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Health and Wellbeing Board

Thursday, 30th September, 2021 at 9.30 am

in Council Chamber Council Offices Market Street Newbury

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Date of despatch of Agenda: Wednesday, 22 September 2021

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Gordon Oliver on (01635) 519486
e-mail: gordon.oliver1@westberks.gov.uk

Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

To: Zahid Aziz (Thames Valley Police), Raghuv Bhasin (Royal Berkshire NHS Foundation Trust), Councillor Dominic Boeck (Executive Portfolio: Children, Young People and Education), Councillor Graham Bridgman (Executive Portfolio: Deputy Leader and Health & Wellbeing), Shairoz Claridge (Berkshire West CCG), Councillor Lynne Doherty (Leader of Council), Matthew Hensby (Sovereign Housing Association), Paul Illman (Royal Berkshire Fire & Rescue Service), Dr Abid Irfan (Berkshire West CCG), Jessica Jhundoo Evans (Corn Exchange), Councillor Steve Masters (Shadow Portfolio Holder (Green Party) for Health and Wellbeing), Sean Murphy (Public Protection Manager), Meradin Peachey (Director of Public Health for Berkshire West), Matthew Pearce (Service Director - Communities and Wellbeing), Garry Poulson (Volunteer Centre West Berkshire), Andrew Sharp (Healthwatch West Berkshire), Andy Sharp (Executive Director (People)), Reva Stewart (Berkshire Healthcare NHS Foundation Trust), Councillor Joanne Stewart (Executive Portfolio: Adult Social Care), Katie Summers (Berkshire West CCG) and Councillor Martha Vickers (Shadow spokesperson for H&WB)

Agenda

Part I

		Page No.
1	**Apologies for Absence** To receive apologies for inability to attend the meeting (if any).	7 - 8
2	**Minutes** To approve as a correct record the Minutes of the meeting of the Board held on 22 July 2021.	9 - 18
3	**Actions arising from previous meeting(s)** To consider outstanding actions from previous meetings.	19 - 20
4	**Declarations of Interest**	21 - 22

To remind Members of the need to record the existence and nature of any personal, disclosable pecuniary or other registrable interests in items on the agenda, in accordance with the Members' Code of Conduct.

The following are considered to be standing declarations applicable to all Health and Wellbeing Board meetings:

- Councillor Graham Bridgman – Governor of Royal Berkshire Hospital NHS Foundation Trust, and Governor of Berkshire Healthcare NHS Foundation Trust; and
- Andrew Sharp – Chair of Trustees for West Berks Rapid Response Cars

5	**Public Questions** Members of Health and Wellbeing Board to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution.	23 - 24
6	**Petitions** Councillors or Members of the public may present any petition which they have received. These will normally be referred to the appropriate Committee without discussion.	25 - 26
7	**Membership of Health and Wellbeing Board** To agree any changes to Health and Wellbeing Board membership.	27 - 28

Items for discussion

Strategic Matters

8	**Berkshire West Health and Wellbeing Strategy 2021 - 2030** To present the final version of the Health and Wellbeing Strategy for endorsement by the Health and Wellbeing Board, and to present the draft Delivery Plan for West Berkshire for comment.	29 - 154
9	**Berkshire Suicide Prevention Strategy 2021 - 2026** To present the final version of the Suicide Prevention Strategy to the Health and Wellbeing Board for approval.	155 - 194

Operational Matters

10	**Working with Refugees and Migrants in West Berkshire** A presentation on how local agencies are working to support refugees and migrants, ensuring they have access to healthcare.	195 - 196

11 **Availability of GP Appointments for Residents** 197 - 198
Discussion around the availability of GP appointments for West Berkshire residents before, during and after the pandemic, and how this has affected Hospital Emergency Departments.

12 **ICP Priority - Rapid Discharge Programme** 199 - 200
To provide an update on the work of the Integrated Care Partnership on their priority around Rapid Discharge.

13 **ICP Priority - Emotional Health and Wellbeing for Children and Young People** 201 - 202
To provide an update on the work of the Integrated Care Partnership on their priority around Emotional Health and Wellbeing for Children and Young People.

14 **Provision of Defibrillators in West Berkshire** 203 - 212
To consider how and where defibrillators should be provided across West Berkshire, in response to Cllr Adrian Abbs' motion to Council on 8 July 2021.

15 **Health and Wellbeing Conference** 213 - 214
To provide an update on preparations for the Health and Wellbeing Board Conference on 15 October 2021.

16 **Members' Question(s)** 215 - 216
Members of the Executive to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution.

17 **Health and Wellbeing Board Forward Plan** 217 - 218
An opportunity for Board Members to suggest items to go on to the Forward Plan.

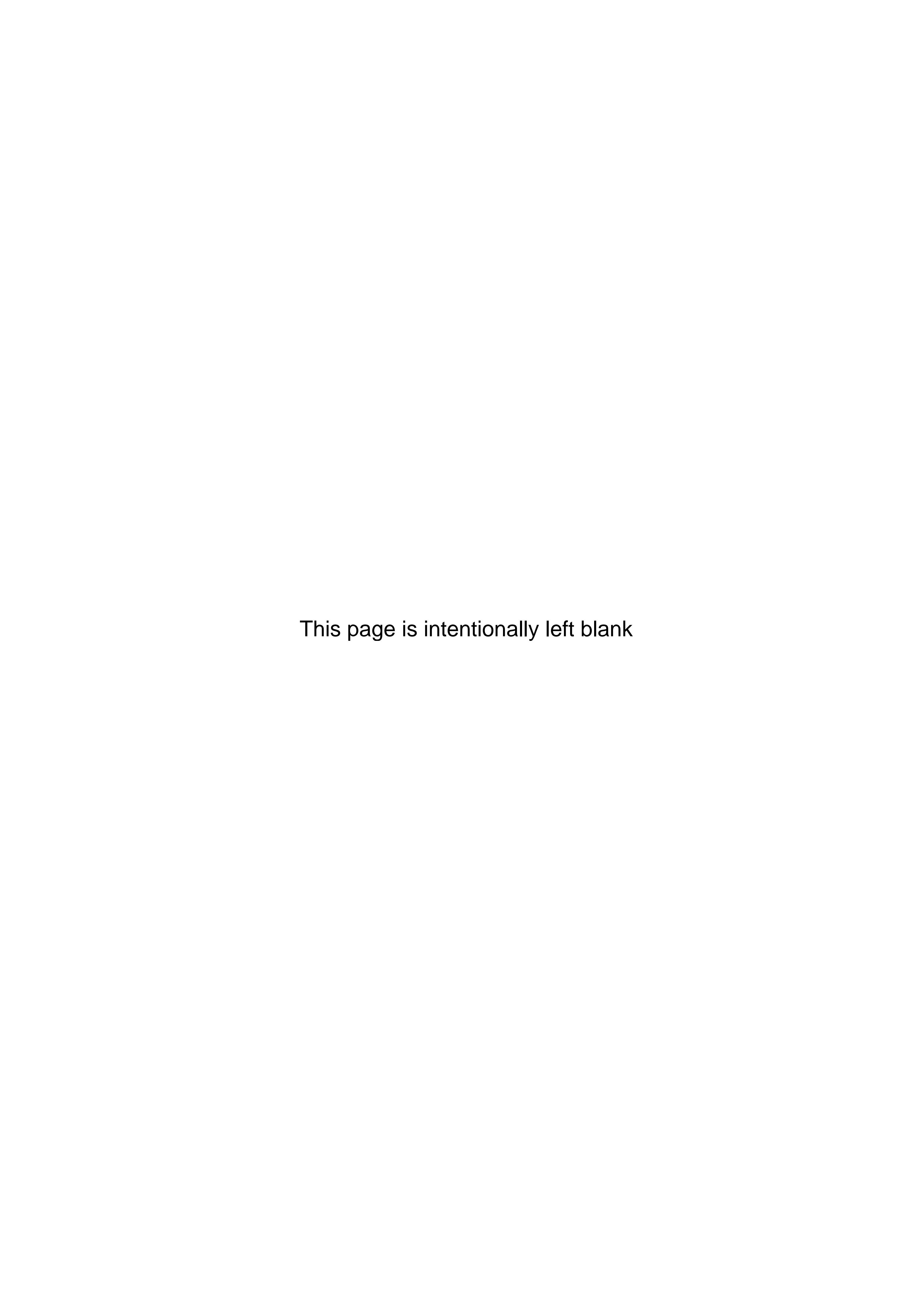
18 **Future meeting dates** 219 - 220

- 9 December 2021
- 17 February 2022
- 19 May 2022

All meetings to start at 09:30.

Sarah Clarke
Service Director: Strategy and Governance

If you require this information in a different format or translation, please contact Stephen Chard on telephone (01635) 519462.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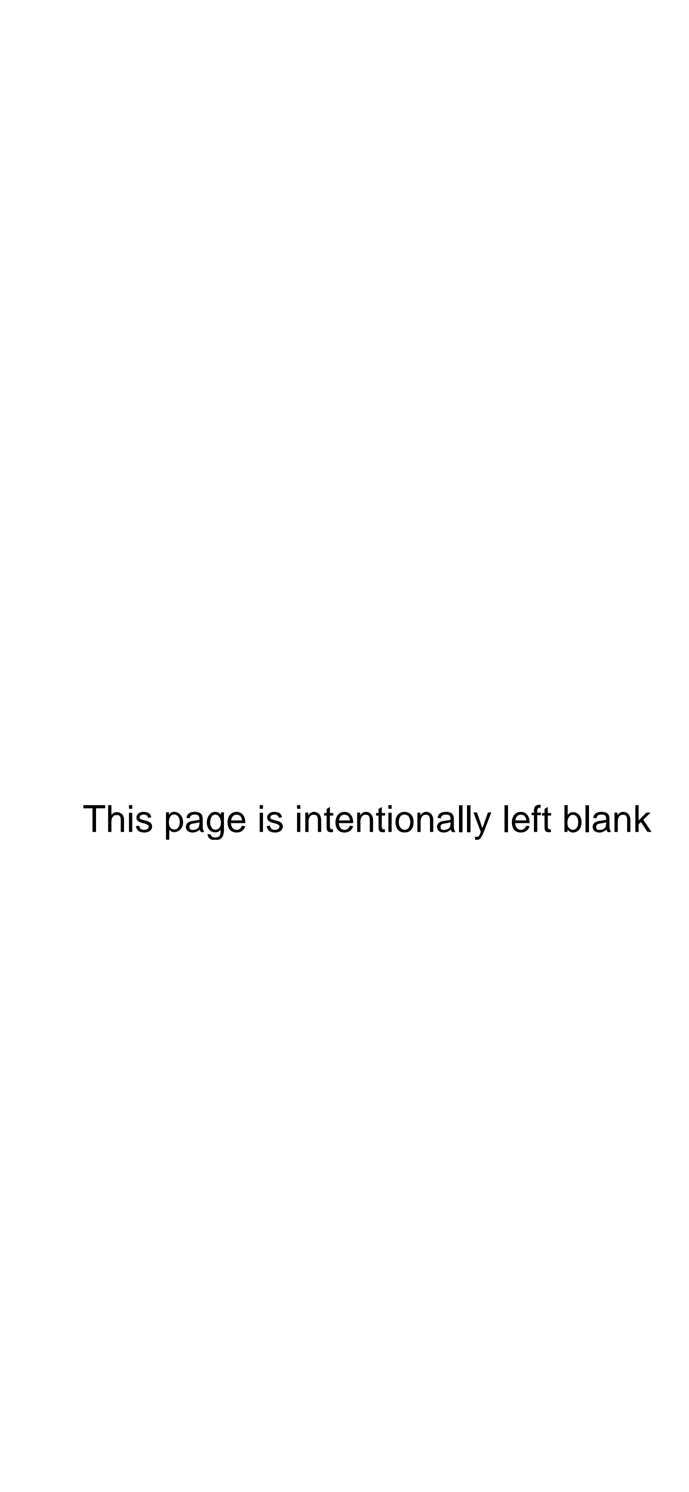
Health & Wellbeing Board – 30 September 2021

Item 1 – Apologies

Verbal Item



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Agenda Item 2

DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 22 JULY 2021

Present: Zahid Aziz (Thames Valley Police), Councillor Dominic Boeck (Executive Portfolio: Children, Young People and Education), Councillor Graham Bridgman (Chairman and Executive Portfolio: Deputy Leader and Health & Wellbeing), Councillor Lynne Doherty (Leader of Council), Dr Abid Irfan (Vice-Chairman, Berkshire West CCG), Jessica Jhundoo Evans (Corn Exchange), Councillor Steve Masters (Shadow Portfolio Holder (Green Party) for Health and Wellbeing), Sean Murphy (Public Protection Manager), Matthew Pearce (Service Director - Communities and Wellbeing), Garry Poulson (Volunteer Centre West Berkshire), Andy Sharp (Executive Director (People)), Councillor Joanne Stewart (Executive Portfolio: Adult Social Care), Katie Summers (Berkshire West CCG) and Councillor Martha Vickers (Shadow Spokesperson (Lib Dem) for Health and Wellbeing)

Also Present: Kamal Bahia (Health & Wellbeing Engagement Group), Gordon Oliver (Corporate Policy Support), April Peberdy (Programme Manager - Public Health), Sarah Rayfield (Acting Consultant in Public Health) and Jade Wilder (Community Co-ordinator Prevention)

Apologies for inability to attend the meeting: Shairoz Claridge, Dom Hardy, Matthew Hensby, Paul Illman, Meradin Peachey and Andrew Sharp

PART I

21 Minutes

The Minutes of the meeting held on 20 May were approved as a true and correct record.

22 Actions arising from previous meeting(s)

Progress was noted as follows:

151 – Andrew Sharp and Gordon Oliver to make one final approach to Thatcham Research regarding the vacant employer position on the Board.

153 – The peer review would be undertaken in 2022.

158 – The Cultural Heritage Strategy would no longer be overseen the Board.

160 – An update on the Recovery Dashboard would be given later in the meeting and the Dashboard was on track to be completed within the next few weeks.

161 - The review of Continuing Healthcare was ongoing and would be discussed as part of the Public Questions item later in the meeting.

164 / 165 – These would be progressed as part of the Delivery Plan for the Joint Health and Wellbeing Strategy,

All remaining actions had been completed.

23 Declarations of Interest

There were no declarations over and above the standing declarations of interest.

24 Public Questions

A full transcription of the public and Member question and answer sessions is available from the following link: Transcription of Q&As

a) The question submitted by Paula Saunderson on the subject of monitoring the review of Continuous Health Care was answered by the Chairman of the Health and Wellbeing Board.
b) The question submitted by Paula Saunderson on the subject of the timescales for delivery of the review of Continuous Health Care was answered by the Director of Place Partnerships for the Berkshire West Clinical Commissioning Group.
c) The question submitted by Paula Saunderson on the subject of the scope of the review of Continuous Health Care was answered by the Director of Place Partnerships for the Berkshire West Clinical Commissioning Group.
d) The question submitted by Paula Saunderson on the subject of the Health Inequalities Task Force was answered by the Chairman of the Health and Wellbeing Board.
e) The question submitted by Paula Saunderson on the subject of the structure chart for Health and Wellbeing was answered by the Chairman of the Health and Wellbeing Board.

25 Petitions

There were no petitions presented to the Board.

26 Membership of Health and Wellbeing Board

The following changes in membership of the Health and Wellbeing Board were noted:

- Katie Summers to replace Shairoz Claridge as representative of the Berkshire West Clinical Commissioning Group.
- Jessica Jhundoo-Evans to replace Charlotte Hall as the cultural sector representative from the Corn Exchange Newbury.

It was noted that membership was related to position, so a vote would not be required.

The Chairman (Councillor Graham Bridgman) welcomed the new members to the Board and asked Dr Abid Irfan to pass on the Board's thanks to Shairoz Claridge for her contribution to the work of the Board, Steering Group and the Locality Integration Board.

Resolved that: the changes be noted.

27 Joint Health and Wellbeing Strategy

Sarah Rayfield presented the report on the Joint Health and Wellbeing Strategy (Agenda Item 8).

She noted that public consultation on the draft strategy would run until 4 August, with the responses being used to refine the strategy before bringing it back to the Board for approval in September along with the delivery plan. Each of the three local authorities (West Berkshire, Reading and Wokingham) would prepare their own delivery plan. The governance arrangements would also be reviewed and discussions had taken place with the Integrated Care Partnership and the Chairs of the three Health and Wellbeing Boards.

Councillor Martha Vickers asked how the consultation would be promoted so as to engage as wide a cross-section of the public as possible. She also asked if there were sections of the public who the Council seldom heard from and how they could be reached.

Sarah Rayfield indicated that a key objective was to find new ways to engage with local communities, particularly those that the Council did not normally hear from. She highlighted the work of EduCafe and the Engaging and Enabling Communities programme. She also stated that a big part of the inequalities work around Covid-19 and the vaccine was focused on building relationships and developing trust with particular communities. In addition, Community Champions would help to engage with seldom heard communities.

The Chairman noted that this had been discussed at the last meeting. He also suggested that Board Members could help promote the consultation.

Councillor Dominic Boeck expressed his support for the Strategy's priorities. He suggested that the priorities in the strategy were not in any priority order, but were equally important and interlinked and would benefit from being delivered together.

Sarah Rayfield agreed, but noted that the priority on reducing the difference in health outcomes sat across the other priorities.

Councillor Boeck supported this and noted that the desire to address difference in health outcomes was a driver for a range of other strategies. He highlighted that paragraph 5.3 referred to reducing 'healthy' rather than 'health' inequalities.

Councillor Vickers asked who was on the Inequalities Taskforce. Also, she suggested that Councillors could help to identify and develop community champions.

The Chairman stated that he had no issue with sharing the membership of the various sub-groups - these would be considered as part of the governance review to ensure they were aligned with the new strategy and delivery plan.

Councillor Jo Stewart stated that she was a member of the Mental Health Action Group in her capacity as Mental Health Champion. She expressed an interest in joining other groups such as the Carers Strategy Action Group. She queried if a vote was required on the options set out in the report. She also asked how far the delivery plan should be progressed if there was a risk that the public consultation might require changes to the strategy, resulting in abortive work.

The Chairman indicated that work was already ongoing in relation to the option in section 6.1 of the report. He suggested that if the result of the public consultation showed opposition to the proposed approach, then the strategy and delivery plan would need to be reviewed. However, the strategy had already gone through a number of public consultation processes and had been agreed across the three Councils, so care would need to be taken if a significant change was needed at this stage.

Sarah Rayfield agreed and noted that the early results from the public consultation on the draft strategy showed support for the strategy's priorities and supporting objectives. She suggested that changes would be more likely around refinement of the strategy and language.

Resolved that: the report be noted.

28 Domestic Abuse Board Terms of Reference

Jade Wilder presented the report on the Domestic Abuse Board Terms of Reference (Agenda Item 9).

The Council had a duty under Part 4 of the Domestic Abuse Act regarding delivery of support to victims of domestic abuse, including children. A key duty was to appoint a Domestic Abuse Board (DAB) to provide advice to the Council about certain functions

and aspects of domestic abuse. The Domestic Abuse Strategy Group has been revised to form the DAB.

The first meeting of the DAB took place on 17 June. A draft Terms of Reference had been reviewed by the DAB, the Building Communities Together Partnership (BCTP) and Housing Board and these were being presented to Health and Wellbeing Board for final approval.

The Chairman indicated that he wished for the DAB and BCTP Terms of Reference (Agenda Item 20) to be considered together.

He noted that the DAB Terms of Reference were in a new format that would provide a template for others across the Council to ensure a consistency of approach.

He indicated that the BCTP Terms of Reference had only recently been taken to BCTP and he had asked for them to be added to this agenda as a late item rather than hold them to the September meeting.

In light of the fact that the Clinical Commissioning Group (CCG) was defined as a responsible authority in the Crime and Disorder Act, he proposed an amendment to the BCTP Terms of Reference, whereby the CCG would be listed as a 'responsible authority' rather than an 'other partner'.

He highlighted that both Terms of Reference had been drafted on the basis of being agreed by Health and Wellbeing Board.

Councillor Martha Vickers welcomed the increased profile for domestic abuse. She noted that there was a lot of money being allocated by Central Government, which was not ring-fenced, and sought assurance that this would be used for the intended purpose. She asked if the Board could proposed that the use of the money be tracked by the Health Scrutiny Committee, drawing on best practice from other areas.

The Chairman stated that the Health Scrutiny Committee was responsible for setting its own priorities and he would not interfere. He indicated that the paper taken to the previous Health and Wellbeing Board meeting set out how the money from Central Government would be spent.

Jade Wilder confirmed that the Council was required to report back to the Ministry for Housing, Communities and Local Government at the end of the financial year on how the money had been spent.

Resolved that:

- The Domestic Abuse Board Terms of Reference be approved.
- The Building Communities Together Partnership Terms of Reference be approved incorporating the proposed amendment with the CCG being recognised as a 'responsible authority' rather than an 'other partner'.

29 COVID-19 Recovery Dashboard

April Peberdy gave a presentation on the Covid-19 Recovery Dashboard (Agenda Item 10). The key points from the presentation were as follows:

- The dashboard was being developed to measure the health and wellbeing impacts of Covid-19 across the life course.
- It would build on work already carried out to identify who was most at risk at a particular life stage.
- It would feature each identified life stage and the relevant data available to monitor the impact of Covid.

- Data would look at the position prior to, during and post-Covid.
- Around 78 data sets had been identified at national and local levels.
- The idea had been discussed with the Berkshire Public Health Data Team and it was felt that the dashboard would be useful for all the Berkshire local authorities.
- Phases 1 and 2 involved uploading and entering national and local data sets.
- It would provide comparative data at national, regional and Berkshire levels.
- It would identify trends over time, monitor progress and highlight where action was needed.
- It would identify health inequalities.
- It would help to drive a recovery action plan.
- It would measure the impacts of actions.
- When completed, the dashboard would be made available on the Berkshire Public Health website: https://ww.berkshirepublichealth.co.uk
- It was hoped to be available from the end of July / early August.
- The dashboard would be regularly updated and added to.
- The intention was to add information around the data over time to facilitate understanding.

The Chairman noted that the Berkshire Public Health website and Covid dashboard provided a useful source of information. He congratulated the Public Health Team and noted that West Berkshire was leading on this, with the life course infographic shared nationally.

Katie Summers welcomed the dashboard. She indicated that some data sets were reported yearly or six-monthly and asked if data could be provided more frequently (e.g. in relation to healthcare provider services).

April Peberdy indicated that she would welcome a discussion on data, and stressed the need for the dashboard to be live, timely and as useful as possible. **Action: April Peberdy and Katie Summers to discuss data availability.**

Councillor Martha Vickers asked if town / parish councils could be made aware of the dashboard to ensure they were aware of what was happening in their communities.

The Chairman noted that a lot of work was being done on Community Engagement, and information flow on this and other subjects was being discussed.

April Peberdy confirmed that there would be communications on the dashboard once it went live. She indicated that it would be accessible to all on the Berkshire Public Health website.

Dr Abid Irfan suggested there would be crossover between data sets used for the Covid Recovery Dashboard and those used to monitor the implementation of the Joint Health and Wellbeing Strategy.

April Peberdy agreed and noted that they would also help with monitoring the Recovery and Renewal Strategy.

Councillor Lynne Doherty noted that people had got used to the Covid dashboard and congratulated the Public Health Team for putting it together. She asked how data could be used to prioritise actions from the Delivery Plan.

April Peberdy agreed that evidence should drive actions and the dashboard would help this process, with data available in one place.

Matt Pearce noted that this would bring the infographic to life. He agreed that some data sets took a long time to come through and suggested that population health management data sets could be used to provide real-time information. He agreed that data should

inform priorities, which may change over time. He also stressed the need to retain the community voice to complement the data to get a full picture of strengths and deficits.

Resolved that: the presentation be noted.

30 Health and Wellbeing Board Engagement Group Communications Toolkit

Kamal Bahia presented the report on the Communications Toolkit (Agenda Item 11).

She noted that the Engagement Group aimed to coordinate, collaborate and communicate with residents, with partners working together to engage residents once rather than separately.

A Toolkit had been developed, consisting of a spreadsheet setting out the groups to be engaged. It also contained details of local Facebook Groups, town and parish council contacts, and details of national / international campaigns. The intention was to create a schedule with all the campaigns being run by Public Health, the CCG and other partners and create a shared resource.

A series of 42 graphic resources had been procured around particular health topics, with a separate set summarising the work of the various sub-groups.

The Board was invited to support and engage with the toolkit to amplify messages, and to identify individuals within their organisations who needed to be involved and have access to the toolkit.

It was noted that an Induction Pack had been developed for Members of the Health and Wellbeing Board and a separate public-facing document was also being developed.

Matt Pearce expressed his support for the project and suggested that it would be good to connect the toolkit with the recovery dashboard and the Public Health Observatory.

Kamal Bahia noted that access to the Toolkit would need to be controlled and suggested that this may be achieved through a closed community on Facebook. She asked if the Board was happy with the approach of launching at the Conference and adopting an iterative approach to updating the toolkit.

The Chairman agreed that engagement should be a key theme for the conference and welcomed the approach. He stressed the need for the public to understand who the Board was and what they did and to ensure that the Delivery Plan was implemented, and suggested that the conference would provide a good platform for this.

Councillor Martha Vickers welcomed the work on engagement and the graphics. She highlighted the need to engage with people who did not use social media and also young people.

Kamal Bahia explained that the Engagement Group was getting articles published in the Newbury Weekly News, but would move towards preparing press releases that could be used by multiple outlets, including parish magazines. She had been working with Pete Campbell to review how best to engage young people, and she was also linking with the Be Well Berkshire campaign, which would help young people with their health and wellbeing.

Councillor Vickers asked about engaging with residents groups, particularly in deprived areas. Kamal Bahia indicated that was part of the toolkit.

Sean Murphy noted that the Public Protection Partnership had done a lot of work on communications and offered to work together. **Action: Sean Murphy to liaise with Kamal Bahia on shared communications.**

Resolved that: the report be noted.

31 Delivering the Health and Wellbeing Strategy Q4 2020/21

The Chairman outlined progress in delivering the Health and Wellbeing Strategy during Quarter 4 of 2020/21 (Agenda Item 12).

He stated that the previous Strategy and Delivery Plan ended in March 2020, so an Interim Delivery Plan had been prepared. It was noted that the spreadsheet provided a RAG rating for each of the key performance indicators with associated targets. Each had a narrative to provide further detail on performance.

It was noted that performance had been affected by the pandemic, with some initiatives stopped, suspended or deferred, but many actions had still progressed. He highlighted that some of the red rated indicators were only just short of their targets.

The Health and Wellbeing Board Engagement Group had been asked to look at preparing a summary of achievements to be presented at the conference in October alongside the new Strategy and Delivery Plan. The focus would be on outcomes to demonstrate the effectiveness of the Board, its sub-groups and partners.

It was proposed to defer further performance reports until the new Delivery Plan was agreed. Work was ongoing to review which of the existing KPIs should be carried over into the new version of the Delivery Plan.

Alternative tools for tracking and reporting performance would be investigated, and it was noted that the Steering Group would like to see more narrative, since the limited range of KPIs did not reflect the full work of the sub-groups.

The Chairman noted that the Delivery Plan was based on the structure of the existing Sub-Groups and Domestic Abuse targets would go to the Domestic Abuse Board under the new structure. He asked why the Serious Case Review Protocol action sat with the Housing Strategy Group rather than Building Communities Together Partnership. He also noted that Multi-Disciplinary Team meetings appeared as an action for the Engagement Group rather than the Locality Integration Board.

Gordon Oliver suggested that when the spreadsheet had been revised to its current format, some rows may have slipped into the wrong group when cells were merged. **Action: Gordon Oliver to review the spreadsheet.**

Councillor Martha Vickers highlighted the lack of information under the action 'Support children and young people at an earlier stage, ensuring they are safe through prevention and early intervention services' and asked if this was due to Covid. She also asked if the Life Education classes for primary schools would be continuing.

Andy Sharp confirmed that the Life Education classes would continue.

Councillor Lynne Doherty asked for a short update on the Suicide Prevention work. Garry Poulson noted that the indicator around the number of events to raise awareness of suicide was probably the wrong measure. He stated that an outreach worker had been appointed in December and her work had replaced the events. She had done letter-drops of resources and had received good feedback. Also, the West Berkshire Suicide Prevention website had been launched and was now the first hit on local searches. In addition, a suicide prevention training day had been held. He suggested that physical contacts could be made now Covid restrictions were being relaxed.

Councillor Doherty noted that the awareness campaign to promote the sustained employment of people from underrepresented groups had been delayed due to Covid. She felt this should be a priority because of Covid and suggested that it should not be

delayed. She indicated that work was ongoing with the Local Enterprise Partnership to help people adapt their skills sets.

Andy Sharp acknowledged the importance of the action and suggested that colleagues from the Skills and Enterprise Partnership (SEP) could be invited to a future meeting of the Board to talk about work being undertaken. **Action: SEP representative to be invited to attend a future meeting.**

Councillor Rick Jones noted that the (SEP) chairman was the Principal of Newbury College, which had been particularly affected by Covid. He suggested that the action could potentially be reassigned in future.

Resolved that: the performance report be noted.

32 Integrated Care Partnership Transformation Programme

Andy Sharp gave a presentation on the Integrated Care Partnership (ICP) Transformation Programme (Item 13 on the Agenda). Key points from the presentation were as follows:

- The most recent meeting of the Unified Executive had focused on Rapid Community Discharge (RCD) and the Better Care Fund (BCF) review.
- RCD had facilitated the flow of patients from hospital during the pandemic, and had helped to avoid delayed transfers of care. This had been used successfully in Berkshire West and there was a desire to retain the benefits beyond the pandemic.
- RCD cost around £900,000 per month to deliver, but there were savings in keeping people out of hospital beds for longer periods. Funding was available from Central Government and through the CCG to cover RCD in the first half of the financial year. Discussions were on-going about how to core-fund RCD beyond this point. It had been agreed that the current arrangement would be funded to October, but a business case would be presented to the Unified Executive for a long-term approach.
- BCF was the flow of resources from Health and Social Care to support initiatives such as rapid discharge and support people to maintain their independence. It had worked well, but the ICP was required to review its approach on a regular basis.
- A scoping document for the review had been completed. All relevant partners would take part in the review, and the outcome of the review would be reported in late autumn. There was no desire to reduce resources or activity within the BCF, but the review would ensure that activity was efficient and effective.
- Flagship priorities for the ICP included:
    - Cardio-vascular disease prevention
    - Ageing well programme
    - Emotional health and wellbeing for children and young people
    - Learning disabilities and autism
    - Prevention – Berkshire West Can
    - Rapid discharge
- Project / programme plans for each of the above had been agreed.

It was proposed that the Health and Wellbeing Board consider progress in each of these priority areas in turn at future meetings.

The Chairman indicated that delayed transfers of care (DTOC) was a major KPI for adult social care and anything that could be done to save money by getting people out of hospital was a good thing. He expressed an interest in understanding more about the Better Care Fund and welcomed the opportunity to look in detail at each of the priorities.

Resolved that: the presentation be noted.

33 Health and Wellbeing Board Forward Plan

The Chairman invited Members to make suggestions for additional items on the Forward Plan (Agenda Item 14).

He noted that an item had been added to the September meeting on defibrillators. This had come via a motion from Councillor Adrian Abbs to Council about the use of defunct BT phone boxes, but given that there would be few phone boxes available locally, the scope of the report could potentially be expanded.

Other items added to the September agenda included the Suicide Prevention Strategy and redevelopment proposals for the Royal Berkshire and North Hampshire Hospitals. He noted that the Health Scrutiny Committee had been invited to be involved in the North Hampshire Hospital proposal.

Andy Sharp that Rapid Community Discharge be added to the agenda for September.

Mike Fereday stressed the importance of West Berkshire representation on the Joint Health Overview and Scrutiny Committee looking at the Hampshire Hospital proposal, since 20 percent of patients at the hospital came from West Berkshire.

The Chairman noted that he had been to two meetings and that Councillor Claire Rowles would arrange for someone to attend on behalf of Health Scrutiny Committee.

Kamal Bahia highlighted that the conference was on the Forward Plan for 15 October. She invited suggestions for agenda topics from Board Members and indicated that this would be brought back to the September meeting.

Resolved that: the Forward Plan be noted.

34 COVID-19 Recovery and Renewal Strategy Update

The Covid-19 Recovery and Renewal Strategy Update (Agenda Item 15) was included in the agenda papers for information only.

Resolved that: the strategy be noted.

35 Healthwatch West Berkshire

The Healthwatch West Berkshire Annual Report (Agenda Item 16) was included in the agenda papers for information only.

Resolved that: the report be noted.

36 Letter to Consultees on the Draft Statement of Gambling Principles 2022 (West Berkshire Council)

The letter to consultees on the draft statement of gambling principles (Agenda Item 17) was included in the agenda papers for information only.

Resolved that: the letter be noted.

37 Members' Question(s)

No questions were submitted by Members.

38 Future meeting dates

The dates for the 2021/22 Municipal Year (Agenda Item 19) were noted.

39 Building Communities Together Partnership Terms of Reference

The Building Communities Together Partnership Terms of Reference (Agenda Item 20) were discussed alongside the Domestic Abuse Board Terms of Reference (Agenda Item 9).

(The meeting commenced at 09:30 and closed at 11:13)

CHAIRMAN …………………………………………….

Date of Signature …………………………………………….

Actions arising from Previous Meetings of the Health and Wellbeing Board

RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
151	24/09/2020	Contact Thatcham Research about becoming an employer representative on the Health and Wellbeing Board	Andrew Sharp	Healthwatch West Berkshire	Health and Wellbeing Board Membership	**Complete (09/09/2021).** Thatcham Research have confirmed that they do not wish to be the Board's employer representative.
153	24/09/2020	Seek another peer review of Health and Wellbeing Board.	Cllr Graham Bridgman	WBC	Health and Wellbeing Board Meetings	**On hold.** To be undertaken post-Covid.
160	28/01/2021	Develop Covid Recovery Dashboard Tracker to monitor the broader effects of the pandemic on our community	Matt Pearce	WBC	Member Questions	**In progress.** Phase 1 is complete, which involves key data sets for nationally available data: https://westberkshire.berkshireobservatory.co.uk/coronavirus Further work will be done to add other local data sets as part of Phase 2, which is yet to start.
164	20/05/2021	CCG to undertake a review of Continuing Health Care and its local application with a view to harmonising this across the Berkshire West footprint and to understand the reasons for the awarding of eligibility.	Katie Summers / Niki Cartwright	CCG	Public Questions	**In progress.** Review to be completed within 6 months with a report back to Health and Wellbeing Board in December 2021.
165	20/05/2021	Ensure the Strategy addresses the transition between mental health services for children and young people and for adults.	Sarah Rayfield	WBC	Joint Health and Wellbeing Strategy	**In progress.** This is incorporated into the Health and Wellbeing Strategy and will also be addressed in the delivery plan for West Berkshire.
166	20/05/2021	Co-ordinate activity between the Inequalities Taskforce and the Integrated Care Partnership's Prevention and Health Inequalities Board.	Sarah Rayfield	WBC	Inequalities Taskforce	**In progress.** The Taskforce will be engaging with the Prevention and Health Inequalities Board as part of the development of the delivery plans. This will help to ensure alignment across the system and also set the foundations for coordination of activity going forward.
167	22/07/2021	Check strategy for errors relating to 'healthy inequalities' rather than 'health inequalities'	Gordon Oliver	WBC	Joint Health and Wellbeing Strategy	**Complete (03/08/2021).** This error was only in the covering report.
168	22.07/2021	Public Health and CCG to discuss data availability for the Covid Recovery Dashboard	April Peberdy / Katie Summers	WBC / CCG	Covid Recovery Dashboard	**Outstanding**
169	22/07/2021	Public Protection Manager and HWEG Chair to discuss potential for joint working / learning on communications	Sean Murphy / Kamal Bahia	PPP / HWEG	Health and Wellbeing Board Engagement Group Communications Toolkit	**Outstanding**
170	22/07/2021	Review the Delivery Plan spreadsheet to ensure that measures and targets related to the correct actions	Gordon Oliver	WBC	Delivering the Health and Wellbeing Strategy Q4 2020/21	**Complete (03/08/2021):** Spreadsheet has been corrected.
171	22/07/2021	SEP representative to be invited to a future meeting of HWB to provide an update on work being undertaken to promote sustained employment of people from under-represented groups.	Gordon Oliver	WBC	Delivering the Health and Wellbeing Strategy Q4 2020/21	**In progress:** Iain Wolloff invited to provide an update to the December meeting.
172	22/07/2021	Provide a response to Council regarding the motion submitted in the name of Councillor Adrian Abbs at the Council meeting on 8 July 2021.	Matt Pearce	WBC	Health and Wellbeing Board Forward Plan	**Complete (22/09/2021):** Report included in the agenda papers for the September meeting.

Last Updated: 22 September 2021

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Health & Wellbeing Board – 30 September 2021

Item 4 – Declarations of Interest

Verbal Item

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Agenda Item 5

Public Questions to be answered at the Health and Wellbeing Board meeting on 30 September 2021.

Members of Health and Wellbeing Board to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution.

(a) Question submitted to the Portfolio Holder for Adult Social Care by Ms Paula Saunderson:

"The Key Influencer measure 35 is indicating a rise in the number of Long Term Care clients supported by West Berkshire Council Adult Social Care, therefore may we please have a breakdown of this measure by broad age bands and care types please?"

(b) Question submitted to the Portfolio Holder for Adult Social Care by Ms Paula Saunderson:

"What are the main sources of ailments that are giving rise to the increase in the number of Long Term Care clients supported by West Berkshire Council Adult Social Care and do they include any Long Covid as a cause for needing Adult Social Care services?"

(c) Question submitted to the Portfolio Holder for Adult Social Care by Ms Paula Saunderson:

"The report for the Key Influencer measures states there are lower than expected occupancy rates in the 3 West Berkshire Council managed Care Homes, therefore are there currently any places that can be used by self-funder families for a loved one in the later stages of Dementia?"

(d) Question submitted to the Portfolio Holder for Adult Social Care by Ms Paula Saunderson:

"In order to help self-funding families in West Berkshire who are prepared to look after their own loved one, will West Berkshire Council please look at the existing supply of adapted housing for Older Adults which might be available for private rental or private purchase, including advice on any sources that are currently available for those not on Housing or Adult Social Care registers? This is not including the schemes that you have to help people in their existing family homes."

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Health & Wellbeing Board – 30 September 2021

Item 6 – Petitions

Verbal Item

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Health & Wellbeing Board – 30 September 2021

Item 7 – Membership of Health & Wellbeing Board

Verbal Item

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Agenda Item 8

The Berkshire West Health and Wellbeing Strategy 2021 - 2030

Report being considered by:	Health and Wellbeing Board
On:	30th September 2021
Report Author:	Sarah Rayfield
Item for:	Decision

1. Purpose of the Report

1.1 To present the Berkshire West Health and Wellbeing Strategy 2021 – 2030 to the Health and Wellbeing Board.

1.2 To present the draft delivery plans for West Berkshire to the Board for feedback and comment.

2. Recommendation(s)

For the Health and Wellbeing Board to endorse the Berkshire West Health and Wellbeing Strategy 2021 – 2030 prior to submission of the Strategy to Council for formal approval.

3. How the Health and Wellbeing Board can help

For the Board to provide feedback on the draft delivery plans and to consider the level of detail the Board would wish to see in this delivery plan document, in particular when the action refers to implementation of a different Strategy or Action Plan.

Will the recommendation require the matter to be referred to the Council for final determination?	Yes: ☒	No: ☐

4. Introduction/Background

4.1 Development of the Berkshire West Health and Wellbeing Strategy (Appendix 1) started in March 2020.

4.2 Regular updates have been provided to each of the three Health and Wellbeing Boards and also to the Unified Executive of the Integrated Care Partnership (ICP).

4.3 The Strategy will be accompanied by a local delivery plan (Appendix 2) for each of the three local authority areas, describing how the Strategy will be implemented in each area.

5. Supporting Information

5.1 The Strategy has been developed through the following stages, also described in the accompanying Roadmap document (Appendix 3):

Phase	Timeframe
Defining the current state	March – July 2020
Prioritisation Process	August – September 2020
Public engagement and further engagement with stakeholders (Appendix 4)	October 2020 – February 2021
Production of the Joint Health and Wellbeing Strategy	March - June 2021
Six week Public Consultation (Appendix 5)	June – August 2021
Development of local delivery plans for West Berkshire (Appendix 2)	June – August 2021
Refinement of the Strategy and production of the final version	August – September 2021

5.2 The new Strategy consists of five health and wellbeing priorities:

(1) Reduce the differences in health between different groups of people;

(2) Support individuals at high risk of bad health outcomes to live healthy lives;

(3) Help families and children in early years;

(4) Promote good mental health and wellbeing for all children and young people;

(5) Promote good mental health and wellbeing for all adults.

5.3 The eight principles of the Strategy are: Recovery from Covid-19, Engagement, Prevention and early integration, Empowerment and self-care, Digital enablement, Social cohesion, Integration, and Continuous learning.

5.4 A six week public consultation on the draft Strategy took place from 24th June to 4th August 2021. The findings of this public consultation are described in the accompanying consultation report (Appendix 5) and were used to further refine and finalise the Strategy.

5.5 The West Berkshire delivery plan contains the actions that will be taken locally to implement this Strategy. The actions are intended to meet the strategic objectives for each of the five priority areas.

5.6 The delivery plan is being developed through engagement with Stakeholders and partners across the system, including members of the Health and Wellbeing Board Steering Group and its sub-groups. It includes actions that will be taken at a West Berkshire level, but also actions at a Berkshire West level, where there are clear benefits to working at scale across a larger geographical footprint.

5.7 The delivery plan will remain as a live working document, however it is intended that there will be a formal refresh after the first three years of the Strategy.

5.8 It is proposed that the following groups will take ownership of each of the new priorities:

Reduce the differences in health between different groups of people	Health Inequalities taskforce
Support individuals at high risk of bad health outcomes to live healthy lives	TBC
Help children and families in early years	Children's Delivery Group
Promote good mental health and wellbeing for all children and young people	Children's Delivery Group (Berkshire West Future in Mind group)
Promote good mental health and wellbeing for all adults	Mental Health Action Group Suicide Prevention Action Group

5.9 Delivery of the second priority (Support individuals at high risk of bad health outcomes to live healthy lives) may be undertaken by a number of existing groups, including: Homeless Strategy Group, Building Communities Together Partnership, Ageing Well Task Group, Skills and Enterprise Partnership and the Carers Strategy Action Group. There is not currently one group which would provide oversight of all of the work against this priority.

6. Options for Consideration

6.1 To endorse the Berkshire West Health and Wellbeing Strategy 2021 – 2030

OR

6.2 To not endorse the Berkshire West Health and Wellbeing Strategy 2021 - 2030

7. Proposal(s)

7.1 For the Board to endorse the Berkshire West Health and Wellbeing Strategy 2021 – 2030 prior to submission of the Strategy to Council for formal approval.

7.2 To continue developing the delivery plan for implementation of the Strategy in West Berkshire, with a view to presenting a final delivery plan to the Health and Wellbeing Board in December 2021.

8. Conclusion(s)

This paper presents the Berkshire West Health and Wellbeing Strategy 2021 – 2030. It is accompanied by a draft delivery plan for West Berkshire for feedback by the Board.

9. Consultation and Engagement

The public engagement undertaken as part of developing this strategy is described in the associated Public Engagement Report (Appendix 4) and in the Report on the Public consultation on the draft Strategy (Appendix 5).

10. Appendices

Appendix 1 – Berkshire West Health and Wellbeing Strategy 2021 - 2030

Appendix 2 – Draft Delivery Plan for West Berkshire

Appendix 3 – Roadmap (development of the Strategy)

Appendix 4 – Berkshire West HWBS Public Engagement Report

Appendix 5 – Report on the Public Consultation on the draft Health and Wellbeing Strategy

Background Papers:

None

Health and Wellbeing Priorities 2019/20 Supported:

☒ First 1001 days – give every child the best start in life
☐ Primary Care Networks

Health and Wellbeing Strategic Aims Supported:

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):

☒ Give every child the best start in life
☒ Support mental health and wellbeing throughout life
☒ Reduce premature mortality by helping people lead healthier lives
☒ Build a thriving and sustainable environment in which communities can flourish
☒ Help older people maintain a healthy, independent life for as long as possible

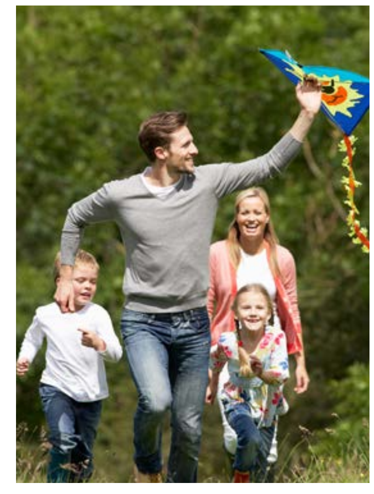
The draft Strategy includes a new set of strategic aims, which once adopted will guide the work of the Health and Wellbeing Board.

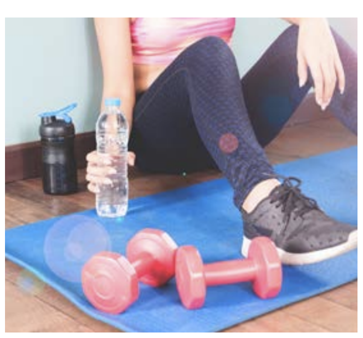
Officer details:

Name:	Sarah Rayfield
Job Title:	Acting consultant in Public Health
Tel No:	*
E-mail Address:	Sarah.rayfield1@westberks.gov.uk

BERKSHIRE WEST HEALTH AND WELLBEING STRATEGY (HWBS)

2021- 2030





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Priority 2: Support individuals at high risk of bad health outcomes to live healthy lives

Priority 3: Help families and children in early years

Priority 4: Promote good mental health and wellbeing for all children and young people

Priority 5: Promote good mental health and wellbeing for all adults

NEXT STEPS

APPENDIX

INTRODUCTION

Health and wellbeing are fundamental for individuals and communities to be happy and healthy; providing the foundations to prosperous societies. Wellbeing has been defined as a state in which every individual can realise their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their economy[1].

Reading, West Berkshire and Wokingham Health and Wellbeing Boards (HWBs) bring together local leaders from the health and social care system, along with voluntary and community organisations, in shared work to improve the health and wellbeing of their local residents.

Each Health and Wellbeing Board has a statutory duty to produce a Health and Wellbeing Strategy, providing a commitment to improving health and wellbeing by setting out priorities for where members of the Board will work together in planning and delivering local services.

The three HWBs come together with the Berkshire West Integrated Care Partnership (ICP) to promote integrated working and strive to secure improvements in population health.

In 2019, the HWBs for Reading, West Berkshire and Wokingham took the decision to develop a shared Health and Wellbeing Strategy with the ICP to make even more improvements in health.

Although each of the individual Health and Wellbeing Boards for Reading, West Berkshire and Wokingham are responsible for their own residents, all three boards have populations in common, with people living, working, socialising and being educated across the three local authorities.

This Strategy has been developed by working closely with local partners from health, social care, local authorities and the voluntary sector along with residents of the three areas. Our Strategy is ambitious, it identifies five key areas in which we will make a difference to people's lives. It takes a ten-year view, understanding that we need a long-term perspective in order to drive real change on the underlying causes of poor health and wellbeing. It seeks to bring together individuals and communities along with professionals in a shared direction, targeting work and resources where they are needed and where we know we can have an impact.

With closing health inequalities and recovery from Covid-19 at its very heart, the Berkshire West Health and Wellbeing Strategy 2021 – 2030 establishes our priorities for the system, and aims to enable all of our residents to live happier and healthier lives.

INTRODUCTION

Reading, West Berkshire and Wokingham make up Berkshire West – an area stretching from rural communities and local, vibrant market towns in West Berkshire and Wokingham, to the commercial urban hubs located in Reading.

The three localities of Berkshire West hold a population of over 500,000 people. It is an area of great diversity and rich culture, representing all age demographics, religious affiliations and ethnicities.

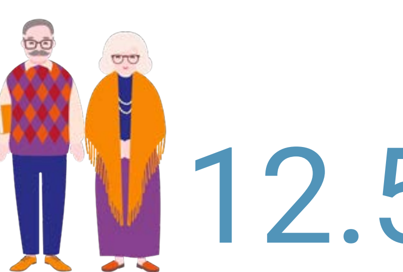
Across the three localities, people travel to work, go to school, socialise and engage with activities and attractions, and as neighbouring local authorities, the residents of Reading, West Berkshire and Wokingham share many services in common including the Berkshire Healthcare NHS Foundation Trust.

East Ilsley Volunteer group

READING

161,780
Total Resident Population

100%
Urban population



12.5%
Population aged 65+

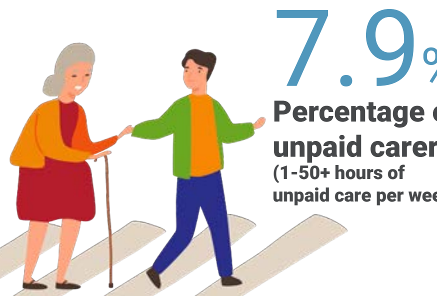
25.3%
Ethnically diverse population

69%
Children achieving a good level of development at early years

7,090
Total number of businesses

9.6%
Full time students age 18+

Unemployment rate
3.6%



7.9%
Percentage of unpaid carers
(1-50+ hours of unpaid care per week)

50.2%
People with very good health

Data collected from multiple sources. Sources found in Appendix A.

WEST BERKSHIRE

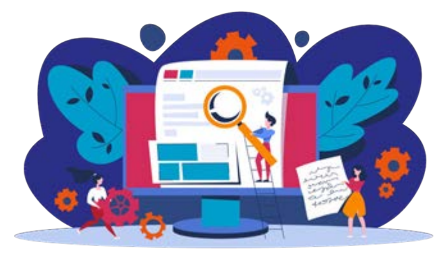
158,450
Total Resident Population

63% Urban population

75%
Children achieving a good level of development at early years

19.3%
Population aged 65+

5.2%
Ethnically diverse population



8,800
Total number of businesses

2.1%
Full time students age 18+

Unemployment rate
2.4%

9.3%
Percentage of unpaid carers
(1-50+ hours of unpaid care per week)

51.6%
People with very good health

Data collected from multiple sources. Sources found in the Appendix A.

WOKINGHAM

171,119

Total Resident Population

83%

Urban population

17.6%

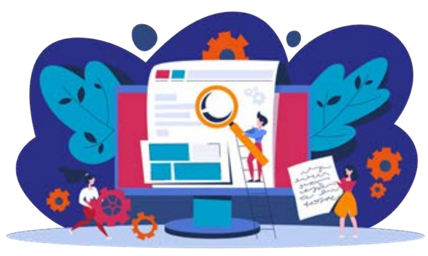
Population aged 65+

11.6%

Ethnically diverse population

77%

Children achieving a good level of development at early years



9,005

Total number of businesses

3.2%

Full time students age 18+

Unemployment rate

2.35%

9.0%

Percentage of unpaid carers

(1-50+ hours of unpaid care per week)

54.3%

People with very good health

Data collected from multiple sources. Sources found in Appendix A.

WORKING TOGETHER: OUR LOCAL SYSTEM

The three Health and Wellbeing Boards for Reading, West Berkshire and Wokingham work both alongside and within the Berkshire West Integrated Care Partnership (BWICP), allowing collaboration between health and social care organisations to improve all services for the local residents.

Established in April 2019, the BWICP brings together seven public sector organisations that are responsible for the health and social care of Reading, West Berkshire and Wokingham residents, providing joined up and better coordinated care in the process.

The BWICP comprises of the Berkshire West Clinical Commissioning Group (BWCCG), Reading Borough Council, West Berkshire Council, Wokingham Borough Council, Berkshire Healthcare NHS Foundation Trust, Royal Berkshire NHS Foundation Trust and South-Central Ambulance Foundation Trust. This integrated system ensures people can smoothly access care across a number of different settings, moving between institutions and support settings as needed.

This shared strategy will serve to ensure greater collaboration between these organisations, empowering and supporting people to take care of their own health and wellbeing and also making sure that all services meet the diverse health and care needs of our residents.

Newbury Rugby Club delivering food parcels during the pandemic (2020)

OUR CHALLENGES

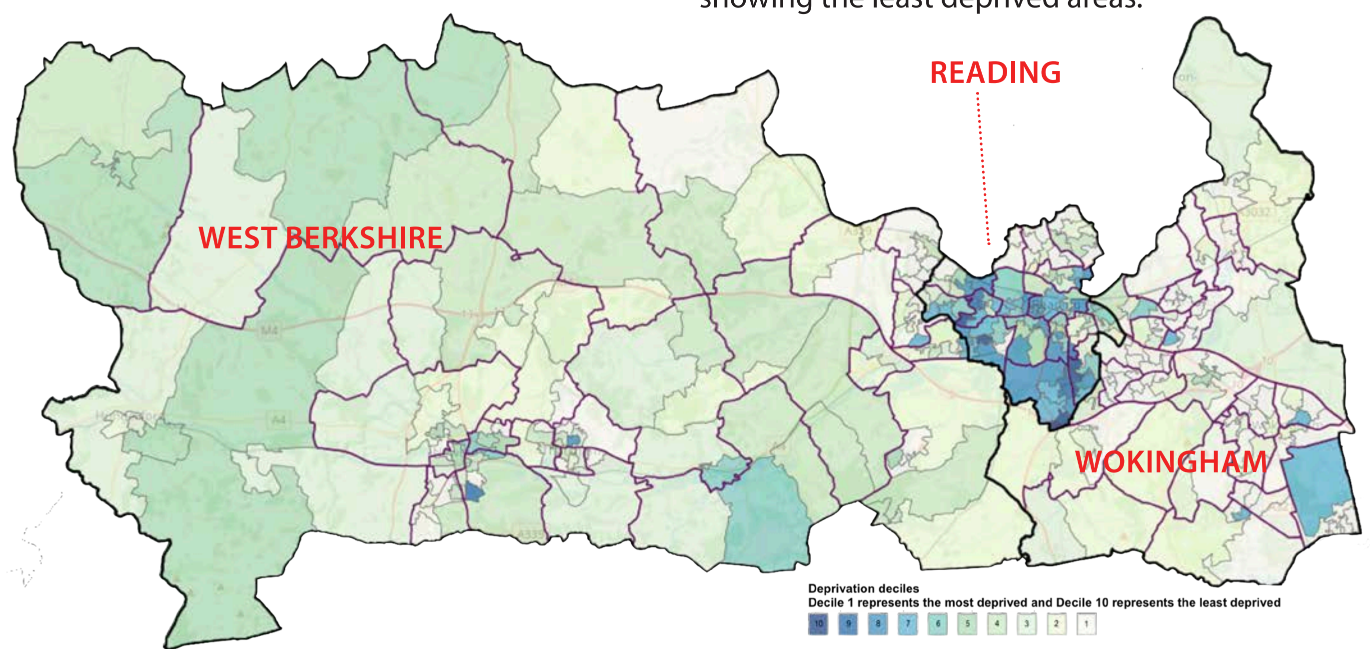
The three areas that make up Berkshire West have a lot to celebrate and be proud of. However, as people live longer with more complex health conditions; combined with the impact of Covid-19 and ongoing financial challenges, we must find new ways to deliver health and social care, strengthen partnerships and put all of our resources together to use in the best way possible. The growing population (with over 10,000 new houses across all three areas to be built by 2026) gives uncertainty of who will make up our diverse and vibrant local population in the future and what their needs may be. This will also mean new families too, giving us opportunities to focus on ensuring every child gets a good start to life.

The three areas already have a growing older population of people aged 65 years and older. As this continues, it is likely to place more pressure on health and social care; with more people living with long term conditions or Dementia. People over 65 across Berkshire West are culturally and socially engaged; making up a large part of voluntary and community sectors, and so their life experience and knowledge adds enormous value to our communities. However, the way people need care and support is changing – we want to empower older people to manage their conditions, through encouraging and supporting healthy lifestyles.

Although the Berkshire West population is generally affluent and healthy, there are pockets of deprivation across the three areas where health outcomes tend to be worse. Health is not just about medicine and accessing health services, but also about the wider social and environmental factors that can influence a person's health and wellbeing. Studies have shown that health services provide only 10% of the influences on whether a person dies prematurely.[2] Social and behavioural determinants of health such as housing, employment and education play a bigger, and sometimes more important role.

These differences mean that the life expectancy of our population varies depending on where people live[3]; those living in the poorest parts of West Berkshire and Wokingham, will live seven years less of healthy life, compared with those people living in the richest areas. In Reading, the healthy life expectancy of those living in the poorest areas is 13 years lower for men and 14 years for women when compared to those living in the richest areas.

