Report of the
Joint Strategic Needs Assessment
for Slough

October 2009

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NHS Berkshire East Primary Care Trust
on behalf of Slough Borough Council
and NHS Berkshire East

Version 6
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Executive summary

This is the second Joint Strategic Needs Assessment (JSNA) for Slough 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 Slough’s 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 national and local strategic themes and key issues from nationally comparable patient/client surveys are highlighted in each section.

The references used to support the recommendations in each section have been sourced from the core dataset recommended nationally, from research and from 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 socio-economic, including 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. The Audit Commission report forecasts that in Wave 2 there will be an increase in mental health problems, domestic violence, alcoholism and addiction. This will further increase demands within an area that is already an outlier on the Child Wellbeing profile (with the exception of the education domain) and on the Health Profile (2009) for; violent crime, drug misuse, early deaths from heart disease and smoking, children in poverty, physically active adults, new cases of tuberculosis, diabetes, obese adults and children and over 65’s not in good health.

The true demographic profile of Slough is much debated owing to under recording at the census and the recent high birth rates (due to the combination of a peak in those from commonwealth and Eastern European countries). This has meant that challenges remain regarding estimating pressures on the range of services provided by LSP partners for example provision of maternity services, number of school places and support needed to meet demands of children in need. ONS projections for older people imply negative growth compared to other unitaries in Berkshire East but among those of working age growth will place demands on services and carers of people who have learning difficulties, long term conditions or mental health problems, a small rise in the prevalence of dementia is also projected. The rising birth rates are impacting already on general practices, hospital, maternity and early years and mental health services.

A new national measure of how councils and the primary care trust are reducing health inequalities is the 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 (e.g. from the London Public Health Observatory) suggests that interventions targeted at males for CHD and stroke risk reduction, males and females for pneumonia and other respiratory diseases should be prioritised to achieve a one year increase in life expectancy to narrow the gap between the most deprived and the most affluent quintile of wards. (LSOA modelling is awaited)

Helping people with long term conditions achieve independent living remains a priority as does tackling community safety and controlling the spread of communicable disease through joint work with housing. 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) and the personalisation of services (as part of the transformation of community and social care services).

Introduction

What is a Joint Strategic Needs Assessment (JSNA)?

Many ‘strategic’ needs assessments have been referenced in this document. The formal title Joint Strategic Needs Assessment (JSNA) is reserved by law for the process being carried out by local government (Slough Borough Council) and the local health service (NHS Berkshire East Primary Care Trust) 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 translate into the strategic plan for the PCT and into the Sustainable Community Strategy and Local Area Agreement plan for Slough. 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 PHICED 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 in its attempt to bring under its purview a much broader range of challenges affecting Slough’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 Slough’s needs.

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. Modelling interventions from the London Health Observatory and lifestyle benchmarks from The Southeast Public Health Observatory have been sourced. The methodology used to capture partner data was interpretative and participatory through a snowball research process as each version of the JSNA was approved and gaps identified. Examples range from quantitative data on returns made to national bodies and research findings. Further findings will be informed through consultation with overview and scrutiny panels and through blogs as people will be encouraged to comment via the SCAN website where the data will be lodged.

The timing of this first draft was planned for delivery in early September to ensure sufficient time for proofing and for 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 PCT websites. This will allow commissioners, whether based in general practice, 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 should be useful 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 Slough’s Sustainable Community Strategy has been written
- 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 (p6).

**How do I use this report?**

Please see the section entitled ‘Structure of the Report’ (p9).

**What happens next?**

This report, and the work which has gone into it, is just the start of the JSNA process. JSNA gives Slough 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 Slough Sustainable Community plan and PCT strategic plan.

**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 Slough Borough 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 on behalf of the signatories:

Signatories of final document

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Pat Riordan</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>Jane Wood</td>
<td>Director of Community and Wellbeing, Slough Borough Council</td>
</tr>
<tr>
<td>Clair Pyper</td>
<td>Director of Education and Children’s Services, Slough Borough Council</td>
</tr>
</tbody>
</table>

Berkshire East co-ordination and analysis

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Angela Snowling</td>
<td>Consultant in Public Health, NHS Berkshire East</td>
</tr>
<tr>
<td>Jo Hawthorne</td>
<td>Strategic Programme Manager, NHS Berkshire East</td>
</tr>
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<td>Sid Beauchant</td>
<td>Information Advisor, Berkshire Public Health Network</td>
</tr>
<tr>
<td>Kevin Watson</td>
<td>Information Manager, NHS Berkshire East</td>
</tr>
<tr>
<td>Nana Wadee</td>
<td>Information support officer, Berkshire Public Health Network</td>
</tr>
</tbody>
</table>

NHS Berkshire East (Slough locality) co-ordination

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viki Wadd</td>
<td>Acting Director of Localities, NHS Berkshire East</td>
</tr>
<tr>
<td>Nadiya Ashraf</td>
<td>Acting Assistant Director Slough Locality, NHS Berkshire East</td>
</tr>
</tbody>
</table>

Slough Borough Council co-ordination

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kevin Gordon</td>
<td>Assistant Director I &amp; D, Transformational Change, Policy and Performance, Slough Borough Council</td>
</tr>
<tr>
<td>Roger Fraser</td>
<td>Performance and Projects Team, Improvement and Development Directorate, Slough Borough Council</td>
</tr>
<tr>
<td>Naveed Mohammed</td>
<td>Local Strategic Partnership Manager</td>
</tr>
<tr>
<td>Jaipal Mondae</td>
<td>Business Information Analyst, Slough Borough Council</td>
</tr>
</tbody>
</table>

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):

Philip Brooks, Diane Clemison, Robin Crofts, Claire D’Cruz, Nigel Dicker, Samuel Ejide, Roger Fraser, Rutuja Kulkarni, James Priestman, Nicky Rayner, Felicity Schofield, Andrew Stevens, Sandra Storey

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 projection methods and health economics were also referenced from the APHO and YHPHO websites.
Collecting the core dataset

The data which is required to be collected as part of the Core dataset was assembled into a structured Microsoft Excel spreadsheet, with the assistance of the Berkshire Public Health Network. This contains 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 PCT 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.

Various draft versions were 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 at the end of each section 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 Co-ordinators, changes in content have been reviewed as have timescales for the process which are now aligned to council and PCT strategic planning cycles for the Local Area Agreement refresh. The layout of the JSNA 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 that 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 Childen’s Services have agreed to cooperate and coordinate this process through the East Berkshire-Joint Strategic Commissioning Board which represents senior members of local organisations responsible for overseeing the JSNA process. Data 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 below:
The structure of the 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 and Safeguarding’, which is a statutory responsibility, and has been included for the first time.

Needs which are important for the Sustainable Community Strategy are shown as 🍃
Needs which are prioritised as outliers in national datasets are shown as ⚪️
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. Where these are marked with a speech bubble (💬) the source cited involved public consultation.
Needs by health and wellbeing determinant

General determinants

**Education**

The January School Census (2009) notes that there were 23,141 pupils in Slough; 12,425 in nursery and primary schools and 9,829 in secondary schools. The following applies to pupils in state education only.

Educational attainment at GCSE (A*-C) is now better than the England average (Health Profile, 2009). According to the CHIMAT health profile, however, results at foundation stage are statistically below the average for England (these relate to academic year 2008) available at [www.chimat.org.uk](http://www.chimat.org.uk).

The percentage of pupils for whom English is an additional language is greater than 70% in the following primary schools; Baylis Court nursery, Godolphin Infant and Junior, IQRA Slough Islamic Primary, Montem, Penn Wood, St Marys, James Elliman and Slough and Eton secondary school. The main languages spoken other than English are related to country of origin, the census reported over 75 languages were spoken.

The most frequent countries of origin other than Britain included; Indian (3,821), Miripuri Pakistani (783), Black Sierra Leonian (700) and those of Eastern European origin (906).

The schools which had the highest rates of Free School Meal entitlement in excess of 25% (highly correlated with deprivation) were; Godolphin Junior, Montem, Penn Wood, IQRA Slough Islamic, Foxborough, Slough and Eton CE and Wexham.

**Ensure sufficient school places and children’s workforce for the future**

CHIMAT have produced nationally comparable population estimates for children and young people based on ONS estimates of children and young people actually resident in the locality. The result for Slough is shown below in five year (quinary) age bands.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2010 Population</th>
<th>2020 Population</th>
<th>Percentage Change</th>
<th>Percentage Change (South East)</th>
<th>Percentage Change (England)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>9,800</td>
<td>9,500</td>
<td>-3.06</td>
<td>4.73</td>
<td>5.45</td>
</tr>
<tr>
<td>5-9</td>
<td>7,900</td>
<td>8,900</td>
<td>12.66</td>
<td>15.79</td>
<td>17.55</td>
</tr>
<tr>
<td>10-14</td>
<td>6,900</td>
<td>8,100</td>
<td>17.39</td>
<td>9.14</td>
<td>9.96</td>
</tr>
<tr>
<td>15-19</td>
<td>7,200</td>
<td>6,800</td>
<td>-5.56</td>
<td>-7.85</td>
<td>-8.81</td>
</tr>
</tbody>
</table>

There is no recognised model for matching quinary age bands to school places as some children attend schools within the area whilst others attend cross border schools in Buckinghamshire and Windsor and Maidenhead. However, shared postcode analysis of all three School Census Results in Berkshire East plus other neighbouring boroughs provides a useful comparison for the 5-9 and 10-14 bands as these bands only include statutory age groups. This comparison indicates that the figures in the table above underestimate the true population figures. The table below compares numbers in year 1 to year 5 with age 5-9 and compares year 6 to year 10 with age 10-14.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>CHIMAT Forecast 2010</th>
<th>Jan 2009 School Census Population by year group</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>9,800</td>
<td>No comparable data</td>
</tr>
<tr>
<td>5-9</td>
<td>7,900</td>
<td>8,392</td>
</tr>
<tr>
<td>10-14</td>
<td>6,900</td>
<td>8,225</td>
</tr>
<tr>
<td>15-19</td>
<td>7,200</td>
<td>No comparable data</td>
</tr>
</tbody>
</table>

Predicting the number of school primary places required based on past movements has proved challenging. For instance, the growth in demand for 2009 has exceeded forecasts produced using past trends by almost 5%. This jump has meant that an additional 140 children required places in 2009/10 over and above the
number available in all Slough schools (as at 11th September 2009). This is a situation originally forecast to happen in 2010.

The past may well not predict the future should changes occur in; house prices, work availability, the volume of asylum seekers, etc.

A major indication of changing need is the increasing birth rate. Slough has seen a growth of 32% between 2001-2 and 2006-7 and indications are that this rises to 39% using provisional 2008-9 data.

<table>
<thead>
<tr>
<th>From - To</th>
<th>Year</th>
<th>Number of births</th>
<th>Comparison with previous year</th>
<th>Comparison with 2001-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-Aug</td>
<td>2001-2</td>
<td>1865</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep-Aug</td>
<td>2002-3</td>
<td>1946</td>
<td>+ 4.3%</td>
<td>+ 4.3%</td>
</tr>
<tr>
<td>Sep-Aug</td>
<td>2003-4</td>
<td>1984</td>
<td>+ 2.0%</td>
<td>+ 6.4%</td>
</tr>
<tr>
<td>Sep-Aug</td>
<td>2004-5</td>
<td>2051</td>
<td>+ 3.4%</td>
<td>+ 10.0%</td>
</tr>
<tr>
<td>Sep-Aug</td>
<td>2005-6</td>
<td>2234</td>
<td>+ 8.9%</td>
<td>+ 19.8%</td>
</tr>
<tr>
<td>Sep-Aug</td>
<td>2006-7</td>
<td>2457</td>
<td>+ 10.0%</td>
<td>+ 31.7%</td>
</tr>
</tbody>
</table>

ONS standardised fertility rates for Slough for 2007 were 130 compared to 107 for RBWM and 96 for Bracknell Forest. The smaller growth rate predicted by ONS would appear unlikely and local planners assume that Slough will remain a young area as people typically move in, establish families and then move out. Nevertheless it is the basis of both local authority and health funding.

The raw birth data (Figure 1) shows that actual births have increased on average by 60 births per month over the period 2003-2008 and by the end of December 2008 were just over 210 per month. Jones 2008 predicted that the excess birth rates since 2003 may have stabilised but would remain on a steady upward trend. He calculated the growth in total births as follows: Using a least squares best fit (linear trend) Jones estimated that the Slough growth was predicted to increase by 105 births per year (Figure 2) (plus or minus up to 3 standard deviations per year).

<table>
<thead>
<tr>
<th>LA</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bracknell</td>
<td>1443</td>
<td>1464</td>
<td>1484</td>
<td>1505</td>
<td>1525</td>
</tr>
<tr>
<td>RBWM</td>
<td>2051</td>
<td>2109</td>
<td>2167</td>
<td>2225</td>
<td>2283</td>
</tr>
<tr>
<td>Slough</td>
<td>2552</td>
<td>2656</td>
<td>2761</td>
<td>2866</td>
<td>2975</td>
</tr>
<tr>
<td>Berks East</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>estimated</td>
<td>6117</td>
<td>6300</td>
<td>6484</td>
<td>6667</td>
<td>6851</td>
</tr>
<tr>
<td>total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This conclusion was based on the coincidence of the maximum birth rate among mothers from Commonwealth countries and among mothers from Eastern Europe which he modelled on a continuing upward curve. Discussions with local acute trust and general practitioners indicates that this is continuing to rise in line with projections.

Two situations are thus proposed; the flat no growth option and a worst case scenario of continuing rise in birth rate and no outgoing migration. Without an in depth understanding of the drivers for migration/mobility further estimation is not possible.

The growth projections reported in the CHIMAT model can be monitored by trends in birth patterns as shown below. An increase can be seen in the average birth rate of about 64 births over a year but there are significant variations in year.
Figure 1- Raw birth counts per month

The projected total number of births per year is shown below from analysis undertaken by Jones (2008)

Figure 2- Birth projections (source Jones 2008)
Children’s Trust priorities in relation to education

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 attendance at primary school in order to improve KS2 performance (based on an NFER research project in spring 2009).

Improving secondary school attendance beyond year 11 is a priority as are targets for KS3 and GCSE. Increased school inclusion and no permanent exclusions in the primary phase are additional educational targets.

Increase education, employment and training for those aged 16 plus

Under the theme of ‘achieving economic wellbeing’ the Children’s Trust plan notes the number of children continuing in learning beyond year 11 as a priority. The measures will include the numbers of children achieving diplomas and apprenticeships. The number of young people who are ‘in learning’ will continue to be collected by Connexions and will be closely monitored through the 14-19 Strategic Group. (The learning and skills council functions will transfer to the local authority this year). The NEET report prepared for the Skills PDG from Connexions in June 2009 noted:

‘The rise in the summer of 2008 was larger than before due to the downturn, and this is also reflected in how the NEET has risen since Christmas. There has been a significant drop in vacancies and the number losing their jobs has grown. The current NEET figure is 6.5% against a target of 4.4%.....The sectors shedding most jobs which affect young people are retail, catering and building trades’

The economic impact was assessed as follows:

Figure 3- NEET rates against target August 2009

An action plan is in place to mitigate the effects with various partners contributing to the NEET Strategy.

Improve support for children with learning disabilities and SEN

Special educational needs categories are used in education in relation to learning difficulties and are different to medical terminology for learning disabilities (see the section on learning disabilities)

The Slough primary school average for the broadest definition of ‘any SEN’ was 21.3% within primary schools and 18.1% in Slough secondary schools. The only category comparable to other boroughs is that of statemented children. The average rate of statemented children was 1.9% in Slough primary schools and 1.6% in secondary schools.
The following primary schools have the highest rates for all SEN categories; Iqra, Foxborough, Claycots, Godolphin Junior, Penn Wood. Among secondary schools Beechwood, Westgate and Baylis have the highest rates. However, it should be noted that there may not be consistency between schools when looking at all SEN categories as these are un-moderated.

