BIRMINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

TUESDAY, 24 APRIL 2018 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/WEBCAST**

The Chairman 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**

3 - 12

4 **MINUTES AND MATTERS ARISING**

To confirm the minutes of the last meeting.

5 **CHAIR'S UPDATE (1505 - 1515)**

Chair of the Health & Wellbeing Board

13 - 38

6 **HEALTH & WELLBEING STRATEGY UPDATE (1515 - 1530)**

Report of Director of Public Health

39 - 66

7 **DISTRICTS AND NEIGHBOURHOOD CHALLENGES EXERCISES - MENTAL HEALTH (1530-1545)**

Report of District Head - Place Directorate

8 **RESPONDING TO THE PLACED BASED AGENDA (1545 - 1630)**

Report of Director of Public Health

67 - 72

9 **JOINT STRATEGIC NEEDS ASSESSMENT PLACE BASED INTELLIGENCE (1630-1640)**

Report of Assistant Director - Public Health

10 **OTHER URGENT BUSINESS**

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

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD
27 MARCH 2018

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY 27 MARCH 2018 AT 1500 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Paulette Hamilton in the Chair; Councillors Lyn Collin and Carl Rice, Professor Graeme Betts, Andy Cave, Professor Nick Harding, Operations Commander Steve Harris, Dr Adrian Phillips, Dr Gavin Ralston, and Stephen Raybould.

ALSO PRESENT:-

Vanessa Devlin, Birmingham and Solihull Mental Health NHS Foundation Trust
Paul Jennings, CEO, NHS Birmingham Crosscity CCG
Richard Kirby, CEO, Birmingham Community Health Care Trust
Mark Lobban, Programme Director Service Improvement, BCC
Dame Julie Moore, CEO, University Hospitals NHS Foundation Trust
Lawrence Tallon, Director of Corporate Strategy and Planning, UHB
Sharon Sinclair, Interim Assistant Director as substitute for Colin Diamond
Errol Wilson, Committee Services, BCC

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At the start of the meeting the Chair invited the Board members who were present to introduce themselves.

NOTICE OF RECORDING

233 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.

DECLARATIONS OF INTERESTS

234 Stephen Raybould declared a non-pecuniary interest in relation to a part of agenda item No. 9 *Health and Wellbeing Strategy Update* – against one element of the health and wellbeing Strategy on personal budgets.

The Chair advised that the *Health and Wellbeing Strategy Update* item would be deferred to the next Health and Wellbeing Board meeting scheduled for the 24 April 2018.

Councillor Carl Rice declared his non-pecuniary interest in agenda item No. 11 *Sustainability and Transformation Plan Update* and stated that his wife works at the QE Hospital.

APOLOGIES

235 Apologies were submitted on behalf of Dr Andrew Coward, Colin Diamond (Sharon Sinclair, Interim Assistant Director attended as substitute), Jonathan Driffill and T/Supt Tom Joyce.

The business of the meeting and all discussions in relation to individual reports was available for public inspection via the web-stream.

MINUTES

Minute No.227, paragraph 2, third sentence – ***dynastic*** should be ***diagnostic***.

236 **RESOLVED:-**

That, subject to the above amendment, the Minutes of the Board meeting held on 20 February 2018 were confirmed and signed by the Chair.

CHAIR'S UPDATE

237 The Chair gave a brief update on the following visits she had made since the last Board meeting: -

- TouchBase Sense – 1st March 2018;
- Freedom Project – 6th March 2018
- LGA Community Wellbeing Board meeting – 14th March 2018
- Carers Event – a joint event with CCG and Birmingham Carers Hub at Birmingham City Football Club. It was noted that there was 107,380 carers in Birmingham.

The Chair highlighted that this week was Stella Manzie, Interim Chief Executive of Birmingham City Council last week. The Chair expressed her thanks on behalf of the Board to Ms Manzie for her hard work during her time in office with the City Council. She added that as they bid goodbye to Ms Manzie, they welcome Dawn Baxendale who takes up the role as the new Chief Executive on the 1st April 2018.

(See document No. 1)

INTRODUCTION TO RICHARD KIRBY

238 Richard Kirby, CEO, Birmingham Community Health Care Trust made the following introductory statements: -

- That this was his 3rd week in the role and he started his NHS career in Birmingham working with a group of GPs in south west Birmingham in a number of roles.
- Subject to their Board's approval, a piece of work would be started on Wednesday to refresh the organisation values and strategy. This will be an opportunity as the work evolves, to return and speak with the HWB about their thinking and where they see the services that they provide was fitting into the health and social care system in the city.
- They were doing this to be consistent with the Sustainability and Transformation Plan (STP) for Birmingham and Solihull and the HWB as they had decided not to proceed with the proposal to merge with the Black Country Mental Health Services.
- Three important things were: - firstly, the quality and safety of the care they provide. Secondly, recognising that the system they operate in was one that would place a premium on the integration of the range of services that helps support people. Thirdly, looking at the range of services they provide in multi-disciplinary team.
- There was a lot they could bring to the work of this Board and the work of the STP. They would be setting out after Wednesday's board meeting the process they would look at concerning services.

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

a. In terms of early challenges, making sure they were seen as and playing a proper role which was important for Birmingham and Solihull health and social care system.

b. Some of the other work they had been engaging in over a period of time may have led to them not putting in quite the level of focus in Birmingham and Solihull system that they should have done. Making sure they were concentrating on the core system.

c. Recognising that as an organisation, they were big and covers a wide range of services with 5000 plus staff in 350 different locations across the city in some specialist services in some of what they do and some real day to day local community care.

d. Making sure that they could bring all of that together into something in that it was coherent and where there was national leading work they were doing specialist services, bringing something to the work that the community nursing was doing to help people stay well in their own homes.

e. Finding a way to continue to innovate and continue to change at a time when resources were strained which may not have faced much of a challenge around resources as some other parts of the public sector, but they had a share of those challenges.

f. Making sure they could find a way of working that frees their teams up to do the right things with partners in social care on the ground with other partner agencies was key to this.

g. Partly the decision not to proceed with the Black Country merger was a necessary step to enabling them to do that, but he did not see it as a sufficient one on its own. There was also something about being clear that the strength of the partnership they had was at a crucial level with Professor Betts and his team and joining the mental health service was

the commission of the CCG and primary care organisations within the city will matter to them which was a personal priority for him.

h. Finding ways to enable our local team to work closely and constructively alongside other staff in those localities, GP surgeries and their teams, social care etc. That sense of creating a locality way of working with our teams could do well alongside the other agencies they work with.

i. His understanding was that the Black Country Mental Health Trust and the Commissioners in the Black Country were working out how they could merge as Sandwell and Black Country Health provider and that work did not involve his Trust.

j. For Birmingham community there was some reaction as a lot of our staff had to put a lot of work into these plans and he wanted to recognise that and that there was a degree of emotional energy and investment in this to respond to properly. They had not taken lightly the decision to pull back from that process.

k. Broadly the reaction he had as he spoke with staff around the city was one of relief as it had enabled them to focus on the local agenda. There was a sense that they were stretched trying to do everything they were trying to do.

l. In the core service delivery for Birmingham, was where our staff wanted the focus of the organisation to be and to that extent, it created the opportunity to do the piece of work on their future contribution to the Birmingham system.

m. In terms of working with the voluntary sector in Birmingham, they wanted to work with them closely, some of which would be citywide cooperation and collaboration and would become a larger part of that sector, but it was suspected that the big prize would come when they were able to support their locality teams. Work patch by patch with the community based groups that made a big contribution to what goes on across the city.

The Chair thanked Richard Kirby for attending the meeting.

PROPOSED BIRMINGHAM INTEGRATED HEALTH AND SOCIAL CARE MODEL FOR OLDER PEOPLE

The following report was submitted:-

(See document No. 2)

Mark Lobban, Programme Director, Service Improvement, BCC, Paul Jennings, CEO, NHS Birmingham Crosscity CCG and Professor Graeme Betts, Corporate Director for Adult Social Care and Health, BCC presented the item.

In response to questions from members, Professor Betts, Paul Jennings and Mark Labban made the following statements:-

a) When the document was being drafted it was more *fluid* and a lot of people would appear in a lot of the boxes. They highlighted on certain groups to demonstrate the principles, but in reality it had to be more *fluid*

than that, e.g. the role of a Social Worker who was engaged throughout the process.

b) Similarly with Mental Health, this was seen as a part of this, whichever box of circle they were looking at, there needed to be a mental health intervention. It was not just the CPN, but there was a whole range of people that would be involved in that some more in one area than others. They needed to ensure that the system could work in that way not just diagrammatically.

c) Another point was that when it came to the CQC review they were not brilliant with communicating with the public and this was an area that they needed to improve. In terms of areas such as social prescribing etc. they needed to get better at getting those messages out and making it more accessible.

d) With regard to organisational boundaries and systems, a key component to this model was the relationship they would have together as an overarching authority in terms of designing the new system, they were putting together as part of the organisational structure.

e) There will be an overarching principle which Professor Betts and Mr Jennings would co-chair to direct the work around aging well in the city. A clear statement from the top was that they would take away some of those organisational boundaries.

f) An important part of their work was the development of the communities' services strategy and how it links with primary care, the place model the local authority had and how that links with the voluntary sector. They had discussion with John Short, CEO, Birmingham and Solihull Mental Health NHS Foundation Trust, about how this would link with HWB and he was keen to be part of that model.

g) This was part of what they were trying to do as they develop the urgent treatment centres and the access as they will be doing the scales with GPs, was to deliberately set out how they would work to design and to work constructively than with boundaries and interfaces.

h) In relation to Mental Health, they were fully engaged as they had meetings, but there was more to be done in terms of the model and the care programme and they needed to continue the dialogue and the conversations. The point concerning boxes was noted, but it was more of an opportunity to define roles and remove organisational boundaries.

i) What was helpful was taking forward this work, but it was complicated as things overlap. The issue was how they would use this to take it strategically forward with the work. The whole communication and engagements needed to be well thought through and they needed to think about communicating messages at all levels.

j) In relation to choice and control, there was something about increasing the number of direct payments and personal health budgets, but they could only do that if people had the right kind of support, they could use to buy the support that they need.

k) They needed to look at market shaping as they could do better at that when it comes to things like home care when they were looking at choice, it was about knowing the name of the person coming to your house. It was about being able to get up when you wanted to not getting up when the carers turned up.

l) In terms of how good they were with that at the moment, it was felt that they could improve things by having more flexible local services.

Mr Lobban gave an example of what was meant by social prescribing and advised that for social prescribing to work there had to be the combination of the GP and the voluntary sector.

The Chair then made the following points on behalf of residents: -

- What was being planned looked good, but they needed to ensure that they brought the staff along with them as they did not want a repeat of what happened with the CQC where they knew where they were going, but the staff were not going along with them.

- People were in the place where they lived and needed to know how to access the service. Going forward, they needed to know what was stated and things were made easier. They needed to ensure that they did not lose sight of the service.

The Chair thanked Professor Betts, Paul Jennings and Mark Labban for reporting to the meeting and it was

239 **RESOLVED:-**

The Health and Wellbeing board: -

(i) Noted the development of a wider comprehensive Joint Strategy for Older People to be discussed at a future meeting of the Health and Wellbeing board;
(ii) Provided any comments to help further shape the Integrated Health and Social Care Framework; and
(iii) Supported the work to date being presented to the STP Board on the 9th April 2018.

COMMISSIONING CHANGES IN BIRMINGHAM

240 The following report was submitted:-

(See document No. 3)

Paul Jennings, CEO, NHS Birmingham Crosscity CCG introduced the item and took the Board through the PowerPoint slides.

Professor Nick Harding stated that they value the formation of the joint committee and that after the 2012 Act., there came a piece of legislation stating

that CCGs were allowed to work together in that way which empowers them to work under the MIU and for them to deliver what was right for the people of West Birmingham.

The Chair highlighted that Dr Gavin Ralston and Dr Andrew Coward had been members of the HWB for a number of years and had worked hard in helping to take the Board to this point. She expressed thanks to them for their hard work and wished them all the best for the future.

CHANGE TO ORDER OF BUSINESS

241 The Chair advised that she would take agenda item 11 ahead of the remaining reports.

SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE

242 Dame Julie Moore, CEO, University Hospitals NHS Foundation Trust introduced the item and Lawrence Tallon, Director of Corporate Strategy and Planning, UHB gave a PowerPoint presentation.

(See document No. 4)

In response to questions, Dame Julie Moore and Mr Tallon made the following statements: -

(i) The STP was taking an overview and ensuring that they tie things together, but the HWB had a bigger role in doing so.

(ii) In terms of governance there was no overarching structure, but what the Chair had done by bringing us together and being on the STP Board was trying to finding a way round.

(iii) Dame Moore, stated that in her opinion there should be a change in legislation to enable some of this happened, but that she did not believe that any of this would happen. They had to work around those structures to make it work properly. The relationships that they had now developed and built up enabled that.

(iv) They had to move more into intervention and they had to look after people, and hospitals were not the best place for people but sometimes it was the only place so they need to develop alternatives. They had a number of discussions concerning this, but they were not there yet, but they had started and had agreed on the way to do that.

(v) There was a combination of national and local action and it was undoubtedly the case to shift model of care to the less acute, but there was not enough resource in the system for them to take money out of hospitals. There had to be something about greater national investment to allow them to shift that model.

(vi) In terms of the model of care this started in school. Reference was made to an event that was held at a school in Chelmsley Wood where

they lifted the aspiration of their community. They had people thinking of much higher aspiration the education attainment improving etc.

(vii) There was something about how they could shift this model of care, some of which would have to be new resources and some that they had to be brave enough and shift things around.

(viii) Technology in specialised health care had driven cost growth, so, generally the cost of health care rose about 2% above of GDP growth, but in the wider economy, technology was seen as the driver of productivity. The question was how they could bring these two together as the technology in health care increase cost, but it allows them to do things differently – example AI delivery and diagnostic scan instead of people and things like that.

The Chair thanked Dame Julie Moor and Lawrence Tallon for attending the meeting and presenting the information. She added that she will be inviting Dame Julie Moore to sit on the HWB as a co-opted member.