The map below shows the Index of Multiple Deprivation (IMD) of Reading, West Berkshire and Wokingham in 2019[4]. This is the official measure of relative deprivation, with blue areas showing the most deprived and green areas showing the least deprived areas.



OUR CHALLENGES: THE IMPACT OF COVID-19

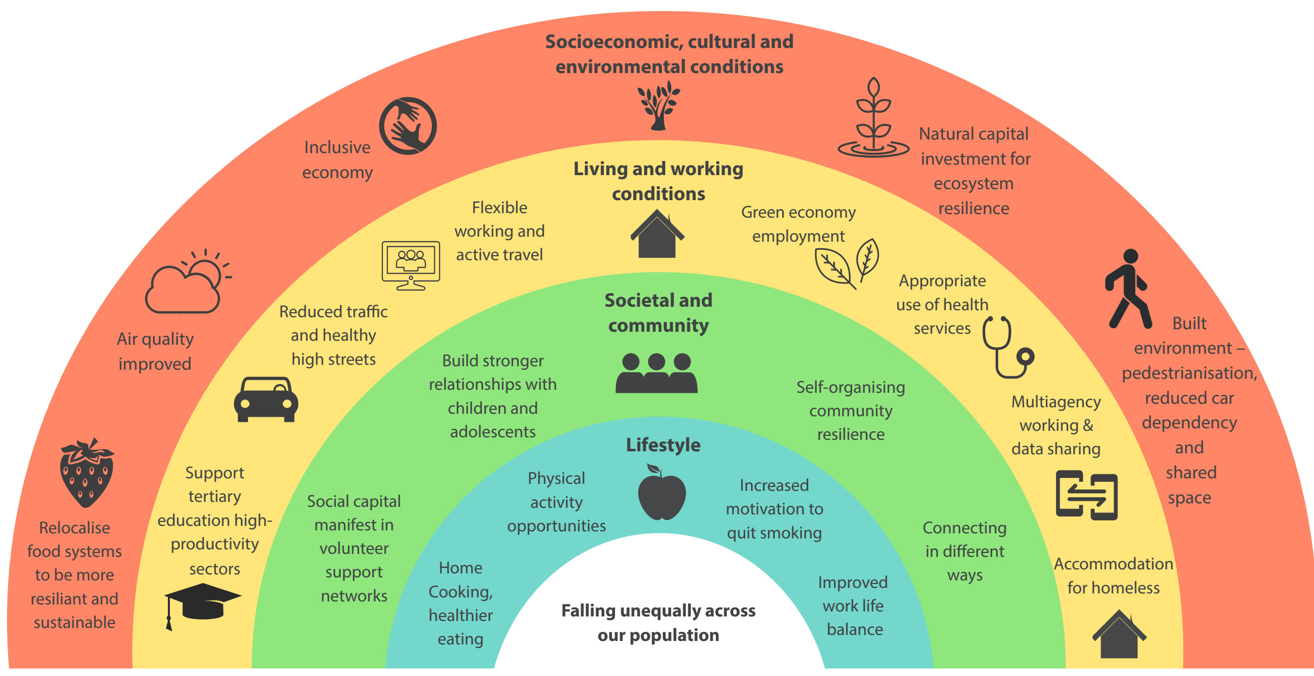
Covid-19 has had a powerful impact across the three areas; businesses have had to shut and health services have been stretched - sometimes to their limit. Covid-19 has affected segments of the local population differently, exacerbating existing inequalities.

Yet in times of adversity there has been ingenuity and wider digitisation in how we deliver health services and work together across the different areas. Additionally, Reading, West Berkshire and Wokingham residents have benefitted from cleaner air, returning nature, and reduced greenhouse emissions during this time.

This pandemic has made it all too clear how intertwined the nation's economic health is with its physical health – better social and economic conditions had led to better health outcomes and vice versa. Covid-19 has also shown us the importance of social cohesion, giving us opportunities to build community resilience and collectively win the fight against the virus.

It is important that Reading, West Berkshire and Wokingham reflect on this episode— the good and the bad — in order to take these lessons forward with a long-term view to "build back fairer" from Covid-19[5] . Enhanced integration and efforts to empower citizens to have everyday resilience, including emergency preparedness, and adaption to other long-term threats such as environmental and climate risk, are here to stay[6]; with the diagram below depicting the growing opportunities and how they should be actioned to rebuild from this pandemic and move forward together.

Opportunities during Covid-19 recovery: rebuilding and moving forward together



OUR VISION

Our vision for Reading, West Berkshire and Wokingham over the next ten years is that all people will live longer, healthier and more richer lives. This involves reducing gaps in the differences of health outcomes between the richest and poorest parts of Berkshire West. This vision encompasses our mission statements, all shown below.

Achieving this vision will need strong partnerships between individuals, local communities and statutory and voluntary sectors. We welcome the aspirations of the NHS White Paper[7] that promotes this greater integration. Integrated care means that care will focus not only on treating specific conditions, but will aim to prioritise healthy behaviours, prevention and supporting people to live more independent lives for longer. Developing this more joined up model of care will also enable the NHS, local government, voluntary sector and other partners in Berkshire West to work together to respond to the needs, priorities and challenges facing our local communities during post-pandemic recovery.

OUR PRINCIPLES

RECOVERY FROM COVID-19

The Covid-19 pandemic has presented an unprecedented challenge to Berkshire West's health and care services and the way residents live their lives on a daily basis. As we move towards a recovery phase, we now have an opportunity to "Build Back Fairer"[5], taking account of the widening health inequalities that have been highlighted by Covid-19 and working together to ensure that equity is at the heart of Reading, West Berkshire and Wokingham's local decision-making to create healthier lives for all.

ENGAGEMENT

Public engagement has been at the core of the development of this Strategy and will be essential to how it is delivered. Reading, West Berkshire and Wokingham will work towards creating more permanent engagement structures and processes to ensure residents' voices are heard as we roll out this plan over the next ten years. This may include the creation of citizen panels, specialist groups and committed champions in our communities who can lead with both their specialist knowledge and local commitment.

PREVENTION AND EARLY INTERVENTION

Prevention and intervening early are key to reducing long term poor health and wellbeing. By shifting our approach away from treating ill-health to preventing it from happening in the first place, we can contribute significantly to reducing physical and mental ill-health.

EMPOWERMENT AND SELF-CARE

We want to support our local people to become more actively involved in their own care and to feel empowered and informed enough to make decisions about their own lives, helping them to be happy, healthy and to achieve their potential in the process.

DIGITAL ENABLEMENT

The Covid-19 pandemic has led to many opportunities in digital transformation for health, social care, both at work and at home. But for those who are unable to participate in online services, it has resulted in greater social isolation and exclusion. We want to embrace the opportunities that digital enablement presents; improving digital literacy and access across the whole of Berkshire West while at the same time ensuring services and support are available for those who prefer not to or who are unable to access them digitally.

OUR PRINCIPLES

SOCIAL COHESION

The diversity of our areas is an asset that we will aim to develop and leverage going forwards. There is already a wealth of community activity taking place across each region and we will work collaboratively with community members, service providers and statutory bodies to help eliminate community-specific health inequalities.

INTEGRATION

Whole systems integrated care is about ensuring every person in Berkshire West can have their needs placed at the centre – this is done through joining up the range of health, social care services and relevant community partners. The aim is to increase access to quality and timely care, supporting people to be more independent in managing their conditions and becoming less likely to require emergency care. To achieve this, we also need to build on existing relationships in the broader Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS)*, linking policies, strategies and programmes with those at the ICS level.

CONTINUOUS LEARNING

The actions that will be delivered through this strategy in Berkshire West will be reviewed and adapted in a timely manner as the world around us changes. We need to accumulate experience, share best practices and learn from one another.

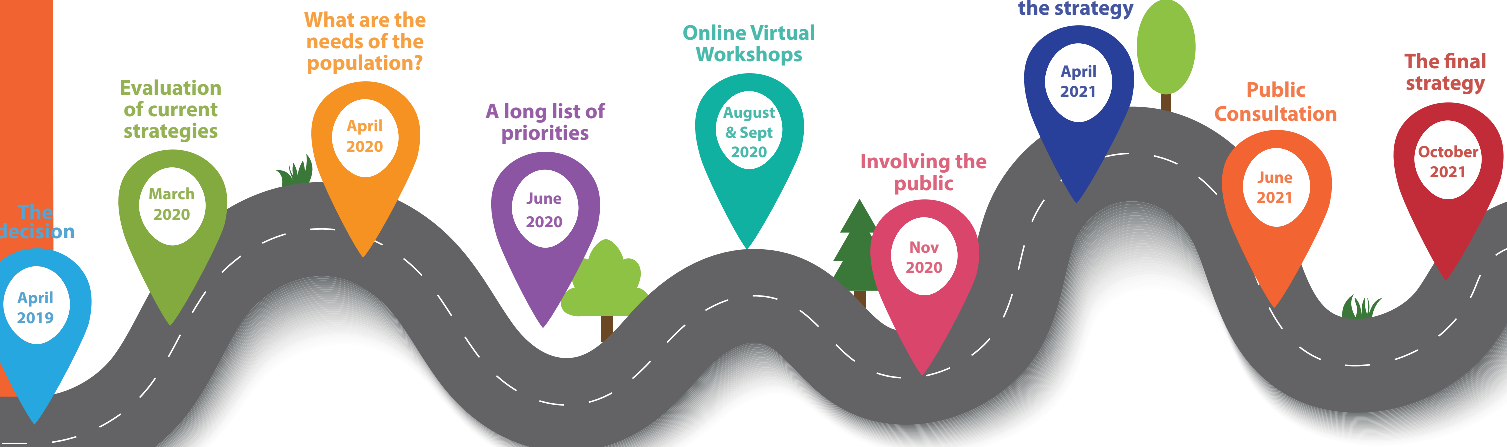
** An Integrated Care System (ICS) brings together health and care organisations to take responsibility for the cost and quality of care for a defined population within an agreed budget. The BOB ICS brings together the Integrated Care Partnerships (ICPs) for Buckinghamshire, Oxfordshire and Berkshire West. The Berkshire West ICP includes: Berkshire West Clinical Commissioning Group (CCG), Royal Berkshire NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust, Reading Borough Council, West Berkshire Council, Wokingham Borough Council and South Central NHS Ambulance Trust (SCAS).*

HOW THE STRATEGY WAS DEVELOPED

The roadmap illustrates how we developed our priorities for the Health and Wellbeing Strategy for Berkshire West. The development was overseen by a monthly steering group whose membership spanned the three local authorities, Berkshire West CCG, Berkshire Healthcare NHS Foundation Trust, Royal Berkshire NHS Foundation Trust, and representatives from voluntary and community organisations.

Public engagement has been at the very heart of this process. A dedicated Consultation & Engagement Task and Finish Group* was created to lead community consultation and engagement efforts and included representatives from local communities (focusing upon typically underrepresented groups). Collectively, this team co-produced and delivered the public engagement strategy that was crucial to the creation of the HWBS. During the public engagement, residents could comment on 11 different potential priorities, which had been narrowed down from an initial number of approximately 30, during the early stages of the Strategy development. Participants were also invited to comment on whether they thought there were any missing priorities. The findings from this engagement were used to refine our final priorities for the Strategy.

A more detailed report on how the Strategy was developed and the outcomes of the public engagement can be found in the Berkshire West Engagement Report.



The engagement task and finish group included: Healthwatch Reading, Healthwatch Wokingham, Healthwatch West Berkshire, Berkshire West CCG, Reading Voluntary Action, Involve Wokingham, West Berkshire Volunteer Centre, Community United West Berkshire, Berkshire NHS Healthcare Foundation Trust, representatives from the public health teams in each of the three local authorities.

FIVE HEALTH AND WELLBEING PRIORITIES

The jointly agreed five priorities over the lifespan of this Strategy which we believe will bring the most positive impact to our health and wellbeing are as follows:

1 REDUCE THE DIFFERENCES IN HEALTH BETWEEN DIFFERENT GROUPS OF PEOPLE.

2 SUPPORT INDIVIDUALS AT HIGH RISK OF BAD HEALTH OUTCOMES TO LIVE HEALTHY LIVES.

3 HELP CHILDREN AND FAMILIES IN EARLY YEARS.

4 PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL CHILDREN AND YOUNG PEOPLE.

5 PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL ADULTS.

These priorities are interrelated and interdependent, with priority number one of reducing the differences in health between different groups of people and the eight principles driving all implementation plans that fall under the other four priorities.

Health inequities are the avoidable differences in health outcomes, often shaped by influences beyond medicine and access to health services.

This includes factors that are primarily social – the conditions in which people are born, grow, live, work, and age, meaning that economic, environmental and social inequalities can all determine people's risk of getting ill. For this reason, reducing health inequity will act as a pillar, underpinning all that is done for the four other priority areas.

1 REDUCE THE DIFFERENCES IN HEALTH BETWEEN DIFFERENT GROUPS OF PEOPLE

WHY IS IT IMPORTANT?

Health inequities are a matter of fairness and social justice[8]. It is the unfair and avoidable differences in people's health across social groups and between different population groups, often expressed as the "social gradient in health". In England, there are still significant unfair and avoidable inequities and in access to and experiences of NHS services.

Many people in our area experience health inequities. This may include groups who are economically disadvantaged, isolated young people, refugees and asylum seekers and people with physical disabilities or those who may find it harder to communicate. The relationship between a person, their wider environment and their health is shown in the Dahlgren and Whitehead model[9] on the right– health is influenced not only by choices that a person makes (such as smoking, or eating a healthy diet), but also by their living and working conditions and the community that surrounds them.

We know that people who experience health inequities may often be those who are at high risk of bad health outcomes and so there is overlap between the groups identified above within this priority, and those who are also identified within Priority 2 of this Strategy: *Support Individuals at High Risk of Bad Health Outcomes to Live Healthy Lives*

Local efforts to reduce health inequities means focussing on reducing gaps in healthy life expectancy amongst those who have the worst outcomes. Building fairer areas will ensure everyone has the best opportunity to live a long life in good health.

There are 3 key issues:

i. Inequities in opportunity and / or outcome: some people don't get a good start in life, have fewer social opportunities, live shorter lives or have longer periods of ill health;
ii. Inequities and lack of access – some people cannot access services, do not know about them cannot use them or need support to use them (for example, due to learning disability or sensory impairment).
iii. Covid-19 – its impact has exacerbated existing health inequities

WHAT YOU TOLD US:

Residents across Reading, West Berkshire and Wokingham considered reducing the differences in health to be an "extremely important" issue.

"Lack of income should not mean poor health

"Make (health and social care) services available to everyone"

Model of social determinants of health [9]

REDUCE THE DIFFERENCES IN HEALTH BETWEEN DIFFERENT GROUPS OF PEOPLE

WHAT ARE WE ALREADY DOING?

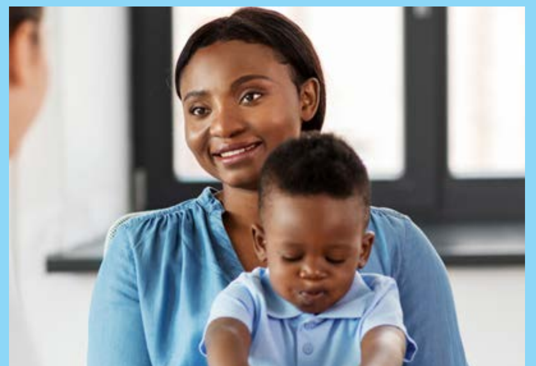
Reading, West Berkshire and Wokingham HWBs have all made significant efforts to reduce health inequalities. All three areas have worked with their residents, statutory organisations and voluntary groups to make sure that residents are empowered to decide where actions should be taken and in what manner to achieve fairness in their community. The three areas have also begun to use a Population Health Management approach; this makes use of rich local population health data to complement and inform these discussions and actions.

SPOTLIGHT

The Alliance for Cohesion and Racial Equality (ACRE)[10] in Reading, is a voluntary organisation that hosts an annual health inequalities conference.

They work to promote equality across nine strands including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation, all in order to build an increased sense of community in Reading.

Alafia, the ACRE Family Support Team, also works to support families caring for a child or young people between the age of 0-25 from all backgrounds.



TO MAKE A DIFFERENCE, WE WILL:

- Use information and intelligence to understand our communities, identify those who are in greatest need and ensure that they are able to access the right services and support.
- Assess how Covid-19 has differentially impacted our local populations, including through the displacement or disruption of usual services. We have to ensure access to these services are available to all during Covid-19 recovery.
- Take a Health in All Policies approach[11] that embeds health across policies and various services. The aim of this approach is that the impact on health will be considered for all of the work that the three council's do, encouraging closer working relationships between statutory bodies and the voluntary and community sectors.
- Address the variation in the experience of the wider social, economic and environmental determinants of health
- Continue to actively engage and work with ethnically diverse communities, the voluntary sector, unpaid carers and self-help groups, ensuring their voices are heard.
- Ensure services and support are accessible to those most in need through effective signposting, targeted health education, promoting digital inclusion and in particular addressing sensory and communication needs. All in a way that empowers communities to take ownership of their own health.

2

SUPPORT INDIVIDUALS AT HIGH RISK OF BAD HEALTH OUTCOMES TO LIVE HEALTHY LIVES

WHY IS IT IMPORTANT?

Differences in health status between groups of people can be due to a number of factors[12], such as income, geography (e.g. urban or rural) and disabilities. The health needs of those groups at high-risk for bad health outcomes could place heavy and unpredictable demands on health services[13], and must therefore proactively be identified and addressed. The broad issues impacting groups at high risk are:

i. Lack of easy access to healthy activities and food;
ii. Limited availability of information about health and wellbeing services;
iii. Increased loneliness and isolation (exacerbated by COVID-19).
iv. Barriers to accessing GPs and primary health services;

People may experience different barriers to accessing services or support. Examples of these include physical barriers such as lack of transportation or barriers due to sensory or communication needs.

HOW DOES THIS IMPACT HEALTH INEQUITIES?

In order to close the gap between groups with existing health inequities, it is important to adopt a "proportionate universalism" approach[14]. This means allowing some form of effective targeting or tailoring of services to different groups that are at greater risk of bad health. This should take place within a broader universal framework, i.e. where the general services or provision is already available for all.

WHAT YOU TOLD US:

Supporting people facing higher risk to live healthy lives is a very important priority across Reading, West Berkshire and Wokingham. 35% of all survey respondents agreed that significant change is required within this priority area. People facing higher risk of bad health outcomes were identified as having a continuing or new need for support (including before and during Covid-19).

Our engagement with the public identified the following groups as being at high risk of bad health outcomes. We will prioritise supporting these groups to live healthy lives, depending on local context and need for each of the three local authorities:

- Those living with dementia
- People with learning disabilities
- Unpaid carers
- Rough sleepers
- People who have experienced domestic abuse

This is our Strategy for the next ten years and we recognise that the groups who are at higher risk may change over this time. We will actively engage with our communities during the life of this Strategy, continuously learning and understanding the needs of our population in order to ensure that we are supporting those at highest risk, even if they are different to those groups that we are starting with.

SUPPORT INDIVIDUALS AT HIGH RISK OF BAD HEALTH OUTCOMES TO LIVE HEALTHY LIVES

WHAT ARE WE ALREADY DOING?

Although different groups may be targeted in Reading, West Berkshire and Wokingham, considerable steps have been taken in each area to ensure nobody falls between the cracks through ways that are most suited to local needs as well as joint working to meet common needs.

SPOTLIGHT

In Wokingham, provisions are in place to identify and effectively support those with Special Education Needs and Disabilities (SEND); a co-produced 2020-2023 SEND strategy is being executed to support CYP aged 0-25 years, their parents and carers. SEND Voices Wokingham is an example of a successful parent-carer forum which promotes participation and co-production in local governance by regularly representing or advocating for service users to service planners, commissioners and providers to design and deliver better services.

West Berkshire has recently refreshed its Domestic Abuse Strategy (2020-2023) to provide high-quality, evidence-based interventions for survivors of abuse and their families as well as training for local practitioners and communities to support those currently at risk. A2Dominion is the local Domestic Abuse Service provider that offers emotional and practical support through phone helplines, places of safety and independent domestic violence advisor support.

TO MAKE A DIFFERENCE, WE WILL:

- Raise awareness and understanding of dementia, and ensure support for people for who have dementia is accessible and in place for them and their unpaid carers. We will work together to ensure the Dementia Pathway is robust, including pre-diagnosis support, improving early diagnosis rates, rehabilitation and ongoing support.

- Improve identification and support for unpaid carers of all ages. Work with unpaid carers and partner agencies to promote the health and wellbeing of unpaid carers.

- Work together to reduce the number of rough sleepers and improve the mental and physical health of rough sleepers and those who are homeless, through improved access to local services

- Prevent, promote awareness and provide support to those who have experienced domestic abuse in line with proposals outlined in the Domestic Abuse Bill.

- Support people with learning disabilities, engaging with and listening to them, through working with voluntary organisations, in order to concentrate on issues that matter most to them.

- Increase the visibility of existing services and signposting to them, as well as improving access for people at higher risk of bad health outcomes, working with and alongside voluntary and community organisations who are supporting these groups.

3

HELP FAMILIES AND CHILDREN IN EARLY YEARS

WHY IS IT IMPORTANT?

Prevention and early actions are key to positive health outcomes. Setting the foundations for health and wellbeing for families and children in early years is crucial to ensure the best start in life for every child[15]. The first 1001 days[16] - from pregnancy to the first two years of a child's life - are critical ages for development. This sensitive window sets the foundations for virtually every aspect of human development – physical, intellectual and emotional[17].

Key improvements need to be made in:
i. Supporting new parents, including single parents, in the transition to parenthood;
ii. Ensuring access to effective interventions throughout the first 2 years of a child's life;
iii. Guaranteeing affordability and timeliness of services during and after Covid-19.

HOW DOES THIS IMPACT HEALTH INEQUITIES?

Inequities in child health and development start early; they exist at pregnancy, birth and during the early years. Not all children and families have the support they need for their children to be physically healthy, emotionally secure and ready to learn. Reasons for this are often social, including income and poor housing quality, and these factors can often accumulate over the lifecourse[18], having long term consequences on not only health, but also social outcomes such as educational attainment and employment. This is why it is so important to ensure we support families to provide as best a start as possible for their children, helping to break the cycle of reproducing health and social inequalities in the next generations and so building the foundations for a more equal society in the future.

WHAT YOU TOLD US:

Around 40% of all survey respondents across the three areas consider this priority to be an "extremely important" issue.

"I would like to have help with childcare".

"It's unclear what support is available."

WHAT ARE WE ALREADY DOING?

It is evident that children and young people (CYP) are our asset and a very cherished part of Berkshire West from the sheer number of partnerships, actions and advocacy at different levels surrounding children, young people and their families locally.

In addition to the spotlight below, the three areas have committed to align the delivery of local health visiting and school nursing services (Healthy Child Programme), promoting a whole systems approach* to make it easier for children, young people and families to receive the care and advice they need.

*A whole systems approach is when partners and stakeholders, including communities themselves, are brought together to develop a shared understanding of the challenges they face, particularly looking at how different factors are interlinked. By taking the whole picture into account, actions and solutions are developed together, aiming to bring about sustainable, long term change.

HELP FAMILIES AND CHILDREN IN EARLY YEARS

SPOTLIGHT

West Berkshire Children Delivery Group and the ONE Reading CYP Partnership are working towards system change in their respective areas. This includes coordinating the contribution of partner agencies to shared visions, principles and priorities, promoting shared workforce development and information sharing. These organisations have also pushed to embed trauma-informed approaches* to CYP services and in school education programmes.

At the community level, different groups have also been providing training sessions and guidance to help practitioners to meet the diverse, complex needs of families. Areas of work which harness the expertise of voluntary groups range from mentoring to the provision of essential needs. The increase in voluntary sector capacity has increased community resilience and has helped to reduce pressures on specialist services.

TO MAKE A DIFFERENCE, WE WILL:

- Work to provide support for parents and carers, during pregnancy and the early years, to improve personal and collective resilience using research and good practice.
- Ensure families and parents have access to right and timely information and support for early years health. Working with midwifery, Family Hubs, healthy visiting and school nursing to improve the health, wellbeing, developmental and educational outcomes for all children.
- Increase the number of two-year olds (who experience disadvantage) accessing nursery places.
- Ensure that our early years settings staff are trained in trauma-informed* practice and care, know where to find information or help, and can signpost families properly.
- Publish clear guidelines on how families can access financial help, including for childcare costs; tackling stigma around this issue where it occurs.

*The King's Fund describes a trauma informed approach as aiming to provide an environment where a person who has experienced trauma feels safe and can develop trust. Individual trauma results from an event, series of events or set of circumstances that is experienced as an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing[19].

4

PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL CHILDREN AND YOUNG PEOPLE

WHY IS IT IMPORTANT?

The mental and emotional health of CYP is as important as their physical health and wellbeing. Mental health problems are a leading cause of disability in children and young people, and can have long-lasting effects; 50% of those with lifetime mental illness experience symptoms by age 14[20]. The three key issues affecting the mental and emotional welfare for local CYP are[21]:

i. Limited access to mental health education and services to support children and young people and prevention services;
ii. Limited resources, service cuts and the impact of Covid-19 and the lockdowns on the ability to access service;
iii. The waiting time to access Child and Adolescent Mental Health Services (CAMHS).

HOW DOES THIS IMPACT HEALTH INEQUITIES?

Children from households in the poorest areas of Berkshire West are four times more likely to experience severe mental health problems than those from the richest areas[22]. Besides social factors, other important contributors to mental health and wellbeing amongst CYP include general health and physical activity. Inequities in the rates of mental illness observed across ethnicities and sexual orientations of CYP also warrant urgent attention[23]. As stated, we know that mental health conditions that start at a young age often persist into later life and limit CYP's opportunities to thrive in both education and in the job market. Closing the gap in CYP mental health and wellbeing in Reading, West Berkshire and Wokingham will therefore be key to ensuring all CYP have the best chance of making the most of the opportunities available to them and fulfilling their potential.

WHAT YOU TOLD US:

Over 70% of people 45 years or younger and about 50% of all survey respondents considered good mental health and wellbeing for all children and young people to be an extremely important issue.

"Not enough support in schools (for mental health)."

"Many families struggle to support their children (with mental health issues)".

WHAT ARE WE ALREADY DOING?

The Berkshire West Future in Mind Plan, is a Local Transformation Plan for CYP Mental Health and Wellbeing in Reading, West Berkshire and Wokingham. Its priorities are to:

- Raise awareness amongst children and young people, families / carers and services to improve confidence in providing informal emotional wellbeing support, as well as better identification and early intervention for children and young people needing additional support for their mental wellbeing.
- Improve waiting times and access to support, including developing support to bridge the gap for those on waiting lists for a mental health assessment or intervention.
- Recognise the diversity of the youth population across Berkshire West and improve both equality of access across all services and reduce stigma attached to mental health.

PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL CHILDREN AND YOUNG

- Develop a systematic approach to hearing the voices of children and young people.
- Strengthen joint working to plan, commission, deliver and promote services which focus on the priority issues for children and young people across Berkshire West.
- Build Berkshire West 0–25-year-old comprehensive mental health offer and review transition arrangements for services offered.

TO MAKE A DIFFERENCE, WE WILL:

- Aim to enable all our young people to thrive by helping them to build their resilience and have the skills to overcome normal life challenges and stresses without long term harm.
- Aim for early identification of those young people in greatest need, or at risk of developing a mental health condition, in order to intervene early to support them with their emotional wellbeing, build self-confidence and so prevent worsening mental health.
- Use evidence to support interventions at the individual, family and community levels to prevent and reduce the risk of poor mental health. We will also improve the equality of access across all services by recognising the diversity of our youth population
- Engage with staff, students, parents, the community and mental health support teams to inform interventions for emotional health and wellbeing, supporting a Whole School Approach to Mental Health[24] and embedding wellbeing as a priority across the school environment.
- Each local authority will proactively support the mental health and wellbeing of their looked after children and care leavers, adopting behaviours and attitudes, acting as any good parent would do by supporting, encouraging and guiding their children to lead healthy, holistic and fulfilled lives (Corporate Parenting Principles[25]).
- Expand our trauma-informed approach among formal and informal service providers, including charities and voluntary organisations, supporting recovery and resilience in our children and young people.
- Improve the process for transition to adult mental health services for our young people, starting the planning early and including the young person themselves in order to ensure that the process is as smooth as possible.

5

PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL ADULTS

WHY IS IT IMPORTANT?

Mental health problems in adults represent the largest single cause of disability in the UK[26]. Adults could be affected by mental health issues at any time. It impacts all aspects of our lives, and both influences and is influenced by physical health. Adult mental illnesses also have a ripple effect on their family, unpaid carers and wider society. In 2019/20, an estimated 17.9 million working days were lost due to work-related stress, depression or anxiety in Great Britain[27]. The key issues are[28]:

i. Lack of early identification of and intervention with mental health problems;
ii. Limited social networks have a significant impact on the health and wellbeing of people, and are a powerful predictor of death, with evidence that adequate social relationships can help improve life expectancy;
iii. Improving the access, quality and efficiency of current services, including post Covid-19 mental health support.

HOW DOES THIS IMPACT HEALTH INEQUITIES?

Inequities also exist in adult mental ill-health across protected characteristics, including sexual orientation, sex, ethnicity, and whether they belong in socially excluded groups (e.g. people experiencing homelessness, asylum and refugees). People with severe mental illness (SMI), such as psychosis and bipolar disorder, have a life expectancy of up to 20 years shorter than the general population[29].

Much like inequities in physical health, mental illness is also closely linked to broader social inequalities which are complex and interrelated, such as unemployment, discrimination and social exclusion. Therefore, tackling mental health inequalities also requires addressing these broader social inequalities.

WHAT YOU TOLD US:

Over 70% of people of 35 years of age or older and about 50% of all survey respondents considered good mental health and wellbeing for all adults an "extremely important" issue, while more than 40% believe that significant further change is required.

"Ethnically diverse communities find it difficult to access mental health resources".

"(physical health is) linked to mental health"

WHAT ARE WE ALREADY DOING?

In times of a global pandemic, the lockdown social distancing and shielding measures meant that people had less opportunity to spend time with loved ones as before. Understanding their impact on mental health and wellbeing, voluntary and service sectors alike have prioritised combating loneliness and social isolation and expanded efforts to address mental health crises and suicide prevention as part of the Covid-19 response.

Across Berkshire West, during this time, our local services have proactively reached out to existing users for wellbeing checks. There has been an overwhelming and heartening response from volunteers in expanding the capacity of charities for befriending support. As we move forward, partner organisations of the three HWBs will remain vigilant and provide enhanced mental health and suicide prevention support around areas of heightened risk.

PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL ADULTS

SPOTLIGHT

Wokingham's Link Visiting Scheme is a charity dedicated to reducing loneliness through enabling friendships. Thanks to the immense support from local communities, the charity has seen an 80% spike in growth and has managed to respond to the quadrupled demand in services during the pandemic. From one-to-one phone calls that match volunteers to older people based on personality and interests, to online Friendship Cafes and craft sessions, the charity has seen many friendships blossom during the pandemic.

West Berkshire have signed up to the Prevention Concordat for Better Mental Health[30], working with different organisations to take a prevention focused approach to public mental health. A new Surviving to Thriving fund has also been set up in partnership with Greenham Trust to support projects that will help to reduce the impact of Covid-19 on mental health.

TO MAKE A DIFFERENCE, WE WILL:

- Tackle the social factors that create risks to mental health and wellbeing, such as social stressors related to debt, unemployment, insecure housing, trauma, discrimination, as well as social isolation and loneliness.[31]
- Work with local communities, voluntary sectors and diverse groups to re-build mental resilience and tackle stigma of mental health; all in order to promote an informed, tolerant and supportive culture.
- Continue to recognise the importance of social connection, green spaces and understanding of different cultural contexts for mental wellbeing. We will increase social prescribing[32] by promoting access and signpost to activities that promote wellbeing, such as physical activity and stronger social networking to improve health.
- Improve access to, quality and efficiency of services available to all who need them, including improved digital offerings for those who can and prefer to use them.
- Work with professionals in workplaces and other settings; using a preventative approach to break down the barriers between physical and mental health, and ensure both are treated equally.
- Improve access to support for mental health crises and develop alternative models which offer sustainable solutions, such as peer mentoring or trauma-based approaches.

NEXT STEPS

THE ROAD AHEAD

As we transition into the post-pandemic era, we now need to look forward to the recovery of population health, rebuilding livelihoods and adapting to a new normal, whilst levelling health inequities across Reading, West Berkshire and Wokingham. In order to do this, each Health and Wellbeing Board will develop their own local delivery plans to implement this Strategy. These plans will be specific to each area, understanding how the five priorities fit in their communities and what local actions need to be taken. This will include the governance and accountability arrangements that will oversee the work.

This Strategy will actively engage with stakeholders to refresh itself on a cycle during its ten-year lifespan. This will ensure that the Strategy is able to meet the needs of our communities as they grow and change during this time.

STRENGTHENING PARTNERSHIPS AND COMMUNITY ENGAGEMENT AS A PLACE-BASED APPROACH

Improving the health and wellbeing of Reading, West Berkshire and Wokingham will always rely on local assets; it is not a task that can be achieved by the Health and Wellbeing Board alone. Faced with these challenges before us, now more than ever is the time to come together to work towards our common goals and recover from the pandemic. We want to strengthen existing partnerships, increase collective action, coordinate the management of common resources, share data and best practices and stimulate innovation at the local level.

We also want to build upon the many conversations we have had with local people and continue directly engaging and involving residents as a way of empowering communities to have a say, take control of their health, find solutions that work for everyone and support one another in this time of crisis. By adopting this place-based approach to health, we can maximise our resources, skills and expertise to increase the pace and scale of change required.

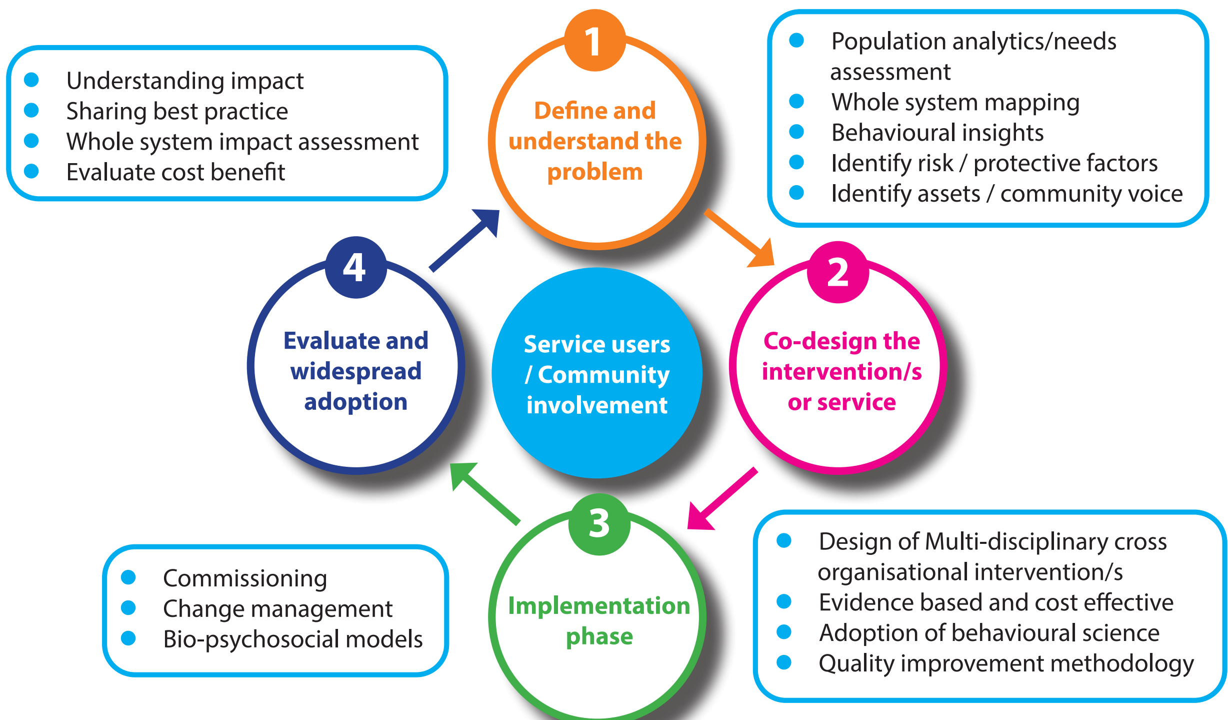
NEXT STEPS

HEALTH AND WELLBEING BOARD COMMITMENTS

Each Health and Wellbeing Board will work towards the five priorities in different approaches to adapt to their local context and reflect on local issues and concerns. Whilst there are specific priorities contained within this Strategy, our ambition is to embed prevention in all that we do. We will achieve this through a public health approach and for each of the five identified priorities, the three HWBs will:

- Assess the current provision and gaps in services compared to national guidance or best practices ensuring that this Strategy coordinates with other strategies across the system and is complementary to those, rather than a duplication of them.
- Define how success may be measured by developing a robust outcomes and indicators framework. This will be presented as outcomes when measuring progress (including the targets), to enable sharper focus and opportunities for the three Boards to discuss progress in their local areas.
- Review the evidence on what works to get us to where we want to be.
- Identify opportunities for improvement.
- Consult the stakeholders for input on the draft implementation plan.
- Identify resources for implementation.
- Oversee implementation of the Strategy and review progress against agreed outcomes.

The diagram below represents a framework that will guide the work in delivering the Health and Wellbeing Strategy



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APPENDIX

APPENDIX A

MEASURE	SOURCE
Total Resident Population	Office for National Statistics (2019)
Urban Population: *The percentage of people living in an urban area, based on the Rural-Urban Classification. The Classification defines areas as rural if they are outside settlements with more than 10,000 resident population, and as urban if inside such settlements.*	Department for Environment, Food and Rural Affairs (2011) https:¬/¬/www.gov.uk¬/government¬/collections-/rural-urban-classification Data
Population Aged 65+	Office for National Statistics (2019)
Ethnically Diverse Population	Office for National Statistics, Census (2011)
Children achieving a good level of development at early years	Department for Education (2019)- Statistics: Early Years Foundation Stage Profile https:¬/¬/www.gov.uk¬/government¬/collections-/statistics-early-years-foundation-stage-profile
Full time students age 18+	Office for National Statistics, Census (2011)
Total number of businesses	Office for National Statistics (2019)
Unemployment Rate	Office for National Statistics (2019)
Percentage of unpaid carers (1-50+ hours of unpaid care per week)	Office for National Statistics, Census (2011)
People with very good health	Office for National Statistics, Census (2011)

Health and Wellbeing Strategy: Delivery plans

1. Reduce the differences in health between different groups of people						
Objective	**Actions**	**Aligns to**	**Owned by**	**Timescale**	**Indicator**	**Target**
1.1 Use information and intelligence to understand our communities, identify those who are in greatest need and ensure they are able to access the right services and support	1.1.1: Undertake a Health needs assessment on health inequalities, including impact of Covid-19	1.2.1	Health Inequalities taskforce	June 2022	Completed HNA	
	1.1.2: Embed Population Health management approach across all programmes, incorporating 2021 census data when available		Public Health/ Berkshire West CCG	ongoing		
1.2: Assess how Covid-19 has differentially impacted our local populations, including through the displacement or disruption of usual services.	1.2.1: To undertake a Health needs assessment on health inequalities, including impact of Covid-19	1.1.1	Health Inequalities taskforce	June 2022		
	1.2.2: Respond to the findings from the Residents survey on impact of Covid-19 on Residents Survey	1.2.2	Recovery & renewal group	June 2022		
	1.2.3: To understand the impact of Covid-19 on care home residents and their families		Healthwatch West Berkshire	March 2022	Visit Care homes and speak with families	5
	1.2.4: Work on the findings of the Healthwatch Covid-19 report - Assess the impact of Covid-19 on DNA's and availability of services		Healthwatch West Berkshire	March 2022	Report on experiences	

	Reassess the impact of covid-19 on the local cancer care					
	1.2.5: Undertake review of NHS HealthChecks and target those most at risk		Shared Public Health team for Berkshire West	December 2022	Review completed Number of checks completed	
	1.2.6: Implementing the Recovery from Covid-19 Strategy	1.2.1	Recovery & Renewal Strategy group		KPIs as under the delivery plan	
	1.2.7: Compete the Covid-19 Dashboard. Including the incorporation of local West Berkshire data		Recovery & Renewal Strategy group (Public Health)	December 2021	Completed dashboard	
1.3: Take a Health in All policies approach	1.3.1: Training/Awareness raising sessions with staff across West Berkshire Council		Health Inequalities Taskforce	June 2022	Number of sessions Number of staff trained % increased understanding % saw relevance to current work	
	1.3.2: Mapping of West Berkshire Strategies to identify areas of opportunity for combined working		Health Inequalities Taskforce	March 2022	Completion of mapping work	
	1.3.3: Develop a HIAP Pilot project: joint initiative between Public Health, Environment, Education and Berks, Bucks and Oxfordshire Wildlife Trust (BBOWT) - focus on promoting a healthy weight in children - Project group established - Mapping of shared goals - Develop project plan - Aim to culminate with Children's Mental Health Week (7-13th Feb 2022)		Health Inequalities Taskforce	February 2022	Project plan actions as developed	

	1.3.4: Establish local authority support network for HIAP		Health Inequalities Taskforce/PH WB	December 2021	Network created First meeting held ToR produced	
	1.3.5: Refine and improve process for reviewing new council policies and impact on health and emotional wellbeing (including a focus on reducing health inequalities)		Health Inequalities Taskforce	December 2022	Process developed Template implemented	
1.4: Address the variation in the experience of the wider social, economic and environmental determinants of health	1.4.1: Pilot a whole community approach in a local ward to tackling health inequalities, using data and engaging with local communities	1.1.1	Health inequalities taskforce	December 2022		
	1.4.2: Public Awareness campaign to promote the sustained employment of people from under-represented groups	1.4.6	Skills & Enterprise Partnership	(tbc)	Delivery of campaign Engagement	One campaign
	1.4.3: CCG actions around encouraging health screening – focus on specific groups/communities - Mapping screening (health protection board) (placeholder)		CCG			
	1.4.4: Development of a health impact policy for planning to support healthy environments	1.3	Communities and Wellbeing Planning	June 2022	Process developed Process implemented	
	1.4.5: Physical Activity Champion training		Workplace Movement project group	June 2022	Number of Champions trained	
	1.4.6: Implementation of the Supported Employment Strategy 2020 - 2024		Skills and Enterprise Partnership	2024		

1.5: Continue to actively engage and work with ethnically diverse communities, the voluntary sector, unpaid carers and self-help groups, ensuring their voices are heard.	1.5.1: Create a stakeholder map our current Community and Voluntary sector partners who are working to address health inequalities	2.9.4 3.2.4 4.3.1 5.2.1	Health inequalities Taskforce	December 2022	Completion of network map	
	1.5.2: Ongoing development of the Health and wellbeing board engagement group communication toolkit		HWB engagement group	June 2022	Completion of toolkit	
	1.5.3: Implement the Comms & Engagement Delivery Plan (key actions) • Reviewing engagement with Parish & Town Councils • Voluntary and community sector support • Co-production framework • Maintaining signposting and connections to community support functions • Develop, distribute and evaluate a new grant fund to support community based co-production work. (aligns with Equality and Diversity Strategy too)		Engaging and Enabling Communities (BCT)	Dec 2021 April 2022 Nov 2021 April 2022 TBC	KPIs as under Comms and Engagement Delivery Plan	
	1.5.4: Ethnically diverse advocacy groups: identifying and engaging with key community contacts amongst the ED community		TBC (?empowering communities partnership)	Ongoing		
	1.5.5: Increase accessibility of Ethnically diverse advocacy services across West Berkshire:		TBC (?empowering	June 2022	Number of outreach community cafes	

	Expansion of Educafe to provide mobile service		communities partnership)			
	1.5.6: Promote the range of events that celebrate the diversity of our community		TBC (?empowering communities partnership)	December 2022	Number of events	
	1.5.7: Support and develop the Community Conversations forum		Taskforce/BCT	Ongoing	Number of community conversations forum meetings held Number of community attendees	12 meetings/yr
1.6: Ensure services and support are accessible to those most in need through effective signposting, targeted health education, promoting digital inclusion and in particular addressing sensory and communication needs. All in a way that empower communities to take ownership of their own health	1.6.1: Increase awareness and uptake of council support services for those most in need e.g. winter grant (placeholder)	1.6.3 1.7.2 2.3.2 2.9.4				
	1.6.2: Develop Digital Inclusion Champions (specific actions around recruitment and numbers in place)		BOB ICS		Number of champions in West Berkshire Geographical areas covered/communities of interest	
	1.6.3: To improve support and both awareness of and access to services with diverse ethnic communities through the support agency Educafe - Weekly community cafe		TBC (empowering communities partnership)	Weekly café newly established	Attendance at café Number of services/partners attending weekly	
	1.6.4: Develop a Whole Systems Approach to Physical Activity - Undertake system workshops - Develop system map - Physical activity strategy	1.4.5	ICP (Prevention Board)	 November 2021 December 2021 December 2022	Number of workshops Development of Physical activity system map	2 workshops

					Development of physical activity strategy	
	1.6.5: Undertake a dental review to understand current provision and identify recommendations for action (placeholder)	2.6.2	? Berkshire West			

2: Support individuals at high risk of bad health outcomes to live healthy lives						
Objective	**Action**	**Aligns to**	**Owned by**	**Timescale**	**Indicator**	**Targets**
2.1: Raise awareness and understanding of dementia and ensure support for people who have dementia is accessible and in place for them and their unpaid carers	2.1.1: Improve Dementia diagnosis rates (partnership work with the ICP)		MH/LD Board Berkshire West	By end of 2022	Diagnosis rates for Dementia	65% (April 22) 67% (Sept 22)
	2.1.2: Restoring all previous Memory Cafés as running again face to face		Dementia Friendly West Berkshire Age UK	1 year (?)	Memory cafes running again face to fall	(all previous)
	2.1.3: Engagement with partners to continuously update and expand the Dementia friendly West Berkshire Website		Dementia Friendly West Berkshire	Ongoing	Visits to website Feedback from partners	
	2.1.4: Induction training on Dementia to be undertaken for all Adult Social Care Staff: Event to be held with existing staff to raise awareness. Will be recorded as a webinar for future new staff		Dementia Friendly West Berkshire Adult Social Care	Autumn 2021 (event)	Event held with existing Adult Social Care staff Webinar to be incorporated into induction training for new staff	Attendance at event Feedback
	2.1.5: Work with local businesses in West Berkshire to raise awareness of role with the community, along with role as an employer for those who are unpaid carers		Carer's Strategy group		Number of businesses Number of Dementia Friendly businesses	
	2.1.6: Work with the Reading Agency to provide a collated collection of self help books around mental health and wellbeing (including Dementia)	4.1.4 5.3.4				

	that people borrow from local libraries. (placeholder)					
2.2: Work together to ensure that the Dementia pathway is robust, including pre-diagnosis support, improving early diagnosis rates, rehabilitation and ongoing support	2.2.1: Engagement event to understand the person's experience and Journey (led by CCG)		Healthwatch			
	2.2.3: Care home support (work not confirmed – placeholder action) - Medication reviews - Managing behaviour changes - Reduce levels depression		Berkshire West CCG			
	2.2.4: Improve the access to and quality of Annual reviews in GP practices to ensure community and partner support for people with dementia		MH/LD Board Berkshire West		Proportion of people with dementia receiving an annual GP check Impact of annual review in improving access to services	
	2.2.5: Commission a Befriending and sitting service for people with more advanced dementia and their unpaid carers		Dementia friendly West Berkshire Age UK			
2.3: Improve identification and support for unpaid carers of all ages	2.3.1: Use findings from the Carers Strategy Survey to understand gaps in support - Including questions on accessing covid-19 vaccine and barriers encountered		Carer's Strategy group	Survey to take place in October 2021	Number of PwD and carers supported weekly	25
	2.3.2: Promotion of Carer's rights day: including information for		Carer's Strategy group (Comms)	25th November 2021		

	carers on financial support (supported by DWP)					
	2.3.3: Embedding new process for online referrals of Young carers and ensuring all partners are aware. • Social media promotion		Young Carers		Numbers of referrals	
	2.3.4: Raise awareness of young carers - Engagement with partner agencies - Advice and information sessions with schools - Young carers groups at schools - Re-establish young carers champions		Young Carers	Ongoing	Number of schools engaged with Young carers champions	
2.4: Work with partner agencies to promote the health and wellbeing of unpaid carers	2.4.1: Update the Health top tips leaflet for carers		Carer's Strategy group	December 2021	Leaflet completed Distribution	
	2.4.2: Review and refresh the Carers Strategy Action plan		Carer's Strategy group	December 2021	Actions as will be contained within the plan	
	2.4.3: Access to respite services (place holder)					
	2.4.3: Using the young carers dashboard to continuously review engagement with services and outreach to new attendees		Young Carers	Ongoing	Number of new young carers identified	
	2.4.4: Use feedback from young carers to inform and expand the activities on offer: online form		Young Carers	Ongoing	Number of responses to online form New activities offered	
	2.4.5: Recruit volunteers to 1-1 mentoring role to work with young carers with particular challenges		Young Carers	Ongoing	Increase in mentor numbers	

					Increase in young carers supported	
2.5: Reduce the number of rough sleepers	2.5.1: Continue to work together to prevent rough sleeping and reduce the number of people who do sleep rough (Implementation of the Homelessness and Rough sleeping strategy)		Homelessness Strategy group	2025	Number of people sleeping rough	< 2
2.6: Improve the mental and physical health of rough sleepers and those who are homeless through improved access to local services	2.6.1: Increase GP registration among rough sleepers and those in temporary accommodation: work with CCG to develop a process for registration (placeholder)		Local Integration Board (Homelessnes s Strategy group) SE inequalities board	December 2022	Process in place for registering	
	2.6.2: Increase dental registration among rough sleepers and those in temporary accommodation: work with CCG to develop a process for registration (placeholder – to be determined)	2.6.2	Homelessness Strategy group SE inequalities board	Year 1	Process in place for registering	
	2.6.3: Adoption of the Serious Case Review Protocol		Homelessness Strategy group	March 2022	Adoption of protocol	
	2.6.4: Develop a clear process from admission through to discharge from hospital settings, to ensure homeless patients are discharged with somewhere to go with support in place (placeholder)		Local Integration Board (Homelessnes s Strategy group) SE inequalities board			

2.7: Prevent, promote awareness and provide support to those who have experienced domestic abuse	2.7.1: Implement the action plan from the Local Domestic Abuse Strategy 2020-2023		West Berkshire Domestic Abuse Board (BCTP)	Refresh due in 2023	Action plan	Action plan fulfilled by 2023
	2.7.2: Domestic Abuse Safe Accommodation Strategy 2021 – 23		West Berkshire Domestic Abuse Board (BCTP)	To be combined with full DA Strategy as part of refresh in 2023	Needs identified being met through action plan	Action plan fulfilled by 2023
	2.7.3: Local needs assessment: need and demand for accommodation based support for all victims		West Berkshire Domestic Abuse Board (BCTP)	Every 3 years (next due 2023)	Less gaps in services identified	
	2.7.4: Review of performance data to identify areas for improvement, opportunities to increase service provision, develop training		West Berkshire Domestic Abuse Board (BCTP)	Quarterly	Discussions at DAB Increase in reporting of DA Further training opportunities offered for 2022/23	
	2.7.5: Lived Experience subgroup to inform decision making and system change		West Berkshire Domestic Abuse Board (BCTP)	Quarterly	Voices/view captured and reported into DAB	
	2.7.6: Number of multi-agency staff trained in Domestic Abuse Awareness		BCTP	Quarterly	Number of individuals trained	8 – 15 per session

2.8: Support people with learning disabilities, engaging with them and listening to them through working with voluntary organisations	2.8.1: Work with Voluntary Community Sector organisations to improve access to health checks for those with learning disabilities Improve the quality of health checks for those with Learning disabilities		Berkshire West CCG NHSE	Annual	% of individuals receiving a health check	67% (target for 2020/21) AHC LTP target is 75% (14+)
	2.8.1: Implement Positive Behaviour Support across Health and Social care		Berkshire West CCG	Oct 2021 – April 2022	4 levels of training to be delivered	?
	2.8.3: Enhanced delivery of a Work and Careers Fair – including participation by local schools and supporting the work on employment opportunities for people with learning disabilities		Skills and Enterprise partnership (working with MP Laura Farris)	14th & 15th October 2021 (Annual)	Delivery of event Attendance Feedback	40
2.9: Increase the visibility and signpost of existing services and improve access to services for people at higher risk of bad health outcomes	2.9.1: Promote alternatives to admission through increased support for people in the community: - Commission an all age IST - Green light toolkit - Post diagnostic support (Placeholder)		Berkshire West CCG			
	2.9.2: Reduce waiting times for Autism and ADHD Diagnosis: current demand being assessed to plan for workload capacity		Berkshire West CCG; Berkshire East CCG BHFT	TBC	TBC	TBC

	2.9.3: Ongoing development of the Health and wellbeing board engagement group communication toolkit		HWB engagement group	June 2022	Completion of the toolkit	
	2.9.4: Create a stakeholder map our current Community and Voluntary sector partners who are working with those at higher risk of bad health outcomes	1.5.1 3.2.4 4.3.1 5.2.1	Communities and wellbeing	December 2022	Completion of the network map	
	2.9.5: Promote awareness and access to the West Berkshire Directory, ensuring that the information within it is kept up to date		HWB Engagement group	Ongoing Quarterly monitoring of access	Hits to Website (?demographic indicators/targets)	
	2.9.6: Undertake a review of the West Berkshire Directory and identify recommendations		Communities and wellbeing	March 2023	Review completed New digital offer in place	
	2.9.7: Pilot aDoddle map – to include community groups. Feedback on map and use		Communities and wellbeing	September 2021 map goes live	Feedback of use of the map: community groups and individuals using it	

3: Help families and children in early years						
Objective	**Action**	**Aligns to**	**Owned by**	**Timescale**	**Indicator**	**Target**
3.1: Work to provide support for parents and carers, during pregnancy and the early years to improve personal and collective resilience using research and good practice	3.1.1: Map the current offer for support to parents and carers from all services		CDG (1001 days)	March 2022	Mapping of provision completed	
	3.1.2: Undertake evidence review of current antenatal classes		CDG (1001 Days)	March 2022	Evidence review completed	
	3.1.3: Promote antenatal classes for expectant parent and improve access		CDG (1001 days)	March 2022	No. of antenatal classes No. of attendees Demographics of those attending	
	3.1.4: Raise awareness of and improve access to parenting support (both 1-2-1 and group support)		CDG 1001 days	March 2022	No. of support classes available No. of attendees Feedback	
3.2: Ensure families and parents have access to right and timely information and support for early years health. Working with midwifery, Family hubs, healthy visiting and school nursing	3.2.1: Implementation of the new PHE Healthy Child Programme and Berkshire West 0-19 service (placeholder)		Communities and wellbeing (Berkshire West)	April 2022	Antenatal midwifery notifications to HV service	100%
	3.2.2: Implement 1001 Days project work: • Mapping of core delivery across services. • Produce an infographic for families and services demonstrating core offer • Map targeted offer across services		CDG (1001 days)	April 2022 – March 2023	Mapping completed Infographic completed Distribution of infographic via partners	
	3.2.3: Promote breastfeeding (placeholder)		CDG	June 2023	Increase Breastfeeding rates at 6 – 8 weeks	65 – 70%

	3.2.4: Create a stakeholder map of our current Community and Voluntary sector partners who are working with families and children in the early years	1.5.1 2.9.4 4.3.1 5.2.1	Communities and wellbeing (CDG)	December 2022	Completion of network map	
3.3: Increase the number of two year olds (who experience disadvantage) accessing nursery places	3.3.1: To establish a named Health visitor for each EY setting taking vulnerable 2 years olds		CDG		% of EY settings with named HV	
	3.3.2: Implement Joint health and educational reviews at 2 – 2.5 years and increase uptake		CDG	March 2023	No of Joint and educational reviews at 2 – 2.5 years (%) No. of joint educational reviews undertaken among 2 year olds experiencing disadvantage	
	3.3.3: Consistent marketing across all sectors, Midwifery, HV, EY, Family Hubs (placeholder)		CDG			
3.4: Ensure that our early years setting staff are trained in trauma informed practice and care, know where to find information or help and can signpost families properly	3.4.1: Undertake an evidence review of trauma informed training, including cost-analysis		CDG	June 2022 (tbc)	Evidence review completed	
	3.4.2: Establish training programme with Early Years providers (to link to introduce EY ELSA target)		CDG	December 2022 (tbc)	% of EY providers offering training % of staff trained	
	3.4.3: Develop support materials and supervision documentation for EY settings.		CDG	June 2022 (tbc)	Completion of support materials Number of EY providers using materials	

