Quarterly Report
Health Improvement Directorate
November 2009

Introduction

During the last quarter NHS Birmingham East and North Health Improvement Directorate have continued to work closely with partner agencies and the public through the commissioning of services that will target those most at risk from health inequalities. This report will outline the various ways in which health inequalities impact on our population and what the Trust is doing in order to reduce these. The report consists of an update on our current performance and achievements for four specific areas and a description of what we are planning for future growth both in life expectancy and long term health improvement. The first part of the report will discuss the level of health inequalities that exist across NHS Birmingham East and North with particular focus on migrant communities. As the following paper will support, there is strong evidence to indicate that health inequalities are largely affecting the population of Birmingham; subsequently, reducing them is now a major priority for NHS BEN.

In order to address these health inequalities, NHS BEN is operating across several health initiatives. It is clear that a joint line of attack alongside our partners is fundamental to reverse the ill health caused by individual lifestyle choices, environmental factors and physical inactivity. Parts two, three and four of this paper will highlight a few of the different approaches that NHS BEN has commissioned in order to tackle these health disparities.

The paper focuses on the following areas,

- Health Inequalities
- Chronic Kidney Disease
- Obesity
- Physical Activity

Directorate Summary

NHS BEN is committed to tackling health inequalities and improve the overall health of the population through working in partnership with our community and involving those who are most affected. So far NHS BEN Health Improvement has delivered a range of health services aimed at enhancing life expectancy for all members of our community and at every life stage, we do however need to continue this pattern and maintain the type of services that are appropriate, safe and effective if we are to tackle the continuing inequalities in our population.

1. Health Inequalities

Key Points

- 51% of the Birmingham population are in the most deprived quintile (20%) nationally. 66.7% of the population is of White British ethnicity and 20.7% of the population is of black and minority ethnic groups

compared to the national average of 5.5%. As the burden of health inequalities falls disproportionately in these two groups, addressing health inequalities is a major priority for the PCT.

- The health needs of the most vulnerable groups including asylum seekers and migrant communities are a key concern and must be addressed. Many of the risk factors for infant mortality and reduced life expectancy are experienced by new migrant families, including ethnic minority status and socioeconomic deprivation.
- A multi disciplinary approach is required to effectively tackle inequalities. The PCT needs to enhance its relationship through the local strategic partnership (LSP) and work through the Local Area Agreement and other agencies such as; housing, education, police and sure start in order to successfully address the wider determinants of health; the root causes of inequality.
- Consideration needs to be given to commissioning of primary and community care services within the third sector and to promote market opportunities.

Introduction / National Picture

There are a number of national policies and supporting frameworks addressing health inequalities as shown in Table One. Evidently it is known that nationally, reducing health inequalities is a continuing problem in England. There are still stark, persistent differences in life expectancy and health. Health inequalities are inextricably linked to social wider determinants of health. They are mostly avoidable as they are a result of differences in access to health care, differences in opportunity, outcomes and experiences of care and individual lifestyle choices including poor health literacy. A report published by the House of Commons Select Committee on 15 March 2009 identifies that health in the UK is improving, but over the last ten years, health inequalities between social classes have widened. Nationally the gap has increased by 4% amongst men and 11% among women.

Health inequalities are not only apparent between people of different socio-economic groups, they exist between different geographical areas, genders, different ethnic groups, the elderly and people suffering from mental health problems or learning disabilities also have the worst health than the rest of the population. It is these groups that are most at risk and placed at the top end of the social scale in terms of vulnerability.

Table One: Key policies and frameworks which support the tackling health inequalities agenda

<table>
<tr><th>Public Service Agreements (PSAs)</th><th>National Policy Context</th></tr>
<tr><td>• Reducing health inequalities (PSA 18.2)
• Improving life expectancy (PSA 18.1)</td><td>• Tackling health inequalities: Consultation on a plan for delivery (2001)
• Saving lives: Our Healthier Nation white paper (1999)
• Tackling health inequalities: A programme for action (2003)
• Choosing Health White Paper (2004)
• Our health, Our care, Our say (2006)
• NHS Operating Framework (2006/07)</td></tr>
<tr><th>Vital Signs</th><th>World Class Commissioning</th></tr>
<tr><td>Contribute to the improving health and reducing health inequalities vital signs:
• The all-age case mortality rate per 100,000 population</td><td rowspan="3">Health Inequalities Coordinator will
• Locally lead the NHS
• Work with community partners
• Engage with public and patients
• Manage knowledge and assess needs
• Prioritise investment
• Stimulate the market
• Promote improvement and innovation
• Make sound financial investments</td></tr>
<tr><th>National Institute of Clinical Evidence</th></tr>
<tr><td>• Community engagement to improve health
• Behaviour change</td></tr>
</table>

Local Picture

Birmingham ranks as the 10th most deprived local authority across the UK, (Life Expectancy Report 2009) reflecting stark differences in health inequalities across the city. This ranking has been based on the seven domains causing health inequalities; income, employment, health, deprivation and disability, education, skills and training, poor housing and services as well as crime and living environments.

Life expectancy in NHS Birmingham East and North

Figure 1 illustrates there has been an increase in male life expectancy across all three PCT's from 95/97 to 05/07. The highest increase can be seen within South Birmingham PCT, 76.32 years (3.63%) followed by NHS Birmingham East and North, 76.01 years (3.46%). Heart of Birmingham teaching PCT is lowest at 73.65 years (3.39) in 05/07. However all PCT's are below national average.

Figure 1 Male Life Expectancy trend by PCT 1995/97 - 2005/07

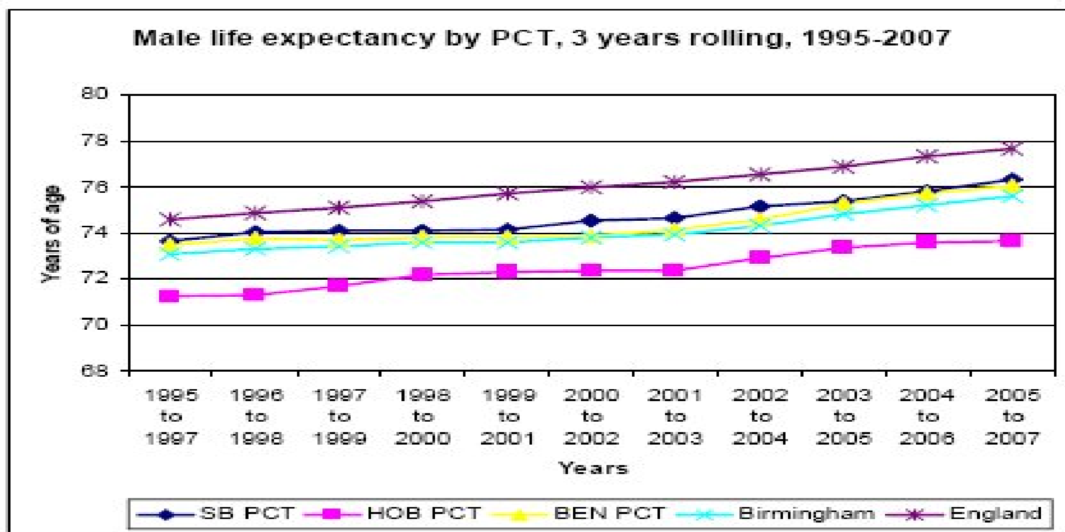
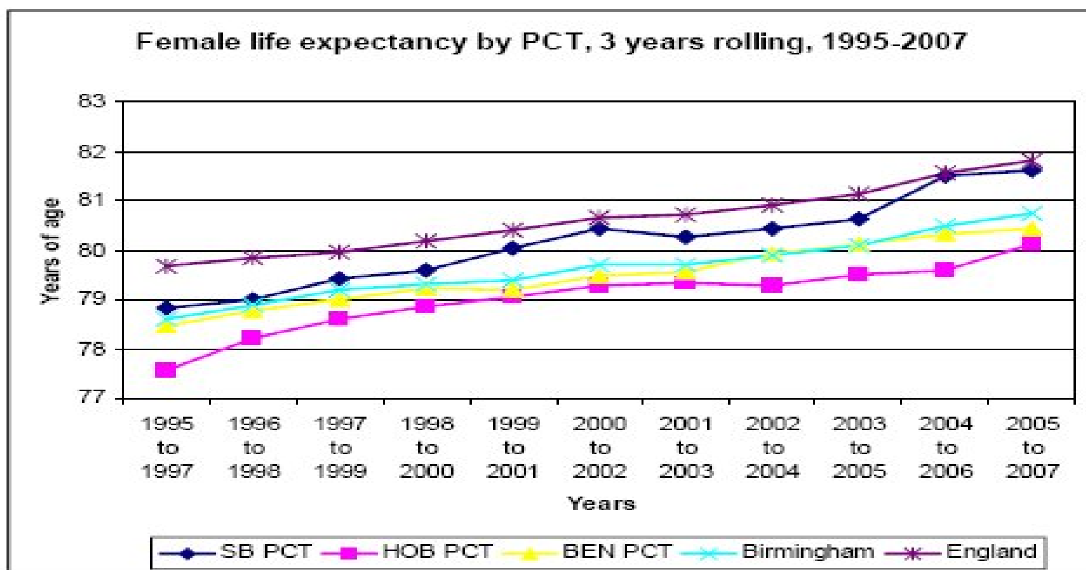


Figure 2 shows that female life expectancy during 1995/97 and 2005/07 has increased across the three PCT's in Birmingham. South Birmingham PCT is the highest in Birmingham and has increased by 2.78 years (3.52%), followed by NHS Birmingham East and North, 1.97 years (2.51%), which lies very close to the Birmingham average. Heart of Birmingham teaching PCT has increased by 2.57 years (3.31%) However, all three PCT's are below the national average.

