BIRMINGHAM CITY COUNCIL

SPECIAL BIRMINGHAM HEALTH AND WELLBEING BOARD THURSDAY, 23 APRIL 2020

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON THURSDAY 23 APRIL 2020 AT 1500 HOURS ON-LINE

PRESENT: -

Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Chair of Birmingham Health and Wellbeing Board
Andy Cave, Chief Executive, Healthwatch Birmingham
Andy Couldrick, Chief Executive, Birmingham Children's Trust
Chief Superintendent Stephen Graham, West Midlands Police
Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Nichola Jones, Assistant Director, Inclusion and SEND, Education and Skills, Birmingham City Council
Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust
Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust
Professor Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Peter Richmond, Chief Executive, Birmingham Social Housing Partnership
Waheed Saleem**,** Birmingham and Solihull Mental Health Trust
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Dr Ian Sykes, Sandwell and West Birmingham CCG
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Cllr Karen Grinsell, Chair of Solihull MBC Health and Wellbeing Board and Vice Chair of the Birmingham and Solihull STP
Professor Simon Ball, Chief Medical Officer, UHB NHS Foundation Trust
David Carruthers, Medical Director Rheumatologist & Honorary Professor (University of Birmingham)
Rachael Ellis, Sandwell and West Birmingham CCG
Dr Giri Rajaratnam, Deputy Regional Director, PHE M&E Regional team
Dr Gavin Ralston, GP Partner, Harborne
Dr Naresh Chauhan, GP South Birmingham
Dr Kazeem Olagoke, GP Ley Hill Surgery, Birmingham and Solihull CCG

Dr Chizo Agwu, Deputy Medical Director, Sandwell and West Birmingham NHS Trust
Carol Herity, Local Director of Partnerships
Brian Carr, BVSC
Carol Cooper, Head of Equality and Diversity, Community Trust
Joy Warmington, Vice Chair Birmingham and Solihull Mental Health Trust and CEO for BRAP
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

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

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Chair of Birmingham Health and Wellbeing Board then made introductory comments and advised that Dr Justin Varney, Director of Public Health will provide an overview of the current coronavirus situation locally, regionally and nationally. She highlighted that they had received over 180 emails many listing over 3-4 questions each, but that due to time constraint they would not be able to address all the questions today but that they had themed the questions raised and will be asking 15 of these questions today for the board members and invited guests to respond to these.

The Chair stated that all the questions sent in were important and will feed into a report produced and that Dr Varney and his team would be responding to each of the questions sent in. She added that following on from the meeting a report would be prepared which will be forwarded to the Secretary of State for Health and Social Care to inform the national consideration of Black, Asian and Minority Ethnic inequalities in the Covid19 outbreak, which would also be shared with the Board.

The Chair then invited the organisations represented at the on-line meeting who were present to introduce themselves. She advised that Councillor Yvonne Davies the Cabinet Member for Health and Social Care in Sandwell was invited to the meeting but was unable to participate today. The Chair welcomed Councillor Karen Grinsell, Deputy Leader of Solihull Borough Council, and Chair of the Solihull Health and Wellbeing Board to the meeting.

DECLARATIONS OF INTERESTS

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

APOLOGIES

455 Apologies for absence were submitted on behalf of Professor Graeme Betts, Director for Adult Social Care and Health Directorate
Gaynor Smith, Senior Employer and Partnership Leader, Birmingham and Solihull District, Department for Work and Pensions

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COVID-19 UPDATE

Dr Justin Varney, Director of Public Health, Birmingham City Council briefly set out the journey they had been on with Coronavirus and advised that the first cases were reported in China to the World Health Organisation (WHO) on the 31 December 2019. The first case outside of China was recorded on the13 January 2020. The first case in the UK came on the 29 January 2020 in York and that was a student who travelled from China and then there were a series of cases in early February in Brighton and East Sussex linked to an individual who had travelled from Singapore via France to the UK.

We saw the first cases of transmission within the UK on the 28 February 2020 and the first death in the UK was confirmed on the 5 March 2020. At that point, there were under a hundred people who had tested positive for the Coronavirus in the UK.

The first case of Coronavirus reached the West Midlands on the 1 March 2020 and the first case was recorded in Birmingham on the 7 March 2020. They then had a rapid increase in the number of cases and the first death in Birmingham was in the week that ended on the 20 March 2020.

As of yesterday, the national case report for Birmingham was 2,431 cases. It was important that they keep in mind that Birmingham was the largest Council in the UK as there was over 1.1m people in residence. It was expected that Birmingham would have more cases of Coronavirus and more death even if they had the same percentage or the same … as other smaller authorities. They were also tracking how Birmingham was progressing this outbreak in terms of the rate of cases. Currently, Birmingham had the fourth highest rate in the West Midlands after Walsall, Wolverhampton and Sandwell and was closely followed by Solihull. They also tracked how they were performing and the pattern against the Core Cities, i.e., the large cities outside of London, and Birmingham was fourth behind Sheffield, Newcastle and Liverpool.

As colleagues will discuss during the meeting today, with the information on deaths was complicated as there were different sources of information as they knew more about deaths in hospitals, than they do for deaths in the community and care homes. This was to do with the way that deaths were reported and

recorded in the system. Normally there was a period of delay between death happening and it being reported. They had been working with Public Health England (PHE) and the government to get a better understanding of this as well as working with the local hospitals to understand their interpretations and their analysis of the situation as it evolves.

Birmingham was doing well as they had been planning for this outbreak since January and a huge amount of work and effort had been going on across the public sector and many of the members of the Board joining us today had worked closely with us in the last few months to ensure that the city could be as prepared as possible for the continuation of this outbreak. It was difficult to say now, as no single set of data gives the full picture.

As people listening would know, they were only testing people when they come into hospitals and in the majority, they were doing some testing in the community, but there were still large gaps in their knowledge in understanding the full picture of this. However, it appeared that they had been climbing the curve as there were early signs of social distancing and all the hard work people were putting in to stay at home was starting to have an impact.

It was hoped to get six to seven days of the slowing of the descent before they start becoming too optimistic. This was down to the hard work of everyone on the call and many of those listening that we are saving lives from the Coronavirus and helping the National Health Service (NHS) to manage this situation and working hard to try and understand more of what was going on and how this outbreak was affecting different parts of the community in the city.

