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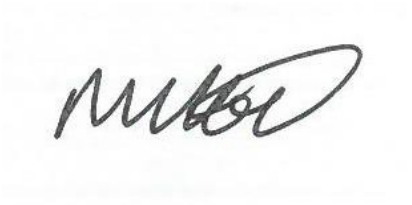
WOKINGHAM
BOROUGH COUNCIL

A Meeting of the **HEALTH AND WELLBEING BOARD** will be held in David Hicks 1 - Civic Offices, Shute End, Wokingham RG40 1BN on **THURSDAY 14 JUNE 2018** AT **5.00 PM**



Manjeet Gill
Interim Chief Executive
Published on 6 June 2018

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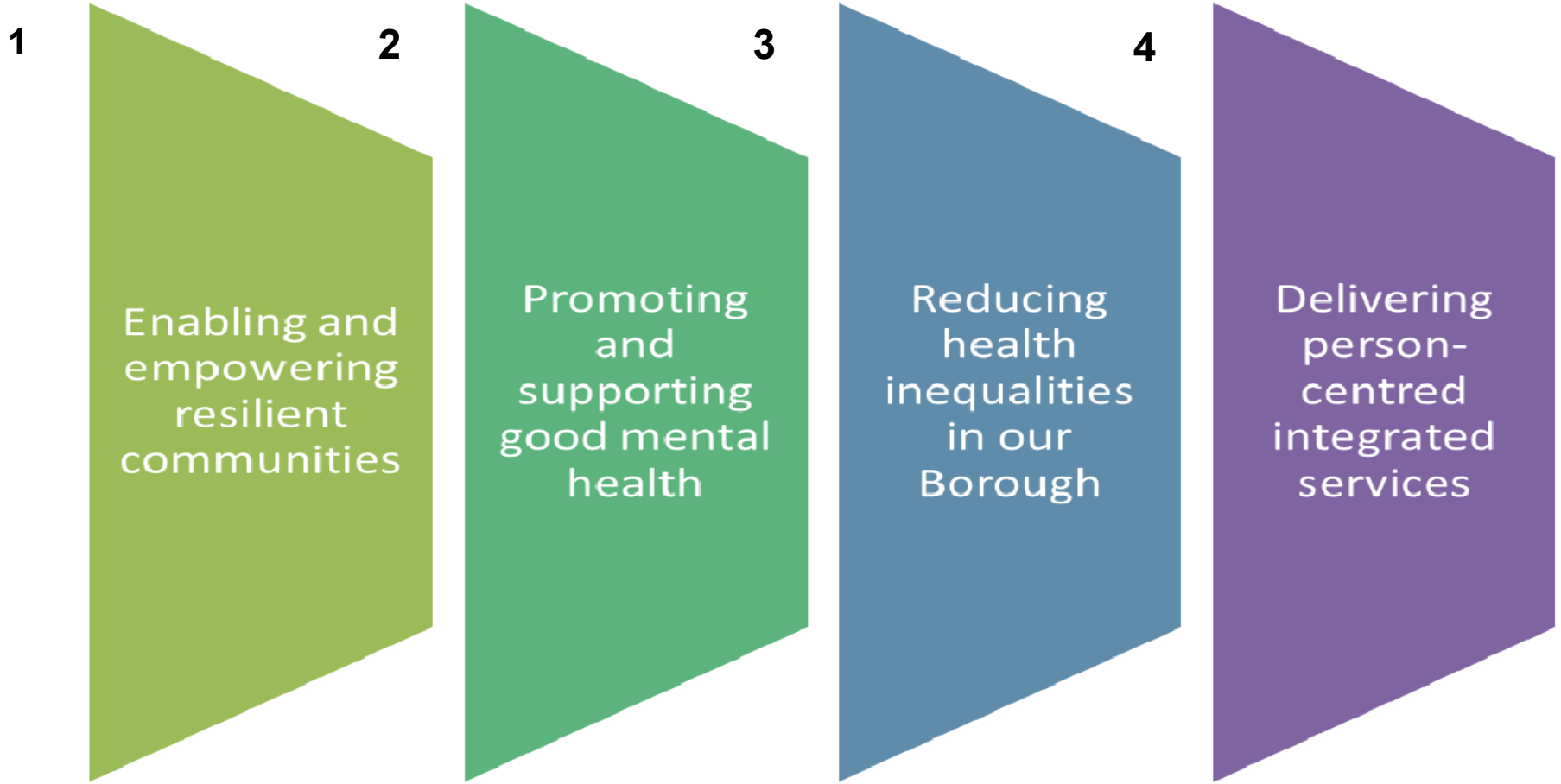
# *Our Priorities*



## MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

| | |
|---|---|
| Nick Campbell-White | Healthwatch |
| Richard Dolinski | Executive member for Adult Social Care |
| Darrell Gale | Acting Strategic Director of Public Health for Berkshire |
| Charlotte Haitham Taylor | Leader of the Council |
| David Hare | Opposition Member |
| Pauline Helliar-Symons | Executive Member for Children's Services |
| Nikki Luffingham | NHS England |
| Clare Rebbeck | Voluntary Sector and Place and Community Partnership Representative |
| Katie Summers | Director of Operations, Berkshire West CCG |
| Shaun Virtue | Community Safety Partnership |
| Dr Cathy Winfield | NHS Berkshire West CCG |
| Debbie Milligan | NHS Berkshire West CGC |

| ITEM NO. | WARD | SUBJECT | PAGE NO. |
|---|---|---|---|
| **1.** | None Specific | **ELECTION OF CHAIRMAN 2018-19**<br>To elect a Chairman for the 2018-19 municipal year. | |
| **2.** | None Specific | **APPOINTMENT OF VICE CHAIRMAN**<br>To appoint a Vice Chairman for the 2018-19 municipal year. | |
| **3.** | | **APOLOGIES**<br>To receive any apologies for absence | |
| **4.** | None Specific | **MINUTES OF PREVIOUS MEETING**<br>To confirm the Minutes of the Meeting held on 5 April 2018. | **7 - 16** |
| **5.** | | **DECLARATION OF INTEREST**<br>To receive any declarations of interest | |
| **6.** | | **PUBLIC QUESTION TIME**<br>To answer any public questions<br><br>A period of 30 minutes will be allowed for members of the public to ask questions submitted under notice.<br><br>The Council welcomes questions from members of the public about the work of this Board.<br><br>Subject to meeting certain timescales, questions can relate to general issues concerned with the work of the Board or an item which is on the Agenda for this meeting. For full details of the procedure for submitting questions please contact the Democratic Services Section on the numbers given below or go to www.wokingham.gov.uk/publicquestions | |

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| **6.1** | None Specific | Bill Luck has asked the Chairman of the Health and Wellbeing Board the following question:<br><br>**Question:**<br>With the concerns being expressed by local residents about delays in getting to see a doctor, are there sufficient numbers of doctors in general practice in the Borough to serve all the current residents and are there any new surgeries planned to serve the significant new development in the Borough, or any shortfall in the current provision, and, if so, are any CIL funds earmarked for such provision? | |
| **7.** | | **MEMBER QUESTION TIME**<br>To answer any member questions | |
| **8.** | None Specific | **HEALTH AND WELLBEING BOARD REFRESH**<br>To consider a Health and Wellbeing Board Refresh. *(20 mins)* | **17 - 32** |
| **9.** | None Specific | **BICESTER HEALTHY NEW TOWN PRESENTATION**<br>To receive a presentation on Bicester Healthy New Town. *(20 mins)* | **33 - 54** |
| **10.** | None Specific | **DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT 2018**<br>To receive the Director of Public Health's Annual Report 2018. *(15 mins)* | **55 - 80** |
| **11.** | None Specific | **JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2018 UPDATE**<br>To consider the Joint Strategic Needs Assessment (JSNA) 2018 update *(15 mins)* | **81 - 254** |
| **12.** | None Specific | **HEALTH AND WELLBEING PERFORMANCE DASHBOARD**<br>To receive the Health and Wellbeing Performance Dashboard. *(15 mins)* | **255 - 274** |
| **13.** | None Specific | **BCF KEY ACHIEVEMENTS 2017-18**<br>To receive a report regarding Better Care Fund Key Achievements 2017-18. *(15 mins)* | **275 - 290** |
| **14.** | None Specific | **HEALTH AND WELLBEING BOARD ANNUAL REPORT 2017-18**<br>To receive the Health and Wellbeing Board Annual Report 2017-18. *(10 mins)* | **291 - 300** |
| **15.** | None Specific | **UPDATE FROM BOARD MEMBERS**<br>To receive updates on the work of the following Board members: | **301 - 302** |

- Place and Community Partnership;
- Voluntary Sector;
- Community Safety Partnership;
- Healthwatch Wokingham Borough.

*(20 mins)*

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| **16.** | None Specific | **FORWARD PROGRAMME**<br>To consider the Board's work programme for the remainder of the municipal year. *(5 mins)* | **303 - 306** |

**Any other items which the Chairman decides are urgent**
A Supplementary Agenda will be issued by the Chief Executive if there are any other items to consider under this heading

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**MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 5 APRIL 2018 FROM 5.00 PM TO 7.10 PM**

**Present**

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| Nick Campbell-White | Healthwatch |
| Richard Dolinski | Executive member for Adults' Services (Chairman) |
| Darrell Gale | Acting Strategic Director of Public Health for Berkshire |
| Charlotte Haitham Taylor | Leader of the Council |
| Ian Pittock | Opposition Member |
| Clare Rebbeck | Voluntary Sector representative |
| Paul Senior | Interim Director People Services |
| Dr Cathy Winfield | NHS Wokingham CCG |

**Also Present:**

| | |
|---|---|
| Madeleine Shopland | Democratic and Electoral Services Specialist |
| Jim Stockley | Healthwatch Wokingham Borough |
| Dr Debbie Milligan | NHS Wokingham CCG |
| Julie Hotchkiss | Interim Consultant in Public Health |
| Barrie Patman | |
| Graham Ebers | Director of Corporate Services |

**74. APOLOGIES**

An apology for absence was submitted from Councillor Mark Ashwell.

**75. MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting of the Board held on 8 February 2018 were confirmed as a correct record and signed by the Chairman.

**76. DECLARATION OF INTEREST**

There were no declarations of interest.

**77. PUBLIC QUESTION TIME**

In accordance with the agreed procedure the Chairman invited members of the public to submit questions to the appropriate Members.

**77.1 Tracey Stone had asked the Chairman of the Health and Wellbeing Board the following question. Due to her inability to attend a written answer was provided by the Interim Director of People Services:**

**Question**

I am hearing conflicting information on the waiting list for CAHMs support in Wokingham. My daughter is eleven and suffers from anxiety and OCD and I was told by my GP that the waiting list for CAHMs could be up to eighteen months so I was offered support from ARC

counselling for six sessions instead which we took but now their funding also seems to have been cut as that is no longer available to me either. Upon attending the workshop on children and young people's mental health on 14 March in Woodley I heard from the CAHMs team presenting there on two occasions during their talks both on stage and in the workshops that the waiting list is around one year. I was then informed that at the last meeting of the Health and Wellbeing Board it was stated the waiting list was now only six weeks. I am now having to pay Cardinal Clinic £350 for each psychiatrist appointment and then £100 for each psychologist appointment following that, can you clarify the time frames for the waiting list and also what is being to address the long waits in the Borough?

**Answer:**
I as the Director of People Services am not directly responsible for CAMHS, CAMHS being Children and Adolescent Mental Health Services, but naturally we do work closely as a local authority with our CCG partners in designing our workstreams around the needs of our children and young people. I have canvassed the views of our CAMHS colleagues to inform the response and I am happy to make sure that Tracey does get full sight of the response but I will read it as if she were here.

Naturally as a local partnership working with our most vulnerable children and people and families we are disappointed and sorry that she has found the process of finding the right support for her child so difficult and appreciate the level of frustration she must have felt with the system. Our colleagues, the CCG, continues to work with GP's to update them on the availability and waiting times of CAMHS services and will take her question as a reminder of the importance to continue to do this. However to provide Tracey with clear information now on the current arrangements for accessing CAMHS as well as local youth counselling services, I am just going to break it down:

In order for a child to access support for Anxiety and Depression from CAMHS, firstly there requires a referral to the Berkshire Healthcare Foundation Trust (BHFT) common point of entry (CPE). The average waiting time in CPE if not an urgent case, based on assessed criteria, is 5 weeks. Once the child has been referred onwards from CPE to the Anxiety and Depression pathway, it is currently, and as this was written, 13 weeks, until the children and family have their first session with the specialist from the anxiety and depression team, for routine cases.

There are currently 70 children waiting to start an intervention on the Anxiety and Depression pathway, with 48 of these (69%) waiting under 12 weeks. This information was accurate as of the end of December 2017 from the end of the Q3 performance report from the Trust.

At the February 2018 Health and Wellbeing Board meeting the CCG and local authority reported progress against the Future in Mind programme. In this report it included waiting time data but that was from Q2 which is at the end of October. At that the time, the average waiting time at this point for CPE was 3 weeks and for the Anxiety and Depression pathway was 10 weeks, and remember that was Q2. Obviously wait times change regularly and recently have increased from Q2 to Q3, but this is mainly due to the consistent increase of referrals into CPE, currently managing an 18% increase on this time in terms of demand on last year, as well as increasing numbers of complex referrals and therefore the need for multidisciplinary interventions and longer care packages.

Lastly, to conclude, both the local authority and the CCG have funded ARC youth counselling service and there has been no reduction in funding for the next financial year,

2018-19, for this service and so we would expect the service to continue to be available to local residents as it is now. The local authority and CCG have regular contract monitoring meetings with ARC so we will look into your experience and work to ensure that this is avoided in the future.

The Interim Director People Services indicated that he would be commissioning the development of a CAMHS Improvement Plan. Dr Winfield requested that this work be located within the Future in Mind Group.

Nick Campbell-White indicated that some people had informed Healthwatch that they had found it difficult to access the Common Point of Entry. He was asked to provide any specific information to the Interim Director of People Services.

With regards to ARC Clare Rebbeck asked whether 6 sessions was standard. Paul Senior commented that he hoped that it was based on the individual needs. Clare Rebbeck also indicated that a community CAMHS awareness event had been held two years previously and that information regarding the different providers was on the Wokingham Direct website.

**77.2 Anne-Marie Gawen asked the Chairman of the Health and Wellbeing Board the following question which was answered by Interim Director of People Services:**

**Question**
"The "Together - Wokingham Your Way" service - (which supported people in Wokingham Borough who were recovering from mental illness in the community, individually or in groups,) has had its service ended prematurely.

What interim service is there in place now to replace it, manage the impact of its closure and to avoid any risks to those in need of the withdrawn service, and how is the "saved" allocated budget being used to provide alternative services to those who need them now?

I understand that there is an aspiration for a mental health Recovery College in Wokingham Borough and that it is hoped to be opened in September 2018. This will provide recovery services, though not the one to one support provided by Wokingham Your Way. September is a long way off, and there are no guarantees that September will see the Recovery College opening. On opening it will inevitably need to build up slowly, so a full service will not all be immediately available then.

I am very concerned that those existing clients of Wokingham Your Way will be required to travel further (I understand Reading Your Way has an interim role until June) and new people may fall through the gap and not receive a service at all. I am aware that people are currently in distress and struggling following the closure of Wokingham Your Way and would like to be able to let them know what support is available to them.

**Answer:**
Because it is quite a complex, wide ranging question, I have broken it down to four categories.

***Q1. "The "Together - Wokingham Your Way" service - (which supported people in Wokingham Borough who were recovering from mental illness in the community, individually or in groups,) has had its service ended prematurely.***

1. WBC Response
The mental health recovery, day support and outreach service was commissioned in 2016 via a competitive tender process. The contract was awarded to Together for Mental Wellbeing (Together) and the service, named Wokingham Your Way, commenced on 1 November 2016 for a period of one year until 31st October 2017 with a possible extension of up to one year.

The service was established and it became apparent around June 2017 that the service had not been meeting the targets of 75% of service provision, as set out in the service specification.

Consequently, the People Commissioning team worked with Community Mental Health Team (CMHT) and Together and in October 2017 we had an agreed service improvement plan with the provider in place. Shortly after this, Together issued notice to terminate the contract having decided they could not continue, even with the full support of Wokingham Borough Council.

Whilst the contract for the 'Wokingham Your Way' service ended on 12 January 2018, we awarded a contract to Together via 'Reading Your Way' to continue to deliver a service from 15 January. Although this is a reduced service, customers are still able to access support via group sessions and 1.1 support. This arrangement is being reviewed regularly and will be amended as appropriate in response to local needs if needs escalate.

***Q2. What interim service is there in place now to replace it, manage the impact of its closure and to avoid any risks to those in need of the withdrawn service, and how is the "saved" allocated budget being used to provide alternative services to those who need them now?***

Q2 WBC Response
A series of exit meetings were set up between Together, People Commissioning and CMHT to agree the move on plan for each individual who was accessing the service and ensure a safe way to exit from the support of the Together service. During the course of these meetings, a short term proposal for CMHT to spot purchase support from the Reading Your Way office in order to allow the support groups to continue as well as some 1:1 support was put forward. CMHT reviewed this and accepted the proposal as a safe and viable option. Customers were consulted about the changes, the reasons for them and their view on the temporary service.

A short term contract has been awarded to Together via the Reading Your Way service with effect from 15 January for a 5 month period with a 3 month extension, dependant on success and need.

The contract permits CMHT to spot purchase up to 10 hours per week for a named support worker to deliver group sessions and 1:1 support as required. As a result of the consultation with customers we know that the groups were important to them, so the groups have continued.

I am running out of time so I have time for one more response and I have a hard copy here that I can give you.

***Q3 I understand that there is an aspiration for a mental health Recovery College in Wokingham Borough and that it is hoped to be opened in September 2018. This will provide recovery services, though not the one to one support provided by Wokingham Your Way. September is a long way off, and there are no guarantees that September will see the Recovery College opening. On opening it will inevitably need to build up slowly, so a full service will not all be immediately available then.***

Q3 WBC Response
One key area of consideration is the establishment of a community Recovery College to focus on emotional, educational and physical needs and teach skills to regulate good mental health and further research will be carried out in the spring. CMHT have explored extensively various models of Recovery Colleges. A Recovery College can be structured in a way that suits the needs of our residents, so if 1:1 is identified as a need this can be built in. The current arrangement with Together has the option to be extended if needed, with the possibility of this phasing out as the new Recovery College launches. People Commissioning and the CMHT are working closely in order to develop a proposal for the new service. Customers, carer and families' feedback and input will be key to developing and shaping these proposals and further consultation events will be held.

**Supplementary Question:**
My concern is around this gap that is currently occurring because people who were accessing Wokingham Your Way have come to let me know that they have not been provided with a service and their mental health needs are quite significant, they cannot leave their home for instance so they possibly were not part of the various meetings that were held. The person in particular that I am thinking of says that the only thing that he can see is to access the Optalis jobs support scheme, but he is not well enough for that yet and his service has been cut. I do not know what to say to him.

**Supplementary Answer:**
Naturally I cannot comment on an individual case of that nature which has been brought to my attention for the first time. The Officers have assured me that they have been working on the exit strategy with all of the previous users of the service, and if there is someone whose needs have not been met and may have fallen between the gaps then if you let me know the information then I will ensure that it is forwarded to the Team Managers to follow up on that. I am sure that we will have a bespoke response on that. The intention is to make sure that no user suffers detriment as a result.

## 78. MEMBER QUESTION TIME
There were no Member questions.

## 79. HEALTH AND WELLBEING BOARD REFRESH
Graham Ebers, Director Corporate Services presented a report regarding a refresh of the Health and Wellbeing Board.

During the discussion of this item the following points were made:

- The Board was advised that interviews would be held shortly for a post that would support both the Health and Wellbeing Board and the Children's and Young People Strategic Partnership (approximately 0.5 FTE each). It was hoped that an appointment would be made in May.
- The Board discussed training. It was noted that a Board wide bespoke training session would be organised to take place before the end of June. In addition the Chairman and

Vice Chairman would undertake a Leadership course in July. A Self-Assessment workshop would be held in October (in the context of the 2020 integration strategy).

- A workshop around integration was being arranged for the last week of May. Members of the Reading and West Berkshire Health and Wellbeing Boards would be invited to this. Dr Winfield requested that the CCG be involved in the planning of the integration workshop to help tailor it accordingly. There were only eight Integrated Care Systems in the country, including Berkshire West and it was important that the Health and Wellbeing Board was sufficiently engaged in this work as the consequences were potentially significant for all partners.
- Paul Senior, Interim Director People Services indicated that full integration was scheduled to be achieved by 31 March 2020. Wokingham was one of five local areas that had been invited to discuss the forthcoming Green Paper on Integration. Wokingham had a number of integration success stories including the Wokingham Integration Strategic Partnership, the Wokingham Integrated Social Care and Health Team and Community Health and Social Care.
- The Integration Strategy would set out the key milestones in integration.
- The Board discussed engagement with the public and branding of the Health and Wellbeing Board. Graham Ebers took the Board through some of the events undertaken by the Community Safety Partnership. It was proposed that a 'Big Tent' event be run annually, incorporating a range of relevant service providers. In addition it was hoped that a combined Health and Wellbeing Board events calendar would help to ensure that opportunities were maximised and that duplication was avoided.
- Darrell Gale, Acting Strategic Director Public Health Berkshire, introduced a revised dashboard. With regards to residents' perception of the fear of crime, Darrell Gale commented that the Health and Wellbeing Board could produce a bespoke online survey on this matter. Dr Milligan questioned whether all vulnerable residents would have access to the internet and was informed that approximately 95% of Borough residents had internet access.
- Councillor Haitham Taylor stated that the dashboard was still very health orientated. She indicated that the fear of crime did not just affect vulnerable residents. With regards to reducing health inequalities she commented that greater reference could be made to prevention pre birth and the role of education. Graham Ebers commented that these suggestions could be incorporated if not captured elsewhere.
- Clare Rebbeck commented that physical and emotional wellbeing were different concepts for different people, and questioned how this could be compared and benchmarked.
- The Board agreed that a short dashboard supported by more detailed action plans for different issues was the preferred approach.
- The Board was updated on the review of the Joint Strategic Needs Assessment.
- It was proposed that the Board's key priorities were allocated to a Councillor and Officer Board member, in order to enhance governance.

**RESOLVED:** That the Health and Wellbeing Board note and support the actions to refresh the Health and Wellbeing Board Agenda.

**80. ADULT SOCIAL CARE STRATEGY PROPOSED PRIORITIES**

Paul Senior, Interim Director of People Services provided an update on the Adult Social Care Strategy Proposed Priorities.

During the discussion of this item the following points were made:

- Paul Senior indicated that the paper was a holding paper. A Department of Health Green Paper on Integration by 2020 was due. It was important that the Adult Social Care Strategy aligned with the Green Paper.
- The Board was taken through priority themes and potential pressures such as the fact that the Borough had an ageing population and financial constraints.
- Clare Rebbeck commented that the number of informal carers was likely to increase.
- Paul Senior referred to the possible impact of the Council's 21st century council project.
- The Strategy would be underpinned by an action plan.
- A further update would be provided at the June Board meeting.
- The use of technology in integration was discussed.
- In response to a question from Dr Winfield, Paul Senior indicated that a Workforce Development Strategy would also be produced.

**RESOLVED:** That the Adult Social Care Strategy Proposed Priorities be noted.

## 81. BERKSHIRE WEST HEALTHY WEIGHT STRATEGY: DEVELOPING A LOCALISED ACTION PLAN

Darrell Gale, Acting Strategic Director Public Health Berkshire presented a report which provided an outline/framework of the localised action plan for Wokingham and next steps to develop a comprehensive action plan.

During the discussion of this item the following points were made:

- A Berkshire West Healthy Weight steering group would be developed to ensure co-ordinated action across the locality.
- Board members were informed that the Sustainability Transformation Plan prevention workstream would be reflected in the localised action plan.
- Dr Milligan commented that the focus was primarily on activity and there needed to be increased reference to the importance of a healthy diet, starting at a young age with school children.
- Clare Rebbeck referred to a voluntary sector initiative which helped less active children to become active. Nick Campbell-White referred to a successful cooking scheme for single parents in Norreys.
- Councillor Pittock emphasised that the sugar tax on soft drinks had come into effect. However, there was still a lot of hidden sugar within foods.
- Councillor Haitham Taylor referred to Tier 3 services and commented that it was important that every contact was made to count in order to reduce obesity levels.
- Clare Rebbeck commented that a community awareness event focused on obesity could be held. She referred to the Harvest Festival event that the Place and Community Partnership would be holding.
- Darrell Gale reminded the Board of a successful pilot scheme run by Wokingham Medical Centre for some patients with diabetes.

**RESOLVED:** That the development of the localised Healthy Weight action plan for Wokingham be supported.

## 82. UPDATES FROM BOARD MEMBERS

The Board received updates on the work of the following Board members:

*Place and Community Partnership:*

- The Place and Community Partnership communications project was starting in April 2018. Raising awareness of the Health and Wellbeing Board and its role and key priorities would be central to the wider engagement piece. A theme each month to highlight positive resources and support available across the Borough would be delivered. This would be carried out on the second Monday of the month. Themes had been selected up to March 2019. The Place and Community Partnership could reach approximately 30,000 people via social media.

*Voluntary Sector:*

- Clare Rebbeck informed the Board that Involve had been involved in the Mayor's Ball and had helped to raise £10,000 for the Mayor's Charity.
- The Voluntary Sector and Place and Community Partnership had begun to attend Community Safety Partnership meetings.
- Board members were informed that changes to funding methods would potentially have a negative impact on a number of local organisations.

*Community Safety Partnership:*

- Graham Ebers outlined the partnership's main priorities.
- With regards to substance abuse, Councillor Haitham Taylor questioned whether there had been instances of drugs such as ketamine in the area. Graham Ebers commented that the use of cannabis and alcohol as well as Xanax (benzodiazepine) and in some instances traces of Class A substances (heroin and cocaine) had been found.
- Clare Rebbeck indicated that Involve would be running a Community Safety Partnership awareness event for the community and the agenda could feature an item on the fear of crime.
- It was confirmed that health representatives attended the Community Safety Partnership.
- With regards to the Drugs and Alcohol and Substance Misuse services, Dr Winfield commented that each of the three local authorities within Berkshire West commissioned their own services, and questioned whether better value for money could be achieved through joint commissioning. Paul Senior stated that scalability was vital for a local authority of Wokingham's size.

*Healthwatch Wokingham Borough:*

- Nick Campbell-White advised the Board that an article regarding Healthwatch Wokingham Borough had been included in the Borough News.
- Healthwatch Wokingham Borough had produced a report regarding Extra Care, making recommendations. However, Nick Campbell-White commented that the new manager of Fosters Extra Care facilities had been unaware of the report. Paul Senior, Interim Director of People Services requested that he be sent the report so that he could ensure that it was followed up.
- The Board was advised that Healthwatch Wokingham Borough would be publishing a report regarding the implementation of the Accessible Information Standards within the Borough, with particular attention being paid to the communication needs of deaf people. Recommendations for improvements had been made. Councillor Dolinski asked whether further work would be carried out with those with mobility issues or who were partially sighted. Nick Campbell-White indicated that anecdotal evidence had been received from the deaf community in particular.

**RESOLVED:** That the updates from Board members be noted.

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| **TITLE** | **Health & Wellbeing Board – Refresh** |
| **FOR CONSIDERATION BY** | Health and Wellbeing Board on 14 June 2018 |
| **WARD** | None Specific |
| **DIRECTOR/ KEY OFFICER** | Graham Ebers, Director Corporate Services, Darrell Gale, Interim Strategic Director of Public Health Berkshire, Katie Summers, NHS Wokingham CCG |

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| Health and Wellbeing Strategy priority/priorities most progressed through the report | This report is intended to progress all 4 of the key priorities |
| Key outcomes achieved against the Strategy priority/priorities | Refresh of; Governance, partnership working, alignment of Business cycles and approach to advance all 4 key priorities |

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| Reason for consideration by Health and Wellbeing Board | The Board's views and their support is considered to be critical to a successful refresh |
| What (if any) public engagement has been carried out? | None |
| State the financial implications of the decision | None specifically |

**RECOMMENDATION**

The Health and Wellbeing (H&W) Board are asked to note and support the actions to refresh the H&W Board Agenda.

**SUMMARY OF REPORT**

The Health and Wellbeing Board considered a paper to 'refresh' its activities and operations on, 5 April, 14 December and 8 February. This report provides an update on progress and actions to advance the key themes of: 'Governance', 'Partnership working' and 'other considerations'. The Health and Wellbeing Board are asked to note and support the actions to refresh the H&W Board Agenda and consider some related proposals.

**Background**

The Health and Wellbeing Board has considered proposals to refresh its' 'agenda' since 14 December. These considerations have been in relation to Governance, Partnership working and Other issues seen to be relevant to improving the effectiveness and the board and enhancing its community engagement (as set out below).

***Governance***

It is suggested that an enhanced vibrancy and enhanced focus could be added to the Health and Wellbeing Board agenda through:

(i) more focused and time limited agenda items;
(ii) agenda items clearly linked to one of the 4 key priorities within the Health and Wellbeing Strategy with clearly stated intended outcomes;
(iii) review of Terms of Reference of Health and Wellbeing Board;
(iv) greater public engagement/attendance through greater publicity and a more vibrant meeting (e.g. including short presentations from 'external' organisations);
(v) a longer term forward programme linked to delivering the 4 key priorities and visible to other partnership groups for awareness and contribution;
(vi) seeking to achieve an equitable consideration of all 4 key priorities through the Board Member Updates which include a cover sheet with intended outcomes against priorities;
(vii) review Health & Wellbeing performance dashboard based on best practice of other authorities.

***Partnership Working***

It is considered that an enhanced collective contribution toward the 4 key priorities could be achieved by:

(i) a stronger alignment of our respective business cycles;
(ii) renewed discussions with the sub groups of Health and Wellbeing Board around actions to achieve the 4 key priorities;
(iii) review of the attendance/representation at Health & Wellbeing Board;
(iv) visibility and input from 'external' organisations delivering on the Agenda (with a protocol for their contribution at the meeting).

**Other**

Further suggestions that may help with an ongoing 'refresh' include:

(i) LGA to provide tailored training around best practice
(ii) Site visits to other H&W Boards
(iii) Review resourcing capacity to support the facilitation, co-ordination and policy issues in respect of the Board.

**Analysis of Issues**

Key developments following the H&W Board meeting of 5 April are set out in bold below:

Health & Wellbeing Board Support

The Director of People's Services is seeking to create a resource that supports both the Health & Wellbeing Board and the Children's and Young People Strategic Partnership (approximately 0.5 FTE each). ***Appointment to this post has now been made***.

Training

The Local Government Association (LGA) has been approached (by the Strategic Interim Director of Public Health Berkshire) to facilitate training, following a skills audit. ***The LGA Self-assessment process "Stepping up to the place: Facilitated integration workshop" has started now with LGA representatives making scoping calls with key leaders, and the half-day workshop itself will be held on the afternoon of 2 July 2018. At the workshop further development needs will be identified and members will commit to future action. At the post event review further support will be discussed in the context of our 2020 integration strategy.***

Sites of Best Practice

The LGA were approached regarding a site of best practice and their advice was that it would be more productive to focus on the training suggested above. An appropriate site may flow from this training, but there is no suggested site at this stage.

Integration

There are 8 Integrated Care Systems across the country, 1 of which is Berkshire West (made up of West Berkshire, Reading and Wokingham). It is important that the H&W Board are sufficiently engaged in this work as the consequences are potentially significant for all partners. ***A Berkshire West wide workshop, including the Health and Wellbeing Boards of West Berkshire and Reading Councils, is being planned by Julie Hotchkiss and Dr Cathy Winfield, and a facilitator recommended by the LGA. The date will most likely will be in September.***

A further significant integration consideration is that of the Health and Social Care Strategy. A best practice model of integration should be based on the collective amalgamation or 'joining up' of front line staff, systems & processes, and leadership & management. The draft programme for the integrated strategy was reported in April. Full integration is scheduled to be achieved by 31st March 2020***.***

Public Engagement/Branding

Health & Wellbeing Board support, as previously referenced, will help with this on an ongoing basis (website presence etc), however it is recognised that promotion is rather fruitless without a 'product' worth promoting. Some of this relates to how well the Health & Wellbeing Board works collectively, engaging with its partnership community, however much also relates to the deliverables and achievements of the Health & Wellbeing Board. It was agreed to seek achievements from the sub groups of the Health & Wellbeing Board.

The Community Safety Partnership list of key achievements were reported in April. ***The Better Care Fund Programme annual performance that is overseen by the Sub Group WISP is reported elsewhere in this agenda.***

***Effective promotion and engagement should include both targeted and universal events. Within this approach it is proposed that a 'Big Tent' event is run annually which can incorporate a range of relevant service providers. A combined Health & Wellbeing Board events calendar will also help to ensure opportunities are maximised and duplication avoided. The Sub Groups are therefore requested to report their respective events calendars to the Health & Wellbeing Board.***

Dashboard of Key Indicators & Data for planning/outcomes

It is considered to more productive for Health & Wellbeing Board to have discussions around a small suite of meaningful indicators (ideally on 1 page), as opposed to pages of detail. If members of the Board required further detail, this could be provided outside of the meeting, or a particular area could be spotlighted at a future Board meeting.

***Building on discussions from the April Health & Wellbeing Board meeting, work has been undertaken to further develop the proposed indicators and gather the baseline data required to enable the Board to set targets where it chooses. A detailed report is presented later in the Agenda.***

A project is currently underway to review our Joint Strategic Needs Assessment (JSNA) data sets. This project involves input from different servicers across the Council and from our key partners. JSNA data will be reported to the H&W Board and will provide information regarding trends, unmet needs and progress against measures taken to address. The timetable for the JSNA project is shown below:

Mid November 2017 – Completion of Borough Profile draft
Early January 2018 – Completion of Starting Well (maternity and 0-4 year olds) draft
Mid March 2018 – Completion of Developing Well (children and young adults) draft
Late April 2018 – Completion of Living and Working Well (adult population) draft
Late May 2018 – Completion of Ageing Well (older population) and People and Places drafts
Late June 2018 – Reviewing all chapters, adding outstanding information. Get JSNA document ready for sign off
Early August 2018 – Uploading all chapters with latest data online

***The draft JSNA chapters are being presented as a separate item in this agenda, seeking input from Board members.***

Health & Wellbeing Board Key Priorities

To enhance our governance it is suggested that each of the Health & Wellbeing Board key priorities are allocated to a Councillor Member of the H&W Board and an appropriate officer. This is intended to improve accountability and deliverability. It is proposed that the key priorities are allocated as follows: ***Enabling and empowering resilient communities (Charlotte Haitham Taylor/Graham Ebers); Promoting & Supporting good mental health (David Hare/Martin Sloan); Reducing Health inequalities in our Borough (Pauline Helliar-Symons/Darrell Gale); Delivering person centred integrated services (Richard Dolinski/Martin Sloan/Katie Summers).***

Other

Following the progression of the integrated Health and Social Care strategy and the appointment of the much needed support to the Board, other issues around the themes of Governance and Partnership Working can be taken forward. This will lead to a complete Action Plan that is reported back to every Board meeting and informs the Forward Programme of future agenda items. Specific issues yet to address, includes the mapping of all sub groups and task groups (how they align to the business of the H&W Board) and establishing a new terms of reference for the Health & Wellbeing Board aligned to its 4 key priorities (including a review of membership).

| **Partner Implications** |
|---|
| It is important that all relevant partners feel engaged with and contribute to both the 'refresh' and the new ways of working. |

| **Reasons for considering the report in Part 2** |
|---|
| None |

| **List of Background Papers** |
|---|
| Peer Review |

| | |
|---|---|
| **Contact** Graham Ebers | **Service** Corporate Services |
| **Telephone No** 0118 974 6557 | **Email** graham.ebers@wokingham.gov.uk |
| **Date** 4 June 2018 | **Version No.** 0119 974 6557 |

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## Wokingham HWBB Community Engagement

| | April | May |
|---|---|---|
| Facebook Likes | 8 | 12 |
| Facebook Follows | 10 | 17 |
| Facebook Reach | 30 | 224 |
| Facebook Interactions | 4 | 15 |
| | | |
| Twitter Follows | 25 | 42 |
| Twitter Reach | 7.9K | 17.8K |
| Twitter Interactions | 8 | 24 |

4th April

The #WokinghamHWBB will share news & information on the 2nd Monday of each month throughout 2018. On April 9th it's our first online event for people to share news, info, advice & events, following the theme of #ActiveApril 🏃 ! #Woky @WokinghamHWBB #ThursdayThoughts


4 retweets 2 likes

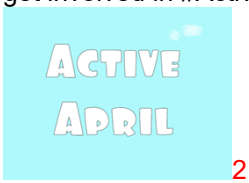
5th April

Want to get involved with the #WokinghamHWBB ? Send a message to @WokinghamHWBB to get in touch with our co-ordinators, who will advise you on how you can get involved in sharing great news & messages on the 2nd Monday of each month! #Woky


2 retweets 3 likes

6th April

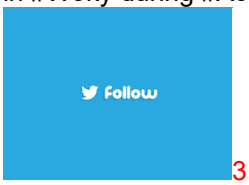
In 3 days time we'll be having our first #WokinghamHWBB ! Follow @WokinghamHWBB to stay updated on ways to get involved in #ActiveApril 🏃 ! #FridayFeeling #Woky




2 retweets 1 like

9th April

Todays the day! It's our first #WokinghamHWBB event! Be sure to follow this account to learn about what's going on in #Woky during #ActiveApril 🏃 !




3 retweets 2 likes

Want to get involved with a walking event next month? On May 13th 2018 the @WokinghamWalk is being held, starting from Howard Palmer Gardens, to raise money for the Ollie Young Foundation. A great way to #KeepActive! https://buff.ly/2HZ3X2o #WokinghamHWBB #ActiveApril 🏃 #Woky


Did you know that every week there are 18 volunteer led walks across Wokingham Borough? These walks can help improve your health by walking briskly. Find out how you can join in on the @healthywalks website: https://buff.ly/2FXZn7R #WokinghamHWBB #Woky #ActiveApril 🏃

Over 60? Want to rekindle a love of cycling or just get out and about in the fresh air with like-minded people? SHINE over 60's rides start on 18th April! Visit the @MJWokingham website to find out more: https://buff.ly/2Gk8uiU #WokinghamHWBB #Woky #ActiveApril 🏃

2 retweets 1 like

Interested in #Woky 's countryside, parks & conservation? 🌳 Every Wednesday, conservation #volunteers assist with many practical tasks, improving the local environment while keeping active. Find out how to join in: https://buff.ly/2q9qoL3 #WokinghamHWBB #ActiveApril 🏃

The Green Gym is a way to get physically active, benefitting your health, wellbeing, community & local environment. 🌱 There is one in Reading with it's next activity being held on April 28th: https://buff.ly/2pw3vC4 @TCVGreenGym #ecotherapy #WokinghamHWBB #Woky #ActiveApril 🏃

3 retweets 5 likes 1 reply

Looking for an activity that's a bit quieter & less active? @WBC_Libraries have various book groups which meet in different places throughout the month. Visit the @WokinghamBC website for more information & how to join: https://buff.ly/2pBHfXl #WokinghamHWBB #ActiveApril 🏃 #Woky

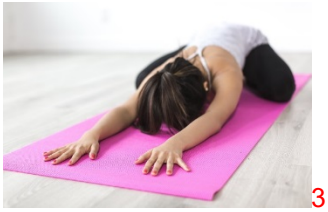
4 retweets

Looking for a relaxing activity? The @havenwellbeing Hub run various therapies & classes such as Yoga, Pilates, Meditation & more, a great place to find something calming for you to do locally: https://buff.ly/2pyL3Zl #WokinghamHWBB #Woky #ActiveApril 🏃

2 retweets 1 like 1 reply

In the May bank holiday, @WokinghamActive Kids are running a sport camps during at Loddon Valley Leisure Centre. Children aged 5 to 12 can attend. Find out more & how to apply here: https://buff.ly/2HZ4QIp #WokinghamHWBB #Woky #ActiveApril 🏃

Every Tuesday evening, Kokopelli Yoga run #yoga sessions for people with #additionalneeds at Finchampstead Baptist Centre. If you or someone you know might be interested in joining in with these sessions, click here: https://buff.ly/2pyruPW #WokinghamHWBB #Woky #ActiveApril 🏃



3 retweets

Interested in swimming? Why not try Open Water Swimming at @WokinghamDAC ? Plunge into the open water for an invigorating swim on Wednesday evening. 🏊 https://buff.ly/2G7aGH3 #WokinghamHWBB #Woky #ActiveApril 🤾

Yoga sessions in #Woky starting today at 3-4pm, running every Monday until 30th April at the Earley Crescent Resource Centre. This is a 4 week trial by @sportinmind & if its successful they'll look to extend the session & run weekly from June! #WokinghamHWBB #ActiveApril 🤾

2 retweets 4 likes

Still stuck for things to do or ways to have an #ActiveApril 🤾? @GetBerksActive have an Activity Finder which shows organisations & events that occur all across Berkshire. Check it out to find your perfect way to #GetActive : https://buff.ly/2qbOnJn #WokinghamHWBB

2 retweets 4 likes

Need to reduce your stress levels? Want to learn techniques to relax & increase your happiness? @PranicUK run #Relaxation & #StressRelief Sessions at St Sebastian's Memorial Hall on the 1st & 3rd Thursday of every month. Next session is 19th April. #WokinghamHWBB #ActiveApril🤾


10th April

Thank you to everyone who shared things yesterday as part of #ActiveApril 🤾! Be sure to keep sharing appropriate things going on in #Wokingham using the hashtag #WokinghamHWBB ! Next month we're showcasing #MayEvents🗓 on May 14th. #SavetheDate


2 retweets

13th

What did you think of the #WokinghamHWBB on Monday? Let us know your thoughts by sending us a message through Facebook or Twitter & we'll try and make improvements so that #MayEvents🗓 on May 14th will be even better! #FridayFeeling #Woky


3 retweets 2 likes

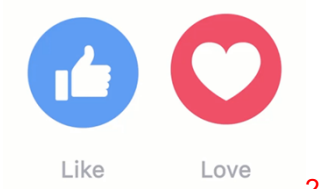
16th

Be sure to let all your friends & family know about the #WokinghamHWBB ! It's a great place for locals to learn about & share news, events & info from all across #Wokingham ! Why not aim to tell three people about #MayEvents🗓 this week?#MondayMotivation

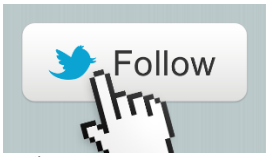
5 retweets 2 likes

19th

Do you like the idea of our #WokinghamHWBB but don't use Twitter enough to keep up to date? Be sure to like our Facebook page too for another way to stay in the know: https://buff.ly/2vb4WuF #ThursdayThoughts #Woky



2 retweets




24th

Want to know more about the #WokinghamHWBB and why it's important? This article from @TheKingsFund explains what #HWBB 's are and why they're relevant: https://buff.ly/2pzlGXn #Woky #TuesdayThoughts

2 retweets

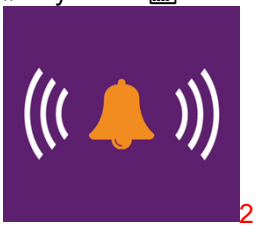
27th

Our aim is to help keep local people happy & healthy! If your friends or family are looking for local events or services in #Wokingham, why not tell them about #WokinghamHWBB? We'll be sharing #MayEvents🗓 on May 14th, so be sure to follow us on Twitter & Facebook! #FridayFeeling

1 retweet

30th

If you have any #Wokingham events that are occurring over the next few months, then be sure to let us know! Send us a direct message or use the hashtag #WokinghamHWBB to get involved, & help spread the word in #Woky about #MayEvents🗓 on May 14th! #MondayMotivation


2 retweets

**May**

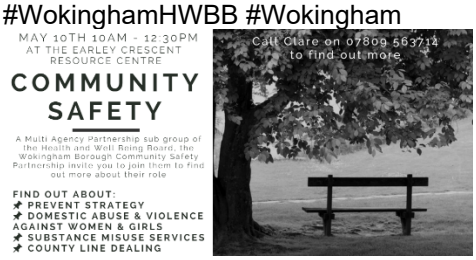
2nd

If you're looking for new fun things to do in #Wokingham over the next few months & into summer, you should be following the #WokinghamHWBB ! This month we'll be showcasing #MayEvents on May 14th, so be sure to get involved in sharing local news & activities! #WednesdayWisdom

2 retweets

5h

This Thursday, we're having a #CommunitySafety event. Come along to find out about prevent strategy, domestic abuse & violence against women & girls, substance misuse services & county line dealing. #MayEvents #WokinghamHWBB #Wokingham




2 retweets 2 likes

7th May

Only 1 week to go until #MayEvents ! We hope you're all having fun & staying safe in the sunshine, especially those of you at the Wokingham May Fayre! Be sure to keep sharing our pages & events over the next week, ready for Monday 14th May! #WokinghamHWBB #MondayMotivaton

1 like

9th

May is #WokinghamCulturalMonth 2018, with events occurring regularly to celebrate arts & culture in #Wokingham. Check out the calendar of upcoming #MayEvents : https://buff.ly/2riAU3T #WokinghamHWBB @LoveWokingham #WednesdayWisdom


3 retweets 3 likes

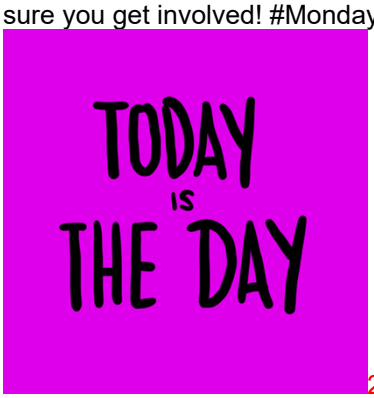
11th MayHave you been following #WokinghamHWBB? In just 3 days time we'll be having our second Health & Wellbeing Board online event, where people can share news & info on keeping healthy in #Woky. This month's #MayEvents ! Follow @WokinghamHWBB to get involved! #SaturdayMotivation


1 like

12th
Tomorrow is the @WokinghamWalk , which is raising money for @OllieYoungOYF , which supports paediatric brain tumour research. You can register on the day between 9am & 10:30am for this great #Woky event: https://www.wokinghamwalk.co.uk/ #WokinghamHWBB #MayEvents📆

1 retweet 2 likes

14th May
#TodayistheDay !! 🎉 Follow the hashtags #WokinghamHWBB & #MayEvents📆 to find out all about what's going on across #Wokingham over the next few months! We'll try and share as many of your posts as possible too so make sure you get involved! #MondayMotivation




2 retweets

#WokinghamBikeathon is a not for profit organisation run by volunteers & supported by local businesses, charities and organisations. This year it's on Sunday 24th June at Cantley Park. Sign up now: https://buff.ly/2ryetXH @Wokinghambike #WokinghamHWBB #MayEvents📆

Want to learn more about hedgehogs & how you can help protect the local wildlife? @HappyHedgehog3 in Yateley are attending many upcoming events to showcase their work, with the next one being The Surrey Heath Show this Saturday: https://buff.ly/2KOvs0E #WokinghamHWBB #MayEvents📆


1 retweet

The @SainsburySinger are a #MusicalTheatre group in #rdguk. Their next show, Anything Goes, will be at @TheHexagon Theatre, in #Reading, 16th-19th May 2018. Visit their website for more info or if interested in joining in: sainsburysingers.org.uk #WokinghamHWBB #MayEvents📆

3 rewteets 5 likes 1 reply

Want to take part in an event that'll raise money for a local charity? @Daisys_Dream have loads of events going on throughout the year that you can attend to help raise money: https://buff.ly/2rzsOmG All funds go towards supporting bereaved children. #MayEvents📆 #WokinghamHWBB

2 likes

There's also lots of events going on to raise money & awareness for @WokinghamLVS , who want to celebrate the work the organisation & it's volunteers have been doing to help lonely people in #Wokingham for 20 years: https://buff.ly/2IxAWyU #WokinghamHWBB #MayEvents📆

June 30th is the @samaritans #Run at Easthampstead Park Community School, Bracknell. Help support the work they do across #Bracknell, #Wokingham , #Ascot & other local areas by signing up: https://buff.ly/2jLz0Vl #WokinghamHWBB #MayEvents📆 @bracknellsamst1 @ReadingSams

The Loddon Valley @RamblersGB run various walks to keep local people active & happy. Find out how you can join in with their next walk or other events on their website: http://www.lvra.org.uk #WokinghamHWBB #MayEvents📆

1 retweet

The @alexanderdevine Children's Hospice Service are building a hospice service for the children of Berkshire and beyond. They've got many events coming up to raise awareness of their organisation: alexanderdevine.org #WokinghamHWBB #MayEvents📆


Bring the kids along for a fun packed few hours at @wadedaycentre 's Summer Fair on June 30th! There will be a variety of stalls, raffles, tombolas & toys. Refreshments are also available plus free parking at Masonic Centre. https://buff.ly/2KPaAXr #WokinghamHWBB #MayEvents📆

Coming up on May 26th , there's a #Wokingham #FunDay , a free event for the children of #Woky at Langborough Recreation Ground. Come along for face painting, magic shows, petting zoo, fairground rides, candyfloss & lots of fun! #WokinghamHWBB #MayEvents📆

1 retweet 1 like

On June 2nd, #ArtFest is coming to the Broad Street in #Wokingham. This is a unique & free festival of art, showcasing many wonderful artists' work. Paintings, limited-edition prints, ceramics, demonstrations & much more! #WokinghamHWBB #MayEvents@ArtFestWoky


After #ArtFest, the #Wokingham International Street Concert will return for its 5th year in the Town Centre at 6pm. There's an international lineup of original & cover artists performing rock, pop, motown, ballads, & jazz. Come & dance the evening away! #WokinghamHWBB #MayEvents


The @TwyfordBeerFest is a #Charity Beer #Festival raising funds for the Men's Cancer Charity @OrchidCancer - https://buff.ly/2qol72r 70 Beers and 10 great bands over 2 days of fun! #WokinghamHWBB #MayEvents


3 rewteets 1 like

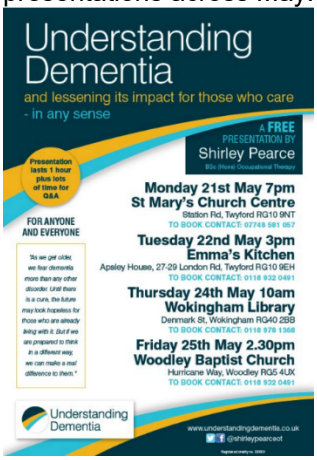
Every other year #Crowthorne hosts one of the biggest village #carnivals. From July 7th, a week-long programme of events culminates with a carnival procession & fete on the recreation field in the centre of town. www.crowthornecarnival.org#WokinghamHWBB #MayEvents


If you're looking for a more local festival, the #WokinghamFestival is occurring on August 24th-26th at Cantley Event Field. Advanced Booking for 2018 tickets opened 10th May. Get your #EarlyBird ticket now: https://buff.ly/2ru6ScK @wokinghamfest #WokinghamHWBB #MayEvents


Interested in something a bit different? @Understandingdm are having a barn dance this Saturday to raise money. What a great excuse to get your dancing shoes on! 🕺 Contact @shirleypearceot for details. #WokinghamHWBB #MayEvents


1 reply

Do you want to learn more about #Dementia & how to lessen it's impact? @Understandingdm are having free presentations across May. Contact @shirleypearceot for details & to book. #WokinghamHWBB #MayEvents📆



1 like

Next week is #DementiaActionWeek . There're many things going on locally including Dementia suitable showing of 'Still Alice' at @southhillpark on Weds & a talk from @alzheimerssoc about @DementiaFriends at @Involve_BF 's Activity Cafe on Thurs. #WokinghamHWBB #MayEvents📆

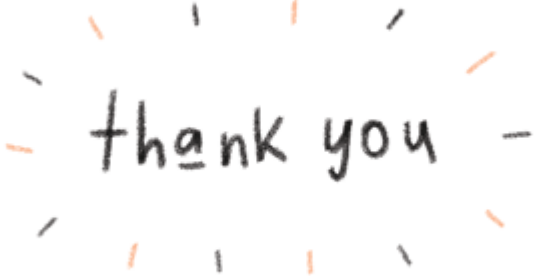
1 like

This week is #MentalHealthAwarenessWeek , when Mental Health & Well-being is the main topic of discussion. If you need to know more about #mentalhealth at work, @involve_WB are now offering workshops for local organisations to support staff. #WokinghamHWBB#MayEvents📆 #MHAW2018

2 retweets

15th

#ThankYou to everyone who took part in sharing things yesterday! We'll still be tring to share as many things from people as possible so continue to use the hashtags to share! #WokinghamHWBB #MayEvents📆



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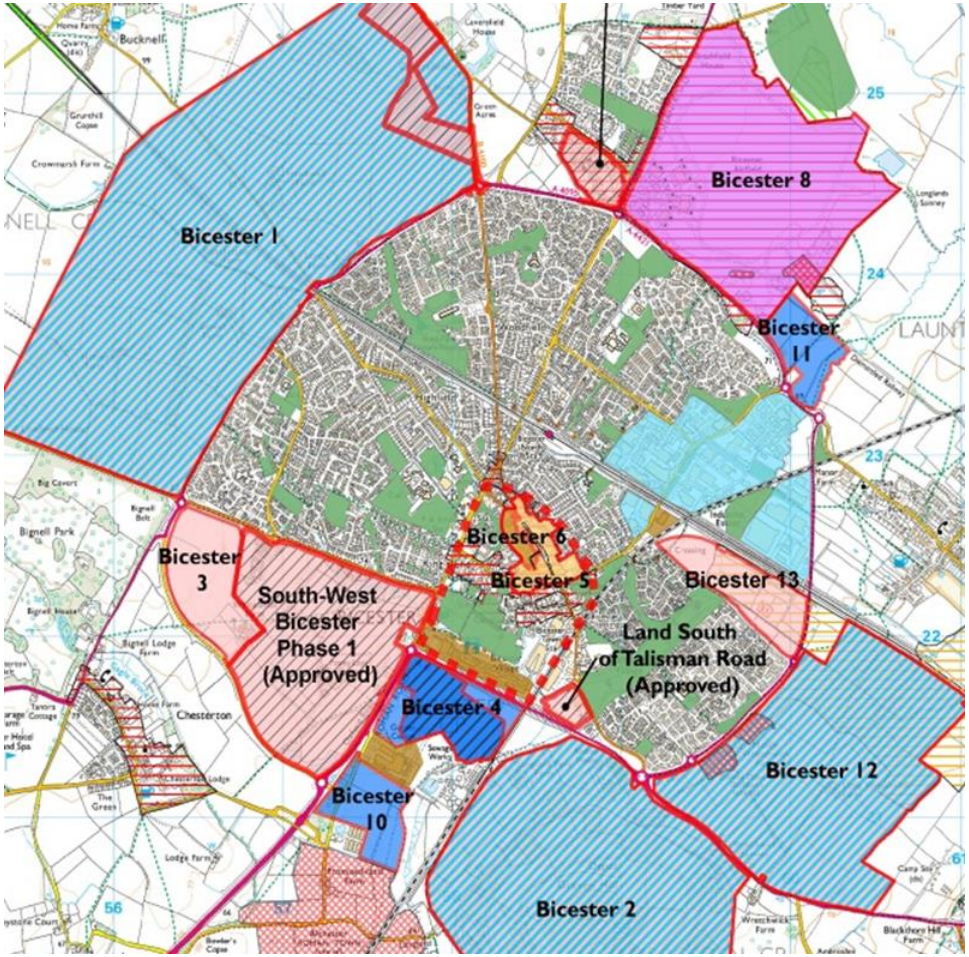
# Bicester Healthy New Town Programme




Promoting Population Health and Wellbeing through Healthy Place making

Dr Rosie Rowe, Bicester HNT Programme Director

# Growing Bicester: a place based approach

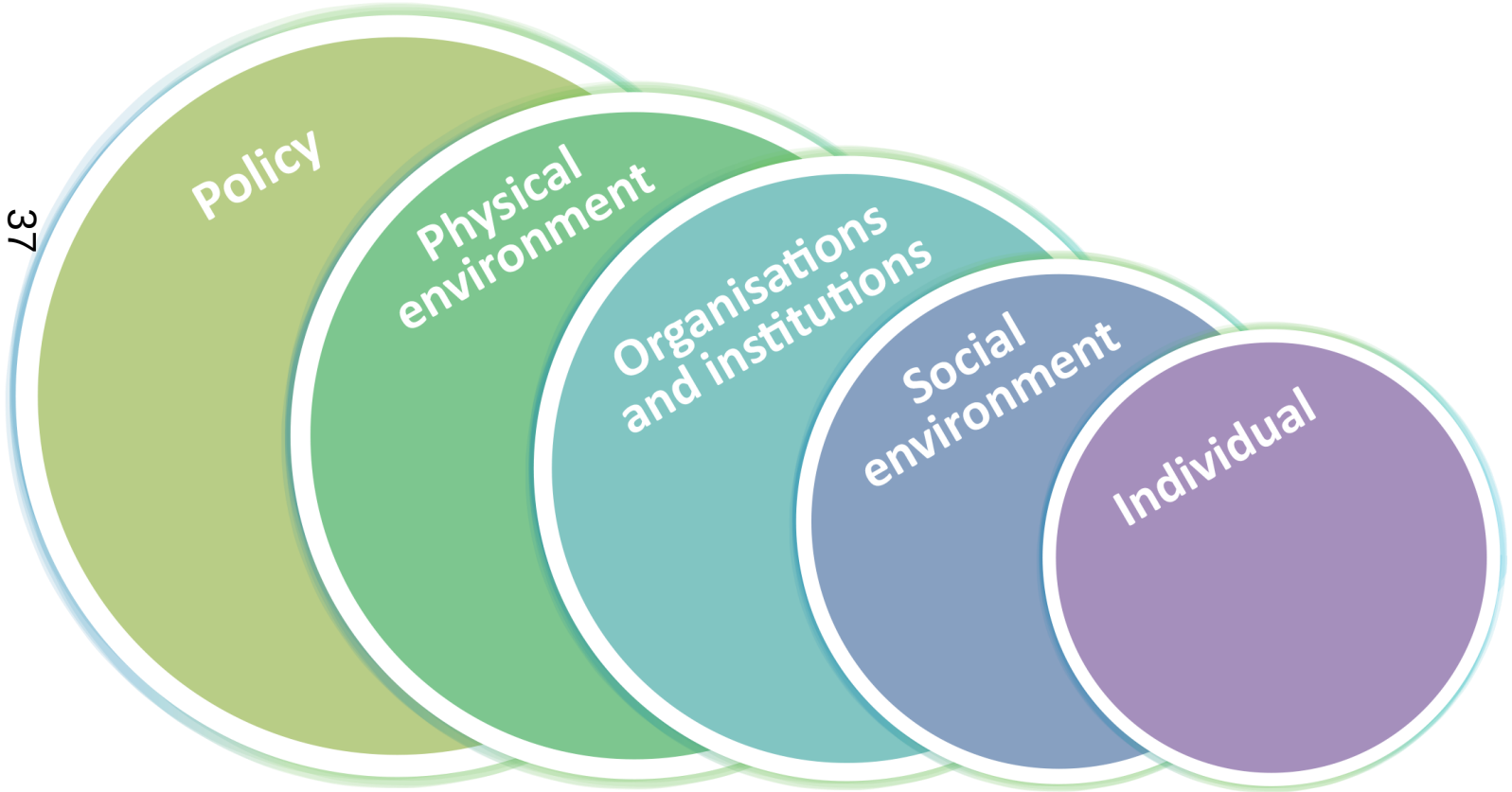


# Individual behaviour change approaches

**I've been told to move around more, lose weight, quit smoking and eat the carrot!**


24 HOUR
FITNESS

# Healthy Place Making requires a whole systems approach



Bicester
Healthy town, healthy lives

# Bicester Healthy New Town Partnership

# Programme Objectives

**Two key priorities:**

- To increase the number of children and adults who are physically active and a healthy weight.