Figure 2 Female Life Expectancy trend by PCT from 1995/97 - 2005/07



Data Source: PCT – PHIT; Birmingham and England – ONS

A key factor in explaining life expectancy within NHS Birmingham East and North is deprivation. Considerable differences exist across wards as outlined in figure 3 with resulting impact on life expectancy as outlined in tables 2 & 3.

Figure 3 Index of Multiple Deprivation in NHS BEN Wards

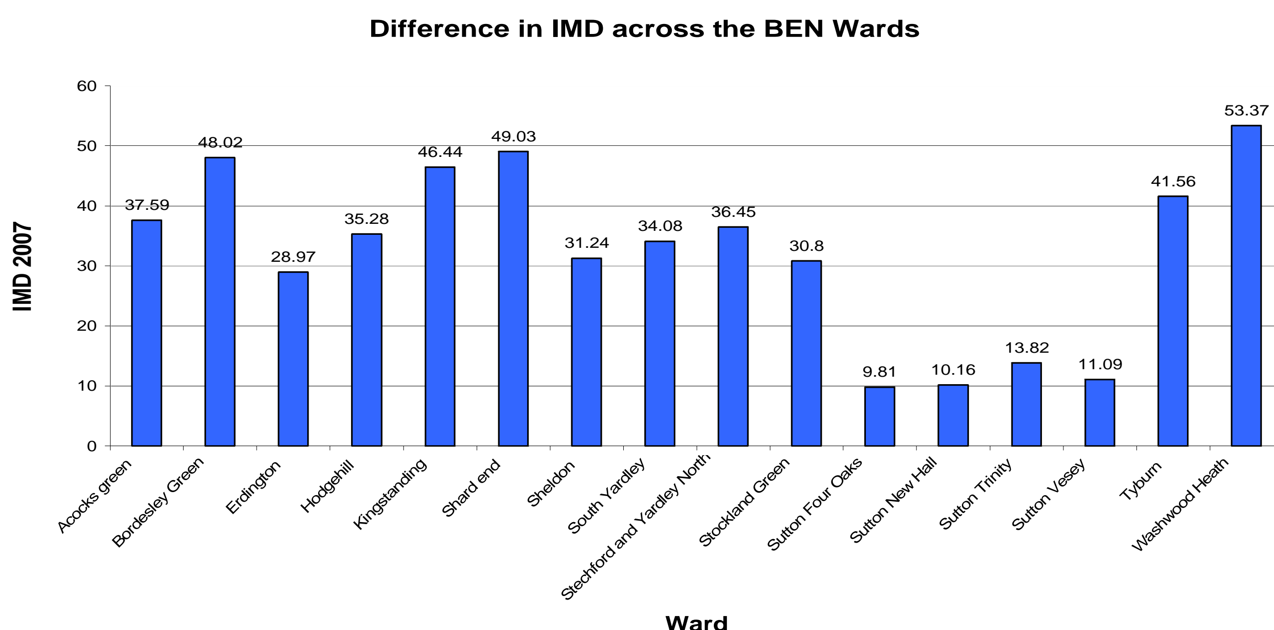


Figure 3 clearly indicates the most disadvantaged wards within the east and north corridor of Birmingham in terms of either lower level expectancy or limited improvement (highlighted in red); Bordesley Green (IMD 48.02), Kingstanding (46.44) Shard End (49.03), Tyburn (41.56) and Washwood Heath (53.37).

Table 2 Male life expectancy in 1995/97 – 2005/07 by Birmingham East and North Wards

Ward	PCT	Male Life expectancy at birth			
		95/97	05/07	Change N*	Change %**
ACOCKS GREEN	BEN	72.89	74.51	1.62	2.2%
BORDESLEY GREEN	BEN	71.82	74.41	2.59	3.6%
ERDINGTON	BEN	72.41	74.26	1.85	2.6%
HODGE HILL	BEN	73.48	75.5	2.02	2.7%
KINGSTANDING	BEN	70.07	73.95	3.88	5.5%
SHARD END	BEN	72.05	73.61	1.56	2.2%
SHELDON	BEN	73.82	77.54	3.72	5.0%
SOUTH YARDLEY	BEN	72.55	75.77	3.22	4.4%
STECHFORD AND YARDLEY NORTH	BEN	71.88	74.91	3.03	4.2%
STOCKLAND GREEN	BEN	72.03	73.04	1.01	1.4%
SUTTON FOUR OAKS	BEN	77.47	80.53	3.06	4.0%
SUTTON NEW HALL	BEN	79.21	81.12	1.91	2.4%
SUTTON TRINITY	BEN	75.74	81.21	5.47	7.2%
SUTTON VESEY	BEN	76.66	79.63	2.97	3.9%
TYBURN	BEN	72.12	73.54	1.42	2.0%
WASHWOOD HEATH	BEN	72.21	73.28	1.07	1.5%

Data Source: PCT – PHIT; Birmingham and England - ONS

Table 3 Female life expectancy in 1995/97 – 2005/07 by Birmingham East and North Wards

Ward	PCT	Female Life expectancy at birth			
		95/97	05/07	Change N	Change %
ACOCKS GREEN	BEN	76.91	78.46	1.55	2.0%
BORDESLEY GREEN	BEN	76.27	77.91	1.64	2.1%
ERDINGTON	BEN	78.95	79.91	0.96	1.2%
HODGE HILL	BEN	80.24	79.97	-0.27	-0.3%
KINGSTANDING	BEN	75.27	77.82	2.55	3.4%
SHARD END	BEN	78.34	79.34	1.00	1.3%
SHELDON	BEN	79.00	82.67	3.67	4.6%
SOUTH YARDLEY	BEN	78.18	81.58	3.40	4.3%
STECHFORD AND YARDLEY NORTH	BEN	78.62	78.31	-0.31	-0.4%
STOCKLAND GREEN	BEN	75.95	80.23	4.28	5.6%
SUTTON FOUR OAKS	BEN	81.70	84.02	2.32	2.8%
SUTTON NEW HALL	BEN	83.49	84.59	1.10	1.3%
SUTTON TRINITY	BEN	82.06	84.17	2.11	2.6%
SUTTON VESEY	BEN	80.55	83.16	2.61	3.2%
TYBURN	BEN	76.34	78.54	2.20	2.9%
WASHWOOD HEATH	BEN	76.91	78.05	1.14	1.5%

Data Source: PCT – PHIT; Birmingham and England – ONS

Table four below illustrates the burden of disease for NHS BEN in relation to the national average for 2007/2008. The PCT mirror the national average across the majority of conditions.

Table 4: National Disease Prevalence in Birmingham East and North

DISEASE	National Disease Prevalence	BEN PCT
	07/08	07/08
Coronary heart disease	3.5%	3.6%
Stroke and transient ischemic attack	1.6%	1.5%
Hypertension	12.8%	12.7%
Diabetes mellitus *	3.9%	4.3%
Chronic obstructive pulmonary disease	1.5%	1.4%
Cancer	1.1%	1.0%
Chronic kidney disease *	2.9%	2.5%

The all age all cause directly standardized mortality rate (AAACM DSR) for Birmingham is 670.47. For England, the DSR sits at 594.73. The Life Expectancy Report (2009) suggests that circulatory diseases (31.12%), coronary heart disease (23.4%) and cancers (15.2%) especially lung cancer (10.5%) are the main contributors to the gap between Birmingham and England.

NHS BEN Typologies - PRIME

Figure 4 illustrates the typology map for Birmingham East and North. A description of the typologies can be found in Appendix one. Typologies Red 1; Benefits and Educated, Red 2; Unwell and Ageing, Red 3; Troubled dependence, and Blue 1; Unemployed teens; illustrate certain health

behaviours. All of these typologies are within the most deprived quintile (20%).

