Bracknell Forest Council

NHS
Berkshire East

JOINT STRATEGIC NEEDS ASSESSMENT

2011-2012

A summary for the

Bracknell Forest Health and Wellbeing Board

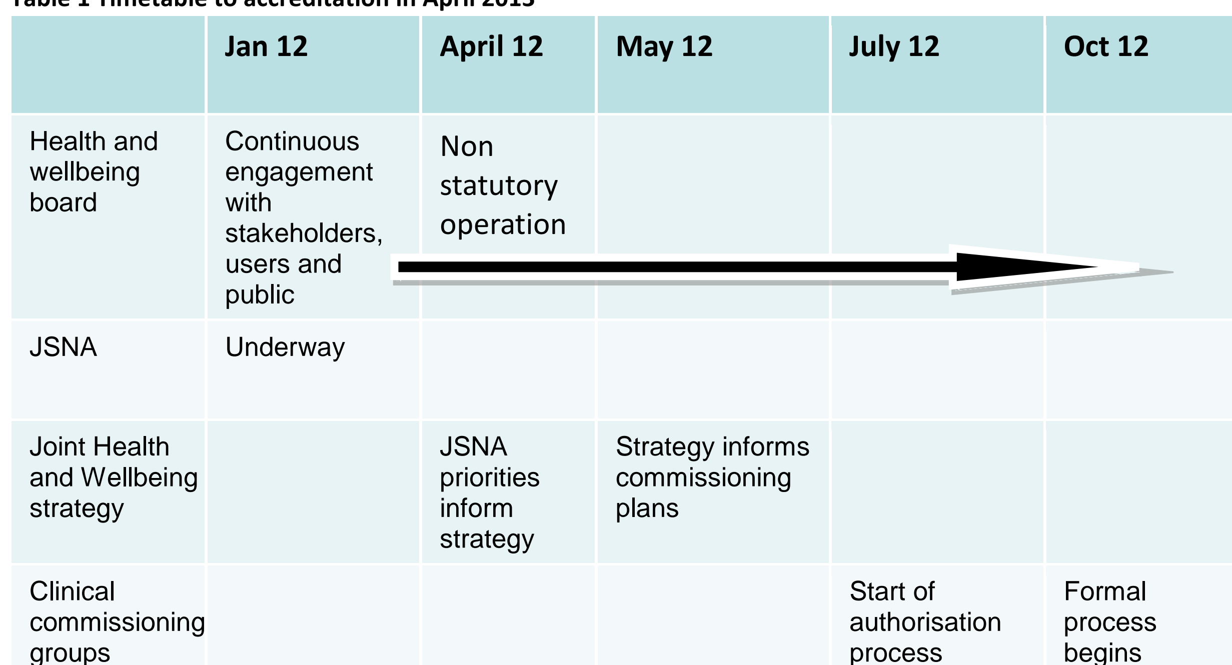
Introduction

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

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

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

Table 1 Timetable to accreditation in April 2013



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

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

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

Local authorities will be responsible for a great range of contracts currently managed by the Primary Care Trust. The contracts will need to be safely transferred by April 2013 and any future changes must be informed by the JSNA findings set out in summary form here and in greater detail in the electronic guide.

Key findings shown here are therefore related to commissioning responsibilities as well as themes identified in the JSNA described in this summary and the board is requested to note;

- The strategic issues which require resolution at PCT and Health and Wellbeing board level
- that stakeholder engagement will commence to further inform the local views sections and the commissioning cycle to 2013 as shown above in Table 1 - from new DH guidance for developing health and wellbeing strategies
- that staff and partners will have electronic access to the JSNA once approved by the board.
- that this report includes a short summary of progress made against the Marmot Themes as required for establishing the local health and wellbeing strategy
- that sections 5 and 7 of the full guide include programme budgeting and Personal, Social Services expenditure data to inform commissioners of the key areas of spend that can be used to recommission services

Process and governance

The process followed reflects feedback from the 2010 JSNA. The local JSNA working group was established with membership representing NHS Berkshire East (NHSBE), Bracknell Forest Borough Council, Bracknell and Ascot CCG and the voluntary sector. This year there was strong representation from commissioners who requested equality impact information from provider services for children and older adults.

