

SLOUGH WELLBEING BOARD

REPORT TO: Slough Wellbeing Board

DATE: 29th January 2014

CONTACT OFFICER: Dr Angela Snowling, Consultant in Public Health, SBC.

(For all Enquiries) 01753 875142

WARD(S): All wards in Slough.

PART I

FOR DECISION & CONSIDERATION

Strategic Asset Planning report – options for improving primary care access

1. Purpose of Report

The purpose of this report is to provide the Wellbeing Board with;

- contextual information about the strategic asset management plan
- a summary of the evidence base that strategic spatial planning impacts on health outcomes
- evidence that improving access to general practices and other primary care facilities reduces health inequalities
- information on where health outcomes are poorest across Slough compared to assets in primary care
- data on population growth and general practice requirements
- quality and outcome framework data (QOF) data which illustrates how this approach could be evaluated
- a checklist and spatial planning guidance for use by the strategic asset management group when assessing future sites for disposal or redevelopment.

NB an illustration of the range of properties for disposal is included but it is not the intention of this report to replace the formal decision making process for these sites, simply to illustrate how a checklist can be used to prioritise sites in future.

2. Recommendation(s)/Proposed Action

The board is asked to

- endorse the use of spatial planning guidance (Kings Fund 2013, TCPA and PHE 2013, Spatial Planning and Health Group 2011) in future decisions about land use, to improve health outcomes such as mental health, obesity, physical activity, alcohol harm reduction etc
- endorse the use of the attached data on ward outcomes when considering the disposal of sites as future health hubs

The board is asked to endorse the adoption of spatial planning as a key enabler in any future revisions of the Wellbeing Strategy

3 **The Slough Joint Wellbeing Strategy, the JSNA and the corporate plan**

The data shown in this report is collated from;

- the JSNA 2013
- GP practice profiles
- Association of Public Health (now PHE) GP profiles
- Localhealth ward level data for the JSNA
- The draft asset management plan for Slough 2014-2017

The Wellbeing strategy contains two key themes to which this report directly relates – health and regeneration. The corporate plan has two key themes to which this report relates to ‘improving customer experience, delivering high quality services to meet local needs, develop new ways of working.

4. **Other Implications**

(a) Financial

Regionally around half of GPs own their surgeries with most of the remainder leasing them from private landlords. Following the sale of Langley Medical Centre to the resident practice, only the Slough Walk-In Centre on the Upton Hospital Site is owned by NHS Property Services Ltd.

Financial and other barriers exist to using ring-fenced educational land as this cannot be secured for alternative use unless through an application to the Secretary of State and Slough has a shortage of school places as well as housing.

Where sites are prioritised the main financial risks of any new development are born by the developer although the council incurs legal costs in securing sites for redevelopment.

The council has two main income streams i.e council tax and business rates; any development that does not generate income from say new housing or business must be balanced against other risks and benefits and a full business case will be required. .

(b) Risk Management

Recommendation	Risk/Threat/Opportunity	Mitigation(s)
Wellbeing board approval will ensure that disposals and acquisitions meet with joint strategic objectives will then be included in the Strategic Asset Management Plan	The NHS Propco, SBC and CCG assets do not yet align with the needs of the population	The recommended sites in the asset management schedule should be include ward based health and wellbeing outcomes as well as existing requirements

Recommendation	Risk/Threat/Opportunity	Mitigation(s)
Detailed population density mapping (gravity mapping) will be needed to model future demand based on the final locations approved	There are key variables which will influence the management plan assumptions such as the flow of new residents into the town into private sector rental and the additional pressures of any extra housing to be built in future	Estimates of population flows can be obtained from the Census as well as new entrant registrations in general practices.
GP practice profiles are used to monitor changes in the ratio of expected to actual cases of disease. That quality and outcome framework data which now improvements in key indicators of care, a reduction in emergency admissions, and increased customer satisfaction with access.	It is not possible to measure the impact of this plan in terms of the long term public health outcomes due to the multiple influences of other strategies on the wider determinants of health	QOF data is displayed annually in GP practice profiles produced by PHE. The national patient survey is an annual survey of patient satisfaction with GP access which is included in that profile.

(c) Human Rights Act and Other Legal Implications

There are no Human Rights Act implications.

(d) Equalities Impact Assessment

The JSNA on which this report is based is a full assessment of the impact of the strategy on different age, gender and ethnic groups as well as those with protected characteristics.

(e) Workforce

There are no immediate workforce implications by accepting this approach. If a change in location of any premises is proposed, the area team has identified that only a coalition of services will be considered by the national property team. This would then require consultation about co-location of for example three or more GP, dental and/or pharmacy services within an area, to ensure that existing property is freed up as part of any merger of services on new sites.

5 Supporting information

5.1 Context

The Localism Act requires local authorities to keep and publish a list of assets of community value. The 2010-14 Slough Strategic Asset Management Plan is being updated and is aligned to the budget setting process. Each year every directorate provides an update on the assets it holds and whether they are; fit for purpose, in the right place to meet future demand, the correct size and have sufficient flexible

space to meet future need, are energy efficient and could secure a greater return through an alternative use or disposal.

The refresh of the plan comprises three stages; the first is now complete. Departmental assessments have been undertaken of asset and accommodation needs in which assets were categorised as A - likely to stay operational, B - could stay operational with potential for co-location, C - are expensive to run, not fit for purpose or have a potential for a capital receipt, D - are vacant and surplus and considered for disposal..

The second phase of the plan is to divest of Category A and B properties that are of poor strategic value. Within this stage there is a long term plan to challenge the use and value all existing assets to ensure they can add value to the delivery of the strategic plan and corporate objectives.

Stage three will involve enhancing the collection of property data from local public, statutory, voluntary and private sector organisations in the development of an integrated area asset management plan.

Strategic land acquisition will occur when; a need is identified, an opportunity arises or a planning project effectively blights an area.

