**Healthier Reading Partnership**

**Tuesday 6 October 2009, 6.00pm, Reading PCT Headquarters, 57-59 Bath Road, Reading, RG30 2BA**

1. Apologies
2. Minutes of Last Meeting (page 1)
3. Matters Arising
4. Draft Partnership Agreement (Grant Thornton) (page 13 – draft Agreement to follow)
5. Local Area Agreement – Q1 2009/10 Performance Report on Health-Related Targets (Grant Thornton) (page 15
6. Joint Strategic Needs Assessment (JSNA) – Verbal Update (Bev Searle)
7. Health and Well-being Strategy – Proposals for Completion (Bev Searle) (page 19)
8. Proposals for HRP Away Day (Grant Thornton) (page 20)
9. Adult Social Care Green Paper – Shaping the Future of Care Together; The Big Care Debate (Janette Searle) (page 22)
10. Special Scrutiny of Children's Health (Kim Wilkins) (page 37)
11. Forward Plan – verbal update (Grant Thornton)
12. Any Other Business
13. Dates of Scheduled Meetings:
    14 January 2010
    13 April 2010

If you have any queries about this agenda, please contact Nicky Simpson in Committee Services, Reading Borough Council.
Tel.: 0118 939 0112 e-mail: nicky.simpson@reading.gov.uk

# HEALTHIER READING PARTNERSHIP BOARD MINUTES – 9 JULY 2009

**Present:**

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| Bev Searle (Chair) | NHS Berkshire West |
| Councillor Ennis | Reading Borough Council |
| Councillor Orton | Reading Borough Council |
| Sarah Gee | Reading Borough Council |
| Anne Laing | Reading Voluntary Action |
| Jackie Lonsdale | NHS Berkshire West |
| Melani Oliver | Reading Borough Council |
| Grant Thornton | Reading Borough Council |
| Kim Wilkins | NHS Berkshire West |
| Deborah Wilson | Berkshire Scout Enterprises Ltd |

**Also in Attendance:**

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| Councillor T Harris | Reading Borough Council |
| Sheena Masoero | Reading LINk |
| Nicky Simpson | Reading Borough Council |
| Rachel Spencer | Reading LINk |

**Apologies:**

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| Chris Turner | Reading Citizens' Advice Bureau |

## 1. MINUTES

The Minutes of the meeting held on 7 April 2009 were confirmed as a correct record and signed by the Chair.

## 2. DRAFT TERMS OF REFERENCE

Further to Minute 3 of the previous meeting, Grant Thornton, Head of Community Planning, submitted a report which set out draft Terms of Reference (ToR) and other arrangements for ratification by the newly constituted Healthier Reading Partnership (HRP) Board. It also set out further work required to develop a more detailed Partnership Agreement for consideration by the Board at its next meeting.

The report explained that, following an externally facilitated review, the HRP had agreed at its last meeting to the establishment of a reconstituted partnership and that it would no longer meet in its then current form. It had also agreed the membership of the new partnership board and interim chairing arrangements, subject to ratification by the newly constituted partnership, and the establishment of a task and finish officer group to work on developing and establishing the new HRPB in collaboration with key stakeholders.

Appendix 1 to the report set out the proposed membership of the reconstituted Partnership Board for formal ratification, as follows:

| Category | Person / Organisation | Comments |
|---|---|---|
| **RBC (5)** | Elected members x2 | From the Executive – to ensure no conflicts of interest in relation to scrutiny activities / functions |
| | Adult Care x1 | Appropriate head of service or Director |
| | Children's Services x1 | Appropriate head of service or Director |
| | Chief Exec's Dept x1 | Appropriate head of service or Director |
| **RBC (2) Observers** | Elected members from the two other main political parties | To ensure cross-party engagement and involvement. |
| **PCT (3)** | Reading Area Director x1 | |
| | Strategic health improvement lead x1 | |
| | Commissioning x1 | |
| **Voluntary/ Community sector (4)** | RVA officer | Role is to advise on voluntary sector involvement in all the work of the HRP and contribute to the effective delivery of the Strategy. |
| | Vol/ Comm Sector rep x2 | Selected via sector election process |
| | LINk x1 | Board member |

The report also proposed that the PCT Area Director continue as Chair on an interim basis, pending the agreement of any new arrangements (to be brought forward as part of a more detailed Partnership Agreement).

Appendix 2 to the report set out final proposed Terms of Reference for the Board, which had been developed as part of the externally facilitated review process, and firmly embedded the role of the Board in a strategic context. The ToR stated that the remit of the HRP included the full spectrum of policy and services across both health and social care, from prevention to intervention and care, and set out the following purpose of the HRP:

"The Healthier Reading Partnership exists to improve health and well-being and reduce health inequalities in the Reading population. It will achieve this by:

- Discussing and agreeing strategic direction and priorities across all relevant organisations and partnerships (public, private, voluntary and community sectors)

- Ensuring co-ordination and integration of strategic planning, business planning and delivery and resources across all the relevant organisations and partnerships"

It also listed the following partnership tasks that the HRP would carry out in order to fulfil its purpose:

a) Lead on the development and delivery of the Healthy People and Lifestyles theme of the Sustainable Community Strategy.

b) LAA
Oversee negotiation on and securing delivery and resourcing of relevant Sustainable Community Strategy priorities and LAA targets.

- Ensure effective performance management of LAA targets linked to the Healthy People and Lifestyles theme.

- Receive progress reports from the LAA Performance Group, keep fully informed regarding risks and issues, and take appropriate action to remedy any problems.

- Supply to the LSP a narrative to the progress report, along with any additional information required and actions taken/needed.

c) Oversee the development, endorsement (by the LSP) and delivery of a joint Reading Health & Wellbeing Strategy and an associated shorter term Action Plan which sat under the Sustainable Community Strategy and linked to other relevant strategies, such as the Strategic Health Authority's regional plan, Children and Young People's Strategic Plan, Social Care and others. The Reading Health & Wellbeing Strategy and Action Plan would need to reference but not duplicate these other strategies and add value.

d) Ensure that the Reading Health & Wellbeing Strategy and Action Plan was regularly reviewed and refreshed, reflecting changes in the evidence base, relevant policies and plans in order that the partnership set the direction for health and well-being in Reading.

e) Ensure that the Reading Health & Wellbeing Strategy and Action Plan was well informed by local evidence, such as the Joint Strategic Needs Assessment and by the views of local people, including the most vulnerable and hard to reach.

f) Influence the development of the Joint Strategic Needs Assessment and ensure it informed priorities and actions.

g) Advocate for and promote the independence of vulnerable people.

h) Maximise the use of existing resources through better alignment and integration of service delivery and seek to attract additional funding.

i) Ensure that the public and service users were involved appropriately in the development and implementation of all its work in accordance with the Duty to Involve.

The report stated that there was a need to develop a more detailed Partnership Agreement to cover a range of issues linked to how the HRPB would operate and manage its business, eg deputising, changes in personnel, co-option etc. It proposed that this detailed work was carried out with a view to submitting a full Partnership Agreement to the next meeting of the Board.

