutions are already out there, or could be achieved through partnership working, so strong relationships and communication are key. Finally, the development of robust tools takes time with scoping existing tools, exploring ideas, validating plans, testing and refining the tools and gaining feedback so it is necessary to be patient.

Test and Learn

The test and learn approach of the COTP has been incredibly effective with this work stream. Continuously reflecting on our approach and feedback, and shaping the next steps, has been key to the momentum that has built in this area.

Executive Summary Work Stream 3 - Embed Health Literacy Development: Identify Barriers and Enablers to Implementation and Practice

About this Work Stream: Our aim was to develop accessible health literacy training modules for the different apprenticeship training levels on offer within Birmingham City Council.

Successes: A team at the University of Birmingham conducted the evaluation of this Work Stream and captured valuable insights and learning that will guide future health literacy projects.

Challenges: Staff changes and short timescales due to the impact of COVID-19 meant that we were not able to achieve a final training module. The rigid procurement processes of a Local Authority can be restrictive during a product development process.

Conclusion: The learning from this evaluation will be valuable in future health literacy project development.

Lessons learned:

- Allow plenty of time for module development to include time pilot-testing, tweaking and re-testing.
- Consider the design of modules separately for different levels of apprenticeship training.
- Ensure the brief for the tendering process is clear to manage expectations.
- Ensure clarity on the different apprenticeship courses offered and consider if the training needs for health literacy are homogenous even within the same levels of apprenticeship training offered.
- Allow plenty of time to follow the process of re-accreditation within established apprenticeship training schemes.
- Ensure adequate resources allocated to address diversity in content and delivery.
- Allow flexibility within local authority tendering processes to enable test and learn approaches.
- Consider what is already available with respect to health literacy training and ensure not duplicating effort.
- Ensure the course is interactive, with practical examples and flexibility in design to fit around busy schedules.
- Use a range of formats to promote accessibility, including a mix of online and face-to-face interaction, and avoid technical language.

Test and Learn

The test and learn approach enabled us to pause this project, review and learn from what had happened, and to adapt our approach going forwards. This means we have a valuable output with which to build future health literacy projects.

Executive Summary Recommendations

- 1. Develop **strong relationships and communication with stakeholders and partners** as many solutions are already out there, or could be achieved through partnership working, so strong relationships and communication are key.
- 2. Work **collaboratively from the outset** with colleagues from other departments, and with partner organisations and stakeholders. This ensures that the solutions produced are suitable for how corporate processes work in reality.
- 3. Ensure a **variety of people are involved with the development of solutions.** This includes scientific and theoretical experts, subject experts, those experienced in practical applications and real world settings. This will ensure that solutions are scientifically robust whilst still being logistically feasible to implement.
- 4. Be patient as the **development of robust solutions takes time.** Need to scope existing evidence and solutions, explore ideas, validate plans, test and refine the solution, gain feedback, and evaluate. Separating the project up into parts can help ensure that each phase influences the next and allows for the plan to evolve over time.
- 5. Utilise participation-observation research techniques to gather insights from real world settings.
- 6. Initially **map existing processes before developing solutions**. Identify opportunities and potential challenges. A solution that doesn't fit into this existing process will likely not be adopted.
- 7. Consider solutions from the **perspective of diverse people** at every stage of the process, and capture feedback from a wide variety of people, to ensure that the solution is as effective as possible.
- 8. Create **living documents that evolve**, rather than static tools, to allow for guidance and policy that continuously develop.
- 9. Ensure that briefs for product development and partner relationships are clear, manage expectations, and regularly review and refine the brief as things evolve.
- 10. Ensure **adequate resources to address diversity in content and delivery**, and to ensure the resources are interactive and engaging, and use a range of formats to promote accessibility.



Contents

Childhood Obesity Trailblazer Programme Final Evaluation Report 2019-2022

- 8 Introduction
- 12 Work Stream Objectives
- 14 Work Stream 1 Integrate Public Health into Built Environment Processes
 - 18 Methodology
 - 22 Findings and Discussion
 - 25 Successes and Challenges
 - 27 Conclusion
- 28 Work Stream 2 Capture Food System Insights and Data
 - 30 Methodology
 - 33 Findings and Discussion
 - 45 <u>Successes and Challenges</u>
 - 47 Conclusion

- 48 Work Stream 3 Embed Health Literacy

 Development: Identify Barriers and Enablers to

 Implementation and Practice
 - 53 Methodology
 - 58 Findings and Discussion
 - 89 Successes and Challenges
 - 90 Conclusion
- **92 COTP Conclusion**
- **94 Recommendations**
- 95 Authors





About the Childhood Obesity Trailblazer Programme

The overarching aim of the Childhood Obesity Trailblazer Programme (COTP) was to create a city which enables all citizens to eat healthily and be active every day, including supporting children and families to achieve a healthy weight. The COTP project was designed to act as a catalyst to address the complex food system in Birmingham, driving forward change in the city.

This aligns with our Birmingham Food System Strategy, which is the city's ambitious eight-year approach to creating a bold, sustainable, healthy and thriving food system. This strategy is the outcome of three years of collaboration with partners and citizens; with the key aim of creating a whole-system strategy that demonstrates what we need to enable radical change locally, and shape a food system for all. We aimed to achieve the overarching aims of the COTP through the following actions:

- Reviewing what shapes the built environment in Birmingham, including planning and land use processes, and identifying opportunities and barriers to improving public health.
- Developing tools, metrics and techniques to enable the effective capturing
 of insights and data across the food system to identify priorities and
 measure impact of actions.
- Improving health literacy across the city through the development of resources, and integrating learning and development resources into existing projects and processes.

Whole System Approach

The COTP project has facilitated and driven forward a highly influential areas of work for Birmingham City Council (BCC) by instigating a whole system approach to public health, through facilitating partnership working and coordinated approaches.

The COTP Journey in Birmingham

When the COTP Programme started in Birmingham in 2019, it was initially led by the Place Team within the Public Health Division in Birmingham City Council. The portfolio of this team included food and physical activity. However, the COVID-19 pandemic and lockdown, and the role of the Public Health Division staff in the city's emergency response, meant that progress with the COTP slowed down and initial plans had to be adapted. The Food System Team was set up in August 2021 and began leading the COTP work streams. The team includes four team members: a service lead, senior officer, officer and graduate officer.

The new Food System Team members brought relevant expertise and experience and brought momentum to make the final year of the project as successful as possible. Their role has been to develop the Birmingham Food System Strategy, lead the Creating a Healthy City Food Forum with partners across the city, deliver on projects related to the food system, and deliver the COTP work stream projects. The graduate officer dedicated to the COTP work streams moved to a new job in December 2021, and the replacement graduate started their role in March 2022.

Running COTP during the disruptions in staffing and systems caused by Covid has required creativity, alongside adaptable plans and timelines to maintain momentum on the work streams. The team has overcome issues such as delays in procurement through remaining agile in the face of obstacles. In the development of projects, contingency plans have always been considered including embedding projects as part of our wider city processes and work streams.

Embedding this work as part of a whole system approach, and linking to existing projects led by other teams and partners, has been a key way to ensure impact and legacy.

The Food System Team has also had to be adaptable to new ways of working due to the Covid-19 pandemic ensuring that, despite these challenges, the goals of the COTP project were met.

Birmingham's Approach

The COTP enabled highly influential pieces of work for Birmingham City Council. Three work streams were developed to create a lasting legacy in Birmingham influencing how future projects are carried out. This has involved:

- Negotiating consensus on the overarching objectives for each of the three
 COTP work streams, so the legacy integrates with other BCC work and priorities.
- Supporting the creation of a whole system approach to achieving these objectives and strengthening partnership and coordinated working.
- Integrating the COTP projects and outputs with other work and initiatives happening within the council and across the city.
- Ensuring the legacy of the COTP continues beyond the end of the programme, and the projects and outputs are integrated into wider delivery plans.

The shift from initially seeing the COTP work streams as a collection of single projects, to working towards broader objectives, has been instrumental in enabling a whole system approach and a joint vision across the council.

Work Streams

Work Stream 1

Integrate Public Health into Built Environment Processes

Work Stream 2

Capture Food System Insights and Data

Work Stream 3

Embed Health Literacy Development: Identify Barriers and Enablers to Implementation and Practice

Work Stream Objectives

Work Stream 1 - Integrate Public Health into Built Environment Processes

Objective: Review what shapes the built environment in Birmingham, including planning and land use processes, and identify opportunities and barriers to improving public health.

Projects: Macro level - Healthy City Planning Toolkit, micro level - Exploration of Utilising Land for Community Growing Projects.

Work Stream 2 - Capture Food System Insights and Data

Objective: Develop tools, metrics and techniques to enable the effective capturing of insights and data across the food system to identify priorities and measure impact of actions.

Projects: Youth Voice, East Birmingham Food System Exploration, Mandala Consortium Collaboration.

Work Stream 3 - Embed Health Literacy Development: Identify Barriers and Enablers to Implementation and Practice

Objective: Improve health literacy across the city through the integration of learning and development resources into existing projects and processes.

Projects: Spiral Curriculum Health Literacy Apprenticeship Modules



Aims of this Evaluation Report

The aim of this final evaluation report is to evaluate the three COTP work streams individually and the COTP project as a whole. This will be achieved through reviewing the following elements in the light of the original objectives:

- The design of the project and its activities.
- Lessons learned from implementing the projects (facilitators and barriers).
- Adapting to Covid-19.
- Progress against plans (achievement of original objectives).
- Results of projects.
- Reflections on what might have been done differently.
- The lasting legacy of the project.
- Plans for sustaining project activities.

This report will highlight the achievements of the COTP project and the key lessons from what has worked well and what has been challenging. It will provide lessons and learning for other local authorities who are looking to undertake similar actions and projects in the future.

Structure of the Report

The report will follow a structure whereby each work stream will be evaluated under the following headings; description of COTP work stream, findings and discussion: implementation and delivery, findings and discussion: outcomes and impacts, sustainability of initiatives/legacy, conclusions and recommendations.

There will then be a broad summary of conclusions and recommendations for the COTP project as a whole.



Description of Work Stream 1

1.1 Aims/Objectives

Our aims were:

- To create a planning and development system that routinely maximises opportunities for creating salutogenic environments, through the adoption of specific policies, practices and frameworks;
- To maximise the opportunities to change planning and development policy that routinely offer improvement to the health and wellbeing of the population.

Our objectives were to test the limits of our planning and health powers and levers by doing the following:

- Building a case to place health/wellbeing within the emerging (refresh)
 Birmingham Development Plan and supporting planning policy documents;
- Ensuring that planning and development decisions prioritise health and wellbeing opportunities for the population;
- Ensuring that the developer toolkit (a toolkit designed to engage planning applicants at the earliest stage of the planning and development process) is embedded into planning policy and is routinely used to create better health and wellbeing outcomes for our citizens;
- Ensuring that section 106 funds are routinely considered, and wherever possible, awarded to work that will improve health and wellbeing;
- Ensuring that there are mechanisms for communities to express their health needs during the planning process;
- Creating environments that allow people to make healthier lifestyle choices, and will impact upon the wider determinants that drive obesity. They include access to safe, abundant physical spaces to be able to participate in habitual/planned physical activity, safer connectivity to encourage active travel, opportunities for community food growing at scale, and opportunities to provide better food/nutrition options, avoiding monopolisation by major retailers and those retailers who routinely provide unhealthy options and encourage poor food and nutrition choices.

Original COTP Work Programme

WP1 Planning and Development - Identifying the Key Levers, Baseline Mapping and Achievement of Time-Sensitive Opportunities

1.2.1 Rationale Behind the Work Stream

- The environment we live in impacts our health. By creating healthier built and natural environments we can prevent premature mortality and disease, enhance social cohesion and encourage physical activity. In contrast, a poorly designed built environment can adversely impact upon population health and lead to inequalities in both health and wellbeing.
- When done well, combining planning and health can achieve measurable improvements for the environment, whilst ensuring economic growth and reducing costs, complexity and delays for developers.
- Birmingham, as the 2nd city, is behind in its application of health/wellbeing as a priority within its own planning and development functions, and we can learn from other cities to address this imbalance, and look to innovate where there are gaps.
- Through working with the BCC planning team and other council
 departments, we can demonstrate the importance of coproduction and
 emphasise the cross over between our priorities. This stresses the
 importance of a whole system approach, which cannot be achieved by a
 single department.

1.2.3 Changes to the initial plan in 2021

We broadened our approach to include considering how we could influence other levers that influence public health, planning and land use in Birmingham, including:

- Considering the processes involved with land use on a micro level from a community perspective, but considering the barriers to community growing;
- Looking at practical solutions for how public health and planning colleagues could work more closely together;
- Developing an action plan to ensure a whole system approach.

Impact of COVID-19

Progress in this work stream slowed during the pandemic. When momentum built back in 2021 we reviewed how a whole system approach to planning and public health could be embedded.

1.3 Wider Policy Context

- There is national guidance on planning and health through the National Planning Policy Framework. As a public health authority, we have NICE and PHE guidance on planning and health, we also have national good practice published through the Town and Country Planning Association (TCPA).
- See National Planning Policy Framework GOV.UK (www.gov.uk), Spatial planning for health: evidence review GOV.UK (www.gov.uk), Healthy Place-making Town and Country Planning Association (tcpa.org.uk)
- There are untapped powers and levers at a local decision, particularly for new developments, that we have not yet implemented or tested, including bylaws, local planning policies, through our Birmingham Development Plans and the Supplementary Planning Documents (SPDs).
- We have been able learn from other cities to address this imbalance and look to innovate where there are gaps.
- Examples of guidance tool and documents include the London Healthy Urban Development Unit (HUDU) assessment tool and related documents, and the World Health Organisation publication, Healthy Urban Planning (by Hugh Barton and Catherine Tsourou).

Learning from other cities

Other Local Authorities have been able to share key learning and resources they developed whilst they went through this process which Birmingham has now benefited and learned from.

During Autumn 2021, the Food System Team had learning sessions with other Local Authorities in England about how they have utilised their own Health Impact Assessment tools within planning processes, and Nottinghamshire have shared their policy and process documents.



1.4 Embedding Public Health Considerations into Planning Processes

This work stream has explored planning policy and processes in Birmingham and incorporated consideration of the health impact of planning proposals in the development of the Healthy City Planning Toolkit. See appendix 1. The intention was that the toolkit will assist in identifying future development of policy and practice for urban planning in Birmingham to further embed health and wellbeing considerations. The toolkit has been designed with a number of prompts for developers, architects and planners to consider and assess the impact that new developments have on the health and wellbeing of the population.

1.4.1 Toolkit Content

- **1.Overview:** This section provides guidance as to how the toolkit can be used. It also describes the three zones in which developments can be divided into; the core zone, the walkable zone and the buffer zone.
- **2.Preliminary Checklist:** The checklist provides you with an 'at-a-glance' summary of the 14 criteria that will form the basis of initial discussions with Public Health and Planning and the areas scrutinised as part of the assessment of the final planning document.
- **3.Rapid Health Impact Assessment (HIA):** A HIA ensures that the impact of the development on both health and health inequalities is deliberated and addressed during the planning process. The toolkit includes a HIA template, setting out key questions for consideration. The assumption is that this will encourage the creation of healthy communities through health-promoting planning. Key themes include housing quality and design, access to healthcare services and social infrastructure and access to open space and nature, heritage and culture.
- **4.Guide and Appendices:** To supplement the HIA, this guide provides links to national and local resources and policy by themed areas, impacts of risk, additional considerations and information.

The Toolkit supports the creation of healthy communities through health-promoting planning policies, design and development management in Birmingham.

It is also being used to identify aspects of the built environment which have an impact upon the health of Birmingham's residents.



