BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

WEDNESDAY, 19 MAY 2021 AT 15:00 HOURS
IN ON-LINE INFORMAL MEETING, [VENUE ADDRESS]

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

2 **DECLARATIONS OF INTERESTS**

Members are reminded that they must declare all relevant pecuniary and non pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the minutes of the meeting.

3 **APOLOGIES**

To receive any apologies.

4 **PROPOSED DATES OF MEETINGS FOR BIRMINGHAM HEALTH AND WELLBEING BOARD FOR THE MUNICIPAL YEAR 2021/22**

To note the proposed dates of meetings for the Birmingham Health and Wellbeing Board for the Municipal Year 2021/2022 as follows:
Tuesday 27 July 2021
Tuesday 21 September 2021
Tuesday 30 November 2021
Tuesday 18 January 2022
Tuesday 22 March 2022

All meetings will commence at 1500 hours. The venue for the meetings are to be arranged.

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5 **MINUTES AND MATTERS ARISING (15:00 - 15:05)**

To note the Minutes of the meeting held on the 16 March 2021.

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6 **ACTION LOG (15:05 - 15:10)**

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

7 **CHAIR'S UPDATE**

To receive a verbal update.

8 **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.
The deadline for receipt of public questions is 5pm on 10 May 2021. Lines of questioning should be submitted via:
https://www.birminghambeheard.org.uk/place/birmingham-health-andwellbeing-board-questions
(No person may submit more than one question)
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's Internet site (www.civico.net/birmingham).
NB: The questions and answers will not be reproduced in the minutes.

9 **CORONAVIRUS-19 POSITION STATEMENT (15:15 - 15:20)**

Dr Justin Varney, Director of Public Health will present this item.

10 **CORONAVIRUS-19 VACCINE UPDATE (15:20 - 15:25)**

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG will give a verbal update on the item.

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11 **INTEGRATION AND INNOVATION: WORKING TOGETHER TO IMPROVE HEALTH AND SOCIAL CARE FOR ALL (15:25 - 15:55)**

Overview of the white paper
STP/ICS Progress Report – Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG, Paul Maubach/Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs.
ICS Inequalities Strategy Updates – Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust and Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs.
Board discussion.

93 - 96

12 **SOCIAL PRESCRIBING (15:55 - 16:25)**

NHS Birmingham and Solihull CCG – Paul Jennings, Chief Executive.
Black Country and West Birmingham CCG – Pip Mayo and Paul Maubach
BVSC – Brain Carr/Stephen Raybould

Board discussion.

97 - 112

13 **CREATING A HEALTHIER CITY STRATEGY (16:25 - 16:55)**

Dr Justin Varney, Director of Public Health will present the item.
Board discussion

113 - 140

14 **WRITTEN UPDATE FROM THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD (16:55 - 17:00)**

This item is for information only.

141 - 152

15 **FORWARD PLAN (16:55 - 17:00)**

This item is for information only.

153 - 172

16 **WRITTEN UPDATES FROM FORUMS (16:55 - 17:00)**

This item is for information only.

17 **OTHER URGENT BUSINESS**

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

18 **DATE, TIME AND VENUE OF THE NEXT MEETING**

To note that the next Birmingham Health and Wellbeing Board meeting will be held on Tuesday 27 July 2021 at 1500 hours. The venue is to be confirmed.

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 16 MARCH 2021

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 16 MARCH 2021 AT 1500 HOURS AS AN ONLINE MEETING

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Chair of Birmingham Health and Wellbeing Board
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Andy Cave, Chief Executive, Healthwatch Birmingham
Mark Garrick, Director of Strategy and Quality Development, UHB
Chief Superintendent Stephen Graham, West Midlands Police
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Nichola Jones, Assistant Director, Inclusion and SEND, Education and Skills
Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Professor Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Dr Ian Sykes, Chair, Sandwell and West Birmingham CCG
Dr William Taylor,
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Yve Buckland, Chair, ICS Board (BSol CCGI)
Louise Collett, Assistant Director, Commissioning, Adults Social Care
Thomas Gauntlett Meryl, JCP
Dr Marion Gibbon, Acting Assistant Director of Public Health
Elizabeth Griffiths, Assistant Director of Public Health, BCC
Stacey Gunther, Service Lead – Governance, Public Health
Carol Herity, NHS Birmingham and Solihull CCG
Debra Howls, Sandwell and West Birmingham CCG
Helen Kelly (Solihull CCG)
Heather Moorhouse, (BCC, CCG)
Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust
Douglas Simkiss, Medical Director
Michael Walsh, Head of Service Commissioning
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

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DECLARATIONS OF INTERESTS

527 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

528 Apologies for absence were submitted on behalf of Professor Graeme Betts, Director for Adult Social Care and Health; Andy Couldrick, Chief Executive, Birmingham Children's Trust; Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust; Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs; Waheed Saleem, Birmingham and Solihull Mental Health NHS Foundation Trust (but Patrick Nyarumbu); Peter Richmond, Chief Executive, Birmingham Social Housing Partnership and Gaynor Smith, Senior Employer and Partnership Leader, Birmingham and Solihull District, Department for Work and Pensions.

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:

529 **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

530 **RESOLVED: -**

The Minutes of the meeting held on 19 January 2021, having been previously circulated, were confirmed.

ACTION LOG

The following Action Log was submitted:-

(See document No. 1)

Stacey Gunther, Service Lead – Governance, Public Health introduced the item and advised that there were no outstanding actions on the Action Log.

531 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

532 The Chair welcomed everyone to the meeting and commented that it had been a busy few months. The Chair then expressed thanks to all our health colleagues here with us today on all the work that had been leading on in the rollout of the vaccines. She added that this was a phenomenal job and they were well on track with meeting and if not exceeding the aspirations that were set for the rollout.

The Chair stated that she had done her bit when she could and as a former nurse had volunteered in giving vaccines. She further added that she had enjoyed working on the frontline which was rewarding but it needed to be appreciated that there were many challenges. The Chair then gave the following update:

Covid Webinars
In February alongside colleagues in Health we held five online question and answer sessions via Zoom to allow members of the public to ask any questions or concerns they had regarding the vaccine. The sessions were very successful and I am grateful for our health involvement including Dr Manir Aslam and Willem van Schaik, Director of the Institute of Microbiology and Infection at the University of Birmingham who also joined the briefings to answer question as well as Dr Justin Varney our Director of Public Health and his colleagues.

Following on from this session I alongside my fellow BAME councillors joined together to do a video encouraging our BAME communities to take up when offered the vaccination. I also did some work nationally on this as there were far too many myths and mistruths being circulated via social media.

LGA -future Health and Social Care

I had also participated in a number of discussions at the Local Government Association on the future of health and social care and the development of Integrated Care Systems. The direction of travel was one that I broadly welcomed and specifically the need to focus on place and localities. The White Paper brought forward a duty to collaborate and a 'triple aim' for NHS organisations to support better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources with the NHS playing a role as an "anchor" organisation to support inclusive growth. There was strong recognition that arrangements at 'place' will assist with the delivery of the wider purpose for an ICS with relation to:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

The White Paper noted that the more successful ICS pilots have had a strong focus on place which has enabled cohesive planning and delivery arrangements and a stronger connection with local communities, particularly reflecting that "place-based" working was a mechanism to deliver health, care and economic benefits and to contribute to the levelling up agenda.

Care home visits from 8 March 2021

On the 8th March, we finally saw our Care Homes open up safely to family/friends' visits, except those with an active outbreak. We all felt the loss of not being able to see loved ones and many had gone a year without seeing loved ones so this was a much welcome step

- **indoor visiting by a 'single named visitor' for every resident**.

These visitors will need to take a rapid lateral flow test and test negative before every visit. They should minimise physical contact with residents. They must observe social distancing and PPE use, and follow all necessary infection control measures.

- **opportunities for every resident to see more people than just their single named visitor.**

By enabling outdoor visiting, use of visitor pods where there were substantial screens and other visiting spaces where there were substantial screens and/or window visits.

HIV conference

Last month I was invited to Chair an Event on ending new cases of HIV by 2030 and the role of local authorities. It was a very thought provoking discussion and there was really sound commitments made. I remember so vividly as I was growing up some of the awful advertisements and fear, disgust and mistruths

that were widely shared and accepted in society and in our press. There has been a recent Channel 4 drama series 'It's a sin' looking back on this now – it seems like alien times – but it was not that long ago. When gays and lesbians had to hide their sexuality, the press used outrageous languages – the gay plague the tombstone Public health - 'Don't Die of Ignorance'. Thankfully society has moved on considerably, but we have yet to get to grips and actively do more to raise awareness on how we could reduce prevalence rates further.

PUBLIC QUESTIONS

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

BIRMINGHAM INTEGRATED CARE PARTNERSHIP

Louise Collett, Assistant Director, Commissioning, Adults Social Care introduced the item and drew the attention of the Board to the information in the slide presentation.

(See document No. 2)

Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust commented that this could not be done without any of us. What was striking about this work was that all of the bits of the system – social care, the acute side and his team came together to make this work. This gave us a good role for applying to other teams in other areas. The things I would underline as we go forward was quite a bit of the change we had accelerated through the last 12 months in response to Covid-19 had being done in a way that was not yet sustainably funded with workforce and between us all we had to work that out within the next few months as it was important that we did so. Mr Kirby stated that he was keen to see the neighbourhood level integrated teams work now progressed as the next phase. This was the big step to helping all the people in the city live well at home as opposed to helping them get better when they were facing a crisis which was what we had been doing so far. Making those integrated teams aligned to the Primary Care Networks (PCN) worked on the ground was the next job we were all up for

Stephen Raybould, Programmes Director, Ageing Better, BVSC commented that he was pleased to see how this was working effectively. The pandemic had accelerated that as far as it was. Mr Raybould stated that there were a number of different models in the city around Birmingham Integrated Care Partnership (BICP), Adult Social Care and Children and Young People. Sometimes they work across different footprints and had different structures for engaging with each other. Mr Raybould enquired whether there was a space that they could thought about how they could all work together, as this was still a challenge that we all had to face.

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG stated that there were two things that came to mind. Firstly, the meeting that the Chair would recollect was the meeting that the Chair had chaired when Mr David

Bean came after the CQC inspection and what they had to say about us then. Mr Jennings stated that he would like them to come back again and say what they now thought about us as it was a different world. He further stated that the other thing that had occurred to him was anecdotal and in the past. Nearly 20 years ago Sir Dick Knowles did a report about older people's care in Birmingham entitled – *They Deserved Better.* It had taken us 20 years to get there but that he honestly thought that all of those things that were in that report that talked about the opportunity for encouraging independence and living at home – all of that we were now realising which was a fantastic achievement. To cap it all off we had worked through the pandemic which was marvellous.

The Chair enquired firstly, how we were ensuring that West Birmingham was involved in all of this; how they were being implemented at present. Secondly, how mental health were being involved in all of this.

Ms Collett advised that West Birmingham was absolutely very much a part of this programme. They were involved in all of the different workstreams and were involved in the overall Board that Professor Graeme Betts chaired that brought it all together. This was both from the Hospital Trusts and the Clinical Commissioning Group (CCG) so that they were at the heart of this already. Mental health was something that we realised in the review we needed to be mainstreamed throughout our programmes. In all of the programmes this was one of our objectives to ensure that mental health was reflected properly. When we spoke of multidisciplinary working in neighbourhoods that was about the mental health community teams. When we spoke about care homes, this was about primary care homes making sure that the appropriate mental health support goes in alongside that. So, this was very much at the heart of it.

In relation to Mr Raybould's query, what we were doing (fairly informally so far) was trying to align our approaches so that the approach through neighbourhoods was aligned through what we were doing in Adult Social Care. We were working closely with colleagues in Children to ensure that their early interventions and their work in constituencies linked in with our neighbourhoods network services. We had been doing that practically on the ground. It may well be that as proposals for the ICS developed it may well be that it was something that formalised it. We were talking to partners across the piece and making those links and making those joined up.

534 **RESOLVED: -**

The Board noted the refreshed vision for the Birmingham Integrated Care Partnership

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BETTER CARE FUND

Michael Walsh, Head of Service Commissioning introduced the report and advised that this was a joint report with Birmingham and Solihull CCG and Sandwell and West Birmingham CCG and that he was joined by his colleague Helen Kelly (BSol CCG); Heather Moorhouse (BSol CCG) and Debra Howls from Sandwell and West Birmingham CCG.

(See document No. 3)

Mr Walsh advised that the report was for approval for the Board to approve the Better Care Plan 2020/21 and to provide assurance that national conditions for the 2020/21 better Care Fund (BCF) had been met. Mr Walsh drew the attention of the Board to the information contained in the report and highlighted the key points in the report. Due to the pandemic the usual approval process around the BCF plans had been suspended this year so there was not the requirement for BCF plans to be submitted as Government departments and NHS England/Improvement had agreed that the formal BCF plans will not have to be submitted for approval this year. However, Health and Wellbeing Boards were required to sign off the plans and provide assurance that the national conditions had been met.

Mr Walsh further drew the attention of the Board to the paragraphs 4.5 and 5.1.2 of the report.

535 **RESOLVED: -**

The Board:

i. Approved the Better Care Fund Plan for 2020/21; and
ii. Provided assurance that the national conditions for the Better Care Fund 2020/21 have been met.

CHANGE TO THE ORDER OF BUSINESS

536 The Chair agreed to take agenda item 15 ahead of the remaining items.

BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM INEQUALITIES WORK PROGRAMME

Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust presented the item

(See document No. 4)

Mr Kirby stated that there was something important to say about working out the role of the Integrated Care System (ICS) in tackling health inequalities. The primacy of the Health and Wellbeing Board (HWB) and the role of the local authority was recognised. What we were seeking to do through the role of the ICS partnership was to bring the right contribution to the wider work around inequalities. This was described in the executive summary in the first couple of pages in the slides appended to the report.

A large part of this was ensuring that NHS partners in the ICS were doing their bit and there was plenty that we had to do to put our own house in order in terms of inequity in access to health care and in terms of outcomes for people receiving health care. One example was if we look at the children who were on the specialist community children's services waiting list, two thirds of them in Birmingham lived in postcodes which were in the bottom two deciles of the

national index of multiple deprivation. This was way over those that were represented on those waiting list. We knew that the health service had a job to do in this space and we also knew that we had a role to play as an effective partner alongside other organisations in working to tackle inequalities and their impact on health.

The NHS was a big employer and extender of a set of things that we could deliver within that anchor institution model that will help as well as a set of further things about our relationship with the communities we served. This was an important piece of work and a fantastic group of people drawn from across our system had been working with him on this and they had pulled together the work programme set out in the report (pages 128 -129 of the agenda pack) which listed nine things we needed to tackle over time working with the HWB and reporting to the HWB. Some of these will be programme of work that we launched ourselves, example, we had committed to some community level engagement work with each of the PCN in the city to help give them more support. Some of this will be help in other work programmes like the ICS digital work to put inequalities at the heart of what they do.

The purpose of bringing the report here was to seek input from the HWB as to whether this was broadly in the right direction or whether there were other issues we needed to add or things which we needed to focus on differently or things we needed to build into our work as we go forward. We shared this with Solihull HWB last week and with Birmingham today. It plays within the development referred to by the Chair earlier in terms of the Forward Plan for the HWB.

The Chair commented that Mr Kirby had set the scene and that the Board would not take any questions at this point. The Chair advised that Dr Simkiss will be speaking to the item later during the discussion on the coronavirus discussion at Agenda item 14.

Following the discussions on the coronavirus at Agenda item 14, it was

537 **RESOLVED: -**

The Health and Wellbeing Board:

a. Offered views on the nine proposed areas for work as the programme developed including which should be our immediate priorities; and
b. Endorsed the approach to health inequalities within the work of the ICS as set out in the report.

CORONAVIRUS-19 POSITION STATEMENT

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

(See document No. 5)

Dr Varney highlighted the following points:-

1. We were seeing case rates reducing at the moment and this was a reflection of the impact of lockdown. The most recent case data was putting Birmingham at 85 cases per 100,000 which was the same rate we had at the beginning of September 2020.

2. Looking at the pattern across case rates we saw reductions across all communities and in all age groups. There was a small increase in school age children and this was a group that had not had high testing until now and as children goes back to school and were being tested more frequently, we were finding Covid-19 that was already there.

3. It was expected that over the next week or so that would slowly *wash out* and we would start to see those case numbers coming down. If this did not happen, we would need to look again at whether there was additional Covid safety measures that was required in schools. We were keeping a close eye on that at the moment.

4. It was important that parents and childcare bubbles around children were all testing with the lateral flow kits. There was information on the Government website and parents were able to order home testing kits now through the post or for collection at a series of sites across the city. The more we were testing regularly the more we will be able to identify cases early and stop the numbers rising.

5. Colleagues would be aware that there had been significant rise in case numbers in southern Europe, particularly in Italy. Italy was much further behind us in terms of vaccination but had also relaxed some of their restrictions earlier than us. This was an important warning of what may happen if we did not maintain strong and steady course through the road map and keep doing everything we could with hands, face, space, ventilation, testing and isolation to contain the spread of the virus across the city.

6. Looking at the death data we were now running about a year since the first case of the virus was identified in Birmingham on the 1st March 2020. This was a solitary reminder of how long that journey had been. Between the 1st March 2020 – 1st March 2021 we went from one case to 96,676 cases in total over that year.

7. Sadly, we had lost 2,828 people to Covid. These were deaths where Covid-19 was included on the death certificates as the cause of death. This accounted for over quarter of all of the deaths last year. We had seen over 817,000 test done for the coronavirus using the PCR testing system and since we started to roll out lateral flow testing just before Christmas, we had over 400,000 people taking a rapid lateral flow test in the city.

8. These were huge numbers which had reflected all of the hard work that was going across the city partnership and many of the Board members were playing a pivotal role in protecting the city over the last year and navigating the challenge of the pandemic. We still had some way to go

towards the June relaxation date and as the Prime Minister reminded us this was always about the data not the dates.

9. Looking at the data we had so far, we remained concerned about the number of the exposures we saw linking people who tested positive to having been to shopping and retail outlets or to workplaces. We were keen to see employers played their part in controlling the spread of the virus to supporting staff to routinely test, to ensure that customers coming into retail outlets were wearing face coverings and were abiding by social distancing and ensuring that we were all playing our part to support people to test regularly and to take up the vaccine once they become eligible.

10. In terms of the Covid-19 Champions, over 780 Covid-19 Champions were recruited across the city and we had been doing some work which will be presented at next week's Local Covid Outbreak Engagement Board meeting to look at the demographics of these champions and the geographical coverage. Dr Varney stated that he was delighted to share that the demographic profile of the champions were in many ways strongly aligned to the population of the city.

11. Although there were some ethnic communities in which we would like to see more champions stepping forward, there was a good diverse representation across the champions. Dr Varney further stated that he was also delighted that last week Public Health had started the journey to launch the Youth Covid-19 Champions with Birmingham Children's Trust and the Youth Services Council and just seeing some of the things the young people were generating to increase testing confidence in other young people were inspiring and a testament to the future of the city and our young people.

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

a. Dr Varney noted the Chair's enquiry concerning meetings with the Covid-19 Champions and advised that weekly meetings by Zoom calls were held where the champions joined him or a member of his senior team. Briefing sessions were held on the latest topics followed by a Q&A session.
b. We were often joined by local GPs from the CCG that spoke about the vaccines. We were doing a lot of joint work between ourselves and the NHS locally to ensure that the champions could help support vaccine uptake and vaccine understanding. Alongside this there were emails that went out and Text messages.
c. The idea of the champions was about giving people reliable factual information to share with the people they love and care for through their social networks. It was important to ensured that everyone in the city understood what they could do in the battle against Covid-19.
d. Dr Varney noted the Chairs enquiry concerning testing centres and what this meant when things were finally relaxed and stated that testing remained an important part of Public Health's strategy to reduce and contained the spread of Covid-19. As we get more access to home

testing kits, (that would become more available) at the moment these were only available to people working in health and social care and the parents of primary school children.

e. Our testing sites needed to continue for some time and businesses were being asked to set up testing sites for their own staff as well. It was expected that that would continue until the early summer at the earliest when we would start to see things winding down in June and July, but until then it was important for all of us to test every three to four days if we were unable to work from home.

f. Dr Varney highlighted that the Council had introduced on the website an interactive map where you could put in your postcode to find where the testing sites were local to you. Dr Varney then demonstrated the interactive map to the Board. Dr Varney noted the Chair's enquiry concerning testing on mental health sites.

Councillor Kate Booth expressed delight concerning children and young people getting involved in this campaign as it was important … getting their photos taken and tweeting and doing their bits on Facebook as it was so important for our children to be tested. Councillor Booth expressed further delight that they were working on community languages and it was a positive thing that young people were able to step up and did what the over 90s, over 80s etc. had been doing.

Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust commented that the BSMHFT were on top of testing in the Mental Health Trust and vaccinations in terms of service users in all the different services that we had that was on offer. It was known that there were situations where there were concerns where patients refused to take the test, but our staff now had very clear processes of how we managed those situations whether it was a clinical setting as an in-patient and also within the community.

Dr Varney stated that the only thing to be added to what Mr Nyarumbu had stated was that Public Health was working with BSMHFT to support them around the testing of visitors particularly long stay mental health inpatients settings. Many people watching would be aware of the testing regime using lateral flow testing to support care home visitors. Unfortunately this was not rolled out in the same way too long-stay hospitals and Public Health was working with the Community Health Care Trust and with the Mental Health Trust to help support them to set up a system for testing, though for relatives who had patients who were long-stay patients we could support them to test when they came to visit to continue to protect those patients as best we could.

The Chair expressed thanks to Dr Varney and his team for the hard work they had been doing as the last year was not an easy one.

The Board noted Dr Varney's slide presentation.

CORONAVIRUS -19 VACCINE UPDATE

539 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG introduced the item and gave the following verbal update:-

1. As of this morning we had administered in Birmingham and Solihull 466,257 vaccinations. That he was confident that with the amount of vaccines in the system they would be at the half million mark by the 23rd March 2021.
2. This had been a fantastic collaboration between the GPs the hospitals and the mass vaccination sites that were operating out of Millennium Point and out of Edgbaston Cricket Grounds and elsewhere.
3. Across Birmingham and Solihull over 83% (and in some age groups more than that) and every person over 65 years old had their first dose of the coronavirus vaccination. When we thought about how we normally do the flu vaccinations this was an impressive number.
4. We had to work very hard in some parts of the city and in some communities to convince people to take up the vaccine. We were continuing to do that and to hold events and one-to-one conversations, but even in the parts of the city where we had to work hard, there were nowhere, where we had achieved less than 70% uptake of people over 70 years old.
5. There was no part of the city where the figure was below that. The older people who were the most vulnerable and most at risk in terms of the coronavirus infection. It was also important as we had to get to a higher number as possible to keep the transmission rate down and to reduce the number of people in the population that had/infected with the virus. We will be moving shortly to vaccinating the younger age groups.
6. Mr Jennings stated that concerns had being raised in the media and in social media about the AstraZeneca vaccine. The World Health Organisation (WHO) stated that the AstraZeneca vaccine was safe. The Medicines Regulator Authority in the UK confirmed that the vaccine was safe, the Joint Committee on Vaccination and Immunisation whose purpose was to ensured that this happened across the board for all vaccinations confirmed that it was safe.
7. Mr Jennings pleaded with people as we moved to the younger age groups to take the vaccinations. That the risk to younger people were less if they became infected with the virus but the issue for us was that we were in a race between the vaccine and the virus. The more transmissions we had the more opportunities there were for mutations. Therefore, we needed to get as many people vaccinated as we could.
8. As Dr Varney had stated we needed many people to follow the rules to ensure that we had as few patients as possible as that was the way we would start to make our population safer and this was the way we would be able to stick to the opportunities we had been given over the next few months to take back a life that felt more like life that we used to have and were more accustomed to have.
9. Mr Jennings concluded that there were great progress on the vaccination process and expressed thanks to all those who had been involved in this. Many of his GP colleagues had worked seven days per week on this since Christmas. Mr Jennings pleaded with everyone who had been offered the vaccine to please take up the offer as it was good for them

and everybody else as they would be helping to supress the virus across the population and gives us all a chance of a better life.

The Chair commented that she was pleased that Mr Jennings had spoken about the AstraZeneca vaccine as it was important that we did not shy away from it . The Chair added that the WHO and the regulators had stated that the vaccine was fine, but because in mainland Europe they had suspended the AstraZeneca vaccine at the moment this would put them further behind. We needed to build on that confidence that what we were doing was right.

Dr Manir Aslam commented that there was work that they had done together around multigenerational household. This work involved listening to challenges the families had particularly from the hard to reach communities digesting that information and feeding it on to the JCBI and then getting a response back that was positive which stated that it was ok to do that and it was the right thing to do. Alongside all of the challenges that we had we were listening and responding to the challenges that people gave to us. This piece of work was important as it recognises the particular challenges in Birmingham and in some of the particular communities in Sandwell and West Birmingham.

The Chair commented that she was impressed with the way Birmingham pushed to ensure that they could vaccinate the whole family. She added that not only have we listened, but we also acted. The Chair added that the multigenerational household work was a good piece of work. She expressed well done to Mr Jennings and Dr Aslam. The Chair then invited Yve Buckland, Chair of the ICS Board, (BSol CCGI) to comment.