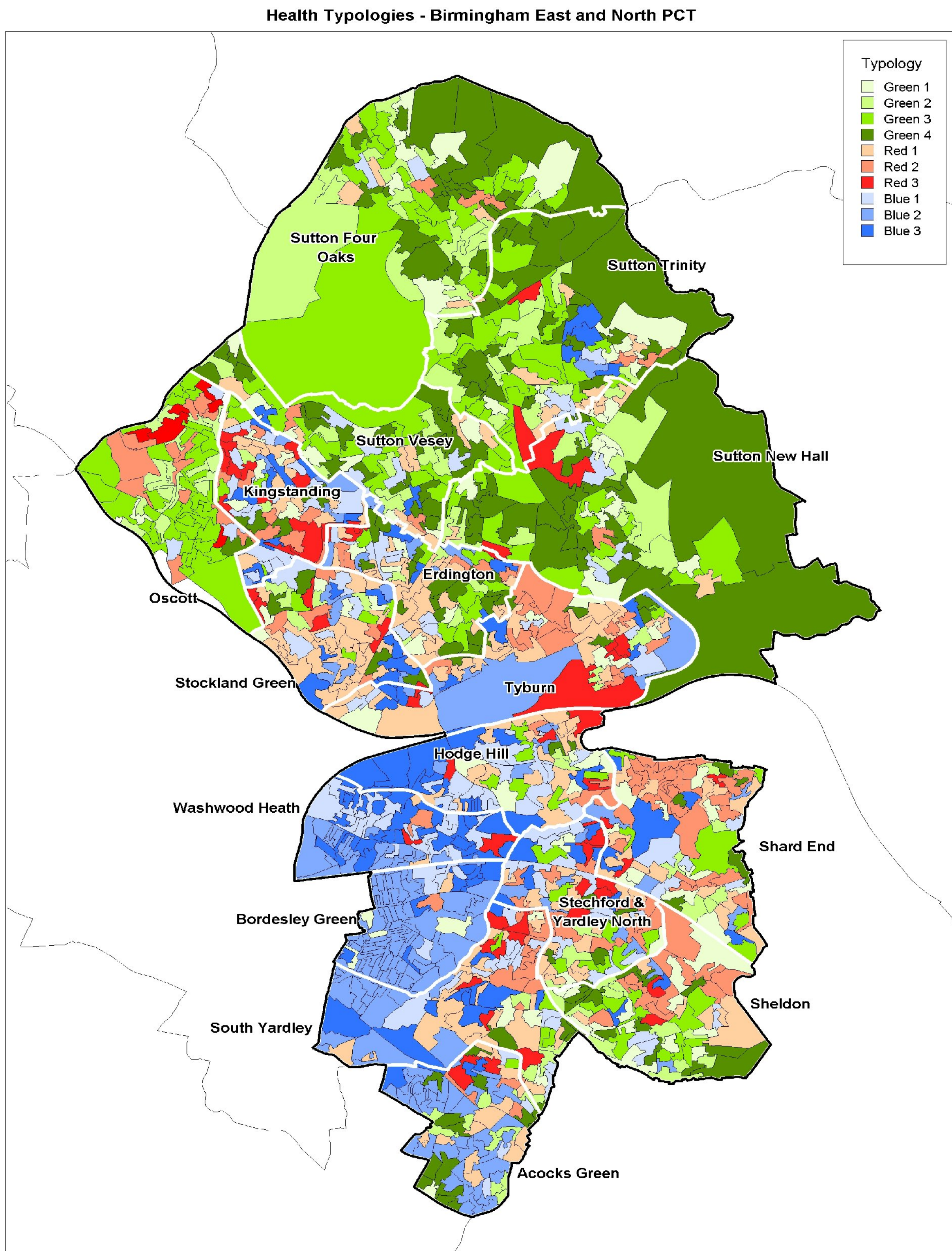


Table Five below shows the percentage of output areas in each typology that were greater than the 75th percentile for each indicator across all BEN output areas. These typologies indicate the greatest proportion of output areas above the 75th percentile and indicate the highest rates of disease burden. The streams can be correlated with the map above. The table clearly indicates a range of health inequalities by geographical area and population

group including disease prevalence, mortality and health service use, reflecting variations in need across the local population.

Table 5: Health Typologies 75th Percentile

Health Typologies – 75th Percentile Data										
Typology	**Stream 1 - Green**				**Steam 2 - Red**			**Stream 3 - Blue**		
Indicators	1	2	3	4	1	2	3	1	2	3
Community Diabetes	19.8 %	17.0 %	12.0 %	7.5 %	25.5 %	29.9 %	19.6 %	33.6 %	35.2 %	48.6 %
Yr 6 Obesity	27.1 %	43.0 %	35.2 %	24.8 %	23.5 %	28.0 %	26.8 %	25.2 %	6.3 %	24.3 %
Reception Obesity	18.8 %	28.0 %	34.4 %	17.4 %	29.5 %	26.2 %	16.1 %	35.9 %	5.7 %	42.1 %
Teenage Pregnancy	19.8 %	14.0 %	12.0 %	6.8 %	27.0 %	32.7 %	35.7 %	22.1 %	13.6 %	29.0 %
Infant Mortality	5.2 %	4.0 %	6.4 %	5.6 %	11.5 %	9.3 %	12.5 %	10.7 %	15.9 %	16.8 %
A & E Attendances	16.7 %	5.0 %	10.4 %	8.7 %	24.0 %	43.9 %	39.3 %	22.1 %	22.2 %	17.8 %
Emergency Admissions	12.5 %	7.0 %	6.4 %	5.6 %	24.5 %	72.0 %	25.0 %	38.2 %	31.8 %	30.8 %
Readmissions	17.7	5.0	8.0	9.9 %	22.5 %	70.1 %	25.0 %	33.6 %	29.0 %	35.5 %
Mortality Rate	21.9 %	18.0 %	5.6 %	8.7 %	31.5 %	41.1 %	42.9 %	30.5 %	27.8 %	32.7 %
Cancer Mortality Rate	19.8 %	21.0 %	12.0 %	16.1 %	38.0 %	33.6 %	35.7 %	26.0 %	23.9 %	24.3 %
Respiratory Mortality Rate	21.9 %	16.0 %	12.8 %	10.6 %	31.0 %	40.2 %	37.5 %	23.7 %	31.3 %	30.8 %

It is quite apparent from the analysis of the work that Dr Foster has undertaken with regards to the health typologies that the health needs are much more complex than simply levels of deprivation in an area. The analysis has unveiled areas where there are some relatively unhealthy pockets of hidden need in relatively affluent areas i.e Sutton localities. Further public health data has shown that while much attention had previously been focused in the most deprived wards and predominantly within the Asian community, there were in fact greater health needs in other mainly white wards.

Migrant Population – Asylum seekers and refugees

Migrants are not a homogenous group. They include economic migrants, asylum seekers, refugees, refused asylum seekers, illegal migrants and individuals who have entered the UK with visa clearance. Immigration status can influence the level of social and economic stability for migrant groups. These factors in turn, can affect health outcomes. Recently arrived migrants, asylum seekers and individuals with no resource or public funds are particularly vulnerable, compared with migrants who moved to the UK decades ago or those who migrate in order to take up employment.

There are many reasons why people choose to seek asylum, including fleeing from armed conflict, potential and social unrest, persecution and sometimes exploitations of their own country of origin. (U.K. Border Agency 2008).

Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs. Within this group there are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill health.

The UK government is signatory to a number of international laws committing them to human rights legislation which also covers asylum seekers. Reducing health inequalities is a government priority and therefore local health strategies must include action to address the needs of asylum seekers.

Health needs of asylum seekers in Birmingham

The asylum seeker* and refugee** population has been highlighted as a priority group for NHS BEN. Combined National Asylum Support Service (NASS) and Interim Authority data in 2005 showed there were 3,792 asylum seekers in the city – some 39 % of the regional total (Phillimore and Goodson, 2006). Estimates of the number of refugees suggested a figure of 69,865 in the region and 27,240 in Birmingham by the end of 2007. The number of refugees living in the city might be even higher, as there is evidence that, once asylum seekers receive a positive decision, they leave other parts of the region to search for work and housing in Birmingham (Phillimore, 2004). Numbers of refugees are further bolstered by several thousand 'newcomers', individuals who have received their refugee status elsewhere in Europe and have moved to the UK. These individuals are largely from a Somali background.

Newly Migrant Communities in NHS BEN localities

Data obtained from the UK Border Agency, West Midlands consortium has provided a breakdown of asylum seekers by Ward across the city as presented in Figure 5. This information was recorded in October 2008 and indicates that the highest number of asylum seekers are located in Washwood Heath, Bordesley Green and Stockland Green. No further information is available to date.

** An asylum seeker is a person who has applied for protection and is awaiting determination of their status*

*** A refugee is a person who has had a positive decision on their claim for asylum and granted leave to remain in the UK*

Figure 5 Asylum seekers by Ward

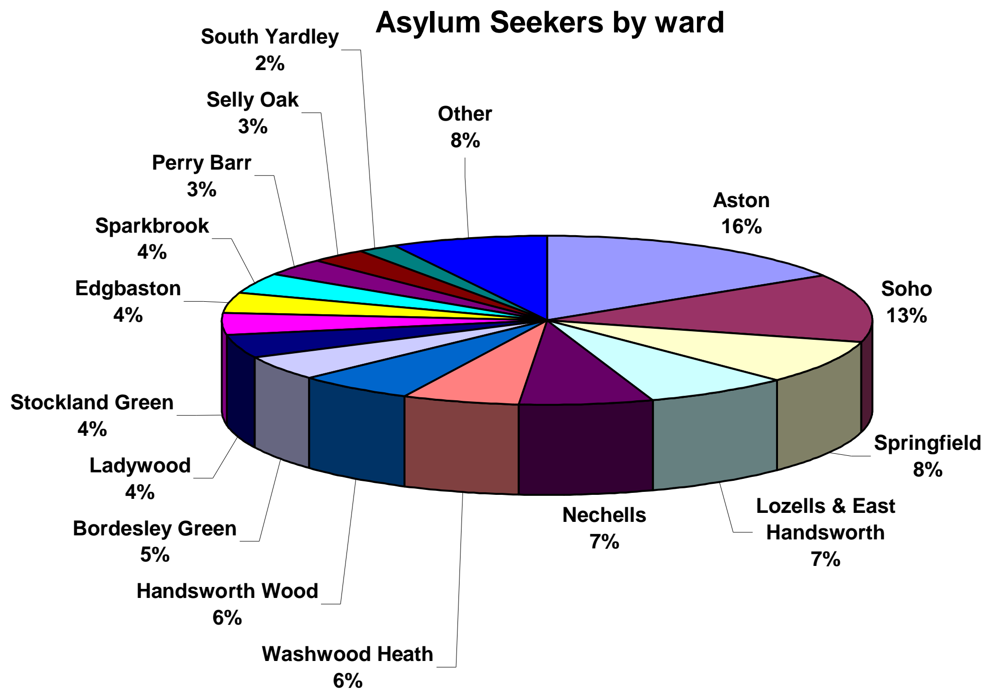
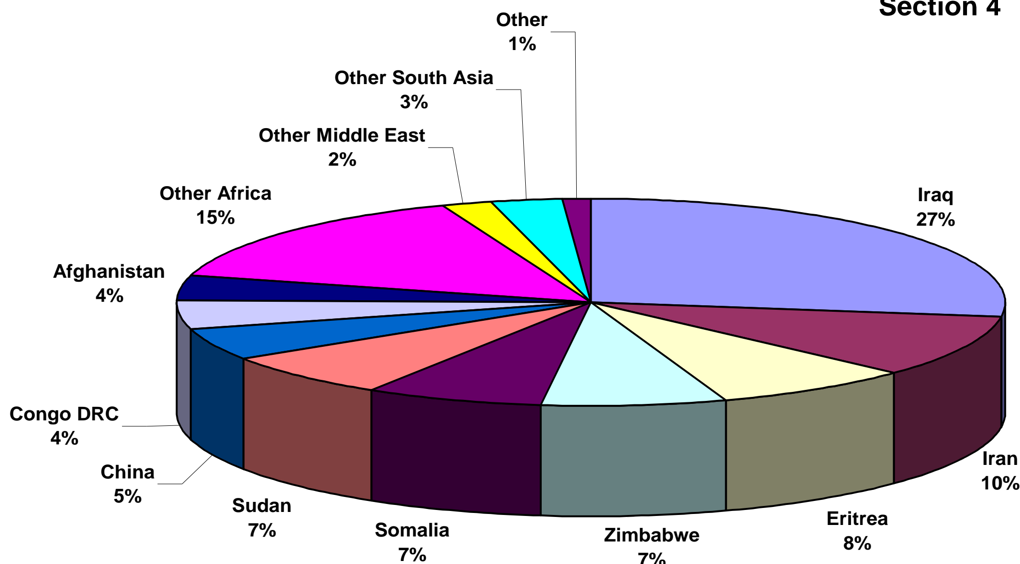