The report proposed, however, that the Board should consider the role of observers at this meeting (both the elected member observers and those co-opted for special topics) and recommended that the following role be agreed to enable clarity and appropriate participation from the outset:

> "Observers would be able to take an active role in the meetings of the HRPB, including participation in debate and discussion (subject to the usual discretion of the Chair in managing the overall business of the meeting), but would not have any voting rights on any formal decisions."

The report also suggested that there should be an officer group to support the work of the Board and to ensure that its work programme was developed and delivered effectively (a model that was being successfully operated by the Local Strategic Partnership). It therefore proposed that an HRP Management Group was formally established, initially comprising:

- Area Director PCT: Bev Searle
- RBC Head of Strategy and Performance: Sarah Gee
- RBC Head of Community Planning: Grant Thornton
- Voluntary sector representative: to be confirmed

The Management Group would support the partnership by co-ordinating the agenda/work programme, drafting and quality assuring reports, and ensuring decisions and tasks were followed through between Board meetings. The report recommended that the voluntary sector representative was agreed through discussion outside the meeting, and that the membership of the Management Group be kept under review to ensure it was fit for purpose and had the capacity to undertake the work required.

Anne Laing reported that the two voluntary/community sector representatives on the HRP Board had been selected via the sector's election process as Chris Turner, from

Reading Citizens' Advice Bureau, and Deborah Wilson, from Berkshire Scout Enterprises Ltd. She also reported that Chris Turner was willing to be the voluntary sector representative on the Management Group, and that Anne would deputise for him in his absence.

It was noted that the external review had proposed that the Royal Berkshire and Berkshire Healthcare NHS Foundation Trusts not be members of the HRPB but had stated that, as provider organisations, they could contribute more positively to standing sub-groups or task and finish groups. It was suggested that these organisations could also be invited to attend HRPB meetings for specific agenda items, as necessary.

The meeting discussed the role of observers, noting the advice given at the last meeting that the statutory responsibilities of the LSP and related partnerships made it appropriate that members of the executive (Cabinet) be appointed to the HRPB, but that lead spokespeople from the other Groups would be able to attend as observers, thus avoiding any conflict of interest with their involvement in the scrutiny process. It was also queried how many observers could attend meetings, and it was suggested that the Management Group consider this further when developing the section of the Partnership Agreement on deputies, etc.

It was suggested that it would be beneficial to have a Black & Minority Ethnic (BME) community representative on the new HRPB, as long as robust links to the BME community could be established, and that the Management Group should investigate how this could work.

**AGREED:**

(1) That the membership of the Partnership Board, as set out in Appendix 1 and above, be ratified, subject to (7) below, and provider organisations be invited to attend HRPB meetings for specific items, as appropriate;

(2) That the PCT Area Director continue as Chair of the HRPB on an interim basis, pending the agreement of any new arrangements;

(3) That the Terms of Reference, as set out in Appendix 2, be agreed;

(4) That the role of observers on the Board be agreed as set out above;

(5) That a more detailed Partnership Agreement be developed for consideration at the next meeting;

(6) That a Management Group be formed to support the HRP, as set out above, with the following membership:

- Area Director PCT: Bev Searle
- RBC Head of Strategy and Performance: Sarah Gee
- RBC Head of Community Planning: Grant Thornton

- Voluntary sector representative: Chris Turner (deputy Anne Laing)

(7) That the Management Group investigate the possibility of having a representative from the BME community on the HRP Board and consider further the attendance of observers and deputies when developing the Partnership Agreement.

## 3. CYCLE OF MEETINGS

Grant Thornton, Head of Community Planning, submitted a report outlining a rationale for adding two extra meetings of the Healthier Reading Partnership Board to the four already scheduled, in order to maximise the impact and effectiveness of the Board.

The report explained that the HRP had previously met quarterly and for the Municipal Year 2009/10 meeting dates had been set on this basis as part of the Council's annual planning cycle, for 9 July 2009, 6 October 2009, 14 January 2010 and 13 April 2010. However, whilst quarterly meetings were usual and could fit well with a performance management cycle, they were not conducive to effective partnership development or strategic impact. The Local Strategic Partnership (LSP) had found that quarterly meetings tended to get dominated by important but routine business and did not allow the space for more blue-sky thinking, strategic policy development, and in the early stages of a partnership, fulfilling the "forming" role and building relationships and effectiveness. The report stated that the LSP had therefore agreed to meet six times a year, four on a quarterly basis but with two "free" dates to focus on more strategic issues and be less encumbered by routine business. It proposed that the HRPB adopt the same model, which could be incorporated in the detailed Partnership Agreement.

The report also stated that the external review of the partnership had strongly recommended that an away day be held for the core Board members of the HRP, perhaps with one or two supporting officers, at an early stage, to give the new Board an opportunity to get to know each other, reflect on the emerging Health and Well-being Strategy and Action Plan and to think about the partnership's future work programme. It recommended that the first additional meeting should be held as an away day, ideally prior to the scheduled meeting on 6 October 2009.

It was suggested that it would be useful for a glossary to be produced, in order to help those involved understand the terms used in health and social care.

**AGREED:**

(1) That, in addition to the quarterly meetings already scheduled, a further two meetings of the HRPB be held in each annual cycle;

(2) That the first additional meeting in 2009/10 take the form of an "away day";

(3) That dates for the additional meetings for 2009/10 be canvassed outside the meeting;

(4) That the Management Group produce briefing material for those involved in the HRPB, including a glossary of terms used in health and social care.

## 4. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Bev Searle, West Berkshire Area Director, NHS Berkshire West, updated the meeting on the development of the Joint Strategic Needs Assessment (JSNA).

She explained that there was a statutory requirement for PCTs and local authorities to produce a JSNA, which provided a detailed and thorough look at the current and future health care, wellbeing and quality of life needs in the area, to provide an evidence base to underpin the Sustainable Community Strategy and Local Area Agreement, and inform commissioning decisions. In 2008, a minimal dataset had been used to comply with government requirements, as the PCT had recently completed a health needs assessment, but the PCT was now working with the three local authorities in its area to develop the next three draft JSNA documents; she would bring the Reading JSNA to the next meeting of the HRPB.

Bev reported that the Reading Health Profile 2009, which gave a snapshot of health in the Reading area, had now been published and circulated copies at the meeting.

It was noted that the previous JSNA had flagged up areas for more in- depth, or "deep dive", analysis, and that a process for agreeing these would need to be established, as there would be many issues vying for the limited resources available. There were already a number of action plans in place in the Local Area Agreement or Children & Young People's Plan to address health indicators significantly below average, but those areas not being picked up by other action plans would need to be identified for deep dive or to be included in the HRP strategy.

The meeting discussed the issue of data provision and circulation, noting the wish of the Board to have access to health data at the most detailed level possible, as well as the importance of managing the resources available for data provision and ensuring that Board meetings were not swamped by data. It was suggested, for example, that data provision at meetings should be linked to specific agenda items where action was being considered. It was proposed that this issue should be considered further by the Management Group, in conjunction with the forward plan and resource management, and at the planned away day.

