BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING TUESDAY, 22 MARCH 2022

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 22 MARCH 2022 AT 1500 HOURS IN CHARLES DICKENS ROOM, BMI, MARGARET STREET BIRMINGHAM B3

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG,
Andy Cave, Chief Executive Officer, Healthwatch Birmingham
Karen Helliwell, Interim Accountable Officer, NHS BSol CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Richard Kirby, Birmingham Community Healthcare NHS Foundation Trust
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
Dr Douglas Simkiss, Medical Director and Caldicott Guardian, Birmingham Community Healthcare NHS Foundation Trust
Councillor Sharon Thompson, Cabinet Member for Vulnerable Children and Families
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Aidan Hall, Programme Senior Officer – Governance, Public Health Division
Carol Herity
Alexander Quarrie-Jones, Programme Officer – Governance, Public Health Division
Monika Rozanski, Service Lead (Inequalities), Public Health Division
Dr Shiraz Sheriff, Service Lead – Governance, Public Health Division
Penny Thompson
Suman McCartney
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

621 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

622 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

623 Apologies for absence were submitted on behalf of Councillor Paulette Hamilton, MP and Chair of Birmingham Health and Wellbeing Board
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Professor Graeme Betts, Director of Adult Social Care,
Andy Couldrick,
Mark Garrick, Director of Strategy and Quality Development, UHB
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
Chief Superintendent Mat Shaer, West Midlands Police
Dr William Taylor, NHS Birmingham and Solihull CCG and Vice Chair for Birmingham Health and Wellbeing Board.

DATES OF MEETINGS

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

2022	2023
Tuesday 17 May	Tuesday 17 January
Tuesday 26 July	Tuesday 21 March
Tuesday 20 September	
Tuesday 29 November	

All meetings will commence at 1500 hours unless stated otherwise.

EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC

The Chair highlighted the reports at Agenda items 6 and 7 and appendices which officers had identified as containing exempt information within the meaning of Section 100I of the Local Government Act 1972, and where officers considered that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report:

625 **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

It was noted that Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust had submitted an apology but that this had been omitted from the Minutes of the meeting held on the 8th February 2022.

626 **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

Aidan Hall, Programme Senior Officer – Governance, Public Health Division introduced the item and advised that there were no outstanding actions on the Action Log.

627 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

628 The Chair read the following statement from Councillor Hamilton, MP:- '*I would like to that all Health and Wellbeing Board Members for their work to improve the wellbeing of all our citizens. I really enjoyed the discussions and progress we have made. We have managed to openly discussed some key aspects of health and inequalities and the last two years responding to the pandemic have showcased how we could collectively work better together to improve our response to our citizens in our health and social care services worked better for*

them. Thanks, and I am sure that I will meet and have further discussions with many of you in my new role representing the constituents of Erdington. I wish the Health and Wellbeing Board continued success as it moved forward and the significant role it will take in the Integrated Care System (ICS). I would also like to thanked Dr Justin Varney, Director of Public Health, Dr William Taylor, Vice-Chair of the Health and Wellbeing Board and each and every one of you for your contributions throughout the year. Thank you very much'

PUBLIC QUESTIONS

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

CORONAVIRUS-19 POSITION AND VACCINE UPDATE STATEMENT

630 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)

Stephen Raybould, Programmes Director, Ageing Better, BVSC commented that there was a period of time reported at the end of last week where the West Midlands was the only region where cases were not rising. He enquired where Birmingham was in that picture and why that was happening.

Dr Varney made the following statements:-

- The overall the trend was that Birmingham was going up and across the West Midlands there was some fluctuation some of which were areas that went up faster.
- A few weeks ago it was Rugby that was top of the country and they were now flattening out. There was some balancing going on between different areas.
- Testing was stable and we continue to monitor wastewater which was showing that there was an increase, but it was not as dramatic as in other areas.
- Some of that was a reflection of working in patterns across the region and across the city.
- Some of this was about how hard we were hit over Christmas and the early part of this year and natural immunity providing some form of protection.
- We were not at the moment a significant out layer, we were just being a little bit slower climbing the stairs which was very much what we did throughout the whole of the pandemic - we took our time to climb.

The Chair expressed thanks to Dr Varney and team for the work they had done over the last two years concerning the pandemic.

COMMONWEALTH GAMES UPDATES UPDATE

631 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)

Karen Helliwell, Interim Accountable Officer, NHS BSol CCG commented that presumably the App was open to a wide geography which was good but just in terms of how we looked at the local impact.