CARE QUALITY COMMISSION REVIEW UPDATE

243 Professor Graeme Betts, Corporate Director for Adult Social Care and Health, BCC presented the following:-

1. The draft report following the Care Quality Commission (CQC) review was issued on the 16th March 2018. Once they had the draft report they were given 5 working days to check it for factual accuracy which they had done and had submitted their comments.
2. The next event as part of the review will be a summit when the CQC formally feedback on the report. The approach they were taking was to propose a draft action plan. The CQC report had 17 points identified which was a basis for the action plan. They will theme them so that they had clear themes to address to demonstrate how they would pick up these points.
3. They wanted to reflect the work that had been going on since January when the review took place as a lot of work had been done that was coming through the HWB. They also wanted to reflect the plans for the future, example, they would be highlighting the conference they would be holding for older people under the theme of *Aging Well* which will take place in May.
4. Another thing that they needed to do as the HWB was central to this, was how they would report to NHS England, who was charged to ensure that these action plans arising from the review was driven forward. They needed to agree how this would be done and would be requesting that the Chair address this issue.

The Chair echoed Professor Betts comment concerning *Growing Old Well in Birmingham* and stated that they had gotten disconnected somewhere and it did not reflected well. The vision for the city was – *a city to grow old in*. The vision the STP Board had was *to grow old well in the place that you live in* and they needed to ensure that they got this right as they were currently a young city. It

needed to be ensured that as our citizens were getting older they felt comfortable in the place they were growing old in.

The Chair expressed thanks to Professor Betts for all the hard work he had done during the CQC visit.

UPDATE OF TERMS OF REFERENCE AND MEMBERSHIP

The following report was submitted:-

(See document No.5)

Dr Adrian Phillips, Director of Public Health, BCC presented the item and drew the Board's attention to the information contained in the report. He highlighted that they could co-opt more members to the Board as required.

The Chair noted Professor Harding's comment concerning Dr Ralston and Dr Coward and advised that she would write to them formally to thank them for their hard work to the HWB.

Dr Ralston expressed thanks to Professor Harding for his comments and stated that he had enjoyed working as vice-Chair and with the Chair. He further expressed his best wishes to the HWB for the future.

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

a. Dr Phillips noted Mr Harris comment and stated that in relation to the Police and Fire, what they needed to discuss, perhaps in the next meeting or in between meetings how they co-opt other significant parties and what they bring to the HWB.
b. The point raised concerning the DWP would be a challenge, but he would ensure that the representative who attended had the necessary authority and responsibility to bring about change.
c. Dr Phillips noted Mr Raybould's comment and advised that previously they had a Secondary Care provider representation, but one of the issues were changes with the STP to get a more rounded view with the health and care system.
d. They could co-opt people as they felt necessary. It was a public meeting and any CEO or other representatives could attend as the Chair had indicated a relaxed approach to bring other non-members into the discussion. In relation to the DWP point, deputies will need to be notified and they had to have delegated responsibility to do something.

The Chair stated that she was relaxed about getting people co-opted to the Board and that it was her aim to make the Board a strong one by the end of this year. She added that they needed to change how people were co-opted and suggested that the Board could co-opt someone from the university with a wide knowledge around health and social care. She emphasised that the HWB was the only Statutory Accountable Body in the system and that they needed to start *pulling their weight.*

The Chair thanked Dr Phillips for reporting to the meeting. It was

244 **RESOLVED:-**

That the Board agreed changes to its composition.

The Chair expressed thanks to Dr Gavin Ralston for his hard work to the Board and added that he had helped her to grow in her role whilst he was the vice-Chair. She added that he will be missed and she wished him all the best in his future endeavours.

The Chair expressed thanks to Councillor Lyn Collin for her hard work and support to the Board and commented that she was a *lioness.* She added that Councillor Collin had challenged, fought for the cause and had been there fighting for the residents, but ensured that the Chair understood what the issues were and that she would be missed from the Board.

The Chair thanked everyone for attending and highlighted that the next meeting was scheduled for Tuesday 24 April 2018.

The meeting ended at 1655 hours.

……
CHAIRPERSON

	Agenda Item: 6
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**24th April 2018**
TITLE:	**HEALTH & WELLBEING STRATEGY UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer	**Adrian Phillips / Carol Herity**

Report Type:	**Information**

1. Purpose:

1.1 To update the Health and Wellbeing Board of progress in developing and establishing potential indicators and targets and accountable groups across the health and social care economy that have the lead on delivering the ambitions in the Health & Wellbeing Strategy.

1.2 To identify issues that may hinder progress delivering the ambitions of the strategy.

2. Implications:

BHWB Strategy Priorities	Detect and Prevent Adverse Childhood Experiences	Y
	All children in permanent housing	Y
	Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	Y
	Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	Y

	Improving stable and independent accommodation for those learning disability	Y
	Improve the wellbeing of those with multiple complex needs	Y
	Improve air quality	Y
	Increased mental wellbeing in the workplace	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. Recommendations
The Board is asked to; - 3.1 Note the developments related to the Strategy. 3.2 Agree to provide specific leadership to individual objectives. 3.3 Agree a programme of receiving more detailed updates from each of the priority leads as a rolling programme over 12 months.

4.	Background
4.1	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. A refreshed Health and Wellbeing Strategy (HWBS) was adopted in January 2017.
4.2	At the July HWBB it was agreed that the Operations Group should look to identify individuals from each area to lead priority areas of the strategy. The Operations Group were tasked with identifying potential indicators, targets and key delivery groups, including areas where gaps existed, and to report back to the HWBB.
4.3	The mechanisms that can be used to progress meaningful actions to improve outcomes in these areas need to be identified.
4.4	**Targets** **Appendix 1** outlines updated strategy in linking objectives with targets, source etc. Difficulties have been encountered in focussing on targets and agreement of sources etc. It is proposed that the Board will provide leadership in developing this further.
4.5	**Board Member Involvement** The strategy must be owned by the Board. It is recommended that Members of the Board consider "leading" the objectives. This would involve relevant Board Members receiving updates on key issues and developments related to the objectives. This would enable them to update at meetings as needed.
4.6	**Next Steps** • The Health and wellbeing Board Operations Group continue to work with partners to ensure plans are in place to deliver the ambitions within the strategy. • The Operations Group to report on continued progress against targets once they have been established.

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 Health and Wellbeing 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	
1.	Health and Wellbeing Strategy Update

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

Health & Wellbeing Strategy Update

Background

In January 2017 the HWBB agree to a set of updated priorities for the HWS. Subsequently the HWBB has asked the Operations Group to identify potential indicators and targets and accountable groups across the health and social care economy that have the lead on delivering these ambitions.

An overview of this work is shown in the table below.

Ambition	Target	Key links/external bodies	Board Lead	Operations Lead
Detect and Prevent Adverse Childhood Experiences	tbc	Birmingham Early Help and Safeguarding Partnership	tbc	Dennis Wilkes BCC
All children in permanent housing	All children in permanent housing	Housing Birmingham	Jonathan Driffill	Kalvinder Kohli BCC
Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	To be agreed with NHSE BCC target 25% by 31/3/18	Integrated Personalised Commissioning Board	tbc	Anita Holbrook CCG Tapshum Pattni / Chris MacAdams BCC
Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	8.9% patients with on CPA in paid employment by 2020/21 Accommodation tbc	Mental Health System Strategy Board Adult Social Care and Health Directorate Leadership	tbc	Jo Carney CCG Melanie Brooks BCC

Ambition	Target	Key links/external bodies	Board Lead	Operations Lead
Improving stable and independent accommodation for those learning disability	tbc	Adult Social Care and Health Directorate Leadership	tbc	Melanie Brooks BCC
Improve the wellbeing of those with multiple complex needs	tbc	West Midlands Combined Authority	Stephen Raybould	Natalie Allen/Ruby Dillon BVSC
Improve air quality	Halve air pollution attributable mortality by 2030	BCC Air Quality Steering Group	Adrian Phillips	Wayne Harrison BCC
Increased mental wellbeing in the workplace	tbc	West Midlands Combined Authority	tbc	tbc

Further details on the indicators, baseline performance and required trajectories, along with an overview of current plans to achieve the ambitions that have been identified are given in attached summaries.

Current position

System-wide work on each of the priorities still seems to be at different stages of development. From the information supplied to the Health & Wellbeing Operations Group each if the areas of the strategy can be categorised as below.

Identified indicators, targets and plans for delivery

- All children in permanent housing
- Increasing employment /meaningful activity for those with mental health problems
- Improving air quality
- Integrated Personal Commissioning

There are established work streams for each of these priorities with proposed and/or agreed targets. For the mental health and employment priority BCC integration with the NHS needs to be better understood.

Plans being developed but targets not yet determined

- Improving stable and independent accommodation for those learning disability
- Increasing stable accommodation for those with mental health problems
- Improve the wellbeing of those with multiple complex needs
- Detect and Prevent Adverse Childhood Experiences

Limited nationally published indicators are available for each of these areas. However, it has been recognised that there are gaps in these areas.

Indicators, targets and plans not yet determined

- Mental wellbeing in the workplace

Next steps

Agree the accountable group and targets for:

- Improving stable and independent accommodation for those learning disability
- Increasing stable accommodation for those with mental health problems
- Improve the wellbeing of those with multiple complex needs

Establish Birmingham indicators, targets and plans for:

- Mental wellbeing in the workplace
- Detect and Prevent Adverse Childhood Experiences

Detect and Prevent Adverse Childhood Experiences

Please provide a brief update on your agreed targets /indicators.

The suite of indicators being used by the Birmingham Early Help and Safeguarding Partnership have been adopted as being the most sensitive to changes in the impact of our local experiences in childhood. Changes due to the prevention of adverse experiences will, however, take time to be measureable.

A more formal assessment of the timeframe for measureable impact will need to be undertaken.

Current progress/developments?

The groups to develop our local responses to the opportunities for secondary and tertiary prevention are being formed to meet in December and report back to the Early Help and Safeguarding Partnership in Quarter 4 of 2017/18.

The Birmingham Child Poverty Action Forum is evaluating its next steps in Q4 of 2017/18

How can the board support you?

Continued support by Board members in their organisations and partnerships.

Seeking opportunities to support the development of a Strategic Partnership approach to developing the common culture and language of adverse experience being developed by the Chairs of the Birmingham Community Safety Partnership, Birmingham Adult Safeguarding Board, and the Birmingham Safeguarding Children Board.

Support for the Birmingham Child Poverty Action Forum in partnership with the Children's and the Equalities Overview and Scrutiny Committees.

Who is the Board Lead?

No one identified

All members have expressed a commitment.

Andrew Coward and Adrian Phillips have been personally involved in the Task & Finish group and ongoing developments

All children in permanent housing

Please provide a brief update on your agreed targets /indicators.

- The Homelessness Prevention Strategy 2017 + was presented at Cabinet December 2017 and City Council January 2018.
- The Pathway domain work is progressing, the first cut of excellence across the five domains - Universal, targeted, crisis, recovery and sustainable housing was presented at the Homelessness Partnership Board November 29th 2017. The next task is to establish audit tools to identify how far off excellence existing services are currently, gaps and best practice.
- The intention is to develop a kite mark for excellence which all agencies and learning institutions sign up to in terms of delivering excellent services in preventing homelessness.

Current progress/developments?

There are a number of new legislative changes which will support this target:

All local authorities are currently preparing for the implementation of the Homeless Reduction Act 2017 which places a much stronger duty on prevention people from becoming homeless. The Local Authority Legal duties covers three key areas:

1) Duty to provide advisory services – Free information and advice on preventing and relieving homelessness, including information tailored to the needs of particular vulnerable groups.

2) An enhanced prevention duty - requiring local authorities to intervene earlier to prevent homelessness (from 28 days to 56 days).

3) A new duty towards those who are already homeless requiring local authorities to work with them for 56 days to help secure accommodation to relieve their homelessness. It is clear that there is a firm expectation that local authorities reduce the numbers of households placed within temporary accommodation as a result of this new legislation.

To support this process, the Supporting People and Homeless Prevention Grant commissioned providers may be asked to closer align some of their service area activity to support the preventative duties as set out within the Act.

The local authority has also been provided with some new burdens monies to support them to put in place the changes required to support the implementation of the new legislation. This includes changes to back office systems, staff training, additional staff, IT infrastructure and potentially some external commissioning.

With regards to young people leaving Care – The new Children and Social Work Act 2017 requires local authorities to put in place a local offer that may assist care leavers in preparing for adulthood and independent living. This includes services relating to health and well-being, relationships, education and training, employment, accommodation and participation in society.

Work is currently underway with the Children's Trust (Shadow) to establish the housing and support requirements associated with this new duty.

The draft Code of Guidance on the Homeless Reduction Act also makes specific reference to the role of housing authorities in working with children services and consult care leavers to ensure the advice and information is i) designed in an appropriate format for the age of the client group; ii) available through communication channels which care leavers are most likely to access iii) understood by children's services authority staff.

A Care leavers Accommodation and Support Framework has been in development for a number of months and this will support the specific requirements with regards to young people leaving care. This will include sustainable, affordable and suitable housing options for young people as they prepare of independent living.

Work is also under way between the Children's Trust (Shadow) and the Place Directorate in order to secure 1 Bed Flats for Care Leavers as a means of more settled accommodation with Support.

Development of the Youth Housing Offer for Birmingham is being progressed through the Housing Birmingham Workstreams with partner agencies. This will include shared living options, pre tenancy support, live and work schemes and employment and training.

Birmingham is also represented on the regional mayoral work streams which include support to families and young people.

How can the board support you?

1) The development and implementation of a homelessness positive pathway for Birmingham requires a systems leadership/systems change approach to be successful. One area that requires specific attention is the contribution of health partners along the different domains of the pathway. This may be very different to what is currently provided. The Board may wish to consider offering some systems change support. Discussions are currently underway with Public Health to see if this can be resourced. Board may also wish to retain some oversight of this specific work stream.

2) The recommendation within the Cabinet Report is that the implementation of the Pathway will report to the Health and Wellbeing Board. Therefore there are boarder issues relating to homelessness and its impact upon the life course on different cohorts of vulnerable groups which are at greater risk of homelessness:

- Victims of domestic abuse

- care leavers
- Mental Health, learning, physical and sensory disabilities
- People leaving prison or with offending backgrounds

The Board may wish to consider boarding its interest to support the development and commissioning activity to respond to the above using the Positive Pathway approach

3) As part of the Homelessness Reduction Act there will be a Duty upon Public Authorities from October 2018 to refer service users who they may think may be homeless or threatened with homelessness to a housing authority. There is a view amongst stakeholders that this wording could be voluntary strengthened by key stakeholder agencies to a voluntary Duty to collaborate and this would be within the spirit of the Homelessness Positive Pathway. The Board may wish to give some consideration as to how this could be agreed as a starting point by agencies represented on the Health and Wellbeing Board?

