BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 22 SEPTEMBER 2020 AT 15:00 HOURS
IN ON-LINE MEETING, MICROSOFT TEAMS

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chairman to advise/meeting to note that this meeting will 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.

2 **DECLARATIONS OF INTERESTS**

Members are reminded 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.

3 **APOLOGIES**

To receive any apologies.

4 **EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC**

a) To highlight reports or appendices which officers have identified as containing exempt information within the meaning of Section 100I of the Local Government Act 1972, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report.
b) To formally pass the following resolution:-
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.

5 - 28

5 **MINUTES**

To confirm and sign the Minutes of the meeting held on the 23 July 2020.

29 - 38

6 **ACTION LOG (15:00 - 15:05)**

To confirm the action log as current and correct and address any issues.

7 **CHAIR'S UPDATE (15:05 – 15:10)**

To receive an oral update

8 **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.
The deadline for receipt of public questions is 5pm on 10 September 2020. Lines of questioning should be submitted via: https://www.birminghambeheard.org.uk/place/birmingham-health-and-wellbeing-board-questions. **(No person may submit more than one question)**
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's Internet site (www.civico.net/birmingham).

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9 **CORONAVIRUS-19 POSITION STATEMENT (15:15 – 15:30)**

Dr Justin Varney, Director of Public Health

59 - 64

10 **FLU PLAN UPDATE (15:30 – 15:50)**

Rachel O'Connor, BSol CCG and Carla Evans Solihull and West Birmingham CCG

65 - 80

11 **UPDATE ON SCREENING AND IMMUNISATIONS (15:50 – 16:10)**

Andrew Dalton, Screening and Immunisation Lead, Public Health England

81 - 124

12 **UPDATE ON PUBLIC HEALTH COMMISSIONED SERVICES (16:10 – 16:30)**

Bhavna Taank, Public Health Adults and Older People care Service Lead and Karl Beese, Commissioning Manager – Adult Public Health Services

125 - 166

13 **EARLY INTERVENTION PROGRAMME - PHASE 2 (16:30 – 16:45)**

Michael Walsh, Head of Service - Commissioning

167 - 188

14 **WRITTEN UPDATE FROM LOCAL COVID OUTBREAK ENGAGEMENT BOARD (16:45 – 17:00)**

Item Description

189 - 202

15 **WRITTEN UPDATES FROM FORUMS (16:45 – 17:00)**

Item Description

203 - 230

16 **WRITTEN UPDATE ON BAME COVID -19 INEQUALITIES WORK (16:45 – 17:00)**

Item Description

231 - 242

17 **FORWARD PLAN REVIEW (16:45 – 17:00)**

Item Description

18 **OTHER URGENT BUSINESS**

To consider any items of business by reason of special circumstances (to be specified) that in the opinion of the Chairman are matters of urgency.

19 **DATE AND TIME OF NEXT MEETING**

To note that the next Birmingham Health and Wellbeing Board meeting will be held on Tuesday 24 November 2020 at 1500 hours as an on-line meeting.

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD THURSDAY, 23 JULY 2020

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON THURSDAY 23 JULY 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
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Andy Cave, Chief Executive, Healthwatch Birmingham
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
Dr Tim O'Neil, Director of Education and Skills, Birmingham City Council
Peter Richmond, Chief Executive, Birmingham Social Housing Partnership
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Waheed Saleem, Birmingham and Solihull Mental Health Trust
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
Elizabeth Griffiths, Assistant Director of Public Health
Chris Naylor, Interim Chief Executive, BCC
Monika Rozanski, Public Health Service Lead on Inequalities
Errol Wilson, Committee Services

The Chair invited the Board members who were present to introduce themselves.

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NOTICE OF RECORDING/WEBCAST

456 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

457 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

458 Apologies for absence were submitted on behalf of Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG
Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust
Professor Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Andy Couldrick, Chief Executive, Birmingham Children's Trust
Professor Graeme Betts, Director for Adult Social Care and Health Directorate
Gaynor Smith, Senior Employer and Partnership Leader, Birmingham and Solihull District, Department for Work and Pensions

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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:

459 **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

460 **RESOLVED: -**

That the Minutes of the meeting held on 21 January 2020 and the Minutes of the Special meeting held on the 23 April 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 all outstanding actions had been progressed and these were currently green for the Suicide Prevention Act Action Plan which had been published and circulated. He highlighted that increased activity had been undertaken around raising awareness of public questions and that a successful Special Health and Wellbeing Board meeting had been held and the learning from that was what more could be done in the future to increase awareness of how to ask questions of the Board.

461 **RESOLVED: -**

The Board confirmed that the Action Log was current and correct.

CHAIR'S UPDATE

462 The Chair made introductory comments and advised that it had been a challenging time over the last five months. She expressed thanks to each Board member and stated that the system in Birmingham had shone at that point as a lot of positive feedback was received in relation to the honesty, the way the system came together, what the Board did at that time to ensure it had delivered for the public and the way the Board was able to get and respond to the questions and responded to the public. The Chair thanked the organisations, and everyone involved for the work they had done and continue to do in terms of the joined-up way in which the system had worked and how people came together to make a difference.

The Chair highlighted that she was impressed with the remote ways of working and the use of technology to ensure that the Board kept in touch with the residents and the way it had been used to developed new ways of working. She added that what the Board managed to achieve was incredible and that it was hoped that as the months goes by the Board did not lose the progress that had been made.

PUBLIC QUESTIONS

463 The following question from a member of the public was submitted:-

When will the Health and Wellbeing Board agree and publish a strategy to meet the health needs of BAME communities across Birmingham. The strategy to identify the overarching and specific health needs of BAME communities, identifying those that require commissioned services, and those that communities can provide for themselves, with support. The strategy to highlight whether services currently meet needs, how BAME communities access services, the obstacles to access, and the actions to be taken to improve delivery of healthcare to BAME communities, with measurable outcomes.

Dr Varney requested that the question be shared for a fuller response from the Health and Wellbeing Board (HWB) as it was a broad reaching question. He highlighted that it was important that the Board acknowledge the question today by giving an initial response at the meeting. Dr Varney advised that an online process was being set up to share questions raised by members of the public through a single portal which would make it easier for the team to respond.

Members of the HWB then made the following statements:-

Dr Varney, Director of Public Health advised that colleagues on the Board would be aware that the Board was refreshing the approach to the Joint Strategic Needs Assessment (JSNA) and prior to Covid had published the first section in relation to children and young people which explicitly had sections looking at inequalities for children and young people from ethnic communities. It also looked at inequalities for children and young people with disabilities and those that had been identified as Lesbians, Gay Bisexual and Transgender (LGBTQ). The aim not to pick out a specific community or minority group but to do this in a way that was assessing inequalities across the city to understand the differences. This then raised the question as to what would be done about the responses.

Dr Varney stated that this was the first response about how the HWB was considering inequalities around ethnicity and was through the JSNA as the Board's first stage. The second was any strategies or framework the Board developed, or its sub-groups developed would go through an equality assessment impact in line with the City Council's policy and those were published at the same time as the frameworks. This was used as an opportunity to reflect further as to whether there were any other inequalities that should be picked up for any of the protected characteristics which include ethnicity.

The third element was in the relation of commissioning of the services. The HWB was not a commissioning body, but was in the Council's Public Health Division looking at how we could assess and work with our service providers to look at the uptake of our services in the different communities by using an equity audit where the demographics were looked at who was using the service compared to who was expected to be using the service. If it was a general service, example, sexual health services, we might compare that to the general population of working age adults in the city. If we were looking at NHS health

checks programme for people over 40 it would not be expected that 20 years old would be attending. The equity audit was tailored to the service.

The mechanism was being developed to do this and we will be working with some of our NHS colleagues to think about how we could share good practice through the Public Health Commissioning Board as a route for that.

The final part which was important to highlight was that the Board was aware that as a partnership with Lewisham, undertaking a health inequality review specifically focussing on our African and Caribbean communities, this was a pilot with a new methodology that we will look to replicate for ethnic minority communities' overtime as we could not do everything at once. It would be a disservice to our communities if we tried to say everyone who was non-white was the same. By taking this year and one half to explore the inequalities that affected our African and Caribbean communities in some details and some depth we would be able to try and understand how we could change inequalities that had lasted for decades and not just pay lip service to that conversation.

Dr Varney stated that this was being approached in many ways rather than having a single strategy that would be easy to put on the shelf and tick the box to say that we have done it. The approach being taken was one that was integrating the consideration of ethnicity and other protected characteristics of minority communities through all the work that the Board was doing. Ensuring that this was an important part of BAME needs assessments but also our impact equality assessment and our equity assessment of both how we commission services and checked that they were reaching and achieving the outcomes we were trying to change.

Waheed Saleem, Birmingham and Solihull Mental Health Trust (BSMHT) stated that a letter from the BSMHT Chief Executive was published widely about the impact of Covid-19 on BAME communities not just on the staff but also the service users. The Trust like all of the NHS organisations were undertaking risk assessments and were offering those to all their BAME colleagues and had had some good uptake. BSMHT were also addressing some of the inequality around their provision and delivery of services and were developing a process and action about how engagement with the communities BSMHT served could be improved by addressing some of the underlying issues concerning health inequalities that had perpetuated the mental health issues in those communities.

Like all NHS organisations the Trust was committed with regards to diversity with their workforce. If the Trust had a diverse workforce service delivery would improve and would be more affective. They were looking at ways of developing their reach to their communities and how the Trust could ensure that they had better representation of BAME colleagues. BSHMT was involved in a number of work programmes that were being undertaken.

Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Trust stated that there were three things. A lot of what the Trust were doing was similar to the things the other organisations were doing. Firstly, the Trust was undertaking a piece of work internally in terms of staffing and how staff was

being supported particularly staff from BAME communities that was operating before the pandemic and had been turbo charged through what was learnt through the pandemic.

Secondly, in terms of work with services and communities there was a first order priority for the Trust about ensuring that the Trust had reliable comprehensive data on ethnicity of the people being served. Mr Kirby acknowledge that the Trust did not have a lot of this as they wanted and the first thing for them was to understand that.

Thirdly the Trust wanted to build on that, particularly where they were providing specialist community services with long-term conditions like diabetes, respiratory conditions or heart failure. We know that we were targeting those of the right people in the right communities and the Trust knew that the way this was being delivered was probably culturally sensitive and culturally competent. The Trust had some great members of staff on the ground who were doing a lot of work with some of the communities in West Birmingham and often on their own initiative and that he was grateful that they were doing that, but the Trust needed to get behind them better as an organisation to help scale this up.

Andy Cave, Chief Executive, Healthwatch Birmingham advised that most of their work was directed at listening to inequalities and getting into communities within the city specifically around the inequalities highlighted by Covid-19 amongst the BAME community. Their next project was identifying particular inequalities within the BAME community, but not looking at BAME as a homogenous group but targeting specific communities within that to try and understand what the unique needs were of these communities and the inequalities that the particular community faced. This information would be fed through the inequalities sub-group of the HWB.

Paul Jennings, Chief Executive, NHS Birmingham and Solihull Clinical Commissioning Group (CCG) advised that the CCG did not provide services but oversaw the services provided by others. The CCG was active in supporting the establishment of a BAME Primary Care Network which was working across organisational boundaries to ensure the CCG heard the voice of those who work in the services. The CCG was doing a lot of engagement work, particularly a piece of work in the Lozells with one of the City's Councillor, a particular piece of work that Dr Varney had invited them to participate in with the Bangladeshi community. The point made by Mr Cave in terms of not being homogenous in their approach was important and the CCG had approached different elements of the BAME community intervention and support.

Stephen Raybould, Programmes Director, Ageing Better, BVSC stated that the voluntary sector was looking at integrating the approach to the recovery strategy including the shifting of resources towards communities that had been affected heavily by the Covid-19 crisis. A collection of organisations was looking at how this impact across the city. In terms of a single strategy, one of the challenges was that across the system there were a number of things happening which was quite positive, and it was hard for people to engage with a single strategy. Even if there were a single strategy, if it could be presented in one place so that people could look at it, it would be helpful in terms of citizens coming to understand what was taking place.

The Chair commented that just having one strategy was difficult and perhaps this might not be the forum where it could happen, but she believed that each organisation was adopting to what the issues were in the place where they were serving and were trying to adopt a strategy to suit that moving forward but will all get to the same place in the end.

CORONAVIRUS UPDATE

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

- We were continuing to see Covid cases and it was important to recognised that the national evidence showed that only 20% of the population has had Covid to date. There were still 80% of the population that did not yet had it. We were still seeing people getting Covid every day in Birmingham and some of those were still ending up going to hospital.
- Sadly, although we had a couple of days without any new deaths, we were still seeing across the country people still dying from Covid. Covid was no less infectious than it was two weeks ago, nor was it any less fatal. We do understand it a bit better now which was helpful.
- In Birmingham what was seen was looking back through the data was a sense of what the data was showing that we saw our first case in Birmingham in the second week in March 2020. The cases in Birmingham hit the first peak in the second week in April 2020 and then dipped again and then came back up before a slow descent.
- There was a bit of a 'camel hump' in terms of the first peak. The number of cases had started to fall quite well, but in the last two weeks a number of new cases were seen as an increase across the city.
- This was pretty general across the city in terms of numbers and in any one Ward was ranging between one or two cases to a maximum of 21 cases in any one area. This was linked to a couple of large households where everyone in the house had Covid. The shift in new cases was predominantly in people between the ages of 20 - 40 years old that had reflected people coming out of their homes more and socialising and engaging and back to work.
- Public Health was proactively working with the business sector and the Chamber of Commerce particularly and the Business Improvement Districts to ensure that businesses had access to the advice and guidance and support to keep their staff and customers safe.
- Public Health was doing work with our community partners, with our faith organisations and our Elected Members and many of our partners on the HWB helping to get the message out so that everyone in the city understood that Covid was still about and we all had a responsibility to try and keep safe and to stop the spread.
- Public Health have also been working with the Department of Health (DOH) and increased access to test facilities and a pilot walk through site at Villa Street in Newtown which was doing quite well as they were seeing 100 people per day. All of whom were booking through the 111-telephone number which nationally was seen as some of the best

practice in the country how well people in Birmingham were using the system to get a test.

- Testing rates had increased over the last three weeks which was positive and was a testament to all of the work that partners were doing to help communities understand how to get tested if they had symptoms. The message was to stay at home if they had symptoms with their family until they knew their results and to engage with the test and trace service to support them and to get advice as to what they should do if they tested positive and how to protect people who may come into contact with them who might be at risk.
- Public Health was continuing to respond to situations and was working with both CCGs and NHS partners to think through what more could be done before the second wave of Covid comes to reduce peoples' risks.
- It was known that there were some things that Public Health cannot not change which was associated with the higher risks of being unwell or dying, age, gender or ethnicity, but they often reflect things that could be changed such as carrying excess weight, being overweight or obese, smoking or having a long-term condition like diabetes or high blood pressure that was not well controlled increases the risks.
- Public Health and NHS partners were working together to see what more could be done to help people over the next three to four months to reduce those risk factors that could be changed as quickly as possible ahead of the next wave.

In response to questions and comments from the HWB, Dr Varney made the following statements:-

1) Dr Varney noted Mr Raybould' s query concerning the voluntary sector capacity planning for the autumn and winter periods and advised that the expectation was that it would look similar to the first wave in terms of the scale of numbers. The peak day in Birmingham was 134 new cases on a single day which was the highest number Birmingham had reached through the first wave which went on over several months.
2) The current thinking around when, there were two schools of thought – One was that as we all come out and we socialise more we forgot to keep our distance. We have not seen people for a while, so we shook their hands and gave them a hug and as well as giving them some love we gave them Covid at the same time. This sees the case numbers rising quickly over the summer.
3) However, if the weather was nice and people had their windows open, most of the socialising would be done outside and people would remember the advice about keeping their distance, washing their hands and got tested quickly if they had symptoms. This may defer the second wave to the autumn when the weather got bad and the second wave would probably be in October/November, possibly alongside the seasonal flu.
4) It was important to recognised that we will be in a different situation this time and the NHS and all the work that was put into the Nightingales, training and getting Personal Protective Equipment (PPE) all of that we were thinking through how we could keep things going so that when the second wave comes we will be in a stronger position to manage it rather

than getting overwhelmed. This meant that we could have a different approach in terms of lockdown and how we approach it.

5) It was unlikely that a vaccine would be available to roll out across the population until probably next year. Even if a vaccine that worked could be found and it was safe, it would take six to seven months to get enough of it and would then take four or five months for everyone to get an injection. Normally it took five months to give the flu injection to the over 65 years old, those under five years old and those with long-term conditions, just think how much work we have to do to give it to everyone. We needed to plan as if we were planning for wave one as it was thought that this would probably come in the autumn in terms of timeline.

At this juncture, Dr Ian Sykes, Sandwell and West Birmingham CCG commented that it was important to be mindful of the coronavirus as it had not gone away. As Dr Varney had stated approximately 20% or so of people have had it. It was known from the latest research that 25% - 30% of those people who had it did not become immune to it. Therefore, because a person had it did not mean that person could not get it again. This therefore meant that most people in our city was not immune to this condition and just because a person had it did not meant that they could go out and forget the regulations as there was a one in three chance that if a person had it that person was still not immune.

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG highlighted that it was needed to do everything that possibly could be done to get the flu vaccine working as soon as possible this year. Different delivery mechanisms were being looked at. Upwards of 300,000 people attending their General Practitioners surgeries was not the way to do this and better ways needed to be found. The CCGs were still waiting to hear what the extended age range would be which could be from 60 years old and were looking to having to deliver half of a million vaccine for flu but were determined to do it much faster than it was done previously.

Dr Varney continued.

6) Dr Varney concurred with Dr Sykes point and stated that this was one of the reasons Public Health was not rushing to roll out the antibody tests as the evidence was showing that a significant group of people either did not develop any antibody despite having had Covid or if they did it wore off quickly. This was because Covid-19 was the same family of viruses as the common cold and it was thought that the body was responding to it in the same way as it did not learn how to fight if effectively and it forgot quickly what it learnt.
7) Dr Varney noted Mr Jennings' point concerning the flu vaccine and stated that it was an important reminder and part of what was needed to be done to be ready for the next wave was to do everything that could be done to protect us and to get as healthy as possible. Getting the seasonal flu jab this year will be important.
8) Dr Varney stressed that if you were one of the people who were eligible because you had a long-term condition, or you fell within the age group it was important for you to get the flu jab. What people did not want to do

was to catch Covid and catching influenza at the same time as this would be a nasty combination.

9) Dr Varney highlighted that people needed to main the 2 metres social distancing the moment we leave our homes we needed to keep the 6 feet/2 metres in our minds from other people, keep washing our hands and do not touch our face until we have washed our hands. He added that this was how we took the virus from something that we touch and put it into our face where it could get inside our bodies.
10) The face covering was important as what it did was to stop you spreading the virus. If you got the infection or very mild symptoms you could be out and about, shouting to someone or singing to yourself and would be spraying that virus onto people. By using a fabric face covering – two or three layers of fabric except knitting as this had holes in it and cover your face if you are going into a building whether that was a shop, taxicab or public transport. Wearing a face covering was about showing respect for other people and by protecting them.
11) It was important to recognise that some people cannot wear a face covering. In some cases this was because they had certain conditions like autism where it was distressing, some people have breathing difficulties and face covering did not make a huge difference to the oxygen and it was expected that asthmatic, but for some people who have fragile lung problems they may not be able to wear one. What would be done in this situation was to encourage people to wear *face* coverings as it would protect the people who could not. This was the other part for having responsibility for our city, our friends and our communities.

Chief Superintendent Stephen Graham, West Midlands Police commented that in terms of enforcement the Police was not going to be issuing tickets as they did not do this during the earlier wave but would rely on people taking on board the educational message. The Police will rely on people taking responsibility for their own actions. If people thought, there would be a 'swarm' of police officers going through the Bull Ring or going to supermarkets giving people tickets who were not wearing a face covering this would not be the case. It was about individuals taking responsibility not just for themselves and their loved ones but for those whom they would interact with in public spaces. This did not mean that people would not get a ticket. If people refuse the advice and refuse the education and the encouragement that people were offering, then they might get a ticket, but the Police were not going to be doing what was the equivalent of the speed trap and have Police hiding in Asda waiting to issue people with a ticket if they were not wearing a face covering.

The Chair commented that in a number of Wards, some people were having outdoor parties and the public were nervous as these gatherings were happening and they were not sure who had the responsibility for dispersing them. Chief Superintendent Graham advised that a few weeks ago when the weather was warm there was a number of what was known as block parties which were unlicensed events where they did raves. The age group was 20 - 40 years old as that was the demographics that was attending these groups as they were frustrated that the pubs and bars were not open at the time and they came together to socialised with their friends. Chief Superintendent Graham stated that members of the public should do what they would do if there was a

noisy party and disorderly behaviour happening and report it to the Police. The police had gone along and try to breakup those that they could as they had to walk the line to see what was achievable and what was not.

There was a saying in Birmingham that what was seen in some parts of London when the Police ended up with pitched battles between the police and local young people as no one wanted this either and so the Police were trying to take a path that reflected the need for people to sometime come out but at the same time they could not have these gatherings as it could lead to a communication in the virus. Chief Superintendent Graham added that Councillors could advise residents that if they saw large gatherings or antisocial behaviours to report it to the Police and if the Police thought it was reasonable to step in and disperse the crowd then they will. What they did not want to see was Police officers wading into young people and striking them with batons.

Dr Varney stated that they did not watch how many people got fined for not wearing a seatbelt as we did it because it was the right thing to do to keep us and our family safe and the vast majority of us drove safely on our roads within the speed limits. It was about keeping other people safe as well as ourselves. It was hoped that most people will view face coverings as a simple thing that we could all do that makes our communities safer. Ultimately the people that ended up being hurt by the spread of the virus was us. It was important that we all take ownership for and lets all work together to keep our city safe.

COVID-19 LOCAL OUTBREAK CONTROL PLAN UPDATE

The following report was submitted:-

(See document No. 1)

Dr Justin Varney, Director of Public Health presented the item and advised that Public Health was asked to develop the Plan in July at relatively short notice and had worked with partners within the City Council, CCG colleagues and voluntary sector colleagues to work this through. This was a joint effort with many members of the HWB.

Dr Varney highlighted that the Plan was not just a document that sat on the shelf as it was being tested with some hypothetical scenarios and it was also being tested every day in response to situations of outbreaks across the city. The Plan was reviewed by the Regional Convenor of the Test and Trace Programme in the Department of Health who gave a positive feedback and commended the Council on its community engagement and communications of the Plan which was one of the annexes of the Outbreak Plan. This was held up as both regional and national best practice which was a positive reflection of all the work that was being done as a partnership to ensure that our communities understand how to keep themselves, their families and the city safe.

In response to questions and comments, Dr Varney made the following statements:-

a. Dr Varney noted Mr Saleem's query concerning the regional response and how the Plan was connected around the regions and stated that all of the Plans across the regions followed a similar format as Public Health across the region were given a specific set of things that needed to be covered. Public Health was sharing information with each other as their Plans were being developed particularly with colleagues in Solihull. This was also being done with colleagues in Walsall and Sandwell where there were perhaps the most flow across the border.
b. The Directors of Public Health met on a weekly basis and had agreed to step this up to three times per week to have a conversation to see where each was going in our own patch and whether there were any cross-border issues we should consider. An example was the outbreaks in Sandwell and the rising number of cases in Sandwell primarily linked to two businesses.
c. In both businesses there were staff that lived in Birmingham who tested positive and there was clear communication between Public Health and his counterpart in Sandwell in terms of understanding what they were doing and whether there was anything he could support with. Public Health was working hard across boundaries and had agreed to support NHS colleagues and worked throughout crisis with the CCGs but had also now had a Lead Director of Public Health for each of the NHS Trusts that had inpatients beds.
d. Birmingham had a lot of hospitals which had been shared with some of his counterparts. The Director of Public Health Solihull had lead for Solihull and University Hospitals Birmingham and his counterpart for Sandwell led for Sandwell and West Birmingham Hospital Trust whilst he (Dr Varney) led for the Mental Health Trust, the Community Trust, the National Orthopaedic Hospital and the Women and Children's hospital Trust. Meetings with the Directors for Infection Control were held to understand what was being done and ensuring the dots were connected with cases that might appear in hospitals particularly in staff and what was happening outside of the hospitals.
e. A lot of work was being done to think that through and were now working towards some regional testing of the plans to put through a scenario if there was a large employer that had staff that lived across the patch where there was an outbreak, how this would be managed. If there was a large event where lots of people came together and perhaps to watch a football match and there was an outbreak associated with that and they went back to where they lived how this would be managed. This testing was being done to ensure they were confident to know how public Health would approach that and to ensure who was leading it and how the rest could play a supporting role.

465 **RESOLVED: -**

The Board:

i. Noted the contents and publication of the Covid-19 Local Outbreak Control Plan;
ii. Noted the Governance arrangement for Test and Trace detailed on pages 5 – 8 of the Covid-19 Local Outbreak Control Plan; and
iii. Noted the request for members of the Board to promote the Local Outbreak Control Plan amongst their networks.

COVID-19 LOCAL OUTBREAK ENGAGEMENT BOARD UPDATE

The following report was submitted:-

(See document No. 2)

Dr Justin Varney, Director of Public Health introduced the item and stated that the important point was to highlight what was done in terms of establishing the Board's Terms of Reference. The Board was set up within a timeline as defined by the Department of Health which was between Health and Wellbeing Board meetings. This went through Cabinet with the support of Councillor Hamilton to approve the formation of the Board in order to meet those timelines to obtain the formal ratification of the sub-group of the Health and Wellbeing Board.

466 **RESOLVED: -**

The Board noted the governance and purpose of the Local Covid Outbreak Engagement Board.

FINDINGS FROM COVID-19 IMPACT SURVEY

The following report was submitted:-

(See document No. 2)

Dr Justin Varney, Director of Public Health made introductory comments and drew the attention of the Board to the information contained in the report.

Members of the Board then made the following comments:-

Stephen Raybould stated that in terms of volunteering one of the things that had happened during the coronavirus crisis was that the formal volunteering was reduced as a result of the lockdown due to certain vulnerable portion of the population that was engaged in this prior to the crisis.

Andy Cave advised that Healthwatch Birmingham did a survey during the lockdown to see how people were feeling and what their needs were during the lockdown period. Healthwatch Birmingham had met with Public Health colleagues to look at their dataset against theirs to see where similarities lye. One of the main things was around mental health and the impact that this had had on the mental health of the city and how mental health services needed to react to that. It would be interesting to see whether people were accessing the mental health service as a result of this moving forward.

Waheed Saleem commented that the Trust had seen an increase in acuity as more people were coming in that were more unwell than previously. The Trust was having to deal with those issues in more detail. The Trust had also seen a slight increase in people accessing our mental health services including things

like their HIAC services etc. This would increase further as lockdown was easing and people were coming out a potential increase would be seen. What was happening in most of the NHS services was that people were reluctant in accessing the services when they previously would have accessed the services a lot earlier and so the Trust was picking up some of this a lot later in presentation in the services.

Paul Jennings advised that conversations had started in terms of what was needed to be done as there was a link as it was known that a 1% rise in unemployment would give a 2% rise in mental health issues. As stated previously, the Trust had already seen an increase in acuity including people who had appeared for the first time and were quite unwell. There was also a long term need around recovery from Covid as there was a large group of people recovering from Covid which was a long slow process that had a physical and mental health impact. There were conversations about how a rehabilitation service would link the physical services with physiotherapy. A lot of preparation was being made at present concerning the issues.

Richard Kirby stated that there were a couple of things such as staff visiting people in their homes which would be described in a much less quantitative way in a similar picture to the one described by Dr Varney. Clearly, some people felt that this was an anxious time and were worried about their interaction with others in the services and the wider communities. The Trust had done its bit to reassure where they could and were well plugged in to local community organisations and voluntary groups, neighbours and friends and getting the type of help there would be. The Trust had seen a huge drop in referrals to their more specialist services, particularly their specialist services with children. If there was a chance to share a message that would be the children who had been referred to the Trust during the pandemic were probably still there and probably still needed the Trust. If people needed help with their development, they needed to contact the health visitors as those services were open but working differently. The Trust will respond if families got in touch and sought help.

Nichola Jones, Assistant Director, Inclusion and SEND, Education and Skills advised that Children's Services, Education was currently working closely with Forward Thinking Birmingham and across the education services particularly with Education Services Psychology across the city. A citywide graduated approach for supporting children and young people was being developed. As part of that process it was seen across the city that referrals into the different services was across both health and education. What was being picked up from schools as the children were returning was that there will be an increased level of needs in social deprivation. Our responses were that we will be doing a graduated approach so that we could work closely with individual schools and will be undertaking a review when schools return in September 2020 and would be looking at what we will be offering across the city as part of the graduated approach, but as part of a joined up approach across health and education.

467 **RESOLVED: -**

The Board members agreed to promote the promote the survey and encourage participation which remained open until the 31st July 2020. The link to the survey is https://www.birminghambeheard.org.uk/place/new-survey/

UPDATE ON PROGRESS SINCE THE APRIL SPECIAL HEALTH AND WELLBEING BOARD MEETING

The following report was submitted:-

(See document No. 3)

Dr Justin Varney, Director of Public Health advised that some of the progress had been summarised since the last special Board. The special meeting of the Board was called to discuss the emerging inequality needs through the Covid outbreak specifically how they were impacting on ethnic communities across the city. The Board had over 600 questions from over 200 members of the public. The Chair had responded to every person who had submitted a question giving a personalised response to each question. This was a testament to the partnership and Board and the many colleagues contributing to those responses. Colleagues were asked to contribute to this report and to give an update from individual member organisations on the Board about the actions that were being taken as a response to the continued concerns around the impact of Covid-19.

It was important to reinforce that Public Health were continuing to learn more each day about the way Covid-19 had disproportionately impacted on different communities. Public Health was increasingly understanding that impact on ethnic communities which had reflected many of the inequalities that had existed before, particularly not just in terms of inequality in the numbers and proportion of people that had long term conditions like diabetes, but also in the quality of care and the management of those conditions.

Recent research had also highlighted the importance of improving the relationship between the NHS and some of the ethnic communities as sadly some of the individuals who presented in hospitals with Covid-19 from ethnic communities presented much later than those from white British communities. It was needed to reinforce to people that the NHS was there for everyone and to support them when they had health problems. The earlier you presented and reached out for help the easier it was to help you and to get a positive outcome. Much of what was seen in the report was the reflection partner organisations both how they were working to address some of these issues but also, they were considering them for their own staff from ethnic communities as well.

Chief Superintendent Stephen Graham, West Midlands Police emphasised that the large gatherings that was seen during the *Black Lives Matter,* which was not the issue, predominantly saw representation from the BAME communities. The research that Dr Varney shared showed that those events did not lead to any spikes in any local outbreaks as there were some real concerns about the coming together in big numbers and there was a breakdown of social distancing in nearly all of those demonstrations. There was nothing that

suggested that those demonstrations particularly the big one on the Thursday afternoon that started in Centenary Square. There was no causal link between that and any spiking in the coronavirus in the City.

The Chair voiced concerns that with the communities now the messages were confusing that the youngsters thought that *this was just a conspiracy to stop them from enjoying themselves*. The Chair added that even though she had agreed that it had no lasting effect it had made it more difficult for us to get the key messages out especially to our young people who were the ones if infected would take it home to family members that were older and more susceptible. The message was not just from the Council the Health Service, Police, and all the statutory bodies that they were absolutely clear.

468 **RESOLVED: -**

i. The Board noted the progress detailed in the report; and
ii. The Board members agreed to continue to work to mitigate disproportional risk of Covid-19 to ethnic communities.

OVERVIEW OF ACTIVITY ACROSS THE CREATING A CITY WITHOUT INEQUALITY PARTNERSHIP TO MITIGATE THE IMPACTS OF COVID-19 ON THE BAME COMMUNITIES

The following report was submitted for information:-

(See document No. 4)

Monika Rozanski, Public Health Service Lead on Inequalities introduced the item and advised that the report was based on information partners had submitted within a short timescale prior to the Board's deadline. Ms Rozanski stated that whilst the aim was to present a complete picture in the report this may not be complete as there may be other initiative that might not be covered in the report.

The inequalities affecting the BAME population had been in sharp focus over the past weeks and the Covid pandemic had exposed some long-term issues and disparities, which had been a factor in causing disproportionate impacts of Covid particularly on Black African and Caribbean communities. Organisations were working with the BAME communities as well as other communities to understand specific issues around Covid-19 and to develop culturally sensitive methods of engagement. The initial findings from the survey referred to by Dr Varney ends on Friday. Public Health were also looking at other ways to engage and utilised existing networks and channels in order to continue with the engagement.

Public Health had initiated a partnership with Lewisham for an in-depth review gathering information on inequalities affecting Black African and Caribbean communities working towards breaking the cycle of inequality. The review was still in its infancy, but it was hope that this would produce a robust evidence and lead to implementing a robust response across the two local authority areas. Specific operations as well as strategic activities were already under way as

specified within the main report in the appendix. The equality and diversity in curriculum in Birmingham schools had been strengthened and the partnership of health offers had been reviewed to ensure it was more effective in tackling some of the systemic inequalities affecting the BAME families.

The Director of Public Health, Dr Varney had engaged with the Faith community leaders and the City's health care providers had been adopting and developing services that were culturally competent with better access to translation and interpretation. The services had been adopted to capturing data so that it could be used more effectively in identifying the needs of the BAME communities and responding to those needs more effectively. The project had been focused on work during Covid and supporting those who had been disadvantaged further by the conditions raised by the pandemic.

Social justice had now been added as a key priority into the Adult Social Care Delivery Plan and the CCGs were working with the local BAME communities to reduce health inequalities in their long-term conditions programme for proactive engagement and marketing of the programme directly to the BAME communities. Providers of mental health helpline and counselling had taken steps to provide access to work and therapist to speak a range of community languages. Specific work was being undertaken by the university Hospitals Birmingham and the Women and Children's Hospital also.

In conclusion the insight into the inequalities and financial impact of Covid-19 on the BAME communities were being developed from many perspectives and by many different groups in all organisations and therefore it was highly important that there was a single strategic oversight.

469 **RESOLVED: -**

The Board noted the report and consider its findings in shaping and influencing future strategies and work across the health and wellbeing partnership.

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470 **LOOKING TO THE FUTURE**

NHS access and service model

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG emphasised that the positivity of seven years of practice working together in their Primary Care Network (PCN) enabled them to ensure that they could maintain good access to some services and maintain safe services. This meant that the PCN used less Personal Protective Equipment (PPE) which might otherwise would be used if they had tried to open up everywhere. It was hoped that this work would continue.

There were two things – we had made lots of advance around the use of IT. We were moving towards the next stage of health care using a digital and artificial intelligence tools to help get people to the right place and the right services the first time. A lot of shunting around of people was done in our health care service and GPs were the key people that often spend a lot of time

dealing with people who could easily have been dealt with by somebody else. GPs were most pressured and, in some ways, rather dwindling resources of workforce. Better use had to be made of all the health care professionals we had and ensuring people were going to the right places.

This was the next piece of action and learning from the work that was seen over Covid-19. Alongside of that was the move to appoint people to services so it goes through 111 and try to get to a point where if a person needed an A&E appointment one could be booked rather than turning up at A&E and booking themselves in and waiting when they could be streamed into the right place. This was one of the positives that was learnt.

Another thing that reflected part of what was stated by the Chair was about collaboration. What was seen in terms of how the NHS interacted around the Care Homes system in Birmingham was fantastic and was something he was desperate that they hang on to. A lot of work was done together understanding workflow and needs; understanding infection control, supplying PPE and helping to educate and support staff so they could hold residents in their own homes rather than moving them into hospital. This was a whole bunch of work that was powerful. The link between social care, care homes and community services to hospitals, the way we wrapped this up all together was a precious thing and he was desperate for them to hold things and make it work in the future. There was no doubt that it provides a better pathway of care for our service users, citizens and patients.

Dr Tim O'Neil, Director of Education and Skills, Birmingham City Council stated that some good joint work with Public Health was being done. He highlighted that a meeting would be held on the 24 July with Dr Varney to look in more detail on the plan around the lockdown and were seeing that the way they had worked together over the last six months had been incredibly positive. One of the ways in which he had measured success or otherwise was the extent to which his mailbox was full of the schools' sector. Dr O'Neill added that his inbox was relatively quiet and was a really good measure of the support and a huge thanks to Public Health and his staff for the work that had been done over the last few months.

The challenges were only just beginning as Dr Varney alluded to as there was some huge challenge ahead. One of the things being spoken of was squaring the circle as Dr Varney rightly spoke of the second wave and were encouraging parents and children to return to schools' settings in September but this was tricky to manage together. Dr O'Neill stated that they were confident in Birmingham to do what they could together.

The Chair placed on record that the work that the Birmingham Community Healthcare NHS Foundation Trust did with other partners they led in this space with Care Homes had been phenomenal. She expressed thanks to Mr Kirby and his team for the work done.

Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust stated that they had learnt the power of bringing together the Primary Care input. The work that the City Council did in commissioning Care Homes and the input his team had been providing on a daily basis to try to

properly help Care Homes get through this challenge. It was hoped this would be appreciated by the Care Homes as their absolute intent was to build this into a system that remain and to do the next stage in consultation with them and engagement from the Care Home managers etc. It was recognised that at the speed worked at, having pulled this together rather than co-produced it and it was hoped that the co-production could be built in next time.

Another bit of work that was connected to this was the work being done across acute community mental health and social care to change the Discharge Pathways to ensure people were not staying in hospital beds longer than they clinically needed to. A measure of the scale of this was when lockdown had started and the Trust responded to the pandemic, they routinely had 600 Birmingham people in acute hospital beds who were well enough to be cared for somewhere else. The number now was 150 and about 500 people were being cared for in the right setting and a number of clinical teams had been freed up to do the right things and because the Trust was able to work with Care Homes. The Trust was keen to work with the system to keep going as they go into autumn and winter

Community sector services
Stephen Raybould, Programmes Director, Ageing Better, BVSC stated that the credit needed to go to the voluntary sector that responded brilliantly and so quickly to the crisis. One of the key points was around dissolving of the boundaries around the different organisations. They were looking to sustain this and the relationship that had been built up with the statutory providers in the city so that they had a system that worked more efficiently. Recovery planning was being looked and this was taking place with different organisations BVSC was looking to build on.

Although there were challenges within the crisis some of the challenges that were gained both in terms of the cultural sector and the capacity of the sector and the citizens and around digital and ensuring that people were better connected.

Local Authority services
Chris Naylor, Interim Chief Executive, BCC stated that there was a strong connection to the conversation about Covid-19 and the impact it had and how we had responded to it. In simple terms if he was asked what the future looked like he would give a Civil Service answer to that which was what Members had advised him to do since his arrival with the City Council. There were two things:

Firstly, to set out in a clear terms as possible what was needed to be done over the next two years, but to do that in the context of where the city was now and where the city could be in the next n10-15 years and what was the pivotal role in particular the City Council and wider partnership to make that change happen.

The context of this was radically different to the context there was before the start of the year. The City Council was fiscally challenged by the impact of Covid, but as other people had stated in the time he had been in the meeting, in simple terms Covid did two things – one was revealed a number of features

of our society and economy of Birmingham that had too long being hidden in plain sight. The differential impact of this pandemic on different parts of the communities was clear for all to see and alongside the Black Lives Matters movement galvanised us to do something about this in a way that was not quite so urgent beforehand.

Secondly, it demonstrated to us the possibility that we had clear admission and focus that we wanted to get things done.

The underpinning things that binds our conversations was a renewed commitment to understand and tackle the structural inequalities that were prevalent in many parts of the lives of the people of Birmingham which required us to do two things:

- Firstly, an understanding of the level of the experience of people who were experiencing these barriers.
- Secondly, we need to understand in quite technocratic data led kind of way how did those barriers manifest the risks in peoples' lives so when we could enquire in some technical way to then understand the right interventions the public sector needed to make to overcome those things.

Where this had taken us in the Council over the last five to six weeks, was to land on four big themes that was needed to underpin our work for the next couple of years.

Firstly, a renewed focus on the right kind of growth in the city. It was absolutely imperative that we have economic growth and ultimately a lot of the issues we were contending with were a product of poverty and destitution and was a kind of material economic baseline that we wanted as many people as possible to reach so they were able to live a healthy life. This required something to think about the economic regeneration model we had in the city for many years and how we ensure that growth in the next 10 -15 years and 20 – 30 years benefitted as many people as possible. We needed to think about what this would look like and how it was going to happen.

Secondly it required us to think again both inside the Council and our partnership about how we afford what we do so that day in day out we focused our priority on understanding the root causes as to why people come into our extensive services and we systematically try to tackle them in quite a preventative way.

Thirdly, all of that required an outstanding relationship of trust between the council or other public sector partners and the individuals that were here to help. The dynamics shifted dramatically, from a situation where a person comes to us in crisis, looking for our help from a situation where we were reaching out to them before they recognise the crisis themselves. This was a completely different dynamic and people will not engage with us unless we think unequivocally our own red side, we had their best interest at heart, and we were here to help. This meant everything from how we answer the phone, the experience on the website and a number of mundane stuffs such as

whether we empty the bins on time or clean the streets was as important to this mission as the social conversations we had.

Finally, the question was what this needed to look like organisationally. The relationship we had inside the Council and the relationship with partners across the city. All of these were in the mix and over the next couple of years we need to answer some of those questions. There were a lot of practical things that could be done now some of which we learnt directly through the Covid experience but there was something slightly bigger and bolder and was within grasp if we give ourselves the time and space to ask the question, answer it properly and then do something about it.

Dr Ian Sykes, Sandwell and West Birmingham CCG stated that the main points which were in the pack, there were four things:

Our Red site was open – Aston Pride and it was also good news that it was open to patients not just from Sandwell and West Birmingham, but Birmingham and Solihull patients as well and was a site that could be used by anyone if it was convenient. The reason for keeping this site going was that they needed to get things back to normal. We needed to be prepared if and when the second wave hits so the Red site will be kept going which meant that patients who were highly likely to have Covid could be seen in a secure environment.

Secondly, General Practice was fully open and functioning as normal as possible. However, local surgery might be closed, but there were other surgeries that would remain open. This was simply because they had to create an area where high risk staff to safely work without being put at risk.

Thirdly they were actively trying to restore normal services as best as possible, particularly the long-term services focussing on things such as diabetes and learning disability, mental health and autism checks as these were vital for the vulnerable groups.

Finally, a talk before you walk – do not turn up at A&E or at your surgery before ringing first as you may not need to be seen physically but could be seen virtually. If you do need to be seen, we could ensure that you will be seen by the right person in the right place.

Paul Jennings stated that was one organisation that was not represented on the HWB - the Acute system. He expressed his gratitude for some of the work that the West Birmingham Hospital and the University Hospitals Birmingham which was already the largest Intensive Care Unit (ICU) at the Queen Elizabeth, the largest ICU in Europe everyday which was never overwhelmed. Enormous gratitude to all the staff who worked in the Acute system with real peril who were so ill. At the peak of the Covid crisis someone was dying every 45 minutes at the QE Hospital which was a lot for staff to take in.
The Chair advised that the issue concerning the Acute system would be addressed shortly. The Chair then drew the attention of the Board to the information reports in the Agenda Pack

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OTHER URGENT BUSINESS

Vaccinations

471 Councillor Bennett raised the issue of vaccinations and advised that this was identified prior to the Covid-19 outbreak as there was a low uptake in some areas which was of concern. He noted that this was in the paperwork for the last item and Dr Varney had referred to it i.e. not wanting Covid and flu. The anti-vaccine sentiments and the scaremongering that was going to apply if and when we get the Covid vaccine. It was important for a number of reasons that the Board revisit that item and ascertain in more detail how the system was planning to address the issue going forward as it was more important than when the issue was first raised.

The Chair commented that this was an important point that will be discussed, and it was hoped to get back to some of the agenda items that were on the Board's work plan. It was also hoped that a report would be submitted to the Board detailing what had been done including the vaccine and the MMR vaccine for children at the next Board meeting.

SCHEDULE OF MEETINGS FOR BIRMINGHAM HEALTH AND WELLBEING BOARD 2020/21

It was -

472 **RESOLVED: -**

The Birmingham Health and Wellbeing Board noted the schedule of meetings for 2020/21 as follows: -

2020	2021
22 September	19 January
24 November	16 March

All meetings will be held at 1500 hours as an online meeting.

The meeting ended at 1705 hours.

