BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 21 JANUARY 2020

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 21 JANUARY 2020 AT 1500 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM B1 1BB

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Chair of Birmingham Health and Wellbeing Board
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Andy Cave, Chief Executive, Healthwatch Birmingham
Chief Superintendent Stephen Graham, West Midlands Police
Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust
Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust
Dr Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Peter Richmond, Chief Executive, Birmingham Social Housing Partnership
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Paul Campbell, Acting Service Lead for Public Health, Birmingham City Council
Harvir Lawrence, Director of Planning and Delivery, Birmingham and Solihull CCG
Errol Wilson, Committee Services

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

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NOTICE OF RECORDING/WEBCAST

432 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

433 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

434 Apologies for absence were submitted on behalf of Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Charlotte Bailey, Executive Director Strategic Partnerships, Birmingham and Solihull Mental Health Trust
Carly Jones, Chief Executive, SIFA FIRESIDE
Andy Couldrick, Chief Executive, Birmingham Children's Trust
Professor Graeme Betts, Director for Adult Social Care and Health Directorate
Sarah Sinclair, Interim Assistant Director, Children and Young People Directorate
Dr Ian Sykes, Sandwell and West Birmingham CCG, but (Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG as substitute)
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:

Item 5 – Private part of Minutes – Exempt Paragraph 4
Item 19 – Exempt paragraph 3
Item 20 – Exempt paragraph 3

435 **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

Stephen Raybould enquired about the agenda items from the cancelled meetings as a result of the pre-election period and what the intention was in relation to these items. The Chair advised that these items would be brought presented to a future Board meeting.

436 **RESOLVED: -**

That the Minutes of the meeting held on 24 September 2019, having been previously circulated, were confirmed and signed by the Chair.

ACTION LOG

437 The following Action Log was submitted:-

(See document No. 1)

Dr Justin Varney, Director of Public Health introduced the item and advised that there was one Red Rag item around Changing Places. They had done the action in relation to engaging with the Commonwealth Games structure workstream to ask them to integrate Changing Places into the planned buildings. The bit that was outstanding was the piece around community engaging formally with the rest of the partners to ask them to do the same in relation to any future new build. They would start to create this as a normal expectation of any new development in Birmingham or with refurbishment.

The other action on the grid which was still outstanding, but there had been action after the papers were submitted for publication was the promotion of public questions, but they had done some work to promote the opportunity of public questions through social media and had also asked colleagues from the Board to continue to raise this through community forums. He reiterated that those who were watching the meeting could submit a public question for the Board to respond to at each meeting and they were encouraging the members of the public to use that as an opportunity to put their questions directly to the partnership.

CHAIR'S UPDATE

438 The Chair gave the following brief update: -

- Last week at Full City Council they had a discussion on the Council Plan Priorities and Councillors Booth and Councillor Jayne Francis along with her set out an overview on delivery of two of the Council Plan priorities for which they were the portfolio leads.
- The two priorities reported om were Birmingham was an inspirational city to grow up in and Birmingham was a fulfilling city to aged well in. She added that it was an interesting and lively discussion and colleagues questioned and raised concerns in relation to the two priorities. They had a long way to go but were on a transformational journey and there were areas where through working more closely, they were making

modernising practices and through earlier interventions improving outcomes for the citizens.

- The Chair highlighted that she had presented the Suicide Prevention Strategy and collectively as the Health and Wellbeing Board had an ambition to reduce deaths from suicide as part of a wider ambition to become a mentally healthy city. This was an emotive discussion and unanimously across the Chamber, they came together to approve the motion and vision set out in the strategy.
- As a Health and Wellbeing Board (HWB), they will be looking at that strategy through the Mentally Healthy City and they will be reporting back to the Board at least once or twice per year.

PUBLIC QUESTIONS

439 The Chair stated that they had been trying but were not getting the questions as they would like, but they would continue trying and would review this again. Andy Cave enquired whether there was any comms messages that they could use to help promote to the message to the public and if something could be put together for them that would be helpful.

Tom Fellowes, Nuffield Health, the UK's largest not for profit health and wellbeing provider and a registered charity, enquired who they could talk to about their schools wellbeing programme which was a free service for schools as they were struggling to access schools in Birmingham. They believed that by working with the HWB they would be able to target those who were in dire need. Their schools wellbeing programme was aimed at the four pillars of health and wellbeing focussing on the emotional wellbeing of children. This was offered free of charge to schools around the city. They also offer a number of other flagship programmes as part of their charitable status, joint pain programmes for patients suffering from joint pains to try and alleviate the demand on the NHS services and was developing a programme around cystic fibrosis and a number of other areas.

The Chair advised that any questions coming to the HWB, needed to be submitted prior to the meeting being held so that a full response could be given at the meeting.

