BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING TUESDAY, 17 MAY 2022

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 17 MAY 2022 AT 1500 HOURS AS AN ONLINE MEETING

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Professor Graeme Betts, Director of Adult Social Care
Andy Cave, Chief Executive Officer, Healthwatch Birmingham
Councillor Jayne Francis, Cabinet Member for Digital, Culture, Heritage and Tourism
Mark Garrick, Director of Strategy and Quality Development, UHB
Karen Helliwell, Interim Accountable Officer, NHS BSol CCG
Councillor Mariam Khan, Cabinet Member for Health and Social Care and Chair for the Birmingham Health and Wellbeing Board
Professor Robin Miller, PhD, Director of Global Engagement for College of Social Sciences, University of Birmingham
Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Chief Superintendent Mat Shaer, West Midlands Police
Dr Douglas Simkiss, Medical Director and Caldicott Guardian, Birmingham Community Healthcare NHS Foundation Trust
Dr William Taylor, NHS Birmingham and Solihull CCG and Vice Chair for Birmingham Health and Wellbeing Board.
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Richard Beeken, Chief Executive Officer, Sandwell and West Birmingham NHS Trust
Carol Herity
Kalvinder Kohli, Service Lead CCoE, Adult Social Care
Ceri Saunders
Dr Mary Orhewere, Assistant Director, Environmental Public Health
Dr Shiraz Sheriff, Service Lead – Governance, Public Health Division
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

639 The Chair welcomed attendees and advised, and the Committee noted, that this meeting will be webcast for live or subsequent broadcast via the Council's meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

DECLARATIONS OF INTERESTS

640 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

641 Apologies for absence were submitted on behalf of Richard Kirby, Birmingham Community Healthcare NHS Foundation Trust
Councillor Sharon Thompson, Cabinet Member for Vulnerable Children and Families
Carly Jones, Chief Executive, SIFA FIRESIDE
Andy Couldrick,
Sue Harrison, Director for Children and Families, BCC
Riaz Khan, Birmingham and Solihull District, Department for Work and Pensions
Peter Richmond, Birmingham Social Housing Partnership

DATES OF MEETINGS

642 The Board noted the following meeting dates for the Municipal Year 2022/23:

2022	**2023**
Tuesday 17 May	Tuesday 17 January
July 2022 - Development Session	Tuesday 21 March
Tuesday 20 September	
Tuesday 29 November	

All meetings will commence at 1500 hours unless stated otherwise.

MINUTES AND MATTERS ARISING

643 **RESOLVED: -**

The Minutes of the meeting held on 22 March 2022, having been previously circulated, were confirmed and signed by the Chair as a true record.

ACTION LOG

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

644 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

645 The Chair advised that there was no update.

PUBLIC QUESTIONS

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

CORONAVIRUS-19 POSITION AND VACCINE UPDATE STATEMENT

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

(See document No. 1)

Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care commented that this was all positive news, but that we have spent a great deal of time talking about Covid over the last couple of years. Councillor Bennett Added that going forward whether we needed to have this level of information at the start of the meeting. He proposed that this be had for information, but that if things changed again for the worst we could revisit that but at the moment he wonder if it was worth taking up the start of the meeting going through this level of details particularly as Dr Varney stated that we did not have the level of data as we used to.

Dr Varney nodded in agreement to Councillor Bennett's comments.

The Health and Wellbeing Board noted the contents of the slide presentation.

The Chair expressed thanks to Dr Varney for presenting the item.

COMMONWEALTH GAMES UPDATES UPDATE

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

(See document No. 2)

The Health and Wellbeing Board noted the presentation.