Of the three special schools Arbour Vale caters for children and young people with moderate to severe learning difficulties including those with autism spectrum disorder. Haybrook College and Littledown cater for children and young people with behavioural, emotional and social difficulties.

An SEN Funding review is underway. This will lead to changes in the way schools are funded and may then have an impact on the number of children who require statements.

The development of Mallards and Breakaway for the delivery of respite care and the development of stable placements are also priorities within the children and young peoples plan for 2010-11.

Extended schools to achieve the core offer by 2010

39 schools currently meet the core offer equivalent to 87%, in line with the national average. The extended school update (June 2009) notes that meeting the national requirement will be a challenge for those schools that opened as new schools in the last year.

Work is underway with the remaining six schools in Slough this year on overcoming the barriers to meeting the core offer which are generally in relation to community access and parenting support. All schools are meeting the swift and easy access criteria.

Improve opportunities for ‘life-long’ learning

The opportunities for learning and skills training for those over 50; young people not in education, employment or training; carers; lone parents; and vulnerable adults (including those with mental health problems, physical and learning disabilities), should be expanded.

Opportunities for remote learning through Open University courses were identified for carers as a priority within the Carers action plan (part of the joint commissioning strategy).

Opportunities also exist at the Thomas Gray Centre and Slough and Eton Adult Learning Centre to gain ESOL skills. These courses enable new entrants to meet Home Office eligibility criteria to access other publicly funded courses provided the person is also on Job Seekers Allowance.

The vision for the newly proposed Skills for Life courses are that, by 2012, the service will have an ‘Integrated Foundation Learning Tier’ (FLT) within the curriculum. The service will:

- Pilot the use of Functional Skills in English and Maths at strategic and operational levels.
- Introduce the Foundation Learning Tier Framework into curriculum planning.
- Provide training on the use of the English and Maths Functional Skills Standards.
- Work in partnership with Information, Advice and Guidance providers, internal and external partners to ensure integrated progression within a smooth referral system.
- Continue to review the curriculum offer in order to meet the needs and interests of learners in line with government priority groups.
- Introduce the concept of personalised learning and new methods of teaching according to Functional Skills Standards for English and Maths.
- Conduct an initial assessment of English and/or Maths skills on FLT courses.
- Integrate English and/or Maths within vocational and ICT courses where appropriate and relevant to the learners’ primary learning goals.

Where does the evidence come from?

Needs by health and wellbeing determinant

General determinants

Housing

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

- Maximise the supply of affordable housing and make the best use of existing buildings.
- Strengthen our communities to make sure all our neighbourhoods are safe and viable and attractive areas to live in.
- Prevent homelessness and tackle housing need.
- Promote independent living and provide appropriate support to those who need it.
- Improve housing conditions in the public and private sectors and make sure new homes are designed and built to high standards.

Future projections in household size as a function of the economic recession can be found at: http://www.statistics.gov.uk/cci/article.asp?id=2260

Increasing the provision of housing

GOSE report that the borough has a total dwelling stock of 49091 and 45000 total households. The difference is due to the many extensions and ‘Slough Sheds’ which are a feature of an area within which limited land development can take place.

72 people were registered as homeless in 2007/8 and the rate of those who are homeless or in need is 1.6/1000.

13.6% of the dwelling stock in 2008 was owned by the local authority and 6.8% by registered social landlords. 79.3% was owner occupied or privately rented.

Data from the housing register shows that demand for social housing has increased by around 40% between 2007 and 2009. The greatest increase in demand is for households in need of one bedroom properties

<table>
<thead>
<tr>
<th></th>
<th>1bed</th>
<th>2bed</th>
<th>3bed</th>
<th>4bed</th>
<th>5bed</th>
<th>Total</th>
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<td>1254</td>
<td>958</td>
<td>127</td>
<td>103</td>
<td>4274</td>
</tr>
<tr>
<td>March 2009</td>
<td>2395</td>
<td>1452</td>
<td>1004</td>
<td>190</td>
<td>106</td>
<td>5147</td>
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<td>+563</td>
<td>+198</td>
<td>+46</td>
<td>+63</td>
<td>+3</td>
<td>873</td>
</tr>
</tbody>
</table>

Source Slough Borough Council, Housing Performance Stats 2009

The Core Strategy (part of the local development framework) notes the key areas of development - Upton, Town Centre, Britwell, Slough Trading Estate, with around 285 affordable homes being developed each year to 2026. The strategy accepts this is a shortfall compared to the estimated need identified as 530-690 units per year from the Berkshire Strategic Housing Market Assessment.

Data from the Housing Stock Condition survey (2009) suggests that the private sector housing stock in Slough has a notably different profile to the housing stock nationally. The following are estimates:

- there are 39,800 private sector dwellings in the Borough; of these 740 are empty.
- there are 9,230 private rented dwellings in Slough.
- 27.5% of private rented dwellings have a Category 1 hazard (2,540 dwellings).
- 1,540 vulnerable households live in non-decent accommodation in the private rented sector. This represents 51.4% of all vulnerable households in the sector.
- there are 1,389 Section 257 HMOs containing 4,861 self contained flats, of these 162 were also Section 254 HMOs (Flats in Multiple Occupation).
- Section 254 HMOs are more likely to have a Category 1 hazard than other private sector dwellings and higher levels of non-decency.
- there are 2,037 other Section 254 HMOs.
- HMOs are more likely to be found in the Upton, Central and Chalvey wards.
Overall, 6,207 private sector households in Slough are in fuel poverty. This represents 15.9% of private sector.

28.5% of those in the private rented sector are in fuel poverty.

the Borough has a higher than average proportion of private rented accommodation, with 23.2% of all private sector dwellings being in this sector, compared to 14.5% across England. An estimated 76.8% of private sector dwellings are therefore in the owner-occupied sector.

72 people were on the homeless register in 2008/9,

there were approximately 3500 houses in multiple occupation (HMOs) and a further one thousand ‘Slough Sheds’ – converted outbuildings located at the rear of single occupancy or HMO properties. Used primarily as a cheaper alternative to traditional houses – these ‘sheds’ lack sanitation and other necessary facilities and are a direct contravention of local and national planning laws (Source HMO Survey 2009.)

In April 2009 over 5000 households were on the councils housing register, nearly 3000 in significant housing need. 111 households were in temporary accommodation awaiting permanent housing and homelessness acceptances have remained consistently low over the past 4 years of between 75 & 65 households.

UK Land Registry prices for Slough June 09 show the mean house price for June 2009 was £159.954 a fall of 17.4% from the previous year. With average wage levels for Slough residents at £24,960 per annum, the affordability ratio of income to house prices was 6.4. In other words, house prices were over six times the average local wage.

Meeting the Housing and Support Needs of People with Special Needs

The Supporting People 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 to reduce the length of time that people are waiting for adaptation to an acceptable level, particularly in the private sector.

Learning Disability Services have reported the need for more suitable accommodation for a small number of 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 units of accommodation and support services that will address their specific needs.

Making the best use of and improving housing condition

The Housing Stock Condition survey estimates show that private sector housing is in fair condition but that the number of houses that are below the minimum standard has risen sharply due to the use of the decent homes standard and the rating system.

A higher proportion, 30% (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 Baylis and Stoke, Central, Chalvey and Colnbrook with Poyle 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 in poor condition, particularly in Chalvey, Upton and Central wards.
Continued joint interventions to tackle fuel poverty and increase influenza immunisations in people over 65 or with long term conditions will take place. Thermal inefficiency in particular is a large problem with much of the existing housing stock. 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.

In Slough 426 referrals and £426,369 was spent on improving property under the Warm Front grant. Timelines were typically 28 days for insulation and 68 days for heating improvements. In view of the delay in getting grants actioned the start time of joint campaigns for flu should be escalated. Private sector Housing service at SBC also spent £100,000 on replacement boilers with funding targeted at those in fuel poverty.

Where does the evidence come from?

Private sector housing service performance data 2008/09
Needs by health and wellbeing determinant
General determinants

**Transport**

**Improve access to services by public transport and noise reduction**

The Audit Commission report (2009) noted that Slough was awarded the most improved Transport Authority in 2008. Bus use was increasing and planning and transport powers were used to reduce congestion. Extensive consultation had been used to develop projects and policies and the policy framework provided a strong basis for sustainability.

The Core Strategy notes that there are an estimated 82000 jobs in Slough and that 40000 commute into the borough to work and a further 20000 commute out to work on a daily basis.

SEPHO ‘Choosing Health in the Southeast 2008’ report identifies traffic noise and access to GPs as outstanding issues identified in national patient surveys. The local transport plan review (2008) describes the joint accessibility plans with NHS Berkshire East and Berkshire Healthcare Trust to improve access to local healthcare provision through sustainable travel (cycling, walking or bus). Access to GP services in Poyle however remains a challenge and does not meet accessibility criteria. 36000 people have been served by the Out and About service in 2007 which included trips to the hospital and to doctors, to day centres, lunch clubs, community facilities etc.

**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. Six further schools implemented School Travel Plans (STP) in March 2009, and we aim to see a further increase in walking with the many rewards on offer to school children.

36 LEA schools now have an STP and only two primary schools of the mainstream LEA Primary Schools do not yet have a travel plan. There are a total of 10 schools that do not have an adopted Travel Plan, of these, three are independent schools. For adults the ‘Sport England Active Travel’ survey notes that 19% of 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 below the Southeast average. This is an LAA priority for 2009/10.

Peak time traffic congestion in the Borough along the M4 from junctions 5-7 and along the A4 east of Junction 6 (Brands Hill) remains high, with consequent air pollution. These two air quality management zones have been in place since 2005 and 24 hour monitoring sites are available on the Slough website. A target has been adopted within the Local Transport Plan to monitor these areas of concern and the Council aims to see no increase in NO\textsubscript{2} emissions over the 2001-04 average baseline level. The average for the four years 2004-07 is down on the baseline figure suggesting that we are on track to meet this target.

**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 increased in 2007 to 49 (2008 data awaited from Info4local.gov.uk). Of these only 11 were children. The overall rates for all road accidents were the highest in the Southeast in 2007 (DTI)

The general trend in all casualties has been downward but as the actual figures are relatively small any increase will have a significant impact.

Cases studied by the Child Death Overview Panel in Berkshire suggests that pre-driver risk perception skills should be available for those over 16 who are no longer in education.
Where does the evidence come from?

Needs by health and wellbeing determinant

Social & cultural factors

The Safer Slough strategic needs assessment (2009) notes that the rates of violent crime are rising and that fear of crime and of antisocial behaviour is high. The report notes:

- Chalvey and the Town Centre are consistent hotspot areas.
- The majority of offenders are male. Probation data suggests that 20% are female.
- Whilst the risks of violent attack for males are far greater than females, the age range is concentrated to 18-34 years. For women, the risk of violent attack remains throughout their life.
- A large majority of adult offenders have multiple needs. Many have drug and alcohol dependency related needs as well as employment and accommodation needs.
- There is a strong association between violence and alcohol: 35% of recorded violence offences have to a degree some relationship with alcohol. 45% of violent offenders misuse alcohol.
- There is a strong link between alcohol and domestic abuse.
- Domestic abuse is increasing; however this may be due to other factors such as better recording, increased agency work and care coordination of victims.
- Violent offences are the second most common offence amongst young people being dealt with by the YOT.

The Safer Slough Partnership therefore 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.

With an estimated 1,195 (1071 – 1468 95% CI) local problematic drug users 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 Slough is estimated at £52,860,000. Figures provided by the NTA indicate that the prevalence rate of crack use in Slough is equivalent to 4.98 crack users per thousand of the population. This is above the South East average of 3.64 crack users per thousand.

Reduce crime and fear of crime

The Child Wellbeing Index (2008) is ranked worse than the national average in all domains in Slough with the exception of the education score. The crime score is a national outlier.

*Figure 4- Child well being index 2008*
The Tellus3 survey showed that 63% of children in Slough feel safe on Public Transport (compared to the national figure of 70%) while 90% of children felt safe in school – the national figure is 88%.

The Children’s Trust has identified the following priorities; reducing the number of first time entrants into the youth justice system and improvements across the youth service and youth offending team.

Levels of crime, fear of crime and perceptions of anti-social behaviour are worse for Slough when compared against the south east or national average. In terms of the first of these, recent figures for national indicators15, 16 and 20 demonstrate Slough’s performance against a range of comparator groups.

<table>
<thead>
<tr>
<th>NI number</th>
<th>Reference</th>
<th>Polarity</th>
<th>West Berkshire</th>
<th>Wokingham</th>
<th>Bracknell Forest</th>
<th>Reading</th>
<th>RBWM</th>
<th>Slough</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI17</td>
<td>Perceptions of anti-social behaviour in the area</td>
<td>Low</td>
<td>12.3</td>
<td>9.8</td>
<td>16.2</td>
<td>27.6</td>
<td>14.3</td>
<td>35.4</td>
</tr>
<tr>
<td>NI41</td>
<td>Perceptions of drunk and rowdy behaviour as a problem</td>
<td>Low</td>
<td>19.5</td>
<td>18.1</td>
<td>25.5</td>
<td>42.9</td>
<td>25.3</td>
<td>40.4</td>
</tr>
<tr>
<td>NI42</td>
<td>Perceptions of drug use or drug dealing as a problem</td>
<td>Low</td>
<td>20.4</td>
<td>14.9</td>
<td>23.4</td>
<td>39.8</td>
<td>22.1</td>
<td>52.8</td>
</tr>
</tbody>
</table>
Finally in terms of fear of crime results from the Thames Valley Neighborhood Survey showed that 44% of Slough residents feel safe during the day. This is the lowest in the Thames Valley region, for example South Oxon has perceptions of safety approximately at 72%. The percentage of respondents in Slough who never feel safe at any time is equivalent to 24%, the highest in Thames Valley.

The survey highlighted that Slough residents worry the most in Thames Valley about crime and levels of anti-social behavior. Across Thames Valley the majority of respondents thought the crime rate in their local area had stayed the same. This is not the case for Slough as 31% stated that there was a little more/lot more crime in their area when compared to the previous year.

Slough also had one of the highest levels of worry of being a victim of crime within the region, at 43%, in particular:

- 54% worry about being burgled,
- 43% worry about items stolen from cars,
- 47% worry about property damage by vandals,
- 41% worry about being mugged/robbed,
- 41% worry about their car being stolen,
- 33% worry about being physically attacked by strangers,
- 26% worry about being insulted/pestered while in street or other public place
- 17% worry about being raped/sexually assaulted,
- 12% worry about being subject to a physical attack because of skin colour, ethnic origin or religion

Work with community to promote healthy food and physical activity

The national indicator of physical activity in children is statistically below the England average and has been rated red in the 2009 Health Profile. The National Child Measurement Programme (NCMP) results show a decreasing trend in year 6 obesity from 2006/7 to 2008/9 but the level remains the second highest in NHS South Central. It is projected that, without further intervention, there will be a rise in the number of overweight and obese adults (Foresight report, 2008).

The national indicator for physical activity in adults NI8 is also a concern as Slough has the lowest reported rates of adult activity in Berkshire, something expected to get worse as the economic downturn progresses. This is a difficult indicator to influence as it records sporting activity rather than physical activity such as walking. A campaign to raise people's awareness is planned. A new delivery plan for NI8 was written in September 2009 and includes some specific and deliverable actions to start addressing the falling levels of participation.