Ms Buckland stated that bar had been raised for other system. Ms Buckland added that she had been involved in the Black Country system and they too had looked at similar issues. The work that colleagues had done in Birmingham around multigenerational households, and had pushed for that, and really pushed this to the top and getting that agreed, was not only going to help the people of Birmingham and Solihull, but would help people elsewhere as this was now rapidly spreading to other areas. Ms Buckland expressed well done *us* and to everyone who had been involved.

At this juncture, the Chair introduced Dr William Taylor to the Board and advised that Dr Taylor was voted in as vice-chair for the Birmingham Health and Wellbeing Board by the CCG just over a month ago.

Dr Taylor advised that he was a GP in south Birmingham for several years and that he had been working with the CCG since it started. He added that he had just started as the CCG chair and was overseeing the CCG framework as it became an ICS in the next 12 months or so. Dr Taylor added that he was pleased to be on the Board and was enthusiastic to be working with the Board.

CORONAVIRUS-19 INEQUALITIES AND RECOVERY DISCUSSION

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

(See document No. 6)

An extensive discussion then took place and the following is a summary of the principal points made:-

Dr Manir Aslam commented that:

- In some of the most deprived areas in West Birmingham it was known that the ethnic breakdown in those areas was strongly in favour of the ethnic minority groups. We had some challenges but we had been nimble in terms of how we met those challenges.
- We did not have any areas or any age group that fell below the 70% uptake and that was much higher than our flu vaccination.
- When we did a small study in my own practice the people that were declining the vaccination year after year, now we had a greater number of people immunised for Covid-19 than we did for flu and we were in a better place than we would be otherwise.
- We had changed our offer, we had spoken about multigenerational households and it was important that we did that piece of work that enabled us to visit people and vaccinated whole household to protect not only the young people in the home, but them passing Covid onto the other generations in the household.
- We had increased the offer and continued to increase the offer at pharmacy so that people could get their vaccine at the pharmacy as we looked at how we transition from where we were now to where we needed to be in six months' time.
- We were going to be vaccinating for a considerable period of time with first doses and with second doses. We needed to think about the sustainability of that model.
- We looked at mass vaccination sites and we had three that were accessible to West Birmingham patients at Aston Villa, Millennium Point and the City Hospital site which continued to function well. Nishkam will start on Soho Road and will start the vaccination process.
- There were a series of pop-up clinics and conversation was had with the Bangladeshi community who had highlighted all of the things that Dr Varney had stated and had queried why they were suffering most out of this.
- There were a range of historic reasons and we cannot allow Covid to make them suffer more. This was an opportunity to tackle some of the inequalities that had been entrenched over time.

Andy Cave stated that:

- It was important for us to understand where the differences lies within Birmingham and where we were imputing interventions working with communities where that made a difference.
- It was positive to hear today that we continue to see the uptake improving in our communities and where we could identify where we needed to do more work. We had those connections in place within communities.
- Some of the things we had learnt was the importance of working in an integrated way across the voluntary sector, health and social care and

how working together with one force with our communities impacted hardship with communities we could see that big difference changing.

- This was critical for our work around inequality – the question was how we continue to listen to the voice of those individuals within our communities most likely to experience inequality and work together to drive improvement.
- Tying in a few of the different presentations today it was important that the learning from Covid-19 fits in with the models of working around the integrated care system.
- Not only around neighbourhood integration and locality working and that community connection that we had in the city was vital for us to do that and very much our role within the system and how we listened to members of the public.
- It was crucial for us to progress as a city to reduce inequality and eliminate inequality.

Carly Jones highlighted that:

- From SIFA FIRESIDE presenting people there, experience their homelessness.
- Possibly the most challenging group of people potentially to be able to hear in our communities around health and inequalities and how they experienced Covid-19.
- Where we were seeing some of that data coming through around issues like loneliness and increased sense of anxiety it will be more prevalent in our population as we come out of Covid-19. We needed to be increasingly aware of that.
- In terms of vaccination access that had been a significant issue for our group and our people to access. We also struggle to understand that homelessness had relatively low case speaking broadly possibly because the access to testing and vaccination was now different for people.
- It was good to be working with Public Health with the data that was being produced and starting to get a better understanding of a group that was generally not heard within this conversation but yet experienced the greatest health inequalities was encouraging.

Dr Ian Sykes advised that:

- From the 1st April 2021 we will be Black Country and West Birmingham CCG and this will be his last meeting for the HWB. Dr Manir Aslam will be the Chair for the West Birmingham place and that he was pleased that Dr Aslam will continue representing our CCG at this Board.
- As a CCG (he was at a shadow Board meeting today) where Paul Moback was able to state categorically that our number one priority was to deal with health inequalities.
- We recognised that problem particularly in West Birmingham and it was our number one priority to try and deal with that. We were pleased that in West Birmingham the approach of trying to get round the multigenerational vaccine was fantastic.
- A couple of local pop-up clinics in multi-faith settings were going to be coming on stream soon in order to help reached those who were difficult to reach, those policies will help.

- As a CCG and in Birmingham additional schemes would employ other people in general practice and primary care particularly our social prescribers had been a big help in trying to reach these people and support those to overcome health and inequalities.

Professor Robin Miller agreed with what was being stated so far and added that it was a fantastic effort all round and to see such transparency within the data that gave the insight to the difficulties people were facing. Professor Miller stated that he was interested to know when the ethnographic research would be completed and when we would see the insights from that.

Debra Howls stated that Dr Aslam covered the issue quite well from West Birmingham perspective. We were committed to this and our work is not done as we were working hard to ensure that no population was left behind.

The Chair remarked that:

a. Everyone was saying everything that was politically correct and she was not disagreeing with them all, but, for her she would like to see some proper timelines for the timescales for the outcomes. That she would like to ensure that the loudness were the ones that got sorted first.
b. Earlier it was highlighted that there were issues within the Bangladeshi community. They were not hard to reach – the question was why the Bangladeshi community was disproportionately being affected in comparison to other communities. We knew there was an issue around Vitamin D up take.
c. In the Council we had seen a large uptake of people needing food through this pandemic, but Public Health had some funding to ensured Vitamin D tablets was placed into each parcels that was given.
d. The Chair enquired what was being done across the sectors. She added that Sarah Marsh at the Children's hospital was doing the same to ensure that the children were give the Vitamin D that they needed. The Chair further queried where the joined up working was being done so that we could prevent inequality happening and that we had to start speaking as systems.

Councillor Matt Bennett stated that:

i. The thing that struck him about the presentation was the information about mental health and anxiety, loneliness and private conversations and family relationships.
ii. It was predictable that people being locked up for a year was going to experience some mental health issues. Certain populations and demographics were more affected by that than others.
iii. One of the items to note later on was about Creating a Mentally Healthy City Forum, but it was noted that this was on hold for the past year and seeing these kind of figures reminded us that this was an important issue that would become prevalent going forward.
iv. It was understood why it was inactive for the past year, but we will need to see some action on this going forward.

Councillor Kate Booth commented that:

- ✓ The effect of the pandemic on our children's mental health goes beyond what we had seen already. What we had already seen was quite devastating in some cases.
- ✓ We have had some children who were quite happy to work from home and found it difficult to go back into school whilst on the other hand the impact of the pandemic was fundamental.
- ✓ It was thought that some of them would not recover educationally from the impact of this last year.
- ✓ She was delighted that we had a number of young people who where they could go to young people and enquired of them how their lives had been affected and start to seek ways to redress those inequalities as it was about inequality.
- ✓ If you were sitting in one of our wealthier Wards with your own laptop and your siblings had also got their own laptops this was a completely different world than living in a tower block where you were sharing mom's mobile phone between a couple of other siblings.

Yve Buckland, Chair, ICS Board (BSol CCGI) stated that:

- The ICS needed to not just wring its hands and share the data. The ICS needed to work on what were the evidence based interventions we could do joined up – what could we fund, what could we resourced and how could we measure our impact on tackling health inequalities.
- It could be currently fashionable to say all the right things but like the Chair she was determined that the four things – what were they and how we could measure – on point.
- The point in relation to the lead up to Covid-19 and what this had thought us was taken on board. The discussions we had on recover around the ICS we were starting to tackling inequalities and this was coming from the chairs at the forefront.
- The question was what interventions will we make to recover our services in health and social care and how would we know.
- Not only were we not making inequalities worst, but was trying to dig out the people who were disproportionally affected and ensuring that they got to the top of the pile.
- The other work that would go on will be in the children's space (we had the presentation earlier about adult care) we needed to provide a collaborative together about what we might do.
- Again, it was the job of the Board to keep our feet to the flames around what it was that we were going to do when by and when could we see the outcomes. That was the commitment she could give in terms of chairing the ICS.

Dr Varney then made the following statements:–

1. In terms of the ethnographic research the interviews were now being completed and that would form part of the Director of Public Health report. The team was working towards publishing that for the end of April 2021, but this depended on the next stage of the pandemic.
2. The ambition was to bring this back to May's Board in terms of the final report from this and will form part of that as there were lots of passion. That he agreed with the Chair on the point about how we turned this into

reality. Dr Varney stated that his ask of all Board members was to reflect on the data.

3. As Carly Jones alluded to one of the issue, we had around understanding the homeless experience during the pandemic was that we did not capture the data routinely, it was not in the dataset.
4. We knew from the survey and from our community engagement partners that Covid-19 had disproportionately affected the LGBTQ population particularly where we had young LGBTQ people living in households where they were not able to be their full selves safely. This was not collected in the data.
5. We knew from what the funeral directors had told us that there had been a disproportionate affect to death in different Faith communities, but because we did not record that in deaths certifications there was no way of analysing that and therefore these had not been seen in the data.
6. Across the city at the moment people will be filling in the 2021 Census and my call not just to partners but also to anyone watching this was please take part in the Census.
7. What he have tried to demonstrate today was the limitations of the data as well as what they were telling us. If we truly were going to address inequalities, we had to get better at data.
8. We had to be able to see people's lives in the numbers that we monitor and in the data that we collect as well as in the stories that we hear and our experiences on the frontline.
9. The Census hopefully would take us one step forward, but it was for all of us as partners to get much better on collecting data and looking at it and listening to what it was telling us so that we did not have the same burden in another 10 years' time.

At this juncture the Chair invited Douglas Simkiss to comment before the Board agreed the recommendations to item 15.

Mr Simkiss commented that it was an interesting Board to observed and that what Mr Kirby would want to say was that the ICS was a large part, but only a part of a whole system and only a small part of the whole city within the communities. The aim in voluntarily bringing the presentation was to check with the Board the direction of travel for this component of the system fitted hand in glove with the larger system that the Board represented so that the nine priorities that we set out got ticked by the Board and agreement that this was the right direction to go and that there would not be a surprise to anyone and that we could add value to the Council which was the most important part of this. Public Health and the Council was a key part of work on social determinants. This was to ensured that we were aligned.

The Chair commented that we were aligned for where we were at the beginning. Sitting on the ICS Board I will be pushing for more.

Dr Varney commented that the key bit was ensuring that the ICS had a commitment on data and transparency. Both contributions that Mr Cave and Ms Jones made highlighted how important it was to have an open and transparent conversation about the inequalities in our city. It was important that the ICS plan was much stronger on that data collection angle and the use of data and information. The other angle that was important was that some of this

was driven from national rather than local was that we must not lose the community engagement that we had learnt through the last year. The voices of systems needed to inform what we were doing. This was probably the area that the ICS most needed to work closely with local authorities on and to ensure that this was driven by the richness of our understanding of place as well as what the data was telling us and the multiple bits of data that was playing out. It was hoped to explore this in more detail at the Away Day in April.

Ms Buckland commented that Dr Varney and director of Public Health colleagues in Solihull were probably playing into the work that Mr Kirby was doing around inequalities. It would be useful for Public Health to come to the Board with the joined up data that they had. Certainly we needed to be data led and we needed to invest in gathering more data which was important, but also with their view of what an evidence based approach might be. This was complex but it was known that there were some evidence around that might work and how we might work together to get to that groundedness. It was useful for the Board to see what we knew already and what we did not know and what the issues were to talk about them in a narrative sense. The notion that 15% of jobs in Birmingham were in the sector that we were all trying to integrate through employment training initiatives we might be able to do something which could light that fire in relation to that element of the work on inequality would be her plea. Ms Buckland undertook to arrange this through the ICS.

The Board agreed the recommendations at Agenda item 15.

JSNA – OLDER ADULTS CHAPTER

Stacey Gunther, advised that this was the third Chapter from the pre-covid JSNA that was brought to the Board for approval and that the Children's Chapter was brought in early 2020 and the Adults Chapter at the last Board meeting in January 2021.

Ms Gunther drew the Boards attention to the information in the report.

(See document No. 7)

Dr Varney stated that colleagues on the Board may or may not know that sadly we had lost Ralph Smith who was one of our Service Leads in our Knowledge and Evidence Governance Team a couple of weeks ago through sudden death. The Late Mr Smith was a huge loss to our Governance Department and our hearts and condolences were with his family. The funeral will take place on Wednesday 17 March 2021 which many of us would be joining virtually. Dr Varney added that he wanted to take a few seconds to acknowledge the Late Mr Smith's huge amount of work over the last year and the year before in reformatting and refreshing the approach to the JSNA. The late Mr Smith took him landing in Birmingham in his stride when I asked him to do all sorts of things differently when he came into JSNA and Evidence. He was always a gentleman and someone whose heart was truly in Birmingham and the Black Country and this was reflected in the JSNA in what was captured there. Dr

Varney stated that he just wanted to acknowledge his contribution and his legacy to the city in this JSNA Chapter as his heart and soul was written through them and we honour him by putting them to good use.

The Chair commented that she could not agree more as she had known the Late Mr Smith for several years and she remembered that we did a memorial service and he always wore lycra or leathers …and she always remembered him for his leathers. She added that she could not believe that he had passed away and that he will be truly missed.

541 **RESOLVED: -**

The Health and Wellbeing Board:

i. Approved the publication of the Older Adults Chapter of the Birmingham Core JSNA; and
ii. Noted the document was written in the pre-Covid era. The content has been updated with the latest data and will be refreshed in 2021/22 to include Covid data/impact.

FORWARD PLAN REVIEW

542 The Chair highlighted the HWB Development Session in April and reminded the Board members to submit their items for the Forward Plan to Stacey Gunther.

INFROMATION ITEMS

543 The Chair advised that Agenda items 17 and 18 were for information only.

OTHER URGENT BUSINESS

544 No other urgent business was submitted.

DATE AND TIME OF NEXT MEETING

545 To note that the next Birmingham Health and Wellbeing Board meeting will be a Development Session on Thursday 29th April 2021 at 0900 hours as an online meeting.

The meeting ended at 1700 hours.

……..……
CHAIRPERSON

BIRMINGHAM HEALTH & WELLBEING BOARD

Action Log 2021

Rag rating :
- Overdue
- In progress
- Complete

Index No	Date of entry	Agenda Item	Action or Event	Named owner	Target Date	Date Completed	Outcome/Output	Comments	RAG

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

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

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

	23/04/2020	COMMUNITY CONCERN RE COVID-19 AND HEALTH INEQUALITIES IN BAME COMMUNITIES	Set up a Special Health and Wellbeing Board meeting in response to rising concern within the community of health inequalities being experienced in Black, Asian and Minority Ethnic (BAME) communities due to coronavirus-19.	Errol Wilson	23/04/2020
	24/09/2019	NHS LONG TERM PLAN: BSOL CCG RESPONSE	Set up a Special Health and Wellbeing Board	Errol Wilson	08/10/2019
	24/09/2019	PUBLIC QUESTIONS	Increase activity around the comms for Public Questions by liaising with partners	Stacey Gunther	21/01/2020
	08/09/2020		Letter to Secretary of State to express concerns with regards to the shortfall of flu vaccinations that have been allocated to	Justin Varney	14/09/2020

	24/09/2019	SUICIDE PREVENTION STRATEGY	Suicide Prevention Strategy Action Plan	Mo Phillips	26/11/2019

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

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

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

23/04/2020	Closed. Meeting took place, with almost 200 public questions submitted		
30/09/2019	Closed. Meeting arranged for 11/11/2019, subsequently cancelled due to Purdah. Presentation item for January 2020 Board		
30/06/2020	Closed	Public Health have committed to tweeting and sharing via Forum networks. A new online form for question submission has been introduced and will be trialed for the July meeting.	
14/09/2020	Closed		

26/11/2019	Updated version provided as part of Forum update.	The Birmingham Suicide Prevention Strategy was adopted by Full Council in January 2020. The Suicide Prevention Working Group has continued to meet through covid to progress the Suicide Prevention Strategy Action Plan; progress of the working group is reported to the Creating a Mentally Healthy City Forum and to the Health and Wellbeing Board.	

Birmingham Health and Wellbeing Board

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19 May 2021**
TITLE:	**OVERVIEW OF THE HEALTH AND SOCIAL CARE WHITE PAPER (PUBLISHED FEBRUARY 2021): INTEGRATION AND INNOVATION: WORKING TOGETHER TO IMPROVE HEALTH AND SOCIAL CARE FOR ALL**
Organisation	**Birmingham City Council**
Presenting Officer	**Aidan Hall, National Management Trainee, Public Health**

Report Type:	**Information**

1.	**Purpose:**
1.1	To provide the Board with a summary of the White Paper published on 11 February 2021 by the Department of Health and Social Care: Integration and innovation: working together to improve health and social care for all.

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

3.	**Recommendation**
3.1	The Board is asked to note the report and reflect on the opportunity presented by the proposed legislation.
3.2	The Board is asked for their commitment to work with partners in the development of the integrated care system (ICS) and to recognise the benefits of working in collaboration with partners in the system.

4. Report Body

This overview has been produced using the White Paper and other summaries, including those from the King's Fund, the Local Government Association and the NHS Confederation. Each theme has been summarised with the relevant proposals.

Introduction

Theme 1: Working together and supporting integration

- Establishing integrated care systems (4.6-4.18)
- Duty to collaborate (4.19)
- Triple aim (4.19)
- Power over foundation trusts capital spend limits (4.20)
- Joint committees (4.21)
- Collaborative commissioning (4.21)
- Joint appointments (4.22)
- Data sharing (4.23-2.24)
- Patient choice (4.25)

Theme 2: Reducing bureaucracy

- Competition (4.27)
- Arranging healthcare services (4.28-4.30)
- National Tariff (4.31)
- New Trusts (4.32)
- Removing local education training boards (4.33)

Theme 3: Enhancing public confidence and accountability

- Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction (4.34-4.36)
- The NHS mandate (4.37)
- Reconfigurations intervention power (4.38)
- Arm's length bodies (ALB) transfer of functions (4.39)
- Removing special health authorities time limits (4.40)
- Workforce accountability (4.41)

Additional Proposals

- Social care
    - Assurance (4.43-4.44)
    - Data (4.45)

- Direct payments to providers (4.46)
- Discharge to assess (4.47)
- A standalone power for the Better Care Fund (4.48)

- Public health
  - Public Health power of direction (4.49-4.50)
  - Obesity (4.51)
  - Fluoridation (4.52)

- Safety and quality (4.53-4.57)

The White Paper and the Health and Wellbeing Board

Introduction

4.1 On 11 February 2021, the Department of Health and Social Care (DHSC) published **Integration and innovation: working together to improve health and social care for all,** a White Paper which outlines proposals for a future Health and Social Care Bill.

4.2 The proposals outlined in the document follow those developed by NHS England that support the NHS Long Term Plan. The White Paper is comprised of three themes:

- Working together and supporting integration
- Stripping out needless bureaucracy
- Enhancing public confidence and accountability

4.3 It also contains additional proposals to support public health, social care, and quality and safety. These proposals have been brought forward by DHSC following the pandemic to support the system to recover and reform.

4.4 The government plans to introduce a Health and Social Care Bill to Parliament in 2021 so that the measures can start to be implemented in 2022. Systems are expected to operate in shadow form from September 2021.

4.5 The White Paper offers a commitment to continue to engage with stakeholders on the detail of the proposals, as well as to work across government to address the interdependencies between health and other social determinants. The Health and Wellbeing Board (HWB) should ensure it collectively responds to proposals in any future consultation opportunities.

Theme 1: Working together and supporting integration

4.6 The main element of this theme is the proposal for integrated care systems (ICS) to become statutory bodies, building on the work following the publication of the NHS Long Term Plan.

4.7 ICSs bring together partners from across a geographical area to integrate care and collectively plan for the benefit of the local population. An ICS will usually serve a population of over one million and therefore contains a series of smaller partnerships to meet the specific needs of local areas.

4.8 The ICS will include an ICS NHS Body and an ICS Health and Care Partnership which are summarised below.

4.9 The public and patient voice will be important in both bodies.

4.10 Clinical Commissioning Groups (CCGs) will close and their functions will be repurposed in the ICS.

4.11 The legislation will recognise and preserve the distinct accountabilities between local government and the NHS.

ICS NHS Body

4.12 The ICS NHS Body will be responsible for strategic planning and decisions involving allocation. It will be responsible for the day to day running of the ICS and will be accountable to its population at a system level for NHS spending. The financial allocation will be set by NHS England and include the cover of the majority of NHS care for its population.

4.13 Some strategic planning functions between non-statutory ICSs and CCGs will merge. The NHS ICS Body will take on CCG responsibilities in relation to local authority overview and scrutiny committees.

4.14 NHS trusts or foundation trusts will remain separate statutory bodies to the ICS NHS Body. However, NHS trusts will be expected to be involved in the partnership and take an active involvement in strategic commissioning.

4.15 The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission (CQC) will remain unchanged. A new duty will ensure providers and ICS NHS Bodies are invested in attaining financial control at system level.

ICS Health and Care Partnership

4.16 The other element of the ICS outlined in the document is the ICS Health and Care Partnership. This partnership will bring together the NHS, local

government and partners. Local areas will be given the flexibility regarding its membership and functions.

4.17 The ICS Health and Care Partnership will develop a plan to address the systems' health, public health, and social care needs. The ICS NHS Body and the local authority will 'have regard to' the plan.

4.18 There is an expectation that ICS NHS Bodies delegate 'significantly' to place level (e.g. Birmingham). ICSs are expected to work closely with HWBs and 'have regard to' the joint strategic needs assessments and joint health and wellbeing strategies in the area.

Other measures in working together and supporting integration

4.19 There will be a duty to collaborate across the NHS and local government which replaces the two existing duties to cooperate. NHS bodies will pursue the 'triple aims' of the NHS Long Term Plan.

4.20 The government will have a new power to impose capital spending limits on foundation trusts that are not working to prioritise capital spending within their ICS.

4.21 There are a range of proposals to allow NHS England and ICSs to work together in different ways to collaboratively commission services (similar to Section 75 arrangements). The legislation will be amended to assist organisations by enabling decisions to be taken by joint committees and to facilitate increased collaboration across different footprints. For example, it will enable NHS England to share some of its direct commissioning functions with ICSs.

4.22 New provisions will allow NHS bodies to make joint appointments with other NHS bodies and with local authorities.

4.23 There are proposals to ensure more effective data sharing across the health and care system, including a requirement to share anonymised information to the benefit of the health and care system.

4.24 The Secretary of State for Health and Social Care will have new powers that allow the requirement of data from all registered social care providers about all services they provide, as well as require data from private healthcare providers. There is also a power that will be introduced to mandate standards for data collections and storage.

4.25 Regarding the strengthening of patient choice and control, one proposal is to repeal section 75 of the Health and Social Care Act 2012 including the Procurement, Patient Choice and Competition Regulations 2013. It proposes to replace this with a new provider selection regime, and this would require bodies that arrange NHS services to protect, promote and facilitate patient choice.

Theme 2: Reducing bureaucracy

4.26 This theme contains several proposals that relate to competition, arrangements for commissioning and providing healthcare services.

4.27 To reduce competition and increase integration, the proposals outline changes that include removing the Competition and Markets Authority's (CMA) role in reviewing mergers involving NHS foundation trusts. Currently the CMA has powers to review mergers involving foundation trusts with the previous aim of improving services through competition. The White Paper proposes allowing NHS England to ensure decisions are made in the best interest of patients. These proposals are alongside the removal of the competition functions of NHS Improvement.

4.28 In arranging healthcare services, the proposals aim to give NHS and public health commissioners more flexibility on when to use competitive procurement processes, including the removal of commissioning of these services from the scope of the Public Contracts Regulations 2015.

4.29 Powers in the bill will enable the development of a new NHS provider selection regime which will be informed by NHS England's public consultation. Commissioners will be under duties to act in the best interests of patients, taxpayers and the local population.

4.30 Public procurement rules will still apply to the procurement of non-clinical services.

4.31 The proposals outline changes to the national tariff payment system. This includes removing the requirement on providers to apply to NHS Improvement where they wish to make local modifications to tariff prices.

4.32 One proposal outlines a change to give the Secretary of State for Health and Social Care the power to create new trusts 'to provide integrated care' and potentially in other circumstances subject to appropriate consultation.