- To reduce the number of people who feel socially isolated or lonely in order to improve their mental wellbeing

# Programme Work Streams

1. **Bicester's built environment**
   - making best use of the built environment to **encourage healthy living**

2. **Community Activation**
   **–** enabling local people to live healthier lives, with the support of **local community groups, families and schools, and employers**

3. **Health and care services**
   - delivering new models of care that are focused on **prevention** and **care closer to home** which minimise hospital based care

# Built Environment – creating policy that supports healthy living

## Transformation of relations between built environment and health professionals

**Outcomes:**

- Stronger policy framework to support health promoting environments (work underway)
- Better working between built environment and health professionals
- Bringing together built form and community developme

# Built Environment - creating an enabling environment

## The built environment is supporting healthier lifestyle

**Outcomes:**

- Built environment acting as a nudge to be active
- Digital innovation addressing social isolation
- Innovation around air quality

# Try a local 5k health route

# Neighbourhood Health Routes
# ‘Bicester’s Blue Line’

- Built environment nudge to make walking part of daily routines
- This project delivers marked routes that are safe and accessible
- Developed with community engagement
- Supported by ‘Health Walk’ programme
- There is no cost to participation
- Suitable for a wide range of ages, at any time of the day


*“...I think the initiative should be encouraged. My daughter and I walked it last night and spent the time chatting away and spending quality time together.”*

# Built Environment - creating an enabling environment


On the Bicester West HR, the *daily* average footfall prior to installation of the Health Route was 557 people: this increased to 708.- a 27% increase

- The social media reach of messaging about the installation of the routes was in excess of 50,000 people.
- The Facebook post pictured reached over 17,000 people (with 140 ‘likes’ in the first 8 hours, and over 60 comments.

# Community Activation - delivery

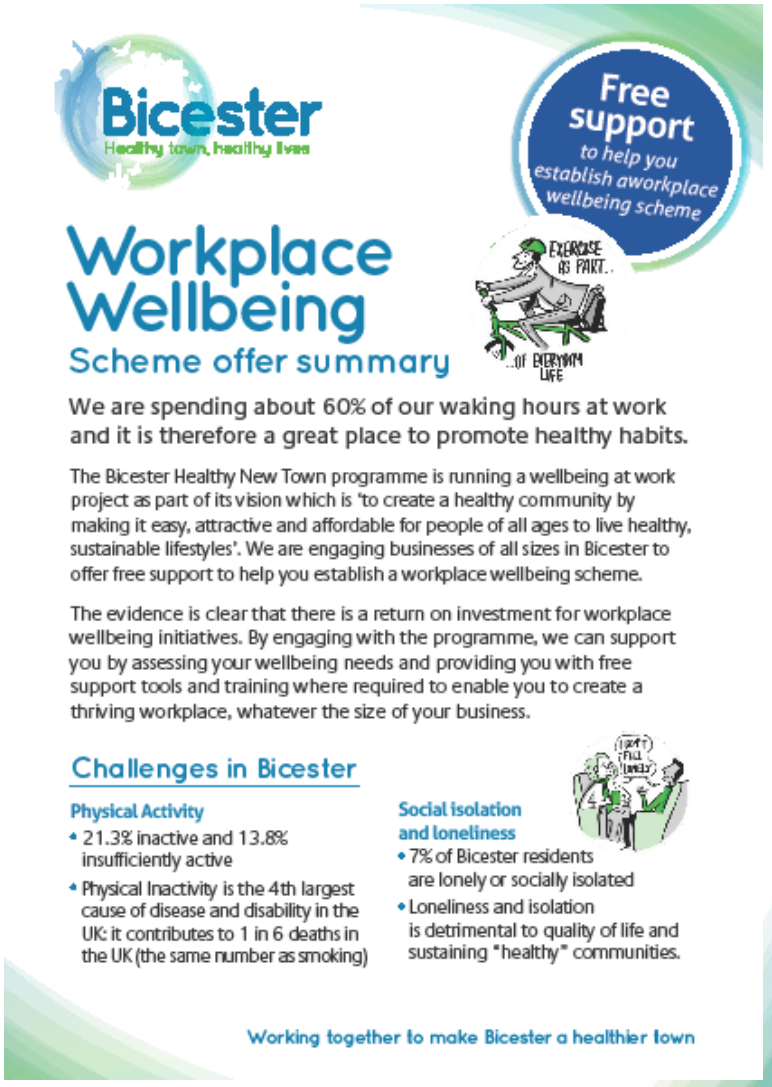
- Local stakeholders working together **to design and deliver the programme** in their organisations
- Health and wellbeing are being promoted in businesses, schools, and voluntary sector
- Targeting the population to change behaviour at ‘Trigger Events’:
  - retirement/moving house/starting school/nursery



# Community Activation: working with businesses

- Working with SMEs and micro businesses
- Mental health training
- Being active in the workplace
- Healthy Eating

- Networking walks

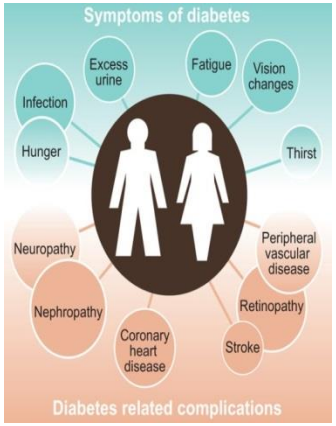


# Health care remodelling

New models of care enabled through use of technology are bei
developed and tested with Bicester acting as a 'demonstrator si

**Outcomes:**

- **Improved health and wellbeing:** working with the third sector and social media e.g. social prescribing
- **Development of sustainable and enhanced primary care** fit to meet the needs of the growing population
- **Testing new ways of delivering care** e.g. diabetes management



# Benefits of healthy place making at 2 year point

Healthy Bicester Facebook page has **1300 followers** (10 joining/week) – a mechanism for engagement of residents with health promotion/self-care campaigns

**2000 primary school children** now run a mile/day at school

**Eight businesses** (SMEs and local businesses) are actively promoting wellbeing at work ranging from SMEs to micro businesses

**Increased take-up** of commissioned services: activity programme for diabetes/weight management programmes/ 50% increase in number of children attending CDC holiday clubs

**469 more people** taking regular guided Health Walks

**School based family programmes** are effectively engaging families to increase their parenting skills, including having active fun with children and offering homework support

# Benefits of healthy place making at 2 year point

**Five food outlets** are participating in '**Eat Out Eat Well' scheme** promoting healthy food options

**All Primary schools** are being supported to promote mental wellbeing through SATS relax sessions /mental health training /MECC training

**Three health routes** have increased walking and social connections

**Joined up planning** between OCCG, practices, local planners and councillors to develop primary care facilities that are future-proofed for population growth


**414 New Users** of PHE Self care Apps

*"Can I just say that I think the current initiatives, with the blue lines and cycling routes and events are wonderful.*

*As an unfit, overweight middle aged woman, even I have been inspired to get my bike out and ride again after a 40 year break, so many thanks for all the hard work that's gone into this!"*

# Core elements of healthy place making

| Building blocks: | These lead to... | Which will build healthy communities with these outcomes: |
|---|---|---|
| › Place based<br>› Asset based<br>› Population based<br>› Co-production<br>› Evidence based<br>› Effective communication<br>› Resources<br>› Political leadership | › three integrated workstreams – built environment /community activation /new models of care<br>› Opportunity for inter-sectoral working<br>› Ability to deliver | › Joined up and future-proofed public services<br>› Inter-sectoral collaboration<br>› Additional investment and economic growth<br>› Increase in social cohesion and community assets<br>› Improvement in population health and wellbeing<br>› Increased self-care<br>› Reduction in demand for acute health and care services |

# Implications for Integrated Care Systems

- Partnership beyond NHS providers: third sector/Local government (District and County Councils) which have
  - Systems for meaningful public engagement
  - Responsibility for promotion of health and wellbeing
  - Responsibility for community development
  - Good links with the voluntary sector
  - Planning lead responsibility for a healthy built environment
  - Strong local accountability
  - Intelligence into local residents' needs
- Need to think beyond medical model and work with partners to address social factors to promote health and wellbeing as well as prevent illness
- Engagement and activation of local people will support self care and build healthier communities

# Follow **Healthy Bicester**

**rosie.rowe@cherwell-dc.gov.uk**

| | |
|---|---|
| **TITLE** | **Director of Public Health's Annual Report 2018** |
| **FOR CONSIDERATION BY** | Health and Wellbeing Board on Thursday, 14 June 2018 |
| **WARD** | None Specific; |
| **DIRECTOR/ KEY OFFICER** | Darrell Gale, Strategic Director of Public Health (Interim) |

| | |
|---|---|
| Health and Wellbeing Strategy priority/priorities most progressed through the report | 1. Enabling and empowering resilient communities<br>2. Promoting and supporting good mental health<br>3. Reducing health inequalities in our Borough |
| Key outcomes achieved against the Strategy priority/priorities | Provides an analysis to inform place-based initiatives. |

| | |
|---|---|
| Reason for consideration by Health and Wellbeing Board | The Board is asked to read and note the DPH Annual Report and its conclusions and to share widely within their respective organisations and local communities, with the expectation that it will be used to inform plans and actions. |
| What (if any) public engagement has been carried out? | No public engagement has been carried out in the production of the Annual Report. |
| State the financial implications of the decision | None. |

**RECOMMENDATIONS**

The Board is asked to read and note the Director Public Health Annual Report and its conclusions and to share widely within their respective organisations and local communities.

***"Creating the Right Environments for Health"*** recommends that;

1. Local authorities and other agencies should continue to encourage community initiatives that make the most of natural space available, with the aim of improving mental health, increasing physical activity and strengthening communities.
2. Existing green space should be improved and any new developments should include high quality green spaces. The use of professional design and

arrangements to ensure the ongoing management of natural environments should be considered if spaces are to be sustainable.
3. Opportunities to increase active transport should be considered when designing new green spaces and in the improvement of existing space.
4. Planning guidance for new developments should specifically consider the use of green and blue space to improve the health and wellbeing of residents and others using the space.
5. Local Authorities and their public health teams should foster new relationships with organisations aiming to improve the natural environment and its use.

**SUMMARY OF REPORT**

Since Public Health moved back into local government in 2013, we have reconnected with many of our valued colleagues in planning, leisure and sports development, parks and recreation, housing and highways (amongst others) to create place-based strategies and deliver actions which bind together these wider determinants of health with our local priorities.

***"Creating the Right Environments for Health"*** aims to reconnect professions, communities and landowners and highlight opportunities for them to work together to support the public's health through creating and maintaining accessible high quality green spaces and natural environments. The report provides information and evidence that can support placed-based strategies to realise the potential of green and natural spaces for the health and wellbeing of local residents and communities and showcases examples of how local communities are already using the natural environment to stay healthy or improve their health and wellbeing.

**Background**

It is a statutory requirement for the Director of Public Health to produce an Annual Report on the health of the population. The form and contents of the report vary year to year. The 2017 report focused on Avoidable and Preventable Mortality. This year (2018) the report has taken a refreshing approach on "Creating the Right Environments for Health" aiming to hit a wider audience. It is in a less technical format, with illustrations and local case studies. The fact that it looks attractive does not make it any less authoritative; it presents an extensive literature review and analysis of the evidence base on the impact of the natural environment on human health. While the report covers the whole population, outcomes are presented in terms of mental health, children and young people, physical activity and communities and health inequalities.

As Wokingham is undergoing such major changes with the development of thousands of new homes and related infrastructure the time is right to use evidence of what impacts positively on the population in planning and design. Ways must be found to balance the loss of green space and it is hoped that this report will be used widely within the Borough.

**Analysis of Issues**

The issues are all thoroughly covered in the Annual Report.

| Partner Implications |
| --- |
| All partners to read and consider how the evidence in the report can be used to inform their policies, use of space and staff and client interactions. |

| Reasons for considering the report in Part 2 |
| --- |
| N/A |

| List of Background Papers |
| --- |
| Creating the Right Environments for Health. The Annual Report from the Director of Public Health (printed copies will be distributed at the meeting). |

| | |
| --- | --- |
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# Creating the Right Environments for Health

The Annual Report from the Director of Public Health

Wokingham Borough

May 2018

WOKINGHAM BOROUGH COUNCIL

# FOREWORD

We are shaped by our environment more than we may realise. Public health through the ages has always understood that environmental factors, from poor housing, lack of sanitation and poor air quality have an important role to play in determining our health; both as immediate threats to life and limb; and as long-term factors creating long-term exposure to potential harms. Other disciplines - and indeed many of our established arts - have sought refuge and inspiration in nature; however, it has taken some time for public health and medicine to identify the evidence base supporting what many of us had long felt; that nature and greenspace is good for us!

This report is intended for a wide audience. Since public health moved back into local government in 2013, we have reconnected with many of our valued colleagues in planning, leisure and sports development, parks and recreation, housing and highways (amongst others) to create place-based strategies and deliver actions which bind together these wider determinants of health with our local priorities. I hope that this report reaches a wide and diverse audience, most importantly to residents and to their representatives such as Councillors and GPs, who are poised to respond to the recommendations laid out herein.

With ever increasing demands for new housing in the South-East of England, and the need to improve and increase infrastructure; so the natural environment can come under pressure and its intrinsic values may be overlooked. Berkshire is as a whole, a green and pleasant place. From the areas of outstanding natural beauty of the North Wessex Downs; to the Green Flag accredited parks of Slough, communities live close by or surrounded by attractive green space. Rivers and waterways play an important part in our communities too – from the Thames at Windsor through to the reclaimed recreational parks and lakes of Dinton Pastures; these provide nature and people with nourishment, peace and pleasure. The new town planners who gave birth to Bracknell in the late 1940s planned a town where greenspace and recreation was a defining generator of the town's layout; and in Reading, the Thames side open spaces at Richfield Avenue and at King's Meadow provide homes to two huge community events; the Reading Festival and Reading Pride respectively.

Berkshire's natural environment can be seen to provide opportunity for peace and tranquillity; gentle and boisterous play; sport, competition and spectacle; natural habitats and preservation of wildlife; and attractive places to walk; cycle and live amongst. That our communities are still able to live amongst and use a variety of natural environments freely for our recreation is testament to many who have fought for their preservation and enhancement. Improvement in and widening access to green and blue space must be a public health ambition in itself, and this report provides the evidence base to build that ambition.

I truly hope that this report reconnects professions; communities and landowners who all have a duty to support the public's health through creating the right environments for health to thrive and benefit us all through the beauty of natural and green spaces.

**Darrell Gale FFPH MSc BA (Hons)**
*Acting Strategic Director of Public Health for Berkshire*



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# ABOUT THIS REPORT

This report was developed and produced on behalf of the Acting Director of Public Health by Shared Public Health Services for Berkshire, and authored and coordinated by Dr Steffan Glaze (Foundation Doctor).

This report is the joint effort of all Consultant-led Public Health teams in Berkshire to produce the statutory annual report of the Director of Public Health both as a pan-Berkshire document, celebrating the history of shared working across the six Unitary Authorities; and also as a unique report for each individual authority.

Case studies were provided by a variety of individuals from local authority public health teams or other groups, such as voluntary organisations who are acknowledged below and with their contributions.

Finally, we acknowledge Judith Wright who was Interim Strategic Director of Public Health for Berkshire from April-December 2017, who conceived of the topic and encouraged us all to find the right environments for health.

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Colleagues in Public Health and other departments of local government, as well as collaborators from other groups, contributed to the case studies found throughout this report or its design and administration.

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# INTRODUCTION –

## The Wider Determinants of Health

There are many factors, or determinants, that come together to affect our health. There are some we cannot change – chiefly, our genes. Of the modifiable factors, some are individual and personal choices such as taking up smoking or choosing to exercise. On a population level, there are the wider determinants of health: a diverse range of economic, environmental and social factors that affect people's health and influence their choices and lifestyles. Difficult to quantify, many of these determinants are shaped by national and local government policies, our environment and the distribution of wealth - things not quickly changed. They include:

- Income and social status
- Educational attainment
- Quality of housing
- Community and social networks
- Activity – the way we live

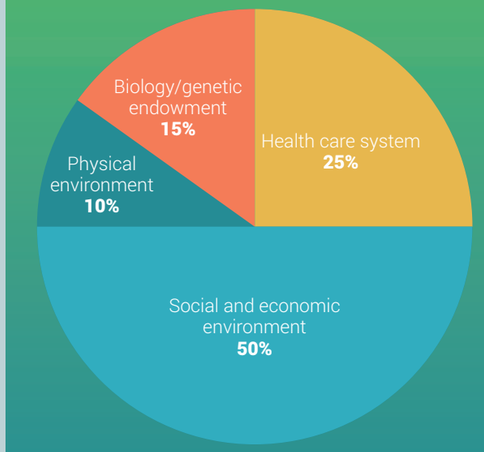
It is generally agreed that these wider determinants of health overall have a more significant impact on the health of individuals that direct interventions in health care.  Estimates vary, but it seems that health care contributes less than 25% of our overall health, with these wider determinants contributing to the majority.

*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*

World Health Organisation, 1948

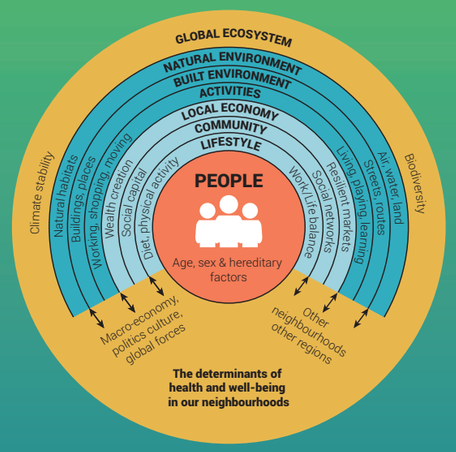
Public health, as a responsibility of local authority, has the opportunity to influence these determinants for the improvement of the health and wellbeing of the population it serves. The benefits may not be quickly realised, but are potentially vast and wide reaching, and could reduce the inequalities in our society and improve health and wellbeing for all of us.

**[1] Estimated impact of determinants on health status of the population**




*Source: Canadian Institute for Advanced Reseach, Health Canada, Population and Public Health Branch AB/NWT 2002*

**[2] Barton and Grant, "A health map for the local human habitat", 2006**




*The health map: Barton and Grant 2006 developed from a concept by Dahigren and Whitehead 1991*



This report will focus on one of the wider determinants of health – the natural environment – and how this could be used to improve our health. We will begin by describing the natural environment and its relationship to other determinants of health, then go on to examine particular health dimensions in this context. Finally, we will consider the challenges – and opportunities – to the natural environment that we can adjust to improve the wellbeing of our communities and from these build recommendations to act on.

Throughout the report, you will find case reports and research. We want to make effective changes, such that investments made will reap benefits for our communities. The research is included to discuss the scientific factual evidence available, and local case studies highlight the ways in which local communities are already using the natural environment to stay healthy or improve their health.

### RESEARCH

Most of the research described in this report comes from scientific journals. Researchers conduct their studies, and then publish their results only after a body of other scientists have reviewed their work for accuracy. It can be difficult to get evidence on a population scale because there are so many things that can contribute to health and wellbeing, making it hard to measure the amount caused by a single aspect. The studies selected are considered to be of good quality, but reflect only a small proportion of the data available.

### CASE STUDY

All of the case studies are examples of the work going on in this local authority in line with the theme of the report. We are pleased to highlight a variety of council, voluntary and national initiatives that are contributing to improving our health.

# THE NATURAL ENVIRONMENT

The natural environment can encompass many parts of our surroundings. We often think of wide open fields, quiet forests or flowing rivers as the truly natural environment, but our urban environments can include natural elements. Often termed 'green space', this includes many things, from sports fields to decorative gardens. The natural environment can also encompass 'blue spaces' such as rivers and lakes, which are features of our area that can enable exercise, time in nature, leisure and relaxation. There is evidence that this natural environment has an influence on health in a variety of ways.

The ways in which the natural environment can improve health are complex and intertwined with many other factors. There are broad themes that have appeared from the research in this field, namely [3]:

- Stress reduction
  - It has been known for a long time that spending time in nature can have restorative effects, through relaxation.
- Improved environmental quality
  - Green spaces are more likely to be biologically diverse, and contribute to improving air quality and reducing the effect of heat concentration in cities.
- Greater social cohesion
  - Areas of natural environment are places that people can socialise and congregate, places of pride in the community and as a result improve the cohesion of neighbourhoods.
- Increased physical activity
  - Green spaces are appealing to visit, and typically need to be walked, cycled or played in to appreciate them.

We will see throughout this report how scientific research has found evidence from an individual to a population level that green spaces and the natural environment can have positive effects on our health and wellbeing. Although the exact mechanism isn't clear, there is still the opportunity to increase the availability, quality and use of natural elements in our communities.

## Policy

The Department for Communities and Local Government published a consultation paper [4] in 2010 on planning policy and shaping healthy environments. Within the paper, the government defined a wide range of green spaces.

- parks and gardens – including urban parks, country parks and formal gardens
- natural and semi-natural urban green spaces – including woodlands, urban forestry, grasslands, common land, wetlands, areas of open and running water, wastelands, derelict open land and rock areas
- green corridors – including canal and river banks, cycle ways and rights of way
- outdoors sports facilities (with natural or artificial surfaces, either publicly or privately owned) – including tennis courts, bowling greens, sport pitches, athletics tracks, playing fields and other outdoor spoors areas
- amenity green space – including informal recreation spaces, green space in and around housing, domestic gardens and town or village greens
- provision for children and teenagers – including play areas, adventure playgrounds, skate parks, basketball courts and other informal areas
- allotments, community gardens, city (urban) farms and land used for permaculture
- cemeteries and churchyards
- accessible countryside in urban fringe areas
- civic spaces, including civic and market squares
- landscape around buildings – including street trees





### RESEARCH

At an individual patient level, in 1983 R Ulrich [5] found that a view over green space could quicken someone's recovery from surgery in a suburban hospital in Pennsylvania, USA. This study compared similar people who had the same operation, but what differed between the two groups compared was the view from their window - either a brick wall or trees. Those with the green view had statistically significant lower length of stays and lower use of painkillers. This early evidence showed that there may be a restorative effect to simply viewing greenery and natural environments.

Looking at the population level, a study in the Netherlands [6] examined the electronic GP records of over 340,000 patients, and measured their illness by how often they saw their GP for various health problems. This was then compared with the percent of greenspace in a radius around their postcode based on satellite imaging. The analysis showed that over half the health problems were less common among the patients who lived in areas with more green space, even when correcting for potential confounding factors such as age and socioeconomic status. The correlation was strongest for anxiety and depression, children under 12 and those aged 46-65. They found that an extra 1% of green space in a person's area was as beneficial to overall health as being a year younger.

## How can we measure Green space?

How can we define how 'green' our neighbourhoods are? There are many ways this is measured in scientific study, the two most common being:

- Satellite imaging – by looking at photographs taken from space, scientists can calculate what percent of an area is covered by plants. This is relatively easy to derive, and data is available for much of Europe. However, it does not account for the quality of the green space, e.g. for access or for food production, or how much we can actually access or use that greenery, as any plants on roofs, within private land, or in the middle of a roundabout would be included.
- Mapping – analysing maps can reveal the different land types in an area, from arable to housing. Counting how much of an area is covered by accessible green space can be used to measure the amount of natural environment in a neighbourhood. This method will miss small areas, such as verges and paths, which contribute to green routes but are not large enough to be documented on most maps.

Although effective at developing a measure of how green an area is, neither of these methods account for how easy the space is for people to access, how much that space is used or the quality of it. This aspect of the natural environment can be heavily influenced by the community who use it and live near it, such that we can all have a part to play in making the most of green spaces in our area.





## Resources

A variety of resources are available for us to find and use green space in our area.

### WOODLANDS TRUST WEBSITE

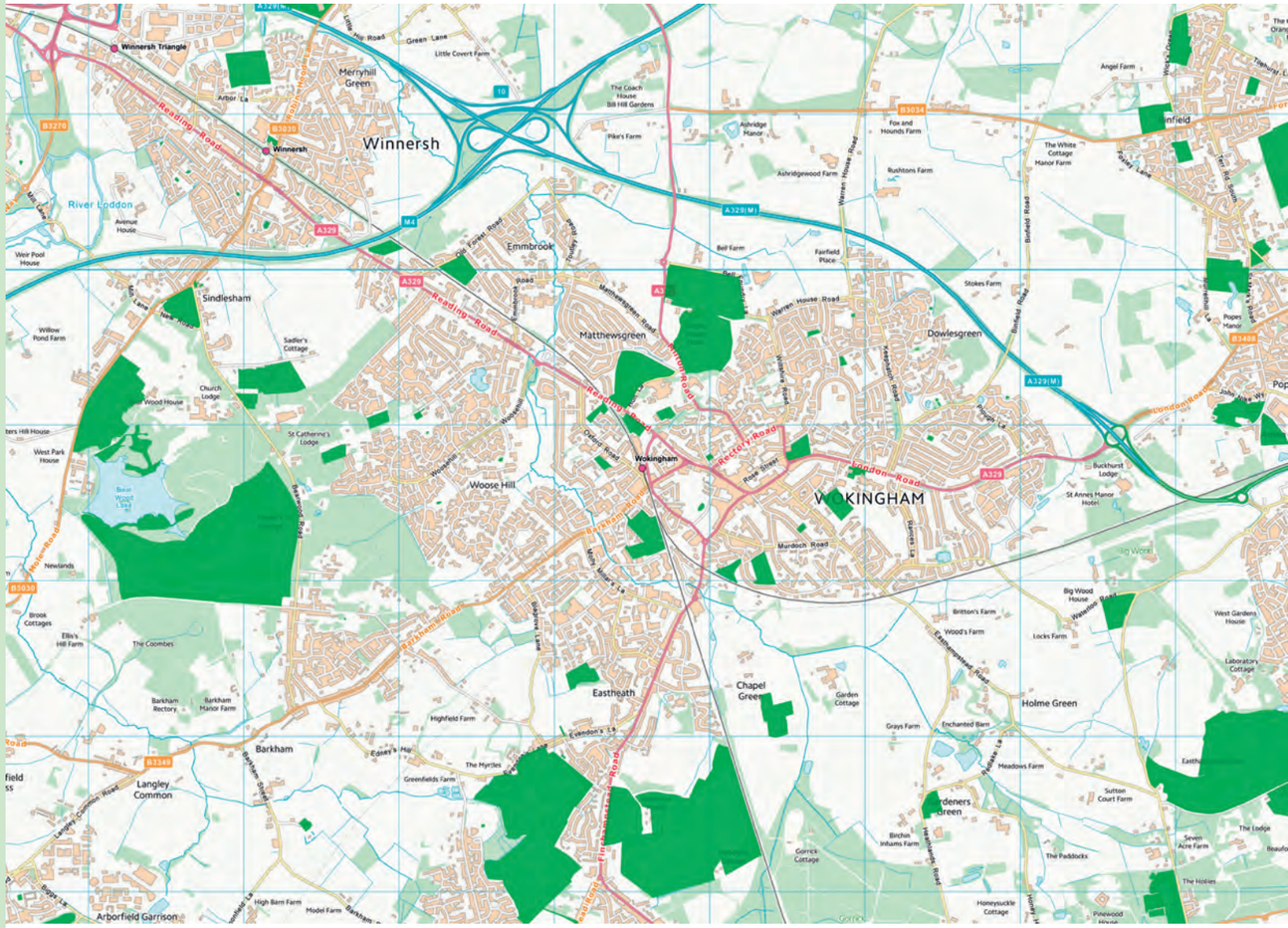
The Woodlands Trust, the UK's largest conservation charity, has an online database of the woods they manage. Using your postcode, you can find more about the woodland in your area.

### OS GREENSPACE

The Ordnance Survey has assessed their own data about land use in the United Kingdom to produce an interactive map which can be used to see where green spaces are, what they are used for and how they can be accessed.

Wokingham Borough Council keeps online records of all the green spaces they manage, which includes details about facilities and opening times. You can find this resource at the following address:
**http://www.wokingham.gov.uk/countryside-parks-and-conservation/**

© Ordnance Survey OpenData (2018)




*Source: © Ordnance Survey OpenData (2018)*

# HEALTH OUTCOMES AND BEHAVIOURS –

## Profiles

The following section describes some of the key health outcomes and behaviours on which there is a firm evidence base for the effect of green space or the natural environment. The relevance of these to our communities is demonstrated by data about the current health and wellbeing of the local communities in a summary graphic. You will also find original research evidence and a case study from your local area.

## Mental Health

Mental health is essential for our overall health and wellbeing, and changes in policies and the NHS is increasingly recognising this. The 2011 report from the Department of Health 'No Health Without Mental Health' identifies some key facts about the national picture:

- mental illness is the single largest cause of disability in the UK
- at least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time
- the costs of mental health problems to the economy in England have recently been estimated at a massive £105 billion, and treatment costs are expected to double in the next 20 years

How could natural environments contribute to changing this picture? It is hard to identify exactly the mechanisms for these benefits, but a variety of evidence is available. It has been shown that exposure to natural environments can reduce stress, anxiety, blood pressure and anger. Over longer periods of time, those who live in greener areas are more likely to report good mental health and wellbeing.

*Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*

World Health Organisation definition

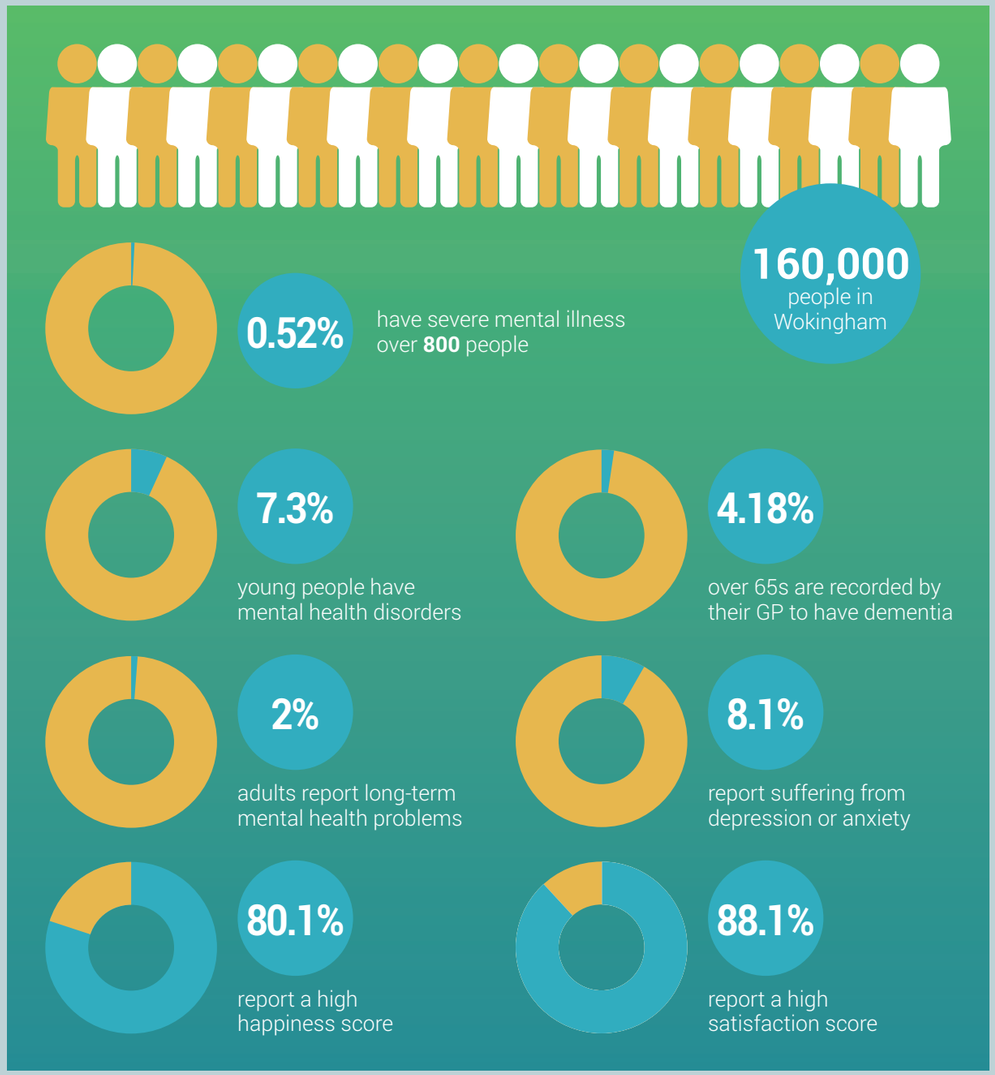
National policies and initiatives recognise the benefits of spending time in green spaces on mental health. For example, Mind's Ecominds scheme found 7 of 10 people experienced significant increases in mental wellbeing by the end of an ecotherapy project [7]. It helped people find full-time employment, with potential savings of around £5,700 for each person in terms of government spend.





### IN OUR AREA

There are currently estimated to be around 160,000 people [8] in Wokingham: 0.52% have severe mental illness – over 800 people. An estimated 7.3% of young people have mental health disorders, and 4.18% of over 65s are recorded by their GP to have dementia. Responding to a GP Survey, 2% of adults report long-term mental health problems, and 8.1% report suffering from depression or anxiety. In terms of self-reported well-being, 80.1% report a high happiness score and 88.1% a high satisfaction score. [9] [10]



**RESEARCH**

Evidence for the effect of green space on mental health looks at both the short-term, temporary effects and long term benefits. Contact with nature can improve emotional state, reduce self-reported anger, fatigue, anxiety, sadness and increase feelings of energy. [11]

Hartig et al [12] tested whether natural environments were more relaxing and restorative than purely urban surroundings, by giving subjects difficult tasks. They measured blood pressure and reported mood throughout, and found that being in nature was associated with quicker returns to normal levels of blood pressure and mood after stress – evidence that being in nature can improve your physical and mental wellbeing in times of stress.

A study by Alcock et al [13] looked at people who moved to greener areas during the years of an annual survey of their mental health. Moving from a less to more green area was associated with improvements in reported mental health.

**CASE STUDY: THE MENTAL HEALTH AND WELLBEING PROGRAMME**

***By Sian Attard, GP Referral and Long Term Health Conditions (LTHC) Manager***

As well as improving physical health, engaging in physical activity can have a significant positive impact on mental wellbeing. The Mental Health and Wellbeing Programme offers participants a range of activities including Badminton, Football, Table Tennis, Circuits, Stretch and Relax and Health Walks. Clients may experience one or more of the following conditions – stress, anxiety, depression, bi-polar, psychosis, personality disorder and/or schizophrenia amongst others. Referrals are made by GPs, health professionals, Community Mental Health Teams as well as by individuals. The programme was launched in May 2015 and has received 133 referrals so far. Activities are delivered free of charge and available to residents over 16 years old, clients can participate in as many classes as they wish.



## Children and Young People

Every child deserves the best start in life to give them the opportunity to thrive in life. Pregnancy and upbringing impacts our physical and mental health during childhood and through to adulthood. Enabling good maternal health can allow a safe delivery and good growth of the foetus, preventing potential poor outcomes from low birth weight or prematurity. The development of a baby's brain and immune system begins in the womb, and continues as they grow.

Green spaces may alter the environmental stimuli we are exposed to, and through this change whether we develop inflammatory diseases such as asthma. They can encourage us to be more active or to connect with our community, which can improve cognitive development. Exposure to the natural environment appears to have an impact on the development of our microbiome – the vast number of microorganisms that co-inhabit the human body. This microbiome may have an impact on the formation of our immune system, and as such the prevalence of allergies and long-term inflammatory diseases – including asthma. There is also evidence that street trees can improve the air quality in urban areas by absorbing some of the particulate matter from pollution, as well as reducing the 'heat island' effect generated by the concentration of hard surfaces and taller buildings [14].

Together with the improvements in mental health through spending time in nature, green spaces can contribute to a positive development for children, especially for play. The natural environment can improve our environment and change our behaviour to help us grow well. A healthy community which is using the green space available for both formal and informal play to increase a child's chance for the best start in life can set them off on the way to greater health and wellbeing.

**RESEARCH**

Dadvand et al [15] studied a group of 2,593 primary school children in 36 schools in Barcelona, Spain. Using repeat measures of memory and inattentiveness as an indicator of cognitive development, they compared this with exposure to green space. They measured the 'greenness' around the children's homes, their route to school and the school itself from satellite data that measures the percent of an area covered by plants. They found greater progress in the children in greener schools and home environments, partly explained by a reduced exposure to air pollution.

An American study [16] examined the association between birth outcomes and residential greenness. Looking at 64,705 births in Vancouver, Canada (1999-2002), they examined the density of vegetation within 100m of participants' homes, their birth outcomes and other aspects of their environment. They found that, independent of air pollution, noise, neighbourhood walkability and proximity to a park, increasing residential greenness was associated with beneficial birth outcomes including higher term birth weight and reduction of likelihood of prematurity.

## IN OUR AREA

Looking at the most recent data for the health of children in Wokingham, we see 4.6% of infants born at a low weight. There were 13,840 attendances to Accident and Emergency by those under 18 years old, and 44 hospital stays last year to treat Asthma. At 4-5 years of age, 6.0% of children are obese which increases to 13.8% at age 10-11.

In terms of being ready for school, 82.8% of children meet the expected level at the phonics screening check and 76.2% had achieved a good level of development at the end of reception year. Looking ahead, 61% of pupils at Key Stage 2 met the expected standard in reading, writing and maths; just over 70% of teenagers achieved five A*-C grades at GCSE. [17] [18] [19]

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**Looking ahead**

**61%** of pupils at Key Stage 2 met the expected standard in reading, writing and maths

just over **70%** of teenagers achieved five A*-C grades at GCSE



## CASE STUDY: BOOST CAMP

***By Sian Attard, GP Referral and LTHC Manager***

In 2017 Wokingham Borough Council commissioned a pilot five-day multi-sport camp for young people, called Boost Camp, in partnership with Reading Football Club (RFC) and Boost, delivered at Bulmershe Leisure Centre in Woodley.

The aim of the pilot was to establish whether the use of biometric tracking (Boost bands) was an engaging and acceptable way of increasing physical activity for young people. The band recorded the child's distance travelled and how many steps they carried out that day, as they completed sporting activities in and around the leisure centre.

The eligibility criteria for the camp were participants had to be between the ages of 11-16 years old, attend a Wokingham Borough School, were overweight or obese and were predominantly inactive. Children were referred either by a parent/guardian or professionals such as children's services or school nurses.

Four camps were delivered in Easter (3rd – 7th April), July (31st July – 4th Aug), August (29th Aug – 1st Sept) and October (23rd – 27th October) 2017 and 18 referrals were made.

Over the course of the 4 camps, the majority attending were motivated to complete at least 10,000 steps per session and the average distance covered was around 9km. This initiative was an exciting use of technology to motivate young people to be more active and be outside.

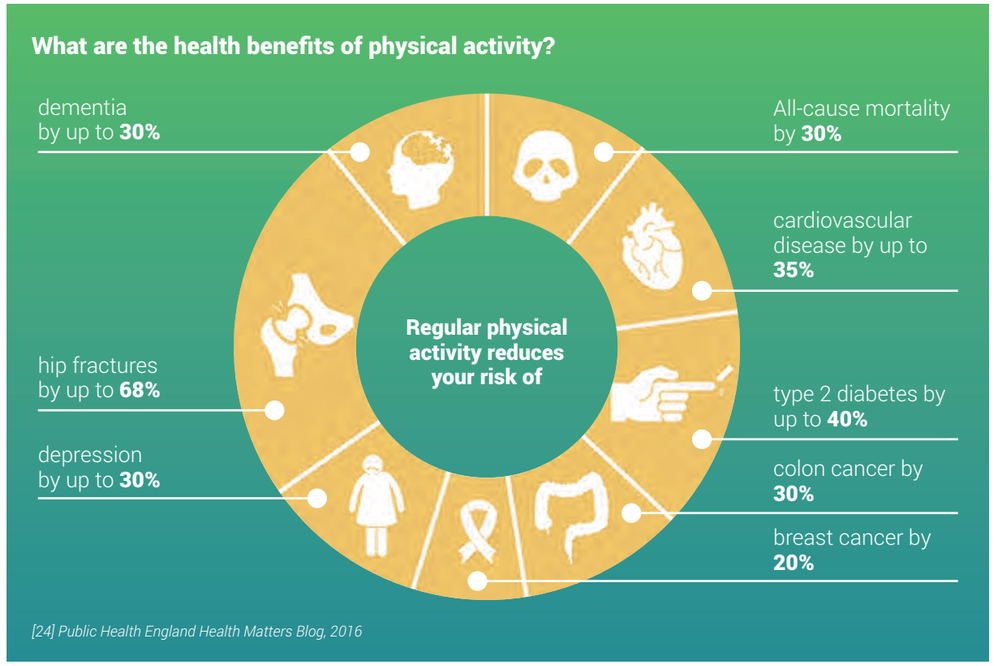
## Physical Activity

Being active can have wide reaching benefits to our health. It has been shown to reduce the risk of coronary heart disease, stroke, type 2 diabetes. It can help maintain a healthy weight, improve self-esteem and reduce depression and anxiety. Physical inactivity contributes to 1 in 6 deaths [20] , estimates suggest that an inactive person is likely to spend 37% more time in the hospital and visit the doctor 5.5% more often than an active person [21]. The Department for Environment, Food and Rural Affairs estimates that the health system could save £2.1 billion per year if everyone had sufficient access to green space and its benefits. [22]

We also know our environment can shape our behaviour, so there is the opportunity to design our neighbourhoods and towns with activity in mind. The links between access to green space and levels of physical activity are well-established in research, which shows higher levels of physical activity in areas with more green space [23]. Careful planning of towns can enable active travel – i.e. walking or cycling as a mode of transport – through making distances achievable and creating safe and aesthetically pleasing routes to travel on. Those who walk or cycle to their place of work are more likely to meet their physical activity needs. If more of us were active, we could significantly improve the health and wellbeing of our communities. The potential benefits are not limited to health – reducing journeys made by car will decrease carbon emissions, air pollution and traffic, and encouraging walking for shopping can boost our local economy.

Accessible, quality green spaces also allow sports and play to increase leisure time activity. Supporting local sports clubs with facilities, giving spaces for community groups and the provision of playgrounds can all enable people at all ages to be more active. We can harness the natural environment to increase physical activity in our community, and be healthier as a result.








### POLICY

Chief Medical Officer Recommendations [25]:

1. Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of ten minutes or more – one way to approach this is to do 30 minutes on at least five days a week.
2. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.
3. Adults should also undertake physical activity to improve muscle strength on at least two days a week.
4. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

## RESEARCH

Analysis of the Danish National Health Survey [26] was able to assess self-reported distances to green spaces, BMI and exercise habits. It revealed that those who reported living over 1km, compared with less than 300m, to green space were more likely to be obese and less likely to exercise. Although based on self-reporting which may be biased, this study highlights the potential benefit of encouraging physical exercise through proximity to green space.

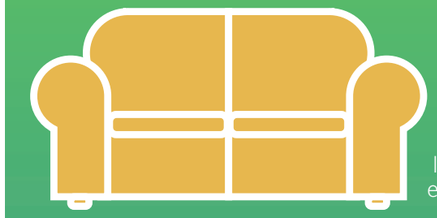
A study [27] in Bristol, UK, used data from the 2005 Bristol Quality of Life in your Neighbourhood survey of 6,821 adults and matched it with a mapping database of neighbourhood and green space information. After statistical analysis, they found that the amount of use reduced with increased distance from the green space, and those living near a formal park were most likely to achieve the recommended amounts of physical activity and were less likely to be overweight.

## IN OUR AREA

In Wokingham, current data shows 67.6% of adults (18-65) report meeting the physical activity guidelines set out by the Chief Medical Officer, yet 21.1% of adults complete less than 30 minutes exercise per week [28]. Less than half (46.5%) of adults do any walking at least 5 times per week. 62.9% of 15 year olds are sedentary for over seven hours per day on average. A study by The Health Survey for England 2008 using an accelerometer found however that only 6% of men and 4% of women met the required levels of activity [29].

Over half of Wokingham's adults are overweight or obese (53%), and this starts in childhood – 26.6% of Year 6 children are overweight or obese. 5,160/4.7% have diabetes, 17,167/12.3% people are living with high blood pressure and 4,973/4.6% suffer from heart disease. 130 people were admitted to hospital last year having broken their hip. [30] [31]





**21%** Completing less than 30 min exercise per week

**53%** Overweight or obese


**68%** Performed the recommended physical activity (based on self-reported surveys)

But only **6%** of men **4%** of women meet the recommended activity levels when objectively measured with an accelerometer

*Source: Health Survey for England 2008*

**If people were more active, what could we reduce?**

**17,167 (12.3%)** with high blood pressure

**5,160 (4.7%)** with diabetes

**4,973 (4.6%)** with heart disease

**130** admissions for hip fractures

## CASE STUDY: DINTON PASTURES

***By Tanya Lee, Centre Manager, and Simon Bartlam, Countryside Operations Officer***

Wokingham Borough Council's Countryside Service manage over 20 sites and 143 miles of accessible footpaths and bridleways within the Borough, enabling people to be active while they engage with the natural environment. One such area in the Borough is Dinton Pastures, which has over 100 acres of meadows and 5 miles of surfaced paths for people to explore, along with three orienteering courses and an inclusive destination play which is accessible to the whole community. There is a free mobility scooter access scheme for visitors with restricted mobility.

