Public Document Pack

WEST MIDLANDS COMBINED AUTHORITY

Wellbeing Board

Date: Friday 19 January 2018

Time: 1.30 pm **Public meeting** Yes

Venue: Room 116, 16 Summer Lane, Birmingham B19 3SD

Membership

Councillor Bob Sleigh (Chair)	Solihull Metropolitan Borough Council
Councillor Ken Meeson (Vice-Chair)	Solihull Metropolitan Borough Council
Councillor Kamran Caan	Coventry City Council
Councillor Les Caborn	Warwickshire County Council
Councillor Paulette Hamilton	Birmingham City Council
Councillor Barry Longden	Nuneaton and Bedworth Borough Council
Councillor Peter Miller	Dudley Metropolitan Borough Council
Councillor Ian Robertson	Walsall Metropolitan Borough Council
Councillor Ann Shackleton	Sandwell Metropolitan Borough Council
Councillor Paul Sweet	City of Wolverhampton Council
Sarah Norman	WMCA Chief Executive Lead
Alison Tonge	NHSE
Andy Hardy	STP Systems Leader NHS
Julie Moore	STP Systems Leader NHS
Andy Williams	STP Systems Leader NHS
Sue Ibbotson	Public Health England
Guy Daly	Universities (Coventry)
Sean Russell	Mental Health Implementation Director
Gary Taylor	West Midlands Fire Service
Sarah Marwick	West Midlands Police

Quorum for this meeting shall be seven members.

If you have any queries about this meeting, please contact:

Contact Wendy Slater
Telephone 0121 214 7016
Email wendy.slater@wmca.org.uk

AGENDA

No.	Item	Presenting	Pages
1.	Apologies for Absence	Chair	None
2.	Minutes of the last meeting	Chair	1 - 10
3.	Matters Arising	Chair	None
4.	Introduction to Public Service Reform	Henry Kippin	None
5.	Progress on Wellbeing Priorities	Jane Moore	11 - 20
6.	WMCA Wellbeing Dashboard and Intelligence	Jane Moore	21 - 52
7.	Transport and Health Strategy	Duncan Vernon	53 - 110
8.	Communication and Engagement with the WMCA Wellbeing Board	Jane Moore	111 - 118
9.	West Midlands on the Move - Physical Activity Implementation	Simon Hall	119 - 126
10.	West Midlands Mental Health Commission Update	Sean Russell	None
11.	Date of Next Meeting - 20 April 2018 at 1.30pm		None

WEST MIDLANDS COMBINED AUTHORITY

Meeting: Wellbeing Board

Subject: Minutes

Date: Friday 6 October 2017 at 1.30pm

Present:

Councillor Bob Sleigh (Chair)	Solihull Metropolitan Borough Council
Councillor Ken Meeson (Vice-Chair)	Solihull Metropolitan Borough Council
Councillor Kamran Caan	Coventry City Council
Councillor Les Caborn	Warwickshire County Council
Councillor Paulette Hamilton	Birmingham City Council
Councillor Peter Miller	Dudley Metropolitan Borough Council
Councillor Ian Robertson	Walsall Metropolitan Council
Councillor Ann Shackleton	Sandwell Metropolitan Borough Council
Councillor Paul Sweet	City of Wolverhampton Council
Guy Daly	Universities
Sue Ibbotson	Public Health England
Sarah Marwick	Office of Police & Crime Commissioner
Sarah Norman	Health Chief Executive Lead for WMCA
Sean Russell	Mental Health Implementation Director
Gary Taylor	West Midlands Fire Service
Alison Tonge	NHS England

In Attendance:

Mark Barrow	(OPE Programme Director, Arcadis)
Mary Crofton	(WMCA)
Simon Hall	(WMCA)
Henry Kippin	(WMCA)
Jane Moore	(WMCA)
Duncan Vernon	(Transport for the West Midlands)

Apologies for absence were received from Councillor Barry Longden, Andy Hardy, Julie Moore, Chris Tidman and Andy Williams.

11. Welcome and Introductions

The Chair welcomed everyone to the meeting and introductions were duly noted. The Chair thanked the Vice-Chair, Councillor Ken Meeson, for 'holding the fort' for the last couple of meetings and reminded colleagues of the importance of the Wellbeing agenda for the WMCA and the people of the West Midlands.

12. Minutes

The Minutes of the meeting held on 28 July 2017 were agreed and signed by the Vice-Chair, as a correct record.

13. Global Thrive Network (I- Circle Event)

Sarah Norman presented a report to share the key learning points from the I-Circle (International City and Urban Regional Collaborative, Supporting Mental Health and Wellbeing to Enable Citizens to Thrive) event that she was attended on behalf of the WMCA.

The report set out the initiatives being undertaken with regards to employers and employee wellbeing, criminal justice and substance misuse, public health, community awareness and engagement, equalities, children and young people, disaster recovery, approaches to transformation and future progress.

In relation to substance misuse, the Chair noted that the West Midlands Police and Crime Commissioner (PCC) would be holding a Drug Policy Summit on 15 December 2017 that included a call for evidence and asked if details could be circulated to the board.

The Vice-Chair reported that he welcomed the report and noted that cannabis use was impacting on mental health.

Sarah Norman considered that the cannabis issue was interesting and reported that the matter may feature at the PCC's call for evidence/Drugs Policy Summit in December.

Guy Daly noted that the link between mental health and physical activity was not included in the paper and reported that he had visited the East and Indonesia and considered that western economies could learn from developing countries as well as the developed world.

Sarah Norman advised that physical activity did not feature at the conference and with regards to future learning reported that the WMCA was part of the global network of Thrive Cities, so could 'tap into' shared into evidence and ideas and this could include university collaboration.

Sarah Norman reported that all cities represented at the event had agreed to establish a framework for future collaboration and advised the board that the next event would be held in Stockholm at the end of May 2018 where it is recommended that the WMCA should be represented to maintain the Authority's profile of its work and strengthen its international collaboration. It was noted that there was also an opportunity for WMCA colleagues to work with Thrive London to host a joint event in the near future.

Resolved:

(1) That the Wellbeing Board and the West Midlands Combined Authority should continue international collaboration with other City Regions that are engaged in whole system transformation to improve the mental health and wellbeing of their citizens and support efforts to establish a thriving virtual network to share evidence, learning and ideas be agreed;

(2) That the Wellbeing Board and the West Midlands Combined Authority should send representation to the event in Stockholm in 2018 be agreed and

(3) That the Wellbeing Board and the West Combined Authority should seek to host a joint event with London in 2018 or 2019 be agreed.

14. West Midlands Mental Health Commission Update

Sean Russell presented a report that updated the board on progress with regards to the West Midlands Mental Health Commission Action Plan.

The report outlined progress since the last meeting on the Employment and Employer, Housing First, Criminal Justice, Improving Care and Community Engagement workstreams.

In relation to an enquiry from the Chair regarding the Employment and Employer – Fiscal Incentive workstream and the involvement of small and medium enterprises (SMEs), Sean Russell confirmed that the SMEs were involved and that he was working closely with the Federation of Small Business, LEPs and the various chambers of commerce and that he wanted to include companies from non-constituent authorities. The Chair added that it was crucial to embed the non-constituent authorities in this workstream.

In relation to Community Engagement and the Zero Suicide Ambition, the Vice- Chair noted the importance of the role played by partners and carers in emotional wellbeing.

Sean Russell advised that the Thrive Cafes had a focus on rehabilitation and that Solihull was working with carers to look for a community asset based model to give support at a lower tier.

In relation to a comment from Councillor Robertson regarding the Thrive into Work programme and the Zero Suicide offering support at an early stage, Sean Russell reported of the need to go back to providing early intervention support and advised that a digital platform is being examined that would sign post people to help.

In relation to Primary Care Mental Health, Alison Tonge enquired what does good look like and asked the Mental Health Implementation Director what he would like to see happen.

Sean Russell reported that connectivity was needed across different sectors as there was a lack of trust in third sector organisations and that he was looking at different approach such as utilising the voluntary and charitable sector for social care. He added that it would be good if there was time to unpick an individual's root cause of the problem.

Alison Tonge considered there was a link to the Five Year Forward View and undertook to discuss how this could be taken with Sean Russell outside of the meeting.

Resolved:

(1) That progress and the update on the current position of the West Midlands Mental Health Commission Action Plan and the work being undertaken since the launch of the programme on 31 January 2017 be noted.

15. Update on Wellbeing Priorities

Jane Moore presented a report that provided an update on the actions pertaining to the Wellbeing Priorities that were agreed by the board at the last meeting.

The report provided updates on progress on the Cardiovascular and Diabetes Programme and on the Children and Young People priorities.

Jane Moore thanked local authority colleagues for their input into the preventative programme and especially those from the Black Country and indicated that the proposals could be taken forward into the devolution discussions.

In relation to the Children and Young People priority, Jane Moore reported that a wider stakeholder event would be held on 18 October and asked that colleagues let her know if they had members of their team who wanted to attend the event.

Sue Ibbotson considered it was exciting that the board had chosen to take forward 'every child fulfils their potential' as part of the Children and Young People priority as this had links to the future potential of the West Midlands.

Jane Moore advised that she was creating to a project group with a wide range of stakeholders that would look at how all parties could add value to this priority.

Resolved:

(1) That progress since the last meeting of the Wellbeing Board on developing the Cardiovascular and Diabetes and Children and Young People Priorities be noted.

16. Feedback from Health and Wellbeing Boards and STPs on the Wellbeing Priorities and Devolution Proposals

A report on the WMCA Wellbeing Priorities and Devolution Proposals had been drafted by Jane Moore following the last meeting for discussion with local authority Health and Wellbeing Boards.

In relation to feedback from the local authority Health and Wellbeing Board meetings, the Vice-Chair reported that the report had been well received in Solihull. However, with regards to membership of this board, it was suggested that the membership be reviewed to consider whether there should be representation from ADCS/ADAS.

The Chair advised that the matter would be picked up as part of the minutes.
The Chair reported that the report had not yet been considered by BSOL STP and asked that colleagues submit the report to their Health and Wellbeing Board if the report had not previously being considered.

Resolved:

(1) That feedback from the Health and Wellbeing Board and STPS on the Wellbeing Priorities and Devolution Proposal report be considered further at the next meeting.

17. Update on the development of Accountable Care Systems and Accountable Care Organisations

Alison Tonge presented a report that outlined the development of Accountable Care and the national programme for this.

Alison Tonge outlined the report which set out the steps being taken towards Accountable Care, how this might lead to Accountable Care Organisation(s) and what this would involve, the implications for commissioning in the NHS and how NHS England would support this new system.

It was noted that in the West Midlands, each STP would be invited to have a discussion on their ambition and to identify if they would be ready to move to an Accountable Care System this year, in early 2018-19, or not yet ready.
Alison Tonge reported that a national programme has been established for early adopters of the Accountable Care System that would be open for applications in October 2017 and it was anticipated there would be applications from the West Midlands.

In relation to an enquiry from the Chair regarding the scale of accountable care systems, Alison Tonge advised that this could be very big as it was based on population and patients registered with a GP.

In relation to an enquiry from Sarah Norman as to how the new Accountable Care Organisation would fit together with STPs, Alison Tonge reported that the

organisations would be 'nested and layered' and whilst the governance has not yet been determined, it would be grounded in a single purpose.

In relation to enquiry from the Chair regarding the financial risk and how this was shared, Alison Tonge reported that this would be based on GPs and population and the money would managed together with NHS England.

Alison Tonge informed the board that they would hear more about Accountable Care Systems through their health and wellbeing boards and STPs.

Resolved:

(1) That the development of Accountable Care Systems and the national programme for this be noted;

(2) That the opportunity for local systems to apply for the national programme in 2017 be noted and

(3) That the opportunity for this new development to contribute to the wider goals for health and wealth through a focus on demand, productivity and inequalities be noted.

18. West Midlands Health and Transport Strategy

Duncan Vernon presented a report that updated the Wellbeing Board on progress by Transport for the West Midlands (TfWM) to develop a health and transport strategy. A draft outline strategy was attached to the report for review.

It was noted that the strategy links with the aims of the Wellbeing Board and the population health plan and the WMCA's Strategic Economic Plan.

The Chair reported of the need to be clear on the health benefits that would be realised from the strategy and how these would be articulated. He added that the economic benefits should also be identified along with the health benefits if the West Midlands was to benefit from investment and cited electronic vehicles as an example.

The Chair and Sue Ibbotson enquired as to whether the health impacts had been considered for public transport systems.

Jane Moore advised that there was lots of expertise in this areas and referred to modelling being undertaken and the research programme being developed by academics that was building the case on why health matters.

Councillor Hamilton commented that the report submitted was an excellent paper and that Birmingham City Council was undertaking a great deal of work in this area. Councillor Hamilton reported on the need to ensure the health and transport initiatives were joined-up to prevent any displacement such as that caused by people parking their cars on the outskirts of the town rather than in

the centre which would move the problem to another area rather than solving it.

Jane Moore concurred with Councillor Hamilton that air quality was a key issue and reported that work was being scoped for cross WMCA actions to prevent any displacement and referred to the recently held air quality workshop. She added that there is strong agreement that everyone needs to work together to provide the health evidence to bring about change.

Resolved:

(1) That the work undertaken to analyse health data that relates to transport and to identify cross-cutting issues be noted;

(2) That the results of the transport and health consultation workshop be noted;

(3) That the proposed structure of the health and transport strategy be endorsed and

(4) The four strategic themes to structure actions that link transport and health be agreed.

19. 'West Midlands on the Move', From Strategic Framework to Implementation

Simon Hall presented a report that accompanied the 'West Midlands on the Move' Strategic Framework that included the two year delivery plan.

The report outlined progress in developing the Strategic Framework, the establishment of a Political Activity Champion, the key features of the 2017-2019 Delivery Plan and the launch of the plan. It was noted that the document would be submitted to the WMCA Board for final approval on 13 October 2017.

In relation to the establishment of the Political Physical Activity Champion, Simon Hall reported that the Chair of the Coventry Health and Wellbeing Board, Councillor Caan had agreed to undertake this role which would serve to provide leadership, advocacy and challenge for the Framework and Delivery Plan's implementation.

Councillor Caan reported that he was looking forward to reporting on the positive impacts of the Delivery Plan and seeing how it would benefits hundreds of people.

In relation to the launch of the Strategic Framework that is planned for 16 November, Councillor Sweet asked that colleagues be notified as soon as possible of the confirmed date so that it is scheduled in diaries.

Simon Hall undertook to confirm the launch date of the Strategic Framework with board members as soon as possible

Councillor Robertson reported that he hoped there would be a fair allocation of resources that would cover the most vulnerable areas.

Jane Moore advised that the WMCA has started discussions with key partners, Government and various agencies and that the power of devolution for the West Midlands is that it would enable the region to determine its priorities and funding across the West Midlands. Jane added that the WMCA wanted to enhance what individual authorities are doing and to allocate funding where it would have the most impact.

Resolved:

(1) That the appointment of the Chair of Coventry Health and Wellbeing Board as Political Physical Champion be approved;

(2) That progress made in understanding and agreeing Constituent Authorities Offer and Asks of the WMCA be noted;

(3) That progress made in agreeing the 2017-19 Delivery Plan, resourcing and progress on immediate priorities be noted and

(4) That the launch proposals on 16 November in Coventry including invitation to Council Leaders, WMCA Board Members and Senior Officers as well as inviting Sport England Management be agreed.

20. Date of the Next Meeting

Friday 19 January 2018 at 1.30pm

21. Exclusion of the Public and Press

Resolved:

That, in accordance with s100(a) of the Local Government Act 1972, the public and press be excluded from the meeting for the following item of business as its likely to involve the disclosure of exempt information as specified in paragraph 3 of the Act.

22. One Public Estate Programme

The One Public Estate (OPE) Director, Mark Barrow presented a report that sought awareness and support for the submission to Government of additional projects for future grant support and also provided an update on progress made in delivering health and care related projects within the current programme.

In relation to the OPE 6 funding bids that are to be submitted by the deadline of 3 November 2017, it was agreed that the One Public Estate Director would circulate these to the board for information/comments and the Chair would sign-off the bids on behalf of the board.

Resolved:

(1) That the development of submissions of future projects for grant funding to the Government Property Unit be supported and
(2) That progress made within the WMCA OPE Programme be noted.

CHAIRMAN

This page is intentionally left blank

Wellbeing Board Meeting

Date	19 January 2018
Report title	Progress on the WMCA Wellbeing Priorities
Portfolio Lead	Councillor Bob Sleigh - Wellbeing and HS2
Accountable Chief Executive	Sarah Norman Email sarah.norman@dudley.gov.uk Tel (01384) 815201
Accountable Employee	Dr Jane Moore -Director of Prevention and Wellbeing Email Jane.Moore@wmca.org.uk Tel 0121 214 7039
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.

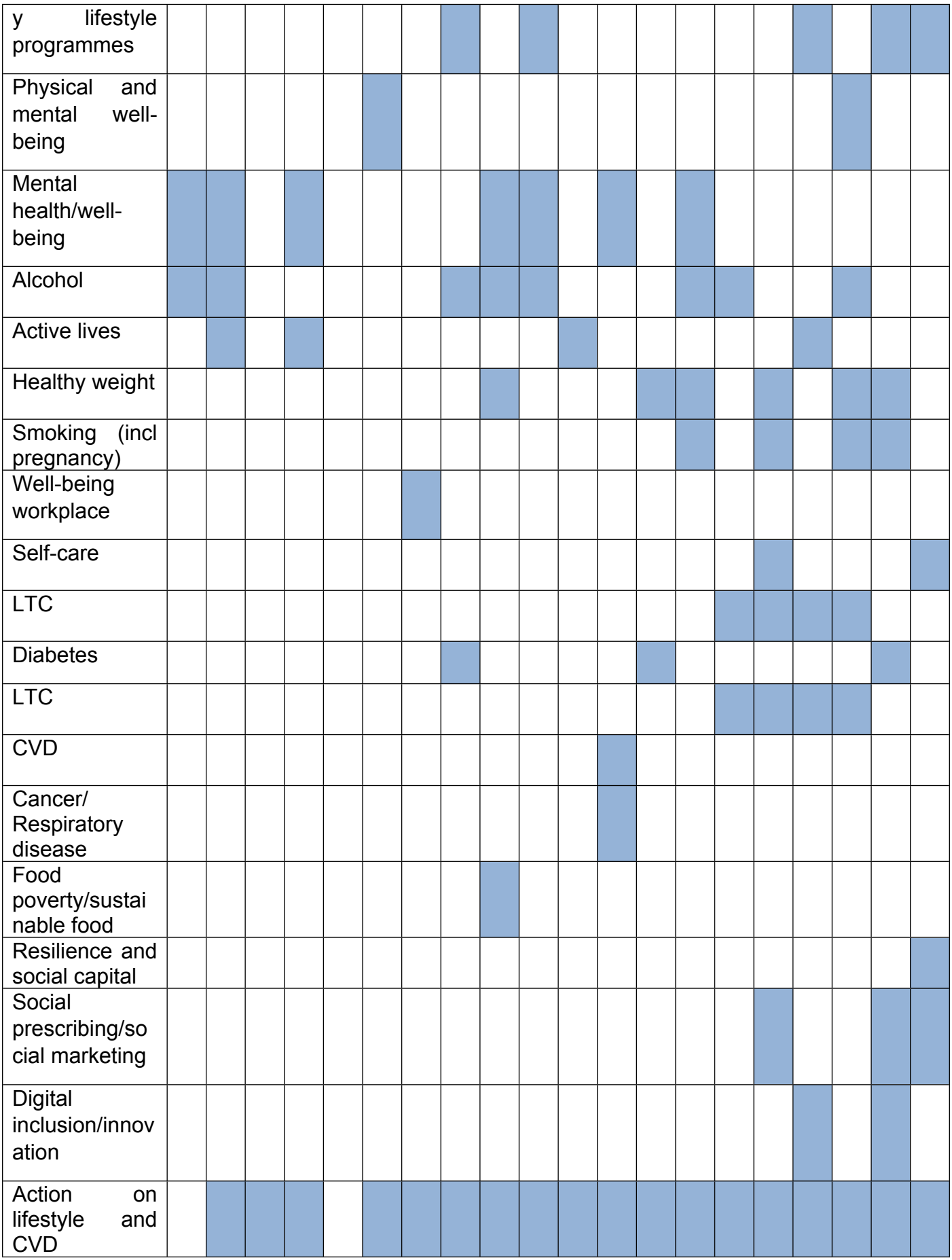
25. Members are asked to support the proposal that a conversation is led by the STPs, WMCA and associated local authority's members via STP boards and local health and wellbeing boards on areas highlighted in paragraph 19.

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.

Author Julie Higgins NHSE

Wellbeing Board Meeting

Date	19 January 2018
Report title	Wellbeing Dashboard and Intelligence update
Portfolio Lead	Councillor Bob Sleigh - Wellbeing and HS2
Accountable Chief Executive	Sarah Norman Email sarah.norman@dudley.gov.uk Tel (01384) 815201
Accountable Employee	Dr Jane Moore -Director of Prevention and Wellbeing Email Jane.Moore@wmca.org.uk Tel 0121 214 7039
Report to be/has been considered by	This paper will be considered by WMCA Programme Board

Recommendation(s) for action or decision:

The Combined Authority Board is recommended to:

1. The Wellbeing Board are asked to consider current progress on developing effective population intelligence across the WMCA/West Midlands area.

2. The Wellbeing Board are asked to agree the:
   - Wellbeing Dashboard
   - Proposals to develop indicators linked to the wider determinants of health

Purpose

1.1 This report sets out proposals for a West Midlands Combined Authority Wellbeing Dashboard.

1.2 The report sets out how the dashboard and other work on the Wellbeing Intelligence Hub and the Intelligence offer will support the objectives and priorities of the Wellbeing Board.

2.0 Background

2.1 The overall WMCA strategic plan already includes wellbeing indicators on healthy life expectancy and health inequalities. This report (appendix 1) builds on these small set of indicators to suggest an initial set of wellbeing indicators that can be used to assess progress on the wellbeing agenda by the WMCA Wellbeing Board and the WMCA Board. It could also form the basis of a real time indicator set that could be used by stakeholders across the West Midlands.

2.2 The report also sets out the work that is being undertaken to develop the a West Midlands Health and Wellbeing Intelligence capacity and how this capacity will support the work of the WMCA and other key stakeholders across the West Midlands to deliver improvements in health and wellbeing outcomes.

2.3 Board also

3.0 Wider WMCA Implications

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

4.0 Financial implications

4.1 None for the report although some elements will be contributing to the work of the Office of Data Analytics

5.0 Legal implications

5.1 None

6.0 Equalities implications

6.1 None

7.0 Other implications

7.1 None.

8.0 Appendices

8.1 Appendix 1 – Creating Intelligence that enables effective action

This page is intentionally left blank

Creating Intelligence that enables effective action - The role of population intelligence in supporting the WMCA objectives

1 Introduction

1.1 The WMCA Wellbeing vision is to generate the good health and wellbeing within the West Midlands population that is essential to strong economic growth. This can best be achieved by keeping people healthy rather than managing the consequences of ill health. This has led the WMCA to develop its vision of a wellbeing agenda based on three premises.

- Keeping people healthy (prevention) will deliver the greatest improvements in outcomes
- Delivering better health and wellbeing for the people of the West Midlands by focusing on outcomes not services:
- Improving wellbeing outcomes requires concerted action across the whole system (private, public, voluntary, communities and individuals).

1.2 In addition the Wellbeing Board has made a clear commitment that all WMCA Wellbeing initiatives will be expected to deliver improvements in health and wellbeing outcomes and deliver changes against one or more of three key objectives that are part of the strategic objectives of the WMCA:

- Reducing the demand for public services and thereby reducing public service expenditure – keeping people healthy so reducing the need for intensive service use
- Improving productivity - healthy people with a good sense of wellbeing are essential to delivering strong economic growth and vibrant communities
- Breaking the cycle of inequalities which both limit the potential of today's working age adults, and, through an intergenerational effect limit "tomorrow's" potential of the children and young people who have a "poor start".

1.3 This agenda with its focus on actions across the system which generate outcomes that have an impact on wide parts of the system (e.g. the links between mental wellbeing and educational attainment) requires a broad understanding of population data and the behaviours and values of people within the West Midlands. This paper explores initial work on developing a dashboard of key wellbeing indicators that will allow the Wellbeing Board to assess the current situation of people in the West Midlands together with how key population indicators can be incorporated into other key WMCA dashboards (e.g. air quality and transport). Secondly this paper sets out how we are starting to build data, evidence and understanding of the West Midlands population into powerful analysis to that enables effective decisions and action. This is in line with the vision for research and intelligence set out in the WMCA's Policy Research Plan - https://governance.wmca.org.uk/documents/s286/Report.pdf

2. WMCA Wellbeing Board Preliminary Draft Dashboard

2.1 The overall WMCA strategic plan and indicator set already includes overarching wellbeing indicators on healthy life expectancy and health inequalities. An initial Wellbeing dashboard has been developed which builds on this small set of indicators to present a broader selection of wellbeing indicators that can be used to assess progress on the wellbeing agenda by the WMCA Wellbeing Board and the WMCA Board. It could

also form the basis of a more 'real time' indicator set that could be used by stakeholders across the West Midlands. The format of the dashboard is in line with other WMCA dashboards but includes additional trend data.

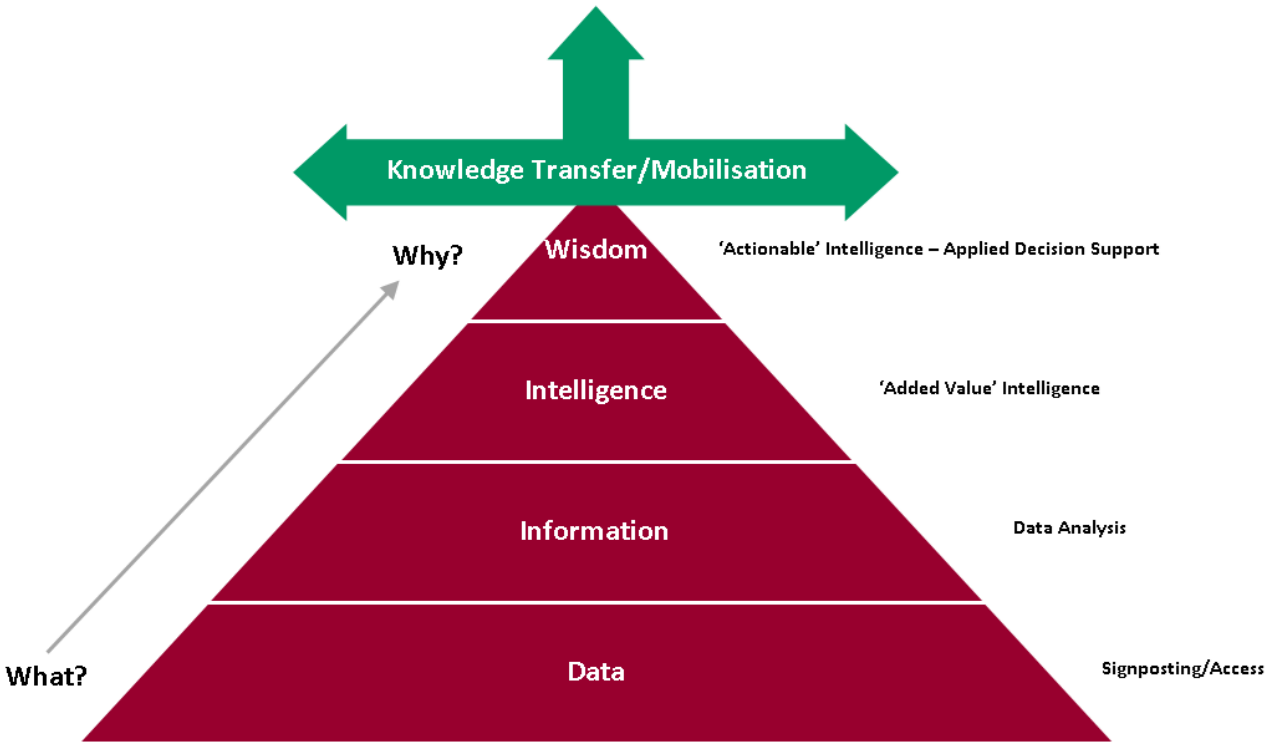
2.2 The set of sentinel indicators have been chosen to allow the Wellbeing Board to assess the current situation in the WMCA constituent member but we could provide this information across the wider West Midlands area as well. It also provides a snapshot of how the WMCA area is currently performing and highlights the progress (or lack of) being made. The dashboard includes overarching indicators looking at life expectancies and general wellbeing, plus indicators on key WMCA Wellbeing Board priorities around children & young people, mental health and CVD/Diabetes prevention. (See Appendix 1)

2.3 In discussion with the WMCA Director of Strategy, it was recognised that the population data available also offers the potential to provide key indicators that address the wider determinants of health within other dashboards also being developed by the WMCA, e.g. housing, transport, etc. We are therefore exploring the potential to provide a greater range of indicators on these wider determinants. In support of our ability to look at this wider population data at a WMCA level, PHE has recently started to analyse the data within its outcomes framework at a devolved authority level. A broad range of online outcomes indicator data is now presented at the WMCA geography in Public Health England's (PHE) Outcomes Framework.

