Wellbeing Board Meeting

Date	19 January 2018
Report title	Progress on the WMCA Wellbeing Priorities
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Report to be/has been considered by	This paper will be considered by WMCA Programme Board

Recommendation(s) for action or decision:

The Wellbeing Board is recommended to:

1. The Wellbeing Board are asked to review progress since the last Wellbeing Board on developing the Cardiovascular and Diabetes and Children and Young People priorities.
2. The Wellbeing Board are asked to agree the proposals for the Local Authority/ Health Inequalities Alliance and to take these proposals to their local Health and Wellbeing Boards and STP Boards for further discussion.

Purpose

1.1 This report presents the work that has been undertaken since the last Wellbeing Board on actions that the Board agreed on the Wellbeing Priorities.

2.0 Background

2.1 At the last meeting of the Wellbeing Board it was agreed that from the six potential priority areas initially identified by the Board that further work would be undertaken on two areas:

1. Cardiovascular Disease and Diabetes
2. Children and Young People

2.2 The Board also agreed that any health devolution proposals would be based on these two priority areas and on the overarching vision for the WMCA Wellbeing agenda that focuses on keeping people healthy by prevention and across system action.

2.3 The Wellbeing Priorities agreed by the Board formed the basis for devolution proposals discussed with central government. This work is running in parallel with identifying the broader workplan under each of the priorities.

3.0 Wider WMCA Implications

3.1 The development and implementation of these priorities will involve non-constituent areas (e.g. within STP geographical areas).

4.0 Progress on Wellbeing Priorities

4.1 The Board agreed that that we should develop proposals for a Cardiovascular Disease and Diabetes Prevention Programme and undertake further scoping work on the Children and Young People Priority to identify where the WMCA could most add value from a Wellbeing perspective.

4.2 Progress on the Cardiovascular and Diabetes Programme

4.2.1 The initial focus has been on three areas:

- ***Improving levels of physical activity in adults and children.*** The progress on developing the WMCA physical activity strategy; - *West Midlands on the Move* will be reported later in the programme. In addition we started devolution discussions with the Department of Education on a WMCA physical activity programme for school aged children. Physical Activity will also form part of the workplace offer that is part of the Thrive Workplace Wellbeing Premium pilot.

- ***A WMCA/STP prevention programme.*** The Board agreed at the last meeting that we should start a discussion across the West Midlands STPs about co-developing and designing a programme of work where action on the wider WMCA/pan STP geography would provide added value. The Board identified the potential contribution of joint work on the early identification of health risks combined with cross system approaches to improving levels of physical activity, mental wellbeing and addressing the wider

determinants of health as areas. In particular the Board asked for a focus on areas where joint action could reduce demand on services and improve the productivity of our working age population. A paper was sent to STPs to support discussions with STP Boards/subgroups. We are currently discussing with STPs how this programme add values to individual STP prevention programmes. We are also engaging a range of other stakeholders on this agenda.

Discussions to date with stakeholders from all the STPs identified two initial areas of interest that were also WMCA priorities. These were the use of digital technology to support social interventions to reduce demand on health and social care services and training professionals in asset based approaches to support individuals improve their wellbeing. These two areas were developed into the proposals used as the basis for the devolution discussions and were endorsed at the STP Execs meeting that brings together the STPs in the NHSE WM area. In addition the Black Country STP agreed to be the lead for developing these proposals into business cases. We are currently setting up a task and finish group that will bring all the relevant stakeholders together to develop the business case for the digital support for social interventions and colleagues from Warwick and Coventry Universities are working on a feasibility study for the training proposals.

- ***Developing a West Midlands joint local government /health alliance.*** A meeting has been held to discuss the potential for an alliance involving professionals and clinicians from local government and health organisations across the whole of the West Midlands that will focus on reducing health inequalities across the region. We presented the WMCA vision that focussed on keeping people healthy and prevention. The meeting were supportive that the areas that the WMCA had prioritised should be the areas that this inequalities alliance focussed on in the first instance. Subsequent to this meeting colleagues from WMCA, PHE, NHSE and local government have been working up detailed proposals for this Health Inequalities Alliance (see appendix 1). The board are asked to review and agree the recommendations in this proposal.