3.5: Publish clear guidelines on how families can access financial help, tackling stigma around this issue	3.5.1: Map out current provision for financial support for families, including childcare costs		CDG	June 2022 (tbc)	Mapping completed	
	3.5.2: Raise awareness of support services available through the Family hubs		CDG Communities and wellbeing	June 2022	Number of financial support services published on the West Berkshire directory	
	3.5.3: Undertake focused engagement to ensure that provision and needs are identified from parent groups and across areas in West Berkshire		CDG	June 2022	Number of focus groups Demographics of attendees Consultation report	3 To include under-represented groups

4: Promote good mental health and wellbeing for all children and young people						
Objective	**Action**	**Aligns to**	**Owned by**	**Timescale**	**Indicator**	**Target**
4.1 Enable our young people to thrive by helping them to build their resilience	4.1.1: Health and wellbeing in schools programme. 1.Health and Wellbeing in Schools Award 2.The Public Health and Wellbeing Health and Wellbeing in Schools programme. 3.Living Well workshops for parents (to improve family health literacy) 4.Living Well – Healthy Me Passports 5. School sleep champion training (placeholder)		WB Public Health	September 21- July 2022	1. No. of schools taking up offer. 2. Universal programme 3. Pilot with two schools 4. Every KS2 child in WB	1. 35 schools 2. Universal offer 3. Pre and post project health literacy questionnaires to parents 4. Every KS2 child
	4.1.2: Number of local primary schools who have received a Life Education Performance		CDG	April 2022	Number of schools	12
	4.1.3: Currently under discussion within CDG as a possible work stream. (placeholder)		WB Children's Delivery Group			
	4.1.4: Work with the Reading Agency to provide a collated collection of self-help books around mental health and wellbeing that people borrow from local libraries. (placeholder)	2.1.6 5.3.4				

	4.1.5: Develop and expand the Young Health Champions programme		Communities and wellbeing (Public Health)		Number of champions recruited Number of young people reached	21/22 – 50 22/23 – 100 (total)
4.2: Aim for early identification of those young people in greatest need, or at risk of developing a mental health condition	4.2.1: Creating a single access and decision-making arrangement across the delivery Partnership		Berkshire West ICP Children's programme Board	Work beginning Autumn 2021	Existing access and referral arrangements realigned into a single Berkshire west approach	Completed Sept 2022
	4.2.2: Building a formal Delivery Partnership arrangement a) A single access and decision-making point that all delivery aligns to b) A joint communication approach and set of tools that explains to CYP, parent and carers, schools, and primary care colleagues how to access support and the type of response and offer they can expect c) A joint workforce development programme.		Berkshire West ICP Children's Programme Board	Autumn conference with Oxfordshire Mind who will work with key parties to build and present a proposal	Berkshire West event in Spring 22	Aligned Commissioning model June 2022
	4.2.3: Meeting the COVID surge demand as it arises		CCG .	March 2022	Meeting three weekly to address need, beginning in August 2021.	
4.3: Use evidence to support interventions at the individual, family and community levels to prevent	4.3.1: Create a stakeholder map of our current Community and Voluntary sector partners who are working on mental health and wellbeing for children and young people	1.5.1 2.9.4 3.2.4 5.2.1	Communities and wellbeing (CDG)	December 2022	Completion of network map	

and reduce the risk of poor mental health	4.3.2: Be Well Campaign		Public Health (joint funding across East Berkshire and Berkshire West)	Oct 21 to July 24	Indicators being finalised but clicks on website and parts of Berkshire accessing it will be measured	
	4.3.3: Continuing temporary contract during Covid for Kooth (online support)		Berkshire West ICP Children's programme Board	Recurrent funding from August 2021	Standard Kooth indicators	No formal target but offered to give YP a choice of services
	4.3.4: Addressing gaps in access and service offer due to inequalities. (cohorts LGBTQ+, Ethnically diverse groups, Learning Disabilities)		Berkshire West ICP Children's programme Board	Outline Plan of interventions needed and funding required by March 2022	Plan for data and monitoring improvement April 2022	Plan for data and monitoring improveme nt April 2022
	4.3.5: Tackling the waiting times in both specialist/ Core CAMHS for access and interventions in key areas: anxiety, depression, Specialist CAMHS, Autism and ADHD.		Berkshire West ICP Children's programme Board	March 2022	Create a 2 year investment plan with BHFT for Core CAMHs to cover 2022 – 2024	Plan delivered March 2022
	4.3.6: Meeting the Eating Disorder waiting times for response to referrals.		Berkshire West ICP Children's programme Board	Joint partner triage set up Sept 2021	Local Berkshire Protocol	Protocol in place by end of 21/22.
	4.3.7: Mobilising a Community Home treatment offer 24/7 access		Berkshire West ICP Children's	Co-production design process	Go live with phased offer January 2022, full	24/7 access for crisis cases

	standard for Crisis cases required locally to meet our 24/7 response commitment in the NHS long term plan		programme Board	with families and partners on model begun July 2021	workforce mobilisation March 2022	
4.4: Support a Whole School Approach to Mental health, embedding wellbeing as a priority across the school environment	4.4.1 Mobilising 2 further Mental Health Support Teams in schools. - Newbury - Reading (South & East)		Berkshire West ICP Children's programme Board	September 2022	MHST teams established	
	4.4.2: Recruit Young Health Champions in Schools		CDG	Sept 21-July 2022	Number of schools engaged	Year 1 – 5 schools 10 YHC per school Year 2 – 5 schools 10 YHC per school
	4.43: Run Living Well Workshops for Year 7 students.		CDG	July 2022	Number of workshops Number of schools engaged Feedback from attendees	
4.5: Support the mental health and wellbeing of looked after children and care leavers	4.5.1: Co-production of an 'In-reach' bespoke service for Children in Care. (placeholder)		Berkshire West ICP Children's programme Board Berkshire West local authorities	Mobilisation meeting end August 2021	To be scoped	To be scoped
4.6: Expand our trauma informed approach among formal and informal service providers	4.6.1: Develop a trauma informed strategy for West Berkshire. - mapping exercise - options appraisal for TI training across BOB		1.West Berkshire Children's Delivery Group	December 2022	1.To be discussed at Sept CDG	

			2 ICS Children's Board		2 Mapping exercise and Options Appraisal completed.	
	4.6.2: Expand the provision of Therapeutic Thinking training for all school staff		WB Education service	Awaiting response due to annual leave	Number of schools engaged Number of staff trained Feedback Persistent absenteeism	
	4.6.3: Provide Therapeutic Thinking Training for Children's Services staff		WB Children's Service	Awaiting response due to annual leave	Number of staff trained Feedback from attendees	
4.7: Improve the process for transition to adult mental health services	(placeholder)					

5. Promote good mental health and wellbeing for all adults						
Objective	**Action**	**Aligns to**	**Owned by**	**Timescales**	**Indicator**	**Target**
5.1:Tackle the social factors that create risks to mental health and wellbeing, including social isolation and loneliness	5.1.1: Ensure residents have access to financial support and advice (e.g. benefit entitlement, debt advice, unemployment)		Mental Health Action Group	Ongoing	Number of clients supported by CAB Number of clients referred to CAB by social prescribers	
	5.1.2: Supporting new residents to West Berkshire with a sense of belonging and awareness of local services	2.9.4 2.9.5	Mental Health Action Group	Ongoing		
	5.1.3: Work with the Homelessness Strategy Group to understand gaps and/links to poor mental health and wellbeing (e.g. reason for eviction)		Homelessness Strategy Group	June 2022	Gaps identified in service provision % of homeless people reporting being support with their mental health (place holder)	
	5.1.4: Raise awareness of interventions that address rural isolation and loneliness		Mental Health Action Group	Dec 2022	No of referrals into activities that tackle isolation and loneliness Increased awareness of activities that support loneliness and social isolation	
	5.1.5: Create a tool which allows policymakers to examine the impact of their proposals and decision making on mental health	1.3.5	Public Health and Wellbeing	Dec 2022	Tool complete	
5.2: Work with local communities, voluntary sectors	5.2.1: Create a stakeholder map of our current Community and Voluntary sector partners who are	1.5.1 2.9.4 3.2.4	Communities and wellbeing	December 2022	Network map completed	

and diverse groups to rebuild mental resilience and tackle stigma	working on mental health and wellbeing for children and young people	4.3.1	(Mental Health Action group)			
	5.2.2: Utilise opportunities to engage with local communities to provide resources (e.g. community café, community larder)	1.5.3	Mental Health Action Group		Number of individuals engaging with community resources	
	5.2.3: Enable local communities (through our surviving to surviving fund) to develop support and services that improve mental health and wellbeing		Mental Health Action Group	March 2022	Number of beneficiaries Amount of funding awarded	
	5.2.4: Develop a new mental wellbeing campaign (Be Well) to connect people from all backgrounds with local support and reduce stigma	4.3.1	MH & LD Board	June 2022	Number of engagements/unique users with new website	
	5.2.5: Run regular service users engagement events to ensure the continuous improvements of local services e.g. Thinking Together	1.5.3	Mental Health Action Group	Mar 2023	Number of Thinking Together events held Number of service users attending events	
	5.2.6: Ensure services are responsive to the needs of vulnerable and marginalised groups in society, e.g. socioeconomically disadvantaged, ethnically diverse communities	1.2.1	Mental Health Action Group			
	5.2.6: Commission Public awareness training sessions on a range of mental health issues including: - self esteem - anger management		Communities and wellbeing (public health)		Number of sessions Number of attendees Feedback	

	- bereavement - coping with redundancy - coping with relationship breakdown - sleep - death and dying (placeholder)					
5.3: Recognise the importance of social connection, green spaces and different cultural contexts for mental wellbeing. Increase social prescribing by promoting access and signpost to activities that promote wellbeing	5.3.1 Set up a mobile outreach steering group and ensure activity is coordinated (Place holder)					
	5.3.2 Establish a Creative Health Alliance to improve the availability and promotion of arts and cultural activities		Cultural Heritage Delivery Board			
	5.3.3. Support the creation of activities and initiatives that enable people to connect with nature and greenspace to improve their wellbeing		Mental Health Action Group		Number of people taking part in health walks	
	5.3.4: Work with the Reading Agency to provide a collated collection of self help books around mental health and wellbeing that people borrow from local libraries. (placeholder)	2.1.6 4.1.4				
5.4: Improve access to, quality and efficiency of services available to all who need	5.4.1: Create a 10 year mental health strategy (placeholder) Completion of Adult Mental Health Needs Assessment		Mental Health Action Group	Dec 2022	Strategy approved by the Health and Wellbeing Board	

them, including improved digital offerings for those who can and prefer to use them						
	5.4.2: Provide welcome packs to target people moving home or new to West Berkshire (e.g. resource pack)		Mental Health Action Group	June 2022		
	5.4.3: Develop a range information and tools to support transition across the lifecourse (e.g. birth, school, college/uni, work moving house, marriage, divorce/separation/widow, bereavement)		Mental Health Action Group	Dec 2022	Number of resources produced	
5.5: Work with professionals in workplaces and other settings; using a preventative approach to break down the barriers between mental and physical health	5.5.1: Support small businesses to promote mental health and wellbeing practices in workplaces (e.g. Mental health first aid project, The Mental Health at Work Commitment)		Public Health and Wellbeing	June 2022	Number of Mental Health First Aiders trained Number of businesses adopting mental health policies (placeholder)	
	5.5.2: Increase uptake of annual health checks for people with serious mental illness and ensure appropriate behavioural support is available e.g. smoking cessation		MH & LD Board Mental Health Action Group	Mar 2023	% of people on GP SMI registers in receipt of all six elements of SMI health checks	
	5.5.3: Promote Public Health England's online Psychological First Aid training to frontline workers and volunteers		Mental Health Action Group		Number of West Berkshire residents completing the course (placeholder)	

	5.5.4 Supporting people to find or stay in work who are in contact with mental health services	1.4.6	Skills and Enterprise Partnership		Employment rates between working age adults in contact with mental health services and the general population.	
	5.5.5: Support West Berkshire council employees through promoting mindfulness • 1x 8 week course • Quarterly taster sessions (online) • Monthly drop in/reconnection sessions		Communities and Wellbeing		Number of staff attending sessions Feedback from sessions Impact on emotional wellbeing	
5.6: Improve access to support for mental health crises and develop alternative models which offer sustainable solutions	5.6.1: Evaluate the roll-out of Breathing space crisis café across Berkshire West		MH and LD Board	March 2022 (?)		
	5.6.2: Implement and deliver the priorities of the new Berkshire Suicide Strategy		MHAG Suicide Action Group			
	5.6.3 Raise awareness of the issue of suicide, its causes and sources of help to those affected by either feeling suicidal or bereaved as a result of suicide.		Suicide Action Group			

Interactive Roadmap for the Berkshire West Health and Wellbeing Strategy

A Happier and Healthier Berkshire

Reading West Berkshire Wokingham

Who is working together to produce the Berkshire West Health and Wellbeing Strategy:

- Reading Borough Council
- West Berkshire Council
- Wokingham Borough Council
- Berkshire West CCG
- Healthwatch Reading, Healthwatch West Berkshire and Healthwatch Wokingham
- Reading Voluntary Action
- Volunteer Centre West Berkshire
- Involve Wokingham
- Representatives from the Royal Berkshire Hospital Foundation Trust
- Berkshire Healthcare Foundation Trust

The decision – April 2019

Evaluation of current strategies – March 2020

What are the needs of the population? – April 2020

A long list of priorities – June 2020

Online Virtual Workshops – August & Sept 2020

Involving the public – Dec 2020 – Feb 2021

First draft of the strategy – April 2021

Public Consultation – June - July 2021

The final strategy – October 2021

- Summary of the what's missing
- Long list of potential priorities
- Step by step reduction in the list

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What’s missing?

Public Health Outcome data was reviewed to understand population need and to identify potential priorities that may have been missing from conversations with professionals. The following tables contain a summary of data we used to develop the long list of potential priorities.

Data was obtained from PHE Fingertips: https://fingertips.phe.org.uk/

Data indicators were included if they were either “red” in one local authority area or “amber” in all three local authority areas.

These ratings indicate if an area is similar to (amber) or significantly worse than (red) the average for England for that indicator.

Data identified	Date/Timeline	Reading	West Berkshire	Wokingham	Possible priority
A and E attendances in Under 5s (Crude rate per 1000)	2013/14-15/16	32	34.7	37.1	The Early Years
C24m - Newborn Hearing Screening - Coverage	2018/19	1321.6	873.6	865.4	The Early Years
Stillbirth rate	2015-17	0.8	1.1	0.8	The Early Years
School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1	2018/19	70.6	75.8	60.5	The Early Years
Proportion of children receving a 12-month review	2017/18	6.7	4.6	4.6	The Early Years
Population vaccination coverage - MMR for one dose (2 years old)	2018/19	32	34.7	37.1	Measles Elimination
School readiness: percentage of children with free school meal status achieving the expected level in the phonics screening check in Year 1	2018/19	71.1	57	60.1	Educational attainment for children on Free School Meals
GCSE achieved 5A*-C including English & Maths with free school meal status	2014/15	64.8	69.2	60.9	Educational attainment for children on Free School Meals
Children in need: Rate per 10,000 children aged <18	2017/18	102.5	113	105.1	Education and health outcomes for children in care
Looked after children aged<5 Rate per 10,000 population aged<5	2017/18	89.4	93.8	94.5	Education and health outcomes for children in care
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2018/19	855.8	441.8	497.2	Mental health and wellbeing of children and young people
Reception: Prevalence of overweight (including obesity)	2018/19	53.4	86.9	46.9	Tackling childhood obesity
Year 6: Prevalence of overweight (including obesity)	2018/19	27.1	30.1	22.6	Tackling childhood obesity
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	2018/19	780	527	360	Tackling childhood obesity
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2018	5.1	1.9	1.5	Not in Education, Employment or Training (NEET)
Adults with a learning disability who live in stable and appropriate accommodation	2018/19	40.2	49.9	41.1	Supporting vulnerable groups
First time entrants to the youth justice system	2018	15.9	8.9	9.7	Supporting vulnerable groups
Under 75 mortality rate from liver disease	2016-18	47.1	43.8	42.1	Long term conditions
Gap in the employment rate between those with a long-term health condition and the overall employment rate	2018/19	11	94.7	89.2	Long term conditions
E07b - Under 75 mortality rate from respiratory disease considered preventable	2016-2018	204.7	148.5	125.3	Long term conditions
C27 - Percentage reporting a long term Musculoskeletal (MSK) problem	2018/19	25812	11335	12580	Long term conditions
Mortality rate from causes considered preventable	2016-18	71.1	61.5	68	Long term conditions
Statutory homelessness: rate per 1,000 housholds	2017/18	56.5	41.4	50.7	Homelessness
Long term claimants of Jobseekers Allowance	2018	37.8	53.3	25.6	Worklessness
Percentage of people aged 16-64 in employment	2018/19	7.4	2.8	(no data)	Worklessness

Data identified	Date/Timeline	Reading	West Berkshire	Wokingham	Possible priority
Emergency hospital admissions for stroke	2013/14-17/18	3.5	3.8	3.4	Cardiovascular disease
Under 75 mortality rate from cardiovascular diseases	2016-18	7066.2	5745.8	5872.2	Cardiovascular disease
E04b - Under 75 mortality rate from cardiovascular diseases considered preventable	2016-2018	56.5	64.1	65.9	Cardiovascular disease
C24e - Abdominal Aortic Aneurysm Screening - Coverage	2018/19	73.9	78.4	79.6	Cardiovascular disease
Incidence of prostate cancer (SIR/per 100)	2012-16	76.8	81.2	81.9	Cancer
Under 75 mortality rate from cancer	2016-18	66.4	64.7	62.3	Cancer
E05b - Under 75 mortality rate from cancer considered preventable	2016-2018	17.8	4.2	6	Cancer
Percentage of adults walking for travel at least three days per week	2017/18	261.5	212.1	194.9	Physical activity
Percentage of physically inactive adults	2018/19	204.7	148.5	125.3	Physical activity
Social Isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs)	2018/19	72	80	83	Social isolation
Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs)	2018/19	23.9	13.9	9.1	Social isolation
B09a - Sickness absence - the percentage of employees who had at least one day off in the previous week	2016-2018	79.1	88.2	87.7	Staff health and wellbeing
Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	2018/19	272	88	102	Substance misuse and drug related deaths
c18 - Smoking Prevalence in adults (18+) - current smokers (APS)	2018	1137	449	494	Smoking cessation
Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2018/19	25.7	15.5	11	Adult mental health and wellbeing
C28c - Self-reported wellbeing - people with a low happiness score	2018/19	90	91.4	79.8	Adult mental health and wellbeing
E10 - Suicide rate	2016-2018	70.1	76.6	79.9	Suicide prevention
Percentage of adults (aged 18+) classified as overweight or obese	2018/19	3.7	0.2	1.4	Prevention
Under 18s conception rate/1000	2017	23.8	33.3	34.4	Sexual Health
Under 18s conceptions leading to abortion (%)	2018	30.6	14.7	18.3	Sexual Health
Chlamydia detection rate/100,000 agef 15-24 <1900 1900 to <2300≥2300	2018	2113	1367	1267	Sexual health
STI testing rate (exc chlamydia aged <25)/100,000	2018	71.1	57	60.1	Sexual health
D07 - HIV late diagnosis (%)	2016-2018	7.5	1.7	4.5	Sexual health

The original long list of potential priorities

A Healthier and Happier Berkshire
Reading West Berkshire Wokingham

- The Early Years (1001 days)
- Improving dental care
- Adverse childhood experiences
- Mental health and wellbeing of children and young people
- Educational attainment for children on free school meals
- Education and health outcomes for children in care
- Tackling childhood obesity
- Measles elimination
- Safeguarding
- Not in Education, Employment or Training (NEET)
- Empowerment and self care
- Supporting vulnerable groups
- Health inequalities
- Worklessness
- Homelessness
- TB
- Sexual health
- Substance misuse and drug related deaths
- Smoking cessation
- Social isolation
- Adult mental health and wellbeing
- Suicide prevention
- Community resilience and integration
- Falls prevention
- Cardiovascular disease
- Physical activity
- Long term conditions (significant health needs)
- Cancer
- Digital enablement
- Improving air quality/climate change
- Prevention
- Staff health and wellbeing

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Step by Step reduction in the list of potential priorities

The Early years (1001 days)
Improving Dental care.
Adverse childhood experiences.
Mental health and wellbeing of children and young people.
Education attainment of children on free school meals.
Education and health outcomes for children in care.
Tackling childhood obesity.
Measles elimination.
Safeguarding.
Not in Education, Employment or Training (NEET).
Empowerment and self-care.
Supporting vulnerable groups
Health inequalities.
Worklessness.
Homelessness.
Sexual Health.
Substance misuse and drug related deaths.
TB.
Smoking cessation.
Social isolation.
Adult mental health and wellbeing suicide prevention.
Community resilience and integration.
Falls prevention.
Cardiovascular disease.
Physical activity.
Long term conditions.
Cancer.
Digital enablement.
Improving air quality/climate change.
Prevention.
Staff health and wellbeing.

Q1

achieve and live healthier lives.
Supporting children to live healthier lives (the first 1001 days).
Support specific groups to become smoke free.
Reduce the harm and impact of alcohol and drug misuse.
Support every employer to become healthier workplaces.
Supporting our communities to look after their own sexual health.
Support communities to be physically active.
Supporting our older population by reducing falls.
Taking a holistic approach to cancer prevention and support for early diagnosis.
Improving quality of life for people with long term conditions.
Taking a whole system approach to reducing childhood obesity.
Protecting our communities from infectious disease.
Taking a trauma informed approach to both prevent Adverse Childhood experiences and reduce their impact.
Supporting communities to become resilient and reduce social isolation.
Promoting positive mental health and wellbeing among all children and young people.
Promoting positive mental health and wellbeing among all adults.

Q2

To stop unfair differences in health between different groups of people.
To help vulnerable people live healthy lives.
To help families and children in early years.
To help people who are addicted to substances (smoking, alcohol or drugs).
Being well and healthy at work.
Physically active communities.
Help households with significant health needs.
Extra support for anyone who has been affected by mental or physical trauma in childhood.
Build strong, resilient and socially connected communities.
Good mental health and wellbeing for all children and young people.
Good mental health and wellbeing for all adults.

Q1: Can this issue be addressed by health and/or social care partners; Does it affect more than one area across Berkshire West
Q2: Is this being delivered elsewhere? Would it help our recovery from Covid-19?

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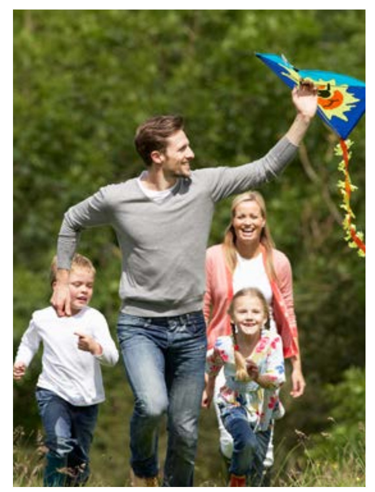
BERKSHIRE WEST HEALTH AND WELLBEING STRATEGY (HWBS)

2021- 2030



Public Engagement Report

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Executive Summary

In 2019, the Chairs of the Health and Wellbeing Boards for Reading, West Berkshire and Wokingham partnered to produce a Health and Wellbeing Strategy for Berkshire West. It was decided that public consultation and engagement would be a critical element to develop the final priorities for the strategy. The public engagement was co-produced and delivered through a Consultation & Engagement Task and Finish group. The engagement took place between 4th December 2020 and 28th February 2021 and was a key part of determining local priorities for the 2021-2030 period.

The public engagement consisted of focus group discussions and an online public survey. Through these, we asked members of the public about the importance of 11 potential priorities for helping themselves and their community live happier and healthier lives. These 11 potential priorities had been refined from a list of approximately 30, during an earlier stage of the Strategy development. Six main themes were identified from the responses to the free-text questions in online surveys, and discussions during focus group meetings. These themes were 1)Health inequalities, 2) Information and guidance, 3) Service integration and appropriateness, 4) Targeted support, 5) Social and physical environment, and 6) Covid-19. Public feedback was largely supportive of the proposed priorities and five top priorities were identified. In no particular order, the top five priorities were found to be: 1) Reduce the difference in health between different groups of people; 2) Support individuals at high risk of bad health outcomes; 3) Help children and families during the early years of life; 4) Promote good mental health and wellbeing for all children and young people; 5) Promote good mental health and wellbeing for all adults.

1. Background

In 2019, the Health and Wellbeing Boards (HWBs) for Reading, West Berkshire and Wokingham took the decision to develop a shared Health and Wellbeing Strategy along with the Berkshire West Integrated Care Partnership (ICP), in order to improve population and community health. From the very beginning, it was agreed that public consultation and engagement would be key to developing the final priorities for the strategy. Therefore, the aim of this public engagement was to actively listen to people's views and to work in partnership with the public to discuss and find consensus on the final priorities for the Berkshire West Health and Wellbeing Strategy. The strategy itself will guide the next ten years of work across the three local authority areas, to create a robust programme of community health and wellbeing priorities and to support the process of recovery from Covid-19.

The vision for Reading, West Berkshire and Wokingham over the next ten years, is to promote longer, healthier and enriching lives for all. The mission statements under this vision are as follows:

1. All our children and young people have the best possible start in life and the opportunity to thrive, no matter what their circumstance.
2. Children and adults most at risk from bad health outcomes are safe and safeguarded.
3. Everyone of working age has access to decent employment opportunities.
4. All people have the best opportunities for good mental health and wellbeing – to realise their potential and connect with the community.
5. Our communities are strong, resilient, thriving and inclusive, with all residents benefitting from a healthy, accessible environment.
6. All people will be able to gain access to integrated health and social care services.

2. Overview and Methodology

How we consulted

A Public Consultation & Engagement Task and Finish Group was established to co-produce and deliver a robust engagement process through a public survey and focus group discussions. The membership of the group spanned across the three local authority areas and included representatives from the public health teams for each council, Healthwatch Reading, Healthwatch West Berkshire, Healthwatch Wokingham, Reading Voluntary Action, West Berkshire Volunteer Centre, Involve Wokingham, Community United West Berkshire, ACRE, Berkshire West CCG and Berkshire Healthcare NHS Foundation Trust. By partnership working with these organisations, it was intended to ensure that diverse ethnic communities and those traditionally marginalised in these types of engagement were represented. The public engagement ran from 4th December 2020 to 28th February 2021.

The engagement was intended to be far-reaching and comprehensive, hearing from as many residents as we could. It included a public-facing web page (on the Berkshire West CCG website) with information on the Strategy and a link to the survey, a generic inbox inviting comments, an online public survey, engagement with Town and Parish Councils and focus groups with targeted communities. An Engagement Toolkit was produced to support the public engagement, including a background narrative to each priority (both a facilitator and a public-facing version) and a feedback template. This was to ensure consistent and robust discussions throughout. This toolkit was used at the focus groups and was also offered to other organisations, to use if they wish, to facilitate discussions amongst their members.

The survey was distributed through a number of different mechanisms. First, an extensive stakeholder list was mapped out by members of the Task and Finish group, each of whom were sent the survey link and asked to share with their contacts. Every Town and Parish Council across Reading, West Berkshire and Wokingham was contacted and invited to engage with the strategy development through the survey and also to share it with their residents. The survey was regularly promoted on social media, including sponsored posts on purposely created “A Happier and Healthier Berkshire” Facebook and Twitter pages. The three local authority communications teams also promoted the survey through their respective Facebook and Twitter pages and also through regular resident e-newsletters.

Focus groups formed another key part of the public engagement. These were planned by the Task and Finish group and facilitated by members including the three Healthwatch organisations. They were intended to ensure engagement with groups who were less likely to participate through different routes or those whose voice was often not heard in public engagement. This included specific focus groups for individuals with learning disabilities, unpaid carers (including young carers), older people, and diverse ethnic communities. In addition, there were three virtual public meetings held which were open to everyone to attend. A number of other organisations chose to hold focus groups with their members and were able to use the Toolkit to do so. In total, 18 focus groups were conducted (Table 1).

Table 1: List of focus groups, by organisations facilitating and number of attendees

Organisation facilitating	Focus	Number of attendees
West Berkshire Council – Young carers	Young carers	9
Strategy group	Older people	20
Strategy group (Reading)	Older people	29
Patient Voice	General public	17
Together UK	Parent, students, ethnic diverse communities, older people	5
Strategy group	General public (3 meetings)	15
Talkback	Learning disability	25
Healthwatch West Berkshire	Maternity/parents (2 groups)	30
Healthwatch West Berkshire	Older people	17
Strategy group	Adults from Ethnic diverse communities	18
Healthwatch Wokingham	Learning disability	15
Healthwatch Wokingham	Carers	9
Healthwatch Reading	Ethnically diverse communities	9
Healthwatch Reading	Young people	10
Patient voice	Patients	16

What we consulted on

During the public engagement, residents were asked to discuss and comment on 11 potential priorities for improving health and wellbeing in their communities. These 11 potential priorities had already been determined through a process of reviewing data on population need and through discussions with stakeholders and organisations. The potential priorities were as follows:

- Reduce the differences in health between different groups of people
- Support vulnerable people to live healthy lives
- Help families and young children in early years
- Reduce the harm caused by addiction to substances (smoking, alcohol or drugs)
- Good health and wellbeing at work
- Physically active communities
- Help households with significant health needs
- Extra support for anyone who has been affected by mental or physical trauma in childhood
- Build strong, resilient and socially connected communities
- Good mental health and wellbeing for all children and young people
- Good mental health and wellbeing for all adults

As part of the online survey, respondents were asked *'how important do you think each of the potential priorities are to helping you and your community to live happier and healthier lives?'*

At the end of each focus group, attendees were asked to rank the 11 priorities together in order of importance to the group.

Methodology for the qualitative data analysis

Qualitative data from the focus group and free-text within the survey were analysed using thematic analysis. This flexible and accessible method consists of the following six iterative phases:

Table 2: Description of the six phases of thematic analysis

Phases	Process
Familiarising oneself with the data	Reading and re-reading the data while noting initial ideas.
Generating initial codes	Systematically assigning codes (i.e. a word or a short phrase that capture the essence of a data segment) to interesting features across the entire dataset.
Searching for themes	Collating codes and their relevant data to form potential themes.
Reviewing themes	Checking that the themes work in relation to (i) the coded extracts and (ii) the whole dataset. Generate a "thematic map" of how the themes and codes relate to one another.
Defining and naming themes	Ongoing analysis to refine the themes and the overall story. Generate clear names and definitions for each theme.
Producing the report	Selecting vivid, compelling extract or quotes for examples; relating the analysis back to the research question and wider literature in writing up the report.

3. Results

3.1 The online survey

Demographics of respondents

A total of 3967 responses were received via the online public consultation survey. Demographic data of the respondents was also collected as part of the survey, and the following results were obtained. However as seen in the below table, many of our respondents (over 50%) chose to not answer the questions specifying their demographic details. Therefore, this may not be truly representative of the demographic profiles of those who answered the survey.

What is your gender?

Answer Choices	Responses	West Berkshire	Wokingham	Reading
Male	12.63%	49.60%	49.50%	50.10%
Female	32.22%	50.40%	50.50%	49.90%
Transgender	0.00%	Only sex data available (not gender)		
Non-binary	0.18%			
No Answer	54.98%			

How old are you?

Answer Choices	Responses	West Berkshire	Wokingham	Reading
Under 18	0.83%	28.80%	30.20%	34.30%
18-24	0.66%			
25-34	4.39%	10.50%	10.50%	16.20%
35-44	7.44%	12.60%	14.40%	14.90%
45-54	9.18%	15.40%	15.10%	12.60%
55-64	9.83%	13.30%	12.30%	9.70%
65-74	9.25%	10.80%	9.30%	6.60%
75 and over	3.58%	8.60%	8.40%	5.90%
No Answer	54.85%			

What is your ethnic group?

Answer Choices	Responses	West Berkshire	Wokingham	Reading
Asian or Asian British	1.92%	2.50%	7.40%	13.60%
Black or Black British	0.71%	0.90%	1.40%	6.70%
White or White British	40.21%	94.70%	88.20%	74.70%
Mixed or multiple ethnic group	0.91%	1.60%	2.10%	4.00%
Gypsy, Traveller or Irish Traveller	0.03%	0.10%	0.20%	0.10%
Other ethnic group – please specify	1.16%	0.20%	0.70%	1.00%
No Answer	55.08%			

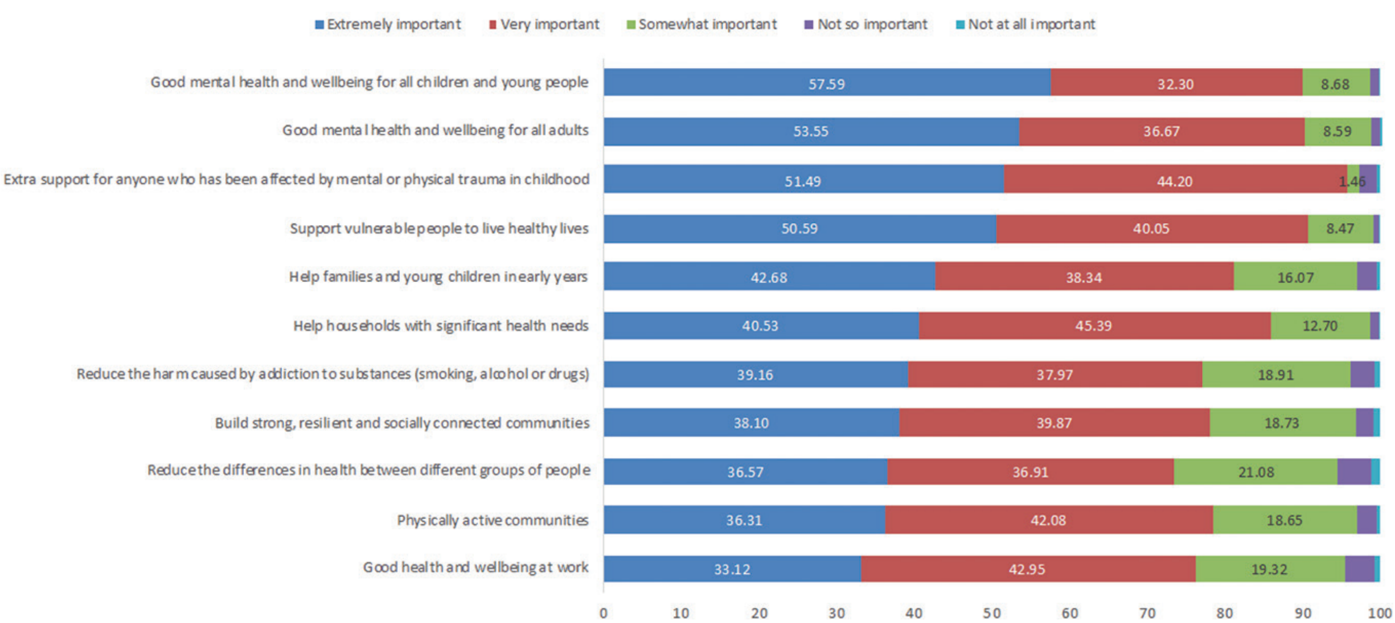
Of the 1786 people who specified, the majority of respondents were female (71.56%), followed by male (28.05%), and non-binary (0.39%). The most common age range specified was 55-64 (21.78%), closely followed by 65-74 (20.49%) and 45-54 (20.32%). A small minority of respondents were 24 or below (3.29%). Most of the respondents who specified (1782) identified as White or White British (89.51%), with Asian/Asian British the next most selected ethnic identity category (4.26%). Black/Black British (1.57%), mixed/multiple ethnic group (2.02%), gypsy/traveller (0.06%), and other ethnic groups (2.58%) were relatively under-represented.

Local Authority	Count of Which local authority area do you live in?
Wokingham	1566 (39.5%)
West Berkshire	1201 (30.3%)
Reading	1200 (30.3%)
Grand Total	**3967**

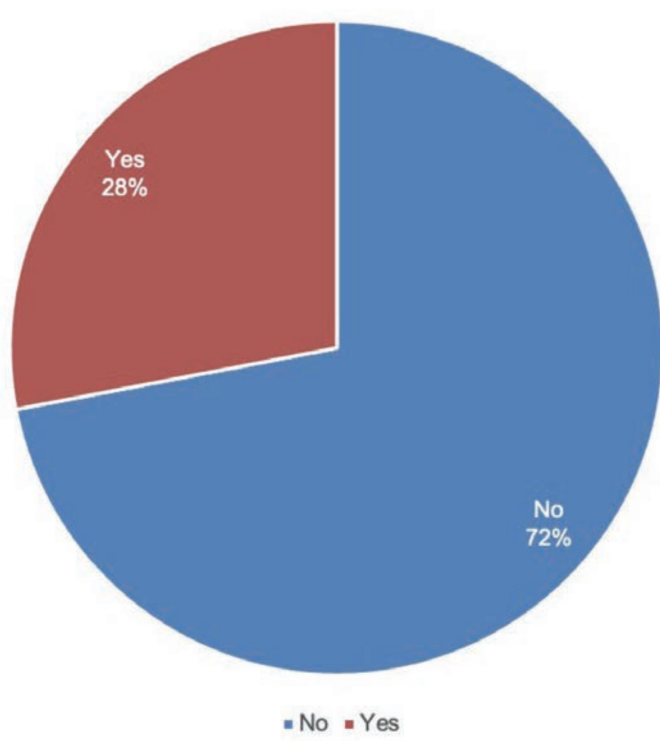
Regionally, most respondents were from Wokingham (39.5%), jointly followed by Reading (30.3%), and West Berkshire (30.3%). The majority of respondents provided feedback as individual respondents, with a small proportion responding on behalf of an organisation (158 responses).

Responses to individual questions

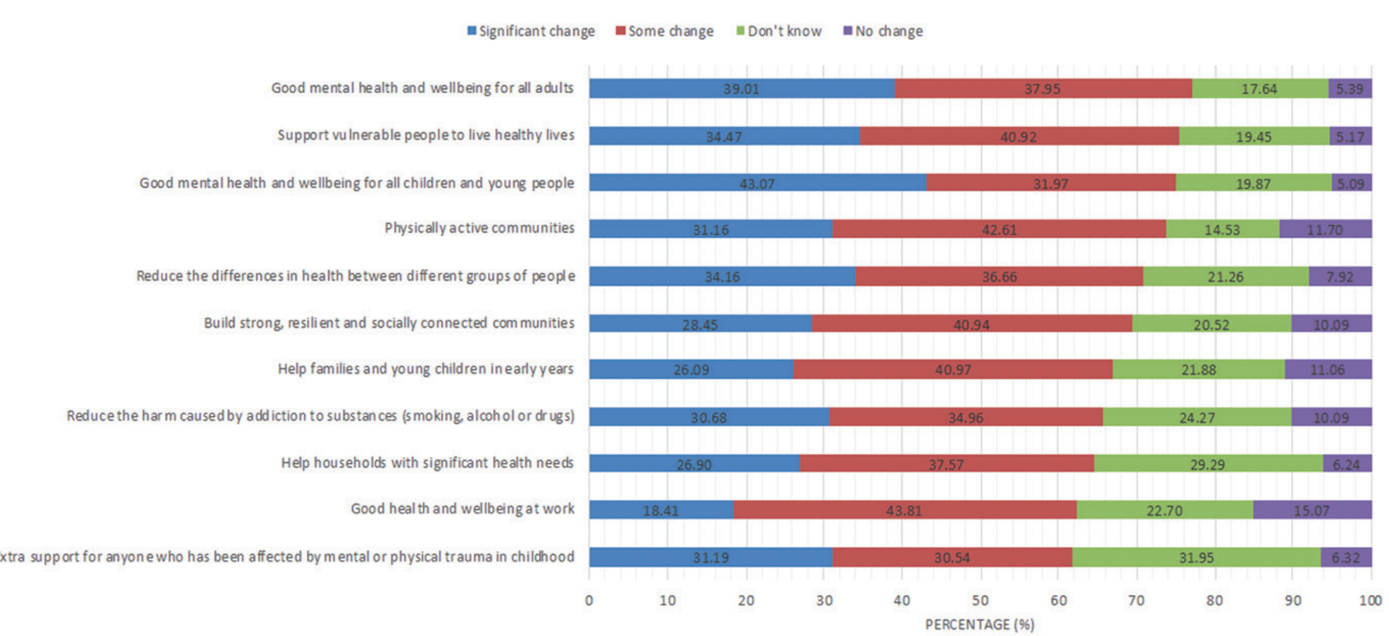
Q2. In order of importance, one being the most important, how would you rank the potential priorities?



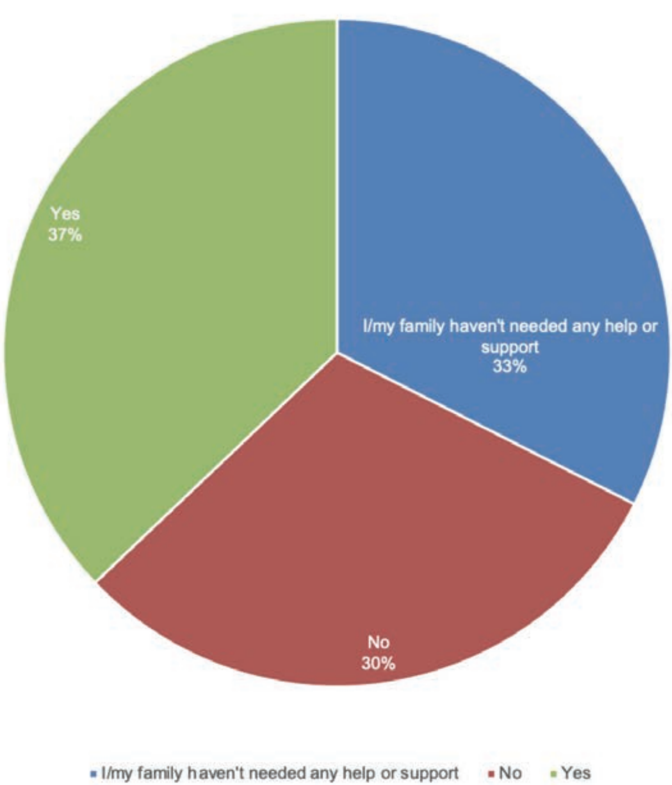
Q3. Are there any other priorities you think we should consider including in the draft Strategy that we haven't mentioned in previous questions?



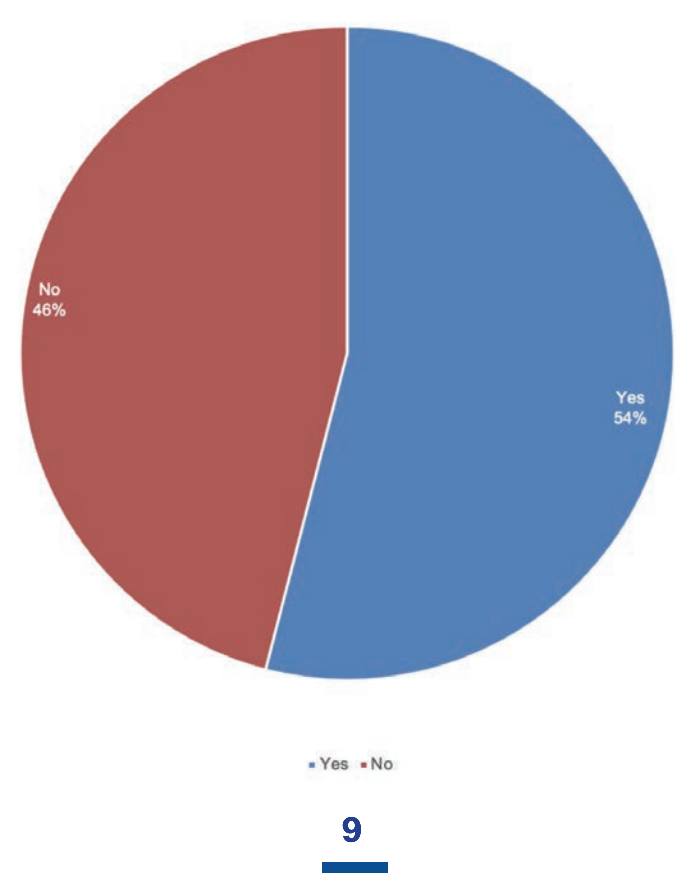
Q4. How much change do you think is required for each priority?



Q7. Are you, your family, or other people you care for able to get all the help or support you/they need for any health and wellbeing problems?



Q8. Has the help or support been sought during the COVID-19 pandemic?



Responses to the free-text questions

We also asked three open-ended questions to follow up on survey questions 3, 4, and 7:

Are there any other priorities you think we should consider including in the draft strategy that we haven't mentioned in previous questions? *Please tell us what priorities you like to see included and why.*

How much change do you think is required for each priority ("no change", "some change", "significant change", "don't know"). *Please tell us the reasons for your response, including details of any changes you think are needed.*

Are you, your family or other people you care for able to get all the help or support you/they need for any health and wellbeing problems? *If no, please tell us about the issues you/ your family have encountered.*

Free-text responses from the first two open-ended questions were analysed and explored in the "Developing the Final Priorities" section. In this section, we will focus on the third question which concerns access to health and social care support. We will first introduce a guiding framework based on a person-centred approach before presenting our findings by themes.

Guiding framework to achieve person-centred health and social services

To achieve a person-centred approach to health and social care access in Berkshire West, we sought to understand the issues people face with getting help and support needed for health and wellbeing problems (Figure 1).

"Are you, your family or other people you care for able to get all the help or support needed for any health and wellbeing problems?

Figure 1: Survey question about issues in accessing help and support for health and wellbeing problems.

Using the framework in Figure 2, we define person-centred access to health and social care as the opportunity to have needs for health and social services or support fulfilled. This involves a series of identifying needs, seeking help, reaching and using the services, shown in the arrow.

From the Service Provider's Perspective (Top Panel)
Accessible health and social care has to be: approachable, acceptable, available, affordable and appropriate
From the Service User's Perspective (Bottom Panel)
Accessible health and social care systems have to empower services users to increase their: ability to perceive health needs, ability to seek help, ability to reach for help, ability to pay and the ability to engage meaningfully with services

The red boxes represent the six themes from our analysis of the responses to this survey question, and where they sit within this framework. These are:

i. Health Inequalities
ii. Information and Guidance
iii. Targeted Support
iv. Service Integration
v. Social and Physical Environment
vi. Covid-19

The boxes above and below the arrow represent some of the specific issues raised by respondents in more detail.

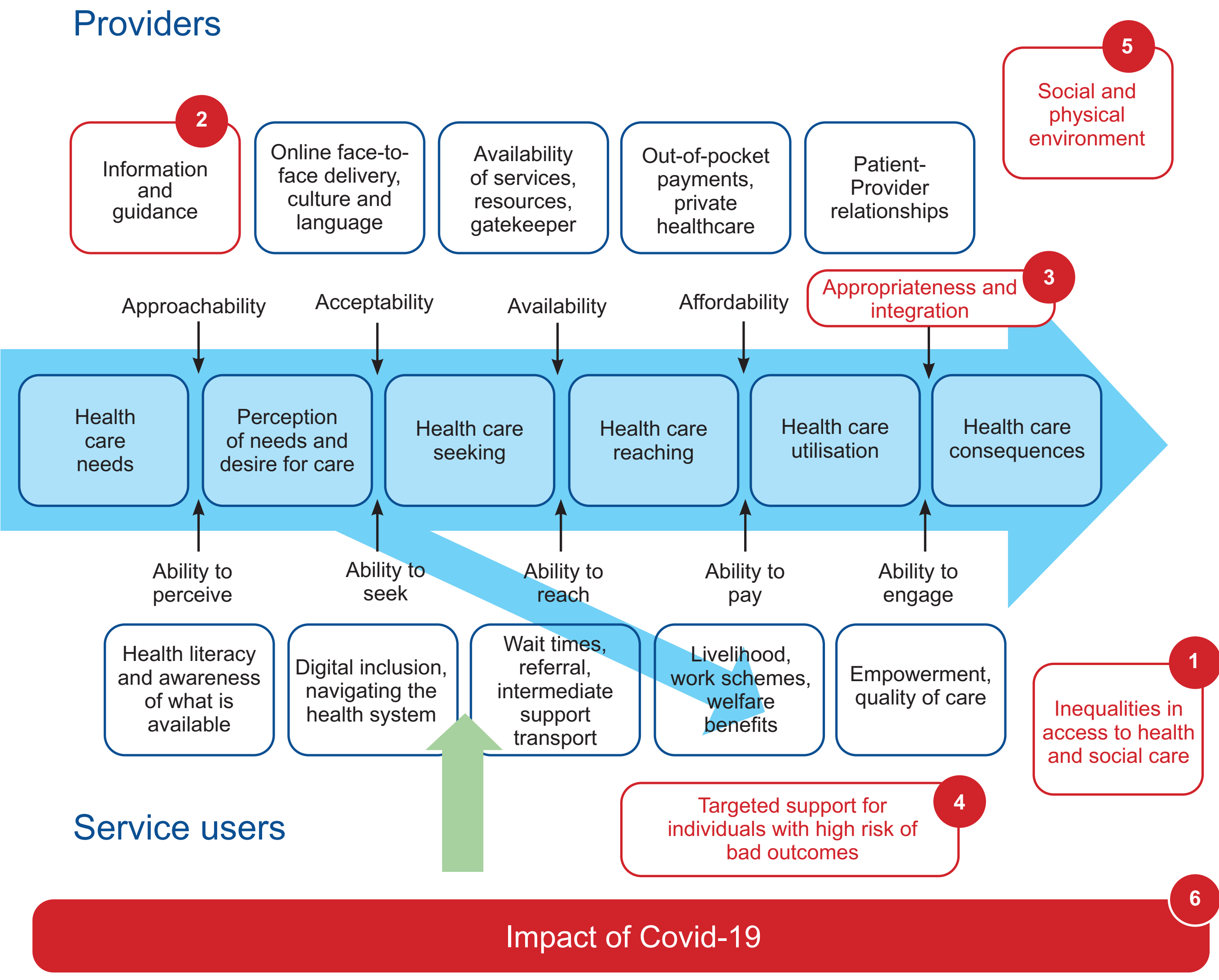


Figure 2: Conceptualisation of the challenges to person-centred access to health and social care services in Berkshire West, as adapted by Chuah et al., 2018 from Levesque et al.'s framework. The red boxes indicate six themes from our public engagement survey and focus group findings.

Theme 1: Health Inequalities

There are apparent inequalities in healthcare access along the lines of (a) public versus private healthcare, (b) physical versus mental health services, and specifically (c) Child and Adolescent Mental Health Services (CAMHS).

(a) Public versus private healthcare

The main challenge begins with accessing primary health care (GPs) due to long waits for telephone and face-to-face appointments. Respondents also indicated the difficulty and the need to see a doctor in person because not everything can be diagnosed over the phone. When they do get hold of their GP, some feel unable to talk to their GPs to properly explain their health condition because of how busy the practice is. To get help, several respondents mentioned the need to be “persistent”, “assertive” and to “chase after help”, which has caused undue worry and stress.

“Access to primary care has been challenging with very long waits for a telephone appointment and lack of response to emails despite this being the way the practice requests patients contact them.”

“Don’t feel I can talk to GP as they are so busy. Don’t know who else to turn to.”

Since GPs are often the first point-of-contact between service users and the healthcare system, not getting timely access to primary care will have cascading effects on delaying secondary and tertiary referrals as well. As a result, some resort to sorting out issues themselves or opt for private healthcare if they can afford it. However, not everyone is able to afford private healthcare.

“We basically get on with life and address the issues ourselves.”

“Only by paying privately for treatment. This feels like “queue jumping” to us.”

(b) Mental health versus physical health

There were some grievances over the lack of recognition of mental health issues to be treated equally as physical health issues. This is partly manifested in a very under-resourced mental health service provision.

“When somebody is drowning / bleeding to death it is easy to see there is a problem. But with mental health you might not feel [or] acknowledge the problem and without the social interaction, there is no one to say: ‘you look like you are drowning, do you need a life jacket?’”

“Mental wellbeing problems are not perceived as serious enough for there to be support, or for there to be understanding in the community. Community members perceive their own exaggerated risks to physical health to be of greater importance than “invisible” mental health risks and issues.”

Respondents noted the difficulty in obtaining therapy and counselling, which could escalate to a crisis point before being seen. Furthermore, some expressed that the current, limited provision of counselling sessions are not enough.

"Mental health counselling is limited on the NHS. I don't understand why.... If you had a heart defect, you have treatment until it was fixed, why is this not the same for mental health?"

(c) Child and Adolescent Mental Health Services (CAMHS)

This was particularly so for Child and Adolescent Mental Health services (CAMHS), where being under-resourced had led to waiting times for as long as 18 months to get assessments.

"My role as Social Prescriber means I can research and connect with many available resources e.g. carers hub for my mum (although she declines). I was disappointed there wasn't an apt equivalent for children to help manage my son's anxiety as CAMHS said it was only for significant difficulties and I have patients waiting over 18 months for support even when in severe distress. Funding really needs to go to this area - healthy children have a better chance of better mental health as adults but currently I don't feel there is enough support there. As a GP practice we are planning to develop support for teens to help address this gap for our patients."

In the meantime, parents and carers expressed their frustration that their children were not reaching their full potential. Still others were concerned about the high threshold to be eligible for support.

"CAMHS told my daughter she wasn't bad enough to get help, even when she was self- harming."

For those who were able to access CAMHS after the long wait, some respondents expressed that help was inadequate, ineffective or inappropriate, such as reliance on medication. This is partly dependent on which therapies are being commissioned.

"My grandson needed help with his mental well-being due to bullying at school but was only offered telephone counselling which was of no use to him..."

Theme 2: Information and Guidance

Several respondents noted what they found helpful in signposting, provision of information and guidance, including postal community bulletins, contacting specific charities for advice and having a Mental Health Nurse or Health Visitor as a point-of-contact.

With reference to Figure 2, improvements could be made on the approachability of health and social care services. Some respondents shared that admitting that they need help and seeking help may not come naturally to them. There is also the issue of stigma surrounding mental health challenges, which seems to be more acutely present among men.

“Huge stigma surround health and well-being issues which make them hard to talk to”

“Honestly, like a lot of guys, I didn’t really talk about my depression or seek help”

At times, a lack of sympathy among service providers have also discouraged users to seek help again.

“Too much stigma around the subject and a less than sympathetic doctor on previous visits had left him unable to lay himself on the line again, he would rather suffer in silence”

“Attempts to get help would be seen as interference and could provoke a very hostile reaction”

Respondents have also brought up the need for clearer information on what is on offer and how to navigate the health and social care system to get the support they need, as some have missed out on support options that they could have benefitted from.

“...maybe here there are lots of support groups around, but you need to spend a fair amount of time to dig the info out”

“I can get help and support because I know how to navigate and challenge the systems in place. Most people do not”

“We have a disabled son and I have become aware that other children at the same school have been offered many support options that we were not even aware existed until recently”

Theme 3: Service Integration and Appropriateness

A person-centred care takes a holistic approach to care that sees the whole person instead of a narrow focus on specific illnesses or symptoms. It includes the need for care to be based on the person's unique needs and understood in the context of their social worlds. It means providing coherent care, treating the person with dignity, compassion and respect while encouraging greater autonomy in their own care.

(a) Integrated Services

Operationally, this involves moving towards more integrated services that consider an individual's diverse health and social care needs in a seamless way. This means ensuring coordinated care and continuity of care across providers or between primary, secondary and tertiary and community-based services, or between CAMHS to adult mental health services. Based on survey responses, the services between mental health and other sectors remain siloed, care is generally fragmented, and needs are sometimes treated episodically.

"GPs only see you for one problem at a time which is a problem for people with multiple health conditions. Also it's hard to get appointments and never see the same doctor which is a problem as they don't know your medical history and don't have the time to fill them in. I had a doctor tell me to take something that would have been harmful because of my arrhythmia if I had taken it."

Experiencing fragmented care has the potential to cause challenges, especially for people with complex needs and comorbidities.

"My mother has a range of unmet needs and is very depressed. She needs input from a range of people, e.g. a counsellor experienced with dementia, physio, chiropodist and simply someone else to talk to. Social services are aware and have arranged care, but this is not enough to provide for the range of needs and anyone seen as a "carer" is rejected by her, as she associates it with loss of independence."