Dr Varney advised that there were a number of providers offering schools wellbeing programmes in the city and there were significant updates by schools and they had several of them that were well evaluated. The competitive market in which he as a Public Health Director perhaps the Health Department encouraged schools to be aware of what was available, but they did not preferentially promote any product over another as there were a lot on the market offering a holistic approach. He added that Mr Fellowes was welcome to email him outside the meeting for further information and they could add that to the general communications that they do to schools.

Dr Varney further stated that it had been mentioned in previous HWB that the work they were currently doing to scope thrive education, colleagues in the West Midlands would be aware that there was a thriving work framework that was for employers to take action on health and wellbeing following discussions

with various educational leads they identified that there was a gap after various after the national Healthy Schools programme. They were in the scoping phase of that piece of work and would bring that back to the Board as part of the Mentally Healthy City Forum which was the group overseeing it. This was scheduled for March/April 2020 and this would then allow them to move forward or not with that piece of work.

At this point the engagement from all of the educational providers and the approach was looking for nursery provision through university to adult education was positive. There was a huge appetite across our schools and education providers but was also a crowded market of providers and they were encouraging schools as commissioners to look at the evidence base behind provision and be critical around what they provide in the outcomes. They would welcome anyone coming into that market providing an evidence-based model.

CREATING A HEALTHY FOOD CITY FORUM - UPDATE

The following report was submitted:-

(See document No. 2)

Dr Justin Varney, Director of Public Health, Birmingham City Council made introductory comments in relation to the report and highlighted the following:-

1. The Big Firm Birmingham Food Conversation – this was launched in October 2019 and was a yearlong conversation with the city about the food system of the city. This had many different components. The ones that were highlighted had progressed far.

2. They had commissioned 40 different focus groups from a large group of different community organisations. The focus groups were exploring citizens relationship with foods.

3. The focus groups were lesbians and gays; focus groups with under 18 boys and under 18 girls separately to look at gender difference in young adults; focus groups with people who arrive in Birmingham within the last two years and focus groups with migrants who arrived over 10 years ago in the city to look at the different relationships and beliefs system about foods.

4. There was a huge amount of information and they had one report left to come and they were in the process of working through those and looking at some of the key findings.

5. Concerning the LGBT focus group there was an interesting reflection that many of the messages they gave the system about food was based in the context of family and particularly in the context of parents and children. A lot of the national campaigns were about what you give to kids and that was the reason they had the healthy food environment and households.

6. The members of the focus group stated that they did not have children predominantly they lived on their own they did not have family and that the messages being put out about giving children health food did not apply to them.

7. The other focus group report he had read so far were predominantly from a set of African citizens, reflecting that they knew what health food was, but they wanted to eat healthy food in the context of their cultural heritage. They wanted to cook food and did not want ready meals, but when they were looking for it, they had to pay a higher price as they had to go to an African focused supermarket or they had to make do with a white British diet option. This was about access to culturally appropriate food at affordable price.

8. Another element was the Birmingham Food Survey which was being run as an open survey and anyone including Board members could take part. Currently 370 people had completed the survey which had 80 questions and take about fifteen minutes to complete. They had taken the first 260 responses and did an analysis and this highlighted that a large proportion of citizens did not recognise the national guidelines on what healthy meals looked like.

9. The Eat Well Guide, which was the national guidelines, they asked them both by naming them they showed them a picture whether they recognised them and the response was no. Almost 60% of people took part in that survey. Another thing that stood out was how few of the citizens regularly drink any water. Very few were drinking more than a glass of water per day which raises a number of questions for them.

10. The Childhood Obesity Trailblazer Programme (COTP) which was a three-armed programme supported by national government and the Local Government Association (LGA) PHE looking at how they could change the food environment of the city. This was looking at it through the lens of how they could change the economic environment of food businesses in the city so that they were better able to offer healthy safe affordable food in every community in the city, not just in the rich areas.

11. The second element was how they looked at the skills escalator or the skills pipeline so that what they were doing through schools, colleges and universities to ensure that the people coming out who wanted to work in the food industry had the right skill set, but also people who were coming through the apprenticeship pipeline had a better awareness of health and wellbeing through the spiral of health and wellbeing curriculum.

12. The third element was looking at how they could capture data to understand the food system in the city. The work that they did with Birmingham Big Food Hunt in June identified that they knew little about what the citizens were buying and throwing away. If they did not know this, how were they going to tackle the challenge of obesity, because it was known that the driver of obesity was poor nutrition, yet they knew nothing about nutrition in the city.

13. Dr Varney referred to the partnership work with Pune, India which was a project called BINDI Project that linked across with our relationship with the Milan Urban Food Policy Pact (MUFPP) and the Deleuze Network which were two international network of cities working on food. With Pune, they had been working on the food survey and they had completed their survey.

14. They got to 5000 households, but they were working towards a more modest sum, but the Pune survey mirrors some of the questions in the Birmingham survey, so they were able to do some comparisons particularly about hot food takeaway delivery Apps.