ICS UPDATE

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

1. It was worth noting that for the Clinical Commissioning Group (CCG) representatives here today, this was our last and final meeting. For Dr William Taylor who was the Vice-Chair for the Health and Wellbeing Board, the CCG will be ceasing as an organisation in about six- and one-half weeks' time.
2. We were working hard now to established and get ready to put in place the new organisation the Integrated Care Board (ICB). We now have all of our executive team appointed to the ICB the details of which will be circulated but those appointments will be critical to taking forward the new agenda.
3. The organisation and the ICS were now working in shadow form and we will see a lot of readiness to operate in our governance and our arrangements were getting into place.
4. In terms of other key areas to note, one of the key areas of interest for this Board was the identification of a masterplan and a strategy which was for the Integrated Care Partnership. This was for the wider group of stakeholders that were going to be brought together across the system.
5. We were delighted that Dr Varney had agreed to lead the development of that masterplan so there were some links there with the work already undertaken in the Health and Wellbeing Board (HWB).
6. A lot of the work around Birmingham as a place – Professor Graeme Betts was leading on this and some of the development sessions there will be opportunities to work through the benefits for citizens.
7. It was not just about creating the organisation, it was about integrating care for the benefit of our citizens and patients and the focus now will be about improving that care and how we go about it. The Board will hear a lot more about that agenda going forward.

Dr Justin Varney, Director of Public Health formally thanked and acknowledged both Dr William Taylor, Karen Helliwell and Dr Manir Aslam. The journey we have been on and the Health and Wellbeing Board has not always been an easy one particularly through the various iterations the structures and governance etc. but it has been one that we have travelled as colleagues. It was important to minute our thanks to them as the journey continues in a new phase by the NHS. Dr Varney added that he valued personally their support and their robust challenge which has been helpful and keep us moving forward.

Professor Robin Miller, PhD, Director of Global Engagement for College of Social Sciences, University of Birmingham echoed Dr Varney's statement and stated that we were very fortunate with our Clinical Commissioning Groups (CCG) colleagues on the HWB. They have contributed to the discussions an brought a sense of their own roles equally we were happy to engage with others. Professor Miller added that the HWB was lucky in that regard.

Professor Miller enquired in terms of the involvement of people's lived experience in terms of health and social care and communities and the new integrated care system whether this was something that was developed and the approach as to how that was going to happen in practice, how it was going to work at different levels and whether this was something that could be shared with the HWB members.

Ms Helliwell made the following statement:-

- There that there was probably quite a few documents that we could start to share. There was a Communities and Engagement Strategy which She and Dr Taylor had just been in a meeting to sign off.
- We were very much looking to the expertise in the local authority for engagement and building on that with partners. It was not thought that the ICB organisation was looking to do it itself. It was looking to build on some of the work that Dr Varney spoke about as well in terms of the vaccination programme and learning that was part of it.
- The operating model of the ICB was very much about devolving responsibility and accountability as close to the citizen as possible ad that was the key part of that.
- There were various initiatives such as the Fairer Futures Fund pot of money which will be organised and led by the local authority to facilitate that change in community which was the key part of our strategy going forward.
- In our arrangements we were putting the resources and a lot of our staff in the CCG out with and into Birmingham. This was something I was passionate about in integrating community commissioning and working closer with neighbourhoods which will be a key part of our arrangements.

Dr William Taylor, NHS Birmingham and Solihull CCG and Vice Chair for Birmingham Health and Wellbeing Board advised that in relation to neighbourhoods, there was a workshop earlier today and the whole point was to have integrated care as close to the people and the communities as possible. Really thinking about how we integrate care in those communities in a way where people did not fall down between the gaps between services which we saw happening now. The key to that was understanding their stories and understanding their voice as we cannot do it without them.

Ms Helliwell commented that we were all going into a new system and a new organisation so clearly West Birmingham colleagues and ourselves were both joining a new system and a new organisation, and we very much welcomed that as well.

Richard Beeken, Chief Executive Officer, Sandwell and West Birmingham NHS Trust apologised for not attending the Board meetings before and that he had committed to Dr Varney that he or his deputy would attend all future HWB going forward. Mr Beeken stated that his question relates to West Birmingham – Ladywood and Perry Barr as a locality moving from the Black Country to the BSol system.

