BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING TUESDAY, 8 FEBRUARY 2022

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 8 FEBRUARY 2022 AT 1500 HOURS IN MAIN HALL, BMI, MARGARET STREET BIRMINGHAM B3

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
Andy Cave, Chief Executive, Healthwatch Birmingham
Mark Garrick, Director of Strategy and Quality Development, UHB
Chief Superintendent Richard North, West Midlands Police
Karen Helliwell, Interim Accountable Officer, NHS BSol CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Professor Robin Miller, Head of Department, Social Work and Social Care, University of Birmingham
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Peter Richmond, Birmingham Social Housing Partnership
Dr William Taylor, NHS Birmingham and Solihull CCG and Vice Chair for Birmingham Health and Wellbeing Board
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Paul Athey, Chief Finance Officer, NHS Birmingham and Solihull CCG
Anna Hammond, BSol Place Development Director
Harvir Lawrence, Director of Planning and Delivery
Ian Sharp, Elective Recovery Clinical Lead, BSol
Dr Shiraz Sheriff, Service Lead – Governance, Public Health Division
Michael Walsh, Head of Service Commissioning, BCC
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

601 The Chair welcomed attendees and advised, and the Committee noted, that this meeting will be webcast for live or subsequent broadcast via the Council's meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw) and that

members of the press/public may record and take photographs except where there are confidential or exempt items.

DECLARATIONS OF INTERESTS

602 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

603 Apologies for absence were submitted on behalf of Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG,
Professor Graeme Betts, Director of Adult Social Care (but Michael Walsh as substitute), Andy Couldrick, Richard Kirby, Birmingham Community Healthcare NHS Foundation Trust and Douglas Simkiss.

DATES OF MEETINGS

604 The Board noted the following meeting date for the rest of the Municipal Year 2021/22:

Tuesday 22 March 2022

This meeting will commence at 1500 hours.

EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC

The Chair highlighted the reports at Agenda items 6 and 7 and appendices 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:

605 **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.

EXCLUSION OF THE PUBLIC

606 That in view of the nature of the business to be transacted, which exempt information of the category indicated, the public be now excluded from the meeting:-

(Exempt Paragraph 3 of Schedule 12A)

READDMITTANCE OF THE PUBLIC TO THE MEETING

609 The public was readmitted to the meeting.

At this Juncture the Chair then handed over the chairing of the meeting to the Deputy Chair, Dr William Taylor due to prior commitments.

Dr William Taylor in the Chair.

ACTION LOG

The following Action Log was submitted:-

(See document No. 3)

Dr Shiraz Sheriff, Service Lead – Governance, Public Health Division introduced the item and advised that there were no outstanding actions on the Action Log.

610 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

611 The Chair commented that as this was our first meeting of the New Year as we had just had a discussion in the private session looking back over the last couple of years and what had gone on there was a huge amount of looking forward to the future.

The Chair stated that he noted that Sajid Javid, MP Health Secretary had announced that the NHS Plan which was on the back of the … One of the things we will see from the Agenda in front of us today was what we were going to do and looking forward into the future and what we were going to do with the future system, whether it was how we were going to work at Place and as an ICS, bringing health and social care together and making decisions to be closer to people as we possibly could regarding their health, welfare and wellbeing and about the things we spoke about earlier.

It was quite an exciting time and looking in terms of our own plans and the legacy effects of … and looking forward to the outcomes of the Commonwealth Games and the legacy that that would bring. This was exciting for Birmingham and Solihull and the surrounding areas. It will have a legacy effect which would heavily impact some of those items we had discussed earlier around health and the wider determinants. This was really something to look forward to on the Agenda.

