Bracknell Forest Council

NOTICE OF MEETING

Adult Social Care Overview and Scrutiny Panel
Tuesday 1 December 2009, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

To: ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Councillor Turrell (Chairman), Councillor Harrison (Vice-Chairman), Councillors Baily, Blatchford, Mrs Fleming, Leake, Phillips, Mrs Shillcock and Ms Wilson

cc: Substitute Members of the Panel

Councillors Mrs Angell, Beadsley, Mrs Beadsley, Brossard, Finch, Mrs McCracken and Simonds

ALISON SANDERS
Director of Corporate Services

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Published: 23 November 2009

Adult Social Care Overview and Scrutiny Panel
Tuesday 1 December 2009, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

AGENDA

Page No

1. **APOLOGIES FOR ABSENCE/SUBSTITUTE MEMBERS**

   To receive apologies for absence and to note the attendance of any substitute members.

2. **MINUTES AND MATTERS ARISING**

   To approve as a correct record the minutes of the meeting of the Adult Social Care Overview and Scrutiny Panel held on 1 September 2009. Arising from the minutes, an oral update concerning mandatory Safeguarding Adults training for staff working within Berkshire Healthcare Foundation NHS Trust and Berkshire East Primary Care Trust will be given. 1 - 6

3. **DECLARATIONS OF INTEREST AND PARTY WHIP**

   Members are asked to declare any personal or prejudicial interest and the nature of that interest, including the existence and nature of the party whip, in respect of any matter to be considered at this meeting.

4. **URGENT ITEMS OF BUSINESS**

   Any other items which, pursuant to Section 100B(4)(b) of the Local Government Act 1972, the Chairman decides are urgent.

PERFORMANCE MONITORING

5. **PERFORMANCE MONITORING REPORT**

   To consider the latest trends, priorities and pressures in terms of departmental performance as reported in the PMR for the second quarter of 2009/10 (July to September) relating to Adult Social Care.

   Please bring the Performance Monitoring Report to the meeting (circulated separately).

BRACKNELL FOREST PARTNERSHIP

6. **REVIEW OF THE HEALTH AND SOCIAL CARE PARTNERSHIP**

   To discuss with the Chairman and Lead Officer of the Health and Social Care Partnership its governance, performance management, financial management, and related issues, with reference to the questionnaire sent in advance of the meeting. 7 - 42

OVERVIEW AND POLICY DEVELOPMENT

7. **REFRESHED JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)**

To inform the Panel of the Council's responsibility in relation to the JSNA prepared in conjunction with the Berkshire East Primary Care Trust and to receive the JSNA for 2009. 43 - 180

8. **PERSONALISATION**

To receive a progress update in respect of the six month TASC (Transforming Adult Social Care) pilot commenced on 1 August 2009. 181 - 232

9. **TRIPS TO THE COALFACE - COUNCILLORS' VISITS TO ADULT SOCIAL CARE SERVICES**

The notes of the three Panel Member visits to Adult Social Care services and facilities are attached to inform the Panel of the findings of the visits. 233 - 248

10. **OVERVIEW AND SCRUTINY QUARTERLY PROGRESS REPORT**

To note the Quarterly Progress Report of the Assistant Chief Executive. 249 - 262

HOLDING THE EXECUTIVE TO ACCOUNT

11. **ANNUAL PERFORMANCE LETTER FROM THE CARE QUALITY COMMISSION (CQC)**

To receive the outcome of the inspection of Adult Social Care services by the CQC.

12. **EXECUTIVE FORWARD PLAN**

To consider forthcoming items on the Executive Forward Plan relating to Adult Social Care. 263 - 268

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ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
01 SEPTEMBER 2009
7.30 - 9.30 PM

Bracknell Forest Council

Present:
Councillors Turrell (Chairman), Baily, Brossard, Mrs Fleming, Leake and Mrs Shillcock

Executive Member:
Councillor Birch

Apologies for absence were received from:
Councillors Blatchford, Harrison and Ms Wilson

Also Present:
Councillor Edger
Alex Bayliss, Safeguarding Adults Co-ordinator
Andrea Carr, Policy Officer
Zoë Johnstone, Senior Head of Service: Adults & Commissioning
Glyn Jones, Chief Officer: Adult Social Care
Amanda Roden, Democratic Services Assistant

18. **Apologies for Absence/Substitute Members**

The Panel noted the attendance of the following substitute member:

Councillor Brossard for Councillor Blatchford.

19. **Minutes and Matters Arising**

There were no matters arising from the minutes.

RESOLVED that the minutes of the meeting of the Adult Social Care Overview and Scrutiny Panel held on 2 June 2009 be approved as a correct record and signed by the Chairman.

20. **Declarations of Interest and Party Whip**

There were no declarations of interest relating to any items on the agenda, nor any indications that members would be participating whilst under the party whip.

21. **Urgent Items of Business**

There were no urgent items of business.

22. **Performance Monitoring Report**

The Chief Officer: Adult Social Care presented the Performance Monitoring Report (PMR) for the first quarter of 2009/10 relating to the Social Care and Learning Department, specifically Adult Social Care.

It was reported that during this quarter Adult Social Care had completed the major statutory returns on time to the Care Quality Commission (CQC). The planned work on refreshing the Joint Strategic Needs Assessment was underway with the Primary Care Trust (PCT) and had an autumn deadline. It was reported that a team had been appointed to work on the pilot of Transforming Adult Social Care and the associated programme board was focused on the pilot which would become operational during the current quarter. It was reported that a replacement care management recording system was due to come into place in early 2010.

Adult Social Care had a successful Annual Review Meeting with the CQC and the judgement on the 2008/09 performance year was due in November 2009 in line with the Comprehensive Area Assessment. The Councils' Older Persons Strategy had been approved by the Executive and a group had been convened from across the Council to implement the actions. Progress on this would be reported back to the Panel. There was still a demand for services in Adult Social Care and performance had been positive. Information on joint indicators had not been obtained yet from the PCT but work was being carried out on this.

It was reported that some indicators were measured annually and others on a quarterly reporting cycle which would affect the level of information available at a given time.

Arising from the Members' questions and comments the following points were noted:

- Performance reports from other agencies would be available when completed.
- Indicators relating to health were related to the PCT and Community Service and were different to the set of performance indicators relating to Heatherwood and Wexham Park Hospitals NHS Trust which would be dealt with by the Health Overview and Scrutiny Panel.
- Staff sickness absence was high in Adult Social Care but figures included twelve staff members who were currently on long-term sick leave.
- The PCT would be reviewing the eligibility criteria for continuing health care and withdrawing some funding for this. The PCT had a duty to review the needs of service users annually. It was reported that new guidance available from 1 October 2009 should make it easier for service users to gain access to continuing health care. Some people would be ineligible for this care but the decision could be appealed if thought to be unjustified.
- An explanation would be provided on performance against indicators NI 123 and NI 40 as information was captured annually rather than quarterly.
- Overall performance regarding transfers of care was very good and hospitals were becoming quicker at alerting the Council to delays.
- It was noted that the Social Care and Learning Department informed the PMR but did not produce the report. Comments would be taken into account for inclusion in the report.
- The figure for NI 139, which was obtained from the 2008 Place Survey and not from service users, showed performance in the lowest quartile but the Place Survey information would be reviewed.
- Information would be sought on the proportions of people stopping smoking.

23. **2008/09 Safeguarding Adults Annual Report**

The Panel noted a report on the work undertaken to ensure the Council would meet its responsibilities in relation to Safeguarding Adults and agreed the outline development plan for the year 2009/10.

The Bracknell Forest Safeguarding Adults Partnership Board had been established to enable greater local accountability and the East Berkshire Safeguarding Adults Partnership Board had been disbanded in its current form. A significant number of staff had received training to increase their awareness of possible abuse and work was being carried out to attract new staff. There had been an increase in the number of referrals to the Department.

From 1 April 2009 there was an increase in statutory obligations. Care and residential homes were subject to the deprivation of liberty safeguards and the Care Governance Board was formed. There was reported to be a high quality of service but more robust arrangements with providers would be considered to make improvements where concerns existed. Objectives would be set for this municipal year to reflect the significant changes taking place in Adult Social Care. The Council was working with Thames Valley Police and the Primary Care Trust (PCT) to raise awareness of safeguarding issues which would be central to the new IT case recording system.

Arising from Members' questions and comments the following points were noted:

- Police attendance at Strategy meetings had increased from 6% in 2007/08 to 9% in 2008/09. As police attendance was not appropriate in the majority of circumstances a realistic figure would be 15% attendance. Police were aware of these figures and were aiming to improve attendance at Strategy meetings.
- Safeguarding Adults training was mandatory for staff working within Berkshire Healthcare Foundation NHS Trust and Berkshire East PCT. Heatherwood and Wexham Park Foundation NHS Trust had set an objective to train 60% of its staff by January 2010 with the aim for 100% of staff to be trained by the following year as a balance was needed between training and running the service. There would be an update on this at the next meeting of the Panel.
- The Council took the decision to no longer use one of the providers of regulated services due to concerns about the quality of service provided. Service users would be offered a service by another provider and support and advice would be offered to those people organising their care directly.

24. **Nomination for Partnership Overview and Scrutiny Working Group**

Councillor Turrell was nominated to join the Partnership Overview and Scrutiny Group being established to co-ordinate Overview and Scrutiny of the Bracknell Forest Partnership and its Themed Partnerships.

25. **Executive Forward Plan**

The Panel noted the forthcoming items relating to Adult Social Care on the Executive Forward Plan.

26. **Work Programme for the 2009/10 Municipal Year**

The Panel noted a report containing the work programme for the Adult Social Care Overview and Scrutiny Panel for 2009/10 which had been adopted by the Overview and Scrutiny Commission.

27. **Overview and Scrutiny Quarterly Progress Report**

The Panel noted the Quarterly Progress Report of the Assistant Chief Executive on Overview and Scrutiny.

28. **Transforming Adult Social Care**

The Chief Officer: Adult Social Care gave a presentation on the work of the Council's Adult Social Care Section, specifically Transforming Adult Social Care (TASC).

TASC was aimed at tailoring care to people's needs and giving service users choice about how money was spent. This involved an individualised budget process including assessment and eligibility criteria and a Resource Allocation System (RAS) which was being refined and tested. The current charging policy did not recognise the personalisation agenda and RAS would include developing a contribution policy as some support may be chargeable. The aim was to be clear about expectations and for people to understand how much money was needed to assist people in being supported.

TASC would involve joint working with Health and other partners. Key objectives for this year would include validating self-assessment, how to deal with the financial contribution appeals process, communicating the programme to people, and managing and reporting performance. TASC would involve working with providers to secure flexible support options and looking at alternative solutions that people may require.

The Panel noted that one of the six work streams associated with TASC was transforming the workforce and, although this would involve changes to methods of service delivery, no need for variation in the number of staff required was envisaged. Although some policies and procedures had been tested through the earlier personalisation of services for people with learning disabilities, others such as the financial contribution appeals process required development. In terms of the commissioning and community capacity building work stream, grants to support self directed support had been agreed by the Executive in July 2009 and an innovative delivery contact was sought. Managing and reporting performance featured a shift from inputs to outcomes which were difficult to quantify and qualify. The Council currently supported 3,000 people per annum, approximately 300 of whom suffered from learning disabilities. Having been advised of the challenges associated with TASC and of the next steps towards its implementation. Members considered Overview and Scrutiny's role in the transformation.

Arising from Members' questions and comments the following points were noted:

- The Self-Assessment Form would be simple to complete and would ask for more general answers to questions regarding e.g. personal care, maintaining the home, employment. There would be 5-6 possible answers for each of the 11 domains covered in the form.

- The Self-Assessment Form was available in English only at present but support would be available to assist people in completing the form via an advocacy service and staff at the Council.
- Assessment of need would be carried out first and then a financial assessment would be undertaken to ascertain a service users' ability to pay for support. Although budgetary impacts would be avoided, it was not possible to predict future changes in the client cohort.
- TASC was thought to be an exciting opportunity for providers to be innovative and engagement work was being carried out with providers locally and nationally. Commissioning arrangements were being considered and it was acknowledged that personalisation would impact on all Council services including housing and leisure.
- All departments within the Council were involved in the Programme Board and Adult Social Care staff would attend Departmental Management Team meetings to advise other departments how they may assist the Adult Social Care Section achieve its aspirations.
- A six month pilot scheme was started on 1 August 2009 involving 29 service users and 5 members of staff so far. An update on how the pilot was started and how it was progressing would be presented to the Panel at a future meeting.
- Work would need to be carried out looking at the risks around people managing their own support and money, and to help people avoid abuse and manipulation.
- Domiciliary care could be charged for but day centre care would not be. It would be difficult to predict the impact of individual charging at this stage.
- Changes in Government policy would involve changing to Self-Directed Support (SDS) but the Council would still have a responsibility to service users to balance risk and duty of care.
- Service users' views would be sought on the success of the scheme and the scheme would be monitored as changes were made.

It was agreed that:

i. A working group be established to undertake a safeguarding adults thematic review of Transforming Adult Social Care; and

ii. Councillors Leake, Turrell, Edger, Mrs Shillcock and Mrs Fleming would form this group. Zoë Johnstone, Senior Head of Service: Adults and Commissioning, was the lead officer on TASC and would act as the group's departmental link officer. Assistance would also be provided by the Performance and Resources Section.

CHAIRMAN

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ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
1 DECEMBER 2009

REVIEW OF THE HEALTH AND SOCIAL CARE PARTNERSHIP

Assistant Chief Executive

1 INTRODUCTION

As part of the agreed approach to the Overview and Scrutiny (O&S) of the Bracknell Forest Partnership (BFP), the Chairman and Lead Officer of each of the BFP theme Partnerships has been invited to meet the O&S Commission or relevant O&S Panel to discuss the Partnership's governance, performance management, financial management, and related issues, with reference to a questionnaire completed in advance of the meeting. The Health and Social Care Partnership is one of the BFP theme partnerships within the purview of the Adult Social Care Overview and Scrutiny Panel.

2 SUGGESTED ACTION

2.1 That the Adult Social Care Overview and Scrutiny Panel discusses with the Chairman and Lead Officer of the Health and Social Care Partnership Board, Councillor Dale Birch and Mr Glyn Jones, respectively, the Partnership's governance, performance management, financial management, and related issues, with reference to the attached completed questionnaire.

3 SUPPORTING INFORMATION

3.1 The approach to O&S of the Bracknell Forest Partnership has been endorsed by the O&S Commission and Panels, also the BFP Board, and implementation has commenced. The agreed approach includes a structured programme of information gathering and initial analysis of the BFP's affairs. This work has been apportioned as follows:

O&S Commission – BFP's Board and the Town Centre Partnership, the Crime and Disorder Reduction Partnership, and the Economic and Skills Development Partnership.

Environment, Culture and Communities O&S Panel - the Strategic Housing Partnership, the Cultural Partnership, the Transport Partnership, and the Climate Change Partnership.

Children's Services and Learning O&S Panel - the Children's Trust, and the Early Years, Child Care and Play Partnership.

Adult Social Care O&S Panel - the Health and Social Care Partnership.

3.2 The information gathering comprises initially asking the Chairmen and Lead officers for the ten Theme Partnerships to complete a questionnaire, and then for the responses to the questionnaire to inform individual meetings by the Commission/Panel concerned with the Chairmen and Lead officers for each of the Theme Partnerships, individually. These will form part of the public meetings of the Commission and Panels throughout 2009/10. The structured series of meetings with the Chairmen and lead officers of the Theme Partnerships will contribute to relationship building.

3.3 The purpose of the questionnaire to be sent in advance of the meetings is to gather all the basic information on the work and organisation of each Theme partnership, to make best use of members' time at the ensuing meetings.

Background Papers

Agenda and minutes of the Overview and Scrutiny Commission on 1 April 2009

Contact for further information

Richard Beaumont – 01344 352283
e-mail: richard.beaumont@bracknell-forest.gov.uk

Draft Questionnaire for completion by the Chairman and Lead Officer of BFP's Board and each of the 10 BFP Theme Partnerships

A: Name of Partnership:	**Comments**
Chairman's name and contact details:	Chairman for 2009/10 municipal year: Councillor Dale Birch, Bracknell Forest Council
Lead Officer's name and contact details:	Glyn Jones, Chief Officer: Adult Social Care, tel: 01344 351458

B: Partnership details	**Comments**
1. Please attach the terms of reference for the partnership. If it is not in the TOR, please outline the agreed aims, key objectives and key functions	Terms of Reference are attached and include aims, objectives and membership.
2. Please provide a few examples of the partnership's major achievements	• Co-ordination of elements of Health and Social Care activity • Commissioning strategy consultation • Healthspace and JSNA developments • A successful conduit for sharing information, providing a forum for discussion and ensuring on-going monitoring of issues
3. Where do you think the partnership currently is in terms of its stage of development? E.g. early formation, delivering shared outcomes, or fully developed?	Developing shared outcomes
4. Please describe any major obstacles towards the partnership's success	None identified

Membership 5. If not in the TOR, please list the current members of the partnership and the organisations they represent	Included in the terms of reference.
6. If not in the TOR, please describe the arrangements for appointing members to the partnership	The partnership itself decides on its membership and which organisations/bodies should be represented. The organisations/bodies are then responsible for appointing their representatives.
Minutes 7. Please provide minutes of meetings in the last year	Attached.

C: Governance arrangements	**Comments**
1. Please provide any recent self-assessment of governance arrangements for the Partnership, or describe any plans to do so.	The partnership reviews its terms of reference on an annual basis.
2. How are decisions made? Is there a scheme of delegation that makes clear who can take decisions?	Decisions are taken at Board meetings by a simple majority as detailed in the terms of reference.
3. How are decisions recorded?	Minutes are the formal record of Board meetings and within the minutes action points are highlighted.
4. Who makes sure decisions are acted upon?	Lead Officer or whoever an action is allocated to and follow up reports given at successive meetings.
5. Please describe how the partnership is held to account, and by whom	The Bracknell Forest Partnership receives quarterly newsletter updates from each themed partnership which highlights the recent work of the partnership. The Bracknell Forest Partnership also reviews the performance of themed partnerships through the quarterly performance monitoring of the Local Area Agreement. If there are indicators that fall into the 'red' category (that are in the remit of a particular partnership), members of the themed partnership will

	be requested to attend a meeting of the BFP to explain why these indicators are failing.
6. Risk management - Has the Partnership itself carried out a formal risk assessment of the Partnership? If yes, please provide details	No.

D: Performance management	**Comments**
1. Please describe the arrangements for setting output/outcome targets, and give details of the partnership's targets for 2008/09	LAA targets form the basis of performance. Progress is tracked from the core group partnerships via annual reports.
2. Please describe the arrangements for monitoring and reporting progress against targets	LAA performance monitoring.
3. How does the partnership agree action on targets that are not likely to be met?	Decisions made through discussion at meetings.
4. How do you demonstrate publicly that the partnership adds value?	Bracknell Forest Partnership has a Communications Group that ensure the work of the partnership is publicised.
5. How does the public know that the partnership achieves value for money?	Through publicity of the work being carried out.
6. Does the Partnership contribute accounts of success to the BFP's communications group?	Yes, through a quarterly newsletter.

E: Financial Management	Comments
1. How is the partnership funded? (on the basis of the last financial year)	The partnership has no budget, Democratic Services administer the meetings.
2. Who decides on how to spend the money?	N/A
3. Can the money be reallocated? If so, who can authorise this?	N/A
4. What are the financial reporting arrangements?	N/A

F: Serving the Public (For response just by BFP's Board)	Comments
1. Does the partnership have a communications policy? If so, please provide this	
2. How does this partnership achieve accessibility for the public? (for example, are meetings open to the public?)	
3. Is there a complaints and suggestions process the public can use?	

G: Overview and Scrutiny of the Partnership	Comments
1. Does the partnership have any views on how O&S can assist in its development and achievement of objectives?	
2. Does the partnership have any suggestions for O&S reviews to be considered for the partnership O&S programme?	

If there are any queries on the completion of this questionnaire, please contact Richard Beaumont, Head of Overview and Scrutiny, Bracknell Forest Council on 01344 352283 or Richard.Beaumont@Bracknell-Forest.gov.uk

HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

TERMS OF REFERENCE

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1. PURPOSE

(a) To establish the needs of the local population of Bracknell Forest through a joint strategic needs assessment and ensuring user and carer involvement.

(b) To approve joint commissioning of services and support for older people, people with learning disabilities, with mental health difficulties, long term conditions and those who misuse substances, Aids/HIV, where an integrated response is required and to monitor and evaluate these arrangements when they have been established.

(c) To promote the use of pooled budgets or other Health Act flexibilities, where necessary, in relation to all of the work of the board.

(d) To contribute to the broader work of the Bracknell Forest Partnership's Sustainable Community Strategy, the Local Area Agreement and the Health and Well-being Strategy

(e) To report to the Bracknell Forest Partnership and liaise with other theme partnerships reporting to it

(f) To develop joint targets in relation to priorities.

(g) To produce an annual work programme and monitor its implementation.

(h) To ensure that the groups reporting to the Partnership Board (see appendix 2) contribute appropriately to the Board's objectives.

(i) To share relevant information between partners

(j) Respond to government initiatives and consultations concerning adult social care and health on behalf of the partners.

(k) Exercise oversight of such functions as may be determined by the Partnership or the partner agencies.

NB: This Partnership Board is responsible for commissioning services for adults. Services for Children are covered by the Children & Young People's Trust.

2. RISK

Each report to the partnership should highlight any potential risks and relevant mitigating factors. Risks to projects or to the partnership should be discussed at meetings and a clear record of any decisions in relation to risks should be made.

3. DECISIONS

Partners shall bring along their own expertise to the decision making process, but decisions will be taken in the overall interest of the Sustainable Community Strategy and the Local Area Agreement. The partnership will endeavour to reach consensus on matters for decision. Where votes are invoked, each representative will have one vote, carrying equal weight. Decisions will be made on a simple majority basis and will require a quorum of at least one member from Berkshire East Primary Care Trust, Bracknell Forest Borough Council and the voluntary sector forum.

3. FREQUENCY AND DURATION

The meetings will take place on a quarterly basis. Each meeting will be no longer than two hours in duration.

4. ADMINISTRATION

The meetings will be administered by Democratic Services at Bracknell Forest Council.
All venues considered for meetings will be accessible.

5. MEMBERSHIP

See Appendix 1.

Membership of the partnership will be reviewed on an annual basis.

The chair of the partnership will alternate every twelve months between Bracknell Forest Council and Berkshire East Primary Care Trust.

6. LINKS TO OTHER PLANNING ARRANGEMENTS

A number of groups/boards report to the Partnership Board to assist it in delivering on its key tasks and are listed in Appendix 2.

NB: This Board covers those services that are jointly commissioned within Bracknell Forest Borough boundaries. The Berkshire East Joint Strategic Commissioning Board is responsible for jointly commissioning services across the three unitary authorities within Berkshire East.

Appendix 1

Membership of the Health and Social Care Partnership Board

1. The Bracknell Locality Non-Executive Member for Berkshire East Primary Care Trust (Irene Douglas)

2. Executive Member for Adult Services, Health and Housing for Bracknell Forest Council. (Councillor Birch)

3. The Director of Adult Social Care for Bracknell Forest Council (or their representative) (Lesley Heale)

4. Director of Localities for Berkshire East Primary Care Trust (or their representative) (Mary Purnell)

5. A representative from Bracknell Forest Voluntary Sector Forum (Martin Gilman)

6. A carer representative (Barbara Briggs)

Those invited to attend and advise the board are:

Chief Executive (or a representative) – Bracknell Forest Council

Chief Officer - Adult Social Care – Bracknell Forest Council

Director of Environment, Culture & Communities (or a representative) – Bracknell Forest Council

Head of Adults and Commissioning, Adult Social Care – Bracknell Forest Council

Head of Older People and Long Term Conditions – Adult Social Care – Bracknell Forest Council

Assistant Director for Bracknell Locality - Berkshire East Primary Care Trust

Member of Berkshire East Professional Executive Committee

Chief Executive (or a representative) – Heatherwood and Wexham Park Hospital Trust

Chief Executive (or a representative) – Berkshire Healthcare Trust

Assistant Director of Offender Management – Thames Valley Probation Service

Director of Bracknell Forest Voluntary Action (or representative)

Director of Public Health (or representative)

Berkshire East Clinical Executive Committee

Director of Community Health Services

To be invited as appropriate

Senior Partnerships Manager – Thames Valley Police

Berkshire Care Association

A representative from Royal Berkshire Fire and Rescue Service

Appendix 2

Reporting to the Health and Social Care Partnership Board

Learning Disabilities Partnership Board

Mental Health LIT

Older People's Strategy Group

Carers' Strategy Group

Public Health Working Group

Physical Disabilities and Sensory Needs Strategy Group

Safeguarding Adults Board

Drug and Alcohol Action Group

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Health and Social Care Partnership Board
01 December 2008
2.00 - 3.35 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

Present:	Councillor Dale Birch Barbara Briggs, Carer's Forum Madeline Diver, PPI Forum Irene Douglas, Berkshire East PCT Martin Gilman, BFVA Lesley Heale, Director of Social Care & Learning Glyn Jones, Chief Officer Adult Social Care Mary Purnell, Berkshire East PCT
In attendance:	Belinda Clack, BFC David Steeds, BFC Ros Middleton, Berkshire East PCT
Apologies:	Colin Hayton, Heatherwood & Wexham Park NHS Trust Angela Snowling, Berkshire East PCT Adam Greig, Berkshire East Professional Executive Committee Lynne Lidster, BFC

Minute	Item
1	**Welcome** The Chairman welcomed Ros Middleton (Interim Project Manager) to the Board meeting.
2	**Declarations of Interest** There were no declarations of interest in relation to any of the items on the agenda.
3	**Minutes** The minutes of the meeting of the Health & Social Care Partnership Board held on 15 September 2008 were agreed as a correct record.
4	**Matters Arising**

	Minute 4, Good Neighbour Transport Scheme It was reported that this Scheme continued to receive requests and that any issues or problems arising were being monitored. Minute 5, Public Health Working Group Exception Report Update It was reported that £7,500 additional funding had been secured for the Alcohol Misuse service.
5	**Public Health Working Group Exception Report** The Board received a joint report from the Primary Care Trust and Bracknell Forest Council to comment on the proposed review of the Integrated Performance Management Exception Quarterly Report. The Board asked that the following information be added to the report: • a column that showed risks • ensure that lead officer details were regularly updated • addition of completion dates It was agreed that; i) the Board noted the timescales for the review of the quarterly exception report and ii) commented on the existing format of the exception report as detailed above. **(Action: David Steeds)**
6	**Local Area Agreement Quarter 2 Performance Report** The Board considered a report that reviewed the Health and Social Care elements of the Bracknell Forest Partnership Performance Overview Report (PPOR) for quarter 2, which included an update on the delivery of the Local Area Agreement targets to the end of September 2008. It was highlighted that in terms of operational risks, two had been identified with a score of 15 or more (out of 25). These were related to children who had experienced bullying and the effectiveness of children and adolescent mental health as detailed on page 11 of the agenda papers. It was noted that the current downturn in the economy may have an impact on indicators and that the Government Office for the South East were currently consulting local authorities on how they thought their areas would be affected by the downturn. It was reported that the voluntary sector could play an important role in the downturn if looked upon to deliver certain areas of public services. It was noted that the impact of the downturn was usually felt by the voluntary sector, 6-12 months after impacting upon the private and public sectors.

	The Director of Social Care and Learning reported that there were numerous potential impacts to health and social care during a downturn in the economy, some of these could included: • Childhood obesity, as low priced highly processed food was chosen • Increase in adults presenting for social care • Increase in domestic violence • Increase in mental health problems for both adults and children • Social contact problems • Maximising benefit take-up • Fuel poverty, particularly among older people The Board agreed to review performance against the indicators that relate to the impacts identified above, closely at the next quarter, with a view to considering re-opening negotiations with GOSE and central government to amend targets and baselines to ensure they remained realistic.
7	**Development of a Joint Work Programme** The Board were asked to identify areas of activity that they wished to prioritise during the upcoming 12 months. It was agreed that the work programme be aligned to the relevant components of the LAA. The Board agreed to receive two sub-group reports at each of their meetings. In addition, if any sub-group came forward to say they had something to report, they could also be added to the agenda as a third sub-group report. It was noted that the Joint Strategic Needs Assessment needed to be added to the work programme and the terms of reference of the Board. **(Action: Glyn Jones)**
8	**Consultation Papers on Commissioning Strategies for People with Dementia and People with Sight or Hearing Loss** The Board received an information report that informed them of the consultation papers for commissioning strategies for; i) people who experienced sight or hearing loss or who were deaf/blind ii) people with dementia. It was agreed that the Chief Officer Adult Social Care would ascertain where the consultation document had been distributed and that if it had not been sent to BFVA, it would be sent to them and the deadline for a response extended. **(Action: Glyn Jones)**
9	**Key Communication Messages**

	• Adult Social Care received a 3* rating from CSCI. Two years ago the Service had received 1*, making it the fastest improved Service in the Country. Congratulations to Glyn Jones and the team in Adult Social Care. (A press release had also been prepared by Councillor Birch) • The Board had agreed a joint work programme that included the Joint Strategic Needs Assessment. **(Action: Priya Patel)**
10	**Date of Next Meeting** Monday 2 March 2009

Health and Social Care Partnership Board
02 March 2009
2.00 - 4.15 pm

Present: Irene Douglas, Berkshire East PCT
Barbara Briggs, Carer's Forum
Madeline Diver, Local Involvement Network
Martin Gilman, BFVA
Lesley Heale
Jillian Hunt, DAAT Co-ordinator
Zoe Johnstone, BFC
Glyn Jones, BFC
Garry Nixon, Berkshire Healthcare
Mary Purnell, Berkshire East PCT
Angela Snowling, Berkshire East PCT
David Steeds, BFC

Apologies: Councillor Dale Birch
Adam Greig, Berkshire East Professional Executive Committee
Viki Wadd, Berkshire East PCT

Action Points

Minute	Item
64	**Welcome** The Chairman welcomed everyone to the meeting, it was noted that Adam Greig from the Berkshire East Professional Executive Committee (BEPEC) would no longer be able to attend meetings of the Board, as he was unable to attend on a Monday due to other commitments. It was agreed that Mary Purnell would speak to BEPEC about their representation at future Board meetings. **(Action: Mary Purnell)**
65	**Declarations of Interest** There were no declarations of interest made at the meeting.
66	**Minutes** The minutes of the meeting of the Board held on 1 December 2008 were agreed as a correct record.
67	**Matters Arising**

	Minute 6: Madeline Diver reported that the Citizen's Advice Bureau had been granted Government funding to allow them to open their office on Fridays from April 09. The Director of Social Care and Learning advised that it would be useful for the CAB to record any increases in demands for their services, which were likely in the current economic climate. *Minute 7:* Glyn Jones confirmed that the Joint Strategic Needs Assessment was already included in the terms of reference for the Board. He noted that the membership of the Board needed to be updated as the terms of reference still referred to the Council's old departmental structure. It also needed to be made clearer, as to who were members/advisors to the Board. He stated that that this would be further considered and brought back to the next meeting of the Board. **(Action: Glyn Jones)**
68	**Public Health Working Group Exception Report** The Board received an update on the review of the Integrated Performance Management Exception Quarterly Report. It was noted that this report would be submitted to the Corporate Management Team and that officers would report to the Board again at the June meeting. It was also reported that the Director of Social Care and Learning would now be responsible for the Public Health Working Group. The Board noted the new timescale for the review of the quarterly exception report.
69	**Local Area Agreement Quarter 3 Performance Report** Belinda Clack reported that the Bracknell Forest Partnership received reports around performance on a quarterly basis, which were then cascaded down to relevant themed partnerships. She reported that whilst none of the indicators were red, there were some indicators where information had not yet been received and this was being followed up. The Board thanked officers for the report and were pleased to see that more and more information was being added to the report to make it more meaningful. The Board noted the performance to date.
70	**Sub-Group Reports** • **Berkshire East Mental Health Local Implementation Team (LIT) and Bracknell Forest Sub-Lit** The report set out the progress in respect of the joint planning of Mental Health Services in Bracknell Forest. It was noted that the Bracknell Forest sub-LIT met bi-monthly and had good representation from voluntary and statutory organisations, as well as representation from service users and

	carers. Mary Purnell reported that plans were not yet fully developed for practice based commissioning. Martin Gilman asked that the voluntary sector be made aware of what this would entail as early as possible. The Board asked that Mary Purnell bring a report to the next meeting of the Board detailing the strategy and approach to this, how the funding would be allocated and what would happen in Bracknell Forest. It was also queried whether any mapping work would be undertaken to take account of existing provision. **(Action: Mary Purnell)** • **Drug & Alcohol Action Team** Glyn Jones reported that this was a good news item, services were strong and continued to improve. Progress against both the adult and young peoples plan in 2008 had been positive and many of the targets had already been achieved. Last year it was expected that the service would suffer from a 5% fall in pooled treatment budget for 2009/10, however due to the steady rise in clients entering treatment, funding had risen by 5%. A joint bid for funding with Windsor and Maidenhead was currently underway in respect of an Alcohol arrest referral scheme.
71	**Joint Strategic Needs Assessment** The Board considered a report that informed them of the process agreed to refresh the Joint Strategic Needs Assessment in 2009/10. It was reported that the JSNA document would continue to develop and increase the understanding of the population. The Director of Social Care & Learning had some concerns around the input of Childrens' Services. It was also highlighted that it was important that the JSNA was seen as a document that underpinned all commissioning priorities. In terms of timeframes it was noted that the Bracknell Forest Partnership would be refreshing the Community Strategy imminently, in addition the Corporate Area Assessment Report would be available in September. It was advised that the JSNA base document would need to be in place by the autumn in order to tie in with the PCT and Council budget setting process. It was noted that the Director of Social Care and Learning had statutory responsibility for signing off the JSNA and that she would only do so once satisfied that the document would deliver the Children and Young People Partnership agenda and the Transforming Adult Care agenda. Glyn Jones would be leading the refresh within Bracknell Forest and the Director of Social Care and Learning would discuss further who should represent the Council on the senior level steering group. **(Action: Lesley Heale and Glyn Jones)**

72	**Transforming Adult Social Care** The Board received an information report on Transforming Adult Social Care. It was reported that a recent White paper had introduced the intention to personalise support arrangements for individuals in need of social care, through the joint vehicles of individual budgets and self-directed support. It was noted that there was an error in the report, on page 25, the Bracknell Forest allocation for 2008/09 was £119K. It was reported that the main work for the coming year would be around running a pilot scheme, evaluating this work and deciding what the next steps should be. It was clarified that individual budgets did not necessarily mean that clients would receive direct payments. Budgets could be managed on behalf of the individual by the PCT or by the Council. For some individuals the most appropriate course of action may be to maintain the status quo. It was noted that it was important that the engagement of individuals, carers and families was done appropriately. It was also noted that it was important that the voluntary sector were kept informed of developments. It was agreed that the arrangements for carers funding would be reported to the Board at their next meeting either through Matters Arising or through a separate item on the agenda. **(Action: Zoe Johnstone/Glyn Jones)** The Chairman requested that the minutes of the Joint Strategic Commissioning Board be added as a standing agenda item at future meetings of the Board. **(Action: Glyn Jones/Priya Patel)** Angela Snowling agreed to bring a report to a future Board meeting on the Community Services budget and how it was spent by the PCT. **(Action: Angela Snowling)**
73	**Key Communication Messages** • Transforming Adult Social Care • Joint Strategic Needs Assessment
74	**Dates of Future Meetings** 8 June 2009 14 September 2009 30 November 2009 1 March 2010 7 June 2010

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Health and Social Care Partnership Board
08 June 2009
2.00 - 4.25 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

Present: Irene Douglas, NHS Berkshire East (Chair)
Barbara Briggs, Carer's Forum
Madeline Diver, VS Forum
Martin Gilman, BFVA
Lesley Heale
Mary Purnell, NHS Berkshire East
Angela Snowling, NHS Berkshire East
Glyn Jones, BFC
Viki Wadd, NHS Berkshire East
Garry Nixon, Berkshire Healthcare Foundation Trust

Apologies: Councillor Dale Birch (Vice-Chairman)

Action Points

Minute	Item
1	**Welcome** The Chairman welcomed Viki Wadd to the meeting.
2	**Declarations of Interest** There were no declarations of interest made at the meeting.
3	**Minutes** The minutes of the meeting of the Board held on 2 March 2009 were agreed as a correct record.
4	**Matters Arising** *Minute 64:* Mary Purnell agreed to get some proposed meeting dates from GPs for future meetings of the Board. *Minute 72:* Glyn Jones agreed to provide a note on carers funding with the minutes of the meeting.

5	**Update on the Swine Flu** Angela Snowling reported that notification had been received of an outbreak at St Mary's School in Ascot. The response to this outbreak had been good and was likely to be shared as good practice nationally. It was reported that individuals now had dedicated roles and responsibilities and so any further outbreaks would be dealt with swiftly. A fact sheet on Tamiflu had been prepared as well as a suggested layout to be used should another outbreak arise. Angela Snowling agreed to attend the next Headteachers meeting to provide a briefing. She also stated that the HPA website offered comprehensive guidance should nurseries and toddler groups wish to access it. Angela Snowling reported that the current strain of Swine Flu was affecting predominantly children, with relatively few adults being affected. Symptoms had included a hacking cough and headaches and so had not been overly serious. She stated that ideally it would be helpful to have a dedicated GP for each school.
6	**Local Area Agreement - Quarter 4 Performance** The Board agreed that Mary Purnell assisted by Angela Snowling would report to the Bracknell Forest Partnership Board on the red indicators for health and social care. It was reported that some of the data was annually recorded and could not be accurately reflected quarterly.
7	**Terms of Reference** Glyn Jones reported that he had tidied up the Board's terms of reference to reflect the new structures of the Council and partners. The original terms of reference had included five members, as well as numerous advisers to the Board. Glyn Jones advised that with the agreement of the Board he proposed that a sixth member be added as a carer representative. It was agreed that Glyn would write to Carers UK on the behalf of the Chairman to ask them to nominate a representative. The following representatives were agreed to be added as advisers to the Board: • Berkshire East Clinical Executive Committee • Director of Community Health Services The Board confirmed that they were satisfied that the chairmanship of the Board should continue on a rotational basis between the Council and the PCT and that it was not necessary to elect a chairman at the beginning of each municipal year.

8	**Strategy & Approach to Practice Based Commissioning** It was reported that Practice Based Commissioning (PBC) was introduced in April 2005 with the intention of engaging primary care clinicians in the commissioning process. GP practices had the clinical expertise and knowledge of their practice populations to inform their commissioning and as the referrers to community and most secondary care services they also controlled the majority of NHS resources. It was reported that the PCT believed that if clinicians were not involved in commissioning at a micro and macro level, services would be delivered to users that were not appropriate. The former Executive Committee was now the Clinical Executive Committee and would operate at a much more strategic level. Its remit would include considering patient safety and quality indicators. A governance structure was also now in place, it was recognised that whilst GP's were being asked to commission services, they were also providers and so conflicts of interest may arise. As a result, an Approval Group had been established. The Approval Group did not include any practice based commissioners and would make decisions around how commissioned services would be delivered. It was reported that practices had started to look at services more widely and strategically rather than just considering their own practices. The Board asked that Viki Wadd provide more information and detail on the tele-health project. Madeline Diver reported that she had been working with all GP practices and that all practice based commissioners had set up patient groups or were in the process of setting up patient groups. Glyn Jones advised that the Council would be responding to the Care Quality Commission consultation document on Guidance about compliance with the Health and Social Care Act 2008. The consultation period was between 1 June and 31 August and the consultation focussed on health and social care services. The document can be accessed at: http://www.cqc.org.uk/getinvolved/consultations/consultationnewregistrationstandards.cfm
9	**Updating the JSNA** Glyn Jones reported that a steering group had been established and had met twice since the last meeting of the Board. The Group were on track to deliver a refresh of the JSNA. Since the production of the last JSNA, aspects of needs analysis had been gathered, this information now needed to be analysed. The steering group had good representation from across service areas and information around children's services had now been strengthened. The Group would be meeting with colleagues from Corporate Services/Chief Executive's Office to see how the data in the JSNA could be stored and accessed by the BFP

	Board. A procedure for using the data contained in the JSNA was also to be developed.
10	**Community Services - PCT Operating Plan** Viki Wadd delivered a presentation on the PCT's Operating Plan for 2009/10. The Board asked if more detail could be given on the figures contained in the presentation. Viki agreed to circulate more detail through the clerk. If members wanted a copy of the full Operating Plan they could e-mail: viki.wadd@berkshire.nhs.uk
11	**Update on the Healthspace** It was reported that the healthspace had generated lots of public interest and a recent public information session had been very well attended by the public. The healthspace would be located on Market Street, making it easily accessible.
12	**Improved Access to Psychological Therapies** It was reported that Bracknell Forest would be the first area in which this service would operate. It was noted that it would need to go through the Children's Trust as the commissioning body. In terms of funding, there would be a 3 year period of funding after which it was likely that funding would be continued and would form part of the PCT's baseline budget. There was recognition nationally, that people would need to be trained.
13	**Report from Sub-group** The Board noted the report and noted that Barbara Briggs was the chair of Carers UK and that the Carers Strategy had been launched in 2009. It was also reported that a slot on Community TV in respect of carers was operating throughout the Borough.
14	**Key Communication Messages** • Update on the Swine Flu • Healthspace • Changes to Practice Based Commissioning

15	**Date of Next Meeting** 14 September 2009

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Health and Social Care Partnership Board
14 September 2009
2.00 - 3.35 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

Present: Irene Douglas, Berkshire East PCT
Barbara Briggs, Carer's Forum
Madeline Diver, PPI Forum
Glyn Jones Bracknell Forest Council
Mary Purnell, Berkshire East PCT

In attendance: Andrea Durn, Bracknell Forest Council
Zoe Johnstone, Bracknell Forest Council
Mira Haynes, Bracknell Forest Council
Alex Bayliss, Bracknell Forest Council
Martin Gilman, BFVA
Liz Sanneh, Democratic Services

Apologies: Councillor Dale Birch, Bracknell Forest Council
Viki Wadd, Berkshire East PCT
Nancy Barber, Berkshire East PCT
Julie Burgess, Heatherwood & Wexham Park NHS Trust

Minute	Item
16	**Welcome and Apologies** The Chairman welcomed members and visitors to the meeting.
17	**Declarations of Interest** There were no declarations of interest made at the meeting.
18	**Minutes** The minutes of the meeting of the Board held on 8 June were agreed as a correct record.
19	**Matters Arising** All actions from the meeting on 8 June had been completed.

20	**Local Area Agreement - Quarter 1 Performance** The Board received a presentation from Andrea Durn, Head of Performance and Partnerships, on the Local Area Agreement Quarter 1 Performance Report, which had been circulated with the Agenda. She informed the Board that there was an update on LAA targets. Following a change in definition of Outcome 6 NI 136 People supported to live independently through social services (all adults) It was proposed that the Council should seek to renegotiate the target. Martin Gilman requested that new definitions should be circulated and Glyn Jones agreed to do this. **Action: Glyn Jones** Berkshire East PCT and Bracknell Forest Council had had a productive meeting on data sharing, looking at process and procedures. They were working together to find a simplified template. It was hoped that by the end of September, procedures would be agreed. Mary Purnell added that there was a real willingness to work together on this. Dawn Hines is leading on performance. The Chairman thanked the Officer for her presentation, and asked whether there were any questions or comments. Glyn Jones told the meeting that in future the report would be amended to reflect those indicators relating to social and health care of adults and public health for this board. At this point in the meeting Madeline Diver joined the meeting, and Andrea Durn left.
21	**Health Issues/Initiatives Update** <u>Bracknell Healthspace</u> Mary Purnell reported that the Healthspace project was continuing. There was a lot of work currently being done, and it was hoped that it would be ready to go to Planning this autumn. The Health Impact Assessment had been successfully completed and showed that the Healthspace would have a positive impact on health. The document outlining the impact on people working and living in the area had been completed, and it was suggested that this be circulated. **Action: Liz Sanneh** The Steering group had seen the draft, but it had not yet been finalised. Collaborative working is ongoing. Glyn Jones informed the meeting that the Chief Executive had brought together the necessary people to assist with supporting the project, and the Health Overview and Scrutiny Panel had a working group to look at the results. <u>Love Bracknell/Wee for a Wii</u> There was a “Love Health” theme during August and two shops in the centre were used. These were very successful and there was a lot of interest, and support from

	colleagues. Outputs from the initiative were being collated at present. Wee for a Wii was a programme for women, encouraging them to exchange a urine specimen (for chlamydia testing) for the chance to win a Wii. This had been extended into September and response had been very good. The Chairman asked that the figures for these initiatives be brought to the next meeting of the Board. **Action: Mary Purnell** <u>Swine Flu</u> Mary Purnell reported that things were quiet at present, but an upsurge was expected during autumn and winter. Emergency planning was underway, with daily reporting to the Health Authority. <u>Transforming Community Services</u> There had been a change in this initiative, the thrust of which had been how the PCT would disengage from provision. This was now the vehicle for taking forward five priority areas of Stroke, End of Life care, Urgent care, Diabetes, and Planned Care close to home. Project leaders will be appointed on a multi-agency basis. The Chairman pointed out that Care Pathways would be impacted by this change, and asked that an appropriate person report on this at the next meeting of the Board.
22	**Safeguarding Adults Annual Report** The Chairman welcomed Alex Bayliss, who presented the Annual Report on Safeguarding Adults. The Report had been circulated with the Agenda papers. Mr Bayliss told the Board that he would give highlights from the report. These included • Safeguarding Adults Partnership Board which offered greater accountability that the one which covered three local authorities • Success in training on safeguarding • Increased number of referrals and alerts in Bracknell Forest • Successful planning and clear processes met legal requirements • Care Governance Board was a framework of high quality, with improvement plans being implemented to drive up standards. Objectives had been set for the coming year, with emphasis on personalisation.. A quality assurance framework was been created. The group continued to work with Thames Valley Police on issues of concern as resources to attend meetings for Police and the NHS, A new ICT system was being planned which would be able to capture safeguarding data.

	The Chairman thanked Alex for his presentation, and said the Board would note it. She was content that the obligations had been met, and she invited questions and comments. Garry Nixon raised the question of single patient care records, and Mr Bayliss responded that there was a number of issues underlying this: where there were joint teams, the reporting was better than in non-shared team information. There was an improving position in Joint Teams for Safeguarding. Data are recorded within the social care mechanism from centralised reporting systems. The Chairman asked what stopped the sharing of information, and Garry Nixon told the Board that single healthcare records would help us understand and drive better reporting and sharing. It was likely that eventually there would be a single patient record across health. Glyn Jones reported that there is a statutory obligation for anyone working with vulnerable people to notify the Local Authority.. The Chairman asked what the next step would be and Mr Bayliss explained that there was a need to target safeguarding in older adult groups. Glyn Jones told the meeting that it was a challenge to ensure that NHSl staff are reporting and alerting accurately. Madeline Diver raised the question of whether or not the local Citizens Advice Bureau has a representative on the Safeguarding Adults Board, and Glyn Jones responded that there was not currently a representative there, but he could take it to the Board for consideration. Alex Bayliss told the meeting that they could give information sharing and awareness raising training with the CAB. Martin Gilman reiterated that it was essential that the voluntary community sector has support and training available, as it was difficult for the voluntary sector to keep up to date. Glyn Jones reported that Adult Social Care at Bracknell Forest would like to use the Board to identify and act on areas where there was a lack of co-operation. At this point Alex Bayliss left the meeting.
23	**Improving Access to Psychological Therapies** Garry Nixon gave a verbal update to the meeting. This was a PCT initiative within Primary Care for mild to moderate mental health problems. The initiative had been instigated by Berkshire Health Trust, in the Reading area and East Berkshire. The first services would be in Bracknell Forest; this was new money, and 12 new staff members had been recruited. Currently there was negotiation taking place on where new services could be accessed. There was a national programme pulling in psychology colleagues with training in CBT for the step programme which would start soon after Christmas. There would be local induction and governance so that the programme could deliver service in practice. There would be some slow provision in the early stages, but eventually there would be self-referral. The funding was currently ring-fenced, but might not be in the future. There is an ambitious national programme of IAPT, and this was good news for the population of Bracknell. Reporting on the initiative would be through the PCT. In response to a question from Glyn Jones about increasing numbers of people seeking therapy because of the economic cycle, Garry Nixon confirmed that

	generally this was a primary care service, but sometimes there were referrals to secondary care. The Chairman asked that the Board receive a further report at their meeting in March 2010. As Glyn Jones had to leave the meeting, he raised the issue of the meeting being Mrs Douglas's last as Chairman of the Board. He thanked her on behalf of the Council and Partnership Board for her involvement, and offered the Board and Council's best wishes for the future. Glyn Jones left the meeting at this point.
24	**Dementia Adviser - Demonstrator Bid** Zoe Johnstone presented the report on the Dementia Adviser, telling the meeting that Bracknell was a national pilot site following Bracknell Forest Council and Partners bidding, which was successful. The Adviser will work in CMHT and with older adults, and interviews for the post were taking place in the week of this board meeting. It was hoped that this appointment would involve as many people as possible. There will be a Project Board in October. The Chairman congratulated the team on their success in winning the bid, and commented that Jane Bremner, the project manager, was to be particularly congratulated. The Council and Partners were very pleased to have the pilot running in the area. Garry Nixon asked whether a needs analysis had been undertaken on the numbers of people likely to present in a year, and whether the memory clinic would need to expand. There were currently around 200 people in memory clinics per year; was there any anticipation of diagnosis in primary care? Mary Purnell indicated that a pragmatic approach would be taken to match local need against national criteria. This was outlined on the website under the commissioning strategy, and Garry Nixon was reassured by this.
25	**National Consultations Adult Social Care** Zoe Johnstone spoke to the report, which had been circulated with the Agenda papers for the Board meeting. She told the Board that there was a plethora of national consultations out at present, and Adult Health and Social Care were co-ordinating responses for Bracknell Forest Council and its partners. The consultation covered "Shaping the Future of Care Together", "New Horizons – Mental Health" and "A Better Future" concerning autism. The consultation would end on 15 September, and it was being co-ordinated by the Policy and Commissioning Officer at the Council. Contact information was given on page 97 of the Agenda pack. Martin Gilman asked how Shaping the Future of Care fit in with provision of local care, and how did this affect funding. Zoe Johnstone responded that this was an

	issue, and there would be greater demand in the future. It would be explored alongside the personalisation agenda. Martin Gilman raised the issue that needs within the NHS were currently met at the point of care with no charge; what would happen with Adult Social Care? Zoe Johnstone assured the board that summaries would be available on line. There was no other business.
26	**Dates of Future Meetings** The date of the next meeting of the Board was confirmed as Wednesday 2 December 2009.

ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
1 DECEMBER 2009

BRACKNELL FOREST JOINT STRATEGIC NEEDS ASSESSMENT REPORT
(Director of Adult Social Care and Health)

1. INTRODUCTION

1.1 The purpose of this report is to inform the Adult Social Care Overview & Scrutiny Panel of the Council's responsibility in relation to the Joint Strategic Needs Assessment (JSNA) and to receive the JSNA for 2009 set out as Annexe A. The statutory responsibility for the JSNA is a joint responsibility of the Director of Adult Social Services and Director of Public Health, together with the Director of Children's Services. Membership of the local group which undertook this development is set out as Annexe B.

1.2 The development of the JSNA is a process that identifies the current and future health and well-being needs of the local population. It builds on work undertaken in both Health and the Council in relation to needs assessment pulling it together in one place. It is a snapshot of the needs of the local population. It signposts more detailed information that exists in determining either care group or partnership strategies.

1.3 The JSNA will be used to inform the Council's activity and priorities as well as that of the NHS Berkshire East. Indeed many of the priorities in the Sustainable Community Strategy, Local Area Agreement, Children's Plan and Adult Commissioning strategies are proposing to meet areas of identified need in the JSNA. As a consequence of these various actions and plans there is an impact to reduce health inequalities.

1.4 The JSNA is not intended to set out the significant achievements that have been made in the Borough over recent years. It is vital to understand this in the context of reading the JSNA. There are really positive messages about the impact that our plans have had on the quality of life, reducing Health Inequalities and improving Life chances amongst other developments which reflect positively on the Bracknell population. The refresh of the Health and Well being strategy will also draw on the JSNA.

1.5 The JSNA is an important source document for all of the various Partnership Boards and Scrutiny panels as they look at the outcomes the various strategies aim to achieve for the various parts of the population. In turn as evidence of need is developed throughout the year from the specific partnerships, it is anticipated that these will inform the JSNA development.

2. SUGGESTED ACTION

2.1 It is suggested that the Adult Social Care Overview & Scrutiny Panel note the information contained in the Joint Strategic Needs Assessment.

3. REASONS FOR SUGGESTED ACTION

3.1 The Local Government and Public Involvement in Health Act (2007) places a duty on upper-tier authorities and Primary Care Trusts to undertake a Joint Strategic Needs Assessment (JSNA).

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 N/A

5. SUPPORTING INFORMATION

Background

5.1 In 2006 the Department of Health White Paper Our Health, Our Care, Our Say sets out a new direction for improving the health and well-being of population in order to achieve:

- Better prevention and early intervention for improving health, independence and well-being
- More choice and a stronger voice for individuals and communities
- Tackling inequalities and improving access to services
- More support for people with long term needs

5.2 *Our Health, Our Care, Our Say* identified the need for Directors of Public Health, Directors of Adult Social Services and Directors of Children's Services to undertake regular strategic needs assessments of the health and well-being status of their populations, enabling local services to plan, through Local Area Agreements, both short and medium term objectives.

5.3 The Local Government White Paper, *Strong and Prosperous Communities*, outlined a vision of responsive services and empowered communities, including a Community Call for Action across local public services.

5.4 The Local Government and Public Involvement in Health Act (2007) places a duty on upper tier local authorities to prepare Local Area Agreements in consultation with others. The Act also places a duty on upper-tier local authorities and PCTs to produce a JSNA. The draft statutory guidance accompanying the Act requires the JSNA to underpin the Sustainable Community Strategy and, in turn, the Local Area Agreements (LAA).

5.5 The performance framework for local authorities contains 198 national priorities for local delivery, many of which are relevant to improving health and well-being. Although performance will be measured against all 198 indicators, each Local Area Agreement has 35 national priority targets that will be subject to performance monitoring, with local partners free to agree additional targets to support improved local delivery and outcomes. The Executive has agreed the priority LAA indicators for Bracknell Forest and these are consistent with the needs identified within the JSNA.