The West Birmingham Partnership Board as it currently exists made it very clear what the conditions for what success would be. Two of them related to subsidiarity and local determination and there was an articulation about how this would be measured. The second being in relation to ensuring that there was not where possible at least essentially two very different approaches to the development of community services in the widest sense between the two parts of the system that his organisation supports.

Looking through the lens of the Midlands Metropolitan Hospital. There was a risk because there was such a significantly different operating model for BSol as compared to the Black Country, there was a risk that two of the three key conditions for success we agreed were not going to be fully assured. There were mitigatable but we did not want to be discussing the details about how they could be mitigated here, but the question was whether you and others felt that there was still a risk. If it was, we have six- and one-half weeks to try and agreed some joint statements about how those risks would be mitigated.

Ms Helliwell advised that there was a level of governance and assurance that was in place to work collaboratively and that we always have between West Birmingham and ourselves, but she would take the point back to the ICB with Paul Athey who was leading on it. Ms Helliwell added that she felt that those risks could be mitigated and if it was identified that there were some outstanding areas, we would continue throughout the next six weeks and beyond as there will be some ongoing issues as place becomes an entity in its own right in the new way. I am sure we were all committed to that going forward as it was not thought that this was a hard and stop work that would be carried on beyond that. Our commitment was that we wanted the right services for citizens all across Birmingham and that inequity was something we would want to address.

Professor Graeme Betts, Director of Adult Social Care made the following statements:-

a. That he would focus on two things the new approach based on subsidiarity and place and this was the best opportunity we have to begin to transform our service to meet the needs of our communities.
b. As we know in Birmingham, the share scale of it was that we have five different localities with different communities within them.
c. Subsidiarity was a key principle and we needed to ensure that this services that was being delivered meet the needs of our local communities and we needed to understand those needs better than we did in the past.
d. This was a huge opportunity both for co-production with communities and community groups and the opportunity to begin to see services being delivered in different ways.

e. We would try to do this in two ways – to begin to build the infrastructure and the multi-disciplinary teams at a local level and the workshop this morning was beginning to take us forward in that way.
f. But there was also other work around strategic commissioning which was very much about getting the right pathways which meets the needs of our local communities. We would want to come back to the HWB about both those areas in terms of how they were being delivered in place.
g. The other key element was the interface with the service integrators like the main Acute Trust etc and about their development pathways. What would be interesting was to see how that would interface with place. This was all to be worked through and the role of the ICB was to help broker that.
h. In terms of the West Birmingham question the reality was that from a Birmingham perspective thinking in particular about the City Council, that was all there had ever been one Birmingham. The rest was several sections of it but one Birmingham.
i. Again we come back to that notion of place where this was recognised that there were different communities in Birmingham, and we need to meet the needs differently.
j. We were always open and remain open to ensure that we looked at best practice so that we could learn from the way West Birmingham was developed.
k. We could look at Solihull and there were lots of models we could build on. It was about learning from the best because ultimately that meant our citizens get the best possible services.
l. Going forward that was what we needed to be mindful of and put to one side what was and what was right or what was wrong. We needed to forget that as we have a great opportunity to move forward.
m. Professor Betts proposed that at the next Board meeting this issue be place on the Agenda so that we could give an update as to where things got to, how things were developing and improving.

The Chair commented that this was sensible idea and it was noted.

SANDWELL AND WEST BIRMINGHAM NHS TRUST FIVE YEAR STRATEGY

650 Richard Beeken, Chief Executive Officer, Sandwell and West Birmingham NHS Trust introduced the item and drew the attention of the Board to the information contained in the report on pages 47 – 55 of the Agenda Pack.