……..……
CHAIRPERSON

BIRMINGHAM HEALTH & WELLBEING BOARD

Birmingham City Council

Action Log 2020

Birmingham Health and Wellbeing Board

Rag rating :
- Overdue
- In progress
- Complete

Index No	Date of entry	Agenda Item	Action or Event	Named owner	Target Date	Date Completed	Outcome/Output	Comments	RAG
	24/09/2019	SUICIDE PREVENTION STRATEGY	Suicide Prevention Strategy Action Plan	Mo Phillips	26/11/2019	26/11/2019	Updated version provided as part of Forum update.	The Birmingham Suicide Prevention Strategy was adopted by Full Council in January 2020. The Suicide Prevention Working Group has continued to meet through covid to progress the Suicide Prevention Strategy Action Plan; progress of the working group is reported to the Creating a Mentally Healthy City Forum and to the Health and Wellbeing Board.	
	08/09/2020		Letter to Secretary of State to express concerns with regards to the shortfal	Justin Varney					

Index No	Date of entry	Agenda Item	Action or Event	Named owner	Target Date
	29.01.2019	IPS - Mental Health	To send a letter to all Board members to encourage them to actively promote and support employment opportunities for people with SMI within members' organisations through the IPS programme.	Board Admin	
		JSNA SEND	Remove the recommendations from the report and send them to the SEND Improvement Board as a reference item.	Fiona Grant	19.03.2019
		Sustainability Transformation Plan (STP)	To submit written bi-monthly update reports to the Board, with updates from the portfolio boards.	Paul Jennings	28.05.2019
344	19.02.2019	JSNA Update	Public Health Division to present the JSNA development and engagement plan at the next	Justin Varney	19.03.2019
	29.01.2019	IPS - Mental Health	members to encourage them to actively promote and support employment opportunities for	Board Admin	
362	19.03.2019	Joint Strategic Needs Assessmnet Update	The two decisions that were needed from the Board were: - A volunteer for each of the four deep dives as champions and to hold us account; and a short discussion around where the Board would like us to look in terms of diversity and inclusion.	Elizabeth Griffiths	30th April 2018
	29.01.2019	IPS - Mental Health	The Chair has requested that a member of HWBB volunteer to attend the IPS Employers Forum to support the development of IPS.	All Board	19.03.2019
352	19.02.2019	Substance Misuse	Consideration to be given to partners' involvement and public engagement in the future commissioning cycle, and to the funding position, taking on board comments made at the meeting.	Max Vaughan	Date to be confirmed
IAN8	18/06/2019	Air quality update report	Board members encouraged to participate in Clean Air Day 20 June	All Board	20/06/2019

346	19.02.2019	Childhood Obesity	DPH was asked to reflect on potential for social marketing high profile campaign - similar to the partnership approach to ‘sugar free’ month promoted by Sandwell Council and partner organisations and 'Fizz Free Feb' led by Southwark Council.	Justin Varney	Development day 14.05.2019
351	19.02.2019	NHS Long Term Plan	It was agreed that, as the local 5-year plan was being drafted, consultation should take place with the Health and Wellbeing Board and engagement with key leaders in the City to enable them to give an input to the plan.	Paul Jennings	19.03.2019
IAN6	18/05/2019	Public Questions	All Board members to promote submission of public questions to the Board	All Board members	24/09/2019
IAN9a	18/05/2019	Active travel update	Board to work with their partners to promote active travel away from main roads and along green spaces where possible	All Board members	ongoing
IAN9b	18/05/2019	Active travel update	Kyle Stott, Public Health, to bring mapping of active travel back to the Board	Kyle Stott	24/09/2019
IAN10	18/05/2019	Developers Toolkit update	Board members to encourage the use of the developer’s toolkit in their organisation’s capital build projects as well as retro-build and refurbishments but to include anything in the present	All Board members	ongoing
IAN11	18/05/2019	Feedback on the Health and Wellbeing Board development session	Board members to look at opportunities for LD/MH employment within their organisations	All Board members	ongoing
IAN12b	18/05/2019	Changing places	Board Chair to write to WMCA around transport infrastructure hubs: where there is a full station refurbishment changing places to be included.	Chair/PH	24/09/2019

IAN12c	18/05/2019	Changing places	Board Chair to write to the Neighbourhoods Directorate to support the implementation of changing places in parks.	Chair/PH	24/09/2019
IAN13a	30/07/2019	Live Healthy Live Happy STP update report	Birmingham and Solihull STP to work with local elected members around awareness raising of ICS & PCNs – what they mean and the implications.	Paul Jennings	26/11/2019
IAN13b	30/07/2019	Live Healthy Live Happy STP update report	The Board raised concern that changes to West Birmingham area could cause destabilisation for the system and the citizen experience Commissioners and providers agreed to meet outside of the meeting and report back to Board on how we get to an integrated system – particular reference to equity of provision for West Birmingham.	Paul Jennings	26/11/2019
	23/04/2019	Special Health and Wellbeing Board meeting	To respond individually to public questions received for the April Special Health and Wellbieng Board meeting	Justin Varney/Stacey Gunther	28/04/2020
IAN12a	18/06/2019	Changing places	Maria Gavin to see whether changing places can be a specific requirement for Commonwealth Games new-builds	Maria Gavin	24/09/2019

	23/04/2020	COMMUNITY CONCERN RE COVID-19 AND HEALTH INEQUALITIES IN BAME COMMUNITIES	Set up a Special Health and Wellbeing Board meeting in response to rising concern within the community of health inequalities being experienced in Black, Asian and Minority Ethnic (BAME) communities due to coronavirus-19.	Errol Wilson	23/04/2020
	24/09/2019	NHS LONG TERM PLAN: BSOL CCG RESPONSE	Set up a Special Health and Wellbeing Board	Errol Wilson	08/10/2019
	24/09/2019	PUBLIC QUESTIONS	Increase activity around the comms for Public Questions by liaising with partners	Stacey Gunther	21/01/2020

Date Completed	Outcome/Output	Comments	RAG
27.03.2019	The letter has been sent out to all Board Members on the 27.03.2019	Awaiting information from Dario Silvestro regarding the Support available for employers	
		Item in Matters Arising in the minutes	
27.03.2019	been sent out to all Board Members on the	information from Dario Silvestro regarding the	
30-Apr-19			
30-Apr-19		Charlotte Bailey nominated by the Chair	
30-Jul-19		Item on agenda 30 July	
20/06/2019			

11/09/2019	Closed and to be tasked to the Creating an Active City Sub-Forum	Paul Campbell informed Kyle Stott to include as part of the work of the forum.	
24/09/2019		Incorporated into forward plan	
24/09/2019	Complete	All organisations to confirm at HWBB 24/09/2019	
24/09/2019	Complete	All organisations to confirm at HWBB 24/09/2019	
06/09/2019	Closed and to be tasked to the Creating an Active City Sub-Forum	Paul Campbell informed Kyle Stott to include as part of the work of the forum.	
05/09/2019	Closed and forward plan to include quarterly round table update.	Quarterly updates does not tally with current meeting calendar - scheduled for every second Board for Minicipal Years 2019-20 and 2020-21.	
05/09/2019	Closed and to be tasked to the Creating a City Without Inequalities Sub-Forum	Paul Campbell informed Monika Rozanski to include as part of the work of the forum.	
18/09/2019	Letter sent by Cllr Hamilton		

18/09/2019	Letter sent by Cllr Hamilton		
26/11/2019	Presentation item for Board 26 November 2019.		
26/11/2019	Presentation item for Board 26 November 2019.		
28/04/2020	Closed		
30/12/2019	Closed	issue of changing places with the CWG leads. New facilities fall under the Organising Committee not the Council I believe. She has asked to join the accessibility forum which is just starting – and which considers all aspects of accessibility (e.g. access for people with sensory impairments, LD) as well as some of the physical requirements. So we are flagging the need for this wherever we can. Quite a few of the facilities are temporary rather than new build though, so we are also encouraging organisers to	

23/04/2020	Closed. Meeting took place, with almost 200 public questions submitted		
30/09/2019	Closed. Meeting arranged for 11/11/2019, subsequently cancelled due to Purdah. Presentation item for January 2020 Board		
30/06/2020	Closed	Public Health have committed to tweeting and sharing via Forum networks. A new online form for question submission has been introduced and will be trialed for the July meeting.	

Birmingham Health and Wellbeing Boaed Update
Covid-19 Data Overview

22/09/2020

Key Points

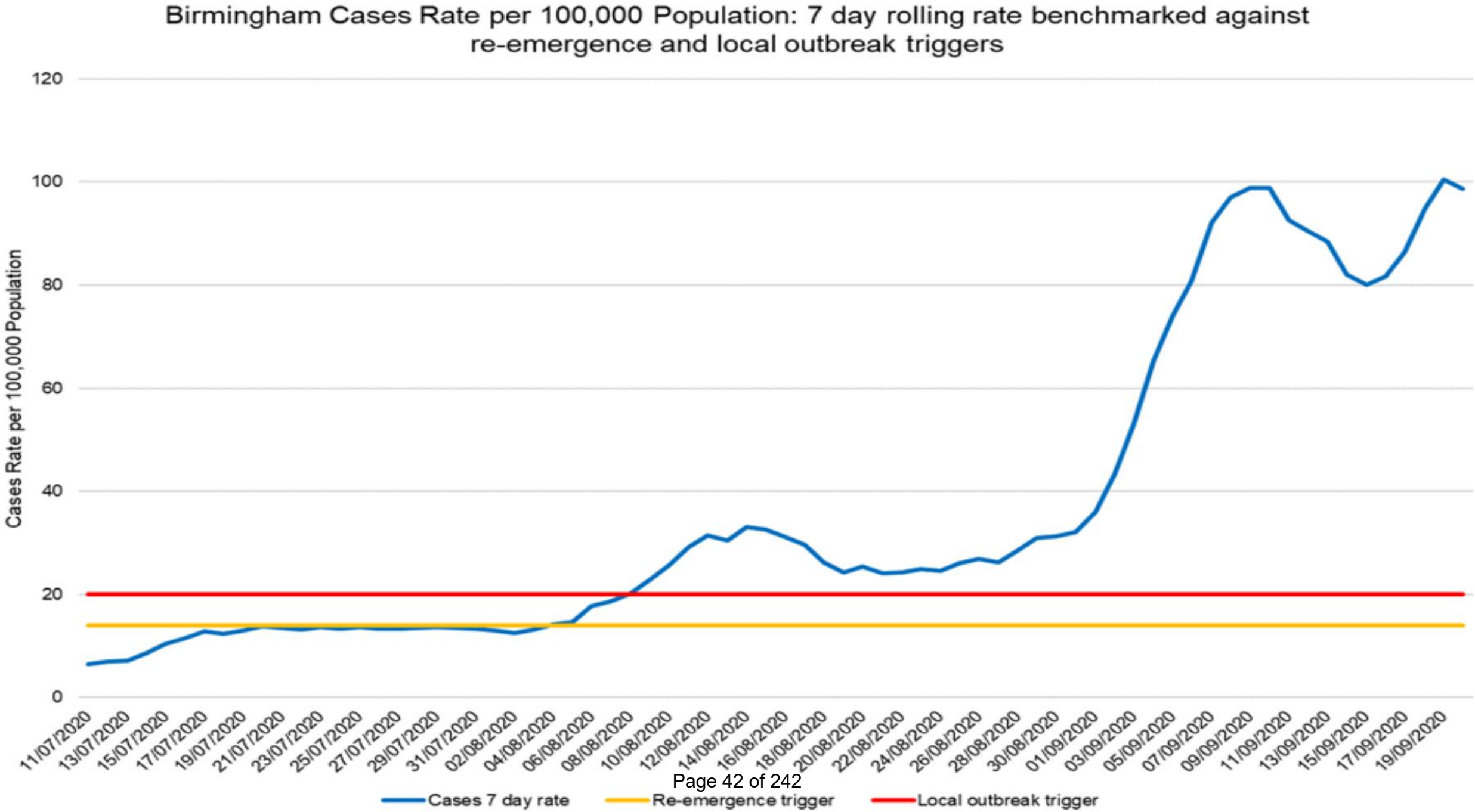
- Case rate is rising and % of positives is fairly stable.
- Testing uptake is improving significantly.
- Geographically rise across many parts of the city and now over three quarters of the wards in the city have had six or more cases in the last seven days.
- Highest new case rate is in Asian community and 30-39yr age group.
- Increasing cases in hospital settings and increase in oxygen supported patient beds.
- Covid Community Champions launched on 21/09/20 to support citizens to help disseminate accurate information through social and personal networks.
- Additional testing sites being negotiated with DHSC for Birmingham.

Data position (latest data is 10/09/2020)

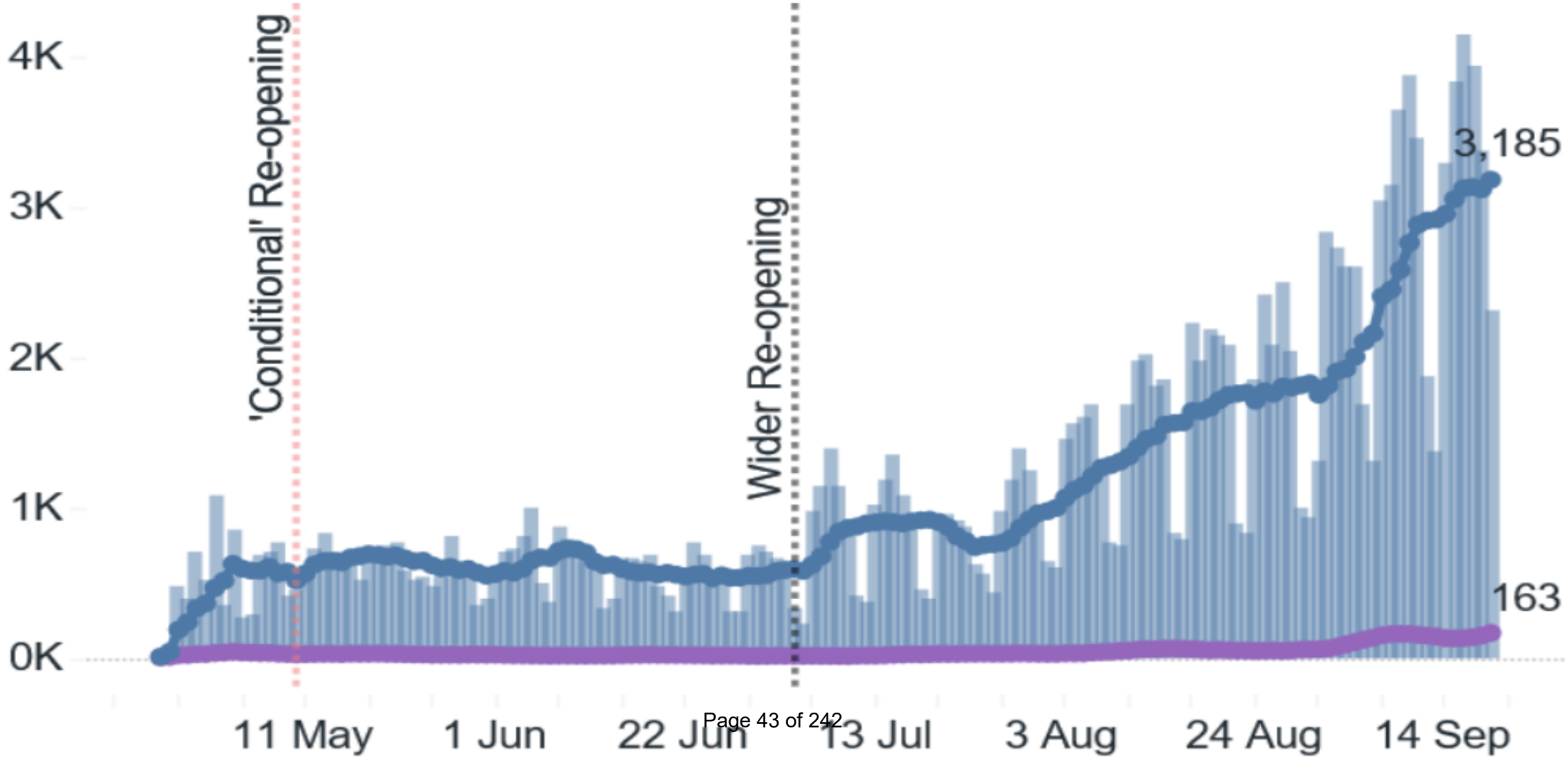
- **7 Day Pillar 2 testing rate at 18th September** **1,707/100K**
  - Rate of testing on 11th September 1,095/100K
  - Ranked 3rd in the region behind Wolverhampton (1,730/100K), highest is Sandwell (1,765/100K), and 24th highest nationally.

- **% of positive tests in Pillar 2 at 19th September** **5.1%**
  - Rate at 11th September 6.9%
  - WM Regional average at 18th 2.6%

- **7 Day Rolling Rate at 19th September (pillar 1 & 2)** **83.6/100K**
  - Rate at 11th September 71.0/100K
  - Ranked 22nd highest nationally, and ranked 1st in WM region, ahead of Sandwell (62.6/100K)


Birmingham Cases Rate per 100,000 Population: 7 day rolling rate benchmarked against re-emergence and local outbreak triggers
Cases Rate per 100,000 Population
120
100
80
60
40
20
0
11/07/2020
13/07/2020
15/07/2020
17/07/2020
19/07/2020
21/07/2020
23/07/2020
25/07/2020
27/07/2020
29/07/2020
31/07/2020
02/08/2020
04/08/2020
06/08/2020
08/08/2020
10/08/2020
12/08/2020
14/08/2020
16/08/2020
18/08/2020
20/08/2020
22/08/2020
24/08/2020
26/08/2020
28/08/2020
30/08/2020
01/09/2020
03/09/2020
05/09/2020
07/09/2020
09/09/2020
11/09/2020
13/09/2020
15/09/2020
17/09/2020
19/09/2020
Cases 7 day rate
Re-emergence trigger
Local outbreak trigger

Daily number of tests and 7 day moving average of **Total** and **Positive** Tests



Testing Site update

Drive Through

Mobile testing sites (drive through), two units rotating sites on 3-4 day blocks:

- Brewery Street (Aston)
- Tower Ballroom Osler Street (Edgbaston)
- Aston Uni Holt Street (Aston)
- Moseley RFC (Billesley)
- Longbridge site approved, awaiting license agreement

Regional drive through site at Birmingham Airport

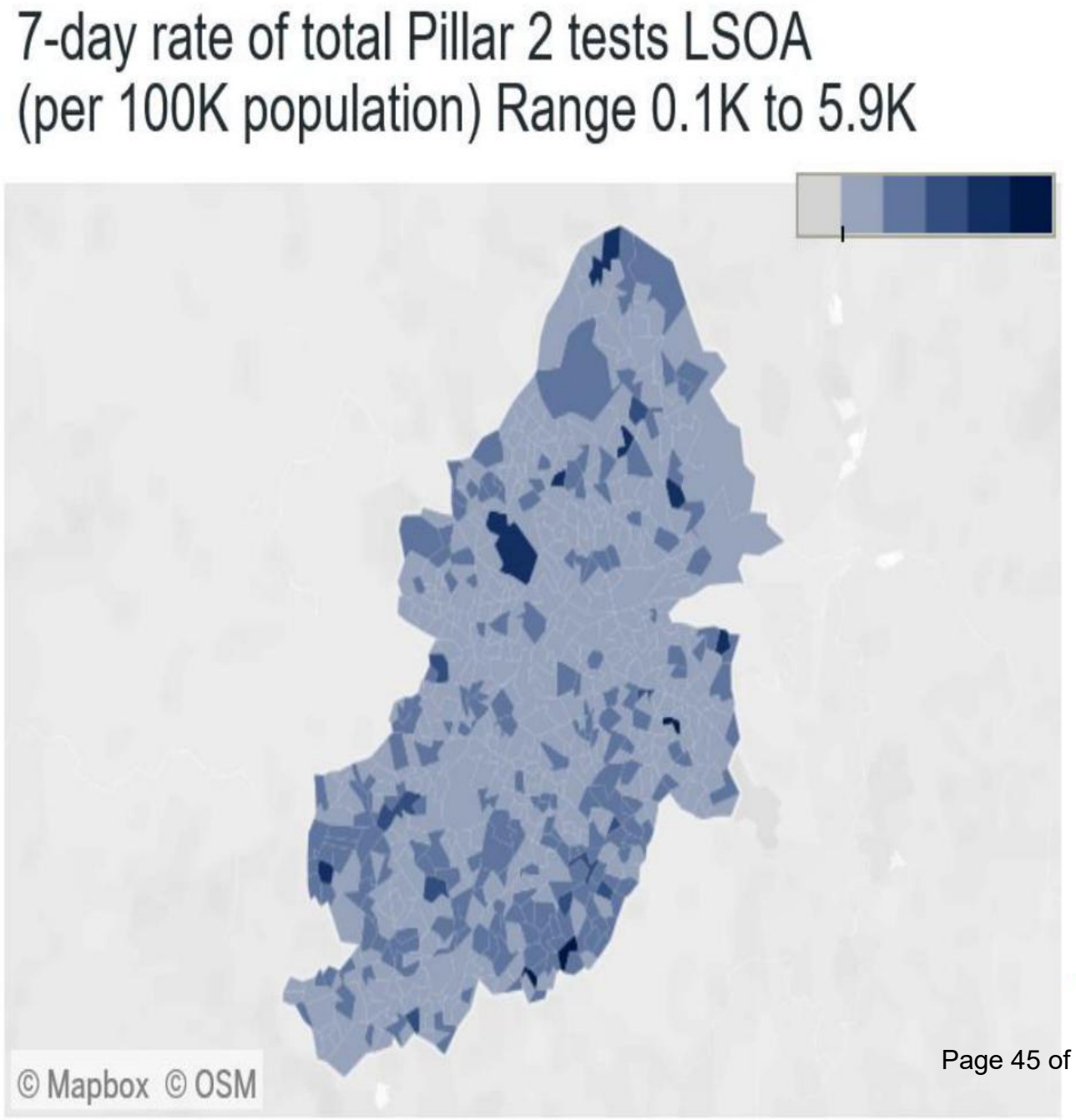
Walk Through

Fixed walk-through testing sites:

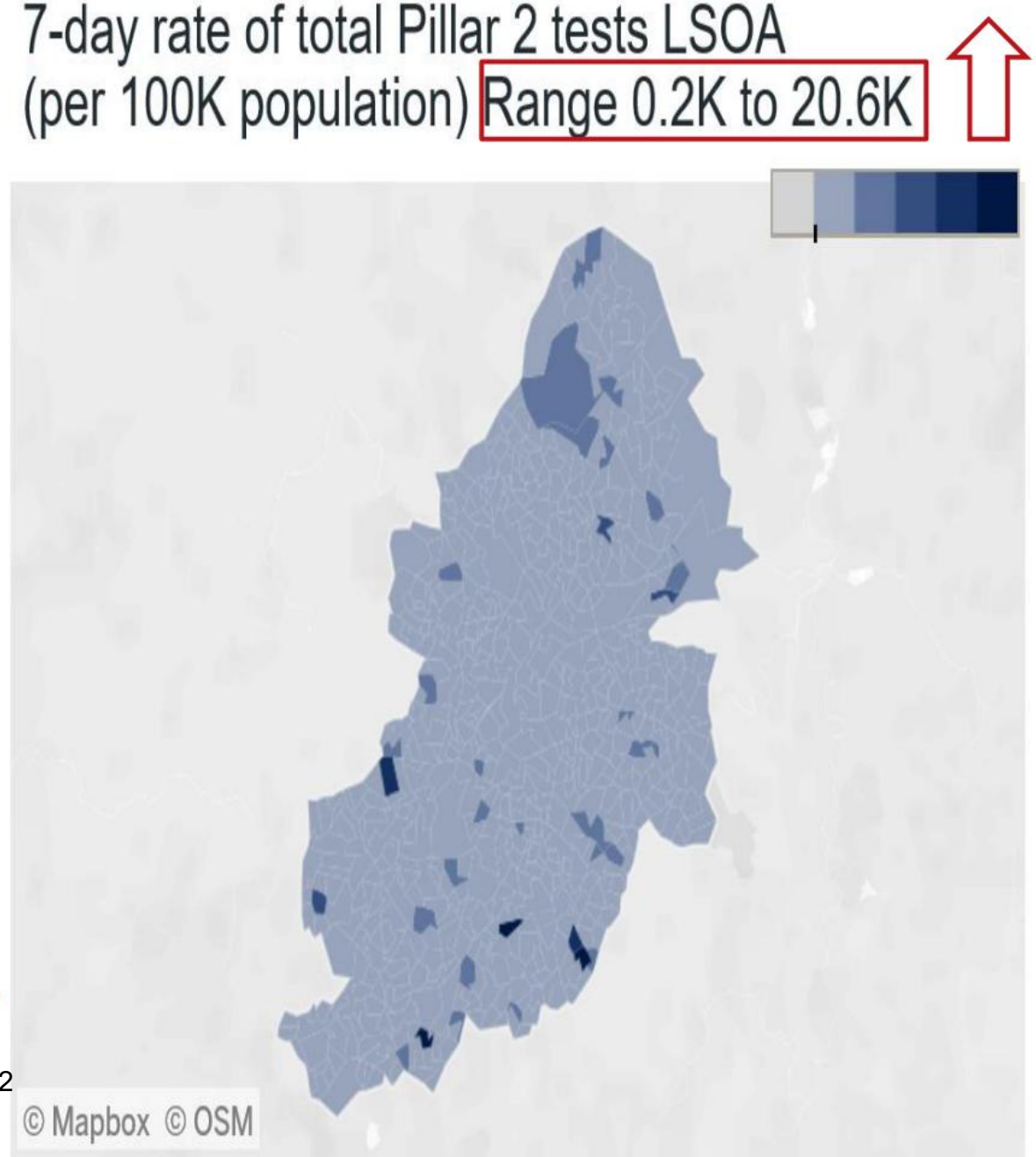
- Villa Street (Newtown)
- Uni. Of Birmingham South Gate Car Park (Selly Oak)
- Saltley Wellbeing Centre (Bordesley Green)
- Woodgate Valley Country Park (Bartley Green)
- South Parade Car Park (Sutton Coldfield)
- Summerfield Centre (Winson Green)
- Alfred Road car Park (Sparkbrook) due to go live 26/09

Scoping sites at UCB, Aston, Hall Green

Up to 10/09/2020



Up to 18/09/2020

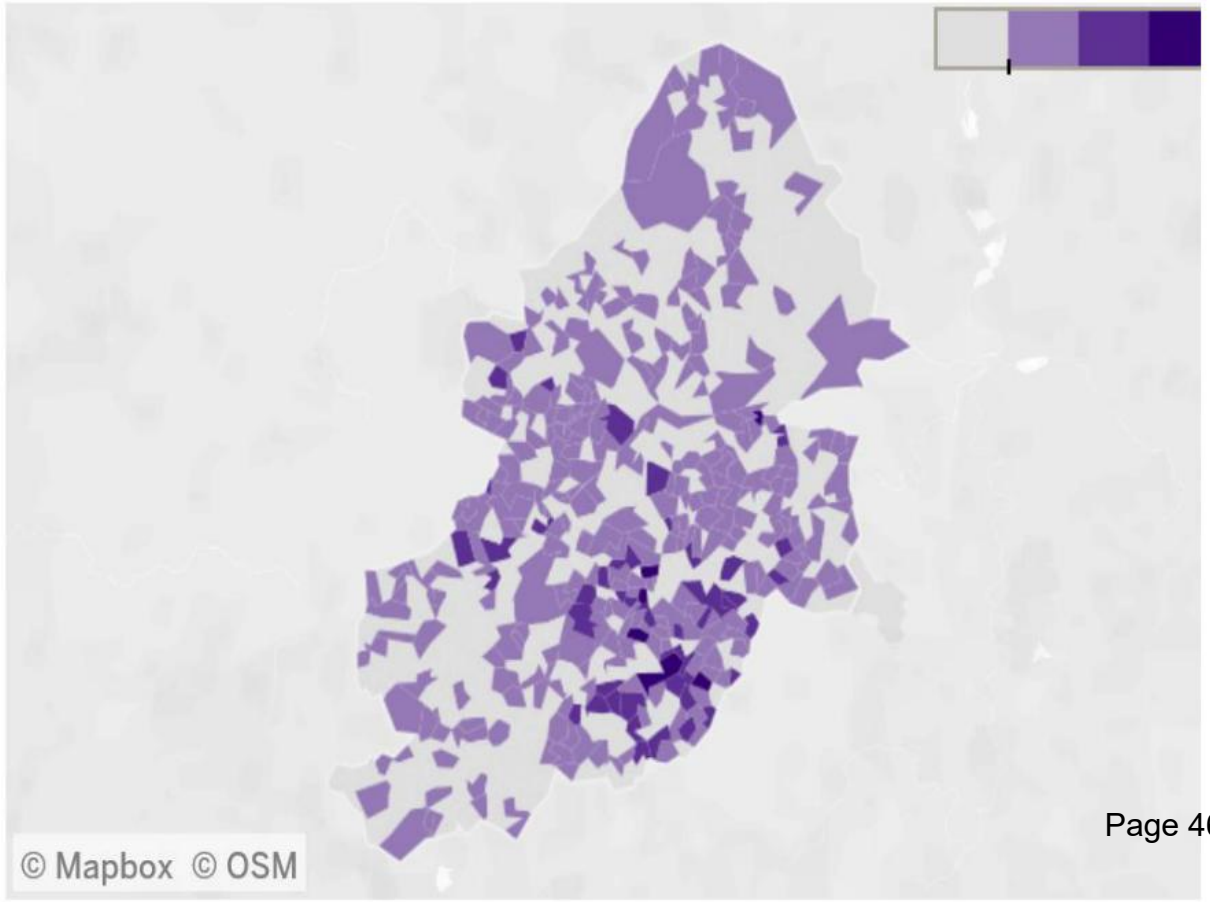


Geographical Distribution

Increase in positive cases across most geographies of the city, increases across most wards or steady state.

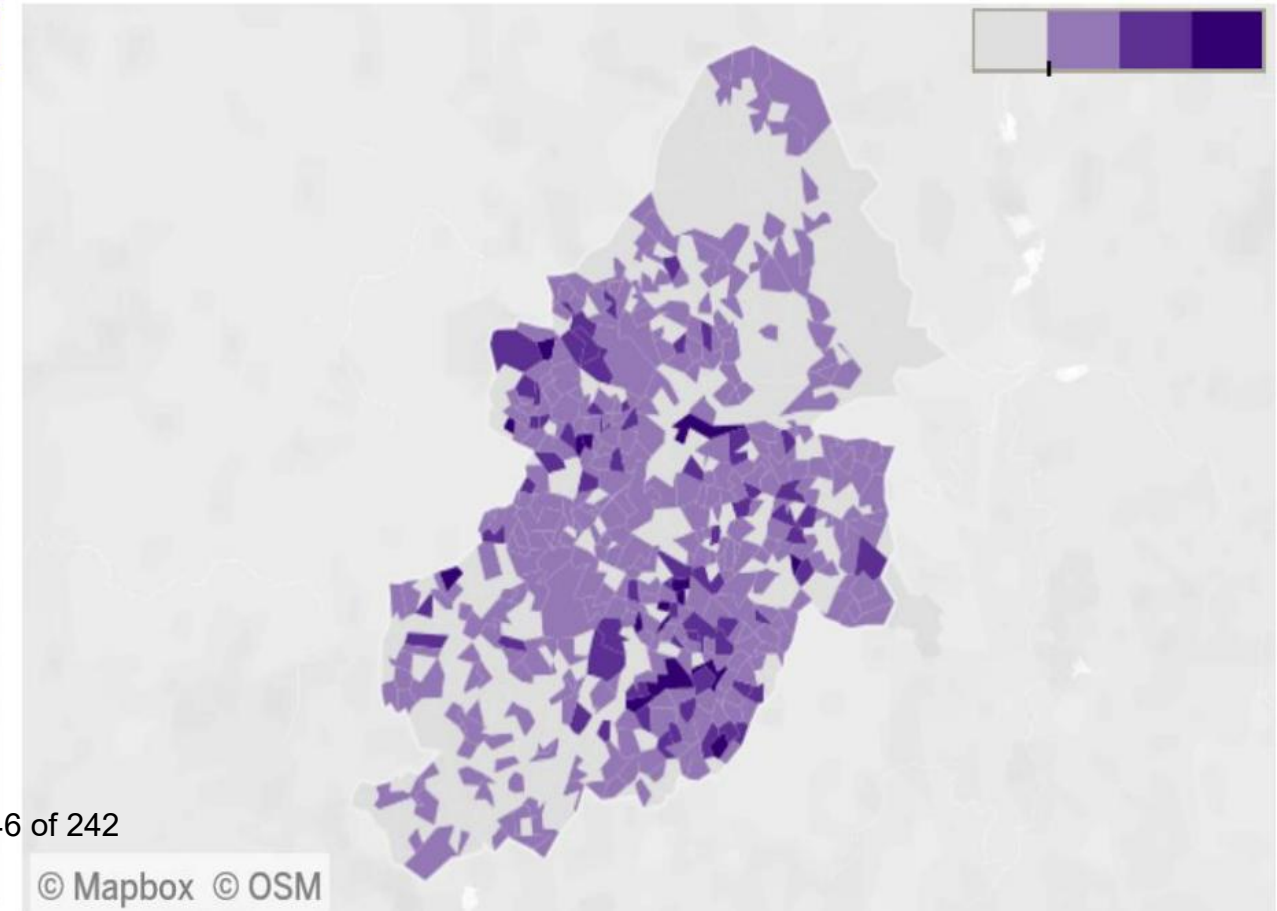
Up to 10/09/2020

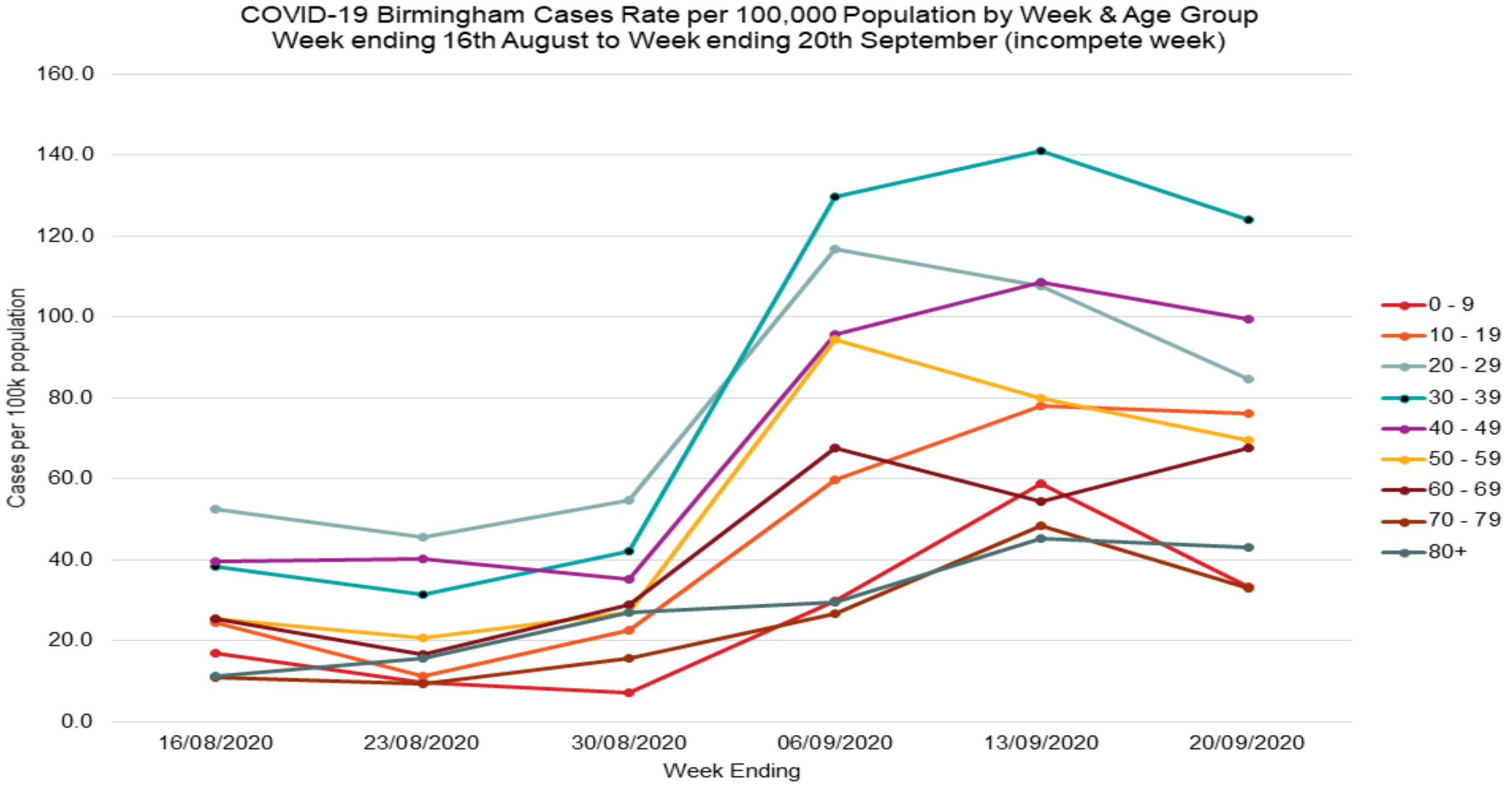
7-day rate of positive Pillar 2 tests LSOA (per 100K population) Range 0.0 to 691.1

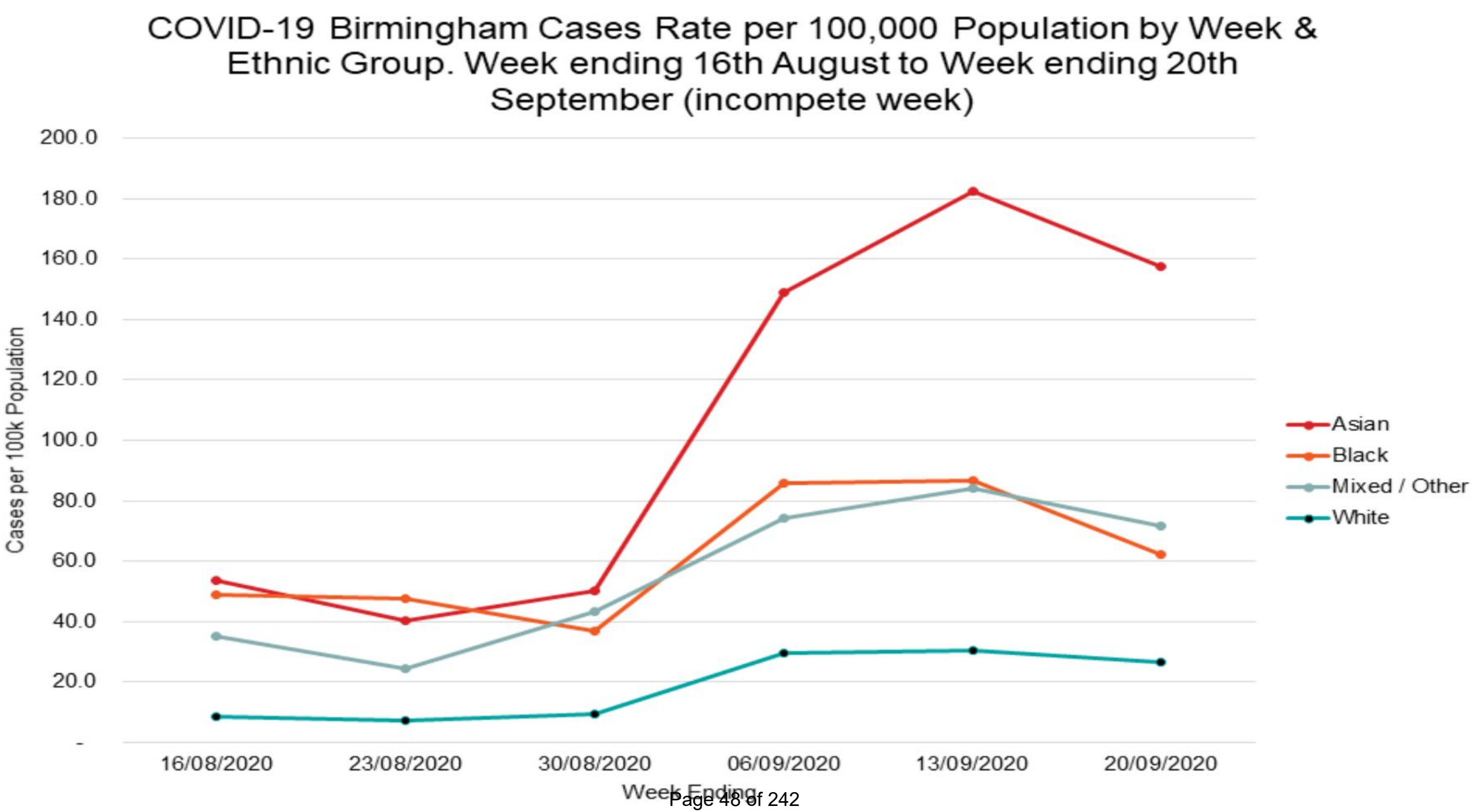


Up to 18/09/2020

7-day rate of positive Pillar 2 tests LSOA (per 100K population) Range 0.0 to 714.8




COVID-19 Birmingham Cases Rate per 100,000 Population by Week & Age Group
Week ending 16th August to Week ending 20th September (incompete week)
160.0
140.0
120.0
100.0
80.0
60.0
40.0
20.0
0.0
Cases per 100k population
16/08/2020
23/08/2020
30/08/2020
06/09/2020
13/09/2020
20/09/2020
Week Ending
0 - 9
10 - 19
20 - 29
30 - 39
40 - 49
50 - 59
60 - 69
70 - 79
80+


COVID-19 Birmingham Cases Rate per 100,000 Population by Week & Ethnic Group. Week ending 16th August to Week ending 20th September (incompete week)
200.0
180.0
160.0
140.0
120.0
100.0
80.0
60.0
40.0
20.0
-
Cases per 100k Population
16/08/2020
23/08/2020
30/08/2020
06/09/2020
13/09/2020
20/09/2020
Week Ending
Asian
Black
Mixed / Other
White

Situation Overview

Week ending	*New situations count*	*Issues*	*Exposures*	*Outbreaks*	*Enquiry*	*Clusters*	*Commentary*
20/09/2020	**188**	**5**	**126**	**29**	**7**	**21**	As of the 20th September 2020 there have been a total of 140 situations in residential care settings, 248 situations in education and early year settings, **an increase of 130 (110%) situations since last week**. 119 situations in workplace settings, 2 situations in households (this has not changed in the last six weeks) and 146 situations in other settings.
13/09/2020	120	2	80	20	3	15	
06/09/2020	61	8	39	11	2	1	
30/08/2020	38	4	26	6	2	0	
23/08/2020	33	2	22	5	3	1	
16/08/2020	47	4	22	12	8	1	
09/08/2020	28	5	11	7	1	4	
02/08/2020	24	1	13	10	0	0	
26/07/2020	25	4	17	4	0	0	
19/07/2020	16	3	9	4	0	0	
12/07/2020	17	3	10	4	0	0	
05/07/2020	11	5	2	4	0	0	
28/06/2020	14	4	6	4	0	0	
21/06/2020	17	7	9	1	0	0	
14/06/2020	10	3	4	3	0	0	
07/06/2020	6	3	1	2	0	0	
Total	655	63	397	126	26	43	
Situations are defined as:							
Issue – suspected case							
Exposure – single confirmed case							
Cluster – two cases linked to a setting within 14 days							
Outbreak – two cases linked to each other in a setting within 14 days							

Evidence of Transmission

- Majority of transmission is between households in private settings, i.e visitors gathering in private homes and gardens.
- Some evidence of transmission in hospitality sector between guests when celebration events being held e.g. wedding receptions.
- Regional and national evidence of transmission in night-time economy hospitality, especially where standing rather than seated, and in queues where social distancing is not observed.

Key actions taken since last Health and Wellbeing Board

- Testing
  - Expansion of testing sites in Birmingham
  - Pilot of drop and collect in specific small geographical areas to help understand community transmission
  - Enhanced local contact tracing will go live in Birmingham over the next ten days
- Engagement and Awareness
  - Significant support from local media to disseminate accurate information
  - Nine community partner organisations and seven community radio stations working with us to focus engagement in specific minority communities
  - Strong partnership working with faith communities and universities
  - Launch of Birmingham Community Covid Champions programme and Bhealthy mortality risk reduction campaign
  - Significant additional translation and dissemination of key messages and advice.
  - Partnership working with the five universities to ensure a proactive approach to risk reduction and outbreak response planning.
- Governance & Response Capacity
  - 90% of posts in the test and trace response team have been appointed and new assistant Public Health Director has taken up her role leading this team
  - Weekly data briefing to members and restricted briefing to Local Outbreak Engagement Board

Birmingham Covid Community Champions Overview

Aim & Objectives

- Birmingham Covid Champions programme aims to create clarity where there is confusion and opportunities for citizens to take action in local communities to contain Covid in our city.