2.4 In early 2018, we anticipate being able to make use of some new functionality within Public Health England's online Fingertips platform to present an online, fully up-to-date interactive dashboard. This will include user defined indicator selection pick lists which should enable users to create custom 'profiles' for the WMCA geography.

3 Moving from Data to Wisdom – the 'What' to the 'Why'!

3.1 The real power of the data and evidence can only be realised if we have the ability to assess and interpret this information so that it allows better decision making and real time assessment of how actions are impacting on the West Midlands population (figure 1).



3.2 Over the last six months we have been bringing together intelligence expertise from across local government, universities, NHS, PHE and other sectors to provide expert interpretation of a broad range of population and public health-related data. This is part of the wider work to develop a Population Intelligence Hub (See box).

3.3 Bringing this expertise together provides the opportunity to translate and present often complex analytical findings as understandable actionable intelligence for strategic decision-makers. This also provides the opportunity to help better understand populations (not just health) – e.g. population segmentation.

3.4 The first areas of collaborative intelligence we have been exploring are linked to current priorities:

1 Developing better intelligence on healthy life expectancy. This has now also led to work with national experts on how we can improve the measurement of healthy life expectancy and work by local authority analysts on the picture in the West Midlands.

2 Children and Young People – as part of the scoping of this priority area we have brought together not only health data but a wide set of population data. In addition with support from our academic collaborators we have started to turn this data and evidence into evidence reviews that will be used to underpin the business case for initiatives to improve outcomes for children and young people. An example is work to understand what lies behind the statistics on educational attainment at 16 (the single biggest predictor of life expectancy in adulthood) which therefore is important from both the wellbeing and skills and productivity perspectives (see appendix 2). This analysis is underpinned by the basic epidemiological principals for trying to understand what is happening in time, in person and in place*[1].

3 Providing intelligence into other WMCA priority areas. This includes discussions with PHE exploring how we could support the youth justice work stream and working with transport colleagues on understanding the implications of air quality on health.

4 Geographic mapping of data and spatial analysis to understand patterns, identify hotspots and highlight anomalies. Again this work is linked to work on Wellbeing priorities (e.g. the data on childhood obesity below) and to wider discussions on how these spatial analytical skills could be used to support the wider work of the WMCA.

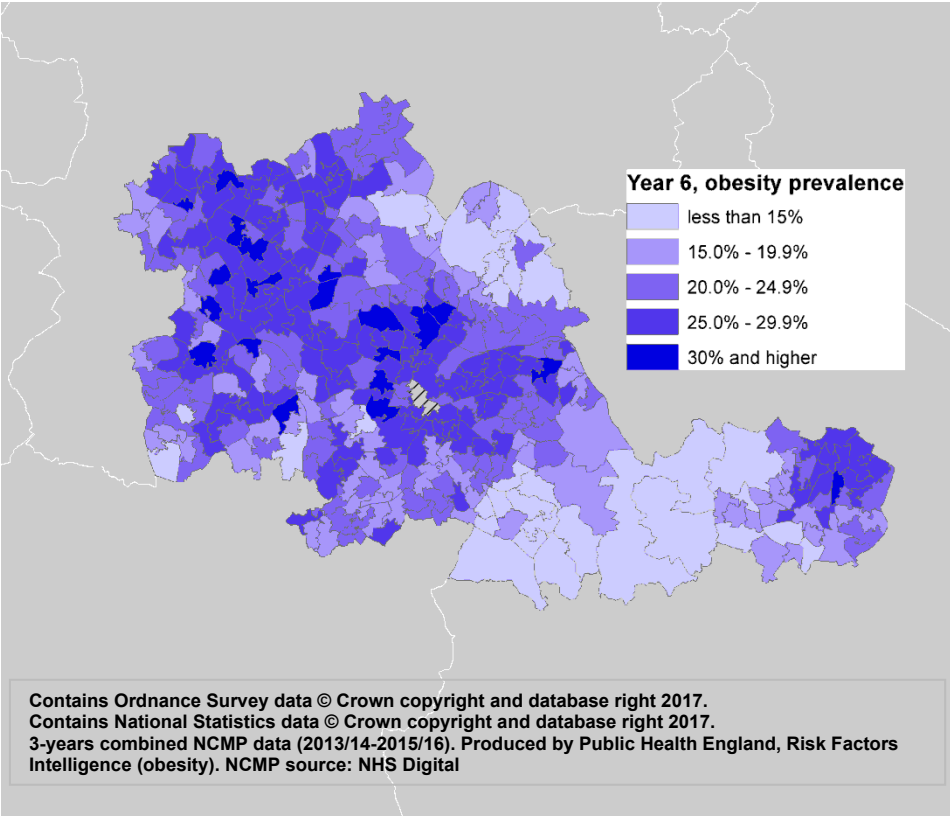
The population hub will be a centre of excellence for the West Midlands. By creating a virtual hub that works closely with the new West Midlands Office of Data Analytics, intelligence and insight for the Combined Authority area can be brought together and delivered from an easy to access centre of expertise. The hub is in development, with a long-term goal of coordinating and strengthening current sources of intelligence skills and expertise within the West Midlands area. It is currently producing outputs to support the work of the Wellbeing Board, and providing input to existing work programmes.

The Population Hub will benefit from dedicated personnel and resources, but will also co-ordinate and maximise available resources situated across the intelligence 'family' in the West Midlands. It is envisioned as an asset for the whole West Midlands area and will be a centre for producing and disseminating the most up to date information in accessible formats

[1] This would also support the thinking emerging from the developing West Midlands ODA about the questions that the ODA needs to be able to answer ('what happened'; 'why did it happen'; 'what will happen'; 'what should we do')

5 The next step is to combine and overlay other supplementary datasets onto spatial maps to add further insight and aid understanding (e.g. the work that PHE and West Midlands Police have doing to bring together police and A&E data to understand patterns and trends in violence across the West Midlands).

Prevalence of obesity in Year 6 (%) across the West Midlands Combined Authority Middle Super Output Areas (2013/14 - 2015/16)



3.5 The spatial map above illustrates the importance of how information is presented so we are also developing the use and application of infographics to bring together the intelligence and evidence in easily digestible slidesets, e.g. school readiness, mental health, children and young people, health and wealth.

4. Moving from wisdom to action – the 'why' to the 'how'!

4.1 Turning intelligence into action requires a foundation of robust information that combines data with an understanding of the local context. Across the West Midlands data and local knowledge are being used to create new ways of working and develop new approaches to solve existing problems. We already have considerable expertise in delivering this complex combination of intelligence and insight (see in Appendix 3 an example from Coventry of work on Multiple and Complex Needs). The intention is we will use the population intelligence Hub to pull together this expertise in conjunction with the WMCA Office of Data Analysis.

4.2 In support of this West Midlands Public Health Intelligence Group (WMPHIG) have been conducting a skills and knowledge audit across WMPHIG to better understand the composition and level of expertise, within the local analytical community. At the

same time, with the support of all the Directors of Public Health in the West Midlands we now have collaborative activity across the WMPHIG with a sub-group of colleagues currently undertaking analytical work at scale on behalf of others.

4.3 In order to develop our ability for the WMCA to turn insight into action we are:

- Developing centres of excellence for the West Midlands, as exemplified by the newly formed Behavioural and Social Science Working Group. This working group provides a point of contact for specialist expertise, and a means of collaboration to enhance existing work streams, e.g. embedding behavioural science techniques into the work of the Thrive Mental Health Commission action plan and developing a feasibility study for behaviour change of professionals. This group is also linked to national experts in behaviour change and we have already held a workshop that brought national and regional experts together.

- Convening specialist workshops in conjunction with national experts and sector leaders, e.g. a Data Science workshop in conjunction with the Association of Directors of Public Health in the West Midlands.

- Developing a West Midlands Virtual Health Economics team as part of the WM PHE Centre and involving health economics and economics academic colleagues. In addition Learning for Public Health West Midlands (LfPHWM) in conjunction with the West Midlands Association of Directors of Public Health (WMADPH) are holding a conference on the 18th January that is focussing on the links between Health and Wealth.

- Utilising and brokering access to specialist public health expertise and knowledge held elsewhere within PHE (e.g. behavioural insight, health economics, advanced statistical modelling, air quality (Centre for Radiation, Chemical and Environmental Hazards (CRCE)) etc.

- Learning from other PHE Local Knowledge & Intelligence Service teams across England, particularly those with combined authorities, e.g. North West LKIS – Greater Manchester, We are planning to run an internal symposium to share learning across these areas. In particular we have already been able to access work undertaken by London on children and young people within the criminal justice system.

- Exploring the potential to develop cross-sectoral, complimentary analyses and sharing of technology, applications, software, e.g. with Transport for West Midlands.

- Using embedded PH registrars to support analytical work. Currently we have PH trainees embedded with both the Thrive and Transport teams.

5. **Moving from action to impact – the 'how' to the 'impact/return on investment'**

5.1 The ultimate aim for the WMCA should be to demonstrate how actions taken have led to sustained and improved outcomes for the people of the West Midlands.

5.2 To achieve this aim, the planning and use of data and intelligence needs to be integrated into the strategic development, planning and delivery processes. This means effective intelligence and insight to support strategic change, modelling the likely impact of this change and measuring the impact as change is implemented and maintained. By accurately measuring and monitoring impact as part of delivery we enable feedback on what is working, to what extent and for whom. In addition by bringing in expertise on qualitative data of peoples experiences we can show how the work of the WMCA is shaping the experiences of its residents, and how this is impacting on their wellbeing.

5.3 At the moment the majority of the work on intelligence to assess the impact of the change we are developing and delivering has been focussed on supporting the delivery of the Thrive West Midlands agenda. This has included support on developing research protocols, embedding behaviour change into the Thrive programmes, accessing academic and national expertise to support the programme and developing evidence based proposals for interventions. However, we are now working with Transport colleagues on how we could model and assess the health, wellbeing and population impacts of the major infrastructure developments that have recently been agreed (e.g. Brierley Hill).

5.4 The work to date has only been possible due to funding and resources provided by PHE, and the resource in kind that has been provided by Local Authorities, NHSE and Universities. Going forward we are working with these stakeholders to establish more sustainable resources. This includes how elements of this agenda could be supported under the ODA, work with our academic partners to submit a bid for major programme funding for a five year period and discussion with PHE nationally about the West Midlands becoming an exemplar for the intelligence approach we are describing.

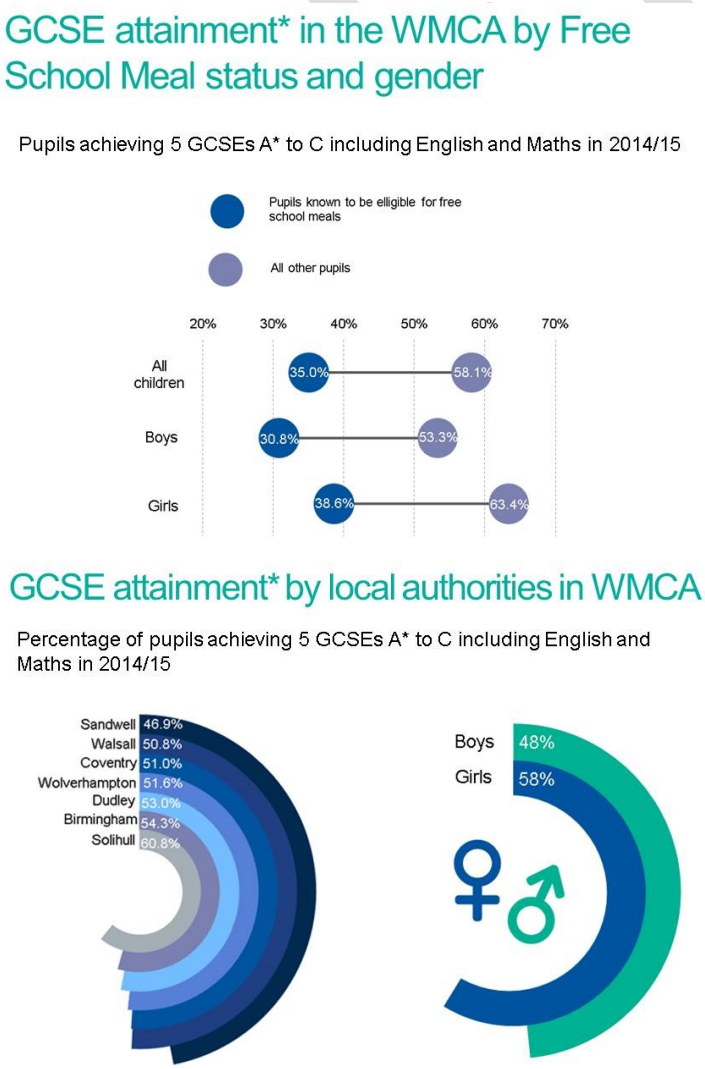
Appendix 2: **Helping to better understand the 'stories' behind headline statistics**

53% of all children in WMCA area achieved 5 GCSEs A*-C including English & Maths.

But there's a series of important 'stories' behind this number…

- How does attainment vary by geography within the WMCA area?
- Are there significant differences by gender?
- If you receive free school meals (FSM), does this have an impact?
- Do children living in more deprived areas perform more poorly?
- Does having English as a second language make a significant difference?
- Are there significant differences by ethnicity?
- If you have a Special Educational Need (SEN), how is this likely to affect your level of attainment?

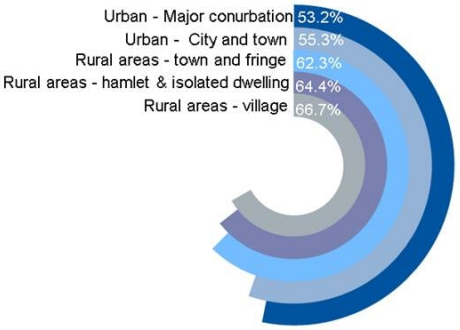
The answer to these questions can be presented visually (see below) and we have been looking at different ways to present this information to help people understand the data.



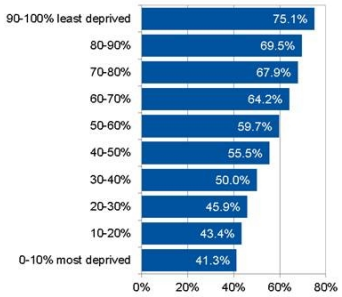
GCSE attainment in the West Midland Region by geographic classification

Pupils achieving 5 GCSEs A* to C including English and Maths in 2014/15
Based on local authority of the pupil's residence, at the end of the academic year

Rural/urban classification



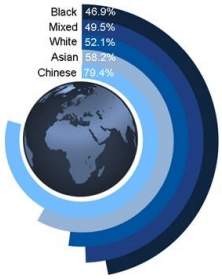
Deprivation classification



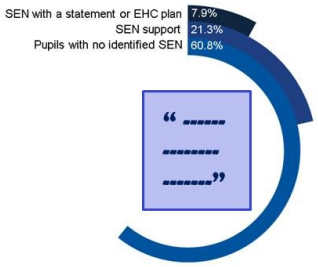
GCSE attainment* in the WMCA

Pupils achieving 5 GCSEs A* to C including English and Maths in 2014/15

Ethnicity



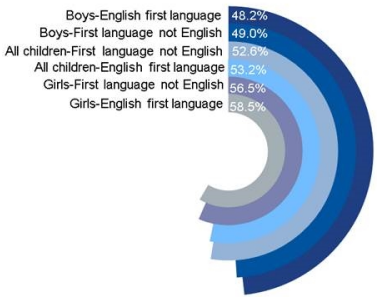
Special Educational Need (SEN) status



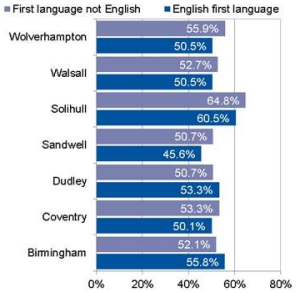
GCSE attainment* in the WMCA by pupils first language and gender

Pupils achieving 5 GCSEs A* to C including English and Maths in 2014/15

First language and sex



First language and local authority



Summary

Just over half (53%) of all children in WMCA area achieved 5 GCSE A*-C including English and Maths which is lower than England average.

- Geography - attainment among children in Solihull (60.8%) was 1.3x higher than in Sandwell (46.9%).
- Gender – Attainment among girls (58%) was 10% higher than for boys (48.4%).
- Free school meals (FSM) - Pupils not in receipt of FSM were 1.7X more likely to achieve 5 A*-C including E&M compared to pupils eligible for FSM.
- Deprivation – Pupils living in the most affluent areas of WMCA were 1.8x more likely to achieve 5 A* to C's including E&M compared to those living in the least affluent areas.
- English as second language – With the exception of Birmingham and Dudley pupils with English as a second language, in all other LA's in WMCA, were more likely to achieve 5 A*-C including E&M at GCSE.
- Ethnicity – Pupils from Chinese and Asian backgrounds had higher levels of attainment whilst Black and Mixed race pupils lower.
- SEN – Pupils with SEN support status were 3 x less likely to achieve 5 A*-C including E&M and pupils with an Education Healthcare Plan 7.7x less likely.

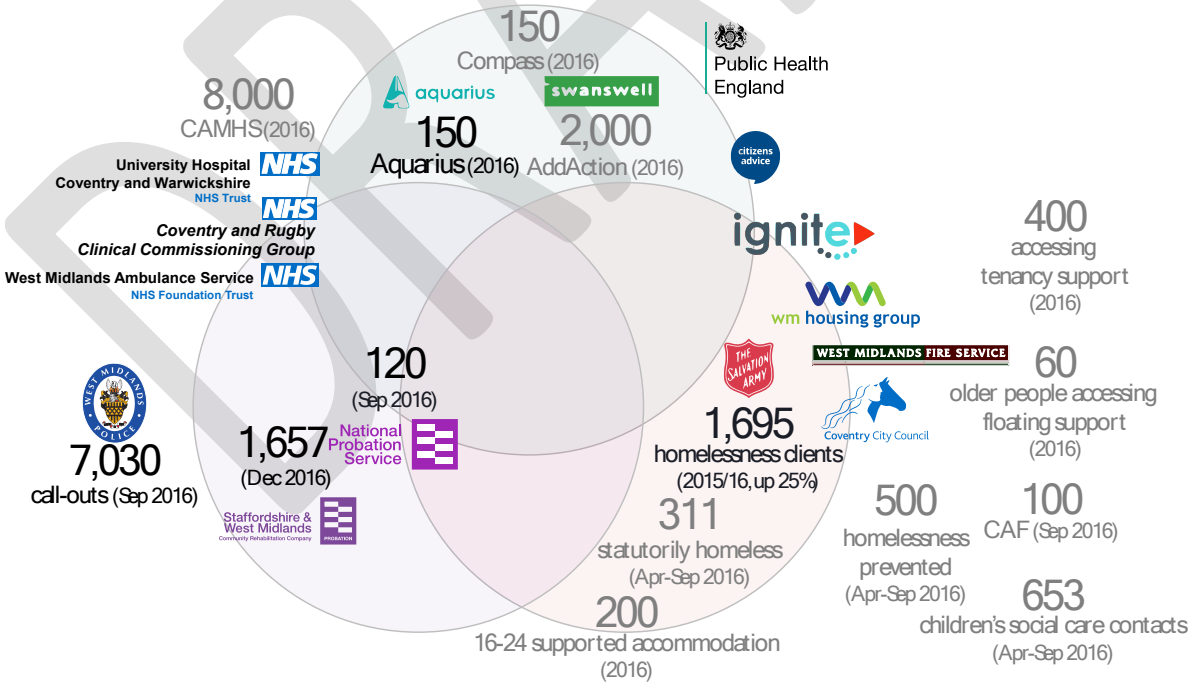
Appendix 2: Using intelligence to inform the work of the Multiple and Complex Needs (MCN) Board in Coventry.

Individuals facing multiple complex needs (MCN) are people who experience several problems at the same time, often face ineffective contact with services, and live chaotic lives. This can be a combination of offending behaviour/violence, homelessness, substance misuse, mental ill-health, or adverse childhood experiences.

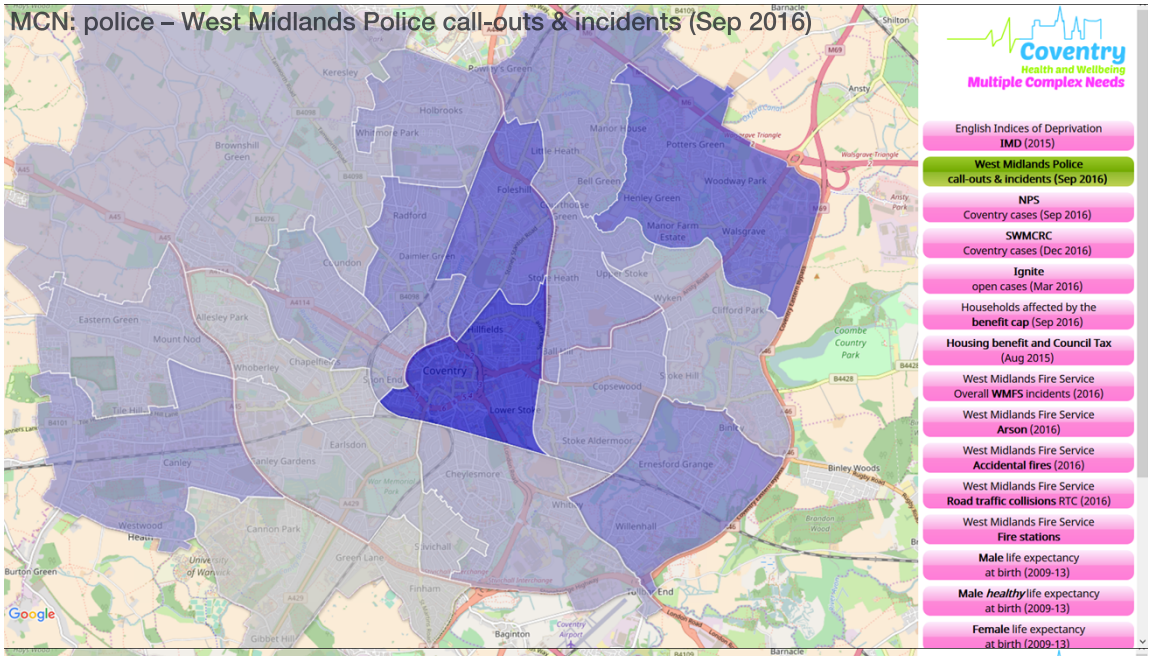
Outcomes for people facing MCN are poor, despite the disproportionate time and resources spent on this group of people across different services such as social care, housing and homelessness, police, fire, NHS, criminal justice, probation and substance misuse services. To services, they are a significant source of repeat demand for public services and are amongst the 'hardest to help'.

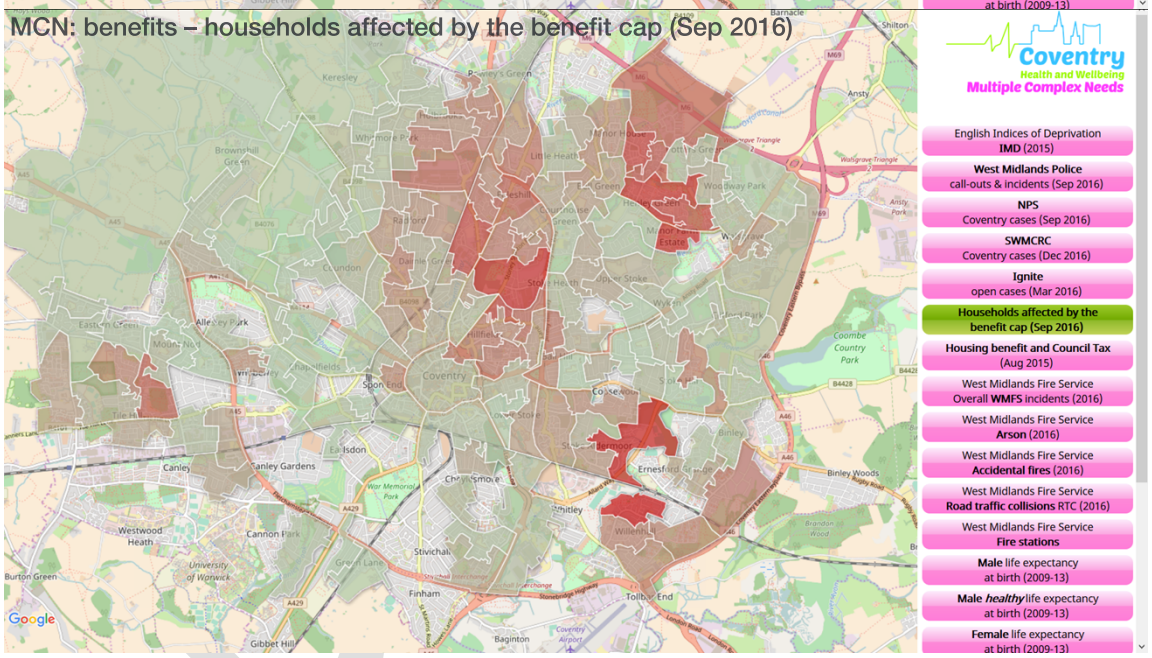
In Coventry, this partnership of over twenty different agencies, including representation from the WMCA, is using intelligence to deliver action to address a local issue of high priority. Their work is informed by local and national data, alongside evidence and insight obtained from evaluating what works.

Local data held by public service agencies has been aggregated and anonymised to give estimates of need across Coventry, and build a better understanding of groups who may be at risk of experiencing multiple and complex needs. An output of this work is shown below.



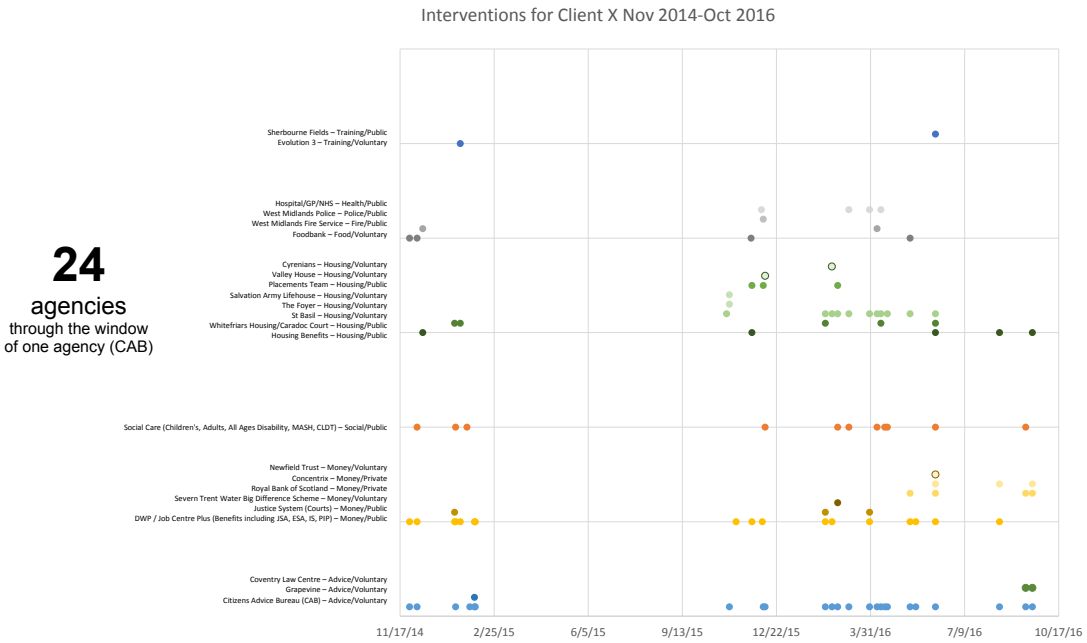
Representing this information geo-spatially made local levels of need and the demand for services more visible.





