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Notice of Meeting

Health and Wellbeing Board

Thursday, 22nd January 2015 at 9.00am

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 14 January 2015

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jessica Bailiss on (01635) 503124
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Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Dr Barbara Barrie (North and West Reading CCG), Leila Ferguson (Empowering West Berkshire), Councillor Marcus Franks (Portfolio Holder for Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Councillor Gwen Mason (Shadow Health and Wellbeing Portfolio Holder), Councillor Irene Neill (Portfolio Holder for Children and Young People), Matthew Tait (NHS Commissioning Board), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs), Nikki Luffingham (NHS England Thames Valley) and Councillor Keith Chopping (Portfolio Holder for Community Care)

Also to: Jessica Bailiss (WBC - Executive Support), Nick Carter (WBC - Chief Executive), Andy Day (WBC - Strategic Support), Councillor Quentin Webb, Councillor Graham Pask, Tandra Forster (WBC - Adult Social Care), Shairoz Claridge (Newbury and District CCG), Councillor Roger Hunneman (Deputy Liberal Democrat Group Leader), Mark Evans (Head of Children's Services), Dr Abid Irfan (Newbury and District Clinical Commissioning Group), Councillor Peter Argyle, Councillor Adrian Edwards, Tony Quinn (Empowering West Berkshire) and Dr Rupert Woolley (North and West Reading CCG)

Agenda

Part I

			Page No.
9.50 am	11	**Finalisation and Agreement of the Health and Wellbeing Strategy (Lesley Wyman)** Purpose: To finalise and agree the Health and Wellbeing Strategy post the consultation period.	3 - 82

Andy Day
Head of Strategic Support

If you require this information in a different format or translation, please contact Moira Fraser on telephone (01635) 519045.

Title of Report:	Health and Wellbeing Strategy – updated version
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	22 January 2015

Purpose of Report:

To share with the Health and Wellbeing Group the amended Health and Wellbeing Strategy following a Public Consultation in November 2014.

Recommended Action:

That the Health and Wellbeing Board adopt this amended Health and Wellbeing Strategy from March 2015.

That the Health and Wellbeing Board make suggestions to improve or clarify any part of the Strategy necessary.

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Executive Report

The Health and Wellbeing Strategy was redrafted and went out for consultation to all stakeholders and the general public from October 27th till November 21st. The consultation was conducted by Healthwatch as agreed at the Health and Wellbeing Board. The final report is attached as appendix 1. This was received on December 9th, 2014.

212 people completed surveys that produced 1685 items of information. 10 people completed the optional long survey. 92% of responders were members of the public. There was a good range of ages of respondents:

15% (n=30) 17 and under,
15% (n=31) 18-29 yos
50% (n=100) 30-49 year olds,
18% (n=37) over 50 yos.

The full survey comments and statistics produced via survey monkey were in excess of 400 pages plus the full notes from the 4 public meetings are available as a separate report. A precis of the collated items are contained within the Final report in appendix 3.

Overall the Health and Wellbeing Strategy was found to be intentional and informative with clear, high level detail. Support for all priorities was in excess of 65% of all respondents.

Details of comments and suggestions and how each of these has been addressed are set out in appendix 1.

Appendix 2 is the amended strategy for consideration by the Health and Wellbeing Board

There was considerable support for the need to include an Implementation Plan within the strategy, showing how the aims of the strategy would be achieved and how each priority would be addressed. There are different ways to achieve this however it is proposed within the Strategy that a multi-agency group is set up to develop the Strategic Implementation Plan that will set out the specific actions that will needed to be taken in partnership to ensure that the priorities are addressed. The Health and Wellbeing Board will be able to have feedback on progress being made throughout the year.

1.1 Members of the group could include the following:

- Public Health and Wellbeing representative
- Adult Social Care representative
- Children's services representative
- Voluntary sector representatives - Learning disabilities, mental health, carers
- Service user representatives
- CCG representative
- community service provider
- secondary care service provider
- community safety representative
- Housing association representative
- Minority ethnic groups representative
- Community groups representative

In setting up such a group consideration will need to be given to the capacity of individuals to take part and the resources needed to support the group. The group would need to be clear and focused on the task and small task and finish groups could work on specific priorities that are most relevant for them. In this way there will be a clarity of purpose and a link in to the performance framework.

.**Appendices**

Appendix 1 – details of the comments made within the consultation and the changes made to the Strategy as a result.
Appendix 2 - The Health and Wellbeing Strategy following the consultation.
Appendix 3 - the full consultation report

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Appendix 1

Detailed comments and actions taken in response

The consultation report sets out the reasons for including each of the priorities and why is each one important within West Berkshire. Respondents were asked to agree or disagree with each of the 11 priorities. Support for all priorities was in excess of 65% of all respondents.

Respondents were then asked to consider each priority, through answering the following questions:

Priority
- Why is it important?
- What is the picture in West Berkshire?
- What we will do.
- How we will do it.
- How we will measure what we have done

Two priorities were challenged as they were written:

51 respondents or 25.37% disagreed with **alcohol** as a priority area
27 people disagreed with **healthy weight** as a priority.
All the other priorities had less than 7 respondents who did not agree them as priorities for West Berkshire.

As a result of these comments these two priorities have been expanded to include additional areas of focus:

- **Priority 5 - Alcohol is changed to Health damaging behaviours :**

  i. We will promote sensible and safe drinking and increase the number of people receiving effective and timely support for alcohol related problems

  ii. We will promote smoke free lifestyles and environments.

- **Priority 6 - Healthy weight is changed to healthy weight and physical activity :**

  We will maintain or increase the number of people who are a healthy weight, by promoting physical activity and healthy eating and providing a range of evidence based weight management interventions and more opportunities for residents to be physically active.

The West Berkshire JSNA demonstrates a clear need to address obesity and drinking alcohol above safe and sensible levels in order to prevent mortality and morbidity from cardiovascular disease, (coronary heart disease (CHD), stroke, diabetes and chronic kidney disease), as well as cancer and liver disease. In addition these two risk factors increase hospital admissions and use of health care services in primary and secondary care.

Respondents were also asked to list any priorities they felt were missing. The 3 topics of note were cancer and terminal illness – 13 responses (6%), maternity – 9 responses (4%) and children's illnesses – 6 responses (3%). As a result of this cancer was added to the priority of cardiovascular disease. It was felt that terminal illness falls under the priority of addressing long term conditions and end of life care.

- **Priority 7 - cardiovascular disease is changed to cardiovascular disease and cancer**.

  We will improve the prevention and early identification of cardiovascular disease and cancer in primary care and community settings through the provision of NHS health checks and screening and ensure access to high quality secondary care services.

One additional priority was added to as a result of comments re the need to tackle loneliness and social isolation as well as mental health and well being. Thus:

- **Priority 4 – mental health and wellbeing in adults is changed to**

  We will promote mental health and wellbeing in all adults through prevention, early identification and provision of appropriate services. We will tackle loneliness and social isolation.

A number of themes attracted considerable number of responses:

1. The importance of education in improving health and wellbeing, especially of young people.
   - This view will be reflected in the implementation of the strategy
2. The need to recognise the importance of long term conditions in relation to the demands of acute care
   - This view is already reflected in priority 9
3. Agreement on the focus on mental health and wellbeing as well as physical health
   - Reflected in priority 1 for children and young people and 4 for adults
4. The need to include physical activity as a priority in addition to tackling overweight and obesity
   - This view has been reflected in the change made to priority 6.

There was considerable support for the need to include an **implementation plan** within the strategy, showing in more detail how the aims of the strategy would be achieved and how each priority would be addressed. This view was also demonstrated by those responding in the longer survey, in that 70% did not agree or disagree that the strategy would be able to drive commissioning of health, social care and other services that impact on health and wellbeing.

Many of the general points raised in the consultation relate to how the priorities can be addressed and there are many ideas that could be incorporated into an implementation plan.

Further views and suggestions that can be incorporated into the strategy itself are clearly set out in the full consultation report (appendix 3). Some of these relate to suggestions for how to measure progress against each priority and others make more general points to be considered. A sample for each priority includes:

Priority 1 - emotional health and wellbeing of children and young people

- outcome measures only focus on children with a specific problem (no universal measure). A suggestion on how to measure outcomes for all children is to use a school survey. This could be considered depending on capacity and resources available.
- the importance of using Child and Adolescent Mental Health Services (CAMHS) and Talking Therapies to keep children and young people from entering the criminal justice system and being labeled.

Priority 2 - health and wellbeing of looked after children

- ensure measures of academic success are compared to those who are not looked after and other cohorts.

Priority 3 - tackling inequalities in health and wellbeing in children and young people

- plea for the use of other measures besides children on free school meals achieving academically
- Many points were made about why some children do not achieve - young carers, learning disabilities, mental health problems, rurality, ethnicity. These issues would need to be addressed.
- The possibility of introducing a measure relating to the health and wellbeing of young people not in education, employment or training (NEETs)

Priority 4 - mental health and wellbeing of adults

- a concern about the measures of success being too focused on depression
- Plea to include post-natal depression as a focus.

Priority 5 – alcohol

- Suggestions to widen the priority to other unhealthy behaviours including tobacco (this has been included)
- concern that mental health and alcohol might not be addressed

Priority 6 - healthy weight

- the importance of including physical activity in addition to healthy weight (this has been included)

Priority 7 - cardiovascular disease

- responders wanted to see a clear, comprehensive pathway that includes prevention and early identification

Priority 8 - carers

- need to specifically reference young carers

Priority 9 - long term conditions and disabilities

- want more focus on the prevention of long term conditions and maintaining independence
- Want more re young people with long term conditions

Priority 10 - falls prevention

- suggestion of using a measure of re-admissions to hospital following a fall

Priority 11 - dementia

- the inclusion of a number of comments about the difficulty of addressing dementia, recognising early dementia, measuring quality of life for those with dementia and involving carers.

The outcome measures, both longer term and shorter term, local indicators have yet to be agreed within the accompanying Performance Framework. This work is under way and all comments will be taken into consideration.

A further number of points that need to be included within the strategy include:

- demonstrating a link to other strategies e.g. Safer Communities Strategy
    - a flow diagram will be included in the strategy showing how strategies and plans link together strategically.
- involve service users in the development of action plans and making sure there is a customer voice
    - a section already exists within the strategy explaining the importance of the public and service users. More explanation has been added to show how an action plan will be developed with wider involvement from all sectors.
- the importance of including workplace health
    - the workplace is an importance setting to address health and wellbeing and this will be part of the implementation plan, focusing on both public and private sector workplaces.

- working with service providers to get their views and ideas

    - service providers will be included in development of the overall implementation plan to ensure that local projects and programmes of work are realistic and achievable.

- work with Fora that already exist e.g. Mental Health Forum, Domestic Abuse Forum

    - Existing multi-agency For a will be mapped and links made to all of them

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Appendix 2

Draft

West Berkshire Health and Wellbeing Strategy

2015 - 2018

Foreword – To be completed after the Health and Wellbeing Board meeting by Councillor Marcus Franks (Portfolio Holder for Health and Wellbeing, West Berkshire Council, Chair of Health and Wellbeing Board)
and Dr Bal Bahia (Clinical Lead, Newbury and Community Clinical Commissioning Group, Vice-Chair of Health and Wellbeing Board)

Introduction

In West Berkshire we want to help people live longer, healthier and more fulfilling lives, and to improve the health of the poorest, fastest. Good health and wellbeing will be achieved by work on many fronts:

- ✓ Ensuring value for money, high quality health and social care services are accessible to all who need them
- ✓ protecting people in emergencies and adverse weather conditions and from communicable diseases,
- ✓ preventing ill health and disease
- ✓ promoting positive health and wellbeing through increasing awareness of health risks and enabling individual behaviour change
- ✓ creating environments where healthy choices are the easy choices
- ✓ tackling inequalities in health, making the health and wellbeing of the people who are the worst off in our district as good as that of the most affluent.
- ✓ partnership working between the NHS, the Local Authority, the Voluntary and Community Sector, the Private Sector and the residents and service users of West Berkshire

Health and wellbeing will be promoted throughout the life course, ensuring services are accessible from pre-conception to the end of life. The NHS, Local Authorities and the third sector are working more closely together to ensure integrated health and social care that is evidence based and value for money, helping vulnerable groups and those with long term conditions and disabilities to be as healthy and independent as they can be.

The picture of health and wellbeing in West Berkshire

- Life expectance at birth is 80.8 years for males and 84.6 years for females. This is better than the national and regional levels. On average a man in West Berkshire can expect to live in good health until he reaches 67.5 years and a woman until she is 68.8. This is better than the national average and similar to the rest of the south east.
- Early deaths from CHD, stroke and cancer have fallen over the last 10 years and the death rates of all of these are lower than national averages.
- Deprivation levels are generally low with long term unemployment, homelessness and levels of violent crime all better than national and regional averages.
- The health and wellbeing of our young people is generally good with lower levels of under 18 conceptions and under 18 alcohol related hospital stays lower than national and regional rates.
- The prevalence of obesity in reception and in year 6 children has slightly decreased since measurements began in 2006/7.

The challenges

- Life expectancy is 6.4 years lower for men and 4.4 years lower for women in the most deprived areas of West Berkshire than in the least deprived areas.
- Smoking prevalence is 18.8% which is higher than the regional average
- 65.5 % of adults are classified as overweight or obese which is slightly higher than regional and national levels
- The rate of people killed and seriously injured on the road is worse than the national average.
- Most hip fractures in adults aged 65 and over are caused by a fall, which can lead to a loss of mobility and independence. Between 2008/09 and 2012/13, 92.3% of hospital admissions for hip fractures in 65+ in West Berkshire were emergency admissions (see falls prevention section).
- There were 1700 alcohol related hospital admissions in West Berkshire in 2012/13 (based on primary and secondary diagnoses).

The Vision for Health and Wellbeing in West Berkshire

All children, young people and adults will have the opportunities to achieve their potential and lead healthy, happy and safe lives. Inequalities in health will be tackled and vulnerable groups supported. There will be access to timely, integrated health and social care services, ensuring rural areas are well served. Our communities will be enabled and empowered to have control over their own health and wellbeing and wider determinants of health will be addressed in partnership.

This shared vision for what success will look like will enable partners to commit to making the best use of public money by working in new ways and sharing resources, including finance, people, buildings and information.

To accomplish our vision our services will be

- Delivered relative to need, ensuring areas with the highest need are targeted to address health inequalities
- accessible to all, taking into account disabilities, rurality and working patterns
- based on integrated care pathways, with all relevant providers working together to maximise the benefits of delivery
- evidence-based and providing value for money
- socially, economically and environmentally sustainable

This Health and Wellbeing Strategy sets out 11 key priorities, derived from the Joint Strategic Needs Assessment (JSNA)), that details West Berkshire's population and its needs, national and local drivers, service users' and carers' views, expert opinion and the evidence base for interventions.

Overarching aims that drive the strategy:

- To prolong life expectancy at birth, whilst maintaining a high quality of life in later years
- To decrease the death rates from all causes, especially for those under the age of 75 years
- To decrease the gap in life expectancy between the least well off in our district and most affluent.

The priorities include promoting healthier lifestyles and positive mental health and wellbeing throughout the life course, preventing ill health plus providing integrated, high quality services though joint working, bringing together health, social care and the voluntary and private sector.

West Berkshire Health and Wellbeing Priorities

Emotional wellbeing	1. We will promote emotional wellbeing in children and young people, through prevention, early identification and provision of appropriate services
Looked After Children	2. We will improve the health and educational outcomes of looked after children through prevention and the provision of high quality health and social care support and services
Tackling inequalities	3. We will improve the educational achievement of children on free school meals to bring them into line with the overall achievement of all children
Mental health and wellbeing	4. We will promote mental health and wellbeing in all adults through prevention, early identification and provision of appropriate services. We will tackle loneliness and social isolation
Health damaging behaviours	5. i. We will promote sensible and safe drinking and increase the number of people receiving effective and timely support for alcohol related problems ii. We will promote smoke free lifestyles and environments.
Healthy weight and physical activity	6. We will maintain or increase the number of people who are a healthy weight, by promoting physical activity and healthy eating and providing a range of evidence based weight management interventions and more opportunities for residents to be more physically active
Cardiovascular disease and cancer	7. We will improve the prevention and early identification of cardiovascular disease and cancer in primary care and community settings through the provision of NHS health checks and screening and ensure the provision of high quality secondary care services
Carers	8. We will promote the health and wellbeing of carers, including young carers
Long term conditions	9. We will deliver integrated services to support and maintain the independence of people with long term conditions and disabilities and ensure end of life care needs are addressed
Falls prevention	10. We will maximise independence in older people by preventing falls, reducing preventable hospital admissions due to falls and improving rehabilitation services.
Dementia	11. We will improve the lives of those residents with dementia through early identification, the provision of excellent, integrated care and support and increased community awareness of dementia.