Figure 6 below illustrates recorded nationality of asylum seekers across the city**.**

Figure 6 Nationality of asylum seekers in Birmingham



The vast majority of asylum seekers are from Africa, Iraq or Iran. The most common age groups are 20-29 & 30-39 years old. It has become evident that the overall general increase in age profile 25-29 years is a reflection of the new arrivals of migrant communities in Birmingham, particularly those gaining accommodation in Birmingham East and North. There is no data to support the ethnic breakdown of this increase, however there is a greater proportion of males between 20-39 years applying for asylum in Birmingham. There is a lack of evidence to support why this may be. It can be assumed the rise could be due to employment opportunities for males. The UK Border Agency West

Midlands Consortium suggests that the increase in women within this age profile is linked to births to women born outside of the UK. Concerns have been raised about issues facing migrant women and babies born in the region. The West Midlands Strategic Migration Partnership is currently undergoing a regional review of new arrivals and the asylum dispersal process across the west midlands. A recommendation from the partnership has highlighted the need for strengthened partnership working across the 3 PCT's in Birmingham to address the needs of the migrant population.

Asylum seekers in NHS BEN, as with those across the city, are likely to arrive in the UK with relatively good physical health; however their health problems can rapidly develop. A jointly commissioned report by Heart of Birmingham PCT and the West Midlands Strategic Migration Partnership in 2008 has reported that difficulty in accessing health care services, lack of awareness of entitlement, problems in registering and accessing primary care and community care services particularly if their claim has been refused and language barriers are all reasons for why physical state of an individual can change. There are a number of reasons for this: a number have faced imprisonment and torture prior to migration and will bear the physiological and psychological consequences of this, many have come from refugee camps where nutrition and sanitation has been poor so placing them at risk of malnutrition and communicable disease, stress and trauma over leaving country of origin. The health needs of asylum seekers have also significantly worsened because of the loss of family and friends, support, social isolation, loss of status, culture shock, racism, communication, hostility from the local population, housing and education difficulties and of course poverty, deprivation and lack of control.

Some of the health experiences of asylum seekers may overlap with other disadvantaged and vulnerable groups in NHS BEN. However there are physical and mental health issues specific to asylum seekers in the local area which coupled with the impact of going through the asylum process, place them at risk of destitution and inequalities. The University of Birmingham Centre for Urban and Regional Studies (CURS) 2007 research undertaken on refugees and asylum seeker mental health needs and experiences of health services within the City has identified a range of impacts and unmet needs for this community. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed. The lack of access to lower mental health services or clear pathways into mental health provision, maybe due to difficulties in accessing a GP, may result in increased levels of depression and mental health problems once individuals become destitute. The state of an individual's mental health may impact on their ability to access a range of health and other services at later stages. This research has also highlighted the shortage of mental health services for asylum seekers and refugees locally. Nationally, communicable diseases, sexual health needs, women's maternal health, chronic diseases and dental disorders are to be commonly reported amongst refugee's and asylum seekers.

What is being addressed currently?

The newly appointed Health Inequalities Coordinator is committed to strengthening access to vulnerable and marginalised groups or those at greatest risk of being disadvantaged. By developing a new multifaceted approach that will engage with wider services, this will ensure a multi policy

response. Inclusion within the Local Area Agreement (LAA) and collaboration with Birmingham Health and Well Being Partnership are the vehicles for the development of this approach.

There is an unknown population in NHS BEN who are not registered with a local General Practitioner. Decisions may need to be taken about whether the PCT is to focus on geographical communities or defined socio-demographic groups. The availability of accurate, in depth community profiling GP data, or support to compile such a profile, can make a big difference and investigations into accessing this data are currently being pursued. Access to the unregistered population is a cross cutting concern across the directorate, in particular for the NHS Health Check Programme and Cancer Screening Programme.

New partnerships with voluntary organisations and the wider third sector, harnessing their skills and commitment to innovation and to support NHS BEN in providing quality standard health and well being services to the most vulnerable groups has been well received. The third sector has an invaluable impact in supporting, empowering and improving the health and well being needs of people suffering from socio-economic disadvantage. Well placed within the community and having built relationships and trust with the most vulnerable groups, this sector can help address some of the key challenges around promoting access and behaviour and lifestyle modification of those that are hard to reach.

In this context, the third sector has a key role as a mainstream partner/provider across the health and social care system. The Health Inequalities Coordinator has built effective relationships with organisations such as Birmingham Council for Voluntary Services (BVSC), Institute of Social Entrepreneurs (i-SE) and the Third Sector Assembly and the Health and Social Care Network for NHS BEN. Currently areas such as the implementation of Birmingham Compact, third sector commissioning and mapping of voluntary and community sector organisations for Birmingham East and North is the prime focus. It is critically important that as a PCT we ensure that third sector involvement is embedded within the commissioning process.

Challenges and Obstacles

A number of key issues still remain challenging for the Health Improvement Directorate which will be placed as the focus of attention for NHS BEN in addressing health inequalities.

New Migrant Population

- Reducing inequalities and engagement with this particular group is a major challenge due to the lack of local data available concerning their health and well being and the monitoring of the dispersal process.
- It is significant to note that within NHS BEN, there is no senior post accountable for the health needs of migrant population. There will be a significant gap in the PCT's ability to address the health needs of this particular population if no investment is made in additional strategic leadership on refugee, asylum seeker and migrant health, considering the inward forecast immigration statistics on those cases known. It will be essential to incorporate the needs of migrants when commissioning services. This huge area can not be addressed alone by any one post.

- There are limited services in existence currently and these cannot be deemed to be in a position to be coping with the current refugee/ asylum seeker numbers in relation to mental health. Local research My Time – Planting The Seeds of Hope, (2009) provides clear recommendations in relation to mental health support of these communities in terms of stigma/ awareness raising and support.

Third Sector

- The lack of effective commissioning understanding of community and voluntary sector services within NHS BEN is hampered by a relative lack of information about the services being provided. This makes it difficult to assess how far services are meeting local health needs and what scope there is for improvements in quality and efficiency. The aim in removing the barriers and building capacity is to maximise the distinctive value that the sector brings to service delivery and will result in more services being accessible and sustainable.
- There is no third sector commissioning lead for NHS BEN and therefore providing timely feedback and raising awareness of third sector needs is a barrier.

Recommendations

1. The approach in tackling health inequalities has to be underpinned by an Equalities Impact Assessment in order to determine which groups are at greatest risk and the appropriate ways in which to deliver appropriate and effective interventions.
2. Consideration needs to be given towards the development of a Health Inequalities Strategy for the Health Improvement Directotate.
3. Tackling health inequalities requires action across several dimensions. There is no single blueprint or formula to tackle health inequalities but a pragmatic approach needs to inform PCT action. Working more closely at government and community level is essential, including effective partnership working at Constituency and Locality level.
4. An approach to identifying the unregistered population's health needs must be clearly actioned by the PCT. In an attempt for the Trust to understand the unknown quantity, data that is gained from secondary care i.e. hospitals on admissions and diagnosis could be analysed. This data could provide the Trust with a valuable insight into the people who are not registered with a GP but are being admitted, whether emergency or elected, with medical problems. Data sourced from walk in clinics to understand who is attending as immediate and necessary treatment once they are displaying acute symptoms could also be analysed. This approach although challenging, could support the development of baseline data for the Trust regarding the unregistered population.

5 Investment in a new post for new migrant population and third sector commissioning lead. Having such roles could strengthen and target investment and focus on integrated service provision with community and voluntary sector organisations.

6 The PCT should incorporate the needs of migrants when commissioning services to prevent exacerbating health inequalities. Services could be commissioned through the voluntary sector where strong links with the migrant community exists.

7. Data routinely collected and the lack of current dispersal information at a regional and local level needs to be addressed and a recommendation for a more systematic approach to collate this

intelligence would be to develop partnerships with stakeholders who collect such data, such as migrant and refugee community organisations.

In summary the board is asked to consider the above recommendations. This paper has highlighted areas for priority and has reviewed the issues and challenges faced by the PCT. The likely impact on the local population if these gaps were to remain would be a widening of the inequalities gap. It is important to build upon the commitment across the Directorate and make sustained improvements.