Dr Varney made the following response:-

- What we were aiming to do was to evaluate them as a bundle of activities rather than as individuals. *Whisk* people could register so one of the things we could do was to look at people's demographics, but they did not have to, but they could.
- What we were aiming to do through that phase was the resources and the *Whisk* resources was to do a more detailed focussed group evaluations working with community organisations to ascertain how do all of this land.
- We were a nation that consumed cookery books more than any other country in the world, with the largest market for cookery books, yet that was not reflected in how much people cooked at home.
- One of the things we have been actively promoting in the *Cook Commonwealth* was affordability. This was a strong narrative in the marketing campaign and the full marketing campaign was in preparation phase and would be launched in April.

Carly Jones, Chief Executive, SIFA FIRESIDE, enquired what happened to *Whisk* post the Commonwealth Games.

In response to Ms Jones' query, Dr Varney made the following statements: -

- ✓ *Whisk* was free and we were not paying to use *Whisk* as this was part of the partnership. *Whisk* was an innovation company that spun out of Panasonic who had approached us two years ago to work collaboratively with the city. There was no money changing hands.
- ✓ From their point of view the benefit was to be able to put the *Whisk* platform in front of a big audience, but also, they were benefitting from testing it.
- ✓ There was an element if you remember pre-Covid where we were using *Whisk* with small medium sized food retailers to reformulate that menu. That was parked because of Covid, but that would be restarting now.
- ✓ Once they were on the platform they stayed there forever, and they stayed within past platforms that was clearly identified as Birmingham and Birmingham's Commonwealth activity.

Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust enquired how we could be more engaged as providers as some of our service users of mental health would want to be actively engaged with this as it was to be

launched later in the year and whether there was anything, we could do to support that.

Dr Varney advised that Public Health had just appointed a Comms and Engagement function as he did not have any resource before to support that. One of their first job is to launch in the regular newsletter that goes out to the Health and Wellbeing Board and to all our partners. As you saw each time, I present to the Board there were a number of good stuff going on, but what we struggled to do was get it out there so you could all used it. That was an important part of that, but we will also be doing some important stuff alongside the Food Strategy Consultation to help promote and raise awareness as well.

UKRAINE CRISIS UPDATE

632 The Chair introduced the item and expressed thanks to everyone. She added that health colleagues had played a key role in the last few weeks in supporting some of the children and their families that had joined us here in Birmingham and across the country. The Chair further stated that there was wide implications with that, but everyone had pulled together well which was good. The Chair expressed thanks to all our partners as we were grateful for that support and the quick action that had taken place.

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.

(See document No. 3)

Dr Varney made the following statements:-

- There had be a huge amount of collaboration work between the NHS and local government particularly supporting the movement of the Ukrainian children with cancer connected to the Women's and Children's Hospital.
- It had been an amazing joint effort where clinical colleagues and local government colleagues came together particularly our colleague Monika Rozanski who was present at the meeting who had been one of the officers that helped who was asked to step up from her normal day job to support the response because of links with the communities.
- That was the first piece of collaboration, now we were moving into preparation and planning for the arrival of other refugees through the various schemes that had been established through Government.
- There was a huge amount of work that was still to come that we were prepping for now around the implications for those arrivals and how we support them through primary care, housing and through the community and voluntary sector.
- When we come back next time as a Board there will be more clarity about those next steps.
- As colleagues around the table knew this was a rapidly changing policy area and there were many questions which we were waiting for national government to give us clarity on and this changes every day very much.
- There was the Inter-agency Management Team (IMT) which was working on this and we had demonstrated through Covid how well we

came together in crisis to protect and support our citizens. This forms a mechanism that was coming into play here.

BIRMINGHAM AND LEWISHAM AFRICAN CARIBBEAN HEALTH INEQUALITIES REVIEW (BLACHIR)

The Chair introduced the item and advised that the ask was for the Board to consider coming forward to champion and to lead on any of the opportunities for the actions that were identified and report back to the Board of what we could do collectively to build a better future and to break the cycle of inequality and disadvantages for African and Caribbean communities. The Chair highlighted that Councillor John Cotton had requested that the fact be urged that this was also about *Everyone's Battle, Everyone's Business* and this was the reason we were pushing for that collaborative piece. The Chair added that this was something that Councillor Hamilton, MP was passionate about too.