Activities are also run by other partners including the successful health walk scheme, offered free of charge by the Wokingham Borough Sports and Leisure Team.

Dinton Pastures aims to be a place where everyone can find something interesting to do. The Activity Centre offers a range of outdoor adventurous options for adults, children and families.

For adults there are Sailing Courses, Running and Multisport Events, Open Water Swimming and SUP Fitness sessions. The afterschool and weekend activities are very well attended by local children with a series of regular participation sessions for children in kayaking and sailing, the latter is supported by RYA OnBoard. The Teenager Programme offers this group an opportunity to learn to become instructors and become volunteers themselves.





## Communities and Health Inequalities

The wider determinants of health, as described in the introduction, have an important role in shaping our health and wellbeing. They were a key focus of the Marmot Review [32], which examined the health of our nation and identified a number of inequalities across our society – those of a lower socio-economic class have a lower life expectancy, a higher frequency of many diseases and poorer mental health. The mechanisms between a lower socio-economic class and poorer health are complex, but can include low quality housing, less healthy diets and lower educational achievement.

Green spaces have been shown to reduce these health inequalities, as the benefits of the natural environment may have a stronger effect for those in lower socio-economic groups. This may be in part due to smaller personal gardens and less aesthetic features in neighbourhoods, but there are often more barriers to the use of green spaces as well – such as crime, traffic and social isolation, which itself has been shown to be associated with increased mortality [33].

An important task of public health is to ensure improvements to health occur throughout society, and inequalities in our area are reduced. Improving green spaces in particular areas of deprivation or using initiatives that reduce isolation and loneliness might be one of the means for us to eliminate health inequalities in our area and improve our communities.

### POLICY

The Marmot Review [32] of 2010 is a key piece of work that identifies many of the health inequalities in our society and gives recommendations for change. Policy Objective E, 'Create and develop healthy and sustainable places and communities' has a number of aims for the improvement and development of green spaces across the social gradient.

**PRIORITY OBJECTIVES:**

- Develop common policies to reduce the scale and impact of climate change and health inequalities
- Improve community capital and reduce social isolation across the social gradient

**RECOMMENDATIONS:**

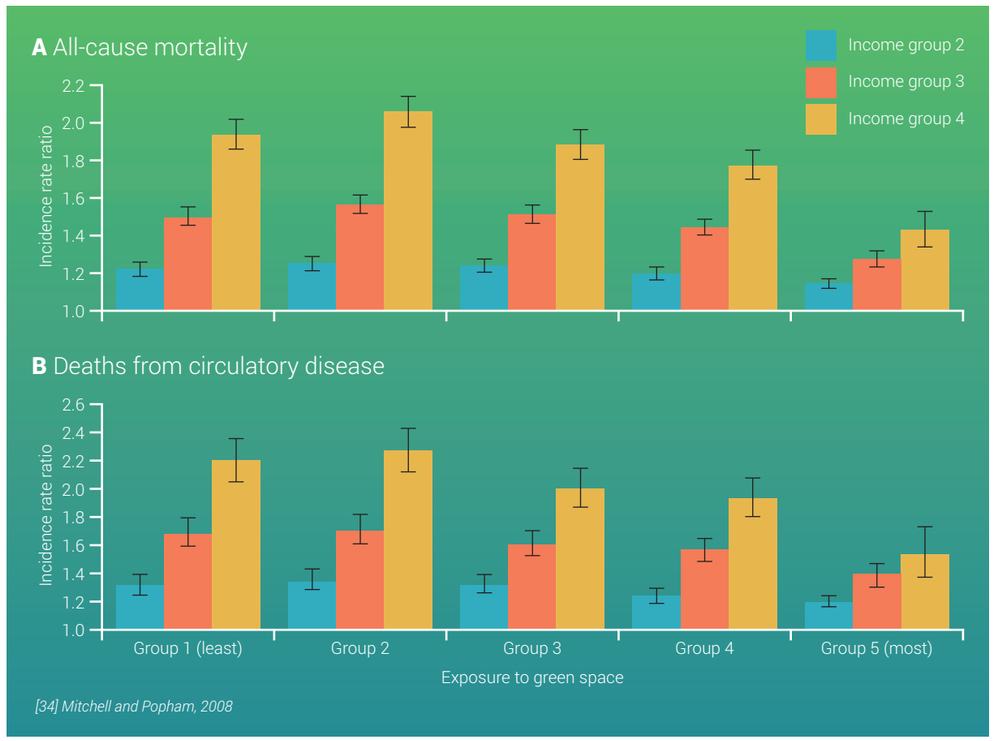
- E1: Prioritise policies and interventions that both reduce health inequalities and mitigate climate change, by:
  - Improving active travel across the social gradient
  - Improving good quality open and green spaces available across the social gradient
- E2: Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.
- E3: Support locally developed and evidence-based community regeneration programmes that:
  - Remove barriers to community participation and action
  - Reduce social isolation.

## RESEARCH

Mitchell and Popham [34] compared different socio-economic groups and the influence of greenspaces on their health. Looking at people of working age in groups of increasing income and comparing them with the same groups in areas of increasing green space, they found that the difference in different health outcomes was reduced in areas with more green space. This can be seen in the graph below by the reducing size of the bars as you move left, which is areas of higher green space.

National data from the Monitor of Engagement with the Natural Environment survey, undertaken by Natural England from 2013 to 2015 [35] found that 12% of children had not visited the natural environment in the previous year, and these children were more likely to be of Black and Ethnic Minority origin or of a lower socio-economic class.

A study [36] in Chicago, USA, looked at the surrounding greenness of 98 publically owned apartment blocks. Residents were randomly assigned to any of the blocks. An examination of police data showed that there were fewer crime reports from apartment blocks with greener surrounding areas when compared to those with less green surroundings.

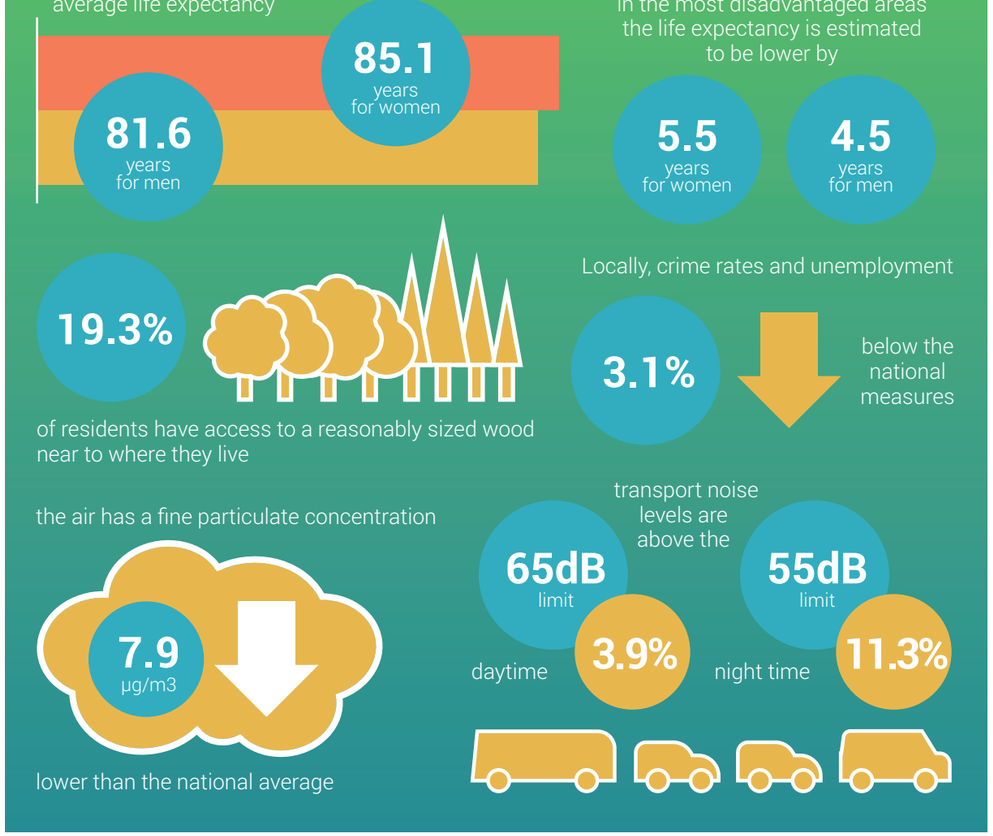



*[34] Mitchell and Popham, 2008*



## IN OUR AREA

The latest data for Wokingham shows the average life expectancy is 85.1 years for women and 81.6 for men. However, in the most disadvantaged areas the life expectancy is estimated to be lower by 5.5 years for women and 4.5 for men, compared to the least disadvantaged areas. There are lots of ways to measure the potential causes – they are often the wider determinants of health discussed earlier in the report. Locally, crime rates and unemployment (3.1%) are below the national measures. In terms of pollution, the air has a fine particulate concentration of 7.9µg/m3 (lower than the national average), but transport noise levels are above the 65dB limit in daytime for 3.9% of residents, rising to 11.3% for the night time 55dB limit. In terms of personal isolation, only 48.6% of adult social care users have as much social contact as they would like. Only 19.3% of residents have access to a reasonably sized wood near to where they live. [37]



## CASE STUDY: SPORTS FOR VULNERABLE COMMUNITIES

***By Glenn Goudie, Physical Activity Projects Coordinator***

The Wokingham Borough Council Sports and Leisure Team have designed a series of programmes targeted at vulnerable communities, who are likely to face poorer outcomes than the general population, to reduce health inequalities. These activities frequently make use of outdoor spaces for leisure and sports.

Walking for Health is led by 17 volunteers with the Wokingham Borough Council Sports and Leisure Team overseeing the programme and training to ensure the programme meets accreditation from Walking for Health. The walks, which are free of charge, are available across the Borough. The average age of attendees is 55-65 years. In February 2018, over 1,500 people were registered on the Walking for Health database. The programme attracts many new people to health & leisure activities.

Sportivate is a programme of activities provided for young people in areas identified as deprived by Wokingham Borough Council. Activities include Cheerleading for girls 11-16 years old, Yoga for girls 16-25 years old and Cycling sessions for children 11-15.

Yoga classes for women were run in three of our areas of deprivation.

Dementia Friendly Activities are offered in partnership with the charity, Young People with Dementia. A range of 40 weekly sessions of activities are provided including walks, bowling, tennis and boccia. Other programmes include seated exercise classes and a drop-in falls prevention class. Old Time Dancing is run at the Memory Clinic in Barkham Hospital.

Here4U is a service for looked after children leaving care. Personalised training sessions are offered by our own qualified Personal Trainer and weekly football sessions. Care Leavers can benefit from a very attractive gym membership at our local leisure providers.



# OPPORTUNITIES AND CHALLENGES

## New Developments and Regeneration

The planning of our local area can influence our health behaviours. Quality, easily accessible green space can enable us to exercise, accessibility to services allows walking and there can be opportunities for social engagement.

With local pressures on housing and the demand for new homes to be built in our area, there are both opportunities and challenges to the amount of quality green space. As urbanised areas already become increasingly built up, there is the need to use green areas on the peripheries of towns to provide enough quality accommodation for our population, often against the wishes of some residents. Although green views can be lost, the majority of these developments take place on private land which is not generally accessible by the public. With careful planning, new developments on previously private land could actually result in more publically accessible green space.

A variety of national policies and frameworks exist to assist local authorities concerning the provision of green spaces. These take the form of general advice through to specific quantifications of how much should be provided and for what purpose. These policies are often used by planning authorities to develop local policies that are relevant to the local situation.

To deliver safe, quality homes and neighbourhoods for all groups in our community it is important to find ways to balance the loss of green areas, the need for more housing and the opportunity to develop new green spaces and use investments to benefit the wider community. By engaging with the planning process and ensuring health and wellbeing of residents is considered in planning, we have the opportunity to develop new assets to improve our neighbourhoods.

### POLICY

The Six Acres Standard [38] is a commonly used set of measures to guide local planners as to the amount of recreational space that should be in a community. It was developed by the National Playing Fields Association (NPFA, operating name Fields in Trust), and has existed in various forms since the 1930s with a specific recent update in 2008. It aims to inform policy that will result in the protection, improvement and green spaces focused on sport and play. Many Local Authorities include the standard in their open spaces policies.

**Fields in Trust recommended benchmark guidelines - formal outdoor space [38]**

| Open space typology | Quantity guideline (hectares per 1000 population) | Walking guideline (walking distance: metres from dwellings) | Quality guideline |
|---|---|---|---|
| Playing pitches | 1.2 | 1200m | • Quality appropriate to the intended level of performance, designed to appropriate technical standards<br>• Located where they are of most value to the community to be served<br>• Sufficiently diverse recreational use for the whole community<br>• Appropriately landscaped<br>• Maintained safely and to the highest possible condition with available finance<br>• Positively managed taking account of the need for repair and replacement over time as necessary<br>• Provision of appropriate ancillary facilities and equipment<br>• Provision of footpaths<br>• Designed so as to be free of the fear of harm or crime<br>• Local authorities can set their own quality benchmark standards for playing pitches, taking into the account the level of play, topography, necessary safety margins and optimal orientation<br>• Local authorities can set their own quality benchmark standards for play areas using the Childrens' Play Council Quality assessment tool |
| All outdoor sports | 1.6 | 1200m | |
| Equipped/ designated play areas | 0.25 | LAPs -100m<br>LEAPs - 400m<br>NEAPs - 1000m | |
| Other outdoor provision (MUGAs and skateboard parks) | 0.3 | 700m | |

The National Planning Policy Framework [39] features a number of policies relating to green and open spaces. They include:

- Promoting healthy communities, through access to high quality open spaces and opportunities for sport and recreation
- Protection for existing facilities and the 'Local Green Space' designation, which can be used to afford special protection for green areas of particular local importance due to their use or features
- Protection of green belt land and the need to positively enhance beneficial use of the land through increasing access, biodiversity of improvement of damaged land



## CASE STUDY: MARKET PLACE REDEVELOPMENT

***By Emy Circuit, Delivery Manager, and Catherine Brimble, Landscape Architect***

Wokingham is an attractive market town with a rich history but it also remains forward looking. The public realm has played a central and lively role in the rich history of this market town and this should continue to be the case. In order to achieve this, it is crucial that the character and quality of Wokingham's public realm is enhanced to match that of its built surroundings reinforcing to local residents and businesses that the town has a strong future encouraging them to promote and have pride in the town.

As part of the town centre improvements in Market Place it was essential that we incorporate large trees within the space not only as replacements for the trees that were removed but because of the numerous benefits and advantages trees can bring to the urban environment apart from the obvious visual impact and seasonal interest.

Large urban trees create a sense of place, local identity and a system of landmarks that attract leisure and community activities helping residents to take pride in their town. Trees also provide a range of environmental benefits and the most important of which is the impact on air quality as trees are able to remove from the air harmful pollutants and fine particulates. Trees help to regulate climatic extremes by cooling the air in urban environments thereby reducing the heat island effect of extensive hard surfaces and reducing the energy demands of buildings. Trees create a positive environment which is shown through studies to improve the physical and psychological heath of residents and contribute to the improvement of anti-social behaviour.

Hornbeam was carefully chosen as the tree species for Market Place as it has good upright form and it is able to tolerate wide range of environmental conditions such as drought and high pollution levels and it is very tolerant of pests and diseases. Large trees in urban spaces can have a long life span provided there is sufficient rooting space. In Market Place this has been supported by the use of the underground structural soils cells which will provide a substantial rooting zone for the trees beneath the paving. These trees have increased the natural elements within an important town regeneration initiative and will offer many health benefits to our residents.

# INCREASING ACCESS

Another way we can maximise the benefits of green space in our area is to make best use of existing spaces. This can be through improving the quality of already available spaces, opening previously private areas and finding new ways to encourage their use.

Access to green spaces can be increased by removing the barriers to their use. These can vary for different groups, and are not restricted to their quantity or closeness to home. Personal concerns for safety, the quality of the spaces, the weather or poor transport infrastructure can prevent people using green spaces.

Local authorities can work to remove these barriers, alongside the wide range of other organisations who aim to improve the natural environment, encourage people to use it and increase healthy behaviours. Finding new ways to collaborate and strengthening existing links can allow us to make the most of the potential benefits for the green spaces already in our area.



## RESEARCH

Volunteering with the Wildlife Trusts [40] improved peoples' mental wellbeing in 6-12 weeks in a study looking at 139 people, some of which were referred by healthcare providers, who volunteered with the Wildlife Trusts as they took part in nature conservation volunteering activities. 95% of participants with low self-reported wellbeing at the start of the project reported an improvement in 6 weeks, this level increased further over the following 6 weeks. Participants reported significantly enhanced feelings of positivity, increased general health and pro-environmental behaviour, higher levels of physical activity and more contact with greenspace at 12 weeks.

An Australian study [41] combined an audit about public open spaces in Perth with over 1,800 personal interviews. After statistical analysis, they found that those with very good access to large, attractive open spaces were 50% more likely to report high levels of walking, when compared with those do not have access to quality public spaces. This is evidence that the proximity and quality of spaces increases their use.



## POLICY

A briefing [42] from the UCL Institute of Health Equity and Public Health England suggests some ways to increase access to green spaces:

1. Create new areas of green space and improve the quality of existing green spaces.
2. Increase accessibility of green spaces and improve engagement with local people.
3. Increasing the use of good quality green space for all social groups.

The Accessible Natural Greenspace Standard (ANGSt) was developed by Natural England to aim to quantify the need for local, useable space near communities. The standards state:

'All people should have accessible natural green space:

- of at least two hectares in size, no more than 300m (five minutes' walk) from home
- at least one accessible 20 hectare site within 2km of home
- one accessible 100 hectare site within 5km of home
- one accessible 500 hectare site within 10km of home'

These criteria account for the need for immediately local smaller spaces, as well as larger areas for sports and walking and are a means by which we can measure the depth and breadth of green spaces around us. Applying the standards to our area might enable us to find particular spaces that could be opened for residents for the widest benefit.

## CASE STUDY: GREENWAYS

***By Andrew Glencross, Green Infrastructure Manager***

### FIRST TRAFFIC-FREE GREEN ROUTE LINKING FINCHAMPSTEAD TO ARBORFIELD GREEN

Wokingham Borough Council's first greenway, which links Finchampstead (The FBC Centre) to new the new development at Arborfield Green (the former Arborfield Garrison) was officially opened by the Mayor of Wokingham borough in December 2017.

The project forms part of the Council's ambitious agenda to develop a network of greenways – traffic-free multi user routes – to link the major development locations to each other and also to the existing communities and places of interest and employment. In addition to the contribution to our sustainable transport strategy, it is hoped that the network will make cycling or walking more accessible to the local community which will inevitably bring a range of health and wellbeing benefits.

The first greenway will provide a safe route for pedestrians, cyclists and other users between the new Arborfield Green Development, and Finchampstead via California Country Park.  The new path boasts a new hard, permeable all weather surface made from a mixture of gravel and recycled car tyres, making the path accessible for most types of users.

Wokingham Borough Council's executive member for environment, Cllr Norman Jorgensen said: "I'm delighted that the first of our Greenways has now opened. These Greenways provide a genuinely attractive alternative to cars for getting around – it's great that our first will be accessible for so many different users – all while providing new designated commuter routes to get people to where they work and go to school."





# CONCLUSIONS

Green spaces can fundamentally define the spaces in which people live and work. The natural environment can have wide ranging health benefits for individuals and our communities and therefore have an important role to play in helping to reduce health inequalities.

Green spaces are free at the point of use and are an accessible asset for all communities, including those who may not be willing or able to pay to use other public or private facilities. It should be noted that Green spaces are assets of value in their own right and are often valued for their relatively undeveloped and unspoilt nature. The quality of such spaces and their benefit to communities depends upon appropriate design and management of them.

We have examined how there is clear evidence for a range of improvements to health and wellbeing, including but not limited to:

- Mental health
- Pregnancy
- Childhood development
- Reduction in cardiovascular disease
- Increasing physical activity
- Reducing health inequalities
- Improving cohesion in communities

We have been able to showcase the wide range of success stories from the local authority and other organisations that are increasing our health and wellbeing by using the natural environment.

We also considered the current health of our population, particularly in the areas that could be improved by green spaces.

There are opportunities and challenges to using green spaces, and we have also considered some of the limitations to achieving these benefits and a few of the ways we might make more use of the assets in our area.

# RECOMMENDATIONS

1. Local authorities and other agencies should continue to encourage community initiatives that make the most of natural space available, with the aim of improving mental health, increasing physical activity and strengthening communities.
2. Existing green space should be improved and any new developments should include high quality green spaces. The use of professional design and arrangements to ensure the ongoing management of natural environments should be considered if spaces are to be sustainable.
3. Opportunities to increase active transport should be considered when designing new green spaces and in the improvement of existing space.
4. Planning guidance for new developments should specifically consider the use of green and blue space to improve the health and wellbeing of residents and others using the space.
5. Local Authorities and their public health teams should foster new relationships with organisations aiming to improve the natural environment and its use.



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Wokingham Borough
May 2018

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| | |
|---|---|
| **TITLE** | **Joint Strategic Needs Assessment (JSNA) 2018 update** |
| **FOR CONSIDERATION BY** | Health and Wellbeing Board on Thursday, 14 June 2018 |
| **WARD** | None Specific; |
| **DIRECTOR/ KEY OFFICER** | Julie Hotchkiss, Consultant in Public Health |

| | |
|---|---|
| Health and Wellbeing Strategy priority/priorities most progressed through the report | All 4 priorities. |
| Key outcomes achieved against the Strategy priority/priorities | The JSNA provides the underlying evidence base and baseline on which to assess progress on the 4 priorities |

| | |
|---|---|
| Reason for consideration by Health and Wellbeing Board | The JSNA is a statutory document that is produced at regular intervals by key stakeholders from the council and its partner organisations. It presents intelligence on the wider determinants of health, highlights areas of inequalities, population needs and current services and gaps across all areas of health and social care. Before the final document is published it needs to be approved and signed off by the HWB board. These rough draft papers are being brought to seek member's views and input. |
| What (if any) public engagement has been carried out? | Internal engagement within relevant council staff has been undertaken, and continues to be undertaken. No formal consultation on the draft report chapters has been undertaken with the public. |
| State the financial implications of the decision | None. |

**RECOMMENDATION**

That the Board reviews the draft chapters and provides feedback and proposes recommendations for consideration.

**SUMMARY OF REPORT**

The report is arranged in six chapter starting with the Borough Profile for general background on the population. The next four chapters are arranged across the life course: starting well, developing well, living and working well and ageing well. The final chapter is People and Places, which provides information on the wider determinants of health, and intelligence on specific groups of people, for example with protected characteristics, which go across the life course.

**Selected key messages highlighted thus far include:**

- Continued population growth; the fastest growing age group is the over 90s at 21% increase, but these are still numerically small. There will be an additional 6,600 people over 75 by 2021.
- However larger numbers of older people are staying healthier longer, "Healthy Life Expectancy" at age 65 is 13 to 14 years – an asset, not a necessarily a need
- There are 4,446 household classified as fuel poor
- Only 37% of mothers receive an antenatal visit from the Health Visitor before the baby is born – lower than the national rate.
- Although 'flu vaccination in pregnant women is the second best in the Thames Valley, it is still only 46% - room for improvement
- Children in receipt of Free School Meals do not reach the same levels of attainment at various stages of their school careers as children who don't receive them
- Only 16% of teenagers achieve the recommended minimum physical activity level of hour of moderate or vigorous activity a day
- Alcohol is by far the most common drug used by teenagers (and adults) in Wokingham Borough Council
- Only 6% of adults report a "low happiness" score, better than the national 8.5%.
- Nearly a fifth of adults report feeling anxious, which is the same as the national level
- The cumulative percentage of Wokingham registered patients who received an NHS Health Check (the check for people aged 40 – 74 years not known to have a vascular disease) is only 21%, compared to the national 36%
- There are probably about 3,000 people with diabetes which has not yet been diagnosed and therefore untreated, need to increase testing for diabetes
- Older people discharged from hospital into rehabilitation/reablement services in Wokingham are less likely to be at home 3 months later (73% compared to national 83%)

**Board Members are asked to complete the attached matrix to ensure that all relevant information has been covered before recommendations are made.**

## Background

The JSNA is a statutory document that is produced at regular intervals by key stakeholders from the council and its partner organisations. It presents intelligence on the wider determinants of health, highlights areas of inequalities, population needs and current services and gaps across all areas of health and social care. The existing JSNA data has been presented as separate sections available online on the Council's website. This version has been prepared synthesising the updated data into a whole document with recommendations to inform delivery of the Joint Health and Wellbeing Strategy. When complete, pdf versions of the whole document and the individual 6 chapters, to facilitate non-specialist staff and a wider audience being able to use the intelligence

These rough drafts are presented at an early stage to ensure partners can make overall comments on the direction and where they feel more analysis is needed.

## Analysis of Issues

In-depth analysis is provided in each of the six chapters attached.

## Enclosures

DRAFT_1.Borough Profile_01042018_v3
DRAFT_2.Starting Well_010620182018_v3
DRAFT_3.Developing Well_16052018_v3
DRAFT_4.Living and Working Well_05062018_v3
DRAFT_5.Ageing Well_05062018_v3
DRAFT_6.People and Places_03062018_V3
Enc 7 HWB JSNA recommendations template 14 June 2018

| **Partner Implications** |
|---|
| All partners are required to engage in the process of production by providing information to inform the JSNA production and recommendations. |

| **Reasons for considering the report in Part 2** |
|---|
| N/A |

| **List of Background Papers** |
|---|
| |

| | |
|---|---|
| **Contact** : **Chrisa Tsiarigli**, **JSNA Lead** Julie Hotchkiss, Consultant in Public Health | **Service** Public Health |
| **Telephone No** Tel: 0118 974 6628 | **Email** julie.hotchkiss@wokingham.gov.uk |

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# Wokingham Borough Profile 2017/18

Public Health Intelligence

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# 1. Key messages

- Population density ?
- The population of Wokingham was estimated to be 163,353 in 2017.
- The population is estimated to increase in the next five years. The highest increase in numbers is estimated to be in people who are aged 10-14, 60-64 and 75-79 years old.
- There are 13 GP Practices in Wokingham borough. The GP Practice registered population in September 2017 was 164,084 persons, of whom 49.7% were males and 50.3% females.
- Wokingham's population is predominantly White (82.2%). The 2011 Census counted 18,146 out of 154,380 people (11.8%) being from a Black and Ethnic Minority (BME) group. The largest BME group in Wokingham is Indian with 3.5% (5,331 people).
- Compared with the average life expectancy in England, people in Wokingham live longer. A boy and a girl born in Wokingham in 2013-15 are expected to live 2.1 and 1.7 years respectively longer, than a boy and a girl born in the same period in the rest of the country, to 81.6 and 84.8 respectively
- Wokingham is the least deprived borough in Berkshire and ranks 325th out of 326 local authorities in the country.
- Wokingham's general fertility rate (GFR) was 61.4 per 1,000 women aged 15 to 44 in 2015. This was similar to the national rate of 62.3 per 1,000 women.
- Wokingham's age-standardised mortality rate in 2015 was 843.6 per 100,000 population, which is lower compared to 987 per 100,000 In England.
- Wokingham has a considerably higher percentage (38.0%) of young people aged 18-24 in full-time education than England (33.0%).
- The employment rate in the population of working age in Wokingham is significantly higher (80.1%) than England (74.4%), but similar to the rest of Berkshire (79.1%) and the south east (77.7%).
- The 2011 Census counted 60,332 households in Wokingham borough. This figure has increased to 64,409 households in 2017; an increases of roughly 1% per year
- There are 4,446 (7.1%) households in Wokingham that are classified as fuel poor.
- The proportion of privately owned homes in Wokingham is higher than England with 89.8% and 82.5% respectively.

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# 2. Introduction

Wokingham is located in the centre of Berkshire. It covers an area of 69 square miles (17,898 hectares) and in 2016 the estimated number of people living in the borough was 161,878. This figure was projected to increase to 163,353 by 2017. From the resident population 80,693 were male and 82,659 female. The population density in Wokingham is currently around 9.0 persons per hectare, which makes it the third least densely populated borough in Berkshire, after West Berkshire (2.2 persons per hectare) and Windsor and Maidenhead (7.4 persons per hectare). Compare to national

Wokingham has 25 electoral wards, 99 LSOAs, and 20 MSOAs. There are between 1,000 and 2,500 people living in each LSOA, between 5,000 and 10,000 in each MSOA and between 5,000 and 15,000 in each ward. Map 1 illustrates the main geographical features in the borough. The borough has 1 hospital, 13 GP Practices, 24 pharmacies, 39 primary schools, 10 secondary schools and one Special Education Needs school. Appendix 1 contains maps of administrative boundaries, schools and pharmacies.

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**Map 1:** Wokingham borough

# 2. Population profile

## 2.1 Population structure

The population of Wokingham was estimated to be 163,353 people in 2017. . This was an increase of 1,469 people (0.9%) on 2015's estimated figures and an increase of 11,330 people (7.5%) on 2006's figures.

Wokingham's median age was 41.6 years in 2016, compared to 39.8 in England. Wokingham's population continues to age with 17.4% of the population aged 65 and over in 2016, compared to 13.4% in 2006. This is slightly lower than the England figure of 18.7%.

The increase in population from 2015 to 2016 in Wokingham was due to natural growth (net increase of 699 people), internal migration (net increase of 518 people) and international migration (net increase of 490 people).

Figure 1 illustrates the population structure by five year age groups and gender, compared with England and table 1 the numbers of people by age group and gender.

Figure 2 shows the estimated population difference in percentages and numbers between 2017 and 2021 by five year age bands.

The highest increase in numbers is estimated to be in people who age 10-14, 60-64 and 75-79 years old.

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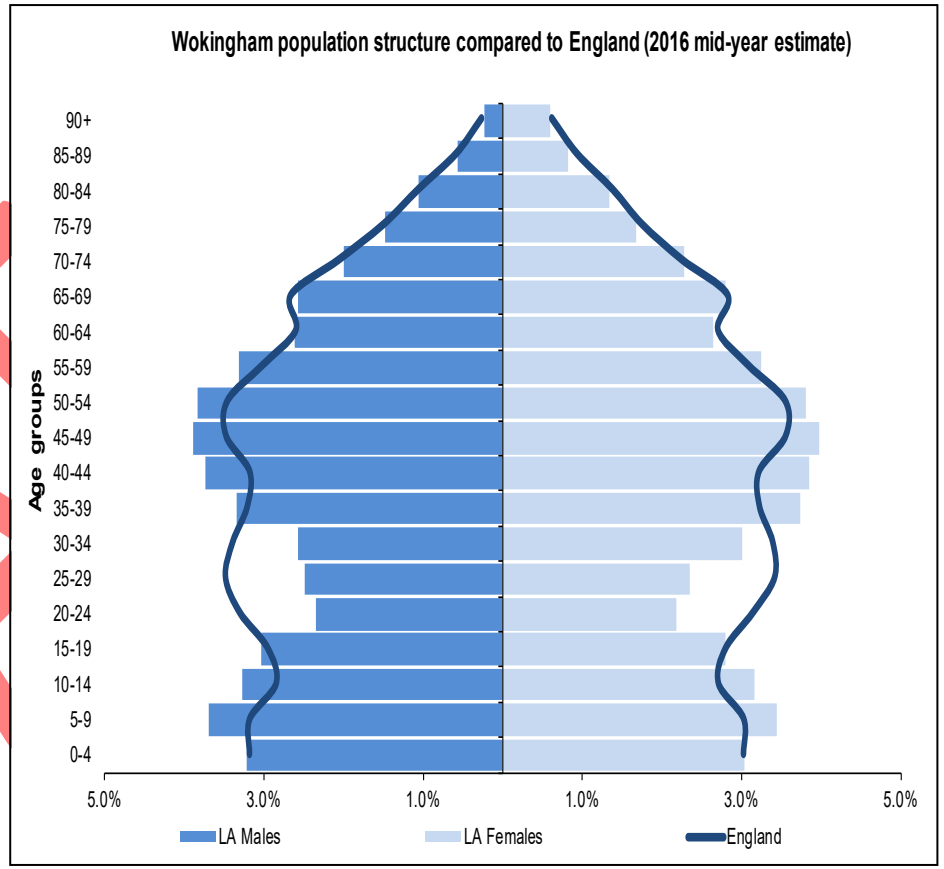


*Source: Office for National Statistics (2017); Population Estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2016*

**Figure 1:** Estimated population by age group and gender in 2016

**Table 1:** Wokingham population by age group and gender (2016 mid-year estimate)

| Age Group | Male | Female | People |
|---|---|---|---|
| **0-4** | 5,198 | 4,904 | 10,102 |
| **5-9** | 5,969 | 5,579 | 11,548 |
| **10-14** | 5,303 | 5,123 | 10,426 |
| **15-19** | 4,907 | 4,530 | 9,437 |
| **20-24** | 3,790 | 3,535 | 7,325 |
| **25-29** | 4,032 | 3,813 | 7,845 |
| **30-34** | 4,152 | 4,866 | 9,018 |
| **35-39** | 5,412 | 6,051 | 11,463 |
| **40-44** | 6,054 | 6,223 | 12,277 |
| **45-49** | 6,300 | 6,438 | 12,738 |
| **50-54** | 6,201 | 6,164 | 12,365 |
| **55-59** | 5,369 | 5,253 | 10,622 |
| **60-64** | 4,225 | 4,273 | 8,498 |
| **65-69** | 4,170 | 4,519 | 8,689 |
| **70-74** | 3,227 | 3,697 | 6,924 |
| **75-79** | 2,401 | 2,715 | 5,116 |
| **80-84** | 1,713 | 2,164 | 3,877 |
| **85-89** | 927 | 1,328 | 2,255 |
| **90+** | 376 | 977 | 1,353 |
| **Total** | **79,726** | **82,152** | **161,878** |

*Source: Office for National Statistics (2017); Population Estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2016*

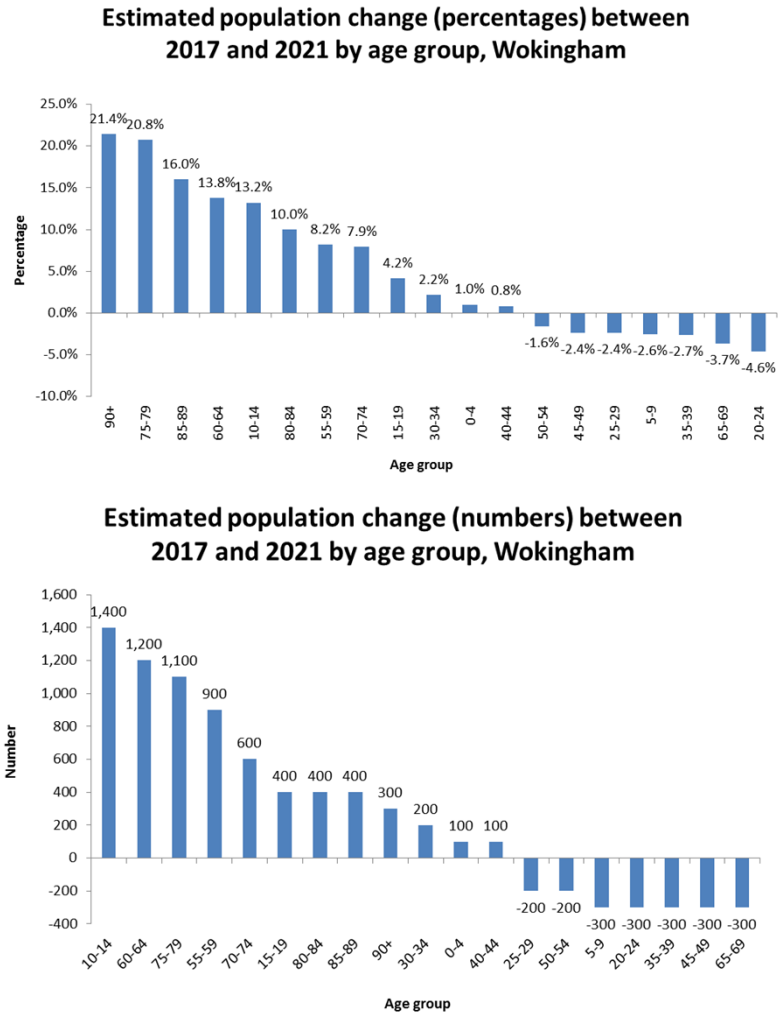


**Figure 2:** Projected difference in population between 2017 and 2021 by age group

*Source: ONS 2015-based subnational population projections*

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## 2.2 GP Practice registered population

There are 13 GP Practices in Wokingham. The GP Practice registered population in September 2017 was 164,084 persons, of whom 49.7% were male and 50.3% female. The GP registrations in Wokingham are 0.5% higher than the estimated resident population number in 2017 (163,353). This could indicate that the either there are more people living in the borough than the estimated population figure, or the GP registers contain people who are deceased or reside outside the borough. There are also likely to be residents who are registered with practices outside of Wokingham, and perhaps one of the new app-based practices in London, but there are no data available to quantify this.

The resident and registered populations in Wokingham are very similar, which means that the majority of residents are registered with a GP Practice in the borough. The numbers of patients by GP Practice differs a lot ranging from 2,259 to 26,895 patients. The table below shows GP Practice list size in September 2017. Map 2 shows the location of GP Practices over population density.

**Table 2:** Registered population by GP Practice and gender, September 2017

| GP Practice | Male | Female | Persons |
|---|---|---|---|
| Swallowfield Medical Practice | 5,818 | 5,981 | 11,799 |
| Wokingham Medical Centre | 11,643 | 11,743 | 23,386 |
| Finchampstead Practice | 7,645 | 7,866 | 15,511 |
| Parkside Practice | 7,325 | 7,284 | 14,609 |
| Brookside Practice | 13,468 | 13,427 | 26,895 |
| Woodley Practice | 5,797 | 6,179 | 11,976 |
| Wargrave Practice | 3,392 | 3,593 | 6,985 |
| Loddon Vale Practice | 7,786 | 7,701 | 15,487 |
| Twyford Surgery | 6,459 | 6,385 | 12,844 |
| The New Surgery | 3,591 | 3,569 | 7,160 |
| Woosehill Practice | 6,065 | 6,298 | 12,363 |
| Wilderness Practice | 1,236 | 1,023 | 2,259 |
| Burma Hill Practice | 1,381 | 1,429 | 2,810 |
| **Total** | **81,606** | **82,478** | **164,084** |

*Source: Wokingham CCG*

**Map 2:** GP Practices over population density

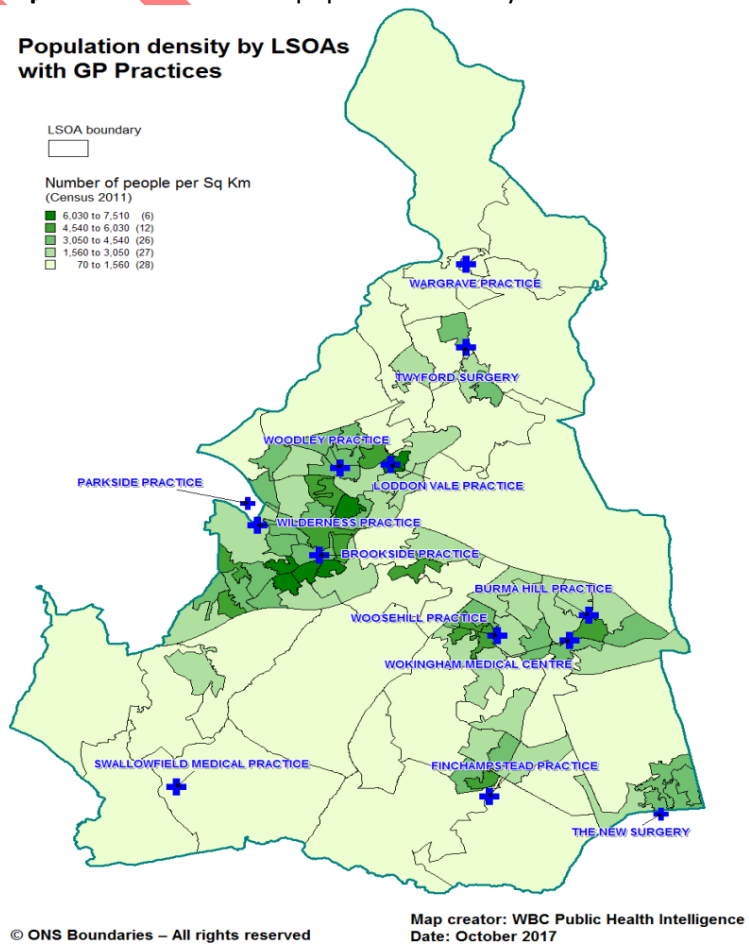


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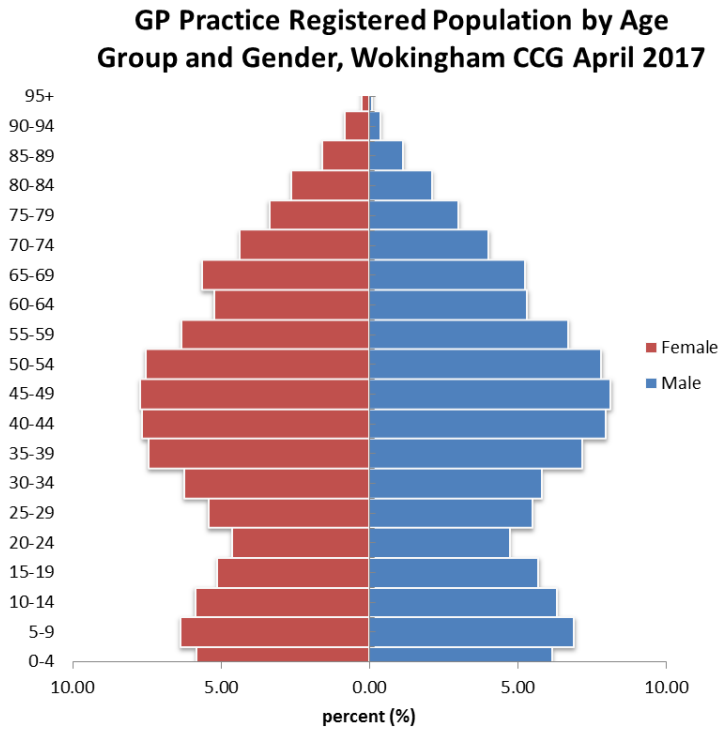
Figure 4 illustrates the GP practice population by 5-year age groups and gender. The majority of the registered population are aged between 35 and 54 years old. There is also a large proportion of 5 to 14 year olds.

**Figure 4:** GP Practice population pyramid by 5-year age group and gender




*Source: NHS Digital*

## 2.3 Mobility

Each year approximately 10,000 people migrate into Wokingham from a different local authority within the UK and 9,600 people migrate from Wokingham into a different local authority within the UK. There are approximately 1,000 people who migrate into Wokingham from abroad annually and 900 who emigrate from Wokingham abroad. Each year around 400 people migrate into Wokingham from another country within the UK and 400 migrate from Wokingham to another country within UK *(Source: ONS 2014-based sub-national population projections with components of change)*.

The population turnover for internal migration into Wokingham was 127.0 per 1,000 resident population in 2015 where there was a population estimate of 160,409. This rate is significantly above the England rate of 101.7 per 1,000 resident population and the comparator rate of 116.7 per 1,000 resident population.

For 2015, there were 1,683 Migrant GP registrations within Wokingham. This is a rate of 10.5 per 1,000 population which is significantly below the England rate of 12.6 per 1,000 population.

Using statistics between January and December 2016, an estimated 18,000 people living in Wokingham were born outside of the UK. That equates to 11.3% of the total local population. England's proportion of people born outside of the UK is 15.4%.

International migration into Wokingham during 2015/16 was 1,197. International migration out was 707. This means the total net migration was +490. Internal Migration during 2015/16 was 10,306 in and 9,788 out, therefore a total net of +518 for internal migration.

For migrants living within the local authority, there were 1,581 new National Insurance Registrations between Jan 2016 and Dec 2016 and

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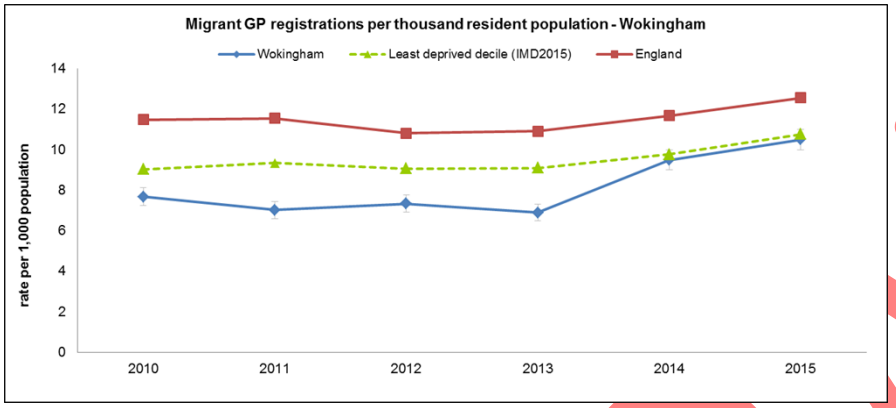
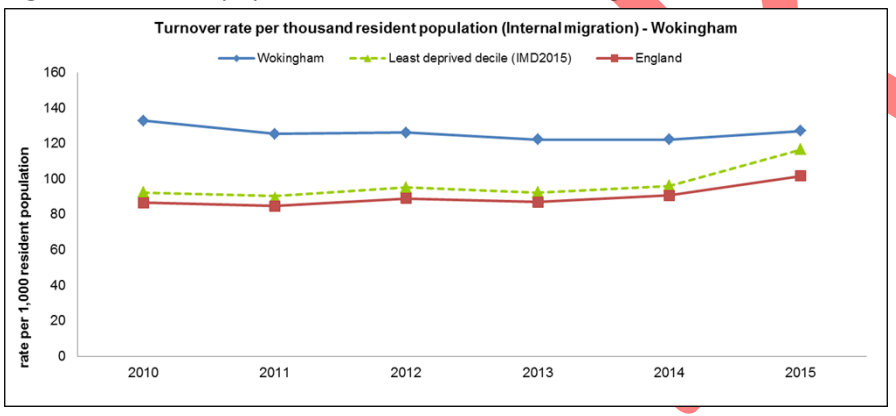
1,658 new GP registrations between mid 2015 and mid 2016. (Source: ONS: Annual rates for Local Area Migration Indicators)

**Figure 5:** Trend in migrant GP registrations




*Source: PHE: Public Health Profiles*

**Figure 6:** Trend in population turnover (internal migration)




*Source: PHE: Public Health Profiles*

## 2.4 Ethnicity

ONS does not produce sub-national population projections by Ethnicity. The most accurate source of ethnicity data for Local Authorities is still the 2011 Census.

Wokingham's population is predominantly White (82.2%). The 2011 Census counted 18,146 out of 154,380 people (11.8%) being from a BME group. The largest Black and Ethnic minority (BME) group in Wokingham is Indian with 3.5% (5,331 people).

**Figure 3:** Proportion of ethnic groups in Wokingham (Census 2011)

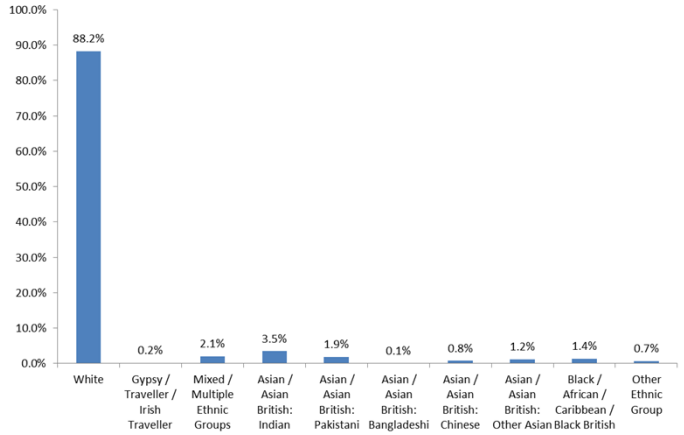



**Table 3:** Number of people by ethnic group

| Ethnic group | Number | Percentage (%) |
|---|---|---|
| All categories: Ethnic Group | 154,380 | 100.0% |
| White | 136,234 | 88.2% |
| Gypsy / Traveller / Irish Traveller | 291 | 0.2% |
| Mixed / Multiple Ethnic Groups | 3,182 | 2.1% |
| Asian / Asian British: Indian | 5,331 | 3.5% |
| Asian / Asian British: Pakistani | 2,865 | 1.9% |

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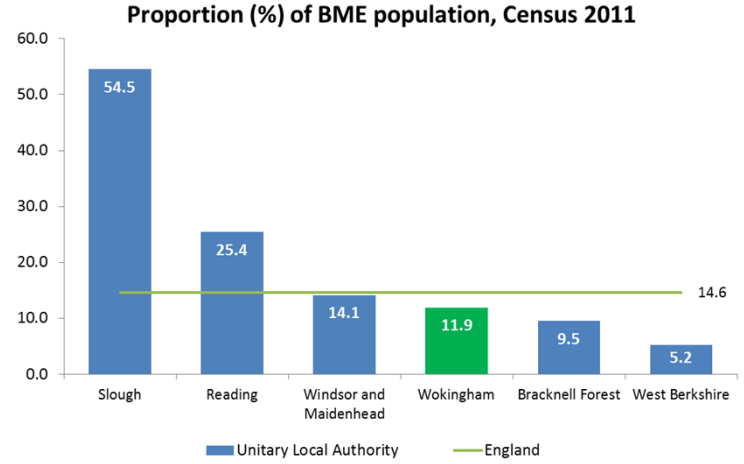
| | | |
|---|---|---|
| Asian / Asian British: Bangladeshi | 222 | 0.1% |
| Asian / Asian British: Chinese | 1,203 | 0.8% |
| Asian / Asian British: Other Asian | 1,817 | 1.2% |
| Black / African / Caribbean / Black British | 2,093 | 1.4% |
| Other Ethnic Group | 1,142 | 0.7% |

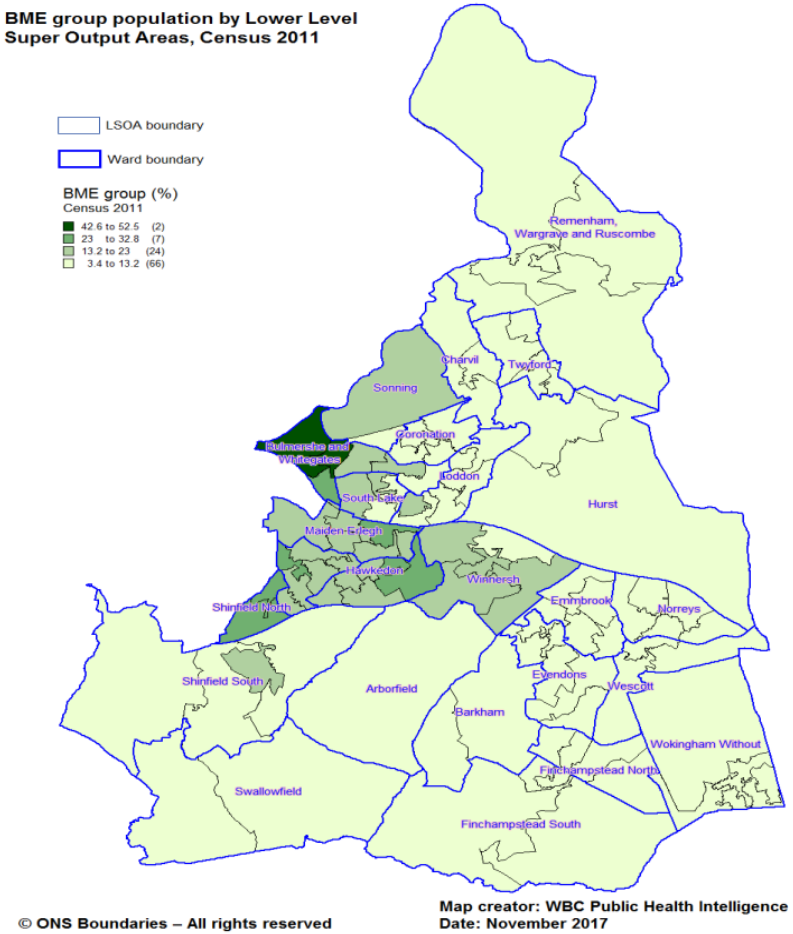
The chart below illustrates the proportion of BME population in Berkshire by unitary authority compared with the South East and England. Wokingham has the third lowest proportion of BME population in Berkshire which is also lower than the national value of 14.6%.