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 Health and Wellbeing Group monitors progress against key indicators for child and adult health and wellbeing targets and the Public Health Working group coordinates this action.

The Children’s Trust have identified the following priorities: increasing the number of young people accessed through healthy schools, reducing obesity in children and increasing their participation in sport.

In addition to the LPSA funded healthy eating and physical activity programmes commissioning plans are in place for the provision of family weight management programmes targeted to young peoples preferred activities.

Where does the evidence come from?

Needs by health and wellbeing determinant

General determinants

Physical/Sustainable environment

National benchmarks for many sustainable community outcome measures were reported recently (DEFRA, 2009). The Audit Commission (2009) report on how Slough council reduces its own environmental impact and concluded that there were two main priorities for Slough’s sustainable development plan:

- Strengthen its own approach to making itself carbon neutral by 2020.
- Communicate more effectively to people about what it is doing and what it is trying to achieve.

The Sustainable Development plan encompasses five principles; living within environmental limits, ensuring a strong, healthy and just society, achieving a sustainable economy, promoting good governance, using sound science responsibly. A carbon management board has been established to monitor the plan.

Providing a sustainable environment

Total carbon emissions per end user were reported as above the England average but not statistically so in the 2009 Health Profile (APHO). The CO₂ emissions per capita grew slightly from 5.6 in 2005-6 to 5.8 per capita in 2006-7 (Environment Agency 2005, 2006, 2007).

The current targets are

- 95% housing to be developed on previously developed land.
- Maintain existing green belt.
- At least 50% new buildings to be in the town centre.
- No increase in car parking within new employment development.
- Annual mean NO₂ air quality levels to be 35 g/m³ by 2021.
- Maximum number of vehicles entering town to be 30000 in the morning peak period.

The three national indicators this supports are NI 185, 186 and 192. The Audit Commission notes that waste, land use and cleanliness have all improved better than the England average.

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 outcomes. The draft sustainable development plan for the PCT should share relevant targets.

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 for 2007-2011 includes the following themes:

- To increase community engagement in play.
- To increase partnership working in play.
- To increase funding available for play.
- To improve access to play.
- To raise the profile of play in Slough.

The provision of play rangers and safer places to play is linked to this plan which contains a list of all the parks and green spaces in Slough. Led walk schemes have particular relevance to the obesity and physical activity targets NI55, 56. The provision of six new play areas is a priority for the Children’s Trust.
6 new play areas, funded by the DCSF, have been installed with work being completed in March 2009. A further eight play areas, funded by the DCSF, and 2, funded by BIG Lottery, will be completed by March 2010 or earlier with the final phase of 8, DCSF, completed by March 2011 or earlier.

The overriding principle to this development is that no child in Slough should have to go any further than ten minutes from home to access a challenging and enjoyable play facility. For this reason all wards in Slough will have a minimum of one new play area with some wards getting two.

All through the summer of 2009 a wide range of play activities were held on the sites of the six completed play areas and four of the play areas in the next phase. These activities were well attended with over 300 young people benefiting from the programme.

Two full time play staff have been appointed to oversee the play development initiative.

Slough Council has allocated £1.2 million extra funding for parks and open spaces in general over the next two years, and a new emphasis on regenerating parks in all areas of the borough will result in formal parks being made more welcoming and accessible to all sections of the community in support of improving access to green spaces and children’s play. Additional resources have been allocated to the cleansing and maintenance of parks and in July 2008 the council’s main contractor has assumed responsibility for the improved cleansing regimes.

The council is seeking green flag status in two Slough parks in the 2010 judging round. In addition to this £1.69 million of funding has been secured form the Heritage Lottery Fund to regenerate Herschel Park in the town centre, thereby providing enhanced access and facilities to a key town centre green space. This park will serve the growing number of people living in the town centre as well as the large number of office staff present in the town on weekdays.

Where does the evidence come from?

Needs by health and wellbeing determinant

General determinants

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 Chalvey, Baylis and Stoke and Britwell although 44 lower super output areas across Slough are within the fifth quintile (i.e. the most deprived) within NHS South Central. As shown below 5 of these are in the most deprived quintile nationally.

**Figure 5 National rank of deprivation by lower super output area (IMD 2007)**

National rank of deprivation (ONS 2007) by lower super output area (Source GOSE) - red is the most deprived nationally.

Life expectancy is significantly lower in lower-income groups in the Borough. The London Health Observatory 2008 model notes a year of life could be saved through working with males with cardiovascular disease. Males in the fifth quintile live on average 6 years less than males in the most affluent quintile.

ONS sociodemographic categories in the most deprived groups are also 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).

One measure of health inequalities (all age all cause mortality by ward AAACM) based on 2005-7 data shows that the rate in Chalvey is not statistically significantly different to those in Central, Baylis and Stoke, Haymill, Colnbrook and Poyle. Chalvey’s AAACM rate is now significantly different to Britwell and the remaining wards. There are many possible explanations; the most optimistic of which would suggest that the sustained activity that has been underway in Britwell is beginning to take effect. Another is that the population is more mobile and is now younger.

Reduce inequalities in employment

**Figure 6** illustrates total number of claimants to Job Seekers Allowance broken down by Berkshire unitary. As can be seen, Slough (along with the other unitaries) experienced a doubling in the number of JSA claimants between July 2008 and July 2009.
Current national unemployment rates are 7.9% (based on the Labour Force Survey August 2009) and 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’

Slough NOMIS figures for 2008 therefore did not yet reflect the fall since January 2009. These showed that employment rates were already below the Southeast Average at 72.8% in Dec 2008 compared to 78.5%. Unemployment rates were thus above the Southeast average in Slough at 6.5% compared to 4.4%.

By July 2009 NOMIS reports recorded 2396 males and 1068 females of working age claiming benefits – a total of 3464 claimants aged 18-64. Of these 670 claimants were aged 18-24.

Some groups are less likely to gain employment: those with mental health problems have a lower employment rate. The IAPT or Improving Access to Psychological Therapies programme will commence in Slough in 2010 and NOMIS data can be used to identify which wards have the greatest numbers of claimants – currently Chalvey, Britwell, Central and Colnbrook and Poyle.

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?

**Needs by health and wellbeing determinant**

**General determinants**

## 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 ‘Scores on the Doors’ programme was introduced in 2008 and continues to be monitored in line with Food Safety and Catering for Health Awards. The Health and Wellbeing fund has sourced a school nutrition lead for 2009/10 to continue to support schools and local catering establishments as part of LPSA2 reward monies.

### Monitor air quality regularly for potential health impacts

Slough has been monitoring air quality for many years and publishes all the monitoring data on line. Pollution levels across the borough are also updated twice daily on line to alert those most affected by poor air quality. There is also a free Airtext alert option that informs people via their mobile, e mail or phone.

Since the Environment Act of 1995, all local authorities have been required to investigate their areas for specified pollutants and declare Air Quality Management Areas (AQMAs) where the air quality does not meet the Government’s health based objectives. There are currently two AQMAs in Slough, both due to the prevalence of nitrogen dioxide. As the prevalence is mainly from road traffic the areas are close to the motorway and main roads. The Council has produced Air Quality Action Plans to attempt to improve air quality. These plans form part of the Local Transport Plan and can be viewed on line.

### Inspect potentially contaminated land

Like many other urban areas across the country Slough Borough Council has had a long history of industrial activity. These former industrial activities can leave contamination in the ground, which if not properly dealt with, can pose a risk to public health or the environment.

The Council tackles land affected by contamination in three ways: the planning process as sites are developed, a statutory inspection process, and through prevention.

The Council’s Contaminated Land Strategy, under Part 2A of the Environmental Protection Act 2000, details how contaminated land will be identified and how they will carry out their duties to ensure that it is cleaned up.

### Monitor flood risk

Although the risk of flooding is generally low in Slough from fluvial risk, a greater risk has been identified from pluvial risk (rainfall). This will be actively monitored in the coming months through a research project with DEFRA. The areas on the Thames closest to Datchet such as the Slough and Eton Roads and the Colnbrook and Poyle areas have been identified on the Environment Agency website with moderate risk of flooding of between 1 in 100 years and 1 in 1000 years.

Various ditches, channels, rivers and brooks have been identified in the Strategic Flood Risk assessment guidance which is on the SBC website at [www.slough.gov.uk/documents/SFra.pdf](http://www.slough.gov.uk/documents/SFra.pdf).

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**Where does the evidence come from?**

- Food law enforcement plan
- Local Transport plan
- 2001 Contaminated land strategy updated in 2005
- 2003 Strategic Flood risk assessment
- Air Quality strategy revised 2005
Needs by health and wellbeing determinant

General determinants

Safeguarding

For Children and Young people

In 2003, the Government published a Green Paper entitled Every Child Matters and following a rigorous consultation process, the resulting Children Act 2004 was implemented. This legislation is the legal underpinning for the Every Child Matters (ECM) programme of change, which sets out the Government’s approach to improving the outcomes and well-being of children and young people from birth to age 19. There are 5 aims of the ECM programme of which ‘Staying Safe’ can be identified as of particular relevance to the Safeguarding Agenda.

Safeguarding can be defined as the process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.

Safeguarding and promoting the welfare of children requires effective co-ordination in every local area. For this reason, the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB). The Slough LSCB is the key statutory mechanism for agreeing how each agency in Slough co-operates to safeguard and promote the welfare of children in Slough, and for ensuring the effectiveness of the methods used.

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

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

Numbers on child protection plans and types of abuse

The total number of children subject to a child protection plan at month end in the financial year of 2008/9 ranged from 68 to 139 and has continued to rise in 2009/10 to a peak of 162 at the end of June 2009. On average, the number of Section 47 Investigations initiated per month is 53. (Source: Slough Children and Families Redbook of Performance Indicators July 2009, Mondae 2009).

Figure 7 Numbers of children subject to a child protection plan
The most frequent abuse categories in Slough among children on child protection plans was neglect, 56% locally compared to 34% nationally. Emotional abuse; 22% locally compared to a national rate of 27%. 2008/09 saw a rise of 46% in the number of social care initial assessments conducted compared to 2007/08 (Source: Slough Children and Families Redbook of Performance Indicators July 2009, Mondae 2009). This rise is having an impact on the work levels of the workforce but is not yet at a heightened alert level.

Key issues identified are

- Ensuring safe services with limited resources and increased activity (increasing before Baby P – now increasing further).
- Ensuring effective member overview of safeguarding activity.
- Informing & engaging local communities in safeguarding.
- Supporting, developing, valuing, retaining social workers.
- Maintaining our commitment to develop preventative services whilst protecting our most vulnerable children.

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 the different hospitals. Improving the quality of this indicator is a priority. A local in depth study for NI70 is underway.

Children and Young Peoples Trust priorities for safeguarding

The main priorities are to:

- to ensure safe staffing in recruitment, to monitor safer recruitment practices and embed them in children’s workforce development.
- develop parenting programmes to deliver universal to intensive targeted services.

HCC 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 achieve 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.

CDOP report recommendations re infant mortality

The 2007 infant mortality level was just slightly above the national average for England at 4.0% in 2007.

The CDOP report noted that Interventions to reduce infant mortality should note the proportional effect of each of the following risk factors:

**Figure 8 Interventions to reduce the gap in infant mortality**

Safeguarding adults

Referral rates in relation to Safeguarding have increased steadily from 190 (2007/2008) through to over 300 (2008/2009). The number of safeguarding alerts received from 1st April 2009 to 30th June 2009 is 59 with 53 progressing to a referral stage. 41 were completed in this period. Awareness raising within Social Work teams and within the community in general, through focussed advertising of safeguarding as an issue, (July 2009) has contributed to rates being recorded at much higher levels. This is supported by indications that during the month of July 2009 an additional 42 alerts were received, bringing the in-year total from 1st April 2009 to 31st July 2009 as 101. Local trends match national tends that higher incidences of abuse occur in a person’s own home and from someone known to them.
A ‘Workforce Development Strategy’ for Safeguarding along with improved internal recording and working processes have heightened awareness. These improved practices from within responding Social Work teams and much higher levels of training are also contributing to better local authority led responses, supported by partners from Thames Valley Police, NHS Partners and the voluntary sector. Strategically, a Slough Safeguarding Vulnerable Adults Board has been in place since April 2009 and is overseeing the partnership developments across the Borough.

Case work audits have been implemented and findings are being analysed at this time. Improvement plans on data collection will follow. Work with Care Quality Commission and registered residential services has identified safeguarding issues and poor quality care in a number of homes, with specific improvement work taking place with service providers, led by the Council supported by partners as necessary.

Promoting the Deprivation of Liberty Safeguards (DoLS) that came into force from 1st April 2009 has been key, with training throughout all core and commissioned services being a priority. Only 2 applications have been received by the Council and the low volumes match comparator local authorities in the region. Raising awareness of DoLS is key and staff are attuned to this through routine work with residential providers.

Multi Agency Public Protection (MAPP) meetings now 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.

Where does the evidence come from?

Needs by health and wellbeing determinant
General determinants
Health and social care services

Joint commissioning for improved health and well being outcomes

A ‘Joint Commissioning Strategy’ (2008-2010) and action plans exist for a range of care groups; carers, older people, those with a disability/impairment, mental health users. 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.

RAP returns for May 2009 indicated that Slough adult social care provided services to 358 people aged under 65 and 1681 people aged over 65 with a physical disability or temporary illness in 2008/9. SBC provided services to 575 people aged between 18-64 and to 203 people aged 65+ with a mental health problem. 139 people over 65 had dementia, 93 of whom were treated at home and 37 were in residential accommodation.

Ensure that the rapid response programme improves access to appropriate care and outcomes

A key priority is the development of an evidence base cross Berkshire East regarding Rapid Response Services to ensure that unnecessary admissions to hospital are reduced. Urgent care and diagnostics services for residents of Slough are planned within Wexham Park Hospital and via the Walk In Centre. Local residents have been fully involved in the Right Care Right Place planning phase.

Slough has the highest rates of emergency admissions in Berkshire East. A key priority is to ensure that emergency admissions are reduced. A local enhanced GP service and a campaign to raise awareness of what intermediate care is, is being evaluated.

