Members are reminded that they must declare all relevant pecuniary and non-pecuniary interests relating to any items of business to be discussed at this meeting

BIRMINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

TUESDAY, 31 JANUARY 2017 AT 15:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING**

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

2 **APOLOGIES**

3 **DECLARATIONS OF INTERESTS**

Members are reminded that they must declare all relevant pecuniary interests and non-pecuniary interests relating to any items of business to be discussed at this meeting. If a 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.

4 **MINUTES AND MATTERS ARISING**

3 - 12

To confirm the Minutes of the last meeting.

5 **CHAIR'S UPDATE**

To receive an update.
(1505-1510)

13 - 38

6 **AIR POLLLUTION AND HEALTH IN BIRMINGHAM**

To consider a report and recommendations on the threat posed to health and the local economy by poor air quality due to outdoor air pollution.
(1510-1530)

39 - 58

7 **HEALTH & WELLBEING STRATEGY**

To consider a report on the proposed priorities for a refreshed Health and Wellbeing Strategy including other associated outcomes.
(1530-1550)

59 - 62

8 **BIRMINGHAM AND SOLIHULL SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE**

To note the report and consider what role this Board may wish to play in the new Improving Health and Wellbeing programme.
(1550-1610)

63 - 74

9 **WEST MIDLANDS MENTAL HEALTH COMMISSION BRIEFING PAPER**

To consider the West Midlands Mental Health Commission's work and its key initiatives.
(1610-1630)

10 **OTHER URGENT BUSINESS**

NB: Only items of business by reason of special circumstances (which are to be specified) that in the opinion of the Chair of the meeting are matters of urgency may be considered.

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD 29 NOVEMBER 2016

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY 29 NOVEMBER 2016 AT 1500 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Paulette Hamilton in the Chair; Andy Cave, Dr Aqil Chaudary, Councillor Lyn Collin, Dr Andrew Coward, Jonathan Driffill, Cath Gilliver, Peter Hay, Councillor Brigid Jones, Chief Superintendent Richard Moore, Dr Gavin Ralston and Dr Adrian Phillips.

ALSO PRESENT:-

Paula Harding, Senior Service Manager, Violence Against Women, BCC
Sue Ibbotson, Director of Public Health England in the West Midlands
Chief Superintendent Chris Johnson, West Midlands Police
Dr Dennis Wilkes, Assistant Director of Public Health, BCC
Rob Willoughby, Area Director, The Children's Society
Paul Holden, Committee Services, BCC

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NOTICE OF RECORDING

169 It was noted that the meeting was being webcast for live or subsequent broadcast via the Council's Internet site (www.birminghamnewsroom.com) and that members of the press/ public may record and take photographs. The whole of the meeting would be filmed except where there were confidential or exempt items.

WELCOME AND APOLOGIES

170 Members introduced themselves and the Chair also congratulated Andy Williams, Accountable Officer, Sandwell and West Birmingham Clinical Commissioning Group (CCG) (who advised that he was attending in place of Professor Nick Harding) on a commendation that he had received for his work at the CCG. The meeting was also advised that an apology for absence had been received from Tracy Taylor.

At the request of the Chair, the Director of Public Health England in the West Midlands, Sue Ibbotson, also introduced herself to the Health and Wellbeing Board. The Director advised members that she was attending as an observer and wished to hear the conversations that were taking place at different Health and Wellbeing Boards.

DECLARATIONS OF INTERESTS

171 Members were reminded that they must declare all relevant pecuniary and non-pecuniary interests relating to any items of business to be discussed at this meeting. If a pecuniary interest was declared a Member must not speak or take part in that agenda item. Any declarations would be recorded in the minutes of the meeting.

In referring to item 9 on the agenda, Dr Andrew Coward declared a non-pecuniary interest as Chair of the Trustees of the Birmingham Freedom Project which was a domestic violence initiative based in Kings Heath.

Dr Gavin Ralston declared that he had taken-up a post two days a week on the GP Committee Executive in London.

MINUTES

Dr Andrew Coward in drawing attention to paragraph 6 of Minute No.167 highlighted that people who had four or more ACEs were 49 times more likely to have ever attempted suicide.

172 The Minutes of the Board meeting held on 27 September 2016 were, subject to the above amendment, confirmed and signed by the Chair.

CHAIR'S UPDATE

173 The Chair informed the meeting that Rhod Mitchell had been appointed as the Chair of the Birmingham and Solihull Health Commissioning Board, a body made up of the Birmingham CrossCity, Birmingham South Central and Solihull Clinical Commissioning Groups (CCGs). She reported that Rhod had therefore been invited to this Health and Wellbeing Board meeting but had been unable to attend. However, the Chair reported that she would soon be meeting with Rhod to discuss the Birmingham and Solihull Sustainability and Transformation Plan (STP) and its relationship to this Board.

Members were also advised that she'd met with both the Chair of the Solihull Health and Wellbeing Board and the Solihull Cabinet Member for Health and Wellbeing to discuss the Birmingham and Solihull STP. The Chair commented that a very constructive meeting was held and that there'd been agreement on many points. It was therefore hoped to build on this and collaborate more closely in the future. The Chair also reported that she'd been invited to serve on the Birmingham and Solihull STP Board and would in the future provide an update on developments.

In relation to the West Midlands Combined Authority (WMCA), the Chair highlighted that the WMCA had recently received a paper from the West Midlands Mental Health Commission which outlined a number of key recommendations. The document was available on the WMCA website or could be circulated to members of the Board if they wished to receive it.

At this juncture, the Chair also notified members that in keeping with changes across the Council this was the last Board meeting at which refreshments would be made available.

HEALTH AND WELLBEING STRATEGY

The following report was submitted:-

(See document No. 1)

Dr Adrian Phillips, Director of Public Health introduced the information contained in the report.

The following were amongst the issues raised and responses to questions:-

1) Further to comments made that there were around half a million disadvantaged people in Birmingham, Dr Gavin Ralston expressed support for the view that the Board was likely to be more effective in improving the health and wellbeing of citizens by concentrating on those who were at most disadvantage.

2) Jonathan Driffill highlighted that the Birmingham Social Housing Partnership was actively involved with Housing Birmingham and that some of the housing-related issues not able to be picked-up through the Health and Wellbeing Strategy could be addressed as part of strategic work that Housing Birmingham was carrying out. He pointed out that there was a specific objective in relation to supporting vulnerable people such as the homeless.

3) In first highlighting that some Adverse Childhood Experiences (ACEs) were children safeguarding issues, Dr Andrew Coward drew attention to the fact that many of the adverse experiences related to what was happening to the children's mothers and fathers (i.e. mental illness, alcohol abuse, drug abuse, domestic violence, parental separation, incarceration). Furthermore, he stressed that of non-communicable conditions ACEs were the most important health risk factor by far and also significant risk factors in terms of people engaging in criminal activity and having a mental health problem. The member therefore considered that the ACEs that pertained to the parents should be placed at the heart of any robust Health and Wellbeing Strategy. He stressed the devastating impact that ACEs had on children's brains and the need therefore to take steps to prevent the occurrence of this neurodevelopmental damage from being inflicted upon them.

4) Chief Superintendent Richard Moore indicated that he supported focusing on a limited number of priorities. He considered that the Board should also take the opportunity to hold non-health partners to account for delivery of core priorities as this would provide added-value to the work of all those providing health and care services.

5) Further to 4) above, the Chair concurred that there was a need to work more closely with partners and to hold them to account. She considered that partners on the Board had been very willing to assist but had not always been used enough. The Chair also indicated that she felt that the membership of the Board should be widened.

6) The Director of Public Health indicated that he felt that there was a need to identify the work that it was considered only the Health and Wellbeing Board could do and the work where it should be establishing formal links and relationships with other Boards and partners and holding them to account.

174 **RESOLVED:-**

(a) That a limited number of priorities be included in the refreshed strategy;

(b) that further development of the refreshed strategy be delegated to the Operations Group;

(c) that a revised draft strategy be received at the next meeting as well as related proposals in terms of key stakeholders.

BIRMINGHAM HEADSTART

The following report was submitted:-

(See document No. 2)

Rob Willoughby, Area Director, The Children's Society introduced the information contained in the report.

Dr Adrian Phillips, Director of Public Health reported that he had considered it important to bring the report to the Board because the work described involved other partners; was concerned with improving the health and wellbeing of children; and linked-up with Adverse Childhood Experiences (ACEs).

The Chair thanked the Area Director for reporting to the meeting.

175 **RESOLVED:-**

(a) That this Board continues to endorse and support the principles of building emotional health, wellbeing and resilience through strategic work in schools that improves the wellbeing of vulnerable children and prevents mental health problems developing and also helps to develop common approaches between the school, Local Authority, NHS and Voluntary Community Sector systems;

(b) that the recommendations made at the Health and Wellbeing Board Operations Group meeting on 4 October 2016 be noted and the Operations Group be asked to develop a costed proposal aligning Adverse Childhood Experiences, NewStart (formerly HeadStart) and the Health and Wellbeing Board priorities to strengthen the support to schools.

A STRATEGIC APPROACH TO REDUCING ADVERSE CHILDHOOD EXPERIENCES

The following report was submitted:-

(See document Nos. 3)

Dr Dennis Wilkes, Assistant Director of Public Health presented the PowerPoint slides accompanying the report.

The following were amongst the issues raised and responses to questions:-

(1) In welcoming the focus on Adverse Childhood Experiences (ACEs), Cath Gilliver highlighted that early intervention to prevent ACEs impacting on children was only part of the picture and that there was a need to consider how to best work with adults who were suffering as a result of their childhood experiences. The Member reported that in Philadelphia a model called Trauma Informed Care had been developed whereby a common approach was used across a range of services e.g. children's services, schools, health services, the criminal justice system and services for the homeless.

