

**Institute of Community Cohesion
Population and Health Inequalities Mapping Project**

**Draft Project Brief
(Version 4.0 - 15/3/07)**

Contents

1. Introduction
2. Background
3. Project definition
 - Project objectives
 - Approach
 - Scope
 - Desired outcomes/Deliverables
 - Resources
 - Assumptions
4. Business case
 - Benefits expected
 - Risks
 - Costs
 - Timescales
5. Project organisation
 - Project Team and roles
6. Communications
 - What and how we will communicate with interested parties.
7. Project quality
8. Project Plan
 - Key activities
 - Product check list with dates and responsibilities
 - Contingency plans.

1.0 Introduction

This document sets out the objectives of this project and describes how we will deliver them. Earlier versions of the project brief were produced in January 2007 as the basis for initiating and managing the project, measuring progress and evaluating results. The project manager consulted all interested parties on its content during the first two weeks of January and gained agreement to it at a meeting on 18th January 2007. This revised version (version 4) has been produced now (15th March) to outline progress on phase 1 and initiate work on phase 2. It will be used as the basis of a tender to the Department of Health who have now published a project specification to commission work on a project of this nature. Our project was initiated in anticipation of such a specification. Phase 1 is now in full swing but we will only be able to move into phase 2 if our tender is accepted by the Department of Health and we win the resources to enable us to complete the project.

2.0 Background

The project was initially commissioned by Ted Cantle, Director of the Institute of Community Cohesion in anticipation of the Department of Health's wish to develop a practical approach to estimating the scale and characteristics of local populations (particularly their health inequalities). The prime source of data for policy making and service planning is the decennial census but new patterns of population change particularly through international migration have made city populations much more dynamic and more difficult to estimate. This is a particular problem for health service planners as new migrant groups have very different health needs compared to the rest of the population. Existing approaches to estimating population change need to be improved or replaced.

Our project has been able to draw on some valuable work that has already been carried out. A scoping study entitled "Cohesion mapping for community dynamics" (COHDMAP) had been produced by an ICoCo team led by Professor Mark Johnson. The COHDMAP work identifies a wide range of potential sources of information and describes their present usefulness and potential value if modified and developed. The team's report recommends that its work could be taken further to provide a basis for a toolkit or model framework for mapping community dynamics. Many of the data sources identified by the report have limited value in isolation but, when brought together, it should be possible to paint a much clearer picture. The main challenge for this project is to find an effective method of painting such a picture and piloting it in Coventry and Leicester.

3.0 Project Definition

3.1 Project Objectives

The project has four objectives:

1. To review and utilise the data held by health and other agencies and, as far as possible, update 2001 census information to facilitate estimates of the current populations of Coventry and Leicester including estimates for ethnic minorities and other vulnerable groups.
2. To identify differences in health conditions and access to treatment amongst different ethnic and faith groups in the population including, if possible, reference to the Muslim community.
3. To develop a methodology (for the above) that may facilitate or permit roll out to other cities.

4. To identify ways of improving methods for collecting and managing data that will enable the production of more reliable population and health inequality estimates in the future.

3.2 Approach

The approach we have already adopted to this project is to involve demographic researchers and local service planners in the following key activities:

- To decide which population categories should be our priorities.
- To identify the data sources which offer the highest probability of accurate estimation for these population groups (either in isolation or when combined with other data).
- To identify the data sources which give the best estimates of health conditions for our priority groups and on how they access health services.
- To identify what data sources are available in Coventry and Leicester or what sources could be made available with relatively little effort.
- To collect the selected data for Leicester and Coventry.
- To use the collected data to estimate the populations of our priority groups and their health characteristics in the two cities.
- To test the estimates using a triangulation approach. This examines differences between data sources.
- To identify ways in which data collection and management could be improved to enable more reliable estimating in future.
- To produce a report on our findings.

In the course of our discussions with local service providers during phase 1 we have decided to focus on two small areas within each city where our priority groups are concentrated. This will give a better understanding of the nature of “population churn” and the way it changes local communities. It has become clear during phase 1 that the knowledge of local people needs to be captured to supplement and test our sources of published data. We have therefore included the use of focus groups and key informer interviews.

3.3 Scope

The project will use published reports and publicly available data but will not involve primary research. It will estimate total populations for the two cities but the priority will be to estimate the scale and characteristics (especially health characteristics) of particular groups (identified in stage 1 of the project). Estimates will be produced for small areas based on ONS Super Output Areas and we will use these estimates to suggest adjustments to the official estimates of city-wide populations. In stage 1 we will need to decide which definition of population to use (eg usually resident, students, armed forces etc) and how it should be disaggregated (eg by age, sex, SEG etc). We will also need to decide on the date for which the estimates are made.

3.4 Desired Outcomes

The desired outcomes are as follows:

- An estimate of population and health characteristics of specified groups using an agreed definition and levels of detail for Coventry and an equivalent estimate for Leicester.
- A report describing the method used and commenting on its strengths and weaknesses with guidance for Local Authorities and other agencies that may want to try out the method for themselves.

- Recommendations (to the appropriate agencies) about how data collection and data management could be improved to enable reliable estimating in future.