Respondents also noted the need for follow-up after surgery and a longer-term approach to support people with mental health issues.

"I personally suffer with mental health issues and have been referred to Newbury hospital previously only to be told there was no long-term support for me. So, I would have to pay to see a counsellor on a regular basis myself. Mental health conditions are normally not short term, so we need a much better long-term approach to support people that doesn't cost them. No one chooses to have issues."

(b) Appropriate care

A second operational definition may include service users feeling listened to and enabled to make informed decisions to choose the type of care that is appropriate for themselves. While there are many excellent and compassionate GPs, health and social care providers, a sample

of the respondents noted experiences where some GPs "do not listen to the patient", "lacked understanding", "showed disinterest", scepticism or hostility. This had dissuaded some patients from asking for further help. Other respondents understood that this could be due to very busy GP services, which is not their fault.

Several respondents mentioned that they were not provided with sufficient information about their health condition.

"I have not been given any information about the condition [hypothyroidism] by the GP. I found everything out myself through the Thyroid UK website. The GP didn't even tell me about that."

"...she was diagnosed with pneumonia, but communication was lacking so my father-in-law had no idea what was wrong. No care package in place..."

Respondents also raised the issue of appropriate treatment plans being dependent on the local offer, which may not be aligned with the patients' preferences or needs.

"I have tried to get help but all the doctors want to do is increase my medication and I don't want to be a walking zombie, so although the help is there it is not the help I need."

"[GP services] are constrained to whatever the local offer is that might not be the right treatment plan for some people... e.g. always referring for CBT when this has already been done."

"not everyone responds well to [talking therapies]. The service should be dependent on the patient, and not the other way around."

Theme 4: Targeted Support

The respondents also highlighted several groups who are at risk of falling between the cracks when it comes to getting the health and social care they need. These include childcare support for parents with young children, people with autism spectrum disorder and other learning disabilities, and caregiving support for elderly parents and people living with dementia.

"There is very little support for new parents….The help I need for the kids I have to really fight for and there is little to no free help."

"Dementia support for my in-laws is based at West Berkshire hospital, but they have no transport. Fortunately, we were able to do a Dementia course online during Covid."

It is important to note that carers themselves, who may be paid or unpaid, are also expressing their need for more support through increased social contact and appropriate advice.

“I as a carer would like a phone call or some form of contact every week. I would like people who work for dementia organisation to all live with someone with dementia for two weeks at least before they give advice to carers.”

There were several mentions of insufficient attention and support being given to people with type 2 diabetes. Finally, respondents have also flagged the need to provide targeted support for adults in vulnerable circumstances, such as people experiencing long term unemployment or have work restrictions due to chronic illness and disability.

“Still waiting since June for government and pension to grant my wife disability payment as unable to walk. Meanwhile, am having to support her as she only has child tax credits to live on”

There were also concerns about eligibility criteria for support.

“...there seems to be too many criteria for qualifying for support. Also, assessments for qualifying appear to try to exclude rather than include.”

Theme 5: Social and Physical Environment

(a) Social Environment

There is a recognition that we need a vibrant creative community to be part of for mental health wellness. We also need to continue addressing stigma surrounding health and wellbeing issues which makes people afraid to talk about them.

In terms of social support, respondents have shown appreciation to friends, family and neighbourhood whom they can rely on. Nonetheless, not everyone is being supported equally.

“I have been prescribed antidepressants over the phone but sometimes feel that if anything happened to me, no one would know as no one checks in... my kids only have me to rely on and I’m struggling to rely on myself.”

(b) Physical Environment

Several respondents drew a link between leisure facilities (e.g. swimming, youth clubs) and mental wellbeing. Other feedback concerned the built environment, such as the lack of accessible facility for those with mobility issues or with young children, as well as the request for safer, wider paths and slower traffic.

“... we literally can’t open the car doors enough to get the infant carriers out in normal spaces”

Theme 6: Covid-19

In many cases, respondents noted the cross-cutting impact of Covid-19 in exacerbating existing issues related to access to health and social care services. While there have been understandable delays, respondents have provided some insights into their experiences and perspectives on the displaced NHS services to prioritise patients with Covid-19, the transition to digital versions of care, the loss of existing social support structures, and the impact of closure in schools and leisure facilities.

(a) Usual services being put on hold

Due to the pressure of Covid-19 on the health and social care system, many usual services had to be put on hold or delayed to prioritise the management of the pandemic. These included outpatient services, preventive measures (e.g. routine screening), treatment for chronic conditions (e.g. cancer, dementia), and rehabilitation (e.g. physiotherapy). There were recognitions that the wider health system was already under-resourced, even before the pandemic. Although respondents raised concerns about not being able to see a doctor when needed, others have also expressed sympathy to NHS staff due to the pressure to cope with the increased demand in services.

“It’s all about either having the virus or not. The rest of health seems to be ignored.”

“...cancellation of ongoing investigations due to covid, my husband had a delay of cancer follow-up due to covid... cancellation of the bowel screening programme, further delay of ASD assessment (now been waiting 3 1/2 years).”

“Suspect that access to tests and diagnosis isn’t as timely as it should be, possibly partly because of the current pandemic but also because of restricted funding for health over a number of years.”

As a result of prioritising Covid-19-related services, some respondents have delayed help-seeking to shield themselves or to avoid adding extra strain on the NHS. Others responded with resignation.

“Didn’t want to add more to an already overloaded NHS”

“I would have seen the Doctor, face to face to discuss my condition - arthritis - but I know it is probably going to be a ‘live with it’ situation.”

Those who have managed to access help for issues not related to Covid-19 have only been able to seek help for major health issues, sometimes only at the point of crisis, but not for minor ailments. Some anticipated that this delay in addressing minor or early-stage health issues may lead to more serious complications later on. Some respondents also stated that they were unable to access particular operations or medications during the pandemic.

“Major issues have been addressed, but minor ones such as dental check-ups and appointment to see podiatrist have been postponed indefinitely.”

“My uncle has had a scan for acoustic neuroma growth cancelled twice now due to Covid 19 and whilst not cancerous it can affect his hearing and facial palsy if it has grown. The quicker removed the better.”

“One essential operation refused by NHS, so I had to use all my savings to go private. Further surgery needed on separate matter, delayed due to Covid.”

(b) Digitisation of health and wellbeing services does not cater for all

During the pandemic, GP services continued for patients, although an initial telephone triage system was introduced for most GP practices. Some respondents have stated their preference for face-to-face GP consultation, and for it to be restored as soon as possible. This is because those responding felt it was not as easy to discuss and provide a full picture of their health conditions over the phone and some were not comfortable with telephone communications.

“This [telephone GP service] is not the same as a 10-minute consultation with a GP and I hope this is not the way of the future.”

“I don’t do phones. At all….Getting things to a point where I can get an appointment or online help is massively stressful - y’know...”

“I’m not managing the internet ‘help’.”

(c) Targeted support during Covid-19 for the elderly or people who are clinically extremely vulnerable (CEV)

Respondents have shared their concerns about the isolation of the elderly due to shielding and elderly voluntary care services being stopped. Some had noted an impact on loneliness and mental health, especially for those living alone.

“...many have been shielding to protect themselves and their mental health has suffered greatly”

A respondent who is clinically extremely vulnerable (CEV) and also a single parent shared their concerns with employment and the risk of school-going children passing on the virus to them.

"Employment concerns due to being a single parent with CEV and having to change to a zero hours when furlough was due to end at the end of October. Central government has provided no extra support/advice to those who are CEV with school age pupils. This is of particular concern to us if our children pass the virus on. Schools are to be applauded for the work they are doing in very difficult circumstances. However, the year group bubbles do not protect those year group pupils from each other. This is a real worry for any parent/carer with CEV..."

(d) Changes in the social and physical environment during the pandemic

Some respondents felt that the social distancing measures and periodic lockdowns have eroded their support network and brought distress. For those who live and care for their family members, some have expressed a growing need for respite.

"Lack of easy access to support. Lockdown is making it harder to use existing coping mechanisms"

"All three children are distressed by the repeated lockdowns and school closures"

Respondents also voiced that reduced access to leisure and exercise facilities have affected their mental or physical health, including the management of chronic conditions such as type 2 diabetes.

"The Berkshire MS Therapy Centre is closed all of the time due to the Covid lockdowns etc. I know they do classes online, but I am not getting enough exercise and my physical health is suffering"

3.2 Focus group findings

In addition to the online survey findings, below are selected quotes from focus groups for them themes identified.

Theme 1: Health Inequalities

(a) Waiting time

Waiting time for primary health care services, mental health services and maternity check-ups was considered too long and often caused diseases or concerns to exacerbate further.

"Seeing the GP is an issue unless it is an emergency and that was before Covid"

"I still haven't had the 6-weeks check and the baby was born in August"

"Mental health support for teens is very poor, with huge waiting lists for CAMHS"

"Despite multiple overdoses and suicide attempts, my daughter faced a 2-year waiting list to access adult mental health services when she became too old to access CAMHS"

(b) Eligibility

Some respondents expressed difficulties in accessing NHS services that were deemed essential to their conditions

"My flu jab I ended up having to get it privately…. and I had to explain how anxious I was, and I was getting upset about being told I was ineligible"

"Thresholds for support are too high for children who are impacted by trauma to be supported effectively"

(c) Differences in service provision and delivery depending on areas and population

Some participants noted that they see differences in service provision and delivery depending on people's income levels, place of residence or schools they go to and how skilful they are in certain areas (e.g. digital literacy).

"Society seems to operate in tiers and that's wrong"

"Accessibility needs to be improved to increase awareness of services amongst different groups and encourage contact"

“I think teachers do a good job in school; I know from experience that I have always been able to send an email saying I’m not feeling too good today, though I know from different schools that they do not have the same relationships”

“The food parcels for those advised to shield during the first lockdown were really unhealthy – white bread, tinned tomatoes and very little fresh food. Although advised to shield, I could afford to get other food, so I gave away those boxes, but charities need healthy food to give to those in need”

“Making sure services have non-digital offerings to meet the needs of those without equipment or digital literacy”

Theme 2: Information and Guidance

(a) Clear information that is easy to understand and follow

Many participants pointed out that there needs to be better information that guide people to the right services and to help people take care of their own health.

“Lack of knowledge within community groups and services about what support is available for different groups within the community”

“Could local councils be used to distribute health and wellbeing information more effectively?”

“Look after yourself where you can but also need to have awareness and knowledge of how to get help when needed. All of those things together help me collectively to stay healthy or become healthy”

“You can go to the gym but then there is no one to help you to check if you are doing it right”

Clear, understandable signposting and guidance is especially important in times of health emergencies.

“Interpretation on helplines is really important”

“There needs to be a redefinition of ‘crisis’, that’s coming from the person that needs help”

“I think the government should make it clear on what message they are putting out to the public. In terms of Covid-19, like exams and other things, because some people don’t understand if they should be staying at home or going to work, if there are exams or not”

One person also noted that language barriers should be considered when delivering information across the borough.

“Language seems to be a major information barrier; how can you get information across if you have not got the language to communicate with”

(b) Training for healthcare and social care professionals

Participants highlighted the need to train healthcare and social care professionals about how to approach patients and service users with disability or additional needs and the importance of their constant efforts to increase awareness in the field.

“I was once told by someone who works in the homeless sector that I don’t look autistic”

“Why isn’t the disabled blue badge recognised as the disabled parking card?”

“Education/support needed so that cycles of trauma are not continued through generations”

On the topic of addiction, participants also touched on the issue of stigma and gave insight into when people might be prone to adopt or engage in addictive behaviours.

“resource would be better spent on reducing the stigma around addiction and making it easier to ask for help, which would mean people could access support more easily, therefore reducing the harm caused”

“The gap / transition between formal education and first job is such a dangerous time for addictive behaviours”

For mental health, participants shared that de-stigmatisation, awareness-raising and training efforts need to continue. It was also noted that it is important that mental health support does not tail off after people leave school. Alternative support that is effective needs to be in place.

“Mental health --there’s still a big stigma and increasing awareness will help”

“Not everyone gets on with Zoom etc. Phone networks and WhatsApp groups have been another useful way to offer alternative support.”

“In terms of secondary school, it (mental health support) starts to drift off, little bit less talked about. You have school nurses, they were less frequent which people didn’t really use. Especially now, college years it’s a lot less support…you have to find support yourself”

“We’re seeing more frontline staff take part in Mental Health First Aid training, but we need senior managers taking part too”

(c) Transparency in governance and resource allocation

Focus groups which contained healthcare professionals as participants, raised concerns on how the allocation of funding will be done for next few years to achieve priorities listed out in the strategy. They also wanted a clearer guidance on who will be part of which team, and how "working together" will be achieved.

"Need to be clear who we see as partners in a Health and Wellbeing Strategy. This should be obviously more than a workplan for a Public Health Team or any other individual team"

"We don't know which levers are free. Health spending is large but much of it is already committed. What could be moved or changed? Are local authority budgets slightly freer?"

Theme 3: Service Integration and Appropriateness

Some respondents recognised the importance of approaching health in a holistic manner. Improving health requires looking at the whole person, beyond symptoms of one disease to broader health-promoting or health-harming factors influenced by social factors.

"For instance, if you are going to have a programme of changing behaviour, you will probably want to look not just at physical activity but also things like diet, sleep, social connections, substance abuse and so on. So, you need to work through some of these possible strategies, look at what bits join up and what don't, where the costs are and then you can start to prioritise"

By having a more well-rounded approach to health, it follows that silo working has to be broken to be effective in meeting complex health and social care needs. Particular attention should be paid to the service 'boundary areas' to ensure a smooth transition and continuity of care between services. This effort towards service integration could include sharing necessary information between providers (with the service users' informed consent) to avoid having to repeatedly explain health conditions and to reduce the risk of re-traumatisation.

"Joined up working between services and agencies and for people to be looked at as a whole, rather than their symptoms looked at and treated separately."

"Services are disjointed, and there are too many gaps, especially as people move from children's services to adults"

"Often people have to go through multiple layers of re-explaining their trauma before receiving support"

Respondents also appreciated the ongoing effort to promote more joined-up services and the benefits to be reaped, including sharing ideas, funding, and exploiting economies of scale. However, some respondents from the voluntary and community sector (VCS) noted the trade-offs between participating in partnership forums and frontline service delivery.

“It is important to have a strategy and it is good that the organisations are coming together”

“From a VCS perspective, staying in touch with the various forums is a challenge. We want to collaborate, but partnership participation sometimes comes at the price of frontline delivery...”

Theme 4: Targeted support

Respondents have highlighted several groups of people who could benefit from tailored support, including ethnically diverse communities (EDC) and people who experienced trauma in childhood.

(a) Culturally sensitive care

A culturally sensitive, person-centred health and social care is one that emphasises providers' behaviour and attitudes, health care policies and a physical environment that ethnically diverse patients identify as being respectful to their culture. Culturally sensitive care enables them to feel comfortable with, trusting of and respected by their service providers and staff. In practice, this could involve recognising and addressing language barriers by providing suitable interpreters; or providing women-only space for leisure activities.

“Ethnically Diverse Community (EDC) needs to be a priority of its own (missed priority) as it has highlighted there is a lot to address”

“Professionals also need to be aware that language can also play a part in understanding someone who is not fluent. Sometimes they talk too fast and it's hard to understand”

“access for women only fitness /swimming sessions for some cultural groups is an issue”

(b) Trauma-informed care (TIC)

Several respondents also raised the need for recognising and supporting those who have experienced trauma in childhood. This is in line with the broader effort in Berkshire West to embed trauma-informed care (TIC) in health, social care services as well as in schools. In essence, trauma-informed care recognises the prevalence and widespread impact of trauma; people who have experienced repeated, chronic or multiple trauma, even in childhood, are more likely to show symptoms of mental illness, health problems or risky health behaviours such as substance abuse. TIC means recognising the signs and symptoms of trauma and to respond accordingly in practices and policy to actively resist re-traumatisation.

“Extra support for anyone who has been affected by mental or physical trauma in childhood”

(c) Specific roles, identities and health conditions

The focus group discussions also reiterated the need to target support to specific groups of people, as mentioned by the survey respondents. This includes families with young children, carers, the elderly and people with autism or sensory sensitivities.

"As an adult carer it is difficult to easily get to medical appointments, to get out to exercise and this all has an effect on my health and wellbeing in a way that doesn't affect many other people who don't have those difficulties"

"Because my arms and legs moved, I was considered fit to find a job, my mental health, autism and sensory sensitivities were completely overlooked."

To achieve a truly person-centred health and social care that can effectively tackle health inequity, health systems can benefit from intersectionality theory. This means moving away from a one- or two-dimensional focus on 'ethnicity', 'age', 'income', 'caring roles', or 'disability', and instead recognising the multiple social roles and identities people hold, that may have a compounding effect in privileging or hindering access to health and social care.

Theme 5: Social and Physical Environment

(a) Social environment

Focus group participants recognised the importance of community spirit in providing emotional and practical support for one another. Social support could come from friends, family members, workers or volunteers.

"...it is important for people to have good relational connections with others - in families, in schools and the workplace and in their wider community... Having good relationships with others is key to mental wellbeing and also means that people have support in dealing with the problems of life."

"people looked out for one another, there was less formal childcare - they looked after each other's children and mothers tended to work part time - and there was more of a community spirit"

(b) Physical environment

To some participants, having a health-promoting environment means having outdoor and indoor infrastructures for leisure activities (e.g. swimming) that are accessible and inclusive.

"It's important to include access to outdoors space, fresh air and sunshine as part of this"

“Our most vulnerable and disadvantaged, who tend to experience the most health issues, have the least space to be active in”

Participants from the third sector voiced the need for more infrastructure to be effective and to be able to deliver what they have to offer.

“The third sector has a great deal to contribute and it would be wise to take note of that. While to some extent it is free, that is not so totally: infrastructure has to be provided for it to be effective and to be really effective it needs a lot of infrastructure.”

Particular attention should be paid to providing safe, private spaces to people experiencing traumatic situations.

“Not having safe spaces to communicate that support is needed around traumatic situations – advertising needed for organisations that can support those affected by trauma in private places”

Participants also raised issues on active transport and general safety.

“Physical activity is about so much more than exercise. It’s about safe and healthy ways of travelling to and from school and work.”

“The roads need to be kept in a good state of repair for this. Cycling in Reading, e.g. by St Mary’s Butts, is really hazardous now”

“People do not feel safe in Reading and there needs to be a greater response to make places safe, and make people feel safe, following incidents such as the attack in Forbury Gardens.”

“[Regarding] housing, I would add that rental culture and security for tenants could be discussed as an issue which makes a big impact on mental health.”

Theme 6: Covid-19

The pandemic has had an impact on everyone, albeit in different ways. For instance, some participants noted that Covid-19 has increased the risk of addictive behaviour and posed challenges to stay physically fit.

“Covid has increased addictive behaviour.”

“It’s been extremely difficult to keep my weight this down.”

For many, the lack of social interaction, particularly face-to-face interaction as opposed to online meetups, has affected their mental health.

“Having to isolate just because you’re over 70 has been hard”

“The pandemic really hasn’t helped my mental health and being cooped up all day with no escape is very disheartening”

“Usually I would go to the park or meet up in the community to take my mind off things, but I can’t do that now and it’s affecting my mental health”

“I’m an older carer and I’m not digitally connected, so with services reduced or closed and not digitally connected, on top of the extra caring I’ve found that together with reduction in community connectivity my mental health has been affected”

“Zoom is OK, but I have 8 hours in front of a screen for school and I don’t always want to spend more time in front of a screen in the evening as its can be exhausting. Lack of being able to meet face to face or variety in life unlike other children is affecting me mentally”

For others, staying at home all the time with their family poses a different set of challenges, especially those with caring responsibilities. Some participants expressed the occasional need for quiet, personal space.

“My house is small and I’m sharing it with my entire family all the time so I’ve no escape from them. I feel I’m being watched and judged because I don’t work and yet the rest of my family are”

“I’ve had a lot of worry and sadness in the family, but I had support from one to one buddies just walking down my street for a while, just being able to share.”

“Life is more stressful, I can’t meet up with friends, school is shut, I’m in the middle of my GCSEs and the house is busy with everyone in live lessons. It’s chaos, I’m working in a shed in the garden. It is affecting my mental health more than usual as a young carer.”

Finally, there were discussions surrounding how to move forward from the Covid-19 pandemic.

“Post Covid, people are going to need a lot of support to re-adjust”

“It’s not clear how the impact of Covid is being considered. We need a ‘new deal’ for health and wellbeing because of this.”

“The strategy should take account of the possibility of future pandemics and the variety of guises in which they might appear”

4. Developing the priorities

Shortlisting of priorities

In order to quantify the key priorities of residents, three ranking systems were devised (see Appendix A). This was in order to establish what survey respondents regarded to be most important to help them and their communities live happier and healthier lives. Quantitative outputs were then consolidated using findings from the focus groups.

Through the three scoring systems to evaluate priority ranking of survey respondents; the top five (out of 11) priorities were found to be consistent across the three areas (Appendix B). This was corroborated by thematic analyses of focus group findings and free text survey analysis. The top five priorities were therefore identified as follows:

- Reduce the differences in health between different groups of people
- Support individuals at high risk of bad health outcomes to live healthy lives
- Help families and children in early years
- Promote good mental health and wellbeing for all children and young people
- Promote good mental health and wellbeing for all adults

The outputs from the free text (from surveys) and focus groups showed a broad alignment with the survey findings. The focus group findings can therefore be used as a deep dive from which to ensure that supporting action plans address the issues raised.

Priority 1: Reduce the differences in health between different groups of people

Reducing the differences in health between different groups of people was considered "extremely important" by 30% of survey respondents and consistently ranked as a top priority across the three local authorities. Below are the comments and feedback from participants or respondents who said "there were significant changes needed" in this priority.

Many focus group participants and survey respondents raised the issue of unequal access to services, particularly for those most in need. As one survey respondent expressed, there is a need to "make it available to everyone". For instance; sports clubs and gyms, healthy nutrition and diet; and health education and promotion are often most accessible to those who are from high-income backgrounds. Participants outlined the impact of this, noting that "people in lower socio-economic groups tend to have worse health and nutrition". Participants also highlighted the need to examine the accessibility of facilities for "physically disabled people" who "do not have the access (some GP surgeries) or are not able to use all facilities (such as swimming) to improve their health". Collectively, these responses point to the importance of addressing the social determinants of health to promote equality of access to services vital for health and wellbeing.

Given this, participants provided suggestions on ways to tackle these root causes, and therefore address health inequities. For example, one survey respondent commented that "reducing the gap in health problems between rich and poor must be a priority, and this starts with a proper living wage, affordable housing and access to healthy living choices e.g. teaching children basic cooking skills, access to subsidised or free sport, fitness opportunities etc.". Focus group participants also suggested introducing universal proportionalism; "at the moment things such as sports clubs, physical activity focuses etc are geared towards higher socio-economic groups or do not focus on other intersects who find it harder to be active such as women & girls or specific ethnic groups".

Regarding access to health information, a number of focus group participants highlighted the need to work more closely with communities for whom English is not their first language and/or those with limited digital literacy. One participant summarised that "those who have English language limitation should have options that best suit them such as interactive dummies, modules, video clips, level of understanding testing tools. Also, can use simple charts. FM radio and other means of accessing health and NHS health service information". Survey respondents also noted that better information routes for those who may not own smartphones should be given, as "a significant proportion of these people - certainly, many more than the council members are aware of - have not been able to use contact-tracing for Covid". This points to the need for innovative and diverse means of disseminating health information and education to ensure accessibility for all.

Poverty was considered to be a major driver of health inequities; this encompasses issues of geography, housing, socioeconomic status and employment. For example, one respondent explained that "lack of income should not mean poor health… People living in deprived areas generally having poorer health, linked to poor housing, lower educational achievement and lower income". Focus group participants highlighted the need to ensure access to services and support regardless of geography. Specifically, they noted that deprivation, isolation and poor health exist beyond areas populated by social housing. One survey respondent commented that "Often they are aware how to live healthy lives, but lack the affordable amenities to do so it may need some support to take that first step", Respondents therefore highlighted the importance of addressing the gap between awareness and availability of services across regions and income brackets.

In order to address inter-group health inequalities and ensure locally-relevant services, participants highlighted the need for inclusion and prioritisation of community perspectives. As noted, "diverse communities have a range of knowledge and understanding about health and wellbeing issues in our local communities", suggesting the value of incorporating local knowledge to understand community health needs. This includes involving ethnically diverse groups, who are already at higher risks of chronic diseases, and those who are disadvantaged by language and cultural barriers. Poverty and low socioeconomic status (linked to housing, employment, education), racial disparities in health access and outcomes, and gender identity and sexuality were all identified as major drivers of health inequality during focus groups.

The impact of the built environment on health inequities and outcomes, including access to green spaces, good air quality, and safe cycle/walking paths, was also noted in focus groups. Participants highlighted the need to address disparities in access to a healthy external environment to promote health and wellbeing, with respondents suggesting that improving air quality was “associated with everything from dementia to asthma”. Focus group participants also specified that “affordable housing with green space could really improve the health and wellbeing for disadvantaged families”. A holistic approach to the built environment was expressed with participants noting its impact on both physical and mental health, and suggesting diverse ways to improve it, such as via changes to transport and outdoor spaces.

Figure 1. Visualisation of words frequently used by focus group participants and survey respondents for priority 1

Priority 2: Support individuals at high risk of bad health outcomes to live healthy lives

Supporting people at higher risk of bad health outcomes was found to be a key priority across Reading, West Berkshire and Wokingham. 35% of all survey respondents agreed that “significant change” is required within this priority area. Below are the comments and feedback from participants or respondents who said “there were significant changes needed” in this priority.

During focus groups, people facing higher risk of bad health outcomes were outlined to have either a continuing or new need for support (including before and during Covid-19). Key groups identified as facing higher risk of bad health outcomes include but are not limited to: those living with dementia; rough sleepers; unpaid carers; people who have experienced domestic abuse; and people with learning disabilities.

In order to support people with dementia, respondents suggested “an offer of ongoing support pre and post diagnosis that is equitable to all ages and inclusive to all”. Consultees also noted the importance of a “timely diagnosis”, post-diagnosis care, and a strengthened “care pathway from diagnosis to death”. This includes “dementia-friendly” access to activities and facilities to support social contact and regular exercise. It was noted that although dementia should be “grouped with mental health”, it should also be “addressed as a standalone” issue. Participants felt that dementia should be “an identified priority in its own right” to ensure appropriate patient management and care. Several survey respondents suggested increasing social and mental health support for dementia patients and their carers, as well as for older people to prevent cognitive decline.

Focus group participants emphasised a rise in homelessness in their communities, as well as those at risk of homelessness; “[I] still see homeless people on the streets and rapid rise in use of food banks indicates that many families are struggling with even the most basic of human needs”. Survey responses also pointed to the health risks associated with this rise in homelessness, and particularly the “need to end the cycle of homelessness, drugs and crime”. Solutions identified included supporting those Not in Education, Employment, or Training (NEET) into work; improving access to emergency and permanent housing, providing advice services (on issues ranging from budgeting to mental health); and encouraging community-based responses. For example, one survey respondent noted the “lack of adult education and its funding to further literacy and numeracy (in particular) amongst the unemployed and poorer sections of society”. Continuing, they suggested that addressing “this in itself would enhance employment opportunities, increase aspirations and thereby a better standard of living.”

Many participants pointed to the importance of the promotion of a healthy diet and good nutrition to reduce poor health outcomes for those most at risk. One focus group participant noted that showing people “how to create nutrition and healthy meals on a budget” would be an opportunity to promote healthy diets. Further suggestions included promoting healthy eating and providing outdoor gyms and free exercise classes to equalise access to the knowledge and resources needed for a healthy lifestyle. Participants noted that this should be coupled with frequent and widespread advertisement of these services to ensure that high-risk groups are aware of available support.

Importance was also placed on promoting the value of carers, particularly unpaid carers. Suggestions included raising community awareness of their importance and providing more services to support their health and carry out their responsibilities “These services need to be better funded, but also greater awareness is required by the public, so communities as a whole are more supportive”, suggested one focus group participant. Similarly, one respondent pointed to the need to redress the lack of recognition of “family unpaid carers especially for older adults”. Focus groups also highlighted an increased need in respite care for those acting as unpaid carers for a loved one. The importance of increasing social support and social cohesion was noted by several survey respondents; one of the comments suggested tackling “loneliness and isolation - this has an impact on many of the other priorities, if people feel connected, they will be more resilient to challenges which may make them less in need of other services”.

Participants outlined the need for “greater support” for those who have experienced domestic abuse. In particular, consultees noted the need for improved visiting and ongoing support for those at home, as well as the importance of support for men who have experienced domestic abuse. Survey respondents pointed to the lack of awareness and access to services for those who have experienced domestic violence – “it would also be good to see more support for victims of domestic violence being advertised”.

Survey respondents highlighted the need for learning disability-inclusive services and community activities. Respondents commented that “they need more activities, with transport included. Cooking, tailored exercise classes”, and that “more long-term support is needed, possibly a stepping stone program”. Better training for all health staff to understand the needs of people with learning disabilities and their carers were noted as key suggestions; “There is still a lot of work that could be done to improve the health of those with learning disabilities by simply working together with the local voluntary sector and without a huge investment of funding.”

Figure 2. Visualisation of words frequently used by focus group participants and survey respondents for priority 2

Priority 3: Help families and children in early years

Around 40% of all survey respondents across the three local authorities considered this to be an “extremely important” issue. Below are the comments and feedback from participants or respondents who said “there were significant changes needed” in this priority.

“Sometimes I would like to have help with childcare”. Focus groups identified how mothers feel isolated and unsupported, with issues exacerbated by Covid-19. Limited childcare and youth support services, including due to Covid-19 closures has meant increased challenges, particularly for young, single or new mothers. Some noted that “funding for youth service activities has been decimated. Better funding for local authority services for young people and for sports facilities is needed”. Focus group discussions highlighted barriers such as loss of self-esteem and expensive childcare; these were often worsened by mothers losing jobs and partners. Despite experiencing these challenges, there was also limited awareness of support services available to parents and families. Focus group participants said, “it’s very important that families are aware of the local opportunities and resources which are open to them”. The need to support working parents was also noted in both survey and focus groups responses; some commented that “childcare for full time working parents outside of school hours is extremely expensive and options are limited”.

Focus groups touched on how the wellbeing of parents is largely linked to the development of their children – participants discussed how parents are able to influence their children when they themselves have good relationships and are emotionally and financially secure as part of a wider resilient community. A survey respondent noted that “maternal mental health” should be addressed, and the community should work on removing stigma around it.

Focus groups highlighted how families with young children often struggle economically. The lack of valuable structural and social support was described and included concerns that “family hubs [were] closed”. Focus groups also underlined the limited access and diversity of services offering help to young families. Some survey participants also noted that “children’s centres were a great hub and source of practical and emotional support” for children and that they “wish[ed] to see more provision”. Many noted that the family activities should include outdoor and/or exercise activities; one participant said, “Personally I am not active enough, I would like activities available for families and better facilities like parks and swimming pools to encourage this.”

It was also identified that “it’s very unclear what support is available” to families. Focus groups underlined that the replacement of universal services with targeted services has, in part, led to the stigmatisation of receiving child support. In addition to this, certain families do not immediately meet the criteria for requiring support within targeted services, and so it is easy for them to “slip through the net”.

Figure 3. Visualisation of words frequently used by focus group participants and survey respondents for priority 3

Priority 4: Promote good mental health and wellbeing for all children and young people

Over 70% of people aged 45 or younger, and about 50% of all survey respondents, considered good mental health and wellbeing for all children and young people to be an extremely important issue. Below are the comments and feedback from participants or respondents who said "there were significant changes needed" in this priority.

"Many families are struggling to support their children". Focus groups discussed that people who live in deprived or disadvantaged circumstances are more likely to have a mental health problem than those who live in the most affluent areas. Focus groups also underlined that children in families at-risk of mental health conditions are more likely to develop a condition as adults. The importance of early prevention programmes was also highlighted. These would focus on ensuring the resilience of children and young people through services such as safe communication spaces, community-based activities and accessible youth clubs. One survey respondent commented that "as part of the provision for the young, free access to arts and activities […] would all help build resilience to mental and physical health of the children and young people".

“Not enough support in schools.” Focus groups highlighted how children and young people require additional support during the Covid-19 pandemic due to the stresses of isolation; it has been recognised that young people are likely to be suffering more in the later, rather than earlier, stages of the pandemic due to ongoing lockdowns. With the reopening of schools, participants drew attention to the need for “dedicated support staff to draw on and support children and not just rely on teachers to do that in addition to their already busy roles.”

Several focus group participants and survey respondents noted the long waiting times for Child and Adolescent Mental Health Services (CAMHS), and the implications of this for young people in need of urgent and/or long-term support. Access to such services was viewed as “important especially during the pandemic, as so many social interactions and relationship[s] have been affected.” Respondents also noted the need for “more specialist support” to safeguard the mental health and wellbeing of children and young people. As noted above, this included suggestions for the expansion of school-based mental health support, which in turn could help to reduce the pressure on CAMHS.

Figure 4. Visualisation of words frequently used by focus group participants and survey respondents for priority 4

Priority 5: Promote good mental health and wellbeing for all adults

Over 70% of people 35 years of age or older, and about 50% of all survey respondents, considered good mental health and wellbeing for all adults an “extremely important” issue; more than 40% of all respondents believe that “significant change” is required in this priority area. Below are the comments and feedback from participants or respondents who said “there were significant changes needed” in this priority.

“Not everyone is online.” Focus groups revealed the impact of the digital divide on access to mental health and wellbeing support and particularly how this affects older people. For instance, participants highlighted that not all individuals know where and how to search for help online. Additionally, it was expressed how loneliness and isolation amongst older people could be overcome through forming both online and in-person community networks. Focus group participants described that physical health is often “linked to mental health”; Individuals who have mental health conditions may end up in a vicious cycle of poor physical and mental health owing to the challenges of maintaining a consistent income, housing and social connections - all critical for maintaining good physical and mental health . Participants commented on the need to improve non-clinical interventions, such as “social prescribing and green spaces”, accessible and subsidised exercise classes, and arts and wellbeing courses.

“Ethnically diverse communities find it difficult to access mental health resources”. Focus group discussions highlighted the challenges for non-fluent and non-native English-speaking communities in accessing mental health resources; these included the lack of communication of available services and culturally appropriate resources. In addition, there were opinions about the need to raise public awareness to reduce stigma surrounding mental health and care-seeking, especially for groups not previously familiar with mental health resources. For example, as “many BAME people find it difficult to access mental health resources”, there is a “need for more interpreting resources”. In addition, “cultural competency training” was suggested to improve the cultural sensitivity of mental health support workers when “dealing with all types of trauma”.

Improving the timeliness and quality of mental health services was considered a key priority by both focus group and survey participants. Similar to responses about CAMHS, focus group participants felt that “the wait time for referrals for mental health issues is too long”, while “the duration of treatment is inadequate to resolve the issue”.

Figure 5. Visualisation of words frequently used by focus group participants and survey respondents for priority 5

5. Conclusion

Through the online survey and focus group discussions, public engagement has been at the heart of the development of the Health and Wellbeing Strategy for Berkshire West. Residents were able to help identify key themes surrounding the current state of health and wellbeing of Berkshire West and what could be done better. Quantitative analysis of survey responses through a robust scoring system identified five priorities to improve health and wellbeing in their communities.

In addition to this, extensive qualitative analysis of free text in surveys and focus group discussions ascertained the results of the quantitative data; allowing the public consultation to inform both the main areas of focus for the five priorities as well as the priorities themselves. These priorities as outlined in the health and wellbeing strategy are: 1) reduce the differences in health between different groups of people; 2) support individuals at high risk of bad health outcomes to live healthy live; 3) Help families and children in early years; 4) promote good mental health and wellbeing for children and young people; 5) promote good mental health and wellbeing for all adults.

6. References

1. The framework in Figure 2 has been adapted from Chuah et al., 2018 and Levesque et al., 2013 https://equityhealthj.biomedcentral.com articles/10.1186/s12939-018-0833-x ; https://equityhealthj.biomedcentral.com articles/10.1186/1475-9276-12-18

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7. Appendices

Appendix A: Scoring Systems

Survey data analysis

1. The first ranking system used was to establish what respondents ranked as number 1. This allowed us to understand what people considered the most important issue. However, this was not an intuitive method to give an overview of all the priorities, as consideration would only be given to what responders placed as their number 1 priority, rather than their top five.

2. The second ranking system allowed us to consider all 11 priorities equally when ranking them. This was done by assigning each priority a score (in accordance with where the priority ranked out of 11) and then totalling the scores. This allowed for a better understanding of the data spread in terms of the ranking. All 11 priorities were equally considered when ranking.

3. The third ranking system assumed that responders gave more importance to what they considered a top three priority when answering the survey. Thus, more weight was put on these responses. The scores were then totalled as they were in (2).

Regardless of which scoring systems was used, the top five was consistently the same (in no particular order):

- Reduce the differences in health between different groups of people
- Support individuals at high risk of bad health outcomes to live healthy lives
- Help young children and families in early years
- Good mental health and wellbeing for all children and young people
- Good mental health and wellbeing for all adults

Focus group and free text analysis

Following the 18 focus group discussions, thematic analysis was done to categorise the issues raised into the 11 priorities. Top three priorities were ranked using the same scoring system as (2).

Appendix B: Overall results on the ranking of priorities

	Counts			Rankings		
Priorities	#1	Average Score (total)	Weighted Score (top 3 weighted more)	**#1**	**Average Score (total)**	**Weighted Score (top 3 weighted more)**
Reduce the differences in health between different groups of people	467	17495	20294	**1**	4	4
Support individuals with high risk of bad health outcomes to live healthy lives	345	20080	23329	**2**	**1**	1
Help families and young children in early years	277	18143	20816	4	**2**	3
Reduce the harm caused by addiction to substances (smoking, alcohol or drugs)	120	14527	15865	8	8	8
Good health and wellbeing at work	48	12859	13768	11	11	11
Physically active communities	151	14591	16103	7	7	7
Help households with significant health needs	118	15747	17145	9	6	6
Extra support for anyone who has been affected by mental or physical trauma in childhood	86	14428	15613	10	9	10
Build strong, resilient and socially connected communities	245	14107	15718	6	10	9
Good mental health and wellbeing for all children and young people	308	18136	20827	**3**	**3**	2
Good mental health and wellbeing for all adults	258	17126	19481	5	5	5

Footnote: The table shows that the top five priorities remain the same and this is shown in green. The red cells show the lowest three priorities. Number 1 represents the most important priority and 11 shows the least important priority.

Appendix C: Questions included in the online survey

1. How important do you think each of the potential priorities are to helping you and your community to live happier healthier lives?

    a. Extremely important, Very important, Somewhat important, Not so important, Not at all important

2. In order of importance, one being the most important, how would you rank the potential priorities?

3. Are there any other priorities you think we should consider including in the draft strategy that we haven't mentioned in previous questions?

    a. Please tell us what priorities you like to see included and why

4. How much change do you think is required for each priority (asked for each individual priority)

    a. No change, some change, significant change, don't know

    b. Please tell us the reasons for your response, including details of any changes you think are needed

5. Have you or your family had any health and wellbeing concerns recently

6. Would you like to tell us briefly what they are? You can skip this question if you would rather not tell us

7. Are you, your family or other people you care for able to get all the help or support you/they need for any health and wellbeing problems?

8. Has the help or support been sought during the Covid-19 pandemic

9. Are there any further comments you would like to make?

Berkshire West Health and Wellbeing Strategy
2021 – 2030

Findings from the Public Consultation on the draft Strategy

Introduction

The Berkshire West Health and Wellbeing Strategy was developed through extensive public consultation and engagement, including an online survey and a series of focus groups with specific communities. The findings from this engagement contributed to the development of the final five priorities and the strategic objectives for each of them.

The public were then invited to comment on the draft Strategy document during a six week public consultation period. The aim of this was to ensure that we had accurately captured the views of the public in our Strategy and to keep public engagement and consultation at the centre of its development. The findings from this consultation have been used to further refine and finalise the Strategy.

Methods

The public consultation on the draft Strategy was delivered through an online survey. This was hosted on West Berkshire Council's consultation portal. The link was promoted by the communication teams for West Berkshire Council and Reading Borough Council. The link was also disseminated through the members of the Public Consultation and Engagement Task and Finish group, who were encouraged to share it widely. The consultation was open to anyone, although Wokingham Borough Council took the decision not to actively participate in the consultation. The survey was open from 24th June to 4th August 2021.

The survey consisted of a series of questions to understand if the respondent agreed with the priorities and the strategic objectives that sit underneath them (see Appendix A for the questions). The respondent was invited to give further detail as to their reasoning. Further questions were also asked on other aspects of the Strategy.

The consultation findings were collated and analysed through both quantitative and qualitative analysis. Broad themes were established across all of the survey responses and these were coded through thematic analysis. Each series of questions were then taken separately to understand the themes in the responses. These were reviewed against the relevant section of the draft Strategy and in the context of the earlier public engagement. The Strategy was updated and refined on the basis of the themes in these responses.

Findings

A total of 162 responses were made through the online survey. The vast majority (80%) were from individuals responding as a member of the public. However, 7.7% were individuals responding in an individual capacity and 12.2% were those

responding on behalf of an organisation. The majority of those responding were from the West Berkshire local authority area (figure 1).

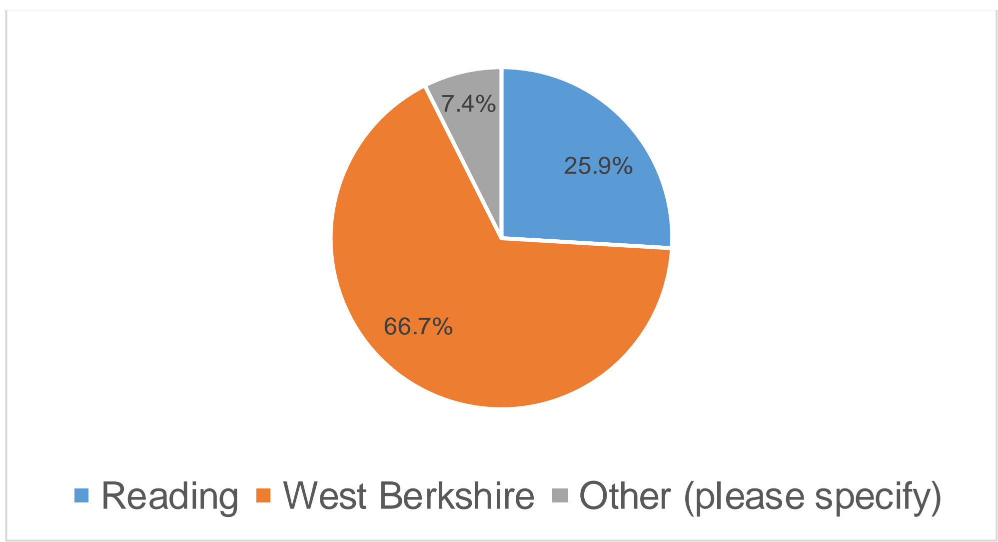


Figure 1: Answers to the question "which local authority area do you live in?"

<u>Demographics of respondents</u>

A series of questions were asked at the end of the survey, to understand the demographics of those who had responded. However, these were only answered by 64 (39.5%) people, out of all who had responded to the consultation, therefore the findings below may not be representative of those responding to the rest of the survey.

The gender and age breakdown of respondents who answered these questions, can be seen in figures 2 and 3, with ethnic group seen in figure 4.

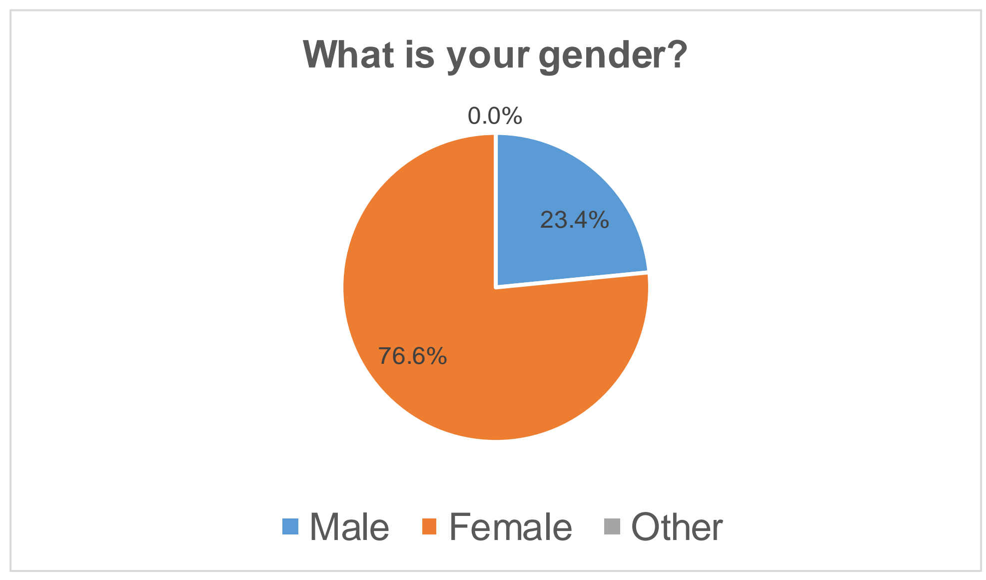


Figure 2: Self-reported gender of those responding to this question

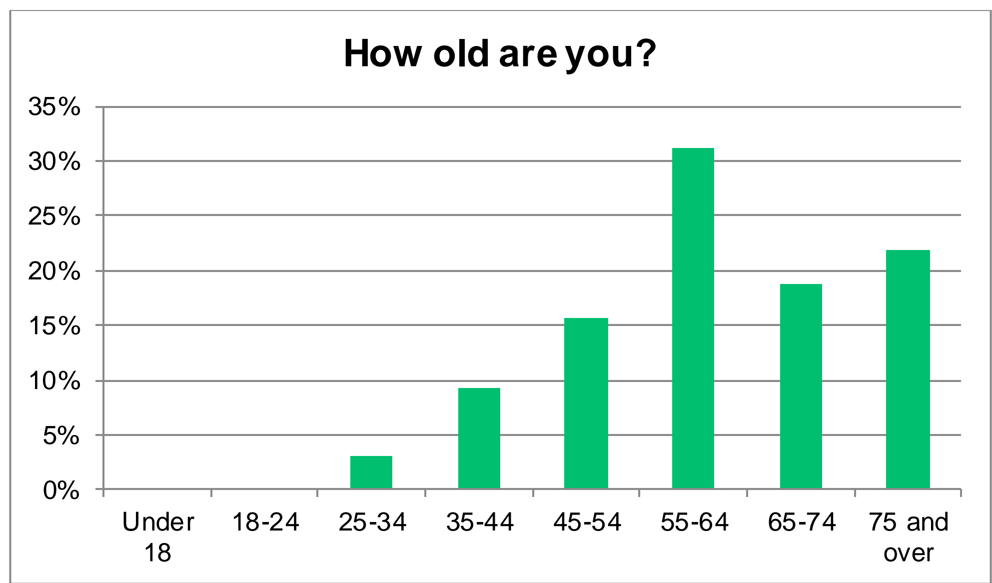


Figure 3: Age breakdown of those responding to this question

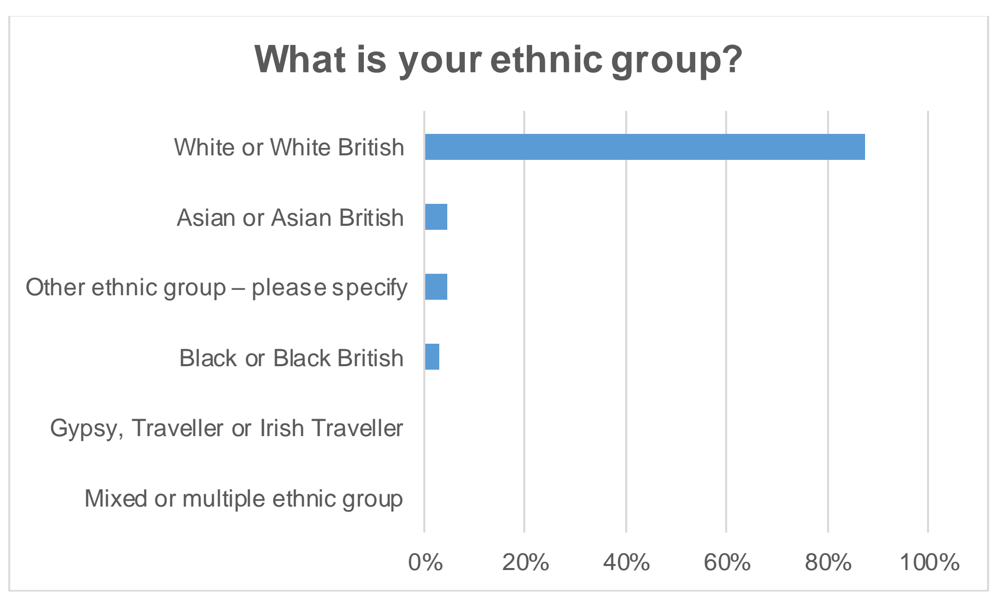


Figure 4: Ethnic group of respondents to this question

<u>General themes</u>

The free text comments throughout all of the questions in the survey were analysed together to identify the main themes from the public consultation. Throughout the responses, there was a general acknowledgement that the priorities identified were both sensible and important issues.

"sensible priorities that should have the greatest combined effect to address health and wellbeing across the community…"

"all the categories are important and should be looked after"

"these priorities reflect my views"

A number of respondents did comment on the fact that the five priorities are interlinked in many ways.

"pleased to see the focus on five key areas, all interrelated"

"in my opinion, many of these issues are also connected to poverty, poor housing and environment…"

"….segments of the population will fall into multiple priorities, it makes the strategy look busier than reality…"

"It is vital to take a holistic approach to supporting people and these priorities provide an opportunity to provide wraparound services, particularly within key areas of deprivation"

"there needs to be a greater recognition of the ways the priorities (and areas within them) and the things to be done to make a difference to them, overlap"

A further recurrent theme was one of accessibility. This was both in relation to accessibility of the Strategy itself and also of health and social care services in general.

"nothing but faced problems in accessing basic health care as autistic adult caused harm to my health or delay in urgent treatment…I feel isolated and uncared for as a disabled person"

"the vision will work if the delivery is accessible, all the elements covered are needed by the Deaf and Deafblind communities, however like the survey and this strategy, it is in English and is not accessible. So one thing missing is being clear about accessible formats and appropriate engagement"

"…however will these challenges be addressed for these communities in the most appropriate and accessible way?"

The development of the Strategy has been undertaken with public engagement at the centre. The responses to this consultation highlighted that this needs to continue and in a way that is meaningful and that people can engage with.

"there needs to be more focus on asking people what the issues are – rather than telling them…"

"prioritise vulnerable groups and those communities that are not hard to reach but are available when you reach to them"

"acknowledging and celebrating achievement and providing transparency through regular public updates on progress to ensure continued community support and engagement"

A number of respondents also commented on individuals taking personal responsibility for their own health and wellbeing and the need to empower people in order to do this.

“individuals have to take responsibility for their own health. If they neglect to do so through ignorance then they should be helped by education, if by lack of money through no fault of their own then they should be assisted…”

“educating the young and their parents/families could prevent poor health decisions which result in health problems later in life”

“encouraging people to take ownership of their health empowers them and encourages healthy lifestyles”

“it will be important to get the people to feel empowered to take action rather than it be imposed on them”

The final general theme was in regards to the next steps for implementation of the Strategy. A number of respondents commented on the need for funding in order to deliver on these priorities. In addition, there was a desire for a clear and specific plan as to what actions will be taken, including measurable targets to achieve. These suggestions were a particularly common theme to the question asking if anything was missing.

“who could disagree with this vision. But these are just warm words we need to see real commitment”

“measurable objectives of quantitative targets [are missing]”

“…it would also benefit by being clearer about what is being done to implement the strategy and what, in more detail, achievement of the strategy would look like”

The Priorities

Respondents were asked whether they agreed with each of the five priorities in the Strategy and then subsequently asked if they agreed with the strategic objectives within each priority area (the vision). Overall there were high levels of agreement with the five priorities (figure 5). In addition, there were also high levels of agreement with the objectives, mostly ranging from 73% to 79% agreement, although it was slightly lower for the priority “Help families and children in early years” to which 65% of respondents agreed with the objectives.

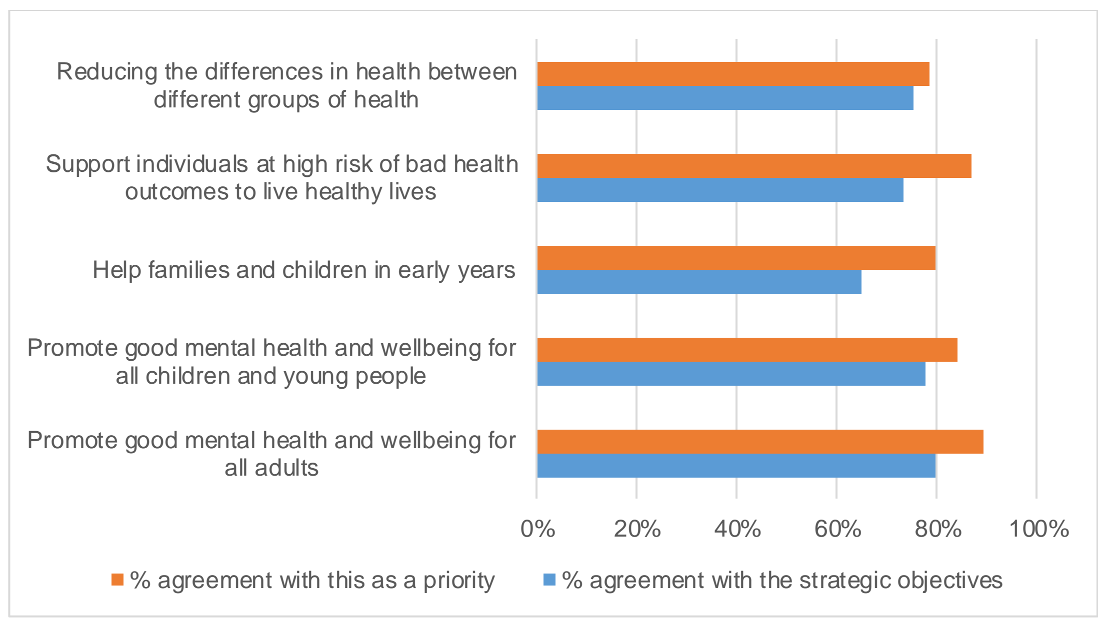


Figure 5: % agreement with the five priorities and their strategic objectives

For each priority in turn, respondents were asked to comment on the strategic objectives and whether there was anything missing. The responses to each specific priority, beyond what has been already covered under the general themes, is outlined below.

Priority One: Reduce the difference in health between different groups of people

As well as the general themes already detailed, within the responses to this priority a number highlighted that the draft Strategy did not include the wider social determinants of health and how these factors had an influence on health. As noted already, the theme of self-empowerment was particularly common in responses to this priority.

"I'd like to see rurality as a factor that might result in poorer outcomes – less easy access to all services, including health, social care and support for carers…"

"there is no step of examining the wider social determinants of health and their inequality. The influence of major determinants should be examined so that action can be taken on all those within the power of the partners to amend"

"people need to be given the opportunity to take control of their health and wellbeing and this can only be done through education and access to choice"

Priority Two: Support individuals at high risk of bad health outcomes to live healthy lives

Although it was acknowledged that the groups identified within this priority are important, a number of respondents did question whether it would only be these individuals whose needs would be addressed.

"…it would be wrong for these, and only these to be 'prioritised' over the next ten years, to the exclusion of other groups, which is what this statement implies"

"these are at least some of the groups at risk of poor health outcomes"

"there are a number of groups that are currently excluded because of not being listed here….there should be scope for these to be included in the Strategy"

A number of respondents described the importance of work to support those living with Dementia and their unpaid carers. It was suggested that Dementia could form a priority on its own.

"looking after someone with dementia is exhausting and assistance at the beginning of diagnosis is vital so that the carers know how to manage the journey so that the dementia sufferer feels comfortable and the carer gets support"

"these groups are not just at risk of poor health, they are stigmatised and hidden by society as a whole. They should be a priority vision, but also given sustainable options of support"

Priority Three: Help families and children in early years

Most responses described the need to provide support for parents of young children. There was an acknowledgement of the importance of acting in these crucial years

"the early years are hugely influential in determining the life course"

"knowledge, understanding rights and access to benefits etc. goes a long way to supporting families"

The access to this support was also mentioned and in particular asking how we can ensure that specific groups are taken account of. This is an example of how the priorities cross over, linking families and children with the earlier two priorities.