  In addition PHE and NHS colleagues have agreed to prioritise action to reduce the number of people in the West Midlands with undiagnosed Atrial Fibrillation (irregular heart beat) and Hypertension (high blood pressure) which are major risk factors for strokes and cardiovascular problems. The first outcome of this has been joint work between WM PHE and the Academic Health Sciences Network to develop a consensus protocol for the identification and management of individuals with these conditions. WM PHE have also committed resources to support the NHS in delivering this agenda with the aim of reducing the number of premature deaths from cardiovascular disease in the West Midlands.

4.3 **Children and Young People**

4.3.1 At the last Board meeting it was agreed that we would undertake further scoping work to set out the current position in the West Midlands (available data and evidence), current initiatives and evidence of best practice (survey work) and stakeholder involvement (an iterative exercise to create consensus on the areas where a WMCA CYP would add most value). We set up a project oversight team with membership from ADCS, DEs, ADPH, Youth Justice, NHS, Skills and Productivity and

Police and brought together intelligence resources from across LAs, PHE, NHE and the Universities to bring together the data, evidence and work and current best practice in the West Midlands as well wider best practice. This initial work has now been completed and the intention is to bring detailed proposals for Children and Young People to the March WMCA Wellbeing Board.

4.4 **Wellbeing Work Plan**

4.4.1 A detailed work plan for 2018/19 and outline plan for 2019/21 is currently being developed and will be brought to the next Wellbeing Board for agreement.

4.4.2 In conjunction with this plan we are working with PHE and NHSE on developing a clear rationale for how the major health and wellbeing stakeholders collaborate to support the delivery of our strategic intentions and work programmes. A paper setting out how the governance and intent of this collaboration will come to the next Wellbeing Board.

5.0 Financial implications

5.1 The financial implications will depend on the development of the programmes for the two priority areas.

6.0 Legal implications

6.1 Any legal implications will depend on the programmes developed.

7.0 Equalities implications

7.1 Any equalities implications will depend on the programmes developed

8.0 Other implications

8.1 None.

9.0 Appendices

Appendix 1: Proposal for a joint Local Authority/Health Inequalities Alliance

Appendix 1.

Proposal for a West Midlands Alliance to address health equity and health inequality
Purpose of Paper

1. This paper sets out a proposal for a West Midlands Inequalities Alliance to address health equity and health inequalities. This will improve health, care and well-being in our communities to live independently and improve sustainability of services.

2. Its proposed role is that it will an engine for sharing good practice and collaboration, developing more connected leadership bringing clinical, public health, and public-sector leaders together to gain synergy; sharing learning and expertise whist supporting evaluation to strengthen local partnerships and connecting initiatives on health inequalities e.g. action on hypertension (blood pressure), health checks, wider determinants of health.

3. The Alliance will raise the profile of health equity and health inequalities starting with the prevention of cardio-vascular disease (CVD) as an initial test bed for this work - that is the prevention of heart problems, stroke, diabetes and their contribution to healthy life expectancy, prosperity and healthy aging.

4. This Alliance proposal includes the 6 Strategic Transformation Plan (STP) areas, West Midlands Combined Authority (WMCA) and the following local authorities: Birmingham, Solihull, Walsall, Dudley, Wolverhampton, Sandwell, Coventry, Stoke on Trent, Telford as well as the counties of Staffordshire, Worcestershire, Herefordshire, Shropshire and Warwickshire. This aligns to PHE and Association of Directors of Adult Social Services footprints.