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. 3)

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG commented that the approach to the report and its recommendations were fascinating. He added that Dr Varney alluded to the fact that he had a conversation with Mr Kirby about how we implement some of these. There was quite a lot that required cross-organisational work which was great as we were in the business of integration. Dr Aslam enquired how this was going to work practically, as we would need to resourced these things if we wanted them to work. But they will have such a significant impact. Dr Aslam further enquired what the strategy was, what success and good looked like and how will we know.

Dr Varney made the following statements:-

a. The Plan would be submitted in May after the local elections (we have brought this to the Board in order to get the report published before the elections). The Action Plan comes after the elections and some of the process given the political sensitivity, we had to respect that.
b. We were now building a team to work in Birmingham on how we implement this and how we do that working across the different partnerships that we have. This was the next phase with the view that we have a date towards the end of May.
c. The plan was that by the end of May we would have the event that would bring together the Academic Board and the Advisory Board to look at what we started to form as the Action Plan to see if was good enough.
d. One of the things we were quite keen on was to maintain that community co-production and involvement in creating the Action Plan. If not, the organisations take it away and adjust it with that co-production to play through.

e. We have had some initial discussions around the resources from Public Health towards that and because of political sensitivity we had to be careful how we phrased it.

Dr Aslam commented that we had health checks that was built in and successfully do them on a large scale, but there were communities that were missed and to their detriment. We talked about diagnostic centres and all of these conversations were happening in separate places. The role of the Integrated Care Partnership was to coordinate that conversation. Ultimately, we probably have enough resources within our system to do this, but it was in different places.

Dr Varney gave the following response:-

- That this was what he and Mr Kirby was talking about from the ICS viewpoint and the Inequalities Board being the kind of nexus for some of the NHS pieces of work.
- Health checks was a good example as we were already starting a journey towards what he called Health Checks 2.0 and the team had been working up a timeline between now and December for how we might change the way we commissioned.
- Health checks could also helped to remind the data because on the dashboard for health checks we could not see them by ethnicity.
- That he was aware that at individual practice level this could be seen, but at the system level we could not so we needed to do that piece of work.
- There was some good work that was being done by the maternity system looking at an equity audit which reflected good practice.
- The question was how we could test whether our services were really reaching our communities properly and we did not do that routinely enough.
- What we will see was across a range of services this will prompt the question. We all need to share the good practice learning, so we do not try to continue to reinvent the wheel.
- For Primary Care it was going to be an important part of the PCN inequality lead roles. Someone explaining how you extracted the data on *EMIS* for this then all the other *EMIS* practices could do it the same way, so we did not kept starting from a blank sheet of paper.
- This he believed was where the ICS system would become helpful in sharing the practice and the learning.

Richard Kirby, Birmingham Community Healthcare NHS Foundation Trust made the following statements:-

1. This was an interesting piece of work much for the way it had been done as for what it stated. Hopefully it will give what it tells us. We needed to do greater power and an opportunity to see it through. There was a couple of reasons why the timing for this was helpful.
2. Firstly, the ICS was in the process of setting out its strategy for inequalities and there was a clear opportunity to take these recommendations which needed the ICS to lean on and put them in the right place with the right level of prioritisation around that. It was hoped that this report would come to the ICS and the Inequalities Programme

Board in a few weeks' time. We should be able to see the big NHS recommendations from here appearing in that work.

3. Secondly, we were in effect thinking what the change model for the various things we needed to do. Some of these things were best for the individual NHS Provider Institutions were best tasked with doing them well for their own services and cracking on in that spirit.
4. Some models will need some (possibly Birmingham and Solihull wide) collaboration as it made sense to do one piece across the bit. But the other bit in other places was clearly for some of our localities (this was a big issue) and particularly in some of the communities in West Birmingham needed us to respond sensibly to these recommendations.
5. There was also a role particularly for the West Birmingham Locality Partnership which was the best developed at the moment of the various partnerships to be asked to work through what it thought was its contribution to this directly.
6. We had a range of ways in and the ICS inequalities strategy document will set out which were the actions which would apply to which. There was a big reflection doing this well and taking this seriously and giving it the response it deserved was a big job.
7. Mr Kirby undertook to speak with Dr Varney more about the NHS side and the Council side about resourcing it properly and seeing it through and all of the things that was talked about.