"…there is no mention of how to make these accessible to our most vulnerable and forgotten community such as the Deaf and Deafblind community"

"families with children that have problems need help and expectant mums need more support I believe…"

"black women are ignored in any strategies and research has shown how their wellbeing is not prioritised hence health professionals and label them as "hard to reach" or "angry black women"

Priority four: Promote good mental health and wellbeing for all children and young people

A number of respondents highlighted the importance of providing support across a number of different services, but in particular, through schools.

"teachers need to have better support to be able to help struggling pupils…"

“schools need to develop robust strategies for identifying and tackling mental health needs of pupils. Specialist staff should be employed as in many schools in larger urban areas”

In addition, some respondents described the lack of funding in mental health services and how services are over-stretched and under-staffed.

“…time taken to be referred can be several months and the downward spiral of the young person is scary for them and the family”

“the mental health service is currently a disaster area due to its very limited resources”

“money needs to be found to support the services that already exist to support mental health”

Priority five: Promote good mental health and wellbeing for all adults

General themes as described above were also mentioned in relation to this priority. Specifically around access to services, funding and the need to empower people to manage their own health and wellbeing. In addition, the role of employers in mental health was discussed by some respondents, along with the practical support both for following a crisis and also for ongoing mental illness.

“work with employers to address mental (and other) health problems in the workplace could be self-financing, by reducing levels of absenteeism and other sources of lower productivity…”

“the practical help for adults in crisis must in place for an increase in need after the pandemic”.

The Principles

Respondents were asked if they agreed or disagreed with the principles in the Strategy. Only 50% of respondents to the consultation answered this specific question and the results can be seen in figure 6.

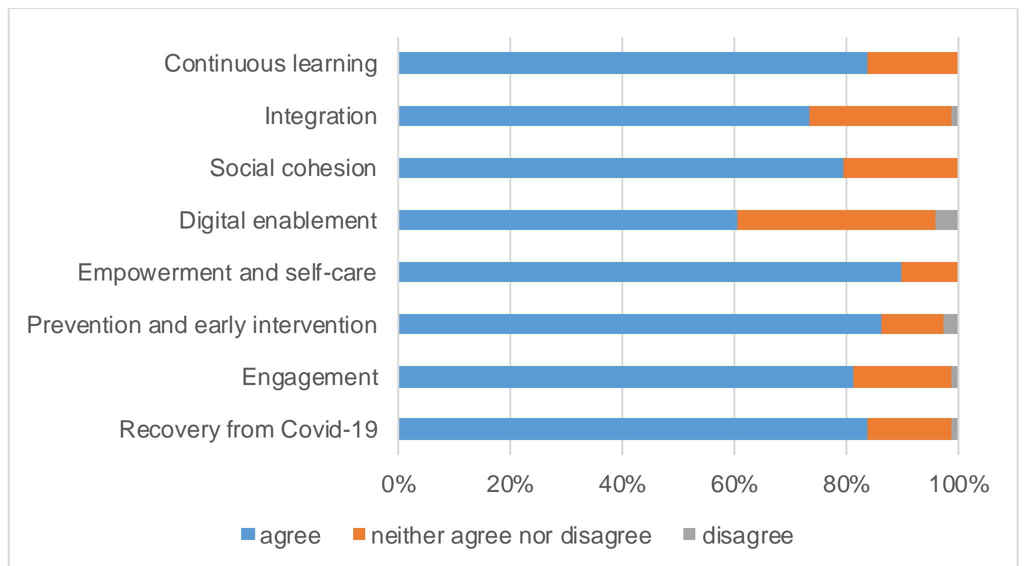


Figure 6: answers to the question "overall do you agree or disagree with the principles that run throughout this Strategy"

Most of the principles had high levels of agreement with very few people actively disagreeing with any of them and this was also shown within the free text comments. The principle of digital enablement had the lowest level of agreement (61% of those who answered this question). This was reflected in the free text comments which included many stating that many people either cannot or would prefer not to use online services.

"it needs to be constantly borne in mind about communities who cannot access digital inclusion…"

"not everyone has the ability to be online, and even for those who do, not everyone WANTS to actively engage in online service…."

"digital enablement takes no account of the people who cannot or do not wish to use internet type services; they are disadvantaged already"

<u>The Challenges</u>

Only 48% of survey respondents answered the question about whether they agreed or disagreed with the existing and future challenges as identified by the Strategy. Out of these, 58% agreed, with 36% neither agreeing nor disagreeing and 5% disagreeing. As described above, the need for accessibility for all communities was highlighted in the comments. In addition to this, the need to reflect the challenge of climate change and environmental issues was mentioned by a few respondents.

Out of those who responded to the question (total 77), 57% agreed that the draft Strategy adequately deals with the challenges identified. The main themes within the free text responses referred to the need for a detailed plan of implementation for the Strategy.

"I've put NO because it is impossible to deal with the challenges all we can do is mitigate them and I feel the strategy does that"

"it is all fine, rather vague and aspirational, but it requires more detail on implementation: how, when"

"it's the implementation that will be difficult…"

Using the public consultation findings to refine the Strategy

The five priority areas were developed using extensive public engagement at an earlier stage of the Strategy development. This public consultation on the draft Strategy has identified broad agreement among respondents about these five priorities and how they are described in the Strategy.

The more general themes raised in this consultation and the specifics of some of the issues raised have contributed to the further refinement of the Strategy and development of the final version. The table below outlines the main findings and how these have been considered for the final Strategy.

Themes from the public consultation	Response
The interlinking of the priorities	This is acknowledged within the Strategy throughout but in particular as the priorities are first described. The Strategy is intended to have reducing health inequities acting as a pillar underpinning all of the priority areas. In addition to this, the delivery plans for implementation of this Strategy, will seek to look for synergies across priority areas and understand where actions taken will have a greater impact.
Accessibility	We will explore publishing this Strategy in different formats, ensuring that is accessible to different communities Where access to services has been described in the Strategy, we have emphasised the need to consider all different barriers to access, and added further detail to ensure this includes sensory and communication needs.
Engagement	Engagement has been at the heart of the development of this Strategy. It is one of the core principles running throughout and is mentioned within the objectives for a number of priority areas. The importance of ongoing active engagement with communities and individuals is a key feature of the implementation of this Strategy and will also be described within the delivery plans.

Personal responsibility and self-empowerment	Empowerment and Self-care is one of the core principles of this Strategy and is described throughout.
The need for a clear plan as to how this Strategy will be implemented	Each of the three local authority areas with Berkshire West is developing a local delivery plan, describing how the Strategy will be implemented. The process for doing this is described within the "Next Steps" section of the Strategy. Each plan will include clear measurable actions, including indicators and targets by which to measure progress.
Social determinants of health (priority one)	An additional strategic objective was added under the first priority, to reflect the need for work to be done to address the variation of the experience of the social, economic and environmental determinants of health.
The groups described within priority two	The text within priority two has been developed to be clearer that although a number of groups have been identified as our initial key focus areas, this will be dependent on local context and need for each of the three local authority areas. In addition, as the Strategy is due to be in place for the next ten years, we will actively engage with our communities, continuously learning and understanding the needs to our population in order to ensure we are supporting those at higher risk.
Dementia as a potential priority area	Reflecting on the findings of the original engagement and consultation, it was decided to keep "Dementia" as a focus group within priority two, rather than have it as a separate priority. People living with dementia are recognised within this priority as an important group, and by remaining within this priority, it also enables the linking of work to address the needs of their unpaid carers as well (also identified as a group at higher risk of bad health outcomes).
Priority three: addressing social determinants of health and support to families.	The descriptions of the strategic objectives were updated following this consultation, in part to make them clearer, but also to highlight the cross over with wider social determinants of health. Support for parents at the earliest stages has been emphasised, although with the need to address financial concerns for families.
Priority four: the role of schools and how services are stretched	The Strategy includes the objective to support a Whole School Approach to mental health and working with staff, students, parents, the community and mental health support teams in order to do that. This Strategy seeks to prevent issues and so look to address mental health issues at an earlier stage, thereby helping to relieve the pressure on services. The strategic objectives emphasis the need to enable all our young people to thrive, but also supporting

	families to prevent and reduce the risk of poor mental health.
Priority five: self-empowerment and working with employers	The text for the strategic objectives were updated to highlight the importance of other activities for mental wellbeing, including social prescribing and working with professionals and employers.
Digital enablement	The text within this principle has been refined to be clear that while we want to embrace the opportunities that digital enablement presents, we also need to ensure that services and support are available for those who prefer not to or who are unable to access them digitally.
Challenges – including climate change	The risk of climate change and environmental implications has been added under the "Our challenges: the impact of Covid-19" section. This highlights the need to adapt to long term threats such as environmental and climate change risks.

Conclusions

The Berkshire West Health and Wellbeing Strategy has been developed through a process of extensive public consultation and engagement. The priorities and their objectives were developed using input from individuals and organisations through an earlier online survey and focus groups with specific communities. This subsequent consultation on the draft Strategy has given further opportunity for the public to comment on the Strategy in its entirety. Although the response rate was lower than to the earlier survey, the responses the findings did show a number of recurrent themes. These findings, along with input from different stakeholders and partners, have been used to further refine the Strategy, thereby ensuring that the final Strategy has had co-production at the centre and engagement as a key feature throughout.

Appendix A: Survey Questions

Which local authority area do you live in?
Are you answering:

- As a member of the public
- As an individual in a professional capacity
- On behalf of an organisation

Overall do you agree or disagree with the selected priorities for the draft Strategy
Do you agree or disagree with our priority one vision
Do you think there is anything missing from our priority one vision?

- What do you think is missing

Do you agree or disagree with our priority two vision?
Do you think there is anything missing from our priority two vision?

- What do you think is missing

Do you agree or disagree with our priority three vision?
Do you think there is anything missing from our priority three vision?

- What do you think is missing

Do you agree or disagree with our priority four vision?
Do you think there is anything missing from our priority four vision?

- What do you think is missing

Do you agree or disagree with our priority five vision?
Do you think there is anything missing from our priority five vision?

- What do you think is missing

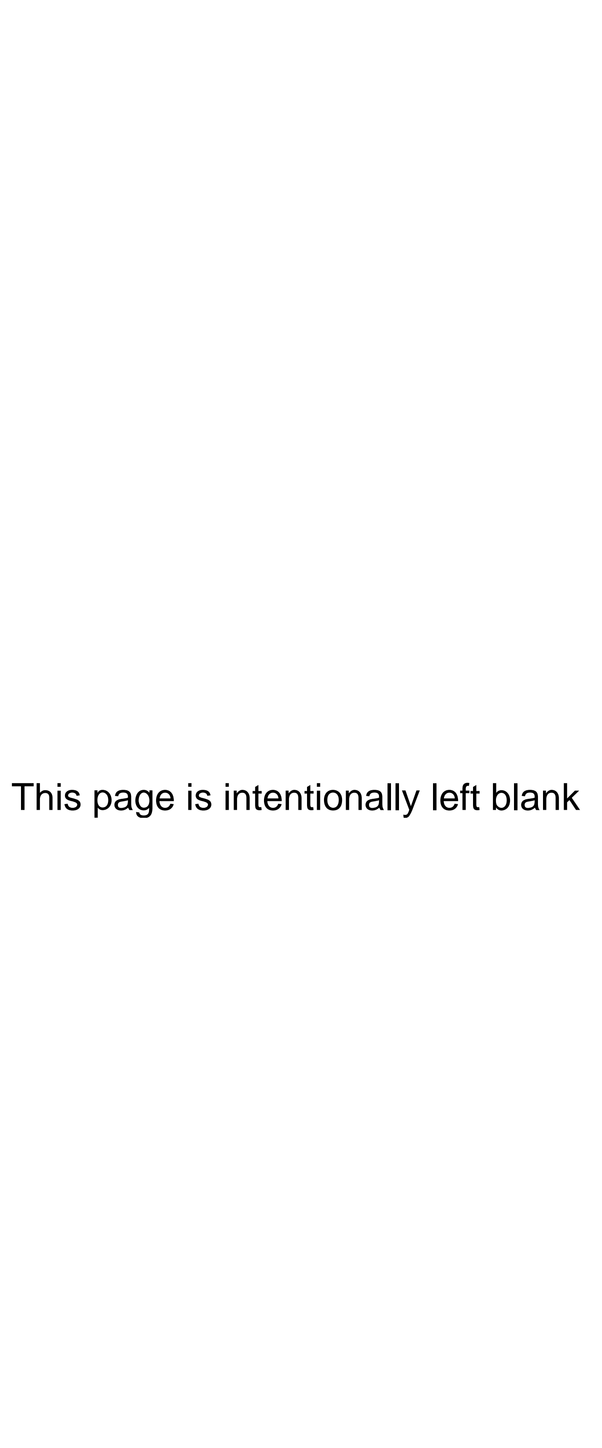
Overall, do you agree or disagree with the principles that run throughout the draft Strategy?
Do you think there is anything missing from our principles?

- What do you think is missing

Do you agree or disagree with the existing and future challenges on pages 7&8 of the draft Strategy?
Are there any other challenges you think should be included in the Strategy

- What other challenges do you think should be included in the Strategy

Do you think the draft Strategy adequately deals with the challenges?
Do you have any other comments on the draft Strategy?



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Agenda Item 9

Berkshire Suicide Prevention Strategy 2021-2026

Report being considered by:	Health and Wellbeing Board
On:	30 September 2021
Report Author:	Rachel Johnson and Matt Pearce
Item for:	Decision

1. Purpose of the Report

The Berkshire Suicide Prevention Strategy 2017-2020 is now out of date. This report presents an update on the refreshed Berkshire Suicide Prevention Strategy that will cover the next five years, 2021-26. This is annexed as Appendix A.

2. Recommendation(s)

For the Health and Wellbeing Board to approve this strategy.

3. How the Health and Wellbeing Board can help

The Health and Wellbeing Board approves the Berkshire Suicide Prevention Strategy (2021-26) as set out in Appendix A.

Will the recommendation require the matter to be referred to the Executive for final determination?	Yes: ☐	No: ☒

4. Introduction/Background

4.1 Following publication of the National Suicide Prevention Strategy in 2021, Preventing Suicide in England, a cross-government outcomes strategy to save lives (HM Government, 2021), councils were given the responsibility of developing local suicide prevention strategies and action plans through their work with the Health and Wellbeing Strategy Boards, Clinical Commissioning Groups and wider partners. It is also reinforced by the Mental Health Taskforce's report to NHS England, The Five Year Forward View for Mental Health (NHS England, 2016).

4.2 The national strategy stresses the importance of engaging with a wide network of stakeholders to develop and deliver these strategies and plans to reduce suicide. Locally this takes the form of the Berkshire Suicide Prevention Steering Group, with one overarching Suicide Prevention Strategy for the whole of Berkshire.

4.3 This strategy has been developed through the work of the Berkshire Suicide Prevention Steering Group that has a range of representation of partners across the system, and is founded upon local data, intelligence and knowledge.

5. Supporting Information

5.1 This strategy builds on the previous Berkshire Suicide Prevention Strategy (2017-2020), and serves as refresh of that strategy, where we take forward the key underlying principles addressed in the former strategy and have updated it with new priorities.

5.2 The vision for this strategy is: “To reduced deaths by suicide in Berkshire across the life course and ensure better knowledge and action around self-harm”.

5.3 The strategy has been developed by the Berkshire Suicide Prevention Steering Group, who have worked together to identify key priority areas, derived from local data intelligence, trends and action. A small sub-group of the Berkshire Suicide Prevention Steering Group was responsible for further defining the content for each of the priorities and providing regular updates to and receiving feedback from the main steering group.

5.4 The priorities of the national suicide prevention strategy (2012), and subsequent progress reports are the guiding principles to how we work to prevent suicide across Berkshire.

5.5 The 7 guiding principles for this strategy are:

1. Reduce the risk of suicide in key, high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Reduce rates of self-harm as a key indicator of suicide risk

5.6 The five core priority areas principally address the national priority to tailor approaches to improve mental health in specific groups, but the commitment remains to all of the national principles and reducing suicide rates across all population groups. Our local intelligence has demonstrated a need to focus on the following key areas:

1. Children and Young People
2. Self-harm
3. Females
4. Economic stresses
5. People bereaved by suicide

5.7 Whilst these are the agreed strategic priorities across Berkshire, there will remain a need to monitor trends and risk factors, particularly from the impacts of Covid-19 and to respond to the latest changes.

5.8 The strategy will directly contribute to priority 4 and 5 in the new Berkshire West Health and Wellbeing Strategy:

- Priority 4 – Promote good mental health and wellbeing for all children and young people
- Priority 5 – Promote good mental health and wellbeing for all adults

5.9 The strategy directly meets this aim through the vision: "To reduce deaths by suicide in Berkshire across the life course and ensure better knowledge and action around self-harm".

6. Options for Consideration

None.

7. Proposal(s)

To adopt the Berkshire Suicide Prevention Strategy as developed by the Berkshire Suicide Prevention Steering Group.

8. Conclusion(s)

This paper has outlined our commitment to a continued focus on preventing suicides across Berkshire. By working together, we have put forward a range of recommendations that demonstrate how we will focus on key risk groups and how we will use local data and intelligence to take action and target our efforts effectively. The scope of our strategy also extends to include self-harm, which is an important risk factor for suicide.

9. Consultation and Engagement

9.1 Whilst there has been no formal public consultation, as was done previously, this strategy has a local focus and contains the perspectives from professionals working in the statutory, private and third sector organisations. Colleagues who support people who have been directly affected by suicide have also been involved, who we have worked with sensitively to engage this group with this strategy. The strategy reflects the commitments of the Berkshire Suicide Prevention Steering Group who worked together on identifying the key priorities, which have been derived from reviewing local data, intelligence, and information.

9.2 A small sub-group of the Berkshire Suicide Prevention Steering Group was responsible for further defining the content for each of the priorities and providing regular updates to and receiving feedback, from the main steering group.

10. Appendices

Appendix A – Berkshire Suicide Prevention Strategy (2021-2026)

Background Papers:

The Five Year Forward View for Mental Health (NHS England, 2016).

National strategy for England, Preventing Suicide in England, a cross-governmental outcomes strategy to save lives (HM Government, 2012)

Health and Wellbeing Priorities 2018/19 Supported:

☒ Support mental health and wellbeing for adults
☐ Improve access to employment for vulnerable people

Health and Wellbeing Strategic Aims Supported:

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):

☐ Give every child the best start in life
☒ Support mental health and wellbeing throughout life
☒ Reduce premature mortality by helping people lead healthier lives
☐ Build a thriving and sustainable environment in which communities can flourish
☐ Help older people maintain a healthy, independent life for as long as possible

The proposals contained in this report will help to achieve the above Health and Wellbeing Strategy aim by 2026.

Officer details:

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Appendix A

Data Protection Impact Assessment – Stage One

The General Data Protection Regulations require a Data Protection Impact Assessment (DPIA) for certain projects that have a significant impact on the rights of data subjects.

Should you require additional guidance in completing this assessment, please refer to the Information Management Officer via dp@westberks.gov.uk

Directorate:	Communities and Wellbeing
Service:	Public Health and Wellbeing
Team:	N/A
Lead Officer:	Public Health Consultant – Suicide Prevention Lead
Title of Project/System:	Berkshire Suicide Prevention Strategy
Date of Assessment:	September 2021

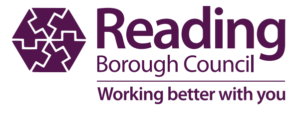
Do you need to do a Data Protection Impact Assessment (DPIA)?

	Yes	No
Will you be processing SENSITIVE or "special category" personal data? Note – sensitive personal data is described as "*data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation*"	☒x	☐
Will you be processing data on a large scale? Note – Large scale might apply to the number of individuals affected OR the volume of data you are processing OR both	☐	☒
Will your project or system have a "social media" dimension? Note – will it have an interactive element which allows users to communicate directly with one another?	☐	☒
Will any decisions be automated? Note – does your system or process involve circumstances where an individual's input is "scored" or assessed without intervention/review/checking by a human being? Will there be any "profiling" of data subjects?	☐	☒
Will your project/system involve CCTV or monitoring of an area accessible to the public?	☐	☒
Will you be using the data you collect to match or cross-reference against another existing set of data?	☐	☒
Will you be using any novel, or technologically advanced systems or processes? Note – this could include biometrics, "internet of things" connectivity or anything that is currently not widely utilised	☐	☒

If you answer "Yes" to any of the above, you will probably need to complete Data Protection Impact Assessment - Stage Two. If you are unsure, please consult with the Information Management Officer before proceeding.

Berkshire Suicide Prevention Strategy

2021-2026



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Acknowledgements

We must particularly thank the Berkshire Suicide Prevention Strategy Working Group who led the development and content of this strategy. We must also acknowledge our colleagues on the Berkshire Suicide Prevention Steering Group who helped to navigate the strategic direction of this strategy. Acknowledgements also extend wider to additional partners who also gave up their time to contribute to the development of this strategy and action plan.

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Foreword

In England, 5,691 people tragically took their own lives in 2019[1]. Reducing this number is of upmost importance nationally and locally and remains a key public health priority. Locally we have seen an increase in female suicide rates, and growing concern over the suicide rates in younger age groups, with the suicide rate in the 20-29 year-old age group being significantly higher than all other age groups (2015-2019).

Suicide is one of the most tragic events for families, friends and communities, with life-long consequences. Those bereaved by suicide are particularly vulnerable to suicide attempts and death by suicide, therefore support for those grieving is of paramount importance.

We know that individual's health and wellbeing has been significantly affected throughout the course of the pandemic and will continue to be affected in the long-term. This strategy recognises this, and across Berkshire, partners and communities will continue to work resolutely towards mitigating the impact of the pandemic on suicide risk.
All stages of life have been considered to develop this strategy and action plan, with the acknowledgement that risk factors at all stages of life must be considered to develop a truly preventative approach. Everyone in society has a part to play in preventing suicides, whether it is a member of the public asking "Are you OK", investing in good mental wellbeing programmes, removing the triggers, supporting young people through the transitional period into adulthood, or ensuring prompt treatment from mental health services.

This strategy helps the people and professionals of Berkshire to understand some of the factors that contribute to suicide in Berkshire and raises awareness of how we can all contribute to preventing deaths by suicide.

Stuart Lines - Director of Public Health for Berkshire East

Meradin Peachey - Director of Public Health for Berkshire West.

[1] Suicide rates in England and Wales 2019 registrations. ONS. Available Suicides in England and Wales - Office for National Statistics (ons.gov.uk). Last accessed 31/08/21

Executive Summary

Suicide prevention remains a key public health issue both locally and nationally. Strong multi-agency working, public health leadership and robust suicide prevention plans are core to this prevention. This suicide prevention strategy for Berkshire encompasses these core elements and sets out our action locally to reduce suicide and self-harm, based on local intelligence, data and strategic priorities.

There were 26.8 years of life lost per 100,000 population from suicide across Berkshire on average between 2017-19. Age specific rates are broadly in line with the England average, peaking in the 50-59-year-old age band before decreasing until the age of 80 plus years. Real time surveillance system (RTSS) data tells us that within Berkshire, female suicides have increased year on year since it started being collected in 2017.

Since the publication of our previous suicide prevention strategy, a Berkshire wide suicide audit has been undertaken (in 2018). Because of the concerns highlighted in this audit and routine RTSS monitoring a female deep-dive analysis was undertaken. NHS England also supported a 0-25 audit because of national trends reflected locally too. This local data and intelligence have been central to the development of the priorities of this refreshed strategy, and in collaboration with system partners. Research and data monitoring will continue to be a key focus for suicide prevention within Berkshire, providing opportunity to review approaches and prioritise efforts accordingly.

The COVID-19 pandemic has exacerbated existing inequalities in suicide risk and has posed new challenges for different groups within the population. The impact of the pandemic on mental health and suicide risk across the lifecourse remains largely unknown, therefore monitoring and mitigation of risk it is a priority for this strategy.

This strategy builds on the previous Berkshire Suicide Prevention Strategy (2017-2020) and serves as a refresh of that strategy, where we take forward the key underlying principles and identify new priorities. These were developed by working with our key partners across the system and making good use of local data and intelligence.

There are seven priority areas for action recommended by the national suicide prevention strategy and subsequent progress reports as follows:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Reducing rates of self-harm as a key indicator for suicide risk

This strategy principally focusses upon the second priority area – 'tailor approaches to improve mental health in specific groups', but the commitment remains to all principles and reducing suicide for all groups.

The vision for this strategy is 'To reduce deaths by suicide in Berkshire across the lifecourse and ensure better

knowledge and action around self-harm'. In order to achieve this vision, this strategy is centred upon local data, trends and action, and has 5 core priority areas agreed across the 6 local authorities, forming a Berkshire wide action plan.

1. Children and Young People; including the impact of trauma and adversity, recovery from COVID-19, neurodiversity, LGBTQ+ and transitions
2. Self-harm; as a risk factor, groups vulnerable to self-harm, hospital admissions, mental health, young people and self harm
3. Female suicide deaths; including perinatal mental health, domestic abuse, parental or carer stress
4. Economic factors; including the impact of COVID-19, debt and poor mental health, benefits, socio-economic disadvantage and gambling
5. Supporting those who are bereaved or affected by suicide; including local suicide bereavement support, specialist suicide bereavement support, and those impacted by suicide in the workplace

Recommendations

The following are recommendations for this strategy, which will form the Berkshire wide action plan for 2021-26.

Overarching recommendations:

1a) To continue to monitor the impact of COVID-19 on suicide across the lifecourse through RTSS data and respond to any identified trends.
1b) To continue to monitor the wider trends emerging from the impact of COVID-19 on people's mental health and suicide risk across the lifecourse, and to support the system to take action where required.
1c) To undertake a Berkshire suicide audit.
1d) Undertake regular reviews of information, resources and channels for people affected by suicide.
1e) Hold an annual multi-agency conference on a range of topics to share information and best practice and raise awareness to the risks for suicide.
1f) Invite additional partners across the System within Berkshire, including the voluntary and community sector to join the Suicide Prevention Group for improved cross-topic working.
1g) Set up sub-groups of the Suicide Prevention Group, informed by local intelligence and data, where there is a need to focus upon a risk factor or group within the population.

Priority area 1: Children and Young People

2a) To raise awareness of the link between trauma and adversity, and suicide across the life course.
2b) Continued investment into the Be Well campaign to encourage the importance of looking after emotional wellbeing, in addition to signposting to local mental health services and support in order to prevent self-harm and suicide in children, young people, and women.
2c) Support the system to adopt a needs-led approach for neurodiverse children and young people, particularly in the prevention and early intervention arena, e.g. in schools and the community.
2d) To explore improving data capture on sexual orientation for all ages in RTSS data and promote this across the suicide prevention system.
2e) To work with local organisations and charities who work with the LGTBQ+ community on suicide prevention.
2f) To raise awareness of the impact of the transitional period (children moving into adulthood) on the mental health impact and the risks of suicide during this period for children and young people.
2g) To link with the work across the BOB and Frimley ICS on the ease of access to shared care records across system partners for transition population (children moving into adulthood).
2h) To support higher education establishments within Berkshire, including universities to adopt a needs-led approach to neurodiversity.

Priority area 2: Self-harm

3a) Decrease the stigma related to self-harm and encourage help seeking behaviour and self-care.
3b) Help friends, family and professionals understand the physical and emotional signs of self-harm, how they can help and where they can get support.
3c) Explore the impact of self-harm on parents and siblings on their own mental health and wellbeing.
3d) Regularly review local intelligence and data on self-harm at the Berkshire Suicide Prevention Steering Group, ensuring additional relevant data from a wide range of sources are included (e.g. development of RTSS to include self-harm, ambulance service data, primary care and schools).
3e) Working with Mental Health Support Teams (MHSTs), ensure a continued focus on the prevention of self-harm by increasing resilience and general coping skills and support for those who self-harm.

Priority area 3: Female Suicide Deaths

4a) Link with the Buckinghamshire, Oxfordshire, Berkshire West (BOB) and Frimley local maternity systems on suicide risks in the perinatal period.
4b) To explore data collection on the perinatal period; risk factors and the link to suicide including data captured in the RTSS.
4c) Promote the need for clear pathways and knowledge exchange between domestic abuse and mental health services.
4d) Improve data collection of domestic abuse data in RTSS.
4e) Include domestic abuse indicators in the Berkshire suicide audit to better understand the link between domestic abuse and suicide.
4f) Provide information to domestic abuse services on how to respond to concerns where clients may be self-harming or considering suicide (whether the client is a victim, survivor, perpetrator or child or young person).
4g) Raise awareness of the information, resources and services available for parents and carers who are experiencing stress, through inputting into local campaigns.

Priority area 4: Economic Factors

5a) Work with colleagues to raise awareness of the risk between debt, mental health and suicide risk among frontline professionals and the wider public. Awareness raising needs to;
- reduce the stigma of 'being in debt' and signpost to access debt and benefit advice and support. This information also needs to be shared with frontline professionals
- encourage people in debt to reach out for help to reduce impact on mental health
- encourage people with poor mental health to reach out for debt advice

5b) Support frontline professionals to feel comfortable about talking about debt and financial problems and the link to poor mental health and suicide risk and what support is available.
5c) Support Berkshire local authorities with a single point of access information site around money matters.
5d) Ensure compassionate debt collection. Make sure the process is supportive and aims to steer residents to places that can provide help and support. Support vulnerable groups at increased risk of debt including people with long-term conditions or disabilities.
5e) Work with key partners to actively promote services that provide help around navigating the benefits system and potentially increasing people's incomes.
5f) Make sure that all parts of the health service where patients showing suicidal intent first make contact, are signposted or triaged appropriately using a process that includes debts and other economic stresses as risk factors.
5g) Work with system partners on the early identification and support of people who are at increased risk of debt and financial concerns (e.g. unemployed or people with long-term conditions) as early as possible and offer effective support to manage personal finances through appropriate referral pathways.
5h) Monitor local data and intelligence on levels of problem gambling within Berkshire and its link to suicide.

Priority area 5: Supporting those who are bereaved or affected by suicide

6a) Ensure our local bereavement offer is culturally and ethnically appropriate for different groups within communities to develop resources and services.
6b) Continued support to the volunteer led local SoBS groups to be able to continue to offer a peer-to-peer support service.
6c) Building in bereavement support to extend to wider family members, friends and communities.
6d) Continue to commission suicide bereavement support services and monitor its impact.
6e) Explore training opportunities for colleagues and workplaces impacted by suicide.
6f) Work with Thames Valley Police and other first responders to a suicide, to share appropriate resources with employers.

Background

National context

Every suicide is a tragedy. It has life changing impacts for those bereaved, and profound impacts on communities and services. Suicide is preventable, not inevitable. Strong multi-agency partnership working, suicide prevention groups and a robust strategy are key to this prevention.

The 2012 national suicide prevention strategy – 'Preventing suicide in England: A cross government outcomes strategy to save lives' (DHSC 2012)[2] alongside five subsequent progress reports (DHSC 2014, 2015, 2017, 2019, 2021) [3 4 5 6 7] sets out seven areas for priority and action, that all local suicide prevention plans should cover on a long-term basis, which are the guiding principles in this strategy:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Reducing rates of self-harm as a key indicator for suicide risk

A practical resource for suicide prevention planning produced by Public Health England (2020)[8] recommends short term actions with a co-ordinated whole systems approach for local plans, alongside the seven priority areas of the national strategy in the long-term.

The most recent national confidential inquiry into suicide and safety in mental health (NCISH) 2021 provides findings relating to people who have died by suicide in the UK between 2008 and 2018[9]. The report recommends that tackling inequalities remains a priority, areas should continue to understand the specific needs for different groups, monitor demands for mental health providers and engage with the voluntary and community sector. Plans must also address the specific needs of the populations they cover.

[2] Preventing Suicide in England: A cross government outcomes strategy to save lives. Department for Health and Social Care (2012) Available Suicide prevention strategy for England - GOV.UK (www.gov.uk) Last accessed 31/08/21
[3] Preventing suicide in England: One year on First annual report on the cross-government outcomes strategy to save lives. HM Government (2014) Available First annual report on the cross-government outcomes strategy to save lives (publishing.service.gov.uk) Last accessed 20/08/21
[4] Preventing suicide in England two years on: Second annual report on the cross government outcomes strategy to save lives. Department for Health and Social Care (2015) Available Suicide prevention: second annual report - GOV.UK (www.gov.uk) Last accessed 20/08/21
[5] Preventing suicide in England: Third progress report of the cross government outcomes strategy to save lives. Department for Health and Social Care (2017) Available Suicide prevention: third annual report - GOV.UK (www.gov.uk) Last accessed 20/08/21
[6] Preventing suicide in England: Fourth progress report of the cross government outcomes strategy to save lives. Department for Health and Social Care (2017) Available Preventing suicide in England: fourth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk) Last accessed 20/08/21
[7] Preventing suicide in England: Fifth progress report of the cross government outcomes strategy to save lives. Department for Health and Social Care (2021) Available Suicide prevention in England: fifth progress report - GOV.UK (www.gov.uk) Last accessed 20/08/21
[8] Local Suicide Prevention Planning: A Practical Resource. PHE (2020) Available PHE_LA_Guidance_25_Nov.pdf (publishing.service.gov.uk) Last accessed 18/08/12
[9] National Confidential Inquiry into Suicide and Safety in Mental Health. Annual report: 2021 The University of Manchester (2021). Available NCISH | Annual report 2021: England, Northern Ireland, Scotland and Wales - NCISH (manchester.ac.uk) Last accessed 20/08/21

Impact of COVID-19

The COVID-19 pandemic has exacerbated inequalities in suicide risk and has presented new challenges for different groups of the population[10], therefore monitoring impact and taking early action must be of paramount importance.

The COVID-19 Mental Health and Wellbeing Recovery Action Plan sets out a broad plan covering 2021 to 2022 in response to the mental health impacts of the pandemic, which will form the foundation for future policy development and delivery as knowledge and understanding of the impacts of the pandemic as it grows. Actions and commitments within the plan aim to support people at risk of self-harm or suicide. This includes supporting the population to take action and look after their mental wellbeing, preventing the onset of mental health difficulties and supporting specialist services to continue to expand and transform to meet needs[11].

In 2020, the NCISH Team was particularly concerned with the impact of the COVID-19 pandemic and measures to control transmission, e.g. lockdowns[12]. They published a report comparing the months pre-lockdown (January-March 2020) to post-lockdown (April-August 2020), concluding that there was no evidence of the large national rise in suicide post-lockdown that many feared. Although suicide rates appeared to be higher in 2020 than in 2019, the context was an upward trend noted pre-pandemic, alongside improvements in local data capture. An important caveat to this NCISH finding was that the national team could not rule out higher rates in some local areas or population subgroups, with the possibility of elevated rates for some being masked by suppressed rates for others. The Chair of the National Suicide Prevention Strategy Advisory Group has also recommended particular vigilance regarding data on suicide rates in younger people and in those with previous contact with secondary mental health services. Another caveat is that other data sets indicate an increase in risk factors for suicide – such as poorer mental health and increased economic pressure – linked to COVID-19, and this could lead to increased suicide rates in the longer term.

Recommendation 1a: To continue to monitor the impact of COVID-19 on suicide across the lifecourse through RTSS data and respond to any identified trends.

Recommendation 1b: To continue to monitor the wider trends emerging from the impact of COVID-19 on people's mental health and suicide risk across the lifecourse, and to support the system to take action where required.

[10] One year on: How the coronavirus pandemic has affected wellbeing and suicidality. Samaritans (2021). Available Samaritans_Covid_1YearOn_Report_2021.pdf Last accessed 17/08/21

[11] COVID-19 mental health and wellbeing recovery action plan Our plan to prevent, mitigate and respond to the mental health impacts of the pandemic during 2021 to 2022. HM Government (2021). Available COVID-19 mental health and wellbeing recovery action plan (publishing.service.gov.uk) Last accessed 17/08/21

[12] Suicide in England since the COVID-19 pandemic - early figures from real-time surveillance NCISH (2020) Available display.aspx (manchester.ac.uk) Last accessed 02/09/21

Suicide Rates in England and Wales

The definition of suicide used for National Statistics includes all deaths from intentional self-harm for persons aged 10 years and over and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 or over. Figures are based on the date on which the death was registered rather than the date which the death occurred. All deaths cannot be defined as caused by suicide until certified by a Coroner following an inquest, and so the death cannot be registered as a suicide until the inquest is complete. This can take months or even years, and this delay between death, inquest, and registration will have been further increased during the Covid-19 pandemic.

In July 2018, the standard of proof used by coroners to determine if a death was caused by suicide was lowered. This may in part account for increases in the numbers of deaths recorded as suicides before and after this date, although the impact of this change appears to be relatively minor[13]. Initial findings suggest that the increases in suicide in 2018 appeared to begin prior to the July change indicating a real increase in numbers not attributable to the coding change.

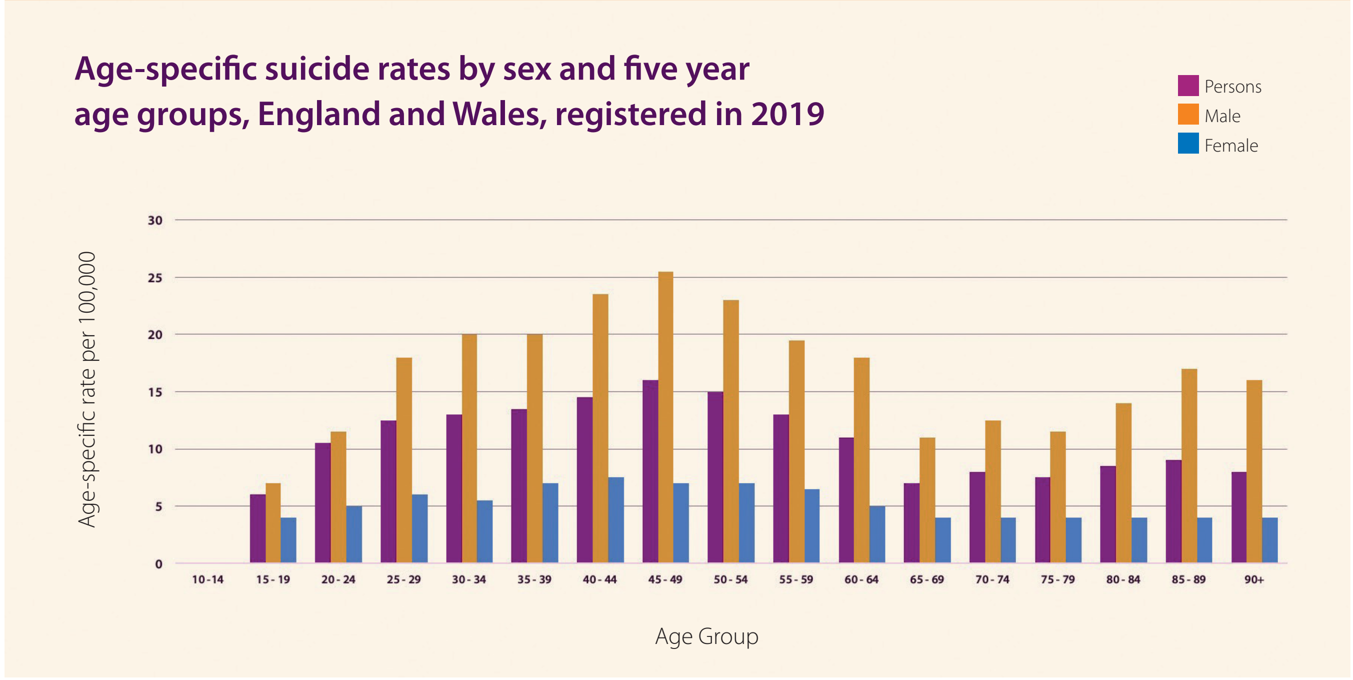
The suicide rate in England and Wales in 2019 was 11 per 100,000. Rates increased from the previous year for both males and females. Males accounted for three-quarters of suicides in England and Wales in 2019 and the male suicide rate in England was the highest seen since 2000. The suicide rate for males in the South East increased significantly to 16.8 per 100,000 from 13.5 per 100,000 in 2018.

Age and Gender England and Wales

Since the early 1980s rates in suicide by age have shown a consistent pattern, peaking among the middle-aged (40-54 years) before decreasing until the ages of 80-84, from which they begin to rise. Male suicide rates have seen a recent increase since 2017 in those aged 10 to 24 years, 25 to 44 years and 45 to 64 years although there has been an overall decrease in suicides since a peak in the late 80's. There was a marked decrease in female suicides between 1981 and the mid 1990's which was mainly driven by a decrease in rates in females aged over 44. Suicide rates in the 10 to 24 and 25 to 44-year-old age group have been historically low and stable. In 2019, the female suicide rate for those aged 10 to 24 years in England and Wales was the highest recorded since 1981. The rate has increased by 93.8% from 1.6 deaths per 100,000 in 1981 to 3.1 deaths per 100,000 in 2019. The rate among females aged 25 to 44 years saw a significant increase from 4.5 to 6.1 deaths per 100,000 between 2016 and 2019.

[13] Change in the standard of proof used by coroners and the impact on suicide death registrations data in England and Wales - Office for National Statistics.

Figure 1: Suicide patterns by age



Source: Office for National Statistics – Suicides in England and Wales 2019

Nationally, the percentage of suicides caused by hanging, strangulation and suffocation has increased in recent years. These account for 62% of suicides among males and 47% of suicides among females. The second most common method of suicide is poisoning, accounting for 16% of male suicides and 33% of female suicides.

Suicide Rates in Berkshire

Table 1 shows the number of deaths in Berkshire local authorities due to suicide over a rolling three-year time period. There was a total of 198 deaths from suicide in Berkshire between 2017 and 2019. This translates to an age-standardised rate of 8.7 per 100,000 population. There has been a non-statistically significant increase in the rate from 2016-18[14].

In 2017-19, rates were highest in Reading and West Berkshire. Wokingham has the lowest rate of suicide. There were 26.8 years of life lost per 100,000 population from suicide across Berkshire on average between 2017-19. West Berkshire has the highest average life years lost at 33 per 100,000 population. However, this is not significantly higher than the South East or England average.

It is important to note that it is difficult to make clear comparisons between areas due to the random fluctuation that can be seen in statistics calculated from small numbers. None of the differences between areas described above or seen in table 1 are statistically significant.

Table 1: Suicides in Berkshire

	Number of deaths			Age-standardised rate per 100,000			Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3-year average)		
	2015-17	2016-18	2017-19	2015-17	2016-18	2017-19	2015-17	2016-18	2017-19
England	**13846**	**14047**	**14788**	**9.6**	**9.6**	**10.1**	**30.8**	**31.3**	**33.0**
South East Region	**2230**	**2194**	**2299**	**9.4**	**9.2**	**9.6**			
Bracknell Forest	32	27	28	10.4	9.1	9.1	28.4	23.6	26.3
Slough	30	38	31	7.7	10.1	8.9	29.8	34.2	25.7
Windsor and Maidenhead	33	33	32	8.5	8.5	8.0	34.3	32.2	25.4
Reading	33	28	38	8.0	7.2	9.9	23.9	18.6	26.2
West Berkshire	35	35	40	8.4	8.5	9.7	26.8	28.8	32.9
Wokingham	35	29	29	8.1	6.7	6.8	22.9	21.4	24.0
Berkshire	**198**	**190**	**198**	**8.5**	**8.3**	**8.7**	**27.7**	**26.5**	**26.8**

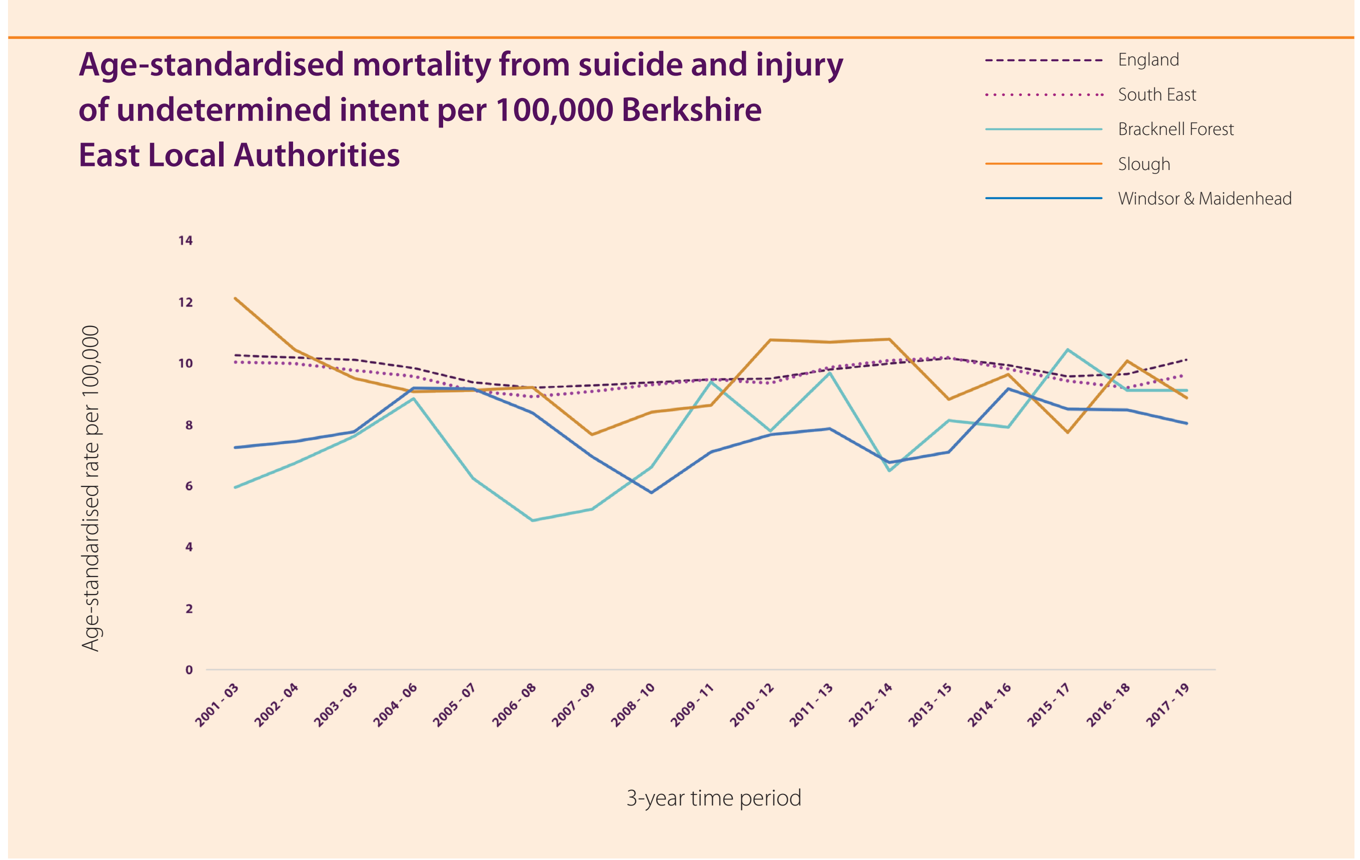
Source: Public Health England Suicide Prevention Profile

[14] ONS, analysed by Public Health

When looking at this data over time, the rates of suicide across Berkshire have remained relatively stable since 2001-03.

Rates in Slough have stayed close to the national and regional averages since 2001-03. Rates in Windsor and Maidenhead decreased significantly below national and regional averages in 2008-10 and 2012-14, but are now in line with the national and regional averages (2017-19). Rates in Bracknell Forest similarly dropped significantly below national and regional averages for the two consultative time periods of 2006-08 and 2007-09 and then again in 2012-14, but again are now in line with the national and regional averages in the time period up to and including 2017-19.

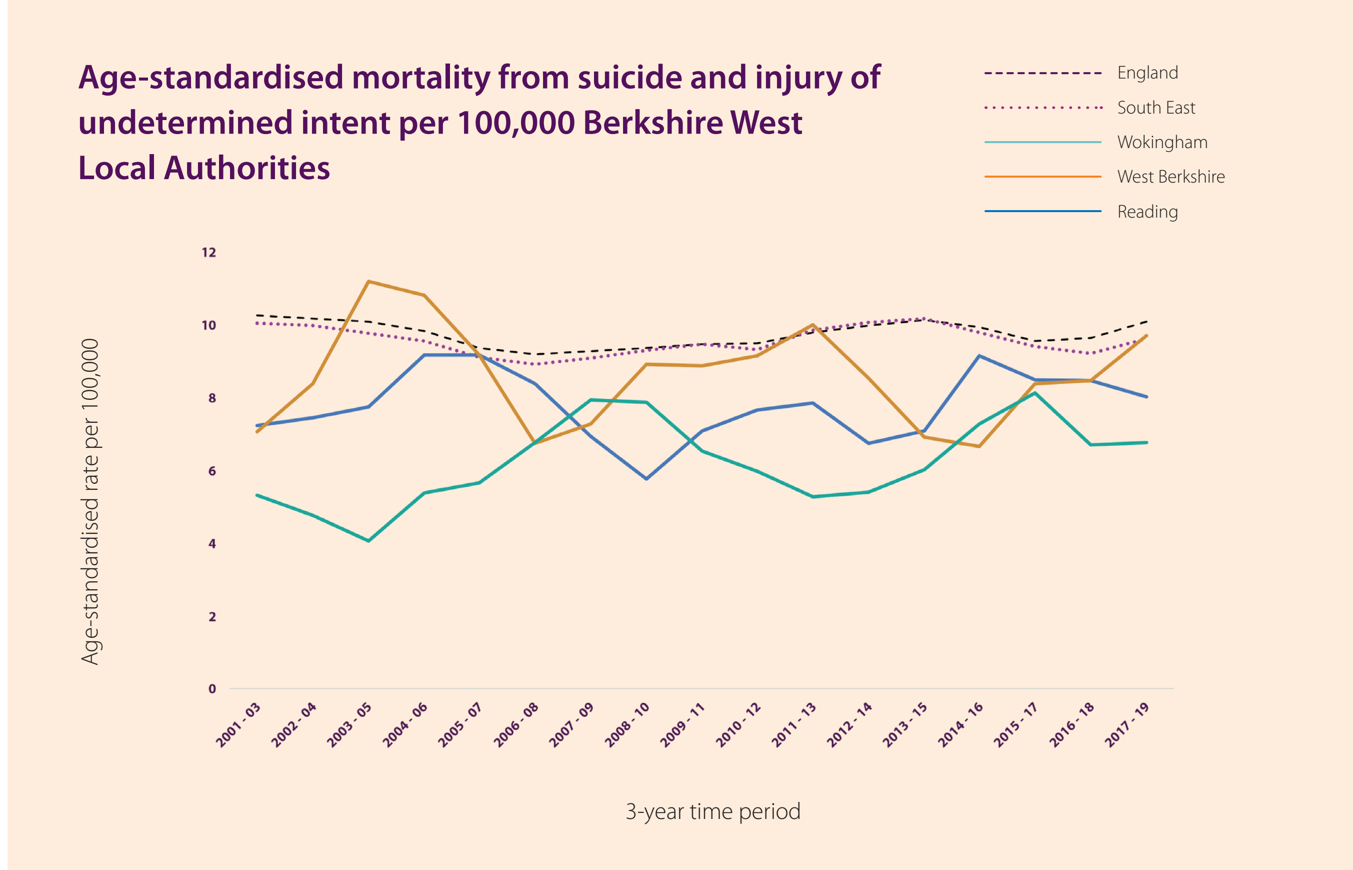
Figure 2: Suicide rates in Berkshire East Local Authorities



Source: Public Health England Suicide Prevention Profile

Rates in Reading have stayed close to the national and regional averages since 2001-03. Rates in West Berkshire dropped significantly below national and regional averages for the two consecutive time periods of 2013-15 and 2014-16, but are back in line with national and regional averages in the time period up to and including 2017-19. Rates in Wokingham are consistently below the regional and national averages, being significantly lower between 2001 and 2007 and again between 2010 and 2015. They remain lower in the time period up to and including 2017-19 although the difference is no longer significant.

Figure 3: Suicide rates in Berkshire West Local Authorities

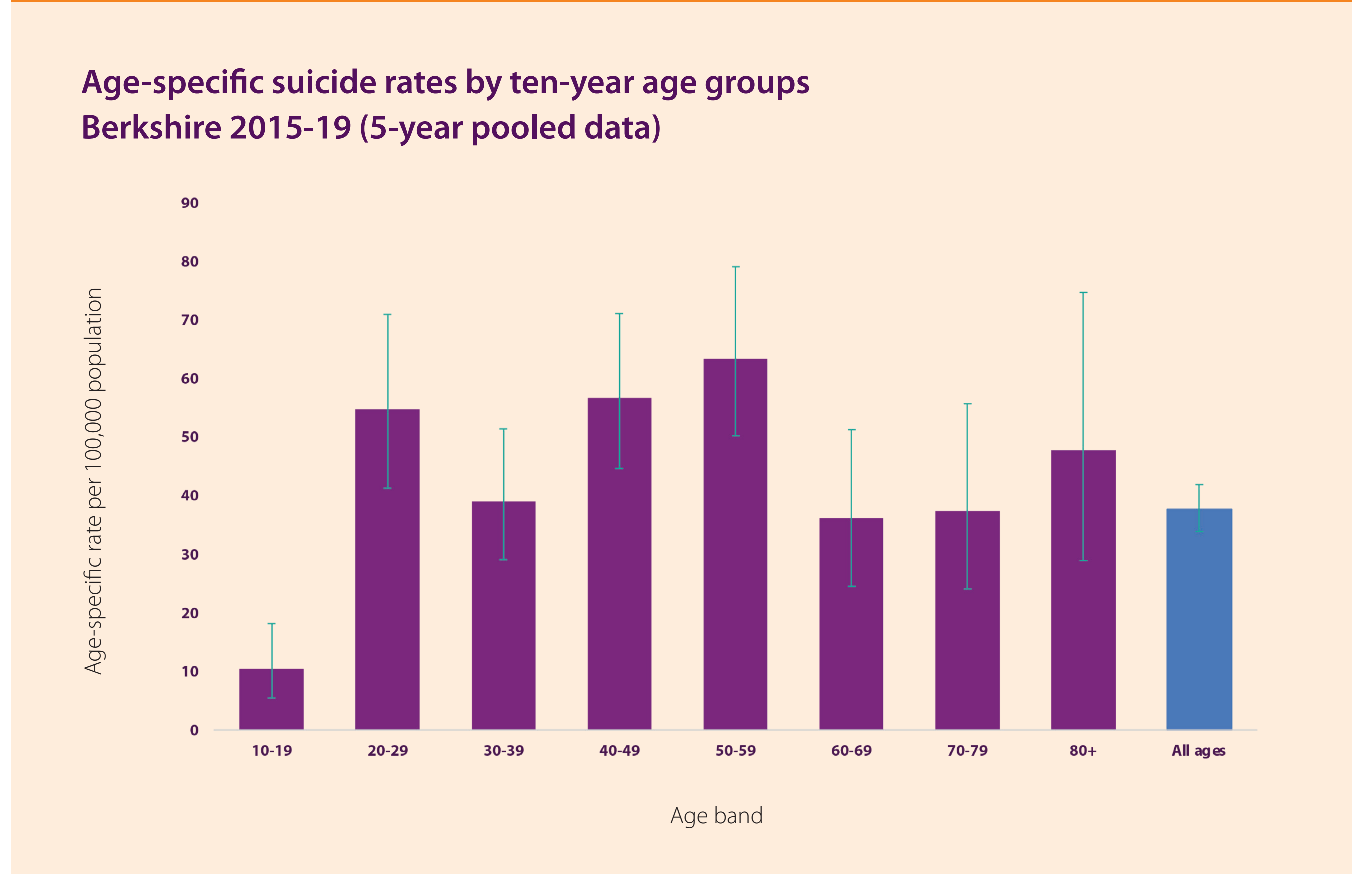


Source: Public Health England Suicide Prevention Profile

Age and Gender Berkshire

Since the 1980s age-specific suicide rates in England have shown a consistent pattern, peaking among the middle-aged (40-54 years) before decreasing until the ages of 80-84, from which they begin to rise. In order to assess age-specific suicide rates in Berkshire, it is necessary to pool together five years' worth of data. This is done to reduce the chance of identifying differences that have occurred at random within the data, which is more likely to happen when numbers are relatively small. It allows identification of statistically significant differences between groups.