5. The WMCA Well-being Board and other relevant stakeholders are asked to:
    a. Consider the proposal
    b. Be involved in shaping the Alliance and its position within the governance arrangements
    c. Support local discussions of the proposals through local authority Health and Well-being Boards and STP Boards

Background

6. Healthy life expectancy (years you can expect to be in good health) in the West Midlands is significantly below the England average and there is a 19-year difference for men and a 17-year difference for women in the most deprived areas compared to the least deprived areas. In rural areas in the wider West Midlands, for some communities, this gap in healthy life expectancy can be hidden.

7. We know that the average age that men and women will start to experience significant health problems in our most deprived areas is in their mid-forties and is likely to correlate with the increased levels of all age disability in the over 40s in the West Midlands and the demand on services.

8. Further to this there is strong evidence that a healthy population is essential for delivering strong economic outcomes and action on reducing health inequalities is essential for good economic growth, supporting aging well and increasing independence. All key priorities for the West Midlands.

West Midland's commitment to reducing health inequalities

9. NHS organisations, STPs and Local Authorities have made strong commitments to reducing health inequalities.

10. Analysis of the STP plans and Health and Well-being Board Strategies demonstrates a strong congruence, prioritising 'starting well' and' living well' and action on CVD as well as action on the aging well, determinants of health (e.g. education, work, place, community, family) and resilient communities. The tables in the appendix summarise the Local Authority Health and Well-being Strategies and STP plan priorities.

11. WMCA has made a commitment to reducing health inequalities including prioritising children's lifestyles leading to CVD. It has agreed to transformation pilots and their evaluation to make a step change in closing the gap in healthy life expectancy. Thrive is addressing inequalities that relate to mental health issues.

12. Further to this there is significant potential to maximise the contribution of population management and prevention collaborations in the Accountable Care Systems as these come on line connecting them to health benefits in policies to develop healthy environments and resilient communities and therefore further outlining the public-sector contribution and commitment.

13. Other opportunities that align to the Alliance and are worthy of further exploration are the West Midlands ADASS commitment to collaborative working on well-being and the role of the Thrive Citizen Jury in shaping activity of health inequalities.

14. This congruence of priority and the opportunities support the proposal for sharing best practice and collaborative working across the West Midlands at scale to maximise impact. Examples of collaborative work include 'do once' communication with the public e.g. Self-help manuals, theatre productions, collective action on digital approaches to health improvement and a commitment for all public-sector bodies to promote healthy lifestyles in their contact with the public to supplement the health checks programme.

A Health Inequalities Alliance

15. It is proposed that an Alliance is formed to provide an offer to the public sector in the West Midlands as an engine for collaboration:
    a. Developing more connected leadership bringing clinical, public health, and public-sector leaders together to gain synergy
    b. Sharing of learning and expertise across a wider footprint and supporting evaluation to strengthen local partnerships

c. Connecting initiatives on health inequalities e.g. action on hypertension (blood pressure), health checks and sector led improvement
d. Connecting and standardising action on wider determinants and community assets with primary and secondary prevention pathways[1] and programmes
e. Helping each public-sector organisation set out their contribution to health inequalities
f. Build a collective view of where the biggest impact of our work is and Identify and drive through 'at scale' and 'do once' opportunities
g. Shaping the 'do once' intelligence function for healthy life expectancy and 'hold a mirror' up to partners using a dashboard to track progress

16. In doing this work the Alliance would support the West Midland's and by working towards a strategic agreement on the priorities, initially for CVD prevention, across the West Midlands and gaining agreement on where it makes sense to work as a collective to ensure that the wide-ranging initiatives are integrated to deliver maximal impact and return on investment.

17. The dashboard in the WMCA Strategic Economic Plan includes healthy life expectancy. The ambition is under development and the proposed Alliance would support the WMCA Well-being Board with the Public-sector Reform Board in developing this commitment to the people of the West Midlands and a process for local members, officers and STP Clinical Chairs, DPHs and other clinicians to sign up to this commitment.