5.6 A key responsibility of the Children and Young People's Trust is to develop a Children and Young People's Plan, which is informed by a comprehensive needs assessment. The guidance for the Children and Young People's Plan [DCSF 2009] states that the needs assessment is a requisite component of the strategic commissioning process

with resultant data driving down through different levels of the partnership to aid decision making and prioritisation. The needs assessment will draw on analyses carried out by partners, in particular that contained in the statutory JSNA.

Source Children and Young People's Plan Guidance DCSF 2009

5.7 The Department of Health Commissioning Framework for Health and Well-being builds on these recent reforms, aiming for a shift towards services that are personal, sensitive to individual need and that:

- Maintain independence and dignity
- Provide strategic reorientation towards promoting health and well-being, investing now to reduce future ill-health costs
- Strengthens the focus on commissioning the services and interventions that will achieve better health, across health services and local government, with everyone working together to promote inclusion and tackle health inequalities.

5.8 *The Commissioning Framework for Health and Well-being* identified eight steps to effective commissioning, which include understanding the needs of populations and individuals. The JSNA identifies the health and well-being needs of Bracknell Forest's population, and over time will lead to more effective service provision by informing the Sustainable Community Strategy, Local Area Agreement, and other relevant commissioning strategies, driving improvements in the health and well-being and ultimately leading to a reduction in health inequalities.

5.9 Eight steps to effective commissioning

- Putting people at the centre of commissioning
- Understanding the needs of populations and individuals
- Sharing and using information more effectively
- Assuring high quality providers for all services
- Recognising the interdependence of work, health and well-being
- Developing incentives for commissioning for health and well-being
- Making it happen: local accountability
- Making it happen: capability and leadership

5.10 In the NHS, the Department of Health's World Class Commissioning programme is intended to improve commissioning capability. The programme consists of three main areas:

- Articulating a vision and purpose for world class commissioning to inspire and motivate the NHS, and setting out the key competencies that commissioning organisations will need in order to become world class
- Creating an assurance model to reward PCTs for delivering world class commissioning and to hold them to account
- Putting in place a support and development framework to help PCTs attain world class commissioner status.

5.11 The world class commissioning competencies emphasise the role of JSNA in driving the long term commissioning strategies of PCTs and their collaborative work with community partners, and include an emphasis on public and patient engagement.

How will the JSNA affect how local services are provided?

5.12 This snapshot of local needs will be essential background reading for people who

- provide services or who 'commission' local services (commissioning is the process of specifying what a local service should achieve, then buying an appropriate and cost-effective service to meet that specification)
- want to understand the wider context around which Bracknell Forest's Sustainable Community Strategy has been written
- involved in writing the Sustainable Community Strategy – a local plan explaining the overall aims for local services over the next few years
- wish to understand the needs of their local communities. The final version will be available on the NHS and Council websites

5.13 The Sustainable Community Strategy and the JSNA will also influence the Local Area Agreement, an agreement between local government, health and other organisations, with regional Government, to provide services which meet locally agreed targets.

5.14 When reading this report it is very important to remember that the whole purpose of the JSNA is to identify current and future priorities (where there are gaps in current services) and how things could be improved; that's the first step to making services better than they already are.

6. NEXT STEPS

6.1 The production of the JSNA is not an end in itself. Once approved, the JSNA data will be able to be downloaded from either Council or NHS Berkshire East websites.

6.2 It is recognised that future strategies will drawn on the JSNA as a source document as strategies grapple with improving services within the Borough. It will influence emerging priorities in the LAA.

6.3 The JSNA itself will be an important document for the various Partnership Boards as they establish priorities. Equally important will be to ensure that the JSNA continues to benefit from work undertaken by the Partnership Boards.

6.4 Scrutiny Panels will need to be aware of the JSNA as they in turn look at the impact which strategies have had on outcomes for the populations they service.

7. ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

7.1 The relevant legal provisions are contained within the main body of the report.

Borough Treasurer

7.2 The Borough Treasurer is satisfied that no significant financial implications arise from this report. Outcomes from the JSNA will be used to inform priorities and targets, the financial implications of which will be considered during the normal budget setting process.

Impact Assessment

7.3 The development of the JSNA identifies Health Inequalities in order that priority action can be addressed.

8. CONSULTATION

Principal Groups Consulted

8.1 N/A

Method of Consultation

8.2 N/A

Representations Received

8.3 N/A

Background Papers

White Paper "Our Health, Our Care, Our Say" (2006)
Strong and Prosperous Communities - Local Government White Paper (2006)
The Local Government and Public Involvement in Health Act (2007)
Guidance on Joint Strategic Needs Assessment (2007)
DH Commissioning Framework for Health and Well-being (2007)
DH (2007) The NHS in England: Operating Framework for 2008/09
Every Child Matters: Change for Children

Contact for further information

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ANNEXE B

BRACKNELL FOREST JOINT STRATEGY NEEDS ASSESSMENT

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Report of the

Joint Strategic Needs Assessment
for Bracknell Forest

October 2009

Dr Angela Snowling, Consultant in Public Health and
Jo Hawthorne Strategic Programme Manager
NHS Berkshire East Primary Care Trust
on behalf of Bracknell Forest Council
and NHS Berkshire East

Version 8

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Executive summary

This is the second Joint Strategic Needs Assessment (JSNA) for Bracknell Forest and is the product of a process implemented by each of the three unitary authorities in Berkshire East in partnership with NHS Berkshire East and members of Local Strategic Partnerships. This needs assessment will be used to inform the refresh of the Bracknell Forest Sustainable Community Strategy and the Local Area Agreement as well as the PCT Strategic and Operating plans in 2010/11.

Separate documents have been produced for each unitary authority area but the methodology for extracting local and national data has been agreed across all three areas. The source data depends on the outcome measure and the impact of the projected demographic changes in the next five to ten years has been modelled to inform the commissioning cycle.

Please note that for each of the health and wellbeing elements of this Assessment, outcome performance has been benchmarked against national data.

Where possible the national and local strategic themes are highlighted at the head of each section and key issues from nationally comparable patient/client surveys.

The references used to support the recommendations in each section have been sourced from the core dataset recommended nationally and by relevant leads in the JSNA subgroup.

The next five to ten years

Both the local authority and the PCT have a duty to commission health and wellbeing services for their local populations within a framework of national must do's and to ensure best value at all times. There is a clear recognition that the financial climate will imply negative growth in the next five to ten years. This does not mean that more effective solutions cannot be found to improve health and wellbeing.

The most immediate impact on health outcomes in the next five to ten years will be the economic downturn. The Audit Commission report (2009) requires councils and PCTs to have recession management plans in place. There is evidence that Wave 1 has commenced with rising unemployment and negative growth - a reduction in housing prices and a rise in acquisitive crime has also occurred. The Audit Commission report forecasts that in Wave 2 there will be an increase in mental health problems, domestic violence, alcoholism and addiction; with longer term ill health sustained in some areas whereas other areas will recover quickly once the recession ends.

The second most influential factor from a demographic perspective is the projected increase in older people which will place significant demands on services and carers of people who have learning difficulties, long term conditions or mental health problems, with a significant rise in the prevalence of dementia.

The new national measure of how councils and the primary care trust are impacting on health inequalities is slope index of inequality which focuses on narrowing the gap in life expectancy for males and females in the most deprived decile of lower super output areas compared to the most affluent. Modelling interventions (e.g from the London Public Health Observatory) suggest that interventions targeted at males for cardiovascular problems and females for COPD should be prioritised to achieve a one year increase in life expectancy to narrow the gap between the most deprived quintile of wards and the most affluent. (LSOA modelling is awaited). Cancer mortality rates are in line with national but are the highest in Berkshire.

Helping people with long term conditions achieve independent living remains a priority as does increasing the numbers of people in employment (e.g through Improving Access to

Psychological Therapies IAPT or NEET programmes). The reduction of child and adult obesity and unnecessary admissions to hospital, together with promoting increased child and adult physical activity levels remain important. Ongoing priorities include providing support for those with English as an Additional Language, safeguarding (whether vulnerable adults or children), the delivery of services closer to home and the personalisation of services (as part of the transformation of community and social care services).

An emerging priority for the Local Strategic Partnership is planning adult basic skills education for the expected influx of older family members of existing and former Gurkhas, as up to 100,000 are expected to arrive in the UK within the next two years. The most likely impact will be on sites close to their former army bases e.g at Sandhurst, Aldershot and other sites in Hampshire and Surrey. The growth of primary and secondary care services to meet the demand will need to be managed.

Introduction

What is a Joint Strategic Needs Assessment (JSNA)?

Joint Strategic Needs Assessment (JSNA) is the process being carried out by local government (Bracknell Forest Council) and the local health service (NHS Berkshire East) and its partners to identify health and well-being 'needs' – areas where improvements can be made – among local residents. These may be existing needs or needs that are predicted to occur in the future over, say, the next five to ten years.

Why is it being done?

The Local Government and Public Involvement in Health Bill (2007) made carrying out a JSNA a legal requirement for local authorities and Primary Care Trusts (PCTs) from 1 April 2008.

The aim of the JSNA this year is to ensure that the needs identified translates into the strategic plan for the PCT and into the sustainable community strategy and Local Area Agreement plan for Bracknell Forest. This document also signposts sources of evidence for developing cost effective joint strategic commissioning plans in 2010/11. To help take the strategic priorities forward this document should be used in conjunction with the NICE and public health evidence base, sample costings and business cases for improving care pathways.

When planning services (for example, those provided by the local authority, Primary Care Trust, or charities) for a local community it is important that these are matched, as far as possible, to the actual problems which exist in the area – rather than a 'one size fits all' approach across the country. For example, by identifying what improvements to the local area residents would like; and what illnesses are common in the local area, we get a better picture of how to use local taxpayers' money to best effect, to improve health and wellbeing. The information will also be of value to the transforming community services programme or to those working on the transformation of social care within local authorities.

What does the JSNA do which is new?

The underlying purpose of the JSNA remains to identify how life expectancy and quality of life gains could be made through addressing inequitable outcomes whether by gender, ethnicity, disability or deprivation. However where the JSNA for 2009/10 departs from its predecessor is on its to bring under its purview a much broader range of challenges affecting Bracknell Forest's communities. This JSNA thus, builds on the health components of previous years, and adds to this with a more in-depth analysis of corollary issues such as community safety, housing, transport etc. The rationale behind this being to make the JSNA a fit-for-purpose document that helps the LSP and its constituent partners better plan and deliver the range of services needed to meet Bracknell Forest's needs.

This revised JSNA starts by identifying strategic health and wellbeing issues that are outliers according to; national benchmark data and then where statistically significant looks at ward level data. It describes how life expectancy gains can be made by tackling inequitable outcomes whether by gender, ethnicity, disability or deprivation.

The methodology has been updated to align with recommendations from the many regional public health observatories, for example; programme budgeting and marginal analysis as promoted by Yorkshire and Humberside Public Health Observatory, population and prevalence projections for the next five to ten years based on recommendations from the Association of Public Health Observatories. Life expectancy from the London

Health Observatory and lifestyle benchmarks from The Southeast Public Health Observatory.

The timing of the JSNA first draft was planned for delivery in early September to ensure sufficient time for proofing. Further work will include discussion with the public on how taxpayers' money is spent locally; the results of these consultations will be included in the bibliography and available to anyone who is planning services in the area.

This year the underlying dataset for the JSNA data can be downloaded from either the council or primary care trust websites. This will allow commissioners, whether practice based, within the PCT or unitary authority, to access data on how the population size is predicted to change over the next five to ten years, or to understand the outcomes that could be jointly delivered to improve health and wellbeing.

How will the JSNA affect how local services are provided?

This snapshot of local needs will be essential background reading for people who

- provide services or who 'commission' local services (commissioning is the process of specifying what a local service should achieve, then buying an appropriate and cost-effective service to meet that specification)
- want to understand the wider context around which Bracknell Forest's Sustainable Community Strategy has been written
- involved in writing the Sustainable Community Strategy – a local plan explaining the overall aims for local services over the next few years
- wish to understand the needs of their local communities. The final version will be available on the NHS and Council websites

The Sustainable Community Strategy and the JSNA will also influence the Local Area Agreement, an agreement between local government, health and other organisations, with regional Government, to provide services which meet locally agreed targets.

When reading this report it is very important to remember that the whole purpose of the JSNA is to identify current and future priorities (where there are gaps in current services) and how things could be improved; that's the first step to making services better than they already are.

How was the JSNA carried out?

Please see the Methods section (p9)

How do I use this report?

Please see the section entitled structure of this report (p13)

What happens next?

This report, and the work which has gone into it, is just the start of the JSNA process. JSNA gives Bracknell Forest an opportunity for the future to understand much better the needs of the local residents, and for that knowledge to cover a wide range of issues, but to be up-to-date. This knowledge will be used to improve services for local residents.

The next steps are that the results will feed into the Bracknell Forest Council Sustainable Community Plan and PCT strategic plan. Joint commissioning plans will be developed and the results will inform joint action plans.

Can I get involved?

Yes. Consultations already take place with local residents over many decisions made by the Council and NHS Berkshire East. These consultations all help improve our understanding of local needs and will contribute to the JSNA data hub. If you would like to take part in any future consultations, please contact Bracknell Forest Council or NHS Berkshire East.

Methods

Co-ordinators and assessment period

Collection of data for this JSNA report took place between May 2009 and September 2009 and was co-ordinated by the following people:

Signatories of final document

Dr Pat Riordan	Director of Public Health
Glyn Jones	Director of Adult Social Services & Health, Bracknell Forest Council
Martin Gocke	Acting Director of Children, Young People & Learning, Bracknell Forest Council

Berkshire East co-ordination and analysis

Dr Angela Snowling	Consultant in Public Health, NHS Berkshire East
Jo Hawthorne	Strategic Programme Manager, NHS Berkshire East
Sid Beauchant	Information Advisor, Berkshire Public Health Network
Kevin Watson	Information Manager, NHS Berkshire East
Nana Wadee	Information Support Officer, Berkshire Public Health Network

NHS Berkshire East (Bracknell Forest locality) co-ordination

Mary Purnell	Assistant Director, Bracknell Forest locality, NHS Berkshire East

Bracknell Forest Council co-ordination

Glyn Jones	Director of Adult Social Services & Health, Bracknell Forest Council
Margaret Gent	Policy and Commissioning Officer, Bracknell Forest Council

Representatives of each of the services who have an opportunity to influence the determinants of health and well being (in the council, voluntary sector and primary care trust) took part in regular meetings to choose and proof the content and shared methodology. However, this did not prejudice the identification of needs in each area, which in many cases were very different in each locality.

Grateful thanks are due to all those listed above and to the many JSNA steering group members and contributors (this is not an exhaustive list):

Jane Bremner, Philip Brooks, Diane Clemison, Sandra Davies, Claire D'Cruz, Clare Dorning, Andrea Durn, Samuel Ejide, Margaret Gent, Martin Gilman, Maria Griffin, Rutuja Kulkarni, David Steeds, Abby Thomas, William Tong

Guidance on JSNA

National government guidance on the JSNA process was followed (DH, 2007), where applicable in carrying out this assessment. The two main documents used were the Commissioning Framework for Health and Wellbeing (March 2007), and the guidance which superseded this, JSNA Guidance (December 2007) which describes the core dataset. Local flexibilities exist to augment this with qualitative data.

Further guidance released in 2009 on projections methods and health economics were also referenced from the APHO and YHPHO websites.

Collecting the core dataset

Information was assembled into a structured Microsoft Excel spreadsheet with the assistance of the Berkshire Public Health Network, containing references to local and national data sources (where available), to enable information to be updated rapidly in future. This spreadsheet is available on the Council and NHS Berkshire East websites.

Relevant information from the Core dataset is given in the appropriate section of the main report. In most instances, only significant deviations from local, regional or national averages are considered here as 'needs'.

Evidence based and attributable data

In order that all needs listed in the JSNA are based on attributable and authoritative sources, any needs mentioned verbally in the JSNA meetings, were required to be backed up with evidence from a report or quantitative (numerical) dataset. In this way, the JSNA can be more easily updated and the sources of all statements made clear. RAG ratings based on national benchmark data have been introduced this year to ensure outliers are identified.

Where the data sources indicate different baselines or projections from last year's JSNA these are highlighted e.g in dementia projections.

The draft was circulated to all stakeholders as part of a verification/refinement process and finalised in October 2009 prior to joint strategic commissioning decisions.

References

The references are listed in footnotes and have been compiled into a simple Excel spreadsheet, with links to internet versions of documents where available; and to individuals who provided the documents.

Improving the process – how this document will be developed in future years

This document is a statement of the 'status quo' (what we currently know) – the most important part of this document is the strategy for ongoing improvement so that the information is frequently updated and influences local service planning.

In response to regular feedback from JSNA needs coordinators changes in content have been reviewed as have timescales for the process which are now aligned to council and PCT planning cycles for the Local Area Agreement refresh. The layout of the JNSA has been adapted as discussed in the "what's new' section.

There are likely to be a number of needs which have not been identified in this process, either because there is currently no evidence of their existence; or because the evidence which exists was not provided within the timescales for inclusion in this report. In both cases it is important that, over time, the description of needs in the area expands to include these.

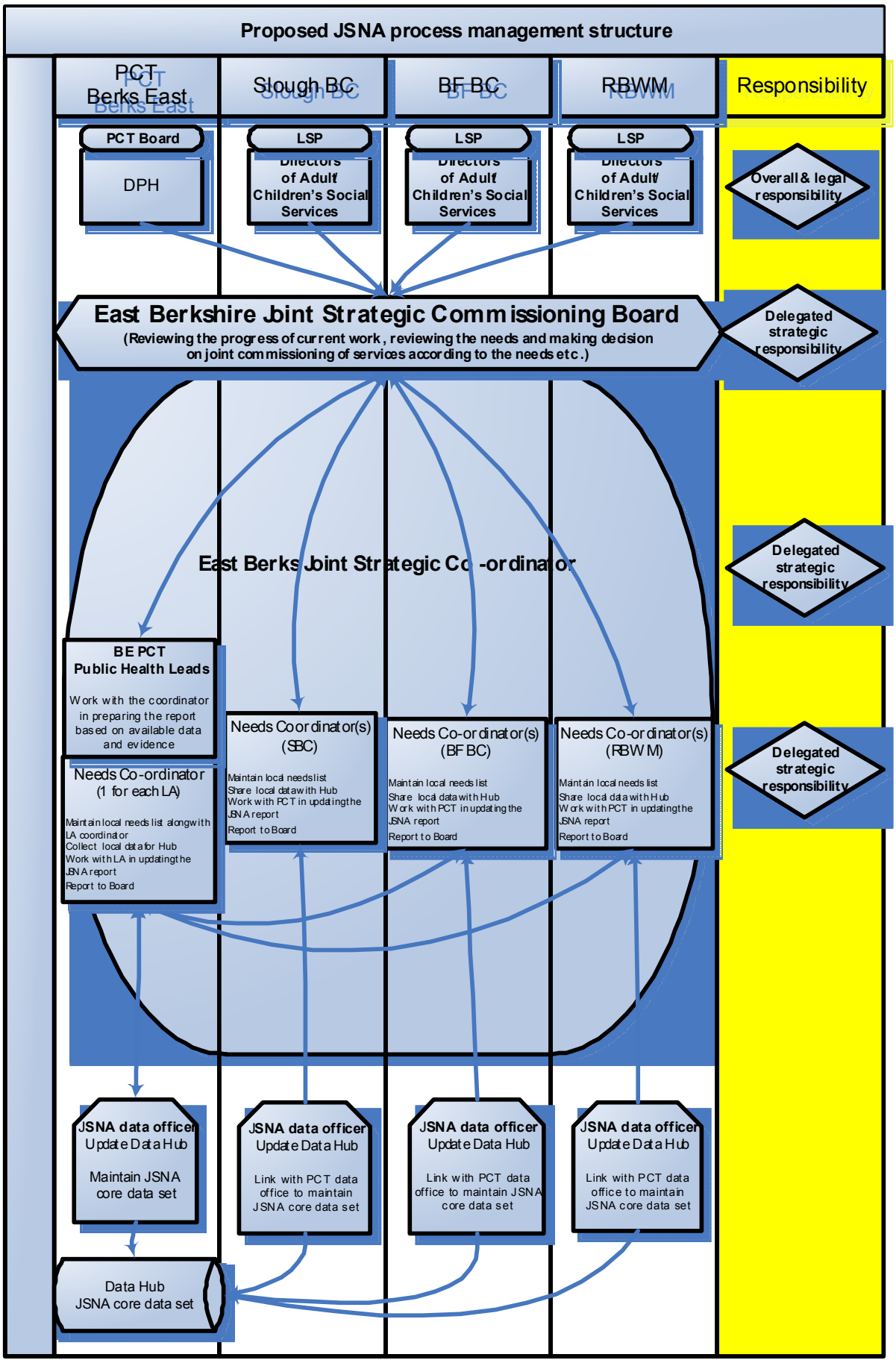
The quality of the information behind the needs listed is important; although all the reports and datasets referenced here have come from reputable sources, their quality and comparability will vary. Data that is nationally or regionally benchmarked is provided as well as locally extracted data.

Leadership

- JSNA is a statutory process which all professionals in the local authority and PCT should be aware of; widening awareness of JSNA within these organisations is an important role and should be undertaken by the JSNA Needs Co-ordinators and

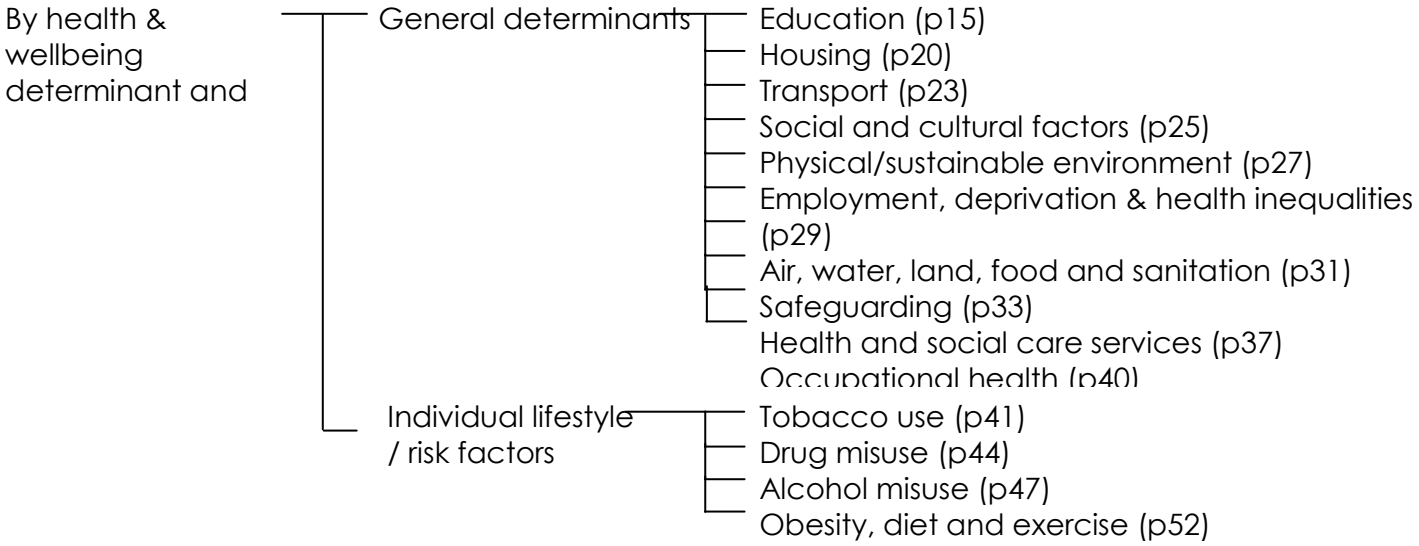
Berkshire East Strategic Programme Manager. All relevant members of staff should be made aware it is their responsibility to log any population-level data collected about needs within the JSNA dataset

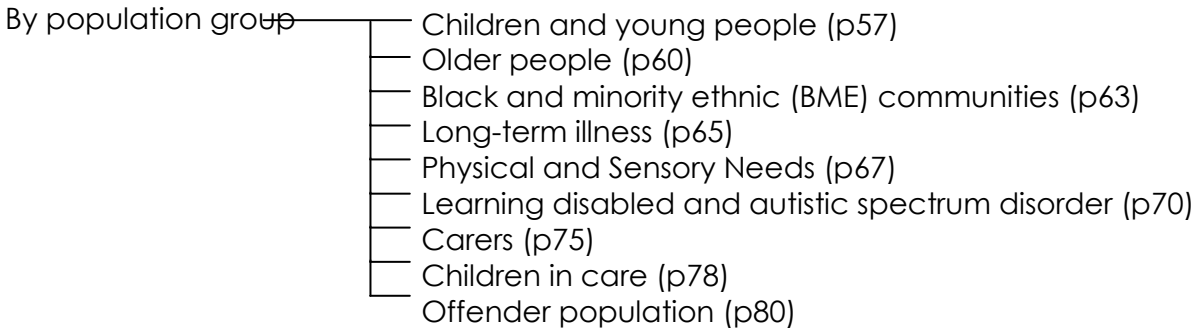
- Ultimately, responsibility for the JSNA rests with the Director of Public Health in the PCT and the Directors of Adult and Children's Social Services in the Council; they have had a central role in raising awareness and championing the importance of the JSNA both as a statutory requirement and invaluable opportunity for improving knowledge about our local community and, hence, improving local health and wellbeing. The Board of the PCT also has a responsibility through the World Class Commissioning programme to develop and maintain the JSNA process
- The Directors of Public Health, Social Care and Childrens Services have cooperated and coordinated this process through the East Berkshire-Joint Strategic Commissioning Board which represents senior members of local organisations responsible for overseeing the JSNA process. Factual data and analysis was conducted by the public health and unitary authority information teams. Local area iterative discussions were led by the Public Health consultant and East Berkshire Strategic Programme Manager, who reports to the East Berkshire-wide Board as shown overleaf

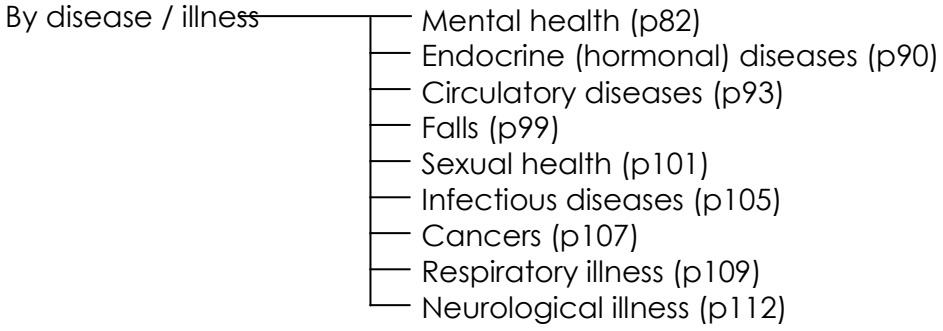

Proposed JSNA process management structure
PCT Berks East
Slough BC
BF BC
RBWM
Responsibility
PCT Board
DPH
LSP
Directors of Adult/ Children's Social Services
LSP
Directors of Adult/ Children's Social Services
LSP
Directors of Adult/ Children's Social Services
Overall & legal responsibility
East Berkshire Joint Strategic Commissioning Board
(Reviewing the progress of current work, reviewing the needs and making decision on joint commissioning of services according to the needs etc.)
Delegated strategic responsibility
East Berks Joint Strategic Co -ordinator
Delegated strategic responsibility
BE PCT Public Health Leads
Work with the coordinator in preparing the report based on available data and evidence
Needs Co-ordinator (1 for each LA)
Maintain local needs list alongwith LA coordinator
Collect local data for Hub
Work with LA in updating the JSNA report
Report to Board
Needs Coordinator(s) (SBC)
Maintain local needs list
Share local data with Hub
Work with PCT in updating the JSNA report
Report to Board
Needs Co-ordinator(s) (BF BC)
Maintain local needs list
Share local data with Hub
Work with PCT in updating the JSNA report
Report to Board
Needs Co-ordinator(s) (RBWM)
Maintain local needs list
Share local data with Hub
Work with PCT in updating the JSNA report
Report to Board
Delegated strategic responsibility
JSNA data officer Update Data Hub
Maintain JSNA core data set
JSNA data officer Update Data Hub
Link with PCT data office to maintain JSNA core data set
JSNA data officer Update Data Hub
Link with PCT data office to maintain JSNA core data set
JSNA data officer Update Data Hub
Link with PCT data office to maintain JSNA core data set
Data Hub JSNA core data set

The structure of this report

Health and well-being needs have been presented here in a number of different categories, which are illustrated below. Links are made between headings to save repetition. Needs are not presented in any particular order on the page – i.e. no order of priority is implied. The heading physical environment has been changed this year to sustainable environment.







Needs which are important for the Sustainable Community Strategy are shown as ✱
Needs which are prioritised as outliers in national datasets are shown as ①
Needs which are projected to get worse in time are shown as 🕖

The sources of evidence used for each topic are given at the foot of the page, with full references.

Education

The following applies to pupils in state education only.

The January 2009 School Census results show a nursery/infant/primary school aged population of 8281 (for those in the state sector and resident in Bracknell Forest) and 6271 in the secondary sector.

Schools which had the highest rates of Free School Meal entitlement (highly correlated with deprivation) greater than 15% were; The Pines, Holly Spring Junior, Fox Hill Primary, Great Hollands Primary.

The entitlement to free school meals by ward [School Census 2008] shows that the borough average is 6%, however when broken down to ward level nine wards out of 18 have a free school meal entitlement of above 6% with a significant difference between the ward with the lowest entitlement [Winkfield and Cranbourne at [07%] and the ward with the highest entitlement [Great Hollands North at 11.2%].

Children's Trust priorities in relation to educational attainment and achievement

Every Child Matters (DFES, 2004) set out five outcome areas; be healthy, stay safe, enjoy and achieve, making a positive contribution and achieve economic wellbeing. Further Children's Trust priorities for 2009-10 are noted in the relevant sections.

Within the theme of 'enjoy and achieve' the Children's Trust has prioritised

- Continue to raise attainment at all levels
- Narrow the gap in educational achievement between children from low income and disadvantaged backgrounds and their peers
- Address the gap in attainment related to gender
- Monitor trends and outcomes in relation to pupils from BME [Black and Minority Ethnic] groups.

Improving achievement, especially among boys, ethnic minorities, travellers and service children

GCSE (5 A*-C) attainment overall by pupils in Bracknell Forest has improved with regard to the previous Health Profile data 2008 (Health Profile, 2009). A recent CAA report indicates however that the relative performance of boys, and young people from some black and minority ethnic (BME) communities should be improved.

The 2008 supplement to the Children and Young People needs analysis records that the percentage of boys achieving 5 A*-C in 2008 was lower in Great Hollands North, Great Hollands South, Priestwood and Garth and a group of wards including Crown Wood, Hanworth, Wildridings and Central and Old Bracknell. The greatest percentage difference (c50%) between the performance of boys and girls was recorded in Priestwood and Garth and Owlsmoor.

This local analysis also shows that the proportion of children from low income families achieving 5+A*-C incl. English and Mathematics is also above the national average. The gap in performance has reduced whereas elsewhere this has either remained the same, or increased.

According to the 2009 school census the schools which have a high number of service children are College Town Infants and Junior Schools with 71 and 85 respectively. Sandhurst School has 62 service children on roll. These are the only significant numbers of service children in the Borough.

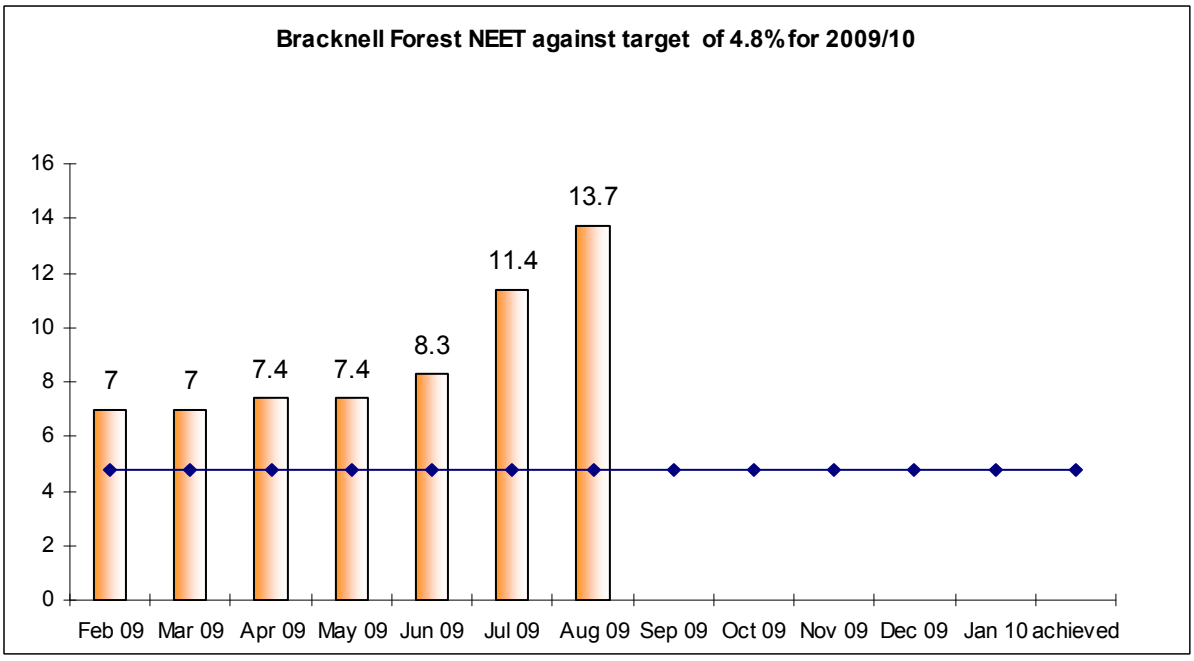
Minority ethnic percentage was recorded as 6% in 2001 and by 2008 was 16.6% in primary schools and 12.4% in secondary schools. St Joseph's Catholic Primary School recorded the greatest percentage of children for whom English is an Additional Language. An increasing number of pupils at schools in the Borough speak a language other than English as their first. Of the 6.8% who speak a different first language, nearly a quarter (1.5%) speak Nepali. In Owlsmoor and College Town 4.83% of pupils speak Nepali and in Bracknell Forest 1.6%. The most common languages other than English recorded in the schools census are; 456 Nepali, 120 Filipino/Tapalog, 116 Urdu. 102 Polish and the range of languages is 76.

For BME groups at the end of Key Stage 2 most attain in line with or above the national average. The weakest performance was from those pupils who were from Black African and Asian other backgrounds. This group includes Nepali children, who have high mobility and a correlation with attainment is evident. Other groups, which comprise less than 4 pupils each in number and fall within this category, are: Pakistani, Black Caribbean and Black Other Gypsy Roma and Irish. Given the very low numbers within these groups, attainment levels for pupils within these groups fluctuate widely from year to year.

Increase education, employment and training for those aged 16 plus

NI 117 sets a target to reduce the % of 16 – 18 year olds in the population of Bracknell Forest who are not in employment, education or training [NEET] to 4.8% by 2010. The past 9 months have been challenging in terms of the opportunities available for young people, the NEET target of 5.0% was not achieved in 2008/09, and figures showed 6.8%, a sharp rise from the previous year.

Figure 1- NEET rates against target August 2009



Improve support for children with learning disabilities and SEN

The primary school average was 1.7% with the greatest percentage of SEN pupils in Meadow Vale Primary and St Josephs Catholic Primary (source - school census Jan 2009). The secondary school average in the same census was 2.5%.

The table below shows trends in placements for children with a statement of special educational needs in recent years (January figures):

Year	Children from Bracknell Forest attending Bracknell Forest schools and early years settings	Children from elsewhere attending Bracknell Forest schools and early years settings	Totals		Children from Bracknell Forest attending schools elsewhere
2002	414	63	477		191
2003	422	62	484		196
2004	433	67	500		197
2005	446	68	514		188
2006	455	66	521		181
2007	451	65	516		169
2008	455	53	508		182
2009	441	48	489		187

SEN in Mainstream Schools in Bracknell Forest

Data in the tables below are derived from the January School Census and submitted by schools.

	Statemented Pupils	%	SEN Without Statement	%
BRACKNELL NORTH				
Primary Schools	75	2.3%	587	18.0%
Secondary School	17	1.3%	248	19.5%
BRACKNELL SOUTH				
Primary Schools	42	1.5%	556	19.3%
Secondary Schools	53	2.8%	537	27.9 %
CROWTHORNE & SANDHURST				
Primary Schools	24	1.1%	368	17.4%
Secondary Schools	50	2.2%	382	16.8%
AIDED				
Primary Schools	15	2.3%	84	12.9%
Secondary School	40	4.3%	54	5.9%
TOTALS	**312**	**2.1%**	**2748**	**18.9%**

Ensure sufficient school places for the future

There is a statutory requirement on Bracknell Forest Council to provide sufficient school places. Discharging this duty involves opening new schools or adding places to existing schools where extra capacity is required. It also means reducing in size or closing schools

with surplus accommodation. The challenge for the Council is to provide the right number of places in the right locations.

The provision of school places is an essential part of Bracknell Forest Council's organisation and planning process. Five year forecasts and detailed commentaries on the supply and demand of school places are published in the annual School Places Plan.

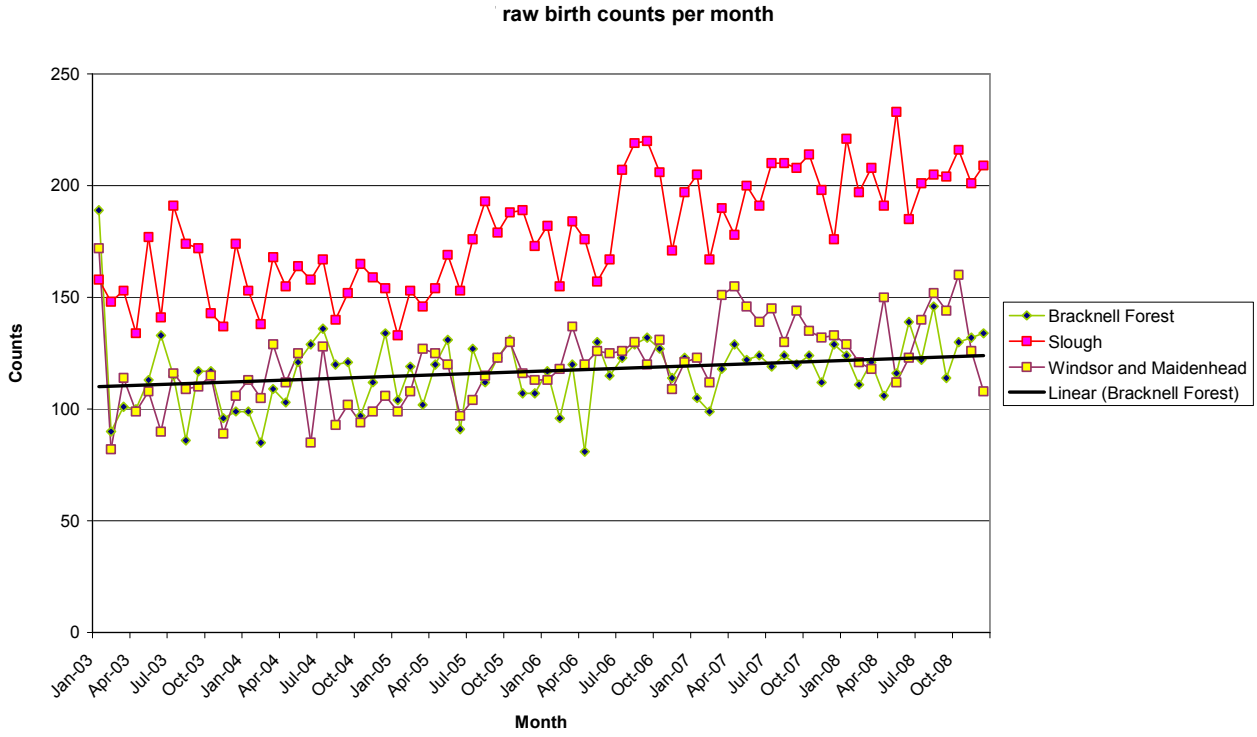
Priority 6 under the 'Enjoy and Achieve' outcome of the CYPP is to '*make available sufficient, suitable and accessible school places to support demographic changes and the needs of learners*'. The School Places Plan therefore supplements the CYPP by providing:

- pupil data and statistics
- forecasts of pupil numbers for the next five years
- commentary on the need to add or remove school capacity
- estimates of future housing growth

As at May 2009, there were 8296 primary-age pupils in schools in the Borough. This number is expected to increase by 16% to 9600 by April 2014. There were 6257 secondary-age pupils in schools in the Borough in May 2009 expected to rise by 6% to 6600 by 2014. Plans are underway to provide additional school capacity to manage the forecast increase in pupil numbers.

The growth projections reported in the CHIMAT model can be monitored by trends in birth patterns as shown below. A small increase can be seen in the average birth rate of about 16 births over 3 years but there is significant variation in year

Figure 2- Raw birth counts per month



Improve opportunities for 'life-long' learning

The Development Plan for Adult Learning 2009 – 2010 [Bracknell Forest Council] has the following priorities for adult / lifelong learning

- Extend the range, appeal and access to learning opportunities, including those that enable, motivate and build self-confidence in new learners. There is recognition of the benefits of linking adult learning to the learning of pupils and students through to a significant family learning service.
- Focus on widening participation and engaging with new learners where confidence, motivation or incentive to be part of the local learning community and for those whom significant course fees may be a barrier to learning.
- Adults with a full Level 2 qualification or those whose personal circumstances prevent them from accessing learning at or above Level 2 are a key priority with deprivation data and locals intelligence used to inform programme planning and targeting those most affected.

The specific support for the expected arrival of over 1000 adults from Nepal who speak up to 17 different dialects is being planned by the Local Strategic Partnership

Where does the evidence come from?
Children & young people's plan 2006-9 Update ➥ School Census January 2009/ Connexions NEET monthly reports / Connexions Business Plan 2009-10/ 2008 Childrens Needs Assessment and statistical supplement. /CHIMAT population projections by age/Birth rates 2006-2008, BSSO/Jones 2008. Maternity Report.
Development Plan for Adult Learning 2009 – 2010 Bracknell Forest Council/

Housing

The Housing Strategy (2009-2014) identifies five strategic priorities

- Increasing the Provision of Housing to meet local needs and Maintain Economic Prosperity
- Making the Best Use of and Improving the Condition of the Housing Stock
- To Pro-actively Address Housing Need through a Housing Options Service
- Meeting the Housing and Support Needs of People with Special Needs
- Providing Desirable Housing and Support to Older People

Future projections in household size as a function of the economic recession can be found at the web site below.

Increasing the provision of housing

The proportion of housing which is socially rented in Bracknell (17.3%) is below the national average but above the Southeast average. About 100 people were on the homeless register in 2008/9, there were approximately 150 homes of multiple occupation and 1000 mobile homes mainly in Sandhurst, Winkfield and Warfield.

In April 2009 there were over 4,000 households on the Housing Register waiting for affordable rented accommodation. Waiting times are typically 4-5 years. Applicants are registered according to their need and their preference so for example single people and childless couples would only be allocated 1 bedroom properties. The type of accommodation required by the 4,000 households on the housing register at 1 April 2009 is as follows:

- 13% are older people requesting sheltered accommodation or older people's bungalows
- 48% are single people and childless couples seeking one bedroom accommodation
- 21% are families waiting for 2 bedroom properties
- 16% are families waiting for 3 bedroom properties
- 2% are families waiting for 4 bedroom or larger properties

September 2008 CACI data shows the income levels that households would need to purchase different types of property in the borough. This indicates that first time buyers need to have a household income of £38,000 to be able to afford to purchase a flat/maisonette, and an income of at least £50,000 to purchase a terraced property. 345 new affordable homes are planned in the next five years.

Meeting the Housing and Support Needs of People with Special Needs

The housing strategy notes success in

- developing floating support and other Supporting People funded assistance for people with learning disabilities
- Increasing expenditure on disabled adaptations in both public and private sector housing
- developing panels to promote access to social housing for disadvantaged young people and adults

Learning Disability Services have reported the need for more suitable accommodation for a small number, approximately 15 people, with learning disabilities who need intensive support but on an un-predictable, out of hour's basis.

There are a number of young people near leaving care age each year who require intensive support. It is planned to develop 8 units of accommodation and support services that will address their specific needs.

As part of the consultation on the Mental Health Commissioning Strategy, people who use mental health services identified accommodation issues such as housing related support, access to housing, respite and support for homeless vulnerable people as areas for development. Currently 94.6% of adults are receiving secondary mental health services in settled accommodation.

The Supporting People programme provides housing related support to a range of vulnerable groups. In 2008/09 the Supporting People grant programme was distributed across the following groups:

Client Group	***Proportion of Programme***
Learning Disabilities	*15%*
Domestic Violence	*7%*
Physical Disabilities	*3%*
Mental Health	*8%*
Homelessness	*45%*
Older People	*19%*
Home Improvement Agency	*3%*

Making the best use of and improving housing condition

The council will be monitoring whether the pledges following transfer of council homes to Bracknell Forest Care have been implemented over the next five years.

The Building Research Council have completed a new in depth model of private sector housing stock across the Borough based on the following key indicators

- dwellings that would fail the decent homes standard
- vulnerable households in decent homes (the former PSA7 target requires 70% to be in decent homes)
- dwellings with Category 1 Health and Housing Safety Rating System Hazard (HHSRS).

The estimates show that private sector housing is in good condition but that the number of houses that are below the minimum standard has risen sharply *due to the comprehensive rating system*.

A lower proportion 14% (cf to 24% nationally) of houses in some areas of the Borough would not meet the 'Decent Homes' standard; although the former PSA target has been met overall.

Key areas estimated to have higher percentages of category 1 HHSRS homes include parts of Ascot and Crowthorne wards. Furthermore, a large number of 'houses in multiple occupation' (i.e. those which contain a number of separate households, such as shared flats) are not suitable as such.

Continue joint interventions to tackle fuel poverty and increase influenza immunisations in people over 65 or with long term conditions

Thermal inefficiency in particular is a large problem with much of the existing housing stock, especially among mobile homes which are relatively common in the Borough. A recent BRE estimate of those living in fuel poverty noted that Ascot, Binfield and Warfield and Bullbrook are the areas most likely to have the highest rates of fuel poverty.

An improvement in the grant maximum from £2,700 to £3,500 has occurred as it was found that on average residents were having to find £8000 towards costs. Tackling fuel poverty is part of a strategic plan to reduce excess winter deaths in people with underlying long term conditions. The programme is jointly promoted through general practices at the same time as increasing influenza immunisation uptake.

Bracknell Forest made 191 referrals and £259,300 was spent on improving property under the Warm Front grant. Timelines were typically 42 days for insulation and 60 days for heating improvements. In view of the delay in getting grant applications actioned the start time of campaigns for flu should be escalated.

Where does the evidence come from?
Census 2001/Building Research Establishment Report into Housing Stock Feb 2009 / Housing strategy 2009-14 / Chamberlain 2009 Recent developments in the housing market. / Mental health commissioning strategy Actvar Travellers' needs assessment / Choosing Healthy Living report /Warm Front Dashboard March 09/ UK Land Registry Report June 2009

Transport

Improve access to services by public transport and noise reduction

The SEPHO Choosing Health in the Southeast 2008 report identifies traffic noise and access to GPs as outstanding issues identified in national patient surveys.

Various local documents have also identified perceived need for improved transport yet much work has already been done to improve services.

The council accessibility strategy targets public transport towards those with the biggest access challenges. An example of this is the subsidised bus service from Bracknell to Wexham Park Hospital, Frimley / Royal Berks Hospitals. This will need to be reviewed.

Encourage sustainable and healthy transport

The council is very active in promoting walking and cycling, and provides substantial investment into improved infrastructure for pedestrians and cyclists, including new routes and crossing points.

Figures from the January 2009 school census show the combined percentage of walking and cycling journeys to school have increased for the third year in a row - 58% of children walk to school, and 4% cycle. Four more schools implemented a School Travel Plan in March, including Kennel Lane Special School. 36 LEA schools now have a STP Only one school, of the mainstream LEA schools does not yet have a travel plan. For adults the Sport England Active Travel survey notes that 24% adults participate in moderate intensity sport and active recreation on 20 or more days in the previous 4 weeks (DCLG,). SEPHO's report Choosing Health in the Southeast (2008) notes that this is in line with the Southeast average.

Peak time traffic congestion in the Borough remains high, with consequent air pollution. An action plan is being developed (see physical environment). Total emissions recorded along the A322 in the census were among the highest in the Southeast (although only just over a third of those on parts of the M25). The levels recorded in 2007 on the environment agency website for CO2 were over 100,000 tonnes. These levels are mostly influenced by industrial power generation and domestic use. Other particulate matter is mainly influenced by traffic conditions and three areas in the borough are being considered for an air quality management plan.

Continue to reduce road casualties

The SEPHO report shows that on average young people from the most deprived areas show a three times increased likelihood of being involved in a traffic accident. The number of people killed or seriously injured on the Borough's roads has fallen in the last decade, this decline is reflected in Bracknell, with 62 road casualties in 2006 and 32 in 2007 (2008 data awaited from Info4local.gov.uk). Of these only two were children.

Road safety education and safer routes to school highways improvements helped to insure that there was only one serious injury to a child on the way to school last year, out of approximately 5.7million trips (source CHL).

Where does the evidence come from?
School Census Jan 2009 / Sport England data on DCLG Hub / Transport plan / Accessibility strategy/ SEPHO 2008. Choosing Health in the Southeast Region /Accessibility strategy / Environment agency 2005-6 data / Response to Audit Commission / Road accident data on Info4local.gov.uk / Health & well-being strategy / Child Death Overview Panel report 2008 / Choosing Healthy Living report

Social & cultural factors

Bracknell Forest Partnership targets the following priorities; violent crime, acquisitive crime, anti-social behaviour, fear of crime and anti-social behaviour, drugs and alcohol, work targeted at offenders and victims. 98 new problematic drug users were entered into effective treatment within the financial year 2008/9. Using Home Office estimates of £44213 per user (in terms of support for mental illness, crime, drug related deaths etc) the total annual estimated financial burden to Bracknell Forest is estimated at £4,433,2874.

Improve effectiveness of services

98 new problematic drug users were entered into effective treatment within the financial year 2008/9. Using Home Office estimates of £44,213 per user (in terms of support for mental illness, crime, drug related deaths etc) the total annual estimated financial burden to Bracknell Forest is estimated at £4,330,000. The Crime Disorder Reduction Partnership estimated that the number of crack cocaine users aged 15 – 64 for 2006/07, with associated 95% confidence intervals for Bracknell forest was 2.46 per 1000 population which was lower that the South East at 3.07 per 1000 population. Estimates of Heroin users for the same period, using the same methodology were 2.53 per 1000 population compared to the South East average of 4.63 per 1000 population. (These figures are using the average estimates rather than the upper and lower estimates – if they are required please let me know.)

Reduce crime and fear of crime ①

In 2008 the Bracknell Forest Crime and Disorder Partnership (CDRP) undertook a strategic assessment of the CDRP Strategy and developed a CDRP Partnership Plan containing 6 priorities with delivery action plans to deliver the outcome of making people feel safe about where they live and work. These priorities are: to reduce crime; to address negative perceptions; to effectively respond to community safety issues; to reduce the harm caused by drugs and alcohol; to reduce the level of anti-social behaviour; to design out crime and disorder resulting from regeneration and development.

The Child Wellbeing Index (2008) is ranked better than the national average in all domains with the exception of the crime score where Bracknell's results are in line with the national average. According to the Tellus3 survey nearly a third (32%) of children in Bracknell feel unsafe on public transport, above the England average, and a fifth (19%) feel unsafe in school. This is a childrens Trust priority for 2009/10.

Although violent crime rates are lower than the rest of the country, there is still a fear of crime among residents of all ages. The wards with the highest crime rates overall are Wildridings & Central, and Priestwood & Garth and Great Hollands North (TVP 2007-8) yet the Place Survey 2009 also lists Old Bracknell and College Town as areas people are concerned about.

Domestic violence can have a significant impact on individuals' mental health, and specific programmes to address this have been implemented. The reporting of repeat events of domestic violence has increased and the focus has moved from Old Bracknell to Great Hollands (2006-7 local TV data).

Work with community to promote healthy food and physical activity ①

The national indicator of physical activity in children has a red rating in the 2009 Health Profile and the National Child Measurement Programme (NCMP) results show a rising trend in year 6 obesity from 2006/7 to 2008/9. It is projected that, without further intervention, there will be a rise in the number of overweight and obese adults (Foresight report, 2008) and children (NCMP 2006-8 results and projections).

The national indicator for physical activity in adults NI8 is also a concern. This is a difficult indicator to influence as it records sporting activity rather than physical activity such as walking. A campaign to raise peoples awareness is underway called BE3.

Although many approaches will be needed to tackle this problem, working with the community and local businesses is an important component, to encourage the uptake of healthier diets, reduce fat, salt and calorie intake and promote physical activity. The Choosing Healthy Living Group monitors action against child and adult targets.

Key challenges remain the take up of school meals, increasing activity levels through the five hour offer, sustaining support for the adult weight management programmes such as Activate in the borough. Commissioning plans are in place for family weight management programmes.

Improve services for people whose first language is not English

An increasing number of pupils at schools in the Borough speak a language other than English as their first. Of the 7.7% who speak a different first language, nearly a quarter (1.5%) speak Nepali. In Owlsmoor and College Town 4.83% of pupils speak Nepali and in Bracknell Forest 1.6%. The most common languages other than English recorded in the schools census are; 456 Nepali, 120 Filipino/Tagalog, 116 Urdu, 102 Polish and the range of languages is 76.

The number of different languages spoken (including English) is 76, although around half of these languages are spoken by 5 pupils or fewer.