Who is the Board Lead?

Jonathan Driffill

Increase the control of individuals over their care through Integrated Personal Commissioning – Personal Health Budgets

Please provide a brief update on your agreed targets /indicators.

No update received

Current progress/developments?

No update received

How can the board support you?

No update received

Who is the Board Lead?

No one identified

Increase the control of individuals over their care through Integrated Personal Commissioning - Direct Payments

Please provide a brief update on your agreed targets /indicators.

Indicator: Proportion of clients for whom a Social Care Individual Budget is being taken in the form of a Direct Payment.

Target: 25% by 31/3/18

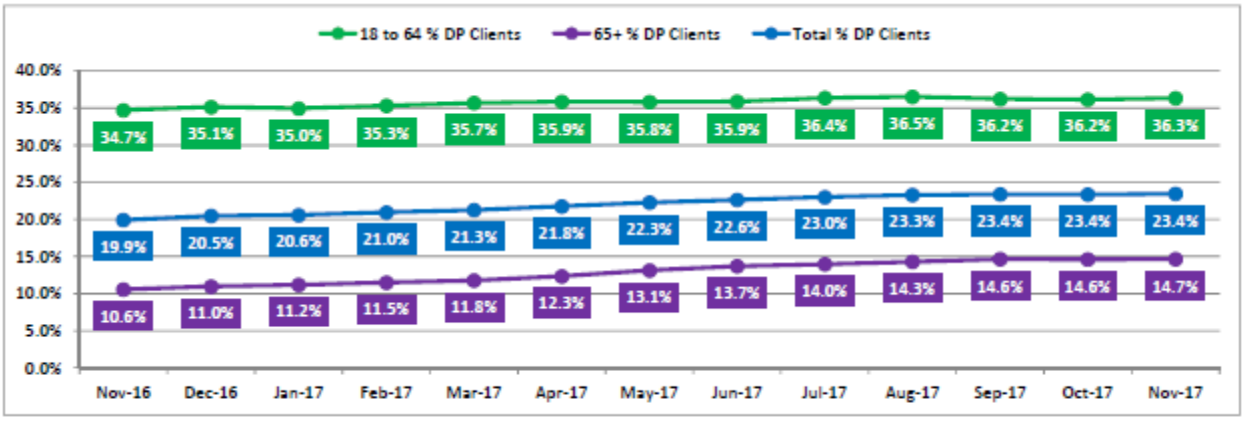
Current progress/developments?

Direct Payments

Showing the number of clients (not carers) receiving a service which is eligible for Self Directed Support (e.g. Direct Payments or Individual Budgets) and the number / proportion of clients who receive this, in whole or in part, as a Direct Payment.

Figures shown as a series of snapshots at the end of each month and on the date of the latest available data

		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	06/11/2017
18 to 64	Eligible clients	3182	3178	3210	3235	3247	3265	3284	3291	3298	3321	3340	3363	3358
	Clients with DP	1105	1117	1122	1143	1159	1171	1176	1181	1200	1213	1210	1216	1220
	% DP Clients	34.7%	35.1%	35.0%	35.3%	35.7%	35.9%	35.8%	35.9%	36.4%	36.5%	36.2%	36.2%	36.3%
65+	Eligible clients	5038	4907	4908	4922	4944	4883	4867	4885	4871	4879	4908	4928	4926
	Clients with DP	532	538	549	566	582	603	639	669	680	697	719	720	722
	% DP Clients	10.6%	11.0%	11.2%	11.5%	11.8%	12.3%	13.1%	13.7%	14.0%	14.3%	14.6%	14.6%	14.7%
Total	Eligible clients	8220	8085	8118	8157	8191	8148	8151	8176	8169	8200	8248	8291	8284
	Clients with DP	1637	1655	1671	1709	1741	1774	1815	1850	1880	1910	1929	1936	1942
	% DP Clients	19.9%	20.5%	20.6%	21.0%	21.3%	21.8%	22.3%	22.6%	23.0%	23.3%	23.4%	23.4%	23.4%



How can the board support you?

No support required from the board at this time.

Who is the Board Lead?

No one identified

Increasing employment/ meaningful activity for those with mental health problems

Please provide a brief update on your agreed targets /indicators.

Birmingham CCGs have recommissioned Mental Health 'day services' and learning and work services to provide a redesigned integrated recovery and employment service for people receiving secondary care mental health services. Employment support will be provided with fidelity to the Individual Placement Support (IPS) model.

Individual Placement Support is an evidence based model which has been proven to achieve higher numbers of people entering and sustaining employment. IPS workers are integrated into community mental health services and provide open ended support to both employee and employer.

The IPS service will fulfil full fidelity principles outlined by the Centre for Mental Health. The commissioned service must therefore exceed 8 quality outcomes, these are:

- To ensure that no service user is excluded from the service
- Employment support and treatment are integrated
- Job search is rapid and intensive
- Only minimal pre-work training is offered and that the focus should be on obtaining sustained employment.
- Service users are offered a personalised job search.
- IPS work with employers to develop links and support.
- Long term support in work, both before, during and after employment.
- Access to welfare and benefits advice.

The Employment and Recovery service will:

Ensure more mental health service users in contact with secondary care services in employment as a result of the introduction of the fidelity Individual Placement Support model.

Increase the number of people with mental health problems preparing for employment by building their work capacity and skills for looking for work.

- Increase the number of people with mental health problems in sustainable employment.

Targets:

Engagement in IPS Service.	Number of people engaged in IPS service	2018/19 – 504 2019/20 – 672 2020/21 – 672
Paid Job Outcomes	Service Users in paid employment (reported under/over 16 hours per week and sustained for 13 weeks)	2018/19 – 120 2019/20 – 190 2020/21 – 190
Job Retention	Number of people in existing paid employment who retain their employment	2018/19 – 12 2019/20 – 19 2020/21 – 19

Current progress/developments?

A tendering process for Mental Health Recovery and Employment Services has been undertaken and a contract has now been awarded to a consortium of providers – Better Pathways, MIND and Creative Support. Better Pathways will be delivering the IPS functions from April 2018.

Plans for mobilisation remain on track for the new service to commence at the start of April.

How can the board support you?

To advise of any opportunities to encourage the Local Authority and other employers to engage with IPS workers.

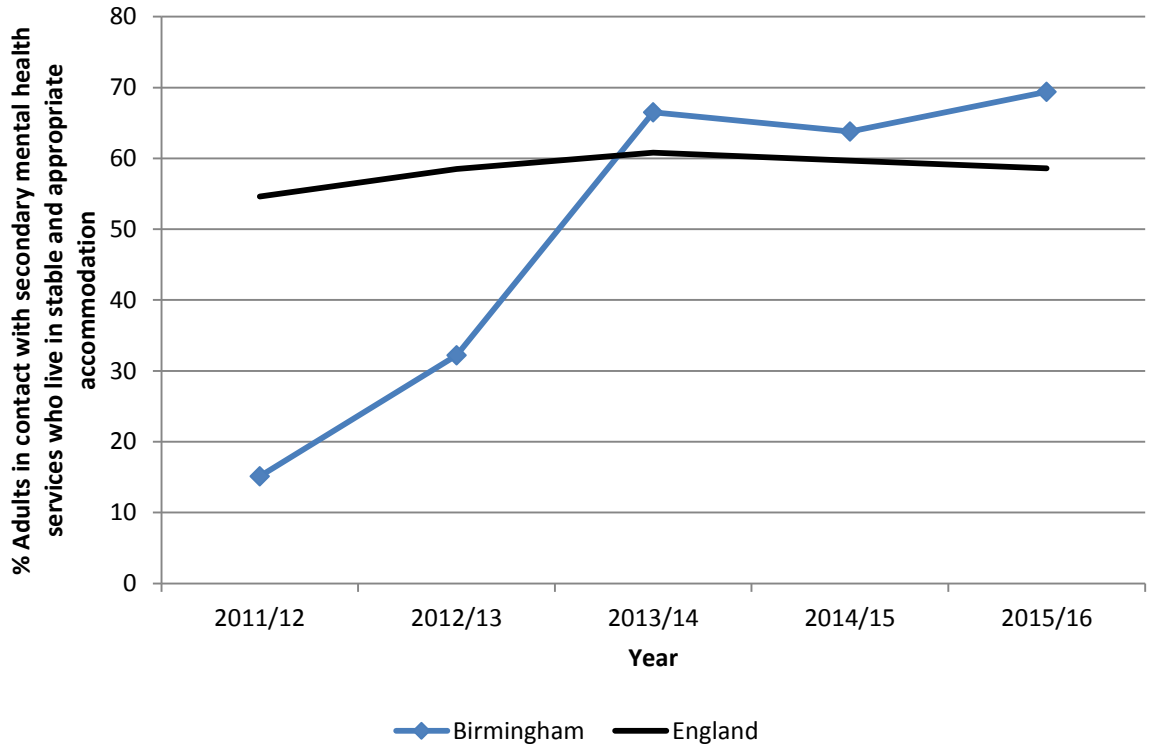
Who is the Board Lead?

No one identified

Increasing stable accommodation for those with mental health problems

Indicator: Adults in contact with secondary mental health services who live in stable and appropriate accommodation (PHOF)

Target: tba



Current plans to achieve ambition

This target is published annually and it is difficult in-year to track and demonstrate progress. It is recommended that the Health and Wellbeing Board consider for 2018-19 a data set that can be measured monthly and that will give assurance that work is delivering progress. It is recommended that Health and Wellbeing Board commission a baseline exercise to understand:

- Number of Adults within Adult Social Care with a Mental Health Problem a Shared Life living arrangement, and number of Adults supported in Support Living
- Number of Adults with a Learning Disability supported within general needs Housing.

- From BSMHT the number of Adults on CPA within stable accommodation.

There are three main pieces of work which will support work in this area:

- **Specialist Impact Team** – This team brings together Social Work, commissioning and family support to target reviews for vulnerable adults with a focus on providing support in the least restrictive setting maximising independence. Alongside the new Commissioning Framework, work will take place with providers to develop their approach to supporting move on plans with the aim of supporting move to independent living.

  The team will prioritise work with the most vulnerable adults whilst working to support better utilisation of supported living schemes in the City. The team will be recruited by January 2018 and impact on performance will be seen from March 2018.

  The recruitment of carers in Shared Lives will provide a greater range of housing options and opportunities for Adults. A specific action plan will be developed to build Shared Lives scheme capacity for Mental Health.

- **Supported living framework and utilisation –** as part of the Commissioning framework the approach to supported living is being reviewed. Work will take place to address the high level of scheme voids, and providers will be supported to adapt or decommission schemes which are not relevant to the needs of individuals.

- **Homeless and housing strategy –** closer links are being made to support the housing strategy work to address the needs of vulnerable adults. Clear actions are not yet in place but will be agreed by January 2018. This will need to include specific actions for BCC, the CCG and BSMHFT.

Council and Mental Health Trust representatives are meeting to look at developing meaningful measures linked to two key objectives:

- How we support individuals to access settled accommodation (cohort to be identified)?
- Individuals living in settled accommodation how do we support them to maintain the accommodation and avoid unnecessary move-on/eviction/abandonment?

Accountable Group

Adult Social Care and Health Directorate Leadership Team and Joint Commissioning Team within the CCG.

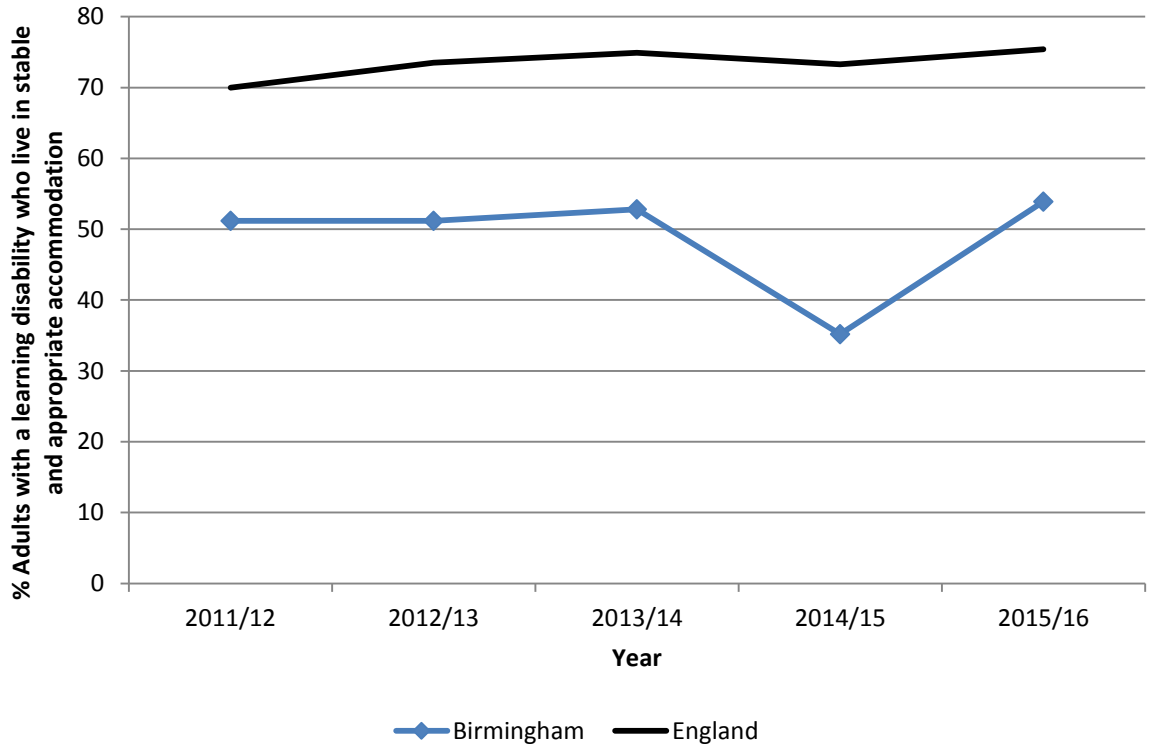
Who is the Board Lead?