<table>
<thead>
<tr>
<th>Top 10 Emergency Admissions Berkshire East Residents: 2006/7 to 2008/9</th>
<th>rank</th>
<th>number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slough</td>
<td>ICD10</td>
<td>Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slough</td>
<td>R10</td>
<td>Abdominal and pelvic pain</td>
</tr>
<tr>
<td></td>
<td>R07</td>
<td>Pain in throat and chest</td>
</tr>
<tr>
<td></td>
<td>I20</td>
<td>Angina pectoris</td>
</tr>
<tr>
<td></td>
<td>J18</td>
<td>Pneumonia, organism unspecified</td>
</tr>
<tr>
<td></td>
<td>N39</td>
<td>Other disorders of urinary system</td>
</tr>
<tr>
<td></td>
<td>J45</td>
<td>Asthma</td>
</tr>
<tr>
<td></td>
<td>J06</td>
<td>Acute upper respiratory infections multiple and unsp sites</td>
</tr>
<tr>
<td></td>
<td>R06</td>
<td>Abnormalities of breathing</td>
</tr>
<tr>
<td></td>
<td>K52</td>
<td>Other non infective gastroenteritis and colitis</td>
</tr>
<tr>
<td></td>
<td>J44</td>
<td>Other chronic obstructive pulmonary disease</td>
</tr>
</tbody>
</table>

Improve preventative services for the older population

Although the 65+ population of Slough is not projected to rise significantly over the next 10 years, indeed a small reduction is estimated by ONS, this does not mean that services cannot be improved for those with long term conditions, physical disability or mental health problems.
ONS quinary age band population projections in thousands for 2009, 2014 and 2019:

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>2009</th>
<th>2014</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>9.7</td>
<td>9.7</td>
<td>9.5</td>
</tr>
<tr>
<td>5-9</td>
<td>7.6</td>
<td>8.7</td>
<td>8.9</td>
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<tr>
<td>10-14</td>
<td>7.1</td>
<td>7</td>
<td>8</td>
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<tr>
<td>15-19</td>
<td>7.3</td>
<td>6.7</td>
<td>6.6</td>
</tr>
<tr>
<td>20-24</td>
<td>8.5</td>
<td>8</td>
<td>7.4</td>
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<tr>
<td>25-29</td>
<td>10</td>
<td>10.7</td>
<td>10.4</td>
</tr>
<tr>
<td>30-34</td>
<td>10.4</td>
<td>10.2</td>
<td>10.9</td>
</tr>
<tr>
<td>35-39</td>
<td>10</td>
<td>9.2</td>
<td>9.2</td>
</tr>
<tr>
<td>40-44</td>
<td>9.2</td>
<td>8.9</td>
<td>8.2</td>
</tr>
<tr>
<td>45-49</td>
<td>8.2</td>
<td>8.4</td>
<td>8.1</td>
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<tr>
<td>50-54</td>
<td>7.1</td>
<td>7.6</td>
<td>7.8</td>
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<td>55-59</td>
<td>5.9</td>
<td>6.4</td>
<td>6.8</td>
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<td>60-64</td>
<td>4.9</td>
<td>5.2</td>
<td>5.6</td>
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<td>65-69</td>
<td>3.8</td>
<td>4.4</td>
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<td>70-74</td>
<td>3.2</td>
<td>3.3</td>
<td>3.8</td>
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<tr>
<td>75-79</td>
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<td>2.6</td>
<td>2.8</td>
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<tr>
<td>80-84</td>
<td>2.1</td>
<td>2.1</td>
<td>2</td>
</tr>
<tr>
<td>85+</td>
<td>1.8</td>
<td>2.1</td>
<td>2.4</td>
</tr>
<tr>
<td>ALL AGES</td>
<td>119.7</td>
<td>121.2</td>
<td>123.1</td>
</tr>
</tbody>
</table>

**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 330 cases in relation to dental queries such as location of dentists, charges and services available. In 2008/9 a rise to 503 contacts occurred in Slough (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 such as Slough 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. This 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**

Slough Borough 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 travellers and asylum seekers**

A research project will be completed in early 2010 and will provide a commissioning toolkit supported by a health needs assessment for asylum seekers.

All unaccompanied Asylum Seeker children accommodated until the Children Act are entitled to a specialist health assessment by the Looked After Children’s Health Team and receive ongoing support if appropriate.

A detailed needs assessment was completed for Travellers in 2006. The Actvar survey (2006) noted the following fixed sites in the Borough; at Poyle and at Foxborough in Langley. An additional 30 sites to the 30 already used was estimated for 2006/11 at the time of the audit. 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. Many were referred to the Walk In Centre by the local enforcement team.

Romania Roma Travellers are mainly encouraged to register at one particular surgery where they have interpreter facilities available. Slough Borough council have set up a multi-agency working group to respond to the specific needs of the community.

A specialist health visitor works with transient families and is attached to the numerous bed & breakfasts in Slough.

A public health nurse runs a drop in clinic at one of the local hospitals and carries out health assessments including TB screening. Slough Borough Council has detached Youth Workers with a specific remit of Teenage Pregnancy and Sexual Health.

Life expectancy is significantly shorter than for resident communities and a 2009 Health Protection Agency study into measles outbreaks in family groups (among Irish Travellers) identified cultural barriers to immunisation uptake.

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Where does the evidence come from?

Occupational health

Increase opportunities for healthy eating and exercise at work

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

The prevalence of musculoskeletal disorders is reported at 2440 per 100000 (CI 2160-2720) (Source 2006/7HSE figures).

Workplace-related stress is the second most common work-related illness in England, after muscle and bone pains. 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 of 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 353.7 per 100000 over 3 day accidents were reported in Slough - higher than the Southeast rate.

The total injury rate was 438 per 100000 compared to the Southeast rate of 433.8 per 100000.

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 9 new diagnoses in Slough. 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.

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 /
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 multi-factorial 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 early death in Slough – a recent public perception survey (SHA, 2008) estimates that over a fifth (22.1%) of people in Slough 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 expectant mothers 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 Central and Foxborough in Slough. The factors underpinning this need to be fully understood and shared.

Figure 9 Smoking cessation rates by ward Q4 2008/9

Reproduced from OS data by permission of Ordnance Survey on behalf of the Controller of Her Majesty’s Stationary Office (Licence No. OS99009412), NAVTEQ data by permission of NAVTEQ Corporation Licence No. IV/MM/20011, IV/MM/20012 GeoPlan data by permission of GeoPlan Licence No. GP/K/006112 © Crown Copyright - 2006 All rights reserved
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 COPD or mental health problems.

The end of year outturn for 2008/9 shows that the overall target for quitters was met but that the harder stretch targets set 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 commence later in 2009. In phase 1 community hospitals such as the Walk In Centre will be targeted whilst in phase 2 all GP surgeries will be offered a Life Channel installation.

A health inequalities funded programme in 2008 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 (estimated at 11,000 persons in Berkshire East) were reported to be smokers but quit rates within such groups were low and services would need to be commissioned differently allowing for longer and repeated attempts (BHCT 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 are willing to report this to maternity services) or 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. The Family Nurse Partnership which works with vulnerable parents for two years has reported sustained change post delivery. A map showing the prevalence by wards in quintiles (5 being the highest prevalence) is shown below.

Figure 10 Quartiles of smoking prevalence by ward Q4 source 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 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?
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 Turning Point, Equinox and Berkshire Drug and Alcohol Specialist Service as well as through GPs via a locally enhanced service. Many of the strategic themes are similar across the three localities in Berkshire East. The Slough Young Peoples Needs Assessment (2008) and treatment plan and the adult needs assessment and drug treatment plan are both updated on an annual basis.

Among young people (defined as 0-17) a higher rate was reported in 2008/9 as in contact with services i.e. 2.54/1000 cf to the SE average of 1.72/1000 (61% of young people reported never injecting). The Tell Us 3 Survey showed promising results for Slough. Results were significantly better than the national average for most of the categories related to alcohol, for smoking and young people who had ever taken drugs.

Slough has the highest rates of 15-64 year olds with problems with drug use (SE regional rate is 6.9/1000 compared to Slough 16.1/1000). Problem drug users are classed as those using either opiates or crack cocaine or sometimes using both drugs together.

Figures provided by the NTA indicate that a prevalence rate in crack use for Slough at a lower level is estimated to be at 400 individuals. This is equivalent to 4.98 per thousand of the population for crack users. This is above the South East average of 3.64 per thousand.

The main drug use from the needle exchange clients is Opiates (64%) followed by both Cocaine and Heroin (15%), stimulants (10%) and performance enhancing drugs (10%).

52.7% local people perceive that drug misuse is a continuing problem placing Slough in the lowest quartile nationally (Place Survey 2008/9). Drug related deaths are primarily due to mental health problems and average around 2.4/100000 in the Southeast. Drug related hospital admissions are estimated at about 830 across the Southeast (SEPHO). The costs to Slough were estimated at £15, 474,550 for the 350 new PDUs in 2008/9.

Priorities arising from the children and young peoples needs assessment

The young people's needs assessment refreshed for 2009/10 identified the following priorities:

- Develop and provide services to narrow the gap between advantaged and disadvantaged children and young people.
- Targeted Youth Support (TYS) Workers specifically targeting substance/alcohol misuse and poor sexual health to provide prevention and early intervention work in the community. Service will provide a Lead Professional role for young people, and bridge the gap between Universal and Specialist provision. This also ensures that young people at risk are identified early and referred swiftly to Specialist services as required.
- Develop and provide family therapy for the families of young people accessing Specialist services.

The ongoing actions for 2009/10 therefore include:

- Incorporate specialist substance misuse services within CAMHS for young people requiring structured care planning, substitute prescribing and hepatitis testing.
- Deliver a collaborative approach for young people requiring psychosocial counselling by broadening the Youth Offending Team Substance Misuse Worker role, and increasing capacity within SYPC Youth Counselling Service.
- Provide targeted services in community venues to engage young people in counselling and positive activities to reduce the harms caused by alcohol and cannabis, which remain the substances most

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1 Drug Strategy Priorities Supplementary Data, November 2008. NTA
2 This is estimated 95% CI at the lower end of the spectrum
misused by young people in Slough. Also to raise awareness of the links between alcohol and poor sexual health, and the harm caused by the misuse of harder drugs.

- Ensure appropriate and good quality information and advice on drugs and sex and relationships education is provided in schools, following results from Tell Us 3 survey which stated that 67% of young people rated this information in schools as “poor”.
- Performance Monitor targeted and specialist services on a quarterly basis to continue targeting interventions effectively, and ensure that no client group is underrepresented, in service provision.
- Prioritise work with the Accident and Emergency Department to improve referrals of young people to Targeted Youth Support Workers following admission for substance or alcohol misuse. Also provide signposting information to young people’s services. Only 2/20 were referred in 2008/9.

### Priorities arising from the adult needs assessment

The following key priorities have been drawn from the Drugs Needs Assessment. On the basis of this research and recommendations Slough DAAT has set the following priorities for 2009/10.

- Work closely with neighbouring DAATs and partners in order to deliver services that meet the needs of drug users in each of the localities in East Berkshire.
- Continue to improve performance management with a focus on parental status, housing and TOP data compliance and use data to improve delivery of services to clients in Slough.
- Increase outreach provision and work more effectively with Tier 1 services to increase the engagement of individuals in effective treatment with a focus on Under 25’s, Women and BME communities.
- Ensure that both service users and carers are directly involved in the planning, decision-making and reviewing of services so that the needs of drug users in Slough are met.
- Continue to develop the provision of ‘wrap around services’ (including housing and access to Education, Training and Employment) in order to support clients to move towards a drug-free life.
- Improve the availability, accessibility and effectiveness of harm reduction services in order to reduce the harm that drug users cause to themselves and others.
- Increase the efficiency of Shared Care within Primary Care that benefits the treatment system and maximises engagement from under-represented groups.
- Ensure that the DIP is successful in engaging drug using offenders in treatment and supports the delivery of National Indicator 38.

### Number of drug users accessing treatment services

The following data originates from the National Data Treatment Monitoring System (NDTMS) website

- The estimated number of Problematic Drug users in Slough is 1195 (CI1071-1488) in 2008/9 which is calculated using the University of Glasgow prevalence data. This represents an increase of 32 from previous estimates in 2007/08 (Source NTA website).
- 16% of drug users who accessed treatment in Slough 2008/09 were injecting which is a reduction of 1% from 2007/08.
- The total number of drug users in effective treatment was 548 in 2008/09 which was an increase of 7% on the previous year.
- The total number of problematic drug users (those using heroin and or crack) in effective treatment was 506 in 2008/09 which was an increase of 8% on the previous year.

Where does the evidence come from?

Alcohol misuse

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 Slough showed that many indicators within Slough were estimated to be statistically above the England average. Three indicators are red rag rated; alcohol related crimes, alcohol related violent crimes and alcohol attributable hospital admissions for males. 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 partly attributable).

Reduce the rate of hospital admissions for children and young people

The 2009 Healthcare Commission report for Berkshire East based on 05/07 hospital admissions for alcohol for children and young people shows a rate of 390.79/100000 for Q4 2007/8 which is above the England average (albeit based on small numbers).

The Slough Alcohol Harm Reduction Strategy (2008/9) has five main themes:

- Binge-drinking in young people should be tackled.
- Workplace alcohol policies should be implemented.
- High risk and vulnerable groups should be targeted.
- Additional treatment services should be commissioned.
- Public health professionals should work together with local partners to tackle crime and disorder.
- To shape an environment that actively promotes sensible drinking.

The Tell Us 3 Survey results for Slough were significantly better than the national average for most of the categories related to alcohol.

Tackle binge drinking as part of the alcohol harm reduction strategy

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

Additional treatment services should be commissioned.

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, have head injuries 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. In 2009 NHS Berkshire East (PCT) produced revised 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).
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 the Slough (41,400 men and 38,709 women) we find we have an estimated 2,485 Males and 778 Females who are Alcohol Dependant, 13,248 Males and 5,835 Females who drink hazardous or harmful levels of Alcohol and 53,881 People who are ‘Low Risk’ alcohol users.

The percentages for categories of problem drinkers are those presented in the 'Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England' report. The low risk drinkers’ percentage is provided by the report ‘Models of care for alcohol misusers (MoCAM)’, National Treatment Agency for Substance Misuse, Department of Health.

In 2007/8 108 clients from RBWM were treated for alcohol problems at BDASS. This figure rose to 174 in 2008/9, but is still small when compared to the potential need identified above.

The 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. 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. 362,000 residents) 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.

<table>
<thead>
<tr>
<th>Month</th>
<th>No. In Treatment</th>
<th>New Presentations</th>
<th>No. In Treatment - YTD</th>
<th>Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-09</td>
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<td>34</td>
<td>333</td>
<td>21</td>
</tr>
<tr>
<td>May-09</td>
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<td>31</td>
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<td>34</td>
</tr>
<tr>
<td>Jun-09</td>
<td>355</td>
<td>38</td>
<td>399</td>
<td>11</td>
</tr>
</tbody>
</table>

Public health professionals should work together with local partners to tackle crime and disorder.

Alcohol control orders currently apply to seven designated public places: Baylis, Britwell, Chalvey, Colnbrook and Poyle, Farnham (including areas of Manor Park), Langley and the Town Centre. A young people’s prevention and early intervention service for alcohol misuse is provided by Targeted Youth Support Workers and Youth Offending Team Substance Misuse Worker

**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:
• Changing Ways Domestic Abuse Perpetrators Programme.
• Risk assessments by Thames Valley Police and Women’s Aid.

**Identify the rate 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.

**Halt the rate of alcohol related hospital admissions**

Hospital admission data for emergency and elective admissions for chronic liver disease alone may be due to a range of contributing factors. These show a rising trend (albeit for very 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 at 15/100,000.

A significant number of people (around 1744) are admitted to hospital each year due to alcohol.

The Berkshire East target is to halt the rate of alcohol related admissions. Local GPs have been influential in choosing this as a priority for their practice based commissioning plans.

The 2006/7 baseline in Berkshire East was 1136 per 100,000 and the adjusted plan for 2010/11 is 1,634.

The alcohol admission rate for Slough for 2007/8 was 1512/100,000 compared to the Southeast (at 1264/100,000). Drunken or rowdy behaviour is still a cause for concern in the Place Survey 2009.

The NWPHO has produced 3 synthetic estimates in relation to the numbers of people who are drinking at a hazardous or harmful level or who binge drink. It should be noted that these figures haven’t been updated since 2006/7. The statistics show that 19.3% of the population are drinking at a hazardous level or who binge drink. It should be noted that these figures haven’t been updated since 2006/7. The statistics show that 19.3% of the population are drinking at a hazardous level, which is slightly better than the regional average of 21%. The figure for harmful drinking is also below the regional average at 3.8% compared to 4.3%. However when it comes to binge drinking, the figure for the borough (16.3%) is higher than the regional average (15.4%).

**Tackle social problems associated with alcohol**

The results of the Place survey show that 40.3% of residents in the Borough think that rowdy or drunk behaviour in public places is a significant problem, and that 52.7% feel that drug use or dealing is a problem.

*Where does the evidence come from?*

National Alcohol Harm Reduction Strategy (CO,2004)/ Slough Alcohol Harm Reduction Strategy 2008/9//NWPHO
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 Slough were above the mean for Berkshire in 2008/9.