Accessibility Integration Effectiveness Sustainability Preventative

Why are these the priorities for West Berkshire?

PRIORITY 1 – EMOTIONAL WELLBEING OF CHILDREN AND YOUNG PEOPLE

Just like physical health, having good emotional health at a young age promotes good emotional health in adulthood. Half of all adults with a chronic mental health problem first experiences symptoms before the age of 14. Poor mental health at a young age can have an impact on educational attainment, poorer physical health and social skills as well as increase the risk of behaviours such as self harm and suicide.

There are higher levels of mental health problems among the following groups of children and young people; those with learning disabilities, disabled children, looked after children, leaving care, children with special educational needs, young carers, young offenders and children in custody, teenage parents, substance misusers, those that have witnessed domestic abuse or those that have experienced physical, emotional or sexual abuse. We need to ensure that services are able to serve the needs of these vulnerable groups.

Promoting the emotional wellbeing of children and young people can be achieved by ensuring that children and young people have good mental health. It is important that children and young people have good self esteem, develop resilience and are able to build positive relationships.

What is the picture in West Berkshire?

- An estimated 1,360 boys aged 5 to 16 in West Berkshire have a mental health disorder
- An estimated 895 girls aged 5 to 16 in West Berkshire have a mental health disorder
- Around 790 referrals were made to the Children and Adolescent Mental Health Service in West Berkshire. In addition, 26 young people were admitted to the Berkshire Adolescent Unit with mental health problems including self harm, eating disorders, psychosis and affective disorders.

PRIORITY 2 – LOOKED AFTER CHILDREN

Children who have become looked after as a result of a legal order or who have been accommodated on a voluntary basis in agreement with their parents/carers, are one of the most vulnerable groups in society. Children enter care for a range of reasons including physical, sexual or emotional abuse, neglect, or family breakdown. Children in care generally have significantly higher levels of health needs than children and young people from comparable socio-economic backgrounds who have not been looked after. Their life opportunities and long term outcomes are also often much poorer and poor health is a factor in this. Past

experiences, including a poor start in life, removal from family, placement location and transitions mean that these children are often at risk of having inequitable access to health services, both universal and specialist. Promoting the health and wellbeing of these looked after children are therefore paramount.

What is the picture in West Berkshire?

- At March 2013, West Berkshire Council was responsible for 144 looked after children. This was a rate of 40.0 looked after children per 10,000 population under 18 – a rate lower than the England average (60 per 10,000). By October 2013, this had increased to 158 children.
- The number of unaccompanied asylum seeking children looked after by West Berkshire Council is fairly stable, and was 10 as at March 2013.
- There are more boys than girls in care in West Berkshire, and this is also true of unaccompanied asylum seeking children.
- The majority of looked after children are placed in family settings with foster carers or adoptive carers (82% at the 31st March 2013) with the rest placed in other settings according to their individual needs (children's homes, specialist homes or nursing establishments or independent living).
- All children in care are subject to a health plan. Health assessments must be undertaken twice a year for children under 5 years, and annually for children and young people aged 5 years and over. The proportion of looked after children who receive an annual health assessment and regular dental checks is quite high (74% for medicals and 83% for dental checks as at October 2013).

PRIORITY 3 – TACKLING INEQUALITIES – CHILDREN

The Marmot Review of Health Inequalities highlighted the social gradient in health whereby the lower your socioeconomic status the poorer your health outcomes. Health inequalities arise from a variety of social determinants of health including income, educational attainment, and environmental factors, such as poor housing or access to green spaces. These factors not only affect children living in poverty but also vulnerable children. By working with children's services, housing, planning, environment and leisure services, Public Health and Wellbeing can work towards improving health outcomes and tackle health inequalities.

What is the picture in West Berkshire?

- In West Berkshire, there are an estimated 3,350 (11.2%) children (16 and under) living in poverty.
- 56% of pupils in Key Stage 2 (aged 7 to 11 years) known to be eligible for free school meals achieved level four or above in reading, writing and mathematics compared with 79% of all other pupils, a gap of 23 percentage points.
- 4,858 16-18 year olds are known to West Berkshire Council. It is estimated that 4.4% (210 individuals) of these children were Not in Education, Employment, or Training (NEETs), which is lower than the national average. Some young

people are more likely to be NEET. These are children of parents who are NEET, teenage parents, young people with a learning disability or mental health problem, and people with alcohol or substance misuse problems. Similarly, disadvantaged pupils who have been excluded or suspended from school, those with children and those who have a disability are more likely to be NEET.

- The National Child Measurement Programme (NCMP) measures the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess the prevalence of overweight and obesity in primary schools. The data demonstrates a strong correlation between deprivation and obesity prevalence nationally.

PRIORITY 4 – MENTAL HEALTH AND WELLBEING IN ADULTS

Mental health and wellbeing consists of how we think and feel (our emotions and satisfaction with life) and how function (good relationships with others, having a purpose in life). We all have mental health and anyone can experience good or poor mental health and wellbeing. In any given year, one in four adults in the UK will experience a diagnosable mental health problem, with mixed anxiety and depression being the most common. There are a variety of risk factors for poor mental health and wellbeing which include; poverty, discrimination, violence, abuse, peer rejection and isolation, stressful life events (such as bereavement and relationship problems) and poor physical health. Conversely, there are also factors that can positively affect mental health and wellbeing. These include; economic security, empowerment, feelings of security, positive interactions with others, physical activity, stable and supportive family environments and a healthy diet and lifestyle.

Poor mental health can impact on physical health in the same way that poor physical health can impact on mental health. For example, poor mental health can increase the risk of cancer, back pain and irritable bowel and reduce life expectancy. National research has shown that around 30% of people with a long term condition also have a mental health problem. Some unhealthy behaviours (such as smoking, excess alcohol consumption, overeating etc) are used to control stress or boast mood.

It is important that we work to; understand and prevent mental health problems, to ensure that we achieve a parity of esteem (by ensuring that we value mental health equally with physical health) and that we promote positive mental health and wellbeing among those living with or recovering from a diagnosable mental health problem and the general population.

The New Economics Foundation (NEF) identifies research that promotes five actions (known as the five ways to wellbeing) that encourage action to improve our mental health and wellbeing; connect, keep learning, give, take notice, and be active. Positive mental wellbeing is associated with good physical health, good

resilience, reduced mental ill health, improved education attainment and reduced risky health behaviours.

"Loneliness can be defined as a subjective, unwelcome feeling of lack or loss of companionship" (Campaign to End Loneliness, 2014). Research has shown that being lonely and socially isolated can affect both physical and mental health and wellbeing. Research has shown that lacking social connections can be as damaging to health as smoking 15 cigarettes per day (Holt-Lunstad, 2010). People that are lonely are more likely to experience depression and have a higher number of GP visits.

Anyone can be affected by feelings of loneliness, but it can worsen as you get older. The personal risk factors for loneliness include; poor health, sensory loss, loss of mobility, lower income, bereavement, retirement, becoming a carer. Additional, there are external risk factors for loneliness which include; lack of public transport, housing, fear of crime and the physical environment (for example no public toilets or benches).

What is the picture in West Berkshire?

- Around 125 people in every 100,000 people living in West Berkshire are admitted to hospital due to mental ill health. This is lower than the national and regional average. In West Berkshire, about 7 people in every 100,000 commit suicide (or injury of undetermined intent).
- An estimated 4,467 (9%) people with depression and/or anxiety in Berkshire West (across Reading, Wokingham and West Berkshire) are receiving treatment through Increasing Access to Psychological Therapies (IAPT). The national rate is 6% of people receiving treatment. Uptake of psychological therapies is higher than the national and regional average, 70% of adults (aged 16+) who are referred for psychological therapy enter into psychological therapies.
- The rate of people recovering from psychological therapy treatment is also higher than the national and regional average. Around 55 people out of every 1,000 people who have completed a psychological therapy treatment were moving towards recovery in 2011/12.
- Significantly more people registered with GP Practices in West Berkshire LA are recorded as having depression than the national, regional, and Berkshire West average.
- 14,718 people registered with GP Practices in West Berkshire LA are on clinical registers recorded as having depression. This equates to 13% of the GP list size population.
- Around 2,150 people aged 65 and over living in West Berkshire are estimated to have depression. By 2020, an estimated 2,672 people aged 65 and over are predicted to have depression.
- Nationally published data for 2010/11 suggests that, in West Berkshire LA, significantly fewer (2.5%, count = 5) of adults in contact with secondary mental

health services are in employment than the national (9.5%) and regional (7.9%) averages. However, we know that this is likely due to a change in the system used for recording this national data. Locally produced figures suggest that closer to 15% of adults in contact with secondary mental health services in West Berkshire LA are in employment. It is expected that the national figure will return to previous levels in 2012/13 once recording issues are resolved.

- An estimated 1,679 people aged 65 and over living in West Berkshire have dementia. This number is expected to rise by almost 500 people to 2,176 in 2020.
- Around 9,000 people aged 65 and over live alone
- 2,000 people aged over 65 are estimated to have depression
- Around 125 people in every 100,000 people living in West Berkshire are admitted to hospital due to mental ill health
- 15,000 (13%) people registered with GP practices in West Berkshire are recorded as having depression. This is greater than the national and regional average

PRIORITY 5 – HEALTH DAMAGING BEHAVIOURS - ALCOHOL AND SMOKING

Although the majority of people drink alcohol responsibly, alcohol misuse is a priority for public health for a number of reasons. Excess alcohol consumption can cause health problems such as liver cirrhosis, obesity, mental health problems such as depression, reduced fertility, high blood pressure, increased risk of cancer, accidental injury, violence, sexually transmitted infections and alcohol dependency. Excess alcohol consumption can also affect the wellbeing of family, friends and the wider society through problems such as crime and anti social behaviour.

Cigarette smoking has an adverse affect on health and is a major cause of death in the UK. Cigarette smoke contains nicotine, tar and carbon monoxide which means both the mind and the body are affected. Nicotine withdrawal can increase cravings, anxiety and headaches. Tar can deposit in the lungs and enter the blood stream. This can make blood thicker, increasing the chance of clot formation. Carbon monoxide can put a strain on the heart and affect the amount of oxygen that enters the body.

One in two smokers will die from a smoking related disease. Smoking causes the following smoke related diseases; lung and other cancers, chronic obstructive pulmonary disease (COPD) and heart disease. Smoking also affects blood circulation, signs of ageing, fertility, menopause. Smoking increases the risk of having a stroke by up to 50%.

Smoking during pregnancy means that the baby is exposed to the 4,000 chemicals contained in cigarette smoke. This can affect the amount of oxygen the

baby which can have an effect on growth and development. Once born, the baby can go through nicotine withdrawal that can make them stressed and irritable.

Stopping smoking is beneficial to health and once someone stops smoking their body starts to recover and some damaged caused by smoking is reversed after years of non smoking.

What is the picture in West Berkshire?

- In 2013/14, there were 130 adults accessing structured alcohol treatment in West Berkshire.
- Estimates of binge drinking behaviour suggest that just fewer than 18% of the population aged over 18 years of age in West Berkshire LA engage in binge drinking. This is comparable to the national and regional averages of 20% and 18% respectively.
- An estimated 19% of the West Berkshire LA population engage in increased risk drinking (quantified as more than 3 to 4 units on a regular basis for men and more than 2 to 3 units for women).This would equate to over 20,000 people in West Berkshire LA risking damage to their health through the misuse of alcohol (LAPE , 2013).
- An estimated 7% of the West Berkshire LA population engage in higher risk drinking (quantified as more than 50 units a week for men and more that 35 units a week for women), which translates to almost 9000 people in West Berkshire LA are seriously damaging their health through alcohol misuse (LAPE, 2013).
- There were a total of 1,185 hospital admissions related to alcohol for residents of West Berkshire LA during 2009/10. Although, 13% of these admissions had a cause specific to alcohol use, people from West Berkshire LA are significantly less likely than the national and regional average to be admitted to hospital for conditions specific to or attributable to alcohol.
- Admissions due to alcohol have increased for both males and females from West Berkshire LA since 2004. Although this rise in admissions has stabilised for males, it is continuing to rise for females.
- The rate of crime in West Berkshire that is estimated to be attributable to alcohol has decreased steadily over the past five years to a rate of fewer than 6 crimes per 1,000 people. This is lower than the national and South East Region averages and is lower than the average for Local Authorities with similar levels of deprivation as West Berkshire. However, despite the overall fall in crimes estimated to be due to alcohol in West Berkshire, the rate of sexual crimes due to alcohol has remained fairly constant. This is a similar pattern to the one seen across the Country and Region.
- There is data available that reveals the number of benefit claimants whose main medical reason to not work is alcoholism. This is shown as a rate per 100,000 people who are of working age. Around 50 people in every 100,000 people of working age in West Berkshire are claiming these benefits for reasons of alcoholism.

- Smoking prevalence in West Berkshire LA is 19%. This would suggest that over 22,000 people (aged 18 and over) in West Berkshire smoke.
- Smoking in the routine and manual group in West Berkshire is 33%.
- 175 people out of every 100,000 living in West Berkshire are estimated to have died due to a condition caused by smoking.
- The estimated output lost from early deaths in West Berkshire is £10.8 million with the cost of society at £36.1 million each year. £6.6 million is accountable through sick days and the NHS Spends £7.1 million a year on care (ASH, 2013).

PRIORITY 6 – HEALTHY WEIGHT AND PHYSICAL ACTIVITY

Weighing too much or too little can cause health problems and it is important to maintain a healthy weight to stay in good health, and to reduce the likelihood of developing conditions associated with obesity, such as type 2 diabetes, cardiovascular disease and cancer. The risks of developing these conditions are greatly increased by being obese. For example, an obese man is 5 times more likely to develop type 2 diabetes, 3 times more likely to develop colon cancer and 2 ½ times more likely to develop high blood pressure (a major risk factor for CHD and stroke). An obese woman is 13 times more likely to develop type 2 diabetes, 4 times more likely to develop high blood pressure and 3 times more likely to have a heart attack. Many other conditions are associated with obesity include angina, gall bladder disease, liver disease, ovarian cancer, osteoarthritis and stroke, as well as mental health problems such as low self esteem and depression.

According the World Health Organisation, physical activity is defined as "is defined as any bodily movement produced by skeletal muscles that requires energy expenditure". Regular physical activity, such as walking, cycling or sport can positively affect health and a reduced risk of certain diseases; diabetes, obesity breast cancer and can improve mental health.

Conversely, physical inactivity is a risk factor in premature death and can lead to a range of diseases including; breast and colon cancer, diabetes and heart disease.

What is the picture in West Berkshire?

- Over 20% of reception year children in West Berkshire are classified as overweight or obese which is less than the national average and comparable to the South East Region averages. Obesity and overweight prevalence in year six rises to approximately 30% of children in West Berkshire.
- An estimated 23.7% of adults in West Berkshire are obese, though this is likely to be an underestimation of true prevalence.
- Different areas in West Berkshire are estimated to have varying levels of obesity. Looking at Middle Super Output Areas (areas of a minimum population

of 5000 and are similar to wards), the estimated prevalence of obesity in West Berkshire ranges from 18% to 28.6%.
- The proportion of West Berkshire adults participating in 30 minutes of moderate intensity sport has decreased over the last 6 years, although participation rates are still higher than the national average.
- According to the 2013 Active Peoples Survey 7, 54.3% of adults in West Berkshire achieved recommended levels of physical activity (30 minutes of moderate physical activity, five times per week).
- Data shows that 27.2% of adults in West Berkshire were classified as inactive (doing less than 30 minutes of moderate physical activity, five times per week).

