Public Document Pack

Notice of Meeting

Health Scrutiny Committee

Tuesday, 11th June, 2024 at 1.30 pm

in Council Chamber Council Offices
Market Street Newbury

This meeting can be streamed live here:
https://westberks.gov.uk/hsclive

Date of despatch of Agenda: Monday, 3 June 2024

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Vicky Phoenix on 07500 679060
e-mail: vicky.phoenix1@westberks.gov.uk

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

West Berkshire COUNCIL

To: Councillors Martha Vickers (Chairman), Jane Langford (Vice-Chairman), Nick Carter, Justin Pemberton, Owen Jeffery and Carolyne Culver

Substitutes: Councillors Billy Drummond, Paul Kander, Biyi Oloko and Stephanie Steevenson

Agenda

Part I

Purpose: The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) to provide an update on activities and commissioning plans.

10 **Healthwatch Update** 153 - 154

11 **Health Scrutiny Committee Work Programme** 155 - 156
Purpose: To receive new items and agree and prioritise the work programme of the Committee.

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.

This page is intentionally left blank

Health Scrutiny Committee – 11 June 2024

Item 1 – Apologies

Verbal Item

This page is intentionally left blank

DRAFT

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

HEALTH SCRUTINY COMMITTEE

MINUTES OF THE MEETING HELD ON TUESDAY 12 MARCH 2024

Councillors Present: Martha Vickers (Chairman), Jane Langford (Vice-Chairman), Nick Carter and Justin Pemberton

Also Present: Paul Coe (Interim Executive Director – People), April Peberdy (Acting Service Director - Communities and Wellbeing), Nerys Probert (Acting Senior Public Health Programme Officer), Jo England (Client Financial Services Manager), Councillor Alan Macro (Executive Portfolio Holder: Adult Social Care and Health Integration), Vicky Phoenix (Principal Policy Officer - Scrutiny), Gordon Oliver (Principal Policy Officer), Helen Clark (NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), David Dean (Pharmacy Thames Valley), Julie Dandridge (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), Sally Murray (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board) and Gayan Perera (Public Health and Wellbeing)

Apologies for inability to attend the meeting: Councillor Nigel Foot, Sarah Webster (Place Director, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board) and Fiona Worby (Lead Officer, Healthwatch West Berkshire).

PART I

36 Minutes

The Minutes of the previous meeting held on 12 December 2023 were approved as a true and correct record and signed by the Chairman.

37 Actions from the previous Minutes

Members were asked to note the progress made in relation to the actions. The Chairman advised:

For Action 19, the Perinatal Equity Strategy had been received and was shared with Members.

For Action 23, Julie Dandridge from the ICB was present and would give an overview of the flexible commissioning scheme during the BOB ICB (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board) update.

38 Declarations of Interest

There were no declarations of interest received.

39 Petitions

There were no petitions received at the meeting.

40 Early Years Health Inequalities

Gayan Perera (Public Health Intelligence Manager) presented the report on early years and school readiness in West Berkshire.

During the presentation the following points were highlighted:

- What happened from pre-conception to age five was fundamental for physical and emotional health all the way through to adulthood.
- National evidence was shared showing how investment in early years intervention saved money in the longer term. The cost vs benefit analysis of different interventions was highlighted.
- Data showed that West Berkshire was doing well compared to Southeast England and National scales for low birth rate, smoking at time of delivery and babies first feed of breastmilk.
- However, it was noted there were hidden communities and inequalities. For example, 2000 children in West Berkshire were identified as children in need by Children's Services.
- Some indicators had room for improvement such as the proportion of children receiving a 12-month review by health visiting services. It was noted that this was improving over time. Newborn hearing screening could also be improved. It was essential to focus on children in need or living in the most deprived areas.
- Immunisation data was shared which advised that rates were good in West Berkshire. However, they were striving for 100% to improve vaccination levels.
- It was highlighted that there were inequalities in school readiness. For primary school children eligible for free school meals, there was a higher rate with a primary need of emotional, social or mental health than those not eligible.
- Interventions were therefore essential for a small cohort of children. To address this, it was important to focus on families, children, communities and services. Data was shared with example indicators that could help to measure and identify areas for focus.
- The five key themes to improve school readiness were good maternal mental health, learning activities, physical activity, parenting support programmes and high-quality early education. Evidence-based interventions were essential.
- An Early Years Inequalities working group had been set up to look into the school readiness indicator that had been highlighted as a concern. This would bring together different partners to identify the reasons for this and to address it.
- It was noted that the number of children on free school meals (240) was small and that may contribute to the poor rating. It was also not the best way to identify disadvantaged children as a child could be eligible one year and not the next.

Avril Allenby (Service Manager for Early Years, Vulnerable Learners & Families) noted some of the work happening in West Berkshire and highlighted the following:

- Family Hubs worked with parents alongside health visiting and maternity services to identify the most disadvantaged children. They selected some groups of parents to work with closely on how to best support their child. There were also some universal offers at Family Hubs around reading and learning together.
- In West Berkshire there was an 82 – 85% uptake of vulnerable two-year old entitlement. The settings that provided this were worked with closely to ensure they were well equipped to support children with speech and language, and early reading.
- There was a Every Child A Talker (ECAT) programme which focussed on developing the four areas necessary for children to be confident in their speech and language. There were very good practitioners in early years settings.
- There was targeted work with parents around early reading called Flying Start. This was a six- or seven-week programme. They worked alongside schools that had the highest number of free school meal entitlements to help parents to come

along to sessions. This was very successful for the children reached, but they hoped to reach more children.

- There was an App called 50 things to do outside. It was a West Berkshire focussed way to get families out of the home and into the local environment and to get children to do physical activities.
- It was noted that the identification of vulnerable two years olds was slightly different to the free school meal entitlement criteria. When school readiness was compared educationally, they used the foundation stage profile which was a teacher assessment of children across a number of areas at the end of the reception age. It was difficult to influence as it sat within schools. In some schools there could be only one child whereas other schools had clusters of children. They tried to support those schools with clusters and so it was harder to support some smaller schools. This was the group causing the gap in school readiness.

Nerys Probert (Acting Senior Public Health Programme Officer) gave a brief overview of the report on the West Berkshire Health Visiting Service.

During the presentation the following points were highlighted:

- The Health Child Programme - Service Model was explained as per the report. This included the universal, targeted and specialist services, and the reviews and visits made with all children until aged two and a half years.
- An overview of the West Berkshire Health Visiting Delivery model was shared. Berkshire Healthcare NHS Foundation Trust (BHFT) was commissioned by the Council to deliver the service. There was a skill mix of health visitors, staff nurses and nursery nurses. There were home visits, well-baby clinics and infant feeding drop-ins that were often at family hubs.
- As commissioners of the service, the Council received reports on safeguarding by the service provider.
- The purpose of the service was primary prevention.
- The indicators showed that West Berkshire was doing the same or better than national targets in most areas except for the 12-month review and the two-to-two-and-a-half-year review. The reviews were still undertaken, but were outside of the timeframe. This was due to catching up following covid and due to a shortage of health visitors nationally. The data in the report was from 2022-23. The Council had more up to date data for last year, it was back on target and all posts were currently filled.

Action: Nerys Probert to provide further detail on the digital offer for three and six-month contacts.

Sally Murray (Head of Children's Commissioning, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)) gave a brief overview of the report on Early Years Inequalities. The following points were highlighted:

- The multi-agency West Berkshire Early Years Inequalities Group would be a key piece of work over the next 12 months. There was a correlation between school readiness, and speech and language needs in early years.
- The ICB therapies review took place in 2023. The services would be recommissioned in 2024. The commissioning arrangements were included in the report.
- The demand for services has increased since the pandemic, however the trend had been increasing pre-pandemic. Of note there had been a 21% increase in speech and language therapy (SLT) demand in less than two years. This meant that the delivery model had shifted towards a more needs led, early advice, prevention and intervention model.

- There was now an advice line where parents could speak with a speech and language therapist two days a week. This had been very successful in avoiding people sitting on a waiting list. There were 177 people on the waiting list at the start of the year, but there was no one on the waiting list at the present time. If an assessment was needed that would be booked in, however strategies were shared in the call, there was an online offering and a referral to an early language development workshop. These were online monthly workshops designed to help parents and carers. There was also an in person workshop on the Health Bus. The workshops were very popular, and families reported a high level of satisfaction with them.
- BHFT also provided Early Years Surgeries for early years settings. They had a targeted training offer available later this year and provided an information pack with advice and strategies.
- The BHFT website provided detailed information and advice on communication and hearing.
- There was also a project called the Through My Eyes project which looked at social communication skills. 650 children were identified as at risk of speech, language and communication developmental delay. Early years settings and parents were enabled to support language development. The children were monitored, and outcomes would be reviewed. This was monitored through the ECAT programme.
- An overview of the Occupational Therapy and support for sensory processing difficulties was shared. There was training and advice for families and settings, Early Years sensory processing workshops, sensory processing videos on YouTube and an online toolkit.
- The Physiotherapy provision was shared. This was based at Royal Berkshire Hospital or by BHFT.
- Emotional health and wellbeing support of early years was for parents and families. The Health Visiting team and GPs offered support. There was also a Health Bus, online forums and the ICB also commissioned Autism Berkshire working with Parenting Special Children.
- It was also noted that in addition to GPs and Health Visitors for general health and development in Early Years, there were paediatricians at the Dingley Child Development Centre who brought together specialists for children who needed help to overcome a developmental issue or a complex illness.

During the Committee's discussion the following points were raised:

- It was noted that the previous model of a referral, waiting list and assessment meant a delay in receiving advice and support. The new model provided advice and support much earlier which had a speedier impact. The advice and support was in the family setting and in the early years setting. Strategies were shared early on. If it sounded like the child needed an assessment they would be added to a list with a shorter wait. It was noted that some people were hard to reach and that was why the family hubs were critical.
- Concern was raised that there was not enough provision for parents to access support. For example, the central family hub was in Thatcham, other provisions in Newbury were either run by volunteers at Educafe or other settings where some payment may be needed. It was agreed that from a primary prevention view, more services such as drop-ins for parents were needed. However, the current health visiting service provided was the best that could be provided with the resources available. There were also limitations in the spaces available.

- Provision in rural areas was also highlighted as the three family hubs were particularly difficult for people living in villages. It was confirmed that in addition to the three family hubs, there were activities at other locations such as sessions at village halls depending on need.
- It was noted that the cost-benefit evidence was overwhelming, but there remained a concern that resources were stretched and parts of West Berkshire were lacking provision. It was agreed that there was a limited budget, but they were using the evidence to inform the range of services provided.
- It was noted that it was essential to target the cohort that were most in need. A question was raised around the use of the free school meal applications as a way to identify those children as not all families claimed the entitlement. This meant that practitioners needed to know the local families effectively. It was also important to ensure data was easily shared between the Council and Health services. It was clarified that Public Health were working with other organisations to improve the model and ensure that data was shared. This would also be part of the work of the Early Years Health Inequalities Group.

Action: An update from the Early Years Health Inequalities Group to be added to the work programme.

RESOLVED to note the report.

41 Pharmacy Provision

Julie Dandridge (Head of Pharmacy, Optometry and Dentistry, BOB ICB) presented the report on Community Pharmacy Provision across Buckinghamshire, Oxfordshire and Berkshire West (BOB).

During the presentation the following points were highlighted:

- There had been a change in community pharmacy provision recently due to Lloyds no longer operating in supermarkets and so there were new providers on the high street. There were fewer large chains, and more independent providers who were more likely to become part of the community.
- Previously the core role of pharmacies was to dispense prescriptions, however the services provided were expanding including Pharmacy First. There had been a shift to internet-based pharmacies delivering prescriptions to homes.
- It was explained that when a pharmacy reported a closure, the ICB worked closely with Community Pharmacy Thames Valley to see whether neighbouring pharmacies had the capacity to pick up the extra demand.
- During and after Covid there were many unplanned closures of pharmacies. In response to that, new regulations were brought in for pharmacies to have continuity plans and to notify the ICB if there was an unplanned closure. Since then, unplanned closures had reduced and only occurred in exceptional circumstances.
- There had been a reduction in pharmacy opening hours as the new regulations allowed for this. This benefitted pharmacies as they could be more financially viable.
- Community pharmacist numbers had been falling due to pharmacists moving to work in Primary Care Networks. Initiatives were being developed to provide incentives for new graduates to go into community pharmacy.
- The next steps highlighted were the progress of the BOB ICB draft primary care strategy, digital improvements and the use of the NHS App for patients to request repeat prescriptions.

David Dean (Chief Executive Officer, Community Pharmacy Thames Valley) confirmed that they worked closely with the ICB. They were also working more closely with GP practices to enable patients to get healthcare more quickly.

During the Committee's discussion the following points were raised:

- It was shared that members of the public were concerned about accessibility to pharmacies and the need for more pharmacy provision. The ICB had received a number of new applications for pharmacies across Buckinghamshire, Oxfordshire and Berkshire West. However, there were clear regulations about what, how and when these applications could be approved. There were appeals processes and timelines to follow. It was a long, complex process and they worked closely with the West Berkshire Health and Wellbeing Board who identified gaps and were a consultee in the process.
- It was noted that the pharmacy provision in Thatcham had improved, despite reducing from four to two pharmacies recently. There was a better service and shorter waiting times. It was agreed that quality over quantity was important. Those that had left the market were because they were not financially viable and so it was important to protect the existing pharmacies for the future. This could be impeded by opening new pharmacies.
- It was highlighted that the Health and Wellbeing Board had raised concerns that in some areas of West Berkshire waiting times at pharmacies had increased. They had requested the ICB and Healthwatch to carry out a check on the resilience of pharmacies. The Health and Wellbeing Board had also looked at two new pharmacy applications in Newbury and Thatcham and they had written in support of those.
- It was clarified that the Health and Wellbeing Board was responsible for the Pharmaceutical Needs Assessment which looked at where there may be gaps in provision. It was a three-to-five-year cycle. The Health and Wellbeing Board could issue supplementary statements if a closure led to a gap in provision. This impacted on how the ICB looked at an application (as an identified need or as an unforeseen benefit) which determined the process. They were also a consultee on new applications.
- Concern was raised about a specific independent pharmacy being unable to access digital prescriptions from the local surgery. It was clarified that this should not be happening. Patients could choose where their prescription was sent digitally. It was also noted this would produce queues at the pharmacy as the medication could not be dispensed in advance. Community Pharmacy Thames Valley were working with pharmacies and the ICB to identify these pharmacies and drive improvements.

Action: Julie Dandridge to investigate and update Councillor Carter.

- It was highlighted that there had been no change in government funding for ten years. Whilst efficiencies had been made, there was more pressure on pharmacies. Funding had reduced by 40% in real terms and was why there were less pharmacies today.
- A query was raised around whether there was the workforce available to provide the extra services provided through Pharmacy First. This would be additional for the existing pharmacist on site, but on occasions another pharmacist may be needed.
- It was advised that all pharmacies and pharmacists, including online pharmacies, were regulated by the General Pharmaceutical Council.

- It was clarified that delivery of prescriptions were not part of the contract with the ICB. They were a service provided by some pharmacies. Patients could request an online pharmacy who would deliver.
- It was advised that there was an annual questionnaire which local pharmacies committed to getting their community to fill in. This provided feedback about the services. Community Pharmacy Thames Valley also worked closely with Healthwatch who would conduct surveys to find out community views.

RESOLVED to note the report.

42 Social Care Inquests

Jo England (Service Lead – Adult Social Care) presented the Social Care Inquests report. During the presentation the following points were highlighted:

- This was the first annual report following the initial report shared with the Committee in March 2023. Since that report, there had been a significant reduction in information requests from the Coroner. There had been only two requests in the last year. Neither request had resulted in West Berkshire Council being added as an interested person in the inquest nor needed to attend the inquests.
- It was not known why there was a sudden increase in requests last year. They would monitor this going forward.

RESOLVED to note the report.

43 Update from Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Helen Clark (Deputy Place Director Berkshire West) gave an overview of the report on the activities of the BOB ICB. During the presentation the following points were highlighted:

- The BOB ICB had produced a draft Primary Care Strategy following the initial phase of the consultation.
- Resilience to NHS Industrial action and the Covid and flu vaccination programme were key priorities.
- The was a new BOB ICB stakeholder newsletter which Members could receive.
- Berkshire West specific updates within the report where shared. These were in relation to the Community Wellness Outreach Service and work to agree the key priorities of the Berkshire West Place.
- It was confirmed that the BOB ICB carried out surveys about patient satisfaction. There was ongoing patient engagement, focus groups, workshops and collaborations with Healthwatch to ensure the patient view was heard.

RESOLVED to note the report.

44 Healthwatch Update

RESOLVED to note the report.

45 Task and Finish Group Updates

The Chairman provided an update on the Healthcare Provision in New Developments Task and Finish Group.

The Task Group had met for two sessions where they had considered the assessment of health needs in new developments, health in planning policy and planning consultations. There would be one more session to look at funding and delivery of Primary Care and

Public Health care services in New Developments. A report would be produced by the task group and presentation at the next Health Scrutiny Committee in June.

46 Health Scrutiny Committee Work Programme

RESOLVED to note the work programme.

(The meeting commenced at 1.30 pm and closed at 3.30 pm)

CHAIRMAN …….

Date of Signature …….

DRAFT

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

HEALTH SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD ON
THURSDAY, 9 MAY 2024

Councillors Present: Jane Langford (Vice-Chairman), Nick Carter and Justin Pemberton

Apologies for inability to attend the meeting: Councillor Martha Vickers

PART I

1 Election of the Chairman

RESOLVED that: Councillor Martha Vickers be appointed as Chairman for the 2024/2025 Municipal Year.

2 Appointment of the Vice-Chairman

RESOLVED that: Councillor Jane Langford be appointed as Vice-Chairman for the 2024/2025 Municipal Year.

(The meeting commenced at 8.35 pm and closed at 8.40 pm)

CHAIRMAN …….

Date of Signature …….

This page is intentionally left blank

Actions arising from previous HSC Meetings HSC is requested to consider the following list of actions and note the updates provided.				
Ref No:	**Date**	**Item/Action**	**Member/Officer**	**Comments/Update**
1	14/06/2022	**JHOSC** To progress the JHOSC creation for RBH Redevelopment	Vicky Phoenix	**In Progress**
24	12/03/2024	**Early Years Health Inequalities** More detail on the 3 and 6 month contact digital offer provided by BHFT	Nerys Probert	**In Progress**
26	12/03/2024	**Pharmacy Provision** To investigate concern raised regarding an independent pharmacy in Mortimer being unable to access digital prescriptions	Julie Dandridge	**In Progress**

Last updated:03/06/2024

This page is intentionally left blank

Health Scrutiny Committee – 11 June 2024

Item 4 – Declarations of Interest

Verbal Item

This page is intentionally left blank

Health Scrutiny Committee – 11 June 2024

Item 5 – Petitions

Verbal Item

This page is intentionally left blank

Healthcare in New Developments Task and Finish Group – Final Report

Committee considering report:	Health Scrutiny Committee
Date of Committee:	11 June 2024
Task Group Chairman:	Councillor Carolyne Culver
Date Task Group Chairman agreed report:	30 April 2024
Report Author:	Vicky Phoenix

1 Purpose of the Report

1.1 This report presents the work undertaken by the Healthcare in New Developments Task and Finish Group and their final recommendations.

1.2 Members of the Task Group would like to thank all the officers, witnesses and Members who gave evidence and supported this scrutiny review.

2 Recommendation

2.1 To consider the Task and Finish Group's final recommendations as outlined in Section 6 of the report and to agree whether these be referred to the Executive and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) for consideration.

2.2 To agree that the Health Scrutiny Committee keeps this under review and invites updates on progress in implementing the report's recommendations.

3 Implications and Impact Assessment

Implication	Commentary
Financial:	There are no financial implications arising directly from this report, although if proposals are accepted, this may result in financial implications which will be assessed in detail if they are taken forward.

Human Resource:	There are no HR implications arising directly from this report, although if proposals are accepted, this may result in HR implications, which will be assessed in detail if they are taken forward.
Legal:	There are no Legal implications arising directly from this report, although if proposals are accepted, they may result in Legal implications which will be assessed in detail, if they are taken forward.
Risk Management:	There are no risk management implications arising directly from this report, although if proposals are accepted, this may result in risk management implications, which will be assessed in detail if they are taken forward.
Property:	There are no property implications arising directly from this report, although if proposals are accepted, this may result in property implications, which will be assessed in detail if they are taken forward.
Policy:	There are no policy implications arising directly from this report, although if proposals are accepted, this may result in policy implications, which will be assessed in detail if they are taken forward.

	Positive	**Neutral**	**Negative**	**Commentary**
Equalities Impact:				
A Are there any aspects of the proposed decision, including how it is delivered or accessed, that could impact on inequality?	X			There are no equalities implications arising directly from this report. However, if accepted, proposals would lead to reductions in health inequalities as detailed in the report.

B Will the proposed decision have an impact upon the lives of people with protected characteristics, including employees and service users?		X		The proposed decision does not have any impact upon the lives of people with protected characteristics.
Environmental Impact:		x		There are no environmental impacts arising directly from this report.
Health Impact:	x			There are no health impacts arising directly from this report. However, if accepted, proposals would lead to improvements in health as detailed in the report.
ICT Impact:		x		There are no ICT impacts arising directly from this report.
Digital Services Impact:		x		There are no Digital Services impacts arising directly from this report.
Council Strategy Priorities:	x			There are no impacts arising directly from this report, but if adopted, the report's recommendations would help to deliver aspects of the Council Strategy related to the priority 'A Prosperous and Resilient West Berkshire' and 'Thriving Communities with a Strong Local Voice'.
Core Business:	x			The report's recommendations support core business activities within Planning and Public Health.
Data Impact:		x		There are no data impacts associated with this report.

Consultation and Engagement:	• Elisabeth Gowens (Senior Programme Officer for the Wider Determinants of Health). • Laura Callan (Planning Policy Manager). • Bob Dray (Development Manager). • Peter Redman (Senior Programme Manager - Primary Care Estates, Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board (BOB ICB)). • Jeffrey Ng (Senior Primary Care Estate Manager, BOB ICB). • Helen Clark (Deputy Place Director Berkshire West, BOB ICB) • Cllr Tony Vickers - Executive Portfolio Holder: Planning and Community Engagement. • Dr Heike Veldtman (GP, Thatcham Medical Centre). • Dr Andrew Buroni (Director of Health and Social Impact Assessment Environment and Infrastructure, Savills).

4 Executive Summary

4.1 The Health Scrutiny Committee (HSC) established a Task and Finish Group to look at healthcare in new developments.

4.2 A key concern regarding proposed new developments is ensuring adequate healthcare services are provided. There is a need to ensure that healthcare commissioners are adequately consulted on the requirements for the primary care services to serve new developments when local populations increase, and that developers engage with health commissioners and planners.

4.3 There is also opportunity to ensure that new developments are designed to promote health and wellbeing, and therefore prevent future demand on primary care services. There is therefore a need to review how the planning application process is encouraging developers to design with long-term prevention and health promotion for all residents across the life-course of the development.

4.4 The scope of the review was broken down into three key areas:

- Part 1: Assessment of health needs in new developments
- Part 2: Health in planning policy and planning consultations
- Part 3: Funding and delivery of primary care and public health care services in new developments.

4.5 The task group has identified a number of recommendations arising from this work, which are set out in Section 6 of this report. The HSC is invited to review the recommendations and consider whether these should be put to the Executive and to the ICB.

5 Supporting Information

Introduction

5.1 The HSC established a Task and Finish Group to look at healthcare in new developments. The Terms of Reference were drafted in collaboration with officers in Public Health and Planning. The scope of the review was broken down into three key areas:

- Part 1: Assessment of health needs in new developments
- Part 2: Health in planning policy and planning consultations
- Part 3: Funding and delivery of primary care and public health care services in new developments.

5.2 The full Terms of Reference are provided in Appendix A.

Background

5.3 A key concern regarding proposed new developments is ensuring adequate healthcare services are provided. There is a need to ensure that healthcare commissioners are adequately consulted on the requirements for the primary care services to serve new developments when local populations increase, and that developers engage with health commissioners and planners.

5.4 The original intention was for the task group to look specifically at healthcare provisions in new developments. After collaboration with Public Health and Planning, the Task Group decided to review the Terms of Reference. The planned work by Public Health on the draft Healthy Planning Protocol (HPP) and Health Impact Assessments (HIA) were also addressing the working relationships and planning processes that impacted on healthcare in new developments. By widening the scope of the Task Group, Members could review this wider work whilst also addressing the concerns regarding provisions and have an opportunity to influence the work whilst it was being developed. The reviewed terms of reference were agreed at the Health Scrutiny Committee on 12 December 2023.