**Figure 4:** Proportion of BME population in Berkshire (Census 2011)




Map 3 shows percentage of BME population by LSOAs with wards overlaid. There is an LSOA in Bulmershe and Whitegates ward which has the highest proportion (54%) of BME population in Wokingham. The areas with the highest percentage of BME groups are in the west part of the borough bordering Reading.

**Map 3:** Proportion of BME group by LSOAs




## 2.5 Life expectancy

Compared with the average life expectancy in England, people in Wokingham live longer. A boy and a girl born in Wokingham in 2013-15 are

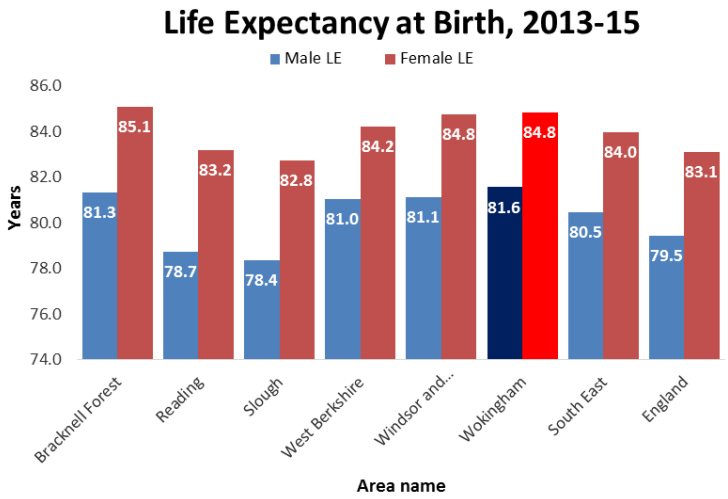
expected to live 2.1 and 1.7 years respectively longer, than a boy and a girl born in the same period in the rest of the country.

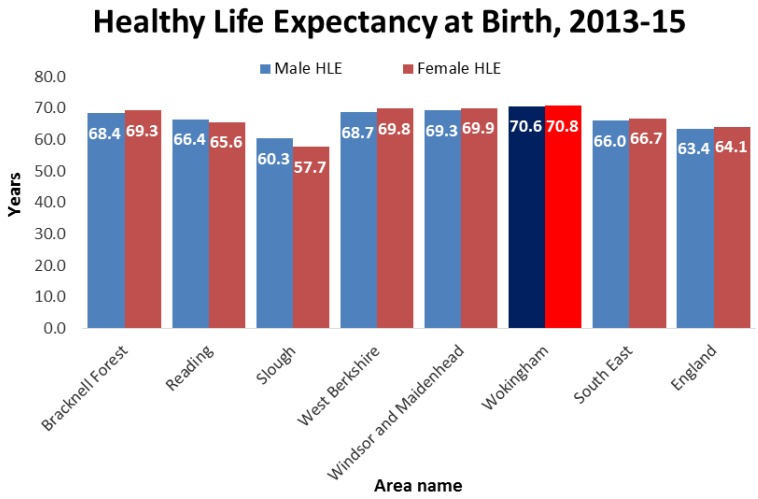
Wokingham has the highest male life expectancy at birth in Berkshire with 81.6 years. The female life expectancy at birth is 84.8 years.

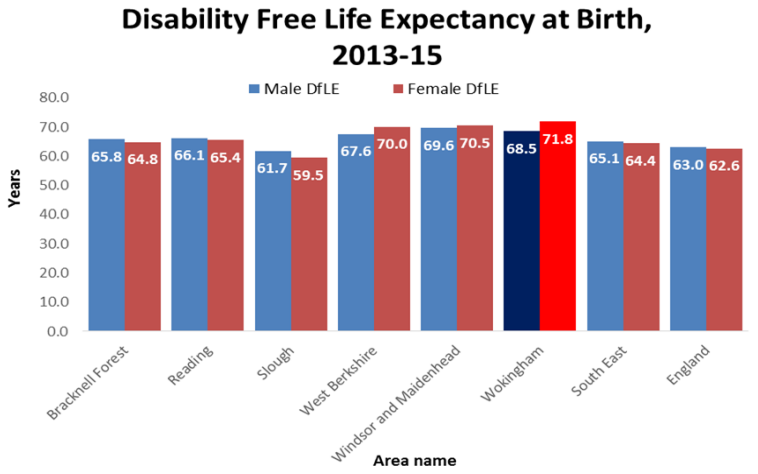
The healthy life expectancy for boys born in 2013-15 in Wokingham was 70.6 years, which was significantly better than the England figure of 63.4 years. The healthy life expectancy for girls born in 2013-15 was 70.8 years, which was also significantly better than the England figure of 64.1 years.

The disability free life expectancy for boys born in 2013-15 in Wokingham was 68.5 years for men and 71.8 years for women.

**Figure 5-7:** Life expectancy, healthy life expectancy and disability free life expectancy at birth




*Source: ONS*

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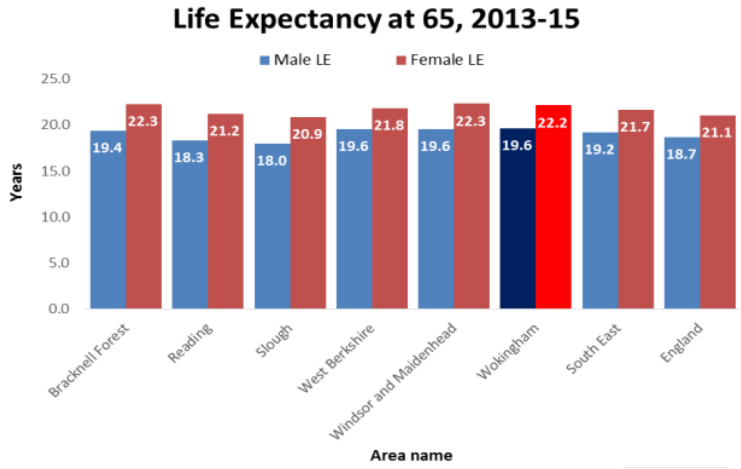
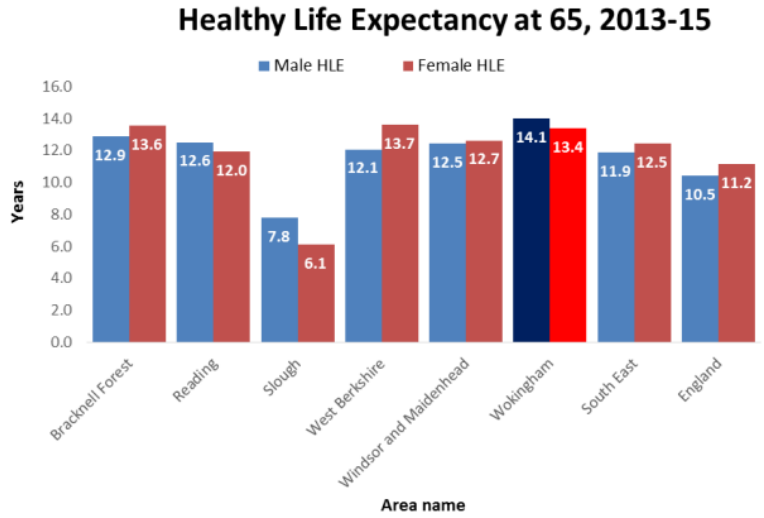
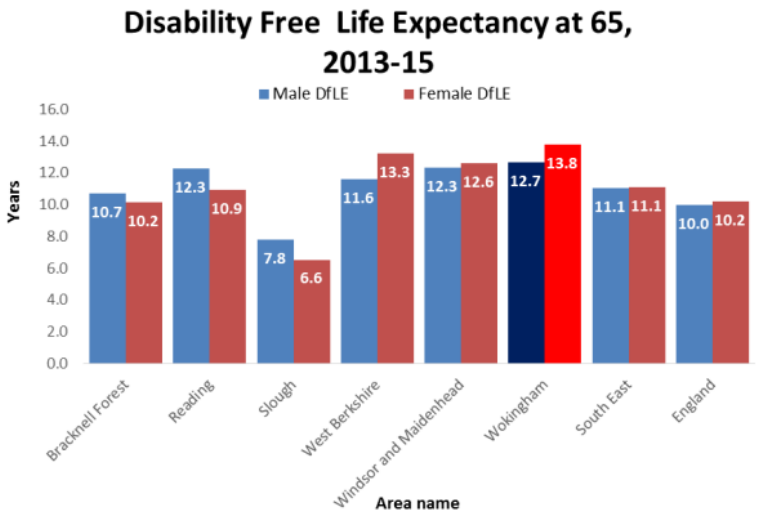
**Figures 8-10:** Life expectancy, healthy life expectancy and disability free life expectancy at 65




*Source: ONS*

## 2.6 Life expectancy inequalities

See section 3.3 on Deprivation for an explanation of what deprivation is and how it is mea
between life expectancy between the most deprived quintile (i.e. the bottom 20%) and th

Table 4: Life expectancy at birth by deprivation (in years)

| | Male | Female |
|---|---|---|
| Most deprived quintile | 79.7 | 82.4 |
| Least deprived quintile | 83.1 | 85.9 |
| Absolute gap | 3.4 | 3.5 |

The Segment Tool has been developed by Public Health England's (PHE) Epidemiology and Surveillance team and provides information on the causes of

death that are driving inequalities in life expectancy at local area level. Targeting these causes of death should have
the biggest impact on reducing inequalities.

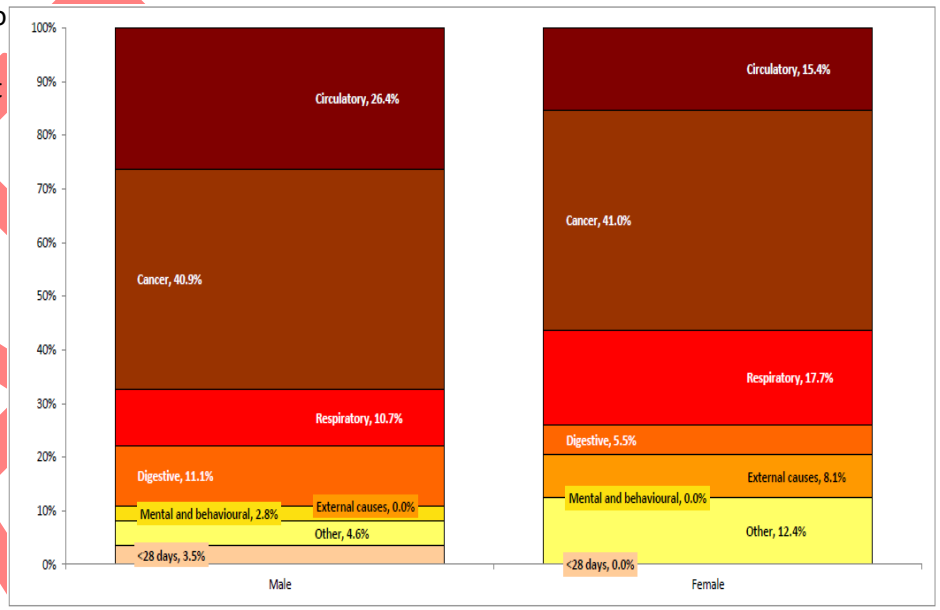
The scarf chart shows, for each broad cause of death, the percentage contributio
that it makes to the overall life expectancy gap between the areas selected.
If a cause shows a contribution of 0, this means that the cause of death does not make any contribution to the life expectancy gap.

In Wokingham the highest cause of death that drives life expectancy inequalities between the most deprived and the least deprived quintile is cancer, which accounts for 41% of deaths in both sexes. In males just over a quarter and in females a smaller percentage (15%) of the difference is due to circulatory diseases, and there is a very strong evidence base on how to reduce cardiovascular risk.

Very interesting is the finding that external causes of death (accidents and intentional harm) do not account for any of the gap in men, this is contrary to findings almost everywhere else; even in West Berkshire external causes account for over 13% of the gap in males. It could be related to the fact that numbers are relatively small (66 deaths), and therefore it could be chance that fewer men from the most deprived quintile died, or relatively more of the least deprived died in the 3 year period 2012-2014.

Also of note is that deaths due to mental and behavioural causes show very little or no variation by deprivation, again this is unusual, and this time it is not small numbers, as the number of deaths in Wokingham from 2012-2014 was 117 men and 241 women.

**Figure 11:** Scarf chart showing the breakdown of the life expectancy gap between Wokingham most deprived quintile and Wokingham least deprived quinitle, by broad cause of death, 2012-2014




Footnote: Circulatory diseases includes coronary heart disease and stroke. Respiratory diseases includes flu, pneumonia and chronic obstructive airways disease. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis. External causes include deaths from injury, poisoning and suicide. Mental and behavioural includes dementia and Alzheimer's disease.
Analysis by Public Health England Epidemiology and Surveillance team based on ONS death registration data, and mid year population estimates, and DCLG Index of Multiple Deprivation, 2015

## 2.7 Births, fertility and deaths

The births and deaths data comes from local register offices across the country and is analysed and published by the Office for National Statistics.

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There is usually a one to two years' time lapse between a birth or a death registration and the time the data is published.

On average there are approximately 1,800 births and 1,200 deaths in Wokingham every year.

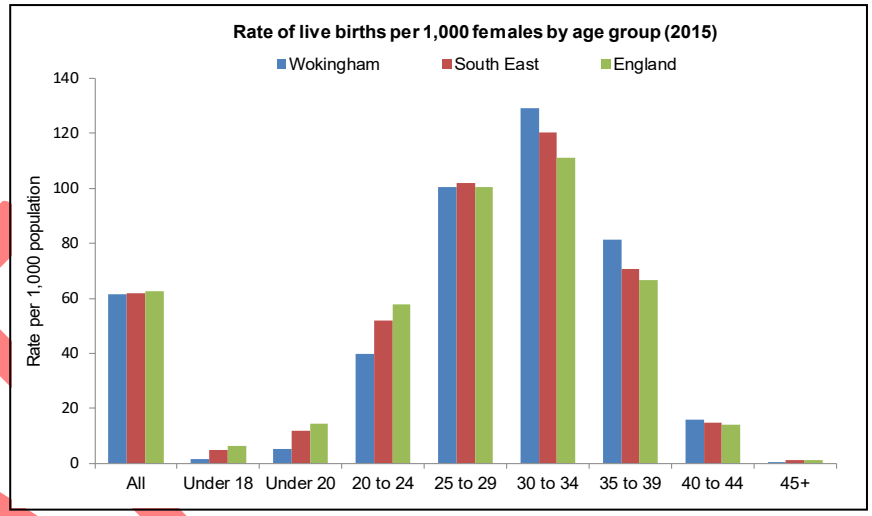
In 2015, there were 1,787 live births and 10 still births in Wokingham.

Wokingham's general fertility rate (GFR) was 61.4 per 1,000 women aged 15 to 44 in 2015. This was similar to the national rate of 62.3 per 1,000 women.

Wokingham's total fertility rate (TFR) was 1.86 children per woman in 2015, compared to 1.82 children per woman nationally.

Source: Office for National Statistics (2016); Birth Summary Tables, England and Wales 2015

0.2% of births in Wokingham were to mothers under the age of 18, compared to 0.9% nationally. 5.8% of births in Wokingham were to mothers aged 40 and over, compared to 4.2% nationally. 28.9% of births in Wokingham were outside of marriage or civil partnership in 2015, compared to 47.9% nationally.




*Source: Office for National Statistics (2016); Birth by mother's usual area of residence in the UK*

Map 4 illustrates birth rates by lower level super output areas. It is evident from the map that birth rates vary across the borough. The highest birth rates are found in smaller areas within the wards of Winnersh, Loddon, Wokingham Without, Bulmershe and Whitegates, Shinfiled South and Barkham.

The general fertility rate measures live births per 1,000 women aged 15-44 years old. Wokingham has the second lowest general fertility rate in Berkshire with 62.3 births per 1,000 females aged 15-44. However figures vary by ward. Arborfield has the highest fertility rate with 98.0 per 1,000, which is significantly higher than the Wokingham average

**Figure 12:** Birth rates by age group

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**Map 4:** Birth rates by LSOAs in 2014

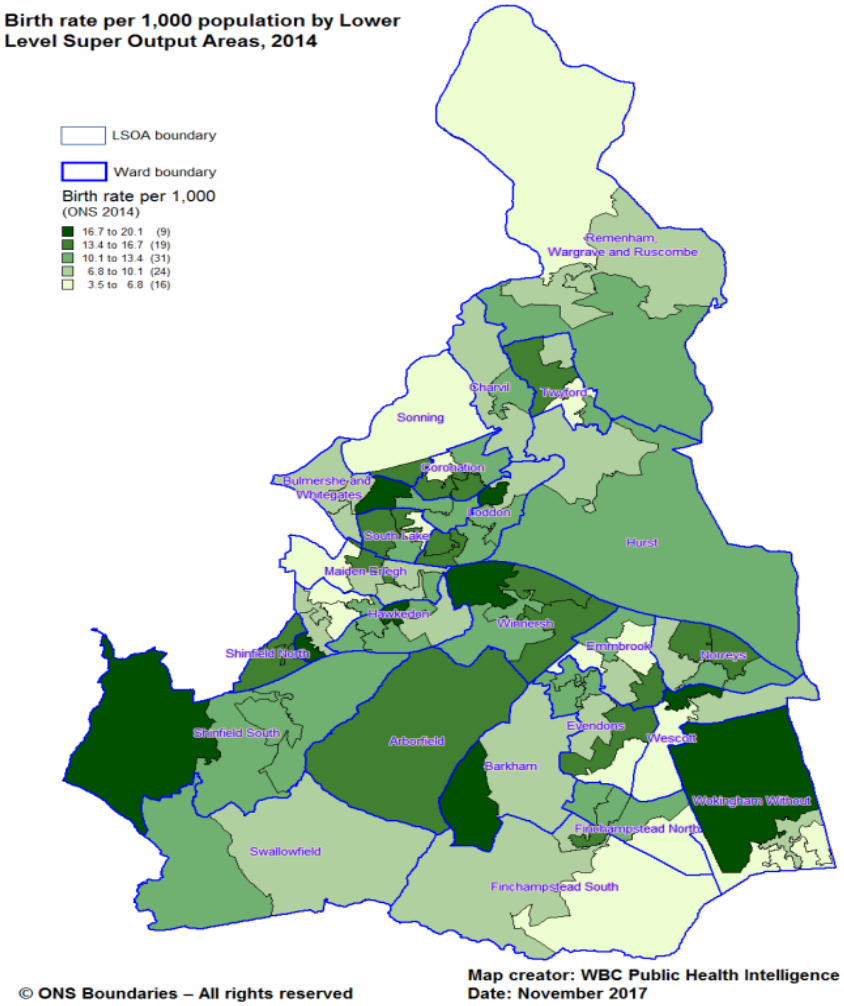
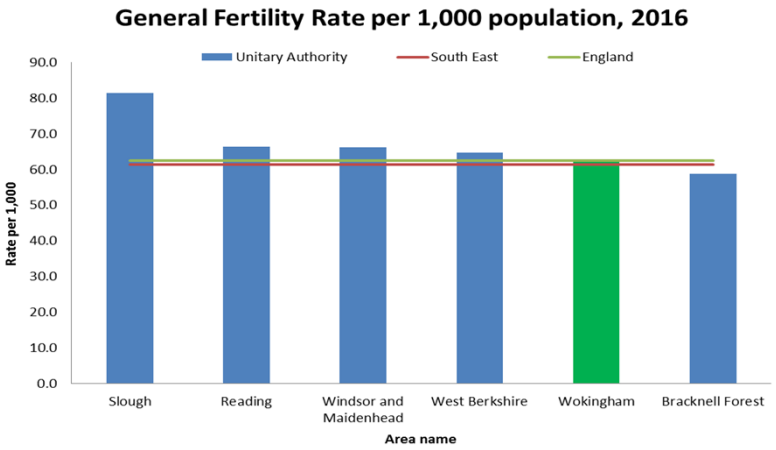



**Figure 13:** GFR – live births per 1,000 females aged 15-44



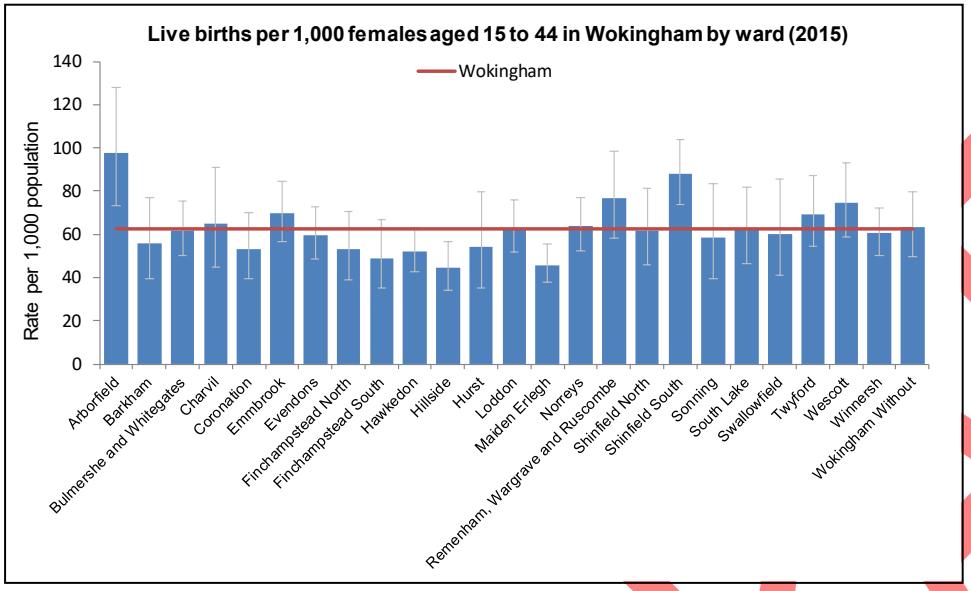

*Source: ONS*

**Table 4:** Number of live births and GFR in 2016

| | **Live births** | **GFR** |
|---|---|---|
| Slough | 2,628 | 81.4 |
| Reading | 2,494 | 66.4 |
| Windsor and Maidenhead | 1,757 | 66.2 |
| West Berkshire | 1,764 | 64.7 |
| Wokingham | 1,809 | 62.3 |
| Bracknell Forest | 1,397 | 58.7 |
| **South East** | **101,982** | **61.4** |
| **England** | **663,157** | **62.5** |

*Source: ONS*

**Figure 14:** General fertility rate by ward - Live births per 1,000 females (aged 15 to 44)




*Source: Office for National Statistics (2016); Annual Births Data*

There were 1,189 deaths registered in Wokingham in 2015 (614 male; 575 female).

Wokingham's age-standardised mortality rate in 2015 was 844 per 100,000 population, compared to 987 In England. This was an increase of 1.6% on 2014's rate.

Wokingham's male age-standardised mortality rate increased by 7.9% in 2015 to 1,045 per 100,000 population. The female age-standardised rate decreased by 5.1% to 694 per 100,000 population.

In 2015, cancer was the most common broad cause of death in Wokingham (28.4% of all deaths), followed by circulatory disease (24.1%) and respiratory diseases (14.0%).

The single main cause of death in Wokingham was dementia and Alzheimer's Disease (13.1%), followed by Ischaemic Heart Diseases (10.1%). This differed for men and women, as the main single cause of death for men was Ischaemic Heart Disease, while for women it was dementia and Alzheimer's Disease. This reflected the national picture.

In 2015, 29.5% of deaths in Wokingham were in people aged under 75. These are termed premature deaths.

The Public Health Outcomes Framework includes a number of indicators that monitor mortality and premature mortality rates at a local authority level. These are shown in the relevant non-communicable disease sections in the JSNA (for example: cancer, circulatory diseases, respiratory diseases).

In 2015, 568 people in Wokingham died from causes that were considered preventable. ('Preventable' means that all or most deaths from that cause could be avoided by public health interventions in the broadest sense.) This was an age-standardised rate of 130.5 per 100,000 population in Wokingham, which was significantly better than the England rate of 184.5 per 100,000 population. Preventable mortality has been coming down steadily; in 2001-2003 the rate in Wokingham was 184.1 or where the England average is now.

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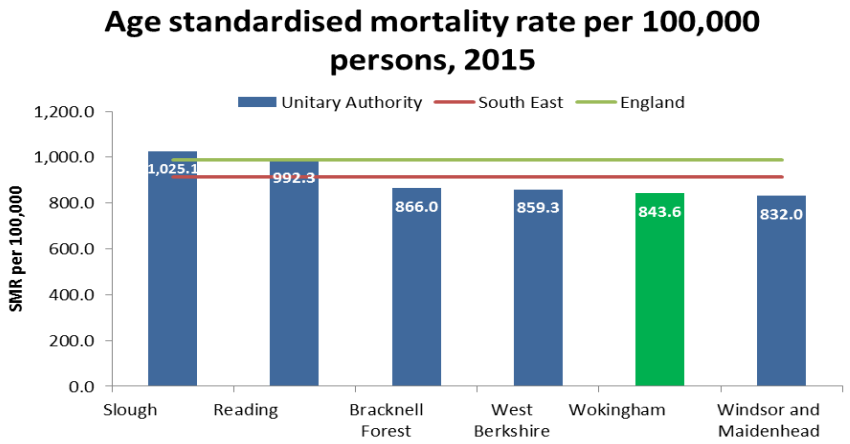
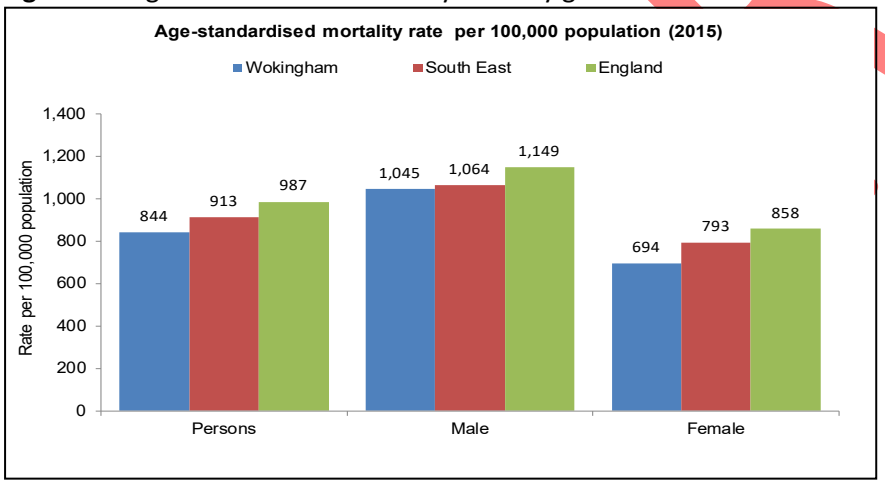
**Figure 15:** Age-standardised mortality rates in 2015



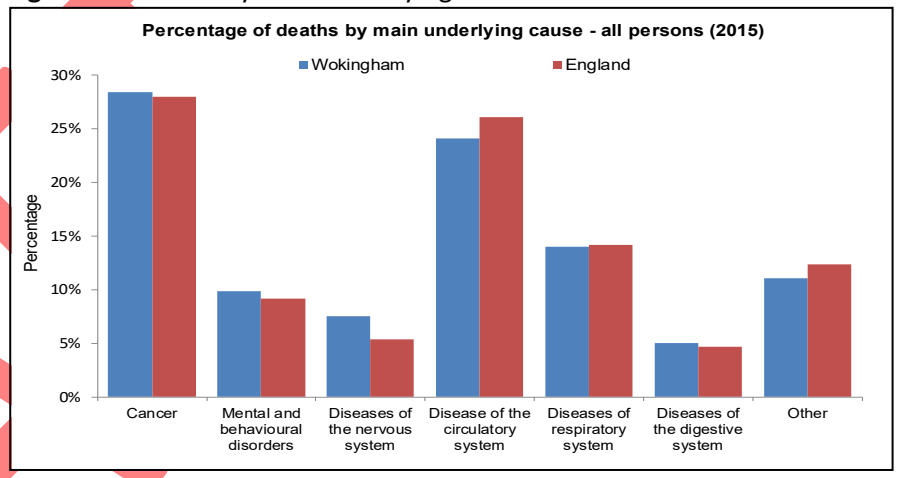

*Source: ONS*

**Figure 16:** Age-standardised mortality rates by gender in 2015



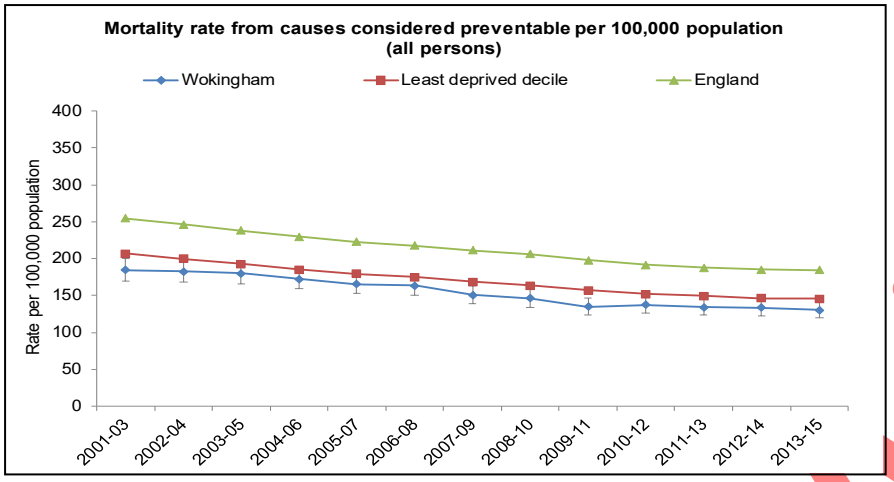

*Office for National Statistics (2016); Deaths registered in England and Wales: 2015 Detailed Release - Data tables*

**Figure 17:** Deaths by main underlying cause




*Source: NOMIS (2016); Mortality statistics - Underlying cause, sex and age (2013 - 2015)*

**Figure 18:** Mortality rate from causes considered preventable (all persons)




*Source: Public Health England (2016); Public Health Outcomes Framework*

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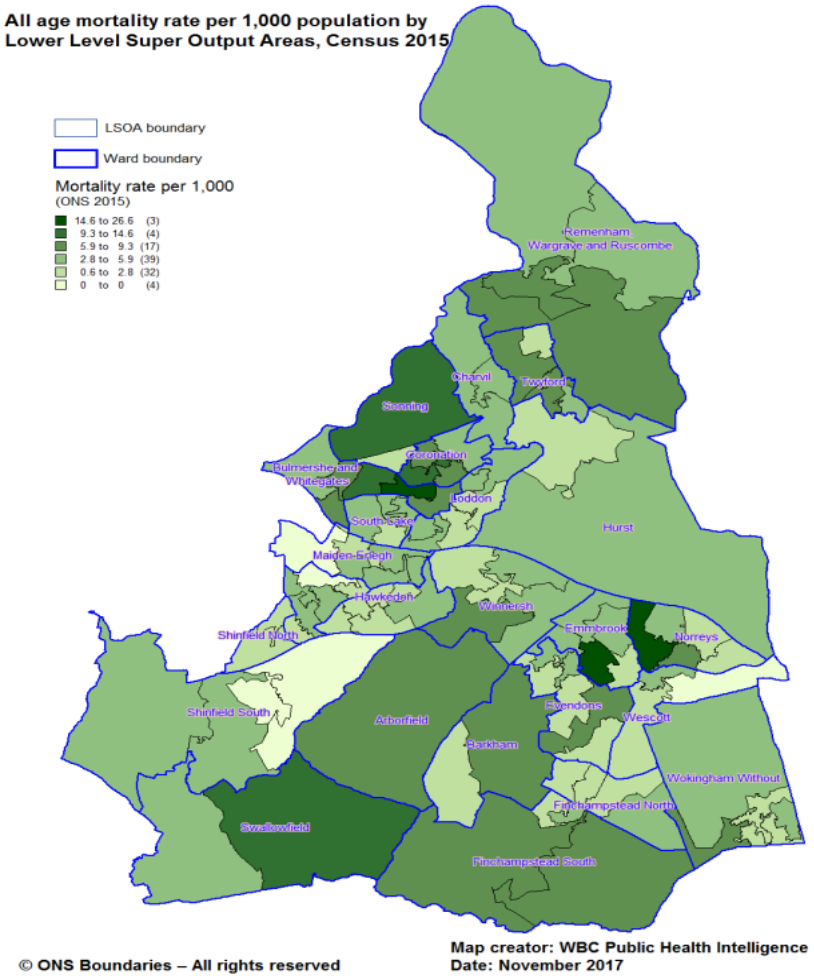
Map 6 shows crude mortality rates per 1,000 persons by LSOA. Appendix 3 contains a map of crude premature mortality rates per 1,000 by LSOA.

**Map 6:** Crude mortality rates BY LSOA, 2015

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# 3.Socio-economic profile

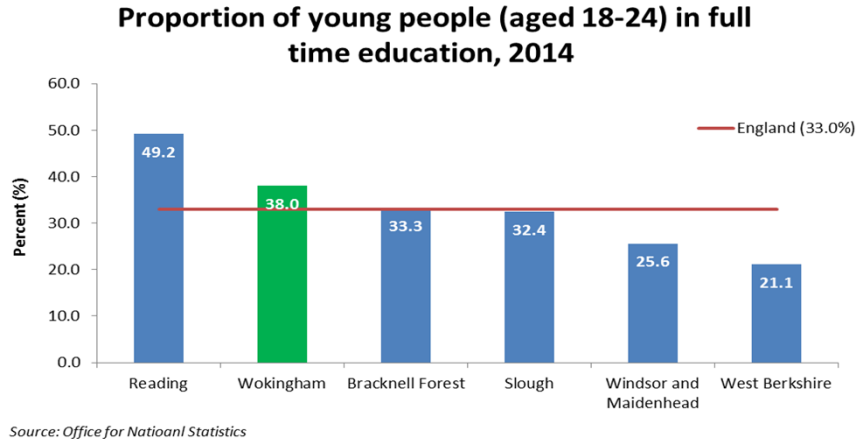
## 3.1 Education

State-funded schools in the Borough of Wokingham include ten secondary schools, one Special Educational Needs (SEN) school and 39 primary schools. There are also a number of independent schools. Maps 1.2 and 1.3 in Appendix 1 show the location of schools in the borough.

Bracknell and Wokingham College is the main further and adult education provider for the borough, just outside the borough its headquarters is in Bracknell. The Borough's closest higher education provider is the main Whiteknights Park campus of the University of Reading immediately north-west.

Wokingham has a considerably higher percentage of young people aged 18-24 in full-time education than England with 33.0%.

**Figure 19:** Proportion of young people in full time education




*Source: Office for Natioanl Statistics*

Include most recent number of Not in Education. Employment or Training (NEET) – I think local authorities have this on a frequent basis, possibly monthly or quarterly.

**Skills-qualifications**

**Income gap**

## 3.2 Employment

The employment rate in the population of working age in Wokingham is significantly higher (80.1%) than England (74.4%), but similar to the rest of Berkshire (79.1%) and the south east (77.7%).

The male employment rate is 85% and female considerably lower at 75.1%. Although it is the lowest gender employment rate gap in Berkshire, it is similar to the South East and England.

**Figure 20:** Employment rate in working age population

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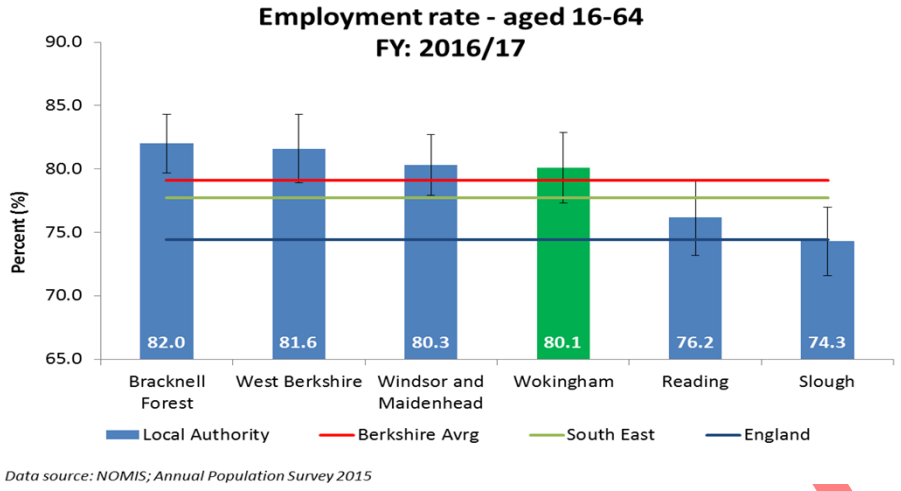
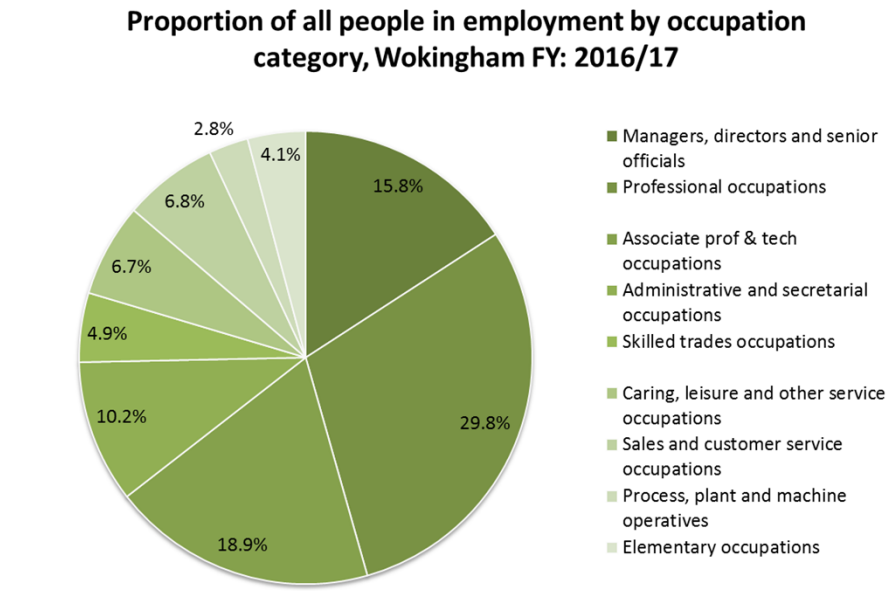



*Data source: NOMIS; Annual Population Survey 2015*

The majority of Wokingham residents (29.8%) have a professional occupation. The second highest (15.8%) occupation category is managers, directors and senior officers.

**Figure 21:** Proportion of occupations




*Data source: NOMIS; Annual Population Survey 2015*

Wokingham has the lowest (0.89) jobs density in Berkshire. However, it is higher than South East (0.86) and England (0.84).

Jobs density is the number of jobs in an area divided by the resident population aged 16-64 in that area. For example, a job density of 1.0 would mean that there is one job for every resident aged 16-64. The total number of jobs is a workplace-based measure and comprises employee jobs, self-employed, government-supported trainees and HM Forces.

Commuters – travel to work

**Figure 22:** Jobs density

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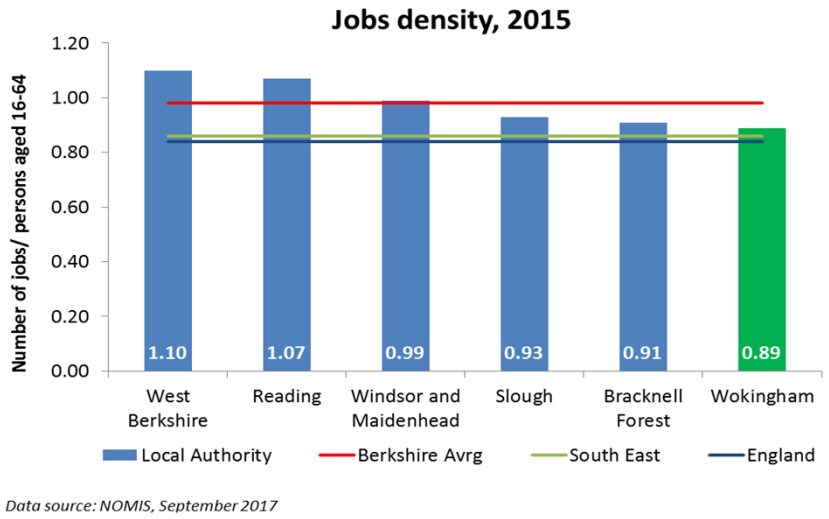
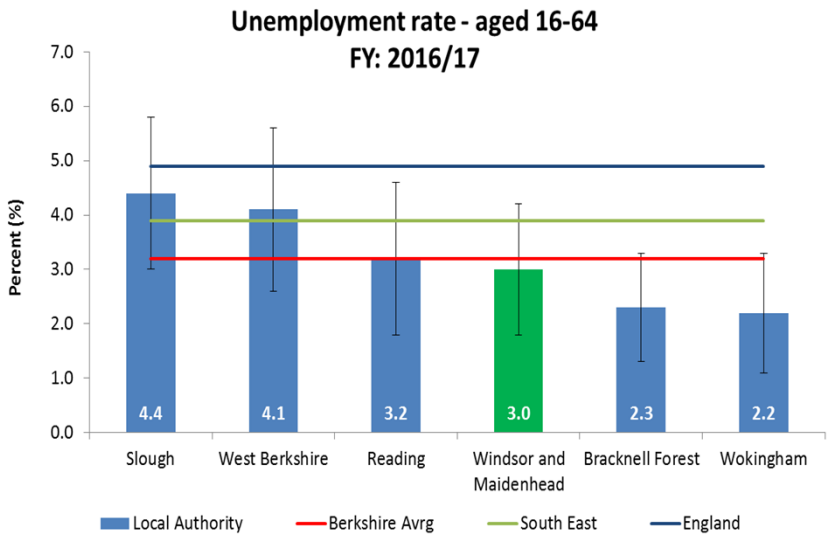



*Data source: NOMIS, September 2017*




*Data source: NOMIS; Annual Population Survey 2015*

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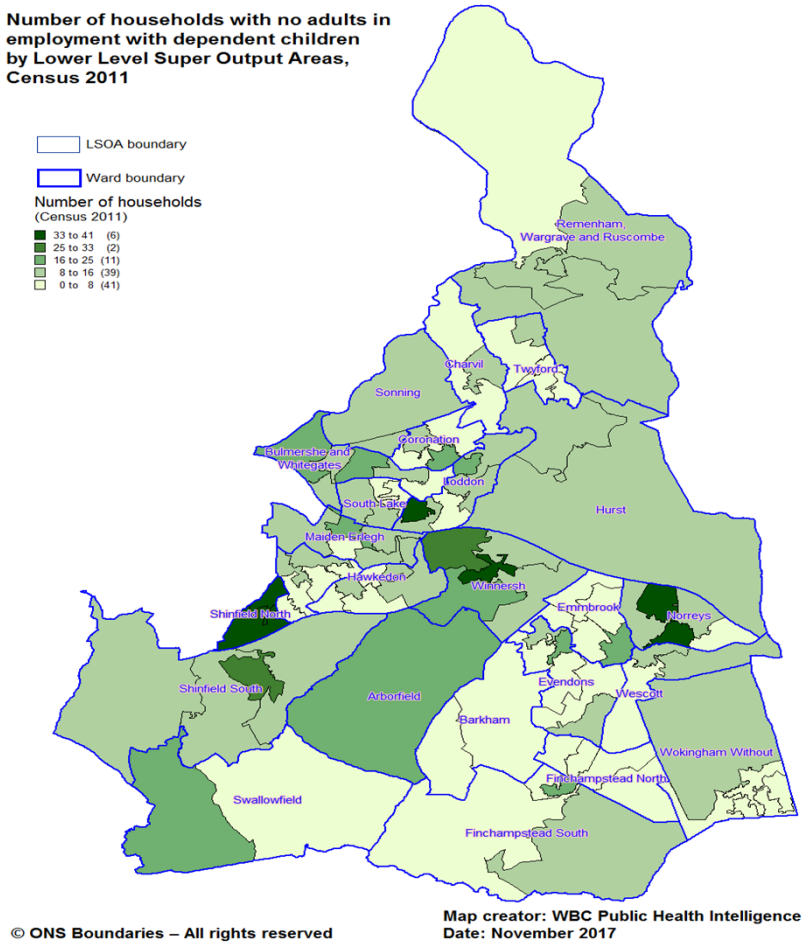
The unemployment rate in the working age population in Wokingham is the lowest (2.2%) in Berkshire and significantly lower than the South East (3.9%) and England (4.9%). Figure 23 shows unemployment rate in Unitary Authorities in Berkshire compared with the South East and England.

**Figure 23:** Unemployment rate in population aged 16-64

Map 7 shows number of households with no adults in employment with dependent children by LSOA. The areas with the highest concentration of households with no adults in employment with dependent children are Winnersh, Norreys, Shinfield North and South Lake wards.

These data are from 2011, but we do not have more recent data combining children and parental employment. A measure of deprivation in childhood is presented in Map 9.

**Map 7:** Households with no adults in employment with dependent children




## 3.3 Deprivation

The Indices of Deprivation 2015 provide a set of relative measures of deprivation for small areas (Lower-layer Super Output Areas) across England, based on seven domains of deprivation. The domains were combined using the following weights to produce the overall Index of Multiple Deprivation (IMD):

- Income Deprivation (22.5%)
- Employment Deprivation (22.5%)
- Education, Skills and Training Deprivation (13.5%)
- Health Deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment Deprivation (9.3%)

In addition to the Index of Multiple Deprivation and the seven domain indices, there are two supplementary indices: the Income Deprivation Affecting Children Index (IDACI) and the Income Deprivation Affecting Older People Index (IDAOPI).

Deprivation data is published approximately every 5 years.

The IMD 2010 in Wokingham was 5.4 and it has slightly increased in 2015 to 5.7.
Wokingham is the least deprived borough in Berkshire and ranks 325th out of 326 local authorities in the country.

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**Table 5:** IMD 2015 - summary

| **Local Authority District name (2013)** | **IMD - Average score** | **IMD - Rank of average score (1 least deprived, 326 LA district areas)** | **IMD - Proportion of LSOAs in most deprived 10% nationally** | **IMD - Rank of proportion of LSOAs in most deprived 10% nationally** |
|---|---|---|---|---|
| Bracknell Forest | 10.5 | 287 | 0 | 200 |
| West Berkshire | 10.2 | 291 | 0 | 200 |
| Reading | 19.3 | 146 | 0.02 | 170 |
| Slough | 22.9 | 112 | 0 | 200 |
| Windsor and Maidenhead | 8.9 | 306 | 0 | 200 |
| Wokingham | 5.7 | 325 | 0 | 200 |

*Source: Department for communities and local government*

Population distribution by English quintile of deprivation

| Deprivation quintile* | Wokingham | Berkshire | South East | England |
|---|---|---|---|---|
| Most deprived | 0% | | | 20% |
| 2nd most deprived | | | | 20% |
| Middle | | | | 20% |
| 2nd least deprived | | | | 20% |
| Least deprived | | | | 20% |

- A quintile is one fifth of the population, or 20%.

Map 8 illustrates IMD 2015 scores by LSOAs. The areas with the highest deprivation score are in Norreys and Wokingham Without wards.

Map 9 shows indices of deprivation affecting older people. The most deprived areas are in South Lake, Norreys, Wokingham Without and Bulmershe and Whitegates.

Map 1.3 in Appendix 1 shows Indices of income deprivation affecting children with secondary schools.