2.Chronic Kidney Disease

Key points

- NHS BEN's current prevalence (2.5%) is similar to other PCTs in our Office for National Statistics (ONS) Cluster but low compared to the National and West Midlands averages. The mortality in BEN is not dissimilar to the National average.
- There is a need to raise awareness around identifying and managing patients with CKD within primary care where appropriate.
- We need to further understand variation at both practice and locality level to enable us to share this with practices in a meaningful way thereby improving patient management.
- Imparting lifestyle advice and relevant case-finding approaches should be further strengthened at the primary care level.
- We need to raise awareness of organ donation across the PCT.

Introduction

The purpose of this report is to inform Board Members on the work that is currently on going around Chronic Kidney Disease. This report also provides an overview of the local picture, lists some of the challenges and makes recommendations for improvement.

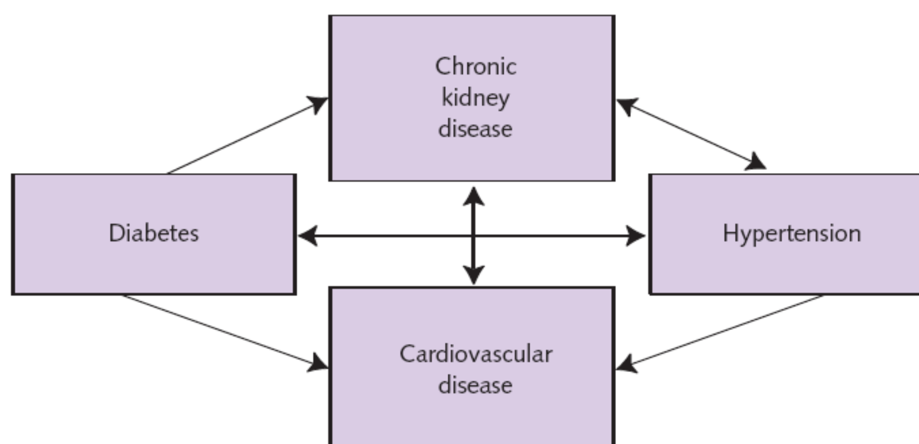
Chronic kidney disease (CKD) describes abnormal kidney function and/or structure. It is common, frequently unrecognised and often exists together with other conditions (for example, cardiovascular disease and diabetes). When advanced, it also carries a higher risk of mortality. The risk of developing CKD increases with age, and some conditions that coexist with CKD become more severe as kidney dysfunction advances.

At its mildest it can be almost undetectable, and for the majority of people with CKD the main risk is cardiovascular disease. However a significant minority of people will go on to develop established renal failure, which is fatal without treatment by dialysis or a kidney transplant.

However, early identification of CKD is important as it allows appropriate measures to be taken, not only to slow or prevent the progression to more serious CKD but also to combat the major risk of illness or death due to cardiovascular diseases. Early detection also allows timely referral to secondary care. As kidney function deteriorates complications increase, such as anaemia; imbalances of calcium and phosphate, and bone disease; and in children, poor growth and development.

National Picture
The people most at risk of CKD are those with diabetes and hypertension. CKD, diabetes, hypertension and cardiovascular disease tend to act and re-act on each other in a complex way (Figure 1). For example it is well recognised that in some people hypertension may be an early sign of undiagnosed CKD, indicating it is important to check kidney function in this group.

Figure 1: Interaction of CKD, diabetes, hypertension and cardiovascular disease



Surveys suggest that up to 5% of adults have CKD out of which two thirds are over 70 years, three quarters (75%) have hypertension, and a quarter (25%) has diabetes. Locally people with diabetes make up more than 30% of the dialysis programme.

The Quality and Outcomes Framework (QOF) data for 2008/2009 show that more than four per cent of adults in England are now recognised to have CKD and are on primary care CKD registers. However, it's estimated that up to 55 per cent of people remain undiagnosed (Renal Network).

On average 30% of people with advanced kidney disease are referred late to nephrology services from both primary and secondary care, causing increased mortality and morbidity. Over 2% of the total NHS budget is spent on renal replacement therapy (dialysis and transplantation) for those with established renal failure.

The key policies and frameworks which the CKD programme can have an impact on and enhance delivery of are summarised in Table 1.

Table 1: Key policies and frameworks & the CKD programme

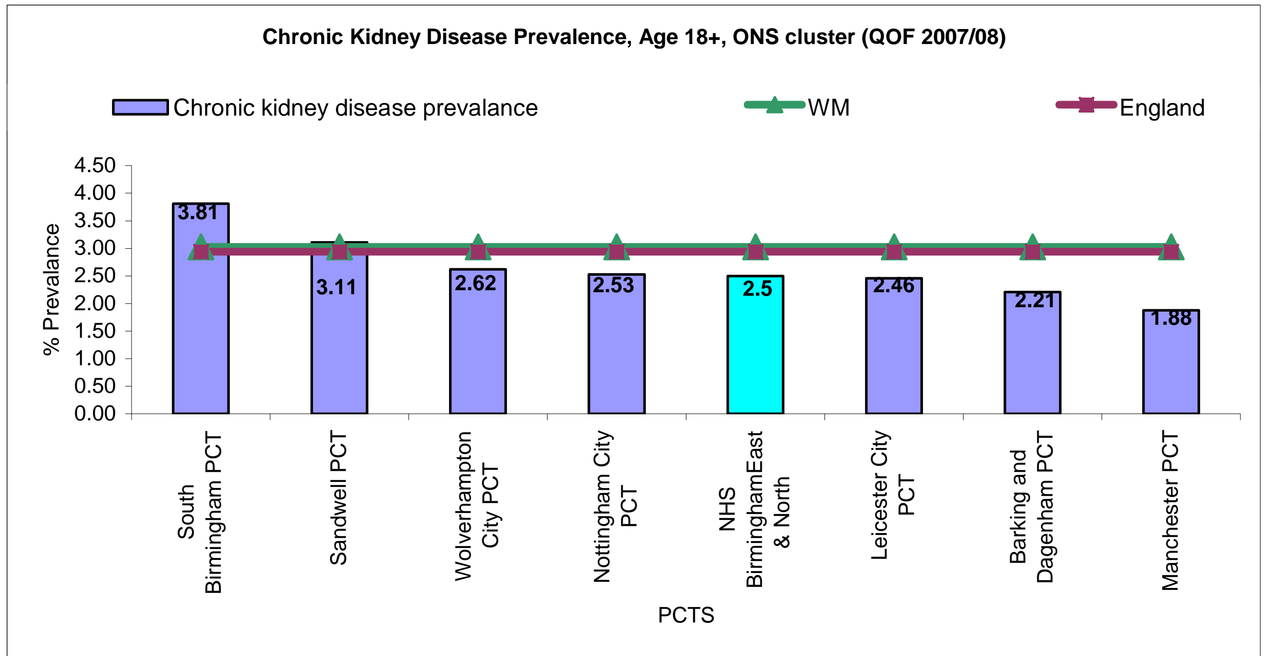
Public Service Agreements (PSAs)	National Service Frameworks (NSF)
• Reducing health inequalities (PSA 18.2) • Improving life expectancy (PSA 18.1) • Reducing mortality from circulatory diseases (SR 2004 PSA 1.1 and 6.1)	• NSF for Renal Disease • NSF for Coronary Heart Disease • NSF for Diabetes • NSF for Older People
Vital Signs / National Indicators	**World Class Commissioning Health Outcomes**
Contribute to the improving health and reducing health inequalities vital signs: • the all-age all case mortality rate per 100,000 population (NI 120) • CVD mortality rate among people under 75 years of age (NI 121) • healthy life expectancy at age 65 (NI 137) • people with a long-term condition supported to be independent and in control of their condition (NI 124)	• Health inequalities • Life expectancy • End of life care • Patient satisfaction

Local Picture

The chances of developing CKD increase with age, male sex, and South Asian and African Caribbean ethnicity. The close relatives of someone with renal failure have a higher risk of developing CKD. People of South Asian origin are particularly at risk of CKD linked to diabetes, as diabetes is more common in this Community; similarly people of African and African Caribbean origin have an increased risk of CKD linked to hypertension.

Our current prevalence is highlighted in Figure 2, which shows that we have a lower prevalence compared to National and West Midlands averages but are similar to other PCTs in our Office for National Statistics (ONS) Cluster. Cluster is a group of similar PCTs as defined by the ONS and BEN falls in the 'Centres with Industry' group. The mortality in BEN is not dissimilar to the National average.

Figure 2: CKD Prevalence



As BEN has a sizeable ethnic population so we would expect to see a higher number of people with CKD especially in areas like Washwood Heath and BSA (Blue streams in our Health Typologies). NHS Health Check programme, which is currently being developed and already in pilot phase in BSA and Kingstanding localities would be of paramount importance in identifying the currently undiagnosed CKD patients.

All the PCTs in West Midlands are being monitored by the Strategic Health Authority on a range of Health Improvement indicators on a quarterly basis. For CKD patients, we are required to report on our performance on Blood Pressure management in these patients at the primary care level. Currently we are within the regional average and a report on this was presented to the Professional Executive Committee in September 2008.

Current Challenges and Gaps in Service Provision & Work being Undertaken

- The size of CKD QOF registers has significantly increased in the last 3 years due to better screening and more effective recording. But at the same time, CKD registers attract high exclusions for instance, where patients are unable to achieve target blood pressures. This may be due to the high numbers of elderly patients who find it hard to tolerate multiple drug regimes or there might be other underlying factors. We have recognised that this requires an in-depth study and are also looking to provide dedicated support (CVD facilitator) to enable practices to manage elderly patients better.
- We need to further understand variation at both practice and locality level to enable us to share this with practices in a meaningful way.
- CKD overlaps with other chronic diseases, including diabetes and hypertension but there is a risk that different conditions are managed in isolation. So we are working with other partners like primary care practitioners and commissioners to develop robust plans for primary care management of CKD. There is considerable scope for integrating the care pathways for diabetes, coronary heart disease and CKD to

manage and reduce the impact of these interacting long-term conditions.