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

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

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

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

The guide, datasets and powerpoints of key findings will now be transferred to the local authority information lead for use by members of the Health and Wellbeing board and partners and for commissioners. They cover

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

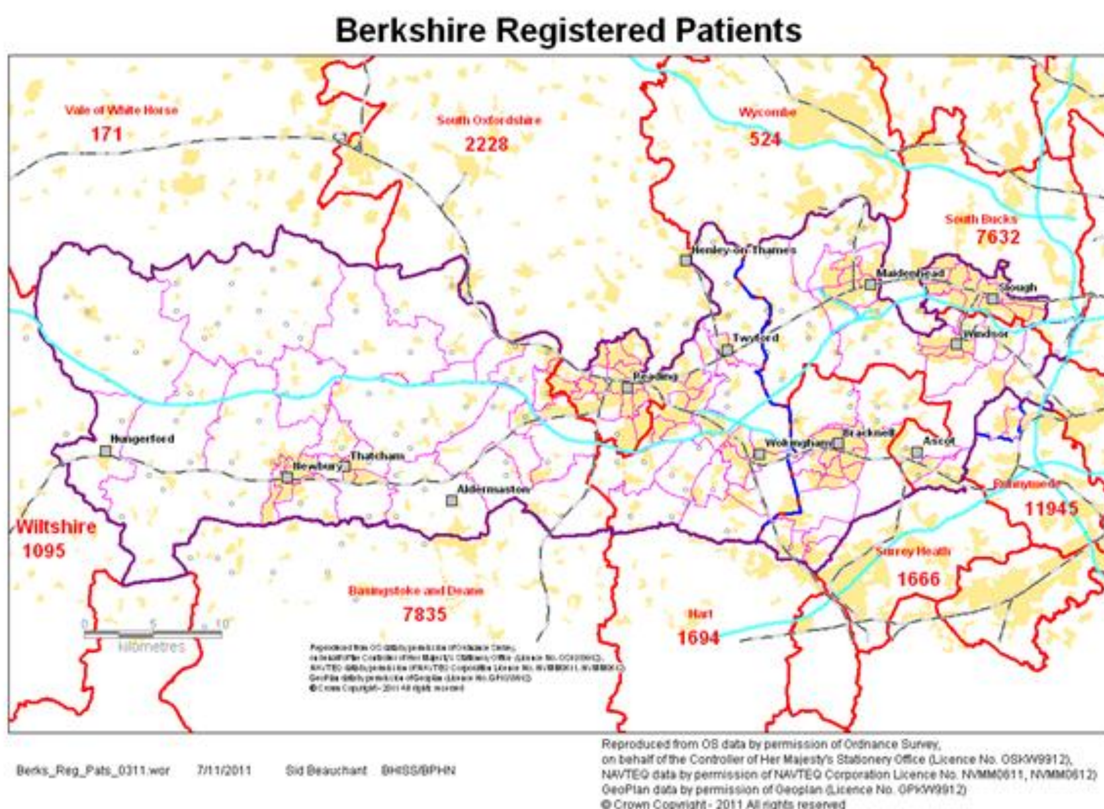
(*)The **next steps** are set out in the timetable in Table 1

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

Strategic issues - population differences

The area covered by Berkshire East comprises the three Unitary Authority areas of Slough, Bracknell Forest and Royal Borough of Windsor and Maidenhead (RBWM). Figure 1 shows how many patients live outside the geographic boundary of the existing PCT in adjacent counties.