At this juncture, the Chair advised that they now move to the first question and concerns raised. She highlighted that the questions received were placed in core themes and that she would ask specific members of the Board to respond to the questions.

What do we know nationally about ethnicity, age or any other risk factors and Covid19 and why isn't this data published routinely nationally or locally?

- **PHE**

Dr Giri Rajaratnam, Deputy Regional Director, PHE M&E Regional Team stated that it was a simple question to ask but was quite complicated to answer. He advised that Public Health England (PHE). The data they got was extracted from the laboratory reports on positive cases. The data that was extracted from there was based on the data transferred from either the written requests form or the electronic request form into the hospital system.

As colleagues knew, the samples for testing came from a variety of sources – the hospitals, general practice out in the community and of course at the early stages of the outbreak, in February and March when they were in the containment phases of the outbreak, there was a lot of community swabbing that was also going on to supplement this. To a large extent, this was the way the data was collected and the data that was routinely collected was age,

gender and postcode as a rule. PHE then tried to use some of the other data sources that it had to hand to then collect additional information around ethnicity, or any other risk factors. The routinely available data which was easy to extract and do an analysis was the bit that was published on the .gov.uk website as part of the dashboard.

The other range of data, it was critically important to understand the disease and the infection to do with ethnicity, the details around diseases morbidity people might have, they had to extract from other sources or they had to use programmes to identify particular characteristics that they might be interested in. Example, with ethnicity the recording of ethnicity was not good and tended to be less than about 50% and they also occasionally use software programmes to look at the names and identify ethnicity using that programme all of which takes time to do. The pandemic started here at the end of January early February and we were now into the twelfth week of that outbreak, and they were only now being able to pull all that data together in a reasonable set of analysis.

At a local level, be it the hospital or a different institution where they were looking after people with Coronavirus, a more immediate analysis might be possible, but doing an immediate analysis within a relatively small institution, as opposed to doing it nationally, could cause scientific problems in being able to interpret it. There will be a lot more research over the coming weeks using large datasets to look at the various scientific questions that needed answering in order to improve their effective approaches in both looking after people with Covid-19 and preventing infection.

Dr Varney requested an explanation and commented that a couple of questions they had were why nationally data was not presented broken down by ethnicity and whether they were able to understand that in the context of faith community – the Sikh community was particularly concerned, but also smaller ethnic communities example, the Irish community, whether it was possible now or whether it was something that would come in the near future. Dr Varney added that many of those communities wanted to understand the picture for their own population.

Dr Giri Rajaratnam stated that he would go into issues around process which may confuse people, but that he would try to be clear as he could. He further stated that once they got int a major situation like this, where there was an important command and control structure that enabled them to respond appropriately, all the communications needed to go through a process. All the work that PHE did in the context of analysis, intelligence etc., was shared with the Chief Medical Officer, the Chief Scientific Officer and the Government.

In terms of formal publication, as part of the rules that they had around major incidence, they needed to go through the government system before they could be published and go into the public domain. The .gov.uk website, was where most of that publication tended to happen. In terms of the ad hoc analysis that goes through the Chief Medical Officer, the Chief Scientific Officer and the agreement was reached on the extent to which it goes on to the public domain.

In the context of ethnicity and so on, it was important to remember that the analysis, the cleaning of the data, the pulling together of the dataset, doing the analysis and trying to understand the analysis, takes time. It was not start today and finish the analysis tomorrow and publication on the evening as they were dealing with a large dataset. It may be possible at a local level in the way it had been described earlier.

In the context of faith communities, they did not tend to be routinely collected, but of course for ethnicity you may be able to draw some broad conclusions around those issues. Normally they would need to undertake much more detailed analysis to explore the hypothesis Dr Varney had alluded to and this maybe one of the series of studies that will take place over the coming months and years. It was important to understand that PHE recognised the importance of all of this and had asked one of its senior directors Kevin Fenton to take the lead on this and he was conscious that Mr Fenton and Dr Varney had made contact and would talk through how some of the PHE efforts around this might reflect on the needs of Birmingham.

The Chair commented that many people from the ethnic minority communities … but at the beginning of all of this what people had struggled with was the fact that organisations like PHE did not have a clue. Even though there were more deaths that were identified from the health service and through communities, all they kept hearing as communities, was that it was not possible to obtain the information. Although you were looking at this and it was not easy, the question was whether there was any learning gained for the future in terms of how data was collected.

Dr Giri Rajaratnam stated that the Chair was correct and that after many instances beside this, they do go through a learning process. The critical issue was that the residents and what was being said was right. By law, the public sector duty did ask them to collect this information where it was important as part of all their contacts with the citizens of the UK. This happened often, but the quality of the data collection was not as good as they needed it to be. They needed 100% collection of that data as part of each contact that the health and care services had with individual clients.

This duty was recognised and was the reason PHE appointed Kevin Fenton to begin to put together a programme of work, but it must be remembered that they were only eight weeks into the outbreak. PHE had undertaken some initial preliminary analysis, but this was only descriptive analysis which was based on the early part of the pandemic in the UK. What that showed was that in terms of risk of infection, the south Asian community, the Indian community had a high risk.

In terms of the other ethnicities, they were much lower than that. In terms of admissions and severe disease, there was no such difference and in terms of death, looking at the early part, i.e. time period in terms of death, again there was no obvious difference in terms of ethnicity. There was difference in terms of age, and gender, but in terms of ethnicity itself there was no difference. It must be emphasised that all the interim analysis was based on the early part of this Pandemic not the last four or five weeks when they were in an upward curve and they began to see much higher instances of disease in the different

types of communities. This was the difficulty as they start at a point at which to do the analysis, but you could only use the data from the previous time period, and this was the reason they were in a difficult arena.

Carol Cooper, Head of Equality and Diversity, Community Trust stated that the issue they were talking about was more entrenched than the Covid-19 data. She added that there were many of them over a long period of time that had tried to get PHE and the Office of National Statistics (ONS) to recognise the importance of ethnicity … and helping to do so for nearly two years. It seemed that this information had not been collected and had they had this information when the outbreak commences, they would have been able to be able to see how the disease was progressing. Data that was analysed from it from NHS perspective in terms of the staff was shown in a clear disparity in terms of people from a black background, Philippino background etc. There was a clear disparity emerging and felt that if the ethnicity field had not been abandoned from the ethnicity neurological data, they would have had sight of this much earlier.

