BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 24 NOVEMBER 2020

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

PRESENT: -

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

ALSO PRESENT:-

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

****

NOTICE OF RECORDING/WEBCAST

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

DECLARATIONS OF INTERESTS

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

APOLOGIES

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

EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC

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

494 **RESOLVED:**

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

MINUTES AND MATTERS ARISING

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

495 **RESOLVED: -**

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

ACTION LOG

The following Action Log was submitted:-

(See document No. 1)

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

496 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

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

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

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

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

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

PUBLIC QUESTIONS

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

CORONAVIRUS-19 POSITION STATEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHILDHOOD IMMUNISATIONS AND VACCINATIONS

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

(See document No. 2)

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

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

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

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

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

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

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

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

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

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

a. The data from West Birmingham PCN would be shared with Mr Dalton so that they could be added to the table. One of the things that she did this morning was that they had the breakdown at a practice level and it could be seen that there were some variance with some practices doing fairly well and a couple hitting the 100% mark whilst others were not doing so well.
b. That she had spoken to some of those who were doing well to try and work out what the difference was. Interestingly a lot of it came down to a proactive and persistent approach from the GP practice. Some were saying that instead of waiting until the child turned up for their immunisation to contact them, they were doing a forward search and inviting people to come in.
c. They were working closely with the health visiting team in the city so that if a child did not come in for their immunisation, they would inform the Health Visitor who would then pick up the conversation around it. One of the other things she had asked this morning was on the question as to the reasons people did not want to come.
d. Some of the parents who were resistant when they were contacted, we were going to see if one or two of them would like to have a more detailed conversation with us about why that was so that we could try and get behind it to understand their reasons for their reticence as it was important to get a sense of that. There were some tools that some of our practices were using around this persistent approach which was paying off and she was happy to share that information as part of the report.

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

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

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

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

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

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

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

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

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

500 **RESOLVED: -**

The Board

i. Noted the work that partners are doing together to improve quality and ensure that the borough is well protected against vaccine preventable diseases.
ii. The Board supported the work that all partners are carrying out, where they can such as the leadership of the health promotion and community enjoyment role of the Local Authority

---

IMPACT OF COVID-19 ON VULNERABLE ADULTS

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

(See document No. 3)

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

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

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

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

Brian Carr, BVSC made the following comments: -

i. That he had recognised much of what Mr Williams had stated and that he concurred with Professor Betts. We were working in Birmingham in the voluntary sector for a number of years and obviously this was very unusual. But, the level of connectivity and collaboration between the sector and the public sector in responding to the needs as they arose at that unprecedented level.
ii. The challenge now was going to be how we kept that going as we moved into different parts of the process and the pandemic. The important thing was keeping those links going and from BVSC view point what we were doing was keeping our Covid-19 support from partnership which was the network we pulled together to help us respond to this. We were keeping this in place as it was not going anywhere and we will continue to work with our public sector partners.
iii. Mr Carr drew the attention of the Board to a new report that was published by BVSC – The State of the Sector Survey. This was a survey of the voluntary sector in Birmingham that had looked at the impact of Covid-19 on the whole for the voluntary sector and its beneficiaries.
iv. The respondents were drawn from a full range of voluntary groups in the city from the largest to the smallest. It covered all areas of the city and it covered organisations that had been in all service areas including a significant proportion who were active in health and wellbeing.
v. In line with the demographics of sector in Birmingham, most of the response was from small groups with fewer than 12 staff and an annual turnover of less that £100k as that was what most voluntary groups in Birmingham were, generally small.
vi. A significant proportion of them were of course groups that were minority ethnic led groups or serving groups. Mr Carr undertook to put a link in the chat which summarises the findings and in that would be the link to the full report.

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

a) The first was not surprising i.e. the voluntary sector was an essential part of the initial response to the pandemic and its ongoing response. Overall the sector had demonstrated considerable resoluteness and robustness in working with public sector partners in this initial wave.
b) What we were seeing now were some significant negative impact on the sector's infrastructure. That was going to be important to keep an eye on as we move forward in terms of collaboration as it would impact on some organisations ability to deliver their services particularly in the remote way, they had to do it at the moment.
c) 25% of our respondents were unsure if they would survive the year. 20% had already made or will be making redundancies; 56% had lost income

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

d) We should not underestimate this and how it would reshape the landscape of community and voluntary sector in the city. Most of them were small organisations as stated earlier and these organisations were involved in preventative services, early intervention services also rehabilitation – things like home from home – hospital support etc. that fed into the theme of this meeting.
e) There were some keen health and wellbeing messages that were coming from the sector and this was what they were hearing from their beneficiaries. They were raising issues of rising mental health a detrimental impact on health more generally particularly in vulnerable and isolated communities as the very necessary restrictions were keeping people apart which had an impact on wellbeing.
f) Increases in domestic violence, potential increase in food poverty although we had not seen the kind of impact there which we might have done which speaks to the robustness of the food networks we had in the city and had been working since the beginning of the process.
g) The final issue was digital exclusion and one of the things we tried to do when Covid-19 first came to mitigate against isolation was to make sure that people were connected digitally.
h) Some people were not connected digitally and not everyone was able to access online support and we saw particularly the deaf community and, in some respect, other disabilities and learning disabilities were particularly excluded if they did not have advocacy support.
i) If those organisation that were helping support those communities were at risk, then those communities were at increased risk.
j) In Birmingham the sector was strong and resolute and, in many ways, robust but it had had the impact of Covid-19 so as things progressed, we were going to find it a different sector that we were dealing with. We needed to be mindful of that as we continue to stay connected and collaborative.

