

# Working Together for a Healthier Community

## BUSINESS PLAN 2009 – 2011

### (DRAFT FOR RELEASE)

The Birmingham Health and Wellbeing Partnership welcomes your feedback on  
the 2009-2011 Business Plan.

Please send your comments to our feedback page: [www.bhwp.nhs.uk/feedback](http://www.bhwp.nhs.uk/feedback)

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# Birmingham Health and Wellbeing Partnership

Alan Lotinga – BHWP Director



“As a new Director for the Partnership I feel I'm joining at an exciting time. This, our first business plan emphasises that sense of excitement but also begins to make plans about our next stages in development.

There is much we need to do to ensure we have a clear shared vision owned and set by all our stakeholders of what we want to achieve for the people of Birmingham.

This document will enable us to turn that vision into the robust and deliverable outcomes, with clear, shared robust systems, structures and processes to help us get there.

Your input on this is essential and welcomed, if we are to get this right. For that reason we have set aside not only the Summit on 19<sup>th</sup> March but a free, open, web-based opportunity for you to make detailed contributions to the structure, content and direction of the Business Plan. In doing this, we know that you will shape the Future of the Partnership, and a better, healthier Birmingham”.

## The Executive

Peter Hay (Birmingham City Council) – Chair of the Executive



"Over recent years we have been improving the way that we serve the people of Birmingham through a greater emphasis on partnership.

The Local Area Agreement and the City Strategic Plan have helped shape both our priorities and our long term goals. We want to ensure that we keep that focus and have agreed an annual business plan. In effect, for the first time, we have brought together in one place our plans to develop services and improve the health and wellbeing of Birmingham's people. We will continue to refine this annual plan as a way of adding value to the way we work.

This is an exciting time for partnership work in this city.

- the largest pooled budget in Britain
- new joint commissioning approaches
- a renewed energy in tackling health inequalities

This ambition and direction is laid out in this plan to guide you and also to hopefully inspire further contributions to our work."

Moira Dumma (South Birmingham PCT) – Vice Chair of the Executive



"We can often feel that the pace of change and the volume of work can become overwhelming, whether we are from the NHS, Local Government, Third or Independent Sectors.

But Partnerships like ours offer us a massive opportunity not just to deliver a shared agenda, but to shape it. Over the next few years, as is evident from this draft Business Plan, the Partnership will consolidate the work it has been doing and deliver real change for our citizens.

I am thrilled to be the Vice-Chair of the Partnership at such a time of change and development”.

Sandy Bradbrook



Heart of Birmingham PCT

Elaine Elkington



Birmingham City Council Housing Directorate

Sophia Christie



Birmingham East and North PCT

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## 1.1 Overview

The Birmingham Health and Wellbeing Partnership (BHWP) was established in 2005 to provide partnership arrangements for health, care and wellbeing agencies in the city of Birmingham. It plays a key part in delivering **Working together for a better Birmingham**, Birmingham's Local Area Agreement (LAA) 2008-11. The BHWP is a voluntary coalition of health and care agencies in the city of Birmingham consisting of the Birmingham City Council and the three Birmingham Primary Care Trusts (PCT);

1. Birmingham East and North (BEN) PCT
2. South Birmingham (SB) PCT
3. Heart of Birmingham (HOB) PCT

The aim of the BHWP is to maximise the impact of health, care and wellbeing services on the health of the people of Birmingham by adopting approaches to partnership which best serve this purpose.

Since 2005 the BHWP has overseen a number of important partnership achievements. Two of these, amongst others include:

1. The establishment and delivery of a 'Call to Quit' phone service. The service offers smokers citywide a single free phone number to ring for help and advice on quitting smoking
2. The establishment and delivery of a 'pregnancy fast track service'. The service aims to reduce infant mortality through a variety of initiatives including free pregnancy testing, access to a dedicated call centre and fast track referral to community midwives, amongst others

## 1.2 Joint Strategic Needs Assessment

Knowing the Birmingham community is the first step towards improving their health and wellbeing. The Joint Strategic Needs Assessment (JSNA) is the process through which we develop this knowledge.

The JSNA in Birmingham is a process that provides information about, and predicts the needs of the local population. The Birmingham approach to the JSNA is that it is a continuous, iterative process which combines overviews with deep dive thematic exercises. It integrates insights from many sources of information, including user and citizen feedback and engagement.

The JSNA is already providing us with information on the health of the people in Birmingham. We know that life expectancy is generally below the national average and that there are big differences between parts of the city. Although there have been improvements over the last ten years, Birmingham continues to suffer from significant health inequalities.

### 1.3 The BHWP Priorities

In developing its approaches to key priorities, the BHWP has sought to ensure local partnership arrangements are fit for purpose. In a number of areas, it is pooling resources and introducing new arrangements for partnership delivery.

The BHWP has identified four priority themes where progress is dependent on partnership working. These are:

1. Tackling Health Inequalities,
2. Personalised Care,
3. Joint Commissioning, and
4. Understanding needs and engaging with communities

The approach to **Tackling Health Inequalities** is based on three key principles: improving access to services that can help to improve health, helping people to adopt healthier lifestyles, and addressing the wider determinants of and influences on ill health.

The strategy for **Personalised Care** is that everyone should be able to live independently and have the best quality of life. This means improving the prevention of problems, enhancing the option of self-directed care, service developments to ensure the availability of high quality services, and developing internal capability to put this approach into practice.

More **Joint Commissioning** of services will be needed to reduce health inequalities and improve the health and wellbeing of people in Birmingham. The BHWP proposes to move forward through developing whole system approaches, putting in place common governance arrangements, and pooling resources.

### 1.4 Governance

New processes are being put in place to ensure sound planning, performance management and governance. A new annual planning process is being developed, of which this first business plan is a part. The intention is to move to a planning cycle that aligns with the operational and budget planning timetables of partner organisations.

The BHWP Executive provides the overall management and strategic direction for the Partnership. Its primary responsibility is to work within the framework established by the Local Area Agreement 2008-11. The Executive is an accountable body with the powers to delegate and enforce direct actions in pursuit of its objectives.

The BHWP is supported by a dedicated partnership team, led by the BHWP Director. The role of the Team is to work to ensure that BHWP priorities and plans both reflect and influence mainstream activities of partner organisations. The BHWP Team is being strengthened, and additional staff are to be recruited to enhance capacity for programme management and for information and intelligence.

The BHWP aims to have a fair, transparent and accessible approach to budget setting and financial management. Financial governance arrangements have been documented so that partners are clear about responsibilities and accountabilities. Arrangements are being put in place to strengthen the BHWP infrastructure to make it fit for purpose.

## 1.5 Performance Framework

The BHWP is developing a performance framework to ensure that key outcomes and targets are achieved and that any problems affecting the achievement of outcomes or delivery of interventions are quickly identified and resolved.

The BHWP Executive will prepare an annual report which summarises performance and progress for each theme and set targets for the next year.

## Section Summary

- The Birmingham Health and Wellbeing Partnership (BHWP) was established in 2005 to provide partnership arrangements for health, care and wellbeing agencies in the city of Birmingham. It plays a key part in delivering *working together for a better Birmingham*, Birmingham's Local Area Agreement (LAA) 2008-11.
- The BHWP has identified four priorities where progress is dependent on partnership working. These are Tackling Health Inequalities, Personalised Care, Joint Commissioning, and Understanding needs and engaging with communities
- The aim of the BHWP is to maximise the impact of health, care and wellbeing services on the health of the people of Birmingham by adopting approaches to partnership which best serve this purpose.
- In developing its approaches to key priorities, the BHWP has sought to ensure local partnership arrangements are fit for purpose. In a number of areas, it is pooling resources and introducing new arrangements for partnership delivery.
- This Business Plan is being produced to summarise what the BHWP is seeking to achieve and how it intends to do it. It brings together information to help partners understand the BHWP work and to help the BHWP to manage its delivery.
- This first BHWP Business Plan is work in progress, and it will be revised annually.

### 2.1 Profile - Birmingham Health and Wellbeing Partnership

The Birmingham Health and Wellbeing Partnership (BHWP) was established in 2005 to provide partnership arrangements for health, care and wellbeing agencies in the city of Birmingham. The original objectives of the Partnership were to

- Deliver government targets relating to health and social care – in particular, the targets within Birmingham's Local Area Agreement.
- Oversee priority work streams in health and social care.

The BHWP provides a vitally important function of taking a city-wide approach in delivering the Be Healthy outcomes of the Community Strategy and in meeting the health challenges facing the city. Its purpose is to reduce health inequalities, enable people to achieve better health outcomes and experience the best quality of life.

The BHWP is one of the seven thematic partnerships within Be Birmingham, the city's local strategic partnership. The work of the BHWP has increasingly focused on collaboration with Be Birmingham and the other thematic partnerships in recognition of its role in 'place-shaping' through 'the creative use of powers and influence to promote the general wellbeing of a community and its citizens'. In particular, the BHWP has established formal arrangements for joint working on

- Health of children and young people (with Children and Young People's Board)
- Housing (with Housing Strategic Partnership)
- Sport and physical activity (with Sports Strategic Partnership)
- Employment and worklessness (with Employment Strategy Group).

The BHWP fulfils its function through a small core Executive and a wider Partnership Summit. The Executive, which consists of the Chief Executives from Birmingham's three Primary Care Trusts together with the Executive Directors for Adults and Communities and for Housing and Constituencies of Birmingham City Council, meets monthly to coordinate and oversee the work of the BHWP. Its members are committed to partnership working and prioritise the business of the Executive. Figure 1 shows the PCT boundaries within the city.

The Summit meets quarterly and brings together the wider partnership: all NHS trusts in the city, relevant departments of Birmingham City Council, third sector organisations, and representatives of communities and service users. Further information on the governance of the BHWP is given in Section 7.

**Figure 1 - Birmingham Geography and PCT Service Area**



Since 2005 the BHWP has overseen a number of important partnership achievements,

Key Achievements for the Partnership	
✓	Preparation and implementation of a Floor Target Action Plan for tackling health inequalities
✓	The establishment and delivery of a 'Call to Quit' phone service. The service offers smokers citywide a single free phone number to ring for help and advice on quitting smoking
✓	The establishment and delivery of a 'pregnancy fast track service'. The service aims to reduce infant mortality through a variety of initiatives including free pregnancy testing, access to a dedicated call centre and fast track referral to community midwives, amongst others
✓	The procurement and implementation of a health bus that moves around the city providing information and screening services on the health of the male prostate
✓	The establishment of a citywide Public Health Information Team (PHIT)
✓	The establishment of b'well, a Lottery-funded initiative to improve mental health in Birmingham.
✓	The establishment of a Partnership website, <a href="http://www.bhwp.nhs.uk">www.bhwp.nhs.uk</a> providing a central point of information to the public on the BHWP
✓	The establishment of a Partnership Summit. Held on a quarterly basis, the Summit provides a great opportunity for the stakeholders and the wider Birmingham community to understand and provide input into the Partnership

Table 1 - Key achievements for the Partnership

## 2.2 Local Area Agreement

The BHWP plays a key part in delivering **Working together for a better Birmingham**, Birmingham's Local Area Agreement (LAA) 2008-11. Be Healthy is one of the five key outcomes on which the LAA is focused. This looks to reduce health inequalities and to shift the emphasis over time from secondary care to primary care and community care, with a greater focus on the customer and those with complex needs.

Be Healthy is delivered through three high level outcomes:

- Reduce inequalities in health and mortality across Birmingham and support more people to choose healthy lifestyles and improve their wellbeing
- Develop personalised care and support for older people and vulnerable children, young people and adults to live healthier, more independent and inclusive lives, and provide better support for people with long term conditions and their carers, including improving end of life care
- Improve the health of Birmingham's children and young people and protect them from potentially damaging lifestyles and behaviour.

Each high level outcome is underpinned by targets for improved performance on a number of key measures from the National Indicator Set.

In addition, the BHWP sees the importance of supporting the achievement of other LAA outcomes. These include

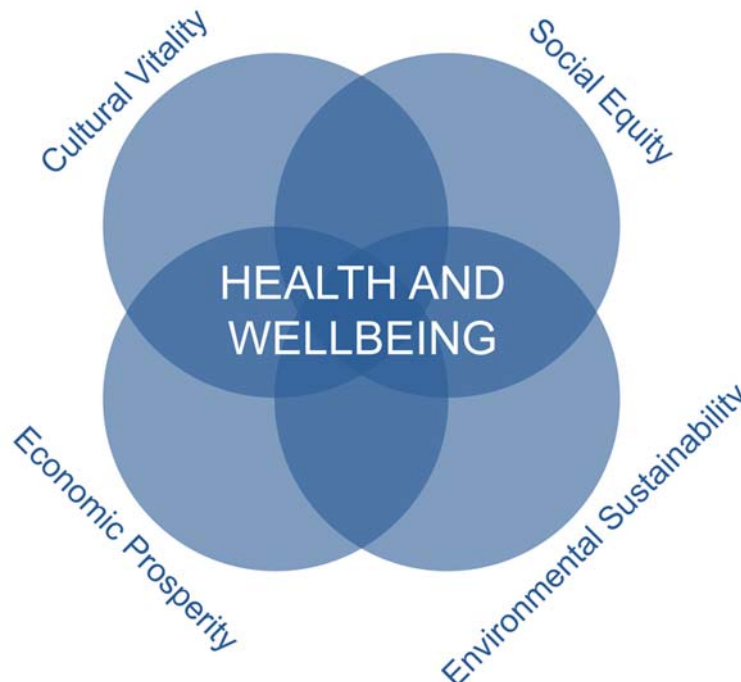
- Increase employment and reduce poverty across all communities through targeted interventions to support people from welfare to work
  - where the BHWP is supporting joint initiatives to reduce the impact of ill-health on worklessness
- Reduce re-offending through the improved management of offenders and effective treatment of drug and alcohol using offenders
  - where the BHWP is supporting initiatives for treating those with drug and alcohol problems
- Raise Birmingham's profile and attract more people, trade and opportunities through renowned facilities and events across the cultural, sport and creative sectors, and ensure residents have access to high quality facilities, programmes and activities locally
  - where the BHWP is supporting work to increase adult participation in sport and active recreation.

The BHWP is committed to working through partnership to achieve the LAA's vision of a better Birmingham.

### 2.3 Our Approach to Partnership

Health, care and wellbeing services in Birmingham are provided by BHWP partners and a range of other organisations in the public, private and voluntary sector. The role of the BHWP is to maximise the impact of this work on the health of the people of Birmingham.

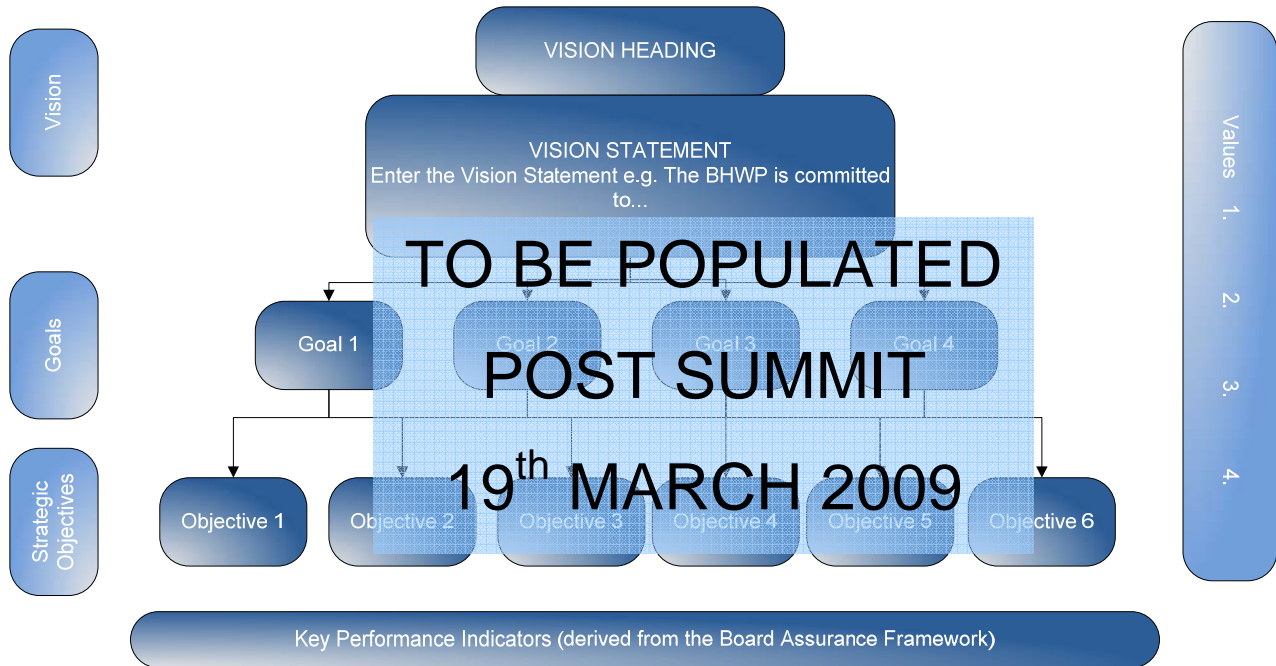
Figure 2 - Approach to Partnership



## 2.4 Ambition, vision, value and goals

The Partnership Summit on 19<sup>th</sup> March 2009 is hosting the vision and values event for the Partnership.