The Chair commented that the same could be said regarding disability and other demographics.

Are there any particular local patterns emerging about ethnicity, age or chronic diseases from the admissions and deaths in hospital?
- **UHBT/SWBHT**

Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust stated that on a small-scale data was being collected and analysed including ethnicity from day one. He advised that Dr Chizo Agwu, Deputy Medical Director, Sandwell and West Birmingham NHS Trust would say something about the patterns that they saw across their hospitals and their services.

Dr Chizo Agwu, Deputy Medical Director, Sandwell and West Birmingham NHS Trust stated that they had seen an increase in death from March 2020 – April 2020 and that the median age of those that had sadly died was 80 years old and there was gender disparity with 63% of the deceased being male and the majority of those that had died had a chronic disease with 72% having hypertension and nearly 60% having diabetes. They were also seeing a change in profile of deaths over time in terms of their sites.

In March 2020 72% of all deaths was at City Hospital, but this seemed to change in April 2020 when most of the deaths by 60% was at Sandwell Hospital and only 40% at City Hospital. There was also a change in profile of death in terms of ethnicity. At city Hospital in March 2020 people from black African and African/Caribbean population were accounted for about 38% of deaths, but this did not carry on in April 2020 so that in April 2020 counted for 19% of death which was more in keeping with their local population.

In terms of other ethnicities, at City Hospital the Asian community accounted for just over 26% of death at City Hospital in March 2020 increasing to 31% in April 2020 and a similar figure was shown for the white Caucasian population. The

proportion of each ethnicity seemed stable in Sandwell over March and April with white Caucasians accounting for over 60% of all deaths and this was the same for March and April. Their data showed that they had an increasing risk of death with increase in age, male sex and the presence of chronic illness especially hypertension and diabetes. Their data seem to reflect a dynamic change in situation in the pandemic and they were continually monitoring it to see what this showed.

Professor Simon Ball, Chief Medical Officer, University Hospitals Birmingham NHS Foundation Trust commented that broadly speaking they were looking at a very similar set of observations. They had analyzed a closed dataset at the end of … which consisted of 2217 diagnosed cases with Covid-19 who had a length of stay for one night or more. Of that group 1482 were White, 415 were Asians and 92 were Caribbean. They had distinguished between African and Caribbean specifically as they were very different population in east Birmingham with a very different age distribution and a different age distribution when they present with Covid-19.

In terms of overall discharge rate, they had discharged 47% of the White ethnic group, locality rates across the groups were 27%, 24.8% and 25%. The mortality as measured last Thursday was the same across the different ethnic groups. The important thing that was being alluded to earlier was that the Asian population was significantly younger and if you adjust for age then there seem to be a significant single signal in the south Asian population, but this was not true in the Caribbean population. Adjusting for age did not suggest that there was a difference in mortality between the Caribbean population and the White population. Professor Ball pointed out that it was a much smaller population at UHB, so the numbers were much smaller.

In terms of co-morbidities, what they saw was that in the Asian and the Caribbean populations, they saw more diabetes in patients who were admitted with Covid-19. 50% of the south Asian population and 64.8% of the Caribbean population admitted with Covid-19 had diabetes compared with 29% of the White population. There were monsters of hypertension – 65% in the White; 54% in the Asians and 71% in the Caribbean population.

Interestingly in the older population the median age of presentation of White population was 80 years and they had seen more dementia, stroke and chronic obstruction air ways disease, much more so than in the Asian population. Much of the increase account in incidence of presentation and of mortality in the south Asian group was attributable to diabetes, hypertension and cardiovascular disease, but there was probably additional signal in the Asian group. They did not saw this in the Caribbean group that was admitted to UHB.

The Chair enquired how well the hospitals were coping with the challenges of the Coronavirus outbreak especially the challenges of Personal Protective Equipment (PPE) and the intensive care and ventilator capacity.

Professor Ball stated that in terms of the intensive care and the ventilator capacity, they acknowledge the fantastic work of Intensive Care Unit of UHB … total number of intensive care patients Covid-19 and non-Covid-19 was 163 just a few days ago with 135 Covid-19 patients they had recently came down to

128. They had pushed the limits of their ventilating capacity and the limits of intensive care in terms of their capacity. They had some ventilators that were acquired by the NHS a couple Saturdays ago. They had provided them with some back-up capacity. They had managed magnificently. In terms of PPE, they had been well served and the supply of PPE have been adequate.

Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust stated that the staff have been magnificent, and the critical care pattern was very much as Professor Ball had described. He added that they had started to see a downward use of clinical ventilation and they continue the increase of non-invasive ventilation. He further stated that they should not be in the language of heroism and campaigns over the impact on staff as well as residents, the death rate was significant.

In terms of PPE they were doing well and were also issuing PPEs to care homes. He did not think between his and Professor Balls team they could reflect that this was a success and there was always work to be done on that. In terms of whether they were coping, the cyclical impact would be with them for a long time, but the big message from the NHS generally was the real worry of people who were not presenting in the health care settings because they were having anxiety about acquiring Covid-19. In terms of health risks, in the next two weeks that feels to them a rally big deal and conversations like this was timely.

There is some evidence that Covid is affecting those with chronic diseases like high blood pressure and diabetes more severely, and concern that these conditions are more common in our African & Caribbean communities, what is primary care doing about this?
- **CCGs**

Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG stated that speaking as a General Practitioner (GP) he wanted it to be emphasised that general practice was still open for all patients. GPs and Practice Nurses were still caring for patients and were particularly looking after patients with long-term conditions. They had just completely redesigned Primary Care in the last three weeks and 95% of their contacts had now had a video consultation. The whole profession was now unrecognisable from just a few weeks ago. He added that he was proud of how the general practice had risen to this challenge. Patients could still be seen face to face if they needed that type of contact, but they needed to go through a triage contact usually with their GP or other health care worker so that they could be seen in the most appropriate setting.