Mapping data held by different public agencies such as the police, fire service and probation services allowed the Coventry Multiple Complex Needs Board to see, for the first time, correlations and patterns in the need and demand for services.

Epidemiological data was enhanced by focusing on individual patient journeys to provide insights into the types of actions that partners could take to alleviate some of the problems faced by this target group.



These insights pointed to combined and integrated efforts for key sub-populations within Coventry. A multi-agency one-stop shop called '*Steps for Change*' has been adopted by the MCN board as an innovative approach to meeting the needs of some of the most vulnerable people in Coventry. This pilot initiative was located in an area likely to be noticed by potential beneficiaries and brings together key agencies in one location to deliver advice and support in an informal setting. It was designed to remove some of the barriers to seeking appropriate help, whilst at the same time providing opportunities for improved data capture and cross-agency working. The Board have also used these insights to re-organise existing activities and trail new ways of working to better suit those they serve. An example of this is the joining-up of existing case management forums by the board; to provide multi-agency input to people at a crucial point in their journey.

Authors

Dr Jane Moore - WMCA
Dr Stella Botchway - PHE/Coventry City Council
Gareth Wrench - PHE

This page is intentionally left blank

WMCA Wellbeing Board Dashboard

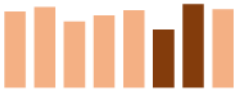
NB: data flagged with * are population weighted calculations

All data from Public Health Outcomes Framework

Key:

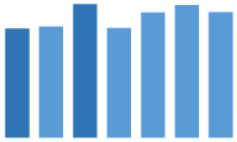
- Not compared with benchmark
- Significantly better than benchmark
- Similar to benchmark
- Significantly worse than benchmark

Overarching Indicators

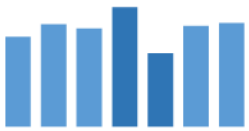
Indicator	Latest WMCA data	Compared with benchmark	Previous period	Variation (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall, Wolverhampton)	Recent trends
Healthy life expectancy at birth (Male)	59.7		59.3		
Healthy life expectancy at birth (Female)	60.3		60.9		
Gap between Life Expectancy and Healthy Life Expectancy – the 'Window of Need' (Male)	18.4		18.4		
Gap between Life Expectancy and Healthy Life Expectancy – the 'Window of Need' (Female)	21.8		21.8		

Indicator	Latest WMCA data	Compared with benchmark	Previous period	Variation (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall, Wolverhampton)
People with a low satisfaction score (%)*	5.4	Confidence intervals can't be calculated	5.3	
People with a low happiness score(%)*	8.7	Confidence intervals can't be calculated	8.7	
Disability free life expectancy (Males)	60.1		n/a	
Disability free life expectancy (Females)	59.2		n/a	

Mental Health

Indicator	Latest WMCA data	Compared with benchmark	Previous period	Variation (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall, Wolverhampton)	Recent trends
Gap in the employment rate (mental health services and overall employment rate)%	58.6		59.7		
Adults in contact with secondary mental health services who live in stable appropriate accomodation* (%)	74%	Confidence intervals can't be calculated	72%		

CVD/Diabetes Prevention

Indicator	Latest WMCA data	Compared with benchmark	Previous period	Variation (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall, Wolverhampton)
Percentage of adults classed as overweight (%)	64.5		n/a	
Smoking prevalence in adults - current smokers (APS) (%)	15.4		16.6	

This page is intentionally left blank

Healthy Life Expectancy at Birth						Trend	Compared with benchmark
Males							
Year	**2009 - 11**	**2010 - 12**	**2011 - 13**	**2012 - 14**	**2013 - 15**		
CA	59.8	59.6	59.9	59.4	59.3		
Birmingham	58.7	58.1	58.4	57.8	58.4		
Coventry	60.7	61.1	62.3	61.3	62.9		
Dudley	62.1	62.5	62.1	62.5	60.7		
Sandwell	57.7	58.3	59.4	59.0	57.7		
Solihull	65.9	65.0	65.3	63.4	63.8		
Walsall	59.0	59.6	59.8	59.1	58.1		
Wolverhampton	59.3	58.1	56.6	57.2	56.4		
Females							
Year	**2009 - 11**	**2010 - 12**	**2011 - 13**	**2012 - 14**	**2013 - 15**		
CA	60.6	60.9	61.2	60.5	60.9		
Birmingham	59.3	59.2	60.6	58.7	59.4		
Coventry	62.7	63.4	63.1	63.4	63.8		
Dudley	63.4	65.1	63.5	63.0	62.7		
Sandwell	57.6	58.2	58.1	57.8	59.7		
Solihull	66.6	66.2	65.8	67.6	67.9		
Walsall	61.3	61.4	60.3	60.4	59.0		
Wolverhampton	58.3	57.9	59.1	58.4	59.5		

Gap between Life Expectancy and Healthy Life Expectancy – the 'Window of Need'						Trend	Compared with benchmark
Males							
Year	**2009 - 11**	**2010 - 12**	**2011 - 13**	**2012 - 14**	**2013 - 15**		
CA	17.7	18.2	18.0	18.5	18.4		
Birmingham	18.5	19.4	19.0	19.4	18.7		
Coventry	16.8	16.8	15.8	17.2	15.5		
Dudley	16.5	16.3	17.0	16.6	18.2		
Sandwell	18.5	18.4	17.5	18.0	19.4		
Solihull	14.9	15.5	14.8	16.8	16.6		
Walsall	18.2	18.2	18.2	18.8	19.2		
Wolverhampton	17.9	19.1	20.8	20.3	20.9		
Females							
Year	**2009 - 11**	**2010 - 12**	**2011 - 13**	**2012 - 14**	**2013 - 15**		
CA	21.4	21.2	21.1	21.8	21.2		
Birmingham	22.5	22.7	21.4	23.3	22.5		
Coventry	19.0	18.6	19.2	18.8	18.5		
Dudley	19.2	17.7	19.5	20.1	20.2		
Sandwell	23.7	22.9	23.2	23.5	21.7		
Solihull	17.6	18.0	18.6	16.6	16.2		
Walsall	20.8	20.7	22.3	21.9	23.4		
Wolverhampton	23.1	23.6	22.8	23.3	21.9		

People with a low satisfaction score						Trend	Compared with benchmark
Year	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**		
CA	10.3	6.1	6.5	5.3	5.4		
Birmingham	13.5	7.4	7.8	4.1	5.5		
Coventry	7.5	4.4	4.8	5.3	5.0		
Dudley	8.0	4.1	4.4	6.0	4.9		
Sandwell	9.3	6.7	5.9	7.0	4.6		
Solihull	6.5	4.9	5.7	5.0	4.4		
Walsall	8.2	5.1	5.8	4.9	5.3		
Wolverhampton	10.0	7.0	8.1	8.5	7.6		

People with a low happiness score						Trend	Compared with benchmark
Year	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**		
CA	13.4	11.0	10.0	8.7	8.7		
Birmingham	16.2	12.8	11.7	7.3	9.5		
Coventry	10.4	7.7	6.5	7.7	6.7		
Dudley	12.1	9.0	11.1	8.5	9.1		
Sandwell	12.4	14.0	10.9	13.2	9.2		
Solihull	10.7	8.9	8.5	7.0	6.9		
Walsall	11.8	10.9	8.6	9.8	8.0		
Wolverhampton	12.5	8.6	7.5	11.0	10.0		

DFLE (males)		Trend	Compared with benchmark
Year	**2014-16**		
CA	60.1		
Birmingham	60.3		
Coventry	60.7		
Dudley	60.2		
Sandwell	58.7		
Solihull	64.0		
Walsall	60.0		
Wolverhampton	56.9		

DFLE (males)		Trend	Compared with benchmark
Year	**2014-16**		
CA	59.2		
Birmingham	57.5		
Coventry	61.7		
Dudley	60.9		
Sandwell	60.0		
Solihull	62.8		
Walsall	59.3		
Wolverhampton	58.6		

This page is intentionally left blank

Public Health England

Mental Health

Key:

- Not compared with benchmark
- Similar to benchmark
- Significantly better than benchmark
- Significantly worse than benchmark

Gap in employment rate						Trend	*Compared with benchmark*
Year	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**		
CA	55.3	57.6	59.3	59.7	58.6		
Birmingham	49.6	54.1	55.1	56.6	55.1		
Coventry	56.2	53.0	56.8	54.3	53.6		
Dudley	65.6	69.0	66.3	66.6	63.7		
Sandwell	57.8	58.5	60.2	56.8	61.5		
Solihull	61.7	62.5	62.0	63.6	63.1		
Walsall	55.5	57.4	56.4	60.5	59.5		
Wolverhampton	56.7	57.1	58.8	57.9	57.5		

Adults in stable and appropriate accomodation						
Year	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	
CA	39.8	47.6	68.2	71.8	74.4	
Birmingham	15.1	32.2	66.5	63.8	69.4	
Coventry	58.8	71.1	78.0	74.6	70.6	
Dudley	48.3	30.0	54.6	81.2	84.9	
Sandwell	59.0	60.5	70.5	72.3	69.7	
Solihull	19.5	65.3	79.6	77.9	79.6	
Walsall	63.0	41.4	56.5	77.8	84.2	
Wolverhampton	77.9	79.1	79.0	79.7	79.7	

Emergency admissions for intentional self harm						
Year	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	
CA	211.4	197.2	207.5	200.3	213.7	
Birmingham	214.4	198.2	193.3	174.5	198.2	
Coventry	317.7	297.9	284.9	264.2	253.4	
Dudley	220.6	177.8	181.2	212.6	230.7	
Sandwell	232.0	215.1	235.1	206.9	241.9	
Solihull	141.0	142.7	198.6	193.9	175.1	
Walsall	167.3	171.0	195.9	186.1	175.5	
Wolverhampton	141.0	142.6	198.6	250.9	268.7	

Suicide rate						
Year	**2010 - 12**	**2011 - 13**	**2012 - 14**	**2013 - 15**	**2014 - 16**	
CA	7.6	7.7	9.5	10.1	9.8	
Birmingham	6.7	7.1	10.3	10.3	10.0	
Coventry	11.4	11.2	10.1	10.0	8.3	
Dudley	7.5	6.4	7.5	9.8	9.5	
Sandwell	8.2	8.3	8.6	10.2	10.8	
Solihull	5.5	5.0	8.2	9.2	10.0	
Walsall	6.5	7.3	9.6	10.5	10.3	
Wolverhampton	8.6	9.5	9.8	10.2	10.1	

This page is intentionally left blank

Public Health England

CVD/Diabetes

Key: Not compared with benchmark; Similar to benchmark; Significantly better than benchmark; Significantly worse than benchmark

Excess weight in adults		Trend	*Compared with benchmark*
Year	**2015/16**		
CA	64.5		
Birmingham	62.0		
Coventry	64.0		
Dudley	66.5		
Sandwell	69.4		
Solihull	62.5		
Walsall	64.4		
Wolverhampton	68.0		

Smoking prevalence in adults - current smokers (APS)						
Year	**2012**	**2013**	**2014**	**2015**	**2016**	
CA	18.3	19.4	17.9	16.6	15.4	
Birmingham	16.9	19.0	17.9	15.9	14.3	
Coventry	17.1	18.8	15.8	16.6	16.3	
Dudley	16.8	20.2	18.4	18.5	15.6	
Sandwell	22.9	22.6	20.4	17.7	19.0	
Solihull	12.9	13.7	12.2	11.6	11.7	
Walsall	21.5	19.5	19.1	17.6	16.0	
Wolverhampton	22.9	21.6	20.9	19.3	16.5	

Cumulative % of eligible pop (40-74) NHS health check	
Year	**2013/14 - 16/17**
CA	44.6
Birmingham	48.8
Coventry	48.4
Dudley	40.5
Sandwell	34.9
Solihull	43.0
Walsall	74.5
Wolverhampton	22.2

Recorded diabetes					
Year	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
CA	6.6	6.9	7.3	7.7	7.9
Birmingham	6.8	7.1	7.6	8.1	8.3
Coventry	5.6	5.7	6.0	6.2	6.5
Dudley	5.9	6.2	6.5	6.8	7.0
Sandwell	7.1	7.4	7.8	8.3	8.6
Solihull	5.6	5.8	6.2	6.8	6.9
Walsall	7.7	8.0	8.2	8.6	8.7
Wolverhampton	7.1	7.4	7.7	7.9	8.1

Under 75 mortality rate from cardiovascular disease					
Year	**2010 - 12**	**2011 - 13**	**2012 - 14**	**2013 - 15**	**2014 - 16**
CA	94.1	92.2	90.3	91.2	90.3
Birmingham	101.2	100.5	99.4	99.2	96.6
Coventry	89.2	88.5	88.7	87.9	88.5
Dudley	79.9	78.4	73.6	72.9	72.7
Sandwell	108.0	104.9	102.0	106.9	101.7
Solihull	66.2	63.1	61.6	60.4	62.2
Walsall	94.3	94.7	91.8	95.4	94.1
Wolverhampton	105.2	97.9	97.4	100.8	106.5

75 mortality rate from cardiovascular disease considered preve					
Year	**2010 - 12**	**2011 - 13**	**2012 - 14**	**2013 - 15**	**2014 - 16**
CA	63.4	61.7	60.0	60.2	58.5
Birmingham	70.6	69.3	67.7	66.7	63.0
Coventry	58.8	58.2	58.6	57.1	57.8
Dudley	54.1	51.9	47.7	47.9	47.4
Sandwell	72.4	69.8	68.8	71.0	68.6
Solihull	42.8	40.9	39.6	37.7	39.2
Walsall	64.0	63.0	61.2	64.3	59.1
Wolverhampton	66.7	62.9	61.6	64.2	65.4

Percentage of physically inactive adults - current method	
Year	**2015/16**
CA	26.2
Birmingham	26.7
Coventry	23.9
Dudley	27.3
Sandwell	28.3
Solihull	20.7
Walsall	25.9
Wolverhampton	27.9

This page is intentionally left blank

Children and Young People

Key: Not compared with benchmark; Similar to benchmark; Significantly better than benchmark; Significantly worse than benchmark

Infant Mortality

Year	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	Trend	Compared with benchmark
Combined Authority	6.5	6.5	6.2	6.2	6.6		
Birmingham	7.2	7.5	7.2	7.5	7.9		
Coventry	4.8	4.8	4.1	4.0	4.6		
Dudley	4.5	3.6	3.9	4.6	5.5		
Sandwell	7.1	7.1	6.7	5.5	5.8		
Solihull	3.6	4.8	4.9	4.7	4.5		
Walsall	7.6	7.1	6.8	6.8	7.1		
Wolverhampton	7.7	6.8	6.4	5.6	5.6		

Children in low income families (under 16s)

Year	2010	2011	2012	2013	2014	Trend
Combined Authority	29.7	28.9	27.1	26.6	29.2	
Birmingham	33.5	32.2	29.9	29.2	32.9	
Coventry	27.0	25.9	23.9	23.5	25.4	
Dudley	23.1	22.8	21.7	21.3	23.1	
Sandwell	30.6	29.9	28.3	27.6	29.6	
Solihull	16.7	16.7	16.0	15.7	16.9	
Walsall	29.5	29.2	27.9	27.2	29.9	
Wolverhampton	32.0	31.5	30.2	29.7	31.0	

Looked after children: rate per 10,000 (under 18 population)

Year	2012/13	2013/14	2014/15	2015/16	Trend
Combined Authority	82.2	82.6	83.3	78.3	
Birmingham	69.0	64.3	70.5	63.9	
Coventry	87.0	86.1	79.6	77.2	
Dudley	108.0	111.6	109.0	106.6	
Sandwell	80.0	74.8	69.5	66.7	
Solihull	72.0	71.8	73.7	79.0	
Walsall	91.0	97.8	93.7	95.2	
Wolverhampton	118.0	135.4	135.3	112.6	

16-18 year olds not in education employment or training

Year	2011	2012	2013	2014	2015	Trend
Combined Authority	6.7	6.7	6.3	5.9	4.4	
Birmingham	6.9	7.5	6.6	7.2	5.2	
Coventry	6.0	5.2	7.4	6.8	4.7	
Dudley	5.3	6.6	5.9	5.7	3.8	
Sandwell	6.6	6.3	5.9	3.7	3.4	
Solihull	6.7	6.0	5.5	4.9	4.2	
Walsall	7.4	6.4	5.8	4.6	3.7	
Wolverhampton	7.6	6.8	6.0	4.1	3.4	

Hospital admissions: injuries in children (aged 0-14 years)

Year	2011/12	2012/13	2013/14	2014/15	2015/16	Trend
Combined Authority	118.2	105.6	115.7	111.5	111.7	
Birmingham	123.6	100.3	102.2	102.7	104.9	
Coventry	143.7	173.0	174.5	149.9	173.2	
Dudley	111.6	94.9	108.0	112.4	105.6	
Sandwell	130.7	115.4	143.0	129.9	121.3	
Solihull	103.2	73.1	94.5	97.5	97.8	
Walsall	82.7	83.0	90.4	93.2	85.9	
Wolverhampton	102.4	95.5	122.3	110.2	97.6	

School readiness: percentage achieving good level by end of receptio

Year	2011/12	2012/13	2013/14	2014/15	2015/16	Trend
Combined Authority		49.6	56.6	61.8	64.2	
Birmingham		49.6	56.4	61.9	63.7	
Coventry		55.4	59.6	63.9	65.4	
Dudley		51.1	57.2	60.6	64.4	
Sandwell		45.6	53.9	57.7	60.5	
Solihull		56.0	61.4	68.4	71.8	
Walsall		46.3	53.3	60.8	64.8	
Wolverhampton		44.2	56.5	60.9	62.4	

Reception: prevalence of obesity

Year	2011/12	2012/13	2013/14	2014/15	2015/16	Trend
Combined Authority	11.4	10.7	11.2	11.0	11.1	
Birmingham	11.9	11.2	11.2	11.2	11.4	
Coventry	11.2	8.7	11.3	9.9	9.4	
Dudley	11.2	10.1	11.6	12.0	11.9	
Sandwell	11.2	10.9	11.2	11.1	11.9	
Solihull	7.2	7.8	9.0	7.5	7.8	
Walsall	11.3	11.5	11.0	11.6	11.3	
Wolverhampton	13.1	12.7	12.6	12.3	12.3	

GCSE achieved 5A*-C, with free school meal status

Year	2012/13	2013/14	2014/15	Trend
Combined Authority	42.5	36.6	35.0	
Birmingham	47.3	41.9	39.7	
Coventry	35.8	33.4	31.5	
Dudley	31.6	28.7	28.6	
Sandwell	37.5	33.1	30.4	
Solihull	41.1	30.4	34.8	
Walsall	34.5	29.0	28.1	
Wolverhampton	43.9	28.5	28.4	

Secondary school fixed period exclusions: % of school pupils

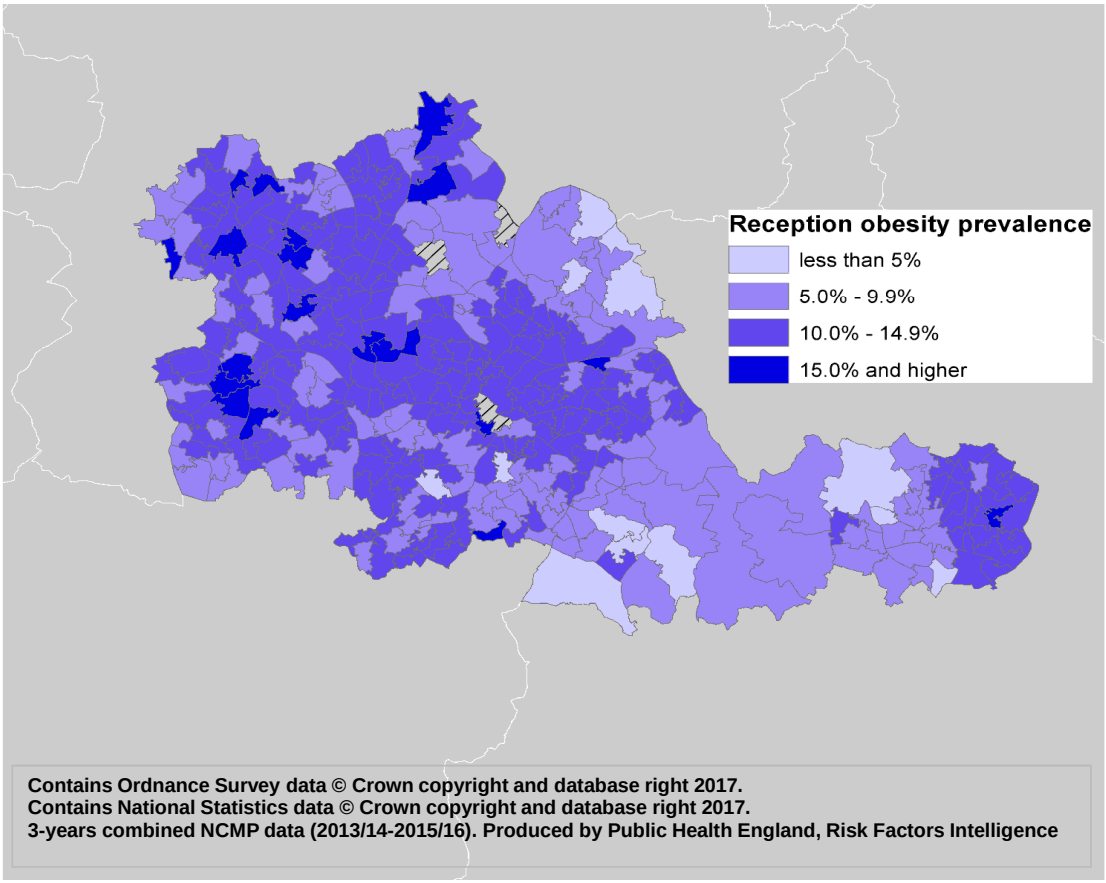
Year	2012/13	2013/14	2014/15	Trend
Combined Authority	7.4	6.8	8.2	
Birmingham	7.4	6.3	7.5	
Coventry	6.4	5.7	5.9	
Dudley	8.9	8.7	9.5	
Sandwell	7.2	7.1	11.8	
Solihull	9.2	9.2	11.1	
Walsall	8.4	6.2	7.0	
Wolverhampton	4.4	5.5	5.9	

First time entrants to the youth justice system

Year	2012	2013	2014	2015	2016	Trend
Combined Authority	506.4	494.6	439.8	454.1	442.6	
Birmingham	582.7	583.4	480.3	498.6	564.2	
Coventry	460.2	332.5	302.9	374.7	449.3	
Dudley	410.5	384.7	459.9	385.7	283.3	
Sandwell	434.5	457.7	466.7	425.3	357.5	
Solihull	348.7	357.2	268.6	391.5	204.7	
Walsall	520.7	521.4	421.3	371.3	273.4	
Wolverhampton	531.7	535.7	519.6	606.0	545.4	

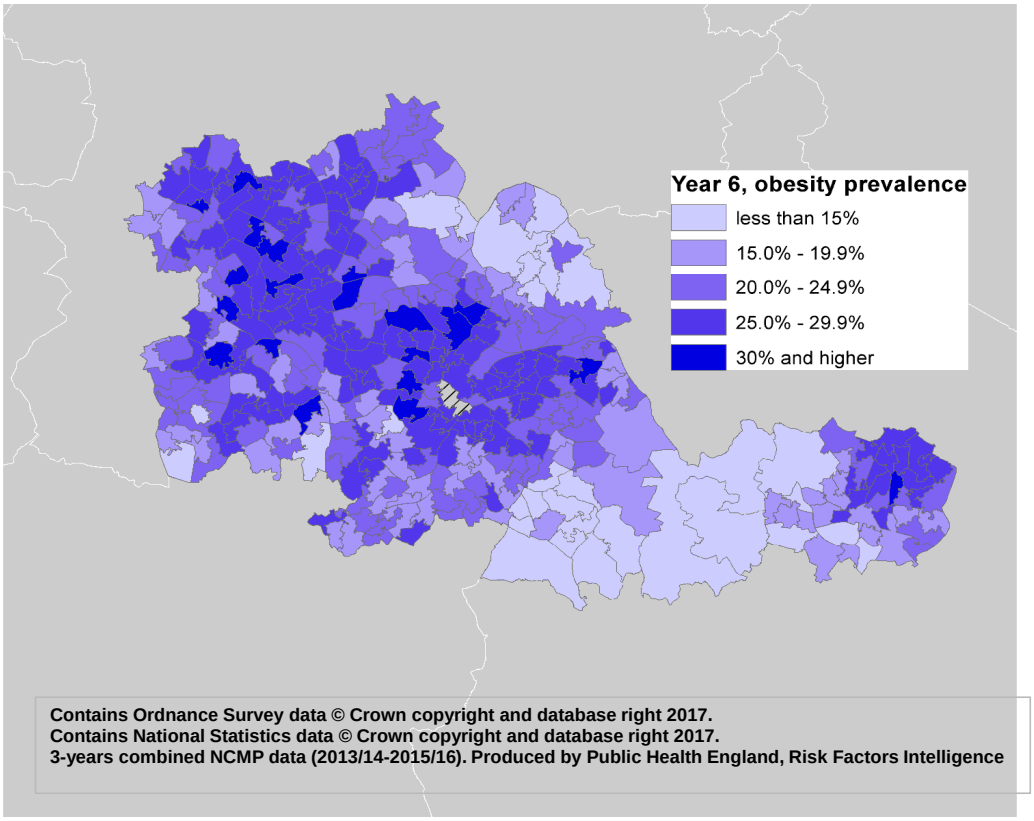
This page is intentionally left blank

Prevalence of obesity in reception (%) across the West Midlands Combined Authority Middle Super Output Areas (2013/14 - 2015/16)



This page is intentionally left blank

Prevalence of obesity in Year 6 (%) across the West Midlands Combined Authority Middle Super Output Areas (2013/14 - 2015/16)



This page is intentionally left blank

Wellbeing board

Date	19 January 2018
Report title	Transport and health strategy
Cabinet Member Portfolio Lead	Councillor Roger Lawrence – Transport
Accountable Chief Executive	Laura Shoaf, TfWM, Managing Director Email: Laura.Shoaf@tfwm.org.uk Tel: 0121 214 7444
Accountable Employee	Duncan Vernon, TfWM, Strategic Health Advisor Email: Duncan.Vernon@tfwm.org.uk Tel: 0121 214 7230
Report to be considered by	Wellbeing Board and STOG

Recommendation(s) for action or decision:

STOG is recommended to:

1. Agree the actions and text of the Health and Transport Strategy.
2. Endorse that the WMCA uses the principles set out in the actions within decision making processes.
3. Endorse the opportunities identified to take forward the four actions and enhance the positive health and wellbeing impact that transport schemes can have.

1.0 Purpose

To update the wellbeing board on the development of the health and transport strategy and how the actions will be taken forward.

2.0 Background

2.1 Following the secondment of Duncan Vernon from Public Health England to TfWM, The Senior Transport Officer's Group (STOG) agreed the proposal to produce a Health and Transport Strategy.

2.2 The aim of the strategy was to set out how to best deliver on the health objectives in Movement for Growth.

2.3 An outline draft of the strategy was presented to the Wellbeing Board in October 2017 for discussion and comments. This has informed the development and priorities of the strategy. A consultation was conducted with professionals working in public health and transport backgrounds in November 2017 to produce the final draft strategy.

2.4 The completed Transport and Health Strategy has been submitted to STOG to approve the actions and text on the 15th January.

3.0 Actions emerging from the strategy

3.8 The full draft of the Health and Transport strategy is included as Appendix A. It sets out the evidence showing how transport can improve public health through its relationship with air quality, physical activity, traffic injury, noise, climate change and mental health.