(2) Further to comments made by Dr Gavin Ralston, the Assistant Director confirmed the importance of intervening in the first couple of years in respect of children. In addition, he highlighted that there was a need to have a framework to help parents understand what was driving their behaviour and how it was harming their family.

(3) Councillor Brigid Jones pointed out that it was hard for an individual to have some ACEs without having others e.g. if there was domestic violence the parents were likely to separate and the perpetrator could be incarcerated. She queried how well services were configured to address this and to what extent the draft Domestic Abuse Prevention Strategy had taken account of research on ACEs.

(4) Paula Harding, Senior Service Manager, Violence Against Women, BCC referred to the importance of early intervention in tackling domestic violence and highlighted that identifying where it was occurring was one of the key challenges.

(5) Councillor Brigid Jones referred to the need to ensure that knowledge of the harm caused by ACEs was not used in such a way that it resulted in the wrong outcomes. In highlighting that she'd been lobbied by groups wishing to keep couples together the member pointed out that there was a limit to how much you should try to do this if the outcome was going to be more domestic violence.

(6) Chief Superintendent Richard Moore reported that his colleague, Chief Superintendent Chris Johnson led on the Neighbourhood Policing Model and Framework for the whole of the West Midlands and had chosen to embed ACEs work at the very heart of their key assessment tool used to address vulnerability/demand in neighbourhoods. Chief Superintendent Richard Moore pointed out that the intergenerational cycle in families created by ACEs especially resonated in policing e.g. a person with 4 or more ACEs was 7 times more likely to be involved in violence, 11 times more likely to have used Class A drugs and was 11 times more likely to

have been incarcerated. Reference was made to work that had therefore taken place on configuring their systems to identify 4 or more ACEs to help inform the Police where they should intervene and bring on board public sector agencies and stakeholders in communities to break the cycle of intergenerational disadvantage. Members were also advised that Chief Superintendent Chris Johnson was working with Birmingham City University to scope out the early findings of the benefits of the interventions.

(7) In response to a question from Dr Aqil Chaudary, the Assistant Director indicated that he had not yet seen any evidence of work on ACEs taking place at a community as against organisational level. He also commented that he had yet to assess whether Philadelphia's city-wide model would be transferable to Birmingham.

(8) Dr Andrew Coward reported that 15% of the population had 4 ACEs or more and that this could shorten a person's life expectancy by up to 20 years; highlighted that ACEs were profoundly associated with health inequalities; and pointed out that there were individuals that as children had suffered neurodevelopmental damage who were then being punished again later in life. However, with the routine enquiry of ACEs there could be a 35% reduction in terms of individuals needing to seek help from health professionals. He therefore considered that there should be a comprehensive systematic approach of primary, secondary and tertiary prevention across the public sector.

(9) The Assistant Director referred to joined-up work that was taking place with partners on ACEs but highlighted that there was now a wish to expand on this work and the opportunities available.

(10) Dr Adrian Phillips considered that if ACE's work was going to be taken forward in Birmingham there needed to be a strategic framework/group to do this. He therefore suggested that he be tasked with arranging for a paper to be brought back to the Board in this regard. Peter Hay also highlighted that this would provide an opportunity to improve both the mental health and wellbeing of both adults and children under a single initiative.

176 **RESOLVED:-**

(a) That the identification of Adverse Childhood Experiences (ACEs) as a means to breaking the intergenerational cycle of harm and dysfunction resulting in ill health and poor achievement be noted and endorsed;

(b) that, further to (10) above, a report be submitted to the Board on proposals for an ACE's strategic framework/group.

DELIVERING THE BIRMINGHAM DOMESTIC ABUSE PREVENTION STRATEGY

The following report was submitted:-

(See document No.4)

Paula Harding, Senior Service Manager, Violence Against Women, BCC introduced the information contained in the report and in referring to discussions earlier in the meeting underlined that domestic violence and abuse were at the core of many of the challenges faced.

The following were amongst the issues raised and responses to questions:-

1) Councillor Brigid Jones advised the meeting that she had met a number of senior and highly educated people who had not accepted how prevalent domestic violence was against women. Consequently, she underlined that there was a need to continue to press home the point. Furthermore, in supporting the approach of the draft Domestic Abuse Prevention Strategy, she considered that it was not appropriate to place upon schools the full burden of identifying domestic violence and working with the young people affected i.e. it was for of all relevant agencies to pull together to address the issue. The member also drew attention to information on page 7 of the draft Domestic Abuse Prevention Strategy that highlighted that the local increase in domestic abuse was consistent with the national picture which had seen violence against women increasing since the economic crash in 2009. She pointed out that many jobs taken largely by men were being created in the construction industry and yet jobs were being cut in the NHS (and public sector as a whole) where they were taken mostly by women. The member voiced concern that this was leading to greater economic inequality and in turn an increase in the number of incidents of domestic violence.

2) Dr Andrew Coward considered that it was critical that the Health and Wellbeing Board made a stand against domestic violence which he regarded as a public health 'epidemic'. He commented that it involved one in three women and had a huge impact on public services. Furthermore, he undertook to share with members a YouTube clip sent to him showing that it was mainly a male against female issue and commented that sadly the perpetrators were often supported by their friends and family. He urged the Health and Wellbeing Board to help shape cultural change in the City by showing true leadership on this issue.

3) The Senior Service Manager referred to activity that had been taking place (e.g. IRIS programme, work of the Police) and indicated that she would like to see everyone becoming better within their own organisations at responding to incidents of domestic abuse at the earliest opportunity and, especially in health settings, ensuring that the early help services were readily available when needed. However, she highlighted that the budget pressures in the public sector made this a challenging task. The Senior Service Manager pointed out that it was when high risk had been identified that organisations particularly needed to work together. In this regard she felt that the current arrangements (i.e. Multi-Agency Risk Assessment Conferences) were working quite well notwithstanding an increase in the number of cases.

The Chair commended the Police for the work that they had been doing in tackling domestic violence and indicated that she felt that the draft Domestic Abuse Prevention Strategy did provide a framework for organisations to plan and work together. She proposed a recommendation that was agreed by the Board.

The Chair thanked the Senior Service Manager for reporting to the meeting.

177 **RESOLVED:-**

That members be requested to assist in extending the consultation on the draft Domestic Abuse Prevention Strategy in their organisations by encouraging staff and stakeholders to participate in the consultation and help secure the wide engagement needed.

(The following report was brought forward on the agenda)

BLACK COUNTRY SUSTAINABILITY AND TRANSFORMATION PLAN

178 The following PowerPoint slides and document were received:-

(See document Nos. 5 and 6)

Andy Williams, Accountable Officer, Sandwell and West Birmingham Clinical Commissioning Group (CCG) and the Sustainability and Transformation Plan (STP) Lead provided an update on the plan. He reported that the key to delivering sustainability was to transform the way that primary, community, social and preventative care services were delivered and thereby reduce the ongoing demand for more expensive and less effective secondary and tertiary interventions. The Multi-Specialist Community Provider (MCP) Vanguard was the initiative that they were using to transform services at a primary care level and the new Midland Metropolitan Hospital the means by which secondary/tertiary services would be consolidated. It was also highlighted that two specific areas that had been given prominence in their STP were mental wellbeing and infant mortality/maternal health services. However, he highlighted that the STP was not a systems-wide plan and that there was a need to move on beyond the STP and look at the wider determinants of health. He advised the Board that changing health and care services alone would not be enough to bring about sustainability and there was a need to bring in other areas (e.g. housing, education, employment) and have broader discussions about systems as a whole. He sought the Board's support to the above approach.

The following were amongst the issues raised and responses to questions:-

1) Andy Cave asked the STP Lead to ensure that the engagement / communication leads for both the Black Country STP and the Birmingham and Solihull STP were having conversations about how to engage with people living in the west of Birmingham so that they were clear about which STP they were part of and to which they should submit their views.
2) The Board was advised that the Birmingham Community Health Care NHS Trust formed part of the Black Country STP; but, the Birmingham Children's, Women's and the University Hospitals Birmingham Trust were not included. However, the STP Lead emphasised that the STP would not result in the creation of any new artificial boundaries and also pointed out that single joined-up processes for Birmingham were adopted where possible e.g. the Better Care Fund, Mental Health Commissioning, Safeguarding. Furthermore, he highlighted that he was mindful of the need for care to be

taken over how information was presented so that it could be seen that the work taking place was a coherent plan for Birmingham as a whole.

3) Members were informed that the Birmingham and Solihull STP was based on the same concepts (e.g. focusing on primary care) as the Black Country STP but in view of the number of specialty health provider organisations in Birmingham the context was different. The STP Lead indicated that he believed that they had picked-up the patient flows into specialty services and reported that this would continue to be addressed.

4) It was considered by the STP Lead that the configuration of the Clinical Commissioning Groups would change as he was of the view that transformation also had to relate to commissioning arrangements.

5) The STP Lead indicated that he accepted as legitimate the criticism from local Councils that they had not been made to feel part of the STP process and reported that he had therefore written to them on this issue. He stressed that there was an overwhelmingly clear case for the integration of health and social care and that it would be an irony if the process that was designed to facilitate integration was what stopped it.

The Chair thanked the STP Lead for reporting to the meeting and with the agreement of members invited him to come back in 4-6 months' time to provide a further update.