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



The Office of National Statistics ONS 2010 estimated *resident* population of NHS Berkshire East at July 2011 was 406,700 (202,800 males and 203,900 females). This is considerably larger than the sum of all three local authority areas which was 393,800 (based on ONS mid

year estimates for 2010). This is because the resident population includes the two Englefield wards. No ONS mid year estimates have been released for 2011 as the census results will reshape local estimates substantively in July 2012.

The Attribution Dataset population for NHS Berkshire East called the registered population was 396,378 in 2010 (196,552 males and 199,826 females). This is calculated by constraining the GP lists to the resident population i.e within the geographic boundary of the region which is then apportioned to each PCT – it is the population for which the PCT is funded. PCT resident populations refer to the people living within the geographic boundary covered by the PCT i.e. in the case of Berkshire East the area covered by the three local authorities plus two wards in North Surrey.

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

- How joint funded health and social care services will be delivered to the patients in the Ascot area that are now part of the Bracknell and Ascot clinical commissioning group. (Three out of five practices in Ascot ward have joined leaving a main and a branch practice within Windsor and Maidenhead CCG)
- The need to agree a consistent population for joint funding purposes in the shadow year.

Future population projections – to 2030

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

Table 2 Numbers and proportions of ADS resident population 2010 in Berkshire East compared to the UK

Age group		Number males	Number females	Total	Proportion
0-18	UK	5,982,768	5,712,926	11,732,580	22.3%
	Bracknell Forest	14,800	14,000	28,800	24.7%
65+	UK	3,701,265	4,730,414	8,756,400	16.7%
	Bracknell Forest	6,300	8,100	14,300	12.3%

Source – The Health and Social Care Information Centre 2011. Lists extracted from the ADS2010 and reconciled to ONS mid 2009 estimates for local authorities (minus special populations)

For young people the 10-14 age band projected to increase most to 2030

Within the area covered by the local authority of Bracknell Forest the population is currently younger than the Southeast. Projections show the gap will close to meet the Southeast average trend by 2030 as the population ages. The greatest growth in Bracknell Forest is projected to be in the age bands 55-59 and 70-74 years

For the Royal Borough of Windsor and Maidenhead (RBWM) the population projections to 2030 are estimated to remain in line with the Southeast average. For RBWM the peak age band for growth is expected among those aged 50-59

Ethnicity

Until the 2011 Census results are published (expected in July 2012) overall the proportion of the population in Bracknell Forest which is from non white ethnic groups is estimated to be 10.4% (source ONS 2009 ethnic estimates). South Asian men are more likely to develop CHD at younger age, and have higher rates of myocardial infarction. Black people have the highest stroke mortality rates. Heart disease, diabetes and learning disabilities are more prevalent nationally in Asian communities and these together with African and some Mediterranean communities have a higher prevalence of sickle cell anaemia.

Birth rates in Bracknell Forest show that in line with national trends one in four new births are now to women not born in the UK. Results of the January school census in Bracknell Forest primary schools show that 16.1% children were from ‘non white’ ethnic groups, whereas in RBWM 17.9% of resident children were from non white ethnic origins.

Deprivation

Bracknell Forest is one of the least deprived areas of the country - ranked 291 out of 326 local authorities in England on the Index of Multiple Deprivation 2010 (IM2010). The overall picture of deprivation in Bracknell Forest masks variations at Lower Super Output Area (LSOA) level (an area containing a minimum of 1000 people).

For instance, eleven primary schools have free school meal eligibility in excess of 10%. 11% of 0-16 year olds in the borough are living in poverty, compared to a national average of 21.6%. However, there are six wards in the borough that have child poverty rates higher than the regional average with the highest ward rate being 23% in line with the national average.

Life Expectancy

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

The average life expectancy for Bracknell in 2007-2009 was above the Southeast average for males at 79.7 compared to 79.4 the Southeast average and statistically above the national average at 78.25 years

For females the average life expectancy was 83.8 years but was not statistically different from the Southeast average of 83.3 years or the national average of 82.31.