1.4.2 Rationale Behind Toolkit Content

- Research for the contents of the toolkit, included reviews of national guidance documents (see section 1.2: wider policy context) and gathering of learning from other Local Authorities in England from their experience of Health Impact Assessment tools within planning processes, e.g.,

 Nottinghamshire.
- Content was checked with colleagues, including planning and legal as part of the pre-consultation to ensure that the content was correct.
- Public Consultation on the toolkit commenced March 2021. The feedback from public consultation was included in the final design of the toolkit.
- Our toolkit is an evolution of the standard HIA, including protected characteristics and digital technology. We included protected characteristics in as the built environment can contribute to a more equal, inclusive and cohesive society if places, facilities and neighbourhoods are designed to be accessible and inclusive for all. Inclusive design aims to remove the barriers that create undue effort and separation.
- Digital and technology were included as future planning for telecom infrastructure within the initial stages of planning can support new technologies, consumer choice, and greater connectivity for those who need it. Both these sections provide additional guidance, currently not included in the national framework.

1.4.3 Public Consultation

- The public consultation for the Birmingham Healthy City Planning Toolkit went out in March 2021 and continued until June 2021.
- For us to get rich feedback, we directly reached out to stakeholders from across the city such as GPs, pharmacies, universities, schools, strategic forums, community partners and more.
- A total of 22 responses were received, and all the findings were collated into a report that has been shared with key colleagues in BCC who are driving this project forwards.

1.4.4 Action Plan

- In February 2022, the Food System Team developed an action plan for the Healthy City Planning Toolkit, detailing how the toolkit could be embedded into planning processes in the long term. This action plan was developed through meetings with the BCC planning department, ensuring co-production across council departments.
- The recruitment process for the new Public Health Built Environment Team, who will be responsible for owning and driving this project, has gained momentum with some positions now in post.

1.4.5 Use of the Toolkit

- The Planning Toolkit is actively being used by planning colleagues, for example, in Spring 2021 it was utilised as a Health Impact Assessment tool as part of developments at the Edgbaston Reservoir, and Perry Barr Athletes Village for the Commonwealth Games.
- The Public Health Built Environment Team will work with the BCC planning team to develop a Birmingham version of the policies and processes that have been shared by other Local Authorities, including Nottinghamshire. The planning team and Public Health Environment Team will also work to influence the Birmingham Development Plan that will underpin housing and other developments over the coming years.

A Living Document

The Planning Toolkit is a living document that will be reviewed and developed to embed other public health priorities into planning and development processes as appropriate.

1.5 Creating a whole system approach to public health and planning that continuously evolves - macro level:

- In the final stages of the COTP project, we expanded our approach considering how our work on the Healthy City Planning Toolkit can link to other areas of work within the council to develop a whole system public health approach to planning.
- For example, we have been considering the overlaps with the Compassionate Cities Charter. This work is being carried out by the Older People team within Public Health, which aims to facilitate improved health and wellbeing through kindness, compassion and how we cooperate and support each other.
- There is an opportunity to align planning processes with achieving best practice guidelines and tackling the priorities across public health through coordinated approaches and working.
- For example, the provision of healthy green spaces and community growing areas achieves several priorities including increasing physical activity, reducing isolation and improving community connections.
- We have moved the Healthy City Planning Toolkit Health Impact Assessment from being a static final document to instead being a living document. This means it will be reviewed and evolve so it builds on the latest guidelines and evidence and can therefore be an agile tool with which to tackle the biggest public health challenges related to our built environment.

1.6 Creating a whole system approach to public health and planning that continuously evolves - micro level:

- In addition, we have been considering how partnership working and improved communication can overcome the barriers within planning and land use processes in our city.
- We have worked with The Active
 Wellbeing Society, who are a member
 of our Creating a Healthy Food City
 Forum, to explore how we can improve
 processes and overcome barriers, so
 communities can engage with Local
 Authorities to identify growing sites and
 release land to local communities for
 food growing purposes.
- Solutions being trialled includes risk assessments and responsibility for safety on the land being held by larger community organisations, rather than individuals. This is forming part of our wider approach to planning and health and improving the city's food system by empowering communities.
- A report on this work will be written later on in 2022 which will be shared on the BCC website.

Findings and Discussion: Implementation and Delivery

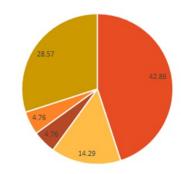
1.7 Key Feedback from Public Consultation

- "The Planning Committee of Birmingham Civic Society consider this a timely and thoroughly considered proposal. We have found in assessing applications that many fail because of a lack of consideration of aspects of design within the Toolkit and having the facilities to assess design in this respect, and better still enforce better design, is very welcome. BCC are to be congratulated for such a thorough document at consultation stage."
- "These proposals have been 10 years in the development, and it is good to see them becoming more formally adopted and integrated into the planning processes."
- "This is a positive initiative towards integrating health in planning..."
- "...Without any targets to reach, it becomes a document easy for planners to write around."

1.7.1 Overall

- Most responders strongly agree with the principle of having such a toolkit.
- Most responders agree that all the indicators should be in the toolkit.
- "This is a timely and thoroughly considered proposal that has allowed the community to bring ideas forward and contribute on how planning can and should impact health positively."

Agreement with the principle of having such a toolkit



Strongly Agree Agree Don't Know Strongly Disagree Not Answered



1.7.2 Concerns

- "The non-binding status of the toolkit makes it not compulsory for planners to consider or implement."
- "The toolkit needs to be clearer, more specific and measurable on what exactly developers need to do."
- "Where will the cost and funding for this come from?"
- "Will it apply to every area or ward in the city?"
- "There is no reference to compliance to BS kitemark scheme, FENSA schemes etc."

1.7.3 Outcomes

- Development of the Healthy City Planning Toolkit as a living document.
- Development of an action plan to implement the Healthy City Planning Toolkit.
- Building relationships with other council departments e.g. BCC planning department, ensuring coproduction across council departments.
- Creation of a new Public Health Built Environment Team, responsible for owning and driving the project.
- Influence over current planning projects, such as the Birmingham Development Plan, highlighting the importance of health with regard to planning policies.



1.6 Progress against objectives

We have made good progress, but we are still working towards achieving the following objectives:

- Building a case to place health/wellbeing within the emerging (refresh) Birmingham Development Plan and supporting planning policy documents;
- Ensuring that planning and development decisions prioritise health and wellbeing opportunities for the population;
- Ensuring that the developer toolkit (a toolkit designed to engage planning applicants at the earliest stage of the planning and development process) is embedded into planning policy and is routinely used to create better health and wellbeing outcomes for our citizens;
- Ensuring that section 106 funds are routinely considered, and wherever possible, awarded to work that will improve health and wellbeing;
- Ensuring that there are mechanisms for communities to express their health needs during the planning process;
- Creating environments that allow people to make healthier lifestyle choices, and will impact upon the wider determinants that drive obesity. They include access to safe, abundant physical spaces to be able to participate in habitual/planned physical activity, safer connectivity to encourage active travel, opportunities for community food growing at scale, and opportunities to provide better food/nutrition options, avoiding monopolisation by major retailers and those retailers who routinely provide unhealthy options and encourage poor food and nutrition choices.

We have the Creating a Healthy City Toolkit, an action plan with steps that are needed next, and have an emerging partnership between public health and planning colleagues, but the journey is still at the early stages in Birmingham.



Findings and Discussion

1.8.1 Successes

- The toolkit has been endorsed by: Birmingham's Corporate Leadership Team (November 2020), Creating a Physically Active City Forum: subgroup of the Health and Wellbeing Board (December 2020), Health and Wellbeing Board (January 2021)
- A presentation on the toolkit was given at the Innovation in Research and Industry Symposium at Birmingham City University in October 2021. Once available, a recording of the presentation will be shared with other local authorities who would like to learn from this work stream.
- The toolkit has been co-produced with key stakeholders. We have
 established a partnership approach with the planning team and Public
 Health Built Environment Team to develop policies and processes and
 embed the approach in BCC planning policy, and both teams are onside,
 taking ownership and aware of what is needed.
- We are exploring the possibility of developing a Healthy Urban
 Development Group for Birmingham, one of the core objectives is to
 ensure that the toolkit is prioritised for adoption into local planning
 guidance and sits alongside the local validation criteria for all major
 developments.
- The creation the Healthy City Development Toolkit action plan outlines how it can be integrated into the planning process, making it easier for the new Public Health Built Environment team to embed it into planning processes when they begin their work. This action plan has been approved by the Director of Public Health.

Review of Planning Processes

The Birmingham Development Plan is currently being reviewed and opportunities to influence public health outcomes are being identified.

1.8.2 Challenges

- We faced the challenge of increasing the number of the members of the public and stakeholders who were engaged in the toolkit consultation. This was because the toolkit was a very long document, which included 14 indicators, which had their own set of questions in the consultation questionnaire.
- As an attempt to overcome this, we approached key stakeholders and encouraged them to complete the consultation and sent reminders. We responded swiftly to feedback and produced a 'How to download the toolkit' guide as some people had trouble accessing it from the Birmingham City Council website. This increased the total number to 22 relevant responses, and we have taken note of this barrier for future consultations.
- From anecdotal feedback, it seemed that some may have felt that the document was not relevant to them due to its technical nature, and did not realise that they could influence it.
- A key learning point has been the importance of making consultations feel relevant and emphasising the value of perspectives from different sectors/areas to reveal issues that we have missed.
- The recruitment process for the Public Health Built Environment Team, who will be taking forward the toolkit work has been challenging, with delays with the implementation of the action plan.

1.8.3 Impact of COVID-19

- Throughout the project, we have become increasingly aware of the effect of COVID-19 and how our internal response to the pandemic has impacted on our ability to deliver all work programmes within the COTP. We closely monitored the progression and milestones to ensure we are able to deliver and evaluate and that we capture all learning along the way.
- The Food System Team have introduced a robust method for capturing key actions, tasks, timelines, updates and feedback to ensure it is captured for effective delivery and evaluation, even with staff sickness or competing priorities due to the Public Health COVID response.

Sustainability of Initiatives and Legacy

1.9.1 Whole System Approach

- The projects carried out through this COTP work stream have instigated a whole system approach to planning and public health within the council and facilitated partnership working and coordinated approaches. This will leave a legacy and have a lasting impact in the city.
- A Public Health Built Environment Team is being recruited, who will
 own and drive this project post-completion of the COTP, resulting in
 longevity of the work stream. This will facilitate closer working
 relationships with planning teams beyond the use of the toolkit.

1.9.2 Living Document

• The Healthy City Planning Toolkit Health Impact Assessment has moved from being a static final document to instead being a living document. This means it will be reviewed and evolve so it builds on the latest guidelines and evidence and can therefore be an agile tool with which to tackle the biggest public health challenges related to our built environment.

Lessons Learned

Lesson 1: Work collaboratively from the outset

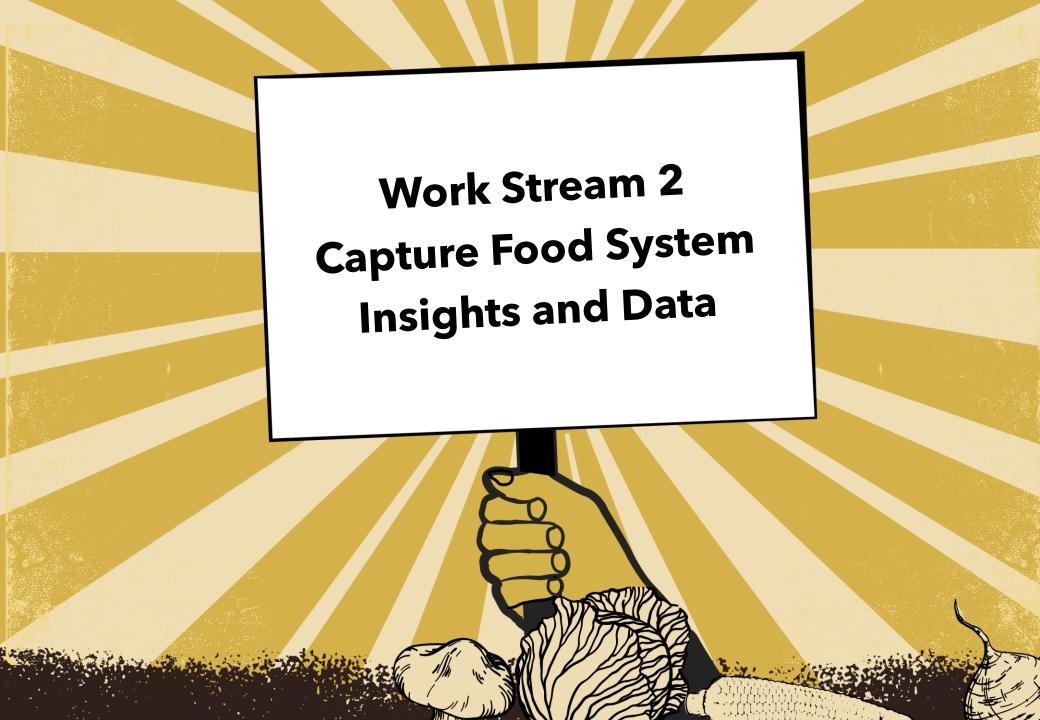
It is essential that planning and public health colleagues work together collaboratively from the start. This ensures that the solutions produced are suitable for how corporate processes work in reality.

Lesson 2: Map existing processes before developing solutions

It is necessary to map out the existing planning processes in order to identify opportunities and potential challenges. A document that does not fit with existing processes will not be adopted.

Lesson 3: Create a living document

Planning and public health guidance and policy are continuously developing, so any solution needs to be designed to evolve, too. No solutions should be static.



Description of Work Stream 2

The purpose of this work stream was to develop a "Birmingham Basket". The intent was for this to reflect the national shopping "basket of goods" by capturing what food citizens typically buy and at what cost, but at a local level. This type of basket measure has not been attempted at a local level before.

1.1 Aims/Objectives

Our aims were:

- To give Birmingham the ability to be able to identify localised baselines of consumer habits
- To capture localised data and utilise an innovative approach to measure our impact and to lever new approaches

Our objectives were:

- To set a national standard and develop and continuously refine high quality, relevant metrics as barometers to measure the impact of our efforts to improve the health and wellbeing of our population, especially from a food/nutrition perspective;
- To develop direct indicators of how good a whole system approach is, or is not, working in relation to food/nutrition;
- To develop a measure of consumer food shopping habits through a "Birmingham Basket" that gives us a clear baseline;
- To ensure we use the metrics available to us in innovative and useful ways;
- To share data and metrics more effectively with stakeholders and partners;
- To be able to use these baselines as a lever to effect change, to measure these changes, and to be able to report success;
- Impact positively on the 'Birmingham Basket' to reduce the overall calorific content and improve the proportion of fruit and vegetables (dependent on support for metric development).

Original COTP Work Programme

WP2 The Birmingham
Basket Metric Identification and
Localised Design Phase

Methodology and Approach

1.2.1 Initial Plan

Our plan for year 1 was to consult extensively with stakeholders with reference to the development of the Birmingham Basket. This especially included Kantar and similar organisations who gather shopping data and have consumer panels to capture purchasing habits of households. We expected to see the development and piloting of the tool in year two, with full adoption in year three.

The ambition for the end of year three was to have a truly unique and practical tool to measure the progress against a baseline of population habits associated with poor and good health and wellbeing.

1.2.2 Changes to the Initial Plan

Our planned approach changed for three key reasons:

1. Stakeholder feedback

Following extensive consultation with stakeholders we realised that the "Birmingham Basket" concept had challenges and it was necessary to explore other tools and approaches. Challenges included a significant gap in accessible data on consumption of food at a local authority level and sample sizes of national data sets not being large enough to be representative of Birmingham.

2. COVID-19 Pandemic

COVID-19, lockdown and Public Health Division staff being redeployed into emergency response roles meant that stakeholder consultation was delayed and the team leading on the project changed.

3. Birmingham Food System Strategy and Birmingham Food Revolution

The emerging food system work taking place in the city is intrinsically linked to this work stream, and the development of tools and metrics has been key to our broader approach.