Figure 3 - Partnership vision values and goals



## VISION

**TO BE POPULATED**

VALUES

**POST SUMMIT**

**19<sup>th</sup> MARCH 2009**

GOALS

## STRATEGIC OBJECTIVES

### **2.4.1 Partnership Priorities**

During 2008 the BHWP and partners reviewed the challenges in health facing Birmingham and how the city might respond to these. Key messages from our Joint Strategic Needs Assessment are set out in the next section. We identified four priorities where progress is dependent on partnership working:

1. Tackling Health Inequalities
2. Personalised Care
3. Joint Commissioning
4. Understanding needs and engaging with communities

In all these areas we will achieve more by working together in a co-ordinated way. Our approach to this is set out in more detail in Section 4 - Strategy.

### **2.4.2 Working in Partnership**

We can work together as partners in a number of ways. Some initiatives are best carried out as collaboration between two or more partners. Others will have their greatest impact when partners pool resources and act through a single system for delivering services, such as a joint staff team. The BHWP is committed to adopting the approach that best meets our goals and targets.

As part of our work to develop co-ordinated approaches to our key priorities, we have decided that our partnership arrangements need to be fit for purpose. In a number of cases, this means moving towards pooling resources and simpler arrangements for partnership delivery. This in turn requires changes and developments to the way the BHWP works and the way in which this work is supported: improvements to the infrastructure of partnership. Our approach to these changes is set out in Section 7 below.

## **2.5 Rationale for Business Plan**

We are responding to the challenge to improve health and wellbeing in Birmingham by putting in place new services and initiatives and by developing the systems to ensure these help to achieve our goals and targets.

Partners need to know what is being done by the BHWP, so that they can plan their own activities to maximise the chances of success. The BHWP itself – and in particular, the Executive – need an overview of plans so that performance can be monitored and any problems or difficulties tackled promptly and effectively. This Business Plan summarises what we are trying to achieve and how we intend to do so. It brings together the information – about approaches, delivery plans, infrastructure and resources – that will help partners to understand how the BHWP work is developing and help the BHWP to monitor and manage it delivery.

## **2.6 Work in Progress**

This Business Plan is the first time such a wide range of information about BHWP priorities and plans has been pulled together. Inevitably it shows where there are gaps or areas where further work is needed. However, by bringing together an initial range of information about partnership intentions, it will help the BHWP and partners in future years to develop better plans and arrangements for partnership working – and the more effective delivery of services that will



improve health and wellbeing in Birmingham. The BHWP Business Plan will be revised and updated annually, and a process for this prepared that helps to co-ordinate partnership working by BHWP partners.

# 3 KNOWING BIRMINGHAM: OUR ASSESSMENT OF NEEDS

## Section Summary

- Knowing our City and its peoples is the first step towards improving their health and wellbeing. The Joint Strategic Needs Assessment (JSNA) is the process through which we develop this knowledge.
- The JSNA in Birmingham is a process that provides information about and predicts the needs of the local population. It provides commissioners with the information they need to make decisions for the future.
- The Birmingham approach to the JSNA is that it is a continuous, iterative process which combines overviews with deep-dive thematic exercises. It integrates insights from many sources of information, including user and citizen feedback and engagement.
- The JSNA is already providing us with information on the health of the people in Birmingham. We know that it is generally below the national average and that there are big differences between parts of the city. Although there have been improvements over the last ten years, Birmingham continues to suffer from significant health inequalities.

## 3.1 Introduction

The City of Birmingham is home to an ethnically, socially and economically diverse mix of people comprising its 1,006,500 residents. The city generally fares worse than England for health – people live shorter lives and are free from disability for less of that life than elsewhere in the Country. The poorest in Birmingham can expect to live up to seven years less than the England Average.

### 3.1.1 The Birmingham Geography and Population

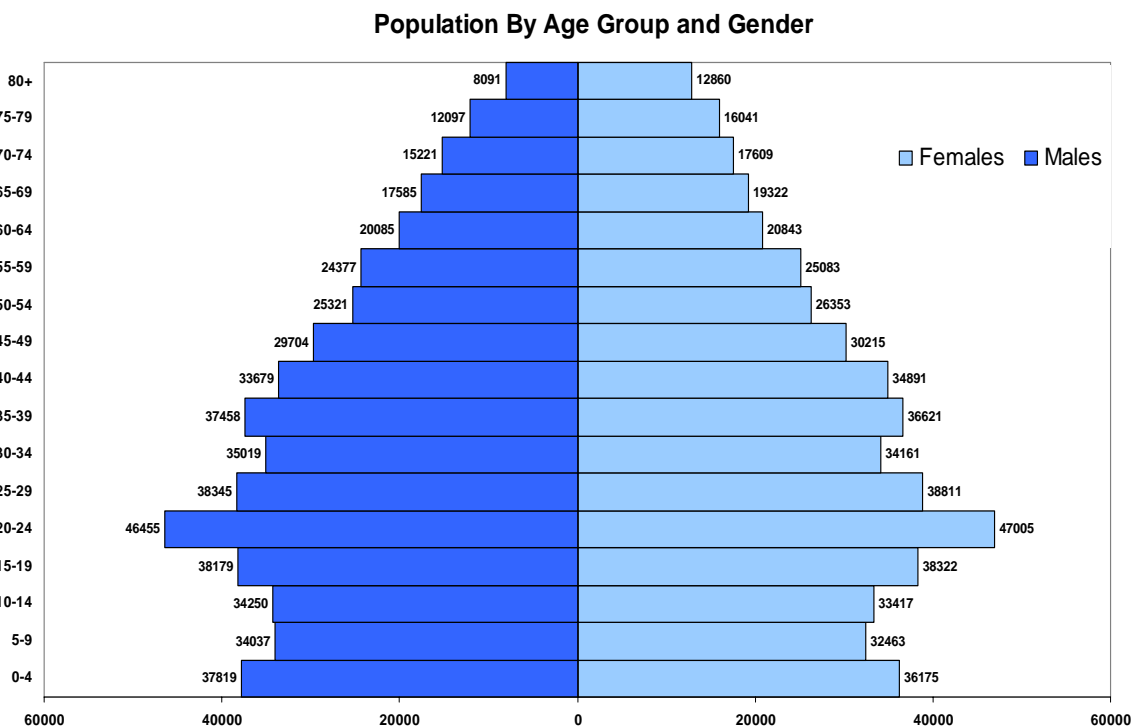
Birmingham – Key Statistics	
Area (hectares)	26,777
Population	Approximately 1 million people reside within Birmingham  This population resides within the following constituencies: <ul style="list-style-type: none"> <li>● Approx 340,000 (33.7%) within South Birmingham PCT</li> <li>● Approx 270,000 (26.9%) within Heart of Birmingham PCT</li> <li>● Approx 400,000 (39.6%) within Birmingham East and North PCT</li> </ul>
Average number of people per household	2.36
Age	Birmingham is a young city; Approx 266,000 (26.5%) are aged 18 or under. In contrast there are relatively few older people; approx 137,000 (13.7%) are over the age of 65.

Births	16,000 (approx; 2003 – 2007 average)
Deaths	9000 (approx; 2003 – 2007 average)
Hospital Admissions	320,000 Hospital admissions in 2007/08
Deprivation	<p>Birmingham has very high levels of deprivation amongst its population, ranking as the 10<sup>th</sup> most deprived Local Authority nationwide in 2007</p> <ul style="list-style-type: none"> <li>• Birmingham ranked as most deprived in terms of Income</li> <li>• Birmingham ranked as most deprived in terms of Employment</li> </ul>

**Table 2 - Birmingham key statistics**

While Birmingham is a young city, it is a city with a high burden of disability and mortality from childhood through adulthood into old age and, for many, a premature death. Infant mortality is much higher than the England average and for some communities there is additional risk of disability in infancy.

**Figure 4 - Birmingham age distribution across Males and Females**



Diseases of lifestyle are also a significant problem in Birmingham, with an increase in obesity in children and adults, and lower levels of uptake of physical activity than the rest of England. This combined with higher levels of smoking, a higher intake of dietary fat as shown in government lifestyle surveys, higher rates of smoking and higher rates of alcohol consumption combine to create in later life the factors which lead to Birmingham’s biggest killers: Cardiovascular disease and Cancers.

## 3.2 Joint Strategic Needs Assessment

We need to know Birmingham and its peoples well to ensure that we improve health effectively. This is the first stage of a knowledge based approach to deciding commissioning priorities and determining whether they have had the desired outcomes. For Birmingham the principal means of delivering this will be through the Joint Strategic Needs Assessment (JSNA.)

The JSNA is a statutory requirement placed upon Local Authority, PCT and Children and Young Peoples' Trust partners to put in place a common process to collect, assess and act upon key information on areas of inadequately met need within their local population. In Birmingham the lead for this process is the Joint Director of Public Health with the Public Health Information Team, and working closely with other analytical and information resources across the City.

Data on current and predicted health and wellbeing issues should be used to describe the “big picture” in terms of local health and well being needs and inequalities. This work should lead to agreed priorities which partner agencies will reflect in their commissioning plans and in their Local Area Agreement (LAA).

The JSNA helps to develop a new approach to providing health and care to the UK population, supporting developments such as:

- greater focus on prevention and early intervention for improved health, independence and wellbeing
- tackling inequalities and improving access to services
- emphasis upon the benefits to be gained from effective commissioning
- work to develop integrated and effective performance management
- recognition that partnership working is at the core of successful planning and provision, and that such partnership will gain from input from all stakeholders, including service providers and receivers of services.

### 3.2.1 Birmingham's approach to the JSNA

In putting in place arrangements for the JSNA, Be Birmingham recognised that a substantial amount of local needs assessment had already been done. Cross cutting partnerships, shared use of information and engagement of interested stakeholders were already widespread. These foundations shaped the local approach to the JSNA in line with Department of Health guidance:

- the JSNA initiative would build upon current work, looking to integrate existing information and processes, support current work, empower stakeholders to access all information, and create a voice for all parties
- work would begin by pulling together all existing needs assessment work to identify ways in which this could be better used to improve the health and wellbeing of the population.

This approach was supported by the initial consultation on the JSNA. Stakeholders felt that much of the work was already in place, based on extensive consultation and engagement. Stakeholders concluded that the challenge was to make better use of existing information.

Initial work on the JSNA therefore sought to identify:

- the sources of information currently used for needs assessment and any issues in their collection of use
- how the processes for using needs assessment could be improved, as stakeholders had expressed concerns that current processes interfered with the potential gains from joint working.

Thus Birmingham's approach has been to seek improvements to current processes of data collection, knowledge management and partnership working to ensure there will be gains from extending the work of joint strategic needs assessment.

3.2.2 Key Findings from the Joint Strategic Needs Assessment	
<p>Life Expectancy 2005/07</p>	<ul style="list-style-type: none"> <li>• Males in Birmingham have a life expectancy at birth of 75.58 years.               <ul style="list-style-type: none"> <li>• Worse than West Midlands (76.87 years) and England (77.65 years)</li> </ul> </li> <li>• Females in Birmingham have a life expectancy at birth of 80.76 years.               <ul style="list-style-type: none"> <li>• Worse than West Midlands (81.4 years) and England (81.81 years)</li> </ul> </li> <li>• The life expectancy gap between the most deprived quintile in Birmingham and the Birmingham average is 4.24 years for Males and 2.19 years for Females.</li> </ul>
<p>Infant Mortality 2005/07</p>	<ul style="list-style-type: none"> <li>• Infant mortality is comparatively high in Birmingham with 8.3 deaths per 1,000 live births.               <ul style="list-style-type: none"> <li>• Worse than West Midlands (6.2 per 1,000) and England (4.9 per 1,000)</li> </ul> </li> <li>• Differences in perinatal mortality (deaths under 28 days) between Birmingham and England account for 14% of the life expectancy gap in Males, and 18% in females.</li> </ul>
<p>Obesity 2003/05</p> <p>Children's Obesity 2007/08</p>	<ul style="list-style-type: none"> <li>• Synthetic lifestyle estimates state that approximately 23.4% of Birmingham's residents are obese (BMI &gt; 30).               <ul style="list-style-type: none"> <li>• Lower than West Midlands (26.5%) and England (23.6%)</li> </ul> </li> <li>• The National Schools Measurement Programme recorded obesity rates of children in Reception Year (Ages 4-5) and Year 6 (Ages 11-12) in all primary schools:               <ul style="list-style-type: none"> <li>• 10.6% of children measured from Reception year were obese, higher than the West Midlands (10.0%) and England (9.6%)</li> <li>• 23.1% of children measured from Year 6 were obese, higher than for the West Midlands (19.6%) and England (18.3%)</li> </ul> </li> </ul>

Smoking 2003/05	<ul style="list-style-type: none"> <li>• Synthetic lifestyle estimates state that approximately 24.9% of Birmingham's residents smoke regularly. <ul style="list-style-type: none"> <li>• Higher than West Midlands (24.0%) and England (24.1%)</li> </ul> </li> </ul>
Binge Drinking 2003/05	<ul style="list-style-type: none"> <li>• Synthetic lifestyle estimate results show that approximately 17.83% of Birmingham's residents binge drink (&gt;8 units for males, &gt;6 units for females in a single session) at least once a week. <ul style="list-style-type: none"> <li>• Lower than West Midlands (17.9%) and England (18.0%)</li> </ul> </li> </ul>
Healthy Eating 2003/05	<ul style="list-style-type: none"> <li>• Synthetic lifestyle estimate results show that approximately 25.1% of Birmingham's residents eat healthily (5 portions of fruit and vegetables per day). <ul style="list-style-type: none"> <li>• Higher than West Midlands (25.08%) but lower than England (26.27%)</li> </ul> </li> </ul>
Physical Activity 2007/08	<ul style="list-style-type: none"> <li>• According to the results of the Sport England Active People survey, 16.9% of Birmingham's residents engaged in 30 minutes of exercise at least 3 times a week. <ul style="list-style-type: none"> <li>• Lower than West Midlands (19.1%) and England (21.3%)</li> </ul> </li> </ul>

**Table 3 - Key findings from the Joint Strategic Needs Assessment**

Taken together, these issues demonstrate significant health inequalities for the people of Birmingham. This is and remains a key element of the Partnership's work, both in delivering a Joint Strategic Needs Assessment to know our City better and creating streams of work which enable our City to be healthier

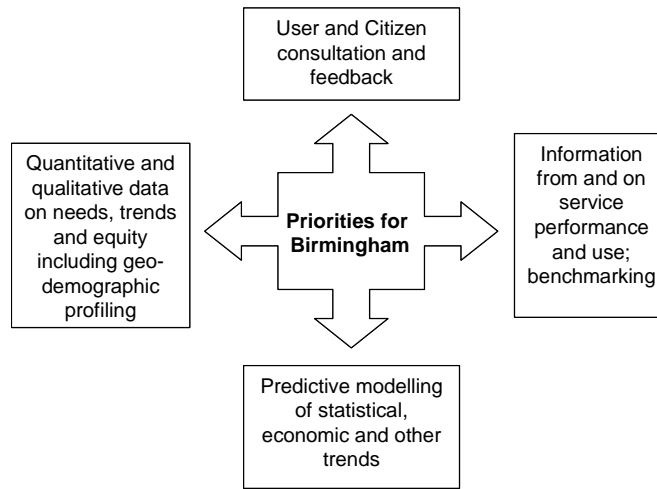
### 3.2.3 Vision – Taking the JSNA Forward

This approach to establishing a JSNA for Birmingham has provided a stepping stone for future work, ensuring a focus on the key policy drivers for improving the Birmingham population's health and wellbeing.

The future direction of the JSNA will be:

1. A tiered and iterative approach to providing information for commissioners on the priorities and needs they should be address
2. The integration of routine, specially collected and other data sources with knowledge from user and stakeholder engagement and commissioned economic and other modelling to create a priorities picture of Birmingham. This will be the JSNA quadrilateral approach to knowledge (Figure 5)
3. The development of a web-based needs assessment bank which will enable commissioners, providers, residents and others to view, interrogate and comment on the needs of our City.
4. The ability to model and predict, rather than just historically describe, the needs of our City will be crucial. This will complete a quadrilateral approach to knowledge. It will, however, need some skills and infrastructure planning.

**Figure 5 - Quadrilateral approach to knowledge**



### 3.2.4 The Tiered Framework for JSNA

The future approach to the JSNA works needs to be tiered. A key principle will be subsidiary – ensuring that work is done at the lowest level possible to achieve the outcome needed to inform commissioners.