PUBLIC QUESTIONS

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

CORONAVIRUS-19 POSITION STATEMENT

613 Dr Justin Varney, Director of Public Health introduced the item and gave the following verbal presentation:-

1. We were seeing case numbers coming down and the testing rates had fallen slightly. We were also monitoring Covid cases in wastewater which allowed us to keep an eye on what was happening in doing the tests.
2. The good news was that it was coming down in our wastewater which gave us some confidence in the pattern and the direction of travel. There remained a significant pressure in our NHS system in terms of our Covid patients, but we had seen clear evidence that our vaccine *does what it states on the tin* in terms of reducing the risk of death and the risk of requiring oxygen and intensive care support. This was validated nationally as well as locally.
3. We had seen quite a shift from the patterns we saw in terms of pressures on the NHS in the previous waves.
4. Omicron was by far the dominant variant across Birmingham and we were now seeing a subset of Omicron emerging, but the good news was that the vaccine was still holding its defence in terms of death and severe illness.
5. Every time a new variant appeared across the world, there was an international effort to look at what the impact was on vaccinations because across the world we were using the same group of vaccines.
6. Until the rate of vaccination improved across the whole world, we will continue to see variants here and that will now mean we were moving into the phase of living with Covid.
7. Covid was not going to disappear in the short term and adopting our society and our way of being through navigating this serious illness, for people who were vaccinated. It could still be pretty unpleasant for people who were vaccinated.
8. Several colleagues who had Omicron recently had testify to the fact that it was not a nice condition to have. More people who were reporting Omicron wee finding that it was a rough experience even though they were showing no symptoms.
9. It was important to stressed that Omicron was more effective at re-infecting people and we were seeing clear evidence that people who

have had the Delta strain in December 2021 then had Omicron in January 2022.

10. The nature of the Omicron variant was that it by-passes our defence that we learnt through natural immunity from previous strains.
11. The good news was that when you had Omicron it did seemed to protect you against Delta and what we were not seeing was this happening the other way, which in some sense gave us some hope that if we saw more variants of Omicron, Omicron protection and our natural immunity plus our vaccination protection was likely to be pretty strong.
12. It was useful to put some numbers against some of the differences we were seeing.
13. There were two things that should be highlighted – Post Covid syndrome - Long Covid, we were seeing more information about this now.
14. The estimates from the Office for National Statistics (ONS) survey and the Department of Health Agencies were that 7.5% of confirmed cases with Covid still had symptoms 12 weeks after infection by limiting their activities.
15. 12 weeks after their initial infection they were still exhibiting symptoms that they were struggling to do certain things like dressing themselves, going to the shops being able to hold conversations and being able to go to work. If we think about the number of people who had Covid, that was a significant burden.
16. The NHS was working hard on a Covid pathway, but we were also still learning about them. This was a new disease and a new set of syndrome. What we were also seeing from the international evidence was that the vaccination reduces the risk of getting Long Covid through any age.
17. One of the things about Long Covid was that it was not particularly an ageist effect. Unlike a severe illness with Covid, where there was a definite age bias where the older you were you were more likely to be sicker, with Long Covid we did not see the same age distribution.
18. We were seeing 20 – 30-year olds with quite severe symptoms. Vaccination does reduce the risk of Long Covid and if you did develop Long Covid and you were vaccinated your symptoms with Long Covid was less severe.
19. There was something going on with Long Covid which probably linked into our immune system, but we do not yet fully understand this which then explained why vaccination was so crucial.
20. The other important thing to mention was the numbers behind the evidence of the impact of vaccine on hospitalisation and death. This was from a report that was published in late January 2022 from the UKHSA.
21. What that showed was that the risk of death within 28 days of a positive test from Covid, if you were aged 30 – 39 years old it was relatively small. It was 1.3 per 100,000 people affected if you were unvaccinated. However, if you were vaccinated it falls to 0.4 per 100,000 people. There was a big drop-off even at a younger age in terms of protection.
22. If we looked at older age groups, there was a difference between unvaccinated and vaccinated in the 70 – 79-year olds the difference between 81 people dying per 100,000, in the unvaccinated populated and 10 in the vaccinated population.

23. Now we started to see some concrete numbers coming through about the evidence and the impact of the vaccination and protecting people. We knew that with Omicron the booster became more important, but what we were seeing from the early data with Omicron was that with the booster, there was an 89% reduction in hospitalisation.
24. These were huge numbers and therefore it was important to encourage people to get vaccinated and answer their questions and respond to their concerns. We were seeing an improvement across the vaccination programme.
25. We were visited earlier today by a member of NHSE national team to review what we were doing, and she was much impressed and that we were doing everything everywhere all the time in a truly global city and the challenges we had in a big city.
26. It was important to remember that we had already vaccinated over 2m people across Birmingham and Solihull which was a huge success.

The Chair commented that this highlighted the importance of vaccination and enquired what the future of the vaccination programme would be.