AIR POLLUTION AND HEALTH IN BIRMINGHAM

The following report was submitted:-

(See document No. 7)

The Chair proposed and it was:-

179 **RESOLVED:-**

That consideration of the report be deferred until the next meeting.

The meeting ended at 1705 hours.

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CHAIRPERSON

	Agenda Item: 6
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**31 January 2017**
TITLE:	**AIR POLLUTION AND HEALTH IN BIRMINGHAM**
Organisation	**Birmingham Health and Wellbeing Board**
Presenting Officer	**Adrian Phillips/Wayne Harrison**

Report Type:	**Decision**

1. Purpose:
1.1. To update the Board of the threat posed by poor air quality due to outdoor air pollution in Birmingham on health as well as to the local economy.

2. Implications:		
BHWB Strategy Priorities	Child Health	Y
	Vulnerable People	Y
	Systems Resilience	Y
Joint Strategic Needs Assessment		Y
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		Y
Financial		
Patient and Public Involvement		
Early Intervention		Y
Prevention		Y

3. Recommendation
It is recommended that the Board: 3.1 Consider adverse outdoor air quality as a theme in its strategy. 3.2 Supports the improvement of air quality by reducing air pollution as a collective priority 3.3 Receives an update in future meetings

4. Background

4.1 Outline of the problem

4.1.1 Man-made outdoor air pollution in Birmingham causes just under 900 deaths per year. It is second only to tobacco-smoke as an avoidable cause of early mortality. Most deaths are due to Stroke and Coronary Heart Disease. It has a harm profile remarkably similar to that caused by tobacco smoke.

4.1.2 Unlike the "smogs" of the 1950s, today's air pollution is mainly unnoticed without special equipment or in extremes. It is caused by two main factors. The first are the very small particles in the air – like smoke but smaller. They are measured in microns and are less than 10 µm in diameter and are known as Particulate matter or PM. The two most common measures are PM 10 and PM2.5. The other main pollutant is oxides of Nitrogen, NOx, especially NO_2.

4.1.3 Both these pollutants are mainly created from the internal combustion engine, especially those powered by diesel fuels. Vehicular road traffic causes the greatest effect. Electric cars as well as other vehicle types do not produce such pollutants.

4.1.4 Outdoor air pollution has attracted attention due to increased evidence of its negative health impact. Five areas in the United Kingdom (UK), including Birmingham, exceed European Union (EU) legal limits. The result is a risk of a financial fine, a requirement upon the City Council to declare itself an Air Quality Management Area and implement an action plan to reduce air pollution in a timely manner.

4.1.5 Birmingham City also performs poorly according to its Public Health Outcome Framework. Pollution undoubtedly also affects Respiratory Health, an area which all Birmingham CCGs have as an adverse indicator.

4.1.6 Birmingham City Council is developing an action plan in line with the requirements but the scale, severity and nature of the threat requires a coordinated, multiagency response.

4.2 Defining the threat of air pollution

4.2.1 Birmingham City Council must coordinate a local response to reduce levels of NO_2 to a yearly average of less than 40µg/m^3 to deliver compliance with the EU Air Quality Directive. Whilst this target is consistent across the EU, some regions, Scotland for instance, have set much lower – less than half that for England - targets for some gases.

4.2.2 The most evidence exists for $PM_{2.5}$, which is why Public Health England currently benchmark on this measure; in the most recent reporting period Birmingham had an average $PM_{2.5}$ of 11.4µg/m^3 compared to an England average of 9.9µg/m^3.

4.2.3 A UK expert panel investigating the health impact ('COMEAP') has declared there are no safe limits for $PM_{2.5}$ and NO_2; every 10µg/m^3 increase in PM_{10} is

associated with a 6% increase in all-cause mortality and every 10µg/m^3 increase in NO_x is associated with a 2.5% increase in all-cause mortality.

4.2.4 The EU targets and Air Quality Index advice are not representative of the full impact on health or the cost of not reducing levels below the current thresholds.

4.3 Impact on health

4.3.1 In Europe air pollution is the biggest environment risk factor for premature death. While other components of air pollution mentioned above damage health, particularly at high levels of exposure, the strongest evidence for harm caused by lower levels is the effect of long-term population wide exposure to $PM_{2.5}$ and NO_2.

4.3.2 In the UK, $PM_{2.5}$ is responsible for 29,000 premature deaths annually and NO_2 is associated with 23,500 deaths, based on current outdoor air pollution. A 10 µg/m3 reduction in PM $_{2.5}$ pollution alone would have a larger impact on life expectancy in England and Wales than eliminating road traffic accidents or passive smoking.

4.3.3 There is strong evidence for the impact of short and long-term exposure to $PM_{2.5}$ on cardiovascular health, reduced lung function and heightened severity of symptoms in individuals with:

- Asthma
- Chronic Lung Disease
- Ischaemic Heart disease
- Stroke

4.3.4 Emerging evidence also suggests an effect of $PM_{2.5}$ on children if their mothers were exposed to higher levels during pregnancy, with links to adverse birth outcomes (low birth weight, preterm birth, premature, neurodevelopmental harm, small for gestational age), airway inflammation and increased susceptibility to respiratory infection.

4.3.5 Children living in more polluted environments based on measures of $PM_{2.5}$ are more likely to experience asthma symptoms, have low lung function and are more vulnerable to Chronic Obstructive Pulmonary Disorder (COPD-a lung disease) in adulthood.

4.3.6 Long term exposure to $PM_{2.5}$ throughout life has also been associated with increased risk of obesity, diabetes, cognitive function including Dementia and social isolation.

NO_2 is a part of the same air pollution that $PM_{2.5}$ is found in and has a separate and additional impact on health; high acute levels are associated with respiratory morbidity, hospital admissions and emergency visits for cardiovascular and/or cardiac diagnoses and mortality. Chronic exposure has been associated with reduced lung function in children and adults, respiratory infections in early childhood including bronchitis, cancer and adverse birth outcomes.

4.3.7 The full extent of these impacts across a person's life such as the effect on quality of life, school attendance and absence from the workforce are not yet fully quantified but some studies have attempted to measure these wider impacts.

4.4 Wider impacts of air pollution and potential benefits of addressing it

4.4.1 Addressing outdoor air pollution is not only a matter of risk avoidance; there is health, social and economic benefits to doing so. There is strong evidence that reducing air pollution increases life expectancy, reduces health inequalities and reduces morbidity for people living with respiratory and cardiovascular conditions in particular.

4.4.2 Evidence also suggests benefits that include increased productivity (e.g. workforce productivity), improved school attainment (through reduced school absence, improved concentration, reduced behavioural disorders), reduced obesity and sedentary behaviour through increases in physical activity (children living with asthma and adults who are obese).

4.5 Vulnerable groups

4.5.1 There are some groups who are more exposed to outdoor air pollution and some that are more likely to experience ill health effects when exposed. Certain occupational groups have an increased exposure, including those who work outside close to traffic pollution. People who spend more time than average in environments with higher levels of air pollution such as long distance commuters, taxi, bus and lorry drivers. One study showed taxi and bus drivers are exposed to three times the levels of outdoor air pollution in their vehicles.

4.5.2 People living in areas of deprivation may not necessarily have increased exposure to outdoor air pollution compared to the general population, although this is the case in some areas. The major concern is that this population group experience a magnified effect as a result of often living in poor housing conditions with greater exposure to pollutants and also experience higher levels of chronic stress, which reduces the bodies resilience to toxicants.

4.5.3 Groups at higher risk of adverse health outcomes due to air pollution include:

- Pregnant women and the unborn child
- Children in high pollution areas are four times more likely to have reduced lung function when they become adults
- For older adults the risk of death from PM_{10} exposure is twice that of younger populations
- Adults with pre-existing medical conditions are at increased risk of serious adverse health events such as asthma attack, stroke and heart attack.

4.6 Options to progress the matter

4.6.1 There are several different tactics which could be employed in addressing air pollution:

Immediate steps to cut local pollution include reducing internal combustion traffic, especially diesels.

4.6.2 Medium term options include reducing the number of polluting engines

4.6.3 Long term approaches depend on the above as well as rebalancing our society away from a reliance on the car and motorized transport

4.7 Conclusion

4.7.1 As described in a recent article in the British Medical Journal "The NHS has borne the brunt of costs associated with air pollution and will benefit directly from improved air quality. For that reason alone the health sector should take a more active role in the decision making process that drives change." BMJ, 29th October 2016.

4.7.2 Air pollution is a major determinant of Health and Wellbeing and merits the attention of the Health and Wellbeing Board.

5. Compliance Issues

5.1 Strategy Implications

Health and Wellbeing Board priorities

Vulnerable people:

- Improve the wellbeing of vulnerable children – potential impact on school attainment, evidence particularly for children living in poverty, reduce cases of asthma and ill health by those with the condition.
- Older people to remain independent, reducing hospital admissions.

Child Health:

- Reducing childhood obesity: there is some evidence that experiencing asthma reduces participation and enjoyment of physical activity for children with asthma. Reduces activity levels increases the risk of obesity.
- Reducing infant mortality: air pollution has been associated with low birth weight at term, small for gestational age and preterm birth, all of which are risk factors for infant mortality.