Early in 2009 a Nepalese Community Support worker was appointed by the Council, jointly funded by the Council, Thames Valley Police and East Berkshire Primary Care Trust, to focus on working with children and families from the Nepali community. The aim of their work is to help further support the integration of the Nepalese community in Sandhurst and build on the existing strengths within the community by providing information, advice and guidance to make life easier in the UK. Thus ensuring that the community has information about the Council and its partners and how to access the services provided. From a health view point this support arose from community concerns about full, informed consent for medical procedures and school based support.

Where does the evidence come from?
Child Wellbeing Index 2008/ Tellus3 Survey / Thames Valley crime data reported in BF Childrens Needs Analysis 2008/ Health Profile 2009/ NCMP results reported on the DCLG hub and national Information Centre/ Index of multiple deprivation 2007 / School census Jan 2009 / Choosing Healthy Living report / TellUs3 / Children & young people's plan progress check / Place Survey 2009

Physical/Sustainable environment

National benchmarks for many sustainable community outcome measures were reported recently (DEFRA, 2009). The priorities for the Sustainable Community Plan are: Sustainable Growth; Somewhere to Live; The quality of social housing will be maintained to Decent Homes standards; Neighbourhoods will be used to best effect; The new town centre will deliver a range of quality services to residents and visitors; and High quality design will make a positive contribution to the character of Bracknell Forest.

Promote sustainable lifestyles

Total carbon emissions per end user were reported as above the England average in the 2008 Health Profile (APHO) and in line with national figures by the 2009 Health Profile. The CO_2 emissions per capita grew from 6.57 in 2005 to 8.58 per capita in 2006 although the total emissions did not. This indicator was heavily affected by the baseline population (Environment Agency 2005, 2006).

Ecological footprint models (which are dominated by CO_2 emissions) are estimates and the methodology has changed since 2007.

The model produced by the Stockholm Institute for York (2002) estimates a 30% reduction in the ecological footprint can be obtained through a policy of encouraging;

- 80% of homes to have double glazing and draft proof stripping
- 50% of houses to have boilers which are 84% efficient
- a reduction of thermostats' temperature by 2 degrees for 50% of the houses
- 90% people to not use the standby function on the TV
- 20% increased use of showers – to replace baths
- 90% of houses to turn off lights when not in the room
- a policy of actively charging for the weight of waste removed

Recommendations for the NHS in the most recent Faculty of Public Health guidance (2009) are equally relevant for local authorities and a shared sustainable strategy would maximise local impact.

Improve access to green spaces and children's play

Residents of all ages, including older people, would benefit from better access to, and protection of, green spaces and a well-maintained community environment. Children in particular need a larger number of easy-to-access play and leisure services.

The play strategy action plan for 2007-2011 includes the following themes; provision of play rangers, training and education, inclusive play, general infrastructure of parks and green places, opening up school grounds, urban design, the introduction of Jabadeo, cultural change and a place for young people.

Where does the evidence come from?

Health profile 2009 / Audit Commission local response/ Faculty of Public Health guidance on sustainable futures /Stockholm Institute of Science (2002) A material flow analysis and ecological footprint of York – technical report/ Core Strategy 2006-2026 available at www.bracknell-

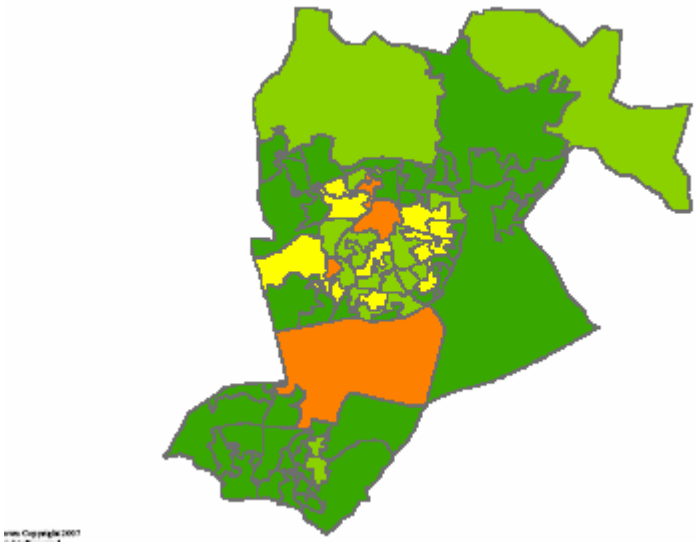
forest.gov.uk/ Local Transport Plan available at www.bracknell-forest.gov.uk/Play strategy 2007-2011 and current action plan

Employment, deprivation and health inequalities

Reduce deprivation, inequalities in health and increase life expectancy

There is a strong link between material deprivation and ill health. Based on the Index of Multiple Deprivation (ONS, 2007) the most deprived quintile of wards in the Borough are Priestwood & Garth, Wildridings & Central, Bullbrook, Harmans Water. Great Hollands North, Crown Wood and Old Bracknell also have lower super output areas within the fifth quintile (i.e the most deprived). With regard to superoutput areas only two are ranked in the fourth quintile nationally in Crowthorne and Great Hollands. The Crowthorne figures for deprivation are skewed by the presence of Broadmoor hospital as nearly all inmates in secure hospitals in the UK claim or have claims made for them (PHRU report).

Figure 3- National rank of deprivation by lower super output area (IMD 2007) – the orange areas are in the fourth most deprived in England.



Life expectancy is significantly lower in lower-income groups in the Borough, and the London Health Observatory 2008 model notes a year of life could be saved through working with males with cardiovascular disease and females with COPD. Males in the fifth quintile live on average 3.4 years less than males in the most affluent quintile.

ONS sociodemographic categories in the most deprived groups also are consistently over represented in emergency admissions to hospital, especially for cardiac, respiratory and endocrine diseases (Source Beauchant ONS geodemographic analysis 2008).

Reducing poverty improves health outcomes but work with areas of deprivation requires sustained effort to make a difference to low aspirations which can develop quickly in the face of recession (Audit Commission 2009).

Reduce inequalities in employment

Current national unemployment rates are 7.9% (based on the Labour Force Survey August 2009) these can be found at http://www.statistics.gov.uk/instantfigures.asp. Employment rates are at 72.9% nationally. The report notes

'The employment rate for people of working age was 72.9 per cent for the three months to May 2009, down 0.9 from the previous quarter and down 2.0 over the year. This is the largest quarterly fall in the working age employment rate since comparable records began in 1971'

By Feb 2009 6400 claimants of all ages were recorded; the main ones being 1730 on Job Seekers Allowance 2500 on Educational Skills Allowance or Incapacity Benefits, 440 on Carers Grants, 510 on disability grants and 890 lone parent claimants. The wards with the greatest number of claimants were Priestwood and Garth, Hanworth and Harmanswater. Crowthorne had the second highest numbers of ESA and incapacity claimants but this may reflect the presence of Broadmoor and Ravenswood.

Some groups are less likely to gain employment: those with mental health problems have a lower employment rate (40%) compared with the Borough as a whole (82%), although this is better than the regional and national averages. Currently 12.4% of adults are receiving secondary mental health services who are in employment. 1 in 20 (5.2%) of school-leavers aged 16-18 are not in employment, education or training. Further support should be made available to people with autistic spectrum disorder in accessing employment and training (see learning disability needs assessment).

The Improving Access to Psychological Therapies (IAPT) programme has commenced in Bracknell and baseline data for this shows that only a small percentage of people 2.5% of the 11.7% who are economically active were on Job Seekers Allowance in Dec 2008. A new national report on the Pathways to Work scheme notes explanatory factors for those clients who did progress into work.

Where does the evidence come from?
Index of Multiple Deprivation 2007 / London Health Observatory Life expectancy scarf models 2008/ Beauchant ONS geodemographic analysis 2008/ Audit Commission 2009 Report. When it comes to the crunch / NOMIS rates of unemployment 2008 /Years of potential life lost data / Health profile 2009 / / Mental health needs analysis/ Pathways to Work report available at http://research.dwp.gov.uk/asd/asd5/rports2009-2010/rrep593.pdf/ NOMIS statistics available at www.nomisweb.co.uk

Air, water, land, food & sanitation

Ensure food safety is maintained and healthy food is offered

In the context of a predicted rise in the number of adults and children in the Borough who are overweight or obese, it is important that healthy food options are available from local catering establishments. The Berkshire wide Catering for Health Award scheme continues to be run by the Environmental Health team when carrying out routine visits to food premises. The Scores on the Doors programme was introduced in 2008 and continues to allow customers online access to food safety information relevant to specific premises within the borough. This is as part of a nationwide online database and is updated monthly.

Monitor air quality regularly for potential health impacts

Under the requirements of the Environment Act 1995, Bracknell Forest Borough Council is required to undertake air quality reviews and assessments in areas where the National Air Quality Strategy (AQS) objectives are not currently met, or where future accidences are predicted, local authorities are required to declare an Air Quality Management Area (AQM). Bracknell Forest Borough Council has completed three rounds of Air Quality Review and Assessments. No AQMA exists in the borough. As part of the review process Bracknell Forest commissioned 2009 Air Quality -updating and Screening Assessment and has been conducted in accordance with LAQM Technical Guidance TG(09)(DEFRA,2009). The report examined the air quality data collected during 2008 and concluded that Bracknell Forest Borough Council is required to proceed with the to a detailed assessment for Nitrogen Dioxide as a result of exceedances at Bagshot Road and Downshire Way and Bracknell Road in Crowthorne. On the basis of the report the council is to commission a detailed assessment of the borough's air quality in 2009-10 to determine if an Air Quality Management Area is required to be declared.

Inspect potentially contaminated land

The 2008 Contaminated Land inspection strategy notes that there is a record in Bracknell Forest of the following potential sources present; breweries, brickworks, chemical works, gasworks, landfills, metal finishers, paper and printing works, petrol stations, scrap yards, sewage works and sewage sludge treatment. All high risk areas have been reviewed and moderate risk areas in the Borough are now undergoing planned inspections over the next 5 years, to identify risks for which intervention is required.

Monitor flood risk 🕐

Although the risk of flooding is generally low in Bracknell Forest, this could well increase with climate change and should be actively monitored. The greatest threat in terms of flooding is from surface water flooding.

Within the planned housing developments for 2010 no new development of highly vulnerable residences have been planned in the higher risk zones, but flood management and mitigation measures have been developed to reduce risks to an acceptable level. These range from traditional flood defences and flood alleviation schemes, to flood resistant and resilient design, and emergency plans.

The planning assumption is that there may be up to a 20% increase in peak river flows by 2050, and up to 30% by 2110 based on current climate change guidance. The Council will

have a number of responsibilities in relation to flood risk management as a result of the draft Floods and Water Bill, expected to be passed through parliament in 2010. The Council has developed an internal flood risk management group and is required to report against NI 189 – flood risk management.

Where does the evidence come from?
Food law enforcement plan / Air quality report 2008 / Transport plan / 2008 Contaminated land inspection strategy / 2006 Flood risk strategic assessment / Draft Floods & Water Bill/

http://www.bracknell-forest.gov.uk/sfra-section-04-strategic-flood-risk-assessment-part-1.pdf

General determinants

Safeguarding

The council has adopted 6 medium term objectives. Objective four is of particular relevance to the Safeguarding Agenda: "Create a borough where people are safe and feel safe".

For Children and Young people

The functions of local safeguarding Children Boards are set out in the Local Safeguarding Children Board regulations 2006. (OPSI)

The Berkshire Safeguarding procedures have been updated and are now available on line.

Working Together (DCFS) guidance is due to be revised shortly. The Bracknell Forest Children and Young Peoples Plan Update (2006-9) notes progress as follows

- A safeguarding toolkit was launched in February 2009 at the Local Safeguarding Children Board (LSCB) conference
- A Section 11 Audit of safeguarding practice was undertaken by all agencies
- Ongoing joint working with colleagues across Berkshire on child deaths and other safeguarding issues
- Developing and implementing a safeguarding training programme

Numbers on child protection plans and types of abuse

The range of numbers of children with a Child Protection plans per month in 2008/9 was between 37 and 54. The range of Section 47 investigations per month in 2008/09 was 9-25.

No serious case reviews were undertaken in 2008/9.

The most frequent abuse category in Bracknell Forest among children on Child Protection plans was emotional abuse, followed by neglect.

National Indicators

Relevant indicators are 59, 60, 64, 65, 67, 68. Comparator data nationally lags one year behind so performance is monitored against trend data. No results were statistically different to targets.

A report into the rate of hospital admissions for unexpected injuries in children and young people NI70 (Beauchant, 2009) showed that the values were affected by proximity to an Accident and Emergency unit and by different coding within different hospitals. Improving the quality of this indicator is a priority.

Childrens and Young Peoples Trust priorities for safeguarding

The main priority is to continue to ensure that safeguarding remains a priority in the work of all agencies.

Safeguarding self review

Detailed actions plans arising from the 2009 Healthcare Commission self review are in place for improving the

- Quality of Individual management reports that underpin serious case reviews to new OFSTED standards
- Recording of Level 1 training within the appraisal process (attendances are 100% but not adequately captured). On line training can also be completed.
- Attendance at multidisciplinary Level 2 training
- GP training (to complete reports or attend court) and increased involvement in case conferences will be reviewed as part of revalidation
- The provision of a fully commissioned safeguarding framework across all partner agencies

The Child Death Overview Panel report for Berkshire (2008) indicates the following as priorities for 2009/10;

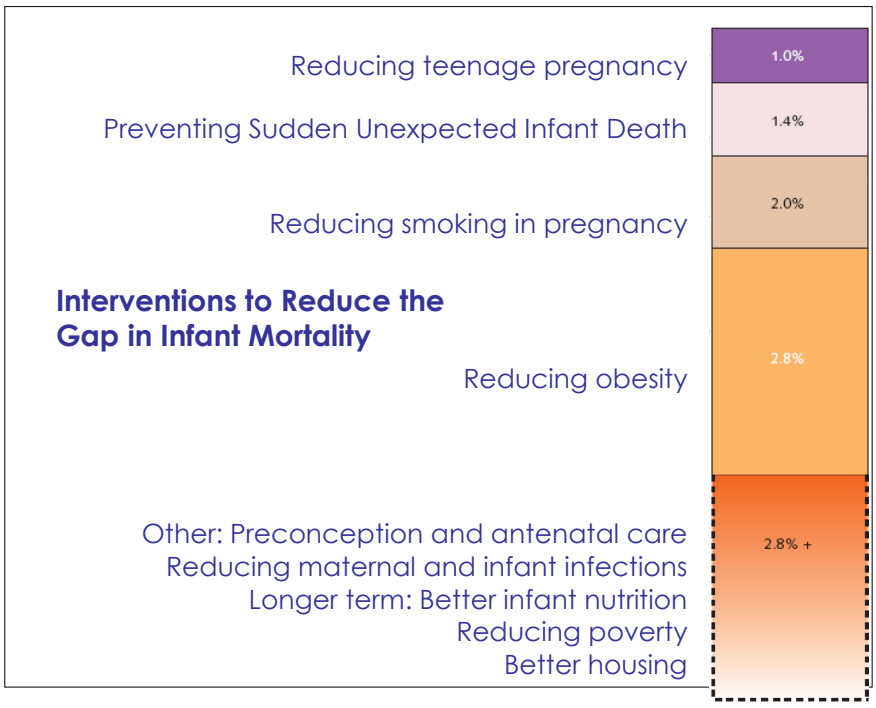
- Improving training in CDOP and Rapid Response processes.
- Improving. data collection on factors such as maternal obesity, maternal age, and parental smoking status and accurate recording of ethnicity according to government-agreed categories.
- Access to maternity and paediatric services and information should be improved. Specifically, access to initiative such as the Healthy Start Vouchers, and access to information on issues such as SUDI and breastfeeding should be improved.
- Barriers to access, including geographic, cultural and language factors, should be addressed, and outreach services to Black and minority ethnic (BME) and socially excluded groups should be increased.
- Targeted interventions are required to address infant mortality. Several initiatives are already in place in Berkshire, including an antenatal smoking cessation scheme; gaining UNICEF Baby Friendly status; piloting an antenatal weight management programme for obese women; a teenage pregnancy strategy; and a Family Nurse Partnership programme. Work is required to increase awareness of, and thereby improve access to, these and other existing initiatives.
- The risk of child deaths due to infection can be addressed by working alongside housing teams, focussing on multiple occupancy homes, and increasing immunisation rates to Department of Health standards.

N.B it is important to note the CDOP report covers the whole of Berkshire; therefore the risk factors they identify are based on a Berkshire wide analysis.

CDOP report recommendations re infant mortality

The CDOP Annual Report 2008 /09 states that "of the 102 child deaths, 53 occurred in infants, representing an infant mortality rate of 4.4 infant deaths per 1,000 live births [95% CI 3.2, 5.6], a rate statistically similar to the national rate of 4.8% [95% CI 4.6. 5.0] in England and Wales over the same period of time. Bracknell Forest had two child deaths reviewed by the CDOP and neither were judged to be preventable. The CDOP report noted that Interventions to reduce infant mortality should note the proportional effect of each of the following risk factors.

Figure 4- Interventions to reduce the gap in infant mortality



For adults

In line with 'No Secrets' Bracknell Forest Council is the lead agency for co-ordinating multi agency procedures that respond to the possible abuse of adults whose circumstances make them vulnerable. To develop this area of work Bracknell Forest Council host the Safeguarding Adults Partnership Board, this is a multi agency board that provides strategic leadership on safeguarding adult's issues.

The BF Safeguarding Adults annual report for 2008/09 identifies the following as key areas for development during 2009/2010:

The Council will review and where appropriate amend all safeguarding procedures to ensure that they compliment the personalisation agenda, and that safeguarding adult issues are reflected in the council's approach to personalisation.

Increased awareness of Safeguarding Adults issues within the voluntary sector. The outcome of this will be evidenced by attendance at the Partnership Board and Forum by representatives of the voluntary sector and an increase in referrals/alerts from voluntary organisations.

Ensuring Safeguarding Adults procedures are accessible to all members of the community, including people who purchase their own care. The outcome of this will be measured by the number of individuals who purchase their own care who are supported through the safeguarding process.

Ensure the Bracknell Forest Safeguarding Adults Partnership Board is a robust Board that both scrutinises the council's own performance in relation to safeguarding, and acts as a critical friend to other member organisations.

Increase referrals number from Thames Valley Police, ensuring through audit processes that staff are considering the need to refer concerns where appropriate to Thames Valley Police.

Continue work with NHS partners to further increase levels of understanding of safeguarding responsibilities. The outcome of this work will be demonstrated by an increase in referral numbers from NHS partners.

A Quality Assurance framework has been developed for services supporting adults with learning disabilities; this will be extended to all services that support vulnerable adults.

Multi Agency Public Protection (MAPP) meetings will ensure that adults whose circumstances make them vulnerable to risk posed by serious and or sexual offenders living within the community can be fully assessed, and where necessary plans put in place to minimise the risk.

Multi Agency Risk Assessment Conferences (MARAC) look at the victims of Domestic Abuse and where appropriate formulate risk management plans to support the victim, work will be undertaken to ensure that were the victim may benefit from support from health and social care appropriate links will be made.

A robust data set will be devised to aid analysis of equality issues in relation to individuals whom have been subject of safeguarding alerts/referrals.

Where does the evidence come from?
BF Safeguarding Annual Report 2008/9/Child death overview panel report 2008 / Beauchant 2009. Review of NI 70/ Children and Young Peoples Plan Update 2006-9/HCC self assessment 2009/BF Adult Safeguarding Report 2008/9 *Berkshire Child Death Overview Panel – Annual Report 2008 – 2009*

Health and social care services

In the past two years care-group priorities for Older People, People with Long Term Conditions, People with a Learning Disability, People with Mental Health problems, People with Dementia and People with Sensory Needs have been developed. The national driver (Transforming Adult Social Care, DH 2008) requires the council to give users greater flexibilities to commission services to achieve the outcomes they value and that are effective.

The Referrals, Assessments and Packages of Care (RAP) statutory returns to central government for May 2009 indicated that Bracknell Forest adult social care provided services to 2283 people with a physical disability or temporary illness in 2008/9, 953 people with a mental health problem and 267 people with a learning disability of working age. The RAP return also indicated Bracknell Forest adult social care provided services to 77 people with dementia. There are also a number of other people who have dementia who are recorded under other categories, such as mental health and physical disabilities. Data from other adult social care sources estimates a total of 315 people with dementia who received support in the year.

Joint commissioning for improved health and well being outcomes①

A comprehensive work programme has been developed by the PCT in partnership with the council and covers the:-

- Joint Dementia Strategy
- Urgent Care Centre
- Rapid Response Service

Implementing Right Care, Right Place, training staff in brief alcohol interventions (DH, models of care) and the roll out of Improved Access to Psychological Therapies are current priorities.

Ensure that the Urgent Care Centre and Rapid Response programmes improve access and outcomes①

A key priority is the development of a Berkshire East Rapid Response Service to ensure that unnecessary admissions to hospital are reduced. Urgent care and diagnostics services for residents of Bracknell Forest are planned for the development within the Health Space from 2011. Local residents have been fully involved in the planning phase and have identified transport issues within a recent health impact assessment.

Over the last three years the following have predominated.

Top 10 Emergency Admissions Berkshire East Residents:2006/7 to 2008/9

(excludes MH Diagnoses)			rank		number
Bracknell Forest		**2006**	**2007**	**2008**	**2008**
ICD10	Name				
R10	Abdominal and pelvic pain	1	2	2	300
R07	Pain in throat and chest	2	1	1	334
I48	Atrial fibrillation and flutter	3	6	6	133
N39	Other disorders of urinary system	4	4	4	170
J18	Pneumonia, organism unspecified	5	3	3	183

I20	Angina pectoris	6	10	10	104
J44	Other chronic obstructive pulmonary disease	7	5	5	165
M79	Other soft tissue disorders, not elsewhere classified	8	12	17	84
J22	Unspecified acute lower respiratory infection	9	7	7	118
S52	Fracture of forearm	10	18	8	117

Plan to provide preventative services for a larger older population

The population of Bracknell Forest is projected to rise significantly over the next 10 years, with particular growth in the age bands above 55.

In Thousands

AGE GROUP	2009 (000)	2014 (000)	2019 (000)
0-4	7.5	8	8.1
5-9	6.8	7.3	7.8
10-14	7.4	6.9	7.5
15-19	7.5	7.1	6.6
20-24	7	7.2	6.9
25-29	8.1	9	9.2
30-34	8.7	9.3	10.1
35-39	9.6	8.8	9.4
40-44	9.8	9.2	8.5
45-49	8.9	9.2	8.6
50-54	7.5	8.3	8.6
55-59	6.2	6.9	7.7
60-64	5.9	5.8	6.3
65-69	4	5.4	5.3
70-74	3.5	3.8	5
75-79	2.7	3.1	3.4
80-84	1.9	2.2	2.6
85+	1.8	2.1	2.6
ALL AGES	**114.8**	**119.5**	**124.3**

On a straight pro rata calculation 2283 people with a physical disability or temporary illness in 2008/9, would thus increase to 2987, 953 people with a mental health problem would increase to 1046 For dementia the numbers are projected to rise from 77 persons over 65 with dementia to 105 and 267 people with learning disability would increase to 282. The use of separate 18-64 and 65+ projections would result in a greater increase.

Improve access to dental services

The 2008 Berkshire East dental health strategy noted that improving access to dental health services, is a priority as a third of UK residents have not accessed dental care in the last two years. This continues to be an issue as in 2007/8 the local Patient Advice and Liaison Service handled 258 cases predominantly in relation to dental queries such as location of dentists, charges and services available. In 2008/9 a rise to 298 contacts occurred in Bracknell Forest (Source PALS report 2008-9).

For adults a national adult dental health survey is planned in 2009 as the previous data was extrapolated from a survey conducted in 1998.

For children the latest survey was conducted in 2006/7 by the British Association for the Study of Community Dentistry (BASCOD) which compared values for five year olds in the most deprived areas of the UK with the average for decayed missing and filled teeth (1.47). High values for five year olds were recorded in areas of socio economic deprivation and in Berkshire East 51.9% of five year olds had a dmft >0 (mean 4.17) compared with 35.3% in NHS South Central (Source East Berkshire Oral Health Needs Assessment 2009).

Apart from dental decay the oral health needs assessment identified the following risk factors for periodontal disease; mainly plaque, together with diabetes, HIV, stress and smoking. The has led to a focused public health initiative such as the assisted tooth brushing programme (in special schools) and the cessation of; smoking, heavy consumption of alcohol, chewing tobacco, chewing betel nut quid with tobacco and the importance of protective factors to reduce the risk of oral cancer.

Continue to plan for and respond to major emergencies

Bracknell Forest Council and Berkshire East Primary Care Trust are 'Category 1 Responders' under the Civil Contingencies Act (2004). It is the responsibility of both organisations, along with other members of the Local Resilience Forum, to continue to plan for civil and health emergencies in the Borough.

These include major accidents, acts of terrorism, flooding and pandemic influenza. The borough has tested the emergency plan with the recent pandemic and is monitoring business continuity. Particularly vulnerable groups in such incidents include the young and old, those with disabilities, individuals in closed communities (such as prisons), and those living near sites of potential danger.

Improved access to health care by the travelling community

The Actvar survey (2006) noted the following fixed sites in the Borough; East Hampstead Park (UA), Ambarrow Farm, Sandhurst (Private authorized) and Seven Acre Farm, Sandhurst (Private authorized). 7 other sites were noted at the time of the audit.

The projected increase in sites was 3 from 2006 to 2011. In the Thames Valley area it is estimated that whilst most of those interviewed did have a GP they would travel up to 20 miles or return to Ireland to see them. Nearly a fifth (18%) of travellers are not registered with a GP, mirroring a national report which found 16% were not registered. Over half (55%) are not registered with a dentist.

Life expectancy is significantly shorter than for resident communities and a 2008 Health Protection Agency study into measles outbreaks in family groups in Bracknell identified cultural barriers to immunisation rates. The lack of a specialist health visitor for travelling families is gap compared to Slough and RBWM.

Where does the evidence come from?

Right Care Right Place 💬 / National Patients' survey 💬 / NHS Berkshire East Emergency Response Plan and Pandemic Flu Plan / ACTVAR Travellers' needs assessment available at http://www.actvar.gov.uk/pdfs/FINAL_REPORT_15-09-061.pdf💬 / NHS Berkshire East Dental Health Strategy 2008 / ONS projections / SEERA projections / HPA report 2009/Health Space health impact assessment 2009💬 BFBC (2009) Commissioning strategy for people with dementia 2009-2014

Needs by health and wellbeing determinant
General determinants

Occupational health

Increase opportunities for healthy eating and exercise at work ①

Adult activity levels have stayed level according to DCLG Hub data based on the Active Travel Survey (Sport England 2007 and 2008) however the Foresight report (2008) notes that significant work is required to halt the rise in the number of individuals who are overweight or obese. Healthy eating and exercise should be encouraged in work places, and when travelling to and from work. (See related reports under Travel)

Continue to address musculoskeletal pain and workplace stress

Workplace-related stress is the second most common work-related illness in England, after muscle and bone pains. The prevalence of musculoskeletal disorders in the 2006/7HSE figures is reported at 2440 per 100,000 (CI 2160-2720).

On average, 30.2 working days are lost for each case of stress each year. Stress has been found to occur more frequently in South East England (HSE 2006/7 report 1400 cases per 100,000 per year) compared with the rest of the country (1220). Although reported stress fell during the middle of the current decade, rates have risen again.

Monitor accidents and ill health at work

Investigations into workplace accidents should be carried out, and efforts should continue to be made to reduce the number of accidents and ill health at work. HSE statistics for 2007/8 show that 237 over 3 day accidents were reported in Bracknell - higher than the Southeast (a total injury rate of 449.4 compared to 433.8 per 100000 baseline).

Death rates in males from mesothelioma have increased steadily over the last twenty five years and in the Southeast were reported in 2004-6 as 74.05 per million suggesting an expected rate of 8.5 new diagnoses in Bracknell. An increase is expected until 2016 in males aged 20-40 dependent on the number of years exposed and the year of exposure. Very few cases are unrelated to asbestos exposure.

Enhance links with local armed forces establishments

Although the armed forces provide health care for their staff (through the Defence Medical Services), the Primary Care Trust has responsibility to ensure primary care needs are met for all members of armed forces families who are resident in the local population.

In Sandhurst there is a current service family population of approximately 2000 in addition to the 1000 service men who receive medical services via the army. The turnover of this population should be considered within emergency planning, health and social care and educational planning.

Where does the evidence come from?
DCLG Hub data from Sport England/ Health & Safety Executive data available at www.hse.gov.uk/statistics/regions/regrate.xls / Berkshire East obesity strategy / Census / Health & safety enforcement plan / Delivering our armed forces' healthcare needs /

Needs by health and wellbeing determinant
Individual lifestyle / risk factors

Tobacco use

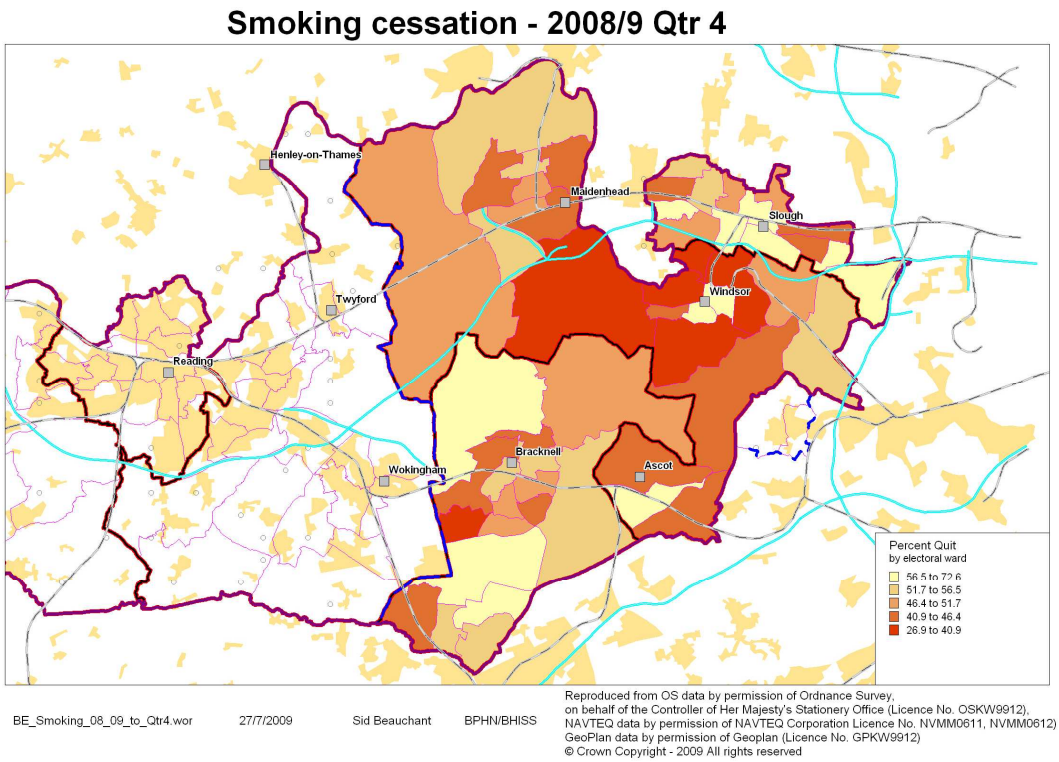
Smoking is causally linked with many cancers and respiratory diseases. Towards Smoking Kills – an update produced in 2008 notes that developing an updated tobacco control strategy and action plan which includes the multifactorial work of many agencies is a priority.

Continue to encourage people to quit smoking

Smoking remains a major public health problem responsible for a significant amount of illness and death in Bracknell – a recent public perception survey (SHA, 2008) estimates that over a fifth (22.1%) of people in Bracknell Forest smoke, and it is estimated that one in six (16.5%) of all deaths in South East England result from tobacco use, especially from lung cancer and heart disease. Whilst local services have increased opportunistic access through venues such as shopping centres, leisure centres and local pharmacies more can be done for deprived communities and for those with chronic obstructive pulmonary disease.

The wards with the lowest quit rates are shown below. Many factors influence quit rates and it is interesting to note that successful quit rates in young people can vary from 0 - 66.7%. The most successful quit rates were in Binfield, Owlsmoor & Crowthorne. The factors underpinning this need to be fully understood and shared.

Figure 5- Smoking cessation percentage quit by ward Q4 2008/9



Target particular groups of smokers through a range of interventions

Towards Smoking Kills an update (2008) identifies priority groups – those living in deprivation and manual employment are associated with higher rates of smoking, mothers smoking in pregnancy and young smokers are prioritised as are those with long term respiratory conditions such as chronic obstructive pulmonary disease (COPD) or mental health problems.

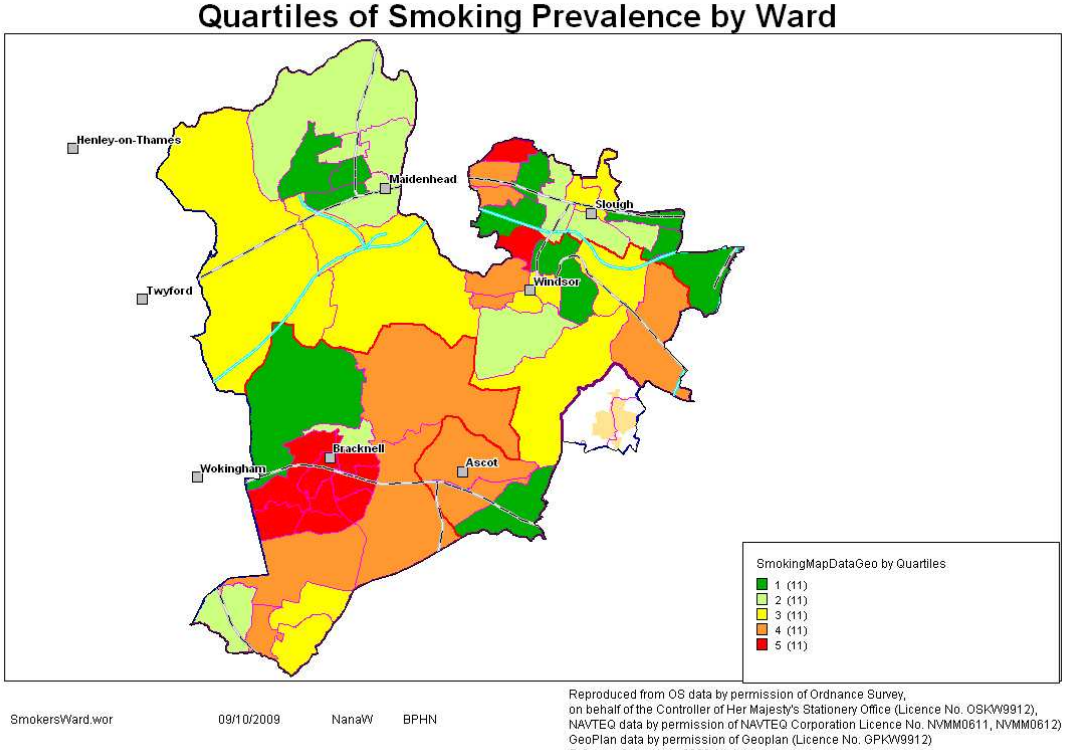
The end of year outturn 2008/9 shows that the overall target for quitters was met but that the harder stretch targets for mothers smoking in pregnancy and for young people were not. A recent consultation with young people (Stannard, 2008) identified barriers to uptake and the findings informed the content of the community television programme. This programme will continue in 2009 and be extended to all GP practices which will be offered a Life Channel installation.

A health inequalities funded programme offered dedicated training to mental health staff and led to increased skills but identified lack of time and capacity to deliver long term smoking cessation support to those with a mental health problem living within the community. From that project it was estimated that up to 70% of people in contact with Berkshire Mental Health Care Trust services were reported to be smokers but the quit rates within such groups were low and services would need to be commissioned differently allowing for longer and repeated attempts (Mental Health Smoking Cessation report 2009).

NHS Stop Smoking Services in the area have reported that although health issues are driving change that smoking cessation in pregnancy is particularly difficult to record accurately (as few mothers who smoke report this to maternity services) and to ensure change is sustained. Community television is just one example where there are multiple opportunities arising from antenatal visits (whether at hospital or in general practice) would which provide up to five occasions in which to advertise support.

A new map shown below reports the QoF prevalence from GP registers by ward quintiles (5 being the highest prevalence). Commissioning increased activity in these wards is likely to yield better outcomes.

Figure 6- Quartiles of smoking prevalence by ward across Berkshire East (QoF 2008/9)



Update the tobacco control action plan

The consultation on Smoking Kills shows that many organisations are contributing to ensuring smoke free environments, a reduction in underage sales, reduced access to tobacco products and improving smoking cessation services etc Environmental health and Trading Standards have already identified and are working on reducing tobacco smuggling and sales of tobacco to minors, including test purchases at local retailers, and enforcing the minimum age for tobacco sales (increased from 16 to 18 in 2007). National guidance on working with retailers on point of sale displays is also being implemented.

The Trading Standards service has been undertaking additional specific work on a South East regional basis funded by the Department of Health. This has included additional targeted test purchasing, including tobacco vending machines, business education, point of sale material and local publicity. All known sellers of tobacco across the region have received a newsletter in July 2009 giving advice regarding the age restrictions on the sale of tobacco and other products.

The local stop smoking services are also continuing their work with the Fire Service to promote smoke free homes and offering opportunistic contacts in an increased range of sites.

The collective efforts of all these agencies should be recognised in the Local Area Agreement revision.

Where does the evidence come from?
Berkshire East smoking cessation LAA data / Smoking in Mental health report 2009 / Hospital admissions due to smoking data / Towards Smoking Kills – an update (ASH, 2008) / Smoke-free Berkshire Alliance Strategic Action Plan / www.tsse.org.uk.

Needs by health and wellbeing determinant
Individual lifestyle / risk factors

Drug misuse

The three DAATs in Berkshire East received commendation in 2009 from the Audit Commission for their performance and collaborative commissioning. Services are commissioned from a range of providers as well as through GPs via a locally enhanced service. Many of the strategic themes are echoed across Berkshire East. The Bracknell Forest Young Peoples Needs Assessment (2008) and the adult drug treatment plan have both been updated in 2009.

Among young people (defined as 0-17) a higher rate was reported in 2007/8 as in contact with services i.e 274/100,000 compared to the SE average of 172/100,000 (90% of young people in treatment reported never injecting and injecting status was not given for 8% of clients). Yet in the Tell Us 3 Survey 93% of those young people surveyed said they had never taken drugs, compared to 86% nationally. The overall figure determined from Tell Us 3 to support the National Indicator Substance Misuse by Young People showed that performance in Bracknell Forest was 4.5% which is better than the England average of 10.1%.

Bracknell Forest had 191.9 adults in treatment per 100,000 population, in 2007/08, lower that the South East Rate of 289.7 per 100,000 (based on 2007 mid year population estimates, ONS). Problem drug users are classed as those using either opiates or crack cocaine or sometimes using both drugs together.

Number of drug users accessing treatment services

The adult DAAT needs assessment identified

- In 2008/09, 82% of problem drug users were retained in treatment for 12 weeks or more and 90% were either retained or their treatment episode of treatment was completed successfully
- The number of Crack Cocaine users in effective treatment, 92%, is significantly higher than both regional (81%) and national (83%) levels.
- The main drug of choice in 2008/09 was Heroin 62.3% followed by Cocaine 16.1% which is comparable to 2007/08
- The number of new problem drug users entering treatment from 1st April 2009 to 31st March 2009 was 96 which was a significant increase from the same period in 2007/08 (52). Problem drug users are classed as those using either opiates or crack cocaine or sometimes using both drugs together.
- The number of all drug users 18 & over new to treatment for the same period was 147

Local people perceive that drug misuse is less of a problem 23.4% in 2008/9 compared to 39% in 2006/7 (Place Survey 2008/9).

Priorities arising from Children and Young Peoples Plan and needs assessment

The Children and Young Peoples Plan for 2009/10 identified the following priority in relation to substance misuse:

- Children and young people know about the impact of substance and alcohol misuse, and fewer choose to misuse drugs or alcohol.

Bracknell Forest had a higher percentage of young people in Tier 2/3 substance misuse services per 100,000 than the Southeast average (CYPP priorities 2009/10).

The ongoing actions for 2009/10 therefore include

- Working with schools through the National Healthy Schools Programme to achieve enhanced status
- Supporting further teachers in gaining PSHE accreditation
- Further evaluation of the Early Intervention Project to increase referrals for those at risk of offending
- Continue the Safe to learn peer mentoring project

Priorities arising from the adult needs assessment

'Indications of Public Health in the regions report 10 on Drug Misuse report (APHO, 2009) highlights the Southeast region as an outlier in terms of numbers of young females (defined as 10-25) who have used any drug, whether cannabis, cocaine, class A* or amphetamines albeit in the period 2003-2006. Rates of male usage were similarly high but not an outlier compared to elsewhere in England.

The 2008/9 DAAT needs assessment notes 19 priorities including data collection improvements, pathway improvements, service delivery and commissioning issues as well as training in dispensing, and life skills and awareness raising of non pharmacy needle exchange. The following strategic priorities for 2009/10 are:

- Clear referral routes and pathways between the commissioned services and Jobcentre Plus in order to increase the community re-integration of problem drug users
- Increase training in dispensing
- Commission training for the family and friends group to include psychosocial interventions
- Provide training for clients on overdose and harm reduction
- Increase the number of General Practitioners who will prescribe and develop a shared care system which will operate across Berkshire East
- The needle exchange scheme has expanded but there are still some areas of the borough where there is no coverage which could lead to an increase in the spread of Blood Borne Viruses. Viral hepatitis and HIV are very serious illnesses which can be transmitted via the bloodstream, so injecting drug users are at particular risk. National guidance for preventing the risk of blood-borne viruses in drug users, includes maintaining needle exchange facilities; ensuring hepatitis B vaccination is available; improving access to general health checks, and hepatitis C and HIV counselling, testing, and treatment.

* Class A Includes heroin, crack cocaine, cocaine, ecstasy, hallucinogens (LSD and magic mushrooms), methadone, methamphetamine and any Class B drug that has been prepared for injection.

Class B Includes amphetamine and cannabis.

Class C Includes ketamine, anabolic steroids, GHB and amyl nitrate.

Monitor number of drug users accessing effective treatment services

The adult DAAT needs assessment identified

- In 2007/08, 82% of clients were retained in treatment for 12 weeks or more and 90% were either retained or their treatment episode of treatment was completed successfully
- The number of Crack Cocaine users in effective treatment, 92%, is significantly higher than both regional (81%) and national (83%) levels.
- The main drug of choice remains the same as 2006/07, Heroin followed by Cocaine
- The number of problem drug users in treatment on 31st March 2008 was 97 which was a significant increase from the same date in 2007 (52). Problem drug users are classed as those using either opiates or crack cocaine or sometimes using both drugs together.

Key issues to improve effectiveness of services

- Low use of non pharmacy needle exchange
- Lack of referrals from prescribing service into through and aftercare services
- Low numbers attending drop in sessions
- Clients unable to move into community prescribing services
- Low numbers of referrals into group programme from Probation via Drug Rehabilitation Requirements.
- Interventions that should be time limited are lasting too long and treatment providers are not regularly reviewing progress or referring on

Where does the evidence come from?
Drug Strategy 2009/ Drug misuse needs assessment 2008 / Place Survey/Tellus3/ Prevalence_data/docs/0607/default.aspx/Numbers of people in treatment available at NDTMS/ DAAT Young People's Needs Assessment 2007 / 08

Needs by health and wellbeing determinant
Individual lifestyle / risk factors

Alcohol misuse data

The national Alcohol Harm Reduction Strategy (CO, 2004) requires improved action on education and communication, access to prevention and treatment services, a reduction in binge and chronic drinking and action on reducing the harms from antisocial behaviour and crime (whether violent or domestic).

Local alcohol profiles

The local authority profile for 2008 for Bracknell Forest showed that many indicators within Bracknell Forest were estimated to be statistically similar to the England average. The profile highlights that alcohol related admissions for females were higher than expected but it *is important to caveat these estimates as they were based on a different profile of conditions attributable to alcohol.* Since then a recalculation of the alcohol attributable fractions has been made. This can also be found at www.nwpho.org.uk and includes up to 52 diseases (13 of which are entirely attributable and the remainder are partly attributable).

Tackle binge drinking as part of the community safety and young peoples strategy

There are no restriction orders in place in Bracknell Forest.

05/07 hospital admissions for alcohol for children and young people in the 2009 Healthcare Commission report for Berkshire East shows a rate of 390.79/100,000 for Q4 2007/8 which is above the England average (albeit based on small numbers).

Support for high risk and vulnerable groups

Mental health users, offenders and homeless people are examples of high risk groups. Specific programmes in place for domestic violence include alcohol awareness:

- Changing Ways Domestic Abuse Perpetrators Programme
- Risk assessments by Thames Valley Police and Berkshire Womens Aid

Improve the recording of alcohol related injury

This strategic priority is possible to achieve if there is additional coding support for ensuring a consistent coding schedule is used within local accident and emergency units. The Cardiff system was piloted and additional administrative capacity should be commissioned.

Reduce hospital admissions for alcohol

Raising awareness of harmful, hazardous and binge drinking levels is underway through a range of local services.

Hospital admission data for emergency and elective admissions for chronic liver disease alone may be due to a range of contributing factors. That data is available at http://www.apho.org.uk/addons/_61566/atlas.swf?filter=filter4,South%20East and shows a rising trend (albeit for small numbers) since 2006/7 for females in Bracknell at 18/100,000 compared to a levelling for Slough at 15/100,000 and for RBWM a rate of 15/100,000.

The 2006/7 baseline in Berkshire East was 1,136 per 100,000 and the adjusted plan for 2010/11 is 1,634.

Reduce the rate of alcohol related hospital admissions

A significant number of people (around 330) are admitted to hospital each year due to alcohol.

The alcohol admission rate for Bracknell Forest for 2007/8 was 1104/100,000 which is below the rate for its statistical neighbours and for the Southeast (at 1264/100,000). By contrast the Slough rate was 1,512 and RBWM 1,031. The Berkshire East target is to halt the rate of alcohol related admissions.

Bracknell Forest does not have the same volume of night time crime related to alcohol to that reported in Windsor but when examined by place of residence (as opposed to place of offence) there is a continuing trend upward in this and domestic violence incidents. Drunken or rowdy behaviour is still a cause for concern in the Place Survey 2009.

Bracknell has local neighbourhood pubs and 2 main night clubs, one in the town centre and one just outside the town centre. This can lead to large groups of people travelling between pubs and then onto the clubs which can in turn lead to flash points for violence or criminal damage to occur.

A number of the neighbourhood pubs have extended opening hours and often have disco's or live music on Friday and Saturday nights. Some incidents can be linked to the staggered opening times of local public houses and refusal to allow entrance after a specific time. This can lead to raised tensions and to flash points. Other hot spots are where large number of people converge i.e. Taxi ranks and Kebab Shops and two local night clubs.

The way that crimes are recorded does not always highlight the link to alcohol making identifying the exact levels of alcohol related crime in Bracknell Forest difficult, however with the data that we can access it is clear that the problem is increasing.

The 2007/08 British Crime Survey figures show that there were 1,706 recorded crimes of Violence Against the Person in Bracknell Forest. Bracknell Forest has a bespoke designed data base, CADIS (crime and disorder information system), which is used to record all police non-crime incidents and anti social behaviour. In the year from April 07 to March 08, there were a total of 10,455 reports entered on to the data base. This database holds information on and provides us with a strong indicator of those issues that are of concern to the public. Of these reports 5,916 were reported via the police and 432 of these reports were directly linked to alcohol. The other reporting agencies, fire service, local authority and parish councils do not include specific data on alcohol.

There are links between domestic abuse and alcohol, although it is not an underlying cause of the abuse. The causes of domestic abuse are more deep rooted than simply the effect of intoxication or alcohol dependency. Many who drink too much do not abuse their partners or family members.

If an abuser is alcohol dependent, it is important that this is treated in tandem with addressing the violent and abusive behaviour. Addressing only one without the other is unlikely to prove successful.

Victims of domestic abuse may also turn to alcohol as a form of escape from the abuse. Sometimes abusers will use their partner's dependency as an excuse for violent/abusive behaviour, or they may use it as a further way of control over the victim.

For incidents of domestic abuse where police attend, a risk indication form is completed where the victim is asked a series of questions, including whether they or the alleged offender have an alcohol, drug or mental health problem. If identified, specialist domestic abuse officers can signpost and make relevant referrals. A voluntary perpetrator programme in Berkshire East, called Changing Ways, is available for violent and abusive men wishing to change their behaviour. As part of their assessment they are asked about their use of drugs and alcohol.

The table below details the number of Domestic Abuse Incidents recorded by Police, and the percentage of them where alcohol was identified as being a risk factor.

Year	No of incidents	No alcohol related	%
Bracknell 2007/08	1675	391	23.3 %
Bracknell 2008/09	1714	409	23.9 %
RBWM 2007/08	1703	419	24.6 %
RBWM 2008/09	1672	423	25.3 %
Slough 2007/08	3680	790	21.5 %
Slough 2008/09	3563	875	24.6 %

NB. This does not mean that alcohol was necessarily involved during that particular incident, and does not identify whether it is the victim or the alleged perpetrator who has alcohol issues.

Commission a comprehensive alcohol service based on models of care

National guidance has been released on optimum interventions across all four tiers for reducing harm from alcohol. Cost effective interventions include commissioning a specialist alcohol nurse which can save £1138 per dependent drinker treated. Direct enhanced services can also save 15 readmissions per month where local GPs are trained to use the Audit tool. The use of the Paddington alcohol test in A+E to screen all those who have had falls, collapse, head or other medical conditions is also promoted.

An alcohol commissioning plan has been developed in each of the three unitaries in East Berkshire and tendering for revised alcohol services is currently taking place.

Tier 1 and 2 services

Practice based commissioning plan improvements to date have centred around GP provision of tier one and two services as noted in DH Models of Care. The latest estimate of need for Level 1 and 2 services in Bracknell Forest is now dated (2006) and should be updated in 2010. In 2007 Berkshire East Primary Care Trust (PCT) produced estimates relating to the drinking habits of 16-64 year olds. They based these figures on national estimates provided by the Alcohol Needs Assessment Research Project (ANARP).

Estimate of problem drinkers (16-64) in NHS Berkshire East for 2006

It is estimated that 6% of Men and 2% of Women are Alcohol Dependant, 32% of Men and 15% of Women drink hazardous or harmful levels of Alcohol and 67.1% of People are 'Low Risk' alcohol users. When applied to the population of Bracknell Forest (39,900 men and 39,500 women) we find we have an estimated 2,390 Males and 790 Females who are Alcohol Dependant, 12,800 Males and 5,900 Females who drink hazardous or harmful levels of Alcohol and 53,000 People who are 'Low Risk' alcohol users. This would mean there could be 3,180 people who need treatment for their alcohol dependency and a further 18,700 might benefit from health education or some form of brief intervention to curb their hazardous and harmful drinking.

Practice based commissioning plan improvements elsewhere in Berkshire East have centred around GP provision of tier one and two services as noted in DH Models of Care. Work on tier 3 and 4 provision is informed by the Berkshire Priorities Committee report.

Tier 3 Alcohol treatment services

Those in the criminal justice system can be referred to the alcohol arrest referral worker but other heavy and dependent drinkers are referred to BDASS (Berkshire Drug & Alcohol Specialist Service) which is the only tier 3 alcohol treatment service in East Berkshire (approx. 390700 residents MYE 2008) and is over capacity. The service was designed to take only clients with a significant problem, however because there are no 'open access' drop-in alcohol services in RBWM, Slough or Bracknell Forest, it has to see clients with a range of needs.

The provision of specialist residential treatment (tier 4 services) is informed by the Berkshire Priorities Committee report.

The National Drug treatment services database reports that for Q1 2009 20 different suppliers of tier 4 residential treatment services were working with Berkshire East residents. None of these services are based in Berkshire.

Alcohol tier 4 treatment data collected for Berkshire East as a whole can be accessed each quarter at /www.ndtms.net/alcohol.aspx?level=datagcy&code=5QG&vernum=15&submit=go .Berkshire East figures reported for Q1 2009 showed that 20 different suppliers of treatment services were working with Berkshire East residents

Month	No. In Treatment	New Presentations	No. In Treatment - YTD	Discharges
Apr-09	333	34	333	21
May-09	344	31	363	34
Jun-09	355	38	399	11

Tackle social problems associated with alcohol

The results of the Place survey show that over half (51.6%) of residents in the Borough think that rowdy or drunk behaviour in public places is a significant problem in Bracknell.

Under the Licensing Act 2003, Bracknell Forest Council Licensing Authority must promote the Licensing Objectives, which include the Prevention of Crime and Disorder and Prevention of Public Nuisance. The Licensing Authority aims to ensure that licensed premises have good operating practices, which can assist in reducing the potential for crime and disorder which can result from alcohol misuse. An example of good practice would be for licensees to be a member of the Bracknell Pub and Drug Watch scheme. This scheme encourages the sharing of information and seeks to address matters such as under-age sales, problems associated with drunkenness and anti-social behaviour. The

Licensing Authority may in certain circumstances attach necessary and proportionate conditions to premises licences to ensure the promotion of the Licensing Objectives.

In order to ensure compliance with the law and licensing conditions, the Licensing Authority carries out regular inspections, based on risk assessments, complaint history and intelligence. The Licensing Authority, Trading Standards Team and Thames Valley Police work in partnership to monitor premises to detect if alcohol is being sold to intoxicated or underage persons.

Where does the evidence come from?

Alcohol Harm Reduction Strategy/NWPHO The LA model is available at http://www.nwph.net/alcohol/lape/LAProfile.aspx?reg=j /East Berkshire alcohol misuse health needs assessment 2006 / HCC report 2009/Place Survey 2008/9 ➲ / Hospital admissions due to alcohol / Audit Commission summaries/Berkshire Priorities Committee report on the effectiveness of detoxification services 2008./Signs for Improvement Commissioning Interventions to Reduce Harm/ Hospital admissions available at www.apho.org.uk/addons/_61566/atlas.swf?filter=filter4,South%20East Bracknell licensing policy available at http://www.bracknell-forest.gov.uk/licensing-policy-january-2008.pdf

Needs by health and wellbeing determinant
Individual lifestyle / risk factors

Obesity, diet and exercise

The Berkshire East Obesity strategy (2008) has been linked with Local Area Agreement priorities to increase levels of adult physical activity, reduce childhood obesity in year 6 and promote cycling and walking. There is also a widespread commitment in general practice to promote physical activity and reduce obesity levels as obesity is known to be causally related to outcomes such as cardiovascular disease, diabetes, high blood pressure, depression, infertility, some cancers and higher risks of perinatal mortality.