Professor Robin Miller, Head of Department, Social Work and Social Care, University of Birmingham applauded Dr Varney and the team, City Council and the wider partners who kept this work going through Covid which was an incredibly task and report. This was an important landmark for the city.

In terms of universities he could see three contributions that universities could make:-

- Firstly there was the research and we also train a lot of the future health and social care professionals and some important messages in this report about cultural appreciation.
- Secondly, the ability to engaged with different communities that was highlighted that we could do something about.
- Thirdly, one thing we had not came across before was the educational opportunity was an access to employment and different career routes to universities.

At the University of Birmingham we have been doing a lot of work recently to try and understand how we could make such opportunities more accessible to Black and African Caribbean communities. Professor Miller enquired what the best way was of having a conversation offline to try and coordinate this response of universities in the city to ensure we engaged with this and look at those three issues of research, training students and also in terms of opening up educational opportunities and to African and Black communities.

Dr Varney undertook to pick up with Professor Miller offline as he was going to send the information to the Vice Chancellors to prompt their thinking. The point on those pipelines were important particularly in the mental health and wellbeing section. We had two individuals from the communities who were clinically trained psychologists who were saying how hard it was to progress.

This also chimed with several academics who felt strongly that their progression was being halted because of their ethnicity and that they were struggling to break through. It was an important point raise by Professor Miller regarding the third point which came out in the detail of the report about career progression and career opportunities, something we all needed to reflect on.

Andy Cave, Chief Executive, Healthwatch Birmingham commented that he welcomed the report coming before the elections. Mr Cave stated that what came through for him was the continuous co-production which was important and a lot of the opportunities that will happen. He added that he was happy that the potential relaunching of that, but equally with the ICS system and elective resource with engagement the involved groups was a real opportunity to come together. It was an opportunity to develop the principles of co-production involved.

Mr Cave enquired whether there was anything that came through in addition to what was in the opportunities that suggested alternative ways of doing co-production that would help us to engage with the African Caribbean communities. There were three areas that came through that echoed some of the learning through Covid that was community advocates, workplace and investment in organisations and whether there was anything else that could be highlighted in good co-production.

Dr Varney made the following statements:-

a. The two things that stood out for him was recognising firstly that African Caribbean communities were not the same community which was important and within African communities there were some significant differences. This came out through the co-production.
b. The engagement was we needed to be better as public sector organisations in understanding that the heritage, culture and identity of a Ghanaian person was different from a South African from an Egyptian and we called them all African because they happened to be on the same continent. Yet, we would be quite affronted if we were called French or Italian as we did not think of ourselves as Europeans. This was the first thing that came out strongly.
c. The second thing was Faith and business and recognising that Faith gets us far but was not the totality and the assumptions of Faith. Again, that came out clearly. We have a large Somalian Muslim population in the city and often with these communities that was Evangelical Church and Christianity was the predominant Faith. So really challenging ourselves to think about who was not being heard and that was where the business network became useful.
d. Another thing we had done through this was working closely with community media and radio stations like New Star Radio have been really supportive. There was more we could do to engage with social media content producers and other routes and mechanisms for co-production and engagement.
e. When we started this journey, we knew it was going to be big, but I am not sure that we quite realised how complexing and big it was going to be, particularly in understanding the African diaspora. This was one of the areas where the review had highlighted the need to dig deeper and

do more and to not assume that someone represented the totality of the community.

Mr Cave referred to health education and enquired whether it was too early to ask what the action plan for that could look like for us as a city.

Dr Varney responded that some of this was being tested with the Commonwealth Games Legacy Project. He reminded the Board of the Community Health Profiles that was launched – the Sikh and Bangladeshi profiles. We have commissioned a range of different African countries to profile linked to the Commonwealth part of which was a test of how much we were able to draw out in difference and understanding with the work we were doing around the physical guidelines. You could consider this as an overkill, but it was part of understanding the languages aligned with the differences in communities within south Asia.

We were starting to test that and there was a recognition from the people we developed the review with that there was not an easy solution. No one was able to say here was an intervention that would solve the problem. What they were able to do was to say quite clearly here was what was not working. There has been mandatory quality training since he qualified in the NHS, yet we failed to closed the discrimination gap in the NHS as long as he had been working in it. This was the kind of stuff they were challenging us on – look at what you were doing and why you were doing it, what was the evidence that made the difference.