The governance of disposals and acquisitions is through agreement by; the Capital Strategy Board, the Corporate Management Team and Cabinet.

Issues related to spatial planning that the Wellbeing board must consider primarily relate to key aims three and five of the asset management strategy

- Key aim three - make a significant contribution to delivering transformational change.
- Key aim five – to hold a rationalised portfolio that is in the right location, is fit for purpose and reduces ongoing revenue costs

The Wellbeing board may also wish to consider key aim 7 as it relates to schools Key aim seven – to manage and deliver the strategic school places plan

Intensive local research into why new entrants use accident and emergency services in preference to primary care shows that the biggest users have only lived in Slough for a few years. Best practice in introducing new entrants to an area shows that people who do not know how services work can benefit from escalator programmes based around English as an Other Language as offered in early years and schools as well as local community centres. Developing health hubs is an evidence based mechanism for the integration of services.

5.2 Evidence that health and spatial planning improves health outcomes and reduces health inequalities

The Kings Fund (2013) published nine key areas in which good quality effectiveness and cost effectiveness studies have been developed to show the impact that can be made on health outcomes. This report cites the recent TCPA/PHE publication – Planning Healthier Places and the checklist developed in 2011 by the Spatial Planning and Health Group.

Recommended actions in the Kings Fund report include

- Actions to lower the risk of flooding (e.g the DEFRA work in Chalvey)
- Increasing access to green space (e.g the Herschel example in the Parks Strategy)
- *Increasing local knowledge of planning issues*
- *Use of the Spatial Planning and Health Groups checklist when scrutinising plans and proposals*
- *Implement the recommendations set out in Planning Healthier Places*
- *Consider accessibility criteria in planning policy*
- *Increase awareness of how planning decisions increase uptake of services through health impact assessments*

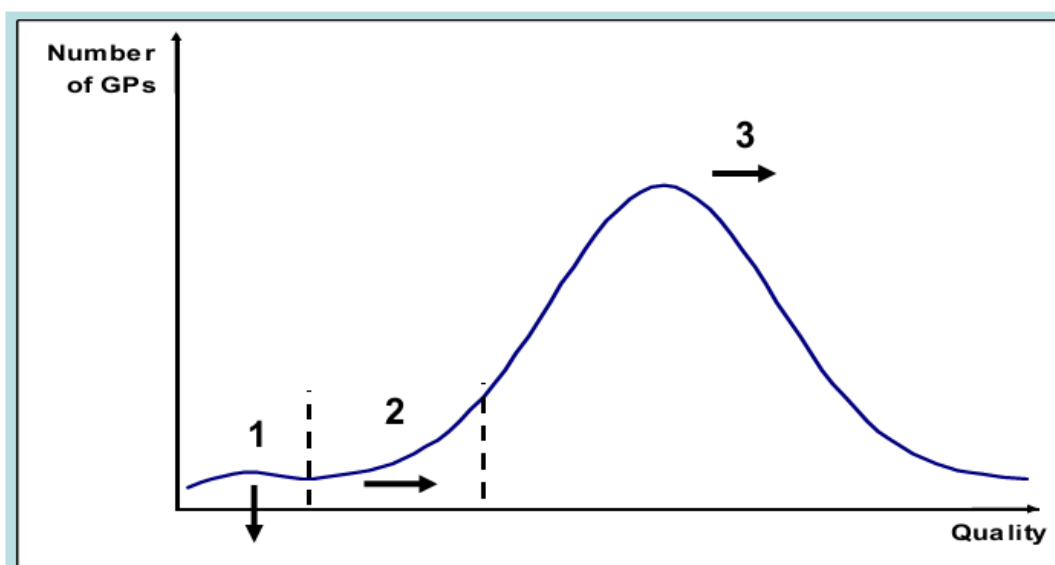
5.3 Evidence that improving access improves health outcomes and reduces health inequalities

5.3.1 NHS Outcomes data for Slough shows Slough has the third highest rate of years of life lost from conditions amenable to healthcare (CCG atlas 2012) and rates of early deaths from cardiovascular disease are also higher than the England average. Emergency admissions for respiratory conditions in children are also higher than expected.

5.3.2 A number of strategic approaches to tackling health inequalities have been developed over the years, to improve health and wellbeing outcomes. The Kings Fund cites original research by the former Health Inequalities Unit (Bentley et al 2008) which highlighted a number of reasons why areas such as Slough could expect to have lower uptake of GP services, especially among ethnic groups that may struggle to understand the language, know how the primary care service works, have different expectations and may be younger and working and have difficulty making and keeping appointments.

5.3.3 Bentley et al (2008) highlighted two key issues that relate to poor access; the first being geographic location of general practices and the second the numbers of GPs per practice compared to the list size. They stressed the importance of more than two general practitioners working together to drive up quality of care and outcomes as measured by the quality and outcomes framework.

Figure 1 Impact on quality of numbers of GPs per practice (Bentley et al 2008)



5.3.4 The number of GPs dictate the maximum list size and the ability to hold clinical sessions. List sizes also dictate revenue which can be used to ensure administrative support to follow up patients, for list cleansing when people move (as 20% of the early years population move around and out of Slough according to local schools) and for funding additional nursing and other staff. The size of the premises in Slough is also critical to the number of clinics offered. There are a number of practices operating from Victorian houses where no more than two practitioners can work at any one time. Others have limited space to store notes and are not sited in the place of greatest need, where for example the birth rate is highest or the numbers of older people with serious long term conditions live.

5.3.5 Confirmation that patients find access to Slough practices difficult comes from the annual patient satisfaction survey and from the Verve Survey (2013) which the CCG initiated. A number of practices in Slough physically report they cannot recruit due to the lease arrangements they hold or due to the limitation of their facilities which limit staffing. Lack of on site parking is also a restriction for staff and patients.