5.5 The Task and Finish Group held 4 sessions to gather key evidence:

Meeting Date	Focus of Meeting	Witnesses
30 January 2024	• Review of current mapping of primary care provision. • Form an understanding of Health Impact Assessments (HIAs), their implementation and the wider preventative approach. • Review how Berkshire Observatory ward data will be used.	Elisabeth Gowens Laura Callan Bob Dray Peter Redman Helen Clark
27 February 2024	• Review the draft Healthy Planning Protocol.	Elisabeth Gowens Laura Callan Bob Dray

	• Review the draft HIA templates and supporting documentation. • Consider engagement and the planning consultation process.	Peter Redman Jeffrey Ng Helen Clark Cllr Tony Vickers
26 March 2024	• Understand how primary care services for new developments are funded. • Review the level of support provided to GP surgeries in securing funding and delivering proposals. • Understand developer contributions for local health infrastructure. • Consider barriers in delivering plans for future population growth.	Elisabeth Gowens Laura Callan Peter Redman Jeffrey Ng Helen Clark Dr Veldtman
10 April 2024	• Interview Savills	Elisabeth Gowens Laura Callan Dr Buroni

Findings

Mapping of primary care provision

5.6 Peter Redman (Senior Programme Manager, BOB ICB) and Helen Clark (Deputy Place Director Berkshire West, BOB ICB) were invited to give evidence in relation to the mapping of primary care provision, in particular GP surgery facilities and GP surgery workforce. Dr Veldtman was invited to share their view from a GP perspective.

5.7 The BOB ICB commission primary care services. This is delivered through GP contracts. The ICB do not have the ability to hold capital nor own estate. They are entirely reliant on third party developers to source buildings and provide capital finance. Primary care estates are indirectly funded through reimbursement of rents and business rates by the ICB. New primary care developments (whether a new building or an extension) need to be GP-led.

5.8 The 16 GP practices across West Berkshire have joined up to form 4 Primary Care Networks (PCNs). The Additional Roles Reimbursement Scheme (ARRS) provides funding for additional healthcare professionals within primary care such as pharmacists, social prescribers and paramedics. ARRS was funded through the Long-term Plan of 2019 to encourage diversifying the workforce. This funding has been extended for a further year. It was noted that there was no additional funding from the ARRS scheme for the space that these roles used. This was a fundamental challenge.

5.9 Data was provided by the BOB ICB detailing GP Practice workforce in all the surgeries in West Berkshire. It was noted that ARRS in GP practices was regarded as very beneficial, but it meant that it was not straightforward to compare resources at practices by looking only at the number of GPs per population. The sizes of practices varied, and the skill mix varied. In addition, the population served by GP Practices varied. For example, deprivation, rurality and age impacted the patient needs of a local area and therefore the health provisions required. There were no official guidelines around workforce per number of patients.

5.10 The BOB ICB would need to be assured that any new estate could be staffed. It was highlighted that it was important to have long term plans around the staffing of primary care to respond to population growth in local areas. Future workforce planning also needed to take into account the age demographic of the workforce, and the numbers approaching retirement.

5.11 The NHS use a strategic health planning system called SHAPE to estimate population growth in each area. For each PCN area, the ICB provided estimated population growth figures.

5.12 Based on BOB ICB experience, a new development needs to be more than 4000 units to warrant a standalone GP Practice. This was rarely the case in local developments, although smaller housing schemes could support new on-site GP premises developments where an existing GP Practice is able to vacate an existing facility . Other mitigations include reconfiguration or expansion of an existing GP practice to provide additional clinical spaces or relocation of existing GP practice(s) to a new GP facility in response to any local population growth.

5.13 The GP described that housing developments and increases in population were an issue. They were working at full capacity, and they could not always get a locum when needed. The demographic of new developments needed to be considered. It would likely be more young families and so this was an opportunity to look at prevention.

5.14 Due to workforce issues, GP practices were tending to focus more on survival than expansion. Some were not currently thinking strategically and so were far less interested in taking on long term leases with third party developer landlords than previously. In other areas, GP practices had expressed that they were not in a position to take on new estate to cater for population growth.

5.15 It was advised that satellite surgeries, such as those used in rural areas, were challenging to staff and it was difficult to help staff feel supported in those settings. There were also time constraints as satellite practices might be further away and more inaccessible by public transport, and other extra costs are associated with them. It was felt from a GP perspective that health improvement opportunities were with bigger practices. A one stop shop for patients for example to see specialists such as physiotherapists.

5.16 The ICB confirmed that the location of primary care estates was a question for GPs. The location of the estate impacted which GPs were consulted about a planning application, but the ICB were flexible on the site location. The ICB supported what was best for GPs and that it was funded by developers' contributions as much as possible.

5.17 It was highlighted that accessibility to surgeries was essential, in rural areas as well as in towns. Enhanced transport links may be needed. It was confirmed by the ICB that in any decision making around the siting of future surgeries or movement, that transport links were taken into account. It was also noted that additional capacity through extensions was difficult due to constrained sites and alternatives may not be ideal. It was important to involve developers in discussions around transport links.

5.18 It was noted that health visitors no longer worked in surgeries, and that public health and prevention should be included in the ICB planning. The ICB confirmed it was

important to think about how primary care worked in the future and how primary care estates were developed to reflect that. That included co-location with other services, preventative work and outreach into communities. The ICB were taking a holistic approach in what they wanted to see happening in primary care going forward. The primary care strategy was in draft currently and this would drive this work going forward.

5.19 Primary care also includes Pharmacy, Optometry and Dentistry (POD). For the purposes of the review, the focus has been on GP provision. This is because POD is very different in relation to provision of healthcare when compared to general practice. The three services are all responsible for their own estate (unlike general practice where the BOB ICB reimburse the cost). They also do not have a registered list and so people can receive treatment anywhere.

5.20 Gaps in community pharmacy service are described in the Pharmaceutical Needs Assessment (PNA) which is regularly reviewed and monitored by the Health and Wellbeing Board. Any significant gap in provision of community pharmacy as a result of a housing development would be reflected in the PNA.

5.21 High street dentistry does not have a registered list and it would therefore be unlikely that the ICB would look to establish a new practice as a result of new developments. Dentistry has very complex and differing challenges which were not under the scope of this review.

5.22 There is more evidence to be heard about integrated planning across all healthcare providers to ensure that future needs are met. This is being considered for review by the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Scrutiny Committee (BOB JHOSC).

Funding of primary care services in new developments

5.23 Bob Dray (Development Manager) provided an overview of the Community Infrastructure Levy (CIL) and S106 for the Task and Finish Group.

5.24 The task group learned that there was a shift towards CIL, however development specific planning obligations (S106) were still needed for major sites as it was a mechanism to secure infrastructure and mitigate the impacts of a development proposal. CIL (developer contribution) was the most effective way to collect contributions for small developments.

5.25 CIL and S106 funds could be used to pay for the same piece of infrastructure if it was directly relating to the development, was necessary and reasonable. It was clarified that CIL had not replaced S106 as intended. S106 was now only for major sites.

5.26 CIL and S106 was guided by legislation, however consultation provided the direction as to what was needed on individual developments. For example, if a larger or new surgery was needed then a S106 negotiation could be made. The need would be largely determined through consultation with the ICB. There would be discussion around when those payments would be made by the developer. It was possible to also do a separate CIL charge.

5.27 The CIL charging structure was renewed every five to ten years. The Clinical Commissioning Group (CCG) (CCGs were the local NHS body prior to the formation of ICBs in 2022) was consulted at the last renewal, but it had been difficult to get a response from them. It was hoped that the charging structure would be renewed in the near future and that the ICB would be clear in communicating to the Council about how much was needed for new developments. It was important to highlight that the CIL charging structure was very influential. Infrastructure providers needed to work together to negotiate appropriate developer contributions. It was in the community interest to do so. This was complicated by the number of stakeholders involved, particularly within the NHS.

5.28 Primary care estates were funded through reimbursement of rents and business rates by the BOB ICB. In the case of owner-occupied premises, the Practice also received a reimbursement figure predicated on an assumed notional lease. The District Valuer (DV) assessed these rents/notional rents, given that the BOB ICB reimburse these amounts. In the case of a Practice relocation to a new facility, rent reimbursement per square metre for a new build facility would be higher than their current premises reimbursement and so this such a relocation would be a significant revenue burden for the ICB to reimburse. Other current challenges to new developments being procured noted included higher interest rates, high build-cost inflation and a reduction in capital values for third party developers.

5.29 The BOB ICB used a proforma which includes a formula to calculate the contribution requested in response to a planning application in circumstances where a very large housing developments could support a stand-alone GP premise. This could translate to a per dwelling cost that varied depending on the size of the dwellings.

5.30 The ICB did not receive capital funding for infrastructure development in their annual budgets and so unless significant S106 or CIL contributions were made, a new facility became extremely expensive when they already had significant revenue challenges across all their budgets.

5.31 One key challenge for the ICB was in relation to the timing of S106 money which meant that the GP premises would be built after the completion of the development. An existing GP surgery would not have the capacity to cope with the extra demand in the meanwhile. To be proactive ahead of the population increase, they needed to receive funding earlier. It was also noted third party developers would not be interested in building the premises prior to receiving the S106 contributions and the BOB ICB would need to see such contributions translating into a lower rent reimbursement.

5.32 Planning advised the profile of this could be raised as local authorities could potentially negotiate with developers to get S106 funding at an early stage within each housing development. However, the constraint for developers was they did not have the revenue from the development at the start of the project to pay the contributions. They built in phases and had the right to appeal. There were other infrastructure requirements and so it could not always be insisted upon especially for a larger site. For a major application there would be pre-application discussions which would engage with infrastructure providers. The ICB could put forward a view and it would be looked at on a case-by-case basis. They advised that they were aware of an example where a GP surgery (not in an ICB area) had been one of the first provisions created in a new estate.

Engagement with the planning process

5.33 The task group reviewed a number of previous and current development consultations. These were chosen in collaboration with all Councillors and Planning. Members asked witnesses questions about engagement on those specific consultations and more generally.

5.34 It was clarified that the CIL / S106 negotiations were evidence based. For healthcare it would include understanding the patient yield, the capacity and whether it could be accommodated. This would take place during the application process and through any pre-application discussions.

5.35 The NHS (ICBs and Primary Care Trusts) are a non-statutory consultee so there is no national guidance on how and when the ICB should be consulted. Historically the local authority consulted the NHS for larger schemes based on site area, but the ICB would now be consulted for any development of ten or more dwellings. The ICB had a duty to cooperate, and they were happy to have regular meetings with planning and in exploring opportunities to be involved in discussions as to when and how the ICB would be consulted.

5.36 The task group found that on some occasions there were no responses recorded from the NHS on a planning application consultation, the responses were delayed or did not have the evidence based behind it. There was an example of the consultation response being after the S106 agreement had been drafted. The GP advised that support from the ICB for primary care regarding major developments could be better. They were not part of the initial discussions and hoped that this would be improved in the future.

5.37 The ICB advised that there were issues with CCG engaging with planning, but that had been improved. They had recently recruited a town planner who would have greater knowledge of the estates and would improve a coordinated approach to town planning across the ICB. This would help the ICB in the timeliness to respond to applications. Planning noted that it was also their role to engage and consult with relevant parties and so they would ensure that primary care was included.

5.38 The ICB advised that they made representations in response to the Local Plan Review consultation in March 2023 but that a response was delayed. The ICB have now met with planning to discuss this in more detail, and they have submitted constructive representations to the Local Plan examination. At the time of this report being drafted, the examination of the Local Plan is about to commence.

5.39 The ICB and planning met between task group meetings to discuss how they would work together in the future. From this they agreed to meet regularly to discuss applications and to find flexible mechanisms to improve how they worked together in the future.

5.40 A key thread throughout the task group's evidence gathering was around best practice and sharing new ways of working. It was noted that health in planning was largely carried out at a local level. The ICB shared some good practice from South Oxfordshire District Council which had a dedicated policy for health facilities and had CIL allocated for facilities. NHS England had a town planner and so the BOB ICB would liaise with them to see if there was anything that could be considered / adapted as this was an

issue nationally. This would continue to be a key part of the regular meetings between the ICB and planning.

5.41 One example highlighted was in Pincents Lane where the developer offered a community building to the NHS. At the time the NHS could not justify a new surgery. A cascade system was implemented so that the building would be offered to the NHS first for the first 2 years. It would then cascade for a different use.

5.42 Ward Members were highlighted as a key stakeholder to be consulted when S106 was being agreed as they would understand the local area.

Planning policy and the delivery of primary care services in new developments

5.43 The task group received input on planning policy including the Infrastructure Delivery Plan (IDP) and the WBC Capital Programme, which distributed CIL funds, from Laura Callan (Planning Policy Manager). It was noted that healthcare was only one of the 'other services' that were allocated 10% of CIL spending. The IDP was due to be updated.

5.44 Examples of good practice from South Oxfordshire District Council and the Vale of the White Horse District Council were shared. This included more emphasis on CIL funding apportioned to healthcare and to support its infrastructure. In South Oxfordshire and Vale of White Horse District Council, 20% of CIL funding was allocated to community health. The BOB ICB found this very useful. They NOW had two decent sized surgery extensions with planning consent in the process of being fully funded by CIL via a funding agreement. This worked well for an extension to an existing site. To do this at WBC, there needed to be a CIL spending strategy and a working group was needed to develop that. CIL had some conditionality, but the ICB found it more able to be used flexibly. Any changes to make the process more flexible would be helpful.

5.45 Recommendations from the Royal Town Planning Institute (RTPI) and the Town and Country Planning Association highlighted the importance of collaboration, and resourcing to facilitate the collaborative working, for creating healthy places.

5.46 The task group discussed the importance of improving health care prevention through local facilities. This was especially the case in rural areas and transport to facilities was key. It was confirmed that the policies to do that were there but needed to be linked up. Health in all Policies was in place and needed more emphasis.

5.47 It was highlighted that CIL spending had to be directly related to the development and be evidenced. There were opportunities in match funding from other sources, but it was for infrastructure to serve that development and evidence was needed on each case to see if it fitted the criteria.

5.48 Other barriers were learned regarding the delivery of primary care services for new developments which included:

- Workforce challenges in primary care meant that GPs were focussing on survival rather than strategic thinking for population growth. It was also noted that GP core business should be with patients rather than estate management / project management.

- Complications associated with expanding existing premises. These included a lack of space to expand, the return on investment, funding to commission feasibility / pre-work studies, the availability of S106 contributions and landlord consent.

- Complications associated with relocating a surgery - if the building was owned, and there had been a high turnover of partners, properties could have become in negative equity due to re-mortgaging. For leased premises they would need landlord permission to end the lease early. It was noted that it was often better to optimise their own space first, expand locally and to look at what was nearby primarily. A move to a new site was probably more costly.

- As a new GP surgery would only generally be sustainable for a new development of 4000 homes, a redevelopment or a relocation of a surgery would be needed. However, that scenario would require the housebuilder to agree to build a larger site which under CIL rules would be not be required to mitigate their own particular development.

5.49 Collaboration between WBC and the ICB at an earlier stage and for WBC to consider being a development partner in a new GP build was suggested. This would involve the local authority owning the estate and the GP surgery would lease from them. This was a departure from the third party developer model which the ICB have been reliant upon for new estates. Further to that it was agreed that NHS requirements should be built into the Council's wider thinking around multipurpose community hubs where a community centre would benefit a local community. It was noted that there was opportunity in local authorities working directly with GPs which would help to avoid the complications from the rent reimbursement scheme currently used by the ICB.

Preventative approach

5.50 Elisabeth Gowens (Senior Programme Officer for the Wider Determinants of Health) advised the task group throughout the review on the public health approach to primary prevention and reducing health inequalities. It was highlighted that there is a 4-year life expectancy gap and 7-year healthy life expectancy gap between the most and least deprived Lower Super Output Areas (LSOA's) in West Berkshire. There is also inequality in health behaviours and health outcomes between those areas. These are directly related to the environments in which people live, work and play.

5.51 Both Elisabeth Gowens and Andrew Buroni (Director of Health and Social Impact Assessment, Environment and Infrastructure, Savills) advised the task group that to improve these health inequalities and reduce the burden on health and social care services, there needed to be a long term, strategic and cross-service approach to health protection, health promotion and healthcare. The local authority, public health and NHS colleagues need to work together to have happy, healthy and prosperous communities and a sustainable and productive workforce.

5.52 The task group heard that the built environment had one of the biggest influences on our decision making, health behaviours and the opportunities available to us in our lives which impacted our quality of life. Evidence was heard that only 10% of population health and wellbeing was related to healthcare. Planning with health in mind prevents more disease than NHS can ever treat and that health legacy is built into the places and spaces that we live. Designing health-promoting environments is one of the most impactful ways that local authorities can embed primary prevention in their work. That if done poorly, it compounds existing poor health and prevents opportunities to build age and neurodiversity friendly design features in later.

5.53 It was highlighted that while planning contributions were helpful, they were not the only way to approach health in new developments. For example, in infrastructure delivery it was beneficial to ensure that a new school was built with SEND capabilities (eg. an adaptive community asset, SEND library, play facilities), a community health centre was multi-functional and adaptive (for example space for a mobile screening unit), a community hub was multifunctional to support networking and housing was intergenerational and for key workers.

5.54 A key theme discussed was homes for life and ensuring the built environment was inclusive for older people and people with reduced mobility. In West Berkshire there was social isolation, an ageing population and high housing costs. For larger infrastructure developments it was therefore essential for health to be integral in planning. For example, dementia friendly design, neurodiversity friendly design, adaptive and resilient design to enable people to be healthy and independent for longer.

5.55 It was explained that there were huge financial costs of poor design for the NHS and local authorities. By providing the right infrastructure that enables an inclusive environment to help all to thrive, it reduces pressure on adult social care and children's services in the future. An example shared was that spaces and places embedded with neurodiversity friendly design supported families and built connections in communities taking pressure off children's services. Dementia friendly design allows intergenerational living and relieves pressure on adult social care services. Community hubs, retirement areas, vibrant communities etc help to address barriers to positive health behaviours.

5.56 It was highlighted that it was no longer viable to have treatment-only healthcare. Diagnostic services and treatment should be embedded in communities By creating 'health hubs' rather than GP surgeries, there would be space to overlap with social care and childcare. Space for GP's, community nursing, phlebotomy, an age and social care adviser, health promotion expert etc. This is not only good for people and a community, but it helps to build the viability of a surgery. This is essential because as the population increases in age, the costs of health and social care increase at such a rate that it is not sustainable. The developer representative, the GP, the ICB, planning and public health were all in agreement that this was the way forward for communities and for financial viability. The ICB primary care strategy includes prevention as a key aspect. For example, someone with raised blood pressure could attend group sessions that provided advice on diet and lifestyle. There could be discounted exercise and meal plan support. Targeted work to support young families in deprived areas. The GP supported de-medicalising of healthcare, the focus on prevention and in multipurpose hubs. These would need health and local authorities to work together and for the infrastructure to be available.

5.57 It was advised that developers were keen to build healthy places but needed guidance and the health benefit of places to be given weight in planning decisions. It was advised that current best practice was to have policy in the Local Plan to support delivery of the Joint Strategic Needs Assessment (JSNA).

Healthy Planning Protocol

5.58 The Public Health proposal is to develop and implement a Healthy Planning Protocol (HPP) to enable the integration of better health promotion and primary prevention into the design of West Berkshire homes, streets and communities. This consists of a suite of policy and guidance documents including the Health Impact Assessment (HIA). HIAs are considered best practice by the Office for Health Improvement and Disparities (OHID) and the Department of Health and Social Care (DHSC). HIAs are not mandated nationally, but Policy DM3 in the Local Plan would enable HIAs to be mandated locally.

5.59 The HPP will be a one stop shop for all the policies, service level agreements and templates for the HIA process. It includes the policy for developers, the service level agreement for the HIA refresh and maintenance and the service level agreement regarding the HIA review process. The HPP also includes a service level agreement on how planning and public health would work together and a roadmap for promoting health through the Local Plan. This is to help each stakeholder to understand what they can contribute and at what stage. Within the draft documents shared with the task group were the rapid HIA template (for developments below a defined threshold), the priority checklist by ward and the detailed HIA evidence checklist to support applicants and officers reviewing the HIA. The review checklist and response template were to make sure that any review of a HIA and HIA response was standardised whether by Planning or Public Health. The West Berkshire Observatory will hold the data and documents. This would enable them to be kept up to date as the health needs of the population changed.

5.60 Throughout the task group's work, Members reviewed the draft documents. They did this in collaboration with the ICB and planning who supported the work and met with public health outside of the task group to review in detail the draft documents and to discuss how to implement it at the pre-application stage. An officer task and finish group will be needed to finalise the HPP. The task group have welcomed the opportunity to work with public health and other stakeholders to carry out pre-scrutiny during the development of the draft HPP. Recommendations from the task group are proposed in section 6 of this report.

5.61 Members agreed that the HPP was very interesting, detailed and comprehensive. The standardised processes were welcomed. The detail on considering provision of public toilets, green spaces, benches, and growing areas were noted as examples.

5.62 Members noted that collaborative working with stakeholders was essential as well as officer capacity to do so. In particular to ensure healthcare needs as well as primary prevention were considered in reviewing HIAs when submitted and to maintain all the documents within the HPP so they remained fit for purpose and effective. As data was not always perfect, it was important to have supporting guidance that was effective and robust. This would ensure that local intelligence, for example from Members, and other public health intelligence was used.

5.63 It was advised that a strong policy and supporting documents were essential in ensuring this was robust in the appeals process. Firstly, it needed to be mandated in the Local Plan. Secondly, it was critical to keep the supporting data and documents up to date. The Planning Inspector would interrogate the evidence base and justification behind any requirements. If the evidence was sound, then the decision would more likely be upheld.

5.64 The task group were advised that the HPP would be a catalyst for more technical conversations with specific teams such as licencing around takeaways, alcohol consumption and vape stores. In addition, if a number of buildings were being developed that would prospectively be used for those types of licensing those conversations could happen early on. It was clarified that there was a process in place for reviewing licencing of hot food takeaways. Planning also had some say through land use class as takeaways needed a separate planning application and so the internal planning policies would be relevant.

5.65 Public Health engaged with the public as much as possible in their health needs assessments. It was more difficult for technical processes like this and so it was important the guidance documents were refreshed regularly, and that part of that should include public consultation. Opportunity for engagement could be built in, but it was highlighted that the evidence base needed to come from many sources such as data and public health intelligence from outreach programmes. It was clarified that public engagement was also an important part in the planning process right from the start. The public were keen to understand how developments were contributing to doctor's surgeries. The expectations on developers' engagement could be looked at. There could be guidance on what developers should be asking the public before HIAs were completed.

5.66 It was confirmed that large housebuilders were very well versed in HIAs. They would have specific experts with the knowledge needed to undertake the process. It may be more difficult for smaller developers and so the guidance alongside HIAs was very important. The rapid HIA was more straightforward and more likely to be used by the smaller developers. Public Health needed to provide any assistance and review the HIAs. As this wasn't a statutory function this could potentially be offered as a discretionary service that would be charged for.

5.67 Currently developers look to remove hazards they may be creating for example through environmental regulations, air quality, noise, traffic etc. In terms of factors to protect health, the promotion aspect is more difficult as it is more emotive and bespoke to a community. The HPP approach encourages the consideration of health-related circumstances specific to the district, a focus on health promotion as well as illness prevention, and suggests healthy features that developers can use in design.

5.68 It was confirmed that developers needed encouragement and guidance. The local authority should set the context, the issues and design solutions that would be encouraged that promote or enhance health, social care and children's services. For example, being clear about what health facility is needed, where and what size. This gives developers weight at the planning committee and so developers want to provide it and actively compete to be the healthiest. Without any weight being placed on health promotion and care in the planning balance, you just won't see the investment needed.

5.69 It was advised that negotiating S106 contributions should not be the first priority. There are advantages for developers to work with local authorities. By working together, the developer's viability is improved and they become more embedded in the community. It helps them retain staff. Developer contributions are too late.

5.70 The task group further considered the introduction of design guides to supplement the HPP. Design guides influence the design of new developments including green infrastructure, open spaces, play areas and design of buildings and homes. An alliance with a broad membership would bring the designs together. It was noted that the design guides would be an opportunity for a clear direction to developers before applications were made. Once at the pre-application stage, the influence was limited. These would need to be accessible and communicated clearly. Strategic health design meetings at local authorities bring planning and public health together would be needed. The ICB can be involved and awareness of this can be raised at the Developers Forum. These needed to be set up annually as health needs change.

5.71 It was asked to what extent could planning ask for certain aspects such as green space and benches. It was confirmed that there was high level support from the National Planning Policy Framework (NPPF). Negotiations need to focus on a package of works to show how developers would be creating an inclusive community and addressing the health indicators. Examples of good practice could be shared with developers as part of the HPP. DM3 in the Local Plan was to hold developers to account. It was highlighted that engagement with an appeal produced some useful statements from the Inspector who said that it was right for public open space and community centre land to be offered to the local council. It was hoped this could be used as a precedent for other developments.

5.72 It was confirmed that the Council has the 'policy hooks' in our emerging Local Plan. Policy DM3 health and wellbeing, SP7 Design Quality - which refers to Healthy Place Making and Policy SP10 which requires protection and enhancement of existing Green Infrastructure assets for the benefit of the health and wellbeing of the community. There is national guidance the Council can rely on in the meantime to strengthen the approach. The local authority can work with developers at the pre-application stage, can use the approach in master plans and implement through the planning process.

5.73 There was a discussion around insulation and noise reduction. Well-insulated properties were essential to tackle fuel poverty and for health and wellbeing. It was confirmed this was predominantly covered by building regulations and so planning were only occasionally involved if there was a conflicting land use. Policy CS15 of the West Berkshire Core Strategy and policy DM4 in the emerging Local Plan also supported this.