PRIORITY 7 – CARDIOVASCULAR DISEASE AND CANCER

Cardiovascular disease (CVD) refers to a range of different conditions that affect the heart or blood vessels (sometimes called heart disease). There are four main types of CVD; Coronary Heart Disease, Stroke, peripheral arterial disease and aortic disease. CVD is caused by a build up of plaque on the arteries, which narrows the arteries, hindering the flow of blood through the arteries. This could result in a blood clot which can stop the blood flow completely, resulting in a heart attack or stroke.

Most deaths caused by CVD are premature and could be prevented by addressing the risk factors. There are number of risk factors for CVD including; high blood pressure, smoking, high blood cholesterol, diabetes, lack of exercise, being overweight or obese, a family history of heart disease and ethnic background. Modifications to lifestyle to reduce CVD risk include; healthy eating, regular physical activity and stopping smoking.

Cancer is a disease where cancerous cells in the body grow and damage healthy tissue and organs. There are over 200 different types of cancer known to us today (Cancer Research UK, 2013). Approximately 30% of these cancers can be prevented through specific lifestyle changes such as stopping smoking, reducing obesity, reducing alcohol intake, and safe exposure to the sun (WHO, 2013).

On average, one in three people will develop cancer and one in four will die from cancer in the UK. The most common types of cancer are; breast, lung, prostate and bowel.

What is the picture in West Berkshire?

- An estimated 28% of adults (aged 16+) in West Berkshire have hypertension (high blood pressure).
- The observed prevalence of coronary heart disease (CHD) for patients those recorded on the 2011/12 GP CHD register is 2.6%.
- In 2012, the coronary heart disease mortality rate (under 75 years) for NHS Newbury and District Clinical Commissioning Group was 27 per 100,000.

- The observed prevalence of stroke is 1.4%.
- In 2013/14, 9,103 eligible people were invited for an NHS Health Check in West Berkshire. A total of 3,827 people received an NHS Health Check either in the community or through their GP practice. This is an uptake of 44%.
- Around 350 in every 100,000 people in West Berkshire will be diagnosed with cancer every year. Rate of diagnoses have remained relatively stable over the past seventeen years, with some fluctuations, and are similar to the rates of diagnosis across the Country.
- In West Berkshire, early deaths due to cancer have significantly fallen over the last decade, with specialist cancer services available in close proximity to residents.
- Approximately 125 males in every 100,000 aged less than 75 years in West Berkshire will die from cancer. This rate is similar to the national and South East Region rate and is similar to the average of Local Authorities with similar levels of deprivation.
- Approximately 90 females in every 100,000 aged less than 75 years in West Berkshire will die from cancer. This rate is similar to the national and South East Region rate, as well as the average of Local Authorities with similar levels of deprivation.
- 57 in every 100,000 people aged less than 75 years in West Berkshire dies from cancer where their death is considered preventable.

PRIORITY 8 – CARERS

Given that the amount of unpaid care provided will increase, due to increases in the ageing population, the role of the carer is pivotal in the context of reducing resources in local authorities. Carers help to ensure that the cared for are able to maintain their independence and stay in their own homes. The health and wellbeing of carers is paramount. It is important that they able to stay healthy and maintain their caring role. To support carers, their needs must be identified and they must be supported with information and advice and are have access to services that support their caring role.

Children who help look after a family member who is sick, disabled or has mental health problems or is misusing drugs or alcohol are known as young carers. Being a young carer means having adult responsibilities such as; cooking, cleaning, shopping, providing nursing care and giving emotional support.

Research has shown that young carers are 1.5 times more likely than their peers to have a special educational need or a disability. They also have significantly lower educational attainment at GCSE level than their peers and are therefore less likely to earn a decent living. Additionally, young carers are more likely than the national average to be not in education, employment or training (NEET) between the ages of 16 and 19. Young carers are over four times more likely to live in a household where no adults are in work (The Children's Society, 2013).

What is the picture in West Berkshire?

- Around 14,000 (9.3% of the West Berkshire population) people in West Berkshire provide unpaid care, although it is likely that there are many unidentified carers. There could be people in West Berkshire that are doing unpaid care who are not known by services.
- The majority of carers are of working age and are adults aged between 25 and 64. Over 10,000 people in West Berkshire people provided 1 to 19 hours of unpaid care a week, 1,461 provided 20-49 hours and 2,505 provided 50 hours or more unpaid care per week.
- The majority of carers were women (57%) and over 70% of women provided 1 to 19 hours of unpaid care per week.
- In West Berkshire, there has been little change in the provision of unpaid care between 2001 and 2011. However, as the population ages, there is an expectation that more people will become a carer at some point in their lives.
- According to the 2011 Census, 6% of carers (834 people) in West Berkshire were young unpaid carers (aged between 0 to 24). This figure is likely to be an underestimate as young carers themselves do not give information themselves and some parents do not want to provide this information.
- 52% of young carers are female and 48% of young carers are male.
- The majority of young carers provide 1 to 19 hours Unpaid Care
- Few young carers reported to have bad or very bad health (9% of young carers). The majority of young carers reported to have very good or good health (81% of young carers).

PRIORITY 9 – LONG TERM CONDITIONS, DISABILITIES AND END OF LIFE CARE

Long term conditions are health problems that can't be cured but are controlled with medication. Examples include; type 2 diabetes, chronic obstructive pulmonary disease, heart disease, dementia and arthritis. Long term conditions can affect a persons quality of life and ability to work. Some lifestyle factors (such as smoking, excess alcohol consumption) can contribute to the prevalence of long term conditions. Preventing long term conditions by supporting people to adopt healthier behaviours is essential to help them mange their long term condition and live healthily and independently.

The Department for Work and Pensions state that the definition of disability is if a person is disabled or has a physical or mental impairment that has an effect on the persons' ability to do normal daily activities. These include sensory impairment, fluctuating, progressive or degenerative condition.

End of life care is support for people who are diagnosed as being at the stage of an health condition where they are considered likely to die within the next weeks or months up to 12 months It can also support people who are caring for people

who are dying. End of life care helps people live their last days as comfortably as possible, and as far as possible in their chosen circumstances.

What is the picture in West Berkshire?

- Long-term conditions are more prevalent in older people (58% of people aged 60+ compared to 14% aged 40 and under) and in more deprived groups (people in the lowest socioeconomic group have a 60% higher prevalence than those in the highest socioeconomic group and 30% more severity of disease).
- An estimated 11% of people in West Berkshire have cardiovascular disease and 28% have high blood pressure.
- The number of people in West Berkshire invited for an NHS Health Check last year was 5,961. In addition, 2,637 people in West Berkshire had an NHS Health Check, either in the community or through their GP practice. The uptake of people in West Berkshire who were invited for an NHS Health Check was 44%.
- In West Berkshire, around 4,800 people (4.2%) of people have diabetes. The figure is based on the percentage of the total population registered with a GP and aged 17 and over. Around 8 in 100,000 people with have a lower limb amputation due to their diabetes each year.
- There are 7,625 people in West Berkshire aged between 18 and 64 who are estimated to have a moderate physical disability and 2,297 estimated to have a severe disability in 2011.
- Projecting Adult Needs and Services Information (PANSI) forecasts how many people aged 18 to 64 will have a physical disability from 2012 to 2020. Around 7,701 people in West Berkshire are estimated to have a moderate physical disability in 2014 with 2,317 estimated to have a serious physical disability. These figures are expected to rise to 2,461 by 2020.
- The majority of people die in a hospital (56.4%) or in their own home (22.2%). The number of people who die in a hospice is low.
- The proportion of end of life patients who died in hospital following an emergency admission. The average length of stay for people who die in hospital is 13 days.

PRIORITY 10 – FALLS PREVENTION

Older people are more vulnerable to slips, trips and falls which could lead to broken bones, admissions to hospital as a result of falls, admissions to a residential/nursing home as a result of falls and a reduction of discharges to residential/nursing homes following a hospital admission as a result of a fall. Having a fall may reduce the confidence of someone who has fallen, possibly making them afraid to leave their homes resulting in social isolation and reduced independence.

Many of the risks of falling can be prevented and may help to reduce the fear of falling, as well as improving balance, strength and stamina. Investing in falls

prevention can to reduce the financial burden on the NHS by preventing fractures and reducing avoidable hospital and/or residential/nursing home admissions.

What is the picture in West Berkshire?

- The rates of injuries due to falls in people aged 65 and over living in West Berkshire are better than the national average. In 2012/13, there were 1,381 emergency hospital admissions for falls in persons aged 65 and over per 100,000 population.
- There were 142 emergency admissions for hip fractures in every 100,000 people aged 65+ in 2012/13.
- In 2012/13 the rate of emergency admissions for injuries due to falls in persons aged 80+ was 3,541 per 100,000 population which is better than the regional average.
- The number of hip replacements being undertaken for people in West Berkshire has increased slightly over the last five years. Around 50% of patients from West Berkshire go home from hospital within 28 days of an emergency admission to hospital with a hip fracture. This is slightly lower than the proportions seen nationally and regionally.

PRIORITY 11 – DEMENTIA

Dementia is an increasingly important public health issue and due to changes in demography, dementia is becoming more prevalent. It is vital that we are able to better care for people living with dementia as well as working to help people to reduce their risk of developing dementia. Dementia not only impacts on the person living with it, but their carers and families as well. There is a lack of general awareness and understanding of dementia, as people often think the symptoms of dementia are a normal part of ageing.

What is the picture in West Berkshire?

- An estimated 17 people aged between 30 to 64 living in West Berkshire have early onset dementia. This figure is set to rise to 19 in 2020.
- An estimated 1,679 people aged 65 and over living in West Berkshire are estimated to have dementia. This is likely to be an underestimate as nationally only half (48.7%) of people with dementia have received a formal diagnosis. This could mean that potentially there are many people in West Berkshire who are living with dementia and are waiting for a formal diagnosis.
- The number of people with dementia is expected to rise by almost 500 people to 2,176 in 2020.
- 0.5% of the population are recorded on GP registers as having dementia.
- 12 people in every 100,000 living in West Berkshire are admitted to hospital with Alzheimer's and other dementias each year. This figure is below that of England and the South East.

- Approximately 15% of deaths in people from West Berkshire had a contributory cause of death as Alzheimer's, dementia, or senility in 2008-10. This is fewer than the proportions for England and the South East Region as a whole.

Achieving the Health and Wellbeing aims in West Berkshire

The 11 priority aims and their related outcomes will present challenges to commissioners and providers of services and to the residents of West Berkshire. In order to improve the health and wellbeing across the district detailed plans will need to be developed and links made with existing strategies and Fora. All relevant organisations will need to work in collaboration with the public, sharing resources and ideas, tackling barriers to health and wellbeing and coming up with innovative, cost effective, achievable solutions.

In order to develop the Strategic Implementation Plan for the delivery of the Health and Wellbeing Strategy, a multi-agency Working Group will be established. This task and finish group will develop detailed action plans for each of the 11 priorities, drawing on the strategies and plans already in existence and linking in with all relevant agencies and groups. The suggested membership of the group is:

Public Health (WBC)
Newbury and District Clinical Commissioning Group,
North and West Reading Clinical Commissioning Group
Adult Social Care (WBC), Children's services (WBC), Education (WBC)
Community service providers (NHS), Secondary care service providers (NHS)
Voluntary sector representatives, Community representatives

This group will be responsible for the development of the Strategic Implementation Plan and there may be time limited sub groups set up to produce specific plans for each individual priority aim, in order to draw on the right groups and individuals.

The Strategic Implementation Plan will relate directly to the indicators and outcomes listed in the Health and Wellbeing Strategy Performance Framework.

The West Berkshire Health and Wellbeing Board

The Health and Wellbeing Board brings together key partners across the District and has the following membership: Leader of West Berkshire Council, West Berkshire Councillors who lead on health and wellbeing, children's services and adult social care, the Director of Public Health for Berkshire, the West Berkshire Director of Communities, GPs from our two Clinical Commissioning Groups – Newbury and District (NDCCG) and North and West Reading (NWRCCG) plus representatives from Healthwatch, NHS England and the Voluntary Sector.

The Board is responsible for

- ✓ preparing and publishing a Joint Strategic Needs Assessment (JSNA) to identify the health and wellbeing needs of the local population;
- ✓ preparing and publishing a Joint Health and Wellbeing Strategy (JHWS) in line with the JSNA, with involvement of Healthwatch and the public;
- ✓ ensuring that the CCG commissioning plans have taken proper account of the Health and Wellbeing Strategy;
- ✓ promoting integrated working between commissioners of health and social care services
- ✓ encouraging integrated working across wider determinants of health

The Public as partners

When planning our future health and wellbeing, it is important not to just consider the services that help us when things go wrong. Everyone has a part to play in preventing ill health and maintaining their health and wellbeing. Lifestyle factors have a massive effect on our health: what we eat, what we drink, whether we smoke and how much we exercise can be linked to many major conditions including heart disease, strokes, diabetes and cancers. The public are equal partners alongside the health service, social care, the voluntary sector and other parts of the local authority.

So the public plays an important role in keeping themselves healthy but equally important is that a large majority of all the care for people with long term conditions is undertaken by the patients themselves or carers. People who care for family or friends were estimated to save the UK economy £119bn a year in 2011 that was bigger than the then £99bn cost of the whole of the NHS.

In addition to managing our own health and caring for others, the public has another role, that of making decisions about our health and wellbeing system. We are all citizens with a democratic role in influencing the operations and future direction of health, social care and wellbeing more general

How can the public be an equal partner in making decisions about health and wellbeing? It can happen at different levels. For example an individual patient can be an active participant in their own treatment, rather than a passive recipient of care. We can also all take a role in managing each other's health and care, such as looking after a child or caring for an elderly parent. In addition we can take a positive attitude to living a healthy life and being part of a community that keeps in touch with others, helping to combat social isolation.

The public can also be part of the big decisions and the overall management of health and wellbeing. We can have our say by voting, responding to consultations, getting involved in interest groups, or participating in other ways

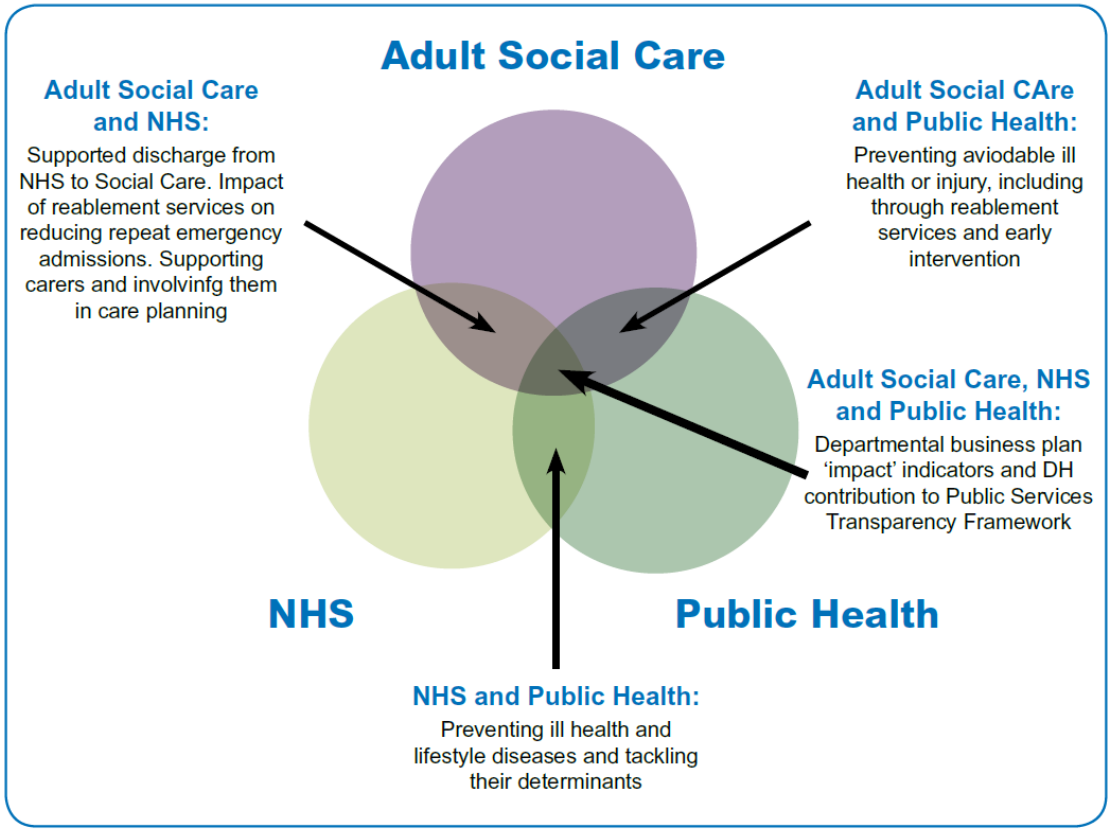
with decision making like asking a question at a Health and Wellbeing Board meeting or a CCG meeting.

