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

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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.

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

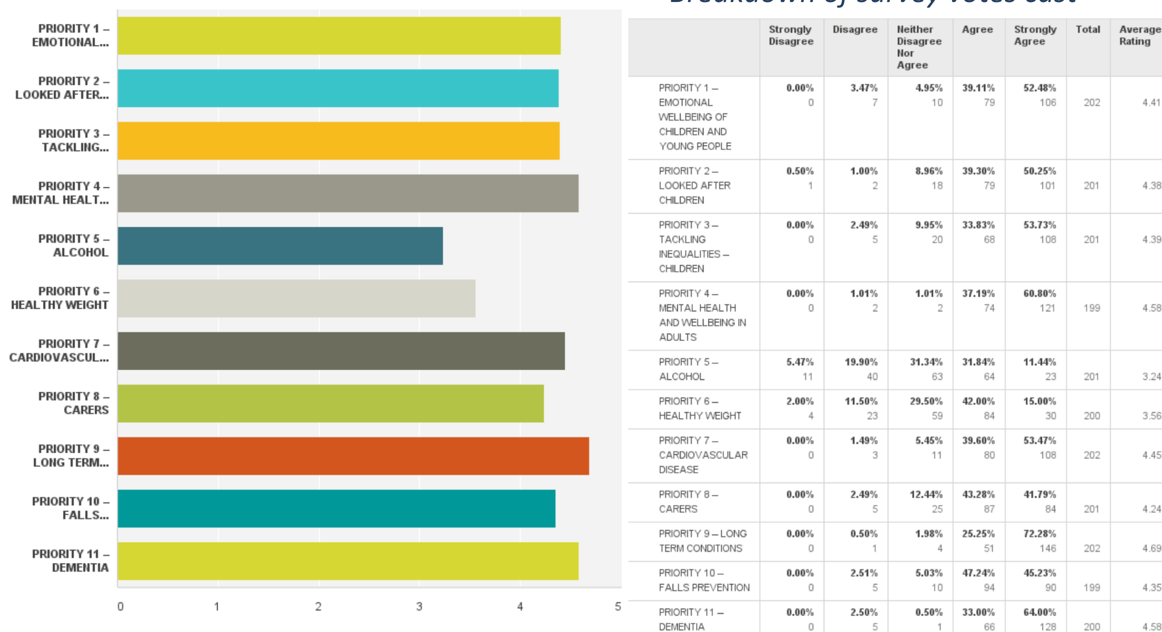
[2] The full notes from the public meetings are available as a separate report but have been included as collated items in précis form in the responses to priorities in section 4

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
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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 80+ 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

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