The local analysis of the annual National Child Measurement programme inform activity with children and families. For reception year no areas in Bracknell Forest were above the mean for Berkshire in 2008/9.

Figure 10 Prevalence of childhood obesity in reception by ward (source local NCMP 2008/9)

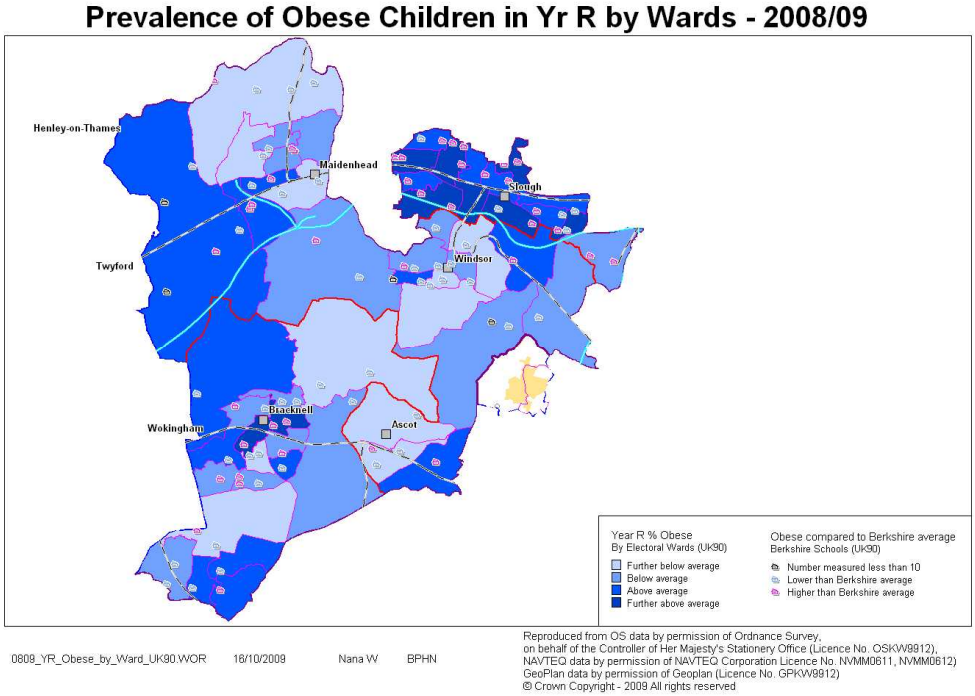
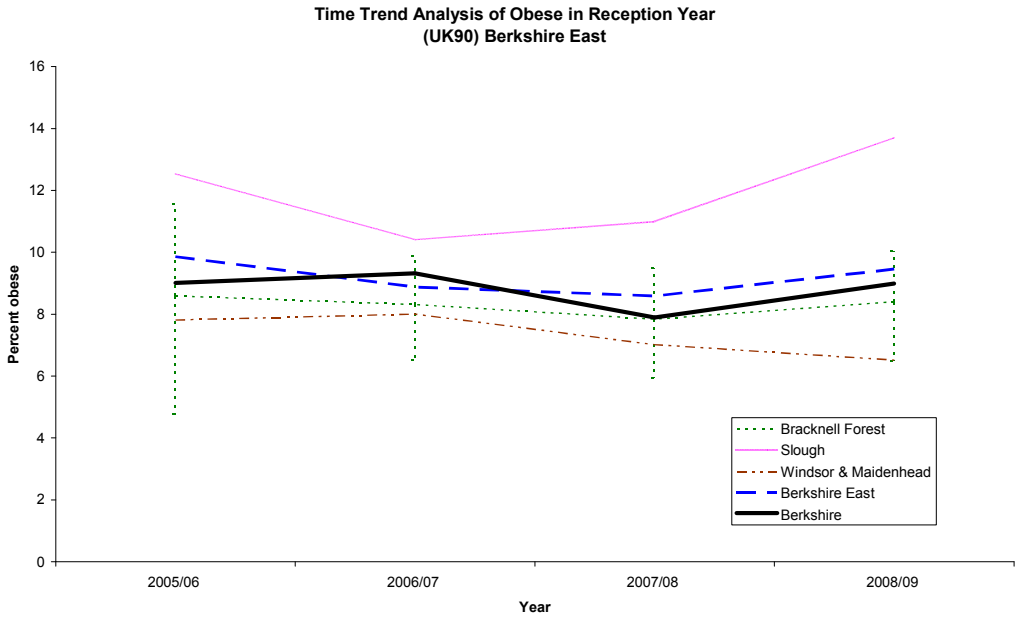


Figure 11 Trend in childhood obesity in reception by locality (source local NCMP 2005/6-2008/9) The trend in reception year obesity levels over the first four years of the NCMP are shown below

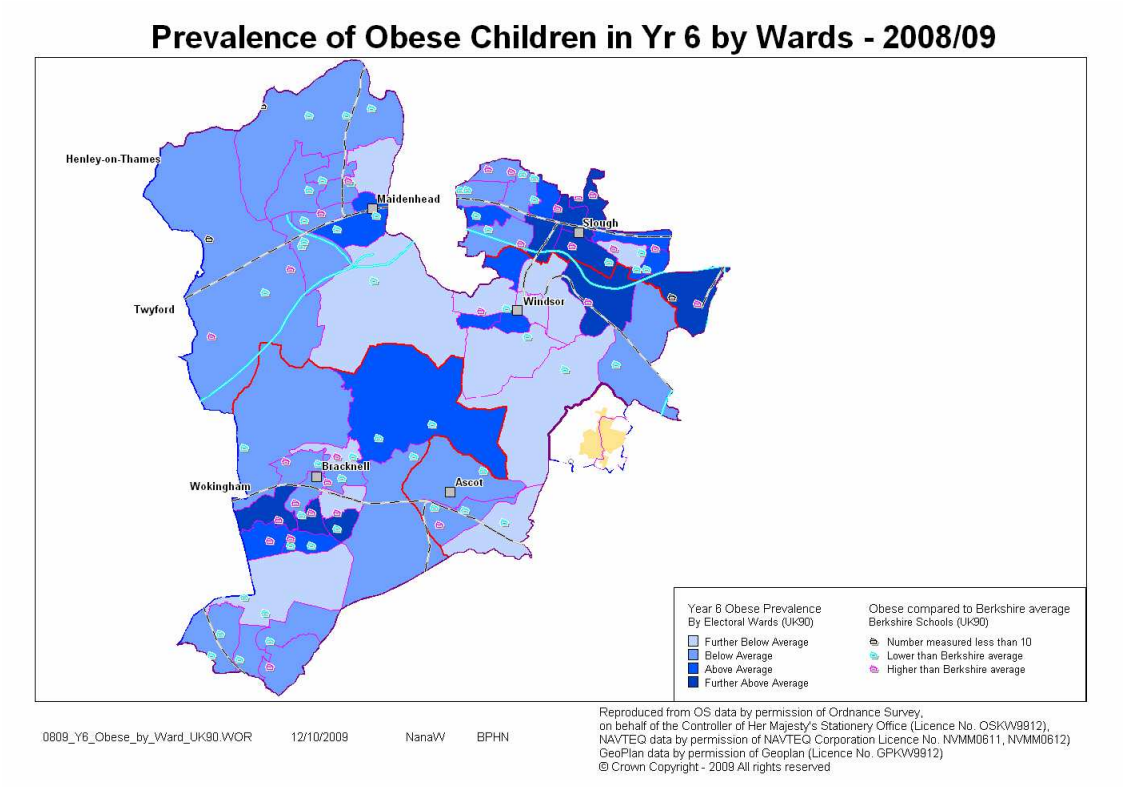


The 2009 Southeast Public Health Observatory report on the quality of the data indicates that changes to date are not statistically significant but the rising trend is of concern nationally

It is important to note that reception year results have decreased over the previous three years in Bracknell Forest but have started to show an increase in 2008/9. The increase is not statistically significant.

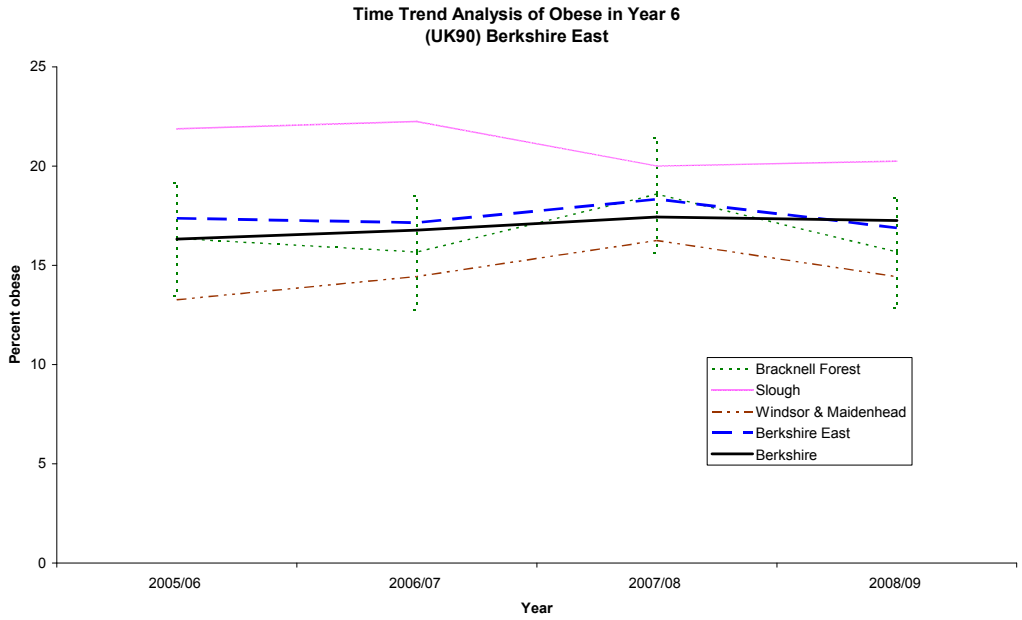
Whereas rates for year 6 pupils shown below indicate that wards such as Great Hollands South, Old Bracknell and crown Wood have higher rates (although not statistically so) and in line with the Southeast average

Figure 12 Prevalence in childhood obesity in year 6 by ward (source NCMP 2008/9)



The local analysis of 2008/9 data will be confirmed by the Information Centre shortly.

Figure 13 Trend in childhood obesity in year 6 by locality (source NCMP 2005/6 2008/9)



A key target to sustain is the percentage measured as higher than 85% is required to accurately estimate prevalence.

The numbers of children measured in 2008/9 by Berkshire East Community Health Services in each local authority are shown below

Local NCMP measurement targets

	Reception year		*Year 6*	
LA of school	*Number measured*	*% measured*	*Number measured*	*% measured*
Bracknell Forest	***988***	***86.8%***	***1104***	***88.7%***
Slough	***1126***	***86.2%***	***1285***	***84.7%***
Windsor & Maidenhead	***1213***	***92.7%***	***1151***	***88.3%***
Berkshire East	***3327***	***88.6%***	***3540***	***87.1%***

Local analysis of NCMP prevalence 2008/09.
Total percentage overweight and obese girls in year 6, Berkshire East PCT

	UK1990 Classification		*IOTF Classification*	
LA of residence	*% Overweight*	*% Obese*	*% Overweight*	*% Obese*
Bracknell	***29%***	***17%***	***26%***	***6%***
Slough	***32%***	***17%***	***27%***	***7%***
Windsor & Maidenhead	***25%***	***14%***	***22%***	***6%***

This data must be viewed with extreme caution as each year is a new intake and not comparable to previous years. In addition due to boundary issues and data collection in Surrey and Buckinghamshire the National Information Centre rates **will differ**. The NIC rates are the rates by which each local authority is monitored for the LAA. It appears that Bracknell Forest still has a challenge to meet the LAA targets for 2010/11 even though the local prevalence appears lower than the Southeast average for 2007/8.

Commission evidence based interventions to reduce obesity①

The Healthy Weight Healthy Lives national commissioning guidance notes the evidence base for multifactorial family based approaches. Reduced weight and increased fitness levels also contribute to improved self image and mental wellbeing, which is a priority for all three Children's Trust Plans. Mental well being and tackling obesity are also key elements of the Darzi Next Stage Review which requires every PCT to commission comprehensive well being programmes for adults and children.

Introduce the Change4life programme in Bracknell Forest ①

The Change4Life social marketing segmentation has also just been released and will inform the recruitment strategy for various family based weight management programmes. It is also being used to support the healthy eating and physical activity themes of healthy schools.

A healthy diet includes regular fruit and vegetables; of those children who participated in the Tell Us 3 survey 27 % stated they ate 5 or more portions of fruit and veg every day, compared to 23% nationally.

NCMP clusters 1-3 will be targeted for increased cooking skills and confidence and offered a range of physical activities.

Continue to encourage breastfeeding

For young babies, breast milk is the best source of nutrition; the proportion of new mothers who start breastfeeding (68.3%) is below the rest of East Berkshire (over 75%), and antenatal visits to discuss breastfeeding should be offered to all pregnant women. Rates of breastfeeding in some wards have improved but are still below the average for the PCT area as a whole. The Family Nurse Partnership has been promoted by the Department of Health as an exemplar early years intervention. The peer support for breastfeeding programmes will be commissioned to extend the support available to mothers as will the Baby Friendly programme.

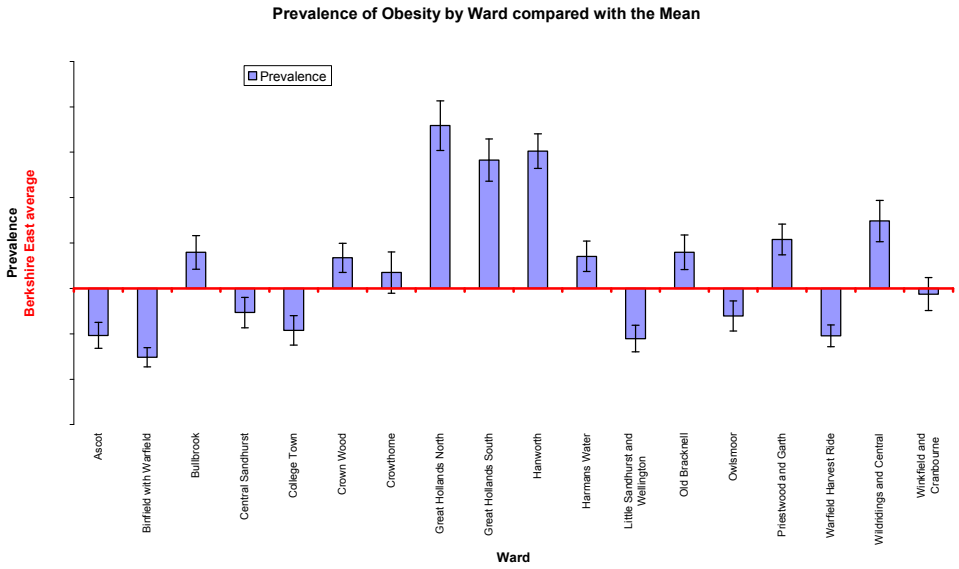
Overall in Berkshire East targets are set for breastfeeding rates at six to eight weeks for both prevalence and coverage. Prevalence rates in 08/09 were 44% and in Q1 for 09/10 were 53%. Coverage in 08/09 was 73% and by Q1 was 87%. Bracknell Forest's prevalence in 08/09 was 43% and coverage was 67%.

Improve the quality of information on adult obesity rates ①

The Foresight report (2008) suggests that over a fifth (21.9%) of adults in Bracknell Forest are estimated to be obese. The actual distribution is unknown as the quality and outcomes framework only requires information on BMI to be collected when a person is over the age of 16 and when the person visits their GP for a health check.

The results of the QoF analysis for 2008/9 show that adult obesity varies as shown below. This could however be a function of reporting thresholds.

Figure 14 Adult obesity rates relative to the mean by ward (source QoF 2008/9)



Improved recording of BMI will be promoted through locally enhanced services commissioned as part of the vascular risk reduction programme and via the direct enhanced service payments designed to improve care planning for those with learning and mental health difficulties.

Increase levels of physical activity in children and adults①

Exercise is one of many factors influencing many long term health outcomes such as mental wellbeing, bone density, heart health, weight management.

Physical activity levels in children were red rag rated in a national benchmark found in Health Profile 2009. 68% of children tell us they exercise at least 3 days a week, although this is still lower than the national average (73%).

According to the Sport England Active People survey less than 1 in 5 adults (24%) in Bracknell Forest currently do the recommended minimum level of exercise each week (30 minutes of moderate activity on 5 days). A sustained advertising programme called the BE3 campaign is underway to encourage walking and to promote the benefits of exercise

Where does the evidence come from?

NHS Berkshire East obesity strategy/ Sport England Active People Survey on DCLG hub / NCMP rates on the Information Centre site / / TellUs3💬 / Children & young people's plan progress check / School meals consultation / Breastfeeding initiation rates / Children & young people's plan update 2006-9💬
http://www.ic.nhs.uk/webfiles/publications/ncmp/ncmp0708/Tables%20for%20NCMP%202007_08%20report%20-%20final_updated050109.xls#LEA!A1

Needs by population group

Children & young people

The five themes of be healthy, staying safe, enjoying and achieving, achieving economic wellbeing and making a positive contribution all have their own action plans and priorities as laid out in the Children's Trust update for 2009.

This section does not include those priorities already noted elsewhere (see sections on educational outcomes, safeguarding, sexual health and teenage pregnancy, healthy eating and physical activity, learning disabilities).

Children's centres to be developed by 2010

Up to eight children's centres are planned by 2010. Three of the phase 2 centres have been awarded full core offer status, with the remaining centres due to achieve full core offer status by 2010.

Making a positive contribution

The Children's Trust monitors participation in positive activities for children and young people, and there are a number of priorities in the Children and Young People's Plan to support this outcome. A Children and Young Peoples version of the plan exists - produced by young people. The Hear by Right framework has been agreed by the Children and Young People's Trust.

The Youth Offending Service has actively engaged in youth crime prevention and early intervention, contributing to good performance re first time offending.

The Anti-Bullying Strategy has trained young people as peers mentors in "Safe to Learn" and this is rolling out across all schools in the borough.

The overall figure determined from the Tell Us 3 Survey [2008] to support the National Indicator NI 110 – Children's participation in positive activities was 85.2% which is significantly higher that the national average of 69.5%.

Enable children to feel safe in public places and in their homes

The Tellus3 survey for 2008 conducted with pupils in Years 6, 8 and 10 noted that 52.6% felt they had experienced bullying which is slightly higher than the England average 50.4%.

Bracknell Forest has the third highest repeat rate of domestic violence in Thames Valley.

Reduce the number of children in low income households

Although Bracknell Forest is a relatively affluent part of England, there are significant pockets of deprivation. The Health Profile 2009 notes that 2500 children in low income households. According to the Child Well Being Index and the 2007 Health deprivation and disability domain over 1 in 5 children (22%) in Great Hollands North live in poverty, a figure above the South East England average (19%).

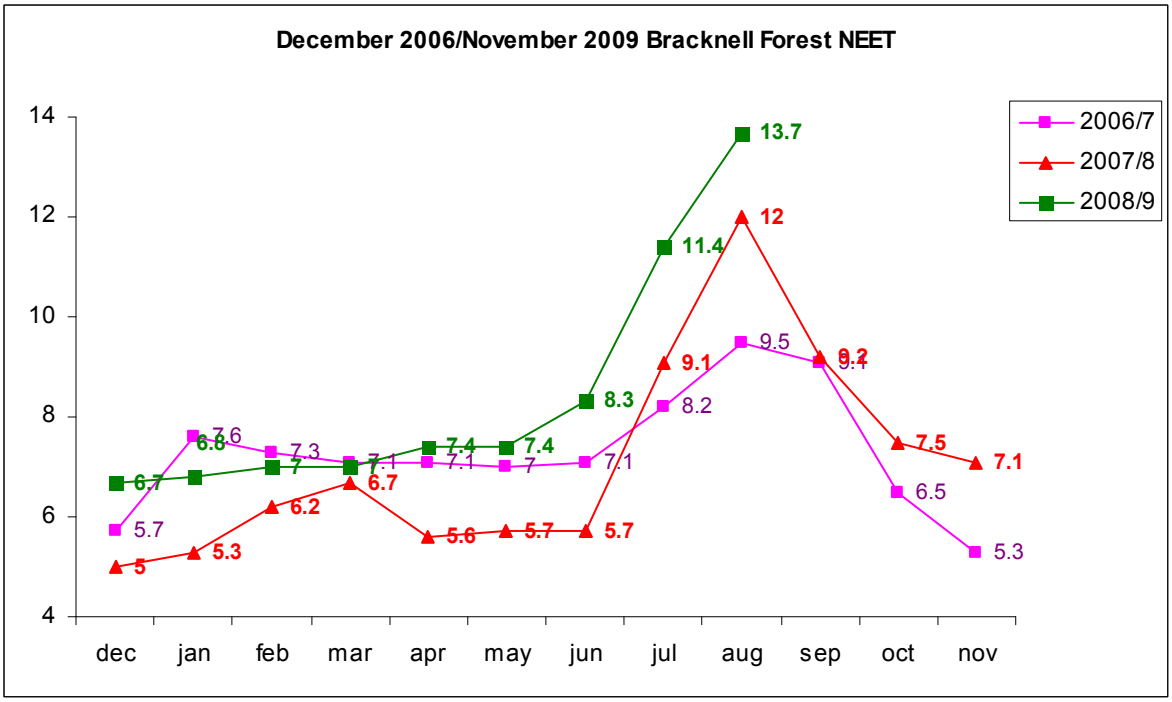
Improve access to education, training and employment post-16

National indicator 117 sets a target to reduce the percentage of 16 – 18 year olds in the population of Bracknell Forest who are not in education, employment or training (NEET) to

4.8% by 2010. The past 9 months have been challenging in terms of the opportunities available for young people especially those with little or no qualifications and were in employment. Despite stringent efforts the already challenging NEET target of 5.0% was not achieved and 2008/9 figure of 6.8% showed a rise from the previous year.

Access to education, training and employment after the age of 16 could be improved for some vulnerable groups, including those in, and leaving, care; a wider range of options for young adults would also be beneficial. The quality of some education provision for those aged over 16 could also be improved.

Figure 16 Trend in NEET rates by year (source Connexions)



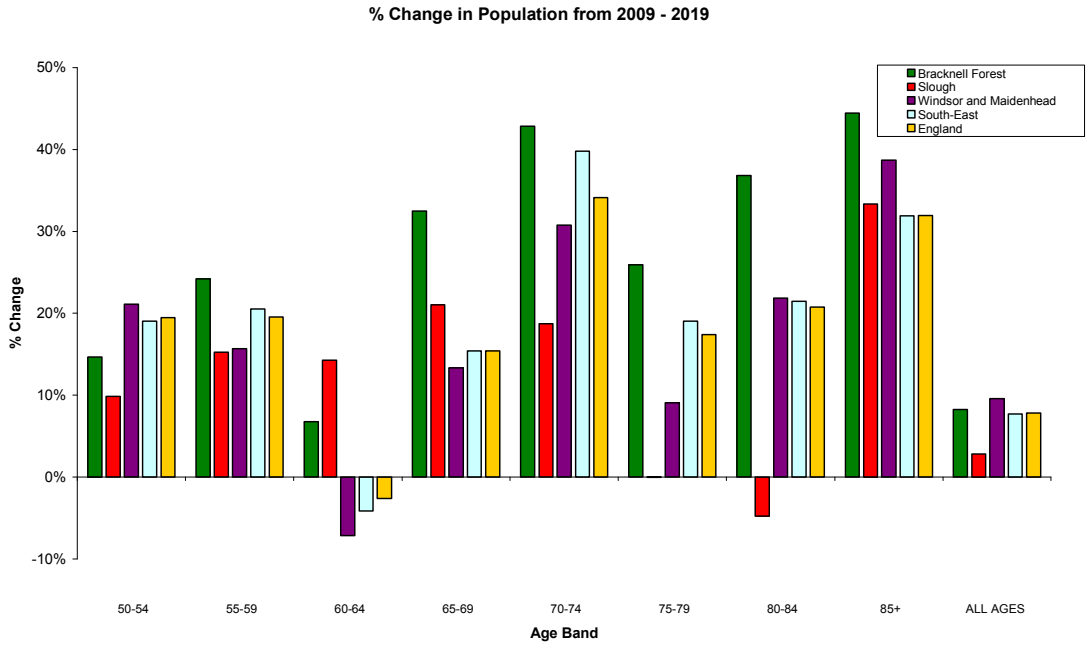
Where does the evidence come from?
Income deprivation affecting children index (IDACI) / Children & young people's plan priorities 2009/10/Tellus3 and 4 surveys/Connexions Business Plan 2009/10

Needs by population group

Older people

The percentage growth in age bands projected for the next ten years is shown below and is based on the table shown under the 'health and social care' section.

Figure 17 Percentage change in population 2009-2019 (source ONS 2006 projections)



Plan for anticipated rise in social care needs

With the projected rise in the population of older people in the Borough – an increase of roughly 1,500 people over the age of 65 between 2009 and 2019 (according to ONS, 2007) – this will have a significant impact on the number of people needing outside help in their daily lives.

Although the percentage of older people living on their own is likely to increase, in addition to an absolute rise in individuals from an estimated 2,820 in 2009 to 3,660 in 2020. Currently over 2,000 older people receive social care services in Bracknell Forest, the majority in their own home (RAP return).

Over time, it is likely that family support may also be less available because the birth rate in the Borough is projected to fall slightly, leading to a smaller teenage population in the next 10 years, and beyond that, a smaller working age population.

Help older people remain independent longer

According to the Place Survey 2008/9 NI 139 – the perceived extent to which older people receive the support they need to live independently was 25% for Bracknell Forest, 5% below the Southeast average. A similar result was achieved in RBWM 25% and Slough 24%. This is likely to be an underestimate as 63% could not answer this question.

Many older people in the area wish to stay in the own homes for as long as possible; independence with daily activities such as dealing with finances is also desired.

Older people with long-term conditions would benefit from more support to manage their illness. The intermediate care team has supported 1465 people aged 18-64 living in the community and 2014 over 65. The provision of remote log in facilities to a nurse based call centre for those with long term conditions is to be piloted in Bracknell.

Improve influenza vaccination uptake

Although over three quarters (75.8%) of the local population of older people is currently receiving the annual influenza immunisation, this rate is slightly below the regional average (77.4% for NHS South Central area) (HPA data). The higher the rate, the better the population is protected against influenza which, in older people and other risk groups, can sometimes be life-threatening. The roll out of the H1N1 vaccination programme will be subject to clinical trials and will be targeted to the most vulnerable groups.

Plan to improve the quality of life for people with dementia

The national dementia strategy (DH and Social Care, 2009) requires a joint commissioning framework to be developed.

As there is a projected increase in the population of older people in Bracknell Forest, it is anticipated there will be a higher incidence and prevalence of dementia. Subsequently, there will be a need for more services and support for people with dementia and their carers. Using national dementia prevalence figures and population projections, it is estimated that in 2008 there were approximately 900 people with dementia living in Bracknell Forest. At any point in time, approximately one third of these people (315) are receiving support funded by adult social care, with the majority receiving support in the community. The number of people with dementia receiving support from adult social care is likely to rise by 20%, to 378 people, over the next 5 years.

Using a simple pro rata increase based solely on population growth (5000) a further 25 cases would be expected. (See Mental Health section for practice prevalence from GP registrations).

Improve availability of dedicated 'end of life' care

In East Berkshire recent analysis of 2007 place of death data showed that 71.2% people died in hospital (including convalescent homes) 9.3% died in a hospice compared with their home (17.1%), compared to a small local survey which found that two thirds (66%) of people wished to die at home.

Improvements have been suggested for availability of dedicated support for 'end of life' care, including improving training opportunities for staff, information on services for carers, better access to designated palliative care service and beds out of hours and at weekends, process for accessing drugs, the absence of a rapid response service across Berkshire East, improved links with OOH services who may not be aware of terminally ill patients and how to communicate across the patch, lack of a 24 hour district nursing service.

A locally enhanced service will monitor the care registers and will provide a named doctor and key worker for every patient on the register.

Enable people to feel safe

The 2008 Place Survey analysis notes that at night people living in Great Hollands North and South, Priestwood and Garth, Wildridings and Central, Harmans Water, Old Bracknell and College Town report feeling less safe. Fear reduces peoples ability to go out and

participate in physical activity and could contribute to poorer health outcomes. Improving street lighting and other community safety issues is a major priority.

Where does the evidence come from?

RAP P1 / ONS population projections / Health profile / Immunisation uptake data / Commissioning Strategy for Older People's Services / East Berks end of life review/2007 Place of death summary/ Commissioning strategy for people with dementia 2009-2014. Original data from ONS (data extract 2008) and Mental Health Observatory 2008.

Community cohesion and the needs of black and minority ethnic (BME) communities

A review of the Community Cohesion Strategy 'All of Us' (2008/9-11/12) notes that its objectives are ensuring everyone has similar life opportunities; there are positive relationships between people; the diversity of people their circumstances and their communities is respected and valued; and support is provided to ensure communities are built and strengthened.

The Community Cohesion and Engagement working group is addressing the issues of increasing volunteering and developing relationships and communicating with various ethnic groups in culturally sensitive ways; examples include work with the Berkshire Travellers Forum, members of the Nepali and Muslim communities. A Migration Impact Fund bid has also been secured for training and providing guidance to teachers in supporting pupils with English as an Additional Language.

Detailed ethnic mapping completed by Experian has increased understanding of the make up of local ethnic communities. This is kept up to date by reviewing the Schools Census Data and DWP National Insurance Registrations data annually, supported by information from the development workers network led by Bracknell Forest Voluntary Action and Bracknell Forest Council. There is also regular engagement with the Bracknell Forest Minorities Alliance, an umbrella group representing BME groups in the borough, to identify community needs and aspirations.

The 2008/9 Place Survey notes that 82.1% of local people surveyed believe that people from different backgrounds get on well together placing Bracknell Forest in the top quartile of local authority areas nationally. 51% of people believe they can influence decisions in their local area. 20.6% of people participate in regular volunteering which is below the All England average of 23%. Civic participation in the local area was 9% compared to a national percentage of 14%.

Many health and wellbeing needs have been already identified such as the increased risk of diabetes and heart disease in South Asians. These are listed under those sections.

Reduce HIV spread in BME communities

Individuals of Sub-Saharan African descent make up a disproportionate number of new HIV diagnoses in the rest of East Berkshire (nearly half of all new diagnoses), so efforts to reduce HIV spread should actively involve this community.

Improve access to health and education for Travellers

With a significant traveller population in Sandhurst with their own specific health needs, the area would benefit from a specialist traveller health worker.

It is known that Traveller communities have significantly poorer health status than other minority groups. Particular causes of this are levels of smoking, and access to education and GP services.

Cultural beliefs which currently pose barriers to immunisation (HPA report 2009) may take many years to implement, as technical improvements (such as the replacement of intramuscular delivery by skin patches) are not due in the immediate future.

Improve access to health services and health outcomes for migrants

The HPA, NHS Berkshire East, SEPHO, the University of Oxford and local unitary authority partners will be undertaking a brief research project across NHS South Central to examine the needs of local migrants to inform service optimisation locally prior to the expected increased demand from the former Gurkha community.

Nationally Dr Ruth Hussey Regional DPH North West noted that CEOS, SHAs and Directors of Adult Social Services had noted the following across England.

'The vast majority of migrants are young and healthy and are here as economic migrants or as students.

A small number of asylum seekers may present with complex medical problems in relation to

- poor physical and mental health; e.g dental and nutritional health can be poor; an impairment or disability may have occurred as a consequence of torture or previous injury.
- Some may have come from countries with a high prevalence of infectious diseases such as TB, viral Hepatitis and HIV and where political and social unrest have disrupted immunisation and treatment programmes.
- In black and minority ethnic communities there is an increased risk of psychosis among migrant populations; with an incidence two to eight times higher than for the host population, and this effect extends to second and subsequent generations.
- Many refugees will experience mental distress as a result of their experiences and this can be confused with mental illness, some however may have been tortured in their home countries
- Antenatal care can be complicated by high prevalence of Female Genital Mutilation amongst asylum seekers, who may also have experienced rape/sexual violence with associated sexually transmitted diseases or HIV in their home countries.
- A significant part of the NHS and Adult Social Care workforce is made up of migrants. Of all Doctors in the UK 38% (90,000) qualified abroad, while nearly 50% of new dentists come from overseas.

Whilst Bracknell Forest does not have the same volume of migrants as for example Slough it will benefit from the learning from this research as a commissioning toolkit is planned as a product of the research

Where does the evidence come from?
Community Cohesion Strategy 2008 / East Berkshire Sexual Health needs assessment 💬 / Travellers' needs assessment 💬 / Health status of Gypsies and Travellers in England 💬

Needs by population group

Long Term Conditions

RAP returns for May 2009 indicated that Bracknell Forest adult social care provided services to 2283 people with a physical disability or temporary illness in 2008/9, to 953 people with a mental health problem of which 77 were over 65 and had dementia, and to 267 people with learning disability.

Definitions of long term conditions include those which cannot be cured such as asthma, diabetes and chronic obstructive disease. The long term conditions National Service Framework referred to neurological conditions.

The council's needs assessment was limited to those people of working age and to those who did not have a learning disability, sensory impairment, dementia or other mental health problem in 2008. This will be refreshed to include all ages and all care groups in 2009 to ensure that there is consistency of planning.

Plan for an increase in people with long-term conditions

Simple projections of need based on ONS population estimates and the quality and outcome registrations show that the top four long term conditions that will grow in the next five to ten years are; COPD, CHD, stroke, and heart failure - as a function of the ageing population.

Projections of long-term conditions are based on 2005/06 QOF data applied to the 2006 population. Projections use the expected distribution of people with conditions by gender and age-group reconciled to the original expected numbers on QOF registers in Berkshire East.

	2009	2014	2019	% Change
CHD	2958	3275	3637	23%
Heart Failure	325	366	425	31%
Stroke	1264	1400	1557	23%
Hypertension	10890	11745	12731	17%
Diabetes	3383	3674	4001	18%
Epilepsy	608	618	636	5%
COPD	1134	1293	1470	30%
Cancer	760	814	889	17%
Hypothyroidism	2699	2984	3303	22%
Mental Health	545	553	569	4%
Asthma	6686	6898	7152	7%

Individual ward reports are shown for respiratory, cardiovascular and mental health problems under the relevant sections.

The number of people with long-term illnesses in Bracknell Forest, will rise from 32,824 (DWP 2008) to 43,590 people in five years. Bracknell Forest Council is redefining the current care management process across adult social care and introducing a system which facilitates self directed support.

The number of people with long-term illnesses in Bracknell Forest, will rise from 32,824 (DWP 2008) to 43,590 people in five years – and health and social care will need to adopt transformational practice to enable people to purchase their own care with advice on what is effective practice.

Reduce inequalities for those with long term conditions

Although fewer residents in the Borough generally considered themselves to have a 'limiting long-term illness' (11.7%) than the South East (15.5%) or England average (17.9%), the wards with the highest number affected in the working-age population were Crowthorne, Wildridings & Central, Great Hollands North and Old Bracknell, which are also some of the most deprived.

Risk factors identified for people with long term conditions include deprivation; inequality in access to income, wealth, housing and living in a healthy environment, education, employment and poor access to transport.

The commissioning priorities highlighted in the BFC Long Term Conditions Strategy include:

- Work with providers to ensure provision of flexible services which are culturally appropriate and equally available to everyone
- Improve access to suitable community and public transport
- Promote the involvement of local people in policy development and decision making
- Make access to information more widely available
- Assist people to gain control of their lives by promotion of self directed support
- Raise the profile of people with long term conditions in local housing strategies
- Support more people with long term conditions to find or return to work

Where does the evidence come from?
RAP 2008/9/Limiting long-term illness data DWP /BFBC Long-term conditions strategy 2008 / Long-term conditions projections BEPCT 2009

Needs by population group

Physical and Sensory Needs

The long term conditions needs assessment (BFBC, 2008) noted that disabled people who are working are more likely to be living in poverty earning on average half that of people without a disability. Educational qualifications are rare and half are unemployed. Hate crime and harassment has been reported by a quarter of those disabled, housing and transport problems are major issues.

Improve estimates of those with a physical and sensory need

The existing commissioning strategies are based on Census data and inevitably as time progresses estimated changes vary between the resident population as estimated by ONS and the registered population as recorded by GP practices which is then rationalised to the unitary authority area. The latter population is called the attribution data set.

Severe disability allowance covers all disabilities - people with mental health problems, learning disabilities, physical disabilities. If RAP figures only were used to estimate physical disability then it would be misleading. The RAP figures cover only people paid for from the ASC budget. Due to the affluence of the area, many people pay for themselves or are signposted to alternative forms of support.

Bearing this in mind RAP returns for May 2009 indicated that Bracknell Forest adult social care provided services to 2283 people aged 18+ with a physical disability or temporary illness in 2008/9.

National estimates of childhood disability can be found at www.chimat.org.uk and are based on the Thomas Coram Units research, the General Household Survey and the Family Fund Trusts register. Based on this they note that

The number of disabled children in England is estimated to be between 288,000 and 513,000 by the Thomas Coram Research Unit (TCRU). The mean percentage of disabled children in English local authorities has likewise been estimated to be between 3.0 percent and 5.4 percent [1]. If applied to the population of Bracknell Forest UA this would equate to between 750 and 1350 children experiencing some form of disability.

Severe disability is proportionately higher in families of semi skilled lower income groups.

Priorities within the 2008 Aiming High Strategy

The Aiming High short breaks strategy is just one aspect of provision under the wider national strategy which will be completed this autumn to include work on Transition to adulthood, Early Support and Parental Participation.

The government requirement is to address the following priorities

- CYP with ASD who may also have other impairments such as severe learning disabilities or have behaviour which is challenging
- CYP with complex health needs which includes those with disability and life limiting conditions, as well as those with other impairments eg physical, cognitive or sensory impairments
- CYP aged 11+ with moving and handling needs that will require equipment and adaptations eg with physical impairments and possibly cognitive and/or sensory impairments
- CYP where challenging behaviour is associated with other impairments eg severe learning disability
- Young people aged 14+ who are severely disabled and require services that are age appropriate

The development of the Bracknell Forest Aiming High Strategy involved consulting with local parents to identify what their priorities are, they identified the following:

- Children with ASD (with SLD of significant behavioural problems)
- Children with complex health needs
- Children aged 11+ with physical impairments
- Children with challenging behaviour and a disability
- Severely disabled young people 14+

Implement the Aiming High Strategy for disabled children

The Aiming High strategy (BFBC, 2008) for children requires four levels of response for those who are at highest risk (see section on physically disabled)

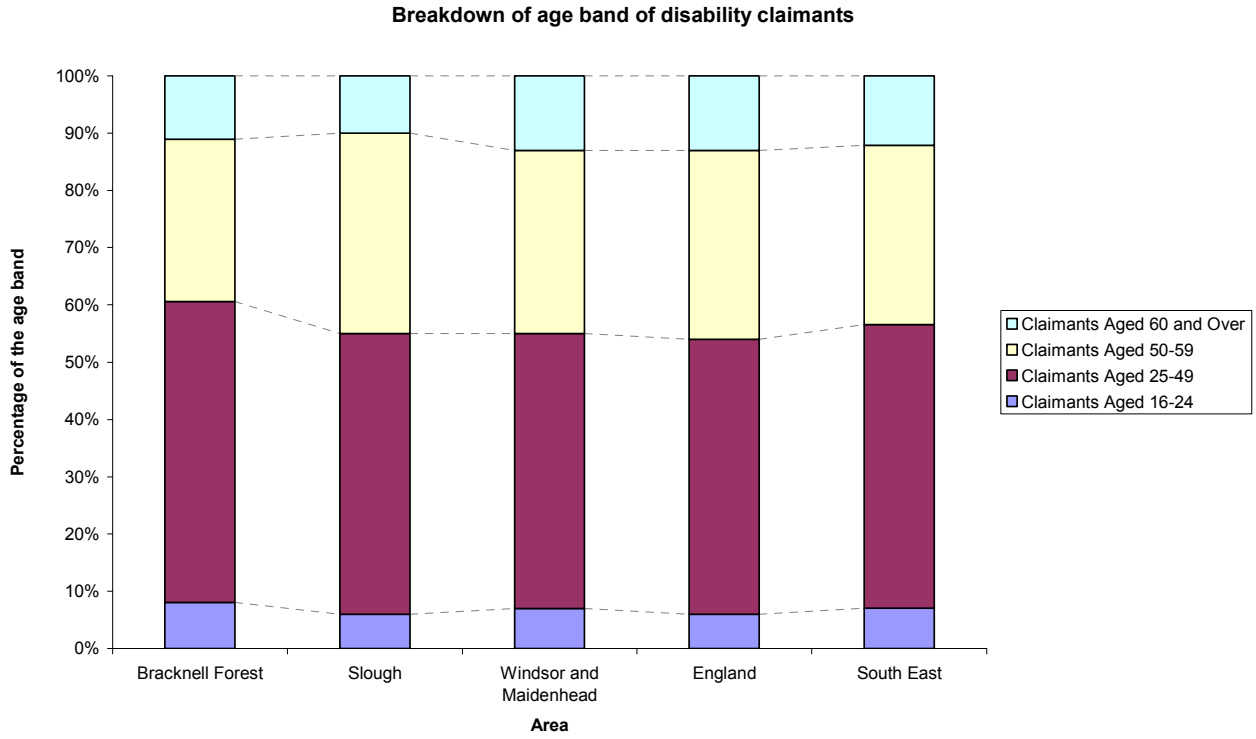
- Level 1 – Increase the use of mainstream services e.g. leisure, mainstream schools
- Level 2 – Increase the amount of targeted support and opportunities for children and their families
- Level 3 – Develop and adapt to the needs of children and their families e.g. Larchwood, Upton Park, Foster Carers, Direct Payments
- Level 4 – Ensure crisis intervention services are in place and can respond quickly

In recognition of the quality of the Aiming High Needs Analysis and plan, Bracknell Forest has been graded as low in terms of Support needed from Together for Disabled Children. Aiming High has funded or enabled a range of activities to take place, and future work will involve reviewing the short break service with parents, and looking at ways in which more effective behaviour and parenting support can be offered.

Enable physically disabled people to get into work

The 2008/9 RAP returns, report that 423 physically disabled people under the age of 65 were receiving social care services, the majority in their own homes. 1860 people over 65 were in receipt of care. 104 people were registered as being hearing impaired and receiving services in 2008, and 116 as visually-impaired. Those in receipt of severe disability allowance in August 2008 are shown below.

Figure 18 Percentage claimants by age (source NOMIS 2008



It is also worth noting that the RAP figures cover only people paid for from the ASC budget. Due to the affluence of the area, many people pay for themselves or are signposted to alternative forms of support.

Use assistive technology and information to support those with sensory needs

There are approximately 24 adults currently registered as having dual sensory loss, i.e. sight and hearing problems.
A recent review of services for the 'deafblind' in Berkshire recommended many changes to the way services are organised; that information should be provided in appropriate formats (e.g. Braille, large print etc.); and that carers of deafblind people are offered Carers' Assessments.

Where does the evidence come from?
CHIMAT disability needs assessment for Bracknell Forest/ BFBC Aiming High Strategy needs assessment 2009/ RAP P1/ Disability Discrimination Act / You know it makes sense

Needs by population group

Learning disabled

Learning difficulties/special educational needs

The Education Act 1996 gives the statutory definition of special educational needs as follows:

A child has special educational needs if he or she:

(a) has a significantly greater difficulty in learning than the majority of children of the same age

(b) has a disability which either prevents or hinders the child from making use of educational facilities of a kind provided for children of the same age in schools within the area of the local education authority

(c) is under five and falls within the definition at (a) or (b) above or would do if special educational provision was not made for the child.

Learning difficulties are characterised in education under 13 headings and there is little consistency between schools across the Berkshire East area. Achieving consistency of terminology across all three areas whilst desirable is not easily achievable as moderation of the various subjective classifications used by different schools would require significant time and additional resource. With this caveat 393 pupils with statements of special educational needs were reported in the January 2009 School Census. A much quicker way of achieving consensus is recommended below.

Learning disability (LD)

The Valuing People definition is

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- A reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development.

Since April 2009, general practitioners have been funded through a direct enhanced service (DES) to ensure that people with learning difficulties have a health check, a care plan and access to exercise. A needs assessment (Malhi, 2009) was undertaken to identify a common classification system and to provide a baseline level of those with mild, moderate and severe learning disabilities across each of the three unitaries. Malhi also cross checked the extracts with estimates in Valuing People Now based on Emerson and Hatton (2004). Based on the latter Malhi calculated that 2438 people had learning difficulties in Bracknell; 458 aged 0-19, 1769 aged 20-64, 210 over 65.

This can be compared with the results of the GP systems reclassification. A total of 902 people were classified as having any learning difficulty, 246 mild, 268 moderate and 388 severe learning disability. This indicates in line with national research that just under a half were identified by local GP services in 08/9.

Plan for a rise in number of people with learning disability

According to the Valuing People projection the number of people with severe learning disability in the Borough (all ages) will increase by about 1.4% each year from 2011 to 2021.

Commission services for those with autistic spectrum disorder

In producing the revised estimates of learning disability Malhi identified that just under a third of all children and young people aged 0-18 on the paediatric registers were either diagnosed with childhood autism or with atypical autism. Some of those diagnosed with autism will have learning disabilities.

People with some forms of autistic spectrum disorder (ASD), such as Asperger syndrome, do not always qualify for statutory learning disability or mental health services, despite significant needs. Adults with Asperger syndrome can sometimes experience problems accessing education, housing and employment opportunities because of this. Access to health and social services, and awareness of ASD among professionals, could also be improved.

Commission services for people with learning disability using the classification and methodology outlined in Malhi 2009

Malhi noted that childhood learning disability was well recorded across Berkshire East and recommended that a common classification system should be used. She identified that the use of the same system for adults would enable improved recording of how services for adults support the needs of people with learning disability. If corrected the planning and evaluation of services for; carers, service users could be improved. This is a priority that will require joint work by both providers and commissioners.

Figure 19 Prevalence of learning disability by electoral ward (source QoF 2008/9)

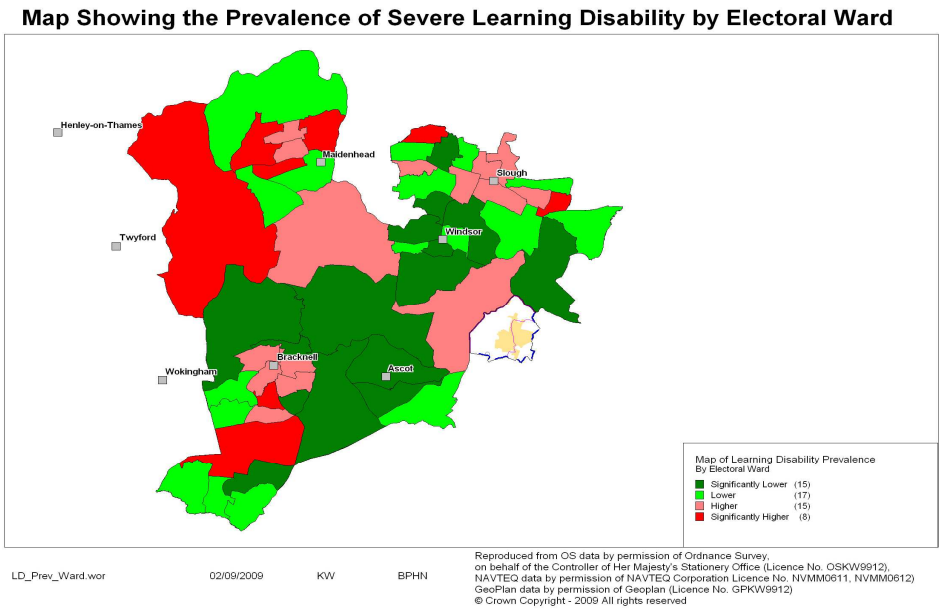
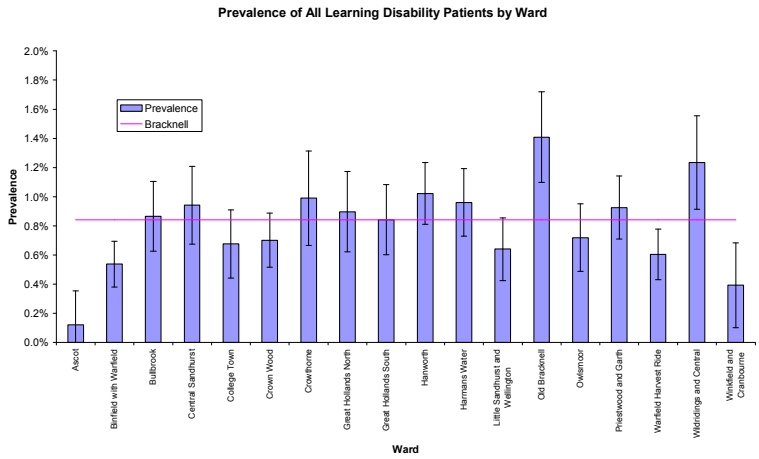


Figure 20 Prevalence of mild, moderate and severe learning disability by wards (Malhi, 2009)



Nationally it is recognised that 1 in 4 people with a learning disability are registered with GPs yet as a result of comparing the Emerson and Hatton (2004) estimates of true need with the 2008/9 QOF registrations it appears that 1 in 2 are recorded as having a severe learning disability.

NB RAP returns for 2008/09 were based on the numbers of people with learning disability known to social services in May 2009. These were completed prior to the results of the GP survey and indicated that Bracknell adult social RAP returns for 2008/09 which indicates that Bracknell Forest; provided care for just under 1 in 3 of all those registered.

Plan for a rise in learning difficulties

Learning difficulties are characterised in education under 13 headings The school census in Jan 2009 reported the numbers of pupils with learning difficulties (rather than learning disabilities) with moderate to severe difficulty as follows:-

- 337 primary pupils and 44 secondary age pupils had moderate learning difficulty
- 13 primary pupils had severe learning difficulty – there were none in the secondary sector
- 162 primary and 38 secondary school children were registered as in need of behavioural support
- 312 pupils had statements of special educational needs

Improve health outcomes for people with learning disability

A new direct enhanced service (DES) payment has been paid to general practitioners from April 2009 to deliver, and offer an annual health check which will support people with learning disability access the healthcare they require and thus promoting health and well being.

A 'Making good health' pilot programme run by the Community Team for People with a Learning Disability (CTPLD) has been running in Bracknell with outcomes such as improved self esteem, increased activity and weight loss. Funding for a revised service has been achieved from Berkshire Sport.

Reduce health inequalities for those with learning disabilities

National research into health outcomes among people with learning disabilities that they suffer from higher rates of obesity, smoking, heart disease, high blood pressure, respiratory disease, diabetes, breast cancer, and stroke, than the general population. Their life

expectancy is also lower - 67 for men and 69 for women in the Borough, compared with the local population as a whole. In particular, cervical and breast cancer screening rates are below the average, and there is some evidence that illnesses may go undiagnosed in people with learning disabilities.

Improve opportunities for employment

The opportunities open to individuals with learning disabilities after leaving school are narrower than for other school-leavers, and this is reflected in the low employment rate. Only 10% of those with learning disabilities in Bracknell Forest are employed, which is line with the rates for South East England and England as a whole. These rates are obviously well below the population without learning disabilities – the comparable figure for the general Bracknell Forest population is 87%. This is a Local Area Agreement target which may be affected by the economic downturn.

Where does the evidence come from?
Berkshire East learning disability needs analysis 2009/ Bracknell Forest learning disability needs analysis 2008 /
RAP returns 2008/9/ Children & young people's plan progress check / Taking Responsibility

Autistic spectrum disorder

Improve access to services for people with childhood autism

A diagnosis of childhood autism as opposed to acquired autism is a life long problem. Over half of all patients on the paediatric registers have this condition. This is a new finding arising from the learning disability needs assessment.

People with some forms of autistic spectrum disorder (ASD), such as Asperger syndrome, do not always qualify for statutory learning disability or mental health services, despite significant needs. Adults with Asperger syndrome can sometimes experience problems accessing education, housing and employment opportunities because of this. Access to health and social services, and awareness of ASD among professionals, could also be improved.

Where does the evidence come from?
Berkshire East learning disability needs analysis 2009/ Bracknell Forest learning disability needs analysis 2008 /
RAP returns 2008/9/ Children & young people's plan progress check / Taking Responsibility

Carers

The principles behind the vision of the National Carers Strategy are that by 2018:

- Carers will be treated with dignity and respect as expert care partners
- Carers will have access to the services they need to support them in their caring role
- Carers will be able to have a life of their own
- Carers will not be forced into financial hardship by their caring role
- Carers will be supported to stay mentally and physically well

The Adult Carer's Strategy is a multi agency partnership document which sets out how partners will work together to deliver the service and support that carers themselves have requested. The strategy focuses on carers taking a break from caring, having the information, advice and support they need to help then live their lives to the full. There is a major drive to promote carers assessments in their own rights to enable each carer to continue in their caring role for as long as wish.

The key themes of the local carers strategy are:

Recognition and Involvement

- Carers must be recognised for the invaluable work they do.
- Carers must be involved in decisions relating to the person they care for.
- Carers are our partners and are key in the future of health and social care provision.

Information and Advice

- Carers must be enabled and able to access useful, practical and inclusive information and advice.

Help and Support (including breaks for Carers)

- Help and Support should be co-ordinated and should be useful and practical.
- Services must be appropriate to specific groups and the needs of marginalised Carers must be taken into account, i.e. ethnic minority Carers, disabled Carers and vulnerable Carers.
- Carers must not be seen only in the context of their caring role, but as an individual with specific needs.
- Carers must be offered the opportunity to get a break from their caring role.
- Carer's breaks should be creative and person centred. This opportunity should include learning and social experiences.

Healthcare Needs

- Carers must be enabled and able to gain access to good quality health care.

Carers Assessments

- Carers must be enabled to access Carers Assessments, and there must be clear support available for those who do.

There were 440 carers registered in Bracknell Forest as in receipt of carers allowance (NOMIS August 2009).