Objectives:

- Recruit 1,500 volunteers to become Covid Champions by
- Provide e-learning modules, webinars and whatsapp support
- Weekly key message & FAQ for champions
- Utilise feedback from Champions to inform local stategy

Birmingham Public Health

BECOME A **BIRMINGHAM** CHAMPION

Preventing the spread of COVID-19

Join our network of local people to help during the COVID-19 pandemic
Anyone living or working in Birmingham can get involved!

Receive the latest information and government guidelines on how to stay safe and healthy

Share this information with your friends, family, colleagues and community

Keeping our communities well informed will help minimise the risk of the virus spreading.

COVID-19 Healthy Brum **CHAMPION**

www.birmingham.gov.uk/COVID-19__Health_Champions

Birmingham Public Health

COVID-19 **BIRMINGHAM** CHAMPION

Preventing the spread of coronavirus

Community Champions Code of Conduct

The purpose of the Community Champion scheme is to help ensure that residents across Birmingham hear correct and consistent information about the COVID arrangements. We recognise that there is often debate, and sometimes disagreement, but our role is to tell people what the rules are so they can work out how to apply them to their everyday lives.

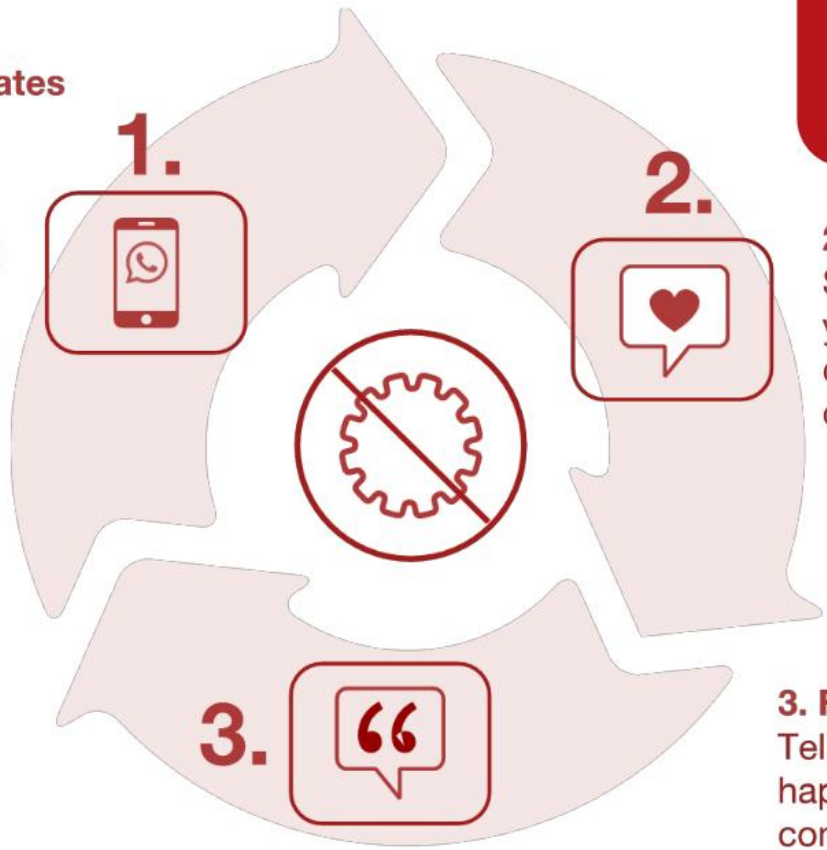
Therefore, as a Community Champion, you are asked a to sign up to the code of conduct, which requires that:

- Any information or advice you circulate comes from the council or the government.
- You do not make political statements in respect of the COVID arrangements.
- You do not debate the merits of the guidance, or criticise the government, council or partners – if somebody is incorrect, simply signpost the correct information. This is to ensure that key messages are not undermined.
- You do not apply your own interpretation of guidelines – if in doubt, ask for clarification.

Content available in multiple different forms, languages and formats including JPEG, audio clips, translated materials.

Weekly virtual engagement sessions for updates and feedback

1. Get live updates on COVID-19
Receive the latest information and government guidelines on how to stay safe and healthy.



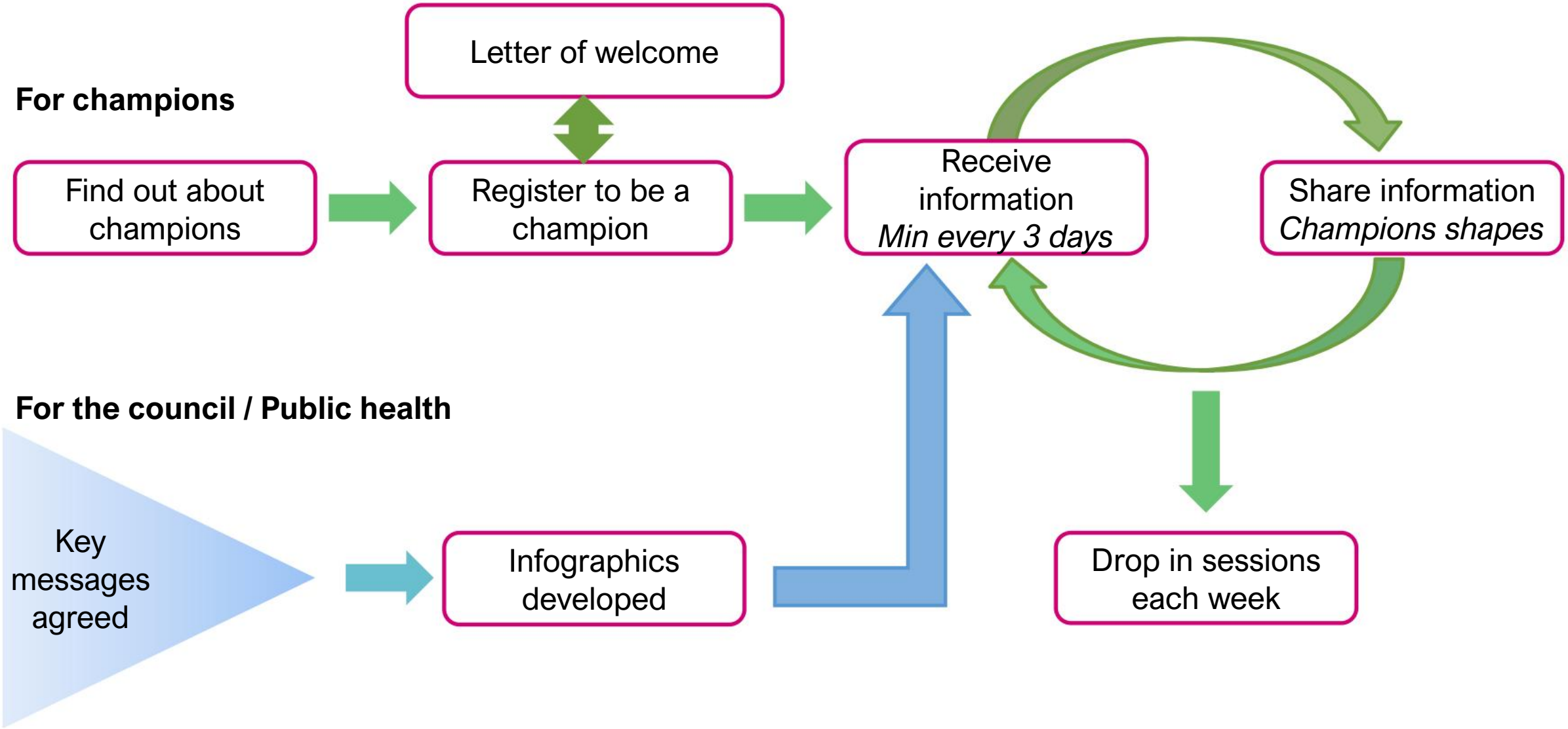
Everyone does it their way: some will spread to their family; others to every church in Birmingham – we support you with the right information in the best way for you

2. Spread the word
Share this information with your family, friends, work colleagues and the wider community.

3. Feedback to us
Tell us about what is happening in your community.

Two Whatsapp channels:

- Daily update channel with key tips and facts
- Q&A channel for champions to raise questions & give feedback


For champions
Letter of welcome
Find out about champions
Register to be a champion
Receive information
Min every 3 days
Share information
Champions shapes
For the council / Public health
Key messages agreed
Infographics developed
Drop in sessions each week

Birmingham Public Health

BECOME A BIRMINGHAM CHAMPION

Preventing the spread of COVID-19

Live or work in Birmingham? Want to help stop the spread of coronavirus?

Become a COVID-19 Health Champion

How does it work?

1. You sign up to be a champion.
2. We give champions the latest information about COVID-19.
3. Champions share this information with anyone in their community, however they want.
4. Champions let us know what is and isn't working.

Register to become a Champion

W: birmingham.gov.uk/COVID-19__Health_Champions

COVID-19 Healthy Brum CHAMPION

birmingham.gov.uk/futurecouncil

@BhamCityCouncil @birminghamcitycouncil @birminghamcitycouncil

Birmingham Health and Wellbeing Board

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22nd September 2020**
TITLE:	**FLU PLAN FOR BIRMINGHAM 2020/21**
Organisation	**Birmingham City Council**
Presenting Officer	**Rachel O'Connor, Assistant Chief Executive Officer, Birmingham and Solihull STP** **Carla Evans, Head of Primary Care, Sandwell and West Birmingham CCG**

Report Type:	**Information**

1. Purpose:

1.1 The Birmingham and Solihull Sustainability and Transformation Partnership (STP) Flu Plan and the Black Country and West Birmingham STP Flu Plan supplement the NHS England and NHS Improvement (NHSE/I) Regional Flu Plan, which outlines the scope and ambitions of the National Flu Programme for 2020/21. The primary purpose of these plans is to set out the STP's approach to achieving the National Flu Programme for 2020/21 and the general NHS response to flu outbreaks. In addition, the plans describe the interface between NHSE/I direct commissioning functions and local STP/CCG flu planning, setting out respective responsibilities and accountabilities.

1.2 This paper outlines a high-level plan for developing and mobilising our local approach to implementation of the seasonal flu vaccination programme across Birmingham. The two commissioning organisations, working together within the wider system aim to deliver the best possible uptake rates in line with national targets and where possible above and beyond the targets, during these unprecedented times and challenges.

1.3 This paper identifies the key details from the plan covering:

- Overall numbers for flu vaccination programme
- Overall delivery models
- Key risks and issues

2. Implications:

BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	x

Joint Strategic Needs Assessment	
Creating a Healthy Food City	
Creating a Mentally Healthy City	
Creating an Active City	
Creating a City without Inequality	
Health Protection	x

3.	**Recommendation**
3.1	The report provides assurance to HWBB on the flu programme plan for mobilisation, noting the key risks regarding notification of how we can obtain and when we will receive the additional stocks needed to reach the target levels.

4. Report Body

4.1 Background

4.1.1 The two STP bodies across Birmingham have developed robust plans to deliver the 2020/21 flu vaccination programme, establishing processes, governance and reporting structures to ensure there is appropriate transparency, accountability and responsibility. This will enable a rapid deployment of activities to meet the demands of the programme whilst providing assurances to key stakeholders.

4.1.2 Our aim is to make every contact count and deliver the best possible uptake rates during these unprecedented times. To successfully vaccinate a large and diverse population cohort, a blended delivery model will be developed, and a combination of workforce used to provide the service across the STPs.

4.2 Numbers

4.2.1 The eligible number of patients and staff for vaccination across Birmingham is circa 706,000. The cohort population breakdown is:

- **c. 167,665** patients aged **over 65**
- **c. 171,798** patients aged **6 months to 65 years, who are at risk**
- **c. 167,094** patients **aged 2-11 years old, who are not at risk**
- **c. 15,107** patients who are **pregnant and not otherwise at risk**
- **c. 14,770** patients who are **carers and are not otherwise at risk**
- **c. 169,198** patients (estimated) who are **aged 50-64** and are not otherwise at risk
- **c. 52,000** Health and Social Care staff

4.3 Delivery model

4.3.1 A collaborative delivery model approach across the system will be in place, ensuring that there are multiple access points for our population, on top of access to general practice, to enable the making every contact count approach to deliver the trajectory. The delivery model will be subject to quality and equality impact assessment (EQIA) as well as a quality checklist.

4.3.2 There will be a **total of 11 access points**, which are listed below:

- General practice
- 'Pop up' vaccinations sites at key community settings
- Drive through facilities
- Care homes
- In the home
- Schools
- Maternity settings
- Hospitals
- Community pharmacy
- Mental health settings
- Workplaces

Note: There is a significant logistical challenge regarding movement of vaccine, scheduling of vaccine supply and cycle time

4.4 Health inequalities

4.4.1 Given the potential for Flu and COVID-19 to be circulating during winter months, the consequences of disruption are more likely to impact on some groups, communities and localities more than others; this has the potential risk to increase health inequalities.

4.4.2 The disproportionate impact of COVID-19 on BAME communities is well documented. There is also evidence to suggest that health inequalities will be widened as a result of the pandemic and therefore inclusive approaches are paramount at this time, to ensure health care services are accessible, timely and responsive to the needs of our diverse population.

4.4.3 We are also mindful of potential for lower uptake in certain faith communities, as a factor of acceptability of vaccines with porcine content. This will require close working with local communities, clinicians and faith leaders to support our making every count approach.

4.4.4 Last year, c. 31.2% of 2 and 3 year olds were vaccinated locally, against a national average c. 44% and national target of 50%. Local intelligence indicates members of some faith groups may find this an unacceptable vaccine, due to the porcine content.

4.4.5 Therefore, targeted action is required at a grass roots level with a focus on those disproportionately affected (at risk) to mitigate any differential impact. This is a key part of a) our communications and engagement plan and b)

ensuring we have a good range of access points both at-scale, but also within local communities.

4.4.6 There is a supporting communication plan in place to deliver a range of communication methods to increase flu vaccine uptake levels.

4.5 Mobilisation / dates / next steps

4.5.1 Based on the delivery dates of vaccines, we are aspiring to deliver most vaccines by December 2020 including the 50-64 year old cohort.

4.5.2 Flu plans will be finalised at the end of September and we will ensure these are shared with Health and Wellbeing Board members.

4.5.3 This is based on the following assumptions:

- 4-11 year olds will be part of the school's programme;
- Modelling based on increase vaccination times due to PPE;
- Based on achieving a 75% vaccination rate for the eligible patient populations and 100% of staff cohorts;
- Sufficient levels of vaccines will be delivered on time to meet the delivery plans, we are awaiting confirmation from NHSE of how we can access additional vaccine supply for the total eligible population.

5.	**Compliance Issues**
5.1	**HWBB Forum Responsibility and Board Update**

5.2	**Management Responsibility**
5.2.1	Programme Oversight is through the Regional NHSE/I Immunisation Board and locally through the Birmingham and Solihull STP Oversight Board for Immunisations and Vaccinations and the Black Country and West Birmingham STP Healthier Futures Partnership Board.
5.2.2	Delivery responsibility is overseen by the BSoL flu operational delivery group and each provider has responsibility for the delivery of their target numbers. Throughout the flu season this group will meet weekly to review operational issues and implementation progress across the various delivery models. It will also look at opportunities for mutual support, peer learning, ensure we maximise the best use of our available capacity, making every contact count.

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Shortfall of vaccines ordered to meet the national target	High	High	Escalation to NHSE and outline given of percentage shortfall. We understand detail will be provided in September of how we can access additional supply.
Funding from NHSE/I regarding the infrastructure expansion and additional cohorts is not yet confirmed	Medium-High	High	Awaiting national confirmation.
There is a risk we have reduced capacity due to COVID-19 restrictions and the expansion of the eligibility criteria.	Medium	High	Modelling at the various eligibility points and delivery being scoped as to what a maximum capacity would look like for 20/21 with at scale delivery options. Use of blended delivery model to maximise our capacity and ensure we use an every contact counts approach to utilise capacity as efficiently as possible.
Productivity and throughput will be lower due to the restrictions of social distancing, infection prevention, estate and operational factors in primary care due to COVID-19.	Medium-High	High	Delivery models have been scoped for at scale and localised delivery, to meet the required target numbers. The financial risk has been escalated to NHSEI, and we are awaiting a response.
Risk that the flu vaccine supply will be delayed, which will increase the timelines for mobilisation of the campaign and protecting patients	Medium	High	Assumptions for modelling and run rate have been based on expected phasing of vaccine delivery.

PPE guidelines and levels of use can impact throughput.	Medium	Medium	Modelling is based on an increased vaccination time due to these measures. Updated IPC guidelines now published.
General public can pay for flu vaccines at pharmacies, regardless of being in the current at risk group or not. This may have an impact on the supply of vaccines for at risk groups if uptake is high	Medium	Medium	Encourage collaborative working between PCNs and pharmacies to prioritise at risk group. Escalate through regional Public Health leads to ensure the risk is on the national risk register in the event of demand greater than supply.
There will not be adequate cold storage available to store vaccines.	Medium-High	High	Discussions ongoing with alternative sites for additional cold storage facility. It is noted that manufacturers will not be able to send vaccines to new sites which will need to be considered.

The following people have been involved in the preparation of this board paper:
Rachel O'Connor, Assistant Chief Executive Officer, Birmingham and Solihull STP (rachel.oconnor@nhs.net)

Carla Evans, Head of Primary Care, Sandwell and West Birmingham CCG (carla.evans2@nhs.net)

Birmingham Health and Wellbeing Board

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22nd September 2020**
TITLE:	**UPDATE ON SCREENING AND IMMUNISATION**
Organisation	**Birmingham City Council**
Presenting Officer	**Andrew Dalton, Screening and Immunisation Lead, Public Health England**

Report Type:	**Information**

1.	**Purpose:**
1.1	To update the HWB on the current provision of screening and immunisation programmes, with focus on impacts of and restoration from the Covid pandemic

2.	**Implications:**	
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	X
Joint Strategic Needs Assessment		
Creating a Healthy Food City		
Creating a Mentally Healthy City		
Creating an Active City		
Creating a City without Inequality		X
Health Protection		X

3.	**Recommendation**
3.1	The Board is asked to note the progress detailed in the report
3.2	Board members are asked to continue to work to mitigate the effects of COVID-19 in the delivery of these services
3.3	The Board is asked to continue to signpost people to services

4. Report Body

Background

4.1 The report includes an overview of the impact of Covid-19 on NHSE&I commissioned screening and immunisation services in Birmingham, further detail will be provided during the presentation.

4.2 Antenatal and newborn screening continued throughout Covid-19 with some alternate venues. A backlog built up during Covid-19 which has mostly been cleared.

4.3 The majority of other screening (Breast screening, bowel cancer screening, cervical screening, diabetic eye screening, abdominal aortic aneurysm screening) paused in March due to Covid-19. In some cases, regional laboratories that test samples were repurposed for Covid-19 testing. Screening restarted between June to August, in some cases high risk screening has been prioritised.

4.4 School age immunisations ceased in March when schools closed. Recommencing at the start of June with some schools allowing access and community provision also being used. Catch up services have been run through the school summer holidays

4.5 Childhood immunisations continued through Covid-19. There was some impact on doses of vaccine between March and May, returning to normal by the end of June.

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

5.2 Management Responsibility

5.2.1 Programme Oversight is through the Regional NHSE/I Immunisation Board and locally through the Birmingham and Solihull STP Oversight Board for Immunisations and Vaccinations and the Black Country and West Birmingham STP Healthier Futures Partnership Board.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk

Appendices
Screening & Immunisation – A Birmingham Update

The following people have been involved in the preparation of this board paper:

Andrew Dalton, Screening and Immunisation Lead, Public Health England

Screening & Immunisation – a Birmingham update

Birmingham Health & Wellbeing Board: 22nd September 2020

For any questions or queries, please contact:andrew.dalton4@nhs.net

NHS England and NHS Improvement

008041/2020

Antenatal & Newborn Screening (ANNB)

- Antenatal and newborn screening has not stopped during the Covid pandemic
- Some relaxation of screening timelines and standards, but these now returned to pre-Covid
- Newborn Hearing Screening Programme (and subsequent audiology referral) developed a backlog through the Covid peak:
    - Services have largely worked through these/ have plans for any remaining work – with clinics at pre-Covid levels
- Some use of alternate venues, such as football grounds for newborn hearing catch up clinics

Breast Screening (BSP)

- Routine breast screening paused in March
    - All services continued to assess women already screened, very high risk screening maintained in 2/3 services (resumed in May)

- Routine screening resumed June-August
    - Initially resumed at a lower rate due to increased infection control, distancing etc.

- National programme changing from tied to open first appointments from September 30th with aim to restore screening intervals faster. Some risk around uptake mitigated through engagement with screening population and GPs

- Some replacement of screening equipment in Birmingham area

Bowel Cancer Screening (BCSP)

- Issuing of new screening kits ceased in March, with screening 'centres' (who managed people with +ve screen) also pausing

- Initial restoration of programme focused on screening centres, assess those already with positive screening result
    - This resumed in early June

- The issuing of new screening kits to the population resumed on 3rd August
    - Screening rates initially below pre-Covid, but ongoing work to increase this to pre-Covid and beyond
    - Screening currently behind the two yearly recall period – now restored focus is to catch this up.

Cervical Screening (CSP)

- The regional laboratory that test screening samples closed in March – equipment repurposed for Covid testing
    - All cervical screening ceased
    - All new invites from the national programme paused from 9th April - 6th June
    - Lab returned to cervical screening work late May

- Laboratory service fully restored. Sample turnaround times for RWT are now back within 14-day target.
    - Additional equipment allows for Covid and cervical screening work in parallel

- Resumption of the national invites: initially below pre-Covid with gradual increase – schedule set to return to screening intervals in May 2021
    - Catch up on ‘higher risk’ cohorts first

- Colposcopy remained open, but were able to defer some patients
    - Deferred patients cleared; ongoing work to ensure clinic capacity meets need

Diabetic Eye Screening (DESP)

- Screening paused on 16th March;
- Resumption of screening split into two phases – higher and lower risk
    - Restoration of screening for higher risk underway
    - Plans and timelines in place for resumption of low risk screening (pts who have previously been screened and showed no abnormalities)
- Capacity in screening and access to screening venues affected by social distancing & infection control measures

Abdominal Aortic Aneurysm Screening (AAA)

- Suspended paused on 23rd March
- Screening resumed on 10th August; both for surveillance and new screening.
    - Initial goal is to clear both 19/20 and 20/20 cohorts – with plans to increase capacity to catch up with annual cohorts.
- Service has reduced access to venues and capacity reduction due to longer appointment times.

Immunisations – School-Age Immunisation Service (SAIS)

BCHC- Birmingham Community Healthcare Trust:

- Providers ceased delivering vaccinations in March when schools closed,
- - they recommenced at the end of June , with some schools allowing access and the provider also used local community venues to deliver services.

- The provider has continued to offer services through the summer holidays to attempt to catch up on some of the activity missed due to the school closures.

- In September BCHC will also be the provider for the Solihull area.

- The plan is to complete the catch up during the upcoming academic year, this is challenging however the provider is planning to achieve this.

Immunisations – Childhood

- Childhood immunisations continued during Covid.
- Some impact on doses of vaccine give in the regional compared to expected (peaking March-May) but returned to expected by June
- Catch up of activity through existing mechanisms in primary care

Immunisations – Flu

- Uncertainties created by Covid-19 have made flu planning a challenge this year. Issues such as staff absences, venues for vaccinations, and possible school closures add complexity, as well as considerations regarding social distancing and infection prevention measures.

- National ambitions have been raised to at least 75% for all groups and the flu programme has been extended to include two additional cohorts:
    - Children in year 7 at school
    - 50 – 65 years (later in the season if the vaccine is available)

- All providers have been asked to review vaccine orders in light of increase.

- STP's flu plans aim to bring all stakeholders together to deliver a systems wide approach in the local health economy.

Return to business as usual

Questions?

Birmingham Health and Wellbeing Board

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22 September 2020**
TITLE:	**UPDATE ON PUBLIC HEALTH COMMISSIONED SERVICES**
Organisation	**Birmingham City Council**
Presenting Officer	**Bhavana Taank, Public Health Service Lead - Adults and Older People Karl Beese, Commissioning Manager – Adult Public Health Services**

Report Type:	**Presentation**

1. Purpose:
To inform the Board and members of the public of the progress on the delivery of Public Health Commissioned Services including Health Checks, Smoking Cessation, Sexual Health and Drugs and Alcohol pre, during and post COVID

2. Implications:		
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	✓
Joint Strategic Needs Assessment		
Creating a Healthy Food City		✓
Creating a Mentally Healthy City		✓
Creating an Active City		✓
Creating a City without Inequality		✓
Health Protection		✓

3. Recommendation
3.1 The Board is asked to note the progress detailed in the report.
3.2 Board members are asked to continue to work to mitigate the effects of COVID in the delivery of these services

3.3 The Board is asked to note that services are operating differently due to COVID 3.4 The Board is asked to continue to signpost people to services 3.5 The Board is asked to note that major contract recommissioning plans have paused for 6 months due to covid

4. Report Body

4.1 The attached paper summarises progress made in the delivery of smoking cessation, Health Checks, Sexual Health and Substance Misuse. Key themes covered include:
 	
• Progress and performance pre COVID
• Performance During COVID
• Delivery Measures implemented and payment arrangements
• Additional resources allocated to enhance service accessibility
• Actions required post COVID 1st Wave
• Preparation for potential 2nd Wave
 	
4.2 The following have contributed to the content of the report:
 	
• Birmingham City Council Public Health
  ○ Adults and Older People Service Lead
  ○ Assistant Director Population and Protection

5. Compliance Issues
5.1 HWBB Forum Responsibility and Board Update
The impact and mitigation of the disproportioned risk of Covid-19 on the delivery of these services will continue to be monitored though the performance management processes within the Public Health Adults and Older Peoples Team.
5.2 Management Responsibility
Dr Justin Varney, Director of Public Health, Birmingham City Council

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Services cease delivery and provide inequity and inequality. Risks of COVID on these groups are also increased	Low	High	Continue partnership working and promote continuation of delivery

Appendices
Progress on the delivery of Public Health Commissioned during and post COVID

The following people have been involved in the preparation of this board paper:

Dr Justin Varney, Director of Public Health
Dr Marion Gibbon, Assistant Direction Population and Protection
Bhavna Taank, Service Lead – Adults and Older People
Karl Beese, Commissioning Manager – Adult Public Health Services

Update on Health Checks and Smoking Cessation – Birmingham Health and Wellbeing Board.

This report summarises progress of Health Checks and Smoking Cessation, pre, during and post COVID-19. As a Health and Wellbeing board we are keen to mitigate against disproportional risk of Covid-19 who access these services.

During March 2020 the Government and PHE detailed a number of services that should continue delivery and those that should stopped. This report highlights the delivery model prior to COVID, the changes that occurred due to COVID and what actions are being taken post wave 1 of COVID.

The following have contributed to the content of this report:

- Birmingham City Council Public Health
  - Adults and Older People Service Lead
  - Assistant Director Population and Protection

NHS Health Checks

Introduction

Cardiovascular disease (CVD) affects the lives of around 7 million people in United Kingdom (UK) and is a significant cause of disability and death, affecting individuals, families and communities, with 26% of all deaths being related to CVD. It is one of the leading causes of premature death in Birmingham and accounts for approximately 24.4% of mortalities for Birmingham residents (ref: 20016 VS3 tables) and 21.2% of deaths under the age of 75 years (this compares to 27.75% nationally). The burden of CVD falls disproportionately on people living in deprived circumstances and on particular ethnic groups, such as South Asians.

Consequently, CVD accounts for the largest part of the health inequalities in our society. Therefore, prevention, early identification and management of CVD remains a key strategic priority for Birmingham City Council Public Health.

CVD conditions, namely coronary heart disease (CHD), stroke, diabetes and chronic kidney disease (CKD), share a number of common modifiable risk factors. Obesity, sedentary lifestyle, smoking, high blood pressure, high cholesterol and impaired glucose regulation all increase an individual's risk of developing CVD. The UK National Screening Committee has provided evidence demonstrating that it is possible to identify CVD risk factors and act to change them. The 'Putting Prevention First' strategy document proposes that early intervention to reduce risk will prevent, delay and in some circumstances reverse the onset of vascular disease. In April 2009, the Department of Health (DH) introduced the NHS Health Check programme, requiring Public Health to implement systematic reviews of its aged 40-74 years population (excluding those already on a CVD register, on a statin, have an actual CVD Qrisk score of 20% and above or have had a previous NHS Health Check within the last 5 years). NHS Health Checks are one of the key mandated Public Health services commissioned by the Local Authority as defined in the Birmingham City Council Public Health Outcomes Framework.

During the response to COVID, the government identified that individuals with certain underlying conditions are at high risk of suffering adverse effects of COVID if they are infected especially those who are of older age. The Health Check Programme acts as a preventative initiative to ensure the key conditions identified by the government such as CHD, Diabetes, Obesity, High Blood Pressure are reduced and caught early, promoting individual to make lifestyle choices to be able to lead a healthy life.

Local Provision and Pre COVID-Performance

The provision of Health Checks is currently delivered via a Primary Care GP model and is delivered by every GP Practice within the Birmingham Boundary. This is a 5-year programme and the national benchmark over the 5 years is to invite 20% of the 5 year eligible cohort every year for health checks and to screen at least 50% of those invited. By using this approach, it would be anticipated that over the 5 years everyone eligible would have been invited for a health check and at least 50% of those eligible over the 5 years would have been screened. The programme is available to all adults between the age of 40 and 74 who do not already have any underlying CVD condition and are not part of a disease register where they would be screened annually anyway. An eligible patient is entitled to one free health check every 5 years.

The current 5-year Health Check programme started on 1st April 2018 and the performance to date is as follows:

	2018/19	2019/20	2020/21 (Q1)	Total Programme to Date
Invite Target	54,631	53,715	13,436	121,782
Invite Actual	81,970	68,619	1,193	151,782
Over/(Under) Acheivement	**27,339**	**14,904**	**(12,243)**	**30,000**
Completed Target	27,315	26,858	6,718	60,891
Completed Actual	33,408	28,286	559	62,253
Over/(Under) Acheivement	**6,093**	**1,428**	**(6,159)**	**1,362**

The 2020/21 (Q1) figure shown on the table as a big underperformance relates to the period April 2020 to June 2021, when it was advised by Government and PHE that Health Checks were to stop activity, until further advised. Given this advice Birmingham Public Health did not ask GP Practices to stop activity altogether, however instead requested them to decide on their own merit f they wished to continue delivery using their own devised safe methods or whether to stop. We advised all GP practices that they would not be penalised for low performance as the programme was a 5-year programme and there will be the ability to ramp up activity post Covid to ensure benchmark targets are met by March 2023.

During Covid Delivery and Payments

Given the government advise, some GP chose to continue to deliver health checks using new socially distanced methods and where there was the ability providing blood tests at home or in specially organised clinics within their practice for their registered patients only. Hence why during quarter 1 there was some minimal activity with the delivery of health checks. Birmingham Public Health have been having conversation with some of these practices t gather information on the methods of delivery to be able to devise a good practice guide to GPs to be able to restart delivery once their doors open to patients again and also if we were to face further lockdowns due to a potential wave 2.

The Local Medical Committee who represent the GPs in Birmingham, enquired whether payment would continue under the Provider Relief Notice by Cabinet Office (PPN 02/20). The Public Health Service Lead review the situation with neighbouring Local Authorities, where the response was very mixed where some authorities were not paying their providers anything for no delivery, some were paying average performance amounts for Quarter 1 allowing providers to keep the funds and some were making payments with the provision that targets will be increased with fund being clawed back at a later date. Given all of the evidence, a fair approach was used where an average payment for Quarter 1 was agreed for all GP Practices with a clawback of 75% of the payment with effect from January 2021 over 4 quarterly period. This would allow GP practices to retain 25% of the payment as goodwill and also push them to deliver more health checks when they restart them to ensure the clawback has a minimal impact on them in the future. The relationship with GP practices has taken many years to develop and it has taken hard work to ensure targets have been over achieved each year and by allowing them to retain a small sum would mean that they would remain engaged with Birmingham Public Health and the restart would be much easier.

17 GP practices decided not to take up this offer either by not returning their variation for additional payment and clawback for qtr 1 or simply confirming they did not want the payment. A new Cabinet

Office briefing for Supplier Relief was issue for Quarter 2 PPN 04/20, which indicates a similar approach to that of PPN 02/20. Currently Birmingham Public Health are in the process of collating variation responses for quarter two where the offer is a choice for GPs to not be paid in Quarter 2 or accept payment and clawback on the same basis as quarter 1.

Post Wave 1 Delivery

The government and NHS have provided guidance to all GPs and CCG to promote the start up of prevention interventions and medical interventions as normally as possible from 1st September 2020. GPs have been requested to open their doors to patients rather than continue to operate on a closed door basis. They have also been requested to upscale Prevention type interventions as quickly as possible to avoid more people falling ill due to COVID if Wave 2 is to strike.

Birmingham Public Health has circulated this information to all GP practices and is continuing to provide restart messages on an ongoing basis. We have also worked with the CCG and CSU to ensure the data for 2020/21 is readily available for GP Practices to access to be able to start sending invites out to patients to be able to book appointments post 1st September. Birmingham Public health is also working closely with a number of GP practices to develop good practice to share wider about alternative ways that Health Checks can be delivered more pro-actively and innovatively.

It is also hoped that post COVID, that activity could be ramped up at scales via GP Practices to make up for underperformance so that overall performance for the 5 year programme is met or over achieved, along with the 50% of the cohort having a Health Check to decrease inequalities, resulting in individuals leading more healthier lives, through better food nutrition, active lifestyles, better mental health, etc.

Smoking Cessation

Introduction

Smoking remains the single greatest cause of preventable illness and premature death in the UK. One in two smokers dies prematurely from smoking-related diseases, on average losing 10 years of life. Every year over 4,500 people in Birmingham die from a smoking related disease. Smoking is directly linked with Birmingham's three biggest killers and is attributable to:

- 1 in 4 of all cancers
- 1 in 5 of all deaths from CVD
- 1 in 3 of all deaths from respiratory disease

There are approximately 120,310 adults over 16 years old who smoke in Birmingham 13.7% of the adult population. National survey data shows that the smoking rates in Birmingham are similar to the England average at 14.9%, although rates are much higher in some areas. Tobacco use is one of the most significant causes of health inequalities and there is a strong link between cigarette smoking and socio-economic groups. Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. Smoking accounts for over half of the difference in risk of premature death between social classes.

Stopping smoking is considered one of the single most effective methods for improving health and preventing illness. National surveys report that around 67% of smokers want to quit. Evidence-based NHS Stop Smoking Services are well established and considered both cost and clinically effective.

NHS Stop Smoking Services offer support to help people quit smoking. This can include intensive support through group therapy or individual one-to-one support. Such services are expected to be widely accessible within the local community and provided by trained advisors.

The National average quit rate at 4-weeks for clients accessing Stop Smoking Services is 45%, although certain population groups (e.g. under 30-year olds; routine and manual workers and pregnant smokers) have lower rates of abstinence.

The core elements of the service are the provision of behavioural support and pharmacotherapy. The service aims to maximize the number of smokers accessing the service and quitting long-term, therefore contributing to the reduction of smoking prevalence in Birmingham. To work most effectively, it will be necessary for the service to focus on specific segments of the population, increasing access from priority groups where smoking prevalence is highest (i.e., routine and manual (R/M) occupational groups, deprived communities, young people and pregnant smokers).

The objectives of the stop smoking service will be to:

- Provide equitable access to all smokers
- Offer the most effective, evidence-based treatments available
- Support people to successfully quit smoking
- Achieve high levels of client satisfaction

Local Provision and Pre COVID-Performance

The local Smoking Cessation Service is primarily provided to individual's via a primary care model via GPs and Pharmacies. There is also one Vape Shop who delivers the service who are IBVTA registered as per PHE guidance. The programme is either based on a 4 week or 12-week basis which consists of fortnightly behavioural support and the provision of Nicotine Replacement Therapy along with the offer of e-Cigarettes. The offer is available to individuals over the age of 12 and anyone who lives, works and studies in Birmingham. The service was delivered by approximately 180 providers equitably throughout Birmingham Via GP Practices and Pharmacies.

The service is not one that is mandated by government, but is a priority for NHS and Local Authority. The vision to reduce smoking prevalence national is a key message which comes out of the NHS 10 year plan and given this vision the number of providers offering smoking cessation has increased by at least 50% over the last 1.5 years.

Due to more people wanting to quit due to health messages being marketed the number of quits have been consistently going up in the pharmacy setting and below is a summary of performance comparisons from one year to another:

	2018/19	2019/20	2019/20 Q1	2020/21 (Q1)
4 wk Quit (GP)	1067	989	232	170
12 wk Quit (GP)	547	543	146	107
4 wk Quit (Pharmacy)	1094	1269	283	157
12 wk Quit (Pharmacy)	475	485	124	112

As shown in the table above the performance from 2018/19 to 2019/20 for GP was slightly less but classed as consistent and for pharmacies there was a clear increase in activity especially 4 week quits. If we look at the Qtr 1 Comparison for Qtr 1 this year when COVID Hit to last year Quarter 1, performance has decreased but not as much as was anticipated at 50%. It seems individual have continued to access smoking cessation service to attempt their quit due to the adverse effects of COVID on smokers. In addition, GPs have maintain a good proportion of their activity.

During Covid Delivery and Payments

The government advise around the delivery of Smoking Cessation during the COVID Outbreak (Wave 1) was to continue delivering the service at some level. Given that GP practices closed their doors to patient, they continued to deliver smoking cessation through a telephone consultation model with NRT provided via an electronic FP10 prescription sent to the pharmacy of their choice or a voucher provided via collection or post. There were however issues with paper vouchers as Pharmacies did not want to handle paper vouchers due to infection spread, so a resolution was sought where vouchers could be provided electronically to overcome this issue.

Pharmacies continued to deliver Smoking Cessation in a socially distanced manor or over telephone consultation however there was an impact on slightly reduced delivery due to GPs closing their doors and patients diverting their support requirements to Pharmacies, which was resource intensive and limiting time for the provision of smoking cessation services.

What supported the deliver was the governments launch of the #QuitforCovid campaign, which was pushing smokers to quit from smoking to ensure they have a positive outcome if they caught COVID,

as smokers have compromised lungs and are likely to suffer much worse effects of COVID. The foresaw a demand in the service and it was decided to implement the use of AI and the Quit with Bella app provided and commissioned via Solutions for Health was implemented to provide a service delivery model with minimal touch points and electronic delivery of NRT and eCigarettes. This has initially proved successful and at the forefront of technology and is a app which Solutions 4 Health further developed and tailormade for Birmingham and if evaluations demonstrate the success seen to date then it is likely that this would be embedded in the current service delivery model. The AI App has the benefit of supporting the brief intervention delivery 24/7 supporting pharmacies and GPs. The app has also been developed as a stand alone stop smoking service where a user can use this app solely to attempt their quit and the NRT and eCigs are sent electronically via a pharmacy system to be dispensed for the patient to pick up so again minimal touch point. This makes the smoking cessation service COVID Wave 2 ready.

In addition to this one of the GP Clinical systems is being adapted to be able to deliver electronic NRT vouchers directly to pharmacies via their dispensing system further reducing touch points and increasing infection control.

As described in the section for Health Checks and the supplier relief note PPN 02/20, it was agreed to pay Pharmacies the average quarter quit payments as a good will for continuing to deliver the service at pace during the pandemic outbreak and the basis of payment was they would either get paid the average quarters activity or actual activity, whichever is higher. It was decided not to pay anything around relief payments to GPs for smoking as they were already getting paid for Health Checks. As a result of the PPN 04/20 relief note, it was agreed through a general consensus by the Local Pharmacy Committee that pharmacies did not require any payment for Quarter 2 and Birmingham Public Health had advised that the payment for quarter 2 would be classed as a payment in advance and all funds paid for quarter 2 would be reclaimed back from future activity payments.

Post Wave 1 Delivery

It is anticipated that activity will continue to rise now that GPs will start to increase their services from 1st September 2020 and that Pharmacies have now got more capacity to continue to deliver services. #QuitforCovid will still continue to be provided and a push for service delivery will be made especially with the campaigns around Stoptober. Birmingham Public Health are also working with a wider range of partners to embed smoking cessation as part of their standard offer which will also enhance the number of individuals quitting within Birmingham.

The Quit with Bella app will be further pushed and it is hoped that this will become the first point of access for anybody through regular communications around the use of the app and promoting citizens who use to download it if they have a smart phone. It is anticipated that all NRT provision will become electronic voucher based so there is no handling of vouchers and individuals can more easily access their pharmacotherapy in the future.

If there is likely to be a Wave 2 of COVID then it is anticipated that the smoking cessation offer is COVID ready to mitigate access to services being limited and that the embedding of some of the interventions during Wave 1 will become part of mainstream delivery post COVID.

Tobacco control strategy including CLeaR assessment

CLeaR tobacco control assessment - This deep dive assessment was conducted in March 2020 and comprised of several influential stakeholders from Birmingham and Solihull CCG. The event was

evidence focused and addressed current challenges, leadership and goals whilst looking at strengths and opportunities to redress smoking related inequalities.

The key findings were:

- The stakeholders agreed that the compliance and enforcement as well as cessation was generally good, however there was scope for development
- Redressing the imbalance of inequalities amongst socio-economic groups
- Target interventions required in hot spot areas of where there's high smoking prevalence
- Review commissioning and planning of service delivery models
- Collaborative work required to achieve shared vision
- Publicity and communications required to achieve outcomes.

A Tobacco Control Alliance Group will be set up with key multi-agency partners to co-design and facilitate the tobacco control strategy and provide strategic guidance whilst focusing on three key objectives as follows:

- Reduce uptake of smoking
- More smokers quitting
- Protection for all from second-hand smoke

Whist smoking effects the wider population, we will focus on three priority groups whereby smoking related inequalities is greatest:

- Children and young people (12 years plus)
- Pregnant women and family members who smoke
- People who are marginalised (i.e. routine and manual workers, BAME communities, low socio-economic groups, etc.)

In light of the COVID pandemic this task has been put on hold and we hope to resume in Autumn 2020 and there will need to be involvement from Environmental Health, whose resources are currently exhausted with responding to the Pandemic.

Business and Planning Act 2020: Temporary Pavement Licence

The temporary pavement licence process introduced a streamlined and a cheaper consent route allows businesses to obtain a licence to place removable furniture on the highway, such as tables and chairs outside of cafes, bars and restaurants. Fees are capped at maximum £100 with consultation, consideration and determination period of 10 working days (excluding public holidays) as opposed to the conventional method of 28 working days.

This bill came into effect on 27th July 2020 in response to social distancing measures and to reduce risks of COVID transmission whilst ensuring safe provisions are in place relating to the promotion of economic recovery and growth.

The bill sets out two conditions which apply to pavement licenses which are either granted or deemed to be granted: a no-obstruction condition and a smoke-free seating condition.

The new licence lasts for 12 months and until the 30th September 2021, at which point the new licensing scheme will end, and businesses will have to apply for an old type Part VII Highways Act

1980 licence if they wish to continue having a pavement café area. Enforcement of this is also the responsibility of Environmental Health and there could be an opportunity here to market the smoking cessation service in Birmingham.

Sexual Health

Introduction

Sexual health is an important area of public health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations. Sexual health is not equally distributed within the population. Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, teenagers, young adults and black and minority ethnic groups. Similarly, HIV infection in the UK disproportionately affects MSM and Black African populations. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

Local Provision

Local authorities are mandated to commission comprehensive open access sexual health services, including free STI testing and treatment, notification of sexual partners of infected persons and advice on, and reasonable access to, a broad range of contraception; and advice on preventing unplanned pregnancy

In Birmingham the Sexual Health service has been delivered by Umbrella, led by University Hospitals Birmingham NHS Foundation Trust (UHB), since August 2015. The contract has recently been extended for a further 2 years until August 2022 with a yearly contract value of £14,038,586.90.

During COVID Delivery & Payments

Throughout COVID Public Health Commissioners have been in regular contact with Public Health Service Leads and Service Providers in order to receive Business Continuity Plans and subsequent updates, Operational Updates/Positions and details of any newly identified risks. In conjunction with this, UHB's Operational Team comprising of Umbrella Senior management meet daily and any risks/issues are be communicated to Commissioners. The Public Health Contracts Board initially met weekly and now bi-weekly in order to be briefed on the operational status of all Public Health Contracts and a bi-weekly contracts update detailing these statuses is produced and circulated to Cllr Hamilton and key partners.

The Birmingham Umbrella Sexual Health service has continued to operate throughout COVID and Birmingham citizens have still been able to access the service since 24th March albeit in a different way and without major disruption.

The biggest impact of COVID was the initial need to reduce face to face interaction with patients as during the initial stages of the pandemic Umbrella were forced to cease all clinical visits. To mitigate against the issue of restrictions to the "open access" Service Umbrella were still able be contacted via telephone and were then able to triage patients, signpost and if required offer a telephone/video consultation.