3.5 Resources

The project was initiated in January in the expectation that some funding would be available from the Dept of Health. A tender specification was not available at that stage but iCoCo decided that the need for this work was clear and we would underwrite the cost of a first phase. We estimate that the total cost of the project is £45,000 (mainly to pay fees to staff used on the project). The local agencies involved in the project are absorbing the cost of their own staff who are working with us.

3.6 Assumptions

We have made the following assumptions:

- That DoH will accept our tender and provide £45,000 funding.
- That Coventry City Council, Leicester City council and the Primary Care Trusts for the two cities will support the project and co-operate as indicated in this document. This has been confirmed.
- That other specialist staff will be available to assist the project within the timescales set out in this document. This has also been confirmed.

4.0 Business case

4.1 Benefits expected

The following benefits are expected from the project:

- More reliable estimates of population levels and characteristics as the basis for sound service planning in Coventry and Leicester.
- Improvements in health in the two cities resulting from better information about vulnerable groups and more evidence based planning.
- Similar improvements in other service areas.
- Service improvements in other cities due to the provision of advice and guidance on population estimating available to statisticians and service planners generally
- Longer term service improvements as a result of our advice on improved data collection methods.
- A possible benefit might be that the Government changes its formulae for grant allocation to reflect a more reliable method of estimating local populations

4.2 Risks

The main risks to the success of the project are as follows:

- That key agencies do not support the project. (This is no longer a risk as support has been confirmed.)
- That DoH funding is not available
- That key staff are not available at the stages of the project when they are needed. (This is no longer a risk).
- That we are simply unable to devise a reliable method of estimation.
- That our findings are ignored by the key agencies that could benefit from them.

4.3 Costs

Our estimate of the funding required for this project is £45,000. This would pay for about 60 days work by the research staff who would be paid from the project

budget plus administration and management costs. The local agencies involved in the project will absorb their own staff costs.

4.4 Timescales

The work will be divided into 2 phases as follows:

Phase 1

Stage 1 (Jan and Feb) - Agree Project Brief, resource commitments etc; develop short list of options for methodology and review data sources available locally; compare method options with local data availability and agree best match.

Stage 2 (March and April) - Estimate small area populations in Coventry and Leicester (using published data supported by focus groups and key informer interviews); draw out implications for city-wide population estimates including estimates for priority groups; produce phase1 report.

Phase 2

Stage 3 (May and June) - Identify health needs and access issues for priority groups in small areas; Produce report of findings with recommendations.

5.0 Project organisation

The project will be managed by a steering group consisting of the following people:

- Andrew Lawrence (iCoCo) – Project manager
- Trevor Montague (iCoCo) – Project support and co-ordination with other projects
- Colin Thunhurst (Coventry University) – Lead researcher
- Mollie Gilchrist (Coventry University) – Deputy Lead researcher
- Jean Arrowsmith (Coventry City Council) – User representative
- Trish Roberts-Thomson (Leicester City Council) - User representative.
- Dept of Health representative (if project moves into phase 2 and is supported by DH funding.)
- Others as necessary.

The project sponsor is Ted Cantle. Ted will attend some of the steering group meetings and Andrew will report to Ted at the end of each key stage to gain his approval before moving to the next stage. Meetings of the steering group will be held to start and sign off each key stage. As lead researcher, Colin Thunhurst will manage most of the research tasks with the support of a research team consisting of Mollie Gilchrist (who will act as Colin's deputy) and other research assistants from Coventry University. Within each of the two cities we will convene meetings between the research staff and representatives of the local agencies who will be asked to provide support on particular tasks. These meetings will be used to agree the way we apply the approach in each city.

6.0 Communications

Each steering group member will be responsible for informing the appropriate people within their respective organisations about the purpose of the project and how it is progressing. Any other external communications and consultation on the key documents (particularly the final report) will be discussed by the steering group and authorised by the project sponsor.

7.0 Project Quality

Each steering group member will be responsible for ensuring that the project is meeting the expectations of the organisation that they represent and for confirming this by their agreement to sign off each key stage of the project.

8.0 Project Plan

8.1 Key work tasks

The following key work tasks will be carried out:

Key Work Task	Key stage	Task manager	Support.	Start date	End date
1. Prepare, consult and agree project brief	1	AL	Steering group	1/1/07	18/1/07
2. Agree approach, priority groups, small area focus, data sources and ways of involving local people	1	CT	Steering group, local agency reps.	18/1/07	28/2/07
3. Estimate small area populations in Cov and Leic using agreed method, draw out implications for city wide pops (including estimates for priority groups)	2	CT	Research team plus local agency reps	1/3/07	30/4/07
4. Produce report on phase 1	2	AL/CT/TC	Steering group	20/4/07	30/4/07
5. Identify Health needs and access issues for priority groups in small areas.	3	CT	Research team and local agency reps	1/5/07	25/5/07
6. Produce final report	3	AL/CT/TC	Steering group	14/5/07	31/5/07

8.2 Product Check list

We will produce the following products:

Product	Lead Responsibility	Date
1. Project Brief	AL	2/1/07 (revised 15/3/07)
2. Phase 1 report	AL/CT	30/4/07
3. Phase 2 report	AL/CT	30/6/07

8.3 Contingency plans

We have identified the main risks to the project at section 4.2 . The main risk is that our tender will not be accepted by the Department of health and we will not receive the resources we have predicted. If this happens we would stop the project at the end of phase 1.

Andrew Lawrence

15/3/07