5.74 Representatives from the ICB supported the Healthy Planning Protocol and advised they would like to be involved in the development of the procedure / guidance on how Planning, ICB and applicants would work together to ensure the role and position of the ICB was clear. They agreed with the trigger points for reviewing it and the SLA's.

5.75 The task group highlighted that it was important that Members were involved in the development of the ward checklists because wards were not homogenous. Any LSOA's of particular concern could be flagged within the checklist. Member development sessions on health in all policies, the West Berkshire Observatory, the HPP and the public health prevention approach would be very beneficial.

5.76 A concern was raised around how facilities and amenities would be embedded in the community and maintained in the long term. Involving town and parish councils would be essential for continuity and accountability as well as local community engagement. This should be in collaboration with the local authority. Public Health involvement in monitoring and the build out phase was important. An example was shared where a bus route paid for by the developer for an initial two years was now an integral part in the bus network. These elements fitting in with the planning process can be integral keeping the communities sustainable.

5.77 A key challenge noted in the discussions was in communication between planning / developers and public health as they had differing priorities. However, it was advised that they were all working to the same objective. Developers were working for a profit, however there was Environmental and Social Governance (ESG) which they have responsibility to work to. There are also financial incentives. For example, if amenities and facilities were in the first phase of development, there is a premium on the land for the second phase. It was in developers' interest to embed and invest in communities. They can showcase the first phase. It was advised that the main approach needed to get developers on board was in recognising if they were providing healthy design and providing health features. To give them some credit for it and to encourage others to do the same. For those that are not, there is no planning weight to be received. They need credit for ticking all ESG components.

5.78 A further challenge was that there was no top-down directive for health in planning and so it needed to be raised by local authorities who defined their own local policy. There are limited resources in local planning teams and limited training and experience in HIAs. The quality of HIAs would be limited if they were not reviewed fully when submitted, if the implementation was not monitored and if the delivery was not confirmed. The resources needed to be available to make the HPP effective.

5.79 It was confirmed that other local authorities in Berkshire West were not as far ahead with this work, but there were other local authorities in other parts of the country further ahead and best practice was used in developing the policy and guidance. The task group felt that a review of the work by OHID would be very beneficial. When it was ready it would need to go to the developer's forum and a review of the communications around it should be carried out.

6 Recommendations

6.1 The Task and Finish Group wishes to put forward the following recommendations for consideration by the Executive and the BOB ICB.

6.2 **Recommendation 1**: **Planning and Health to continue to improve collaboration on planning consultations and in developing flexible ways of working well together**.

a) The Development Manager, Planning Policy Manager, Senior Primary Care Estate Manager and Senior Programme Manager (Primary Care Estates) to meet regularly to review their engagement on applications and that responses are timely and evidenced. To seek out and together review best practice regularly and make improvements in their ways of working. To hold each other to account and communicate effectively. To work closely on negotiations and to think broadly about the needs of the community and involve other stakeholders.

b) The West Berkshire Council Planning Team to work with GP practices directly to understand their needs and requirements for new developments.

c) The ICB to review how they work with GPs regarding the primary care needs of new developments and to consider any improvements that could be made.

6.3 Recommendation 2: New opportunities in funding and delivery of primary care in the community.

a) The Senior Primary Care Estate Manager and Senior Programme Manager (Primary Care Estates) to consider how they can input into the CIL charging structure when it is next reviewed. To be prepared through seeking best practice elsewhere to provide evidence requested and to be clear how much is needed for new developments.

b) The Planning Policy Manager to consider a review the CIL spending strategy.

c) The Council, in collaboration with key stakeholders, to consider the opportunity of health hubs or multipurpose community facilities. This could be owned by the local authority and leased to the ICB or GPs, or created by developers in the first phase of development and sold to GP practices for a nominal fee. To consider best practice, the local approach and new ways of delivering provisions. The NHS requirements to be built into the Council's wider thinking around multipurpose hubs.

d) The ICB to continue work on workforce planning and staffing to support any infrastructure and to work closely with the local authority. The Berkshire West Place Director to keep the Health Scrutiny Committee updated.

6.4 **Recommendation 3: The Healthy Planning Protocol**.

a) The Senior Programme Officer for the Wider Determinants of Health to request a peer review of the Healthy Planning Protocol from relevant colleagues at the Department for Health and Social Care (DHSC) that specialise in healthy place shaping and the planning process. Consider implementing any changes and recommendations that arise through the review.

b) Further collaboration by Senior Programme Officer for the Wider Determinants of Health, the Development Manager and Planning Policy Manager with developers to finalise guidance and supporting documents with developers. To consider how to guide developers when consulting with the public for HIAs.

c) The Health Scrutiny Committee to endorse the Healthy Planning Protocol, including Health Impact Assessments and any associated Service Level Agreements, to Heads of Service and Corporate Board.

6.5 **Recommendation 4: Implementation of the Healthy Planning Protocol.** Resources are needed to facilitate collaborative working and stakeholders need to be trained and have the appropriate expertise.

a) The Health Scrutiny Committee to endorse an application to Corporate Board/Financial Review Panel to approve a new Officer post whose role would include:

i. Overseeing the implementation of the HPP.
ii. Monitoring and maintaining all the documents within the HPP so they remained fit for purpose and effective.
iii. Reviewing submitted HIAs.
iv. Maintaining an active relationship with the ICB.
v. Supporting and guiding developers.
vi. Working with other stakeholders.
vii. Leading on the next phase of this work.

b) The Senior Primary Care Estate Manager and Senior Programme Manager (Primary Care Estates) to work with the Senior Programme Officer for the Wider Determinants of Health to ensure the HPP is suitable for the ICB and staffed accordingly. The ICB to ensure there is suitable resource to implement this effectively in collaboration with stakeholders.

c) The Planning Policy Manager and Development Manager to review if Planning have adequate resources needed to implement HIAs, improve collaboration and deliver the appropriate training. National guidance is available which can begin to strengthen the approach whilst the HPP is in development.

d) The Senior Programme Officer for the Wider Determinants of Health, Development Manager and Planning Policy Manager to consider how best to engage with developers, for example via the developers' forum, to encourage them to use healthy design, provide health features in developments, and remind them that such actions help to fulfil their own companies' ESG commitments.

e) Public Health to deliver a public health prevention approach workshop for all elected Members, including public health data skills (the West Berkshire Observatory and Public Health Outcomes Framework data) and the HPP.

f) The Senior Programme Officer for the Wider Determinants of Health, Development Manager and Planning Policy Manager to consider further training on healthy places in planning for all Members.

6.6 **Recommendation 5: Wider approach to Healthy Places.** The task group have heard evidence regarding the importance of creating a health-promoting legacy in new developments. In addition to the HPP, the below are recommended for further consideration:

a) The Council to explore 'design guides' or frameworks to supplement the HPP and supporting documents for prospective developers. These to be shaped around public health and council priorities.

b) The Council to consider community engagement and engagement with town and parish councils and West Berkshire Council Members for continuity and accountability in design and in keeping the communities sustainable.

6.7 The HSC may choose to accept the Task and Finish Group's recommendations in full or in part or amend the recommendations before putting them to the Executive and the BOB ICB. Alternatively, the HSC may choose not to put any of the Task and Finish

Group's recommendations to the Executive or ICB if it considers that they are not appropriate.

7 Conclusion

7.1 For the reasons outlined above, the recommendation is for HSC to accept the Task and Finish Group's recommendations in full and put them to the Executive and the BOB ICB for consideration.

8 Appendices

8.1 Appendix A – Healthcare in New Developments Task and Finish Group Terms of Reference.

Subject to Call-In:

Yes: ☐ No: ☒

The item is due to be referred to Council for final approval	☐
Delays in implementation could have serious financial implications for the Council	☐
Delays in implementation could compromise the Council's position	☐
Considered or reviewed by Scrutiny Commission or associated Committees, Task Groups within preceding six months	☒
Item is Urgent Key Decision	☐
Report is to note only	☐

Wards affected: All wards

Officer details:

Name: Vicky Phoenix
Job Title: Principal Policy Officer (Health Scrutiny)
E-mail: Vicky.Phoenix1@Westberks.gov.uk

Document Control

Document Ref:	HSC – Healthcare in New Developments	**Date Created:**	19 April 2024
Version:	2.0	**Date Modified:**	30 April 2024
Author:	Vicky Phoenix		
Owning Service	Legal and Democratic Services		

Change History

Version	Date	Description	Change ID
1	19 April 2024	Draft for Task Group / Officer feedback	
2	30 April 2024	Amended with Member and Officer feedback. For Corporate Board.	

This page is intentionally left blank

Health Scrutiny Review Matrix

Review Topic: Healthcare in new developments	**Timescale** **Start: January 2024** **Finish: May 2024**

Review Rationale:

A key concern regarding proposed new developments is ensuring adequate healthcare services are provided. There is a need to ensure that healthcare commissioners are adequately consulted on the requirements for the primary care services (GP surgeries and pharmacies) to serve new developments when local populations increase, and that developers engage with health commissioners and planners.

There is also opportunity to ensure that new developments are designed to promote health and wellbeing, and therefore prevent future demand on primary care services. There is therefore a need to review how the planning application process is encouraging developers to design with long-term prevention and health promotion for all residents across the life-course in mind.

The scope of the review will include:

- The assessment of the health needs of a local population and how future primary care and public health care services are planned with consideration for housing growth and demographic changes.
- Clarity around planning policy and planning consultations with key stakeholders.
- Reviewing a proposed Health Impact Assessment policy, including supporting guidance documentation.
- Greater understanding of how primary care services for new developments are commissioned, and the level of support for securing funding and delivering proposals.

Terms of Reference:

The Task and Finish Group will consider the following:

Part 1: Assessment of health needs in new developments.

- Review of current mapping of primary care provision (including dentistry, pharmacies and optometry) in new developments and planned population growth.
- Form an understanding of Health Impact Assessment's (HIA), their implementation and the wider preventative approach.
- Review how Berkshire Observatory ward data will be used by developers completing HIA's.

Part 2: Health in Planning policy and Planning consultations.

- Review the draft Healthy Planning Protocol (HPP).
- Consider partnership working and the planning consultation process.
- Review engagement with the Integrated Care Board to be assured that the planning process is accessible for NHS partners.
- Review the draft HIA templates and supporting documentation to be used by developers when submitting an application within agreed parameters, in order to design with long-term prevention, health promotion and healthcare in mind.

Part 3: Funding and delivery of Primary Care and Public Health care services in New Developments.

- Greater understanding of how primary care and public health care services for new developments are funded.
- Review the level of support provided to Primary Care Networks / GP Surgeries in securing funding and delivering proposals.
- Understand developer contributions for local health infrastructure through S106 and CIL agreements.
- Consider the barriers in delivering the plans for future population growth.

Review Membership:
Cllr Carolyne Culver
Cllr Nigel Foot
Cllr Owen Jeffery
Cllr Jane Langford
Cllr Martha Vickers

Chairman: Cllr Carolyne Culver

Vice-Chairman: Cllr Martha Vicker

Scrutiny Officer: Vicky Phoenix

Information Required:

- The draft Healthy Planning Protocol.
- Health Impact Assessment templates and supporting documents.
- CIL and S106 funding processes.
- Baseline data about primary care services.
- Existing proposals to serve planned developments.
- Health Policy in the draft Local Plan.

Witnesses:

- Senior Programme Officer for the Wider Determinants of Health.
- Planning Policy Manager.
- Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board – Primary Care providers and commissioners.

- Cllr Tony Vickers - Executive Portfolio Holder: Planning and Community Engagement

Desired Outcomes:

Members will collate their recommendations which will then form the basis of a report to be considered by the Health Scrutiny Committee.

This page is intentionally left blank

Public Health in West Berkshire

Our Ambitions, Our Journey

Foreword by the Director of Public Health

It is my privilege to present the first public health annual report dedicated and singularly focused on the unitary authority of West Berkshire Council. Public health reports such as this have been produced for the best part of 200 years since the country's first Medical Officer of Health, William Henry Duncan, established the tradition in 1840s Liverpool. The long history of public health annual reports carries with it an acceptance of their independence from corporate or other influence; traditionally they have been presented to the annual public meeting of the Council, open to public and media scrutiny.

There was a gap, from 1974, following the abolition of the post of Medical Officer of Health and the movement of public health into the NHS during the reorganisation of local government, but this was short lived. In 1988 the new position of Director of Public Health (DPH) was established, and with it the renaissance of the annual report.

In the early 2000s the post of DPH was opened up to trained public health professionals from backgrounds other than medicine, and in 2014 public health was returned from the NHS to its spiritual home in local government. This was in recognition of the fact that most of the building blocks of health and wellbeing lie outside of and upstream from health services.

In recent years West Berkshire has operated as a unitary authority with the combined powers of a non-metropolitan county and district council; these powers include those to provide public health advice and protection for the citizens of the district, in this case currently under the leadership of a joint Director of Public Health for Reading and West Berkshire. Until now, public health annual reports have covered more than one council area in Berkshire West, this being the first to focus exclusively on West Berkshire.

This is a fantastic opportunity to reflect on the successes and achievements to date, shining a spotlight on the district. With a new Director of Public Health for West Berkshire taking up leadership in 2024, this is an ideal time to review our position and set out the priorities for the future.

Despite the period of recent uncertainty resulting from changes in Public Health leadership, there has been real progress and achievement in public health in the district. It is intended that this report will provide a comprehensive overview and the basis for

continuing improvement in the years ahead.

Children and Young People

Our focus on children and young people is aimed at producing the best start in life. We must continue to strive to improve health and wellbeing, prevent disease, develop resilience, and promote equality from before birth through adolescence and into young adulthood. The first thousand days of life (beginning at conception) are now recognised to be of crucial importance as building blocks to a stable confident and self-assured child able to realise its potential and have a happy life. Other way-markers on this journey include the avoidance of Adverse Childhood Events (ACE);[1] parenting support where needed; school readiness; the avoidance of school exclusion, which brings with it the potential of undesirable street influences; and readiness for adult life, higher and further education and the world of work.

Work with children and young people is the most effective and cost-effective approach to preventing ill health in later life. The COVID-19 pandemic has had a particularly damaging impact on children and young people, not least in relation to their socialisation at critical developmental stages and the effect on mental health, which may prove enduring without remedial support. Inequalities have widened, and in the specific area of vaccination against infectious disease, reduced coverage has left many vulnerable to diseases which we thought had been banished.

The Public Health Team in West Berkshire is mandated by the national Office of Health Improvement and Development (OHID) to commission specific programmes and services for children and young people from the ring-fenced public health budget, currently set at £6,481,369 for the year 2024-25. These services include health visiting and school nursing, Family Hub programmes, breast feeding support, early intervention services (for example dads' postnatal support and 'Every Child a Talker' programme) and wellbeing programmes in schools. Additionally, we fund the Emotional Health Academy and 'Time2Talk' youth counselling.

[1] Adverse Childhood Experiences (ACEs) are "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence and include physical abuse; sexual abuse; emotional abuse; parental or household substance abuse; exposure to domestic violence; living with someone who has gone to prison; living with someone with serious mental illness; losing a parent through divorce, death or abandonment.

The approach of the Public Health Team has been and will continue to be that of working in evidence-based partnerships across the Council and beyond into the community. Our ambition is for West Berkshire Council to become a Public Health Organisation in which the health and wellbeing of residents is the ultimate outcome of all work. Activity encompasses Early Years, Public Protection, Children's Services, Education and Schools. We are part of the Children's Prevention and Early Help Partnership subgroup of the West Berkshire Health and Wellbeing Board, the Early Years Inequalities Group, the Berkshire west Safeguarding Children Partnership's West Berkshire Independent Scrutiny and Impact Group, the West Berkshire Child Exploitation Strategic Group, Parenting Network Meetings, and the Youth Offending Team Management Group (YOT).

Health Protection

Until the recent COVID-19 pandemic, health protection has received less emphasis compared to previous years, although support has remained available in the form of advice and guidance during outbreak situations, particularly focusing on schools and vulnerable residents.

Since 2020, our community outreach programme has taken preventive action to support the COVID-19 and influenza vaccination programmes, especially in spring and autumn. The flu vaccinations have been a significant aspect of our Stay Well in Winter Campaign, conducted in close collaboration with NHS services.

Preventing infectious diseases continues to be a public health priority, requiring collaborative efforts with health and social care, as well as action to improve vaccination uptake among individuals and communities to protect against disease.

Vaccinations still play a crucial role in safeguarding against preventable diseases such as measles, rubella, and polio. However, since 2013, there has been a decline in childhood vaccine uptake in England, a trend that has further worsened since the COVID-19 pandemic.

Sexual Health

Over the past year, we have worked with the voluntary sector on a HIV viral testing campaign, with the aim of increasing awareness of the importance of testing for HIV and increase the number of HIV tests that are done in West Berkshire. We have also been

working on extending our sexual health contracts; Emergency Hormonal Contraception, commonly referred to as the "morning-after pill," as well as Long-Acting Reversible Contraception (LARC). LARC methods encompass intrauterine devices (IUDs or coils) and contraceptive implants.

To support young people's sexual health, we have commissioned a new provider to deliver sexual health and relationship training to school staff, council staff and practitioners or volunteers who work with young people in the community. This will enable young people to have supportive conversations around sex and relationships with people they trust.

Working in collaboration with our sexual health service provider, we are updating the service to meet the demands of the post COVID-19 "new normal." This year they have revised their opening hours and have ensured that young people are able to access online STI testing.

Our focus for the next year is to review condom distribution, extend the national HIV testing week campaign by three months to increase HIV testing, review and support women's health hubs, and look to enhance links with substance misuse services and those supporting individuals with learning disabilities. Additionally, we aim to improve data collection and update our sexual health needs assessment.

Smoking cessation

Smoke Free Life Berkshire has been offering a tiered model of 'Stop Smoking' support across West Berkshire and Wokingham since 2021. This tiered approach allows clients to access the service with greater flexibility to meet individual needs and time commitments. As a result, more people have been setting quit dates and successfully quitting smoking compared with previous year. In the 2022-23 period, 710 people in West Berkshire set a quit date, of whom 469 (66%) remained smoke-free after four weeks. This success rate compares favourably with services across the country.

Drugs and Alcohol

West Berkshire has been working to reduce harm from drugs and alcohol through membership on the Combatting Drugs Partnership. The Partnership oversees delivery against the national outcomes framework and local investment and planning to improve

outcomes and support government ambitions set in the Government's Harm to Hope strategy, covering each of the three priorities to tackle demand; prevent supply; and offer world class treatment & recovery services and support.

As part of a strategic response to substance misuse, a multi-agency Substance Misuse Harm Reduction Partnership oversees the delivery of an integrated adult and young people drug and alcohol behaviour change service locally, commissioned by Public Health.

Suicide Prevention

The West Berkshire Implementation Action Plan is in the process of being revised to support the implementation of the Pan Berkshire Suicide Strategy 2021-2026. The local action plan will ensure that approaches are aligned with the new national strategy. This will facilitate local actions in prevention activity. Over the coming year, we will be commissioning suicide first aid training which will allow more people to spot the signs that someone might be at risk of suicide and able to intervene safely.

Ageing well and dementia

West Berkshire is experiencing a rapidly ageing population that is more marked than in some other areas of the country. It is therefore an especial priority to ensure that all residents have the opportunity of ageing well. A member of the Public Health Team chairs West Berkshire's multiagency Ageing Well Task Group (a sub-group of the Health and Wellbeing Board).

As regards older people in West Berkshire there has been a focus on falls prevention and reducing social isolation, targeting those more vulnerable residents at increased risk of poor health outcomes. Communications have been developed in a variety of formats for this group to enable them to receive information and to access services.

There has also been specific focus on supporting residents living with dementia and their unpaid carers and a dementia friendly community programme called 'Dementia Friendly West Berkshire '(DFWB) has been commissioned. This programme brings together statutory, voluntary and community partners, local businesses and residents to raise awareness and understanding of dementia in the community. The aim of this partnership is to promote the range of services for people living with dementia, reduce

social isolation and advocate for the inclusion of people with dementia in the activities of everyday life.

Population Health Care

The Public Health Team has been collaborating closely with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) to capitalise on opportunities for the NHS to prevent ill health and address inequalities. This collaboration includes funding a Community Wellness Outreach Service aimed at identifying individuals at risk of cardiovascular diseases (CVD) and improving access to the NHS Health Checks in underserved populations. The service will be delivered in community settings across West Berkshire.

Health in All Policies

In order to narrow the differences in health outcomes between groups of people in West Berkshire, the Council has committed to developing and embedding a Health in All Policies (HiAP) approach at a corporate level. This approach will better enable the entire organisation to address the structural issues that contribute to these health inequalities. To embed this approach, we have conducted a Local Government Association workshop on HiAP for senior leadership across the Council, focusing on how all service areas can contribute to the 'starting well' and 'ageing well' agendas. By doing so, we will strengthen our primary prevention efforts and begin to reverse the trend of increasing demand on health and social care services in the long run.

Community engagement

The Public Health Team has been actively involved in community initiatives aimed at improving health and wellbeing, fostering community resilience, and promoting community asset development. This has included initiatives like Memory Cafes. Additionally, the team has assisted in crafting the West Berkshire Co-production Framework in collaboration with staff, residents, and external partners. As part of this framework, a community mapping tool was devised to engage grassroots community groups and bolster place-based initiatives.

At a place level, voluntary organisations and community groups, along with vulnerable residents, have received support in accessing the Household Support Fund amid the

current cost of living crisis. This assistance extends to hard-to-reach groups, historically unheard or underserved populations. Through effective community engagement, easily accessible information, and clear guidance, individuals have been able to access resources such as food banks, heating assistance, and household goods.

Our Engaging and Enabling Local Communities Programme has provided valuable opportunities to listen to residents and communities, gather insights, and share vital public health information. As a public health team, we have established strong, trusted relationships with a wide array of Voluntary and Community Sector organisations in West Berkshire. These relationships are leveraged to facilitate the targeted delivery of programs such as Vaccine Outreach and Cardiovascular Disease (CVD) Health checks. By collaborating in this manner, vulnerable residents and communities receive better support in accessing essential services and enhancing their overall health and wellbeing.

The scope of work to protect and improve the health of the people we serve is broad and goes well beyond the usual narrow range of personal health and social care services. Inequalities seen in small pockets of deprivation in West Berkshire, along with the growing ageing population are of particular public health concern locally and should continue to be prioritised. This time of public health leadership transition within West Berkshire Council provides the opportunity to pause and reflect in order to plan the future direction of travel. The advancement of the Health in All Policies agenda in particular provides the opportunity to continue to move upstream towards action on the determinants of health and the maintenance of a full life by working at a place level, engaging with communities and mobilising community assets with the support of statutory agencies. Our role within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) provides us with the opportunity to work with colleagues in supporting the reorientation of the NHS towards a health service rooted in public health principles and grounded in population based primary health care. The social goal is for all to 'die young as old as possible' while reducing inequality and the prevalence of long-term conditions whilst maintaining independent living.

Prof. Dr John R Ashton C.B.E. Interim Director of Public Health Reading and West Berkshire 2023-2024.

Acknowledgments

It has been an immense privilege to act as the Interim Director of Public Health for West Berkshire for the past year and to work with such dedicated and committed colleagues. I am very proud of the members of the Public Health Team and their collaborators who have given so much of themselves in 2023/24. I would like to thank them for the support they have given to myself during my time here and trust that we have together put in place sound public health foundations for the people of West Berkshire.

I wish especially to acknowledge Mike Bridges and Charlotte Pavitt for their authorship of the report and Gayan Perera, Sabrina Kwaa and Nana Wadee for the insightful analysis contained within. I would also like to acknowledge and thank the following for their work in public health in West Berkshire and their contributions to this report.

Vikki Angel

Sue Butterworth

Zoe Campbell

Paul Coe

Paul Graham

Catherine Greaves

Elisabeth Gowens

Rachel Johnson

Gordon Oliver

April Peberdy

Nerys Probert

Kate Toone

Setting the scene

The History of West Berkshire Unitary Council

Initially established as the Newbury District Council under the Local Government Act 1972, West Berkshire Council replaced five preceding local authorities: Bradfield Rural District Council, Hungerford Rural District Council, Newbury Borough Council, Newbury Rural District Council, and Wantage Rural District Council. On April 1, 1998, the entity underwent the name change to West Berkshire Council and adopted the status of a unitary authority. Consequently, it absorbed the powers and functions previously held by the abolished Berkshire County Council within the district. The current council is divided into 24 wards represented by 43 Councillors.

Prior to the establishment of Berkshire County Council, Sanitary Districts were instituted in response to the Public Health Act of 1872. This legislation aimed to tackle public health issues through an organised and systematic approach to sanitation and public health administration. Sanitary districts were designated geographic areas tasked with implementing public health measures, encompassing sanitation, waste disposal, and disease control.

The Public Health Act of 1872 was a pivotal component of the 19th-century movement to enhance public health and sanitation, addressing prevalent unsanitary conditions in urban areas. Empowering local authorities, the act facilitated measures to prevent disease spread, regulate housing conditions, and oversee sanitation infrastructure.

The landscape of public health administration underwent evolution over time, resulting in changes to local government structures. Notably, the establishment of sanitary districts led to the development of contemporary local government frameworks and health authorities and legislative developments and reforms continued to shape the health and sanitation systems in England and Wales.