GPs are also encouraged to record carer status in order to facilitate assessments.

254 carers aged 18-64 were supported by Bracknell Forest Council according to RAP returns 2008/9. An additional 118 carers were over the age of 65. 233 were caring for someone with a physical disability, 76 for a person with mental heath problems and 60 for someone with a learning disability. 34 carers were under the age of 18, these were young people accessing the Young Carers Project managed by Bracknell Forest Voluntary Action.

Young Carers

The definition of a young carer as found on teachernet is

'a child or a young person who is carrying out significant caring tasks and assuming a level of responsibility for another person which would usually be taken by an adult. The term refers to ... young people under 18 years caring for adults ... or occasionally siblings ... [not those under 18 caring for their own children]. Nor does the term refer to those children who accept an age appropriate role in taking an increasing responsibility for household tasks in homes with a disabled, sick or mentally ill parent".

The needs and issues arising for young carers have been a concern on both a local and national level for some considerable period of time, this need being recognised in the most recent Government document Carers at the Heart of 21st Century Families and Communities [2008] where a whole chapter is dedicated to young carers.

The number of children and young people who are carers living in Bracknell Forest is currently unknown, this is a picture reflected across the country, with young carers often being referred to as a "hidden group".

National research by Loughborough University suggests that young carers represent 1.5% of the population, which in Bracknell Forest represents around 450 children and young people. It is important to note that whilst this number may be high, the needs of young carers as with many other groups of children and young people who are vulnerable can be considered across a pyramid with universal needs at the bottom, and crisis / specialist support at the top. Their needs may be evident at various levels of the pyramid and at various times in their lives.

A Young Carers Strategy – First Steps has been developed which has identified and addressed some of the key issues that have arisen as a result of consultations and research. It is recognised that this forms the first steps of moving towards a more comprehensive strategy to support young carers, and a review of the progress against actions is recommended within a year to ensure the document develops and evolves in line with the progress and implementation of the first stages, these include:

- Raising awareness of the needs of young carers with all agencies that work with or support children and young people.
- Provide better information for young people who may be carers to ensure they know where and how to get advice, and assistance.
- Assessment and referral using the most appropriate assessment tool, CAF for early identification and intervention, and statutory assessments for specialist / crisis intervention.
- Joining up and working together to ensure effective multi-agency working.

The Aiming High Strategy for disabled people provides opportunities for joint working to provide carers with a break. GPs are also encouraged to record carer status in order to facilitate assessments.

Reduce health and social inequalities for carers

Nationally, it is known that people caring for others suffer from poorer health than the rest of the population (an estimated 1 in 5 carers class themselves as being in poor health). In addition, many carers have to forfeit their work in order to continue their caring role, and approximately a third face of them financial difficulties as a result of caring. The level of

care supplied is highly correlated with the disease stage of the person being cared for and with the carers own health status (Kings Fund, 2009).

As a person cares for someone with stroke, dementia or multiple sclerosis the rate of manual handling may increase. Assessments are vital to reduce the risk of back pain, depression or anxieties which may arise from social isolation or the impact of loss of financial stability as the carer can no longer work.

Improve access to services

The Aiming High Strategy for disabled children provides funding opportunities for joint working to provide carers with a break. Carers should be involved in decisions relating to the person they care for Improving options at Larchwood and Kennel Lane are priorities for the Childrens Trust.

Opportunities for breaks from caring responsibilities should be accessible, and the needs of particular groups of carers taken into account (including those from BME groups; disabled carers; and other vulnerable groups). The Aiming High programme has an action plan for 2009/11.

Improve availability of advice

There is now an advice leaflet for those who are in need of respite care for those caring for disabled children. Advice to adult carers comes from a range of voluntary agencies and is coordinated via the Bracknell Forest Voluntary Action group.

Where does the evidence come from?
RAP 2008/9/ Carers UK / Children & young people's plan progress check / Children & young people's plan update 2009 / Bracknell Forest Carers' Strategy/ Aiming High for disabled people strategy 2009 *Young Carers Strategy – First Steps 2009 /*

Needs by population group

Children in care (looked-after children) and care leavers

The Children Act 1989 established the legislation that underpins provision by local authorities and primary care trusts to enhance the health and wellbeing of their looked after children.

In this Act, any reference to a child who is looked after by a local authority is a reference to a child who is

(a) In their care; or

(b) Provided with accommodation by the authority in the exercise of any functions (in particular those under this Act) which stand referred to their social services committee under the [1970 c. 42.] Local Authority Social Services Act 1970

The number of children looked after may fluctuate from month to month and is a relatively small cohort, with an average of 60 – 75 children looked after at any one time. This is an important consideration when looking at planning and balancing resources as a swing in numbers either way could have a significant impact.

At 30 June 2009 there were 81 Looked After Children [excluding children in agreed short term breaks].

At 30 June 2009 there were 28 young people 16+ who were looked after and at 30 June 2009 there were 74 young people accessing the services of the After Care Team, out of these 46 were care leavers (young people who are aged between 16- 21 or who are aged up to 24 if they are in full time further education or have special needs).

There are a high number of national indicators which relate to ensuring that outcomes for looked after children and care leavers and the priorities in the Children and Young People's Plan include:

- Children and young people looked after are healthy
- Children and young people looked after have security and stability
- Sustain support for the education of looked after children and extend support to 19 years [including care leavers]

Improve health and education opportunities for children in care

Overall the health of looked after children and care leavers is good. The average % of looked after children [who had been looked after continuously for at least 12 months] who have had their teeth checked by a dentist and an annual health assessment has risen over a number of years and in 2007/08 was higher than the statistical neighbours and the England average [*APA dataset 2008*].

Year	***Bracknell Forest***	***Statistical Neighbours***	***England Average***
2005/06	*86%*	*82%*	*81%*
2006/07	*81%*	*83%*	*84%*

2007/08	*90%*	*84%*	*85%*

[Table shows the % of LAC who have had a dental check and an annual health assessment in previous 12 months]

In the twelve months ending September 2007, there were 55 children and young people who had been looked after for at least 12 months, of these 43 were school age. [*DCSF*]

- 20 [40%] had a Statement of Educational Needs [SEN] compared to a South East average of 32% and an England average of 27.9%
- 0 [0%] had been permanently excluded from school compared to a South East average of 1% and an England average of 0.5%
- 5 [16%] had missed at least 25 days from school compared to a South East average of 13% and an England average of 11.9%

The % of young people leaving care aged 16 or over with at least one GCSE at grade A* - G or a GNVQ in 2007 – 08 was 72.7% which is higher that the statistical neighbours [62.2%] and the England average [57.3%].

Increase number of foster care placements

Although there is a shortage of foster carers nationally, in the Borough this is particularly acute in the provision of care for adolescents, children with complex needs, and some Black and minority ethnic (BME) groups.

Identify needs of care leavers

It is thought that gains made to children's health during the period they are in care are at risk of being lost once they leave care. In particular, problems with tobacco, drugs, alcohol, diet and teenage pregnancy, are suspected to be common. However, little formal work has been done to date to identify the needs of this group of children, in order to provide appropriate services to maintain their health and wellbeing after leaving care. A Connexions worker has been appointed to work with care leavers to support them into education, employment or training.

Where does the evidence come from?
Children & young people's plan progress 2009/10/ Care matters: time for change / Promoting the health of looked-after children / Joint area review / Looked-after children report / Cabinet Office social exclusion data/

Needs by population group

Offender population

There is a Crime and Disorder Reduction partnership action plan which incorporates the actions of the youth offending service the Prolific and Priority Offender Group, this will work with the Integrated Offender Management Group which will focus on all highly active offenders.

There is no prison in Berkshire East (although Broadmoor Hospital does contain convicted patients) and there is a detention centre in Colnbrook, yet there is a national requirement for NHS Berkshire East and its partners to commission services that do not discriminate against offenders *in the community*.

The Bracknell Forest CDRP records that there were 18 PPOs when the numbers were at their highest in 2008-09 although these numbers have now reduced. The Bracknell Probation Service was supervising 315 individuals at the highest point in 2008-09. These numbers remain fluid and are subject to constant change and do not include Bracknell clients being supervised in other areas (i.e. Unpaid Work Orders in Reading). The Bracknell Forest Youth Offending Service worked with 195 young offenders during 2008.

It is known that people in contact with the criminal justice system, in particular children, are more likely to have problems with mental health, substance misuse, sexual health and physical well-being than their peers. In young people, roughly 1 in 3 has mental health issues and 1 in 4 learning disabilities. In addition, the majority (roughly two-thirds) come from difficult family backgrounds, with 1 in 3 having been in care at some point in their lives. Maintaining links with family while in custody is desirable.

The Bradley report recommends that Criminal Justice Mental Health teams should be a mandatory part of the NHS contract for commissioning mental health and learning disability services.

Specific requirements are

- A minimum dataset
- Partnership planning of services for detainees in approved premises such as bail hostels
- Joint work with the SHA to commission integrated information services
- Primary mental health teams with a skilled workforce working to robust models of care to assess those with mild to moderate mental health problems
- Work with statutory and non statutory third sector agencies to provide support to prisoners with mental health or learning disabilities
- Commission the delivery of programmes to promote health and well being
- Urgent commissioning of services for prisoners with a dual diagnosis of mental health and alcohol and drug problems
- Audit of the adequacy of provision of alcohol and mental health treatment services
- Joint care planning between mental health services and drug and alcohol services for prisoners on release
- Ensure a comprehensive mentoring programme is in place for people leaving custody with mental health or learning disability

The Sainsbury Mental Health Trust lists ten top tips for PCT boards available at www.smht.org

The guidance notes

Many women in prison suffer from mental health problems in relation to separation from their children.

1 in 3 women prisoners have suffered a psychiatric condition, half of all self harm in prison is among women yet they only make up 6% of the total of all prisoners.

BME prisoners are less likely to be referred to psychological therapies yet they are over represented in the acute psychiatric wards, in custody and in secure hospitals such as Broadmoor.

Children in the youth justice system are three times more likely to show signs of mental ill health and youth justice diversion and liaison workers should be employed to screen entrants to the youth justice system as part of an early intervention approach. Their role is to liaise with the youth offending team and the police and the courts and provide a referral to an appropriate support service such as CAMHS.

Forensic medical services provide secure detention in NHS annually funded settings at approximately £150,000 each. The provision of step down services and low security services enable these to be released more quickly.

Third sector secure places of safety need to be commissioned for people detained under section 136.

24 hour staffed medical and nursing provision should be commissioned either in police stations or via telelinks.

A locally enhance service should be commissioned for ex offenders and the homeless using innovative delivery models staffed by primary health care, social care, drug and alcohol and mental health teams.

Resettlement and aftercare provision for youth offenders should be extended to adults – a worker meets to plan their aftercare before their release, then picks them up and helps them to sort out their problems and keep appointments.

Where does the evidence come from?
CDRP 2009/Bradley Report/Sainsbury Mental Health Trust/DH Offender Health team

Needs by disease / illness

Mental health

A new benchmark report for NHS South Central has just been produced by SEPHO (2009) which analysed data from 2006-7, which is summarised below.

Burden of mental illness

Comparisons of prevalence between PCTs based on QOF returns are to a limited extent borne out by 'bench-marking' data. Berkshire East has consistently among the lowest rates. The prevalence of severe mental illness in Berkshire East at 0.6% is below the Strategic Health Authority (SHA) and national averages. Berkshire East has the second lowest recorded prevalence rate of dementia in NHS South Central (based only on non age-standardised QOF returns) at less than 0.3%.The regional rate is above the national average. The QOF prevalence is of patients identified by GPs but the National Dementia strategy identifies the need for earlier recognition by GPs.

Within Berkshire East there is variation in prevalences between practices in localities; the highest practice in Ascot includes a nursing home for people with mental health problems. Estimates appear to indicate a relatively higher prevalence of common mental health disorders in Berkshire East than might be expected in comparison with other PCTs.

The percentage of people aged over 16 claiming incapacity benefit for mental health problems in Berkshire East was just below SHA average and well below the national rate. These account for about 45% of all claimants in Bracknell, 41% in Slough and 40% in RBWM.

The MINI Index score (Mental Illness Needs Indicator is an estimate of hospital admission rates based on census data with the national level set at 1) in Berkshire East at about 0.68 is intermediate level within the SHA. The level is highest in Slough at 0.9 where some wards are above 1. The levels in Bracknell are 0.58 and RBWM 0.55.

Programme budget data for 2006/07 reveal substantial variation in spend per head between PCTs. The Berkshire East figure is the lowest within the SHA area at £126 per head. The costs according to 2007-8 programme budgeting figures were higher and the national rank was 143 out of 152 PCTs. A previous report by the Kings Fund showed weighted spending per head to be lowest in Bracknell, just below RBWM; Slough had the highest per capita spend in Berkshire East.

Monitoring

According to QOF figures for the percentage of practices achieving maximum scores, Berkshire East significantly exceeds the national average for both severe mental illness and depression monitoring, and 100% of practices achieve maximum scores for dementia monitoring.

Berkshire East has the second lowest rate of exception reporting for mental health QOF indicators, after Milton Keynes which has the lowest rate.

Altogether, the monitoring of dementia appears to be the most effective and of depression least effective, although the overall score for depression across NHS South Central is almost 95% - several percentage points higher than the national average.

Whilst most practices in Berkshire East achieve maximum scores, some do not. There is wider variation in the specific measures, eg documented care plans.

Prescribing

The prescribing of antipsychotic drugs and of antidepressants increased slightly between 2006-07 and 2007-08 in all PCTs in the South East.

The difference between PCTs in prescribing rates for antipsychotics is greater than for antidepressants, but appears roughly consistent with differences in prevalence. Low prescribing rates for hypnotics and anxiolytics are generally regarded as consistent with good clinical practice. Berkshire East has amongst the highest levels of prescribing for these drugs, while Berkshire West has the lowest.

Hospital admissions

Admission rates for schizophrenia vary substantially between PCTs within NHS South Central SHA. Berkshire East has the second lowest rate (after Berks West). These differences do not seem to be fully explained by differences in prevalence.

The hospital admission rate for depression in Berkshire East is at the national average (which may be higher than expected) but low rates for schizophrenia and dementia, while Berkshire West has low rates across the board. Median length of stay for psychiatric admissions also varies somewhat between PCTs; Berkshire East has average rates. Just over 3% of patients in NHS South Central SHA who are discharged from hospital after a psychiatric admission are readmitted as an emergency within 28 days. The figure is 3.5% for Berkshire East, the fourth highest.

Mental Health Minimum Dataset

The proportion of mental health patients formally detained in NHS South Central is very similar to the national average (just over 30%). There is substantial variation between PCTs in the region. Berkshire East is about 40%. These figures need to be interpreted in conjunction with overall admission rates as there is likely to be a higher proportion of more ill patients if overall admission rates are low.

Just under 40% of patients in NHS South Central in contact with mental health services had a CPA review in the last year – again very close to the national average. There is substantial variation between PCTs, with the highest at over 70% in Berkshire East. Although these are 'experimental statistics', the variation suggested here is worth investigating further.

Mortality

The suicide rate for men in NHS South Central is significantly lower than the England average. The Berkshire East rate is around the national and SHA averages
Suicide rates in women are significantly lower than in men in every PCT. Berkshire East and West have amongst the lowest rates. Within Berkshire East the overall suicide rate is lowest in Bracknell Forest and just highest in Slough.

Self-assessment by Local Implementation Teams (LITs)

Aspects of mental health service commissioning and delivery which are causing concern to a high proportion of LITs in NHS South Central include suicide prevention at commissioner level; mental health promotion; improving access to psychological therapies; and services for dual diagnosis. Other areas of concern include the primary-secondary care interface, services for older people and race equality in mental health services. Berkshire East is among those with generally good scores.

Emergency admissions for adults

Top 10 Mental Health Emergency Admissions Berkshire East Residents: 2006-2008

		rank			Admissions
Bracknell Forest		**2006**	**2007**	**2008**	**2008**
ICD10	Name				
F99	Mental disorder, not otherwise specified	1	1	1	63
F10	Mental and behavioural disorders due to use of alcohol	2	2	2	33
F32	Depressive episode	3	3	3	27
F20	Schizophrenia	4	4	4	11
F31	Bipolar affective disorder	5	5	6	6
F03	Unspecified dementia	6	12	12	-
F60	Specific personality disorders	7	7	10	-
F23	Acute and transient psychotic disorders	8	14	8	-
F00	Dementia in Alzheimer's disease	9	6	7	-
F41	Other anxiety disorders	10	9	5	8

The improved recording of diagnoses is a requirement of revised commissioning plans

Estimated prevalence of mental health problems in children and young people in thousands

The CAMHS needs assessment (2008) estimated (using HASCAM) that in Bracknell 1507 children aged 5-10, 2062 children aged 11-15 and 831 young people aged 16-18 would have mental health problems. The split per tier was estimated from HAS sources as follows.

	Age 5-10	Age 11-15	Age 16-18*	Total
Bracknell	1507	2062	831	4400
Slough	1892	2082	823	4797
RBWM	1788	2288	990	5066

A much smaller number was estimated to require a service

Requiring a service	Tier 1	Tier 2	Tier 3	Tier 4
1121	660	330	17	2
1222	720	360	18	5
1290	760	380	19	6

There are two methods of estimating those with mental health problems aged 16-18. The estimated results using adult classifications are as shown below

	Neurotic	Personality	Probable psychotic
Bracknell Forest	648	172	11
Slough	643	169	11
Windsor & Maidenhead	761	217	12

Estimated prevalence of mental health problems in adults

Mental health problems in adults are thought to be a major public health problem by residents of the Borough. Over 19,000 people are estimated to have a mental health problem in Bracknell Forest, with RAP returns reporting that over 500 people (541) under the age of 65 received social care support in 2008/9.

The Mental Health Observatory model estimates that 12,700 people have a mental health problem in Bracknell Forest in the age band 16-64

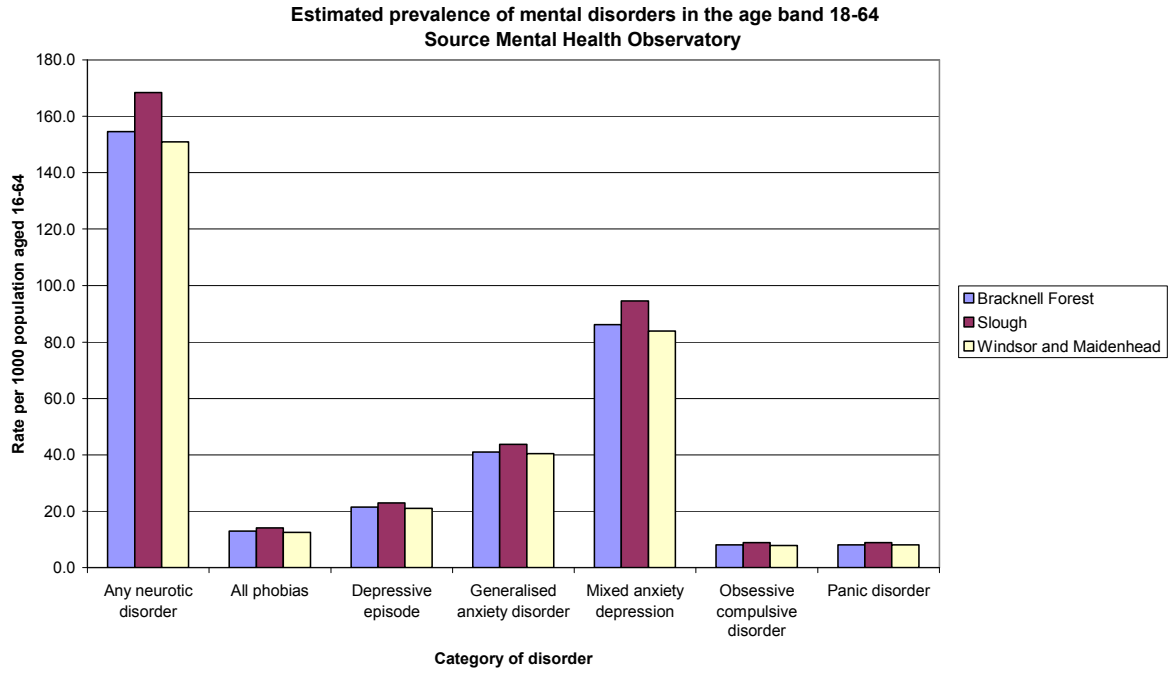
LA name	Any neurotic disorder (Rate)	All phobia	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic dis-order	Any neurotic disorder
Bracknell Forest	154.6	13.0	21.5	41.0	86.1	8.1	8.2	127,000
Slough	168.4	14.1	23.0	43.7	94.6	8.9	8.9	14,600
Windsor & Maidenhead	151.0	12.4	21.0	40.5	83.9	7.8	8.1	15,000
Berkshire East	159.0	13.2	22.0	41.5	89.0	8.4	8.4	44,000

RAP returns reported that 575 people with mental health problems aged 18-64 received social care support in 2008/9. Berkshire Healthcare Trust estimates their services reach a population across Berkshire East of circa 11000 yet the estimates above indicate this may be just over a quarter of the true prevalence among those of working age alone The estimates are based on the 2000 psychiatric morbidity survey. Please note that the proportion for 16-18 year olds is calculated separately above.

DWP data on incapacity payments (2005-7) showed that 45% Bracknell claimants had a mental health problem. Current NOMIS data (August 2009) does not disaggregate employment, skills allowance (ESA) from incapacity benefit (IC) so it is not possible to determine the proportion of the current 2500 with physical and mental health problems. Yet those on the latter are likely to be suffering from depression.

Over the next 10 years it is estimated that the number of people with a severe mental health problem in the Borough will rise significantly, by around 17%. Bracknell has the highest admission rate for elderly people among all the Berkshire unitaries (BHCT, 2005-7).

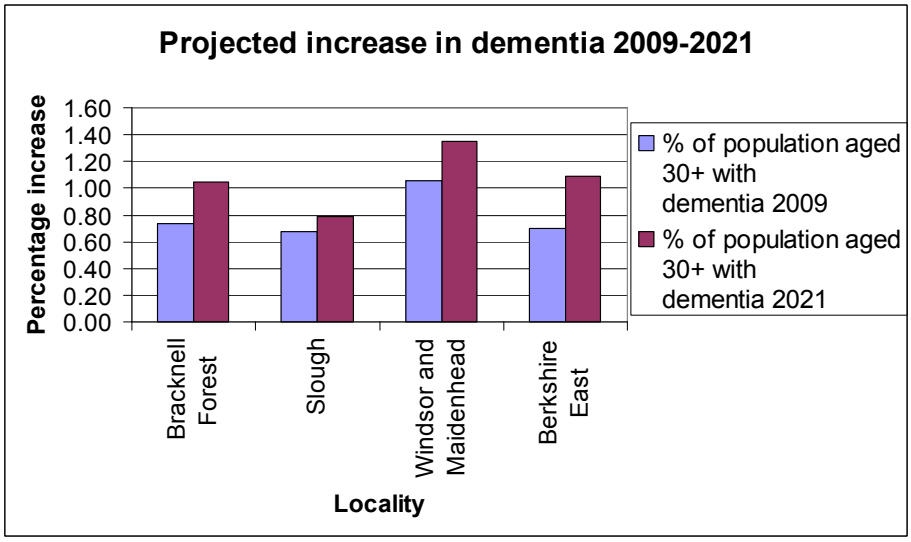
Figure 21 Estimated prevalence of mental disorders in age band 18-74 (source Qof 2008/9)



Estimated prevalence of dementia

The national estimates based on Mental Health Observatory (MHO) projections from ONS 2006 base data are significantly higher than actual results either from the quality and outcomes framework data (2007/8) or from contacts with mental health teams or by analysing services received from adult social care. Note that the MHO projections are for 2021 rather than 2019.

Figure 22 MHO estimates of percentage increase in dementia from 2009-2021



The MHO projections note that the number of men and women with dementia in the Borough is projected to rise from 822 people in 2009, to 1,195 in 2021, a rise of 45% although the prevalence overall will remain at around 1.4%.

Actual practice register size

The MHO estimates above must not be confused with QOF registration prevalence which was nearer to 3% in 2008/9.

QOF data indicate that the Ascot practice is an extreme outlier with a 33% prevalence rate and that others in the borough also have higher than national rates.

Annual contact rate with Berkshire Healthcare Trust

Average annual mental health related contact rate (per 1,000) with Berkshire Healthcare Trust, by age-group, for Unitary Authorities, 2007

	0-4	5-14	15-44	45-64	65-74	75+
Bracknell Forest UA	2.2	103.6	236.2	287.5	255.3	493.1
West Berkshire UA	4.3	151.1	223.1	248.5	268.6	642.1
Reading UA	4.8	144.3	343.8	512.9	314.2	1082.5
Slough UA	4.4	114.3	409.6	772.0	465.7	561.5
Windsor & Ascot UA	2.4	110.9	181.8	174.6	171.1	401.1
Wokingham UA	7.3	143.3	153.1	186.9	199.4	582.7

The annual contact rate is a crude measure of activity in each area. For many years Bracknell Forest had the highest rate in Berkshire in the 75 age range. This rate has fallen compared to previous years.

Address physical health problems

People with mental health issues have higher rates of long-term illness and alcohol dependence, and are more likely to smoke and have a poor diet, than their peers. It is therefore important that physical health needs are met in people with mental illness. (See section on tobacco control, alcohol and obesity). The development of vascular risk assessments for those with mental health problems is a priority.

Action on emotional health of children and young people

In Bracknell Forest prevalence data indicates an estimated 4400 children and young people (5-18 year olds) who have a mental health problem. The Children's Plan Review notes the ongoing need to commission services at tier 3 differently. Work on linking tier 1 and 2 services to CAMHS (tier 3), GPs and schools continue to have a high priority.

Yet 50% of secondary school pupils and 70% of year six pupils recently reported concern about bullying and the 'Safer Together, Safer Wherever' action plan aims to increase reporting and promote effective interventions to tackle bullying based on a sound multi-agency approach. Strategies to tackle bullying include a strong peer mentoring scheme across all secondary schools and innovative use of drama.

The action plan prepared by the CAMHS Partnership 'We all have a part to play…' already promotes the Social and Emotional Aspects of Learning (SEAL programme), a single referral hub, pathways for 5-10,11-16 and 16-18 year olds and targeting resilience through the Pyramid Club in year 3 children and in teenagers. Other effective interventions include work healthy schools to improve PSHE certification for teachers re sex and relationship education and the extension of the Family Nurse Partnership to Bracknell Forest.

Provide targeted support for mental health in schools

Nationally Young people who have learning disabilities, are in care, and those from BME communities, do not currently use CAMHS as much as would be expected, suggesting these groups are unable to access the service adequately. Children in or leaving care, with learning disabilities, or in the criminal justice system also may require more specialist support than is currently available (CAMHS needs assessment 2008). Integrated care pathways have been established to enhance access to interventions for children and young people with moderate mental health needs, who would not meet the criteria for the specialist tier 3 CAMH service. These have strong links to the Common Assessment framework (CAF). Particular emphasis has been placed upon supporting the needs of children in care, those who are known to YOT and those with learning disability. Ethnicity data are being monitored with a view to ensuring that there is equal access to services across BME communities. Specific measures will be developed to improve access should local figures suggest there is a discrepancy.

The borough is a phase 3 pathfinder of the Targeted Mental health in schools (TaMHS) project. This is a national project which is being rigorously evaluated by UCL in order to clarify which mental health interventions developed and delivered in schools are able to bring about most positive impact on children's well-being. Through the TaMHS project schools will assist in piloting new approaches in the borough, and those proving most successful will be rolled out borough wide. It is being lead by the educational psychology service.

Getting people into employment

Among claimants of incapacity benefit claimants 45% (1130) had a mental health problem (source DWP August 2008). Getting people back into work is a key priority and estimates of the proportion of economically males who are unemployed by ward show that Bullbrook, Harmans Water, Priestwood and Garth and Great Hollands North and South should be prioritised for the introduction of IAPT services.

Current ESA and incapacity benefits claimants in Bracknell Forest total 2500 but it is unclear how this is split (NOMIS August 2009).

Priorities for commissioning

Bracknell Forest Council published a commissioning strategy for adult mental health in 2008, which identified commissioning priorities from 2008-2013. These include:

- Address the needs of people with less severe mental health problems and make psychological therapies more available
- Work with housing providers to address accommodation and support needs
- Develop employment and training support for people with mental health problems

The Bracknell Forest Council commissioning strategy for people with dementia includes the commissioning priorities:

- Improving intermediate care for people with dementia
- Work with the NHS towards good quality early diagnosis and intervention
- Improve specialist home care provision
- Expand day options and respite care options
- Increase provision of assistive technologies to enable people with dementia to stay at home for longer
- Develop a dementia adviser service

For adults see recommendations for commissioning under offender health, tobacco control and physical activity

Where does the evidence come from?

East Berkshire mental health needs assessment 2009/ Children and young people's plan progress check / CAMHS needs assessment 2008 / Children and young people's plan 2006-9 / TellUs3 / Mental health commissioning strategy 2008 / Health Profile for Bracknell 2009/ BFBC (2008) Commissioning strategy for adult mental health 2008-2013

Needs by disease / illness

Endocrine (hormonal) diseases

Diabetes is a chronic and progressive disorder that impacts upon almost every aspect of life. It can affect children, young people and adults of all ages, and is becoming more common. There are 2 types of diabetes – Type 1 and type 2. It is estimated that 2,440,000 people in England had diabetes in 2008. This represents 4.67% of the population. By 2025, it is forecast that 3,605,000 people or 6.48% of the population will have diabetes. Approximately half of the predicted rise in diabetes prevalence will be due to the increasing prevalence in obesity and half will be due to an aging population.

In Berkshire East the prevalence of diabetes for 2007-8 was 3.7% with a higher prevalence in Slough of 4.8%, followed by 3.3% in the Royal Borough of Windsor and Maidenhead and 3.3% in Bracknell Forest. The estimated prevalence based on modelling is 4.52% for Berkshire East, 5.76% for Slough, 4.19% for the RBWM and 3.69% for Bracknell Forest for 2010.

Risk Factors associated with Diabetes:

- **Age** - The prevalence of diabetes increases with age, with the probability of increasing over the age of 45 years
- Obesity – Increase in body weight increases the risk of developing diabetes. It is estimated that diabetes is 3 times more likely in people who have gained 30 kgs. in body weight in adult life. It is thought that just over half of the forecast increase in diabetes between 2005-2010 will be due to increase in obesity.
- People from back and ethnic minority communities, in particular South Asians (where type 2 diabetes is 6 times more common compared with the white population) and in African-Caribbeans (where Type 2 diabetes is 3 times more common) are particularly vulnerable to developing diabetes. In these communities diabetes tends to occur at a younger age
- People from deprived backgrounds - Prevalence of diabetes in people from socially disadvantaged groups. In 2006/7 diabetes in the most deprived fifth of neighbourhoods was 57% higher that in more affluent areas

Diabetes estimated need from the YHPHO PBS3 model

The estimated prevalence of type 2 diabetes using the PBS Diabetes Prevalence Model suggests that the
across Berkshire East the prevalence is as follows:

Area	2005 Estimate – (No.) and prevalence %	2010 Forecast – (No.) and prevalence %	2015 Forecast – (No.) and prevalence %	2020 Forecast – (No.) and prevalence %	2025 Forecast – (No.) and prevalence %
South East	4.18% (341,874)	4.60% (386,219)	5.02% (432,734)	5.50% (486,445)	5.99% (543,527)
South Central	3.93% (155,629)	4.36% (176,305)	4.78% (197,967)	5.25% (222,334)	5.73% (247,896)
Berkshire East	4.05% (15,210)	4.51% (17,026)	4.99% (19,086)	5.47% (21,201)	6.01% (23,602)
Bracknell Forest	3.26% (3,634)	3.69% (4,131)	4.12% (4,672)	4.53% (5,209)	5.00% (5,842)
Slough	5.10% (6,061)	5.76% (6,746)	6.49% (7,574)	7.18% (8,377)	7.94% (9,324)
RBWM	3.88% 5,317)	4.19% (5,885)	4.51% (6,483)	4.87% (7,158)	5.24% (7,852)

Results from the National Diabetes Audit (2007-8)

The report summary covers registrations, complications, care processes and treatment targets. Key findings were that;

- the national prevalence of diagnosed diabetes in those aged 16 and over is now 3.9% - an increase over the previous year.
- Ethnicity recording has improved but in the NHS South Central region is lower than the national average.
- Complications of diabetes include kidney failure, diabetic ketoacedosis, myocardial infarction, stroke, heart failure and amputation. Apart from eye disease all complications of diabetes have a twofold increase according to the quintile of deprivation in which the person lives and increase with age although a large percentage in the age band 25-40 should not be ignored
- National findings show that diabetic ketoacidosis events occur more commonly in the 25-40 age group and the prevalence rate of - of renal failure in that age group is highest albeit only 0.39%..
- Regarding care processes whilst the recording of blood pressure, HbA1c and cholesterol in diabetes is high - urine albumin creatinine is low nationally at 60% and eye and foot examinations were also lower than the other indicators.
- 60% of people measured in the audit year achieved HbA1c levels below 7.5% (NICE recommendation), 30% achieved target blood pressure of 135/90 mmHg (NICE recommendation). 70% of those who had their cholesterol checked achieved < 5 mmol/l (NICE recommendation).

Local priorities

Plan for an increase in people with diabetes

Estimating the number of people with diabetes is important for planning adequate community (primary) and hospital (secondary) health services.

It has been estimated that the number of people in the Borough with diabetes will rise over the next few years. Since obesity is a major risk factor for adult-onset (Type 2) diabetes, how much diabetes will rise depends in part upon whether obesity levels rise. If obesity in the Borough rises, the percentage of the population with diabetes is estimated

to be 4.5% by 2020 (compared with 3.7% in 2010) - this is equivalent to a relative increase of over a fifth (22%) between 2001 and 2010. If the number of people with obesity starts to fall, the number with diabetes may only rise modestly.

Improve local diabetic retinopathy screening services

A national External Quality Audit in 2008 defined the priorities for improving the local service which is currently commissioned from providers in Berkshire West. This service aims to invite all eligible patients to an annual screening

Key public health actions arising from this audit are

- Increase capacity and equipment to cope with the expected increase in diabetic patients and the requirement to improve take up to 80%
- Improve practice awareness of the importance and frequency of updating lists
- Increase the uptake in screening to 80% especially among disadvantaged groups
- Conduct a health equity audit for diabetes across Berkshire
- Ensure funding for the service expansion
- Ensure the diabetic retinopathy care pathway is followed in pregnancy

Where does the evidence come from?
YHPHO diabetes estimates/East Berkshire diabetes needs assessment / Diabetes prevalence projections/ National diabetes audit 2008/9/Berkshire Diabetic Retinopathy Action Plan 2009

Needs by disease / illness

Circulatory diseases

For primary prevention plans see section on obesity, healthy eating and physical activity.

Risk factors for circulatory diseases are abdominal aortic aneurysm, *atherosclerosis, cerebrovascular disease, coronary heart disease (all of which are caused by smoking except * which is causally associated with smoking) (Surgeon General report 2004).

The NHS Improvement website www.improvement.nhs.uk/heart/ contains updated information on improvements in the prevention, management and surgical interventions for heart disease and stroke and lists the following priorities for heart health improvement

- Prevention and earlier diagnosis
  - Vascular checks (to be offered to those with no established diagnosis of CHD, diabetes, CKD or stroke)
  - Rehabilitation - implementing the NICE guidelines
- Sustainable cardiac pathways
- Pathways for Heart failure Care
- Reperfusion, primary angioplasty and pre-hospital thrombolysis
- Sudden Cardiac Death/Inherited cardiac conditions and implantable devices.

Plan for a rise in strokes and Transient Ischaemic Attacks

Strokes are the third biggest cause of death in the UK, the most common cause of disability and a cause of high bed occupancy in hospitals (20%) and long term care (25%). Transient Ischaemic Attacks (TIAs) are brief episodes similar to a stroke but only lasting less than a day but they are a high risk warning of an imminent full-blown stroke. The treatment of strokes has changed rapidly over recent years and now need to be treated as a medical emergency requiring immediate assessment and appropriate interventions.

The National Stroke Strategy (DH, 2007) has the following priorities; raising awareness, early intervention following a transient ischaemic attack, access to scans and specialist care within 24 hours for those who may go on to a full medical emergency, meeting service standards as set out by the Royal College of Physicians, the coordination of health, social care and voluntary services, increased advocacy and inclusion of people who have had a stroke in planning services, ensuring people have the right mix of skills and participation in a stroke network. Available at http://www.dh.gov.uk/en/Healthcare/Stroke/DH_099065

The prevalence of Stroke and TIA in QOF in 2007/8 was 5,105 (1.23%) in Berkshire East, comprising 1175 ((1.1%) in Bracknell, 1523 (1.15%) in Slough and 2407 (1.37%) in RBWM, of whom 459 were in Ascot, 1,108 in Maidenhead, and 840 in Windsor.

The total number is predicted to rise by almost a thousand to 6084 by 2015. The greatest predicted increase is in Bracknell Forest. As shown in Figure 24.

The expected incidence of TIAs is 254 per year of which two-thirds ere likely to be high risk.

Of the total population aged 65 or over, 3% are predicted will have a longstanding health condition caused by a stroke.

Overall, about 900 people have a stroke each year in Berkshire East, of whom about 30% die in the first three weeks, 35% recover, and 35% survive with a disability requiring rehabilitation. Of the total annual number of strokes, about 70 are under retirement age.

Overall, there are about 2000 people living in Berkshire East with a disability following a stroke.

National funding for 3 years has been provided to each unitary authority, at around £80,000pa each. Local plans have been developed to use this funding in conjunction with voluntary sector and patient and carer groups to meet local needs.

Figure 23 Qof prevalence of stroke by ward in Berkshire East (2008/9)

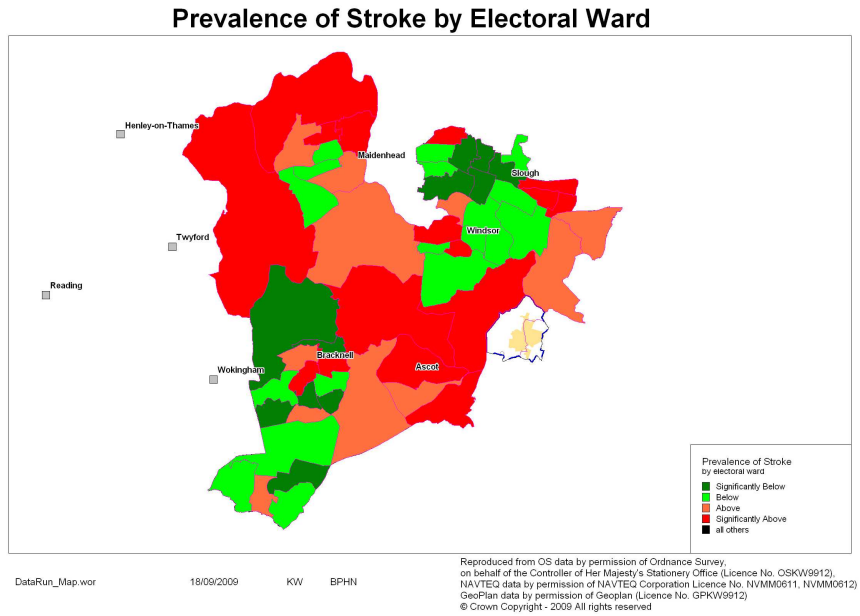


Figure 24 Qof prevalence of stroke by ward in Bracknell Forest (2008/9)

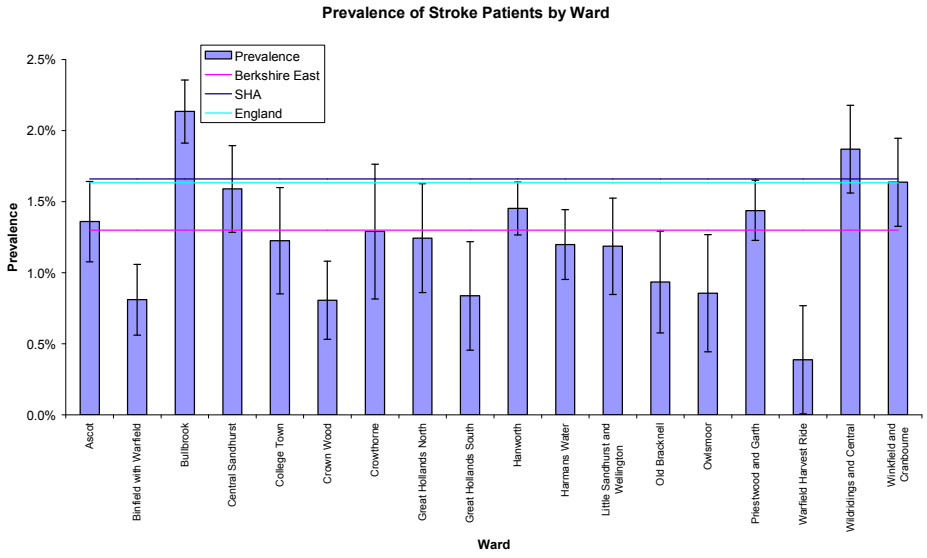
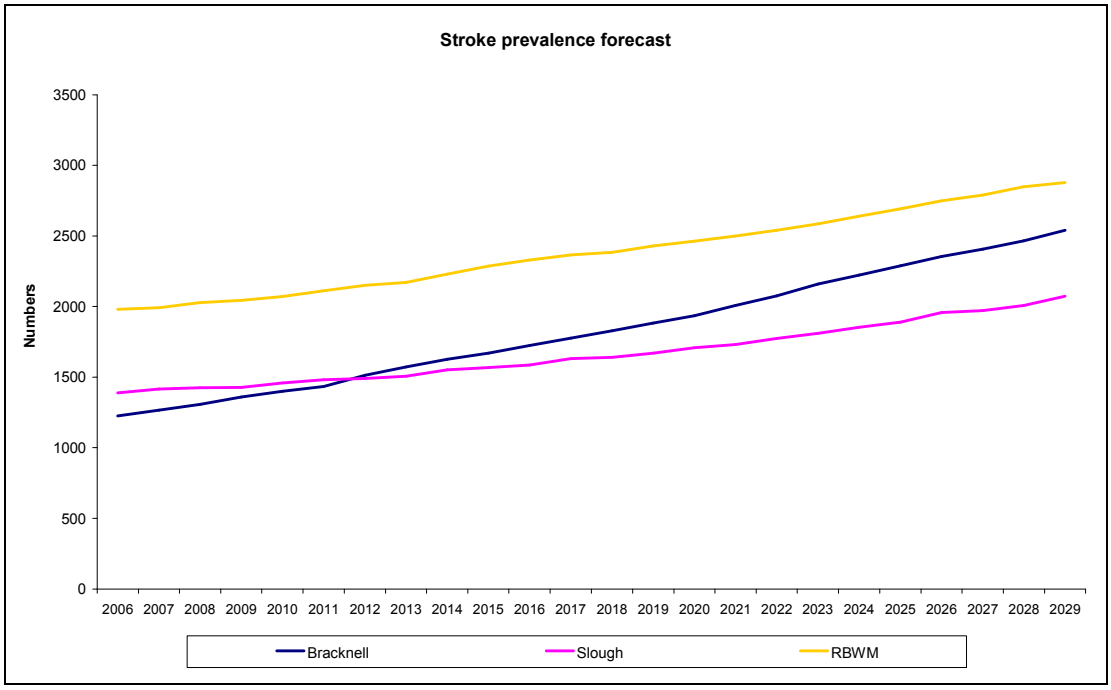


Figure 24 Stroke prevalence projections by locality (based on QoF 2005/6 and ONS projections)



Plan for an increase in people with coronary heart disease (CHD)

Figure 25 CHD prevalence by ward (QoF 2008/9)

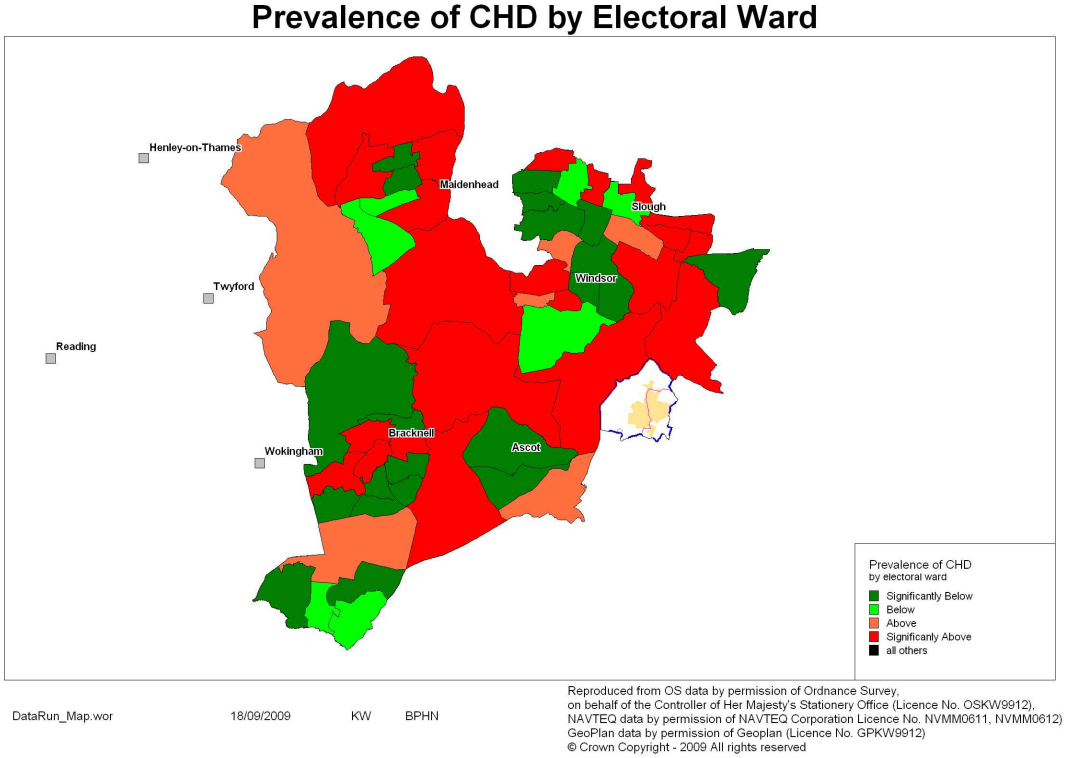
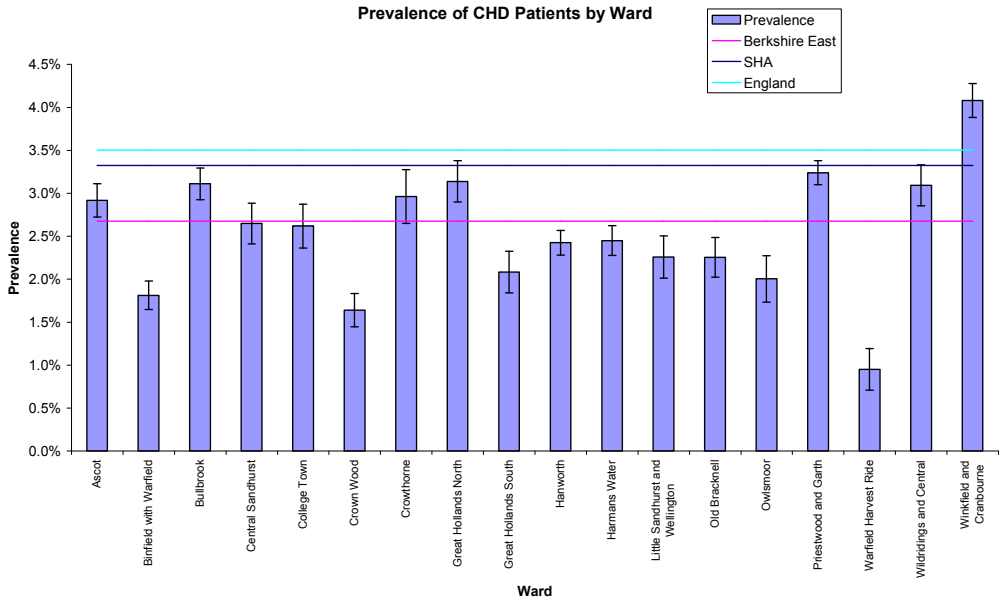


Figure 26 CHD prevalence by ward (QoF 2008/9)



CHD prevalence as measured by QoF shows that Winkfield and Cranbourne is statistically significantly above the mean for Berkshire East, and England. The growth in CHD due to the ageing population will exceed that in RBWM by 2023.

Chronic kidney disease prevalence from QoF registers is shown below to inform the vascular risk strategy although patients with diagnosed CHD, diabetes, CKD will not be screened as their condition is known and already being managed. The vascular risk programme, as described nationally, targets those with risk factors rather than established disease as it is a preventative programme

Figure 26 CKD prevalence by ward in Berkshire East (QoF 2008/9)
CKD prevalence is not statistically different to the mean for England though higher in the wards shown as red below

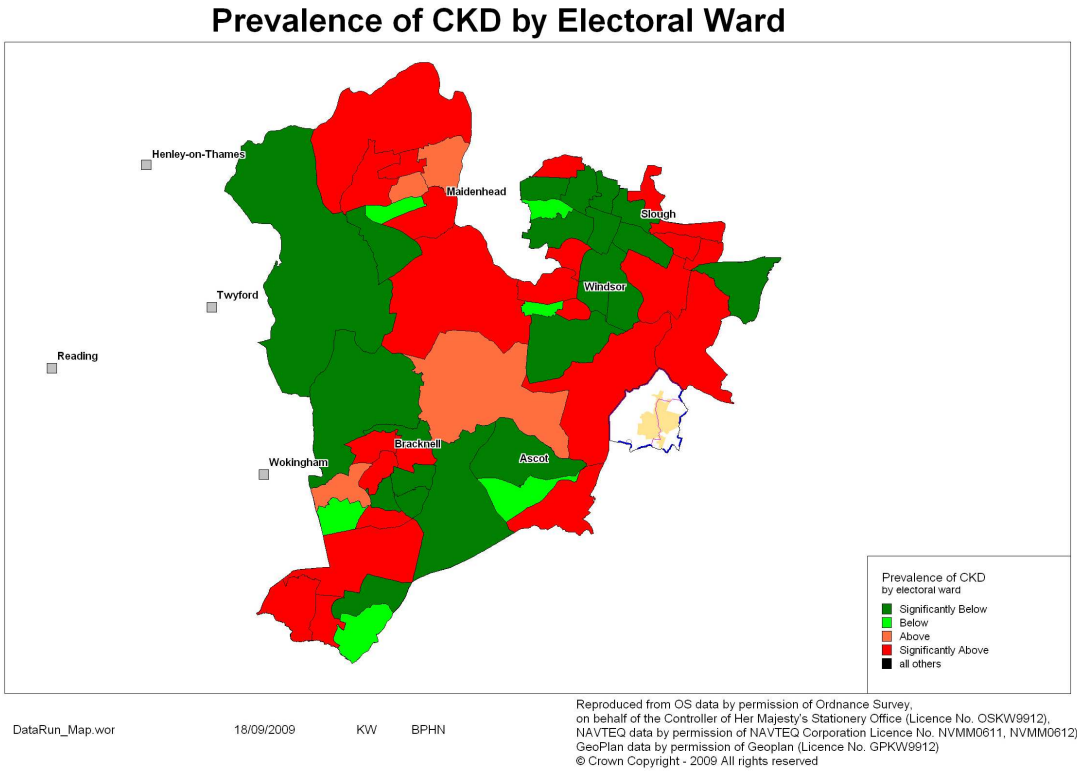
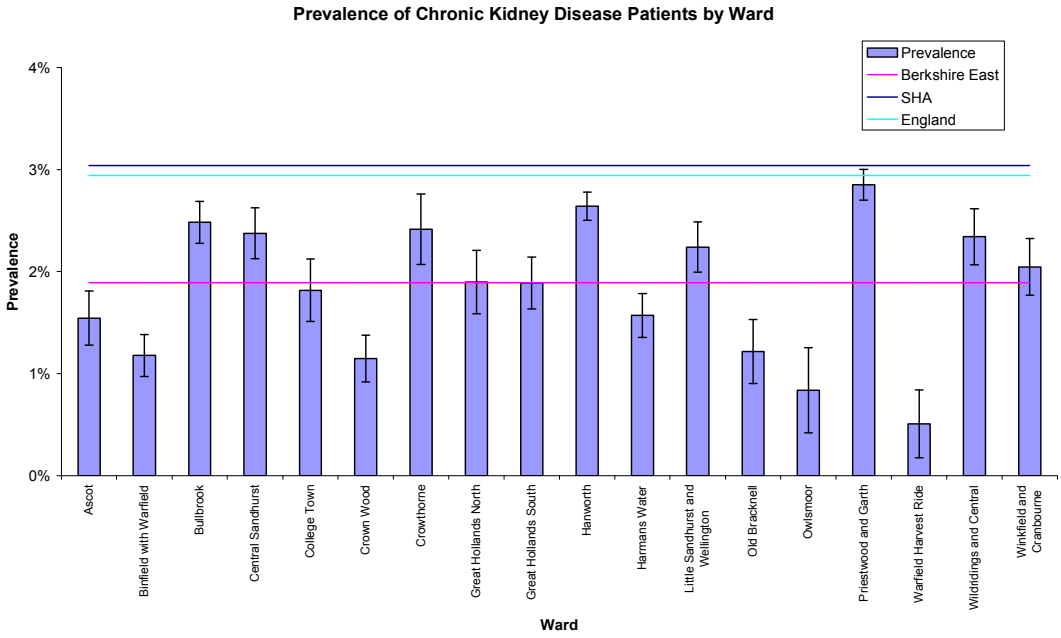


Figure 27 CKD prevalence by ward (QoF 2008/9)



Plan for increase in people with circulatory diseases

Due to a combination of an ageing, and larger, population in the Borough over the next 10 years, the number of people diagnosed with coronary heart disease (CHD), heart failure, stroke (also classified as a neurological disorder) and high blood pressure, are all estimated to increase significantly.
Rises of between a third to a half are projected for each condition – coronary heart disease (41%), heart failure (51%), stroke (41%), high blood pressure (33%).

Introduce the vascular risk screening programme in 2010

There is a requirement of all PCTs to offer a vascular screening programme by the end of 2009/10 and a vascular risk strategy is under development.