System Resilience

- Common NHS and Local Authority approaches: the matter of air pollution has impacts for health, welfare and social care usage as well as potential workforce productivity losses for both agencies and their supply chain, through working days lost and attendance at work when feeling unwell as well as reduced efficiencies because of road congestion impacting upon trade and staff mobility. In addition, both agencies have authorities to take action to

	reduce road traffic and mitigate the impact such as standards for supply chain, implementation of local policy, public awareness raising, improving local infrastructure such as transport.
5.2	***Governance & Delivery***
	A legal requirement not to exceed statutory levels A representative of the CCG to be invited to the local Air Quality Board
5.3	***Management Responsibility***
	Feedback to the HWBB through the DPH and Cabinet members (as a corporate council responsibility)

6. Risk Analysis

Likelihood: 0 = will never happen; 4 = definite outcome
Impact: 0 = no impact; 4 = death/legal challenge

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Premature mortality	3	4	
Morbidity among people with respiratory and cardiovascular conditions	4	3	
Morbidity among children living in poverty and children with respiratory conditions	3	3	

Appendices

Presentation Slides – Health Effects of Air Pollution in Birmingham

Signatures	
Chair of Health & Wellbeing Board (Councillor Hamilton)	
Date:	

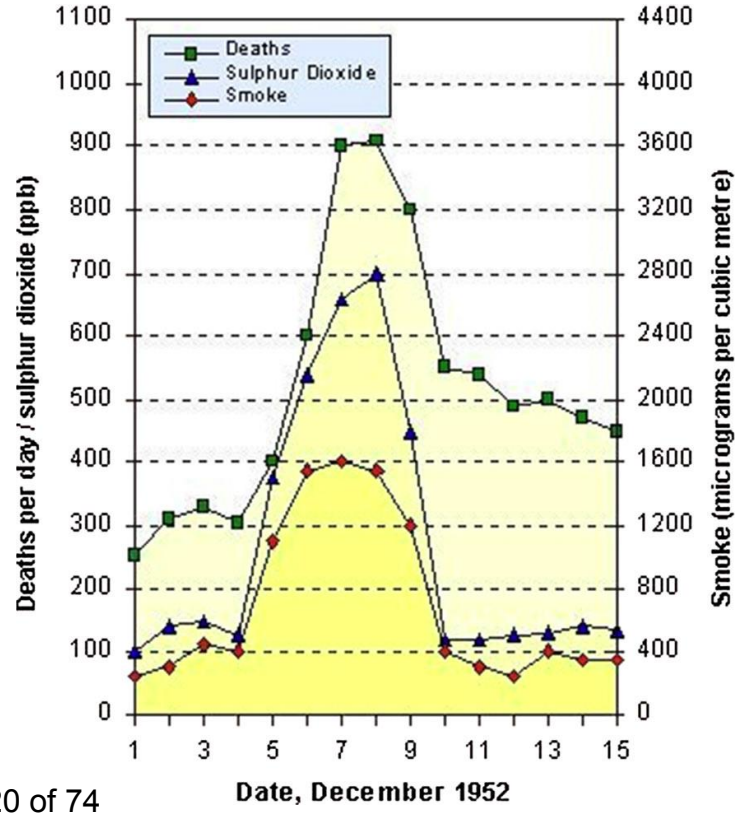
The following people have been involved in the preparation of this board paper:

Rebecca Willans
Wayne Harrison
Adrian Phillips

Health Effects of Air Pollution in Birmingham

Historical Air Pollution

- Typified by acute increases in smoke and SO_2
- 1952 London smog
  - Worst air pollution disaster in UK history
  - Enormous increase in respiratory and cardiovascular complications
  - 4000–12,000 deaths



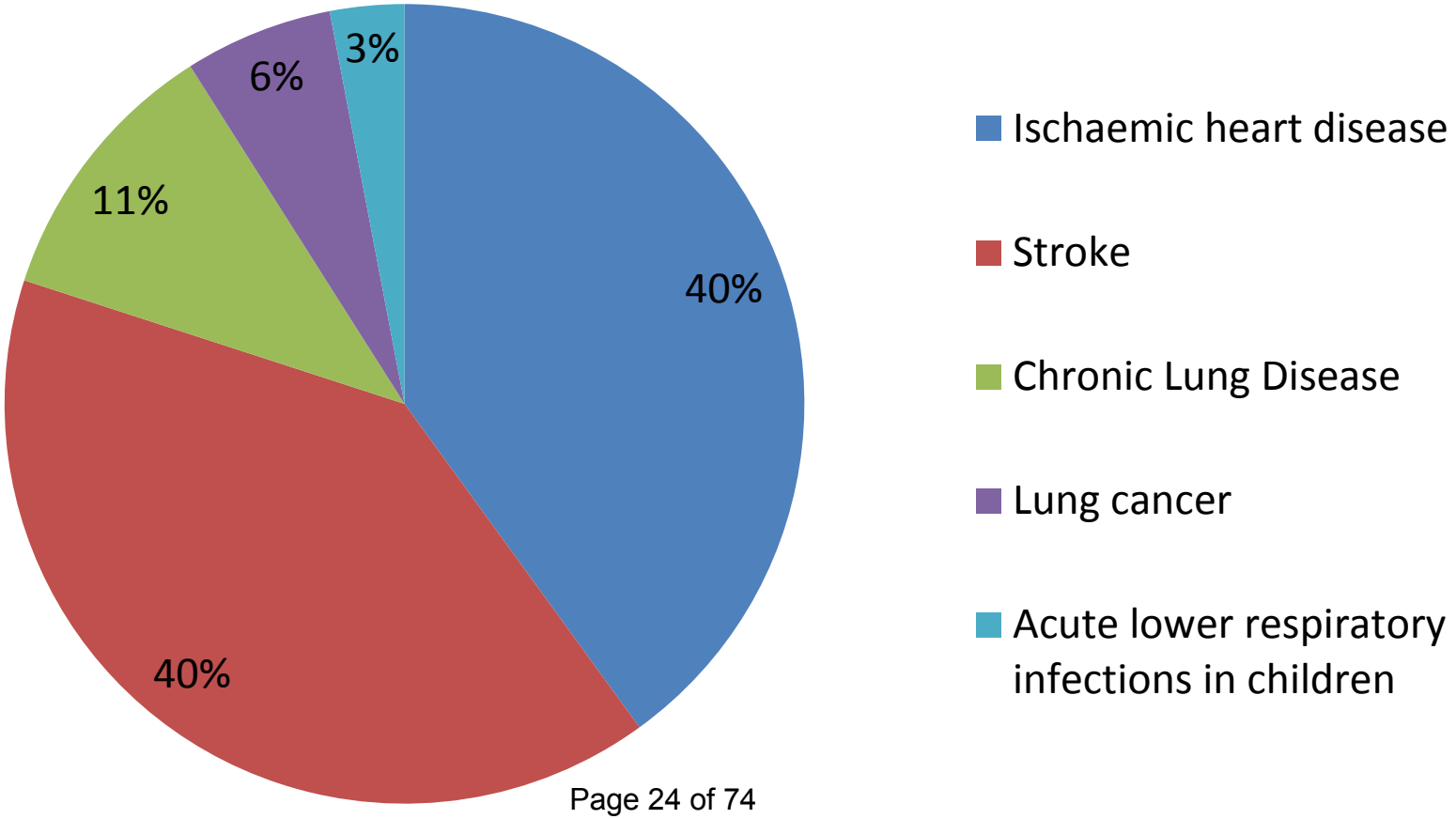
Modern-day Air Pollution

- Acute smog events can still occur
  - Exacerbate chronic conditions
- Concern now is invisible pollutants, indiscernible at ground level. Those with most evidence of health harm are:
  - Nitrogen oxides
  - Ozone (O_3)
  - Exceptionally small particulate matter (PM_{10} and the more abundant $PM_{2.5}$)
- Outdoor air pollution largely due to road traffic
  - UK road traffic 10 times higher in 2012 than 1949
  - Increased use of diesel vehicles from 14% to 50% between 2000 – 2014 in the UK
- Smaller particles are more complicated! (temperature, micro-climate, etc..)

Global Impact of Air Pollution

- Air pollution has overtaken poor sanitation and a lack of drinking water to become the main environmental cause of premature death
- In 2012, approximately 3.7 million people died from outdoor air pollution (WHO 2014)
- In Europe, air pollution is the biggest environment risk factor behind premature death (EEA 2014)
- Indonesia fires – 100,000 XS deaths in 2015!

Air Pollution Deaths



Air Quality Standards

- There are standards set for a number of pollutants
  - SO_2, NO_X, PM, Pb, CO, Benzene, Ozone
- The main focus is on:
  - NO_2 – basis of the Clean Air Zone
  - $PM_{2.5}$ – linked to mortality in the Public Health Outcomes framework
- Vehicle emissions are the major source of both NO_2 and $PM_{2.5}$
- Both are linked to a range of health effects

Impact on Health

- In the UK $PM_{2.5}$ air pollution by itself is responsible for at least 29,000 premature deaths
- UK wide estimated some 23,500 deaths annually on the basis of NO_2 concentrations
- A 10 µg/m^3 reduction in ambient $PM_{2.5}$ pollution would have a larger impact on life expectancy in England and Wales than eliminating road traffic accidents or passive smoking (IOM 2006).