- Primary and secondary care have complementary roles in the management of CKD, and will be most effective if services are co-ordinated. The PCT is actively developing a local triage system for assessment, management and referral of patients.
- All CKD patients are at risk of cardiovascular disease, hospitalisation and premature death. Once identified patients with CKD therefore primarily need cardiovascular risk management. Such management would also reduce the risk or progression to renal failure. The patients that are progressing, or are at risk of progressing, need to be identified early to enable timely referral to nephrology services to improve survival, decrease hospitalisation rates, improve quality of life, and increase the likelihood of using more cost effective options, such as peritoneal dialysis or transplantation.
- There has been a growth in nephrology services in secondary care to manage expanding Established Renal Failure programmes. There has been an increase in referrals of patients to secondary care with earlier stages of chronic kidney disease since the introduction of National Guidelines on referrals. There is not enough capacity within secondary care to manage all these patients. In the majority of cases however kidney care can and should remain in primary care.
- End Stage Renal Failure is relatively rare but its treatment is expensive. Currently less than 0.1% of the population receives dialysis or has received a transplant but it accounts for 2% of the total NHS expenditure. The number of patients receiving renal replacement therapy is currently rising at about 5% per annum in the UK and this rate of growth is expected to continue for at least the next decade. The West Midlands Haemodialysis 5 year Capacity Plan confirms that there continues to be this predicted level of growth across the West Midlands.
- Other challenges include:
    - Ensuring the PCT has identified link for renal disease.
    - Improving clinical chemistry laboratories
    - Renal units to continually develop and update algorithm of management for patients with CKD.

Recommendations

The Board members are requested to support the team in implementing this important but challenging programme.

a) Life-style Advice

- Life-style changes that reduce the risk of diabetes, cardiovascular disease and hypertension by improving diet, cutting salt intake, reducing obesity, ceasing smoking, moderating alcohol consumption and increasing physical activity, are also likely to reduce CKD. Similarly the strict control of blood pressure and blood glucose can reduce the development of CKD.
- The CKD patients need to be encouraged to take exercise, achieve a healthy weight and stop smoking.
- Where the clinician in discussion with the patient has decided that dietary intervention to influence progression of CKD is indicated, an appropriately trained professional, for instance in the dietetics team,

should discuss the risks and benefits of using appropriate diet also ensuring that malnutrition is prevented.

b) Management and Education of CKD in General Practice

- The aim has been to continually examine the CKD register and identify gaps in provision and offer advice around treatment plans and on going management. This has provided support to GPs and staff and provided a systematic referral pathway where necessary to secondary care and the specialist nephrology team.
- To support practices with the skills and knowledge to manage CKD effectively, the CKD Nurse Specialist has been providing clinical input for patients in targeted practices starting with Washwood Heath.
- Birmingham Own Health (BOH) has now incorporated a CKD module to extend to practices using the telephone based service.
- The ABLE project (A Better Life Through Education) with Kidney Research UK will train peer educators from the community to support patients to understand their condition and manage themselves. They will be from the local community and will tackle all areas of CVD prevention to raise awareness of risk factors and lifestyle issues.
- Education and self management can be offered to patients via the Expert Patient Programme for chronic disease management. A new group has been set up with Asian speakers to support the local community in Washwood Heath.
- All the relevant NICE Guidelines around renal disease, hypertension, diabetes and blood lipids should be fully implemented where appropriate.

c) Case finding – improving prevalence to be further enhanced

- As the progression of CKD can be slowed or halted in certain circumstances, before dialysis or transplantation become necessary, early identification of kidney disease and timely interventions can be key to prevention. Prevalence recording is not consistent in practices. The presence of chronic diseases would expect to be similar in certain geographical areas i.e. those with a high prevalence of diabetes and hypertension would be expected to have a higher prevalence of CKD. Discrepancies in prevalence could be improved by active case finding.
- GP practices have the facility to search for CKD patients in their computer software and that should be fully utilised to identify undiagnosed patients.
- **NHS Health Check** programme will identify previously undiagnosed cases and practices should be actively participating in this programme once it is rolled out across the PCT.

d) Kidney Donor Awareness

- There is a need to improve organ donation registration in primary care as there is a long wait for organs for transplant.
- There has been a recent increase in number of people registering as organ donors but the numbers remain small from South Asian communities.

- There are plans within the BME communities to educate high profile and religious leaders to highlight the myths around organ donation and its importance for family members.

3. Obesity

Board Report Update on Obesity

Key Points

1. A review of all obesity services is currently being undertaken by the Health Improvement directorate
2. Future foci will include maternity and early years, a family approach to tackling obesity and ensuring adequate services to meet the increased demand expected as a result of the NHS health check programme (cardiovascular risk screening programme for people aged 40-75) and feeding back results to parents of the National Child Measurement Programme which measures the height and weight of all reception and year 6 school children

Introduction

The focus of this report is to update the Board on the key developments relating to obesity prevention and management since April 2009 and to outline plans for the future. Obesity increases the risk of a number of diseases including the two major killers, cardiovascular disease and cancer. It is estimated that on average obesity reduces life expectancy by between 3 and 13 years, the risk is greater the more severe the obesity and the earlier it develops[1]. As a result, tackling obesity will impact on the PCT's goal 'that the health and well being of the population will have improved so much that people will enjoy 10 more years of healthy life' and on our World Class Commissioning Outcomes relating to health inequalities, coronary heart disease and life expectancy.

The obesity strategy and care pathways were written and approved by the Board and Professional Executive Committees (of North and Eastern Birmingham) in 2005 and updated in 2007. Since 2005, the PCT has invested in the development or piloting of services within each level of the obesity care pathway for children and adults. The health improvement directorate are currently undertaking a review of all obesity services with a view to reinvigorating the obesity strategy and ensuring that the obesity services are evidence based, fit for purpose, cost effective and contribute to reversing the rising trend of obesity prevalence. Priorities for the future will include:

- Development of a maternity and early years obesity care pathway to tackle obesity as early in the life cycle as possible where there is most chance of reversing the obesity epidemic.
- Commissioning cost effective adult weight management programmes to manage the demand created by NHS health checks
- Informing parents of the results of the National Child Measurement Programme and developing family weight management services to

[1] Jebb S. (2004) Obesity: causes and consequences. www.medicinepublishing.co.uk

support the families of very overweight children to make lifestyle changes

National Picture

The Government's Foresight report indicates that unless effective action is taken, up to 60% of adults and 25% of young people under the age of 20 will be obese by 2050[2]. The Government's ambition is to be the first major nation to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight[3]. The initial focus is on children with the PSA target to reduce the proportion of children who are overweight or obese to levels seen in 2000 by 2020[4].

Local Picture

The important obesity challenges facing Birmingham have been recognised by its strategic partnerships including the 'B' Birmingham Partnership (BSP), the Birmingham Health and Well-being Partnership (BHWP), the County Sports Partnership (CSP), and the Children and Young People Executive Board (CYPEB). This recognition has influenced the choice of several local targets linked to the city's current Local Area Agreement (LAA), 2008-2011, particularly:

Table 1 LAA 2008/9-2010/11 Childhood Obesity Trajectory Year 6 (National Indicator 56)

	Baseline (2006/7)	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Prevalence	21.5%	22.0%	21.9%	21.8%	21.7%	21.2%	20.7%
Required reduction in number of obese children			-406	-406	-406	-456	-506

Table 2 shows the results of the 2007/8 year 0 and year 6 child measurement programme as well as the 2007/8 QOF estimates for adult obesity weighted using Jan 2008 GP population data to match Birmingham wards. Ten of the PCT wards have one of the 4 highest results for either adults, year 0 or year 6 which illustrates how significant the obesity problem is for the entire population, of Birmingham East and North.

Obesity in year 0 children is higher than the national average. Obesity in year 6 is also higher than the national average but lower than the other Birmingham PCTs. There is a rise in obesity from year zero to year 6.

Obesity is closely linked to deprivation which is indicated by the wards with the highest prevalence. Mapping obesity against the health typologies indicates that Blue 1 (unemployed tweens) and blue 3 (cohesive communities)

[2] McPherson K et al (2007) Modelling future trends in obesity and the impact on health. Foresight talking obesities: Future Choices. London: Department for Innovation, Universities and Skills; 2007.

[3] Cross Government Obesity Unit, Department of Health, Department for Children, School and Families. (2008) Healthy weight, healthy lives: A cross-government strategy for England. London: DH, DCSF.

[4] PSA 12 Indicator 3 Childhood Obesity. DH & DCFS (2007). The PSA 12 Childhood Obesity target is jointly owned by the DH and DCFS liaising with DCMS, CLG, Defra and DfT.

have high levels of child obesity whilst adult obesity is prevalent in Red 2 (unwell and aging) and red 3 (troubled dependence).