**Figure 11 Prevalence of childhood obesity in reception by ward (source local NCMP 2008/9)**

**Figure 12 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 increased in 2008/9 against a falling trend in previous years. The increase is not statistically significant however as the confidence intervals.

Obesity in year 6 in 2007/8 and 2008/9 was above the average for Berkshire in areas such as Britwell, Baylis and Stoke and Colnbrook although the numbers were low with wide confidence intervals. The 2008/9 data show that rates for year 6 pupils have stayed in line with 2007/8. Within year 6 data wards such as Britwell and Wexham Lea however still have statistically higher rates compared to the Southeast average.

**Figure 13 Prevalence of 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.


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.
Figure 14 Trend in childhood obesity in year 6 by locality (source NCMP 2005/6 2008/9)

Time Trend Analysis of Obese in Year 6 (UK90) Berkshire East

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

<table>
<thead>
<tr>
<th>LA of school</th>
<th>Reception year</th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number measured</td>
<td>% measured</td>
</tr>
<tr>
<td>Bracknell Forest</td>
<td>988</td>
<td>86.8%</td>
</tr>
<tr>
<td>Slough</td>
<td>1126</td>
<td>86.2%</td>
</tr>
<tr>
<td>Windsor &amp; Maidenhead</td>
<td>1213</td>
<td>92.7%</td>
</tr>
<tr>
<td>Berkshire East</td>
<td>3327</td>
<td>88.6%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>LA of residence</th>
<th>UK1990 Classification</th>
<th>IOTF Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Overweight</td>
<td>% Obese</td>
</tr>
<tr>
<td>Bracknell</td>
<td>29%</td>
<td>17%</td>
</tr>
<tr>
<td>Slough</td>
<td>32%</td>
<td>17%</td>
</tr>
<tr>
<td>Windsor &amp; Maidenhead</td>
<td>25%</td>
<td>14%</td>
</tr>
</tbody>
</table>

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 obesity

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.
Rates of childhood obesity in reception are showing a small increase compared to 2007/8 and the introduction of early years based programmes such as the Henry programme are priorities for practice based commissioners in Slough.

Introduce the Change4life programme in Slough

The Change4Life social marketing segmentation has also just been released and will inform the recruitment strategy for various family based weight management programmes. A healthy diet includes regular fruit and vegetables, but 70% of local children eat less than the recommended 5 portions each day according to the Tellus3 survey 2008. 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 in some wards such as Britwell. Antenatal visits to discuss breastfeeding should be offered to all pregnant women. Rates of breastfeeding in some wards have improved due to the intensive support provided by the Family Nurse Partnership - an exemplar early years intervention now widely promoted by the Department of Health. Peer support for breastfeeding programmes will be commissioned to extend the support available to mothers alongside the introduction of the Baby Friendly programme within local hospitals and children’s centres.

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

Improve the quality of information on adult obesity rates

The Foresight report (2008) suggests that over a fifth (21.9%) of adults in Slough 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.

Figure 15 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 (DES) payments designed to improve care planning for those with learning and mental health difficulties.

**Work with the community to promote healthy food and physical activity**

The national indicator of physical activity in children is statistically below the England average and has been rated red in the 2009 Health Profile. The National Child Measurement Programme (NCMP) results show a decreasing trend in year 6 obesity from 2006/7 to 2008/9 but the level remains the second highest in NHS South Central. It is projected that, without further intervention, there will be a rise in the number of overweight and obese adults (Foresight report, 2008).

The national indicator for physical activity in adults NI8 is also a concern as Slough has the lowest reported rates of adult activity in Berkshire. This is a difficult indicator to influence as it records sporting activity rather than physical activity such as walking. A campaign to raise people’s awareness is planned. A new delivery plan for NI8 has been written in September 2009 and this includes some specific and deliverable actions to start addressing the falling levels of participation.

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 Health and Wellbeing Group monitors progress against key indicators for child and adult health and wellbeing targets and the Public Health Working group coordinates this action.

The Children’s Trust have identified the following priorities; increasing the number of young people accessed through healthy schools, reducing obesity in children and increasing their participation in sport.

In addition to the LPSA funded healthy eating and physical activity programmes commissioning plans are in place for the provision of family weight management programmes targeted to young peoples preferred activities.

**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 for 2007-2011 includes the following themes:

- To increase community engagement in play.
- To increase partnership working in play.
- To increase funding available for play.
- To improve access to play.
- To raise the profile of play in Slough.

The provision of play rangers and safer places to play is linked to this plan which contains a list of all the parks and green spaces in Slough. Led walk schemes have particular relevance to the obesity and physical activity targets NI55, 56. The provision of six new play areas is a priority for the Children’s Trust.

6 new play areas, funded by the DCSF, have been installed with work being completed in March 2009. A further eight play areas, funded by the DCSF, and 2, funded by BIG Lottery, will be completed by March 2010 or earlier with the final phase of 8, DCSF, completed by March 2011 or earlier.

The over riding principle to this development is that no child in Slough should have to go no further than ten minutes from home to access a challenging and enjoyable play facility. For this reason all wards in Slough will have a minimum of one new play area with some wards getting two.

All through the summer of 2009 a wide range of play activities were held on the sites of the six completed play areas and four of the play areas in the next phase. These activities were well attended with over 300 young people benefitting from the programme.
Two full time play staff have been appointed to oversee the play development initiative.

**Increase levels of physical activity in children and adults**

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

Physical activity levels in children were red rag rated in a national benchmark (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 Slough currently do the recommended minimum level of exercise each week (30 minutes of moderate activity on 5 days). A sustained advertising programme has been proposed to encourage walking and to promote the benefits of exercise.

Many partners including Slough Borough Council, Slough Community Leisure, Berkshire Sport, Slough Schools Sport Partnership and NHS Berkshire East are jointly working on initiatives to address this situation. There are a number of national projects such as Sport Unlimited, the 5 hour sport offer and the South East Coast NHS Chances 4 Change programme that are being utilised to maximum effect.

One of the key issues which the Slough Sport and Physical Activity Forum is tasked with is finding the best ways to co-ordinate everything that is available to adults and young people and make this information easily available. A one stop shop of all opportunities to take part in physical activity is developing as the way forward but again this will need to be well and appropriately promoted.

Another issue is one around data relating to levels of participation. The Slough Sport and Physical Activity Forum is again leading this problem and potential solutions will evolve during the autumn. A series of local proxy indicators will be developed very soon to underpin all the NI’s in the LAA relating to health and physical activity at all ages. The data gathering process will be integral to being able to measure these indicators and track improvement.

*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
- School meals consultation
- Breastfeeding initiation rates
- Children & young people’s plan priorities 2009/10

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 priorities for 2009/10

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 ten children’s centres are planned by 2010. Eight are complete and a further two will be launched.

**Making a positive contribution**

The Children’s Trust monitors participation in positive activities and an action plan is in place. The desired outcome is that young people’s participation in decision making increases. A Children’s and Young Peoples version of the plan exists - produced by young people.

For those undergoing reviews an indicator of success will be an increased proportion being involved in and communicating their views at the review. A similar priority exists for those involved with the youth service or Youth Offending Team.

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

The Tellus3 survey for 2008 noted that 52.6% felt they had experienced bullying which is slightly higher than the England average 50.4%. This is likely to be higher in the general school population as the proportion of those who participated who were eligible for FSME or with a disability was lower than the national average. Slough has the highest rate of domestic violence in Thames Valley.

**Reduce the number of children in low income households**

Slough is a relatively deprived part of England. The Health Profile 2009 notes that there were 7309 children in low income households, a rate of 28.7 compared to the England average of 22.4 (data from 2007).

**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 Slough 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 4.7% was not achieved, although the actual 2008/9 figure of 5.3% actually showed an improvement on the previous year (5.8% for 07/08) with Slough bucking the trend for the rest of Berkshire. However the target set for 09/10 of 4.4% now presents an unrealistic target given the economic recession. [Connexions Business Plan 2009/10]

The highest rates were among those from white British (54%) and Pakistani ethnic groups (15.2%) (Source: Connexions data September 2009). August is traditionally the highest month for NEET but this year the gains made in 2007/8 in the back ground rates during the year have been lost as shown in the figure below.
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.

Where does the evidence come from?
Needs by population group

Older people

The percentage change projected over the next ten years is shown below in five year age bands and is based on the table shown under the ‘health and social care’ section. Although the absolute values have been contested many times in parliament the JSNA subgroup has agreed this percentage variance can be used by applying this to the existing adult population.

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

<table>
<thead>
<tr>
<th>% Change</th>
<th>Bracknell Forest</th>
<th>Slough</th>
<th>Windsor and Maidenhead</th>
<th>South-East</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>-10%</td>
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<td></td>
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<tr>
<td>50%</td>
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</tbody>
</table>

**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 24% for Slough, 5% below the Southeast average. A similar result was achieved in RBWM 25% and Bracknell 25%. 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. A support project called ACSABE has been funded through the LPSA2 reward programme to deliver improved care plans.

Older people with long-term conditions would benefit from more support to manage their illness. The council supported 1027 people aged 18-64 living in the community and 2023 over 65 in 2008/9.

**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. Many older people and those with long term conditions such as cardiovascular disease and diabetes will be prioritised.
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.

Whilst the projected rise in the population of older people (aged 65+) is small in the Borough at 1900 extra people by 2019 compared to the two neighbouring local authority areas) planning for an increase in dementia should be undertaken. In the year 2008/9, 139 were supported at home with dementia and 37 were residential. This represents a rate more than twice that in Bracknell which currently has a similar elderly population profile. The source of this difference should be examined. Using a simple pro rata increase based solely on population growth (1900) a further 10 cases would be expected. (See Mental Health section for practice prevalence from GP registrations)

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>2009</th>
<th>2014</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-54</td>
<td>7.1</td>
<td>7.6</td>
<td>7.8</td>
</tr>
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<td>55-59</td>
<td>5.9</td>
<td>6.4</td>
<td>6.8</td>
</tr>
<tr>
<td>60-64</td>
<td>4.9</td>
<td>5.2</td>
<td>5.6</td>
</tr>
<tr>
<td>65-69</td>
<td>3.8</td>
<td>4.4</td>
<td>4.6</td>
</tr>
<tr>
<td>70-74</td>
<td>3.2</td>
<td>3.3</td>
<td>3.8</td>
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<tr>
<td>75-79</td>
<td>2.8</td>
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<td>80-84</td>
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</tr>
<tr>
<td>85+</td>
<td>1.8</td>
<td>2.1</td>
<td>2.4</td>
</tr>
</tbody>
</table>

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 and a 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 older people to feel safe

The 2008 Place Survey analysis has not been analysed by ward but it does report many indicators which are in the lowest quartile in England. Fear reduces people’s 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?
Needs by population group

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

The Place survey 2008/9 noted many responses in the lowest quartile nationally for how people perceive they get on well with their neighbours or belong to their neighbourhood.

The community cohesion Partnership Delivery Group (PDG) has addressed the issues of volunteering and of communicating with ethnic groups in culturally sensitive ways; examples include work with the Sikh, Muslim and Hindu Communities, Berkshire Travellers Forum, members of the Polish and Somali communities.

Reduce HIV spread in BME communities

Individuals of Sub-Saharan African descent make up a disproportionate number of new HIV diagnoses in Slough and the rest of East Berkshire (nearly half of all new diagnoses), so efforts to reduce HIV spread should actively involve this community. Nationally the rate of HIV infection in Slough is 3.75/1000 a level that places it above the line for intervention according to an HPA national report in 2008.

Improve access to health and education for Travellers

With a significant settled traveller population in Poyle and Foxborough and a transient community with their own specific health needs the area benefits from a specialist traveller health worker. Methods of engaging with young males to tackle perceptions of risk prior to driving are indicated.

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. Access to services at the Walk In Centre is promoted.

Cultural beliefs which currently pose barriers to immunisation (HPA report 2009) may take many years to overcome, as technical improvements (such as the replacement of intramuscular delivery by skin patches) are not due in the immediate future. Measles outbreaks have occurred among travellers of Irish descent as well as among those in the BME communities.

Improve access to health services and health outcomes for migrants

In a national presentation 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.

• Making use of migrant care workers has allowed the private sector to maintain cost pressures on residential care and care homes. Costs could rise as migrants return home.

Berkshire East and each of the unitaries will be invited to contribute to a brief research project across NHS South Central which will examine the needs of local migrants as a prelude to making recommendations for service optimization locally.

Where does the evidence come from?
Long-term illness

RAP returns for May 2009 indicated that Slough 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.

Plan for an increase in people of working age 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 increase in Berkshire East over the next five to ten years are; COPD, CHD, stroke, and heart failure - as a function of the ageing population in the other two unitaries.

Among the Slough population the conditions associated with older age (over 65) are not forecast to grow to the same extent yet there will be a pro-rata increase among those of working age.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>2009</th>
<th>2014</th>
<th>2019 % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD Slough</td>
<td>3490</td>
<td>3678</td>
<td>3892</td>
</tr>
<tr>
<td>Heart Failure Slough</td>
<td>493</td>
<td>546</td>
<td>590</td>
</tr>
<tr>
<td>Stroke Slough</td>
<td>1394</td>
<td>1454</td>
<td>1534</td>
</tr>
<tr>
<td>Hypertension Slough</td>
<td>13069</td>
<td>13591</td>
<td>14204</td>
</tr>
<tr>
<td>Diabetes Slough</td>
<td>5459</td>
<td>5691</td>
<td>5868</td>
</tr>
<tr>
<td>Epilepsy Slough</td>
<td>578</td>
<td>580</td>
<td>583</td>
</tr>
<tr>
<td>COPD Slough</td>
<td>1178</td>
<td>1288</td>
<td>1394</td>
</tr>
<tr>
<td>Cancer Slough</td>
<td>514</td>
<td>533</td>
<td>557</td>
</tr>
<tr>
<td>Hypothyroid Slough</td>
<td>2444</td>
<td>2590</td>
<td>2728</td>
</tr>
<tr>
<td>Mental Health Slough</td>
<td>803</td>
<td>801</td>
<td>802</td>
</tr>
<tr>
<td>Asthma Slough</td>
<td>6746</td>
<td>6730</td>
<td>6764</td>
</tr>
</tbody>
</table>

Current QOF data has been used to populate individual ward reports under the relevant sections for respiratory, cardiovascular and mental health problems.

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 illness

Although fewer residents in the Borough generally considered themselves to have a ‘limiting long-term illness’ (150.6/100000) above the South East average (128.1) or England average (156.3), the wards with the highest number affected in the working-age population were Britwell, Foxborough, Baylis and Stoke and Chalvey which are also the most deprived.

Residents with long-term illness are also less likely than the average to have access to a car, or central heating, both of which could impact on their ability to manage their illness. Poor access to transport is also known to result in problems accessing employment in this group.

Where does the evidence come from?
RAP 2008/9//Slough Joint commissioning strategy 2008-2011 / Long-term conditions projections BEPCT 2009
Needs by population group

Physical and sensory needs

The long term conditions needs assessment (SBC, 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 that are disabled and housing and transport problems are major issues.

Improve estimates of those with a physical and sensory need

RAP returns for 2008/2009 indicated that Slough adult social care provided services to 358 people aged 18-64 and to 1661 people aged 65 + with a physical disability or temporary illness in 2008/9.

The RAP returns, reported 16 adults aged 18 and over as registered as hearing impaired and receiving services in 2008/9, and 19 as visually-impaired.

16+ adults in receipt of severe disability allowance in August 2008 are shown below:

Figure 18 Percentage claimants SDA by age (source NOMIS 2008)

National estimates of childhood disability can be found at [www.chimat.org.uk](http://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 Slough UA this would equate to between 815 and 1,466 children experiencing some form of disability.’