BIRMINGHAM

WORKING TOWARDS A HEALTHY CITY, HEALTHY PLACE

Birmingham City Council

Public Health, August 2016
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Numbers have been rounded

EFFECTS OF AIR POLLUTION

IN 2010/11

891

DEATHS

linked to man-made air pollution

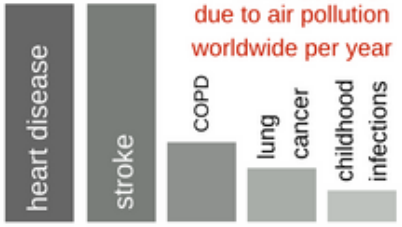
EACH YEAR

LINKED TO

* Cancer * Diabetes * Asthma * Obesity * Stroke * Dementia * Heart Disease *

Deaths

due to air pollution worldwide per year



affects the **vulnerable** and **deprived** areas most

exposed to 21% higher levels of pollution

33.9 % travel to work by car

LINKED TO

* Low birth weight * premature deaths * still births* infant deaths * organ damage*

CHILDREN in HIGH POLLUTION AREAS are 4x more likely to have reduced lung function when they become adults

BUS & TAXI DRIVERS are exposed to **3x more** pollution than anyone else

Data sourced from: Public Health Outcomes Framework (PHE), "Every Breath We Take - the lifelong impact of air pollution" (2015 RCP & RCPCH), Marmot Cold Homes. Active Travel Survey 2015

Cardiovascular & Respiratory Disease

Strong evidence for impact of short and long-term exposure to $PM_{2.5}$ on cardiovascular health:

- Reduced lung function
- Heightened severity of symptoms in individuals with:
  - Asthma
  - COPD
  - **Ischaemic heart disease**
  - **Stroke**
- **Remarkably similar to harm caused by tobacco smoke**

Emerging evidence for $PM_{2.5}$

- Exposure in pregnancy
  - Airway inflammation
  - Increased susceptibility to respiratory infections
- Exposure in childhood
  - Increase in asthma symptoms
  - Low lung function
  - Vulnerability to COPD in adulthood

New Health Outcomes

- Emerging evidence linking long-term exposure to $PM_{2.5}$ with:
  - Adverse birth outcomes
    - Low birth weight at term
    - Small for gestational age
    - Preterm birth
    - Neurodevelopmental harm
    - Miscarriage
  - Diabetes
  - Obesity
  - Cognitive function (?Dementia)
  - Social isolation

NO_2 Health Outcomes

An independent effect of NO_2 has also been found that is additional to $PM_{2.5}$ effects and has both immediate and long term effects:

- Acute exposure:
  - respiratory morbidity,
  - hospital admissions and emergency visits for cardiovascular and/or cardiac diagnoses,
  - mortality due to the effect of associated compounds

- Chronic exposure;
  - Reduced lung function in children and adults
  - Respiratory infections in early childhood including bronchitis
  - Cancer incidence
  - Adverse birth outcomes

Potential Vulnerable Groups

Some groups are at higher risk of exposure to outdoor air pollution:

- Certain professional groups:
  - Taxi and bus drivers are exposed to 3x more pollution than anyone else
  - Urban based traffic police
  - Street cleaners
- Deprivation

Potential Susceptible Groups

Some groups are more susceptible to adverse outcomes following exposure:

- Pregnant women and the unborn child
- Children in high pollution areas are 4x more likely to have reduced lung function when they become adults
- Older adults: risk of death from PM_{10} exposure twice that of younger populations
- Adults with pre-existing medical conditions
  - Aggravate asthma
  - Increase risk of adverse health events

Safe Levels

- There are none
  - There is no threshold below which there would be no impact on mortality

- Every 10µg/m^3 increase in NO_x is associated with 2.5% increase in all cause attributable mortality

- Every 10µg/m^3 increase in PM_{10} is associated with 6% increase in all cause attributable mortality

Estimated Direct Health Effects of Current Air Pollution in Birmingham

- $PM_{2.5}$: **520** deaths in 2010
  - 6.4% deaths attributable to this form of anthropogenic air pollution
  - 5,707 years of life lost
- NO_2: **371** deaths in 2011
  - Range of 2.9% to 8.7% deaths attributable to NO_2 alone (independent of effect with $PM_{2.5}$)
- Combined effect **891 deaths per year**, over half that due to tobacco

Potential Benefits of Reducing Air Pollution

Strong evidence for:

- Increased life expectancy

- Reduced health inequalities

- Reduced morbidity for people living with respiratory and cardiovascular conditions

Potential Benefits of Reducing Air Pollution

Evidence for:

- **Increased productivity** (GDP, workforce productivity)
- **Improved school attainment** (through reduced school absence, improved concentration, reduced behavioural disorders)
- **Reduced use of health care** (most research looked at hospital admissions)
- **Reduced obesity and sedentary behaviour; increase in physical activity** (evidence for children living with asthma and evidence regarding obesity in adults)

BIRMINGHAM

WORKING TOWARDS A HEALTHY CITY, HEALTHY PLACE

Birmingham City Council

Public Health, August 2016
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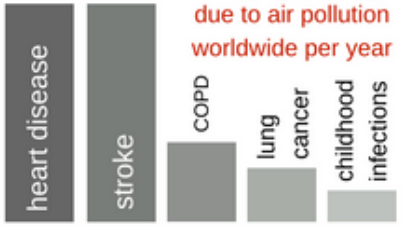

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	Agenda Item: #
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**31st January 2017**
TITLE:	**Health & Wellbeing Strategy**
Organisation	**Birmingham City Council**
Presenting Officer	**Adrian Phillips, Director of Public Health**

Report Type:	**Decision**

1.	**Purpose:**
	To recommend priorities for a refreshed strategy

2.	**Implications:** # Please indicate Y or N as appropriate]	
BHWB Strategy Priorities	Child Health	Y
	Vulnerable People	Y
	Systems Resilience	Y
Joint Strategic Needs Assessment		Y
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		N
Financial		Y
Patient and Public Involvement		Y
Early Intervention		Y
Prevention		Y

3.	**Recommendation**

That the Health and Wellbeing Board:

- **Agrees the limited number of priorities for the refreshed strategy**
- **Delegates further development of measures to the Operations Group**
- **Commissions a Task and Finish group to identify suitable outcomes related to Adverse Childhood Experiences (ACEs)**
- **Invites the Mental Health System Strategy Board to comment on the proposed outcomes or suggest alternatives**
- **Liaise with other Boards as appropriate**

4. Background

The Health and Social Care Act 2012 required Local Authorities in England to have a Health and Wellbeing Board (HWBB). Boards should ensure that local health needs drive local decision-making, bringing together partners to improve health. The initial Health and Wellbeing Strategy (HWS) was adopted in June 2013. The HWBB has indicated the need to review and refresh the strategy.

Current Strategy
The current strategy was presented on a page and highlights its vision to improve the health and wellbeing of the most vulnerable individuals in Birmingham as its most important priority. The strategy is divided into three sections and consists of ten outcomes with actions, measures and targets with timeframes given. The outcomes included for each key area is as follows:

Vulnerable People

- Make children in need safer
- Improve the wellbeing of children
- Increase the independence of people with a learning disability or severe mental health problem
- Reduce the number of people and families who are statutory homeless
- Support older people to remain independent

Child Health

- Reduce childhood obesity
- Reduce infant mortality

System Resilience

- Health and care system in financial balance
- Common NHS and Local Authority approaches
- Improve the primary care management of common and chronic conditions

Guiding principles for a new strategy
A previous paper outlined a set of principles which the HWBB supported. These included:

- 3 or 4 clear priorities grounded in the population's needs – fewer priorities/outcomes can focus Board work and make best use of limited resources
- Priorities should be important to all stakeholders and be areas to which all stakeholders can contribute
- Priorities that affect and can add value to most people's lives
- Strategic fit with the current landscape
- Using an asset-building approach as opposed to stopping a deficit or problem
- Consider the Direct role of the Board as well as Indirect mainly through other Boards
- Improving communication and collaboration between agencies
- A changing culture of promoting independence and the role of services to support this notion

The Board has expressed keen support for Mental Health and ratified the Mental Health System Strategy Plan. It has also received updates from the Mental Health Commission which is due to report shortly.

In addition there is interest in Adverse Childhood Experiences (ACEs) although there is still uncertainty on the outcomes of any work in this area (for adults or children).

Board approach to achieving outcomes
Following the discussion at the November Board, it is proposed that a number of outcomes are negotiated with and delegated to other Boards, such as the Housing Board. This may require the HWBB undertaking other responsibilities for those groups.

The Board has already supported the Mental Health System Strategy Plan. It is proposed that discussions are entered with that Board with a view to appropriate outcomes and also for that body to become a sub-group of the Board.

It is suggested that the HWBB commissions a Task and Finish group to determine the relevant place of an outcome related to ACE (either adult or child or both).

Proposed Priorities for the Health & Wellbeing Strategy
Taking the above into account a set of priorities for the Health & Wellbeing Strategy is suggested below. Suggested approaches to strategic delivery have been suggested

	Ambition	Delivery
Improving the wellbeing of children	Detect and Prevent Adverse Childhood Experiences	Await recommendations of the task and finish group
	All children in permanent housing	Negotiation with Housing Board
Improve the independence of adults	Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	Health and Wellbeing Board
Improving the wellbeing of the most disadvantaged	Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	Mental Health Systems Strategy Board (TBC) Negotiation with Housing Board
	Improving stable and independent accommodation for those learning disability	Health and Wellbeing Board
	Improve the wellbeing of those with multiple complex needs **To Be Agreed**	**To Be Agreed**
Making Birmingham a Healthy City	Improve air quality (and be legally compliant)	Negotiation with Air Quality Board

	Increased mental wellbeing in the workplace **To Be Agreed**	Consider joint working with adjoining Health and Wellbeing Board **To Be Agreed**

There are fewer direct objectives for the HWBB. It requires negotiation with two other City-Boards (Housing and Air Quality) as well as the Mental Health Systems Strategy Board. It also depends on discussion with adjoining HWBB regarding wellbeing in the workplace (a likely recommendation from the Mental Health Commission)

Next Steps

- The Health & Wellbeing Board agrees the proposed areas for the strategy, especially those areas marked in the table
- Commissions a Task and Finish group to identify suitable outcomes related to Adverse Childhood Experiences (ACEs)
- Invites the Mental Health System Strategy Board to comment on the proposed ambitions or suggest alternatives
- Liaise with relevant Boards both within and adjacent to Birmingham
- Measures and targets will be proposed by the Operations group to the Board
- Key stakeholders and other relevant Boards etc. will be identified
- Board members to consider their leadership role in each area

Once the strategy is agreed, the Operations Group will:

- Firm-up indicators and targets against each of the priorities;
- Establish the system wide activities and plans to deliver against each of the priorities;
- Report back to the Board on progress against the agreed targets and potential concerns in achieving these.