Tier	Level of work	Leads	Typical Outcomes
Joint and Strategic	Work which addresses priorities and needs across the City which are of strategic significance to achieving better health citywide	The Joint Director of Public Health, Public Health Information Team	Key priorities for commissioners Themed priorities for commissioners Refreshes of JSNA overviews Deep-dive thematic JSNA projects e.g. children Assessments of unmet need and effectiveness
Strategic	Work which is strategic as above but does not cover the entire City. It may be localised to one PCT or constituency.	To be determined issue by issue	Reports on the topic with commissioning priorities
Local Priorities	Work within a PCT or Constituency which, while raising significant health issues, is not citywide and does not relate to a shared strategic priority	The local lead agency, but the outcomes and products will be fed into the partnership and captured by the JSNA Bank	Needs assessment reports on issues at local level

**Table 4 - the Tiered Framework for JSNA**

A Memorandum of Understanding will be developed and signed between partners to enable this to happen in a rational and clearly understood way. An appropriate infrastructure will be needed to be able to deliver this. Further details on this are contained within the financial plan.

## Section Summary

- The BHWP has identified four major priorities for its work. For each it has developed a general strategic approach.
- The approach to Tackling Health Inequalities is based on three key principles: improving access to services that can help to improve health, helping people to adopt healthier lifestyles, and addressing the wider determinants of and influences on ill-health.
- The starting point for Personalised Care is that everyone should be able to live independently and have the best quality of life. This means improving the prevention of problems, enhancing the option of self-directed care, service developments to ensure the availability of high quality services, and developing internal capability to put this approach into practice.
- More Joint Commissioning of services will be needed to reduce health inequalities and improve the health and wellbeing of people in Birmingham. The BHWP proposes to move forward through developing whole system approaches, putting in place common governance arrangements, and pooling resources.
- High quality services depend on an accurate Understanding of people's needs and of their views and expectations of services. The Joint Strategic Needs Assessment will improve the ways in which information about needs and expectations is collected. Engaging with local people will be developed through developing shared standards for engagement activity, collecting and sharing information on people's views, and commissioning engagement activity to fill gaps in knowledge.

### 4.1 Strategic direction for the priority themes

The BHWP has identified four thematic priorities for improving health and wellbeing in Birmingham. This section describes our strategic approach to these priority themes, each of which is championed by a member of the BHWP Executive. These set a framework for action for all the relevant agencies in Birmingham. More detailed delivery plans are being prepared to take forward initiatives in a number of areas. These are summarised in Section 5.

### 4.2 Theme 1: Tackling Health Inequalities

The goal of the Birmingham Health and Wellbeing Partnership is to reduce health inequalities and improve the health of people in Birmingham.

#### 4.2.1 Our strategic approach

There are many ways to do this. For some conditions, a clear short-term imperative is to improve access to clinical treatment. But there are also wider influences on health. Nationally it is thought about half the difference in health inequalities may be due to differences in lifestyle, where smoking, diet and exercise are key factors. Work, housing and the wider environment can also affect health and wellbeing. Our strategic approach will be based on evidence of what works best to tackle both immediate and underlying problems, and based on three key principles: improving access to services that can help to improve health, helping people to adopt healthier lifestyles, and addressing the wider determinants of and influences on ill-health.

#### **4.2.1.1 Improving access**

We will improve access to services that can help to improve health, help people to adopt healthier lifestyles, and address the wider determinants of and influences on ill-health. We will reduce inequalities in access through our investment in services, through devising new ways to provide services, and through engaging proactively with individuals and communities to ensure that changes meet their needs.

#### **4.2.1.2 Helping people to adopt healthier lifestyles**

We will actively encourage the adoption of healthy lifestyles through the ways we provide services and facilities. We will provide information, advice and support with the aim of empowering people to adopt healthier ways of living.

#### **4.2.1.3 Addressing the wider determinants**

High levels of worklessness, and poor housing and living environments, are particular problems for some parts of Birmingham and for some of its communities. We will seek to act directly on the wider determinants of health through helping people to gain the health benefits of work and through our investments in housing and in the wider environment. We will also seek reduce inequalities through the ways we act as employers and as procurers of goods and services.

### **4.2.2 Our shared principles**

To enable partners to work together effectively to reduce health inequalities, the Birmingham Health and Wellbeing Partnership has adopted the following shared principles. This constitutes our approach to delivery.

#### **4.2.2.1 Shared evidence and priorities for action**

The JSNA programme will provide a shared assessment of needs and we will use this to agree our priorities for action and to ensure that effort is focused on the neighbourhoods, groups and communities which are most in need of help. We will ensure that our shared assessment is up to date and we will regularly review our evidence to ensure we are focused on the highest priorities. A priority will be to build on the JSNA to improve our focus on priority neighbourhoods and groups.

Components of this programme will include:

- Information sharing protocols
- Citywide shared overviews of priorities and needs
- Thematic in-depth assessments at City Level
- Agreement on what priorities require assessment by Directors of Public Health
- Epidemiological and other statistical and economic modelling and future casting to support decisions on priorities.

We will also ensure that evidence of effectiveness and impact is placed at the heart of assessing what we will deliver and how.

#### **4.2.2.2 Co-ordinated planning**

We will use, and expect partners to co-operate with, a programme management approach to health inequalities. The health inequalities theme will be managed as a programme, and individual work streams will be managed as constituent projects within the health inequalities programme.

We will co-ordinate our planning, so that each partner at board or executive level reflects in our approach in its key documents and decisions about investment or changes to services. We recognise this as essential to the achievement of a co-ordinated focus on our agreed priorities. In this way we will act together to have the greatest impact on the worst health inequalities in the city.

#### **4.2.2.3 Increasing the impact of services**

We will ensure that all our services and functions have regard to their impact on health and on health inequalities. We will identify those services and functions that can have a direct beneficial effect on health and these will prepare plans showing how they can reduce health inequalities in Birmingham. We will ensure that outcomes are set for these services, and that they are monitored.

#### **4.2.2.4 Engaging with individuals and communities**

We will collaborate to provide information and advice that will help individuals to improve their health. We will work together to consult communities about their needs and to empower them to address these needs. We will ensure that our community engagement work reflects best practice and evidence, that it is included within the JSNA programme and that it is used by commissioners.

#### **4.2.2.5 Building capacity**

We will ensure that all those working for and with us have the knowledge and expertise to reduce health inequalities, and that they are motivated to do so. We will work with partners in the private and third sector to foster their contributions to reducing health inequalities across the city. This will include specialist public health workforce, commissioners and the wider public health workforce, front line and other staff in key agencies across statutory, independent/commercial and third sectors.

#### **4.2.2.6 Public Health Leadership**

We will expect our four Directors of Public Health, with the Director of the Health and Wellbeing Partnership, to work together to create a highly motivated, highly functioning senior public health team and culture across the partners. This team will:

- work together to ensure we have an accurate picture of need, and evidence of the effectiveness and impact of programmes
- produce a shared public health vision for Birmingham and a shared view of the priorities for achieving this
- work together to influence commissioning on the basis on this shared view, shaping a healthier city
- work together to ensure that citywide programmes achieve effective local flexibility and targeting.

#### **4.2.2.7 Targeting neighbourhoods and communities most affected**

Health inequalities disproportionately affect certain neighbourhoods and communities. We will identify those neighbourhoods or parts of the population which should be our priorities for action, and review how we currently serve these priority neighbourhoods or communities so that we can target those with the greatest needs, co-ordinating our planning and engaging with the communities themselves.

## 4.3 Theme 2: Personalised Care

We want everyone to be able to live independently and have the best quality of life.

### 4.3.1 Our vision for personalised care

For many – in particular, older people, those with long-term health conditions, disabled people and those with mental health problems – personal care is the support that makes this a reality. We know that many receive such support through their family and friends, and that support to such carers is also part of personalised care.

The role of public sector agencies is to help to make appropriate personal care available to all who need it. This means having in place arrangements that enable people to make informed choices about the type of help they need and how it is provided. The right to self-determination is at the heart of our vision of personalised care, subject only to the need to protect those who through illness or disability are genuinely unable to express their needs or exercise control.

We also recognise that personalised care is constrained by finite resources, both private and public. Statutory agencies must focus their limited resources on those who are unable to support themselves. In doing this, we must seek the best outcomes for the funding available. However, those who fund their own care are also entitled to help in making this cost-effective.

### 4.3.2 Our approach to personalised care

Our starting point is the **prevention** of problems through increased take up of a range of mainstream services that can reduce the need for personal care.

At the heart of our approach will be a system of **self directed care**, based on coherent assessment processes, access to advice about service options, and personal budgets that give genuine choice and control to the service user.

We know that there are variations in the availability of high quality services in Birmingham, so a system of self-directed care needs to be underpinned by a programme of **service development**.

Finally, we need to make sure we have the **internal capability** to put this approach into practice. This means developing our knowledge about the need and demand for services, ensuring that vulnerable individuals are suitably protected, and enhancing workforce skills.

#### 4.3.2.1 Prevention

We know that many people can benefit from access to mainstream services, whether provided by the public, private or voluntary sectors. For example, regular exercise will keep older people healthy and reduce the risks of problems, such as falls, that can lead to the need for additional care. A primary aim of our approach to prevention must be to encourage take up of services that enhance wellbeing.

In addition, we can offer services proactively to those identified as at greater risk of problems. For example, by systematically identifying carers, we can offer them a range of support that will enhance the quality of their life and of the life of the person for whom they are caring.

In order to do these things, we need to improve the range and quality of information available to people – and their ease of access to it. An increasing number of people are able to access information through the internet, but this may not be appropriate for all, so we need to develop a range of communication channels. Here we have a range of existing arrangements, both within the City Council and in individual PCTs, on which we can build.

We also need to develop the use of information systems to identify individuals who might benefit from proactive advice and offers of services. Again we have a range of existing expertise – for example, from the male life expectancy programme – on which to build.

#### **4.3.2.2 Self directed care**

Self directed care is at the heart of our approach. It comprises three main elements.

##### Assessment

Any plan for personal care must be based on an assessment of needs. We see a single coherent assessment process as the starting point for the planning of care. This process should include self-assessment: citizens should be able to make their own self-assessment, using on-line systems or support as appropriate. The assessment process must be designed to make explicit potential risks so that decisions can be made about their management.

##### Care planning

People should be helped to plan the support they need to achieve the outcomes they want. Some people will be able to manage and direct their own care services without recourse to special advice: on-line assessment and information may be all they require. Others may want additional help, perhaps through discussing options through a contact centre before making their own decisions about care. Others may need more detailed help or advice through advocacy or brokerage services, which can help negotiate with service providers. Finally, some people will need the specialist support provided by qualified social workers to plan their care.

##### Personalised budgets

The third element of self-directed care is the development of personal budgets. Those who self-fund their care are already able to choose their own support services and manage them as they choose. Personalised budgets will extend this approach to those whose services are supported from public funds. A number of options are available, which we are planning to develop.

- **Direct payments** are cash payments given to service users for them to purchase the care services they are assessed as needing. Nearly 1,000 service users in Birmingham already benefit from direct payments, and the city has set a target in its Local Area Agreement to increase this number substantially.
- **Personal budgets** are an allocation of funding to service users following an assessment. This budget can be taken as a direct payment or the council may manage the budget on behalf of the service user in line with their choices.
- **Individual budgets** allow funding from a number of sources and agencies to be combined and managed as for personal budgets.

#### **4.3.2.3 Service development**

A wide range of services are already available in Birmingham, but in some cases there is a need to increase the scale of support or improve access. There are two main challenges. One is

to support the development of new services or the change of existing services to meet developing needs: for example, Telecare, the use of information technology to support personal care. We have identified through Birmingham's Local Area Agreement two services which will be priorities for service development: end of life care and services for carers.

The second main challenge is to develop arrangements for commissioning care services, including developing suppliers and markets. It is important that commissioning is developed jointly by the members of the BHWP to ensure a consistent approach. The development of commissioning could also include the preparation of advice and information for those who are funding their own care and commissioning and managing their own services.

#### **4.3.2.4 Internal capability**

A number of pieces of work will be needed to support our vision of personalised care.

The development of preventative services will require good information about needs and service users' requirements. The JSNA will underpin the data requirements, with good arrangements for engaging with and consulting with service users. This will mean building on existing good practice.

Giving individuals greater responsibility for assessing their own needs and choosing their own care services must be balanced by the responsibility of statutory agencies to protect vulnerable adults. The Birmingham Safeguarding Adults Board has an existing development programme; this will need to reflect moves towards personalised care. A significant challenge is to devise ways to incorporate risk assessment into self-assessment processes.

Personalised care also poses questions about the way service quality is assured and performance monitored. If more people are managing their own care, how will its quality be open to checking, and how will the achievement of outcomes be monitored? Existing systems will need to adapt to the new requirements of personalised care. We have included in Birmingham's Local Area Agreement a local indicator which will help target improvements to local care homes with nursing: this will help us to begin to develop quality assurance and performance monitoring systems for externally provided care services.

Finally, these changes will demand new skills of staff, as well as new staff roles. A workforce development plan will be required to set out how changes to systems will be underpinned by staffing training and development.

## **4.4 Theme 3: Joint Commissioning**

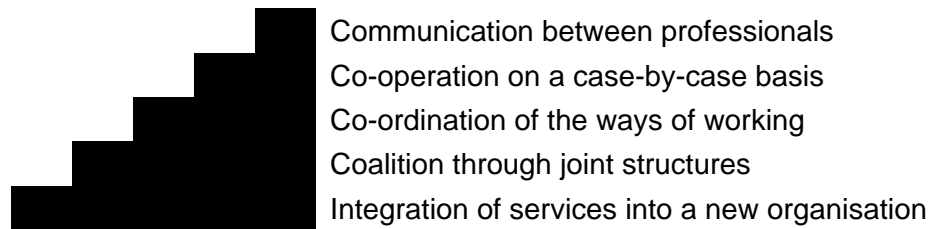
We want to reduce health inequalities and improve the health and wellbeing of people in Birmingham. We want people to be able to live independently and to enjoy a good quality of life. In order to achieve these goals we need to undertake more joint commissioning of services, so that people get the best combination of services without having to deal with a number of different providers.

### **4.4.1 Our approach to Joint Commissioning**

Joint Commissioning is complex: there are various different ways in which services can work together to meet individual needs (Figure 2). When individual agencies are subject to different accountabilities to government or regulators, partnership working can be difficult to put in place.

But the BHWP is committed to adopting the best approach that meets individual needs and helps to achieve the Partnership's goals and targets.

**Figure 2 – Aspects of joint commissioning**



There is already a wide range of good practice in communication and co-operation between professionals and services. This is the foundation on which we must build more systematic processes for joint working.

We propose to move forward by developing **whole system approaches** to service delivery. We will put in place arrangements for unified information, advice and guidance for service users and the general public. We will introduce common processes: in particular, single assessment processes that enable different services and professionals to provide help on the basis of a unified assessment of needs. We will align the ways we measure and manage performance, so that services are working towards common targets and goals. We will develop new ways to ensure those working with individual service users have a shared understanding of needs and support: for example, through joint professional training.

We will develop **common governance arrangements**, so that partners can share the same priorities and accountabilities. We will ensure there is a shared understanding of strategic issues, based on the JSNA, and that partners share the same strategic views and priorities. We will establish ways to measure and manage performance that reflects these strategic priorities. We will ensure that accountabilities between and within partner organisations align with our shared strategic vision.

We will develop ways to **pool resources** when this provides the best way to meet our common goals. We will improve our understanding of how we currently use resources to achieve our shared aims – and how these resources might be better used. Where appropriate, we will pool resources, establishing new financial arrangements and systems to help us manage funding in partnership. We will enhance our procurement skills to make a reality of the joint commissioning of services.

#### 4.4.2 Our priorities for joint commissioning

We have identified the following service areas as our priorities for the development of joint commissioning processes.

- Mental health
- Learning disabilities
- Physical disabilities
- Sexual health

- Supporting people
- Drugs and alcohol
- Older people
- Complex care

We do not assume that the same standard approach will be adopted in all eight areas. Further details about developments and progress are given in the next section.

## 4.5 Theme 4: Needs assessment and engagement

Improving the collection and use of information on individuals' views and behaviours is an important part of the JSNA process. But it is only one aspect of engagement. In developing its approach to engagement, the BHWP will adopt the strategy of Birmingham City Council, which is set out in *Talking Together: Working Together* (Figure 3).


### 4.5.1 Needs assessment

The development of the Joint Strategic Needs Assessment is the main way in which information about needs and expectations is collected, analysed and used to inform the provision of services. The JSNA and plans for its development were described in the previous section.

### 4.5.2 Engagement

Improving the collection and use of information on individuals' views and behaviours is an important part of the JSNA process. But it is only one aspect of engagement. In developing its approach to engagement, the BHWP will adopt the strategy of Birmingham City Council, which is set out in *Talking Together: Working Together* (Figure 3).