Test and Learn

This work stream has continuously developed in response to feedback, and has been connected into a whole system approach.

1.3 Evolving context

The stakeholders, partners, and priorities in Birmingham have developed since this COTP work stream began in 2019. This evolving landscape has shaped the approach we have taken as part of a whole system approach.

The Mandala Consortium

In 2019 we reached out to food system experts and began conversations to explore food system metrics and research. These conversations inspired a consortium of universities to focus their research project application on our city.

The Mandala Consortium is conducting research into food system transformation focused on the city of Birmingham. The research consortium includes international experts in population health, food and nutrition, environmental sustainability, health economics and commerce, renowned for their disciplinary expertise, theoretical and methodological developments, and capability for strategic leadership.

The research began in 2021 and is being funded through the <u>UK Research and Innovation</u> (UKRI) <u>Strategic Priorities Fund (SPF)</u>, with a budget of £6 million for research that will take 5 years. The Birmingham Food System Team lead on both the COTP work streams and the partnership work with the Mandala Consortium. They have been instrumental with the development of this work stream in particular, as they have been conducting interviews and focus with people from across the food system, and are developing insight tools and metrics. They are using their findings to develop and test pilot food system projects in Birmingham in the coming years.

East Birmingham Inclusive Growth Strategy

We are supporting the 2021 East Birmingham Inclusive Growth Strategy. This strategy sets out the council's 20-year vision for the transformation of East Birmingham. This will be delivered through a focus on both places, including improving transport connections and stimulating growth, and people including involving local communities in shaping this growth and partnership working to improve the way that the public sector works. We have utilised this opportunity to capture insights about the food system in this area of Birmingham.

1.4.1 Our revised approach

We adapted our plan to not limit ourselves to the development of one specific tool, and instead broaden our approach to the development of metrics and tools in general to gain insights into the food system. Our revised approach included:

- Increasing our stakeholder engagement and co-production approaches with universities, community organisations and communities themselves;
- Exploring the feasibility of measuring consumer food purchasing habits on a localised level;
- Developing tools in response to need demonstrated during engagement activities with stakeholders and partners;
- Developing tools and approaches to capture barriers and facilitators to increasing supply and demand of healthier and more sustainable food.

1.4.2 Guiding principles of the tools

Key principles of the tools we wanted to develop included:

- Ensuring the tools capture data that is useful and needed;
- Engaging with experts and being influenced by evidence and best practice to ensure the tools are scientifically robust;
- Co-producing tools with those that will utilise them, or use the data that comes from them, to ensure they are fit for purpose;
- Considering costs, staffing and logistics for using a tool and analysing the data in the long term, to ensure their continued use is feasible and sustainable.
- Identifying opportunities to connect with other work and priorities across the city;
- Considering data sharing, confidentiality, GDPR, logistics of collection, storing and sharing of data and possible limitations.

There is increasing interest in capturing food system insights and data so this work stream has been guiding Birmingham's approach at a pivotal time. We are now having conversations with experts and stakeholders on a local, national and global level with a joint ambition of developing tools.

Findings and Discussion

1.5.1 Stakeholder and Partner Engagement Pre-COVID 2019-2020

- Established 'Creating a Healthy Food City Forum of stakeholder from across the city reporting to Health & Wellbeing Board.
- Engaged with topic experts including academics, universities, ONS and Kantar consumer research company to explore what data and tools are already available.
- Seldom Heard Voices where 27 local (expert) providers appointed to carry out consultation within communities across 23 community groups. Within the findings, citizens have said that the food environment of the city is not supporting them to live healthy lives and asked us to change this.
- Committed to developing a new strategy to Create a Healthy Food
 City and through this to be able to track impact and progress in terms
 of food consumption at meaningful scale.
- Launched the Birmingham Food Conversations to increase understanding of people's relationship with food across Birmingham including surveys and focus groups which formed part of the National Food Strategy.
- Continued with international partnerships including the Milan Urban Food Policy Pact (MUFPP), a European partnership for action on creating healthy food environments in cities and towns, with a network of 217 cities across the world. An exercise was conducted to map food indicators against the Milan Urban Food Policy Pact indicator suite and found many gaps.

Birmingham Digital Food Hunt

This activity was carried out in June 2019 to map data sources across the food system in Birmingham.

The conclusion of this work was that you should not assume that the data, information and insight on food is available.

This is a local and national issue for food system and there is a significant gap in accessible data on consumption of food at a local authority level or sub-geography level.

The hunt identified very limited access or availability of local level data on the food system. None of the national data sets on food have a large enough sample size in Birmingham to be representative.

Findings and Discussion

1.5.2 Stakeholder and Partner Engagement Post Lockdown 2021-22

Work on the COTP projects slowed due to the Covid-19 pandemic lockdown and Public Health Division's role in the emergency response. The work built up momentum again in September 2021 when the new Food System Team were set up and led on the COTP as well as developing the Birmingham Food System Strategy.

In April 2021, Birmingham became a member of the Steering Committee of the Milan Urban Food Policy Pact. Birmingham is leading the pan city thinking on cultural dimensions of the food system and the political narrative around Food Justice. In 2021, we also formed part of the Food Cities 2022 Learning Partnership. These partnerships, together with the Mandala Consortium food system research project, have been instrumental in ensuring that the tools we have been looking to develop are being shaped by world leading food system experts.

The pandemic cast a harsh light on our food security and revealed how important our food systems are. There was increased awareness across the city about food supply chains and how many people don't have access to enough food. This has led to a united movement and willingness to work together to transform our city's food system, and instigated the Birmingham Food Revolution.

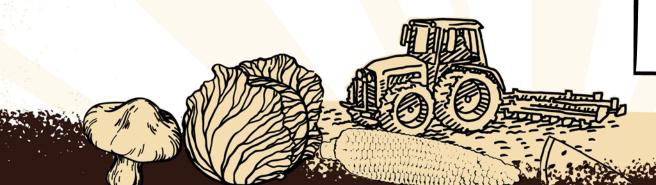
Birmingham Food Revolution

The Creating a Healthy Food City Forum led the development of the Birmingham Food System Strategy.

A key driver of the food system transformation taking place across the city has been the city-owned Birmingham Food Revolution, and capturing the stories and best practice from our Local Food Legends.

Meaningful engagement with a wide variety of stakeholders has been key to the development of the strategy. This includes universities, Kantar, Food Justice Network (200+ community organisations and volunteers who supported citizens with food parcels during the pandemic), youth boards, eight pre-consultation focus groups, as well as many public consultation workshops, surveys and meetings (still ongoing as of August 2022).

Data and tools to capture insights have formed a key part of our conversations.



1.5.3 Key insights from stakeholder engagement

- A key driver with this work stream has been stakeholder and partner engagement. The conversations and ongoing partnerships that have been developed have driven forward the food system insight work taking place across the city.
- Our stakeholder and partner engagement revealed that many tools have been created over the years and it is important to:
 - Utilise tools that have been shown to be successful and have an evidence base;
 - Discover what it is about tools, how they are delivered, and what data they produce, that makes them successful, or not.
 - Learn from what has worked and hasn't worked in the past and use this to shape future approaches.
- Tools must be logistically feasible to use, produce data that is
 useful, and be owned and driven by an organisation or team that
 benefits from the data it produces in order for it to be utilised in the
 long term.
- Duplication happens frequently as partners aren't always aware of what has been developed by others, or in other sectors. Whole system approaches mean that tools are developed by diverse people, so improved communication is key to driving this work area forwards.

Co-production of Tools

- Universities, academics and researchers are key partners for developing scientifically robust tools. Recognising and utilising their expertise in the development of questions for surveys, scales and methodologies for data collection is vital.
- It is vital to engage with community and voluntary organisations and settings, citizens and young people from the outset. Their perspective can help validate whether the key premise that is driving the development of a tool is accurate. They also support with developing tools that are realistic, useful, logistically feasible and sustainable in the long term.
- The private sector routinely capture huge amounts of data, and developing stronger relationships with them to see how the insights gathered could benefit everyone is an area that could bring positive developments.

Findings and Discussion

1.5.4 Development of Tools to Capture Data and Insights

We have been developing tools and approaches to support with capturing data and insights from across the food system. These include:

- Birmingham Basket Consumer Panels and Data
- Food Affordability Toolkit
- Asset Mapping
- Community Researchers
- Youth Researchers
- Focus Groups
- Surveys and Questionnaires

In the next section we will share more detail about each of these tools and approached, including:

- Purpose of this type of tool/approach
- Our approach
- Strengths of this type of tool/approach
- Challenges with this type of tool/approach
- Conclusion
- Next steps

Creation of Tools

A partnership approach is key to developing useful insight tools that capture meaningful data from the food system. Each partner brings varied ideas and solutions.

Birmingham Basket - Consumer Panels and Data

Purpose of this type of tool/approach

National consumer research companies routinely capture purchasing data from industry (e.g. supermarkets), and also have consumer panels where they recruit representative samples of households across the country to regularly record what they have purchased. The data related to food purchases and particular geographic areas can be isolated from the rest of the data, then purchased and analysed by organisations that want to gain further insights.

Our approach

We explored what data was available with Kantar consumer research company and they collect useful food purchasing data. We also discussed our plans with the Mandala Consortium who revealed they were also utilising consumer research panel data in their Birmingham food system research project, so there was a risk of duplication if we were to purchase this data too.

Strengths of this type of tool/approach

Can compare city averages to the national average, or to comparator cities.

Can compare data over time. The data is routinely collected already, so you only have to purchase access to a data set, rather than having to commission the collection of the data.

Challenges with this type of tool/approach

In 2021, Kantar had approximately 500 consumer panel households in Birmingham. This sample size is too small to get localised data beyond the city level. The data is owned by the consumer research company so it is necessary to negotiate purchasing that data at each time point you require, which can be challenging in a public sector setting where staff and budget changes mean that the future procurement processes and priorities are uncertain.

Conclusion

This data is useful if you have the budget for it, but does not provide localised data. It is more suitable for city to city, or city to national average, comparisons.

Next steps

Since the Mandala Consortium were exploring this type of data, we decided to focus on the development of other tools instead.

Take home message

This data is expensive to collect, and is suited to city to city, and city to national, comparisons rather than providing localised data.

Food Affordability Toolkit

Purpose of this type of tool/approach

Our aim was to create a tool to capture the cost of a nutritious and sustainable food shopping basket that would support a healthy diet in a wide variety of shops and locations across Birmingham. In addition, we wanted to capture the cost, and availability, of healthy, sustainable, ultra processed and high fat sugar and salt foods. We wanted to create a picture of the food available to citizens across the city, and the inequalities in access to and the cost of food depending on where people live and shop.

Our approach

We based our approach on the one outlined in the <u>Monitoring Food Affordability Reference Document 2018</u> from the Population and Public Health Division in Ontario, Canada. We built on this approach by incorporating foods that are good for the planet and sustainability, as well as for people and health, by using the foods recommended in the <u>EAT-Lancet Planetary Health Diet</u>. In addition, we included ultra processed and high fat, sugar and salt foods. We developed the tool within the Public Health Division, initially as an Excel document, and then as an online survey. We partnered with local universities and students visited shops to record the food available and to test the tool and provide feedback.

Strengths of this type of tool/approach

This tool would enable us to capture the costs of a variety of foods across the city, compare geographical areas, different types of shops, and at different time points.

Challenges with this type of tool/approach

The tool was difficult to utilise in a real-world setting and took two hours to complete per shop. There were challenges when the weights and quantities of food available in the shop did not match what was listed on the tool. The staff resource required to get a representative and meaningful collection of data from across the city would be huge. This tool would only capture what food is available - not what is bought.

Conclusion

This tool has potential, but needs to be a research project partnered with a university, and to have software developed to aid with data capture.

Next steps

We have a list of publications and references, draft tools that were developed, food lists, and feedback from those who tested the tools about their experience. We would be willing to share these with a university partner who was interested in developing a project in this topic area.

Take home message

Logistically very challenging to develop and deliver. Requires a lot of expert resource and development time. Bespoke software would support the process.

Asset Mapping

Purpose of this type of tool/approach

Gain understanding of what assets are available to people across Birmingham, including food system assets such as community food projects, growing spaces and affordable food as well as other services. Share information with partners and citizens across the city and raise awareness of what is available.

Our approach

Our approach has been to capture what asset maps are already available in the city, what works well, and what the limitations are of each. We have also been sharing details about the asset maps we have discovered with other stakeholders and partners to enable a coordinated approach. We supported the Food Justice Network with updating the map of food banks to ensure the locations listed are still open and available to citizens. In addition, we captured the data about food banks and other affordable and community food projects in an Excel format to enable it to be utilised in a future mapping project. We are also aware of other asset lists, including growing spaces and allotments and we have identified other asset lists and maps including:

- Connected Communities developed by the <u>Neighbourhood Network Scheme</u>,
- <u>Connect to Support</u> online directory,
- Root to Wellbeing guide to local voluntary and community health and care services in Birmingham utilised by the Early Help initiative,
- The Waiting Room which lists health and wellbeing services in Birmingham and Solihull,
- Birmingham's SEND Local Offer Website with services available to Children and Young People with Special Educational Needs,
- Bring it on Brum Holiday Activities and Food Programme.

Strengths of this type of tool/approach

Capture assets from across the city.

Challenges with this type of tool/approach

Risk of duplication, information gets out of date quickly, would require significant investment in a technology platform to create a genuinely usable and interactive interface that can be easily updated by multiple stakeholders and filtered to be used for different purposes.

Conclusion

Useful resource in principle, but often not well connected across sectors and services. Need a directory of all the asset maps and directories available.

Next steps

Continue to capture the asset maps and lists we come across and raise awareness of what's available with stakeholders and partners.

Take home message

Useful tools but often duplicated or out of date.
Need to connect with people and organisations across the city to coordinate approach.

Community Researchers

Purpose of this type of tool/approach

Conduct research in communities and empower local people to lead on gathering research and insights driven by their needs.

Our approach

We have developed participation-observation research training and resources so students and our staff can volunteer at community cafés and projects and capture insights at the same time. We are also co-producing tools with community researchers to enable them to lead on Food System Exploration projects in communities. This is an ongoing area of work in Birmingham.

Strengths of this type of tool/approach

- Research is community owned and they can get insights from places that may not engage with academic researchers;
- Tools that are developed can be shaped based on feedback to continuously improve them;
- It empower peoples in communities to capture food system insights;
- Gather insights in real world and natural settings.

Challenges with this type of tool/approach

- Tools, methods and analysis can lack scientific robustness unless an experienced researcher is involved;
- Requires community researcher training and tools that are straightforward to use with clear instructions;
- Fair pay and working conditions and a reliable workforce are important when conducting a study, so this often requires the research to be led by an organisations with the capacity to manage this process.
- The data and insights collected don't always get reported in a format that is shared with those who could utilise it (e.g. not always published and easily available).

Conclusion

Fantastic approach if a collaborative and co-production approach is utilised with community researchers. Birmingham is creating more tools in this area.

Next steps

Continue to refine tools that have been developed and share them on our website once we have the final version.

Take home message

Huge amount of potential and valuable insights if robust tools are developed with clear training and instructions.

Youth Researchers

Purpose of this type of tool/approach

Empower young people to develop tools, conduct research and capture food system insights from their perspective.

Our approach

Young people play an active part in our Creating a Healthy Food City Forum and contributed to the Birmingham Food System Strategy consultation workshops and focus groups in 2021-22. As a result of this existing connection, we have begun a project with the Birmingham Youth Service to harness the youth voice in developing food system assessment tools. We are working to ascertain how young people (aged 13-18) perceive the food system in and around their schools, what they would like to know about these environments, and what changes they would like to see.

Strengths of this type of tool/approach

This work is being driven by passionate young people who see the food system from a different perspective to policy makers so it is essential that their voice is amplified and they play a part in shaping their future food system. The tools and solutions suggested have been innovative and utilise technology.