Dr Varney stated that we will see another wave in autumn/winter across the world. If we look at the Covid-19 pandemic there were five waves before it burnt itself out and we had four of Covid so far. It made sense to suspect that the majority of the world and the southern hemisphere was not yet vaccinated. Covid was to some extent will be like the seasonal flu. It was expected to see a new variant in the southern hemisphere as they come through winter and they started to move into the northern hemisphere in the autumn. By that time we will be able to adjust to the vaccine.
Dr Varney further stated that it was strongly suspected that there will be an annual vaccination programme for Covid alongside flu. It was not thought that this would be for all ages as we were seeing immunity in younger adults once they were vaccinated maintained pretty much good immune system but in older adults this was not so good. It was suspected that we would have an annual Covid jab for vulnerable groups and possibly over the next two years.

Whether it became a permanent thing was dependent on what happened to Covid. There was also a promising research on all the coronavirus vaccines which was something being developed for over a decade since we had SARS. They had been working on these variants since SARS 1. It was expected that by July/August 2022 we will have a sense of what would be happening.

CORONAVIRUS -19 VACCINE UPDATE

614 Karen Helliwell, Interim Accountable Officer, NHS BSol CCG introduced the item and gave the following verbal update:-

i. In line with the national offer we were still seeing people coming in for their first dose. People were coming when they wanted to come along and we were trying to make the offer as flexible as possible.
ii. There was an audit around all of the ways in which we deliver the vaccination particularly the inequalities and those hard to reach groups.

iii. We were based in all of the areas in relation to the homeless and around the maternity providers. We were trying to be as bespoke as possible using every opportunity.

iv. In line nationally, we had seen a drop off in the booster, but it was a fantastic effort over the Christmas period by all providers having to deliver that piece of the programme. But it was still something that we would continue to work through.

v. In terms of local gaps we still had to offer and deliver the flu vaccine so that up take was a little bit lower. We had just appointed a new director of vaccination. There was still a huge amount of work to do but we needed to look at how we develop it going forward as a flu programme.

COMMONWEALTH GAMES UPDATES UPDATE

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

(See document No. 4)

A brief discussion then ensued following the slide presentation. In response to comments and questions, Dr Varney made the following statements:-

- Dr Varney noted Ms Jones query concerning the wider determinants of health and advised that this was the case but not within the Commonwealth Games legacy.
- The Food Strategy which was going to the next Cabinet meeting for approval and consultation, many colleagues were involved in the pre-consultation engagement ad we hope it would allow for affordability.
- We added in a 9th workstream in the strategy on food security which was specifically around food policy so that it was absolutely clear that that was a priority in the dedicated workstream.
- As you were aware the challenge of how we addressed food poverty was that we were looking at the system, how we changed what was being sold, how it was sold as well as what we could to influence national policy and welfare and the amount of money that goes into this.
- We were trying to get past the sticking plaster of food banks and to really start getting into how we create a city which was truly to celebrate the culture we have.
- There was a separate workstream on education and skills and adults and schools which we input into some of which was around the relationship with the Games and partnership as different partners were leading on different bits.
- This was something we could request through the Secretariat and get some update from Education and Skills Directorate.
- One of the things we started to do if the Board recalled that when Sue Harrison came to the previous Board and spoke of her ambition as the new director for Education and Skills to take a different look on how we create health schools.
- This builds on some of the practice in West Birmingham where there were some interesting examples of GPs working with local schools to help working together with the PCN system and the wider public health system.

- As a result of the Covid pandemic it has not been as fast as we would like but it was on the agenda for going forward. Where we have moved it faster was to secure money on mental health prevention … where we were able to commission Birmingham Education partnership to work with a number of primary schools to create a mentally healthy school environment and this has been really successful.
- One of the challenges was that this was quite expensive, but we could not afford to implement it across the whole city. The aim was to move it forward across the whole city in a step by step way.
- It was not about the curriculum, but the environment of the school, the culture, the physical and social environment of the whole structure and creating an environment where health and wellbeing was implemented across the entire school in the same way we try to get health and wellbeing across the entire health and social care system.

ICS TRANSITION UPDATE INCLUDING DESIGN AT PLACE

616 Karen Helliwell, Interim Accountable Officer, NHS BSol CCG introduced the item and drew the attention of the Board to the information contained in the report. Ms Helliwell then gave a quick whistle-stop tour of where they were at concerning the ICS transition update.