We want the residents of West Berkshire to be equal partners in managing their health and wellbeing and this may need a change of mindset, both for the public and those working in organisations. However adopting this approach can not only make better use of a vast, under-utilised resource but make use of the extensive expertise which exists in local people.

The priorities outlined in this strategy identify outcomes, both short term and longer term, that need to be achieved.

Integrating health and social care in West Berkshire

In West Berkshire the proportion of over 65s has increased from 2001 to 2011 by 23% compared to a rise regionally of 13%. The projected increase in West Berkshire from 2011 to 2021 in the proportion of over 65 year olds is estimated to be 34%. This is an increase of just over 8000 people in this older age group. It is also projected that there will be an increase in the number of older people with complex physical and mental health problems, including diabetes, dementia and depression that will require more health and social care services, more carers and will result in a greater cost to society. The importance of prevention and integrating health and social care services will be paramount.



Our vision for integrated care is based on improving outcomes for individuals through the delivery of care which is responsive, enabling and available as close to home as possible. We are committed to doing things with (rather than to) service users/patients and therefore meaningful engagement is a key part of how we will implement change.

The biggest challenge to West Berkshire is the increasing ageing population. It is projected that the number of older people with complex physical and mental health problems (for example dementia) and increased social care requirements will increase, along with the number of ageing carers and the societal costs of supporting them. Therefore, primary prevention to help older people maintain positive social engagement, good physical health and mental wellbeing is crucial.

Our current system is under pressure with a number of challenges including:

- An increasing population, particularly in those over the age of 65
- Increasing growth in non-elective care
- Increasing A&E attendances, and pressure on urgent and emergency capacity

- Rising delayed transfers of care, and subsequent bed days lost
- Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is significantly shrinking
- Increasing demand for planned (elective) care
- Inequality of access to services across the “whole system :the whole week”
- Care Workforce Availability
- Care Act 2014 – new national eligibility criteria for social care

Recognising the challenges that face the local health and social care system and understanding the increasing demand for services indicates that our current systems are not sustainable. Funding pressures are set to continue and we will need wide scale transformation to be able to meet future needs.

The Better Care Fund (a pooling of NHS and LA budgets) is an opportunity to stimulate the integration of Health and Social Care Services both within West Berkshire and across West of Berkshire and a range of projects have been created to help deliver this.

By 2019 we expect to achieve the following through integrated working:

- Person centred services that will make a difference to the health and wellbeing outcomes of residents
- Provision of good quality information and advice that empowers people to make good choices and self-manage
- Care closer to home as the first option
- Flexible services that operate across 7 days a week where appropriate.
- Services will be simpler to access, have less duplication and reach service users/patients earlier.
- Delivery of health and social services to be localised wherever possible including access to crisis, A&E and other services that meet local residents’ needs – with appropriate specialist or wider access to regional services that improve outcomes on a sustainable basis.
- A greater range of local services that promote independent living
- Reduction in avoidable hospital admissions.
- Lengths of stay in Hospitals will be kept to a minimum
- Increased numbers taking up Health and Social Care Personal Budgets

Delivery of this vision will make health and social care systems more sustainable and cost effective. We will commission new models of care based on integrated Health and Social care pathways that focus on improved outcomes for users/patients.

In achieving this transformational change we will draw on our patient’s and population’s views, and use robust health needs assessment in identifying our ongoing priorities. The commissioning and redesign of services will be informed

by evidence of effectiveness, recognised best practice, and performance data analysis.

As a partnership we will jointly commission services that will deliver the following:

- Enable us to respond to the needs of our local populations by targeting services to give the greatest impact on health and social care outcomes
- Address the views expressed by our local populations of how they wish services to be provided through partnership and co-production
- Avoid duplication and ensure value for money & efficiency
- Enable us to combine resources, sharing best practice and expertise.

Joint Commissioning in the future

The Health and wellbeing Board exists in a time when there are exceptional financial pressures on both the NHS and local government. Demand for services continues to rise, despite no real-terms increases in NHS resources and local government budgets being cut by more than 30 per cent. Our demographic changes, the increasing burden of disease and pressures on urgent care necessitate real changes in how we fund, commission and deliver our health and social care services.

The Health and Wellbeing Board was responsible for 'signing off' on local plans for the use of the new £3.8 billion Integration Transformation Fund – now called Better Care Fund (BCF). Although this represents only 3 per cent of the combined total NHS and adult social care budget nationally, this enabled the Board to begin to shape a key spending decision and it could be seen as a first step to overseeing the total health and social care budget in time.

The Board will need to develop further to do more than share information, co-ordinate high level strategies and plans, react to proposals and plans from partners, and oversee specific public health programmes.

The aim for our own Health and Wellbeing Board is that it will develop an 'executive decision-making role' across the whole local system of health, social care and public health, having an explicit remit to oversee commissioning of all services and to produce an agreed framework for integrated care, thus driving through the transformation of local services. This would be consistent with a policy thrust towards more integrated commissioning across the local NHS and local government.

There are legal powers for CCGs and local authorities to establish joint or integrated commissioning arrangements and this would enable the role of the Board to be strengthened without the need for further reorganisation. “Strong and purposeful relationships between CCGs and their respective local authorities – based on partnership not takeover – offer the best prospects for boards to lead the integration and transformation of local services effectively” (Health and Wellbeing Boards one year on, Kings Fund, Oct 2013).

This Health and Wellbeing Strategy will drive the development of the commissioning plans of both the Clinical Commissioning Groups within the NHS and Adult Social Care and Children’s Services Commissioning within the Local Authority. We will move towards an alignment of commissioning plans across the whole Health and Wellbeing system. The Health and Wellbeing Board will lead this integrated system ensuring all partners work in collaboration to achieve the best outcomes for the residents of West Berkshire.

The Care Act

The Care Act 2014 introduces a major set of reforms to the way that care for elderly people and other adults with care needs is provided and paid for. Key new features of the legislation for councils are:

· a duty to promote people's wellbeing and to prevent needs for care and support
· a duty to provide an information and advice service about care and support
· a requirement to carry out an assessment of both individuals and carers wherever they have needs, including people who will be "self-funders", meeting their own care costs
· a duty to facilitate a vibrant, diverse and sustainable market of care and support provision and to meet people's needs if a provider of care fails
· a national minimum eligibility threshold for support – a minimum level of need which will always be met in every council area
· a requirement to offer a universal "deferred payment" scheme, where people can defer the costs of care and support set against the value of a home they own
· a duty in some cases to arrange "independent advocacy" to facilitate the involvement of an adult or carer in assessing needs and planning for care
· new safeguarding adults arrangements
· councils taking over responsibilities for social care in prisons

The Act sets out clear duties around ‘prevention’ of the need for ongoing Care and Support, requiring Local Authorities to ensure the provision or arrangement of ‘services, facilities and resources’ to help prevent or delay the need for care and support. This duty extends to all people in the Local Authority area, including carers, regardless of whether they have needs for care and support, and is a responsibility much wider than adult care alone.

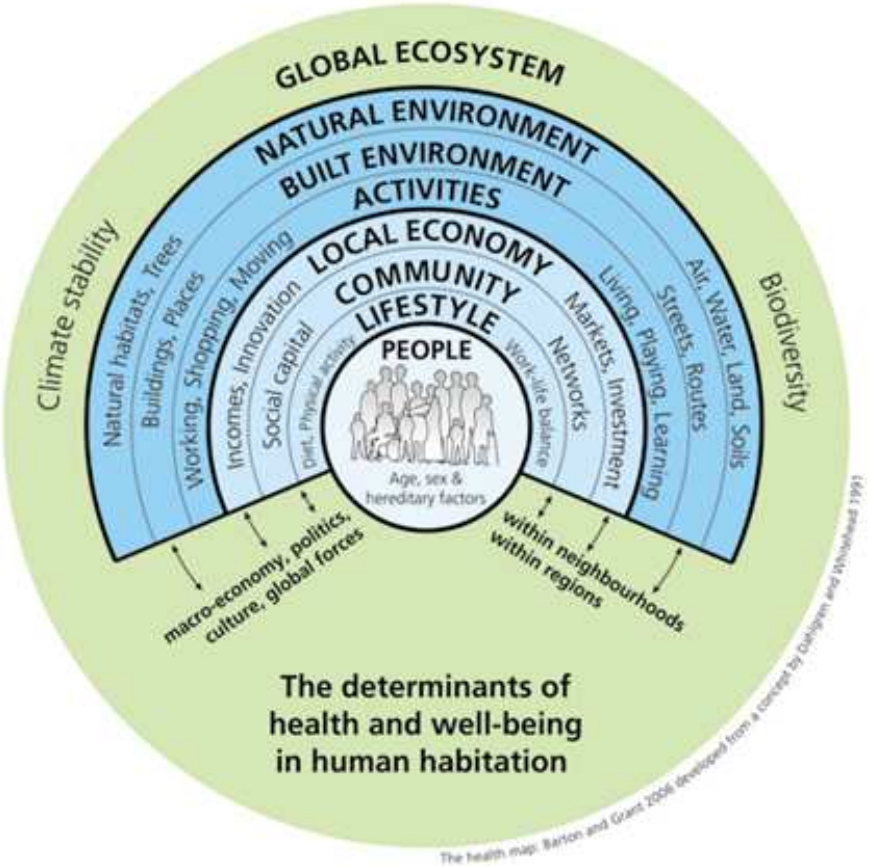
A key element of the preventative approach is for Local Authorities to support individuals to make the most of the resources available to them in their community – for instance, universal services, local support networks or voluntary services – as well as to build and develop their own strengths and capabilities.

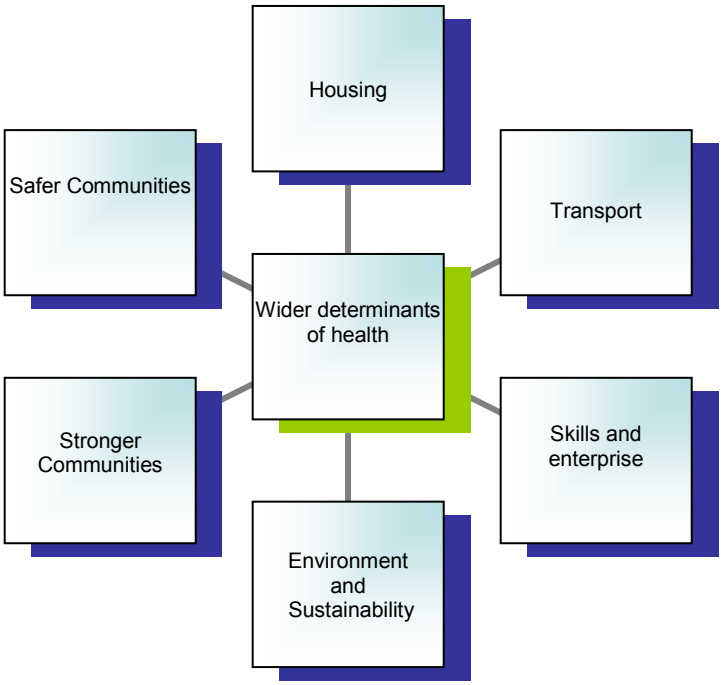
The Health and Wellbeing Board must consider a local approach to ensure coherence of preventative services that already exist and are delivered by partners across the Local Authority, Health and Voluntary sector; connecting key areas, identifying any gaps and working with partners to effectively commission and deliver services to meet this prevention duty.

Addressing the wider determinants of health within the Health and Wellbeing Strategy in the future

The Health and Wellbeing Strategy links directly to West Berkshire Council's Sustainable Communities Strategy – 'A Breath of Fresh Air' that focuses on improving the wider determinants of health including housing, transport, economic prosperity, as well as safer and sustainable communities. In time the two strategies will be merged to create a single Health and Wellbeing Strategy that includes all aspects of health and wellbeing including the wider determinants of health

What does affect our health and wellbeing?





Housing	We will increase the provision of affordable housing as needed and improve the condition of existing housing to combat fuel poverty
Skills and enterprise	We will increase employment opportunities, especially in rural areas, address the skills gap, ensure all young people transition successfully into jobs and improve tourism
Transport	We will improve and promote opportunities for healthy, sustainable travel, making the best use of West Berkshire transport assets.
Safer communities	We will work in partnership to keep the incidents of crime and anti-social behaviour low, ensuring that West Berkshire is a safe place to live, work and visit.
Environment and Sustainability	We will increase the use of renewable energy and recycling, and conserve our environment for the future
Stronger communities	We will work with communities across the district to empower and enable them to be cohesive and strong, having control of their own health and wellbeing.

HOUSING

Historically house prices in West Berkshire far exceed the national average and make West Berkshire one of the more expensive parts of the country to live, outside of London. This makes affordable housing a strategic concern for the Council and its partners.

The association between housing conditions and health are well documented. Poor housing conditions often go hand in hand with other forms of deprivation such as unemployment, social isolation and poor education. According to the World Health Organisation, respiratory and cardiovascular diseases from indoor air pollution, communicable diseases and death from temperature extremes are all housing related health problems.

Housing has a substantial impact on health with a warm dry and secure home is associated with better health. Conversely, it's known that living in a cold home can be damaging; with the elderly, children and those who are disabled or have a long-term illness being especially vulnerable.

Households in fuel poverty are those that are required to spend 10% or more of their net household income on heating and hot water just to obtain an adequate level of supply. It's estimated that 6,100 (10%) dwellings in West Berkshire are in fuel poverty, whilst still below the national average of 14% this remains a concern. Furthermore, the highest incidents of fuel poverty are seen in West Berkshire's rural areas (The Private Sector House Condition Survey, 2008).

The Indices of Multiple Deprivation (IMD) includes a domain which measures household overcrowding, homelessness and housing affordability; 20 of West Berkshire's Super Output Areas are within the bottom third in the country on this measure. The worse affected are specific locations within Burghfield, Kintbury, Cold Ash and Basildon.

What's the picture in West Berkshire?

- As at January 2013, the average house price in West Berkshire was £233,906 compared to £162,441 for England and £211,054 for the South East. This reflects a trend where historically West Berkshire is above the national average.

- The issue of housing affordability impacts on the workforce particularly in terms of recruiting younger staff, key workers and care workers.

- In 2013 the Council adopted a new Housing Allocations Policy and there are 1,014 households currently registered for housing assistance as of 1st September 2014.

- Whilst the number of households approaching the Council as homeless did increase between 2010/11 and 2011/12, the number of homeless acceptances has remained fairly static over the last three years at around 53 households.

- The Private Sector House Condition Survey (2008) estimated that 6,100 (10%) dwellings in West Berkshire were in fuel poverty, compared to approximately 14% in England.

- The House Condition Survey found that rural areas in West Berkshire had the highest incidences of fuel poverty at 10.8% of all households. Tackling fuel poverty in rural areas can be particularly difficult, as many households do not have access to gas, the cheapest fuel for heating homes.

- In rural areas 890 households are overcrowded (33% of all such households) equating to 4% of all households in rural areas this is higher than the average across rural England (3%).

SKILLS AND ENTERPRISE

Employment is one of the more important determinants of health. Having a job or an occupation is an important factor in self-esteem. It provides a vital link between the individual and society along with wages that can improve the overall quality of an individual's life.

The World Health Organisation identifies a number of ways in which employment benefits mental health. These include the provision of structured time, social contact and satisfaction arising from involvement in collective effort. Therefore the loss of a job or the threat of losing a job is detrimental to health.

Within West Berkshire 83% of the working age population in West Berkshire is economically active this is higher than the rate for both the region (79%) and nationally (77%) based on 2011/12 data. Salaries across Berkshire have historically been higher than the South East and national averages. However there is significant disparity in earnings by gender both in West Berkshire and across the country. Women workers continue to earn less than male workers, about 25% less based on gross weekly pay in West Berkshire and nationally 19% less than their male counterparts.

