BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD INFORMAL MEETING WEDNESDAY, 19 MAY 2021

MINUTES OF AN INFORMAL MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON WEDNESDAY 19 MAY 2021 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
Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
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
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Professor Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Dr William Taylor, NHS Birmingham and Solihull CCG
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Steven Connolly, BSol CCG Contract Manager
Alan Ferguson, BSol CCG
Aidan Hall, National Management Trainee, Public Health
Maria Gavin, Assistant Director, Quality and Improvement, Adult Social Care
Elizabeth Griffiths, Assistant Director of Public Health, BCC
Stacey Gunther, Service Lead – Governance, Public Health
Harvier Lawrence, Director of Planning and Delivery
Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCG
Rhy Roper
Douglas Simkiss, Birmingham Community Healthcare NHS Foundation Trust
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

546 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

547 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

548 Apologies for absence were submitted on behalf Chief Superintendent Stephen Graham, West Midlands Police and Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust .

PROPOSED DATES OF MEETINGS FOR BIRMINGHAM HEALTH AND WELLBEING BOARD

549 The Board noted the following meeting dates for the Municipal Year 2021/22:

2021	**2022**
Tuesday 27 July	Tuesday 18 January
Tuesday 21 September	Tuesday 22 March
Tuesday 30 November	

All meetings will commence at 1500 hours. The venue for the meetings will be arranged.

MINUTES AND MATTERS ARISING

550 **RESOLVED: -**

The Minutes of the meeting held on 16 March 2021, having been previously circulated, were noted.

ACTION LOG

The following Action Log was submitted:-

(See document No. 1)

Stacey Gunther, Service Lead – Governance, Public Health introduced the item and advised that there were no outstanding actions on the Action Log.

551 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

552 The Chair welcomed everyone to the meeting and stated that we have good news with the vaccine rollout which was gathering momentum and she will be doing her bit and will be helping out on Friday with vaccinations.

Queens Speech

We had the Queens speech early this month with some snippets of good news on funding being made available to support health and wellbeing – tackling obesity and improving mental health which was very much welcomed.

However, it was disappointing to see that the promised and much needed urgent social care long term funding solution was missing yet again.
The renewed commitment to social care reform was welcomed, but it would have been great to understand when our Prime Minister will set out when he will fix social care which he boldly pledged to do in his election victory in 2019 – we were still waiting Boris…

It was worrying as a survey for Age UK found the pandemic had significantly increased older people's social care needs, with nearly a quarter (23%) of those aged 60 and over saying their ability to carry out everyday activities had worsened since the first lockdown.

We all understand the immense strains Covid has created on our health and social care sector which desperately needed strengthening.

With lockdown easing – we were beginning to open up and our day centres and care homes were opening to visitors which was crucial for us all. Social Isolation was something that we need to look at addressing.

This morning I attended a meeting to discuss Mental Health Prevention and Promotion and the additional funds will help in supporting our communities affected by Mental Health – which continues to emerge as a key issue.

Community Wellbeing Board

At the LGA Community Wellbeing Board meeting last week we looked at the Dementia Strategy 2021 - 2041 update as the LGA alongside the Alzheimer's Society will oversee the strategy as Dementia Programme Board members.

It will be a three-year strategy. It was proposed that year 1 will be focussed on Covid recovery and issues arising from the pandemic. Years 2 and 3 will look at

issues agreed by the Dementia Programme Board prior to the pandemic. Councils had a key role in delivering/commissioning services for people with dementia in the community. The strategy will need to reflect the diverse needs of communities – particularly around raising awareness, risk reduction and ensuring appropriate support and stigma in this area.

Infant Mortality

Last month at Full Council I responded to a task and finish review of Infant Mortality and I have asked for this to be discussed at Health and Wellbeing Board soon. It was a very hard read – we needed to do more - the preventable loss of life of a baby was the most devasting consequence any family could ever face and the fact that in Birmingham our rates were so high was distressing and makes uncomfortable reading.