In particular, the 2013 Health and Social Care Act marked a significant milestone in the evolution of health and social care in England. One notable change brought about by the act was the transfer of public health responsibilities from the National Health Service (NHS) to local government authorities. This shift aimed to integrate public health efforts

more closely with other local services and empower local authorities to address the specific health needs of their communities.

The Context of Public Health in West Berkshire in 2024

The Victorian foundations of local public health work lay in the registration of births and deaths, the notification of infectious disease, and advice to town and borough councils. Today we would describe those early environmental efforts to prevent and respond to infectious disease as falling within the category of health protection, encompassing the many external threats to health whether they be biological, chemical, radiological or arising from natural or man-made disasters. These threats also include behavioural determinants such as violence or the pernicious effects of commercial determinants praying on human weakness in the form of addictions including those to alcohol, nicotine and gambling. Today Public Health broadly consists of three domains of action: Health Protection (as described); Health Improvement; and the Healthcare Public Health.[2]

Health Protection protects the population from health threats, emergencies and disasters. The development of emergency response plans; guidance on the management of public health emergencies such as infectious disease outbreaks, natural disasters or chemical incidents

Health Improvement includes health promotion campaigns and awareness raising about healthy lifestyles (on topics such as nutrition, physical activity, sexual health, smoking and substance use), disease prevention and the importance of vaccinations. It also includes influencing and ensuring all of the right building blocks for health are in place such as resilient and connected communities and social networks; stable jobs; good pay; quality housing; and good education.

Healthcare Public Health ensures health services are of consistently high quality and evidence-informed and value-based and address issues of effectiveness, efficiency and equity, and includes the emerging proactive of population health management and care.

[2] What is Public Health? - FPH - Faculty of Public Health

Health Protection

The Covid-19 pandemic that began in 2019/20 as the most devastating threat to global public health in 100 years, not only resulted in millions of premature deaths and led to a long tail of long covid ill health, but also had a profound impact on the public understanding of public health. This understanding has included an awareness of the importance of maintaining vigilance over the enduring challenge of protection against novel viral and other types of infectious disease. Local authorities in particular, with their proud tradition of work in this area, have been alerted to the importance of continuing to build resilience in the health protection function for which they have responsibility.

Until the pandemic it is fair to say that health protection had generally received less priority than pre-1974, although support had remained available in the form of advice and guidance in outbreak situations, particularly focusing on schools and vulnerable residents.

Since the pandemic it has become a priority to build on the lessons of Covid and to strengthen the health protection function while continuing with established programmes to combat infectious disease. Our community programme has taken preventive action to support the COVID-19 and influenza vaccination programmes. Vaccinations continue to play a crucial role in safeguarding against preventable diseases such as measles, rubella, and polio. A particular current challenge is to rebuild trust in vaccination programmes that was badly damaged by vaccination sceptics during the pandemic to the detriment of child health. This is well illustrated by the current return of measles, a serious childhood infection that can lead to death and lifelong disability.

Health Improvement

During the 1970's there developed a momentum for a revival of public health that had been eclipsed by the application of science-based advances in medicine and therapeutics and that had led to the rise of hospital medicine to the detriment of both prevention and primary health care. The resulting New Public Health stressed the importance of reorientation health systems away from hospitals towards public health and primary and community care with a particular emphasis on recognising that most care is provided at home in the form of self-care with family and community support.

Key elements of this were captured in the concept of Health Improvement, a broad-based approach aimed at enabling people to have more control over the determinants of ill health, an approach that saw health as a resource for everyday life rather than an end in itself. At its heart was to be public engagement and multidisciplinary working.

This fresh approach was expressed in clear terms by the World Health Organisation in its Ottawa Charter of 1986 which called for the building of policies that support health; the creation of supportive environments to protect health and make the healthy choices the easy choices; the strengthening of community action; the development of personal skills and the reorientation of health services. Coming up to forty years on from Ottawa progress has been made but it is salutary to note that since 2015 the proportion of NHS budgets spent on hospital work has continued to increase at the expense of public health, primary and community care.

Healthcare Public Health

Healthcare public health draws on core public health skills and science and applies them to the planning, commissioning and provision of health and social care services. It aims to improve population health by ensuring health services are of consistently high quality and especially that they are evidence-informed and value-based and aim to understand need and variation in order to address issues of effectiveness, efficiency and equity. This helps drive improvements in population outcomes and a reduction in health inequalities in a cost-effective manner.

With the emergence of Integrated Care Systems (ICSs) in 2022, there is even more impetus to establish sound healthcare public health practice at a local level. Collaboration is key to success and the involvement of a range of stakeholders from across the NHS and other agencies, organisations and communities is important to facilitate productive links between professionals, managers, policymakers, academic researchers and public/patient representatives.

The prevention of ill health

One of the most important lessons to have come from the advances in scientific medicine that began with the discovery of insulin and penicillin almost 100 years ago is

that by enabling people to live who might previously have died, the burden of disease may actually increase and with it the costs of maintaining people's health over many years. Examples of this include diabetes, cardiovascular disease, and HIV/AIDS. The message from this is that only by addressing the determinants of ill health in populations, so-called Primary Prevention, can we avoid ever increasing demands on national resources to be spend on treatment and care. In an age of much increased life expectancy and growing numbers of frail elderly preventing the preventable becomes an imperative.

Where primary prevention has its greatest potential to make a contribution is to be found in the first twenty-five years of life. From then onwards patterns have been established and disease processes may gather momentum. This becomes the territory of Secondary Prevention in which screening and the early identification and intervention of emerging problems is the bread and butter of Primary Medical Care, and Tertiary Prevention represented by the combined efforts of the health and social care system is aimed at enabling those with established conditions to continue to live as full and as long a life as possible.

Introduction: Public Health Comes Home

In the Victorian era the threat posed by pandemics of infectious disease galvanised local action, not least through the development of a broad-based public health movement based in town council areas. Typically, this consisted of a partnership of local politicians, businessmen, the churches, and the local press, together with enlightened medical practitioners who were interested in preventing disease. In the vanguard of this movement was the Health of Towns Association, which sprang up following the publication of Edwin Chadwick's Report on 'The Sanitary Conditions of the Labouring Classes', in 1842, and which drew attention to the high death rates in the nation's slums. Until that time, it had been assumed that because the urban economy was booming, as a result of industrialisation, life was better for everybody in the towns compared with the countryside.

The Health of Towns Association was formed at an inaugural meeting at Exeter Hall on the Strand in London, on 11 December 1844, described as being "an avowedly propagandist organisation, of capital importance."[3]

This early example of an evidence-based campaign to address the root causes of avoidable death, that fell disproportionately on the poor, was the beginning of a tradition that has extended down the years via the Quaker Rowntree reports on poverty in Victorian slums, to the Marmot reports on Inequality in Health today[3]. In the case of the work of the Health of Towns Association, its emphasis on disseminating facts and figures drawn from official reports; organising public lectures on the subject, reporting on the sanitary problems in districts; providing instruction on the principles of ventilation, drainage, and civic and domestic cleanliness whilst campaigning for parliamentary action to give powers of intervention to local authorities, led to the passing of the first Public Health Act in 1848.

This Act built on the innovative action of Liverpool in passing its own parliamentary 'Sanatory (sic) Act' in 1846 which enabled the town to appoint the country's first full time Medical Officer of Health. The 1848 enabling Act extended this power to the many other

[3] Ashton, J. (2019). Practising Public Health - An Eyewitness Account. Oxford University Press

towns and cities that followed suit over the next 20 or so years, until this became a requirement in the later Public Health Act of 1875.[4]

Report to the General Board of Health on a Preliminary Inquiry into the Sewerage, Drainage, and Supply of Water and the Sanitary Conditions of the Inhabitants of the Borough of Newbury

The 1852 report by William Lee Esq, Superintending Inspector, describes the Borough of Newbury as a "serious sanitary evil." The inquiry illustrates the living conditions of Newbury's residents and those in the surrounding rural areas. The report vividly portrays witness accounts detailing sanitary conditions such as sewage, drainage, lack of drinking water, overcrowding and flooding. It also highlights excessively high mortality rates resulting from preventable diseases among the inhabitants. These insights are gleaned from testimonies of residents, local medical practitioners, and statistical comparisons with other districts nationwide.

The report highlights that the town's health could be significantly improved through the actions of the local authority, comprising the Town Council and Improvement Commissioners. The suggested means include enacting the Local Improvement Act to provide water to local residents, ensuring adequate drainage for houses, abolishing cesspools, and supplying other essential requisites for good health.

The inquiry report delves into mortality rates and the root causes of diseases, emphasising the urgency of implementing preventive measures. The Local Improvement Act is proposed as a mechanism for vesting powers in the Town Council through the Local Board of Health. This stresses the vital role of Public Health today, emphasising the need for collaborative efforts across various sectors within our council. These efforts should underpin and inform the work of Housing, Social Care, Environmental Health, Regulatory Standards, and beyond. The report serves as a powerful reminder that Public Health remains essential in contemporary society, guiding preventative partnership initiatives crucial for the well-being of the community.

Annual public health reports such as this have represented not only a snapshot of population health at a moment in time, and a reference point for action, but also are documents of record for the future, of value to policy makers, practitioners and the public,

[4] Frazer, W.M. (1947). Duncan of Liverpool. An account of the work of Dr w. H. Duncan, Medical Officer of Health of Liverpool, 1847-63. Hamish Hamilton Medical Books, London

that enable us to learn from the past, to see how far we have come, and, hopefully, avoid repeating previous mistakes.

The work of the early pioneers of public health from the 1840s onwards was organised around the principle that came to be known as 'The Sanitary Idea' and focused on the separation of human, animal, and vegetable waste from food and water. Twenty years before the discovery of the germ theory of disease by Louis Pasteur in Paris, this led to concerted action on sanitation, cleanliness, scavenging, street paving, safe municipal water supplies, street washing and slum improvement. Over time, with the increased credibility of local government resulting from its effective action in tackling epidemic disease through these measures, other programmes of work became possible, including the creation of municipal parks as lungs of towns and cities, giving access to fresh air and exercise for industrial workers on their day of rest; municipal bath and washhouses; early examples of municipal housing; and other infrastructure initiatives such as gasworks and hygienic slaughterhouses.

The advent of safe household water supplies and mains sewerage systems together with the mass manufacture of soap by Lever Brothers on Merseyside, together with the new insights into the germ causation of infectious disease, paved the way for a shift from the sanitary focus of the early years to one on hygiene from the 1870s onwards. At the same time, personal health and social services such as health visitors, social workers, and community nurses began to emerge from their environmental roots in household inspection, based yet again in local government. Examples of specific initiatives included the health visitor movement that began in Salford in 1862; the first Society for the Prevention of Cruelty to Children, in Liverpool in 1883; and the first depot to provide milk to nursing mothers, in St Helens, in 1899. Innovation and rollout by local councils came thick and fast.

Despite this, an event of particular importance in the evolution of British public health came as a result of the Boer war from 1899 to 1902 when 40% of men who had volunteered for military service were deemed to be unfit to serve and concerns were expressed about how the nation would deal with the increasing military threat posed by Germany. An interdepartmental government enquiry into the "physical deterioration" of the nation led to a comprehensive programme of action:

- A continuing anthropometric survey;
- Registration of stillbirths;
- Studies of infant mortality;
- Centres for maternal instruction;
- Day nurseries;
- Registration and supervision of working pregnant women;
- Free school meals and medical inspection of children;
- Physical training for children, training in hygiene and mother craft;
- Prohibition of tobacco sales to children;
- Education on the evils of drink;
- Medicals on entry to work;
- Studies of the prevalence and effects of syphilis;
- Extension of the Health Visiting Service.

At the time, there were arguments over community versus family responsibilities for health and wellbeing, an echo of the contemporary debates about the so-called 'nanny state', but the interests of the nation prevailed and, with them, the establishment of the School Meal and School Health Services. Over 100 years on the range of local government initiatives looks impressive and comprehensive. Sadly, it was not to endure in the face of scientific medical advances and the increasing domination of hospital medicine as the therapeutic era based on pharmaceutical and other technical interventions took centre stage.

The widely accepted definition of public health as first coined by Charles Winslow, Dean of Public Health at Yale School of Public Health, in 1920, is that "Public Health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health"[5].

[5] Winslow, C. E.A. (1920). The Untilled Fields of Public Health, Science.

This comprehensive approach attracted widespread support after World War 1, building on the Boer War report but being extended to include Prime Minister Lloyd George's major programme of 'Homes Fit for Heroes'. When the Poor Law was abolished in 1929 and its responsibilities, including for the relief of poverty and for the workhouse hospitals, passed to local government, the era of local government public health reached a peak. At this point, the Medical Officer of Health was responsible for the traditional environmental services of water supply, sewage disposal, food control and hygiene; for the public health aspects of housing; for the control and prevention of infectious disease; for the maternity and child welfare clinics, health visitors, community nurses and midwives. He (sic) was also responsible for the tuberculosis (TB) dispensary and venereal disease (VD) clinic. Under his other hat he oversaw school health, to which was added the responsibility for the administration of the local hospital[6]. Some of the larger public health teams consisted of thousands of staff. What could possibly go wrong?

What happened next was in fact the advent of the new, therapeutic era, in public health with major scientific advances beginning with the discovery of insulin and the early antibiotics. Until this time, medical interventions made precious little difference to life expectancy and chronic ill health. Rather, the major improvements that had taken place and had led to dramatic falls in mortality from childhood and water and food-borne infections had come about as a result of improved living and working conditions; safe water and sanitation; increased agricultural productivity that had made cheap food abundantly available for the poor; the adoption of birth control leading to smaller families competing for scarce family resources and the beginnings of vaccination for a range of infections. These included the later BCG vaccination together with medication to control tuberculosis, one of the "captains of the men of death", along with epidemic pneumonia.

[6] Integrated care systems (ICSs) became legally established through the Health and Care Act 2022, on 1 July 2022

Berkshire County Council Public Health Report compiled by Gerard C. Taylor OBE County Medical Officer of Health

The 1923 Berkshire County Council Public Health Report reveals significant advancements in population health, attributed to the effectiveness of public health interventions, medical progress, improvements in sanitation infrastructure and favourable socio-economic conditions when compared to the previous Report to the General Board of Health in 1852.

From 1852 to 1923, the population of Newbury Borough steadily increased from 6,568 to 12,295. This demographic shift is ascribed to various factors, including an aging population, high birth rates, a decline in infantile mortality, and net migration. However, there was a notable decline in the number of men aged between 20 and 40, compared to women, both nationally and locally. This was a consequence of the significant loss of servicemen during the First World War (1914-1918). Subsequently, there was a spike, indicating a rise in the number of post-war babies being born in the 1920's. A reduction in mortality rates is credited to advancements in nutrition, hygiene, housing, sanitation, the control of infectious diseases, childhood immunisation, and other public health measures.

In 1918, arrangements were made for the implementation of a comprehensive scheme encompassing maternity and child welfare work, including the establishment of centres and clinics. By 1923, 63 percent of child births registered in the County were attended by a registered midwife, marking a significant increase compared to the pre-war years. In 1920 the first Council houses were built in Newbury in St George's Ave. Additionally, the West Berkshire Museum opened in Newbury in 1904, while the first public library opened in 1906, and the first cinema in 1910 bringing education, culture, art, entertainment and improvements to the physical and emotional wellbeing of the working-classes.

Epidemiological insights from the County Medical Officer of Health report highlighted prevalent diseases, including smallpox, measles, German Measles (Rubella), scarlet fever, whooping cough, diphtheria, typhus, enteric fever, and diarrhoea. Notably, during 1923, there were 71 notifications of infectious diseases in Newbury (32 cases) and the Rural Districts (39 cases), reflecting ongoing efforts to monitor and manage disease outbreaks.

The coming of the NHS in 1948 marked a dramatic change in emphasis with a widespread belief that public health had completed its historic task. It came to be believed that the future would be largely based around hospital medicine with a pill for every ill and extended possibilities for surgery posed by antibiotics preventing wound infections. This also marked the point at which medical careers between hospital medicine and general practice sharply divided and both public health and general practice went into a sharp decline.

By the time of the major local government reorganisation in 1974, the public health workforce was demoralised and struggling to recruit. Other professional groups such as social work, environmental health, and community nursing, were vying for their own professional space, away from the hierarchical leadership by the Medical Officer of Health, and the role was abandoned and reinvented as an administrative one in the NHS, that of Community Physician, one that was to be short lived.

The creation of new joint posts in the control of communicable disease between the NHS and local government in 1988 marked the beginning of the slow transfer back of public health to its proper home in local government. It was to take 27 years, until 2013, before this was implemented in full.

In the meantime, beginning in the 1970s there had been an increasing recognition internationally that countries may be on the wrong path with their infatuation with hospitals at the expense of public health and primary care, and that a rebalancing was necessary. The publication of the Alma Ata Declaration by the World Health Organisation in 1978 had called for a reorientation of health systems towards primary health care grounded in a public health framework which emphasised public participation and extensive partnership working with a focus on the need for cross-cutting policies that promote and improve health.

At the heart of these initiatives was the implication that our approach to health had been distorted not only by the undue emphasis on the role of hospitals in improving health but also the over-professionalisation of everyday maladies and the management of long-term conditions. This extended to the neglect of support for the overwhelming contributions of lay and self-care by individuals, family, friends and communities.

In addition, the limitations of the original 'sanitary idea' that drove public health in the nineteenth century have become apparent. Dumping sewage and chemical waste into the rivers and building tall chimneys to move air pollution beyond the city limits may solve problems in the short term but over time have led to our soiling our own planetary nest and contributed to global warming and the climate emergency.

The New Public Health that has emerged during the past thirty years puts emphasis on the ecological nature of the challenge facing us and stresses the need for us to live in a sustainable way in the habitats that nurture and protect us. This thinking has led to the reconnection of public health to town planning to which it was akin to a Siamese twin in previous times. Four principles of ecological town planning have been identified:

1. Minimum intrusion into the natural state with new developments and restructuring reflecting and respecting the topographic, hydrographic, vegetal, and climatic environment in which it occurs, rather than imposing itself mechanically on locations.
2. Maximum variety in the physical, social and economic structure and land use, through which comes resilience.
3. As closed a system as possible based on renewable energy, recycling and the ecological management of green space.
4. An optimal balance between population and resources to reflect the fragile nature of natural systems and the environments that support them. Balance is required at both administrative district and neighbourhood levels to provide high quality and supportive physical environments as well as economic and cultural opportunities[2].

This understanding has informed the development and adoption of the United Nations' Sustainable Development Goals to be attained by the year 2030 and to which the British government is a signatory. Although government endorsement is necessary for progress to be made with these ambitions, it is not sufficient, and it is likely that the concerted action of local authorities globally will be essential.

Table 1. The United Nations Sustainable Development Goals[7]

No poverty	Gender equality	Industry, innovation and infrastructure	Life below water
Zero hunger	Clean water and sanitation	Reduced inequalities	Life on land
Good health and wellbeing	Affordable and clean energy	Sustainable cities and communities	Peace, justice, and strong institutions
Quality education	Decent work and economic growth	Responsible consumption and production	Partnerships to achieve the goals

The lack of sustainability of the current path being followed together with the rapidly increasing demand for medical and social care in an ageing population was recognised in the UK in 2002. At that time, the then Chancellor of the Exchequer, Gordon Brown, invited banker, Derek Wanless, to review the case for bringing NHS funding up to the level of comparable European countries. In supporting the case for increased funds, Wanless and his team examined three scenarios based on: the status quo; the implementation of evidence based best practice universally across the present system; and the complete transformation of the NHS into one grounded in public health and full public engagement.[8]

Only under the last scenario could he justify increased funding; with both scenarios one and two the NHS was predicted to fall over either in 20 years or more slowly. Sadly, the significant increase in funds subsequently made available those 20 years ago was appropriated into a new hospital building programme together with large pay increases for NHS staff without the transformation envisaged. Now in 2024, a combination of these flawed decisions with the aftermath of the pandemic have brought the situation to a head. Time is short and the need for real change urgent. However, the experience of the COVID-19 pandemic has resonances with the cholera pandemics of the nineteenth

[7] United Nation. Sustainable Development Goals. Sustainable Development Goals | United Nations Development Programme (undp.org)
[8] Wanless, D. (2002) Securing our Future Health: Taking a Long-Term View. Wanless.pdf (yearofcare.co.uk)

century in that we have an opportunity to learn from that experience and build on the responses that were made.

The Organised Efforts of Society for Public Health in West Berkshire

In recent years the World Health Organisation has advocated a comprehensive set of 10 functions seen to be necessary to deliver a robust public health response:

1. Surveillance of population health and wellbeing (intelligence);
2. Monitoring and response to health hazards and emergencies (health emergency planning);
3. Health protection, including environmental, occupational, food safety and other threats;
4. Health promotion including action to address social determinants of health and health equity;
5. Disease prevention including the early detection of illness;
6. Assuring governance for health and wellbeing;
7. Assuring a sufficient and competent public health workforce;
8. Assuring sustainable organisational structures and finance;
9. Advocacy, communication, and social mobilisation;
10. Advancing public health research to inform effective intervention.

Under the Health and Social Care Act of 2012, the Director of Public Health (DPH) is accountable for the delivery of their authority's public health duties and is an independent advocate for the health of the population, providing leadership for its improvement and protection.

The Director of Public Health is a statutory officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning the three domains of public health; health improvement, health protection, and population health care and the holder of a politically restricted post by section 2(6) of the Local Government and Housing Act 1989, inserted by schedule 5 of the 2012 Act. (4)

The statutory functions of the Director of Public Health include a number of specific responsibilities and duties arising directly from Acts of Parliament - mainly the NHS Act 2006 and the Health and Care Act 2012 - and related regulations. Some of these duties are closely defined but most allow for local discretion in how they are delivered.

The most fundamental health protection duties of a DPH are set out in law and are described below. How these statutory functions translate into everyday practice depends on a range of factors that are shaped by local needs and priorities from area to area and over time.

Section 73A (1) of the 2006, inserted by section 30 of the 2012 Act gives the Director of Public Health responsibility for:

- All of their local authority's duties to take steps to improve the health of the people of their area;
- Any of the Secretary of State's public health and health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations; these include services mandated under regulations made under section 6C of the 2006 Act, inserted by section 18 of the 2012 Act.

Health protection mandated functions include:

- Director of Public Health exercising their local authority's functions in risk assessing, planning for, and responding to, emergencies that present a threat to their area's public health.
- Preventing and controlling incidents and infectious disease outbreaks to protect their population.
- Carrying out public health aspects of the promotion of community safety.
- Taking local initiatives that reduce the public health impact of environmental and communicable disease risk.

The Director of Public Health has an overarching duty to ensure that the health protection system works effectively to the benefit of its local population.

From time-to-time other responsibilities are placed upon the public health function within the local authority, including those directed in relation to the deployment of the centrally

provided public health grant. At the moment, one such responsibility is that of collaborating with the NHS England and Office of Health Improvement and Disparities (OHID) approach to support the reduction of health inequalities in conjunction with the United Kingdom Health Security Agency (UKHSA). Most recently the establishment of Integrated Care Boards and Partnerships by the NHS is intended to bridge the gap in approach between prevention, treatment and care and reduce health inequalities. CORE 20 Plus 5 identifies the most deprived 20% of the population as the focus for action together with five clinical priority areas:

1. Maternity
2. Severe Mental Illness
3. Chronic respiratory disease
4. Early cancer diagnosis
5. Hypertension case finding.

The Public Health Vision for West Berkshire and the strategic context

This will be delivered within a wider strategic context and will contribute to the West Berkshire Council Strategy that aims to support: ***thriving communities*** *with a strong local voice, helping our residents to lead fulfilled and active lives*; ***more people enabled to be physically active*** *supported by the sports and leisure opportunities available in the District; and the* ***reduction of social isolation****, especially in rural areas and for young people.*

In addition, Berkshire West has a Joint Health and Wellbeing Strategy with a vision for Reading, West Berkshire and Wokingham that over the next ten years all people will live longer, healthier and more richer lives and we will reduce gaps in the differences of health outcomes between the richest and poorest parts of Berkshire West. West Berkshire's Public Health commitment compliments this vision and the five key priorities that were jointly agreed to have the greatest impact to health and wellbeing, 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 children and families in early years;
- Promote good mental health and wellbeing for all children and young people;
- Promote good mental health and wellbeing for adults.

Where are we now?

It is important to understand what the data is telling us in respect to health and wellbeing need now and in the future; how it varies within our own communities and compared with other areas; and which groups have greatest need in order to apply Public Health approaches most effectively. This section explores our population and communities in terms of age, deprivation and life expectancy. We then dive into the detail to understand what is driving what we are seeing in the numbers and in residents experience of living and working in West Berkshire.