Table 2 QOF estimates and NCMP data by ward for NHS BEN (highest marked in red and lowest in green)

	Children		**Adults**
Ward	**Year 0 obesity %**	**Year 6 obesity**	**QOF obesity**
Acocks Green	11.3	22.4	8.4
Bordesley Green	12.0	24.0	9.2
Erdington	8.9	27.6	9.9
Hodge Hill	10.0	23.6	9.9
Kingstanding	8.6	24.4	9.7
Oscott	11.7	19.7	8.9
Perry Barr	8.7	27.0	8.6
Shard End	13.0	23.6	10.4
Sheldon	10.7	21.6	10.2
South Yardley	11.1	25.8	8.4
Stetchford & Yardley North	10.0	19.6	10.2
Stockland Green	10.1	25.0	9.7
Sutton Four Oaks	6.4	14.4	5.4
Sutton New Hall	5.1	16.6	6.7
Sutton Trinity	5.9	17.8	5.5
Sutton Vesey	4.4	20.7	6.2
Tyburn	13.1	20.7	11.1
Washwood Heath	14.4	23.9	8.3
PCT average	10.1	21.3	8.8

Note GP-level QOF data has been weighted to produce the ward-level estimates

Among the eight core cities, Birmingham has the second highest rate of childhood obesity among children in year 6 behind Manchester, the least physically active adult population, and the highest proportion of adults, with type II diabetes.

Table 3 Prevalence of adult and child obesity across England's 8 core cities 2007-8.

Core City	**Childhood obesity year 0 %**	**Childhood obesity year 6%**	**Estimated prevalence of obese adults %**
Birmingham	**10.6**	**22.1**	**23.4**
Bristol	**9.7**	**15.2**	**22.5**
Leeds	**9.2**	**17.8**	**20.6**
Liverpool	**10.6**	**18**	**21.9**
Manchester	**11.5**	**22.8**	**25.8**
Newcastle	**10.9**	**21.3**	**22.6**
Nottingham	**12.5**	**20.1**	**27.6**
Sheffield	**6.9**	**14.8**	**24.3**

Current Challenges - Obstacles

- Tackling obesity in pregnancy is not only key to impacting on the obesity epidemic but it has a significant role to play in reducing perinatal mortality[5], foetal abnormalities[6] and maternal deaths[7].There is therefore a need to develop a shared care pathway for the identification

[5] *Chu et al, AJOG, 2007*
[6] *Waller et al, AJOG, 1994*
[7] *Saving Mother's Lives 2003 – 2005,* CEMAC 2007

of and management of obesity in pregnancy within Birmingham East and North.

- Birmingham East and North does not have a systematic approach to the prevention of obesity in the early years

- There is a need to further develop an adult weight management programme that can meet the significant additional anticipated demand for the NHS health checks programme. Unmet demand based on current service provision and projected referrals would be 3303 patients per year[8].

- There is limited parental awareness of weight status and health risks, only 14% of the parents of obese children considered their child to be overweight[9] and therefore the Department of Health are encouraging PCTs to feedback the results of the National Child Measurement Programme to parents. This will result in an increased demand for childhood weight management programmes of 727[10] per year

Current actions

Obesity in Pregnancy -NHS BEN provided the clinical leadership for the development of a model for the management of obesity in pregnancy and early years as part of the SHA Investing for Health Programme. This model is currently being piloted in 6 PCTs within the West Midlands with results due in June 2010. Initial feedback is positive therefore a business case is being developed to implement this service within Birmingham East and North

£384k has been secured through the Working Neighbourhoods fund by the Citywide Obesity Delivery Group to implement:

- Early Years Healthy Settings Award which is similar to the Health schools award but in nurseries and early years settings in 18 additional venues
- Cooking Mentors programme; 16 Local people will be trained to run cooking groups with their peers, using recipes provided by Food Net.
- Citywide Healthy Catering award scheme. This award seeks to increase the availability of healthier options in cafes, takeaways and other establishments – at least 24 venues to have the award
- Healthy Start Cook4Life courses; this initiative aims to reach new families at an early stage in parenthood, maximising the potential benefits of Healthy Start on family nutrition from pregnancy onwards (400 families)
- Family Food Growing (98 families)

The PCT is piloting routine feedback from the National Child Measurement Programme in Shard End, Stockland Green and Washwood Heath and

[8] *Assumptions*
18,015 demand over 5 years based on local modelling of DH and WMPHO data
Assuming 20% per year = annual demand 3603 per year
Current annual capacity = 300, assuming that 50% service used by age group 40-74
[9] National Opinion Poll for OfCOM (2004) Childhood Obesity Food Advertising in context.
[10] Based on 50% of numbers identified as obese in reception and year 6 across the PCT

proactive follow up of those classified as very overweight in Tyburn. The pilot will measure parental satisfaction and impact on services.

A health trainer service has been established (Sept 09) to provide family based support to the families of overweight children to facilitate lifestyle change. This service compliments the childhood weight management programmes run through the Nutrition and Dietetic services. A central referral system and contact point for patients has been established to avoid confusion between the different services which are required for different age groups.

The PCT is working with the Strategic health authority to develop an online family healthy lifestyle plan, which will include an assessment resulting in a personal report about the family's current lifestyle behaviours. The online tool supports the family to set goals for change and provides interactive follow up incorporating behaviour change strategies. The intention is that this service could be available across the PCT to meet the demand for child weight management programmes, thus enabling targeting of high risk families for more intensive support.

The PCT provides adult weight management services via the Nutrition and Dietetic Service and has recently undertaken two pilots with commercial weight management organisations; Slimming World and Weight Watchers. Local evaluation has been undertaken to compare the outcomes of the different programmes. The results show that Slimming World was the most effective and cost effective option although these programmes were not set up to enable direct comparison and therefore care needs to be made in interpreting the results. Results of a trial set up to compare the effects of different weight management programmes in South Birmingham will be available in December 2009.

A weight maintenance service will be launched in December 2009 through Birmingham Own Health. This has been developed to minimise the numbers of people who are supported to lose weight who subsequently regain.

Recommendations / Next Steps

- Finalise review of obesity strategy and commissioned services and develop a business case through investment disinvestment for adult weight management services and maternity and early years service
- Your family Health Plan pilot to run November 09– April 10
- Recruit patients to weight maintenance service from December 2009
- Evaluate pilot of feedback of NCMP
- Undertake focus groups with South Asian communities to better understand their specific needs in relation to weight management services
- Active engagement with Citywide obesity delivery board (under Birmingham Health and Wellbeing partnership) to develop prevention agenda

4. Physical Activity

Brief Statement:
A draft NHS Birmingham East and North Physical Activity Strategy (2009 - 2012) is in development and will outline the proposed direction of physical

activity for the PCT, including existing service provision, partnerships and delivery and commissioning of evidence-based services. This will reflect the current Birmingham City Council and 3 PCT partnership support of the Be Active programme**.** Physical activity supports the PCT's goal '…that the health and well being of the population will have improved so much that people will enjoy ten more years of healthy life...' It therefore directly relates to a number of World Class Commissioning (WCC) Outcomes, including, reducing inequalities and improving health (and well-being), improving life expectancy, reducing stroke admissions and reducing risk of coronary heart disease.

Introduction and National Picture

There are several key national physical activity targets, these include:

- The Government's target of 2 million more adults active by 2012 (Be Active Be Healthy, 2009).
- The Government's recommendation to increase physical activity levels so that 70% of the population are reasonably active (for example 30 minutes of moderate exercise five times a week) by 2020 (Game Plan, 2002).
- Local Area Agreement NI8 regarding 'adult participation in sport and active recreation'

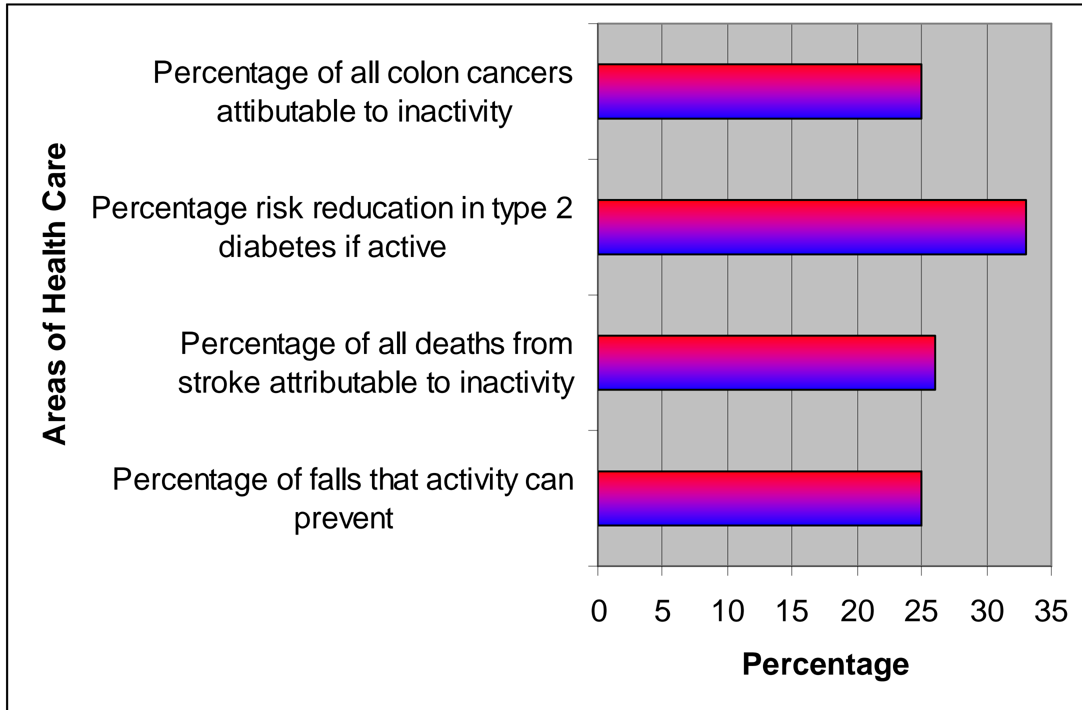
The multiple health (and well-being) benefits of physical activity e.g. preventative health – reduction in disease risk factors, management of long term conditions and improved mental health are reflected in a series of key policy documents:

Game Plan - a strategy for delivering Government's sport and physical activity objectives (2002)
Choosing Health - making healthy choices easier (2004)
Choosing Activity - a physical activity action plan (2005)
Tackling Inequalities - a programme of action (2002).
National Service Frameworks (NSF's) include: coronary heart disease (CHD), older people, diabetes, the NHS Cancer Plan and children, young people and maternity services.
NICE - multiple sets of guidance reflecting behaviour change, promotion and workplace initiatives.

