Report for ACTION by the Health & Wellbeing Board
Item Number:

Contains Confidential or Exempt Information	NO – Part I
Title	Joint Strategic Needs Assessment (JSNA) 2012/13
Responsible Officer(s)	Dr Pat Riordan, Director of Public Health
Contact officer, job title and phone number	Angela Snowling, Asst. Director and Consultant for Public Health, 01753 636859 or 078180 15342 John Scaife, RBWM Rutuja Kulkarni, , Asst. Director and Consultant for Public Health, 01753 636334 or 07876 562539
Member reporting	Councillor Dudley
For Consideration By	Health and Wellbeing Board
Date to be Considered	3rd Feb 2012
Implementation Date if Not Called In	April 2012 onwards
Affected Wards	All
Keywords/Index	Needs, Joint Strategic Needs, Inequalities, health of RBWM

Report Summary

1. This report deals with future health and well being needs of the population in light of the existing services
2. It recommends that the Health and wellbeing Board endorse the JSNA priorities for 2012/13 and that these priorities inform the Joint Health and Wellbeing Strategy for 2012/13 for RBWM
3. These recommendations are being made because combination of the JSNA, joint health and wellbeing strategy and aligned commissioning plans have the potential to be transformational in improving health, care and wider services for people in our communities
4. If adopted, the key financial implications for the Council for 2012/13 are the alignment of commissioning plans.
5. An additional point to note is that Public Health budgets will be held within the NHS Berks Cluster for 2012/13 and the shadow budgets within Local Authority will be planned during 2012. The Public Health budget is expected to be ring fenced when the services are transferred to local authorities from 2013 (*Healthy Lives, Healthy People 2010 and House of Commons Health Select Committee, 12th Report Session 2110-12, Nov 2011*).

If recommendations are adopted, how will residents benefit?	
Benefits to residents and reasons why they will benefit	Dates by which residents can expect to notice a difference
1. Health and wellbeing boards and CCGs will have a duty to encourage **integrated working** of commissioners and providers in order to improve the health and wellbeing of the local population, reduce inequalities, and improve the quality and experience of services for the local population (*Joint Strategic Needs Assessment and join health and wellbeing strategies explained – commissioning for populations Dec 11*).	From April 2102
2. Collaboration between Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards will enable them to commission on the basis of mutual priorities across the broader health and care landscape, not simply from a health perspective resulting in more holistic services (*Joint Strategic Needs Assessment and join health and wellbeing strategies explained – commissioning for populations Dec 11*).	Oct 2012 onwards
3. The technical evidence in the JSNA is complemented by local perceptions and insights on services. These local insights can help in the design of services so that they are commissioned and delivered in a way that can bring maximum benefit from the resources used (*JSNA: Data Inventory, LGID 2011*)	April 2012 onwards

1. Details of Recommendations

RECOMMENDATION: It is recommended that

- **The Health and Wellbeing Board endorse the JSNA priorities**
- **JSNA to inform the Health and Wellbeing Strategy that will developed through the Health and Wellbeing Board with the involvement of all relevant stakeholders (Local Authorities, CCGs, Director of Public Health, Health Watch, other relevant clinicians)**

2. Reason for Recommendation(s) and Options Considered

The reason for the above recommendations is rooted in the seminal White papers *Liberating the NHS* and *Healthy People, Healthy Lives 2010* both of which state that the Health and Wellbeing Boards (HWB) will bring together key sector representatives to produce the JSNA and the Joint Health and Wellbeing Strategy (JHWS).

3. Key Implications

The key role of HWBs will be to promote “integrated working” between NHS, public health and social care commissioners. Under the Health and Social Care Bill (which is passing through the House of Lords), putting together the JSNA will be a joint

statutory obligation of local authorities and CCGs (exercised through the HWB) (*House of Commons Health Select Committee, 12th Report Session 2110-12, Nov 2011*). This will have the benefit of providing a local context and collective priorities for the key players in the new system, including CCGs, to develop their commissioning plans from April 2013 when the statutory responsibility passes from the PCT.

Working under delegated authority from PCT cluster boards, CCGs will want to contribute to the JSNAs and these will inform the first joint health and wellbeing strategies and CCG commissioning plans for their first year of operation. CCGs will commission the majority of services, with the NHS Commissioning Board directly commissioning the remainder of services, both of these processes will be supported by the evidence in the JSNA.

In endorsing the JSNA priorities, the HWB will not only support the process of the development of the JHWS, a vital requirement of the white papers (*Liberating the NHS* and *Healthy People, Healthy Lives 2010)*, but also creating a foundation for their future statutory duty. Under the Health and Social Care Bill, local authorities and CCGs will be obliged to compile a JHWS.

Local Government Association, the NHS Confederation and early implementer of HWBs plan to develop statutory guidance on JSNAs and JHWSs in January 2012 and to take this forward through the National Learning Network of HWBs (*Joint Strategic Needs Assessment and join health and wellbeing strategies explained – commissioning for populations Dec 11*).

4. Financial Details

a) Financial impact on the budget (mandatory)

Public Health budgets allocated to local authorities will be ring fenced (*Liberating the NHS; Healthy People, Healthy Lives* and *House of Commons Health Select Committee, 12th Report Session 2110-12, Nov 2011).*

The allocation to local authorities using a centrally devised formula, details of the allocation methodology and shadow allocations were to be published in the System Reform Update on public health funding by the end of 2011(*House of Commons Health Select Committee, 12th Report Session 2110-12, Nov 2011)*. These are now expected in Feb 2012.

b) Financial Background (optional)
Public Health budget summaries have been submitted to the Department of Health as required in Sept 2011 based on the 2010/11 out turn spend by the NHS Berks Cluster as per national requirements.

5. Legal Implications
The Health and Social Care Bill, of which the JSNA is a component, is being considered in the House of Lords at present. It has passed through the Committee stage and is now in the Reporting stage (process outlined in the previous paper to the HWB).

6. Value For Money
It is expected that there are a number of ways in which the JSNA could demonstrate value for money. Namely, comparative data can help to assess the extent to which

improvements could be made taking into account the current level of provision or state of need on the ground.

Financial information sources can help to identify how money is being spent locally in comparison with other parts of the country. This can help raise questions for further investigation and can assist in comparing actual spend on services with the desired pattern based on local population need.

Local services mapping process can help to identify duplication or gaps that could be addressed in the commissioning cycle and improve value for money.

The benefits of integrated working are not merely for the local system and organisations; they will improve the quality of services, and experiences and outcomes for service users, their families and carers in accessing services centred around them. In a period of both economic and demographic pressure, this alignment of service planning and provision could also be of great benefit to the taxpayer, with the opportunity for more efficient use of shared resources (*Joint Strategic Needs Assessment and join health and wellbeing strategies explained – commissioning for populations Dec 11*).