5.3.6 The Health Inequalities Unit report argued that quality can also be improved through ensuring the estimated level of a disease in a practice is compared with the actual registers to identify the shortfall and then develop list cleansing approaches and targeted communications. The general practice profiles for Slough show a significant shortfall for hypertension and for cardiovascular disease overall that can only be explained following audits.

5.3.7 Ensuring equal access to primary care is an essential strategy to narrow the gap in inequalities in health and wellbeing outcomes (Health Strategy for Slough - Healthy Lives, Healthy People, 2013-16). The time of day services can be accessed is also a factor as Slough has a younger working population with c 40000 leaving to work in London or Heathrow every day

5.4 Which areas of Slough have the worst health outcomes?

Appendix 2 (from the localhealth profiles) and the JSNA 2013 has identified that the worst long term health and wellbeing outcomes are in;. Chalvey, Colnbrook and Poyle, Baylis and Stoke, Central and Wexham Lea.

Other wards where improvements can be made are in Cippenham Meadows which has the highest birth rate outside of Chalvey which requires special consideration, as children aged 0-4 years and older people aged 65+ are the largest users of GP services.

The wards of Upton (in the Yew Tree Road area in particular) together with Britwell, Wexham Lea show the highest percentage of residents aged 65+.

All areas in Slough have higher than expected emergency cardiovascular emergency hospital admissions. Ward profiles already show this information and will be collated on a single map to be called the 'JSNA on a page' when complete.

5.5 What size of property is required to house a modern surgery?

Only those sites which are physically large enough to house GP surgeries (i.e greater than 0.5HA) can be selected. If parking is provided elsewhere on site, 0.5 of a Ha will provide a site sufficient to develop a single storey surgery for c. 6,000 patients. However this would be a very small surgery for modern primary care,

especially in an urban area - albeit an improvement on some of the very small practices currently in central Slough- such a surgery is unlikely to be viable in the medium term. Much larger premises perhaps housing several practices are the way forward. For example, the same 0.5 HA site could, over two or three storeys, provide a surgery for 16,000 patients

5.6 What are the minimum requirements for general practice sites to 2021?

The Office of National Statistics (ONS) has projected that Slough's population will rise from 147,091 in 2014 to 159,992 in 2021. This means that there will need to be a minimum of 10 modern GP practices to cover the population of Slough
Appendix 5 contains the expected population growth by age band to 2012.

5.7 What are the opportunities to utilise properties in the next year?

The Wellbeing Board comprises all key partners involved in commissioning and monitoring health and wellbeing outcomes. The NHS England area team leads on commissioning primary care services from GPs, Dentists, Pharmacists and Optometrists. Slough Clinical Commissioning Group commissions clinical services in the acute sector and in the community and Slough Borough Council commissions a range of clinical and preventative services.

Community health and wellbeing services which are delivered by NHS providers (not co-located with SBC services) are housed in sites leased from and managed by NHS Property Services Ltd, or one of the provider trusts. Primary Care – including General Medical, Dental, Pharmaceutical and Optometric services - is provided in Slough from premises either owned by the provider or leased from private landlords.

Whether a potential site is NHS property or SBC property the board is asked to note the opportunity that co-location of services in an area could bring. For example the current use of the Walk in Centre is being reviewed in 2014 as it serves a population that is younger and of working age, with children, who do not access routine GP services easily during the day.

Further opportunities are shown below in the current list of assets within SBC

Table 1 The range of potential development sites in the asset management plan

Operation Type	Number	Value
Adult centre	1	
Allotments	12	
Car Parks	9	
Cemetery	2	
Childcare Centre	10	
Children's Home	1	
Community & Youth Centres	17	
Courts	1	
Day Centres	3	
Depot	1	
Graduated Children's Centre	2	
Industrial units*	31	
Land – agriculture amenity agriculture	3	

Libraries	7	
Mental health resource centre	1	
Operational offices	9	
Park lettings	4	
Public Parks Open Spaces	53	
Recycling Centre	2	
Schools - nursery	3	
Schools - primary	14	
Schools – secondary etc.	1	
Schools – caretaker houses	8	
Slough Community Leisure - sites	7	
Travellers sites	4	
Waste & Pumping Station	2	
Total	206	

Table 2 Illustration of assets for consideration in 2014

Asset	Public health issues	Access to primary care
Lynch Pin Public House	In Britwell which has the following health and wellbeing outcomes ranked higher than the Slough average <ul style="list-style-type: none"> • Violent crime • Alcohol admissions • Respiratory admissions - COPD • Elective admissions all causes • Emergency admissions • Child poverty and domestic abuse 	Only 0.19 HA so does not meet requirements
Weeks Drive Community Centre	Health and wellbeing outcomes ranked worse than Slough average for <ul style="list-style-type: none"> • Rate of low birth weight is 8.9% • 32% of the population have difficulty accessing services NB This area has the second highest birth rate in Slough.	No dental practice in this ward. Branch surgery only
Earl of Cornwall public house	As above in Cippenham	Only 0.24 HA so does not meet requirements
Land at former Cross Keys public house	Health and wellbeing outcomes ranked worse than Slough average for <ul style="list-style-type: none"> • IMD • JSA claimants • Children living in poverty • KS2 and GCSE results • All cause mortality – Slough worst rank • Life expectancy - males and females • Emergency hospital admissions all causes • Rate of low birth weight 9.4% • This area has the highest birth rate in of Slough • 3.3% no central heating ASB rate	Approved at Cabinet for Chalvey health hub

83 Elliman Avenue	Health and wellbeing outcomes ranked worse than Slough average for <ul style="list-style-type: none"> • Hypertension • Diabetes 	Only 0.04 HA so does not meet requirements
Longmead Pumping Station	See as for Upton ward below	Only 0.01 HA so does not meet requirements
OTHERS (ALPHA STEET)	Upton ward. Health and wellbeing outcomes ranked worse than Slough average <ul style="list-style-type: none"> • % with no access to central heating • Crime rate, ASB, theft and handling and criminal damage • Population density aged 65-74 >14 per 1000 • Diabetes • CHD • Dementia 	0.7HA so meets requirements