3.9 The strategy identifies that the health and wellbeing impact of transport schemes can be maximised by considering all of these relationships when planning or delivering schemes, and by addressing the needs of groups who are more likely to be affected by them.

3.9 Four main actions were identified to enable this. These are summarised below:

- ACTION ONE: We will use data on population health to help prioritise and target interventions. This can help to make the strategic case for transport schemes that will increase health and wellbeing. In order to do this we will produce health and transport profiles for each local authority in the WMCA using the public health outcomes framework and create an interactive dashboard of health data in smaller areas. We will refer to local authority Joint Strategic Needs Assessments that identify local health priorities.

- ACTION TWO: Through our Equality Impact Assessment process we will assess the equity of health impacts. We will incorporate questions that identify health inequalities and propose how they can be addressed through transport schemes.

- ACTION THREE: We will understand the social impact of transport schemes. We will do this by calculating the financial value on improved health and reduced sickness absence to improve the economic case for schemes that improve health. Some schemes might benefit from a health impact assessment and to systematically understand how to increase the health benefits or reduce negative impacts and we will identify opportunities to conduct these,

- ACTION FOUR: We will set out an evidence based statement of what makes a healthy and active street and trial the approach. The built environment can have a cross-cutting impact on health but often the evidence hasn't been drawn together in a way that will

show that. The West Midlands Cycle Design Guidance also sets out how high-quality standards for cycling can be introduced and equivalent guidance to support healthy outcomes from transport environments will place this in context.

4.0 Action One: Making use on health and wellbeing data in transport scheme development and delivery.

4.1 Data on population health and wellbeing can be used to help prioritise and target interventions. This is available for local authorities and published in the Public Health Outcomes Framework. The Public Health Outcomes Framework is a set of indicators that align with government priorities and measure health outcomes, or factors closely correlated to health outcomes.

4.2 Data for all of the indicators identified is available at Local Authority level. As the data is collected across England, statistical neighbours can be identified for each local authority and appropriate benchmarking can be carried out.

4.3 To make best use of health and wellbeing data for smaller areas within local authorities. TfWM are developing a health and transport data tool. This will show the health of people around transport corridors in the Movement for Growth 10 year delivery plan.

4.4 This data can be used to plan and help prioritise transport schemes that improve health and wellbeing. Joint working between public health and transport professionals within WMCA and local authorities can use this data to enhance the impact that transport schemes will have on health and wellbeing.

5.0 Action Two: Including health and wellbeing in equality impact assessments of schemes.

5.1 The strategy has helped to bring together the evidence about the impact of transport schemes on the health and wellbeing of people with protected characteristics, as well as people who live in areas of deprivation.

5.2 The PHE Health Equity Assessment Tool has been used to develop the questions around health that are used within the WMCA Equality Impact Assessment process, so that health and wellbeing is considered as a specific issue.

5.3 Sharing of assessments, good practice, and data and evidence about the use of this tool between PHE and WMCA will help to develop this process.

6.0 Action Three: Understanding the social impact of transport schemes.

6.1 There are several tools that can be used to place a financial value on improvements in health that are approved for use by the Department for Transport in formal business cases. Whilst these have been more commonly used for cycling and walking schemes, the health benefits from walking to public transport can also be estimated.

i. The World Health Organisation have produced a tool that will estimate the social value on preventing deaths by increasing physical activity.
ii. Sickness Absence Reduction Tool (SART) estimates the lost productivity from sickness absence that can be avoided.

6.2 By using health evidence and working with transport planners in TfWM, methodologies have been developed to apply these tools to proposed walking and cycling schemes, and public transport schemes in the 10 year delivery plan. This has been applied to series of case studies such as proposed train station openings, the SPRINT bus network, and the West Midlands cycle network.

6.3 Other tools have been developed that are not approved by the DfT for use in business cases. These include Sport England's MOVES tool that estimate NHS costs saved from increased physical activity, and a forthcoming PHE tool to estimate the health and social care costs saved by reducing exposure to air pollution.

6.4 The Sport England MOVES tool was used to calculate the potential NHS cost savings in the West Midlands if every adult cycled once a week. This would meet the cycling charter target to reach 5% of trips by bike. There would be a predicted £1billion NHS saving over 25 years from this amount of cycling.

6.5 There is the potential in future to share data and intelligence that allows the calculation of these costs.

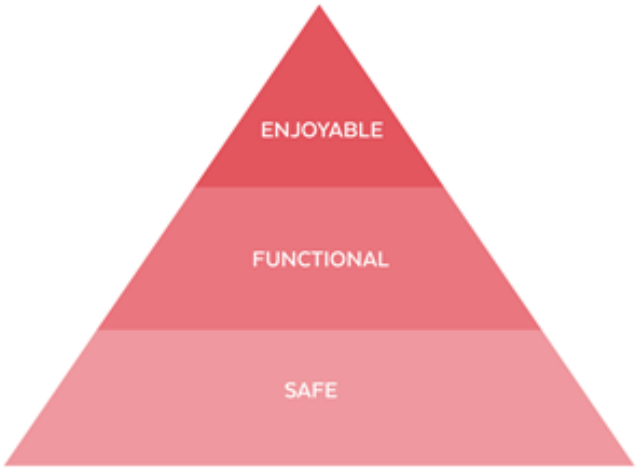
6.6 The strategy sets out the role that health impact assessments play in understanding the health and wellbeing impact from transport schemes. There is the opportunity for TfWM to | work with public health professionals to conduct health impact assessments. The evidence in the strategy and data tool will support the conduct of future assessments.

7.0 Action Four: Understanding what makes a healthy and active street, and trial the approach

7.1 The design of streets to encourage and support healthy behaviours is one of the ways that transport can have the greatest impact on health. This is because of the large number of people who might benefit from interventions over a long period of time. There is now a large and growing evidence base that sets out what street characteristics encourage walking. This has a wider impact on mental health, as greater amounts of walking for transport improve the sense of community and community cohesion.

7.2 A large evidence review on how to increase the walkability of streets was conducted and included as Appendix B. This identifies people's enjoyment of the environment, the functional ability of the street, and the safety and perceived safety as important concepts. More specific characteristics have been identified in the review.

7.3 The concept can be trialled by identifying a series of locations where there is the opportunity to increase walking, implementing several of the characteristics, and evaluating the impact that this has on health and travel.



Walking and cycling is a pleasure	The street carries people efficiently and wayfinding is clear	The air is safe to breath and the noise does not interrupt daily life
The design of the street promotes wellbeing	People of all abilities are able to use and cross the street	Traffic speeds are set to not cause fatal injuries in a collision
People living there know each other and there is opportunity to socialise	The street is well connected to places people want to go	The street is designed to protect the most vulnerable from harm

Characteristics of a healthy and active street identified in the evidence review

8.0 Financial implications

8.1 No financial implications envisaged in relation to this report.

9.0 Legal implications

9.1 No legal implications envisaged in relation to this report.

10.0 Equalities implications

10.1 One result of the strategy was to embed questions about health into the Equality Impact Assessment process used within the WMCA, and identifying published research that showed how the health of groups with protected characteristics might be effected by transport.

This page is intentionally left blank

Movement for Growth:
Health and Transport Strategy
Draft 04/01/2017

Executive summary

Everyone travels or lives on streets. Where they are well designed with health and wellbeing goals in mind, they can be at the heart of cohesive and supportive communities. They can encourage physical activity by making it easier to walk and cycle, and have wider impacts on everyone's health by reducing air pollution and increasing the feeling of safety.

Streets that make the west midlands healthier and happier will also make it more economically active. Transport can play a large part in increasing productivity and reducing the demand for public services by preventing ill health and improving the wellbeing of people at work.

Life expectancies in the West Midlands have increased, even since 2001, and in some areas men are expected to live to 80.4 years old and women 84.2 years old. However, recent years have seen a slow-down in the rate that they are increasing, and life expectancy in some parts of the West Midlands may even be decreasing.

Healthy life expectancies are lower. The lowest male healthy life expectancy is in Wolverhampton where men are expected to live 56.4 years in good health. Similarly, in Walsall women are expected to live 59 years in good health.

There are also inequalities in health. Some of the more deprived areas within the West Midlands have even lower healthy life expectancies and people might only expect to life for 50 years in good health. This is a barrier to inclusive economic growth in the West Midlands.

Transport investment to improve health has a large impact. The number of people who might benefit from interventions can be large. Transport can improve health by several different ways, and where schemes are designed to address many of these the benefits can be maximised.

Cleaner air

Emissions of many pollutants has been falling since the 1970s, although the trend has slowed in recent years, the concentration of pollutants that people are exposed to has not fallen as quickly. This means that in the urban parts of the west midlands large numbers of people are living in areas of poor air quality and large amounts of traffic. This harm is more likely to fall on people living in deprived areas who contribute fewer emissions to the problem.

Particulate matter is made up of small particles suspended in the air. It is caused by emissions from vehicles exhausts, but the wearing down of tyres, roads and brakes also contributes roughly the same amount of pollution. It is of importance because of the consistently strong evidence that it causes heart and lung disease, such as heart attacks or lung cancer. It can be particularly harmful to children and can cause early deaths, asthma, or developmental issues. The elderly are also more at risk, as well as people living with long term conditions.

Nitrogen dioxide is another harmful pollutant that can be caused by combustion in car's engines, and it leads to increased amounts of heart or lung disease. In 2017 each of the constituent members of WMCA have a road above legal limits for this pollutants and both Birmingham and Coventry have been identified as having to take further action to be legally compliant by 2020.

Physical activity

One of the most convenient ways for people to be physically active is to build it into daily routine. This includes cycling and walking, and walking to and from public transport can also help people get enough physical activity during the week to have a protective effect. The Chief Medical Officer's advice is to get 150 minutes of moderately intensive physical activity every week and people who cycle for transport are four times more likely to meet that.

In the West Midlands around 3 in every 10 people get less than 30 minutes of physical activity every week. 90,000 fewer people would be inactive if the rate could be increased to the England average. Physical inactivity is more common in the elderly, people in semi-routine or routine occupations and people with disabilities.

Physical inactivity has been linked with early deaths and the onset of many health conditions such as circulatory disease, type 2 diabetes, some cancers such as breast and colon, and depression. Even small increases of physical activity can have a big protective impact against ill health, especially amongst people who would otherwise be physically inactive. Because of the large impacts, increasing physical activity is an effective way to reduce short term sickness absences.

In 2011 around 1.8% of adults cycled to work and through the Cycling Charter there is the ambition to increase this to 5% by 2023. There are many people who are more casual cyclists and around 10% of adult's cycle at least once a month who might be encouraged to cycle more. There is a similar picture for walking. There is strong evidence that dedicated cycling infrastructure and improvements to make the streets feel safer can increase the amount of walking and cycling.

Good wellbeing and social connectedness

Street design can have a big impact on how people feel. When residents think their neighbourhood is poor because of characteristics like dirty and inadequate streets, they are also more likely to suffer from depression. Characteristics of the streets themselves such as higher volumes of traffic also increase psychological distress.

One of the biggest impacts that streets have on wellbeing is whether they encourage social contact and increase community cohesion. Strong social networks can prevent mental ill health in children and reduce loneliness and isolation in adults. Being able to walk to local services such as shops, and lower traffic volumes increases the strength of social networks.

Busy or wide roads can prevent social contact where they disconnect communities from each other, and can have a greater impact on the elderly who can be more reluctant to cross a busy road, and children who are given more parental restrictions on their independence living close to busy roads.

Commuting can also contribute to good wellbeing, and people with shorter commutes have more time for other activities that are good for wellbeing such as sleep, exercising or spending time with friends and family. There is developing research that cycling into work also improves wellbeing at work and makes people feel more productive.

Safer streets

Most of the West Midlands has lower injury rates than England, however, this is not necessarily true of all groups and children are more at risk of serious or fatal injury. Children living in more deprived

areas are 4 times more at risk of being seriously injured or killed than children living in the more affluent areas. In part this is because of more unsafe roads and larger amounts of walking.

Several countries have taken the ethical position that streets should be designed so that a human error that causes a driver to hit a pedestrian is unlikely to lead to a death. This is known as a 'safe systems' approach and countries that have adopted provide dedicated infrastructure for cyclists and pedestrians on high speed roads and reduce vehicle speeds in areas where this cannot be provided. Vehicle speeds of around 20mph are unlikely to kill pedestrians in a collision and many local authorities in the West Midlands are introducing 20mph speed limits across wide areas.

Noise

Transport is a source of noise, and this can be caused by a range of sources on vehicles, such as engines, tyres and wind resistance. Sounds can affect people in different ways, but typically they are more likely to be seen as an annoyance if people feel that it is unfair that they should hear it or that they have no control over it.

Even at low volumes, noise can damage health and wellbeing. It can cause stress and heart disease and disturb sleep. Over 200,000 people in the West Midlands are exposed to levels of night time noise that the World Health Organisation describes as critical for human health.

Groups with longer and fragmented sleep patterns are more at risk from night time noise such as children, the elderly or pregnant women. Children have not yet developed the same coping mechanisms to noise as adults and are less able to deal with the stress caused by noise, and there is evidence that it can impact on children's mental health and school performance.

Sustainability

Sustainability is a wide issue and covers economic productivity and health. There are predicted to be direct health impacts from climate change and in the West Midlands summer temperatures are predicted to increase by 1.1 to 4.3 degrees and winter temperatures by 1.1 to 3.2 degrees.

Heat waves cause increased numbers of deaths, mainly from heart attacks caused by the increased stress on the circulatory system. Recent health waves lasting several days were estimated to have caused around 150 deaths in the West Midlands. Urban areas are typically hotter than the surrounding countryside and this can worsen the impact of heat waves without green urban spaces.

Action to reduce carbon emissions can often have positive benefits for health that can be capitalised on, and carbon reduction through increased levels of cycling has the greatest health benefits. Higher temperatures and lower summer rainfall might lead to a greater preference for cycling as a mode of travel.

Our approach to improving health through transport

There are actions that we can take to maximise the positive impacts that transport has on health and wellbeing. This can be done by embedding health and wellbeing considerations in to our approach to planning and delivering transport schemes. This allows the connections to be made across transport and health that might be missed if the focus is only on one issue. It also helps focus on groups who are more at risk, such as children, the elderly and people living in deprived areas.

ACTION ONE: We will use data on population health to help prioritise and target transport interventions. This can help to make the strategic case for transport schemes that will increase health and wellbeing. In order to do this we will produce health and transport profiles for each local authority in the WMCA using the public health outcomes framework and create an interactive dashboard of health data in smaller areas. We will refer to local authority Joint Strategic Needs Assessments that identify local health priorities.

ACTION TWO: Through our Equality Impact Assessment process we will assess the equity of health impacts. We will incorporate questions that identify health inequalities and propose how they can be addressed through transport schemes.

ACTION THREE: We will understand the social impact of transport schemes. We will do this by calculating the financial value of improved health and reduced sickness absence to improve the economic case for schemes that improve health. Some schemes might benefit from a health impact assessment and to systematically understand how to increase the health benefits or reduce negative impacts and we will identify opportunities to conduct these,

ACTION FOUR: We will set out an evidence based statement of what makes a healthy and active street and trial the approach. The built environment can have a cross-cutting impact on health but often the evidence hasn't been drawn together in a way that will show that. The West Midlands Cycle Design Guidance also sets out how high-quality standards for cycling can be introduced and equivalent guidance to support healthy outcomes from transport environments will place this in context.

1. Introduction: health and wellbeing is a resource for everyday life

Transport investment has an essential role in building a healthier and happier West Midlands. Good health and wellbeing means more to people than not just being ill, but it is also a key resource that people draw upon to improve their life. Good health and wellbeing is an important driver of economic growth, and allows people to build strong friendships and contribute to the lives of others.

The design of the streets we use has a crucial role in promoting good health and wellbeing. Streets can create healthy and active cities that are made up of vibrant places. This promotes community cohesion and social interaction, busy high streets for people, and encourage investment and access to opportunities for the people who live there.

The way that we travel also promotes health and wellbeing. Often the easiest and most acceptable ways to be physically active are when it can be built into daily routines. Cycling and walking gives people this opportunity, and journeys to and from public transport are also important ways to be active.

Investment in transport can have a big impact on health and wellbeing. It can influence many of the more direct causes of illness by providing opportunity to adopt healthy lifestyles or improve mental wellbeing. As it has a wide impact, it can create inequalities in health where the burden falls more heavily on some groups.

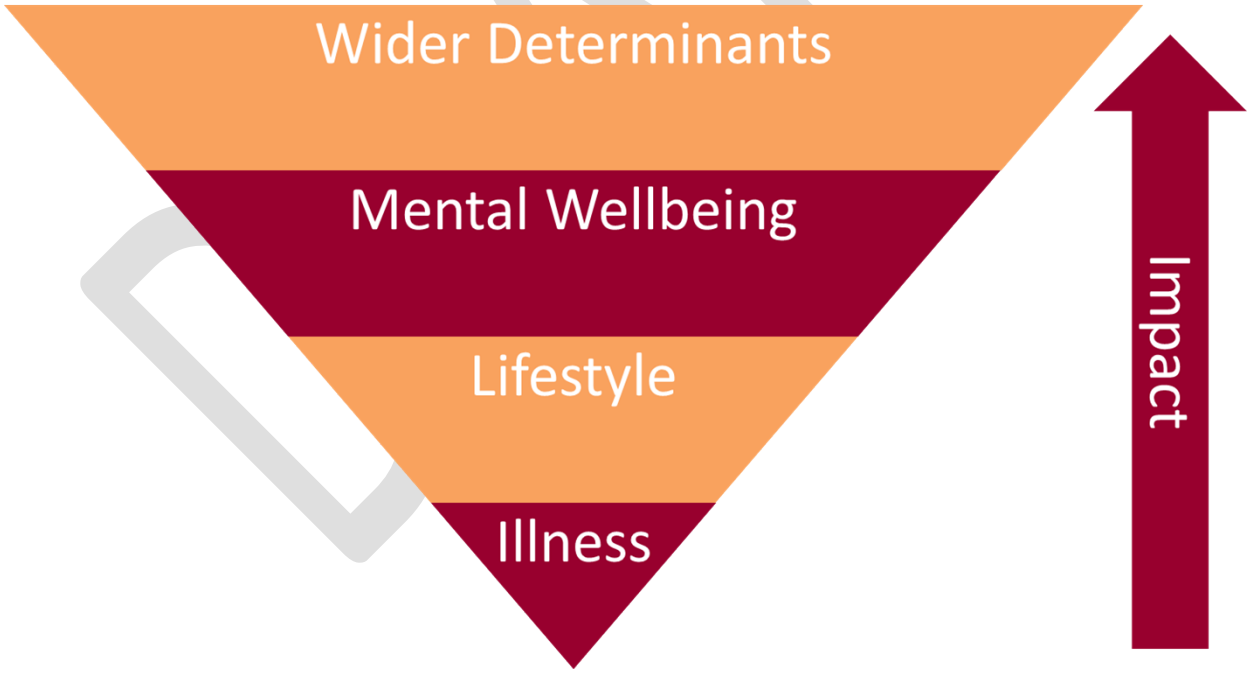


FIGURE 1: WHERE TO INTERVENE TO HAVE THE GREATEST IMPACT ON HEALTH AND ILLNESS

This strategy sets out the wide-ranging positive impact of transport on health and wellbeing. It presents the evidence that shows how transport can encourage and support people to be physically active and how streets can promote good mental wellbeing by encouraging social contact and making people feel safe.

There are negative impacts of transport on health and wellbeing, such as traffic injury or air quality. These often have more severe impacts on vulnerable groups such as children and the elderly. Major

roads can be barriers and can exclude people from services or the rest of their communities. This increases the use of local authority and healthcare services.

Within the West Midlands there is the ambition that transport will improve health. This is set out in Movement for Growth, which is the Strategic Transport Plan for the West Midlands Combined Authority area. There are a range of objectives in the strategy that impact health:

a. ENV1 To significantly improve the quality of the local environment in the West Midlands Metropolitan Area.
b. ENV2 To help tackle climate change by ensuring large decreases in greenhouse gas emissions from the West Midlands Metropolitan Area.
c. PUBH1 To significantly increase the amount of active travel in the West Midlands Metropolitan Area
d. PUBH2 To significantly reduce the number and severity of road traffic casualties in the West Midlands Metropolitan Area
e. PUBH3 To assist with the reduction of health inequalities in the West Midlands Metropolitan Area
f. SOC1 To improve the well-being of socially excluded people.

This strategy sets out a series of more detailed actions to achieve these ambitions, and maximise the positive impact that transport can have on health and wellbeing. It covers the proven connections between health and transport and importantly addresses how the positive social impact from health and wellbeing can be assessed and incorporated into transport investment decisions.

This strategy also develops the link between Movement for Growth and the health objectives within the West Midlands Combined Authorities' Strategic Economic Plan. There are high-level ambitions to improve healthy life expectancy and reduce inequalities in healthy life expectancy in the West Midlands. Accompanying this, there are objectives to reducing physical inactivity and sickness absence, carbon emissions and days of poor air quality.

West Midlands on the Move is the Physical Activity Strategic Framework that has been adopted by the West Midlands Combined Authority. This has a theme and actions to increase the contribution that transport makes to physical activity in the West Midlands. This strategy builds on those actions by supporting the case for investment in active forms of travel.

This strategy supports the work of Thrive West Midlands in improving the mental health of the West Midlands. It does this by identifying the strongest links between transport and mental health and where investment can have a positive impact on mental health and wellbeing.

By developing the case for health and transport, the strategy also helps to link healthy travel with West Midlands Combined Authority ambitions around managing demand for public services, improving productivity, and closing the inequality gap.

MANAGING DEMAND	• Reducing health impacts of air pollution, noise and traffic injury. • Promoting health by encouraging active forms of travel including public transport • Creating street environments that promote wellbeing
IMPROVING PRO-DUCTIVITY	• Reduced sickness absence. • Developing social networks and opportunities to improve skills. • Reducing the impact that noise disturbance has on productivity • Active travel as a key strand in supporting individuals to recover from ill health.
CLOSING GAPS IN INEQUALITIES	• Urban environments that elderly or vulnerable adults can move around promoting independence for longer. • Broader access to jobs and reducing social isolation. • Identifying vulnerable populations and targetting interventions where there is greatest need.

FIGURE 2: THE RELATIONSHIP BETWEEN HEALTHY TRANSPORT AND AIMS FROM THE STRATEGIC ECONOMIC PLAN

2. Health and wellbeing within the West Midlands

Life expectancy describes how old an average person in an area can expect to live and can be used to describe the health of an area, as lower life expectancies suggest that ill health causes people to die earlier. In England, the life expectancy for men at birth is 79.5 years old. On average, women tend to live longer and female life expectancy at birth is 83.1 years old in England.

Six of the seven local authorities in the West Midlands have lower life expectancies at birth than England. The lowest male life expectancies are 77.1 years in Birmingham and Sandwell, compared with the highest of 80.4 years in Solihull. There is variation in female life expectancies, and in it is 81.3 years old compared against 84.2 years in Solihull. The differences of several years show that some areas of the West Midlands are in poorer health.

Life expectancies for both men and women have increased across all the West Midlands since 2001-2003. There is some evidence that since at least 2011-13 life expectancies have not increased as quickly as they did the decade before, and some areas in the West Midlands are seeing decreases in life expectancy.

More recently, healthy life expectancy has been used to describe how many years a person would expect to live in good health. It is based on people's perceptions of their own health and can also describes wellbeing and mental health issues as well as where long term conditions are having an impact on people's health.

There are differences in healthy life expectancy at birth within the West Midlands. In Wolverhampton, the healthy life expectancy for men is 56.4 years, compared against 63.8 years in Solihull. Women generally have higher healthy life expectancies and amongst women the lowest healthy life expectancy is 59 years in Walsall and the highest is 67.9 years in Solihull.

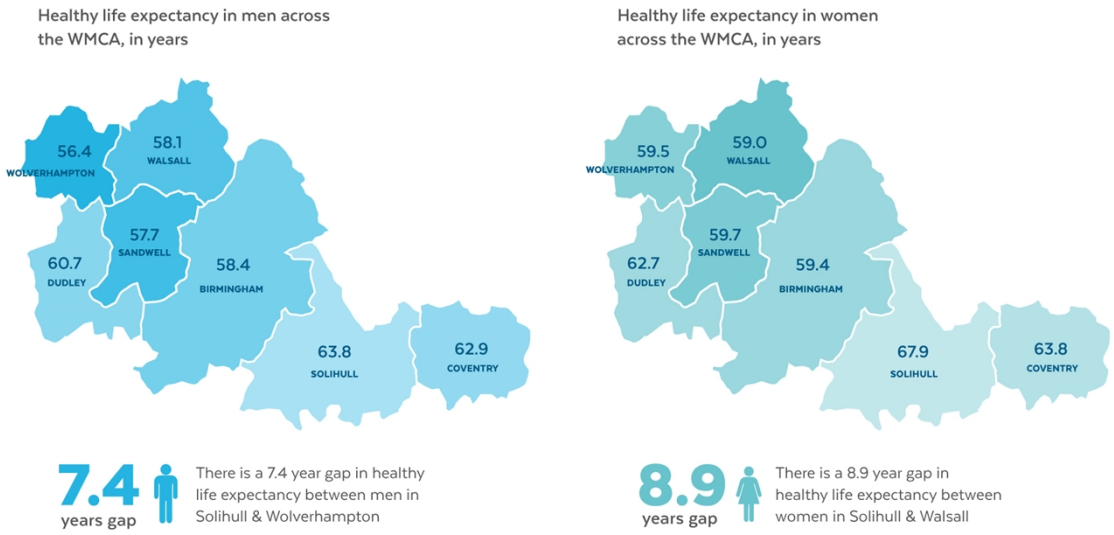


FIGURE 3: HEALTHY LIFE EXPECTANCIES IN THE WEST MIDLANDS

Local authorities with lower life expectancy typically also have higher rates of unemployment and more people with long term sickness and disability. In areas of low healthy life expectancy over half of men aged 25 to 64 who are out of work and not seeking work have long term illnesses.[1]

There is a connection between healthy life expectancy and skills. Fewer people in areas of low healthy life expectancy have a qualification of NQF Level 4 and above. However, people with similar educational levels were more likely to report better health in areas of higher healthy life expectancy.

Many lifestyle-related risks are more common in areas with low healthy life expectancies, including smoking and alcohol related harm. There are also more common life-style related risks that can be reduced by improving the built environment and encouraging more active forms of travel such as obesity and physical inactivity.

Differences in health within local authorities

Healthy life expectancies for local authorities are the average of the diverse communities within them. This means that the difference in healthy life expectancy within each local authority can be more than the difference between them. In some deprived areas in the West Midlands area, people are expected to live for 20 fewer years in good health than people in the most affluent.

The healthy life expectancy in some parts of the West Midlands is as low as

46 years for women

49 years for men

The healthy life expectancy in the more deprived parts of the West Midlands is as low as 49 years for men and 46 years for women.

The proportion of life spent in good health also changes between the most and least deprived areas. In some of the most deprived areas, people spend on average a third of their life in poor health, compared to a tenth in the most affluent areas.

In more deprived areas, people are also more likely to have multiple health issues, often including both physical and mental health. This shows the complexity of illness experienced by many. [2]

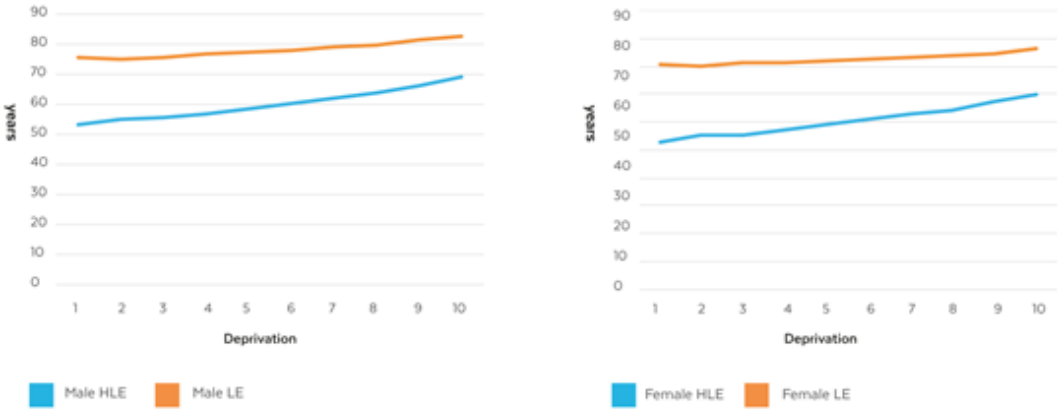


FIGURE FOUR: MALE AND FEMALE HEALTHY LIFE EXPECTANCIES IN THE WEST MIDLANDS BY DEPRIVATION

3 The impact that transport has on health and wellbeing

This section sets out several ways that transport interventions can improve health. This includes finding approaches to reduce environmental hazards such as air pollution and noise, as well as reducing traffic injuries and promoting physical activity and good mental health.