4.33 Finally, this section proposes to remove the requirement for Local Education and Training Boards.

Theme 3: Improving accountability and enhancing public confidence

4.34 This section focuses on the accountability arrangements of the NHS and enhancing public confidence. It sets out several legislative proposals with the aim to formally bring together NHS England and NHS Improvement (statutory footing).

4.35 It proposes abolishing Monitor and the NHS Trust Development Authority (who work together under the name NHS Improvement) and transferring their

functions to merge fully with NHS England. This body will now be formally considered to be responsible for providing 'unified, national leadership for the NHS'.

4.36 The White Paper proposes that the Secretary of State for Health and Social Care is given 'appropriate' and 'structured' powers of direction in relation to NHS England. It is outlined that this will maintain clinical and day-to-day operational independence for the NHS but support accountability. These powers will not allow the Secretary of State to direct local NHS organisations or intervene in individual clinical decisions.

4.37 There is a proposal to change the frequency with which the Secretary of State is required to publish the NHS mandate. The NHS mandate is a document that sets out the objectives that NHS England is expected to achieve. Currently it is published on an annual basis. The White Paper proposes a new requirement to always have a mandate in place to provide flexibility.

4.38 Reconfigurations involve changing the way NHS services are delivered to patients. The White Paper proposes that the Secretary of State be given power to intervene in local service reconfigurations at any point to speed up decision-making. The Secretary of State would be required to seek appropriate advice before intervening, and to subsequently publish it afterwards.

4.39 This section also proposes to establish a new power in primary legislation that would allow the Secretary of State to transfer functions to and from specified arm's length bodies (ALB) and to abolish ALBs where they become redundant as a result of any such transfers. However, it is outlined that there are no immediate plans to use this and that formal consultation would be required before any use in the future.

4.40 Currently, the Secretary of State is required to review and formally extend the existence of any special health authority established after 2012. The White Paper proposes to remove this.

4.41 Finally, to ensure workforce accountability and provide transparency, this section has a proposal that involves a new duty on the Secretary of State to publish a report every parliament that sets out the roles and responsibilities for workforce planning and supply. This includes the NHS and the workforce across health and social care.

Additional proposals

The remaining proposals are targeted and intended to address specific issues highlighted during the pandemic, and which require primary legislation.

Social Care

4.42 According to the document, ICS legislation will complement place-based partnership working between the NHS and social care (including HWBs). The ICS Health and Care Partnership will support closer integration and collaborative working between health and social care.

4.43 The Health and Care Bill will introduce a new duty for the CQC to assess local authorities' delivery of their adult social care duties as part of an assurance framework for social care. The government proposes to introduce a power for the Secretary of State to intervene where, following assessment under the new duty, it is considered that a local authority is failing to meet its duties. The White Paper makes it clear that these provisions will be secured in primary legislation at a high level, prior to working with the sector on detailed system design.

4.44 The initial focus of the assurance framework for social care will be to improve the quality, timeliness and accessibility of adult social care data. The assessment and intervention elements will be introduced over time.

4.45 The White Paper proposes to improve the quality and availability of data across health and social care to remedy gaps to help understand capacity and risk in the system. It also highlights the gap in data on services provided to people who fund their own care, as well as data that would help show how money flows to providers and the workforce. It sets out how more and better data will aid planning for the future care of the population.

4.46 The government will legislate to amend the Health and Social Care Act 2008 to expand the powers of the Secretary of State so they can make direct payments any bodies engaged in the provision of social care services (they can currently only make such direct payments to not-for-profit bodies). It is clear that the power will not be used to amend or replace the existing system of funding adult social care and will only be used in exceptional circumstances.

4.47 The White Paper updates the approach to hospital discharge by changing the legislative framework to enable a 'discharge to assess' model. This model includes enabling assessment for NHS continuing healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, to take place after an individual has been discharged from acute care. The proposals outline plans to repeal existing requirements to assess for care needs before hospital discharge, and the accompanying process of assessment and discharge notices.

4.48 The White Paper proposes to create a standalone legal basis for the Better Care Fund (BCF), separating it from the NHS Mandate setting process, which will no longer be on an annual basis (as stated above in 4.37). This is a technical change and will not have any impact on the function or purpose for the fund.

Public Health

4.49 Under section 7A of the 2006 NHS Act, the Secretary of State for Health and Social Care can make arrangements for public health functions to be exercised by others including NHS England. They cannot require NHS England to take the delegated function.

4.50 The government proposes to bring forward measures to give the Secretary of State the power to direct NHS England to take on specific public health functions delegated by the Secretary of State alongside the existing section 7A provisions.

4.51 Building on the government's obesity strategy, there are proposals to give ministers powers to introduce new strengthened food labelling requirements, including changes to front-of-pack nutrition labelling and mandatory alcohol calorie labelling. It is also the government's intention to introduce further restrictions to prohibit advertisements for products high in fat, sugar or salt being shown on TV before 9pm.

4.52 The White Paper also proposes changes to water fluoridation schemes in England by transferring the responsibilities (including consultation responsibilities) from local authorities to the Secretary of State for Health and Social Care.

Safety and quality

4.53 This section outlines proposals to support and enhance safety and quality in the provision of healthcare services.

4.54 The Healthcare Safety Investigation Branch (HSIB) will be put on a statutory footing.

4.55 DHSC will be given more powers to amend the governance of healthcare professionals' regulation. This aims to ensure that the level of regulatory oversight is proportionate to the risks to the public. DHSC will be able to reduce the number of regulatory bodies and extend professional regulation to NHS managers and leaders.

4.56 Within the NHS, a statutory medical examiner system will be introduced to scrutinise all deaths which do not involve a coroner.

4.57 The Medicines and Healthcare products Regulatory Agency (MHRA) will be permitted to develop and maintain publicly funded and operated medicine registries. This is to enable evidence-based decision-making.

The White Paper and the Health and Wellbeing Board

4.58 HWBs will remain in place and will continue to have an important responsibility at place level to bring local partners together. The White Paper refers to the HWBs experience as place-based planners. The ICS NHS Body will also 'have regard to' the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

4.59 Government will support HWBs and ICSs (with guidance) to work together closely to complement each other and share learning and expertise.

4.60 According to the White Paper, members of the ICS Health and Care Partnership could be drawn from a number of sources including HWBs.

4.61 Responses to the White Paper including the LGA have commented on the need for clarity on the roles and responsibilities of the ICS NHS Bodies and the ICS Health and Care Partnerships and how they relate to HWBs.

4.62 The White Paper and the development of the integrated care should complement the existing work, aims and priorities of the HWB in reducing health inequalities, particularly using the experience of the pandemic. The White Paper states that tackling health inequalities and the wider determinants of health cannot be addressed by one part of the system alone.

5.	**Compliance Issues**
5.1	**HWBB Forum Responsibility and Board Update**
	The government plans to introduce a Health and Social Care Bill to Parliament in 2021 so that the measures can start to be implemented in 2022. The Board will monitor the proposals and subsequent legislative changes needed to progress the White Paper.

5.2	**Management Responsibility**
	Dr Justin Varney, Director of Public Health, Birmingham City Council

6.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Understanding the role of the HWB in the system and ensuring a strong and	Low	Medium	Continued dialogue and engagement with the Board on the proposals set out in

representative voice in future engagement opportunities and development of the ICS			the White Paper and the development of the ICS

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

Aidan Hall, National Management Trainee, Public Health

Birmingham Health and Wellbeing Board

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19 May 2021**
TITLE:	**BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM TRANSITION UPDATE**
Organisation	**Birmingham and Solihull Integrated Care System**
Presenting Officer	**Rachel O'Connor, Chief Operating Officer**

Report Type:	**Presentation**

1.	**Purpose:**
1.1	To inform the Health and Wellbeing Board of the transition update on the development of the Birmingham and Solihull Integrated Care System.

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

3.	**Recommendation**
3.1	The Board is asked to note the following contents of the Integrated Care System transition update presentation: • BSol ICS Fundamental Purpose • BSol Outcome Framework – Ambitions • Development of BSol ICS • ICS Operating Model • Role of Place Partnerships • Outcome Principles for Place

3.2	The Board is also asked to note the key next steps for Place Partnership and ICS key milestones.

4. Report Body

The attached presentation provides a breakdown of the following key items:

4.1 Purpose of an integrated care system

An integrated care system is a collaborative way of working for the benefit of the local population. We will bring together the expertise of health and care professionals from our partner organisations to look after people's physical, social, and mental health needs. As a system we will be able to tackle better inequalities and improve outcomes for local people by prioritising our efforts helping everyone in Birmingham and Solihull to live the healthiest and happiest lives possible.

4.2 BSol ICS Fundamental Purpose

This particular area focuses on the 'quadruple aim' of Birmingham and Solihull Integrated Care System (BSol ICS):

- Improving population health and healthcare
- Tackling unequal outcomes and access
- Enhancing productivity and value
- Support broader social and economic development

4.3 BSol Outcome Framework – Ambitions

The key ambitions of Birmingham and Solihull Integrated Care System is discussed here, and were informed by our previous STP public and professional engagement sessions, they take a life course approach, and areas that as a system we can better achieve through our collective efforts

- Born Well
- Grow Well
- Live Well
- Age Well

4.4 Development of the Birmingham and Solihull Integrated Care System (BSol ICS)

This focuses on the broader building blocks, fundamental purpose and the frameworks that encompass the development of our Integrated Care System.

4.5 ICS Operating Model

An overview of the four key aspects of the Integrated Care System Operating Model:

- ICS Health and Care Partnership
- ICS NHS Board
- Place Partnership
- Provider Collaborative

4.6 Role of Place Partnerships – Defining Place

This section provides a summary of the spatial levels of our places of Birmingham and Solihull across System/ Place/Locality/Neighbourhoods/PCNs:

System The ICS	**Birmingham and Solihull Integrated Care Partnership**					
Place Local Authorities	**Solihull MBC**	**Birmingham City Council**				
Locality c.200-250k population	**Solihull**	**West** Ladywood & Perry Barr	**South-East** Selly Oak & Hall Green	**South-West** Edgbaston & Northfield	**North** Erdington & Sutton Coldfield	**East** Hodge Hill & Yardley
Neighbourhoods/PCN c.30-50k population	**5 PCNS**	**5 PCNS**	**7 PCNS**	**6 PCNS**	**6 PCNS**	**6 PCNS**

4.7 Outcome Principles for Place

The outcome principles for Place are highlighted in this section and particularly focuses on that people's experience of health and care should be integrated and personalised. It is also noted that Health and care should be provided in community settings wherever possible, with acute care only when essential. A particular focus on addressing health inequalities is stated including the underlying drivers of these inequalities.

4.8 Place Partnership Next steps

As part of the key next steps for Place Partnership one of the fundamental building blocks is as follows:

- Further develop and define role of the different spatial levels of place; building on what is already there and starting with purpose rather than structures

- Locality partnerships will need to be established where they are not currently in place – distributed leadership model that is routed in the place

- Strengthen emphasis on co-production with citizens for place-based working – a partnership with citizens for their health and well-being
- Focus on the variation and health inequalities that exist at place to provide the direction, narrative and shared purpose for effective place-based working. This will require a granular evidence base

- Align proposed care programmes with place

4.9	ICS Key Milestones
	The key milestones for BSol Integrated Care System is illustrated in this section which highlights both the statutory arrangements and the local arrangements that will be taking place throughout 2021/22 provided with a quarterly breakdown. It is anticipated that the formal ICS operating model will go live on 1 April 2022. It is worth noting here that the confirmation of Integrated Care System's being on a statutory footing is expected in Parliament as part of a second reading of the White Paper Bill in June 2021. **We recently agreed at the Health and Wellbeing Development session that we would bring a monthly report for HWBB assurance and key products as they are developed.**

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
	This presentation will help the Board and its Forums to understand the ongoing developments as we move into an integrated care system.

5.2	Management Responsibility
	The ICS transition led through partners across Birmingham and Solihull ICS and Health and Wellbeing Members including BSol ICS Chief Operating Officer, and Birmingham City Council's Interim CEO, Director of Public Health.

6.	Risk Analysis – *in development*		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Appendices
Appendix 1 - Presentation - ICS Transition Update

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

Rachel O'Connor, Chief Operating Officer, Birmingham and Solihull ICS
Lehnul Mansuri, Strategic Policy Officer, Birmingham and Solihull ICS
Louise Collette, Acting Director Adult Social Care, Birmingham City Council

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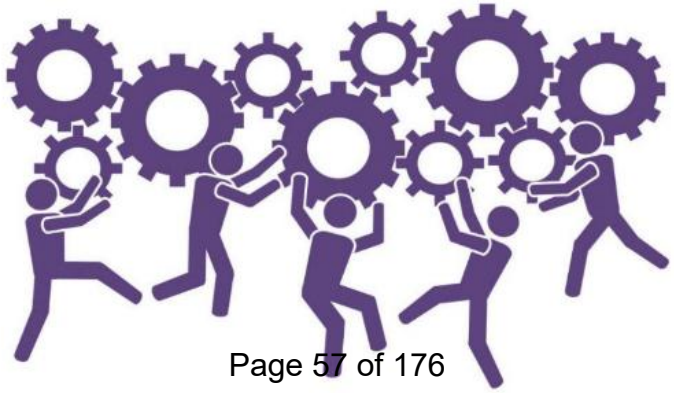
ICS Vision
Public Health and Wellbeing Board
19 May 2021

ICS Vision and Model

Purpose of an integrated care system

- Collaborative way of working for the benefit of the local population.
- Brings together the expertise of health and care professionals from partner organisations to look after people's physical, social, and mental health needs.
- Together we can tackle better inequalities and improve outcomes for local people by prioritising our efforts.
- Helping everyone in Birmingham and Solihull to live the healthiest and happiest lives possible.



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BSol ICS Fundamental Purpose

Quadruple Aim

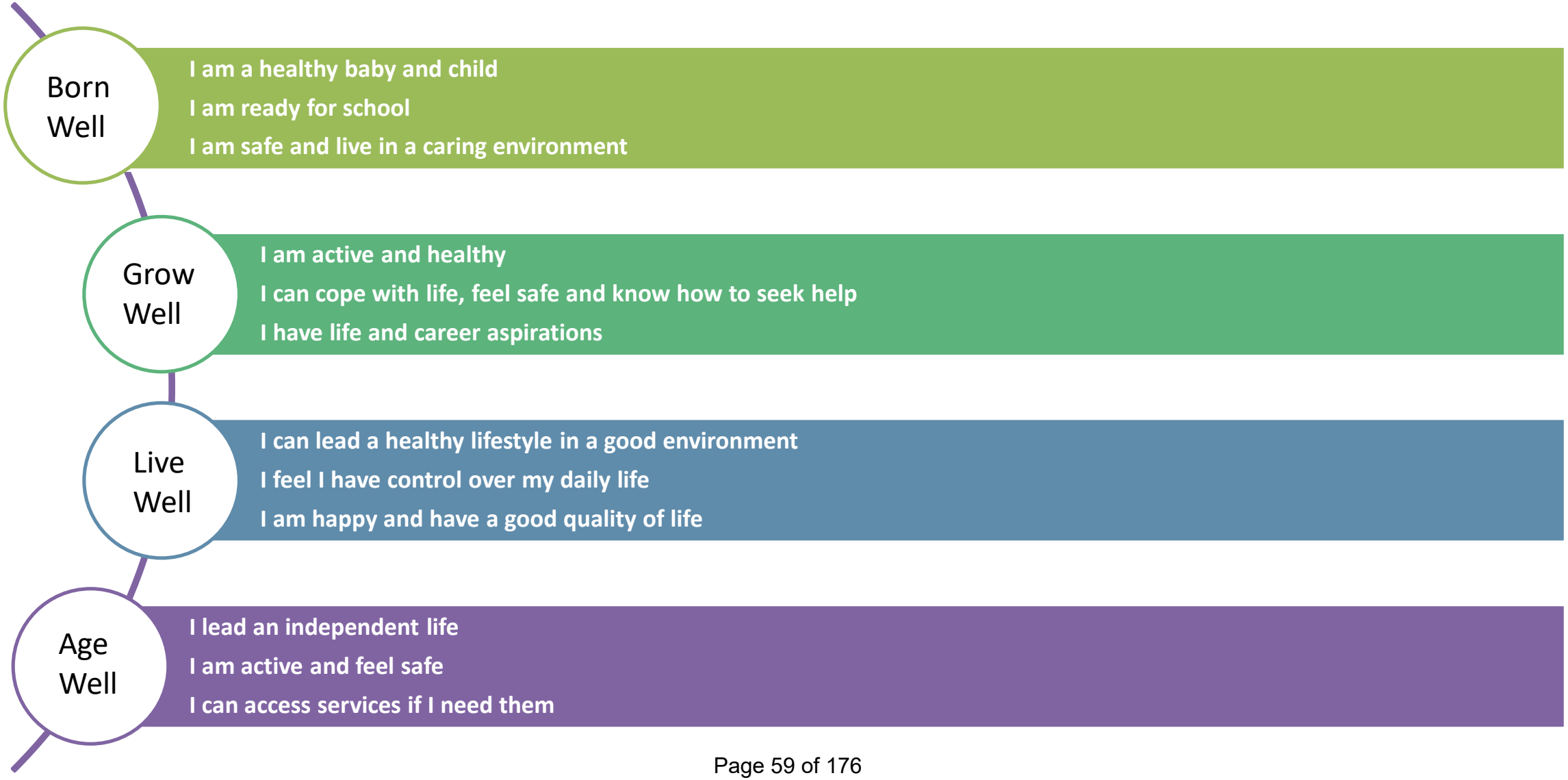
Improving population health and healthcare

Tackling unequal outcomes and access

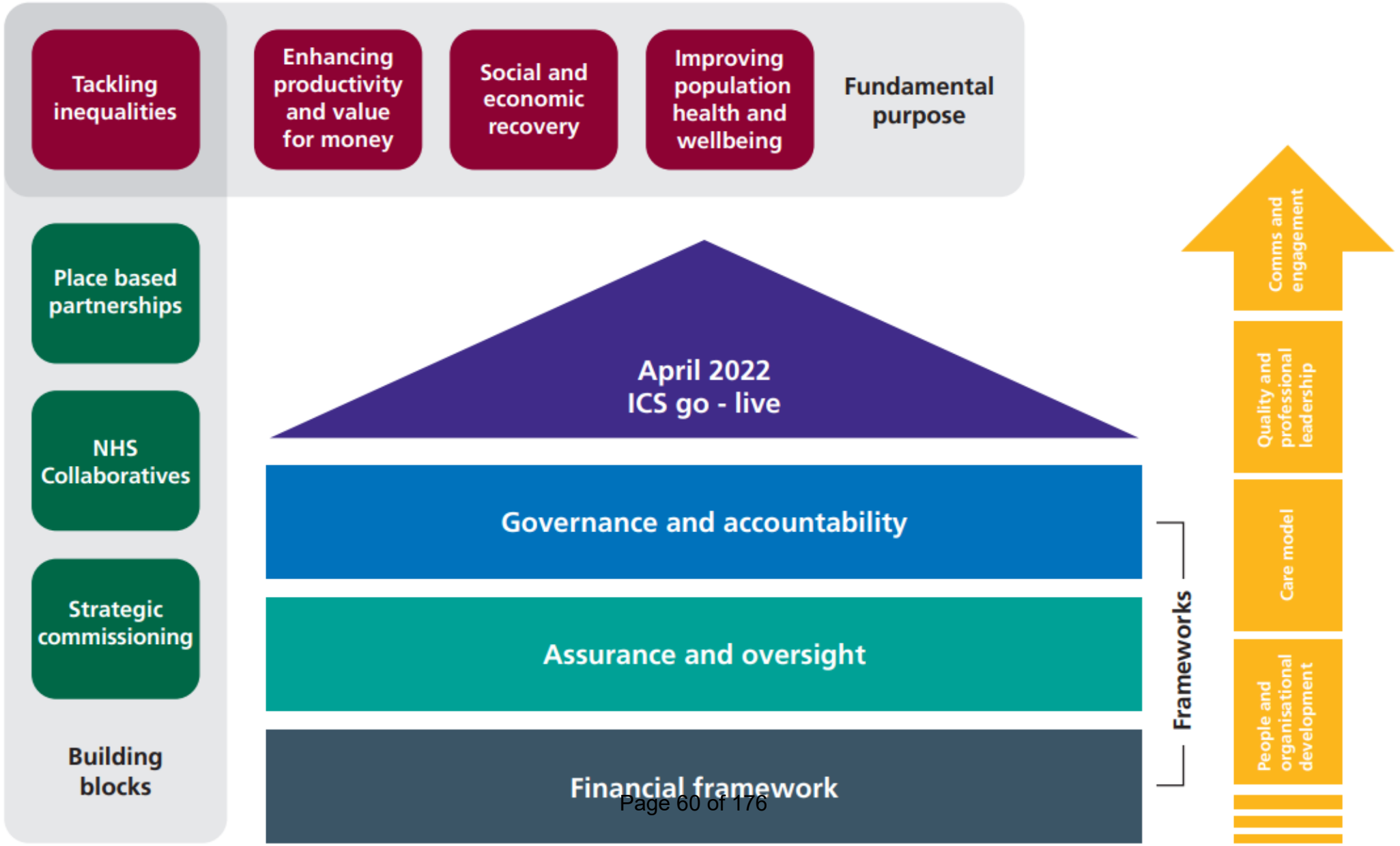
Enhancing productivity and value

Support broader social and economic development

BSol Outcome Framework - Ambitions



Development of the Birmingham and Solihull Integrated Care System (BSol ICS)



ICS Operating Model

ICS Health and Care Partnership	Responsible for developing a plan that addresses the wider health, public health, and social care needs of the system.
ICS NHS Board	Will have to have regard to the above plan when making decisions. Will be directly accountable for NHS spend and performance within the system.
Place Partnership	Will be formed by health (including primary care), local government providers and third sector partners to contribute to the local population's health and care. Ensuring that everyone stays well, can access preventative services, simple joined-up care and treatment including digital services and seek care proactively.
Provider Collaborative	Collaborations of providers who have agreed to work together to deliver integrated care pathways for their local population.

The Role of Place Partnerships

Defining Place

System The ICS	**Birmingham and Solihull Integrated Care Partnership**					
Place Local Authorities	**Solihull MBC**	**Birmingham City Council**				
Locality c.200-250k population	**Solihull**	**West** Ladywood & Perry Barr	**South-East** Selly Oak & Hall Green	**South-West** Edgbaston & Northfield	**North** Erdington & Sutton Coldfield	**East** Hodge Hill & Yardley
Neighbourhoods/PCN c.30-50k population	**5 PCNS**	**5 PCNS**	**7 PCNS**	**6 PCNS**	**6 PCNS**	**6 PCNS**

But - multiple geographical administrative and population arrangements exist and communities and networks also exist outside of administrative boundaries eg. GP populations and schools. Communities of interest exist across places and – accelerated by the pandemic – across virtual places.

Outcome Principles

- People's experience of health and care should be integrated.
- People's experience of care should be personalised – they are often the "expert" on the management of their needs / health condition.
- Carers (family / friends / neighbours) have the support to continue to care.
- Health and care should be provided in community settings wherever possible, with acute care only when essential.
- Service quality should be the best.
- Quality services and experience of people needing support and / or care should assure safeguarding.
- A focus on addressing health inequalities – including the underlying drivers of these inequalities.

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Place Partnership Next steps

- Further develop and define role of the different spatial levels of place; building on what is already there and starting with purpose rather than structures
- Locality partnerships will need to be established where they are not currently in place – distributed leadership model that is routed in the place
- Strengthen emphasis on co-production with citizens for place-based working – a partnership with citizens for their health and well-being
- Focus on the variation and health inequalities that exist at place to provide the direction, narrative and shared purpose for effective place-based working. This will require a granular evidence base
- Align proposed care programmes with place

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ICS Next Steps and Key Milestones

ICS Key Milestones

Rachel O'Connor

By end Q1 21/22	By end Q2	By end Q3	By end Q4	1 April 22
❖ *Statutory arrangement*: Update System Development Plans and confirm proposed boundaries, constituent partner organisations and place-based arrangements. ❖ Transition Programme Set up ❖ Engagement on Operational model ❖ High Level ICS Operational Model agreed ❖ ICS Transition Plan developed and submitted ❖ ICS CEO recruitment commences ❖ Detailed policy framework design to enable the Operational Model including governance and accountability framework, system oversight framework, financial framework	❖ *Statutory arrangement*: Confirm designate appointments to ICS chair and chief executive positions ❖ *Statutory arrangement*: Confirm proposed governance arrangements for health and care partnership and NHS ICS body. ❖ Formal Case for change developed and considered by the board ❖ Mobilisation for shadow form ❖ Shadow form ICS go live ❖ ICS Chair/ICS CEO In post ❖ New System Oversight Framework go live ❖ Place MOU established	❖ *Statutory arrangement:* Confirm designate appointments to other ICS NHS body executive leadership roles, including place-level leaders, and non-executive roles. ❖ Continue phased transfer of functions to and across the ICS operating model ❖ Mobilisation of the operating model ❖ Teams starting to work at place	❖ *Statutory arrangement*: Confirm designate appointments to any remaining senior ICS roles. ❖ *Statutory arrangement*: Complete due diligence and preparations for staff and property (assets and liabilities) transfers from CCGs to new ICS bodies. ❖ *Statutory arrangement*: Submit ICS NHS body Constitution for approval and agree "MOU" with NHS England and NHS Improvement ❖ Formal CCG close down	❖ *Statutory arrangement*: Establish new ICS NHS body; with staff and property (assets and liabilities) transferred and boards in place. ❖ *Statutory arrangement:* CCG functions will be subsumed into the ICS NHS body and some NHS England and Improvement direct commissioning functions will be transferred or delegated to ICSs ❖ Formal ICS operating model go Live

***NB*. the confirmation of the ICS being on a *statutory footing* are expected in Parliament as part of second reading of the bill, June 2021.**

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Final Comments

- An real opportunity for innovation and co-design with the Health and Wellbeing Board
- Aspects still to consider and work through
- ICS progress update slot at the Board

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	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19TH MAY 2021**
TITLE:	**BIRMINGHAM & SOLIHULL ICS – INEQUALITIES WORK PROGRAMME UPDATE**
Organisation	**Birmingham & Solihull Integrated Care System**
Presenting Officer	**Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS FT**

Report Type:	**Information**

1. Purpose:	
1.1	The purpose of the report is to provide an update for the Health & Wellbeing Board on the work of the Birmingham & Solihull ICS Inequalities Work Programme.