**Figure 3 – Aspects of engagement**

- 
- Information: obtaining information through market research to inform services and planning
  - Consultation: listening and offering choices to those consulted, taking views into account.
  - Community Empowerment: giving stakeholders a way to influence what is done and take action themselves
  - Involvement: enabling stakeholders to contribute to the decisions which affecting them
  - Acting together: working in partnership with individuals and communities and sharing responsibility

#### 4.5.2.1 Our approach to engagement and capturing user experience

Engagement activity and understanding user experience are priorities for the BHWP, and will inform work across all thematic priorities. Collaboration between partner organisations will enable us to do this most effectively. In everything we do we will involve local people in the development and evaluation of services. We consider this to be a cornerstone of good quality health and care. Partners have statutory obligations to engage with local people, but the BHWP

sees engagement and understanding user experience as informing commissioning and service improvements, as well as empowering and involving communities and service users. We will always engage with established community representatives and groups that share particular interests. But we will also seek the broadest range of views and perspectives from individuals and organisations, to get closer to those people whose voices are not usually heard. We will seek to involve people in planning and decision-making at the earliest opportunity, and ensure that participants and the wider community are well informed about what we do.

#### **4.5.2.2 Initial priorities**

Our initial priorities for improving engagement are as follows.

##### Standards

We will ensure consistency in the way we engage people by agreeing common standards. These will outline a model of working to guide partners and promote effective engagement as a mainstream activity, not simply something carried out separately by specialists. They will draw on and existing guidelines and principles, current legislation and national and local targets.

##### Our approach to sharing data and experience

We already have much information from previous engagement and research on local views and perspectives of health and care provision. There is also considerable experience of and expertise in engagement within BHWP partners and other local organisations. Relevant data is also collected and maintained regionally and nationally. But at present, it is difficult to access this data and expertise. We will organise this information into a shared store, providing full and open access to partners. through an integrated database, accessible to partners and other stakeholders.

##### Local Voices in Planning and Informing the Joint Strategic Needs Assessment

As part of the further development of the JSNA, we will commission activities to improve our insight into the views and perceptions of local people, particularly where existing provision does not adequately meet the requirements of the target population. Where necessary, bespoke engagement or research activities will be commissioned to fill gaps in our understanding. We will ensure that local communities are involved both in the development and the delivery of the JSNA.

# 5 DELIVERY PLANS

## Section Summary

- The BHWP has put in place a process for preparing and approving delivery plans, which set in detail how thematic priorities will be achieved. As they are finalised, Delivery Plans will be endorsed by the BHWP Executive, which will receive regular reports on performance and progress.
- Detailed delivery plans have been prepared for the priority workstreams to Tackle Health Inequalities. Delivery plans are being prepared for priority workstreams for the other three thematic priorities.

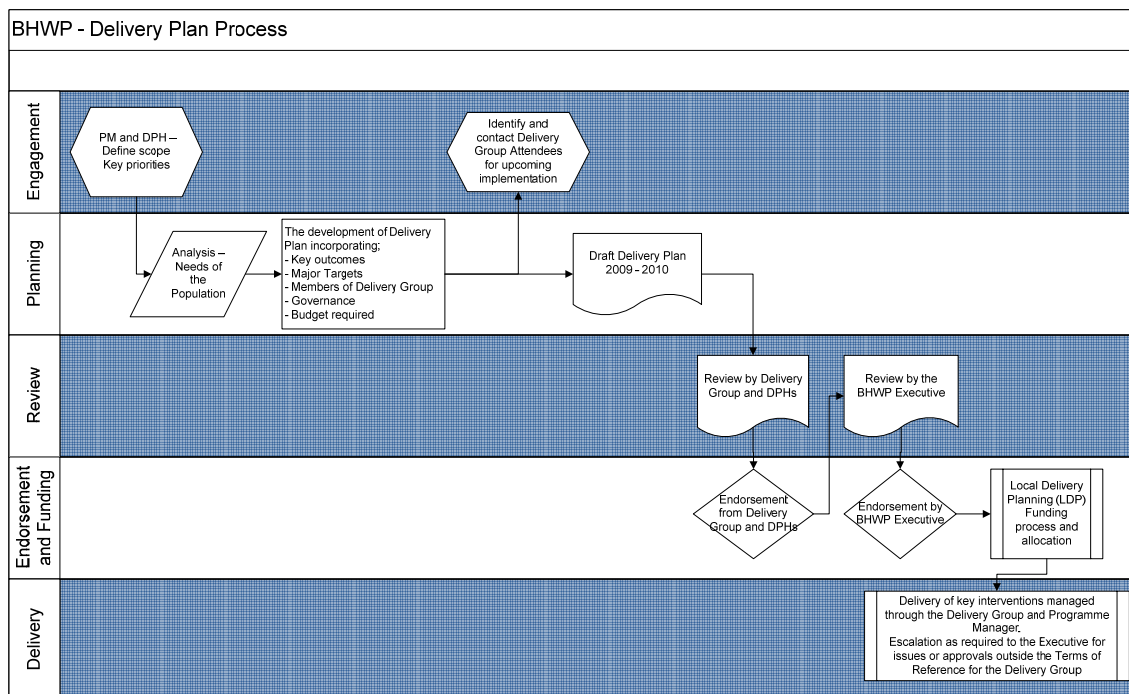
### 5.1 Introduction to Delivery Plans

The previous section set out the BHWP's strategic approaches to its key thematic priorities. To underpin these approaches, a number of delivery plans are being prepared which set out in more detail the immediate priorities for action and planned activities. This section explains how delivery plans are being prepared, and provides brief overviews of the key features of individual delivery plans. Full delivery plans are available separately.

#### 5.1.1 The Delivery Plan process

The following diagram (Figure 4) provides a generic high-level overview of the creation and endorsement of the delivery plans across the BHWP.

**Figure 4 - BHWP Delivery Plan Process**

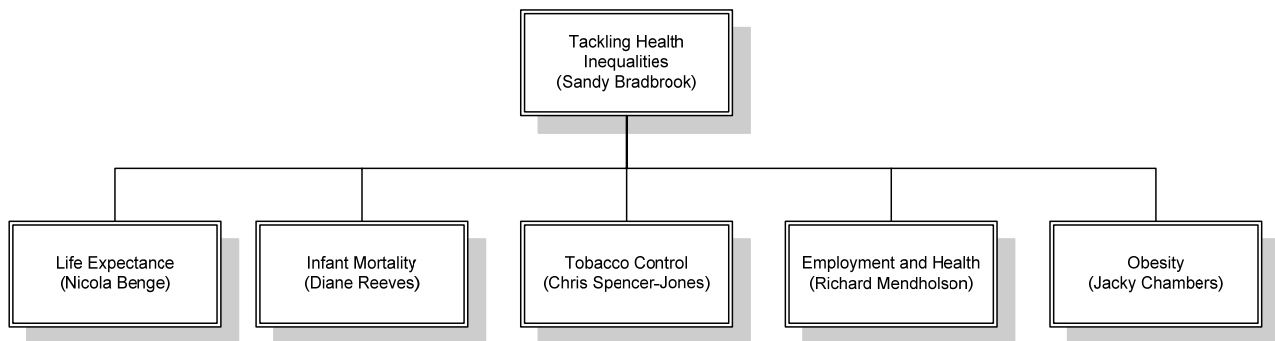


Each delivery plan is the responsibility of a senior officer of a BHWP partner organisation. Delivery Plans are being prepared in conjunction with Delivery Groups – meetings of relevant officers from BHWP partners – to ensure engagement with mainstream services. As they are finalised, Delivery Plans will be endorsed by the BHWP Executive, which will receive regular reports on performance and progress. Performance will be managed through a performance management framework, which is described in more detail in Section 9 below.

## 5.2 Theme 1: Tackling Health Inequalities

The thematic priority Tackling Health Inequalities is led on behalf of the BHWP Executive by Sandy Bradbrook, and has five main workstreams (Figure 5). An overarching health inequalities plan is being produced by the Joint Director of Public Health and will provide more information on this.

**Figure 5 – Tackling Health Inequalities: workstreams and workstream leads**



### 5.2.1 Life expectancy

Sponsor	Nicola Bengé
Programme Manager	Russell Hamilton (Interim Programme Manager) Darren Wright
Description	The Life Expectancy work stream focuses on improving access to screening and follow up interventions, targeting those communities and groups who experience the greatest burden of disease, increased morbidity and early mortality. It is a key contributor to the achievement of the LAA target to reduce Birmingham's All-age All-cause mortality rate. It is a complex work stream consisting of multiple interventions and sub-activities. These are focused on five priorities.
Key Objectives	The Life Expectancy work stream has the objective of achieving the LAA agreed ' <i>all-age all cause mortality rate</i> '.  The target for 2009/10 being to achieve: <ul style="list-style-type: none"> <li>• A) Directly Standardised Mortality Rates (DSR) for Males: 721.6 per 100,000</li> <li>• B) Directly Standardised Mortality Rates (DSR) for Females: 511.0 per 100,000</li> </ul>
Key Activities	Below is a snapshot of the key activities for each of the five target groups.  <b>Target Group 1: Overarching enablers and infrastructure</b>

	<ul style="list-style-type: none"> <li>Establish a single active patient management system and call centre for Birmingham</li> <li>Commission epidemiological modelling of life expectancy to identify where the greatest gains are to be made.</li> <li>Commission epidemiological modelling on future health inequalities in Birmingham to establish whether services are placed to meet arising needs.</li> </ul> <p><b>Target Group 2: Cardiovascular disease including stroke, chronic kidney disease and diabetes</b></p> <ul style="list-style-type: none"> <li>Implement targeted vascular checks for 30,000 people in key wards for those &lt;40 years of age and ensure systematic follow up to reduce 'lost to service numbers' for people who do not respond to call / recall.</li> </ul> <p><b>Target Group 3: Cancer including lung, cervical, breast, colo-rectal and breast:</b></p> <ul style="list-style-type: none"> <li>Implement targeted screening programmes for 10,000 in key wards for those who meet the agreed profile / criteria (tumour site specific).</li> </ul> <p><b>Target Group 4: Vulnerable People including mental ill health and well being, learning difficulties, homeless, living in sheltered accommodation, migrant communities, drug &amp; alcohol dependents</b></p> <ul style="list-style-type: none"> <li>Develop a city wide strategy for Birmingham to address health inequalities for vulnerable groups incorporating detailed plans for the integration of support for vulnerable people into other interventions and work streams for the purpose of eliminating inequalities.</li> </ul> <p><b>Target Group 5: Lifestyle Interventions including obesity, tobacco control, physical activity and substance misuse:</b></p> <ul style="list-style-type: none"> <li>Ensure appropriate capacity exists for referrals to other work streams (performance monitoring).</li> </ul>
Benefits	The delivery of the Key Objective in achieving the LAA 'all-age all cause mortality rate'
Timescales	2009 and beyond
Budget	£2.948 (funding approval required)

## 5.2.2 Infant mortality

Sponsor	Diane Reeves
Programme Manager	Susan Luce (interim) Chris Baggott (Assistant Programme Manager)
Description	Infant mortality rates in Birmingham are significantly higher than the rest of England. By understanding the full picture across the city will enable specific areas of work to be carried out that will contribute to the reducing of health inequalities and in turn reduce infant mortality.
Key Objectives	The objective for infant mortality underpins the Governments Health Inequalities PSA target 'to reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth. And states: 'Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the

	population as a whole'.
Key Activities	<p>The Infant mortality work stream has five key intervention activities that will deliver the key objective. These are:</p> <ol style="list-style-type: none"> <li>1. Implementation of the Maternity Services specification</li> <li>2. Early access to Maternity Services</li> <li>3. Achieving baby friendly status</li> <li>4. Housing – reducing overcrowding</li> <li>5. Pregnancy outreach workers</li> </ol> <p>These interventions are further broken down into specific activities that will use Kips to measure progress. These activities are available in the Infant Mortality delivery plan 2009 – 2011 available by contacting the Partnership directly.</p>
Benefits	<ol style="list-style-type: none"> <li>1. A reduction in the infant mortality rate</li> <li>2. Equality of access to maternity services, particularly in early pregnancy</li> </ol>
Timescales	2009 – 2011
Budget	To be completed in the final version of the Business Plan

### 5.2.3 Smoking Cessation and Tobacco Control

Sponsor	Chris Spencer-Jones
Programme Manager	John Sutherberry (interim)
Description	<p>The Birmingham Life Expectancy is lower than the England average and the difference remains a major concern for BHWP. Reducing smoking levels is a high priority in our efforts to ensure that male life expectancy in Birmingham improves towards the England average.</p> <p>The challenges for Birmingham is clear - to ensure that we reduce prevalence in the more challenging groups: <i>routine &amp; manual workers and pregnant women</i>.</p>
Key Objectives	<p>The following are key objectives for the Smoking Cessation and Tobacco Control work stream:</p> <ol style="list-style-type: none"> <li>1. Reduction in the smoking prevalence rate amongst adults to 21% or less by 2010</li> <li>2. Reduction in the smoking prevalence rate in pregnancy to 15% by 2010</li> <li>3. Reduction in the smoking prevalence rate in routine and manual workers to 26% or less by 2010</li> </ol>
Key Activities	<p>The following key activities have been prioritised and endorsed by the work stream sponsor, delivery group and Executive:</p> <ol style="list-style-type: none"> <li>1. <b>Pregnancy term pilot</b> – commissioning of a specialist city-wide team dedicated to working with pregnant smokers for 18 month pilot</li> <li>2. <b>Smoking prevalence citywide survey and Tobacco Control</b> (baseline establishment)</li> <li>3. <b>Engagement with priority groups</b> (Targeted outreach – e.g. 'Hard core', BME &amp; workplace cessation).</li> </ol>
Benefits	Delivery of the Key Objectives for the work stream including a reduction in the smoking prevalence rate across adults, pregnant women, and routine and manual workers

Timescales	2009 – 2011
Budget	£1.05m (funding approval required)

## 5.2.4 Employment and Health

Sponsor	Dr Richard Mendelsohn
Programme Manager	Roger Matthews (interim) Armanda Winwood
Description	The Employment and Health work stream, which is organised jointly with partners from the employment and skills sector, aims to tackle the barriers that stop people with health problems from working – and to secure the improvements to health that employment can bring.
Key Objectives	<ul style="list-style-type: none"> <li>● enhance the role of GPs and other primary care staff in facilitating return to work</li> <li>● increase the availability of support for people with health and employment problems, enhancing their ability to gain and remain in employment</li> <li>● improve employers' management of health in the workplace, including the recruitment and retention of people with health problems.</li> </ul> <p>In addition, the work stream is looking to increase the recruitment of those out of work in priority areas by health and care employers in Birmingham.</p>
Key Activities	<p>Its priority activities are as follows.</p> <p><b>Fit for Work service pilot</b></p> <ul style="list-style-type: none"> <li>● Establish a pilot Fit for Work service to help people who are off sick to return to their employment</li> </ul> <p><b>Developing capacity in primary care</b></p> <ul style="list-style-type: none"> <li>● Provide information, training and support on health and work issues for staff working in primary care – in particular, GPs</li> <li>● Organise training for community-based healthcare staff so they can signpost service users to employment services</li> </ul> <p><b>Back-to-work support</b></p> <ul style="list-style-type: none"> <li>● Set up a pilot scheme to help people who are out of work because of their health to make progress back towards employment</li> <li>● Increase opportunities for voluntary work for those out of work because of ill health</li> </ul> <p><b>Work with employers</b></p> <ul style="list-style-type: none"> <li>● Establish a Healthy Workplaces Forum to co-ordinate activity to help employers manage workplace health effectively</li> <li>● Encourage public sector employers in Birmingham to develop exemplary practice in health in the workplace</li> </ul> <p><b>Health and care recruitment</b></p> <ul style="list-style-type: none"> <li>● Support improvements in workforce planning that will identify job opportunities for workless people</li> </ul>

	<ul style="list-style-type: none"> <li>Expand the availability of pre-employment schemes which help those of work compete more effectively for jobs in health and care.</li> </ul>
Benefits	Delivery of the key objectives linked to LAA Outcome 4 <i>"Increase employment and reduce poverty across all communities through targeted interventions to support people from welfare to work"</i> .
Timescales	2009-2011
Budget	£2.5m (funding approval required)

