BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD
29 NOVEMBER 2016

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

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

ALSO PRESENT:-

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

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NOTICE OF RECORDING

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

WELCOME AND APOLOGIES

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

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

DECLARATIONS OF INTERESTS

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

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

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

MINUTES

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

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

CHAIR'S UPDATE

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

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

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

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

HEALTH AND WELLBEING STRATEGY

The following report was submitted:-

(See document No. 1)

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

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

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

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

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

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

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

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

174 **RESOLVED:-**

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

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

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

BIRMINGHAM HEADSTART

The following report was submitted:-

(See document No. 2)

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

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

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

175 **RESOLVED:-**

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

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

A STRATEGIC APPROACH TO REDUCING ADVERSE CHILDHOOD EXPERIENCES

The following report was submitted:-

(See document Nos. 3)

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

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

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

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

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

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

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

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

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

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

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

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

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

176 **RESOLVED:-**

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

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

DELIVERING THE BIRMINGHAM DOMESTIC ABUSE PREVENTION STRATEGY

The following report was submitted:-

(See document No.4)

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

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

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

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

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

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

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

177 **RESOLVED:-**

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

(The following report was brought forward on the agenda)

BLACK COUNTRY SUSTAINABILITY AND TRANSFORMATION PLAN

178 The following PowerPoint slides and document were received:-

(See document Nos. 5 and 6)

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

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

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

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

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

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

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

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

AIR POLLUTION AND HEALTH IN BIRMINGHAM

The following report was submitted:-

(See document No. 7)

The Chair proposed and it was:-

179 **RESOLVED:-**

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

The meeting ended at 1705 hours.

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CHAIRPERSON