<u>Impact / Costs</u>

On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual. In contrast, people who are physically active can reduce their risk of developing stroke and type 2 diabetes by up to 50%, and the risk of premature death by about 20 to 30%. Examples of the Impact of physical activity / inactivity across healthcare are outlined in Figure 1.

Figure 1: Impact of Physical Activity / Inactivity across Health and Well Being



The British Heart Foundation Health Promotion Research Group identified that the financial cost of inactivity to each PCT is around £5.2 million a year (2006 / 2007). However, the costs and impacts go far beyond financial implications and reach across different levels, including, individual, social, community, environmental and societal.

Local Picture

As identified within the Sport England Active People Survey (2007 - 2008) only 19.1% of the adult (16+) population (825,900) undertake 3 x 30 minutes of sport or active recreation per week across the West Midlands Region (21.3% nationally). The Survey also identified that Birmingham at 16.9% sits within the lowest quintile (13.3 to 19.4% - representing 'low levels' of participation) in physical activity. This places Birmingham in the bottom 25% across the West Midlands. PCT level data is limited, however the following reflects estimates from the Active People Survey (07/08) and P. E, School Sports and Club Links Strategy (PESSCL, 2007 / 2008) for children (5-15):

- **Adults:** The number of adults not participating in 3 x 30 minutes per week moderate intensity sport and recreation' = 285,343 within BEN.
- **Children:** The number of schools not achieving 2 hours Physical Education per week = 56 / 146 schools (38%).

Table One identifies participation rates by sub group in adults (16+) within BEN as based on the Active People Survey (2007 - 2008).

Table One: Participation in Physical Activity by Sub Group

Sub Group	Number participating in physical activity	Percentage participating
Males	36, 159	21.1%
Females	22, 187	12.9%
• 16-34 years • 35-54 • 55+	27, 920 18, 631 9, 282	24.5% 15.5% 8.5%
Ethnicity • White • Non-White	 58, 215 14, 228	 16.57% 16.23%

Physical inactivity is typically a population-wide issue and challenge, however, certain population groups (and geographical areas) are at higher risk of being inactive, these include individuals living in areas of high deprivation such as Washwood Health, Shard End and Bordesley Green. In addition, females, disabled individuals and those experiencing health complications (e.g. long term conditions), black and minority ethnic groups and older adults are at particular risk of inactivity. Although as identified within the Sport England Active People Survey (2007 - 2008) ethnic groups are reasonably similar (White 16.57% and Non-White 16.23%), differences can be found amongst minority ethnic groups e.g. Asian (Indian, Pakistani, Bangladeshi and Chinese) men and women are less likely to meet physical activity recommendations (Health Survey, 2006).

Current Activities

As part of the NHS Birmingham East and North approach to physical activity a wide range of physical activity services and opportunities for both adults and children are provided and promoted across the Trust. This includes partnership activities as part of wider collaborative working across health, education and other sectors. These include:

- **Be Active:** Birmingham City Council, in partnership with the 3 Birmingham PCTs, is now offering all Birmingham residents: free swimming, group exercise classes and gym sessions for the next 18 months (starting September 2009) as part of a population approach to increasing access to physical activity across Birmingham. The scheme also aims to maximise all physical activity opportunities across the wider environment, including, walking, running and biking. A 'soft launch' has taken place in September 2009 and the scheme is up and running across Birmingham; a full launch will take place in December 2009. To date, over 17,000 new members (Leisure Centres) have now signed up to the scheme since the initial launch. To ensure the greatest impact upon health and well being and in particular health inequalities, a targeted segmentation approach has been taken to all promotional / marketing activities and also to performance management. As such, individual targets have been set for each 'typology' group to ensure maximum uptake from deprived, BME communities.
- **Exercise on Prescription (EoP):** Based upon GP referral, this service provides a programme of exercise predominantly for individuals with long term conditions. Between 2008 and 2009 the service saw 1,459 patients. The service has been effective in reaching BME population

groups - in particular Pakistani / Caribbean e.g. April 2008 - March 2009 = 423 (BME) / 1459 (Total) (29%). However, overall concerns exist regarding inappropriate referral and poor uptake with regards to long term conditions. The service is therefore currently under review - reflecting national and local performance data.

- **Physical Activity Mapping:** A directory of all physical activity opportunities across the Trust has been created to ensure adequate promotion of available resources in addition to supporting high levels of uptake across all commissioned services. This directory will be launched in time with the December Be Active launch date.
- **Healthy Schools Programme**
  Physical activity is one of the key themes for participating primary and secondary schools. The physical activity theme covers a range of criteria and actions each school is expected to implement. This includes a whole school physical activity policy, transport plan, structured physical activity and consultation. The current expectation is that children participate in at least 2 hours (increasing to 5 hours) a week of structured physical activity. Currently 98% of PCT schools are engaged with the programme and 75% have healthy schools status. Furthermore, 10% have been targeted as part of the new enhanced model.
- **Extended Schools Programme**
  The programme offers a range of extended services and activities, including, 'community access to school facilities'. This includes greater access to sport (physical activity) e.g. resources, facilities and opportunities. Various services and activities will vary depending upon the school (cluster). All PCT schools are engaged in 'extended provision'.
- **Villa Vitality**
  Physical activity is a key component of this programme. This includes activities as part of the 2 day visit to Aston Football Club; links to the children's ICE Gym, coaches delivering physical activity within schools and weekly challenges which include physical activity. For the period (2008 / 2009) 1,800 children went through the programme.
- **Health Trainers**
  Health Trainers provide support for people who have been advised by a health professional to change their lifestyle for health reasons. This includes help with planning and achieving their goals which includes support around physical activity and putting their plans into action.
- **Expert Patient Programme**
  This free programme is for patients aged 18 and over who have a long-term health condition (LTC). The 6 week course looks at impacts of LTC's; managing symptoms and taking control. The service offers physical activity advice and support to clients as one of a number of topics covered across healthy lifestyles. For the period (2008 / 2009) there were 515 clients through the service.
- **Size Down** (Birmingham Nutrition and Dietetics Services)
  This free weight loss group is run by Food Net and is open to adults across the PCT (and Birmingham). The course consists of 8 sessions over 14 weeks during which individuals attend 6 weekly 2 hour sessions (with 2 follow-up sessions) covering a range of key areas. This includes appropriate physical activity advice and support as part of the focus around weight management. For the period (2008 / 2009) there were 180 clients through the service.

NHS BEN Physical Activity Strategy
The above activities will form core components of a Trust physical activity strategy, currently in development. The strategy will link into both the wider lifestyles agenda for the Trust and in particular to the Obesity Strategy. The Strategy provides direction over a 3 year period for the development of physical activity across the Trust. As part of the strategy a model and pathway will be developed, with actions / services proposed at (3) different levels. These include: Prevention and Early Intervention (promotion), Targeted Services and Initiatives (supported self-care) and Case / Disease Management. The model will respond to current gaps in service provision and variation in local need through an evidence based commissioning strategy but in addition will maximise all opportunities provided through partnership working (including health, local authority, voluntary and community, education and transport). However the focus will stretch beyond service provision to supporting and promoting a healthy lifestyles culture across multiple settings, including, communities, workplaces and health (and other) services by encouraging the incorporation of physical activity across daily living.

Current Challenges

- Ensuring that we meet the varying needs of our local community regarding physical activity within one strategy in light of the multiple factors associated with inactivity within different sub groups.
- Promoting a cultural shift in attitudes towards activity thereby ensuring that physical activity opportunities do not become synonymous with service provision and instead become an integral part of each individual's lifestyle.
- Maximising partnership working so that responsibility for physical activity and the outcomes of inactivity, which are experienced across the wider health and social economy, are recognised by all key stakeholders.

Implications if action not taken
The risks of taking no action is wide and far reaching given the well-recognised impacts and influences of physical inactivity; and benefits for improving health and reducing inequalities where there is regular participation. The increasing burden of disease and long term conditions will give rise to even greater demand and pressure on services and budgets; where physical activity (as a cost-effective public health intervention) can play a significant role in reducing these risks. However, the benefits of being physically active go beyond health and well-being, and include social, economic and environmental perspectives. For example, physical activity plays an important social function within communities (social networks), town planning creates more vibrant and connected and cohesive communities while active travel reduces harm on the environment.

Recommendations / next steps

- Implementation of the NHS Birmingham East and North Physical Activity Strategy outlining a range of proposed services and actions. Including recognition of the diverse physical activity needs and preferences of the local community, targeted approaches to reflect differences in deprivation and associated risk factors for inactivity and engagement with the existing gaps in physical activity service provision within primary, secondary and community care. In addition, maximising opportunities across partnerships at policy, environment, community

and individual level including the 2012 Olympics (West Midlands); Active Transport and Healthy Workplaces Community-based (services)

- Ongoing distribution and update of NHS BEN physical activity mapping
- Ongoing monitoring and evaluation of the Be Active initiative ensuring that feedback of uptake within targeted groups is consistently reflected within local and Birmingham wide marketing and promotional activities.
- A review of the Exercise on Prescription (EoP) service, in accordance with national and local guidelines and performance data.