Transport schemes or programmes can have the greatest impact when they are designed to have a positive influence on many of these. Understanding these links helps to prioritise interventions that will have the greatest impact and maximise the benefits of investments to improve health through transport.

Not everyone benefits equally from the same intervention. There are groups of people or areas within the West Midlands where there is a greater potential to improve health and wellbeing. The benefits of transport schemes can also be maximised when they are designed to reduce health inequalities and are targeted at these areas or groups.

Benefits can also be maximised when street modifications or improvements are carried out and consider the wide health and wellbeing needs or residents or people who use the street. By doing this, the same intervention can often help to improve health and wellbeing in a wide range of ways, even when primarily targeted at one issue. Unintended negative impacts can also be identified and prevented by taking this approach,

This section sets out the current evidence base on the relationship between transport and health to identify where these connections exist.

3.1 Cleaner air

There are many different pollutants in outdoor air that can cause ill health. These come from a variety of sources including industry, agriculture, power generation, and transport. In the UK between 1970 and 2015 the total emissions of harmful pollutants across all sectors has been declining.

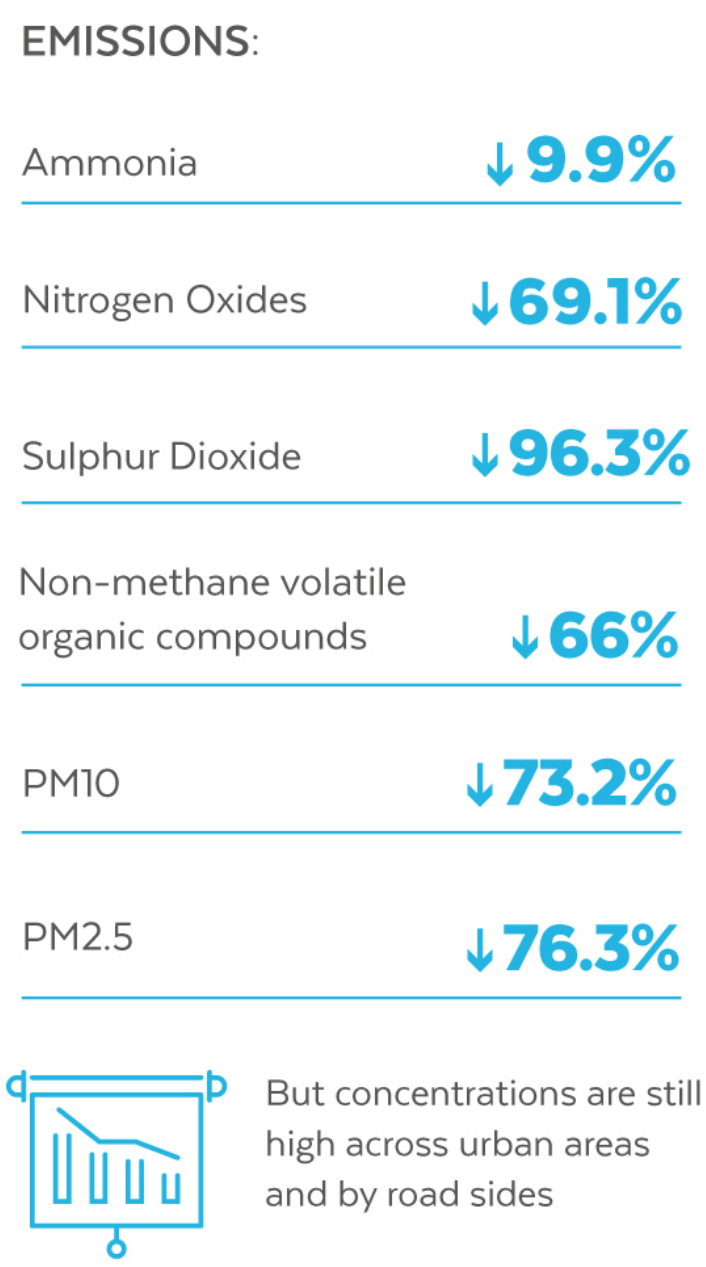


FIGURE FIVE: EMISSIONS OF POLLUTANTS SINCE 1970

Changes to society and industry has influenced the type and amount of pollutants emitted every year. The trend has historically been downwards, although this has slowed for some pollutants, there is still an ongoing health risk. Over time the evidence base on the harms has continued to grow, and as recently as 2013 outdoor air pollution was formally recognised as capable of causing cancer at levels seen in many European cities.[3]

Local authorities have the statutory obligation (since 1997) for local air quality management (LAQM). This requires them to review and assess the air quality in their area against Air Quality Objectives/Standards. They are also required to establish AQMAs, write action plans and provide annual status reports to Defra on their progress.

Whilst action to prevent exposure to all pollutants is important, particulate matter and nitrogen dioxide are identified as particularly importance in this strategy because of the current harm they cause to people and the potential to reduce the contribution that transport makes to these pollutants.

Sulphur dioxide, non-methane volatile organic compounds and ammonia also contribute to air pollution. Ozone is another important pollutant, and although it is not directly emitted by people, it can form at ground level when other pollutants react together, typically in strong sunlight.

Although the trend in emissions of harmful pollutants across all sectors has generally been downwards the concentrations of the pollutants that people are exposed to has not always reduced as quickly.[4]

Urban areas in many parts of the West Midlands have large numbers of people living in small areas and high traffic levels. This means that large numbers of people can be exposed to high background concentrations of traffic related pollutants even when they are away from the most polluted roads. In order to protect people from air pollution, action therefore needs to be wider than measures that target individual roads.

The harm from traffic related pollution often falls on relatively more deprived areas and contribute to inequalities in good health. Households in deprived areas contribute fewer emissions than more affluent households, in this way people who live in some of the most polluted areas contribute less to the problem.[5]

Particulate matter

Particulate matter are small particles suspended in the air and are usually categorised by their size in microns, and measuring the amount of particulate matter less than 2.5 microns ($PM_{2.5}$) and less than 10 microns (PM_{10}) being the most commonly used measurements. They are created from a variety of natural or manmade sources with, the latter being the greatest contributor in urban areas.

In 2015, it was estimated that traffic isresponsible for around a quarter of all man-made $PM_{2.5}$.[6] Vehicles emit particulate matter from their exhausts and the amount has been decreasing over time with improvements in vehicle engines. However, the wearing down of tyres, brakes and roads contributes around half of the amount of fine particulate matter from road transport, and this is likely to increase or decrease with the amount of traffic on the road. [7]

There is very strong evidence that particulate matter, especially $PM_{2.5}$ has a significant impact on health. The Committee on the Medical Effects of Air Pollution carried out an extensive review of

published studies in this field and concluded that each 10µg/m^3 increase in average exposure raises the number of attributable deaths by around 6%.

The health impacts may be greater. More recent studies have identified that twice as many attributable deaths could be caused by that increase and also concluded there is no safe amount of $PM_{2.5}$. in outdoor air[8] This means that reducing concentrations of $PM_{2.5}$ has an important contribution to improving health, even when levels are relatively low.

Amongst adults, the other main health effects of poor air quality are increases in the number of people who have heart disease and heart attacks, and respiratory conditions such as lung cancer. Again the evidence supports the need for action to reduce concentrations even when regulatory levels are achieved. [9] Within the West Midlands over 5% of deaths are attributable to long term exposure to particulate matter.[10]

Children are particularly at risk. This starts from before birth and parents who are exposed to higher levels of particulate matter are more likely to have low birth weight births. [11] After children are born and are developing, their lungs are relatively larger compared to adults and so they breathe in greater volumes of pollution for their size. Because of this, particulate matter pollution has been linked with increased numbers of infant deaths[12,13] .

Exposure to higher concentrations of $PM_{2.5}$ has also been linked with the development and exacerbation of asthma amongst children[14,15,16.] This can cause hospital admissions, and there are at least 2000 hospital admissions due to asthma in under 19 year olds every year in the West Midlands.[17]

There is developing evidence that particulate matter has other impacts on children, including their neurological development and the likelihood of autism spectrum disorder.[18]

Elderly individuals are also more susceptible to the effects of poor air quality, and are at greater risk of diseases such as Chronic Obstructive Pulmonary Disease (COPD) and pneumonia.[19] This is especially true when people with pre-existing illnesses are exposed to poor air quality.

Particulate matter air pollution damages the health of children by increasing

- infant deaths
- low birth weight births
- development and exacerbation of asthma
- delayed mental and physical development

Nitrogen Dioxide (NO_2)

Nitrogen Dioxide is a product of combustion, including those that occur in car engines. In high concentrations, it can cause people's airways to become inflamed.

The concentration of nitrogen dioxide has not decreased as much as expected. Explanations for are that recent diesel engines have failed to achieve the expected emissions standards in real world driving conditions [20], [21] and there has been an increase in the number of new diesel cars registered each year from less than half a million in 2001 to 1.2 million in 2015

There is a legal target to reduce roadside concentrations of NO_2 to 40µg/m^3 by 2020. DEFRA air quality models of roadside concentrations have estimated that each of the constituent members of the WMCA currently have roads above this limit.

If no additional action is taken to improve air quality by 2020, DEFRA predict that some roads in Birmingham and Coventry will still be above this threshold. In December 2015 Defra published a plan to reduce NO2 emissions in the UK and this introduced a programme of Clean Air Zones (CAZ) for five cities including Birmingham. A revised air quality plan for NO2 in UK was published in July 2017, which also identified that Coventry City Council were required to take action.

In producing the plans Defra modelled the concentrations at roadsides around the UK. Of the roads in the west midlands, on road transport was responsible for around 80% of all NO_2 pollution, with 60% being from vehicles travelling on that road.[22]

Given that concentrations of nitrogen dioxide in urban areas are typically high in the same locations as particulate matter and both are emitted by traffic, it has often been difficult to untangle the contribution that both make to ill health separately.

The best current estimate is that a 10µg/m^3 increase in NO_2 concentrations raises the number of attributable death by 4%. Increased levels of deaths from cardiovascular or respiratory disease were seen.[23] A similar study linked NO_2 with lung cancer and showed how living closer to busy roads increased this risk.[24]

The Committee on the Medical Effects of Air Pollution are currently repeating the rigorous process used to identify and review evidence about the increased deaths from particulate matter to agree a similar value for NO_2.

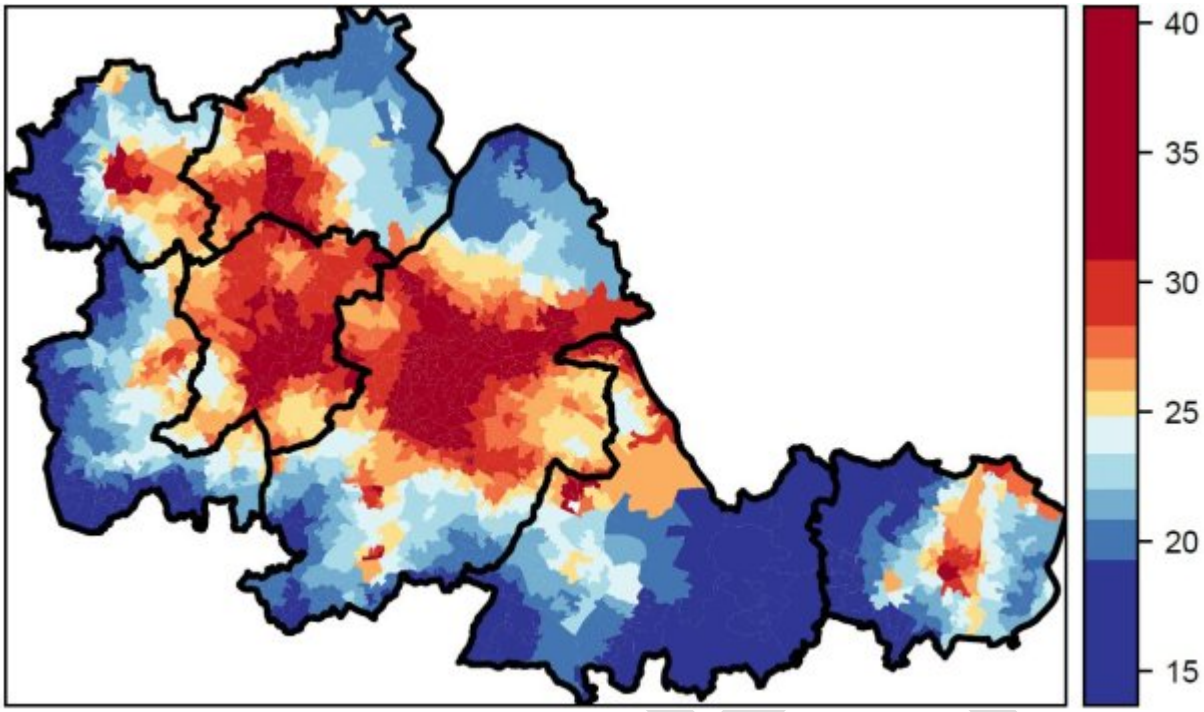


FIGURE SIX: BACKGROUND CONCENTRATION LEVELS OF NO_2 across the WMCA area

3.2 Increased physical activity

Through West Midlands on The Move, the WMCA has a vision to increase physical activity. Through the West Midlands Cycling Charter there is the aim to increase cycling to 5% of trips to work by 2023. An Action Plan outlines the delivery of schemes and programmes to achieve this goal.

One of the most convenient ways for people to get more physically active is to build it into their daily routine.[25] This is usually through encouraging people to walk or cycle. Public transport also plays an important part in increasing physical activity when people walk or cycle as part of their journey.

The Chief Medical Officer's (CMO) advice is that adults get 150 minutes of moderately intensive physical activity each week, or that 75 minutes of intensive activity can have the same effect.

There are an estimated 580,000 adults who are inactive and achieve less than 30 minutes of physical activity a week in the West Midlands. In the West Midlands it is estimated that 3 out of every 10 adults are not achieving that across all their activities for the whole week.[26] This is lower than the England average, and if physical activity levels were increased to this average then 90,000 fewer people would be inactive.

There are inequalities in how likely people are to be physically inactive. Data from across England shows that:

a) 54 out of 100 people older than 75 years are physically inactive, compared with 15 out of 100 16-25 year olds
b) 27 women in every 100 are inactive compared with 24 out of every 100 men
c) 32 out of every 100 people in semi-routine or routine 33 out of every 100 people with a long term disability are physically inactive, compared with 21 out of every 100 with no impairments. The more impairments an individual has, the more likely they are to be physically inactive
d) 37 out of every 100 people in semi routine or routine occupations are inactive, compared with 17 out of every 100 people in managerial or professional jobs.[27]

People with disabilities or long-term conditions are less likely to be physically active and less likely to cycle or walk the whole journey to work.[28]

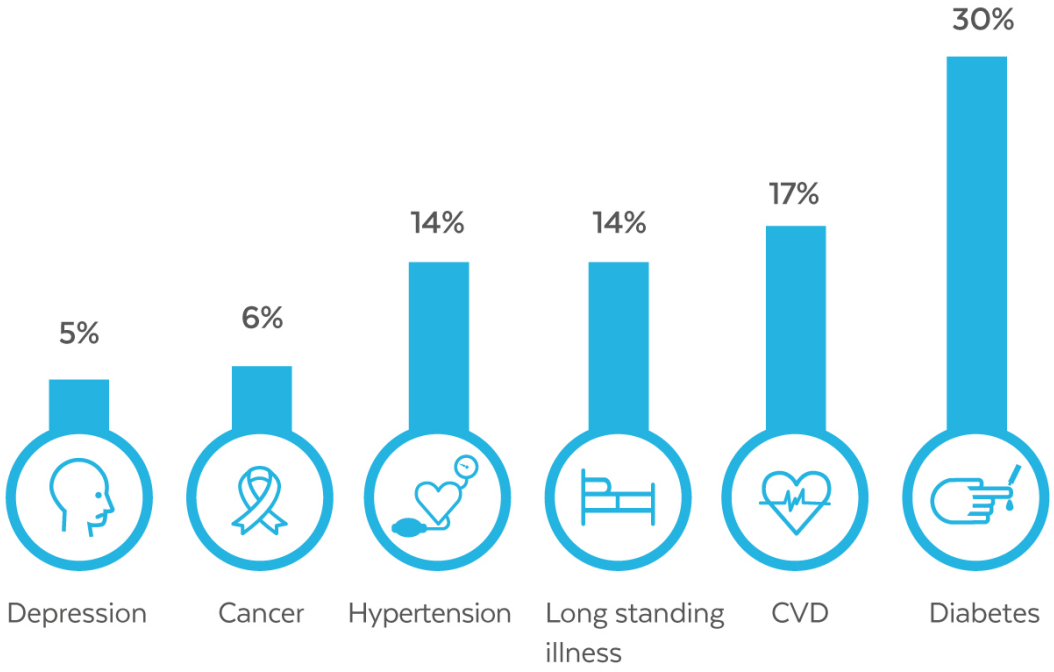


FIGURE SEVEN: REDUCED LIKELIHOOD OF CYCLING OR WALKING TO WORK BY PEOPLE WITH DIFFERENT LONG TERM CONDITIONS

Increasing the range of opportunities to walk and cycle creates an accessible way to get physically active. People who cycle for transport purposes are 4 times more likely to meet physical activity guidelines.[29] Walking and cycling to and from public transport is an important source of physical activity.

There are numerous health benefits that can be achieved from encouraging physical activity. Across the whole of the UK, if physical inactivity was eliminated then it would add an additional year to the national average life expectancy.[30]

The more intensive or longer the physical activity is for, the greater the protective effect. The more that people are physically active for, the lower their risk of premature death.[31]

Even small increases in physical activity can have a significant impact. For someone who is inactive, doing around 25 minutes of walking per day can reduce the risk of premature death by about 9%. The same amount of time spent doing more intense cycling reduces the risk of premature death by 17%. [32,33]

FIGURE EIGHT: REDUCED LIKELIHOOD DEATH BY AMOUNT OF WALKING OR CYCLING EACH WEEK

Physical activity has the greatest effect on health when people who would be otherwise inactive are enabled to become active. Whilst walking for around 25 minutes every day reduces the risk of death by 10%, reducing this risk by a further 10% requires five times the amount of walking. [34] Transport schemes that reduce the number of people who are inactivity are likely to have a bigger impact for each person than schemes aimed at people who are already physically active.

As cycling is usually more intensive exercise than walking, it can reduce the risk of death by a large amount, especially when done regularly. Forty to sixty nine year olds who reported regularly cycling to work are 40% less likely to die.[35]

The benefits of physical activity can be gained even after someone has been physically inactive for a long time. In those over 60 year olds, 2 hours of walking every week translated as a 22% reduced likelihood of death. Greater benefits were seen with more activity[36]

Physical activity prevents illness

Physical activity protects people from many of the diseases that contribute to lower healthy life expectancies, such as heart disease and stroke [37] [38], and type 2 diabetes. [39] [40] [41]

The greatest benefit in reducing the likelihood of breast and colon cancer, diabetes, heart disease and stroke is gained when physically inactive individuals become more active.

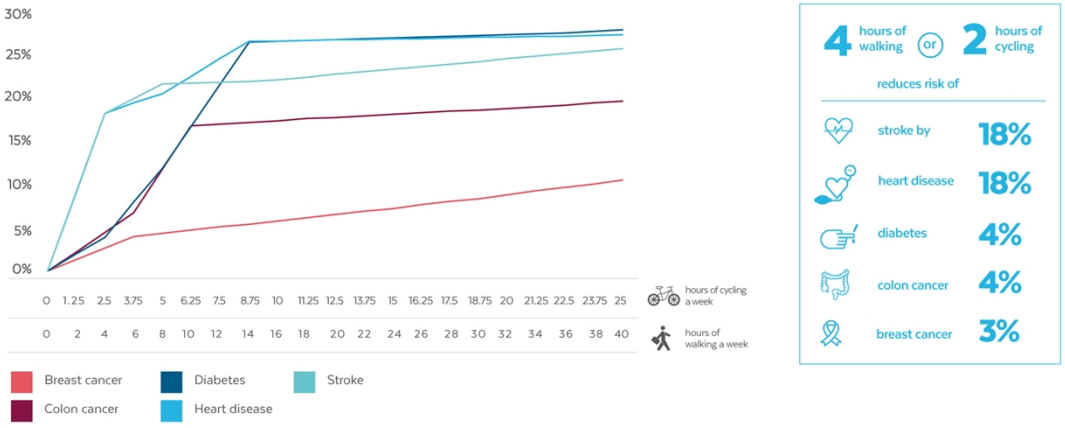


FIGURE NINE: REDUCED LIKELIHOOD DIFFERENT DISEASES BY HOURS CYCLING (TOP) AND WALKING (BOTTOM)

Physical inactivity contributes to obesity. In the West Midlands currently, between 30 to 36 adults out of every 100 are not obese or overweight.[42] On current trends, it is predicted that by 2050 this will reduce to around 10 of every 100 men and 15 out of every 100 women.[43]

Adults who switch from commuting by car to a more active form of commuting such as walking and cycling or public transport are much more likely to reduce their body weight and likelihood of obesity. The opposite is also true and typically people will increase in bodyweight when changing from one of those forms of transport to a sedentary form of commuting, such as driving.[44] [45]

Childhood obesity is also relatively high in the West Midlands. In Year 6, around 4 in every 10 children in the West Midlands are either overweight or obese.[46] This is higher than the England average. Obese children are more likely to become obese adults, and intervening early to reduce the weight of children has a long term impact on reducing ill health in adulthood.

There is a proven link between physical activity and mental health. There are a growing number of studies that show how walking for a commute also reduces the likelihood of depression or anxiety. [47] [48] [49]

Physical activity prevents sickness absence

Across the WMCA constituent members, around 1.1% of working days are lost due to sickness absence. This is not just due to long term sickness absence and roughly 1.9% of workers take at least a day's sickness absence each week.[50]

Physical activity reduces short term sickness absence. Even relatively small increases in physical activity when continued over the course of a year.[51] Where employees have had exercise once a week over the course of a whole year, sickness absences have reduced by around 25% [52] [53] [54] [55] [56].

This same relationship between activity and sickness absence has been found when employees use active travel. Commuting by bike reduces sickness absence by around one day per year for each cycling employee, even after taking into account other factors that might explain the reduction.[57] [58]

Cycling for transport in the West Midlands

Currently, around 1.8% of commuting trips are made by bike. This varies between local authorities.

Local authority	% of commuting trips made by bike
Birmingham	1.65%
Coventry	2.82%
Dudley	1.32%
Sandwell	1.66%
Solihull	1.52%
Walsall	1.68%
Wolverhampton	1.80%

More adults have access to a bike and cycle than cycle for commuting purposes, and in some parts of the West Midlands over 10% of adults report cycling at least once a month.

Local authority	% of adults cycling at least 3 times a week	% of adults cycling at least once a month
Birmingham	3.3%	10.8%
Coventry	3.7%	12.9%
Dudley	1.8%	8.6%
Sandwell	1.0%	6.5%
Solihull	2.2%	13.4%
Walsall	1.7%	11.8%
Wolverhampton	2.3%	8.4%

This shows that there are more casual cyclists in the West Midlands than people who cycle to work. and that there is opportunity to increase the amount of cycling amongst casual or leisure users.

The built environment and perceived safety of the roads can often be a barrier to cycling. Dedicated cycling infrastructure such as cycle parking and dedicated cycle lanes increase the amount of people who cycle [59] [60] [61]

Women have a higher preference for predicated cycle lanes and their provision may reduce the inequalities in physical activity between genders. [62]

The Combined Authority board has approved the development of a strategic cycle network across the area, and which links between constituent and non-constituent members. This can be integrated with local networks. West Midlands Cycle Design Guidance has also been approved in order to create better environment for cyclists.

Birmingham City Council is planning a segregated cycleway along the A38 (between city centre and Selly Oak) and A34 (between city centre and Perry Barr) as part of the Birmingham Cycle Revolution programme.

Walking for transport in the West Midlands

Walking is the most likely way that most adults will meet the CMO recommended physical activity levels.[63]

Currently around 1 in every 10 journeys to work in the west midlands are entirely by foot, however, this disguises many more walking trips. Many people walk to and from public transport such as buses and train stations. Although these are relatively short distances, they are important ways to improve health and wellbeing, especially amongst people who would otherwise be inactive.

More people walk during the week than is suggested using commuting statistics. Counting walks of only 10 minutes or more, over 40% of adults walk five times a week and most walk at least once. These might be trips to destinations other than work, or for leisure.

Local authority	**% of adults walking at least 5 times a week**	**% of adults walking at least once a week**
Birmingham	49.8	77.2
Coventry	58	83.3
Dudley	44.6	75.1
Sandwell	43.8	74.5
Solihull	46.1	79.7
Walsall	40.3	74.8
Wolverhampton	42.6	73.4

The Movement for Growth 10 year delivery plan sets out the importance of the built environment to encourage walking by improving the public realm and reducing vehicle speeds through area wide 20mph speed limits.

3.3 Good mental wellbeing and social cohesion

'Thrive West Midlands: an Action Plan for change', sets out the ambition to improve mental wellbeing in the West Midlands and reduce the impact that poor mental health can have on people's lives. It is estimated that over 200,000 adults in the West Midlands aged between 16-74 has either a mixed anxiety or depressive disorder at any one time. There would be 30,000 fewer if the CA average was the same as the average across the whole of England.

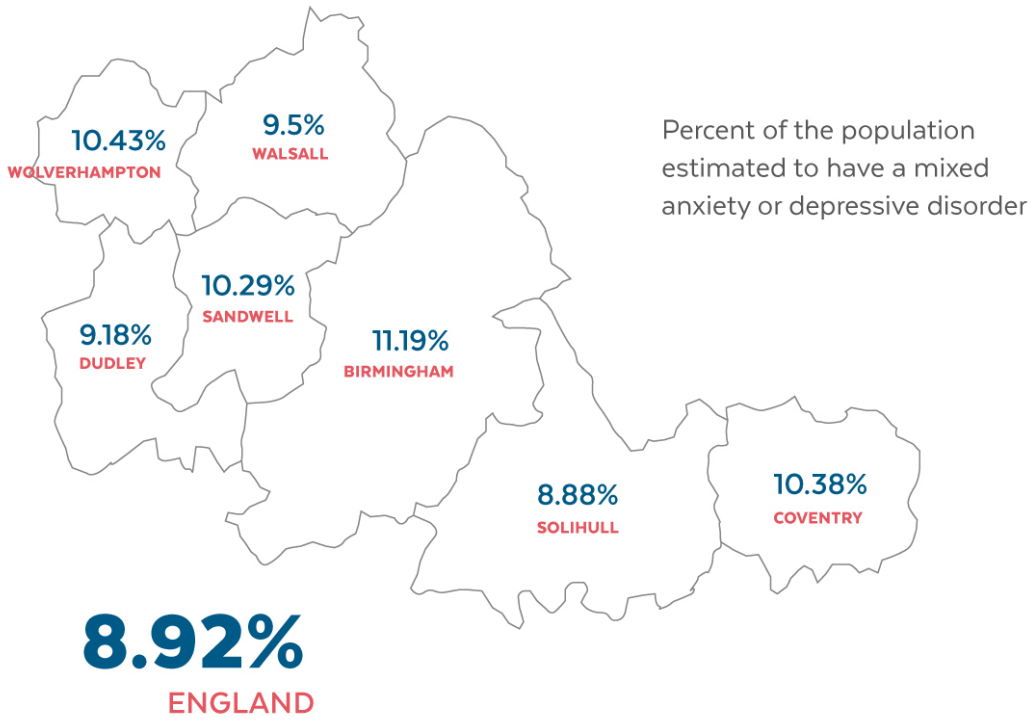


FIGURE TEN: ANXIETY AND DEPRESSION IN EACH LOCAL AUTHORITY

There are mental health benefits from reducing transport related noise and injury, and improving physical activity and perceived safety. The design of the transport system and street environment can also directly influence wellbeing.