When ready the JSNA on a page will include information under the new ward boundaries

Examples of issues in other areas

Health and wellbeing outcomes ranked worse than Slough average for Wexham

- Emergency hospital admissions all causes – 3rd rank
- Lower access to services (IMD)
- Low birth weights (2nd rank)
- Obesity year R and year 6
- 29.5% living in socially rented accommodation
- 4% were JSA claimants
- Lowest educational rank for GCSE's and post 16 qualifications

Health and wellbeing outcomes ranked worse than Slough average for Colnbrook and Poyle

- All cause mortality under 75
- Life expectancy in males and females
- Very poor air quality near junction 5
- Lone parent with dependant children
- Population density aged 60-64 >14 per 1000
- 2nd highest rate of early deaths from stroke
- High alcohol admissions
- Single parent families
- Unemployment rates ranked 2nd

6 Comments of Other Committees

Subject to endorsement by the Wellbeing board this report will be provided to the Strategic Asset Management Group for inclusion in the revised 2014-17 Strategic Asset Management Plan.

Subject to Cabinet and CMT approval this plan will shape opportunities to redesign the delivery of integrated services not only with primary care but also with adult social care and community hubs.

7 **Conclusion**

The board is requested to note

- that Slough CCG is now ranked third in the country in terms of years of lives lost through conditions amenable to health care and in the worst quintile in the country for patient perceived ease of access to GP services.
- the ward level health and wellbeing outcomes data from local profiles as shown in Appendix 2 show that; Chalvey, Colnbrook and Poyle, Central are the wards with the greatest rates of deaths under 75 years. Other outcomes are shown in the all ward rankings in Appendix 2
- that work underway to increase patient access where needed is hampered by the condition of the property, floorspace, parking and physical size of the premises which has secondary impact on list sizes, the numbers of partners that can be engaged and the numbers of clinical session a practice can offer

The board is requested to debate the evidence and endorse the inclusion of nationally approved strategic planning guidance in the review of the Strategic Management Plan for 2014-17.

The success of any such changes will be monitored through a range of information available within practice profiles.

The board is requested to note the current opportunities in Table 2 as a illustration which could become an annual review of options by the board prior to sign off of the Asset Management Plan schedule each year.

8 **Appendices Attached**

Appendix 1: Spatial Planning and Health Checklist

Appendix 2: Ward statistics from the Association of Public Health (2006-10)

Appendix 3: Slough practice population by age and gender 2013

Appendix 4: Slough population pyramid by age 2012

Appendix 5: Population density by lower super output area (Census 2011)

Appendix 6: Population projected growth by age band (2012-2021)

Appendix 7: Maps of new ward boundaries with sites of current general practices, dental practices and pharmacies

9 **Background Papers**

APHO 2011. Spatial Planning and Health Group Checklist available at <http://www.apho.org.uk/resource/item.aspx?RID=116029>

Bentley C. (2008) Systematically addressing Health Inequalities available at <https://www.dur.ac.uk/wolfson.institute/guestlectures/fullpresentation/?itemno=7296&rehref=%2Fwolfson.institute%2Fguestlectures%2F&resubj=Guest+Presentations%20Headlines>

Healthy Lives Healthy People; a public health strategy for Slough 2013-16.

Marmot 2012, Implications for spatial planning available at http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CEkQFjAA&url=http%3A%2F%2Fwww.nice.org.uk%2Fnicemedia%2Ffive%2F12111%2F53895%2F53895.pdf&ei=IDXFUpiPAafT7AaAvoGYCg&usq=AFQjCNGAvCAoIVBJA4ueitKmRW3JxkFu9Q&sig2=NC_adFWVDIKnq7MsROuDow

Planning Healthier Places a report from the re-uniting Health with Planning project (2013) available at <http://www.tcpa.org.uk/pages/reuniting-health-with-planning-phase-2-project.html>

Appendix 1

SPATIAL PLANNING AND HEALTH GROUP CHECKLIST

USE OF THE CHECKLIST

This checklist should be used in scoping to identify the potential health impacts of a proposal. It can

be used in a process that involves a small group of stakeholders to bring different perspectives to the identification of the relevant issues. It should also be used by those engaged in neighbourhood planning, to scope the potential impact of plans and proposals. The checklist should be used as part of the decision making process when considering planning applications. Reject plans and projects that do not take appropriate account of issues relating the health and wellbeing i.e. do not demonstrate application of health promoting design principles.

Spatial Planning and Health Group Checklist

Area	Questions to ask of strategies, plans and proposals
Mix of land use	<p>Will the proposal:</p> <ul style="list-style-type: none"> - Provide a diverse mix of land uses? - Improve the availability, affordability and quality of housing? - Improve water management and reduce flood risk? - Promote diversity?
Street layout and connectivity and active travel	<p>Will the proposal:</p> <ul style="list-style-type: none"> - Enhance neighbourhood attractiveness, layout and design? - Improve walkability and cyclability? - Promote physically active travel (such as walking and cycling) and general levels of physical activity? - Limit traffic speeds and traffic noise, and make the street environment safer and more pleasant for walking and cycling and community interaction? - Reduce or avoid steady flows of traffic preventing communal use of the street on streets where people live?
Access to public and other services	<p>Will the proposal:</p> <ul style="list-style-type: none"> - Improve access to health care, education, employment, leisure facilities, and social, cultural and sporting facilities? - Increase access to services for marginalized groups?
Safety and security	<p>Will the proposal:</p> <ul style="list-style-type: none"> - Increase the resilience of the area to the potential impacts of climate change? - Reduce crime and fear of crime?
Open and green space	<p>Will the proposal:</p> <ul style="list-style-type: none"> - Provide open spaces and a green infrastructure (such as tree planting in urban areas)? - Preserve and enhance existing green infrastructure, for example with green roofs, green security, planted areas, living walls?
Affordable and energy efficient housing	<p>Will the proposal:</p> <ul style="list-style-type: none"> - Reduce energy use? - Help the development of practices and/or technologies that are low-carbon or carbon neutral? - Reduce fuel poverty?
Food access	<p>Will the proposal:</p> <ul style="list-style-type: none"> - Improve the location of food production and availability of local food outlets to meet local needs? - Improve opportunities for growing local produce such as allotments? - Provide for the control of outlets for unhealthy food?
Air quality and noise	<p>Will the proposal:</p> <ul style="list-style-type: none"> - Enhance land, air and water quality? - Enhance pollution prevention and control?
Access to Employment	<p>Will the proposal:</p> <ul style="list-style-type: none"> - Influence investment, including the creation of employment and the development of employment skills, including for vulnerable groups? - Offer opportunities for training?