I am committed to doing all I could to reverse this – the report highlighted that some of these deaths were preventable through a range of earlier actions and awareness and earlier conversations on lifestyle choices prior to conception and during pregnancy.

There was more we needed to collectively undertake together with our health partners, our communities and with our citizens.

We will be looking for a Chair, to chair that taskforce and we were looking for someone that had the passion and drive. This needed to be someone that could give the overview and push that it needed as the City Council takes this issue seriously. We intended to ensure that the outcomes were met in this area.

PUBLIC QUESTIONS

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

CORONAVIRUS-19 POSITION STATEMENT

554 Dr Justin Varney, Director of Public Health introduced the item and advised that as we had the Local Covid Outbreak Engagement Board meeting next week he would not be doing the full slide presentation. Dr Varney then gave the following overview concerning the direction of travel: -

(See document No. 1)

1. Case numbers in Birmingham continues to decline which was good news and reflected all of the hard work of citizens and partners where we were working together to bring the Covid outbreak under control. However, we were not out of the woods yet, and if we look to the north areas like Bolton and Blackburn and Darwen the rapid escalation of the April variant (previously known as the Indian variant) had led to rapid increase in case rate.

2. Unfortunately this had now started to translate into hospitalisation amongst predominantly people who had no vaccine or only one dose of the vaccine. This was a caution to us all.
3. In Birmingham we were seeing a relatively small number of variants of concern of any type, but we were now starting to get data from Public Health England (PHE), but will give a fuller presentation on variants of concern next week.
4. Of those that we were aware of that were the April variant of concern in total up to the 14 May 2021 we had 29 cases in the city. Of those where the contact tracing was completed, over half were either directly travellers themselves or lived and were direct contact with someone who had come from overseas.
5. What we were not seeing in Birmingham was a significant number of cases in the communities where there were no history of travel. Colleagues would be aware that we had in recent weeks ran three Operation Eagles which were around cases of the South African variant, where we identified individuals that were not linked to travel and we had done surge testing to try and see if there were any different pattern or any evidence to more spread in the community.
6. Those operations did not identify any further cases of the variants although they did find a small number of additional cases of people who were positive and did not know it. It was always a benefit when we did these surge testing and we found potentially more cases we can further reduce the transmission of the virus across the city.
7. We had been preparing and running some scenario exercises around what might happen if we saw escalation in a similar picture to what we saw in Bolton.
8. At next weeks' Local Covid Outbreak Engagement Board meeting, there will be a fuller presentation from the learning of Operation Eagles and also some of the work we were doing in preparing for various scenarios looking to the future.
9. It was important to remind everyone that Covid remained a risk and it was important that we continue to follow the guidance – maintaining hands, face and space and now adding in ventilate as the weather had gotten better.
10. As we learned more about the virus it became more important that we keep windows open particularly when we were in an environment with people we did not live with. If you were having people over, under the rule of having six people from different households or two households coming together indoors please ensure that you keep the windows open and the rooms well ventilated, maintain distance and keep washing your hands.
11. The lessons from Bolton and Blackburn showed that these numbers could escalate quickly and the new April variant present a serious risk particularly, because the evidence emerging was that it was more infectious than the Kent variant we had at the beginning of the year.
12. It may or may not be more dangerous in terms of putting more people into hospital, but simply the fact that it was more infectious meant more people would become infected and even if the same proportion ended up in hospital meant more pressure on the NHS.
13. Dr Varney reiterated the importance of getting vaccinated. All of the evidence currently internationally showed that the vaccines we were

using in the UK were effective against the new variants and reduced the risks of hospitalisation and significantly reduced the risk of dying.

14. The situation we saw from Bolton – the vast majority of people who were admitted to hospital were people who were in the priority groups, were eligible for vaccine and had chosen or were unable to take up the vaccine and sadly as this wave swept through Bolton they succumb and ended up in hospital and sadly some of them had died.