The working population of West Berkshire is relatively well qualified when compared to regional or national figures. In 2011, there were just over 21,000 people with no qualifications, representing 17% of the adult population; this rate has reduced from 22% in 2001.

NEET refers to young people Not in Education, Employment or Training. NEET numbers are low in West Berkshire, as most young people participate in some

form of education, employment or training. However, the effects of being NEET, especially between the ages of 16-18 can have far reaching consequences for the young person. For example the young person is more likely to be unemployed or have reduced earnings in future; they are also more likely to suffer from depression and poor health.

What is the picture in West Berkshire?

- Within the district 83% of the working age population were economically active using 2011/12 data; however this figure disguises the fact that gender inequalities exist with women earning approximately 25% less than male workers in West Berkshire.

- In 2011, 32% (or just under 39,500) residents highest qualification was level 4 or above (i.e. a degree). This compares with 30% of people in the South East and 27% nationally, showing a strong skills base within the area.

- West Berkshire has a self employment rate of 12% this is higher than regional (11%) or national (10%) levels.

- In 2013 in West Berkshire there were 1,201 new business start-ups, an increase of 257 new businesses since 2012.

- The number of young people classified Not in Employment, Education or Training (NEET) has reduced across the district. By August 2014 the number of young people categorised as NEET was 181 representing a 30% reduction in numbers over a year. Initiatives such as 'Elevate Me' have been designed to provide opportunities and prevent young people in West Berkshire becoming NEET.

- Nationally, levels of employment for people with a learning disability or a mental health problem are low. In West Berkshire only 4% of adults with a severe mental health condition (i.e. those in contact with secondary mental health services) are in employment, compared to 8% across the South East.

TRANSPORT

The availability of local transport is a key factor in reducing health inequalities by providing safe and convenient access to local services such as schools, shops, health services, places of employment and green spaces.

Walking and cycling are the easiest ways for most people to increase their physical activity levels. Efforts to reduce the volume of urban traffic and to promote walking and cycling are likely to have appreciable net benefits to population health.

Although links to and from the area are good, access to services within the District can be a challenge for some, especially in the rural areas. Independence is critical to the wellbeing of older people and transport is critical to living independently. With 15% of West Berkshire's population over 65 years old we must work to ensure that these individuals have access to suitable transport. According to the Royal Voluntary Service (RVS), a lack of suitable transport has a devastating effect on wellbeing; with research conducted in 2013 showing that 7% of older people feel lonely because they are unable to get out and about and 3% feel depressed.

A reduction in road traffic speed is the best way to prevent serious accidents and make the roads feel safer for all road users. In West Berkshire 55 individuals were killed or seriously injured (KSI) on roads within the District during 2013. Another specific finding is that 30% of all West Berkshire resident motorcycle riders during the last five years have been involved in KSI collisions; this represents a higher incidence compared to other road user groups..

A range of joined up initiatives will be needed to encourage active travel, reduce car speeds and prevent the number of those killed or seriously injured in West Berkshire.

What is the picture in West Berkshire?

- The proportion of people using public transport is highest in relatively urban areas fed by bus routes, or with a train station in the vicinity for example Westwood, Purley, Pangbourne, Basildon and the Reading fringe of Calcot and Birch Copse.

- The more urban areas in Newbury of Victoria, Northcroft and Clay Hill have a high proportion of people walking to work.

- In West Berkshire 100% of schools have Travel Plans - the implementation of which has seen a significant reduction in the use of the car journeys to school and an increase in active travel. In 2014, 61% of journeys to school were being made on foot, by bike, by bus or by rail.

- 11% of households in rural areas in West Berkshire have no access to a car or van. This is lower than across rural areas in England (14%). This reflects the affluent nature of West Berkshire and the relatively high levels of car ownership (Oxford Consultants for Social Inclusion, 2010).

- 73% of households are more than 10km from principal employment centres, this is higher than across England (50.4%) highlighting the sparse pattern of West Berkshire's rural settlements (Oxford Consultants for Social Inclusion, 2010).

- In West Berkshire 55 individuals (including residents and others) were killed or seriously injured (KSI) on the District's roads during 2013; this equates to a 30% decrease in those KSI from the year before.

- During 2012, and the five years before, 30% of West Berkshire's resident motorcycle riders were involved in collisions where one or more individuals were killed or seriously injured (KSI). This is higher than the national average (28%) and shows a higher incidence compared to other road user groups.

SAFER COMMUNITIES

Overall, West Berkshire is a relatively safe place to live. Thames Valley Police data for West Berkshire since 2011/12 shows a downward trend in all crime.

There are links between health, crime and the safety of communities. A person's health can be affected directly by crime if they are the victim of a violent crime, sexual offence or another offence against the person. The fear of crime can affect the health of people in the community if they are afraid to walk the streets or let their children play outdoors. Older people can experience social isolation if they are too scared to leave their home. People can experience psychological harm from crimes such as burglary or vandalism. Drug and alcohol misuse can increase crimes such as theft or robbery in an area.

Preventing and reducing reoffending, domestic abuse and violent crime in public places and ensuring that more people successfully complete structured drug and alcohol treatment programmes will help reduce crime, the fear of crime and anti-social behaviour so that people will feel safe in their homes and neighbourhoods.

What is the picture in West Berkshire?

- At the end of 2012/13 there had been an 18% reduction in all crime in West Berkshire from the previous year, which means there were 1,794 fewer crimes compared to 2011/12 (9,946 crimes in 2011/12).

- In 2013/14 the overall number of crimes was 8,130 which has remained fairly static compared to 2012/13 (8,152 in 2012/13).

- During 2013/14 the crimes most reported by residents and businesses in West Berkshire were criminal damage, shoplifting, violence offences and non-dwelling burglaries.

- Domestic abuse is a major issue for police and partner agencies with 754 crimes and 1,439 other incidents reported in 2013/14.

- There has been a significant drop in youth offending by West Berkshire's young people aged 10-17 years, this figure includes looked after children in

out of area placements. A total of 100 formal outcomes from the Police or Courts were recorded in 2013; this represents a 52% decrease in offending since 2010 when 209 formal outcomes were reported.

- Since 2010, more first offences have been dealt with by less formal sanctions; such as Youth Cannabis Warnings and Youth Restorative Disposals. In 2013, there were 124 individuals dealt with through such mechanisms. Offences of violence continue to be the most prevalent offence by young people.

- The areas of the district where there is a higher incidence of crime are mainly concentrated in the more urban areas of Newbury, Thatcham and the Reading fringe. However, there are some rural areas of the district which also experience higher incidence of crime including Theale, Bucklebury, the Leckhampstead and Peasemore, Speen, the Lambourn Valley and Burghfield.

ENVIRONMENT AND SUSTAINABILITY

Good health and wellbeing is not solely the absence of illness; the role of the environment we live in is hugely important in shaping our lives and our health. Having access to high quality, local natural environments is critically important to promoting physical health and wellbeing in children and adults.

The Institute for Health Equality 2014 report shows that older people live longer in areas where there is more green space close to their homes and children who live close to green spaces have higher levels of physical activity and are less likely to become overweight and obese over time.

Access to nature is highly valued by people living in West Berkshire with around a third of residents saying that this is one of their top priorities for making an area a good place to live. Nearly three quarters of West Berkshire is classified as part of the North Wessex Downs Area of Outstanding Natural Beauty (AONB) - a landscape of the highest national importance.

Whilst the vast majority of the District is open countryside and generally air quality is very good, there are inevitably conflicts between the development of land and transport links and impact upon air quality as a result of increased traffic on our roads. Air Quality Management Areas (AQMAs) exist in the centre of Newbury and in Thatcham to monitor the levels of Nitrogen Dioxide (NO2) in these areas.

The Council and partners work to reduce carbon emissions and set a target to reduce all West Berkshire emissions by 9.4% by 2011 from the 2005 baseline. The latest figures released by Department of Environment and Climate Change (DECC) for 2011 show a 19% reduction achieved since 2005.

A number of main rivers flow through West Berkshire; the most prominent are the River Kennet, River Lambourn, River Pang, River Thames, River Enborne and the Foudry Brook. There is a risk of flooding within West Berkshire arising not only from rivers but also from surface water and groundwater flooding.

The majority of West Berkshire parishes were adversely affected in the summer 2007 floods with certain settlements more prone to repeat flood incidents, as seen in the winter of 2013/14. Flooding can have a great impact on people's psychosocial needs and mental health. Therefore mitigating the risk of flooding remains a priority for the Council as described within the Local Flood Risk Management Strategy.

STRONGER COMMUNITIES

Overall the District of West Berkshire is the 38th *least* deprived District in England; however this fact obscures the finding that certain pockets of deprivation exist. For example the rural nature of West Berkshire means that certain residents have significant distances to travel to access essential services. Similarly, living in a high house price area can be a barrier to accessing suitable housing. Below standard housing, overcrowding and lack of essential services can clearly have a detrimental impact on health and wellbeing.

Deprivation is also associated with lower life expectancy, high risk of smoking, alcohol and drug dependencies and a higher chance of developing a long-term illness.

The West Berkshire District Profile data highlights inequalities in educational scores within Greenham, Lambourn, Clay Hill and Thatcham, all known localities with areas of deprivation. Educational attainment has a significant impact on future life opportunities and therefore deserves consideration within the wider determinants of health and wellbeing.

Data from the Oxford Consultants for Social Inclusion (OCSI) shows that nationally the majority of deprived people do not live in deprived areas. This is another finding which suggests that deprivation exist both in particular localities and at an individual level across the District. It's important that through partnership working all opportunities are taken to reduce inequalities and deprivation wherever they are found.

What's the picture in West Berkshire?

- Overall, the District of West Berkshire ranks 288 out of 326 local authority areas i.e. it is the 38th least deprived district in England.

- West Berkshire's average 'score' on the Indices of Multiple Deprivation (IMD) for all Super Output Areas is 9.98, which is well below the national average of 19.15 and compares well with the South East (14.14).

- 'Barriers to housing and access to services' is one particular concern flagged by the IMD data most likely to be a consequence of housing affordability and the distances some rural residents have to travel to access essential services.

- Super Output Areas ranked as being more deprived are overall, largely clustered around Newbury, with other areas in Calcot, Lambourn, Thatcham and Aldermaston.

- The Nightingales estate in Greenham is ranked as the most deprived area in West Berkshire. More specifically, Greenham is particularly deprived in terms of income and education, ranked only in the 17th and 5th percentile nationally. Similarly areas of Lambourn, Clay Hill, Calcot and Thatcham all score poorly on education.

- Lambourn Valley (around Mill Lane area) is the most deprived rural area, with Sulhamstead (Englefield) and Aldermaston (Aldermaston village and Soke), collectively being the top three most deprived rural areas in West Berkshire.

What's the picture in West Berkshire?

- Within West Berkshire 42% of all local conservation sites were positively managed, compared to a national average of 46% (2012/13) (Single data list 160.00)

- Households in West Berkshire use more than the national average of electricity. Average annual domestic electricity consumption in West Berkshire in 2012 was 5,342 kWh per household compared to 4,229 kWh nationally. West Berkshire's consumption has decreased by 7% since 2005.

- The level of gas consumption in West Berkshire is relatively comparable to the national average. The average annual domestic gas consumption in 2012 was 14,798 kWh per household in West Berkshire compared to 14,080 kWh nationally. West Berkshire's consumption has decreased by 24% since 2005.

- The Air Quality Management Areas (AQMA) for A339 / A343 / Greenham Road junction came into force in May 2009 and the A4 in Chapel Street, Thatcham in November 2011.

- The River Kennet is one of the main geographical features in the district and OFWAT's (the Water Services regulator) assessment of chemical quality shows that 86% of the lengths of rivers in West Berkshire were considered to be of good chemical quality.

- Flood risk is a concern, as only 18 of 69 Town and Parish communities avoided being flooded in the summer of 2007 this equated to 2,131 residential properties which flooded.

- Recent figures show that approximately 182 domestic properties and 35 commercial properties flooded in West Berkshire between December 2013 and March 2014.

Appendices

Appendix 1 – consultation plan
Appendix 2 – performance monitoring framework

Report on a consultation of the Draft Health and Wellbeing strategy for West Berkshire

Heather Hunter

December 2014

1. Overview and methodology

Overview

Healthwatch West Berkshire was requested to undertake a consultation with members of the public and stakeholders on the draft health and wellbeing strategy on behalf of the Health and Wellbeing Board. The Health and Wellbeing Board approved an operational plan and the consultation was carried out within the agreed time scale, concluding on the 21st November 2014 and an interim report of the raw data was made to the Director of Public Health.

Methodology

The Health and Wellbeing Board agreed an operational plan for the consultation. The plan was produced in August and the timescale was amended in October 2014.

The consultation commenced on the 27th October and ran for 28 days concluding on the 21st November 2014. Information about it was published on the Healthwatch website and on Healthwatch social media. An item about it was carried by The Breeze radio station on 12th November. There was also a press release.

The Healthwatch West Berkshire website carried two surveys which could be accessed from computers or from mobile devices. Paper copies of the surveys were also printed and the completed forms were returned to the Healthwatch office where they were uploaded to the survey monkey web site and collated with the online surveys received.

There were 20 outreaches across West Berkshire and 212 people completed surveys that produced 1685 items of information.[1] There were four events for members of the public to attend that were widely advertised. Those attending contributed their thoughts and suggestions in a general discussion-based presentation where the free discussion points were recorded from eight hours of debate.[2] The events were themed and were run with specific target audiences in mind although they were all also advertised as being open to the general public. The four target audiences were the voluntary and community sector; providers of healthcare; mental wellbeing and commercial providers.

As noted the work was carried out within the agreed time scale and all results were completed by the 21st November 2014. Healthwatch then analyzed the data to spot trends and areas of praise or discontent; to determine the overall message emanating from engagement with the public and to publish its findings.

[1] The full survey comments and statistics produced via survey money run into excess of 400 pages and are not included in this report.

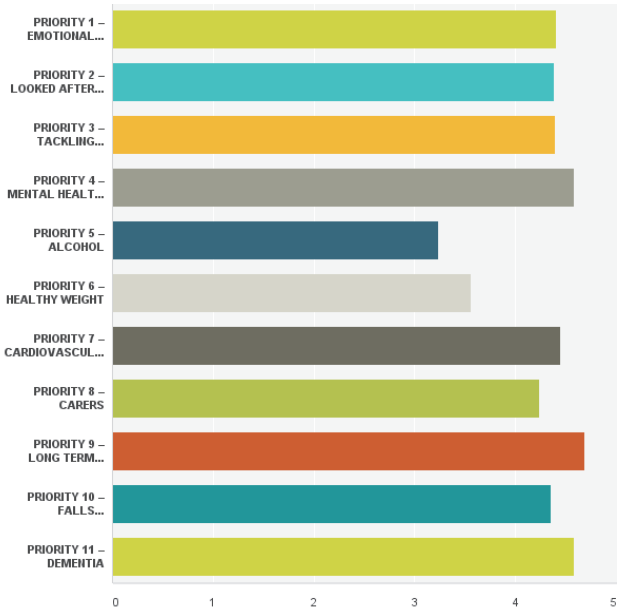
[2] The full notes from the public meetings are available as a separate report but have been included as collated items in précis form in the responses to priorities in section 4

2. A one page consolidated overview of the public engagement

The response to surveys

Do you agree with Priorities Identified? Overall satisfaction on a scale of 1 – 5

Breakdown of survey votes cast



	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree	Total	Average Rating
PRIORITY 1 – EMOTIONAL WELLBEING OF CHILDREN AND YOUNG PEOPLE	0.00% 0	3.47% 7	4.95% 10	39.11% 79	52.48% 106	202	4.41
PRIORITY 2 – LOOKED AFTER CHILDREN	0.50% 1	1.00% 2	8.96% 18	39.30% 79	50.25% 101	201	4.38
PRIORITY 3 – TACKLING INEQUALITIES – CHILDREN	0.00% 0	2.49% 5	9.95% 20	33.83% 68	53.73% 108	201	4.39
PRIORITY 4 – MENTAL HEALTH AND WELLBEING IN ADULTS	0.00% 0	1.01% 2	1.01% 2	37.19% 74	60.80% 121	199	4.58
PRIORITY 5 – ALCOHOL	5.47% 11	19.90% 40	31.34% 63	31.84% 64	11.44% 23	201	3.24
PRIORITY 6 – HEALTHY WEIGHT	2.00% 4	11.50% 23	29.50% 59	42.00% 84	15.00% 30	200	3.56
PRIORITY 7 – CARDIOVASCULAR DISEASE	0.00% 0	1.49% 3	5.45% 11	39.60% 80	53.47% 108	202	4.45
PRIORITY 8 – CARERS	0.00% 0	2.49% 5	12.44% 25	43.28% 87	41.79% 84	201	4.24
PRIORITY 9 – LONG TERM CONDITIONS	0.00% 0	0.50% 1	1.98% 4	25.25% 51	72.28% 146	202	4.69
PRIORITY 10 – FALLS PREVENTION	0.00% 0	2.51% 5	5.03% 10	47.24% 94	45.23% 90	199	4.35
PRIORITY 11 – DEMENTIA	0.00% 0	2.50% 5	0.50% 1	33.00% 66	64.00% 128	200	4.58

Support for all priorities was found to be in excess of 65% of all respondents

The highest support was for long-term conditions closely followed by mental health and wellbeing in adults. The third most popular priority was dementia care. The least support was for alcohol-related conditions and weight management.