Improve the diagnosis and treatment of heart failure

A new heart failure pathway has been introduced as a practice based commissioning led programme.

New commissioning guidance (2009) for the prevention of stroke which highlights the importance of focusing on improved management of atrial fibrillation is available at http://system.improvement.nhs.uk/ImprovementSystem/ViewDocument.aspx?path=Cardiac/National/Website/AF_Commissioning_Guide.pdf

Improve access to high quality PPCI

The British Cardiovascular Society has noted the following recommendations for PPCI national rollout

- PPCI (percutaneous coronary interventions) should be 24/7 and have sufficient caseload to ensure clinical standards are met.
- A call to balloon time of 120 minutes (applicable to 97% of STEMI cases in England)
- Hybrid services leading to out of hours thrombolysis and daytime PPCI are not satisfactory
- Early coronary angioplasty is required in all patients who receive thrombolytic therapy

Treat more people with high blood pressure

A large number of people in the Borough 10,894 have high blood pressure (QOF 2008/9). It is estimated that less than two in five (39%) are currently receiving treatment for their condition. This is below the national average of 41.2%, although this latter figure should not be seen as a 'target', since the majority of those with high blood pressure should be offered treatment.

Where does the evidence come from?
NHS Improvement website/ Long term conditions strategy 2008 / Long term conditions projections BEPCT / CHD ward map from Quality and Outcomes data 2008/9 BEPCT/ SEPHO CHD report 2008

Needs by disease / illness

Falls

Promoting good bone health and a reduction in risk of falling and fracturing is a key component of preventing unnecessary admissions. A multidisciplinary Berkshire East Falls Strategy was developed in June 2005 and the services that collectively deliver that strategy were audited by the Healthcare Quality Improvement Partnership (HQIP) in 2009.

Preventing falls for example by making sure a patient's medication is optimal; by offering exercise which helps strength and balance or checking a house for loose carpets or trip hazards are very beneficial. Also, checking bone density for osteoporosis and prescribing bone building medication in the first place is the best way of preventing this type of fracture. Key recommendations are noted below.

Falls and fracture rates by locality

During 2008-09, 301 older people were referred to the Bracknell Forest falls Service.

Projected fall and fracture rates

It is estimated that each year in East Berkshire over 10,000 residents over the age of 65 sustain an injury after falling. Hip fracture is a common and dangerous consequence of falling and the number of hip fractures in Bracknell Forest during 2008-09 was 72 (total figure for east Berkshire was 333).

However, the population of older people is projected to rise significantly in the area over the next 10-20 years, so the number of people at risk of falls will also increase. Whereas the number of people aged 65 and over was 12.900 in 2008, this is expected to rise to 20.700 by 2028, an increase of 60%.

Improve falls training and access to bone density scans

Those referred to the Bracknell Forest falls service, are provided help to get them back on their feet and reduce the risk of subsequent falls. Although this service is generally valued by those who receive it, there is a waiting list for scans to measure bone density (DXA scans): it is estimated that approximately one third the number of scans which are required can currently be carried out routinely.

Falls prevention training is provided to BECHS clinical staff caring for in- patients and is also on offer to BECHS staff working in the community. However it would greatly benefit the local population if the training was available routinely among all health and social care agencies.

Commissioning priorities

Berkshire East took part in the 2008 National Audit of the Organisation of Services for Falls and Bone Health of Older People. National recommendations, also applicable locally, were that:

Primary care organisations should develop commissioning strategies that include:

- Case finding systems in hospital and community settings to identify high risk fallers
- Adherence to NICE treatment guidelines with monitoring by local audit
- Clinical leaders including a consultant with job plan commitment
- A fracture liaison service
- Widespread and accessible evidence-based exercise programmes
- Targeted use of validated home safety assessments.

Where does the evidence come from?
Berkshire East Falls Strategy 2005 BECHS Information Team, National Audit of the Organisation of Services for Falls and Bone Health of Older People (HQIP 2009), data collected by Specialist Practitioner in Falls Prevention and Bone Health BECHS

Needs by disease / illness

Sexual and reproductive health

Investment in sexual health services can deliver healthcare savings through preventing unplanned pregnancies and reducing the transmission of Sexually Transmitted Infections (STIs) including HIV. There is evidence that investment in sexual health interventions is good value for money (within the cost-effectiveness range accepted by the NHS) and in many cases cost-savings. Primary Care Trusts (PCTs) are responsible for ensuring sexual health services meet local population needs and reduce health inequalities.

Protecting confidentiality is a key issue for attendees at local genitourinary services, making data disclosure very difficult. This situation has been partially overcome with the introduction of new software and by the collaboration in 2008 between SEPHO and the HPA which has resulted in the production of a Southeast regional sexual health report. The following extracts have been reproduced with the permission of the HPA. This has allowed a comparative analysis by unitary authority area (which does not contravene confidentiality agreements).

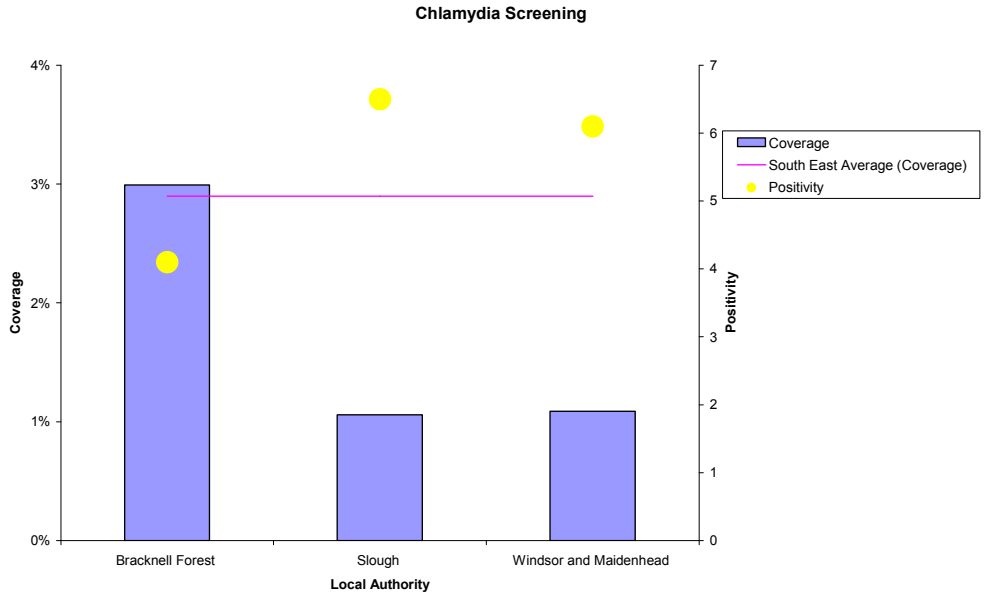
Sexuallly Transmitted Infections The HPA annual report for the Southeast shows that Genital chlamydial infection is the most commonly diagnosed sexually transmitted infection (STI) among young people with some 6893 cases in 2008. Genital warts are the next most frequent at 6123 cases, then herpes at 1968, gonnorrhea at 565 and syphilis at 113.

Chlamydia Screening rates

Target for 2009/10 25% 14-24 year olds screened, this amounts to 12,000 screening tests to be carried out across East Berkshire.

Rates of screening in Berkshire East are among the lowest in the UK. The provision of out reach testing sites in schools, colleges and other facilities such as GP surgeries and pharmacies is enabling quicker access to screening but meeting the targets will prove challenging.. Q4 results for Bracknell Forest for 2008/9 are shown below

Figure 28 Chlamydia screening rates by locality (2008/9)



The HPA annual report for the Southeast shows that Chlamydia remains the highest number of new infections recorded with some 6,893 cases in 2008. Genital warts are the

next most frequent at 6123 cases, then herpes at 1968, gonorrhoea at 565 and syphilis at 113.

Rate of conceptions

Rates of teenage conceptions leading to pregnancy are inversely correlated with deprivation according to the SEPHO/HPA report.

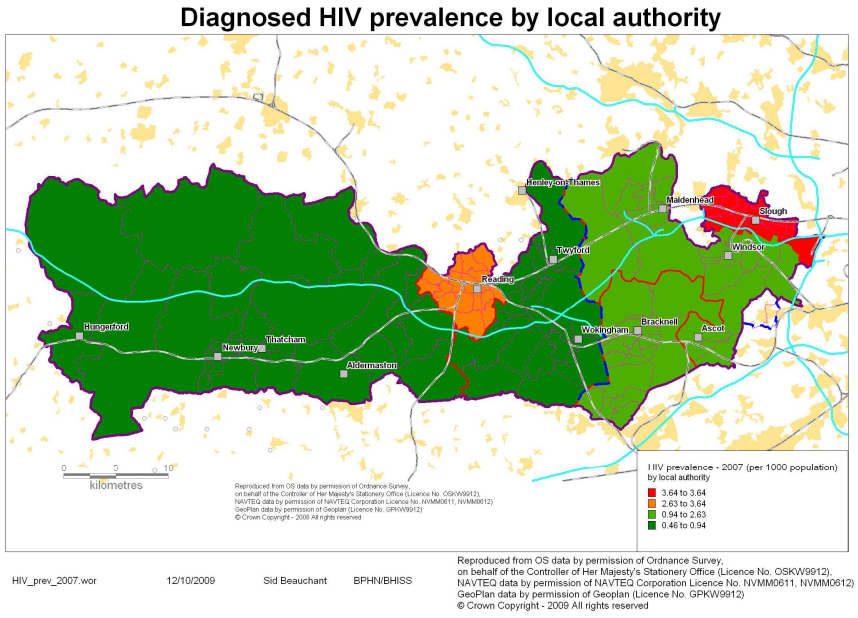
In Bracknell Forest teenage conception rates remain low and are now lower than the Southeast and England average.

HIV rates

The HPA report into the prevalence of HIV in the UK (2008) notes that Bracknell has a rate of 0.95/1000 of the population, this is a relatively low rate compared to Slough which has a rate of 3.75/1000.

HIV in Slough and nationally is disproportionately found among the BME community A significant amount of work is being done by the NHS Sexual Health Promotion Specialist for Disadvantaged Communities to raise awareness of HIV in all communities. Projects to date include; for Sexual Health Awareness Week, year round leaflet displays and information on HIV and TB, collections and public events in association with World Aids Day, Continuing to target the BME population and in particular Sub-Saharan African nationals in a non-judgemental way will increase awareness around TB and HIV with the aim of decreasing stigma around both HIV and TB (in ethnic minority groups.) However, greater funding for HIV and TB in the Sub-Saharan African community is required to reach a larger audience within a shorter time frame.

Figure 29 HIV rates by locality (2008/9)



Sexual violence against women

By comparison with other local authorities in NHS South Central rates of sexual violence against women were below the average in Bracknell Forest but underreporting is an issue nationally. A local sexual abuse and rape centre will be established in Berkshire East in 2010.

You're Welcome

A key priority to 2020 is the need to ensure that all clinical services accessed by young people meet the new quality standards called You're Welcome. These were introduced

by the Department of Health this year. The priority services this year are; "sexual health drop in" sessions at schools and Further Education settings, general practice contraceptive and Family Planning clinics, pharmacies offering early hormonal contraception and abortion services. Services can now download the standards; self assess and work towards them at their own pace from the link below in evidence.

Continue to offer dual STI and family planning advice to reduce the rate of STIs and terminations

A dual strategy of preventing sexually transmitted infections (STIs), including HIV and Chlamydia and offering family planning advice is being offered through secondary schools and outreach clinics.

Screening for chlamydia among young people should also continue to be supported and developed.

Although the number of teenagers becoming pregnant has fallen in Bracknell Forest over recent years, data for the first quarter of 2008 shows an increase. Work to reduce conception rates is dependent on continuing to offer support and advice to all sexually active people, including advice on contraception.

Rates of terminations have risen over the last two years and are typically greater among women who are in their 30's and 40's and those who are affluent.

Maintain rapid access to sexual health clinics

The number of people offered access to genitourinary medicine (GUM) clinics rapidly (within 48 hours) for advice and support with sexual health issues, is very good (100% for East Berkshire as a whole,). However more people are choosing to delay their appointment and this is impacting on those actually attending i.e 90% versus a target of 95% (Q2 2009).

Improving access to local services via GP centres other than at the Garden Clinic has been a shared priority for some six years. New funding to improve the delivery of extra sites for early hormonal contraception and long acting reversible contraception will ensure the delivery of newly more locally delivered services in Berkshire East.

You're Welcome Quality Standards

You're Welcome quality standards were introduced by the Department of Health this year, to ensure health services are young people friendly. A key priority towards 2020 is the need to ensure that all health services for young people are appropriate and accessible, wherever they are delivered. The priority services for ensuring the standards are introduced this year are; Sexual Health Drop Ins at schools and Further Education settings, General Practice Contraceptive and Family Planning clinics, Pharmacies offering Emergency Hormonal Contraception and Abortion services. The PCT Lead for You're Welcome should encourage services to download the standards and self assess their own services against the criteria.

The prevention of pelvic inflammatory disease is a priority in Slough as it is statistically above the NHS South Central average.

Pelvic inflammatory disease is a common infection of the womb, fallopian tubes and other reproductive organs. Arising typically from complications of sexually transmitted infections it can result in ectopic pregnancy, infertility and chronic pelvic pain.

Reducing unnecessary admissions to hospital is a key priority.

Where does the evidence come from?
SEPHO/HPA Report on the Sexual Health of NHS South Central 2008/East Berkshire Sexual health needs assessment 2009 / Children & young people's plan priorities 2009/10 / HPA report into HIV rates in Britain 2008/HPA extract for the South East - number of new episodes of selected diagnoses 2004-2008
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097571

Infectious diseases

Implement the recommendations for recommissioning TB services

In Berkshire East the TB rates in Slough area higher than in London and a needs assessment recommended (Balakrishnan, 2008) that TB services should be redesigned to provide integrated secondary and primary and social care support and services. This service has yet to be fully operationalised but will be a Berkshire East service.

Ensure the take up of seasonal flu vaccination is increased

The Berkshire East Pandemic Flu plan has been tested in the since May 2009 and revisions based on the learning from that should be shared. The vaccination programme for swine flu HINI has been introduced and it will be important to ensure take up to avoid very serious consequences for some people. We may face a challenge in relation to vaccination and public confidence, particularly among pregnant women.

Increase the number of children receiving pre-school immunisations

The number of children in East Berkshire who receive their pre-school boosters at around three and a half years old, is relatively low compared to the new more challenging target of 95% of all children to be immunised through the child health immunisation schedule.

Berkshire East figures for Q1 (2009/10) show that Diptheria, Tetanus and Polio (DTP) at 5 years and Mumps, Measles and Rubella (MMR) at 5 years are the furthest below target at 79.6% and 76.7% respectively. DTP at one year was 94.8%, Haemophilus Influenza B (Hib) /Meningitis C at 2 years 92.5%, Polio CVB at 2 years was 90.1% and MMR at 2 years was 89.4%.

High levels of immunisation in the population are important to reduce the transmission of these potentially serious infections between people, including un-immunised adults. The lack of the second dose of MMR means that immunity is reduced in the population and has been associated with measles outbreaks in travellers in 2008/9.

Monitor all age all cause mortality rates

All age all cause mortality rates were higher than expected against a challenging target for 2008 for Berkshire East as a whole. Annual analysis is undertaken to understand changes in trends. Interventions to reduce rates of cardiovascular disease and cancer are underway therefore any recent increases may reflect other key contributors such as respiratory and infectious diseases.

It was evident that in 2007 the rates of death due to pneumonia (lung infection) and other infectious diseases (the latter in women only) were higher in Bracknell Forest than the rest of the region or the country as a whole, even when the age and sex-profile of the area was taken into account (the South East generally has a relatively elderly population, so without correction for this it might be expected to see more pneumonia cases).

Death due to pneumonia was recorded as 35.82 per 100,000 people per year in Bracknell Forest in 2007, compared with 29.37 for England and Wales; and for infectious and

parasitic disease in women, 11.71 per 100,000 per year, compared with 7.63 in England and Wales.

Although this may be a genuine rise, it is most likely that it is due to variation in how death certificates are filled in across the country, but could also be a function of the numbers of care homes (13) in the area.

Where does the evidence come from?
Thames Valley Health protection report/Immunisation data from TVPCA:Child Health/Mortality data / Immunisation uptake data from TVPCA; seasonal flu lead / RDPH letter Sept 09

Needs by disease / illness

Cancers

Cancer mortality for all cancers (Source National Cancer Registry) is falling in line with predicted trends nevertheless it is the greatest cause of years of life lost.

Years of life lost 2005-2007

UA Code	All Cancers	Circulatory Disease	CHD	Accidents
Bracknell Forest UA	155.0	56.7	30.7	31.5
West Berkshire UA	151.9	60.4	32.1	37.6
Reading UA	147.5	93.9	54.0	22.9
Slough UA	124.3	119.1	70.3	32.5
RBWM UA	131.4	64.8	36.5	22.6
Wokingham UA	122.2	58.0	30.8	21.5
Berkshire	137.7	73.5	41.0	27.4

The World Health Organisation cites the following risk factors as causally related from the General Surgeons report (2004)

- High intake of alcohol is causally related with the onset of cancers.
- Being overweight or obese is causally related to some cancers as well as type 2 diabetes..
- Physical inactivity is causally related to cancers
- Smoking is causally related to bladder, cervix, oesophagus, kidney, liver, lung, oral cancer, pancreas and stomach cancer as well as acute myeloid leukaemia. Lung cancer is causally related to smoking which remains the most influential risk factor and strongly associated with poverty
- By contrast the consumption of at least five portions of fruit and vegetables is protective against some cancers.

The chronic diseases of affluence are very different to those of poverty. Bowel and breast cancer are more strongly associated with obesity and affluence in developed countries. The South East cancer inequalities report highlights Slough in Berks East as having high levels of deprivation. Specifically, lung cancer incidence and mortality rates are higher in Slough and mortality rates are higher in females in Bracknell Forest.

Screening programmes for breast cancer, cervical cancer and bowel cancer screening are all selected as part of World Class Commissioning priorities by the primary care trust.

Plan for rise in cancer cases

The number of people diagnosed with cancer is expected to rise significantly (by 34.3%) over the next 10 years, in part due to an ageing population. Health and social care services will need to take this into account when planning community (primary) and hospital (secondary and tertiary) care.

The Cancer Reform Strategy details the Cancer Research UK's Reduce the Risk campaign results- only 5% of the population could unprompted name four of the six lifestyle the factors linked to cancer (smoking, obesity, healthy diet, physical activity, excessive alcohol intake and excessive exposure to sunlight) and 77% could only name two or fewer of them. Awareness of risk factors was also identified as being particularly low among deprived groups. Raising public awareness of the risk factors for cancer will be critical to facilitate the process of behaviour/lifestyle change.

Monitor skin cancer death rates locally

The male death rate for a serious skin cancer, malignant melanoma, 8.0 per 100,000 residents per year, is significantly above that for England (2.38). The most likely explanation for this is that it is a chance finding (a 'blip') which won't be repeated in subsequent years, because the number of people suffering with this cancer is very small. However, it would be sensible to monitor this carefully, and investigate any confirmed trend of higher death rates. Malignant melanomas are sometimes associated with excessive sun exposure.

Monitor infectious diseases and promote HPV vaccine uptake

Hepatitis B causes liver cancer. Helicobacter pylori causes stomach cancer, HIV infection causes cancers such as Karposi's sarcoma and Non Hodgkin's lymphoma, and Schistosoma haematobium causes bladder cancer. Some types of Human papilloma virus cause cervical cancer and promoting uptake of the HPV Vaccine is ongoing in school and out of school settings.

Where does the evidence come from?
National Cancer Registry/ TV Cancer commissioning guidance/ WHO Mortality data / Long-term condition projections/NCHOD mortality data Cancer Inequalities in the South East: the burden of cancer/ Cancer Reform Strategy

Needs by disease / illness

Respiratory illness

Smoking is causally related to the development of chronic respiratory diseases such as; chronic obstructive pulmonary disease and asthma which can be exacerbated by environmental triggers such as damp or poorly ventilated housing, benzene emissions, house dust mites etc.

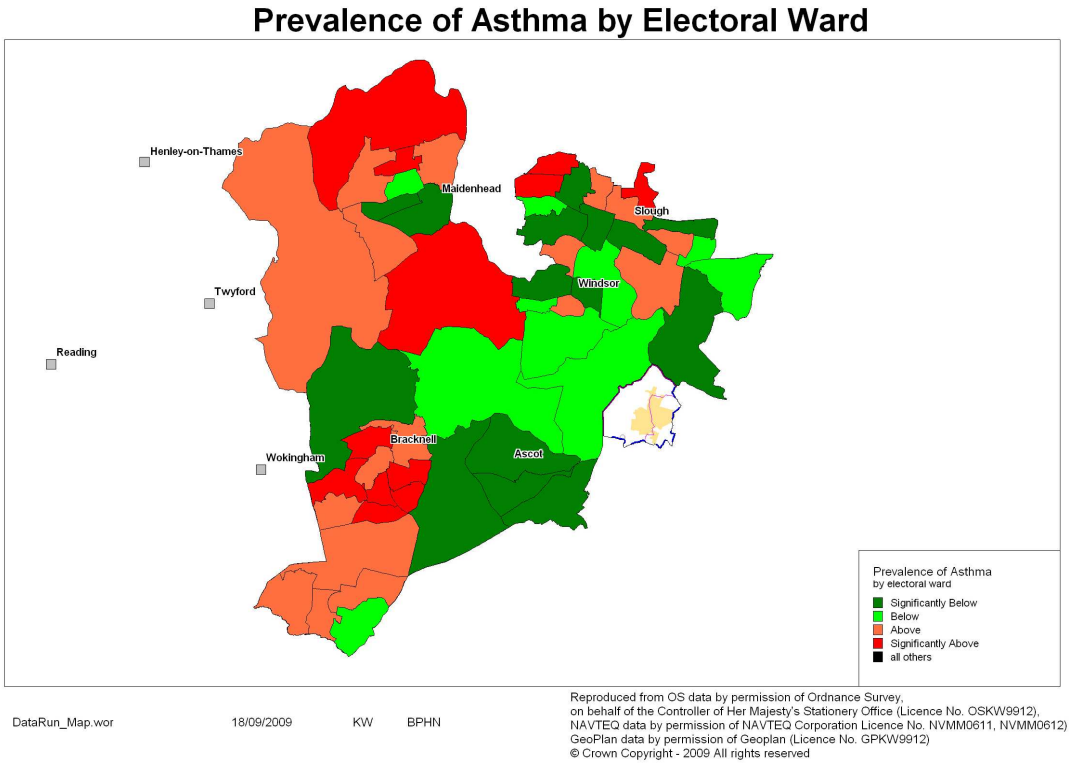
Pneumonia, respiratory effects in utero and in children and young people are also causally related to smoking. Smoking is a risk factor for infectious diseases such as Meningitides neissera.

Childhood asthma rates nationally are increased and local patterns of disease are being monitored in local areas where there is concern about air quality.

The WHO have identified risk factors such as tobacco, occupational exposures, indoor exposures from biomass fuel, and childhood exposure to respiratory infections.

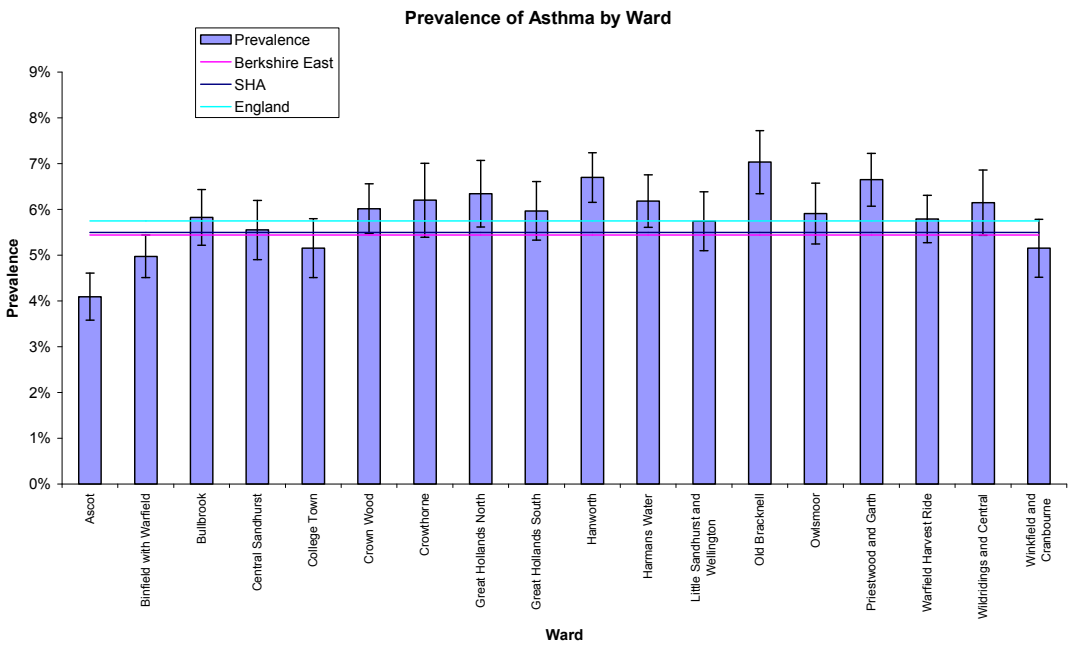
Asthma by ward

Figure 30 Prevalence of asthma by ward in Berkshire East (Qof 2008/9)



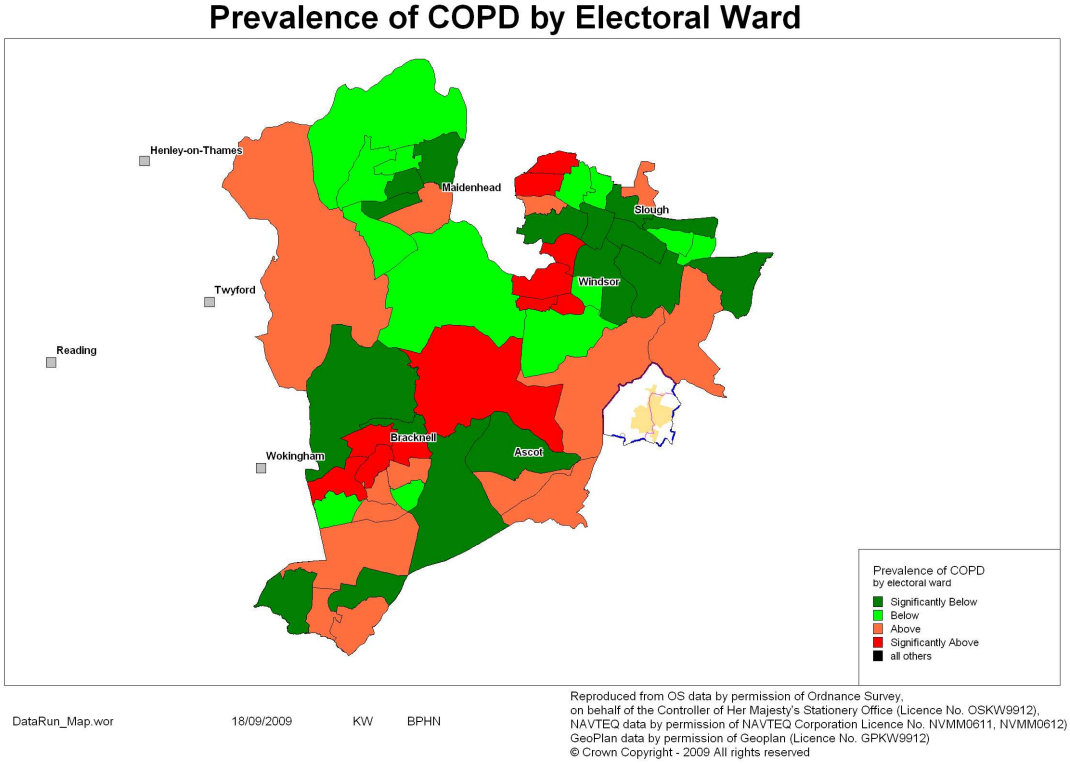
Only Hanworth and Old Bracknell are statistically above the mean for England

Figure 31 Prevalence of asthma by ward (Qof 2008/9)



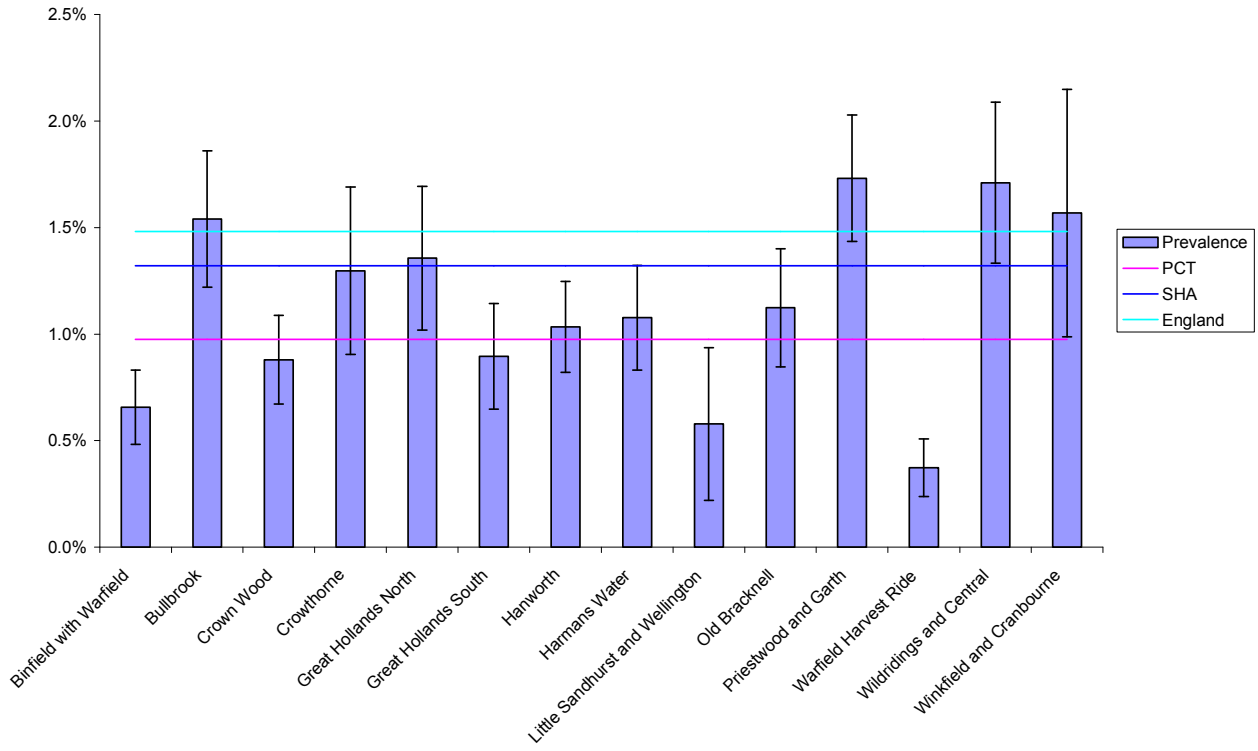
Chronic obstructive pulmonary disease by ward

Figure 32 Prevalence of chronic obstructive pulmonary disease by ward (Qof 2008/9)



Only Priestwood and Garth and Wildridings and Central are above the PCT and SHA mean

Figure 33 Prevalence of COPD by ward



Plan for rise in people with respiratory illness

The number of people diagnosed with long-term breathing (respiratory) problems is expected to rise significantly over the next 10 years. Asthma is projected to rise by a 7% and chronic obstructive pulmonary disease (COPD), a diagnosis which includes bronchitis and emphysema, to rise by 30%. Health and social care services will need to take this into account when planning community (primary) and hospital (secondary and tertiary) care.

Where does the evidence come from?
Long-term condition projections

Neurological illness

The local long term conditions needs assessment focussed on the working age population and will be refreshed in 2010 for all ages.

The National Service Framework for Long Term Conditions (DH 2004) focused on neurological diseases. It covers 11 Quality Requirements:

1. A person centred service
2. Early recognition, diagnosis and treatment
3. Emergency and acute management
4. Early and specialist rehabilitation
5. Community rehabilitation
6. Vocational rehabilitation
7. Equipment and accommodation
8. Personal care and support
9. Palliative care
10. Support for family and carers
11. Care during admission to hospital or other health and social care settings

MS is the most common neurological disorder among young adults, which affects about one person in 600 in the UK which is equivalent to 85,000 people

Parkinson's disease is estimated to affect 100 -180 people per 100,000 of the population, around 120,000 people in the UK. The number of people with Parkinson's disease in the UK, is expected to double to 200,000 by 2030.

Motor Neurone Disease – The number of people who will develop MND each year is about two people in every 100,000. The prevalence or number of people living with MND at any one time is approximately seven in every 100,000.

Update the needs assessment for long term neurological conditions

A needs assessment was conducted for neurological conditions in 2005 in an adjacent borough this should be replicated across the area taking into account the recommendations of the Kings Fund.

Enable those with learning disability to manage their medications

The management of epilepsy is through medication and many people with learning disability also have epilepsy. National studies suggest epilepsy is prevalent in 40% of those with a learning disability. Patient education should be prioritised with this group.

Epilepsy by ward

The management of epilepsy is through medication and many people with learning disability also have epilepsy. National studies suggest epilepsy is prevalent in 40% of those with a learning disability.

Plan for rise in people with epilepsy

The number of people diagnosed with epilepsy in the Borough is expected to rise significantly over the next 10 years, by 18.0%, partly due to local population expansion. Health and social care services will need to take this into account when planning community (primary) and hospital (secondary and tertiary) care.

Where does the evidence come from?
Long-term condition projections

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Glossary

Ambulatory Care Sensitive (ACS) conditions	These are defined as long-term health conditions that can often be managed with timely and effective treatment in the community without hospitalisation, implying that a proportion of ACS admissions could be prevented.
A & E	Accident and Emergency
Acute Hospital	A hospital that provides urgent or planned treatments or operations, and outpatient appointments
Admission	A term used to describe when someone requires a stay in hospital.
AF	Atrial Fibrillation is a cardiac arrhythmia (abnormal heart rhythm) that involves the two upper chambers (atria) of the heart.
Age Standardisation (AS)	A statistical method used so that disease and death rates of populations with different age profiles can be compared meaningfully, since we know that people are more likely to become ill and die as they get older. There are 2 commonly used variations – direct and indirect.
Age Standardised Mortality Rate (ASMR)	ASMR is calculated to compensate for the fact that men and women have different death rates and that these rates are also vary by age. ASMRs then allow for different populations to be compared. ASMRs applied to a standard population (an ideal population that doesn't actually exist) are known as Directly Standardised Mortality Rates (DSMRs).
Alcohol related Attributable Crimes	These figures are estimates based on applying a national alcohol-related proportion to total crime figures so they may simply indicate high crime figures rather than crimes where alcohol actually was a factor.
Annual Extract of Deaths	Berkshire Public Health Network PH Intelligence team's mortality data for Berkshire West and East.
Antidepressants	Medications used to treat depression
APHO	Association of Public Health Observatories
AST	Assured shorthold tenancy
Asylum Seekers	People who have fled their home country, who have applied for asylum and are awaiting a decision to grant them refugee status.
Audit Commission	The Audit Commission is an independent body responsible for ensuring that public money is used economically, efficiently and effectively.
Binge Drinkers	Binge drinking is defined as "consuming 8 or more units on a single occasion for men and 6 or more units for women". *a pattern of heavy drinking that occurs during an extended period of time set aside for drinking. Has been described as 5/4 binge drinking: five or more drinks in a row on a single occasion for a man or four or more drinks for a woman.*
BCS	British Crime Survey. The British Crime Survey is a very important source of information about levels of crime and public attitudes to crime and other Home Office issues. The results play an important role in informing Home Office policy.
BDASS	Berkshire Drud and Alcohol Service
BF	Bracknell Forest Borough Council
Black and Minority Ethnic (BME)	Defined by ONS as including White Irish, White other (including White asylum seekers and refugees and Gypsies and Travellers), mixed (White & Black Caribbean, White & Black African, White & Asian, any other mixed background), Asian or Asian British (Indian, Pakistani, Bangladeshi, any other Asian background), Black or Black British (Caribbean, African or any other Black background), Chinese, and any other ethnic group.
BMI (Body Mass Index)	An estimation of body fat based on height and weight. BMI can be used to determine if people are at a healthy weight, overweight, or obese. To

	figure out BMI, use the following formula: Weight in kg ÷ (Height in metres X Height in metres) A body mass index (BMI) of 18.5 up to 24.9 refers to a healthy weight, a BMI of 25 up to 29.9 refers to overweight and a BMI of 30 or higher refers to obese.
Cardiovascular Disease (CVD)	Cardiovascular disease refers to conditions that involve the heart or blood vessels. They include CHD (about 50%) and stroke (about 25%), and all other diseases of the circulatory system.
Care Quality Commission (CQC)	Successor to Healthcare Commission, Commission for Social Care Inspection and
CABG	Coronary Artery Bypass Graft
CAMH	Child and Adolescent Mental Health
CCHI	Compendium of Clinical and Health Indicators
Census	A national survey of the population of the UK undertaken every ten years. The last Census was in 2001.
Chlamydia	A common sexually transmitted infection which many people do not know they have because they often don't have any symptoms. Left untreated, Chlamydia can cause infertility in women. *A sexually transmitted infection caused by the bacterium Chlamydia trachomatis. Infection may not cause symptoms and long term consequences can include infertility. Effective testing and treatment are available.*
CHD	Coronary Heart Disease. Heart disease caused by poor circulation of the blood to the heart muscle because the blood vessels have become blocked. Consequences include chest pains (angina) and heart attack (myocardial infarction).
Child Protection Plan	If a child's name is added to the child protection register, a child protection plan is drawn up to make sure the child is kept safe and to help the family.
Child Protection Register	The child protection register is a confidential list of children and young people in an area that are believed to be in need of protection.
Young People Plan	Children's Services with the help of the children and young people of the city. It sets out the vision, priorities and actions.
NCSP	National Chlamydia Screening Programme - A plan to begin implementing a national screening programme for chlamydia was included in the Department of Health's National Strategy for Sexual Health and HIV.
CDOP	Child death overview panel
CHIMAT	Child and maternal health
CIPFA	Chartered Institute of Public Finance and Accountancy
Circulatory Disease	Diseases of the circulatory (blood) system including heart disease and stroke.
CKD	Chronic Kidney Disease
Commission for Social Care Inspection	Body which regulates, inspects and reviews all adult social care services in the public, private and voluntary sectors in England. Replaced by Care Quality Commission

Commissioning a patient-led NHS	This document builds on the NHS Improvement Plan and Creating a Patient-Led NHS. Its focus is on creating a step-change in the way services are commissioned by front-line staff, to reflect patient choices. Effective commissioning is a pre-requisite for making these choices real. It does so in the overall context of improving the health of the whole population.
Clostridium difficile (or C.difficile) – C Diff	A bacterium that can cause an infection of the gut and is an important cause of hospital associated diarrhoea.
Commissioning Framework for Health and Well Being	A DH framework for commissioners of services to enable improvement in the health, well being and independence of the population living in an area This document described JSNAs.
Community Care Act	National Health Service and Community Care Act 1990.
Community services	Services provided by the council in peoples' homes eg homecare, direct payments, day care
Confidence Interval (CI)	The range of values within which we are 95% confident that the true population value lies.
Confidence Limits	The upper and lower values of a confidence interval.
COPD	Chronic Obstructive Pulmonary Disease Lung disease characterised by coughing, wheezing, breathlessness and fatigue. Most often associated with smoking. A chronic condition frequently requiring health and/or social service input.
Correlation	In statistics, correlation, also called correlation coefficient, indicates the strength and direction of a linear relationship between two variables.
Coterminous	Areas that have the same boundaries.
CDRP	Crime and Disorder Reduction Partnerships - The 1998 Crime and Disorder Act established partnerships between the police, local authorities, probation service, health authorities, the voluntary sector, and local residents and businesses. These partnerships are working to reduce crime and disorder.
DAAT	Drug and Alcohol Action Team
Decent Homes	A home that meets the Decent Homes Standard. This means housing is in a reasonable state of repair, has reasonably modern facilities and services, and provides a reasonable degree of thermal comfort. As a minimum all council homes will have to meet these standards by 2010 to comply with Government requirements.
Dementia	Dementia is the loss (usually gradual) of mental abilities such as thinking, remembering and reasoning. There are many different types of dementia, each with their own causes.
Deprivation Quintiles	Deprivation quintiles divide areas in fifths according to some measure of deprivation, and can be used to analyse variations in health between deprived and affluent sections of the population regardless of where they live.
Determinants of Health	The range of personal, social, economic and environmental factors which determine the health status of individuals or populations. They include health behaviours and lifestyles, income, social and economic status, education, employment, working conditions, access to health services, housing and living conditions and the wider physical environment.

Directly Age Standardised Rates (DASR)	Directly Age Standardised Rate – this allows the comparison of incidence rates between populations of differing age and sex structure. Most standardisation is done to the European Standard Population. Usually rates are expressed per 100,000. These rates are directly comparable relative to each other. *Standardisation adjusts rates to take into account any changes in the age structure of the population at risk and allows comparison over time and between different geographical locations. Rates have been standardised to the European Standard Population.*
DH	Department of Health
DoH	Department of Health
Diastolic blood pressure	Blood pressure (strictly speaking: vascular pressure) refers to the force exerted by circulating blood on the walls of blood vessels. The diastolic arterial pressure is the lowest pressure (at the resting phase of the cardiac cycle)
Diabetes	A condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. It can lead to serious complications or damage to organs, particularly if the condition is not well controlled.
Diabetic Retinopathy	People with diabetes are at risk of vascular problems including eye problems as a complication of diabetes. Diabetic retinopathy is caused by damage to the blood vessels in the retina. Over time, diabetic retinopathy can cause vision loss.
Direct Payments	Direct payments create more flexibility in the provision of social services. Giving money in place of social care services means people have greater choice of provider for their care.
DMFT	Diseased, Missing, Filled Teeth
DSR	Directly Standardised Rate – see DASR *The direct method of age standardisation (q.v.) calculates the rate of events that would occur in a standard population (usually the European standard population) if it had the age-specific rates of the subject population.*
EAL	English as an Additional Language
Early Learning	Foundation stage curriculum (3 to 5 years) has 6 areas of learning.
Economically Active	Collective description of people, including full time students, who are working or looking for work and are available to start work within 2 weeks.
EET	Employment, Education or Training
Elective Admission	A patient admitted to hospital for a planned clinical intervention, involving at least an overnight stay.
Electoral ward	An electoral ward is a division of an administrative area used to elect councillors to serve on councils of the administrative areas. *A geographical area which is an administrative subdivision of a local authority (q.v.), representing the level at which councillors are elected. Electoral wards are the key building blocks of UK administrative geography.*
Emergency Hormonal Contraception (EHC)	Available over the counter from pharmacies
Emergency (non-elective) Admission	An unplanned admission to hospital at short notice because of clinical need or because alternative care is not available.
Fasting Glucose	A measurement of the blood glucose in the morning prior to the ingestion of any food for the prior 12 hours.
Fixed Term	A fixed period Exclusion means that a pupil is not allowed into school or Exclusion onto school grounds for a set number of days.
FSM	Free School Meals
GCSE	General Certificate in Secondary Education

General Household Survey (GHS)	Continuous national survey carried out by the Social Survey Division of the ONS (q.v.)
Gonorrhoea	Is a common sexually transmitted infection also known as 'the clap'. It's serious because if not treated early it can lead to some very serious health problems.
GP	General Practitioner
GUM	Genito-Urinary Medicine The branch of medicine that deals with the male and female sexual organs and the urinary system (the system in the body that produces, stores and gets rid of urine). GUM clinics are specialist services to care for people with sexually transmitted infections
GUM Clinic	Genitourinary Medicine clinics, sometimes known as Sexual Health clinics for all aspects of sexual health. You receive free, confidential advice and treatment.
Health Inequalities	Variations in health identified by indicators such as infant mortality rate, life expectancy which are associated with socio-economic status and other determinants.
Health Protection Agency (HPA)	National agency to provide health protection specialist advice and leadership.
Healthcare Associated Infection (HCAI)	Infections that are associated with admission to hospital or as a result of healthcare interventions in other healthcare facilities, to a patient or healthcare professional.
Herd Immunity	Resistance of a population to spread of an infectious organism due to the immunity of a high proportion of the population.
Hepatitis B	Is an acute viral infection of the liver caused by a virus. It can be transmitted by sexual contact, shared needles, needlestick injury, transfusions of contaminated blood products, ineadequately sterilized equipment, tattooing, mother to baby transmission (during or shortly after childbirth). Hep B can cause jaundice, permanent liver disease or liver failure and cancer. Most people have no obvious symptoms, and there is no known cure.
Hepatitis C	Is an infection of the liver caused by a virus. It can be transmitted by contact with blood or body fluids. Modes of transmission include; unprotected sexual contact, contaminated equipment, use of shared toothbrushes and razors, tattooing, skin piercing, medical and dental procedures with contaminated blood products and as well as maternal transmission. Hep C can cause chronic liver disease, cirrhosis and rarely liver cancer. Most people have no obvious symptoms, and there is no known cure.
HIV	Human Immunodeficiency Virus is a retrovirus that can lead to acquired immunodeficiency syndrome (AIDS). HIV *stands for Human Immunodeficiency Virus and is a virus that can damage the body's defence system so that it cannot fight off certain infections. If someone with HIV goes on to get certain serious illnesses, this condition is called AIDS which stands for Acquired Immune Deficiency Syndrome*.
HNA	Health Needs Assessment
Hospital Episode Statistics (HES)	A data warehouse containing details of all admissions to, and treatments in NHS hospitals in England.
Housing Option Service	The Housing Options Service delivers a range of services to people with housing accommodation needs, including those who are homeless or threatened with homelessness. We assess the client's needs for rehousing, give advice to clients on the options available, arrange temporary accommodation for homeless people in line with Government legislation, and allocate permanent housing.
HPA	Health Protection Agency

HSE	Health Survey for England, also Health and Safety Executive *The Health Survey for England (HSE) is a series of annual surveys about the health of people in England, beginning in 1991. Each year the Health Survey for England focuses on a different demographic group and looks at such health indicators as cardio-vascular disease, physical activity, eating habits, oral health, accidents and asthma*
Human Papillomavirus (HPV)	The name for a group of related viruses, some of which occur on the cervix and are risk factors for cervical cancer.
ICD 10	International Classification of Diseases, version 10 (International Statistical Classification of Diseases and Related Health Problems)
IMD	Indices of Multiple Deprivation *This is calculated by scoring different dimensions of deprivation – income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services. A higher score implies greater deprivation. (For more information see the website for Communities and Local Government http://www.communities.gov.uk)*
Immunisation	Protection of susceptible individuals from communicable disease by administration of a living modified agent, a suspension of killed organisms or an inactivated toxin.
Incidence	Rate of occurrence of new cases of disease (within a given population over a given time period)
Infant Mortality Rate	Mortality of those aged less than one year. *The number of deaths of infants under age 1 per 1,000 live births in a given year.*
Inequalities	A lack of equality or fair treatment in the sharing of wealth or opportunities between different groups in society
In-patient	A person who has been admitted to hospital.
IOTN	Index of Orthodontic Need
ISA	Independent safeguarding authority
Intrauterine Device (IUD)	Contraceptive device
JSNA	Joint strategic needs assessment – a statutory needs assessment – see definition.
Key Stage 1	Children aged 5 – 7, – at the end of each key stage, each National Curriculum subject has a target: children should reach a particular level of skills, knowledge and understanding.
Key Stage 2	Children aged 7 – 11, – at the end of each key stage, each National Curriculum subject has a target: children should reach a particular level of skills, knowledge and understanding.
Key Stage 3	Children aged 11 – 14, – at the end of each key stage, each National Curriculum subject has a target: children should reach a particular level of skills, knowledge and understanding.
Key Stage 4	Children aged 14, – at the end of each key stage, each National Curriculum subject has a target: children should reach a particular level of skills, knowledge and understanding.
LAA	Local Area Agreement – LAAs set out the priorities for a local area agreed between central government and a local area (the local authority and Local Strategic Partnership) and other key partners at the local level.
LARC	Long Acting Reversible Contraceptives. An example of Depot (injection based) forms of contraception.
LD	Learning disability (e.g mild, moderate and severe)
LDP	Local Delivery Plan

Life Expectancy (LE)	LE is a statistical measure of the average length of survival of a living thing. It is often calculated separately for differing gender and geographic location. *Life expectancy is an estimate of the number of years a new-born baby would survive if they were to experience the particular area age-specific mortality rates for that time period they were born in throughout their lives. It is important to note that a life expectancy at birth of 80 years does not mean than someone born today can, on average, expect to live 80 years (in fact, they can expect to live longer if mortality rates continue to fall). It is legitimate to say however, that a population with a life expectancy of 80 years is healthier (or at least has lower mortality) than a population with one of 70 years.*
Limiting Long Term Illness (LLTI)	A self assessment of whether a person has a limiting long-term illness, health problem or disability which limits their daily activities or the work they can do, including problems that are due to old age. Part of the decennial census
Live Births by Maternal Age	The number of live births to mothers resident in an area by age. The lowest rank is allocated to the lowest percentage.
Local Authority (LA)	In most of England outside the major towns and cities, there are two levels of local government - county and district – run by their respective councils, and responsible for different types of local services. District councils can be borough councils or city councils. There is a system of Unitary Authorities (UAs) which combine the functions of county and district councils. There are six UAs in Berkshire.
Local Development Frameworks	The Government has introduced a new plan system to manage how development takes place in towns and the countryside. Together with the Regional Spatial Strategy it will determine planning system will help to shape the community.
Local Resilience Forum (LRF)	Sits at the apex of local civil protection arrangements in local government, providing vision, leadership and cabinet responsibility to all responders.
Localities	*Practice Based Commissioners come together either under a locality or consortia arrangement, with devolved indicative practice budgets, to achieve the best health outcomes for the populations they represent. The Locality Groups are not a legal entity but are able to work together to submit a business plan on behalf of the group rather than on an individual practice basis.*
Locality	A particular neighbourhood, place, or district
LSCB	Local safeguarding childrens board
Malignant Melanoma	The most dangerous form of skin cancer, a malignancy of the melanocyte, the cell that produces pigment in the skin.
Medfash	The *Medical Foundation for AIDS & Sexual Health* is a charity which works Standards for with policy-makers and health professionals, to promote excellence in the Sexual Health prevention and management of HIV and other sexually transmitted Services infections. They are supported by the British Medical Association. Medfash have published standards for Sexual Health Services.
MH	Mental Health
MSM	Men who have sex with men
Months of Life Lost	Months of life lost from alcohol related conditions 2002-2004, persons aged under 75. Based on expectation of life tables (Government Actuarys Department) and death statistics (Office for National Statistics). This figure allows for the future months of life lost as a result of death.
Morbidity	The extent of disease in a population.
Mortality	The incidence of death in a population.
National Curriculum	The National Curriculum is a framework used by all maintained schools to ensure that teaching and learning is balanced and consistent.

National Census	A census is a survey of all households in the country. It provides essential information from national to neighborhood level for government, business, and the community. There has been a census almost every 10 years since 1841. The most recent census was in 2001
National Clinical and Health Outcomes Development (NCHOD)	Organisation which produces the Compendium of Clinical and Health indicators – regularly updated sets of national and local health statistics.
National Child Measurement Programme (NCMP)	A programme established in 2005 in order to weigh and measure children in Reception year (aged 4-5 years) and Year 6 (aged 1011 years) to assess overweight and obese levels.
NDTMS	National drug treatment monitoring system
NEET	Not in Employment, Education or Training
NFER	National Foundation for Educational Research
NFER Statistical Neighbours	The NFER Statistical Neighbours are the ones that both Education and Children's social care have to use. More information on them can be found at http://www.dfes.gov.uk/rsgateway/DB/STA/t000712/index.shtml
NHS	National Health Service
NHSBSA	NHS Business Services Authority
NI	National indicator
NICE	National Institute of Clinical Excellence
NRT	Nicotine replacement therapy (NRT) is the use of various forms of nicotine delivery methods intended to replace nicotine obtained from smoking or other tobacco usage
National Service Framework (NSF)	NSFs are strategies for improving specific areas of care. They set National Standards, identify key interventions and put in place agreed time scales for implementation, to ensure equity and consistency of approach
NCMP	National Child Measurement Programme
Obesity	Obesity is a condition in which the natural energy reserve is increased to a point where it is associated with certain health conditions or increased mortality. body mass index (BMI), is a simple and widely used method for estimating body fat. A BMI over 30 is obese.
OHN	Our Healthier Nation –sets out the proposed 'Contract for health' as a partnership between the Government, local organisations and individuals. Published in 1999.
ONS	Office of National Statistics. *The Office for National Statistics (ONS) is the government department that provides UK statistical and registration services.*
ONS Cluster	The cluster analysis method places each area in a group with the other areas to which it is most similar in terms of the forty-two Census variables selected. This enables similar areas to be classified according to their particular combination of characteristics. The classification consists of two parts: a hierarchical classification of supergroups, groups, and subgroups, and an overlapping classification of "corresponding areas".
OPCS	Office of Population, Census and Surveys (former name for ONS)
Out of Area Care	provided to residents or registered patients of Berkshire PCT Placements outside of Berkshire PCT.
Output Area Classification (OAC)	An ONS tool which segments each Census Output Area (OA; approx 124 households) into one of 7 Super-groups, 21 groups and 52 subgroups. The classification was created from 41 Census variables and classifies every output area in the UK based of its value for those variables.
PALS	Patient advice and liaison service
PBB	Programme Based Budgeting – In 2002, the Department initiated the National Programme Budget Project. The aim of the project is to develop a source of information, which can be used by all bodies, to give a greater understanding of where the money is going and what we are getting for the money we invest in the NHS.