15. A small number of them had the first dose but not the second dose. There was one case in an extremely frail individual who had two doses but still became extremely unwell.

16. This reinforces the importance for everyone if you were in those eligible priority groups, particularly individuals who were considered clinically extremely vulnerable, those who were shielding or those considered clinically at risk and those who had the flu jab normally in a year – those were the people who should be taking the extra step to ensure they got their vaccine now as we wanted to close that gap and get those vaccines into you as soon as possible before we saw that wave of new April variant moving down across the country.

17. There was still a way to go and we will still see these challenges around new variants appearing the next year. We were in a good place and were doing everything that was asked of us and had to keep going at it to avoid ending up in a situation that other areas in the country currently found themselves.

CORONAVIRUS -19 VACCINE UPDATE

555 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG introduced the item and gave the following verbal update:-

a. The vaccine rollout continues and we continue to go down through the age groups. We were now administering the Pfizer vaccine to individuals aged under 40 years old.
b. The supply of vaccines were coming through to allow us to reach our second dose application whether it was the Pfizer or the AstraZeneca vaccine.
c. Probably over this weekend or early next week we will reach the point where we would have administered 1m vaccines across Birmingham and Solihull. Around ¾ of those was through Primary Care and a ¼ through the mass vaccination sites and hospital hubs which was an astonishing achievement.
d. Mr Jennings reemphasised Dr Varney's comments that no one gets left behind on this. If at any point you had chosen not to have the vaccine and/or you did not felt that you could for whatever reason, if at any point you changed your mind, you would be warmly welcomed to have your vaccine and to join those who were taking on a level of protection that worked well against all of the versions of the virus we currently had in circulation.
e. It was a fantastic and mammoth effort and people were working had at this now since we have started just before the New Year. We had been at this for just over five months now. In line with what Dr Varney had stated we were also planning for any potential surge.

f. In Bolton you would have seen the buses with people queuing up to have the vaccine. Most of those were people who could have had the vaccine and did not take it.
g. We will have plans in place, we have a fantastic capacity for vaccines here and working flat out we know that we could do about 120,000 per week. We never had that level of supply, but if we did find ourselves in a surge situation, he was reasonably confident that we had the resources, skill, planning capability ,and the competences and most important a committed workforce most of whom were volunteers to enable us to deliver what was required should it be needed.
h. In the meantime we carry on the vaccine programme as it stands. We will work with the cohorts and get to the point around summer where every single adult would have been offered the opportunity to be vaccinated and protected before we move on into the winter.
i. We have not had our summer yet but we planned to carry out our flu programme and Covid vaccine booster programme that it appeared we would be doing this year too.

Dr Aslam made the following comments:-

i. We had done well and had delivered 1m vaccine, this was much more than we could have hoped for, there was still a challenge. Dr Varney had pointed to it that in Bolton those people who were not vaccinated were suffering and the infection was spreading quickly amongst those people and a significant proportion of those people were becoming unwell.
ii. In West Birmingham, compared to the rest of the Black Country, we were seeing 10% behind on vaccination rates in most of the priority cohorts. Although we had lots of things in place including revamping our community pharmacy offer and making vaccines available in practices and continuing the work that we had done at the city sites that will extend into the winter period.
iii. We will continue to deliver large scale vaccination into the winter period and the vaccination site at Aston Villa and Millennium Point we still had a challenge. Our system was at risk of Covid spreading quickly within our communities and we had a significant portion of people that were not vaccinated.
iv. Although he was excited that we got this far, and it was much better than we ever did with the flu campaign previously, there were more for us to do and we will continue to do that work as Mr Jennings described if you had given up the opportunity to have your vaccination on one occasion that was fine. If you changed your mind we were here as we had the access point for you to get vaccinated.