**Map 8:** Index of Multiple Deprivation 2015

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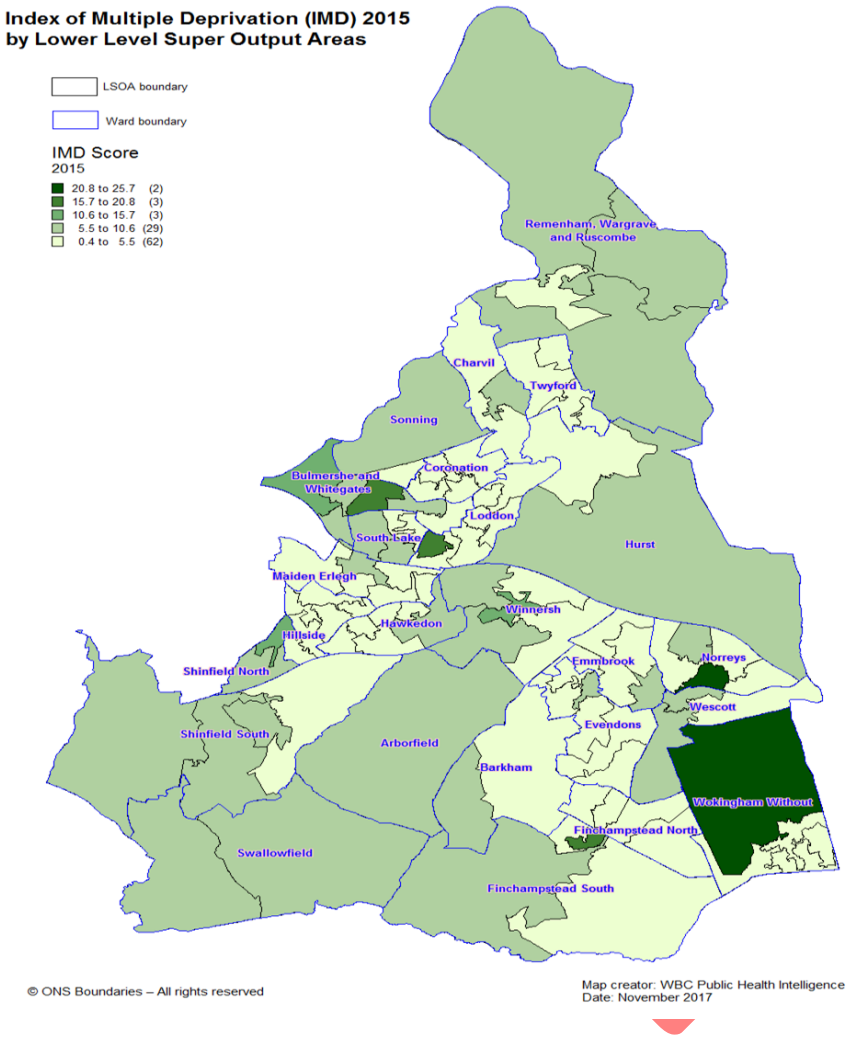
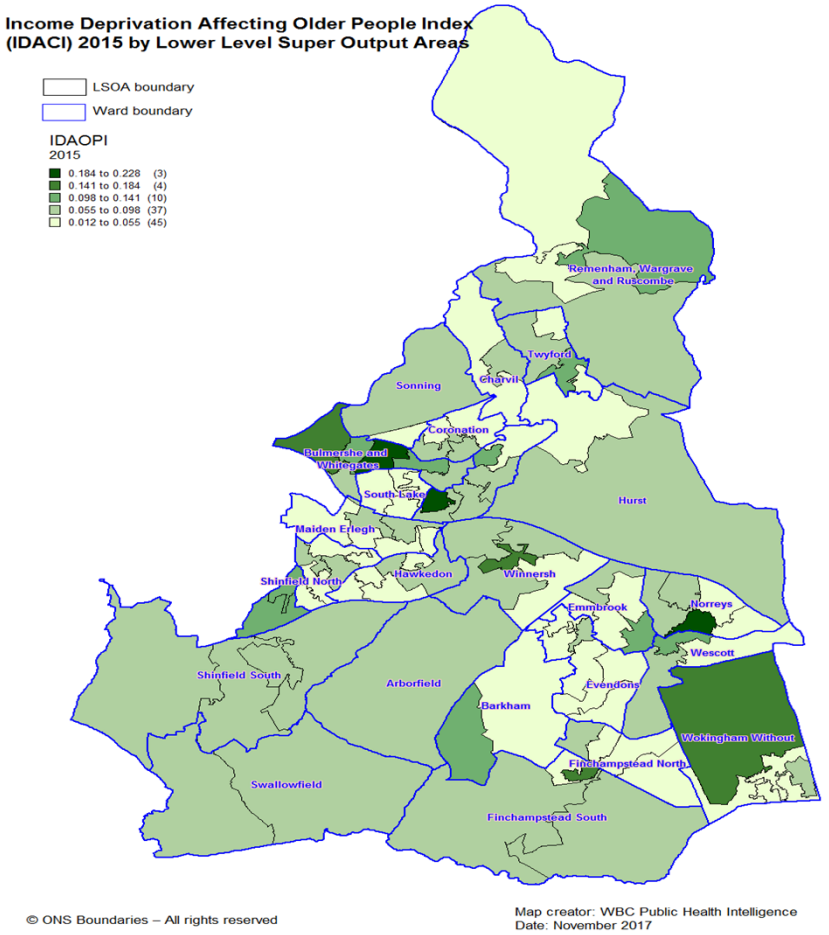


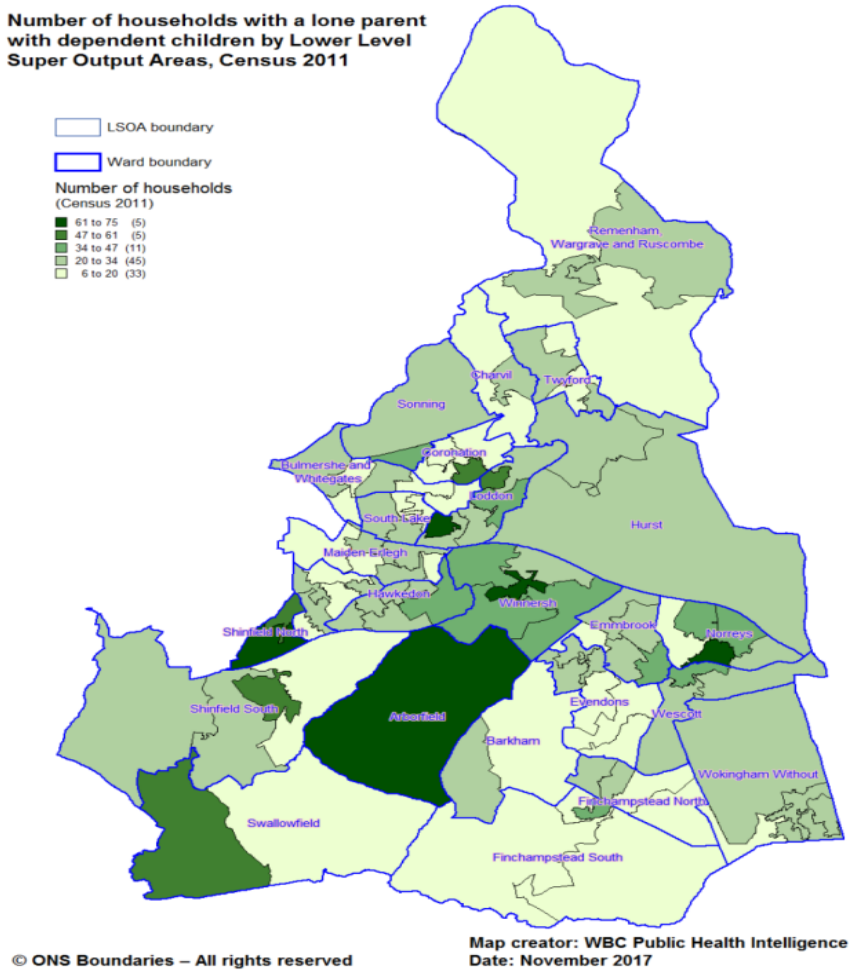

**Map 9:** Index of Deprivation Affecting Older People (IDAOPI) 2015



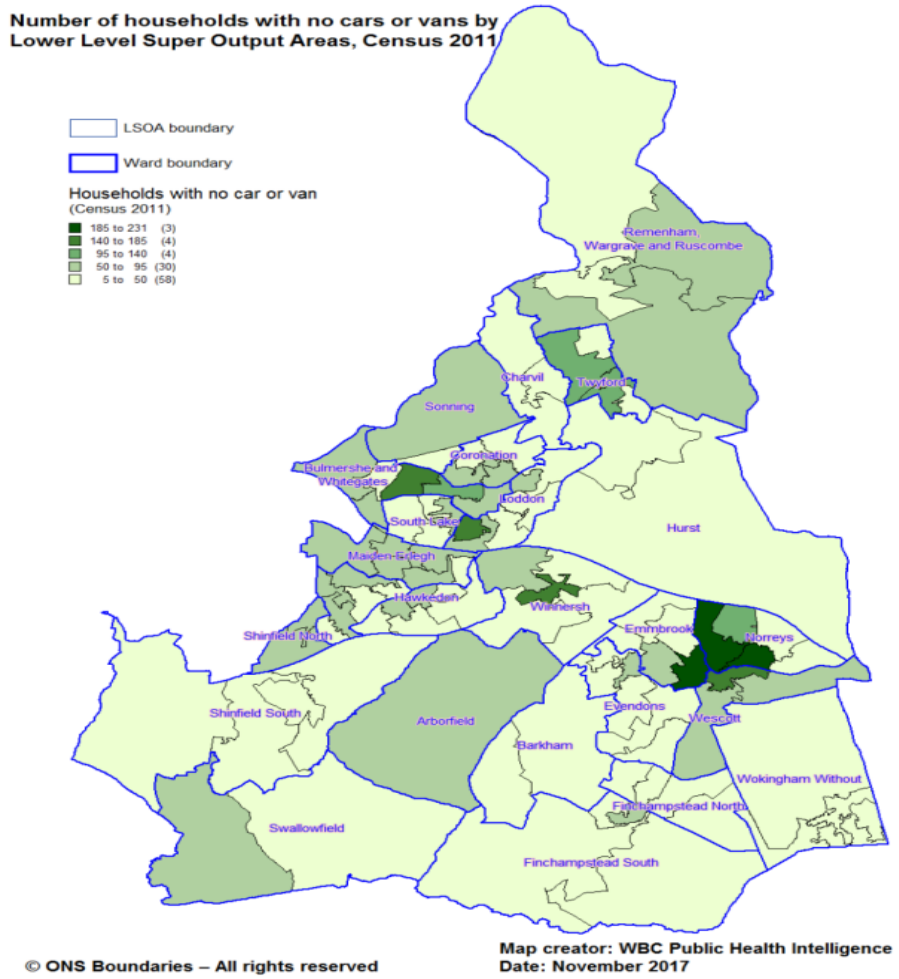

In Wokingham there are 2,679 (4.4%) households with a lone parent with dependent children (what year?). The proportion of households with a lone parent with dependent children varies across the borough. The areas with the highest concentration are in Norreys, Winnersh, Shinfield North and Arborfield wards.

There are also 5,422 (9%) households with no car or van. Maps 10 and 11 show numbers of households with a lone parent with dependent children, and numbers of households with no cars or vans respectively by LSOA.

**Map 10:** Households with a lone parent with dependent children




**Map 11:** Households with no cars or vans

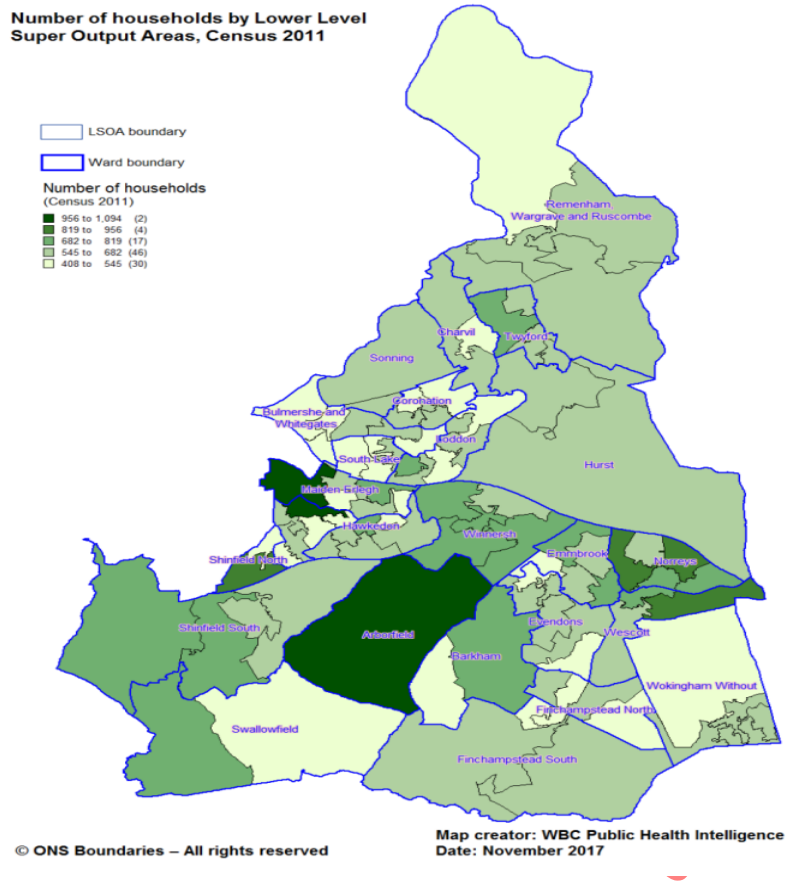



## 3.4 Housing and homelessness

The 2011 Census counted 60,332 households in Wokingham. This figure has increased to 64,409 households in 2017.

Map 12 shows numbers of households by LSOA as counted in the 2011 Census. The 2017 household data is now available at LSOA level.

**Map 12:** Census 2011 number of households




64.6% of all households in Wokingham are occupied by couples where the representative person of the household is a male (it is worth explaining what this means)yes.

Wokingham has the highest percentage of households occupied by couples in Berkshire (56.4%) which is also higher than England (52.8%).

Table 6 below shows proportions of households in Berkshire by the gender of the household representative and relationship type.

**Table 6:** Percentage of households by gender, relationship type and unitary local authority, 2017

| Sex of household representative | Male | Male | Male | Female | Female | Female |
|---|---|---|---|---|---|---|
| **Relationship** | Couple | Previously married | Single | Couple | Previously married | Single |
| **Bracknell Forest** | 56.8% | 9.0% | 9.3% | 0.0% | 16.4% | 8.5% |
| **Reading** | 49.3% | 8.7% | 14.2% | 0.0% | 15.1% | 12.7% |
| **Slough** | 52.4% | 9.7% | 9.8% | 0.0% | 17.4% | 10.7% |
| **Windsor and Maidenhead** | 58.6% | 8.4% | 8.8% | 0.0% | 16.5% | 7.7% |
| **Wokingham** | 64.6% | 7.3% | 7.1% | 0.0% | 15.0% | 6.0% |
| **Berkshire** | 56.4% | 8.6% | 9.9% | 0.0% | 16.0% | 9.1% |
| **England** | 52.8% | 9.3% | 10.1% | 0.0% | 17.5% | 10.4% |

*Source: Department for Communities and Local Government Household Projections model 2014-based*

## Tenure

The majority of the houses in Wokingham are privately owned. The proportion of privately owned homes in Wokingham is higher than England with 89.8% and 82.5% respectively.

The number of dwellings that are owned by WBC has decreased over time. However the number of dwellings that are owned by other public sector organisations has increased considerably, from 487 in 2009 to 2,340 in 2016.

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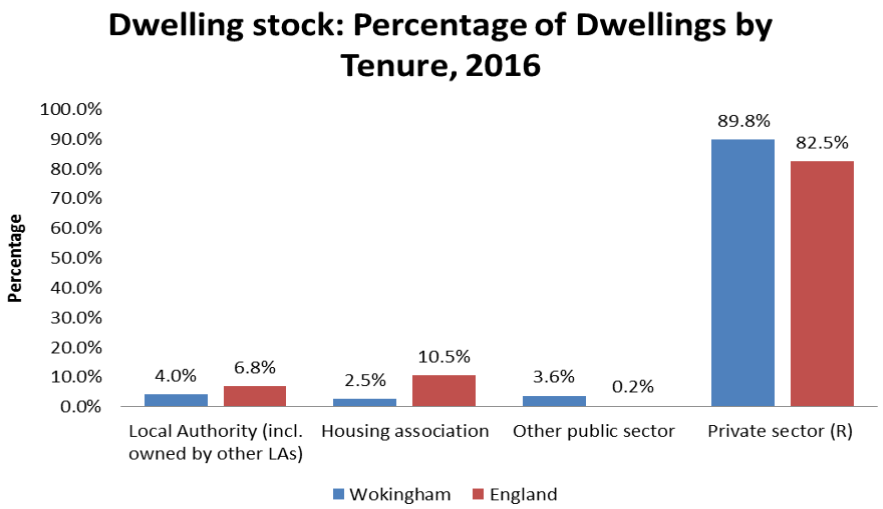
**Figure 24:** Dwellings by tenure




*Source: Department for Communities and Local Government*

**Table 7:** Trend in dwelling stock (numbers) by tenure in Wokingham borough

| Year | Local Authority (incl. owned by other LAs) | Housing association | Other public sector | Private sector (R) | Total (R) |
|---|---|---|---|---|---|
| 2009 | 2,923 | 1,301 | 487 | 57,380 | 62,090 |
| 2010 | 2,919 | 1,280 | 487 | 57,600 | 62,290 |
| 2011 | 2,914 | 1,329 | 487 | 57,740 | 62,470 |
| 2012 | 2,720 | 1,430 | 490 | 58,110 | 62,750 |
| 2013 | 2,720 | 1,470 | 2,040 | 56,920 | 63,150 |
| 2014 | 2,700 | 1,520 | 2,140 | 57,290 | 63,640 |
| 2015 | 2,690 | 1,560 | 2,240 | 57,600 | 64,100 |
| 2016 | 2,610 | 1,650 | 2,340 | 58,130 | 64,730 |

*Source: Department for communities and local government*

Wokingham borough has two traveller caravan sites with a combined capacity of 35 caravans. The Gypsy and Traveller Accommodation Assessment (2017) projected a need for 90 pitches in the borough by 2036.

Table 7 shows details of the caravan sites.

**Table 7:** Traveller and Travelling Showpeople Caravan Sites Provided by WBC and Private Registered Providers in England, July 2017

| Site and Address | Date Site Opened | Date of Last Site Changes | Total Number of Pitches | Residential | Transit | Caravan Capacity |
|---|---|---|---|---|---|---|
| Carters Hill Park, Binfield RG40 5QL | 1997 | 2011 | 4 | 4 | 0 | 15 |
| Twyford Orchards, London Road, Twyford, Reading RG10 9HF | 1976 | 2012 | 14 | 14 | 0 | 20 |

*Source: Department for Communities and Local Government*

Over the last five years an average of 581 additional dwellings have been completed each year with the number of completions increasing year on year. In 2016/17 933 dwellings were completed. This trend is projected to continue. An assessment undertaken for the Western Berkshire Housing Market Area identified a need for an additional 894 homes annually in Wokingham. The figure below shows the net additional dwellings year on year in Wokingham borough since 2001/02.

**Figure 25:** Net additional dwellings

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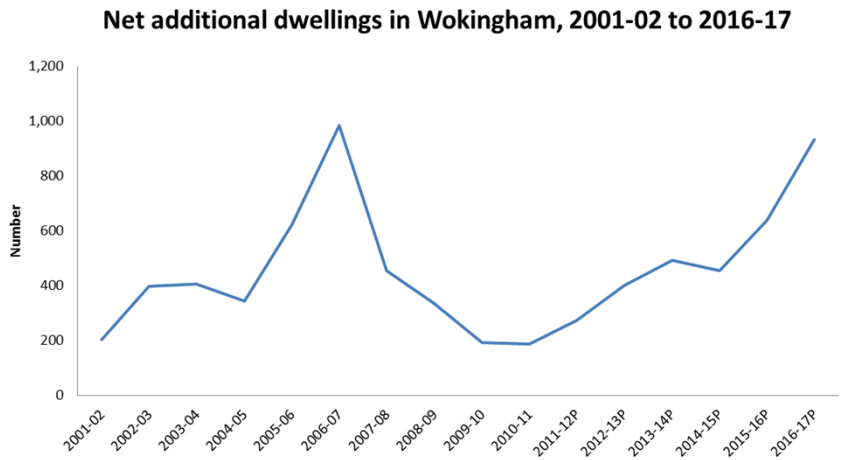
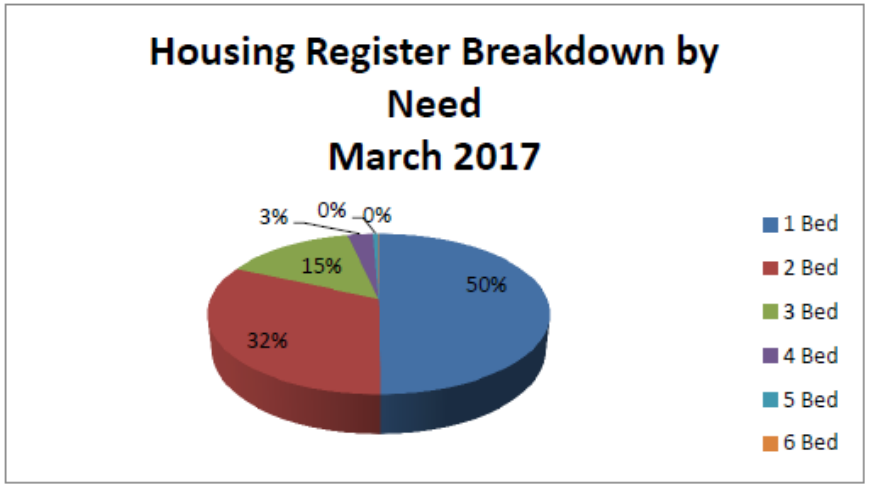



*Source: Department for Communities and Local Government*




*Source: Housing strategy 2015-18 - facts and figures*

## Housing affordability (add map as appendix)

## Satisfaction with new developments – survey data

### Housing Need

As of March 2017 there were 1,876 people on Wokingham Borough Council's Housing Register. This compares to 1,759 recorded in the previous quarter; an increase of 117 people.

The graph below shows that the majority of applicants on the register are in need of a 1 bed property (50%), followed by 2 bed properties (32%).

**Figure 26:** Housing register by need

### Fuel poverty

There are 4,446 (7.1%) households in Wokingham that are classified as fuel poor. Map 13 illustrates the proportion of fuel poverty across the borough by LSOA.

**Map 13:** Fuel poverty

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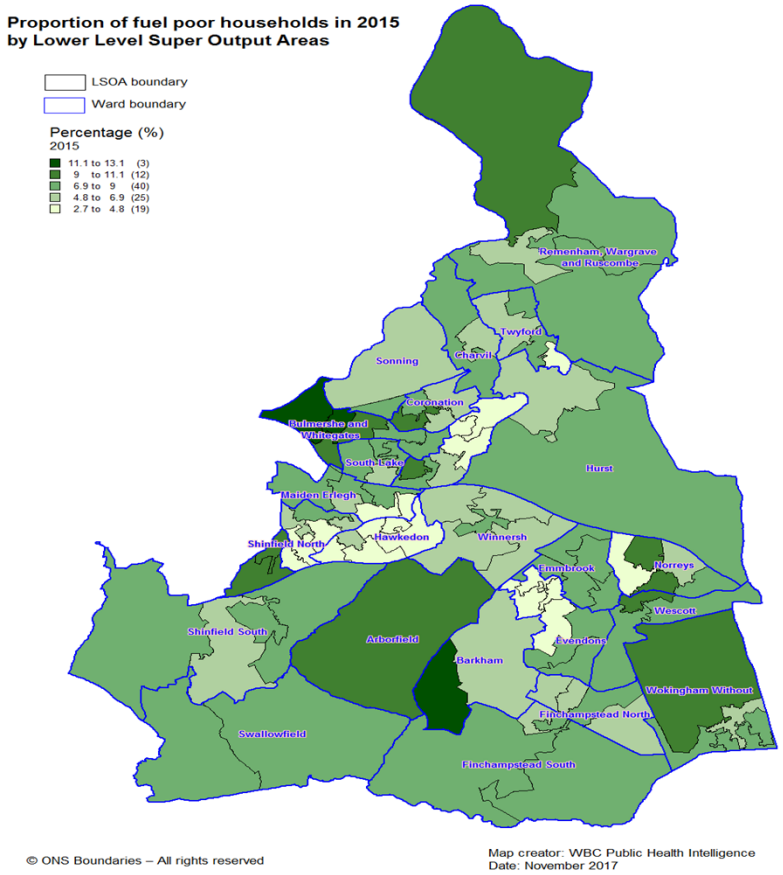
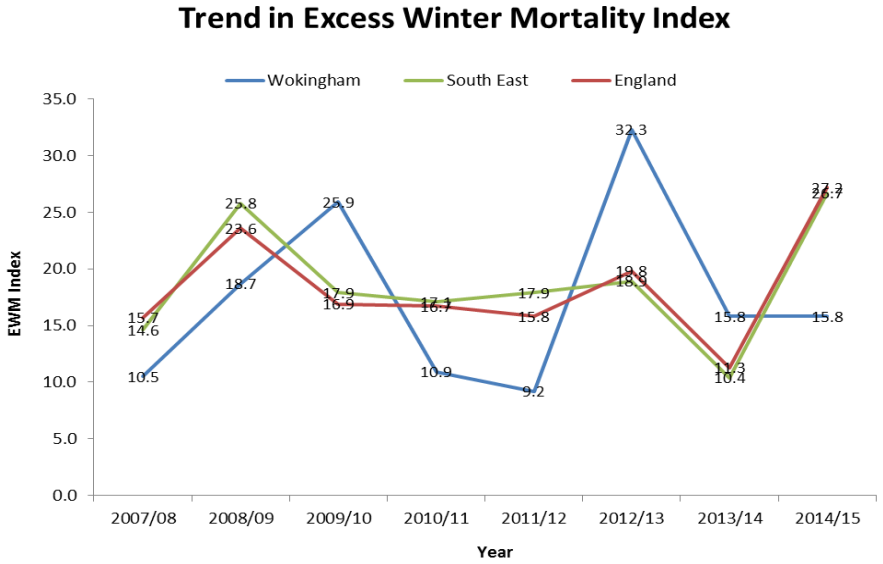



## Excess winter deaths

The Excess Winter Mortality (EWM) index is calculated so that comparisons can be made between sexes, age groups and regions, and is calculated as the number of excess winter deaths divided by the average non-winter deaths. The EWM index shows the percentage of extra deaths that occurred in the winter and is reported to 1 decimal place.

The EWM index in Wokingham has been fluctuating over time and it was 15.8 in 2014/15.

**Figure 27:** Excess winter mortality



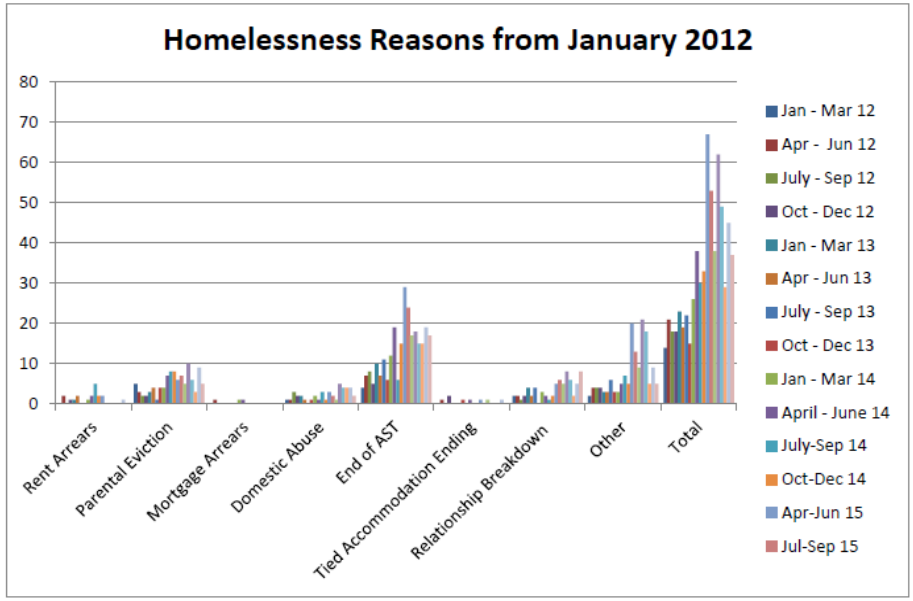

*Source: ONS: Excess winter mortality data, England and Wales, 2015/16 (provisional) and 2014/15 (final)*

## Homelessness

The Housing Needs Team has seen an increase in the level of homelessness presentations in comparison to last quarter with a total of 72 presentations; an increase of 27 from the previous quarter.

The graph overleaf shows that the main reason people were accepted as homeless was because of Assured Shorthold Tenancies (ASTs) ending (17), followed by relationship breakdown (8). For this quarter 'Other' included license ending and enforcement orders.

**Figure 28:** Homelessness reasons




*Source: Housing strategy 2015-18 - facts and figures*

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# 4. Healthwatch

The health and social care reforms of 2012 set a powerful ambition to put people at the centre of health and social care. To help realise that ambition, the reforms created a Healthwatch in every local authority area across England and Healthwatch England, the national body.

Healthwatch is the independent consumer champion for all people using health or social care services.

Healthwatch Wokingham Borough is an independent community interest company that exists to listen to what local people like about services and what could be improved. No matter how big or small the issue, Healthwatch wants to hear about it. Healthwatch shares views with those with the power to make change happen.

Healthwatch focuses on ensuring that people's worries and concerns about current services are addressed. Healthwatch works to get services right for the future. Healthwatch has the power to make sure that people's voices are heard by the government and those running services. Healthwatch's sole purpose is to help make care better for people.

You can also speak to Healthwatch to find information about health and social care services available locally.

**Local Healthwatch has 7 main functions to carry out:**

1. Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.

2. Enable local people to monitor the standard of provision of local care services and whether and how local care services could and should be improved.

3. Obtaining the views of local people regarding their needs for, and experiences of, local care services and to make these views known.

4. Making reports and recommendations about how local care services could or should be improved. These should be directed to commissioners and providers of care services, and people responsible for managing or reviewing local care services and shared with Healthwatch England.

5. Providing advice and information about access to local care services so choices can be.

6. Formulating views on the standard of provision and if and how the local care services could and should be improved; and sharing these views with Healthwatch England.

7. Making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations, and to make recommendations to Healthwatch England to publish reports about particular issues.

8. Providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

To contact Healthwatch Wokingham Borough please call the helpdesk on 0118 418 1418 (Mon-Fri 9-5pm) or go to http://www.healthwatchwokingham.co.uk/

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# 5. Clinical Commissioning Group (CCG) (add link to CCG Profile)

The Health and Social Care Act 2012 established Clinical Commissioning Groups (CCGs) as the cornerstone of the NHS. Every GP practice in England is part of a CCG. CCGs commission the majority of health services, including general practice, emergency care, elective hospital care, maternity services, and community and mental health services.

In Wokingham Borough; the majority of GP practices are members of NHS Wokingham CCG. Read more about the CCG and find out how to contact them via the NHS Wokingham CCG website

Only a small part of the Borough of Wokingham – the GP practice at Shinfield – is covered by another CCG, in this case the NHS South Reading CCG. Read about this CCG and how to contact them via the NHS South Reading CCG website.

From April 2018 all four CCGs in Berkshire West, including Wokingham, will merge into a single clinical commissioning group. A Wokingham locality function will continue to operate within the new CCG.

All CCGs in Berkshire West are working with partner organisations to:

- Prevent ill-health within our local populations;
- Support people with complex needs to receive the care they need in their community.
- Support people to take more responsibility for their health and wellbeing and to make decisions about their own care;
- Co-ordinate care in a way that is person centered.
- Ensure people will only be admitted into hospital, nursing or residential homes when the services they require cannot be delivered elsewhere.
- Ensure services that respond to people with an urgent need for care operate together as a single system, ensuring that people with urgent but not life-threatening conditions will receive responsive and effective care outside hospital.

The Berkshire West CCGs are collaborating with the two local NHS providers (Royal Berkshire Hospital Foundation Trust and Berkshire Healthcare Foundation Trust) to establish a new way of working together known as an 'Accountable Care System' (ACS). The ACS is a complete transformation of how the NHS organisations within Berkshire West will work and transact with each other. By moving away from a system of contractual transactions and closer to an allocative distribution of monies coming into the local health economy, the ACS seeks to move to a system whereby resources are allocated to the efficient delivery of pathways at cost rather than price.

A strong and effective primary care sector is a critical aspect of an effective and high performing health care system. In April 2016 local CCGs took on delegated responsibilities for general practice medical services from NHS England. The CCGs have developed a strategy which sets out how they will address current challenges and create a sustainable and strengthened primary care sector working. The strategy, together with the CCG's other plans, can be found on the NHS Wokingham CCG website.

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# Starting Well 2017/18

Public Health Intelligence

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# 1. Key messages

- Smoking at time of delivery is considerably lower (7%) in Wokingham when compared with the South East (11.0%) and England (9.8%).
- Flu vaccination uptake in pregnancy is the second highest in Berkshire with 45.6%.
- 25.3% of all deliveries in Wokingham are to mothers who are over 35 years old.
- Breastfeeding rate at 6-8 weeks after birth in Wokingham (60.1%) is significantly higher than the national rate of 43.2%.
- The percentage of low birthweight babies in Wokingham is the lowest in Berkshire (4.6%)
- Wokingham has the second highest stillbirth rate (5.9 per 1,000) in Berkshire and ranks above the regional and national rates.
- Only 37% of mothers received a first face-to-face antenatal contact with a health visitor, which is lower than the national value.
- Wokingham has a higher uptake in 6-8 week, 12 month and 2-2.5 year reviews than England.
- Admissions for respiratory tract infections in 1 year olds and in 2-4 year olds are higher in Wokingham than in England and the South East.

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# 2. Pregnancy

## 2.1 Healthy pregnancy

A healthy woman is more likely to give birth to a healthy baby.

There are a number of factors that can increase the risk of harm to the unborn baby and many of these are influenced by health inequalities. Some of these factors are smoking, alcohol consumption, mother's blood sugar levels during pregnancy, unhealthy diet, social isolation and stress, limited access to good quality care, luck of antenatal screening and immunisation. Some of these factors can be measured because there is routinely collected data. However, there is no data collected for all of them.

## 2.2 Alcohol consumption in pregnancy

The Chief Medical Officers for the UK recommend that if you're pregnant or planning to become pregnant, the safest approach is not to drink alcohol at all to keep risks to your baby to a minimum.

Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink, the greater the risk. When you drink, alcohol passes from

your blood through the placenta and to your baby. A baby's liver is one of the last organs to develop and doesn't mature until the later stages of pregnancy. Your baby cannot process alcohol as well as you can, and too much exposure to alcohol can seriously affect their development.

Drinking alcohol, especially in the first three months of pregnancy, increases the risk of miscarriage, premature birth and your baby having a low birth weight. Drinking after the first three months of your pregnancy could affect your baby after they're born. The risks are greater the more you drink. The effects include learning difficulties and behavioural problems.

(Source: NHS Choices: https://www.nhs.uk/conditions/pregnancy-and-baby/pages/alcohol-medicines-drugs-pregnant.aspx )

The NHS Choices website provides further information on how to avoid alcohol consumption during pregnancy, what is a unit of alcohol and on local alcohol support services.

There is no routinely data collected on alcohol consumption and pregnancy. There may be some service use data which can give an indication of alcohol consumption during pregnancy, but it is not very robust.

During 2016/17 there were no new pregnant women in Wokingham accessing support for alcohol misuse from SMART.

## 2.3 Smoking in pregnancy

Smoking during pregnancy can be very harmful for the baby. Smoking while pregnant will:

- Lower the amount of oxygen available to you and your growing baby
- Increase your baby's heart rate
- Increase the chances of miscarriage and stillbirth
- Increase the risk that your baby is born prematurely and/or born with low birth weight
- Increase your baby's risk of developing respiratory (lung) problems
- Increases risks of birth defects
- Increases risk of Sudden Infant Death Syndrome

The more cigarettes you smoke per day, the greater your baby's chances of developing these and other health problems. There is no "safe" level of smoking while pregnant.

Secondhand smoke (also called passive smoke or environmental tobacco smoke) is the combination of smoke from a burning cigarette and smoke exhaled by a smoker.

The smoke that burns off the end of a cigarette or cigar actually contains more harmful substances (tar, carbon monoxide, nicotine, and others) than the smoke inhaled by the smoker. If you are regularly exposed to secondhand smoke while pregnant, you will have an increased chance of having a stillbirth, a low birthweight baby, a baby with birth defects, and other complications of pregnancy. Babies and children exposed to secondhand smoke may also develop asthma, allergies, more frequent lung and ear infections, and are at higher risk for sudden infant death syndrome (SIDS).

Smoking status during pregnancy is recorded at the time of delivery. However there is no routinely data being recorded on pregnancy and passive smoking.

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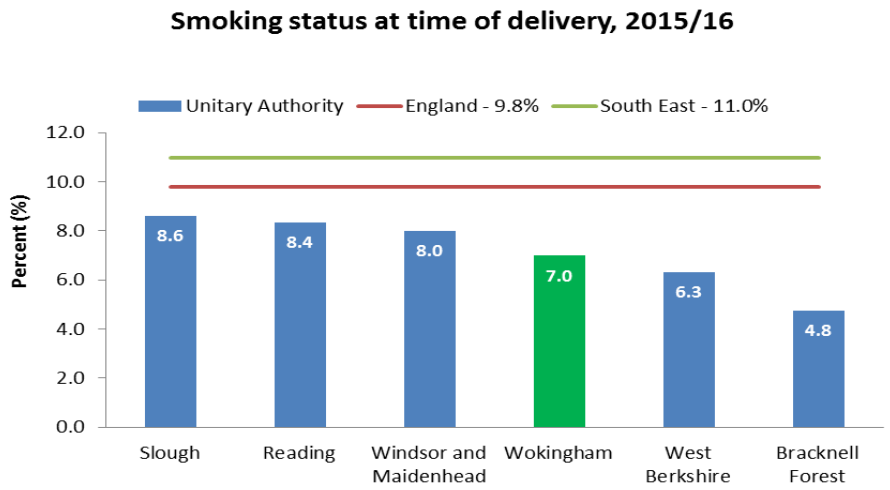
Wokingham ranks third lowest in Berkshire in the percentage of mothers with a smoking status at the time of delivery. It is also considerably lower than the South East and England.

The national ambition is currently at 11% or less.

**Figure 1.1:** Smoking in pregnancy




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

## 2.4 Pre-natal screening

Find out all about the ultrasound scans and checks and tests you'll be offered as part of your antenatal care, including screening for Down's syndrome All pregnant women are offered screening for Syphilis and HIV as part of routine antenatal care.

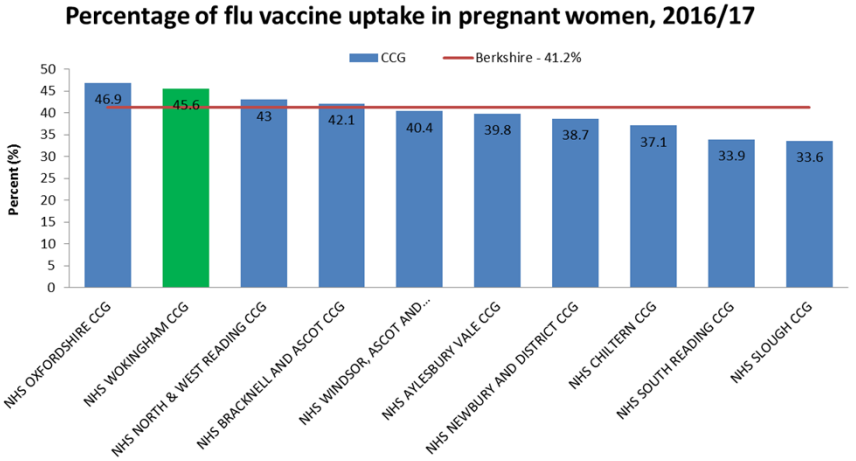
## 2.5 Vaccination

Pregnant women should be encouraged to have the seasonal flu vaccination which will protect both mother and baby.

Add national guidelines and figure.

Wokingham has the second highest (45.6%) uptake of flu vaccine in pregnant women in Berkshire.

**Figure 1.2:** Flu vaccination rate in pregnancy




*Source: Wokingham Public Health team*

Pregnant women are now offered a single dose of a pertussis containing vaccine (dTaP/IPV) between gestational weeks 16 and 32. This maximises the likelihood that the baby will be protected against whooping cough during the early weeks after birth until 8 weeks when the childhood immunisation schedule commences from birth.

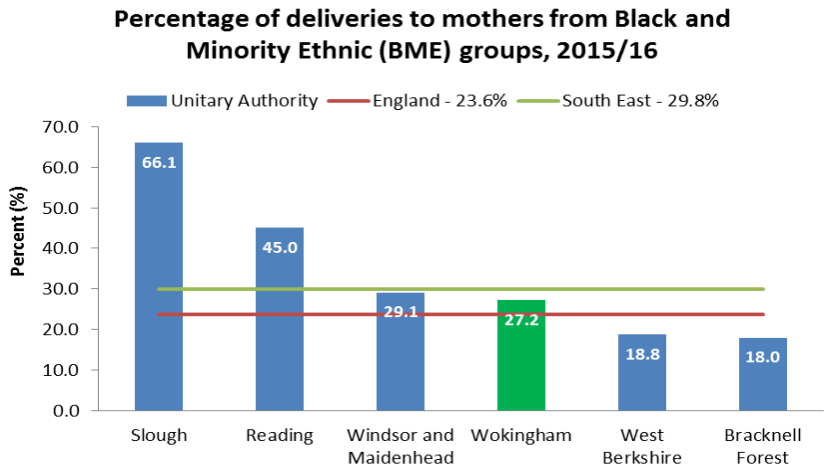
# 3.Post-natal

## 3.1 BME deliveries

The Infant Feeding Survey 2010 found that mothers from all minority ethnic groups were more likely to breastfeed compared with White mothers. (Source: http://content.digital.nhs.uk/article/3895/Infant-Feeding-Survey-2010)

Around one quarter (27.2%) of all deliveries in Wokingham are to mothers from a BME group. This proportion is lower than the regional but higher than the national figure.

**Figure 1.3:** Deliveries to mothers from BME groups




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

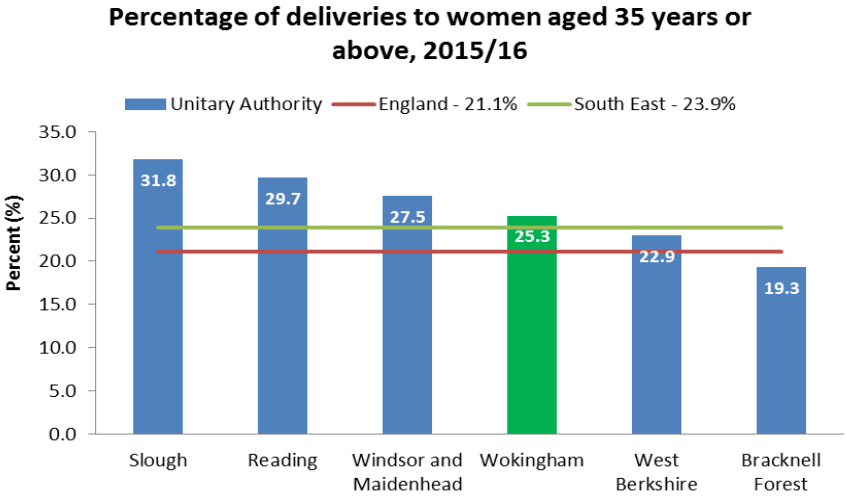
## 3.2 Deliveries to women over 35

Mothers aged 30 or over are more likely than younger mothers to start breastfeeding, and to continue for six months or more.

(Infant Feeding Survey - UK, 2010. Copyright Â© 2012, Health and Social Care Information Centre. All Rights Reserved.)

Although Wokingham has one of the lowest rate of mothers over 35 years old in Berkshire, it is still higher than the South East and England.

**Figure 1.4:** Deliveries to mothers over 35 years old




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

## 3.3 Breastfeeding

The World Health Organisation (WHO) recommends exclusive breastfeeding for the first six months of a baby's life. They also

recommend continued breastfeeding with complimentary food up until the age of two.

*(Source: World Health Organisation)*

The Lancet reports that in the UK in 2010 34% of mothers were breastfeeding at 6 months, and 23% were breastfeeding at 9 months. This is estimated to drop to 10% by 12 months. (Source: The Lancet)

Complete national data on breastfeeding prevalence is collected at two time periods in England; at birth (breastfeeding initiation) defined as the number of mothers who give their babies breast milk in the first 48 hours after delivery; at six to eight weeks defined as the number of infants that are totally or partially breastfed. Breastfeeding initiation data is collected from Hospital Trusts as the providers of maternity services and is presented at a provider, Clinical Commissioning Group (CCG) and GP Practice level. Breastfeeding at 6 to 8 weeks is collected from Health Visiting Service providers and is presented at Local Authority level.

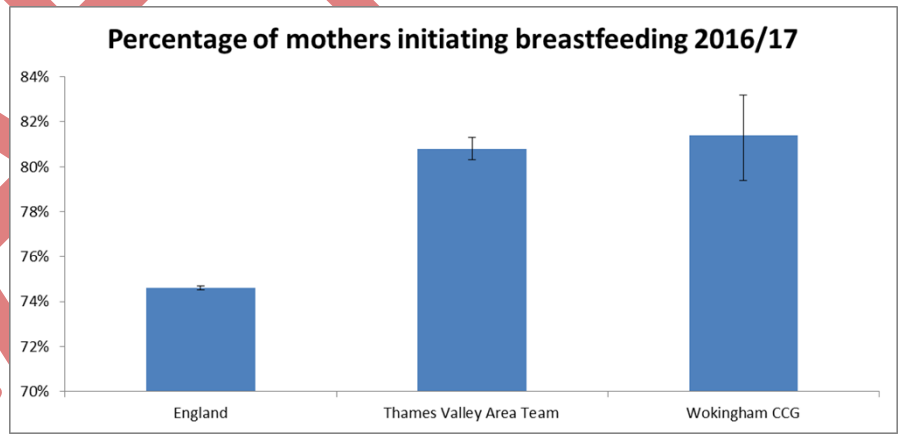
Breastfeeding initiation during 2016/17 in England was 74%. This dropped to 44% of babies being breastfed at 6 to 8 weeks. The 6 to 8 week data is based on an interim data collection due to the transfer of responsibility for commissioning children's public health for 0-5 year olds from NHS England to local authorities. Data from local authorities had to pass a three stage validation process with 71 out of 150 local authorities passing all three stages of validation.

*(Source: Maternity and Breastfeeding, NHS England Breastfeeding at 6 to 8 weeks after birth)*

The likelihood of a mother breastfeeding is known to be influenced by the following measurable factors; levels of deprivation, caesarean births, and age of mother with mothers from more deprived areas, those having a caesarean delivery and younger mothers less likely to initiate breastfeeding. The caesarean section rate in England is 26%, and 0.9% of births are to mothers aged under 18 years of age.

*(Source: Early Years Profiles, Public Health England)*

**Figure 1.5:** Breastfeeding initiation




*Source: Maternity and Breastfeeding, NHS England*

The chart below shows the percentage of infants in Wokingham who are partially or totally breastfed at 6-8 weeks compared to the national average. Missing data indicates that the data did not pass all three stages of data validation.

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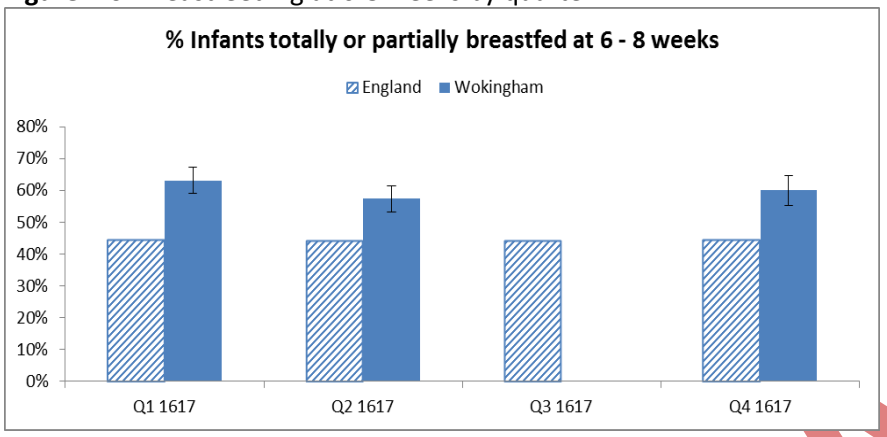
**Figure 1.6:** Breastfeeding at 6-8 weeks by quarter



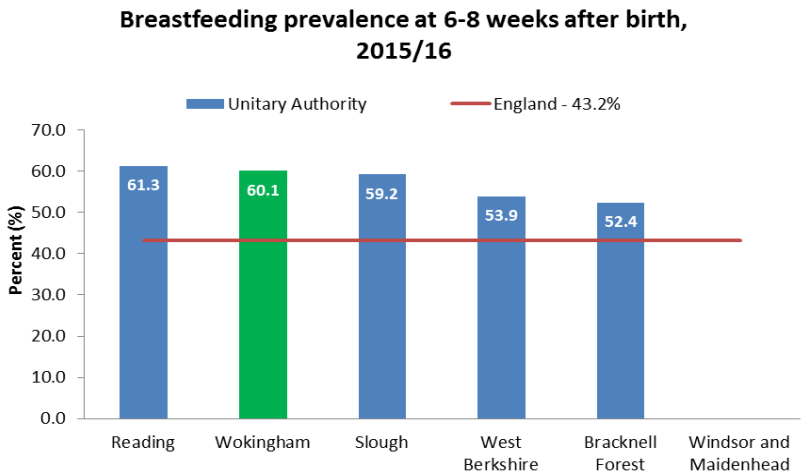

Out of 152 Upper Tier Local Authorities, Wokingham ranks number 152 on the Index of Multiple Deprivation where the lower the rank, the higher the level of deprivation. The caesarean section rate in Wokingham during 2015/16 was 27%. This is the same as the national rate and the same as the rate for the South East Region. 0.4% of births to females living in Wokingham are to females aged less than 18. This is lower than the national average.

*Source: Department for Communities and Local Government*

*Early Years Profiles, Public Health England*

When compared with the rest of Berkshire, Wokingham has the second highest breastfeeding prevalence rate (60.1%) at 6-8 weeks, which is also higher than England (43.2%).

**Figure 1.7:** Breastfeeding prevalence at 6-8 weeks




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

## 3.4 Teenage mothers

Children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birthweight which impacts on the child's long-term health. Teenage mothers are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth. Teenage parents and their children are at increased risk of living in poverty.

Wokingham's teenage pregnancy rate is substantially lower (3.9 per 1,000) than the national (7.1) and regional (8.7) rate.

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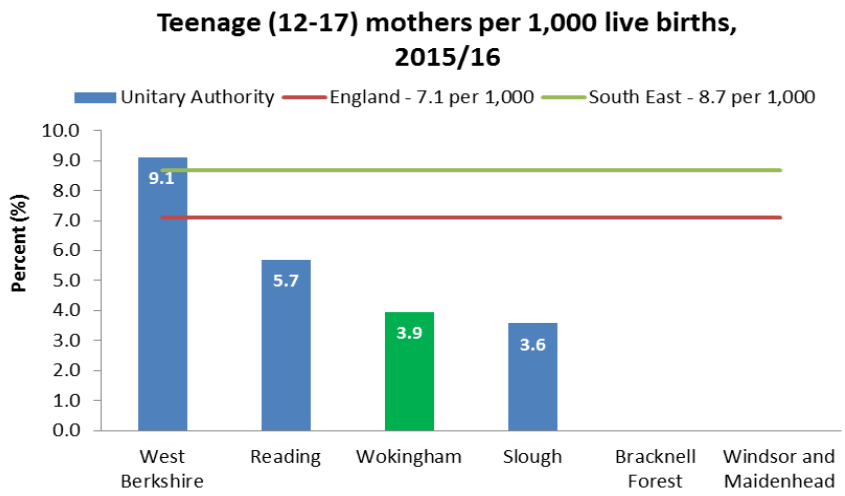
**Figure 1.8:** Teenage pregnancy




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

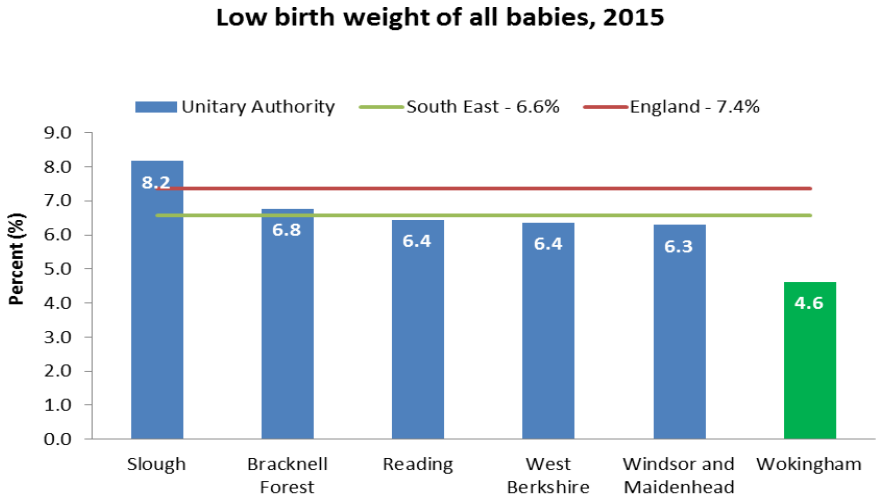
## 3.5 Low birth weight

Low birthweight is an enduring aspect of childhood morbidity, a major factor in infant mortality and has serious consequences for health in later life (NICE). There are social inequalities in low birthweight in England and Wales and these inequalities are likely to affect childhood and adult health inequalities in the future, hence strategies will need to address differences in low birthweight and further monitoring of trends is therefore desirable (Moser K, Li L, and Power C, Social inequalities in low birthweight in England and Wales: trends and implications for future population health, Journal of Epidemiology and Community Health 2003).

Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services.

Wokingham has the lowest low birth weight in all babies and also in term babies in Berkshire, and it is considerably lower than the national and the regional value (see figures 1.9 and 1.10).

**Figure 1.9:** Low birth weight of all babies




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

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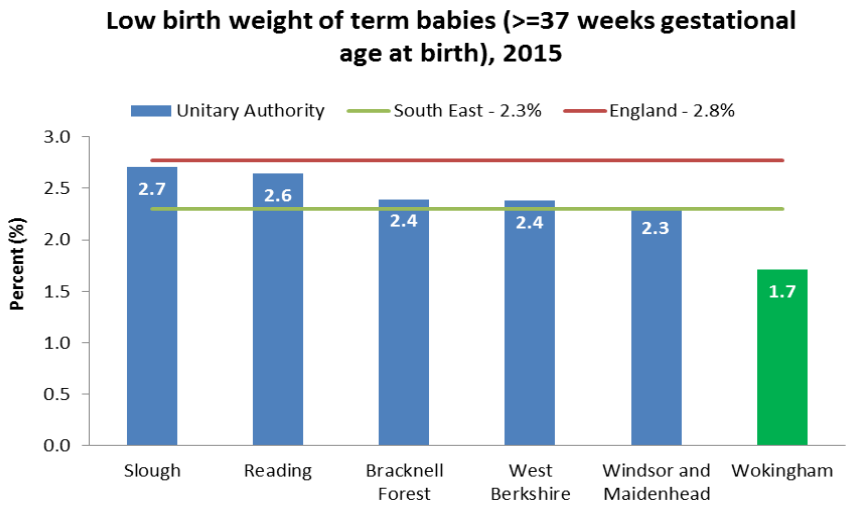
**Figure 1.10:** Low birth weight of term babies




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

## 3.6 Post-natal screening

NB1: Newborn blood spot screening – coverage (CCG responsibility at birth):

The proportion of babies registered within the clinical commissioning group (CCG) both at birth and on the last day of the reporting period who are eligible for newborn blood spot (NBS) screening and have a conclusive result recorded on the child health information system (CHIS) at less than or equal to 17 days of age

## 3.7 Maternal mental health

**Post-natal depression**

Postnatal depression is a type of depression that many parents experience after having a baby. It's a common problem, affecting more than 1 in every 10 women within a year of giving birth. It can also affect fathers and partners, although this is less common.