No one identified

Improving stable and independent accommodation for those learning disability

Indicator: Adults with a learning disability who live in stable and appropriate accommodation (PHOF)

Target: tbc



Current plans to achieve ambition

This target is published annually and it is difficult in-year to track and demonstrate progress. It is recommended that the Health and Wellbeing Board consider for 2018-19 a data set that can be measured monthly and that will give assurance that work is delivering progress. It is recommended that Health and Wellbeing Board commission a baseline exercise to understand:

- Number of Adults within Adult Social Care with a Learning Disability placed within Residential Care/Specialist Placement, number of Adults within a Shared Life living arrangement, and number of Adults supported in Support Living

- Number of Adults with a Learning Disability supported within general needs Housing.

There are three main pieces of work which will support work in this area:

- **Specialist Impact Team** – This team brings together Social Work, commissioning and family support to target reviews for vulnerable adults with a focus on providing support in the least restrictive setting maximising independence. Alongside the new Commissioning Framework, work will take place with providers to develop their approach to supporting move on plans with the aim of deescalating care or supporting move to independent living.

  The team will prioritise work with the most vulnerable adults whilst working to support better utilisation of supported living schemes in the City. The team will be recruited by January 2018 and impact on performance will be seen from March 2018.

  The recruitment of carers in Shared Lives will provide a greater range of housing options and opportunities for Adults.

- **Supported living framework and utilisation –** as part of the Commissioning framework the approach to supported living is being reviewed. Work will take place to address the high level of scheme voids, and providers will be supported to adapt or decommission schemes which are not relevant to the needs of individuals.

- **Homeless and housing strategy –** closer links are being made to support the housing strategy work to address the needs of vulnerable adults. Clear actions are not yet in place but will be agreed by January 2018.

Learning Disability and Employment

Work is also being undertaken to address issues around learning disability and employment, we are addressing this through the Day Opportunities Strategy and we have established links with the apprentice scheme; the economies commissioned services and are planning an employment challenge for 10 of our day centre service users.

Accountable Group

Adult Social Care and Health Directorate Leadership Team.

Who is the Board Lead?

No one identified

Improve the Wellbeing of those with Multiple Complex Needs

Please provide a brief update on your agreed targets /indicators.

Project Outcomes	Change Indicators	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	Total
(A) People with multiple and complex needs are able to manage their lives better through access to more person-centred and co-ordinated services.	1) Individuals accessing the programme report and demonstrate improved confidence, self-esteem, mental health, physical health, housing status, and reducing substance misuse and re-offending.	48	176	279	349	349	325	325		1851
	2) Individuals accessing the programme reduce inappropriate use of emergency and crisis services and report easier and more streamlined access to appropriate psychologically informed services.	0	0	88	108	136	134	128	128	722
	3) No Wrong Door Network agencies adopt a Psychologically informed Environment (PIE) approach to service delivery	0	0	15	0	0	0	0	0	15
Project Outcomes	**Change Indicators**									
(B) Services are more tailored and better connected and will empower users to fully take	1) Agencies demonstrate that their services are better coordinated and fully reflect service user input in their design and delivery.	0	15	0	0	0	0	0	0	15

part in effective service design and delivery.	2) Individuals accessing the programme report greater involvement in service design and evaluation of delivery (unique service users engaged)	9	33	24	24	24	24	12	0	150
	3) Individuals accessing the programme report services are more tailored to their needs and better connected	0	0	158	194	244	244	228	228	1296
Project Outcomes	**Change Indicators**									
(C) Shared learning and the improved measurement of outcomes for people with multiple and complex needs will demonstrate the impact of service models to key stakeholders.	1) The local system of services for people with complex needs is based on a stronger evidence-base and a greater understanding of good practice in complex needs service models		0	15	0			0	5	20
	2) Services for people with complex needs are planned and commissioned as a holistic 'package' rather than in silos		0		0			0	20	20
	3) Robust evidence of effective practice and potential cost savings is communicated widely to key stakeholders	0	0	30	30	30	30	30	0	150

How can the board support you?

- Identify individuals with Multiple and Complex Needs as a priority group due to their disproportionately poor outcomes and effect on future generations
- Support the work of Birmingham Changing Futures Together (BVSC)
- Engages partner organisations to simplify their offer and support appropriate work placements especially through the STP process
- Works with housing partners in terms of stable accommodation

In addition, the Board is invited to "Walk the Frontline" with Birmingham Changing Futures Together and experience life first hand for this group and use the experience of learning to:

- Challenge policy, partner organisations etc. and promote systems change within their position of influence.

Overall ambition

Address gaps in services to effect systems change and to ensure that individuals with Multiple and Complex Needs achieve their aspirations and make their own vision of a 'fulfilling life' a reality

Who is the Board Lead?

Stephen Raybould

Improve Air Quality

Please provide a brief update on your agreed targets /indicators.

No updates available for the air quality indicators.

Current progress/developments?

The Clean Air Zone (CAZ) feasibility study is progressing. An outline business case for the CAZ has been presented to DEFRA by the DPH. An integrated impact assessment has also been developed.

Plans are progressing to provide NO_2 monitoring equipment and air pollution educational tools to schools throughout Birmingham to improve data collection and raise awareness.

The Health & Wellbeing Board Operations Group discussed the "Health Outcomes of Travel Tool" that has been developed by the NHS Sustainable Development Unit. The tool helps NHS organisations measure the impact their travel and transport has in environmental, financial and health terms to allow the creation of a plan and targeted initiatives to reduce the NHS's impact from travel and transport.

https://www.sduhealth.org.uk/delivery/measure/health-outcomes-travel-tool.aspx

How can the board support you?

Members of the Board are encouraged to respond to the air quality policy consultation when launched and promote it within their networks.

NHS bodies should consider the use of the Health Outcomes of Travel Tool to explore reducing their impact on air pollution. Other partners should work to similarly reduce their contribution to air pollution within the city.

Who is the Board Lead?

Adrian Phillips

Increased mental wellbeing in the workplace

The WMCA Mental Health Commission has developed a 'West Midlands Workplace Wellbeing Commitment' where public and private sector employers sign up to demonstrate their commitment to the mental health and wellbeing of their staff.

The Commission has also committed to work with the Government to trial an innovative 'Wellbeing Premium' - a tax incentive that rewards employers demonstrating their commitment to staff wellbeing. The trial will reveal if such a financial incentive, accompanied by an employer action plan, reduces staff sickness absence, improves productivity and prevents people leaving work due to ill health.

Improving wellbeing in the workplace is also a work stream for the Birmingham & Solihull STP.

Monitor Deloitte have recently published an Independent Review of Mental Health and Employers to understand how employers can better support all individuals currently in employment (including those with poor mental health or wellbeing) to remain in, and thrive through work.

https://www2.deloitte.com/uk/en/pages/public-sector/articles/mental-health-employers-review.html

It is proposed that the Health & Wellbeing Board hold a workshop based around this report to consider the implication of mental wellbeing in the workplace for Birmingham

Who is the Board Lead?

No one identified

	Agenda Item:7
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**24th April 2018**
TITLE:	**DISTRICT AND NEIGHBOURHOOD CHALLENGE EXERCISES (MENTAL HEALTH)**
Organisation	**Neighbourhood & Community Services , Place Directorate**
Presenting Officer	**Mike Davis – District Head**

Report Type:	**Information Report**

1. Purpose:

1.1 The District Committees of Erdington & Hodge Hill both took decisions in 2016/17 to undertake a Neighbourhood Challenge exercise designed to enable Elected Members to better understand mental health related issues nationally and locally and to identify and implement any actions or recommendations arising from the exercise.

1.2 One of the recommendations arising from the exercise, supported by local Elected Members, was that the Neighbourhood Challenge reports should be shared with the *Birmingham Health & Wellbeing Board* for information and, where possible, to join up any local initiatives with city and regional plans to address mental health issues.

2. Implications:

BHWB Strategy Priorities	Child Health	Y
	Vulnerable People	Y
	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.	Recommendation
	That the Birmingham Health & Wellbeing Board
3.1	Notes the content of this report and supports the recommendations of the respective Neighbourhood Challenge (mental health) reports produced in conjunction with Erdington and Hodge Hill District Committees.

4.	Background
	Please see the two reports attached for Erdington & Hodge Hill Districts respectively for background information.

5.	Compliance Issues
5.1	***Strategy Implications***
5.2	***Governance & Delivery***
5.3	***Management Responsibility***

6.	Risk Analysis		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
#	#	#	#

Appendices
Erdington District Neighbourhood Challenge Mental Health Report
Hodge Hill District Neighbourhood Challenge Mental Health Report

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

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

Mike Davis,
District Head, Place Directorate

Email: mike.davis@birmingham.gov.uk
Tel: 0776 692 4147

Report to Erdington District Committee

District Neighbourhood Challenge Mental Health Report

Date – 28 March 2017

Recommendations:

Committee is asked to:

1. Note the content of this report
2. Approve the specific recommendations contained within the report and propose any additional recommendations desired
3. Agree to receive updates at six monthly intervals through 2017/18

Purpose of the District Neighbourhood Challenge

At its Annual General Meeting in May 2015, Birmingham City Council gave a new responsibility to the ten District Committee's to undertake a "Neighbourhood Challenge." This involves putting the spotlight on a district issue affecting local residents and exploring ways to improve the experiences of local people.

The Erdington District Committee agreed, in July 2016, to use the powers available to it to undertake a second challenge exercise into mental health related issues. The report that follows begins to explore the issues surrounding mental wellbeing and outlines some recommendations applicable locally for the financial year ahead.

The Mental Health challenge exercise is designed to assist elected members to better understand the extent of the problem national and locally and what the district committee can do to support residents who experience mental health problems and their families and also what can be done to support mental health practitioners in the district.

Erdington District will also aim to join up its mental health work with other city and regional initiatives around mental health to ensure any local recommendations are complimentary and take account of wider initiatives.

Mental Health – the National Picture

How common are mental health problems?

1 in 4 people in the UK will experience a mental health problem each year.

Different types of mental health problem.

A survey every seven years is done in England to measure the number of people who have different types of mental health problems each year. It was last published in 2009 and reported these figures:

Depression	2.6 in 100 people
Anxiety	4.7 in 100 people
Mixed anxiety and depression	9.7 in 100 people
Phobias	2.6 in 100 people
Obsessive Compulsive Disorder	1.3 in 100 people
Panic Disorder	1.2 in 100 people
Post traumatic stress disorder	3.0 in 100 people
Eating disorders	1.6 in 100 people

Some problems are asked about over a person's lifetime, rather than each year:

Suicidal thoughts	17 in 100 people
Self harm	3 in 100 people

Estimates for bipolar disorder, schizophrenia and personality disorders are usually described over a person's lifetime rather than each year. Estimates for the number of people with these diagnoses do vary but the most commonly reported figures are:

Bipolar disorder	1 to 3 people in every 100
Schizophrenia	1 to 3 people in every 100
Personality disorder	3 to 5 people in every 100

NOTE: all these surveys report figures for people living at home, so places like hospital and prison are not included. **Statistics obtained from mind.org.uk**

Key National Facts & Trends

In March 2016 the *Mental Health Network* produced a 12 page factsheet detailing key facts and trends related to mental health problems. Some headlines from this factsheet are outlined below:

Investment

- The official survey relating to **investment in adult & older people's MH services** published by the Department of Health for 2011/12 found MH funding had fallen in real terms compared with the previous year by 1% for adults 16-64 and 3.1% for older people's MH services.
- In March 2015, research by Community Care and BBC News found funding for NHS Trusts to provide MH services had fallen 8.25% or £600 million in real terms from

2011 to 2015. (Based on Freedom of Information requests to 56 mental health trusts in England.)

- The King's Fund and Centre for Mental Health estimate that between 12% and 18 % of NHS expenditure on the treatment and management of long term conditions is linked to poor mental health.

- The UK invests £115 million per year on MH research. MH receives 5.5% of the UK health research spend. This represents approximately £9.75 on research per person affected by MH problems.

Trends in Morbidity

- Women are more likely to report ever having been diagnosed with a MH problem (33% compared to 19% of males.)

- People from lower income households were more likely to have ever been diagnosed with a MH problem.

- By 2030 it is estimated that there will be approximately two million more adults in the UK with MH problems than there were in 2013

- 30% of the general population suicides (in 2013) had been in contact with MH services in the 12 months prior to their death.

Service Activity

- Research from Community Care & BBC News found between 2011 and 2015 average referrals to community MH teams increased by 19% and referrals to crisis and home treatment teams increased by 18%

- Analysis of 2014/15 Health & Social Care Information Centre data shows 1,835,996 people were in contact with MH and learning disability services at some point in the year. This was a 5.1% increase on the previous year. This corresponds to approximately 1 person in 28. 54.7% of people were women.

- From the same data 103,840 service users spent time in hospital during 2014/15 which represents a 6% reduction on the previous year. This is a continuation of the trend seen in earlier years. The total time spent in hospital by those 103,840 service users was 8, 523,323 days in the year (82 days each on average.).

Outpatient & Community Services

- Most people in contact with MH and learning disability services (94.3%) during 2014/15 did not spend any time in hospital

- In 2014/15 Improving Access to Psychological Therapy (IAPT) services received 1,267,193 referrals of which 39% were self-referrals. Of all referrals 64% (or 815,665) entered treatment with an average wait of 32 days between referral and first treatment / appointment. Conversely, 1,123,002 referrals ended of which

468,881 finished a course of treatment which typically averaged 6.3 treatment appointments resulting in 60.8% showing reliable improvement.

Primary Care

- Many people with MH problems will be seen by their GP. According to a care Quality Commission report from 2015, at any given time, an average of 1 in 4 patients of a full time GP requires treatment for a MH condition.
- There were nearly 3 million adults on local GP registers for depression in 2013/14 and nearly 500,000 for a serious mental illness.

Mental Health Legislation

- In 2014/15 the Mental Health Act 1983 was used more than 58,000 times to detain people representing the highest year on year increase ever recorded (approximately 10%)
- There were 137,540 Deprivation of Liberty safeguards applications received by councils in 2013/14 the most since the safeguards were introduced in 2009. This is a tenfold increase from the previous year (13,700 applications.)
- 62,645 applications were completed by councils in 2014/15 with 83% granted.
- **Service User & Staff Experiences**
- More than 13,000 servicer users responded to the 2015 CQC survey of people using community mental health services across 55 NHS trusts.
    - When asked if the person or people they saw most recently listened carefully to them 70% said they 'definitely' did compared to 73% in 2014
    - 62% said they were definitely given enough time to discuss their needs and treatment compared to 66% the previous year.
    - 73% said they always felt they were treated with respect and dignity compared to 75% the previous year.
- Of those who in the last 12 months wanted or needed support, help and advice:
    - 32% said the MH service definitely gave them help to obtain financial and benefit advice and support
    - 25% said MH service definitely gave them advice or directed them to support for finding or keeping work
    - 33% said MH service definitely directed them to advice and support relating to finding or keeping accommodation.
    - Of those who wanted friends and family involved in their care 55% said that a family member or friend had definitely been involved as much as they would like.
- In the 2015 NHS Staff Survey 59% of staff in mental health or learning disability trusts agreed or strongly agreed they would be happy to recommend the standard

of care provided by the organisation to a friend or relative needing treatment compared to 69% across all NHS trusts.