Kim Wilkins and Melani Oliver reported that data was currently being collated for a joint scrutiny review of children's health and that this information could be circulated once available.

**AGREED:**

(1) That Bev Searle bring a report on the JSNA to the next meeting;

(2) That the Management Group work on developing a forward plan for the HRPB and consider associated information requirements, including data provision and circulation, and that this be considered further at the planned away day;

(3) That Kim Wilkins and Melani Oliver circulate the information collated for the joint scrutiny review of children's health, once available.

## 5. DRAFT READING HEALTH & WELLBEING STRATEGY

Bev Searle, West Berkshire Area Director, NHS Berkshire West, submitted an initial draft of the Reading Health & Wellbeing Strategy. The Strategy set out a vision to achieve a healthier Reading by working in partnership, aiming to:

- Reduce health inequalities
- Achieve more people living healthier lives and preventing more ill health
- Enable older people and people with long term conditions to live at home
- Give children and young people the best start in life through improving their own and their families' health and well-being

The document put the strategy into context, referring to government papers and initiatives, explained the HRP, the Sustainable Community Strategy and Local Area Agreement, described the HRP Action Plan and gave details of the key priorities for action.

The meeting discussed the draft strategy and the points made included:

- The draft strategy was a good start, but the vision needed sharpening up, to define more clearly what a "healthier Reading" meant;

- As the HRP developed its own action plan and targets, it would be important for the Board to be aware of and not replicate the existing LAA and health and social care targets which had already been agreed with the Government Office for the South East, the Strategic Health Authority and the Care Quality Commission;

- It was noted that many older people's problems were caused by isolation, and it was reported that there was a scheme sponsored by Age Concern to provide befrienders to those whom GPs identified as at risk of admission to secondary care because of loneliness. This scheme could be added to the "priorities for action" section of the strategy;

- Once the strategy had been agreed, it could be decided how the other existing partnerships such as the Older Persons' Strategic Partnership would link and report to the HRP.

**AGREED:**

(1) That the comments raised above be taken on board and any further comments or ideas on the strategy be submitted via Nicky Simpson;

(2) That the Management Group develop the draft strategy for further consideration at the next scheduled meeting of the HRPB.

## 6. READING LINK

Sheena Masoero, Reading LINk Coordinator, and Rachel Spencer, Advice Manager for Reading Voluntary Action, gave a presentation on the work of the Reading Local Involvement Network (LINk). Copies of the presentation slides and the Reading LINk Annual Report 2008/09 were distributed at the meeting.

They explained that Local Involvement Networks (LINks) had been set up to replace Public & Patient Involvement (PPI) Forums, but with a wider remit, and to give citizens a stronger voice in how their health and social care services were delivered. The role of LINks was to find out what people liked and disliked about local services, monitor and investigate local services, use their powers to hold the appropriate commissioners or providers to account and make recommendations to them to help improve and shape services to meet local need.

The Council had contracted Reading Voluntary Action to act as the host organisation to advise, support and promote the activities of the Reading LINk. A Reading LINk Interim Board was already in place, with the current members bringing a wide variety of experience and knowledge, and elections to the 12 seats would be taking place in October 2009. A Reference Group of individuals and organisations had also been established, but not yet fully utilised.

A Stakeholder Event had been held in January 2009 which had highlighted two themes which the LINk had decided would form the focus for its work programme, which were "The need for person-centred health and social care services" and "Access to information relating to health and social care".

The LINk had statutory powers to request information from commissioners, make recommendations to commissioners, providers, managers and scrutinisers of local care services, enter specific services and view care provided, and also to refer matters to the Housing, Health & Community Care Scrutiny Panel. The LINk would prioritise and look into specific issues of concern to the community and was currently carrying out two pilot projects on Diabetes Care and Provision of Toenail Cutting for the Elderly. It expected to carry out around four such projects a year, involving Task & Finish Groups comprising Board members, professionals and service users, and was in discussion with the University of Reading about employing a researcher to deal with more complex issues.

Rachel suggested that the LINk could support the HRP by: providing a mechanism for communicating the views of local people to the HRP, meeting the Duty to Involve; providing a route for local people to take part in consultation; contributing ideas, reforms or innovations from LINk activities for providing better value from services;

and enabling the HRP to be well informed by local evidence. She suggested that the HRP could support the LINk by: providing context to local activities to avoid duplication and providing wider options for LINk issues and projects; reviewing and implementing LINk recommendations across services; providing evidence of changes which had occurred related to LINk activities; and recognising the independence of the LINk.

Sheena reported that a decision on which LINk Board member would be the representative on the HRPB had not yet been made and so the host staff would attend meetings until after the LINk Board elections in October 2009.

The meeting discussed how the HRP and the LINk could work together and in the discussion the points made included:

- The HRP would review and respond to LINk recommendations as appropriate, but would not always be able to implement recommendations, depending on issues such as resourcing;

- The HRP and the LINk should be able to help improve the quality of consultations on health and social care by working together on the planning and coordination of consultations and ensuring that all appropriate networks, reference groups and databases were used;

- If the specific interests of the members of the LINk Reference Group could be identified, this could help when carrying out consultations. It was also important to disaggregate the views of individuals and agencies/organisations in consultation responses;

- Whilst it was important for the LINk and HRP to work together and a member of the LINk Board would be on the HRPB, it was vital that the LINk retained its independence.

**AGREED:** That Rachel and Sheena be thanked for their presentation.

## 7. BROAD STREET MALL WALK-IN HEALTH CENTRE

Bev Searle, West Berkshire Area Director, NHS Berkshire West, updated the meeting on progress of the establishment of a GP-led Walk-In Health Centre in Broad Street Mall in partnership between NHS Berkshire West, Assura and a number of local GPs.

She reported that the five year contract for the centre would start on 10 August 2009, the centre would provide a flexible range of bookable appointments, walk-in services and other services for both registered and non-registered patients (as long as they lived in Berkshire West), and it would be open from 8am to 8pm, seven days a week.

She said that all those involved were keen to make the most of the opportunities afforded by the new centre, especially in relation to making contact with and providing services to non-registered patients. It was reported that non-registered patients, as well as registered patients who could not get GP appointments as quickly

as they wanted, often clogged up Accident & Emergency departments and that there was a need to educate the public on healthy lifestyles and the appropriate uptake (or not) of health services; it was suggested that the HPRB should consider this further at a future meeting.

The meeting discussed the importance of good publicity about the new centre, not just so that patients knew about the new service, but also to inform the public about how health service money was being spent well on services for them. It was suggested that the HRPB could look at public perception of services as part of its work planning, as provision of and access to information was a key theme which came from public consultations and this emphasised the need for consistent publicity to keep raising public awareness.

**AGREED:**

(1) That the position be noted;

(2) That public perception of services, public relations and information provision, including education of the public on healthy lifestyles and the appropriate uptake of health services, be an agenda item for a future meeting of the HRPB.

## 8. FORWARD PLAN

Grant Thornton, Head of Community Planning, said that a number of items for future consideration by the Board had already been raised at the meeting, and a forward plan for the HRP would need further consideration by the Management Group and at the away day.