The table below shows the estimated numbers of perinatal mental illness amongst women living in Wokingham. Estimates are calculated by applying the national prevalence figures to the total number of maternal episodes in the area.

| Indicator Name | Number |
|---|---|
| Postpartum psychosis | 5 |
| Chronic Serious Mental Illness in perinatal period | 5 |
| Severe depressive illness in perinatal period | 55 |
| Mild-moderate depressive illness and anxiety in perinatal period (lower estimate) | 175 |
| Mild-moderate depressive illness and anxiety in perinatal period (upper estimate) | 260 |
| PTSD in perinatal period | 55 |
| Adjustment disorders and distress in perinatal period (lower estimate) | 260 |
| Adjustment disorders and distress in perinatal period (upper estimate) | 515 |
| **TOTAL** | **1,330** |

*Source: Perinatal Mental Health Profiles, Public Health England*

671 mothers from Wokingham received a first face-to-face antenatal contact with a health visitor during 2016/17. If we apply this figure to the total number of births (including still-births) during 2016 then this equates to 37 percent of mothers. This is lower than the national percentage. 90 percent of births receive a face to face New Birth Visit (NBV) within 14 days. This is higher than the national percentage. 91 percent of infants received a 6-8 week review by the time they were 8 weeks old. This is higher than the national percentage. 6.8 percent of mothers are referred onwards following a maternal mood assessment at the 6-8 week review. This equates to 123 mothers from Wokingham.

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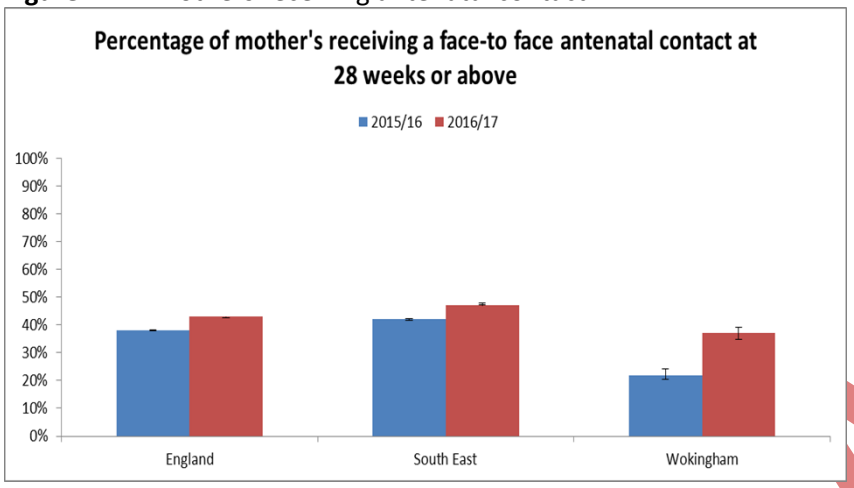
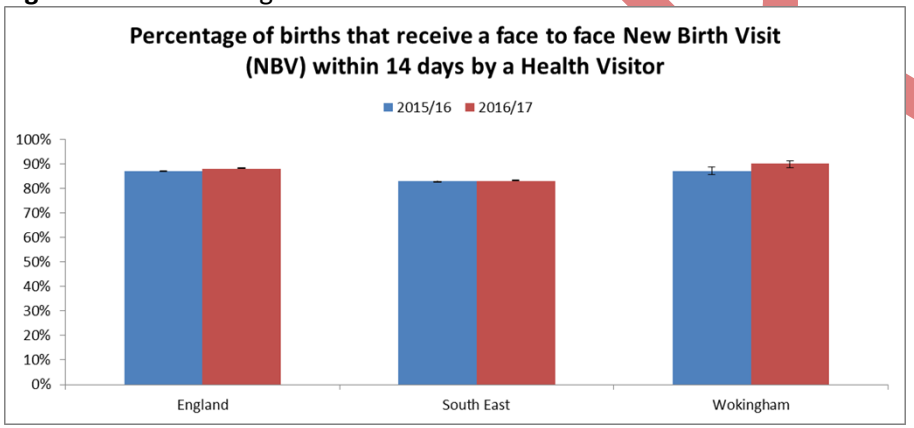
**Figure 1.11:** Mothers receiving antenatal contact



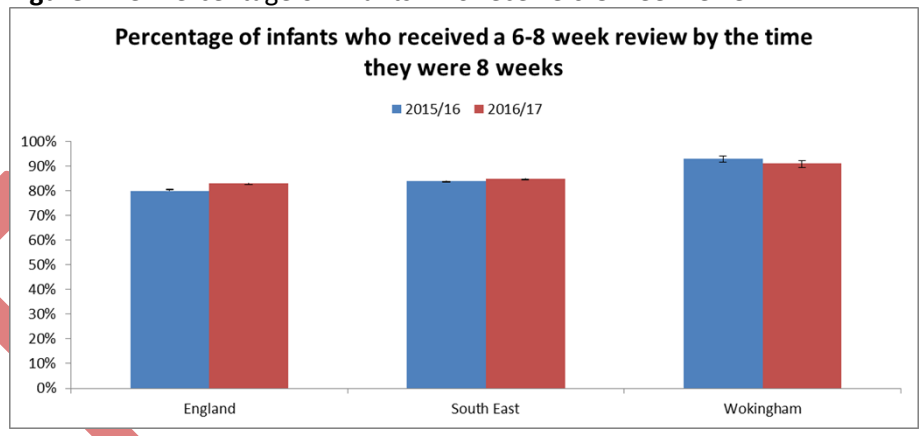

*Source: Health Visitor Service Delivery Metrics, Public Health England/Berkshire Healthcare Foundation Trust (Maternal Mood)*

**Figure 1.12:** Percentage of births that receive new birth visits




*Source: Health Visitor Service Delivery Metrics, Public Health England*

**Figure 1.13:** Percentage of infants who receive 6-8 week review




## 3.8 Infant mortality

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn.

Infant deaths under 1 year of age per 1000 live births.

Crude rate per 1,000 live births: The number of infant deaths is divided by the number of live births in the same area and multiplied by 1,000.

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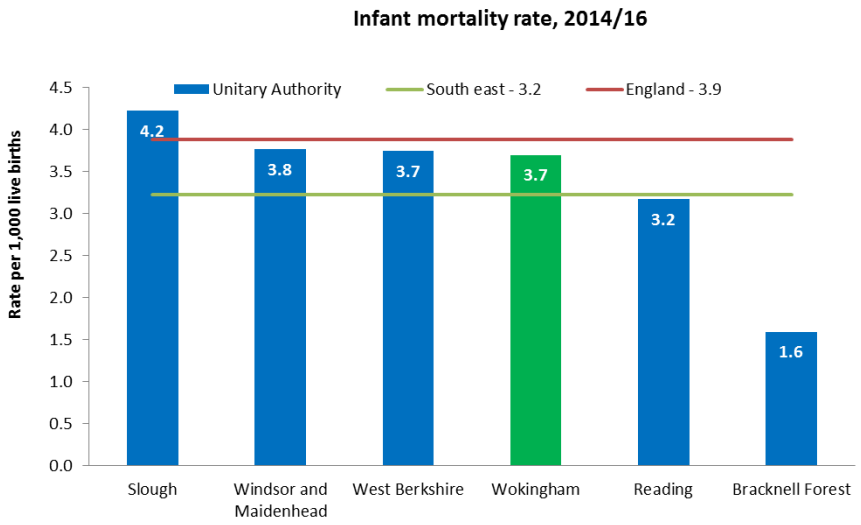
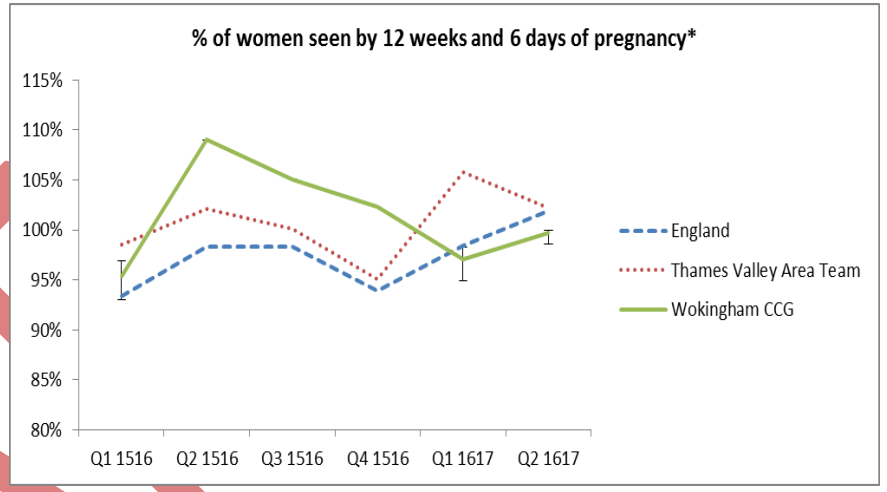
**Figure 1.14:** Infant mortality rate




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

**Figure 1.15:** Percentage of women seen by 12 weeks




*Source: Maternal 12 week risk assessment, NHS England*

*The table below shows data from the HES and MSDS for the local maternity providers where women from Berkshire are most likely to receive care. Data is for 2016/17.*

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*Source:Maternity Services Dataset, NHS Digital*

| Area | Hospital Episode Statistics | | | | MSDS | | |
|---|---|---|---|---|---|---|---|
| | Gestation at birth <38 weeks* | | Delivery method emergency caesarean | | Skin-to-skin contact within 1 hour | | Months submitting data |
| | Number | % | Number | % | Number | % | Number |
| **ENGLAND** | 80,636 | 13% | 98,557 | 15% | 192,741 | 80% | |
| South of England Commissioning Region | 17,936 | 12% | 22,246 | 15% | | | |
| Frimley Health NHS Foundation Trust | 1,222 | 12% | 1,397 | 14% | 4,475 | 90% | 12 |
| Great Western Hospitals NHS Foundation Trust | 552 | 12% | 650 | 15% | | | 0 |
| Oxford University Hospitals NHS Foundation Trust | 1,052 | 13% | 1,124 | 14% | | | 4 |
| Royal Berkshire NHS Foundation Trust | 553 | 11% | 683 | 13% | 1,300 | 88% | 10 |

** Figures may show as above 100% for the following reasons;*

*"Firstly that the indicator definition compares bookings for mothers having assessments at a trust to the number of maternities at the point of delivery at that trust 2 quarters later. However the maternity at the point of delivery figure may be lower than the number of mothers having assessments due to mothers suffering miscarriage, women choosing to undergo a termination or women transferring to another hospital.*

*Secondly that women who live in urban areas where there are multiple hospitals they could chose to delivery at often chose to undergo assessments at more than one hospital to enable them to compare maternity service provision. As a result women may be double counted, leading to a higher ratio of assessments to deliveries."*

## 3.9 Stillbirths

Stillbirth rates in the United Kingdom have shown little change over the last 20 years, and the rate remains among the highest in high income countries. Risk factors associated with stillbirth include maternal obesity, ethnicity, smoking, pre-existing diabetes, and history of mental health problems, antepartum haemorrhage and foetal growth restriction (birth weight below the 10th customised weight percentile). In 2015 the government announced an ambition to halve the rate of stillbirths by 2030.

Wokingham's stillbirth rate is above the national and regional rate, and one of the highest in Berkshire.

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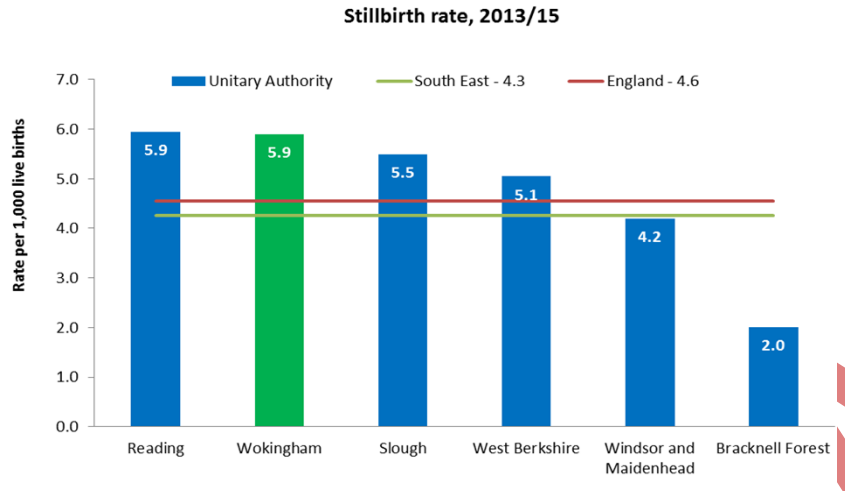
**Figure 1.16:** Stillbirth rate




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*



# 4. Early years

## 4.1 Health visiting

Health visiting teams lead and deliver the Department of Health's Healthy Child Programme (an early intervention and prevention public health programme) for all children aged 0–5.

Health visitors are highly trained specialist community public health nurses. The wider health visiting team may also include nursery nurses, healthcare assistants and other specialist health professionals.

Local authorities have a responsibility to promote and protect health, tackle the causes of ill-health and reduce health inequalities (Local government's new public health functions Department of Health 2011). Commissioning high-quality public health services for those aged 0–5 (as part of the Healthy Child Programme) can help to achieve this.

The data in figures 1.17-1.21 illustrates quarterly uptake of 6-8 week reviews, 12 month reviews and 2-2.5 year reviews in Wokingham compared with England and the South East.

(Source: https://www.gov.uk/government/publications/health-visitor-service-delivery-metrics-2016-to-2017 )

Overall, Wokingham has a higher uptake than both England and the South East in health visiting reviews.

**Figure 1.17:** Infants who received a 6-8 week review

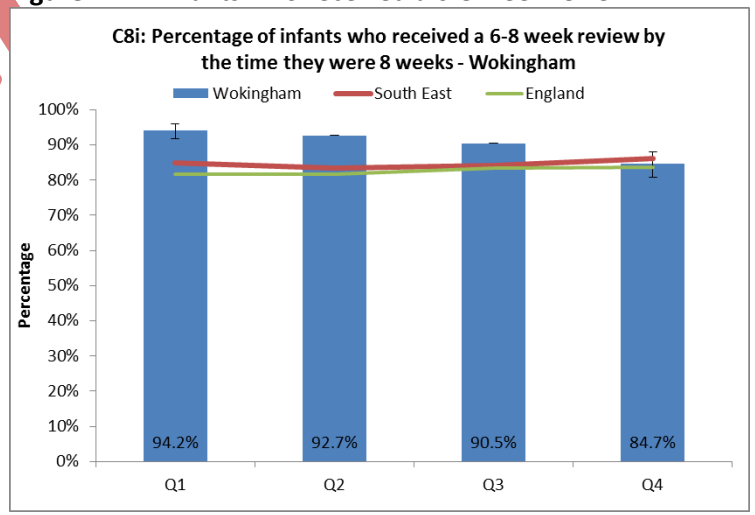



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**Figure 1.18:** Infants who received a 12 month review by the time they turned 12 months

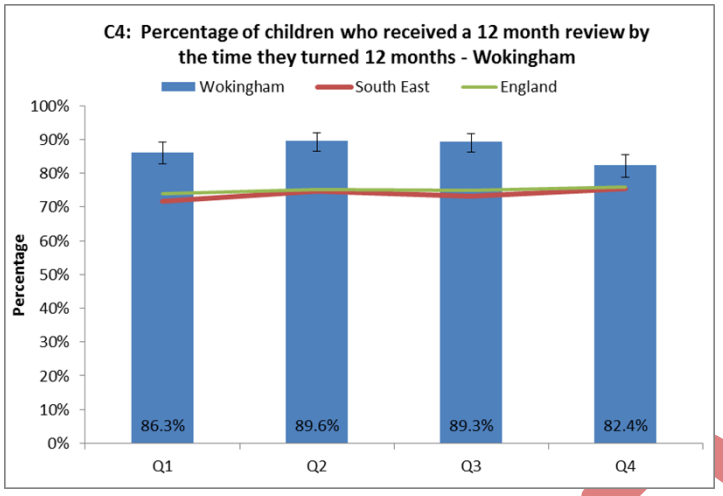



**Figure 1.19:** Infants who received a 12 month review by the time they turned 15 months

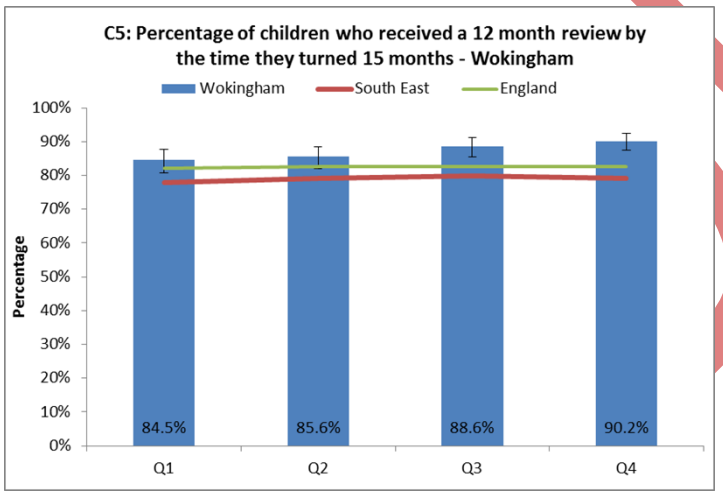



**Figure 1.20:** Children who received a 2-2.5 year review

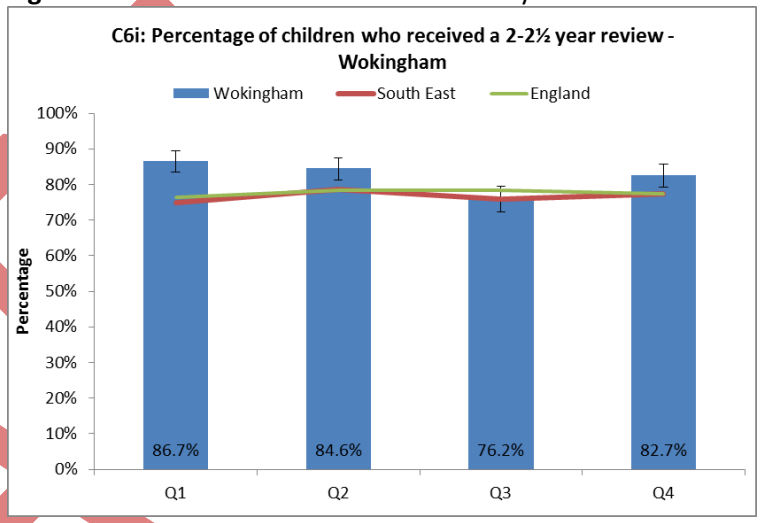
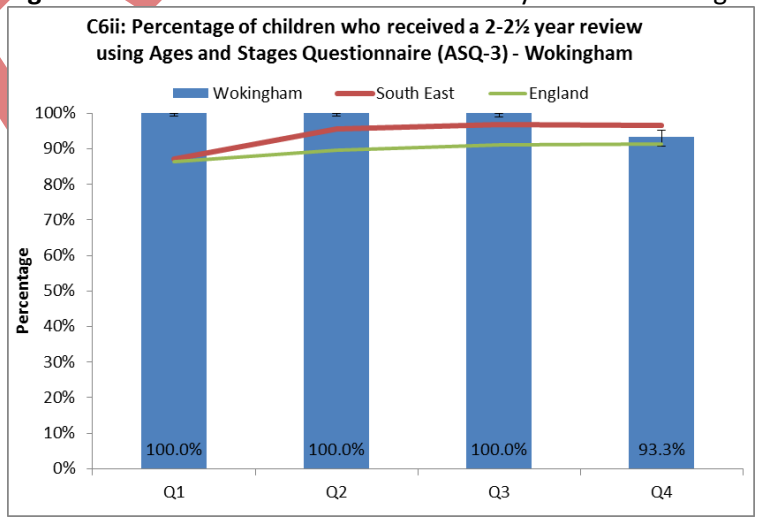



**Figure 1.21:** Children who received a 2-2.5 year review using ASQ-3

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**Health visiting summary (annual averages), 2016/17**

| | 6-8 Week Review | 12 Month Review (by 12 months) | 12 Month Review (by 15 months) | 2 - 2.5 Year Review | 2 - 2.5 Year Review using Ages & Stages Questionnaire |
|---|---|---|---|---|---|
| **Wokingham** | 90.5% | 86.9% | 87.2% | 82.6% | 98.3% |
| **South East** | 84.6% | 73.7% | 79.0% | 76.7% | 94.0% |
| **England** | 82.5% | 74.9% | 82.5% | 77.7% | 89.6% |

## 4.2 Immunisations

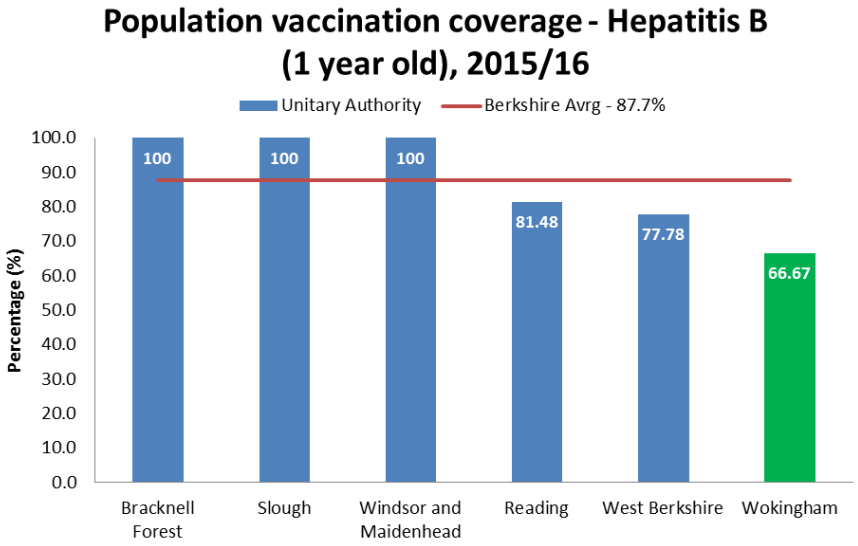
Infants born to hepatitis B virus (HBV) infected mothers are at high risk of acquiring HBV infection themselves. Babies born to infected mothers are given a dose of the hepatitis B vaccine after they are born. This is followed by another two doses (with a month in between each) and a booster dose 12 months later. Around 20% of people with chronic hepatitis B will go on to develop scarring of the liver (cirrhosis), which can take 20 years to develop, and around 1 in 10 people with cirrhosis will develop liver cancer.

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

Since April 2000 it has been recommended that all pregnant women in England and Wales should be offered testing for hepatitis B through screening for HBsAg, and that all babies of HBsAg seropositive women should be immunised (HSC 1998/127). A dose of paediatric hepatitis B vaccine is recommended for all infants born to an HBV infected mother as soon as possible after birth, then at 1 and 2, and 12 months of age.

Wokingham has the lowest coverage for Hepatitis B in 1 year olds in Berkshire.

**Figure 1.22:** Vaccination coverage for hepatitis B – 1 year




Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

**Figure 1.23:** Vaccination coverage for hepatitis B – 2 years old

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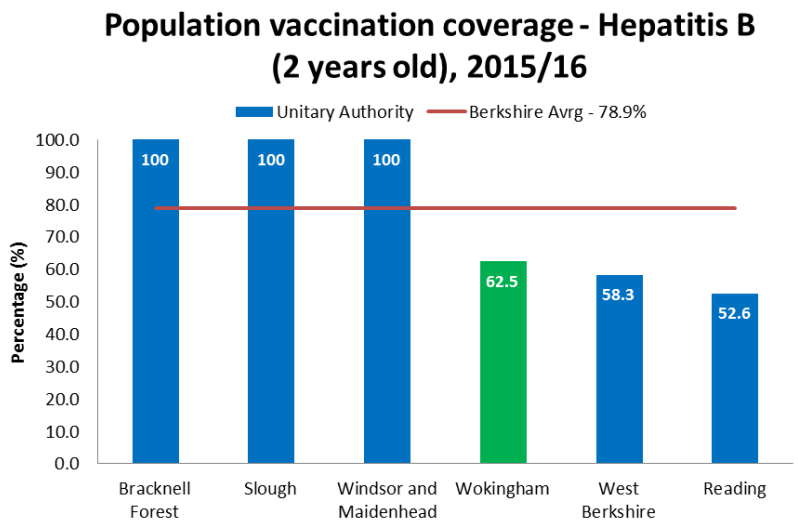



Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

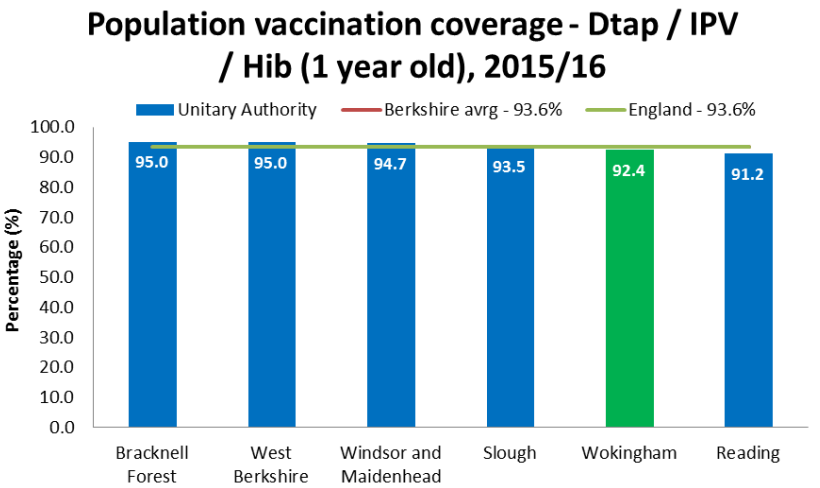
The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against diphtheria, pertussis (whooping cough), tetanus, Haemophilus influenza type b (an important cause of childhood meningitis and pneumonia) and polio (IPV is inactivated polio vaccine).

The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against these five diseases. The vaccine is offered when babies are two, three and four months old.

Children for whom the PCT is responsible who received 3 doses of DTaP/IPV/Hib vaccine at any time by their first birthday as a percentage of all children whose first birthday falls within the time period.

Vaccination coverage for Dtap/IPV/Hib in Wokingham is similar to the national value and in line with the rest of the Berkshire Authorities.

**Figure 1.24:** Vaccination coverage for Dtap/IPV/Hib – 1 year




Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

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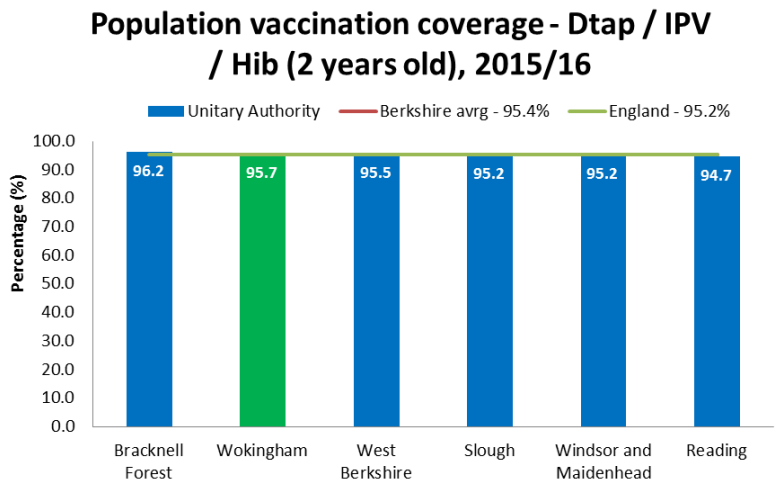
**Figure 1.25:** Vaccination coverage for Dtap/IPV/Hib – 2 years old



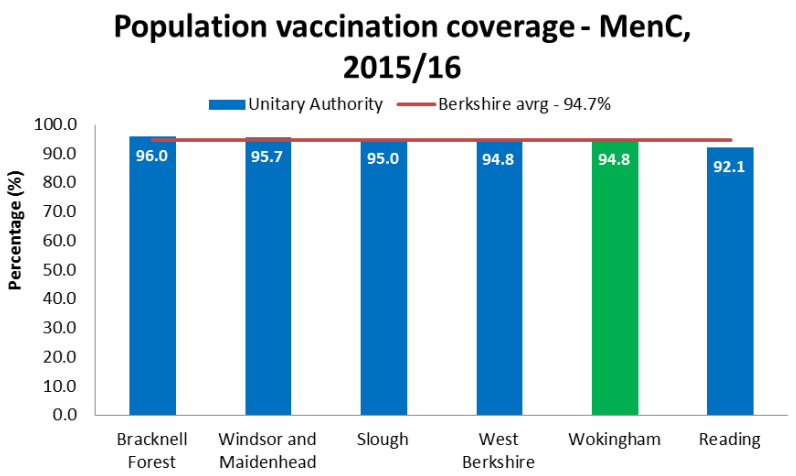

Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

The meningococcal C conjugate (MenC) vaccine protects against infection by meningococcal group C bacteria, which can cause meningitis and septicaemia.

Figure 1.26 shows all children at age one who have received the completed course of MenC vaccine as a percentage of all children for whom the PCT is responsible whose first birthday falls within the time period.

Wokingham's coverage of MenC vaccination is similar to the overall value in Berkshire.

**Figure 1.26:** Vaccination coverage for MenC




Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

The PCV vaccine protects against pneumococcal infections that can cause pneumonia, septicaemia or meningitis. The PCV vaccine is given to all children under two years old as part of the childhood vaccination programme.

Wokingham's coverage of PCV vaccination is similar to the overall value in Berkshire.

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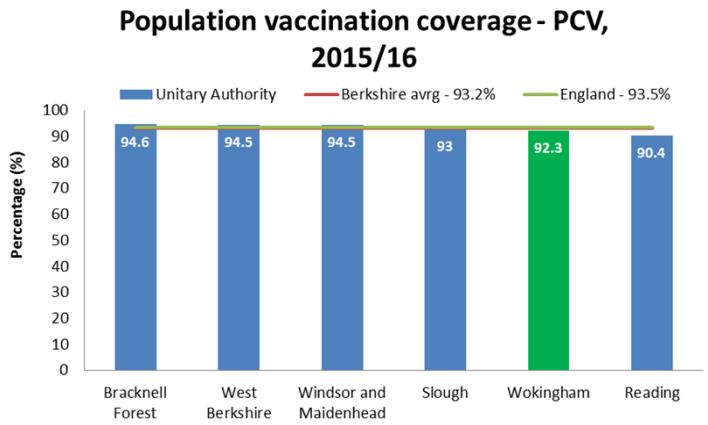
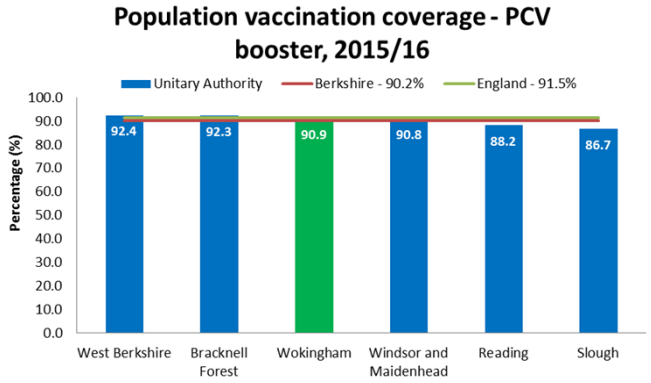
**Figure 1.27:** Vaccination coverage for PCV




Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

**Figure 1.29:** Vaccination coverage for PCV booster

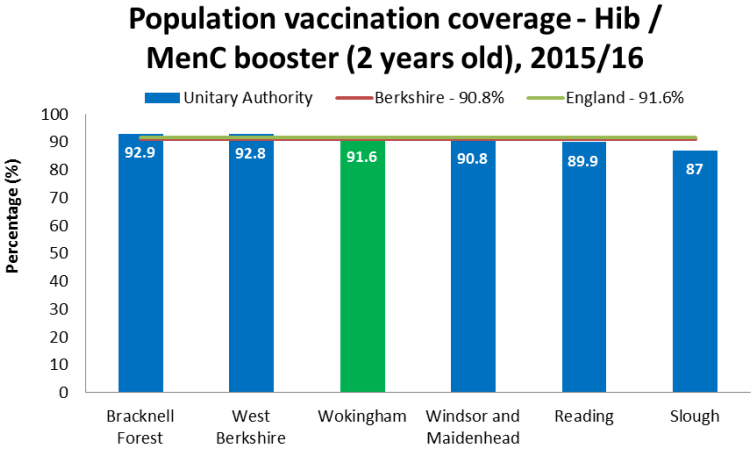



Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

All children at age two years who have received one booster dose of Hib/MenC vaccine resident within each reporting area as a percentage of all children at age two years.

The Hib / MenC booster increases the protection a child gets from the first course of Hib vaccine when they are 8, 12 and 16 weeks old, and the MenC vaccine when they are 12 and 16 weeks. This boosted immunity lasts into adulthood.

**Figure 1.28:** Vaccination coverage for Hib/MenC booster – 2 years old




Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

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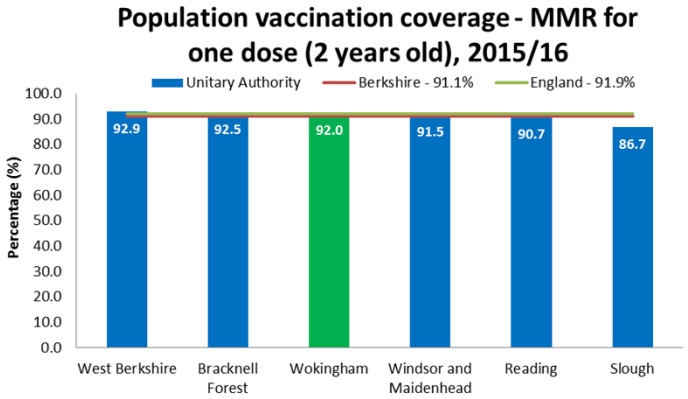
MMR is the combined vaccine that protects against measles, mumps and rubella. Measles, mumps and rubella are highly infectious, common conditions that can have serious complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.

The first MMR vaccine is given to children as part of the routine vaccination schedule, usually within a month of their first birthday. They'll then have a booster dose before starting school, which is usually between three and five years of age.

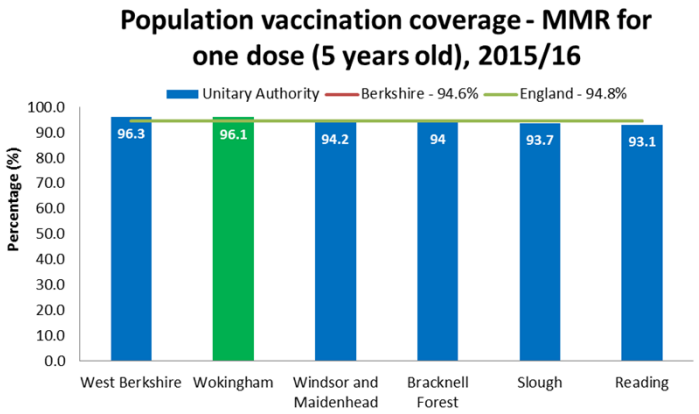
MMR coverage in Wokingham is one of the highest in Berkshire and similar to the national value.

**Figure 1.30:** Vaccination coverage for MMR – 2 years




Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

**Figure 1.31:** Vaccination coverage for MMR – 5 years




Source: PHE: Child and Maternal health (ChiMat)
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations

## 4.3 Hospital admissions

High levels of admissions of either mother or babies soon after birth can suggest problems with either the timing or quality of health assessments before the initial transfer or with the postnatal care once the mother is home. Dehydration and jaundice are two common reasons for re-admission of babies and are often linked to problems with feeding.

The figure below shows emergency admissions from babies aged 0-13 days (inclusive) expressed as a crude rate per 1,000 deliveries.

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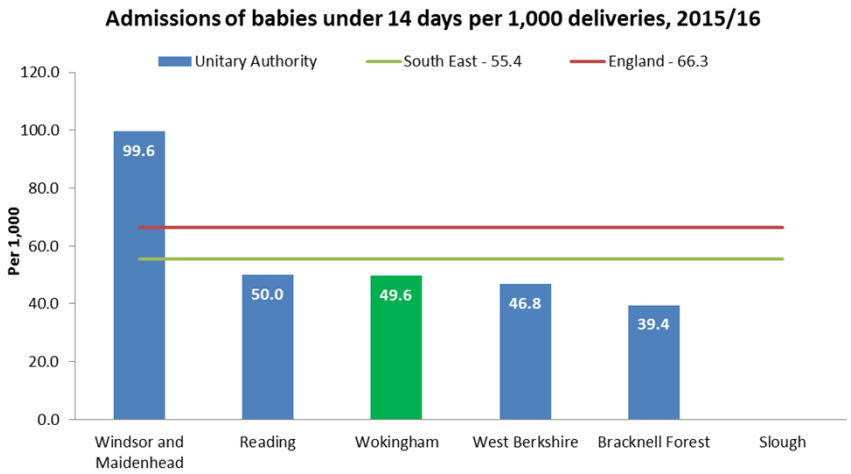
**Figure 1.32:** Hospital admissions of babies under 14 days



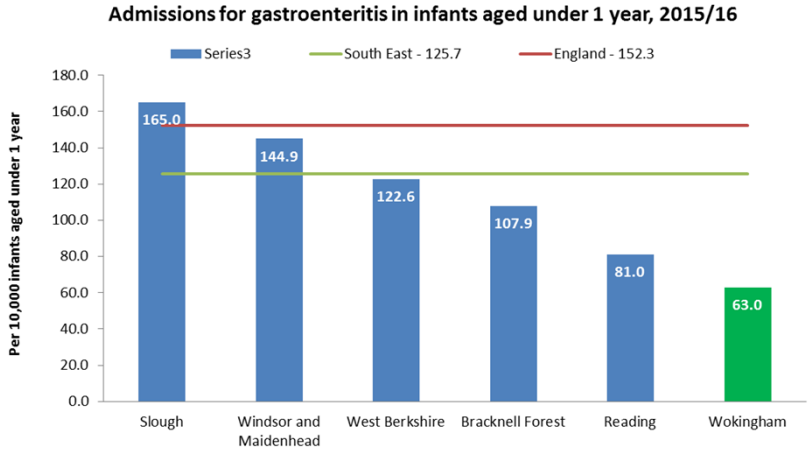

*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

Figures 1.33 – 1.38 show rates (crude) of emergency admissions for gastroenteritis and respiratory tract infection, in infants aged under 1 year, 1 year, and 2-4 years.

The purpose of the indicator is to help monitor National Health Service (NHS) success in treatment outside hospital of types of childhood gastroenteritis and respiratory tract infections that have limited morbidity or need for hospital-based care and low mortality, through e.g. encouraging breast feeding, better diet, hygiene, and management of infections; better support for young parents in the care of their children and in the management of illnesses in the home; providing support as well as facilitating access to health advice and therapy through NHS Direct; and enhanced primary care.

As the charts below reveal, Wokingham's hospital admission rate for gastroenteritis is one of the lowest in Berkshire and considerably lower than England and the South East. However, Wokingham has the highest rate in hospital admissions in respiratory tract infections in infants aged 1 year and 2-4 years.

**Figure 1.33:** Admissions for gastroenteritis in infants under 1 year




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

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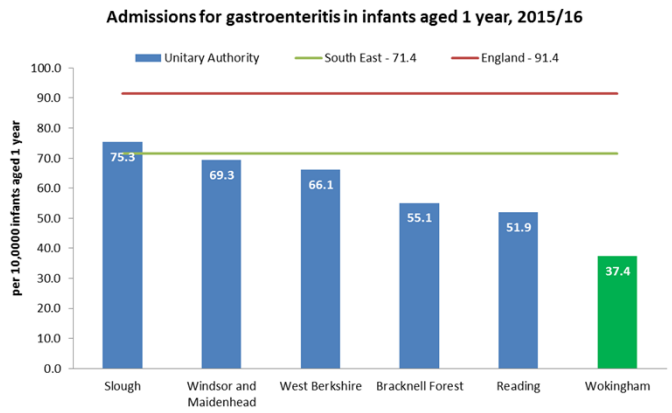
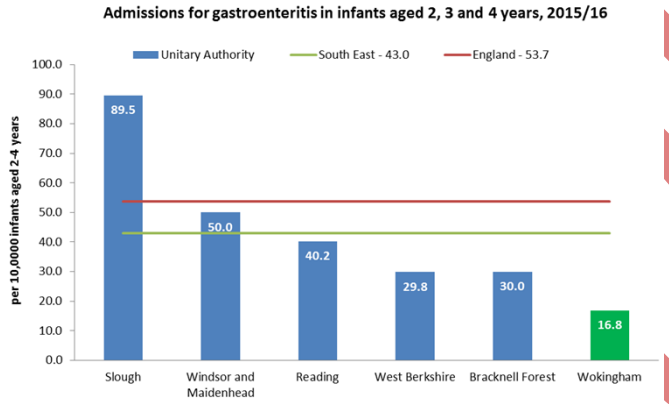
**Figure 1.34:** Admissions for gastroenteritis in infants aged 1 year



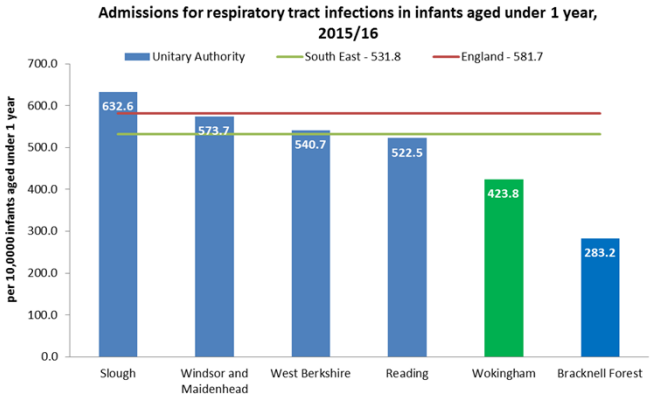

*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

**Figure 1.35:** Admissions for gastroenteritis in infants aged 2-4 years



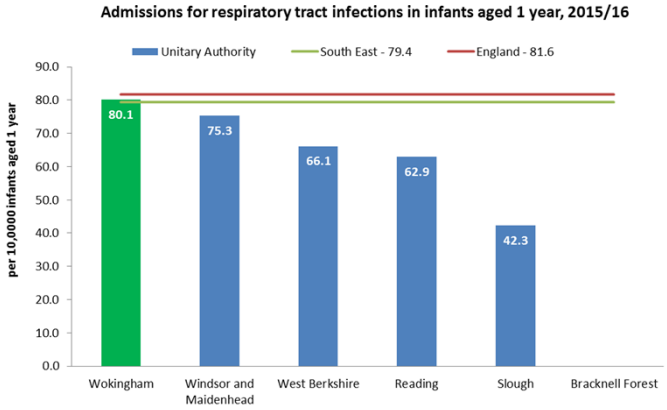

*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

**Figure 1.36:** Admissions for respiratory tract infections in infants under 1 year




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

**Figure 1.37:** Admissions for respiratory tract infections in infants aged 1 year




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

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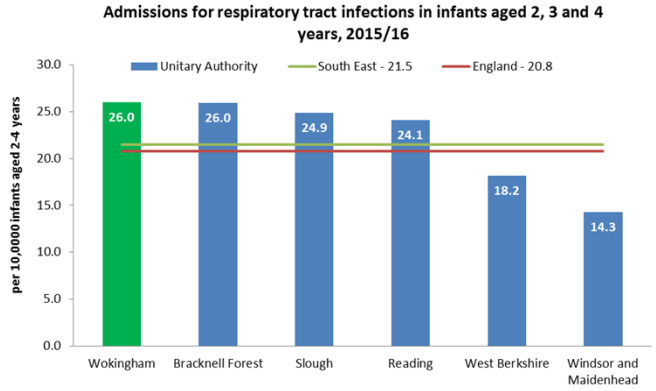
**Figure 1.38:** Admissions for respiratory tract infections in infants aged 2-4 years




*Source: PHE: Child and Maternal health (ChiMat)*
*https://fingertips.phe.org.uk/profile-group/child-health*

To add map of A&E attendances by ward – Wokingham CCG

## 4.4 Children in care

As at March 2017, Wokingham had 20 children in care per 10,000 children under 18 against the national average of 60 per 10,000 and the South East regional average of 48 per 10,000.

Children in care in Wokingham are primarily in the older age group (11 and over). As at 31st March 2017 Wokingham's children in care population was made up as follows:

| Age | Numbers | Percentage |
|---|---|---|
| Under 4 | 6 | 7.8% |
| 5-10 | 5 | 6.5% |
| 11-15 | 33 | 42.9% |
| 16+ | 33 | 42.9% |
| **Total** | **77** | |

There is a tendency for more children to come into care between the ages 5-10 and 11-15.

| Year | 0-4 | 5-10 | 11-15 | 16-17 |
|---|---|---|---|---|
| **2011** | 23 | 28 | 16 | 5 |
| **2012** | 22 | 29 | 16 | 5 |
| **2013** | 23 | 33 | 26 | <5 |
| **2014** | 16 | 28 | 25 | 3 |
| **2015** | 9 | 29 | 32 | 4 |
| **2016** | 12 | 27 | 27 | 7 |
| **2017** | 7 | 26 | 34 | 10 |

During the year April 2016 to March 2017 there was a reduction in the numbers of children coming into care and in the number of children who were no longer in care. There are also more boys than girls in care and 88% of boys in care are aged between 10 and 17 compared to 82% of girls.

| Year | Number of children taken into care in year, in care on 31st March |
|---|---|
| **2011** | 10 |
| **2012** | 8 |
| **2013** | 13 |
| **2014** | 10 |
| **2015** | 11 |

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| | |
|---|---|
| **2016** | 15 |
| **2017** | <5 |

# 5. Other data

Paternal health – no data

Grandparents living with family with children 0-4 – no data

Passive smoking – no data

What we don't know – why is it necessary to commission the right services (indicators by ethnicity, mother's age and socio-economic status)

Disabilities- Sarah Sesay

Map children's services and children's centres

6 centres

11

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# Developing Well 2017/18

Public Health Intelligence

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# 1. Key messages

The total children and young adult population (4-25) in Wokingham was estimated at 42,162 persons in 2017. There are 29,272 pupils attending schools in Wokingham

- Young people in Wokingham enjoy amongst the best health in England, as measured by a range of indicators
- Overall school attainment is good (xx% of children achieve at least) 5 A*-C, however … gap, etc
- There are a about 800 children with a Statement of Special Educational Needs (SEN) or from April 2018 Education, Health and Care (EHC) plan, of which xx% are in mainstream schools.
- Absence from school in Wokingham (4.1%) is better than the national average (4.6%)
- Only 16% of teenagers achieve the recommended physical activity level of one hour of moderate to physical activity every day,
- Alcohol is by far the most common drug used by teens in Wokingham, 14% of 15 year olds report being drunk in the last month, which is the same as the national average.
- Hospital admissions due to alcohol in young people are about half the national rate.
- 7.3% of children and young people in Wokingham are estimated to have a diagnosable mental health disorder – 1828 people.
- It is estimated that there may be between 1700 and 1900 young people aged between 16 and 24 living in Wokingham who are at risk of developing an eating disorder
- 56% of looked after children in Wokingham have a score on the Strengths and Difficulties Questionnaire (SDQ) which would indicate a cause for concern. The national figure is 38% This suggests that children in care have more problems, or more difficulty dealing with them in Wokingham than in other less affluent areas.
- Hospital admissions for self-harm have risen three fold since 2011/12, from a position well below the national average, to now slightly exceeding it.
- Mental health
- CAMHS
- Teenage pregnancy
- STIs
-
- Smoking
- Youth offending
- Children in Need
- NEET
- Children in Care
- Physical disability
- Learning disability
- Asthma
- Diabetes
- Epilepsy
- FGM
- Safeguarding
- Mortality

Recommendations

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1. That moderate to vigorous activity be widely promoted in school and home settings, with targets of 15% and 20% of girls and boys respectively at age 15 reporting at least one hour of per day by 2021.
2. Planning approval of the layout of new housing and design of new road, pedestrian and cycle routes maximises opportunities for active travel (this recommendation needs to be repeated in People and Places).

# 2. Introduction

A healthy and balanced childhood and young adulthood development is vital for a person's health and wellbeing later in life. Healthy habits develop early in life and it is important they are adopted at home and at school and while a person is still young. The opposite applies to unhealthy habits. They need to be avoided at a young age. For instance it is estimated that 40% of regular smokers began smoking before the age of 16.

This chapter looks at the overall health and wider determinants of the population from school age up to 25 years old. However, because not all data is available by age and some data, like youth offending, is not pertinent to younger children, not every section contains data for the same age group. However all sections focus at children and/or young adult population. The table below shows estimated population numbers of children and young adults by age group in Wokingham borough.

**Table 1:** Estimated numbers of children and young adult resident population (source: ONS, 2014-based subnational population projections)

| | 2016 | 2017 | 2020 | 2025 | 2030 |
|---|---|---|---|---|---|
| **4-9** | 13,593 | 13,778 | 13,578 | 13,409 | 13,406 |
| **10-14** | 10,351 | 10,637 | 11,648 | 12,053 | 11,859 |
| **15-17** | 5,933 | 5,880 | 6,263 | 7,256 | 7,131 |
| **18-25** | 11,864 | 11,868 | 11,338 | 11,528 | 12,816 |
| **Total** | 41,742 | 42,162 | 42,827 | 44,246 | 45,212 |

# 3. Overall health

Young people in Wokingham enjoy amongst the best health in England, as measured by a range of indicators. Wokingham scores consistently in the top percentile each of the measures except three, and those three are not statistically different from the England average due the numbers being very small (thankfully).

Insert image of the Child Health profile from Fingertips

# 4. Wider determinants

## 4.1 Deprivation

The levels of economic deprivation in Wokingham are very low, as described in the Borough profile. Children aged 5 – 10 years living in low income families is only 5.6%, which is the lowest in England.

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Low income in this indicator means a family which is in receipt of Working Tax Credits, Child Tax Credits, Income Support, or Jobseekers Allowance.

Xx% of children are in receipt of Free School Meals.

## 4.2 Education (core data to be updated in July 2019)

### 4.1.1 School population

Between January 2016 and January 2017 the number of pupils in the school system in England rose by 110,000 with the majority of this increase being in primary schools. There has also been a greater increase seen in secondary schools than there has been in recent years. 14% of pupils were claiming free school meals which is the lowest proportion seen since 2001. 5.4% of Key Stage 1 pupils were in classes of more than 30 pupils: a decrease from a peak of 6.2% in 2015. The proportion of pupils from minority ethnic groups has risen steadily since 2006 and 32% of Primary School children and 29% of secondary school children are now from minority ethnic groups. The proportion of children for whom English is a second language is also steadily rising to 21% of Primary School children and 16% of Secondary School children in 2017.

In Wokingham … data here on growth in school population, primary, secondary and special schools over the last 5 years – keep it here with the national data for contextAs of January 2017 there is a total of 80 schools in Wokingham. 53 of these are state-funded Primary schools, 10 are state-funded Secondary Schools, and 2 are state-funded Special Schools. There is a total of 29,272 pupils attending schools in Wokingham. 15,083 of these attend state-funded Primary schools, 10,418 attend state-funded Secondary Schools, and 252 attend state-funded Special Schools. 3% of key stage 1 pupils are in classes of 31 or more pupils. This is less than the national average of 5%. 5% of state-funded nursery and primary school pupils and 5% of state-funded secondary school pupils in Wokingham schools are known to be eligible for and claiming free school meals. The national averages are 14% and 8% respectively. 6799 pupils in state-funded nursery, primary, and secondary schools in Wokingham are from Minority Ethnic Backgrounds. This is 31% of all Primary school pupils and 28% of all Secondary school pupils. Nationally 17% of Primary school children and 14% of Secondary school children are from Minority Ethnic backgrounds.