The Thomas Coram Unit also noted that 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 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 within the short break transformation strategy:

- 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 e.g. physical, cognitive or sensory impairments.
- CYP aged 11+ with moving and handling needs that will require equipment and adaptations e.g. with physical impairments and possibly cognitive and/or sensory impairments.
- CYP where challenging behaviour is associated with other impairments e.g. severe learning disability.
- Young people aged 14+ who are severely disabled and require services that are age appropriate.

Local parents noted the following priorities (Special Voices Parents’ Group):

- Children with autistic spectrum disorders (ASD) whose behaviour can present as challenging.
- Children under the age of 8 years.
- Teenagers who require discreet support.
- Children with sensory impairments.
- Children who are not interested in sports.
- Children who have complex medical needs.
- Children whose parents/carers prefer them to access single sex provision for overnight stays.

The Aiming High strategy identified 750 pupils with a learning disability and nationally it is projected that the number of people with severe learning disability in the Borough (all ages) will increase by about 1% each year for the next 15 years.

Use assistive technology and information to support those with sensory needs

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?
Needs by population group

Learning difficulties, learning disabled and autistic spectrum disorder

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 shown 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 2,555 people had learning difficulties in Slough; 502 aged 0-19, 1,845 aged 20-64, 208 over 65.

Plan for rise in number of people with learning disability

The ‘Valuing People Now Strategy’ indicates a 1% increase should be modelled over 15 years as life expectancy among those with learning disability has increased.

This projection could be applied to the estimated 750 pupils with a severe learning disability identified in the Slough ‘Aiming High Strategy’ however there may well be differences in classification requiring moderation.

A more robust method is to apply this to the reclassified data from general practices in Slough.

Commission services for those with autistic spectrum disorders

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**

The 2009 needs assessment (Malhi) has made recommendations for improving data collection and for moderating differences of classification which if corrected could improve planning and evaluation of services for; carers, service users, providers and commissioners.

For learning disability as a whole a higher prevalence was identified in Britwell.

**Figure 19 prevalence of learning disability by ward**

![Prevalence of Learning Disability by Electoral Ward](image)

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

![Prevalence of All Learning Disability Patients by Ward](image)

*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 Slough adult social care provided services to 253 adults of working age with learning disability.*
For childhood autism alone a crude prevalence from those on paediatric services in 2009 compared to the total population.

Reduce health inequalities for those with learning disabilities

National research into health outcomes among people with learning disabilities shows 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 80.4 and 83.8 respectively within the second quintile and 74.2 and 85 in the most deprived quintile of the population. 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. Yet some employers are positively recruiting those with specific learning disabilities, however only 10% of those with learning disabilities nationally are employed. These rates are obviously well below the population without learning disabilities – the comparable figure for the general Slough population was 72.8% (August 2009).

Implement the Aiming High Short Breaks strategy

The ‘Aiming High Short Breaks Strategy’ (SBC, 2009) has the aim of enabling ‘as many disabled children and young people as possible to remain living at home with support from community services to lead normal family lives and have access to universal settings or more specialist local services in accordance with their wishes.’ This vision has been approved by the parents group Special Voices and the SEN/LDD forum and the Children’s Trust Board.

Currently 420 children/young people are on the SBC database who could all potentially access the short break service. Priority groups locally are:

- Children with autistic spectrum disorders (ASD) whose behaviour can present as challenging.
- Children under the age of 8 years.
- Teenagers who require discreet support.
- Children with sensory impairments.
- Children who are not interested in sports.
- Children who have complex medical needs.
- Children whose parents/carers prefer them to access single sex provision for overnight stays.

National guidance also requires provision for:

- 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 e.g. physical, cognitive or sensory impairments.
- CYP aged 11+ with moving and handling needs that will require equipment and adaptations e.g. with physical impairments and possibly cognitive and/or sensory impairments.
- CYP where challenging behaviour is associated with other impairments e.g. severe learning disability.
- Young people aged 14+ who are severely disabled and require services that are age appropriate.

Joint funding plans will include joint nursing appointments with RBWM to staff the additional service developments (although a virtual team will also be established from existing services). In 09/10 capital funding to be spent on adaptations to Carers’ homes and in 10/11 on developing Breakaway.

Where does the evidence come from?
Malhi (2009) Information Collection Project for People with Learning Disability/ Slough Aiming High Strategy 2009 including the communication strategy, short breaks strategy and workforce strategy
RAP returns 2008/9/ Children & young people’s plan priorities 2009/10
Needs by population group

Carers

There is a joint health social care and voluntary sector ‘Slough Carers Strategy’.

The key themes from the Joint Commissioning Strategy for Slough 2007-2015 are:

- Access to information and advice.
- Time off - short breaks.
- Meeting the needs of Carers from BME communities and other hard to reach groups.
- Young Carers – identifying and meeting the needs of Young Carers in Slough.
- Flexibility and choice to plan and arrange a Direct Payment.
- Social inclusion and involvement.
- Training and development.
- Promote health and wellbeing.
- Identify need through Carers assessments.

There were 690 carers registered in Slough as in receipt of carers allowance (NOMIS August 2009).

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

A total of 774 carers were registered on Slough RAP returns. 241 carers aged 18-64 and an additional 533 carers over the age of 65. 584 were caring for those with a physical disability, 101 for those with mental health problems and 88 for those with a learning disability.

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 (roughly 1 in 5 class themselves as being in poor health). In addition, many carers have to forfeit their work in order to continue their caring role, and roughly a third face financial difficulty 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 arising from social isolation or the impact of loss of funding as the carer can no longer work.

Improve access to services

The ‘Aiming High Strategy’ for disabled people provides opportunities for joint working to provide carers with a break. Improving options via Breakaway and Mallards is a priority for the Children’s Trust. Mallards is not part of Aiming High as it is not for disabled children and does not provide short breaks in this way. If this is a priority for the Children’s Trust it is not related to Aiming High for Disabled Children.

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 is targeted at those with a disability and has an action plan for 2009/11.

Carers should be involved in decisions relating to the person they care for.

Improve availability of advice

There is now an advice leaflet for those who need to access the short break service for disabled children. Activities are offered by a range of voluntary and local authority providers and the short break service is coordinated by the Service for Children with Learning Difficulties and Disabilities.
Further identify and support young carers

The definition of a young carer (Source Becker, 2000, Young Carers, in the Blackwell Encyclopaedia of Social Work) is:

‘children and young persons under 18 who provide or intend to provide care, assistance or support to another family member. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility which would usually be associated with an adult. The person receiving care is often a parent but can be a sibling, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with the need for care, support or supervision.’

As part of the strategy all schools in Slough have been offered a 60 minute awareness-raising session for staff. This session covers local support for young carers through Crossroads and promotes recommended guidelines for good practice for schools to adopt in order to support young carers (Frank, 2002). Around 23 schools have taken up this offer to date. Crossroads Young Carers Project also offers direct work with children in primary and secondary schools.

As a result of this intervention 34 young carers under the age of 18 have been identified. Referrals are also made by the Children and Families and currently approximately 250 Young Carers are known to Crossroads.

Ensure the young carers strategy is implemented

Slough won a bid to access support from the Include project, led by the Children’s Society and the Princess Royal Trust for Carers, and as a result Slough hosted a Young Carers Conference in Spring 2009.

Slough also has a multi agency Young Carer’s Steering Group and with support from the Include Project Team are developing a Young Carers Strategy and a protocol.

Where does the evidence come from?
RAP 2008/9/NOMIS extract August 2009/Carers UK / Children & young people’s plan priorities 2009-10/ Slough Carers’ Strategy/ Aiming High for disabled people strategy 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 PCTs 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.

At the end of July 2009 the numbers of children in care were as follows: (source: Slough Children and Families Redbook of Performance Indicators July 2009, Mondae 2009)

**LAC**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children In Care Full Time</td>
<td>136</td>
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<tr>
<td>Children In Care Respite</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>162</td>
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</tbody>
</table>

**Care Leavers**

<table>
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<tr>
<th>Category</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Relevant Care Leavers</td>
<td>2</td>
</tr>
<tr>
<td>Former Relevant Care Leavers</td>
<td>86</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>88</td>
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</tbody>
</table>

**Ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>54</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>46</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>14</td>
</tr>
<tr>
<td>Mixed</td>
<td>19</td>
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<tr>
<td>Other Ethnic Groups</td>
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<tr>
<td><strong>Total</strong></td>
<td>136</td>
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</table>

**Full Time LAC - Legal Status**

<table>
<thead>
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<th>Legal Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim care order</td>
<td>10</td>
</tr>
<tr>
<td>Full care order</td>
<td>29</td>
</tr>
<tr>
<td>Placement order</td>
<td>7</td>
</tr>
<tr>
<td>Section 20</td>
<td>89</td>
</tr>
<tr>
<td>Under police protection</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>136</td>
</tr>
</tbody>
</table>
Slough Joint Strategic Needs Assessment 2009

**Figure 21 Total number of looked after children at month end from April 2007**

<table>
<thead>
<tr>
<th>Month</th>
<th>Total</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-07</td>
<td>135</td>
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<tr>
<td>May-07</td>
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<td>Jun-07</td>
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<tr>
<td>Jul-07</td>
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<tr>
<td>Mar-09</td>
<td>133</td>
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</tr>
</tbody>
</table>

**Figure 22 Looked after children per 100000 population aged under 18 at month end**

<table>
<thead>
<tr>
<th>Year</th>
<th>LAC per 10,000 population aged under 18 (excl. respite) at month end</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>35</td>
</tr>
<tr>
<td>2002</td>
<td>40</td>
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<td>2003</td>
<td>45</td>
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<td>2005</td>
<td>55</td>
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<tr>
<td>2006</td>
<td>60</td>
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<tr>
<td>2007</td>
<td>65</td>
</tr>
<tr>
<td>2008</td>
<td>70</td>
</tr>
</tbody>
</table>

Slough’s rate of Looked After Children per 10,000 of the population aged under 18 is lower than both the England and Slough’s Statistical Neighbours average and has been since September 2005.

**Continue to improve health and education opportunities for children and young people in care**

93.8% of children who had been in care for at least one year as at 31st March 2009 had had health assessments and dental checks. This compares to 80% for statistical neighbours and the England average of 85%.
Children in care are more likely to have mental health problems than those not in care (nearly 1 in 2 – 45% – compared with around 1 in 10 of the general population), and may also have problems accessing health services. Educational achievement is below the average for their age, and as a group a high proportion will not go into training, education or employment after age 16. Young women aged 15 to 17 who have been in care are three times more likely to become teenage mothers than their peers.

Of the September 2008 OC2 cohort of children in care pupils who sat their GCSEs in June 2008, 28.5% obtained 5A*-C grades and 57.1% gained five or more grades at A*-G (percentages are based on very small numbers as only 7 pupils were eligible).

Of the September 2008 OC2 cohort of care leavers none in Slough were not in education, employment or training on leaving care, compared with 61% for South East England, and 62% for the country as a whole. Among those aged 18+ 15% were classified as NEET.

In Slough a multi agency team, ‘Pathways Through Care’ provides social care professionals, including post 16 personal advisors, education and health professionals who deliver specialist support to all children and young people, including unaccompanied asylum seekers, on entering and leaving the care system.

**Improve access to ‘positive activities’ for children in care**

It is recognised nationally that access to leisure activities such as sport or music can be difficult for children in care, and needs to be improved. Children in care are currently more likely to be involved in criminal activity on average than their peers. This was confirmed in the Corporate Parenting report which noted that compared to the Thames Valley average of 2.1% of children in care being involved with youth offending teams, 9.1% were reported in Slough in 2008.

As a result a number of young people took part in a number of organised out of school activities which were funded from the Youth Opportunities Fund. Young people in care are encouraged to take part in local youth provision provided by the council and do attend youth clubs in Chalvey and Manor Park.

**Increase number of foster care placements locally**

The co-location of fostering, adoption and permanency services and the residential children’s home ensures improved planning and delivery and Slough performs well on measures of mobility for children and young people in care and leavers of care. 64% of children in care were fostered either by an independent fostering advisor, local authority or family relative or friend acting as a foster carer.

Children and young people in the care of Slough are also afforded the opportunity to access an Independent Visitor, a service which is commissioned by the local authority and delivered by Action for Children. Independent visitors are trained volunteers who befriend and support our young people. Each of our children and young people has an allocated Independent Reviewing Officer who ensures that their Reviews are held within the statutory timescales.

In addition Slough has been running the Family Nurse Partnership programme since April 2007 which is commissioned by the PCT and works with the most vulnerable families.

At the end of September 2008, there were 24 internal short term carers, 6 long term carers, 3 relative carers and 28 Home from Home carers. Specialist foster carers are being trained to work with children with complex behavioural and social and emotional difficulties. 15% were in supportive residential settings but more flexible residential placements are needed locally as current provision is predominantly through Breakaway and Arbour Vale House.

The Fostering Panel now consider kinship carers’ applications and notifications from private foster carers in addition to their usual role of approving short term and long term carers, short break carers and supported lodgings carers. There has been an increase in emergency placements with friends or relatives made under Regulation 38 of the Fostering Regulations and these are closely monitored by the Fostering Panel. In addition, the local authority is required to have in place a Pathway Plan for every young person in care aged 16+ which outlines the plan of support for their transition to adulthood.

Where does the evidence come from?

Needs by population group

Offender population

The Safer Slough partnership action plan brings together the actions of the youth offending service and the move to integrated offender management. There is no prison in Berkshire East (although Broadmoor does take ex prisoners 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 Safer Slough Partnership action plan notes that there were 31 PPOs, 357 young offenders and 158 adult probation offenders in 2008. 594 adults were on a licence or supervision order working with TVP Probation.

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 Commissioning guidance available at www.smht.org 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 funded settings at approximately £150000 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 local 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.

Continue to improve key crime performance indicators

Despite the high benchmark position for crime in the Health profile 2009 youth offending team performance data shows that crime rates are reducing:

Where does the evidence come from?
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 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 following:

- The need for earlier recognition by GPs.
- Within Berkshire East there is variation in prevalence's 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.
- 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 is 0.68 and is at an 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, e.g. 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.

One of the earliest indicators of a recession is a rise in mental health problems. All localities have reported a rise in referrals from GPs to adult mental health services. Increased attention is being directed to the link between mental health problems and debt and sources of support, e.g. leaflet produced by the Faculty of Public Health.

Adult mental health diagnoses are based on the International Classification of diseases ICD10 codes and these may or may not be used by admitting physicians for emergency or elective admissions (see below) as diagnosis can often only be confirmed after a period of consultations. In the same period there were 47 elective admissions in 2006, 46 in 2007 and 29 in 2008.
Emergency admissions for adults

Top 20 Mental Health Emergency Admissions Berkshire West Residents: 2006-2008

<table>
<thead>
<tr>
<th>Windsor and Maidenhead</th>
<th>rank</th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD10</td>
<td>Name</td>
<td>2006</td>
</tr>
<tr>
<td>F10</td>
<td>Mental and behavioural disorders due to use of alcohol</td>
<td>1</td>
</tr>
<tr>
<td>F31</td>
<td>Bipolar affective disorder</td>
<td>2</td>
</tr>
<tr>
<td>F99</td>
<td>Mental disorder, not otherwise specified</td>
<td>3</td>
</tr>
<tr>
<td>F32</td>
<td>Depressive episode</td>
<td>4</td>
</tr>
<tr>
<td>F03</td>
<td>Unspecified dementia</td>
<td>5</td>
</tr>
<tr>
<td>F20</td>
<td>Schizophrenia</td>
<td>6</td>
</tr>
<tr>
<td>F11</td>
<td>Mental and behavioural disorders due to use of opioids</td>
<td>7</td>
</tr>
<tr>
<td>F41</td>
<td>Other anxiety disorders</td>
<td>8</td>
</tr>
<tr>
<td>F05</td>
<td>Delirium not induced by alcohol and other psychoactive subs</td>
<td>9</td>
</tr>
<tr>
<td>F52</td>
<td>Sexual dysfunction not caused by organic disorder/disease</td>
<td>10</td>
</tr>
</tbody>
</table>

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 Slough 805 children aged 5-10, 877 children aged 11-15 and 823 young people aged 16-18 would have mental health problems. The split per tier was estimated from HAS sources as follows.