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

3. Recommendation	
The Health & Wellbeing Board is recommended to:	
3.1	NOTE the progress report from the ICS Inequalities work programme.

4. Report Body

Introduction

4.1 The establishment of an Inequalities work programme as part of the Birmingham & Solihull and an initial overview of our principles and priorities was shared with the Health & Wellbeing Board at its meeting in March 2021. Since then we have continued to develop the work programme and to ensure a close fit with the priorities of the Health & Wellbeing Board including through the Board development day in April 2021.

Establishing the Inequalities Work Programme

4.2 Since the March meeting, we have held the first formal meeting of the ICS Inequalities Board. Amongst others the Board includes the Executive Leads for inequalities from the ICS partner organisations. I am also pleased to be able to welcome Salma Yaqoob who has now joined us as our ICS Inequalities Programme Lead. As I write, recruitment is also underway for an ICS non-executive director lead for this work.

4.3 We will now be working through our nine workstreams to identify leads and agree priorities for first stage of the work. We will also be using the NHS Midlands Health Inequalities toolkit to help inform our future work.

4.4 Importantly, we are also making contact with the Primary Care Network inequalities leads to review the issues arising from the inequalities toolkit assessment that they have completed and agree how we can support them to make progress on this agenda.

4.5 We will be inviting representatives from the PCNs in the West locality of Birmingham to join the Board although they are formally part of the Black Country & West Birmingham ICS.

Principles and Priorities

4.6 Since our discussion at the March Health & Wellbeing Board we have further developed the principles and priorities for our work programme.

4.7 We have adopted the following two guiding principles:

- Reducing health inequalities and workforce inequalities is mainstream activity that is core to and not peripheral to the work of the NHS.
- Interventions to address inequalities must be evidence-based with meaningful prospects for measurable success.

4.8 We have also defined three big priorities which drive our eight workstreams.

- *Ensuring inequalities are at the heart of our ICS* – ensuring that everything the ICS does contributes to tackling inequalities.
- *Ensuring the NHS plays its full part in tackling inequalities* – addressing variation in access, experience and outcomes for patients and service users.

- *Supporting wider work to tackle the causes of inequality* – working with partners to tackle the factors that drive inequalities including access to employment.

4.9 Our eight workstreams and their first priorities are set out in the accompanying diagram. Our priorities for Prevention will be developed further to reflect the importance of addressing Infant Mortality (across the Local Maternity System, Birmingham Forward Steps and Forward Thinking Birmingham) and work to improve the management of people living with long-term conditions in the city.

Progress

4.10 The focus since March has been on getting the work programme up and running and the Board and workstream established. There are some areas however where we have been supporting early work.

4.11 *PCN Community Engagement.* With some resources from NHSE/I we are supporting two PCNs (Washwood Heath in Birmingham's East locality and North Solihull North) to develop approaches to local community engagement that can help us build a framework for use with all our PCNs.

4.12 *COVID19 Vaccinations.* We have been working with the COVID19 Vaccination Inequalities Group chaired by Ruth Tennant to support the delivery of the vaccination programme in Birmingham and Solihull.

4.13 *COVID19 Recovery.* We have agreed the approach that the ICS will take to analysing waiting lists by ethnicity and deprivation as we seek to tackle the backlog of patients following lockdown. This will extend to analysis of referral patterns to identify differences in access to secondary care as services are restarted.

4.14 *Locality Needs Analysis.* Building on the work of the Public Health team in producing locality health needs assessments for the five Birmingham localities we will be working with the stakeholders in the localities to agree how their local priorities can be taken forward.

4.15 *Anchor Institutions.* We have begun to scope the work that is already taking place with the NHS providers in the ICS to provide innovative routes into employment for people across all the communities we serve. We are also scoping the way that the Social Value procurement policy agreed by the ICS is being used by the NHS trusts in practice.

Next Steps

4.16 We have made a start but there remains much to do to being to demonstrate an impact on inequalities and their impact on health in Birmingham and Solihull. The immediate next steps for the ICS Inequalities work programme include:

- completing the establishment of the ICS Inequalities Board and its workstreams;
- agreeing how we will use the NHS Midlands Health Inequalities toolkit;
- working more closely with the PCNs inequalities leads;

- continuing to ensure inequalities are addressed in COVID19 recovery and elective backlog clearance;
- supporting the NHS input into work on infant mortality;
- agreeing how we approach tackling variation in the care provided to people living with long term conditions.

4.17 The Health & Wellbeing Board is recommended to NOTE the progress report from the ICS Inequalities work programme.

5. Compliance Issues
5.1 HWBB Forum Responsibility and Board Update
5.1.1 Creating a City without Inequality

5.2 Management Responsibility
5.2.1 Richard Kirby, ICS Inequalities Lead and Chief Executive, Birmingham Community Healthcare NHS FT.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
That a lack of engagement undermines impact.	Low	High	Engagement workstream within the programme to address this during the first half of 2021/22.
That a failure to align work with partners reduces impact.	Medium	High	Engagement with Health & Wellbeing Boards and ongoing work with local authorities and Directors of Public Health.
That a failure to commit resources reduces impact.	Medium	High	Commitment from the ICS Board to the work programme and initial support for the programme team.

Appendices
ICS Inequalities Work Programme – Priorities 2021/22

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

- Richard Kirby, Chief Executive, BCHC.

Birmingham & Solihull ICS Inequalities Work Programme Priorities 2021/22

Workstream	Priorities 2021/22				
Inequalities as ICS Core Business	Midlands Health Inequalities Toolkit	BSol Inequalities leads Network	HI Priorities for ICS workstreams	HI Priorities for NHS trusts	HI leadership development
Data	NHS activity ethnicity coding	Locality & PCN level data	Mapping access to NHS services	Activity analysis joint with BCWB	Tracking Impact inc ICS OF
Community Engagement	PCN-level prototypes (x2)	Locality stakeholders	BLACHIR – NHS input	Link to Healthwatch Community offer	
COVID Response & Inequalities	Waiting Lists – equality analysis	Vaccination – inequalities grp	Long COVID equity of access	Equality impact of recovery plan	
Prevention	Maternity pathways (BUMP)	Early Years pathways (BFS)	Mental Health pathways	Long Term Condition pathways	
Anchor Institutions	Joint work with the People Board	Recruitment Opportunities	Social Value procurement	Living Wage commitment	
Digital Inclusion	Joint work with the Digital Group	Digital inclusion strategy			
Population Health Management	Led by the PHM programme	Inequalities built into PHM approach			

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System operational planning 2021/22
Stakeholder briefing

Harvir Lawrence, Director of Planning and Delivery
Lesa Kingham, Head of Planning and PMO

May 2021

Objectives

- Summarise the current context, challenges and priorities
- Highlight the national requirements for planning for 2021/22
- Highlight Birmingham and Solihull plans for 2021/22
- Seek your views on the plans for 2021/22

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Challenges and COVID impacts

COVID has had a significant impact on our area. Whilst we have worked effectively together to respond to the challenges and delivered excellent work in some areas it has had a negative impact on a range of areas:

- **Widening health inequalities** – negative impacts on our vulnerable and ethnic minority communities plus wider economic prosperity
- **COVID rates and hospital impacts** – comparable rates of infections to other large urban areas but we have experienced a greater level of hospitalisations linked to COVID – treating 11k COVID inpatients, 4k more than the nearest comparable hospital system (Barts in London)
- **Services suspended/changed and our future plans** – we accelerated transformation initiatives to deliver care including digital but a range of services were suspended to release staff to support our most COVID critical patients in hospitals and in the community linked to our hospital impacts
- **Increasing number of people waiting for care** – due to COVID, there are now growing numbers of people waiting for care and people are unfortunately waiting longer (c15k people now waiting 52 weeks and c22k people waiting 42 weeks)
- **Financial challenges** – before COVID, we recognised we needed to become sustainable. COVID has not alleviated these background pressures and there are still challenges regarding affordability
- **Workforce challenges** – before COVID, we had challenges in relation to recruitment, retention and staff shortages. COVID has added to that plus our staff are tired after months of pressure.

Priorities for Birmingham and Solihull (1)

- **Addressing widening health inequalities** – improving access, exploring new ways of working and reaching out more to our ethnic minority communities and disadvantaged groups.

- **Transition to our ICS** – linked to national policy, our core structures will change to facilitate greater joint working and maximise resources in health and care. This reflects our natural progression in joint working throughout COVID and the mutual aid we have delivered to prioritise resources where this is needed most.

- **Reduce the elective care backlog –** linked to our Elective Recovery Fund, this will pool resources and deliver mutual aid based on prioritising the most clinically vulnerable alongside ethnicity and postcodes to address inequalities. Harm reviews will be conducted and we will fast track transformation initiatives to protect theatres and the associated workforce.

- **Restore and recover as many services as possible –** this will include strategically prioritising the services to deliver in 2021/22 aligned to our financial and workforce resources. Not everything will be possible during 2021/22 given the focus on essential services and recovery.

Priorities for Birmingham and Solihull (2)

- **Continue to respond to COVID** – through our vaccination programme, we will put in place services to support people with long–COVID and also respond to any future surges of COVID e.g. we will need to protect Intensive Trauma Units (ITU), patient flow in hospitals, staffing and adult urgent crisis services including mental health.

- **Support our staff to recover** – this is so they have greater resilience and can thrive in terms of health and wellbeing and also through career opportunities. It is also about attracting people to come and work in health and social care.

- **Carry out a long term review of priorities** – COVID has changed how we operate and we need to revisit our plans for beyond 2021/22, linked to our Long Term Plan. This will support our overall recovery and address issues such as inequalities.

- **Ask people what they think** – we need to continue to engage so people understand the current position and so we can seek their views on the priorities going forward and any proposed permanent service changes we need to consult on.

Risks to delivering our priorities

Even before COVID, we were managing a number of risks. These risks and associated impacts have largely increased due to COVID:

- **Widening inequalities** – as we restore our services, there may be a continued negative impact from COVID on our ethnic minority, high risk and vulnerable people
- **Long waiting times –** these may worsen in the event of a further surge of COVID and as we recover services. This will widen health inequalities and increase mortality rates. Areas of risk are cancer, elective care, longer waiting times for mental health services, speech and language therapy, physio, OT and specialist assessment services
- **Increased demand for services** – we are likely to see an increased demand for different services e.g. mental health services as the pandemic continues.
- **Long term impacts for children** – we know the pandemic has been hard on children and young people – socially, educationally and through increased poverty levels. These issues may cause long term developmental impacts if we do not act now.
- **Future surges of COVID** – whilst we are planning to mitigate these, further national lockdowns and impacts on hospital will affect our communities both in health and wellbeing but also economically
- **Workforce capacity issues** – whilst we are proactively recruiting and addressing workforce challenges, even before COVID we had insufficient staff numbers. In the event of a surge in COVID infections there may be insufficient workforce resources to manage this and manage many of the services we have been working to restore
- **Funding** – financial constraints could be exacerbated further in 2021/22 which impacts on COVID delivery, restoration, recovery and long term transformation
- **ICS delivery** – there are risks relating to delays of introducing the ICS (due to national government policy, resources, clarity on final arrangements) which could affect how we use resources during this transition year
- **Boundary changes** – there are potential risks relating to changes in boundary for the Birmingham and Solihull ICS.
- **Lack of engagement** – there is a risk that we do not keep stakeholders informed which helps them understand the current operating environment and services available, which impacts on timely access to the most appropriate care.
- **Mitigations** - are in place for all of the risks and challenges. These are being monitored closely by senior leaders in our system.

National planning priorities for 2021/22

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention.
B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.
F. Working collaboratively across systems to deliver on these priorities.

Additional policy and technical guidance has also been provided on:

- System development and ICS establishment
- Elective recovery framework
- Health inequalities
- Maternity and Neonatal transformation priorities.

Birmingham and Solihull's response

Summary

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Health inequalities

Birmingham & Solihull ICS Inequalities Work Programme Priorities 2021/22

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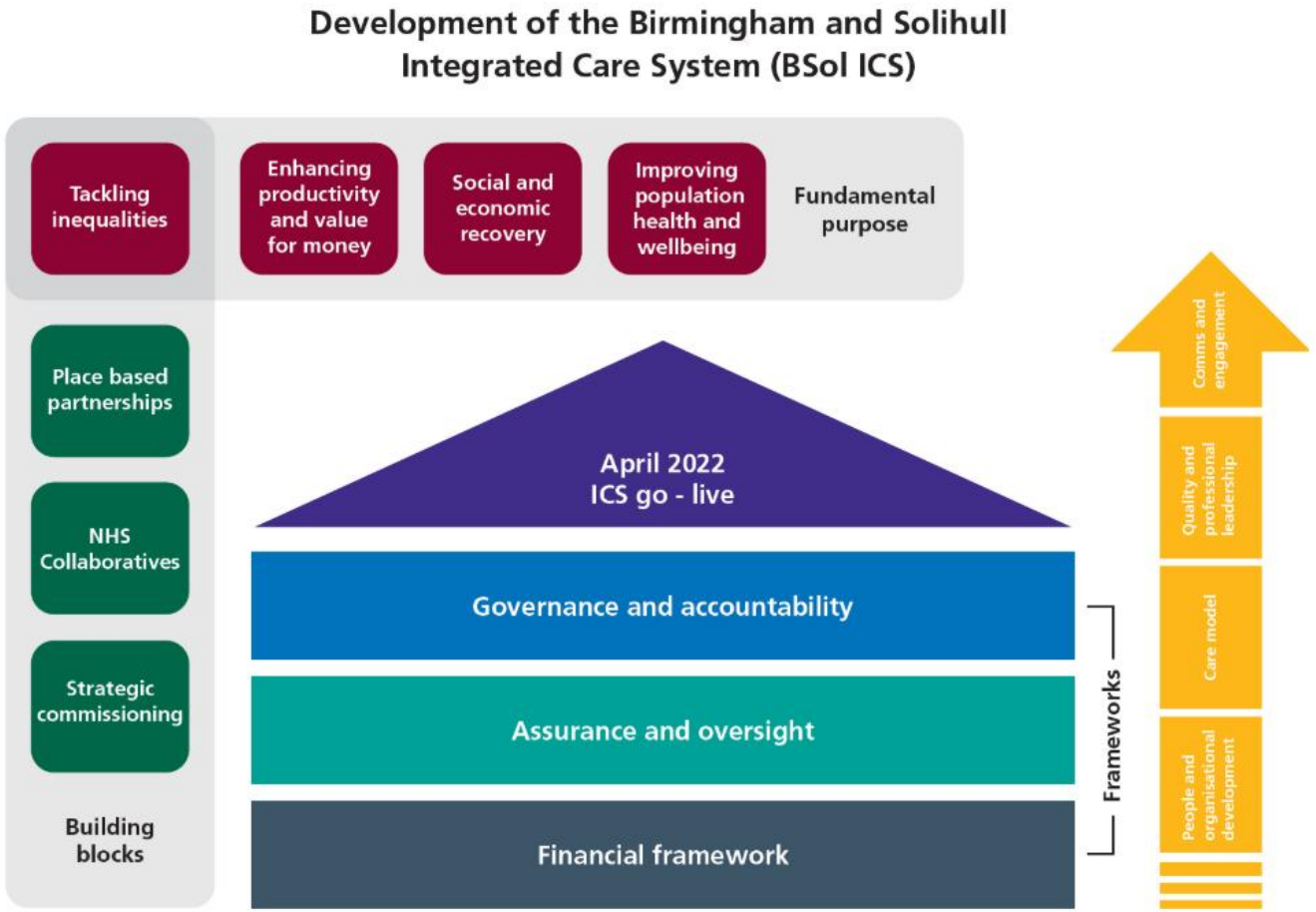
System development and ICS establishment



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A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

- **Continue to roll out and evaluate the enhanced Occupational Health and Wellbeing Offer** - for Staff and the Mental Health Hub to support people to recover from COVID
- **Deliver the objectives within Regional Equality, Diversity and Inclusion Strategy** - 6 High Impact Recruitment Actions and develop a clear action plan to address inclusion within recruitment
- **Review learning from the pandemic** – includes digitalisation, transferability of skills and competencies. and working across organisational boundaries
- **Increase focus on new ways of working** - supports both the mitigation of workforce capacity risks and deliver greater workforce integration and co-operation; includes ICS Bank and Reservist workforce
- **Address workforce gaps** – e.g. through new roles; retention of recently retired clinicians; GP training scheme; working with universities; apprenticeships; Careers Hub to attract hard to reach communities; entry level jobs; expansion in trainee nursing associates, primary care, international recruitment of theatre nurses, health care assistants
- **Work to be employer of choice** – by delivering the above and measuring this via Workforce Race Equality Standard, Workforce Disability Equality Standard and staff survey indicators

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

- **Continue with COVID vaccination management programme** – first dose to adults by end July 2021 and target via local vaccination units low-uptake amongst specific communities
- **Continue to deliver support services virtually and at home for those who are COVID positive** - aim is to prevent admission to hospital, where appropriate
- **Deliver post Covid-19 Syndrome (PCS) rehabilitation** – to be delivered via 2 assessment clinics; integration of teams across all providers for both children and adults; dedicated website; building on current pathways of care
- **Develop health inequalities plan across all pathways** - aim is to ensure equitable access to post COVID assessment and long COVID rehabilitation
- **Develop specialist children post ITU multi-disciplinary team clinics** where required
- **Develop the communications plan for raising awareness of the service** within the local community, working across commercial, charitable and voluntary sector

C. Transform the delivery of services based on learning from the pandemic, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services (1)

Elective and cancer care

- **Pool resources to deliver the elective recovery programme** – creating a single patient waiting list (one for adults, one for children), supported by a demand and capacity planning tool to maximise efficiency
- **Continue to carry out clinical prioritisation and harm reviews for all patients** – ensuring diagnostics and treatments are expedited as quickly as possible
- **Maximise use of theatres, ITU and high dependency units** and explore triage options to maximise capacity
- **Maintain COVID 19 'green pathways' for elective surgery** – for essential urgent and cancer and spinal services whilst working through the orthopaedic backlog
- **Continue to improve patient flow** e.g. discharge to assess pathways, 'home first' cultures
- **Plan for any surges of COVID activity**
- **Support delivery of Rapid Diagnostic Centres** philosophy
- **Working with providers to ensure 2 week wait referrals are stable**
- **Support patients with advice and guidance and virtual outpatients for faster access** and to free up essential capacity

C. Transform the delivery of services based on learning from the pandemic, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services (2)

Learning disability and mental health

- **Continue to support all patients with learning disabilities to ensure health checks**
- **Continue to learn from the Learning Disability Mortality Review Programme** and implement 100% of all actions identified
- **Continue to focus on inpatient admission avoidance for adults and children** with a learning disability
- **Continue with development of iThrive model of mental wellbeing and care** for young people up to 25 and increase coverage of 24/7 crisis response services
- **Increase access to IAPT** (improve access to psychological therapies
- **Expand mental health community services for early intervention**, people with serious mental illness
- **Increase diagnosis rate for dementia** and support continued offer of memory assessment clinics

C. Transform the delivery of services based on learning from the pandemic, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services (3)

Children and young people's services

- **Commence children and young people's inpatient pathways, hospital admission avoidance transformation programmes**
- **Develop a place based approach** for children and young people's services based on transformation initiatives
- **Deliver the actions to improve Special Education Needs and Disabilities (SEND) services,** supporting education and health care plans, reviewing quality and reducing waiting times
- **Deliver the recommendations for the 1001 critical days** (i.e. first 3 years of a child's life)
- **Address health inequalities by reviewing service delivery based on access, data**
- **Support delivery of services for children's chronic illnesses** e.g. respiratory, diabetes, epilepsy to ensure care is delivered closer to home
- **Develop system wide neurodevelopment service** for people with Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder and review assessment processes and pathways to reduce time of referral to diagnosis
- **Focus on clearing the backlog of childhood immunisations due to COVID**

C. Transform the delivery of services based on learning from the pandemic, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services (4)

Maternity and neonatal transformation priorities

- **Deliver Ockenden recommendations for maternity services** including supporting partners to access appointments, supporting women from ethnic minorities via increasing support to at-risk pregnant women, tailoring communications, discussing vitamins and supplements, recording data (postcode, age, co-morbidities, BMI to provide enhanced support, particularly to people in more deprived areas)
- **Increase access to community based specialistic perinatal mental health** and widen the criteria to extend the period of access from 12 to 24 months for new mums
- **Increase access to psychological therapies for pregnant women and new mums**, to include postnatal depression service
- **Complete study into perinatal mental health services from ethnic backgrounds** to inform service delivery
- **Review psychological therapies services** to ensure they are culturally competent.

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

- **Continue to work with Practices, PCNs and GP Providers to review access** - plus support with a range of improvement initiatives to support the backlog of appointments, support long term conditions management and address health inequalities
- **Continue with Local Dental Network and Managed Clinical Networks (MCN)** – these provide clinical forums to support service development and recovery. Some of these such as Urgent Care, Restorative, Paediatrics, Oral Medicine, Secure Settings and Special Care are West Midlands wide whereas there are specific local MCNs to cover Oral Surgery and Orthodontics
- **Continue delivering the Local Maternity System Wide Stop Smoking Service** – to improve smoking cessation rates in pregnancy
- **Ensure focus remains on disease prevention and health promotion across a range of long term conditions**
  - Fully-integrated and system-wide approach to delivering diabetes care and Single Point of Access
  - Embed the Cardiovascular disease (CVD) projects and cardiac rehabilitation pathway. Also include heart failure pathway
  - Gather evidence (as one of 10 sites) to test the Low Calorie Diet Pilot
  - Review Birmingham and Solihull stroke pathway
  - Develop respiratory pathway for patients with COPD, Asthma, Bronchiectasis and Interstitial Lung Disease (ILD).

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

- **Embed Discharge to Assess pathway approach** by focusing on reducing length of stay in hospital; 'home first' approach; reviewing workforce model; development of single hub to expedite decision making; continue daily multi-agency reviews of all patients delayed from discharge; continue with the specialist palliative care and urgent response
- **Ensure community services for intermediate care** – supporting COVID+ patients needing bedded provision
- **Agreed system dashboard for monitoring 2 hour crisis responses**
- **Roll out Discharge Hub Management System** to aid one system view of patient flow
- **Deliver local awareness of NHS111 as a primary route into all urgent care services** in collaboration with national and regional NHS111 marketing campaigns and local targeted communication approaches and reviewing what will be most effective for our area given breadth of different communities and languages spoken
- **Develop a direct line for referrals for same day emergency care assessment areas** to prevent referral delay and expediate the patient journey to the appropriate facility
- **Work closely with all providers (via Birmingham and Solihull Directory of Service lead, monthly working group and Urgent Care Operational Group) to ensure the local Directory of Service is kept fully up to date** with service availability and that service descriptions are clear for NHS 111 staff
- **Establish Task and Finish group to ensure that the data is consistently and correctly recorded to report the new information in compliance with the Emergency Care Data Set requirement -** will involve ED clinicians, Information analysts and Divisional Management to ensure consistency of approach across all sites

Engagement

We will update and inform and engage on the plan with the following:

Partner **Key stakeholders who will work in partnership to help us deliver the activity**	• NHS staff – clinical • NHS staff – non-clinical • NHS England and NHS Improvement • General practice • NHS Birmingham and Solihull CCG • University Hospitals Birmingham NHS FT (UHB) • Birmingham Women's and Children's NHS FT (BWC) • Birmingham and Solihull Mental Health NHS FT (BSMHFT) • Royal Orthopaedic Hospital (ROH) • Birmingham Community Healthcare NHS FT (BCHC) • Birmingham City Council (BCC) • Solihull Metropolitan Borough Council (SMBC)
Involve and engage **Stakeholders who will need to be actively involved and engaged**	• Existing patient networks and forums • Statutory committees e.g. HOSC, HWBB • MPs and Councillors • Third sector – via BVSC (Birmingham) and CAVA (Solihull) • Healthwatch Birmingham • Healthwatch Solihull • Local Medical Committees • Other stakeholders, as appropriate
Inform* **Stakeholders who need to be aware, kept informed and have an opportunity to respond**	• Existing patients • Wider public in Birmingham and Solihull • Local media, inc. radio • Hyper-local media outlets

Next steps

- Carry out engagement exercise and feed in comments
- Finalise plan for 2021/22 and submit to NHS England/Improvement by 3 June 2021
- Start to consider longer term strategic priorities and plans (October 2021-March 2021) and engage on these
- Continue to transition to an Integrated Care System by September (shadow form) and new legal entity (April 2022).