The Umbrella website https://umbrellahealth.co.uk/ is continually updated and details how and where services can be accessed as well as offering Coronavirus information for patients.

The number of telephone calls taken by Umbrella during COVID is detailed below:

Month	Total Telephone Calls	Number of Patients Signposted	No. of patients receiving a Telephone Consultation
July 2020	8,163	4,264	3,899
June 2020	6,064	3,994	2,070
May 2020	3,786	2,698	1,088
April 2020	2,416	1,567	849
Total	**20,429**	**12,523**	**7,906**

Since April telephone calls have increased by approx. 238%, signposting by 170% and telephone consultations undertaken by 360%. The vast increase in telephone activity and telephone consultations is encouraging and Commissioners expect to see further increases in August's figures which will be available the 18th August.

As well as offering telephone consultations, where appropriate Umbrella have also been offering video consultations and approx. 150 patients monthly have been utilising this service.

A postal medication service has also been introduced and offered during COVID and there has been a consistent increase in the dispensing of postal medications which negates the need for a face to face visit to a Clinic or Pharmacy.

SH Medications Issued	RSH	GUM
July 2020	144	130
June 2020	98	94
May 2020	82	76
April 2020	32	101
Total	**356**	**401**

RSH – Reproductive Sexual Health; Contraception
GUM - Genitourinary Medicine; predominantly sexually transmitted infections (STI's) and HIV testing

From the 4th May Umbrella re-opened their Complex Clinic at Whittall Street which continues to offer referral-based face to face appointments for complex procedures such as difficulties in removing a coil and the need for a scan/removal by a consultant.

Whittall Street Face to Face Appointments	GUM	RSH	INT	Total
July 2020	754	196	54	1,004
June 2020	507	377	264	1,148
May 2020	436	248	199	883
Total	**1,697**	**821**	**517**	**3,035**

Face to face activity saw a slight decrease in July when compared to June, this can be attributed to Whittall Street only being able to see a set number of patients per day due to social distancing guidance, therefore if patients do not attend an appointment, they are unable to see walk-in patients. From the 11th May Umbrella re-opened their General Procedures Clinic at Boots (High Street, City Centre) in order to offer referral-based face to face appointments for uncomplicated long acting reversible contraception (LARC) and subdermal contraceptive implants (SDI's):

Boots City Centre Face to Face Appointments	GUM	RSH	INT	Total
July 2020	14	161	3	178
June 2020	1	206	0	207
May 2020	0	139	2	141
Total	**15**	**506**	**5**	**526**

Face to face activity saw a slight decrease in July when compared to June, this can be attributed to Boots only being able to see a set number of patients per day due to social distancing guidance, therefore if patients do not attend an appointment, they are unable to see walk-in patients.

The re-opening of clinics has meant that Umbrella have been able to fit long acting reversible contraception (LARC) throughout COVID:

Umbrella Clinic LARC Fitting:

Month	Coil Fittings	Coil Removals	SDI Fittings	SDI Removals
July 2020	120	82	127	140
June 2020	111	38	123	142
May 2020	61	31	51	82
Total	**292**	**151**	**301**	**364**

The increase in LARC activity during July is encouraging when compared to May and Commissioners expect to see a further increase in August's activity.

The number of LARC fittings by GP's has also been gradually increasing, following a drop off in April and May due to the Royal College of General Practice advising that the fitting of LARC was on a non-essential service. However, figures for June show a marked increase in activity (June data is the latest available as GP data is produced 2 months in arrears)

Month	Coil Fittings	SDI Fittings
June 2020	141	106
May 2020	65	29
April 2020	13	6
Total	**219**	**141**

The vast increase in GP LARC activity during June is positive and Commissioners expect to see a further increase in July's activity

Pharmacies have also played a key role in delivering elements of the Umbrella Service during lockdown in terms of providing free condoms, emergency hormonal contraception (morning after pill),

chlamydia treatment, contraceptive pill, contraceptive injections, continuation of hepatitis B vaccine injections started at an Umbrella clinic and acting as a collection point for STI self-sampling kits ordered online. Total Pharmacy activity in June was 3,276 - an increase of 62% compared to May and 96% compared to April and 33% lower when compared to June 2019. However, June's figure is a marked improvement compared to May (2,028) and April (1,676) and is expected to increase further in July. As with GP data, June data is the latest available as Pharmacy data is produced 2 months in arrears.

In terms of re-opening complex sexual health clinics within Birmingham, offering video triage/consultations and dispensing medications by post, the Umbrella service has been leading the way nationally in terms of best practice which has been recognised by the Faculty of Sexual and Reproductive Healthcare (FSRH).

The ability for all Birmingham and Solihull to request STI Home testing kits via telephone or the Umbrella website has been a feature of the Umbrella since its commencement in 2015 and throughout COVID this service has still been available.

Month	**STI Kits Issued**
July 2020	5,742
June 2020	4,406
May 2020	3,448
April 2020	2,818
Total	**16,414**

The marked increase in the number of kits issued confirms that people are aware that STI Kits can still be ordered by phone or online and the July figure of 5,742 is in line with pre-COVID figures.

To summarise, throughout COVID whilst the way in which the Umbrella Service is delivered has changed with fewer face to face appointments, Birmingham and Solihull residents have still been able to:

- Receive telephone triage and if required telephone and video consultations
- Have face to face appointments when required
- Have long acting reversible contraception fitted
- Order STI testing kits to be delivered to their home address
- Order medication over the telephone and have it delivered to their home address
- Access Pharmacies for services which includes; free condoms, emergency hormonal contraception (morning after pill), contraceptive pill and contraceptive injections

It should also be noted that throughout COVID BCC and SMBC have continued to pay Umbrella as normal with no reductions to their funding.

Post Wave 1 Delivery

As of 10th September 2020, Umbrella envisage having all Sexual Health clinics re-opened by the end of September, seeing a set number of pre-booked patients per day due to social distancing guidance.

Commissioners have also been working with Umbrella in terms of their Recovery Planning in terms of restarting practices that have been reduced due to COVID such as:

- Increasing face to face attendances and appointments clinics

- Re-instating walk-in appointments
- Extending clinic opening hours
- Working with Delivery Partners face to face
- Re-introducing face to face staff training sessions
- Training teams being able to attend partner training

Commissioners have also been working with Umbrella in terms of amplifying new practices that have worked well during COVID such as:

- Maintaining a measure of reduction in walk-in patients through other access mechanisms to the service.
- Increasing Video consultations
- Telephone consultation process for streamlining patients
- Increasing engagement with key partners
- Increasing Postal medication and prescriptions
- Increasing condoms by post
- Increasing STI kit distribution
- Increasing support for victims of domestic violence
- Integrate Independent Sexual Violence Advisors (ISVAs) presence with Umbrella clinics

Longer term impact of COVID

The current Umbrella contract ends on the 9th August 2022 and Commissioners, Public Health and key partners are already meeting to discuss what the service model will look like as well as initiating a needs assessment. Initial indications show that COVID will not impact on the re-procurement timeline. This is being monitored regularly and if this position does change it will be raised firstly with the Public Health Contracts Board, the Director of Public Health and Councillor Hamilton as the Cabinet Member for Health and Social Care

Substance Misuse

Introduction

The provision of adult drug and alcohol treatment services is defined as one of the "grant conditions" as part of the Public Health Grant. Spending the grant, a local authority has to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services".

Substance misuse treatment has been evaluated by researchers on a wide range of measures, including: drug use; abstinence from drug use; drug injecting; overdose rates; health and mortality; crime; social functioning, including employment; housing; family relations, and the perceptions of service users about their recovery status. The breadth of these measures reflects the broad range of benefits anticipated from providing effective substance misuse treatment.

The demand on the substance misuse service continues to increase with regards to the prevalence of misuse of illicit drugs that include heroin, cocaine and novel psychoactive substances (NPS) and from alcohol. The complexity of service user presentations also continues to increase citywide.

Local Provision

The current drug and alcohol treatment and recovery provision in Birmingham is delivered by the third sector organisation 'Change Grow Live' (CGL). They were awarded a 5-year contract for the period 1st March 2015 – 28th February 2020 and BCC have exercised the option to extend the contract for a further two years from March 2020 to February 2022 with a yearly contract value of £14,190,609.00

A 'recovery' approach has been taken regarding the treatment for Birmingham citizens experiencing the harms associated with drug and alcohol misuse. This currently involves the treatment and care of approximately 7000 service users.

To support the recovery focused delivery model CGL provide service users with the necessary advice and support delivered via a 5-tier model which responds to differing levels of case complexity. The tiers include:

Tier 1: Advice & Information; including signposting to other services which include advocacy and mutual aid.
Tier 2: Non-dependent drug and alcohol use – Group / 1:1 work up to 12 weeks
Tier 3: Dependent alcohol use, opiate use, heavy crack cocaine/synthetic cannabinoids etc. – Group/1:1 work, longer term, structured support
Tier 4: In-patient specialist unit (Park House in Hockley) which delivers detoxification and stabilisation
Tier 5: Aftercare provision – Group/1:1 work

During COVID Delivery & Payments

Throughout COVID Public Health Commissioners have been in regular contact with Public Health Service Leads and Service Providers in order to receive Business Continuity Plans and subsequent updates, Operational Updates/Positions and details of any newly identified risks. In conjunction with this, CGL hold a daily Bronze Local meeting, a Silver meeting with Regional Directors and a Gold National meeting with the CGL Executive Management Team and the Board of Directors. CGL also have a Consultant permanently on call if required.

The Public Health Contracts Board initially met weekly and now bi-weekly in order to be briefed on the operational status of all Public Health Contracts and a bi-weekly contracts update detailing these statuses is produced and circulated to Cllr Hamilton and key partners.

The CGL website https://www.changegrowlive.org/drug-and-alcohol-service-birmingham is continually updated and details how and where services can be accessed as well as offering Coronavirus information for service users.

CGL have developed a Service Delivery Roadmap which details the 5 COVID phases and the services/method of delivery that will be offered during each phase.

CGL Bham Road Map Final.docx

The Birmingham CGL Substance Misuse service has continued to operate throughout COVID and Birmingham citizens have still been able to access the service since 24th March albeit in a different way and without major disruption. The biggest impact of COVID was the need to reduce face to face interaction with service users, changes to the service are detailed below.

Locality Hubs

Prior to COVID four CGL locality hubs provided accessible and welcoming spaces for service users designed to develop the tackling substance misuse/prevention agenda within local communities. There are multi-disciplinary teams based at each of the four hubs, with a wide range of expertise that includes; Doctors, Nurses, Recovery Co-ordinators and Outreach Workers.
Throughout COVID all 4 Locality Hubs (North, South, East, Central & West) have remained open 9am – 5pm with a critical staffing level of 1 Team Leader and 4 Frontline staff working at each Hub as well as a Consultant on call. Only the most vulnerable service users (both new starts and restarts) are being seen at a Locality Hub. This only applies to service users who must provide a urine test in order to receive Opioid Medication Assisted Treatment – specifically Physeptone (Methadone) and Espranor. New starts and restarts for service users who will be prescribed Buprenorphine can be done remotely without the need for the service user to visit a Locality Hub. CGL are looking at staff rotas and individual risk assessments with a view to having more and a greater variety of staff within Hubs, such as nursing staff and recovery co-ordinators.

Contact with Service Users and Utilising Technology

Throughout COVID CGL have been in regular contact with all service users via telephone, face to face in locality hubs where necessary and by utilising technology wherever possible to meet virtually. CGL have segmented their entire caseload and identified the levels of risk for each service user and Recovery Co-ordinators are contacting higher risk service users twice weekly by telephone and lower risk service users fortnightly by telephone.

CGL are holding Service User Welcome meetings via Skype, CGL Partners (DATUS, KIKIT & Intuitive Recovery) are delivering SMART Recovery Groups for Phase 2 (Non-dependent drug and alcohol) services users utilising Skype & Zoom. CGL run virtual groups for Phase 3 service users (Dependent opiate use, heavy crack cocaine/synthetic cannabinoids use and Alcohol dependant) and a day programme for Phase 5 service users (Aftercare Provision).

New Referrals to Service

Throughout COVID the CGL service has been open and accessible to all Birmingham citizens, cumulatively from 23rd March there have been 1,341 new treatment starts; 807 opiate and 534 alcohol.

Service Capacity

As CGL have started 1,341 new service users since 23rd March they are mapping the amount of new starts pre COVID-19 to starts during COVID-19 in order to map any potential impacts on service capacity. Currently there is capacity due to minimal referrals being received from GP's and Hospitals.

Medication Assisted Treatment (MAT)

During the initial lockdown phase of COVID all service users on supervised consumption were moved to unsupervised and provided with 2 weeks take home supply. This was to reduce the pressure on Pharmacies following discussions with the Local Pharmaceutical Committee (LPC) and to ensure that 2,750 service users were still able to receive Opioid Medication Assisted Treatment required to manage their medical condition. To support this approach CGL hand delivered prescriptions (to avoid postal delays) to all Pharmacies, delivered opiate substitute medication to all service users self-isolating, if a service user was self-isolating and had no appointed person to collect their MAT CGL delivered the medication to the service user directly and ensured that where needed all service users received a safe storage box for their medication as well as Naloxone.
CGL continue to case manage the prescribing arrangements of the MAT cohort of 2,750 service users on a daily basis based on levels of risks (1-4 High Risk, 5-8 Medium Risk and 8+ Low Risk) with all service users categorised 1-9. CGL monitor those who present the highest risk which predominantly is the homeless cohort.

Homeless Housing Provision at the Holiday Inn

Whilst the Holiday Inn was being used to house rough sleepers the CGL Lead Nurse & CGL Safeguarding and Quality Lead delivered training for Support Workers in the hotels/hostels which covered the use of Nasal Naloxone, the use of MAT, Alcohol Dependent & Treatment Response Plans and the new ways of working based on social distancing guidelines.
Support Workers within the Holiday Inn were given burner phones in order for service users to be able to contact CGL on a SPOC number.

Inpatient Detox at Park House (Hockley)

The CGL inpatient detox facility was closed due to COVID in mid-March 2020. Park House re-opened on 17.08.2020 to provide a 2-week in-patient detox for drugs and alcohol, the initial intake on 17.08.2020 was 6 service users (usually 18) and the reduced capacity is to enable patients to adhere to social distancing guidance. The re-opening of Park House on 17th August went smoothly and the initial intake of 6 in-patients all respected social distancing guidance. CGL are looking to gradually increase the fortnightly intake up to 8 and then 10 inpatients whilst still adhering to social distancing guidance.

Home Detox for Alcohol

During lockdown CGL have successfully completed 81 alcohol home detox's which have only been offered to service users when it is completely safe to do so. CGL's Lead Nurse is completing a paper on the approach taken home detox by CGL with a view to adopting the same approach for home detox for opiates.

Hepatitis C Postal Testing & BBV Pathway

CGL launched their new BBV Pathway on 6th August. This includes a new self-test postal option which involves Change Grow Live staff sending out a DBST (Hep C & HIV) to the home of the individual who has agreed to complete the self-test. A range of supporting documents have been developed to support the new process including a 'How To' video, written guidance for staff and service users and step by step implementation guides.

Veterans Group

CGL have worked in partnership with BCC and the British Legion and have started a Veteran's group with the first meeting of the group taking place on Wednesday 12th August. It will initially be run by the CGL Lead Nurse and Quality Audit Governance Manager both of whom are veterans. The idea of the group is that service users will be with people who have a shared experience and will be supported to access a range of services that help those from a forces background in addition to treatment focused groups.

CGL Staying Free Telephone App

CGL have developed an App that is available to download via Google Play and the Apple App Store. This App provides mindfulness, urge surfing, getting active, activity diary and staying aware advice and is available for anyone to access. Someone currently not engaged with CGL could use the App initially and then if they feel they would like to engage with CGL can then find the service local to them and contact CGL. Details of the App have been shared extensively across the city with key partners and stakeholders through various channels.

Illegal Drug Shortages, Purity & Increased use of NPS

There has been an increase in the use of NPS by the Homeless/Rough Sleeping Community due to supply chain issues regarding the supply of heroin. Dr Prun Bijral (Medical Director at CGL) is part of a National PHE working group looking at purity & supply, therefore if there is tangible evidence a Formal Drug Alert will be sent to the Professional Information Network (PIN) immediately.

Drug Alerts & Fortnightly Coronavirus Drug Alert

CGL send out an informal Drug Alert fortnightly to the Professional Information Network (PIN) along with harm reduction advice and advising our partners that CGL are still open for business albeit in a different way. Commissioners liaise with CGL regarding including any emerging intelligence on street drug purity.

Mutual Aid Groups

Government Guidance on Mutual Aid Groups meetings has been shared with all 3 mutual aid groups (Narcotics, cocaine and Alcoholics Anonymous). They all continue to deliver online groups which are well attended and AA have advised that a few groups have gone back to 'live' meetings in full cooperation with the venue hirers – predominantly churches. At present CGL are not hosting groups within the 4 Hubs due to social distancing.

Cost Pressures

Commissioners are finalising CGL's cost pressures which are twofold; for additional costs incurred by their Community Service and for the period when Park House was closed. When these costs are confirmed they will be included in a Major Incident Decision Report which will be shared with the Public Health Contracts Board prior to briefing Cllr Hamilton and submitting to the BCC Strategic Cell.

To summarise, throughout COVID whilst the way in which the CGL Service is delivered has changed with fewer face to face appointments, Birmingham residents have still been able to be referred into CGL in order to commence treatment as well as:

- Visit Locality Hubs in order to receive Opioid Medication Assisted Treatment
- Attend welcome meetings and recovery groups via Skype
- Be in regular contact with their Recovery Co-ordinator
- Have face to face appointments when required
- Access the CGL phone App
- Receive inpatient detox (from mid-August)
- Access Medication Assisted Treatment
- Access Treatment for BBV's
- Undertake home detox

It should also be noted that throughout COVID BCC have continued to pay CGL as normal with no reductions to their funding.

Post Wave 1 Delivery

Commissioners have been working with CGL in terms of their Recovery Planning in terms of: Increasing face to face attendances at locality hubs

- Re-instating face to face Recovery Groups
- Re-opening Locality Hubs
- Re-instating face to face mutual aid groups at Locality Hubs
- Increasing the digital offer
- Working with Delivery Partners face to face
- Re-introducing face to face staff training sessions

Additional impacts of COVID

The current CGL contract ends on the 28th February 2022 and re-procurement timelines have been impacted by COVID. There has been a delay in commencing the public consultation on the draft substance misuse strategy for the period post February 2022 which in turn has impacted on the re-procurement timeline which means that the constituent re-procurement tasks cannot be completed within the original designated timeframe. As a result, Commissioners and the Director of Public Health are finalising the costs of extending the current CGL contract for an additional year up until February

2023 which when completed will be presented to Councillor Hamilton as the Cabinet Member for Health and Social Care before going through the required BCC governance process.

Update on Health Checks and Smoking Cessation – Birmingham Health and Wellbeing Board.

This report summarises progress of Health Checks and Smoking Cessation, pre, during and post COVID-19. As a Health and Wellbeing board we are keen to mitigate against disproportional risk of Covid-19 who access these services.

During March 2020 the Government and PHE detailed a number of services that should continue delivery and those that should stopped. This report highlights the delivery model prior to COVID, the changes that occurred due to COVID and what actions are being taken post wave 1 of COVID.

The following have contributed to the content of this report:

- Birmingham City Council Public Health
    - Adults and Older People Service Lead
    - Assistant Director Population and Protection

NHS Health Checks

Introduction

Cardiovascular disease (CVD) affects the lives of around 7 million people in United Kingdom (UK) and is a significant cause of disability and death, affecting individuals, families and communities, with 26% of all deaths being related to CVD. It is one of the leading causes of premature death in Birmingham and accounts for approximately 24.4% of mortalities for Birmingham residents (ref: 20016 VS3 tables) and 21.2% of deaths under the age of 75 years (this compares to 27.75% nationally). The burden of CVD falls disproportionately on people living in deprived circumstances and on particular ethnic groups, such as South Asians.

Consequently, CVD accounts for the largest part of the health inequalities in our society. Therefore, prevention, early identification and management of CVD remains a key strategic priority for Birmingham City Council Public Health.

CVD conditions, namely coronary heart disease (CHD), stroke, diabetes and chronic kidney disease (CKD), share a number of common modifiable risk factors. Obesity, sedentary lifestyle, smoking, high blood pressure, high cholesterol and impaired glucose regulation all increase an individual's risk of developing CVD. The UK National Screening Committee has provided evidence demonstrating that it is possible to identify CVD risk factors and act to change them. The 'Putting Prevention First' strategy document proposes that early intervention to reduce risk will prevent, delay and in some circumstances reverse the onset of vascular disease. In April 2009, the Department of Health (DH) introduced the NHS Health Check programme, requiring Public Health to implement systematic reviews of its aged 40-74 years population (excluding those already on a CVD register, on a statin, have an actual CVD Qrisk score of 20% and above or have had a previous NHS Health Check within the last 5 years). NHS Health Checks are one of the key mandated Public Health services commissioned by the Local Authority as defined in the Birmingham City Council Public Health Outcomes Framework.

During the response to COVID, the government identified that individuals with certain underlying conditions are at high risk of suffering adverse effects of COVID if they are infected especially those who are of older age. The Health Check Programme acts as a preventative initiative to ensure the key conditions identified by the government such as CHD, Diabetes, Obesity, High Blood Pressure are reduced and caught early, promoting individual to make lifestyle choices to be able to lead a healthy life.

Local Provision and Pre COVID-Performance

The provision of Health Checks is currently delivered via a Primary Care GP model and is delivered by every GP Practice within the Birmingham Boundary. This is a 5-year programme and the national benchmark over the 5 years is to invite 20% of the 5 year eligible cohort every year for health checks and to screen at least 50% of those invited. By using this approach, it would be anticipated that over the 5 years everyone eligible would have been invited for a health check and at least 50% of those eligible over the 5 years would have been screened. The programme is available to all adults between the age of 40 and 74 who do not already have any underlying CVD condition and are not part of a disease register where they would be screened annually anyway. An eligible patient is entitled to one free health check every 5 years.

The current 5-year Health Check programme started on 1st April 2018 and the performance to date is as follows:

	2018/19	2019/20	2020/21 (Q1)	Total Programme to Date
Invite Target	54,631	53,715	13,436	121,782
Invite Actual	81,970	68,619	1,193	151,782
Over/(Under) Acheivement	**27,339**	**14,904**	**(12,243)**	**30,000**
Completed Target	27,315	26,858	6,718	60,891
Completed Actual	33,408	28,286	559	62,253
Over/(Under) Acheivement	**6,093**	**1,428**	**(6,159)**	**1,362**

The 2020/21 (Q1) figure shown on the table as a big underperformance relates to the period April 2020 to June 2021, when it was advised by Government and PHE that Health Checks were to stop activity, until further advised. Given this advice Birmingham Public Health did not ask GP Practices to stop activity altogether, however instead requested them to decide on their own merit f they wished to continue delivery using their own devised safe methods or whether to stop. We advised all GP practices that they would not be penalised for low performance as the programme was a 5-year programme and there will be the ability to ramp up activity post Covid to ensure benchmark targets are met by March 2023.

During Covid Delivery and Payments

Given the government advise, some GP chose to continue to deliver health checks using new socially distanced methods and where there was the ability providing blood tests at home or in specially organised clinics within their practice for their registered patients only. Hence why during quarter 1 there was some minimal activity with the delivery of health checks. Birmingham Public Health have been having conversation with some of these practices t gather information on the methods of delivery to be able to devise a good practice guide to GPs to be able to restart delivery once their doors open to patients again and also if we were to face further lockdowns due to a potential wave 2.

The Local Medical Committee who represent the GPs in Birmingham, enquired whether payment would continue under the Provider Relief Notice by Cabinet Office (PPN 02/20). The Public Health Service Lead review the situation with neighbouring Local Authorities, where the response was very mixed where some authorities were not paying their providers anything for no delivery, some were paying average performance amounts for Quarter 1 allowing providers to keep the funds and some were making payments with the provision that targets will be increased with fund being clawed back at a later date. Given all of the evidence, a fair approach was used where an average payment for Quarter 1 was agreed for all GP Practices with a clawback of 75% of the payment with effect from January 2021 over 4 quarterly period. This would allow GP practices to retain 25% of the payment as goodwill and also push them to deliver more health checks when they restart them to ensure the clawback has a minimal impact on them in the future. The relationship with GP practices has taken many years to develop and it has taken hard work to ensure targets have been over achieved each year and by allowing them to retain a small sum would mean that they would remain engaged with Birmingham Public Health and the restart would be much easier.

17 GP practices decided not to take up this offer either by not returning their variation for additional payment and clawback for qtr 1 or simply confirming they did not want the payment. A new Cabinet Office briefing for Supplier Relief was issue for Quarter 2 PPN 04/20, which indicates a similar

approach to that of PPN 02/20. Currently Birmingham Public Health are in the process of collating variation responses for quarter two where the offer is a choice for GPs to not be paid in Quarter 2 or accept payment and clawback on the same basis as quarter 1.

Post Wave 1 Delivery

The government and NHS have provided guidance to all GPs and CCG to promote the start up of prevention interventions and medical interventions as normally as possible from 1st September 2020. GPs have been requested to open their doors to patients rather than continue to operate on a closed door basis. They have also been requested to upscale Prevention type interventions as quickly as possible to avoid more people falling ill due to COVID if Wave 2 is to strike.

Birmingham Public Health has circulated this information to all GP practices and is continuing to provide restart messages on an ongoing basis. We have also worked with the CCG and CSU to ensure the data for 2020/21 is readily available for GP Practices to access to be able to start sending invites out to patients to be able to book appointments post 1st September. Birmingham Public health is also working closely with a number of GP practices to develop good practice to share wider about alternative ways that Health Checks can be delivered more pro-actively and innovatively.

It is also hoped that post COVID, that activity could be ramped up at scales via GP Practices to make up for underperformance so that overall performance for the 5 year programme is met or over achieved, along with the 50% of the cohort having a Health Check to decrease inequalities, resulting in individuals leading more healthier lives, through better food nutrition, active lifestyles, better mental health, etc.

Smoking Cessation

Introduction

Smoking remains the single greatest cause of preventable illness and premature death in the UK. One in two smokers dies prematurely from smoking-related diseases, on average losing 10 years of life. Every year over 4,500 people in Birmingham die from a smoking related disease. Smoking is directly linked with Birmingham's three biggest killers and is attributable to:

- 1 in 4 of all cancers
- 1 in 5 of all deaths from CVD
- 1 in 3 of all deaths from respiratory disease

There are approximately 120,310 adults over 16 years old who smoke in Birmingham 13.7% of the adult population. National survey data shows that the smoking rates in Birmingham are similar to the England average at 14.9%, although rates are much higher in some areas. Tobacco use is one of the most significant causes of health inequalities and there is a strong link between cigarette smoking and socio-economic groups. Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. Smoking accounts for over half of the difference in risk of premature death between social classes.

Stopping smoking is considered one of the single most effective methods for improving health and preventing illness. National surveys report that around 67% of smokers want to quit. Evidence-based NHS Stop Smoking Services are well established and considered both cost and clinically effective.

NHS Stop Smoking Services offer support to help people quit smoking. This can include intensive support through group therapy or individual one-to-one support. Such services are expected to be widely accessible within the local community and provided by trained advisors.

The National average quit rate at 4-weeks for clients accessing Stop Smoking Services is 45%, although certain population groups (e.g. under 30-year olds; routine and manual workers and pregnant smokers) have lower rates of abstinence.

The core elements of the service are the provision of behavioural support and pharmacotherapy. The service aims to maximize the number of smokers accessing the service and quitting long-term, therefore contributing to the reduction of smoking prevalence in Birmingham. To work most effectively, it will be necessary for the service to focus on specific segments of the population, increasing access from priority groups where smoking prevalence is highest (i.e., routine and manual (R/M) occupational groups, deprived communities, young people and pregnant smokers).

The objectives of the stop smoking service will be to:

- Provide equitable access to all smokers
- Offer the most effective, evidence-based treatments available
- Support people to successfully quit smoking
- Achieve high levels of client satisfaction

Local Provision and Pre COVID-Performance

The local Smoking Cessation Service is primarily provided to individual's via a primary care model via GPs and Pharmacies. There is also one Vape Shop who delivers the service who are IBVTA registered as per PHE guidance. The programme is either based on a 4 week or 12-week basis which consists of fortnightly behavioural support and the provision of Nicotine Replacement Therapy along with the offer of e-Cigarettes. The offer is available to individuals over the age of 12 and anyone who lives, works and studies in Birmingham. The service was delivered by approximately 180 providers equitably throughout Birmingham Via GP Practices and Pharmacies.

The service is not one that is mandated by government, but is a priority for NHS and Local Authority. The vision to reduce smoking prevalence national is a key message which comes out of the NHS 10 year plan and given this vision the number of providers offering smoking cessation has increased by at least 50% over the last 1.5 years.

Due to more people wanting to quit due to health messages being marketed the number of quits have been consistently going up in the pharmacy setting and below is a summary of performance comparisons from one year to another:

	2018/19	2019/20	2019/20 Q1	2020/21 (Q1)
4 wk Quit (GP)	1067	989	232	170
12 wk Quit (GP)	547	543	146	107
4 wk Quit (Pharmacy)	1094	1269	283	157
12 wk Quit (Pharmacy)	475	485	124	112

As shown in the table above the performance from 2018/19 to 2019/20 for GP was slightly less but classed as consistent and for pharmacies there was a clear increase in activity especially 4 week quits. If we look at the Qtr 1 Comparison for Qtr 1 this year when COVID Hit to last year Quarter 1, performance has decreased but not as much as was anticipated at 50%. It seems individual have continued to access smoking cessation service to attempt their quit due to the adverse effects of COVID on smokers. In addition, GPs have maintain a good proportion of their activity.

During Covid Delivery and Payments

The government advise around the delivery of Smoking Cessation during the COVID Outbreak (Wave 1) was to continue delivering the service at some level. Given that GP practices closed their doors to patient, they continued to deliver smoking cessation through a telephone consultation model with NRT provided via an electronic FP10 prescription sent to the pharmacy of their choice or a voucher provided via collection or post. There were however issues with paper vouchers as Pharmacies did not want to handle paper vouchers due to infection spread, so a resolution was sought where vouchers could be provided electronically to overcome this issue.

Pharmacies continued to deliver Smoking Cessation in a socially distanced manor or over telephone consultation however there was an impact on slightly reduced delivery due to GPs closing their doors and patients diverting their support requirements to Pharmacies, which was resource intensive and limiting time for the provision of smoking cessation services.

What supported the deliver was the governments launch of the #QuitforCovid campaign, which was pushing smokers to quit from smoking to ensure they have a positive outcome if they caught COVID,

as smokers have compromised lungs and are likely to suffer much worse effects of COVID. The foresaw a demand in the service and it was decided to implement the use of AI and the Quit with Bella app provided and commissioned via Solutions for Health was implemented to provide a service delivery model with minimal touch points and electronic delivery of NRT and eCigarettes. This has initially proved successful and at the forefront of technology and is a app which Solutions 4 Health further developed and tailormade for Birmingham and if evaluations demonstrate the success seen to date then it is likely that this would be embedded in the current service delivery model. The AI App has the benefit of supporting the brief intervention delivery 24/7 supporting pharmacies and GPs. The app has also been developed as a stand alone stop smoking service where a user can use this app solely to attempt their quit and the NRT and eCigs are sent electronically via a pharmacy system to be dispensed for the patient to pick up so again minimal touch point. This makes the smoking cessation service COVID Wave 2 ready.

In addition to this one of the GP Clinical systems is being adapted to be able to deliver electronic NRT vouchers directly to pharmacies via their dispensing system further reducing touch points and increasing infection control.

As described in the section for Health Checks and the supplier relief note PPN 02/20, it was agreed to pay Pharmacies the average quarter quit payments as a good will for continuing to deliver the service at pace during the pandemic outbreak and the basis of payment was they would either get paid the average quarters activity or actual activity, whichever is higher. It was decided not to pay anything around relief payments to GPs for smoking as they were already getting paid for Health Checks. As a result of the PPN 04/20 relief note, it was agreed through a general consensus by the Local Pharmacy Committee that pharmacies did not require any payment for Quarter 2 and Birmingham Public Health had advised that the payment for quarter 2 would be classed as a payment in advance and all funds paid for quarter 2 would be reclaimed back from future activity payments.

Post Wave 1 Delivery

It is anticipated that activity will continue to rise now that GPs will start to increase their services from 1st September 2020 and that Pharmacies have now got more capacity to continue to deliver services. #QuitforCovid will still continue to be provided and a push for service delivery will be made especially with the campaigns around Stoptober. Birmingham Public Health are also working with a wider range of partners to embed smoking cessation as part of their standard offer which will also enhance the number of individuals quitting within Birmingham.

The Quit with Bella app will be further pushed and it is hoped that this will become the first point of access for anybody through regular communications around the use of the app and promoting citizens who use to download it if they have a smart phone. It is anticipated that all NRT provision will become electronic voucher based so there is no handling of vouchers and individuals can more easily access their pharmacotherapy in the future.

If there is likely to be a Wave 2 of COVID then it is anticipated that the smoking cessation offer is COVID ready to mitigate access to services being limited and that the embedding of some of the interventions during Wave 1 will become part of mainstream delivery post COVID.

Tobacco control strategy including CLeaR assessment

CLeaR tobacco control assessment - This deep dive assessment was conducted in March 2020 and comprised of several influential stakeholders from Birmingham and Solihull CCG. The event was

evidence focused and addressed current challenges, leadership and goals whilst looking at strengths and opportunities to redress smoking related inequalities.

The key findings were:

- The stakeholders agreed that the compliance and enforcement as well as cessation was generally good, however there was scope for development
- Redressing the imbalance of inequalities amongst socio-economic groups
- Target interventions required in hot spot areas of where there's high smoking prevalence
- Review commissioning and planning of service delivery models
- Collaborative work required to achieve shared vision
- Publicity and communications required to achieve outcomes.

A Tobacco Control Alliance Group will be set up with key multi-agency partners to co-design and facilitate the tobacco control strategy and provide strategic guidance whilst focusing on three key objectives as follows:

- Reduce uptake of smoking
- More smokers quitting
- Protection for all from second-hand smoke

Whist smoking effects the wider population, we will focus on three priority groups whereby smoking related inequalities is greatest:

- Children and young people (12 years plus)
- Pregnant women and family members who smoke
- People who are marginalised (i.e. routine and manual workers, BAME communities, low socio-economic groups, etc.)

In light of the COVID pandemic this task has been put on hold and we hope to resume in Autumn 2020 and there will need to be involvement from Environmental Health, whose resources are currently exhausted with responding to the Pandemic.

Business and Planning Act 2020: Temporary Pavement Licence

The temporary pavement licence process introduced a streamlined and a cheaper consent route allows businesses to obtain a licence to place removable furniture on the highway, such as tables and chairs outside of cafes, bars and restaurants. Fees are capped at maximum £100 with consultation, consideration and determination period of 10 working days (excluding public holidays) as opposed to the conventional method of 28 working days.

This bill came into effect on 27th July 2020 in response to social distancing measures and to reduce risks of COVID transmission whilst ensuring safe provisions are in place relating to the promotion of economic recovery and growth.

The bill sets out two conditions which apply to pavement licenses which are either granted or deemed to be granted: a no-obstruction condition and a smoke-free seating condition.

The new licence lasts for 12 months and until the 30th September 2021, at which point the new licensing scheme will end, and businesses will have to apply for an old type Part VII Highways Act

1980 licence if they wish to continue having a pavement café area. Enforcement of this is also the responsibility of Environmental Health and there could be an opportunity here to market the smoking cessation service in Birmingham.

Sexual Health

Introduction

Sexual health is an important area of public health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations. Sexual health is not equally distributed within the population. Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, teenagers, young adults and black and minority ethnic groups. Similarly, HIV infection in the UK disproportionately affects MSM and Black African populations. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

Local Provision

Local authorities are mandated to commission comprehensive open access sexual health services, including free STI testing and treatment, notification of sexual partners of infected persons and advice on, and reasonable access to, a broad range of contraception; and advice on preventing unplanned pregnancy

In Birmingham the Sexual Health service has been delivered by Umbrella, led by University Hospitals Birmingham NHS Foundation Trust (UHB), since August 2015. The contract has recently been extended for a further 2 years until August 2022 with a yearly contract value of £14,038,586.90.

During COVID Delivery & Payments

Throughout COVID Public Health Commissioners have been in regular contact with Public Health Service Leads and Service Providers in order to receive Business Continuity Plans and subsequent updates, Operational Updates/Positions and details of any newly identified risks. In conjunction with this, UHB's Operational Team comprising of Umbrella Senior management meet daily and any risks/issues are be communicated to Commissioners. The Public Health Contracts Board initially met weekly and now bi-weekly in order to be briefed on the operational status of all Public Health Contracts and a bi-weekly contracts update detailing these statuses is produced and circulated to Cllr Hamilton and key partners.

The Birmingham Umbrella Sexual Health service has continued to operate throughout COVID and Birmingham citizens have still been able to access the service since 24th March albeit in a different way and without major disruption.
The biggest impact of COVID was the initial need to reduce face to face interaction with patients as during the initial stages of the pandemic Umbrella were forced to cease all clinical visits. To mitigate against the issue of restrictions to the "open access" Service Umbrella were still able be contacted via telephone and were then able to triage patients, signpost and if required offer a telephone/video consultation.

The Umbrella website https://umbrellahealth.co.uk/ is continually updated and details how and where services can be accessed as well as offering Coronavirus information for patients.

The number of telephone calls taken by Umbrella during COVID is detailed below:

Month	Total Telephone Calls	Number of Patients Signposted	No. of patients receiving a Telephone Consultation
July 2020	8,163	4,264	3,899
June 2020	6,064	3,994	2,070
May 2020	3,786	2,698	1,088
April 2020	2,416	1,567	849
Total	**20,429**	**12,523**	**7,906**

Since April telephone calls have increased by approx. 238%, signposting by 170% and telephone consultations undertaken by 360%. The vast increase in telephone activity and telephone consultations is encouraging and Commissioners expect to see further increases in August's figures which will be available the 18th August.

As well as offering telephone consultations, where appropriate Umbrella have also been offering video consultations and approx. 150 patients monthly have been utilising this service.

A postal medication service has also been introduced and offered during COVID and there has been a consistent increase in the dispensing of postal medications which negates the need for a face to face visit to a Clinic or Pharmacy.

SH Medications Issued	RSH	GUM
July 2020	144	130
June 2020	98	94
May 2020	82	76
April 2020	32	101
Total	**356**	**401**

RSH – Reproductive Sexual Health; Contraception
GUM - Genitourinary Medicine; predominantly sexually transmitted infections (STI's) and HIV testing

From the 4th May Umbrella re-opened their Complex Clinic at Whittall Street which continues to offer referral-based face to face appointments for complex procedures such as difficulties in removing a coil and the need for a scan/removal by a consultant.

Whittall Street Face to Face Appointments	GUM	RSH	INT	Total
July 2020	754	196	54	1,004
June 2020	507	377	264	1,148
May 2020	436	248	199	883
Total	**1,697**	**821**	**517**	**3,035**

Face to face activity saw a slight decrease in July when compared to June, this can be attributed to Whittall Street only being able to see a set number of patients per day due to social distancing guidance, therefore if patients do not attend an appointment, they are unable to see walk-in patients.

From the 11th May Umbrella re-opened their General Procedures Clinic at Boots (High Street, City Centre) in order to offer referral-based face to face appointments for uncomplicated long acting reversible contraception (LARC) and subdermal contraceptive implants (SDI's):

Boots City Centre Face to Face Appointments	GUM	RSH	INT	Total
July 2020	14	161	3	178
June 2020	1	206	0	207
May 2020	0	139	2	141
Total	**15**	**506**	**5**	**526**

Face to face activity saw a slight decrease in July when compared to June, this can be attributed to Boots only being able to see a set number of patients per day due to social distancing guidance, therefore if patients do not attend an appointment, they are unable to see walk-in patients.

The re-opening of clinics has meant that Umbrella have been able to fit long acting reversible contraception (LARC) throughout COVID:

Umbrella Clinic LARC Fitting:

Month	Coil Fittings	Coil Removals	SDI Fittings	SDI Removals
July 2020	120	82	127	140
June 2020	111	38	123	142
May 2020	61	31	51	82
Total	**292**	**151**	**301**	**364**

The increase in LARC activity during July is encouraging when compared to May and Commissioners expect to see a further increase in August's activity.

The number of LARC fittings by GP's has also been gradually increasing, following a drop off in April and May due to the Royal College of General Practice advising that the fitting of LARC was on a non-essential service. However, figures for June show a marked increase in activity (June data is the latest available as GP data is produced 2 months in arrears)

Month	Coil Fittings	SDI Fittings
June 2020	141	106
May 2020	65	29
April 2020	13	6
Total	**219**	**141**

The vast increase in GP LARC activity during June is positive and Commissioners expect to see a further increase in July's activity

Pharmacies have also played a key role in delivering elements of the Umbrella Service during lockdown in terms of providing free condoms, emergency hormonal contraception (morning after pill), chlamydia treatment, contraceptive pill, contraceptive injections, continuation of hepatitis B vaccine injections started at an Umbrella clinic and acting as a collection point for STI self-sampling kits

ordered online. Total Pharmacy activity in June was 3,276 - an increase of 62% compared to May and 96% compared to April and 33% lower when compared to June 2019. However, June's figure is a marked improvement compared to May (2,028) and April (1,676) and is expected to increase further in July. As with GP data, June data is the latest available as Pharmacy data is produced 2 months in arrears.

In terms of re-opening complex sexual health clinics within Birmingham, offering video triage/consultations and dispensing medications by post, the Umbrella service has been leading the way nationally in terms of best practice which has been recognised by the Faculty of Sexual and Reproductive Healthcare (FSRH).

The ability for all Birmingham and Solihull to request STI Home testing kits via telephone or the Umbrella website has been a feature of the Umbrella since its commencement in 2015 and throughout COVID this service has still been available.

Month	**STI Kits Issued**
July 2020	5,742
June 2020	4,406
May 2020	3,448
April 2020	2,818
Total	**16,414**

The marked increase in the number of kits issued confirms that people are aware that STI Kits can still be ordered by phone or online and the July figure of 5,742 is in line with pre-COVID figures.

To summarise, throughout COVID whilst the way in which the Umbrella Service is delivered has changed with fewer face to face appointments, Birmingham and Solihull residents have still been able to:

- Receive telephone triage and if required telephone and video consultations
- Have face to face appointments when required
- Have long acting reversible contraception fitted
- Order STI testing kits to be delivered to their home address
- Order medication over the telephone and have it delivered to their home address
- Access Pharmacies for services which includes; free condoms, emergency hormonal contraception (morning after pill), contraceptive pill and contraceptive injections

It should also be noted that throughout COVID BCC and SMBC have continued to pay Umbrella as normal with no reductions to their funding.

Post Wave 1 Delivery

As of 10th September 2020, Umbrella envisage having all Sexual Health clinics re-opened by the end of September, seeing a set number of pre-booked patients per day due to social distancing guidance.

Commissioners have also been working with Umbrella in terms of their Recovery Planning in terms of restarting practices that have been reduced due to COVID such as:

- Increasing face to face attendances and appointments clinics
- Re-instating walk-in appointments

- Extending clinic opening hours
- Working with Delivery Partners face to face
- Re-introducing face to face staff training sessions
- Training teams being able to attend partner training

Commissioners have also been working with Umbrella in terms of amplifying new practices that have worked well during COVID such as:

- Maintaining a measure of reduction in walk-in patients through other access mechanisms to the service.
- Increasing Video consultations
- Telephone consultation process for streamlining patients
- Increasing engagement with key partners
- Increasing Postal medication and prescriptions
- Increasing condoms by post
- Increasing STI kit distribution
- Increasing support for victims of domestic violence
- Integrate Independent Sexual Violence Advisors (ISVAs) presence with Umbrella clinics

Longer term impact of COVID on Re-procurement

The current Umbrella contract ends on the 9th August 2022 and Commissioners, Public Health and key partners are meeting regularly to discuss what the service model will look like as well as initiating a Needs Assessment. Initial indications show that currently COVID will not impact on the re-procurement timeline, this is due to there being capacity within the existing timeframe of 2 years to complete the constituent re-procurement tasks and the process is less complex than Substance Misuse in terms of Public Consultation.

The timeline is being monitored regularly and if this position does change due to increased COVID pressures it will be raised firstly with the Public Health Contracts Board followed by the Director of Public Health and Councillor Hamilton as the Cabinet Member for Health and Social Care

Substance Misuse

Introduction

The provision of adult drug and alcohol treatment services is defined as one of the "grant conditions" as part of the Public Health Grant. Spending the grant, a local authority has to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services".