(See document No. 3)

Mr Beeken made the following statements:-

a. The Trust had a strategy that had elapsed in 2020 which was largely pointed to the opening of the new Midlands Metropolitan Hospital which did not open on that date.
b. Covid had happened since that point and the Integrated White Paper had happened since that point.

c. The national NHS approach to collaboration horizontally has happened since that point and at Sandwell and West Birmingham the Trust had slipped backwards in terms of both the regulatory opinion of the quality of its services but also staff and patients surveyed opinion of the quality of its services as well.
d. There was clearly a need in the context of all of that to look forward five years and try to align what we were doing to the ambitions of both of the systems that we served, and it was hoped that this strategy reflected that.
e. From our starting point was really to be clear about our purposes were and our organisation really should do that we were clear from the beginning that we wanted to do more than just being an organisation that treats the sick.
f. We could quite easily continue to structure ourselves to do that but by being one of the biggest employers around and by being the biggest health care providers around and by being the host of the place-based partners in Sandwell already we had the ability to do much more than that as a so-called anchor institution.
g. Our purpose was to contribute to improving the life chances in the health service with outcomes of the two very distinct populations that we serve.
h. We tried to keep things simple by saying that we have three strategic objectives the first of which relates to our service users and our patients and that was because as an organisation that was rated improvements required by the Care Quality Commission and as an organisation that was languishing in the bottom quarter with national survey opinion we have to get the fundamentals of care right and we were not doing so at the moment.
i. There was a structured and far reaching approach to the continuous quality improvement and launching to get the rock on which we stand to be far more stable than it had been in the last two to three years.
j. Firstly, we had been clear that the natural workforce crisis could be ignored, and we could stick our heads in the sand, or we could accept that the recruitment retention and inspiration of our clinical and non-clinical staff was going to help us deliver better outcomes for people and therefore we were focusing our approach on four areas.

   Obviously, culture and how we interact with each other was one of those. We were also taking international research evidence from the public sector which clearly stated that staff experience was also heavily influenced by how intuitive digital technology was that they used.

k. Secondly, by the physical environment in which they work and there was nothing more powerful than a tweet he had received a few weeks ago from an over exhausted junior doctor who basically stated *that I don't want yoga lessons, I don't want wellbeing sessions. What I want was a car parking space, somewhere to get hot food at 2:00am in the morning, enough colleagues to work with on my shift and somewhere to hang my coat and hat when I get to work*.

   Focussing on those fundamentals was a key part of our people plan as was perhaps the more highfaluting organisation development aspirations.

l. Thirdly and most critical to this Board was our third objective which was our population. We were stating the rather obvious statement, but it needed stating to a lot of his colleagues within my organisation that we were not an island and we would only improve health outcomes and life chances relations by working with other organisations both vertically through localities and places but also horizontally across the two systems that we serve.
m. We do have a bit of challenge within my organisation as we do serve two systems so that that horizontal partnership with colleagues in Birmingham and Solihull was going to be something that we had to give equal attention to because 47% of the activities within my organisation that delivers the patient care contacts comes from the Birmingham and Solihull system.
n. As regards population there was essentially two elements to our work the first was that either being a leader in the integration space in Sandwell or being a partner in Birmingham as we were in Ladywood and Perry Barr which was one half.
o. The other half was an unexplored area that I was starting to move into because it was quite clear when you look for example at the Midland Metropolitan Hospital development, its regeneration potential, the Trust existing work programme around and widening participation for some of the more marginalised members of our society.
p. The fact that we have a massive jump to make in terms of making what we do as an organisation greener more sustainable how we could contribute as a so-called anchoring institution for economic regeneration in improving the ability to economic participation for our citizens.
q. We did not believe we were a leader in that space and would not want to be trampling on other people's toes, but what we were saying to people was that we were more than an hospital and please see us as more than an hospital because we deliver community services.
r. We have an interest in ensuring that some of the more diverse and deprived communities that we serve as we all knew were some of the most deprived and diverse in the country we could play a part in helping those people get back on their feet as much as other statutory and non-statutory partners.
s. With regard to the Midland Metropolitan Hospital that was our biggest single strategic enabler that would underpin those three objectives that we were seeking to achieve as it will impact upon each of them because it will if we get our care model right enable us to provide better care in a better-quality buildings. It will enable us to attract and retain more staff and reduce our reliance on temporary staffing.
t. Thirdly it will through developments like the learning campus on site like the local universities and colleges it will give us the opportunity and our footprints would be necessarily more overtly wider than it was not just as a hospital or health care provider.