Finally, the JSNA will strengthen local accountability, enabling HWBs to work with the local community and partners to identify needs and assets, and to jointly decide and agree actions to address them and utilise their potential. Through this involvement, the local community will have the ability to influence local services and, have an understanding of what other factors have influenced service provision in their area. There is an opportunity here for greater partnership with local stakeholders and the community, through which local assets and resources can be offered and used as a way to work together to address local needs and tackle the wider determinants of health in a different way.

7. Sustainability Impact Appraisal

It is planned that the JSNA will be hosted on the RBWM website as well as the NHS Berks Cluster website thus reducing the requirement of paper copies and fitting in with sustainability goals. CD ROMs are also to be used to share the JSNA details, providing an environmentally friendly option.

8. Risk Management

Risks	Uncontrolled Risk	Controls	Controlled Risk
Lack of ownership of Public Health and the JSNA within and across the new organisations and new hosts	N/A	DH and LGA /region led information dissemination Widespread dissemination of local transition plans Workshops to engage new organisations and new hosts	N/A

9. Links to Strategic Objectives

The JSNA supports both the RBWM and the NHS Berks Cluster strategic objectives. Specifically, by using the Marmot themes of assessing needs across the life course it supports children and young people, aims to improve health, reduce inequalities and build stronger and safer communities. By paying attention to projected future position, scope for improvement and resource impact, it facilitates future capabilities. Additionally, the very nature of the JSNA and the JHWS involves working and delivering with key partners.

10. Equalities, Human Rights and Community Cohesion
JSNA and JHWS will enable commissioners to plan and commission integrated services that meet the needs of their whole local community, in particular for the most vulnerable individuals and the groups with the worst health outcomes.

Vulnerable groups are identified in this comprehensive dataset. Each service template provided includes equality impact monitoring information

11. Staffing/Workforce and Accommodation implications:
NA

12. Property and Assets
NA

13. Any other implications:
NA

14. Consultation
The JSNA has been presented to the Partnership Boards in the Borough and to the consultation event held on 28th Nov 2011. This consultation event covered both the JNSA and the Joint Health and Wellbeing Strategy, further information regarding the consultation feedback can be found in the Joint Health and Wellbeing Strategy report to the Health & Wellbeing Board 3rd February 2012 meeting.

15. Timetable for Implementation
It is anticipated that the JSNA will inform the JHWS and the timetable set out for its development.

16. Appendices

JSNA Executive Summary for RBWM

17. Background Information
Details of past papers presented to the Health and Wellbeing Board in RBWM can be found in the links below or on the Council website.
04/11 PROGRESS AGAINST 2010/11 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

23/11 UPDATE ON THE PROGRESS OF THE JSNA REFRESH AND PRIORITIES

The statements in this document are subject to the successful passage of the Health and Social Care Bill through Parliament and reflect the current intentions of the Department of Health in relation to the JSNA and joint health and wellbeing strategy

following Royal Assent (*Joint Strategic Needs Assessment and join health and wellbeing strategies explained – commissioning for populations Dec 11*).

18. Consultation (Mandatory) – N/A

Name of consultee	Post held and Department	Date sent	Date received	See comments in paragraph:
Internal				
External				

Report History

Decision type:	Urgency item?
Non-key decision	No

Full name of report author	Job title	Full contact no:
Rutuja Kulkarni	Assis. Director and Consultant in Public Health	01753 636334

Schedule for writing and reviewing report
It is important that enough time is allowed for each stage of the writing and review process. To help ensure the report is started in time and no stage is rushed, please write in the date for the final stage of your report in the appropriate box below. Then, working backwards, add dates to the remaining boxes, allowing up to five working days for each stage.

Stages in the life of the report – N/A

Stages in the life of the report (not all will apply)	Date to complete
1. Officer writes report (in consultation with Lead Member)	
2. Report goes for review to head of service or DMT	
3. To specialist departments: eg, legal, finance, HR (in parallel)	
4. To lead member	
5. To SMT or CMT	
6. To the leader	
7. To overview or scrutiny, if a cabinet report	
8. To cabinet	

The Royal Borough Windsor & Maidenhead

NHS Berkshire East

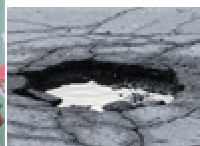
JOINT STRATEGIC NEEDS ASSESSMENT

2011- 2012

A summary for the

Royal Borough of Windsor and Maidenhead

Health and Wellbeing Board



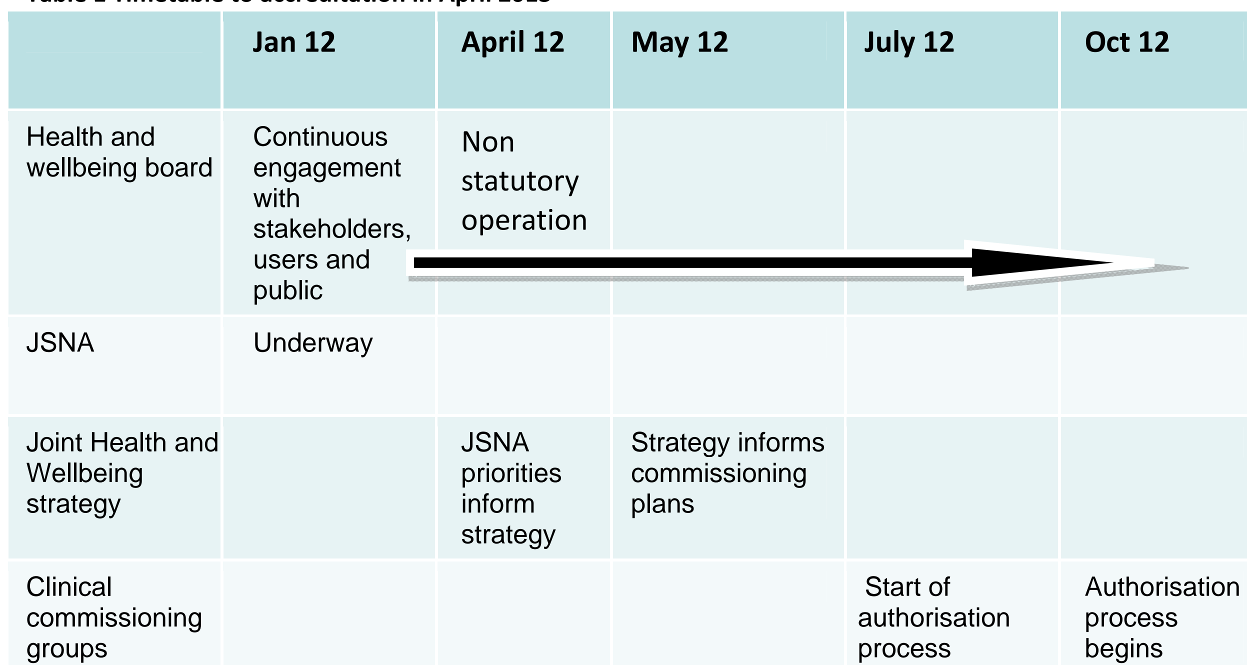
Introduction

The requirement for Primary Care Trusts and upper tier Local Authorities to develop a Joint Strategic Needs Assessment (JSNA) for their local populations is contained in statutory regulation - the Local Government and Public Involvement in Health Act of 2007. The JSNA is a process by which the current and future health and social care needs of a population are identified in the light of existing services. Recommendations are made to address those needs.