Challenges with this type of tool/approach

It takes careful planning to ensure the project is genuinely youth led and utilises an authentically co-produced approach, whilst still producing robust tools that produce insights that will shape policy and practice.

Conclusion

Interestingly, the move to online forum meetings and workshops that came from the increase in homeworking during the pandemic has been beneficial for engaging with young people, as they are able to join meetings from a school computer. Youth Workers are valuable in guiding the co-production approach to ensure the project is youth led, whilst still providing the necessary support.

Next steps

Tools and resources that are developed by young people in Birmingham will be shared on our website. This project is ongoing.

Take home message

If you empower young people to drive the approach then innovative solutions are produced. Facilitation is needed to ensure what is produced will influence policy and practice.

Focus Groups

Purpose of this type of tool/approach

Engage with a group of people to gain insights on their experiences, perspectives or thoughts on a topic area and capture key themes and actions to guide the next steps in a project or approach.

Our approach

Focus groups have been key for the early stages of the Birmingham Food System Strategy development. We have:

- Commissioned local organisations to deliver focus groups with communities as part of the Birmingham Food Conversations;
- Held online focus groups to explore key food system themes, to shape the strategy, and to gain feedback on ideas, as well as part of the public consultation;
- Conducted in-person focus groups with young people in school and college settings as part of the strategy consultation.

Strengths of this type of tool/approach

Powerful way to explore a topic area and gather insights, key themes, different perspectives and gain feedback on plans. Also a valuable tool for evaluation.

Challenges we faced with this type of tool/approach

- In-person recruitment has been challenging during the pandemic, and not all stakeholders are comfortable with online meetings or don't find them engaging;
- Only get insights from those who engage with you so not all voices are represented, and there is a risk the insights may not be representative;
- Requires staff resource and skills and experience in qualitative research;
- A productive focus groups requires strong facilitation and focus group guides.

Conclusion

A useful approach to explore topic areas and to guide next steps, as well as gaining feedback on a planned approach. Necessary to consider how to increase engagement and ensure feedback is representative of the population.

Next steps

Continue to utilise focus groups to shape the approach taken in Birmingham to transform the city's food system.

Take home message

Vital tool to shape project plans and approaches during the development phase, and to capture feedback during evaluation.

Surveys and Questionnaires

Purpose of this type of tool/approach

Capture qualitative and quantitative data on a large scale in a standardised way.

Our approach

We have utilised questionnaires to get city-wide feedback on key food system topics, and as part of the survey feedback as part of the Birmingham Food System Strategy public consultation. We are working with the Mandala Consortium food system research project to develop a city-wide survey that will be repeated at regular time points to track changes over time.

Strengths of this type of tool/approach

- Can engage with a sample size large enough to be representative of a population;
- Can create a standardised tool to compare one time point to another, or one population group to another, and to reveal insights;
- Can gain an understanding of agreement levels and thoughts of topic areas and plans;
- Is an straightforward way to capture quantitative data and to measure impact.

Challenges we faced with this type of tool/approach

- Engagement with questionnaires and surveys can be low;
- There is fatigue due to people seeing multiple surveys and consultation questionnaires for many topic areas from many partners;
- The quality of questions is key to ensure they measure what you want them to measure, they produce reliable results, and are worded in a way that respondents understand;
- Skills and experience are needed to develop questionnaires and to analyse the results.

Conclusion

Surveys and questionnaires are useful tools for tracking changes over time and producing a measurable indicator if produced in a scientifically robust way.

Next steps

We will continue to utilise surveys and questionnaires to gather city-wide insights and feedback whilst utilising other insight tools, too.

Take home message

Ensure questionnaires are developed by someone with skills and experience to make them robust and effective.

1.6 Progress against objectives

We have achieved or are working towards the following objectives:

- To set a national standard and develop and continuously refine high quality, relevant metrics as barometers to measure the impact of our efforts to improve the health and wellbeing of our population, especially from a food/nutrition perspective;
- To develop direct indicators of how good a whole system approach is, or is not, working in relation to food/nutrition;
- To ensure we use the metrics available to us in innovative and useful ways;
- To share data and metrics more effectively with stakeholders and partners;
- To be able to use these baselines as a lever to effect change, to measure these changes, and to be able to report success;

We have made strides to work to achieve these objectives, and the work that has taken place as part of this COTP work stream will ensure we continue to work towards them. Developing tools, utilising data, increasing coordinated partnership working and measuring success are key parts of the Birmingham Food System Strategy and our city-owned Birmingham Food Revolution which are now embedded in our city.

We have not achieved the following objectives:

- To develop a measure of consumer food shopping habits through a "Birmingham Basket" that gives us a clear baseline;
- Impact positively on the 'Birmingham Basket' to reduce the overall calorific content and improve the proportion of fruit and vegetables (dependent on support for metric development).

However, the process of developing this work stream has meant we have refocused our approach.



Findings and Discussion

1.7.1 Successes

- The test and learn approach of the COTP has been incredibly effective with this work stream. Continuously reflecting on our approach and feedback, and shaping the next steps, has been key to the momentum that has built in this area.
- Strong relationships have developed between stakeholders and partners across the city, and a truly open and collaborative culture has come as a result.
- Birmingham has become known as leading in food system thinking, which then attracts even more food system experts, research and organisations. This means progress towards food system transformation is speeding up.
- The tools we are creating are being:
 - Developed based on need;
 - Validated, tested and developed from many angles, including theoretical and scientific perspectives, and real world and logistics perspectives;
 - Designed to be realistic, sustainable and useful tools in the long term;
 - Will be shared freely and widely on our website as part of our global learning and partnership approach.
- This work stream has evolved into a whole system approach and is embedded in the Birmingham Food System Strategy and Birmingham Food Revolution.

Test and Learn

The test and learn approach has been at the core of this work stream and generated innovative and exciting projects that will leave a lasting legacy.

1.7.2 Challenges

- Expectations of what can be measured, and the reality, are often very different. Developing measurement tools, metrics and gathering insights takes time and expertise.
- Stakeholders and partners across the food system come from very different sectors and backgrounds, with diverse priorities and pressures, so strong and tailored communication is key to maintaining good engagement and strong relationships.
- There is a huge risk of duplication with the development of any tools, so strong communication with a variety of stakeholders, evidence gathering and scoping is key to ensuring we build on successes, and learn from failures, rather than reinventing the wheel.
- GDPR and data laws mean that even when data is collected, it often cannot be shared between partners. Clear plans, consent and agreements are key.
- Scientifically robust tools are not always realistic in real world settings, and non-academic tools aren't always scientifically robust, so it is essential to utilise co-production techniques and recognise and value the different priorities and perspectives that diverse groups bring.

1.7.3 Impact of COVID-19

- Staff capacity has been stretched;
- In-person research has been challenging, however there has been increased engagement with some population groups due to increased confidence with online meetings, and increased accessibility with being able to connect online;
- The food supply shortages, and people not having enough to eat, has acted as a call to action, and has unified people from across the city to collaborate and transform our city's food system as part of the Birmingham Food Revolution;
- Many projects were paused during the pandemic, which meant the development phase of the projects aligned well once work started up again. Partners across the food system have been able to have a say in other projects, and to learn from partners, and shape their approach.

Sustainability of Initiatives and Legacy

1.8 Whole System Approach

- Capturing food system insights and data has been embedded into the Birmingham Food System Strategy so there is a lasting legacy beyond the end of the COTP programme.
- The conversations in 2019 that were instigated by this COTP work stream have led to the Mandala Consortium focusing their food system research project on Birmingham, and collaborating in the development of food system insight tools and capturing data.
- The Mandala Consortium are developing a food system data dashboard for Birmingham in order to support with measuring the impact of interventions. They are developing system wide tools that could be rolled out to cities across the globe.
- The Food System Team who have been leading on the COTP work stream have focused on creating co-produced tools that will capture localised insights and support with the development of policy and interventions.

Lessons Learned

Lesson 1: Ensure a variety of people are involved with the development of insight tools

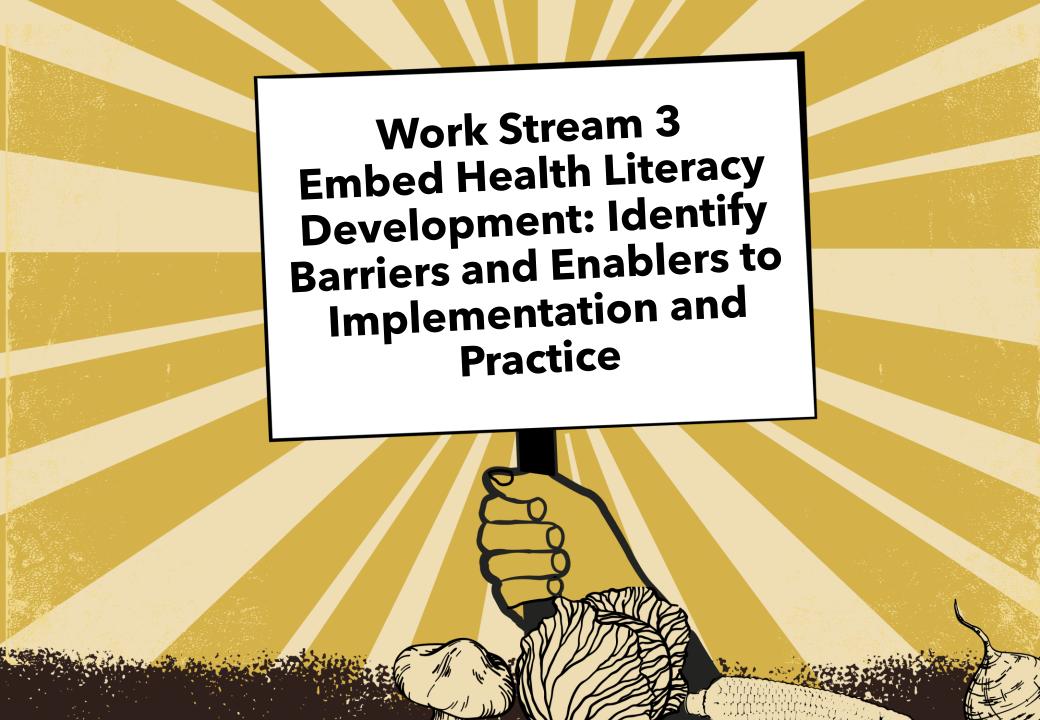
Engage with scientific and theoretical experts as well as those who are experienced in practical applications in real world settings to ensure any tools are scientifically robust, and logistically feasible to use.

Lesson 2: Develop strong relationships and communication with stakeholders and partners

Many solutions are already out there, or could be achieved through partnership working, so strong relationships and communication are key.

Lesson 3: Be patient

The development of robust tools takes time with scoping existing tools, exploring ideas, validating plans, testing and refining the tools and gaining feedback.



Description of Work Stream 3

About Work Stream 3

This section begins with a summary of why health literacy is important, the level of evidence for intervention effectiveness, and the rationale for why it was chosen as the focus for the third work stream. The methods for both the quantitative and qualitative evaluation of the health literacy work, led by our research partner organisation - The University of Birmingham, are explained.

3.1.1 Background to Health Literacy

Concern about the health literacy levels of the general population and how this translates to lifestyle decisions for self-management as well as in the workplace are under explored. The World Health Organisation in 2015 defined health literacy as "The personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health"

It is estimated that between 43% and 61% of adults working in England do not understand health information. Low health literacy is associated with increased use of health services, poorer health outcomes, higher mortality in older people and less preventive care.

Increasing attention is being given to health literacy in the workplace, in recognition of how much time the adult population spend at work, the impact of rapid digitisation, and the blurring of work-life boundaries. The development and promotion of health literacy in the workplace can lead to improved lifestyle decisions within homes and thus represents an upstream intervention that has the potential to influence households and improve childhood obesity levels.

Original COTP Work Programme

WP3 Employment, Skills,
Training and Apprenticeships Creating and Proof of Concept
Testing

3.1.2 Level of evidence

In terms of interventions to address health literacy, in 2011, a published review identified 42 studies that had reported on intervention effectiveness and found insufficient evidence for effect on outcomes of behavioural intent. This review concluded that there is a need to develop and test interventions in a wide range of settings. The majority of interventions focused on a health care setting and called for health care professionals to communicate with patients using health materials that are accessible, and efforts to raise general health literacy through educational programmes, leading to a positive impact on health.

A more recent review (2021), summarised the current state of quantitative research on health literacy within the workplace. Several interventions were identified with a different design such as workshops, educational interventions and group trainings. The review found that most were aimed at mental health literacy, defined as knowledge about mental disorders that support detection and management, and were found to either have a significant positive impact on mental health outcomes, or improve attitudes towards mental health

Interestingly, this review did not find any published evaluations using either of the two purpose-built instruments developed to measure individual work-related health literacy, so this remains an under-researched area. The authors advocated a broad measure of outcome that considers outcomes beyond mental health, embracing the full definition of health literacy, to include physical health, and aspects of work-life balance.

We identified one published review of qualitative research of workplace health literacy interventions where key enablers and barriers were identified.

In terms of health literacy course structure, the enablers noted were opportunities for small group discussion, having miniprojects in place to be completed by pairs of participants and thus support peer-to-peer interaction, and opportunity to apply content to local practice.

The barriers noted were that the course content can be too academic and theoretical, with limited practical examples to help digest theoretical knowledge, and the modules can be too spaced out making the learning feel disjointed.

3.1.3 Apprenticeship training

For this work stream, the focus was on developing an intervention to improve health literacy through the route of apprenticeship training. Apprenticeships are designed to provide 'on the job' training so employees usually spend one or two days a week studying for a formal qualification, while still being paid to continue with their job.

At the end of the study programme, a nationally recognised qualification is awarded which can include functional skills (GCSE-level education); National Vocational Qualifications (NVQs) from Level 2 (comparable to 5 GCSEs) to Level 5 (equivalent to postgraduate degree); technical certificates such as a BTEC; or academic qualifications such as a Bachelor's or a Master's degree.

3.1.4 Food business perspective on jobs and skills

Alongside the primary focus of creating the training, we also wanted to explore the wider employment training programmes across Birmingham, working alongside targeted food SME's and business.

Our intention was to hold multiple focus groups with the Chamber of Commerce, local food SME's and larger regional and national food business; to explore the gaps and needs of these business compared to what the catering colleges and vocational training centres offered providers.

BCC have a vibrant and diverse apprenticeship training programme. The programmes run from 12 months up to 4 years depending on the pathway followed.

Aims and Objectives

3.2 Aims and Objectives

The original aim of this work stream was to estimate the effect upon the health literacy of apprenticeship trainees from delivering an enhanced training programme that included embedded health literacy and health and wellbeing (HWB) training using a spiral curriculum approach. We also wanted to explore applicability of this approach more broadly across the food and drink sector.

Original set of objectives:

- To develop accessible health literacy training modules for the different apprenticeship training levels on offer within Birmingham City Council, embedded using a spiral curriculum approach.
- To undertake a quantitative assessment of the impact of this training by measuring the following:
- The 'baseline' health literacy levels of all council trainees prior to starting the apprenticeship training programme.
- To assess levels of health literacy, health and wellbeing, and productivity outcomes, after completing the modules, compared with 'baseline' levels.
- To identify differences in health-related quality of life, productivity and workforce wellbeing between baseline and follow-up levels.
- To undertake a qualitative assessment using one-to-one interviews adopting a purposive sampling approach to ensure all perspectives are captured. Specifically, the perspectives to be captured were:
 - The apprentices who had completed the module training.
 - The external organisation responsible for module development.
 - BCC staff involved with this work stream.
- To explore applicability of this approach across the food and drink sector



Methods

3.3.1 Development of module

After consultation with the apprenticeship training providers, the council team realised that the objective of embedding health literacy training within established training courses, using a spiral curriculum approach, was not going to be possible within the timeframe of the study. The reasons for this are highlighted in full within the qualitative section 2.4. The work stream therefore reverted to a focus on developing the training as a suite of optional stand-alone modules that would sit alongside (rather than within) the apprenticeship training programmes.