15. Some of the things that the Pune survey highlighted was that they were unable to find the socio-economic gradient in the use of those Apps. This showed that people were as likely to order takeaway from a *Deliveroo* or *Uber Eats* or *Just Eat* in the slums in Pune as they were in the high-rise apartments.

16. This shocked the researchers as this was not what they were expecting. The area that Pune had most interest on was the work with food retail and street food retail and looking at how they could learn from each other.

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

a. Dr Varney undertook to circulate the LinkedIn group link to the Board and added that the information could be obtained by going into the LinkedIn group and creating a city Birmingham and they would find the information.
b. All of the forums had a LinkedIn group and they had committed that all of the forums will place information on the LinkedIn group to make it transparent and accessible and to enable any citizen that wanted to engage in this conversation to join in the conversation because they would only move this city if they move it together.
c. The survey was opened at the moment, but they had closed it briefly after Christmas to take the data off and then re-opened it. What they were planning to do to help publicised that, was to use Fizz Free February campaign and they were talking with the dentist, pharmacist and GPs across the city to help publicise that through their TVs in their waiting rooms, through their patient interactions.
d. They had spoken with the schools and children's centres and would be using this month-long conversations and wanted people to think before they open a can of pop as they know it contributes to the largest amount of sugar to children's diet and it damages all of our teeth.
e. The aim for this month to try putting it aside. If they could do Dry January, perhaps they could do Fizz Free February for children. In the councils that had done this, many families used this as an opportunity to have a conversation about where this had come from.
f. Too often we open a bottle of pop and not think about it or what it was doing to the environment. They will also be talking about the supply chain and the global impact of the soft drinks industry as well as the personal impact on our teeth and on our waistline.

g. In terms of the coordination with other strategic structures in the city, the advantage they had in Birmingham was that Birmingham led several of the key workstreams if that ask was to be made, particularly the structure one.
h. They were leading the work on regulation and licensing. There were two elements that started – the Healthy City Planning Toolkit which was being piloted through the Perry Barr development and this was now being used in the evaluation of the first pilot.
i. They were looking to publish that over the next couple of months the planning toolkit and all the evidence of good practice nationally and some of the international information. It was not just about food, but about crime and violence, age friendly, child friendly and older adults friendly approaches in one single toolkit.
j. This was a large piece of work that was finally coming to fruition. They were encouraging other partners in the Commonwealth Games Partnership Team to use this in the same way.
k. There was a Public Health Advisory Group which sat under the Chief Executive Group of the Commonwealth Games which he co-chairs with Public Health England's Regional Centre Director, Sir Robertson and that group was explicitly trying to coordinate Public Health ASK so that they were all on the same sheet.
l. They had a slight advantage in Birmingham as he (Dr Varney) was the Lead Director of Public Health for the Commonwealth Games on behalf of the West Midlands Director of Pub Health.
m. In essence, at the moment, the focus was trying to build on the environment infrastructure piece and the regulation and licensing pieces within the remit of what was local decision making.
n. There were some things like the sponsorship packages which were international decisions on behalf of the Commonwealth bodies which, although they had expressed views, they had no control over, but within the regional footprint there was a strong alignment and they were ensuring that they were asking multiple things of multiple people.

440 **RESOLVED: -**

I. The Board noted the function, priorities and actions of the forum;
II. Identified whether any of the other forums share and/or can support the priorities; and
III. Where appropriate, offered guidance as to how best this joint working and/or support could be implemented.

JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) DEEP DIVES – PROGRESS REPORT

The following report was submitted:-

(See document No. 3)

Paul Campbell, Acting Service Lead, Public Health, Birmingham City Council made introductory comments relating to the report and advised that within the City Council they took a two-pronged approach to the Joint Strategic Needs Assessment (JSNA). They had the Core Data Set which will cover the general

public giving a high level of the broad overview, but they were aware that they were a diverse city dealing with lots of different populations. What they thought was beneficial was that they had the Deep Dives that came specifically on those on the interest groups.

Mr Campbell drew the attention of the Board to the information contained in the report and highlighted the topics for the first four years as detailed in paragraph 4.2 of the report.

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

i. The point of the Deep Dives was in essence to raise the issues from looking at the evidence from the data of the focus groups. The work that the focus groups had done had highlighting this as an issue and the reflection was not just that individuals may not have had that conversation, but also that professionals may not necessarily be having the conversation with them.
ii. This resonate with what the national and international evidence was showing and also some of the work … but the work around end of life care in the NHS which strongly encourages health care professionals to have a much earlier conversation about death and dying.
iii. The other aspect of this was an interesting reflection that the team would be asked to bring back at the next update the focus groups where they had challenges was commissioning them. There were some particular communities where repeatedly they were finding that when they were going out to market, for focus groups, people were not coming forward so organisations were not applying.
iv. Now they were in the fourth or fifth round of the focus groups commissioning they were getting a clear idea about which particular communities they were struggling to find organisations that providers would facilitate. This was something where they would welcome a partnership discussion as it raises a concern about how those individuals within those communities voices were being heard.
v. In terms of what they find, care plans were not routinely put in place for people during end of life situations. It known from the evidence that the vast majority of people would prefer to die at home, however, this did not happen and this was a strange disparity that people were not able to die in the manner and place.
vi. In terms of what they would recommend around that there was some work going on with Birmingham and Solihull End of Life Oversight Group and they would like to feed into and influence that and see how they could assist in getting the message wider to the health and social care communities.