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Questions and discussion points

- Do you think we have captured the challenges effectively?
- Do you agree with the priorities for Birmingham and Solihull?
- How will being an Integrated Care System help us improve health and care, from your perspective?

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SOCIAL PRESCRIBING AND VCFSE SECTOR PATHWAYS:

A Strategy Paper for Birmingham Health & Wellbeing Board

1.0 CONTEXT

On 28/04/21, BVSC organised an online workshop to consider the current situation regarding social prescribing and referral pathways into VCFSE provision. The workshop was hosted by Engage for Good, the recently established civil society forum, and there were over 50 participants. The aim of the workshop was to start a structured conversation with key VCFSE organisations from across the city regarding the strategic challenges that social prescribing presents and to identify how best these can be overcome.

The VCFSE sector in Birmingham is working across communities and systems to help ensure that Birmingham citizens have access to the activities, support and services they need in order to live well, improve their health and wellbeing and to live fulfilling lives. A number of social prescribing initiatives, both formal and informal, already exist to help connect citizens with this provision.

The workshop discussion revealed that participants are committed to making continuing progress in social prescribing, both as part of post-COVID recovery and in the longer-term as a key contribution to the Prevention First agenda, the continuing integration of statutory and community-based health and wellbeing provision, and the support of some of the city's most vulnerable communities and groups. Participants agreed that that the following are of particular importance to achieving these goals:

- Ensuring that citizen experience rather than system need is at the heart of social prescribing and should shape its continuing development.

- Enabling VCFSE providers to exercise greater control in developing and managing effective pathways into and across VCFSE provision.

- Ensuring that a strategic overview of social prescribing exists and that this enables a shared understanding of needs and priorities and a planned approach to developing pathways, infrastructure, capacity and investment.

2.0 STRATEGIC CHALLENGES

Discussion during the workshop identified a number of strategic challenges to social prescribing. Broadly speaking, these can be summarised under the following five headings:

- The need to be able to identify a city-wide offer.
- Providing access for both practitioners and citizens.
- The need for collective planning.

- A single platform/method.
- Resources – how can resources follow the user?

Key points are very briefly summarised below.

2.1 The need to be able to identify a city-wide offer

The current system is fragmented, with no means of presenting an overall, city-wide offer that provides an intelligible picture of *all* of the activities and assets that contribute to Birmingham's health and wellbeing – from complex, critical 'crisis' services through to early prevention and grassroots community provision.

New initiatives to improve social prescribing and/or referral operate in silos, with no single approach/method having critical mass. The various parts of the system are not joined up. Very few of the existing initiatives are citizen-facing.

2.2 Providing access for both practitioners and citizens

The longer-term development of social prescribing and referral pathways has to be intelligible to both practitioners and citizens. Citizens should be at the heart of social prescribing and as a process it should begin from the citizen experience rather than system need.

2.3 The need for collective planning

No one has strategic overview of social prescribing. This militates against a collective ability to plan, forecast and develop capacity to meet specific social prescribing priorities. It is impossible to plan to meet demand, to build up or flex sector capacity, or to meet shifting social prescribing priorities.

Even where robust working relationships exist with Link Workers it has proven difficult to meaningfully extend these relationships to include PCNs and GPs. Lack of co-terminous service boundaries (local authorities, PCNs, GPs etc) adds further difficulties.

2.4 Lack of a single platform/method

No single platform or method has consensus or universal traction. Whatever method is chosen has to be capable of coping with all types of referrals (self-referral, intra-agency and intra-sector referrals, and referrals into VCFSE provision). It has to be amenable not just to guiding citizens through the referral journey, but also to enabling them to track their progress and outcomes. It has to operate in such a way that it will foster and support a culture shift towards 'wellness' and away from avoidable clinical intervention.

Communication is key: VCFSE organisations have activities and services to offer but don't know where to present them or who to tell; citizens are seeking services and support but don't know where to go. Any single platform/method has to be capable not just of ensuring a 'pathway': it has to be able to assess the strength and effectiveness of that pathway, whether the pathway is meeting need and is part of a process that is improving outcomes.

2.5 Resources – how can resources follow the user?

The key challenge is that even if collective planning existed to enable social prescribing need, priorities and demand to be anticipated and sector capacity flexed accordingly, there is currently no mechanism to ensure that 'resourcing follows need' – i.e. that referral carries with it a *responsible contribution* in funding that will help meet the cost of support. The VCFSE cannot simply meet demand elastically; there are cost implications and a need for equitable redistribution of resources throughout the 'supply-chain'.

3.0 SOLUTIONS TO THESE STRATEGIC CHALLENGES

Using the same five headings, the workshop identified a number of possible solutions to these strategic challenges:

3.1 The need to be able to identify a city-wide offer

It is of primary importance that a city-wide overview of available health and wellbeing services is available and is accessible to both practitioners (all sectors) *and* citizens. At the moment, deciding the precise method of presenting the city-wide offer should take second place to establishing its fundamental operating principles. It should:

- Offer a full, detailed overview of provision that explains service networks, thematic provision, routes of access. It should explain service pathways by theme and location.

- Be supported by all partners (statutory and VCFSE) as the primary and only method, rather than continuing investment in separate, stand-alone initiatives.

- Be flexible, amenable to incorporating performance indicators and to enabling pathways to be tested for effectiveness and robustness and in a variety of scenarios.

3.2 Providing access for both practitioners and citizens

Whatever platform or method is eventually adopted to 'broadcast' Birmingham's health and wellbeing offer it should be accessible to practitioners and to citizens. This has implications for the language it adopts and for how activities are constructed and described. At present, virtually all social prescribing initiatives use language that is essentially 'system facing' rather than 'citizen facing'. Citizen accessibility and user experience should guide and shape our chosen solutions at every stage.

3.3 The need for collective planning

A solution that enables a collective, strategic overview of social prescribing needs, priorities and intentions is central to any ability to plan to meet demand. There should be at least a six-month lead-in time involved in any change to social

prescribing priorities in order to allow for planning, pathway development/review, and investment or reallocation of resources.

It must be borne in mind that not all VCFSE delivery consists of commissioned services. The sector's independent, voluntary contribution is of increasing significance, both in financial and social contribution made and by volume. Planning properly has the potential to increase the overall resources available to social prescribing.

3.4 A single platform/method

Whatever platform or method is eventually adopted to 'broadcast' Birmingham's health and wellbeing offer and fully enable social prescribing it must be a solution designed for the *whole system* and not just a part of it. Continued investment in separate, stand-alone initiatives is only serving to further fragment the social prescribing and pathways landscape.

There must be a single, unified platform or method that is supported by all partners (statutory and VCFSE), regarded as the primary and only method and the focus of long-term development and investment. It must be accessible to practitioners and to citizens and citizen accessibility and user experience should guide and shape its development at every stage.

3.5 Resources – how can resources follow the user?

Realistically, there are only two ways in which resources can follow referral: either through an effective, fully functional individual budgets mechanism that enables users to fund the services they require (in those cases where the service is not free at the point of delivery); or through targeted investment that enables the sector to meet increased demand.

A reformed and fully operational individual budgets system still seems distant and for this reason planned and targeted investment that supports specific social prescribing priorities seems a better way forward. Statutory agencies do not need to meet the full costs of service but a responsible contribution does need to be made. Locking this into formalised social prescribing planning processes/structures will also increase the potential for this financial contribution to be leveraged by the sector, unlocking further funding from independent grant-makers and other philanthropic sources.

Stephen Raybould
StephenR@bvsc.org
BVSC
17/05/21

Birmingham Health and Wellbeing Board

	Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th May 2021**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney**

Report Type:	**Discussion**

1. Purpose:

1.1 To outline the draft content and planned timelines for the Birmingham joint Health and Wellbeing Board Strategy, Creating a Healthier City 2022-2030.

1.2 To build upon discussions at the April Board Development Session to advance the strategy development cohesively as a Board to support Birmingham citizens to achieve their potential for a happy, healthy life.

2. Implications:

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

3. Recommendation

It is recommended that the Board:

3.1 Note themes, proposed ambitions, leadership for action and key actions included within the draft Health and Wellbeing Board strategy and be prepared to contribute further to their development.

3.2	Agree to support the development of the joint Health and Wellbeing Board Strategy.
3.3	Agree to support the Birmingham position statement on Discrimination and Diverse Communities during and beyond the Covid-19 pandemic.

4. Report Body

4.1 Context

4.1.1 The Health and Wellbeing Board is required to have strategy as part of the statutory functions of the Board, building upon the Joint Strategic Needs Assessment.

4.1.2 The Board last agreed priorities in 2017, this was not crystalised into a clear strategy and delivery plan.

4.1.3 The 2017 priorities were to:

- Improve the wellbeing of children.
- Improve the independence of adults.
- Improve the wellbeing of the most disadvantaged.
- Make Birmingham a Healthy City.

4.1.4 In 2019 a consultation on the public health priorities for the City was undertaken which engaged citizens in shaping a future strategy alongside a refresh of the Joint Strategic Needs Assessment.

4.1.5 Work on developing the strategy was deferred in 2020 because of the Covid-19 pandemic.

4.2 Birmingham position statement on Discrimination and Diverse Communities

4.2.1 To sit in parallel with the emerging Joint Health and Wellbeing Board, Creating a Healthier City Strategy the board have developed a position statement on discrimination and diverse communities during and beyond the Covid-19 pandemic.

4.2.2 This statement acknowledges the exposed and worsened inequalities exposed by Covid-19 and the disproportionate impact on Birmingham's Black and Asian communities. Whilst the emphasis of this position statement is on the inequalities experienced in the Black and minority ethnic communities, the Board also recognises the disproportionate number of Covid-19 related deaths in people with a learning disability.

4.2.3 These issues cannot be solved by any single agency or professional group, this draft Health and Wellbeing Board statement has been written as a public commitment to clarify the Boards position as a partnership that Racism is a public health issue that undermines the health of our city and needs actions.

4.2.4 It is proposed that the Health and Wellbeing Board act on this commitment through evidence, truth, leadership and culture and heritage. The full statement can be found in **Appendix 1.**

4.3 Creating a Healthier City Strategy

4.3.1 The draft strategy has been developed building upon the public health priority public consultation in 2019/20, the Seldom Heard voices focus groups and ethnographic research and insight surveys over 2020/21.

4.3.2 The strategy spans a proposed eight-year time period, running from 2022 to 2030.

4.3.3 The draft shared vision is to create a healthier city where every citizen, at every stage of their life, in all communities can make healthy choices that are affordable, sustainable, and desirable to support them to achieve their potential for a happy, healthy life.

4.3.4 The vision is underpinned by three shared principles for action:

- Citizen focused and informed by citizens lived experience.
- Consciously focused on reducing inequalities and promoting equality and inclusion.
- Data and evidence-informed, and action research enabled action.

4.3.5 The strategy has ten core proposed themes for action. These bring together three life course themes, alongside action on wider determinants, health protection and environmental public health. The draft Creating a Healthier City Strategy can be found in Appendix 2.

4.3.6 The 10 proposed core themes for action are:

1. Getting the best start in life
2. Mental wellness and balance
3. Healthy and affordable food
4. Active at every age and every ability
5. Working and learning well
6. Protect and detect
7. Ageing well and dying well
8. Closing the gaps
9. Contributing to a green and sustainable future
10. Mitigate the legacy of Covid

4.3.7 The draft strategy was discussed at the Health and Wellbeing Board Development Session on 29.04.2021. 15 Board members were in attendance.

4.3.8 The Board members provided feedback to support the development of the framework in smaller discussion groups and via Menti.com.

4.3.9 The initial feedback will be incorporated into the development of the evolving Creating a Healthier City Strategy document.

4.3.10 Following the development session and updated overview has been created. It is detailed in **Appendix 1.**

4.4 Creating a Healthier City Strategy draft timeline and consultation plan

4.4.1 **Appendix 1** details the timeline for strategy development, and includes key phases in the strategy development, public and partner consultation and the target completion date.

4.4.2 There are four key phases in the development of the strategy:

- Partner consultation
- Seeking approval for public consultation
- Consultation findings report
- Seeking approval for the final document

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

5.1.1 The development of the Joint Health and Wellbeing Board Strategy is managed by the Health and Wellbeing Board.

5.2 Management Responsibility

Dr Justin Varney, Director of Public Health

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Stakeholders/partners lack of engagement	Medium	Medium	Consultation with partners, stakeholders and public included in timeline.
Changes suggested to the elements within the draft strategy	Low	Low	Changes will be prioritised in officer's work programmes.

Appendices

Appendix 1 – Creating a Healthier City Strategy Overview

The following people have been involved in the preparation of this board paper:
Dr Justin Varney – Director of Public Health
Elizabeth Griffiths – Assistant Director of Public Health
Stacey Gunther – Service Lead, Governance

Health and Wellbeing Board: Creating a Healthier City Strategy

Birmingham Health & Wellbeing Board Strategy

The Health and Wellbeing Board is required to have a strategy as part of the statutory functions of the Board building on the Joint Strategic Needs Assessment.

The Board last agreed priorities in 2017 but this was not crystalised into a clear strategy although there is clear evidence of delivery plans and action being taken.

In 2019 a consultation on the public health priorities for the City was undertaken which engaged citizens in shaping a future strategy alongside a refresh of the JSNA.

Work on developing the strategy was deferred in 2021 because of the pandemic.

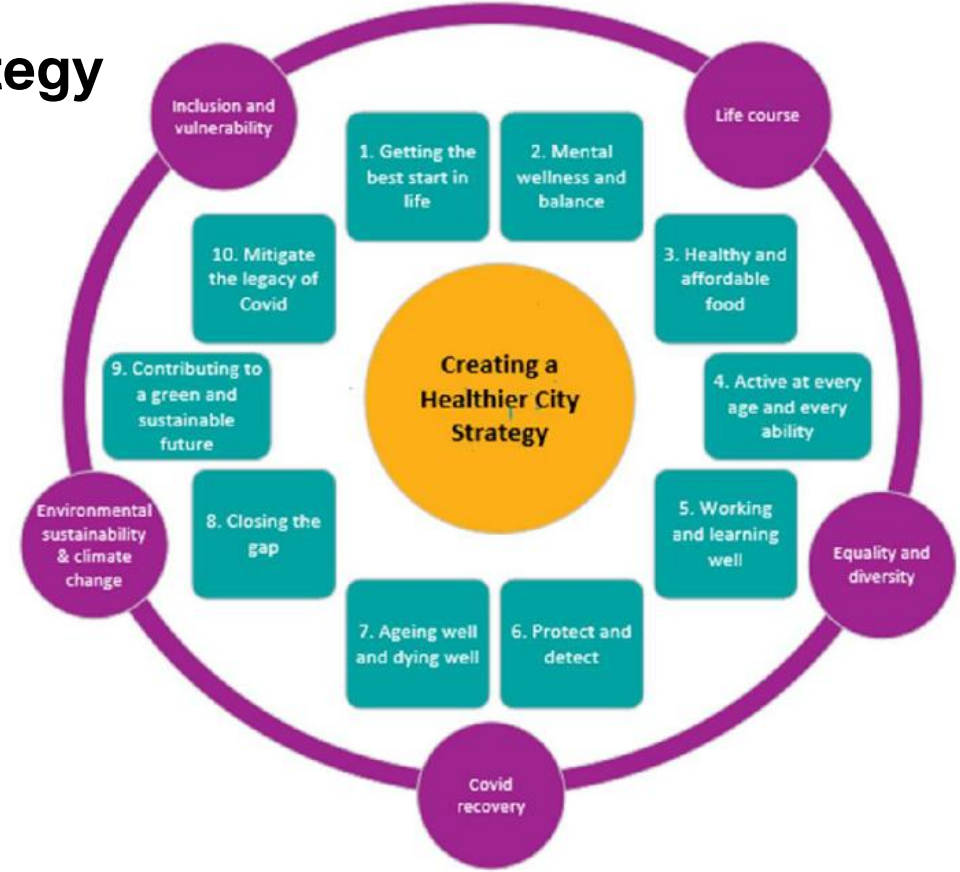
2017 Priorities	Ambition
Improve the wellbeing of children	Detect and prevent Adverse childhood experiences All children in permanent housing
Improve the independence of adults	Increase the control of individuals over their care through integrated personal commissioning
Improve the wellbeing of the most disadvantaged	Increase employment/ meaningful activity and stable accommodation for those with mental health problems Improving stable and independent accommodation for those with learning disabilities Improve the wellbeing of those with multiple complex needs
Make Birmingham a Healthy City	Improve air quality Increase mental wellbeing in the workplace

Progress against 2017 priorities

Proxy Indicators			
Indicator	2016/17	2018/19	Change
% of children achieving a good level of development at the end of Reception	65.9%	67.3%	Better
Households with dependent children owed a duty under Homelessness reduction rate per 1,000 housholds	N/A	21.8	N/A
Proportion of clients for whom a Social Care Individual Budget is being taken in the form of a Direct Payment.	21.0	24.4 (2017/18)	Better
Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (percentage points gap)	59.5	61.5	Worse
Adults in contact with secondary mental health services who live in stable and appropriate accommodation	55.0%	44.0% (19/20)	Worse
Adults with a learning disability who live in stable and appropriate accommodation`	61.7%	68.9% (19/20)	Worse
Fraction of mortality attributable to particulate air polution	6.1% (2016)	5.8% (2019)	Better
Percentage of working days lost due to sickness absence	1.1% (2015-17)	1.1% (2017-19)	Stable

Creating a Healthier City Strategy (2022-2030)

- Developed building on the consultation in 2019/20 and the Seldom Heard voices focus groups, ethnographic research and insight surveys over 2020/21.
- Proposed eight-year strategy for action to bring the strategy into line with decades in 2030.
- Ten core themes for action bringing together three life course themes alongside action on wider determinants, health protection and environmental public health.



Draft Vision Statement

Our shared vision is to create a healthier city where every citizen, at every stage of their life, in all communities can make healthy choices that are affordable, sustainable and desirable to support them to achieve their potential for a happy, healthy life.

Draft Strategic Principles

- Citizen focused and informed by citizen's lived experience
- Consciously focused on reducing health inequalities and promoting equality and inclusion
- Data and evidence informed and action research enabled

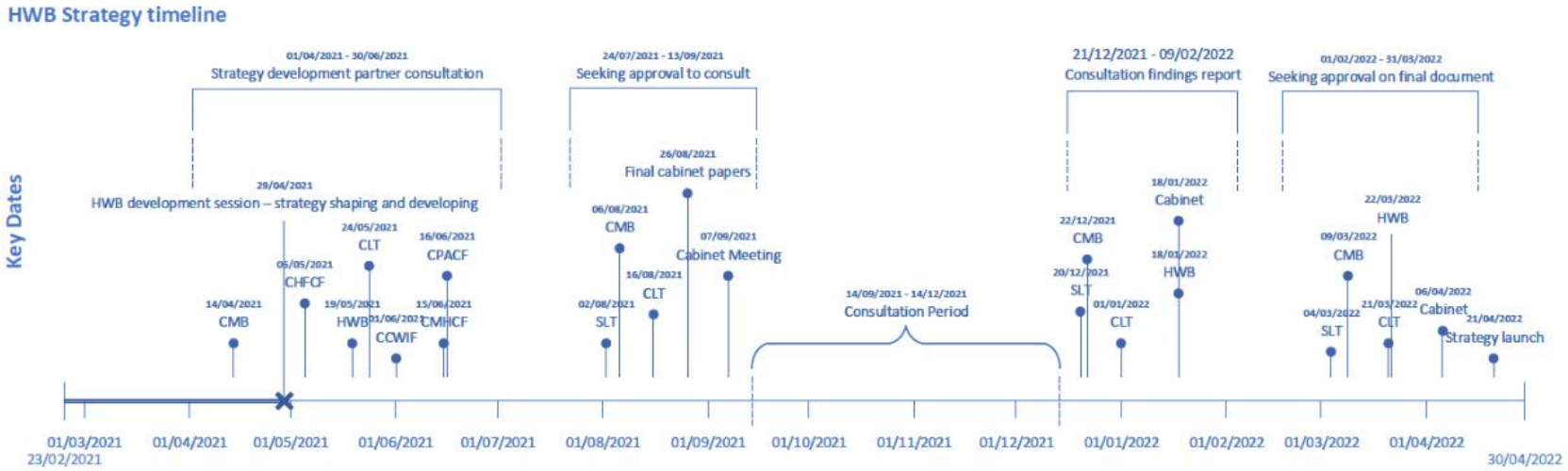
Ten Themes for Action

- Getting the best start in life
- Mental wellness and balance
- Healthy & affordable food
- Active at every age & ability
- Working and learning well
- Protect & Detect
- Ageing and dying well
- Closing the gap
- Contributing to a green and sustainable future
- Mitigating the impact of Covid

Developing the Strategy for Creating a Healthy City

- Pre-consultation phase
  - Engagement with Board partners, H&W Forums, internal engagement within Council directorates/departments
- Public consultation
  - Be Heard
  - Ward Forums
  - Community listening events
- Consolidation
- Ratification and publication

Creating a Healthier City Strategy



Board Strategy development session feedback

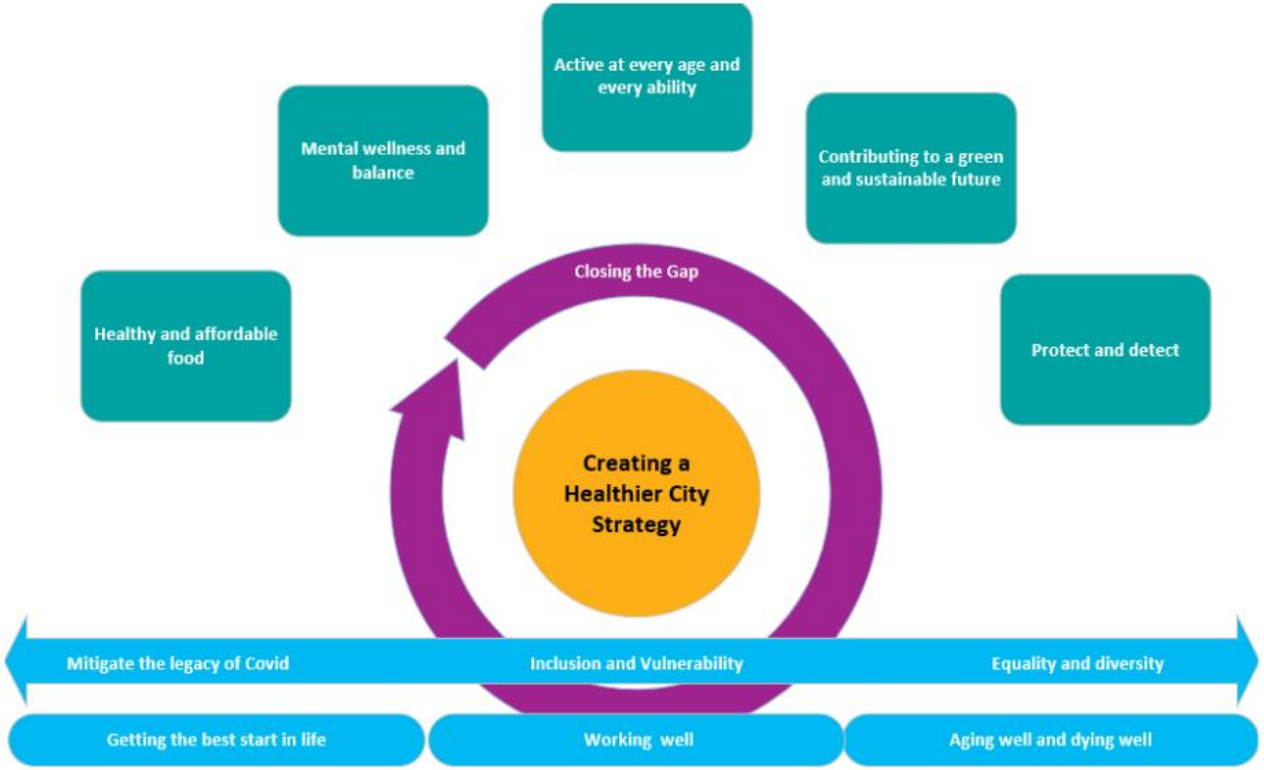
- The Health and Wellbeing Board development session collected Board members views on the draft Creating a Healthier City Strategy.

- Board members provided feedback via Menti.com around the draft vision, strategy themes and priorities.

- Discussion around indicators and leadership for each proposed theme took place in breakout groups.

- Emerging feedback – support for themes, potential to accelerate delivery around small number of outcomes, support for cross cutting themes of citizen voice, equality & inclusion, strong potential to link to Integrated Care System and other partners emerging work on inequalities. Prioritisation of inequalities linked to deprivation, ethnicity, place and inclusion groups (e.g. homeless).