Substance misuse treatment has been evaluated by researchers on a wide range of measures, including: drug use; abstinence from drug use; drug injecting; overdose rates; health and mortality; crime; social functioning, including employment; housing; family relations, and the perceptions of service users about their recovery status. The breadth of these measures reflects the broad range of benefits anticipated from providing effective substance misuse treatment.

The demand on the substance misuse service continues to increase with regards to the prevalence of misuse of illicit drugs that include heroin, cocaine and novel psychoactive substances (NPS) and from alcohol. The complexity of service user presentations also continues to increase citywide.

Local Provision

The current drug and alcohol treatment and recovery provision in Birmingham is delivered by the third sector organisation 'Change Grow Live' (CGL). They were awarded a 5-year contract for the period 1st March 2015 – 28th February 2020 and BCC have exercised the option to extend the contract for a further two years from March 2020 to February 2022 with a yearly contract value of £14,190,609.00

A 'recovery' approach has been taken regarding the treatment for Birmingham citizens experiencing the harms associated with drug and alcohol misuse. This currently involves the treatment and care of approximately 7000 service users.

To support the recovery focused delivery model CGL provide service users with the necessary advice and support delivered via a 5-tier model which responds to differing levels of case complexity. The tiers include:

Tier 1: Advice & Information; including signposting to other services which include advocacy and mutual aid.
Tier 2: Non-dependent drug and alcohol use – Group / 1:1 work up to 12 weeks
Tier 3: Dependent alcohol use, opiate use, heavy crack cocaine/synthetic cannabinoids etc. – Group/1:1 work, longer term, structured support
Tier 4: In-patient specialist unit (Park House in Hockley) which delivers detoxification and stabilisation
Tier 5: Aftercare provision – Group/1:1 work

During COVID Delivery & Payments

Throughout COVID Public Health Commissioners have been in regular contact with Public Health Service Leads and Service Providers in order to receive Business Continuity Plans and subsequent updates, Operational Updates/Positions and details of any newly identified risks. In conjunction with this, CGL hold a daily Bronze Local meeting, a Silver meeting with Regional Directors and a Gold National meeting with the CGL Executive Management Team and the Board of Directors. CGL also have a Consultant permanently on call if required.

The Public Health Contracts Board initially met weekly and now bi-weekly in order to be briefed on the operational status of all Public Health Contracts and a bi-weekly contracts update detailing these statuses is produced and circulated to Cllr Hamilton and key partners.

The CGL website https://www.changegrowlive.org/drug-and-alcohol-service-birmingham is continually updated and details how and where services can be accessed as well as offering Coronavirus information for service users.

CGL have developed a Service Delivery Roadmap which details the 5 COVID phases and the services/method of delivery that will be offered during each phase.

CGL Bham Road Map Final.docx

The Birmingham CGL Substance Misuse service has continued to operate throughout COVID and Birmingham citizens have still been able to access the service since 24th March albeit in a different way and without major disruption. The biggest impact of COVID was the need to reduce face to face interaction with service users, changes to the service are detailed below.

Locality Hubs

Prior to COVID four CGL locality hubs provided accessible and welcoming spaces for service users designed to develop the tackling substance misuse/prevention agenda within local communities. There are multi-disciplinary teams based at each of the four hubs, with a wide range of expertise that includes; Doctors, Nurses, Recovery Co-ordinators and Outreach Workers.
Throughout COVID all 4 Locality Hubs (North, South, East, Central & West) have remained open 9am – 5pm with a critical staffing level of 1 Team Leader and 4 Frontline staff working at each Hub as well as a Consultant on call. Only the most vulnerable service users (both new starts and restarts) are being seen at a Locality Hub. This only applies to service users who must provide a urine test in order to receive Opioid Medication Assisted Treatment – specifically Physeptone (Methadone) and Espranor. New starts and restarts for service users who will be prescribed Buprenorphine can be done remotely without the need for the service user to visit a Locality Hub. CGL are looking at staff rotas and individual risk assessments with a view to having more and a greater variety of staff within Hubs, such as nursing staff and recovery co-ordinators.

Contact with Service Users and Utilising Technology

Throughout COVID CGL have been in regular contact with all service users via telephone, face to face in locality hubs where necessary and by utilising technology wherever possible to meet virtually. CGL have segmented their entire caseload and identified the levels of risk for each service user and Recovery Co-ordinators are contacting higher risk service users twice weekly by telephone and lower risk service users fortnightly by telephone.

CGL are holding Service User Welcome meetings via Skype, CGL Partners (DATUS, KIKIT & Intuitive Recovery) are delivering SMART Recovery Groups for Phase 2 (Non-dependent drug and alcohol) services users utilising Skype & Zoom. CGL run virtual groups for Phase 3 service users (Dependent opiate use, heavy crack cocaine/synthetic cannabinoids use and Alcohol dependant) and a day programme for Phase 5 service users (Aftercare Provision).

New Referrals to Service

Throughout COVID the CGL service has been open and accessible to all Birmingham citizens, cumulatively from 23rd March there have been 1,341 new treatment starts; 807 opiate and 534 alcohol.

Service Capacity

As CGL have started 1,341 new service users since 23rd March they are mapping the amount of new starts pre COVID-19 to starts during COVID-19 in order to map any potential impacts on service capacity. Currently there is capacity due to minimal referrals being received from GP's and Hospitals.

Medication Assisted Treatment (MAT)

During the initial lockdown phase of COVID all service users on supervised consumption were moved to unsupervised and provided with 2 weeks take home supply. This was to reduce the pressure on Pharmacies following discussions with the Local Pharmaceutical Committee (LPC) and to ensure that 2,750 service users were still able to receive Opioid Medication Assisted Treatment required to manage their medical condition. To support this approach CGL hand delivered prescriptions (to avoid postal delays) to all Pharmacies, delivered opiate substitute medication to all service users self-isolating, if a service user was self-isolating and had no appointed person to collect their MAT CGL delivered the medication to the service user directly and ensured that where needed all service users received a safe storage box for their medication as well as Naloxone.
CGL continue to case manage the prescribing arrangements of the MAT cohort of 2,750 service users on a daily basis based on levels of risks (1-4 High Risk, 5-8 Medium Risk and 8+ Low Risk) with all service users categorised 1-9. CGL monitor those who present the highest risk which predominantly is the homeless cohort.

Homeless Housing Provision at the Holiday Inn

Whilst the Holiday Inn was being used to house rough sleepers the CGL Lead Nurse & CGL Safeguarding and Quality Lead delivered training for Support Workers in the hotels/hostels which covered the use of Nasal Naloxone, the use of MAT, Alcohol Dependent & Treatment Response Plans and the new ways of working based on social distancing guidelines.
Support Workers within the Holiday Inn were given burner phones in order for service users to be able to contact CGL on a SPOC number.

Inpatient Detox at Park House (Hockley)

The CGL inpatient detox facility was closed due to COVID in mid-March 2020. Park House re-opened on 17.08.2020 to provide a 2-week in-patient detox for drugs and alcohol, the initial intake on 17.08.2020 was 6 service users (usually 18) and the reduced capacity is to enable patients to adhere to social distancing guidance. The re-opening of Park House on 17th August went smoothly and the initial intake of 6 in-patients all respected social distancing guidance. CGL are looking to gradually increase the fortnightly intake up to 8 and then 10 inpatients whilst still adhering to social distancing guidance.

Home Detox for Alcohol

During lockdown CGL have successfully completed 81 alcohol home detox's which have only been offered to service users when it is completely safe to do so. CGL's Lead Nurse is completing a paper

on the approach taken home detox by CGL with a view to adopting the same approach for home detox for opiates.

Hepatitis C Postal Testing & BBV Pathway

CGL launched their new BBV Pathway on 6th August. This includes a new self-test postal option which involves Change Grow Live staff sending out a DBST (Hep C & HIV) to the home of the individual who has agreed to complete the self-test. A range of supporting documents have been developed to support the new process including a 'How To' video, written guidance for staff and service users and step by step implementation guides.

Veterans Group

CGL have worked in partnership with BCC and the British Legion and have started a Veteran's group with the first meeting of the group taking place on Wednesday 12th August. It will initially be run by the CGL Lead Nurse and Quality Audit Governance Manager both of whom are veterans. The idea of the group is that service users will be with people who have a shared experience and will be supported to access a range of services that help those from a forces background in addition to treatment focused groups.

CGL Staying Free Telephone App

CGL have developed an App that is available to download via Google Play and the Apple App Store. This App provides mindfulness, urge surfing, getting active, activity diary and staying aware advice and is available for anyone to access. Someone currently not engaged with CGL could use the App initially and then if they feel they would like to engage with CGL can then find the service local to them and contact CGL. Details of the App have been shared extensively across the city with key partners and stakeholders through various channels.

Illegal Drug Shortages, Purity & Increased use of NPS

There has been an increase in the use of NPS by the Homeless/Rough Sleeping Community due to supply chain issues regarding the supply of heroin. Dr Prun Bijral (Medical Director at CGL) is part of a National PHE working group looking at purity & supply, therefore if there is tangible evidence a Formal Drug Alert will be sent to the Professional Information Network (PIN) immediately.

Drug Alerts & Fortnightly Coronavirus Drug Alert

CGL send out an informal Drug Alert fortnightly to the Professional Information Network (PIN) along with harm reduction advice and advising our partners that CGL are still open for business albeit in a different way. Commissioners liaise with CGL regarding including any emerging intelligence on street drug purity.

Mutual Aid Groups

Government Guidance on Mutual Aid Groups meetings has been shared with all 3 mutual aid groups (Narcotics, cocaine and Alcoholics Anonymous). They all continue to deliver online groups which are well attended and AA have advised that a few groups have gone back to 'live' meetings in full cooperation with the venue hirers – predominantly churches. At present CGL are not hosting groups within the 4 Hubs due to social distancing.

Cost Pressures

Commissioners are finalising CGL's cost pressures which are twofold; for additional costs incurred by their Community Service and for the period when Park House was closed. When these costs are confirmed they will be included in a Major Incident Decision Report which will be shared with the Public Health Contracts Board prior to briefing Cllr Hamilton and submitting to the BCC Strategic Cell.

To summarise, throughout COVID whilst the way in which the CGL Service is delivered has changed with fewer face to face appointments, Birmingham residents have still been able to be referred into CGL in order to commence treatment as well as:

- Visit Locality Hubs in order to receive Opioid Medication Assisted Treatment
- Attend welcome meetings and recovery groups via Skype
- Be in regular contact with their Recovery Co-ordinator
- Have face to face appointments when required
- Access the CGL phone App
- Receive inpatient detox (from mid-August)
- Access Medication Assisted Treatment
- Access Treatment for BBV's
- Undertake home detox

It should also be noted that throughout COVID BCC have continued to pay CGL as normal with no reductions to their funding.

Post Wave 1 Delivery

Commissioners have been working with CGL in terms of their Recovery Planning in terms of: Increasing face to face attendances at locality hubs

- Re-instating face to face Recovery Groups
- Re-opening Locality Hubs
- Re-instating face to face mutual aid groups at Locality Hubs
- Increasing the digital offer
- Working with Delivery Partners face to face
- Re-introducing face to face staff training sessions

Additional impacts of COVID on Re-procurement and Board decision required

The current CGL contract ends on the 28th February 2022 and re-procurement timelines have been impacted by COVID. There has been a delay in commencing the Public Consultation (approved by BCC Cabinet in March 2020) on the draft Triple Zero Substance Misuse Strategy for the period post February 2022. Legal advice is that any public cannot be done solely online as undertaking a consultation "virtually" carries a high risk of challenge due to not everyone having access to the internet.

This delay has directly impacted the re-procurement timeline which means that the constituent re-procurement tasks cannot be completed within the original designated timeframe for a new contract to be in place from 1st March 2022 onwards. The CGL contract has performed well since it's commencement in February 2015 in terms of achieving its outcomes and compares favourably when benchmarked against other core cities. As a result, Commissioners and the Director of Public Health are finalising the costs of extending the current CGL contract for an additional year up until the end of

February 2023 which when completed will be presented to Councillor Hamilton as the Cabinet Member for Health and Social Care before going through the required BCC governance processes.

Permission is sought from the Health & Wellbeing Board to progress a year-long extension to the contract up until February 2023 will also allow for the alignment of timelines for the reprocurement of the Young People's Substance Misuse service in order to deliver a more robust Substance Misuse service.

Birmingham Health and Wellbeing Board

	Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22 September 2020**
TITLE:	**EARLY INTERVENTION PROGRAMME – PHASE 2**
Organisation	**Birmingham City Council**
Presenting Officer	**Michael Walsh, Head of Service - Commissioning**

Report Type:	**Information**

1.	**Purpose:**
1.1	To update the Board on the progress to date and the direction for the next phase of work to be undertaken by health and social care partners within the Birmingham Older People's Partnership (BOPP) in relation to the on-going improvement of Early Intervention (EI) services (Intermediate Care Community Pathways).

2.	**Implications:**	
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	X
Joint Strategic Needs Assessment		
Creating a Healthy Food City		
Creating a Mentally Healthy City		
Creating an Active City		
Creating a City without Inequality		
Health Protection		

3.	**Recommendation**
3.1	To review the attached report. In particular to:-
3.1.1	Note the outcomes from Phase 1 of the programme;
3.1.2	Give consideration to the role of the Board in relation to Phase 2 of the Early Intervention Programme.

4. Report Body

Background

4.1 The Early Intervention programme commenced in October 2018 and was the first integrated programme of work in Birmingham that was supported by an external partner, Newton Europe.

4.2 The programme set out 5 components of a future Early Intervention Service, through engagement with senior health and social care practitioners in the Birmingham system:

- **OPAL**: A geriatrician lead multi-disciplinary team that ensures individuals presenting at the front door of the acute hospital get the most appropriate onward care.
- **Hubs**: A multi-disciplinary team that work at the point of discharge from acute hospitals to ensure timely discharge on the most appropriate discharge pathway.
- **EI Beds**: A single bedded intermediate care provision to support people to recover as much independence following a crisis as possible, ideally returning home.
- **EI Community Team**: A single at home intermediate care offer that supports people to recover in their own homes and minimise the ongoing level of need an individual has and therefore the support they require.
- **Mental Health Wards**: Specialist mental health provision to care for people experiencing an acute mental health episode.

4.3 The EI Programme sought to measurably deliver the following outcomes:

- Increasing the proportion of people remaining home after a crisis by 8%
- The reduction of non-elective admissions by 4,000 each year
- The reduction of length of stay in acute beds for 7,000 people going through complex discharges each year, by 4 days per person
- A reduced level of ongoing need for people after a crisis 9,000 people per year

Phase 1

4.4 Phase 1 of the programme is the period during which the system commissioned support from Newton Europe. This terminated on 24th July 2020.

4.5 The attached **Appendix 1** provides a summary of the outcomes of Phase 1. These include:

- On average people now spend 11.5 fewer days within EI components – indicating more efficient and effective processes and reducing the likelihood of citizen's capacity deteriorating unnecessarily as a result of delays in the system;

- The need for ongoing care has reduced by an average of 5.7 hours a week – an indicator that people are leaving EI with greater levels of independence;

- The system now uses 77,000 fewer acute bed days and 19,000 fewer non-acute bed days;

- Financial benefits with an annual value of £25.8m have been achieved.

Phase 2

4.6 The bulk of **Appendix 1** looks forward to the next phase of the programme. As part of the exit strategy Newton worked with the system to scope out the next phase of the programme. The design of this phase has been greatly influenced by the impact of COVID-19 on the system. In particular, the model has been adapted to reflect the discharge pathways that have been put in place since March.

4.7 Phase 2 of the programme will be delivered through the following system implementation groups, in addition to a coordinating group that will work at a programme level (the EI Steering Group'). The 4 provision groups align to 4 of the operational components established through the previous work

The 5 implemation groups are:

- 4 provision groups:
  - OPAL
  - Integrated Hub (including acute and co-ordination hubs and their underpinning processes)
  - Pathway 1
  - Pathway 2

- A commissioning group

4.8 The cross-cutting nature of mental health and end of life provision has been recognised as will be embedded within each of the 5 groups.

4.9 In considering the priorities for the programme moving forward, the rationale has been to focus on:

- Sustaining and embedding the improvements made to date through the EI Programme and the COVID response

- Delivering the outstanding improvements from the original EI benefits case

There is a recognition that the aspirations, around the services being considered, go further than the improvements that have been made so far. However, the realities of the current situation mean they will need to be captured here but picked up later (likely to be coming out of winter into 2021). At a high level, the short-term deliverables can be considered as:

- **An interim commissioning framework** to provide a means of ensuring the sustainability of services (and associated funding) throughout the winter period.

- **Operational changes** within each component to sustain or further improve performance

- **Operational resilience** within each component and across the system to ensure performance and services are maintained in the event of a 2nd COVID-19 spike, anticipated difficult winter pressures coupled with increased prevalence of flu and potential BREXIT disruptions.

5.	**Compliance Issues**
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	TBC

5.2	**Management Responsibility**
	TBC

6.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
N/A			

Appendices
Appendix 1 – The Early Intervention Programme

The following people have been involved in the preparation of this board paper:

Judith Davis – University Hospital Birmingham
Michael Walsh – Birmingham City Council

Making Birmingham

a great place to grow old in.

The Early Intervention Programme (Intermediate Care Community Pathways)

Part of the Birmingham Older People's Programme.

Forward Plan - July 2020

Live healthy Live happy Birmingham and Solihull

Birmingham City Council

NHS

Contents

Introduction

This document summarises the progress to date and sets the direction for the next phase of work to be undertaken by health and social care partners within the Birmingham Older People's Partnership (BOPP) in relation to the on-going improvement of Early Intervention (EI) services (Intermediate Care Community Pathways). It builds upon the overarching framework agreed for the integrated improvement of services for older people, and those with similar needs, by system partners in July 2018 – 'Making Birmingham a great place to grow old In'. The workstream sits alongside the two other BOPP workstreams: Care Homes and Integrated Neighbourhoods.

This document set outs the following aspects of the next phase of the EI workstream:

- The relevant background and results to date
- The project structure that will be used to run the workstream
- The nominal leads at a workstream and project level
- The governance that will be used to run the workstream
- The short term, priority deliverables and associated measurable outcomes
- The expected timelines for these deliverables
- The longer term deliverables for the EI workstream and associated measurable outcomes

This document has been pulled together through collaboration involving the following individuals from health and social care providers and commissioners in Birmingham:

- **Birmingham and Solihull CCG**: Paul Athey, Karen Helliwell, Helen Kelly
- **Birmingham City Council**: Louise Collet, Mike Walsh, Balwinder Kaur, Andrew Marsh
- **Birmingham Community Healthcare Foundation Trust**: Chris Holt, Ben Richards, Liza Walsh
- **University Hospital Birmingham Trust**: Andrew McKirgan, Zoe Wyrko, Judith Davis
- **St Mary's Hospice and John Taylor Hospice**: Penny Venables
- **Birmingham and Solihull Mental Health Foundation Trust**: Derek Tobin
- **Sandwell and West Birmingham CCG**: Pip Mayo

It's acknowledged that West Midlands Ambulance Service will need to be engaged through this work and the group is comfortable this can be done at an operational level.

Early Intervention

The Early Intervention programme commenced in October 2018 and was the first integrated programme of work in Birmingham that was supported by an external partner, Newton Europe. The programme has had active involvement from all the partners listed on the previous page, except for the hospice trusts.

The programme set out 5 components of a future Early Intervention Service, through engagement with senior health and social care practitioners in the Birmingham system:

- **OPAL**: A geriatrician lead multi-disciplinary team that ensures individuals presenting at the front door of the acute hospital get the most appropriate onward care
- **Hubs**: A multi-disciplinary team that work at the point of discharge from acute hospitals to ensure timely discharge on the most appropriate discharge pathway
- **EI Beds**: A single bedded intermediate care provision to support people to recover as much independence following a crisis as possible, ideally returning home
- **EI Community Team**: A single at home intermediate care offer that supports people to recover in their own homes and minimise the ongoing level of need an individual has and therefore the support they require
- **Mental Health Wards**: Specialist mental health provision to care for people experiencing an acute mental health episode

Health and social care professionals worked together to identify several **principles** that would underpin a future model:

- Our aim is to have one integrated model across our entire system.
- The person must be at the centre of everything we do (with family and carer input also valued).
- Our aim is to support an older person's life not simply deliver a service.
- We need to make sure each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- People should only have to tell their story as few times as possible.
- Staff across organisations work together (co-locating where appropriate) to champion the 'home first' ethos.
- And the result of all these points -more people will live more independently in later life.

Working this way would mean:

- Organisational boundaries should not have a detrimental impact on an older person's care.
- No wrong door for someone that needs help.
- Clearly defined roles to maximise skills and capacity.
- Efficient distribution of resources within a locality.
- Overall consistency accepting local variation where it makes sense.

The EI Programme sought to measurably deliver the following outcomes:

- Increasing the proportion of people remaining home after a crisis by 8%
- The reduction of non-elective admissions by 4,000 each year
- The reduction of length of stay in acute beds for 7,000 people going through complex discharges each year, by 4 days per person
- A reduced level of ongoing need for people after a crisis 9,000 people per year

COVID19

In January 2020 the world was made aware of the beginnings of a global viral pandemic, subsequently named COVID-19. A national response to the pandemic was instigated giving little flexibility in locally designed responses, the most relevant document for the EI programme and associated discharge functions throughout the system was published on 19th March 2020. It was entitled the *'COVID-19 Hospital Discharge Service Requirements'* and flexibilities identified were enacted through the COVID Act in parliament in March 2020.

Significantly for this programme it required the establishment of the following:

- A language and reporting mechanism around 4 pathways out of hospital (0-3)
- The suspension of key requirements around Continuing Heath Care with safeguards put in place to ensure any requirements were completed at a later date
- The ability of Local Authorities to suspend key Care Act requirements with safeguards put in place to ensure any requirements were completed at a later date
- Health community service organisations placed in a leadership role with regards to hospital discharge with the role of other organisations, and a nominated lead within each organisation defined.
- A redeployment of community-based staff to support critical services

All the components of the EI programme were identified as critical and all had significant changes to adopt. The redesign and improvement work of the previous 15 months placed the service in a positive place to respond and make the most of the changes presented. Each part of the service has worked exceptionally hard in challenging circumstances and the benefits are clear in the outcomes identified above.

An assessment of the changes to the components because of Covid-19 specifics are given in the 'Detailed Briefs' at the end of this document.

A new Birmingham and Solihull governance structure was identified during the peak of the wave of the pandemic between February/March and June 2020. However, BOPP has recently reconvened and has agreed the next phase of 'Making Birmingham a Great Place to Grow Old In' which builds on:

- The successful work of the EI programme (and other two programmes – On-going personalised Support and Prevention)
- The positives of the COVID experience and changes around primary care networks in the last 12 months

The on-going improvement of integrated intermediate care has been agreed as a key priority and will continue with the name 'Early Intervention'.

The largest impacts on system outcomes due to COVID have been:

- The current acute length of stay for complex discharges is 4.5 days lower than the targeted levels
- The current EI Bed length of stay is 17 days lower than the targeted levels
- There is an opportunity to reduce 2,800 people ongoing social care needs per year as the referrals from Community Social Work Teams to the EICT were consciously delayed (to preserve acute step down capacity) and are in the process of being activated
- There is an opportunity to reduce NELs by a further 3,000 per year as the OPAL teams at BHH and GHH have been impacted by the COVID response.

At the end of August, further national guidance has emerged for managing Winter 20/21 and this is being incorporated into planning.

Current Performance Position

The following tables summarise the system performance levels as of 22nd July

EARLY INTERVENTION SYSTEM IMPACT (22/07/20)

Getting more people home	In the old world, if someone interacted with an EI component, there was a **65% likelihood of going home** **Now, there's a 63% likelihood of going home** *To get more people home, we should look first at OPAL as that's where most people aren't going home at the moment* *If we want to improve further, we should then look at Hubs*
Using fewer acute bed days	EI components today mean we need to use **77000 fewer acute bed days than we used to** **This is better than the diagnostic predicted!** Our biggest area of success has been with the Hub teams! *To use fewer acute bed days, we should first look to make further improvements with the OPAL teams* *To make even more improvements, we should work with Juniper teams*
Using fewer non-acute bed days	Compared to the old world, the Birmingham system is using **19000 fewer non-acute bed days** **Reduced admissions means 1300 fewer days are needed** **Shorter length of stay means 17300 fewer days are needed** *To reduce our use of non-acute bed days, we need to focus on reducing admissions to EI Beds from our Hubs*
Reducing system length of stay	Across all EI components, people spend **11.5 fewer days in the system** **This is better than the diagnostic predicted!** Our biggest area of success has been with the EI Community teams, taking 20.7 days off the baseline length of stay! *To help people move through the system quicker, we should first look to the EI Bed teams* *To make even more of an impact, we should look at the Hub teams*
Making a positive financial impact	Our new EI services are having a impact of **£25.8million saved for Birmingham** The diagnostic indicates we could achieve **further financial benefits of £7.8million** Our biggest area of success has been with the Hub teams, with a £14.3m run rate financial benefit! *To have a bigger financial impact, we should look at the our EICT volumes, as this has a value of £9.1million* *The next area of priority would be our OPAL teams, as this has a value of £3.6million*

Staff Perspectives

The most recent engagement with staff across all the EI service was an event held in December 2019, inviting contributions from front line management across all 5 components. Supporting this event, a video was produced to showcase staff perceptions of the EI Programme. The video can be found here and some quotes and stats from the event are listed below.

"This is great for the older population of Birmingham and feels like patients are being given a voice"

"There is a level of MDT and cross organisational working that wasn't there before"

"What we've got to work on now is sustainability… and keeping everyone motivated"

More recently, following the mobilisation of the EICT across the city in March 2020, an OD report was produced focussing specifically on the staff within this component. Whilst it is only one of the 5 components of EI, the conclusions could we have thematic relevance for the whole service:

Headlines

Summary

- People are generally feeling engaged with the concept and potential benefits of EICT, although some practical and process challenges are impacting on overall engagement levels
- Team cohesion is improving and people feel they are starting to work together well, but still need greater understanding of different roles & disciplines
- There are some practical skill and knowledge gaps (systems and processes in particular) and people feel a more robust induction would be beneficial

Skills & knowledge	• There are still some gaps for the teams in their understanding of key processes and systems but some work is happening to address these areas (e.g. Rio training) • There are some mindset / behavioural gaps which may also need some focus • People have found practical training and peer and manager support have been most useful for them so far
Engagement	• The large majority of people are engaged with the potential benefits of the EICT, but some practical challenges are impacting on overall engagement levels (e.g. people working in different places) • Generally people feel part of the team and positive about the possibilities of EICT • However, a number of people feel unclear on their own roles and responsibilities as well as those of others which is impacting on their engagement and motivation; and volume and duplication of paperwork is also impacting on this quite consistently
Team cohesion & ways of working	• Overall people feel the teams are starting to work in a well integrated way despite the challenges of COVID • There is more work to do to make sure people get to know each other, and really understand each others' roles and expertise • Most of the key ways of working are starting to be at least partly demonstrated across the teams but more work is needed to fully embed these

Further staff engagement is planned in the coming months – in the very short term, a 'thank you' card and small gift has been sent to staff to acknowledge the efforts that have gone in to the COVID response. Looking slightly further ahead, an event is planned in September to align with the Health and Wellbeing Board to more holistically feed back to staff about the achievements of the Programme and gather views from front line staff on what changes should happen next.

Stories of Difference

The Early Intervention service interacts with hundreds of new people that live in Birmingham every single week. Gathering stories of difference and patient feedback has been at the core of the approach throughout the programme.

We've received some excellent feedback on the EICT:

And some incredible stories collected that show how valuable the changes across all the components are when they are brought together:

"Sam pulled her pendant alarm after a fall. The ambulance crew came to see her and immediately phoned "Ask OPAL" for a remote consultation as they believed Sam needed to be admitted. After speaking with the OPAL team at QE, Sam actually stayed at home and was referred to the EICT instead. Sam was seen by a nurse from the EICT and had an initial assessment that outlined some care requirements and a recovery plan. This included realising that Sam had not been taking her medication – an important part of keeping her safe and well at home. The nurse noticed that Sam had mobility issues, particularly with one shoulder. Through the daily MDT in the EICT, the nurse was able to bring in a physio to work with Sam as well to help her recover her mobility and her ongoing independence. After two weeks of intensive support, Sam was discharged from the EICT fully independent and taking her medication meaning she's much more stable on an ongoing basis."

Project Structure, Leads and Governance

The EI programme sits as part of the wider BOPP governance and will have relationships with other BOPP level groups. A strategic group is being proposed at a BOPP level to look across all programme so there is no need for an EI specific strategic group.

To deliver the EI programme, it has been agreed to create 5 project implementation groups that will deliver the programme, in addition to a coordinating group that will work at a programme level (the EI Steering Group'). The 4 provision groups align to 4 of the operational components established through the previous work

The 5 project groups are:

- 4 provision groups:
  - OPAL
  - Integrated Hub (including acute and co-ordination hubs and their underpinning processes)
  - Pathway 1
  - Pathway 2
- A commissioning group

The leads for each group is shown on page 10.

There is an acknowledgement that there will be a lot of crossover in the people that need to review the performance of these operational teams (established through the EI Programme – part 1) against their established KPIs. Therefore, the project delivery governance needs to intertwine with system operational performance governance.

The proposed approach is to convene the EI Steering Group **fortnightly** with the remit of discussing either of the following as required:

- Progress of deliverables outlined in the brief for each project group
- The operational performance of components

Programme Approach

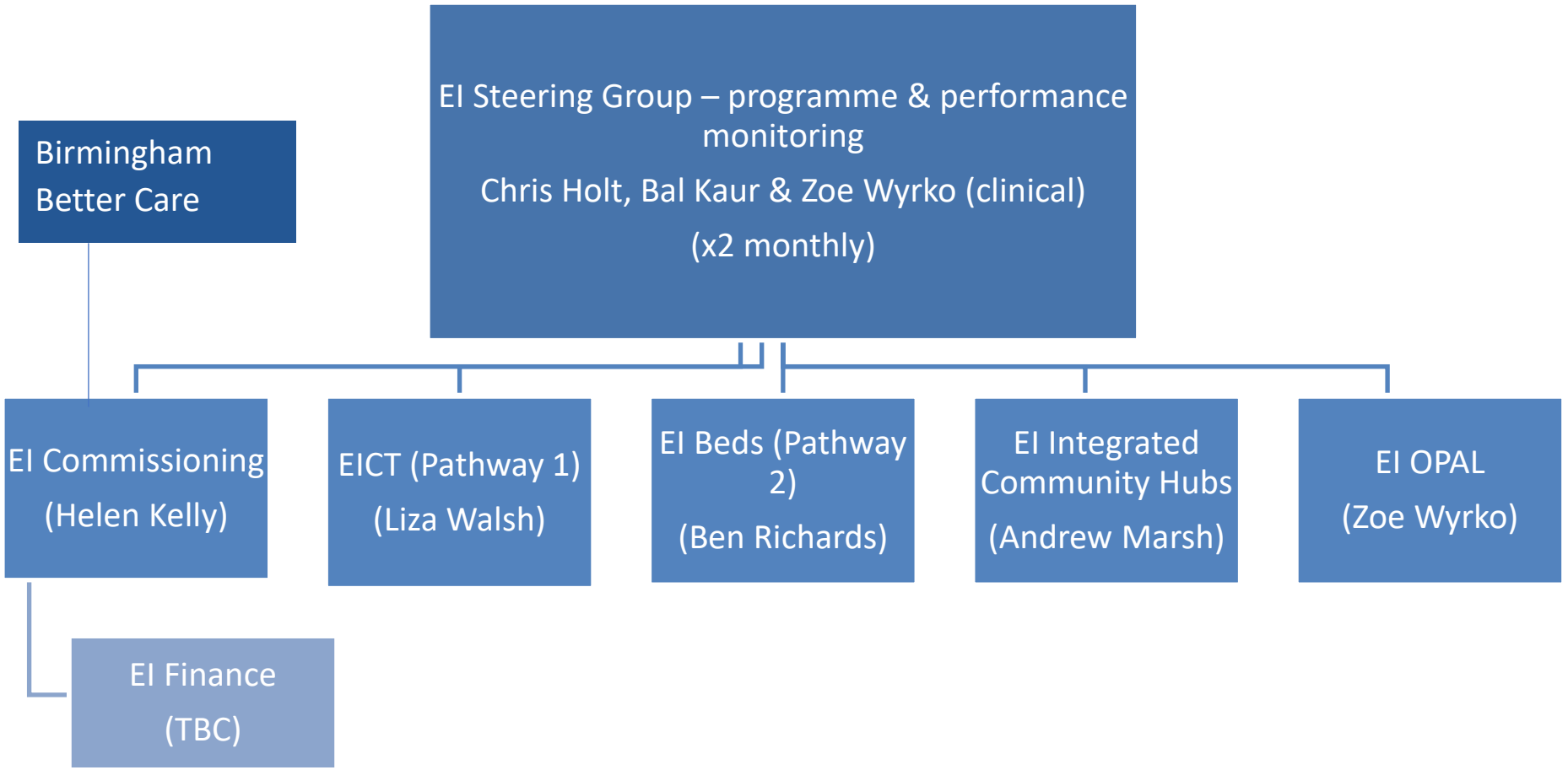
The EI programme to date has followed a methodology commissioned and contracted from Newton Europe, this has included the development of the role of Improvement Manager. Currently there are 2 individuals who have worked in the programme for 18 months and have an advanced set of improvement skills, as opposed to project management skills. A further 4 individuals have a more limited set of improvement skills, but none the less are significant.

The approach taken has had four fundamental underlying principles:

- The identification of need for change is data driven
- The change is co-designed with front line staff
- The change will be delivered through the following approach – changes to process designed, tools designed to help process change and identifying impact, people coached to use tools
- The later is delivered through a series of improvement cycles

The improvement managers have skill sets across the breadth of these principles to a greater or lesser degree, and as far as possible these principles will be maintained moving forwards.

Programme Governance



End of Life Care and Mental Health Service Involvement

End of Life Care and Mental Health services apply to the whole of BOPP and therefore will need to have representation in the right project groups of the EI programme moving forward. The schematics below show how End of Life Care and Mental Health services interface with the three BOPP workstreams.

End of Life Care

The End of Life Care Oversight Group has worked alongside partners for the last two years to improve and integrate end of life and specialist palliative care across the health and social care economy. Before the outbreak of the Covid-19 pandemic the End of Life Care Delivery Group had been established and work completed on a shared vision for the future of services agreed. Evidence for Birmingham and Solihull indicating higher numbers of people than the national average ending their lives in an acute hospital has driven the vision to deliver urgent and rapid response to these patients needs on a 24/7 basis across the economy.

End of life services cross all health services including acute, primary care and community and those provided by not for profit providers and it is therefore important that in the next stages of the Early Intervention programme this work is integrated into all the new work streams. Phase two of this work will help to deliver change and integration of services to allow specialist input and education where required in the system and new pathways to open up access to specialist health professionals.

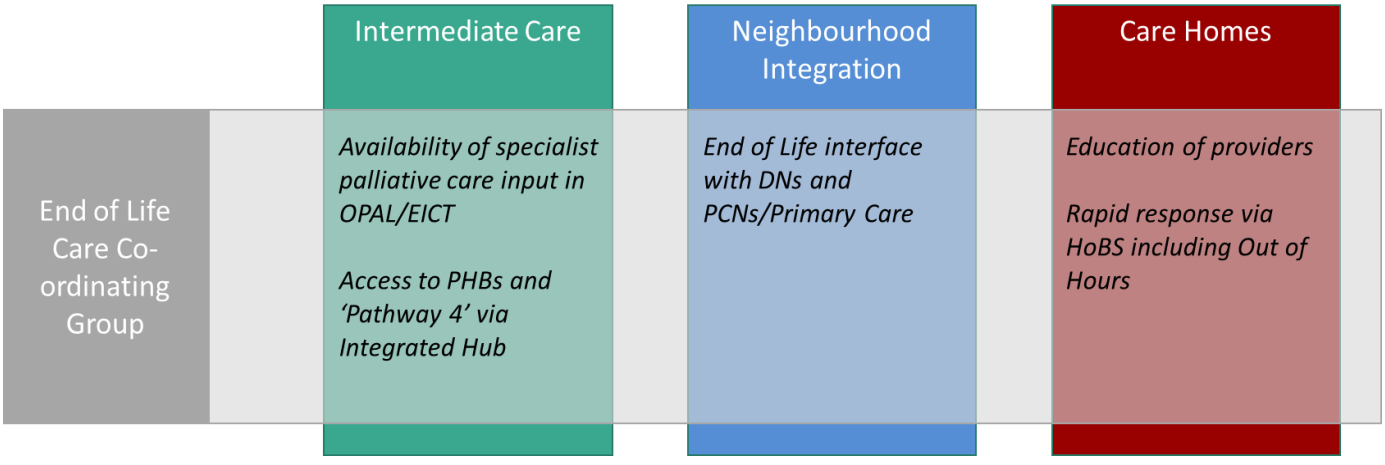
As part of the end of life care programme, partners have agreed the following set of priorities for focus:

- Development of a sustainable model of HoBS (EOLC CO-Ordination Hub and rapid response service)with wider involvement of more partners
- A Review, streamlining and simplification of community services across all providers
- CHC fast-track redesign to include use of Personal Health Budgets at end of life
- Care homes work on support and education
- Wider communication around changes to EOLC

To progress these end of life care colleagues will work within the following new groups:

- OPAL Project
- EICT Project
- Integrated Hubs Project
- EI Beds project

In addition colleagues will link into the Neighbourhood Integration and Care Homes work streams of the Birmingham Older Peoples Board. This will allow the development of pathways between providers and the integration of both the elective and urgent provision of specialist palliative care to be achieved with other health and social care services.



Mental Health

The development of phase two of the Early Intervention programme provides system partners the opportunity to integrate mental health across all work streams. As well as local drivers outlined in this document there are two key national documents that support this approach. No Health without Mental Health (2011) advocates the integration of mental health and physical health for those who experience mental health difficulties but also the mental health well-being of people who experience physical health problems that can impact on their mental health. The document outlines that one in four people will experience a mental health problem over the course of their lifetime which would suggest that people who experience mental health problems are already presenting to services outlined in this document and demonstrates that mental health is "everybody's business." The integration of mental health is therefore central to addressing the needs of those individuals and to ensuring that they receive the right support at the right time in the right place. More recently the Long Term Plan (LTP) for mental health advocates enhanced access to mental health services across all ages and sets out expectations around partnership working to achieve better outcomes in terms of mental and physical health.

The programme of work set out in this document will enable system partners to be innovative in their approach to the integration of mental health and physical health and to make this explicit across the work streams.

To date the Early Intervention programme has been inclusive of mental health and the mental health acute inpatient facilities at the Juniper Centre/Reservoir Court were one of the five test sites referred to earlier in this document. This work enabled the development of a more integrated approach with the other test sites and focused on enhanced flow through the mental health wards and promoted a home first philosophy which was advocated across the system. As this work developed and through data collection it highlighted that between 20% and 30 % of acute mental health admissions come via the acute hospitals. Enhanced flow through the wards and closer partnerships have helped to reduce length of stay on the mental health wards and reduce waiting times for transfer of patients from the acute hospitals which enhances quality of care through ensuring that appropriate care is provided within the most appropriate environment. An integrated approach is therefore central to the further development of the EI programme.

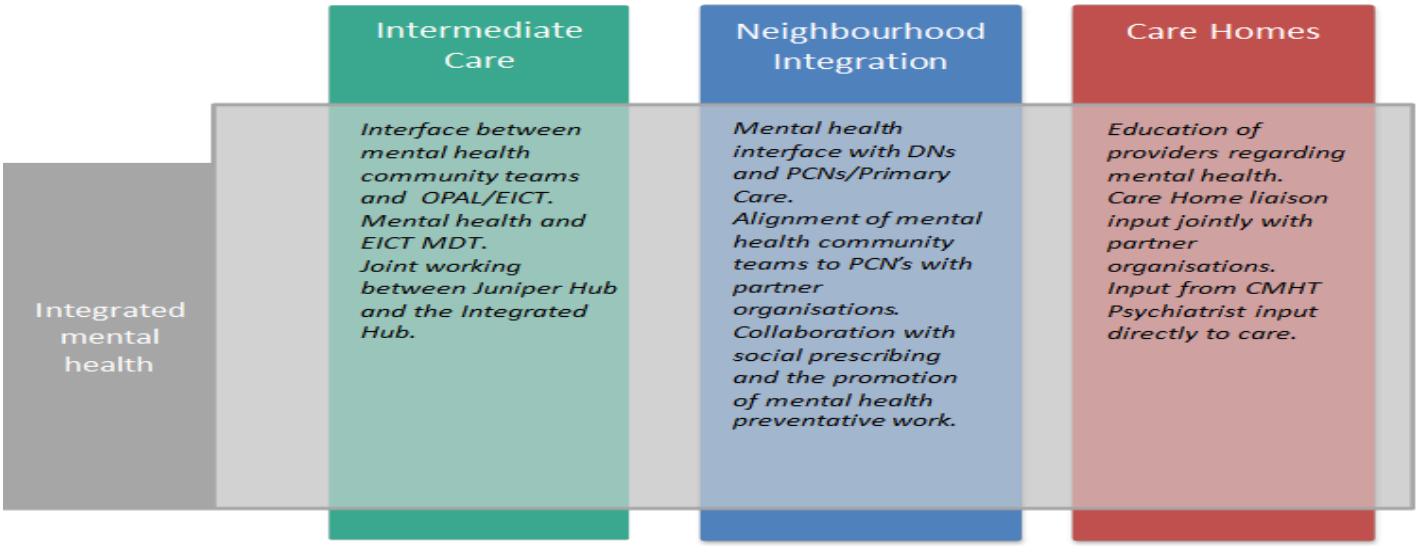
Phase two of the programme will enable work to develop across the mental health community teams, Community Mental Health Teams (CMHT), Memory Assessment Service (MAS) Rare Dementia Service (RDS), Care Home Liaison (CHL), Community Enablement and Rehabilitation Service (CERT).

Mental health services will therefore specifically link into the following EI projects:

- EICT Project
- Beds Project
- OPAL Project
- Integrated Hub Project

This will ensure that specific issues related to mental health across partner services are picked up and addressed at the earliest opportunity in the interest of those people who experience mental health problems. For older people it will also ensure awareness of a broad range of mental health issues ranging from dementia through to functional mental health problems for example, psychosis, anxiety, and depression. The table below provides an outline of how mental health will integrate within the BOPP workstreams.

Integration of mental health within the workstream groups



Deliverables and Timeline – Short Term

In considering the priorities for the programme moving forward, the rationale has been to focus on:

- Sustaining and embedding the improvements made to date through the EI Programme and the COVID response
- Delivering the outstanding improvements from the original EI benefits case

There is a recognition that the aspirations, around the services being considered, go further than the improvements that have been made so far. However, the realities of the current situation mean they will need to be captured here but picked up later (likely to be coming out of winter into 2021).

The detailed deliverables are broken down by project in the subsequent sections. At a high level, the short-term deliverables can be considered as:

- **An interim commissioning framework** to provide a means of ensuring the sustainability of services (and associated funding) throughout the winter period.
- **Operational changes** within each component to sustain or further improve performance
- **Operational resilience** within each component and across the system to ensure performance and services are maintained in the event of a 2nd COVID-19 spike, anticipated difficult winter pressures coupled with increased prevalence of flu and potential BREXIT disruptions

The interim commissioning framework will need to include:

- The outcomes and performance expectations from the services in scope and how they will be measured
- The specification for the services to be delivered and how providers will work together to meet the specification
- The financial envelope for the services to operate within

Given that the commissioning framework will require an iterative collaboration between providers, commissioners and finance colleagues it is anticipated that tis will be completed by mid - September

The operational changes not connected to the interim commissioning framework will be delivered by the relevant project group, with an end of October deadline.