The intention would be to create a framework of agenda items for the year ahead from key themes, with flexibility to add extra items as necessary. Items were likely to emerge from discussions on the JSNA, and the HRP should be focussing where possible on preventative rather than reactive issues, and areas where partnership working could add value.

**AGREED:** That the Management Group consider key themes for the HRP and produce a draft forward plan of agenda items for consideration at the planned away day.

## 9. OTHER BUSINESS – TOBACCO CONTROL COORDINATOR

Bev Searle, West Berkshire Area Director, NHS Berkshire West, said that a jointly-funded Tobacco Control Coordinator Post had been established for Berkshire West, but that Reading Borough Council had not previously been in a position to contribute funding towards this post. She asked whether the Council could reconsider the possibility of providing the £6,000 required, and said that she could provide the necessary information on costs and benefits to support the request.

**AGREED:** That Bev Searle provide further information on the request for the Council to contribute £6,000 to the Tobacco Control Coordinator Post, and Grant Thornton take the request through the appropriate channels.

## 10. DATE OF NEXT MEETING

**AGREED:** That a date for an away day be arranged and the next scheduled meeting of the Healthier Reading Partnership be held on Tuesday 6 October 2009.

(The meeting started at 6.00pm and closed at 7.45pm)

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| **TO:** | **HEALTHIER READING PARTNERSHIP** | | |
| **DATE:** | **6TH OCTOBER 2009** | **AGENDA ITEM:** | **4** |
| **TITLE:** | **HRP PARTNERSHIP AGREEMENT** | | |
| **LEAD OFFICER:** | **GRANT THORNTON** | **TEL:** | **0118 939 0416** |
| **JOB TITLE:** | **HEAD OF COMMUNITY PLANNING (RBC)** | **E-MAIL:** | **grant.thornton@reading.gov.uk** |

## 1. EXECUTIVE SUMMARY

1.1 The report is to consider a new draft Partnership Agreement (Appendix 1) for the HRP that formalises how the Partnership will operate and conduct its business. It enshrines and builds on the Terms of Reference that were agreed at the last meeting.

## 2. RECOMMENDED ACTION

**2.1 That the HRP consider and comment on the Draft Partnership Agreement.**

**2.2 That the HRP endorses the Partnership Agreement subject to any recommended changes at 2.1 above.**

## 3. POLICY CONTEXT

Since the HRP's initial establishment there has been a significant shift in the legislative context for partnership working and especially the role of the Local Strategic Partnership (LSP) and its delivery partnerships. Whilst the HRP shares a non-legislative status with the LSP it does have similar statutory responsibilities in relation to delivery of the Sustainable Community Strategy (SCS) and associated Local Area Agreements (LAAs). Statutory requirements on key partner agencies also include the duty to co-operate and duty to involve and are impacted collectively by the new Comprehensive Area Agreement (CAA) inspection regime. In parallel there are strong drivers for closer and more effective joint working across the spectrum of public health, mainstream community care and children's well-being.

## 4. THE PROPOSAL

### (a) Current Position:

At its last meeting the Partnership ratified the membership of the Partnership Board and agreed overarching Terms of Reference. It also acknowledged and agreed the need for a more detailed Partnership Agreement.

### (b) Options Proposed

The draft Partnership Agreement attached at Appendix 1 builds on and incorporates the Terms of Reference agreed at the last meeting. It develops these into a more detailed agreement that covers how the Partnership will operate both in relation to mechanics and roles, responsibilities and values. It incorporates:

- Purpose and Aims
- Status
- Make-up of the Board
- Roles and responsibilities – including deputies and observers, ways of working
- Board meetings
- Chair and Vice Chair
- Management Group – membership and role

The Agreement is modelled on that for the LSP but simplified to be more appropriate for the thematic role of the partnership. It also contains a commitment to the Nolan Principles of Public life which, whilst somewhat stilted, really embody the desire to work collectively to achieve shared goals for the public good. The management group is particularly keen that the Partnership Board embraces the spirit of these principles in taking the health and well-being agenda forward in what will be undoubtedly challenging financial times.

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| **TO:** | **HEALTHIER READING PARTNERSHIP** | | |
| **DATE:** | **6TH OCTOBER 2009** | **AGENDA ITEM:** | **5** |
| **TITLE:** | **LAA Q1 09/10 PERFORMANCE REPORT** | | |
| **LEAD OFFICER:** | **JILL MARSTON** | **TEL:** | **0118 939 0699** |
| **JOB TITLE:** | **SENIOR POLICY OFFICER** | **E-MAIL:** | **jill.marston@reading.gov.uk** |

## 1. EXECUTIVE SUMMARY

1.1 The report presents performance for LAA1 and LAA2 for quarter 1 09/10.

## 2. RECOMMENDED ACTION

**2.1 To note performance for LAA1 and LAA2 for quarter 1 09/10.**

**2.2 To consider whether further information is required in order to adequately monitor performance against the targets.**

## 3. BACKGROUND

3.1 LAA1 runs from 2007-2010 and is now in its final year. Reward grant of up to around £4 million is available if all targets are achieved. The current prediction is for around 64% PRG. LSP Board has recently agree a model for PRG allocation whereby 20% will be top-sliced for LSP development and new priorities, while the rest will be allocated according to a review process.

3.2 LAA2 runs from 2008-2011 and has a reward grant of around £1 million attached. To date there have been some issues with data and commentary provision, while for a number of indicators data is not yet available nationally.

## 4. LAA1 PERFORMANCE

4.1 Appendix 1 sets out the performance for LAA1 health related targets for Q1 09/10.

4.2 Four targets are currently green (57%), while three are red (43%). Of these, 9b physical activity and 11a pension credit are expected to remain red while the position regarding 11c is unclear (though note that this is only worth 2% of the whole target).

## 5. LAA2 PERFORMANCE

5.1 Appendix 2 sets out the performance for LAA2 'Healthy People and Lifestyles' targets for Q1 09/10.

5.2 There are five reward related (designated) targets in this theme, along with three 'local' (non-reward related) targets.

5.3 Q1 data is only available for three of the targets, the others are either annual indicators or the Q1 data is not yet available. Commentary has not been received for all targets.

5.4 For indicators NI131 and NI130, the targets are being reviewed and need to be re-set (this is possible are they are local targets). These need to be agreed before LAA2 is re-published, as required if there are changes to local indicators.