It is important to note that the Health Profile 2010 spine chart used life expectancy estimates based on a three year rolling average from 2006-8 data. Yet when calculating differences in life expectancy between quintiles of deprivation the 2011 Health profile used five years (2005-9). Life expectancy gaps between the most affluent and the most deprived *therefore provide different estimates based on the years used.* It is likely that three year estimates will be used in the Public Health Outcomes framework when published.

Using five year estimates from the Health Profiles for 2011 there was a gap between the most affluent and the most deprived wards for males of 4.02 years and for females of 1.21 years in Bracknell Forest (based on 2005-9 data)

Births and deaths

The population of Bracknell Forest and Ascot will continue to rise to 2030. The population pyramid for Bracknell Forest was estimated in 2010 (ONS MYE 2010) to be overrepresented compared to the Southeast by those aged under 59 with the exception of the age band 20-24 and underrepresented over the age of 60. This will change over the next twenty years as the population ages and increases to match that of the Southeast profile.

23.5% of new births in Bracknell Forest are to women whose country of origin is not the UK.

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

Using three year averages (based on all 2008-10 mortality data shown in the 2011 End of Life profiles) the percentage of deaths from all cancers was statistically above national in Bracknell Forest at 29.57% compared to 27.71% nationally. The RBWM rate was 27.88 but not statistically above national. Cancer deaths in Bracknell were statistically higher among females in the 65-84 year age band. Analysis of single year annual district death data from 2010 shows that within 'all cancers' colorectal cancers in males and females are ranked the highest.

In addition in Bracknell Forest deaths from other causes were statistically higher than national in males aged 65-84.

Cardiovascular disease mortality rates were statistically lower than national in Bracknell Forest yet cardiovascular disease in males and females remains among the top three categories in the CCG area – based on a single year extract from Annual District Deaths for 2010.

Groups that might have additional needs

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

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

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

- Theme A – giving every child the best start in life. (Chapters 2.3 and 4.2 of the guide). The key indicator explored this year at a local level was the performance of children on entry to school. The measure nationally is the whole Early Years Foundation Stage score. This is a composite of the communication and language scores, the emotional health and wellbeing scores and others. The first two have been analysed separately and show important findings in relation to where pupils live and then go to school. The key finding is that in order to reduce inequalities before entry to school the work of the early years

teams, speech and language teams and others will need to be directed outside of the borough boundaries, as residents in the borough take their children to schools in Bracknell or Slough and in-migration of pupils from those areas is significant. This has implications for commissioning for example the Family Nurse Partnership, speech and language services and various parenting programmes.

- Theme B – enabling all children, young people and adults to maximise their capabilities (Chapter 2.3 and 4.3 of the guide). The results for those not in education employment and training are covered in 2.4 as is the underperformance of boys and some BME groups - a local and national issue.
- Theme C – fair employment and good work for all (chapter 2.2 and 4.4 in the guide). This reviews employment rates and claims which are similar to last year
- Theme D – ensuring a healthy standard of living for all (chapters 1.5 and 2.2 in the guide). The small increase in the numbers of claims by carers and those with a disability is not statistically significant
- Theme E – create and develop healthy and sustainable places and communities (chapter 2.1, 2.3, 2.5, 2.6 in the guide). It is too early to show impact in a single year – the 2010 BMG local resident surveys is referenced in section 2.1
- Theme F - strengthen the role and impact of ill health prevention (chapters 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 4.5, 4.6, 4.7, 4.8 in the guide). Improvements in disease specific outcomes are shown in section 4.6, 4.7. Reductions in the adverse health outcomes of problem drug use and the social and economic costs of drug related crime are shown in section 3.3. Reductions in preventable and avoidable death and disability across the social gradient are shown in section 5.2.