General Recommendations from members of public

- 7.5% of respondents noted cancer and terminal illness as a missing priority.
- 4.5% of respondents highlighted the need for maternity care to be a priority.
- Operational steps to achieve the outcomes to be included in the document.
- A timeframe should be set to provide a target for achievement
- The indicators of achievement should not include personal academic performance measurement of an individual child. It is recommended a different means of measurement be found.
- Free school meal entitlement was not considered a good or accurate measure of poverty and consideration should be given to finding a different measure

Overall

- The document was found to be intentional and informative with clear high level detail.
- The addition of an operational plan to show how the strategic aims will be achieved was thought to be needed to make the document complete.

3 Gathering the public response

Surveys

The public surveys sought to obtain reaction and responses to the strategy document by way of examining the priorities against the identified need, and considering the methodology of the measurement of the performance of those priorities in relation to that need. There were two surveys: - a general survey to gather short responses and an optional longer survey for those who wanted to offer a more in-depth response. This also gave those who did not have the time to attend one of the four public events the opportunity to make wider comment on the strategy and its presentation

- 208 West Berkshire residents completed the general survey and this resulted in 1,685 response details.
- 10 people completed the optional long survey. Their interest in the strategy together with their supporting demographics and detailed responses are shown separately to those of the respondents who completed the shorter general survey.

Public meetings

The public meetings were an opportunity for all members of the public attending to debate the priorities, examining them in the light of the identified need. They also provided a chance to consider the proposed methodology for measuring the effectiveness of the applied strategy. Not many people came to the meetings but there was lively debate between those who did attend and the comments and contribution were of a high standard. The public meetings debated each priority in turn and the response to these debates was captured for later analysis.

Report

To facilitate the reading of this report the survey responses received are presented first, together with the demographics of the respondents. Each individual supporting question raised is then presented followed by a précis of the consolidated strands that have emerged. The public meetings addressed each priority individually. To assist readers of this report the key drivers of the strategy have been replicated under each issue. These are:

- Priority
- Why is it important?
- What is the picture in West Berkshire?
- What we will do.
- How we will do it.
- How we will measure what we have done

This is followed by a précis of the strands of responses under the three headings,

- General points raised in debate
- Recommendations from debate to support work on this priority
- Comments on measures

3.1. Surveys

3.1.1. The interest of the respondent in the strategy – short survey

Answer Choices		Responses	
Member of the public		92.42%	183
Ward Councillor		0.51%	1
Service Provider		4.04%	8
Commissioner of services		1.52%	3
Voluntary or Community Sector organisation		1.52%	3
Business organisation		0.00%	0
Other group or organisation		0.00%	0
Other (please specify / or provide further information)	Responses	3.03%	6
Total Respondents: 198			

3.1.2. The interest of the respondent in the strategy – long survey

Answer Choices		Responses	
Member of the public		30.00%	3
Ward Councillor		10.00%	1
Service Provider		40.00%	4
Commissioner of services		0.00%	0
Voluntary or Community Sector organisation		30.00%	3
Business organisation		0.00%	0
Other group or organisation		0.00%	0
Other (please specify / or provide further information)	Responses	10.00%	1
Total Respondents: 10			

3.1.3. Demographic of those who filled in the short survey

Answer Choices	Responses	
17 or younger	15.15%	30
18-20	6.57%	13
21-29	9.09%	18
30-39	31.31%	62
40-49	19.19%	38
50-65	12.63%	25
66-74	3.03%	6
75 and older	3.03%	6
Total		198

3.1.4. Demographic of those who filled in the longer survey

Answer Choices	Responses	
17 or younger	0.00%	0
18-20	0.00%	0
21-29	0.00%	0
30-39	30.00%	3
40-49	0.00%	0
50-65	50.00%	5
66-74	20.00%	2
75 and over	0.00%	0
Total		10

3.1.5. Do you agree with priorities identified?

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree	Total	Average Rating
PRIORITY 1 – EMOTIONAL WELLBEING OF CHILDREN AND YOUNG PEOPLE	0.00% 0	3.47% 7	4.95% 10	39.11% 79	52.48% 106	202	4.41
PRIORITY 2 – LOOKED AFTER CHILDREN	0.50% 1	1.00% 2	8.96% 18	39.30% 79	50.25% 101	201	4.38
PRIORITY 3 – TACKLING INEQUALITIES – CHILDREN	0.00% 0	2.49% 5	9.95% 20	33.83% 68	53.73% 108	201	4.39
PRIORITY 4 – MENTAL HEALTH AND WELLBEING IN ADULTS	0.00% 0	1.01% 2	1.01% 2	37.19% 74	60.80% 121	199	4.58
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PRIORITY 9 – LONG TERM CONDITIONS	0.00% 0	0.50% 1	1.98% 4	25.25% 51	72.28% 146	202	4.69
PRIORITY 10 – FALLS PREVENTION	0.00% 0	2.51% 5	5.03% 10	47.24% 94	45.23% 90	199	4.35
PRIORITY 11 – DEMENTIA	0.00% 0	2.50% 5	0.50% 1	33.00% 66	64.00% 128	200	4.58

3.1.6. Is there anything not listed as a priority that you believe should be a priority?

The individual responses were:-

Asthma	1
Diabetes	1
Smoking	1
Support for single parents	1
Children's illnesses	6
Maternity	9
Cancer and terminal illness	13
Parents of children with disabilities support	1
Support for commercial providers of services	1
Healthy Weight should be changed to Healthy Weight and Physical Inactivity	2
Domestic Abuse	1
Recognizing signs of Lymphoma	1
Rural isolation	1

3.1.7. Do you think the strategy document and priorities provide a clear direction for improving health and wellbeing and reducing inequalities?

Answer Choices	Responses	
Yes	60.00%	24
No	42.50%	17
Total Respondents: 40		

There were many comments made by the public included in the raw data collected. The following themes attracted the greatest number of responses:

- A definite feeling that public education, especially of young people, with regard to health and wellbeing would improve health.
- Long-term conditions appear to be marginalized due to the demands of acute care.
- Higher input into, and raising awareness of, mental health is needed as it can become a drain on resources because this issue is not properly addressed in society.
- Physical inactivity was noted as an independent risk factor in many physical and mental conditions. It was therefore suggested that it should be listed separately to weight because:
  a) physical inactivity is seen as an independent risk factor
  b) it was noted that getting people more active will positively impact on many of the other priorities such as CVD, dementia and emotional wellbeing.

3.1.8. Do you have any views on the implementation of the strategy and priorities identified?

The overall response to the high level strategy as outlined in the draft document was well-received and all priorities were approved by over 65% of respondents as the correct response to the assessment of need in West Berkshire.

There was however disappointment that there were no clear steps or easily identifiable pathways of action to ensure that the priorities would be met. Members of the public would like an operational document to accompany the high-level draft strategy document to show clearly what is being done to achieve the aims.

It was also suggested that if the wider determinants surrounding Health and Wellbeing are to be addressed efficiently there is a need for more collaborative working between the Health and Wellbeing Board and other multi-agency partnerships e.g. the Safer Communities Partnership. It was noted that although it is not necessary to bring all strategic documents together, strategic approaches do need to align.

[The responses to this question relative to individual priorities have been moved to the next section of this document and amalgamated into the specific priority identified]

The remaining questions were included on the extended survey only

3.1.9. Do you think the strategy will be able to drive commissioning of health, social care and other services that impact on health and wellbeing?

	1. Strongly Disagree	3. Disagree	5. Neither Disagree Nor Agree	8. Agree	10. Strongly Agree	Total	Average Rating
(no label)	0.00% 0	10.00% 1	70.00% 7	20.00% 2	0.00% 0	10	5.40

The response to this section was neither positive nor negative, with 70% of respondents indicating a neutral position. Overall the responses indicated that people were satisfied with the high level strategy but there appeared to be no particular assurance that it would drive or influence commissioning.

3.1.10. Do you have any comments about how the partners on the Health and Wellbeing Board should work together to achieve the strategy and who else they should work with?

The feedback received from the public surveys relative to how the partners on the Health and Wellbeing Board should work together centered round operational rather than relational working, dwelling more on centralised IT and working platforms rather than making any significant suggestions about relational working at board level.

There was however a significant call for the board to work closer and more collaboratively with other well-established partnerships and forums such as the

Mental Health Forum, Safer Communities Partnership and the Domestic Abuse Forum. There was also a particular plea to include commercial service providers as they are delivering at the point of need and of necessity on tightly-balanced budgets.

The other providers who particularly featured in the public responses as those with whom the Health and Wellbeing Board should work were groups who provided physical activity opportunities such as Get Berkshire Active. Such groups promote physical activities and deliver national programmes locally and can provide support and advice to Local Authorities, Public Health teams and Clinical Commissioning Groups on matters relating to sport and physical activity.

3.1.11. Do you have any other comments to make about the strategy and the identified priorities?

There were a number of responses calling for a greater involvement of communities and individuals in 'new' ways rather than simply focus groups, public debates and surveys. It was suggested that social media could be used skillfully to engage people and their opinions particularly if this was a well-managed community, such as the Healthwatch social media network, where public response can be readily accessed.

It was suggested that within the section – 'What does affect our health and wellbeing?'- the Safer Communities element should read: 'We will work in partnership to keep the incidents of crime and anti-social behavior low, ensuring that West Berkshire is a safe place to live, work and visit.'

The priorities were not further questioned. However the measurements used for gauging the effectiveness of the strategy were questioned. In particular the use of 'free school meals' entitlement an accurate measurement of poverty was severely questioned by many respondents, some of whom offered accounts of friends or neighbours who had children receiving the entitlement. Here is a typical example: "We have neighbours from excellent professional backgrounds who after a catastrophic redundancy experience are left with little income so their children have a free school meal entitlement. Nevertheless they continue to live in a four bedroom home, wear nice clothes and have polite children who do not get in trouble with the police".

4. Public debate of Priorities as set out in the draft strategy of the vision for Health and Wellbeing in West Berkshire

The public debates were arranged in several areas of West Berkshire and advertised in the localities and across West Berkshire. A registration process was used to determine the likely attendance in each area. No registrations were received for three rural areas including Hungerford and therefore the planning of four public engagements was as follows:

- Consultation Event 1 – Target audience - service users and carers.
  - Weds 12th Nov -The Langdon Room, Newbury Rugby Club, Monks Lane, Newbury RG14 7RW
- Consultation Event 2 – Target audience - commercial service providers.
  - Thurs 13th Nov - Frank Hutchins Community Centre Bradley-Moore Square, Harts Hill Road, Thatcham, RG18 4QH
- Consultation Event 3 –Target audience - voluntary service sector.
  - Fri 14th Nov -Greenham Community Centre The Nightingales Newbury RG14 7SZ
- Consultation Event 4 – Target audience - general public
  - Mon 17th Nov - Hilton Newbury Pinchington Lane, Newbury, RG14 7HL

Those attending were presented with a general overview of the aims of the draft strategy document, these being:-

The vision for health and wellbeing in West Berkshire:

- All children, young people and adults will have the opportunities to achieve their potential and lead healthy, happy and safe lives. Inequalities in health will be tackled and vulnerable groups supported
- There will be access to timely, integrated health and social care services, ensuring rural areas are well served
- Our communities will be enabled and empowered to have control over their own health and wellbeing and wider determinants of health will be addressed in partnership
- This shared vision for what success will look like will enable partners to commit to making the best use of public money by working in new ways and sharing resources, including finance, people, buildings and information

To accomplish this vision, services will be

- Delivered relative to need, ensuring areas with the highest need are targeted to address health inequalities
- Accessible to all, taking into account disabilities, rurality and working patterns
- Based on integrated care pathways, with all relevant providers working together to maximise the benefits of delivery
- Evidence-based and provide value for money
- Socially, economically and environmentally sustainable

The attendees were reminded that the Health and Wellbeing Strategy sets out 11 key priorities, derived from the Joint Strategic Needs Assessment (JSNA) that details West Berkshire's population and its needs; national and local drivers; service users' and carers' views; expert opinion and the evidence base for interventions.

It was also noted that the priorities include promoting healthier lifestyles and positive mental health and wellbeing throughout the life course, preventing ill health plus providing integrated, high quality services though joint working, bringing together health, social care and the voluntary and private sector.

Attendees were then asked to debate each priority. An overview précis of the contents of the strategy document was presented to assist in reminding people of the content. Each priority was presented in the same way:

- Priority
- Why is it important!
- What is the picture in West Berkshire?
- What we will do.
- How we will do it.
- How we will measure what we have done

To assist readers of this report the précis information is provided followed by comments and input from those in attendance. Some information overlaps between various headings but to provide a simple overview for readers the information has been grouped as follows:-

- General points raised in debate
- Recommendations from debate to support work on this priority
- Comments on measures

4.1. PRIORITY 1 – EMOTIONAL WELLBEING OF CHILDREN AND YOUNG PEOPLE

Why is it important?

- Good emotional health at a young age promotes good emotional health in adulthood
- Poor mental health at a young age can impact on:
  - educational attainment
  - physical health
  - social skills
  - Increased risk of self harm and suicide

What is the picture in West Berkshire?

- An estimated 1,360 boys aged 5 to 16 have a mental health disorder
- An estimated 895 girls aged 5 to 16 have a mental health disorder
- Around 790 referrals were made to the Children and Adolescent Mental Health Service
- 26 young people were admitted to the Berkshire Adolescent Unit with mental health problems

What we will do

- We will promote emotional wellbeing in children and young people

How we will do it

- Through prevention
- By early identification
- By providing appropriate services

How we will measure what we have done?

- Rate of 10-17 year olds receiving their first reprimand, warning or conviction
- Rate of people aged 10 to 24 years admitted to hospital as a result of self harm
- Number of Help For Families enquiries with an identified emotional wellbeing or mental health issue
- Number of Educational Psychology referrals
- Number of support and achievement or Education Health and Care plans for children with SEN that identify a mental health issue

PUBLIC RESPONSE

General points raised in debate:

- Schools could do more to support emotional resilience and to promote positive mental health.
- Mental health needs to be an open subject about which young people feel able to talk.
- There is a risk of hidden problems not being recognised, e.g. rural schools.
- It is not clear how the priority will be achieved. It is rather vague, though good to leave scope to try different things.
- If someone is admitted to hospital for self-harm there should be earlier

support information available.

Recommendations from debate to support work on this priority:

- Training for teachers, young people and families about mental wellbeing should be more available.
- The introduction of family intervention projects to promote mental wellbeing.
- More primary care mental health specialists.
- More work could be done to encourage community a group e.g. scouts, to promote mental wellbeing.
- Teachers could be offered training to run peer support projects to help prevent eating disorders. e.g. 'A' level students helping younger students learn about body image
- The varying needs of different groups should be met, e.g. children who are deaf or hard of hearing. Also target people with learning disabilities and physical disabilities.
- Mental health is a taboo in some countries and therefore particular work is required to educate some ethnic communities.