## LAA1 2007-2010 - QUARTER 1 09/10 PERFORMANCE

| No | LAA 2007 Indicator | Lead partner | PRG allocation | *Target at end 07-08* | Actual at end 07-08 | *Target 08-09* | Actual at end 08-9 | *Target Q1 09-10* | Actual Q1 09 10 | *60% PRG target 09-10* | *Target 09-10* | Commentary |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RT9a | Number of smoking quitters | PCT - Chrissy Long | 60% (£209,741.25) | *177* | **173 GREEN** | *360* | **366 GREEN** | *402* | **443 GREEN** | *52.3* | *549* | All GP's and Pharmacies regularly contacted to be supported, updated and motivated in the service. Clinics in all four wards running well. The POD in the broad street mall is working very well. Mini pods which will refer on to clinics are under way in supermarkets in Inequality areas. |
| RT9b | Percentage of adults participating in sport or physical activity | RBC - Lisa Pierce | 40% (£139,827.50) | *25%* | **N/A** | *26.50%* | **18.2% RED** | *N/A* | **N/A** | *26.2%* | *28%* | **NOTE:** the Active People survey 2008 data shows a 5.3% decrease in physical activity levels, whereas other local measures show an increase; there may be issues with the Active People methodology though this remains the accepted measure for this target.<br><br>Sport Reading portfolio partnership is being delivered - current activity reported. |
| RT10a | Breastfeeding initiation rates | PCT - Jan Bartlett/Penny Cooper | 60% (£209,741.25) | *70.50%* | **62.9% RED** | *73.50%* | **75% (Dec 08) GREEN** | *N.A* | **N/A** | *75.3%* | *76.50%* | **NOTE:** latest data is Dec 08 - 75%<br><br>Momentum around broader Baby Friendly activity needs to be kept up, including developing plans to ensure that staff have capacity across the partnership to undertake Baby Friendly training where this is identified. Community nursing service is undergoing a transformational change. This work should be finished around mid October. Any implications for breastfeeding activity need to be identified and considered. |
| RT10b | Number of pregnant smoking quitters | PCT - Meyrem Rawes-Enver | 40% (£139,827.50) | *14* | **15 GREEN** | *32* | **40 GREEN** | *37* | **49 GREEN** | *44* | *54* | Refer All Pregnant Smokers evaluation has been completed and is indicating a possible 303% increase in referrals from 08/09 to 2009/10 and theoretically additional 222% quitters over the same period. |
| RT11a | Numbers people 60+ receiving Pension Credit | RBC - Rob Poole | 58% (£202,749.87) | *6060* | **5510 RED** | *6218* | **5540 (Feb 09) RED** | *6283 (May)* | **N/A** | *6276* | *6480* | **NOTE:** Latest figures are Feb 09. Q1 0910 figures due Nov 09. March 2010 figures not expected til July-Sept 2010 or later. |
| RT11b | Numbers people 60+ receiving Attendance Allowance | | 40% (£139,827.50) | *2600* | **2510 AMBER** | *2740* | **2770 (Feb 09) GREEN** | *2776 (May)* | **N/A** | *2816* | *2960* | **NOTE**: as above<br>Gone green, on track to achieve target. Next activities include Raise interrogation to find clients without FAB contact, Mail shot to Home owners regarding impact of service charges/mortgage on PC entitlements and AA info, interrogating HB data to find straight forward PC entitlements and ones to be "constructed" by identifying likely additional premiums. |
| RT11c | Numbers people aged 60+ using Direct Payments | | 2% (£6,991.38) | *105* | **43 RED** | *135* | **72 RED** | | **63 RED** | *141* | *165* | The figures have reduced from the previous quarter due to a) death b)people going into residential homes - direct payments cannot be used to pay for residential care. We are looking to offer direct payments routinely to people coming through the new re-ablement service, and to promote the use of direct payments for telecare (although many of these packages are 'one off payments' and therefore do not count in this target) |

**RAG STATUS KEY:**

| |
|---|
| More than 10% out |
| up to 10% out |
| Achieved |

## LAA2 2008-2011 - Q1 (APRIL - JUNE) 09/10 PERFORMANCE

| No | LAA2 Indicator | Lead partner | *Target 08-09* | Actual 08/09 | *Target 09-10 Q1* | Actual 09-10 Q1 | *Target 09-10* | *Target 10-11* | *Direction of travel based on last available data* | commentary |
|---|---|---|---|---|---|---|---|---|---|---|
| | **HEALTHY PEOPLE AND LIFESTYLES** | | | | | | | | | |
| NI 121 | Mortality rate from all circulatory diseases at ages under 75* | Jeremy Speed, NHS Berkshire West | **91.6** | **N/A** | **N/A** | **N/A annual** | 89.9 | 88.2 | no previous data available on system | **NOTE:** 2008 data expected Nov/Dec 2009 (2007 figure is 85.56)<br><br>RISKS: Influenza Pandemic could lead to workforce pressures. ISSUES: Recruitment to Tobacco control post should take place in Q2.GP weight management LES has under recruited. Action in place to support practices. |
| NI 125 | Achieving independence for older people through rehabilitation/intermediate | Suzanne Westhead, RBC | **80%** | **80.9% GREEN** | **N/A** | **N/A annual** | 82% | 84% | no previous data available on system | |
| NI 150 | Adults in contact with secondary mental health services in employment | Suzanne Westhead, RBC | **N/A** | **N/A** | **N/A** | **N/A** | to be confirmed when baseline available* | minimum statistically significant improvement on baseline data for 08/09 | no available data | **NOTE:** baseline not available til Sept 09 |
| NI 132 | Timeliness of social care assessments | Suzanne Westhead, RBC | **70%** | **70.8% GREEN** | | **79.7% GREEN** | 75% | 80% | ⇧ | |
| NI 39 | Alcohol-harm related hospital admissions | Linda Dines, NHS Berkshire west | **1371 per 10,000** | **N/A** | **N/A** | **N/A** | 1563 | 1750 | no previous data available on system | **NOTE:** 2008/9 data expected Feb 2010<br><br>RISKS: · 1 Practice has dropped the LES due to the DES work.· Possible poor uptake of EBI service or patients may DNA· New tier 2 service in place for GPs to refer High Risk patients to – implementation of these services is still in the early stages and may become overloaded.· New tier 2 service in place for GPs to refer High Risk patients to – implementation of these services is still in the early stages<br>ISSUES:· DNAs at SBI training has reduced maximum stakeholders attendance.· Practices may underperform or drop out of LES due to new alcohol Tier 2 service and refer direct to Tier 2 services instead of in-house EBI (LES)service.· DH DES released with out of date terminology and screening tools which has caused confusion in GP practices which may increase drop out rate of Alcohol LES in favour of Alcohol DES. · GPs may drop alcohol LES due to alcohol data requirement of CVD LES . |
| | **LOCAL INDICATORS** | | | | | | | | | |
| NI131 | Delayed transfers of social care from hospital | Garry Briggs | **15** | **13.6 GREEN** | **8.80** | **11 RED** | 8.8 | | ⇧ | TARGETS NEED TO BE ESTABLISHED |
| NI130 | Social Care clients receiving self directed support (under 65s) | Debbie Wright | | **160.4** | | **128.4** | | 30% | ⇩ | TARGETS NEED TO BE ESTABLISHED |
| NI146 | Adults with learning disabilities in employment | Lyn Harrington | **6.8% (+3 people)** | **6.3% AMBER** | **N/A** | **N/A annual** | 7.8% (+4 people) | 8.9% (+4 people) | no previous data available on | |

| | |
|---|---|
| | **RAG STATUS KEY:** |
| | More than 10% out |
| | up to 10% out |
| | Achieved |
| | Data missing |

**Healthier Reading Partnership.**
**6th October 2009**

## Health and Wellbeing Strategy - Proposals for completion

### Background

The Healthier Reading Partnership has recently revised its terms of reference, and is in the process of developing further its aims and objectives. As part of this, a Health and Wellbeing Strategy will be developed to provide an overarching guidance document, underpinned by an action plan. The aim is to produce a relatively short strategy, with the emphasis on the definition of clear objectives within the action plan – which are focused on the delivery of specific outcomes through partnership working.