5.	**Compliance Issues**
5.1	***Strategy Implications***
	This paper concerns development of the strategy
5.2	***Governance & Delivery***
	To be overseen by the Health and Wellbeing Board
5.3	***Management Responsibility***
	The Board

6.	**Risk Analysis**
	A risk assessment cannot be completed until the draft strategy has been agreed

Identified Risk	Likelihood	Impact	Actions to Manage Risk
#	#	#	#
#	#	#	#
#	#	#	#

Appendices

Signatures	
Presenting Officer: Adrian Phillips	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	
Date:	

Proposed task and finish group for ACEs:

Public Health – Chair (Dennis Wilkes Assistant Director)
Birmingham Children's Services (Dawn Roberts Early Help & Partnerships)
WM Police
Birmingham Women's and Children's Hospital (via Birmingham & Solihull United Maternity Programme BUMP)
BSMH FT NHS Trust (Adult Mental Health Trust)
Forward Thinking Birmingham (0-25 yrs Mental Health)
CLG (Adult Substance Misuse)
Birmingham Education Partnership
BCHC NHS Trust Children and Families Division

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

Gunveer Plahe – Speciality Registrar in Public Health
Wayne Harrison – Assistant Director, Public Health
Dennis Wilkes – Assistant Director, Public Health

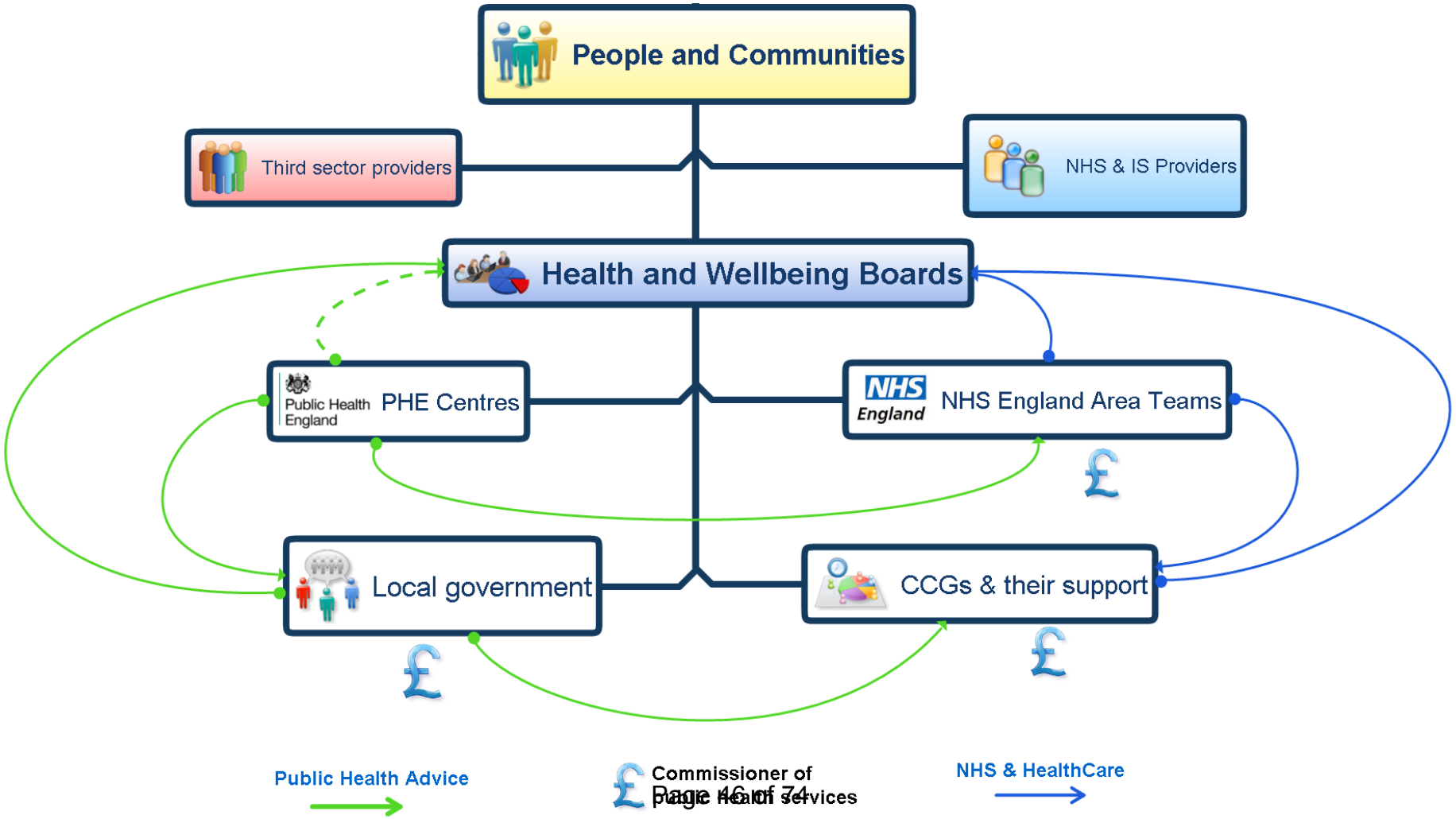
Public Health England

Supporting Birmingham's Health and Wellbeing Priorities

Dr Sue Ibbotson, Director, PHE West Midlands

Public Health England

Place based approach to public health



Public Health England

Proposed Priorities for Birmingham's Health & Wellbeing Strategy

	Outcome or Area
Improving 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 (Personal Health Budgets & Direct Payments)
Improving the wellbeing of the most disadvantaged	Increasing employment and stable accommodation for those with severe mental health problems
	Improving stable and independent accommodation for those learning disability
	Improve the wellbeing of those with multiple complex needs To Be Agreed
Making Birmingham a Healthy City	Improve air quality (and be legally compliant)
	Increased mental wellbeing in the workplace To Be Agreed

Public Health England

Improving the wellbeing of children

The importance of school readiness

School readiness starts at birth with the support of parents and caregivers, when young children acquire the social and emotional skills, knowledge and attitudes necessary for success in school and life

Children who don't achieve a good level of development aged 5 years struggle with:

Social skills | Reading | Maths | Physical skills

which impacts on outcomes in childhood and later life:

Educational outcomes | Crime | Health | Death

Preventing ACEs in future generations could reduce levels of:

Poor diet
(current)
by 14%

Binge drinking
(current)
by 15%

Smoking
(current)
by 16%

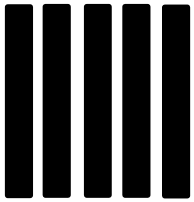
Early sex
(before age 16)
by 33%

Cannabis use
(lifetime)
by 33%

Unintended teen pregnancy by 38%

Violence victimisation
(past year)
by 51%

Violence perpetration
(past year)
by 52%



Incarceration
(lifetime)
by 53%

Heroin/crack use
(lifetime)
by 59%

slide with thanks to Karen Hughes, John Moore's University

Public Health England

Improve the independence of adults

The right home environment is essential to health & wellbeing, throughout life

Key features of a 'healthy' home:

- A home in which to start, live and age well
- Warm and affordable to heat
- Free from hazards; safe from harm
- Enables movement around the home and is accessible
- Promotes a sense of security and stability
- Support available if needed

Public Health England

Improving the wellbeing of the most disadvantaged

Increasing employment & stable accommodation for those with severe mental health problems

- Support West Midlands Homelessness and Housing groups
- Regional Offender Accommodation Group
  - Improving pathways to accommodation for people in the justice system
- Migrant Health
- Promoting Health Inequality and Equity Assessment Tool (HEAT)
- Alcohol Licensing Forum includes Birmingham
  - Injury Surveillance Data produced by PHEWM informs local decision making

Public Health England

Improve the wellbeing of those with multiple complex needs

- Support LA commissioners to improve recovery rates
- Support Birmingham's ongoing work on employability - ‘Getting into Work’ ADPH priority.
- Connect 5 train the trainers programme
- Workplace health charter
- Promote forthcoming JSNA toolkit and national ROI work to facilitate local prevention concordats and help local areas articulate joint planning arrangements.