There is a direct relationship between mental health and the built environment as a whole. People who rate the built environment in their neighbourhoods as poor can be around 30% to 60% more likely to report having depression in the last six months, with higher rates of lifetime depression.[64]

Compared with physical health, there has been less discussion and research on street design and its relationship to mental health and wellbeing. This is an important area for research to understand how streets can meet the objectives of Thrive West Midlands.

There have been few studies on the relationship between how the design of streets encourages people to walk and mental health. Whilst the overall relationship between mental health and street design is unclear, some characteristics such as increased volumes of traffic have been shown to increase psychological distress.[65]

Transport and social cohesion

Street design can increase social contact between residents. Social contact and supportive social networks strengthen mental resilience in children[66] and improve community cohesion. People who are socially isolated are at greater risk of poor mental health[67], [68] and isolation can have much wider impacts on early deaths, hospital admissions in the elderly and cardiovascular disease. [69] Whilst isolation can occur at any age, the elderly are more at risk of being socially isolated.

If street design helps people to walk to places then it will directly impact on the strength of the local community. People who can walk to local services know more neighbours, are generally more trusting of people, and have more social contact.[70] The ease of accessibility of local services such as shops, parks or other facilities also increases the number and strength of social connections that people have.[71]

Streets with less traffic encourage larger social networks and places where people are more likely to stop and chat. People on streets with smaller traffic volumes are more likely to have more friends and acquaintances.[72]

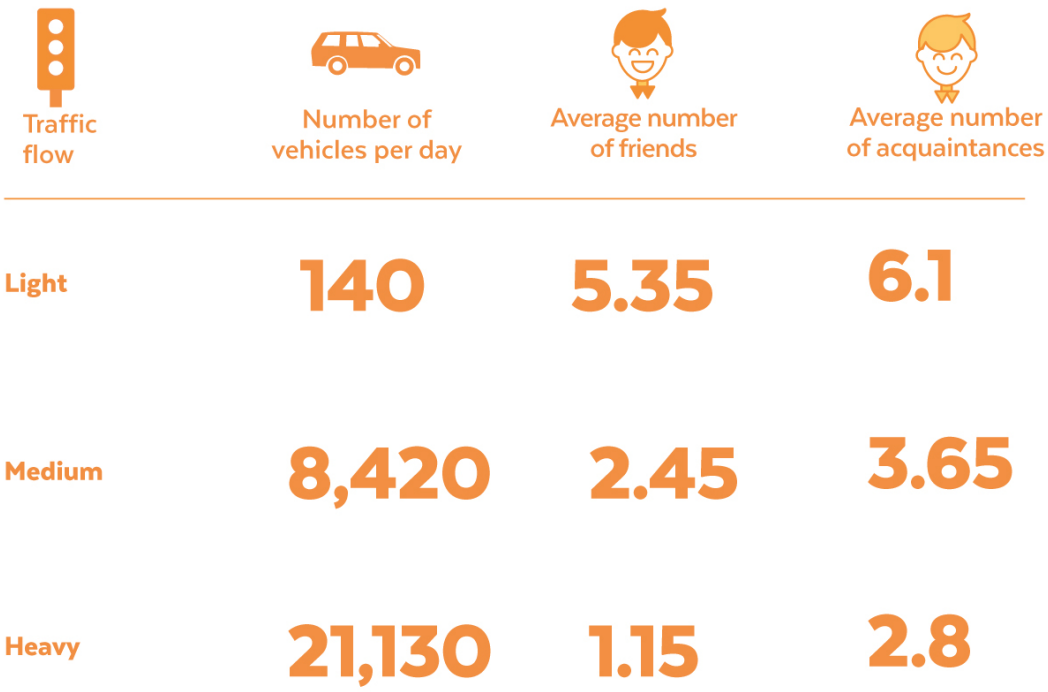


FIGURE ELEVEN: RELATIONSHIP BETWEEN NUMER OF VEHICLES AND SIZE OF SOCIAL NETWORK IN A TYPICAL UK CITY.

High traffic flow can also create a barrier that prevents people from accessing local shops or other services and visiting friends. This is often referred to as 'severance' and can be especially true on dual carriageways and high-speed roads. Reluctance to cross a main road is more common in elderly

individuals and can also result in parents placing more restrictions on the independent travel of their children due to concerns about the street.[73]

Ring and Ride can also reduce isolation and increase independence by providing accessible and low cost door to door transport. In the west midlands there are around 850,000 journeys every year to 12,000 registered users, and the service supports older people and those with a disability to access services like employment, training, leisure and retail.

Commuting

Commuting can have a negative impact on mental health. Shorter commute times increase job satisfaction and reduce turnover, as well as increase satisfaction with leisure time and improve mental health.

The shorter the commute, the greater the positive impact on mental health. The opposite is true with longer commutes and bus users particularly feel increased negative impacts on mental from longer commutes. [74]

People in Britain who commute longer distances are less satisfied about their health and more likely to visit their GP. [75] This is mostly seen on forms of transport where there is more likely to be crowding, congestion or delays, and these can lead to the feeling of not being in control lead to poorer mental health.

Longer commutes reduce time for other health promoting activities, such as spending time with family or friends, sleep, or exercise.[76]

There is developing evidence that commuting by bike can have a positive impact on productivity. Cyclists were more likely to agree that they arrived at work 'energised' than commuters using different modes.[77]

The relationship between commuting mode and productivity is an important area for further research. The potential health impacts of working from home is also an area where more research is needed.

3.4 Safer streets

Safer streets are essential in helping people move around the West Midlands without perceived or genuine risk of injury. Reducing the danger that people are exposed to decreases the risk of injury, but also encourages people to walk or cycle.

If hit at **20mph**, **3 out of every 200** pedestrians will be killed. At speeds of 30mph, the risk of death is around one in every ten.

85% of serious and fatal child pedestrian injuries occur on roads with **30mph** limits

Human error is often cited as the major cause of traffic collisions[78]. One perspective is that errors are a result of a set of circumstances and they can be prevented rather than being random events. [79] Roads can also be designed so that errors do not result in deaths.

Addressing these underlying causes and ensuring that common errors do not lead to deaths can also reduce road danger and improve perceptions of safety. In this way, action to improve road safety can have a much wider influence on health beyond preventing injuries.

The World Health Organisation has promoted a 'safe systems' approach to road safety based on the Vision Zero approach in Sweden and Sustainable Safety in the Netherlands. Under these approaches, it is considered unethical to design roads where an error could lead to deaths.

Based on the understanding of how likely people were to die in a typical collision on different road types, speed limits were set to reduce the chances of this happening and segregated facilities provided for cyclists and walkers on roads that required higher speed limits. Over half of all deaths could be prevented by adopting a safe systems approach.[80] [81]

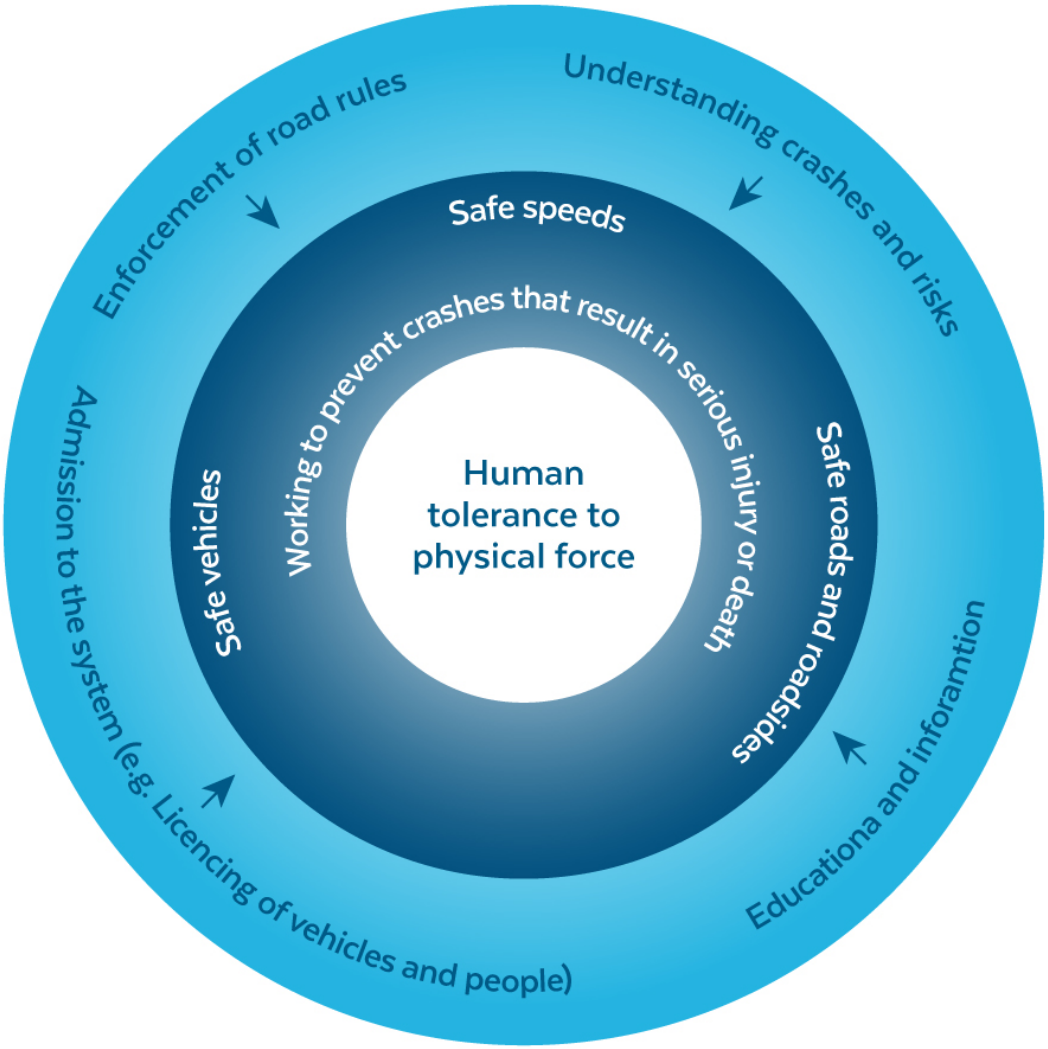


FIGURE TWELVE: COMPONENTS OF THE WHO SAFE SYSTEMS APPROACH TO PREVENTING INJURIES

Part of a safe systems approach is 20mph limits in areas where pedestrians are at risk. If hit at 20mph, 3 out of every 200 pedestrians will be killed. At speeds of 30mph, the risk of death is around 1 in every 10.[82] A recent analysis has shown that across England, around 85% of serious and fatal child pedestrian injuries occur on roads with 30mph limits, showing the wide potential of reducing vehicle speeds.[83]

This approach that reduces the speed of traffic also improves people's perceptions of safety. This supports other ways of keeping healthy, such as increasing people's confidence to cycle and walk.[84]

The Movement for Growth 10 year delivery plan identifies areas where 20mph areas will be introduced to encourage active travel and improve safety. This includes Coventry's ambition to be a 20mph city.

Children who live in deprived areas are more likely to be killed on the roads as pedestrians and cyclists. This is because of the more unsafe road environment, and the larger amount of walking that children do.[85] Within the WMCA area there are typically higher rates of child serious and fatal injuries than the England average.[86]

Across England, children aged 5-9 who live in the most deprived 20% of households are nine times more likely to be killed or seriously injured as a pedestrian than children who live in the 20% most affluent areas. Among 10-14 year olds the rate was just under four times as high. A similar picture is seen for child cyclists.

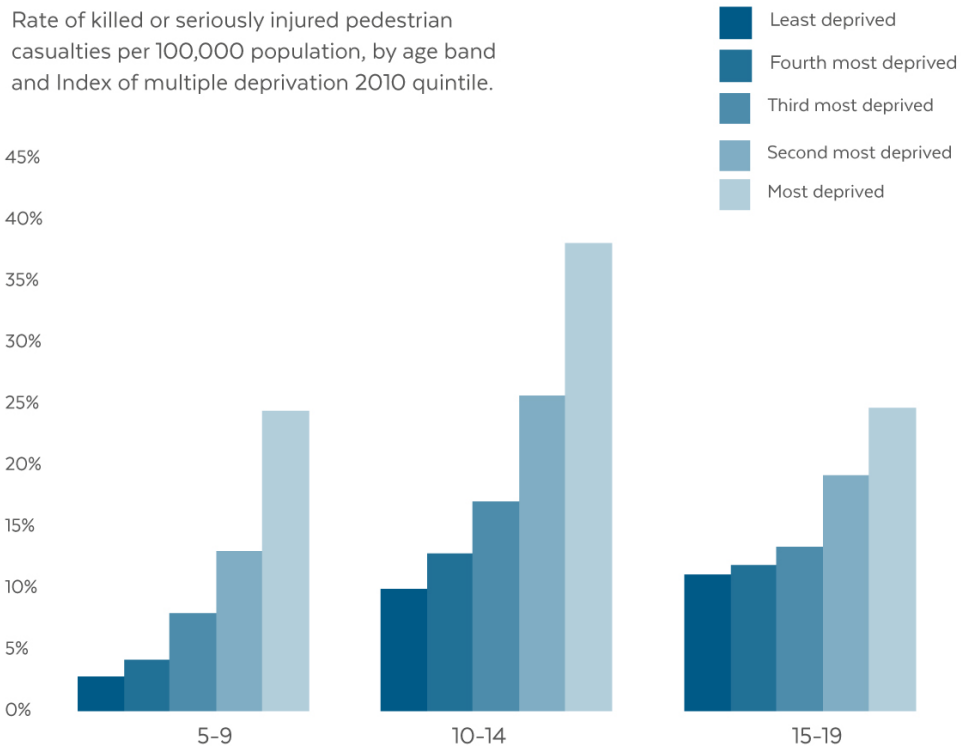


FIGURE THIRTEEN: RISK OF SERIOUS OR FATAL CHILD PEDESTRIAN INJURY BY RELATIVE DEPRIVATION

Traffic injuries have longer term impacts including psychological distress or other mental health issues for up to three years following the crash.[87] [88] More severe physical injuries seem to lead to higher levels of psychological distress. [89]

3.5 Noise

Transport is a source of noise. This noise comes from a variety of sources such as vehicle engines, the interaction between tyres and the ground, and wind resistance.

Sound can affect people in different ways, depending on the situation and the environment as well as sensitivity to the noise and attitudes about it. If people do not feel in control over a sound or that it is unfair that they should hear it, they are more likely to notice it and react negatively.

Quiet or calming sounds, particularly from natural sources, can have a positive effect on people. Quieter places indicate safety and put people at ease. Alternatively, louder pleasant sounds from a bustling public space can create a lively and exciting place that people enjoy.[90]

Positive effects can be lost, particularly when sound is unwanted or when it masks quieter reassuring sounds. Loud noises produced at a distance can have this a negative impact.

Although excessive exposure to loud noise can damage hearing, there are also health implications at lower volumes. Even at low volumes, transport noise can be perceived as negative and act as a cause of stress or disturb sleep. This is how it has a direct impact on health as well as quality of life.

Night time noise is usually measured as an annual average and between 11pm and 7am. During this period, exposure to average noise levels of around 55db and above are considered by WHO as increasingly dangerous to public health.[91] This is slightly quieter than many fridges. Over 200,000 people in the Birmingham and Black Country urban conurbation are exposed to average road traffic noise above this level at night.[92]

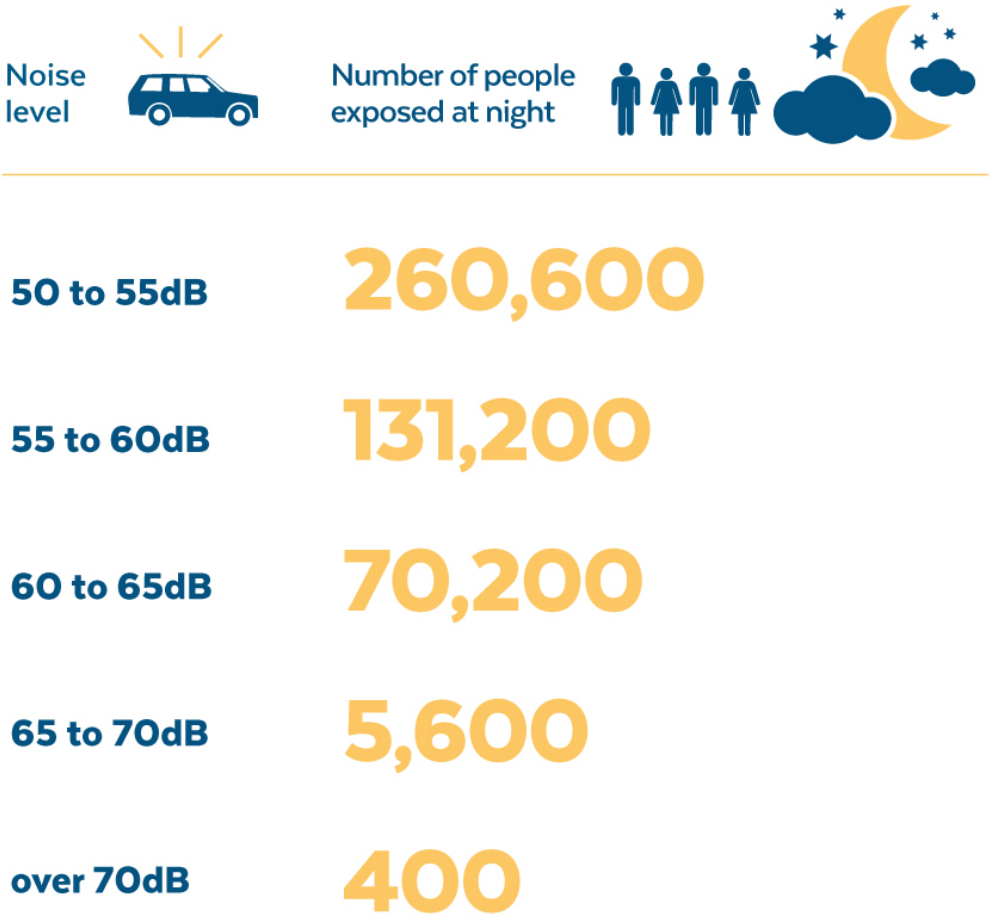


FIGURE FOURTEEN: NUMBER OF PEOPLE IN THE BIRMINGHAM AND BLACKCOUNTRY EXPOSED TO HIGH VOLUMES OF NIGHT-TIME NOISE

Sleep disturbance and waking can occur at much lower volumes. People in groups who typically sleep longer or have fragmented sleep patterns are considered more at risk of the effects of night time noise. Groups with these sleeping patterns include children, the elderly, pregnant women, people with ill health, and shift workers.

The highest burden from noise on health and wellbeing is predominantly through sleep disturbance and annoyance. [93] Noise annoyance can effect wellbeing by causing negative responses, such as anger, disappointment, dissatisfaction, withdrawal, helplessness, depression, anxiety, distraction, agitation or exhaustion. Noise also increases the risk of heart disease due to increased stress, which can have physical symptoms such as tiredness and stomach-discomfort, and raised blood pressure.[94]

The evidence is developing about a range of other plausible health impacts such as increased risk of diabetes[95] and low-birth weight births.[96] There is a potential relationship with diagnosed mental health and people with depression are being more likely to report noise as a problem in urban areas.[97]

Children are less able to deal with the stress caused by noise as they have not developed the same coping mechanisms as adults. In children there is evidence that noise is linked to emotional symptoms, conduct problems and hyperactivity. [98]

Some studies have shown that road and rail noise also has a negative impact on mental health in primary school children, and predominantly in children who were born pre-term low birth weight.[99]

Noise also has an impact of school performance and learning outcomes. Higher levels of noise exposure worsens memory, performance in tests and can cause a delay in reading age. WHO recommend that background noise should not exceed 35dB during teaching sessions.[100]

Across the west midlands there are variations in the number of people exposed to road, rail and air traffic noise.

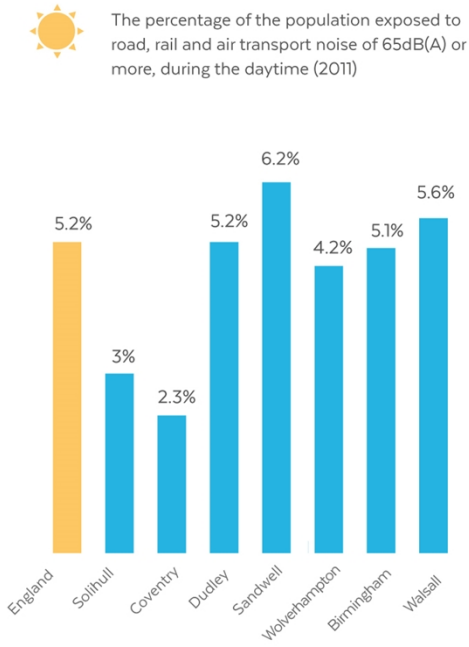


FIGURE FIFTEEN: PERCENTAGE OF PEOPLE EXPOSED TO HIGH VOLUMES OF DAY-TIME NOISE IN EACH CONSTITUENT MEMBER

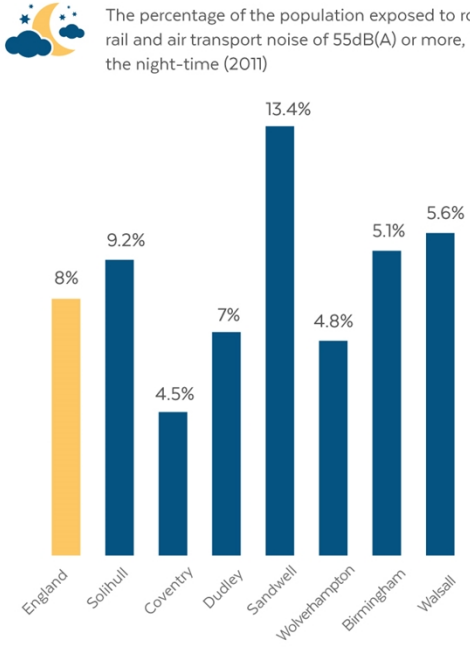


FIGURE FIFTEEN: PERCENTAGE OF PEOPLE EXPOSED TO HIGH VOLUMES OF NIGHT-TIME NOISE IN EACH CONSTITUENT MEMBER

3.6 Sustainability

Sustainability cuts across a wide range of health and transport issues. Within the Strategic Economic Plan, targets around economic productivity, carbon emissions reduction and health inequality all contribute to sustainability. Climate change from carbon emissions will also have a significant impact and is covered in more detail in this section.

Climate change

In 2014, 22,708 kilo tonnes of carbon dioxide were emitted across constituent and non-constituent members. Compared to the other eight Combined Authorities this makes the West Midlands the highest emitter. The higher emissions are in part to do with the size of the region compared to other Combined Authorities. On average, each person emitted 5.6 tonnes of carbon dioxide, compared with the average of 7.4 tonnes of carbon dioxide in the other combined authority areas

There has been a 14.5% reduction in carbon dioxide emissions since 2010 across the wider Combined Authority geography that includes constituent and non-constituent members.

Changing climate will have a range of impacts on human health. The main and most likely immediate health impact will be due to increasing average temperatures and the likelihood of heat waves occurring. Periods of very warm weather higher than 25 degrees can be followed quickly by a sharp increase in deaths.

The main causes of excess deaths related to increased temperatures are respiratory and cardiac events. Cardiac events are caused as the body tries to circulate more blood close to the skin, causing excess strain on the heart and circulatory system.[101]

Air pollution can be worse during warmer weather, in part because it creates the conditions to for ground level ozone to form. Individuals more at risk include the elderly, people with existing long-term conditions, and children.

It was estimated that a 10 day heat wave in August 2003 caused 2,000 excess deaths across England and similar heat waves occurred on 2006 and 2009. In the 2006 heat wave, there were an estimated 150 excess deaths in the whole of the wider West Midlands alone. [102]

Models for the UK Climate Change Risk Assessment estimate that after 2040 in the West Midlands, there is likely to be a 1.2 to 3.2 degrees increase in winter temperatures and 1.1 to 4.3 increase in summer temperatures.

The impact of heat waves are worse in built up areas such as much of the West Midlands, as there is an urban heat island effect. During the 2003 heat wave, Birmingham had on average a higher temperature by 3.2 degrees, with a maximum of 5.6 degrees higher. Wolverhampton had a maximum of 6.8 degrees higher than

Previous heat waves in the west midlands have been estimated to cause around **150 deaths**

2040 in the West Midlands, there is likely to be a **1.2** to **3.2** degrees increase in winter temperatures and **1.1** to **4.3** increase in summer temperatures

the rural average. Even areas close to the edge of the city such as Coleshill had temperatures 1.5 degrees higher than expected.[103]

The urban health island effect means that deaths from heat waves may be underestimated, and at least 90 excess deaths were attributed to the 2003 heat wave in the West. Presuming nothing is done to adapt the environment to reduce the effect of the health wave a similar heat wave could cause around 280 deaths in 2080.[104]

The climate change risk assessment identifies that increased temperatures risks the supply of resources that provide the foundation for good health such as the water supply to the public and for agriculture, as well as risks to domestic and international food production. This can often disproportionally impact on deprived communities.

A transport related opportunity from climate change may be an increased preference for cycling and walking given increased temperatures and lower summer rain fall.

Action to reduce carbon emissions can have a significant positive impact on other health issues. The greatest opportunity to improve the co-benefits are from a large shift to cycling and walking. This has a much greater impact on health than replacing the same travel with electric vehicles.[105]

3.7 Summary of the relationship between transport and health

There is a wide-reaching relationship between transport and health. Some of the largest health benefits can be realised where physical activity is increased, or where air quality is improved. It is likely that there are large opportunities to improve mental health and wellbeing that are being missed because the evidence base strongly suggests a link but the type of interventions to best capitalise on it have not been widely evaluated.

Looking at the different issues as a whole highlights common themes. Investment in more deprived areas can have a larger impact on health, and the health and wellbeing needs of children and the elderly should have a greater consideration when planning and delivering transport interventions.

The role of the built environment in improving health is another common theme and where interventions improve the public realm with a range of health and wellbeing goals in mind it enables behaviour change and healthy transport choices as well as increasing community cohesion.

4. Our approach to improving health through transport

There are actions that we can take to maximise the positive impacts that transport has on health and wellbeing. This can be done by embedding health and wellbeing considerations in to our approach to transport. By doing this opportunities and implications of schemes can be identified and acted upon. A set of actions has been developed to embed health into our approach.

To consider the breadth of health and wellbeing issues, a range of public health data and evidence is available. There is expertise in interpreting this data in the public health teams in constituent members. Often this evidence can be used to develop the business cases of schemes that improve health and wellbeing.

There are connections between different health and transport issues that might be missed if there is only a focus on single issues. Attention needs to be focussed on to groups who might have the greatest health and wellbeing benefit and to protect groups most at risk. This report has identified children, the elderly and people living in deprived areas as groups where attention should be focussed.

The design of streets and public places is an example of a transport intervention that can impact on multiple health issues. This report has identified many urban design interventions that can improve health and wellbeing by encouraging more walking.

ACTION ONE: We will use data on population health to help prioritise and target interventions

There is data and information that describes the health of local authorities and smaller geographies within them that can be used to assess health needs and how much benefit can be gained. That data will be included in the strategic outline cases for transport schemes that will improve health and wellbeing.

Across local authorities, the Public Health Outcomes Framework contains a set of indicators that explain the relative health and wellbeing of the area areas. This draws on a wide range of sources of data and is regularly updated when new data becomes available. To make best use of it, we will identify indicators that relate to transport and health and publish and update profiles for each local authority.

To make best use of health data for smaller areas within local authorities, we will develop health and transport dashboards that will show the health of people around transport schemes and corridors.

Local authorities can communicate their health priorities to TfWM through their Joint Strategic Needs Assessment. These should reference health and transport. We will work with the public health departments of our WMCA members to make sure that they have access to relevant data sets to help identify priorities.