Karen Helliwell, Interim Accountable Officer, NHS BSol CCG commented that she welcomed the report and that the new organisation of the ICP, the Commissioner this will very much play around how we prioritised commissioning and resources which covers the regional services. Hopefully this will help on the screening of Sickle Cell and the more specialist areas which she had known from her previous roles in the past which was important to get right. Ms Helliwell stated that she was happy to help in that respect and enquired whether in terms of Lewisham whether the twinning of the comparing and contrasting the learning with Lewisham would be kept as it always helped if it worked as a partnership.

Dr Varney stated that we had decided to move from being siblings to being cousins in this in the next phase with Lewisham partly because we were in quite different stages of the process and partly because the ICS structure were quite different. He added that he along with the Director of Public Health in Lewisham felt that now was the time to part ways, but we would continue to communicate on learning. Some of that also in relation to the emphasis and the data pack which was still being produced that will go alongside this for the May launch which we hoped will be an interactive data pack on Power BI demonstrated that there were quite some significant differences between ourselves and Lewisham.

Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust echoed Dr Varney's earlier statements in reference to the identification of African and Caribbean communities and made the following comments:-

- We needed to be more specific with our interventions as Africa was a continent of 54 countries. The broad brush of Africans we needed to start being more specific by our interventions as this relates to how people experience of services. If we were not specific, we constantly keep it at a high level. There was a level of fatigue out there about the number of reports we produced the route into any difference in terms of the day to day challenges that people faced. We needed to think about how we were going to really focussed on how this makes a difference. This report had tapped into some things that was recorded in our systems as we talked about the recording of ethnicity.
- We had seen a very high prevalence in terms of the use of the Mental Health Act something that we were currently focussing on and will be taking some of these recommendations to our providers as we have a number of pledges that speaks to the same things. This was another point of frustration that we had reviewed and tells us the same things, but what were we doing about it.
- We needed to ensure that we get into the details behind some of the inequality that we did not get consumed into the wider machinery of what we were talking about. These were some of the challenges that could get consumed into the big machinery and we lose sight of what we were trying to deliver.
- That he was committed to supporting this and to act as a champion from a mental health perspective.

Stephen Raybould, Programmes Director, Ageing Better, BVSC commented that he welcomed the report and the inclusion of the contributions that the community organisations could make. He added that as a general point he was more confident about resourcing communities of place than we had been about resourcing organisations for communities of interests. This was the reason for the change. What we had done previously was try to make everyone inclusive rather than trying to be specific about what we needed and what was capable of reaching out to the groups. It was a challenge back to the whole system to be brave and welcome the report.

Dr Varney commented that Mr Raybould's point was a powerful one. He stated that we found through Covid whereas a public health team we tried to commissioned partners to work with us for communities of identity. There were lots of gaps and the communities of place organisations did not have the cultural engagement and were not trusted by the communities to engage with them. This was something that as we go through this year of living safely with Covid that the team that had been leading that were now looking at how we transition that into some community partners to work with specific communities of identity as we already had good strategies with neighbourhood networks and communities of place but were weaker on communities of identity and communities of experience. For a city of this size it was disappointing that we had not been able to maintain those, and it was not known whether in our history it existed or not. They were not there as we came into the pandemic and we needed them there for the next one as well as for addressing these inequalities.

Dr Aslam stated that for the next paper that we have how as a strategy from now until 2030 it was not going to take us this long to address these issues in

this document. If it was not how will we judge whether this was going well and how will we comeback to it to hold each other to account to say that this has not gone as well as we would have liked. We needed to change tact.
Dr Varney gave the following response:-

a. This will come through in May's report with the Action Plan and the Data Pack. One of the challenges in this was that we did not routinely collect data on ethnicity on a whole load of outcomes.
b. It may be in the computer, but it was not extracted – example talking therapies the IAP service so the data on ethnicity was absolutely in the system but the IAP dashboard only allows access of ethnic data on one of the nine indicators of IAP. This was not routinely extracted.
c. There were some short-term things that we would expect to see in that Action Plan as a milestone within the next 18 months across the ICS and the Council services that were committed to analysing and reporting on our data publicly and transparently so we start to move to a way where we could track progress.
d. It was hard at this point to say here were the three indicators that would show success as the three indicators I could see in the data were probably the one that we would necessarily choose to track.
e. An important part of this was getting the data management right and through that setting milestones.
f. As we have been going through this, we had not sat on our hands particularly in the maternity area where there was damming evidence and the local maternity system had been proactive and responding to the initial findings.
g. They had already starting to commission culturally competent materials for maternity staff to better understand different ethnicities and cultural practices around birthing, weaning and breastfeeding. This was already a good example of things where we were moving fast.
h. There were some other areas where we needed to take this report to our national and NHS colleagues. Some of this was about the way the computers were built to make it hard to get stuff out.
i. It was hoped that when we come back to the Board in May there will be an Action Plan and a milestone alongside that for the Board to be able to clearly see and it was one of the recommendations for us to seek the Board's approval to bring this back on a regular basis so the Board could hold us to account.