The Chair enquired what inhibitive ways were you trying to work with communities to make the vaccine more accessible for the communities. Mr Jennings advised that we had mobile vaccine sites, the vans were going around and we had been working with Faith Groups and community groups. We were offering vaccines sessions where specific languages were spoken. We proliferate more sites into pharmacies because these were more local areas that were more trusted by individuals. In the first three months of the campaign we had nearly 80 engagement with communities and leaders etc. This pattern was reflected in the west of the City.

Dr Varney commented that he had access to three different websites that he had logged into to look at the vaccine data, some of which Mr Jennings, Ms Mayo and Dr Aslam had access to and some that displayed the data in a different way. The access to that was restricted to the information about Birmingham residents and the two STP, ICS NHS systems that we work with. Dr Varney added that he could see the data for Birmingham and Solihull, West Birmingham and Sandwell and the rest of the Black Country, but he did not have access to the Bolton data to be able to look at whether their vaccination uptake was particularly different from ours in terms of whether we were less at risk vaccinated than where we were currently.

Dr Varney stated that he could not do that kind of analysis which he thought was what Mr Raybould was hinting at. Where we looked at the uptake we were doing well. We still had some communities that if they changed their minds and come back – there was no blame no judgment here. The reality was that the April variant was posing a real threat now. If you were watching the news and saw people from India and you thought about it and felt you were now ready to have the vaccine, please get in touch with the NHS and book through the NHS website. If you had a medical condition and you wanted to talk it through, please talk with your pharmacist or to your GP practice about your personal circumstances.

In terms of the demographics of our populations, we were not that dissimilar from Blackburn and Darwen which was also doing an uplift. Bolton was slightly less diverse in the way that we were and was slightly older, but we were not radically different. If this was happening in Devon, he would be slightly less concerned than he was about it happening in Greater Manchester.

INTEGRATION AND INNOVATION: WORKING TOGETHER TO IMPROVE HEALTH AND SOCIAL CARE FOR ALL

556 Aidan Hall, National Management Trainee, Public Health introduced the item and gave a brief overview of the Government's Health and Social Care White Paper published in February 2021. Mr Hall then drew the attention of the Board to the information contained in the slide presentation.

(See document No. 2)

Doug Simkiss, Birmingham Community Healthcare NHS Foundation Trust presented the information on behalf of Richard Kirby, Lead for the ICS Inequalities Work. Mr Simkiss then drew the Board's attention to the information contained in the report.

(See document No. 3)

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG introduced the item and drew the attention of the Board to the information contained on page 58 of the Agenda Pack which highlights the four things the ICS was here to do. Mr Jennings then advised that Harvir Lawrence, Director of Planning and Delivery will give a slide presentation on the item.

Ms Lawrence then drew the attention of the Board to the information contained in the slide presentation

(See document No. 4)

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

1. One of the additional components in terms of our journey towards becoming an ICS was that we knew that integrated care worked best when NHS services were well integrated with local authority services. This was well proven with the work we did so far.
2. In the White Paper and the guidance that accompanied that there was a clear expectation that sets out that CCG boundaries and local authority boundaries become aligned to support that integration.
3. We knew that West Birmingham currently sat in a different CCG system to the rest of Birmingham with BSol.
4. The challenge on us as system leaders to work over the coming year to see how we resolved that for the benefit of local people. At the moment we were working closely with Mr Jennings team in BSol to set out what that might mean for us and what our journey might be.
5. This was something that might be useful for us to bring back in more detail at a subsequent meeting. We were on a trajectory to bring the health economies back together in Birmingham for the benefit of integrated care.

Dr Varney commented that he welcomed Ms Mayo's statement and that Mr Jennings and Dr Aslam had both alluded to the way West Birmingham had worked collegiately with BSol through this had demonstrated and had changed a lot of the dynamics around how we deliver to the citizens of Birmingham effectively as a whole city which was positive.

In relation to Ms Lawrence's presentation Dr Varney enquired whether those priorities had gone through the West Birmingham Integrated Care Partnership (ICP) as part of the pre-journey before they came to the Board. He added that one of the key bits he would like to see was West Birmingham was supportive of them. In terms of the request for members to feedback on those eight priorities, Dr Varney suggested that this be done electronically so that a more detailed and thought through approach could be had.