Lots of work has happened in practices so that vulnerable patients were identified by their GP so that GPs on a whole could try and identify high risks patients – those with long-term illness, co-morbidities and certain drugs or certain elements of past medical history. Patients were then being sent a letter and an alert being place on their clinical record so that if the patient then contact the practice, the clinician concern knows immediately that's were high risks patient. Dr Ingham highlighted that he would like to encourage all patients

from every ethnic background if they need support to feel confident to contact their GP or hospital. He echoed Dr Toby Lewis' sentiments as they were worried that patients seem not to contact their surgeries, but he would encourage them to do that if they become unwell and that they should not be frightened to contact them.

Dr Kazeem Olagoke, GP Ley Hill Surgery, Birmingham and Solihull CCG commented that they have had an increase in the number of patients with chronic disease ringing them and this was across ethnicity. They were actively looking through their caseloads for patients who could poorly control their diabetes and hypertension even though they were not able to see them face to face, they were still offering advice by telephone and were trying to manage their condition because of the risk of complication from Covid-19 where their conditions were not well managed.

Dr Olagoke stated that he practiced in an area where there was an African/Caribbean population, but they had not seen much difference in terms of the way they access health care. They had a good response when they contact then about managing their conditions and they were taking up screening quite well. This was a way in which Primary Care could help to ensure that the uptake of the screening for people at risks with diabetes that was more prevalent in this ethnic group

Dr Naresh Chauhan, GP South Birmingham stated that they have a large population with hypertension and diabetes and they were encouraging their Primary Care Network which was 10 in their organisation to actively seek out the people who were not in control of their medical conditions and try and encourage them to come in. They have also arranged for patients who were not able to visit the practice for the citywide visiting service so that they were visited to ensure their condition was well managed as far as possible without putting them at an additional risk

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG expressed his condolences for the 867 people that had lost their lives so far 252 in Sandwell and West Birmingham and 615 across the rest of Birmingham. He added that any loss of life was tragic. Dr Aslam advised that they have been given a list by NHSE to shield patients that did not include ethnicity but was based on age and a range of chronic diseases including respiratory diseases.

They have had a proactive programme to manage patients with hypertension and diabetes and they were working closely with the team at the Trust to ensure that they manage diabetes and hypertension in a way that was along the lines of best practice. They had focussed extra attention on all their diabetic and hypertensive patients as the new evidence emerges and it was hoped that this would yield some benefits. They needed to shield these patients clearly as they were at an increased risk even if they were not on the NHSE shielded list. They were doing more virtually as they had a large amount of people with diabetes and hypertension in Sandwell and West Birmingham. This was an on-going piece of work and they were focussed on that population.

Andy Cave, Chief Executive, Healthwatch Birmingham enquired if patients have not received a letter but believe they were in a high-risk group (blood pressure and diabetes) what should they do to get a letter.

Dr Justin Varney advised that it was important that they clarified what shielding meant. Shield was a letter that was sent to people that were at the highest risks with their immune system which most compromise from Coronavirus. Basically, the letter was telling them to take extra special care and for them to stay inside for the next 12 weeks. The advice for the majority of the rest of us where we have long-term conditions like high blood pressure or diabetes was something that reminds us that we should be taking all those steps and not touch our face, to wash our hands, to only go out when it was essential for shopping or medicine or to take that short daily exercise. The shielding letter itself was an extra nudge to take action, but it did not change anything in terms of what you do.

For those people who were struggling to get support now who have health conditions and were worrying about going to the supermarket or cannot afford food now, as well as the shielding support, there was help available. All the food banks in the city were working together with BCVS etc. and there was a help line on the City Council's website and on the Active Wellbeing website which people could ring if they needed support. Dr Varney encouraged people not to sit at home in silence, but to reach out for help to the NHS and if they needed help with food or getting those essentials to reach out to the helplines that were available as they were doing as much as they could to make sure people were supported through this whilst they protect their own health and help them manage the outbreak.

There is concern that testing has been slow to ramp up to meet the need, especially testing for health and social car staff that don't have a car, how many health and social care staff in Birmingham have been tested so far and has there been any equity audit of testing to ensure that there is no discrimination happening in who gets a test and who doesn't?
- **NHS – Rachael Ellis**

Rachael Ellis, Deputy … Officer for Sandwell and West Birmingham CCG advised that part of her role was to work with West Midlands Ambulance Service and 111. She highlighted that testing had begun eight weeks ago in relation to testing when they were at the stage of containment when they were testing the public. Through West Midlands Ambulance Service early testing began of our population. They were quite quick as they were first in the country to ramp up testing in eight weeks and they continued to develop testing as they now moved into the delayed phase. Across Sandwell and West Birmingham population they had available two forms of testing - a commercial pillar which was run by Boots and their testing routes which was through our hospitals and our PHE laboratories.

Currently they have over 10,000 of their population excluding all of the test that had taken place in hospital. They currently had every day available now across the two sites that were the commercial site and the Swabbing Centre in

Wolverhampton, they had over 400 test per day at Edgbaston, 200 tests per day available in Smethwick. There had not been any audit in relation to who was accessing the testing.

Full testing was available for all their population now. They were as they move into the delay some time to set up the commercial testing arm, but she was pleased to say all of that challenge had been resolved. They were in a phase now where their population could access testing remotely so they could test effectively for the postal test. There were also pop-up testing sites that were becoming more available.

In answer to the question across Sandwell and West Birmingham and Birmingham population, there was now significant access to testing, and it was now available for all the keyworkers. There was a new way of getting all those tests set up as they were also on-line for people to book on-line over the coming days. Rachel Ellis stated that she did not have the exact number of the Health and Social care staff that were tested, but the testing was available now since the last ten days.

Toby Lewis commented that it was important to be candid that the testing had taken too long to 'gear up' against what they would all want. There has been good access in the West of Birmingham to workers beyond the NHS both in the prison and bus companies and for social care, but the system for which people got into that he thought as Rachel Ellis confirmed it was going to get easier because they needed to recognise that it had been challenging.

In terms of the ethnicity of people tested, certainly for their organisation, they could confirm that more Black Asian Minority Ethnic (BAME) staff had access testing than was represented in their staff population. There was no discernible pattern in a more positive test that would suggest that there was not a barrier to the NHS staff accessing testing certainly in their geography.