Carly Jones, Chief Executive, SIFA FIRESIDE enquired about commissioning frameworks coming into the programme and whether there was a vision for voluntary sector organisation to be commissioned i.e. that this will be built into commissioning frameworks. She further enquired whether contractual obligations were being created for them to support and whether this extends beyond the big players such as the NHS bodies but filters down to the whole of our system and whether this was the intent for what would happen.

Dr Varney stated that it was thought that this was something particularly in the Inequalities Forum that we needed to work through. As much as we had done this for the African and Caribbean communities, we could have equally done it for our visually impaired communities or for other ethnic communities and it would have probably came out with very similar issues. As commissioners we needed to be smarter to understand and reflect the differences and the work on

maternity was a good example of that where there was a specific difference affecting African and Caribbean women. A specific taskforce was now established to focussed on those inequalities and what it was that we needed to do differently in the maternity system. It was about balancing that – progressive universalism which was a term we used in Children's Commissioning a lot - meaning that we expected everyone to be inclusive and competent. We expected to see targeted services where the need demands it and the evidence drives us. We needed a more robust approach to communities identity in a much smarter way.

The Chair commented that there was a strong need for collaboration and co-production and ensuring that the Third Sector was involved at the different levels. A great opportunity in terms of help with the NHS and what happened with the ICS.

633 **RESOLVED: -**

The Health and Wellbeing Board:-

1. Approve the content of the report from the Birmingham and Lewisham Black African and Caribbean Health Inequalities Review (BLACHIR);

2. That these opportunities for action are submitted for the Health & Wellbeing Board's consideration and for the partners to take forward this work to build a better future and to break these cycles of inequality and disadvantage for African and Caribbean communities;

3. The Board considered nominating a champion who will be responsible to ensure the Board partners respond to the review; and

4. That regular 6 monthly progress updates be provided to the Board, whilst the overall progress on the implementation of the relevant opportunities for action will be monitored by the Creating a City Without Inequality Forum.

BIRMINGHAM JOINT HEALTH AND WELLBEING STRATEGY

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 highlighting the key points.

(See document No. 4)

Stephen Raybould, Programmes Director, Ageing Better, BVSC enquired about progress in relation to the joint Health and Wellbeing Strategy. He referred to the map showing life expectancy and queried why that could not be done around ethnicity before. He added that there was a challenge around the way that the way that the information systems were constructed to enabled that to be produced. It was known that it was better n the Covid crisis but there were still limitations. Mr Raybould further enquired whether there was enough progress to get good visibility going forward around life expectancy.

Dr Varney advised not on life expectancy yet, but this was a conversation he had with the Chair at the beginning of the pandemic concerning death certificates which did not record ethnicity. Although the government had made a commitment as far as he was aware this still had not happened yet as they have not changed, he books. The death certificate was a handwritten bit of paper.

Until that happens it was very difficult to get life expectancy by ethnicity. The only way it was done in Covid was the Office for National Statistics (ONS) was able to connect people's death certificate with their NHS number and from their NHS number they were able to identified their ethnicity, and this was how it was done. It was a huge piece of resource and was not something that we could mimic at a local level unfortunately, let alone the mass of life expectancy which was a complicated piece of calculation.

Aside from that until government changed the death certificate to explicitly include ethnicity, we would not be able to create that kind of roadmap for inequalities in a robust enough way. Where we had progress and it had reflected to some extent in the strategy was that there were more indications now that we could get different data not just for ethnicity but for other dimensions in identity and we needed to do more to continue to build that because the code sat within the NHS system, we just did not extract the analysis.

The maternity piece of work was a good example of we could start to do that moving forward. We need to build across that into looking at example – hospital admissions for acute heart attacks. Public Health cannot access this at the moment. The population data by ethnicity for the local level was within the system – through our population health management programme we could start to develop that, so it become a routine report. This was a key part of the underpinning foundational change that we had to make.