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Citizen Engagement

The EI programme was established on the basis of citizen engagement to develop the Birmingham Better Care Fund and subsequent discussions with citizens forums established by Birmingham City Council. The design principles identified by citizens and EI staff were consistent with each other. The main messages from citizens were:

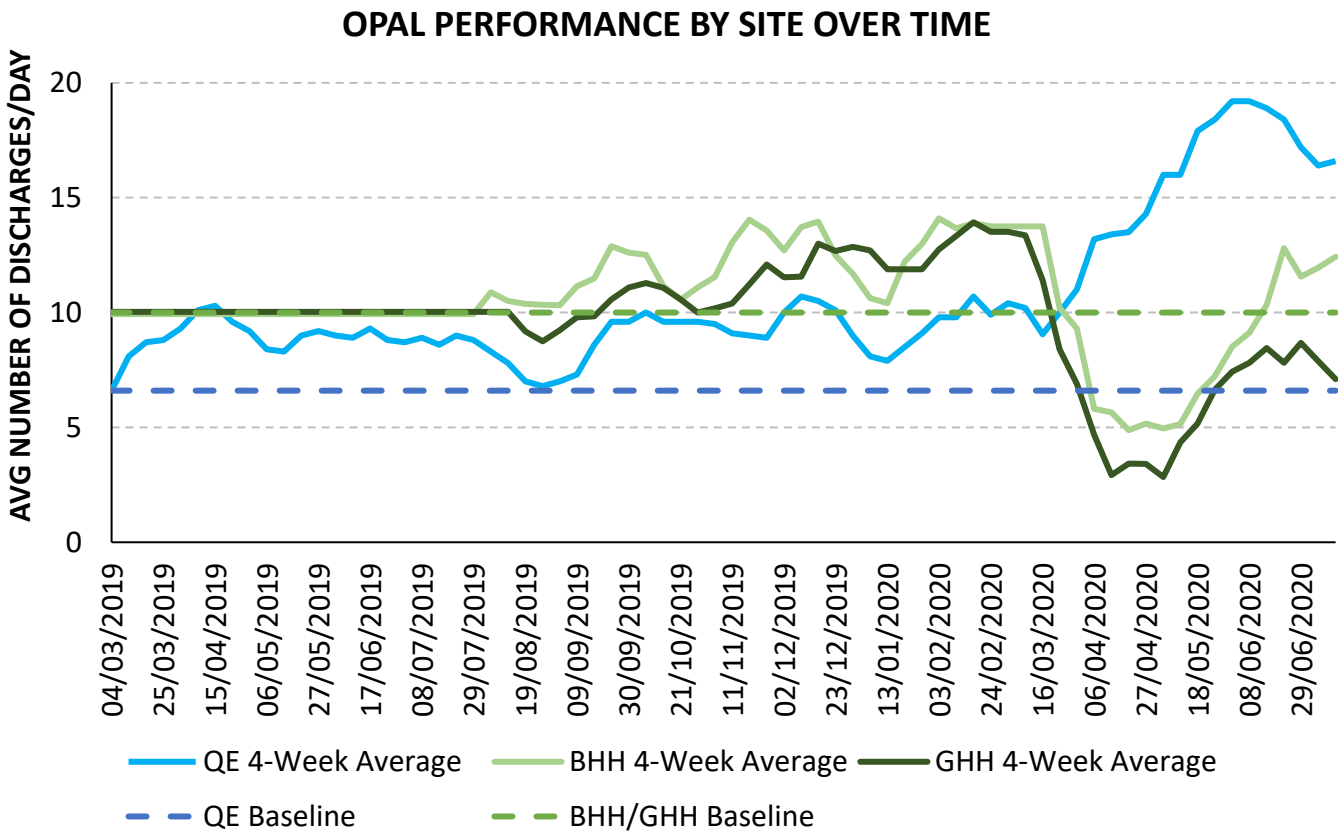
- I want to tell my story only once
- I only want to be assessed once as far as possible
- I want to be in control and plan my care together with professional people who understand my culture and are non-judgemental
- If I'm receiving my support at home I want as few strangers as possible entering my home
- I want help, not barriers put in place for me to get the support I need
- I don't want to go into hospital unless I need to

In 2019 Healthwatch Birmingham undertook a review of the EI programme with regards to citizen engagement and use of feedback information. The report identified many positives but also made a series of recommendations and Healthwatch gave a commitment to help deliver the recommendations. The circumstances around Covid – 19 have stopped this work however it will be picked up again if possible, at an appropriate point within the programme. The programme was also visited in 2019 by the national Healthwatch Board following the local report.

Moving forwards, in addition to the Healthwatch work as previously described, the programme will continue to use BCC forums, and those of any other organisation, as has been the case to date.

Detailed Brief: OPAL

The graph below shows how OPAL performance has varied over time since the beginning of the programme.



The ongoing changes delivered through the EI Programme are:

- Confirmed that proactive patient identification, and a co-located multidisciplinary team is the optimal OPAL model
- Used data collection and analysis to drive improvements in OPAL performance and allow challenge between the sites
- On QE site, audit and modelling led to the required uplift in staff to hit target activity levels

The changes introduced during the COVID response are:

- Redeployment of consultant staff at QE site, and introduction of Covid rotas, allowed a trial of 12 hour consultant shifts which has been successful and now forms the basis for senior medical rotas.
- Repurposing of Solihull Hospital resulted in the OPAL Solihull team being dispersed between the three acute sites, with the majority of non-medical staff moving to Heartlands
- OPAL QE offered direct advice to WMAS paramedic crews and BCHC ANPs through #AskOPAL. EICT and non-acute beds have been essential to the success of this work

The following short term operational deliverables have been agreed:

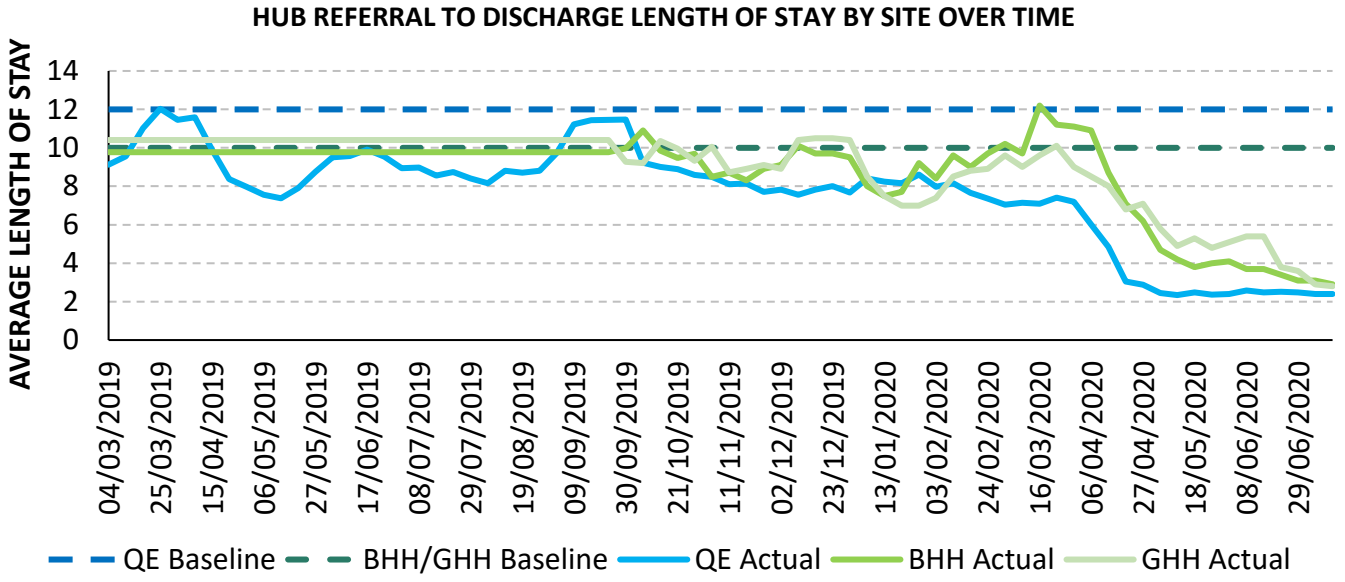
- Supporting the Interim Commissioning Framework
    - OPAL specific items relate to determining any further uplift in demand expected over winter and ensuring the commensurate levels of staffing are in place to meet it.

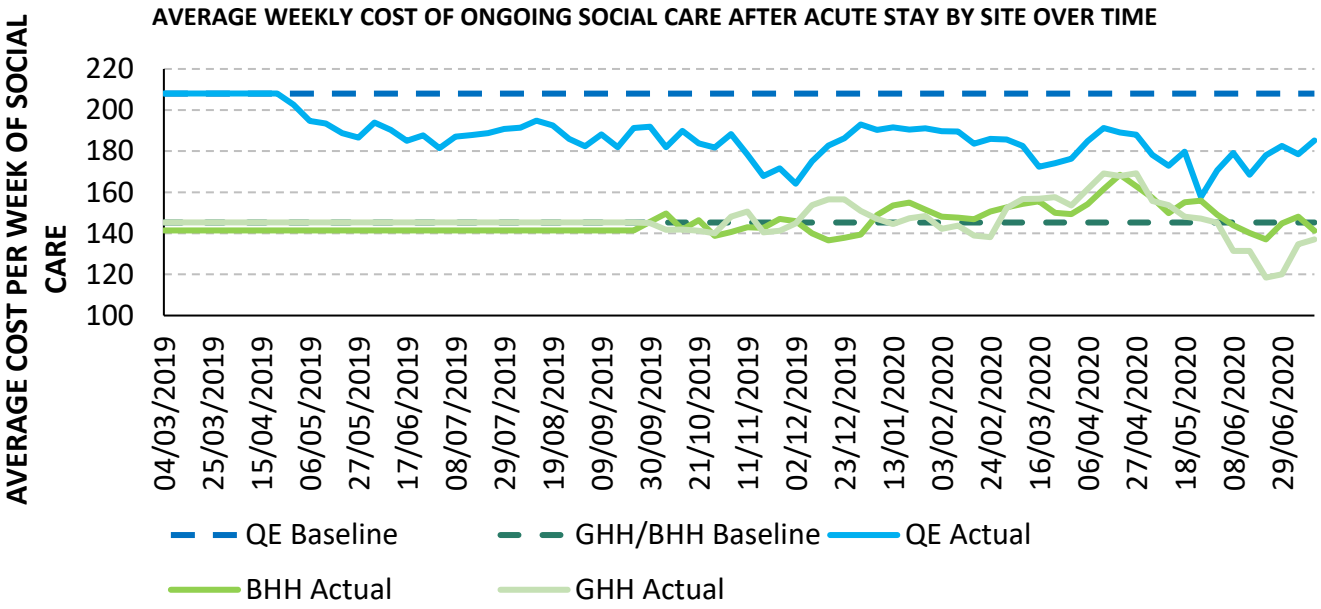
- To establish the OPAL teams at BHH and GHH given the impact COVID has had here and ensure the design ways of working are being adhered to
- Ensure that all OPAL teams have staff rotas and proper allocated staff (where necessary incorporating REACT, REACT +, FAEC and others), covering the required OPAL working hours (8am – 8pm Monday to Friday, minimum 8am – 6pm weekends and bank holidays).
- Unsure all staff are familiar with referral routes, including (but not limited to) EICT, Solihull Community Services, HoBS, non-acute beds
- In conjunction with the 'beds/P2' work stream, agree a medical workforce model across UHB and BCHC to support OPAL, EIB and other appropriate community teams

Detailed Brief: Integrated Hubs

The graphs below show the performance of QE, GHH and BHH discharge hubs since the beginning of the programme. The hubs have had 2 operational KPIs:

The performance against the two metrics is shown below, with the length of stay performance particularly enhanced by the COVID response.





The ongoing changes delivered through the EI Programme were:

- Combining previously separate complex discharge nurse, acute social worker and ward-based therapy teams into single discharge hubs
- Setting up daily patient level tracking to highlight patients not heading home or those blocked in their discharge pathway
- Forming MDT 'clusters' and a redesigned discharge assessment process to ensure the optimal discharge pathway is targeted for an individual

- Using the patient tracking and cluster structure to challenge sub-optimal discharge pathways and discharge blockages
- Creating a multi-organisational escalation structure across all three acute sites to monitor performance and receive escalations

The COVID response made some key changes to discharge operations that have drastically improved length of stay performance. These include:

- Changes to CHC, long term placement, housing and budget approval process that reduce the overall workload for practitioners progressing discharge (data captured through the EI model shows these processes accounted for the biggest delays in beds)
- The changes above also increased the flow through Pathway 2 beds. In combination with changing Pathway 2 bed provision across the city to accept all Pathway 2 referrals, this led to a massive improvement in flow through EI Beds and therefore a reduction in delays in the acute.
- The point above was augmented with the creation of a 'Co-ordination Hub' overseeing flow from acute beds, through pathway 2 beds and into long term settings. This became the primary escalation structure to enable system flow, with clear patient by patient actions.

The short term deliverables for the Integrated Hub workstream focus on sustaining the gains achieved over COVID. The following short term deliverables have been agreed:

- Supporting the Interim Commissioning Framework:
    - The co-ordination hub is currently staffed by temporary/redeployed staff. Using the Interim Commissioning Framework to stabilise this staffing base over the winter period will be critical to its continuation.
- Continue to embed front line operational processes to support acute flow during winter i.e. how the Acute Interface Team interface with the acute setting and how acute based staff interact with the co-ordination hub and the Pathway 1/Pathway 2/Pathway 3 placements. This will include access to hospice beds and access to personal health budgets.
- Continue to embed the processes that have changed through COVID (CHC, placements, budget approvals, housing) so that they can sustain the improved flow as much as possible. This is whilst acknowledging the discharge guidance is likely to change and some constraints are likely to be reintroduced that were lifted in the original discharge guidance
- Agree resource commitments from partner organisations to maintain new roles and integrated working (particularly BCHC, BCC, CCG)
- Provide oversight on pathway delays, Medically Fit For Discharge (MFFD) metrics, bed capacity and occupancy and overall system flow
- Map current resources across the system from across all Partners and outline proposals on potential options on future configuration

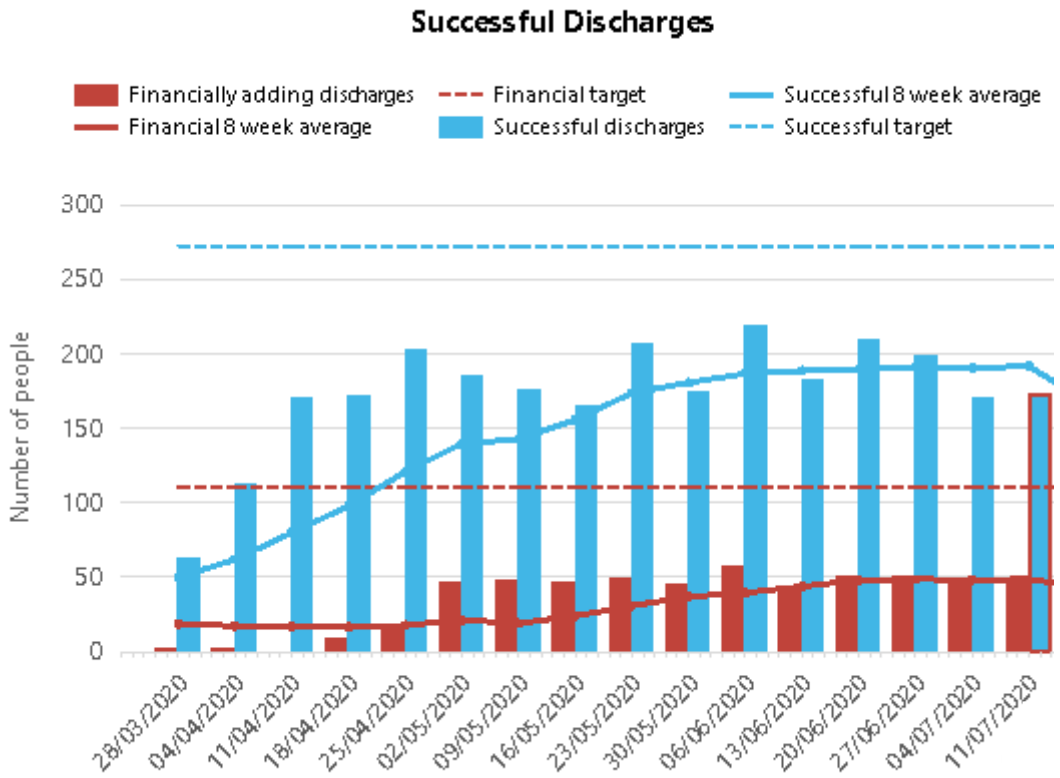
Detailed Brief: Pathway 1

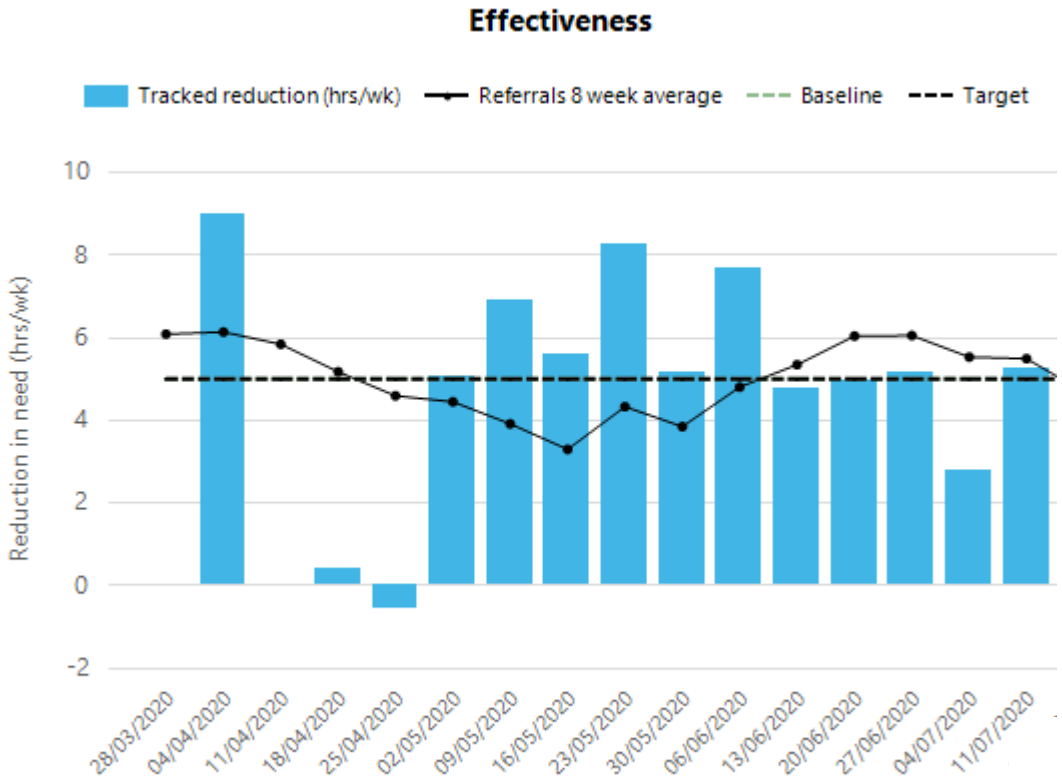
The vision for EI services included a single intermediate care service that would have the capability to deliver the opportunities above in addition to capabilities to intercept people during their escalation of need and avoid acute admission.

To deliver on the vision and the opportunities the Early Intervention Community Team (EICT) was created after a successful pilot and agreement of a city wide business case in September 2019. The EICT was comprised of previous services including:

- BCHC's Rapid Response Team
- BCC's Post Hospital Discharge Social Work Team
- BCC's OT Team (that had previously supported the enablement service)
- Unregistered staff provided by Sevacare through the Quick Discharge Service contract
- BCHC's Home Based Therapy Team
- UHB's Supported Integrated Discharge Service
- SWB's Own Bed Instead (OBI) model

The EICT was mobilised in March 2020 across the city in 5 locality teams. The team is more effective at reducing someone's ongoing need after a crisis than the initial target but the team is not currently seeing the number of people on social care pathways that were originally planned. This is primarily due to referrals from Community Social Work Teams not being 'switched on' after conscious delay to this as part of the COVID response





As well as mobilising the 5 teams, additional work was delivered to ensure the opportunities were delivered:

- Patient level data tracking was set up so that performance can be reported at locality and city levels
- Performance dashboards have intelligent prompting built in to guide the user to clear operational priorities (hosted on BCHC systems)
- Front line governance was established including structured, data-informed MDTs and weekly performance reviews. This has included coaching staff to break down organisational and professional boundaries to enable a more collaborative management team.
- A single integrated assessment and review methodology was bespoke designed and implemented, reducing duplication between professions
- Feedback from unregistered Sevacare staff visits is collated in a structured way and fed back to registered staff

During COVID the EICT was deemed an integral part of the city's response, forming the primary part of Pathway 1. This required additional work primarily involving redeploying 150 staff into the EICT. The result of this was that during the entire COVID response the EICT had only one instance of having to reject a referral due to capacity.

The detailed short-term deliverables for the EICT are:

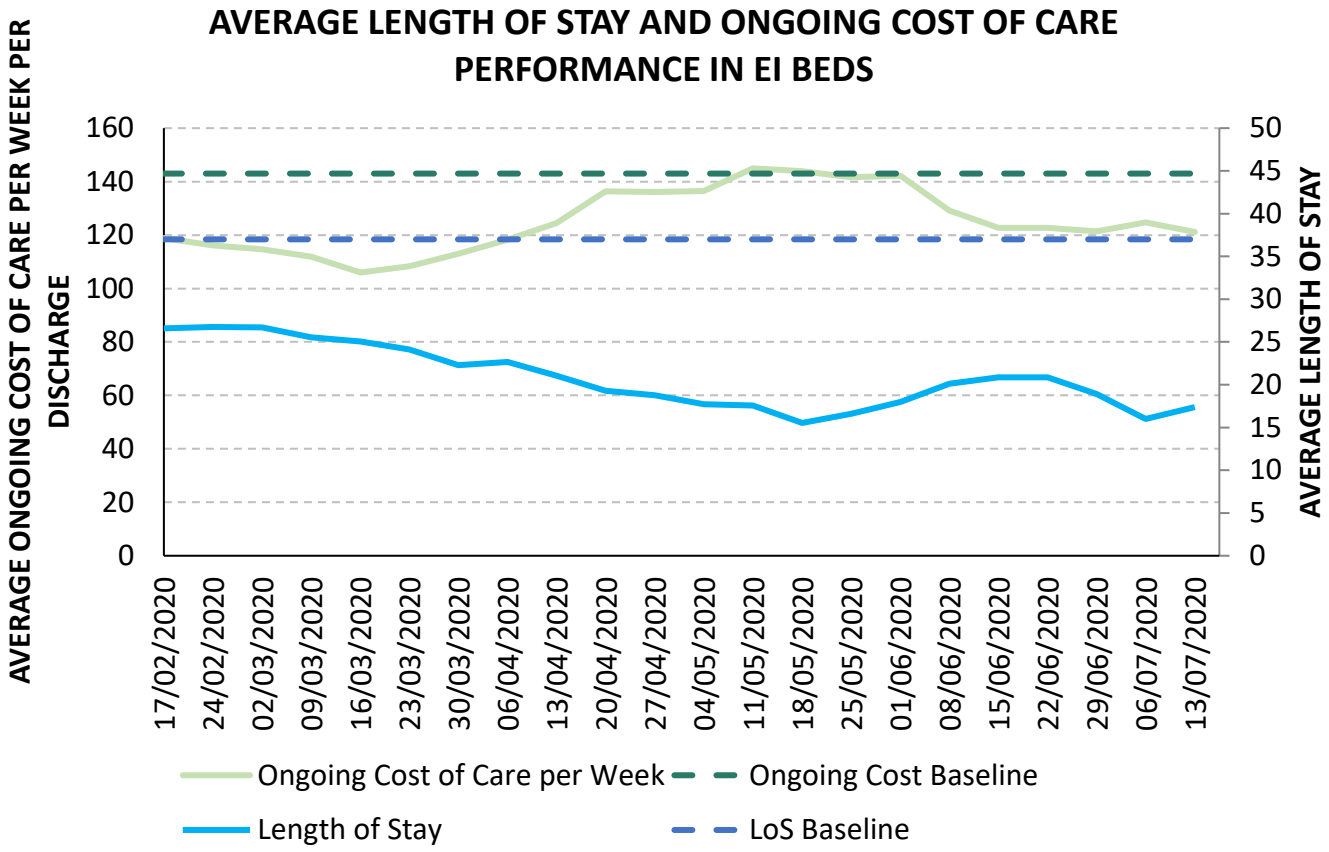
- Work with CSWTs to mobilise and achieve target referral levels
- Support the Interim Commissioning Framework by:
    - Confirm the staffing in EICT split by funding route (recurrent and non-recurrent)
    - Determine any uplift in staffing required for winter/COVID resilience
    - Confirm overall funding requirements
- Ensure funded staffing levels are agreed for EICT Phase 1
- Define, agree and fulfil staffing model for winter (and COVID) resilience and associated impact assessment
- Stabilising the current management team in the EICT localities, specifically Locality Operational Managers
- Ensuring the MDT with BSMHFT sustains over winter
- Review other pathway 1 services and agree alignment with EICT

Detailed Brief: Pathway 2

The graphs below show the performance of EI Beds (Norman Power, Moseley Hall W4,5,6, Perry Trees and CU27) since the beginning of the programme. The EI Beds have had 2 operational KPIs:

- The length of stay from the point of admission to discharge
- The average ongoing cost of social care support per person

The performance against the two metrics is shown below, with the length of stay performance particularly enhanced by the COVID response.



As part of the EI Programme, the following changes were delivered:

- Patient level outcome and next step tracking was introduced to each site
- A daily MDT between nursing, therapists and social workers was introduced to progress patients to the best possible outcome
- An escalation structure enabling blockages in flow to be raised
- Discharge links with the EICT
- Modelling to determine the long term viability of a 5 care centre bed model including the associated staffing and costs

The COVID-19 response improved length of stay in EI Beds significantly. This was due to:

- Changes to CHC, long term placement, housing and budget approval process that reduce the overall workload for practitioners progressing discharge (data captured through the EI model shows these processes accounted for the biggest delays in beds)
- The creation of a 'Co-ordination Hub' overseeing flow from acute beds, through pathway 2 beds and into long term settings. This became the primary escalation structure to enable system flow, with clear patient by patient actions.
- Redeploying staff (mainly from social care) so that all EI Beds provided the same care and did not have criteria for entry

The short-term deliverables for the Pathway 2 project are:

- Support the Interim Commissioning Framework by:
    - Working with commissioners, delivering demand and capacity modelling to determine winter bed requirement, including estate and workforce. This needs to clearly set out performance and outcome expectations for the beds.
    - Determine the financial envelop for the whole provision to work within, based on available funds/resource and the requirements from the point above
    - Determine the proportion of the beds and the subsequent strategy for EABs
- Continue to embed the performance standards, monitoring and review processes established through EI across all sites to maintain LOS and flow
- Determine the desired medical model to proceed with over winter
- Formalise definition / classification of bed base (generalist / specialist) and how capacity will be provided to meet demand modelling (including use of EAB and flex capacity)
- Define, agree and pilot medical workforce model to operate over winter, optimising workforce across UHB and BCHC and adoption of technology
- Agree appropriate model and timeline for future provision and running of Norman Power beds

Detailed Brief: Commissioning

Birmingham and Solihull CCG (BSol CCG), Sandwell and West Birmingham CCG and Birmingham City Council, as the commissioners, currently commission separate elements of the early intervention clinical model through a number of different contractual and payment mechanisms. The challenges this brings is that there is not a single clear specification and set of outcomes for the service being commissioned through one route. All commissioners had agreed to develop and deliver an integrated commissioning approach for the Early Intervention model. The ambition is to achieve a single commissioner voice, contractual mechanism and payment methodology with the aim of commissioning a single provider model such as an alliance or prime provider model. The intention is for the Integrated Commissioning to be via the Birmingham Better Care Fund (BCF) to ensure the single funding stream, integrated governance and processes for monitoring the service. Detailed work had taken place to understand the existing commissioning/ contractual arrangements alongside the financial framework. In particular work had taken place to develop an Early Intervention Bed Strategy as there were numerous commissioning consideration – such as capacity and demand modelling, the mixed market approach to providers of bedded care, varying access and fragmented support offer, contractual and financial implications.

An integrated commissioning road map had been developed and 2020/21 was going to be a transitional year to the new integrated commissioning and delivery arrangements. The first step was designing service specifications which would also facilitate provider alliance discussions as each specification would form part of that provider's contract.

Prior to the COVID response, the system had draft specifications to review for OPAL, EI Beds and EICT. These had been jointed created by the CCG and BCC and had been initially circulated amongst partners with a view to iterating them ahead of the 20/21 contract year.

It's important to recognise the different time horizons now being considered in the work. There is a need for strategic commissioning piece of work to enable the long-term aspirations of the system and this was the mind set taken to the work on the specifications mentioned above. However, in the short term it has been agreed that the system needs to focus on preparedness for winter and the aspiration is not to move to the 'end state' for winter. Therefore, the commissioning work needs to enable sustaining as much of the positive changes as possible for winter, with a view to the longer term work commencing once that is in place.

The short term deliverables for the Commissioning project are:

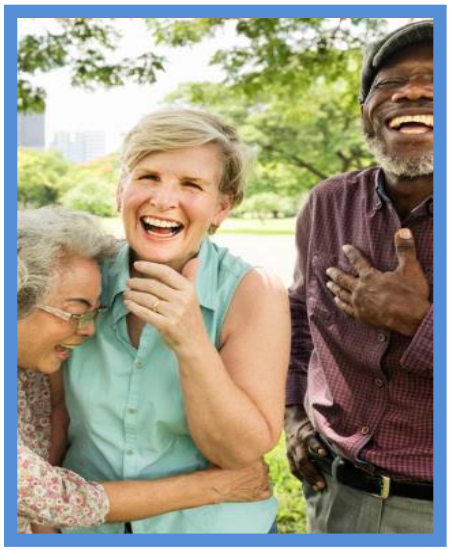
- An agreed statement of intent for commissioning EI; setting out an outline framework and approach for the commissioning of services within scope of Pathways 1-3, OPAL and an Integrated Pathway Hub including and assessment of the financial envelope for EI as we move to a sustainable deliver model.
- An Interim Commissioning Framework in recognition of the need to enable EI's winter response by:
    - Setting the expected demand/outcomes/performance by component for winter
        - Specifically for EI beds, to determine winter bed requirement, including estate and workforce. This needs to clearly set out performance and outcome expectations for the beds.
    - Setting the expected financial envelop for each component/service for winter
        - This will be significantly impacted by the ability to make the notional financial benefits of the Early Intervention service cash releasing. This will be worked through specifically by FPDG and fed into this work.
        - There is a recognition that EI inherited a large amount of non-recurrently funded front line staff from the services that existed before that. It's acknowledged that if these non-recurrently funded staff were removed from the 'old system' then front line operations would have broken down. Therefore the ask for this group is to find a pragmatic way to bring assurance to these staff being funded rather than whether these staff should be funded.

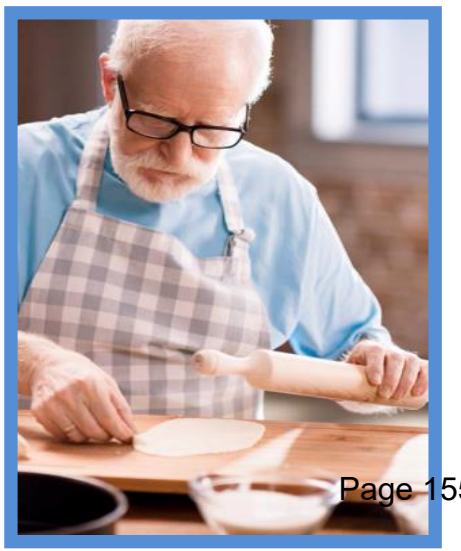
- Setting out any additional expected resource to support the EI winter response (i.e. redeployed staff from other services)
- Setting out any further specification of the services that are to be provided for winter

Birmingham Older Peoples Programme

Making Birmingham a great place to grow old in

The Early Intervention Programme - Intermediate Care Community Pathways





Birmingham City Council

NHS

PROGRAMME PRINCIPLES

designed with front line staff and the public

- Our aim is to have one integrated model across our entire system.
- Our aim is to support a person's life not simply deliver a service.
- The person is at the centre of everything we do (with family and carer input valued).
- We need to make sure each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- People should have to tell their story as few times as possible.
- Staff across organisations work together (co-locating where appropriate) to champion the 'home first' ethos.
- And the result of all this -more people will live more independently in later life.

WHAT WAS THE PROGRAMME?

The programme set out 5 components of a future Early Intervention Service, through engagement with senior health and social care practitioners in the Birmingham system:

- **OPAL**: A geriatrician lead multi-disciplinary team that ensures individuals presenting at the front door of the acute hospital get the most appropriate onward get
- **Hubs**: A multi-disciplinary team that work at the point of discharge from acute hospitals to ensure timely discharge on the most appropriate discharge pathway
- **EI Beds**: A single bedded intermediate care provision to support people to recover as much independence following a crisis as possible, ideally returning home
- **EI Community Team**: A single at home intermediate care offer that supports people to recover in their own homes and minimise the ongoing level of need an individual has and therefore the support they require
- **Mental Health Wards**: Specialist mental health provision to care for people experiencing an acute mental health episode

Early Intervention – Outcomes of the Programme

Data to 20th July 2020

EARLY INTERVENTION SYSTEM IMPACT (22/07/20)

Getting more people home

In the old world, if someone interacted with an EI component, there was a 65% likelihood of going home

Now, there's a 63% likelihood of going home

To get more people home, we should look first at OPAL as that's where most people aren't going home at the moment

If we want to improve further, we should then look at Hubs

EI components today mean we need to use 77000 fewer acute bed days than we used to

This is better than the diagnostic predicted!

Our biggest area of success has been with the Hub teams!

To use fewer acute bed days, we should first look to make further improvements with the OPAL teams

To make even more improvements, we should work with Juniper teams

Using fewer acute bed days

Using fewer non-acute bed days

Compared to the old world, the Birmingham system is using 19000 fewer non-acute bed days

Reduced admissions means 1300 fewer days are needed

Shorter length of stay means 17300 fewer days are needed

To reduce our use of non-acute bed days, we need to focus on reducing admissions to EI Beds from our Hubs

Across all EI components, people spend 11.5 fewer days in the system

This is better than the diagnostic predicted!

Our biggest area of success has been with the EI Community teams, taking 20.7 days off the baseline length of stay!

To help people move through the system quicker, we should first look to the EI Bed teams

To make even more of an impact, we should look at the Hub teams

Reducing system length of stay

Making a positive financial impact

Our new EI services are having a impact of £25.8million saved for Birmingham

The diagnostic indicates we could achieve further financial benefits of £7.8million

Our biggest area of success has been with the Hub teams, with a £14.3m run rate financial benefit!

To have a bigger financial impact, we should look at the our EICT volumes, as this has a value of £9.1million

The next area of priority would be our OPAL teams, as this has a value of £3.6million

Staff Perspectives in EI

From staff event in December 2019

- ***"This is great for the older population of Birmingham and feels like patients are being given a voice"***
- ***"There is a level of MDT and cross organisational working that wasn't there before"***
- ***"What we've got to work on now is sustainability… and keeping everyone motivated"***

Staff Perspectives in EICT

Rolled out across 5 localities in April 2020 during the pandemic – surveyed 2-3 months later

Headlines

Summary

- People are generally feeling engaged with the concept and potential benefits of EICT, although some practical and process challenges are impacting on overall engagement levels
- Team cohesion is improving and people feel they are starting to work together well, but still need greater understanding of different roles & disciplines
- There are some practical skill and knowledge gaps (systems and processes in particular) and people feel a more robust induction would be beneficial

Skills & knowledge	• There are still some gaps for the teams in their understanding of key processes and systems but some work is happening to address these areas (e.g. Rio training) • There are some mindset / behavioural gaps which may also need some focus • People have found practical training and peer and manager support have been most useful for them so far
Engagement	• The large majority of people are engaged with the potential benefits of the EICT, but some practical challenges are impacting on overall engagement levels (e.g. people working in different places) • Generally people feel part of the team and positive about the possibilities of EICT • However, a number of people feel unclear on their own roles and responsibilities as well as those of others which is impacting on their engagement and motivation; and volume and duplication of paperwork is also impacting on this quite consistently
Team cohesion & ways of working	• Overall people feel the teams are starting to work in a well integrated way despite the challenges of COVID • There is more work to do to make sure people get to know each other, and really understand each others' roles and expertise • Most of the key ways of working are starting to be at least partly demonstrated across the teams but more work is needed to fully embed these

Citizen Satisfaction with Changes

Review Supported by Healthwatch

Feedback for EICT

PATIENT FEEDBACK

We asked patients on our service if they'd recommend EICT to friends and family, should they need similar care or treatment...

everyone

said 'yes'!

Strictly Private and Confidential

What did patients and their families say?

"I don't know what I would do without your help"

"Very friendly, very helpful, dealt with all issues properly and respectfully"

"All the team are very professional, respectful, kind and extremely caring"

"Just keep doing what you're doing"

"All the team have made a big difference"

"All the people that come to see me are great"

STORY OF DIFFERENCE

- citizen's name changed

"Sam pulled her pendant alarm after a fall. The ambulance crew came to see her and immediately phoned "Ask OPAL" for a remote consultation as they believed Sam needed to be admitted. After speaking with the OPAL team at QE, Sam actually stayed at home and was referred to the EICT instead.

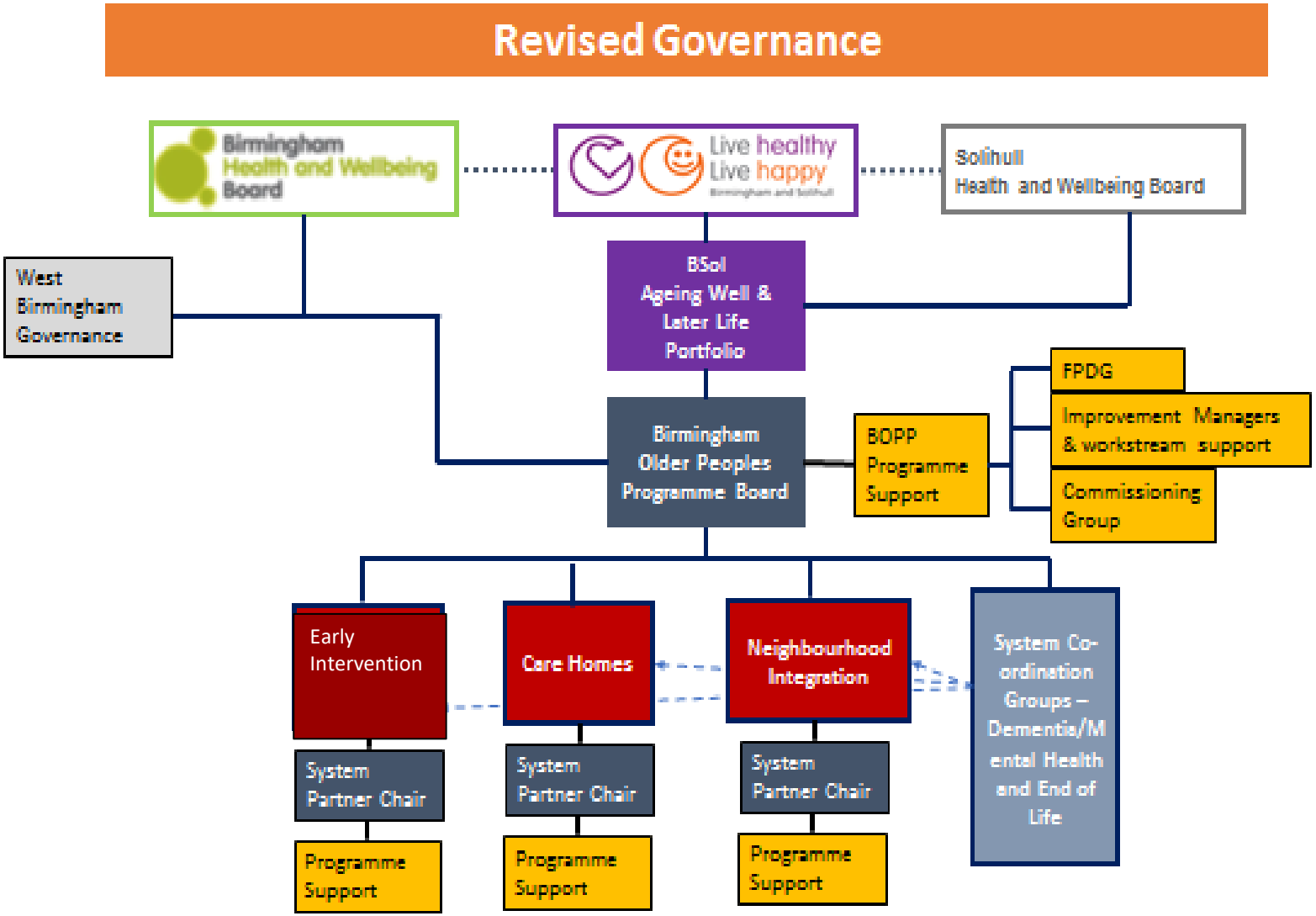
Sam was seen by a nurse from the EICT and had an initial assessment that outlined some care requirements and a recovery plan. This included realising that Sam had not been taking her medication – an important part of keeping her safe and well at home.

The nurse noticed that Sam had mobility issues, the EICT, the nurse was able to bring in a o work with Sam as well to help her her mobility and her ongoing dence.

After two weeks of intensive support, Sam was ged from the EICT fully independent and er medication meaning she's much more n an ongoing basis."

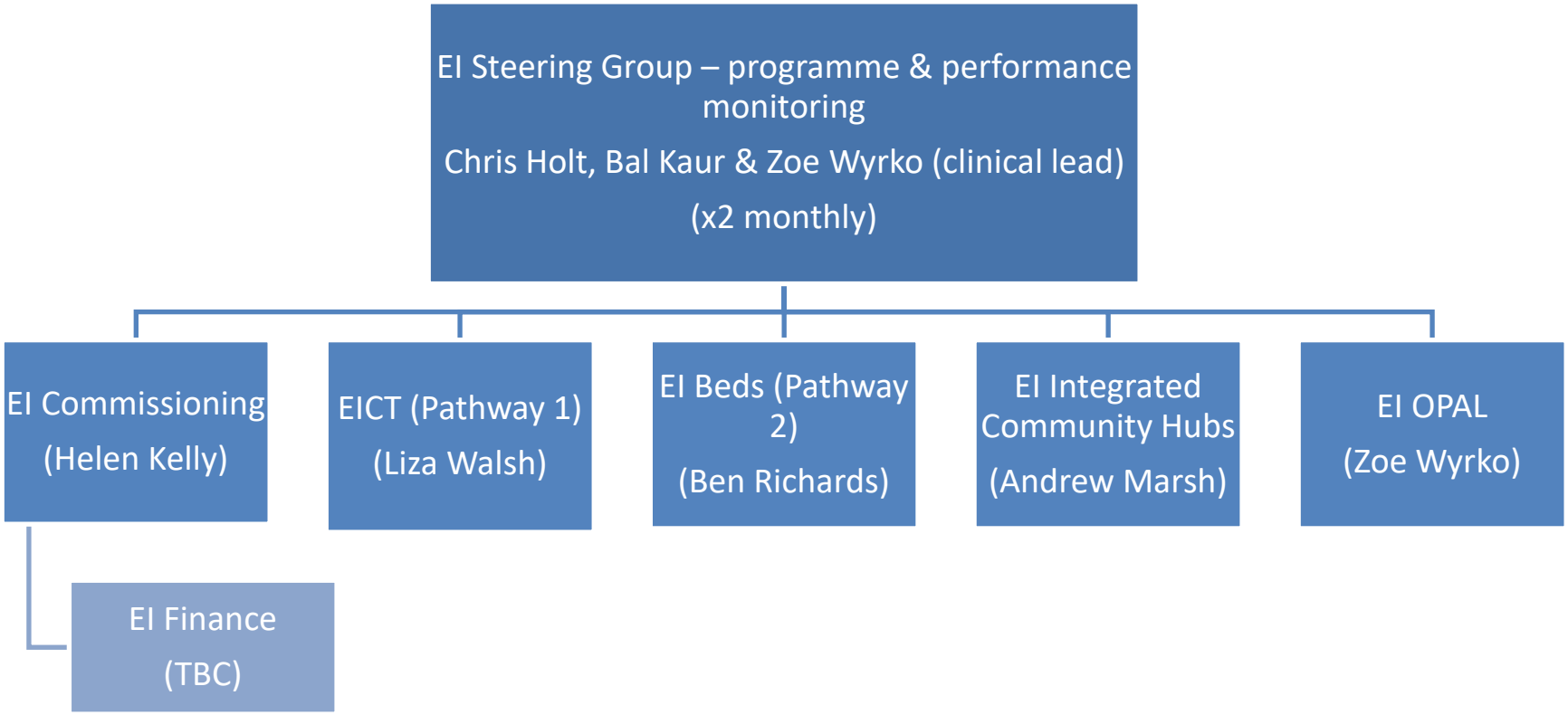
THE NEW EARLY INTERVENTION PROGRAMME

BIRMINGHAM OLDER PEOPLES PROGRAMME GOVERNANCE



EARLY INTERVENTION PHASE 2 PROGRAMME GOVERNANCE

Meeting Structure



EARLY INTERVENTION PHASE 2

- PRIORITY DELIVERABLES

1.	Interim Commissioning Framework
2.	Performance oversight and sustainability of phase 1 components
3.	EI hub workforce stabilisation and local policy/process agreements
4.	Confirming and establishing winter bed base
5.	EICT sustainable workforce
6.	EI medical model and technology
7.	Stabilise links with EOL and mental health

EARLY INTERVENTION PHASE 2

- PROGRAMME FOCUS FOR 6 MONTHS

- To prepare for winter and COVID
- To deliver over winter together as a partnership
- To continue to protect the workforce and deliver better outcomes for citizens
- Building upon the experience and progress we have made in working together to further improve:
  - The number of people who avoid a hospital admission if they can be better cared for elsewhere
  - The number of people cared for at home
  - The length of stay in hospital (acute and community based) for those who need a stay
  - The number of citizens who are more independent at the end of an intervention and ideally remain at home as part of their communities

Birmingham Health and Wellbeing Board

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22 September 2020**
TITLE:	**LOCAL COVID OUTBREAK ENGAGEMENT BOARD**
Organisation	**Birmingham City Council**
Presenting Officer	**Elizabeth Griffiths, Assistant Director of Public Health**

Report Type:	**Information**

1. Purpose:

To inform the Board of Governance and purpose of the new sub-Group of the Health and Wellbeing Board, the Local Covid Outbreak Engagement Board.