The Chair commented that the perception was that testing had not been available as it needed to be and that it was time limited so that a person had to have had Covid-19 one to three days and that anything over that the test became unreliable. There was a high percentage of test that was false negative. The Chair enquired whether Toby Lewis could explain (as people did not understand) why their relatives had been brought into hospital and being told that they had been Covid-19 positive and then they had the test which was negative and they then felt that they had been lied to and that their relatives had just been put into areas …

Toby Lewis responded that the conversation was focused on City Hospital and that the answer to the question was that the test as the Chair stated did not always produced an accurate answer and it was sensitive to how it was done, when it was done and other things as colleagues at the meeting will explain.

In terms of the pattern of who was tested on admission to hospital, certainly at City Hospital and he would imagine that this was true at other hospitals in the city, an assessment was made by a clinician on admission a test was undertaken. That test maybe re-run during the time the person was in hospital

or may be required after they had entered down stream and was assessed as unlikely to be Covid positive.

It was absolutely not the case that there was the process of *'moving people into RED Covid stream on an unwarranted basis'*. One of the challenges that they faced as an area was that there was a lay perception that there were a series of symptoms for Covid and if you did not have those it was not possible that you had Covid.

Classically, a temperature would be clear to clinicians (and the Health and Wellbeing Board had made a video about it recently) that there were a series of other indicators etc. and precisely as it was complicated was the reason they had expert clinicians who made the judgments where patients should be placed in an hospital in their best interest when they should be tested. Toby Lewis emphasised that there was absolutely no racial profiling going on in the allocation of patients to wards or patients to death.

Councillor Matt Bennett stated that he had a leaflet that was shoved through his letter box offering a range of testing for Covid-19. He enquired whether anyone else came across this as it was obviously a private sector moving into patients as he had not heard of this happening before. Rachel Ellis stated that she had seen lots of offers of that coming forward but that she would advise that all NHS workers could access testing and they would also support patients through 111 as well.

The message was that if people were feeling unwell, they should call 111 rather than using the leaflet being pushed through their door and they would work with people as a health support for their needs. It was important that they get the test at the right day and at the right time and they were working to ensure that that was available. It was also important to note that general practice was open for business and that they did not think that every illness was linked to Covid-19.

Carly Jones, Chief Executive, SIFA FIRESIDE requested clarification around testing in relation to other keyworkers that were not NHS staff, voluntary sector organisations, other care providers. There seemed to be a lot coming out that it would be widened out, but there was lack of clarity around this now. Rachel Ellis advised that the two sites they had in the area – Edgbaston and Smethwick were sites that were available for wider keyworkers that locally they were testing public transport keyworkers and they should be able to access that through their organisation as they share that live with colleagues if they have not got access through that as they should be able to access that more easily. There was also an on-line portal which would be coming online over the next couple of days.

Chief Superintendent Stephen Graham, West Midlands Police stated that this was a time when people were scared and feeling vulnerable and unfortunately there were some people who would take advantage of that. He advised that if anyone receives a letter through their letter box offering a miracle cure or that there were stuff on-line or giving immunity to the antibody tests, they should refer to the NHS as already been stated, ring 111 or the trusted website NHS.gov.uk where they could either get tested or seek advice from. He further

stated that people should not think that there was a £50 solution to this as there were some unscrupulous people out there unless it was the Government's authorised Boots test, they were being referred to.

What treatments have been stopped due to the Covid outbreak and what does this mean for these patients e.g. cancer treatments?
- **CCG/NHSE**

Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG stated that some non-urgent treatments had been paused such as elective surgery and routine diagnostics such as x-rays. It was felt that this was right and proper at a time when the risks of catching Covid-19 infection would outweigh the need for that routine care. He emphasised that urgent work had continued, and many services had moved site rather than stop such as chemotherapy that had moved from Good Hope Hospital to Solihull Hospital and gynaecological assessment had moved from the Heartlands Hospital to Good Hope Hospital. Outpatients services through secondary care were available online as virtual consultation much in the same way as he had explained about Primary Cere earlier. Transplantation services had been paused nationally and non-urgent cancer services had also been paused but urgent cancer care was on-going as it should be and was being dealt with, with support from the private sector and the Royal Orthopaedic.

Birmingham Community Health Care Trust - Ethnic minority people are often over-represented in the lowest paid role in the front line of health and social care, there are concerns that they are not protected and being disproportionately put at risk, is this true?
- **BCHC**

Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust advised that there were two things – firstly, the guidance around PPE supply was clear about the kinds of levels of support that everybody working with patients who may have Covid-19 or who may be suspected of having Covid-19 was necessary. This was about the kind of equipment and protective gear that they provide - aprons, gloves, mask and the kinds of things that got covered in the shorthand of personal protected equipment or PPE.

It was not role specific but area specific and intervention specific so they were as clear as could be and they have already heard that al the NHS in Birmingham had adequate supply of PPE it needed though it had been difficult. He added that he was grateful to colleagues for support and regardless of level staff work they had the protective equipment they needed to do their jobs. They were also working as hard as they could to try to make all social care colleagues in care homes have the PPE they needed. He knew both UHB, Sandwell and West Birmingham and Birmingham Community Healthcare NHS Foundation Trust were helping the care homes with PPE supply when they were in trouble. There were lots more to do nationally to get that working, but

they were all working closely together as they could to ensure the PPE they had was used properly.

Healthwatch – How are patient concerns and experiences being monitored during Covid19, there have been several experiences that people have shared that suggest less than optimal care from people in our ethnic communities?
- **Healthwatch**

Andy Cave, Chief Executive, Healthwatch Birmingham stated that this was an important point and they should not forget the importance of understanding people's experiences during this period to enable us to improve services for individuals. Also, to understand that the usual pathway that patients and the public were used to had all changed and through increased worrying and anxiety it was difficult for people understand what was right and wrong to do. It was vital to keep communicating with the public about this. This include listening to their experiences.