The Chair stated that it would be good for the sake of the Board if we could get a few comments on the points that Ms Lawrence had raised in her presentation and the points that was raised by Ms Mayo. The Chair voiced concerns that as an HWB if we were going to play a significant role going forward particularly around Mr Hall's presentation in relation to the White Paper, we needed to have some strong positive/negative views so that as the ICS was developing, they saw us as a Board that had 'bite'.

An extensive discussion then took place and the following is a summary of the principal points made:-

Professor Robin Miller:-

a. The aspirations that had been set out here today and we also hear about at the Away Day, were inspirational. What was great to see was the health care service that had totally embraced the notion of general wellbeing, inequalities and were trying to work on a more community orientated and a socially friendly way.
b. That he was reassured about the plan for the ICS and if they were to build on the previous relationship that was established with the HWB underlined that.
c. In relation to the West Birmingham question it had always hard as an independent observer to comment on that as there were so many complicated discussions that were on-going with that it was hard to provide any meaningful insight.
d. It was complicated and had a tendency to work to the same boundary and the city one was where people worked to the city boundary where most people live in. It was hard as an external commentator to note that.
e. All of what we were talking about here would require our workforce to behave differently. There were two key elements - our ability to collaborate and the ability to work with communities.
f. This was not unfamiliar to them – we wanted to see a step change up in the way that they do. The question was what their engagement was like with universities.
g. A further question was whether they felt like they understood what was required of a future HWB as social care professionals and were they providing the right development support for you. That the Board come back to a future HWB meeting if it was not the time now.

Stephen Raybould:-
In terms of the priorities with the digital conversation – in relation to West Birmingham it was important that in lots of ways, West Birmingham was in the Birmingham system. It was just the challenges that we had two systems and that did not work for citizens. If the direction was towards merger, the primary experience for the people who were anxious and concern about it and what that might meant, that was experience as a merger rather than a takeover and the absorption of West Birmingham into the BSol system. There were lots that were brilliant and the relationship to the voluntary sector in West Birmingham had historically been excellent. We would like to see that carried into the wider space.

Dr Manir Aslam:-

I. Ladywood had some of the most deprived areas in the country and that he made no apologies for arguing for those people to have better outcomes than they have at the moment.
II. The idea that we managed health and inequalities as their primary driver was exactly what his work was about and not what he would like the work of the HWB to be about.
III. It was important that we listen to local people, that we allowed decisions to be made locally that could be implemented or that those decisions were enacted as close to the point where those decisions were made as possible.
IV. Localism was important here as the best work we had done through Covid was when we were engaged with communities; when GPs had contacted patients about vaccinations because they did fine; when

communities had contacted each other about vaccinations they had done well.

V. It needed to be borne in mind that Ladywood had suffered from poor health and social inequalities for some time over the years. Despite it being in the legislation that we mange health and inequalities they got worst over the last 10 years.

VI. There was something that we needed to do together differently to change the outcome which was an important point to make – we tried and did not got there.

VII. We needed to try again, but this time it cannot be about '*what are you doing and what am I doing*,' it had to be about what we were doing together to achieve those aims.

VIII. We needed to hold ourselves to account in f5 – 10 years' time to say did we set ourselves a set of outcomes that we achieved and if not, why not. If we were all pulling in the same direction there was no reason why we could not make the lives a lot better for those people living in West Birmingham.

IX. In one sense it did not matter which system we were in, what mattered was the work that we do for the people in West Birmingham was beneficial for them and it achieved the outcomes that we set.