ACTION TWO: Through our Equality Impact Assessment process we will assess the equity of health impacts.

No-one should be disadvantaged from achieving their potential to be healthy and everyone should have a fair opportunity to be in good health. Some areas and groups within the West Midlands have poorer health. By identifying and understanding the needs of disadvantaged groups at an early stage we can make sure that schemes help everyone to achieve good health and wellbeing.

We will consider how transport schemes impact on health inequalities through the existing WMCA Equality Impact Assessment process.

ACTION THREE: We will understand the social impact of transport schemes.

There are many benefits from investing in health. These might be directly to the health service or local authorities because of reduced need for health and social care or the value that people put on preventing early deaths or lost productivity and informal care costs. By calculating this value we will include health in the business cases and the benefit-cost ratio that is used to understand the value of the scheme.

We will use The World Health Organisation 'Health Economic Assessment Tool' to calculate the benefits of increased physical activity from cycling, walking and public transport schemes. This is in line with Department for Transport guidance.

The Department for Transport also approve the use of the Sickness Absence Reduction Tool. This gives a financial value on reduced sickness absence from increased physical activity.

There are other opportunities to describe NHS and local authority savings, but which are not approved for use in business cases by the Department for Transport's appraisal. We will explore the use of these tools internally to understand the size of benefits that might be currently missed.

Some significant transport schemes will benefit from a health impact assessment to identify opportunities to mitigate any health impact of the scheme on health, or capitalise on the opportunities to improve health. These can help to complete TfWM objectives to prevent the exacerbation of air quality problems. We will identify opportunities to conduct health impact assessments of transport interventions.

In some constituent member local authorities these are being built into the planning process and highlighted in the local plan, and these should also refer to the opportunity to conduct HIA on transport schemes. We will work with local authorities to conduct health impact assessments, as part of broader sustainability and environmental impact assessments, whether lead by the local authority or TfWM.

The health and wellbeing issues identified in this report will be used to structure and assess any health impacts and should be considered by transport consultancies who have been commissioned to carry out Health Impact Assessments, alongside issues such as access to health care.

ACTION FOUR: We will set out an evidence based statement of what makes a healthy and active street and trial the approach

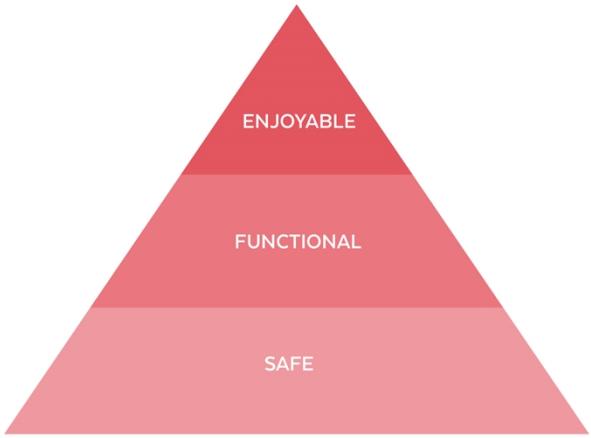
Streets can be an asset to improve the health of people who live and work close to them. This is a role beyond protecting people from the risk of injury or poor air quality. Streets that increase social contact or walking and rather are health promoting environments. This helps to address transport challenges of people walking or cycling short distances.

There is now a large and continually growing evidence base that sets out how people use places such as streets and how to encourage more walking and cycling for travel.[106] This has a wider impact on wellbeing as greater amounts of walking for transport improve the sense of community or community cohesion.[107] [108] [109]

The WMCA has approved cycle design guidance for the West Midlands to achieve high standards for key cycling routes. The Guidance can be used to develop spaces that encourage physical activity and social contact and reduce conflict between pedestrians and cyclists.

We will set out the evidence base for a healthy and active street environment that create better conditions for walking and improve community cohesion. This will provide a benchmark that streets can be evaluated against and set principles to enhance the public realm and local conditions for active travel.

We will work with constituent members to trial and evaluate a series of healthy and active streets projects over the next 2 years.



Walking and cycling is a pleasure	The street carries people efficiently and wayfinding is clear	The air is safe to breath and the noise does not interrupt daily life
The design of the street promotes wellbeing	People of all abilities are able to use and cross the street	Traffic speeds are set to not cause fatal injuries in a collision
People living there know each other and there is opportunity to socialise	The street is well connected to places people want to go	The street is designed to protect the most vulnerable from harm

10. References

[1] ONS. What affects an area's healthy life expectancy? (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/articles/whataffectsanareashealthylifeexpectancy/2018-01-18) (Accessed 13/11/2017)
[2] Barnett K. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet 2012; 380: 37–43
[3] Loomis D et al, for the International Agency for Research on Cancer Monograph Working Group. The carcinogenicity of outdoor air pollution. Lancet Oncol 2013;14:1262–63
[4] Carslaw D et al. Trends in NOx and NO2 emissions and ambient measurements in the UK. DEFRA. July 2011.
[5] Barnes J and Chatterton T. An environmental justice analysis of exposure to traffic-related pollutants in England and Wales. WIT Transactions on Ecology and the Environment. 2017;210:431-442.
[6] Karagulian F et al. Contribution to cities' ambient particulate matter (PM) A systematic review of local source contributions at global level. Atmospheric Environment. 2015;120:475-483
[7] Air Quality Expert Group. Fine Particulate Matter (PM 2.5) in the United Kingdom. 2012
[8] Beelen R et al. Effects of long-term exposure to air pollution on natural-cause mortality: an analysis of 22 European cohorts within the multicentre ESCAPE project. Lancet 2014; 383: 785–95

[9] Ole Raaschou-Nielsen O et al. Air pollution and lung cancer incidence in 17 European cohorts: prospective analyses from the European Study of Cohorts for Air Pollution Effects (ESCAPE). Volume 14, No. 9, p813–822, August 2013
[10] Public Health England. 3.01 - Fraction of mortality attributable to particulate air pollution. Public Health Outcomes Framework. 2015.
[11] Shah P et al. Air pollution and birth outcomes: a systematic review. Environment international. 2011;37:498-516.
[12] Woodruff T et al. The relationship between selected causes of postneonatal infant mortality and particulate air pollution in the United States. Environmental health perspectives. 1997;105:608.
[13] Glinianaia S et al. Does particulate air pollution contribute to infant death? A systematic review. Environmental health perspectives. 2004;1:1365-70.
[14] COMEAP. Does Outdoor Air Pollution Cause Asthma?
[15] Bowatte G et al. The influence of childhood traffic-related air pollution exposure on asthma, allergy and sensitization: a systematic review and a meta-analysis of birth cohort studies. Allergy. 2015;70:245-56.
[16] Khreis H et al. Exposure to traffic-related air pollution and risk of development of childhood asthma: a systematic review and meta-analysis. Environment International. 2016;21
[17] Public Health England. Hospital admissions for asthma (under 19 years). Public Health Outcomes Framework. 2015/16
[18] Suades-González E et al. Air Pollution and Neuropsychological Development: A Review of the Latest Evidence Endocrinology. 2015;156:3473–3482
[19] Simoni M et al. Adverse effects of outdoor pollution in the elderly. J Thorac Dis. 2015; 7: 34–45.
[20] Henschel S et al. Trends of nitrogen oxides in ambient air in nine European cities between 1999 and 2010. Atmospheric Environment. 2015; 117: 234-241.
[21] TNO. Emission factors for diesel Euro-6 passenger cars, light commercial vehicles and Euro-VI trucks. 2016
[22] Calculated from: DEFRA. 2017 NO_2 Projections from 2015 data. (https://uk-air.defra.gov.uk/library/no2ten/2017-no2-projections-from-2015-data Accessed December 2017)
[23] Faustini A et al. Nitrogen dioxide and mortality: review and meta-analysis of long-term studies. European Respiratory Journal. 2014; 44:744-53.
[24] Hamra G et al. Lung cancer and exposure to nitrogen dioxide and traffic: a systematic review and meta-analysis. Environmental health perspectives. 2015;123:1107.
[25] Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers. 2011
[26] Sport England. Active Lives, Adult Survey. May 16/17 report. Published October 2017.
[27] Sport England. Active Lives, Adult Survey. May 16/17 report. Published October 2017.
[28] Celis-Morales C et al. Association between active commuting and incident cardiovascular disease, cancer, and mortality: prospective cohort study. BMJ. 2017;357:j1456. Original Article, submitted September 2016.
[29] Stewart G et al. Quantifying the contribution of utility cycling to population levels of physical activity: an analysis of the Active People Survey. Journal of Public Health. 2016;38: 644–652.
[30] Lee I-M et al. Impact of Physical Inactivity on the World's Major Non-Communicable Diseases. Lancet. 2012; 380: 219–229.
[31] Guenther S et al. Domains of physical activity and all-cause mortality: systematic review and dose–response meta-analysis of cohort studies. International Journal of Epidemiology 2011;40:1382–1400
[32] Woodcock J et al. Non-vigorous physical activity and all-cause mortality: systematic review and meta-analysis of cohort studies. International Journal of Epidemiology. 2010;40:121-38.
[33] Kelly et al. Systematic review and meta-analysis of reduction in all-cause mortality from walking and cycling and shape of dose response relationship. International Journal of Behavioral Nutrition and Physical Activity. 2014,11:132
[34] Kelly et al. Systematic review and meta-analysis of reduction in all-cause mortality from walking and cycling and shape of dose response relationship. International Journal of Behavioral Nutrition and Physical Activity. 2014,11:132
[35] Celis-Morales C et al. Association between active commuting and incident cardiovascular disease, cancer, and mortality: prospective cohort study. BMJ. 2017;357:j1456
[36] Hupin D et al. Even a low-dose of moderate-to-vigorous physical activity reduces mortality by 22% in adults aged≥ 60 years: a systematic review and meta-analysis. Br J Sports Med. 2015 Jul 2:bjsports-2014.

[37] Hamer M and Chida Y. Active commuting and cardiovascular risk: a metanalytic review. Preventive Medicine 2008;46: 9–13.
[38] Saunders L et al. What Are the Health Benefits of Active Travel? A Systematic Review of Trials and Cohort Studies. PLoS ONE. 2013;8:e69912.
[39] G. Hu. Occupational, commuting, and leisure-time physical activity in relation to risk for Type 2 diabetes in middle-aged Finnish men and women. Diabetologia (2003) 46:322–329
[40] Sato K et al. Walking to work is an independent predictor of incidence of Type 2 diabetes in Japanese men. Diabetes Care. 2007;30:2296-8.
[41] Smith A et al. Physical activity and incident type 2 diabetes mellitus: a systematic review and dose–response meta-analysis of prospective cohort studies. Diabetologia. 2016;59:2527–2545.
[42] Public Health England. 2.12 - Percentage of adults (aged 16+) classified as overweight or obese - historical method. Public Health Outcomes Framework. 2013-15
[43] Government Office for Science. Foresight report. Tackling Obesities: Future Choices– Project Report 2nd Edition. 2007
[44] Martin A et al. Impact of changes in mode of travel to work on changes in body mass index: evidence from the British Household Panel Survey. J Epidemiol Community Health. 2015 Apr 3:jech-2014.
[45] Flint E et al. Change in commute mode and body-mass index: prospective, longitudinal evidence from UK Biobank. Lancet Public Health 2016;1:e46–55
[46] Public Health England. 2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds. Public Health Outcomes Framework. 2015/16.
[47]Hamer M. Dose–response relationship between physical activity and mental health: the Scottish Health Survey. Br. J. Sports Med. 2009;43:1111–1114
[48] Mammen G and Faulkner G. Physical Activity and the Prevention of Depression. A Systematic Review of Prospective Studies. Am J Prev Med. 2013;45:649–657
[49] Rebara A. A meta-meta-analysis of the effect of physical activity on depression and anxiety in non-clinical adult populations. Health Psychology Review. 2015;9: 366–378
[50] Public Health England. 1.09 - Sickness absence. Public Health Outcomes Framework. 2015/16.
[51] Kerr J and Vos M. Employee fitness programmes, absenteeism and general well-being. Work Stress. 1993;7: 179–90
[52] Song T at al. Absenteeism, employee turnover and sustained exercise participation. J Sports Med. 1982;22:392-399
[53] Baun W et al. A preliminary investigation: Effect of a corporate fitness program on absenteeism and health care cost. J Occup Med. 1986;28:18-22
[54] Eriksen W and Bruusgaard D. Physical leisure-time activities and long-term sick leave: a 15-month prospective study of nurses' aides. J Occup Environ Med. 2002;44:530-538.
[55] Lechner L et al. Effects of an employee fitness program on reduced absenteeism. J Occup Environ Med. 1997; 39:827-831.
[56] van Amelsvoort LG et al. Leisure time physical activity and sickness absenteeism; a prospective study. Occup Med. 2006;56:210 – 212.
[57] Mytton O. Longitudinal associations of active commuting with wellbeing and sickness absence. Preventive Medicine. 2016; 84: 19-26
[58] Hendriksen I et al. The association between commuter cycling and sickness absence. Prev Med. 2010;51:132-5
[59] Song Y et al. New walking and cycling infrastructure and modal shift in the UK: A quasi-experimental panel study. Transportation research part A: policy and practice. 2017;95:320-33.
[60] Fraser S and Lock K. Cycling for transport and public health: a systematic review of the effect of the environment on cycling. European journal of public health. 2011;21:738-43.
[61] Pucher J et al. Infrastructure, programs, and policies to increase bicycling: an international review. Preventive medicine. 2010;50:S106-25.
[62] Aldred R et al. Cycling provision separated from motor traffic: a systematic review exploring whether stated preferences vary by gender and age. Transport reviews. 2017; 37:29-55.
[63] NICE Guidance. Physical activity: walking and cycling. 2012
[64] Galea S. Urban built environment and depression: a multilevel analysis. J Epidemiol Community Health. 2005;59:822–827
[65] G Yi et al. A systematic review of the relationship between objective measurements of the urban environment and psychological distress. Environment International. 2016;96:48–57

[66] Olsson C et al. Adolescent resilience: a concept analysis. J Adolesc. 2003;26:1-11
[67] Cacioppo J et al. Loneliness as a Specific Risk Factor for Depressive Symptoms: Cross-Sectional and Longitudinal Analyses. Psychology and Aging. 2006; 21: 140–151.
[68] Cacioppo J. Perceived Social Isolation Makes Me Sad: Five Year Cross-Lagged Analyses of Loneliness and Depressive Symptomatology in the Chicago Health, Aging, and Social Relations Study. Psychol Aging. 2010; 25: 453–463.
[69] Leigh-Hunt N et al. An overview of systematic reviews on the public health consequences of social isolation and loneliness. Public health. 2017; 152:157-71.
[70] Leyden K. Social Capital and the Built Environment: The Importance of Walkable Neighborhoods. Am J Public Health. 2003;93:1546–1551
[71] Mazumdar S et al. The Built Environment and Social Capital: A Systematic Review. Environment and Behavior. 2017:0013916516687343.
[72] Hart J and Parkhurst G. Driven To Excess: Impacts of Motor Vehicles on the Quality of Life of Residents of Three streets in Bristol UK
[73] Mindell J and Karlsen S. Community severance and health: what do we actually know?. Journal of Urban Health. 2012;89:232-46.
[74] Chatterjee K. The Commuting and Wellbeing Study https://travelbehaviour.com/outputs-commuting-wellbeing/ (last accessed December 2017)
[75] Kunn-Nelen A. Does commuting affect health? Available online at: http://ftp.iza.org/dp9031.pdf (last accessed December 2017)
[76] RSPH. Health in a Hurry. 2006.
[77] Loong C et al. On time and ready to go: An analysis of commuters' punctuality and energy levels at work or school. Transportation Research Part F. 2017; 45: 1–13
[78] Carsten
[79] Reason J. Human error: models and management. BMJ. 2000; 320: 768–770.
[80] Stigson H et al. Use of fatal real life crashes to analyse a safe road system model, including the road user, the vehicle, and the road. Traffic Inj Prev. 2008;9:463-71.
[81] Wundersitz L and Baldock M. The relative contribution of system failures and extreme behaviour in South Australian crashes. CASR Report CASR092. 2011
[82] Rosén, E. et al. Literature review of pedestrian fatality risk as a function of car impact speed. Accident Analysis and Prevention. 2011; 43: 25-33
[83] PHE. Reducing unintentional injuries on the roads among children and young people under 25 years. 2014
[84] Jacobsen P L et al. Who owns the roads? How motorised traffic discourages walking and bicycling. Injury Prevention. 2009;15:369–373
[85] RoSPA. Social Factors in Road Safety. 2012
[86] Public Health England. Children killed or seriously injured in road traffic accidents. Public Health Outcomes Framework. 2014-16.
[87] Li L et al. Physical and psychological effects of injury: data from the 1958 British birth cohort study. The European Journal of Public Health. 2001;11:81-3.
[88] Ameratunga S et al. A Population-Based Cohort Study of Longer-Term Changes in Health of Car Drivers Involved in Serious Crashes. Ann Emerg Med. 2006;48:729-736
[89] Jeavons S. Predicting who suffers psychological trauma in the first year after a road accident. Behaviour Research and Therapy. 2000;38: 499-50
[90] Andringa T and Lanser J. How pleasant sounds promote and annoying sounds impede health: A cognitive approach. International journal of environmental research and public health. 2013; 10:1439-61.
[91] WHO. Night noise guidelines for Europe. 2009
[92] DEFRA. Noise exposure data – England. 2014 (https://data.gov.uk/dataset/noise-exposure-data-england accessed December 2017)
[93] WHO. Burden of disease from environmental noise. 2011.
[94] Fu W et al. Association between exposure to noise and risk of hypertension: a meta-analysis of observational epidemiological studies. J Hypertens. 2017; 35:2358-2366
[95] Clark C et al. Association of Long-Term Exposure to Transportation Noise and Traffic-Related Air Pollution with the Incidence of Diabetes: A Prospective Cohort Study. Environ Health Perspect. 2017;125:087025.
[96] Nieuwenhuijsen M et al. WHO Environmental Noise Guidelines for the European Region: A Systematic Review on Environmental Noise and Adverse Birth Outcomes.Int. J. Environ. Res. Public Health 2017:14;1252.

[97] Shiue I. Neighborhood epidemiological monitoring and adult mental health: European Quality of Life Survey, 2007–2012. Environmental Science and Pollution Research. 2015; 22: 6095–6103
[98] Dreger S. Environmental noise and incident mental health problems: A Prospective cohort study among school children in Germany. Environmental Research. 2015;143:49–54
[99] Lercher P. Ambient neighbourhood noise and children's mental health. Occup Environ Med 2002; 59:380–386
[100] WHO. Guidelines for community noise. 1999.
[101] PHE. Heatwave plan for England. Making the case: the impact of heat on health – now and in the future. 2015.
[102] PHE. Heatwave plan for England. 2015
[103] Heaviside C et al. The effects of horizontal advection on the urban heat island in Birmingham and the West Midlands, United Kingdom during a heatwave. Quarterly Journal of the Royal Meteorological Society. 2015;141:1429-1441.
[104] Heaviside C et al. Attribution of mortality to the Urban Heat Island during heatwaves in the West Midlands, UK. Environmental Health. 2016;15:49-59.
[105] Woodcock J et al. Public health benefits of strategies to reduce greenhouse-gas emissions: urban land transport. Lancet. 2009; 374: 1930–43
[106] A.E. Bauman and F.C. Bull. Environmental Correlates of Physical Activity And Walking in Adults and Children: A Review of Reviews. Review undertaken for National Institute of Health and Clinical Excellence. February 2007
[107] French S et al. Sense of Community and Its Association With the Neighborhood Built Environment. Environment and Behavior. 2014;46:677–697
[108] Leyden K. Social capital and the built environment: The importance of walkable neighborhoods. American Journal of Public Health. 2003; 93:1546-1551
[109] Lund H. Pedestrian environments and sense of community. Journal of Planning Education and Research. 2002; 21: 301-312.

This page is intentionally left blank

Healthy and Active Street: Evidence Statement
Draft 04/01/2018

1. Healthy and active streets: an evidence statement

Streets are a community asset that can improve the health and happiness of people in the West Midlands. They can be designed to by protecting people from harms associated with travel, or to promote health and wellbeing by increasing social contact between neighbours or the amount of activity that people get.

Good quality street environments in the right place can help to solve the problems of congestion and delays on the road network. Around 2 out of every 5 journeys under 2 miles in the West Midlands are made by car. Walking and cycling can be encouraged over these distances, yet proportion of trips that are walked is declining. In more walkable cities, journeys happen by foot in the morning and afternoon rush hours, and during the day at weekends. [1]

This is where streets can play a role. Even when only considering a small number of easily measured characteristics of streets and the urban environment, places that encourage walking increased everyone's amount of physical activity by 20 minutes each week. For many, this will be enough to prevent inactivity and the harms from it.[2]

There are no cost barriers to walking around a friendly urban space, and for this reason more walkable streets can reduce the inequalities seen in physical activity. Increasing the number of steps in the most inactive can be four times more effective at reducing obesity rates than if those steps were split between everyone. Cities with a more walkable environment have lower inequalities in the amount of activity.[1]

A more walkable environment has an influence on people's behaviour, and the amount of walking that they do. One study tracked the behaviour of people who moved between areas with a high and low walkability. People who moved to areas with a higher walkability increased the amount of walking they did for travel. Similarly, the longer that someone lived in a more walkable environment, the more walking they did. This influence was true amongst people who were previously inactive.[3]

There is strong evidence that walking and cycling improves health. There is now a large and continually growing evidence base that sets out how the built environments and streets encourage more walking and cycling for travel.[4] However the evidence has not been brought together and the links between different areas of health have not been made. This evidence statement addresses that gap.

Walking and cycling is a pleasure	The street carries people efficiently and wayfinding is clear	The air is safe to breath and the noise does not interrupt daily life
The design of the street promotes wellbeing	People of all abilities are able to use and cross the street	Traffic speeds are set to not cause fatal injuries in a collision
People living there know each other and there is opportunity to socialise	The street is well connected to places people want to go	The street is designed to protect the most vulnerable from harm

The characteristics of a healthy and active street

Walking and cycling is a pleasure

Streets that make people feel happy are more likely to be used. This is not easy to measure, but is important to acknowledge to make sure that streets are designed to improve people's wellbeing.

The science is developing to capture this emerging agenda. Questions about aesthetics, or the number of interesting things to look at, are often used to measure this relationship. The amount of walking for leisure rather than travelling also reveals streets that a preference to use some environments.

The attractiveness of buildings and connection with natural sights have been identified as aesthetic reasons why people might choose to walk for leisure. This is related to the total amount of physical activity that people do.[5,6,7] The strength of the relationship is not always the same in each country, but it is also be one of the largest influences of whether people walk for leisure or not.[8]

Places that visually stimulate people are most likely to be aesthetically pleasing. It has been argued that the most visually attractive places offer new details every 4 or 5 seconds.[9]

Changing arrangements of the traffic and lay out of the street also offers a way to increase the prominence of existing features.[10]

The importance of engaging people and learning about the place can identify important features to draw out.[11]

Although the aesthetics of the environment increase both walking and cycling, people often rate the aesthetics of cities poorly, showing there is often potential to improve this characteristic of streets.[12] This is important to address as the look and feel of the street can often explain why people don't walk in what might otherwise seem to be a well-connected urban environment.[13]

The design of the street promotes wellbeing

Streets can promote mental wellbeing. The importance of parks and other greenery in promoting wellbeing and healthy living have wide impacts, going as far as helping to explain why people who walk in green spaces have longer life expectancies than people from similar backgrounds who walk the same amount in less green spaces.[14]

Green space improves wellbeing and has a positive impact on people's self-reported mood and feeling, and can help to reduce fatigue.[15] Greater visual connections can be made between the streets around the park and the green space itself and this promotes easy access. Well-designed green spaces encourage greater use.[9]

Elsewhere, there are opportunities to introduce natural elements such as plants and running water into streetscapes. Green walls are one way to incorporate natural landscape elements into the environment.[11]

There is generally positive although mixed evidence about whether green space directly reduces clinical diagnoses of mental health issues[16]. The quality of research on this area has generally been low and there is an important developing research agenda on how street design influences wellbeing and resilience.

The provision of high quality parks and open spaces has been shown to increase walking and physical activity, especially in the elderly [5,17,18]

Other ways of improving wellbeing are to give people a greater feeling of control over the environment. Designs that encourage the use of the space, such as movable furniture or other interactive features and invite participation and make people feel more empowered.[11]

Engaging communities and understanding the needs of groups who use the street can draw out more opportunities to improve wellbeing.[11]

Streets can have a positive role on the mental wellbeing and development of children, and t is important to look beyond playgrounds when considering how to design public space for children. Children often have different needs for independent active play than is typically provided, and currently many urban spaces do not have the diverse range of flexible play spaces that children prefer.[19]

Children in neighbourhoods with less traffic have more positive feelings about their neighbourhoods and this in turn increases their connection with the local area and development. Children can draw more accurate maps of the areas where they enjoy playing.[20]

People living there know each other and there is opportunity to socialise

Improving both health and social cohesion are often achieved by taking the same approaches to urban design. Busy roads reduce the social cohesion of neighbourhoods by weakening the number and strength of friendships on the street. The sense of community is an important aspect of feeling

safe and walking in urban environments[21] and lower levels of social cohesion can reduce the amount of walking.

As well as social contact having a positive impact on mental health, there is a positive knock on effect that people who can walk with someone else are more likely to do so for exercise.[7]

A walkable environment will have an impact on other important issues. Greater amounts of walking for transport improve the sense of community or community cohesion.[21,22,23]

Streets can be designed to encourage interactions. This can be done by providing spaces to meet around focal points and which are accessible to children, families and people of all abilities. High streets particularly benefit from this type of focal point and this approach can re-enforce them as the heart of neighbourhoods.[24]

Housing developments that have low traffic or are traffic free promote social contact. Public spaces that are shared or have direct access from housing have more community activity.[9]

The street carries people efficiently and wayfinding is clear

Active streets can carry people efficiently. Manual for Streets recommends a hierarchy of user priorities, with the needs of more physically active modes such as walking or cycling considered first, followed by public transport and then private vehicles.

This approach can help to produce the walking-friendly infrastructure that does increase the amount of walking.[5] This is true overall as well as in specific groups, and pedestrian infrastructure increases the likelihood of children walking to school[25] and walking amongst the more elderly.[17]

Similarly where cycling and walking tracks are provided, including alternative routes, it can help people maintain the amount of walking that they do over time or increase the amount of walking in people who had otherwise stopped.[26]

People of all abilities feel safe and able to use and cross the street

The feeling of safety can have a large influence on whether people walk or cycle. Environments that appear unsafe reduce the amount of walking.[5,26] This is especially true in some groups, and poor perceived safety is likely to reduce the amount of walking that women do during the day[27] and the elderly.[17]

People might feel unsafe for a range of reasons. The fear of crime has been linked with decreased walking26 fear of traffic also discourages walking and cycling[28] with traffic speed and volume on roads influencing perceptions of safety. 17,18

Given some of these perceived barriers, supporting people to cross the road is a way to mitigate some of these issues. However, research consistently shows that times at pedestrian crossings do not give sufficient time for elderly individuals to cross.[29,30,31]

One way of reducing crossing time is to reduce crossing distances by using build outs that narrow the road at the crossing. Wider crossings also increase the feeling of comfort in busy spaces.[10]

People use many visual environmental clues that tell them about the safety of the environment, including litter, vandalism and decay[17] benches and other places to sit[17] and also the presence and

condition of pavements and lighting. [32,33] The same is true of likely destinations, and suitable and well maintained pavements close to places of work increase the amount of walking to work.[34]

There is some developing evidence that noise and air quality are also factors that influence perceptions of safety.[35]

The street is well connected to places people want to go

Well-connected streets increase the amount of walking. Sometimes land use mix is used as a proxy of residential areas closer to places of work, and this does increase walking for leisure as well as travel.[8,17,36] Some studies found residential density as the important factor instead.[2]

Accessible shops and services has been repeatedly and strongly linked to increased amount of walking [5,17,26,27,36,37]. Making shops accessible by foot is an important part of increasing footfall to creating social high streets. Being able to get to shops can have a huge impact on the quality of life of elderly residents in particular.[9]

Parks or other green space are another important local asset that increases the amount of walking [5,26,27,38] showing the importance of local or communal green space as well as green design being integrated into the built environment. Children in particular can benefit from local green space as they do not travel as far from home.