Updated strategy overview following the Board Development session



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Birmingham Health and Wellbeing Board

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19 May 2021**
TITLE:	**LOCAL COVID OUTBREAK ENGAGEMENT BOARD**
Organisation	**Birmingham City Council**
Presenting Officer	**Daragh Fahey, Assistant Director of Public Health**

Report Type:	**Information**

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

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

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

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

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

4.3 The Board has been set up to:

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

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

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

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

4.7 Appended to this report are the publicised minutes of the LCOEB subsequent to those reported to the last Health & Wellbeing Board in March 2021.

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

5.1.1 Governance of the LOMP will seek to ensure the following:

- The Local Covid Outbreak Engagement Board is responsible for approving the LOMP on behalf of the Health and Wellbeing Board and Cabinet.
- Implementation of the plan is overseen by the Local Covid Outbreak Engagement Board.
- The plan is supported by all of the contributing partners through the Birmingham City Incident Management Team.

- There is robust monitoring of progress of the management of outbreaks individually and collectively through BCC's Test and Trace Business Unit under the oversight of the Director of Public Health (DPH) in partnership with PHE.

- BCC can continually reflect, learn, and improve our response working with partners.

5.1.2 The DPH is accountable for delivery of the LOMP to the Local Covid Outbreak Engagement Board that has been established as a sub-committee of Cabinet and the Birmingham Health and Wellbeing Board. The Board meets monthly and the papers are published through the Council CIMS web platform with the meeting being live streamed through this platform.

5.1.3 The Birmingham City Incident Management Team (BCIMT) is a regularly meeting of a wider strategic partnership of the city including representatives from WM blue light services, Universities, the Clinical Commissioning Groups, the Universities and Education sector, the Chamber of Commerce and the Community & Voluntary Sector.

5.1.4 BCC has now transitioned from its Emergency Plan structures into a Recovery model whereby Covid-related operational activity is being delivered by the Test and Trace Business Unit, Co-ordination and Response Group (CRG) and the wider Council Directorates. The Test and Trace Business Unit sits within the Council's Public Health Division of the Partnerships, Insight and Prevention (PIP) Directorate; Covid-related delivery within each of the Council's Directorates is monitored by the CRG.

5.1.5 In parallel, the Test and Trace Business Unit also feeds into the Birmingham Health Protection Forum, chaired by the Assistant Director of Public Health (Environmental Public Health & Health Protection), which is a sub-Forum of the Health and Wellbeing Board.

5.1.6 These parallel arrangements allow operational oversight whilst providing a sustainable and resilient response to the pandemic.

5.1.7 The CRG connects to the West Midlands Conurbation Local Resilience Forum (WMCLRF). The LRF is a statutory multi agency partnership organisation that brings everyone together. WMCLRF is made up of seven metropolitan councils (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall and Wolverhampton). The conurbation borders three counties; Warwickshire, Staffordshire and Worcestershire. The structure of WMCLRF arrangements is illustrated below. The aim of the West Midlands Conurbation LRF is to ensure:

- There is an appropriate level of preparedness to enable an effective multi-agency response to emergency incidents such as COVID-19, which have a significant impact on the communities of the West Midlands Conurbation.

- All services and organisations work together ensuring the best possible preparations and plans are in place for emergencies. These are regularly tested and updated so that agencies can respond immediately and effectively to any threat.

5.1.8	Alongside these formal governance structures there is close collaboration between the West Midlands Chief Executives and Directors of Public Health through a series of weekly information sharing meetings. This provides opportunities for cross-border collaboration beyond the LRF footprint and meetings also involve the Regional Convenors team and NHS Midlands representation.
5.1.9	There are also weekly meetings between the Council and the NHS Chief Executives groups and this links through the Council Chief Executive into the Council Strategic Group.
5.1.10	There is a battle rhythm to these meetings. The Health and Wellbeing Board meets every two months, the Local Covid Outbreak Engagement Board and Health Protection Forum meets every four weeks. This rhythm can be ramped up as necessary with the Test and Trace Business Unit offering a 7-day response.

Appendices
Appendix 1 - Local Covid Outbreak Engagement Board Minutes – 24.02.2021
Appendix 2 - Local Covid Outbreak Engagement Board Minutes – 24.03.2021

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

Daragh Fahey, Assistant Director of Public Health Test and Trace

BIRMINGHAM CITY COUNCIL

LOCAL COVID OUTBREAK ENGAGEMENT BOARD WEDNESDAY, 24 FEBRUARY 2021

MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON WEDNESDAY 24 FEBRUARY 2021 AT 1400 HOURS ON-LINE

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Andy Cave, Chief Executive, Healthwatch Birmingham
Elizabeth Griffiths, Assistant Director of Public Health
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Councillor Brigid Jones, Deputy Leader of Birmingham City Council;
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Councillor Paul Tilsley
Dr Justin Varney, Director of Public Health
Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the LCOEB

ALSO PRESENT:-

Richard Burden, Chair, Healthwatch Birmingham
Mark Croxford, Head of Environmental Services, Neighbourhoods
Julia Dule-Macrae,
Daragh Fahey, Assistant Director, PIP
Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

122 The Chair advised, and the Committee noted, that this meeting would be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

APOLOGIES

123 Apologies for absence was submitted on behalf of Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB; Chief Superintendent Stephen Graham, West Midlands Police and Dr Mary Orhewere, Interim Assistant Director of Public Health

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DECLARATIONS OF INTERESTS

124 The Chair reminded Members that they must declare all relevant pecuniary and non-pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the Minutes of the meeting.

WELCOME AND INTRODUCTIONS

125 The Chair welcomed everyone to the Local Covid Outbreak Engagement Board meeting.

MINUTES

126 **RESOLVED:-**

The Minutes of the meeting held on 27 January 2021, having been previously circulated, were confirmed by the Chair.

COVID-19 SITUATION UPDATE AND TEST AND TRACE IMPLEMENTATION AND ENGAGEMENT PLAN UPDATE

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

(See document No. 1)

Councillor Matt Bennett commented that he was curious regarding the fall in the number of testing and that this was of concern. He enquired if it was known why and how Birmingham sat within the region and the rest of the country, whether this was a trend we were in line with or was it out of line and what the reason was thought to be behind that.

Dr Varney advised that there was an overall national decrease in testing uptake, some of this was believed to be testing fatigue rather than anything else but we were tracking against the region lowest in terms of testing uptake when we look at symptomatic and asymptomatic testing. Some of that was the challenge of the size of Birmingham for us to achieve the same kind of rate of testing as other areas as we had to be doing some 20,000 – 30,000 more test

per week rather than just a 1,000. We had to close that gap but that did not meant that everyone in every part of the city needed to test. Dr Varney highlighted that the next couple of slides in his presentation on Lateral Flow testing will start to show the difference coming out.

Dr Varney continued the slide presentation.

Dr Varney noted Councillor Tilsley's enquiry concerning retail which was an area of content and yet when we got to the statistics it appeared that the majority of contacts were through households and advised that Covid was infectious and if we lived with someone who tested positive, although it was not inevitable that we could catch Covid from them, it was highly likely. The people we lived with was by definition close contacts and it would be unusual to have an household in which you did not end up within 2 metres of someone we shared a house with at some point during the day. After those household contacts, work places were the next most common place that we saw contacts identified. It was not saying that household contacts were not important, but outside of the home the next most common place that we saw was work place.

Dr Varney noted Mr Burden's enquiry concerning whether there was any information on how geared up schools were to undertake increased testing regime and made the following statements: -

1. That schools were being testing already, particularly secondary schools as they were made open for vulnerable children of essential workers. Many secondary schools already had testing sites established and primary schools were relatively familiar with testing of teachers through the use of home testing kits.
2. We were waiting for clarity from the Department of Education on some of the finer details of how testing would be rolled out across schools. That it was understood that this was likely to be a hybrid of testing in schools with secondary school children and staff and home testing of primary school staff and primary school families. He added that he was saying this with some caution as policies in these areas could change rapidly.
3. Public Health had some initial steer from the Department of Education for local authorities to look at how they support the distribution of testing kits to families and children.
4. We had started to think through how we might be able to in the weekend ahead of the 8th March 2021 to support schools by promoting parent to take children to test at the many community testing sites across the city so that there was not the first day of term for many of these children did not meant the whole of the day going through testing process.
5. We needed more clarity from the Department of Education of the time window between testing and attending school for the first time and whether using the three days before the 8th March to encourage parents to take children to be tested at community sites might alleviate some of the pressures on schools for that first day.

The Chair commented that it was quite a challenge for schools to carry out testing and the Council was lending support where we could by way of the community testing sites. The Chair added that we will probably know more as we go through the next week and we approach the 8th March.

That the Board noted the presentations.

VACCINATION ROLLOUT AND UPTAKE

128 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG and Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG presented the item.

Mr Jennings drew the attention of the Board to the slide presentation in the Agenda pack and expressed that to Dr Varney and his team for the tremendous amount of work that they had done to extract the data from the NHS system to give is some comprehensive insight as to what was happening both on a Constituency and Ward basis. This was helpful to us in terms of targeting our work as we had tried to do over these last few weeks in areas where we knew it was harder to get the vaccine uptake to the levels we would like to see and needed to see if it was going to be effective.

Mr Jennings then made the following statements: -

a. Firstly, we were now working hard on trying to target those individuals who up to this point we were not able to persuade. That targeting took a number of initiatives and approaches including trying to move the vaccine closer to people rather than moving people to the vaccine.
b. This include a lot of one to one conversations between clinicians and patients to encourage them. It includes conversations with households. It involves the use of vans so that we could take the vaccines out to places we would not otherwise go.
c. We had been running for a few weeks the first pharmacy in a Mosque in England and it was hoped to have the second one next week in Green Lane Mosque.
d. We will continue to plug away at this so that no one got left behind without the vaccine who if we were going to be effective, we had to include as much of the population as possible if we were going to make progress on the vaccine being the way out of the problem that we faced with the virus.
e. Over the next couple of weeks the vaccine supply will really start to broaden out and more vaccine available and the consequence of that was both extending the date of operation in Primary Care and we will be extending the number of people we saw at the vaccination sites and will be adding to those vaccination sites as well.
f. Additional supply of vaccine and capacity will enable us to start delivering second dose which was not starting to be due and the kind of numbers we would see as we moved further down the cohorts to the larger numbers of the younger population that we needed to immunise

Dr Aslam made the following statements:-

a. That he had spent quite a long time this week looking at long-covid and that one of the questions that people were asking was that they had seen some of the challenges we had in some of our communities about

the uptake of the vaccination. There were lots of details emerging about long-covid and this was not pleasant as it was a really difficult set of physical conditions that would impact on your ability to carry out your normal activities for daily living.

b. It was recognised that 1 in 5 people would have symptoms lasting five weeks and it was thought that as the data was emerging that 1 in 10 would have symptoms for 12 weeks. The symptoms were things like deep vein thrombosis, scarring which was potentially permanent scaring on the lung, heart attacks, chronic fatigue and brain fog and heart rhythm disturbances.
c. This would have serious impact on people and they were going to have serious long-term impact. The best way of avoiding long-covid was not to get Covid in the first place. The second best way was to get vaccinated.
d. The data that came from Scotland was that one dose of the Pfizer vaccine after 35 days gave 85% protection of getting into hospital avoiding hospitalisation. The AstraZeneca vaccine had a 94% effectivity of avoiding hospitalisation. These were very good numbers and were astounding.
e. Whilst there were challenges and there were always challenges about preventative measures in particular communities taking up things like vaccinations (we knew this with flu and other childhood immunisation), there was a significantly good case for us to promote the data and encourage people to take up the vaccination.
f. The same challenges around deprivation, BAME communities where there was lower uptake in higher deprivations and higher ethnicity mix. It was clear for all to see and all the things that Mr Jennings had described we will do.
g. We will encourage a more personalised approach, have more conversations with West Birmingham residents with Councillor Hamilton. We will do as much as we could together but ultimately people needed to make a personal decision about protecting themselves and their families. He encouraged everyone to take the advice and look at the consequences of not having an immunisation or protection against this particularly cruel illness.
h. Long-covid would create a lot of work for the NHS, but it would disturb people's lives significantly. These were the key points for people not willing to take up the vaccination. The data was good as it was worldwide data. It was localised for us but we had lots of good data coming out of Israel pointing at the same thing as well.
i. A way out of this Covid crisis was to vaccinate people and if you were not getting vaccinated please maintain the conditions of washing your hands, covering your face and ensure you were staying a good distance away from people.

The Chair commented that the initial data that was issued was encouraging about the effectiveness of the vaccinations in preventing hospitalisations and deaths. The symptoms being described by Dr Aslam of long-covid sounded very unpleasant and no one would want to go through that. The Chair encouraged people to look at the data and look at the evidence and come forward if they had any reluctance and speak to the professionals about taking the vaccine and also talk to people who had already been vaccinated and their

experience. The way out of this was to get many people as far as possible vaccinated and the way to avoid getting Covid or the symptoms of Covid was to get a vaccination. The Chair encouraged everyone to come forward.

Councillor Matt Bennett stated that he was interested in hearing about the work being done to try and persuade the reluctant people. We could see from the figures what the overall uptake was, but was interested to know if they had any idea how different those figures would be if they were not doing those things. Example, phoning or contacting everyone who was reluctant and a second follow up as well. Councillor Bennett enquired how successful were those things and whether people genuinely responded to that and whether it was harder to change people's minds. Secondly the increasing supply and whether they were able to scale things up. When we first started to roll out the vaccines, there were some talk in the media and amongst politicians about having vaccination centres opened 24 hours per day and it was thought that this was not good at the time, largely because the people being vaccinated at the time but that was being ruled out. That he had read somewhere that there was a pilot in one part of Birmingham and if there was a pilot whether this was successful.

In response to the questions, Mr Jennings made the following statements: -

i. There was a pilot in Birmingham in a couple of the hospitals which was around immunising the night staff. He added that he did not think that in terms of the capacity that they had there was huge value in getting people to work through the night in getting people to get to the centres etc.
ii. What we could do was to extend our capacity during the 12 hour working day. The GPs in Birmingham and Solihull could double what they currently did in terms of vaccination and the sites could treble what they did with the additional sites. It was not thought that it was necessary to go overnight to let it work to get to where we needed to get to.
iii. In terms of making a difference, this was slow but we could see it so that in some of those areas that were 50% plus was now 60% plus and those that were 60% wee now 70% plus, but it was slow. T
iv. he clinicians who were doing this was mainly the family doctors who were making the difference here. The compensation in taking half an hour each to persuade someone to come on board.
v. We were hoping that as we moved into the lower cohorts, we could move into immunising whole households which we believe might be effective both as a technique in terms of persuasion. Certainly one of the things he had heard anecdotally was that it was the younger population who were more social media savvy who were picking up the stuff about the anti-vaccine and then telling granny not to have it.
vi. The GPs were having to work with granny and with the younger person who was getting the stuff from social media that we needed to work against. Quite a lot of work was done around social media to try and counter the messages. Most of this was a direct person to person approach.

Dr Aslam commented that we had been running the vaccination programme in West Birmingham for approximately two months and had broken it down into three separate areas:

a) Firstly, was the vaccine acceptable to people – You would have heard from Mr Jennings where running vaccination sites in Mosques because there was religious acceptability, cultural and ethical acceptability and there was particular multimedia messages around particular communities -the black community and infertilities in women if they had the vaccine. These were untrue statements and were very hard to unpicked once they were in people's minds.

b) The second thing was trust – Did we had enough information about this vaccine. One of the questions people asked was whether we had rushed through this vaccine. We did not rushed it through as it went through all the appropriate safety processes to get regulated and now we had real world data. Long-covid was a consequence of 1 in 10 people. If we think about the number of people that had been infected in this country. 1 in 10 people was a massive number and it was about making people trust the information given to them from a variety of sources particularly when they were embedding a seed of doubt.

c) The third thing was around access – how could we make access easier. We talked about implementation in pharmacies and we were looking at GP practices running small lists of patients that could be managed within their practices. It had been difficult, but what was not heard from a cohort of patients (and he had spoken with patients on a daily basis particularly regarding this) was lots of absolutely that they were not going to have it. Some people had had Covid and had to wait 28 days, some people wanted to have a think and a bit more information and to think about whether this was the right thing for them.

Dr Aslam further stated that there were a significant number of people that had declined the vaccination when we spoke to them, but then we got notification that they had been to a mass vaccination site and took the vaccination. Dr Aslam added that in West Birmingham in his practice they had had low flu uptake and that the numbers they were seeing at the moment mirrored the flu immunisation. He added that his practice took a personalised approach to immunisation and were agreeing on all the flu parameters this year although they did not have the flu outbreak. This took a personalised approach when people could make decisions in their own time and it was important that they did not railroad people into making a decision that they were uncomfortable with because we were going to asked them to get vaccinated again and probably again in the winter time. It was important that we treat people with the appropriate respect so that they could make decisions given the right information so that they were making decisions off their own backs and then could live with those decisions.

Mr Burden commented that the slides were welcomed as he along with others from Healthwatch Birmingham and Solihull had been pressing for some time for this kind of breakdown of vaccination data by area and by ethnicity to be made public. Mr Burden referred to vaccine hesitancy and stated that one of the

issues relates to transport as being one of the factor in low vaccine take up. He added that this was something that came up this week in an Healthwatch England report and an article in the Health Service Journal, both of which had suggested that there was an increasing number of what they described as *informally housebound people* who were not going to get their vaccines not because they were anti-vaccine but because they were having difficulties getting there either because they were uncertain and not confident about travelling at the moment or because of the availability of transport or lack of access to a car.

Mr Burden enquired whether we had looked at how far this was a factor in the Birmingham area and if it was a factor whether there was a correlation between this and those areas and ethnicities where there were issues around low vaccine take up generally.

Dr Aslam advised that a list of all their housebound patients and potential housebound patients were kept and that all of those patients had been visited at home to give them their vaccination. He added that if there were people that felt that they were in that position they would try to give them the information as much as they could so that they could have access to where the vaccine sites were. If this was difficult for them to get to contact their GP practice and explain the challenges that they had. Dr Aslam stated that they wanted to vaccinate them and to create the opportunity to do that. If they were absolutely housebound, we would register them as housebound and ensured that somebody visit them. Although we visited our own patients, we were working closely with the Community Trust to ensured that access to vaccine for people who had challenges with travel was equal to those that did not.

Mr Jennings commented that he concurred with Dr Aslam's statement.

Mr Cave commented that they had heard from a few people that they had received a letter advising of the mass vaccination centres but had decided to wait until they could access their Primary Care Network. The few people that had contacted us had stated that they tried to contact their GPs but were constantly told to wait and they were getting anxious about it now. Mr Cave enquired whether there was another place they could signpost individuals to if they were not getting the answers from their local GPs.

Dr Aslam advised that the GPs were all working in networks and each of the networks would have a site where they were delivering their vaccinations from and that there should be no barriers in accessing that site. He stated that he could not see any barriers apart from the one pointed out by Mr Burden concerning transport, but if they could get there, they should have the opportunity to be vaccinated. There had been some confusion in terms of the cohorts we had vaccinated telling some people to wait until other had their vaccination and that the messaging about this could be clearer.

The Chair commented that the efforts of the NHS in rolling out the vaccine had been absolutely tremendous. The Chair expressed thanks to all the NHS staff for the part they played in ensuring that the vaccine had been rolled out in a really speedy way.

The Board noted the verbal update.

CHANGE TO ORDER OF BUSINESS

129 The Chair advised that he would take agenda item 15 ahead of the remaining reports as it had now transpired that we could take this item in the public arena.

OPERATION EAGLE

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

(See document No. 2)

The Chair commented that this was a tremendous effort by all involved and that everyone in the Board meeting would like to joint with him in expressing our thanks to everybody who was involved in Operation Eagle. This was a superb effort in getting on top of the South African variant in that part of the city.

The Board noted the slide presentation.

ENFORCEMENT UPDATE

Mark Croxford, Head of Environmental Health, Neighbourhoods introduced the item and drew the Board's attention to the information in the slide presentation.

(See document No. 3)

131 **RESOLVED: -**

That the Board noted the report.

UPDATE FROM THE NHS

132 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG and Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG presented the item.

Mr Jennings then gave the following verbal update:-

- Dr Varney had outlined earlier in his presentation the admission rate was coming down. The NHS remains under considerable pressure in relation to Covid and the number of people in Birmingham Hospitals to day was less than it was at Peak 1 but more than it was at Peak 2. The numbers were coming down, but it was coming down quite slowly.

- Whilst this was happening, we were now turning our attention to recovery and starting to plan how we work our way through the extensive backlog list that had developed both of interventions that needed to be made and also of diagnostic tests etc.

- It was anticipated that we needed to have some careful conversation with the Primary Care system as we would like them to do as much as they could in Primary Care because as people moved into hospital system which had build up bigger and bigger the potential waiting list. There was a lot of planning work to be done around that at present.

- There was a considerable piece of work that was going on in terms of how we deal with long-covid. We had some referral packages in place and services in place that we were clearly going to need more of those to cope with the growing cohorts of people who still manifest Covid symptoms sometimes months after their infection as Dr Aslam had stated earlier. There was real consequence of that that would stay with them for ever.

- Restoration of services and recovery of services and long-covid and the other major issue for us would be around Mental Health services. We saw through Covid that Mental Health services were maintained but often virtually the rate of referrals both for children and adolescences and adults were at an historical high as a consequence of Covid. It was anticipated that we will see more of this over the next few months as the economic impact of Covid started to roll through the population. This would have an impact on Mental Health services.

- We were beginning to understand what the previous speaker talked about what lock-in looked like for the NHS, but it came with a considerable long list of things to do and a real need for a lot of work around clinical prioritisation to ensured that what we did do we do it in the right order.

Dr Aslam made the following statements:-

- Dr Aslam echoed the things that Mr Jennings had stated. That what we did do when we talked about restoration work recovery was that there was a fatigued workforce that had not been able to take annual leave. Staff had also given up their spare time that they had to be in hospitals and take care of patients in Primary Care and tried to contact patients to provide a virtual support.

- This needed to be factored in and that was in the mind of the Chief Executive and NHS England. We needed to factor in a recovery period for the workforce as without that we were stuck. That he was personally looking forward to talk about cancers and obesity and stopping people smoking rather than just Covid.

- There was something about the mental health impact on the workforce that had gone through the NHS and there were numbers of 5% and 10%

of people who needed support and counselling from what was a post-traumatic stress event.

- We needed to bear this in mind and that we were coming out of this period and hopefully the vaccination programme would continue at the pace that it was going on which would help support the recovery. We had a workforce that had been fatigued through this process and we needed to support them.

The Chair commented that no doubt stress as well, particularly with the second wave for the last few weeks must have been an incredible time for people working on the frontline and in the NHS. The Chair stated that he was in agreement with Dr Aslam's comment concerning people's mental health issues arising from that was going to need some help going forward.

Pip Mayo mad the following statements: -

- There was not that much to add as Mr Jennings and Dr Aslam had spoken their way through this for us. The final bit of jig-saw was to take some timeout to reflect on some of the lessons that we had learnt as we had gone through the second wave of the virus and what this meant for us in terms of how services were delivered in the future.

- Probably pause to connect back with communities and listen to their experiences and priorities as we move forward. There were things coming out about moving forward together with the community that we served and to ensure that the way we delivered services in the future met their need.

- Ms Mayo echoed some of the issue that Dr Aslam had raised in relation to how tired the workforce were at present and giving people an opportunity to take a break to recover from all the time that had been put in over this period as well.

The Chair commented that the NHS staff and frontline workers deserved a well earned break for everything that they had been doing over the last 10-11 months. That was extraordinary as no one had thought that since last March this could still be going on some 12 months later. The Chair expressed thanks to everyone in the NHS for all of their efforts over the last 11 months.

The Board noted the update.

PUBLIC QUESTIONS SUBMITTED IN ADVANCE

The Chair introduced the item and advised that there had been some questions that were submitted around two themes – vaccination and housing and invited Elizabeth Griffiths, Assistant Director of Public Health to respond the questions being asked.

(See document No. 4)

Ms Griffiths advised that there were two questions that were submitted to the panel in advance of the meeting one of which was the Covid vaccination which Mr Jennings had covered in his Covid vaccination presentation. The second was a question on housing.

(Due to technical difficulties experienced by Ms Griffiths, Dr Varney presented the rest of the item).

Dr Varney stated that the question we had on housing related to whether people could be evicted whilst self-isolating. He advised that there was information on the Shelter website nationally about this which provided guidance for people who were in that situation.

Dr Varney then highlighted the following:-

- ✓ Nationally there were restrictions on evictions anywhere at the moment. Even if a court did state that an eviction could go ahead, the guidance stated that the bailiffs must not carryout an eviction if you or anyone in your household were self-isolating because you were symptomatic or had coronavirus or at high risk because you were clinically extremely vulnerable and shielding.
- ✓ Bailiffs must give you two weeks' notice of an eviction date. If you found yourself in this situation then you should contact the court and the bailiff to explain your symptoms and your health conditions.
- ✓ Obviously if you were a case with Covid or you were contacted and told to be in isolation you should have evidence from the NHS test and trace system to be able to demonstrate that which would be a text message or the email or App alerting you to go into isolation.
- ✓ The court and bailiffs will expect to see evidence of this. If you are shielding as clinically extremely vulnerable you should have information from the NHS showing that you are a shielding person as part of the clinically vulnerable group. As a result of that the eviction should be postponed.