Source: Steps to Healthy Planning: proposals for action (June 2011). By the Spatial Planning and Health Group, <http://www.apho.org.uk/resource/item.aspx?RID=105724>. The SPAHG was constituted from the NICE Spatial Planning and Health Programme Development Group (PDG), appointed by NICE to examine the available evidence related to spatial planning and health. SPAHG began after the PDG was ended in November 2010.

Appendix 2

Ward based health and wellbeing statistics (2006-2010) APHO (2013).

Note: All of the statistics below are based on data collected and collated over four years (2006-2010), reflecting long-term outcomes and endpoints.

Some of these are graphically presented below in several types of Standardised Ratios (SR), which are compared to the England average, which is presented as '100'. The Standardised Mortality Ratio (SMR) quantifies the increase or decrease in mortality of a selected population group with respect to the general population. This is where the $SMR = \text{observed/expected} \times 100$

Similarly, the SAR (Standardised Admission Ratio) quantifies the increase or decrease of hospital admissions in a selected population group with respect to the general population.

All Slough Ward Matrix – Rankings by a Selection of APHO Indicators

Ward	Deaths all causes - all ages	Deaths all causes - <75	Deaths from CVD - All ages	Deaths from CVD - <75 years	Emergency MI	Deaths from stroke	Deaths from respiratory causes	Child poverty	Fertility	Low birth weights	Obesity - Year R	Obesity - Year 6	GCSE	Child development age 5	Elective admit - all causes	Emergency admit children	Emergency admit - all causes	Emergency admit - CHD	Alcohol admit	Knee replacement
Britwell	8	9	13	1	10	13	3	2	10	3	10	10	13	6	1	2	2	5	2	2
Farnham	5	3	4	11	5	2	9	11	7	11	5	14	8	10	11	9	9	9	9	9
Haymill	4	8	12	2	14	5	13	9	8	13	6	13	4	2	7	5	12	12	10	7
Baylis and Stoke	7	4	7	8	4	4	5	4	3	1	7	7	11	12	8	14	5	3	7	6
Wexham	6	11	6	9	9	6	6	8	9	2	2	5	12	7	5	11	3	6	4	4
Cippenham Green	13	14	9	14	12	9	8	14	13	9	14	10	6	3	9	10	14	14	14	12
Central	3	2	1	13	1	3	7	3	3	5	7	1	10	11	12	13	4	2	8	8
Cippenham Meadows	9	7	10	12	6	14	10	7	2	7	9	8	5	9	13	8	11	4	11	3
Chalvey	1	1	2	4	2	1	1	1	1	6	11	1	14	14	10	3	1	1	3	5
Langley St Marys	14	13	14	7	13	10	12	13	11	10	13	4	2	1	3	7	10	11	12	13
Upton	10	5	8	10	8	11	11	12	12	13	4	6	1	5	14	12	13	13	13	14
Kedermister	11	12	11	5	11	12	4	10	14	12	3	12	9	4	6	6	8	10	6	11
Foxborough	12	6	5	6	7	7	14	6	6	3	12	8	3	8	2	4	6	7	1	10
Colnbrook & Poyle	2	10	3	3	3	8	2	5	5	7	1	3	7	13	4	1	7	8	5	1

Slough Wards with the Poorest Outcomes

Several wards feature repeatedly at the top of the tables for the indicators in which Slough is generally worse than England average:

Ward	Features in top 3	Ranked 1st	Ranked 2nd	Ranked 3rd
<u>Chalvey</u>	<u>15</u>	<u>11</u>	<u>3</u>	<u>1</u>
Colnbrook and Poyle	8	4	3	1
Britwell	8	1	6	1
Central	8	3	2	3
Foxborough	5	1	1	2
Wexham	5		2	3
Baylis and Stoke	5	1		4

Further indicators follow, with the top three ward's statistics shown:

All Cause Deaths, All Ages

Rank	Ward	Actual no. of deaths	Expected no. of deaths	Indicator value - SMR (England avg = 100)	Lower CI	Upper CI
<u>1</u>	<u>Chalvey</u>	<u>384</u>	<u>250</u>	<u>153.5</u>	<u>138.6</u>	<u>169.7</u>
2	Colnbrook and Poyle	146	114	127.8	107.9	150.3
3	Central	306	284	107.8	96.1	120.6

Deaths from Cardiovascular Disease in the Population of <75 Years of Age

Rank	Ward	Actual no. of deaths	Expected no. of deaths	Indicator value - SMR (England avg = 100)	Lower CI	Upper CI
<u>1</u>	<u>Chalvey</u>	<u>28</u>	<u>14</u>	<u>203.4</u>	<u>135.2</u>	<u>294</u>
2	Central	29	15	194.2	130	278.9
3	Farnham	30	16	191.3	129.1	273.1