Transport connections also increase the amount of walking, and either the total number of transport connections[2] or how close by they are 34,36 are important factors.

As well as destinations, streets need to be well connected themselves. Direct routes increase the amount of walking[36] Cul-de-sacs and dead ends decrease walking, especially for leisure, and areas with fewer cul-de-sacs have more walking.[8]

Connected walking routes that connect popular destinations are important. If they are provided in places where they are not needed then they are unlikely to be used well.[9] A reallocation of road space for more active forms of transport or closing roads off to some traffic can help to locate infrastructure in the right place. [39] A mix of social public spaces, local landmarks and interesting frontages can create more interesting walking routes.[10]

The air is safe to breath and the noise does not interrupt daily life

Protecting people from the harmful impacts of environmental hazards such as noise and poor air quality are fundamental to the role of streets. People are often aware of the type of environments that have poor air quality and it is related to their experience of streets.[40]

On a street level, this can also include designs to reduce exposure to individuals, especially including buildings such as nurseries, schools and care homes that more vulnerable individuals are likely to access. Street layouts can also avoid the build-up of pollution in areas where people are expected to use and landscape trees and other vegetation can also be methods of reducing exposure to air pollution where they don't restrict ventilation.[41] In some areas, vegetation has been used to reduce noise. NYC
Environments with high buildings might cause air pollution to build up on streets that people use and these should be avoided. NICE DISABILOITY

Traffic speeds do not cause fatal injuries in a collision

Approaches to safety such as Vision Zero in Sweden and Sustainable Safety in the Netherlands are endorsed by WHO and stress the importance of a forgiving environment. These make it unlikely that a crash results in a death. The WHO set out the following key principles that inform a Safe System approach and speed limit setting:

- people do make errors when using the roads, and that can result in a death. These errors can be reduced through behaviour change but are not entirely preventable
- people are vulnerable to injury in a crash. The greater the speed of a collision, the more likely the injury is to be fatal.
- the responsibility for safety is shared between the road designers as well as the road users
- it is unacceptable that common errors lead to deaths and these are not inevitable in a crash
- streets play a wider role in society beyond ensuring safety, including economic development and improving health [42,43]

Town or city wide 20mph speed limits are a recommended way to reduce vehicle speeds, and can be particularly effective when used alongside measures such as raised junctions. Engineering measures to provide safe routes can be considered where children are likely users. [44]

The street is designed to protect the most vulnerable from harm

There are a wide range of potential harms that arise from transport and travel that have been highlighted throughout this strategy. The needs of the most vulnerable users and children need to be considered during street design.

Seats with arms and backrests can be important to encourage many groups to walk and can be used to add to the social life and informal surveillance of spaces.[9]

Maintained pavements to replace or prevent broken paving slabs can remove trip hazards and improve the feel of the environment. [10,45] Keeping pavements free from obstruction allows easier use for people with disabilities or parents with pushchairs. Dropped kerbs to street level or other ways to prevent steps between roads and pavements can be essential for many disabled users.[45]

2. References

[1] Althoff T et al. Large-scale physical activity data reveal worldwide activity inequality. Nature. 2017;547:336–339.
[2] Sallis et al. Physical activity in relation to urban environments in 14 cities worldwide: a cross-sectional study. 2016;387:2207–2217
[3] Wasfi R et al. Exposure to walkable neighbourhoods in urban areas increases utilitarian walking: Longitudinal study of Canadians. Journal of Transport & Health. 2016;3: 440–447
[4] A.E. Bauman and F.C. Bull. Environmental Correlates of Physical Activity and Walking in Adults and Children: A Review of Reviews. Review undertaken for National Institute of Health and Clinical Excellence. February 2007
[5] Barnett et al. Built environmental correlates of older adults' total physical activity and walking: a systematic review and meta-analysis. International Journal of Behavioral Nutrition and Physical Activity. 2017; 14:103
[6] Carnegie M et al. Perceptions of the Physical Environment, Stage of Change for Physical Activity, and Walking among Australian Adults. Research Quarterly of Exercise and Sport. 2002;73:146–155
[7] Ball K et al. Perceived Environmental Aesthetics and Convenience and Company are Associated with Walking for Exercise among Australian Adults. Preventive Medicine. 2001;33:434–440.
[8] Sugiyama T et al. Perceived neighbourhood environmental attributes associated with adults' recreational walking: IPEN Adult study in 12 countries. Health Place. 2014;28:22–30.
[9] World Health Organisation. Towards more physical activity: Transforming public spaces to promote physical activity — a key contributor to achieving the Sustainable Development Goals in Europe. 2017 (http://www.euro.who.int/__data/assets/pdf_file/0018/353043/2017_WHO_Report_FINAL_WEB.pdf accessed December 2017)
[10] IHE. Street Design for All. (https://www.theihe.org/wp-content/uploads/2014/12/street_design_2014.pdf accessed December 2017)
[11] NYC DDC. Design and Construction Excellence 2.0 Guiding Principles (https://www1.nyc.gov/assets/ddc/downloads/DDC-Guiding-Principles-2016.pdf accessed December 2017)
[12] Kerr et al. Perceived Neighborhood Environmental Attributes Associated with Walking and Cycling for Transport among Adult Residents of 17 Cities in 12 Countries: The IPEN Study. Environ Health Perspect. 124:290–298.
[13] Van Dyck D et al. Environmental perceptions as mediators of the relationship between the objective built environment and walking among socioeconomically disadvantaged women. International Journal of Behavioral Nutrition and Physical Activity. 2013;10:108
[14] Takano T et al. Urban residential environments and senior citizens' longevity in mega city areas: the importance of walkable green spaces. Journal of Epidemiology and Community Health, 2002;56: 913-18.
[15] Bowler D et al. A systematic review of evidence for the added benefits to health of exposure to natural environments. BMC Public Health. 2010;10:456.
[16] Mireia G et al. Mental Health Benefits of Long-Term Exposure to Residential Green and Blue Spaces: A Systematic Review. Int. J. Environ. Res. Public Health. 2015;12:4354-4379
[17] Cerin E at al. The neighbourhood physical environment and active travel in older adults: a systematic review and meta-analysis. International Journal of Behavioral Nutrition and Physical Activity. 2017;14:15
[18] McCormack G and Shiell A. In search of causality: a systematic review of the relationship between the built environment and physical activity among adults. Int J Behav Nutr Phys Act. 2011;8(1):125
[19] Lee et al. A meta-study of qualitative research examining determinants of children's independent active free play. International Journal of Behavioral Nutrition and Physical Activity. 2015;12:5
[20] Appleyard B. The meaning of livable streets to school children: An image mapping study of the effects of traffic on children's cognitive development of spatial knowledge. Journal of Transport & Health. 2017;5:27–41
[21] French S et al. Sense of Community and Its Association With the Neighborhood Built Environment. Environment and Behavior. 2014;46:677–697
[22] Leyden K. Social capital and the built environment: The importance of walkable neighborhoods. American Journal of Public Health. 2003; 93: 1546-1551.
[23] Lund H. Pedestrian environments and sense of community. Journal of Planning Education and Research. 2002;21: 301-312.
[24] ARUP. Cities Alive: designing for urban childhoods (https://www.arup.com/-/media/arup/files/publications/c/cities_alivedesigning_for_urban_childhoods.pdf accessed December 2017)
[25] Saelens B and Handy L. Built Environment Correlates of Walking: A Review. Med Sci Sports Exerc. 2008;40(7 Suppl):S550–S566

[26] Sugiyama T et al. Neighborhood environmental attributes and adults' maintenance of regular walking. Medicine & Science in Sports & Exercise. 2015;47(6):1204–1210
[27] Foster C et al. Environmental perceptions and walking in English adults. J Epidemiol Community Health. 2004;58:924–92
[28] Jacobsen P L et al. Who owns the roads? How motorised traffic discourages walking and bicycling. Injury Prevention. 2009;15:369–373
[29] Musselwhite C. Environment–person interactions enabling walking in later life. Transportation planning and technology 2015;38: 44-61.
[30] Asher et al. Most older pedestrians are unable to cross the road in time: a cross-sectional study. Age and Ageing. 2012;41: 690–694.
[31] Webb E et al. Crossing the road in time: Inequalities in older people's walking speeds J Transp Health. 2017; 5: 77–83.
[32] Renalds. A systematic review of built environment and health. Fam Community Health. 33: 68-78
[33] Green J et al. Reduced street lighting at night and health: A rapid appraisal of public views in England and Wales. Health & place. 2015;34: 171-180.
[34] Adams A et al. Are perceptions of the environment in the workplace 'neighbourhood' associated with commuter walking? Journal of Transport & Health. 2016;3:479–484
[35] Calogiuri G and Chroni S. The impact of the natural environment on the promotion of active living: An integrative systematic review. BMC Public Health. 2014;14:873
[36] Ewing R and Cervero R. Travel and the Built Environment. Journal of the American Planning Association. 2010;76: 265-294
[37] Van Holle V et al. Relationship between the physical environment and different domains of physical activity in European adults: a systematic review. BMC Public Health. 2012;12:807
[38] Tzoulas K. Promoting Ecosystem and Human Health in Urban Areas using Green Infrastructure: A Literature Review. Landscape and Urban Planning. 2007;81: 167–178
[39] NICE. Physical activity: walking and cycling. 2012. PH41.
[40] Day R. Place and the Experience of Air quality. Health and Place. 2007;13:249-260
[41] NICE. Air pollution: outdoor air quality and health. NG70, 2017
[42] WHO. World report on traffic injury prevention, 2004
[43] Johansson R. Vision Zero – implementing a policy for traffic safety. Safety Sci. 2009;47:826-831
[44] NICE. Unintentional injuries on the road: interventions for under 15s. PH31. 2010.
[45] NICE. Physical activity and the environment (update). GID-PHG97. 2017.

This page is intentionally left blank

Wellbeing Board Meeting

Date	19 January 2018
Report title	Communication and engagement with the WMCA Wellbeing Board
Portfolio Lead	Councillor Bob Sleigh - Wellbeing and HS2
Accountable Chief Executive	Sarah Norman Email sarah.norman@dudley.gov.uk Tel (01384) 815201
Accountable Employee	Dr Jane Moore -Director of Prevention and Wellbeing Email Jane.Moore@wmca.org.uk Tel 0121 214 7039
Report to be/has been considered by	This paper will be considered by WMCA Programme Board

Recommendation(s) for action or decision:

The West Midlands Combined Authority (WMCA) Wellbeing Board is recommended to:

1. Agree the proposed approach to regular written updates from the Wellbeing Board to improve engagement with between the Wellbeing Board and local boards.

2. Approve the development of a format for communication as set out in Appendix 1.

1.0 Purpose

1.1 To set out a proposed approach to written updates from the Wellbeing Board and to seek feedback so that it can be used as a regular tool to inform stakeholders of progress and to engage them in action.

2.0 Background

2.1 Currently, the Minutes, Committee Reports and associated papers from previous Wellbeing Board Meetings are available to view on the WMCA website. However, a frequent action from the Board discussions is for Board members to disseminate key messages and to discuss the reports within their local forums.

2.3 Board members have access to written papers online to aid in disseminating and debating the boards work. However, this still requires Board members to pull messages together from across the papers presented to the board and the minutes of the meeting. Therefore in order to provide better support to Wellbeing Board members in engaging their local stakeholders it is suggested that a regular focussed summary of the outcomes and issues for local discussion is produced after each Board. This would provide a standard report for Board members to use with a range of stakeholders and also set out the issues where the WMCA Wellbeing Board would welcome feedback.

2.4 Following the August 2017 Board, a summary of agreed actions on the Wellbeing Priorities was sent to all Health and Wellbeing Boards to enable discussion and feedback on the priorities. This provides a basis for developing the Board Summaries.

2.5 The proposed written progress updates will support the board, and strengthen the dialogue and synergy with the work of local Health and Wellbeing Boards and also the work of Sustainability and Transformation Plans within the Combined Authority area.

3.0 Discussion

3.1 It is proposed that written updates will be prepared following each Wellbeing Board meeting. These updates will be agreed with the Chair and then distributed to stakeholders.

3.2 Appendix 1 provides an outline of how the current key work areas could be reported and would also include requests for feedback to the Board at the next scheduled Wellbeing meeting.

3.4 The proposed audience of the proposed written updates are those working in health and wellbeing in local authorities and other organisations. This includes Health and Wellbeing Boards, Association of Directors of Public Health and their respective local teams, Public Health England, NHS England and Sustainability and Transformation Partnerships.

4.0 Wider WMCA Implications

4.1 It is envisaged that adoption of additional communication updates from the Wellbeing Board will strengthen the work of other programmes within the WMCA. Population health and wellbeing is a key component in delivering other

priorities of the WMCA such as economic growth, skills and reforming public service.

5.0 Financial implications

5.1 There are no immediate financial implications.

6.0 Legal implications

6.1 There are no immediate legal implications.

7.0 Equalities implications

7.1 Effective communication with stakeholders will support WMCA equalities responsibilities.

8.0 Other implications

8.1 None noted.

9.0 Schedule of background papers

9.1 None.

10.0 Appendices

Appendix 1 – WMCA Wellbeing Board Progress Update (January 2018)

WMCA Wellbeing Board Progress Update

Wellbeing Board Context

In July 2017, the Wellbeing Board considered six potential wellbeing priorities for the West Midlands Combined Authority. These were;

- Long term conditions – cardiovascular disease and diabetes
- Prevention at a WMCA level – with options for a broad prevention programme linked to a long term condition or work focussed on a specific lifestyle issue such as obesity, smoking, alcohol, physical activity
- Children and Young People – mental wellbeing, resilience and good childdevelopment that supports effective transition into adulthood (i.e. getting into work)
- Transport – Active and other health impacts of
- Housing and the built environment
- The potential for delivering population and individual behaviour change across the WMCA

Of these, the areas of Cardiovascular Disease and Diabetes and Children and Young People were agreed to be developed further in the short term.

Progress

Full Minutes of recent meetings can be viewed here

The below is an overview of the progress of key work areas;

Children and Young People

Scoping work is being undertaken to set out the current position in the West Midlands. This involves collating available data and evidence, surveying current initiatives and best practice and also stakeholder involvement to create consensus where WMCA would add most value. Completion of scoping work is due for the end of December.

Lead – Jane Moore. E: Jane.Moore@wmca.org.uk

Cardiovascular Disease and Diabetes

Initial focus has been on improving levels of physical activity in children and adults. See below for further information on WMCA physical activity strategy; *West Midlands on the move*

Also conversations taking place 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.

Lead - Jane Moore. E: Jane.Moore@wmca.org.uk

WMCA Physical Activity Strategy – West Midlands on the Move

The strategy was launched in November 2017 and sets out proposed actions across 6 themes of; Transport and HS2 Growth, Housing and Land, Community Resilience, Creative and Digital, Skills for Growth and Employment and lastly, Wellbeing. A strategy group to direct implementation actions has been formed.

Lead: Simon Hall E:Simon.Hall@wmca.org.uk
Further information: https://www.wmca.org.uk/what-we-do/public-service-reform/west-midlands-on-the-move/

Thrive West Midlands Implementation

The WMCA Mental Health Action Plan was launched in January 2017. Progress is on-going in the following areas;

Employment and Employers

- Individual Placement Support trails
- Fiscal Incentive trials
- Wellbeing charter
- Social value procurement

Housing First

- Evidence gathered on existing models of Housing First
- From the evidence, a proposed model of Housing First being developed for testing
- Focus of the 2nd devolution deal in Nov 17 – see further detail below

Criminal Justice

- Engagement programme
- MH Treatment Requirements

Improving Care

- Primary Care Mental Health
- Merit Vanguard (Mental Health Provider approach)

Community Engagement

- Zero suicide ambition
- Mental Health literacy
- Global city network

Lead: Sean Russell. E: Sean.Russell@wmca.org.uk
Further information: https://www.wmca.org.uk/what-we-do/mental-health-commission/

Health and Transport Strategy

Transport for West Midlands (TfWM), the WMCA's transport arm, prepared a West Midlands Strategic Transport Plan – 'Movement for Growth' in 2017, with an accompanying 10 year delivery plan.

With Movement for Growth there is the ambition that transport will improve health. The Health and Transport Strategy will build upon this ambition and will identify synergies and connections between the different issues.

This strategy will also help develop the link between Movement for Growth and the health objectives of The West Midlands Combined Authorities Strategic Economic Plan. There are high level ambitions to improve healthy life expectancies and reducing inequalities in healthy life expectancies in the West Midlands. Accompanying this, there are objectives to reducing physical inactivity and sickness absence, carbon emissions and days of poor air quality.

By developing health and transport, the strategy will also help to link healthy travel with ambitions to managing demand for public services; improve productivity and closing the inequality gap. A draft strategy is currently under preparation.

Lead: Duncan Vernon. E: Duncan.Vernon@tfwm.org.uk

2nd Devolution Deal

The second Devolution Deal between government and the West Midlands Combined Authority was announced in the Chancellor's Autumn Budget Statement on 22 November 2017.

The agreement includes approval for the Housing First pilot to take place in the West Midlands, a new approach to tackling rough sleeping in the region. It also sets out continuing support for the work of the Mental Health Commission Thrive West Midlands.

Among the other measures in the devolution deal:

- Funding to create a Delivery Team to drive an ambitious house-building programme, and investment in high-tech economic sectors.
- The confirmation of £250m for transport infrastructure which will be used for the extension of the Midland Metro from Wednesbury to Brierley Hill. This includes support for the transfer of ownership of the non-operational section of the Round Oak to Walsall railway route.
- Establishing one of the first Skills Advisory Panels that will create new local partnerships to plan investment in skills around local labour market needs.
- A proposal to combine the Police and Crime Commissioner role into the responsibilities of the Mayor in time for elections in 2020.
- The creation of a digital hub in Birmingham as part of the TechNation programme and a share of a £2m pilot for Coventry and Warwickshire for ultra-fast broadband roll-out.
- A commitment to work alongside government to identify new funding opportunities to deliver high quality cycle infrastructure to achieve the aim of raising levels of cycling across the region to 5% by 2023.
- A commitment to work with the WMCA, Urban Growth Company and HS2 to ensure the maximum benefit from UK Central in Solihull.
- Funding to develop a business case to create a Regional Integrated Control Centre to improve resilience on the road, rail and tram networks.

This page is intentionally left blank

This report is PUBLIC
[NOT PROTECTIVELY MARKED

Wellbeing Board Meeting

Date	Friday 19 January 2018
Report title	West Midlands on the Move physical activity implementation.
Cabinet Member Portfolio Lead	Councillor Bob Sleigh – Deputy Mayor & Wellbeing Board Chair
Accountable Chief Executive	Sarah Norman Email sarah.norman@dudley.gov.uk Tel 01384 815201
Accountable Employee	Simon Hall Email simon.hall@wmca.org.uk Tel 0121 214 7093
Report to be/has been considered by	Cllr Kamran Caan Cabinet Member for Health and Sport, Coventry CC & WMCA Political Physical Activity Champion.

Recommendation(s) for action or decision:

The Wellbeing Board is recommended to:

1. Note the physical activity outcome of the West Midlands Devolution deal and discussions with Local Authorities and the approve a collaborative approach to work Government, local authorities and commissioning agents to pilot work to get more people active.
2. Congratulate Birmingham, Coventry and Solihull for their considerable success in securing major events and investment into sport and physical activity, for which the West Midlands will benefit.
3. Approval for the WMCA to open discussions on a West Midlands wide co-ordinated commitment (legacy) to get more people active leading to and post Games.
4. Agree to receive a report at the next meeting on the developing Sport England framework and the scope of the disability and physical activity work.

5. Approval the initial priorities set out in this report.

1.0 Purpose

1.1 The WMCA Wellbeing Board is timely given the significant recent sport, culture and physical activity announcements such as the City of Culture and Commonwealth Games which has the potential to increase economic growth and improve wellbeing and physical activity. This report seeks consideration and approval for a number of inter-connected West Midlands on the Move physical activity priorities.

2.0 Background

2.1 Following WMCA Board approval, the Mayor and Deputy Mayor launched the "West Midlands on the Move" Strategic Framework in November 2017. A strategic Framework, which aims to reduce the levels of physical inactivity and inequality that exists in the West Midlands. The West Midlands continues to have the highest levels of adult physical inactivity in England.

2.2 Too often physical activity has not been built into the way we live, work and travel as well as spending their leisure time. Too address this challenge at scale, we need to work collaboratively and further up the system. This is why West Midlands on the Move focuses on those WMCA responsibilities which have the greatest potential to get people moving and active including transport, housing and land, wellbeing, productivity, employment and skills as well as digital economy and community resilience. In doing so, contributing to the West Midlands Industrial Strategy and Inclusive growth.

2.4 The strategic framework provided the context for the physical activity elements in the 2nd Devolution Deal and the exciting announcements of the City of Culture, Commonwealth Games and Sport England's Place based pilots provides an important platform and new context to take forward the implementation of this work.

3.0 Physical Activity and Devolution

3.1 The West Midlands second devolution deal included discussions with Government to devolve some physical activity and policy resources to the West Midlands including the Primary School Sport Premium (Sugar Tax Levy and cycling/active travel). Although unsuccessful, the Government confirmed that increasing levels of physical activity and reducing inequalities is of the "utmost importance".

3.2 In the second devolution deal, Government added that "Government will work with the WMCA, Local Authorities and other commissioning agents to fund and deliver local pilots to get more adults and children and young people active". This provides an opportunity to demonstrate to Government our collaborative approach and the social value impact of getting more people active. A key feature of this work will be brokering new partnerships with commissioners to strengthen the potential to go back to Government with further proposals.

4.0 Commonwealth Games and City of Culture

4.1 The WMCA congratulates Coventry for winning the City of Culture 2021 and Birmingham for the Commonwealth Games. A great opportunity for West Midlands people, economic growth (pre, during and after) and a "once in a lifetime" opportunity to use international events to boost the economy; improve wellbeing and get more people active (and those who are active doing more). For example, Glasgow's Commonwealth Games contributed £740m to the Scottish economy. 2,100 additional jobs from 2007-2014 and also the prompt to introduce the City Cycle Hire scheme.

4.2 The City of Culture bid includes opportunities to encourage more people to move and be active around the City such as through its heritage trail, walking and cycling as well as volunteering.

4.3 The Commonwealth Games will see an exciting new volunteer/ ”Gamesmakers” programme for which we should encourage a commitment to improving mental wellbeing through volunteering. There is also lots of communication and opportunities about shaping a Commonwealth Games legacy focusing on grass roots and getting more people active. Rather than waiting for the Games to finish, West Midlands on the Move encourages a co-ordinated 4 year commitment across the West Midlands to getting more people active leading up to the Games which then beyond.

4.4 The WMCA is encouraging a co-ordinated West Midlands wide approach to take this forward and use the opportunity to work with Government that is set out in the response to Devolution 2 to deliver innovative pilots to get more people active. There is also additional Sport England funding available to support activity to get more people active alongside major events.

4.5 The WMCA seeks the Wellbeing Board’s approval to open discussions with Birmingham City Council and other local authorities and stakeholders to encourage a West Midlands wide approach to a West Midlands commitment to improve wellbeing and physically active leading to and beyond the Games and to report to the Board at the next meeting on the scope of this work.

5.0 Sport England and Birmingham and Solihull Placed Based Pilot

5.1 The other major sport announcement late last year was the success of Birmingham CC and Solihull MBC in being selected as 1 of the 12 national Sport England Place Based Pilots. Place based pilots focuses on working with communities to understand and address both the system and individual behaviour changes to get more people active. Birmingham’s and Solihull’s innovative partnership focuses on working with some of the deprived communities across the 2 Boroughs. This also includes a commitment to share learning across the West Midlands.

5.2 Coventry CC was not successful with its bid, however Sport England has agreed a commitment to work with the Council to take elements forward. This evidences the commitment to innovative pilots and collaboration across the West Midlands.

5.3 The Wellbeing Board also gave the WMCA approval to open discussions with Sport England. These have focused on West Midlands on the Move priorities and what could be achieved by working at a West Midlands level that brings added value and does not cut across their commitments to Local Authorities and organisations such as County Sport Partnerships. Sport England is designing a draft framework that connects their commitments across the West Midlands. We aim to work with the West Midlands on the Move Theme Group to shape this Sport England Framework bringing it to the next Wellbeing Board for consideration.

6.0 Immediate Implementation Priorities

6.1 Ongoing discussions with Local Authorities and stakeholders have shaped the WMCA immediate (first 2 year) priorities, where there is agreed added value in using resources across the WMCA. For example, the Strategy’s media “human power station” launch demonstrated the static exercise bikes outside Coventry station which can be used to charge phones. This has generated considerable interest from local taxi drivers as well as from other areas to consider how we can pilot similar schemes across the West Midlands with an emphasis on reducing sedentary behaviours.

6.2 This is best summarised in the diagram below. A detailed draft delivery plan will be brought to the next Wellbeing Board meeting. In addition outline business cases are being developed with the West Midlands on the Move Theme Lead Group:

6.3 At the heart of this work is reducing the inequalities that exist in those who are taking part which we have termed "inclusive physical activity growth."

7.0 Disability Centre of Excellence

7.1 Sport England's Annual Active Lives Survey suggests that 80.6% of disabled adults are physically inactive across the West Midlands 3 LEP geography. The WMCA hosted a round table on 11 January with 15 disability stakeholders to explore the aspiration of working together to get the West Midlands the leading area for active disabled people. This was chaired by Cllr Caan and there was a key note speech from the West Midlands Mayor, A short verbal report outlining the findings and initial next steps will be provided at the next meeting.

8.0 Financial implications

8.1 Consideration is been given to how the WMCA works with Local Authorities, other commissioning agencies and stakeholders and Government to fund local pilots to get more adults and children and young people physically active, as set out in West Midlands second Devolution Deal.

8.2 There is no immediate financial implications flowing from this report.

9.0 Legal implications

9.1 There are no immediate legal implication flowing from this report.

10.0 Equalities implications

10.1. The Strategic Framework focuses on reducing levels of inactivity and the inequalities that exist by women; disabled people; black, minority and ethnic communities; lower socio-economic groups and by age, especially adults 45 years plus.

10.2 The WMCA with the West Midlands Mayor is encouraging a collaborative approach to become the leading area of the number of disabled people who are physically active.

11.0 Other implications

11.1 There are no further implications.

11.0 Appendix

11.1 Human Power Station launch

Appendix 1

Mayor Andy Street teamed up with former Olympian David Moorcroft to launch a new keep fit campaign for the region.

They were at Coventry railway station to launch the West Midlands Combined Authority's (WMCA) physical activity strategy West Midlands On The Move

David, the Coventry-born former Olympic middle and long distance runner and ex-chief executive of UK Athletics, joined the Mayor, WMCA and Coventry City Council staff to demonstrate a 'human power station'.

David Moorcroft and Andy Street (opposite) at the launch West Midlands On The Move at Coventry railway station.

This uses exercise bikes to generate electricity – with a work-out at the same time.

Mr Street said: "This is an issue that matters to every single citizen in the West Midlands.

"Physical inactivity is bad in some parts of the region, especially in disadvantaged areas, and we cannot be comfortable that it is not up to the same standards everywhere.

"If we don't get this right there will be lots more demands on public services such as the NHS, and on our mental and physical health, so we must change trajectory around physical activity.

"By doing so we make the West Midlands the kind of place where active communities are vibrant and attract people into them, along with more inward investment."

David Moorcroft is a former middle and long-distance runner who represented Great Britain at the Montreal, Moscow and Los Angeles Olympics and held the world record for the 5,000 metres.

He said: "This scheme is a fantastic idea as the West Midlands suffers from some of the lowest levels of physical activity in the country.

"There are many reasons for this, so it's great to see the Mayor and leaders of the councils in the West Midlands working together to try and tackle it and get people active."

Cab drivers at the station were already queuing up for a go on the bikes and said they would like to see more.

Taxi driver Tara Heer said: “It’s great for us, so much better than sitting in cars all day – this is brilliant.

“It’s good to see the Mayor here promoting this and I think we need more - in the summer it is going to be packed.”

END

This page is intentionally left blank