Development of a 'health literacy' training module across an apprenticeship programme was completely new and previously untried and therefore the council worked with an external organisation to create the content for the modules. The course was designed to fit the needs of the trainees on all levels 2 to 7 as follows:

- Trainees on levels 2 and 3 to complete Universal level.
- Trainees on levels 4 and 5 to complete Manager and Universal level.
- Trainees on levels 6 and 7 to complete Universal, Manager and Senior Leader level.

Each course comprised 5 online modules developed to provide training on a range of health and wellbeing topics including health care, digital health, food health, physical health, and self-care (mental health). The emphasis was on sharing little 'hacks' that could make a big difference and was adapted to fit the different levels of training by changing the emphasis from individual behaviours (Universal), to team behaviours (Managerial), to organisation behaviours (Senior Leader level). Each module comprised 2 to 3 lessons, and each lesson was a 10-15-minute video followed by some downloadable activities. The modules were deliberately designed to be flexible, either to be completed according to the apprentice's schedule, or to be done all in one week. On completion, a CPD certificate was awarded.

Due to the pandemic, and public health staff being restructured and repurposed within Birmingham City Council, there were unavoidable delays to putting out the tender for contract for the module development.

This resulted in delays and left little time available for the module development and therefore, the modules were developed at pace with the external organisation over the summer of 2021, to be implemented on time for the start of most of the apprenticeship training programmes from September 2021.

Key lessons have been learned through this process which are reported in later sections below.

3.3.2 Methods for the quantitative evaluation

The design for the quantitative evaluation was a before-and-after study. The participants to be targeted were all council apprentices who had signed up to a council apprenticeship programme on all levels 2 to 7 from September 2021 to June 2022. It was planned that, as part of their training, the apprentices would be invited to complete the stand-alone modules. Before beginning the modules, they would be asked to complete a 'baseline' survey comprising questions to measure health literacy, health and wellbeing. Immediately after completing all 5 modules, they would then be asked to complete the survey again, and then again 3-months later to assess if levels were sustained.

Selection of outcome measures

The outcome measure chosen to assess health literacy was the HLS-Q12 instrument. This was chosen based on a scoping review designed to identify health literacy assessment tools. From this scoping search, it appeared that many health literacy assessment tools have been designed to assess language barriers to accessing information within a health care context.

Three potential instruments were identified from this scoping review and appeared relevant to this evaluation – two on the basis that they were developed either within a European or UK context (AAHLS and HLS-Q12) and the third because of the perceived relevance of the instrument dimensions (ABCDE-HL). The HLS-Q12 was selected as it offered a 4-point Likert-type response scale anchored with the phrases "very difficult (1)", "difficult (2)", "easy (3)" and "very easy (4)". Adding up the scores for each apprentice, the lowest possible score would be 12 and the highest 48. On the basis of Rasch modelling and using joint standard error to estimate confidence intervals' upper bound, three benchmark cut-off values for statistically different levels of performance (four levels of HL) have been identified with the four levels being:

• 12-26 points is below level 1 and could be classified as having inadequate health literacy

• 27-32 = level 1

• 33-38 = level 2

39-48 = level 3

A systematic review published in 2018 of tools for assessing health literacy among the general population found that although there is an increasing trend for assessing health literacy, there is no clear consensus in the dimensions of health literacy tools.

Additional Outcome Measures

In addition to the HLS-Q12, additional outcomes were measured including health-related quality of life (EQ-5D-5L instrument), workplace wellbeing, personal health and workplace health literacy.

Planned statistical analysis

To examine the association of health literacy across different categories (as defined above) with levels of exposure to the modules, a linear regression model was planned on health literacy (before and after levels) adjusting for baseline health literacy and potential confounders, and allowing for the clustering of data within programmes.

Logistic and linear regression models were planned for the secondary outcomes, as appropriate. The confounders for all the analyses were to include language other than English spoken at home, ethnicity, age, marital status, and socioeconomic status (proxied by household postcode).

Planned recruitment method

The plan for recruitment was to target apprentices at the point of registration to a new training programme. At the point of registration, an invitation was sent via email that explained the purpose of the modules, with a link included to sign up and complete the modules.

Once the apprentices logged into the online module training, they were then invited to participate in the evaluation led by the University of Birmingham, their decision to take part did not affect their ability to complete the modules.

The apprentices were provided with a participant information sheet explaining the purpose of the evaluation, and then invited to provide consent and complete the online survey to capture 'baseline' measures.

Sample size

The study did not include a formal sample size calculation as given the pragmatic nature in design, the plan was to recruit as many apprentices as possible within the study period available.

3.3.3 Methods for the qualitative evaluation

The one-to-one interviews were all undertaken by a researcher within the University of Birmingham team who up to the point of interview, had had little involvement with the study and was therefore completely independent.

Recruitment and consent

To identify participants for the one-to-one interviews, the following methods were applied -all apprentices who had completed the online training and indicated within the baseline survey that they would be happy to be contacted for further research, were sent a follow-up email inviting them to an interview. The external organisation who had developed the module was sent an email invitation to an interview; and finally council staff who were known to be involved with this work stream at various stages of development were identified either by the University team, or through contact with the lead members from the council team, and were also sent an email invitation to an interview.

For all participants, verbal consent was taken in advance of the interview and after the participant had time to review the information sheet and consent form in their own time, and had their questions answered to their satisfaction.

Phone or video conferencing software was used. Prior to starting the interview, the researcher talked through each statement on the consent form, and the participant was asked to give their agreement to each statement. This process was audio-recorded, and the consent recording was saved among the study records as proof of consent. The consent form (completed by the researcher) was sent to the participant for their own records.

Written consent was not used in this study as verbal consent enabled participation from a wider pool of people as it did not require postage and/or access to printing and scanning equipment, and minimised contact considering the ongoing COVID-19 pandemic.

All individuals to be invited to an interview were approached by email up to three times.

The email invitation included a participation information sheet and offered an optional phonecall to discuss the study if more information was required.



Data collection

The participants were not known to the interviewer prior to the interview. Preliminary topic guides were formulated in advance, informed by the research aims and adapted specifically to the perspective of the interviewee in relation to the online modules. The topic guides were iteratively refined to explore participant perspectives and cover areas relevant to the research objectives.

For the apprentices, questions broadly covered: their interest and expectations of the course; its content and delivery; their application of the training and its wider uptake. For the developer, questions related to their experience of working with the council and their use of feedback. For the council team, questions related to their assessment of the training; the development process; and the future plans for the programme.

Data collection was undertaken by a researcher with experience of qualitative methodology. Sessions were conducted using video-conferencing software and were audio-recorded. Each interview was transcribed verbatim.

Data analyses

Transcripts were analysed using directed thematic analysis by the researcher. An initial coding framework was developed informed by the research aims. A flexible and iterative approach was used to continually develop and refine the coding frame, allowing for the identification of novel themes. Additional codes were developed and integrated as analysis progressed and the framework was modified as required.

Ethics

Ethical permission for both the quantitative and qualitative evaluation was granted from the University of Birmingham Research Ethics committee (Ref: ERN_19-1987).

3.4.1 Findings and Discussion: Implementation and Delivery

This section first reports the findings from the quantitative evaluation and in particular the challenges encountered with engaging trainees with the modules, and with completing the surveys. The next part reports the findings from the qualitative interviews and draws insight with respect to the implementation and delivery of the online course.

3.4.2 Challenges with recruitment to the quantitative outcome evaluation study

Recruitment was a challenging part of the outcome evaluation study; both in terms of engagement with the health literacy course and participation in the evaluation.

The qualitative evaluation revealed some insights from different perspectives - which are reported in section 3.5. The decision to use email to invite apprentices to participate was considered the most efficient, uniform way of reaching them - however due to the nature in which apprentices 'signed-up' to the training programmes within the council, and the dynamic process between employee and line-manager, this proved a challenging way to engage participants.

Despite repeated attempts to re-energise the study and advertise the opportunity through various means, the response rate remained low.

3.4.3 Challenges with implementing the modules

Furthermore, due to the rapid pace with which the modules were developed, the challenges to the quantitative evaluation were also compounded by a decision from the council team that more work (and time) was needed to reflect on and adapt the modules before they were ready to be rolled-out further across the council apprenticeship training schemes.

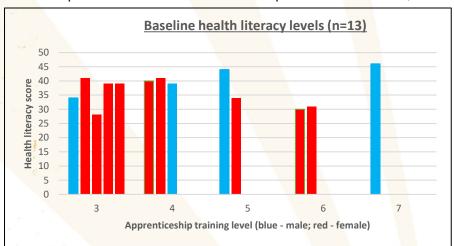
More detail on why this was the case is within the qualitative evaluation below and resulted in a halt to the planned quantitative evaluation and further efforts to recruit apprentices to complete the outcome measurements.

As a result of this decision, resources were repurposed to focus on the qualitative evaluation to reveal the enablers and barriers to developing and implementing the modules, as detailed in section 3.5.

3.4.4 Sample characteristics

Of the apprentices that did take part in the course and complete the quantitative surveys, 13 participants completed the baseline survey - 4 male and 9 female. There was no clear pattern in baseline literacy levels by level of apprenticeship training.

Of note, prior to starting the training, 4/13 (31%) participants had a baseline health literacy level equivalent to level 1, 2/13 (15%) scored level 2, and 7/13 (54%) scored the highest level of health literacy (level 3). In terms of health-related quality of life, the following were reported (quality of life scored on a 0 to 1 scale, with 1 reflecting a state of perfect health, and zero equivalent to dead).



Baseline Health-Related Quality of Life Scores

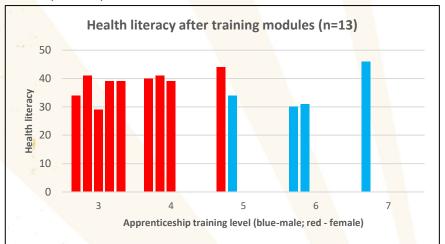
Individual Scores			Average Scores		
Apprenticeship training level	Utility Score (0-1 scale)*		Apprenticeship training level	Utility Score (0-1 scale)*	
Level 3	0.320		Level 3	0.716	
Level 3	1.000		Level 4	0.806	
Level 3	0.795		Level 5	0.695	
Level 3	0.696		Level 6	0.745	
Level 3	0.768		Level 7	0.577	
Level 4	1.000				
Level 4	0.711				
Level 4	0.708				
Level 5	0.736				
Level 5	0.654				
Level 6	0.768				
Level 6	0.721				
Level 7	0.577				

^{*}These scores have been generated using the EQ5D-3L crosswalk value set.



13 participants completed the online training and the 'after' survey. The resulting health literacy levels are presented in the graph below. Note that not necessarily the same participants completed both the baseline and the 'after' survey so unfortunately the planned analyses were not possible, and we were unable to assess impact on change in health literacy over time.

After the training, 3/13 (23%) achieved level 1 health literacy, 2/13 (15%) scored level 2, and 8/13 (62%) reported the highest level of health literacy. Caution should be exercised over interpreting these numbers as the sample size was small and the measures were not taken on the same participants before and after.



In terms of quality of life, the following were reported:

'After' Health-Related Quality of Life Scores

Individual Scores		Average Scores		
Apprenticeship training level	Utility Score (0-1 scale)*	Apprenticeship training level	Utility Score (0-1 scale)*	
Level 3	0.320	Level 3	0.609	
Level 3	1.000	Level 4	0.806	
Level 3	0.795	Level 5	0.695	
Level 3	0.164	Level 6	0.745	
Level 3	0.768	Level 7	0.577	
Level 4	1.000			
Level 4	0.711			
Level 4	0.708			
Level 5	0.736			
Level 5	0.654			
Level 6	0.768			
Level 6	0.721			
Level 7	0.577			

^{*}These scores have been generated using the EQ5D-3L crosswalk value set.

3.5 Findings from the qualitative evaluation

As described earlier, the quantitative evaluation ceased because of ongoing recruitment issues. Following a decision by a senior council officer, resources were repurposed towards the qualitative research to draw out the main findings from the process of developing and implementing the modules, to inform future ways of working.

The qualitative data collection took place from February-April 2022, involving one-to-one interviews with 10 participants. Interviews lasted approximately 40-60 minutes. Four participants were part of the council team, five were apprentices, and one was the external developer. Three of the apprentice participants had undertaken the training designed for line-managers, the remaining two had received the universal training for apprentices at lower levels. Two of the council delivery team had only been involved with the training during the early stages of its development and were unable to comment on its eventual delivery or final content. Of the two other council team members, one had contact with the programme at every stage of its development and delivery while the other had joined the team at a later stage. Unfortunately, the audio recording of the interview with the external developer failed, and so insights from this interview were drawn from the written notes taken by the interviewer during the interview, and reflective notes after the interview was completed.

The findings from the qualitative evaluation in this section are presented in four parts. The first relates to the ambitious plans, the second - the process for course development, the third about the impact of COVID-19, and finally the suggested solutions to ease implementation and delivery.

3.5.1 Ambitious Plans

The idea for the "health-by-stealth" health literacy spiral curriculum originated during the "discovery phase" at the start of the project and the planning for delivery followed. Compared to other local authorities bidding for the same funds, one participant reported Birmingham City Council's plans to be ambitious:

"So the trailblazer started with what they called a discovery phase and I think that was for one year prior to the delivery phase which was a three year section"

"[the funder] seemed quite excited about the work in Birmingham because we were doing something guite big, quite large scale, some other areas because of their COVID response and understandably had pitched a lot simpler, a lot more straightforward... we'd gone full on, 'No, we want to aet involved in directly in people's education and use that for health literacy purposes.' Other people had just said, 'We want to get posters on campus to signpost people into services, which is fine, but I just didn't feel the ambition was there as much as it was with us."

3.5.2 Process for course development

Conceptualising the training modules:

The original plan was for the modules to be developed internally within the council. However, it was reported that after early consultation with the apprenticeship training providers, the council team realised that the original plan for taking an embedded spiral curriculum approach would not be feasible, and at the same time, the council team also recognised that they did not have the expertise to develop the modules themselves, so consequently prepared a tender to seek help from an external provider:

"We were planning to create the content internally and then I think after that wakeup call conversation with the service providers of all the things we couldn't do I think it also suddenly clicked into my head I don't know how to write a module for a university course and I don't think anyone in public health does ... I did ask around and we have academia background... people who had lectured or people who had supervised dissertations and things like that, but not people who'd actually been the head of a module design and module development. So yeah, but we then took the decision that what we need is someone with both public health, health literacy, food health literacy background as well as a background in designing academic training modules... I had to have the conversation of can I take some of the budget that I'd badged against something else and repurpose it into a tender for module design?"

Furthermore, it was explained that adding to, or adapting existing apprenticeship training programmes would require a lengthy re-accreditation process and one of the senior team described the bureaucracy associated with making any changes:

"through some of the initial conversations [advisors] said that that might be a challenge in terms of getting it embedded into accredited courses, ...There are processes and it takes ages...just the smallest things changed on curriculums ... So having this idea about how do we get all of this embedded into an accredited course was a great idea... but practically if that wanted to happen it was a very much longer process and a very difficult process"

This was particularly problematic because the health literacy content was not related to several of the apprenticeship courses so may have jeopardised accreditation and its addition perhaps being construed by managers as misrepresentation or dilution of the course. A member of the council development team was also advised that the use of apprenticeship courses as a vehicle for public health context could be interpreted as a misuse of apprenticeship funds.

"[health literacy] is not relevant to the role and therefore the people who are engaging in that degree, they would've been mis-sold almost I think. That they think they're getting a degree that's relevant to their role and then they're getting a degree that's partially relevant to their role and partially around health literacy. ... A very similar position with the manager in that they're freeing up staff time for them to get a degree that is relevant to their role and we're then diluting that with something else. So yeah, for the person involved and the manager we'd have misled them as to what they were going to be learning. And then the last angle was around misappropriation of the apprenticeship funds themselves on the basis that again they are there for people to develop skills for their career, not for us to embed health literacy skills."