133 **RESOLVED: -**

The Board considered the public written questions and responded accordingly.

TEST AND TRACE BUDGET OVERVIEW

Elizabeth Griffiths, Assistant Director of Public Health presented the item and drew the attention of the Board to the key information contained in the report.

(See document No. 5)

The Chair commented that it was worth noting that since the original allocation in June 2020 we had received significant further funding over the months that now amounts to a total in excess of £28m.

134 **RESOLVED: -**

That the Board noted the report.

OTHER URGENT BUSINESS

135 No items of urgent business were raised.

DATE AND TIME OF NEXT MEETING

136 It was noted that the next Local Covid Outbreak Engagement Board meeting would be held on Wednesday 24 March 2021 at 1400 hours as an online meeting.

The Chair advised that there were no private items for this meeting and that the private part of the agenda will not be needed.

The meeting ended at 1530 hours.

CHAIRMAN

BIRMINGHAM CITY COUNCIL

LOCAL COVID OUTBREAK ENGAGEMENT BOARD WEDNESDAY, 24 MARCH 2021

MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON WEDNESDAY 24 MARCH 2021 AT 1400 HOURS ON-LINE

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Andy Cave, Chief Executive, Healthwatch Birmingham
Chief Superintendent Stephen Graham, West Midlands Police
Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Councillor Brigid Jones, Deputy Leader of Birmingham City Council;
Councillor Paul Tilsley
Dr Justin Varney, Director of Public Health
Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the LCOEB

ALSO PRESENT:-

Richard Burden, Chair, Healthwatch Birmingham
Gary James, Operations Manager, Environmental Health
Sharne Maher, BVSC
Julia Dule-Macrae,
Daragh Fahey, Assistant Director, PIP
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

137 The Chair advised, and the Committee noted, that this meeting would be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

APOLOGIES

138 Apologies for absence was submitted on behalf of Mark Croxford (but Gary James as substitute); Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs; Elizabeth Griffiths, Assistant Director of Public Health and Stephen Raybould, Programmes Director, Ageing Better, BVSC (but Sharne Maher as substitute)

DECLARATIONS OF INTERESTS

139 The Chair reminded Members that they must declare all relevant pecuniary and non-pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the Minutes of the meeting.

WELCOME AND INTRODUCTIONS

140 The Chair welcomed everyone to the Local Covid Outbreak Engagement Board meeting.

MINUTES

141 **RESOLVED:-**

The Minutes of the meeting held on 24 February 2021, having been previously circulated, were confirmed by the Chair.

REVIEW OF LOCAL OUTBREAK MANAGEMENT PLAN

142 Dr Justin Varney, Director of Public Health introduced the item and advised that the Department of Health had requested that the Local Outbreak Management Plan be updated. He added that this was a rapid piece of work to meet the Department's timeline. Dr Varney then drew the attention of the Board to the information contained in the slide presentations.

(See document No. 1)

The Chair commented that as part of the presentation this had been truly an extraordinary year and expressed thanks and appreciation to everyone who had been working to get us through this pandemic over the last 12 months.

The Board noted the presentation and agreed to endorsed the Local Outbreak Management Plan.

COVID-19 SITUATION UPDATE

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

(See document No. 2)

Councillor Tilsley referred to the *Top Ten Case Rates by Ward* on page 6 of the slide presentation and commented that the statistics were of concern particularly with Shard End and Garretts Green which had seen a spike. Councillor Tilsley added that his own statistics over the past fortnight in Sheldon had remained the same, but there was a meeting point – the Radley's Shopping Centre. As Dr Varney would be aware, we had a number of comments from the mail out that he did on a weekly basis as a Covid Marshall and as a result of that the Covid Marshalls visited the Radley's Shopping Centre on Monday and gave him a detailed report which he will share with the Chair outside the meeting. Councillor Tilsley reiterated his concern that he had seen doubling the statistics of cases in Garretts Green seeing it was a small Ward.

The Chair commented that the figures were worrying for this part of Birmingham and what was not seen in the statistics were the numbers for north Solihull.

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

I. It was a reminder to everyone who was watching that these numbers could go up. The way this virus spreads was through people not following the rules – hands, face, space.
II. There were concerns that there were case rate rises in north Solihull and that the intelligence Public Health had from that was that there had been cases where families had stayed overnight, particularly children staying overnight outside of their childcare bubble which had led to transmission.
III. What Public Health was seeing in east Birmingham was a slightly different picture from north Solihull in that the case rate had been rising more in the 20 – 35 year olds rather than in children per se, whereas in north Solihull they had a rapid increase in primary school children.
IV. Some of this was about families and some was also about social interaction outside of the house and between households.
V. It was an important reminder that people needed to follow those recommendations and guidelines. If we could not get these numbers under control, we may have to do more enforcement and a much tighter regime in specific parts of the city to try and get things under control which would be unfortunate.
VI. The ask was for everyone in these parts of the city to take this as a warning. We had seen how areas like Alum Rock, Aston and Lozells had taken the challenge and agreed that as a community they needed to own this and respond to it.
VII. Public Health will be doing more work over the days and coming weeks particularly in Shard End to pick this up and address this and to see what

more could be done to support local communities to own this challenge and take control of the situation.

Dr Varney then continued the slide presentation.

The Chair commented that it was good news that case rates were coming down particularly in the over 60s age group. The Chair added that we could not afford to drop our guards as we were not through this yet and we needed to continue to encourage people to come forward and take the vaccination as this was ultimately the way out of the situation.

Councillor Brigid Jones, Deputy Leader reiterated that in relation to the vaccine it was fantastic news that approximately half of the adult population had received the first dose of the Covid vaccine, but half of us had not yet received the first dose and may still be waiting months for it. Councillor Jones added that she had noticed that people were starting to relax more recently and feeling that they could break the rule a bit because they had a jab. Councillor Jones reminded everyone that we could not break the rules as we were still not immune if we had the jab and if we had both doses, we were still not immune from catching Covid. The people around us were probably had less immunity that us if we had one or no jabs. That everyone should get the message that half the adult population plus the children had not had the vaccination and were still vulnerable to this disease and it was no time for us to be letting our guard down.

That the Board noted the presentations.

VACCINATION ROLLOUT AND UPTAKE

144 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG and Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG presented the item.

Mr Jennings then drew the attention of the Board to the information in the slide presentation.

(See document No. 3)

Dr Aslam then highlighted a couple of things that were in the news last week that:-

a. There were problems with some of the vaccine and there were media interest in the AstraZeneca vaccine around clots.
b. A report from the United States of America had this week stated that of 32,000 patients showed that the AstraZeneca vaccine was 100% effective at reducing hospitalisation and severe illness. 79% effective at reducing symptomatic illness. It was a good vaccine.
c. In the study of the 32,000 patients they did not find any or an increased risk of clots in any of those patients. This was a safe vaccine and based on the evidence it was better than the other vaccines. If you wanted a vaccine, we had lots of it, it was available so take the vaccine.

d. The AstraZeneca vaccine was good for you and it came with the NHS approval and had been approved by a variety of regulators around the world. We did have some issues with people booking but not wanting to have the AstraZeneca vaccine and it was hoped that this evidence now would help them to make a decision as the vaccine will save lives.
e. In the Black Country and West Birmingham we now had a programme to vaccinate multigenerational households. So households that had any patients or any people that were in cohorts 1-9 could get vaccinated. This did not just apply to one house it applied to bubbles of people.
f. We had a conversation with the Bangladeshi community who had highlighted some areas where they were concerned about the access to vaccination. They had coordinated themselves to have some questions at the CCG. They had set up a Call centre and had 400 people booked in themselves to come and have the AstraZeneca vaccine.
g. They had given us the Bangladeshi Centre on Victoria Road in Lozells and they started their vaccination centre today. They had raised the issue with us 10 days ago and today they had vaccinated 100 people. It was phenomenal that we were able to be as flexible as we needed to, to meet the needs of our communities.
h. A lot of those people were called by their GPs to ask if they wanted the vaccination and had refused/declined and when they had conversations with their own community, they realised that they were converted. It was a trusted source of information which was important as was highlighted by Dr Varney earlier.
i. The Bangladeshi Centre today, next week we will do Lozells Methodist Church and will target the African and Caribbean community which also had an uptake that was slightly challenged and the Nishkam Pharmacy that was delivering vaccinations from Soho Road.
j. There were a variety of options – the mass vaccination sites and the pharmacies could be booked if you booked through the national vaccination service by ringing 111 and the GPS could book you into the local vaccination sites as well.
k. There was capacity and there was sit in the Black Country and West Birmingham 100,000 people that fits into the cohorts we would like to vaccinate some of whom were difficult to convert from not wanting a vaccine, but we think that a significant proportion of them do want the vaccine.
l. If you do want the vaccine it is our responsibility to ensure that access was not difficult for you and we would ensure that we do all we could to support that.

m. In terms of care homes the vaccine had made a great deal of difference as we only had 2 Covid outbreaks across the Black Country and West Birmingham now bearing in mind that number was close to 100 earlier in the year. It was making a difference, it was saving lives, and the vaccination programme was the right thing to do.

The Chair commented that he had spoken to someone two Fridays ago who had Covid-19 last summer who had described to him what he went through when he had the virus which was truly awful. The Chair stated that he would not like to go through anything like that and as stated earlier he had had the AstraZeneca vaccine and was grateful to the NHS for that and was looking

forward to getting the second dose in due course. Even though there had been stories in the press, what was known beyond and above that was that vaccines worked and do save lives and this was a vaccine that worked and will save lives.

Richard Burden, Chair, Healthwatch, Birmingham raised the issue of vaccination websites and that both the Black Country and West Birmingham and Birmingham and Solihull both of which had really useful information for residents including local vaccination sites and hospital hubs. The problem was that residents were not necessarily know whether they were in Birmingham and Solihull CCG area or the Black Country and West Birmingham CCG area. The danger was if they go onto the site and quote the wrong one they would not necessarily see any information that applied to them. Mr Burden suggested that information for Birmingham be shared across both websites whether it be the Black Country and West Birmingham CCG area or whether it be the Birmingham and Solihull CCG area. If this was not possible for information to be shared on both that links be put on those websites for residents one to the other.

Mr Jennings advised that this could be done. Dr Aslam stated that if there was any confusion to book you vaccination, people could ring 119 who could book you into the appropriate vaccination site as they had access to pharmacies which they were expecting to roll out in larger numbers. The information on the website could be made consistent.

The Chair thanked Mr Jennings and Dr Aslam for their presentation and requested that they take back the Board's thanks to the NHS for everything they had done over the last 12 months and were continuing to do to keep us all as safe as we could be.

The Board noted the vaccination rollout update.

ENFORCEMENT UPDATE

Gary James, Operations Manager (H&S Lead), Environmental Health, Neighbourhoods and Chief Superintendent Stephen Graham, West Midlands Police presented the item. Mr James drew the Board's attention to the information contained in the slide presentation on *Covid Marshall and Enforcement Update*.

(See document No. 4)

The Chair commented that as the restrictions were eased and we go through the roadmap out of the lockdown the Regulations around *hands face space* were going to remain in place so we will need to continue to follow that guidance as we come out of the lockdown.

Chief Superintendent Graham then drew the attention of the Board to the information contained in the report on *Enforcement and Associated Activities Around Coronavirus* with particular emphasis on the information on pages 257 - 258 of the Agenda Pack.

(See document No. 5)

The Chair referred to the demonstrations and gatherings that were unlawful and commented that the West Midlands Police reaction to the gatherings that took place in Victoria Square on the 13th March 2021 was exemplary as it was a low key approach. He added that it was the correct approach and we did not experience the kind of problems that was witnessed in London and what was seen in Bristol.

145 **RESOLVED: -**

That the Board noted the reports.

PUBLIC QUESTIONS SUBMITTED IN ADVANCE

146 The Chair introduced the item and advised that there was no questions from the public for this meeting.

TEST AND TRACE BUDGET OVERVIEW

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

(See document No. 6)

Dr Varney stated that each time Public Health did the budget report, usually about two days before it was completed, we suddenly got told that the Government was giving us some more money. As a result, we had a sizeable unallocated budget. However this had been useful and prudent as it allowed us to have certainty that we could resourced the capacity to deliver the Local Outbreak Management Plan (LOMP) over 2020/21 and 2021/22 for the duration of the financial year. This had also provided some certainty both to the specialist Public Health capacity we had created and also to the additional enforcement capacity that colleagues from Environmental Health took us through. We were reprofiling the budget for that £20m to allow us to be confident that we could support the totality of the 2021/22 financial year and be robust in our continued response to Covid-19.

Dr Varney then drew out the rational as to the reason there was a large unallocated sum and that the significant underspend of the budget was due to several things happening:

- The Government decided to fund us for asymptomatic testing at a value of approximately £14 per test. They then modified that to take into account all reasonable cost.
- The budget we had created was no longer needed and therefore could be repurposed for the on-going test and trace response. Public Health were successful in our bid to MHCLG to secure additional funding for community engagement. That was used to reduce the pressure on communications and engagement budget by £440K.

- We also received additional funding for Operation Eagle which we were not anticipating.

Dr Varney advised that the forward budget plan would be submitted at the next Board meeting for 2021/22 which will take into account all of the pressures for next year based on the full delivery of the LOMP. It was expected that the remainder would be allocated and the number would be reduced, but we will have a budget moving forward which would be retained as a contingency budget should the situation changed or accelerated. Throughout this year one of the challenges had been the uncertainty of the budget allocation for the local authorities for the response to Covid-19. We had been judicious in holding money back which was now standing us in good stead to ensure that we could have a robust response for 2021/22

147 **RESOLVED: -**

That the Board noted the report.

OTHER URGENT BUSINESS

148 No items of urgent business were raised.

DATE AND TIME OF NEXT MEETING

149 It was noted that the next Local Covid Outbreak Engagement Board meeting would be held on Wednesday 28 April 2021 at 1400 hours as an online meeting.

EXCLUSION OF THE PUBLIC

150 **RESOLVED: -**

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

Exempt Paragraph 3 of Schedule 12A.

Birmingham Health and Wellbeing Board

Draft Forward Work Programme

April 2020-21

Board Members:

Councillor Paulette Hamilton (Board Chair)	Cabinet member for Adult Social Care and Health	Birmingham City Council
William Taylor (Vice Chair)	Chair	NHS Birmingham and Solihull CCG
Councillor Kate Booth	Cabinet Member for Children's Wellbeing	Birmingham City Council
Councillor Matt Bennett	Opposition Spokesperson on Health and Social Care	Birmingham City Council
Dr Justin Varney	Director of Public Health	Birmingham City Council
Louise Collett	Interim Director for Adult Social Care and Health Directorate	Birmingham City Council
Tbc	Director of Education and Skills	Birmingham City Council
Paul Jennings	Chief Executive	NHS Birmingham and Solihull Clinical Commissioning Group
Paul Maubach	Chair, Sandwell and West Birmingham CCG.	Sandwell and West Birmingham CCG.
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Children's Trust
Dr Robin Miller	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham Education Sector
Chief Superintendent Stephen Graham	Chief Superintendent	West Midlands Police

Gaynor Smith	Senior and Employer Partnership Leader	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust.	Birmingham Social Housing Partnership
Doug Simkiss	Medical Director and Deputy Chief Executive of Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Mark Garrick		University Hospitals Birmingham NHS Foundation Trust
Co – optees		
Carly Jones	Chief Executive of SIFA FIRESIDE.	SIFA FIRESIDE
Waheed Saleem	Executive Director Strategic Partnership.	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

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Schedule of work April 2020-21

Formal Meeting		Presentation Items	
17th March 2020 CANCELLED Replaced with 23 April – BAME Covid update meeting Venue : Rooms 3 & 4, Council House – 3pm -5pm Peter Ingham to Chair	Draft Report Deadline for Pre- agenda : 19th February 2020 Pre – agenda meeting : 24th February 2020 Final Report Deadline: 5th March 2020 Agenda and Reports Dispatch Date: 6th March 2020	Better Care Fund 2019/20 Plan Creating a Mentally Healthy City Forum Update JSNA Core Data Set – Children and Young People Chapter Pre-Conception Conversation Birmingham Forward Steps / Early Years Contract Families in Temporary Accommodation East Birmingham Corridor Consultation Triple Zero Coronavirus Update **Information Items** Health and Wellbeing Board Fora updates Sustainability and Transformation Plan Update Delayed Transfers of Care workshop Feedback **Private Items** Director of Public Health Annual Report JSNA Core Data Set – Working Age Adults Chapter	Mike Walsh Elizabeth Griffiths Ralph Smith Marion Gibbon Richard Kirby Saba Rai Mark Gamble Chris Baggott Justin Varney Justin Varney Ralph Smith

Development Day 28th April 2020 Venue: TBC CANCELLED due to covid response	Draft Report Deadline for Pre- agenda : 1th April 2020 Pre – agenda meeting : 6th April 2020 Final Report Deadline: 16th March 2020 Agenda and Reports Dispatch Date: 17th March 2020	TBC	TBC

Formal Meeting		**Presentation Items**	
July 2020	Draft Report Deadline for Pre- agenda: 1st July 2020	Appointment and Terms of Reference	TBC
		Social Prescribing	Pip Mayo
	Pre – agenda meeting: 8th July 2020	Birmingham Community Safety Partnership Consultation	Amelia Murray
		Creating an Active City Forum Update	Kyle Stott
	Final Report Deadline: 14th July 2020	JSNA Core Data Set – Working Age Adults Chapter	Ralph Smith
	Agenda and Reports Dispatch Date: 15th July 2020	JSNA Core Data Set – Needs of Older People Chapter	Ralph Smith
		JSNA Core Data Set – Wider Determinants Chapter	Ralph Smith
		JSNA Deep Dives – H&WB of Armed Forces Veterans in Birmingham(TBC)	Susan Lowe
		JSNA Deep Dives – Death and Dying in Birmingham (TBC)	Susan Lowe
		JSNA Deep Dive – H&WB of Public Sector Workforce in Birmingham (TBC)	Susan Lowe
		JSNA Deep Dive – Diversity and Inclusion (TBC)	Susan Lowe
		Information Items	
		Health and Wellbeing Board Fora updates	TBC
		Sustainability and Transformation Plan Update	Paul Jennings
		Healthwatch Birmingham Annual Report	Andy Cave

Formal Meeting September 2020	Draft Report Deadline for Pre- agenda: 26th August 2020 Pre – agenda meeting: 2nd September 2020 Final Report Deadline: 11th September 2020 Agenda and Reports Dispatch Date: 12th September 2020	**Presentation Items** Chairs update COVID position statement LOCEB – written update Flu Plan update 30 mins – Bsol Screening, Imms Commissioned services **Information Items** BCF Health and Wellbeing Board Fora updates	 Justin Varney Elizabeth Griffiths Rachel O'Connor (BSol CCG) PHE/NHS England BCC Michael Walsh Stacey Gunther

Formal Meeting November 2020	Draft Report Deadline for Pre- agenda: 28th October 2020 Pre – agenda meeting: 4th November 2020 Final Report Deadline: 13th November 2020 Agenda and Reports Dispatch Date: 16th November 2020	**Presentation Items** Chairs Update Childhood immunisations and vaccinations Impact of Covid on vulnerable adults Children's Social Care **Information Items** HWB Forward Plan Local COVID Outbreak Engagement Board Health and Wellbeing Board Fora updates Sustainability and Transformation Plan Update	 Ash Banerjee/Andrew Dalton PHE John Williams BCC ASC Andy Couldrick Birmingham Children's Trust Stacey Gunther Elizabeth Griffiths Stacey Gunther Paul Jennings

Formal Meeting		**Presentation Items**	
January 2021	Draft Report Deadline for Pre- agenda: 23rd December 2020 Pre – agenda meeting: 4th January 2020 Final Report Deadline: 8th January 2021 Agenda and Reports Dispatch Date: 11th January 2021	Chairs Update BLACHIR -Birmingham Food strategy/food conversation -Food poverty -International Partnerships update Childhood obesity trail blazer data/update -Sustainable food partnerships JSNA Adult Chapter Public Health Annual Report Developer Toolkit **Information Items** HWB forward plan Local COVID Outbreak Engagement board Health and Wellbeing Board Fora updates	Justin Paul Campbell Ralph Smith Justin Varney Kyle Stott Stacey Gunther Elizabeth Griffiths Stacey Gunther

Formal Meeting March 2021		**Presentation Items** Social Prescribing Birmingham Integrated Care Partnership Better Care Fund Creating a Mentally Healthy City Forum Update Suicide prevention strategy Waiting Room Cultural update Employee wellness JSNA Older Adults Public Health Annual Report **Information Items** HWB forward plan Local COVID Outbreak Engagement board Health and Wellbeing Board Fora updates	 Rachel O'Conner BSol/Pip Mayo West Birmingham Graeme Betts, Director, Adult Social Care Sarah Feeley Commissioning Manager – Strategy and Integration Mo Phillips Ralph Smith Justin Varney Stacey Gunther Elizabeth Griffiths Stacey Gunther
Development Day April 2021		Health and Wellbeing Board Priorities – Review and Refresh	TBC

Formal Meeting May 2021		**Presentation Items** Chairs Update Coronavirus-19 position statement and vaccine update Discussion meeting: Integration and innovation: Working together to improve health and social care for all Social Prescribing Creating a Healthier City Strategy	 Justin Varney/Paul Jennings Justin Varney

Standard Agenda

1. Notice of Recording
2. Notice of Potential for Public Exclusions
3. Declaration of Interests
4. Apologies
5. Minutes and Matters Arising
6. Action Log
7. Chair's Update
8. Public Questions
9. Presentation Items (see detail above)
10. Information Items (see detail above)
11. Forward Plan Review
12. Finalise Agenda for next Meeting
13. Date, Time and Venue of next Meeting
14. Notice of Recording Ceased
15. Private Items (see detail above)

Notes

Any agenda change request must form part of prior HWBB information item with as much lead in as possible but no later than the HWBB immediately prior to the agenda change request, including requests from sub-groups (see below).

Health Inequality Focus and Childhood Obesity Focus agenda presentations can be several items if appropriate but all must include decision(s) and / or action(s) for the Board.

Health and Wellbeing Board Fora will provide a written update to each Board meeting; each will have an annual formal presentation to the Board on a rotational basis.

Any decisions and actions shall be subject to providing an update to the Board on the substantive outcomes, either via presentation or information item as deemed appropriate by the Board, at a future date to be agreed as part of said decision or action.

Supporting Documents Requiring Development

Agenda change request form
Report draft template
Report final template
Action / Decision request form
Action / Decision update report template

Birmingham Health and Wellbeing Board

	Agenda Item: 16
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19 May 2021**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham City Council**
Presenting Officer	**Stacey Gunther, Service Lead, Public Health**

Report Type:	**Information**

1. Purpose:

1.1 This update report details recent, current and future work related to:

- Creating a Healthy Food City
- Creating a Physically Active City Forum
- Creating a Healthy Food City Forum
- Creating a City Without Inequalities Forum
- Health Protection Forum Update

1.2 Sub forum meetings, excluding the Health Protection Forum, were initially paused as the Public Health Division diverted resource to support Covid-19 response. Forums are currently working online with partners or holding meetings online via Teams to move Covid-19 related items forward. Forum meetings are scheduled to restart during May and June 2021.

2. Implications:

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

3.	Recommendation
3.1	It is recommended that the board note the contents of the report.

4.	Report Body
4.1	The Birmingham Health and Wellbeing Board has five thematic forums. The forums oversee the development and delivery of shared action to drive city-wide improvement. The forums are: Creating a Mentally Healthy City, Creating a Healthy Food City, Creating an Active City, Creating a City Without Inequality, and the Health Protection Forum.
4.2	All forums are providing written updates for the May 2021 Board meeting. Following the May meeting, forums will continue to present on a rota basis, with each theme presenting at least annually.
4.3	This report is formed of 5 written updates. Further detail specific to each Forum can be found in **Appendices 1-5**.

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	Regular updates will be reported to the Health and Wellbeing Board via a joint update report in this format, with each forum providing a presentation item rather than an information item update at least annually.
5.1.2	Action logs of the forums shall be recorded and reviewed at every forum to ensure actions are delivered.