COMMISSIONING PRIORITIES

IMPROVING OUTCOMES FOR CHILDREN LIVING IN POVERTY

This is an ongoing national and local priority for Bracknell Forest. A child poverty strategy has been developed and an Early Intervention Strategy is being developed across the council which will tackle the determinants of health inequalities set out in the Marmot report (DH, 2010). The results published in the Health profile show 2595 children were living in poverty based on 2008 data from Her Majesty's Revenue and Customs (HMRC). The results for 2009 will be published in the 2012 Health Profile. More recent quarterly Directorate of Work and Pensions data (Dec 2011) can however be used as a worst case scenario to target services until revised HMRC data is available. These indicate that 7500 families are claiming although not all will meet the definition HMRC use which is 'The proportion of children living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income'

Gaps identified

- That the gap between the median and the bottom 20% for the Early Years Foundation profile is narrowing and that the overall score is rising in each area. There is still scope to improve this in the central wards of Bracknell Forest.
- Referrals from health visitors to early years teams are viewed as vital for vulnerable children and families. Increasing the capacity of the health visitor workforce is essential

to ensure that pre birth visits and two year review assessments can be systematically implemented and used to measure the impact of early interventions.

- Improved targeting of the Family Nurse Partnership is required in areas of deprivation where low emotional health and wellbeing scores have been identified (from local analysis of the early years foundation stage indicator).
- Cross boundary commissioning of early interventions is required (such as speech and language and parenting programmes) as children are entering schools from adjacent boroughs. Examples include the Every Child a Talker programme to prevent language delay
- Family members and day care provide just over half of all childcare. Ensuring childminders gain 'good' or better OFSTED grading is a key priority.

IMPROVING MENTAL HEALTH ACROSS THE LIFECOURSE

There are 12943 patients (12.4%) on depression registers in the Bracknell and Ascot CCG. This prevalence rate is statistically above the national average and above the Berkshire East average of 11.2%. Mental health registers show there are 777 people on local CCG registers. Overall QoF prevalence remains at 0.6% for the CCG i.e below the national rate of 0.7%. Wards identified as most likely to have higher than national values on the Mental Health Needs Index (2007) are Crowthorne and Old Bracknell in Bracknell Forest. NB no area in RBWM is estimated to be above national reflecting lower levels of deprivation.

There is scope to redesign services before the contracts transfer to local authority control as the Programme Budget information for 2010 for the PCT has identified that both expenditure on Child and Adolescent Health Services and on psychotic disorders is higher than comparator areas and second highest in England. Standardised outpatients attendances are also significantly higher than England.

Gaps identified

- Best practice post natal depression estimates (BMJ 2011) vary from 7-19% among mothers yet there is no systematic recording to inform commissioning and the current thresholds for referral are high. Improved reporting needs to be implemented to inform lower levels of targeted support
- The rates of children becoming looked after is increasing – since April 2007 a 21% increase in Bracknell Forest and a 15% increase in RBWM. There is under representation of looked after children (a group in whom 45% are estimated to have a psychiatric disorder, and 38% a conduct disorder) and of children and young people with conduct disorder in local CAMHS services compared to estimated need.
- There is currently no provision of a court Divert service - a gap compared to the west of Berkshire
- GPs have identified there is a gap in provision of low level anger management programmes although perpetrators of for example domestic abuse are offered access to anger management programmes
- Standardised mental health admissions are below the expected rate in the CCG area but conversely standardised outpatients attendances are above the England average at 13807 compared to 4657 in Bracknell Forest and 14944 compared to 5278 in RBWM.
- Despite the higher prevalence in two practices overall dementia prevalence in local practice registers is below the national average in the CCG area. Using PANSI and POPPI

Oct 2011 estimates together there are 1067 patients in 2011 rising to 2084 in 2030 in Bracknell Forest yet just under half (458) are listed on 2010-11 quality and outcomes registers. Intensive work is underway to ensure early diagnosis and support is in place to prevent unnecessary admissions as part of the dementia strategy. This includes prescribing reviews and the provision of a dementia care advisor

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

LONG TERM CONDITIONS

The World Health Organisation (WHO) defines long term conditions (also called chronic conditions) as health problems that warrant continuous management over a prolonged period, usually years or decades. The term "chronic diseases" includes an array of conditions including heart disease, stroke, diabetes, chronic respiratory diseases and cancer.