### Current Position

A draft document was produced for consideration by the Partnership on 09.07.09. There was broad agreement about the priorities and structure of the document, but further work was required on the vision statement, and some sections of the document required additional information.

### Completion

It is proposed that the following timetable will enable the completion of the Health and Wellbeing Strategy for Reading:

| Action | Deadline | Lead |
|---|---|---|
| Completion of 2nd draft circulated by email for comment by HRP | 31.10.2009 | BS |
| Comments on 2nd draft by HRP | 30.11.2009 | HRP |
| Completion of 3rd draft for final approval by HRP | Planning Day 12.2009 | BS |
| Completion of Consultation Draft for wider circulation | 30.12.09 | BS |
| Consultation | 01.2010 – 03.2010 | TBC |
| Publication of final draft | 04.2010 | TBC |

Bev Searle. Area Director, NHS Berkshire West

| | | | |
|---|---|---|---|
| **TO:** | **HEALTHIER READING PARTNERSHIP** | | |
| **DATE:** | **6TH OCTOBER 2009** | **AGENDA ITEM:** | **8** |
| **TITLE:** | **PROPOSALS FOR HRP AWAY DAY** | | |
| **LEAD OFFICER:** | **GRANT THORNTON** | **TEL:** | **0118 939 0416** |
| **JOB TITLE:** | **HEAD OF COMMUNITY PLANNING (RBC)** | **E-MAIL:** | **grant.thornton@reading.gov.uk** |

## 1. EXECUTIVE SUMMARY

1.1 This report sets out the need for and potential content of an away day for the partnership to consolidate knowledge, understanding and effective working.

## 2. RECOMMENDED ACTION

**2.1 That the HRP agrees to holding an away day prior to its next scheduled meeting on the 14th January 2010.**

**2.2 That the HRP agrees a date and timing for this away day.**

**2.3 That the HRP delegates the detailed planning of the away day to the Management Group (taking into account the views of the partnership).**

## 3. POLICY CONTEXT

Since the HRP's initial establishment there has been a significant shift in the legislative context for partnership working and especially the role of the Local Strategic Partnership (LSP) and its delivery partnerships. Whilst the HRP shares a non-legislative status with the LSP it does have similar statutory responsibilities in relation to delivery of the Sustainable Community Strategy (SCS) and associated Local Area Agreements (LAAs). Statutory requirements on key partner agencies also include the duty to co-operate and duty to involve and are impacted collectively by the new Comprehensive Area Agreement (CAA) inspection regime. In parallel there are strong drivers for closer and more effective joint working across the spectrum of public health, mainstream community care and children's well-being.

## 4. THE PROPOSAL

### (a) Current Position:

At its last meeting the Partnership agreed to a cycle of 6 meetings per year, 4 to be on a quarterly basis with an additional 2 out of cycle meetings. It also agreed that the 1st of these meetings would be an away day. This followed on from the external review of the partnership strongly recommended that an away day be held for the core Board members of the HRP, perhaps with one or two supporting officers, at an early stage. Aim would be to give the new partnership Board an opportunity to get to know each other, gain shared knowledge of key issues, reflect on the emerging Health and Well-being Strategy and Action Plan and to think about the partnership's work programme into the future.

### (b) Options Proposed

It has not been possible to progress the away day proposal in advance of tonight's meeting for both very pragmatic workload issues and because of the need to develop further thinking on the Health and Well-being Strategy in light of the emerging evidence base and JSNA. Now that significant progress has been made it is considered that it would be highly beneficial to hold the away day in advance of the January meeting, ideally towards the end of November / early December.

The Management group has considered further the purpose and potential content of the away day. Key elements would include:

- Evidence base – JSNA
- Policy overview
- Change and transformation agendas
- Developing the Health and Well-being Strategy

The latter would be facilitated via workshops that would consider emerging challenges likely to encompass:

- Geographic inequalities and service gaps
- Similarly in relation to BME groups and communities of interest
- Preventative services and health improvement
- Financial context, joint commissioning and greater efficiencies.

Taken together these would greatly strengthen shared knowledge across the partnership, drive forward the health and Well-being Strategy and help determine the implementation priorities for the HRP and its future work programme.

# *Shaping the Future of Care Together:* briefing note


## Summary

*Shaping the Future of Care Together* is the source document (Department of Health Green Paper) behind The Big Care Debate (a national public consultation running until 13th November 2009). It contains two key concepts – the vision for **a National Care Service** and a series of **funding options**.


A new National Care Service would be defined by six elements.

1. **prevention services** – services to help people stay independent and well for as long as possible and to stop care and support needs getting worse, including a specific proposal for the right for up to 6 weeks re-ablement when people leave hospital.
2. **national assessment** – a standard assessment with central government setting the level of need at which someone qualifies for state funding. The results of the assessment would be portable – i.e. applicable when people move areas.
3. **joined up service** - one assessment for a range of care and support services which work together smoothly.
4. **information and advice** - to enable everyone, including those who pay for their care, to understand and navigate the care and support system easily.
5. **personalised care and support** - designed around individual needs, with greater choice and wherever appropriate personal budgets.
6. **fair funding** - everyone who qualifies for care and support from the state will get some help meeting the cost, and funding will be used wisely.

On funding, the government proposes three models.

**Partnership** - in which everyone who qualifies for state care and support would be entitled to a set proportion of their costs paid for by the state. The proportion would vary from, for example, a quarter or a third, to the entire amount dependent on ability to pay.

**Insurance** – in which people could choose to cover the additional costs through a voluntary insurance scheme supported by the state, building on the partnership model.

**Comprehensive** – in which everyone over retirement age who has the means would be required to pay into a state insurance scheme and everyone would receive free basic care and support.

The government also seeks views on whether it should set the amount of funding to which individuals would be entitled, which could vary in different parts of England, or whether local authorities should be able to set this amount. This would have implications as to whether social care funding should be raised through national tax or council tax.

Background

- The Green Paper proposals seek to address perceived unfairness in the current system in two respects:
    - Penalising those who have acquired assets through careful financial planning & management; and
    - The so-called 'postcode lottery' whereby the level of need at which someone is eligible for social care services varies between local authority areas.

- Consultation leading up to the Green Paper indicated that most people felt care costs should be shared between individuals and the state, but there was little consensus as to where the balance should lie.

- The stated intention is to achieve greater equality between health and social care, although how this would be achieved in some practical respects is uncertain, e.g. some commentators have suggested that moving to a national social care eligibility level could lead to transferability of funds between local authorities and the NHS?

The vision

- The vision for a National Care Service very much follows on from the priorities identified in *Our Health Our Care Our Say* and developed through *Putting People First*. The proposed move to a national eligibility level framework and the funding options proposed are new, however.