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG commented that things will happen quickly and enquired whether this was one of the things that will happen quickly. He added that he did not bought into the issues that we had to wait for the death certificate as we could use the same information the ONS used. We could pull out the clinical data from the system as one of the population management tools that could facilitate that bit. Dr Aslam stated that he was keen that we avoid delay waiting for something to happen.

Dr Varney advised that in terms of population management stuff the first piece of work was on infant mortality and two further pieces of work that were happening on diabetes and Covid vaccinations. Part of that was matching data across the various bits of primary and secondary care to bring those together which for colleagues who were not in the NHS you would think was relatively straightforward. In reality this was horrendously complex and although there were quite rapid movement with things like integrated care records which would make it easier, that was still going to be a while before it became available.

Life expectancy was not as straightforward as just pulling the age at which someone dies, there was a whole piece of maths which sat behind and was not

easy which was why we were reluctant to try and calculate it locally without significant university support. There were stuff that we absolutely could do much to look at the preventative causes of death and cardiovascular disease now which across the NHS we recognised and across the system was one of the largest drivers of early death in the city. There was a lot of data we could pull by ethnicity and by other dimensions of identifying that and faster and to driver the action that we needed to.

Dr Aslam referred to the number of universities within Birmingham and that we had Aston University, which was sitting in West Birmingham, but we did not have direct conversations with them. He enquired whether Dr Varney has had that conversation with the universities.

Dr Varney responded that through Covid he had expanded his contact with the universities. He added that he had contacts with the five large universities, but less so with the four specialist, example, Birmingham University of Law which was a small specialist university with about 400 students. With the four specialist ones generally they were not public health focussed. With the five they have got different levels of engagement and one of the things outside of the meeting he had being doing was working with the Vice-Chancellors on how we flex the academic capital of the city more to support the work we needed to do on inequalities and think beyond the medical schools. Medical schools were important, and we did some really great stuff, but we needed the support of Social Sciences to be working with us on this.

Dr Varney highlighted that he was due to meet the University of Birmingham's Head of School for Social Science next week to talk through that point and would then mirrored that with the other four universities.

Th Chair commented that we could tell by the strategy that it had pulled together the ambitions of the Health and Wellbeing Board. The Chair expressed thanks to every that had contributed to the consultations, the engagements, research and the huge amount of work that had been put into this and also those that had collated all of the evidence and pulled the strategy together. This had taken a lot of work in the background. Thanks to everyone who were involved in that piece of work.

634 **RESOLVED: -**

The Health and Wellbeing Board:-

I. Agreed the Health and Wellbeing Strategy: 'Creating a Bolder, Healthier City 2022-2030' and publish findings from the public consultation; and
II. Recommended the strategy for approval by Cabinet.

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

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 highlighting the key points.

(See document No. 5)

The Chair commented that she found the report incredibly useful and a good reflection which would be useful moving forward at we addressed some of the health inequalities and the things it had flagged up that we did not realised that was there. The Chair expressed thanks to Dr Varney and officers for the work that had been done in this area.

635 **RESOLVED: -**

The Health and Wellbeing Board:-

a. Noted the contents of this report;
b. Provided feedback on this report;
c. Agreed to support the identified recommendations of the report; and
d. Approved the Annual Report for publication.

PERINATAL AND INFANT MORTALITY TASKFORCE

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 highlighting paragraph 4.8 of the report - identifying the three workstreams that came through the co-production approach. At the heart of the Task Force had been a strong approach co-production.

(See document No. 6)

Dr Varney stated that one of the powerful things of the Task Force was the voices of women with the lived experience of infant mortality and how passionate they were to act as part of the solution to prevent other parents going through that loss. They had made some strong recommendations about things that we needed to do in the short term to improve support for families affected by infant mortality.

636 **RESOLVED: -**

The Health and Wellbeing Board noted the contents of the report.

AGENDA ITEMS 16 - 17

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

The Chair reminded the Board that anyone wishing to be Champions within their organisations to please get back to Dr Varney on any of the things they had volunteered for as this would be most appreciated.

The Chair expressed thanks to Councillor Paulette Hamilton, MP who had chaired the Board meetings for a long time and for all her work and dedication to the Board.

OTHER URGENT BUSINESS

638 There was no other urgent business for this meeting.

The meeting ended at 1628 hours.

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CHAIRPERSON