Dr Justin Varney, Director of Public Health made the following statements:-

i. Two things stood out for him – the ambition to become more than an anchoring institution. This was something where in Birmingham we had a network of anchoring institutions which clearly supports that the Board

had previous representations on. There was some opportunities for us to connect you with that.

ii. Also under the ICS inequalities programme there was a specific ambition around increasing the NHS and social care anchor footprint beyond large institutions.

iii. The question was how we work so that the large anchors connect to medium and smaller anchors reaching right down across to community pharmacy and primary care practice level so that we started to maximise all of those services that were fixed into place because they had bricks and mortars in a much more coherent way.

iv. There was a real opportunity to bring you into the ICS fold which was not just about place.

v. One of the things we were seeing was a slightly different way of behaving with the ICS was that there were pieces of work really anchored in place in localities around transforming services.

vi. Where there were things that it made much more sense for us to do across the 1.3m people at the system level we were now having real conversations about what does that meant.

vii. It would be wise to have a connection with Richard Kirby about how the Trust connected into the Inequalities Board and the Inequalities Programme as that was one of the opportunities where the Trust could forged new grounds.

viii. At the moment we did not have a Trust representative for any of the providers other than Mr Kirby as the Community Trust Chief Executive. There was some synergy there at the system level as well as at the place level and there were some real opportunities.

ix. Although some of our NHS anchors had done great work, there were some exemplary work from other non-NHS organisations that we were all learning from in the city.

x. This was one of the real opportunities particularly from the University of Birmingham who did some innovative work around place and anchorage. It was that cross pollination across the public sector that was key in this

Professor Robin Miller, PhD, Director of Global Engagement for College of Social Sciences, University of Birmingham commented that one of the things he saw a long time ago about the new Midland Metropolitan Hospital was that you were going to try and use and deploy social value through your purchasing and try to buy local produce and sustainability etc. Professor Miller enquired whether this was still part of the plan.

Mr Beeken stated that it was and that we tracked our performance against it as well. He added that he needed to cross-referenced his numbers. For example we stated that we could be committed in the business case from 2016 to 60% of the goods and services procured to essentially construct and open the building would be secured from organisations and procured from a 25 miles radius - that was the commitment. That was tracked on a not frequent basis but on a regular basis through our Boards Committee that was devoted to opening the Midland Metropolitan Hospital. He added that he could offer to provide the latest performance of that if that was useful off-line.

As you could imagine, the unavailability of sub-contractual labour because of HS2 and other things and the hyperinflation of materials leading us to look

elsewhere globally as well as nationally has perhaps put a dent in that in terms of latest figures because our priority now was to get that hospital open. We were providing services on the Dudley Road site that were now creaking at the seam in terms of their viability for the 21st Century health care provisions.

Professor Miller stated that linked to that going forward things like catering services, cleaning services etc. will there be any engagement with social enterprising with not for profit businesses as well as there would be a long-term commercial footprint that will be had.

Mr Beeken advised that prior to his time the trust made a commitment which he was now dealing with to provide estate maintenance services through a large multinational. However, catering remained stubbornly in-house, portering services and cleaning services remained stubbornly in house and will do so. The big opening space in the new hospital was the Winter Garden so-called. We have already got a partnership with local community groups and local artists and that he thought it would be outside of Birmingham City Centre the largest Art and Gallery space in the West Midlands when it was fully open. This was just an example of the social value stuff – it was #Morethananhospital that we were trying to push.