### 5.2.5 Obesity

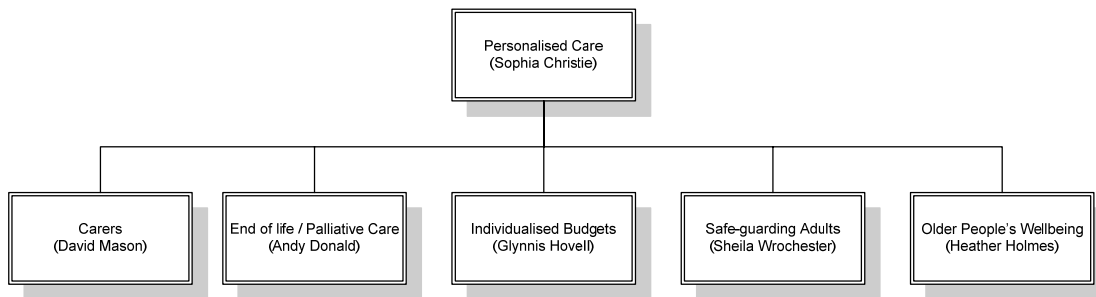
Sponsor	Jacky Chambers
Programme Manager	Kay-L. Edwards (interim)
Description	Among the eight core cities, Birmingham has the least physically active adult population, the highest proportion of adults, with type II diabetes, and the second highest rate of childhood obesity among children in year 6.
Key Objectives	<p>The following Key Objectives have been identified for the Obesity work stream: they will be in line with the PSA (public sector agreement) target for obesity, and NICE Clinical Guideline 43.</p> <ul style="list-style-type: none"> <li>To reduce obesity in year 6 children to 21.8% 09/10 To halt the rate of increase in childhood obesity in school aged children (year 6) and reduce the overall prevalence of obesity in their age groups by 0.1% (LAA target and NI 56)</li> <li>To increase adult participation to at least 3 times a week in moderate physical activity.</li> <li>To increase children and young people's participation in high quality physical exercise and sport.</li> <li>By 2010, increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women. Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.</li> </ul>
Key Activities	<p>The Obesity work stream has four key target areas to deliver the key objectives, which are supported by an overarching set of enablers.</p> <p>These target areas all follow the same four elements, physical activity, nutrition, obeseogenic environment, and motivation and behaviour. Each one of these elements will consist of a number of activities, specific to the target group.</p> <p><b>Target Group 1: Children, children and families</b> We will utilise existing children's services throughout the city, including partners in education, and the voluntary sector, for both nutrition and physical activity, for children aged 0 – 15 years, encouraging parental involvement. Community involvement will be encouraged and developed through community audit.</p> <p><b>Target Group 2: Adults</b> Offer a city wide physical activity programme throughout the city, to encourage the whole population to "Move a Little, Change a Lot".</p> <p><b>Target Group 3: Those with BMI's over 25</b> Facilitate targeted access to screening programmes for vulnerable groups city wide. Revisit the exercise on prescription programme, with dedicated evaluation of the realised health benefits.</p>

	<p><b>Target Group 4: Motivation and Behaviour Intervention</b></p> <p>Apply motivational and behavioural interventions, through the provision of health trainers, as applied across the health inequality programme.</p> <p>It is anticipated that the health trainers will assist participants on any physical activity programme to make the cultural change required to reach and maintain a healthy weight.</p>
Benefits	Delivery of the Key Objectives for the work stream promotes effective partnerships for the provision of high quality physical exercise (including sport). Reduction in the rate of obesity over time through effective partnership working through all four elements.
Timescales	2009-2011
Budget	To be completed in the final version of the Business Plan (funding approval required)

## 5.3 Theme 2: Personalised Care

The thematic priority Personalised Care is led on behalf of the BHWP Executive by Sophia Christie, and has five main workstreams (Figure 6).

Figure 6 - Personalised Care: work streams and work stream leads



### 5.3.1 Carers

Sponsor	David Mason
Programme Manager	
Description	The Government's vision for carers is that by year 2018 carers will be universally recognised and valued as being fundamental to strong families and strong communities: a key strand of Birmingham's Sustainable Community Strategy. The role of carers in supporting the delivery of health and wellbeing in Birmingham is an absolutely vital factor.
Key Objectives	<p>The Key Objectives for the Work stream include:</p> <ol style="list-style-type: none"> <li>1. Information, advice and support provided for carers are effective, flexible and inclusive.</li> <li>2. Improvement of short break services for carers of ALL vulnerable adults and children is standard.</li> <li>3. The needs of carers from Birmingham's wide and varied ethnic communities, including excluded and hard to reach groups is fully supported.</li> <li>4. There are more flexible ways of identifying and meeting the needs of young carers in Birmingham.</li> <li>5. There is an improvement in the coordination, recruitment, retention, and supply of training opportunities. Training needs to be commissioned to assist carers in their caring roles, as well as to improve life skills. Carers should not be excluded from employment either whilst they are caring, or after they cease to be carers.</li> <li>6. There is access to health promotion services to reduce carer's stress, and methods to intervene to reduce the preventable effect of physical and mental ill health.</li> <li>7. There is improved performance in the quality and quantity of carer assessments by making the process clearer and easier to access.</li> </ol>
Key Activities	<p>The following activities have been identified to deliver the key objectives:</p> <p><b>Emergency and Contingency Planning</b> A one-year pilot to set up systems and processes that will then be mainstreamed.</p> <p><b>Continuing to look into ways of improving the identification of Carers and ensure information on Carers Assessments and services are recorded appropriately</b></p>

	<p><b>Promotion and communication of support for carers</b> Identification of more carers.</p> <p><b>Carers Involvement Framework</b> Improving the involvement and empowerment of carers in health and social care.</p>
Benefits	<p>Improve the quality of wellbeing services for carers and act as referral and advice for carers to receive assessments and help improve upon baseline (Target = 500 Carers)</p> <p>Will increase the numbers of carers receiving a carers assessments and add to the current baseline of 40% - Current baseline = 800 Carers Target = 1800 Carers</p>
Timescales	2008 – 2009
Budget	To be completed in final version of the Business Plan

### 5.3.2 End of life and palliative care

Sponsor	Andy Donald
Programme Manager	To be completed in final version of the Business Plan
Description	Home death rates vary considerably nationally, and the necessity for a composite response to the issue can create variability of outcome even across geographic areas within Birmingham.
Key Objectives	<p>End of life access to palliative care enabling people to choose to die at home</p> <p>Increase home death rate from 18.32 % to 25.32% by 2011</p>
Key Activities	<p>The following activities have been identified to deliver on the key objectives;</p> <ol style="list-style-type: none"> <li>1. A care plan will be offered to every patient and carer, to help ensure services are provided to meet their needs and preferences.</li> <li>2. Every organisation involved in providing end of life care will be expected to adopt a coordination process, such as the Gold Standards Framework</li> <li>3. Patients and carers will have access to dedicated 24/7 telephone help lines</li> <li>4. Specialist palliative care outreach services will be established in every area. _</li> <li>5. A care pathway approach for management of the last days of life, such as the Supportive Care pathway will be rolled out across England; and Facilities will be provided to support relatives and carers who wish to stay with a patient in hospital.</li> <li>6. A dedicated professional national support team will work with _ commissioners and providers to identify and spread good practice.</li> </ol>
Benefits	Delivery of the key objective to enable the opportunity for patients to choose to die at home, and increase the number of patients doing this by 2011
Timescales	2008 –
Budget	To be completed in final version of the Business Plan

### 5.3.3 Individualised Budgets

Sponsor	Glynnis Hovell / Dr Richard Mendelsohn
Programme Manager	
Description	Birmingham has made considerable progress in increasing the numbers of people in receipt of direct payments since 2003/04. An analysis of average annual costs of direct payment packages has shown that the majority of direct payment expenditure in Birmingham is above £5,000 per annum. This supports the fact that Birmingham uses direct payments for ongoing support of service users in lieu of an ongoing care package as opposed to using direct payments for clients sporadically throughout the year.
Key Objectives	<p>The following Key Objectives have been identified for the Individualised Budgets work stream;</p> <ol style="list-style-type: none"> <li>1. Complete revision of forms and financial information including making the process easier for service users and carers</li> <li>2. More extensive promotion and publicity for potential service users and carers and also with agencies and providers of services to reflect the changing demands and requirements of service users and carers</li> <li>3. Continued training of staff and introduction of training for carers employed with direct payments</li> <li>4. Continued work with the support agency for direct payments</li> <li>5. Development of direct payments for carers. Hence there is a connection to NI 135</li> </ol>
Key Activities	<p>The following high-level activities have been identified to realise the key objectives;</p> <ol style="list-style-type: none"> <li>1. Individual Patient Budget Pilot</li> <li>2. Notional individual budgets for physically disabled people</li> <li>3. Priority areas for development on Direct Payments</li> <li>4. Work stream plan in Transformation Programme on Individual Budgets</li> </ol>
Benefits	The delivery of the key objectives for the Individualised Budgets work stream including further work with support agencies for direct payments and development of direct payments for carers.
Timescales	2008-2011
Budget	To be completed in final version of the Business Plan

### 5.3.4 Safeguarding adults

Sponsor	Sheila Wrochester
Programme Manager	To be completed in final version of the Business Plan
Description	There is no LAA target directly relating to the quality of care provided in local Care Homes with Nursing for Older People (CHNs). This target has been generated for Birmingham, in recognition of a local need to manage the market for such services in a way that enhances the quality of care provided and expands the range of services available to the citizens of Birmingham.
Key Objectives	<p>The following key objectives have been identified for the Safeguarding Adults work stream;</p> <ol style="list-style-type: none"> <li>1. A reduction in the number of Care Homes with Nursing for Older People in Birmingham classified by CSCI as Poor Providers at Standards level 1.</li> </ol>

	<p>2. The target that has been set is to reduce the number of CHNs in Birmingham rated as Poor by CSCI by 2 per year, resulting in a total of no more than 6 CHNs still being rated at 1 by the end of 2011.</p> <p>3. A secondary target is therefore to establish a local rating process for services in Birmingham, bringing together the CSCI rating and intelligence generated by the Council and partner agencies.</p>
Key Activities	<p>The following activities have been identified to realise the key objectives;</p> <ol style="list-style-type: none"> <li>1. Multi-agency training re Safeguarding Adults</li> <li>2. Raise Awareness of Safeguarding Adults issues</li> <li>3. Consistent Commissioning procedure for CHN services</li> </ol>
Benefits	The delivery of the key objectives for the safe guarding adults work stream including better standards for nursing homes
Timescales	2008 –
Budget	TBC

### 5.3.5 Further documentation

At time of draft release, information surrounding the following work streams within *Theme 2: Personalised Care* had not been compiled:

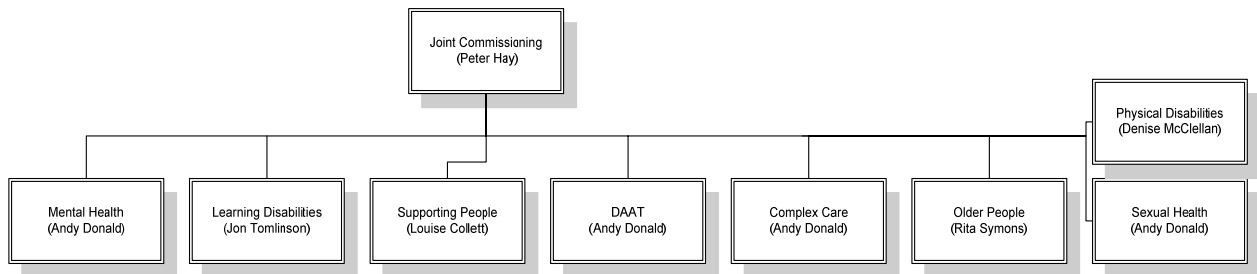
1. Older People's Wellbeing

Documentation on this work stream will be available upon release of the final version of the Plan.

## 5.4 Theme 3: Joint Commissioning

The thematic priority Personalised Care is led on behalf of the BHWP Executive by Peter Hay, and has eight main workstreams

Figure 7 - Joint Commissioning work stream and work stream leads



### 5.4.1 Mental health

Sponsor	Andy Donald / Jon Tomlinson
Programme Manager	Jane Collier
Description	
Key Objectives	<p>The following key objectives have been identified:</p> <ol style="list-style-type: none"> <li>1. Developing a robust Primary Care Mental Health Services through the national stepped care model.</li> <li>2. Local Community Based services for people with Personality Disorders</li> <li>3. Developing some innovative answers to the need for increasing housing options available for adults of working age with mental health problems.</li> <li>4. Developing Older People's Mental Health services.</li> </ol>
Key Activities	<p>The key activities are outlined below:</p> <ol style="list-style-type: none"> <li>1. Funded plans to introduce the stepped model of care in Primary Care Mental Health are underway across all three PCT's. In 2008/2009 each area of the city improved the step three high intensity treatments in Primary Care. The joint commissioning team submitted a bid to the NHS West Midlands for national funding for IAPT; the team have been successful and awarded £2.5 million. Full rollout of the stepped model of care can begin in 2009/2010.</li> <li>2. There is a national requirement in the Autumn Assessment to have an agreed, funded and implemented Personality Disorder Strategy. A Birmingham wide commissioning specification had been agreed with service users and shared with Birmingham and Solihull Mental Health Foundation Trust. In October 2008 the Community Personality Disorder service was launched and was fully operational in January 2009.</li> <li>3. Too many young adults with severe and enduring mental ill health are condemned to a life in residential care because of a lack of innovative supported housing and tenancy projects in partnership with health, social care, housing and supporting people. A project manager was appointed in October 2008 to lead on this piece of work, the project manager and a brief for the project produced. The accommodation forum has</li> </ol>

	<p>now been established and will be taking forward the issue of move on within supporting people and the availability of housing. The project manager will also be exploring the development of a long stay unit for those clients with severe and enduring mental illness where Supporting People is unfortunately not an option.</p> <p>4. Older people with functional mental illness eventually need to be cared for by services which can also understand their needs in relation to ageing. Historically these services have been poorly funded and not had access to crisis support or home treatment this is particularly unsuitable for older people as we know that stays in hospital are likely to reduce independence and increase the chances of not being able to return home.</p> <p>A service specification was agreed for community rehabilitation and support team across Birmingham, Birmingham and Solihull Mental Health Foundation Trust are now our service provider and were fully operational January 2009. A service specification was also developed for a memory assessment service and the funding will hopefully be agreed within the 2009/10 PCT investment plans.</p>
Benefits	<p>Increasing access to psychological therapy within a primary care setting, service users not having to go to a secondary care service for Mental Health services.</p> <p>The Community personality disorder service will give service users another option of treatment rather than the only original service which was main house - a residential therapeutic community service.</p> <p>The housing project will give younger adults the opportunity of living independently and or with support rather than condemned to a life of residential care.</p> <p>The additional older adult's services will complement the National Dementia Strategy and the Darzi Dementia pathway and increase the services available.</p>
Timescales	2008-2010
Budget	To be completed in final version of the Business Plan

#### 5.4.2 Drugs and alcohol

Sponsor	Andy Donald
Programme Manager	Jenny Northcote
Key Objectives	<p>The following key objectives have been identified for the DAAT work stream</p> <p><b>Alcohol Related Harm:</b> Agree a partnership base line and partnership target based on PCT's vital signs targets.</p> <p><b>Treatment System re-design</b> Increase treatment systems ability to respond to diverse and changing needs.</p>
Key Activities	<p>The following activities have been identified to realise the delivery of key objectives for the DAAT work stream;</p> <ol style="list-style-type: none"> <li>1. Clear understanding of how base line data is calculated, and ensure that there is commonality across each contributing PCT.</li> <li>2. Further enhance pathways into treatment – stake holder involvement in proactively promoting and supporting pathways into treatment through service protocols, referral protocols, operational practises and systems e.g. screening, early identification shared care planning, cross agency care planning and staff training.</li> <li>3. Improve Information exchange, through agreement of data exchange policies systems</li> </ol>

	and processes.
Benefits	The delivery of the key objectives for the DAAT work stream including a reduction in alcohol related harm and treatment system re-design
Timescales	2008 – 09
Budget	TBC

### 5.4.3 Complex care

Sponsor	Andy Donald
Programme Manager	Glenn Warren / Sam Davis
Description	
Key Objectives	<p>The following key objectives have been identified for the Complex Care work stream;</p> <ol style="list-style-type: none"> <li>1. The transfer of commissioning of the Under £40K Continuing NHS Health Care Packages from SBPCT Complex Care Team to the Continuing Health Care Commissioning Team will be effective from 1<sup>st</sup> April 2009. Further work to review the work of the team together with developing and agreeing a clear pricing structure will be finalised by late Spring 2009.</li> <li>2. The review into the role of the community health care co-ordinators across the city is ongoing and options papers for consideration will be complete by late Spring 2009.</li> <li>3. In line with the requirement to issue National Contracts to all providers commissioned to deliver Continuing Health Care Services from both statutory and independent sector providers contracts documentation containing detailed service specifications and quality and performance indicators will be developed for all placements in nursing homes and packages of care.</li> <li>4. To establish a provider forum for independent sector providers of NHS Continuing Health Care ( Nursing Homes, Care Package Providers, NHS providers)</li> <li>5. To agree and develop a local dispute resolution process for NHC Continuing Health Care.</li> <li>6. To work with providers in developing a User/Carer forum.</li> <li>7. To integrate complex care into client based pathways ensuring clear links with Specialised Commissioning and PCT based commissioning.</li> </ol>
Key Activities	<p>The following activities have been identified to realise the key objectives;</p> <ol style="list-style-type: none"> <li>1. review the service provided by SBPCT complex care nursing team.</li> <li>2. review the role of the community health care co-ordinators across the City.</li> </ol>
Benefits	The delivery of the key objectives for the Complex Care work stream
Timescales	2009 – 2010
Budget	To be completed in final version of the Business Plan