Figure 4: Age-specific suicide rates



Source: ONS Civil Registrations Data provided under license by NHS Digital

Age-specific suicide rates in Berkshire generally show a similar pattern to the national picture. They peak in the 50-59-year-old age band before decreasing until the age of 80 plus years. In Berkshire, suicide rates in the 40-49-year-old age group (57 per 100,000) and in the 50-59-year-old age group (63 per 100,000) are significantly higher than the average for all age groups (37 per 100,000). Nationally, suicide rates in males aged 10 to 24 years, and 25 to 44 years have been increasing since 2017. In 2019, the suicide rate among females aged 10 to 24 years in England and Wales is the highest recorded since 1981. In Berkshire, the suicide rate in the 20-29-year-old age group is significantly higher (55 per 100,000) than the average for all age groups.

In England, three quarters of all suicides are male suicides. In Berkshire between 2017 and 2019, the male age-standardised suicide rate was 14.1 per 100,000 which is lower than the rate for England (15.5 per 100,000) and similar to the rate for the South East (14.6 per 100,000). The proportion of suicides that were male suicides for Berkshire local authorities between 2017 and 2019 range from 69% in Windsor and Maidenhead to 90% in Slough. Age-standardised rates for male suicides range from 11.1 per 100,00 in Wokingham and Windsor and Maidenhead, to 16. 6 per 100,000 in Bracknell Forest. Numbers are too small to detect any statistically significant differences between Berkshire local authorities, or between Berkshire local authorities and the regional and national averages but do suggest some variation between areas in both the male suicide rate and the proportional of all suicides that are male suicides.

Table 2: Male suicides

	Male deaths			Male age-standardised rate per 100,000			Proportion of all deaths by suicide that are male deaths		
	2015-17	2016-18	2017-19	2015-17	2016-18	2017-19	2015-17	2016-18	2017-19
England	**10392**	**10592**	**11145**	**14.7**	**14.9**	**15.5**	**75%**	**75%**	**75%**
South East Region	**1643**	**1606**	**1707**	**14.3**	**13.9**	**14.6**	**74%**	**73%**	**74%**
Bracknell Forest	30	24	24	19.7	16.9	16.6	94%	89%	86%
Slough	26	34	28	13.0	17.9	16.0	87%	89%	90%
Windsor and Maidenhead	20	21	22	10.7	11.1	11.1	61%	64%	69%
Reading	27	20	28	13.2	10.4	13.8	82%	71%	74%
West Berkshire	27	28	32	13.5	14.0	15.8	77%	80%	80%
Wokingham	25	19	23	12.0	9.1	11.1	71%	66%	79%
Berkshire	**155**	**146**	**157**	**13.7**	**13.2**	**14.1**	**78%**	**77%**	**79%**

Source: Public Health England Suicide Prevention Profile

The numbers of female suicides at a local authority level are very small. There were 41 female suicides across all Berkshire local authorities between 2017 and 2019. Age-standardised rates can only be calculated for Reading, and Windsor and Maidenhead local authorities for this time period, as these are the only local authorities with 10 or more female suicides. The 2017-19 female suicide rate for Reading is 5.5 per 100,000 and the rate for Windsor and Maidenhead is 5 per 100,000. These figures are both in line with England (4.9 per 100,000) and the South East Region (4.8 per 100,000).

Occupation Group

Office of National Statistics (ONS) death registration statistics categorise a person's occupation using the Standard Occupational Classification (SOC) 2010. The analysis below looks at the Major SOC Group of people who have died from suicide or an injury of undetermined intent who were resident in Berkshire and who died between 2015 and 2019. Anyone aged less than 16 has been excluded. 'Student' is not included in the SOC so this category has been added based on the occupation recorded on the death registration. This resulted in 237 deaths being included in the analysis based on data on deaths registered between 2015 and 2019.

Table 3: Major Occupation Groups

Major Occupation Group	Deaths from suicide and injury of undetermined intent 2015-19	% of all deaths from suicide and injury of undetermined intent	Lower limit	Upper limit
Administrative and Secretarial Occupations	*	*	*	*
Associate Professional Occupations	31	13%	9%	18%
Caring, Leisure and Other Service Occupations	18	8%	5%	12%
Elementary Occupations	**26**	**11%**	**8%**	**16%**
Managers, Directors and Senior Officials	**22**	**9%**	**6%**	**14%**
Process, Plant and Machine Operatives	20	8%	6%	13%
Professional Occupations	30	13%	9%	17%
Sales and Customer Service Occupations	*	*	*	*
Skilled Trades Occupations	61	26%	21%	32%
Student	14	6%	4%	10%
Total Deaths	**237**			

Source: ONS Civil Registrations Data provided under license by NHS Digital

In Berkshire, between 2015 and 2019, a quarter of people dying from suicide had an occupation group of 'Skilled Trades Occupations' (26%).

Seasonal Variation

A count of the number of suicides in Berkshire by the season in which death occurred does not reveal any seasonal variation, ranging from 70 in the Winter to 95 in the Autumn (see Joint Strategic Needs Assessment (JSNA).

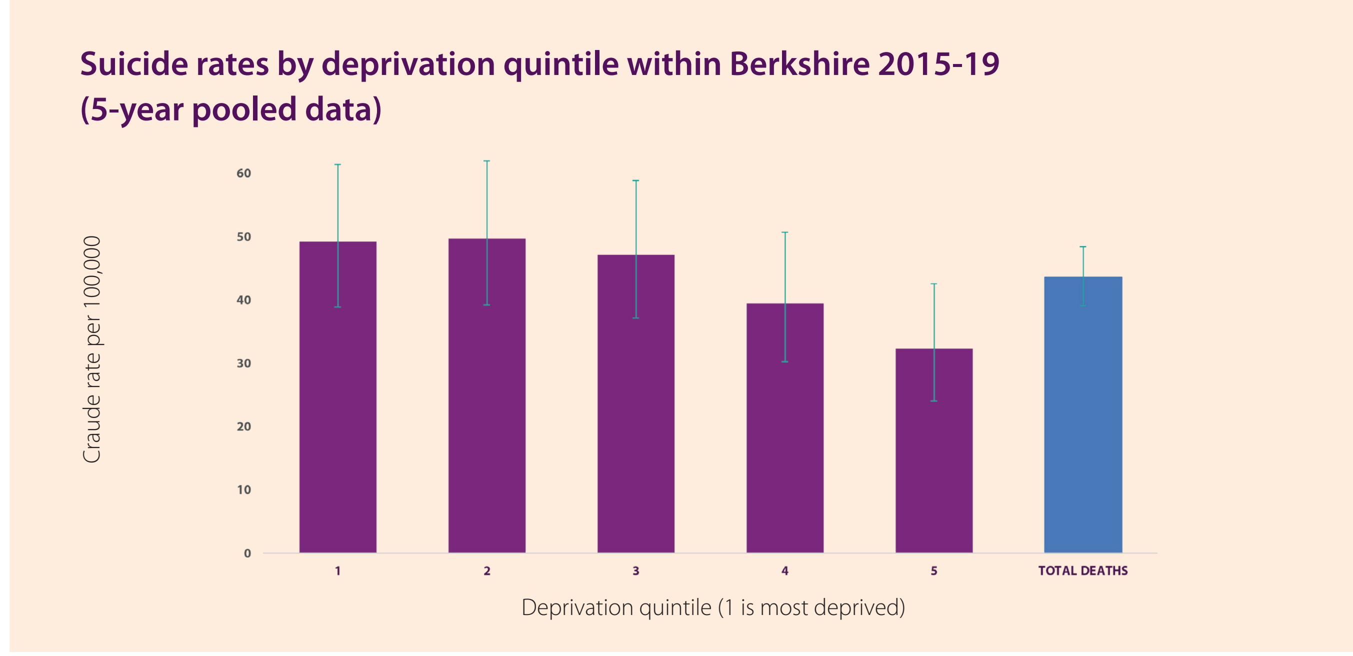
Deprivation

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England. It is an overall measure of deprivation experienced by people living in every Lower Super Output Areas (LSOA), or neighbourhood, in England. All neighbourhoods are ranked according to their level of deprivation and are grouped into 10 equal groups (deciles). These groups describe each area based on which decile of the IMD it falls into. Group 1 being the most deprived 10% and group 10 being the least deprived 10%.

Neighbourhoods in Berkshire are not evenly distributed across these 10 national deciles with neighbourhoods in some Local Authority areas in Berkshire being heavily skewed towards the least deprived deciles. Therefore, to assist in looking at suicide data in Berkshire by deprivation, Berkshire neighbourhoods have been ranked in order of deprivation when compared to all other neighbourhoods in Berkshire. They have been split into 5 equal groups (quintiles) in order to describe each neighbourhood in terms of how deprived it is in relation to all other Berkshire neighbourhoods. Group 1 neighbourhoods are the least deprived in Berkshire, group 5 neighbourhoods are the most deprived in Berkshire.

Suicide rates are lowest amongst people living in the least deprived areas (32 per 100,000 in quintile 5) and higher amongst those living in the more deprived areas (49 per 100,000 in quintiles 1 & 2), although this is not statistically significant.

Figure 5: Suicide rates by deprivation



Source: ONS Civil Registrations Data provided under license by NHS Digital

Real-Time Surveillance System Data

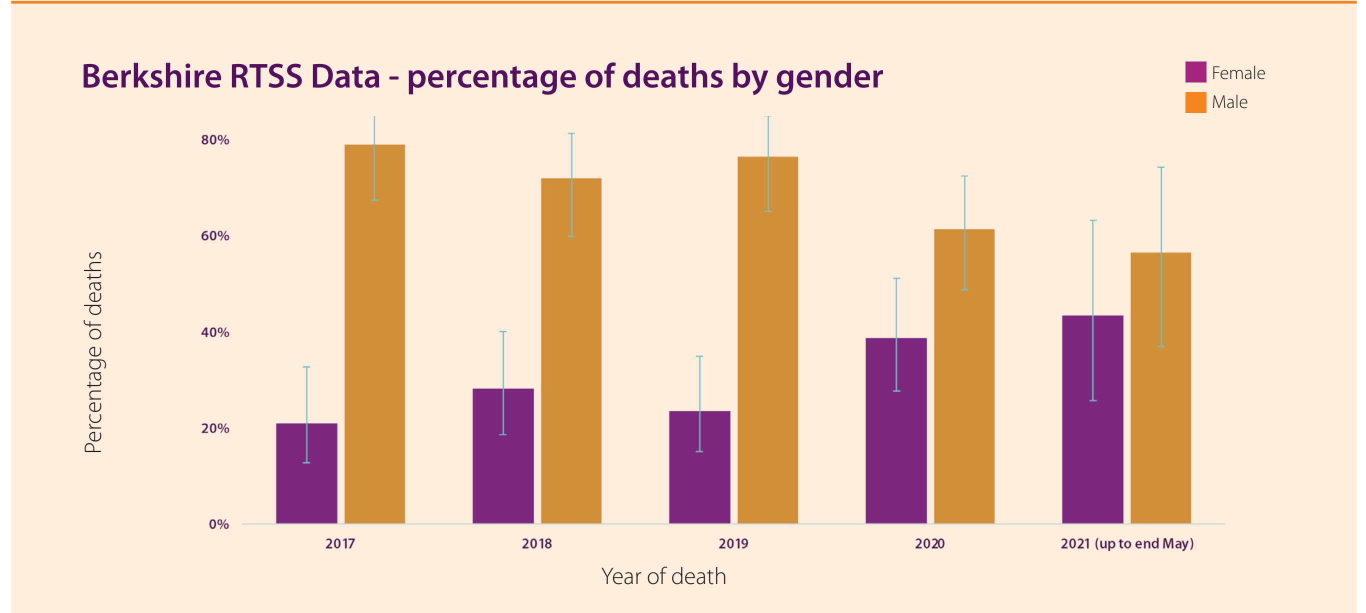
Because of the delay between a death by suicide being counted in the ONS data, Local Real Time Surveillance Systems (RTSSs) have been developed to allow early data capture and sharing of information amongst key partners working on suicide prevention. This means that ahead of a formal verdict, organisations involved in suicide prevention work can review incidents so that trends or patterns can be spotted and acted on quickly, e.g. in terms of enhanced surveillance or additional promotion of support to groups at higher risk.

Details of suspected suicides are usually gathered by a police officer attending the scene of a sudden death, but sometimes by a coroner's officer receiving a sudden death report, or by a member of hospital staff. What information is available regarding an individual's background and circumstances is very much dependent on what relatives or close friends are available to share, and how well informed they may be.

In addition to demographic information such as gender and age, the RTSS in Berkshire captures marital status, occupation, local authority area of residence, GP details, known contact with mental health services, and any other information on circumstances which appears may be relevant to the suicide at the time of compiling the initial report. Since March 2020, any known impacts of the Covid-19 pandemic on the individual are also noted, e.g. reduced access to support, impact of isolation, additional economic or other stresses.

280 suspected suicides were recorded in the Berkshire RTSS between 1st January 2017 and 27th May 2021. Two thirds were male. However, the gender difference in suicides recorded in the RTSS notably reduced in 2020 with 39% of all suspected suicides being female suicides. This can be compared to 21% of all suspected suicides being female suicides in 2017. The gender difference became no longer statistically significant in 2020 and this trend appears to be continuing into the early part of 2021. Suspected suicides amongst females have increased year on year since Berkshire RTSS data began been collected in 2017

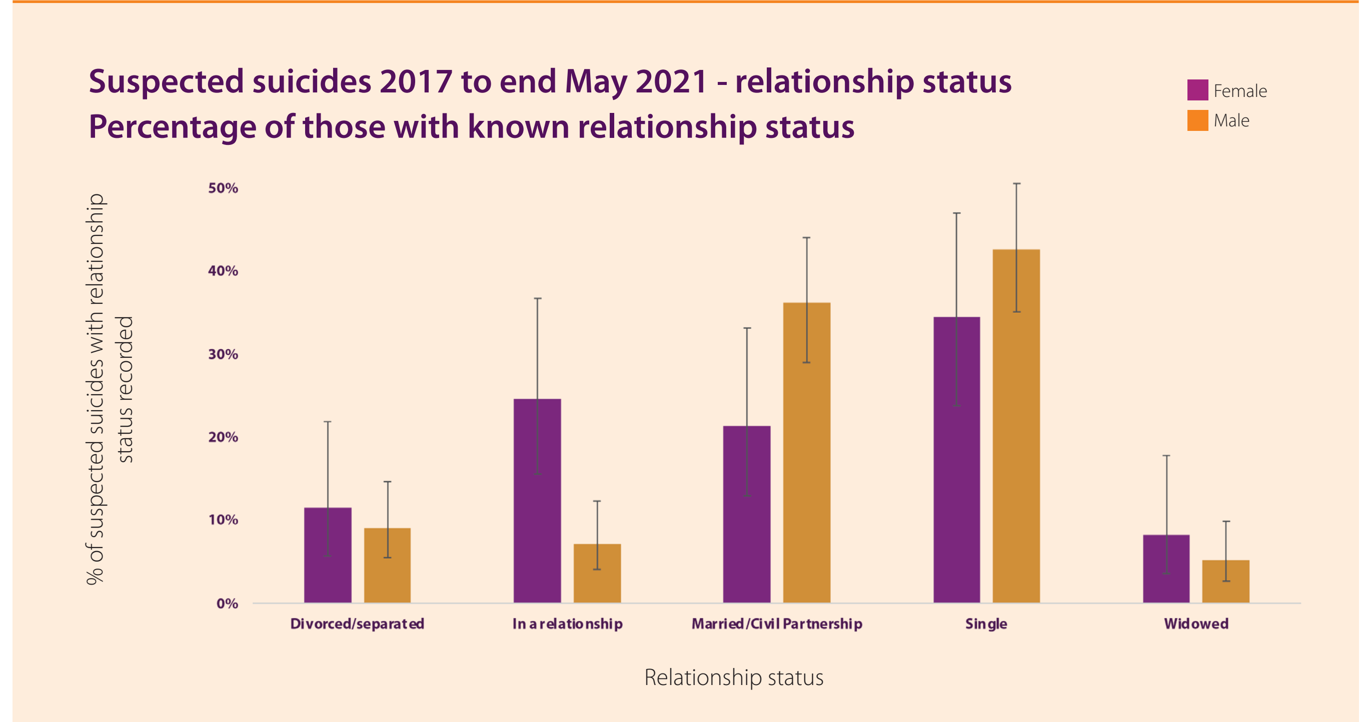
Figure 6: Suspected suicides by gender



Source: Berkshire Real Time Suicide Surveillance Data

Almost 80% of suspected suicides had information detailing relationship status collected via the RTSS. Of those with known relationship status, 40% were single (35% of females and 43% of males). Relationship status varies by gender with females been significantly more likely to be in a relationship (not including marriage and civil partnerships) than males.

Figure 7: Suspected suicides by relationship status and gender



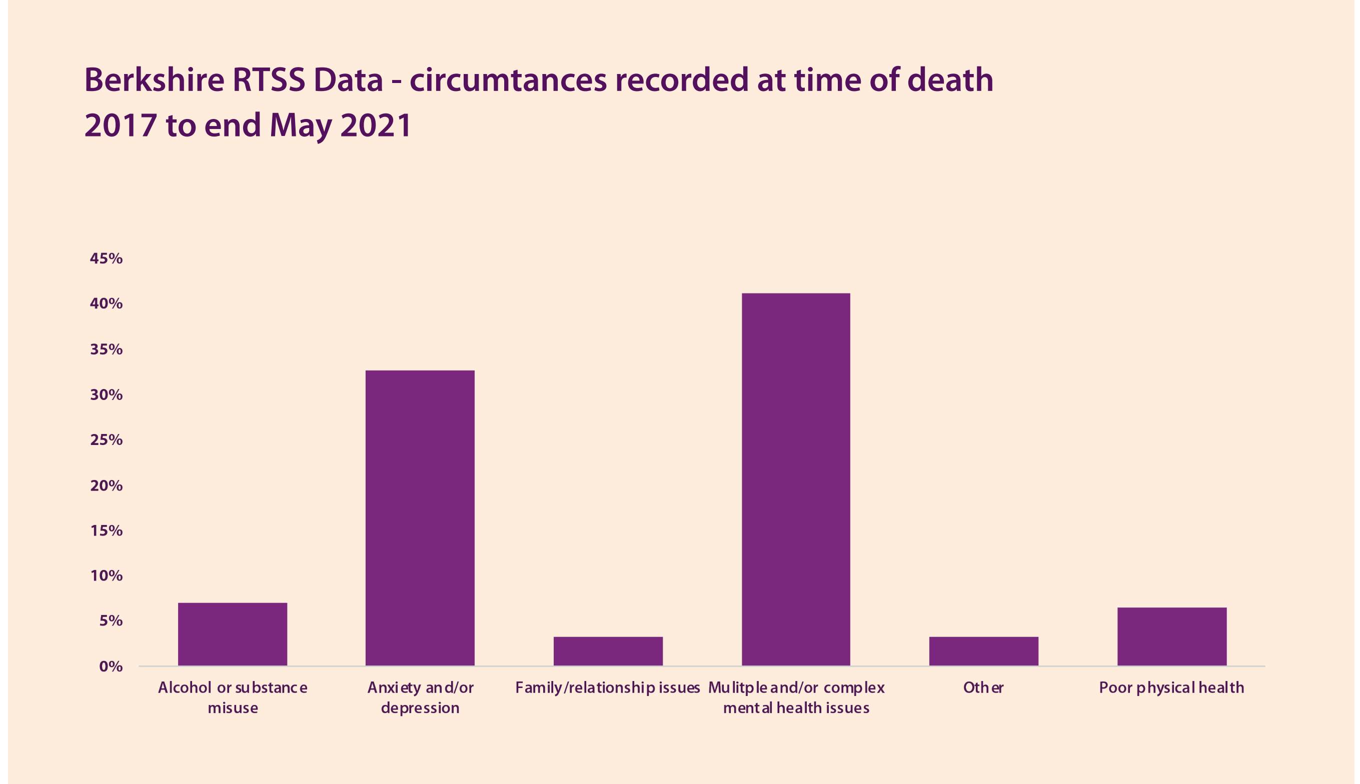
Source: Berkshire Real Time Suicide Surveillance Data

67% of suspected suicides occurred in a person's own home, 20% occurred in a place accessible by the general public and the remainder occurred in a communal establishment or hotel. Analysis of method of suicides indicate a similar pattern to the national picture with hanging, strangulation, and suffocation recorded for 66% of suspected suicides and poisoning recorded for 20% of suspected suicides.

As part of RTSS, information is collected on medical history of the individual including known illnesses, contact with health services, and anything else that may be relevant. There is also a section for describing the circumstances leading up to the death. These are extracted and summarised to provide a description of any individual circumstances that may be relevant to the potential suicide. For the purpose of this strategy, these circumstances have been grouped into 10 categories. This will not be a full and complete picture of the circumstances leading to individual deaths but will be indicative of patterns at a population level that may warrant further investigation.

From the 187 potential suicides where information was provided around the relevant medical history and/or the circumstances leading to death, 41% had multiple or complex mental health issues. A further 33% have a history of anxiety and/or depression. Other reported factors included alcohol or substance misuse in the absence of any other recorded mental health issue (7%) and poor physical health (6%). Previous suicide attempts were mentioned in relation to 22 deaths (12%). Direct links to the Covid-19 pandemic were flagged in 8 suspected suicides.

Figure 8: Suspected suicides by circumstances recorded at time of death



Source: Berkshire Real Time Suicide Surveillance Data (data with underlying numbers of <5 have been suppressed)

It is likely that this data will be skewed towards the more immediately apparent factors with other, indirect contributing factors only coming to light through further investigation into the death. At inquest, for example, additional information is usually reported regarding the circumstances and personal characteristics of the person who died, although there is some variation between coroners' courts and in how much information it is possible to confirm in individual cases.

Berkshire Audits and Deep-dive Analyses

The purpose of suicide audits is to review coroner court reports to gain richer demographic, risk and protective factor intelligences than can be derived from the ONS data sets or from RTSS data. Deep-dive analysis is done where audit or RTSS data indicates concerns that require further investigation.

Berkshire Suicide Audit (2018)

The most recent Berkshire Suicide Audit covered coroner verdicts across the period 1st April 2014 through to 31st March 2018 and included a review of 241 hearings.

- The Berkshire profile broadly matched the national profile in terms of gender.
- Some age variations were noted but not at a statistically significant level.
- No statistically significant difference was found between suicide rates in areas of relative deprivation in Berkshire.
- The majority of people included were either in full-time work (24%), unemployed (20%) or retired (18%).
- 80% of all of those who were employed had a job title recorded and 43% of these worked in a skilled trade.
- 6% of all people included were recorded as being in education at the time of death.

The 2018 Audit highlighted the following personal and social factors as seen on a recurring basis in inquest reports:

- Relationship difficulties (67%)
- One or more mental health diagnosis (63%)
- One or more physical health condition (61%)
- History of self-harm (21%)
- Work-related stress (20%)
- Financial issues (19%)
- Involvement with police or courts (15%)
- Bereavement by suicide (6%)

This information is helpful in identifying risk factors which can help to target local interventions and signposting to support services to work towards preventing deaths by suicide.

The 2018 Audit included a review of which services individuals were known to have been in contact with.

- 10% of all individuals were known to substance misuse services in their lifetime. 20% had a documented history of alcohol misuse and 17% had documented history of drug misuse.
- 51% of those who died and who were registered with a GP had seen their GP within 1 month prior to the date of death (compared to 45% nationally).
- 36% of all deaths occurred to people known to mental health services (compared to 33% nationally), and 31% of individuals had been in contact with mental health services in the 12 months prior to their death (compared to 30% nationally).

This information is particularly useful in identifying which agencies to target for suicide prevention activities such as awareness training for staff, as well as potential locations for signposting material. It should be noted that the 2020-21 deep dive analysis of female suicides (see below) suggests some changes in health support seeking behaviour since this audit was completed.

Recommendation 1c: To undertake a Berkshire suicide audit.

Recommendation 1d: Undertake regular reviews of information, resources and channels for people affected by suicide. This action is applicable to all areas of this strategy.

Berkshire 0-25 Audit (2020)

NHS England has co-ordinated a series of reviews into deaths from suicide by children and young people, including a Berkshire audit of people aged 0-25 who died by suicide in the period 2015-20. This focused work helps to mitigate against the risk of issues particularly pertinent to young people getting overlooked in an all-age approach, within which deaths by younger people are a minority.

For the Berkshire 0-25 Audit, information was drawn from the Child Death Overview Panel (CDOP), Berkshire Healthcare Foundation Trust, Thames Valley Police, and the Coroner's Office. A total sample of 35 young people were included in the analysis. Analysis around ethnicity; and wider experience of adversity, trauma, and socio-economic risk factors were based on the CDOP qualitative sample of 7 young people. Key findings of the audit are highlighted below with an acknowledgement that caution needs to be given when deriving patterns from a relatively small sample size.

- Females were over-represented by comparison with national data (a trend mirrored in the female deep-dive analysis summarised below)
- The Berkshire age profile did not align with the national picture, but indicated local peaks in the 15-19 and mid 20s age ranges
- Young people from black or minority ethnic groups were over-represented by comparison to national data
- Data on faith, gender identity and sexuality were difficult to source
- Adverse childhood experiences (which includes domestic abuse, parental separation, involvement with criminal justice, poverty within this audit) – were noted in 71% of cases
- Neurodiversity was an identified risk factor
- Postvention support for young people following a suicide attempt was indicated as an area for development.

Berkshire female deaths deep-dive analysis (2021)

RTSS data had highlighted an increase in the proportion of all suicides which are female suicides from 21% in 2017 to 39% in 2020. Female suicides have shown a small but steady increase from 13 in 2017 to 24 in 2020. Whereas male suicides have not followed this increasing pattern but have overall decreased from 49 in 2017 to 38 in 2020. There is a continuing unusual pattern in the numbers of females dying by suicide in Berkshire, by comparison with previous years and by comparison with patterns in the RTSS data for other parts of the Thames Valley.

The Berkshire Suicide Prevention Group agreed in 2020 that the number of female suspected suicides in Berkshire was sufficiently unusual to convene a response group to look at cases in more depth. A sub-group was therefore formed to carry out a deep-dive review.

This deep-dive was based on RTSS data and further supplemented by further enquiries of GP practices, secondary mental health care (particularly Serious Incident Review findings), and of bereaved families where appropriate and possible, without re-traumatising. Further information from families was also gathered via contact with Berkshire's specialist postvention service, where families elected to take up this service. Information was obtained from GP records for 80% of the women whose deaths were considered as part of this analysis. In most cases, however, little information was available from primary care sources to supplement what was already captured within the RTSS. Several GPs volunteered that the patient had not been seen by the practice for some time prior to death. Given the findings from the 2018 Berkshire audit that around half of the people included in that review had seen their GP within a month of their death, this may indicate a change in health supporting seeking behaviour during the COVID-19 pandemic, a pattern which has been observed from other surveys over this period.

Across the period January 2020 to May 2021, female deaths were highest in Slough and Reading of the six Berkshire unitary areas, accounting for 26% and 37% of all female deaths respectively. Up until the age of 60, there is an increasing trend in the number of suicides by age. When considering 10-year age bands, deaths are highest in the 40-49 and 50-59 year-old age groups, with these two groups accounting for 49% of deaths by suicide in females.

Although the numbers are too small to identify statistically significant themes, several issues were identified for more than one of the women who died:

a. A mental ill-health diagnosis and /or history of contact with mental health services (found to be the case for all women where it proved possible to obtain further information from GP records)
b. Adverse Childhood Experiences - most often related to sexual abuse, but also loss of or separation from parents
c. History of self-harm
d. History of alcohol or substance abuse
e. Parenting / carer stress
f. Financial stress
g. Domestic abuse
h. Workplace stresses and adjustment challenges, particularly for those in a health, care or other frontline role (including childcare and police)
i. Neurodiversity
j. Bereavement and grief
k. History of disordered eating
l. Denial of suicidal intent at the time of last contact with services

Although clear and direct links to the impact of COVID-19 appear in only a small number of the cases considered so far, there may be other and more subtle links, such as have come to light where it has proved possible to have further discussion with bereaved relatives. As the pandemic and associated control measures have disrupted access to services for many people, this makes it more difficult to gather information about people's circumstances just prior to death, e.g. via enquiries of primary care. The impact of COVID-19 remains an issue to consider.

Local development of this strategy

Our previous Berkshire Suicide Prevention Strategy 2017-2020 mirrors the national 2012 strategy, and so remains current as there has been no national update. This strategy is therefore a refresh of the previous strategy, using local data and intelligence to prioritise our efforts across Berkshire to reduce suicide risk.

Methodology

This strategy has been developed with the view that it builds on and takes forward the information, knowledge and action that is covered in the Berkshire Suicide Prevention Strategy 2017-2020. In this sense, it is a refreshed strategy that benefits from utilising the expertise of members of the long-established Berkshire Suicide Prevention Steering Group that has been in place for over five years.

Whilst there has been no formal public consultation, as was done previously, this strategy has a local focus and contains the perspectives from professionals working in the statutory, private and third sector organisations. Colleagues who support people who have been directly affected by suicide have also been involved, who have worked with sensitivity to engage this group with this strategy. The strategy reflects the commitments of the Berkshire Suicide Prevention Steering Group who worked together on identifying the key priorities, which have been derived from reviewing local data, intelligence, and information.

A small subgroup of the Berkshire Suicide Prevention Steering Group was responsible for further defining the content for each of the priorities and providing regular updates to and receiving feedback, from the main steering group.

Principles

This strategy is a refresh of our previous strategy, in that our priorities last time, and the priorities of the national strategy, are now our guiding principles to how we work to prevent suicide across Berkshire. The 7 guiding principles for this strategy are;

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Reduce rates of self-harm as a key indicator of suicide risk

Vision

The suicide prevention group have acknowledged that there is a need for a more personalised strategic direction in how we prevent suicide locally, and that we need to consider risk factors across the whole lifecourse to truly prevent suicide.

Vision: To reduce deaths by suicide in Berkshire across the lifecourse and ensure better knowledge and action around self-harm.

Priority areas for action

Rather than the 6 action plans from the last strategy across each local authority, there has been an agreement to agree common priorities for action across Berkshire.

Based on the local data, and what is happening locally, we have agreed to focus on 5 core priority areas. These principally address the national priority to tailor approaches to improve mental health in specific groups, but we remain committed to all our principles and reducing suicide rates across all population groups. Our local intelligence has demonstrated a need to focus on the following key areas;

1. Children and Young People
2. Self-harm
3. Female suicide deaths
4. Economic factors
5. People bereaved or affected by suicide

Whilst these are our agreed strategic priorities across Berkshire, there will remain a need to monitor trends and risk factors, particularly from the impacts of COVID-19 and to respond to latest changes.

Governance

Our suicide prevention steering group is a well engaged group of stakeholders across the Berkshire system, including public health colleagues across the 6 local authorities, Clinical Commissioning Group (CCG) colleagues across the 2 CCG areas, representation from those bereaved suicide, and the voluntary sector. This group has worked to the evidence base and has responded flexibly to meet the changing patterns in deaths by suicide to prevent suicide.
Leads will be identified for each priority area, and working groups established to take these recommendations forward. The suicide prevention group will continue to have overall responsibility of the delivery of the recommendations set out in this strategy.

Recommendation 1e: Hold an annual multi-agency conference on a range of topics to share information and best practice and raise awareness to the risks for suicide.

Recommendation1f: Invite additional partners across the System within Berkshire, including the voluntary and community sector to join the Berkshire Suicide Prevention Steering Group for improved cross-topic working.

Recommendation1g: Set up sub-groups of the Berkshire Suicide Prevention Steering Group, informed by local intelligence and data, where there is a need to focus upon a risk factor or group within the population.

Priority Area 1: Children and young people

The UK has a relatively low rate of suicide by children and young people compared to other countries, however suicide is one of the leading causes of death in children and young people in the UK[15]. There has been growing concern over the rising rates of suicide and self-harm in children and young people[16]. Childline has reported that the number of referrals their counsellors have made to external agencies due to suicidal concerns has seen a steep increase since 2009/10 to 2018/19, from 283 to 3,518 referrals[17].

The Royal College of Paediatricians and Child Health's 2020 report into the State of Child Health notes that suicide in children and young people may be associated with many factors, including poor mental health; self-harm; academic pressures or worries; bullying; social isolation; family environment and bereavement; relationship problems; substance misuse; or neglect. Adverse childhood experiences, stressors in early life and recent events also contribute to the risk. Suicide represents the extreme end point of mental ill-health in children and young people, there are many more that experience suicidal ideation, attempt suicide and an even higher number self-harming. Although most children and young people who self-harm may not take their own life, it is a strong risk factor for suicide in the future[18]. A retrospective study found that for every suicide death in the age range of 12 – 17 year olds, it is estimated that there are 100 and 1000 times more hospital attendances for self-harm for males and females respectively[19]. This is discussed in more detail within the self-harm chapter of this strategy.

Good mental health and emotional wellbeing in children and young people can help build resilience, and in turn become a protective factor against suicide. The NHS five-year forward view recognises that children and young people are a priority group for mental health promotion and prevention. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care[20].

The NCISH 2017 report on suicide by children and young people highlighted themes that should be specifically targeted for prevention[21];

- Support and management of family factors like mental illness or substance misuse
- Childhood abuse
- Bullying
- Physical health
- Mental ill health
- Alcohol or drug misuse

[15] Royal College of Paediatrics and Child Health (2020) State of Child Health. London: RCPCH. Available at: stateofchildhealth.rcpch.ac.uk Last accessed 10/08/21
[16] Samaritans (2019) Suicide Statistics Report – Latest statistics from the UK and Northern Ireland. Surrey: Samaritans. Available at SamaritansSuicideStatsReport_2019_Full_report.pdf Last accessed 10/08/21
[17] Royal College of Paediatrics and Child Health (2020) State of Child Health. London: RCPCH. Available at: stateofchildhealth.rcpch.ac.uk Last accessed 10/08/21
[18] Bould H, Mars B, Moran P, Biddle L, Gunnell D. Rising suicide rates among adolescents in England and Wales. Lancet 2019; 394: 116–7
[19] Geulayov G, Casey D, McDonald KC, et al. Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study. The lancet Psychiatry 2018; 5: 167–74
[20] NHS Five Year Forward View. NHS (2014). Available Five Year Forward View (england.nhs.uk) Last accessed 02/09/21
[21] NCISH Suicide in Children and Young People. NCISH (2017) Available NCISH | Suicide by children and young people in England - NCISH (manchester.ac.uk) Last accessed 12/08/21

Groups highlighted to be at increased risk of death from suicide included young people who are bereaved, students, looked after children, young people who identify as LGBT. Previous self-harm was a crucial indicator of risk with around half of young people who had died by suicide having previously self-harmed.

Within Berkshire, children and young people's mental health and wellbeing is a strategic priority across the system. It is therefore important that this strategy and the work of the suicide prevention group collaborates with the system to ensure complementary action. This includes the Berkshire West Health and Wellbeing Strategy for Reading, West Berkshire and Wokingham for which priority 4 is to 'Promote good mental health and wellbeing for all children and young people'. Each of the three local authorities in the East (Bracknell Forest, Slough, and Windsor and Maidenhead) also have a strategy addressing children and young people and/or mental health as a priority for their areas.

CCGs with system wide partners refresh their Children and Young People's Mental Health and Wellbeing Local Transformation Plans (CYP MH&WB LTP) and LTP's cover investment within prevention, postvention and bereavement support for children and young people.

Key data relevant for the work of this strategy are presented under each priority area for action. A full list of local data around the risk factors in childhood and adolescent are presented in the suicide data deep-dive analysis JSNA.

Five areas for action have been identified for Berkshire based on local data and intelligence;

- Experience of adversity or trauma
- The impact of COVID-19
- Neurodiversity
- Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Ace (LGBTQ+)
- Transitions

Experience of adversity or trauma

The 0-25 suicide audit (2020) identified that adverse childhood experiences (ACE's) were present in 71% of the cases (CDOP sample of 7 young people). In addition, the female suicide deaths deep-dive analysis (2021) found that ACE's were a theme common to more than one of the women who died. There is no universally agreed definition of ACE's, but studies addressing issues have converged on the list below, as outline by the Early Intervention Foundation[22]:

- physical abuse
- sexual abuse
- psychological abuse
- physical neglect

[22] Adverse childhood experiences What we know, what we don't know, and what should happen next. Early Intervention Foundation (2020). Available: adverse-childhood-experiences-summary (1).pdf. Last accessed 02/09/21

- psychological neglect
- witnessing domestic abuse
- having a close family member who misused drugs or alcohol
- having a close family member with mental health problems
- having a close family member who served time in prison
- parental separation or divorce on account of relationship breakdown.

ACE's occur before the age of 18, however the effects are often experienced over the lifecourse. A toxic stress response can be triggered by these experiences in the acute phase. Adversities can affect development in numerous ways, with early exposures that are persistent over time more likely to lead to lasting impacts[25]. There is strong empirical evidence that links ACE's with suicide across the lifecourse[23 24].

Although there isn't data available specific to ACE's on a localised level, data relating to the numbers of Children in Need give an indication of the numbers of children experiencing trauma and adversity across Berkshire. On the 31st March 2020, nearly 7,000 children were identified as being in need across Berkshire, as shown in the table below. The most common primary need, accounting for over half of cases, was abuse or neglect. This was followed by family dysfunction and family being in acute stress which, combined, accounted for over 1,440 cases[25].

Table 4: Children in need by primary need at initial assessment, Berkshire 2020

Local authority	All cases	Abuse or neglect	Child disability or illness	Parents disability or illness	Family in acute stress	Family dysfunction	Socially unacceptable behaviour	Low income	Absent parenting
Bracknell Forest	879	486	72	49	65	104	47	0	10
Reading	1451	713	111	68	225	131	44	c	c
Slough	1589	1190	129	54	29	65	68	10	29
West Berkshire	930	397	100	12	136	198	38	0	49
Windsor and Maidenhead	883	421	73	21	128	194	13	0	33
Wokingham	1039	519	96	52	124	49	c	0	35
Berkshire Total	**6771**	**3726**	**581**	**256**	**707**	**741**	**210**	**10**	**156**

Source: Department for Education

[23] Adversity in childhood is linked to mental and physical health throughout life BMJ 2020; 371 doi: https://doi.org/10.1136/bmj.m3048 (Published 28 October 2020)
[24] Ports KA, Merrick MT, Stone DM, et al. Adverse Childhood Experiences and Suicide Risk: Toward Comprehensive Prevention. Am J Prev Med. 2017;53(3):400-403. doi:10.1016/j.amepre.2017.03.015
[25] NHS Digital calculated using ONS mid-2020 population estimates

Many children and young people who have experienced ACE's go on to lead healthy and productive lives. Protective factors, such as having a stable and caring child-adult relationship and feeling connected with others can build resilience. An enhancement of these factors has been shown to mitigate negative outcomes[26]. Across Berkshire there are a wealth of services and interventions in place to prevent and mitigate the impact and reduce harm for children and young people who are at risk of or have experienced trauma and adversity. This work is happening across schools, police, NHS and voluntary sector organisations. Our role is therefore to complement this workstream and highlight the link between ACEs and suicide risk.

Recommendation 2a: To raise awareness of the link between trauma and adversity, and suicide across the lifecourse.

Recovery from the COVID-19 Pandemic

The impact of the COVID-19 pandemic and subsequent lockdowns has raised concerns that children and young people's mental health will be adversely affected and will need to be closely monitored[27]. It has been noted that outbreaks of suicidal thoughts have increased during lockdown, especially among young adults[28]. Additional stressors during the pandemic may include fears that a family member or oneself will develop COVID-19, the impact of bereavement, isolation, loneliness and loss of social supports, disruptions to care and support and fears about accessing it, school closure and exam disruption, and exposure to domestic violence and family tensions[29]. Many of these stressors are documented risk factors for suicide in children and young people and have potentially increased the risk of children experiencing ACE's, therefore the impact must be monitored.

A COVID-19 flag has recently been introduced for RTSS data locally for Berkshire. Since this has been introduced, no suicide cases have been flagged within the cohort of 0-25 as related to COVID-19, however there is a need to continue to record and monitor this.

In response to the impact of the pandemic and concerns around mental and emotional wellbeing of children and young people, all Berkshire local authorities have committed to a mental wellbeing campaign "Be Well: Berkshire Emotional Wellbeing". The campaign aims to mobilise younger residents and women at risk of suicide across Berkshire to access support services, to help them stay mentally well during the Covid-19 pandemic and as we recover. Mental health support is also offered through Kooth, an online counselling and emotional wellbeing platform. Within Berkshire, the top presenting concerns in the year 2020/21 have been anxiety and stress, suicidal thoughts and self-harm. There is a need to both ensure increased access to support as we recover from COVID-19 and ensure we link with the wider system to prevent suicide risk.

Recommendation 2b: Continued investment into the Be Well campaign to encourage the importance of looking

[26] The evidence behind Adverse Childhood Experiences. Available: Evidence-based early years intervention - Science and Technology Committee - House of Commons (parliament.uk) Last accessed 10/08/21
[27] BMA. The impact of COVID-19 on mental health in England; Supporting 1 services to go beyond parity of esteem. 2020 Available [bma-the-impact-of-covid-19-on-mental-health-in-england.pdf] Last accessed 10/08/21
[28] Covid-19: Suicidal thoughts increased in young adults during lockdown, UK study finds BMJ 2020Available at]Covid-19: Suicidal thoughts increased in young adults during lockdown, UK study finds | The BMJ Last accessed 02/09/21
[29] Holmes EA, O'Connor RC, Perry VH, et al. Multidisciplinary research priorities for the COVID19 pandemic: a call for action for mental health science. The Lancet Psychiatry 2020; 7: 547– 60

after emotional wellbeing, in addition to signposting to local mental health services and support in order to prevent self-harm and suicide in children, young people, and women.

Neurodiversity

Neurodiversity was identified as a risk factor for suicide in the 0-25 suicide audit (2020), with further qualitative analysis recommended of the impact of waiting for an autism assessment on children and young people's mental health and suicide risk. Neurodiversity refers to the different ways the brain works and interprets information. It is often used as an umbrella term for a spectrum of conditions such as autism, attention deficit hyperactivity disorder (ADHD), dyslexia, dyspraxia, tourette syndrome and complex tic disorders. It is estimated that 1 in 7 people (approximately 15% of the UK population) are neurodiverse[30].

It is well documented throughout literature that neurodiverse conditions can increase the risk of suicide, for both adults and children and young people. NICE guidance recognises that people with autism are at higher risk of suicide[31]. Research also shows that late diagnosed adults appear to be at the highest risk of suicidal thoughts and behaviours, demonstrating the importance of identification and addressing needs at the earliest opportunity[32].

Data on the number of children and young people with a statement of special educational needs (SEN) or education, health and care (EHC) plan for 2020/21 by primary need for pupils enrolled in schools and nurseries in Berkshire[33] gives an indication of the number of children that are neurodiverse. The most consistent pattern to emerge is for children with a primary need of Autistic Spectrum Disorder, with the majority of local authorities having higher rates of children with SEN support and or/statements/EHC plans with this as their primary needs than the regional average. The full local data on SEN and EHC plans can be found in the JSNA.

There are a number of neurodiversity projects taking place within Berkshire. This includes a service redesign for East Berkshire Healthcare Children and Young People autism and/or ADHD services with a core focus to reduce waiting times for assessments and thus access to support. In Berkshire West all referrals are triaged at the BHFT CAMHs Common Point of Entry and referred to services as appropriate. Across Berkshire we have a wraparound offer of support with the provision of pre-assessment and post-diagnosis support; in the East through GEMS and in the West this is through Autism Berkshire, a voluntary sector organisation. There also exists a virtual Helpline, "SHaRON" that provides support for parents and carers of neurodiverse children and young people in Berkshire.

A needs-led rather than diagnosis led approach has been adopted throughout Berkshire, which means that families without diagnosis are also supported. This approach to neurodiversity allows for pre-diagnostic support to be put in place for children and young people once needs become apparent, through interventions such as changing environments to be more neurodiversity friendly and accessing peer networks. This support potentially reduces the risk of suicide for neurodiverse children and young people as interventions can be put in place as soon as needs are apparent and can reduce isolation experienced.

[30] Autism and.. Oxford Health (2021). Available Autism and.. - Oxford Health NHS Foundation Trust. Last accessed 26/08/21
[31] NICE (2018). NICE guidance on preventing suicide in community and custodial settings [NG105]. National Institute for Health and Care Excellence. Available: https://www.nice.org.uk/guidance/ng105. Last accessed 04/08/21
[32] Supporting autistic children and young people through crises: Autistica. Available: https://www.autistica.org.uk/downloads/files/Crisis-resource-2020.pdf Last accessed 17/08/21
[33] Figures are for state-funded nursery, primary, secondary and special schools, non-maintained special schools and pupil referral units. They do not include independent schools

Recommendation 2c: Support the system to adopt a needs-led approach for neurodiverse children and young people, particularly in the prevention and early intervention arena, e.g. in schools and the community.

Lesbian, gay, bisexual, transgender, queer, questioning and ace (LGBTQ+)

Data on the LGBTQ+ community at a local level is very limited and there is a reliance on national survey data to understand the needs of this group. Experimental statistics were published in May 2021 by the ONS looking at sexual orientation in the UK in 2019 using data from the Annual Population Survey. Younger people (aged 16 to 24 were most likely to identify as lesbian, gay or bisexual (6.6% of all 16 to 24-year olds). Facts and figures presented by Stonewall, a UK based LGBTQ+ charity include the following findings which are particularly relevant to the topic of suicide in young LGBTQ+ people:

- Half of LGBTQ+ people said that they've experience depression in the last year
- 2/3 bisexual women and just over half of bisexual men having experienced anxiety
- Nearly half of LGBTQ+ pupils are bullied for being LGBTQ+ in Britain's schools
- More than 4/5 transexual young people have self-harmed
- 3/5 lesbian, bisexual, and gay young people who are not transexual have self-harmed
- More than 2/5 transexual young people have attempted to take their own life
- 1/5 gay, lesbian and bisexual young people who are not transexual have attempted to take their own life.

The lack of local level data and intelligence surrounding the needs of LGBTQ+ children and young people makes this group a priority for action, to better understand their needs, and reduce suicide risk.

Recommendation 2d: To improve data capture on sexual orientation for all ages in RTSS data and promote this across the suicide prevention system.

Recommendation 2e: To work with local organisations and charities who work with the LGTBQ+ community on suicide prevention.

Transitioning from childhood to adulthood

A key transitional period in the life course is when we transition from childhood to adulthood (aged 16-25). This period is often characterised by changes and adjustments as young people are often expected to make key life changing decisions as they move into higher and further education, employment and their living situations. This may also be a time of new challenges, particularly around increasing independence and responsibility, and developing self-esteem.

During this period, young people may also transition with regards to their mental health treatment, from children's mental health services to adult mental health services. Consequently, this can mean changes to treatment, support workers and where they access services[37, 38]. This can also increase the likelihood of young people not attending and

disengaging from services. There is therefore an increase of worsening mental health, and thus increased suicide risk during this period. It is therefore of importance that this transition is managed carefully and effectively so that the correct support and service is accessed and engaged with at the correct time.

University and work all present children and young people with new opportunities and challenges. For children and young people that face added risk factors at an individual level, such as those who have experienced trauma, or have special educational needs, they can be particularly vulnerable to experiencing a challenging transition[34]. A successful transition can help build resilience, self-confidence and self-esteem[35] which in turn can act as protective factors for mental ill health and suicide risk.

Locally, The University of Reading can be used as an example to demonstrate these complexities. . The University's student services run a variety of programmes to aid the transition for students. However, the university reports that the change from a home environment to campus life is sometimes a difficult transition, and is consequently a top reported student concern. Moving from one locality to another means a loss of support systems and friends, and can result in isolation.

There are additional complexities around transitioning medical care, if a student has existing difficulties, to a new locality and being able to access assessments for neurodiversity, where diagnosis was not arranged before arrival, in order to access the correct level of support.

Recommendation 2f: To raise awareness of the impact of the transitional period (children moving into adulthood) on the mental health impact and the risks of suicide during this period for children and young people.

Recommendation 2g: To link with the work across the BOB and Frimley ICS on the ease of access to shared care records across system partners for transition population (children moving into adulthood).

Recommendation 2h: To support higher education establishments within Berkshire, including universities to adopt a needs-led approach to neurodiversity.

[34] Bilsen J. Suicide and Youth: Risk Factors. Front Psychiatry. 2018;9:540. Published 2018 Oct 30. doi:10.3389/fpsyt.2018.00540
[35] Improving transition from children to adult mental health services Learning, messages and reflections from the LGA conference. Available at: https://www.local.gov.uk/sites/default/files/documents/39.2%20Improving%20transition%20from%20children%20to%20adult%20mental%20health%20services%20WEB.pdf. Last accessed 09/08/21

Priority area 2: Self-harm

Self-harm has been identified as a key priority and it's an area that the Berkshire Suicide Prevention Steering Group have wanted to explore for a while, due to the high rates in some areas. Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. It is often difficult to say whether the self-harm act is suicidal as a person's reasons and intentions when self-harming can change over time. According to the Samaritans, self-harm is often not suicidal but is a risk factor for later suicidality and young people who self-harm are more likely than others to die from suicide[36]. Self-harm covers a wide range of behaviours that can cause injury or harm in some way, including isolated and repeated events. These can include[37];

- cutting with sharp or blunt instruments (e.g. razor blades, broken glass, plastic utensils)
- taking excessive amounts of over the counter medicines or prescribed drugs
- poisoning or ingesting
- scratching (with fingernails or other objects)
- banging, hitting or punching themselves to break bones and bruise themselves
- hair pulling,
- causing bruises to the body,
- interfering with wound healing,
- sticking sharp objects into the body
- inhaling substances (e.g. glue, aerosols, lighter fuel etc)
- swallowing inappropriate objects (e.g. razor blades)
- burning or scalding with hot water.

Every episode of self-harm is different, and people will experience it in different ways. Whatever method is used, the underlying feelings and distress underlying the behaviour must be taken seriously.

Self-harm and suicide attempts can also be detrimental to an individual's long-term physical health for example, paracetamol poisoning is a major cause of acute liver failure. Overdosing in particular is extremely dangerous as it is difficult to predict how your body will cope and can be impossible to reverse. Self-cutting can result in permanent damage to tendons and nerves. Many actions to prevent and reduce suicide will have physical health benefits for those who self-harm.

Self-harm is an important public health issue and often people keep self-harm a secret because of shame or fear of it being seen or being labelled or judged. They may cover up their skin in order to avoid discussing the problem. Sometimes there are psychological scars that are difficult to cope with, often unseen by others. Self-harm is not typically an attempt at suicide but self-harm is an important risk factor for suicide.

[36] Samaritans: Pushed from pillar to post (2020). Available https://media.samaritans.org/documents/Samaritans_-_Pushed_from_pillar_to_post_web.pdf. Last accessed 16/09/21
[37] https://wirralchildcare.proceduresonline.com/p_self_harm_suicide.html

Young people and self-harm

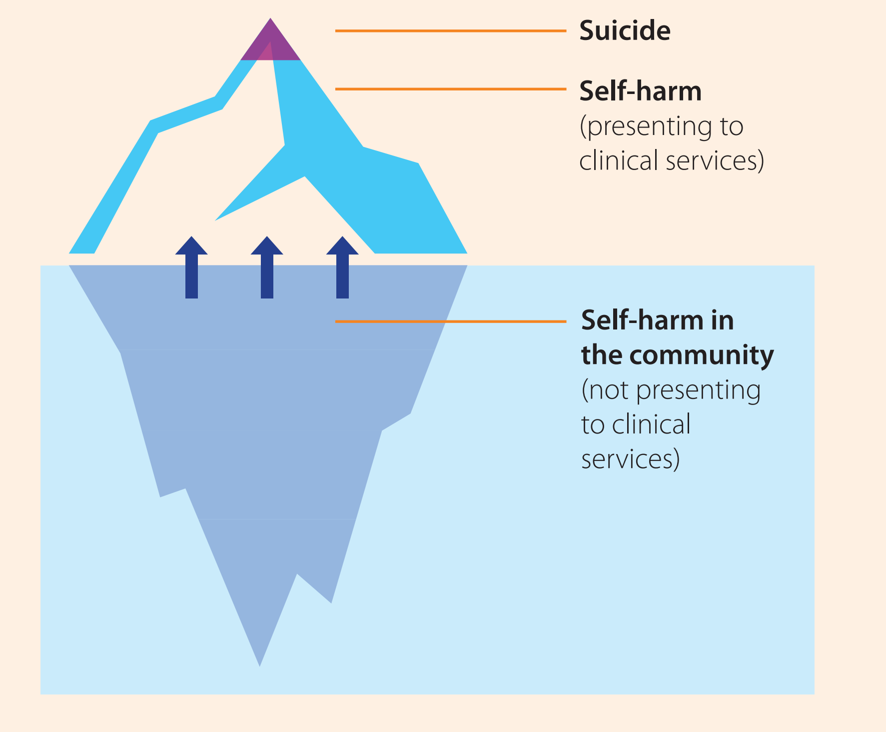
Public Health England (PHE) has also evidenced the continued increase in incidence of self-harm in the UK over the past 20 years, unlike trends in completed suicide[38]. Levels of self-harm among young people in the UK are among the highest rates in Europe. Trends in self-harm rates show that there has been an increase in self-harm, especially among young women where self-harm is more common. According to PHE, those who self-harm in mid-late adolescence potentially face increased risk of developing mental health issues.

Analysis of data from the Health Behaviour in School-aged Children survey for England (aged 11-15 years) conducted in 2014 found that 22% of 15 year olds reported that they have ever self-harmed. In addition, nearly three times as many girls as boys reported that they had ever self-harmed (32% of girls compared to 11% of boys). Findings from this survey also found that the likelihood of self-harming varied by socioeconomic status and structure of households, with incidence of self-harming associated with lower family influence[39].

Establishing an accurate prevalence of self-harm is difficult to precisely determine. This is because there is a "hidden" population of young people who self-harm in the community but do not present to local services for treatment. This is illustrated in the Iceberg model of self-harm, in that for every young person that presents to hospital for self-harm there are at least 10 further individuals who do not present at hospital for self-harm. At the tip of the iceberg are suicides, which are highly visible, beneath are higher rates of hospital-treated self-harm and at the base are very common but hidden self-harm (Hawton, 2019).

Figure 9: Iceberg model of self-harm and suicide in young people

(University of Oxford, 2019)



[38] Public Health England definitions https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/21001/age/1/sex/4/cid/4/tbm/1

[39] https://www.gov.uk/government/publications/health-behaviour-in-school-age-children-hbsc-data-analysis

Only a small proportion of young people who have harmed themselves report seeking help from medical or psychological services. There needs to be a greater understanding on where people can get appropriate and timely support for self-harm, as well as fully understanding what may prevent this group from accessing support.

NHS England continues to work to ensure that every person who presents at an emergency department for self-harm receives a psychosocial assessment and is directed to appropriate support. And within South Central Ambulance Service (SCAS) a steering group is in place to evaluate training from an expert reference group to adapt and adopt content to different audiences, including universal clinician, social care and voluntary sector.

Understanding self-harm and its link to suicide risk

Those who repeat self-harm are at significantly greater risk of completing suicide than those who have a single episode. It can be difficult to differentiate behaviours where there is an intent to die (e.g. cutting with suicidal intent) from those where there is a pattern of self-harm with no suicidal intent (e.g. habitual self-cutting). Any intentional harm to the body counts as self-harm. 'Minor' self-harm can lead to progressively become more serious or frequent. Sometimes people harm themselves in ways that are dangerous, and they might accidently kill themselves (e.g. cutting too deep on certain parts of the body or overdosing). Young people in particular may lack judgement about the level of self-harm they have applied and this could lead to irreversible harm or accidental death.

The Berkshire Suicide Audit found that 21% of people who died by suicide had a history of self-harm, and previous self-harm is flagged in local RTSS data as a feature in the relevant medical history of those who have died.

For these reasons, it is important to address concerns around self-harm early, support people to find alternatives and distractions to self-harm and identify what triggers self-harm. People who self-harm can also be supported to stay safe if they do self-harm (e.g. having a self-harm first aid kit available and pain relief, avoiding certain parts of the body etc) as well as when to avoid self-harming (e.g. when tired, or under the influence of alcohol). It might not be possible for someone who self-harms to stop doing so immediately, but they should be encouraged to get help.

Recommendation 3a: Decrease the stigma related to self-harm and encourage help seeking behaviour and self-care.

People self-harm for a range of reasons, for some it is a way of coping with difficult or distressing feelings, but research has shown that long term self-harm does not help to reduce that distress. Some of the typical reasons why someone may self-harm are shown in table 5 below.