Children & Young People

- The last national morbidity survey for children and young people's mental health was carried out in 2004. At that time:
    - 10% between 5 years and 16 years were reported as having a clinically diagnosed MH disorder
    - 4% had an emotional disorder – anxiety or depression
    - 6% had a conduct disorder
- In 2013/14 there were 51,000 referrals of 15-19 year olds to psychological therapies with referrals of young women double the number of referrals for young men.
- Around half of 'looked after children' are reported to have emotional or behavioural difficulties.

Stigma

- 'Time to Change's report on 'Attitudes to Mental Illness' 2014 illustrated that attitudes are continuing to change for the better. The number of people acknowledging they knew someone close to them who has had a mental illness increased from 58% (2009) to 65% in 2014. 40% said they would feel comfortable talking to their employerabout a MH problem although nearly half (48%) said they would feel uncomfortable showing there is some way to go to improve attitudes.

Employment

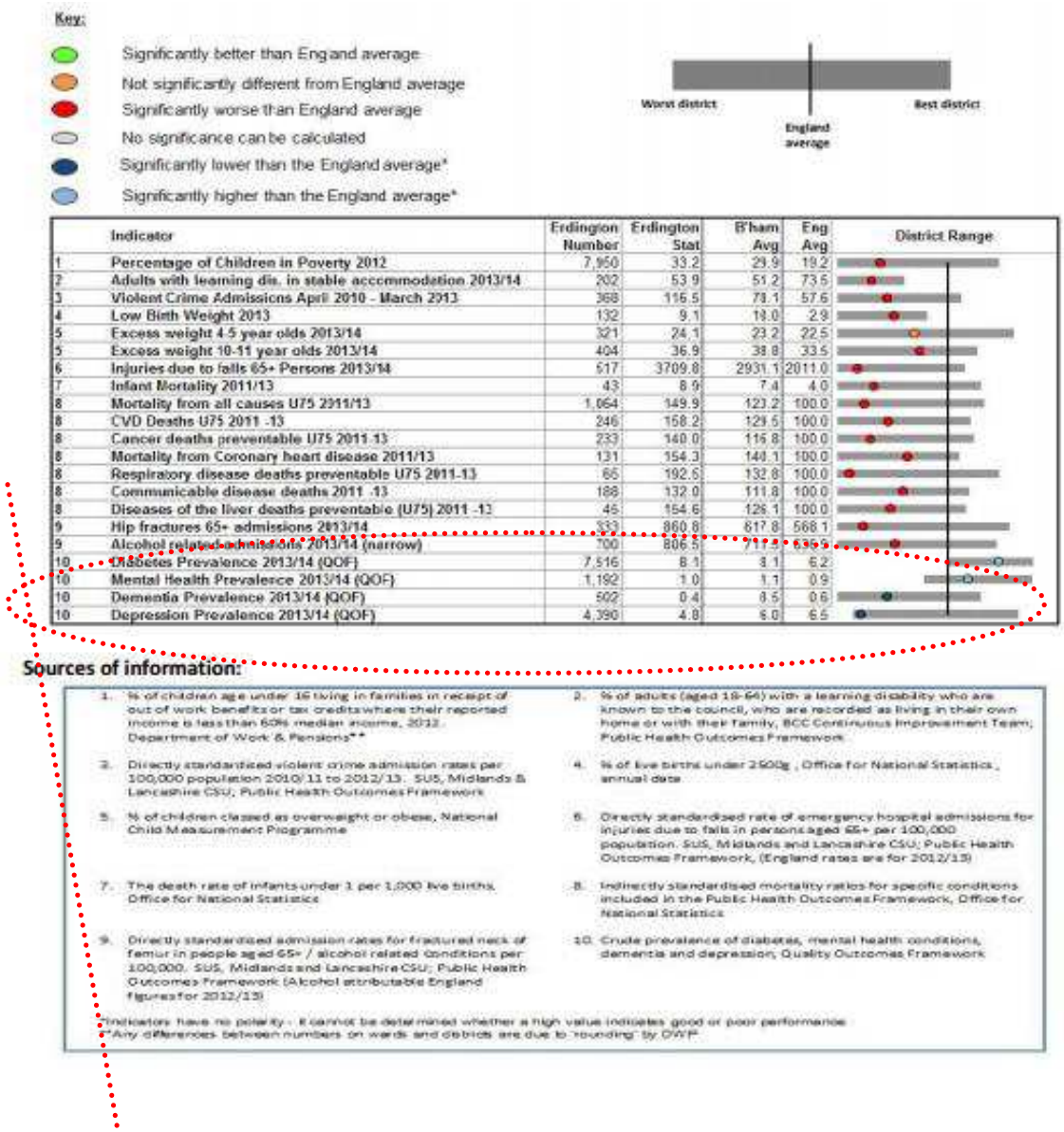
- In August 2015, of 1,941,050 employment & support claimants in England, 48.1% were recorded as having a mental or behavioural disorder (up from 46.9% the previous year.)
- Office for National Statistics report in England, Oct 2014 - Sept 2015 - 64.9% of people with a physical health condition or illness lasting more than 12 months were in work compared to 40% of people with a mental health or learning disability. Similarly, 5% of persons with a physical health condition lasting over 12 months were classified as unemployed compared with 7.6% classified as unemployed with a mental health or learning disability for 12 months or more.

Mental Health - The Erdington District Picture

The following chart shows the prevelance of specified illnesses and diseases wih the grey spine (line showing the rate across all districts and the coloured spot signifies where Erdington District sits within the overall district result.

Erdington District

Health indicators – spine chart



	Indicator	Erdington Number	Erdington Stat	B'ham Avg	Eng Avg	District Range
1	Percentage of Children in Poverty 2012	7,950	33.2	29.9	19.2	
2	Adults with learning dis. in stable accommodation 2013/14	202	53.9	51.2	73.5	
3	Violent Crime Admissions April 2010 - March 2013	368	116.5	78.1	57.6	
4	Low Birth Weight 2013	132	9.1	10.0	2.9	
5	Excess weight 4-5 year olds 2013/14	321	24.1	23.2	22.5	
5	Excess weight 10-11 year olds 2013/14	404	36.9	38.8	33.5	
6	Injuries due to falls 65+ Persons 2013/14	517	3709.8	2931.1	2011.0	
7	Infant Mortality 2011/13	43	8.9	7.4	4.0	
8	Mortality from all causes U75 2011/13	1,064	149.9	123.2	100.0	
8	CVD Deaths U75 2011 -13	246	158.2	129.5	100.0	
8	Cancer deaths preventable U75 2011-13	233	140.0	116.8	100.0	
8	Mortality from Coronary heart disease 2011/13	131	154.3	148.1	100.0	
8	Respiratory disease deaths preventable U75 2011-13	66	192.5	132.8	100.0	
8	Communicable disease deaths 2011 -13	188	132.0	111.8	100.0	
8	Diseases of the liver deaths preventable (U75) 2011 -13	45	154.6	126.1	100.0	
9	Hip fractures 65+ admissions 2013/14	333	860.6	617.8	568.1	
9	Alcohol related admissions 2013/14 (narrow)	700	806.5	711.4	636.5	
10	Diabetes Prevalence 2013/14 (QOF)	7,516	8.1	8.1	6.2	
10	Mental Health Prevalence 2013/14 (QOF)	1,192	1.0	1.1	0.9	
10	Dementia Prevalence 2013/14 (QOF)	502	0.4	0.5	0.6	
10	Depression Prevalence 2013/14 (QOF)	4,390	4.8	6.0	6.5	

Sources of information:

1. % of children age under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2012. Department of Work & Pensions**
2. % of adults (aged 18-64) with a learning disability who are known to the council, who are recorded as living in their own home or with their family, BCC Continuous Improvement Team; Public Health Outcomes Framework
3. Directly standardised violent crime admission rates per 100,000 population 2010/11 to 2012/13. SUS, Midlands & Lancashire CSU; Public Health Outcomes Framework
4. % of live births under 2500g , Office for National Statistics , annual data
5. % of children classed as overweight or obese, National Child Measurement Programme
6. Directly standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population. SUS, Midlands and Lancashire CSU; Public Health Outcomes Framework, (England rates are for 2012/13)
7. The death rate of infants under 1 per 1,000 live births. Office for National Statistics
8. Indirectly standardised mortality ratios for specific conditions included in the Public Health Outcomes Framework, Office for National Statistics
9. Directly standardised admission rates for fractured neck of femur in people aged 65+ / alcohol related conditions per 100,000. SUS, Midlands and Lancashire CSU; Public Health Outcomes Framework (Alcohol attributable England figures for 2012/13)
10. Crude prevalence of diabetes, mental health conditions, dementia and depression; Quality Outcomes Framework

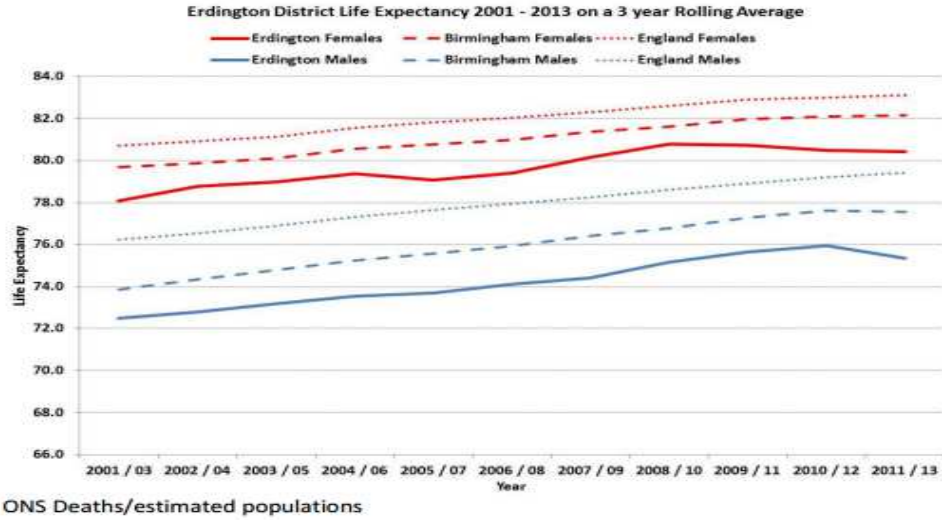
*Indicators have no polarity - it cannot be determined whether a high value indicates good or poor performance
**Any differences between numbers on wards and districts are due to 'rounding' by DWP

For consideration

Based on GP records the prevalence of mental health issues is above the national average for Erdington District residents.

Erdington District

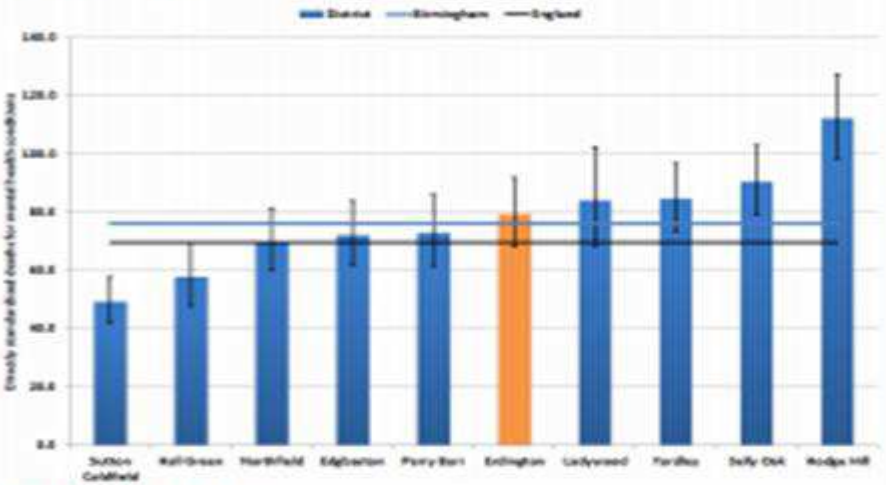
LIFE EXPECTANCY



Source: ONS Deaths/estimated populations

Life expectancy in Erdington is 77.9 years (Birmingham average 79.9). It is highest in Stockland Green ward (persons 79.4., females 81.5 and males 77.5 years) and lowest in Kingstanding ward (persons 77.1, females 80.0 and males 74.1 years).

Figure 15: Directly standardised death rates per 100,000 (all ages) from mental health conditions 2011/13 (district in orange)



Source: ONS Deaths/Vital Statistics

- People with severe Mental Health problems have an average reduced life expectancy of between 10 and 25 years. It is not generally what appears on an individual's death certificate but poor mental health is more likely to trigger or be accompanied by risk factors such as smoking, physical inactivity, obesity, and the side effects of psychiatric medication.

- Conversely persons with poor physical health including diabetes, hypertension, respiratory diseases and disabilities may be more likely to also experience mental health problems.

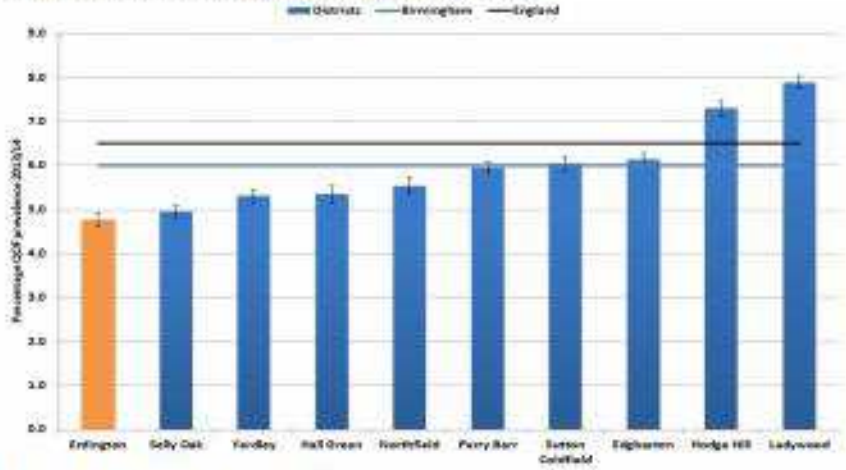
Erdington District:

Prevalence of depression, Number of prescriptions for anti-psychotic drugs

Mental ill health represents 23% of reported ill health in the UK and costs England an estimated £105 billion a year.