#### 5.4.4 Older people

Sponsor	Rita Symons
Programme Manager	
Description	
Key Objectives	The following key objectives have been identified for the Older People work stream; <ol style="list-style-type: none"> <li>1. Creating a city wide approach to strategically reduce delayed transfers of care</li> <li>2. Intermediate care – the ability for a patient to return to a fulfilling life upon discharge</li> </ol>
Key Activities	The following activities have been identified to realise the key objectives; <ol style="list-style-type: none"> <li>1. Home care service to be redesigned to focus on re-ablement</li> <li>2. Telecare to be developed</li> <li>3. Extra care or mixed tenure housing to be established</li> <li>4. Special care centres to be further developed</li> <li>5. Establishment of a robust process for jointly commissioning care homes with nursing</li> </ol>
Benefits	
Timescales	2008 – 2009
Budget	To be completed in final version of the Business Plan

#### 5.4.5 Physical disabilities

Sponsor	Denise McClellan
Programme Manager	To be completed in final version of the Business Plan
Description	Patient experience and promoting independence are key issues across the local health environment where choice to receive health and social at home is not available. This has resulted in delayed discharges where people have been assessed as not being able to be discharged, where residential care becomes the next and only option and where hospitalisation becomes the default for many people.
Key Objectives	The following key objectives have been identified for the physical disabilities work stream; <ol style="list-style-type: none"> <li>1. A single co-located city wide physical disability team for neurological conditions</li> <li>2. Joint user engagement programme</li> <li>3. Single Agreed pathways around transition, crisis and end of life care</li> <li>4. telephone access for patients and generalists seeking specialist advice</li> <li>5. Pilot a very small number of personal budgets for health and social care needs</li> <li>6. Development of a small number of joint interim care beds</li> <li>7. Support to Carers as part of the Birmingham wide work</li> <li>8. Development of a joint training strategy for generalists to support mainstream care</li> </ol>
Key Activities	To be completed in final version of the Business Plan
Benefits	To be completed in final version of the Business Plan
Timescales	To be completed in final version of the Business Plan
Budget	To be completed in final version of the Business Plan

### 5.4.5 Delayed transfers of Care

Sponsor	Rita Symons		
Programme Manager	Scott Cooper (interim)		
Description	To reduce delays in discharging patients from both acute hospitals and non-acute community based provision when they are medically fit for discharge.		
Key Objectives	Reduction to following targets, per 100,000 of population aged 18+		
	<b>2008/2009</b>	<b>2009/2010</b>	<b>2010/2011</b>
	15.3	12.7	10.2
Key Activities	<p>The activities that will realise the key objectives are still to be confirmed, however it is likely to include:</p> <ol style="list-style-type: none"> <li>1. Reduction in funding delays for younger adults</li> <li>2. Reduction in housing delays</li> <li>3. Address short-term geographical inequality for home care</li> <li>4. Achieve long-term vibrant sustainable market for home care</li> <li>5. Implementation of BUPA Health Dialogue risk assessment tool</li> </ol> <p>These interventions are further broken down into specific activities and enablers that will deliver these interventions. These activities are available in the Delayed Transfers of Care delivery plan 2009 – 2011 available by contacting the Partnership directly.</p>		
	Benefits		
Benefits	The delivery of the key objectives for the Delayed transfer of Care work stream including a reduction in the length of time people spend in hospital and an increase in the quality of outcomes.		
Timescales	2009 – 2011		
Budget	To be completed in final version of the Business Plan		

### 5.4.6 Further documentation

At time of draft release, information surrounding the following work streams within *Theme 3: Joint Commissioning* had not been compiled:

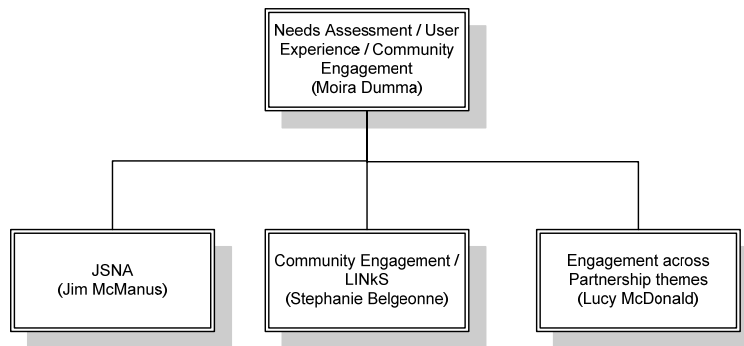
1. Sexual Health
2. Learning Disabilities
3. Supporting People

Documentation on this work stream will be available upon release of the final version of the Plan.

## 5.5 Theme 4: Needs assessment and engagement

The thematic priority Needs assessment and engagement is led on behalf of the BHWP Executive by Moira Dumma, and has four main workstreams, two of which – marketing and access, and user experience benchmarking – are still being planned (Figure 8).

**Figure 8 Needs assessment and engagement**



### 5.5.1 Joint Strategic Needs Assessment

Sponsor	Jim McManus
Programme Manager	Dr Iris Fermin
Description	
Key Objectives	The following key objectives have been identified for the Joint Strategic Needs Assessment work stream: <ul style="list-style-type: none"> <li>Develop and agree common standards and a framework of</li> </ul>
Key Activities	The following activities have been identified to realise the key objectives: <ul style="list-style-type: none"> <li>Creation of a JSNA Work Plan and infrastructure</li> <li>Production of the Birmingham Health Profile annually</li> <li>Production of the JSNA Overview</li> <li>Production of theme reports. The first theme reports for 2009-10 will be 1) Life Expectancy and 2) Children</li> </ul>
Benefits	The following benefits will be realised in the event that the activities are successfully implemented: <ul style="list-style-type: none"> <li>All partners will understand the key needs of Birmingham</li> <li>All partners will understand the commissioning priorities to address those needs</li> <li>All partners will have a series of aids to commissioning which triangulate and combine quantitative data with user and carer feedback and other sources of intelligence</li> <li>The annual public health reports for Birmingham will move to a focus on public health performance</li> </ul>
Timescales	2009 - 2011
Budget	To be completed in final version of the Business Plan

## 5.5.2 Community engagement

Sponsor	Stephanie Belgeonne
Programme Manager	Lucy McDonald (interim)
Description	
Key Objectives	<p>The following key objectives have been identified for the Community Engagement work stream:</p> <ul style="list-style-type: none"> <li>• Develop and agree common standards for engagement for the Partnership</li> <li>• Generate more detailed research evidence regarding seeking user and public views in relation to NHS and health issues, linked to Local Area Agreement and local targets.</li> <li>• Analysis of needs assessment linked to Joint Strategic Needs Assessment and Local Area Agreement from user/public perspective</li> <li>• Integration of data capture and publication of health and social care engagement activity.</li> </ul>
Key Activities	<p>The following activities have been identified to realise the key objectives:</p> <ul style="list-style-type: none"> <li>• Consultation to produce common standards for engagement.</li> <li>• Negotiate integration of research and engagement data by partners.</li> <li>• Create accessible local database of engagement activity.</li> <li>• Conduct targeted primary research.</li> </ul>
Benefits	<p>The following benefits will be realised in the event that the activities are successfully implemented:</p> <ul style="list-style-type: none"> <li>• All partners employ Best Practice in engagement activity, complying with legislation.</li> <li>• Partners make best use of resources.</li> <li>• A growing local database of engagement and consultation activity informs commissioning in Birmingham.</li> <li>• Agency partnerships with neighbourhoods and communities are strengthened through effective engagement, involvement and communication.</li> </ul>
Timescales	2009 - 2011
Budget	

### Further documentation

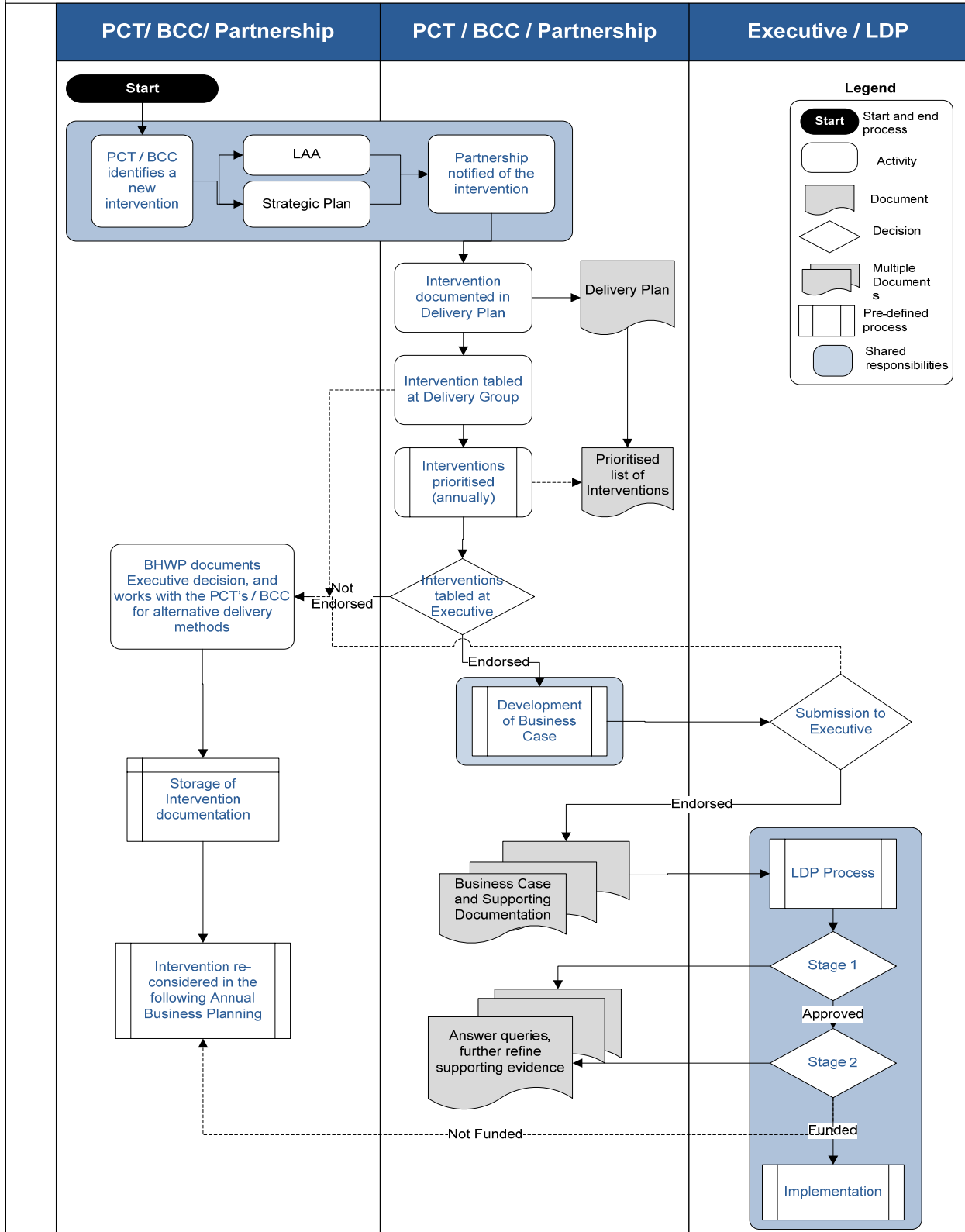
At time of draft release, information surrounding the following work streams within *Theme 4: Needs Engagement* had not been compiled:

1. Engagement across Partnership themes

Documentation on this work stream will be available upon release of the final version of the Plan.

## Interventions: A draft framework for prioritisation

### The identification and prioritisation of Partnership interventions



## Section Summary

- The BHWP is a voluntary coalition of health and care agencies in the city of Birmingham.
- The BHWP Executive provides the overall management and strategic direction for the Partnership. Its primary responsibility is to work within the framework established by the Local Area Agreement 2008-11. The Executive is an accountable body with the powers to delegate and enforce direct actions in pursuit of its objectives.
- The BHWP Summit meets quarterly and brings together the wider partnership. Through the Summit, partners are committed to delivering agreed outcomes within Birmingham's Local Area Agreement and other priority work.
- The BHWP is supported by a dedicated partnership team, led by the BHWP Director. The role of the Team is to work to ensure that BHWP priorities and plans both reflect and influence mainstream activities of partner organisations.
- The BHWP aims to have a fair, transparent and accessible approach to budget setting and financial management. Financial governance arrangements have been documented so that partners are clear about responsibilities and accountabilities.

### 6.1 Partnership governance

The Birmingham Health and Wellbeing Partnership is an unincorporated body – a voluntary coalition of health and care agencies in the city of Birmingham. It is one of seven thematic partnerships that support the work of Be Birmingham, the city's local strategic partnership. The BHWP has three key components:

- BHWP Executive
- BHWP Summit
- BHWP Team, led by the BHWP Director

This section outlines the governance arrangements through which the BHWP operates. The BHWP believes that appropriate and rigorously applied governance and accountability arrangements are critical to producing successful outcomes. Governance arrangements must be fit for the purpose of supporting the increasing responsibilities of BHWP and providing clarity to partners. Governance arrangements should be kept under review to ensure they remain appropriate.

### 6.2 BHWP Executive

The BHWP Executive provides the overall management and strategic direction for the Partnership. Its primary responsibility is to work within the framework established by the Local Area Agreement 2008-11 to

- take overall accountability and oversight of the partnership structure
- be responsible for the strategic direction of planning and commissioning for the BHWP
- ensure delivery against key targets

- produce regular reports to the BHWP Summit of progress and identify and resolve emerging issues.

The Executive is the highest level of accountability within the BHWP. The Executive is a responsible and accountable group with the powers to delegate and enforce direct actions in pursuit of its objectives.

As at March 2009, the Executive meets on a monthly basis and consists of the following voting representatives.

Name	Role	Organisation
Peter Hay	Strategic Director of Adults and Communities	Birmingham City Council
Moira Dumma	Chief Executive	South Birmingham PCT
Elaine Elkington	Acting Strategic Director of Housing and Constituencies	Birmingham City Council
Sandy Bradbrook	Chief Executive	Heart of Birmingham PCT
Sophia Christie	Chief Executive	Birmingham East and North PCT

Peter Hay is the Chair of the Executive and Moira Dumma the Vice-Chair.

In addition the following non-voting representatives attend the Executive:

Name	Role	Organisation
Jim McManus	City Director of Public Health	Birmingham City Council
Alan Lotinga	Director	Birmingham Health and Wellbeing Partnership
Jon Tomlinson	Director of Joint Commissioning	Birmingham City Council

The Executive's terms of reference were originally drafted in October 2005. These have recently been reviewed and revised, and are scheduled for approval at the March meeting of the Executive.

The Executive meets monthly, and its [revised] terms of reference all meetings to satisfy arrangements for good governance and freedom of information. Agendas and supporting papers should be circulated five working days before the date of the Executive meeting; minutes and action logs should be circulated within five working days of the meeting. The Executive must also ensure that all its work is compliant with relevant codes of conduct, standing financial instructions, policies and procedures.

The Chair of the Executive is responsible for ensuring that any urgent issues arising between meetings are dealt with through appropriate communications between Executive members.

### 6.3 BHWP Summit

The BHWP Summit meets quarterly and brings together the wider partnership including all NHS Trusts, City Council departments, Third Sector, representatives from neighbourhood and communities, including user and carer groups and the Birmingham Local Involvement Network (LINKS).

Through the BHWP Summit, partners are committed to delivering agreed outcomes within Birmingham's Local Area Agreement and other priority work within the BHWP's Annual Plan through an approach based on the Joint Strategic Needs Assessment, designing programmes based on evidence which is relevant and responsive to targeted populations and individuals

## 6.4 BHWP Team

The BHWP is supported by a dedicated partnership team, led by the BHWP Director. The role of the Team is to work to ensure that BHWP priorities and plans both reflect and influence mainstream activities of partner organisations with the aim of providing better health outcomes and quality of life for the people of Birmingham. The Joint Director of Public Health and Director of Joint Commissioning will also collaborate closely with the BHWP Director to achieve the Partnership's mission.

The BHWP Team is being strengthened and expanded, and details of this development are given in the next section on BHWP Infrastructure. The Team supports the BHWP in

- strategic planning: developing partnership vision and preparing outcome focused delivery plans to achieve it
- performance management: ensuring outcomes and other aspects of performance are suitably monitored and managed through the BHWP
- partnership development: supporting the engagement of partners and other stakeholders in the BHWP's work and ensuring that appropriate links are made with Be Birmingham and the other thematic partnerships in the city
- external liaison: helping partners with co-ordinated responses to external developments from national Government, regulatory organisations and regional bodies.