Furthermore, the practical complexity associated with what was being requested may have also put off the apprenticeship training providers:

"I think what they [training providers] disliked was the complex, lengthy process of reaccrediting their modules. That's what they didn't want to do. I don't think they were averse to the idea of actually embedding it. I think it was the governance process that they would have to engage to enable that to happen"

Consequently, the focus shifted towards working with an external provider to develop a stand-alone course that would fit alongside the apprenticeship training schemes.

Timing for development of the course

Participants from the senior council team described how the initial phases of course development were rushed through as there was insufficient time for testing and refining the course. The issue of time was considered by one participant to be common in local authority settings:

"The product development process is really, really useful... testing it, tweaking it and then developing it further. I was a little concerned because local authorities often have very short timescales to develop products and they don't tend to have that development tool phase. Sadly, I was right about that in that it was being rushed through. Not that what they were going for wasn't right; it's just that there's so much to learn from the Beta testing but if you rush to the final product, you miss out on all of those rich insights."

This was reiterated by the module developer, who described how the first draft was the version used without editing and removing background noises, advising that 6 months were required for development rather than 3 months.

The issue of timing was also raised with respect to the procurement process within the public sector. In addition, the ambitions of the kind of media and delivery that could be used was not possible with the funds and resource available:

"this was non-recurrent funding for one year I think or two years. There were time limits, which when you take into account public sector procurement takes about three months. We were already running massively behind"

"There are so many engaging types of videos that you can find online that you could learn from and capture the best bits; feature people from diverse cultures and backgrounds; make it engaging in terms of changing landscapes that are on the video rather than having one static type of shot. That was also a limitation of the funds that were available and the time that was available"

Clarity of the brief

The course developer (herein described as the developer) described their experience. They felt that the original brief was clear, and the budget was appropriate, and that this was to develop an online course. However, over time, the requirements deviated from this original brief with the additional requirement for the course content to be adapted to different apprenticeship levels.

The senior council team also explained that the team overseeing the execution of the course were unclear about the work stream aims and requirements which meant there was a mismatch in terms of what was wanted by the council, and what was delivered by the developer:

"our side wasn't on top of it and didn't understand really what they were buying. Which is one of the challenges actually, if you don't understand what you're buying the person selling it to you can't give you the right product."

"If people don't capture what they're hoping and are very specific about what they want in the output, then everybody has got a different vision of what they think they're working towards." One participant described how having re-read the specification, it was understandable that those reading it could interpret its contents differently:

"The spec ... didn't really have much detail in it... there was very little shared expectations. There were a lot of assumptions by everybody and very little on paper very explicitly saying what was expected, how it should be delivered, what should be included, what was considered good practice and what would make it something that was good. None of that was there and so if people are disappointed that something wasn't there and it wasn't written down, which none of these things were, there's no way it could ever be realised and it's just a missed opportunity in some ways"

This led to differences within the council team regarding what was to be accomplished:

"the people who worked on this project before me felt like the goalposts kept moving and people kept saying that it was working towards different things. I couldn't work out whether it was miscommunication because people didn't understand each other's perspectives or if the goalposts were physically changing and the expectations were evolving."

This sentiment was shared by the developer who felt that the brief kept changing. As a result, there were efforts within the council team to clarify aims and these were understood by all. There may have also been a lack of understanding around who the target groups were for the training which may have meant that the course was pitched in the wrong way:

"there was also a perception that apprentices meant young people entering work for the first time but that isn't at all how apprentices are in Birmingham. You've got apprentices who are just learning about some different skill or area that is just very different to what they're in. They are absolutely world leaders in what they do but they're apprenticing in another area as well."

3.5.3 Impact of COVID-19

The extent to which the discovery phase and the second year became useful parts of the process was limited by workforce capacity issues and then coronavirus:

"In year one basically very, very little happened. So the idea was still on a page. So I came in year two and it was still kind of like the idea was there, but nothing had really been done with it... it was impacted by staff absence and the pure volume of the work. That would've been up until the start of COVID effectively. I then took over ... it did heavily affect how much I was able to do in that year too, notwithstanding the fact that we also found out that we couldn't do what we wanted to and had to basically redo the whole project from the ground up."

Those involved in the course development and planning perceived that the planning and delivery of the course was affected by staff illness and turnover, in addition to the refocusing of efforts due to COVID that led to reduced oversight from the senior team. This led to a vacuum whereby a junior team was responsible for delivery but did not have a detailed understanding of the aims of the course and there was limited ownership and buy-in:

"it was after Covid and we were trying to wrap up a programme... They basically just thought, 'Is this not done already?' So it's difficult to get buy-in because things just change and evolve, especially when staff changes and leadership changes. It's often something that has been inherited from someone else. You're not going to get buy-in when someone's just inherited a project that somebody else started."

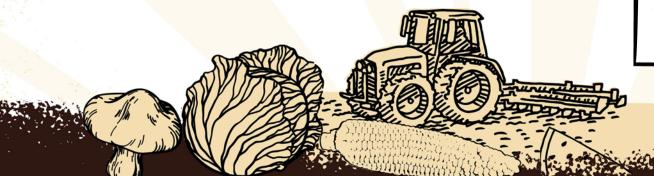
"one of the key members of staff had a significant period of sickness absence. So there's been a lot of churn in that team and I think that has meant that the provider has been left with a very limited steer, probably by staff that were a bit too junior to understand what we were trying to achieve."

"And then COVID hit and so the vast majority of public health work was paused because of the emergency response...We didn't stop working on the trailblazer, but it reduced dramatically because of COVID... So it wasn't a fluid journey"

Despite the restructuring within public health as part of the COVID-19 response, the council team worked hard to continue with the work stream:

"I was basically told... 'There's some food work we just can't stop because it's too high profile and the funding is time-limited.' You know, politically it would've just been just a nightmare to just go, 'We're not going to do this work around food' during a time where food bank usage shot through the roof."

"COVID had a massive impact on how much I was able to deliver because I basically had another job and a half's worth of work to go on top of the food portfolio which in itself is massive if I'm honest."



3.5.4 Finding solutions

After consultation with the apprenticeship training providers, the modules were appended onto the apprenticeship rather than being integrated as a spiral curriculum:

"that's when we started engaging with colleges and university staff and other training providers, like apprenticeship providers. ...we had a couple of online sessions ... to talk through what our idea and our vision was and to sort of say, 'You are the experts, you understand how things work in your area, can we do this? And if we can't do this, can you give us an idea of how we maybe could do a different version of this that would work in your settings? ...' So we had those sessions, that was really, really useful to think through, that it could sit alongside rather than being a part of the accredited courses."

However, as this was not the original aim, this had to be accepted by the senior management team:

"I then went away and fed this back to my senior management team and director and they were like, 'Well that's not a spiral curriculum and we said we were going to deliver a spiral curriculum, that's what we're being funded to do.' So yeah, I think I had a really hard sell with the management team to say it has our specs of a spiral curriculum, it delivers in a way that the learning is scalable across different learning levels. The elements are there, but we can't deliver it in the way we want to deliver it... set out a clear point by point business case of, 'We can't do it because of these reasons, but we can do this and it will achieve the outcome that we want."

Pivot to evaluation

As described previously, because of the delays to the work stream and the rapid nature at which the modules were developed, the focus was shifted to the qualitative evaluation.

For many of the interviewees, re-framing the work to a reflective exercise meant that the lessons learned could be formalised and the experience could be used to inform future activities:

"it wasn't that it was a final product but that we wanted people to help shape the product. That meant that if people took part of the course and didn't like it, that was perfectly valid and it didn't matter because we wanted their feedback. Whereas, if they thought that was a final product and then did it and didn't like it, that would have been quite reputationally tricky. Equally, if people did do it and they loved it, that was fine too and that could add to the evaluation. So reframing the expectations of what people had going in to testing the module was really important."

For one participant, the work had always been a pilot to inform rolling training out to a wider cohort and this was the ethos of the funding:

"we were using the Birmingham cohort as the pilot for something that we could push wider and say, 'Well why don't we just put this onto every university programme?' The reason for using the Birmingham cohort very simply is it's easy to access for us because it's in-house. ... if It works how do we scale it to the point where basically it just becomes part of everyone's degree."

"it can be a bit more fluid and a bit more open to change as the process goes. In fact very much what the trailblazer was about, they called it a test and learn approach and I think to an extent this example particularly really drove that home for me that that's how you should work."

Flexibility with tendering

One proposed solution to the issues encountered was to amend the tendering process, so that it included a consultation period and guidance that enabled potential bidders to have a better understanding of what was being requested, and to incorporate opportunity to flag issues. This would enable councils to work in new areas:

"I don't know whether it would be appropriate..., [we'll say], 'We're going to do an information session maybe on this day.' .. But then at least then everybody that's interested and has seen the tender opportunity up to that point has got the opportunity to go and learn more about what the ask is."

"a final tweak opportunity ... [because] I don't think providers necessarily feel confident enough to say, 'Hang on a minute. You need to change your timelines to allow for Beta testing and feedback.' Instead, they respond to the tender that's asked and so they say, 'This is the spec. I'll meet the spec and then I can be commissioned.' There needs to be, at some point, somebody saying, 'Hang on, that's not right. We need to rethink this.' I think the strict process involved with tenders means that the people writing the tender spec in the council don't know about product development and the people applying are then trying to match what's being asked for... What would be amazing is for local authorities ... having more insight into what's involved with the process and how you'd make sure that you get something really robust and good at the end, having best practice guidelines of this is what you should follow if you're commissioning someone to develop a service programme or product of a training resource. I think having a resource such as that would have helped that process."

They (the council team) shared their view on the compatibility of the rigid tendering process with the amorphous nature of public health work:

"Public health is quite flexible, so the projects that we're working on like the trailblazer, like other things that we tender for, ... we want to reach many people, there are different ways in which to do that. But when you come to a tendering process it's very rigid and you have to try and fit all of this kind of like cloud stuff, all this kind of like marshmallow-y stuff that can stretch and absorb other things into these very rigid boxes that sometimes don't quite fit in... We're not a rigid service, but that is a rigid process that we have to go through."

This is because what is known about a planned intervention may change throughout the development and delivery process, or little may be known in the first instance particularly if the work is novel, but the aim is still for it to be effective and have maximum benefit for as many people as possible, and this is an important feature of public health research:

"you might not know exactly how it works and it might actually have to change because there is no point going along that journey sticking rigidly to something if you come up against something three quarters of the way through that goes, 'Actually yeah that's not going to work because we didn't know that at the beginning.' So there has to be some degree of flexibility in order to have a project that has every chance it can to succeed."

"public health ... It's very much like, 'How do we help all these very different people with very different needs in very different situations in different ways?' So everything that we do is not a one cap fits all. Like none of it is, none of it's a one cap fits all and that's very hard. Because you actually have to have a cap knowing that it won't fit everybody because otherwise you can't do a lot of things."

Working closely with the developer

The developer had appropriate experience and engaged with the process:

"the module developer ... appeared to be fairly proficient in that area of developing sort of online pers<mark>onal learni</mark>ng modules in that health field. They'd shown that they'd got previous experience in that area and various different contracts that they've worked for the government and other people. And they were keen to get information and understand more clearly what the ask was and what the expectation was."

However, the gap between what was understood by the developer and the council team soon became evident:

"we got to the post-interview stage the module developer I think was a little bit concerned about the level of work, the timeframe and actually I'm not sure the tender provided the information that was then being given verbally afterwards to

say, 'This is what we want and this is what we're expecting and this is how it needs to work and how can we do this and where can we host it?""

One interviewee shared concern and again referred to the limited timeframe to work-up the course design:

"One of the challenges I had was that the concepts of what were going to be presented within the module were already written and very set. It was like, 'These are the slides. I need your approval by next week,' but really, what should have happened was, 'Here's the outline of what I'm thinking of pulling together. Have you got any suggestions about whether this is the right focus or whether this key message...?' It should have been evolving in partnership and it should have been Beta tested with users all along that period... Again, that's down to the funding that was available and the time that was available being really tight. I think with projects that I'm doing at the moment where we've got timelines that are a problem, instead of rushing it through to hit the timeline, I have just simply worked out a way to change the timeline. You can't rush. It's much more important to have quality rather than speed."

The developer shared how they had been in frequent contact at the start of the contract but this changed after the first month. They described how they had enjoyed being part of an interdisciplinary team and that it had been quite robust and collaborative, sharing the example of how they had decided to proceed with naming the website, 'Healthy Brum'.

This insight demonstrates



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3.5.5 Feedback on course content

The next section draws out the insights of what was valued and suggestions for improvement in the course design.

Meeting the needs of both junior and senior apprentices

The senior team described the difficulty of being able to use the same module content with apprentices at different levels of training and considered the feasibility of this. This was due to the extremes in terms of the needs for each end of the spectrum, that those on senior apprenticeships were world leaders and would have very different requirements to more junior colleagues:

"How do you do something that works for a level three and a level seven? And actually maybe the answer is you don't. You know, it's too complicated to do them all at once and we should've been less ambitious ... the content for level one to three is probably okay ... But it's completely inappropriate for a level five to seven because where they are in their education attainment and capacity, they would discount and disconnect too quickly from the kind of waffle."

One participant described how trying to encompass both meant that the needs of both the junior and the senior apprentices were unmet. As a result, a course targeting senior apprentices may need to be commissioned separately so that it would be fit for purpose:

"we were trying to do level one and level seven and we ended up with level one mess basically. And I think if we start at the other end and we go level seven, can we commission something which is specifically around managing your own health and wellbeing as a senior leader and managing the health and wellbeing of a high functioning team"

By focusing on the two separately, the individual needs of the apprentices could be explored to a greater degree:

"in the context of level seven business apprenticeships which the MBA is one ... We might want to include managing across cultures. Health and wellbeing in the context of international business, health and wellbeing in the context of a global workforce"

Additionally, the feasibility of the spiral curriculum and its incompatibility with the heterogeneity of the apprenticeship courses meant that this element was not realised:

"Unfortunately the apprenticeship [training] providers very quickly came back and went, 'You just can't do it because a level three in hairdressing is completely different from a level three in business administration.' So it is too complicated to create a spiral curriculum that will actually work in the context of the diversity of apprenticeships."

Junior apprentice course content

A member of the council team described how everyone below a certain level of seniority had been positive about the training:

"it was pitched more at the don't know much about Public Health or health literacy angle and that worked well for everyone I spoke who was new to the area or didn't know much about it. Everybody at that level loved it."

Some apprentice participants shared this sentiment and a junior apprentice described how the course contained unfamiliar content:

"it gave me something new, thinking about my health and different things about health that I normally don't pay attention to, such as digital health, and also active walking, and taking care of your portion sizes and stuff like that. I wouldn't say I don't care about it, but I never thought of it in this perspective that the training presented it in."

This was echoed by a managerial apprentice participant who felt the content was appropriate for newcomers to the subject.

Managerial apprentice course content

One participant not working in public health but with an interest in health felt the level of information was appropriate for someone with limited prior knowledge of health:

"I did recognise that the course was very much aimed at people who had limited or no knowledge. There were a couple of times where I found it a bit simplistic but I don't think it should be changed because of that. That's more about the fact that I already know a bit about that and I get it but there's a bit more to it than that. If you gave that level of information to somebody that was coming to it new, I think you'd overload them."

A one-size-fits-all approach to developing health literacy will not work. Both the content and the delivery method needs to be tailored to the audience.

The other senior apprentice participants worked in public health. Two of these described how they felt some of the content was flawed and contradicted their own understanding of public health and food behaviours:

"I did find the way that the food stuff was framed to actually be quite unhelpful. ... And I think, yeah, again, with that kind of public health nutrition hat on, I think that personally that isn't the ideal way of trying to get people to eat healthily. That's kind of like a quick fix."