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG commented on the end of life death and dying and stated that when the work started, he did not connect the research with that point to the STP work and to check that that connection was being made with a substantial work that linked in to that point that was made. He requested sight of the document before publication as he had not seen anything yet.

The Chair voiced concerns that they were saying in the report that they were struggling to get that information, but that the information was out there and the veterans were a group of people that absolutely and utterly love to talk. They also had a veteran champion in the City Council, Councillor Mike Sharpe who was good at this and former Councillor Anita Ward and they just needed to ask. There were groups such as the Salvation Army. They had also stated that on the 2 January, there was a closing date as they were going out to procurement for another group to help to do the work.

The Chair commented that she was not certain they were working in collaboration with anyone and doing this in isolation would get the results that they were getting.

Dr Varney continued

vii. The veterans work had been actively engaged with the veterans group in the Council through the development piece and through Suwinder Bains, Lead Officer for supporting that group. They were well sighted. They did go to market for nine different focus groups that they were looking to commission with different groups of veterans.

viii. They were conscious that one of the challenges they had with any of these areas was that they go back to the same group of people every time and it was those that shout the loudest got heard.

ix. They talked about veterans as a homogeneous group, they were looking for a focus group with veterans with physical disabilities; a separate focus group with mental health issues which they were able to award; a veterans group with those discharged within the last two years; a veterans group with those discharged more than 10 years ago that they were able to award; a group with non-British armed force veterans.

x. Veterans living in the city from other armed forces – they were unable to award that; a group with female veterans, they were able to award that BME veterans group they were able to award; with people who had left the service early and people who had left ahead of their normal discharge through medical reasons, they were unable to award that and a focus group with reservist and they were able to award that.

xi. Of the nine they were able to award contracts to half of the focus groups, but there were significant gaps. One of the things they were reflecting on having gone through that market tender they could go in with more niche and identify people working with some of the partners, but it did reflect some of the challenges.

xii. They did not want to view veterans as a homogeneous group and this was the reason, they added this focus group on this level of granularity, to try and explore the different experience of being a veteran as too often it was the people that left the armed forces several years ago and we ignore the voices of those who were recent leavers and some of the differences of experience particularly for women; BME and those who were from armed forces not from the UK.

xiii. They were actively addressing, and if other members from the Board had any other ideas about people, they could approach they could contact Dr Varney or any members of the team.

In response to a question from the Chair, Dr Peter Ingham advised that he felt engaged with the process as he had met with both Sue … and Elizabeth Griffiths on two occasions and they had sent him through the draft report which he had read and commented on the document. Dr Ingham added that he had some communication with the RAF Benevolent Fund earlier this week which he had forwarded to the team and they were trying to visit the Barberry Centre initially but were not able to do so. Stephen Raybould commented that in response to the challenges, BVSC could get them to where they needed to get to in terms of specific communities. The commissioning process did not support engagement with small communities, but there might be something they could do to smooth this over.

441 **RESOLVED: -**

That the Board noted the progress.

NHS LONG TERM PLAN – BIRMINGHAM AND SOLIHULL CCG

The following report was submitted:-

(See document No. 5)

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG informed the Board that the NHS Long Term Plan – Birmingham and Solihull CCG was to be treated as a draft as they had not yet agreed the final *touches* around the finance. Technically the Plan had not yet been signed off by NHS England and Improvement. They were not far off agreement, but they would not go into what the issues were through the middle of interactive negotiations with bodies as it was outside of the public remit. The balance for them was between doing all of the business as usual that they needed to do and addressing the grossing business as usual as well as addressing the new issues that the Plan had asked them to look at. Mr Jennings advised that Ms Harvir Lawrence, Director of Planning and Delivery, Birmingham and Solihull CCG will be talking us through the strategic level rather that a detailed level that the Plan seeks to address.

Harvir Lawrence, advised that the purpose of the presentation was to seek support from the HWB in terms of the direction of travel based on the Long-Term Plan.