Comments on measures:

- Although the priority is about all young people, the outcome measures only focus on those with a problem.
- There should be a more general measure across the age group.
- Proposed additional outcome measure: mental wellbeing of young people generally e.g. using a survey of schools as most of the current measures are targeted at a limited range of people.
- In relation to the measure concerning 'first reprimand' - Mental health should be closer to the police so people do not just go into the justice system but are diverted to mental health services. These could be IAPT or CAMHS.
- There is also an issue of labelling people as offending which should be picked up e.g. conduct disorder rather than offending.

4.2. PRIORITY 2 – LOOKED AFTER CHILDREN

Why is it important?

- Children enter care for a range of reasons including physical, sexual or emotional abuse, neglect, and family breakdown.
- Children in care generally have significantly higher levels of health needs than other children and young people
- Their life opportunities and long term outcomes are often poorer and poor health is a factor in this.
- Removal from family, placement location and transitions mean that these children are often at risk of having inequitable access to health services, both universal and specialist

What is the picture in West Berkshire?

- March 2013, the Council was responsible for 144 looked after children. [40 per 10,000]

- October 2013, the Council was responsible for 158 looked after children.
- The number of unaccompanied asylum-seeking children looked after by West Berkshire Council is 10
- There are more boys than girls in care

What we will do

- We will improve the health and educational outcomes of looked after children through high quality health, and social care support

How we will do it

- The majority of looked-after children are placed in family settings
- Others placed in settings according to their individual needs e.g. nursing establishments or independent living
- All children in care are subject to a health plan

How we will measure what we have done?

- Emotional wellbeing of looked-after children
- Number of looked-after children having timely health assessments (DfES)
- Number of looked-after children having their teeth checked annually by a dentist (DfES)
- Number of looked-after children who have up to date vaccinations (DfES)
- Number of looked-after children obtaining 5 GCSEs (DfES)

PUBLIC RESPONSE

General points raised in debates:

- A child should have a voice and be provided with an advocate.
- Could more be done to link children in care into community and voluntary organisations that may help them manage their physical and emotional wellbeing?
- Putting people in family settings is excellent. Could more be done to advertise the need for support families?
- All the targets should be SMART.

Recommendations from debate to support work on this priority:

- There should be an assessment and a care plan in place as soon as children go into care.
- Could a measure be introduced to track a young person's progress a year or two after leaving care?
- Pregnant women have a 'red book' record. Could children in care have a similar record handed to them, so they have the record in their possession rather than it being held elsewhere?
- All young people in care should have a care coordinator – this does not now seem to be the case.

Comments on measures:

- The target of GCSEs is measuring the performance of the youngster rather than the provider.
- The measure of achieving 5 or more GCSEs needs to be compared with

similar data from previous years and also compared with that of children not in care.

• There is a need to show the improvement for looked-after children, but also whether their outcomes are catching up with the rest of the population.

• Checking teeth is not really a realistic measure unless it is compared against a record of children not in care.

4.3. PRIORITY 3 – TACKLING INEQUALITIES – CHILDREN

Why is it important?

- The Marmot Review of Health Inequalities highlighted that the lower your socio-economic status the poorer your health outcomes.
- Health inequalities arise from a variety of social determinants including income, educational attainment, poor housing or access to green spaces.
- These factors not only affect children living in poverty but also vulnerable children

What is the picture in West Berkshire?

- An estimated 3,350 (11.2%) children living in poverty
- 56% of pupils in Key Stage 2 (aged 7 to 11 years) known to be eligible for free school meals achieved level four or above in comparison with 79% of other pupils, a gap of 23%
- It is estimated that 4.4% (210 individuals) were Not in Education, Employment, or Training (NEETs).
- Those more likely to be NEET - children of parents who are NEET, teenage parents, people with a learning disability or mental health problem, those involved with alcohol or substance misuse
- The National Child Measurement Programme data demonstrates a correlation between deprivation and obesity

What we will do

- We will improve the educational achievement of children on free school meals to bring them into line with the overall achievement of all children

How we will do it

- By working with children's services, housing, planning, environment and leisure services, Public Health and Wellbeing can work towards improving health outcomes and tackle health inequalities

How we will measure what we have done?

- - School readiness – the % of year 1 pupils with free school meal status achieving the expected level in the phonics screening check
- - School readiness – the % of year 1 pupils with free school meal status achieving a good level of development at the end of reception
- - % of those young people in Key Stage 4 with free school meals status achieving 5 or more A*-C grades including English and Maths

PUBLIC RESPONSE

General points raised in debates:

- Free school meals are one benchmark. Others are needed.
- There is no mention of disabilities as a cause of health inequalities.
- Each child needs a plan that will help them and that won't stigmatise them, e.g. extra tuition, after school clubs.
- Young carers suffer as a result of health inequalities and this should be included in the strategy.
- There is more control over nutrition at primary school. This could be extended to senior schools.
- There is a need to tackle the inequalities of the parents to impact on the children.
- There does not appear to be enough support for those with learning disabilities or mental health problems.
- There is a lot of affluence in West Berks, as well as some areas of poverty. Children are likely to be at school with people of varying degrees of affluence which can create a problem. In other areas, even at a lower social level, pupils may be more homogeneous. Children will notice the difference. They can feel like one of the 'have nots' from an early stage.
- In schools it needs to be made less clear who is receiving free school meals, given the stigma and bias it can create for the child.
- If there were more school checks – nurses checking teeth etc. it would stop a lot of health inequalities and it would cover everyone, whether deprived or not.
- If a child is vulnerable, it doesn't matter if they have wealthy parents if they are neglected.
- Rurality can be a cause of inequality.
- Other protected characteristics should be considered e.g. ethnicity.

Recommendations from debate to support work on this priority:

- There are various projects that work with students who are at risk of becoming NEET and these should be included e.g. referrals from YOT, or social services.
- There is a link between lack of confidence in going to school or college because of disabilities or lack of relevant life skills and becoming NEET. Projects need to be devised to help such students at a younger age.
- Less emphasis should be placed on GCSE attainment and new measures/projects introduced to help prevent young people falling through the gaps.

Comments on measures:

- Free school meals are one benchmark but you need others. Children can come on and off free school meals.
- There are no measures of health and health inequality across all children so it would be good if some could be added.

- The measures should be looking at a broader range of inequalities.
- The target of GCSEs is measuring the performance of the youngster rather than the provider.
- The measure of achieving 5 or more GCSEs needs to be compared with similar data from previous years and also compared to children not in care.
- A measure on NEETs should be introduced.
- School readiness at reception stage should be extended to readiness for transition at secondary age.
    - However if when a child reaches secondary school they are deemed not ready, there is a risk of taking children through the same year again, which is a waste and can put them off.
    - There needs to be something about primary and secondary schools talking more to each other.

4.4. PRIORITY 4 – MENTAL HEALTH AND WELLBEING IN ADULTS

Why is it important?

- In any given year, one in four adults in the UK will experience a diagnosable mental health problem.
- Risk factors for poor mental health and wellbeing include: - poverty, discrimination, violence, abuse, peer rejection and isolation, stressful life events and poor physical health.
- Factors that can positively affect mental health and wellbeing include: - economic security; empowerment; feelings of security; positive interactions with others; physical activity; stable and supportive family environments and a healthy diet and lifestyle.
- Poor mental health can impact on physical health in the same way that poor physical health can impact on mental health.
- National research has shown that around 30% of people with a long-term condition also have a mental health problem.
- Some unhealthy behaviours are used to control stress or boast mood.
- It is important to ensure that we achieve a parity of esteem (by ensuring that we value mental health equally with physical health) and that we promote positive mental health and wellbeing

What is the picture in West Berkshire?

- Around 125 people in every 100,000 people are admitted to hospital due to mental ill-health. This is lower than the national and regional average.
- In West Berks, about 7 people in every 100,000 commit suicide (or injury of undetermined intent).
- An estimated 4,467 (9%) of people with depression and/or anxiety in West Berks are receiving treatment through Increasing Access to Psychological Therapies
- Uptake of psychological therapies is higher than the national and regional average
- The rate of people recovering after psychological therapy treatment is also higher than the national average
- Significantly more people registered with GP Practices in West Berks are recorded as having depression than the national, regional, and Berkshire

West Health CCG area average.
- 14,718 people registered with GP Practices are on clinical registers recorded as having depression. This equates to 13% of the GP list size population.
- Around 2,150 people aged 65 and over living in West Berks are estimated to have depression
- Nationally published data for 2010/11 suggests that, in West Berks LA, significantly fewer (2.5%) adults in contact with secondary mental health services are in employment than the national (9.5%) and regional (7.9%) averages

What we will do
- We will promote mental health and wellbeing in all adults

How we will do it
- Through prevention,
- Early identification
- Provision of appropriate services

How we will measure what we have done?
- % of adults in contact with secondary mental health services who live in stable and appropriate accommodation
- Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate
- Excess under 75 mortality rate in people with serious mental illness
- Self reported wellbeing – low satisfaction score
- Self-reported wellbeing – low worthwhile score
- Self-reported wellbeing – low happiness score
- Self-reported wellbeing – people with a high anxiety score
- Mortality rate from suicide
- % of adults on the QOF depression register
- Numbers of people attending Talking Therapies

PUBLIC RESPONSE

General points raised in debates:

- Physical health is an important factor in mental health. It may be related to the drugs they are on. People cannot necessarily look after themselves properly when they are unwell.
- There are places of health and support such as churches which need to be offered training and encouraged to assist.
- Many suicides have not been of physically healthy patients, as statistics indicate many have seen a GP in the previous seven days, so GPs have a big part to play and deserve additional training support.
- There should be more information for the public on general display.
- There is not enough done publicly in West Berks to tackle depression early on.
- There has been a lack of mental health service and support in West Berks for a long time. There is IAPT which is working but secondary care

psychology has a waiting list of a year.

- There is a need to do work in schools to raise awareness of metal wellbeing and its importance.
- Physical activity is particularly important in depression and this needs to be promoted.
- People are more likely to have mental health problems if they have a long-term condition.
- Anxiety and panic is common for people with disabilities.
- The public transport network in West Berks is poor. There is a link between mental health and loneliness and isolation. Cuts to transport are being made all the time and the effect on mental wellbeing should be considered when such cuts are considered.

Recommendations from debate to support work on this priority:

- GPs need more training and it should be readily available.
- Rethink provision of peer support; helping people at a lower level in more practical ways. Other community groups and organisations should be mapped to provide a support network locally.
- Adults should be screened for things like Asperger's and ADHD.
- Everyone with diabetes should be screened. Diabetics Nurses should be trained to ask the right questions to identify mental health issues.
- GP surgeries could have a trained wellbeing nurse to do the mental health screening.
- The 'recovery college' works well elsewhere. It runs as courses which are open to the public more generally. It could be introduced in West Berks and delivered in rural community centres, as with adult education
- The strategy ought to include other mental health issues, as well as depression.

Comments on measures:

- The outcome measure of the percentage of adults on the depression register is not necessarily a good or accurate measure. It may mean more people are being recorded, which is good, or that there are more people who are depressed, which is bad.
- There was concern that the depression register may not continue.
- The strategy should be structured within a timeframe of 5 or 10 years (or other specified period of time.
- The measures do not do much beyond depression and could be extended.
- Is postnatal depression included as it ought to be and also used as a separate measure in regard to maternity support requirements

4.5. PRIORITY 5 – ALCOHOL

Why is it important?

- Excess alcohol consumption can cause health problems such as liver cirrhosis; obesity; mental health problems such as depression; reduced fertility; high blood pressure; increased risk of cancer; accidental injury; violence; sexually transmitted infections and alcohol dependency.
- Excess alcohol consumption can also affect the wellbeing of family,

friends and the wider society through problems such as crime and anti-social behavior

What is the picture in West Berkshire?

- In 2013/14, there were 130 adults accessing structured alcohol treatment
- Estimates of binge drinking behaviour suggest that just under 18% of the population aged over 18 years of age engage in binge drinking.
- An estimated 19% of the West Berks LA population engages in increased risk drinking. This would equate to over 20,000 people in West Berks
- An estimated 7% of the West Berks LA population engage in higher risk drinking which equates to 9000 people
- There were a total of 1,185 hospital admissions
- Admissions due to alcohol have increased since 2004
- Increased benefit claims due to alcoholism

What we will do

- We will promote sensible and safe drinking

How we will do it

- We will increase the number of people receiving effective and timely support for alcohol-related problems

How we will measure what we have done?

- Under 75 mortality rate from liver disease considered preventable
- Alcohol-related admissions to hospital
- % of those referred accessing Tiers Two and Three treatment
- % of residents referred into treatment who reduce their drinking to safe levels
- % of residents leaving treatment with a completed plan of care
- Number of alcohol and health campaigns successfully run

PUBLIC RESPONSE

General points raised in debates:

- Why is this a priority and not tobacco that is a much bigger killer?
- There are problems in linking alcohol and drugs, because one is illegal, so that affects how you deal with it.
- There's a need to challenge people on alcohol consumption, as many are not aware what is safe and what is not.
- There is an issue in that it is possible to buy alcohol at any time of the day.
- This is not identifying dual diagnoses, e.g. if someone is using alcohol as part of a mental health problem. There is no measure about that.
- Maybe the alcohol priority should be widened to other unhealthy behaviours and addictions.

Recommendations from debate to support work on this priority:

- All those with hospital admissions should have a standard follow-up pathway.
- People do not want to go to groups such as Turning Point because there

are people there with drugs problems. Therefore a specific group to assist those with alcohol-related problems should be made available.

- It would be better to have support on alcohol nearer to people's homes.
- This priority could be extended and phrased in a different way, e.g. risky or harmful behaviors
- There is a need to look at how people with co-morbidity issues are assisted.

Comments on measures:

- The measures should be clear what (high or low figure) is good or bad. For example, '% referring to tiers 2 and 3' – What is good, more or less?
- It was proposed that 'risk drinking' be included as a measure as this figure is reported on when looking at the situation in West Berks.
- In the measures 'successfully run' alcohol campaigns are cited but
  - clarity on how a 'successful campaign' is measured required as this is not clear.
  - a campaign could be considered an output but does not indicate its impact on the problem.
  - there is an issue of knowing whether they are the right campaigns.
- It was acknowledged that campaigns could help with alcohol as they have with smoking.

4.6. PRIORITY 6 – HEALTHY WEIGHT

Why is it important?

- Weighing too much or too little can cause health problems and it is important to maintain a healthy weight to stay in good health.
- To reduce the likelihood of developing conditions associated with obesity, such as type 2 diabetes, cardiovascular disease and cancer.
- Many other conditions are associated with obesity include angina, gall bladder disease, liver disease, ovarian cancer, osteoarthritis and stroke, as well as mental health problems such as low self esteem and depression

What is the picture in West Berkshire?

- Over 20% of Reception Year children are classified as overweight or obese
- Obesity and overweight prevalence in Year Six rises to approximately 30% of children in West Berks.
- An estimated 23.7% of adults in West Berks are obese, though this is likely to be an underestimation of true prevalence.
- Different areas in West Berks are estimated to have varying levels of obesity. The estimated prevalence of obesity in West Berkshire ranges from 18% to 28.6%

What we will do

- We will maintain or increase the number of people who are a healthy weight

How we will do it

- By promoting physical activity and healthy eating

- By providing a range of evidence-based weight management interventions

How we will measure what we have done?

- Excess weight in 4-5 year olds and 10-11 year olds
- Excess weight in adults
- % of physically active and inactive adults
- Number of people completing a weight management intervention (Eat4Health, dietician-led course, Barometer) (local indicator)
- Number of people enrolling on a health walk
- Number of children completing a 'Let's Get Going' after school intervention

PUBLIC RESPONSE

General points raised in debates:

- It is good that there are increased opportunities for healthy walks
- More could be done on workplace health
- It was noted that this is a government-driven matter at the moment so it was queried if it really needed to be a local priority

Recommendations from debate to support work on this priority:

- More should be done to encourage workplace health
- The dangers of physical inactivity should be highlighted

Comments on measures:

- Physical inactivity is more problematic than being overweight.
- It was believed that the measurements used were likely to be very inaccurate as they are based on people registered for walking or a weight management programme

4.7. PRIORITY 7 – CARDIOVASCULAR DISEASE

Why is it important?

- There are four main types of CVD; Coronary Heart Disease, Stroke, peripheral arterial disease and aortic disease.
- Most deaths caused by CVD are premature and could be prevented by addressing the risk factors including: high blood pressure; smoking; high blood cholesterol; diabetes; lack of exercise; being overweight or obese; a family history of heart disease, and ethnic background

What is the picture in West Berkshire?