5.2	Management Responsibility
Stacey Gunther, Service Lead, Public Health Mo Phillips, Service Lead, Public Health Paul Campbell, Service Lead, Public Health Kyle Stott, Service Lead, Public Health Frances Mason, Service Lead, Public Health Chris Baggott, Service Lead, Public Health Elizabeth Griffiths, Acting Assistant Director, Public Health Dr Justin Varney, Director of Public Health	

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Partners not delivering on the assigned actions required to enable the forums work.	Medium	Medium	Robust monitoring and regular update reports via the relevant forum

Appendices
Appendix 1 - Creating a Physically Active City Forum Appendix 2 - Creating a Healthy Food City Forum Appendix 3 – Creating a City Without Inequalities Forum Appendix 4 – Creating a Mentally Healthy City Forum Appendix 5 – Health Protection Forum

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

Stacey Gunther, Service Lead, Public Health
Mo Phillips, Service Lead, Public Health
Paul Campbell, Service Lead, Public Health
Chris Baggot, Service Lead, Public Health
Kyle Stott, Service Lead, Public Health
Frances Mason, Service Lead, Public Health
Elizabeth Griffiths, Assistant Director, Public Health

Birmingham Health and Wellbeing Board

Appendix 1 – Creating A Physically Active City (CPAC) Forum Highlight Report

1.1 Context

The CPAC met on Wednesday 21st April and continues to meet as scheduled throughout the disruption caused by COVID-19. The CPAC focus for this meeting contained two main agenda items, the first being a focus on developing an action plan for the CPAC in line with the Health and Wellbeing Board targets and the objectives embedded into the CPAC terms of reference, this was led by Public Health. The 2nd main item was an update on progress to date with the Commonwealth Games Active Communities (CAC) Sport England (SE) bid, this is being led by Sport Birmingham.

1.2 Current Circumstance

The forum received updates on:

1. Progress and next steps for the development of a CPAC action plan.
2. Progress and next steps for submission of the CAC SE bid.
3. Green and Blue Space mapping update.
4. Earth Stories, update and call to action.
5. A verbal introduction to Healthy Happy Holidays.
6. A verbal introduction to disability and physical activity opportunities.
7. An introduction to obesity funding mapping.

The chair has requested that a final action plan is completed that sets out the priorities of the forum and contains identified areas of action to address these priorities. A further request is that the action plan is complete on or before the 16th June, including adoption, and is brought to the 16th June CPAC meeting for note.

The chair noted the status and progress of the CAC bid and has asked to be kept informed of the outcome of the bid; Sport England have indicated that applicants can expect to hear the outcome w/c 17th May 2021.

A task and finish group has been agreed to develop the action plan, and an action plan development workshop is being planned and will take place at some point in May, the date of adoption for the action plan is on or before the 16th June 2021, this is the next scheduled meeting of the CPAC. There was a specific request from the Chair of the CPAC (Cllr Zaffar) that Active Travel is a strong objective within the plan. Other areas of the plan being scoped out include tackling inequalities with reference to physical activity, and exploring equality and diversity, in the first instance with a focus on people with disabilities.

Mike Chamberlain CEO of Sport Birmingham provided an in-depth update on the progress of the CAC SE bid, the headlines include:

- At this stage, an expression of interest form (EOI) was due for submission to Sport England on or before 5pm, 14th April 2021. I can confirm that the submission was successfully submitted.

- The title of the approach is “Uniting Birmingham’s Communities”, the aspiration is for a city and region where physical activity is the norm, where inequalities around physical activity are reduced, where systems are changed to remove barriers and where sport and physical activity is accessible and integrated within daily life, it also recognises the impact of COVID-19 on communities and the impact that this has had on inequalities.

- The delivery areas/locations for activity are based upon excellent intelligence, data, insight, and mapping from several key organisations across the city, including Public Health, TAWS, and Sport England. This is also taking into consideration LDP learning too, although places are not ultimately defined at this stage, there is clear commitment to build on the LDP and other place-based interventions.

- A successful bid is reliant on transformational change in the context of physical activity, the bid focuses on removing and reducing barriers to physical activity, and promoting resilience, this is underpinned by; working in a whole-system/system leadership way; distributive leadership, doing ‘with’, not ‘to’, communities; working with unusual suspects as well as more traditional groups; co-creating resilient communities.

- From a people perspective, the bid will focus on the inactive / least active; those disproportionately affected by COVID; children, Young People and Families; those from an ethnically diverse background; those with LTHC and/or Disability; those in the lowest socio-economic groups / those poorest.

- From a “spaces” perspective, the bid focuses not just on built facilities, but will include parks, routes (transport and leisure/recreation), urban routes, and blue and green space, there will be a focus on inclusivity and accessibility, it is acknowledged that there is a special opportunity to exploit blue and green space, especially pockets of unused space within communities. Wayfinding and active-travel routes can also be improved to make them year-round routes and not just CWG travel corridors.

- From a leverage perspective, the bid will utilise opportunities such as the LDP pilot investment, the tackling inequality fund, the violence reduction unit, the PCC and other national partners. The future Parks Accelerator and social prescribing investment and capacity will also be considered.

- The lead named organisation for the submission is Sport Birmingham. Other leaders and organisations supporting the bid are: BCC (Public Health) (CWG Unit) (Neighbourhoods and Wellbeing Service), TAWS, Active Communities (LDP Pilot), Canals and River Trust, Activity Alliance/WMCA.

- Collaboration is through CPAC members, the CWG PAWLG and Sport Birmingham “Birmingham Community Sport and Physical Activity Alliance”.

- We expect to hear the outcome of the EOI w/c 17th May 2021.

1.3 Next Steps and Delivery

- To hold a meeting of the action plan task and finish group.
- To hold a wider CPAC workshop to assist with developing the action plan.
- To produce and adopt a CPAC action plan on or before the 16th June 2021.
- To monitor the progress of the CAC SE bid and to respond to next steps in May 2021.
- For CPAC members to sign up to “Include Me West Midlands”, a regional approach to making the West Midlands an exemplar region for engaging disabled people and people with long term health conditions to be physically active.
- For CPAC members to liaise with the Director of the Future Parks Accelerator programme to produce their own Earth Stories.

Birmingham Health and Wellbeing Board

Appendix 2 – Creating a Healthy Food City Forum Highlight Report

1.1 Context

The main purpose of the Forum is to work together to apply a whole system approach to understanding the food landscape of the city and improving the food behaviours at a population level across Birmingham by ensuring that a joint action plan is developed and delivered.

The forum last met 05 May 2021. Due to timing of the Forum and Board governance this report focuses on activity that does not include the discussion of the most recent Forum.

1.2 Current Circumstance

1.2.1 Food Strategy

During late 2019 and early 2020 there were multiple rounds of consultation with partners on the Birmingham Food Strategy, with the intention of public consultation shortly thereafter. The COVID-19 response placed these conversations and the strategy itself on hold.

As part of the Forum held 14 January 2021 there was a call for volunteers to support the development of the Food Strategy into a robust, shared document that all partners can subscribe to. Several organisations present are willing to contribute, and a task and finish group was established to develop the draft.

The group met on 15 March 2021 and following this a briefing note was submitted to the Cabinet Member for Health and Wellbeing to detail the suggested revisions and reframing of the document through the lens of the Rome Declaration. The document is being revised and the intention is to consult in quarter three of 2021/22.

1.2.2 Emergency Food Plan

There have been some preliminary discussions on creating an Emergency Food Plan as an interim measure during the ongoing COVID-19 response to ensure that parts of the Birmingham Food Strategy that have been placed on hold, but would be of assistance to the response, can be strategically shaped and implemented.

A workshop was convened for 19 February 2021 with invitations extended to members of the Health and Wellbeing Board, the Creating a Healthy Food City Forum, the Food Justice Network, and the Food Poverty Core Group.

The information collated was incorporated into the plan and shared. Subsequently some of the new actions identified now have potential lead organisations and conversations will continue to develop and implement the plan as a live document.

1.2.3 Birmingham Food Conversation

The Birmingham Food Conversation consisted of two substantial pieces of

primary data collection.

Firstly, the **Birmingham Food Survey**; although this was cut short to prevent the bias inherent on continuing the survey during the COVID-19 response there were 394 responses received and results highlights were provided to the previous Health and Wellbeing Board. We are using the the findings of this report to frame and inform partnership work on the food systems approach to multiple strands of work. Most recently selected extracts were presented to national partners as part of COTP framing, and international partners as part of Emergency Food Plan conversations.

Secondly, thirty-one different organisations were commissioned to deliver **'Seldom Heard Food Voices' research**. The groups were facilitated by community research consultants, employees of organisations serving the needs of specific target groups, and occasionally a combination of organisations matching research expertise with organisational reach. All organisations reported details of scripts and resources used as well as the structure focus group. All groups covered the questions highlighted in the tender specification. The facilitators delivered these questions in a range of ways, adapting them where appropriate for the groups they were working with. We have completed draft version of the final report, and are in the governance process around the consensus opinions on what is required to create a healthy city (as well as some unexpected and unsolicited comments on how to engage better as part of future consultation processes) and how these can be best taken forward.

1.2.4 Food Poverty

In November 2020 Birmingham City Council re-established the Food Poverty Core Group to better understand the systems level responses we can put in place across the local systems in Birmingham to ensure a robust and coordinated response to the various issues around food poverty. The three themes we need to focus on;

1) prevention of people going into food poverty.
2) crisis management – how do we get them out of it.
3) recovery – moving forward, long term impact.

A rapid evidence review will be completed on each theme for action / discussion by the group.

The April 2021 meeting focused on crisis management although the minutes are not yet available so an update on this will be provided to the next Board.

1.2.5 International Partnerships

The **Food Foundation Partnership** contract assists with implementation of national and international food policies and guidelines, and specialist advice, support and management of Birmingham's international relationships. We are now over a quarter of the way through the four-year contract and the benefits have already been notable.

The partners have been in ongoing conversations to discuss key project

deliverables by quarter over the life of the contract, and a draft delivery plan has been drafted.

Birmingham has been successful in securing membership of the steering committee for the next two years for the **Milan Urban Food Policy Pact**. This makes Birmingham unique as the only UK member of the steering committee, and one of only three European cities. On 14 April 2021 the newly elected Steering Committee virtually met for its first meeting. We look forward continuing our joint work in making our community stronger and contributing to shape a new, global role of cities, which today stand out as front-runners for sustainable development.

There has been agreement in principle that the **Delice network** will refocus from gastronomy to policy levers and as a result of this that lead organisation status for Birmingham will pass to Birmingham City Council. The DPH decision notice to formalise this has been approved by the Director of Public Health and Delice contacted via Food Foundation to formalise arrangements.

Commonwealth Cities 2022 launch took place on 27 January 2021 and the initial conversation focused on the announcement of the plans to convene a meeting of the cities in Birmingham to coincide with the Commonwealth Games in the city. We have secured backing from Department for Digital, Culture, Media & Sport and a full application will be submitted when they are able to be received.

1.2.6 Sustainable Food Places Application

The decision has been taken to not apply for Sustainable Food Places Award in the 2021 round of applications. A submission will be made in 2022 when the food strategy has been consulted on and embedded, meaning we are better placed to meet the full criteria. The lessons learnt from this process will be used to inform improvement to the food partnership work that will enable a future application to be successful.

1.2.7 Childhood Obesity Trailblazer Project

The Childhood Obesity Trailblazer is a national project to encourage Local Authorities to focus their efforts on becoming healthy food places. In Birmingham we have three workstreams to enable this ambition.

Workstream 1 - **Creating a health food planning and economic climate through creation and implementation of a developer toolkit.** The content of the toolkit is for the most part created, and we will shortly enter the design phase. The delivery been led by the Place Service Lead within the Wider Determinants Team of Public Health to enable better resource capacity to deliver, and to ensure that benefits of the toolkit are maximised by considering as many Public Health place based development outcomes as possible and also be complementary to a healthy food city environment. The developer toolkit has been well received and is now in the process of full public consultation.

Workstream 2 - Creating a better **understanding of food in the city through the Birmingham Basket**. Through initial market scoping we have identified at

least one supplier capable of delivering the required data, information and insight to understand how the people of Birmingham purchase food. However, we have decided a full competitive tender process should be utilised to ensure we commission the most innovative, and value for money solution. A final draft of the invitation to tender documents was submitted to the Director of Public Health and Assistant Director for Wider Determinants late April 2021.

Workstream 3 - **Creating a healthy apprenticeship workforce that understands health, healthy eating and can support a healthier food economy.** We are using our leverage through the corporate management team and health and wellbeing board to ensure that commissioning specifications for employment, skills and apprenticeships services for Birmingham City Council employees carry a health and wellbeing spiral curriculum. A spiral curriculum is an approach to education that involves regularly re-visiting the same educational topics over the course of a student's education. Each time the content is re-visited, the student gains deeper knowledge of the topic. Base line data collection commenced 12 October 2020 having agreed the evaluation process and methodology. Following a workshop with employment, skills and apprenticeship providers in October 2020, where we gauged interest of providers, the project delivery has been reframed. A final draft of the invitation to tender documents to allow for content creation for the curriculum was submitted to the Director of Public Health and Assistant Director for Wider Determinants late April 2021.

1.3 Next Steps and Delivery

- Continue to develop the **Food Strategy** and provide regular updates on progress with a view to consultation in Quarter three of 2021/22.
- Continue to shape, refine and deliver the content of the **Emergency Food Plan**, ensuring named leads against each action.
- Finalise governance on **Seldom Heard Voices** report and begin to implement findings.
- Rapid evidence review on next area of focus for the **Food Poverty Core Group**.

Birmingham Health and Wellbeing Board

Appendix 3 - Creating a City Without Inequalities Forum Highlight Report

1.1 Context

Due to the Public Health Division refocusing capacity to support the health protection response to Covid-19, on the 21st September future meetings of the forum were postponed. Communication with the forum continued in the interim via the LinkedIn group, with several projects continuing virtually.

1.2 Current Circumstance

The forum will restart with a refreshed approach which will be shared with members at the introductory meeting on 1st June 2021. The refreshed approach to the forum will embed the Marmot review '*Fair Society, Healthy Lives*' through a focus on the six policy areas for action, turning these into tangible and collaborative actions for our City, facilitating joined-up working across agencies and systems. These six priority objectives and areas of recommendations for reducing health inequalities will underpin each of the workshops and meetings of the forum alongside the Health and Wellbeing Boards' new strategy. The six priority objectives for reducing/mitigating inequalities are as follows:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

The Poverty Truth Commission contract has commenced, and the inequalities team are working with the provider Thrive Together Birmingham to initiate phase 1 of the project. We have set up an oversight group to develop and maintain a strategic approach to enable the Poverty Truth Commission to fulfil aspirations to become a rolling model of engagement between policy makers and citizens. A key part of this project is the engagement of 'City Leaders', the professional members of the commission, likely to be council officers. The process of engaging with these city leaders has commenced and colleagues from organisational development are supporting us with a strategy for optimal engagement with these officers. The project is projected to run until early 2023. The initial theme of exploration is lived experiences in relation to housing.

The BLACHIR project has also continued. The partnership project with Lewisham local authority has completed two pillars to date: Racism and Discrimination and Early Years and Pregnancy. The Children and Young

Person's theme (led by Lewisham) has completed both the academic board and advisory board and the recommendations are currently being shaped and defined by the Lewisham team. The current theme for Birmingham is 'Ageing Well' and the academic board meeting is scheduled for 12th May where recommendations will be developed following assessment of the evidence review.

1.3 Next Steps and Delivery

- Introductory meeting scheduled for 1st June 2021. Members have been invited to attend.
- The forum is working in collaboration with Birmingham Youth Service to ensure youth representation on the forum to provide an important voice from this group. The advertisement for the opportunity is in the process of being finalised and expected to be posted soon.
- BLACHIR ageing well academic board meeting 12th May.

Birmingham Health and Wellbeing Board

Appendix 4 - Creating a Mentally Healthy City Forum Highlight Report

1.1 Context

1.1.1 The Health and Wellbeing Board established the 'Creating a Mentally Heathy City Forum' (CMHC) to focus actions on improving mental health and wellbeing across the City. The emphasis is on upstream prevention and working co-productively so that we can create a city where everyone, at every age, and in every community can achieve their potential, lead fulfilled lives and prosper.

1.1.2 The aim of the CMHC is to work with strategic partners, stakeholders, Third and Voluntary sectors, Academics, Charities, Sporting organisations, and Faith Groups to improve mental health and wellbeing at the preventative stage.

This includes access to mental health services for the most vulnerable and disadvantaged groups through the programmes mentioned in the Joint Strategic Needs Assessment (JSNA), The Health and Wellbeing Strategy 'Creating a Healthy City', the actions in the Prevention Concordat and the Suicide Prevention Strategy. We work holistically with our Public Health colleagues from the other Health and Wellbeing Board Fora: Creating a City without Inequality; Creating a Healthy Food City; Creating a Physically Active City; and Health Protection on bridging the inequality and mental health gap. This provides us with a joint approach to tackling mental health and inequality and helps us to pool resources, share and build knowledge and insight, so we can realise our vision of addressing inequality and supporting vulnerable citizens back to a path of good mental health and wellbeing.

1.1.3 We are currently in a pre-election period and aim to resume scheduled meetings on 17 June 2021 subject to agreement from the Chair of the Forum. These were disrupted by the COVID-19 pandemic along with other public health work at population level.

1.1.4 A Wellbeing Cell was created to take on messages and guidance to the public on health and wellbeing, including mental health and suicide prevention. We carried out three surveys: a) YouGov survey to find out the state of people's health and wellbeing due to the pandemic and lockdown; b) Covid-19 Health and Wellbeing Impact Survey carried out after three months in which there were 3095 participants; c) a service mapping survey to establish what mental health and suicide prevention services were available to local people through the life course. Also, with the help of industry experts at both local and national level we were able to deliver a series of webinars on good mental health and wellbeing, suicide prevention, long-term health conditions and addiction. These webinars were delivered to professionals and community workers who were able to disseminate good practice to citizens. Additional information from partners and messages on good mental health and wellbeing were posted on the Creating a Mentally Healthy City LinkedIn site.

1.1.5 Full Council ratified The Birmingham Suicide Prevention Strategy which sets out a series of key priorities bringing together partners knowledge about groups at higher risk of suicide; applying evidence through effective interventions and recognising the autonomy of local organisations to decide what will work best in Birmingham with its ambition for zero suicides.

This work programme, too, has been disrupted by Covid and a refresh of the Strategy and Action Plan will be undertaken at the next meeting which is scheduled for 27 May 2021 between 10am and 12pm.

The Suicide Prevention Data Sharing Agreement has been tentatively agreed pending the appointment of a Real Time Surveillance System (RTSS) Coordinator funding for which the newly appointed Project Manager is working on securing. The Data sharing Agreement is still with our legal team for the Real Time Surveillance System Pilot. A meeting took place with the coroner on 6th April to discuss the benefits of Birmingham and Solihull having a Real Time Surveillance System (RTSS) in place and supporting evidence of how the RTSS system currently works in Leicestershire as a best-practice example has been sent to the coroner along with a Job Description that has been used in recruiting an RTSS Coordinator in South Yorkshire and Bassetlaw.

We will soon be launching the free 20-minute suicide prevention training, entitled 'Zero Suicide: Basic Awareness', from the Zero Suicide Alliance which is being hosted on the TLDS Learning Pool website. We have been granted access to a Shareable Content Object Reference Model (SCORM) file from The Zero Suicide Alliance which will allow us to collate demographic details of who across Birmingham and Solihull will be accessing this awareness training and actively monitor the need for training across different sectors and communities of interest.

The training is simple, effective and easily accessible and in taking this training, anyone in Birmingham and Solihull will be able to log on to this platform anytime, from anywhere, using any device, to take the course and make a real difference to our Region.

1.2 Current Circumstance

1.2.1 It is recognised that the pandemic has posed a great threat to mental health and general wellbeing and the effects have been felt across the life course. The combination of the disease, and the resultant lockdown, has had major social and economic consequences on the population and has affected the mental health and wellbeing of children and young people, working age adults, and older people alike.

1.2.2 We are beginning to see a greater demand for support with mental health issues from our partners e.g. mental health Helplines across all age groups, digital platforms that offer support to children and young people, and people wanting to get more access to community assets. At the start of the pandemic, demand for mental health services dropped as people stayed away from GP surgeries, hospitals and support organisations. Now there is an increase with contacts from all communities and groups such as BAME

and LGBT. The dip has been followed by a surge in people seeking help; this shows no sign of abating.

1.2.3 In addition to the Health and Wellbeing Impact Survey and the Service mapping carried out, an ethnographic survey on the impact of the pandemic on local people was commissioned as insightful information to inform decisions on future work on mental health and wellbeing.

1.2.4 The BHealthy series of webinars intended mainly for professionals who had direct reach to communities through their trusted relationship with community leaders, social prescribing link workers, and faith leaders who could disseminate messages on improving the health and wellbeing of people they have daily contact with, were designed to improve their health and wellbeing. These were supported by experts in their field. These webinars can be viewed on the Healthy Brum YouTube channel.

They included behaviour changes, advice on how to handle long-term conditions, lifestyle changes e.g. smoking, alcohol, gambling, and advice on managing mental health and wellbeing issues.

There were two webinars specifically aimed at mental health and wellbeing: Getting Mind Ready and Sleep which can be found on the Healthy Brum YouTube channel. Together they have been viewed over a hundred times.

1.3.4 Inequalities within our communities have been highlighted further by Covid. The areas with the greatest Covid mortality and the highest rates of Covid infection – which often corresponds to areas of greatest deprivation are where we have particularly high rates of mental illness.

1.3.5 Loneliness and isolation are a cause for concern which was exacerbated due to almost a year of restrictions such as lockdown and social distancing measures, depriving people of elemental human contact.

A combination of the first lockdown, shielding for the most vulnerable, Care Home visit prohibition, self-isolating as a result of guidance messages as well as isolating due to Covid infection has spread fear for their own wellbeing and highlighted the social need for togetherness.

1.4 Next Steps and Delivery

1.4.4 To re-establish both the CMHC Forum and Suicide Prevention Advisory Group (SPAG) as soon as practicable after Purdah, in the most appropriate way, to progress in earnest discussions on moving forward post pandemic.

1.4.5 Review and fresh both the purpose, strategy and group membership of the CMHC Forum and SPAG to ensure both are pertinent post Covid-19.

1.4.6 We are currently developing action plans that aim to tackle the wider causes so we can aid recovery through joint work with our partners and stakeholders.

Options have been put forward which aim to prevent, and respond to, the different needs on services (both mental wellbeing and suicide prevention)

highlighting the need for alternative services and encourage co-production that will allow communities to come together.

Initial thoughts are that the plan would take a life course approach and include Neurodiversity and a Universal theme where the focus would be Bereavement services, LGBGT, BAME and Disability group. This will ensure mental wellness and inequalities in mental wellbeing are addressed.

1.4.7 To hold a workshop/focus group as soon as possible to put forward ideas, where partners and stakeholders can participate and agree actions that will add years to life and give hope of a better future to our most vulnerable citizens.

- To deliver on the actions at pace and ensure regular shared updates to Creating a Mentally Healthy City Forum and the Health and Wellbeing Board

- The CMHC Forum will oversee and support the development and delivery of the action plan / framework to deliver a measurable impact upon citizens in Birmingham and regularly brief the Health and Wellbeing Board on progress.

1.4.8 Birmingham is committed to becoming a City where everyone can enjoy good mental and physical health. A place where people can make positive choices and take personal control of their wellbeing and flourish to the best of their ability.

A collaborative and whole system approach is being taken to support every citizen to thrive, have a sense of self, hope, connection, and wellbeing.

Birmingham Health and Wellbeing Board

Appendix 5 – Health Protection Forum Highlight Report

1.1 Context

The Health Protection Forum (HPF) is currently meeting monthly to facilitate the transition from a majority focus on Covid-19 to the other 'business as usual' health protection areas of work. Covid is still being covered at the Forum, but more time will be allocated to screening, immunisation, emergency planning, communicable and non-communicable diseases.

1.2 Current Circumstance

The terms of reference (ToR) are currently being reviewed and updated to reflect changes in organisations, roles, governance and focus going forward for the HPF. Membership is also being updated and engaging the most appropriate representatives in the forum will form the focus in the short-term.

The standing agenda items remain the same as in the last update report and cover the following issues:

1. The HPF coronavirus discussions include:

    a. Current situation regarding case rates, test positivity rates, testing activity, cluster and outbreak summaries, ongoing plans and changes to Covid response processes, vaccination activity
    b. Review of activity related to different setting types (education, residential, clinical, workplaces and others)

2. Non-coronavirus discussions include:

    a. Challenging health protection cases (including TB, blood-borne viruses, and other communicable diseases or environmental hazards situations)
    b. Vaccination and screening programme uptake activity, delivery and plans (including flu, MMR and other childhood vaccinations)

1.3 Next Steps and Delivery

- The NHS seasonal flu programme that is commissioned by NHSE&I and delivered by GPs, pharmacies, hospitals and vaccination service providers has now ended the 2020/21 season and discussions will move to lessons learned and planning for the 2021/22 season. Planning is led by BSol STP (and includes the West Birmingham area) and uptake activity will be reported into the HPF.

- Delivery of the SARS-CoV2 (known as Covid) vaccination programme is ongoing and will report into the HPF. This is being led by the NHS.

- The Forum will also be seeking assurance on plans for catch-up child vaccination programmes and national screening programmes that have been impacted by the pandemic.

- Monitoring of Covid case/contact data, outbreaks, intelligence will continue and be used to inform the response.

- Case studies of recent incidents will be presented to the refreshed HPF membership to ensure that lessons learned are identified and inform future service delivery.

- Current situation reports for the different areas of health protection will be produced and these will inform the development of the work programme of the HPF for the next 12 months.