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG made the following statement:-

- 45% of your referrals came from West Birmingham. From Primary Care 80% of our referrals were into City and Sandwell Hospitals which was a massive part of our referral process.
- It was not just about the hospital and it will not be juts about the hospital going forward.
- The integration we had done with consultants coming into our practices and managing our diabetes better, our respiratory services better having a gold standard or a CQC outstanding rating meant that we have had some of the best services in Birmingham.
- Although the hospitals were challenged, some of the services we provided for the most deprived population were some of the best that we got.
- What we did not wanted to do was to unpicked the great work we had done, we have not thought about organisations as we had been going along, but we had been thinking about our patients and what we provide to them. We maintained our focus and those services must stay in place.
- We must not be disadvantaged by moving – we have always been one Birmingham place and that has never been different. The way that our NHS functioned and the way that our Primary Care integrates with its hospitals were different.
- University Hospitals Birmingham (UHB) was the main provider or the rest of Birmingham, it was not for West Birmingham. We were functionally different, and it was a plea to say don't unpicked those things because putting them back together would be difficult.

(At 1600 hours Councillor Jayne Francis and Professor Graeme Betts left the meeting due to a prior engagement).

Dr Justin Varney in the Chair

BCC EARLY INTERVENTION AND PREVENTION PROGRAMME

Professor Graeme Betts, Director of Adult Social Care introduced the item and stated that it was important to state that one of the key programmes we had for transforming the Council was brought here and had huge implications for the work we were doing not just within the Council but a system as a whole. Professor Betts advised that he had taken this presentation to the Chief Executives across the BSol system and felt that it would be good to bring it to the HWB as well. He added that Kalvinder Kohli, Service Lead CCoE, Adult Social Care was leading on this and had done a fantastic job.

Professor Betts then invited Kalvinder Kohli to present the item.

Kalvinder Kohli, Service Lead CCoE, Adult Social Care presented the item and drew the Board's attention to the information contained in the slide presentation.

(See document No. 4)

Dr William Taylor, NHS Birmingham and Solihull CCG and Vice Chair for Birmingham Health and Wellbeing Board commented that it sounds like a comprehensive programme of work across a huge amount of areas. Dr Taylor made the following points:

The names were incredibly confusing given that we already got a partnership programme with the City Council called Early Intervention – we now have two. We needed to think about that as we cannot have the Early Intervention Partnership Programme with Birmingham City Council and this one. Having looked at it first I thought it was a completely different subject, so it was worth thinking about that.

It was not clear form the presentation how this interacts with place – things like the conversation we had this morning around neighbourhood integration, interaction with health, neighbourhood networks. These could not be seen from the presentation and it feels like something that sat within the Council rather than something that sat within the partnership. I have not seen much in terms of partnership work around this and its design into that place-based offer. He added that he would be interested in hearing more about that as this was important.

Dr Varney advised that there were a lot of external partners who were involved in shaping some of this.

Kalvinder Kohli apologised to Dr Taylor and advised that this was the shortened version of the presentation and that there was a Programme Board for the Early Intervention and Prevention Programme which includes ICS colleagues as well. In terms of the place-based agenda this would be routed in that place-based approach. As was stated at the beginning of the presentation, this was not a

programme that stand alone, it was connected to the much broader activity. Neighbourhood networks for example came up time and again – what we did know was that there were (when I spoke about fragmented experience) parts of the Council that did not utilised neighbourhood networks for example. It depended on where those citizens landed as to whether they were told about and were accessing our networks. It was about bringing all of those thigs together. Apologies we do have a longer slide which probably brings that information out far better than this had.

The point around the name, again, Dr Taylor was correct. The reason we were calling this Early Intervention and Prevention Programme at the moment was because we struggling to agree upon an appropriate name for the programme, but it was hoped that by the time we get to the Cabinet report in December we would have a better working title than the one we have at the moment.

Stephen Raybould, Programmes Director, Ageing Better, BVSC commented that this speaks to Dr Taylor's point earlier and that he wondered whether at some point this could be thought about in terms of adoption by the ICS and not just being a Birmingham City Council approach. He added that he appreciated that this was done with other partners, but he was just aware that we focussed on health and inequalities, but there was a lot of activities in what was in effect a similar space where gains had o be made there. Pulling all of this together was likely to give a better outcome across both programmes. Perhaps looking at a stronger alignment and then integration down the line would be a useful way to progress.