Key evidence: No health without mental health (2011) https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

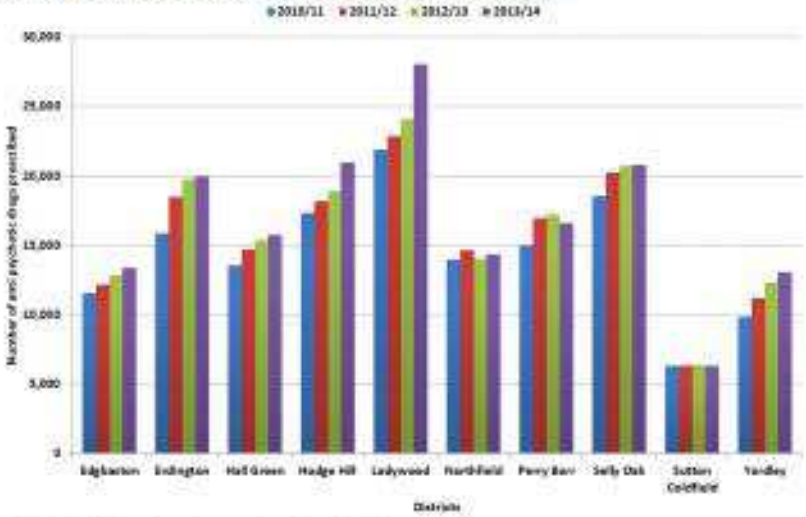
Figure 11: Prevalence of Depression 2013/14 (district in orange)



Source: Quality Outcomes Framework 2013/14

Note: QOF disease prevalence data is collected for GP practices only. Prevalence percentages and 95% confidence intervals for districts are estimated by calculating weighted averages according to the geographical distribution of the whole practice population.

Figure 12: Number of prescriptions for Anti-psychotic drugs 2010/14



Source: Centre for Medicines Optimisation (Keele University)

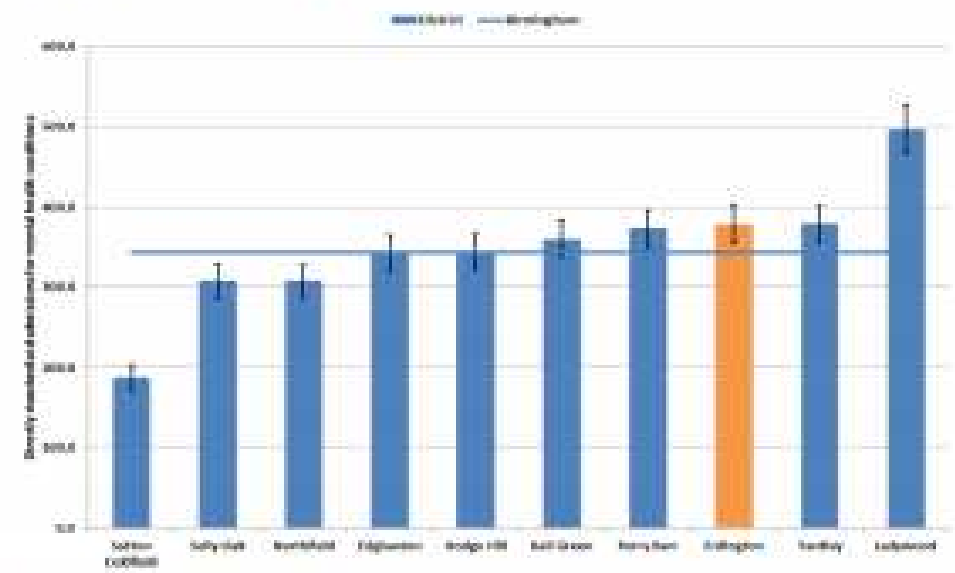
These graphs are drawn from GP's figures and the low incidence of depression in Erdington District (figure 11) may suggest it is under-reported. However, those who do report it are likely to received prescribed drugs for it (figure 12.)

Erdington District

Hospital Admission rates for Mental Health

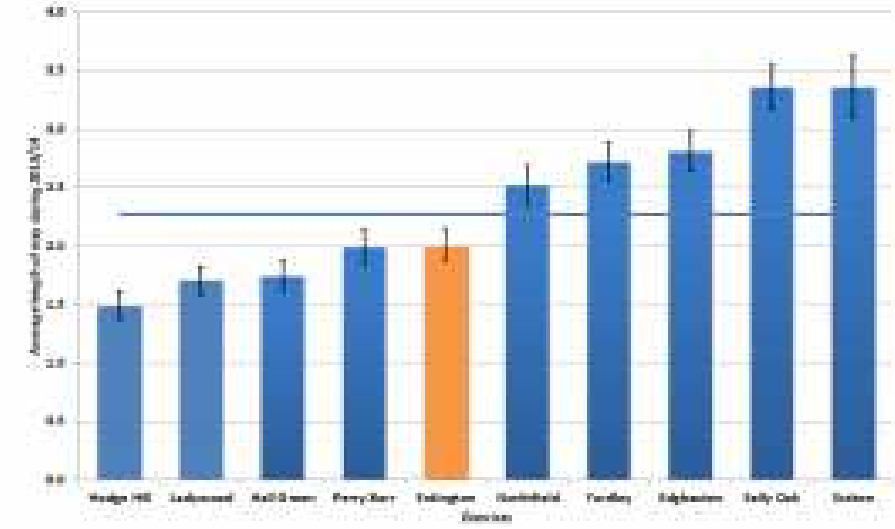
Erdington District is above district average for admissions but below average for the length of stay in hospital.

Figure 13: Admission rates per 100,000 (all ages) for mental health conditions 2011/14 (district in orange)



Source: SUS Midlands and Lancashire CSU

Figure 14: Average length of stay of mental health inpatients 2013/14 (district in orange)



Source: SUS Midlands and Lancashire CSU

Conclusions:

Mental illness is defined by experts as a significant dysfunction in a persons thinking, emotional control and behaviour. The condition often disrupts a person's ability to relate to others and to deal with the demands of life.

Mental disorders directly affect 1 in 4 persons. Additionally, it has an indirect impact on the family and friends of those with the condition. On that basis most of us will be impacted by mental disorder either now or at some point in our lives. Persons in Erdington District experience poor mental wellbeing and are more likely to seek GP's help for poor mental wellbeing than the national average.

Poor mental health affects people of all backgrounds. The severity of symptoms can vary in length and intensity depending on the individual and the particular condition of circumstances. It is not the result of a personal weakness or a character flaw.

Poor mental health and poor physical health or not mutually exclusive. By addressing the whole person, including mental wellbeing, it is more likely that physical health will benefit with less likelihood of smoking, obesity, physical inactivity which frequently accompany poor mental health.

Most mental disorders are treatable. With appropriate medical care individuals can be treated and live productive and rewarding lives. Many people with mental illness refrain from seeking treatment because of the stigma associated with it. So the first step on the road to treatment is to overcome any reluctance to talk to others about mental illness. Treatment may include talking to a trained professional who can help an individual understand his / her illness, assist to resolve practical problems and reinforce the need not to give up on treatment.

Tips for promoting mental wellbeing

1. Follow the treatment prescribed by qualified mental health professionals
2. Maintain a balanced and stable daily routine
3. Stay physically active
4. Get enough sleep
5. Take time each day to relax
6. Eat a nutritious and balanced diet
7. Limit alcohol consumption and drugs not prescribed for you
8. Avoid isolation; spend time with people whom you trust and who care for you.

Recommendations:

It is important to recognise that this district neighbourhood challenge is not a weighty piece of academic research but simply an attempt to better understand the issues around mental health locally and what members may be able to do to support improvements in this field.

The recommendations below take account of the fact there are no financial resources readily available at this time to progress and also very limited human resources to pursue desired actions. On that basis, it is perhaps best that district committee notes other mental health initiatives at a city or regional level and seeks to support such initiatives and influence the outcomes of those so that benefits can be felt within Erdington District and for the benefit of its residents.

Therefore, some specific recommendations are as follows:

Recommendations
1. Explore the potential for committee members to receive mental health first aid training. **Jan 18 update**: THRIVE lead has asked for one nomination per Ward interested in partaking in mental health 'light' / taster (2 hour) awareness training. This may then lead to Mental Health First Aid training 2 days) and to the identification of mental health champions. Mike Davis to canvass for nominations.
2. Note the contents of the WMCA 'Thrive' study into mental health and seek to support delivery of its action plan with an emphasis on bending outcomes to benefit Erdington District **Jan 18 update**: Meeting held with WMCA THRIVE lead, Sean Russell in late 2017. He is aware of issues relating to mental health in Erdington and, in his oversight of 21 mental health related projects across the Combined Authority, he will look to see what can be directed toward Erdington including the potential for wellbeing support cafes with specialist support at specific opening hours. Also exploring how to link North Employment Board (mental health sub-group) to the THRIVE agenda given the barriers to employment associated with stress, depression and mental health.
3. Monitor progress & outcomes from two specific scrutiny committee reports into Mental Health & the Criminal Justice System and Homeless Health with a view to learning the lessons for our district **Jan 2018 Update**: Sean Russell reports an initiative being pursued in 2018 designed to direct offenders toward specialist community provision and support at a local level as a viable alternative to imprisonment for low level offences where the offender is deemed unwell.
4. Use the North Vulnerable Adults sub group (of the North Community Safety Partnership) as a mechanism to raise awareness and progress issues around mental health in Erdington District. **Jan 2018 update**– Mike arranged a presentation delivered in January from Pam Powis on the work of the Vulnerable Adults Group to the North Employment (mental health sub-group) which

encouraged more participation in the panel meetings and more referrals.

5. **Maintain a sub-group of district committee (one per Ward) to consider issues sand actions as necessary throughout the coming year.**

   Jan 2018 update: To date some limited progress has been possible without significant seeking local member support although Mike is aware it will be forthcoming if required.

6. **Liaise with the East Community Safety sub-group consisting of housing providers, mental health professionals, council and police looking at links between mental health and ASB and lift and shift outcomes to Erdington District**

   Jan 2018 update – there has not been a Community Safety Coordinator on the East for some months but this will be resolved this month and this action can be considered with the new appointee.

7. **Provide copy of this challenge report to the Birmingham Health & Wellbeing Board seeking its direction in the coming year to compliment any mental health initiatives planned at a pan Birmingham level.**

Jan 2018 update: To be provided to THRIVE lead officer Sean Russell and to Wellbeing and Public Health lead Adrian Phillips.

8. **It is proposed that committee receives an update report on any progress with these specific recommendations in September 2017 and a final report back in March 2018**

   Jan 2018 update: timetable has slipped but back on track with this update report..

Hodge Hill District Neighbourhood Challenge Report

Topic – Mental Health

1. Recommendations:

Committee is asked to:

1. Note the content of this report
2. Approve the specific action plan contained within the report and / or propose any additional actions desired
3. Agree to receive updates at six monthly intervals.

2. Purpose of the District Neighbourhood Challenge

At its Annual General Meeting in May 2015, Birmingham City Council gave a new responsibility to the ten District Committee's to undertake a "Neighbourhood Challenge." This involves putting the spotlight on a district issue affecting local residents and exploring ways to improve the experiences of local people. For its first challenge exercise the committee chose to consider Youth Unemployment.

Then in November 2016, Committee agreed to undertake a second challenge exercise into mental health related issues. The report that follows begins to explore the issues surrounding mental wellbeing and outlines some actions applicable locally for the year ahead.

The Mental Health challenge exercise is designed to assist elected members to better understand the extent of the problem national and locally and what the district committee can do to support residents who experience mental health problems and their families and also what can be done to support mental health practitioners in the district.

Hodge Hill District will also aim to join up its mental health work with other city and regional initiatives around mental health to ensure any local actions progressed are complimentary and take account of wider initiatives

3. Findings – the National Picture

(a) How common are mental health problems? 1 in 4 people in the UK will experience a mental health problem each year.

(b) Different types of mental health problem.

A survey every seven years is done in England to measure the number of people who have different types of mental health problems each year. It was last published in 2009 and reported these figures:

Depression	2.6 in 100 people
Anxiety	4.7 in 100 people
Mixed anxiety and depression	9.7 in 100 people
Phobias	2.6 in 100 people
Obsessive Compulsive Disorder	1.3 in 100 people
Panic Disorder	1.2 in 100 people
Post traumatic stress disorder	3.0 in 100 people
Eating disorders	1.6 in 100 people
Some problems are asked about over a person's lifetime, rather than each year:	
Suicidal thoughts	17 in 100 people
Self harm	3 in 100 people

Estimates for bipolar disorder, schizophrenia and personality disorders are usually described over a person's lifetime rather than each year. Estimates for the number of people with these diagnoses do vary but the most commonly reported figures are:

Bipolar disorder	1 to 3 people in every 100
Schizophrenia	1 to 3 people in every 100
Personality disorder	3 to 5 people in every 100

NOTE: all these surveys report figures for people living at home, so places like hospital and prison are not included. Statistics obtained from mind.org.uk

(c) Key Facts & Trends

In March 2016 the Mental Health Network produced a 12 page factsheet detailing key facts and trends related to mental health problems. Some headlines from this factsheet are outlined below:

Investment

- The last official surveys relating to **investment in adult & older people's MH services** were published by the Department of Health covering the financial year 2011/12. It found MH funding had fallenin real terms compared with the previous year by 1% for adults 16-64 and 3.1% for older people's MH services.
- In March 2015, research by Community Care and BBC News found funding for NHS Trusts to provide MH services had fallen 8.25% or £600 million in real terms from

2011 to 2015. (Based on Freedom of Information requests to 56 mental health trusts in England.

- The King's Fund and Centre for Mental Health estimate that between 12% and 18 % of NHS expenditure on the treatment and management of long term conditions is linked to poor mental health.

- The UK invests £115 million per year on MH research. MH receives 5.5% of the UK health research spend. This represents approximately £9.75 on research per person affected by MH problems.

Trends in Morbidity

- Women are more likely to report ever having been diagnosed with a MH problem (33% compared to 19% of males.)

- People from lower income households were more likely to have ever been diagnosed with a MH problem.