18. The Alliance would not, at this time, be requesting additional resources and will work with coalitions of the willing contributing time and leadership.

19. This paper proposes that a conversation is led by the STP Boards, WMCA and associated local authorities in their localities through health and well-being boards. These groups are asked to
    a. consider and shape and governance arrangements of the Alliance
    b. contribute to determining where the focus that adds value by action at both the local and West Midlands level
    c. support this ambition to working together and consider how we identify a framework for collective ambition and delivery and build a concordat on how we work together on these issues.

20. Together we can create a high ambition to be the 'best in class' in outcomes for CVD.

Governance

21. The accountability for reducing health inequalities will remain embedded within the statutory bodies and build on the opportunities afforded by WMCA.

[1] Levels of prevention: primordial – measures aimed at avoiding risk factors in first place in early life e.g. work with future parents; primary – measures aimed at avoiding/eliminating disease e.g. healthy eating; secondary – methods to detect and address existing disease before the appearance of symptoms e.g. blood pressure; tertiary – methods to reduce harm of symptomatic disease e.g. surgery, rehabilitation

22. The Alliance membership would reflect all public-sector organisations, clinical networks and local academia. It is proposed that this Alliance in the initiation period is chaired by the Director of PHE, West Midlands, Sue Ibbetson and Medical Director, West Midlands NHS England, Kiran Patel. The Alliance meetings will be a forum for information exchange rather than a board arrangement.

23. This Alliance would agree and report on its work programme with local Health and Well-being Boards, the STP Execs and WMCA Well-being Board. Task and finish groups will be formed as appropriate.

Recommendations and a process for support

24. Members of the Well-being Board and other relevant stakeholders are requested to support the proposal for a Health Inequalities Alliance.

25. Members are asked to support the proposal that a conversation is led by the STPs, WMCA and associated local authority's members via STP boards and local health and wellbeing boards on areas highlighted in paragraph 19.

26. Members are asked to recommend that Directors of Public Health, Directors of Adult Social Care and STP Clinical Leads support this process.

27. Members are asked to support a further paper coming to the WMCA Well-being Board once these local discussions have taken place that will set out the final proposals for the Alliance and a framework for how we will build a concordat to work together on these issues

Annex: Summaries of STPs and Health and Well-being Board's Live well priorities

	Wolverhampton City Council	Walsall MBC	Sandwell MBC	Dudley MBC	Coventry City Council	Warwickshire CC	Birmingham City Council	Solihull MBC	Stoke on Trent City Council	Staffordshire CC	Worcestershire CC	Herefordshire Council	Shropshire Council	Telford and Wrekin Council	Black Country STP	Coventry/War-shire STP	Birmingham/Solihull STP	Staff-shire/Stoke STP	Wor-shire/Here-shire STP	Shropshire/Telford STP
Prevention/Early intervention/healthy life expectancy																				
Behaviour change/Health																				

y lifestyle programmes																				
Physical and mental well-being																				
Mental health/well-being																				
Alcohol																				
Active lives																				
Healthy weight																				
Smoking (incl pregnancy)																				
Well-being workplace																				
Self-care																				
LTC																				
Diabetes																				
LTC																				
CVD																				
Cancer/ Respiratory disease																				
Food poverty/sustainable food																				
Resilience and social capital																				
Social prescribing/social marketing																				
Digital inclusion/innovation																				
Action on lifestyle and CVD																				

Relative contribution of the determinants of health to health outcome – demonstrating how health in all policies can make a difference

Health Behaviours 30%	**Socio-economic Factors 40%**	**Clinical Care 20%**	**Built environment 10%**
Smoking 10%	Education 10%	Access to Care 10%	Environmental Quality 5%
Diet/Exercise 10%	Employment 10%	Quality of care 10%	Built Environment 5%
Alcohol use 5%	Income 10%		
Poor sexual health 5%	Family/Social Support 5%		
	Community Safety 5%		

Source: LGA Health in Policy: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute.

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