(See document No. 4)

Dr Varney stated that it was useful to understand that at the Integrated Care Partnership (ICP) level where this Board sat. The Integrated Care System (ICS) was like a super drug and enquired how this would be made meaningful. Ms Helliwell stated that it was recognised at pace where the strength was around engagement with communities and tapping into the resources through the local authorities was going to be key in those local communities, local partners whether that be the Police or GPs.

It was not thought that we would want to construct something on top of that to duplicate, but certainly in terms of membership on the ICP, that was being discussed with Healthwatch through the partners on how we embed that into the ICP. The organisation of the ICP would take that view from the ICP and other stakeholders. It was utilising and developing what we have straight from what we learnt from vaccinations for example and communicating with communities and tapping into it and supporting and developing what we have rather than a big organisation at the top that was trying to develop its own communication infrastructure. This was work in progress and definitely one that we would want to input into.

The Chair commented that it was partnership working through local authorities and other organisations and businesses.

Professor Miller commented that the services were important to the local authority areas in terms of things like housing, exercise and enquired whether this would be incorporated within the ICP or whether there would be something parallel or would local authority be responsible for that aspect and the ICP

would be responsible for deliver or whether this would take a bit of working through.

Ms Helliwell stated that it will take a bit of working through, but that the ICP was the group that would be the most important part of the overall strategy. This was the broad-church strategy. The membership of that will be from local authorities and community lay members spear setting the local framework and the delivery for all partners. This will involve the expertise and an understanding of the population health management and links with the communities, getting a rich diverse view of what that Masterplan will be about and using that information.

We knew that every organisation could not be represented but we were trying to get that connection and the Health and Wellbeing Board would be a key part of that. The delivery of that whether it was around the wider determinants of health to tap in at different levels. If there was some service that would be key to acting by itself that could be delegated to the Board.

The issue would be where was the best approach. If it was a consistent policy around early years or alternately it could be that it was decided that that could go across Birmingham and Solihull. It was thought that where some of this could be delegated to depended on what makes sense or where it was best to make those decisions safely.
Clearly if it was housing or social care for those local communities you would not want to delegate it to place. This was going to be the key once the Masterplan was set how to delegate it to the right level.

Dr Varney referred to the two ICS Boards and the ICS he and his colleague from Solihull was involved with and commented that there was no prerequisite for a Health and Wellbeing Board which had a statutory footing which had the right partners. Looking at some of those challenges through the principles of the NHS as the employer, the NHS as the economic power, there was a lot of work and it sounded that it was leaning on the networks and how it took some great learning from UHB team which was known for a while and how we take that learning and apply it to GP practices, the PCNs and work that through.

The Prevention Board was more focussed on commitments and the long-term plan where there was a series of things that the NHS must do as part of the 10-year plan and the Prevention Board was taking that on with the programme management. We were still working through all of that and the Population Health Management bit as he was responsible for the inside intelligence thinking. We were dividing this up between each other and trying to avoid replication with everyone sitting in the same room.

Ms Helliwell commented that we will start to see practical way of working on issues with a particular programme to understand how it might work so that we could work and learn together.

Councillor Bennett commented that from his perspective this looked rather complex and potentially bureaucratic. He added that we have an ICP and a Health and Wellbeing Board, the ICB, 8 place bases committees etc which had the potential to be incredibly bureaucratic. Although we had no control over this

if we were starting from scratch it was not certain why we needed to have the Health and Wellbeing Board and an ICB as separate organisations. The question was how we were going to prevent this from becoming bureaucratic.

Ms Helliwell stated that if you took away the governance a lot of what we were trying to do was to get partners to work clever and to integrating services in a better way. It was going to be about how we work with partners and used the best way of navigating this at the lowest possible level. Ms Helliwell added that she saw the Place Board and the Health and Wellbeing Board being absolutely critical and that delegation at place was going to be critical. From that level down there were some real opportunities to have concerning resources the dimension of what we wanted to do but not giving you the prescriptive way of doing it which was what we did not have.

To a large degree it was about assurance and we have learnt how not to do it and to do it properly and to make that as simple as possible. We were all trying to make it as understandable, but for the citizens who were going to receive it we needed to understand what our priorities were. If we pick those priorities whether it be vaccinations, maternity etc we had to learn by doing some of these examples. Some of these were statutory and with the ICP and the ICB it was how we could make them as best as we possible could to be flexible.