Table 5: Reasons for self-harm

Reason	Examples
Social problems	Being bullied, having difficulties at work or school, having difficult relationships with friends or family, coming to terms with sexuality, coping with expectations, wanting to have a break from difficult things in life, money worries, being in contact with the criminal justice system, housing, loneliness, excessive screen time, cyberbullying, lower family income, family breakdown, student debt
Trauma	Physical, emotional or sexual abuse, grief after death of a close family member or friend, having a miscarriage, have lost a loved one through suicide
Psychological causes	Having repeated thoughts or voices telling them to self-harm, disassociating (losing touch with who they are and with their surroundings), borderline personality disorder, a way of punishing themselves, low self-esteem, struggling with stress, anxiety or depression
Express difficult feelings	Trying to feel in control, reliving unbearable tension

Source: Health Service Executive Ireland and Mental Health Foundation

Although the data shows that the majority of self-harm occurs among people aged under 18 and is strongly associated with puberty, especially in girls, self-harm can affect people of any age, social status gender identity, sexuality, race or culture. People who self-harm may have a diagnosable mental health condition or they may have none. There are many people at risk of self-harm and these include:

- Women
- Young people
- Older people
- People who have or are recovering from drug and alcohol problems
- People who are lesbian, gay, bisexual or gender reassigned
- Socially deprived people living in urban areas
- Women of South-Asian ethnicity
- Individual factors (e.g. personality traits, family experiences, life events, exposure to trauma, cultural beliefs, social isolation and income)
- Societal factors (e.g. education, housing, unemployment rates).

Source: Public Health England, 2021

There are some young people who are at more risk of self-harm (e.g. victims of abuse) because they are more at risk of anxiety and depression. And although self-harm appears to be less frequent in adults, self-harm can continue into adulthood, and certain methods of self-harm are associated with a greater risk of later suicide (Hawton 2012).

Recommendation 3b: Help friends, family and professionals understand the physical and emotional signs of self-harm, how they can help and where they can get support.

Recommendation 3c: Explore the impact of self-harm on parents and siblings on their own mental health and wellbeing.

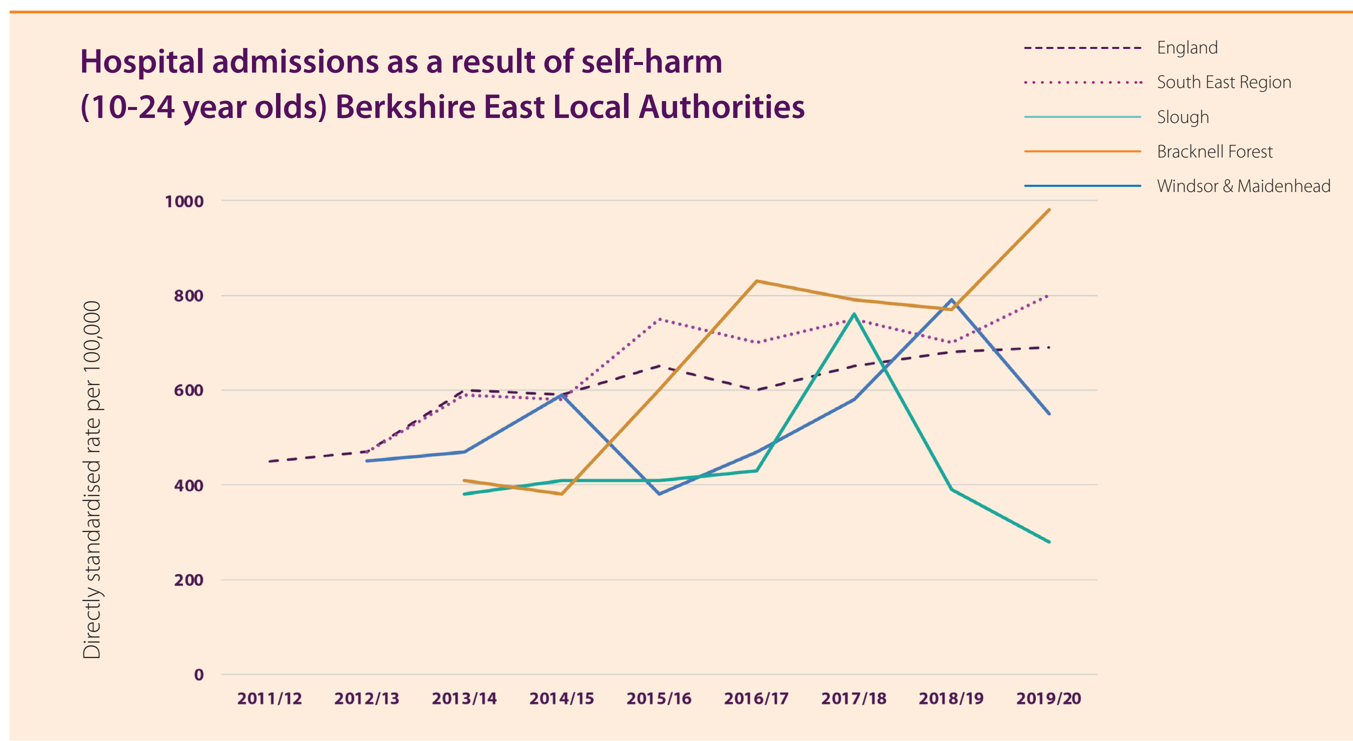
Hospital admissions for self-harm

Self-harm is one of the top five causes of acute hospital admissions in the UK (PHE, 2021). PHE state that those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year and one study showed a subsequent suicide rate of 0.7% in the first year which is 66 times the suicide rate in the general population[40]. This means that someone who has self-harmed is more likely to die by suicide compared to someone who has never self-harmed.

The data below looks at the number of young people aged 10 to 24 who were admitted to hospital as a result of self-harm (primary reason for admission). This counts number of admissions and not persons, a person may be admitted on multiple occasions during each time period. Indicators based on hospital admission may be influenced by local variation in referral and admission practices as well as variation in incidence. Data does not include attendances at Accident and Emergency which do not result in an admission.

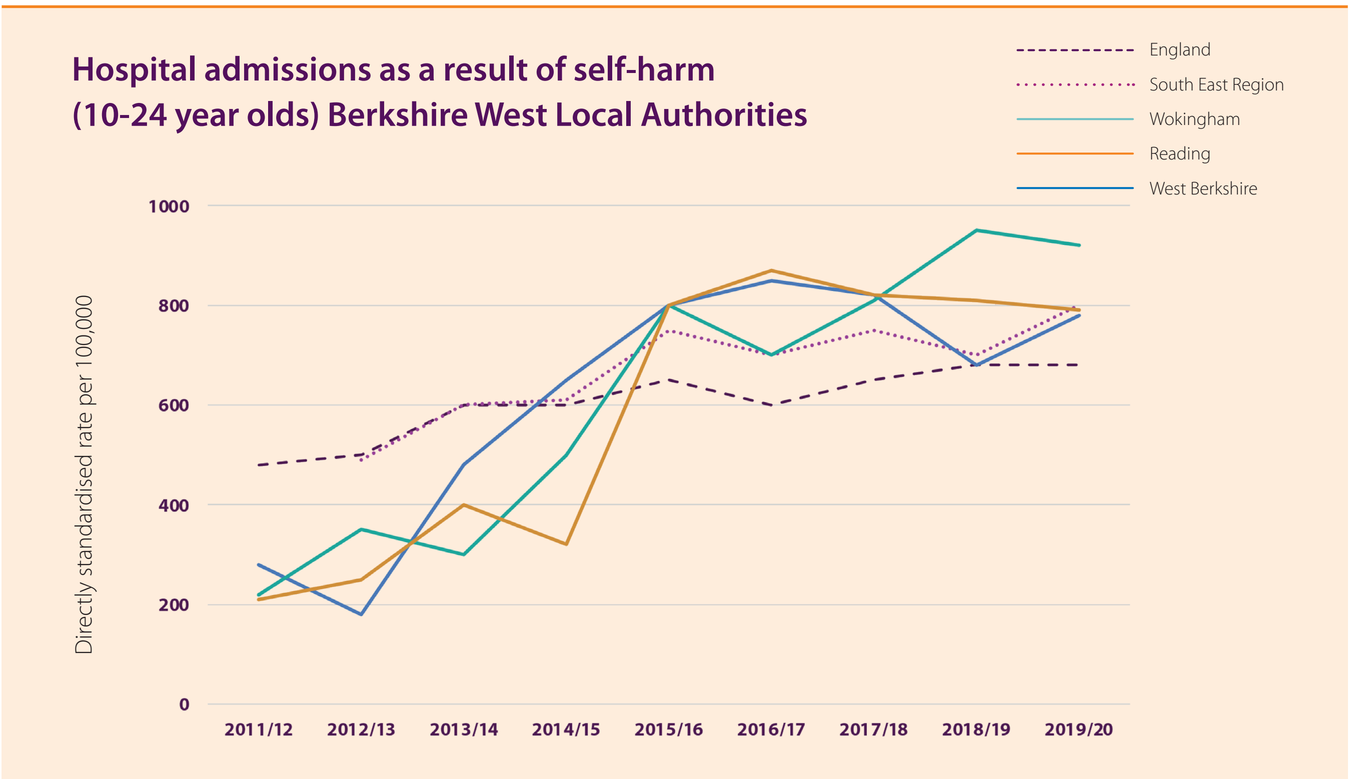
During 2019/20, there were 705 admissions of children and young people from Berkshire to hospital as a result of self-harm. Rates for each local authority since 2011/12 can be seen in the charts below. Rates of admission were significantly lower than the regional average for children and young people living in Slough, and Windsor and Maidenhead. Rates were higher than the national average but comparable to the regional average in Bracknell Forest and Wokingham. In Bracknell Forest, rates jumped from 2014/15 to 2015/16 and have risen again between 2018/19 and 2019/20. Rates in Wokingham, however, have continued to remain above the national average. Rates in Reading and West Berkshire show a similar pattern to each other, increasing up to a peak in 2016/17, prior to falling back in line with national and regional averages.

Figure 11: Hospital admissions for self-harm (10-24-year olds)



Source: Public Health England

[40] Fingertips https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/21001/age/1/sex/4/cat/-1/ctp/-1/cid/4/tbm/1



Source: Public Health England

Data since 2011/12 has shown that admissions are highest in the 15-19-year-old age band, accounting for 54% of admissions (380 admissions) during 2019/20.

Recommendation 3d: Regularly review local intelligence and data on self-harm at the Berkshire Suicide Prevention Steering Group, ensuring additional relevant data from a wide range of sources are included (e.g. development of RTSS to include self-harm, ambulance service data, primary care and schools).

Mental health and self-harm

Mental health problems such as anxiety, depression, ADHD and eating disorders are common in young people who present at hospital for self-harm or who die by suicide[41]. Other important factors present in this cohort are; alcohol misuse, emerging personality disorder, low self-esteem, poor problem solving and perfectionism.

Recommendation 3e: Working with Mental Health Support Teams (MHSTs), ensure a continued focus on the prevention of self-harm by increasing resilience and general coping skills and support for those who self-harm.

[41] https://www.psych.ox.ac.uk/news/self-harm-in-children-and-adolescents-a-major-health-and-social-problem-of-our-time

Priority area 3: Female suicide deaths

Within England and Wales, there has been a growing increase in female deaths by suicide. In 2019, the suicide rate among females and girls was 5.3 deaths per 100,000, up from 5.0 in 2018 and the highest since 2004[42]. Risk and protective factors for suicide can affect men and women differently, therefore understanding the relationship between gender and these risk factors is of importance for effective suicide prevention. For example, risk factors such as domestic abuse disproportionally affect women[43].

Within Berkshire, male suicide rates are higher, but importantly have been decreasing, while the female rates have increased. The increase of female suicides seen locally is detailed above. Throughout the strategy there is due attention to males throughout the other principles and priorities, and many of the actions discussed within this section are also applicable to males.

The findings of the females deep-dive review have informed this priority, identifying three key areas for recommendation based on local need and gaps in intelligence – the perinatal period, domestic abuse and parental/carer stress. Other risk factors identified through the female suicide deep dive are covered within this strategy in the other four priority areas.

Perinatal mental health

In Berkshire, the female deep-dive and the work of the suicide prevention group has highlighted a gap in our knowledge on the perinatal period.

The perinatal period refers to pregnancy and the first year following the birth of a child. Perinatal mental health problems are mental health problems that occur during this period. They affect up to 20% of new and expectant mothers and include a wide range of conditions including depression, anxiety, and psychosis. If left untreated, perinatal mental health issues can have significant and long-lasting impacts on the woman, the child, and the wider family. The latest confidential enquiry into maternal deaths in the UK and Ireland (2019) found that suicide is the second largest cause of direct deaths in mothers occurring during or within the 42 days at the end of pregnancy[44].

Research has shown that in some mental disorders, such as postnatal depression, bipolar disorder and postnatal psychosis, there is an increased risk of suicidal ideation, suicidal attempt, or suicide[45]. Prevalence of mental illness varies by maternal age, with many studies finding a significant correlation between young age and depression or anxiety during pregnancy. Some studies have also found high rates of mental illness amongst older mothers[46]. Agencies across the maternity system involved in the care of expectant and new mothers must carefully monitor and early identify suicide risk and potential risk factors, to reduce suicide risk within this group.

[42] Saving lives, improving mothers' care 2019 report (2019) Available MBRRACE-UK Maternal Report 2019 - WEB VERSION.pdf (ox.ac.uk). Last accessed 02/09/21
[43] Orsolini, Laura et al. "Suicide during Perinatal Period: Epidemiology, Risk Factors, and Clinical Correlates." Frontiers in psychiatry vol. 7 138. 12 Aug. 2016, doi:10.3389/fpsyt.2016.00138
[44] Biaggi A, Conroy S, Pawlby S, Pariante CM. Identifying the women at risk of antenatal anxiety and depression: A systematic review. J Affect Disord. 2016 Feb;191:62-77. doi: 10.1016/j.jad.2015.11.014. Epub 2015 Nov 18. PMID: 26650969; PMCID: PMC4879174.
[45] Orsolini, Laura et al. "Suicide during Perinatal Period: Epidemiology, Risk Factors, and Clinical Correlates." Frontiers in psychiatry vol. 7 138. 12 Aug. 2016, doi:10.3389/fpsyt.2016.00138

Recommendation 4a: Link with the BOB and Frimley local maternity system on suicide risk in the perinatal period.

In guidance for commissioners of perinatal mental health services, the Joint Commissioning Panel for Mental Health, drew together data from various research into the prevalence of perinatal mental health conditions to provide the overview of prevalence shown in the table below. By applying the national prevalence estimates to the total number of maternities in Berkshire, we can estimate numbers at a local level. These estimates do not consider socioeconomic factors or any other factors that may cause local variation in prevalence. We cannot estimate the overall number of women in Berkshire with a perinatal mental health condition, as some women will have more than one of these conditions.

Table 6: Rates of perinatal psychiatric disorder per 1,000 maternities

Condition	Rate per 1,000 (Joint Commissioning Panel for Mental Health report)	Berkshire maternities (ONS, 2019)	Estimated number of women in Berkshire with condition
Postpartum psychosis	2	713	21
Chronic serious mental illness	2		21
Severe depressive illness	30		311
Mild-moderate depressive illness and anxiety states	100-150		1,037-1,555
Post-traumatic stress disorder	30		311
Adjustment disorder and distress	150-300		1,555-3,110

Source: Joint Commissioning Panel for Mental Health, 2012/Office for National Statistics 1

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression. Having a poor relationship with a partner is also a risk factor for postnatal depression[46]. The number of births which were outside of marriage or civil partnership and sole registered (by one parent only) in Berkshire during 2019 was 375. Risk factors outlined are likely to have been further affected by COVID-19 and the lockdown measures, and thus the potential to increase suicide risk, therefore should be monitored going forward.

Recommendation 4b: To explore data collection on the perinatal period; risk factors and the link to suicide including data captured in the RTSS.

[46] NICE (2020) Postnatal and Antenatal depression – what are the risk factors? Available Risk factors | Background information | Depression - antenatal and postnatal | CKS | NICE. Last accessed 26/08/21

Domestic abuse

The female deep-dive analysis for Berkshire also highlighted a gap in our knowledge on the links between suicide and domestic abuse locally. The Domestic Abuse Act 2021 came into force on the 30th April 2021, making vital changes to the act, going beyond criminal justice and encompassing family courts, housing and health, acknowledging the impact of domestic abuse on victims and survivors lives[47]. It is widely evidenced that domestic abuse victims and survivors are more at risk of suicide and suicidal thoughts. ONS figures estimate that approximately 2.3 million adults aged 16 to 74 years within England and Wales experience domestic abuse in the last year (ending March 2020); the true scale of this however remains unknown. Research focussing upon more than 3,500 women supported by Refuge, a charity supporting victims of domestic abuse, has shown that almost a quarter (24%) of those supported by the charity had felt suicidal, and 83% reported feelings of hopelessness and despair. Domestic abuse and suicide risk are clearly linked, therefore mental health services and those working with victims of domestic abuse should work together to mitigate this risk.

Recommendation 4c: Promote the need for clear pathways and knowledge exchange between domestic abuse and mental health services.

Transforming Health and Social Care in Kent and Medway partnership (STP) have researched the link between domestic abuse and suicide in their county. They found that suicide victims were categorised into four cohorts - current victims of domestic abuse, those who had historically experienced domestic abuse, perpetrators, and young people living in households where domestic abuse was occurring[48].

Children witness to or living in a household where domestic abuse is present is a highly traumatic experience and can lead to lasting harms and risk-taking behaviours throughout the lifecourse. Perpetrators, as found in Kent, are also at risk of suicide, where the perpetrator is currently under investigation, or is being convicted of the abuse. It is clear therefore, that domestic abuse has a profound impact for those experiencing, witnessing and perpetrating, increasing risk immediately, and throughout the life course. Within Berkshire, further data collection is required locally in order gain a greater understanding of the links between domestic abuse and suicide for those impacted.

Recommendation 4d: Improve data collection of domestic abuse data in RTSS.

Recommendation 4f: Include domestic abuse indicators in the Berkshire suicide audit to better understand the link between domestic abuse and suicide

Recommendation 4g: Provide information to domestic abuse services on how to respond to concerns where clients may be self-harming or considering suicide (whether the client is a victim, survivor, perpetrator or child or young person)

[47] Domestic Abuse Act 2021. Womens Aid. Available Domestic Abuse Act - Womens Aid. Last accessed 07/09/2021
[48] Highlighting the relationship between domestic abuse and suicide: Progress and next steps (2021) Transforming Health and Social Care in Kent and Medway

Parental or carer stress

Parental or carer stress has been identified through the female deep-dive audit as a key risk factor for suicide. Anecdotal feedback within acute hospital teams in 2020 found that these stresses are particularly pertinent when parenting neurotypical children, and suicide attempts amongst older people are often linked to carer strain.

Parental stress, anxiety and depression has also been found to have increased over the period of the COVID-19 lockdown. The key concerns highlighted by parents in this report was around struggling with competing demands of meeting their child's needs, home-schooling and work commitments. Data has shown that the parents and carers from single adult households, and lower income families (<16,000 p.a), and those who have children with special educational needs and/or neurodevelopmental differences have been particularly vulnerable to elevated mental health symptoms[49]. It is widely accepted that mental ill health is a risk factor for suicidal ideation and behaviour, therefore this increase in mental health symptoms must be acknowledged and monitored[50].

There are a wide range of services within Berkshire that support parents and carers. Family information services are available, which provide free and impartial information and signposting for families. Easily accessible resources and information around available services are key for parents and carers accessing the support they need at the correct time, and the work of this strategy should consider this forum as a means to prevent suicide risks in this group.

Recommendation 4h: Raise awareness of the information, resources and services available for parents and carers who are experiencing stress, through inputting into local campaigns.

[49] [1] Parental mental health worsens under new national COVID restrictions (2021). Available Parental mental health worsens under new national COVID-19 restrictions | University of Oxford Last accessed 26/08/21

[50] Samaritans research briefing: Gender and Suicide (2021). Available ResearchBriefingGenderSuicide_2021_v7.pdf (samaritans.org) Last accessed 02/09/21

Priority area 4: Economic factors

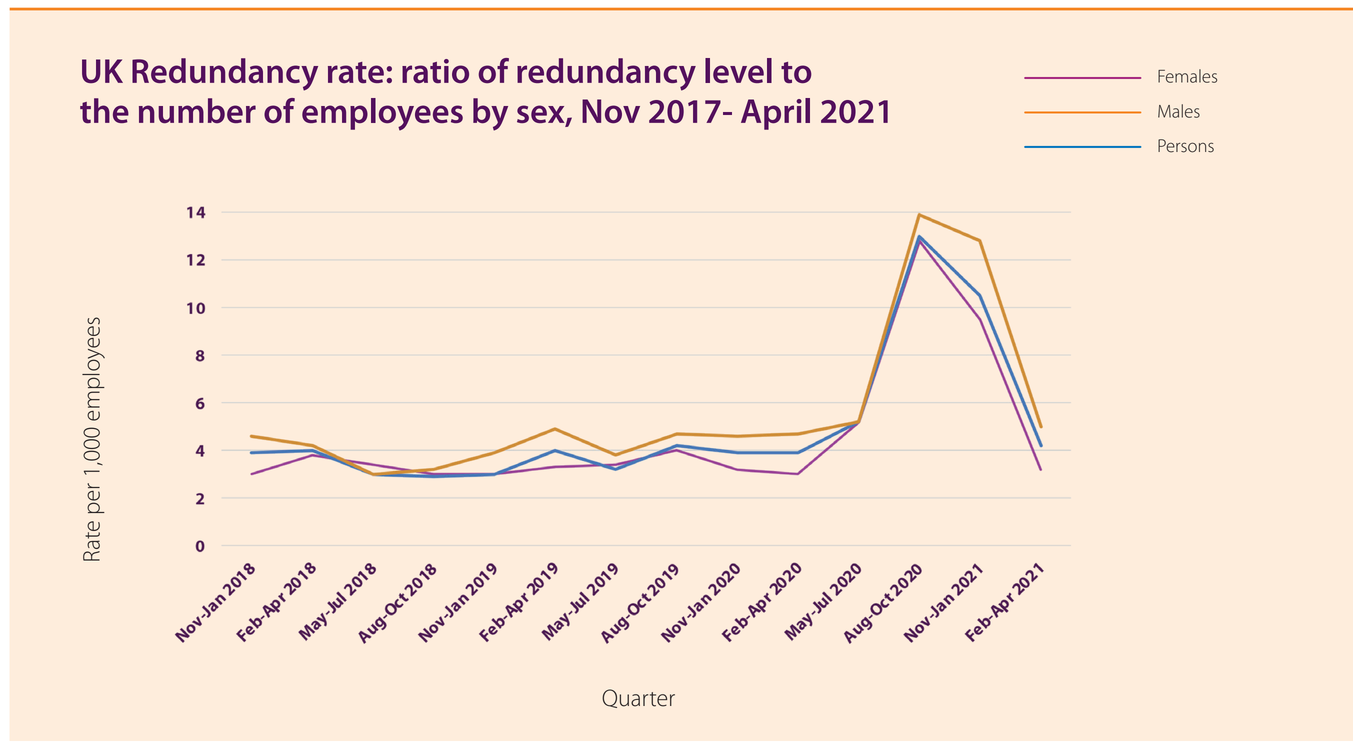
Impact of COVID-19

Some people are more economically or financially vulnerable than others, and this number is on the rise. Individuals who are young, low-paid, Black, in self-employment and those with low education levels or live in large families have been disproportionately affected by the current COOVID-19 pandemic. These groups are more likely to have lost their jobs, not be working any hours or had their pay cut[51].

During the COVID-19 pandemic in 2020, the number of people with low financial resilience (e.g. people with high levels of debt, low savings or erratic earnings) has increased by a third from 10.7 million to 14.2 million, representing more than a quarter of the UK adult population[52]. The COVID-19 pandemic has had a huge impact on employment and income, with some survey respondents expecting to struggle to make ends meet and experience financial hardship. They may need to rely on foodbanks or take on additional debt in order to meet the shortfall. In comparison, some other workers have been able to work from home and save money on commuting costs. Around 48% of adults have not been financially affected by COVID-19 and 14% have seen improvements to their financial position.

The chart below illustrates how the redundancy rate (persons) has risen from 3.9% in Feb-April 2020 to 5.5% in May – July 2020, a sharp rise to 13.3% between Aug-Oct 2020 and a slight drop to 11% between Nov 2020 and January 2021 in the UK. The redundancy rate is the ratio of the redundancy level for the given quarter to the number of employees in the previous quarter, multiplied by 1,000.

Figure 12



Source: PHE Wider Impacts of COVID-19 on health (WICH) monitoring tool

[51] COVID-19 recession is having a disproportionate impact on most vulnerable. LSA (2020) Available: https://www.lse.ac.uk/News/Latest-news-from-LSE/2020/h-August-20/COVID-19-recession-is-having-a-disproportionate-impact-on-the-most-vulnerable Last accessed: 09/09/21

[52] Financial lives 2020 survey. FCA (2020) Available: https://www.fca.org.uk/publications/research/financial-lives-2020-survey-impact-coronavirus Last accessed 09/09/21

In the past, periods of economic uncertainty have seen increases in suicide rates, particularly among men. Economic factors, particularly unemployment have been shown as strong risk factors of suicide (e.g. Lewis G and Sloggett A, BMJ 1998; 317:1283). Suicide rates increased from a record low in 2006 post the economic recession suggesting the national recession could have been an influencing factor in the increase in suicides. Studies have found that local areas with greater rises in unemployment had also experienced higher rises in male suicides[53].

The government's furlough scheme has helped employers to pay peoples wages in order to reduce financial insecurity during the pandemic and period of economic upheaval. On the 30th March 2021, 49,700 jobs were furloughed across Berkshire and there has been a total of 164,500 jobs furloughed in total since 23rd March 2020 across Berkshire. The cumulative number of jobs on furlough across Berkshire local authorities ranges from 25,800 for people living in Windsor and Maidenhead to 31,400 in Slough. Figures are based on the local authority of the business and not residence.

Table 7 Cumulative number of jobs on furlough at 31st March 2021 (local authority of business)

Local Authority	Cumulative number of jobs on furlough
Bracknell Forest	23,100
Reading	31,300
Slough	31,400
West Berkshire	26,700
Windsor and Maidenhead	25,800
Wokingham	26,200
Berkshire total	**164,500**

Source: HM Revenue and Customs

During the first national lockdown, women and young people were more likely to be furloughed and are more likely to face financial difficulties as recovery progresses (Women's Budget Group, 2020, IFS, 2020, IFS 2020a). In the lowest earning 10% of employees, 80% were employed in a sector that was shut down or are not able to work from home, compared to 25% in the highest earning 10% (IFS) - (*Note this excludes key workers).

[53] Barr et al BMJ 2012; 345:5142

Debt and poor mental health

Unmanageable debt is a risk factor for suicidal behaviour, with those in debt three times as likely to consider suicide than people not in problem debt (Mental Health Policy Institute (MMHPI), 2018). Unemployment, unmanageable debt and job insecurity are also risk factors for suicidal behaviour.

Across England, more than 1.5 million people are experiencing both problem debt and mental health problems. An estimated 46% of people in problem debt also have a mental health problem. Almost one in five (18%) people with a mental health problem are in problem debt. Financial problems are a common cause of stress and anxiety with people in this position not asking for help due to stigma around being in debt. Suicide can be seen as a way out of debt for some people who are struggling and more than 100,000 people in England attempt suicide while in problem debt each year (MMHPI) (2018)[54].

Long-term factors such as persistent poverty and financial insecurity can put people at an risk of becoming suicidal, as can sudden triggers like the intimidating and threatening letters people receive from lenders. Providing debt management advice and support to people in debt will help to reduce an individual's risk of death by suicide, especially if they are experiencing poor mental health. There is a lot of support and help available for people, but awareness can be low.

Recommendation 5a: Work with colleagues to raise awareness of the risk between debt, mental health and suicide risk among frontline professionals and the wider public. Awareness raising needs to;

- reduce the stigma of 'being in debt' and signpost to access debt and benefit advice and support. this information also needs to be shared with frontline professionals
- encourage people in debt to reach out for help to reduce impact on mental health
- encourage people with poor mental health to reach out for debt advice

Recommendation 5b: Support frontline professionals to feel comfortable about talking about debt and financial problems and the link to poor mental health and suicide risk and what support is available.

Recommendation 5c: Support Berkshire local authorities with a single point of access information site around money matters.

People who had a long-term condition or disability were three times as likely to have fallen behind on paying their council tax, compared to those without. People who receive an income-related benefit (e.g. universal credit) were almost four times as likely to have fallen behind on council tax compared to those not receiving benefits.

Recommendation 5d: Ensure compassionate debt collection. Make sure the process is supportive and aims to steer residents to places that can provide help and support. Support vulnerable groups at increased risk of debt including people with long-term conditions or disabilities.

[54] A silent killer. Money and mental health (2018) https://www.moneyandmentalhealth.org/wp-content/uploads/2018/12/A-Silent-Killer-Report.pdf Last accessed 09/09/21

Benefits

National government data shows that there is over £15 billion pounds of unclaimed benefits, in addition to unclaimed Universal Credit available. This could mean that many individuals and families are living on less money than they need to be and unnecessarily finding it difficult paying priority bills (e.g. heating and food). Barriers preventing people claiming the benefits they are entitled to include;

- a lack of awareness about what benefits are available and the claims process.
- a perceived stigma around benefits creating a reluctance to consider them. This has particularly affected people who have recently been struggling financially during COVID-19 pandemic.
- a lack of access to or no IT skills which are necessary to access services online (e.g., digital applications)

The proportion of the population aged 16 to 64 across Berkshire who were claiming benefits during May 2021 was just under 5%. This is the same as the figure for the South East Region as a whole. There is some variation between Berkshire Local Authorities with the claimant counts being higher in Slough (8.4%) and Reading (6.4%).

Table 8: Berkshire Benefit claimants May 2021

	Bracknell Forest	Reading	Slough	West Berkshire	Windsor and Maidenhead	Wokingham	South East
Benefit claimant count	3,145	6,845	7,965	3,545	3,775	3,135	274,810
Percentage of 16-64 year old population	4	6.4	8.4	3.7	4.1	3	4.9

Source: ONS Crown Copyright Reserved [from Nomis on 2 July 2021]

Recommendation 5e: Work with key partners to actively promote services that provide help around navigating the benefits system and potentially increasing people's incomes.

Recommendation 5f: Make sure that all parts of the health service where patients showing suicidal intent first make contact, are signposted or triaged appropriately using a process that includes debts and other economic stresses as risk factors.

Socioeconomic disadvantage and suicidal behaviour

The Berkshire suicide audit 2018 found that the majority of people with financial issues prior to death had 'other debts', such as student loan, loans and credit cards. Other reasons for financial issues included utility bills/rent, work related issues (business accounts, sick pay stopped), drug debt, gambling, bankruptcy and being the victim of a scam. The Berkshire Suicide Audit also showed that between 2007 and 2018, the percentage of suicides that were amongst people who were unemployed ranged from 11% to 38%. If we consider this against the fact that 4% of the overall population in Berkshire are unemployed, then people who are unemployed are over-represented in the number of suicides in Berkshire.

Figure 15: Financial issue (s) prior to death across audit years

	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 - 2013/14	2014/15 - 2015/16	2016/17 - 2017/18
Total	9%	6%	<5%	24%	27%	13%

Source: Berkshire Suicide Audit (2018)

It is well recognised that the reasons why people die by suicide are complex, arising from a wide range of psychological, social, economic and cultural risk factors. People who are socioeconomically disadvantaged or who live in areas of socioeconomic deprivation have an increased risk of suicidal behaviour. Features of socioeconomic disadvantage include; low income, unmanageable debt, poor housing conditions, lack of educational qualifications, unemployment and living in a socioeconomically deprived area[55]. What is more, poor mental health makes it harder to deal with money problems and vice versa[56].

Recommendation 5g: Work with system partners on the early identification and support of people who are at increased risk of debt and financial concerns (e.g. unemployed or people with long-term conditions) as early as possible and offer effective support to manage personal finances through appropriate referral pathways.

[55] Dying from inequality. Samaritans (2017). Available:https://media.samaritans.org/documents/Samaritans_Dying_from_inequality_report_-_summary.pdf. Last accessed 09/09/21

[56] Money and mental health, the facts. Money and mental health (2019). Available: https://www.moneyandmentalhealth.org/wp-content/uploads/2017/06/Money-and-mental-health-the-facts-1.pdf. Last accessed 09/09/21

Gambling

Gambling related harm is a risk factor for suicide and is a growing area of public health concern. In 2019/20, 11% of gamblers contacting the National Gambling Helpline said they had experienced suicidal thoughts, either currently or in the past[57].

Additional funding is being made available to support treatment services for problem gambling and to monitor the impact of COVID-19 on gambling behaviour. Gambling operators are putting in place additional measures to increase protections for those who might be at risk of gambling harm. These were clear themes within the National Strategy to reduce Gambling Harms[58] although there has been little progress on addressing gambling related suicide.

PHE have plans to publish an evidence review on gambling harms on the prevalence of gambling and associated health harms and their social and economic burden. This work has been put on hold due to COVID-19.[59]

The National Confidential Inquiry into Suicide and Safety in Mental Health's 2021 report on suicide by middle-age men[60] found a number of findings associating suicide with economic precursors. Overall, 57% of men were experiencing economic problems including unemployment, financial problems, or problems finding stable accommodation. Almost a third of men included in the study were unemployed at the time of death, with almost half of these unemployed for over 12 months. Twice the proportion of men were living in the most deprived areas of England (27%) compared to those living in the lest deprived areas (14%). Alcohol and drug misuse were particularly common amongst men who were unemployed, as it was amongst those who were bereaved, or had a history of violence or self-harm.

Recommendation 5h: Monitor local data and intelligence on levels of problem gambling within Berkshire and its link to suicide.

[57] Suicide awareness and prevention training.
Gamcare (2020https://www.gamcare.org.uk/news-and-blog/news/gambling-charity-and-samaritans-launch-bespoke-suicide-awareness-and-prevention-training/
[58] Reducing gambling harms. Gambling Commission (2021) https://www.gamblingcommission.gov.uk/about-us/reducing-gambling-harms Last accessed 09/09/21
[59] Progress report on the national strategy to reduce gambling harms. Gambling Commission (2021)
https://www.gamblingcommission.gov.uk/print/absg-progress-report-on-the-national-strategy-to-reduce-gambling-harms-year Last accessed 09/09/21
[60] Suicide by middle aged men. NCISH (2021). Available NCISH | Suicide by middle-aged men - NCISH (manchester.ac.uk). Last accessed 02/09/21

Priority area 5: Supporting those who are bereaved or affected by suicide

Those who are bereaved by suicide face a higher risk of mental ill-health, suicide attempts and death by suicide.[61, 62, 63] The Support After Suicide Partnership summarises the particular challenges which mean that those bereaved by suicide are less likely to receive support from family and friends than others going through a bereavement. [64] Sudden deaths can lead to a complex bereavement, with those bereaved by suicide often experiencing particularly intense shock, as well as challenges linked to the stigma of suicide.[65] These stigmatising factors can mean the bereaved person is avoided or feels judged, and connections with social and support networks are weakened. People's awkwardness in discussing death is often magnified when the death is by suicide, and this can leave the person who is bereaved feeling especially isolated. Conversely, high interest in the suicide – from communities and from the media – can make it difficult for people to grieve in private.

Experiences of bereavement affect everyone in different ways but is usually characterised by grief. Grief is a process that people go through as they gradually adjust to loss. Again, grief is experienced differently by different people with people often moving in and out of the stages of grief and the range of associated emotions. Grief is an entirely normal process and there is no time limit on how long grief lasts. However, sometimes people experience grief in a way that, rather than becoming manageable overtime, worsens and affect day-to-day living for a long time.

Throughout this strategy we have seen how bereavement can be a key factor contributing to death by suicide. Bereavement is highlighted in the Berkshire Suicide Audit, the Berkshire deep-dive into female suicides, and The National Confidential Inquiry into Suicide and Safety in Mental Health's reports into suicide amongst both children and young people and middle-age men.

Bereavement by suicide can be particularly devasting to the lives of those around the person who has died. People bereaved by suicide are at a greater risk of suicide themselves. Bereavement by suicide was highlight in 6% of subsequent suicides in the Berkshire Suicide Audit (2018).

In 2020, Suicide Bereavement UK published a report entitled 'From Grief to Hope: The collective voice of those bereaved or affected by suicide in the UK.' [66] The report lays out key findings and recommendation based on an online survey completed by over 7,000 people who have been bereaved by suicide. The number of people responding to the survey increased steadily by age band, peaking at age 45-54 before dropping off more rapidly for the 55-64 and 65+ age groups. 97% of respondents were White. Of non-White respondent, the majority (47%) reported their ethnicity as 'multiple/mixed'. 89% identified as heterosexual and 75% were in paid employment. 33% had been bereaved by more than 1 suicide. The key survey findings are summarised in the following table below.

[61] Qin P, Agerbo E and Mortenson PB (2002) Suicide risk in relation to family history of completed suicide and psychiatric disorders:
a nested case-control study based on longitudinal registers. Lancet 360: 1126–1130.
[62] Pitman et al (2014) Effects of suicide bereavement on mental health and suicide risk The Lancet Psychiatry, 1(1): 86-94 http://www.thelancet.com/journals/lanpsy/ article/PIIS2215-0366(14)70224-X/fulltext
[63] Pitman et al (2016) Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UKwide study of 3,432 young bereaved adults. BMJ Open 6:e009948.
doi:10.1136/ bmjopen-2015-009948 http://bmjopen.bmj. com/content/6/1/e009948
[64] Finding_the_Words.pdf (supportaftersuicide.org.uk)
[65] Pitman et. Al. (2016) The stigma perceived by people bereaved by suicide and other sudden deaths: a cross-sectional UK study of 3,432 bereaved adults. Journal of Psychosomatic Research 87:22-29.
[66] From Grief to Hope: The collective voice of those bereaved or affected by suicide in the UK Suicide Bereaved UK (2020). Available display.aspx (manchester.ac.uk)
Last accessed 02/09/21

Table 9: Key findings from Suicide Bereavement UK's 2020 report

Topic	Finding
Impact	82% reported that suicide had a moderate or major impact on their lives
	Serious adverse consequences included relationship break-up, unemployment and finical problems
	Over a third reported mental health problems with this been particularly common for women
Link to self-harm and suicide	8% reported self-harming
	38% had considered taking their own life
	8% had made a suicide attempt
	36% of those making a suicide attempt did so over a year after being bereaved by suicide
Relationship to deceased	The most common relationship reported was the loss of a friend to suicide
	Participants who had lost friends were more likely to have experienced multiple suicides and often reported feeling overlooked by services
Accessing support	60% did not access support following a suicide
	Over a third did not know what types of services were available
	62% perceived the provision of local bereavement support to be inadequate
Support requested	Immediate, proactive support is important
	Some, not always ready to receive help straight away, said that information should be presented in an easily accessible format such as a booklet or person to contact for support when they were ready
	Ongoing bereavement support should be available with a follow up at 3, 6, 12, or 18 months after the suicide occurred

Source: Suicide Bereavement UK, From Grief to Hope, 2020

Survivors of Bereavement by Suicide (SoBS) is a national charity set up to offer support to adults bereaved by suicide. It is the only organisation offering peer-to-peer support to all those over the age of 18, impacted by suicide loss in the UK. It helps those bereaved by suicide to support each other, at the time of their loss and in the months and years that follow. SoBS offers peer led support groups, online virtual support groups, a national telephone helpline, online community forum and email support. It offers a unique and distinct service for bereaved adults across the UK, run by the bereaved for the bereaved. Suicide recognises no social, ethnic or cultural boundaries and neither does SOBS. The helpline and groups are open to all survivors of bereavement by suicide aged 18 years and over.

Recommendation 6a: Ensure our local bereavement offer is culturally and ethnically appropriate for different groups working with communities to develop resources and services.

Local SoBS groups exist to meet the needs and break the isolation experienced by those bereaved by suicide. It is a self-help organisation that aims to provide a safe, confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other. It also strives to improve public awareness and maintain contacts with many other statutory and voluntary organisations. Each local SoBS group needs to have 3 trained volunteers to run a group and they must have been bereaved by suicide for at least 2 years. Finding volunteers is a challenge given the commitment involved. Each group is also responsible for finding suitable premises, funding itself, and following guidelines set by the national charity. This makes the group vulnerable, and we have a role to support this group.

There is currently one SoBS group in Berkshire, in Wokingham but they often support people from further afield where there is no closer group to join. The Wokingham SoBS group has been running for over 7 years, and its co-ordinator is an active member of the Berkshire Suicide Prevention Strategy Group. Numbers actively involved in the SoBS group fluctuate, with an average attendance rate of 15 people pre-COVID-19 and an average of 12 people attending the current virtual offer. The group has many recently bereaved members, but also members who were bereaved many years ago and have not had the opportunity to talk before - usually because of the stigma which still surrounds suicide.

Recommendation 6b: Continued support to the volunteer led local SoBS groups to be able to continue to offer a peer-to-peer support service.

There is sometimes a tendency to assume that the impact of a suicide is confined to the close family and friends of the person who died, but there can be repercussions throughout wider networks, communities, places of work or study, and within services called upon to respond to a suicide in a professional capacity. In offering support to those affected, it is important not to make assumptions which limit how widely information about support is shared. People may identify with a suicide because of something they have in common with the person who died, without necessarily having had recent or frequent contact with that person. Over 7,000 individuals contributed to a study carried out by Suicide Bereavement UK, which illustrates this significant ripple effect[67].

A range of national resources for people bereaved by suicide are available and are shared by our first responders

[67] McDonnell S, Hunt IM, Flynn S, Smith S, McGale B, Shaw J (2020). From Grief to Hope: The Collective Voice of those Bereaved or Affected by Suicide in the UK. Manchester: University of Manchester. Available at: https://supportaftersuicide.org.uk/wp-content/uploads/2020/11/From-Grief-to-Hope-Report-FINAL.pdf

across Berkshire to a suspected suicide, e.g. coroners, funeral directors, police, doctors and bereavement counselling and support organisations. This includes 'Help is at Hand', a national publication which aims to provide people affected by suicide with both emotional and practical support[68], as well as several other useful resources.

Recommendation 6c: Building in bereavement support to extend to wider family members, friends and communities.

Specialist Suicide Bereavement Support

There is now specific investment in developing support for people who are bereaved by suicide within the NHS Long Term Plan. Transformation funding has been issued to enable different parts of the country at different stages to develop suicide bereavement support services, and this will reach all areas by 2023-24. Berkshire has been in receipt of NHSE funding to develop suicide bereavement support since 2019-20 as part of the Berkshire Oxfordshire and Buckinghamshire (BOB) Integrated Care System.

From the work of the Berkshire suicide prevention group we now have a specialist Bereaved by Suicide Support Service in place which provides advocacy and support for those bereaved by suicide. Current support for Berkshire residents bereaved by suicide includes the services of a Bereavement Liaison Co-ordinator within Thames Valley Police. The Co-ordinator works with officers involved in gathering RTSS data and establishes early contact (with consent) with bereaved individuals to offer a supportive presence. The Co-ordinator carries out an initial assessment of need and provides practical advice. This role has created additional capacity within the police to provide an accessible and consistent point of contact for individuals and families who may not be ready for signposting or referral into local support services at initial contact but may require such in the future.

Local and ongoing practical and emotional bereavement support is provided by a Bereavement Liaison Supporter. The Liaison Supporter will remain alongside the bereaved as they access other services, supporting referral and fast tracking as appropriate, and maintaining a good overview of working relationships with other local providers. Preparing people for media involvement and interest is a key element of this role, as well as supporting navigation through the coroner's court. Other areas of practical and emotional support are available, based on individual client need.

The Berkshire Bereavement Liaison Support Service is currently provided by Victim Support and builds on an established and successful model of support for people bereaved by homicide. Any Berkshire resident can access the service. Adults are supported directly, and the service facilitates links to specialist children's bereavement support services. A dedicated member of Victim Support staff is the primary point of contact with the service, but clients can contact Victim Support 24/7 in the event of needing to talk to someone outside of the working hours of the project lead.

[68] HIAH Booklet. Support after suicide (2021) HIAH_Booklet_2021_V5-1-2.pdf (supportaftersuicide.org.uk) Last accessed 09/09/21

A recent evaluation of the various components of the BOB-wide service found that the most valued features were:

- A mechanism that connects families with services as soon as possible after the death
- Practical support and advocacy (e.g. around inquests, collecting belongings, media interest)
- Signposting to local services and organisations based on sound local knowledge
- Emotional support to deal with loss, trauma and feelings of isolation, exacerbation of existing health problems and the emergence of mental health problems.

Suicide bereavement support will be re-commissioned from 2022 as a single service across the Thames Valley. This will generate some economies of scale, and also build in some flexibility for local co-ordinators to support one another across county boundaries to help manage peaks in demand.

The current commissioned services focus on meeting the needs of 'close relatives' of people who have died by suicide. However, the providers have offered wider community support through forums and in response to some specific requests. In re-commissioning the service, we will explore how to tap into such expertise and experience for wider community benefit in future, whilst ensuring those in need of the one-to-one practical and emotional support following a suicide can still access this in a timely manner.

Recommendation 6d: Continue to commission suicide bereavement support services and monitor its impact.

Support for those impacted by suicide in the workplace

There is recognition that staff may feel responsible for a suicide event, or not having done more to prevent it. Although these feelings are always misplaced, they can prolong the trauma if not managed effectively. Staff members may also experience anger, flashbacks and post-traumatic stress.

Recommendation 6e: Explore training opportunities for colleagues and workplaces impacted by suicide.

Recommendation 6f: Work with Thames Valley Police and other first responders to a suicide, to share appropriate resources with employers.

Glossary

Age-specific mortality rate
The total number of deaths per 100,000 people of an age group

Age-standardised mortality rate
A weighted average of the age-specific mortality rates per 100,000 people and standardised to the 2013 European Standard Population. Age-standardisation allows for differences in the age structure of different populations and therefore allow valid comparisons to be made between geographic areas, the sexes, and over time.

Registration delay
The difference between the date which a death occurred and the date which a death was registered

Statistical significance
The term "significant" refers to statistically significant changes or differences based on unrounded figures. Significance has been determined using the 95% confidence intervals, where instances of non-overlapping confidence intervals between figures indicate the difference is unlikely to have arisen from random fluctuation

Years of life lost
Years of life lost is a measure of premature mortality and gives an estimate of the length of time a person would have lived had they not died prematurely. It can be used to compare the premature mortality experience of different populations and quantify the impact on society from suicide.

Berkshire Wide Action Plan

This action plan is a continuously working document lead by the Suicide Prevention Steering Group who have the ultimate responsibility for delivery. Timeframes and specific indicators are to be defined by the group. For the purpose of this strategy the recommendations are listed below.

Priority Area	Recommendation	Outcome
1. Overarching Aims	**1.a)** To continue to monitor the impact of COVID-19 on suicide across the lifecourse through RTSS data and respond to any identified trends.	Impact of COVID-19 on suicide across the lifecourse further understood and trends responded to by the Suicide Prevention Group.
	1.b) To continue to monitor the wider trends emerging from the impact of COVID-19 on people's mental health and suicide risk across the lifecourse, and to support the system to take action where required.	Impact of COVID-19 on mental health and suicide risk further understood, support for the action taken where required across the system in place, informing the Suicide Prevention Group's approach.
	1.c) To undertake a Berkshire suicide audit.	Suicide risk and trends identified and analysed, informing the Suicide Prevention Groups focus and approach.
	1.d) Undertake regular reviews of information, resources and channels for people affected by suicide	Accurate, high quality information, resources and channels available for those affected by suicide.
	1.e) Hold an annual multi-agency conference on a range of topics to share information and best practice and raise awareness to the risks for suicide.	Knowledge and understanding of focus areas improved. Awareness raising of focus areas.
	1.f) Invite additional partners across the system within Berkshire, including the voluntary and community sector to join the Suicide Prevention Group for improved cross-topic working.	The Suicide Prevention Group benefit from further insight and knowledge from additional organisations, informing their approach, and other groups benefit from our expert input.
	1.g) Set up sub-groups of the Suicide Prevention Group, informed by local intelligence and data, where there is a need to focus upon a risk factor or group within the population.	Better understanding of, and potential reduction in suicide risk for identified risk factors or groups within the population.
2. Children and Young People	**2.a)** To raise awareness of the link between trauma and adversity, and suicide across the life course	Link between trauma and adversity across the life course is clear and understood by partners, professionals and the voluntary and community sector.
	2.b) Continued investment into the Be Well campaign to encourage the importance of looking after emotional wellbeing, in addition to signposting to local mental health services and support in order to prevent self-harm and suicide in children, young people, and women.	Emotional wellbeing improved as a preventative factor for children, young people and women's suicide and self-harm risk.
	2.c) Support the system to adopt a needs-led approach for neurodiverse children and young people, particularly in the prevention and early intervention arena, e.g. in schools and the community.	Neurodiverse children and young people pre-diagnosis and supported and adaptations made for their needs, reducing suicide risk.

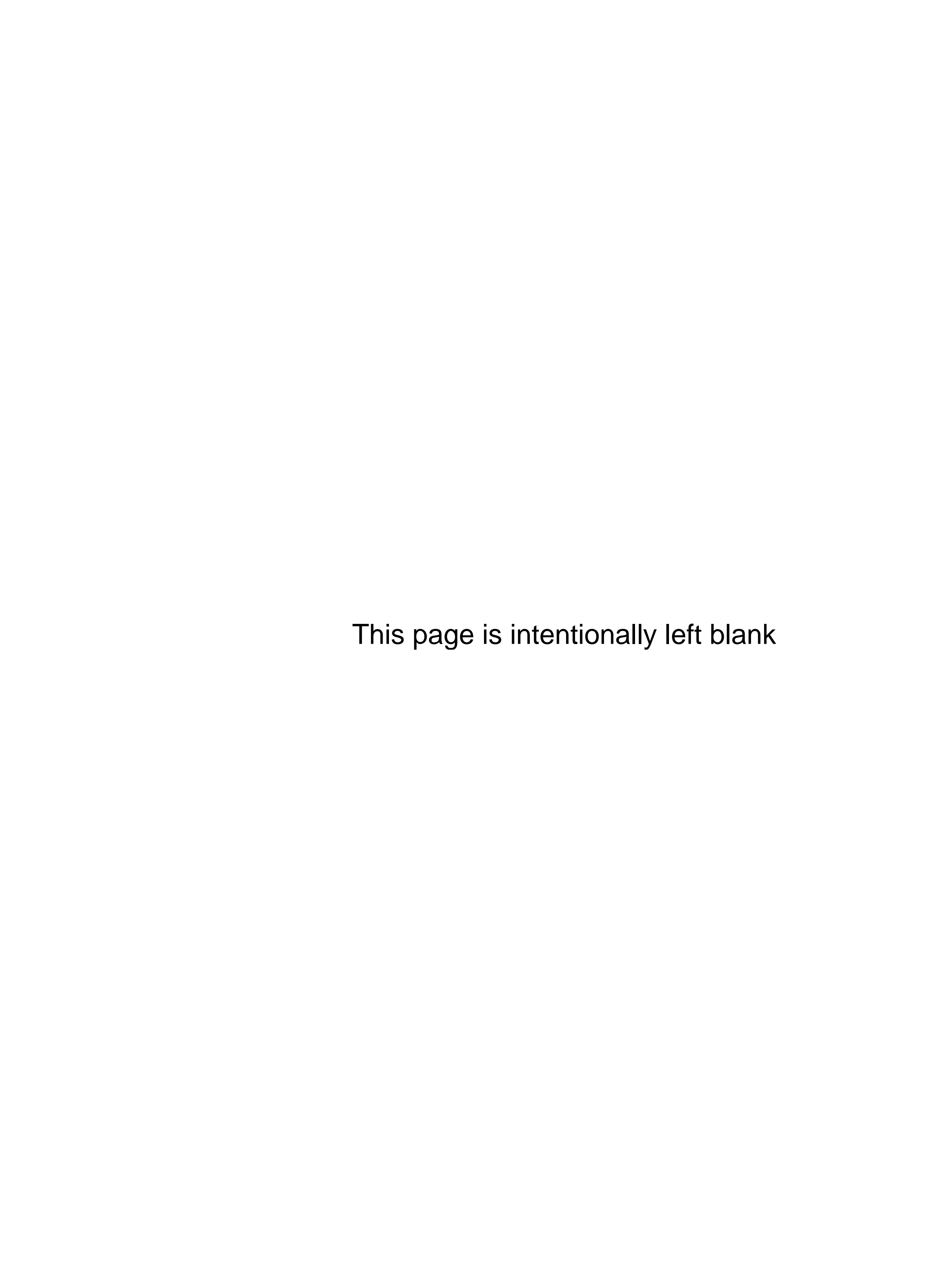
Priority Area	Recommendation	Outcome
2. Children and Young People (cont...)	**2.d)** To explore improving data capture on sexual orientation for all ages in RTSS data and promote this across the suicide prevention system.	Improved understanding and insight into LGBTQ+ as a risk factor for suicide, informing the Suicide Prevention Groups focus and approach.
	2.e) To work with local organisations and charities who work with the LGTBQ+ community on suicide prevention.	Improved insight and knowledge into the LGBTQ+ community and suicide prevention and risk, informing the Suicide Prevention Groups focus and approach.
	2.f) To raise awareness of the impact of the transitional period (children moving into adulthood) on the mental health impact and the risks of suicide during this period for children and young people.	Improved knowledge and understanding on the impact of the transitional period on mental health and suicide risk for children and young people for partners, professionals and the education sector.
3. Self-harm	**3.a)** Working with Mental Health Support Teams (MHSTs), ensure a continued focus on the prevention of self-harm by increasing resilience and general coping skills and support for those who self-harm.	School pupils at risk of self-harm or self-harming have improved coping skills, support and resilience.
	3.b)Decrease the stigma related to self-harm and encourage help seeking behaviour and self-care.	Those who self-harm feel able to seek help with less fear of stigma and have improved self-care.
	3.c) Help friends, family and professionals understand the physical and emotional signs of self-harm, how they can help and where they can get support.	Friends, family and professionals are able to identify and understand self-harm, how they can help and where to get support. Those who self-harm feel better supported by professionals, their friends and family.
	3.d) Explore the impact of self-harm on parents and siblings on their own mental health and wellbeing.	Further understanding of the impact of self-harm on parents and sibling's mental health and wellbeing, allowing future interventions into how to support these groups to be well informed.
	3.e) Explore means to improve local intelligence and data on self-harm to be regularly reviewed at the Berkshire Suicide Prevention Steering Group.	The Suicide Prevention Group able to respond to trends in self-harm and take action where appropriate.
4. Female Suicides	**4.a)** Link with the BOB and Frimley local maternity systems on suicide risks in the perinatal period	Awareness raised of the suicide risk in the perinatal period for local maternity systems. Local maternity systems aware of the work of the Suicide Prevention Group.
	4.b) To explore data collection on the perinatal period; risk factors and the link to suicide including data captured in the RTSS.	Improved understanding and insight into the risk factors and link to suicide within the perinatal period.
	4.c) Promote the need for clear pathways and knowledge exchange between domestic abuse and mental health services.	Domestic abuse services and mental health services have an improved understanding of the links between domestic abuse and suicide and are confident in utilising the pathways between the services.

Priority Area	Recommendation	Outcome
4. Female Suicides (cont...)	**4.d)** Improve data collection of domestic abuse data in RTSS.	Improved understanding and insight into domestic abuse as a risk factor for suicide within Berkshire.
	4.e) Include domestic abuse indicators in the Berkshire suicide audit to better understand the link between domestic abuse and suicide	Improved understanding and insight into domestic abuse as a risk factor for suicide within Berkshire.
	4.f) Provide information to domestic abuse services on how to respond to concerns where clients may be self-harming or considering suicide (whether the client is a victim, survivor, perpetrator or child or young person)	Improved knowledge and understanding of suicide risk and self-harm for domestic abuse professionals for all groups affected. Clients within the domestic abuse services who are at risk of self-harm or suicide feel better supported and able to access the services they need.
5. Economic Factors	**5.a)** Work with colleagues to raise awareness of the risk between debt, mental health and suicide risk among frontline professionals and the wider public. Awareness raising needs to; • reduce the stigma of 'being in debt' and signpost to access debt and benefit advice and support. this information also needs to be shared with frontline professionals • encourage people in debt to reach out for help to reduce impact on mental health • encourage people with poor mental health to reach out for debt advice	The risk between debt, mental health and suicide risk is further understood by frontline professionals and the wider public. The stigma of 'being in debt' is reduced for both frontline workers and the wider public, therefore potentially increasing the number of those seeking help. Frontline professionals feel confident to signpost to debt and benefit advice and support, encourage people to reach out for help, and for debt advice, therefore potentially increasing the number of those seeking help.
	5.b) Support frontline professionals to feel comfortable about talking about debt and financial problems and the link to poor mental health and suicide, and what support is available.	Frontline professionals feel comfortable and able to talk about debt and financial problems and can link this to poor mental health and suicide, and support available. Those with poor mental health benefit from accessing debt and financial support where needed following conversations with frontline professionals, reducing suicide risk.
	5.c) Support Berkshire local authorities with a single point of access information site around money matters.	There is a single point of access for information on money matters, allowing for up to date and consistent information being accessible to all.
	5.d) Ensure compassionate debt collection. Make sure the process is supportive and aims to steer residents to places that can provide help and support. Support vulnerable groups at increased risk of debt including people with long-term conditions or disabilities.	Reduction in stress and anxiety for those who are facing debt collection. Support and help highlighted to those facing debt collection, reducing stress and anxiety.
	5.e) Work with key partners to actively promote services that provide help around navigating the benefits system and potentially increasing people's incomes.	Improved understanding of navigating the benefits system, therefore potentially increasing incomes and reducing financial stress, reducing suicide risk.