"[that] there's this need to trick the brain, and I just wonder if that's a positive message to convey... rather than encouraging this change of perspective, and also embracing the fact that lots of healthy food is actually really tasty. It's just that marketing and capitalism has told us otherwise."

A senior management participant reported how for those more experienced in public health, it was missing the elements they would expect, such as evidence and scientifically driven models:

"people who were more experienced in Public Health, quite knowledgeable in the field and so on, it didn't hit the right angle for them. I think there was a lack of evidence and models that were scientifically driven, systemthinking and Public Health leadership type approaches... it didn't hit the mark for people who were leading, like genuinely world-wide leaders in system change. I think it felt perhaps a little boring and patronising but that's why it needs to be developed in a different way for those audiences."

These individuals and the other participant who worked in management (who had worked in fitness and nutrition previously) felt that the course did not teach them anything new. For one participant, this was one reason they had doubts about doing the course in the first place considering their workload:

"perhaps maybe slightly that it would be a repetition of lots of things that I potentially already knew, and that it would take out time"

"As an apprentice I didn't feel particularly engaged, as a level seven apprentice I was going, 'Hold on, I'm a senior executive and you're making me listen to quite long, being talked at, not very engaging education modules"

Despite this, one participant shared that there were parts that were new to them and clearly conveyed:

"there were definitely some bits where I definitely learnt something, and I think there was important content around... there were things around food packaging and prescription labels that I don't think get talked through that much, actually, and it was really clear and concise and useful."

Ensure representation and diversity

The participants referred to how the training had captured the range of cultures and ethnicities of Birmingham. The developer described how they had included content that represented Birmingham's diversity but could have supplemented this with footage from the council, such as recordings of people's tips and tricks, to capture this. However, he also shared that this would not have been possible due to: the COVID restrictions at the time; the limited budget; and insufficient time. A member of the senior council team described how representation could have been achieved had this been a goal from the start and a course that did not capture this would not be fit for purpose for Birmingham's population:

"having different people leading it, or different actors, or different presenters doing different elements because what you want is everyone to feel like there is someone like me on there. ..."

Several participants described how the course was limited by its representation of diversity and inclusivity. One of the junior apprentices shared how some of the examples used in the course were not relevant to them as they related to alcohol and eating pork:

"It didn't because with regard to ethnic backgrounds, some of the stuff ...didn't actually apply and I was thinking, 'It would be better if there was someone who understood our culture ... In our community, we have weddings and festivals and maybe they could talk about that because then they could talk about the healthier options there and that would have been more interesting. ... it would have been more beneficial to take into account people's backgrounds, especially if it's about wellbeing."

One apprentice participant noted how using more than one presenter may have made the course more engaging for more people:

"where there are a couple of people. It's a change then, isn't it? It's a different type of delivery. One person you might not be able to resonate with but then another person, you might. I just feel it's more interesting and engaging."

Culture, religion and available money are just some of the things that influence health behaviours and choices. Birmingham is the most culturally and ethnically diverse city outside of London.

41% of children in Birmingham live in poverty, compared to the national average of 31%. Any initiatives need to be appropriate for our diverse city.



Accessibility

The extent to which the course was accessible was considered by the participants. One described how subtitles might have increased accessibility:

"I don't have any, but I just thought that while I was looking at it, that some people that might have hearing impairments may not be able to hear it properly because there wasn't any subtitles. That may have been not as accessible for some."

Use of a range of delivery formats would have also promoted accessibility:

"I can't help but feel that perhaps to increase the accessibility, you would potentially have the talker there the entire time but with the information in the background."

Some participants, described how the presenter was likeable and relatable, which may have made the training more inclusive:

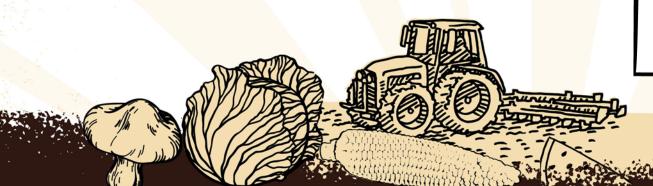
"the guy seemed approachable and friendly, and I think he might have appealed to some people. ..."

"I think anyone would have been able to listen in. It wasn't overly jargoned or lots of technical language or anything like that. I think it was accessible"

It was noted that the approach inherent in the course was pragmatic and accessible - this was important because health should be accessible to all:

"I quite liked as well, just in terms of the general content, right at the start about the honesty about, "Look, we're not here to try and make you climb a mountain every day or to take on things that are unrealistic." It was really like a realistic approach to just making small incremental changes as well. And I think the content reflected that."

"This is accessible to everybody, basically. This isn't just an elite club of people that are much more capable than the rest of us, like anybody is capable of doing this."



Comparison with other courses

Most participants compared the training delivery to other courses they had previously received or described how content could be delivered in different ways to make it more engaging or promote its retention. Some felt this course was lacking in comparison. However, there was an appreciation from the senior team and the developer that use of a range of media and formats would require a larger budget than was available:

"I thought it would just be any normal course, you read stuff and then take a quiz or something like that. But it was different from what I expected, actually... all of the learning content was in a lecture style, because it was videos...it wasn't reading and there weren't any activities apart from a quiz that you could do to consolidate your learning"

"there wasn't any use of graphics or text box or highlight moments to kind of go, 'This is the bit that I want you to remember and take home.' So there was no billboard-ing of the key messaging, which would've made it a lot better." For one participant, they felt the health literacy course was delivered to a higher standard than their apprenticeship:

"the apprenticeship I'm on ... there have been a few delivery issues and a few people have been a bit disgruntled about the quality of the delivery of what's gone on. So compared to that, yours is brilliant! [Laughter]"

It was felt that expectations of this training would differ from courses from which the recipient would get a qualification and that the format was appropriate in this case:

"yours is very much an entry level and it's about raising awareness of what to do. If there was something that I needed and you said, 'Come and do this and get a Level 2 in nutrition or a Level 2 in fitness,' then I'd expect it to be more interactive than it is but I think for where you are and for what you're doing, as I say, I think it's the right medium."

3.5.6 Feedback on course design

Some felt the course was clearly delivered while others felt it was not and was instead somewhat erratic:

"it was very clear through everything, properly. Even sometimes when he would say stuff, there would be a list next to him and he would read from that list. So, yeah, it was quite clear."

"it jumped around, the presentations jumped around... Because it's gone from eating, to brushing your teeth, to physical activity, to sleep. There were no anchors to hook it to, to kind of go, 'This is helping me remember' or positioning it in the context of a working life."

Others felt it was unnecessarily long:

"the delivery was quite long, so there could have been fewer stuff in there and it still would have had the same impact, I think."

Participants described how the course was delivered without use of a script by the presenter which meant the content was not delivered in a way that was to the point and they digressed into inaccuracy:

"a lot of talking, not very engaging, quite ambling, rambling. Didn't really bring out for me clear, coherent cause to action or things to do. Didn't really use anything that would help anchor that learning."

"it seemed like they didn't use a script, which is good in terms of like not just reading off a script. Obviously, that's really boring, but at the same time, it did just feel quite like verbose, it just could have been more to the point"

For one participant, they felt they would not have gone ahead with the course had they known it would be delivered in this way:

"There was nothing interactive about it. If I knew it was going to be someone just talking about one topic and then talking about the next topic, I don't think I would have signed up for it."

The same participant felt that as a result, the course made very little impact:

"I can't really remember it but I think that's a sign that it wasn't really that impactful [laughter]. Sorry... There were no real visual aids or anything. It was just someone... I don't know but I don't find that kind of learning interesting." One participant described that use of additional ways of delivering information would have made it easier for recipients of the training but also would take pressure off the presenter:

"the switch between the talking and the ability to see the key bullet points for me perhaps made it just a little bit less easy to digest, I think." And I think it made it harder for the presenter because they were having to explain everything."

Another participant shared how the quizzes used in the course did not serve the intended purpose but instead served as prompts to indicate key areas to note:

"And because you did the quiz at the beginning, you then knew exactly which facts to memorise. So I kind of was just like, "Oh yeah, I need to memorise that one," and I just wrote them all down ... you were kind of like just listening out in the video for those facts and you could zone out a bit because it didn't really, like you knew how to pass the quiz."

The scientific basis for the quizzes was also questioned:

"... It's really hard in a quiz or a survey to actually measure motivation for change, knowledge to... I guess you'd have to use one of the different behavioural change models, but to actually kind of measure that would be quite challenging"

The developer shared how they had received negative feedback from the participants about the quizzes and that they would remove them. Participants described how they would have preferred if the course used a range of media and graphics or had a seminar style rather than only a lecture-style presentation where the participant was passive. One participant said they were used to this though, having recently done most of their undergraduate degree remotely. They also described how use of other formats would be more convenient:

"I think the lecture format was good, but obviously, when you do it, you need a quiet space, you can't just do it in an environment where there's noise or distractions, because you need to be able to listen to the video properly. So if it was just reading or doing some activities, that would have maybe been more convenient at some times because everything was just the video."

However, for some the delivery was such that participants described how they were able to fit it into their schedules and pick it up and put it down again which meant it was not at odds with their other work:

"Yeah, it was good. I just did it whenever I had free time, or sometimes I even set time aside in the day to specifically just finish that training"

"You know, you could come back to it, basically, which was really, really helpful within a working day."

3.6 Key learnings for future engagement with apprentices on health literacy and health and wellbeing

The following section summarises the key learnings from the qualitative interviews with quotes added to provide illustration of the different perspectives. The section starts with a report of the impact from participating with the course, and then provides a summary of suggestions for future course design.

3.6.1 Application of course content

Use of course in personal lives

Many participants reported having used some of the course content in their personal lives and this included sharing information from the course with a friend/partner/relative:

"one thing that I've done is being big on active walking, because that's something that the training pointed out. So now I count my steps with a pedometer, and I pointed that out to my sisters as well, that they should maybe look at doing active walking more instead of taking the bus or a taxi or something like that everywhere. Because from the training, I then read that being active is taking 8,000 to 10,000 steps a day, whereas the average Brit only takes about 3,000-4,000 steps a day."

"I actually thought most helpful was the physical activity section... I think the thing that stuck with me was trying to do half an hour of basically non-walking exercise per day. And I have been trying to do that since I did the training."

"a friend and I now have this thing that's happy, healthy habits where you do a half an hour of something when you can and do the exercise that you feel like doing on that day rather than forcing yourself to, I don't know, do something you don't really feel like"

For one participant, the training was timely as they had surgery and it reinforced the healthy habits they had stopped while recovering:

"I think it came at quite a good time because ... I'm off the back of recovering from a very minor surgery, so I had a bit of a pause in being able to be physically active, which I really like to do. The surgery was GI-related, so it was affecting what I could and couldn't eat and that type of thing. So I've been on the road to recovery with that. So again, it served as a really nice refresher too at a time where I already was feeling quite a kick to be eating right and eating enough and also going back to activity. So, yeah, I'd say it's been of use"

Use of course in professional role

One participant described how the course provided them with a new perspective and that they had applied it in their work:

"It opened my eyes to some aspects of health which I do work on, in my everyday job, and I feel like it will just help me to put things into a different perspective, which I always need within my job, to put things in a different perspective."

"I've been trying to apply healthy eating and thinking about... because healthy eating is important for maintaining good oral health, and the training did help with thinking of ideas of what to put into the plan for my project."

One participant anticipated that they would start line-managing soon and explained that some of the content resonated with the kind of role-modelling they intended to use in their role:

"I would want to be a manager that models taking screen breaks, for example, because I do, and models getting up and being physically active, whether you can fit that in before work, during work, after work"

Another participant reported applying principles in their management role but felt that this is something they had done previously because of their own background and experience, however the course had given them more confidence to do so and changed their approach in doing so:

"I probably already was though, as I say, because I already have a degree of knowledge about that... One of my team has been having a certain health problem ... I recommended she went to her GP and just asked a couple of questions. It turns out she's got something different and is feeling a lot better. So yeah, I am using it in proactive and positive ways ... the way that your training was presented, I suppose it gave me a little bit more confidence about doing that sort of thing ... Possibly by being a little bit more empathetic, a little more understanding and a little bit more gently persuasive rather than saying, 'No, no, you should be doing this"

One apprentice who was not in a managerial, but a customer-facing role, shared how they used the training with a customer who was suffering from depression:

"she was telling me about how she was feeling low and thinking about suicide. She said the medication wasn't agreeing with her but then I just remembered some stuff from the training and I said, 'Maybe speak to someone.' I just remember some of the stress tips from there, like meditation and I was telling her about the apps like Headspace. I think he did mention stuff like that on there and so I gave my customer some tips from there."

Adapting the course design

3.7.1 Engagement with stakeholders/advisory panel

Early engagement with stakeholders to understand context:

One of the senior participants considered the utility of engaging with key stakeholders at an early stage so that this would inform the development of the tender to ensure questions about feasibility are addressed. Some discussions had taken place early on but did not relate to practical elements of how the course would be delivered:

"I was going to do this again I would engage with those people at a much earlier part of the process to say, 'This is what we're thinking about and we'd like you to be on this journey from the beginning so that we've got the right people and the right voices that can guide us the right way through doing this'

"I start projects with conversations with the people I'd like to be in the projects before putting pen to paper..."

Early engagement with stakeholders to develop content and process:

Despite the training providers feeling that the initial idea was flawed, they were keen on the general principals and keen to support further development of the training so it was feasible:

"They were like, 'This is great', because this is part of our personal health and wellbeing offer that they are obliged to do, health and wellbeing and all of that ... You know, so it worked for them in that way."

One participant felt that relationship development over time with these partners could have enabled the apprenticeship health literacy training to proceed as originally planned as it would have allowed collaborative development of a product that met a mutually agreed, pre-identified need:

"you can't just expect to develop a collection of modules and then just say, 'Oh, can you put this in place please?' without any relationship development. The relationship development takes months to develop...."

Also, once started, use of an advisory panel with those with relevant specialist knowledge would help to ensure the development of such a course had the necessary monitoring (e.g. use and approval of story boards etc.).

3.7.2 Fitting the modules within a training programme

One participant advised how the health literacy course climate has since changed so the contribution of such a course would need to be reconsidered. They advised how since the inception of the training, there are now new health literacy courses available and more consideration of where this training would fit would be required:

"Health Education England have really taken that forward in terms of embedding Public Health and behaviour science and those approaches there. So I already know a lot of the people involved with Health Education England modules. So there are other NHS platforms and learning platforms where there are health literacy modules and what we've been doing initially is capturing what's actually available on there and scoping out what there is and where it might be appropriate. So

it's more of a reflection on what's already out there that we don't need to duplicate."

The senior council team were confident in the level of buy-in from apprenticeship providers and their demand for such a course. One senior participant advised how provisional agreement had been secured from the NHS and other public sector service to integrate the course (once reworked) into their apprenticeships. The course would not be mandated but part of their respective induction programmes:

"we have already secured provisional agreement from across the NHS and the other public sector services to integrate it into the commissioning requirements of apprenticeships funded by public sector bodies... we had that provisional agreement from the wider public sector that once we got the modules then yes absolutely they would require it for their apprentices and apprenticeship providers and therefore we get to a tipping point in terms of critical mass."

There is interest in health literacy training and initiatives. Other organisations have been developing health literacy courses over the last few years so it is necessary to review and reflect on what is already available, and identify the gaps.



Further to this, the way in which the training would be included within the various apprenticeship schemes would be subject to processes internal to organisations through which the apprenticeships receive their accreditation, and the way their courses are organised:

"rather than creating things separately, building on existing things that work really well and add health literacy into lots of other things as opposed to making it stand-alone...if they're embedded and integrated, it's easier to ensure that they stick in the long-term. So if we want health literacy culture and education to change, it's got to be thought about quite strategically on a much larger level."