Depending on the severity of the condition risk reduction and self management are the primary goals but where health or social care services are needed such as intermediate care the aim is to increase a person's ability to manage personal care, daily living tasks, or achieve outcomes such as maintaining independence and reducing dependency on statutory services

CARDIOVASCULAR DISEASE, CORONARY HEART DISEASE, DIABETES, STROKE AND CHRONIC KIDNEY DISEASE

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

Cardiovascular disease in males and females was the leading cause of death in Bracknell Forest in 2010, accounting for 108 males and 97 female deaths. Within this CHD was the next most common with 56 males and 39 female deaths whilst stroke was the third with 26 males and 30 female deaths.

There are 14907 patients on the CCG hypertension register and 3460 patients on the CHD register. The biggest contributing factors to the development of coronary heart disease are high blood cholesterol (46%) and physical inactivity (37%). CHD admissions were statistically higher than the Berkshire average in Crown Wood (based on 2007-10 HES data).

There are 4946 patients registered with diabetes in the CCG. Diabetes prevalence at 4.7% was below the PCT and national average of 5.5%. Diabetes is a major cause of ill health and premature mortality, mainly due to cardiovascular complications such as heart attacks, stroke, peripheral vascular disease, eye disease and kidney disease. Approximately 75% of patients with diabetes develop cardiovascular disease. South Asian and Black people are at greater risk of type II diabetes, with cases occurring from the age of 25, compared to from 40 years in the general population (Diabetes UK). Diabetes is more common in deprived populations. There are 144 children diagnosed with type 1 diabetes but as yet this has not been disaggregated to local authority boundaries.

There are 2831 patients with chronic kidney disease in the CCG a prevalence of 2.7% - below the national rate of 2.9%.

There are 1752 patients registered with a stroke on CCG QoF 2010/11 registers. Stroke admissions in the wards of Ascot, Crown Wood and Harmanswater were above the Berkshire average in 2007-10. The Projecting Older Peoples Population (POPPI) estimates that there are 338 people aged 65 and over with long term health needs following stroke. This is predicted to rise to 602 by 2030 an increase of 78.1%. The premature mortality rate under 75 years for stroke in Berkshire East was 15 per 100000 in 2007-9, higher than England (12.8) and significantly higher than South Central (10.6). Male mortality rates exceed female mortality rates Stroke emergency admissions were above the Berkshire average in Ascot, Crown Wood and Harmanswater (based on 2007-10 HES data)

There are 1563 patients with atrial fibrillation in the CCG a leading risk factor for stroke. Atrial fibrillation admissions were higher than the Berkshire average in Ascot, Bulbrook and Central Sandhurst (based on 2007-10 data extracted from HES)

There are 676 patients with heart failure in the CCG.

Gaps identified

- To fully commission the NHS Health Checks screening programme
- To increase uptake of diabetic retinopathy screening to national standards
- To embed the roll out in primary care of the atrial fibrillation locally enhanced service
- To provide Myquest support to ensure that practices can load and use the Guidance on Risk Assessment & Stroke Prevention tool (GRASP)
- To follow the South Central post stroke care pathway recommendations in the community

CANCERS

There are now 2028 people on cancer registers in local practices in the CCG. Cancer mortality trends for 2007-9 were noted in the 2010 JSNA and will be updated when new data is available.

Cancer mortality percentages for each local area are available in the End of Life profiles for 2011. For Bracknell 29.57% of deaths in 2008-10 were due to cancer and 27.88% in RBWM. The only statistically significant age bands were in Bracknell for females aged 65-74 (a rate of 32.95% compared to 32.8% nationally) and for males aged 8% plus in RBWM (a rate of 23.3% compared to 19.52% nationally).

No indicator on the 2011 cancer profile for the PCT as a whole is statistically better or worse than England. Urological cancer incidence is however higher in RBWM.