- The Green Paper seeks to accelerate moves towards a universal offer of care (whereas many self funders have had very little contact with statutory services hitherto) and a focus on preventative approaches (thought to have been sacrificed in favour of meeting most acute needs in some cases, particularly where local authorities have tightened their eligibility criteria).

- The idea of portable assessments is intended to facilitate choice and give people more options to stay in touch with families, but could raise safeguarding issues for receiving local authorities.

- In future, the local authority role in social care is expected to become more strategic – facilitating choice and control through ensuring provision of information, advice and guidance, monitoring and projecting local needs and using this information to help shape local markets.

Funding

- The Green Paper proposes combining some disability benefits, e.g. the non means tested Attendance Allowance, with social care funding. This is being opposed by various disability rights groups, and regarded by some as undermining the preventative agenda.

- The funding options proposed assume that the average 65 year old will need care costing £30k. Under the partnership arrangement, people would

contribute on average £20k. The comprehensive model would cap individual payments at around £17-20k. The cost to individuals under the voluntary insurance scheme are harder to predict and largely dependent on take up, but estimated to be in the region of £20-25k.

- Some of the issues still to be explored with the various funding options are:
    - to what extent preventative services should be part of the social care system;
    - the extent to which insurance premiums would be standardised or adjusted to reflect e.g. lifestyle choices; and
    - how local authority charging would work under the partnership model.

- The Green Paper says relatively little about those of working age who have care & support needs (which has attracted criticism, e.g. from In Control) save to say that this element of social care should continue to be funded through general taxation.

- In the part-national/part-local model the local authority would set the total amount of funding to be allocated to an individual. This would allow funding to be determined in line with local circumstances and flexibility, but could be seen as unfair since people would receive the *same proportion,* but *different amounts* of funding in different areas. This model would work with the partnership system and the comprehensive system but may be more difficult with the insurance system.

- In the fully national model, national government would set the amount of funding for each level of need, which could be consistent across the country or could vary according to location. This would seem fairer, but would make it difficult for local authorities to respond to local circumstances. It would work with all three funding options. If this approach were taken, social care funding would be raised through national taxation rather than council tax.

- The LGA is keen to see local authorities free to spend in a way which reflects local circumstance, and it opposes a national system which could undermine local accountability.

HM Government

**Care**
**Support**
**Independence**

# Join the **big**

# debate

... help shape the
**future of care** together

## The Big Care Questionnaire



visit **www.careandsupport.direct.gov.uk**

# Join the Big Care Debate and help shape the future of care and support

The Government's new Green Paper **Shaping the Future of Care Together** sets out a vision for a **National Care Service for all adults in England**. A service that is fair, simple and affordable for everyone, underpinned by national rights and entitlements and personalised to individual needs. It asks for your views on some difficult choices that we need to make for this vision to become a reality. The proposals in this Green Paper are some of the most fundamental reforms ever in this area.

## Why do we need a debate

We are an ageing society. For the first time ever there are more people over the age of 65 than there are under the age of 18. Life expectancy is going up and advances in medical science mean that people with a disability are living longer. This is worth celebrating but it does mean we need to radically change the way care and support is provided and paid for. The current system has its basis in the 1940s and there have been huge social changes in terms of what we value and what we want from public services. People now want more independence, choice and control, and we need to reflect these demands.

As a society we will have to spend more on care and support in the future. One of the most important issues we want your views on is what is fair to ask people to pay for themselves, and how we protect people from having to pay a huge bill if they need long-term residential care.

## The process

The Green Paper has been informed by a six-month engagement process that took place in 2008 in which thousands of people were asked about their views on the challenges that we face for the future and the problems with the current system.

## The debate questions

We'd like you to answer as many of these as you can, but don't worry if there are some you don't have a view on, just leave them out.

When answering these questions you may want to consider any impact our proposals may have on race, disability, gender, sexual orientation, religion, belief or age equality for you or your service users.

## 1 The vision for the future

We have suggested six key things that everyone should expect from a National Care Service and we want your views on them.

- **Prevention services**
  You will receive the right support to help you stay independent and well for as long as possible and to stop your care and support needs getting worse.
- **National assessment**
  Wherever you live in England, you will have the right to have your care and support needs assessed in the same way and you will have a right to have the same proportion of your costs paid for.
- **A joined-up service**
  All the services you need will work together smoothly, particularly when your needs are assessed. You will only need to have one assessment of your needs to access a whole range of care and support services.
- **Information and advice**
  If you need care and support, or you are preparing for it, you will find it easy to get information about who can help you, what care and support you can expect, and how quickly you can get it.
- **Personalised care and support**
  Your care and support will be designed and delivered around your individual needs. As part of your care and support plan, you will have much greater choice over how and where you receive support, and the possibility of controlling your own budget wherever appropriate.

- **Fair funding**
  Everyone who qualifies for care and support from the state will get some help meeting the cost of their care and support needs. Your money will be spent wisely to fund a care and support system that is fair and sustainable.

**1a) Is there anything missing from this list?**

**1b) How should this work?**

## 2 Making the vision a reality

We think that to deliver this vision three main changes are required to the care and support system.

- **More joined-up working** between health, housing, social care and benefits systems.
- **A wider range of care and support services**, so people have a greater range of services to choose from.
- **Better quality and innovation**. Staff must have the right training and skills, and services should be based on the best and most recent information about what works well in providing care.

2a) Do you agree?

2b) What would this look like in practice?

2c) What are the barriers to making this happen?

## 3 Funding care and support in the future

We will achieve this vision by making better use of taxpayers' money so funding is focused on people who can benefit from it and need it most. But the money in the system at the moment won't pay for all of everyone's care in the future.

In deciding how to fund care and support, there are some very difficult decisions to make.

### Funding options

We have therefore proposed three options for funding a National Care Service.

**(i)** **Partnership:** The responsibility for paying for care and support would be shared between the Government and the person who has care and support needs. The Government provides between a quarter and a third of the cost of care and support, more for people on a low income. Today's 65-year-olds will need care and support costing on average £30,000.

The Partnership system would work for adults of all ages. Under this system we expect many people born with a care and support need to qualify for free care, as they do under the current system. Those working-age adults who do not qualify for free care (those who are better off) would have the same offer around funding as people over 65.

**(ii)** **Insurance:** The same as Partnership but the Government could help people prepare to meet the costs that they would have to pay for themselves through an insurance-based approach. As well as providing people with between a third and a quarter of the cost of care and support, the Government would make it easier for people to take out insurance to cover care and support costs if they want it. It is estimated that the cost of insurance could be around £20,000 to £25,000.

The Insurance part of the second option would be likely to be less relevant to people who have been born with a care and support need, since people cannot insure against the risk of something that has already happened. However, many people born with a care and support need are likely to qualify for free care under the Partnership element of the system.

**(iii) Comprehensive:** Everyone over retirement age who can afford it would pay into a state insurance scheme, so that everyone who needs care and support will receive it free. It is estimated that the cost of being in the system could be between £17,000 and £20,000.

The Comprehensive system would be for people over retirement age, but we would also look at having a free care and support system for people of working age alongside this.