## 6.5 Financial Governance

The BHWP aims to have a fair, transparent and accessible approach to budget setting and financial management.

Financial support to the BHWP is provided by Birmingham East and North PCT. BEN PCT as the lead agency takes responsibility for the financial management, procurement, monitoring and probity of BHWP. This includes Conflicts of Interest and Codes of Conduct. The BHWP will be expected to comply with BEN PCT's own financial standing orders and regulations.

The details around funding streams and payment terms can be found within Appendix 1.

### 6.5.1 Calculation of contributions

Each partner pays an annual contribution to BEN PCT based on agreed interventions. A resource mapping exercise is under way to provide the baselines upon which these contributions will be based. The results of this exercise will form part of any BHWP agreement with partners. This agreement will specify the shares to be contributed by partners and identify any exceptions in the treatment of surpluses and deficits. Any changes to the plan, and therefore the annual subscription, which may be required during the financial year, will be submitted to the BHWP Executive for a formal decision. Changes will be made using agreed methodologies that support the principles of appropriate risk sharing and equity between Partners.

All interventions included in the subscription arrangements will be operated as a pooled resource (with over-performance on one intervention offset by under-performances on others) and adjustments for over or under performance will be made only on the total budget. Any alternative methodology will only be used following approval by the BHWP Executive. Under FRS9 a pool is not an entity and so cannot be used to carry forward surpluses or deficits. Surpluses or deficits at year-end will be notified by BEN PCT to partners in proportion to their original contributions (unless otherwise agreed under fair and demonstrable reasoning), and shown within their individual accounts.

Similarly under FRS9 partners need to reflect their share of the assets, liabilities and cash flows within their accounts, and BEN PCT will need to ensure appropriate notification of these balances. Carry forwards and other accounting policies will be subject to the policies adhered to by BEN PCT as host.

Where resources can be identified within other thematic partnerships to support the BHWP elements of delivery, it is proposed that Be Birmingham facilitate the building of appropriate joint-working opportunities, enabling transfer of funds and aid the resolution of any disputes.

### **6.5.2 Reporting and Communication**

BEN PCT, as the Accountable Body, will ensure that robust performance management procedures are in place. Monthly reports will be sent to BHWP, with quarterly financial monitoring reports for the BHWP Executive.

The BHWP Executive will acknowledge the need for timely communication of decisions to necessary stakeholders within their individual partner organisations. Key contacts for operational issues around finance will be clearly identifiable within each organisation.

### **6.5.3 Consistency**

The key underlying principle of partnership working is a significant reduction in duplication. Collective BHWP Executive decisions on funding should be actionable directly within the LDP processes of each partner, without the need for submissions to approval by the individual internal processes or partner organisations.

It is recommended that comprehensive agreements are created between each partner and the BHWP for its overall resource requirements to deliver the full BHWP agenda. Agreements should not be formed on an ad hoc basis for individual elements of BHWP unless absolutely necessary, to enable the optimum use of resources and avoid inconsistencies.

### **6.5.4 Audit**

The BEN PCT Finance Director will certify annually that the performance and financial monitoring returns are correct. The Finance Director will also be required to pass to relevant accountable bodies an Annual Audit Statement certifying that the expenditure claimed has been fairly stated and is in accordance with any related terms and conditions.

When detailed governance arrangements are developed, lines of accountability and escalation will be defined.

### **6.5.5 Planned Developments**

As part of creating a comprehensive signed annual SLA between all Partners and the BHWP, a number of other planned developments are to be pursued. These include Terms of Reference, detailed governance arrangements and other standing financial instructions.

It should be noted that ultimately BHWP aims to have a statutory section 75 (NHS ACT 2006) agreement. In addition to the above, a resource mapping exercise is currently taking place to determine the level of resources for each partner aggregate for each intervention within the BHWP agenda.

## Section Summary

- Arrangements are being put in place to strengthen the BHWP infrastructure to make it fit for purpose.
- The BHWP Team is being strengthened, and additional staff are to be recruited to enhance capacity for programme management and for information and intelligence.
- New processes are being put in place to ensure sound planning, performance management and governance.
- A new annual planning process is being developed, of which this first business plan is a part. The intention is to move to a planning cycle that aligns with the operational and budget planning timetables of partner organisations.
- New governance arrangements are being put in place in a number of areas to support specific workstreams through the establishment of Delivery Groups.
- The resources to underpin these new arrangements, and to support the implementation of delivery plans, are being put in place.

### 7.1 Developing a Partnership infrastructure

#### 7.1.1 Background

When the BHWP was established in its current form in 2005, it was recognised that the Partnership, and partnership activity, would require dedicated resources if it was to be effective.

This became clear in 2006, when the BHWP prepared a Floor Target Action Plan which outlined its priorities for addressing health inequalities in Birmingham. Two citywide programmes were established as a result of the Floor Target Action Plan: one focused on reducing infant mortality and one focused on improving male life expectancy. Dedicated programme staff was employed to develop and implement the interventions proposed in the Floor Target Action Plan. Subsequent evaluation has shown the effectiveness of some key interventions, and one element of the male life expectancy programme was a finalist for the Health Service Journal awards in 2007.

At the same time as employing staff to organise citywide programmes, the BHWP put in place arrangements to support its general work. This core infrastructure consisted on an interim Director supported by a performance management post and administrative support. Birmingham East and North PCT provided personnel and financial support.

In early 2008, the BHWP Executive initiated a review of its priorities and the arrangements for achieving them. It identified the four thematic priorities on which it wished to focus:

1. Tackling Health Inequalities
2. Personalised Care
3. Joint Commissioning
4. Understanding needs and engaging with communities

Within each theme, priority workstreams have been identified, details of which are given in Section 5. Some of these workstreams already had staff and resources to support their work; others have required new arrangements to co-ordinate and implement activity. During 2008-09, a number of interim managers have been helping the BHWP to develop detailed plans for this work.

## **7.2 Proposals for infrastructure development**

The following arrangements are being put in place to strengthen the BHWP infrastructure to make it fit for purpose for achieving its priority outcomes and targets.

### **7.2.1 BHWP Team**

A permanent BHWP Director has been appointed, who takes up post at the end of April 2009. They will be supported by [an assistant director;] an office manager and administrative support; a communications manager; [a performance manager;] and increased financial and HR support.

### **7.2.2 Information and intelligence**

The Public Health Information Team moved to become part of the BHWP during 2008. A Head of Information and Intelligence has been appointed, reporting to the Joint Director of Public Health. This post will oversee the work of an expanded Public Health Information Team, as well as the management of the Joint Strategic Needs Assessment and the employment of public health science and health economist specialists to support improved commissioning.

### **7.2.3 Programme management**

A number of workstreams will be taken forward by newly appointed programme managers, who in some cases – for example, life expectancy, infant mortality, employment and health – will be supported by other programme staff. The aim is that all priority workstreams should have dedicated and clearly accountable lead officers. Programme managers will be part of the BHWP Team unless otherwise specified.

### **7.2.4 Joint Commissioning**

A number of existing arrangements are already in place for developing joint commissioning for specific groups: for example, people with learning disabilities. A new Director of Joint Commissioning has been appointed to oversee the development of joint commissioning arrangements across the priority areas identified by the BHWP (see Section 5). [These arrangements are likely to lead to the organisation of citywide joint commissioning teams for key population groups and service areas.]

### **7.2.5 Partnership processes**

This expansion of citywide activity and co-ordination requires new processes to ensure sound planning, performance management and governance. Performance management is described in the next section; new arrangements for planning and governance are summarised below.

## Planning

A new annual planning process is being developed, of which this first business plan is a part. A broad strategic direction has been set for each of the four thematic priorities; these are described in Section 4. Within each theme, priority workstreams are required to prepare delivery plans to a common template: these set out the main aims for the workstream and how these will be achieved. These delivery plans form the basis for determining the allocation of BHWP and partners resources to achieve priorities. Section 5 has summarised key points from these delivery plans.

At this stage, these plans and planning processes are still under development. The intention is to move to a planning cycle that aligns with the operational and budget planning timetables of partner organisations.

## Governance

The arrangements for the overall governance of the BHWP were described in the previous section. In addition, new governance arrangements are being put in place in a number of areas to support specific workstreams through the establishment of Delivery Groups; a number of co-ordinating groups already exist for some workstreams, and these will also become accountable for achieving outcomes and targets in their area. Standard terms of reference have been drafted for Delivery Groups, and formal processes are being put in place to ensure the Group transact business effectively. Delivery Groups will be accountable to their thematic lead and through them to the BHWP Executive.

The main elements of financial governance for the BHWP were described in the previous section. These cover the general approach, contributions, reporting, consistency and audit. In addition, more detailed guidance on financial governance is being drawn up to provide clarity on funding streams, payment terms and the management of agreements. Details are given in Appendix 1.

## **7.3 Assets**

The Partnership is currently based at 146 Hagley Road, Edgbaston, Birmingham B16 9NX

The Partnership is currently going through a phase of growth in its functions, and this inevitably has implications for Partnership infrastructure.

There are several key areas where the infrastructure of the Partnership will need to develop or change over the coming year:

- Establishment structure and complement – Themes within the Partnership are developing work programmes and with these work programmes staff, systems and processes will be needed.
- Systems and structures – Partnership governance arrangements, financial and performance reporting systems and processes will all need to develop further to keep track of the work of the Partnership and ensure it is delivering
- Premises – The office accommodation for the Partnership needs to ensure there is sufficient space for Partnership business to be conducted

Within all of this lies the need to reflect the 3Es duty – Efficiency, Economy and Effectiveness. Improving efficiency while holding costs down is a priority. Current means of doing this are exploring premises costs, sharing and pooling office management, business support and reception etc facilities and ensuring we have sufficient meeting space to minimise the amount of external meeting space we use.

At the time of writing a premises strategy is being developed and implemented. This has the following areas of focus:

1. Immediate (1 – 3 months) the focus here is on having sufficient space and facilities to accommodate the Joint Commissioning teams and immediate expansion in PHIT, BHWP and co-located functions. Telephony, desking, IT and other basic facilities to enable business critical work to continue.
2. Short term (6 months onwards) the focus here is on ensuring we have sufficient space to deliver Partnership business. This will need to involve the leasing of extra accommodation and options are currently being explored for this.
3. Medium Term (1 – 3 years) Ensuring our office accommodation and the locations of teams enable Partnership culture and business to be delivered.
4. Longer Term (3 – 5 years). Exploring options for relocation longer term as functions continue to grow.

The Partnership currently accommodates just fewer than 30 people with the Cardiac Network co-located. It is currently estimated that the Partnership needs to provide accommodation for up to 105 people by 2010.

A key priority during this is to minimise disruption to Partnership business, and ensure that the phasing of accommodation is contiguous with recruitment and financial processes and timescales.

## 7.4 Finance

This section summarises the financial planning of the BHWP for 2009-10 and 2010-11. For that period, the main sources of finance for the work of the BHWP are:

- Contributions from partners for agreed core and pooled expenditure
- Working Neighbourhoods Fund: the BHWP has been allocated £3 million for the period by Be Birmingham
- Support for activities through partners' mainstream budgets: for the PCTs, a key source is the allocation of funding as part of the Local Development Plan (LDP)
- Working Neighbourhoods Fund allocated by Be Birmingham to the city's Worklessness Delivery Plan is expected to fund some of the activities set out in the Employment and Health Delivery Plan.
- Other sources of funding highlighted below is the communities for health budget managed by Birmingham City Council. This is a non-recurrent allocation by the Department of Health.

### 7.4.1 Spending plans

The BHWP's proposals for developing a fit for purpose infrastructure are outlined above. Some of these proposals have already been approved by the BHWP Executive and resources allocated; others have been approved but await resourcing decisions; others are proposals awaiting approval and resourcing. The current position is summarised in Tables 5 and 6.

**Table 5 - Summary of infrastructure budget proposals**

	2009-10	2010-11	Total
Resourced infrastructure	958	958	1,916
Existing commitments	471	472	943
Additional proposals	641	644	1,286
Infrastructure total	2,070	2,074	4,145

**Table 6 - Summary of infrastructure funding proposals**

	2009-10			2010-11		
	Partners	WNF	Other	Partners	WNF	Other
Current infrastructure	849		109	849		109
Existing commitments	313	158		313	158	
Additional proposal	194	448		157	488	
Total	1,356	606	109	1,320	646	109

Note: WNF is the Working Neighbourhoods Fund under the control of the BHWP; WNF from other sources is included in "Other".

In addition, the health inequalities Delivery Plans have put forward a range of proposed activities, the funding for which is still under discussion. Table 7 summarises the total proposed spending and the potential sources of funding.

**Table 7 - Summary of funding proposals from health inequalities delivery plans**

2009-10				2010-11			
Partners	WNF	Other	Total	Partners	WNF	Other	Total
5,078	1,368		6,446	5,455	1,800		7,255

*Note: WNF is the Working Neighbourhoods Fund under the control of the BHWP; WNF from other sources is included in "Other".*

Table 8 summarises the proposals for funding infrastructure and health inequalities activities.

**Table 8 - Summary of BHWP funding proposals**

2009-10				2010-11			
Partners	WNF	Other	Total	Partners	WNF	Other	Total
6,434	1,974	109	8,516	6,775	2,446	109	9,329

### Section Summary

- The BHWP is developing a performance framework to ensure that key outcomes and targets are achieved and that any problems affecting the achievement of outcomes or delivery of interventions are quickly identified and resolved.
- The BHWP Team will put in place arrangements to collate the data needed to monitor performance and to prepare performance management reports.
- The BHWP Executive will prepare an annual report which summarises performance and progress for each theme and set targets for the next year. An end-of-year report will also be prepared for each delivery plan.
- The BHWP has to respond to a wide range of risks which require effective management and mitigation. A risk scoring matrix has been devised and used to prepare an initial assessment of risks. Risks will be recorded and monitored through a BHWP risk register.

## 8.1 Performance Framework

### 8.1.2 Introduction and performance requirements

Birmingham Health and Wellbeing Partnership (BHWP) recognises that to successfully promote improvements in the lives of those who suffer inequality to produce the necessary increase in life expectancy; the monitoring and evaluation of delivery plans is essential.

The Performance framework within the Partnership is in its relative infancy. Existing performance indicators are in the process of being mapped against the proposed outcomes for all work streams that form part of the Partnership Business Plan 2009-2011. The framework will consist of both national and local indicators that together will support the performance improvement required to achieve Birmingham's ambition to deliver a better quality of life for people within the City. The interventions set out in this Business Plan are being developed to target specific areas of the BHWP's 2009/11 priorities. Where appropriate they will contain key milestones to be achieved throughout the year and the date those milestones will be achieved. This will facilitate monitoring; and the progress made will provide updates for each of the identified work streams and their agreed interventions

The Partnership will use the Performance Framework for three purposes:

1. To make decisions about the effectiveness of historical programmes and using demographic data target future programmes;
2. To measure the impact of programmes by considering outcomes against investment; and
3. To measure the improvement in Partnership working.

The 2008 – 11 LAA has the commitment of local agencies to:

‘Reduce inequalities in health and mortality across Birmingham and support more people to choose healthy lifestyles and improve their wellbeing’.

There are seven key targets (see LAA Be Healthy) for the BHWP which cut across the four themes of Health Inequalities, Personalisation, Joint Commissioning, and Needs and Engagement. Each theme has one or more delivery plans.

**The Performance Management framework will be completed throughout 2009. At present a suite of performance measure are under development.** Once agreed these measures will be used to monitor, review and challenge performance. The Public Health Information Team (PHIT) will have a key role in its development, analysis and reporting working with those responsible for programmes and targets to ensure they provide reports.

Discussion and scoping of ICT systems for performance has shown that at present a move to Performance Accelerator would be unnecessary. The needs of the partnership can be met for the present with Excel, SPSS®, MapInfo® and other specialist software which the Public Health Information Team hold.

## 8.2 Theme(s) Overview

The following provides a snapshot of the National Indicators (NI) and/or Key Performance Indicators (KPI’s) across each theme and work stream that will need to be mapped to performance measurements.

### 8.2.1 Theme: Health Inequalities

Health Inequalities has been divided into five key work streams which aims to contribute to an improved ‘all age/all cause mortality’ rate (NI 120). Each one has a delivery plan which sets out the planned programmes to reduce inequalities across the city.

#### Work stream: Life expectancy

NI	Descriptor
120	All-age all cause mortality
121	Mortality rate from circulatory disease
122	Mortality rate from all cancers

The overall life expectancy for Birmingham is reported annually from the Office for National Statistics. At time of writing, the Directors of Public Health are seeking to renegotiate a single life expectancy target for Birmingham based on new modelling of data. It is hoped this target will cover both Local Area Agreement and NHS performance management and be agreed by both Government Office and NHS West Midlands.