It is important to consider that while the data provides a useful aerial picture of the need in West Berkshire it is important to work with our partners and the communities

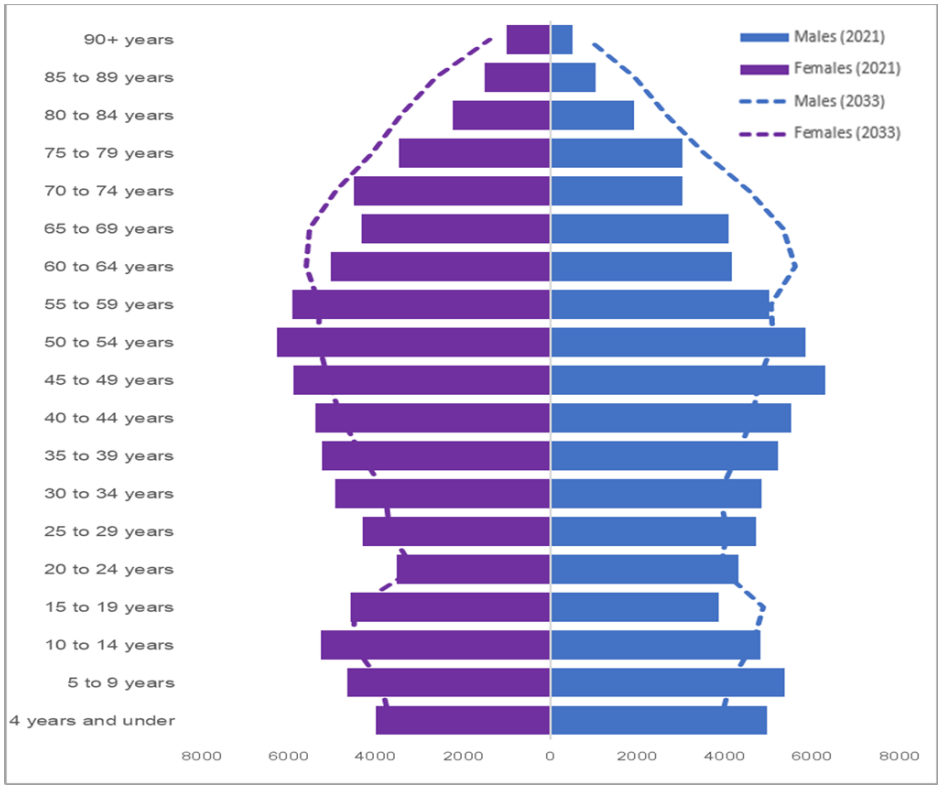
> *"Statistics are patients with the tears wiped off."*

themselves to really understand what is happening locally in order to organise support, interventions and services most efficiently and effectively.

This pen picture gives a sense of the challenge facing us if we are to reduce the profound inequalities in health that face us and require us to address both risk factors and risk conditions to support healthy, long lives.

We can see from the following figures that overall West Berkshire is an affluent, healthy community with long life expectancy. However, there are pockets of deprivation and with that will come poorer health and wellbeing outcomes. In addition, we have an ageing population that again will bring challenges to the health and wellbeing of our communities. We must bear these challenges in mind in our public health approach locally.

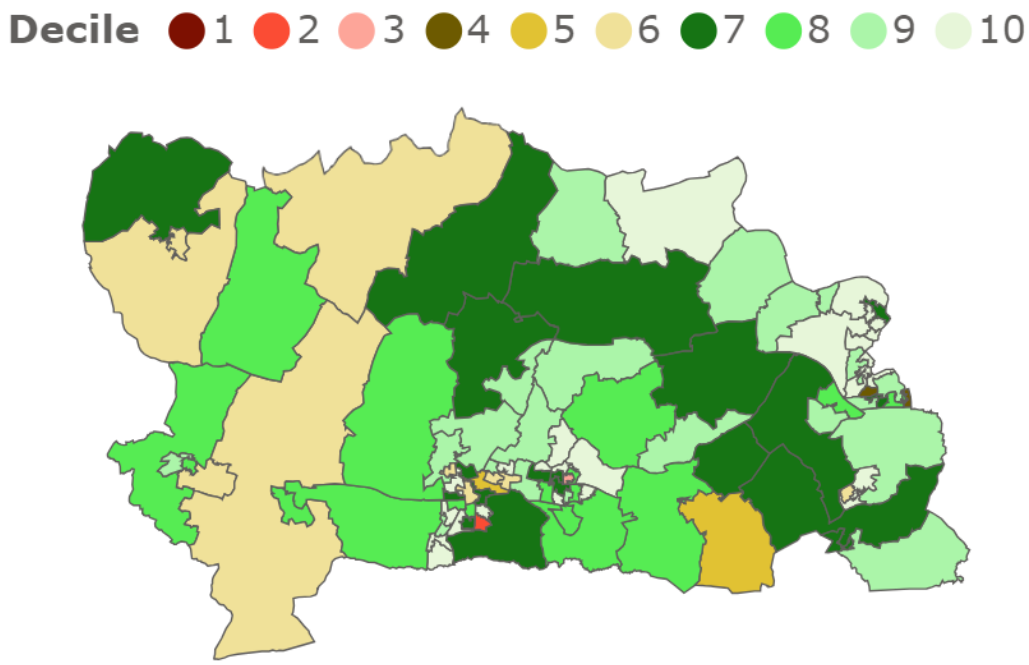
Figure 1: 2021 Mid-year population estimates[9] and 2033 projected population in West Berkshire, by age group[10].



[9] Office of National Statistics. Mid 2021 Population Estimates

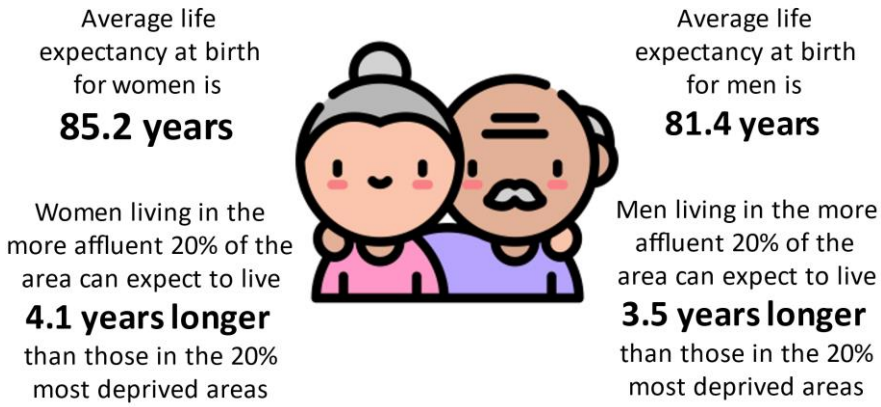
[10] Office of National Statistics. Subnational Population Projections for England: 2018-based

Figure 2: Overall deprivation in West Berkshire[11]



Life Expectancy at Birth. OHID Fingertips Tool. Public Health Outcomes Framework - OHID (phe.org.uk)

Figure 3: Average life expectancy at birth, by gender, in West Berkshire[12]



[11] GOV.UK. English Indices of Multiple Deprivation 2019

[12] Life Expectancy at Birth. OHID Fingertips Tool. Public Health Outcomes Framework - OHID (phe.org.uk)

West Berkshire demographic headlines[13]

- Based on the 2021 Census, **the population size of West Berkshire has increased by 4.9% from 153,800 in 2011 to 161,400 in 2021.** This is lower than the 6.6% increase in England over the same period but still a significant number of individuals requiring health and social care support and services.
- Between 2011 and 2021, **there has been an 8.6% increase in children and young people aged under 15** compared with a 5.0% increase in England over the same period; an 11.7% increase in adults aged 15-64 compared with a 3.6% increase; **and a 17.2% increase in people aged 65 years and over** compared with a 20.1% increase in England. Health and social care need is greatest in the very young and very old and therefore these higher than average in the case of children and large increase in rate of the elderly will see a significant impact on the demand for support and services.
- There are now **85,659 people aged 0-19 and 65,361 people aged 65 and over**. Among those aged 65 and over, 14,705 were aged 75 and over and 4,045 were aged 85 and over. By 2033, the number of people aged 85 and over is projected to increase to around 6,825.
- The **number of households has increased by 6.5% from 62,340 in 2011 to 66,400 in 2021**, an increase of 4,060 households. This is a comparable increase to the national increase of 6.2% during the same period in England.
- In 2021 27.0% (18,009) of households were one person households; this compares with 30.1% in England. Of those with more than one person **67.9% were single family households compared with 63.0% in England.** The remainder (5.1%) were a variety of household types including multiple person households (compared to 6.9% in England).
- **A higher percentage of people in West Berkshire were classified as white (91.9%) in the 2021 census compared with 81.0% in England** (and thus a much lower percentage (7.4%) classified as Asian, Black, or Mixed ethnicity compared with

[13] GOV.UK. English Indices of Multiple Deprivation 2019

16.8% in England). The proportion of Asian, Black, or Mixed Minority ethnic groups has increased by 2.9% since 2011 (3.2% in England).

- **95.2% of people in West Berkshire specified English as their main language in 2021** (90.8% England); 0.6% (968 people) could not speak English or speak English well (1.9% England).
- **91.2% of people aged 16 and over in 2021 identified themselves as heterosexual (compared to 89.4% in England)**, 2.3% as non-heterosexual (3.2% England).
- **14.7% of people in 2021 were classified as disabled under the Equality Act,** which is 23,726 people.
- **31.6% of households in 2021 were classified as deprived on one dimension of deprivation (education, employment, health, or housing), compared with a higher percentage of 33.5% in England.** This percentage difference between West Berkshire and England as a whole becomes more pronounced as you increase the dimensions of deprivation, indicating not only lower rates of deprivation in West Berkshire but also less complexity/fewer dimensions of deprivation locally. 10.2% were deprived on two dimensions (14.2% England); 2.0% were deprived on three dimensions (3.7% England); and 0.1% were deprived on all four dimensions, lower than England (0.2% England)
- **In total, 8,204 households (12.3%) were experiencing multiple deprivation** (deprived on two or more dimensions), much lower than the England average of 18.1%.
- **The most deprived areas of West Berkshire were located around main urban centre of Newbury.**
- **Life expectancy** for males in 2020-22 was 81.0 years, which is better than England at 78.9 years, and for females it was 84.6 years, which is higher than England at 79.0 years. Male life expectancy in the most deprived areas was 3.5 years lower than in

the least deprived areas (England 9.7 years lower); female life expectancy differed by 4.1 years compared with 7.9 years in England.[14]

The Way Ahead

Our strategic intentions as set out in this year's Public Health Report are the basis for our delivery plans and work with other council directorates and external bodies over the next three years. It is not possible for them to be set in stone as they will need to change and evolve in response the threats to health and the changing health needs of the population, changes in national policy and local priorities.

Health Protection

At a local level the work of Health Protection aims to anticipate, prevent, respond to, and mitigate risks and threats to health arising from communicable diseases and exposure to environmental hazards including chemicals and radiation. However, the broader health protection function extends to a wide range of external threats including those from commercial activities, whether legal or otherwise, and behaviours that involve violence and aggression. Everybody has a right to be protected from both infectious and non-infectious environmental hazards to health and it has long been a primary duty of government at different levels to safeguard the public in this respect.

The effective delivery of local health protection requires close partnership working between West Berkshire Council, Reading Council, Wokingham Council, the UK Health Security Agency (UKHSA), together with other local, regional, and national agencies and bodies, including the NHS. Over the past four years the national and local health protection response has been in the spotlight due to the COVID-19 pandemic. During this period, we have built up expertise, developed relationships and established systems to ensure an effective response to COVID-19 and other health protection threats. Building trust with our communities has been essential to providing an effective response. As we move forward in the recovery from the pandemic, we do so against a

[14] Life Expectancy at Birth. OHID Fingertips Tool. Public Health Outcomes Framework - OHID (phe.org.uk)

backcloth of growing health inequalities and the imperative of responding to the climate emergency which will bring with it a range of new public health challenges.

COVID-19 is still circulating in the community, albeit in a more controlled manner, and the resurgence of other viral and respiratory illnesses, including influenza, is putting pressure on health and healthcare systems. The recent return of measles in the face of reduced population levels of protection with MMR vaccine should alert us to the importance of maintaining eternal vigilance against infectious diseases that we thought had been defeated.

Other risks and hazards are currently present and the circulation of Avian flu among the national poultry flock and wild birds is a warning of what could be possible should another novel virus migrate from livestock and become responsible for person-to-person spread. Additionally, the climate emergency is galvanising local authorities to ensure that they play their part in the sustained long-term threat to human populations and our ecosphere.

At the moment some aspects of the core functions and responsibilities of the Director of Public Health in West Berkshire including Environmental Health, Health Emergency Planning, Trading Standards and aspects of Community Safety (Violence Prevention), are not sitting within the remit of the Office of the Director of Public Health. It is intended that stronger functional links will be developed with these areas of work in the coming year.

The COVID-19 pandemic has worsened existing inequalities, especially affecting vulnerable communities. This includes challenges such as low vaccine uptake, impacting especially groups such as migrants, people in the criminal justice system, those with substance misuse, and the homeless. At-risk groups based on ethnicity or sexual orientation may also face inequality.

What we have achieved so far

Seasonal vaccination

The ‘Be Well This Winter’ service was designed to provide targeted outreach for those residents of West Berkshire who were most in need of support during the winter months in 2022/23. The Service aimed to reduce inequalities between groups with respect to

broad aspects of population health including vaccine uptake, cardiovascular outcomes and general wellbeing during the 'cost of living' crisis being experienced at the time, following extraordinary inflationary pressures upon the wider economy. The Service utilised a proportionate universalism approach, allowing it to target those most in need of support but also remaining available to the population of West Berkshire as a whole.

The Service was delivered in the form of support for the 'Health on the Move' van', a mobile covid-19 vaccine delivery unit. Alongside this, 'Be Well This Winter' sessions enabled engagement with service users to signpost them to useful information outlets to support their health and wellbeing during wintertime.

Overall, this service proved to be of value in its contribution to reducing health inequalities amongst those most in need. It was able to deliver a significant number of covid-19 vaccines to those populations who are at the greatest risk of developing severe complications from respiratory infections. Large numbers of conversations were had, and relevant literature was distributed to residents signposting them to services such as CVD check-ups and cost of living support hubs.

The 'Be Well This Winter' programme serves as a reminder that targeted approaches to delivering public health interventions, when executed properly, can be an extremely useful in tool in ensuring that those most in need are provided with the means to support their health and wellbeing.

Protecting Children from Infections and Diseases – Measles in West Berkshire

Once celebrated as a triumph in Public Health, the World Health Organisation (WHO) declared that the UK had eliminated measles in 2017. This was short lived, and that status was rescinded a year later. Since then, there has been a resurgence of Measles in England and during the past year, significant increases in the incidence of cases in London and outbreaks in the West Midlands were reported. However, all regions in England have reported cases.

In West Berkshire, the number of unvaccinated pre-school children is less than 10%. Nevertheless, there is no room for complacency as neighbouring boroughs are some of the worst for vaccine uptake in the region. Due to the high transmissibility of the virus, it is anticipated that the situation will worsen before it gets better as most clinical cases

of preventable childhood infection are unvaccinated. This is notable as Measles is one of the most contagious vaccine-preventable diseases.

The cause of the increase in unvaccinated cases is twofold. The first being foreign travel and immigration with individuals entering the U.K. who did not receive the Measles Mumps and Rubella (MMR) combined vaccine in childhood. The second being the decline in vaccination coverage that can largely began with the discredited linking of childhood autism with MMR vaccination by Dr Andrew Wakefield. This was later compounded by irresponsible negative propaganda about vaccination by so-called 'anti-vaxers' during the Covid pandemic.

Uptake of MMR is low in areas of deprivation and in migrant and refugee populations. This has been made worse by vaccine hesitancy which has continued to spread, resulting in the rise of unvaccinated children and young adults. The clinical consequence of high levels of unvaccinated individuals is that the population becomes more susceptible to infection. Measles is not only a childhood disease and can be serious at any age. Those at high risk of severe illness and death are infants, pregnant women and individuals with compromised immune systems.

To ensure that more people are protected, it is important that we focus efforts to increase uptake of the MMR vaccine as part of the routine pre-school childhood immunisation programme as well as catching up older children and young adults who missed out previously. There is a call to action to reduce this threat with activity taking place at all levels:

- At a global level the World Health Organisation (WHO) has revitalised partnerships with other international health organisations to coordinate efforts to prevent severe illness and death caused by Measles.
- Nationally, the United Kingdom Health Security Agency (UKHSA) launched the MMR catch- up campaign. From January 2024, a national recall exercise will target unvaccinated and partially vaccinated children aged 6 -11 years (primary school age).
- Local awareness campaigns are being rolled out that focus on low vaccinated groups including schools and parent groups.
- GPs are being supported to improve MMR uptake using a regional MMR GP Toolkit.

- Targeted community and stakeholder engagement including media briefings led by local influencers and clinicians from under vaccinated communities.
- The local authority is ensuring it is in a state of readiness to ensure the manage potential outbreaks and minimise onward transmission of the measles virus.

Where are we now?

West Berkshire Health Protection Headlines[15]

- In West Berkshire, 95.3% of babies aged one year were vaccinated against a range of diseases including diphtheria, whooping cough, polio, meningitis, and pneumonia in 2022/23. This was higher than the England average of 91.8%. Among two-year-olds vaccination uptake was higher at 95.8% compared to 92.6% in England.
- In 2022/23, 93.9% of two-year-olds in West Berkshire were vaccinated against measles, mumps and rubella (MMR, one dose), compared to the lower England average of 89.3%. At five years of age, uptake for one dose was 96.5%, and 93.0% for two doses compared with 92.5% and 84.5% for England.
- In West Berkshire, 90.1% of girls aged 12-13 had received the HPV (Human Papilloma Virus) vaccination (one dose) in 2021/22, which helps protect against cervical and some other cancers including throat and anus, in both men and women and cancer of the penis in males. This compared with an uptake of 69.6% in England. Among girls aged 13-14, 90.5% received two doses compared with 62.4% in England. 90.0% of boys aged 12-13 in West Berkshire received the HPV vaccination (one dose) in 2020/21 compared with 62.4% in England.
- In 2021/22, 100% of boys and girls aged 14-15 in West Berkshire had received the MenACWY (meningococcal bacteria strains A, C, W and Y) vaccination, which helps protect against meningococcal meningitis, compared with 79.6% in England.
- Overall childhood vaccination uptake in West Berkshire is good, however local data suggests variation, with some areas, schools and groups of our population having much lower uptake compared to our overall average and the national average. For

[15] Population Vaccination Coverage. OHID Fingertips Tool. Public health profiles - OHID (phe.org.uk)

example, 1 dose of MMR in some of our primary schools locally may be a low as 50% or less.

- 77.2% of adults aged 65 and over in West Berkshire in 2020/21 had received the PPV Pneumococcal Polysaccharide Vaccine (PPV), which helps protect older people against diseases including bronchitis, pneumonia, and septicaemia (blood poisoning). This is higher than the England rate of 70.6%, but still means nearly a quarter of our over 65 age group are not vaccinated.
- In 2022/23, 59.9% of those considered to be at clinical risk under age 65 in West Berkshire were vaccinated against influenza; this was higher than the England average of 49.1% but still only just higher than half of our vulnerable population. Among the population of all those aged 65 and over the West Berkshire coverage was 86.5% compared with England at 79.9%.

STI Diagnosis[16]

- The rate of all new Sexually Transmitted Infections (STIs) diagnoses in West Berkshire in 2021 was 260 per 100,000 population (421 diagnoses from a population of 161,400), which is significantly lower than the England rate of 694 per 100,000 population. These lower local rates may be a result of a number of reasons including lower incidence but also poorer uptake of or access to services.
- Within this overall figure for sexual infection the diagnostic rates of syphilis (4.9 per 100,000) and gonorrhoea (29 per 100,000) were lower than the England rates of 15.4 and 156 per 100,000 respectively in 2021; the chlamydia detection rate among young people aged 15-24 in 2022 was 952 per 100,000, nearly half the England rate of 1,680 per 100,000.
- In 2022, there were 81 people aged 15-59 living with HIV. The diagnosed prevalence rate (0.88 per 1,000 population) was lower than England (2.34).
- In 2020-22, 0% of people aged 15 and over with HIV were diagnosed late, lower than the England average of 43.3%; the proportion diagnosed late was much lower than

[16] Health Protection Profile. OHID Fingertips Tool. Public health profiles - OHID (phe.org.uk)

the recommended national target of 50% which suggests good performance in West Berkshire

- In 2022, 28.9% of eligible people were tested for HIV, lower than the England average of 48.2%.

Our priorities moving forward

- Continuously strengthen our preparedness against future health protection threats and improve the quality of our services to protect health.
- Fulfil the assurance role of ensuring that appropriate health protection arrangements are in place to protect the health and wellbeing of the residents of West Berkshire.
- Ensure that organisational and system level governance arrangements are in place across Berkshire West through the Berkshire West Health Protection and Resilience Partnership Board (HPRPB).
- Ensure that environmental, biological, chemical, radiological, and nuclear threats and hazards are understood, and that health protection issues are addressed through close collaboration with Emergency Planning Teams, Environmental Health and other appropriate colleagues.
- Work proactively with Environmental Health, Emergency Planning, Trading Standards and the Communications Team on incident and outbreak investigation, response and management.

Wider Health Protection

An important part of the health protection function is that of protecting the population against a range of external threats and hazards that go well beyond infectious disease and are not intrinsically related to biology. Rather they are those that arise from the social, physical and economic environment and include those are commercially influenced and determined.

Most recently the World Health Organisation has begun to focus attention on what have come to be known as the commercial determinants of health. This includes an emphasis on industries such as those promoting drugs and alcohol, tobacco, gambling

and online media that play on inherent weaknesses and influence behaviour in ways that is often detrimental to mental and physical health and wellbeing.

Existing public health programmes including smoking cessation and the provision of substance misuse (drug and alcohol) services have addressed some of these threats but there is more that needs to be done. The recent appearance of the major problem of teenagers inhaling nitrous oxide from balloons and using cheap, disposable, flavoured vapes creating a new generation of nicotine addicts bring potential threats to physical health including neurological and heart disease problems in the future. In a situation like this downstream intervention with treatment services is necessary but insufficient to get to grips with a problem that requires national action as well as intervention locally for example through the work of Trading Standards bringing enforcement to bear on rogue retailers.

Other external challenges are a consequence of the way we plan and design housing and our local neighbourhoods to be fit for purpose for everyday living in ways that are supportive, safe and sustainable. The COVID-19 pandemic revealed how inadequate much of the housing stock is when coping with infectious disease and the trials of a lockdown in which many families had no access even to a balcony for fresh air let alone access to green space. The cumulative impact of these external hazards, combined with social and economic factors, means that the most vulnerable in society are at greatest risk of ill health.

What we have achieved so far

Throughout 2023 we have been working with our Planning Policy colleagues to develop a Health Impact Assessment policy and process for new developments in West Berkshire. By implementing a requirement for planning applicants to include Health Impact Assessments for developments over a given threshold, we aim to optimise the health benefits and minimise the potential harms, while maintaining a focus on reducing inequalities.

We will be implementing the newly developed Health Impact Assessment policy which requires the formal adoption of the West Berkshire Local Plan Review. While we await the adoption, we will be developing accompanying Health Impact Assessment templates and guidance for prospective developers. These will be tailored to the unique

needs of different environments and communities in the district, for example with a "priority checklist" for developments in different West Berkshire wards. Later in 2024 we will implement the Health Impact Assessment policy and start to promote the newly developed assets.

Where are we now?

Wider Health Protection[17]

- 11.3% of adults aged 18 and over in West Berkshire were current smokers in 2022, lower than the England average of 12.7%.
- 66 people died from lung cancer in 2021. The mortality rate (40.6 per 100,000) was lower than England (48.5 per 100,000).
- There were 61 alcohol-related deaths in 2021. The mortality rate (36.8 per 100,000) was similar to England (37.8 per 100,000).
- There were 13 deaths from drug misuse in 2018-20. The mortality rate (2.8 per 100,000) was nearly half the England rate (5.0 per 100,000).
- The rate of known domestic abuse related incidents and crimes in adults aged 16 and over in 2021/22 was 24.8 per 1,000, lower than the England average of 30.8 per 1,000.
- There were 3,256 violent crime offences in 2021/22 – the rate of offences (20.6 per 1,000) was lower than England rate of 34.9 per 1,000.
- There were 327 violent sexual offences in 2021/22 – the rate of offences (3.5 per 1,000) was higher than England (3.0 per 1,000).

[17] Public Health Outcomes Framework. OHID Fingertips Tool. Public Health Outcomes Framework - OHID (phe.org.uk)

Our priorities moving forward

- Work with planners, other council officers, the general public, and others to ensure the design of safe, supportive, and sustainable housing, neighbourhoods and communities.
- Through our Health in All Policies (HiAP) we will work with Development Control, Planning, Licensing and Trading Standards, and Environmental Health to reduce externally driven harms to the vulnerable.
- Develop a public health approach to violence prevention, using an evidence base to understand populations at risk and the impact of interventions.
- Work with local communities and Family Hubs to identify problems related to health and wellbeing and mobilise and support community assets in the battle against anti-health influences.
- Work with organisations across West Berkshire to develop a strategic approach to combatting the threat of addiction whether by alcohol, tobacco, drugs and other harmful substances, risky sexual activity, or gambling, supported by high quality, evidence-based services to reduce harm.
- Work with other bodies, organisations, and interested parties to reduce the hazards that increase the risk of falls in the vulnerable and the elderly.