The Local Government Improvement and Development Data Inventory (LGID 2011) was used this year as it provides a consistent and transparent way of comparing diverse priorities.

DH guidance released in December 2011 sets out the timetable (see Table 1) for ensuring the JSNA informs the development of local health and wellbeing strategies by May 2012 and commissioning plans prior to accreditation. Local shadow Health and Wellbeing boards are required to follow this timetable and to ensure that stakeholder engagement has occurred throughout 2012.

Table 1 Timetable to accreditation in April 2013



	Jan 12	April 12	May 12	July 12	Oct 12
Health and wellbeing board	Continuous engagement with stakeholders, users and public	Non statutory operation			
JSNA	Underway				
Joint Health and Wellbeing strategy		JSNA priorities inform strategy	Strategy informs commissioning plans		
Clinical commissioning groups				Start of authorisation process	Authorisation process begins

Public health commissioning responsibilities set out under the Health and Social Care Bill (DH, 2011) include the commissioning responsibilities for Public Health England, the NHS Commissioning board, clinical commissioning groups and local authorities. These are set out clearly in a recent DH publication available at

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131901.pdf

With this in mind the JSNA findings summarised here are cross referenced to the relevant sections of the full electronic guide and to themes in the Marmot report (the focus of the 2010 JSNA) as suggested in the guidance on what an effective health and wellbeing strategy should contain.

The board is requested to note;

- The strategic issues which require resolution at PCT and Health and Wellbeing board level

- That stakeholder engagement will commence to further inform the local views sections and the commissioning cycle to 2013 as shown above in Table 1 - from new DH guidance for developing health and wellbeing strategies
- That staff and partners will have electronic access to the full JSNA once approved by the board and to two presentations – one relating to population density and the other to the findings (as attached)
- That the full report includes an update of progress made against the Marmot Themes as required for establishing the local health and wellbeing strategy
- that sections 5 and 7 of the full guide include programme budgeting and Personal, Social Services expenditure data to inform commissioners of the key areas of spend for re-commissioning services

Process and governance

The process followed reflects feedback from the 2010 JSNA. The local JSNA working group was established with membership representing NHS Berkshire East (NHSBE), The Royal Borough of Windsor and Maidenhead (RBWM), the Windsor, Ascot and Maidenhead Clinical Commissioning Group and a wide range of partners including the police, local providers and the voluntary sector. This year there was strong representation from commissioners who requested equality impact information from provider services for children and older adults.

The Assistant Director of Public Health for Bracknell led the process on behalf of the Director of Public Health and the NHS Changes Project Manager on behalf of the Director of Adult Social Care. Informatics support was provided by leads in both NHSBE and RBWM. Data transfer was managed in accordance with the Data Protection Act - aggregate level data only was shared and many of the data sources are nationally available (as set out in the LGID guidance).

Themed templates and local reports were supplied by working group members for each of the locality versions. Evidence based templates for each theme have been collated for the Health and Wellbeing board to enable them to view how priorities were identified under the six headings of: numbers affected, potential severity or harm averted, projected future position is no action is taken, scope for improvement, resource impact, contribution to reducing inequalities and local views (public, patient and other stakeholder perspectives of needs).

A key development this year is that in-depth service templates and activity data were supplied for services for children and young people and for older adults, with a focus on those that will become the responsibility of local authorities or clinical commissioning groups to commission from 2013. These comply with equality impact monitoring requirements and can be further developed by commissioners throughout 2012. This will aid transparency as contracts move to local authority control in 2013.

A first draft (without electronic links to the datasets or templates) was sent to each local working group, to approve the structure and content in early December. Final feedback was received on 3.01.2012. Hyperlinks were then inserted into the electronic guide to the underlying datasets and templates. These are now live and the electronic guide is a substantial public health resource for all commissioners to use once approved by the board.

The guide, datasets and powerpoints of key findings will now be transferred to the local authority. Local determination will need to be made by information governance leads about how they are distributed to members of the Health and Wellbeing board, partners and commissioners. Within the NHS the guide will be available to all GPs, to commissioners and to

public health staff. This summary and a PDF of the guide (without links) will be viewable on the NHS Berkshire cluster website once approved by the PCT board

The electronic guide covers

- the health and wellbeing needs of local people
- the evidence base for each determinant of health and wellbeing
- key outcomes which are statistically worse or better than the Southeast
- a directory of commissioned services for children and older people
- the scope for future improvement
- a local views section* for each chapter which will be developed through further stakeholder engagement
- information on health inequalities