Ms Lawrence then made the following statements:-

a) The National Long-Term Plan was published in January 2019 and provided the national direction of travel alongside a set of national must do requirements in terms of key transformational enablers for delivering a set of health priorities over a 10-year period.
b) Later in July 2019, The National Technical Guidance was published and the Guidance document asked STP to produce a series of documents to describe how they intend to deliver the commitments of the National LTP over a five-year period as the system.
c) In response to that they had produced a five-year delivery plan for Birmingham and Solihull and wanted to ensure that that plan aligned

with the STP Strategy. They did not want to push this piece of work to the side but wanted to ensure that there were alignment and Birmingham and Solihull LTP flowed through the STP Strategy and reflected their local priorities.

d) The long-term plan for the system was essentially a set of delivery plans to implement transformation improve quality and safety with a shift on prevention and delivering better outcomes. This was so that they could capture some of the major inequalities that exists at the moment. Another significant focus of the plan was that they were continuing to work together as a system. It refers to the direction of travel around developing themselves and the integrated care system.
e) In terms of the development approach, early on the plan was health focussed when it was published nationally, but they recognised that they needed to work with their partners in local government to enable them to support and help them deliver their local priorities.
f) They ensured that they were engaged with system partners across health and council in the development and co-design of the plan. They wanted to ensure that they used an inclusive and collaborative approach. They had set up a governance around that and stakeholders from their partner organisations formed a group that held the reign on producing the LTP for the system.
g) Throughout the process they had engaged with Birmingham and Solihull Health and Wellbeing Boards and had also commissioned an insight into public views for the plan through a piece of work with Healthwatch Birmingham. This piece of work showed what the public wanted to see in our plan was aligned with the vision and priorities in terms of prevention self-care and improving access.
h) Another thing they did as part of developing the plan was to have a robust confirm and challenge process. They had brought together a group of external stakeholders to be their critical review and challenge the developing of the plan.
i) They had held two critical review meetings with that group which was helpful in testing out the business plan as to whether it was local enough for Birmingham and Solihull, whether it addressed the priorities and challenges within the system. This helped to shape what the what the plan looked like today. This approach was commended by our regulators in terms of our inclusivity and challenge.
j) With regards to finance, the plan was still considered as a draft as discussions were still on-going with NHS England and Improvement. Within the plan there was a set of key themes that were outlined. The plan was comprehensive as it sat at around 260 pages which may seem lengthy, but they had a complex system – they had a set of challenges, numerous partners that needed to be involved and they needed to ensure that they were responding to each of the commitments and requirements that were being set out nationally.
k) It was felt that the plan told the Birmingham and Solihull story. They had a real focus on aligning it to the STP Strategy with a particular focus on place, prevention and the life courses as set out in the STP plan.
l) The structure of the plan was in line with the life courses the STP Strategy, but they wanted to ensure that they captured the key enabling things that would support delivery of those national requirements. They had thread this through those workforce development, finance, digital

transformation, research social value etc. which were golden threads throughout the whole plan.

m) It was prudent to carry out a risk assessment and had set out some strategic risks within the plan and the mitigations around that and they had also undertaken an equality impact assessment which had indicated that the overall development was positive. In tandem to this they had also produced a public summary so that when they come to launch/publish the plan they will be setting that out through their communication along with the full plan.

n) In terms of where they were with the matrices, there was a performance framework that was set out that underpinned the plan, but these were national matrices which the system was required to deliver. There was a total of 31 matrices across the whole plan and were based across the programme on life courses.

o) As part of developing the plan, they were able to commit to delivering the majority of the matrices, but there were a few exception areas where they were able to fully commit due to further work that was required in those areas. Additional funding was needed to be able to fully commit to those. These exceptions had been agreed locally with their regional teams NHS England and Improvement.

p) In terms of the next steps, discussions were continuing with the regulators to be able to sign off the plan. Once this was done, they would be able to launch the plan and there was guidance that was due to come out nationally and how they go about doing that. The other process that was starting soon was their routine process around operational planning.

q) The guidance nationally was to be published next Monday 20 January 2020 and Tuesday 21 January 2020. They were now entering into the annual planning process in developing a system operational plan which would be due for the regulators – the draft towards the end of February and then the final plan by the end of the financial year and they will need to have agreed contracts with their provider organisation by then.

r) They would also be looking at the assurance and governance framework that sits around the plan where they could report back on their delivery and track progress. This was currently being reviewed. Once they had looked at communications and engagement aligned to the individual initiatives and programmes within the plan and they will follow due process in terms of their obligations around communication and engagement and consultation. The individual delivery plans were being developed.

Dr Robin Miller commented that it was a long plan, the NHS Plan was an extensive plan, but he felt it was well articulated, accessible and the … structured well complemented the team on doing such a good job. Good to see reference to HWB as part of their scrutiny he enquired whether they were able to add a bit more detail as people may not know what HWB was. Dr Miller enquired what they think HWB would add to their scrutiny functions. Dr Miller referred to page 80 of the document " our systematic approach …" He added that this was something he had felt that they had worked on for a long time and health care services. He enquired whether Ms Lawrence could articulate what it was that they wanted

In response to questions and comments, Ms Lawrence made the following statements: -

1. In terms of the HWBs roles in overseeing the plan and what they would like from the Boards, was the objective view that goes beyond health and being able to offer a level of scrutiny that challenges them and test that they were on track and delivering the plan.
2. It helps in strengthening and having a robust governance in place and ensuring that the appropriate mitigating actions were being taken if there were any slippage.
3. They wanted to work in full transparency with their partners and have the HWB as part of that process and seeing the information and data that they also see as part of the scrutinise delivery of the plan.
4. Paul Jennings stated that one of the things they were keen about in terms of their work with the STP was to maintain a crucial link with local government and the HWB was the place where the care system came together with local government.
5. Although they recognised their contributions to prevention and reducing inequality in health, they knew that where that really happened was to the paths where local government touches and unless they came together under the HWB with Public Health they would not meet their objectives.