At Healthwatch Birmingham, they had reviewed what they were doing now all their resources firmly focussed on hearing people's experiences of Covid-19 and on experiences of the lockdown and the social impact that had on people. They currently had a survey out now which was circulated across social media and a website of working partnership with the voluntary sector and as wide and had targeted advertising through social media to ensure they were hearing from the right groups of people including those BAME communities.

What they did with that was to feed that experience into the hearing to partner organisations both from the voluntary sector and the health and social care system so that they could understand what people were saying to them, so that Healthwatch Birmingham could respond back to the public and let them know what was happening in health and social care to enable them to access services to support them.

Equally, the public fully understood the pressure that health and social care was under now. They were pleased that the standard routes for people to feedback in health and support through PALS was still opened. He urged people to contact PALS or customer services department to get the information they needed and encourage them to seek the help and support they needed from the NHS and through general practice. It was important that across health and social care they think about the work that Healthwatch Birmingham did and to get a good understanding about what was happening as collectively they could feed that in to where decisions were being made.

University Hospital Birmingham - Is it true that doctors have the authority not to resuscitate patients if they want to and how is this discussed with patients, especially those who are very unwell, and their families?
- **UHBT**

Professor Simon Ball, Chief Medical Officer, University Hospitals Birmingham NHS Foundation Trust stated that there had been no change in the policy discussing resuscitation status and feelings of care with patients irrespective of Covid-19 or not. This involved discussing patient's wishes with them whenever there was an opportunity if the patient was not able to have that discussion, example, if they required immediate admission to intensive care then they would discuss their wishes with family members and so forth. It was suspected that this question came out from news coverage of situations of the sorts they had seen in northern Italy for example, where health service was overwhelmed. This had not been the case in any of the hospitals across Birmingham and Solihull for example.

The short answer was that they had taken a business as usual approach to those discussions. They have not changed policies, importantly, they had put a significant amount of senior clinical staff at the front door and reviewing patients early. What they had done as suggested was that there were discussions documented on every single patient that comes through the front door for absolute clarity. This was good practice in any case as they did a lot by ensuring that the service had been delivered.

Toby Lewis commented that a particular concern was the restriction on visiting which meant that it could be difficult for people towards the end of life and for families, example in their Trust, they did not have face to face visiting other than in certain circumstances and even in an end of life circumstance they had a upper limit of two people who were able to physical visit their relatives. He appreciated that the hurt and the long-term disquiet that created, but he thought that that augments the concern. He added that he agreed with Professor Ball's message that nothing had changed about the way in which they organised and operate those difficult decisions.

Professor Ball, echoed Toby Lewis' comments and stated that the measures they had to be put in place were extremely distressing to family members. They did as much as they possibly could do to but they could not do enough to try and abrogate that with having medical students involved in contacting family members on a daily basis giving updates for example, that was important in intensive care for example, where staff members found it difficult to come in and out of intensive care and also recent significant investment in availability for things like Tablets and the like that they could make available to patients so that they could speak face to face with their families.

Professor Ball stated that he did not think that they could remotely underestimate the profound effects that the restrictions that they had to put in place have had on people's experience of loved ones dying. They had been dealing with this and the fallout from this, potentially, for years to come.

Dr Giri Rajaratnam, Deputy Regional Director, PHE M&E Regional Team commented that having had personal experience not in this region but outside this region, he had to give credit to the hospitals in the way they had handled this. It was extremely sensitive, and they had taken the right approach in terms of the sensitivity to the individuals concerned both the relatives and the person going through that process as well as the need to ensure that the infection was contained as much as possible. So, they needed to give credit for the way that

the hospitals had handled this issue under very difficult circumstances that they were facing.

The Chair commented that this has got to be perceptions and that perceptions were something that was causing problems. She enquired how the perceptions in the communities could be improved.

Professor Ball stated that this was difficult, clearly by talking about the specifics as they were today it was important in making the point that people were genuinely frightened as this was undoubtedly a very serious illness with a very high mortality. This was true right across the population particularly amongst groups of people and was distressing for everyone to see. They do need to keep talking about it and the fact that this was not focussed across any particular ethnic group and was a disease that particularly targeted those with long-term conditions like diabetes and hypertension and making people aware of being seen and being cared for in an appropriate point when they come into hospital.

The last thing they wanted was for people coming very ill when they had the opportunity to potentially provide them with supportive care that would help them such as oxygen, hydration etc. They needed to keep talking about it and keep looking back at the figures and keep explaining the figures. It could be seen why people were concluding with the disease that was unprecedented. Trying to make sense of it was a real challenge for even those of them that were dealing with this every day. Continuous discussion of these sorts was hugely valuable.

Joy Warmington, Vice Chair Birmingham and Solihull Mental Health Trust and CEO for BRAP stated that they needed to speak to the fear. There was also a lot of media coverage about how people from the BAME communities and African people, were being carriers of the disease. There were also social media footages of people being refused entry into shops, and people being thrown out of their country. She believed that there was something else going on as it linked into racial discrimination and it makes people more fearful about the way the coronavirus was being seen, who was being seen to be at risks and who was being carriers. The more that we they could do to dispel some of those myths the better it would be, especially given that there was another information that was given through other media sources that was telling people what was happening across the globe.

Joy Warmington enquired how were they supporting the staff, delivery persons, supermarket personnel's etc. as she had nothing but praise for all the frontline staff as they were all brilliant. She added that given what they had heard about who was likely to be more impacted by this disease, what support they were given to BAME health care staff who may need some additional assurance at this time. She stated that they were doing some experiential research in communities and networks that they were aware of to get some understanding of how BAME communities were doing at this time. She stated that if colleagues had some questions, they could contact her after the meeting so they could get more evidence as to what was happening.

Carol Cooper, Head of Equality and Diversity, Community Trust advised that she was one of two regional advisors to the trust on matters that affects the BAME workforce in the NHS and the population. She further advised that they were doing several things and to date they had two well attended virtual meetings with over 300 people on each call. They were reaching out to staff mainly online and will be repeating this across the regions in the country to listen directly to staffs concerns. A lot of this was taking place at NHS England and they were developing a culturally intelligent psychological support for BAME staff.