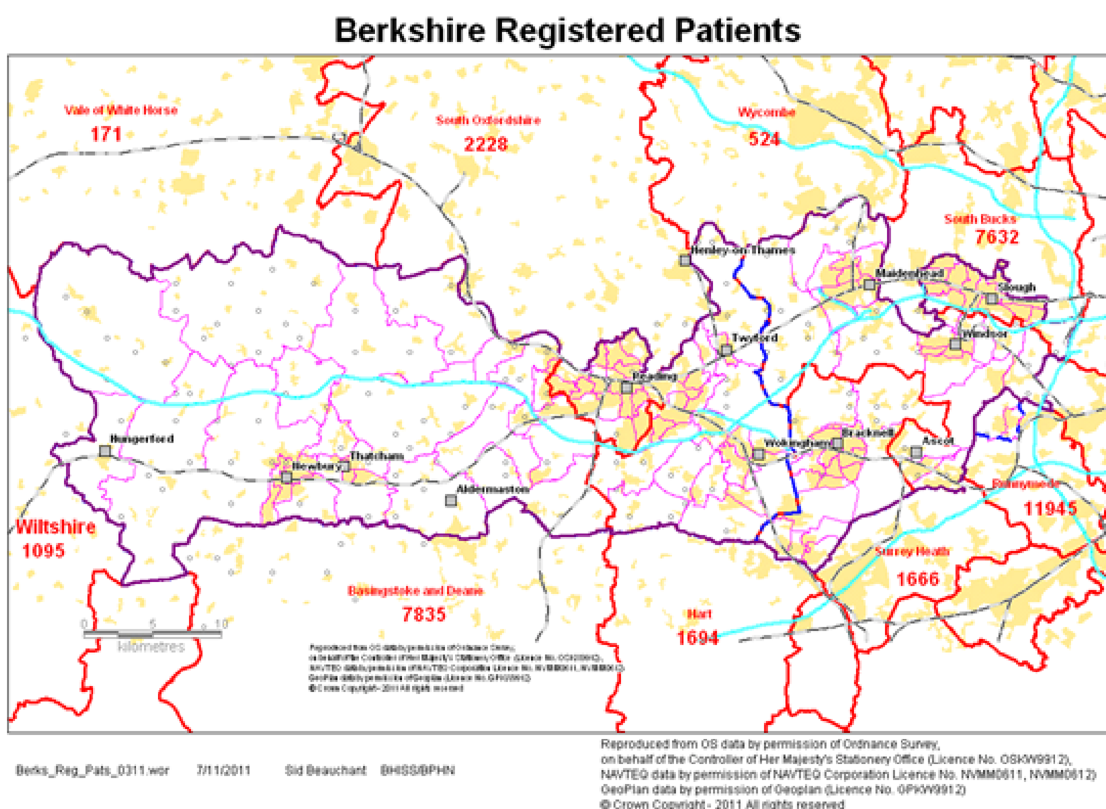
(*)The **next steps** are set out in the timetable in Table 1

Wider stakeholder engagement must now commence to further inform the ‘Local Views’ sections and 2013 commissioning plans. This will ensure JSNA is aligned with the commissioning cycle for the local authority, clinical commissioning group and NHS Commissioning board

Strategic issues - population differences (Chapter 1.1 in the guide)

The area covered by the Windsor, Ascot and Maidenhead CCG comprises RBWM and the wards of Englefield Green East and Englefield Green West in the Runnymede district of north Surrey. Figure 1 shows how many patients live outside the geographic boundary of the existing PCT in adjacent counties.

Figure 1Registered patients living in neighbouring counties outside the geographic boundary of Berkshire



The Office of National Statistics (ONS) 2010 estimated *resident* population of RBWM at July 2010 was 146,200 (72,200 males and 74,000 females). No ONS mid year estimates have been released for 2011 as the census results will reshape local estimates substantively in July 2012.

As yet there is no *resident* equivalent population for the Windsor, Ascot and Maidenhead CCG as boundaries have yet to be agreed. The July 2011 list size was 149,103 (74,251 males and 74,852 females).

Key population issues relevant to RBWM (for resolution prior to CCG accreditation), which relate to non coterminous boundaries include:

- Agreement of responsibility for commissioning health services from Surrey for the Runnymede district which includes the two Englefield wards in North Surrey – this affects 11,945 patients.
- Resolution of social care responsibility for the patients in the Ascot area that are now part of the Bracknell and Ascot clinical commissioning group. (Three out of five practices in Ascot ward have joined leaving a main and a branch practice within Windsor, Ascot and Maidenhead CCG)
- The need to agree a consistent population for joint funding purposes in the shadow year. (No national funding allocation has been agreed for clinical commissioning groups at this stage).

Future population projections – to 2030

RBWM currently has a slightly younger population profile than the UK average with a higher proportion of those aged 0-18 and a lower proportion of those aged 65 plus as illustrated in Table 2 below.

Table 2 Numbers and proportions of ONS MYE resident population 2010 in RBWM compared to the UK

Age group		Number males	Number females	Total	Proportion
0-18	UK	5,982,768	5,712,926	11,732,580	22.3%
	RBWM	19300	16800	27400	24.7%
65+	UK	3,701,265	4,730,414	8,756,400	16.7%
	RBWM	10000	12900	22900	15.6%

Source – ONS MYE 2010

For RBWM the population projections to 2030 are estimated to remain in line with the Southeast average. For RBWM the peak age band for growth is expected among those aged 50-59. For young people the 10-14 age band is projected to increase most to 2030

Ethnicity (Chapter 1.2 in the guide)

Until the 2011 Census results are published (expected in July 2012) overall the proportion of the population in RBWM which is from white British ethnic groups is estimated to be 72.1% for pupils resident in the borough and 59.6% for those who come into the boroughs schools. There is great variation at ward level. For this JSNA (for pupils entering school at the age of 5) ethnicity, special educational needs, language, black and minority ethnic groups have been mapped by ward. This has allowed identification of wards where pupils may have greater health and wellbeing needs.

For example BME percentages are highest in Boyn Hill (44%) and Maidenhead Riverside (46%), then Belmont (33%). SEN percentages are highest in Furze Platt (43%) and Maidenhead

Riverside (39%) but also in Oldfield (38%), Pinkneys Green (40%), Boyn Hill (36%) and Belmont (27%). The overall percentage differs for pupils coming in to school from outside the borough and for those living in the borough.

Birth rates in RBWM show that in line with national trends one in four new births are now to women not born in the UK.

Key health outcomes that are related to ethnicity are that South Asian men are more likely to develop CHD at younger age and have higher rates of myocardial infarction. Those with black ethnic origins have the highest stroke mortality rates. Heart disease, diabetes and learning disabilities are more prevalent nationally in Asian communities and these together with African and some Mediterranean communities have a higher prevalence of sickle cell anaemia.

Deprivation (Chapter 2.2 in the guide)

RBWM, which is situated in the relatively affluent South East region, ranks 291 out of 325 local authorities in England. (In terms of the weighted population average rank, where a score of 325 represents the most affluent in England). This measure is taken from the Index of Multiple Deprivation (IMD) 2010. The overall picture of deprivation in RBWM masks variations at Lower Super Output Area (LSOA) level (an area containing a minimum of 1000 people). Relative deprivation and rural isolation remain important issues for these populations. There are no LSOAs in the most deprived quintile nationally

Life Expectancy (Chapter 4.4 in the guide)

Life expectancy is the number of years that a person of a specific age can expect to live on average in a given population. It is a commonly used summary measure based on death rates in the population in a given year. Life expectancy at birth is defined as an estimate of the number of years a new-born baby would survive, were he or she to experience the particular area's age-specific mortality rates for that time period throughout his or her life.

For RBWM based on 2008-10 data average life expectancy was 79.8 years for males above the England average of 78.6 and 83.6 for females – above the England average of 82.6 (ONS, 2011)

Life expectancy gaps (quoted by different sources) between the most affluent and the most deprived *will provide different estimates based on the numbers of years used* to calculate and average. When further subdivided either into quintiles or deciles the confidence intervals are very wide so caution is required. Deprivation information may also change in those periods adding to interpretation problems.