- By 2030 it is estimated that there will be approximately two million more adults in the UK with MH problems than there were in 2013

- 30% of the general population suicides (in 2013) had been in contact with MH services in the 12 months prior to their death.

Service Activity

- Research from Community Care & BBC News found between 2011 and 2015 average referrals to community MH teams increased by 19% and referrals to crisis and home treatment teams increased by 18%

- Analysis of 2014/15 Health & Social Care Information Centre data shows 1,835,996 people were in contact with MH and learning disability services at some point in the year. This was a 5.1% increase on the previous year. This corresponds to approximately 1 person in 28. 54.7% of people were women.

- From the same data 103,840 service users spent time in hospital during 2014/15 which represents a 6% reduction on the previous year. This is a continuation of the trend seen in earlier years. The total time spent in hospital by those 103,840 service users was 8, 523,323 days in the year (82 days each on average.).

Outpatient & Community Services

- Most people in contact with MH and learning disability services (94.3%) during 2014/15 did not spend any time in hospital

- In 2014/15 Improving Access to Psychological Therapy (IAPT) services received 1,267,193 referrals of which 39% were self-referrals. Of all referrals 64% (or 815,665) entered treatment with an average wait of 32 days between referral and first treatment / appointment. Conversely, 1,123,002 referrals ended of which

468,881 finished a course of treatment which typically averaged 6.3 treatment appointments resulting in 60.8% showing reliable improvement.

Primary Care

- Many people with MH problems will be seen by their GP. According to a care Quality Commission report from 2015, at any given time, an average of 1 in 4 patients of a full time GP requires treatment for a MH condition.
- There were nearly 3 million adults on local GP registers for depression in 2013/14 and nearly 500,000 for a serious mental illness.

Mental Health Legislation

- In 2014/15 the Mental Health Act 1983 was used more than 58,000 times to detain people representing the highest year on year increase ever recorded (approximately 10%)
- There were 137,540 Deprivation of Liberty safeguards applications received by councils in 2013/14 the most since the safeguards were introduced in 2009. This is a tenfold increase from the previous year (13,700 applications.)
- 62,645 applications were completed by councils during the year 2014/14 with 83% granted.
- **Service User & Staff Experiences**
- More than 13,000 servicer users responded to the 2015 CQC survey of people using community mental health services across 55 NHS trusts.
- When asked if the person or people they saw most recently listened carefully to them 70% said they 'definitely' did compared to 73% in 2014
- 62% said they were definitely given enough time to discuss their needs and treatment compared to 66% the previous year.
- 73% said they always felt they were treated with respect and dignity compared to 75% the previous year.
- Of those who in the last 12 months wanted or needed support, help and advice:
    - 32% said the MH service definitely gave them help to obtain financial and benefit advice and support
    - 25% said MH service definitely gave them advice or directed them to support for finding or keeping work
    - 33% said MH service definitely directed them to advice and support relating to finding or keeping accommodation.

- Of those who wanted friends and family involved in their care 55% said that a family member or friend had definitely been involved as much as they would like.

- In the 2015 NHS Staff Survey 59% of staff in mental health or learning disability trusts agreed or strongly agreed they would be happy to recommend the standard of care provided by the organisation to a friend or relative needing treatment compared to 69% across all NHS trusts.

Children & Young People

- The last national morbidity survey for children and young people's mental health was carried out in 2004. At that time:

  - 10% between 5 years and 16 years were reported as having a clinically diagnosed MH disorder

  - 4% had an emotional disorder – anxiety or depression

  - 6% had a conduct disorder

- In 2013/14 there were 51,000 referrals of 15-19 year olds to psychological therapies with referrals of young women double the number of referrals for young men.

- Around half of 'looked after children' are reported to have emotional or behavioural difficulties.

- **Links with Physical Health**

- People with severe MH problems have an average reduced life expectancy of between 10 and 25 years. Risk factors include smoking, physical inactivity, obesity, and the side effects of psychiatric medication.

- **Stigma**

- TimeTo Change's report on 'Attitudes to Mental Illness' 2014 illustrated that attidues are continuing to change for the better. The number of people acknowledging they knew someone close to them who has had a mental illness increased from 58% (2009) to 65% in 2014. 40% said they would feel comfortable talking to their employer about a MH problem although nearly half (48%) said they would feel uncomfortable showing there is some way to go to improve attitudes.

Employment

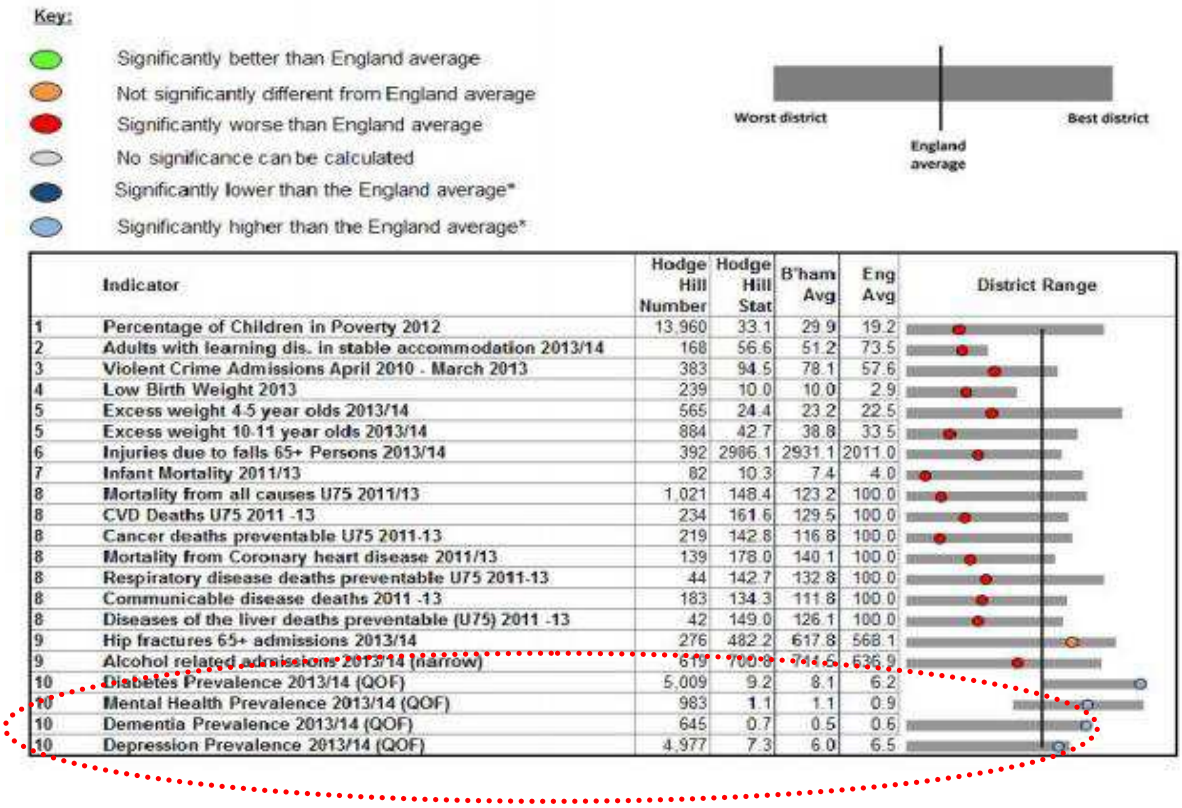
- In August 2015, of 1,941,050 employment & support claimants in England, 48.1% were recorded as having a mental or behavioural disorder (up from 46.9% the previous year.)

- Office for National Statistics report in England between Oct 2014 and Sept 2015 that 5% of persons with a physical health condition lasting over 12 months were classified as unemployed compared with 7.6% classified as unemployed with a mental health or learning disability for 12 months or more.

4. Mental Health – The Local Picture in Hodge Hill.

The following chart shows the prevelance of specified illnesses and diseases wih the grey spine (line showing the rate across all districts and the coloured spot signifies where Erdington District sits within the overall district result.

Hodge Hill District Health indicators – spine chart



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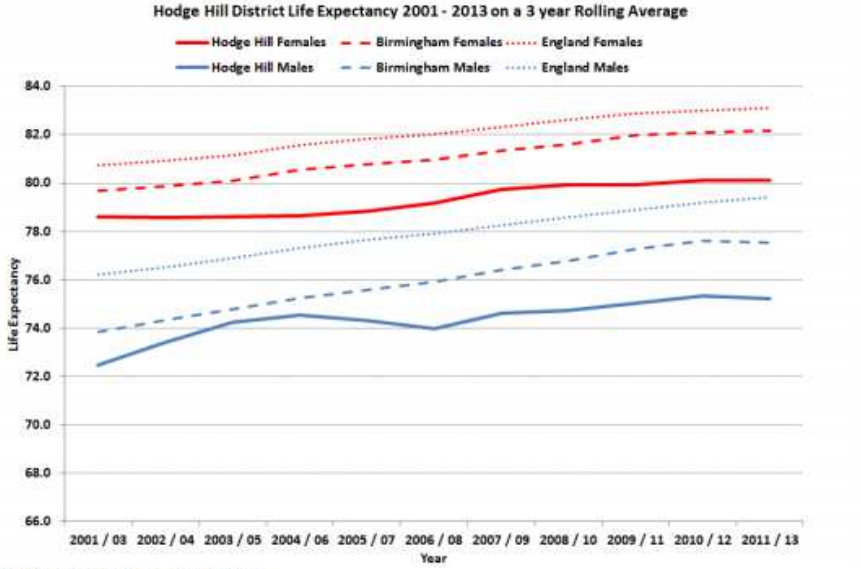
10	Mental Health Prevalence 2013/14 (QOF)	983	1.1	1.1	0.9	
10	Dementia Prevalence 2013/14 (QOF)	645	0.7	0.5	0.6	
10	Depression Prevalence 2013/14 (QOF)	4,977	7.3	6.0	6.5	

For consideration

Based on GP records the prevalence of mental health issues is well above the national average for Hodge Hill District residents (as is dementia and depression.).



Source: ONS Deaths/estimated populations

Life expectancy in Hodge Hill is 77.7 years (Birmingham average 79.9). It is highest in Hodge Hill ward (persons 79.5, females 82.3 and males 76.6 years) and lowest in Shard End ward (persons 75.8, females 78.6 and males 73.1 years).

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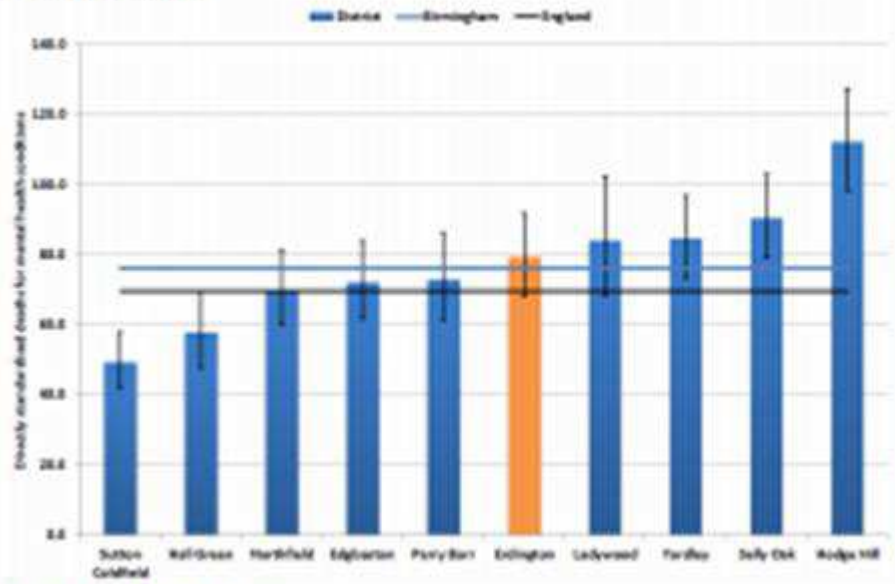

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- People with severe Mental Health problems have a reduced life expectancy of between 10 & 25 years. It is not generally what appears on an individual's death certificate but poor mental health is more likely to trigger or be accompanied by factors such as smoking, physical inactivity, obesity, and side effects of psychiatric medication. Conversely persons with poor physical health including diabetes, hypertension, respiratory diseases and disabilities may be more likely to also experience mental health problems.

Prevalence of depression, Number of prescriptions for anti-psychotic drugs

Mental ill health represents 23% of reported ill health in the UK and costs England an estimated £105 billion a year.