PbC	Practice-based Commissioning A government policy which devolves responsibility for commissioning services from PCTs to local clinicians. Under PBC, GP practices are given a commissioning budget which they use to provide services. The PCT acts as their agent in procurement of these services
PCT	Primary Care Trust *PRIMARY CARE TRUST - an NHS statutory body that is responsible for the planning and securing of health services and improving the health of their local population.*
PLD	Profound Learning Disability
Pneumococcal Infection	Pneumococcal disease is caused by the bacterium *Streptococcus pneumoniae*. This infection can cause a range of illnesses including: pneumonia (infection of the lungs), otitis media (infection of the middle ear), and meningitis (infection of the membranes around the brain). The pneumococcal vaccine protects against pneumococcal infection.
Projecting Older People Population Information (POPPI)	Online information and database system, provided by care services improvement partnership (CSIP). www.poppi.org.uk (See pansi)
Premature Mortality	Any death under the age of 75 years.
Prevalence	The extent to which a disease or condition is to be found in a population. Prevalence is a function of how many people contract a disease, and how long the condition lasts.
PCT	Primary care trust. Commissions health care in a defined local area whether in the community (not at hospital) or from acute care providers..
PDU	Problem drug user
Projecting Adult Needs & Service Information (PANSI)	Online information and database system provided by care services improvement partnership . www.pansi.org.uk (See poppi)
PSD	People with Physical and Sensory Disabilities
Public Service Agreement (PSA)	High level national targets set by Government for public services
Pupil Level Annual School Census	The Census is the Department's largest and most complex data collection exercise. The Census collects information from every school in England under Section 29 of the Education Act 1996 and Section 42 of the Schools Standards and Framework Act. The provision by schools of individual pupil records is a statutory requirement under Section 537A of the Education Act 1996. Local Authorities, other government departments, external agencies and educational researchers all use this information.
Quartile	A quarter of a distribution i.e., the first, second and third quartile points of 100 are 25, 50 and 75
QMAS	The Quality Management and Analysis System, known as QMAS, is a national IT system which gives GP practices and Primary Care Trusts objective evidence and feedback on the quality of care delivered to patients.
QOF	The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results.
RAG	Red, amber and green codes for performance indicators
RBWM	Royal Borough of Windsor and Maidenhead
Referrals, Assessments & Packages return (RAP)	Annual Department of Health statutory return for referrals , assessments and packages of care
READ Codes	A coded classification of clinical terms designed to enable clinicians to make effective use of computer systems

Registered population	The registered population is the population that the PCT are responsible for to provide health care. Everyone registered with a GP practice are included in the registered population count.
Registered Social Landlord	Shared ownership property is a home that has been built, usually by a Registered Social Landlord (a housing association) specifically to sell on a shared ownership basis.
Resident population	The resident population is the population physically living within a given area.
Secondary care	Health care provided in a hospital setting at a general hospital rather than a specialist hospital (when it is known as tertiary care).
SHA	Strategic Health Authority
SOA	Super Output Area. Standard geographical areas created for statistical purposes, to provide continuity of areas. Two levels; Middle and Lower.
SOPHID	Survey of Prevalent HIV Infections data
SR1	Supported Residents Return Annual Department of Health statutory return for residential and Nursing care
SSEN	The term 'special educational needs' (SEN) has a legal definition, referring to children who have learning difficulties or disabilities that make it harder for them to learn or access education than most children of the same age.
STI	Sexually Transmitted Infection
Syphilis	Is a sexually transmitted infection that can spread without either partner knowing. The first signs are often painless sores or rashes followed by flu-like symptoms. Left untreated, it can lead to heart disease or brain damage.
Systolic blood pressure	Blood pressure (strictly speaking: vascular pressure) refers to the force exerted by circulating blood on the walls of blood vessels. The systolic arterial pressure is defined as the peak pressure in the arteries, which occurs near the beginning of the cardiac cycle.
TB	Tuberculosis. An infection caused by a species of mycobacterium (q.v.) which still remains a major worldwide health problem. Deaths from this disease have declined since the1950's, but there has been a recent increase in tuberculosis incidence. It is transmitted from person to person by an aerosol of organisms suspended in tiny droplets that are inhaled.
TIA	Transient Ischaemic Attack – causes symptoms similar to a stroke - but symptoms last less than 24 hours. The most common cause is due to a tiny blood clot.
ToP	Termination of Pregnancy
Total Period Fertility Rate	The average number of live births that would occur per woman resident in an area if women experienced that area's current age-specific fertility rates throughout their childbearing life span.
Teen Pregnancy Unit (TPU)	National strategy unit for teenage pregnancy. Part of Department of Children, Schools and Families (DCSF)
UDA	Units of Dental Activity – Courses of treatment are divided into three bands depending on the complexity and length of treatment with Band 3 attracting the most UDAs.
Unemployment	Claimant count unemployment rates (proportion of working age people claiming Job Seekers Allowance).
UNICEF BFI	United Nations Children's Fund - Baby Friendly Initiative – The Baby Friendly Initiative is a global programme of UNICEF and the World Health Organization which works with the health services to improve practice so that parents are enabled and supported to make informed choices about how they feed and care for their babies.
VRA	Vascular risk assessment – now called the healthcheck

VS	Vital signs (A, B or C) a set of national indicators
WCC	World Class Commissioning
Ward	Strictly electoral ward, an administrative area that is laid down in statute. Berkshire covers 126 wards.
Weighted Capitation Population	The unified weighted population is used to allocate resources and budgets in the NHS and is a modified registered population.
WHO	World Health Organisation
WIC	Walk in Centre
YP	Young Person
YPLL (or PYLL,YLL)	Years of Potential Life Lost. A measure of premature mortality (q.v.). As a method, it is an alternative to death rates that gives more weight to deaths that occur among younger people. It uses a reference life expectancy (usually 75) to calculate a person's YPLL at death. Deaths over this age are rated zero.

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ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
1 DECEMBER 2009

PERSONALISATION UPDATE
(Director of Adult Social Care and Health)

1. INTRODUCTION

1.1 To note the work undertaken to ensure the Council meets its responsibilities in response to the Putting People First Agenda (Personalisation) and the outline plans to meet the milestones to March 2011.

2. SUGGESTED ACTION

That Adult Social Care Overview and Scrutiny Panel:

2.1 Notes the progress report, including the new "milestones", progress against which will be reported to the Executive in January; and

2.2 Notes the Personalisation Annual Report at Annexe B.

3. REASONS FOR SUGGESTED ACTION

3.1 The "Putting People First" Concordat set out the shared agreement between Government, Local Government and their partners for how people with additional support needs should be supported. It clearly sets the agenda for change in a number of key areas:

- Choice and control for adults with support needs
- Information and advice for people with support needs, regardless of who pays for the support
- Support that promotes independence
- Universal services
- All stakeholders working together to shape communities
- Cost effective, quality, outcome focused support

3.2 The Local Authority Circular DH 2008(1), Transforming Adult Social Care (TASC), demands that people be supported to understand the money and community resources available to them and will be encouraged to use these imaginatively to meet their needs. Councils need also to ensure that the supply and type of support that people need and want to buy. Creating capacity in the community and enabling natural support networks are integral planks to this agenda. Bracknell Forest Council approved an approach to personalisation and the associated programme of work including the pilot in summer 2008 which is being funded through a specific grant from the Department of Health.

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 None

5. SUPPORTING INFORMATION

Personalisation Pilot

5.1 In July 2009, Bracknell Forest Council began a seven month pilot study to test self-directed support for adults who meet the social care eligibility criteria and who would currently receive either services or a direct payment. Self-directed support will enable people and their family or informal support networks to have greater control over the type of support that is provided and the way in which it is delivered.

5.2 Self-directed support and personal budgets were already in place for adults with a learning disability. Although this will not be a new way of working to people who are supporting people with a learning disability some aspects of the pilot such as testing the new Resource Allocation System will still apply.

5.3 The pilot study is to test an approach to implementing self-directed support in Bracknell Forest.

- Individuals who are eligible for social care support complete a supported self-assessment questionnaire. The completed questionnaire is scored and weighted and the result determines the personal budget amount that the individual is entitled to pay for their support.

- Individuals receive a financial assessment and their contribution to their support costs (if they can afford it) is calculated.

- The individual develops a support plan, with help if needed, which will be agreed by the Council.

- The individual then chooses how they want to manage their budget – this could be via a direct payment to themselves or a third party (i.e. to a trust or a broker), through the personal facilitator working for the Council or a combination of those options.

The Council retains the duty to ensure that people's support plans are keeping them safe and their support needs are being met.

People taking part in the pilot still have access to specialist assessments, advocacy and a social worker if they need them.

5.4 The pilot study aims to test the following areas:

- Experiences and outcomes for people and carers taking part in the pilot, and their carers – in comparison with the traditional approach

- Testing of the personalisation procedures – including self-assessment and the Supported Self-Assessment Questionnaire, the Resource Allocation System, support planning, accessing support and information and review.

- Implications for other services/functions – including social work, occupational therapy, links with health, providers and community and voluntary groups
- Flexibility of support options and capacity within the community - what choices are people making and what supports and activities need to be developed further
- Implications for Council support services – including finance, legal, safeguarding, brokerage and commissioning
- Cost-effectiveness in comparison with standard approaches – need to record costs and estimate traditional cost for comparison

5.5 An evaluation tool for the pilot has been developed. The aim of the evaluation is to identify challenges and improvements associated with implementing the personalisation agenda. The evaluation covers both the developing processes and outcomes of personalisation by identifying key lines of inquiry as follows:

- Experiences and outcomes for people taking part in the pilot, and their carers
- Testing of the personalisation procedures
- Flexibility of support options and capacity within the community
- Implications for Council and other services
- Cost-effectiveness in comparison with standard approaches

The evaluation period is during February to March 2010 with the report available in April 2010.

5.6 The pilot is being carried out by a team of Personal Facilitators that was recruited for the purpose and is being managed by a Personalisation Development Manager.

5.7 The aim is to support a minimum of 40 individuals through the pilot split between care groups as follows:

- 3 older people with Mental Health problems
- 7 people with Long Term Conditions
- 5 people with Mental Health problems
- 25 older people

People selected will include -

- a representative sample of people in terms of the Bracknell Forest demographic, including both new and re-referrals, with varying support needs;
- at least a representative sample of people from BME groups.

All people approached to take part in the study will be informed that it is a pilot and they are asked to agree to take part in it.

5.8 The pilot has been accepting referrals for 3 months and is currently working with 47 individuals on the pilot which breaks down as follows:

- 15 people with a long term condition
- 25 older people
- 4 older people with mental health problems and
- 3 adults (18 – 65) with mental health problems

An additional 16 people with a learning disability are also being supported by the Personalisation Team. Two more referrals are needed to have a sufficient number of individuals to enable the pilot to be fully evaluated.

5.9 Of the 47 people on the pilot, 23 people have been informed of their indicative allocation (the amount of money the Council has assessed as being needed by the individual to pay for their support). These individuals are now in the process of developing support plans with a member of the team, their families and an advocate if needed.

5.10 Three people have been supported to present their support plans to the Council. It remains the duty of the Council to ensure that the support plan will keep people safe. Of the plans presented, two individuals have long term conditions and the other is an older person with dementia. The plans describe the individual, what is important in their life and their aspirations. It also details their current support arrangements, including any issues with those arrangements, and support that any carers may need to continue in their caring role. Finally, it details the new support arrangements and how the personal contribution and any contribution that the individual might make will be spent.

5.11 All the plans that have been presented to the Council have been approved and the individuals and families involved have identified significant benefits resulting from the changes to their support arrangements. All three people are choosing to take their budget as a direct payment and to employ personal assistants for some of their support. This enables the individual to know who will support them and to have control over what support is provided and when. As a result of positive feedback from one family, the Council has been contacted by a local support group to refer six older people with mental health conditions to the Personalisation Team.

<u>Department of Health Transforming Adult Social Care Milestones</u>

5.12 In September 2009 the Department of Health and its partners published milestones with targets for Councils for the implementation of the TASC circular. Appended to this report is the completed milestones document for Bracknell Forest. The milestones will be monitored locally through the Personalisation Programme Board and reported to the Council's Executive in January 2010.

5.13 The Personalisation Communication Strategy and the Corporate Engagement Strategy have action plans to address the milestones to ensure that all stakeholders are informed of the council's progress and have opportunities to contribute to strategic planning. By December 2010 every Local Authority area should have at least one user-led organisation. We are working with local groups to identify options and accessing support from the regional personalisation support team.

5.14 The Council has a mechanism (Supported Self-Assessment Questionnaire and Resource Allocation System) to allocate personal budgets. This is in operation for people with a learning disability and is being piloted for people in all other care groups. The evaluation of the pilot will inform the rollout plans and the workforce strategy to ensure that we meet the NI 130 target by March 2011 (that 30% of the people we support have a personal budget and/or a direct payment). This is a challenging target for the Council as a significant proportion of individuals supported do not go on to receive ongoing support from the Council following reablement. In December the Programme Board will set targets for each team.

5.15 The Council have a service, funded by a pooled budget with the PCT, to provide reablement services in order to prevent people, where possible needing ongoing support from the Council. There is a joint board to monitor the impact of the service. Monitoring the impact of preventative services to determine cashable savings is complicated and guidance from Department of Health is awaited.

5.16 An Information and Advice strategy for Adult Social Care is in development to ensure that individuals have universal access to information and advice. The front desk system, already in operation, provides a first point of contact for information and advice for all new calls to adult social care. An IT system to host information is currently being investigated.

5.17 The Council have commissioning strategies in place for all care groups which are due to be refreshed in the light of personalisation. The strategies are informed by the Joint Strategic Needs Assessment which is refreshed annually. A workshop was held in April to educate providers, from all sectors, about the personalisation agenda and the Council's programme for implementation. A further workshop is planned, in partnership with BFVA, following the pilot. The Community Capacity Building work stream and the internal Development Liaison Group are working to identify needs in the community and to co-ordinate future development work. A workshop will be held in May 2010 to understand the future commissioning requirements based on the aggregated needs of individuals.

6. ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The relevant legal provisions are contained within the report.

Borough Treasurer

6.2 The Borough Treasurer is satisfied that no significant financial implications arise at this time. However, the wider introduction of personalisation could have significant financial implications for individuals and the Council. For example, the introduction of the Resource Allocation System, and the potential redistribution of funding presents a financial risk. The completion of the pilot programme will help to undertake a detailed evaluation and to establish more clearly the financial implications and the potential impact on the budget.

Impact Assessment

6.3 The Personalisation agenda aims to make support flexible and responsive to meet the diverse needs of the community and to ensure that universal services are accessible.

Strategic Risk Management Issues

6.4 The risk log for the programme is within the annual report.

Other Officers

6.5 N/A

7 CONSULTATION

Principal Groups Consulted

Personalisation Implementation Team
Personalisation Programme Board
Departmental Management Team

Method of Consultation

7.1 Meetings

Representations Received

7.2 All recommendations have been incorporated within this version of the report

Background Papers

Putting People First, December 2007
LAC 2008 (1) DH Transforming Adult Social Care

Contact for further information

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Doc. Ref

Personalisation Annual Report 2008/9 & Milestones

PERSONALISATION

ANNUAL REPORT

Version 4 July 2009

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1. Introduction

1.1 This is the 2008/9 Annual Report of the Personalisation Programme (formerly Transforming Adult Social Care). It reports progress on the programme from the approval of the Project Initiation Document in summer 2008 until June 2009.

1.2 This programme of work in Bracknell Forest is the Council's response to the personalisation agenda, set out in "Putting People First", the multi-agency concordat launched in December 2007, which sets out a vision for adult social care for the next decade and beyond. Personalisation is the term that is increasingly used as it reflects the need for change in the wider community, rather than just within Adult Social Care.

2. Background

2.1 The "Putting People First" Concordat set out the shared agreement between Government, Local Government and their partners for how people with additional support needs should be supported. It clearly sets the agenda for change in a number of key areas:

- Choice and control for adults with support needs
- Information and advice for people with support needs, regardless of who pays for the support
- Support that promotes independence
- Universal services
- All stakeholders working together to shape communities
- Cost effective, quality, outcome focused support

2.2 The Local Authority Circular DH 2008(1), Transforming Adult Social Care, demands that people be supported to understand the money and community resources available to them and will be encouraged to use these imaginatively to meet their needs. Councils need also to ensure that the supply and type of support that people need and want to buy. Creating capacity in the community and enabling natural support networks are integral planks to this agenda.

2.3 Bracknell Forest Council approved an approach to personalisation and the associated programme of work including the pilot in summer 2008. This report is a progress update on that report and a look forward to future developments.

3. National Progress

3.1 One year on since the first round of the Social Care Reform Grant (SCRG), the Department of Health is continuing to work with its partners and councils to identify barriers to implementation, and provide examples of where it works. Through the "Personalisation Toolkit", developed by CSIP, councils can share examples of best practice. In summer the Department of Health published a Green Paper, "Shaping the future of care together", based on the principles in "Putting People First".

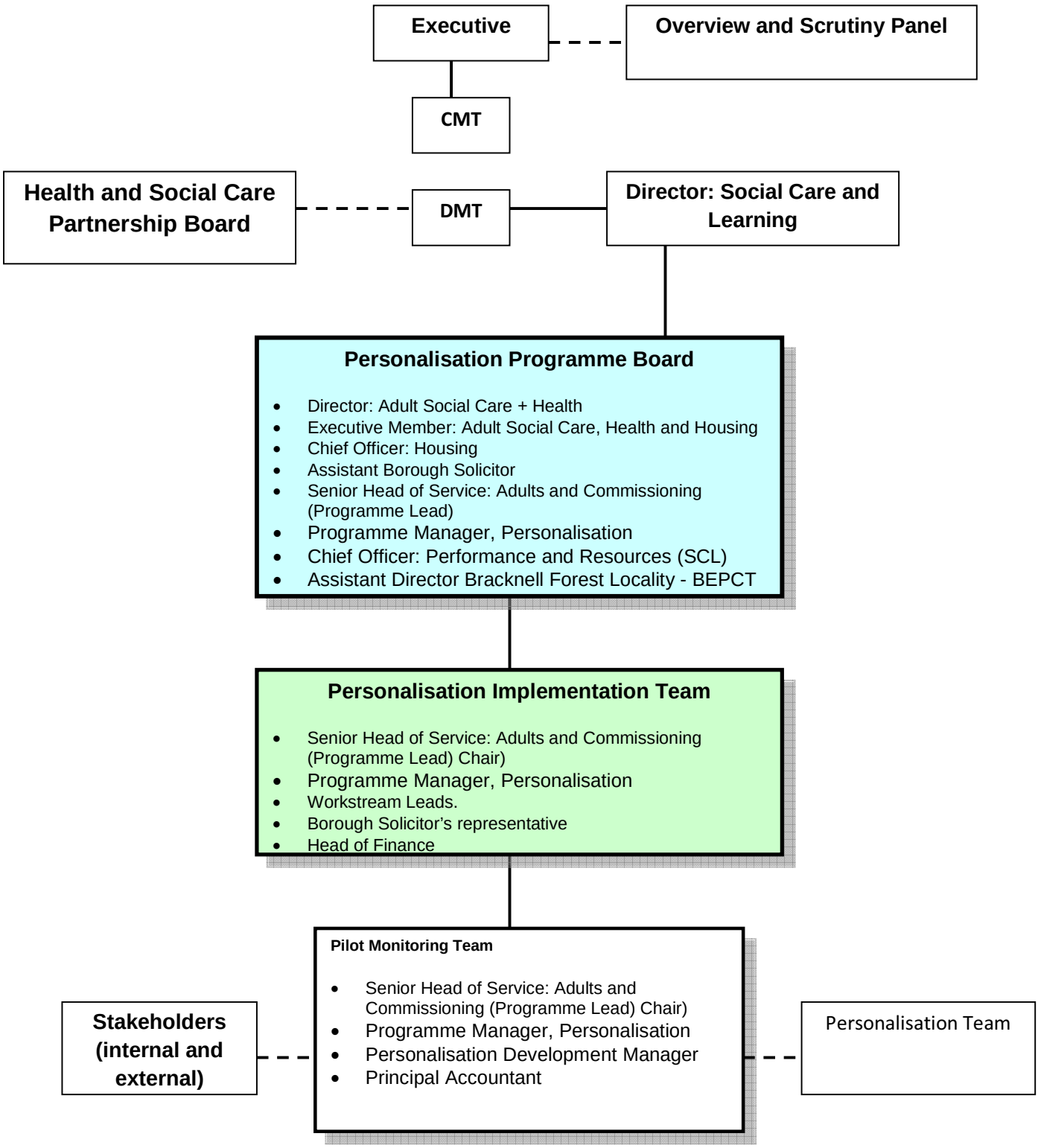
3.2 Published in autumn 2008, the IBSEN evaluation of the national individual budget pilots presents the positive benefits and the challenges of making personalisation a reality for people who need support to live their lives. The research showed a significant increase in positive outcomes for most people with a learning disability, with a mental health problem or with a long term condition. One of the key findings suggested many older people and their carers did not want the additional burden that they associated with planning and managing their own support. Additional guidance has been developed by DH to address the implementation of self-directed support for older people. This guidance will be adopted during the pilot in Bracknell Forest.

3.3 According to DH, in the first year of the SCRG significant progress has been made by some Councils. The expectation is that progress will accelerate significantly during 2009/10. The 2011 target for self-directed support, National Indicator 130, is that 30% of individuals who are being supported will be taking advantage of self-directed support. The transformation agenda is supported by regional improvement and efficiency agencies, the local government National Director of Social Care Transformation and Joint Improvement Partnerships.

4. Programme Governance

4.1 Following the Local Authority Circular (DH)(2008) 1 : Transforming Social Care, a Project Initiation Document (PID) for implementing personalisation in Bracknell Forest was developed by Zoë Johnstone, Programme Lead. The PID was approved in June 2009 following which the Project Implementation Team and the Programme Board were constituted.

4.2 The programme of work has eight workstreams, each having a lead officer. The Programme Manager took up post in September 2008.


Executive
Overview and Scrutiny Panel
CMT
Health and Social Care Partnership Board
DMT
Director: Social Care and Learning
Personalisation Programme Board
Director: Adult Social Care + Health
Executive Member: Adult Social Care, Health and Housing
Chief Officer: Housing
Assistant Borough Solicitor
Senior Head of Service: Adults and Commissioning (Programme Lead)
Programme Manager, Personalisation
Chief Officer: Performance and Resources (SCL)
Assistant Director Bracknell Forest Locality - BEPCT
Personalisation Implementation Team
Senior Head of Service: Adults and Commissioning (Programme Lead) Chair)
Programme Manager, Personalisation
Workstream Leads.
Borough Solicitor's representative
Head of Finance
Pilot Monitoring Team
Senior Head of Service: Adults and Commissioning (Programme Lead) Chair)
Programme Manager, Personalisation
Personalisation Development Manager
Principal Accountant
Stakeholders (internal and external)
Personalisation Team
Accountability
Information and Consultation

5. Bracknell Forest Personalisation Pilot

5.1 Bracknell Forest Council has committed to run a pilot study to test a personalised approach for a specified number of adults who meet the social care eligibility criteria and who would currently receive either services or a direct payment. A personalised approach will enable people and their family or informal support networks to have greater control over the type of support that is provided and the way in which it is delivered.

5.2 The project will be evaluated; lessons learned will inform the full implementation of the personalisation programme of work.

5.3 The pilot will be delivered by the Personalisation Implementation Team, sponsored by the Personalisation Programme Board and monitored by the Personalisation Pilot Monitoring Group. The seven-month pilot commenced on the 1st July 2009. The Programme Board approved the Project Initiation Document for the pilot in February 2009.

5.4 The principle objectives of the project are:

- To redefine the current care management processes across Adult Social Care to a system which facilitates self directed support
- To test the Supported Self-Assessment Questionnaire and Resource Allocation System
- To allow analysis of the choices that individuals made and the support they required to inform future commissioning and community capacity building
- To create a resource to champion and support the move to personalised social care
- To allow analysis of the impact of self-directed support on carers
- To highlight legal, risk management and safeguarding implications to inform the TASC programme of work
- To allow analysis of the impact of self-directed support on joint working
- To ensure that new IT and financial monitoring systems allow the recording of self-directed support and outcome based commissioning

- To allow analysis of spend on current provision versus personalised support to facilitate projection/mapping of future need

- To provide significant evidence to support the implementation of whole system change across Adult Social Care; delivering better outcomes to individuals living in Bracknell Forest

- To allow analysis of the impact of new ways of working on back office staff.

5.5 The pilot aims to support a minimum of 40 individuals through the pilot split between care groups as follows:

- 3 older people with Mental Health problems
- 7 people with Long Term Conditions
- 5 people with Mental Health problems
- 25 older people

In addition, any referrals made to the Autistic Spectrum Disorder Virtual Team will be considered for the pilot.

*Self-directed support is already in place for people with a learning disability

5.6 It is proposed that people selected should include –

- a representative sample of people in terms of the Bracknell Forest demographic, including both new and re-referrals, with varying support needs
- at least a representative sample of people from BME groups

All people approached to take part in the study will be informed that it is a pilot and will need to expressly agree to take part in the pilot.

5.7 Self-directed support and personal budgets are already in place for adults with a learning disability. In order to build on and share the learning that has taken place it is proposed that two part-time members of staff from the learning disability team join the team of Personal Facilitators.

5.8 An evaluation model has been developed; it outlines the methodology for gathering information and conducting the evaluation of the pilot. Five lines of inquiry will form the basis of the evaluation of the Personalisation Pilot:

- experiences and outcomes for people taking part in the pilot, and their carers
- Testing of the personalisation procedures
- Flexibility of support options and capacity within the community
- Implications for Council and other services
- Cost-effectiveness in comparison with standard approaches

6. Transforming the workforce

Progress

6.1 A new Personalisation Team has been created to take forward the development of self-directed support. The Personalisation Development Manager, who took up post on The 1st June, leads the team. In addition to managing the team this role will also work to develop capacity in the community for the benefit of all care groups.

6.2 The Personal Facilitator role has been developed to support individuals to complete the self-assessment questionnaire and to plan and broker their support. The post was evaluated and was the subject of consultation with staff and trade unions before being advertised nationally.

6.3 Three permanent Personal Facilitator positions were successfully recruited to and will be joined by 1.2 fte Facilitators currently employed in the Community Team for People with a Learning Disability. The posts will be filled on 6th July 2009 with the postholders initially working on the pilot.

6.4 A training programme for the Personal Facilitators is under development. The comprehensive programme will be delivered in the fortnight commencing 13th July.

6.5 To support the programme a TASC Programme Assistant post has been advertised; the postholder will engage with individuals to participate in the development of our approach to personalisation.

6.6 A staff champion has been appointed in the Community Mental Health Team to take a specific role in promoting awareness and developing expertise in personalisation within the mental health teams in Bracknell Forest. This member of staff has extensive knowledge in the use of direct payments in mental health and will follow the broader national personalisation developments in mental health and understands the issues and challenges. They will also report to the LIT on progress in that specific area. Champions have also been sought from other teams.

Future Developments

6.7 The Department of Health published a workforce strategy document in April 2009, “Working to Put People First: The Strategy for the Adult Social Care Workforce in England”. One of the key themes to this strategy is workforce remodelling to respond to the personalisation agenda - ensuring the right workforce with the right skills are able provide the care and support that people want.

6.8 Together with workforce partners, the current workforce strategy will be reviewed to ensure the six "key themes" priorities of Putting People First are incorporated:

- The effective leadership of local employers in workforce planning
- Ensuring effective recruitment, retention and career pathways
- Workforce remodelling and commissioning to achieve service transformation
- Workforce development
- More joint and integrated working between social, health care and other sectors
- Regulation for quality in services as well as public assurance
- A significant amount of work has already been achieved on a number of these priorities. The Adult Workforce Strategy group will ensure this positive work continues to deliver the Putting People First strategy over the coming years.

6.9 To undertake a project in partnership with Skills for Care looking at skills needed by the workforce to deliver the personalisation agenda. The project will particularly focus on the skills needed by people other than social workers. In order to deliver this project the Council have been awarded £70,000 by Skills for Care.

7. Policies and Procedures

Progress

7.1 To aid understanding and develop ownership of the processes this work has been tasked to staff working in the pilot. The framework for policies and procedures is being developed and will be available when the staff in the Personalisation Team take up their posts.

7.2 The Council took part in a Research in Practice for Adults (RiPfA) Self-Directed Support 360 project. The aim of the project was to bring together teams from authorities at different stages to share learning and to inform national best practice.

Future Developments

7.3 The following are areas for future work

- The pathways and interface between Intermediate Care and longer term self-directed support – to be undertaken during the pilot
- A process for validating supported self-assessments which needs to be light touch to reflect the spirit of personalisation
- To clarify links with Community Care Assessments and Single Assessment Process
- To ensure that the processes within self-directed support clarifies the relationship of the Supported Self-Assessment and professional assessments
- To work with other fund holders to develop approaches to self-directed support
- To develop an appeals process in relation to the self-assessment and Resource Allocation System
- To further develop approached to Person Centred Planning and to embed them in practice

8. Communicating the Programme

8.1 The Communications Strategy for the programme was approved by the Board in June The strategy highlights key messages, audiences and risk for the programme. The action plan detailing progress is shown below.

Date	Event/method	Target audience	Lead officer/s	Status
Early January	Workshop – to discuss pilot and recruitment. Feedback to be circulated via email.	Staff	Zoë Johnstone, Lynne Lidster and Caroline Little	completed
March 2009	Job vacancy advert in newspapers, Boris and on the BFC and jobs go public website	Wider community, staff	Zoë Johnstone, Lynne Lidster and Paul Young	completed
April 2009	Provider Workshop	Providers, partners and voluntary sector	Zoë Johnstone & Lynne Lidster	completed
September 2009	TASC Newsletter	Staff, partners and providers	Zoë Johnstone Lynne Lidster & Kaylee Godfrey	
Summer 2009	Presentation about the pilot to groups	Members	Glyn Jones and Zoë Johnstone	
June/July	Team meetings about the pilot Confidential focus groups	Staff	Zoë Johnstone, Lynne Lidster, Ilona Cowe & Derek McCarthy	completed
July 2009	Voluntary Sector Forum AGM	Voluntary Sector organisations	Zoë Johnstone Lynne Lidster	completed
July 2009	Personal facilitators and team manager to meet teams	Staff	Zoë Johnstone, Lynne Lidster and personal facilitation team	completed

September 2009	Develop holding statements for press to be used if needed	Wider community	Zoë Johnstone Lynne Lidster Kaylee Godfrey	
September 2009	DVD	All stakeholders particularly individuals and families	Zoë Johnstone Lynne Lidster Kaylee Godfrey & Derek McCarthy	
September 2009	Forest Views & Town and Country	Staff & all other stakeholders	Zoë Johnstone Lynne Lidster Kaylee Godfrey	
Autumn	Staff workshops	Staff	Zoë Johnstone and Lynne Lidster	
September 2009	Launch of Pilot – stories in local newspapers and on local radio	Wider stakeholders	Zoë Johnstone Lynne Lidster Kaylee Godfrey	
September 2009	Launch of the pilot – Event for families	Residents requiring support	Zoë Johnstone, Lynne Lidster and Personalisation Team	
July - December	During the launch • Staff - team meetings and updates on BORIS. • Managers' Forum • Providers – email asking for feedback from the pilot. • Residents requiring support – regular case reviews	Staff, providers, residents requiring support	Zoë Johnstone, Lynne Lidster , Kaylee Godfrey and personalisation team	

February 2010 - after evaluation	• Staff - team meetings and updates on BORIS. • All residents – article in Town & Country about individual budgets. Press release issued to the local media. • Providers – email with feedback from the pilot.	All	Zoë Johnstone, Lynne Lidster and Personalisation Team. Kaylee Godfrey	

9. Commissioning

Progress

9.1 A workshop was held with providers in April at the Grange Hotel in Bracknell; over 100 providers attended it from all sectors. The purpose of the event was to raise awareness of:

- Personalisation agenda nationally and in Bracknell Forest
- Self-directed support and personal budgets
- The impact of personalisation on providers
- What providers might need to change to market themselves to individuals
- National best practice examples from other providers

The event was chaired by Research in Practice for Adults; speakers at the event included national providers, officers from BFC and the DH regional transformation team. A conference report is available including feedback from participants.

9.2 A provider has been secured to provide independent advocacy for individuals who are taking part in the pilot. The need for independent advocacy is vital to ensure that individuals are supported to voice their needs and aspirations for their future. Advocacy is particularly important when considering the needs of the most vulnerable people and those without family carers or friends to make their voice heard. An advocacy strategy and a community engagement plan are in development.

9.3 The Learning Disability service is in the process of awarding framework contracts or community support. The tender process is completed and recommendations will be submitted to the Executive for approval in June.

Future developments

9.4 In collaboration with Corporate Procurement and Legal Services, the tender exercise for flexible community-based support is underway. The new framework agreements will replace the existing domiciliary support, meals on wheels and domestic support service contracts. Soft market testing with existing providers has taken place. The tender will be undertaken on the basis of "lots"; the agreements are expected to result in more flexible and a wider range of options to be available to people.

9.5 The small grants (grants under £5,000) criteria will be updated for 2010/11 to ensure that grants support the development of self-directed support.

9.6 Work will continue with providers to find tailored solutions to meet the needs of individuals.

9.7 Further developments include:

- To further develop approaches to Person Centred Planning, and embed them in practice across the sector.
- To clarify the roles of independent advocacy
- To explore and develop options for independent brokerage
- To work with providers to develop a range of affordable and flexible support options

10. Modernising In-house services

Progress & future developments

10.1 The Launch of Green Machine, a Community Interest Company, took place in February and now 8 people are employed. Work is focusing on obtaining contracts.

10.2 Breakthrough (Supported Employment Service) moved to a town centre location in Charles Square location in December in order to increase accessibility for individuals.

10.3 Carers' Service for people with a learning disability: A feasibility study was commissioned from Surveyors to accommodate Carers' Service (overnight breaks and daytime respite) on the Waymead site. Surveyors and Corporate Property Services reported to Steering Group 12th March 2009 with potential options. Those options have now been scrutinised and further developed. An options paper will be discussed at Adult Management Team / Departmental Management Team and once the preferred supported option is clear a business case will drafted for Corporate Management Team for approval in July.

10.4 Revised CQC registration for Waymead is being submitted, to reflect extended options for individuals.

10.5 The modernisation of In House Home Support has seen the creation of a Long Term Conditions specialist team, now due for evaluation, an increase in community-based support for people with dementia and an increase in reablement. The teams continue to focus on developing services that promote reablement, independence and community care and support.

10.6 Consultation and discussion around the modernisation of services for older people continue. A Service Manager has been appointed to lead the developments and will take up post in July.

10.7 The modernisation programme for the supported living at Glenfield House, for working age adults with mental ill health, is moving forward and encompasses early facilitation of self-assessment and personal budgets once the pilot, new process and systems are implemented.

11. Managing and reporting performance

Progress

11.1 Local Area Agreement Targets for National Indicator 130 (expressed as people self-directing their support per 100,000 of population) for 2008/9 and the following 2 years were set against a baseline of 220 per 100,000 and were as follows:

Baseline: 220 per 100,000 (2007/8)
242 per 100,000 (2008/9)
266 per 100,000 (2009/10
292 per 100,000 (2010/11)

11.2 Under the new definition, Bracknell Forest reported an 2008/9 outturn of 8.15% for NI 130, the indicator which measures self directed support and direct payments. This places us 33rd out of a list of 136 council's who reported 2008/9 data on this indicator, which is better than the draft England average of 6.5% and South East average of 5.7%.

Future developments

11.3 The target for all councils is 30% of all people receiving community-based support to be achieved by March 2011. Based on the numbers of people receiving community based support in 2008/9, this equates to 1,215 people in Bracknell Forest by March 2011, an increase of 869 people. A work stream has commenced to develop a profile for this for the coming months

12. IT

Progress

12.1 The first phase of the procurement of the Adult Social Care IT systems Replacement Project was completed with preferred supplier, LiquidLogic, appointed April 2009. The solution is a flexible user friendly system with staff using web forms and on / off line access to information for staff to enable mobile working to and to support the shift to reducing office space. It also provides easier and faster access to information through more structured forms and to management information for staff at the point of entry.

12.2 The budget has been secured for the implementation of the supplier solution and the second phase of the project is underway. The contract has been signed and the Project Initiation Document and initial project plan has been approved.

Future developments

12.3 The second phase of the project will be completed with "go live" due for January.

12.4 A review of the IT requirements of In House Home Support and the Replacement of the Webroster system will be completed by April 2009.

12.5 Review of the impact of the Personalisation pilot on the new IAS system. Outcomes of the pilot will be assessed against the functionality of the IAS system after go live to identify with the supplier what changes will need to be made to the system to reflect the new ways of working for Adult Social Care.

13. Resource Allocation System and Supported Self Assessment Questionnaire

Progress

13.1 The "In Control" model for the development of the Resource Allocation System (RAS) was reviewed and adapted use by BFC. Specific service and support budgets to be allocated through the RAS have been determined, which subject to review during the pilot. The provisional RAS has been modelled and evaluated by comparing an individual's current cost compared to the calculated RAS allocation. 29 individuals whose current support costs differ significantly from the potential RAS allocation have been re-evaluated.

13.2 The supported self-assessment questionnaire (SAQ) has been developed and has been tested using a desk-top exercise which involved staff completing SSAQs using information about 189 people who are currently supported by Adult Social Care. It captures information about carers about the support needs of carers to enable them to remain in their caring role. The questions have been weighted to enable the calculation of the RAS allocation.

Future Developments

13.3 An easy read guide to explain the RAS and SSAQ is being developed.

13.4 A methodology for calculating people's contribution to the support costs needs to be developed for use during the pilot.

13.5 Following evaluation of the personalisation pilot the following tasks will be undertaken:

- Review and finalise total service and support budgets to be included in RAS
- Review and finalise SSAQ and RAS score weighting
- Consider whether transitional budget protection arrangements are required to protect individuals whose RAS allocation is significantly lower than the cost of the support they are Integrate RAS /SSAQ into ASC IT systems
- Develop appropriate financial management and accounting arrangements for Personal budgets
- Produce detailed manual and associated documentation for RAS
- Costs for in-house services and supports

14. Creating Capacity within the Community

Progress

14.1 A Reference and Information Sharing group to take forward community capacity building is well established. The group has terms of reference, a council-wide membership plus partners from other sectors. It has been agreed that these meetings will be used to focus the priorities of the group and to plan and discuss ideas that can facilitate community capacity growth and links. One area of discussion will be an information day / workshop for local businesses and providers etc. To help take this agenda forward the newly appointed Development Manager will play a role in undertaking the work to build capacity within the community.

14.2 An internal group has been formed of officers in the Council who undertake development work as part of their role. This group will co-ordinate and undertakes the actions for this workstream.

14.3 The CSIP project to engage people from BME groups in the development of the personalisation agenda locally has been completed and evaluated by CSIP. Isabel Fernandez-Grandon, Community Mental Health Team, led “It’s Up To You” - the project for Bracknell Forest. The project focussed on people from the traveller community with Mental Health problems – giving individuals a “test” individual budget. One individual, also caring for a relative with a long-term condition, purchased a washing machine with her budget – this has had a positive impact on the family, especially the mental health of the individual due to greater ease of her caring role. A more detailed evaluation looking at outcomes for the individuals is being prepared locally. The Council match-funding to the bid is to be used to support the development of a community group – a need that has been identified by the individuals participating in the project and other members of the community. The objective of the group will be to enable individuals to get easier access to support and information and also to participate in the wider Bracknell Forest community.

Future developments

14.4 The priorities for the workstream are to:

- Co-ordinate and communicate the work that is currently taking place to create capacity in the community.
- Gather information about the resources that are available to people in the community - not just for people who are eligible for support from Adult Social Care but also as preventative activities or support and for individuals who fund their own support.
- (With the Commissioning workstream) to engage with providers to create flexible support options for people to access.
- Develop a mechanism for finding out what support options and activities are not currently available in the community that need to be developed.

15. Budget

	Social Care Reform Grant	Actual/Projected Spend
Year 1 2008/9	119,000	73,000 (46,000 agreed carry forward)
Year 2 2009/10	279,000 + 46,000 carried forward = 325,000	317,000 (8,000 to be carried forward)
Year 3 2010/11	346,000 + 8,000 carried forward = 354,000	354,000

In addition to the Social Care Reform Grant the Council have been successful in bids with Skills For Care (£70,000) and Improvement and Efficiency South East (£15,000) to develop a Timebank.

16. Action Plan

RAS/SAQ Workstream

Action	Lead	Due date
Finalise draft of self-assessment questionnaire	Zoë Johnstone /Paul Clark	Completed
Determine number of individuals to be included in pilot	Zoë Johnstone	Completed
Need to determine representative make-up of pilot group, covering demographics and care groups	Zoë Johnstone	Completed
Estimate amount of support time each participant will require based on their care group *	Zoë Johnstone	Completed
Consider inclusion of people with Learning Disabilities – if just for testing of SAQ/RAS	Zoë Johnstone	Completed
Develop RAS & pilot draft	Zoë Johnstone /Paul Clark	Completed
Develop individual contributions policy for use during the pilot	Zoë Johnstone /Paul Clark	August 2009
Develop easy read guide to self-assessment and the Resource Allocation System	Zoë Johnstone	September 2009
Review and finalise RAS	Zoë Johnstone /Paul Clark	Ongoing through pilot and following evaluation

*IB pilots showed that people had more contact time with support coordinators over the 6 month pilot.

Workforce Planning Workstream

Action	Lead	Due date
Determine the role of the Facilitator	Paul Young	Completed
What, specifically, is the facilitator responsible for?	Paul Young	Completed
What proportions of the Facilitators' role will be spent doing different tasks?	Paul Young	Completed
Complete Job Evaluation	Paul Young	Completed
Recruit Personal Facilitators and Manager	Paul Young	Completed
Job Description and Person Specification to be developed	Paul Young	Completed
Decide where to advertise vacancies. Jobs Go Public and/or Community Care?	Paul Young	Completed
Determine usage of Skills for Care money	Paul Young	Completed
Deliver required training	Paul Young	Completed
Develop training programme for Facilitators. To include: working with BME groups, working with different groups of individuals (depending on Facilitators' backgrounds), giving consistent advice (barrier for older people), safeguarding (Berkshire Safeguarding Procedures)	Paul Young	Completed
Provide a work-base for the Facilitator team	Paul Young	Completed
Develop management arrangements for the Facilitator team.	Paul Young	Completed
Develop Workforce Strategy in response to "Working to put people first"	Paul Young	Following evaluation of the pilot
Undertake project in partnership with Skills for Care	Paul Young	March 2010

Policy & Procedures Workstream

Action	Officer	Due date
Develop outline framework for procedures based on those in place for people with learning disabilities*	Zoë Johnstone / Lynne Lidster	Completed
Determine role of facilitation	Paul Young	Completed
Determine pathways into the pilot and to specialist assessments and support	Zoë Johnstone / Lynne Lidster	Completed
Develop personalisation policies and procedures following the pilot	Zoë Johnstone / Lynne Lidster	Following evaluation of pilot

* To then be developed by the facilitator group.

IT & Performance Management Workstreams

Action	Officer	Due date
Develop performance monitoring and management arrangements for the pilot	Mark Gittins	August 09
What new information/data will need to be collected in the pilot, including that for evaluation purposes?	Mark Gittins	Completed
What performance indicators need measuring during the pilot? Which NIs? Any others?	Mark Gittins	Completed
How will information/data be collected?	Mark Gittins	completed
How will information/data be recorded? SWIFT?	Sandie Slater	completed
Who will monitor performance and the impact on	Mark Gittins	completed

PIs during the pilot?		
Develop team targets and profiles for NI 130	Mark Gittins	September 2009
Go live for new IAS system	Sandie Slater	January 2010

Community Capacity Building & Commissioning Workstreams

Action	**Officer**	**Due date**
Create capacity within the community	Mira Haynes/ Nick Ireland	Ongoing
Co-ordinate and communicate the work that is currently taking place to create capacity in the community	Mira Haynes/ Nick Ireland	Ongoing
Gather information about what resources are available to people in the community - not just for people who are eligible for support from Adult Social Care but also for as preventative activities or support and for self-funders	Mira Haynes/ Nick Ireland	Ongoing
Develop a mechanism for finding out what support options and activities are not currently available in the community that need to be developed	Mira Haynes/ Nick Ireland	Ongoing
How do we link with the NHS? – How do we work with people who have NHS funding?	Mira Haynes/ Nick Ireland	During pilot
Engage with providers to create flexible support options for people to access	Mira Haynes/ Nick Ireland	Ongoing
Determine role of advocacy	Jane Bremner	completed

Commission advocacy for use during the pilot	Jane Bremner	completed
Contribute to the development of a local User-led Organisation	Sarah Scales	December 2010
Develop a strategy for Information and Advice		October 2010

Communication Workstream

Action	**Officer**	**Due date**
Develop Communications Plan for pilot	Kaylee Godfrey	completed
Communicate pilot to current staff – develop methods and determine frequency	Kaylee Godfrey	completed
Liaise with trade unions	Paul Young	Initial discussions held - ongoing
Communicate pilot to providers - RIPFA bid for working with providers, possibly to run an event (through use of Provider Forums?)	Kaylee Godfrey	ongoing
Communication with people taking part in the pilot – develop materials and guidance for staff that are accessible for all	Kaylee Godfrey	ongoing
Communication about participation with BME people with mental health problems - CSIP Project	Isabel Fernadez-Grandon/ Kaylee Godfrey	completed
Develop Implementation Plan for Engagement Strategy	Sarah Scales	November 2009
Further actions re communication – see section 8 of this report	Kaylee Godfrey	Ongoing

Evaluation Methodology

Action	Officer	Due date
Develop evaluation tool	Caroline Little	completed
Undertake evaluation of pilot	Lynne Lidster / Derek McCarthy	During and following pilot

Implementation Team

Action	Officer	Due date
Develop transparent criteria for the selection of individuals to be included in the pilot*	Zoë Johnstone	Completed
Careful attention to the needs and barriers to participation for older people (given evidence in the IBSEN report) – look at case studies in briefing *Making Personal Budgets Work for Older People – Developing Experience.*	Implementation Team	ongoing
Specifically target involvement of BME people with mental health needs – lead by Isabel Fernadez-Grandon, BME Community Development Worker, Berkshire NHS Trust. Funding of £2000 has been secured for this work from the Care Services Improvement Partnership.	Isabel Fernadez-Grandon	Ongoing throughout pilot
Develop ongoing risk register and mitigating actions	Lynne Lidster/ Caroline Little	Completed
Part of the purpose of the pilot is to test risks so that the final programme plan is better informed – what are these risks that need testing?	Lynne Lidster/ Caroline Little	completed
What are the risks to people taking part in the pilot? Consider safeguarding implications.	Facilitation Team	Ongoing
Develop a framework for quality assurance	Lynne Lidster/ Facilitation Team	Throughout pilot

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17. Risks to the Programme

RISK LOG

INTERNAL/EXTERNAL ELEMENTS THAT AFFECT THE PROJECT AND ACTIONS YOU WILL TAKE TO MITIGATE IMPACT

INTERNAL/EXTERNAL ELEMENTS THAT AFFECT THE PROJECT AND ACTIONS YOU WILL TAKE TO MITIGATE IMPACT

ID	Date Raised	Date Last Updated	Description	Impact (1-5) 1-low 5-high	Probability (1-5) 1-low 5-high	Risk Rating Impact x probability	What are you going to do about it?	Raised By (initials)	Status (Open/ Closed)
1.	February 09	28.07.09	Current workforce resistant to change	4	3	12	Ongoing communication with staff and recruitment of staff champions from existing teams Further staff workshops to be held focussing on progress and the process of change	Imp Team	Open

ID	Date Raised	Date Last Updated	Description	Impact (1-5) 1-low 5-high	Probability (1-5) 1-low 5-high	Risk Rating Impact x probability	What are you going to do about it?	Raised By (initials)	Status (Open/ Closed)
2.	February 09	05.06.09	Not enough people in the community wanting to be part of the pilot	5	3	15	Review Communication Strategy – develop promotional leaflet & DVD & hold an event with families Recruit to the staff champion role from existing teams	Imp Team	Open
3.	February 09	09.02.09	Over commitment of staff resources	4	4	16	Monitor progress/delays and escalate difficulties to Programme Board when needed	Imp Team	Open
4.	February 09	05.06.09	Lack of provider flexibility	4	3	12	Hold provider workshop with RiPfA 24th April (Completed) Ongoing dialogue with providers Host workshop run by Voice Marketing	Imp Team	Open

ID	Date Raised	Date Last Updated	Description	Impact (1-5) 1-low 5-high	Probability (1-5) 1-low 5-high	Risk Rating Impact x probability	What are you going to do about it?	Raised By (initials)	Status (Open/ Closed)
5.	December 08	03.08.09	Delay in development and approval of the ASC Contributions Policy as a result of new guidance from Department of Health	5	3	15	Communication with Board Members Policy under development	Imp Team	Open
6.	March 09	31.03.09	Potential that existing staff ask for their grades to be re-evaluated	1	4	4	Communicate with unions	Imp Team	Open
7.	March 09	05.06.09	Risk to DSB should grant funding for Personal Facilitators and Personalisation Development Manager cease	4	1	4	Workforce development and modernisation to meet the Personalisation agenda	Prog Board	Open
8.	March 09	05.06.09	RAS Allocations differing from assessment of needs	5	3	15	Desktop exercise followed by revisiting weightings	Imp Team	Open
9.	June 09	05.06.09	Vacant posts in Corporate Comms Team resulting in lack of support for Comms Strat.	4	4	16	Discuss resource requirement and potential solutions with Interim Head of Communications	Imp Team	Open

ID	Date Raised	Date Last Updated	Description	Impact (1-5) 1-low 5-high	Probability (1-5) 1-low 5-high	Risk Rating Impact x probability	What are you going to do about it?	Raised By (initials)	Status (Open/ Closed)
10.	August 09	06.08.09	Outbreak in Swine Flu delays programme	4	2	8	Monitor sickness and report potential delays	Prog Board	Open

Closed Risks

11.	December 08	21.05.09	Delay in some aspects of the modernisation of services	2	5	10	Recruit to Service Manager post (This post will be filled in June 2009)	Imp Team	Closed
12.	February 09	05.06.09	Insufficient resources to deliver CCB programme of work	5	3	15	Recruit to 0.5 Development Manager post (post was filled on 01.06.09)	Imp Team	Closed
13.	December 08	05.06.09	Partial or total unsuccessful recruitment to facilitator team	5	2	10	Advertise the post widely (posts will be filled on 1st July 2009)	Imp Team	Closed
14.	February 09	28.07.09	Delay in the recruitment of the Facilitator Team	4	1	4	Negotiate delay in the start of the pilot	Imp Team	Closed
15.	December 08	21.05.09	Delay in some aspects of the modernisation of services	2	5	10	Recruit to Service Manager post (This post will be filled in June 2009)	Imp Team	Closed

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Personalisation Programme – Communication Strategy Action Plan

The purpose of the communications strategy is to raise awareness of self-directed support and the pilot to stakeholders.