The gap* between the most affluent and the most deprived wards for males was 6.1 years lower in the most deprived areas of Windsor and Maidenhead than the least deprived areas (*Source 2005-9 data as used in the 2011 Health Profile). For females the gap was 2.1 years.

*NB *The technical definition for the life expectancy outcome indicator is not yet defined in the Public Health Outcomes Framework (DH 2012). The Health Profiles quintile data is a summation of the APHO Slope Index of Inequality decile data.*

Births and deaths (Chapter 1.4b in the guide)

The population of RBWM will continue to rise to 2015, an increase of 3.8%. The population pyramid for RBWM is equivalent to the Southeast by those in the age bands 0-4, 25-39 and underrepresented in the age range 55 plus

27.4% of all births in RBWM are now to women whose country of origin is not the UK.

Cause of death codes on death certificates are very variable and it is particularly important to know which years are being pooled to calculate mortality percentages or to draw inference about mortality rates by age or gender that might be statistically different to national figures.

Using three year averages (based on all 2008-10 mortality data shown in the 2011 End of Life profiles) the percentage of deaths from 'all cancers' was not statistically different to national in RBWM at 27.88%. In RBWM cancer deaths in males aged 85+ and respiratory deaths in females aged 85+ were statistically higher (Source End of Life Profiles 2011)

The percentage of deaths from cardiovascular disease (2008-10) was just lower than national at 29.48% lower than national (29.57%). Cardiovascular disease in males and females remains among the top three categories – based on an extract from the Annual District Deaths for 2010.

Groups that might have additional needs (Chapter 1.5 of the guide)

Estimates of need and projections of future need are provided for a wide range of vulnerable groups and include local views expressed by users of services. Groups covered include: those with learning disability, mental ill health, special educational needs, children on child protection plans, children in need, looked after children, veterans, older people living alone, those not in education employment or training, carers, offenders, teenage parents, homeless, those with physical disability or sensory impairment, gypsies and travellers, migrant workers and their children. These can now be compared with actual service activity levels shown in chapter 5.

Update on the Marmot recommendations (Chapter 6 of the guide)

To enable the board to produce a Health and Wellbeing Strategy in line with the Marmot themes (as recommended in recent guidance from DH 2011 and as used in the 2010 JSNA) Chapter 6 of the electronic guide reviews key indicators in the Marmot report. There are connections to each theme throughout the document as shown below

- Theme A – giving every child the best start in life. (Chapters 2.3 and 4.2 of the guide). The key indicator explored this year at a local level was the performance of children on entry to school. The measure nationally is the whole Early Years Foundation Stage score. This is a composite of the communication and language scores, the emotional health and wellbeing scores and others. The first two have been analysed separately and show important findings in relation to where pupils live and then go to school. The key finding is that in order to reduce inequalities before entry to school the work of the early years teams, speech and language teams and others will need to be directed outside of the borough boundaries, as residents in the borough take their children to schools in Bracknell or Slough and in-migration of pupils from those areas is significant. This has implications for commissioning for example the Family Nurse Partnership, speech and language services and various parenting programmes.
- Theme B – enabling all children, young people and adults to maximise their capabilities (Chapter 2.3 and 4.3 of the guide). The results for those not in education employment and training are covered in 2.4 as is the underperformance of boys and some BME groups - a local and national issue.
- Theme C – fair employment and good work for all (chapter 2.2 and 4.4 in the guide). This reviews employment rates and claims which are similar to last year

- Theme D – ensuring a healthy standard of living for all (chapters 1.5 and 2.2 in the guide). The small increase in the numbers of claims by carers and those with a disability is not statistically significant
- Theme E – create and develop healthy and sustainable places and communities (chapter 2.1, 2.3, 2.5, 2.6 in the guide). It is too early to show impact in a single year – the 2010 BMG local resident surveys is referenced in section 2.1
- Theme F - strengthen the role and impact of ill health prevention (chapters 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 4.5, 4.6, 4.7, 4.8 in the guide). Improvements in disease specific outcomes are shown in section 4.6, 4.7. Reductions in the adverse health outcomes of problem drug use and the social and economic costs of drug related crime are shown in section 3.3. Reductions in preventable and avoidable death and disability across the social gradient are shown in section 5.2.

JSNA KEY ISSUES

IMPROVING OUTCOMES FOR CHILDREN LIVING IN POVERTY (CHAPTER 2.2 IN THE GUIDE)

Child poverty is an ongoing national and local priority. Ongoing analysis is planned for the child poverty strategy and a detailed template has been provided by the JSNA working group. None of the ward rates identified was above national or regional rates in 2008/9. However there were discrete lower super output areas which were and where effort has been concentrated.

According to the definition just published in the Public Health outcomes framework (DH 2012) the original HMRC definition from 2008 will be retained i.e the percentage of children living in relative poverty living in households where income is less than 60% of median household income before housing costs. The Local Authority Health Profile will contain this information annually and the 2011 profile which cited 2870 under the age of 19 will be replaced with the 2009 (3145) figure when the 2012 profile is released.

The 3145 figure is derived from Her Majesty's Revenue and Customs (HMRC) data updated in January of this year based on new ward boundaries and a snapshot in August 2009 where an increase of 275 children and young people under 19 was noted and a small percentage increase from 9.7% to 10.4%.

Until the next health profile is released quarterly HMRC Work Tax Credits data provide a worst case scenario snapshot as they do not adjust for median household expenditure (Dec 2011). These indicate 6,900 families are now claiming. Working tax credit is paid to those who work, but are on low income. A claim for Working Tax Credits is based on the hours you work and get paid for, or expect to be paid for – either as an employee or a self employed individual. A claim for Tax Credits does not take into account unpaid work. Until new HMRC data is released this can be used as a proxy indicator.

Gaps identified

- Poverty and academic performance are related. Although the gap between the median and the bottom 20% for the Early Years Foundation profile is narrowing, and the overall score is rising, there is scope to further improve this in the lower super output areas shown in the powerpoint.
- Referrals from health visitors to early years teams are viewed as vital for vulnerable children and families. A Health Visitor Expansion Plan is in place, increasing the capacity of the health visitor workforce is essential to ensuring that pre birth visits and two year

review assessments can be systematically implemented and used to measure the impact of early interventions.