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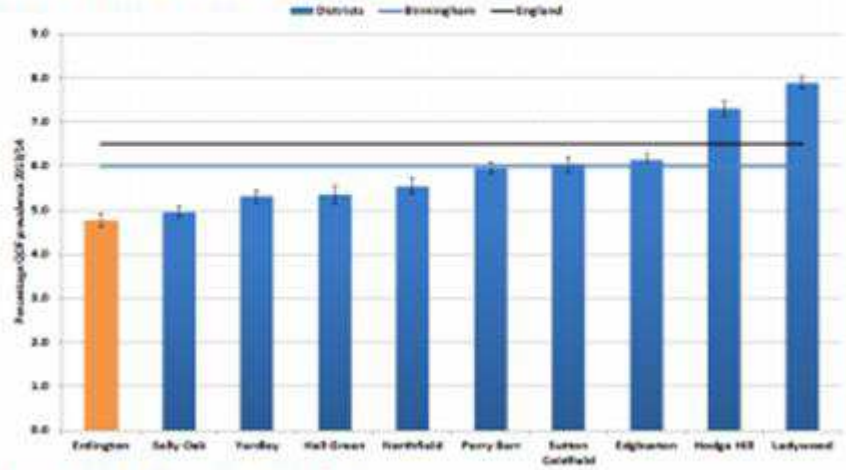

Source: Quality Outcomes Framework 2013/14

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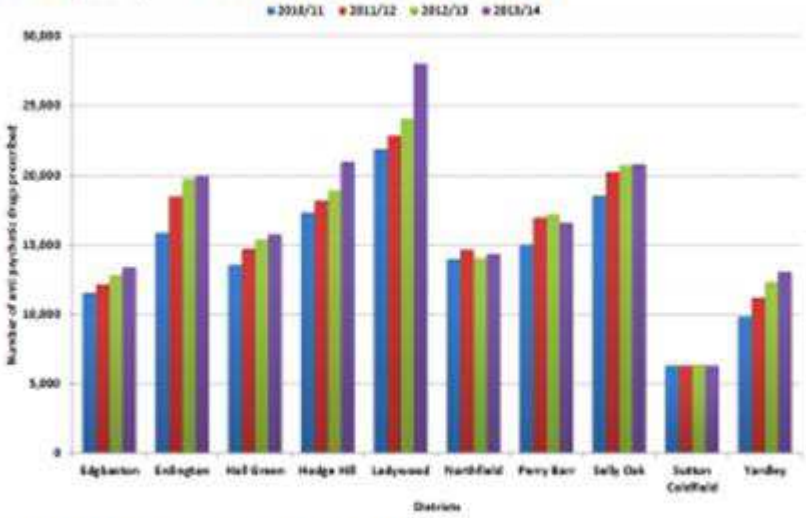


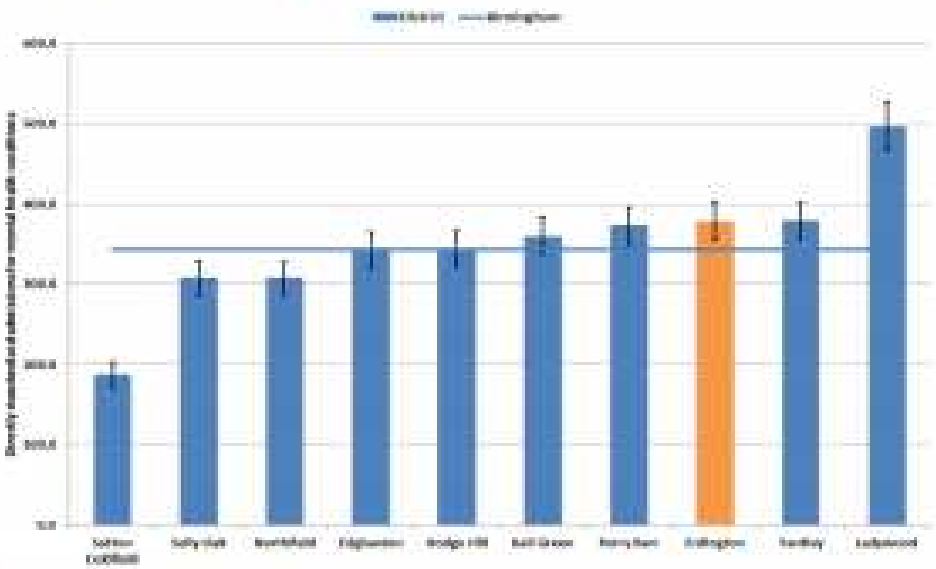
Source: Centre for Medicines Optimisation (Keele University)

These graphs are drawn from GP's figures with Hodge Hill having the second highest incidence of depression (figure 11.) There is a correlation in Hodge Hill between those reporting with depression and prescribed drugs for it (figure 12.)

Hospital Admission rates for Mental Health

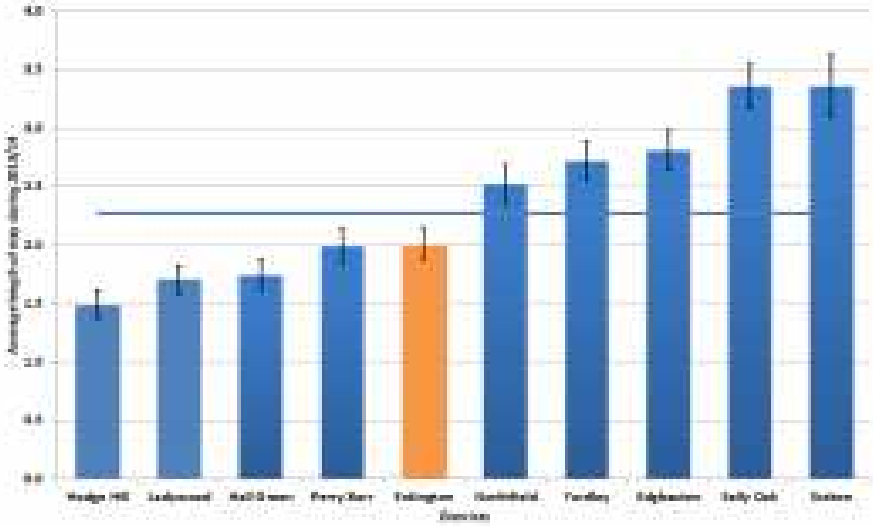
Hodge Hill District has an average number of hospital admissions for mental health but well below average for the length of stay in hospital.

Figure 13: Admission rates per 100,000 (all ages) for mental health conditions 2011/14 (district in orange)



Source: SUS Midlands and Lancashire CSU

Figure 14: Average length of stay of mental health inpatients 2013/14 (district in orange)



Source: SUS Midlands and Lancashire CSU

5. Conclusions:

Mental illness is defined by experts as a significant dysfunction in a persons thinking, emotional control and behaviour. The condition often disrupts a person's ability to relate to others and to deal with the demands of life.

Mental disorders directly affect 1 in 4 persons. Additionally, it has an indirect impact on the family and friends of those with the condition. On that basis most of us will be impacted by mental disorder either now or at some point in our lives. Persons in Erdington District experience poor mental wellbeing and are more likely to seek GP's help for poor mental wellbeing than the national average.

Poor mental health affects people of all backgrounds. The severity of symptoms can vary in length and intensity depending on the individual and the particular condition of circumstances. It is not the result of a personal weakness or a character flaw.

Poor mental health and poor physical health or not mutually exclusive. By addressing the whole person, including mental wellbeing, it is more likely that physical health will benefit with less likelihood of smoking, obesity, physical inactivity which frequently accompany poor mental health.

Most mental disorders are treatable. With appropriate medical care individuals can be treated and live productive and rewarding lives. Many people with mental illness refrain from seeking treatment because of the stigma associated with it. So the first step on the road to treatment is to overcome any reluctance to talk to others about mental illness. Treatment may include talking to a trained professional who can help an individual understand his / her illness, assist to resolve practical problems and reinforce the need not to give up on treatment.

Tips for promoting mental wellbeing

1. Follow the treatment prescribed by qualified mental health professionals
2. Maintain a balanced and stable daily routine
3. Stay physically active
4. Get enough sleep
5. Take time each day to relax
6. Eat a nutritious and balanced diet
7. Limit alcohol consumption and drugs not prescribed for you
8. Avoid isolation; spend time with people whom you trust and who care for you.

6. Action Plan:

It is important to recognise that this district neighbourhood challenge is not a weighty piece of academic research but simply an attempt to better understand the issues around mental health locally and what members may be able to do to support improvements in this field.

The recommendations below take account of the fact there are no financial resources readily available at this time to progress and also very limited human resources to pursue desired actions. On that basis, it is perhaps best that district committee notes other mental health initiatives at a city or regional level such as the West Midlands Combined Authority THRIVE Report into mental health and seeks to support such initiatives and influence the outcomes

of those so that benefits can be felt within Hodge Hill District and for the benefit of its residents.

Therefore, some specific proposed actions are as follows:

Action Plan:

1. **Explore the potential for committee members to receive mental health first aid training.**

Nov 17 update: THRIVE lead has asked for one nomination per Ward interested in partaking in mental health 'light' / taster (2 hour) awareness training. This may then lead to Mental Health First Aid training 2 days) and to the identification of mental health champions. Mike Davis to canvass for nominations.

2. **Note the contents of the WMCA 'Thrive' study into mental health and seek to support delivery of its action plan with an emphasis on bending outcomes to benefit Hodge Hill District**

Nov 17 update: Meeting held with WMCA THRIVE lead, Sean Russell. He is aware of issues on the East including Hodge Hill and in his oversight of 21 mental health related projects across the Combined Authority he will look to see what can be directed toward Hodge Hill including the potential for wellbeing support cafes with specialist support at specific opening hours. Also exploring how to link East Employment Board to the THRIVE agenda given the barriers to employment associated with stress, depression and mental health.

3. **Monitor progress & outcomes from two specific scrutiny committee reports into Mental Health & the Criminal Justice System and Homeless Health with a view to learning the lessons for our district.**

Nov 2017 Update: Sean Russell reports an initiative being pursued in 2018 designed to direct offenders toward specialist community provision and support at a local level as a viable alternative to imprisonment for low level offences where the offender is deemed unwell.

4. **Liaise with the East Community Safety sub-group consisting of housing providers, mental health professionals, council and police looking at links between mental health and ASB and lift and shift outcomes to Erdington District**

Nov 2017 update: Mike Davis to request an update.

5. **Consider establishing a sub-group of district committee (one per Ward) to consider issues and actions as necessary throughout the coming year.**

Nov 2017 update: To date some limited progress has been possible without seeking local member support.

6. **Provide copy of this challenge report to the Birmingham Health & Wellbeing Board seeking its direction in the coming year to compliment any mental health initiatives planned at a pan Birmingham level.**

Nov 17 update: To be provided to THRIVE lead officer Sean Russell and to Wellbeing and Public Health lead Adrian Phillips.

7. **It is proposed that committee receives an update report on any progress with these specific recommendations in September 2017 and a final report back in March 2018**

Nov 17 update: timetable has slipped but November update to be shared with members at next opportunity.

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	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**24th April 2018**
TITLE:	**JSNA PLACE BASED INTELLIGENCE**
Organisation	**Birmingham City Council**
Presenting Officer	**Wayne Harrison / Susan Lowe**

Report Type:	**Information**

1. Purpose:

1.1 To inform the Health and Wellbeing Board of locality level place based intelligence resources currently available as part of the JSNA.

1.2 To seek the Boards support in identifying wider place based intelligence resources to further develop the JSNA.

2. Implications:

BHWB Strategy Priorities	Detect and Prevent Adverse Childhood Experiences	N
	All children in permanent housing	N
	Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	N
	Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	N
	Improving stable and independent accommodation for those learning	N

	disability	
	Improve the wellbeing of those with multiple complex needs	N
	Improve air quality	N
	Increased mental wellbeing in the workplace	N
Joint Strategic Needs Assessment		Y
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		N
Financial		N
Patient and Public Involvement		N
Early Intervention		N
Prevention		N

3.	**Recommendations**
3.1	The Board to note the place based intelligence available to inform development of a place based approach to delivering services.
3.2	That Board Members feedback any additional locality based intelligence resources and needs as part of the further development of the JSNA.

4.	**Background**
4.1	A proposed locality model for a place based approach to delivering health & social care service has been presented to the Board previously. Five localities have been identified in Birmingham, each consisting of two current local authority districts.
4.2	Currently the JSNA web site does not contain place based resources amalgamated at the proposed locality footprint. However, a series of health profiles at district level, on which localities are based are available.
4.3	The District Health Profiles were launched in January 2018 having been

developed over time with district committees based on data routinely available at district and/or ward level.

These can be found at:

https://www.birmingham.gov.uk/info/50120/public_health/1332/district_health_profiles/1

4.4 There is a variety of information available on each district and ward, including population, age, employment and health. A guide to using the profiles is attached.

4.5 The web page also links to ward level data available from an automated Public Health England reporting system and summary District data from the 2011 Census.

5.	**Future development**
5.1	The Public Health Intelligence team is currently working to amalgamate relevant data at a locality level. However, given the size of localities and the diversity within them data may still be better presented at district or lower level.
5.2	The Health & Wellbeing Operations Group will be looking to include relevant intelligence resources from wider partners that are reported at a locality level as part of the JSNA development.
5.3	Ideally, in the longer term we would like to develop an automated reporting system at locality and district level to ensure that up to date data are available. However, this is dependent on overcoming internal IT issues.

6.	**Compliance Issues**
6.1	***Strategy Implications***
	This paper concerns sources of intelligence to develop local strategic decision making.
6.2	***Governance & Delivery***
	To be overseen by the Health and Wellbeing Board

6.3	***Management Responsibility***
	The Health and Wellbeing Board

6.	**Risk Analysis**		
N/A			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
#	#	#	#

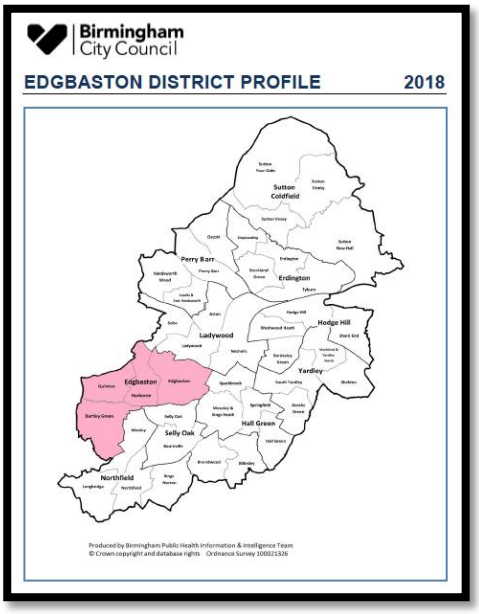
Appendices	
1.	Quick Guide to Using Birmingham District Profiles

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

District Profiles 2018

Quick Guide to using Birmingham District Profiles

Birmingham's district profiles provide a summary or an overview of your local area, across all four wards which make up that district.



What is in your District Profile?

Each district profile contains information on:

population estimates	**life expectancy**
years of life lost	**childhood obesity**
together with other indicators which may be useful	

Additional information about individual wards within your district can be found online via Local Health Profiles or Birmingham Public Health.

What does the information mean?

Some data is shown using charts and graphs, with a short description where needed, to explain complex data in a more visual way to help you understand what is going on in your local area.

At present, there are 10 districts in Birmingham, each containing four wards. When looking at the profile for your area, it can be useful to also look at neighbouring profiles – especially if the area of interest is near to another district border. It may be that the needs of the communities based along the border, align more closely with the needs of the neighbouring district.

How can they be used to support your district and work?

These district profiles can be accessed by anyone interested in the health of their districts, including Councillors, support or community groups, charities, commissioners and the general public. The data shown in each profile can be used to:

help to identify areas of need	**show differences in health between districts**
Inform health and wellbeing decisions	**provide local evidence for funding bids**

If printing the profile, you may prefer to print in colour as they are then clearer and easier to understand.

Further help and guidance

About these Profiles	About Health Conditions	Further data and statistics for your ward or district
Birmingham Public Health www.birmingham.gov.uk publichealth@birmingham.gov.uk	NHS Choices https://www.nhs.uk/Conditions/Pages/hub.aspx	Public Health England – Fingertips https://fingertips.phe.org.uk/profile/health-profiles