   At this juncture, the Chair welcomed Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust to the HWB.
   Mr Lewis stated that his question came from a plan STP viewpoint and enquired where they felt the plan positioned the system in terms of particularly in employment poverty. He added that his question was specific to what commitment they were feeling able to give within this plan to the real living wage given the intention of the city to be potentially declared as the first real living wage city in the UK. He further stated added that the STP he was a part of were nudging towards committing towards a living wage system.

   Mr Jennings advised that this was the conversation they were having through the HR Directors Forum across the STP, but it was not yet in the plan. They were having that conversation given the status of University Hospitals Birmingham (UHB) with 21,000 employees now which was the most significant employer after the City council.

   Ms Lawrence continued

6. In response to Dr Miller's question around development, culture and the maturity of the system she stated that he was correct as there was a lot of work that had been done and it was felt that a lot of work was being done in terms of the individual organisations in terms of addressing culture.
7. It was known that there had been a lot of change through the Birmingham and Solihull system with the merger of the three CCGs, the merger of UHB and the other developments. The reference around immaturity was around the ICS work in terms of the direction they wanted to go in in terms of developing themselves as a single system.

8. There was still some way to go, but there was a lot of work happening over recent years in terms of working in an integrated way with health and local authority partners – mental health and children's – where they were working in an integrated way and what they wanted to see was this happening at that scale and with the move towards place-based working.

Dr Varney commented that he was pleased of the way they had worked together. It was a series of sprint and a marathon to get here. It was important for the HWB to be aware that working with the STP and the CCG, they had established a Prevention Board which with Nigel and he as co-chairs will help them move forward. He added that this was one of the things that they were keen to work through to have that Board formally linked to the HWB moving forward.

They were actively talking to the Black Country STP around what their approach might be and whether they would mirror that model as the Black Country had six Directors of Public Health. This was slightly complicated to work through, but he felt that it was worth the Board being aware that they had established that as a particular governance space to ensure that the HWB and the Public Health agenda and the STP and CCG were all on the same page and had some inter-connections.

The Chair expressed thanks to Ms Lawrence and colleagues for being so inclusive. She stated that as a Councillor she felt that they had *bent over backwards* to ensure they were a part of this process. They also came in to see the other Cabinet Members and did a special meeting with them due to the timescales for the other Cabinet Members who had agreed the draft Plan at that time. The Chair commented that she cautiously welcome the five-year Plan, but that she was aware that they had a long way to go, but she knows that they will get there. The Chair stated that she was in agreement with Dr Varney's comments as there were lots of opportunities to do the joined-up work and the challenges that was needed. The Chair further stated that she was in agreement with Dr Miller's comments as the document was an easy read.

The Chair expressed well done to Harvir Lawrence and colleagues and Paul Jennings for the work they had done concerning the document.

442 **RESOLVED: -**

The Board agreed to support the direction of the Long-Term Plan to enable the respective councillor members (Councillor Hamilton) and officers (Dr Justin Varney and Graham Betts) to approve the Plan at the STP.

WEST BIRMINGHAM ALLIANCE UPDATE

The following report was submitted for information:-

(See document No. 6)

Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust introduced the item and advised that many partners around the table were already involved what was now the Ladywood and Perry Barr Integrated Care Partnership (ICP).

Mr Lewis drew the Board's attention to the infographics appended to the report. Setting the ICP in the west of Birmingham in the context of the West Birmingham, Black Country and STP, the battle plan was to tackle poverty – described as healthier people, being a decent employer, the Third Sector as being the best place to work. It was important as an STP team and with the assistance of the HWB, that they keep these things in the order he had just described them. Whilst it may have seemed obvious, it took a lot of arguments to get it into that order, in a system where STP and ICS were migrating towards being the delivery arm of the local NHS system, which was happier talking about NHS systems than it was about inequality.

Recognising that the governance of the STP was in the process of changing from the end of March 2020, they would expect the five places to migrate to a position where the STP was no longer governed by its constituent organisations coming together which was now in the Black Country and West Birmingham, towards a position where they had the maturity to pick up Dr Miller's point, to have each of the places represented and to have the headline governance of the STP, formally on a place basis, not on an organisational basis. He stated that he was pleased to say that the City Council, Primary Care Networks (PCN) and the NHS bodies had agreed a representative model which meant that the west of Birmingham was represented in the STP as a whole. To reflect Dr Varney's point from the earlier item of trying to ensure that the STP in the Black Country and West Birmingham was *essentially built place up rather than ICS down* as nothing else made sense. It was their intention to try and build *bottom up not top down,* but it would *need constant gardening* to make that truly work.