- Once the reliability of the scoring has been checked with local teachers, improved targeting of early intervention services is required in areas of deprivation where low emotional health and wellbeing scores have been identified (from local analysis of the early years foundation stage indicator).
- Cross boundary commissioning of early interventions is required (such as speech and language therapy and parenting programmes) as children are entering schools from adjacent boroughs. Examples include the Every Child a Talker programme to prevent language delay

IMPROVING MENTAL HEALTH ACROSS THE LIFECOURSE

There is scope to further develop a public mental health approach starting from the early years and ending in later age. New programme budgeting information for 2010 (a measure of the amount spent on mental health in both primary and secondary care) has revealed that the PCT is ranked 2nd and fifth in England for the highest spend on community services for Child and Adolescent Mental Health and for spend on adult psychotic disorders. This is inconsistent with the PCT rank nationally and warrants investigation as there were below national rates of depression reported in general practices (10,056 patients a rate of 8.5%, significantly below the national average) and below national rates of people on mental health registers (943 people a rate of 0.6% compared to 0.7% nationally) in Windsor, Ascot and Maidenhead CCG at the end of March 2011. There were also below national rates of dementia prevalence 0.4% compared to 0.5% nationally) a total of 633 patients. The rate itself is so small that caution is required in interpreting it.

Gaps identified

- Best practice post natal depression estimates (BMJ 2011) vary from 7-19% among mothers yet there is no systematic recording to inform commissioning and the current thresholds for referral are high. Improved reporting needs to be implemented to inform lower levels of targeted support
- The rate of children becoming looked after is increasing – a 15% increase in RBWM since 2007 (BHFT annual report 2010-11). There is under representation of looked after children (a group in whom 45% are estimated to have a psychiatric disorder and 38% a conduct disorder) and of children and young people with conduct disorder in local Child and Adolescent Mental Health Services (CAMHS) services compared to estimated need.
- There is currently no provision of a Court divert service - a gap compared to the west of Berkshire
- GPs have identified there is a gap in provision of low level anger management programmes, although for example perpetrators of domestic abuse are offered access to anger management programmes. Local voluntary groups and a range of services do provide support but this needs to be made explicit in the children's services directory.
- Standardised mental health admissions are below the expected rate in RBWM but conversely standardised outpatients attendances are above the England average at 14944 compared to 5278 in RBWM reflecting the programme budget results.
- Using different estimates there are between 1,678 – 1,715 people with dementia in RBWM (PANSI Oct 2011, Delphi consensus - Lancet 2010) yet only 633 are listed on quality and outcomes registers in the CCG. Intensive work is underway to ensure early diagnosis

and support is in place to prevent unnecessary admissions as part of the dementia strategy. This includes prescribing reviews and the provision of dementia care advisors

- A review of reporting requirements for both the child and adult mental health contracts is required (prior to transfer of the budget to local authorities) to ensure that information is reported for the resident population in each unitary authority rather than simple counts of attendances at bases within those areas. In addition improved diagnosis recording would enable commissioning for outcomes rather than activity.

LONG TERM CONDITIONS

The World Health Organisation (WHO) defines long term conditions (also called chronic conditions) as health problems that warrant continuous management over a prolonged period, usually years or decades. The term "chronic diseases" includes an array of conditions including heart disease, stroke, diabetes, chronic respiratory diseases and cancer. A range of support programmes have been identified through the JSNA and need to be aligned with CCG plans.

Long Term Health conditions are often inter-related to long-term social care support. For example long term conditions can impact on managing personal care, daily living tasks, or achieving outcomes such as maintaining independence and reducing dependency on statutory services.

Cardiovascular Disease, Coronary Heart Disease, Diabetes, Stroke and Chronic Kidney Disease

Due to the way in which each cancer is coded separately cardiovascular disease (CVD) is the biggest cause of death in the UK, accounting for one in three deaths each year. CVD is the main cause of premature deaths – deaths under 75 years. It is a major cause of health inequalities as it more commonly affects people living in deprived communities. Heart attacks and strokes are the most common form of CVD.

All circulatory diseases accounted for 168 deaths in 2010 in males and 184 females. Within that coding coronary heart disease in males and females is the leading cause of death in the borough accounting for 172 deaths in males and 130 in females in 2010. Stroke is the third with 26 deaths in males and 43 in females.

There are 4,019 patients on CHD registers and 16,419 patients on hypertension registers. The biggest contributing factors to the development of coronary heart disease are high blood cholesterol (46%) and physical inactivity (37%).

There are 5,537 patients registered with diabetes in the CCG a rate of 4.6% below the PCT and national average of 5.5%. Diabetes is a major cause of ill health and premature mortality, mainly due to cardiovascular complications such as heart attacks, stroke, peripheral vascular disease, eye disease and kidney disease. Approximately 75% of patients with diabetes develop CVD. South Asian and Black people are at greater risk of type II diabetes, with cases occurring from the age of 25, compared to from 40 years in the general population (Diabetes UK). Diabetes is more common in deprived populations. There are 144 children diagnosed with type 1 diabetes within the PCT area but this can not be analysed at locality level.

There are 3,696 patients with chronic kidney disease in RBWM a prevalence of 3.1% just slightly above the 2.9% national rate.

There are 2,172 patients registered with a stroke or transient ischaemic attack on QoF 2010/11 registers. 272 people aged under 65 years are estimated to have long term health needs following a stroke. This is predicted to increase to 319 by 2030 - an increase of 17.2%.

(Projecting Adult Needs and Services, PANSI, 2011). The Projecting Older Peoples Population (POPPI) estimates that there are 530 people aged 65 and over with long term health needs following stroke. This is predicted to rise to 797 by 2030 an increase of 50.4%. The premature mortality rate under 75 years for stroke in Berkshire East was 15 per 100,000 in 2007-9, higher than England (12.8) and significantly higher than South Central (10.6). Male mortality rates exceed female mortality rates.

There are 2,100 patients with atrial fibrillation in RBWM a leading risk factor for stroke.

There are 795 patients registered with heart failure in RBWM.

Gaps identified

- To fully commission the NHS Health Checks screening programme
- To increase uptake of diabetic retinopathy screening to national standards
- To embed the roll out in primary care of an anticoagulant and DVT service for patients diagnosed with atrial fibrillation
- To provide Myquest support to ensure that practices can load and use the Guidance on Risk Assessment & Stroke Prevention tool (GRASP)
- To follow the South Central post stroke care pathway recommendations in the community
- Further explore the use of Telecare/Telehealth to help people manage their own conditions.
- Review the way social care data is collected for people with long-term conditions to enable more detailed analysis of the services being provided and outcomes achieved.

CANCERS

There are now 2,258 people on cancer registers in local practices in RBWM. Cancer mortality trends for 2007-9 were noted in the 2010 JSNA and will be updated when new data is available.