They were listening to their concerns and were looking to developing equality and human rights analysis that looked at how they could minimise the needs of the BAME staff. BAME staff made up most frontline staff consistently across the country which was what the data told them. If they were to pull them off the frontline, they would have a serious issue with regards to service delivery. They were looking at innovative ways of how they could minimise exposure, risks, listening to people's concerns and to support them in a variety of ways and would be rolling out a spiritual support which they knew was important to the ethnic minority communities.

Andy Cave stated that what they could do as a system around the perception and the fear the community had. It was important that collectively they have a great reach within the communities through the voluntary sector. If they could start to capture some of these positive stories and the good news stories and start flooding social media with them this could go a long way to doing something about the perception as to what was happening in hospitals. If they could start to capture these stories coming through and sharing these this would be a powerful thing to do. He felt that it was important at this stage that a record of victims of hate crime be sent to the police so that it was logged.

Brian Carr, BVSC concurred with Andy Cave's statement and stated that one of the things BVSC was doing with their separate partners was compiling a learning log of things they were picking up in terms of good practice and they were hoping to share that as they should be putting that out in terms of good stories and good practice across the partnership.

BVSC & BCC - What is being done to ensure that there is culturally appropriate food being supplied to our ethnic minority and faith communities?

- **BVCS & BCC**

Brian Carr, BVSC stated that in relation to the culturally sensitive food they had contacted their Food Team Lead Karen Stevens at the Health and Wellbeing Society. He read a response to the meeting that was sent by Karen Stevens.

Stephen Raybould, Programmes Director, Ageing Better, BVSC advised that in terms of communication a lot of the anxiety that was raised had been fuelled partly by previous experiences in the system but also around capacity and they had a good news story to tell around capacity. If people felt like it was accessed to care testing, if people felt there was enough capacities some of the

concerns would be allayed. Starting their communication with the idea that there was not enough capacity certainly within the NHS would make a big difference and this was an important story they could tell locally.

In response to Stephen Raybould' s point, Dr Justin Varney highlighted that as colleagues in the NHS stated there was capacity in the NHS both in primary and secondary care. Our hospitals and GPs, pharmacists and many other health care professionals had been working for months to ensure they were ready and so far, the curve had stayed below the overall capacity of the system. This reflected all the work that had been done.

In terms of the food parcels, what they had done in Birmingham, was to work with BVSC and the Health and Wellbeing Society to ensure they had provision for the shielded list which in Birmingham was over 23,000 on that list. Many of those did not need support so appropriate in assessing in contact to asked if they needed help or not. Many had families and friends that were helping them, and they were still getting food. There was just under 7,400 who were receiving a weekly food delivery either from the Council or through the national drop by BRAKES.

As Brian Carr alluded to, what they tried to do both through that provision and through the partnership with the voluntary sector and the Food Banks and the additional support they put into that partnership to ensure there was food going into these was to predominantly give a vegetable offer and to be as culturally sensitive as they could be given that everyone knew that there had been challenges for them to get the food to give to them.

Dr Varney highlighted that this was a huge operation and was one of the things that was a legacy that came out of this for all of them - the ability that the public sector came together to find solutions at pace for things like this, the local solution for Free School Meals as well had ensured that families were not caught short when national things did not quite worked as smoothly as planned and to ensured that people in the city had been safe and supported during this period.

City Council and Clinical Commissioning Group As we look towards the longer term impacts of Covid19, there are specific concerns from our ethnic minority communities about mental health and wellbeing, how are these being considered and what is being done to keep people well while they stay at home?
- **BCC/CCG**

Councillor Kate Booth commented on children's health and stated that they subscribed to podcast which was available and was out on twitter and the Council's website. This had also gone out to schools. Nichola Jones advised that they were working with a wide range of professionals to look at what they currently had to support children and young people across our agencies. They were also working with some experts in the field to understand from families how they cope with Covid-19 affecting them, and how they would take forward the wrap around support for families and children and young people as they progressed through the journey.

Councillor Booth stated that within schools and within the Children's Trust all their vulnerable children were being Rag Rated so the schools and social workers were going through to see which children needed daily contact and which children could manage with weekly contact and were ensuring that the families and the children within those families were safe and well.

Dr Varney advised that on the Council's website like many other Councils in the region, here is a section on *Staying Healthy at Home* which included things to support people on five ways to wellbeing and how to maintain your mental health and wellbeing during this period when they had to stay at home more. They were also working closely with the CCG around what else they could do. They had boosted the capacity of the Bereavement Service and the Voluntary sector Bereavement Support and because many people had been touched by death in a way that they had not before. They were looking at what more could be done to support volunteers as well as help Health and Social Care staff to process and manage some of what they saw.

As colleagues had alluded to, although many of them had trained for this kind of emergency response, they hoped and prayed that they never saw it. This in itself was quite difficult to process for anyone so they had been working a lot to try and think that through and to think about what more they could so, where they needed to think about this for specific communities and ensuring that services were culturally appropriate and culturally competent to support all of Birmingham's health and wellbeing both now and in the recovery phase when they come out of this moving forward. Though mental health was a fact during the lockdown people would take a period to work through and to recover from.

Stephen Raybould commented that there was specific mental health support from Mind around Covid-19 and Lockdown that could be accessed through Mind helpline.
There was over 300 voluntary sector services in Birmingham and there was lots of information out there if people look under the Covid-19 tab.

Dr Ingham stated that they acknowledge that the Pandemic would have a wide range of influence on people's mental health and wellbeing. During these times for those individuals with mental health problems it was a more difficult time. They were responding to this by setting up a support offer for their local population and this was being widely publicised and was well summarised on the Birmingham and Solihull CCG website under the section *Your Health and Mental Health Support Offer.*

The support revolved primarily around dedicated telephone line access and there was support for the Northway Teams in Birmingham for under Nineteens in Solihull and the over 18s in Birmingham and Solihull. There was also a telephone support line for key workers so that patients could contact keyworkers on that line. These services were available 7 days per week with extensive opening hours. The counselling service Coutes and the website. The CCG specifically commissioned several services – the Pathigift Services which gives counselling by telephone all virtually to BAME communities. There was the Ashram Services which offers services to south Asian women and the

Community Development Workers accessible through MIND. There were several services commissioned by the CCG for the BAME community.