NO

**Educational attainment**

A new secondary school accountability system was implemented in 2016 which includes five key stage 4 (GCSE and equivalent) headline measures. A description of the measures can be found in the following document.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/584473/SFR03_2017.pdf

The national results on these measures can be seen on the next sheet alongside the Local Authority data. In 2016 attainment across schools increased in all of the five headline measures compared to 2015. Attainment gaps are seen between pupils with a first language other than English and those with English as a first language; between boys and girls; between those who are considered to be disadvantaged and all other pupils; between those receiving free, school meals and all other pupils;

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and between those with special educational needs and those with no special educational needs.

A new 16-18 school and college accountability system was implemented in 2016 with new headline measures and changes to the methodology for calculating 16-18 results. Bring the Wokingham GCSE data straight after the national.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/584124/SFR05_2017__A_level_and_other16-18_results_in_England_SFR_revised.pdf

The A-level average point score in England and was 31.8 in 2015/16 (C+ grade) in 2015/16 and has remained stable between 2014/15 and 2015/16. Students' points scores are on average lower at the end of 16-18 studies than they were at the end of key stage 4. The number of pupils completing 16-18 studies remained stable between 2014/15 and 2015/16 despite a drop in the potential number of students (i.e. those completing Key stage 4 two years earlier). 13% of students entered for one or more A-level or applied A-leave? achieved 3 A*-A grades or better and 22% achieved grades AAB or better.

Again – bring the Wokingham A level data straight after.

We can then write something to effect of "Wokingham generally has very good school attainment…

In 2015 94% of pupils were in sustained education, employment or training in the year after key stage. 88% of students were in sustained education or employment after key stage 5. Disadvantaged students are less likely to be employed or in higher education after key stage 5.

### 4.1.2 Special needs

Nationally, the number of children with a Statement of Special Educational Needs (SEN) or an Education, Health and Care (EHC) plan has increased each year since 2010. Local Authorities are required to transfer all children with SEN statements to EHC plans by April 2018: 33% of children had been transferred as of January 2016. Children aged 11-15 account for the largest proportion of children with SEN statements or EHC plans (39%). 45% of children with a statement or EHC plan are receiving provision in mainstream schools.

In January 2017, 802 children and young people in Wokingham had a SEN statement or EHC plan. This is an increase from January 2016 when there were 756 statements/plan in place. The majority of children and young people with statements/plans are placed in Special schools (41%); followed by mainstream schools (39%). In 2016 and excluding exception cases 90% of EHC plans were issued within the 20 week target. Of those with statements of SEN in January 2016 24% had been transferred to an EHC plan by January 2017.

The number and rate of permanent exclusions have increased nationally in 2015/16 compared to 2014/15 from 0.07% to 0.08%. The number and rate of fixed period exclusions have also increased over the same time period from 3.88% to 4.29%. Persistent disruptive behaviour is the most common reason for these exclusions. Exclusions are more common in older age groups and boys are three time more likely to receive a permanent exclusion than girls. Pupils receiving free school meals and those with SEN are more likely to be excluded than their peers. Exclusions are more likely amongst Gypsy/Roma and Traveller of Irish Heritage Ethnic groups as well as amongst Black Caribbean pupils.

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In 2015/16 there were 30 permanent exclusions and 600 fixed period exclusions in state-funded primary, state-funded secondary, and special schools in Wokingham this equates to 0.12% and 2.37% of all pupils respectively. The majority of fixed-period exclusions were due to persistent disruptive behaviour followed by all other reasons. These accounted for 41% of all fixed-period exclusions.

## Absence

The overall absence rate across primary, secondary, and special schools in England in 2016/17 was 4.7%, very similar to the 4.% in 2015/16 and 2014/15. Overall absence rates have shown a downward trend since 2006/07it was 6.5%. Illness remains the most common reason for absence (57.3% of all absences). One in ten pupils were considered to be persistent absentees (missing 10% or more of possible sessions). Absence is higher for pupils eligible and claiming free school meals than other pupils (7% compared to 4.1%). Absence is also higher for those with special educational needs or an education healthcare plan than other pupils (7.7% compared to 4.2%). Absence rates increase with levels of deprivation. They are highest amongst those of Traveller or Irish Heritage and Gypsy/Roma pupils.

The overall absence rate across primary, secondary, and special schools in Wokingham was 4.1% in 2016/17, as it had been the previous 2 years.In 2015/16, the absence rate for authorised reasons was 3.4% and the absence rate for unauthorised reasons was 0.7%. 62% of all missed sessions were due to authorised illness

The tables below shows attainment at key stage 4 (GCSE and equivalent) for pupils attending schools in Wokingham.

In 2016 a school would be considered below floor standard if the average progress 8 score is below -0.5 (meaning that the average score for the school is half a grade lower than the national average) AND the upper confidence interval of the progress 8 score is below zero.

**Figure X:** Education, Health and Care plans issued with 20 weeks

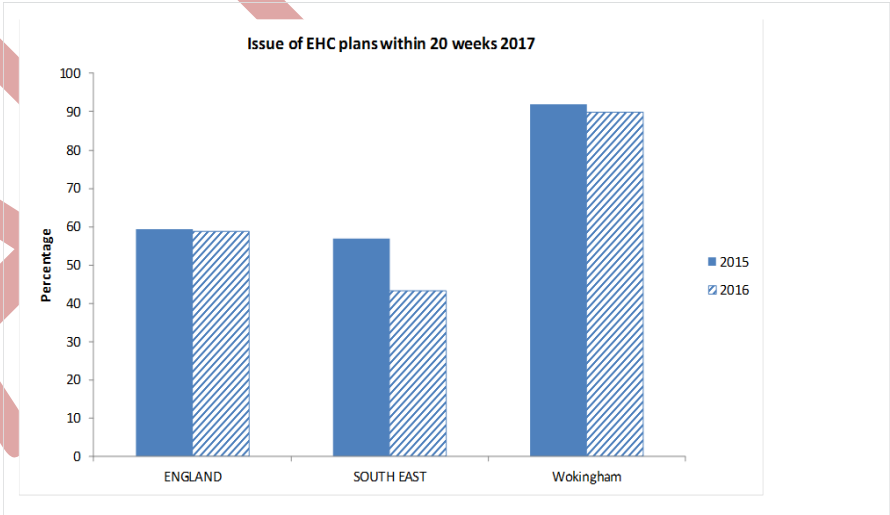


**Figure X:** Placement of children and young people with SEN/EHC plans

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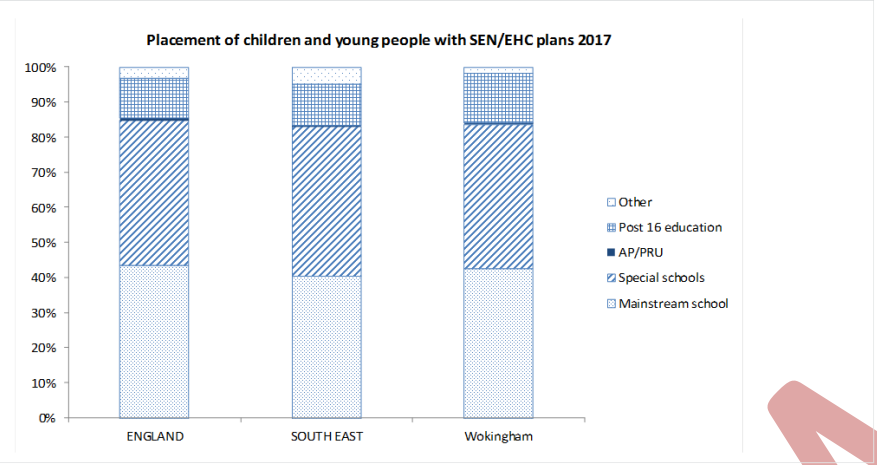



**Figure X:** School sessions missed due to absence, arranged in reverse order

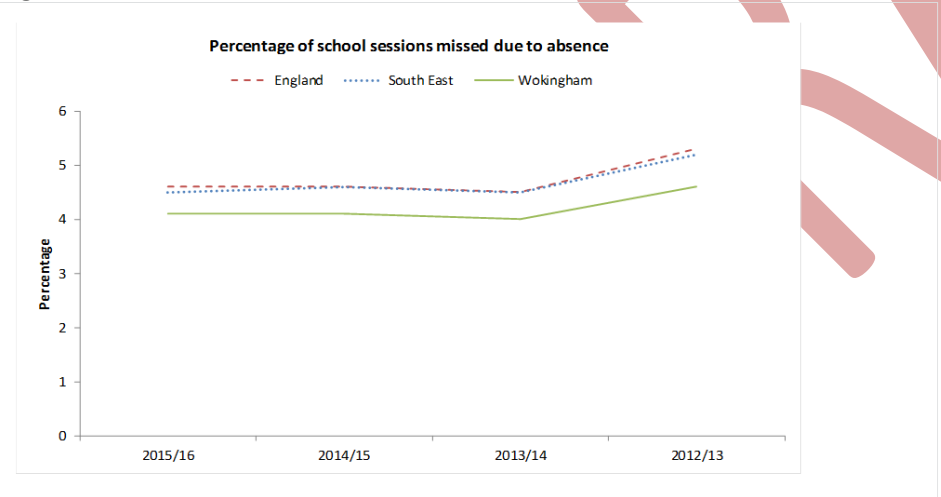



**Figure X:** Average attainment 8 scores at the end of key stage 4

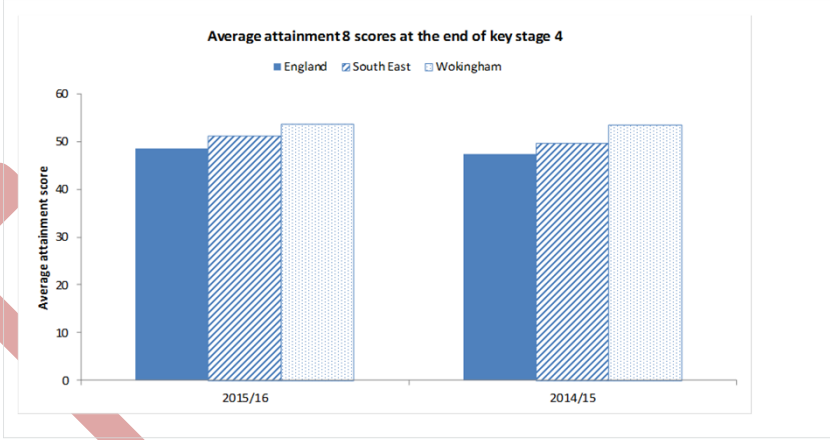
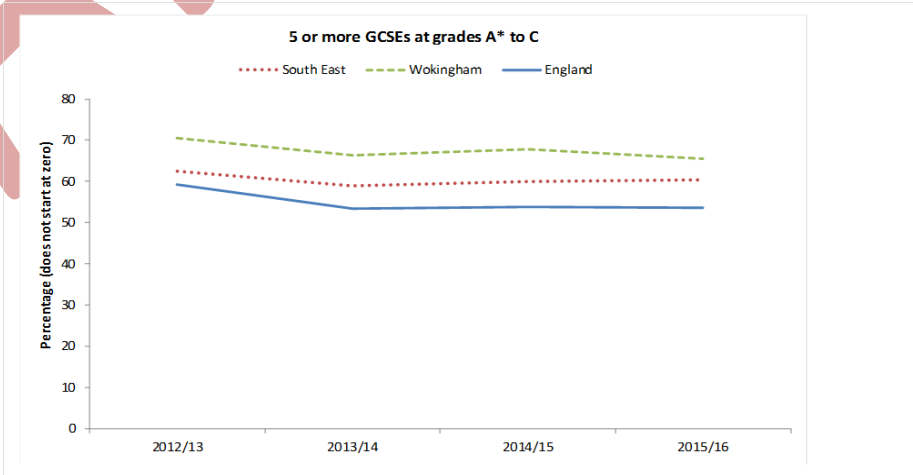



**Figure X:** 5 or more GCSEs at grades A* to C




# 4. Lifestyle

Young people in Wokingham live comparatively healthy lifestyles compared to other areas, but there is little room for complacency as

overall lifestyle in England, as with the rest of the developed world, is not healthy enough. There are predictions that the generation who are children now will have shorter life expectancies than their parents if current trends in physical inactivity and obesity continue on their current trajectory.

**Physical Activity**

The latest data we have is from the What about YOUth survey in 2014/15

| Measure | Wokingham | England average |
|---|---|---|
| Eats 5 portions or more of fruit and veg per day | 63% | 52% |
| Physically active for at least one hour per day seven days a week | 16% | 14% |
| Young people thought they were the right size | 53% | 52% |
| Mean daily sedentary time in the last week over 7 hours per day. | 63% | 70% |

The guidelines for physical activity state that young people aged 5 – 18 should have one hour of moderate to physical activity every day to develop and maintain good health.

For comparison, here is some international data on % of 13 and 15 year olds who reported at least one hour of moderate to physical activity daily in 2013:

| Country | Girls aged 13 | Girls aged 15 | Boys aged 13 | Boys aged 15 |
|---|---|---|---|---|
| England | 14 | 9 | 23 | 14 |
| Ireland | 16 | 9 | 36 | 25 |
| Netherlands | 17 | 12 | 21 | 22 |
| Scotland | 13 | 11 | 19 | 14 |
| Spain | 18 | 12 | 36 | 28 |

Source: Health Behaviour in School Age Children 2013/14

Generally levels of moderate to vigorous physical activity drops off as young people mature, and consistently the male level is higher than the female. It does indicate that it is possible to achieve better results in similar countries, for instance even Scotland which fares poorly compared to England on many health statistics achieves a fifth more girls moderately active at age 15 (11%). Wokingham has many factors in its favour and should aim for much higher levels of physical activity. It is proposed that targets of 15% and 20% of girls and boys respectively at age 15 report at least one hour of moderate to vigorous activity per day by 2021 be agreed.

Children with disabilities

It is harder for young people with physical or learning disabilities to be physically active (find some data which shows this to be the case)

Travel to school

An important contribution to our level of activity is how we get about day-to-day. If children (or adults) do not regularly walk anywhere they are missing one of the fundamental activities which contributes to health. The same factors apply to wheelchair-users or others with impaired mobility – using one's own body to provide the energy to get around. Travel to school is a good marker of population travel patterns.

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Results as a figure (bar chart)

Interpretation of the results

Recommendation arising from the results – something to the effect of "Planning approval of the layout of new housing and design of new road, pedestrian and cycle routes maximises opportunities for active travel."

## 4.3 Weight and childhood obesity

### 4.2.1 National data

The UK is experiencing an epidemic of obesity and there is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood.. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

*NCMP - England, 2015/16 school year*

The National Child Measurement Programme (NCMP) measures the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children within primary schools. This data can be used at a national level to support local public health initiatives and inform the local planning and delivery of services for children. Local Authorities are asked to collect data on children's height and weight from all state maintained schools within their area. The data are submitted to NHS Digital and all of the returns are collated and validated centrally. The national participation rate for reception children was 95.7% and 94% for year 6 pupils. The total participation rate was 94.9%. The participation rate in Wokingham for reception children was 96.9% and 94.7% for year 6 pupils. The total participation rate was 95.7%.

Obese children (4-5 years) 9.3 Decreasing and getting better

Obese children (10-11 years) 19.8 Increasing and getting worse

**Key facts**

Over a fifth of reception children were overweight or obese. In year 6 it was over a third.

The prevalence of obesity has increased since 2014/15 in both reception and year 6.

In reception it increased to 9.3 per cent from 9.1 per cent, and in year 6 to 19.8 per cent from 19.1 per cent.

In reception obesity prevalence was lower than in 2006/07. In year 6 obesity prevalence was higher than in 2006/07 but the early years of the

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NCMP are known to be an underestimate for obesity prevalence for this older year group.

Obesity prevalence was higher for boys than girls in both age groups.

Obesity prevalence for children living in the most deprived areas in both age groups was more than double that of those living in the least deprived areas.

The deprivation gap as measured by the differences in obesity prevalence between the most and least deprived areas has increased over time.

Obesity prevalence varied by local authority. For reception this ranged from 5.1 per cent in Richmond upon Thames to 14.7 per cent in Middlesbrough.

In year 6 the range was from 11.0 per cent in Richmond upon Thames, to 28.5 per cent in Barking and Dagenham.

*NCMP - England, 2015/16 school year*

### 4.2.1 Wokingham data

In 2015/16 6.5% of 4 to 5 year olds in Wokingham were obese. This was better than the England average of 9.3% and is not a significant change from previous years figures.

In 2015/16 14.6% of 10 to 11 year olds in Wokingham were obese. This figure was not a significant change from previous years and was better than the England average of 19.8%.

**Figure X:** Obesity in Reception Year

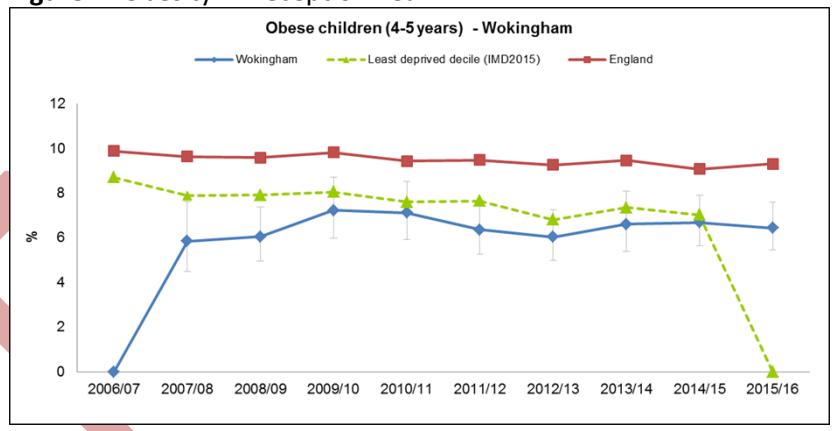


**Figure X:** Obesity in Year 6

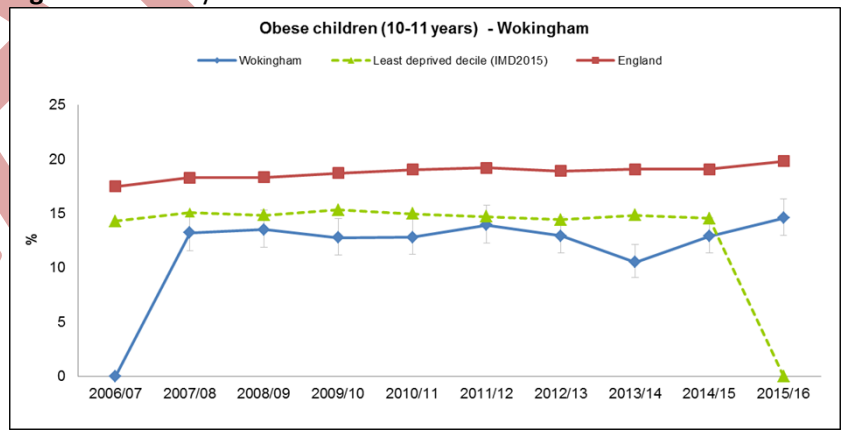


**Figure X:** Weight measurement in Reception Year

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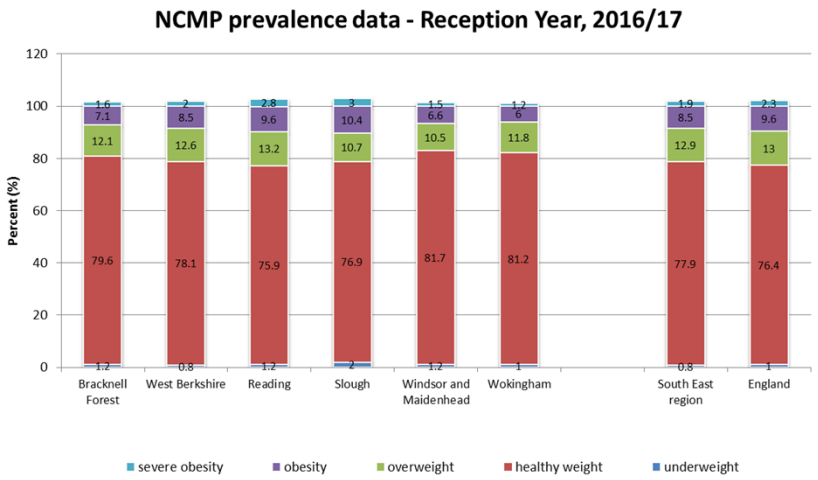
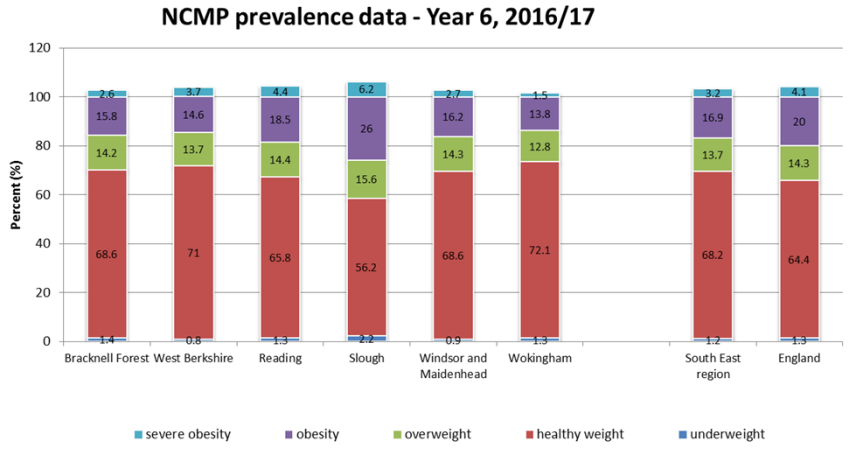



**Figure X:** Weight measurement in Year 6




Add ward data on prevalence of childhood obesity when it is updated

Look at Weight management strategy

## 4.4 Smoking

**Health effects of smoking among young people:**

Among young people, the short-term health consequences of smoking include respiratory and non-respiratory effects, addiction to nicotine, and the associated risk of other drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who smoke regularly continue to smoke throughout adulthood.[1] Cigarette smokers have a lower level of lung function than those persons who have never smoked.[11] Smoking reduces the rate of lung growth. [1]

- In adults, cigarette smoking causes heart disease and stroke. Studies have shown that early signs of these diseases can be found in adolescents who smoke. [1]
- Smoking hurts young people's physical fitness in terms of both performance and endurance—even among young people trained in competitive running. [1] On average, someone who smokes a pack or more of cigarettes each day lives 7 years less than someone who never smoked. [22]
- The resting heart rates of young adult smokers are two to three beats per minute faster than non-smokers. [1]
- Smoking at an early age increases the risk of lung cancer. For most smoking-related cancers, the risk rises as the individual continues to smoke. [1]
- Teenage smokers suffer from shortness of breath almost three times as often as teens who don't smoke, and produce phlegm more than twice as often as teens who don't smoke. [3]
- Teenage smokers are more likely to have seen a doctor or other

[1] CDC, Preventing Tobacco Use Among Young People—A Report of the Surgeon General, 1994

[2] Lew EA, Garfinkel L. Differences in Mortality and Longevity by Sex, Smoking Habits and Health Status, Society of Actuaries Transactions, 1987

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health professionals for an emotional or psychological complaint. [33]

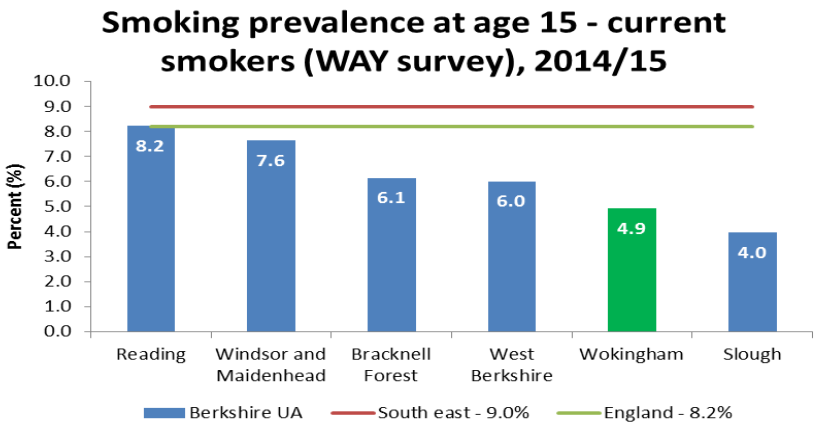
- Teens who smoke are three times more likely than non-smokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine. Smoking is associated with a host of other risky behaviours, such as fighting and engaging in unprotected sex. [1]

*(Source: World Health Organisation)*

The prevalence of smoking in children has been decreasing ….
It is estimated that in England 3% of children under the age of 16 smoke regularly, 18% of children under 16 have tried smoking, and 40% of regular smokers began smoking before the age of 16. *(Source: Cancer Research UK; http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/childhood-smoking)*

The table below shows prevalence of smoking among children and young adults in Wokingham compared with the rest of Berkshire, the South East region and England.

**Figure X:** Smoking prevalence at 15




*Data source: Public Health England*

Smoking is a major cause of preventable morbidity and premature death. There is a large body of evidence showing that smoking behaviour in early adulthood affects health behaviours later in life. The Tobacco Control Plan (July 2017) https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england highlights the importance of reducing the number of young people taking up smoking, as it is "an addiction largely taken up in childhood". One of the national ambitions set out in the document was to reduce rates of 15 year old regular smokers to 3% by 2022.

## 4.5 Alcohol and substance misuse (core data to be updated in May 2018)

According to the 2014 survey of the Smoking, Drinking and Drug (SDD) use of children and young people in England, 38% of pupils have ever had an alcoholic drink (NHS Digital). This figure has declined since the survey begun in 2003. 8% of 11 to 15 year olds had had an alcoholic drink in the week prior to the survey with males and females reporting similar frequencies of drinking. However, there is variation in the form of alcohol

[3] AJHP, Arday DR, Giovino GA, Schulman J, Nelson DE, Mowery P, Samet JM, et al. Cigarette smoking and self-reported health problems among U.S. high school seniors, 1982-1989, p. 111-116

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drunk with females drinking more spirits and wine than males. Consumption levels varied widely amongst those who reported drinking with an average weekly consumption of 10 units. Low wellbeing and risk-taking behaviours were positively associated with the likelihood of children having had a drink in the previous week.

In the What about YOUth? (WAY) Survey (Department of Health) also conducted in 2014, 62% of 15 year olds surveyed reported ever having had an alcoholic drink. 6.2% described themselves as regular drinkers and 14.6% had been drunk in the previous 4 weeks. It should be noted that the two surveys described above differ in that the SDD survey is completed in exam conditions at school whereas the WAY survey is completed at home. It is possible that parental presence may have an negative influence on the young people's willingness to admit to risky drinking behaviour in the case of the WAY survey.

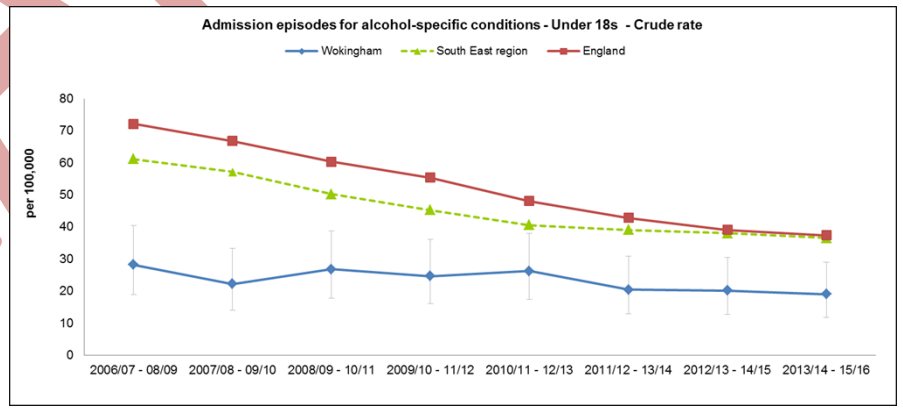
The percentage of Wokingham 15 year olds responding to the 'What About YOUth?' survey who have ever had an alcoholic drink is 61%, the same as the England average, but better than the South East Regional average. Those responding that they were regular drinkers was 4.4%, better than both the England and South East Regional average, this rate is better. The percentages reported having been drunk in the last 4 weeks is 14% in Wokingham, the South East Regional and England

**Figure X:** Alcohol-specific hospital admissions in under 18

Nationally a rate of 37.4 per 100,000 young people under the age of 18 are admitted to hospital due to an alcohol-specific cause (alcohol is wholly attributable for the condition). This figure relates to the time period 2013/14 to 2015/16 and has decreased overtime, as shown in Figure X.

The rate of under 18 year olds admitted to hospital for alcohol-specific conditions amongst young people living in Wokingham is 19 per 100,000, or about half England average. Data refers to the same time period (2013/14 - 15/16).

Nationally females are more likely than males to be admitted to hospital with an alcohol-specific cause. For the period 2013/14 to 2015/16 a rate of 29.4 per 100,000 males were admitted to hospital compared to 45.8 per 100,000 females. *(Source: Public Health England Local Alcohol Profiles)*




*Source: Public Health England Local Alcohol Profiles for England/What About YOUth? Survey*

Alcohol hospital admissions in under 18 by ward – waiting for CCG data
Drugs data to add (HD)
Very few children report having taken drugs other than alcohol, tobacco and cannabis in Wokingham, considerably less than 1%. However it is

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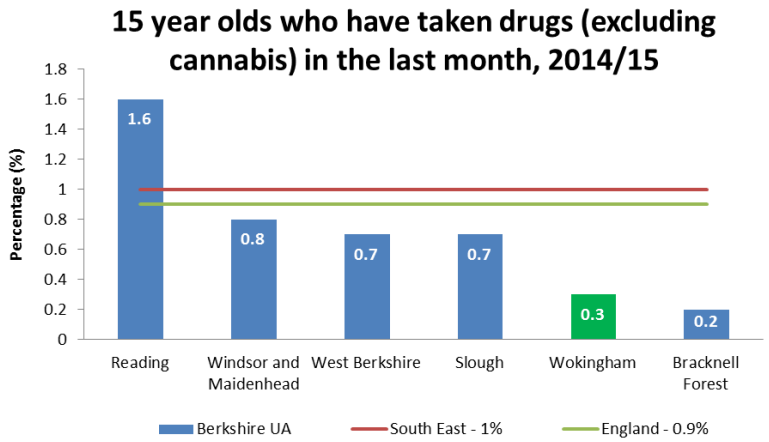
worth bearing in mind the possibility of bias in the survey due to it being undertaken in the home (where presumably parents may be able to see the survey).




*Source: What About YOUth (WAY) survey 2014/15*

# 5. Child and adolescent mental health

## 5.1 Prevalence

A brief general introduction to mental health before outlining the difficulty of measuring it. . Prevalence for this age group is estimated from national and local surveys, mental health related hospital admissions and child and adolescent mental health (CAMHS)service use. . Prevalence of common mental health disorders is recorded by GP Practices, however it is not available by age, therefore it is not possible to use this to estimate prevalence in children and young adults.

Figures 1-2 show estimated prevalence in population aged 5-16 for all mental health disorders and emotional disorders. Prevalence estimates were taken from table 4.14 from the ONS survey 'mental health of children and young people in Great Britain' in 2004 (http://www.hscic.gov.uk/pubs/mentalhealth04) and were applied to the number of children aged 5-16 resident in the area stratified by age, sex and socio-economic classification. Figure 3 shows prevalence of pupils with social, emotional and mental health needs.

Wokingham ranks lowest in Berkshire in prevalence of mental health disorders with 7.3% and a lot lower than the South East and England with 8.5% and 9.3% respectively.

Wokingham is also the lowest in Berkshire in prevalence of emotional disorders with 2.9%.

However, it ranks 3rd higher in Berkshire in prevalence of pupils with social, emotional and mental health needs with 1.9%.

**Figure 1:** Estimated prevalence of mental health disorders

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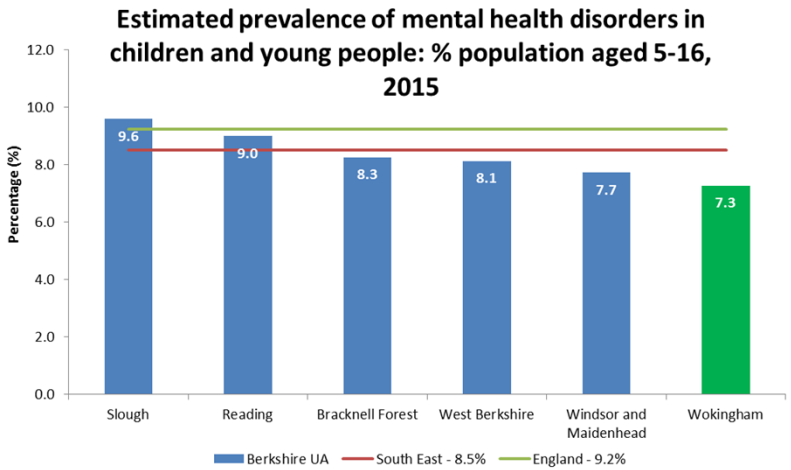
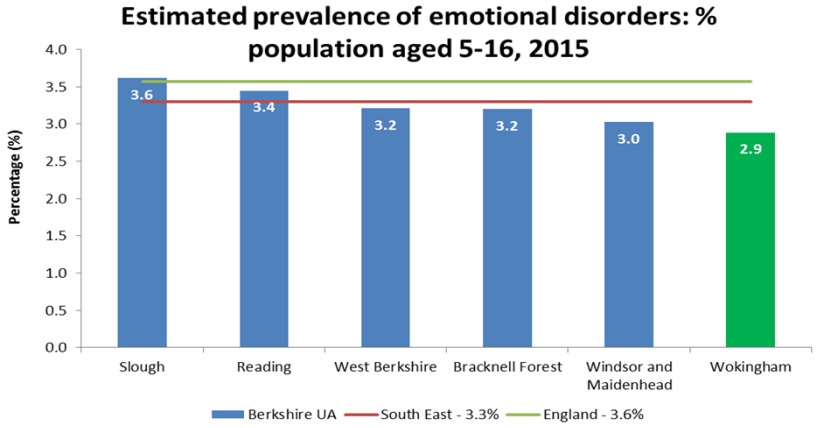


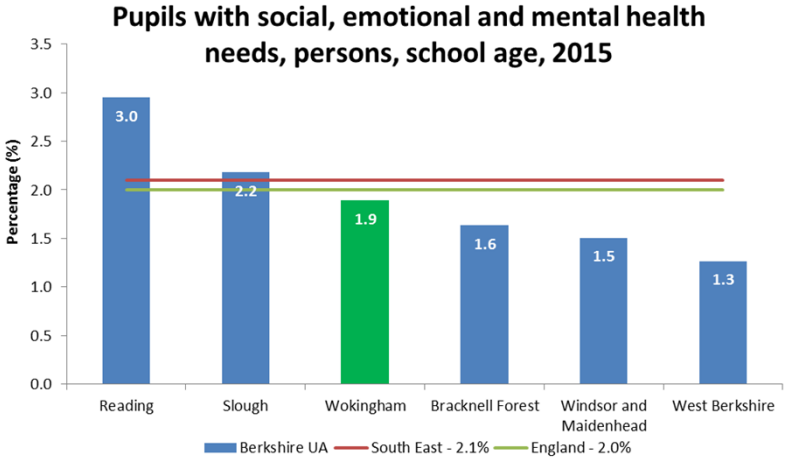

*Source: PHE (https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh)*

**Figure 2:** Estimated prevalence of emotional disorders




*Source: PHE (https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh)*

**Figure 3:** Estimated proportion of pupils with social, emotional and mental health needs




*Source: Department for Education special educational needs statistics (https://www.gov.uk/government/collections/statistics-special-educational-needs-se)*

Hospital admissions as a result of self-harm by age and ward – waiting for CCG data

## 3.2 CAMHS

Public Health England's Children and Young People's Mental Health and Wellbeing profiles includes data around; identification of need, protective factors, prevention, and finance. The data quality of indicators relating to identification of need is variable with some or significant concerns around data quality attached the majority of these indicators. Based on the national data, 9.2% of the 5-16 year old population with have a diagnosable mental health condition. 430 per 100,000 children and young people between the ages of 10 and 24 were admitted to hospital during

2015/16 as a result of self-harm. 2.34% of school age children were identified as having significant social, emotional and mental health needs.

"In 2015, CCGs and partner organisations submitted Children and Young People's Mental Health Services (CYPMH) Local Transformation Plans (LTP) to NHS England outlining how they aim to make improvements to services across the whole care pathway. The reports provided baseline data insights into current CYPMH services in the Thames Valley which tell us that;

There are 93 per 1,000 5-16 year olds with diagnosable mental health conditions

£29,794,000 was spent on CYPMH in 2014/15 (includes CCG, Local Authority and NHS England spend)

There are 17.09 CYPMH referrals per 1,000 total population (Tiers 2 and 3)

Bring in the data on Wokingham here

The Children and Young People with an Eating Disorder (CYP ED) Waiting Times data contains information on the number of children and young people who have accessed, or are waiting for NICE-approved treatment following a routine or urgent referral for a suspected eating disorder. At the end of Q1 2017/18 73% of children and young people receiving treatment for an eating disorder started treatment within 1 week of been referred. This is an increase from 65% at the end of Q1 2016/17.

7.3% of children and young people in Wokingham are estimated to have a diagnosable mental health disorder. This would equate to 1828 children and young people. Behavioural disorders are the most common type of mental health disorder in this age group with 4.1% of children and young people living in Wokingham estimated to have a conduct disorder. 2.9% of children and young people living in Wokingham are estimated to have an emotional disorder. These percentages equate to 1033 and 726 children and young people respectively*.

It is estimated that there may be 1889 young people aged between 16 and 24 living in Wokingham who are at risk of developing an eating disorder. However, the data quality around this estimate is highlighted as poor so this figure should only be taken as an indication of the true value**.

It is estimated that there may be 2000 young people aged between 16 and 24 living in Wokingham who have Attention Deficit Hyperactivity Disorder (ADHD). However, as with the eating disorder estimate the data quality around this figure is highlighted as poor so, again, should only be taken as an indication of the true value**

During 2015/16, 124 children and young people aged between 10 and 24 living in Wokingham were admitted to hospital as a result of self-harm. This is a rate of 464 per 100,000 and is the same as the national  regional averages.***

494 pupils in Wokingham have significant social, emotional and mental health needs. This equates to 1.9% of all pupils and is lower than the national and regional averages.****

56% of looked after children in Wokingham have a score on the Strengths and Difficulties Questionnaire (SDQ) which would indicate a cause for concern. The national figure is 38%.

*Source: Children and Young People's Mental Health Profile, Public Health England*

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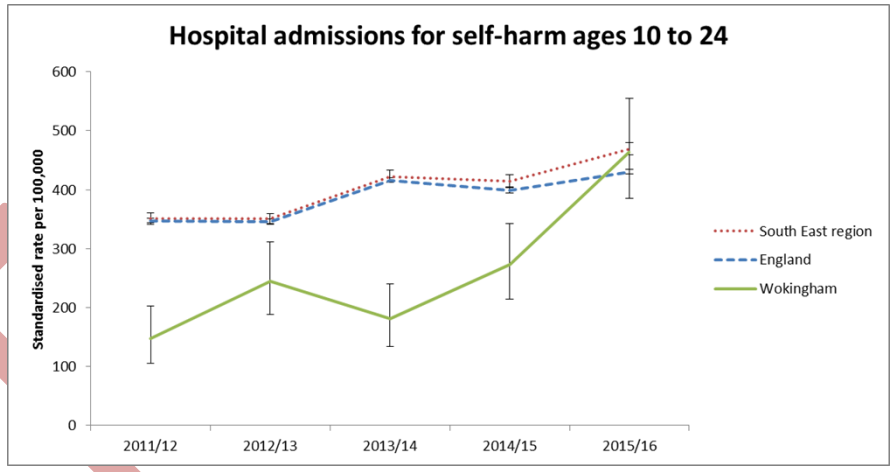
*Based on the prevalence from the ONS Survey Mental Health of Children and Young People in Great Britain (2004) adjusted for age, sex, and socio-economic classification

**Based on the prevalence from the Adult Psychiatric Morbidity Survey (2007)

***Directly standardised rate of finished admission episodes where the main recorded cause was intentional self-harm

**** Number of pupils with SEN where the primary need is social, emotional and mental health

So we need a summary of the main mental health issues for young people. My understanding is that there is a great need for services, especially that below the Tier 3 and 4 which would qualify for CAMHS, and I understand that Holli is commissioning a new primary care CAMHS – so need to get more detail. Lisa HumNataphries expressed a need for a home-based alternative to hospital for severe mental illness crisis intervention – I'll see if she has anything written about this/data we can use.




*Source: Children and Young People's Mental Health Profile, Public Health England*

**Figure 4:** Trend in hospital admissions for self-harm

# 3. Sexual health (15-25 year olds)

We aim to produce children equipped to enjoy safe and fulfilling relationships. This includes protecting them from sexual exploitation and from violent and coercive relationships. It involves empowering girls to control their own fertility, protecting them from unwanted pregnancy and able to enjoy a healthy sex life once they are mature. Both boys and girls need to understand the risk of sexually-transmitted infections and how to protect themselves against them before they engage in their first sexual activity.

Young people's attitudes and behaviour

Availability and use of contraception

Emergency Hormonal Contraception

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## 3.1 Teenage pregnancy (core data in this section to be updated in May 2018)

Teenage pregnancy is both a cause and consequence of health and education inequalities. Teenage mothers are at higher risk of missing out on further education – a fifth of young women aged 16 to 18 who are not in education, employment or training are teenage mothers. Their children can have a 25 per cent higher risk of a low birth weight, 44 per cent higher risk of infant mortality, 63 per cent higher risk of experiencing child poverty and at age five are more likely to have developmental delays. *(Source: Local Government Association and Public Health England (2016); Good progress but more to do: Teenage pregnancy and young parents)*

.

The conception rate for young women in England has been halved since 1998; 21 conceptions per thousand women aged 15 to 17 in 2015; and is now the lowest it has been since recordkeeping began in the late 1960s. However the conception rate still remains higher than other western European countries and the progress made has been uneven across England.

The estimated number of conceptions to women aged under 16 fell to 3,466 in 2015, compared with 4,160 in 2014, a decrease of 17%.

*(Source: Office for National Statistics (2017); Conception Statistics, England and Wales, 2015)*

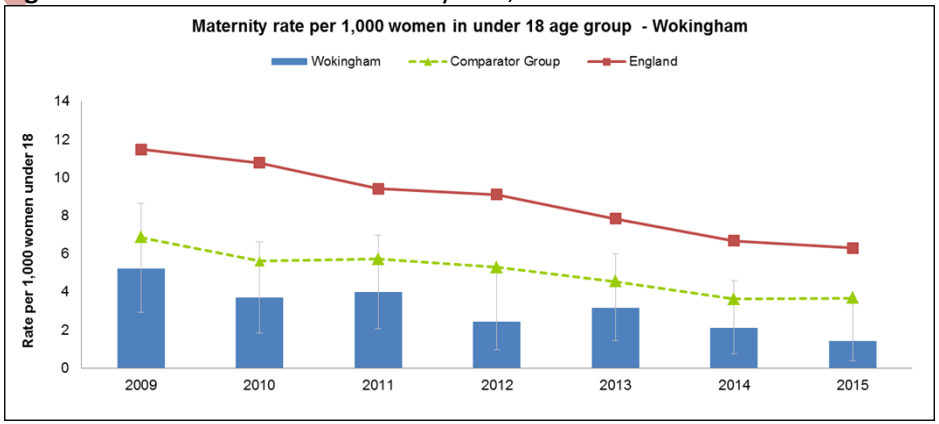
**Wokingham teenage pregnancy**

In 2015 there were 23 conceptions to women aged under 18 in Wokingham. This was a rate of 8.1 per 1,000 female population aged (15-17) which was significantly better than the England rate of 20.8 per 1,000 population.

In 2015 there were 9 conceptions to women aged under 16 in Wokingham. This was a rate of 3.2 per 1,000 female population aged (13-15) which was similar to the England rate of 3.7 per 1,000 population.

In 2015, of the 23 conceptions under 18 Years of age in Wokingham, slightly more than half led to an abortion, this was similar to the England figure at 51.2%.

**Figure 4:** Trend in under 18 maternity rate, 2009-15




*Sources: Public Health England: Sexual and Reproductive Health Profiles*

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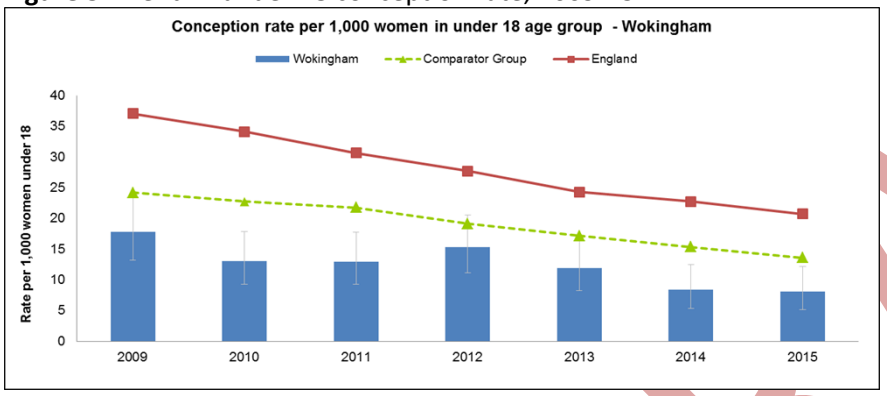
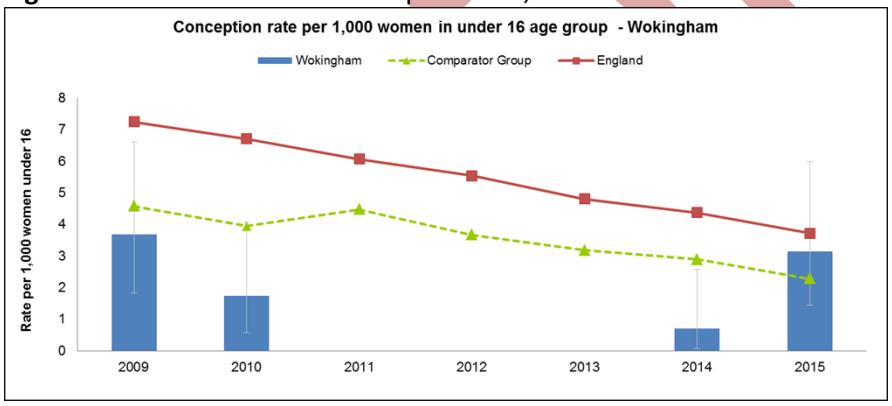
**Teenage parents**

**Figure 5:** Trend in under 18 conception rate, 2009-15



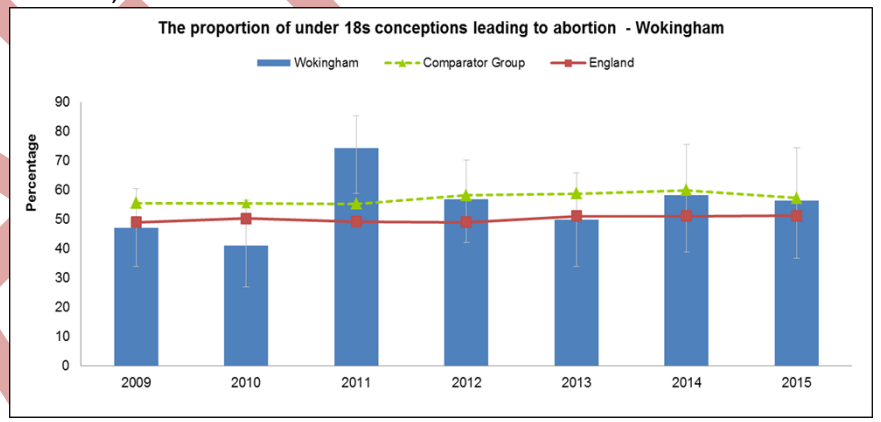

*Sources: Public Health England: Sexual and Reproductive Health Profiles*

**Figure 6:** Trend in under 16 conception rate, 2009-15




*Sources: Public Health England: Sexual and Reproductive Health Profiles*

**Figure 7:** Trend in the proportion of under 18 conceptions leading to abortion, 2009-15




*Sources: Public Health England: Sexual and Reproductive Health Profiles*

Note: Wokingham's Comparator group is LAs in the 'least deprived decile'. This group changed slightly following the update of the Index of Multiple Deprivation, so data for 2014 onwards reflects a different group of LAs to previous years.

## 3.2 Sexually-transmitted infections - Chlamydia (core data to be updated in August 2018)

Local information on chlamydia testing and diagnoses in 15 to 24 year olds is available through the National Chlamydia Screening Programme.

The annual reports provide a summary of the data captured through the Chlamydia Testing Activity Dataset (CTAD), which all Programmes are required to upload data to. The information shown below is from the NCSP annual report for 2015.

In 2015, the last year for which there is data available, 2,578 chlamydia tests were completed in Wokingham. This means that 15.6% of the population aged 15-24 were tested in the year. This is significantly "worse" than the national figure (which is xx%) and significantly worse than the comparator group (xx%). In 2013 only 13.1% of the population were screened.

The targets are based on a mathematical model. It is important to get every person at risk of infection tested as soon as possible after each new exposure, and this number is very difficult to quantify, so we use crude percentages of the population numbers. The true prevalence of the infection is unknown. To assess whether we are getting the "right people" tested, rather than lots of tests of low risk people, is to look at detection rate, i.e. the number of Chlamydia tests done in which Chlamydia bacteria are found (positive tests).

Wokingham residents (aged 15 to 24) had 177 positive chlamydia tests in 2014. This detection rate was 1,072 per 100,000 population (aged 15 to 24), compared to 1,985 (check this value) per 100,000 in 2013. Wokingham's detection rate for 2014 was significantly worse than the national figure and significantly worse than the comparator group. It did not meet the national ambition of 2,300 per 100,000 population.

6.9% of the chlamydia tests for Wokingham residents (aged 15 to 24) were positive in 2014. This compares with 8.4% nationally. In 2013, Wokingham's positivity rate was 7.5%.

In 2014, 60% of the chlamydia tests completed for Wokingham residents were in a GUM clinic.

*Source: Public Health England (2015); National chlamydia screening programme (NCSP) data tables*

**Figure 8:** Trend in chlamydia detection rate, 2012-15

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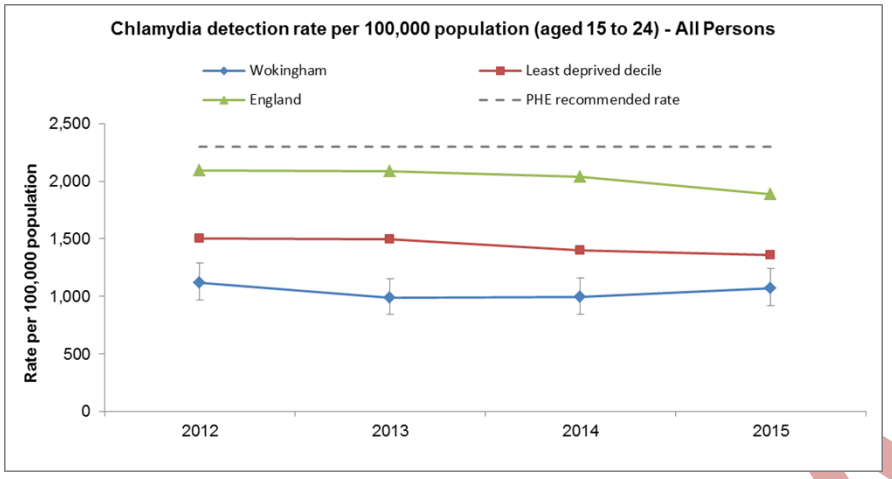


*Source: Public Health England; Sexual and Reproductive Health Profiles*

Note: Results are available online within 48 hours and young people receive a text or email indicating results are available. Young people who test positive can choose to access treatment at a local sexual health clinic or at a number of local community pharmacies. They are also given support to notify partners.

### Chlamydia self-testing

West Berkshire, Wokingham, and Windsor and Maidenhead commission an online self-testing chlamydia kit service as part of the 'Safe Sex Berkshire' campaign. The table below summarises the results of this programme in Wokingham in 2016/17 and 2017/18. In 2016/17 453 kits were ordered of which 278 were returned with 20 being diagnosed positive. The number of kits ordered in 2017/18 dropped to 330.