Mr Lewis advised that the report described two things – The first was that there were five bullet points (paragraph 4.2.3 on page 424 of the agenda pack) that sets out the sort of things that they had been discussing over the last year and a half, but with different velocity and different participation by different agencies. It was hoped that the five things, whilst they were not priorities for change reflected a common-sense approach to try to get things to move forward for our populations.

- Firstly, that they understand that population as it was more than a statistical thing, a feeling and a listening thing aided by both Healthwatch Birmingham and the Third Sector.
- Secondly that they build on the asset-based approach that the Council had adopted and has been a feature of the number of discussions that had taken place across the west of Birmingham.
- Fourthly, they did not focus on money as the currency, not because they object to talk about money, but because the real currency of the partnership was time.
- When they talk about moving services around and what they could do better for isolated older people, or how they sustain genera l practice, they were really having a conversation about how they could use abuse misuse each other's time either by patients, carers or service providers and the smarter they could be about the time they save and the time they devout to care, the better and this was really the currency.
- The next thing was to get ready for the Midland Metropolitan Hospital which was a partnership endeavour rather than a Sandwell and West Birmingham endeavour. They had signed the contract they had done

that before but they were now expecting to open in 2022 and that releases the resource into the wider system and they needed to ensure that it work.

- The final point was essentially the priorities that the partners had chosen. These were priorities that could be added to but were not came to as a shortlist without some thought. They intend to focus on obesity and end of life care. The language for public presentation may change, but that was where they think the partnership would make a difference.
- As they develop the governance and they signed off in draft forms in terms of reference at their last meeting, other priorities would come into place and the things listed in the Birmingham and Solihull plan would be considered there and they were all good things and there was no rational reason why one would not want to adopt all or many of those things. Those two areas were the initial focus of work which was much of a learning thing as well as a doing thing as they have got to work out as a set of partners how to work together.
- All of the partners round the West Birmingham Alliance Table work together for many years. The question was whether they could deliver a better outcome to people and this was an activity that they were working out what they might do differently, specifically in those two spaces to get a new and better result. They were not averse to adding additional priorities but were cautious about ending up saying they were going to do everything and ending up doing nothing.

In the discussion that followed, the following were amongst the principal points made: -

i. Mr Lewis noted the Chair's question concerning obesity and stated that the answer to how they got to it was through discussions with the clinicians involved on the basis that it was something that they felt that the partners could do together and could make a difference that then unlocked either resource and/or wellbeing in the population.
ii. When compared with Sandwell for example, it was not the standout health issue faced by partners, but it was sense that in an arear where currently there was not enough collective endeavour, therefore more could be done. The conversation was particularly focussed on children rather than adults. But the answer to the how question was the collective will of the clinical community and partners round the table.
iii. Dr Varney commented that they were glad that they had now established a clearer partnership for both Council and particularly the health department with the partnership as he thought that there was a lot where they were working across the city particularly in the areas of prevention of obesity recognising that as he alluded to the work that they did when he presented Food City.
iv. The focus was *on turning off the tap* of some of these challenges which ties in with the role around poverty and depravation driving inequalities particularly in parts of west Birmingham.
v. The question was around the space where they had significant inequality particularly in Ladywood around COPDs chronic-airways disease and cardio-vascular disease, where clinical management and early identification could be really quick wins.
vi. The question … was yes, they welcomed the broader partnership piece, but also in the context of where they fit in that in closing the gap on

clinical management space as it was not clear from the meetings held so far how that sits.

vii. Mr Lewis stated that to offer one view, once they had agreed as a group of people was that they would have a meaningful partnership. They needed to have a part one and a part two conversation. The conversation was these were the things they tried to manage in common which they probably could not do if they were not working together. The other was areas where an organisation … had a priority and it was entitled to ask for assistance or listening time for everybody else – the issue of everybody in the partnership was probably two or three partners.

viii. If we were smart about using data particularly live data, and data regarding people being in contact with services or not that the smart use of the services would be a distinguishing character particularly to pick up the point Dr Varney made that that was where pointing more of our efforts to better identify cohort people would be smart. We might hold ourselves to account for becoming pre-outstanding the way we use live data in common.