Date	Event/method	Target audience	Lead officer/s	Status
Early January	Workshop – to discuss pilot and recruitment. Feedback to be circulated via email.	Staff	Zoë Johnstone, Lynne Lidster and Caroline Little	completed
March 2009	Job vacancy advert in newspapers, Boris and on the BFC and jobs go public website	Wider community, staff	Zoë Johnstone, Lynne Lidster and Paul Young	completed
April 2009	Provider Workshop	Providers, partners and voluntary sector	Zoë Johnstone & Lynne Lidster	completed
July 2009	Presentation about the pilot to groups	Members	Glyn Jones and Zoë Johnstone	Completed
June/July/August	Team meetings about the pilot	Staff	Zoë Johnstone, Lynne Lidster, Val Bray & Derek McCarthy	Completed
July 2009	Voluntary Sector Forum AGM	Voluntary Sector organisation	Zoë Johnstone Lynne Lidster	Completed
July 2009	Personal facilitators and team manager to meet teams during induction	Staff	Zoë Johnstone, Lynne Lidster Derek McCarthy & Personalisation Team	Completed
August 2009	Forest Views	Staff	Zoë Johnstone Lynne Lidster Derek McCarthy Kaylee Godfrey	Completed

September 2009	Frequently Asked Questions on BORIS	Staff	Zoë Johnstone, Lynne Lidster, Derek McCarthy and team	Completed
September 2009	Presentation to Access Panel	Members and other stakeholders	Zoë Johnstone	Completed
September 2009	TASC Newsletter	Staff	Zoë Johnstone Lynne Lidster, Derek McCarthy & Kaylee Godfrey	Completed
October/November 2009	DVD	All stakeholders particularly individuals and families	Zoë Johnstone Derek McCarthy Lynne Lidster Kaylee Godfrey & Derek McCarthy	
October 2009	Presentation to staff in corporate services	Staff	Zoë Johnstone Derek McCarthy	Completed
November 2009	TASC Newsletter	Partners and providers	Zoë Johnstone Lynne Lidster, Derek McCarthy & Kaylee Godfrey	
November 2009	Stand at PCT consultation event	Residents	Zoë Johnstone Lynne Lidster, Derek McCarthy & Kaylee Godfrey	Completed
November 2009	Presentation to Local Involvement Network Meeting	Residents	Lynne Lidster	
December 2009	Staff Briefings	Staff	Zoë Johnstone, Lynne Lidster, & Derek McCarthy	
December 2009	Develop holding statements for press to be used if needed	Wider community	Zoë Johnstone Lynne Lidster Kaylee Godfrey	

December 2009	Pilot – stories in local newspapers and on local radio (from DVD Launch event)	Wider stakeholders	Zoë Johnstone Lynne Lidster Kaylee Godfrey	
December 2009	Launch of the pilot – Event for families and invitation to press and other stakeholders	Residents requiring support	Zoë Johnstone, Lynne Lidster and Personalisation Team	
Spring 2010	Town and Country	Residents	Zoë Johnstone, Lynne Lidster , Kaylee Godfrey	
July - December	During the launch • Staff - team meetings and updates on BORIS. • Managers' Forum • Providers – email asking for feedback from the pilot. • Residents requiring support – regular case reviews	Staff, providers, residents requiring support	Zoë Johnstone, Lynne Lidster , Kaylee Godfrey and personalisation team	
February 2010 - after evaluation	• Staff - team meetings and updates on BORIS. • All residents – article in Town & Country about individual budgets. Press release issued to the local media. • Providers – email with feedback from the pilot.	All	Zoë Johnstone, Lynne Lidster and Personalisation Team. Kaylee Godfrey	

The full Communication Strategy is available from Lynne Lidster x 1610

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APPENDIX A - NATIONAL TRANSFORMING ADULT SOCIAL CARE MILESTONES

1. Effective partnerships with people using services, carers and other local citizens

April 2010				
Target	**Progress**	**Actions**	**Risks/Blockages**	
1.1 That a communication has been made to the public including all people supported by Adult Social Care and to all local stakeholders about the agenda and its benefits for them.	A Communication Strategy has been developed and has been approved by the Programme Board. A workstream, with a representative from Corporate Communications, co-ordinates the actions.	➢ See attached Communication Strategy Action Plan	None identified	
1.2 That the move to personal budgets is well understood and that local people are contributing to the development of local practice. (Dec 2009)	A Corporate Engagement Strategy has been developed to ensure individuals and carers make a contribution to local developments. An implementation plan, which will address the personalisation programme of work, is being developed. The In Control approach for people with a learning disability is embedded – this was developed in partnership with individuals and families. Individuals from the traveller community were involved in shaping the development of local practice in the "Its up to you" project in partnership with CSIP.	➢ Local people are contributing to the development of our approach through the pilot and the evaluation process. ➢ Local voluntary groups are being engaged as are people through the care group strategy boards. ➢ Representatives from carers groups to attend workshops and conferences with staff	None identified	
1.3 That individuals and carers are involved with and regularly consulted about the councils plans for transformation of adult social care	See above	See above	None identified	

1. Effective partnerships with people using services, carers and other local citizens

October 2010				
Target	**Progress**	**Actions**	**Risks/Blockages**	
1.4 That individuals understand the changes to personal budgets and that many are contributing to the development of local practice.	The next phase of the Communication Strategy is to target people in the community and partners. ➢ Host a personalisation stand at a PCT consultation event ➢ Article in town and country ➢ Launch of the DVD with press coverage ➢ Event for individuals ➢ Event for providers	➢ By April 2010 to complete the evaluation of the pilot and to determine the roll out of personalisation and the involvement of individuals and other stakeholders. ➢ By May 2010 to develop a joint approach with BFVA to engaging providers and local groups	None identified	

April 2011				
Target	**Progress**	**Actions**	**Risks/Blockages**	
1.5 That every council area has at least one user-led organisation who are directly contributing to the transformation to personal budgets. (By Dec 2010)	The Council was unsuccessful in seeking funding from Improvement and Efficiency South East to develop a Use-Led Organiosation however there is support from the region to assist in this area of work.	➢ By November 2009 to identify the support offered for the region and to develop an action plan for this area of work. ➢ Options are being explored with local voluntary groups.	Identifying an existing organisation who wish to become a user-led organisation	

2. Self-directed Support and Personal Budgets

April 2010				
Target	**Progress**	**Actions**	**Risks/Blockages**	
2.1 That every council has introduced personal budgets, which are being used by existing or new individuals/carers	Personal budgets are in place for everyone with a learning disability who wants one. A pilot to roll out personal budgets to individuals in other care groups is underway involving 40 people.	➢ By April 2010 – to complete the evaluation of the pilot and to present plans for the rollout of personalisation across Adult Social Care to DMT and CMT thereafter.	Required workforce development may not be delivered to timescales	
October 2010				
Target	**Progress**	**Actions**	**Risks/Blockages**	
2.2 That all new individuals/carers (with an assessed need for ongoing support) are offered a personal budget	Personal budgets will be phased in for everyone who is eligible for financial support from adult social care following the evaluation of the pilot.	➢ By April 2010 – to complete the evaluation of the pilot and to plan the rollout of personalisation across Adult Social Care. ➢ By May 2010 to develop a workforce strategy to ensure that the workforce can support the rollout of personal budgets.	As above & Finalising and obtaining approval for Resource Allocation System and Contributions Policy.	
2.3 That all individuals whose care plans are subject to a review are offered a personal budget	As above	As above	As above	
April 2011				
Target	**Progress**	**Actions**	**Risks/Blockages**	
2.4 That at least 30% of eligible individuals/carers have a personal budget	Current performance is 8%	➢ By November 2009 – targets to be set for all teams	Including people who are supported by the reablement service who don't have ongoing support needs in the calculation of the indicator.	

3. Prevention and Cost Effective Services

April 2010				
Target	**Progress**	**Actions**	**Risks/Blockages**	
3.1 That every council has a clear strategy, jointly with health, for how it will shift some investment from reactive provision towards preventative and enabling/rehabilitative interventions for 2010/11. Agreements should be in place with health to share the risks and benefits to the whole system.	A reablement service, joint with health and with a pooled budget, is in place. Joint community teams have been established to support people with a learning disability and for working age and older adults with a mental health problem. These teams have a focus on prevention and early intervention and advice and information for individuals and carers. Bracknell Forest has been selected as a demonstrator site for a new Dementia Adviser post. The Stroke Grant is being used to re-able individuals who have had a stroke and to fund groups in the community.	➢ By November 2009 supported access to the existing Local Exchange Trading Scheme will be established. The LETS scheme enables people in the community to trade skills with each other using a currency determined by the scheme other than money.		
October 2010				
Target	**Progress**	**Actions**	**Risks/Blockages**	
3.2 That processes are in place to monitor the whole system impact of this shift in investment towards preventative and enabling services. This will enable efficiency gains to be captured and factored into joint investment planning, especially with health.	The intermediate care partnership board meets on a quarterly basis to monitor the impact of the reablement service on outcomes for people. The Stroke Strategy Group meets quarterly to monitor the impact of the funded services on the outcomes for individuals against the national Stroke Strategy. There is PCT representation on the Health and Social Care Partnership Board.	➢ Await research from DH re assessing the impact of preventative services.		

3. Prevention and Cost Effective Services

April 2011				
Target	**Progress**	**Actions**	**Risks/Blockages**	
3.3 That there is evidence that cashable savings have been released as a result of the preventative strategies and that overall social care has delivered a minimum of 3% cashable savings	A personalisation pilot is underway which encompasses preventative will be evaluated. One of the workstreams of the personalisation programme is to build capacity in the community including preventative services and supports.	➢ By April 2010 to complete the evaluation of the pilot. ➢ By July 2010 to complete the evaluation of the Timebanking project ➢ Monitor National Indicator 125 – Achieving Independence for Older People through Rehabilitation/Intermediate Care		
3.4 There should also be evidence that joint planning has been able to apportion costs and benefits across the whole system	There are pooled budgets in place for reablement services and community equipment.	➢ Ongoing work with PCT looking at whole system access and availability. ➢ Participation in transforming Community Services Programme Board.		

4. Information and Advice

April 2010				
Target	**Progress**	**Action**	**Risks/Blockages**	
4.1 That every council has in place a strategy to create universal information and advice services	Adult Social Care has a "front desk" system that takes all initial calls and queries and provides a sign-posting service.	➢ By January 2010 to develop and information and advice strategy.	None identified	
October 2010				
Target	**Progress**	**Action**	**Risks/Blockages**	
4.2 That the Council has put in place arrangements for universal access to information and advice	The Council has identified a potential IT solution to assist with this area of work.	➢ By October 2010 to develop a business case for the Open Objects IT solution - a web-based directory of support and activities	Resources required to establish and maintain the information hub – to be explored in the business case	
April 2011				
Target	**Progress**	**Action**	**Risks/Blockages**	
4.3 That the public are informed about where they can go to get the best information and advice about their care and support needs	Review of current arrangements/leaflets	➢ By February 2010 to incorporate actions to publicise information and advice into the communications strategy	None identified	

5. Local Commissioning

April 2010				
Target	**Progress**	**Action**	**Risks/Blockages**	
5.1 That Councils and PCTs have commissioning strategies that address the future needs of their local population and have been subject to development with all stakeholders especially individuals and carers; providers and third sector organisations in their area	The Council has commissioning strategies for all care groups that were developed with input from all stakeholders including the PCT and informed by the JSNA. The strategies also identify health care needs alongside social care needs. The structure to support joint commissioning is in place.	➢ January 2010: Review the Older People's Strategy in the light of the personalisation agenda ➢ Programme to be developed to refresh other care group strategies		
5.2 These commissioning strategies take account of the priorities identified through the JSNA	As above	➢ JSNA is reviewed annually in partnership with the PCT to coincide with planning table		

5. Local Commissioning

October 2010				
Target	**Progress**	**Action**	**Risks/Blockages**	
5.3 That providers and third sector organisations are clear on how they can respond to the needs of people using personal budgets.	A provider workshop, attracting providers from all sectors, was held in April 2009.	➢ A further provider workshop is planned for April 2010 in partnership with BFVA. ➢ There is an ongoing programme of engagement through visiting local groups and the provider forum	Lack of flexibility and willingness to change by providers.	
5.4 An increase in the range of service choice is evident.	The Development Liaison Group is using information about gaps in provision to inform new developments and to monitor progress on delivery.	➢ By May 2010 to implement guidance - Working Together for Change : Using person centred information for commissioning		
5.5 That Councils have clear plans regarding the required balance of investment to deliver the transformation agenda	An evaluation model for the pilot has been developed. The evaluation will inform the plans to implement the agenda.	➢ Reporting from pilot is planned for April 2010.		

5. Local Commissioning

April 2011				
Target	**Progress**	**Action**	**Risks/Blockages**	
5.6 That stakeholders are clear on the impact that purchasing by individuals , by publicly (personal budgets) and privately funded, will have on the procurement of councils and PCTs in such a way that will guarantee the right kind of supply of services to meet local care and support needs.		➢ By April 2010 – Information to be gathered through evaluation of pilot. ➢ By May 2010 – stakeholder workshop to be held		

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ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
1 DECEMBER 2009

TRIPS TO THE COALFACE – COUNCILLORS' VISITS TO ADULT SOCIAL CARE SERVICES

Panel Chairman

1 INTRODUCTION

This report introduces the notes of visits to Adult Social Care services.

2 SUGGESTED ACTION

2.1 **That the Adult Social Care Overview and Scrutiny Panel notes the attached notes of visits to Adult Social Care services.**

3 SUPPORTING INFORMATION

3.1 Members of the Adult Social Care Overview and Scrutiny Panel made a number of visits to various adult services on 24 September, 1 and 8 October 2009. The main purpose was familiarisation with operations at the coalface, and by going in small groups it was possible to see a great deal, as is shown by the notes taken by Andrea Carr and Victoria Bale.

3.2 We were impressed by the professionalism of the staff in circumstances which can be trying. Many people are unaware of the range of services provided until they, or someone they know, needs them. The series of visits have helped us to see what some of the challenges are, and appreciate some of the types of cases and numbers involved.

3.3 Our thanks are due to the many staff who made us welcome and willingly answered our large number of questions.

Background Papers

None

Contact for further information

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ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
MEMBER VISIT TO THE COMMUNITY MENTAL HEALTH TEAM
THURSDAY 24 SEPTEMBER 2009
(2:00 pm to 4:00 pm)

Present: Councillors Turrell and Blatchford

In Attendance: Zoë Johnstone, Chief Officer: Adults and Commissioning
Tony Dwyer, Adult Services, On-going Care
Community Mental Health Team Members
Andrea Carr, Policy Officer (Overview and Scrutiny)

1. **VISIT TO THE COMMUNITY MENTAL HEALTH TEAM AND GLENFIELD HOUSE**

As part of the Adult Social Care Overview and Scrutiny Panel's programme of visits to Adult Social Care facilities, Members met representatives of the Community Mental Health Team (CMHT) at Church Hill House prior to a tour of Glenfield House and discussion with its Manager. CMHT was an integrated team comprising Health and Social Services staff. The Team provided services to people living in Bracknell Forest with severe and enduring mental illness through care co-ordination.

Memory Clinic and Referrals

Members met the CMHT (Older Adults) Manager and Dementia Nurse to explore Dementia services which featured the Memory Clinic. All referrals to the Clinic, which could vary from 1-2 up to 15-16 per day in number, were out patients who were treated at Church Hill House or Woodlands Day Hospital on the site of Heatherwood Hospital. Treatment consisted of an assessment of the patient's condition, a CTC scan, investigation of patient history, diagnosis of Dementia and prescription of one of three types of inhibitor drugs. Assessment included a memory test and when low test results were evident the consultant psychiatrist, who offered weekly clinical supervision, would decide whether medication should be withdrawn or restored in the case of those whose condition had significantly worsened following withdrawal. Patients remained in contact with the Clinic for the duration of their drug prescription which could vary from a few weeks to five or six years. Although the majority of Dementia patients were elderly and in excess of eighty years of age, an increasing number in their 50's and 60's were being referred. Dementia was a progressive condition and once diagnosed would remain with patients for the remainder of their life with a probable timespan of 15-16 years.

All Dementia services in Berkshire operated within the National Institute for Clinical Excellence guidelines which stipulated that people with mild Dementia should not be treated until their condition had worsened to a specified level. Funding had been secured to appoint to a new Dementia Advisor post and the postholder would support people in the latter situation by undertaking continuous monitoring of their condition and signposting them towards assistance. The Council's award winning Dementia Home Support Service (DHSS) actioned patients' care plans which were formally reviewed at least once per annum according to statute.

Future service delivery options, reflecting the ambitions of the transforming adult social care agenda, the needs of carers and increased home support, were being considered as current services required development to meet the demographic pressure of an ageing population, exacerbated by the characteristics of a new town.

Officers identified an expanded DHSS, increased access to resources such as the Re-ablement Team, re-ablement training for the DHSS and an improved system to support Dementia patients discharged from hospital as desired service developments.

Duty / Access and Perinatal Services

The Working Group met the Community Services Manager and team members to learn about the range of specialist services within the CMHT. These were:

- Duty and Access – this team operated a single point of referral for all mental health services within Bracknell Forest for adults aged 16-75 and was able to offer crisis and short-term management. People over 75 and presenting symptoms of Dementia would be referred to the CMHT for older people.
- Assertive Outreach Team – the three team members of this service provided intensive support to clients with severe and enduring mental illness supported in the community who traditionally had not engaged with mental health services.
- The On-going Care Team of two operated the Bipolar Education Group and undertook family work.
- Early Interventions Psychosis - this service offered intensive assessment and support to people aged 16-35 with first presentation psychosis.
- Home Treatment Team - this team offered alternatives to admission to hospital where this was not seen to be the best option and provided short-term intervention of up to 8 weeks.

The main sources of referrals to the Duty and Access Team were telephone, letter, GPs, health visitors and school nurses. Once referrals had been processed and logged onto information systems a decision would be made as to which Team was best placed to assist the client. Some referrees required multi-agency support whilst in-patient hospital treatment was necessary for others. Immediate action was taken in the event that any risk to the client or others was identified. The Team received 90-100 referrals per month for initial assessment and had 35 contacts per day by telephone or personal visit. Clinical services for blood tests etc were available.

Perinatal referrals were currently high at 30-40 in number. Referrees typically suffered from anti and postnatal depression and there were some cases of depression following stillbirth and instances of complex needs possibly resulting in self harm. One in six mothers suffered from a degree of postnatal depression within a year of their child's birth. The Surestart and Parents & Children Together initiatives were involved in referrals and liaison. Although only one unitary authority area in Berkshire was currently providing pre-conception counselling, this service was being rolled out across the remaining five localities in the county.

One team member was predominantly a mental health professional with a varied and heavy caseload of both secure clients and those supported in the community. Her work involved courts and tribunals etc.

The Mental Health Act 1983 legislated the work of the Team which was recovery focused and sought alternatives to admission to care. A recovery focused environment encouraged clients to progress and there were several successful support groups including the Bipolar Education, Wellbeing, Link and Carers Groups. Although there were some clients who would remain in need of mental health services, the object was to support clients to progress from the mental health arena to access provision in the community. It was necessary for some clients to be detained under the Act and the length of applications for admission varied. Those retained for

a long term remained under constant review and monitoring. Re-Think, a mental health charity, sought to aid recovery and support people to access mainstream activities such as employment and leisure.

The Team liaised with employers and the local College with a view to assisting mental health sufferers to sustain their employment or studies and early intervention was key. Underperformance at work or College could be stressful and lead to mental health relapses. A contact at the job centre also assisted. People suffering from mental health problems were often stigmatised in society.

Proposed future developments included robust plans to support clients, such as those suffering from an Autistic Syndrome condition who may not fall into traditional service models, to facilitate early prognosis and treatment and to ensure that the appropriate agency took the lead. Educating GPs, counsellors and schools staff etc to detect early signs of psychosis would be beneficial.

Glenfield House

Members completed the session with a visit to Glenfield House where they met the Supported Living Manager and toured the facilities. A supported living project funded by the Supporting People programme operated at Glenfield House where service users could be supported to gain the necessary skills for independent living. There were 17 tenancies at the premises, the majority of which were of a two year temporary nature supporting residents to equip them to move on to independent living. Other tenancies were long term and Glenfield House was home to such tenants. The CMHT were able to make direct referrals. The accommodation included one dedicated bed for a homeless person and four respite care beds which were available at times of crisis or could be booked for carers' respite breaks. Some office accommodation was being converted to a respite unit to improve provision and create separate facilities for men and women.

Glenfield House was resourced with nine Supported Living Advisors and an administrator and there was limited staff turnover leading to stability and continuity for tenants. The reason for and duration of tenancy was made clear to clients and staff offered emotional support and worked with tenants to build trust and rapport. Although clients were encouraged to take responsibility for their lives, many would have on going related support needs to sustain a tenancy and quality of life. Those moving on to independent living in the community were offered out reach support whilst they settled into their new surroundings from the staff member who had supported them at Glenfield House in the interests of consistency.

Following the transfer of the property from the Council to Bracknell Forest Homes, respite care and office accommodation were now leased back by the Council whilst clients were the tenants of Bracknell Forest Homes. Lease arrangements and responsibilities were currently being clarified. Repairs and a deep clean were taking place and a need for some redecoration had been identified.

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ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
MEMBER VISIT TO COMMUNITY TEAM FOR PEOPLE WITH LEARNING DISABILITIES
THURSDAY 1 OCTOBER 2009
(2:00 pm to 4:30pm)

Present: Councillors Turrell and Blatchford

In Attendance: Zoë Johnstone, Senior Head of Service: Adults & Commissioning
Nick Ireland, Head of Learning Disabilities
Victoria Bale, Support Officer (Overview and Scrutiny)

1. VISIT TO THE COMMUNITY TEAM FOR PEOPLE WITH LEARNING DISABILITIES (CTPLD)

Members met staff and received a tour of CTPLD, Weymead Short Term Care Unit, Day Services, Green Machine, Breakthough and Headspace as part of the Adult Social Care Overview and Scrutiny Panel's programme of visits to Adult Social Care facilities.

Members met Yvonne Griffiths, the Team Manager, CTPLD who lead the tour of the office, along with Nick Ireland, Head of Learning Disabilities (LD). The following was noted about the team:

- It was formed of 30-40 staff, from 4 different organisations: Berkshire East PCT, Berkshire West PCT, Berkshire Healthcare NHS Foundation Trust and Bracknell Forest's Adult Social Care.
- It was the first point of call for people with LD where the initial consultation was carried out and assessment of their needs, such as health requirements and/or support needs, were arranged.
- The team had a holistic approach, providing social work, physiotherapy, occupational therapy, dietary advice etc.
- It provided support as and when required to assist individuals to achieve their chosen lifestyle. For instance, individuals were assisted to spend their Direct Payments to purchase appropriate care and meet their needs.
- It could also arrange for the provision of a personal assistant, identify a service provider, provide a face-to-face assessment of the individual and assist the individual to undergo a self-evaluation.
- The team currently supported just under 400 people and was working with a large number of these to pursue their chosen lifestyle. Some sought an advocate to ensure that the team was aware of their needs and wishes.
- The team shared its employees across Berkshire, providing services across the East, and ensuring continuity and consistency.
- The team had relocated from Time Square, where poor sound proofing had sometimes led to confidentiality issues, to Church Hill House which was more accessible being in walking distance for many users who felt more comfortable attending. Although there were plenty of meeting rooms at Church Hill House, the majority were upstairs and the absence of a lift presented the greatest challenge.

Members were advised that in terms of new people over the age of 18, the increase the number of new cases was not significant. Currently, few people with LD were moving into the area and therefore the number of new referrals was low enabling the Team to respond rapidly to them. Referrals from Children's Services in relation to individuals identified as having LD or a mental health condition etc were received and the Team would take responsibility for them once they became 18 years of age. The CTPLD proposed to modernise its information storage system. Information regarding

referrals from Children's Services was easily transferable despite not currently operating the same IT system.

Major challenges faced by the Team were meeting the requirements of each of the four different organisations of which it was formed. There was also an issue of capacity as demand for support was high and the provision of quality support was time consuming. These challenges were also faced by other similar teams.

In terms of staff turnover, the previous position of virtually relying on agency staff had been successfully addressed by recruiting newly qualified staff in order to develop them. In particular, care management and health were very well established within the team. The drawback of this approach was that when faced with more complicated situations, the pressure could shift to the more experienced members of staff.

2. WAYMEAD SHORT TERM CARE UNIT

Here, Members met Rachel London, Provider Services Manager for Waymead Short Term Care Unit and Day Services. The Unit was registered as a residential home for adults on short respite breaks, from one weekend per month to a week or two per month. All care was provided for the users, enabling a break for their carers, and there was now an increased emphasis on making the stay meaningful for the visitors by providing appropriate activities.

The Provider Services Manager escorted Members on a tour of the Unit where they noted the following:

- Facilities consisted of a multi-activities room providing access to the internet and a games station etc., a conservatory with television and a laundry area where residents were able to undertake their own washing.
- The kitchen was in need of modernisation in order to make it more accessible for wheelchair users to help them prepare meals, increasing independence.
- All but three bedrooms were upstairs which presented an issue as the Unit was without a lift.
- Bedrooms did not have en-suites, which were now required of all new builds.
- Although ceiling tracking hoists should be present throughout, they were not fitted in the bedrooms and only one of the bathrooms had been adapted, reducing accessibility for those who required this form of assistance.
- The bedrooms upstairs were now smaller than the regulations for room size and the bathroom was not adapted for wheelchair users.

The Unit had been recently inspected by the Care Quality Commission and received a 2 star rating owing to the need for some rooms to be improved and modernised, for training gaps to be filled and for issues with staff inductions due to changes and amendments in regulations to be addressed. The Carers Strategy sought to redevelop the whole site in order to provide a more suitable building.

With regard to staffing, the first vacancy for a while had arisen and two assistant mangers had been recruited recently. Job descriptions utilised as part of the recruitment process were being amended and staff were being given the opportunity to work at both this Unit and Day Services to provide the incentive of flexibility.

3. DAY SERVICES

Members then visited the Day Services centre and met Mark Hunt, Team Leader/AUM who conducted a tour of the premises and advised the following:

- The location of the centre within an industrial estate was inappropriate and a town centre location enabling clients to be more stimulated and engaged with the rest of the community was sought.
- The building was too large for purpose and over half of it remained empty making it inefficient to heat.
- There had been numerous unsuccessful attempts in past years to identify an alternative occupier(s) for the whole building. Although the Drug and Alcohol Action Team had expressed an interest it would only occupy two thirds of the building and, owing to the nature of its work, identifying an additional occupier to share the building presented difficulties.
- The number of people utilising the service was below 40 and it was anticipated that this number would reduce the following year unless a significant transition from other facilities was experienced.
- Young people were not keen to attend the centre for five full days per week as they did not find it stimulating.
- As the majority of clients attended other facilities such as college during the day, the number present at any given afternoon rarely exceeded ten.
- The kitchen was unnecessarily large and over equipped due to the declining number of people attending the centre.
- Staff retention was enhanced by the flexibility of working both at this centre and Waymead Short Term Care Unit.

4. DEPOT: GREEN MACHINE

Members met Mark Methven, Community Development Worker for Green Machine, and Mark Sanders, Development Manager for Green Machine and Breakthrough, both of whom assisted adults with LD who wished to undertake voluntary work, gain work experience or enter full or part time employment.

Green Machine was a social firm that assisted disadvantaged and disabled people to access employment. It offered a quality gardening and maintenance service, employing people with disabilities to provide genuine work opportunities. Green Machine had recently joined the East Berkshire future jobs fund to increase recruitment and was currently staffed by eleven people, four of whom were disabled.

Due to the current economic downturn, Green Machine was considering reviewing its marketing strategy to gain more contracts and links with businesses. Optimism around Green machine's success remained. A number of advertising flyers had been recently circulated and a contract with a housing association to provide a range of services to a number of properties had been secured. This contract would allow workers to gain a reference, increasing their chances of obtaining further work. Other work for individuals would be developed and expanded and those that had offered work opportunities would be contacted again in February to seek any further placements/opportunities.

5. BREAKTHROUGH

Members then visited Breakthrough, a recruitment agency within Bracknell town centre which focused solely on adults with LD. Members spoke with Karen Scott, Team Leader, and again with Mark Sanders, Development Manager.

The Development Manager explained that the agency was due to establish a forum with other town centre recruitment agencies to encourage cooperation. Although Breakthrough had originally been part of Day Services, it had split from the centre in recent years to gain it its own identity. It could now be accessed by people who did

not attend the centre and in December 2008 it had relocated to its town centre position and become recognised as an agency.

- Currently, around 41 out of 50 people registered with Breakthrough were in some form of employment. A number were volunteering to gain experience.
- Considering the current economy, Breakthrough was focusing on identifying placements to provide references and employment skills.
- The team within the town centre office consisted of the Team Leader and three supporting staff.
- Reviews with employed clients were undertaken every six months and, due to the economic climate, an increasing number were losing their jobs.
- Breakthrough supported new employees for up to six weeks within new jobs on the basis that if by that time they were unable to carry out the work it was not the correct position for them.
- The benefits system was an issue as it did not encourage people to work full time and become tax payers although some chose to.
- The LAA facilitated contact with local companies. One local supermarket had been approached on several occasions but had declined involvement with Breakthrough whilst others were happy to recruit from their books. Difficulties attracting from the corporate area were experienced.
- Unfortunately, the NHS and the Council were not leading the way in recruiting disadvantaged employees and it was felt that more could be done in this area.
- Having a robust central lead from the Council would help to promote Breakthrough as a recruitment agency.
- Breakthrough required more backing and support owing to the shrinking market.
- The team came into contact and assisted more people with LD than those with physical disabilities or mental health conditions. This was because most people with a physical disability would not come into contact with Adult Social Care and mental health problems could develop during employment, whilst those with LD were never considered to be employable.

6. HEADSPACE

Members then completed their trip with a visit to Headspace, and met Marc Box, Community Arts and Disability Officer who was assisted by six volunteers. Headspace was the result of a partnership between the Council, South Hill Parks Art Trust, U3A and Rethink and had opened in October 2008. It had received £10,000 funding from Oliver Bentalls and refurbished the building with paint and furniture from the waste and recycling centre. Headspace was within the town centre, and served as an art gallery in addition to accommodation for art, dance, music and crafts activities and sessions for disadvantage and disabled people. The sessions and activities were provided on week days and one weekend day per week, providing the opportunity for visitors to meet their peers in addition to new people. It also produced a radio show twice per week which served as a useful advertising tool.

ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
MEMBER VISIT TO THE COMMUNITY RESPONSE & RE-ABLEMENT TEAM AND OLDER PEOPLE & LONG TERM CONDITIONS SERVICE
THURSDAY 8 OCTOBER 2009
(9:00 am to 12:00 pm)

Present: Councillors Turrell and Blatchford

In Attendance: Naoma Dobson, Service Manager, Community Support & Well-being
Victoria Bale, Support Officer (Overview and Scrutiny)

1. 9:15 AM SHADOW FRONT DESK

Members shadowed workers on the front desk who dealt with the initial referral for a client requiring social care and support. This occurred either by telephone or fax, and ranged from self-referrals, those under Section 2 for hospital discharges, referrals from GPs, district nurses or family members. The callers were thoroughly questioned and once the call was received, the details were logged into the system and case notes were created. These were then transferred to the social workers who allocated the work to the appropriate team/staff. The front desk also facilitated hospital discharges, regularly contacting hospitals to receive updates on patients in order to prepare for when they were discharged. Currently there were 46 people on the database who were in hospital. The desk received an average of 20-30 referrals via fax per day.

Front desk workers dealt with adults over the age of 18 who had long term disabilities or age related problems. A large percentage of those they dealt with were elderly.

2. 9:30 AM SHADOW COMMUNITY RESPONSE AND RE-ABLEMENT DUTY OFFICER

Members then moved on to the duty social work desk. Here social workers spent a day per week dealing with the referrals which had been logged by the front desk. Some of the referrals transferred to social care, some to therapy (physiotherapy and occupational) and some required both. Every client was referred to re-ablement before long term care in the hope that they would not need the latter.

All details were recorded on the computer system known as SWIFT. The system was being replaced in January 2010 in order to improve and update processes as certain aspects of the system were problematic. In addition, paper copies of the assessments were retained.

It was explained that problems could occur when communication with hospital staff broke down, particularly under Section 2 and Section 5 when there were increasingly tight time pressures to assess clients who consequently could be wrongly referred e.g. admitted to an intermediate care unit when they should remain in hospital or be at home.

A main issue faced by the team was resources which were greatly needed in the interests of efficiency and avoiding complaints. There were currently a number of people on the waiting list for intermediate care services.

3. 9:45 AM DUTY OCCUPATIONAL THERAPIST AND ASSISTANT TEAM MANAGER

Members met the Duty Occupational Therapist. The following was discussed:

- The Duty Occupational Therapist informed Members that between 35-45 or just a few referrals could be received per day.
- The team also dealt with rapid response cases where it needed to act within hours to identify and send out the most suitable team member to assist.
- There was a 3 to 4 week waiting list which consisted of those who were not fully independent but able to perform necessary basic daily tasks.
- Every morning there was a meeting to allocate the cases to team members in a way that best met the needs of the client.
- Members of the therapy team had a case load of between 25 and 30 at any one time, but junior members of staff had between 20 and 25 cases.
- The work of the team prevented hospital admissions and increased discharges.
- The team was funded by both Adult Social Care and the PCT.
- A problem faced by the team was not being informed about people being discharged from hospital who are unable to support themselves once they returned home. On discovering that such an individual had returned home the team then needed to act rapidly to provide the care and support needed. In these cases the team contacted the GP and hospital to ascertain the situation.

Members then met the Assistant Team Manager who was responsible for social work and explained the following:

- There were only a small number of people in need of care being discharged from hospital without the team's knowledge. This usually occurred where people previously unknown to the team had suffered accidents and it was the source of the majority of its younger clients.
- The majority of people assessed were already known to the services. Those who were not were received without prior knowledge which could be beneficial as their situation could be addressed afresh. Care was taken to avoid making assumptions around new clients' circumstances.
- When clients arrived at the front desk the team was clear as to what assessments were needed due to the in-depth questions asked during preceding telephone calls.
- In terms of staffing, the social work team was very stable and the newest member joined the team two and a half years ago.
- The prime aim of re-ablement was to return people to independence. A half way goal was for them to be living at home with as little support as they needed. People becoming passive recipients of care needed to be avoided.
- The team was moving towards self-assessment and thus personalisation. Much work was being undertaken in this area and a pilot had been produced.
- In terms of respite care, the aim was for the carer to be confident that whilst he/she was away the client was being safely looked after.

4. 10:15 AM BUSINESS SUPPORT TEAM MANAGER, GAIL EBDEN

Members met the Business Support Team Manager, Gail Ebden, to explore the disabled Blue Badge process. The following was noted:

- Applicants for a blue badge must meet strict criteria, although issue was discretionary according to the applicant's disability.

- Those wishing to apply for a badge needed to complete an application form from the Council. Consideration was being given to making the form available online.
- Applications were considered by a panel of occupational therapists who could request a second opinion from a GP at a cost of £30 per applicant. The cost of a badge was £2.
- The issue of blue badges could take up to 2 weeks.
- For unsuccessful applicants there was an appeals process.
- At the Council's discretion temporary badges could be issued.
- Currently over 3,500 residents in Bracknell Forest possessed a badge.
- The badges were valid for 3 years after which renewal was required.
- The team worked with transport police who could levy fines for misuse of badges.

5. 10:45 AM OLDER PEOPLE AND LONG TERM CONDITIONS TEAM MANAGER, ALISON MELABIE

In discussion the following was noted:

- Anyone receiving care was treated as an open case and would receive a review.
- Inadequate resources were currently causing a waiting list for care with associated pressures and other ways of working to improve the situation were being explored.
- Occupational therapists were looking at long term adaptations for clients by supplying equipment such as stair lifts to increase independence and allow them to remain in their own home. This process required an assessment by the occupational team for whom there were time constraints.
- The team dealt with a broad mix of people, some of whom were deteriorating and may be in need of long term care. The aim was to support them at home for as long as possible.
- When asked if the long term goal was for clients to no longer require care, the Team Manager advised that by the time someone needed long term care the best had already been provided to increase their independence. In some cases scope to improve remained, but at a slower rate.
- The team was currently supporting someone to leave residential care after 5 years which illustrated the importance of reviewing cases and acknowledging that people could and did improve.
- Some clients appreciated carers coming into their homes who could become their only social contact. There was therefore a risk of becoming both emotionally and physically dependent on care. This was particularly the case with the numerous amount of clients without children, for whom carers were likely to become a significant part of their lives.
- As the average age of clients was increasing their children were becoming older themselves and less equipped to help.
- As far as possible the team supported people in their own homes.
- In terms of choosing a residential care home, the amount of guidance needed from the team varied from person to person. Although the team could not recommend homes owing to possible perceptions of bias, it did direct people towards Care Quality Commission (CQC) inspection reports.
- Issues around finance were significant for families in relation to care homes.
- A scheme where people considering residential care could experience a placement flat for 2-8 weeks and receive care was being commenced. The scheme was working well and reduced any anxieties families often had. Bracknell Forest currently had 1 flat for this scheme.
- The team also worked with and supported carers, and liaised with carers link officers who assessed the carers' support needs.

- Although many people in hospital claimed to be independent, they received support from family members often without recognising it as caring.
- Work was commencing with the Stroke Association and with stroke patients and their carers to provide further information.
- Safeguarding was a growing aspect of the work of the team which was responsible for all clients in Bracknell Forest, including the self-funded. Issues in relation to safeguarding could be referred from paramedics and the police.
- Financial abuse was becoming increasingly common and worsened by the recession. There had been situations of misuse of a disabled person's pension.
- The team received an annual sum from the Department of Health but this did not cover expenditure. Some cases were so complex that they almost required a care manager just for themselves.

6. 11:00 AM COMMUNITY SUPPORT AND WELL-BEING MANAGER, JANE BROWN

The following was noted:

- Community Support and Well-Being consisted of 2 sub-teams; 1 for people with long term conditions who would not recover but may stabilise; the other was for people with Dementia. Both were referred by care managers.
- The long term team worked closely with the care management team whilst the Dementia team worked closely with the mental health team.
- An aim was to support those with Dementia to live at home whilst it remained safe to do so. Services were quality assured and clients were monitored in their own homes. The team worked hard to ensure that members were recognised when visiting clients and wearing uniforms assisted in this area.
- The team, which received on-going training, consisted of full and part time staff who worked shifts of 7am - 11pm and were salary paid.
- A steady stream of referrals was received.
- The team had been recently inspected by CQC and received an excellent rating.
- Consideration was currently being given to introducing hand held monitors for social workers which would act as a telephone and clock mileage. Although this may involve initial expenditure, it was expected to increase efficiency and reduce cost in the long term.
- The Look In, a coffee shop in the centre of Bracknell for the over 50s, was also part of the service.
- The Downside Resource Centre was managed by the team and those currently attending were predominantly older people.

7. **11:30 AM TOUR OF BRIDEGWELL INTERMEDIATE CARE CENTRE, LADYBANK**

Members met Elaine Boyes, Unit Manager, for a tour of Bridgewell, an intermediate care unit forming part of Ladybank residential care home. The following was noted:

- Bridgewell was jointly funded with the PCT.
- Although most users were over 60 years, anyone over 18 could attend.
- The aim was to provide a home environment to help support people return home. Clients were able to bring personal belongings, which would not be allowed in hospital, and there were no specified visiting times.
- The Unit Manager was currently working on achieving the high standard for infection control as expected within a hospital, but balanced with the level of one's own home. Although there had been a few cases of C-Diff and MRSA 6 months ago, in recent months there had only been 1 case of MRSA which was hospital acquired.

- In terms of staff turnover, the team was well established and stable.
- Clients were encouraged to complete everyday tasks themselves, according to the level of their ability. This approach allowed staff to assess and monitor ability.
- In addition to physical rehabilitation the Unit offered social benefits.
- Whilst not all of the bedrooms had en-suite facilities as required of new builds, this was not thought to be a problem in an intermediate care unit. However, the small size of rooms created difficulties when using hoists.
- Members were shown the therapy room which was very small and contained walking equipment, steps and bars to help assess the mobility of users.
- The visit included the staff office which had been converted from a single bedroom and was therefore rather small and cramped for a fairly large team.
- Whilst lack of spaciousness within the Unit was an issue, this did not detract from the high quality of work delivered there.

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ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
1 DECEMBER 2009

OVERVIEW AND SCRUTINY – QUARTERLY PROGRESS REPORT
Assistant Chief Executive

1 INTRODUCTION

1.1 This report sets out the Overview and Scrutiny (O&S) activity over the period August to October 2009, also the national and local developments in O&S.

2 SUGGESTED ACTION

2.1 That the Adult Social Care Overview and Scrutiny Panel notes the Overview and Scrutiny activity over the period August to October 2009, set out in section 5 and Appendices 1 and 2.

2.2 That the Adult Social Care Overview and Scrutiny Panel notes the developments in Overview & Scrutiny set out in section 5.

3 SUPPORTING INFORMATION

(i) Overview and Scrutiny Activity

Overview and Scrutiny Working Groups

3.1 The table at Appendix 1 sets out the current status of the O&S Working Groups, along with the list of completed reviews. Reports finalised and published in the quarter included: the Working Group reports on the review of NHS Core Standards, the review of Waste and Recycling, and the review of the Housing and Council Tax Benefits Improvement Plan.

Partnership Scrutiny

3.2 Good progress has been made with implementing the agreed approach to partnership scrutiny. Responses have been received to most of the questionnaires previously sent to the ten Theme Partnerships. The Partnership Overview and Scrutiny Group held its first meeting on 28 September, electing Councillor Edger as Chairman, having a presentation and discussion on the approach being implemented; and consideration of the group's Terms of Reference and work programme. The group's next meeting will be in January 2010.

Overview and Scrutiny Commission

3.3 The O&S Commission continues to meet on a two-monthly cycle. At its meeting on 24 September, the main items considered were: the Commission's response to the Government consultation document on 'Strengthening Local Democracy'; considering the Annual Report on Procurement for 2008/09; the quarter 1 2009/10 Performance Monitoring Reports for the Chief Executive's Office and the Corporate Services

Department; and the response by the Executive Member to the Overview and Scrutiny report on the Review of the Implementation of the Housing and Council Tax Benefits Improvement Plan. The Commission's next meeting will be held on 19 November.

Environment, Culture and Communities O&S Panel

3.4 The Panel has continued to meet on a three-monthly cycle. It held its last meeting on 8 September at South Hill Park, and the main items included: having a tour and receiving a presentation from officers regarding the Lottery Fund grants to restore South Hill Park; considering a report setting out the progress achieved to date in the implementation of the Council's Carbon Management Plan; reviewing the Department's Performance Monitoring report for quarter 1; meeting the Chairman and Lead Officer of the Cultural Partnership; and receiving reports in respect of the sports pitches at Priory Fields and the use of covert CCTV in the Borough. The Panel's next meeting is on 8 December.

Health O&S Panel

3.5 The Panel has continued to meet on a three-monthly cycle. At its meeting on 3 September, the Panel: met representatives of the Local Involvement Network Steering Group, noting their annual report and work programme; received a presentation from the Chief Executive of Thames Hospicecare on how the organisation operates; discussed with the Chief Executive and Finance Director of Heatherwood and Wexham Park Hospitals NHS Foundation Trust their financial position and the outcome of the 'Saving More Lives' consultation; and established the NHS Core Standards Working Group. On 9 October, members of the Health O&S Panel took part in a workshop focused on the progress on the Joint Strategic Needs Assessment and refreshing the Health and Well-Being Strategy. The Panel's next meeting is on 3 December.

Children's Services and Learning O&S Panel

3.6 The Panel is continuing a three-monthly meeting cycle. At its meeting on 16 September the main items considered by the Panel included: the department's 2009/10 Performance Monitoring report for the first quarter; a discussion with the Chairman and Lead Officer of the Children's Trust; receiving an update on the 'Grow Our Own' project; noting the recent work of the 14-19 Working Group; and receiving the Executive's response to the 'Children's Centres and Extended Services' review. The Panel's next scheduled meeting is on 16 December.

Adult Social Care O&S Panel

3.7 The Panel continues to meet on a three-monthly cycle. At its last meeting on 1 September, the main items considered by the Panel included: reviewing the statutory annual report for safeguarding adults; receiving a presentation on transforming adult social care; considering the work programme; and reviewing the department's latest Performance Monitoring Report, also the quarterly report of O&S. Panel Members have completed a structured round of visits to adult social care establishments. The Panel's next scheduled meeting is on 1 December.

Joint East Berkshire Health O&S Committee

3.8 This Committee continues to meet broadly on a three-monthly cycle, rotating between the three Councils' venues. The last Committee meeting was on 14 September in Slough, when the Committee: established a Working Group for car parking charges at NHS establishments; received a presentation from the Director of Finance and Planning for Berkshire East PCT on their budgetary position; and received presentations from the Director of Public Health on the Joint Strategic Needs Assessment and secondly on swine flu. The Committee's next meeting will be on 10 December at Maidenhead.

3.9 Responses to the feedback questionnaires on the quality of O&S reviews are summarised in Appendix 2.

3.10 Quarterly review meetings between O&S Chairmen, Vice Chairmen, Executive Members and Directors are taking place regularly for the Commission and the Panels. Agenda-setting meetings continue to be held, usually in combination with the review meetings.

3.11 The Overview and Scrutiny team made an input to the Member Charter assessment process, contributing to BFC being re-awarded the Charter.

3.12 External networking on O&S in the last quarter has included: delivering a presentation to the Bracknell Forest Partnership on 10 September; attending the South East Employers Joint Member and Officer O&S Network on 21 October; and agreeing to participate in an INLOGOV survey of O&S in local government.

(ii) Developments in O&S

3.13 The Local Democracy, Economic Development and Construction Bill is gradually nearing a conclusion and Communities and Local Government anticipate Royal Assent in November. As advised in the last quarterly report, the main clauses relating to Overview and Scrutiny relate to the handling of petitions and a requirement for a statutory officer designation for O&S.

3.14 The regulations and guidance for the O&S provisions in the Local Government and Public Involvement in Health Act 2007 are still awaited, despite the Act having commenced on 1 April 2009. CLG is continuing to work with the Centre for Public Scrutiny to develop these.

3.15 The Council has responded to the Government's consultation entitled *'Strengthening Local Democracy',* with the O&S Commission providing the responses to the O&S questions. CLG have advised that they have received over 250 responses and they are currently going through these. There has been broad support for the expansion of O&S to Utility companies, etc, and common themes in the responses covered resources, training and local discretion. The Government's response to the consultation outcome will be issued in the 'winter of 2009'.

Background Papers

Minutes and papers of meetings of the Overview and Scrutiny Commission and Panels.

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Appendix 1

OVERVIEW AND SCRUTINY WORKING GROUPS – 2009/10
Position at 30 October 2009

Overview and Scrutiny Commission								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	DRAFT REPORT / SUBMISSION	FINAL REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
No current Working Groups								

Adult Social Care Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	DRAFT REPORT / SUBMISSION	FINAL REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Safeguarding Vulnerable Adults	Turrell, Leake, Edger, Mrs Shillcock	Zoe Johnstone	Andrea Carr					The first meeting has been arranged for 14 December when Members will scope the review.

Environment, Culture and Communities Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	DRAFT REPORT / SUBMISSION	FINAL REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Strategic Review of Waste	Brunel-Walker (Lead), Mrs. Angell, Beadsley, Mrs. Ryder, Wade (Crowthorne), Allen (S'hurst & Ms Healy (Warfield)	Steve Loudoun / Janet Dowlman	Andrea Carr	√	√	√	√	Completed - The Executive response is due for consideration at the next Commission meeting in November.
Supporting People (SP)	Mrs. Shillcock (Lead) & Mrs. Fleming	Simon Hendey / Clare Dorning	Andrea Carr	√	07/08 √ (Annual monitoring)	07/08 √ (Annual monitoring)	N/A	The Working Group met on 30 September 2008 to monitor progress against implementation of the SP programme and reported its findings to the Panel on 18 December 2008. It will meet again later in 2009/10 to monitor progress.
Review of Highway	Mclean (Lead) Beadsley,	Steve Loudoun	Richard Beaumont	In draft				The second meeting is

Maintenance	Brossard, Leake and Parish and Town Councillors: Edwards (Binfield) Kensall (Bracknell) Withers (Crowthorne) Mrs Cupper (Sandhurst) Young (Winkfield)		(Victoria Bale to support)					arranged for 16 November 2009.

Health Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	DRAFT REPORT / SUBMISSION	FINAL REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
NHS Core Standards	Virgo (Lead), Thompson, Mrs Angell,	N/A	Richard Beaumont	√	√	√	N/A	Completed – The Group met on 25 September and subsequently letters were sent to Heatherwood and Wexham Park Hospital NHS Foundation

								Trust, Berkshire East PCT, and Berkshire Healthcare Trust.
Preparedness for Public Health Emergencies	Burrows (Lead), Mrs. Angell, Thompson. Mrs. Mattick,	David Steeds	Andrea Carr	√				The Group met in October with John Pullin, the PCT's Deputy Director of Commissioning . The Group's next meeting has been arranged for 26 November 2009 where they will meet the South Central Ambulance Service.
Bracknell Health Space	Virgo (lead) Mrs Angell, Baily, Leake, Mrs Shillcock	Glyn Jones/ Mary Purnell	Richard Beaumont	√	In draft			Ten meetings held to date with various visitors. Further meetings are arranged for November 2009. The key conclusions have been drafted.

Joint East Berkshire Health Overview and Scrutiny Committee								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	DRAFT REPORT / SUBMISSION	FINAL REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Hospital Discharge Procedures	Baily, Coad (Slough BC), Napier (RB W&M)	N/A	Andrew Scott (RB W&M)	√	N/A	N/A	N/A	Working Group now disbanded.
Hospital Car Park Charges	Plimmer (Slough), Virgo, Endacott (RB W&M) Jacky Flyn (LINK)	TBC	Sunita Sharma (Slough BC)					First meeting being arranged

Children's Services and Learning Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	DRAFT REPORT / SUBMISSION	FINAL REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
14-19 Years Education Provision	Mrs Birch (Lead) Dr Josephs-Franks, Kensall, Mrs McCracken, Mrs Ryder	Martin Surrell	Andrea Carr (Victoria Bale to support)	√				The Working Group has met on fifteen occasions to date. A visit to Garth Hill College is proposed for December and

								a questionnaire has been sent to local employers. The conclusions are soon to be drafted.

Completed Reviews

Publication Date	Title
December 2003	South Bracknell Schools Review
January 2004	Review of Adult Day Care Services in Bracknell Forest (Johnstone Court Day Centre & Downside Resource Centre)
May 2004	Review of Community & Voluntary Sector Grants
July 2004	Review of Community Transport Provision
April 2005	Review of Members' Information Needs
November 2005	The Management of Coronary Heart Disease
February 2006	Review of School Transfers and Performance
March 2006	Review of School Exclusions and Pupil Behaviour Policy
August 2006	Report of Tree Policy Review Group
November 2006	Anti-Social Behaviour (ASB) – Review of the ASB Strategy Implementation
January 2007	Review of Youth Provision
February 2007	Overview and Scrutiny Annual Report 2006
February 2007	Review of Library Provision
July 2007	Review of Healthcare Funding
November 2007	Review of the Council's Health and Wellbeing Strategy

Publication Date	Title
December 2007	Review of the Council's Medium Term Objectives
March 2008	2007 Annual Health Check Response to the Healthcare Commission
April 2008	Overview and Scrutiny Annual Report 2007/08
May 2008	Road Traffic Casualties
August 2008	Caring for Carers
September 2008	Scrutiny of Local Area Agreement
October 2008	Street Cleaning
October 2008	English as an Additional Language in Bracknell Forest Schools
April 2009	Overview and Scrutiny Annual Report 2008/09
April 2009	Healthcare Commission's Annual Health Check 2008/09 (letters submitted)
April 2009	Children's Centres and Extended Services in and Around Schools in Bracknell Forest
April 2009	Older People's Strategy
April 2009	Services for People with Learning Disabilities
May 2009	Housing Strategy
July 2009	Review of Waste and Recycling
July 2009	Review of Housing and Council Tax Benefits Improvement Plan

Appendix 2

Results of Feedback Questionnaires on Overview and Scrutiny Reports

Note – Departmental Link officers on each review were asked to score the key aspects of each O&S review on a scale of 0 (Unsatisfactory) to 3 (Excellent)

	Average score for previous 10 Reviews[1]
PLANNING Were you given sufficient notice of the review?	**2.8**
Were your comments invited on the scope of the review, and was the purpose of the review explained to you?	**2.9**
CONDUCT OF REVIEW Was the review carried out in a professional and objective manner with minimum disruption?	**2.7**
Was there adequate communication between O&S and the department throughout?	**2.7**
Did the review get to the heart of the issue?	**2.6**
REPORTING Did you have an opportunity to comment on the draft report?	**2.9**
Did the report give a clear and fair presentation of the facts?	**2.5**
Were the recommendations relevant and practical?	**2.5**
How useful was this review in terms of improving the Council's performance?	**2.6**

[1] Road Traffic Casualties, Review of the Local Area Agreement, Support for Carers, Street Cleaning, Services for Adults with Learning Disabilities, English as an Additional Language in Schools, Children's Centres and Extended Services, Waste and Recycling, Older People's Strategy, and Review of Housing and Council Tax Benefits Improvement Plan.

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ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
1 DECEMBER 2009

EXECUTIVE FORWARD PLAN ITEMS RELATING TO ADULT SOCIAL CARE
Assistant Chief Executive

1 INTRODUCTION

This report presents current Executive Forward Plan items relating to Adult Social Care for the Panel's consideration.

2 SUGGESTED ACTION

2.1 **That the Adult Social Care Overview and Scrutiny Panel considers the current Executive Forward Plan items relating to Adult Social Care appended to this report.**

3 SUPPORTING INFORMATION

3.1 Consideration of items on the Executive Forward Plan alerts the Panel to forthcoming Executive decisions and facilitates pre-decision scrutiny.

3.2 To achieve accountability and transparency of the decision making process, effective Overview and Scrutiny is essential. Overview and Scrutiny bodies are a key element of Executive arrangements and their roles include both developing and reviewing policy; and holding the Executive to account.

3.3 The power to hold the Executive to account is granted under Section 21 of the Local Government Act 2000 which states that Executive arrangements of a local authority must ensure that its Overview and Scrutiny bodies have power to review or scrutinise decisions made, or other action taken, in connection with the discharge of any functions which are the responsibility of the Executive. This includes the 'call in' power to review or scrutinise a decision made but not implemented and to recommend that the decision be reconsidered by the body / person that made it. This power does not relate solely to scrutiny of decisions and should therefore also be utilised to undertake pre-decision scrutiny.

Background Papers

Local Government Act 2000

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ADULT SOCIAL CARE OVERVIEW & SCRUTINY PANEL

EXECUTIVE WORK PROGRAMME

REFERENCE	I019138

TITLE: Consultation on Contribution Policy

PURPOSE OF DECISION: To approve details for consultation on changes to the current method of charging for Adult Social Care Services.

FINANCIAL IMPACT: The consultation proposals will change the way in which people are charged for Adult Social Care. There are no financial implications for the Council.

WHO WILL TAKE DECISION: Executive Member for Adult Services, Health and Housing

PRINCIPAL GROUPS TO BE CONSULTED: Not appropriate

METHOD OF CONSULTATION: Letter
Meeting(s) with interested parties
Public Meeting
Which will take place after the decision to consult

DATE OF DECISION: 23 Nov 2009

REFERENCE	I019632

TITLE: Contract Extension: Meals on Wheels Service

PURPOSE OF DECISION: To enable the Council to undertake a tendering process to establish a number of framework agreements to help people live independently at home. The framework agreements will replace the existing contracts for meals on wheels service and the domestic support service.

FINANCIAL IMPACT: None.

WHO WILL TAKE DECISION: Executive Member for Adult Services, Health and Housing

PRINCIPAL GROUPS TO BE CONSULTED: None

METHOD OF CONSULTATION: None

DATE OF DECISION: 8 Dec 2009

REFERENCE	I019140

TITLE: Stroke Strategy

PURPOSE OF DECISION: To enable a strategic approach to support for people recovering from stroke and their families and carers.

FINANCIAL IMPACT: No financial implications.

WHO WILL TAKE DECISION: Executive Member for Adult Services, Health and Housing

PRINCIPAL GROUPS TO BE CONSULTED: Senior managers in Adult Social Care at the Council
Members of the Stroke Strategy Group that includes Berkshire East PCT colleagues, representatives from BFVA and Age Concern Bracknell & Age Concern Slough.
Operational teams at the Council
People who have had a stroke
Carers and families of people recovering from stroke

METHOD OF CONSULTATION: Meeting(s) with interested parties

DATE OF DECISION: 8 Dec 2009

REFERENCE	I019633

TITLE: Asset Management Plan 2010-13

PURPOSE OF DECISION: To approve the Asset Management Plan for Adult Social Care & Health.

FINANCIAL IMPACT: Indication of identified need for investment in Adult Social Care & Health buildings and facilities.

WHO WILL TAKE DECISION: Executive Member for Adult Services, Health and Housing

PRINCIPAL GROUPS TO BE CONSULTED: Previously an AMP consultation working group has met to consider the AMP.

METHOD OF CONSULTATION: To be determined

DATE OF DECISION: 18 Dec 2009

REFERENCE	I019640

TITLE: Personalisation Update

PURPOSE OF DECISION: To note the work undertaken to ensure the Council meets its responsibilities in response to the Putting People First Agenda (Personalisation), and agree the outline plans to meet the milestones to March 2011.

FINANCIAL IMPACT: None.

WHO WILL TAKE DECISION: Executive

PRINCIPAL GROUPS TO BE CONSULTED: Personalisation Implementation Team
Personalisation Programme Board
Departmental Management Team

METHOD OF CONSULTATION: Meetings with interested parties

DATE OF DECISION: 19 Jan 2010

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