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

1) The points made by Mr Carr about how important the voluntary and Third sector had been. We could not have developed the offer that we had and from a mental health perspective without the support and the mobilisation from the Third Sector mental health providers.
2) They were tremendous in terms of how they mobilised. Going back to Mr Williams point in terms of the learning from that first wave, we were still learning, we were still getting to grips with and coming to terms with the impact through this period.
3) We had worked through the CCG with all of our providers to review their risk assessment frameworks and their early warning frameworks and traffic lighting around those individuals we were concerned about in the system to ensure we were getting help and support out to them.
4) The final point was how important our collective workforce was here across health and care, across primary care and across the Third sector. We had just had a successful bid through the STP in terms of establishing a mental health and wellbeing hub for our collective

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

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

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

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

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

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

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

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

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

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

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

501 **RESOLVED: -**

The Board:

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

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

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

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

(See document No. 4)

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

a. Mr Couldrick had already alluded to the partnership approach we had in place that had gotten us through the first wave and the second wave we found ourselves in currently.
b. This was a robust and a tremendous effort across the whole partnership from Police, health, care, public health and from experts with lived experiences in terms of ensuring that we had resilient oversight across mental health and the children's world to make sure that we try to do our best during this difficult period. Services had had to change rapidly in terms of the way that they were delivered.
c. It was important to note that from a children's mental health perspective no services were stopped during this period although there was a big change in terms of the way some of those services were presented and delivered.
d. There was a real blend in terms of the digital platforms and face to face work and the clinicians and our teams that we were doing. We had seen higher levels of acuity and complexities that young people and children were now starting to present with. I have already referenced some of the ways we had improved access to services in terms of the 24/7 helpline which was a life course approach.
e. We have had over 7000 calls through that helpline supporting individuals since the helpline was set up in the first wave in April 2020. We had some concerns originally back in April and the demand was increasing but since July 2020 we had seen a surge.
f. However, the good news was that our Did Not Attend (DNA) rates were low as were all cancelled appointments. This meant and signalled that young people were embracing the technology and the digital platforms that were put in place in order for them to access and support.
g. I have already referenced the point how we support our workforce through this period recognising that psychological first aid and how important it was across all sectors as it was known that this impacted on the quality and the outcome of the care that individuals received.
h. We also knew and it was referenced here that there was a disproportionate impact in terms of our BAME communities. We were doing some focussed work through our community development networks and organisations that had good links and had been to those communities with protected characteristics to understand what the impacts had been on them, what we could do to improve; what we could do to be better. There was some interesting insight recommendations coming out of that work.
i. In terms of strengthening our offer ever further - acuities and complexities - we had a consistent blended model in terms of supporting team medicine and face to face work. We were working through the

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

j. We had previously through this meeting mentioned KOOTH which was an online digital platform supporting children and young people's mental health and wellbeing had been commissioned. There had been a staggering 17,000 logins to date from young people with over 85% of those returning for support. What was good to see was that 44% of these young people were from BAME backgrounds.
k. We had also commissioned extended capacity through our bereavement offer recognising how difficult this period had been in terms of people who had lost individuals as a direct impact of Covid-19 or other reasons. An all age pathway which went live in June 2020 was now supporting over 1,000 people with a 30% increase in terms of children and young people who were accessing that support.
l. In terms of the BAME specific pathway through the bereavement offer there was 51% increase in terms of individuals from an Asian background and 115% increase in terms of individuals from a black background.

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

1. The integration of service models and the collaborative work across partners had been phenomenal. Many people will know that the rapid adaptation of the Mental Health Services
2. meant that we had to quickly move from face to face to tele-medicine. Our remote digital platforms became really important and communicating with our service users with how we did that was a rapid piece of work that happened across the system.
3. Our focus was about maintaining an eye on those who were most at risk and those who were most vulnerable whilst being able to provide a range of services across the system.
4. In terms of disruption the only service that we had to change because it was drop in system was the PAUSE City Centre Hub. The design gave us further opportunity and that was working with our colleagues at the Children's Trust around the acceleration of the alignment around the locality area.
5. PAUSE was now not the City Centre Hub but it was working in the locality which covered 10 localities. They were currently linked into the domestic violence, they were supporting those families in accommodations, a reach out in our Food Banks and leaflets and was able to provide additional contacts through the Food Banks. We had been working in the neighbourhood localities and reaching into the Mosques and Faith Leaders.
6. We have been running a Salvation Community Focus Group and was managing within localities matching our referrals with areas that we knew access was not as good. We had been working in the Ladywood areas and the South Teams. We had been supporting the Refugees Migrant Project so there was a young group of service users that we had been focussing on.

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

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

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

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

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

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

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

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

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

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

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

502 **RESOLVED: -**

The Board:

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

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

---

INFROMATION ITEMS

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

OTHER URGENT BUSINESS

504 No other urgent business was submitted.

DATE AND TIME OF NEXT MEETING

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

The meeting ended at 1705 hours.

……
CHAIRPERSON