Richard Kirby offered the following reinforcing observations -

- Birmingham Community Healthcare NHS Foundation Trust which he was a part of was part of the partnership and he underlined with what Mr Lewis had stated about how they were trying to put it together.
- There was a structural bit and it was recognised that whilst they were at a point where west Birmingham was in one STP, but remaining as part of the city of Birmingham, this structure gives us a way of managing those interfacing intentions so that the early years team that was on the ground that could reflect the kind of priorities coming out of the STP around this work but could also sit within the context of the Birmingham wide service, without that becoming impossible to manage.
- The Midland Metropolitan Hospital issue was important as he was involved when it came out in 2010 a big change in the way services work in that part of the city having a framework for them to do that sensibly was important. The obesity issue was their way of saying getting children off to a good start in life matters to us.
- Some of the Black Country discussions might work with that and it may not be the biggest issue in Birmingham, but if it provokes some hard thinking about how the public sector in that part of the city helps parents to support children to get the best start in life they could that was what really mattered.

Stephen Raybould stated that in terms of obesity one of the system challenges for the NHS to reach out beyond its institutional boundaries and picking something that gives it no choice but to do was helpful. Even though it might not be reinforced entirely in terms of geography, as a system this was helpful and was welcomed in that part of the city.

The Chair commented that they wanted Mr Lewis to attend the Board meetings as for too long they were guessing what was happening. The partnership work that was happening was a positive way forward. Sometimes if you could not get what was needed and you could get 50% or 60% until you get it serves the

people of this city. The Chair again welcomed Mr Lewis to the Board where he could share what was happening in that part of the city.

In response to a question from the Chair, Mr Kelly stated that there was a compare and contrast exercise in saying what was best for Birmingham and how do they ensured that they were finding solutions that levelled up across the city. He added that there was work to do in ensuring that they structured the conversation and that the intention was there. Once they got the data and their ideas together, they needed to look across the city and see where there was best practice and be opened to sharing that so there was no exclusion.

As an HWB they could hold the NHS to account for focussing on the outcomes, not just clinical outcomes but human outcomes that would be helpful. The systems could look different in west Birmingham, but what mattered was whether they delivered the outcomes that people were entitled to expect. If they could collectively stay focused on that it would be helpful to all.

(At 1638 hours, Paul Jennings advised that he and Richard Kirby had to leave the meeting as they had a prior engagement).

443 **RESOLVED: -**

The Board noted the opportunities created by joint working in the locality.

HEALTH AND WELLBEING FORUM UPDATES

444 The following report was submitted for information:-

(See document No. 7)

Dr Justin Varney, Director of Public Health, Birmingham City Council advised that this item was for information and that there were written papers providing updates for the other forums.

PUBLIC HEALTH GRANT BUDGET UPDATE

445 The following report was submitted for information:-

(See document No. 8)

Dr Justin Varney, Director of Public Health, Birmingham City Council advised that this item was for information and was approved by Cabinet in December for the reallocation of the grant .

FORWARD PLAN REVIEW

446 The following report was submitted for information:-

(See document No. 9)

Dr Miller requested that somewhere in the Forward Plan (FP) time be allocated for discussing social prescribing as this was a key development around Primary Care Networks (PCN). As he interface between the statutory sector and the voluntary community sector as he felt that it would be an interesting example of one dynamic in their system that they could explore in the FP.

Dr Varney stated that the last time that the Board met it was discussed in a presentation. They subsequently had discussions with the CCG about where social prescribing was and it was felt that it was too early to bring it for discussion to this Board. The different PCN were in a different position across the city. However, through the Forums there had been more detailed discussions about how social prescribing was being implemented and connected with those programmes. They would go back to the CCGs about putting this back on the agenda as they were keen to have that conversation.

The Chair suggested that this be placed on the agenda for summer to give the PCNs time to get themselves together. Stephen Raybould stated that unless they got ahead of the implementation there was not much of an opportunity to influence as there were significant challenges around where people were going to go and the destination for prescribing. It would be useful to provide these earlier rather than when there was a problem.

Dr Varney stated that they had repeatedly and publicly through this Board highlighted the tensions with national policy on social prescribing and the funding provided to the NHS to fund someone to write the prescription. They had a conversation about the failure to provide adequate resource through the public health grant through the local government or through the voluntary and community sector to provide what was actually being prescribed. He highlighted that there were specific partnership groups that exist. The Adults Social Prevention Group had been looking specifically at social prescribing in the context of adults.

There was no social prescribing currently in the city for children and young people and this was something they were thinking about and was in discussions with the CCGs. The Chair advised that nationally they were having the same problems – this was not something that was set in stone and would change with time. To rush to try and do it now when the health service was uncertain of what was happening was not the right time. March 2020 was too early to have this item on the agenda, but for the next meeting in summer they were hoping to have some information concerning the issue.

FINALISE AGENDA FOR THE NEXT MEETING

447 This was as detailed in the Forward Plan.

OTHER URGENT BUSINESS

448 None submitted.

DATE OF NEXT BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING

449 It was noted that the next Birmingham Health and Wellbeing Board meeting will be held on Tuesday 17 March 2020 at 1500 hours, in Committee Rooms 3&4, Council House, Victoria Square, Birmingham, B1 1BB.

EXCLUSION OF THE PUBLIC

450 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 Paragraph 4