Dr Douglas Simkiss, Medical Director and Caldicott Guardian, Birmingham Community Healthcare NHS Foundation Trust commented that we feel like we were getting closer, but there were so many different elements of this. Dr Simkiss added that the bit he wanted to check was that you talked about this being about children, but mostly it seemed to be adult relate. Dr Simkiss enquired whether this was a life course strategy or whether it was largely an adult strategy. The vision talked about starting when we were children continuing through their life, but it seemed mainly adult related.

Kalvinder Kohli advised that this was whole life course and would evolved in terms of alignment, so we were working closely with our colleagues around the early help offer – example around children and families and how we aligned that into this space. This will form part of the detailed design work we engaged with including the Birmingham Children's Trust in terms of their early help offer to ensure that we could have a front door around early help that we complimented and supported that space. It was not an adult space exclusively, but similarly, we were mindful of the fact that the factors that brought people to the front door was often related around things like debt, income, abuse etc. If we look at domestic abuse and we look at the number of children in care, domestic abuse was part of their back story. By inference there was a whole life approach t this and as we developed the work packages it became clearer as to the work we needed to focussed on in the different cohorts of population.

Dr Simkiss stated that there were a number of different hubs, there were children centres, family hubs and there were chid development centres. There were a number of existing bodies which could be pulled together for the whole

families. The other bit was around homes and money advice and he as speaking to our registrar about trying to make every contact count. There as the physical activity and the health care parties and there was a number f ways in which we were drawing closer together in terms of a suite of interventions – we could end up with a single piece of paper with all of these and coming together as a whole workforce not juts across health and social care, but across all of the Council and all of the other things that work. They were coming together but they were still different elements.

The last one was the library and there had been a lot of discussions through the pandemic as we moved to virtual consultation around digital poverty and there was some work with her chief clinical information officer with libraries about whether they could become pods in libraries where they could do a consultation virtually if they did not have digital equipment at home.

651 **RESOLVED: -**

The Health and Wellbeing Board:-

a. Agreed to be mindful of EI&P programme and to help identify alignment opportunities with BHWB strategies and current priorities – implications of EI&P across BHWB strategic priorities and programmes, as detailed in the report;
b. Identified any additional stakeholders, including staff, citizens and partners, to be involved in research and codesign for EI&P;
c. Helped identify appropriate SMEs (internal and external); and
d. Defined cadence of board appearances receive reports or how best to work moving forward – to keep both parties aware and aligned of programme developments.

BIRMINGHAM AND LEWISHAM AFRICAN CARIBBEAN HEALTH INEQUALITIES REVIEW (BLACHIR)

652 Dr Justin Varney, Director of Public Health then presented the item and drew the attention of the Board to the information contained in the slide presentation highlighting the key points.

(See document No. 5)

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Dr Mary Orhewere, Assistant Director, Environmental Public Health presented the item and drew the attention of the Board to the information contained in the slide presentation highlighting the key points.

(See document No. 6)

The Chair commented that he acknowledged Dr Orhewere and her team's hard work in putting the report together.

653 **RESOLVED: -**

The Health and Wellbeing Board:-

a. Noted the findings from the Director of Public Health Annual Report 2021/22:
Creating a built environment that makes Birmingham a healthier place to live.

b. Agreed to support the identified recommendations of the report.

AGENDA ITEMS 16 - 17

654 The Chair acknowledged Items 16 and 17 on the Agenda were for information only.

Birmingham Health and Wellbeing Board Chair

655 At this juncture the Chair invited Cabinet Member for Health and Social Care and new Chair for the Birmingham Health and Wellbeing Board who was observing today's session to address the Board.

OTHER URGENT BUSINESS

656 Professor Robin Miller, PhD, Director of Global Engagement for College of Social Sciences, University of Birmingham invited members of the Board to attend his inaugural lecture as a professor on the 6th June 2022. He advised that this will be about collaboration and leadership which he has drown a lot of experience from the HWB.

The meeting ended at 1636 hours.

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CHAIRPERSON