2. Implications:

BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	✓
Joint Strategic Needs Assessment		
Creating a Healthy Food City		
Creating a Mentally Healthy City		
Creating an Active City		
Creating a City without Inequality		
Health Protection		✓

3. Recommendation

3.1 The Board is asked to note this update of the Local Covid Outbreak Engagement Board.

4. Report Body

4.1 The Local Covid Outbreak Engagement Board is a new sub-committee of the Birmingham Health and Wellbeing Board. The Board is required by national guidelines for each upper tier local Authority's response to the Covid 19 outbreak.

4.2 The purpose of the Board is to provide political ownership and public-facing engagement and communication for outbreak response to Covid19 in Birmingham.

4.3 The Board has been set up to:

- Take an overview of the progress of the local implementation of Test and Trace.
- Ensure that the Test and Trace response in Birmingham is delivering the right interventions to protect the health and wellbeing of citizens
- To influence the development of the local Test and Trace programme.
- To promote communication and engagement with stakeholders and residents of Birmingham related to Covid 19 and the Test and Trace programme.

4.4 The Board is chaired by the Leader of the Council; membership comprises five elected Members, the Director of Public Health, Assistant Director of Public Health, the Birmingham and Solihull and the Sandwell and West Birmingham Clinical Commissioning Groups, WM Police, BVSC and Birmingham Healthwatch.

4.5 The first meeting of the Local Covid Outbreak Engagement Board (LCOEB) was held on 24 June 2020, with meetings held on a monthly basis.

4.6 The LCOEB receives a regular Covid19 situation update – both at the monthly meeting and on a weekly basis to members of the Board. These updates include the latest position in relation to Covid19 cases across the city, testing uptake, the proportion of tests taken that return a positive result. As this is a rapidly changing situation the latest epidemiology is presented to the Board.

4.7 Appended to this report are the confirmed minutes of the LCOEB.

5.	**Compliance Issues**
5.1	***HWBB Forum Responsibility and Board Update***

5.1.1 Whilst Birmingham's emergency plan is activated, the Test and Trace Cell will form part of the "Silver" command structure as a cell of the Tactical Cell. In parallel, the Test and Trace Cell feeds into the Birmingham Health Protection Forum, chaired by the Director of Public Health, which is a sub-group of the Health and Wellbeing Board.

5.1.2 Recognising that Test and Trace is likely to extend beyond twelve months, at such a time as the emergency response structures are stood down, formal governance of the Test and Trace Cell will be via the Health Protection Forum.

5.1.3	The Local Covid Outbreak Engagement Board will provide democratic oversight to the Test and Trace response.

5.2	***Management Responsibility***
	The Director of Public Health is responsible for publishing the Local Outbreak Response Plan for the City and Chairs the Health Protection Forum. The Assistant Director of Public Health chairs the Test and Trace Cell and is responsible for the local operational delivery of Test and Trace in Birmingham.

Appendices
Appendix 1 - Local Covid Outbreak Engagement Board Minutes - 29.07.20 Appendix 2 - Local Covid Outbreak Engagement Board Minutes - 24.06.20

The following people have been involved in the preparation of this board paper:

Elizabeth Griffiths, Assistant Director of Public Health

BIRMINGHAM CITY COUNCIL

LOCAL COVID OUTBREAK ENGAGEMENT BOARD WEDNESDAY, 29 JULY 2020

MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON WEDNESDAY 29 JULY 2020 AT 1400 HOURS ON-LINE

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB
Andy Cave, Chief Executive, Healthwatch Birmingham
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Councillor Brigid Jones, Deputy Leader of the City Council
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Councillor Paul Tilsley
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

15 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.

APOLOGIES

16 Apologies for absence were submitted on behalf of Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care; Chief Superintendent Stephen Graham, West Midlands Police; Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the LCOEB and Elizabeth Griffiths, Assistant Director of Public Health

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DECLARATIONS OF INTERESTS

17 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.

WELCOME AND INTRODUCTIONS

18 The Chair welcomed everyone to the Local Covid Outbreak Engagement Board meeting and invited the members of the Board who were present to introduce themselves.

MINUTES

19 **RESOLVED:-**

The Minutes of the meeting held on 24 June 2020, having been previously circulated, were confirmed by the Chair.

COVID-19 SITUATION UPDATE

Dr Justin Varney, Director of Public Health introduced the item and shared a slide presentation on *Birmingham Covid Outbreak Overview* with the Board.

(See document No. 1)

In response to questions and comments, Dr Varney made the following statements:-

a. Dr Varney noted Councillor Tilsley' s comments regarding the statistics from the *Times* Newspaper and advised that the article was referring to the new information that was published in the last week or two on Medium Super Output area.
b. Any member of the public could go onto the .gov website and go to the Coronavirus Data Dashboard and put in their postcode in the map at the bottom of the page which would give the number of cases there had been over the last week.
c. Public Health was looking at this in two ways (a) by monitoring the rate on a daily basis in terms of what Public Health had been told which was much faster as the website was only updated weekly. Public Health was looking at both in terms of absolute numbers and as rates as there was some variation between different sizes of population.
d. In general the most that was seen in one Medium Super Output area which was the level down from the Ward was 21 which was linked to a household from the same family, which was not of concern. One of the issues they had was some of the data that could be accessed by the

postcode was that people could look at these and get anxious about the 21 cases in the area. The area in that particular situation had approximately 6,000 residents which meant that it would be highly unlikely for those 6,000 people would come into contact with them.

e. Public Health was monitoring this closely on a daily basis. People could look at the total number of cases to date in their area. There were variations across Birmingham, but where there was more visible variation was between Birmingham and some of the more rural areas such as Herefordshire or Staffordshire where the case in those geographical areas were much lower. Some of this was about population density and the cities that had been impacted harder.
f. Dr Varney noted Dr Manir's question in relation to the delay with data around ethnicity and advised that there were a couple of reasons for the delays, one being the way the data was coming through the national test and trace system. There was data that Public Health receive on a daily basis of new cases which did not include ethnicity.
g. Often that dataset include positive cases over the last three to four days which was about how the labs were loading data onto the system and how Public Health England (PHE) was able to retrieve if from the system to give to Public Health.
h. Further work was being done nationally to try and match data from the labs and what was put into the system when people booked test and their ethnicity. A third of people did not fill in the ethnicity box.
i. Currently the gap Public Health had was that the national system had not yet provided data on the ethnicity of people taking the test which was an important piece of information that was needed. If it was seen for example that the majority of people testing currently were from the Asian community, and there were 53% of overall cases testing positive over the last month from the Asian community, then this reflected the community taking the message seriously and the communications were working.
j. If what was seen was only 10% of test was from the Asian community, and this was generating all the positive, that would be a different picture and the concern would be whether communications were being done correctly. This was something the directors of Public Health raised nationally on Friday and Public Health was told that there was significant work being done nationally to resolve the issue.
k. Another element was Pillar 2 testing community testing was going through multiple laboratories and the big difference Public Health had between the NHS Pillar 1 testing and Pillar 2 was that in the NHS testing there were 12 to 14 laboratories in the West Midlands all doing this all using the same software and the same approach and it was much easier to pull data.
l. For Pillar 2 testing community testing this was all the lighthouse laboratories that was seen in the news. These were all different and were working in different ways and there was a piece of work that tried to join all the data and get it in the same format which was causing some delay.
m. Dr Varney noted the Deputy Leader's query concerning Pillar 2 testing with regard to women who were more likely to be tested than men and stated that the *Age Profile of Pillar 2 Covid-19 Cases* slide was showing the confirmed cases rather than people being tested. The gender and

the age of people having the test was not known and it was unknown whether this was telling Public Health that women were less likely to get a test than men.

n. Over the whole of the outbreak, women were more likely to test positive which may reflect that women were more likely to be working in a social care sector for example and may be more likely to be working in the NHS sector where they had earlier access to testing through the NHS and the essential working programme.
o. The majority of new cases were in younger working age men which was raising an issue for Public Health as to how to get the message across to men that Covid affects them, particularly to young men. There was concern around this and was the reason they were looking at this age profile carefully.
p. Although relatively few young adults will get severely ill, many were living with their parents/grandparents and could take the virus back into their house and infect their parents/grandparents. If intergeneration *bleed* was seen, the bulge above the younger adults get bigger which would suggest that the message was not getting across strongly to young people, particularly young adults of working age that they could take the coronavirus home and there was evidence that they were taking it home.
q. Although for them it may not be high risk for the people, they live with it may be a high risk.

At this juncture, the Chair expressed concern that amongst some communities as testing involve taking their details and storing these on databases etc. this was putting people off from getting tested. The Chair queried whether there was any evidence of this coming through.

r. Dr Varney advised that a clear answer could not be given concerning the issue as the demographic of testing up take was not known. He added that Public Health was looking on a daily basis at the rate of testing across the city.
s. Although Birmingham was a diverse city and many of the Wards were quite diverse some communities were more geographically based. If Public Health were starting to see for example the African/Caribbean community not taking up testing, then it would be expected to see areas like Handsworth, Holyhead, Lozells and Aston falling down the ranking compared to others.
t. Dr Varney highlighted that Public Health was looking at this closely and voiced concerns about the myths that were in the community. He stated that there were some incredible technical ones – example as the swab to the back of the nose was quite uncomfortable some one was trying to insert a chip into the brain. Dr Varney advised this was not true and that it was beyond the capability of the NHS to be that clever. He highlighted that it was important to *bust* some of these myths and to encourage communities to understand that the reason this was the NHS test and trace system was that it was being governed in the same way that the General Practitioners records were.
u. The same level of confidentiality and to secure data and there was a lot of work to ensure it was safe and robust for people to give their information and in the same way they did their doctors. This was a health initiative and a health crisis.

v. In relation to the fall in testing figures, Dr Varney advised that some of this was when the data was looked at and when the weekend effect came through. There was a need to check on the figures the same day each week to see whether there was a pattern. A drop-in figure was seen across the whole of the West Midlands region – Solihull was 760 test and were now down to 560 and wee second only to Sandwell who were doing a lot of testing as a result of the two workplace outbreaks.

w. As yet it was uncertain why the West Midlands had dropped down in testing, but there had been some changes in the drive through testing sites. The site that was at the Midlands Metro car park was closed and was relocated to Sandwell. The Edgbaston site was closed last week, and a new site was being opened up. There was a variation in access to testing which may be the reason for the fall in testing and would be worried if it fell below 400 and would be happier if it was above 500.

20 **RESOLVED: -**

The Board noted the discussion at the meeting.

TEST AND TRACE IMPLEMENTATION UPDATE

Dr Justin Varney, Director of Public Health presented the item and drew the Board's attention to the information contained in the report.

(See document No. 2)

In response to questions and comments, Dr Varney made the following statements:-

I. Dr Varney noted Dr Manir's comments concerning the close proximity of the Newtown Project to Aston Pride in relation to appointments and stated that the other 5% should have an appointment and that the majority of the 5% were referred by their GP. It was noted that some GPs were referring people to the site and were forgetting to advise them to say ring 111 first.

II. Dr Varney further noted Dr Manir's comments concerning joined up work with both sites and advised that he would take this outside the meeting, but there was a faster solution where testing could be done at the *Red* site.

III. Dr Varney added that he was in active negotiation with the Department of Health (DOH) and had been told that at some point the Director of Public Health will be given an allocation of test kits each day to distribute how Public Health say fit which would allow them to do some proactive testing with high risk communities. This would also allow for support of the *Red* sites for those Clinical Commissioning Groups (CCG) doing testing on their own sites as it seemed illogical to have someone seeing a clinician and not swabbing them whilst they were there.

IV. In terms of looking for sites around the city where test and trace could be done quickly, over the last month Public Health was trying to get clarity from NHS England and Deloitte and the HSE on how much space was needed. Dr Varney advised that one of the challenges had been until

recently they had acquired a tarmac space which was equivalent to a 100-space car park. This was the car park space in front of the Warwickshire County Cricket Club, Edgbaston which was the car parking space that was needed.

V. There were few of these within the city that could be utilised, and this was the criteria that Public Health had, and they had asked for more flexibility which came through this week. Now that Public Health had the new specification, they could start to scope alternative sites. There were three types of site that was being looked at – the 100-space car park; a site that was .08 of an acre which was about the size of a small office car park which would be a similar outdoor tent set up with portacabin as was case in Villiers Street.

VI. The other had been some in Leicester for indoor testing sites which require a large room of around 10 to 15 square metres with tiled or vinyl floor that could be cleaned with a chlorine and bleach product. Public Health was in the process of looking at what was in the City Council's estate and with some of their partners like the universities to look at potential sites that could be used.

VII. This proposal would then be taken back to the DOH to get agreement to start to mobilise some of these and to look at which of those they could use as a semi-permanent site like the Villiers Street site for two or three months versus sites that might be rotational like the Berry Street car park was at the moment. Dr Varney undertook to bring back a much clearer plan concerning this to the next Board meeting.

21 **RESOLVED: -**

The Board noted the discussion at the meeting.

TEST AND TRACE ENGAGEMENT PLAN UPDATE

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

(See document No. 3)

The Board members then made the following comments/statements: -

Councillor Brigid Jones, Deputy Leader of the City Council commented that in terms of the work done at the Ward Forums it was a useful approach particularly for her Ward which was unusual as there was half students and permanent population and was a unique mix of issues with students coming from across the country moving in and out all the time. She added that people had described some of this year's wave of freshers' flue as being fresher's flue on steroids and were worried about it as it had Covid in the mix as well.

Councillor Jones highlighted that this was really useful as they had done two with Dr Varney attending her Ward Forum meeting and was able to reassure the permanent residents about what was being done. She advised that on Tuesday evening, they had a good conversation involving the University of

Birmingham, the Guild of Students representing the student body, members of the public and the community groups.

Councillor Tilsley commented that the constant dialogue they wee able to have he was lucky that from the point of view that he sat on the Health and Social Care Overview and Scrutiny Committee and the Joint Health and Social Care Sandwell and Solihull Committees where he work collectively not only to disseminate information which was of primary importance and every now and then to challenge some preconceived ideas and was particularly concerned with the misinformation that was being circulated in the community. These were some of the issues they needed to challenge particularly amongst the young and some community groups.

Dr Varney stated that Public Health was working with the CCGs around doing some GP awareness education events. Sessions were also being done with the British Medical Association (BMA) West Midlands. In Solihull Public Health had done two sessions for GPs through presentation and they were able to ask questions. Public Health was looking at how they could use that model and offer this to dentists and pharmacists and potentially a model for social care.

Andy Cave, Chief Executive, Healthwatch Birmingham commented that an amazing amount of work was being done around engagement and they were doing as much as they could. He added that it would be useful if they could tap into some of those resources that could be shared with Healthwatch Birmingham to ensure that they were getting the key messages right and the right target audience so that they could retarget their resources to get into communities.

Dr Varney advised that the link in Public Health was Ricky Bandall. He added that they had been working with the communication and engagement leads in both CCGs and had been learning from each other as they were sharing for example both CCGs had put forward GPs to join the meetings with Faith leaders with the Bangladeshi community and he was working with both communication and engagement leads in both areas.

Stephen Raybould, Programmes Director, Ageing Better, BVSC stated that the voluntary sector appreciated the appointments being put in by Public Health and that Dr Varney was speaking to one of their groupings this week. Mr Raybould added that Public Health could not be everywhere all of the time and that BVSC had additional networks that they could distribute information including targeting information to particular communities and particular interest groups and groups that were vulnerable. BVSC could engage with Public Health as to how they could get that information across. Mr Raybould stated that he was aware that they would need to do this as the recovery and resilience period move forward to do this repeatedly especially around particular outbreaks and were looking to do this over the next six to nine months.

Councillor Jones stated that it was amazing to see all the work that was being done to engage all the communities and to get the message out. She added that the root cause of them having to do this in the first place was that the

government guidance the Council got needed to be crystal clear. Much clearer message coming from the centre was needed.

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG stated concurred with Dr Varney's statement earlier concerning collaboration in relation to the specific pieces of work with the Bangladeshi community and the work they were doing in Lozells. In general there was a lot of points of connection and Primary Care Network was kept woven into this. In a broader sense, the conversation that needed to be had with the public as they work their way through this as more and more people were getting the sense of returning to normal, but in reality, we were still a long way from normal. Some of our services provision and capacity will be a long way from normal for a long time to come.

Dr Varney commented that he welcomed the positive feedback and agreed with Mr Raybould' s point that public Health could not be everywhere all the time and would pick up both his and Mr Cave's offer and ensuring the scripts and messages to help were getting to them to get the message out. Dr Varney stated that a lot had been learnt through the journey of the first wave, but that we were not through this yet as there would be a second wave. He added that the more they could start to think through how this could be done sustainably over the next year and as highlighted by Councillor Jones, how we make this part of being in Birmingham and our on-going approach to working with communities which was a real strength from the positives being seen particularly working with the Faith communities where the guidance had been vague for most of the outbreak.

It was through the collaboration with the Mosques that they had safe Eid and not seeing huge rise in cases. Through working with the Gurdwaras that had not become a vector of transmission of Covid. It was working with our Churches, particularly with our Evangelical Churches to help them navigate how to celebrate their faith without the pleasure of song which was a core part of their worship that public Health had supported them and work through with them. There were still much more to do and as the Chair had challenged him, Public Health was looking at Newham and their champion programme and will update on that at the next Board. Dr Varney stated that he welcomed the positive feedbacks and continue to do what they could to ensure everyone in the city had the information to keep them, their families and the city safe.

22 **RESOLVED: -**

The Board noted the discussion at the meeting.

PUBLIC QUESTIONS SUBMITTED IN ADVANCE

23 The Chair introduced the item and advised that there were no public questions submitted for this meeting. She advised that she was keen on receiving questions from the public as the public helps to see if we got things right or wrong. The Chair further stated that the reason questions from the public was needed was to be able to measure what was going on. The Chair suggested that if members of the Board members were asked a public health question by

members of the public that this be used as a public question for the Board so as to ensure they were bringing the public along with the Board.

TEST AND TRACE BUDGET OVERVIEW

Dr Justin Varney, Director of Public Health presented the item and drew the Board's attention to the information contained in the report.

(See document No. 4)

In response to questions Dr Varney made the following statements:-

- In terms of the recruitment for six Environmental Health Officers Dr Varney advised that in the recruitment of the 31 additional posts Public Health was creating, including the six Environmental Health Officers, a mixed method approach to recruitment was being taken.
- Public Health was approaching agency whilst advertising for internal secondments.
- As these were fixed term posts and it was uncertain as to whether they were needed for six months or 12 months they were needed now as Public Health did not have the time to go to a full external recruitment unless they were unable to fill the posts internally or through agency.
- Dr Varney advised that Environmental Health colleagues were working with an agency and had identified a *sweep* of candidates over the last few days and will be interviewing them over this week.
- It was hoped that by next week Public Health would have the additional capacity in place.
- It will take slightly longer for the public health roles as a whole suite of job descriptions were created which had made it through the first Human Resources (HR) hurdles in 48 hours which was a record for the City Council and reflected how well the City Council was putting this together as part of the emergency response.
- These were going to agency today and internal advert on Monday and it was hoped that candidates would be received for all of them within two weeks for those posts with interviews in August and the successful candidates starting in September.

It was proposed that the budget should be a standing item on the agenda for the board meetings to note.

24 **RESOLVED: -**

The Board noted the discussion at the meeting and agreed for the budget to be a standing item on the agenda for future meetings.

OTHER URGENT BUSINESS

25 No items of urgent business were raised.

DATE AND TIME OF NEXT MEETING

26 It was noted that the next Local Covid Outbreak Engagement Board meeting would be held on Thursday 27 August 2020 at 1400 hours as an online meeting.

EXCLUSION OF THE PUBLIC

27 **RESOLVED: -**

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

Exempt Paragraphs 1 and 2 of Schedule 12A

BIRMINGHAM CITY COUNCIL

LOCAL COVID OUTBREAK ENGAGEMENT BOARD WEDNESDAY, 24 JUNE 2020

MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON WEDNESDAY 24 JUNE 2020 AT 1400 HOURS ON-LINE

PRESENT: -

Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB
Andy Cave, Chief Executive, Healthwatch Birmingham
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Councillor Brigid Jones, Deputy Leader of the City Council
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Chief Inspector Sarah Tambling, West Midlands Police
Councillor Paul Tilsley
Dr Justin Varney, Director of Public Health, Birmingham City Council
Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the LCOEB

ALSO PRESENT:-

Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

1 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.

APOLOGIES

2 Apologies for absence were submitted on behalf of Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG; Chief Superintendent Stephen Graham, West Midlands Police, but Chief Inspector Sarah Tambling as substitute and Elizabeth Griffiths, Assistant Director of Public Health

DECLARATIONS OF INTERESTS

3 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.

WELCOME AND INTRODUCTIONS

4 The Chair welcomed everyone to the first Local Covid Outbreak Engagement Board meeting and invited the members of the Board who were present to introduce themselves.

LOCAL COVID OUTBREAK ENGAGEMENT BOARD TERMS OF REFERENCE

The following Local Covid Outbreak Engagement Board (LCOEB) Terms of Reference was submitted:-

(See document No. 1)

5 **RESOLVED: -**

The Board agreed the Local Covid Outbreak Engagement Board terms of reference.

COVID-19 SITUATION UPDATE

Dr Justin Varney, Director of Public Health provided the Board with a verbal update:

- The Board was provided with the latest number of cases confirmed through Pillar 1 testing(swab testing in Public Health England (PHE) labs and NHS hospitals for those with a clinical need, and health and care workers) and Pillar 2 testing (swab testing for the wider population) were provided.
- Based upon Pillar 1 testing covid-19 rates Birmingham was ranked sixth highest in the West Midlands behind Walsall, Sandwell, Wolverhampton, Solihull and Stoke on Trent. Birmingham was ranked fifth amongst the core cities outside London, behind Sheffield, Newcastle, Liverpool and Manchester.
- It should be noted that there was no calculation for the 'R' rate reproduction number below the level of the West Midlands, which was estimated at 0.8, but the range was wide. It was important to recognise that the 'R' calculation was not effective or useful the smaller the area that was looked at as the range gets bigger.

- It was important to recognised that the estimate from the national surveillance was that 20% of the population have had Covid so far
- There were significant risks of seeing a second peak similar to the experiences the city had during April/May. This was the reason *Test* and *Trace* was important during this period as the city comes out of lockdown as they were able to get on top of outbreaks as they occurred and tried to control the spread as happened in early March after the first case appeared in Birmingham around the 8th March 2020.

In response to questions and comments, Dr Varney made the following statements:-

a. The rate at present for Pillar 2 testing was slightly lower in Birmingham than the rest of the West Midlands but was in line with the national average.

b. Birmingham, working with Birmingham and Solihull CCG, has taken a proactive approach to testing in care homes and nursing homes, undertaking test through Pillar 1 through the NHS laboratories.

c. The public health team had taken the decision to translate the test and trace national posters into multiple languages to explain the test and trace process. It was hoped that these would be launched by the end of this week to encourage citizens whose first language was not English to be aware of the opportunity to test for free and what it meant if they tested positive.

d. A detailed Communications and Engagement plan is in place for Test and Trace.

e. The Public Health team was working with the government to create a walk-in-testing site where people could pre-book and be able to walk-in for testing. The appropriate land site for this was being arranged and it was hoped that this would be up and running within the next couple of weeks.

6 **RESOLVED: -**

The Board noted the verbal update.

IMPLEMENTATION OF TEST AND TRACE IN BIRMINGHAM

The Chair commented that the Government was engaging more with local authorities as they move into the next phase of the pandemic. The Chair added that they would be given more responsibilities around test and trace and that they needed to ensure that they got this right if they were going to continue to keep people as safe as they possibly could across the city. The Chair then invited Dr Varney to make his presentation.

Dr Justin Varney, Director of Public Health, Birmingham City Council introduced the item and gave the following PowerPoint presentation

(See document No. 2)

Dr Varney highlighted the following and gave responses to questions and comments raised by the Board: -

1. With regard to people's cooperation concerning self-isolation, there was the potential that under the Covid legislation and the existing Public Health legislation, if someone refused to self-isolate who had tested positive for the coronavirus or as a contact, as a last resort they could take enforcement action.
2. In terms of contact tracing; exposure was considered to be 15 minutes or more within a two-metre radius.
3. Wearing face coverings further reduced the risk of spread in enclosed spaces such as a bus or train carriage.
4. In the context of individuals who were contacts and were considered highly vulnerable or difficult to engage with i.e. where someone had been identified as testing positive for the coronavirus and was homeless or attended a night shelter and the local authority needed help to work with PHE and the NHS on how to track down the contacts in that vulnerable group.
5. Secondly, where the location was a complex location – the team had been working closely with partners in the NHS throughout the outbreak, the voluntary sector and the private sector in terms of responding to outbreaks in care homes. (Dr Varney acknowledged the hard work that Paul Jennings' team, Birmingham and Solihull CCG had put in working with them alongside Adult Social Care and Children's Trust colleagues.) They had moved quickly ahead of some of the national guidance to support care homes and residential settings around outbreak management.

With regard to the *Local Outbreak Control Plan* this covered seven areas as detailed on slide 5 of presentation. The aim was to publish the Plan by the end of June 2020 a draft of which was submitted to the regional coordinator who had given a positive feedback to the plan.

In relation to the *Birmingham Outline Governance* a report was approved by Cabinet on the 23 June 2020 that approved the formation of the Local Covid Outbreak Engagement Board (LCOEB), formally as a sub-group of the Health and Wellbeing Board.

Paul Jennings commented that a fantastic piece of work was done around care homes with local government and health working together. Mr Jennings highlighted that working on infection prevention control and working on education and testing had appeared to him that for the first time in many years that they had been working in the health and care system that they finally wrapped their arms collectively around the care homes sector. The planning that took place around discharge from hospitals had been a revelation and something they were determined to keep as part of the system for the future.

Concerning the *Structure Responsibilities*, the Health Protection Cell was a 7 days per week function whilst most of the other structures were Mondays to Fridays. The Health Protection Cell had been in operation for the last 10 -12 weeks as a 7 days per week function. Dr Varney gave credit to his team members – Chris Baggot, Mo Phillips and Rachel Chapman who had been leading this work and the team around them. A huge amount had been done both within the Council and with partners that had helped the city weather this achieve lower rates that than had been predicted in February.

Capacity has already increased in Health Protection to 22 whole time equivalent staff as Public Health was asked to operate a 7-day system. Public Health was in the process of recruiting further staff to provide resilience to the response. The full Public Health division was being trained up which would enable them to serve at full capacity in the worst-case scenario with 70 people across the Health Protection response which was a real expansion if needed. Public Health was currently in the process of securing additional testing capacity and integrated infection control support into the testing capacity contract for non-care homes settings. Care homes settings were already provided through the relationship of the Council and the CCGs. This was for settings like schools and workplaces to be able to access support and advice in the context of the outbreak.

In response to questions and comments concerning the local implementation issues and risk, Dr Varney made the following statement:-

i. An impact survey was being undertaken in Birmingham to capture people's understanding and experiences and the impact Covid had on their health and wellbeing.

7 **RESOLVED: -**

The Board noted the presentation.

TEST AND TRACE COMMUNICATION AND ENGAGEMENT DRAFT PLAN

Dr Justin Varney, Director of Public Health, Birmingham City Council introduced the item and drew the Board's attention to the draft Communication and Engagement Plan.

(See document No. 3)

Dr Varney highlighted that the aim of the plan was to support the test and trace at a local level in Birmingham, to increase the awareness of individuals in accessing testing and to further increase understanding and awareness of the contact tracing process. He stated that it was important to engage with the process and the understanding of the national guidelines, particularly around isolation. The plan provides an opportunity for two-way conversations and that it was not just about putting out posters and leaflets but was about creating spaces for conversations with communities to hear and understand their concerns and issues. Dr Varney advised that the Deputy Regional Test and Trace Lead commented that the draft Plan was an example of good practice.

As part of the Covid response, nine organisational partners had been commissioned from the community and voluntary sector partners to work with Public Health on specific communities of identities. The partner organisations had demonstrated real value in two-way conversations so that it was better understood what the communities' concerns were as well as helping them understand how to engage with them better.

Dr Varney stated that there was a strand around how they were engaging and communicating with Elected Members and other key stakeholders that they anticipated through regular briefings which may also include outbreaks of specific communications where there was impacts on particular geography or portfolio responsibilities.

Members of the Board then made the following comments/statements: -

Councillor Hamilton enquired when they started to work in local communities whether they would be asking people to be co-opted onto the LCOEB to get some detailed work done quickly or whether this would be done separately.

Dr Varney advised that he would provide the Board with a monthly update on activity against the engagement and communications plan

Andy Cave commented that the Plan was detailed with good use of all the resources in the city, but that there was one group he did not see mentioned – the older adults, particularly those that were not connected or quite isolated in their local communities. He questioned whether that needed to be pulled out in the Action Plan .

Dr Varney stated that they were having detailed conversations about the issue, but it was a draft plan and one of the things they were looking through was how they expand on the community partnership programme around this specific point about how do they ensured that they had thought about how to connect people who were digitally excluded particularly older adults who may live alone and not in receipt of community services.

Councillor Hamilton stated that Birmingham Public Health was seen as an exemplar in terms of its community engagement.

8 **RESOLVED: -**

The Board agreed the draft Test and Trace Communication and Engagement Plan.

PUBLIC QUESTIONS AND DISCUSSIONS – QUESTION GOVERNANCE

9 The Chairman introduced the item and advised that this was an item for members of the public to submit questions to the Board for a response. It was noted that there were no questions submitted to this first meeting of the LCOEB.

SCHEDULE OF FUTURE MEETINGS 2020/2021

It was -

10 **RESOLVED: -**

The Local Covid Outbreak Engagement Board noted the schedule of meetings for 2020/2021 as follows: -

2020	2021
29 July	27 January
27 August	24 February
1 October	24 March
27 October	28 April
26 November	27 May (Provisional)
22 December	

All meetings will be held at 1400 hours except for November's and December's meeting which will commence at 1500 hours and 1300 hours respectively.

OTHER URGENT BUSINESS

11 No items of urgent business were raised.

EXCLUSION OF THE PUBLIC

12 **RESOLVED: -**

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

Exempt Paragraphs 1 and 2 of Schedule 12A

Birmingham Health and Wellbeing Board

	Agenda Item: 15
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22 September 2020**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham City Council**
Presenting Officer	**Stacey Gunther, Service Lead, Public Health**

Report Type:	**Information**

1. Purpose:

1.1 This update report details recent, current and future work related to:

- Creating a Healthy Food City
- Creating a Physically Active City Forum
- Creating a Mentally Healthy City Forum
- Creating a City Without Inequalities Forum
- Health Protection Forum Update

1.2 Sub forum meetings were initially paused as the Public Health Division diverted resource to support Covid-19 response. All forums have now restarted with meetings been held online via Teams. Due to increasing Covid-19 pressures these may be paused or run as short focused meetings until 2021.

2. Implications:

BHWB Strategy Priorities	Childhood Obesity	Y
	Health Inequalities	Y
Joint Strategic Needs Assessment		N
Creating a Healthy Food City		Y
Creating a Mentally Healthy City		Y
Creating an Active City		Y
Creating a City without Inequality		Y
Health Protection		Y

3. Recommendation

3.1 It is recommended that the board note the contents of the report.

4.	Report Body

Background

4.1 The Birmingham Health and Wellbeing Board has five thematic forums. The forums oversee the development and delivery of shared action to drive city-wide improvement. The forums are: Creating a Mentally Healthy City, Creating a Healthy Food City, Creating an Active City, Creating a City Without Inequality, and the Health Protection Forum.

4.2 At each Birmingham Health and Wellbeing Board meeting a presentation will be given from 1 of the thematic forums for discussion. The other forums will provide written update reports. The themes will present on a rota basis, with each theme presenting at least annually. Health protection is the board theme for the September meeting, this will be covered in item 3 on this occasion, with a written update included with the other forum reports.

4.3 This report is formed of 5 written updates. Further detail specific to each Forum can be found in **Appendices 1-5.**

5.	Compliance Issues

5.1	HWBB Forum Responsibility and Board Update

5.1.1 Regular updates will be reported to the Health and Wellbeing Board via a joint update report in this format, with each forum providing a presentation item rather than an information item update at least annually.

5.1.2 Action logs of the forums shall be recorded and reviewed at every forum to ensure actions are delivered.

5.2	Management Responsibility

Stacey Gunther, Service Lead, Public Health
Andrea Walker-Kay, Senior Public Health Officer
Kyle Stott, Service Lead, Public Health
Paul Campbell, Service Lead, Public Health
Monika Rozanski, Service Lead, Public Health
Chris Baggott, Service Lead, Public Health
Marion Gibbon, Interim Assistant Director, Public Health
Elizabeth Griffiths, Acting Assistant Director, Public Health
Dr Justin Varney, Director of Public Health

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Partners not delivering on the assigned actions required to enable the forums work.	Medium	Medium	Robust monitoring and regular update reports via the relevant forum

Appendices
Appendix 1 - Creating a Healthy Food City Appendix 2 - Creating a Physically Active City Forum Appendix 3 - Creating a Mentally Healthy City Forum Appendix 4 – Creating a City Without Inequalities Forum Appendix 5 – Health Protection Forum

The following people have been involved in the preparation of this board paper:

Stacey Gunther, Service Lead, Public Health
Paul Campbell, Service Lead, Public Health
Andrea Walker-Kay, Senior Public Health Officer
Chris Baggot, Service Lead, Public Health
Kyle Stott, Service Lead, Public Health
Monika Rozanski, Service Lead, Public Health
Elizabeth Griffiths, Assistant Director, Public Health

Birmingham Health and Wellbeing Board

Appendix 1 – Creating a Healthy Food City Forum Highlight Report

1.1 Context

The main purpose of the Forum is to work together to apply a whole system approach to understanding the food landscape of the city and improving the food behaviours at a population level across Birmingham by ensuring that a joint action plan is developed and delivered.

The forum has not met since the last update to the Health and Wellbeing Board and such meetings have been placed on hold due to the need for Public Health to focus resources on the Enhanced Measures being taken against COVID-19 in Birmingham.

1.2 Current Circumstance

While the Forum itself has been cancelled, work continues to be delivered on the work programmes as detailed below:

The **Childhood Obesity Trailblazer Project** is in the process of:

- Finalising an invitation to tender for the Birmingham Basket to establish a retail basket tracker to provide timely insight into the food purchasing behaviour of Birmingham.
- The workshop arranged for late July 2020 to finalise the spiral curriculum content regarding food knowledge and skills, has been postponed until 15 October 2020. A spiral curriculum is an approach to education that involves regularly re-visiting the same educational topics over the course of a student's education. Each time the content is re-visited, the student gains deeper knowledge of the topic.
- Finalising the content of the Developers Toolkit to support the creation of healthy communities through health-promoting planning policies and development management in Birmingham, has now been handed over to the Creating a Physically Active City Forum, although this Forum will contribute as appropriate.

Current activity on the **Birmingham Food Conversation** includes:

- Engagement through the launch of the National Food Conversation and a complementary BeHeard survey for Birmingham. The BeHeard survey launched on 22nd October 2019 through BeHeard platform, questionnaire based on Pune initial work and with input from academic partners. There have been 394 participants to date, key findings from initial quantitative analysis are in Appendix A (as previously shared with the Board), the further work to analyse the qualitative feedback has now been completed and incorporated.
- Thirty-one different organisations were commissioned to deliver ‘Seldom Heard Food Voices’. The groups were facilitated by community research consultants. A total of 372 persons were

engaged across all the focus groups. All organisations reported details of scripts and resources used, as well as the structured focus group content. We are still in the process of reviewing the documents to identify appropriate actions to take forward in both the short and long term.

The **Sustainable Food Places Award** is designed to recognise and celebrate the success of those places taking a joined-up, holistic approach to food and that have achieved significant positive change across six key food issues. A full summary was reported to the last Board. We have subsequently held discussions with the awarding body to finalise the application and be accredited as a food partnership that is making healthy and sustainable food a defining characteristic of Birmingham.

The **Food Foundation Partnership** to assist with implementation of national and international food policies and guidelines, and specialist advice, support and management of Birmingham's international relationships launched on 01 July 2020. The partners have been in discussions and negotiations regarding how best to deliver on the goals of the partnership. The partners have been in ongoing conversations to discuss:

- Milan Urban Food Policy Pact's planned Milan Pact Talks event and the submission of video or videos to highlight the work in Birmingham.
- Need to be really engaged in the UN food systems summit which is now July 2021.
- The upcoming joint update meeting regarding the BINDI project (Birmingham Public Health partnership with Pune, India), and how we can maximise sharing knowledge on nutritious food systems and work together towards Commonwealth 2022 legacy.

1.3 Next Steps and Delivery

- Finalise the tender for the Birmingham Basket.
- Hold Spiral Curriculum Workshop in October 2020.
- Finalise Seldom Heard Voices recommendations.
- Submit revised drafts of 2 sections of the Sustainable Food Places application and seek further feedback before completing remaining sections.
- Continue to engage with Food Foundation and wider partners.

Birmingham Health and Wellbeing Board

Appendix 2 – Creating a Physically Active City Forum Highlight Report

1.1 Context

The forum met virtually on 12 August 2020, the second meeting since business as usual activity had paused following the COVID-19 emergency response. The forum noted progress against actions and, also where progress had been delayed or halted due to the COVID-19 emergency response.

1.2 Current Circumstance

The August meeting of the Forum was chaired by Cllr Waseem Zaffar, Cabinet Member for Transport and the Environment. It was attended by 16 participants. The meeting maintained focus on the impact of COVID-19, and discussed the impact on participation, impact on programme delivery, the Emergency Transport Plan and the Emergency Travel Fund. The agenda included:

- An overview of the test and Trace system
- An introduction to BHealthy, a series of translated, practical resources to support partners working directly with communities to reduce the risk of their communities becoming seriously ill from COVID-19. Physical activity forms part of the content and forum members are involved in content development and webinar delivery
- An update on the BeHeard COVID-19 impact survey, highlighting the physical activity levels and behaviours reported by Birmingham citizens. At the point of presentation 50% reported participating in less physical activity now than pre COVID-19, with walking being the most popular form of physical activity.
- An update on the Emergency Transport Plan and emergency travel fund with detail on the 4 big moves that underpin its actions.
- The forum members took part in a workshop to explore how they could support the emergency transport plan with ideas and resources to enable the best possible outcomes for citizens of Birmingham
- Updates on forum work areas, including Future Parks Accelerator, Partnership for Healthy Cities (Bloomberg), The Active Wellbeing Society's Activity Communities Local Delivery Pilot and the Birmingham Community Sport and Physical Activity Alliance, co-ordinated by Sport Birmingham.

1.3 Next Steps and Delivery

- Continue to engage and support partners on FPA, Bloomberg, and BCSPAA.

Birmingham Health and Wellbeing Board

Appendix 3 – Creating a Mentally Healthy City Forum Highlight Report

1.1 Context

1.1.1 The aim of the Creating a Mentally Healthy City Forum (CMHC) is to work with strategic partners, stakeholders, Third and Voluntary sectors, Academics, and Faith Groups to improve mental wellbeing including access to mental health services for the most vulnerable and disadvantaged groups through the programmes mentioned in the Joint Strategic Needs Assessment (JSNA), the call to action in the Prevention Concordat, and the Suicide Prevention Strategy, along with other HWBB Forum: Creating a City without Inequality; Creating a Healthy Food City; and Creating a Physically Active City.

1.1.2 The scheduled bi-monthly meetings were disrupted by the COVID-19 pandemic. Since then one Forum meeting was stepped-up on 10 June, but due to a work programme at population level, aimed at reducing the risk of becoming seriously ill, a decision was made to step down the CMHC Forum until c. October 2020.

1.2 Current Circumstance

1.2.1 We continue the mapping exercise to establish the availability of mental health services across the life course in Birmingham; this combined with the results from our YouGov survey and COVID-19 impact survey on how people were managing their mental health and wellbeing will identify future areas for development.

1.2.2 Carried out a mapping exercise on how Suicide Prevention services have changed during COVID-19. Four questions were asked: where and how services were being delivered; how levels of uptake changed during COVID-19; what the observations on needs were; and what are the insights on the current services. There has been an increase in online referrals, and people phoning helpline for support. Self-harm has reported an increase and provisions being made to support people in this area. People are reluctant to seek help as they think COVID-19 is of greater importance than their mental health and they would prefer face-to-face support than online services and telephone calls.

1.3 Next Steps and Delivery

1.3.1

- Continuation of the mapping exercise, with an updated report, on mental health and wellbeing support across the City
- Closer working relationship with Birmingham and Solihull CCG to maximise input and building relationships for collaborative work, which will also involve input from our partners in CMHC
- Suicide Prevention initiate working with hospitals to ensure GPs are notified when vulnerable patients self-discharge. This to ensure they have continued support in the community as they often fall out of the system

Birmingham Health and Wellbeing Board

Appendix 4 – Creating a City Without Inequality Forum Highlight Report

1.1 Context

The Forum was stepped down in March 2020 as a result of the coronavirus outbreak as partners re-directed their efforts to support our citizens during the pandemic. The impacts of Covid on health and wellbeing and their extent are not yet fully understood, but we already know that the pandemic, and the wider governmental and societal response, have brought health inequalities into sharp focus.

The Forum resumed on 2 July 2020 via Teams. It was attended by 37 participants, including non-members. It was chaired by Cllr John Cotton, Cabinet Member for Social Inclusion, Community Safety and Equalities, focusing on the impacts of COVID-19 on health inequalities. The agenda included:

- An overview and progress report on the Birmingham-Lewisham Partnership to undertake a review on health inequalities affecting African and Caribbean communities;
- An update on food distribution and tackling food poverty during Covid;
- An overview of Covid-19 and its impacts on health inequalities as reported nationally and anecdotally;
- A presentation of initial findings from Public Health surveys capturing the impacts of Covid-19 on health and wellbeing of the residents of Birmingham;
- A discussion and exercises to map Covid impacts on health inequalities across the life course, looking at challenges, opportunities, actions and services and existing and/ or anticipated gaps.

1.2 Current Circumstance

The meeting scheduled for the 19 August 2020 was cancelled due to high number of apologies. Instead, a virtual request to report on short and long-term effects of the pandemic and its impacts on health inequalities across the life course has been made. This sits alongside measures to address those gaps in view to develop a joint strategic action that will strengthen/ complement the activity already under way.

1.3 Next Steps and Delivery

- The developed insight and maps will be used to create a joint action to prevent, mitigate and address the adverse impacts of Covid and health inequalities building on and through the wider partnership networks, including the Financial Inclusion Partnership, the homelessness and domestic abuse prevention agendas, the community recovery programme as well as the other Health and Wellbeing Board's sub-groups.

- Progress will be reported to the Health and Wellbeing Board regularly.

- The next meeting will be held on 14 September 2020 and will continue to focus on Covid impacts and mitigation and recovery action across the partnership.

Birmingham Health and Wellbeing Board

Appendix 5 – Health Protection Forum Highlight Report

1.1 Context

Due to the covid outbreak the Health Protection Forum have been meeting every 2 weeks since the 30th June 2020. Approximately 80% of each meeting is devoted to discussing the current coronavirus situation and response, with the remainder of the meeting covering other health protection concerns.

1.2 Current Circumstance

The coronavirus content of the meetings includes discussions on the outbreak plan, swabbing plans, mobile testing logistics, outbreak summaries, trends in the results, development of plans in response to results observed and other intelligence. Infection Prevention Control plans and issues are also discussed at the meeting.

Non-coronavirus situations are also discussed at the forum and include challenging health protection cases including TB and other blood-borne viruses that present a public health risk because of individual behaviours. The forum discusses the assessment of risk and escalation when necessary.

1.3 Next Steps and Delivery

The future plans for the Health Protection Forum meetings will focus on the recovery plans for NHS screening and vaccination programmes, and their implementation. The immediate focus is on planning and delivery of the seasonal influenza programme. Planning is ongoing and advanced with NHS England and Improvement, BSol CCG and is addressing the planned increase in targets and demand, alongside the challenged for delivery because of the current coronavirus situation and restrictions.