We have ruled out a system based on tax funding, because it would put a large burden of paying for care and support on people who are working. Given demographic changes, there will be an increasing pressure on a shrinking proportion of working-age people. In 2007, the number of people aged over 65 became greater than the number of people under 18 for the first time. Because the majority of people benefiting from a reformed care and support system will be pensioners, it is fairer to think about more targeted ways of bringing in extra funding, rather than placing a lot of the burden of the system on people of working age.

### Disabled people of working age

At the moment, people who are disabled when they are born, or who become disabled during their working lives, are likely to have lower incomes and so will struggle to meet the cost of their care and support. In the future, more disabled people will be working, but those who are on low incomes will have their care and support funded by the state.

### What about accommodation costs?

It is important to note that these options consider only the cost of people's care and support. People entering a care home would have to pay for their accommodation costs, such as the costs of food and lodging. This is because the state would not pay for people to buy their food or pay their mortgage or rent if they were living at home.

Of course, the state will always have a role in supporting people who are in a care home who cannot afford these costs.

3a) Which of the three funding options do you prefer and why?

## A national or local system?

We believe that the care and support system should be fair and universal. But we also need to ensure that the system is flexible enough to respond to local circumstances and encourage innovative approaches. There could be two different approaches to how the system works – either a part-national, part-local system or a fully national system. The two approaches have different implications for the way money is raised and distributed around England.

3b) Should local government say how much money people get depending on the situation in their area, or should national government decide?

If you want to learn more or run your own Big Care Debate and tell us about it, there are some materials that can help you and can be downloaded at **www.careandsupport.direct.gov.uk**

The Big Care Debate lasts until 13 November 2009.

## About you

Please provide us with some information about yourself. This will help us to determine whether we have captured the views of everyone. All the information you provide will be kept completely confidential. No identifiable information about you will be passed to on to any other bodies, members of the public or press.

**What is your sex?**

- ☐ Male
- ☐ Female

**Which age group do you belong to?**

- ☐ Under 18
- ☐ 18–24
- ☐ 25–34
- ☐ 35–44
- ☐ 45–54
- ☐ 55–64
- ☐ 65–79
- ☐ 80 yrs and over

**What region do you live in?**

- ☐ London
- ☐ South East
- ☐ East of England
- ☐ South West
- ☐ East Midlands
- ☐ West Midlands
- ☐ North East
- ☐ North West
- ☐ Yorkshire and Humberside

**What is your marital status?**

- ☐ Single
- ☐ Married/living as married/civil partner
- ☐ Divorced/separated/widowed

**What is your current working status?**

- ☐ In work
- ☐ Unemployed
- ☐ Retired
- ☐ Student

**Do you have any children in your household?**

- ☐ Yes
- ☐ No

**Do you own your home?**

- ☐ Yes
- ☐ No

**Which of the following descriptions best reflects your involvement in the care and support system at the moment?**

- ☐ A member of the public with an interest in care and support issues
- ☐ Care user
- ☐ Informal carer
- ☐ Professional worker in the sector
- ☐ Representing individual carers and care users
- ☐ Representing other organisations supporting carers and care users
- ☐ Representing managers and professional workers in the social care sector
- ☐ Representing individuals and organisations responsible for commissioning or delivering social care
- ☐ Academic/research organisation/think tank
- ☐ Central government department/agency/non-departmental public body
- ☐ Other (please specify)

**What is your ethnic group?**

**White**

☐ British ☐ Irish

Any other White Background, please write below

**Mixed**

☐ White and Black Caribbean ☐ White and Black African

☐ White and Asian

Any other Mixed Background, please write below

**Asian or Asian British**

☐ Indian ☐ Pakistani ☐ Bangladeshi

Any other Asian Background, please write below

**Black or Black British**

☐ Caribbean ☐ African

Any other Black Background, please write below

**Chinese or other ethnic group**

☐ Chinese

Any other, please write below

---

**Do you have a disability as defined by the Disability Discrimination Act (DDA)?**

☐ Yes ☐ No

The Disability Discrimination Act (DDA) defines a person with a disability as "someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities".

If yes, please tick all which apply

☐ Partial or total loss of hearing
☐ Partial or total loss of vision
☐ Speech impediment or impairment
☐ Mobility impairment or difficulty moving around
☐ Learning difficulty or learning disability
☐ Mental health condition or disorder
☐ Severe physical disfigurement
☐ A longstanding illness or disease
☐ Other medical condition or impairment (please specify)

---

**What is your religion or belief?**

☐ Christian ☐ Buddhist ☐ Hindu
☐ Jewish ☐ Muslim ☐ Sikh
☐ Other (please write below)

---

**Which of the following best describes your sexual orientation?**

Only answer this question if you are aged 16 years or over.

☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual
☐ Other ☐ Prefer not to answer

## Find out more

Building a new system for care and support is not a simple task. It is vital we get the views of everybody affected, and that is why we're inviting and encouraging everyone to participate in the debate.

- ☐ If you are interested in receiving materials to help take this important debate forward, please tick this box and complete your details below.
- ☐ If you would like to receive further communications from the Department of Health on care and support, please tick this box and complete your details below.
- ☐ If you would like to receive further communications from the Department of Health on wider policy areas, please tick this box and complete your details below.

Title

First name

Surname

Email address

Telephone

Postal address

The Department of Health will not share your details with any third parties.

**Confidentiality of information**

Please be aware that under the Freedom of Information Act 2000, we may be asked to share the information we receive as part of this consultation.

If you would like your response to remain confidential, it would be helpful if you could explain why. If we receive a request to disclose the information, we will take full account of your explanation but we cannot guarantee that confidentiality can be maintained in all circumstances. Your name, address and any other personal data as defined under the Data Protection Act is exempt from disclosure.


1p 12k (SMP)
If you require further copies of this title visit
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Minicom: 0300 123 1003 (8am to 6pm Monday to Friday)



Gateway reference 12462

## SPECIAL SCRUTINY MEETING ON CHILDREN'S HEALTH: Update

A special scrutiny session on Children's Health and Education for members of the Housing Health and Community Care and Education and Children's Services scrutiny panels is being held on Wednesday 14 October 2009.

The aim of the joint scrutiny meeting is to consider the relationship between poverty and deprivation and children's health outcomes and educational attainment.

A report has been produced for members of the panels which provides an overview of poverty and deprivation in Reading, including local population and demographic data relating to children and young people. The report goes on to consider some of the social and environmental factors that can impact on health and education outcomes and summarises some key evidence around the factors that can influence lifestyle and behaviour change.

In addition, nine topic areas were selected by scrutiny for particular attention. Further information on the following topics, consisting of local and comparative data, a summary of current action, gaps and opportunities for further development has been produced.

1. Teenage pregnancy
2. Substance Misuse
3. Smoking in pregnancy
4. Childhood immunisations
5. Oral Health
6. Infant Mortality
7. Childhood obesity
8. Breastfeeding
9. Early Years Foundation Stage Profile

Following the joint scrutiny meeting, the papers and outputs from the session will be circulated to the Healthier Reading Partnership for information and consideration.