Cancer mortality percentages for each local area are available in the End of Life profiles for 2011. 27.88% of deaths in 2008-10 were due to cancer. The only statistically significant age bands were for males aged 85% plus in RBWM (a rate of 23.3% compared to 19.52% nationally).

Urological cancer incidence was however higher in RBWM as shown in the 2010 JSNA.

Gaps identified

- The need to recommission the breast screening age extension programme and to offer digital mammography has been recognised in the quality and improvement plan for the PCT.

END OF LIFE CARE

There has been widespread adoption of the gold standard framework for care management. Apart from acute provision the following community services currently provided include: community initiatives in each local authority, a night sitting service, medicines management, care homes education, practice nurse education programmes and voluntary sector bereavement support.

Gaps identified

- Palliative care codes in all three major acute providers remain statistically significantly above the England average (at between 20-30% of all deaths). Further work will be needed to evaluate whether the level of community provision is sufficient to meet the need identified.

RESPIRATORY DISEASE

There are 7,792 patients registered with asthma in RBWM (QoF 2010-11).

COPD is an umbrella term covering a range of respiratory diseases. Men in unskilled manual occupations are 14 times more likely to die from COPD than men in professional roles. There were 1,464 people registered with COPD in 2010/11 on QOF registers, a prevalence of 1.0% in RBWM compared to 1.6% nationally.

Gaps identified

- There is a pulmonary rehabilitation service in RBWM, but this needs to be linked in order to target the wards identified in the JSNA where excess admissions are reported or where there are frequent attenders.
- Wards with excess admissions compared to expected admissions have been identified for: asthma, bronchiolitis, upper and lower respiratory and chronic obstructive pulmonary disease. Further investigation is required as there are multiple potential triggers including: poor self management, housing conditions, smoking etc.
- There is scope to develop better links with local services and develop a Telecare/Telehealth service for COPD patients.
- There is scope to ensure further patients access the expert patient programme.

LIFESTYLE INTERVENTIONS - SMOKING

Smoking has been identified as the single greatest cause of preventable illness and premature death in the UK. It is known to be a major risk factor in many diseases including cardiovascular disease, respiratory diseases, and many cancers. Passive smoking has also been shown to be harmful to health and is a particular concern in the children of smokers.
Smoking accounts for half of the difference in life expectancy between social classes I and V (Acheson Report 1998). Following last years JSNA a re-tendering process is underway based on an outcomes based tariff to improve the local service. This is being undertaken in partnership with all local authorities in Berkshire.

ALCOHOL

The 2009 Report on Alcohol statistics (National Information Centre) estimated 1 in 3 men and 1 in 6 women were hazardous drinkers and 6% of males and 4% of females were harmful drinkers. PANSI estimates (Oct 2011) estimated 5,317 people were alcohol dependent. Among those in treatment the level of drug users who also have an alcohol dependency is reported as 21% nationally. Local alcohol profiles for 2011 show an increase in hospital admissions in RBWM to 1,226 per 100,000 across all areas although these are below national. Local drug and alcohol teams commission a range of services. The numbers in tier 4 residential services across the area were low (reported as 25 for all Berkshire East in 2010-11)

The only two indicators that were red at local authority level in the 2011 Local Alcohol Profile for England profile were 'alcohol related violent crime' and 'alcohol related recorded crime'. According to the North West Public Health Observatory, the level of binge drinking across the borough is estimated to be 18.2%. (Violence related to binge drinking is not treated in the same way as alcohol dependency. Criminal justice system interventions include Thinking Skills training).

Gaps identified

- Further development of Identification and Brief Advice in pharmacies and in tier 1 settings in particular GP surgeries and among staff in Adult & Children's Services.
- Slough has a pilot locally enhanced service for a tier 1-3 range of interventions. Once the results are known they will be evaluated for local application.
- The need for Alcohol Liaison Nurses in Accident and Emergency departments.

SUBSTANCE MISUSE

The JSNA contains new estimates of adults with a drug dependency. The local drug and alcohol action team have made recommendations for further commissioning improvements. Detailed performance information and projections showing financial impact has been produced by the National Drug Treatment agency to support JSNA commissioning decisions. This information is restricted but can be provided to commissioners.

OBESITY

73.3% of young people are a healthy weight at age 10/11 as shown in the latest National Child Measurement programme, this result is above the national rate of 65.3%. For children a range of services are in place to normalize weight across the life course.

The prevalence of adult obesity in RBWM (and associated costs to the NHS and social care) is projected to rise. 9,148 adults are registered as obese although the prevalence recorded in local practices in RBWM (7.8%) is below the national rate (quality and outcomes framework prevalence underestimates true prevalence as it is only recorded for those on disease registers).

Gaps identified

- The lack of a dedicated psychosocial support programme for morbidly obese children
- A clear documented strategic approach for addressing adult obesity at tier 3 and 4 should be developed.

PHYSICAL ACTIVITY

The latest Active People Survey (Dec 2011) noted that 26.4% in RBWM undertook the minimum exercise of three sessions a week of at least 30 minutes. This places them in the highest quartile. However this is less than the number of sessions recommended for health.

Gaps identified

- The need to promote the new early years guidance on appropriate activity levels throughout all childrens centres
- Increase commissioning of physical activity programmes in line with the national No Health without Mental Health strategy
- Map and align existing provision for those identified via the vascular risk check (a national health check screening programme for those aged 40-74 who are not on any existing disease registers) who meet the referral criteria from the NHS health check programme

HOUSING

Detailed analysis from the local templates shows increasing demand for homes among young families with waiting lists of 2,168 in RBWM.

The prevention of homelessness is a key priority as there has been a rise in temporary placements which has a detrimental effect on children who may be placed out of the area in

which they attend school. Increasing supported living options for those with learning disabilities and mental health problems is a priority for RBWM.

Extra Care Housing is also a priority. Extra Care Housing is designed for older people with additional needs and with varying levels of care and support available on site. People who live in Extra Care Housing have their own self contained homes, their own front doors and a legal right to occupy the property. Extra Care Housing is also known as very sheltered housing, assisted living, or simply as 'housing with care'. It comes in many built forms, including blocks of flats, bungalow estates and retirement villages. It is a popular choice among older people because it can sometimes provide an alternative to a care home and supports independent living.

CQC information (extracted Dec 2011) shows the difference between the numbers of beds and the numbers of care homes across the PCT area.

Table 2 Beds and care homes provided by locality

Bracknell	RBWM	Slough
485 beds 23 homes	1,412 beds 48 homes	475 beds 24 homes

Gaps identified

- The highest areas of joint expenditure for both the NHS and councils are in nursing and residential care placements and for assessment and care management yet differences in the way in which NHS funding is recorded within local councils' 'Personal Social Services Expenditure' make interpretation difficult. Further work is needed once final figures are released for 2010 to ensure that support is proportionate to need.