## Snapshot of Performance Mapping for Life Expectancy

The following table gives a snapshot of how the Performance measures will be mapped to the National Indicators

	Indicator (by type N, L, proxy, PCT, LA, LAA? Any others?)	Where collected and held in Birmingham	Who collects it for use pan Birmingham	Format	What outcome is measured by it	Performance Indicator
Work stream: Life expectancy	N 120 VSB01	PCTs – CHECK with Health Improvement/ Public Health departments for each PCT	ONS death registration and population, data received monthly by PCT	To be determined by the PHIT Team	All age, all cause mortality	To be determined by PHIT Team
	NI 121 VSB02		ONS death registration and population, (annual) received monthly by PCT		Mortality rate from circulatory disease	
	NI 122 VSB03		ONS death registration and population, (annual) received monthly by PCT		Mortality rate from all cancers	

### Work stream: Infant mortality

Four KPIs have been agreed as performance measures to demonstrate progress towards the target of reducing the infant mortality rate:

KPI	Descriptor
1	Early booking
2	Continuity of carer
3	Detection of foetal growth restriction
4	Breast feeding

### Work stream: Smoking cessation and tobacco control

A key target for Smoking cessation and tobacco control work stream is to reduce smoking in adults by 21% by 2010. At time of writing, Directors of Public Health are currently negotiating a new shared target for Birmingham.

The three KPI's for smoking cessation and tobacco control are:

KPI	Descriptor
1	reduction of smoking in pregnancy (reduction of 156 per quarter)
2	the numbers of 4 week quitters, (1015 per 100,000 for each PCT) and
3	Successful quitters from targeted programmes: <ul style="list-style-type: none"> <li>• BME groups in particular Bangladeshi and Pakistani men ;</li> <li>• Under 16s;</li> <li>• Mental health and wellbeing + learning difficulties;</li> <li>• Gay men &amp; women; Long term unemployed;</li> <li>• People with long term conditions;</li> <li>• Young people 16 -24.</li> </ul>

### Work stream: Obesity

National evidence points to the single most effective factor in reducing obesity is regular exercise

The following three NI's for the obesity work stream has been identified:

NI	Descriptor
56	To halt the rate of increase in childhood obesity in school aged children (year 6) and reduce the overall prevalence of obesity in their age groups by 0.1%
8	To increase adult participation to at least 3 times a week in moderate physical activity.
57	To increase children and young people's participation in high quality physical exercise and sport.

### Work stream: Health and Work

Initially reporting will be on progress of implementation of the systems. Then key data reported will be:

KPI	Descriptor
1	Fit for Work schemes
2	Back to Work support schemes
3	Volunteering Placement scheme
4	Numbers placed in health and social care
5	Direct work with employers as providers of healthy workplaces; and
6	Capacity building with GPs

### 8.3 Theme: Personalisation

Within Personalisation there are a number of National Indicators that will need to be performance measured to demonstrate that services are becoming more flexible and person centred.

NI	Descriptor
130	Use of Direct Payments or Individual Budgets
129	End of life care – dying at home
135	Numbers of carers receiving an assessment or review and a specific carer's service, or advice and information
124	Safeguarding adults

### 8.4 Theme: Needs and Engagement

The Joint Director of Public Health will report quarterly on the progress of the JSNA both improvement in its development and progress in implementation.

Separately there will be reports on the progress of LINKS in the role of development of effective relationships and consistent city wide responses.

There are a number of different mechanisms for engaging with the citizens of Birmingham. The Patient Experience Manager will report quarterly on progress of the development of pan Birmingham Engagement standards and a review of activity. This will be used to recommend a programme of engagement to measure satisfaction and service quality.

### 8.5 Theme: Joint Commissioning

#### Work stream: Older people

It has been agreed that progress on Joint Commissioning services for Older People will be measured using indicators relating to:

NI	Descriptor
131	acute and non-acute delays (part of the delayed transfers of care work stream)

#### Work stream: Mental Health services

Responsibility for developing a joint commissioning plan for mental health services has transferred to a newly developed team. Some parts of planning are still at an early stage. It is planned to produce a report for the May BHWP setting out the process, timetable, and intended outcomes from joint commissioning.

#### Work stream: Learning disability services

More work is needed to identify how to take the performance issues in learning disability work from the Partnership forward. It is planned to present a report for the August BHWP setting out the process, timetable, and intended outcomes from joint commissioning. The Executive will be able to make decisions on whether sufficient progress is being made.

#### Other Services

In future the Executive will need to consider Sexual Health, Drug and Alcohol Services, Complex Care, Physical Disability and Supporting People. There are structures in place for many of these but there are no robust arrangements for joint commissioning of Physical Disability services.

Report	Themes Reported	Frequency	Contents
Programme Manager report to Executive (incorporating Delivery Group input)	1) Health Inequalities  2) Joint Commissioning  3) Personalisation  4) Needs Assessment	Monthly	Operational performance indicators incorporating, milestones, deliverables, financial expenditure, risks, issues and deviation from Plan
Bespoke reports to Partnership		Monthly	Trend analysis
Performance Indicator Reports to Executive		Quarterly	Incorporating delivery, local (Birmingham) and National Performance Indicators to deliver progress against the internal/external targets
Bespoke report to Executive		Quarterly	Detailed examination (as required) across areas where the trend suggests investment is not producing results.
Human Resources and Finance Reports to Executive		Quarterly	Recruitment, departures, staff turnover statistics and the overall cost of delivering the Partnership
Finance Reports to the Partnership		Monthly	
Performance Report to Executive		Annually	Reports progress for each theme and sets targets for the next year. This report will include progress against the Be Healthy targets <sup>1</sup> for 2026.
Programme Manager Exception report to the Executive		Quarterly	Covering the following elements; co-operation, shared planning, shared information for decision making, appropriate delegation for lower level decisions, continuing communication
Joint Director of Public Health Report on the JSNA		Needs Assessment	Quarterly
Joint Director of Public Health Report on LINKS	Needs Assessment	Quarterly	Covering the progress of LINKS in the role of development of effective relationships and consistent city wide responses.
The Patient Experience Manager Report to the Executive	Needs Assessment	Quarterly	Covering the progress of the development of pan Birmingham Engagement standards and a review of activity.

<sup>1</sup> Active lifestyles – exercise three times a week; Longer life for all – improved life expectancy in the ‘worst’ ward; Low teenage pregnancy rates; and Best City in which to grow old – adult care packages made available within four weeks of assessment.



## 8.7 Risk Management

The BHWP has to respond to a wide range of risks which require effective management and mitigation. Risk can be defined as the chance of something that will happen which will have an impact on achieving the BHWP's aims and objectives. Risk in this context can be measured in terms of likelihood (frequency or probability of the risk occurring) and the consequence (severity or magnitude) of the effect of the risk occurring.

In line with the Birmingham East and North PCT Risk Management Strategy and Severity Assessment, identified risks are scored using the matrix shown in Figure 9 below and recorded and monitored via the BHWP central risk register.

**Figure 10 - Risk scoring matrix**

IMPACT	LIKELIHOOD				
	1 RARE	2 UNLIKELY	3 POSSIBLE	4 LIKELY	5 ALMOST CERTAIN
5 CATASTROPHIC	5 (Low)	10 (Moderate)	15 (Moderate)	20 (High)	25 (High)
4 MAJOR	4 (Very low)	8 (Low)	12 (Moderate)	16 (High)	20 (High)
3 SERIOUS	3 (Very low)	6 (Low)	9 (Low)	12 (Moderate)	15 (Moderate)
2 MINOR	2 (Very low)	4 (Very Low)	6 (Low)	8 (Low)	10 (Moderate)
1 INSIGNIFICANT	1 (Very low)	2 (Very Low)	3 (Very Low)	4 (Very Low)	5 (Very Low)

To ensure consistency of measuring levels of risk across the Partnership, a framework has been developed detailing the consequences of risk from a number of dimensions. An extract of this framework, highlighting impact from a financial perspective and the performance objectives is shown below.

**Figure 11 - Significance scoring**

Value	1	2	3	4	5
Financial Loss - Partnership	< £5,000	< £10,000	< £50,000	< £100,000	> £100,000
Objectives / Projects	Insignificant cost / schedule slippage / Barely noticeable reduction in scope or quality	Budget / Schedule slippage <5% / Minor reduction in Scope or quality	Budget / Schedule slippage <10% / Reduction in scope or quality	Budget / Schedule slippage <25%. / Failure to meet secondary objectives	Budget / Schedule slippage > 25%. / Failure to meet Primary Objectives

Risk identification and assessment are in relative infancy within the BHWP, so establishing and embedding a formal risk management process is a key priority during the next six months of 2009.

An initial assessment of key risks for the BHWP and of their mitigation is given in the tables below. These risks are focused purely on the delivery of BHWP aims and objectives. It is assumed that partners, including the PCTs and Birmingham City Council have their own risk management processes, which document more risks. As part of the development of BHWP governance, links will be made with the PCTs and Birmingham City Council to ensure that the BHWP is aware of and takes account of any wider risks.

<b>STRATEGIC RISKS</b>					
<b>Risk Title</b>	<b>Risk Description</b>	<b>Like- lihood</b>	<b>Impact</b>	<b>Score</b>	<b>Risk Mitigation</b>
Business Planning for the Partnership	<p>There is a risk that BHWP Business Planning and Governance is not aligned to the future delivery plans and directions for the Partnership.</p> <p>This includes:</p> <ul style="list-style-type: none"> <li>- transparency of resource planning and availability of resources to complete work</li> <li>- Understanding of roles and responsibilities</li> <li>- Whereabouts of the team members on a week to week basis</li> </ul>	4	3	12	<ol style="list-style-type: none"> <li>1) Undertake a proper Business Planning period that encompasses resources and processes available, what the future delivery plans detail and how these can be linked to upcoming planning required.</li> <li>2) Develop clear roles and responsibilities across the Partnership</li> <li>3) Improve the communication processes across the Partnership, so the team has access to the daily whereabouts of their colleagues</li> </ol>
Partnership Funding Allocation	There is a risk that in this difficult economic environment that the BHWP does not obtain the appropriate level of funding to deliver on the required objectives	3	4	12	<ol style="list-style-type: none"> <li>1) Prioritise the interventions of most importance within the delivery plans</li> <li>2) Fully understand the financial requirements and available funding for delivery of service</li> <li>3) Approve the must do interventions that are most realistic to fund within the service</li> <li>4) Focus on the economies of scale associated with joint Partnership funding</li> </ol>
Partnership Strategic Aims	There is a risk that the BHWP struggles to achieve its strategic aims	2	5	10	<ol style="list-style-type: none"> <li>1) Address problems quickly through active escalation to the Executive and direction from the Executive to delivery groups</li> </ol>

<b>OPERATIONAL RISKS</b>					
<b>Risk Title</b>	<b>Risk Description</b>	<b>Like- lihood</b>	<b>Impact</b>	<b>Score</b>	<b>Risk Mitigation</b>
Stakeholder relationships within the partnership	<p>There is a risk that the BHWP objectives are not going to be achieved due to poor stakeholder relations across the broad delivery structure from Executive all the way down to resource who are implementing.</p> <p>The poor stakeholder relations encompass:</p> <ul style="list-style-type: none"> <li>- a lack of engagement from key stakeholders</li> <li>- a lack of clarity around the BHWP's role in delivery</li> <li>- knowledge sharing as appropriate</li> <li>- the management engagement to enforce BHWP working</li> </ul>	4	5	20	<ol style="list-style-type: none"> <li>1) Executive engagement on the partnership function</li> <li>2) Clear boundaries around whom is getting involved in the delivery of BHWP objectives</li> <li>3) Enforcement and accountability towards those whom are engaged in the BHWP</li> <li>4) Establishment of reporting and escalation of issues process within the BHWP</li> </ol>
Business continuity within the partnership	There is a risk that due to the large number of contractors delivering BHWP objectives there is going to be corporate knowledge loss on their departure, and an unnecessary amount of time and cost is spent on getting the resource up to speed on the current situation and direction	4	4	16	<ol style="list-style-type: none"> <li>1) Undertake a thorough handover process between existing contractors and incoming replacements</li> </ol>

OPERATIONAL RISKS (continued)					
Transparency and accountability of process within the BHWP	There is a risk that BHWP objectives are slowed, stalled, in incorrectly enacted (opening ourselves up to poor audit review) due to a lack of accountability and transparency of mandated processes for the management of partnership delivery. This risk covers areas including: - Finance (budget management) - Funding processes (LDP) - Approval processes - Difficulty in identifying the appropriate departments who managed day-to-day services including procurement, asset management etc	4	4	16	1) Identify and engage with key stakeholders to define mandated processes across the essential elements of partnership delivery
Quality assurance and validation of data	There is a risk that BHWP objectives are seriously hampered by supporting data that is not sourced or managed according to appropriate quality assurance standards. This includes: - no naming or titling conventions - different sources of data which are not properly referenced and conflict - of questionable data integrity - does not demonstrate ownership	3	4	12	1) Continue to progress dialogue as required with the PHIT team, to ensure standards are clear, and issues are resolved 2) Conduct an audit of the existing data sources used within the BHWP, the processes used to obtain and analyse the data and the ongoing management of data 3) Identify the improvements and enforce an improved quality assurance methodology that makes those collecting and analysing data accountable for data integrity
Performance management	There is a risk that the BHWP may fail to embed a performance management culture	3	3	9	1) Fully embed Performance Framework 2) Management development and appraisal to focus on performance management

FINANCE AND HUMAN RESOURCES RISKS					
Risk Title	Risk Description	Like-likelihood	Impact	Score	Risk Mitigation
Financial controls	There is a risk that the BHWP may develop inaccurate/incorrect financial projections due to a lack of robust financial controls	3	4	12	1) Monthly monitoring of budgets and review of financial projections 2) Long-term and short-term cash flow forecasting and monitoring
Recruitment, development and retention	There is a risk that the BHWP has difficulty in recruiting suitably qualified staff to work stream in a timely fashion and the resource is retained	3	3	9	1) Re-skill existing staff to develop appropriate skills 2) Assess effective ways of improving employment opportunities 3) Establish greater workforce flexibility
Flexible workforce	There is a risk that the BHWP will face difficulties in flexing staff in line with new or evolving work streams and projects	3	2	6	1) Re-skill existing staff to develop appropriate skills 2) Focus on career development in line with staff goals 3) Exploit new technology to enable remote or flexible working

## Appendix 1 FINANCIAL GOVERNANCE ARRANGEMENTS

### Payment Terms

Each Partner will pay an annual contribution to BEN PCT (as host), based on the Agreed Interventions. This will be agreed on an annual basis between BHWP and each Partner by no later than the 31st January in each financial Year for the following financial Year.

Any changes to the plan, and therefore the annual subscription, which may be required during the financial year, will be submitted to the BHWP Executive for a formal decision.

BEN PCT will decide with partners on the appropriate frequency and timing of payments/recharges. Payments to BHWP will not be withheld past allotted timescales in case of a dispute; any adjustments resulting from these will be made by BEN PCT post-resolution.

The BHWP executive will identify the pooled and aligned budgets that should be allocated to delivering LAA outcomes.

BEN PCT will provide the necessary information to facilitate any VAT recovery applicable to its partner BCC (as a non-NHS body), in consultation with HMRC. However each delivery body will have responsibility for managing its own value added tax recovery arrangements. Unless explicitly agreed by BEN PCT, pooled funding will not be transferred to a delivery body in advance of any related expenditure being incurred.

### Funding streams

For clarity, the ways in which funding streams can be pooled or aligned are set out below.

- Pooled funding streams These refer to funding streams that are pooled before being paid to BEN PCT. These are wholly 'owned' and accounted for through the BHWP governance mechanism and cease to be subject to existing monitoring and reporting mechanisms.
- Aligned funding streams These are committed to the delivery of the BHWP agenda but continue to be held by their original 'owner'. These continue to be paid to the fund holder who retains ultimate accountability for delivery of a service but delivers in full co-operation with BHWP. In the main, these funds will continue to be subject to existing monitoring and reporting arrangements unless specific changes are negotiated in advance.

Where partner organisations transfer mandatory and ring-fenced funds to the pool, these funds will be wholly committed to meeting the BHWP targets. Where further funds are transferred on a discretionary or non-ring-fenced basis, the contributing organisation will retain the discretion and flexibility to redirect these resources to other commitments and priorities within its own budget. It is envisaged that any such redirection of resources would only be made in exceptional circumstances and after both full consultation with BHWP and a review of its commitments. The terms and conditions of grant support from central government would also be considered to ensure that the receipt of this funding is not compromised in any way (e.g. match funding).

## GLOSSARY AND TERMS

### Acronyms

Acronym	Definition
BCC	Birmingham City Council
BEN	Birmingham East and North
BHWP	Birmingham Health and Wellbeing Partnership
DPH	Director of Public Health
FTAP	Floor Target Action Plan
HMRC	Her Majesty Revenue Commission
HOB	Heart of Birmingham
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LAA	Local Area Agreement
NI	National Indicator
PCT	Primary Care Trust
PHIT	Public Health Information Team
SB	South Birmingham
VAT	Value Added Tax