Andy Cave:-

- There were two aspects - firstly, the priorities for the ICS and secondly, West Birmingham.
- One of the challenge for the HWB at this moment in time was that we all had different levels of involvement in the ICS process and different levels of understanding.
- As an organisation that currently was not involved in the BSol ICS conversations (he would welcome in dept conversations about our role and function) and actually how patients and the public were influencing these priorities especially when we got into the finer details of that and how we could work at a locality level within the place of Birmingham and overcome some of the challenges of that.
- In terms of West Birmingham, there was a lot that could be learnt and the ICP across all localities of Birmingham. He would welcome the conversations of learning from the ICP in West Birmingham and how we could move that model and learn from it for the other localities as well.
- There was real involvement from a Healthwatch perspective in the Black Country and West Birmingham. Both NICP level in West Birmingham, but we also had representation at Board level in the Black Country. How we learn to increase involvement with all of the Board members was important.

The Chair commented that the voluntary sectors were saying that they needed a voice.

Andy Couldrick:-

- In relation to Professor Miller's last point there was much more that we should be able to do together to improve the offer that social work students received to prepare them for practice which was something we were keen to work on in the Trust with universities including Birmingham.

- On the wider point about children, what was key, was that we remembered that our focus on early help and intervention did not just meant early years and school readiness etc.
- It meant the earliest point in the beginnings of problems emerging for children and young people and families whether they were five weeks old or 15 years old.
- The second point was that it was only going to work (Professor Miller Was right when he talked about practitioners needed to change the way they practice).
- Leaders equally needed to change the way they led the system in order to make integration felt real and safe for the workforce that felt comfortable in their separate silos if we want integration to be real in the way that we took forward some of these priorities.
- The focus on how our workforce worked together in new and different ways was going to be critical.

Councillor Matt Bennett:-

- In relation to the West Birmingham issue, it could be easy to focus on the structural changes and disappearance of the organisational side of it.
- To people out there this meant absolutely nothing and it should not really mean anything and it should not be terribly important how the various commissioning groups were organised or anything.
- It should be about getting the best possible services. Sometimes organisations could get themselves and devote a huge amount of energy and time to the structural stuff that ultimately did not mean anything to ordinary people.
- He was not dismissing the importance of getting it right, but we should not allow a huge amount of time and energy to be focused on this at the expense of other more important things.

The Chair commented that Ms Lawrence raised eight points in her presentation which were key points. The report was for noting, but the issue of waiting times kept coming back from the doorsteps. People that needed to be seen especially in her Ward felt that others would be given priority before them. The Chair enquired what work the Chief Executives were doing to ensured that we got a level of equality across the system and those that truly needed intervention were not waiting and it then became too late for them.

Ms Lawrence stated that in terms of tackling our waiting times there was a substantial backlog that had built up due to Covid for a variety of reasons. We could take an approach and clinically prioritised these patients and completely ignore the inequalities aspect of it, but we have taken a proactive approach to take account of the index of multiple deprivation into how we were tackling our waiting list.

We were getting into the detail of not just looking at clinical priority, but taking account of that layer of inequalities into how we were delivering our services and were bringing in patients for their treatment. This was novel for us as we had done it in this way. It was new to us but we recognised the importance of doing that and have had good conversations with Richard Kirby, our Systems and Equalities Lead around how you embed inequalities to everything that we do as a system. This was in the fabric of the ICS and we did the hearts and

mind piece of work around that which was not a separate piece of work as it was embedded into everything we do.

In presenting those priorities, what we will be reinforcing was those inequalities thread that runs through all of it.

Mr Jennings started that we were back at levels of waiting not known for a very long time if at all. The first thing to be honest about the challenge and the second was to say that this was driven primarily by our response of clinical prioritisation as well as inequality. Mr Jennings advised that he will be joining a weekly meeting of the medical directors shortly as he had done over the last few weeks, across the system which include primary care where their conversation was entirely about doing the best we could in terms of what we had in terms of resources - how do we prioritise patients, how do we constantly review patients, how do we ensure that we minimise harm as much as we possibly could. Thirdly, we have to start to try to assemble a means of being able to communicate effectively with patients about where they were in terms of their waiting position, but also to be able to hear from those whose situation and circumstances changed and therefore our clinical response to them will need to change.