Priority Area	Recommendation	Outcome
5. Economic Factors (cont...)	**5.f)** Make sure that all parts of the health service where patients showing suicidal intent first make contact, are signposted or triaged appropriately using a process that includes debts and other economic stresses as risk factors.	Identification of debt and economic stresses as risk factors upon first contact, therefore allowing professionals to have a better-informed approach to support, signposting and guidance, reducing suicide risk. Self-help or advisors for debts and practical issues (housing, relationships) highlighted to patients, therefore potentially reducing anxiety and stress.
	5.g) Work with system partners on the early identification and support of people who are at increased risk of debt and financial concerns (e.g. unemployed or people with long-term conditions) as early as possible and offer effective support to manage personal finances through appropriate referral pathways.	Reduction in debt and financial stresses as a risk factor for suicide for those who are at an increased risk.
	5.h) Monitor local data and intelligence on levels of problem gambling within Berkshire and its link to suicide.	Improved understanding of the levels of problem gambling and its link to suicide within Berkshire, informing the Suicide Prevention Group's approach.
6. Bereaved by Suicide	**6.a)** Ensure our local bereavement offer is culturally and ethnically appropriate for different groups within communities to develop resources and services.	The local bereavement offer is available and accessible for all groups within Berkshire and has accessible resources and services. Different groups within communities feel the services are culturally and ethnically appropriate.
	6.b) Continued support to the volunteer led local SoBS groups to be able to continue to offer a peer-to-peer support service.	Those bereaved by suicide can access and benefit from a peer-to-peer support service.
	6.c) Building in bereavement support to extend to wider family members, friends and communities.	Wider family members, friends and communities are able to access bereavement support, and feel able and supported in doing so, potentially improving their emotional and mental wellbeing.
	6.d) Continue to commission suicide bereavement support services and monitor its impact.	Bereavement support services are available and accessible across Berkshire, providing consistent support for those bereaved.
	6.e) Explore training opportunities for staff impacted by suicide.	Training for staff impacted by suicide in place and being delivered where appropriate, potentially improving emotional and mental wellbeing for staff following suicide.
	6f) Work with Thames Valley Police and other first responders to a suicide to share appropriate resources with employers	Employers able to better support their staff who have been affected by suicide.

Berkshire **Suicide Prevention** Strategy

2021-2026



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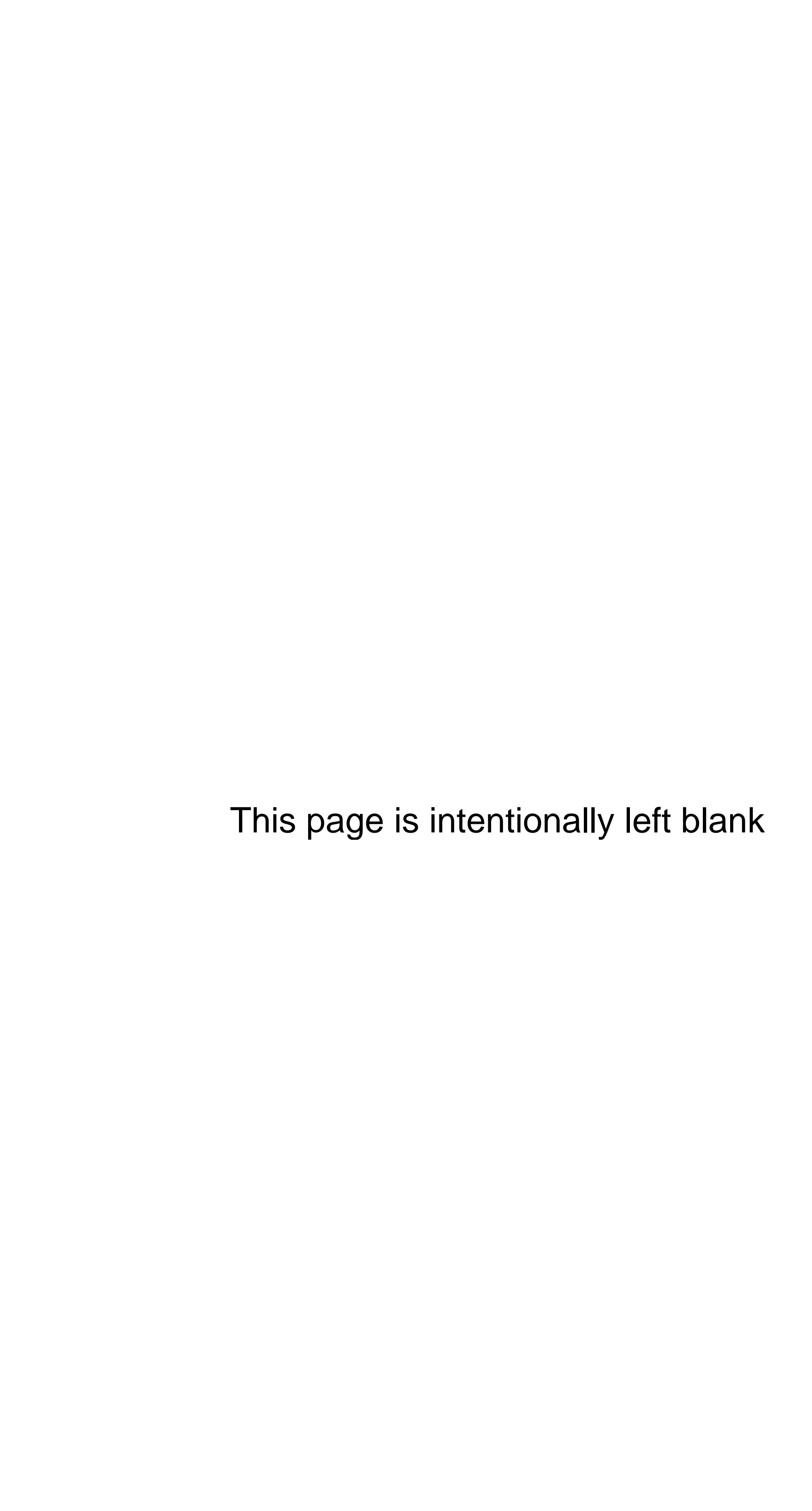
Health & Wellbeing Board – 30 September 2021

Item 10 – Working with Refugees and Migrants in West Berkshire

Verbal Item



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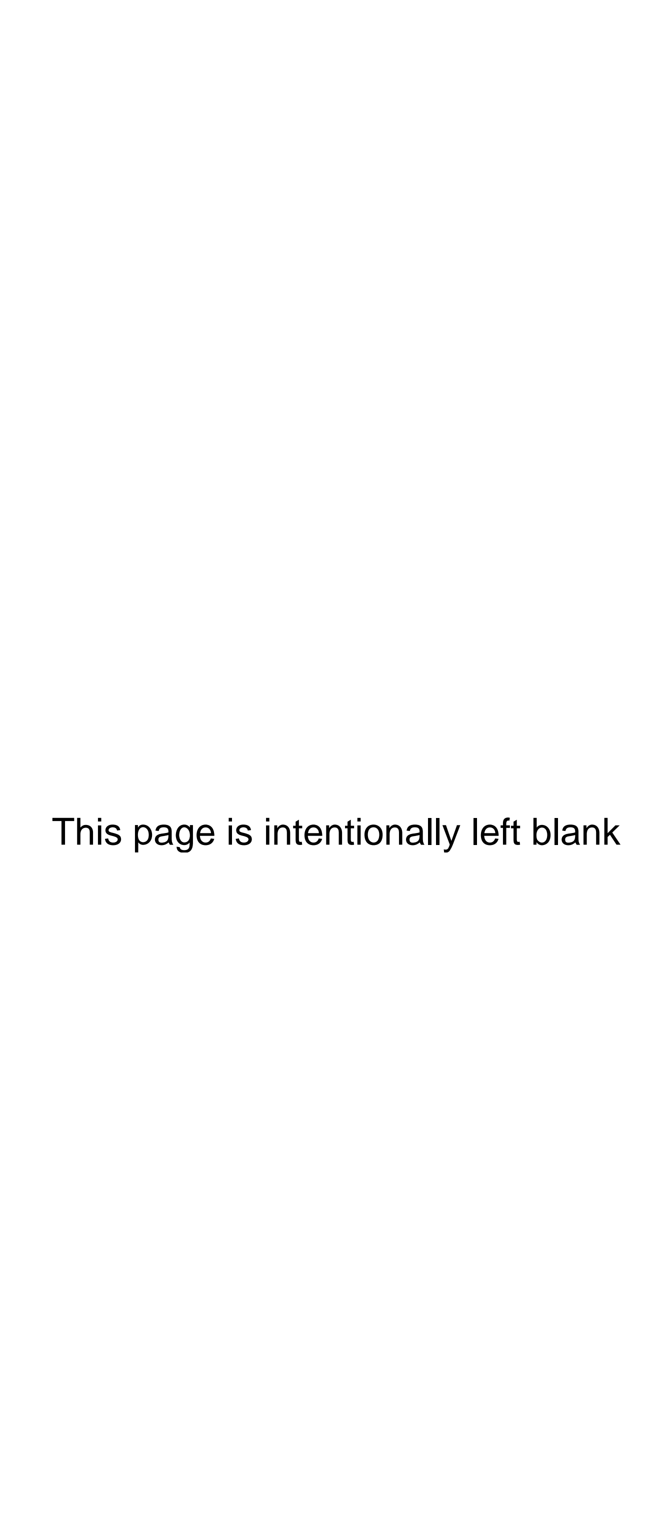
Agenda Item 11

Health & Wellbeing Board – 30 September 2021

Item 11 – Availability of GP Appointments in West Berkshire

Verbal Item



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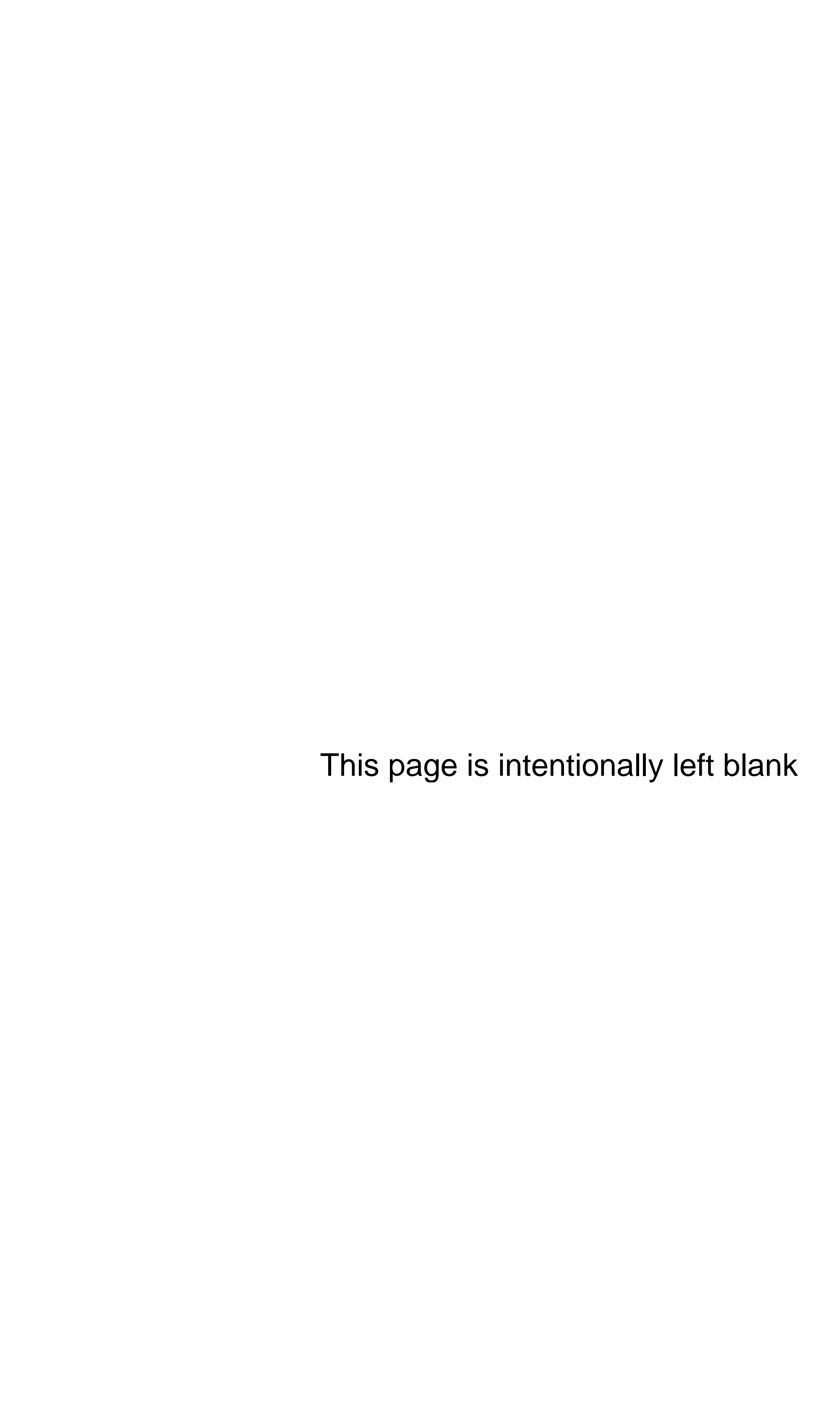
Agenda Item 12

Health & Wellbeing Board – 30 September 2021

Item 12 – ICP Priority: Rapid Discharge Programme

Verbal Item



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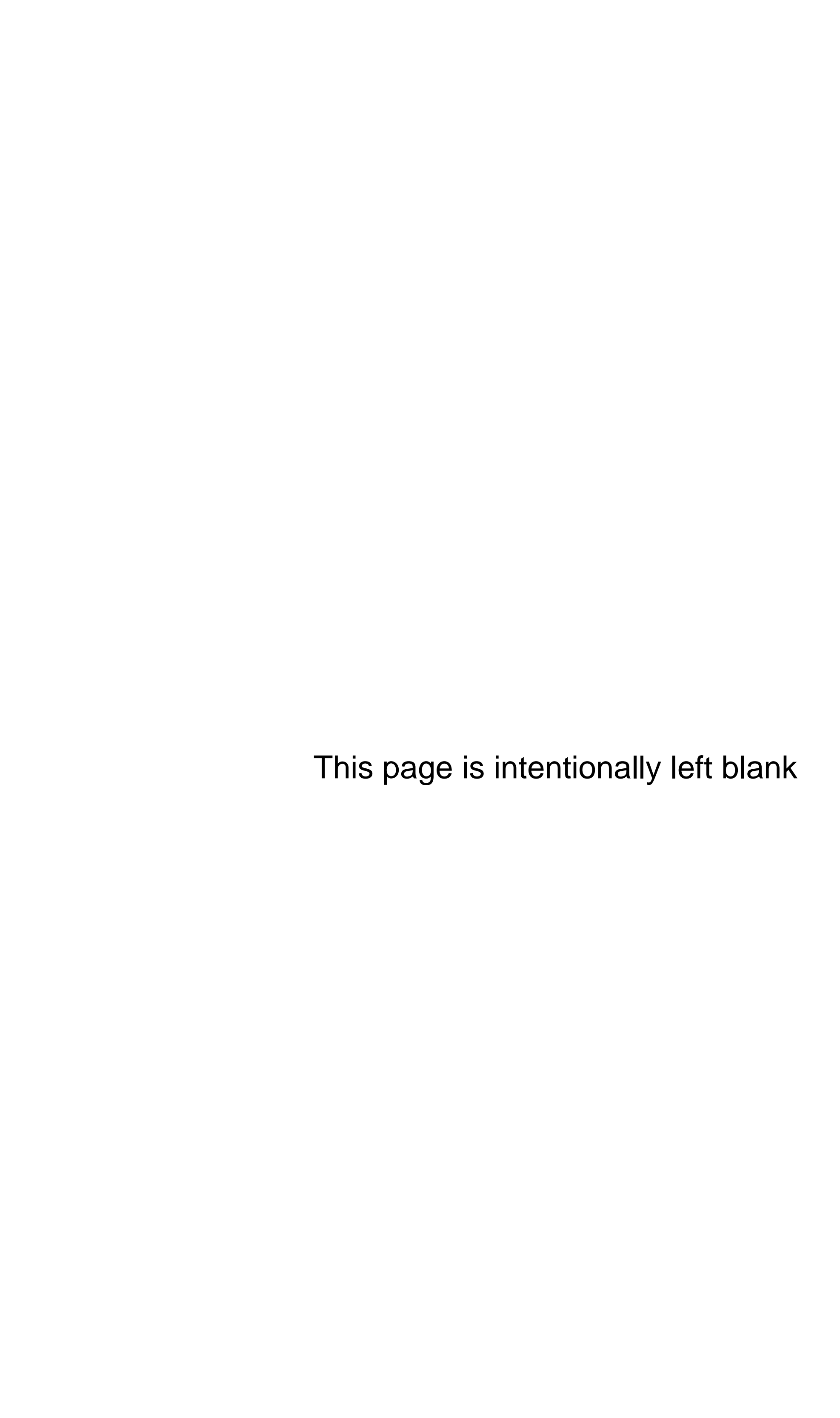
Health & Wellbeing Board – 30 September 2021

Item 13 – ICP Priority: Emotional Health and Wellbeing for Children and Young People

Verbal Item



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Response to the Council Motion relating to the use of phone boxes for defibrillators

Report being considered by:	Health and Wellbeing Board
On:	30 September 2021
Report Author:	Matthew Pearce and Gordon Oliver
Item for:	Decision

1. Purpose of the Report

To provide a response to the motion submitted in the name of Councillor Adrian Abbs at the Council meeting on 8 July 2021, which was referred to Health and Wellbeing Board for further consideration, namely:

This Council notes:

- *That existing telephone boxes are being offered to the council for free or as little as £1.*
- *That telephone boxes make ideal environments to place public access defibrillators due to their existing power and the shelter they offer.*
- *That defibrillators are known to save lives.*
- *That those minutes and seconds are critical to a positive outcome where defibrillators are used.*

This Council, therefore resolves to:

1.1 take a default position where it would adopt any telephone boxes being offered throughout West Berkshire for use as an Open Access Defibrillator location.

1.2 install an Open Access Defibrillator in each adopted box should another defibrillator not be present within 100 metres.

1.3 make residents local to that defibrillator aware of its presence

1.4 provide a "how to use a defibrillator" guide to all residents within 400 metres of the device.

1.5 ensure the location of the device is added to the emergency services register of defibrillators.

1.6 undertake the minimal servicing required to keep the devices active or devolve this to the local parish or town council.

Costs are maximum £1500 per defibrillator including purchase and installation.

2. Initial observations

2.1 In July 2021, following notice of the Motion, Cllr Bridgman (Chairman of the Health and Wellbeing Board) addressed an enquiry to BT which resulted in a response that 34 telephone kiosks had been adopted across the district (but with no details of the uses they have been put to) and that there were (apparently) only two "live" kiosks left within West Berkshire that hadn't been adopted or removed - one outside the Post Office in High Street, Hungerford (RG7 0DP) and the other outside the Telephone Exchange in Newbury Street, Lambourn (RG17 8PD).

2.2 It is considered that this response might underestimate the number of telephone kiosks (suitable for other uses) that exist in the district (whether adopted or not).

2.3 There are several databases of defibrillators available, but most only appear to have partial data sets, and are of limited value, as well as being confusing to members of the public. The Circuit is being promoted as the national data set. This is supported by the British Heart Foundation, St John Ambulance, Resuscitation Council UK and the Association of Ambulance Chief Executives.

3. Recommendations

3.1 That the Health and Wellbeing Board (via the Councils' Public Health Team) undertakes the following research/actions:

- Ask all town/parish councils to confirm the locations of telephone kiosks within the town or parish and whether they are in use or defunct and, if defunct, identify whether they have been adopted via the BT scheme, and if so by whom and for what purpose.
- Ask all town/parish councils to also identify publicly accessible Automated External Defibrillators (AEDs) within their local area and to check these against the locations on the Save a Life App, with any missing devices registered via The Circuit.
- A cost-benefit analysis to assess whether additional defibrillators should be provided and where any new devices would be most effectively deployed.
- Following that analysis, and where additional units are considered likely to be effective, to approach town/parish councils and local communities to identify suitable sites (including phone boxes), and to ask those respondents if they would be willing to take responsibility for the installation and ongoing maintenance of any new AEDs.
- An investigation into all available funding streams for new AEDs.
- Initial publicity to ensure residents are aware of existing AED locations and how to locate them in the event of encountering someone experiencing cardiac arrest.
- Consideration of funding a programme of First Aid training in schools and colleges and the wider community, to include the use of AEDs.

3.2 That following the research and a Report as to findings, the Board considers what recommendations should be made to Council (and possibly to other partners) in response to the Motion and as to how funding and resources can best be used to address the health and wellbeing needs of local residents.

Will the recommendation require the matter to be referred to Council for final determination?	Yes: ☒	No: ☐

4. Introduction/Background

What is a Defibrillator?

4.1 A defibrillator is a device that gives a high energy electric shock to the heart of someone who is in cardiac arrest. This high energy shock is called a defibrillation, and it's an essential part in trying to save the life of someone who is in cardiac arrest. A defibrillator may also be referred to as a 'defib', an AED, or a PAD (Public Access Defibrillator when purchased for public use).

4.2 An AED is an easy to use, portable defibrillator which provides clear step-by- step instructions so it can be used by anyone from a bystander to a trained professional. Once the pads are placed on the patient's chest, the defibrillator checks the heart rhythm, providing voice instructions to guide the rescuer through each step of the rescue, and if needed, provides a shock to the patient either automatically or at the press of a button. Some defibrillators come with additional features, such as an LCD display screen for visual instructions, real time

cardiopulmonary resuscitation (CPR) feedback to let the rescuer know the quality and effectiveness of their CPR, or electrocardiogram (ECG) display for more professional models.

4.3 Defibrillators can be used on adults or children over one year old. By using a defibrillator before an ambulance arrives, you can significantly increase someone's chance of survival.

4.4 Defibrillators can be used on adults or children over one year old. By using a defibrillator before an ambulance arrives, you can significantly increase someone's chance of survival.

5. Supporting Information

National/Charity Guidance

5.1 When considering an AED in a community setting, the Resuscitation Council UK has the following guidance:

- There should be a process in place to ensure all equipment and supplies are in working order.
- All organisations should conduct a risk assessment regarding the provision of an AED.

5.2 To achieve this, organisations should have systems in place to:

- Ensure that emergency equipment is located and signposted appropriately and checked according to manufacturers' guidelines;
- Ensure that training covers the use, location and checking of equipment;
- Monitor the checking of equipment, including record of expiry dates and functionality of equipment, using signed and dated checklists;
- Where owned or leased by the organisation, ensure the AED is registered with the local ambulance service and/or national defibrillator network.

5.3 There are different recommendations in regards to where a defibrillator should be kept, which can vary by different local ambulance trust. Points to consider include:

- Community locations should be accessible 24/7;
- Locations should be highly visible;
- Units should have a heated cabinet when located outside;
- The cabinet should have a keypad lock to prevent theft/vandalism (the ambulance service can provide the keypad code when the user dials 999);
- The cabinet requires a power supply for the heater;
- Lighting and CCTV should be considered to improve security;
- Community guardians should be assigned to carry out weekly maintenance checks and reset units/replenish pads after use.

5.4 It is also recommended by St John's Ambulance, The British Heart Foundation, Resuscitation Council UK and UK Ambulance Services that defibrillators are registered with The Circuit so that they can be easily located and accessed.

How effective are defibrillators?

5.5 If a defibrillator is used within 3 -5 minutes of cardiac arrest, survival rates increase from 6% to 74%. (First Aid for Life).

5.6 The National Institute for Health Research (NIHR) conducted a systematic review of 41 observational studies that compared out-of-hospital cardiac arrest survival according to the

use of a defibrillator. Their study found that following a cardiac arrest, the survival rate was higher following defibrillator attachment from a bystander. The study also highlighted the importance of having defibrillators in the community, saying that, 'providing a shock using a defibrillator to people with out-of-hospital cardiac arrest before the arrival of emergency medical services increases their chance of survival'. Overall the review findings support the need for installation of publicly available defibrillators so that members of the public can assist those experiencing cardiac arrest until emergency services arrive and in turn increase that individual's chances of surviving.

5.7 Figures published by London Ambulance Service also show that when a PAD was used by a bystander and at least one shock was delivered to patients, the survival rate was more than five times higher (57.1%) than conducting CPR.

5.8 Unfortunately, there is a scarcity of literature reporting hospital costs for treating out of hospital cardiac arrest (Petrie et al., 2015). However, the review at a London hospital conducted by Petrie et al (2015), confirmed that high quality survivors of cardiac arrest are less likely to stay in ICU as long and therefore cost less. Whereas, the stay in ICU for low quality survivors of cardiac arrest was significantly longer. This confirms that there is a significant correlation between length of stay and cost.

5.9 Overall, the use of defibrillators has been shown to be effective in increasing survival rates for victims of cardiac arrest, especially if they are used early. Therefore, the use of a defibrillator during cardiac arrest can be attributed to an individual who is a high quality survivor. The use of a defibrillator is likely to help reduce the demand on the NHS, but also the cost, as patients are more likely to be discharged from hospital.

Would having more AEDs in the community prevent more deaths?

5.10 A cardiac arrest can happen to anyone. Every year approximately 55 out of every 100,000 people experience an out-of-hospital cardiac arrest, with most occurring in the home or workplace. In 7 out of 10 cases, CPR is attempted by a bystander. In less than 1 out of 10 cases is an AED reported as being used (St John's Ambulance).

5.11 In the UK per year:

- 12 people under the age of 35 die each week from sudden cardiac arrest;
- 270 children die from sudden cardiac arrest suffered on school premises;
- Of the 30,000 out-of-hospital cardiac arrests, 80% happen at home and 20% occur in public places;
- In the south East of England each year there are 4,500 Cardiac Arrest out of hospital.

5.12 Every minute's delay giving CPR and defibrillation reduces a victim's survival rate by 7-10% and therefore, quick action is absolutely vital, as without immediate treatment, 90-95% of cardiac arrests prove fatal (Online First Aid).

5.13 The British Heart Foundation supports the use of defibrillators in the community and reports that for every minute someone is in cardiac arrest without CPR and access to a defibrillator their chances of survival drops by 10%. Having a public access defibrillator available in an emergency can be lifesaving, especially in rural areas where response times can be longer.

5.14 Ambulance arrival times at life threatening emergencies in West Berkshire vary greatly depending on location and demands. The following statistics were correct as of 16 September 2021 (http://www.ambulanceresponsetimes.co.uk):

- RG17 postcode (Lambourn, Great Shefford, Hungerford, Inkpen area):
  - 18% of life-threatening calls responded to in under 8 minutes
  - Median response time = 12 min 42 sec

- RG7 postcode (Aldermaston, Bradfield Burghfield, Mortimer, Theale):
  - 44% of life-threatening calls responded to in under 8 minutes
  - Median Response time = 8 min 33 sec
- RG14 postcode (Newbury):
  - 85% of life-threatening calls responded to in under 8 minutes
  - Median response time = 5 min 6 sec

5.15 In the UK, survival rate is far lower than in Scandinavian countries where higher importance is placed on the education and training of school children and the general population to ensure that they are sufficiently skilled and equipped to be able to immediately help someone when they collapse.

5.16 A bystander performing CPR and using an AED can increase the chances of survival by two to four-fold. (Resuscitation Council UK).

5.17 When a defibrillator is used correctly in conjunction with good CPR, the odds of someone's survival can increase from around 6% to 74% (First Aid For Life)

5.18 In the population-based cohort study by Petrie et al (2015), application of an AED in communities before the emergency services arrived, was associated with nearly a doubling of survival after out-of-hospital cardiac arrest. These findings supported the expansion of strategically placed community-based AED programs.

5.19 Wide dissemination of AEDs throughout a community increases survival from cardiac arrest when the AED is used; however, the AEDs are utilized in a very small percentage of all out-of-hospital cardiac arrests. AEDs save very few lives in residential units such as private homes or apartment complexes. AEDs are cost effective at sites where there is a high density of both potential victims and resuscitators. (Winkle, RA 2011).

Current defibrillator locations and databases

5.20 Currently, many defibrillators never get used because emergency services don't know where they are or how to access them (British Heart Foundation).

5.21 There are several AED databases available, but most only appear to have partial data sets, and are of limited value, as well as being confusing to members of the public. The Circuit is being promoted as the national data set. This is supported by the British Heart Foundation, St John Ambulance, Resuscitation Council UK and the Association of Ambulance Chief Executives.

5.22 SCAS uses The Circuit and has developed the Save a Life App to show where units are provided in their area. This database shows numerous AEDs across West Berkshire, with multiple units in larger settlements and individual units in many local villages. However, there do appear to be some gaps (eg Upper Lambourn, West Woodhay, East Woodhay, Hamstead Marshall, Upper Basildon, Lower Basildon).

5.23 Locations include town and parish council offices, businesses, churches, village/community halls, sports clubs, schools, leisure centres, health centres and phone boxes.

5.24 The Motion to Council referred specifically to the adoption of phone boxes to accommodate AEDs. In some ways, phone boxes are well-suited for this purpose, since they are publicly accessible and are often in visible locations at the roadside. They also provide shelter, power and lighting. BT currently operates an 'adopt a kiosk' programme where phone boxes can be adopted by the local community for as little as £1.00.

Purchase Costs

5.25 The cost of a defibrillator can vary depending on the model and its features. Typically, defibrillators can cost between £800 and £2,500 (St John's Ambulance). South Central

Ambulance Service (SCAS) quote the cost of an AED at £1,850 including a secure box excluding fitting charges. The cost includes:

- AED
- Ready kit (towel, razor, gloves, pocket mask, scissors)
- Cabinet with heating/alarm
- Theft insurance for the warranty period
- AED Management software and download software
- Warranty of up to 10 years and indemnification policy
- Replacement electrodes within the warranty period
- Replacement battery within the warranty period
- Access to e-learning

5.26 SCAS can also provide AED awareness training to those who purchase one.

5.27 Defibrillators come with varying degrees of protection from dust and water, making some models more suitable in harsher environments than others. St Johns Ambulance has a useful guide on their website showing a range of AED and their costs (https://www.sja.org.uk/get-advice/i-need-to-know/defibrillator-guide-for-first-time-buyers/).

Maintenance

5.28 Some defibrillators self-test on a daily, weekly or monthly basis – so the device would signal with a flashing light or audible alert if there was a problem, for example, pads not correctly connected, or low battery. Defibrillators also run through a self-test when activated, prior to use.

5.29 The defibrillator is required to be inspected regularly to ensure the pads are in date, and the battery hasn't expired. This can be aided through a defibrillator checklist.

5.30 Defibrillator pads and batteries can cost anything from £20 to £300 to replace depending on the model, Pads and batteries will need to be replaced when they expire or when the pads have been used in a rescue (St John's Ambulance).

Funding

5.31 There does not appear to be any source of public funding currently available for AEDs. However, there are some other sources of funding available to organisations wishing to purchase and install AEDs for public use.

5.32 British Heart Foundation (BHF) has an online application system for public access defibrillators. They will part-fund an AED, and the procuring organisation will still need to contribute the remaining funds. A successful application will also need to show that the defibrillator must be freely accessible to the public 24/7 and be placed externally in an unlocked and un-coded cabinet. There must be a clear need for the device (eg a location with high footfall or in a rural area) and there must be a commitment to train the local community in the use of the AED. This funding stream is currently paused due to the Covid 19 pandemic, but it is expected to resume in the future.

5.33 Some town/parish councils have secured funding for AEDs through the National Lottery Community Fund, with grants for individual units to larger programmes.

5.34 The Football Association has recently announced that it will fund the provision of AEDs at grassroots football clubs and facilities. Working in partnership with the Football Foundation and The Football Association, the first phase of the Premier League Defibrillator Fund rollout will have AEDs provided to Football Foundation funded facilities which currently are without a

life-saving device onsite. In the second phase, grassroots clubs that own their facilities will be able to apply for funding for a defibrillator, with more than 2,000 sites benefiting.

6. Options for Consideration

6.1 West Berkshire Council could seek to adopt some/all of the remaining public phone boxes in the district and install additional AEDs in order to increase coverage across the district. In addition to the £1,850 typical purchase cost for the AED, there would be an ongoing cost for electricity usage at each site. Also, there would be a resource implication in terms of undertaking regular checks of all locations in the district.

6.2 Alternatively, town/parish councils and community groups could be encouraged to adopt their local phone boxes and install AEDs, appointing volunteer guardians to carry out regular maintenance inspections.

6.3 However, phone boxes may not always be situated in the most appropriate location for an AED. For example, an AED installed in a rural phone box may never be used because it is away from centres of population where there are likely to be significant concentrations of people experiencing cardiac arrest and passers-by who could act as responders. Similarly, phone boxes may be close to an existing AED location, which would render them obsolete. A wider review considering all potential AED locations within the District (not just phone boxes) would be more appropriate and deliver greater benefits.

6.4 Public awareness is key to the effectiveness of defibrillators. Knowledge of how to and when to use the unit and how to find a defibrillator in the community helps to increase their use and effectiveness. It is important that all units are registered on a database that is available to the emergency services so they can direct people to their nearest unit and provide instructions about how to access and use it.

6.5 Also, knowledge of first aid/CPR can be beneficial in terms of complementing the use of an AED and delivering improved outcomes for the person experiencing cardiac arrest. Online and in person training can help to improve knowledge within the community.

7. Proposal(s)

7.1 As a first step, it is proposed that all town/parish councils be asked to confirm the locations of publicly accessible AEDs within their local area. These should be checked against the locations on the Save a Life App, and any missing devices registered via The Circuit.

7.2 It is proposed that a cost-benefit analysis should be carried out to assess whether additional defibrillators should be provided and where any new devices would be most effectively deployed.

7.3 Where additional units are considered likely to be effective, town/parish councils and local communities should be approached to identify suitable sites (including phone boxes). They would also be asked if they would be willing to take responsibility for the installation and ongoing maintenance of any new AEDs, identifying volunteer guardians to carry out the weekly checks.

7.4 A PR campaign should be linked to any roll-out of defibrillators so residents are aware of their locations and how to locate them in the event of encountering someone experiencing cardiac arrest. This would be likely to utilise a multi-media approach, which may include leaflet drops to residents in the vicinity of each site.

7.5 Consideration should also be given to funding a programme of First Aid training in schools and colleges and the wider community, to include usage of AEDs.

8. Conclusion(s)

8.1 Defibrillators can be effective in saving lives. However, units need to be optimally located in populated areas where there are more likely to be higher number of cardiac arrests and people

available to use the defibrillators. While phone boxes can be utilised to house AEDs, they must be in the correct locations in order to be effective.

8.2 Public awareness is also key to the effectiveness of defibrillators - knowing how and when to use the unit and how to find a defibrillator in the community helps to increase their use and effectiveness. This requires all units to be registered on a database that is accessible to the emergency services, so they can direct people to the nearest unit, provide the access code, and give detailed instructions on how to use it.

8.3 Increased community knowledge of first aid would deliver additional benefits over and above those associated with the increased deployment and use of AEDs.

9. Consultation and Engagement

The report has been informed by a literature review on the effectiveness of AEDs, but no specific consultation and engagement had been undertaken to date

10. Appendices

None

Background Papers:

Ambulance Response Times
http://www.ambulanceresponsetimes.co.uk/

British Heart Foundation
https://www.bhf.org.uk/how-you-can-help/how-to-save-a-life/cpr-training-in-communities/defibrillators-in-communities
https://www.bhf.org.uk/how-you-can-help/how-to-save-a-life/defibrillators/apply-for-a-public-access-defibrillator

BT
https://business.bt.com/campaigns/communities/adopt-a-kiosk

The Circuit
http://www.thecircuit.uk

First Aid For Life
https://firstaidforlife.org.uk/all-about-defibrillators-aeds-what-they-are-and-how-to-use-them/
www.FirstAidforLife.org.uk

Football Foundation
https://footballfoundation.org.uk/grant/premier-league-defibrillator-fund

London Ambulance Service
https://www.londonambulance.nhs.uk/2020/01/29/we-release-new-stats-on-cardiac-arrests-showing-survival-rates-outside-of-hospital-reach-all-time-high/

National Institute of Health Research
https://evidence.nihr.ac.uk/alert/use-of-public-defibrillators-linked-to-out-of-hospital-cardiac-arrest-survival/

Online First Aid
https://onlinefirstaid.com/defibrillators-save-lives/?nowprocket=1

Petrie, J., Easton, S., Naik, V., Lockie, C., Brett, S. and Stumpfle, R., 2015. Hospital costs of out-of-hospital cardiac arrest patients treated in intensive care; a single centre evaluation using the national tariff-based system. *BMJ Open*, 5(4), pp.e005797-e005797.

Resuscitation Council UK
https://www.resus.org.uk/library/2021-resuscitation-guidelines
https://www.resus.org.uk/library/quality-standards-cpr/quality-standards-cpr-and-aed-training-community

St John's Ambulance
https://www.sja.org.uk/get-advice/first-aid-advice/unresponsive-casualty/how-to-do-cpr-on-an-adult/
https://www.sja.org.uk/get-advice/i-need-to-know/defibrillator-guide-for-first-time-buyers/
https://www.sja.org.uk/first-aid-supplies/defibrillators-accessories-and-training-models/
https://www.sja.org.uk/globalassets/checklists/defib_checklist_20213.pdf

South Central Ambulance Service
https://www.scas.nhs.uk/news/campaigns/savealife

Winkle RA. The effectiveness and cost effectiveness of public-access defibrillation. Clin Cardiol. 2010 Jul;33(7):396-9. doi: 10.1002/clc.20790. PMID: 20641115; PMCID: PMC6653549

Health and Wellbeing Priorities 2019/20 Supported:
- ☐ Give every child the best start in life
- ☐ Primary Care Networks

Health and Wellbeing Strategic Aims Supported:

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):
- ☐ Give every child the best start in life
- ☐ Support mental health and wellbeing throughout life
- ☒ Reduce premature mortality by helping people lead healthier lives
- ☐ Build a thriving and sustainable environment in which communities can flourish
- ☐ Help older people maintain a healthy, independent life for as long as possible

The proposals contained in this report will help to achieve the above Health and Wellbeing Strategy aim by reducing the number of deaths from cardiac arrest.

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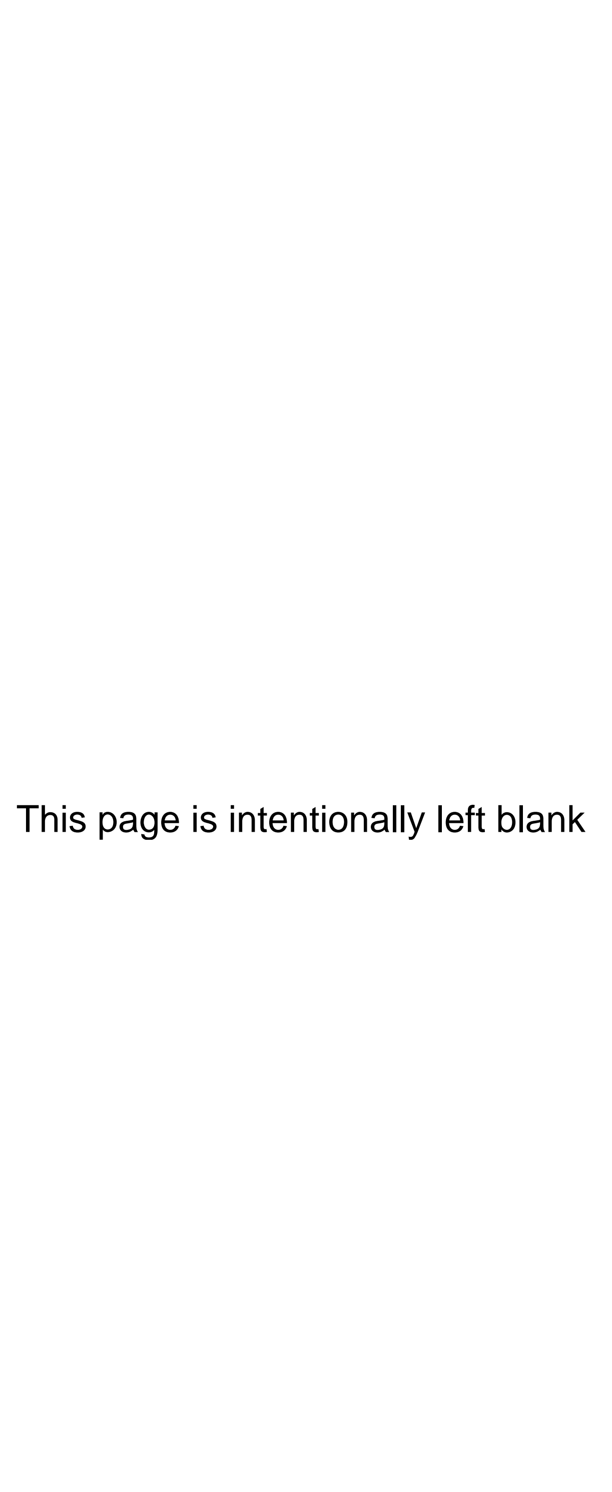

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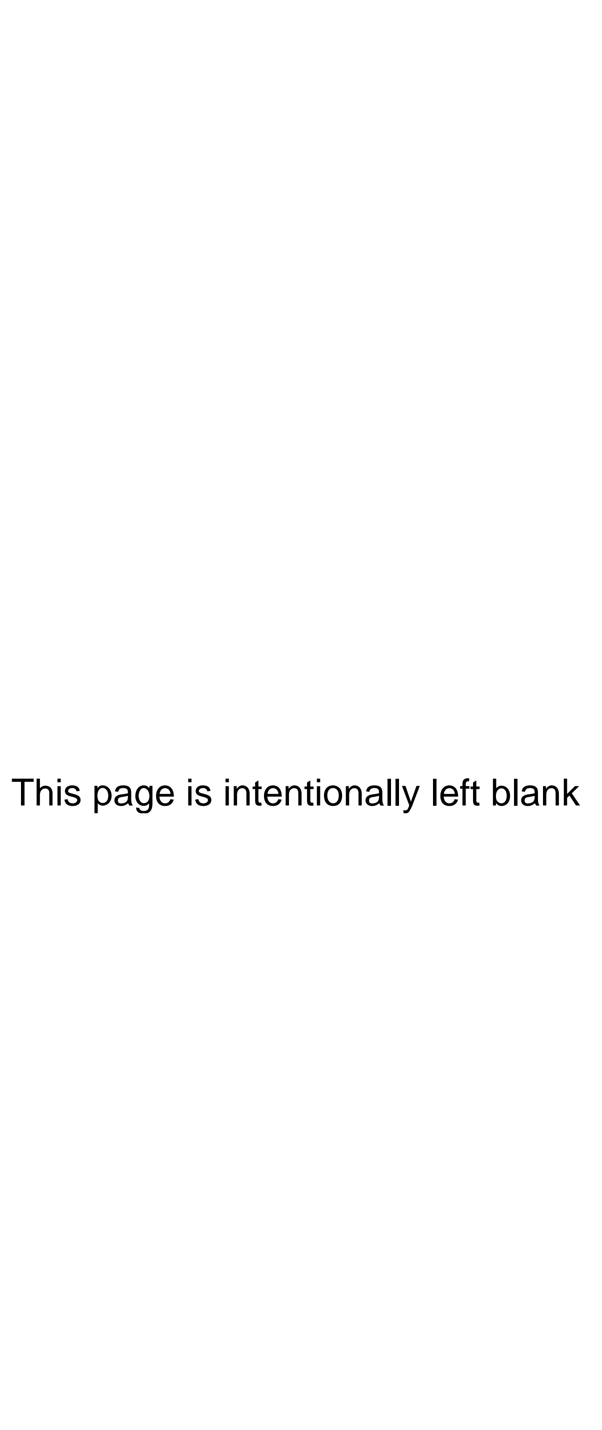
Health & Wellbeing Board – 30 September 2021

Item 15 – Health & Wellbeing Conference

Verbal Item



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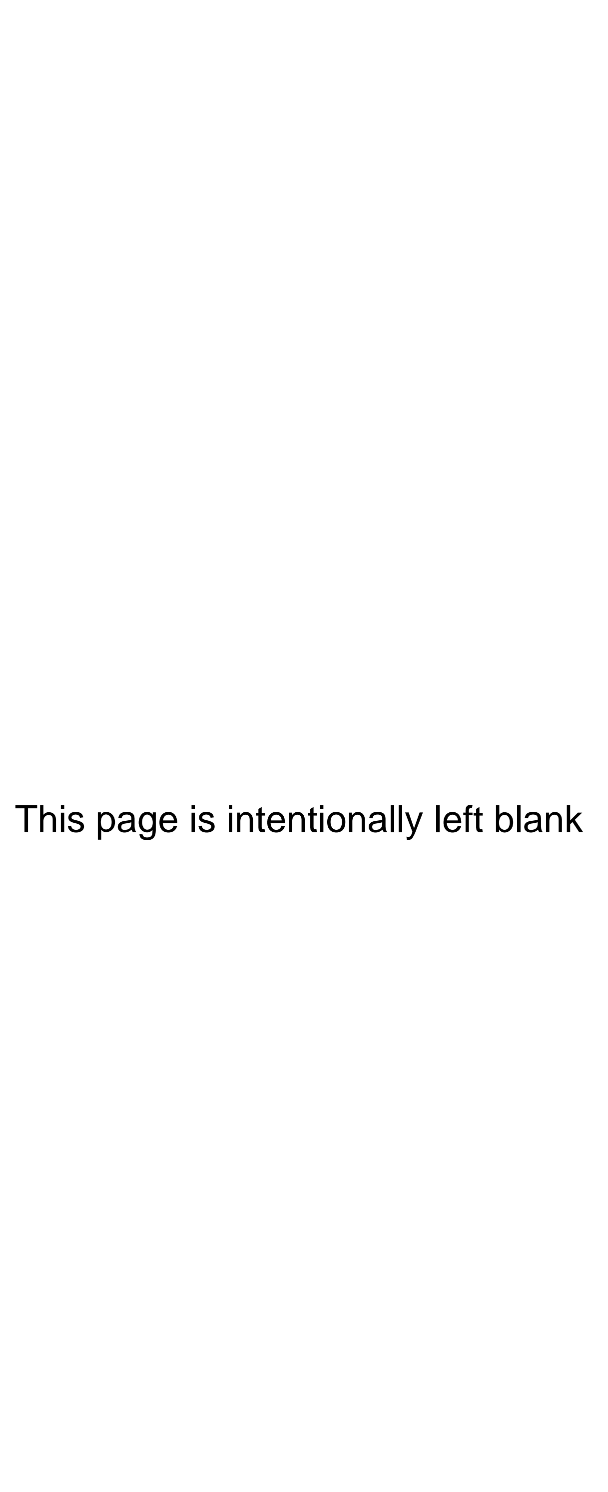
Health & Wellbeing Board – 30 September 2021

Item 16 – Members' Questions

Verbal Item



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Health and Wellbeing Board Forward Plan 2020/21 (All meetings are on a Thursday, starting at 9.30am in the Council Chamber except where otherwise stated)

There is a fire alarm and lockdown alarm in the Council Chamber at 10am on Thursdays.

Item	Purpose	Action required by the H&WB	Date Agenda Published	Lead Officer/s	Those consulted
15 October - Conference					
Date TBC - Hospital Developments (Informal Meeting)					
Royal Berkshire Hospital Development Proposal	Royal Berkshire NHS Foundation Trust to provide an update on their hospital redevelopment proposal.	For information and discussion	TBC	TBC	Health and Wellbeing Steering Group
North Hampshire Hospital Development Proposal	Hampshire Hospitals NHS Foundation Trust to provide an update on their hospital redevelopment proposal.	For information and discussion	TBC	TBC	Health and Wellbeing Steering Group
09 December 2021 - Board meeting					
Strategic Matters					
Joint Health and Wellbeing Strategy Delivery Plan 2021 - 2024	To present the final version of the Delivery Plan for approval.	For decision	01/12/2021	Sarah Rayfield	Health and Wellbeing Steering Group
Review of Health and Wellbeing Board Sub-Groups	To agree the structure of the Health and Wellbeing Board Sub-Groups to reflect the priorities identified in the Joint Health & Wellbeing Strategy.	For decision	01/12/2021	TBC	Health and Wellbeing Steering Group
Review of Health and Wellbeing Board Terms of Reference	To agree the updated terms of reference for the Health and Wellbeing Board and Steering Group to reflect the new Joint Health and Wellbeing Strategy.	For decision	01/12/2021	TBC	Health and Wellbeing Steering Group
National Health and Social Care Levy	To consider the new Health and Social Care Levy and what it means for West Berkshire.	For information and discussion	01/12/2021	Paul Coe / Katie Summers	Health and Wellbeing Steering Group
Joint Funding (Health and Social Care)	To present the outcome of the review of Joint Funding for Health and Social Care.	For information and discussion	01/12/2021	Katie Summers / Niki Cartwright	Health and Wellbeing Steering Group
Annual Report from the Director of Public Health	To present the annual report into the health and wellbeing of people in Berkshire as prepared by the Director for Public Health.	For information and discussion	01/12/2021	Meradin Peachey	Health and Wellbeing Steering Group
Operational Matters					
COVID Recovery	To provide an update on implementation of the Recovery Strategy	For information and discussion	01/12/2021	Joseph Holmes	Health and Wellbeing Steering Group
Skills and Enterprise Partnership Update	To provide an update on the work of the work of the Skills and Enterprise Partnership to promote the sustained employment of people from underrepresented groups	For information and discussion	01/12/2021	Iain Wolloff	Health and Wellbeing Steering Group
ICP Transformation Programme	To provide a detailed updated on one of the ICP priorities for 2021/22 (TBC)	For information and discussion	01/12/2021	Andy Sharp	Health and Wellbeing Steering Group
17 February 2022 - Board meeting					
Programme Management					
Delivery of Health & Wellbeing Strategy - Q3 2021/22	To provide the performance dashboard for the delivery of the health and wellbeing strategy and highlight any emerging issues.	For information and discussion	09/02/2022	Gordon Oliver	Health and Wellbeing Steering Group
Strategic Matters					
West Berkshire Vision 2036	To provide a progress report and consider whether the vision needs to be updated	For information and discussion	09/02/2022	Nigel Lynn / Catalin Bogos	Health and Wellbeing Steering Group
West of Berkshire Safeguarding Adults Board	Presentation of Annual Report for 2019/20	For information	09/02/2022	Teresa Bell - Independent Chair of SAB	Health and Wellbeing Steering Group
Voice of Disability	To report back on the recommendations made in relation to the Healthwatch VoD report	For information and discussion	09/02/2022	Andrew Sharp	Health and Wellbeing Steering Group
Operational Matters					
ICP Transformation Programme	To provide a detailed updated on one of the ICP priorities for 2021/22 (TBC)	For information and discussion	09/02/2022	Andy Sharp	Health and Wellbeing Steering Group
April 2022 (TBC) - Workshop					

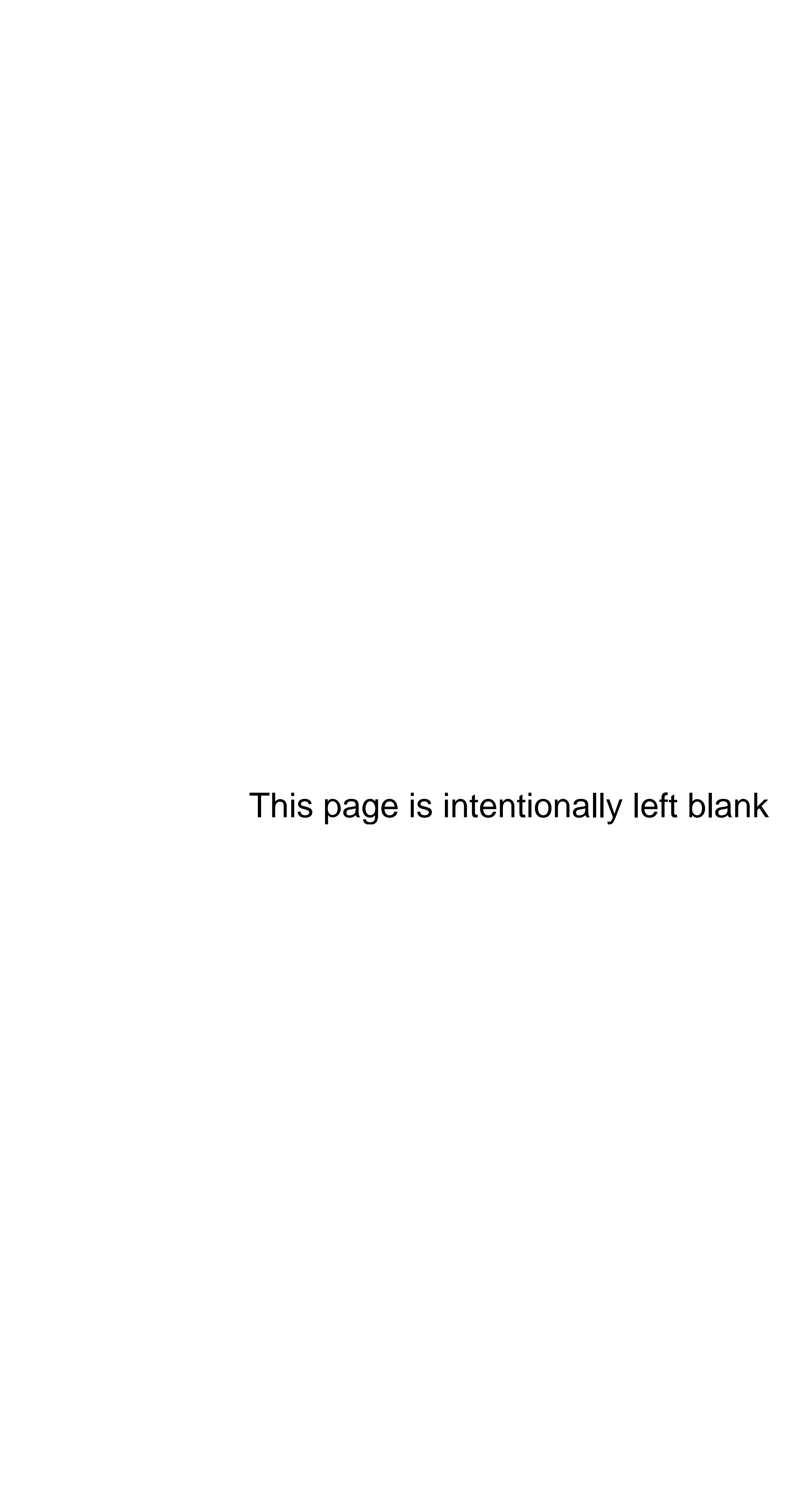
19 May 2022 - Board meeting					
Programme Management					
Delivery of Health & Wellbeing Strategy - Q3 2021/22	To provide the performance dashboard for the delivery of the health and wellbeing strategy and highlight any emerging issues.	For information and discussion	11/05/2022	Gordon Oliver	Health and Wellbeing Steering Group
Strategic Matters					
Draft Pharmaceutical Needs Assessment	To agree the draft Pharmaceutical Needs Assessment for public consultation.	For information and discussion	11/05/2022	TBC	Health and Wellbeing Steering Group
Leisure Strategy	To present the Leisure Strategy, which is due to be adopted in Autumn 2021.	For information	11/05/2022	Matt Pearce	Health and Wellbeing Steering Group
Operational Matters					

Health & Wellbeing Board – 30 September 2021

Item 18 – Future Meeting Dates

- 9 December 2021
- 17 February 2022
- 19 May 2022

All meetings to start at 9:30am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