END OF LIFE CARE

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

Gaps identified

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

RESPIRATORY DISEASE

There are 7824 patients registered with asthma in the CCG (QoF 2010-11). Rates are just below national in Bracknell Forest yet emergency admissions for asthma and other respiratory conditions are higher in Binfield with Warfield and Central Sandhurst for those aged under five years. The coding of asthma in such a young age group is more likely to be due to viral wheeze according to local clinicians. Ensuring one day length of stay admissions from accident and emergency are reduced in both in the Royal Berkshire Hospital and in Frimley is a priority.

COPD is an umbrella term covering a range of respiratory diseases. Men in unskilled manual occupations are 14 times more likely to die from COPD than men in professional roles. There were 1360 people registered with COPD in 2010/11 on the CCG QOF registers, a prevalence of 1.0% compared to 1.6% nationally. Emergency admissions for COPD were higher than the Berkshire average in the wards of Harmanswater and Warfield Harvest Ride (HES extract 2007-10). Emergency admissions for other respiratory diseases (including influenza) were higher in College Town and for pneumonia were higher in Central Sandhurst and Harmanswater. Bronchiolitis emergency admissions were higher in Wildridings and Central and College Town.

Gaps identified

- The need for a pulmonary rehabilitation service which targets areas of excess admissions reported in the JSNA and frequent attenders
- Wards with excess admissions compared to expected admissions have been identified for: asthma, bronchiolitis, upper and lower respiratory and chronic obstructive pulmonary disease. Further investigation is required as there are multiple potential triggers including: poor self management, housing conditions, smoking etc

LIFESTYLE INTERVENTIONS - SMOKING

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

ALCOHOL

The 2009 Report on Alcohol statistics (IC) estimated 1 in 3 men and 1 in 6 women were hazardous drinkers and 6% of males and 4% of females were harmful drinkers. PANSI estimates (Oct 2011) estimated 4529 people were alcohol dependent. Among those in treatment the level of drug users who also have an alcohol dependency is reported as 21% nationally. Local alcohol profiles for 2011 show an increase in hospital admissions in Bracknell to 1332 per 100000 – the second highest rate in the county.

No indicator was red at local authority level in the 2011 Local Alcohol Profile for England yet. According to the North West Public Health Observatory, the level of binge drinking in the local authority is estimated to be 19.0%. (Violence related to binge drinking is not treated in the same way as alcohol dependency. Criminal justice system interventions include Thinking Skills training).

Local drug and alcohol teams commission a range of services. The numbers in tier 4 residential services across the area were low (reported as 25 in 2010-11). Payment by results information is being monitored nationally and is restricted. It can be provided to commissioners.

Gaps identified

- Further development of Identification and Brief Advice in pharmacies and in tier 1 settings in particular GP surgeries and among staff in Adult & Children's Services.
- The payment by results service is being evaluated locally and nationally and will inform future delivery.
- The need for Alcohol Liaison Nurses in Accident and Emergency departments.
- The need to ensure access to alcohol treatment services is consistent for all local practices in the CCG.

SUBSTANCE MISUSE

The JSNA contains new estimates of adults with a drug dependency. Bracknell is being monitored as part of a national payment by results pilot. Detailed performance information and projections showing financial impact have been produced by the National Drug Treatment agency to support JSNA commissioning decisions. Most of this information is restricted but can be provided to commissioners.

OBESITY

In Bracknell Forest 81% of reception year children and 68.2% of young people at age 10/11 are a healthy weight compared to England rates of 76.4% and 65.3% respectively as shown in the latest National Child Measurement programme (2010/11). The reception result is significantly higher than England.

In Bracknell Forest the prevalence of obesity among children entering school in reception and at year 6 remains just below national rates at 7.6% and 15.6% respectively compared to 9.4% and 19% nationally.