Public Health England

Making Birmingham a Healthy City

- Centre for Radiation, Chemicals and Environmental Hazards (CRCE)
  - Expert advice, presenting health evidence associated with air pollution

- Workplace wellbeing

Public Health England

ADsPH West Midlands Network

Health, Wellbeing & Wealth "Faces of the Same Coin"

Sue Ibbotson Director PHE WM
Jane Moore DPH Coventry City Council
Ros Jervis DPH City of Wolverhampton Council

Public Health England

PHE WM offer to support WMCA

1. Contribute knowledge, intelligence, & specialist advice to support:
   - understanding the relationship between health, jobs & wealth
   - the HWB “gap” across the WMCA
   - the evidence of “what works” in prevention to improve the public’s HWB
   - how investment in prevention can reduce demand on public services & realise financial savings, improve economic productivity and support the most vulnerable.
2. Lead the development of a health premium that will make both positive economic & health impacts by influencing investment decisions designed to bring about economic growth.
3. Lead the active travel & workplace wellbeing agenda
4. Bridge the divide between population change (non-NHS) & individual behaviour change (NHS) to scale up ill health prevention

Public Health England

WMCA HWB Metrics

- Healthy life expectancy
- Inequality in healthy life expectancy
- Re-offending levels
- First time entrants to the youth justice system
- Physically active adults
- Suicide

Public Health England

Summary

- Crossover with PHE WM & Birmingham's shared priorities
- PHE specific joint work with Birmingham
- WMCA work contributing / will assist with delivery of your priorities

Birmingham and Solihull Sustainability and Transformation Plan
Update for Health and Wellbeing Board – 31st January 2017

The previous Birmingham and Solihull Health and Wellbeing Boards have received updates outlining the progress in developing the Birmingham and Solihull (BSol) STP. It should again be noted that the STP is the only route to bring NHS transformation monies into the health and care system.

The Board is aware that a draft plan was submitted to NHS England (NHSE) in late October for review. The following day the BSol draft narrative submission was published in full on the Birmingham City Council website with links from all partner websites. This had been previously agreed with NHS England despite concerns on their part. This was the first publication of an STP and enabled public discussion to take place at both Birmingham and Solihull Health and Care Oversight and Scrutiny Committees (OSCs) in the following days.

STP Review

Subsequently formal feedback has been received from NHSE. This made a number of observations about how the plan could be improved and also outlined were the plan was judged to be best in class or good – maternity and newborn, mental health and engagement planning.

This feedback alongside other feedback from initial stakeholder events and key stakeholders including discussions at OSCs, recommendations by previous funded support and reviews of other plans has been brought together to inform a series of recommendations to the STP Board which require action. These recommendations will place the plan in a better position to support public engagement and to articulate the approach to detailing the transformations of care and services for the citizens of Birmingham and Solihull with them.

In addition this period of review has allowed partner organisations to consider their approaches and engagement within the STP to best meet the needs of their organisations and those they serve. This has been particularly the case with Birmingham City Council and its approach to adult social care but also in clarifying the significance of the ‘west Birmingham question’ for members.

The reality that the STP does not sufficiently articulate the approach to new models of care is a key omission and one that is recommended to be resolved as soon as possible.

Partners in the Solihull part of the footprint have started to explore the options open to them from the way services are currently configured, which is different to those in Birmingham.

STP Recommendations

The following recommendations have been accepted:

- A strengthening of governance and collective decision making (already underway)
- A rewrite of the plan is undertaken to better support public, staff and patients to understand the issues and inform it. This should include a better articulation of our vision and strategy.
- The programme is presented and managed differently to make it more understandable and easier to manage.
- The discussion about new models of care takes place as a matter of urgency particularly in Birmingham, building upon discussions already undertaken in Solihull.
- There is a stronger link between the priorities identified in the gap analysis of health and wellbeing, care and quality and financial opportunities and the phasing of work within the programmes
- The engagement plan is implemented as soon as possible following the rewrite of the plan

The New Programme

A number of changes to the way the programme will be presented have been agreed:

1. Commissioning Reform remains
2. A new Maternity, Children and Young People programme – to provide a single focus in this important area
3. An individual Mental Health programme – to better ensure parity of esteem
4. Fit for Future Secondary and Tertiary Services remains – in response to the Community Care First transformation programme but also to reduce variation in clinical practice and improve outcomes and to optimise the benefits of world class tertiary provision
5. A new Improving Health and Wellbeing programme – underpinning other programmes but also ensuring a clear and focused footprint wide approach to links with Local Authorities and the Combined Authority to impact upon the co-determinants of ill-health

The further organisation of work around general practice, long term conditions and complex need including adult social care has yet to be agreed.

Health and Wellbeing Board Involvement

Improving Health and Wellbeing (prevention) is now a separate programme. Early discussions took place about a role for the Health and Wellbeing Boards in this programme. These discussions, if still relevant and desired, could be resumed with a lead role for Health and Wellbeing Boards, supported by Directors of Public Health in this programme.

Engagement

As the programme is finalised and the plan rewritten to support public, patient and staff engagement the engagement programme can be implemented.

The Director of Communications for UHBFT will initiate the delivery of this plan which will also ensure appropriate links between the STP communication and engagement plan and those of the merger considerations within the footprint.

An initial emphasis will be placed upon updating members, governors, and MPs including any local forums that they oversee, to build confidence that decisions are not being made in 'darkened rooms' and to receive input into plans as they emerge prior to any consultations that may be required. It is anticipated that these activities can commence from April 2017.

Recommendations

The Health and Wellbeing Board is asked to:

- note the review of the STP feedback
- note the amended programme framework
- consider any role it may wish to play in the Health and Wellbeing programme
- note the proposals for engagement.

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**31st January 2017**
TITLE:	**WEST MIDLANDS MENTAL HEALTH COMMISSION BRIEFING PAPER**
Organisation	**West Midlands Mental Health Commission**
Presenting Officer	**Sean Russell**

Report Type:	**Information**

1. Purpose:
1.1. To provide a very short overview of the commission work, highlight a number of key initiatives and seek support for ongoing interventions as outlined in the Thrive Action Plan.

2. Implications: # Please indicate Y or N as appropriate]		
BHWB Strategy Priorities	Child Health	✓
	Vulnerable People	✓
	Systems Resilience	✓
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		
Financial		
Patient and Public Involvement		
Early Intervention		✓
Prevention		✓

3. Recommendations
3.1 It is recommended that the Board reviews the Commission work and establishes the priorities from the Thrive Action plan it is most appropriate to support.

4.	Background
4.1	The Board has previously been updated on the work of the West Midlands Combined Authority on public sector reform and the specific work of the Mental Health Commission within this.
4.2	On the 31 January 2017 at 1200 the West Midlands Mental Health Commission are launching the Thrive Action Plan to formally report on the activity of the Commission and the direction of travel for moving forward over the next 2 years.
4.3	The governance framework has been established through the West Midlands Combined Authority Board and a West Midlands wellbeing board created which has representation from the Health and Wellbeing chairs cross the region.
4.4	The circulated report gives a further short overview of the commission work. Additionally, an another report will be circulated highlighting a number of key initiatives for ongoing intervention as outlined in the Thrive Action Plan

Signatures	
Presenting Officer:	**Sean Russell**
Chair of Health & Wellbeing Board (Councillor Hamilton)	
Date:	

West Midlands Combined Authority

Mental Health Commission
Briefing paper

Prepared by:

Steve Appleton
Managing Director – Contact Consulting
Project lead

Introduction

Poor mental health and wellbeing is a significant driver of demand for public services and reduced productivity and has therefore been identified as a potential area for which the Combined Authority could deliver public sector reform.

A Mental Health Commission was established in October 2015 to identify the contribution that devolution can make to addressing poor mental health and wellbeing. This is an important opportunity to transform mental health and wellbeing services to re-balance them to prevent demand for public services and critically to improve outcomes.

Aims of the Commission

The Commission has the following aims

a) To assess the scale of poor mental health and wellbeing across the combined authority area and its cost and impact on public sector services, the economy and communities

b) To review national and international research and best practice to establish what works best in addressing the impact that poor mental health and wellbeing has on public services, the economy and local communities. Establish the relative costs and benefits of the application of this evidence to the West Midlands

c) To identify, and consider the outcome from, work currently under way and/ or being piloted in the West Midlands to improve mental health and wellbeing

d) To make recommendations to both Government and the West Midlands Combined Authority on:

- How public services should be transformed to reduce the impact that poor mental health and wellbeing have on public services, the economy and communities in the West Midlands, within the current resource envelope.

- How resources currently spent on managing and treating mental ill health can be re-directed to measures that keep people mentally well and enable recovery.

- The potential for a devolution deal for mental health and wellbeing, and if appropriate specify the nature of a devolution deal.

- The outcomes that can be delivered by public service reform, within existing resources, to address poor mental health and wellbeing and the impact on demand for public services and productivity.

Membership of the Commission

Rt. Hon. Norman Lamb MP (Chair of the Commission)
Former coalition government Minister for Care Services at the Department of Health (Sept. 2012 – May 1015). Liberal Democrat health spokesperson and MP for North Norfolk.

Paul Anderson
Managing Director – Deutsche Bank Birmingham

Professor Dame Carol Black
Advisor to government on employment and health and Principal of Newnham College, Cambridge.

Professor Kevin Fenton
Director of Health and Wellbeing – Public Health England

Steve Gilbert
Serious Mental Illness - Living Experience Consultant
West Midlands Mental Health Commission Criminal Justice KLoE Lead

Craig Dearden-Phillips
Chief Executive and founder of Stepping Out

Dr Geraldine Strathdee
Former national clinical director for mental health at NHS England

Steve Shrubb
Former NHS mental health Trust Chief Executive and Director of the NHS Confederation Mental Health Network

Professor Swaran Singh
Head of Mental Health & Wellbeing Division at Warwick Medical School, University of Warwick

Karen Turner
Director of Mental Health – NHS England (joined Commission in April 2016)

Other attendees at Commission meetings

Sarah Norman
CEO of Dudley Council and lead officer for the Commission

Steve Appleton
Managing Director - Contact Consulting
Secretariat to the Commission

Simon Gilby

CEO of Coventry & Warwickshire Partnership NHS Foundation Trust
Attending on behalf of local NHS provider Trusts

Dr Paul Turner
Clinical commissioning lead for mental health at Cross-Birmingham CCG
Attending on behalf of clinical commissioners

Detective Chief Inspector Sean Russell
Mental health lead for West Midlands Police and attending in his role as Chair of the Commission's steering group

Summary of activity

Baseline assessment

The Health Services Management Centre (HSMC) of the University of Birmingham, were commissioned to conduct a baseline assessment of the current position in the area covered by the West Midlands Combined Authority (the seven metropolitan borough councils) in relation to mental health and wellbeing, in particular in relation to the economic costs and demands on public services.