Health Improvement

Health Improvement children and young people

The aim of health improvement for children and young people is to promote their physical, mental, and emotional well-being, to support them in achieving their full potential and leading healthy lives. This work includes initiatives aimed at preventing illness and injury, promoting healthy behaviours, and addressing any health inequalities or vulnerabilities that may exist. The overarching goal is to ensure that children and young people have the best possible start in life and are equipped with the resources and support they need to thrive and be resilient as they grow and develop.

Working with children and young people is the most effective and cost-effective way of preventing ill health in later life. In public health terms, this is where primary prevention, or preventing the causes of ill health in later life, has its best chance of success for the whole population. The COVID-19 pandemic has been particularly detrimental to children and young people and has widened inequalities. Many have lost opportunities for early development, missed out on crucial personal and social development, and experienced mental ill health. Mitigating the impact of the COVID-19 pandemic on children and young people will be critical over the next few years.

The broad aims for this stage of life have already been identified as:

- Planned parenthood
- The first 1,000 days of life beginning with conception
- Support for parenting
- Prevention of Adverse Childhood Experiences (ACEs)
- School readiness
- Prevention of school exclusions
- Readiness for the world of work and adult life.

Health Improvement Adults

The goal for improving adult health is to help people stay healthy and to live as full a life as possible as they become older. This requires supporting and encouraging behaviours that support both mental and physical well-being throughout adulthood. Health should be regarded as a resource for everyday life that maintains independence despite the inevitable biological decline that comes with age. Reducing the burden of long-term conditions which varies so much between geographic areas and population groups also reduces the strain on health and social services. This is a priority given the current ageing demographic of West Berkshire.

Improving health and wellbeing in adulthood is dependent of a wider range of factors, including those opportunities for behavioural change, through optimising the natural and built environment, personal development and work opportunities, social networks and communities backed up by accessible high quality clinical and social care services. Actions in these areas can reduce the risk of major groups of communicable disease such as cancer, heart disease, stroke, depressions, respiratory illness and diabetes

Achieving good mental and physical health in working age adults provides benefits in older age, promoting independence and reducing the demand on health and social care services.

The local public health team has a range of programmes and services designed to provide appropriate support to the adult population. This includes targeted health check-ups through the NHS, programs to help quit smoking, and services for supported weight management. We recognise the importance of different organisations including other council departments, the NHS, and wider civic partners, to work together to promote adult health. In addition to specific services commissioned from the public health grant the public health team has a convening and facilitating role in optimising concerted action focused on improving population adult health

What we did

Children and Young People

Our focus on children and young people is aimed at producing the best start in life. This begins before birth, the foundation being planned parenthood as far as this is possible to ensure that all babies are born into a nurturing, supportive and stress-free environment. West Berkshire Public Health has continued to commission, fund and develop various Public Health services, programs and initiatives for children and young people.

This includes the nationally mandated and integrated **0-19 years Public Health Nursing Service** (up to 25 for those with Special Educational Needs and Disabilities (SEND), including the provision of both Health Visiting and School Nursing. This is very much an “upstream” public health service that is community based and needs-led, with action based on the principles of proportionate universalism, i.e., it is universal in its reach but personalized and proportionate in response in order to meet need.

Health Visitors and School Nurses have a variety of roles. They act as leaders of the Healthy Child Programme (HCP) within multi-professional teams and care pathways. They ensure their service is integrated to support both a healthy pregnancy and children through to the age of 19 years (25 years for SEND individuals). Nurses work in

partnership with families to understand their needs and then where necessary arrange a programme of more intensive support as needed.

The HCP includes five mandated touch points (Antenatal, New Birth Visit, 6 – 8 weeks appointment, 9 – 12 months assessment and 2 – 2.5yrs assessment). As children enter the school system, the National Child Measurement Programme (NCMP) provides two additional touchpoints in Reception and Year 6.

The Public Health grant currently makes a significant contribution to the funding of Family **Hubs** in some areas of the borough. The funding is provided to support the objective of giving every child the best start in life, by

- Decreasing the attainment gap through focus upon school readiness.
- Support child health through a range of public health initiatives.

This work is delivered in the 3 Family Hubs (East, Central and West) and through outreach work to universal families, targeted groups and one to one support.

The work includes but is not limited to:

Antenatal – 4-week evening course covering wellbeing, feeding your baby, preparing for the birth, changes to relationships, one session is led by a RBH midwife and covers birth

Postnatal and Dad's Postnatal - The dad's postnatal is a 2-hour evening session run jointly with a male Health Visitor. Both courses look at mental health and wellbeing, where to get support, sleep, weaning, common childhood illness, play and development

Flying Start - This was a series of 3 evening sessions which focused on the following areas:

1. Communication & Language
2. Developing a love of reading & phonics
3. Physical development & early writing skills

The aim is to guide parents in how best to prepare their child for starting school and support their learning at home.

Uptake of Vulnerable Two Entitlements - Working closely with the wider early years team the family hubs liaise with local early years provision identifying local available

places for families of vulnerable 2-year-olds. Taking families on visits to provision and encouraging uptake of the offer.

Every Child a Talker (ECAT) - ECAT focuses on supporting early years settings (e.g., nurseries, pre-schools, family hubs) to work on the following three aims:

1. Identifying and supporting children who may be at risk of delay.
2. Developing the knowledge and skills of practitioners.
3. Helping parents to understand the stages of development and how they can help their child.

ECAT is led by a teacher and an NHS speech and language therapist. Three cluster meetings are offered per term that focus on different topics. This helps to build practitioners knowledge and skills of the stages of development and how to help children who have speech, language, and communication difficulties.

Each setting has a lead practitioner for ECAT, but all practitioners understand that they have a role in supporting children's speech, language, and communication skills. Settings complete termly monitoring of all children so that they know the children who are struggling and can put support in place.

Reading together - Universal offer to families a programme of sessions via zoom to introduce good reading habits and support families to become readers.

Chatterbox - 5-week course for children who have a speech delay

Five ways to wellbeing and BOOST - These courses cover looking after oneself, building confidence, being assertive, managing anger and supporting positive change.

Best Start in Life – Digital Offer (1001 Days Platform)

The Best Start in Life is a digital platform providing convenient advice and information to families and new parents when they need it (Best Start in Life Vision). It is a centralised digital hub providing advice, tips, and answers to common questions, fostering a sense of support and community.

1-2-1 and group accredited **community breastfeeding support** is delivered by family Support Workers via Family Hubs. The service offers support to minimum of 170 new mothers each year. This is approx. 11% of the annual births in West Berkshire.

Family Hubs are not UNICEF Baby Friendly accredited, although they have attended UNICEF Baby Friendly training, and the service is aligned with UNICEF Baby Friendly guidance.

The service supports mothers to breastfeed up until 8 weeks (where appropriate), and longer where possible.

The Cooking & Nutrition (CAN) initiative has continued to support the Family Hubs in West Berkshire to deliver Cooking and Nutrition Programmes to supported families, for the third year running. This is a small-group 6-8 week course, helping to develop skills and confidence in the kitchen and with family nutrition – including weekly budgeting. One Family Hub has gone on to develop a Phase Two cooking course, working with the local cricket club, delivering ongoing practical cooking classes for those families who are keen to keep learning. In 2021-2022 we worked with 38 families, by the end of this round of courses we hope to have worked with 55.

The West Berkshire **Health and Wellbeing in Schools Programme** supports children and young people in developing their health literacy. This includes an emphasis on resilience, confidence and independence – and help to keep physically and mentally healthy. This is achieved through working closely and in partnership with schools to develop a whole school approach which extends to and including the wider school community.

Other work this year has included but is not limited to:

The West **Berkshire Youth Survey** was carried out in partnership with Berkshire Youth and the Office of the police and crime commissioner in January and February 2023 with over 6300 responses from academy and maintained secondary school students (approximately 50% of all students). reports were sent to town and parish councils in September 2023 and work is continuing to promote the findings of the survey. The data from the survey has been an extremely valuable tool in helping to shape strategies with youth provision. It has also been used by partners to successfully bid for funding to provide support and provision for young people. The survey will be repeated in January 2025.

Young Health Champions – The Young Health Champions Project has successfully created over 30 new young health champions, across 3 secondary schools in West Berkshire. Young health champions is a qualification and a movement set up by the Royal Society of Public Health. Once trained, our young health champions receive a level 2 certificate and then set about creating health campaigns in their schools. This year in March 2024 at our annual conference; the young health champions reported back on work that they had undertaken focussing on self-care and encouraging peers not to take up vaping.

Relationships, Sex and Health Education – We continue to lead the secondary network for subject leader providing support, advice and local and national updates to schools. We contribute to a primary network for school subject leaders. Over the last year we have provide direct support to 8 schools. We have briefed primary school headteachers on the upcoming Relationships, sex and health education curriculum review. Our Year 3 workshops have been delivered in 32 primary schools supporting the relationships and health curriculum. The workshops teach children about the Eat Well guide, 5 a day, food labels and added sugar and the 5 ways to wellbeing.

We have delivered a parent's workshop in a local secondary school about the challenges of social media, making the presentation available to other settings to use.

As well as this we have also joint commissioned sexual health CPD for school staff, professionals and volunteers.

Health and Wellbeing in Schools award – 3 school settings continue to work on their award and 2 new settings have signed up to complete our award this year. The Health and Wellbeing in schools award is a plan, do, review approach to whole school approaches to health and wellbeing in schools, based on Public Health England's 8 whole school principles. The award guides schools to identify priority areas to improve the health and wellbeing of their setting.

Vaping - We have helped worked with schools to develop policies for young people and vaping. This has included campaigns to encourage youngsters in not taking up vaping unless as a smoking cessation tool. We also commissioned continued professional development for professionals on youth vaping.

Risking it All - We have Commissioned and coordinated a theatre intervention project into schools that looks at exploitation and child drug and alcohol use and unhealthy relationships. The project was delivered into 9 local secondary schools in February 2024 reaching over 2000 students. 89% of students agreed that the performance helped improve their understanding of the issues raised in the performance.

Safer Streets - Working with Building Communities Together we are leading on the education element of the safer streets funding. Safer streets funding has been made available from the office of the police and crime commissioner to reduce anti-social behaviour in the Nightingales estate in Newbury. We are working with schools on a project to deliver workshops in schools to reduce anti-social behaviour and improve wellbeing and behaviour outcomes in students from schools in the catchment area of the Nightingales area of Newbury. We are commissioning a social skills programme to help support young people's emotional and social literacy in a bid to reduce Anti-Social Behaviour.

Youth Counselling

'Time to Talk West Berkshire' is commissioned to provide emotional and psychological support service for young people aged 11-25 and parents connected to West Berkshire.

Healthy Weight

Excess weight is a significant health risk and is associated with an increased risk of diabetes, heart disease and some cancers. Its impact is disproportionally spread, with those living in areas of disadvantage, and particular groups including some ethnic minorities and those with learning disabilities and mental ill-health impacted greatest.

We have updated our Healthy Weight Needs Assessment in partnership with Reading Borough Council. The aim of the assessment is to analyse data and interact with the community to understand their health needs better. We reached out in particular to about 350 individuals, and to healthcare providers, and professionals working with children and young people. This has allowed us to understand the concerns and preferences of our residents to guide our future initiatives. The finalised report on this work will be published through the Berkshire Health Observatory in early 2024.

In 2023 the Council commissioned a new Leisure provider, 'Everyone Active', to manage the leisure centres in West Berkshire. 'Everyone Active' will continue to deliver the well-established exercise on referral programme and promote this to our residents. As part of the new leisure contract, 'Everyone Active' will also be delivering a series of outreach physical activity programmes across the district, with a focus on the most vulnerable areas and groups of West Berkshire that may face additional challenges in accessing leisure facilities.

Smoking Cessation

In the year 2021-2022, 'Smoke Free Life Berkshire' helped 353 West Berkshire residents to quit smoking. This represents 54% of smokers who set a date to quit smoking. Prevalence of smoking in West Berkshire in 2022 was 11.3%, similar to the England average.

People employed in routine and manual occupations in West Berkshire are over twice as likely to be smokers compared with those employed in other occupations. Rates of smoking are even higher amongst people who are in treatment for substance misuse, where 72.3% of people smoke.

During the past 12 months the smoking cessation service has held marketing activities and campaigns at Ikea, Calcot, focusing on the staff working there; Two Saints Homeless Hostel, Newbury; Regency Park Hotel, Thatcham, and Best Western Hotel Calcot, supporting the resident refugees. Outreach workers have attended Newbury College on a monthly basis, Newbury Mosque, and have also supported West Berkshire Council information events in Thatcham and Lambourn.

Cardiovascular Disease **Health Check, Community Wellness Outreach Service.**

The Cardiovascular Disease Health Check, Community Wellness Outreach Service is aimed at identifying individuals at risk of cardiovascular disease and aims to improve access to NHS Health Checks in underserved populations.

The public health team has commissioned 'Solutions 4 Health' to deliver this service in community settings across West Berkshire. The service includes a community engagement programme with priority population groups that are disproportionately impacted by cardiovascular disease but are not currently well served by the universal

health check offer. Social prescribing of signposting to appropriate initiatives is offered to support ongoing lifestyle and behaviour change. By working collaboratively with voluntary associations and agencies, together with local employers, the engagement programme ensures that this programme reaches the right groups. By taking an asset-based approach the service will link in with, and build on, existing resources, networks and assets. This will avoid duplication and work to increase the sustainability of existing assets.

A further element of this engagement is to better understand the barriers to accessing universal services faced by different priority groups. Feedback from the community engagement is being used to further inform delivery of the service for priority groups.

Sexual Health

The public health team plays a crucial role in promoting good sexual and reproductive health by providing and commissioning advice, information, education, and services related to contraception, sexually transmitted infections (STIs), and HIV. The effective provision of these services prevents unplanned pregnancies and unnecessary abortions; psychological harm from sexual abuse; the spread of sexually transmitted infections; and potential complications including pelvic inflammatory disease, which can cause ectopic pregnancies and infertility.

While everyone who is sexually active may face the risk of sexually transmitted infection, certain groups are at higher risk. These young people, individuals from black and minority ethnic groups, gay, bisexual, and other men who have sex with men (MSM), those in multiple relationships, and those in the most disadvantaged areas. In West Berkshire, young people have the highest rates of sexually transmitted infection. Although they make up only 10% of the population, they represent a significant percentage of new cases.

In the past year, we have worked to extend the provision of emergency hormonal contraception (EHC) and long-acting reversible contraception (LARC) provision for another year pending a review of the commissioned services. We have worked in partnership with neighbouring local authorities to create a local sexual health action plan based on our main priorities. We are collaborating with our sexual health service

provider to update the service to meet post-COVID needs, closely monitoring service data to improve services.

Mental Health

The aim of public mental health is to promote mental health and wellbeing and prevent mental illness as far as this is possible. Good mental health is essential for making the most of our lives and goes well beyond the occurrence of major psychiatric breakdown. Developing a mentally resilient population of children and young people should be a top priority. Focusing on how you feel on the inside or how we are emotionally.

The public health team regularly provides information about things we can all do to support, improve and maintain good mental health. We routinely promote 'Every Mind Matters' and ' Five Ways to Wellbeing' materials during national mental health campaigns. The public health team also provides information on what to do if you are struggling with poor mental health by signposting local organisations that offer support for mental health. The ' mental health z card' produced by the team is a recognised source of information amongst key partner agencies.

This year the public health team worked with the library service to refresh the contents of the Wellbeing Bags that are available for loan at all West Berkshire libraries. The Wellbeing Bags include a selected mix of books, activities and ideas to help maintain health and wellbeing; they have been well received by our residents. Working with key stakeholders, the public health team has supported a project focusing on how mental health can be affected by financial difficulties. One outcome from this work was the development of a resource for schools about financial literacy and mental health. We have also updated the mental health z card to include information about where to access support for money worries.

For the first time, this year the public health team explored how creativity can improve mental health by launching a Poetry in Mind campaign during mental health awareness week in May. This involved our residents submitting their own poems which were themed around anxiety, socialisation and finding refuge. The public health team arranged for selected poems to be displayed in public spaces for other residents to read and enjoy. An event was held on World Mental Health Day at Shaw House, which allowed residents to talk about the benefits of expressing their emotions through poetry.

Ageing Well & Dementia

Falls prevention work includes ensuring an offer of seated exercise options for the prevention falls and to support residents who have fallen to regain strength and confidence. This includes working with our leisure provider, 'Everyone Active' for the delivery of a 'Steady Steps' programme, working with voluntary partners through our Ever Active Consortium for Love to Move, seated exercise and seated yoga classes across the district.

There is a danger that scarce public health resources are drawn into the provision of individual clinical and social interventions which are properly the responsibility of the National Health Service. The primary concern of public health in falls prevention must be in orchestrating and supporting the combined efforts of a range of partners from housing, town planning, environmental health together with community and neighbourhood groups to ensure that older people are living in safe environments where they can still live a full life without risk of injury.

Reviewing the local Falls Pathway with our partners. This must refocus away from individual interventions and create a practical public health framework for falls prevention grounded in public health principles of social and environmental as well as 1:1 action.

Setting up a weekly drop in Ageing Well Community Café at Theale Library that will incorporate social connection and activities along with providing opportunities for information sharing and active signposting.

Delivering a Nature for Health project that delivers integrational activities that encourage residents to be more physically active and socially connected out in nature.

Working with partners to expand the current offer of community led memory and friendship cafes across the district.

Working with a local arts provider to support engagement in their Ageing Creatively programme.

Where are we now?

Child and Maternal Health[18]

- 1,507 babies were born in West Berkshire in 2021.
- 5.6% of mothers smoked during pregnancy in 2022/23. This was lower than the England average of 8.8%.
- 1.6% of babies born in 2021 had a low birth weight (under 2,500 grams), lower than the England average of 2.8%.
- There were 18 infant deaths under one year of age in 2020-22. The infant mortality rate of 4.0 (per 1,000) was similar to the England rate of 3.9. 56.1% of babies were breastfed 6-8 weeks after birth in 2022/23, higher than the England average of 49.2%.
- 5,135 children aged 0-4 attended A&E in 2021/22 – the A&E attendance rate (1,097.8 per 1,000) was higher than the England rate (762.8 per 1,000).
- 240 children aged 0-5 were admitted to hospital for tooth decay and extraction in 2018/19-2020/21. The hospital admission rate (309 per 100,000) was higher than the England rate (221 per 100,000).
- 17.5% of Reception year children (aged 4-5 years) in 2022/23 were overweight or obese, lower than the England average of 21.3%; this proportion increased to 31.7% among Year 6 children (aged 10-11 years), again lower than the 36.6% in England, but still nearly a third of our 10-11 year olds.
- 48.8% of children and young people aged 5-16 were classified as being physically active in 2021/22, similar to the England average of 47.2%.
- There were 25 pregnancies in girls aged under 18 in 2021. The conception rate (8.3 per 1,000 females aged 15-17) was lower than the England rate (13.1).

[18] Child & Maternal Health Profile. OHID Fingertips Tool. Child and Maternal Health - OHID (phe.org.uk)

- In 2021, 17 under 18 pregnancies (68.0%) led to abortions (53.4% England). Among girls aged under 16, there were less than 5 pregnancies in 2021, and the conception rate (1.2 per 1,000 females aged 13-15) was significantly lower than the England rate (2.1).
- The hospital admission rate for alcohol-specific conditions among children under 18 was 37.5 per 100,000 in 2018/19-2020/21, this was higher than the England rate of 29.3 per 100,000.
- The hospital admission rate for substance misuse among young people aged 15-24 was 69.4 per 100,000 in 2018/19-2020/21, lower than the England rate of 81.2 per 100,000.
- 235 children and young people were admitted to hospital due to unintentional and deliberate injuries in 2021/22. The admission rates (per 10,000) were lower among children aged 0-14 compared with England (82.5 versus 84.3), and higher for young people aged 15-24 (127.9 versus 118.6).
- The hospital admission rate for self-harm among children aged 10-14 was 328.6 (per 100,000), higher than the England rate of 307.1. The rate for young people remained higher than the England rate, for young people aged 15-19 (797.3 per 100,000 for West Berkshire versus 641.7 for England) and those aged 20-24 (405.4 per 100,000 for West Berkshire versus 340.9 for England) in 2021/22.

Adult Health[19]

- In West Berkshire, 39.8% of eligible adults aged 40-74 who were offered an NHS Health Check, received a Health Check between 2018/19-2022/23, lower than the England average of 42.3%.
- 4.9% of people (17,549) in West Berkshire described their general health as 'bad' or 'very bad' according to the 2021 Census which is slightly lower than the England average of 5.2%.
- In 2021/22, 6.2% of adults aged 16 and over reported low levels of life satisfaction (England 5.0%), 5.9% reported low levels of worthwhile (England 4.0%), 8.3%

[19] Public Health Outcomes Framework. OHID Fingertips Tool. Public Health Outcomes Framework - OHID (phe.org.uk)

reported low levels of happiness (England 8.4%), and 20.5% reported high levels of anxiety (England 22.6%) –wellbeing outcomes were similar to England, with more people reporting low levels of worthwhile locally.

- 72.2% of adults over 19 years of age were found to be physically active in 2021/22, higher than the England average of 67.3%; 16.8% were defined as inactive, lower than the England average of 22.3%.
- In 2021/22 33.9% of adults aged 16 and over were eating the recommended '5-a-day' portions of fruit and vegetables, slightly higher, but largely comparable to the England average of 32.5%.
- In 2021/22, 61.3% of adults aged 18 and over were classified as overweight or obese, lower than in England (63.8%); 24.5% of these adults were obese compared with 25.9% in England.
- 13.9% of adults in West Berkshire were recorded with depression on GP registers in 2022/23 (13.2% England), 14.9% had hypertension (14.4% England), 5.9% had diabetes (7.3% England) – these were the three highest recorded long-term conditions.
- There were 270 emergency hospital admissions for intentional self-harm in 2021/22 in West Berkshire – the hospital admission rate (168.2 per 100,000) was slightly higher than the England rate (163.9 per 100,000).
- In 2020-22 there were 33 suicides among people aged 10 years old and over in West Berkshire, a rate of 7.9 per 100,000, lower than the England rate of 10.3 per 100,000.
- There were 2,149 hospital admissions for alcohol-related conditions in 2021/22 – this admission rate (1,303 per 100,000) was lower than the England rate (1,734 per 100,000).
- There were 61 deaths in under 75s from cancers considered preventable in 2021. The mortality rate (40.9 per 100,000) was lower than England (50.1 per 100,000).
- In the under 75s, there were 31 deaths from cardiovascular diseases considered preventable in 2021. The mortality rate (19.8 per 100,000) was lower than England (30.2 per 100,000).

- There were 11 deaths in under 75s from respiratory diseases considered preventable in 2021. The mortality rate (7.1 per 100,000) was less than half the England rate (15.6 per 100,000).
- 16.4% of adults reported a long-term musculoskeletal problem in 2022, lower than the England average of 17.6%.
- There were 565 emergency hospital admissions due to falls in people aged 65 and over in 2021/22. The admission rate (1,779 per 100,000) was lower than England (2,100 per 100,000).
- There were 150 hip fractures in people aged 65 and over in 2021/22 – 40 were among those aged 65-79, 105 in those aged 80 and over; the hip fracture rate in people aged 65 and over (500 per 100,000) was similar to England (551 per 100,000).

Our priorities moving forward

Children and Young People

- We will continue to advocate for evidence-based Policies, Programmes, and Practices for children and young people in West Berkshire and ensure that public health grant is invested optimally for their benefit. We have more evidence than any other generation about what is important and what works.
- We know that the building blocks of future health and lifetime success are laid in the earliest years of life and that this is the phase of life where primary prevention is most possible. Yet, despite all this evidence, too many babies, young children and families are currently being failed by fragmented health policies that fail to meet the scale of need.
- Increased population need with widening health inequalities means more children experience poor health and are being harmed by conditions that are largely preventable. The UK has some of the worst child health outcomes compared to other similar nations, with widening health inequalities (Royal College of Paediatrics and Child Health (2020) State of Child Health).

Healthy Weight

- The Public Health team will continue to work with our partners in the voluntary sector to deliver a range of physical activities for different target groups, under the 'Ever

Active' service. This service is provided by Get Berkshire Active, Age UK, Mencap and Berkshire Vision.

- We will continue to develop our free volunteer-led activity programmes, 'Run Together' and 'Wellbeing Walks', which maintain high levels of participation and deliver running and walking groups for all abilities.

Smoking

- **'**Solutions4Health' will hold regular clinics at the following locations across West Berkshire; Kingsland Centre, Thatcham, Tesco, Pinchington Lane, Newbury and Sainsbury's, Calcot.
- We will continue to work on strengthening 'Solutions4Health' relationships with partners and will support West Berkshire Council's 'Smokefree Sidelines' campaign through the attendance of outreach workers at children's football tournaments held across West Berkshire.

Sexual Health

- We will continue to commission emergency hormonal contraception (EHC) and long-acting reversible contraception (LARC) provision. Working in partnership with our service provider we will meet post-COVID needs of our population closely monitoring and improving the service and delivering sexual health promotion.
- Our focus for the next year is to review condom distribution, expand HIV testing, review and support women's health hubs, and look to enhance links with substance misuse services and those supporting individuals with learning disabilities. Additionally, we aim to improve data collection and update our sexual health needs assessment.