Child Poverty

Rank	Ward	Actual no = numerator	Expected no = denominator	Indicator value - SR (England avg = 100)	Lower CI	Upper CI
<u>1</u>	<u>Chalvey</u>	<u>835</u>	<u>2180</u>	<u>38.2</u>	<u>36.2</u>	<u>40.3</u>
7	Britwell	718	2253	31.9	30	33.8
3	Central	790	2612	30.2	28.5	32

Obesity Year 6 Children

Rank	Ward	Actual no = numerator	Total measured per ward	Indicator value - SR (England avg = 100)	Lower CI	Upper CI
1	Central	93	355	26.2	21.9	31.0
<u>2</u>	<u>Chalvey</u>	<u>74</u>	<u>282</u>	<u>26.2</u>	<u>21.5</u>	<u>31.7</u>
3	Colnbrook and Poyle	38	160	23.8	17.8	30.9

Emergency Hospital Admissions – All Causes

Rank	Ward	Actual no. of admissions	Expected no. of admissions	Indicator value - SAR (England avg = 100)	Lower CI	Upper CI
<u>1</u>	<u>Chalvey</u>	<u>5357</u>	<u>4003</u>	<u>133.8</u>	<u>130.3</u>	<u>137.5</u>
2	Britwell	5413	4452	121.6	118.4	124.9
3	Wexham	5498	4691	117.2	114.1	120.3

Alcohol-Related Hospital Admissions

Rank	Ward	Actual no. of admissions	Expected no. of admissions	Indicator value - SAR (England avg = 100)	Lower CI	Upper CI
1	Foxborough	767	588	130.4	121.4	140
2	Britwell	950	773	122.8	115.1	130.9
<u>3</u>	<u>Chalvey</u>	<u>801</u>	<u>677</u>	<u>118.3</u>	<u>110.3</u>	<u>126.8</u>

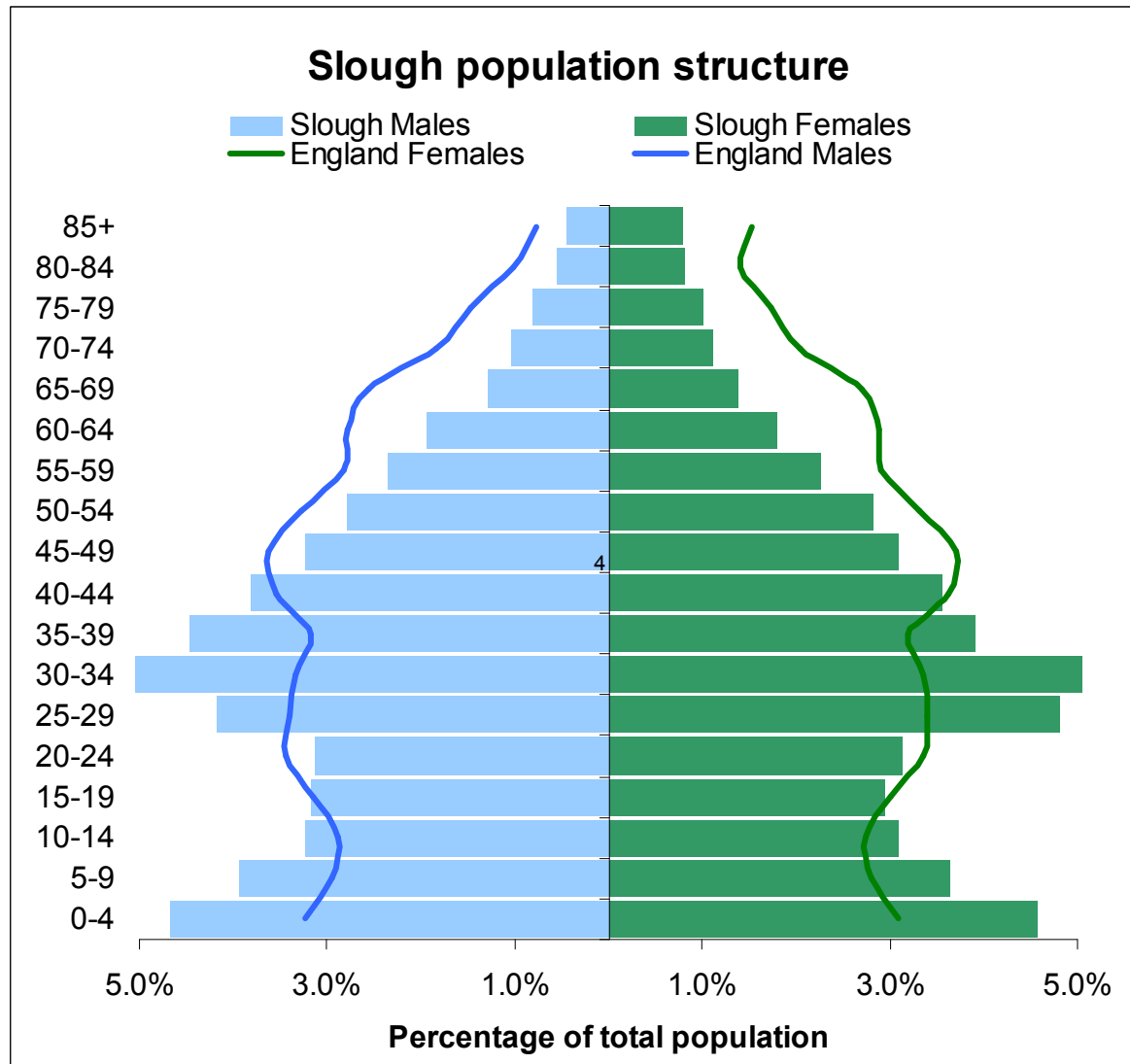
Appendix 3a: Slough male population by age band and practice (2013)