The prevalence of adult obesity in Bracknell Forest and the CCG (and associated costs to the NHS and social care) is projected to rise. Synthetic estimates show 28% of the adult population eat healthily and the adult obesity prevalence is estimated to be - slightly lower than the England average. Yet the prevalence of adult obesity recorded in local practices in Bracknell Forest in quality and outcomes registers show a prevalence of 9.5% i.e below the national rate of 12.5% (QoF underestimates true prevalence as it is only recorded for those on disease registers).

Gaps identified

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

PHYSICAL ACTIVITY

The latest Active People Survey (Dec 2011) noted that 24.7% of adults in Bracknell undertook the minimum exercise of three sessions a week of at least 30 minutes. This places them in the highest quartile however this is less than the number of sessions recommended for health.

Gaps identified

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

SEXUAL HEALTH

Poor sexual health is an important cause of health inequalities, with a higher risk of poor sexual health and barriers to services among young people, with a particular additional risk for those who are looked after, those not in education, training or employment; BME groups, asylum seekers and refugees; gay and bisexual men; sex workers; and drug mis-users. Rising rates of all sexually transmitted infections are noted although none are statistically higher than England in 2010. Whilst current provision is therefore considered good yet there is scope to improve as follows

Gaps identified

- The need to resolve shared care pathways in advance of the introduction of a national tariff in 2013 when commissioning responsibility moves to local authority control. This is a strategic health authority led programme.
- The HIV burden is underestimated by one third and commissioning should be informed by the outcomes of an early identification pilot for HIV in Slough
- Almost half of the teenage conceptions in the PCT area in 2010 ended in abortions and the reasons for repeat abortions need further investigation.
- There are no data on the extent of psychosexual problems in the CCG area, or on local psychosexual service provision or uptake.
- Local LINks reports show a continuing demand for sex and relationships education in schools

HOUSING

Detailed analysis from the local templates shows increasing demand for homes among young families with waiting lists of 3478 in Bracknell Forest.

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

Increasing supported living options for those with learning disabilities and mental health problems is a priority.

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

CQC information extracted shows the difference between the numbers of beds and the numbers of care homes in the area. Two practices have responsibility for a number of care homes and as a result have a dementia prevalence that is significantly above the England average

Table 2 Beds and care homes provided by locality

Bracknell	RBWM
485 beds 23 homes	1,412 beds 48 homes

Gaps identified

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

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

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

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

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

EDUCATION AND SKILLS DEVELOPMENT

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

Bracknell Forest is in the process of agreeing the local action plan for their Children and Young Peoples partnership priorities. These will be included in the electronic version when ready and will include actions for enhancing outcomes for boys at GCSE and for vulnerable groups.

Gaps identified

- There are opportunities to further promote local childcare and childcare provision in those Children's Centres that will remain following restructuring. Local parents, including teenage parents benefit from a wide range of parenting programmes, health and wellbeing advice and access to education, training and employment opportunities. Welfare and benefits advice is also available to maximise benefit take up, and links with Jobcentre Plus to encourage and support labour market participation by parents.

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

DOMESTIC ABUSE

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

SAFEGUARDING ADULTS

The recommendations in the JSNA relate to safeguarding children (which have a separate section in Chapter 1 and looked after children which are discussed in Chapter 5).
A recent Association of Directors of Social Services report which makes reference to many commissioning recommendations that are already in place in service specifications, invitations to tender and contracts. The goal will be to ensure that governance arrangements are in place to identify trends and ensure that the outcomes of referrals are known.
Local adult safeguarding reports include a key recommendation i.e to redress the under-reporting by health services. All general practices should have access to the Berkshire East wide adult safeguarding policy and procedures which can be found on line.

HEALTH PROTECTION

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

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Appendix 1 Navigating the JSNA – guide to key findings

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APPENDIX 2 Public Health Commissioning Responsibilities

Local authorities will be responsible for:

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)

- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

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

CLINICAL COMMISSIONING GROUPS

- Abortion services

NHS COMMISSIONING BOARD

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

Public Health England

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