With such work, inventive ways of integrating various components of health literacy training could be used that would enable course material to be tailored to the individual:

"you could almost have some sections of things that could be chopped and changed with a video with an intro for different population groups or different settings. If you developed online and digital type resources, you could be quite creative with how you make the messages feel relevant to someone else. You could take a collection of health literacy segments, for example, then develop a tailored version of that, for example, teacher training courses. ... with apprentices within the council where they are at every level and every background. They're just people. They just arbitrarily happen to be apprentices. There's no unifying feature of an apprenticeship group that makes one person more related to another. They've probably got more commonalities with other people based on their cultural background, or where they live, or their interest, or something like that."

One of the apprentice participants felt that inclusion of the course in mandatory training would be reasonable and another felt it would make sense as part of induction material due to its universal relevance:

"I think it could be embedded better ...as a part of a company's induction programme. 'Come and work for us. You're going to do all this. We'll talk to you about health and safety. We'll talk to you about safeguarding. We'll talk to you about IT security. We'll also talk to you about your own personal health and wellbeing.' It's a natural fit, isn't it?"

"I suppose you could use it in any aspect of life, not particularly as an apprentice. Every human being could benefit from wellbeing and improved health and so for that reason, I'd say yes. I'm right near the end of my course and so maybe this should be something at the beginning."

3.7.3 Future course content

For future iterations of the training, to ensure the course would have appeal to more senior apprentices, the content would need to be such that it was clear the course would enable recipients to understand about health and wellbeing in the context of their leadership position:

"it is about how do you manage your own personal health and wellbeing in a senior role and then how do you manage the wellbeing of your staff? ... you're now starting to think about how you're applying theory, it's all about supporting you into senior roles. So we give you this option of an additional learning opportunity"

The content of the course and its delivery may need to be restructured so that participants would be able to follow-up on aspects of interest:

"I think we tried to cram too much into too short a time period and instead kind of going, 'Here's an intro and then here's a group, here are options.' So if off that intro you want to know more about how to look after your sleep, 'Here's a follow up module.' So it would be a branching, with the first module being the kind of strongly recommended one"

An apprentice participant advised that more training on healthy eating behaviour and how to access health services would be useful:

"I think if you did almost like that as like a behaviour change module and kind of took people through what was in say, like, Coke or, I don't know, like a ready meal, and what it actually does to things like your brain and your appetite and your hormones and things like that. And then kind of, yeah, just sort of took people through and kind of actually really got down into the nitty-gritty of changing people's behaviour through knowledge, through motivation, through all those different areas in behavioural change science. I think that'd be amazing... when do you actually call 999, when do you call 111? ... some really good training that like really did change the population's views and actions in terms of using services that they didn't need to use. I think that'd be really, really useful, maybe in the services bit"

We will reflect on the learning from this evaluation and this process will influence the future approach to health literacy modules and initiatives within Birmingham City Council.

3.7.4 Style of delivery

Some participants felt that in particular, the use of face-to-face delivery could reinforce learning in ways not possible with remote methods:

"having some of the delivery in-person would definitely be of huge benefit, it helps to generate discussion. It helps the opportunity to learn from your peers as well as the facilitator of the session, and perhaps to pair that with the interactive side ...on their phones or devices or laptops or whatever I think would be potentially quite a powerful combination, because, you know, the danger of any web-based training is that it's super easy to switch off and disengage, even when you're not meaning to, you know, even when you're really trying to, because you just don't have that same level of energy and engagement that you would if you were in a room with people. And I think again, there's also that opportunity to, if you're delivering stuff in-person for people to use the tools with a bit of support in real time."

"I think that really and even just on a basic human level as well, it's always really great to hear what other managers are doing to encourage their staff to improve their health and wellbeing. It's just that idea to crowd source information. You know, somebody sat at your table saying, "Oh, well, actually, I've tried this and it's working really well," is really valuable."

Another participant described how live training could be delivered remotely and how this was a more interactive medium:

"we were doing it over Teams with a trainer and me and my colleagues were all listening...It's just more engaging. Obviously, my colleagues might ask some questions in the comments box on Teams and with that, it's a bit more interactive, isn't it?"

Although some participants acknowledged that the format worked well for them, they acknowledged that people have different styles of learning and described how use of different modes of delivery might enable the recipient of the training to engage in a way that suited them.

"It worked well for me as it was. I'm not a great one for podcasts. I find if I'm listening to something entirely, my eyes will pick up other things. Like we're talking now, I can see you and I can focus on you using my mind, ears and everything. There's nothing else distracting me. So I can't think of a different format that you would necessarily give... we've all got different learning styles and we all engage in different ways but I think it probably would be a good general delivery for



"Maybe if I was clicking through stuff myself or I guess had some sense of ownership of how long it took to get the information, I think that probably would have made it more engaging"

Participants acknowledged that more delivery formats would have resource and practical implications and so being pragmatic about being about to meet general needs was necessary:

"I do know that other people react in different ways, like if you had the time and resources to provide it as a podcast, for instance. If you've got all the reading materials there, some people would just prefer to go and read. There are some people who would like the ability to be a bit more interactive and to ask questions but then you've got to deliver that as an actual course - virtual or otherwise, it's got to be a classroom-based thing. To a certain extent, that's very much down to who you're trying to reach and what your resources are as to how you deliver it. I think the way that you've done it for general consumption is good."

The developer shared that their team would have been able to use a range of formats for the course, such as delivering in-person, using social media, or posters and podcasts, but that the contract was for an online course. A senior participant identified how a range of delivery modes for the course content would need to be used in future iterations:

"video alone e-learning is probably as dry as purely text-based learning. And that for this to really work actually probably what we needed was an e-learning provider that could provide a mixture of text-based modules and video inserts rather than what we got which was completely video."

Preferences for how people like to learn vary so any future health literacy modules or initiatives need to consider that in the development process.



3.8.1 COVID-19 and Capacity - Food business perspective on jobs and skills

Our intention to engage with supermarket retailers via the chamber of commerce and the wider focus groups with local food SME's and regional/national food businesses became unviable due to a combination of:

- Challenges reaching out to industry no central point or local peak body for engagement with food retail and food businesses.
- Challenges for industry in responding at a time when COVID-19 pressures were pushing the sector into survival mode.
- Challenges for us staff sickness and the lack of efficient engagement routes means that we had insufficient staff capacity to deliver the original scope,

Therefore we adapted our approach to focus primarily on the health literacy and apprenticeship element of the workstream.

3.8.2 Learning and Future Opportunities

Following the initial challenges faced during the height of the COVID-19 pressures on both internal staff delivery and on the wider food and drink sector, we explored the opportunity to build a lasting programme from what we learnt.

We adapted and developed the community researchers platform to develop tools and begin the conversation with food SME's on their need and seek opportunities for growth. We will look to then extend this work further once the food and drink sector begins to recover from the challenges faced following COVID-19 and the current cost of living crisis.

We are also working closely with University College Birmingham, the leading catering training provider in Birmingham, to create a Centre of Urban Food which will become a central point for both food and drink training, alongside food and drink business sector.

Key learning from the initial scope has created the foundation for a future platform of collaboration and development between the food business sector and local leading catering training sector.

Summary of Qualitative Evaluation

The development of the course was impacted by staff change and absence, limited planning, and the coronavirus pandemic. It had been ambitious in its scope and stakeholders among apprenticeship providers had expressed their interest and support. Participants recommended that future endeavours in this area would benefit from engaging with key stakeholders early and working collaboratively to identify what is needed and how it may be realised within the local context.

For those who received the training, their experiences were varied. Many participants were working within public health although their seniority varied. It was unclear what level of prior health knowledge would be best suited for the training. Some apprentices who were more junior reported having been interested in some of the content and seeking additional information independently as a result. Several participants reported having applied the course content on a personal and professional basis, however, senior public health leaders felt that the content was at odds with their own requirements. Many saw the value in the objective of equipping managers to promote healthy behaviours among their staff, but the extent to which this was integrated within the course was thought to be limited by some. The style of delivery was not favoured by many participants, although some acknowledged it was easy to incorporate within their working day. The extent to which the training was culturally appropriate, and representative of the Birmingham population was considered to be limited. However, the way in which the health concepts were delivered were thought to be accessible and the manner of delivery approachable.

The developer described challenges relating to changes in the brief and a lack of continuity of council personnel. They advised they had met the brief as it evolved but the timeframes did not allow them to complete the usual finishing stages in terms of editing.

The module was not completed in the way in which it was originally intended or with the planned scope. However, those who had completed the training reported ways in which it had appeared to have positively impacted upon their health literacy.



3.9.1 Sustainability of initiatives and legacy

This work stream has generated shared learning of the enablers and barriers to developing and implementing enhanced training designed to improve health literacy levels across the workforce.

Apprenticeship providers have indicated their support for such an initiative and are keen to form working partnerships to further co-develop a training package.

With further adaptation, informed by the insights from this research, the health literacy training can be routinely embedded within established training programmes across the City.

Ongoing development of a platform of collaboration and development between the food business sector and local leading catering training sector will facilitate industry engagement and further development and uptake of training.

3.9.2 Conclusions

Working with an external provider, a pilot health literacy course was created and a comprehensive qualitative study undertaken to generate insights to inform future design.

Work was undertaken to explore wider applicability which identified learning on facilitating industry engagement.

Next Steps

This evaluation will be shared with those creating health literacy modules and initiatives at Birmingham City Council to inform their approach. We will also share the report on our website so others can benefit from the insights and learning, too.



Work Stream 3 - Lessons Learned

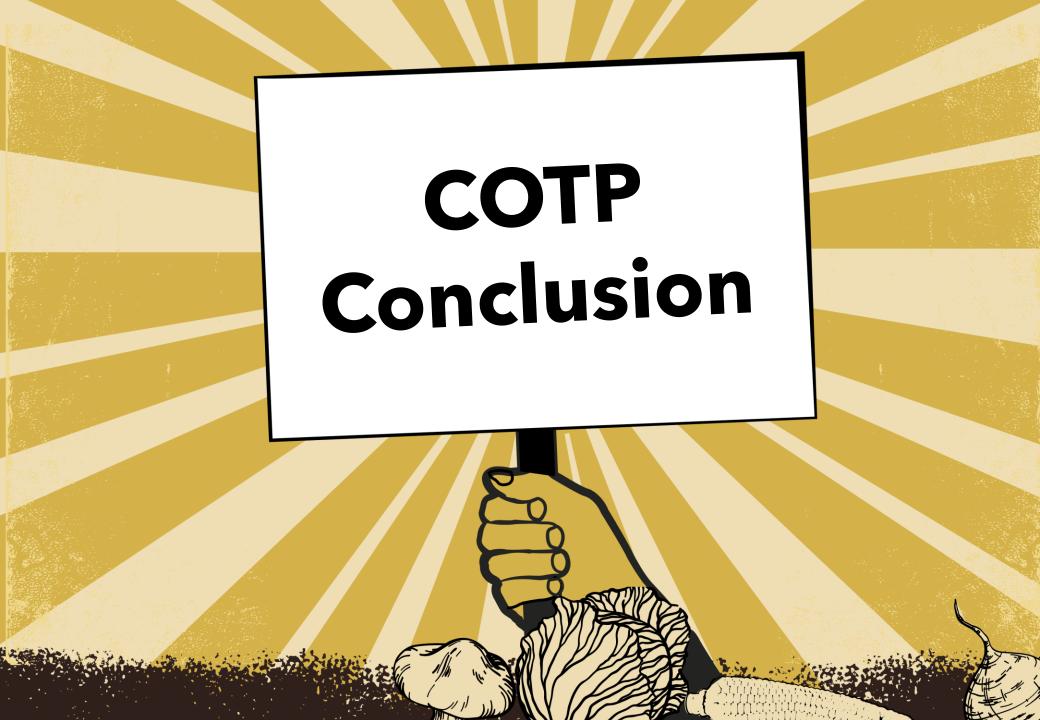
The work stream represented an ambitious plan but the COVID-19 pandemic resulted in staff being restructured and repurposed meaning resources to deliver were limited.

In terms of lessons learnt, the following presents a summary of insights:

- Allow plenty of time for module development to include time pilot-testing, tweaking and re-testing.
- Consider the design of modules separately for different levels of apprenticeship training.
- Ensure the brief for the tendering process is clear to manage expectations.
- Ensure clarity on the different apprenticeship courses offered and consider if the training needs for health literacy are homogenous even within the same levels of apprenticeship training offered.
- Allow plenty of time to follow the process of re-accreditation within established apprenticeship training schemes.
- Ensure adequate resources allocated to address diversity in content and delivery.
- Allow flexibility within local authority tendering processes to enable test and learn approaches.
- Consider what is already available with respect to health literacy training and ensure not duplicating effort.
- Ensure the course is interactive, with practical examples and flexibility in design to fit around busy schedules.
- Use a range of formats to promote accessibility, including a mix of online and face-to-face interaction, and avoid technical language.

To help facilitate the development and implementation of health literacy training, we have generated two outputs from this work stream. The first output is a guidance document to support local authorities when developing public health interventions more generally, and the second output consists of more specific guidance for the development of a health literacy training course. Both outputs have been developed as accessible, downloadable 1-page documents available at Birmingham City Council website. These outputs have been generated to serve as a practical guide for local authorities summarising the insights from this work stream.





Discussion and Conclusion

- All projects have made progress towards achieving the work stream objectives, and Birmingham is still on a journey to achieve them.
- The test and learn approach of the Childhood Obesity Trailblazer Programme was very effective, and enabled us to closely monitor progress and milestones and to adapt our approaches as required.
- The vision of WHAT we are trying to achieve was fixed, but HOW it was to be achieved evolved.
- A whole system approach is vital for driving change, but this approach led to complexities due to there being many partners and stakeholders, and existing processes that needs to be accounted for. Strong relationships, good communication, and building flexibility and review points into projects is important.
- COVID-19 had a significant impact on the delivery of all work streams due to the Public Health Division's role in the emergency response which led to competing priorities, as well as staff sickness. However, it also united the city and led to a shared city-wide vision as part of the Birmingham Food Revolution, and partners and stakeholders working together collaboratively to achieve system change.
- Working with the community and using participation-observation research methods has helped with increasing citizen involvement and their engagement in public health initiatives.

In conclusion, there will be a lasting legacy for each of the work streams as they have been integrated into other projects, and embedded into the Birmingham Food System Strategy. The learning gathered through the Childhood Obesity Trailblazer Programme will shape the future approaches to tackling obesity in our city.



Recommendations

- 1. Develop **strong relationships and communication with stakeholders and partners** as many solutions are already out there, or could be achieved through partnership working, so strong relationships and communication are key.
- 2. Work **collaboratively from the outset** with colleagues from other departments, and with partner organisations and stakeholders. This ensures that the solutions produced are suitable for how corporate processes work in reality.
- 3. Ensure a **variety of people are involved with the development of solutions.** This includes scientific and theoretical experts, subject experts, those experienced in practical applications and real world settings. This will ensure that solutions are scientifically robust whilst still being logistically feasible to implement.
- 4. Be patient as the **development of robust solutions takes time.** Need to scope existing evidence and solutions, explore ideas, validate plans, test and refine the solution, gain feedback, and evaluate. Separating the project up into parts can help ensure that each phase influences the next and allows for the plan to evolve over time.
- 5. Utilise **participation-observation research techniques** to gather insights from real world settings.
- 6. Initially **map existing processes before developing solutions**. Identify opportunities and potential challenges. A solution that doesn't fit into this existing process will likely not be adopted.
- 7. Consider solutions from the **perspective of diverse people** at every stage of the process, and capture feedback from a wide variety of people, to ensure that the solution is as effective as possible.
- 8. Create **living documents that evolve**, rather than static tools, to allow for guidance and policy that continuously develop.
- 9. Ensure **that briefs for product development and partner relationships are clear**, manage expectations, and regularly review and refine the brief as things evolve.
- 10. Ensure **adequate resources to address diversity in content and delivery**, and to ensure the resources are interactive and engaging, and use a range of formats to promote accessibility.



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