Males 2013	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
K81645	184	148	119	116	143	207	183	167	138	112	106	100	58	36	31	22	14	13
K81083	575	545	458	415	525	680	741	652	525	356	313	309	232	161	114	110	50	40
K81034	398	339	338	320	454	629	667	571	471	452	401	272	213	139	122	115	64	48
K81089	110	100	94	105	129	174	182	140	199	160	161	127	89	55	55	48	29	28
K81608	266	250	215	174	239	302	319	271	234	128	115	111	89	30	45	35	13	14
K81075	1086	1012	723	751	716	884	1092	1015	1059	936	816	586	447	326	229	170	126	79
K81043	539	410	329	301	319	446	660	558	513	461	365	281	263	196	161	110	76	61
K81616	164	152	118	158	163	224	223	169	161	143	157	149	92	68	54	42	24	22
K81024	653	596	462	422	488	491	651	682	605	598	526	443	347	288	230	192	151	89
K81086	375	368	346	367	387	507	509	383	355	307	320	320	264	121	137	79	41	16
K81085	202	172	150	183	285	419	342	215	245	191	192	208	164	71	69	72	35	20
Y00265	362	275	149	130	117	310	494	336	234	157	121	81	36	22	19	11	10	8
K81039	280	276	242	257	245	213	228	216	215	236	189	207	164	107	61	70	59	59
Y00437	299	310	277	257	196	242	280	339	332	316	209	178	133	85	58	46	34	23
K81082	675	570	450	376	346	500	629	638	597	533	413	329	221	173	128	86	69	60
K81005	161	179	136	120	147	197	219	235	201	169	139	93	94	50	48	45	25	27
Total	6329	5702	4606	4452	4899	6425	7419	6587	6084	5255	4543	3794	2906	1928	1561	1253	820	607

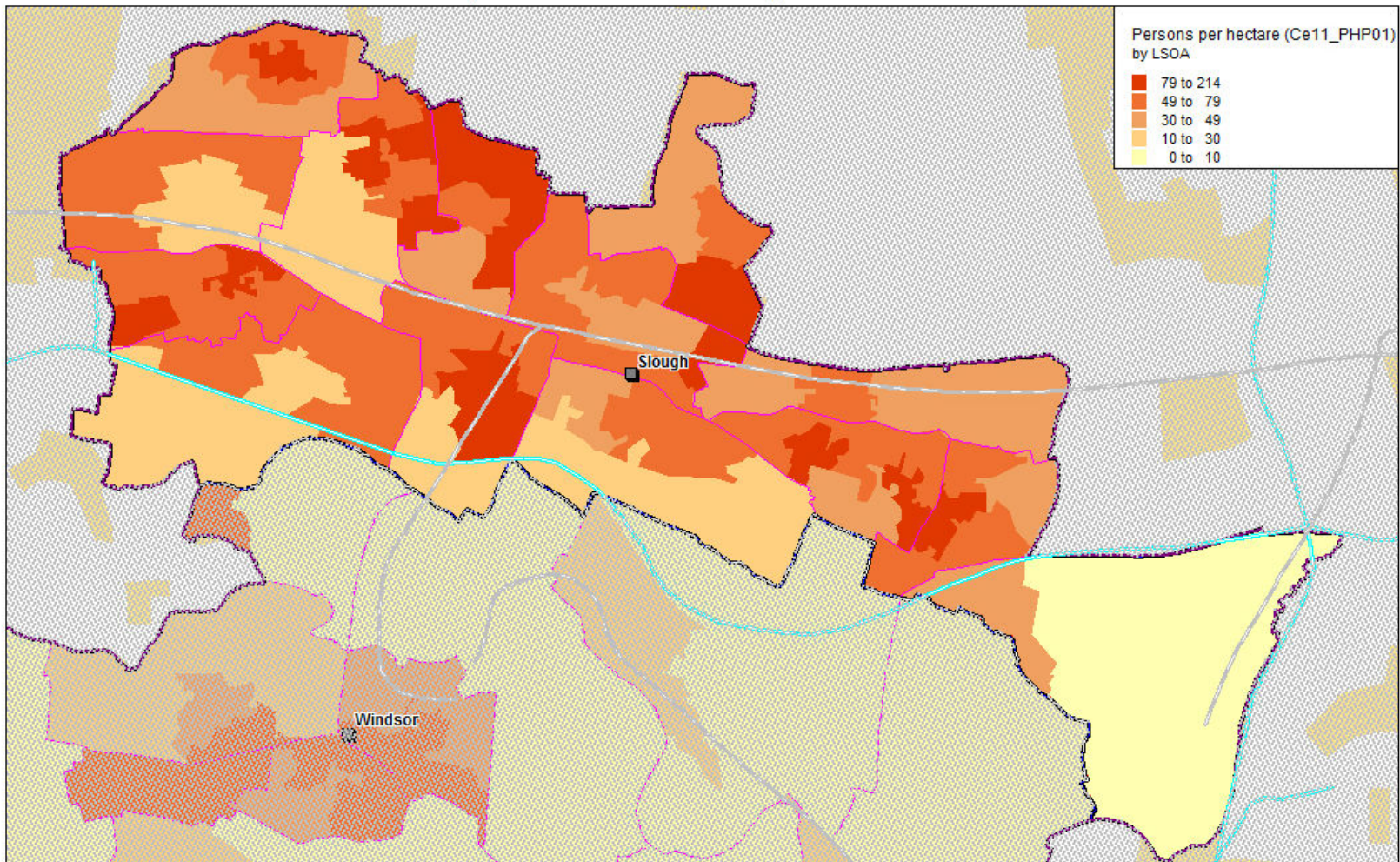
Appendix 3b: Slough female population by age band and practice (2013)