Due to the impact of coronavirus on childhood vaccination plans, the Forum has an additional focus on catch-up vaccination plans for childhood immunisations including MMR and planning for SARS-CoV2 vaccination.

Birmingham Health and Wellbeing Board

	Agenda Item: 16
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22nd September 2020**
TITLE:	**UPDATE ON BAME COVID-19 INEQUALITIES WORK**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney, Director of Public Health**

Report Type:	**Presentation**

1.	**Purpose:**
1.1	To inform the Board and members of the public of the progress since the July Health and Wellbeing Board meeting to mitigate risk and support ethnic communities from Covid-19

2.	**Implications:**	
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	✓
Joint Strategic Needs Assessment		
Creating a Healthy Food City		
Creating a Mentally Healthy City		
Creating an Active City		
Creating a City without Inequality		
Health Protection		

3.	**Recommendation**
3.1	The Board is asked to note the progress detailed in the attached report
3.2	Board members are asked to continue to work to mitigate disproportional risk of Covid-19 to ethnic communities.

4.	Report Body

4.1 The attached paper summarises progress made to date from the organisations listed below. Key themes covered include:

- Further understanding of the population to mitigate risks associated with protected characteristics and social economic conditions
- Accelerated preventative programmes including flu and obesity
- Support Health and Wellbeing of staff, those with protected characteristics have received a risk assessment
- Working collectively to use resource effectively to protect the most vulnerable
- Working to develop and resource BAME community leadership around health inequalities
- Outreach work to reach priority communities including faith communities
- Understanding community Covid experiences, particularly those from BAME communities.

4.2 The following partners have contributed to the content of the report:

- Sandwell and West Birmingham NHS Trust
- NHS Birmingham and Solihull Clinical Commissioning Group
- Sandwell and West Birmingham Clinical Commissioning Group
- Healthwatch Birmingham
- BVSC
- Birmingham City Council

4.3 Details of the discussion at the April Special Health and Wellbeing Board Meeting can be found in the minutes of the meeting.

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
	The impact and mitigation of the disproportioned risk of Covid-19 on ethnic minority communities will continue to be monitored though the HWB member organisations.

5.2	***Management Responsibility***
	Dr Justin Varney, Director of Public Health, Birmingham City Council

6.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Board member organisations cease to mitigate risk and support ethnic communities from Covid-19 leading to further increase in health inequalities	Low	High	Continue to facilitate discussions

Appendices
Update on BAME Covid-19 Inequalities Work Since the July HWB meeting

The following people have been involved in the preparation of this board paper:

Dr Justin Varney, Director of Public Health
Stacey Gunther, Service Lead – Governance

Update on BAME Covid-19 inequalities work since the July HWB meeting

This report summarises progress to mitigate risk and support ethnic communities from Covid-19 across Birmingham since the July Health and Wellbeing Board Meeting. As a Health and Wellbeing board we are keen to mitigate against disproportional risk of Covid-19 to ethnic communities whilst in parallel reduce the anxiety and fear that exists in these communities.

The following partners have contributed to the content of this report:

Sandwell and West Birmingham NHS Trust
NHS Birmingham and Solihull Clinical Commissioning Group
Sandwell and West Birmingham Clinical Commissioning Group
Healthwatch Birmingham
BVSC
Birmingham City Council

Sandwell and West Birmingham NHS Trust

The phase 3 (31/7/20) letter from the CEO and COO of the NHS requires us to name an "Executive Board Member to be responsible for tackling inequalities in September" for SWB NHS Trust this is Acting CEO, David Carruthers.

The phase 3 letter also states that "recommended urgent actions have been developed by an expert national advisory group" and that they will be published shortly. These include:

- Enhanced analysis of our population to mitigate risks associated with protected characteristics and social and economic conditions - Our work at ICP level and at Trust level has access to a population health and social deprivation database which has the ability to understand our population and focus interventions accordingly. This includes (amongst others): an ability to identify the patients most at risk of Covid based on key characteristics which can inform Shielding suggestions; identifying the characteristics of those patients that DNA most frequently; identify the characteristics of those patients who have had most still births; identify the characteristics of those patients that present with later stage cancer. Working alongside our Primary Care Community and Therapies Team, our Research and Development team and our ICP partners we are looking to use this data to alter how we provide better care for our population. Operationally we are prioritising inpatient activity based on clinical risk first and length of wait second and are beginning to look at this across our Outpatient waits as well.

- Restore NHS services inclusively including new performance monitoring of service use and outcomes from the most deprived neighbourhoods and from Black and Asian communities by 31 October and understanding who is using our digital pathways – development of this is underway

Accelerating preventative programmes like:

- Flu vaccinations - A Board agreed Flu vaccination programme plan is already in place - which is being delivered via local flu champions within the organisation, called 'Flooper Troopers'. This is based on an ABBA themed campaign, delivered within local clinical settings. The National Skills for Health Training is currently being undertaken by the local peer vaccinators who will deliver colleague to colleague vaccinations within their own clinical areas. This will be supplemented by flu clinics for bank and substantive staff, with vaccinators available at

induction for new starters. There will be comprehensive reporting available, that is real time and can be interrogated more regularly than previous reports. The Trust are also scoping the possibility of a Drive Through Facility for the Flu Jab, to enable shielders / colleagues working from home to access the vaccine. If a Covid vaccine becomes available the Trust can use this same network of delivery, but will need additional resources to back fill the staff who are peer vaccinators, pay for additional temporary staff to vaccinate, and pay for rooms and communications as well as the Covid vaccines themselves, that are not in any base funding for the Trust. Drive through facilities for the vaccine and reporting would also need to be made available.

- Better prevention and management programmes – both our ICPs have a focus on Obesity and we are running a campaign within our own Trust initially for our own staff. We have not allowed smoking on our sites since July 2019. We are working on ensuring we use local suppliers wherever possible. Our Midland Met University Hospital project contractually must ensure that 70% of the spend is incurred within 30 miles of the building. We are also working to ensure we spend 2% of our annual non-pay budget (some exclusions apply) locally – tier 1 is Sandwell and West Birmingham, Tier 2 is Black Country and Birmingham and Solihull, the remainder Tier 3. We are also working to ensure we pay local suppliers as quickly as possible. We believe wealth and health go hand in hand. We are an accredited national living wage employer and have been instrumental in linking the Living Wage Foundation to the wider Black Country STP, to ensure other NHS partners begin the same journey. We are also developing an e-bike project as part of clean air strategies in Bham and Sandwell.

Our people plan will consider the requirement to publish an action plan showing how over the next 5 years its board will senior staffing will in % terms match the overall BAME composition of our workforce or local community; this will be on the November Board agenda.

Beyond our Trust and ICPs

- At STP/ICS level one of the seven programmes is focussed on reducing Inequalities and two others are likely to contribute further: Healthier Communities and Population Health;
- At Midlands level the Regional Director has set up STaR Board which has 4 working Groups. One of these is “strategies and approach to addressing inequalities and prevention” the Trust will be taking forward the outputs of this group in due course

<u>NHS Birmingham and Solihull Clinical Commissioning Group</u>

For staff

- The health and wellbeing of staff continues to be a critical priority building on achievements during the emergency response, including continued focus on staff risk assessments, access to psychological support and a range of wellbeing offers. Staff with protected characteristics have been asked to review their risk assessments, should their circumstances change, and various Black, Asian and Minority Ethnic (BAME) staff networks are being established and supported, alongside listening events.
- We are reviewing our governance, so we achieve a more representative population at board level. This also includes identifying a STP lead to address inequalities. This will also be further embedded with a named lead in each NHS organisation and within Primary Care Networks.
- We have established a Health Inequalities Task Group, which has set out priorities for action in the next 1-2 years. This includes using our roles as ‘anchor institutions’ to create economic prosperity and to support our staff.

- There has been enhanced action and support on our equality, diversity and inclusive leadership development, with increased focus on tailored programmes of support. There are also race equality training sessions planned so that we understand and gain new perspectives to support our collective action to address inequalities.

For our communities

We are working as a collaborative partnership to use our resources effectively to protect the most vulnerable, which includes:

- We have commissioned Primary Care Network Profiles to enhance understanding of place and support local plans. This will support a population health management approach.
- We have been developing accessible and inclusive flu plans in place that address the needs of vulnerable and at-risk groups – further information is provided below.
- We are building on system wide collaboration on programmes such as 'Right to register' and 'Safe Surgeries' to support access to health care for homeless and vulnerable groups.
- We have disseminated and developed a raft of accessible information in a range of languages and formats to diverse communities and will continue to develop in-time simplified messages that are culturally appropriate on reducing risk.
- We are currently engaging with our protected characteristic communities through a range of initiatives including the CCG protected community engagement. We also intend to collaborate on our learning across the system, to reduce health inequalities and inform future commissioning plans.
- We are assessing the equality impacts of all our restoration and recovery plans and will build on this work at a system level; strengthening our understanding and response health inequalities for at-risk groups focusing on intersectionality, social value, and inclusion health.
- We are focusing on improving uptake on specific services, such as cancer screening and health checks for people with learning disabilities and autism to improve service uptake. There is also a focus on 'making every contact count' so people are appraised of the risks of not progressing with treatment as well as supporting information to explain the safe working practices in treatment settings. We hope this will go some way to provide reassurance to people on the safe working practices that have been adopted in light of COVID-19.
- Triage, telephone and digital consultations are continuing to take place, reducing the need for vulnerable people to travel to specific sites for treatment.
- We intend to review digital usage and the potential impacts of our digital transformation programme to prevent people from being excluded from accessing services. This is being considered through the use of proxy information from digital systems to understand who is using them and we will also be reviewing how we address digital poverty, linking into the work that Birmingham City Council is doing.

<u>Sandwell and West Birmingham Clinical Commissioning Group</u>

All staff at Sandwell and West Birmingham CCG, and all Primary Care Network staff have had a risk assessment. The CCG are co-ordinating responses to ensure all staff are properly protected.

Primary Care Networks are moving into recovery. They now have green, Covid free/secure, sites, amber sites for same day or urgent work, and either at a separate time or ideally, separate site (purple) for all planned routine care. This is so we can start getting all routine checks back on track, specifically diabetes, Mental Health and LD checks.

Sandwell and West Birmingham CCG continue to operate at primary care network, rather than individual practice level to help support our smaller practices. We continue with our "green/amber/red" site working to ensure that there are sites which are patient/covid free so high risk staff can work safely.

All patients however can still have a face to face appointment if needed, which may be at a local practice if their own surgery is not open for face to face appointments. The red site (based at Aston Pride Surgery) is still operational where patients suspected of having covid can be seen safely.

The BC and WB CCG's have now appointed a Chief medical officer (Dr Masood Ahmed), who is also from the BAME community, which hopefully also shows our commitment to support all our medical staff, especially those with a BAME background.

The BC&WB STP recovery meeting (on 7 9 20) had a development session with the "BRAP" charity to see how we can better react to ensuring as an organisation we treat all our staff equally and fairly.

Our CCG is also currently undertaking a series of mortality reviews for the period April-June 2020, including care home deaths, to try to find if there any "themes" and potential learning that we can use to help plan services and respond to covid in the future.

BVSC

BVSC Activity

During the development of the Covid-19 crisis it became apparent that BAME communities were disproportionately suffering the devastating impact of the virus. It was equally clear that the organisational structures and supporting infrastructure within the VCSE had not enabled these communities to leverage the type of change within the city that would have addressed health inequalities. Maintaining a focus on health inequalities for BAME communities BVSC are developing routes by which communities can engage with, inform and influence immediate Covid recovery planning. As well as playing a much longer-term role in addressing health, social, cultural and racial inequalities in the city. The aim of this work will be to develop and resource BAME community leadership around health inequality, promote community voice and stimulate positive system change.

- This activity has now been resourced and will be developed over the next six months.
- During October BVSC will be undertaking a wider consultation on community recovery focused on supporting those communities most effected by the pandemic.
- BVSC is supporting and advocating for the development of place-based funding formulas that address health inequalities across the life course. These will respond much better to the needs of marginalised communities than city wide commissioning approaches.

VCFSE Sector Activity

Through the C19 partnership sector leaders have been developing their approaches to addressing health inequalities in BAME communities. BRAP have launched of The Equality Republic. The Republic is a movement of organisations and individuals who want to critically examine the impact of equalities practice and the kind of work that organisations and practitioners should be doing if we really want to stand a chance of addressing systemic injustices. The Equality Republic was founded to help people working on these issues learn, connect, and be more authoritative about the types of interventions required if we are really going to change the status quo.

The VCFSE understands the importance of us all working together to shape and deliver a response to Coronavirus that recognises communities have been impacted differently. With partners we are ready to shape and deliver community resilience and recovery that aims at building back better.

- The community representative on the city board has been involved in challenging the diversity of representation of leadership structures around the city.
- Within the disability sector a consultation is going to be undertaken to look the look at the intersectionality of race and disability in Birmingham.
- Wider locality resilience responses are being implemented within the sector to support local assessment and remediation of gaps during a further lockdown.

Healthwatch Birmingham

Hearing people's experiences during lockdown

Between April and June 2020, 577 Birmingham residents told us their experiences of lockdown by completing the questionnaire. People were particularly appreciative of General Practices and pharmacies working well together to support their patients. We also heard praise for district nurses conducting home visits, gratitude for care homes that went the extra mile for their residents and their families during lockdown and appreciation for food delivery from Birmingham City Council. Areas that people needed more support with included access to supplies, the provision of shielding letters to all people that need them, access to medication and appointments, the treatment for ongoing conditions and emotional support.

We also ran a focus group to hear the experiences of the African-Caribbean community. This was in partnership with Sandwell and West Birmingham Clinical Commissioning Group (S&WB CCG). This format worked well, and we aim to run similar focus groups. Twenty-five service users discussed their experiences during lockdown, their concerns, and what health and social care providers need to consider for this community should there be another lockdown. S&WB CCG responded to each of these issues or took the point away for consideration. Examples of issues raised included concern about good access to services for vulnerable and elderly African-Caribbean people, health inequalities and structural racism affecting access to health and social care for African-Caribbean communities and comorbidities during Covid19 within African-Caribbean communities.

Healthwatch Birmingham will continue to:

- Develop new ways of reaching out to diverse communities.
- Hear about the ongoing experiences of people with 'long Covid-19'*
- Celebrate positive feedback
- Encourage health and social care providers and commissioners to listen to and use service user feedback to identify gaps in needed support during the previous lockdown.
- Hear service user feedback indicating that health and social care commissioners and service providers have:
    - Reduced service gaps, revealed by pandemic/lockdown
    - Communicated improvements in the design and delivery of services to service users
    - Ensured that service users have heard and understand these changes to services, and the improved support available
    - Ensured that service users have access to, and are using, health and social care support and there is no inequality in access to these services between different communities
    - Developed novel ways of hearing feedback from a diverse selection of communities across Birmingham

Birmingham City Council

Increasing the understanding of the impact of Covid-19 on ethnic communities

- In addition to the community organisations commissioned to work with BAME, disabled, and LGBT communities to understand specific issues around COVID-19 and to develop culturally sensitive methods of engagement. The Public Health Division are currently tendering for additional community support services to ensure Birmingham's communities have an awareness and understanding or Covid-19, assess to testing, knowledge of to respond if they test positive or are told that they are a contact of a case and knowledge of how to reduce the risk factors associated with the increased risk of severe illness or death from Covid-19.

- To compliment the community discussion, a structured online covid impact survey has been conducted through the BeHeard platform. Over 3,000 people have completed the survey which ran from 2nd May to 31st July. About 20% of these are from ethnic communities in Birmingham.

- The Director of Public Health continues to hold engagement meetings with different community groups and organisations to share current information and heard from communities directly how Covid is impacting on them, this has included:
    - Faith community leaders
    - Ethnic community leaders including Roma, Somali, African and Bangladeshi communities
    - Women's organisations and community leaders
    - LGBT community organisations and members
    - Young people via Instagram and Facebook live sessions as well as digital forums
    - Ward forum and place-based community groups
    - Bi-lingual sessions in Mirpuri and Romanian

- The Council is also assessing the inequalities in wider impact of Covid-19 and lockdown in terms of the impact of businesses and employment and education to inform the approach to preparation ahead of the next wave and recovery.

Increasing awareness of national guidelines and risk reduction in ethnic communities

Nationally there are limited translated resources available for the emerging national guidelines, therefore, to support this the Council has commissioned translations of the national test and trace materials as well as translated audio versions of the national radio adverts. These are being distributed via social media and community Whatsapp networks.

Reducing the risk of mortality from Covid-19

The Council Public Health Division have launched their BHealthy campaign, a series of webinars and practical resources to enable leaders and professionals with direct reach to communities for example, community leaders, social prescribing link workers or faith leaders, to support their communities to reduce their risk of becoming seriously ill from Covid-19. The BHealthy webinar series will be rolled out through September and October and cover a variety of topics, including minimising the risk from chronic diseases such as diabetes, high blood pressure and kidney disease using the long term disease check model alongside work to increase healthy eating, physical activity, vaccination and smoking cessation. Culturally tailored resources are also available to support individual ethnic communities to access the information and support they need to build their health resilience ahead of the next wave.

Supporting our BAME staff

The Council updated its risk assessment in line with the NHS best practice guidelines for staff once the inequalities in mortality linked to ethnicity became clear. This is a staggered risk assessment which focuses first on the physical space, then the service provision, then individual staff members. We continue to review this as the evidence base developed working with other public sector partners.

Birmingham Health and Wellbeing Board

	Agenda Item: 16
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**23 July 2020**
TITLE:	**UPDATE ON PROGRESS SINCE THE APRIL SPECIAL HEALTH AND WELLBEING BOARD MEETING**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney, Director of Public Health**

Report Type:	**Presentation**

1. Purpose:
To inform the Board and members of the public of the progress since the July Health and Wellbeing Board meeting to mitigate risk and support ethnic communities from Covid-19

2. Implications:		
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	✓
Joint Strategic Needs Assessment		
Creating a Healthy Food City		
Creating a Mentally Healthy City		
Creating an Active City		
Creating a City without Inequality		
Health Protection		

3. Recommendation	
3.1	The Board is asked to note the progress detailed in the report.
3.2	Board members are asked to continue to work to mitigate disproportional risk of Covid-19 to ethnic communities.

4.	Report Body

4.1 The paper summarises progress made to date from the organisations listed below. Key themes covered include:

- Further understanding of the population to mitigate risks associated with protected characteristics and social economic conditions
- Accelerated preventative programmes including flu and obesity
- Support Health and Wellbeing of staff, those with protected characteristics have received a risk assessment
- Working collectively to use resource effectively to protect the most vulnerable
- Working to develop and resource BAME community leadership around health inequalities
- Outreach work to reach priority communities including faith communities
- Understanding community Covid experiences, particularly those from BAME communities.

4.2 The following partners have contributed to the content of the report:

- Birmingham Community Healthcare NHS Foundation Trust
- Sandwell and West Birmingham NHS Trust
- NHS Birmingham and Solihull Clinical Commissioning Group
- Sandwell and West Birmingham Clinical Commissioning Group
- Healthwatch Birmingham
- BVSC
- Birmingham City Council

4.3 Details of the discussion at the April Special Health and Wellbeing Board Meeting can be found in the minutes of the meeting.

5.	Compliance Issues
5.1	***HWBB Forum Responsibility and Board Update***

	The impact and mitigation of the disproportioned risk of Covid-19 on ethnic minority communities will continue to be monitored though the HWB member organisations.
5.2	***Management Responsibility***
	Dr Justin Varney, Director of Public Health, Birmingham City Council

6.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Board member organisations cease to mitigate risk and support ethnic communities from Covid-19 leading to further increase in health inequalities	Low	High	Continue to facilitate discussions

Appendices
Update on BAME Covid-19 Inequalities Work Since the July HWB meeting

The following people have been involved in the preparation of this board paper:

Dr Justin Varney, Director of Public Health
Stacey Gunther, Service Lead – Governance

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This report summarises progress to mitigate risk and support ethnic communities from Covid-19 across Birmingham since the July Health and Wellbeing Board Meeting. As a Health and Wellbeing board we are keen to mitigate against disproportional risk of Covid-19 to ethnic communities whilst in parallel reduce the anxiety and fear that exists in these communities.

The following partners have contributed to the content of this report:

Birmingham Community Healthcare NHS Foundation Trust

Sandwell and West Birmingham NHS Trust

NHS Birmingham and Solihull Clinical Commissioning Group

Sandwell and West Birmingham Clinical Commissioning Group

Healthwatch Birmingham

BVSC

Birmingham City Council

Birmingham Community Healthcare NHS Foundation Trust

During July and August, BCHC concentrated on delivering the programme of support for BAME colleagues agreed through discussion with our BME Staff Network earlier in the pandemic. This included a series of externally-provided, “emotional survival” sessions as well as wider health and wellbeing activity. As we had promised our July trust board received in public an assessment of the impact to date of the pandemic on BAME colleagues.

We also undertook a two-stage risk assessment process for all our staff achieving 99% coverage. Everyone undertook an initial self-assessment; colleagues with risk factors then had a more detailed risk assessment. 29% of colleagues had the more detailed risk assessment (and 52% of these were BAME colleagues) which resulted in a number of changes to mitigate risks including altered working patterns, moving to working from home or moving team or location.

The impact assessments undertaken for each of our 100 services as they restarted included an assessment of impact on equality. We are now undertaking an analysis of key elements of our service recovery to assess and address the impact on different communities including long waiting times in children’s services and in dental services, school age immunisation service backlogs, intermediate care caseloads and high risk families in Birmingham Forward Steps.

For the longer-term our Board in September agreed our “Inclusive Organisation” action plan setting out the steps we will take over the next 12 months to maintain momentum with equality, diversity and inclusion. Our newly launched Inspire leadership development programme includes “inclusive leadership” as a core competence for our line managers. Looking to the communities we serve; we have refreshed our community engagement strategy and are working through with the board how to bring to life our commitment to supporting to “healthy communities”.

Sandwell and West Birmingham NHS Trust

The phase 3 (31/7/20) letter from the CEO and COO of the NHS requires us to name an "Executive Board Member to be responsible for tackling inequalities in September" for SWB NHS Trust this is Acting CEO, David Carruthers.

The phase 3 letter also states that "recommended urgent actions have been developed by an expert national advisory group" and that they will be published shortly. These include:

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- Restore NHS services inclusively including new performance monitoring of service use and outcomes from the most deprived neighbourhoods and from Black and Asian communities by 31 October and understanding who is using our digital pathways – development of this is underway

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working to ensure we spend 2% of our annual non-pay budget (some exclusions apply) locally – tier 1 is Sandwell and West Birmingham, Tier 2 is Black Country and Birmingham and Solihull, the remainder Tier 3. We are also working to ensure we pay local suppliers as quickly as possible. We believe wealth and health go hand in hand. We are an accredited national living wage employer and have been instrumental in linking the Living Wage Foundation to the wider Black Country STP, to ensure other NHS partners begin the same journey. We are also developing an e-bike project as part of clean air strategies in Bham and Sandwell.

Our people plan will consider the requirement to publish an action plan showing how over the next 5 years its board will senior staffing will in % terms match the overall BAME composition of our workforce or local community; this will be on the November Board agenda.

Beyond our Trust and ICPs

- At STP/ICS level one of the seven programmes is focussed on reducing Inequalities and two others are likely to contribute further: Healthier Communities and Population Health;

- At Midlands level the Regional Director has set up STaR Board which has 4 working Groups. One of these is “strategies and approach to addressing inequalities and prevention” the Trust will be taking forward the outputs of this group in due course

NHS Birmingham and Solihull Clinical Commissioning Group

For staff

- The health and wellbeing of staff continues to be a critical priority building on achievements during the emergency response, including continued focus on staff risk assessments, access to psychological support and a range of wellbeing offers. Staff with protected characteristics have been asked to review their risk assessments, should their circumstances change, and various Black, Asian and Minority Ethnic (BAME) staff networks are being established and supported, alongside listening events.

- We are reviewing our governance, so we achieve a more representative population at board level. This also includes identifying a STP lead to address inequalities. This will also be further embedded with a named lead in each NHS organisation and within Primary Care Networks.

- We have established a Health Inequalities Task Group, which has set out priorities for action in the next 1-2 years. This includes using our roles as 'anchor institutions' to create economic prosperity and to support our staff.

- There has been enhanced action and support on our equality, diversity and inclusive leadership development, with increased focus on tailored programmes of support. There are also race equality training sessions planned so that we understand and gain new perspectives to support our collective action to address inequalities.

For our communities

We are working as a collaborative partnership to use our resources effectively to protect the most vulnerable, which includes:

- We have commissioned Primary Care Network Profiles to enhance understanding of place and support local plans. This will support a population health management approach.

- We have been developing accessible and inclusive flu plans in place that address the needs of vulnerable and at-risk groups – further information is provided below.

- We are building on system wide collaboration on programmes such as 'Right to register' and 'Safe Surgeries' to support access to health care for homeless and vulnerable groups.

- We have disseminated and developed a raft of accessible information in a range of languages and formats to diverse communities and will continue to develop in-time simplified messages that are culturally appropriate on reducing risk.

- We are currently engaging with our protected characteristic communities through a range of initiatives including the CCG protected community engagement. We also intend to collaborate on our learning across the system, to reduce health inequalities and inform future commissioning plans.

- We are assessing the equality impacts of all our restoration and recovery plans and will build on this work at a system level; strengthening our understanding and response health inequalities for at-risk groups focusing on intersectionality, social value, and inclusion health.

- We are focusing on improving uptake on specific services, such as cancer screening and health checks for people with learning disabilities and autism to improve service uptake.

There is also a focus on ‘making every contact count’ so people are appraised of the risks of not progressing with treatment as well as supporting information to explain the safe working practices in treatment settings. We hope this will go some way to provide reassurance to people on the safe working practices that have been adopted in light of COVID-19.

- Triage, telephone and digital consultations are continuing to take place, reducing the need for vulnerable people to travel to specific sites for treatment.

- We intend to review digital usage and the potential impacts of our digital transformation programme to prevent people from being excluded from accessing services. This is being considered through the use of proxy information from digital systems to understand who is using them and we will also be reviewing how we address digital poverty, linking into the work that Birmingham City Council is doing.

Sandwell and West Birmingham Clinical Commissioning Group

All staff at Sandwell and West Birmingham CCG, and all Primary Care Network staff have had a risk assessment. The CCG are co-ordinating responses to ensure all staff are properly protected.

Primary Care Networks are moving into recovery. They now have green, Covid free/secure, sites, amber sites for same day or urgent work, and either at a separate time or ideally, separate site (purple) for all planned routine care. This is so we can start getting all routine checks back on track, specifically diabetes, Mental Health and LD checks.

Sandwell and West Birmingham CCG continue to operate at primary care network, rather than individual practice level to help support our smaller practices. We continue with our "green/amber/red" site working to ensure that there are sites which are patient/covid free so high risk staff can work safely.

All patients however can still have a face to face appointment if needed, which may be at a local practice if their own surgery is not open for face to face appointments. The red site (based at Aston Pride Surgery) is still operational where patients suspected of having covid can be seen safely.

The BC and WB CCG's have now appointed a Chief medical officer (Dr Masood Ahmed), who is also from the BAME community, which hopefully also shows our commitment to support all our medical staff, especially those with a BAME background.

The BC&WB STP recovery meeting (on 7 9 20) had a development session with the "BRAP" charity to see how we can better react to ensuring as an organisation we treat all our staff equally and fairly.

Our CCG is also currently undertaking a series of mortality reviews for the period April-June 2020, including care home deaths, to try to find if there any "themes" and potential learning that we can use to help plan services and respond to covid in the future.

BVSC

BVSC Activity

During the development of the Covid-19 crisis it became apparent that BAME communities were disproportionately suffering the devastating impact of the virus. It was equally clear that the organisational structures and supporting infrastructure within the VCSE had not enabled these communities to leverage the type of change within the city that would have addressed health inequalities. Maintaining a focus on health inequalities for BAME communities BVSC are developing routes by which communities can engage with, inform and influence immediate Covid recovery planning. As well as playing a much longer-term role in addressing health, social, cultural and racial inequalities in the city. The aim of this work will be to develop and resource BAME community leadership around health inequality, promote community voice and stimulate positive system change.

- This activity has now been resourced and will be developed over the next six months.

- During October BVSC will be undertaking a wider consultation on community recovery focused on supporting those communities most effected by the pandemic.

- BVSC is supporting and advocating for the development of place-based funding formulas that address health inequalities across the life course. These will respond much better to the needs of marginalised communities than city wide commissioning approaches.

VCFSE Sector Activity

Through the C19 partnership sector leaders have been developing their approaches to addressing health inequalities in BAME communities. BRAP have launched of The Equality Republic. The Republic is a movement of organisations and individuals who want to critically examine the impact of equalities practice and the kind of work that organisations and practitioners should be doing if we really want to stand a chance of addressing systemic injustices. The Equality Republic was founded to help people working on these issues learn, connect, and be more authoritative about the types of interventions required if we are really going to change the status quo.

The VCFSE understands the importance of us all working together to shape and deliver a response to Coronavirus that recognises communities have been impacted differently. With partners we are ready to shape and deliver community resilience and recovery that aims at building back better.

- The community representative on the city board has been involved in challenging the diversity of representation of leadership structures around the city.

- Within the disability sector a consultation is going to be undertaken to look the look at the intersectionality of race and disability in Birmingham.

- Wider locality resilience responses are being implemented within the sector to support local assessment and remediation of gaps during a further lockdown.

Healthwatch Birmingham

Hearing people's experiences during lockdown

Between April and June 2020, 577 Birmingham residents told us their experiences of lockdown by completing the questionnaire. People were particularly appreciative of General Practices and pharmacies working well together to support their patients. We also heard praise for district nurses conducting home visits, gratitude for care homes that went the extra mile for their residents and their families during lockdown and appreciation for food delivery from Birmingham City Council. Areas that people needed more support with included access to supplies, the provision of shielding letters to all people that need them, access to medication and appointments, the treatment for ongoing conditions and emotional support.

We also ran a focus group to hear the experiences of the African-Caribbean community. This was in partnership with Sandwell and West Birmingham Clinical Commissioning Group (S&WB CCG). This format worked well, and we aim to run similar focus groups. Twenty-five service users discussed their experiences during lockdown, their concerns, and what health and social care providers need to consider for this community should there be another lockdown. S&WB CCG responded to each of these issues or took the point away for consideration. Examples of issues raised included concern about good access to services for vulnerable and elderly African-Caribbean people, health inequalities and structural racism affecting access to health and social care for African-Caribbean communities and comorbidities during Covid19 within African-Caribbean communities.

Healthwatch Birmingham will continue to:

- Develop new ways of reaching out to diverse communities.
- Hear about the ongoing experiences of people with 'long Covid-19'*
- Celebrate positive feedback
- Encourage health and social care providers and commissioners to listen to and use service user feedback to identify gaps in needed support during the previous lockdown.
- Hear service user feedback indicating that health and social care commissioners and service providers have:
    - Reduced service gaps, revealed by pandemic/lockdown
    - Communicated improvements in the design and delivery of services to service users
    - Ensured that service users have heard and understand these changes to services, and the improved support available
    - Ensured that service users have access to, and are using, health and social care support and there is no inequality in access to these services between different communities
    - Developed novel ways of hearing feedback from a diverse selection of communities across Birmingham

Birmingham City Council

Increasing the understanding of the impact of Covid-19 on ethnic communities

- In addition to the community organisations commissioned to work with BAME, disabled, and LGBT communities to understand specific issues around COVID-19 and to develop culturally sensitive methods of engagement. The Public Health Division are currently tendering for additional community support services to ensure Birmingham's communities have an awareness and understanding or Covid-19, assess to testing, knowledge of to respond if they test positive or are told that they are a contact of a case and knowledge of how to reduce the risk factors associated with the increased risk of severe illness or death from Covid-19.

- To compliment the community discussion, a structured online covid impact survey has been conducted through the BeHeard platform. Over 3,000 people have completed the survey which ran from 2nd May to 31st July. About 20% of these are from ethnic communities in Birmingham.

- The Director of Public Health continues to hold engagement meetings with different community groups and organisations to share current information and heard from communities directly how Covid is impacting on them, this has included:

    - Faith community leaders
    - Ethnic community leaders including Roma, Somali, African and Bangladeshi communities
    - Women's organisations and community leaders
    - LGBT community organisations and members
    - Young people via Instagram and Facebook live sessions as well as digital forums
    - Ward forum and place-based community groups
    - Bi-lingual sessions in Mirpuri and Romanian

- The Council is also assessing the inequalities in wider impact of Covid-19 and lockdown in terms of the impact of businesses and employment and education to inform the approach to preparation ahead of the next wave and recovery.

Increasing awareness of national guidelines and risk reduction in ethnic communities

Nationally there are limited translated resources available for the emerging national guidelines, therefore, to support this the Council has commissioned translations of the national test and trace materials as well as translated audio versions of the national radio adverts. These are being distributed via social media and community Whatsapp networks.

Reducing the risk of mortality from Covid-19

The Council Public Health Division have launched their BHealthy campaign, a series of webinars and practical resources to enable leaders and professionals with direct reach to communities for example, community leaders, social prescribing link workers or faith leaders, to support their communities to reduce their risk of becoming seriously ill from Covid-19. The BHealthy webinar series will be rolled out through September and October and cover a variety of topics, including minimising the risk from chronic diseases such as diabetes, high blood pressure and kidney disease using the long term disease check model alongside work to increase healthy eating, physical activity, vaccination and smoking cessation. Culturally tailored resources are also available to support individual ethnic communities to access the information and support they need to build their health resilience ahead of the next wave.

Supporting our BAME staff

The Council updated its risk assessment in line with the NHS best practice guidelines for staff once the inequalities in mortality linked to ethnicity became clear. This is a staggered risk assessment which focuses first on the physical space, then the service provision, then individual staff members. We continue to review this as the evidence base developed working with other public sector partners.

Birmingham Health and Wellbeing Board

Draft Forward Work Programme

2019-20 to 2020-21

Board Members:

Councillor Paulette Hamilton (Board Chair)	Cabinet member for Adult Social Care and Health	Birmingham City Council
Dr Peter Ingham (Vice Chair)	Clinical Chair	NHS Birmingham and Solihull CCG
Councillor Kate Booth	Cabinet Member for Children's Wellbeing	Birmingham City Council
Councillor Matt Bennett	Opposition Spokesperson on Health and Social Care	Birmingham City Council
Dr Justin Varney	Director of Public Health	Birmingham City Council
Professor Graeme Betts	Corporate Director for Adult Social Care and Health Directorate	Birmingham City Council
Dr Tim O'Neil (Nichola Jones as substitute)	Director of Education and Skills (Assistant Director, Inclusion and SEND, Education and Skills)	Birmingham City Council
Paul Jennings	Chief Executive	NHS Birmingham and Solihull Clinical Commissioning Group
Ian Sykes	Chair, Sandwell and West Birmingham CCG.	Sandwell and West Birmingham CCG.
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Children's Trust
Dr Robin Miller	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham Education Sector
Chief Superintendent	Chief Superintendent	West Midlands Police

Stephen Graham		
Gaynor Smith	Senior and Employer Partnership Leader	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust.	Birmingham Social Housing Partnership
Richard Kirby	Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Mark Garrick		University Hospitals Birmingham NHS Foundation Trust
Co – optees		
Carly Jones	Chief Executive of SIFA FIRESIDE.	SIFA FIRESIDE
Waheed Saleem	Executive Director Strategic Partnership.	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

Board Support:

Committee Board Manager
Landline: 0121 675 0955
Email: errol.wilson@birmingham.gov.uk

Business Support Manager for Governance & Compliance
Landline:0121 303 4843
Mobile : 07912793832
Email : Tony.G.Lloyd@birmingham.gov.uk

Schedule of Work: April 2020-March 2021

Board Meeting Date	Deadlines	Scheduled Agenda Items	Presenting Officers
Board Development Day 14th May 2019, Venue: 10 Woodcock Street , Aston Birmingham	Time : 1pm - 5pm	**Workshop Group Discussion Items** Health Inequalities Childhood Obesity	 Elizabeth Griffiths Kyle Stott
Informal Meeting 18th June 2019 Venue : Committee Rooms 3 & 4, Council House, 3pm – 5pm	Draft Report Deadline for Pre- agenda : TBC Final Report Deadline: tbc June 2019 Agenda and Reports Dispatch Date: tbc June 2019	**Themed : Place** **Discussion Items** Air Quality Update Report Active Travel Update Report Developers Toolkit Update Report Feedback on the Health and Wellbeing Board Development Session Changes Places Live Healthy , Healthy Happy STP Update Report	 Duncan Vernon Duncan Vernon Kyle Stott Kyle Stott and Elizabeth Griffiths Maria Gavin Paul Jennings
Formal Meeting 30th July 2019 Venue : Committee Rooms 3 & 4, Council House, 2pm – 5pm	Draft Report Deadline draft reports : 3TH July 2019 Pre – agenda meeting – 8th July 2019 Final Report Deadline: 19th July 2019 Agenda and	**Discussion Items** Development of Health & Wellbeing Board Sub-Committee structure Making every adult matter overview Complex severe mental health : Dual diagnosis /personal disorder Drug and alcohol – Change , Grow and Live : Peer mentor Birmingham older people	 Justin Varney Justin Varney Tom Howell Max Vaughan Andrew McKirgan,

	Reports Dispatch Date: 22nd July 2019	programme : Update on the ageing well programme Homelessness overview Birmingham Health & Wellbeing Board Forward Plan	Andy Lumb Cllr Sharon Thompson and Kalvinder Kohli
Formal Meeting 24th September 2019 Venue: Committee Room 3&4, Council House, 3pm – 5pm	Draft Report Deadline for Pre- agenda : 28th August 2019 Pre –agenda meeting : 2nd September 2019 Final Report Deadline: 13th September 2019 Agenda and Reports Dispatch Date: 14th September 2019	**Presentation Items** Suicide Prevention Strategy NHS Long Term Plan: BSOL CCG Response Health and Wellbeing Board Priorities Update: Health Inequalities, Forward Trajectory CAMHS Access and Mental Health Pathway Improvement **Information Items** JSNA Deep Dive Forward Plan Public Health Priorities Green Paper Response Better Care Fund Governance Agreement Report **Private Items** NHS Long Term Plan: BSOL CCG Response	 Justin Varney Harvir Lawrence Justin Varney Carol McCauley Harvir Lawrence

Formal Meeting 26th November 2019 Venue: N/A	Draft Report Deadline for Pre- agenda : 30th October 2019 Pre – agenda meeting : 4th November 2019 Final Report Deadline: 14th November 2019 Agenda and Reports Dispatch Date: 15th November 2019	**Cancelled due to Pre-Election Preparation Period**	
Formal Meeting 21th January 2020 Venue: Rooms 3 & 4, Council House, 3pm -5pm	Draft Report Deadline for Pre- agenda : 2nd January 2019 Pre – agenda meeting : 6th January 2020 Final Report Deadline: 9th January 2020 Agenda and Reports Dispatch Date: 13th January 2020	**Presentation Items** Creating a Healthy Food City Forum Update JSNA Deep Dives – Progress Report NHS Long Term Plan West Birmingham Alliance Update **Information Items** Health and Wellbeing Board Fora updates Public Health Budget **Private Items** JSNA Core Data Set – Children and Young People Chapter	Kyle Stott Paul Campbell Harvir Lawrence Toby Lewis Paul Campbell Dr Justin Varney Dr Justin Varney

Formal Meeting 17th March 2020 Venue : Rooms 3 & 4, Council House – 3pm -5pm Peter Ingham to Chair	Draft Report Deadline for Pre- agenda : 19th February 2020 Pre – agenda meeting : 24th February 2020 Final Report Deadline: 5th March 2020 Agenda and Reports Dispatch Date: 6th March 2020	**Presentation Items** Better Care Fund 2019/20 Plan Creating a Mentally Healthy City Forum Update JSNA Core Data Set – Children and Young People Chapter Pre-Conception Conversation Birmingham Forward Steps / Early Years Contract Families in Temporary Accommodation East Birmingham Corridor Consultation Triple Zero Coronavirus Update **Information Items** Health and Wellbeing Board Fora updates Sustainability and Transformation Plan Update Delayed Transfers of Care workshop Feedback **Private Items** Director of Public Health Annual Report JSNA Core Data Set – Working Age Adults Chapter	 Mike Walsh Elizabeth Griffiths Ralph Smith Marion Gibbon Richard Kirby Saba Rai Mark Gamble Chris Baggott Justin Varney Justin Varney Ralph Smith

Development Day 28th April 2020 Venue: TBC	Draft Report Deadline for Pre- agenda : 1th April 2020 Pre – agenda meeting : 6th April 2020 Final Report Deadline: 16th March 2020 Agenda and Reports Dispatch Date: 17th March 2020	TBC	TBC

Formal Meeting July 2020		**Presentation Items** Appointment and Terms of Reference Social Prescribing Birmingham Community Safety Partnership Consultation Creating an Active City Forum Update JSNA Core Data Set – Working Age Adults Chapter JSNA Core Data Set – Needs of Older People Chapter JSNA Core Data Set – Wider Determinants Chapter JSNA Deep Dives – H&WB of Armed Forces Veterans in Birmingham(TBC) JSNA Deep Dives – Death and Dying in Birmingham (TBC) JSNA Deep Dive – H&WB of Public Sector Workforce in Birmingham (TBC) JSNA Deep Dive – Diversity and Inclusion (TBC) **Information Items** Health and Wellbeing Board Fora updates Sustainability and Transformation Plan Update Healthwatch Birmingham Annual Report	 TBC Pip Mayo Amelia Murray Kyle Stott Ralph Smith Ralph Smith Ralph Smith Susan Lowe Susan Lowe Susan Lowe Susan Lowe TBC Paul Jennings Andy Cave

Formal Meeting September 2020		**Presentation Items** Chairs update COVID position statement LOCEB – written update Health Protection Forum Update Flu Plan update 30 mins – Bsol Screening, Imms Health checks **Information Items** BCF Health and Wellbeing Board Fora updates	 Justin Varney Elizabeth Griffiths Chris Baggott Rachel O'Connor (BSol CCG) PHE/NHS England BCC Michael Walsh TBC
Formal Meeting November 2020		**Presentation Items** Creating a Physically Active City Forum Update Bloomberg Active Travel FPA Commonwealth Games work TAWS Sport Birmingham JSNA Deep Dive – topic TBC **Information Items** Health and Wellbeing Board Fora updates Sustainability and Transformation Plan Update	 Kyle Stott Kyle Stott Inclusive Growth – Joe Green? Hamira Sultan Cat Orchard/new director Steven Rose Mike Chamberlain Susan Lowe TBC Paul Jennings

Formal Meeting January 2021		**Presentation Items** Creating a Healthy Food City Forum Update Birmingham Food strategy/food conversation International Partnerships update Childhood obesity trail blazer data/update Sustainable food partnerships JSNA Deep Dive – topic TBC **Information Items** Health and Wellbeing Board Fora updates	 Paul Campbell Justin Varney/Paul Campbell Food Foundation Justin Varney Paul campbell Susan Lowe TBC
Formal Meeting March 2021		**Presentation Items** Creating a Mentally Healthy City Forum Update Suicide prevention strategy Waiting Room Cultural update Employee wellness JSNA Deep Dive – topic TBC **Information Items** Health and Wellbeing Board Fora updates Sustainability and Transformation Plan Update	 Mo Phillips Susan Lowe Stacey Gunther Paul Jennings
Development Day April 2021		 Health and Wellbeing Board Priorities – Review and Refresh	 TBC

Standard Agenda

1. Notice of Recording
2. Notice of Potential for Public Exclusions

3. Declaration of Interests
4. Apologies
5. Minutes and Matters Arising
6. Action Log
7. Chair's Update
8. Public Questions
9. Presentation Items (see detail above)
10. Information Items (see detail above)
11. Forward Plan Review
12. Finalise Agenda for next Meeting
13. Date, Time and Venue of next Meeting
14. Notice of Recording Ceased
15. Private Items (see detail above)

Notes

Any agenda change request must form part of prior HWBB information item with as much lead in as possible but no later than the HWBB immediately prior to the agenda change request, including requests from sub-groups (see below).

Health Inequality Focus and Childhood Obesity Focus agenda presentations can be several items if appropriate but all must include decision(s) and / or action(s) for the Board.

Health and Wellbeing Board Fora will provide a written update to each Board meeting; each will have an annual formal presentation to the Board on a rotational basis.

Any decisions and actions shall be subject to providing an update to the Board on the substantive outcomes, either via presentation or information item as deemed appropriate by the Board, at a future date to be agreed as part of said decision or action.

Supporting Documents Requiring Development

Agenda change request form
Report draft template
Report final template
Action / Decision request form
Action / Decision update report template