This was an incredibly complex issue when you have the tens of thousands of people that we have currently on the list. Mr Jennings gave his assurance that the hearts and mind of those clinical leaders were precisely around that prioritisation piece.

Dr Aslam stated that sometimes we look at waiting list as the things that hospitals do and we do not look at the impact we had on Primary Care. Primary Care has been robust, but it was at breaking point. There were lots in the media about general practice having being closed, but we have worked fully throughout this pandemic. We delivered services in a different way, but we were fully engaged with our patients, but it had been difficult. It was difficult for us as a society, but it had been difficult for primary and secondary care. We delivered the largest scale vaccinations than we had ever delivered as a country and we delivered it successfully. It was just a please to say general practice the conversation around general practice and access to general practice will need to be part of that wider conversation around waiting list and the restoration and recovery that we will need to go through.

SOCIAL PRESCRIBING

557 Stephen Raybould, Programmes Director, Ageing Better, BVSC and advised that it was an emerging issue across the sector. There was a substantial meeting involving over 50 organisations at the end of April looking at the challenges around Social Prescribing. There was broad agreement that patients experience needed to be placed at the centre and that the voluntary sector providers needed to exercise some control in developing and managing effective pathways across their provision and that a strategic overview be taken after activity. The broader ask was that this be seen in a wider context that their pathways into the voluntary sector were varied. One of the things that would be of great advantage certainly to the health service and to Primary Care was that

if people could find their way to voluntary sector activity without having to go through Primary Care, it would be quicker for citizens and takes the pressure off Primary Care.

There were a number of strategic priorities which were identified in the paper and some of that was around visibility of service

(See document No. 5)

Stephen Connolly, BSol CCG Contract Manager advised that he came along to the meeting to see if there was anything that the Board needed from a CCG perspective. He stated that his role was the Contract Management for the Social Prescribing Service within the Primary Care Network (PCN). That he supported the PCNs and ensured that they were doing what they were supposed to. The funding for the PCN came through from NHS England to the PCN DES. The PCN had a choice as to how many social prescribers they employed. There was a minimum target of one per PCN. We were at the mercy of the PCN and how they decided to employ their staff.

Mr Raybould commented that there were challenges around social prescribing, but there was a broader challenge around where they were being sent to. Although the prescription had been resourced, the other bit had not been resourced and he did not think that there was a plan around it sufficiently that we could begin to think how we tackle it.

Alan Ferguson, Locality Development Manager advised that his responsibility was to coordinate the social prescribing across the footprint and that he had met with Mr Raybould on a couple of occasions. He stated that he knew that this was one of the questions that had cropped up, but it was around capacity and signposting into the right areas. One of the things that came out of the meeting that Mr Raybould referred to was the agreement that we would start to have a better level of communication across the two areas so that we could try to sort out some of the potential problems that may come about in the coming months. Mr Ferguson stated that he was aware that the providers for these social prescribing via the link workers had also been made aware of this and they wanted to have a dialogue that hopefully could bring some form of solution to that helped the citizens.

Mr Raybould commented that there was general recognition that the approach had been forced upon the local system by the national approach and we had to do the best with it as we could. But this did not take away the challenge of the risk of the huge number of referrals where there is no capacity.

Mr Ferguson stated that unfortunately, the pandemic had hijacked a lot of the initial work that we started to do. One of the key things that came into play at the beginning of 2020 was a joint meeting of the Neighbourhood Networks and the newly appointed social prescribers. This brought a conversation that contributed to some working within BSol that we felt would take us forward. Unfortunately, within a month of that meeting we had the pandemic and we went to virtual working which did not help the situation. This was a real opportunity for us to visit where we were 12 months ago and started to build new plans.