Females	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
2013																		
K8164	150	145	117	130	153	240	191	115	135	124	100	95	57	56	44	32	30	27
K8108	605	498	401	410	445	650	675	479	414	305	233	270	207	134	127	97	65	53
K8103	427	345	273	246	367	522	508	403	337	313	258	212	162	125	114	101	72	82
K8108	119	94	83	115	115	161	135	119	119	145	144	92	67	57	47	51	44	40
K8160	247	250	188	145	164	268	261	192	153	113	106	82	67	43	43	20	25	17
K8107	1070	868	706	719	699	1130	1249	1054	924	876	691	491	375	320	250	224	178	173
K8104	506	410	333	294	316	654	684	464	447	361	317	268	216	224	143	136	106	102
K8161	149	150	137	120	159	217	227	144	121	111	143	96	83	54	44	48	26	27
K8102	664	543	465	425	443	672	754	655	569	501	503	407	337	315	247	255	189	149
K8108	416	353	331	350	390	475	480	303	313	284	312	299	208	133	139	114	53	31
K8108	202	187	174	154	213	307	259	192	137	150	180	179	119	82	80	58	47	27
Y0026	344	249	124	134	204	466	493	305	196	117	111	66	42	16	17	12	9	17
K8103	258	268	201	209	221	241	267	215	213	256	212	173	130	109	83	100	83	112
Y0043	300	279	264	233	203	270	340	368	334	246	203	150	121	94	82	69	57	47
K8108	694	466	416	366	426	662	773	587	520	438	395	290	232	191	145	108	108	121
K8100	159	187	146	94	126	190	228	185	143	97	79	65	58	47	43	33	38	34
Total	6310	5292	4359	4144	4644	7125	7524	5780	5075	4437	3987	3235	2481	2000	1648	1458	1130	1059

Appendix 4: Slough population pyramid by age (mid year estimate 2012)



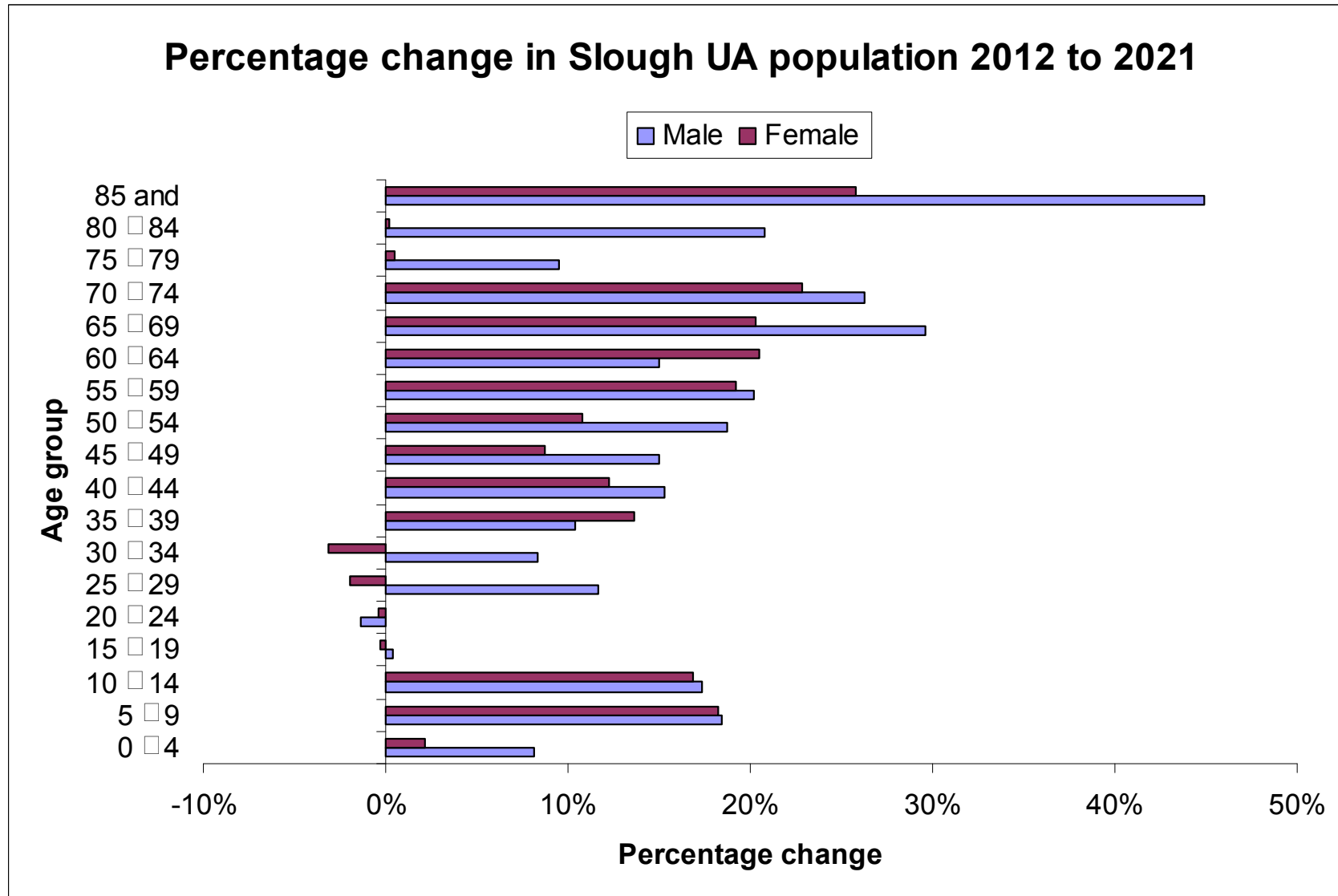
Appendix 5: Slough population density – Census 2011



Ce11_PHP01_PopDensity_LSOA_00MD.wor 22/08/2013 Sid Beauchant BHFT

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Appendix 6: Projected population growth 2012 - 2021



Appendix 7: Maps of new ward boundaries with primary care GP, dental and pharmacy sites

Slough service alignment