Dr Varney commented that we do quite a lot of wrestling with whether we should make the Place board and the Health and Wellbeing Board the same both in Birmingham and Solihull. Where we got to was that in the initial first couple of years the Place Board was going to focus on delivery of the NHS Trust vaccinations more than the strategic discussions about the environment etc. It was becoming clearer that the Place Board was around operational delivery driving operation transformation at place and in the first couple of years the ICP and ICB would be where the strategic system sat and trying to merge it was not practical. In Solihull, independently they came to the same conclusion.

Speaking with colleagues nationally, everyone has got to the same place that in the first two years they needed to stay separate, but this was not a forever decision. What was impressive comparing with colleagues nationally, was that here we had grown up conversations about what we could do – could we make it work as there were national hoops to jump through. In other areas it was not so positive. This would be how we navigate the years of transition.

The other issue which we should not forget which was seismic was West Birmingham as we will for the first time have Birmingham Place with one set of meetings for Birmingham which was an important step forward. Part of this was the locality structure and recognising that West Birmingham locality worked well navigating the Black Country and West Birmingham CCG. There was also the issue of what we could learn from West Birmingham about our delivery at place as this has not yet been incorporated into Birmingham.

Ms Helliwell stated that there were still some opportunities to get more views particularly about the Place Committee with this Board. Any comments or suggestions about that would be helpful. Given the work to date, we had the priorities for this Board would prove that this work in today's localities and those forums. There were opportunities to engage in that and the next steps was to

refine the functions and look at the opportunities to delegate out and what would be retained.

The Chairman commented that this was a work in progress.

BIRMINGHAM AND SOLIHULL SYSTEM RECOVERY PLAN

Harvir Lawrence, Director of Planning and Delivery and Ian Sharp, Elective Recovery Clinical Lead, BSol presented the item and drew the Board's attention to the information contained in the report.

(See document No. 5)

Dr Varney enquired whether there was some active strands of work to ensure we were addressing inequalities proactively.

Mr Sharp advised that this was something that was at the front of what they were doing both in terms of the backlog recovery and the wider investment planning that we were trying to make with regard to the capital for next year. It was fair to say that meaningful assessment of inequalities within our system and the impact of whatever step we might take was built into that planning guidance. It was thought that this was not deliberate as previously we knew about inequalities as being an issue, but we did not really have to address it operationally whereas now it was built into the operational decision making much more effectively which helped.

We had some data but there was quite some way to go in terms of building more meaningful datasets around all the various aspects of inequalities. It was in our thinking and was close to the front of our planning and our decision making about what we do next. But as all the members of the Board would know, there was significant amount of work to do on it.

617 **RESOLVED: -**

The Board noted the contents of the BSol System Recovery Plan update presentation.

AGENDA ITEMS 16 - 20

Dr Justin Varney, Director of Public Health drew the attention of the Board to items 16 – 20 on the Agenda and advised that in terms of the Sexual Health Strategy, that was now moving forward to the consultation stage which will go to March's Cabinet meeting for consultation. We would welcome any feedback from the Board to the Committee Manager or Mr Sherriff during the consultation period. In terms of the Deep Dive report, this has been a long time coming, but unfortunately Covid had got in the way, but he was pleased that this was now finally published. The report sets out some clear opportunities for action which had already been taken forward.

The Health Protection Forum was our annual report and as you would understand Covid did slightly got in the way, but he would request that Board members took some time to read the report as it does reiterate that whilst Covid was happening there were lots of other things that was challenging in the city. The final BLCHIR report will be presented at March Board meeting and that entered its journey through committees to get to us as of yesterday.

There were 39 opportunities for action set out in the BLACHIR review community partners reiterated that the breath of the Health and Wellbeing Board listened and take part in this report. The two years had identified decades of inequality and the loss of trust and confidence in our African/Caribbean communities in the public sector and this report gives us the opportunity to address that. Finally the City of Nature Update report was approved by Cabinet this morning for the Council will be moving forward into operational delivery.

618 **RESOLVED: -**

The Board noted the information in items 16 -20.

AGENDA ITEMS 18 - 22

619 The Chair acknowledged Items 21 - 24 on the Agenda were for information only.

OTHER URGENT BUSINESS

620 There was no other urgent business for this meeting.

The meeting ended at 1650 hours.

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CHAIRPERSON