Professor Miller commented that it was recognised that the social prescribing model was brought in at the same time and we agreed with the principles. This was a good case for the HWB asking for a joint commissioning plan across health and social care and how they were going to work together in terms of the way they support our communities and other organisations. A lot of research had shown in the past that organisations had to respond to similar request from different commissioners by providing different source of information, different source of contracts etc. Professor Miller stated that he would like to understand how this was joined up across the local authority and in deed our health colleagues. For the voluntary sector a simple ask was to build the capacity and structure that they needed and to get the financial support that they required to meet the needs of the citizens they had been prescribed to receive.

Maria Gavin commented that it was an excellent opportunity to pick up the work that started with Neighbourhood Networks. Neighbourhood Networks had continued to work at pace throughout the pandemic adjusting their offer through Covid with support. Throughout the pandemic we made joint offer to work with our voluntary sector organisations for children's services with the ambition to have that all age approach to working with the voluntary sector. There were some good established networks build upon and we were working closely with BVSC. There were some positive strong structures with a good sense of local need that could be brought together with the social prescribing approach. There were rules and as colleagues were aware, a number of platforms – social care, users connect support and many organisations used the waiting room, but this integrating the approach into systems and structures which were developing strongly was a good opportunity to pick back up.

The Chair commented that the point that was raised by Professor Robin Miller regarding doing some joint work to see how we could be more inter-linked, for this to be taken away as an action that could be looked at and brought back to a future HWB meeting.

Dr William Taylor commented that we had a gathering storm in many ways because what we have done was started answering the question that health and wellbeing was more than just prescribing a medicine or changing someone's blood pressure, but it was not. It was about the whole person which was what this Board was saying for a very long time. The problem was what we created then was an unmet need which was what was what Mr Connolly was alluding to. Dr Taylor stated that if there was an unmet need, we needed to address that. It had to be positive and that he would support the idea of a collaborative commissioning structure which was a true cross organisation piece which was certainly something we should push for, for our ICS and a real test for our ICS to see if this would be successful.

Mr Jennings undertook to take this up as an action. He added that he was impressed with Professor Miller's comment about having a joint way of doing this making it all simple and straightforward for the voluntary sector. We had to speak with the voluntary sector as he imagined that they had the same level of bureaucratic organisations that we had.

CREATING AN HEALTHIER CITY STRATEGY

558 Dr Justin Varney, Director of Public Health introduced the item and drew the attention of the Board to the information contained in the slide presentation.

(See document No. 6)

Dr Aslam commented that he was in attendance at the Development Session and that the principles that Dr Varney had outlined was good. He added that one of the first HWB he attended one of the question that was raised was how do we get away from strategy fatigue as we had seen a lot of strategies at the HWB but we have not seen any improvements in our city over the last 10 years. Dr Aslam added that he was keen and that this was a new opportunity and we could make good progress. He enquired how we could keep a check on ensuring we were making progress and that things were improving.

Dr Varney advised that one of the pieces being done alongside the work on the strategy was a matrix of indicators that we could track. What we were keen to do was not just look at things that we could measure once a year or only measured once every three year. If we take an indicator like infant mortality, it was published as a three year rate, and was only published once per year. But, actually, we knew about infant deaths through the Child Death Overview Panel in real time.

It was looking at how we create indicators where we track progress. The indicators were going to take time to change like childhood obesity, healthy life expectancy – what were the proxies that we could monitor every year and more frequently to move things forward. One of the things that was done well by the Board in 2016/17 under the previous strategy was a clear matrix of data that they were tracking which was reported back to the Board on a regular basis. We would seek to build on that model moving forward so that we were demonstrating progress as well as having a strategy that we could pull all of this together.

INFROMATION ITEMS

559 The Chair advised that Agenda items 14, 15 and 16 were for information only.

OTHER URGENT BUSINESS

560 No other urgent business was submitted.

DATE AND TIME OF NEXT MEETING

561 To note that the next Birmingham Health and Wellbeing Board meeting will be held on the 27th July 2021 at 1500 hours.

The meeting ended at 1650 hours.

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CHAIRPERSON