<table>
<thead>
<tr>
<th>Age 5-10</th>
<th>Age 11-15</th>
<th>Age 16-18</th>
<th>Total</th>
<th>Requiring a service</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bracknell</td>
<td>1507</td>
<td>2062</td>
<td>831</td>
<td>4400</td>
<td>1121</td>
<td>660</td>
<td>330</td>
<td>17</td>
</tr>
<tr>
<td>Slough</td>
<td>1892</td>
<td>2082</td>
<td>823</td>
<td>4797</td>
<td>1222</td>
<td>720</td>
<td>360</td>
<td>18</td>
</tr>
<tr>
<td>RBWM</td>
<td>1788</td>
<td>2288</td>
<td>990</td>
<td>5066</td>
<td>1290</td>
<td>760</td>
<td>380</td>
<td>19</td>
</tr>
</tbody>
</table>

Another lower estimate has calculated for those aged 16-18 (based on adult psychiatric models) as shown below:

<table>
<thead>
<tr>
<th>Neurotic</th>
<th>Personality</th>
<th>Probable psychotic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bracknell Forest</td>
<td>648</td>
<td>172</td>
</tr>
<tr>
<td>Slough</td>
<td>643</td>
<td>169</td>
</tr>
<tr>
<td>Windsor &amp; Maidenhead</td>
<td>761</td>
<td>217</td>
</tr>
</tbody>
</table>

The following is taken from Berkshire Healthcare Foundation Trust Epex3 report of March 09
The CAMHS service actually takes tier 2 and 3 referrals so actual numbers using the service were reported as 1845 in 2008/9.
Referrals by age

Numbers using the service in 2008/09

<table>
<thead>
<tr>
<th></th>
<th>0-4 years</th>
<th>5-9 years</th>
<th>10-14 years</th>
<th>15 years</th>
<th>16-18 years</th>
<th>&gt;18 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAM</td>
<td>8</td>
<td>106</td>
<td>194</td>
<td>42</td>
<td>100</td>
<td>2</td>
<td>452</td>
</tr>
<tr>
<td>Bracknell</td>
<td>4</td>
<td>162</td>
<td>269</td>
<td>70</td>
<td>159</td>
<td>4</td>
<td>668</td>
</tr>
<tr>
<td>Slough</td>
<td>16</td>
<td>182</td>
<td>270</td>
<td>88</td>
<td>163</td>
<td>6</td>
<td>725</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>450</td>
<td>733</td>
<td>200</td>
<td>422</td>
<td>12</td>
<td>1845</td>
</tr>
</tbody>
</table>

New referrals

<table>
<thead>
<tr>
<th></th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAM</td>
<td>367</td>
</tr>
<tr>
<td>Bracknell</td>
<td>512</td>
</tr>
<tr>
<td>Slough</td>
<td>660</td>
</tr>
<tr>
<td>Total</td>
<td>1539</td>
</tr>
</tbody>
</table>

Inappropriate referrals

<table>
<thead>
<tr>
<th></th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAM</td>
<td>82</td>
</tr>
<tr>
<td>Bracknell</td>
<td>137</td>
</tr>
<tr>
<td>Slough</td>
<td>244</td>
</tr>
<tr>
<td>Total</td>
<td>463</td>
</tr>
</tbody>
</table>

NB New referrals - all received into CAMHS.
Inappropriate referrals – signposted to a more appropriate service or no longer require service from CAMHS – no contact made.

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. The Mental Health Observatory model estimates that 14,627 people have a mental health problem in Slough in the age band 16-64.

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

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 11,000 yet the estimates above indicate this may be just a quarter of the true prevalence based on 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 41% Slough 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.
Figure 23 Estimated prevalence of mental disorders in the age band 18-64 (source MHO)

![Estimated prevalence of mental disorders in the age band 18-64](image)

**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. The National Dementia Strategy identifies that patients with dementia tend not to be recognised or referred at an early stage so there is a significant level of under-reporting. (Note that the MHO projections are for 2021 rather than 2019). Projections of the increasing number of people with dementia are based not just on the higher number of older people but also the extent to which dementia prevalence rates increase substantially in the oldest age-groups.

**Figure 24 projected increase in dementia 2009-2021**

![Projected increase in dementia 2009-2021](image)

The MHO predictions 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 less than 1%. A range of health, social and voluntary services will need to meet the needs of this growing population and their carers.

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

Actual practice register size

2008/9 QOF data indicate that of the 53 practices in Berkshire East, The Avenue and The Chapel are the only ones statistically above average for rates of dementia.

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

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

Address physical health problems

People with mental health issues have higher rates of premature death, 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.

Getting people into employment

Current ESA and incapacity benefits claimants in Slough total 4640 but it is unclear how this is split (NOMIS August 2009).

Among claimants of incapacity benefit claimants 41% had a mental health problem (source DWP August 2008). Getting people back into work is a key priority and estimates of the proportion of males who are unemployed by ward show that Britwell, Baylis and Stoke, Chalvey and Foxborough should be prioritised for the introduction of IAPT services.

The national introduction of 'Improving Access to Psychological Therapies' is a priority aimed at helping people into employment and reducing the number of people on benefits due to mental health problems.

Action on emotional health of children and young people

The recent comprehensive Child and Adolescent Mental Health Service (CAMHS) strategy and Targeted Mental Health in Schools (TaMHS) submission estimates need for 3000 young people aged 0-19 compared to the 1500 children in Slough (5-16 year olds) estimated to have mental health problems (CAMHS needs assessment 2008).

The CQC inspection (2009) reviews of the CAMHS in Slough rated the service as one of the most improved in the country. Yet the National Indicator NI50 is a perception based response based on children’s friendships and willingness to share their concerns with friends, parents or other adults. The
composite result for years, 6, 8 and 10 was reported in the Tellus3 survey as among the lowest quartile nationally, although this was a relatively small sample.

The Emotional Health and Wellbeing action plan aims to improve understanding of the definition details a range of activities designed to improve emotional health. Slough Borough Council has been successful in securing a specific government grant to further support children’s emotional health and the TaMHS grant will provide additional opportunities. Activities include promoting the Social and Emotional Aspects of Learning (SEAL programme), Playing to Learn and Socialise, promotion of a single CAMHS hub and targeting resilience through the Pyramid Club in year 3 children and in teenagers. Other effective interventions to tackle bullying include peer mentoring and restorative justice to tackle bullying and resolve difficulties, work with substance misuse, an alcohol worker based with the youth offending team and the Family Nurse Partnership.

Provide specialist support for vulnerable young people

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 require more specialist support than is currently available (CAMHS needs assessment 2008).

There is evidence however (October 2008) that when therapeutic support is provided locally in schools 35% of children and young people are from BME communities compared to 18% of referrals to specialist CAMHS (latter needs checking). Additionally the majority of these have learning difficulties at Arbour vale school are able to access support of a music and drama therapist and a Primary Mental Health Worker is available for consultation. These therapies are available for children with learning difficulties in Slough primary schools.

Priorities for commissioning

The Mental Health Commissioning Strategy 2008-2011 themes are; improving health and emotional wellbeing, improving quality of life, making a positive contribution, increased choice and control, increasing access to psychological therapies, freedom from discrimination or harassment, economic wellbeing and dignity and respect.

Where does the evidence come from?
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 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.
- **BME** - 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 African-Caribbean (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.
- **Deprivation** – There is a 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 across Berkshire East the prevalence is as follows:

<table>
<thead>
<tr>
<th>Area</th>
<th>2005 Estimate – (No.) and prevalence %</th>
<th>2010 Forecast – (No.) and prevalence %</th>
<th>2015 Forecast – (No.) and prevalence %</th>
<th>2020 Forecast – (No.) and prevalence %</th>
<th>2025 Forecast – (No.) and prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>South East</td>
<td>4.18% (341,874)</td>
<td>4.60% (386,219)</td>
<td>5.02% (432,734)</td>
<td>5.50% (486,445)</td>
<td>5.99% (543,527)</td>
</tr>
<tr>
<td>South Central</td>
<td>3.93% (155,629)</td>
<td>4.36% (176,305)</td>
<td>4.78% (197,967)</td>
<td>5.25% (222,334)</td>
<td>5.73% (247,896)</td>
</tr>
<tr>
<td>Berkshire East</td>
<td>4.05% (15,210)</td>
<td>4.51% (17,026)</td>
<td>4.99% (19,086)</td>
<td>5.47% (21,201)</td>
<td>6.01% (23,602)</td>
</tr>
<tr>
<td>Bracknell Forest</td>
<td>3.26% (3,634)</td>
<td>3.69% (4,131)</td>
<td>4.12% (4,672)</td>
<td>4.53% (5,209)</td>
<td>5.00% (5,842)</td>
</tr>
<tr>
<td>Slough</td>
<td>5.10% (6,061)</td>
<td>5.76% (6,746)</td>
<td>6.49% (7,574)</td>
<td>7.18% (8,377)</td>
<td>7.94% (9,324)</td>
</tr>
<tr>
<td>RBWM</td>
<td>3.88% (5,317)</td>
<td>4.19% (5,885)</td>
<td>4.51% (6,483)</td>
<td>4.87% (7,158)</td>
<td>5.24% (7,852)</td>
</tr>
</tbody>
</table>
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 ketoacidosis, 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 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. Assuming a predicted rise in obesity based on the Health Survey for England 1996-2006 obesity rates, the percentage of the population with diabetes in the borough will rise to 5.76 % by 2010. These predictions take into account the higher proportion of people from South Asian and African Caribbean communities living in the borough.

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%.
- Ensure funding for the service expansion.
- Improve practice awareness of the importance and frequency of updating lists.
- Conduct a health equity audit for diabetes across Berkshire to identify which groups are not accessing the service.
- Increase the uptake in screening to 80% and develop plans to target disadvantaged groups.
- Ensure the diabetic retinopathy care pathway is followed in pregnancy.

Where does the evidence come from?

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.

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 they 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 TIA, 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.

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 the graph below.

The expected incidence of TIAs is 254 per year of which two-thirds are 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 25 Qof Prevalence of stroke by ward in Berkshire East (2008/9)

Prevalence of Stroke by Electoral Ward

Britwell and Foxborough have rates statistically above the England rate

Overall Slough has a younger population and stroke whist increasing will not increase at the rate expected in RBWM or Bracknell Forest
Figure 27 Stroke prevalence projections by locality (based on QoF 2005/6 and ONS projections)

Stroke prevalence forecast

- Bracknell
- Slough
- RBWM

Figure 28 Prevalence of CHD by ward for Berkshire East (QoF 2008/9)
CHD prevalence by ward

Figure 29 CHD prevalence by ward (QoF 2008/9)

The wards of Britwell and Wexham Lea show statistically higher rates than for the SHA.

![Prevalence of CHD Patients by Ward](image)

Figure 30 CHD prevalence by ward (QoF 2008/9)

The prevalence of CHD will rise but is projected to rise by 10%, less steeply than in RBWM and Bracknell, as the population in Slough is predominantly younger.

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.

An added complication is that infectious diseases such as hepatitis B and C are present at higher rates in Slough and some of the CKD may be related to long term kidney damage from this and other sources such as alcohol abuse. No one ward is statistically higher than the England mean. Yet analysis of CKD admissions are higher in Slough than elsewhere (SHA report 2007/8)
**Figure 31 CKD prevalence by ward (QoF 2008/9)**

![Prevalence of CKD by Electoral Ward](image)

**Figure 32 CKD prevalence by ward (QoF 2008/9)**

![Prevalence of Chronic Kidney Disease Patients by Ward](image)

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**Plan for increase in people with circulatory diseases**

Due to a combination of an expanding and predominantly South Asian 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) are all estimated to increase. (See long term conditions projections)
Introduce the vascular risk screening programme in 2010

There is a requirement on all PCTs to offer a vascular screening programme by the end of 2009/10 and a vascular risk strategy is under development. It should be noted that the prevalence data shown in the ward based QoF data for CHD, CKD and stroke is not relevant as vascular risk strategy targets those with as yet undiagnosed disease.

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 arterial fibrillation has been introduced.

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.

Where does the evidence come from?


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, 506 older people were referred to the Slough Falls Service.

Estimated 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. 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 13,700 in 2008, this is expected to rise to 18,700 by 2028, an increase of 36%.

Improve falls training and access to bone density scans

Those referred to the Slough 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 roughly one third of 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 can create cost-savings. 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).

Sexually 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, gonorrhoea at 565 and syphilis at 113.

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. Tackling STIs such as Chlamydia is one of the main interventions to reduce excess unnecessary admissions for pelvic pain and ectopic pregnancy shown in the health and social care section.

Chlamydia Screening Rates

The Target for 2009/10 is to ensure that 25% of 14-24 year olds are 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 2008/9 are shown below:

Figure 33 Chlamydia screening rates by locality (2008/9)
Reduce HIV rates in Slough
The HPA report into the prevalence of HIV in the UK (2008) notes that Slough has a rate of 3.75/1000 of
the population which places it among the highest in the Southeast. When such levels are announced a range
of local actions need to take place as advised in the report. These are:

- a shared care protocol with local practitioners.
- closer working relationships with the Garden Clinic.
- joint training in confidentiality should be facilitated through You’re Welcome standards training.

HIV in Slough is disproportionately found among the BME community. A significant amount of work is
being done on a joint working basis between the NHS Sexual Health Promotion Specialist for
Disadvantaged Communities and the local community leads. Projects embarked on to date include; Sexual
Health Awareness Week, year round leaflet displays and information on HIV and TB, collections and public
events in association with World Aids Day, networking with key staff to raise awareness and also extensive
networking within the Sub-Saharan African community across Slough to raise awareness and reduce
common myths and stigma.

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 and hopefully build towards decreasing stigma
around both HIV and also the stigma associated with TB (in ethnic minority groups.) However, greater
funding is required in specific relation to HIV and TB in the Sub-Saharan African community if we want to
be able to reach a larger audience within a shorter time frame.

Figure 34 HIV rates by locality (2008/9)

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

Slough’s Teenage Conception Rate is 43.5 per 1000 female population aged 15-17, a reduction of 23% from
the baseline in 1998, but still slightly above the England average of 41.7, and requiring a large reduction to
meet the target rate of 31.1 by 2010. Abortions account for 53% of all teenage conceptions in Slough, but
lack of data sharing means it is impossible to target services effectively towards these preventable
pregnancies.

Sexual violence against women
By comparison with other local authorities in NHS South Central rates of sexual violence against women
were above the average in Slough but underreporting is an issue nationally. A new sexual abuse and rape
centre will be established in Slough in 2010.
Continue to offer dual STI and contraception/family planning advice to reduce the rate of STIs and terminations

Screening for chlamydia among young people should continue to be supported and developed more widely across Slough, including greater involvement with voluntary and community sector groups to increase uptake rates, and negotiations with schools to provide the service on school sites.

Although the number of teenagers becoming pregnant in Slough has reduced by 23% since 1998, a concerted effort is required to reach the 2010 target, including more locally accessible and school based health services offering STI screening and contraception, including Long Acting Reversible Contraception methods.