The final version of the report is now complete and has been shared with Commission members. It is a thorough and wide ranging report that identifies not only the costs of the impact of poor mental health and wellbeing across the WMCA area, but also demography, prevalence trends, how support and treatment is currently provided and emerging good practice in the area. The information presented will be used to inform the development of the Commission report and discussions are taking place about the wider circulation of the baseline assessment, perhaps as a companion document to the Commission report.

Among its key findings were the following:

- Poor mental health costs the region £12.5 billion pounds per year – this breaks down to £3,100 per person per year.
- 23.8% of adults in the region have a mental health problem
- The costs of crime related to mental health are £1 billion pounds per year
- 70,000 people are economically inactive due to mental health problems, this costs £2.2 billion per year
- 475 deaths were recorded as suicide in 2013
- 4.1 million working days per year are lost as result of mental health problems

Engagement

The Commission has placed particular importance on creating the opportunity for those other than the commission members to deliberate, have their voices heard and to influence the outcomes of the process.

Public listening events took place in the spring in Birmingham, Coventry and Dudley. The report of these events, which outlines the key themes to emerge is now complete and has been used in the development of the Commission report.

A Citizen's Jury was established. Participants were people who have current or previous lived experience, or those who are carers. The profile of citizens reflected local diversity (age, ethnicity, income, geography). The Jury held eight sessions and presented their recommendations to the Commission. The Commission met with the Citizen's Jury members again in November to discuss its emerging actions and to get further input from them. It is also exploring ways in which the members of the Citizen's Jury can continue to play a part in the implementation of the Commission's recommendations.

The report of the Citizen's Jury, including their recommendations about areas of focus for inclusion in the Commission report has now been published on the WMCA website.

Gathering evidence

The Commission issued a call for written evidence relating to the key lines of enquiry (KLOE). These requests were sent to a range of experts and organisations both local, nationally and internationally.

The submissions received were collated and scrutinised by the project lead in conjunction with the Deputy Chief Executive of the Centre for Mental Health (CfMH). The CfMH are an independent charitable organisation with particular expertise in research and policy development, review and evaluation. A report of the scrutiny of evidence was completed and has been shared with Commission members. It provided details of where the evidence might best contribute to the Commission report to support its recommendations and the approaches being trailed.

Emerging actions from the Commission

The Commission has been concerned to ensure that its work leads to practical action that makes a difference to mental health and wellbeing in the West Midlands. It is therefore seeking to get agreement from relevant partners to actions published in the form of a Concordat, rather than publishing a set of recommendations.

Drawing on the evidence received the Commission has now developed a series of proposed actions relating to its key lines of enquiry. It is expected that before the document is published, all the key organsations and stakeholders in the region including the NHS (commissioner and providers), WMCA and the Police will have signed up to support the actions and their implementation. The proposed actions are grouped under six themes:

- Supporting people into work
- Providing safe and stable places to live
- Mental health and criminal justice
- Developing approaches to healthcare
- Getting the community involved
- Working with other cities and regions

Supporting people into work

We will:

- Launch a three-year programme to help 5,000 more people with mental health needs gain and stay in employment. This has never before been attempted on this scale.

- Launch a ‘West Midlands Workplace Wellbeing Commitment' in Spring 2017, where public and private sector employers sign up to demonstrate their commitment to the mental health and wellbeing of their staff.

- Encourage companies bidding for public sector contracts to show this commitment by including it in relevant procurement criteria.

- Work with the Government to trial an innovative 'Wellbeing Premium' - a tax incentive for employers demonstrating their commitment to staff wellbeing - that will reduce staff sickness absence, improve productivity and prevent people leaving work due to mental ill health.

Providing safe and stable places to live

We will:

- Help to develop an innovative scheme based on the principles of Housing First to support those with complex needs or who are homeless to move into good quality housing and where possible, into work. We will bid for funding from social enterprises and the Government to roll out this scheme.

Mental health and criminal justice

We will:

- Implement a programme to make more regular and widespread use of the Mental Health Treatment Requirement in the Magistrates and Crown Courts, which offers offenders with mental health problems the option of a treatment plan that addresses the underlying causes of offending. Working with the Ministry of Justice, this programme will help recovery, reduce reoffending, and reduce the cost and impact of crime on the local community.

- Develop a programme that more effectively supports people with mental ill health as they prepare to leave prison and settle back in the community. We will pilot this scheme within a prison in the WMCA footprint.

Developing approaches to healthcare

We will:

- Launch a ‘Zero Suicide Ambition’ approach – which aims to prevent and reduce suicides across the region. Involving NHS organisations, local authorities, the police, community organisations and the wider community, it will aspire to save lives, challenging the assumption that for some people, suicide is inevitable

- Establish a group of local and national experts to recommend a primary mental health care model for the region that ensures people’s mental health needs are more effectively supported. We want mental health to be embedded into primary care by the end of 2018.

- Help to ensure the region meets national access and waiting time standards for early intervention in psychosis services. Our region is falling behind other areas where this is very successful – for example in Cornwall around half of people receiving early intervention return to education and employment.

- Establish a group of local and national experts to examine if the principle of early intervention should be applied to other areas of mental health care, so we could support people much earlier, whatever their age.

- End out of area placements for acute mental health patients (except in exceptional circumstances where specific specialist treatment is required) – where mental health patients are placed outside the area of the five NHS Trusts in the region - by the end of 2017.

- Help to explore effective alternatives to inpatient care that meet the individual needs of people with mental ill health, and test which work best before implementing them. Working with housing associations, the NHS and local authorities, we'll establish a network of crisis houses, and explore the case for host families in the region

- Apply for a grant for a major project to substantially reduce the use of restraint in inpatient settings.

- Help to trial 'Integrated Personal Commissioning' in the region for those with mental ill health, where health and social care funds available for an individual are pooled, giving power to that person to spend resources as they wish. We'll work with NHS England

- Establish a group to develop better specialist 'perinatal' mental health services across the region for women during pregnancy and after they give birth to their babies

- Examine why detentions under the Mental Health Act are rising in the region, particularly numbers of repeat detentions, and if there are inequalities.

Getting the community involved

We will:

- Launch a programme of community initiatives to raise awareness of mental health and wellbeing, guided by people with experience of mental ill health and driven by the community. This includes:

    - an annual 'Walk out of Darkness' - a 10k sponsored walk through the region to raise funds for organisations supporting people with mental ill health awareness of mental health (This will take place on 10 May 2017)

    - an annual awards ceremony to recognise people in local communities who do amazing work supporting others

- Launch a large public health programme to train up to 500,000 people across the region in Mental Health First Aid and wider mental health literacy over the next ten years that will improve people's knowledge of mental health and how they can support each other. We'll campaign for Government to amend First Aid legislation for employers, to include mental health first aid.

Working with other cities and regions

Working with the International Institute for Mental Health Leadership (IIMHL) the region will participate in the development a global network of city regions, all of which have chosen to pursue major city-wide initiatives on mental health and wellbeing. The region will join cities such as London, New York, Philadelphia, Vancouver, Stockholm and Melbourne in this initiative to build links between key leaders in these cities, to share learning, ideas and programmes of work.

Next steps

The delivery of the actions to be set out in the Commission's action plan report will be subject to the agreement of the WMCA as well as other partner organisations and stakeholders. The process of seeking that agreement is now underway, including the establishment of a Task & Finish Group involving the Constituent Councils, the LEPs, NHS and other relevant partners which is working through the proposed actions from the Commission, identifying any obstacles to implementation and agreeing how these can be overcome, and identifying how commitments to the actions can be secured. We are seeking to launch the action plan on 31st January 2017.

Work has already commenced on a number of the actions in order to provide a platform for ongoing implementation. The work will be led and overseen by an Implementation Director. Following positive discussions with the Police & Crime Commissioner and the Chief Constable, agreement has been reached to second Superintendent Sean Russell to the role of Implementation Director for a period of two years, starting at the end of November 2016. Superintendent Russell will report to Sarah Norman, CEO of Dudley Borough Council.

Finance

The costs of the Implementation Director post are split three ways, with the WMCA, the Police and Crime Commissioner and NHS England (national mental health policy department) each contributing a third of the costs.

The Commission has been successful in securing funding from the Work and Health Unit within the Department of Work and Pensions and the Department of Health to support to actions relating to the programme to help people with mental health needs into employment. This programme of work forms part of the recent Green paper on Disability and Employment published on the 31st October.

An approach has been made to a social enterprise entrepreneur and Comic Relief with further discussions being had with the Department for Communities and Local Government as part of its homelessness prevention programme to support the action relating to Housing First.

The Commission is working with an organisation called Social Finance to explore and potentially secure social investment to aid the further funding of the actions relating to employment and housing including the development of the well being premium, which is also being discussed with the Treasury and Department for Work and Health as part of fiscal devolution discussions.

The Commission is exploring funding for the proposed mental health and criminal justice programmes with the Ministry of Justice, NHS and the Police & Crime Commissioners Office.

There may be other modest resources required to support implementation which are still being quantified.