Mental Health

- We will continue to work with partners to develop and deliver a mental health promotion programme and implement our suicide prevention strategy.
- We will promote the use of wider services that support emotional and mental wellbeing, such as libraries, leisure services and green spaces. This includes maximising opportunity by working smartly and imaginatively with health and community partners, to promote good mental health and wellbeing. Our aim is to build

on the success of our previous mental health grant scheme with a renewed focus away from covid-19. This will allow non-for-profit organisations to apply for small pots of funding for projects aimed at promoting good mental health.

- For the first time, the public health team is working on a new death literacy project, starting with a film screening during 'Dying Matters' (a campaign by Hospice UK to improve the quality of life and support for people who are dying or grieving) and working with partners to consider how to take this work forwards.
- We will continue our efforts to provide information and resources to residents and professionals about mental wellbeing and the importance of seeking early help for mental health issues. This will be achieved by promoting the 'Reading Well' books scheme, which supports individuals to understand and manage their health and wellbeing using helpful reading.
- Together with partners, we are working on a new 'life transitions' project, which will explore how our residents can maintain good mental health whilst they go through important transitions in life and the experience of loss, such as bereavement, becoming a parent or starting a new job.

Drug and Alcohol Services

- We will work in partnership to support the delivery of national ambitions to reduce drug use, drug-related crime, and drug-related deaths together with partners in education, employment and accommodation, treatment and criminal justice.
- We will work to prevent and minimise harm from alcohol and drug use among young people and adults. Our focus will be to improve referrals, capacity, quality and outcomes in treatment and recovery.

Leisure and activity physical health (sports and leisure)

- We will develop a new healthy lifestyle service for adult residents with learning disabilities. Unfortunately, adults with learning disabilities in the UK face a higher burden of poor health outcomes than their peers, with life expectancy being around 16 years lower. West Berkshire is no exception, and we are working to develop our health improvement offering for this population.

- We will be commissioning a 12-month pilot service, open to adults with learning disabilities and carers, which will focus on balanced diets and being physically active, in 2024. Our aim is to secure meaningful and well-paid employment for these groups.
- We will be reviewing how the public health team can best support the development of Council-funded supported employment programmes, working with vulnerable groups and residents to obtain and continue in good quality employment.

Aging well and dementia

- Work in partnership with the Local Integration Board in the development of additional Falls Prevention initiatives
- Work in partnership with West Berkshire Community Hospital and Royal Berkshire Hospital to use the Fall Proof resources to encourage physical activity and falls prevention for in patients on the wards
- Work in partnership with the Environment and Waste teams, Business Improvement District and VCS partners to explore how the national Refill scheme could be implemented locally to support improved hydration.
- Explore IT support sessions for older people in the community.

Healthcare Public Health

The Public Health Team has been collaborating closely with the Integrated Care Board to capitalise on opportunities for the NHS to prevent ill health and address inequalities. This collaboration includes funding a Community Wellness Outreach Service aimed at identifying individuals at risk of cardiovascular diseases (CVD) and improving access to the NHS Health Checks in underserved populations. The service will be delivered in community settings across West Berkshire.

Health Care Public Health or Population Based Health Management is the application of public health principles, including epidemiological methods, to the planning, provision and evaluation of health care in a defined population. Work with the NHS and the provision of specialist public health advice and leadership is a core part of the public health function in a local authority bringing to bear the tools and perspectives of public health practice on the provision of health and care. In West Berkshire until now with one

interim Director of Public Health covering both Reading and West Berkshire, and in the absence of a dedicated public health consultant for West Berkshire, this has been a stretch. The appointment of a permanent joint Director of Public Health together with a consultant for West Berkshire should go some way to alleviating this problem.

Intrinsic to the tools of public health is the epidemiological method with its basis in both quantitative and qualitative assessment and surveillance of health and wellbeing. This had its origins in the registration of births and deaths, official notification of cases of infectious disease and decennial household censuses that date from the earliest days of public health in the nineteenth century. The work of the early Medical Officers of Health was based on these systems of registration and notification to advise the local authorities of their day.

In more recent times, the importance of qualitative perspectives including the lived experience of individuals, families, and communities has been recognised as being as important as a purely numerical understanding, as have anthropological, sociological and other insights from social psychology and communication science in producing a full picture; commissioned and pure research are also important in answering specific questions and informing practical advances based on theoretical exploration. The limitations of a narrow, biological and quantitative perspective were shown up vividly both in the Ebola epidemic of 2014 and the recent COVID-19 pandemic when a failure to understand the spread of infection from a broader public health point of view led to delays in effective action and avoidable deaths.

The application of epidemiology in its various forms has a number of valuable applications including in the understanding of the priorities, working and effectiveness of health and social care. The public health perspective involves segmenting the way we look at populations into three: the whole population; populations at risk; and populations suffering from defined medical conditions where medical and social care can make a difference.

In general, the contribution from local government and its partners can be seen as its role in assuring the protection of the population's health by tackling the upstream determinants of health and disease by primary prevention while the contribution of the National Health Service hospitals and specialist clinics is largely one of tertiary

prevention. That is to say through providing specialist treatment to save life or mitigate the impact of serious ill health on everyday living.

Where the work of local government meets that of the NHS is in the secondary prevention work of primary health care through vaccination and screening programmes, and early intervention to prevent disease progression or to support rehabilitation in the community and continuing care through the partnerships of statutory and voluntary social efforts.

The NHS Long Term Plan highlights the opportunities for prevention at an earlier stage, supporting those at an early stage of illness from progressing and from systematically identifying opportunities to prevent ill health occurring. Public Health Teams in councils have continued working closely with the NHS on shared priorities, including prevention, addressing inequalities and health protection. This will continue to be an important part of our work stream.

The NHS organisational landscape has changed considerably over the last couple of years with the formation of the NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) and the formation of the Integrated Care System (ICS) and the Integrated Care Partnership (ICP). (6). These new organisations provide opportunities for organisations to work more closely together to collectively improve the health of the local population and reduce inequalities. Public health expertise in these organisations is important to ensure services are designed to improve public health outcomes and reduce inequalities.

Our priorities moving forward

- Provide strong, visible public health leadership within the Berkshire West healthcare system to protect and promote health.
- Develop an integrated approach to generating and using public health evidence and intelligence in decision making within the NHS and across the Integrated Care Partnership (ICP).
- Promote a focus on prevention and inequalities in the commissioning and delivery of NHS functions, including strong links with the factors influencing health outcomes such as employment, education, housing and the environment.

- Work with the NHS to ensure good knowledge, systems and processes are in place for responding to health protection threats.
- Work from the bottom up at a community level with an Asset Based Community Development philosophy as far as possible, within a wider local authority and NHS strategic framework.

Commissioning

A significant portion of the West Berkshire Public Health Grant is allocated to externally contracted services provided by organisations outside of the council. The role of Public Health as the commissioner of services is to design the requirements of the service, find suitable organisations to deliver the service, monitor performance and work with those providing services on continuous improvement.

Externally commissioned services cover children's services, including health visiting, school nursing, drug and alcohol services, leisure services and specialist sexual health services and NHS Health Checks.

The external environment is rapidly changing with rising inflation, workforce challenges, and increased competition for organisations to deliver services. Our approach to commissioning must respond to these issues, and to use all the elements of the commissioning process to maximise public health outcomes. We have recently undertaken a comprehensive review of our investment of the public health grant to ensure that it is in full accordance with the mandate from the Office of Health Improvement and Disparities. In future investment decisions will be taken at a Public Health Development Board that has been established.

Research, evidence, and intelligence

Evidence and intelligence constitute the cornerstone and one of the bookends of public health. What we do is driven by understanding patterns of health and disease, identifying needs of our local population and prescribing those interventions that are most effective in improving health and wellbeing. We must also monitor and evaluate

the performance of our local services while understanding the economic impact of our decisions. Evidence gained from qualitative methods such as interviews and focus groups are just as important as analysis of quantitative data. We need to be using intelligence from those with the lived experience to inform the design of services and public health programmes.

There will always be gaps in understanding, and strong links with academic institutions, especially our local University of Reading. Such links have important benefits including the provision of educational and career opportunities for local people, providing a sustainable local pipeline of staff for local health, social care, and wellbeing services, and having ready access to appropriate research expertise to throw light on pressing issues.

Our priorities moving forward

- Work with partners across and beyond the council to develop a joined-up, evidence and intelligence function to support commissioning decisions.
- Build on new tools and techniques for data linkage, enabling measurement of the impact of a change in one part of the system on other parts.
- Work with stakeholders to develop the Joint Strategic Needs Assessment and Asset mapping, reflecting the priorities of the Integrated Care Partnership and Health and Wellbeing Board.
- Strengthen the evaluation of public health interventions delivered across the council and wider system, providing clarity on health and economic impact.
- Improve the experience of the public users of public health services with clear service offers and the increased ability of managers to be self-sufficient in access to intelligence resources through the use of tools such as Microsoft Power BI.
- Build relationships with academic institutions and research networks within the ICB to ensure development of a public health research programme within the council.
- Improve how we use information from those with lived experience to develop services and further embed the use of citizen science and understanding of the lived experience of local people.

Communications

Good communications are one bookend of a robust and effective public health function, the other being sound intelligence. Clear messaging and information are central to any modern public health service. We need to be visible in and trusted by our communities to achieve our objectives. It is important that the tone and content are right to ensure that the desired outcomes are achieved, whether this is informing, warning or advising. The use of multimedia was critical during the COVID-19 pandemic and its value should not be underestimated, nor conversely overused. Effective campaigns will help people better manage their own health.

Our priorities moving forward

- Work with council communications team to deliver a communications programme of awareness raising and information to the public.
- Send out adverse weather warnings via social channels and internal messaging channels, hot weather June to September and cold weather November to March using United Kingdom Health security agency (UKHSA) resources and supporting documents from the Adverse Weather and Health Plan.
- Continue to promote Covid-19 vaccine and, flu vaccine, and other messages via social channels and internal messaging channels using UKHSA resources.
- Continue to promote Measles, Mumps, and Rubella (MMR) vaccine using West Berkshire Council measles and MMR messaging plan and UKHSA resources.
- Strengthen our internal communication so other teams in the council understand the work of public health and opportunities for engagement.
- Use our learning from the COVID-19 pandemic of those approaches that work best with different groups in our local community.
- Use internal messaging channels ('In the Know', 'Reporter', 'Residents Newsletter')
- Continue to provide expert advice, underpinned by data and evidence, and informed by behavioural insights.

Diverse and skilled workforce

The skills and capacity of the West Berkshire Public Health Team and wider workforce are essential to the improvement of population health and delivery of all those programmes that protect and improve health.

Within the Public Health Team itself we are fortunate to have a highly skilled and motivated workforce. We have expertise drawn from a range of professional, including clinical and non-clinical, backgrounds and highly motivated staff many of whom are involved in professional public health training.

Our aim is to provide an escalator of opportunity, providing the environment and resources for individuals to develop skills, be inspired and realise their aspirations. We intend to build capacity and capability for public health both within the West Berkshire Public Health team and across the council with a programme of developmental opportunities.

We have a Public Health Workforce Development Officer who is funded one day a week by NHS England to support sustainable workforce development across the three Berkshire West Public Health Teams. The workforce development officer works closely with the named lead for Berkshire West public health workforce development (DPH Wokingham) who is the Thames Valley Public Health School Board representative, to support the planning and development of a skilled public health workforce to increase capacity and competence in public health and building on locally agreed priorities.

Over the last 12 months, the workforce development officer has facilitated several continued professional development (CPD) days aimed at supporting career development, enhancing skills, and expanding knowledge. Additionally, the Workforce Development Officer has supported ‘Get Active Berkshire’ and ‘Home-Start West Berkshire’ in applying for the Public Health Wider Workforce Development Educational Projects fund. Both organisations were successful in obtaining the funding, which is awarded to projects addressing the workforce needs of the wider public health arena within health and care, voluntary, and third-sector organisations.

Our priorities moving forward

- Continue to deliver workforce development training and opportunities to the Public Health Team and the wider workforce.
- Broaden our public health training offerings, building expertise to deliver high-quality public health training across the council and external stakeholders.
- Support all career stages, including the development of an apprenticeship program for those early in their careers and providing specialist training for aspiring consultants.
- Ensure that our ways of working foster a diverse workforce, where staff from all backgrounds feel equally valued and accepted.
- Develop innovative approaches to our training and development, positioning us as leaders across the system and as an employer of choice.
- Provide the necessary training and support to ensure strong leadership at all levels.

Building and maintaining a strong public health function

Strong foundations that enable both the public health function and specific public health services to be delivered effectively and efficiently are essential for the future.

Following the impact of the COVID-19 pandemic there are opportunities for West Berkshire to develop in line with modern public health values and aspirations to meet local need. There are opportunities for new ways of working in partnership that were built up during the pandemic.

To ensure that we have the best opportunity to deliver excellent public health services, we will continue to invest in services to promote, protect, prevent ill health and reduce inequalities.

What we did:

- Cross directorate working between communities, culture, libraries, leisure, adult social care and public health to maximise opportunities to improve health and wellbeing. Examples include a poetry project to improve creativity, wellbeing and social connection, outreach drug and alcohol recovery services in leisure centres.
- Develop a delivery plan for the Joint Berkshire West Health and Wellbeing Strategy
- Deliver a refurbished lido at Northcroft Leisure Centre to increase physical activity

opportunities.

- Partnership working between West Berkshire Council, BOB Integrated Care Board and Primary Care to develop a joint cardiovascular disease prevention outreach service.
- Set up an early years inequalities group to ensure children and young people have the best start for life.
- Nature for health activities for improving physical activity and social connection.
- Agreement for a Health in All Policies approach and Health Planning Protocol.
- Cross Council workshops on Health in All Policies and Systems Thinking.

Our priorities moving forward

- Make the biggest impact by addressing the building blocks of health, these are the natural and built environment in which we live, work, move, and play; the quality of the work we do and the resources available to us either through income or access to facilities to live a full life.
- Tackle health inequalities and ensure we have equal opportunities for all.
- Embed a Health in all Policies approach within West Berkshire Council and work in partnership to promote health and wellbeing at every opportunity.
- Tackle preventable cardiovascular disease through delivery of a community wellness outreach service, taking lifestyle support and health checks to communities.
- Continue to deliver on the joint Health and Wellbeing Strategy.

Conclusion

This report reflects on the public health advancements that have already been made across West Berkshire along with the benefits felt by our local communities. It also importantly sets out the ambitions for the West Berkshire Public Health Team, the wider council and for our partner organisations and local communities so we can work together to promote health and wellbeing for all whilst reducing the inequalities experienced by some groups of our society.

This is a challenging time for the public health team with the continued impact of the COVID-19 pandemic on physical and mental health which is becoming more apparent, affecting all age groups and disproportionately impacting those who are most disadvantaged. Simultaneously, many are struggling with the continued cost of living crisis.

Our Priorities

Moving forward, we will take a balanced approach to improving public health in West Berkshire. Action is needed at three levels: interventions that impact the whole population; targeted intervention for groups at risk of ill health; and support for those with established disease to prevent further ill health and enable people to live well and independently with established medical conditions. Particular focus on targeted interventions to tackle the inequalities we are aware of in West Berkshire will be key in the coming years, working closely with those communities affected to really understand and coproduce the solutions to the issues identified.

Embedding the Public Health Approach

Throughout this report we highlight the importance of working in partnership with other teams in West Berkshire and with other individuals, groups, bodies, and organisations outside it ('The Organised Efforts of Society') to achieve public health outcomes.

Taking this approach means that we can reach many more people than the Public Health Team can reach alone, and which statutory services may only scratch the surface of. It also provides the opportunity to influence the wider determinants of health – factors such as education, housing, employment, the built and natural environment, our social and community networks, and the roots of crime and violence – all of which are strongly

linked to health outcomes. This is where there is a significant opportunity to influence health and wellbeing outcomes and reduce health inequalities.

Evidence-based Decisions and Communications

We have also focused on high quality evidence-based decision making and strong communication – the bookends of public health. Evidence and intelligence underpin everything we do in public health and require a wide-ranging approach. We need to ensure we have this range, from generating new knowledge from research; to using new techniques to turn data from multiple sources into intelligence; to working with individual and local communities to understand their experience and use this to design services. Strong communications with our local communities have been vital in our response to the COVID-19 pandemic and we will continue to build on this experience.

High Quality Public Health Services

We will continue to commission and deliver public health services to our local communities, and this remains a vital part of our service delivery. Services include public health services such as health visiting, NHS health checks, specialist sexual health services, substance misuse services, smoking cessation and weight management services. Our workforce is key; building the skills and capacity of the Public Health Team and wider workforce is central to delivering our ambitions.

The West Berkshire Public Health Team welcomes the challenge of protecting and improving the health of our local people in the years ahead.

To quote Cicero "The Health of the People is the Highest Law'.

[20]

[20] Cicero. De-Legibus Book 3,3,8. Contained in Bentham's Book of Quotations ,1948.

Supporting documents

Milestone, A., Maragakis, L. (2023) Measles: What You Should Know. John Hopkins Medicine. https://www.hopkinsmedicine.org/health/conditions-and-diseases/measles-what-you-should-know Accessed 15.02.2024.

WHO (2023) A New Era in the Fight Against Measles and Rubella. https://www.who.int/news/item/22-02-2023-a-new-era-in-the-fight-against-measles-and-rubella Accessed 15.02.2024.

West Berkshire Annual Public Health Report 2024

Prof. Dr John R Ashton C.B.E. Interim Director of Public Health Reading and West Berkshire

West Berkshire COUNCIL

Content

- Setting the scene
- Public Health comes home
- A Public Health vision for West Berkshire
- Health Protection; Health Improvement; Healthcare Public Health
  - Where are we now?
  - What have we achieved?
  - Priorities moving forward
- Conclusions and priorities

Source:

West Berkshire COUNCIL

Setting the scene

- Public Health leadership transition within West Berkshire Council provides the opportunity to pause and reflect in order to plan the future direction of travel.
- Health in All Policies in particular provides the opportunity to continue to move upstream.
- Our role within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) provides us with the opportunity to reorientate towards population-based health care.
- It is important to understand the history locally and of the Public Health system to inform our future direction of travel.
- Today Public Health broadly consists of three domains of action: Health Protection; Health Improvement; and the Healthcare Public Health.
- Prevention is key, but in enabling people to live who might previously have died, the burden of disease may actually increase and with it the costs of maintaining people's health over many years.
- The social goal is for all to 'die young as old as possible' while reducing inequality and the prevalence of long-term conditions whilst maintaining independent living.

Source:

Public Health comes home

Public Health intervention dates back to Victorian movements. Sanitary Act 1846 and Annual Public Health reports emerge providing a snapshot of population health at a moment in time

1900s comprehensive programme to address physical deterioration and concern over military fitness

Public Health definition in 1920 – the science and art of preventing disease, prolonging life and promoting physical health

Progress in medical advances, vaccination and the emergence of the NHS In 1948 saw a shift in PH focus to hospital medicine

1988 and the creation of joint Control of Communicable Disease posts saw the start of the shift back to Local Government, completed in 2013.

Source:

A Public Health vision for West Berkshire

West Berkshire Council is committed to improving the health of everyone in West Berkshire. To support this Council vision, the Public Health team's commitment is summarised below:

- To develop and support population level interventions to protect and improve health that are based on high quality intelligence and evidence to inform best practice.
- To take a Place and Asset-based approach to working with local communities and develop a Community Orientated Health and Social Care System building on existing strengths to create a sustainable future.
- To maintain a relentless focus on reducing health inequalities.
- To work in partnership with all those who value the health and wellbeing of the people of West Berkshire.
- To commission and deliver evidence based, high quality, value for money, public health services.

Source:

West Berkshire COUNCIL

Health protection – where are we now?

- High vaccine coverage
- Local variation and pockets of low uptake
- Poorer uptake of vaccination in older age
- Low levels of STI and HIV diagnosis – lower incidence, but possibly also poorer access and uptake
- Smoking and alcohol misuse rates in line with England but inequalities persist

Source:

Health protection – what have we achieved?

- Seasonal vaccination through the *Be Well This Winter* service
- Childhood vaccination and measles protection in West Berkshire
- Health Impact Assessment policy and process for new developments in West Berkshire
- Existing public health programmes including smoking cessation and the provision of substance misuse (drug and alcohol) services have addressed some of these wider threats but there is more that needs to be done.

Source:

Health protection – priorities moving forward

- Continuously strengthen our preparedness against future health protection threats and improve the quality of our services to protect health.
- Fulfil the assurance role of ensuring that appropriate health protection arrangements are in place to protect the health and wellbeing of the residents of West Berkshire.
- Ensure that organisational and system level governance arrangements are in place across Berkshire West through the Berkshire West Health Protection and Resilience Partnership Board (HPRPB).
- Ensure that environmental, biological, chemical, radiological, and nuclear threats and hazards are understood, and that health protection issues are addressed through close collaboration with Emergency Planning Teams, Environmental Health and other appropriate colleagues.
- Work proactively with Environmental Health, Emergency Planning, Trading Standards and the Communications Team on incident and outbreak investigation, response and management.

Source:

Health protection – priorities moving forward

- Work with planners, other council officers, the general public, and others to ensure the design of safe, supportive, and sustainable housing, neighbourhoods and communities.
- Through our Health in All Policies (HiAP) we will work with Development Control, Planning, Licensing and Trading Standards, and Environmental Health to reduce externally driven harms to the vulnerable.
- Develop a public health approach to violence prevention, using an evidence base to understand populations at risk and the impact of interventions.
- Work with local communities and Family Hubs to identify problems related to health and wellbeing and mobilise and support community assets in the battle against anti-health influences.
- Work with organisations across West Berkshire to develop a strategic approach to combatting the threat of addiction whether by alcohol, tobacco, drugs and other harmful substances, risky sexual activity, or gambling, supported by high quality, evidence-based services to reduce harm.
- Work with other bodies, organisations, and interested parties to reduce the hazards that increase the risk of falls in the vulnerable and the elderly.

Source:

Health improvement – where are we now?

- Child health
  - Higher rate of 0-4 year olds attending A&E compared to England
  - Higher rate of 0-5 year old admissions for tooth decay compared to England
  - Nearly a third of year 6 children are overweight or obese
  - High rate of alcohol related and self-harm hospital admissions for under 18s compared to England
- Adult health
  - Well over half (61.3%) of adults are over wight or obese
  - The three highest recorded long-term conditions locally were depression, hypertension and diabetes.
  - Mortality rate from preventable cancer; cardiovascular disease and respiratory disease was lower than the national average but we still saw over 100 deaths that were preventable in West Berkshire in 2021

Source:

Health improvement – what have we achieved?

Extensive health improvement programmes of work covering the following areas:

- Children and young people, including: Public Health nursing service; contribution to family hubs; Antenatal, Postnatal and Flying Start parenting and family courses; Every Child a Talker and Chatterbox to support developmental delays; Best Start in Life parenting support; Health and Wellbeing in Schools and Youth Counselling
- Healthy weight needs assessment and commissioning of new leisure provider
- Smoking cessation service provision
- Cardiovascular disease Healthcheck and community wellness outreach service
- Sexual health commissioning of advice, information, education and services related to contraception, STIs and HIV
- Mental health promotion of the Every Mind Matter and Five Ways to Wellbeing campaigns
- Ageing well including falls prevention, community and memory cafés and nature for health

Source:

Health improvement – priorities moving forward

Children and Young People

- We will continue to advocate for evidence-based Policies, Programmes, and Practices for children and young people in West Berkshire and ensure that public health grant is invested optimally for their benefit. We have more evidence than any other generation about what is important and what works.
- We know that the building blocks of future health and lifetime success are laid in the earliest years of life and that this is the phase of life where primary prevention is most possible. Yet, despite all this evidence, too many babies, young children and families are currently being failed by fragmented health policies that fail to meet the scale of need.
- Increased population need with widening health inequalities means more children experience poor health and are being harmed by conditions that are largely preventable. The UK has some of the worst child health outcomes compared to other similar nations, with widening health inequalities (Royal College of Paediatrics and Child Health (2020) State of Child Health).

Healthy Weight

- The Public Health team will continue to work with our partners in the voluntary sector to deliver a range of physical activities for different target groups, under the 'Ever Active' service. This service is provided by Get Berkshire Active, Age UK, Mencap and Berkshire Vision.
- We will continue to develop our free volunteer-led activity programmes, 'Run Together' and 'Wellbeing Walks', which maintain high levels of participation and deliver running and walking groups for all abilities.

Smoking

- **'**Solutions4Health' will hold regular clinics at the following locations across West Berkshire; Kingsland Centre, Thatcham, Tesco, Pinchington Lane, Newbury and Sainsbury's, Calcot.
- We will continue to work on strengthening 'Solutions4Health' relationships with partners and will support West Berkshire Council's 'Smokefree Sidelines' campaign through the attendance of outreach workers at children's football tournaments held across West Berkshire.

Source:

Health improvement – priorities moving forward

Sexual Health

- We will continue to commission emergency hormonal contraception (EHC) and long-acting reversible contraception (LARC) provision. Working in partnership with our service provider we will meet post-COVID needs of our population closely monitoring and improving the service and delivering sexual health promotion.
- Our focus for the next year is to review condom distribution, expand HIV testing, review and support women's health hubs, and look to enhance links with substance misuse services and those supporting individuals with learning disabilities. Additionally, we aim to improve data collection and update our sexual health needs assessment.