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 among those who are more affluent.

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.

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.

All community pharmacies should continue to provide Emergency Hormonal Contraception free for under 18s, and be encouraged to provide condoms and signposting to Sexual Health Services following request for EHC. New contraception funding to improve local delivery should result in contraception, including long acting reversible contraception, and STI screening for young people in Britwell and East Berks College.

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.

Where does the evidence come from?


NHS South Central Chlamydia screening report Q4.
Needs by disease / illness

Infectious diseases

Hepatitis A, B, C and HIV rates in Slough are among the highest in England. Notifications to the Health Protection Agency may considerably underestimate need as the influx of people who have contracted disease abroad, from high risk areas such as parts of Eastern Europe and the Commonwealth countries, requires constant monitoring and high levels of contact tracing when found.

Implement the recommendations for recommissioning TB services

Tuberculosis rates in the Slough area are higher than in London and a needs assessment (Balakrishnan, 2008) recommended that TB services should be redesigned to provide integrated secondary and primary and social care support. This service has yet to be fully staffed.

Ensure the take up of seasonal flu vaccination is increased

The Berkshire East Pandemic Flu plan has been tested since May 2009. The vaccination programme for swine flu H1N1 has been introduced and it will be important to ensure take up to help 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 Diphtheria, 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.

Examine all mortality rates by cause and age

All age all cause mortality rates are higher than expected for 2008 for Berkshire East as a whole and further analysis is required once the data are validated to understand trends. Interventions to reduce rates of cardiovascular disease and cancer are underway therefore as it is likely that respiratory diseases such as Influenza, COPD and pneumonia are increasing.

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 significantly higher in Slough 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 40.29 per 100,000 people per year in Slough in 2007, compared with 29.37 for England and Wales; and for infectious and parasitic disease in women, 9.07 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 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. / RDPH letter Sept 09
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

<table>
<thead>
<tr>
<th>UA Code</th>
<th>All Cancers</th>
<th>Circulatory Disease</th>
<th>CHD</th>
<th>Accidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bracknell Forest UA</td>
<td>155.0</td>
<td>56.7</td>
<td>30.7</td>
<td>31.5</td>
</tr>
<tr>
<td>West Berkshire UA</td>
<td>151.9</td>
<td>60.4</td>
<td>32.1</td>
<td>37.6</td>
</tr>
<tr>
<td>Reading UA</td>
<td>147.5</td>
<td>93.9</td>
<td>54.0</td>
<td>22.9</td>
</tr>
<tr>
<td>Slough UA</td>
<td>124.3</td>
<td>119.1</td>
<td>70.3</td>
<td>32.5</td>
</tr>
<tr>
<td>RBWM UA</td>
<td>131.4</td>
<td>64.8</td>
<td>36.5</td>
<td>22.6</td>
</tr>
<tr>
<td>Wokingham UA</td>
<td>122.2</td>
<td>58.0</td>
<td>30.8</td>
<td>21.5</td>
</tr>
<tr>
<td>Berkshire</td>
<td>137.7</td>
<td>73.5</td>
<td>41.0</td>
<td>27.4</td>
</tr>
</tbody>
</table>

The World Health Organisation cites the following risk factors as causally related to cancers from the General Surgeons report (2004):

- High intake of alcohol.
- Being overweight or obese as well as type 2 diabetes.
- Physical inactivity.
- 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 and Cervical Screening are well established in Berkshire East. Nationally cervical screening saves approximately 5000 lives a year and almost half of the 3,500 new cases of cervical screening in the UK occur in women who have never attended for screening. Coverage (the percentage of women that had a screening result in the previous 5 years) of 80% can results preventing around 75% of cervical cancer cases. Increasing coverage of cervical screening is a World Class Commissioning priority in NHS Berkshire East.

Breast cancer Screening In 2006-7, over 1.6 million women were screened and 13,443 cases of cancer diagnosed in England. 76% of women had a screening result in the previous three years (coverage) and 74% of women accepted their invitations to be screened (uptake). In 2007-8 in Berkshire East, 80.2% of women had a screening result in the previous three years(coverage) compared with 79.2% in NHS South Central and 75.9% in England. Currently women aged over 70 can self refer for screening every 3 years, and in 2006-7 over 47,000 women aged over 70 were screened. The risk of breast cancer increases with age. Currently breast screening is aimed at women aged 50 years and over but some women have to wait until they are nearly 53 before their first invitation. By extending the programme to women aged 47 to 49, all women will be guaranteed an invitation for breast screening by the age of 50. This age extension has been recommended in the Cancer Reform Strategy, 2007 and is to be implemented by 2012. Plans are underway to implement the age extension for breast screening. Plans are underway to implement the age extension in Berkshire East.
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

Cancer mortality has reduced below the England average. The male death rate for a serious skin cancer, malignant melanoma, is 8.0 per 100,000 residents per year and is significantly above that for England (2.38). The most likely explanation for this is that it is a chance finding because the number of people suffering with this cancer is very small. However, it would be sensible to monitor this carefully. 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 Kaposi’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 an ongoing priority in school and out of school settings.

Where does the evidence come from?
Needs by disease / illness

Respiratory illness

Childhood asthma rates nationally have 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.

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.

Asthma by ward

Figure 35 Asthma Qof prevalence rates by ward in Berkshire East (2008/9)

- Rates in Britwell are statistically higher than the England average.
Chronic obstructive pulmonary disease by ward

Figure 37 COPD Qof prevalence rates by ward (2008/9)
Rates in Britwell are statistically higher than the England average

Figure 38 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 12% and chronic obstructive pulmonary disease (COPD), a diagnosis which includes bronchitis and emphysema, to rise by 20%. Health and social care services will need to take this into account when planning community (primary) and hospital (secondary and tertiary) care. Britwell is a significant outlier and key preventative actions should be prioritised in this ward.

Where does the evidence come from?
Long-term condition projections

Needs by disease / illness

Neurological illness

The National Service Framework for Long Term Conditions (DH 2004) focused on neurological diseases. It made the following recommendations

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.

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”.

**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.

**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:

\[
\text{BMI} = \frac{\text{Weight in kg}}{\text{Height in metres} \times \text{Height in metres}}
\]

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.

**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.

**Cardiovascular**
Cardiovascular disease refers to conditions that involve the heart or blood vessels. They
<table>
<thead>
<tr>
<th><strong>Disease (CVD)</strong></th>
<th>include CHD (about 50%) and stroke (about 25%), and all other diseases of the circulatory system.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Quality Commission (CQC)</strong></td>
<td>Successor to Healthcare Commission, Commission for Social Care Inspection and Care Quality Commission (CQC)</td>
</tr>
<tr>
<td><strong>CABG</strong></td>
<td>Coronary Artery Bypass Graft</td>
</tr>
<tr>
<td><strong>CAMH</strong></td>
<td>Child and Adolescent Mental Health</td>
</tr>
</tbody>
</table>
| **CCHI** | Compendium of Clinical and Health Indicators  
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)
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

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.

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.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Electoral ward</td>
<td>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.</td>
</tr>
<tr>
<td>Emergency Hormonal Contraception (EHC)</td>
<td>Available over the counter from pharmacies</td>
</tr>
<tr>
<td>Emergency (non-elective) Admission</td>
<td>An unplanned admission to hospital at short notice because of clinical need or because alternative care is not available.</td>
</tr>
<tr>
<td>Fasting Glucose</td>
<td>A measurement of the blood glucose in the morning prior to the ingestion of any food for the prior 12 hours.</td>
</tr>
<tr>
<td>Fixed Term</td>
<td>A fixed period. Exclusion means that a pupil is not allowed into school or exclusion onto school grounds for a set number of days.</td>
</tr>
<tr>
<td>FSM</td>
<td>Free School Meals</td>
</tr>
<tr>
<td>GCSE</td>
<td>General Certificate in Secondary Education</td>
</tr>
<tr>
<td>General Household Survey (GHS)</td>
<td>Continuous national survey carried out by the Social Survey Division of the ONS (q.v.)</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>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.</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GUM</td>
<td>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</td>
</tr>
<tr>
<td>GUM Clinic</td>
<td>Genitourinary Medicine clinics, sometimes known as Sexual Health clinics for all aspects of sexual health. You receive free, confidential advice and treatment.</td>
</tr>
<tr>
<td>Health Inequalities</td>
<td>Variations in health identified by indicators such as infant mortality rate, life expectancy which are associated with socio-economic status and other determinants.</td>
</tr>
<tr>
<td>Health Protection Agency (HPA)</td>
<td>National agency to provide health protection specialist advice and leadership.</td>
</tr>
<tr>
<td>Healthcare Associated Infection (HCAI)</td>
<td>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.</td>
</tr>
<tr>
<td>Herd Immunity</td>
<td>Resistance of a population to spread of an infectious organism due to the immunity of a high proportion of the population.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>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, inadequately 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.</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>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.</td>
</tr>
<tr>
<td>HIV</td>
<td>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.</td>
</tr>
<tr>
<td>HNA</td>
<td>Health Needs Assessment</td>
</tr>
<tr>
<td>Hospital Episode Statistic (HES)</td>
<td>A data warehouse containing details of all admissions to, and treatments in NHS hospitals in England.</td>
</tr>
<tr>
<td>Housing Option Service</td>
<td>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.</td>
</tr>
<tr>
<td>HPA</td>
<td>Health Protection Agency</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>HSE</td>
<td>Health Survey for England, also Health and Safety Executive</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td>The name for a group of related viruses, some of which occur on the cervix and are risk factors for cervical cancer.</td>
</tr>
<tr>
<td>ICD 10</td>
<td>International Classification of Diseases, version 10 (International Statistical Classification of Diseases and Related Health Problems)</td>
</tr>
<tr>
<td>IMD</td>
<td>Indices of Multiple Deprivation</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Protection of susceptible individuals from communicable disease by administration of a living modified agent, a suspension of killed organisms or an inactivated toxin.</td>
</tr>
<tr>
<td>Incidence</td>
<td>Rate of occurrence of new cases of disease (within a given population over a given time period)</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>Mortality of those aged less than one year.</td>
</tr>
<tr>
<td>Inequalities</td>
<td>A lack of equality or fair treatment in the sharing of wealth or opportunities between different groups in society</td>
</tr>
<tr>
<td>In-patient</td>
<td>A person who has been admitted to hospital.</td>
</tr>
<tr>
<td>IOTN</td>
<td>Index of Orthodontic Need</td>
</tr>
<tr>
<td>ISA</td>
<td>Independent safeguarding authority</td>
</tr>
<tr>
<td>Intrauterine Device (IUD)</td>
<td>Contraceptive device</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint strategic needs assessment — a statutory needs assessment — see definition.</td>
</tr>
<tr>
<td>Key Stage 1</td>
<td>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.</td>
</tr>
<tr>
<td>Key Stage 2</td>
<td>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.</td>
</tr>
<tr>
<td>Key Stage 3</td>
<td>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.</td>
</tr>
<tr>
<td>Key Stage 4</td>
<td>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.</td>
</tr>
<tr>
<td>LAA</td>
<td>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.</td>
</tr>
<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraceptives. An example of Depot (injection based) forms of contraception.</td>
</tr>
<tr>
<td>LD</td>
<td>Learning disability (e.g. mild, moderate and severe)</td>
</tr>
<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
</tr>
<tr>
<td>Life Expectancy (LE)</td>
<td>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.</td>
</tr>
<tr>
<td>Limiting Long Term Illness (LLTI)</td>
<td>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</td>
</tr>
</tbody>
</table>
**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.

**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 children’s 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 Actuaries 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 10-11 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
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.

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.

Office of National Statistics. The Office for National Statistics (ONS) is the government department that provides UK statistical and registration services.

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 superfirms, groups, and subgroups, and an overlapping classification of “corresponding areas”.

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.

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.

Patient advice and liaison service

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.

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.

Primary Care Trust

Primary care trust. Commissions health care in a defined local area whether in the community (not at hospital) or from acute care providers.

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.

Online information and database system, provided by care services improvement partnership (CSIP). www.poppi.org.uk (See pansi)

Any death under the age of 75 years.

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.

Primary care trust. Commissions health care in a defined local area whether in the community (not at hospital) or from acute care providers.

Problem drug user

Online information and database system provided by care services improvement partnership. www.pansi.org.uk (See poppi)

People with Physical and Sensory Disabilities

High level national targets set by Government for public services.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Pupil Level Annual School Census</td>
<td>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.</td>
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<tr>
<td>Quartile</td>
<td>A quarter of a distribution i.e., the first, second and third quartile points of 100 are 25, 50 and 75.</td>
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<tr>
<td>QMAS</td>
<td>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.</td>
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<tr>
<td>QOF</td>
<td>The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results.</td>
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<tr>
<td>RAG</td>
<td>Red, amber and green codes for performance indicators</td>
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<td>RBWM</td>
<td>Royal Borough of Windsor and Maidenhead</td>
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<tr>
<td>Referrals, Assessments &amp; Packages return (RAP)</td>
<td>Annual Department of Health statutory return for referrals, assessments and packages of care</td>
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<tr>
<td>READ Codes</td>
<td>A coded classification of clinical terms designed to enable clinicians to make effective use of computer systems</td>
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<tr>
<td>Registered population</td>
<td>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.</td>
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<tr>
<td>Registered Social Landlord</td>
<td>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.</td>
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<tr>
<td>Resident population</td>
<td>The resident population is the population physically living within a given area.</td>
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<tr>
<td>Secondary care</td>
<td>Health care provided in a hospital setting at a general hospital rather than a specialist hospital (when it is known as tertiary care).</td>
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<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
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<tr>
<td>SOA</td>
<td>Super Output Area. Standard geographical areas created for statistical purposes, to provide continuity of areas. Two levels; Middle and Lower.</td>
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<tr>
<td>SOPHID</td>
<td>Survey of Prevalent HIV Infections data</td>
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<tr>
<td>SR1</td>
<td>Annual Department of Health statutory return for residential and Nursing care</td>
</tr>
<tr>
<td>SSEN</td>
<td>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.</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>Syphilis</td>
<td>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.</td>
</tr>
<tr>
<td>Systolic blood pressure</td>
<td>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.</td>
</tr>
<tr>
<td>TB</td>
<td>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 the 1950’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.</td>
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<td>TIA</td>
<td>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.</td>
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<tr>
<td>ToP</td>
<td>Termination of Pregnancy</td>
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<tr>
<td>Total Period Fertility Rate</td>
<td>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.</td>
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<tr>
<td>Term</td>
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<tr>
<td>Teen Pregnancy Unit (TPU)</td>
<td>National strategy unit for teenage pregnancy. Part of Department of Children, Schools and Families (DCSF)</td>
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<tr>
<td>UDA</td>
<td>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.</td>
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<tr>
<td>Unemployment</td>
<td>Claimant count unemployment rates (proportion of working age people claiming Job Seekers Allowance).</td>
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<tr>
<td>UNICEF BFI</td>
<td>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.</td>
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<tr>
<td>VRA</td>
<td>Vascular risk assessment – now called the healthcheck</td>
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<td>VS</td>
<td>Vital signs (A, B or C) a set of national indicators</td>
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<tr>
<td>WCC</td>
<td>World Class Commissioning</td>
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<tr>
<td>Ward</td>
<td>Strictly electoral ward, an administrative area that is laid down in statute. Berkshire covers 126 wards.</td>
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<tr>
<td>Weighted Capitation Population</td>
<td>The unified weighted population is used to allocate resources and budgets in the NHS and is a modified registered population.</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WIC</td>
<td>Walk in Centre</td>
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<tr>
<td>YP</td>
<td>Young Person</td>
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<tr>
<td>YPLL (or PYLL, YLL)</td>
<td>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.</td>
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</tbody>
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