- An estimated 28% of adults (aged 16+) in West Berkshire have hypertension (high blood pressure).
- The observed prevalence of coronary heart disease
- In 2012, the coronary heart disease mortality rate (under 75 years) for NHS Newbury and District Clinical Commissioning Group was 27 per 100,000.
- The observed prevalence of stroke is 1.4%.
- A total of 3,827 people received an NHS Health Check either in the

community or through their GP practice. This is an uptake of 44%

What we will do

- We will improve the prevention and early identification of cardiovascular disease in primary care and community settings

How we will do it

- Through the provision of NHS health checks
- Screening for other key risk factors

How we will measure what we have done?

- Rate of mortality considered preventable from all cardiovascular diseases (including heart disease and stroke) in those aged 75 per 100,000 population
- Smoking prevalence among persons above 18 years of age
- Number of people quitting smoking at 4 weeks and 12 weeks
- % of eligible adults aged 40-74 who are offered an NHS health check
- % of those offered who have a completed NHS health check

PUBLIC RESPONSE

General points raised in debates:

- There is a need to make the link with other problems that impact on CVD, e.g. mental health or diabetes.
- People need to be made aware whether the drugs they are prescribed increase the risk of CVD.
- There is a suggestion that 'activity' should be the priority as this affects cardiovascular disease but also other health problems.
- There is an issue of what happens after someone has had a health check and what services they are directed to, and also if those services work.

Recommendations from debate to support work on this priority:

- It would be good to have better screening for mini-strokes, e.g. through eye checks.
- There is a need to consider co-morbidities e.g. People with disabilities and from ethnic backgrounds.

Comments on measures:

- There is a risk that people quit smoking but then take up e-cigarettes.
- There is an issue of how you measure those stopping smoking if they're not on a programme
- NHS health checks were considered helpful

4.8. PRIORITY 8 – CARERS

Why is it important?

- Carers help to ensure that the cared-for are able to maintain their independence and stay in their own homes.
- The health and wellbeing of carers is paramount. It is important that they

are able to stay healthy and maintain their caring role.
- To support carers, their needs must be identified and they must be supported with information and advice and have access to services that support their caring role

What is the picture in West Berkshire?
- Around 14,000 (9.3% of the West Berks population) people provide unpaid care, although it is likely that there are many unidentified carers. The majority of carers are of working age and are adults aged between 25 and 64.
- Over 10,000 people provided 1-19 hours of unpaid care a week, 1,461 provided 20-49 hours and 2,505 provided 50 hours or more unpaid care per week.
- In West Berks, there has been little change in the provision of unpaid care between 2001 and 2011

What we will do
- We will promote the health and wellbeing of carers of all ages

How we will do it
- Seek to identify carer needs as they must be supported with information and advice and have access to services that support their caring role

How we will measure what we have done?
- Social isolation – the % of adult carers who have as much social contact as they would like
- Carer-reported quality of life
- Health-related quality of life for carers
- Number of carers who are offered and take up an NHS health check
- Number of carers receiving an assessment

PUBLIC RESPONSE

General points raised in debates:

- There is a need for enough paid carers to do what they are supposed to do or the burden falls on the unpaid carers.
- Some people are both carers and cared-for but with different needs. E.g. couples who are joint carers.
- Hidden carers are a concern as their numbers are unknown and they need support.
- There are issues around respite that should be noted; that this does not necessarily mean carers need to be away from those they look after – although sometimes they want to be – but that they have respite from the duties of caring.
- Adaptations are important. There is a big backlog for assessments, and that needs to be addressed. Lack of adaptations is a big thing that disables people and leaves them sitting in a chair all day.
- Caring can have a big financial impact if it means the carer has to change their work position (e.g. step down to a lower level) or work fewer hours.

- It may be hard to identify carers if they don't live with the person being cared for
- In Berkshire, most carers' events are in Reading which does not assist those living in rural West Berks.

Recommendations from debate to support work on this priority:

- People who have been in a mental health hospital have carers who can get access to online support. It might be possible to provide dedicated online support for other carers.
- Education for carers is needed e.g. they can feel that they have to molly-coddle the person for whom they are caring when they may sometimes need to encourage independence. It doesn't stop the caring role but may help them do it better.
- There should be a specific reference in the strategy to young carers.
- There is a need to capture the different roles of carers e.g. parents looking after children, working age or elderly, in order to provide the best information for the specific care requirement.
- Working age carers could be encouraged to take up part time employment as a break away from being a carer.
- There need to be more carer-specific groups for carers, e.g. young carers.

Comments on measures:

- Could a measure of employment be added? Some carers may be in employment, but there are difficulties of staying in employment without additional support
- Carer assessments and health checks should have a timeframe guarantee after request e.g. within a month.

4.9. PRIORITY 9 – LONG TERM CONDITIONS AND DISABILITIES

Why is it important?

- Long term conditions are health problems that can't be cured but are controlled with medication.
- Long term conditions can affect a person's quality of life and ability to work
- Preventing long term conditions by supporting people to adopt healthier behaviours is essential to live healthily and independently.
- The Department for Work and Pensions state that the definition of disability is if a person has a physical or mental impairment that has an effect on the person's ability to undertake normal daily activities

What is the picture in West Berkshire?

- An estimated 11% of people have cardiovascular disease and 28% have high blood pressure.
- The number of people invited for an NHS Health Check last year was 5,961. The uptake of people of this service was 44%.
- Around 4,800 people (4.2%) of people have diabetes.
- There are 7,625 people aged between 18 and 64 who are estimated to have a moderate physical disability and 2,297 estimated to have a severe

disability,

What we will do

- We will deliver integrated services to support and maintain the independence of people with long term conditions and disabilities and ensure end of life care needs are addressed

How we will do it

- Support and maintain the independence of people with long term conditions and disabilities and ensure end of life care needs are addressed

How we will measure what we have done?

- Emergency re-admissions within 30 days of discharge
- Proportion of people who use services who have control over their daily life
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Proportion of people who use services who feel safe
- Delayed transfers of care from hospital, and those which are attributable to adult social care
- Health related quality of life for people with long-term conditions
- Proportion of people feeling supported to manage their condition
- Employment of people with long-term conditions
- Number of patients admitted to an acute stroke unit within four hours
- Number of patients receiving thrombolysis following an acute stroke
- Number of patients attending Activity for Health specialist classes
- % of people receiving personal health budgets
- Number of patients being monitored at home using tele monitoring
- Bereaved carers' views on the quality of care in the last 3 months of life

PUBLIC RESPONSE

General points raised in debates:

- Bereaved carers' views on the quality of care is important but must be handled sensitively.
- Nothing is said about prevention of long term conditions.
- Nothing is mentioned about young people with long term conditions.
- Could there be more about people maintaining their independence?
- There is an issue of people who have more than one condition. People need holistic care. What support do they get if they have to go into hospital for something else? E.g. the deaf community – it can be hard to get support to engage with other things.

Recommendations from debate to support work on this priority:

- There was a general consensus in all discussions that the priority was well stated and the measurements realistic
- There should be parity of esteem for mental health services. There is little or no support after discharge from secondary mental health services.

- There is a need to make provision for people who do not have family to help them.
- There needs to be independent collection of information from children and young people rather than simply via the parents.

Comments on measures:

- There was a general consensus in all debates that the measurements were realistic and covered the majority of areas
- It was noted that the proposed measure of 'feeling safe', should not just be physical, as in falling over, but emotional e.g. living near drug addicts, facing threats, extortion etc.
- People are not automatically offered personal budgets. In the list of measures there is a need to add social care personal budgets as a mandatory offer

4.10. PRIORITY 10 – FALLS PREVENTION

Why is it important?

- Older people are more vulnerable to falls which could lead to broken bones; admissions to hospital as a result of falls; admissions to a residential/nursing home as a result of falls and a reduction of discharges to residential/nursing homes following a hospital admission as a result of a fall.
- Having a fall may reduce the confidence of someone who has fallen
- Many of the risks of falling can be prevented. This may help to reduce the fear of falling, as well as improving balance, strength and stamina.
- Investing in falls prevention can reduce the financial burden on the NHS

What is the picture in West Berkshire?

- In 2012/13, there were 1,381 emergency hospital admissions for falls in persons aged 65 and over.
- There were 142 emergency admissions for hip fractures in every 100,000 people aged 65+
- In 2012/13 the rate of emergency admissions for injuries due to falls in persons aged 80+ was 3,541.
- The number of hip replacements being undertaken increased slightly over the last five years.
- Around 50% of patients from go home from hospital within 28 days of an emergency admission to hospital with a hip fracture

What we will do

- We will maximise independence in older people by:
  - preventing falls
  - reducing preventable hospital admissions due to falls
  - improving rehabilitation services

How we will do it

- Prevent falls
- Reduce preventable hospital admissions due to falls
- Improve rehabilitation services

How we will measure what we have done?

- Rate of emergency hospital admissions for injuries due to falls in people aged 65 to 8o+ years
- Rate of emergency hospital admissions for fractured neck of femur in people aged 65 to 80 +years
- Number of people attending falls prevention classes – Steady Steps
- Development of a comprehensive falls prevention pathway

PUBLIC RESPONSE

General points raised in debates:

- There is more that could be done on adaptations in homes.
- All homes for those with disabilities should have a call system activated by the person requiring help via a device worn around the neck.
- An alert system between partners so one can contact the other is available and could be more widely advertised and used.

Recommendations from debate to support work on this priority:

- Check people who have had falls whether they have cataracts.
- More enablement for people whose mobility is reducing, not just those who have had a fall.
- Falls within care homes or hospitals should be tracked in case there are problems in management or facilities

Comments on measures:

- The inclusion of information about re-admissions would be a good additional measure

4.11. PRIORITY 11 – DEMENTIA

Why is it important?

- Dementia is an increasingly important public health issue and it is vital that we are able to better care for people living with dementia as well as working to help people to reduce their risk of developing dementia.
- Dementia not only impacts on the person living with it, but their carers and families as well.
- There is a lack of general awareness and understanding of dementia, as people often think the symptoms of dementia are a normal part of ageing.

What is the picture in West Berkshire?

- An estimated 17 people aged between 30 and 64 have early onset dementia.
- An estimated 1,679 people aged 65 and over are estimated to have dementia. This is likely to be an underestimate as nationally only half (48.7%) of people with dementia have received a formal diagnosis.
- 0.5% of the population is recorded on GP registers as having dementia.
- 12 people in every 100,000 are admitted to hospital with Alzheimer's and other dementias each year.
- Approximately 15% of deaths had Alzheimer's, dementia, or senility as a

contributory cause of death

What we will do

- We will improve the lives of those residents with dementia

How we will do it

- Through early identification,
- The provision of excellent, integrated care and support
- Increased community awareness of dementia.

How we will measure what we have done?

- Estimated diagnosis rate for people with dementia
- Quality of life for people with dementia
- Number of people with dementia prescribed anti-psychotic medication
- Directly standardised rate for hospital admissions for Alzheimer's and other related dementia
- Percentage of adults with dementia

PUBLIC RESPONSE

General points raised in debates:

- It is common for people with learning disabilities to have early onset dementia.
- There could be more social activities provided e.g. reminiscence groups.
- If GPs are not hearing from older people, someone should be commissioned to follow them up, e.g. village agents
- To get feedback on dementia, you need to ask the carers.
- Doing things for people with dementia is intimately linked with doing things for carers.
- The greater problem is people with mild early dementia, not yet recognised by the health services. That's where the burden on society is; not with the 10% who are in the latter stages.
- A lot of people don't want to recognise that they've got dementia.
- It is very hard to measure quality of life for people with dementia and for their carers.
- There were a number of questions raised relative to dementia, falls and long term conditions asking if there was enough locally going on in villages and community services and if so could these be better advertised and supported.

Recommendations from debate to support work on this priority:

- There should be more training for carers of people with dementia.
- Carers or family members should be monitored to ensure they are given help with dealing with the person as it gets worse.
    - Carers need to be educated in what they should and should not do e.g. do not leave car keys around if the person with dementia can no longer drive.

- There are 'Walking for the brain' and 'Singing for the brain' schemes that could be better advertised, supported and used.

Comments on measures:

- The general measurements were accepted as reasonable
- The dispensing of anti-psychotic medication as a measure is a concern as it is not clear if it is good or bad indicator. The measure needs to be better expressed to make it clearer.
- Should the percentage of adults with dementia be used as an outcome measure since there is nothing that can be done about it i.e. it is simply a statistic and statement of fact?

4.12. Other general comments received from the public and not recorded elsewhere

- Support is needed for GPs, medical and social services and the voluntary sector to assist them to support the person
- It appears that because it is easier to measure physical health, the priorities that are individually measurable, rather than those promoting wellbeing, are to do with NHS and GPs. GPs are already under pressure.
- Everything seems to be linked to deprivation, even obesity and healthy weight.
- How are we engaging with people with learning disabilities?
- When there are clear implementation steps for the strategy it would be helpful if these are published for comment.
- It is unclear how some areas are targeted e.g. socio-economic categories; protected characteristics. This needs to be strengthened in the document
- The strategy should enable people to get access locally to support which helps them like the Berkshire Therapy Centre

5. Response to the draft Health and Wellbeing strategy document by Healthwatch West Berkshire

The strategy document is comprehensive and intentional, clearly stating what is to be achieved. On presentation to the public the overall response to the chosen priorities indicated that they were easily understood in principle and there was a broad agreement on the issues to be addressed.

Priorities

Following engagement with over 250 people the public call for change to the priorities was the addition of just two further priorities the first being long-term conditions and the second requesting greater attention to the needs of maternity services. On the basis of the responses received it is clear that the chosen priorities stood up to public scrutiny and although two additional possible priorities were identified neither suggested that there had in any way been a significant lack of understanding of the current needs as perceived by the public.

Strategy

The public response to the strategy document in general was positive with regard to the objectives. There was a call by many engagers for a plan of action to achieve the aims to be added to the document. Healthwatch is of course acutely aware that the actual number of different service delivery agents and providers required to provide the underlying service platform is vast and that to provide a detailed plan of action is not realistic. It is however recommended that a high level plan of action is produced that will give the public an overview of how the desired outcomes will be achieved.

Timeframes

At the moment there is no set timeframe for any particular priorities and this was noted in the public debates on several occasions. Healthwatch understands that this is likely due to the strategy being considered a rolling operation. However, it would be useful for the public to know if there are specific time frames for a particular percentage of aims to be achieved. It is therefore recommended that the addition of time frames where possible should be added with target indicators as this will strengthen public support for the priorities and objectives as published.

Stakeholders

The intent of the strategy document is all embracing and any future strategy document will be strengthened if there is a clearer focus on the individual component members of the Health and Wellbeing Board working together with other stakeholders, particularly other parts of the council, the CCG and NHS to bring the strategy into fruition. It would assist the public to know what specific role in the strategy each organization represented on the board plus the role any other stakeholders would play in the strategic aims being realized. In particular if such role is in efficiencies, improvement, directing delivery or commissioning.

Identifying cost savings
The strategy, as it is realized, will result in savings and therefore funds soon being released and being made available to meet other needs. In any housekeeping exercise the need to keep track of funds that are released into the wider economy on a gradual basis is necessary otherwise it risks such funds not being specifically allocated to other purposes. It is therefore recommended that where possible all savings and efficiencies be immediately allocated into a specific reserve that will fund the next iteration of the strategy.

Development of new / ongoing strategy
In the light of savings being realised over a relatively short period it is clear that the next iteration of the strategy should be in development now, to allow the identification of 'next step' projects or new initiatives. To that end the public voice could be used to help develop additional or new priorities through early consultation which could be focused on wider specific areas of concern, such as those living in rural areas, with the intention of using the public voice as a tool to identify the grassroots issues in order to help shape the strategy by pinpointing particular needs or concerns before they become serious problems. Thus the strategy document could effectively transitions into a proactive tool for future development.

Thank you
We would like to thank those who have assisted us in the consultation process by providing the use of their premises to set up outreach stands to allow us to engage with the public. Above all we wish to thank those members of the community who took the time to fill in the surveys and all those who attended the public events.

Healthwatch West Berkshire has welcomed the opportunity to manage the consultation process on behalf of the Health and Wellbeing Board.

Heather Hunter

4/11/2014

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