Mental Health

- We will continue to work with partners to develop and deliver a mental health promotion programme and implement our suicide prevention strategy.
- We will promote the use of wider services that support emotional and mental wellbeing, such as libraries, leisure services and green spaces. This includes maximising opportunity by working smartly and imaginatively with health and community partners, to promote good mental health and wellbeing. Our aim is to build on the success of our previous mental health grant scheme with a renewed focus away from covid-19. This will allow non-for-profit organisations to apply for small pots of funding for projects aimed at promoting good mental health.
- For the first time, the public health team is working on a new death literacy project, starting with a film screening during 'Dying Matters' (a campaign by Hospice UK to improve the quality of life and support for people who are dying or grieving) and working with partners to consider how to take this work forwards.
- We will continue our efforts to provide information and resources to residents and professionals about mental wellbeing and the importance of seeking early help for mental health issues. This will be achieved by promoting the 'Reading Well' books scheme, which supports individuals to understand and manage their health and wellbeing using helpful reading.
- Together with partners, we are working on a new 'life transitions' project, which will explore how our residents can maintain good mental health whilst they go through important transitions in life and the experience of loss, such as bereavement, becoming a parent or starting a new job.

Source:

Health improvement – priorities moving forward

Drug and Alcohol Services

- We will work in partnership to support the delivery of national ambitions to reduce drug use, drug-related crime, and drug-related deaths together with partners in education, employment and accommodation, treatment and criminal justice.
- We will work to prevent and minimise harm from alcohol and drug use among young people and adults. Our focus will be to improve referrals, capacity, quality and outcomes in treatment and recovery.

Leisure and activity physical health (sports and leisure)

- We will develop a new healthy lifestyle service for adult residents with learning disabilities. Unfortunately, adults with learning disabilities in the UK face a higher burden of poor health outcomes than their peers, with life expectancy being around 16 years lower. West Berkshire is no exception, and we are working to develop our health improvement offering for this population.
- We will be commissioning a 12-month pilot service, open to adults with learning disabilities and carers, which will focus on balanced diets and being physically active, in 2024. Our aim is to secure meaningful and well-paid employment for these groups.
- We will be reviewing how the public health team can best support the development of Council-funded supported employment programmes, working with vulnerable groups and residents to obtain and continue in good quality employment.

Aging well and dementia

- Work in partnership with the Local Integration Board in the development of additional Falls Prevention initiatives
- Work in partnership with West Berkshire Community Hospital and Royal Berkshire Hospital to use the Fall Proof resources to encourage physical activity and falls prevention for in patients on the wards
- Work in partnership with the Environment and Waste teams, Business Improvement District and VCS partners to explore how the national Refill scheme could be implemented locally to support improved hydration.
- Explore IT support sessions for older people in the community.

Source:

Healthcare Public Health – what have we achieved?

- Collaborating with the Integrated Care Board to fund a Community Wellness Outreach Service aimed at identifying individuals at risk of cardiovascular diseases (CVD) and improving access to the NHS Health Checks in underserved populations.
- Recruitment of a Consultant in Public Health and Director of Public Health across West Berkshire and Reading to provide specialist public health advice and leadership to the ICB and ICS bringing to bear the tools and perspectives of public health practice on the provision of health and care.
- Externally commissioned Public Health services.
- Understanding patterns of health and disease, identifying needs of our local population and prescribing those interventions that are most effective in improving health and wellbeing through the JSNA

Source:

Healthcare Public Health – priorities moving forward

- Provide strong, visible public health leadership within the Berkshire West healthcare system to protect and promote health.
- Develop an integrated approach to generating and using public health evidence and intelligence in decision making within the NHS and across the Integrated Care Partnership (ICP).
- Promote a focus on prevention and inequalities in the commissioning and delivery of NHS functions, including strong links with the factors influencing health outcomes such as employment, education, housing and the environment.
- Work with the NHS to ensure good knowledge, systems and processes are in place for responding to health protection threats.
- Work from the bottom up at a community level with an Asset Based Community Development philosophy as far as possible, within a wider local authority and NHS strategic framework.

Source:

Research/evidence base – priorities moving forward

- Work with partners across and beyond the council to develop a joined-up, evidence and intelligence function to support commissioning decisions.
- Build on new tools and techniques for data linkage, enabling measurement of the impact of a change in one part of the system on other parts.
- Work with stakeholders to develop the Joint Strategic Needs Assessment and Asset mapping, reflecting the priorities of the Integrated Care Partnership and Health and Wellbeing Board.
- Strengthen the evaluation of public health interventions delivered across the council and wider system, providing clarity on health and economic impact.
- Improve the experience of the public users of public health services with clear service offers and the increased ability of managers to be self-sufficient in access to intelligence resources through the use of tools such as Microsoft Power BI.
- Build relationships with academic institutions and research networks within the ICB to ensure development of a public health research programme within the council.
- Improve how we use information from those with lived experience to develop services and further embed the use of citizen science and understanding of the lived experience of local people.

Source:

Communications – priorities moving forward

- Work with council communications team to deliver a communications programme of awareness raising and information to the public.
- Send out adverse weather warnings via social channels and internal messaging channels, hot weather June to September and cold weather November to March using United Kingdom Health security agency (UKHSA) resources and supporting documents from the Adverse Weather and Health Plan.
- Continue to promote Covid-19 vaccine and, flu vaccine, and other messages via social channels and internal messaging channels using UKHSA resources.
- Continue to promote Measles, Mumps, and Rubella (MMR) vaccine using West Berkshire Council measles and MMR messaging plan and UKHSA resources.
- Strengthen our internal communication so other teams in the council understand the work of public health and opportunities for engagement.
- Use our learning from the COVID-19 pandemic of those approaches that work best with different groups in our local community.
- Use internal messaging channels (‘In the Know’, ‘Reporter’, ‘Residents Newsletter’)
- Continue to provide expert advice, underpinned by data and evidence, and informed by behavioural insights.

Source:

West Berkshire COUNCIL

Workforce – priorities moving forward

- Continue to deliver workforce development training and opportunities to the Public Health Team and the wider workforce.
- Broaden our public health training offerings, building expertise to deliver high-quality public health training across the council and external stakeholders.
- Support all career stages, including the development of an apprenticeship program for those early in their careers and providing specialist training for aspiring consultants.
- Ensure that our ways of working foster a diverse workforce, where staff from all backgrounds feel equally valued and accepted.
- Develop innovative approaches to our training and development, positioning us as leaders across the system and as an employer of choice.
- Provide the necessary training and support to ensure strong leadership at all levels.

Source:

Public Health function – priorities moving forward

- Make the biggest impact by addressing the building blocks of health, these are the natural and built environment in which we live, work, move, and play; the quality of the work we do and the resources available to us either through income or access to facilities to live a full life.
- Tackle health inequalities and ensure we have equal opportunities for all.
- Embed a Health in all Policies approach within West Berkshire Council and work in partnership to promote health and wellbeing at every opportunity.
- Tackle preventable cardiovascular disease through delivery of a community wellness outreach service, taking lifestyle support and health checks to communities.
- Continue to deliver on the joint Health and Wellbeing Strategy.

Source:

Conclusion and priorities

- A balanced approach to improving public health in West Berkshire across three levels:
  - Interventions that impact the whole population;
  - Targeted intervention for groups at risk of ill health; and
  - Support for those with established disease to prevent further ill health and enable people to live well and independently with established medical conditions.
- Embedding the Public Health approach through partnership working to reach more people and address the wider determinants of health
- Advocate for evidence-based decisions and communications
- Continue to commission and deliver high quality Public Health Services

The West Berkshire Public Health Team welcomes the challenge of protecting and improving the health of our local people in the years ahead.

To quote Cicero "The Health of the People is the Highest Law'.

Source:

This page is intentionally left blank

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Diabetes Overview – West Berkshire

Peter Hunt

Long Term Conditions Implementation Manager (Berkshire West)

May 2024

What is Diabetes?

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Diabetes is a serious condition where an individual's blood glucose levels are too high.

It can happen when the body doesn't produce enough insulin, the insulin it produces isn't effective; or when the body can't produce any insulin at all.

- **Type 1 Diabetes** is a lifelong condition where the body's immune system attacks and destroys cells that produce insulin.
  The cause of Type 1 is unknown, diet and lifestyle factors do not affect the risk of developing it and it cannot be put into remission.
  All patients with Type 1 Diabetes need insulin to survive.

- **Type 2 Diabetes** is more common than Type 1…**over 90% of people in the UK who have diabetes, have Type 2.**
  People who are overweight or obese and people from some ethnic backgrounds are most at risk of developing the condition.
  Type 2 diabetes is where the body does not produce enough insulin or the body's cells do not react to insulin properly.
  For many people, Type 2 diabetes can be put into remission through weight loss and lifestyle changes.
  If left undiagnosed, blood levels can rise to very high levels. If high blood glucose levels are left untreated, they can cause serious health complications such as : eye diseases which can lead to blindness, circulation problems which lead to heart attack, stroke, and vascular problems contributing to amputations, kidney problems and nerve damage, amongst others.

- **Type 2 Diabetes** can be prevented in most cases by eating healthily, maintaining a healthy weight and waist size, and keeping active.
  These factors make it easier to maintain a healthy blood glucose level and prevent insulin resistance.
  10% of the NHS budget for England and Wales is spent on diabetes treatment, management and complications.

BOB ICB Integrated Diabetes Delivery Network (IDDN)

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

The IDDN is the key group of stakeholders across the ICB, who come together to facilitate a **collaborative approach to deliver on local, regional and national diabetes priorities.**

It is also their responsibility to identify and address variation, share best practice and enable integrated care that is high quality and patient-centred.

In addition, they aim to address health inequalities & plan for and address the increase in demand for services, provide strong clinical leadership and enable effective working across organisational boundaries.

Their **key priorities**, set out in the Joint Five Year Forward Plan are to:

- Support education and training of our workforce.
- Reduce clinical variation and health inequalities.
- Adopt new diabetes care technologies and treatments, and to improve access to services.
- Continue to improve primary prevention of type 2 diabetes and secondary prevention to slow the progress and reduce likelihood of complications of all types of diabetes.
- Embed supported and personalised self-care to enable people with diabetes to manage their health so they can live the life they want to live.

They aim to achieve this by :

- Reaching and exceeding pre-pandemic attainment of the **eight diabetes care processes (8CPs) and the three treatment targets (TTTs)** as set out in the National Diabetes Audit.
- Innovation and service development focusing on digital technologies to improve outcomes and reduce inequalities.
- Deliver a high-quality integrated care approach, promoting self-care for primary and secondary prevention so people with diabetes experience fewer preventable complications.

Why does this need ICB/ICS action?

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

National

- Over **4.3 million** people are living in the UK with a diagnosis of diabetes with approximately 90% of those diagnosed with type 2.
- Without the right care and support people with all types of diabetes can be at risk of developing serious complications. Every week in the UK, diabetes leads to **184 amputations**, more than **770 strokes**, **590 heart attacks** and **2,300 cases of heart failure**.
- Diabetes UK predict that without significant action up to **5.5 million** people in the UK could be living with diabetes by 2030 – that's as many as one in 10 adults.

BOB

- Across BOB 86,140 of our residents have a diagnosis of type 2 diabetes and 8,733 are living with type 1 diabetes.
- In BOB-ICS, 68.1% of people with diabetes have **one or more comorbidities.**
- Diabetes accounts for significant resource use within BOB-ICS – e.g. Average acute expenditure per capita: £2,542.
- Diabetes is the single most common **"at risk" condition for Covid-19 vulnerability** in BOB ICB.
- There is significant variation in the achievement of NDA targets across BOB-ICB by sub-ICB/place – e.g. the variation in 8 care process achievement ranges from 25.0% to 86.6% for practices in Berkshire West.

Data obtained from ICB's IDDN Deep Dive Jan 24

Focus on West Berkshire, as part of the ICB footprint

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

The West Berkshire footprint covers **4 Primary Care Networks (PCNs)**:

- A34 (2,025 registered as being Type 2 Diabetic out of 49,000 registered patients)
- Kennet (2,310 out of 43,000)
- West Berkshire Rural (1,040 out of 23,000)
- West Reading Villages (1,875 out of 43,000)

Total number of patients in West Berkshire with Type 2 Diabetes: **7,250**

Total West Berkshire PCN patients registered: **158,000**

'T2 patient data' taken from National Diabetes Audit (NDA) (Jan – Dec 2023). 'Patients registered' data taken from NHS Digital Dashboard (May 2024).

Diabetes Prevalence in West Berkshire

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

- The Type 2 Diabetes prevalence in West Berkshire is **lower than the national average** but (just) **above the BOB ICB** average. However, you will see that prevalence has **increased** in West Berkshire and at ICB & national level.

	Type 2 Prevalence 2019/20	Type 2 Prevalence 2022	Type 2 Prevalence 2023/24
A34	3.5%	3.9%	4.1%
Kennet	4.4%	4.9%	5.4%
West Berkshire Rural	4.5%	4.5%	4.5%
West Reading Villages	3.8%	4.0%	4.4%
West Berkshire	4.1%	4.3%	4.6%
BOB ICB	4.2%	4.2%	4.4%
National	5.3%	5.4%	5.6%

'T2 Prevalence' worked out by total T2 patients / total registered patients.

'T2 patient data' taken from National Diabetes Audit (NDA) (Jan – Dec 2023). 'Patients registered' data taken from NHS Digital Dashboard (May 2024).

8 Care Processes & Three Treatment Targets

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

8 Care Processes

Body Mass Index (BMI)
Blood Pressure
Cholesterol
Creatinine eGFR
Foot Screening
HbA1c
Smoking Status
Urine ACR

The ninth care process is retinal screening. This is managed by secondary care and coded in the primary care record.

Three treatment targets

HbA1c
<= 58 mmol/mol

Blood Pressure
<= 140/80

Cholesterol
< 5 mmol/L

8 Care Processes & Three Treatment Targets – West Berkshire

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

	Achievement of all 8 Care Processes	Achievement of three treatment targets
A34	55.8%	35.9%
Kennet	69.5%	36.5%
West Berkshire Rural	63.0%	35.0%
West Reading Villages	64.5%	38.1%
West Berkshire	63.2%	36.4%
BOB	60.4%	35.8%
National	51.3%	36.6%

Data taken from National Diabetes Audit (NDA) (Jan – Dec 2023)

Place Based work being delivered in West Berkshire

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Pre-Diabetes / Non-Diabetic Hyperglycaemia – now BOB ICB Pre-Diabetes Locally Commissioned Service (LCS)

In 2023, practices in West Berkshire were offered a financial incentive to monitor and support people at risk of developing Type 2 diabetes: the Pre-Diabetes Locally Commissioned Service (LCS).

This scheme is ending this June 2024, and is being replaced by a fit-for-purpose **BOB wide harmonised Diabetes LCS**. This ensures that we align the work being covered in all three places within BOB ICB. The LCS will focus on improved management of diabetes and improving timely access to insulin initiation and management.

NHS Diabetes Prevention Programme (NDPP)

West Berkshire practices are incentivised to refer patients to the NDPP through the **Weight Management Enhanced Service**. Our practices continue to **exceed** target numbers of referrals.

Diabetes Structured Education (DSE)

- The ICB has a number of programmes of work to support West Berkshire patient education / self-management :

    - **T2Day:** a locally commissioned service has been developed to support primary care to improve outcomes for people with Early Onset Type 2 Diabetes (18-39y) and increase awareness among HCPs of the additional challenges this cohort faces. Resources have also been developed to support both HCPs and patients, including a set of patient information videos: Type 2 diabetes - Stay Well (staywell-bob.nhs.uk)

    - **Type 2 Path to Remission** (formerly the Low Calorie Diet):
        - the service launched in BOB on 1 September 2023 in Wave 2 of the national roll-out. The service will run for two years with 250 places available per year for eligible BOB residents. As of 30 November 2023, just three months after its launch, 125 referrals had been made to the service and 30 people had started the total diet replacement programme. This is more than double the number of referrals made to our provider from any other ICB in wave 2.
        - The ICB has been **commended by NHS England** on our efficient management of the launch of the service; as such we have been invited to speak and share learning at national webinars for the ICBs launching in wave 4 of the roll out

- Our Community (BHFT) offering CHOICE programme for T1 patients; and X-PERT for T2 patients. There is now also a much shorter programme offered to T2 patients known as DEAL.

- RBH and BHFT are beginning to roll out the NICE Technology Appraisal on **Hybrid Closed Loop (HCL)** systems (artificial pancreas) for adults and children with type 1 diabetes. There will be a five-year implementation of HCL systems which is in-line with NICE guidance.

Patient Pathway (across BOB system)

Prediabetes / Non Diabetic Hyperglycaemia (NDH)

Patient identified as NDH

Patient invited for annual review which includes blood test, weight, waist circ and BP. Care plan agreed and offered referral to NDPP

Patient attends NDPP/Other lifestyle interventions.

Patient declines referral to NDPP

Patient recalled for annual blood test and review.

Blood test normal

Patient stays on the NDH register. Risk stratification used to determine frequency of blood test reviews

Blood test confirms NDH. Patient continues on NDH recall register for annual blood test.

Blood test confirms Type 2 Diabetes

Type 2 Diabetes

Patient diagnosed with Type 2 through Health Check or opportunistic screening

Type 2 Diabetes diagnosis code added to patient record and automatically added to the recall register

- Baseline assessment inc 8CP metrics
- CVD risk assessment
- Medications started as appropriate to achieve the three treatment targets
- Patient offered referral to Diabetes Structured Education (DSE).
- Referred for annual retinopathy screening

Patient invited for an annual review based on either their birth month or month of diagnosis or more frequent reviews as required.

Patient attends first appointment to have 8CP metrics collated

Second appointment to review data and diabetes management. Support with goal setting and life style advice. DSE offered if not attended previously.

Medication initiated and optimised on an ongoing basis as appropriate, using a personalised care approach throughout Type 2 pathway to keep the patient managed within the parameters of the three treatment targets.

Lifestyle advice inc. weight management, smoking cessation, physical activity, mental wellbeing and sleep advice and support offered throughout pathway.

This page is intentionally left blank

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Health Scrutiny Committee update

May 2024

BOB ICB Board Meeting

BOB ICB Primary Care Strategy

Covid-19 Spring Booster Campaign

BOB ICS performance data

1. ICB Board Meeting

BOB ICB board meeting 21 May 2024; papers on the BOB ICB website

2. BOB ICB Primary Care Strategy

The Buckinghamshire, Oxfordshire and Berkshire West (BOB) Primary Care Strategy has been approved by the BOB Integrated Care Board.

The strategy has been in development since July 2023 by BOB ICB and sets out details of the ambition for a new model of primary and community-based care. It describes how primary care should streamline access, provide continuity of care for those with complex conditions and focus more on prevention.

It is expected that as an Integrated Care System, we will improve health outcomes for our population, tackle variation and reduce inequalities, using the resources available across BOB in the most effective and efficient way.

Integration remains at the heart of the model with the following high-level priorities:

- Everyone who lives in BOB to be able to receive the right support when it is needed and with the right health and/or care professional. Our communities are finding it difficult to get an appointment in General Practice or with an NHS dentist, and this needs to change.

- Integrated Neighbourhood Teams to care for those people who would benefit most from proactive, personalised care from a holistic team of professionals, for example those at most risk of emergency hospital admissions.
- To help communities stay well with an initial targeted focus on our biggest killer and driver of inequalities, cardiovascular disease (CVD).

The development of the strategy has been informed by research, analysis, and engagement. The nine-month journey, with initial support from delivery partners KPMG, has been complex but insightful, providing a glimpse of the challenges ahead for its implementation.

As part of this programme of work, extensive engagement was undertaken with a wide range of partners, stakeholders, and the public. The supporting documents 'Primary Care Strategy Development Public Engagement Report' and 'Our Response to the Feedback Report' provide details of activity undertaken, identify the key themes from all the feedback and how this insight has been used to inform the final version of the Primary Care Strategy.

3. Covid-19 Spring Booster Campaign

The Spring COVID-19 vaccination campaign started on 22 April and runs until 30 June 2024 for the following eligible groups:

- Adults aged 75 years and over.
- Residents in a care home for older adults.
- People aged six months and over who are immunosuppressed (as defined in the Green Book).

We have been well prepared for the campaign across BOB. Where gaps in coverage have been identified due to slightly lower levels of GP practice participation, we have arrangements in place with alternative providers to ensure local availability of vaccination clinics and visiting services for care homes and housebound patients.

Access and inequality funding was secured for 15 projects, to improve uptake and reduce variation across communities including:

- Communications
- Vaccine hesitancy training
- Maternity events
- Health on the move vans
- Immunosuppressed clinics and outreach through pop-up and roving services.

As a result of our work, we are among the top systems in the country with our uptake of vaccinations in those who are most vulnerable.

4. BOB ICS performance – latest data

Emergency Department (ED) 4-hour performance across Buckinghamshire, Oxfordshire and Berkshire West recovered in February and showed a further small improvement in March. Ambulance handover performance has improved slightly during March and Trusts are continuing to work with SCAS to reduce ambulance handover delays to support ambulance Cat 2 response times.

Within elective (planned care) the system reduced the number of patients waiting more than 78 weeks through February starting at 264 and ending with 208. All three Trusts forecast achieving the system's plan and national ambition to reach zero patients waiting over 78 weeks for elective treatment except for a small number of complex patients by the end of March 2024.

The total number of NHS Provider open pathways (people waiting for care) was 163,664 against the end of February plan of 137,629.

Diagnostics performance is challenged across BOB, however the percentage of patients waiting over six weeks in February was 19%. That is the lowest percentage since October 2022.

The system has been challenged in cancer 62-day performance for some months. However, we are now seeing sustained improvement with all BOB Trusts showing consistent reductions in the number of patients waiting over 62 days. An increase in percentage of patients treated within 31 days of a decision to treat and within 62 days of an urgent GP referral for suspected cancer. BOB achieved the faster diagnosis standard in February. Only Buckinghamshire Healthcare (BHT) missed the 75% target (by 1.1%).

In terms of access to Primary Care appointments, general practice continues to improve the percentage seen within two weeks increasing to 85.9% -the highest percentage since February 2023.

This page is intentionally left blank

healthwatch West Berkshire

Report to the Scrutiny Board June 2024

Priority	Update
2024/2025 Workplan Healthwatch West Berkshire Annual Workplan 2024 -2025	We have produced our annual workplan and will be concentrating on the following areas. **Pharmacies** – Looking at wait times for services, and how Pharmacy First is being used and perceived by the community. **Health Inequalities:** We will be listening to the under-represented communities to hear about their experiences of getting treatment, and how they access health services. **Maternal Health:** We will be looking at how good practices have the recommended improvements in the national Better Births report have been implemented within maternity services in our local hospitals. **Youth Health:** We will be talking to Young People aged 16-25 about how they access health services, and if they need more support and/or information, and how that information should be presented. **Social Care at Home -Unpaid Carers:** We will be hearing from residents in our area who look after people with Dementia or Alzheimer's. How do they access support? What is their awareness of support currently available, and what is the impact caring has on them and their own health? **Army Spouses -** Army personnel's health needs are catered for by the army; however, where personnel are stationed, their spouses must access local services. We want to find out how they access the services and what their experiences of the services
Annual Report	We are currently working on our annual report for 2023/2024 which will published in early July.
Healthwatch Monitoring	Accessibility is our overall theme for 2024/2025, and we will be ensuring this theme is taken into account with every project we undertake.
Looking Forward	• GP Access Project – 1st Draft is ready, delayed due to illness. Due to be published mid-June • Projects are underway, and we will be working in collaboration with Solutions4Health regarding our Health Inequalities

This page is intentionally left blank

Health Scrutiny Committee Work Programme

The following items will be considered in addition to Standing Items: Updates from Task and Finish Groups

Last Updated: May 2024

Ref	Item	Purpose	Health Body	Prioritisation Score
17 September 2024 (Report Deadline 30 August)				
16	Dementia	To receive an update on dementia diagnosis rates, pathways and the BOB ICB strategy on Dementia pathways since attending the Health Scrutiny Committee in June 2023. To include the strategic approach to prevention including involvement of public health.	Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	N/A
17	Eastfield House Surgery	To review the proposed relocation of Eastfield House Surgery including the public consultation process.	Eastfield House Surgery	14
18	Suicide Prevention	To review the approach to suicide prevention in West Berkshire.	TBC	13
10 December 2024 (Report Deadline 22 November)				
19				
20				
21	Access to Primary Care	An update on access to primary care across West Berkshire since attenting Health Scrutiny Committee in September 2023.	Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	14
11 March 2024 (Report Deadline 21 Februrary)				
22				
23				
24	Early Years Health Inequalties	To received an update from the Early Years Health Inequalities Group	West Berkshire Council and Berkshire Healthcare NHS Foundation Trust	N/A
Other Items to be programmed				
Standing Items				
	Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Boad	To receive an update from the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Boad on their activities.	Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Boad	At every meeting
	Healthwatch West Berkshire Report	To receive an update from Healthwatch West Berkshire on patient feedback received, reports prepared and other activities.	Healthwatch West Berkshire	At every meeting
	Director of Public Health Annual Report	To review the Director of Public Health Annual Report	Public Health	Annual
	Inquest Review Panel	To receive the annual report from the Inquest Review Panel	West Berkshire Council	Annual - March

This page is intentionally left blank