Joy Warmington commented that given that a higher percentage of BAME communities were likely to be in lower paid roles - mental health support was not just about culture – it was about the challenge of day to day life.

Referring to Joy Warmington' s comment, Dr Varney stated that it was important – Covid-19 was hitting poverty, inequalities in the city and it was hitting those communities the hardest. There was a whole series of other work around economic and financial recovery about trying to understand the different ways this was interacting in people's life.

One of the things that was agreed at Cabinet earlier this week was that his Director of Public Health report for next year will be specifically on the impact of Covid-19 on not how many people caught it but what it did to people's lives. They were in the process of commissioning a research that really captured the voices of people living through Covid now to help to understand how to support them to find rebalance and a better future on the other side of this. The lessons they were learning today could not be forgotten the moment Covid comes under control. These were systemic cultural issues they had to really start to undo and not just ignore them.

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG commented from the Sustainability and Transformational Plan (STP) perspective that they always strived hard in the STP to ensure that they integrate health and care and had a proper understanding of economics and inequalities and as Dr Varney had stated that this was going to be even more important in the future. People kept saying that this was not a sprint, it was a marathon followed by about 10 more marathons along to run. This will take them years to work through and the consequences and damage to the economic impact particularly for those whose health was impacted by this inequality and poverty.

Carly Jones, Chief Executive, SIFA FIRESIDE stated that within those groups they will see a much higher risk of homelessness as a knock-on effect of homelessness happening and needed to have that support, thinking process and the legacy potentially that comes after.

Dr Giri Rajaratnam stated there were two things – comments around the homeless and other particularly vulnerable groups. PHE was working with colleagues to produce some guidance and support for local authorities and other local partners. He added that he had seen some information concerning the homeless which will be shared to everyone within the homeless network. The second thing was concerning inequalities.

Dr Rajaratnam commented that if he was a betting man and they had all this research done around Covis-19 which will be done on the impact of Covid-19 on ethnicity and all the other factors, he would probably bet that at the end of it all, the overall conclusion would be that the socio-economic circumstances in which ethnic minorities were born, worked, played and died was mixed together and the key issue will be those socio-economic inequalities rather than ethnicity

itself. There would be an issue around that, but it will be the deprivation that will be the major factor.

Dr Gavin Ralston, GP Partner, Harborne commented that general practice had undergone phenomenal transformation over the last few weeks. Probably things had happened that might had taken five or ten years that would never have happened, and the result was that they were now doing lots of telephoning and consultation using new technology like QRX and the various platforms which were user friendly.

The working patterns had changed as well, and people were popping in and doing surgeries at different times in the evenings and at weekends and it was not thought that these changes would disappear and might continue when things goes back to more normal life. This might have a benefit for people with mental health problems as they would be offered a more flexible service rather than having to make an appointment to come in. It would be much easier for them to get through to someone which would be better.

Practitioners were working more closely together and every knew about these Primary Care Network (PCN) that may have taken a long time to bedded in but because they had to create these number sites and purple sites where they did the face to face consultations it will make practices worked more closely as this format would bring in mental health workers and other associated professionals which would work much more closely with GPs and groups of practices. It was believed that some good things will come out of this pandemic and they would give a better service to people suffering mental health issue in the future.

Dr Manir Aslam echoed Dr Ralston's comments and stated that they had gone through this massive transformation and he did not think that there was a possibility to go back to where they had started even a few months ago. One of the things they needed to be mindful of was that they did not create a system that was doctor centric and getting patients involved in what this new normal looked like as going forward was important. One of the things they were doing was setting up focus groups for different segments of the population lie their diabetics, under fives and people with respiratory problems so they could understand what their challenges were now and what they would like the service to look like going forward.

It was important that people engaged with Healthwatch but engaged with their patient groups as their will be different and they could help to design that and be part of that process.

Joy Warmington stated that many people living in Birmingham had seen and lived and were still living through inequality. She added that she had looked back at some data that was 22 years old that did not seem any different from data they had now about systemic inequalities and where there were now. There was an urgent need to think about how they work differently to do something about this. They have had times of plenty and had not touched this and now they were moving into a serious time when things were not good and the outlook for people who did not have it good was that I was worse. She stated that it was incumbent upon us them to think how they worked differently,

who they work with to help them work differently and how they used the scarce resources that they will have going forward to try to support these communities.

NEXT STEPS

Dr Varney expressed thanks to everyone who had sent in questions. He added that they had tried to do justice to many of them and there was a lot that they did not answered but they would be responding to individuals personally over the next week or so to give specific answers to the questions they had asked. They would be feeding all those questions and the reflections from this meeting up to ministers and to the Public Health England review that Dr Giri Rajaratnam mentioned to help informed their thinking.

Dr Varney further stated that since he had been in the city, just over a year ago, one of the things he was keen to do was to work with Councillor Hamilton to get citizens voice at the centre of what they do. Today had been a fantastic example of that. They were committing to continuing to work with their ethnic communities as many parts of the city were ethnic majority communities not ethnic minority communities, to continue to move forward to build through this and beyond this. It was not straightforward, and these were not easy things to do to turn around as Joy Warmington highlighted.

Many of these inequalities had been going here decades and this meant that they were not going to turn them round in weeks. He added that he was committed and that he thought they were all committed as a Board to change that and to break that, so they were not returning in 2030 and saying nothing had changed. This had been a huge moment of upheaval for everyone's lives and the way they work and as Dr Manir Aslam had highlighted, we have all learnt different ways to do things. Ultimately and hopefully, it would lead to a better future for all.

Dr Varney further stated that he was committed to continuing this conversation and ensuring that they break some of these cycles of inequality as this moved on . There would be more coming out from them over the next few weeks about how they were going to create a structure and a way to do that so that it keeps feeding into the Board and keeps informing their thinking.

The Chair expressed thanks to all for their input and the time they had taken out of their busy schedules to participate in this meeting. She further expressed thanks for the incredible work they and their organisations were doing to support us all during this on-going emergency. The Chair encouraged everyone to stay safe, stay in and protect we and others to reduce the spread of the coronavirus.

OTHER URGENT BUSINESS

None submitted.

DATE OF NEXT BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING

It was noted that the next Birmingham Health and Wellbeing Board meeting was to be arranged.

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