The scope for improvement suggested in the themed templates underpinning this section include the provision of extra care housing such as

- Examining how extra care housing can support people with dementia and widen the scope beyond frailty
- Working with housing associations to look at tenure options - leasehold can be appealing for people who wish to rent where extra care housing units at a lower cost to the tenant.
- Increasing the stock of private extra care housing and social rented extra care housing

Other recommendations include the use of joint health and social care assessment tools to ensure thresholds do not differ between agencies especially where health agencies work across all three localities.

There is also scope to re-commission using the current PCT contribution in section 256 agreements (formerly called section 28A agreements) where high level need is identified.

EDUCATION AND SKILLS DEVELOPMENT

Key indicators recommended in the Marmot report and the 2010 JSNA have been monitored again this year. The JSNA examines outcomes at each life stage from entry into school, through transition to secondary school and work based learning.

RBWM is in the processing of agreeing local action plans for their Children and Young Peoples partnership priorities. These will be included in the electronic version.

Gaps identified

- There are opportunities to further promote local childcare and childcare provision in those Children's Centres that will remain following consultation. Local parents, including

teenage parents benefit from a wide range of parenting programmes, health and wellbeing advice and access to education, training and employment opportunities. Welfare and benefits advice is also available to maximise benefit take up, and links with Jobcentre Plus to encourage and support labour market participation by parents.

- Along with schools and community venues, Children's Centres provide a number of adult learning and English as an Other Language (ESOL) classes to develop skills and employability amongst the adult population. With the current review of chidrens centres local commissioners will need to plan services according to need and accessibility. The findings of the analysis for early years foundation scores should be shared with local schools and actions identified at a local level as well as a commissioning level
- Commissioners should work together to ensure that plans are for the delivery of the school nursing services link to plans for the child health service when future commissioning responsibility moves to local authorities for those aged above five years (after April 2013).
- Those not in education, employment or training and those in transition remain priorities although the method of recording outcomes will be challenging as local services report in different ways. Early identification of those young people at risk of becoming NEET may help to target resources / support more effectively.

DOMESTIC ABUSE

Much work has been done by the local Community Safety Partnership and yet repeat rates of abuse remain the same. NICE guidance is awaited in 2012 on the evidence base for a range of interventions. Work with local safeguarding children boards shows the pressure community nursing teams are under as this now comprises 60% of their workload. Recommendations from Berkshire and Buckinghamshire Womens' Aid about how women access medical services are included in the local views section.

SAFEGUARDING CHILDREN AND ADULTS

There are specific recommendations in the JSNA which relate to safeguarding children (which have a separate section in Chapter 1 and looked after children is discussed in Chapter 5).

A recent Association of Directors of Social Services report makes reference to many commissioning recommendations that are already in place in NHS service specifications, invitations to tender and contracts. The goal will be to ensure that governance arrangements are in place to identify trends and ensure that the outcomes of referrals are known.

The local adult safeguarding reports include a key recommendation i.e to redress the under-reporting by health services. All general practices should have access to the Berkshire East wide adult safeguarding policy and procedures which can be found on line.

HEALTH PROTECTION

The recommendations in the JSNA overlap with those already outlined under the sexual health section (see HIV and Chlamydia recommendations in the full JSNA document). Reducing the rise in cases of Clostridium difficile is now a corporate priority.

AUTHOR DR ANGELA SNOWLING, Assistant Director of Public Health Version 5: 25.Jan 2012

Appendix 1 Navigating the JSNA – guide to key findings

	Contents
Chapter 1 Population	1.1 Age and gender 1.2 Ethnicity 1.3 Migration 1.4a Births 1.4b Deaths 1.5 Groups that might have special needs
Chapter 2 – Social and Place Wellbeing	2.1 Community wellbeing 2.2 Economy and income 2.3 Environment 2.4 Education 2.5 Housing 2.6 Crime and disorder 2.7 Local views and inequalities
Chapter 3 – Lifestyles and Health Improvement	3.1 Physical activity 3.2 Healthy eating 3.3 Alcohol 3.4 Drug misuse 3.5 Smoking 3.6 Health improvement 3.7 Local views and inequalities
Chapter 4 – Health and wellbeing status	4.1 Overall wellbeing 4.2 Life expectancy and mortality 4.3 Children and young people 4.4 Disability 4..5 Mental health 4.6a Cardiovascular health 4.6b Cancers 4.6c Respiratory health 4.7 Sexual health 4.8 Other key health issues – health protection 4.9 Local views and inequalities
Chapter 5 – Service utilisation	5.1 Social care indicators of service use 5.2 Health care indicators of service use 5.3 Benchmark costs 5.4.Public health outcomes and equality monitoring 5.5 Safeguarding children recommendations 5.6 Safeguarding adults recommendations
Chapter 6 - Marmot update	6.1 Theme A – giving every child the best start in life 6.2 Theme B – enabling all children, young people and adults to maximise their capabilities 6.3 Theme C – fair employment and good work for all 6.4 Theme D – ensuring a healthy standard of living for all 6.5 Theme E – create and develop healthy and sustainable places and communities 6.6 Theme F strengthen the role and impact of ill health prevention

	Contents
Chapter 7 – Clinical variations	7.1 Long term conditions summary 7.2 Identifying demand – results of the clinical group analysis 7.3 Orthpaedics 7.4 Urology 7.5 Cataracts 7.6 Cardiac procedures 7.7 Caesarian sections 7.8 Ear, nose and throat 7.9 Reducing demands on accident and emergency and paediatrics
Appendices	Appendix 1 Aims and ojectives, methodology, governance Appendix 2 Gap analysis for the Healthy Child Programme Appendix 3 Index of service templates

APPENDIX 2 Future Public Health Commissioning Responsibilities

Local authorities will be responsible for:

- **tobacco control and smoking cessation services**
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- **NHS Health Check assessments**
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- **comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)**
- local initiatives to reduce excess deaths as a result of seasonal mortality
- **the local authority role in dealing with health protection incidents, outbreaks and emergencies**
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

Only some are mandated and in 2012-13 these are marked in bold. There is flexibility to make local determination for the remainder. (NB By 2015 local authorities should be prepared to commission health visiting services in accordance with health visiting expansion plans currently underway)

CLINICAL COMMISSIONING GROUPS

- Abortion services

NHS COMMISSIONING BOARD

- Sexual assault and referral centres
- Campaigns to promote the diagnosis of cancer
- Commission effective child health systems for transfer to local authorities in 2015.

PUBLIC HEALTH ENGLAND

- To specify child health systems
- To commission the increased health visiting workforce and new health visiting service model until the local arrangements for the Healthy Child Programme is in place