**Table 2:** Summary of chlamydia self-testing kits that were ordered online

| | BioScience Performance Data | | | Population | | | Assessment against Quarterly Target | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Ordered | Returned | Positive | Ordered tests | Returned tests | Positivity of returned tests | Ordered | Returned | Positive (10%) | Positive (8%) |
| 2016/17 | 453 | 278 | 20 | 2.7% | 1.7% | 7.2% | 68.5% | 60.1% | 43.2% | 54.0% |
| 2017/18 | 330 | 203 | 15 | 2.0% | 1.2% | 7.4% | 49.9% | 43.9% | 32.4% | 40.5% |

## 3.3 STIs

The table below shows rates of new STI diagnoses per 100,000 population by age group in Berkshire and England.

**Table 3:** Rates of new STI diagnoses per 100,000 population

| | Rates of diagnoses per 100,000 population | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Total | <15 | 15-19 | 20-24 | 25-34 | 35-44 | 45-64 | 65+ | Not Known | Total |
| Bracknell Forest | 0 | 1312.0 | 2947.4 | 730.2 | 271.6 | 117.4 | 36.9 | - | 394.2 |
| Reading | 128.6 | 3262.1 | 3631.3 | 1553.0 | 578.4 | 241.9 | 20.6 | - | 910.1 |
| Slough | 0 | 1462.2 | 2137.7 | 1141.5 | 431.9 | 175.3 | 21.6 | - | 492.0 |
| West Berkshire | 25.6 | 1709.3 | 3597.2 | 951.0 | 205.6 | 91.0 | 10.8 | - | 407.6 |
| Windsor and Maidenhead | 0 | 1105.4 | 2536.8 | 1069.6 | 327.0 | 135.9 | 3.7 | - | 369.0 |
| Wokingham | 51.0 | 1951.1 | 3214.4 | 988.4 | 336.9 | 93.7 | 18.1 | - | 422.7 |
| **England** | **61.6** | **2664.5** | **3719.5** | **1698.9** | **609.6** | **198.7** | **20.6** | **-** | **740.5** |

*Source: GUMCADv2, February 2018*

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# 5 Youth offending

There were approximately 16,000 10-17 year olds receiving their first reprimand, warning or conviction in England in 2016. This equates to a rate of 327.1 per 100,000 10-17 year olds, which is a decrease from 2015 where the rate was 368.6 per 100,000 10-17 year olds.

In England in 2014/15, there were approximately 36,000 children and young people aged 10 to 18 years supervised by a youth offending team (6.5 per 1,000 population). This rate has reduced year on year from 14.1 per 1,000 in 2010/11 to 7.0 per 1,000 in 2013/14 and now to 6.5 per 1,000 as the latest figure.

*PHE Public Health Profiles: Wider Determinants of Health*

The overall number of young people in the Youth Justice System (YJS) continued to reduce in the year ending March 2016. Reductions have been seen in the number cautioned or convicted for the first time (First Time Entrants, FTEs). There have also been reductions in the total number of young people receiving youth cautions and court convictions and in those receiving custodial sentences.

Compared with the year ending March 2006, there are now 83% fewer young people who were FTEs, 81% fewer young people who received a youth caution or court conviction1 and 66% fewer young people in the average custodial population.

Total numbers of reoffenders and re-offenses have also continued to fall (by 15% and 10%, respectively, compared to the previous year), while the 12 month reoffending rate for young people (March 2015 cohort) was 37.9% - stable compared to the previous year, although 4.3 percentage points higher compared to the year ending March 2006.

In the year ending March 2016 the police carried out a total of 896,200 arrests in England and Wales, of which 88,600 were of people aged 10-17 years, 10% of the total; this is the same as the proportion of young people in England and Wales in the general population that are of offending age (that is, those aged 10 years or older).

The number of arrests of young people has fallen by 7% compared with the year ending March 2015 and by 75% compared with the year ending March 2006. There have been year on year decreases since arrests peaked in the year ending March 2007.

In the year ending March 2016 there were 18,300 FTEs. This represents a fall of 12% in the last year and a fall of 83% since the year ending March 2006. Of the 18,300 FTEs in the year ending March 2016, 66% received a caution, with the remaining receiving convictions (predominantly resulting in community sentences). In the year ending March 2006, youth cautions accounted for 91% of FTE disposals.

There were 32,900 individual young people who received a youth caution or court conviction in England and Wales in the year ending March 2016, of which females accounted for 18% of these compared with 82% for males. This number has reduced by 13% from the year ending March 2015 and by 61% since the year ending March 2011.

Overall young people were convicted or cautioned for a total of 79,600 proven offences in the year ending March 2016. The number of proven offences has been decreasing; it has fallen by 9% from the year ending March 2015 and by 74% since the year ending March 2006. The most

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common offence types committed by young people were: violence against the person (26% of the total); theft and handling offences (14%); and criminal damage (12%).

MET statistics (common crimes, victims, offenders)

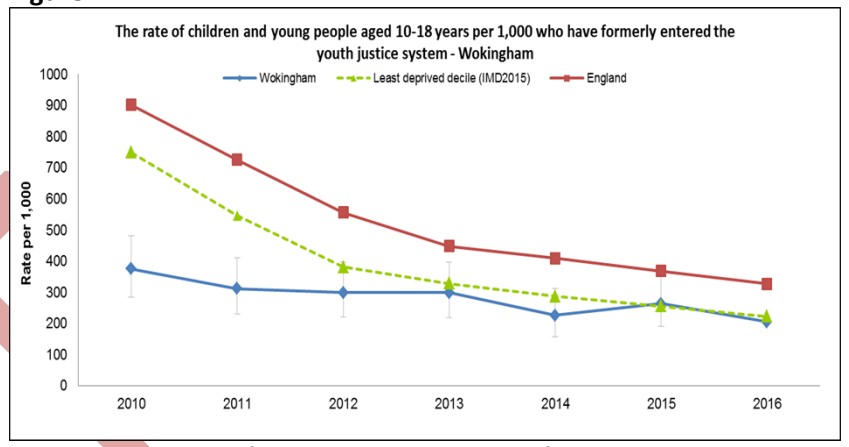
In 2016, there were 33 first time entrants into the Youth Justice System in Wokingham. This is a rate of 204.8 per 100,000 population of 10-17 year olds. This rate was significantly better than England's (327.1 per 100,000) and similar to the comparator group (223.2 per 100,000 aged 10-17 year olds).

The rate of children and young people aged 10-18 years per 1,000, who have formally entered the Youth Justice System in 2014/15 for Wokingham is 2.6, which equates to approximately 47 people. The LA rate is significantly better than England (6.5 per 1,000 children aged 10-18) and the least deprived decile (IMD 2015) with a rate of 4.3 per 1,000.

*Source: PHE Public Health Profiles: Wider Determinants of Health*

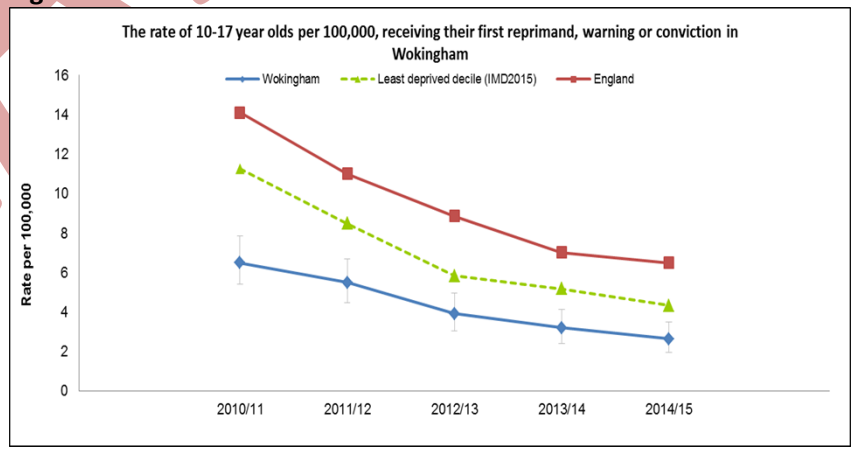
The top three offence types for the year ending March 2016, of proven offences by young people recorded by the youth offending team in Wokingham were for 'criminal damage' (24 offences), 'violence against the person' (21) and 'theft and handling stolen goods' (16 offences). The South East Region's top three are the same however a slight variance in order with 'violence against the person' being top (2,664 offences), 'theft and handling stolen goods' second (1,702) and 'criminal damage' third (1,321 offences). (*Source: Youth Justice Statistics -2015-2016 (Ministry of Justice)*

**Figure X:**




*PHE Public Health Profiles: Wider Determinants of Health*

**Figure X:**




*PHE Public Health Profiles: Wider Determinants of Health*

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# 6 Children in Care/Need and NEET

## 6.1 Children in Care

Viki's team to provide data and text

## 6.2 Children in Need

PHE data

## 6.3 NEET

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. The PHOF indicator 1.05 is included to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training and work.

In 2015 there were 74,120 16-18 year olds not in education, employment or training. This equates to 4.2% of the 16-18 year old population compared with the 2015 mid-year estimates. This is a significant decrease on the previous period of 2014 (4.7%) showing improvement for this Public health outcomes indicator.

*Source: Public Health Outcomes Framework*

The overall proportion of 16-18 year olds not in education, employment or training (NEET) fell by 0.5 percentage points in the last year (as at end 2016) to 6.0%, the lowest rate since consistent records began.

When comparing 2015 and 2016 data, the largest annual change was seen at age 18 where the NEET rate fell by 1.5 percentage points to 9.8%. The NEET rate also fell slightly at age 16, by 0.3 percentage points to 2.9%.

At age 17 the NEET rate increased slightly by 0.3 percentage points to 5.2%. The increase was driven by a large fall in the employment rate of those 17 year olds not in education and training (NET).

*Source: GOV.UK: Participation in education, training and employment: 2016*

The NEET Scorecard provides information about young people's participation and attainment in education, employment or training in one single publication. The latest publication from October 2016, shows there were 7.1% of 16-17 year olds NEET or whose activity was not known, as at the end of 2015. Of which, 2.7% were NEET and 4.4% of 16-17 year olds, their activity was unknown.

Between November 2015 and June 2016 in England, there were 7.9% of 16-17 year olds who were classified as NEET re-engaging in education, employment and training. This figure is a decrease from November 2014 to June 2015 which recorded this as 8.5%.

*Source: Young people NEET or activity unknown: comparative data scorecard - GOV.UK*

The law requires all young people in England to continue in education or training until at least their 18th birthday. Whilst the department for education provides the framework to increase participation and reduce

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the proportion of young people NEET, responsibility and accountability lies with local authorities.

The department monitors the performance of local authorities in delivering their duties, and specifically in their tracking and supporting of 16 and 17 year olds, using data collected by authorities and submitted to the National Client Caseload Information System (NCCIS). NCCIS includes data showing the numbers of young people participating in education or training, those who are not participating, those who are NEET or those whose current activity is not known.

*Source: Department for Education: Statutory guidance for participation of young people in EET*

In 2015, there were 1.9% of 16-18 year olds not in either employment, education or training in Wokingham. This is significantly better than England (4.2%) and the comparator group (3.0% Least deprived decile 2015).

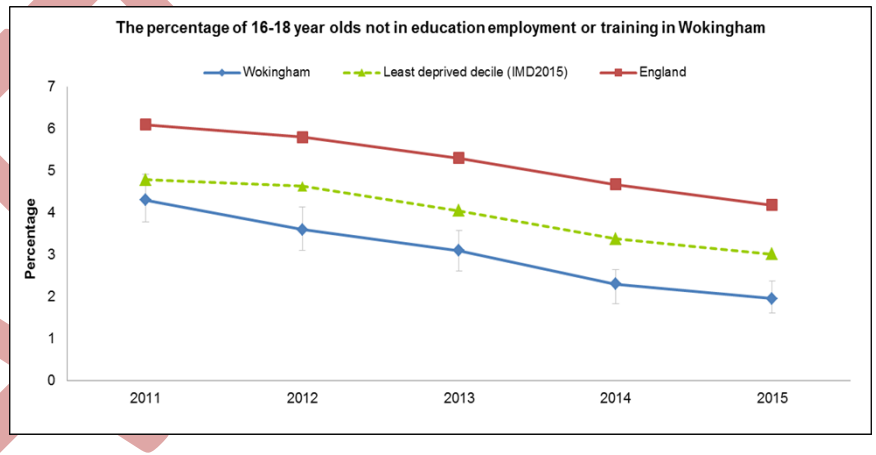
Wokingham's figures have decreased year on year since monitoring in 2011, with 2015's being the last recorded figure. Each year, Wokingham has been significantly better than England's percentages.

*Source: Public Health Outcomes Framework*

The NEET scorecard shows there were 3.7% of 16-17 year olds NEET or whose activity was unknown as at the end of 2015 for Wokingham. Of which, 1.3% were NEET and 2.4% whose activity was not known.

Between November 2015 and June 2016 Wokingham saw 12.7% of 16-17 year olds NEET re-engaging in education, employment or training. This is an increase from 11.7% recorded between November 2014 and June 201 5 for Wokingham.

**Figure X:**




*Source: Young people NEET or activity unknown: comparative data scorecard - GOV.UK*

*The estimated number of 16-18 year olds not in education, employment or training divided by the total number of 16-18 year olds known to the local authority whose activity is either not in education, employment or training (NEET), or in education, employment or training (EET)*

# 7 Disabilities and long-term conditions

## 7.1 Physical disability

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**Table X:** Estimated numbers of young people with a physical disability (PANSI, February 2018)

| Physical disability | 2017 | 2020 | 2025 | 2030 | 2035 |
|---|---|---|---|---|---|
| People aged 18-24 predicted to have a moderate physical disability | 418 | 402 | 410 | 463 | 467 |
| People aged 18-24 predicted to have a moderate personal care disability | 61 | 59 | 60 | 68 | 68 |
| People aged 18-24 predicted to have a serious personal care disability | 41 | 39 | 40 | 45 | 46 |
| People aged 18-24 predicted to have diabetes | 87 | 83 | 86 | 95 | 97 |
| People aged 18-24 predicted to have a serious visual impairment | 7 | 6 | 6 | 7 | 7 |
| People aged 18-24 predicted to have some hearing loss | 184 | 176 | 181 | 203 | 205 |

SEND monthly report – analysis and text to be provided by Viki's team.

## 7.2 Learning disability (add data from report that I did for Darrell)

GP registers, PANSI estimates

## 7.3 Diabetes

"There are about 31,500 children and young people with diabetes, under the age of 19, in the UK although this is likely to be an underestimation by about 10,000 as not all children over the age of 15 are managed in paediatric care."

The vast majority have Type 1 diabetes 95.1%; about 1. 9% have Type 2 diabetes and 2.7% have Maturity Onset Diabetes of the Young (MODY), cystic fibrosis related diabetes or their diagnosis is not defined.

Slightly more boys seem to have diabetes than girls: 52% boys and 48% girls, though girls are twice as likely to have Type 2 diabetes.

The current prevalence estimate of Type 1 diabetes in children and young people under the age of 15 in England & Wales is 187.7 per 100,000.

The incidence of Type 1 diabetes in children under the age of 15 is 22.8 per 100,000, and the peak age for diagnosis is between 9 and 14 years of age.

According to the National Paediatric Diabetes Audit in 2012, children of Asian origin were 8.9 times more likely to have Type 2 diabetes than their White counterparts and children of Black origin were 5.8 times more likely.

*(Diabetes UK, Facts and Stats, Oct 2016)*

## 7.4 Asthma

1.1 million children in the UK are currently receiving treatment for asthma, (1 in 11), and it is the most common long-term medical condition. On average there are three children with asthma in every

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classroom in the UK. The UK has among the highest prevalence rates of asthma symptoms in children worldwide.

A child is admitted to hospital every 20 minutes because of an asthma attack. Asthma prevalence is thought to have plateaued since the late 1990s, although the UK still has some of the highest rates in Europe and on average 3 people a day die from asthma.

In England, 4,500,000 people (1 in 11) are currently receiving treatment for asthma. This consists of 932,000 children and 3,600,000 adults. The NHS spends around 1 billion a year treating and caring for people with asthma.

(Asthma UK)

38,894 children aged 0-18 in England had emergency admission to hospital due to asthma, diabetes and epilepsy during 2015/16.

(HSCIC, indicator portal 2017)

## 7.5 Epilepsy

The total number of children aged 4 years and under with epilepsy is approximately 1 in 509. The prevalence of epilepsy in the UK in children aged under 16 years is estimated at 1 in 240 (Epilepsy Action)

The number of childr

en and young people aged 18 years and under with epilepsy is near 1 in 220. The numbers of young people who are 25 years and under with epilepsy is around 112,000. More than one in five people with epilepsy have learning or intellectual disabilities.

In the UK 1,150 people died of epilepsy related causes in 2009. In England and Wales 10% or 11% of those deaths were young adults or children under the age of 25.

(Young Epilepsy)

The rate of unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s in Wokingham in 2015/16 was 226.1 per 100,000 population. This was better than the England average of 311.7 per 100,000 population.

The CCG rate for unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s for Wokingham CCG in 2015/16 was 226.7 per 100,000 registered patients. This was better than the England average of 312.3.

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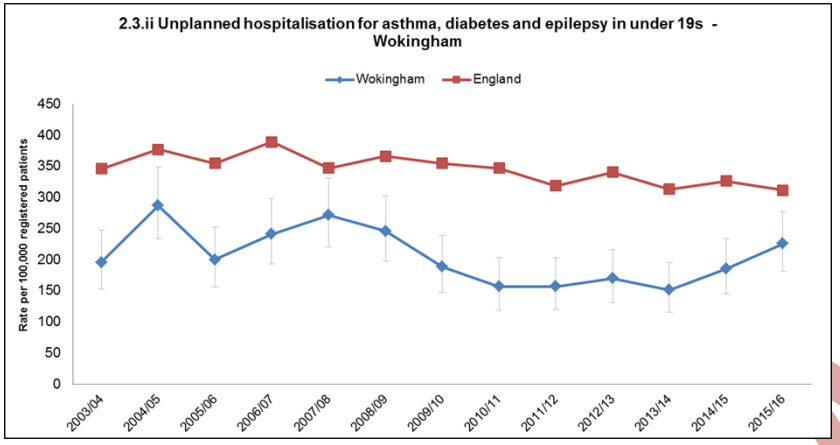
**Figure X:**




*Source: HSCIC indicator portal 2016*

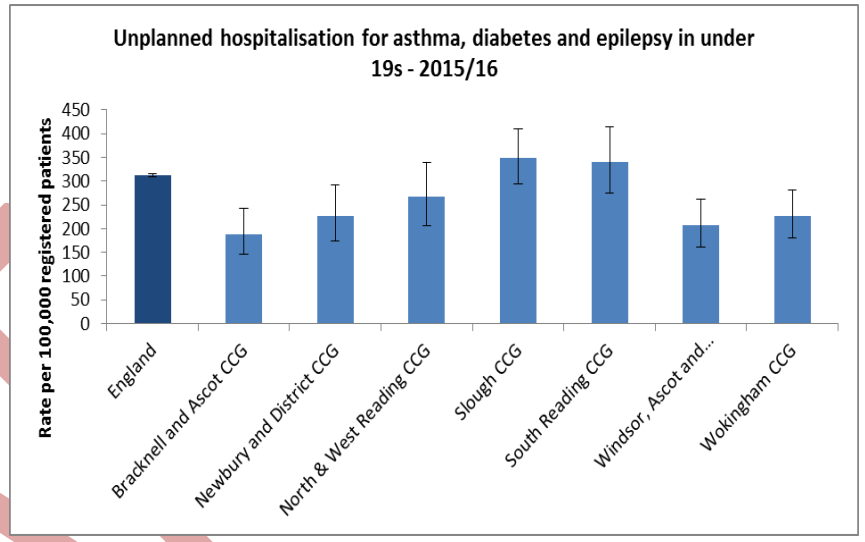
It is estimated that there are between 91 and 74 children under the age of 19 with diabetes living in Wokingham.

It is estimated that there are between 3025 children under the age of 19 with asthma living in Wokingham.

It is estimated that there are between 139 children under the age of 19 with epilepsy living in Wokingham. Estimates based on applying national prevalence estimates to local population (ONS 2015)

One of the NHS Outcome Framework Indicators measures potentially avoidable emergency hospital admission for asthma, diabetes, and epilepsy in under 19 year olds. During 2015/16, 84 children from Wokingham CCG were admitted for these conditions.

**Figure X:**




*Source: HSCIC indicator portal 2016*

# 8 Female genital mutilation (council team leading on FGM to update this section)

School census survey data (autumn 2017); Number of school girls who come from communities who speak: Somali Arabic (Sudan) Krio Afar - Saho Amharic Oromo Arabic (Yemen) Kurdish Edo / Bini Wolof Yoruba Efik - Ibibio Akan Twi - Fante Akan Twi Asante Akan Fante Swahili/Kiswahili Hausa Ebira Arabic (Iraq) Urdu Pashto / Pahkto

| | Grand Total |
|---|---|
| **School** | |
| **NURSERY AND PRIMARY SCHOOLS** | |
| The Ambleside Centre (Nursery) | * |
| Aldryngton Primary School | **11** |
| All Saints C.E. (Aided) Primary School | * |

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| | |
|---|---|
| Bearwood Primary School | * |
| Beechwood Primary School | **6** |
| Charvil Piggott Primary School | * |
| Floreat Montague Park Primary School | * |
| Hatch Ride Primary School | * |
| HAWKEDON PRIMARY SCHOOL | **12** |
| Highwood Primary School | **22** |
| Hillside Primary School | **8** |
| Keep Hatch Primary School | **6** |
| Loddon Primary School | **21** |
| Nine Mile Ride Primary School | * |
| Radstock Primary School | **14** |
| Rivermead Primary School | * |
| Robert Piggott CE Jnr School | * |
| Shinfield Infant & Nursery Sch | * |
| Shinfield St. Mary's CE (VA) Junior School | **8** |
| Sonning Church of England Primary School | * |
| South Lake Primary School | **12** |
| St Dominic Savio Catholic Schl | **14** |
| St Paul's C of E Junior School | * |
| ST PETER'S CE PRIMARY SCHOOL | **19** |
| St Sebastians CE Primary Sch | * |
| St Teresa's Catholic Academy, Wokingham | * |
| The Coombes C of E Primary | * |
| The Hawthorns Primary School | * |
| Walter Infant School | * |
| Westende Junior School | * |
| Whiteknights Primary School | **10** |
| Willow Bank Infant School | * |
| Windmill Primary School | * |
| WINNERSH PRIMARY SCHOOL | **15** |
| Woodley CE Primary School | * |
| **SECONDARY SCHOOLS** | |
| MAIDEN ERLEGH SCHOOL | **41** |
| ST CRISPIN'S SCHOOL | * |
| THE BULMERSHE SCHOOL | **31** |
| The Emmbrook School | * |
| The Holt School | **45** |
| The Piggott Senior School | **8** |
| Waingels College | **26** |
| **Grand Total** | **379** |

# 9 Safeguarding children

Safeguarding team to update this section

CDOP to add

In 2008, Child Death Overview Panels (CDOPs) were statutorily established in England under the aegis of Local Safeguarding Children Boards (LSCBs) with the responsibility of reviewing the deaths of all children (0 to <18 years) in their resident population. In Berkshire the CDOP is a subgroup of the six Unitary Authority Local Safeguarding Children Boards. It is made up of representatives from across the county from a range of organisations, including health, social care and police. The CDOP also has representation from those with experience of supporting families bereaved through a child's death. This is because experience and

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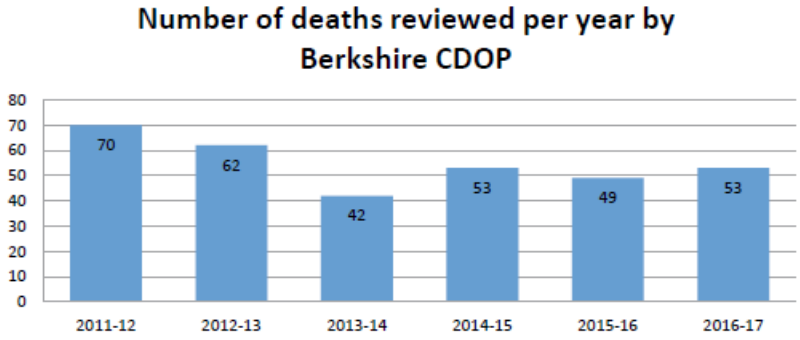
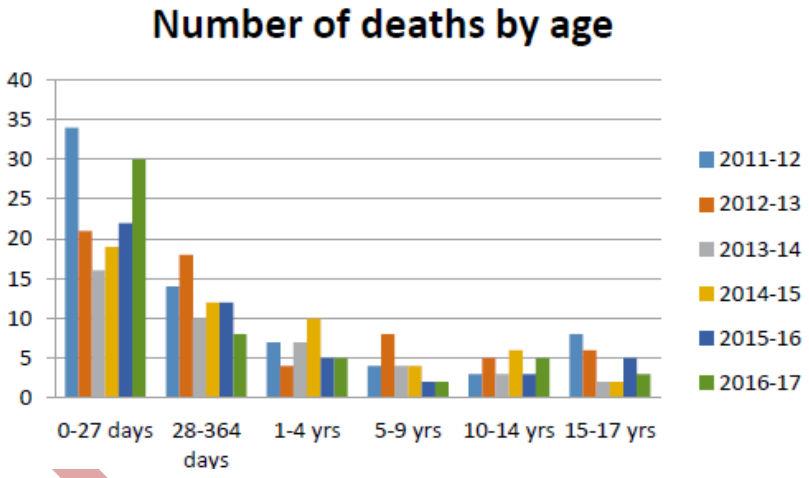
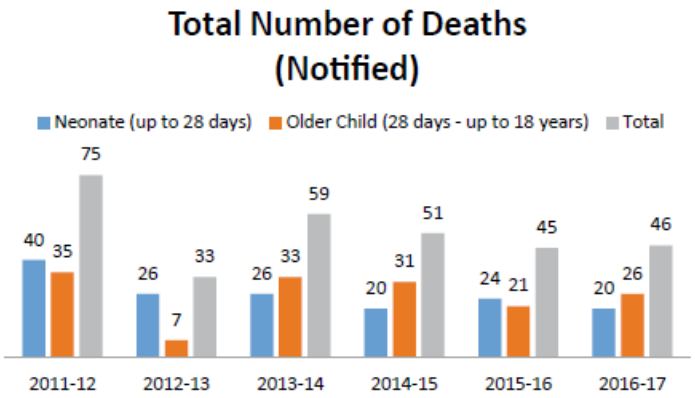
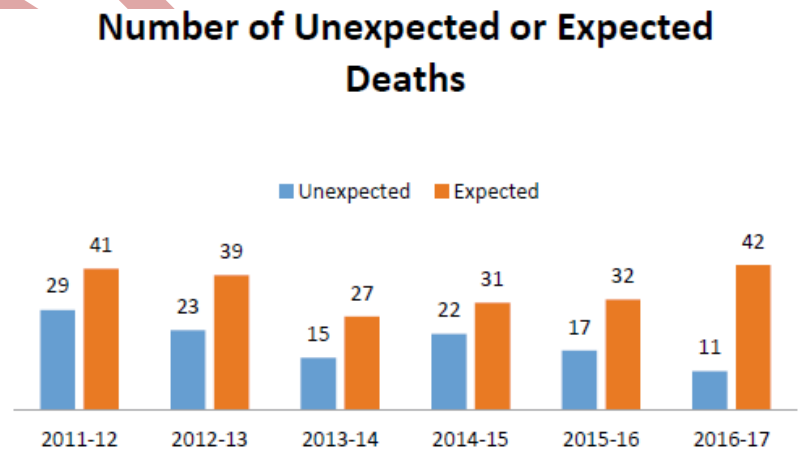
evidence tells us that what happens when a child is dying, or has died, can affect how families grieve and face life with this sorrow always present.

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# Living and Working Well 2017/18

Public Health Intelligence

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# 1. Key messages

- Total adult (18+) population by age group
- Nationally, there have been improvements for all measures of personal well-being for those aged 30 to 34, 40 to 59 and 65 to 69 years, since personal well-being started being measured in 2011.
- Conversely, at national level, the proportion of adults with poor mental health scores has increased since 2012, from 15% to 19%. This increase is particularly apparent among young men aged between 16 and 34, and young women aged between 16 and 24. Although the survey covers Wokingham, the number of people sampled is too small to allow local breakdown.
- So it appears that health and wellbeing are increasing for the middle-aged, but not for the younger adults.
- There are estimated to be 3,142 people with undiagnosed diabetes in Wokingham.
- Physical activity – large number inactive adults
-
- Weight and obesity – excess weight
- Smoking
- Alcohol
- Mental health prevalence
- Sexual health
- Chlamydia?
- HIV
- Diabetes
- Cancer
- Respiratory disease
- Cardiovascular disease
- Chronic kidney disease
- Liver disease
- Long term neurological conditions
- Physical and sensory impairment
- Preventable sight loss
- Antimicrobial resistance
- Cancer screening
- Non cancer screening
- Communicable diseases

# 2. Introduction

This chapter looks at the health and wellbeing and health and care needs of the working age population in Wokingham borough.

Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. Current estimates are that about half of the health status of a population is due to the social and economic environment, about 15% from our genes, 25% from the health care system and 10% form the physical environment. The 2018 Annual Report from the Director of Public Health focuses on the impact of the physical environment, and particularly the effect of green space on the people of Wokingham.

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The Borough Profile covers education, employment, deprivation and housing. This chapter covers issues the affect general wellbeing and mental health, numbers of people with mental health conditions, then moves on through lifestyle factors: weight, physical activity, alcohol, smoking and then moves on to specific conditions. Groups within the population such as carers, people of certain ethnicities, with learning disabilities and so on are discussed in the final Chapter – People and Places.

Diseases: sexually transmitted infections, diabetes, cancer, respiratory disease, cardiovascular disease, chronic kidney disease, liver disease, long-term neurological conditions, preventable sight loss, physical and sensory impairment.


*Source: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?*

## 2.1 General health and wellbeing

Health is not just about the presence of disease or illness (be that physical or mental), but also about how well people are. As a nation we are living longer than ever before. The nature of health has changed dramatically over the last 150 years, so much so that we now often take for granted the dramatic gains made to society from improved public health.

Mental health and wellbeing are critical dimensions of health. We know that mental ill health is responsible for a high proportion of the overall burden of ill health and prevalence has been rising.

Wellbeing is a key issue for the Government, but very difficult to measure. To address this the Office for National Statistics is leading a programme of work to develop new measures of national wellbeing. People with higher wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

*Source: Department of Health: Our Health and Wellbeing Today (Nov.2010)*

The Health Survey for England 2016 examines the prevalence of well-being and mental ill- health, using the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) and the 12-item General Health Questionnaire (GHQ-12). It compares wellbeing and mental ill health in different population groups by age, sex, region, household income and area deprivation as well as lifestyle factors, Body Mass Index (BMI) and physical activity.

WEMWBS is scored on a range from 14 to 70; average wellbeing scores for both men and women in England in 2016 were 50. This is a decline from 2015 when the scores for both sexes were 52.

Men and women living in more deprived areas had lower well-being scores, on average, than those living in less deprived areas, although magnitude of the difference was not very large. Those living in the most deprived areas had average wellbeing scores of 49 for men and 47 for women, compared with 52 and 51 respectively among those living in the least deprived areas.

The GHQ-12 is scored on a range from 0 to 12, with a score of 4 or more indicative of probable mental ill health. Women were more likely than men to report a GHQ-12 score of 4 or more (21% of women and 16% of men).

The proportion of adults with high GHQ-12 scores has increased since 2012, from 15% to 19%. This increase is particularly apparent among young men aged between 16 and 34, and young women aged between 16 and 24.

*Source: NHS Digital: Health Survey for England (2016)*

In the year ending September 2017, there continued to be slight improvements in the UK for average ratings of life satisfaction, feeling that the things done in life are worthwhile and happiness; but there was no overall change in reported anxiety levels.

In the year ending September 2017, women reported higher life satisfaction, worthwhile and happiness ratings compared with men but also reported higher levels of anxiety.

There have been improvements for all measures of personal well-being for those aged 30 to 34, 40 to 59 and 65 to 69 years, since personal well-being started being measured in 2011.

*Source: Office for National Statistics: Personal well-being in the UK (October 2016 to September 2017)*

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The Office for National Statistics (ONS) measure personal well-being based on four questions included on the Integrated Household Survey. Responses are given on a scale of 0-10.

In 2016/17, 4.5% of people in England, and 3.9% of people in the South East Region responded with a low satisfaction score. This is a score between 0 and 4. The percentage for Wokingham is unknown due the number of cases being too small to calculate. In 2014/15 this score was recorded as 3.0%, which is the latest data recorded, and is highly unlikely to have changed within one year

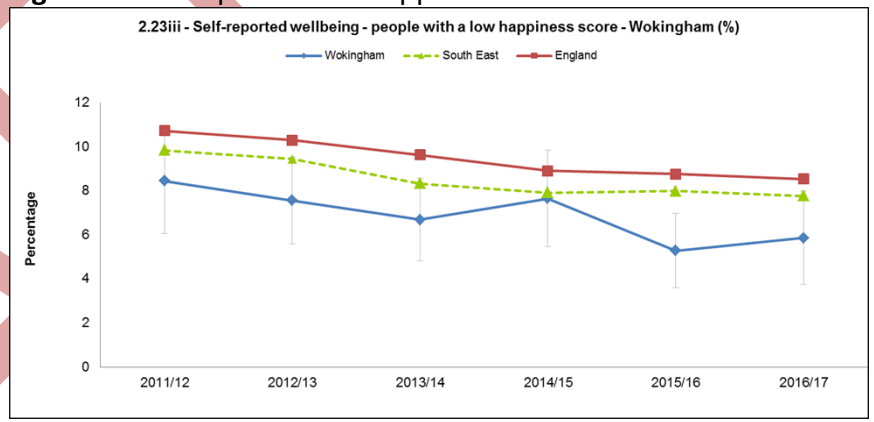
**Figure X:** Self-reported low satisfaction


*Source: Public Health Outcomes Framework*

Happiness: the survey asked "Overall, how happy did you feel yesterday? (0 is 'not at all happy; 10 is 'completely happy').

The level of respondents report a low happiness score (0-4) has gradually decreased since 2011/12 from over 8% to about 6% in 2016/17. The same trend has happened nationally, but at a consistently higher level.

**Figure X:** Self-reported low happiness




*Source: Public Health Outcomes Framework*

Anxiety: the survey asked "Overall, how anxious did you feel yesterday? (0 is 'not at all anxious'; 10 is 'completely anxious').

The self-reported wellbeing for people with a high anxiety score (respondents scoring 6-10 to the above question) in Wokingham was 19.3%. Again, since 2011/12 this has been statistically consistent. The lowest percentage for the LA was 16.4% recorded in 2014/15 and the highest was 21.0% in 2012/13.

Comparing the anxiety scores to England and the South East, Wokingham has stayed similar to both year on year. The 2016/17 figures for England and the South East were 20%.

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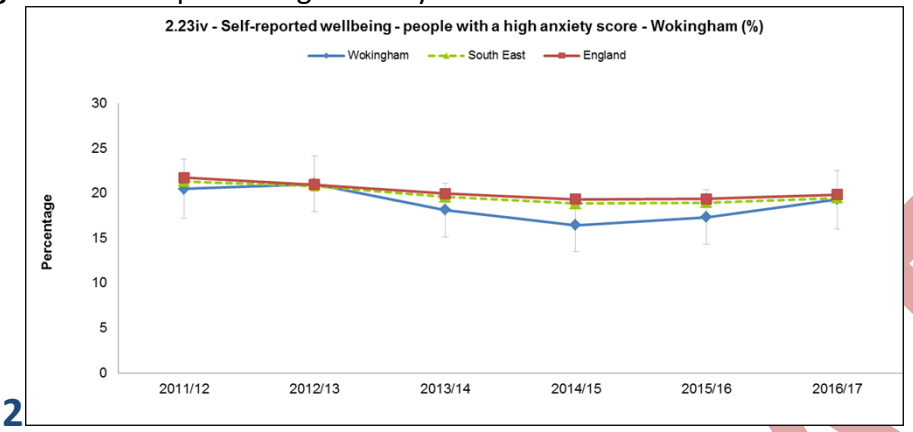
**Figure X:** Self-reported high anxiety




## 2.2

**Source: Public Health Outcomes Framework**

## 2.3 Mental health (data being updated from shared services May 2018)

Mental health is not just the absence of a mental disorder. It is defined as a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make their contribution to society. – World Health Organisation definition.

Good mental health and resilience can be developed by certain key factors. These have been helpfully expressed as the 5 ways to wellbeing:

1. Get active
2. Keep learning
3. Take notice
4. Give
5. Connect

There is a good explanation of these on the MIND website: https://www.mind.org.uk/workplace/mental-health-at-work/taking-care-of-yourself/five-ways-to-wellbeing/

We present intelligence on each of these 5 ways below.

1. Get active

Physical activity (data update from Shared services April 2018)

Sports England data

Local Sport and Leisure Team data to be brought in here

Travel to work patterns (active travel)

2. Keep Learning

Any Data on adult learning?

3. Take notice

Is there any intelligence we could add here?

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4. Give

Volunteering – data from Involve?

5. Connect

Anything on number of clubs, etc??

The 2018 DPH report, cited previously, gives the evidence base for how green space is beneficial for mental health. People who live in greener areas are more likely to report good mental health and wellbeing. Exposure to the natural environment can reduce stress, anxiety, blood pressure and anger.

Certain stressors lead to poor wellbeing and mental health. These would include home circumstances such as living with someone who makes demands (however unwittingly) for instance:

- a person requiring an amount of care over and above average family demands, whether adult or child
- a person with an addiction, be it substances or, for instance, gambling
- a person with mental health problems
- an abusive person

Social circumstances

- social isolation
- being poor (insufficient income to meet expected living standards
- living in what you consider to be a poor environment

Life events, for instance:

- bereavement
- relationship breakdown
- loss of employment

and events which may be positive, but stressful:

- moving home
- leaving home
- starting a new job or course

Need to quantify as many of the stressors above as possible in Wokingham

Carers

9% of the population are carers, including 1.5% of the population who provide over 50 hours of unpaid care per week (source CCG Locality Profile) – probably means adult carer as registered with GP, but need to check.

There are xxx children with special needs creating xxx families with the demands that puts on parents (and other children)

DRAFT

Domestic violence is estimated to effect xxxx adults and xxxx children

About 26% of people over 65 live on their own (source CCG Locality Profile)

Xxxx households are classified as low income, 6% of children live in low income families, xx% are classified as fuel poor. Xxxx claim benefits.

The food bank in Wokingham reports that it sees about xx people per week ( are there other Food Banks – we need contacts)

*Mental health profiles (PHE)*



**Figure X:**

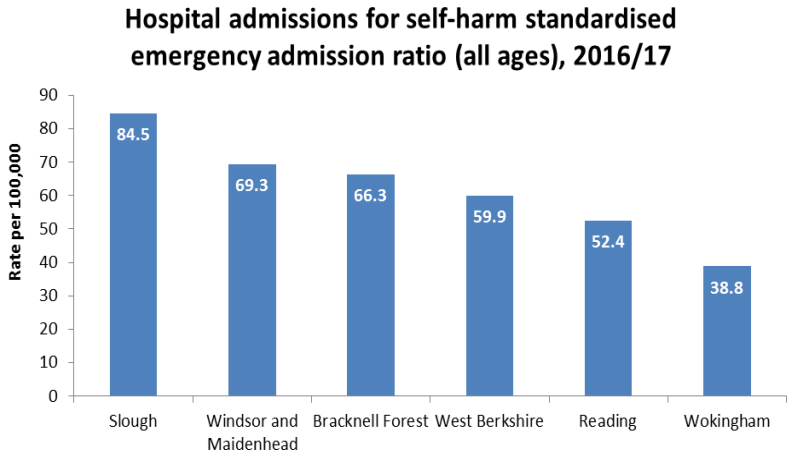
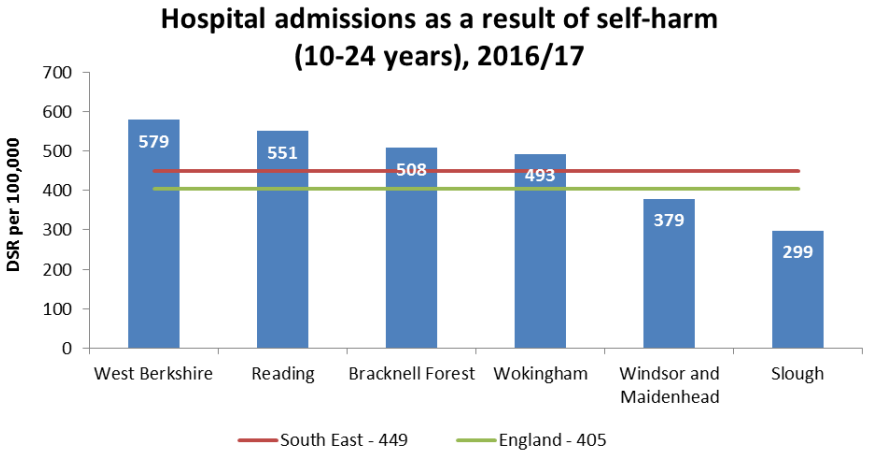



**Figure X:**




Mental health hospital admissions – Wokingham CCG – PHE Profiles

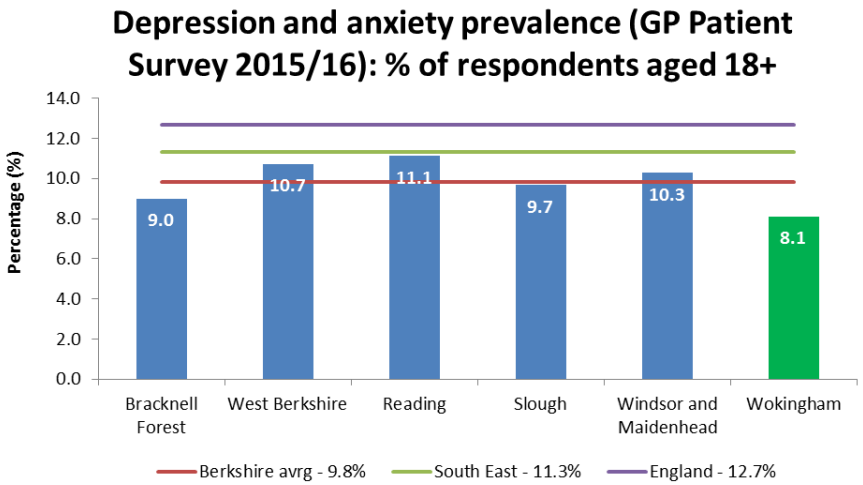
### 2.3.1 Depression and anxiety

Depression and anxiety are common conditions. Definitions vary, and severity varies, from a person feeling depressed or anxious at times but still able to carry out normal activities to severe incapacity. We can estimate prevalence in a number of ways. One is to simply ask people and there is a GP Patient Survey where a sample of patients are asked "What is the state of your health today?" those who answered "moderately anxious or depressed" are considered to be so. The results from this survey are shown in Fig X . About 8% of adults feel depressed or anxious in Wokingham, the national average is over 12%, so clearly there are positive factors going on locally to protect against depression and anxiety,

likely to be relative affluence, high levels of employment, high levels of green space and low crime rate

Adult Psychiatric Morbidity Survey, 2014
http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf

**Figure X:** Prevalence of depression and anxiety




*Source: Mental Health and Wellbeing JSNA (https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna)*

### 2.3.2 Severe mental health disorders

QoF prevalence

The percentage of patients aged 18 years and over with schizophrenia, bipolar affective disorder and other psychoses.

There are 892 persons in Wokingham who are on a GP Practice mental health register. This is equivalent of 0.55% prevalence. However, prevalence varies among GP Practices. Burma Hill Practice has the highest mental health prevalence with 0.81% and Wilderness Practice the lowest with 0.23%. The figure below illustrates mental health prevalence by GP Practice compared with Wokingham CCG, the Berkshire CCG average, the South East and England. There is a nearly 4-fold difference, and likely does not reflect a true variation in the prevalence of mental illness, but rather variation in practice, and the GP's propensity to diagnose and record mental illness on a patient's notes. There is still stigma attached to mental illness and a GP may discuss the issue with the patient and come to a joint decision not to register the diagnosis. Alternatively the practice may not recognise mental illness, A significant proportion of people that have depression are not diagnosed (1)

**Figure X:** Registered mental health prevalence by GP Practice

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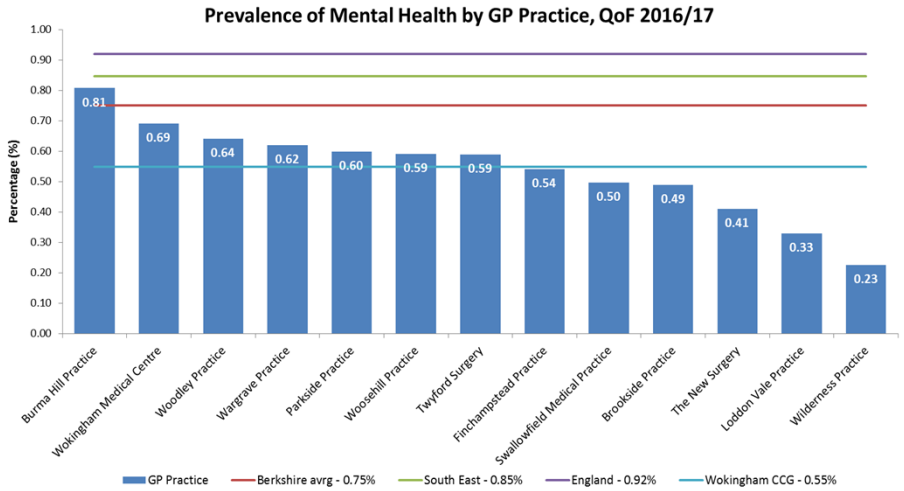


*Source: [http://digital.nhs.uk/catalogue/PUB30124](http://digital.nhs.uk/catalogue/PUB30124)*

**Table X:** Number of patients with a mental health problem by GP Practice, QoF 2016/17

| Practice name | List size (18+) |
|---|---|
| Burma Hill Practice | 1,927 |
| Wokingham Medical Centre | 18,526 |
| Woodley Practice | 9,074 |
| Wargrave Practice | 5,597 |
| Parkside Practice | 10,919 |
| Woosehill Practice | 9,227 |
| Twyford Surgery | 9,691 |
| Finchampstead Practice | 11,880 |
| Swallowfield Medical Practice | 9,008 |
| Brookside Practice | 20,590 |
| The New Surgery | 5,525 |
| Loddon Vale Practice | 12,388 |
| Wilderness Practice | 1,822 |
| **Total** | **126,174** |

# 3. Healthy lifestyle

## Physical activity

a lot to add here

## 3.1 Weight and obese adults

[httsW//www.helpguide.org/harvard/how-excess-weight-affects-your-health.htm](www.helpguide.org/harvard/how-excess-weight-affects-your-health.htm)

Adult obesity and Diet (shared services April 2018)

Weight management strategy data

Healthy weight…

We are living in what has been termed an “obesogenic environment”, i.e. the way we are living makes us fat. This is complex and multifactorial, but involves:

- Availability (relatively low cost) of high sugar, high fat foods
- Natural response to sweet and high calorie food (tastes good), and natural inclination to not waste calories by moving around when we don’t have to
- More sedentary lifestyle meaning we don’t use up calories at a sufficient rate

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- Promotion (advertising) of food, including unhealthy foods
- Cultural traditions of giving and receiving food unrelated to our biological need for it
- Food as entertainment
- Processing of foodstuffs (huge area in itself)
- Agriculture
-

Adult obesity rates are rising and driving an increased risk of chronic disease.

Obesity presents a major threat to health. It is associated with an increased risk of diseases including diabetes, heart disease, osteoarthritis and cancer. Estimates suggest that being overweight (BMI 25 to less than 30) reduces life expectancy by about three years, and being obese (BMI 30 or more) can reduce life expectancy by 10 years *(Source: Health Survey for England 2010 ).*

The table below indicates the extent to which obesity increases the risks of developing a number of diseases relative to the non-obese population. The relative risks are based on a comprehensive review of international literature that was carried out by the National Audit Office, to provide the best estimates that could be applied to the English population *(Source: Tackling obesity in England. Report by the comptroller and auditor general HC220 Session 2000- 2001: 15 Feb 2001 ).*

*Insert table here*

What data is available to monitor adult obesity?

We don't have comprehensive local data on adult weight in the way we do for children. The Household Survey for England has been measuring weights for many years, but this is a national survey, and therefore has very few respondents from Wokingham. From this source we know that the majority of the population carry excess weight (i.e. are overweight or obese. 2015 – local authority estimates.

GP Practices register people as obese when they are weighed – but these data are known to be very incomplete.

The prevalence of adult obesity as recorded by the GP Practice registers in Wokingham borough is currently 6.6%, which is lower than the average in of 7.4% in Berkshire and lower than the south east region and England. However, the prevalence of adult obesity varies greatly among practices and this can be seen of figure X. Woosehill practice has a higher prevalence (8.4%) of adult obesity than the South East and the Berkshire prevalence.

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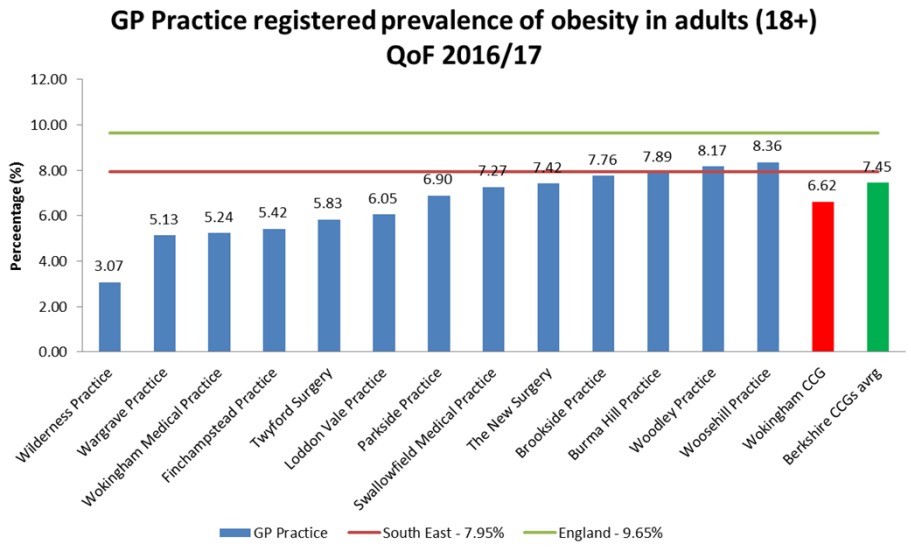



Source: QoF 2016/17

Prevalence of overweight and obese adults (LSOA or ward?)

<u>Hospital admissions for obesity</u>

Finished Admission Episodes with a primary diagnosis of obesity, by region and Local Authority of residence, and gender

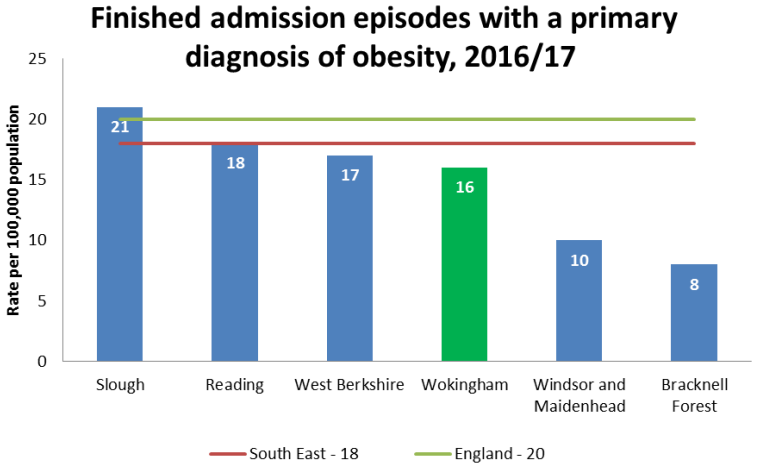
A finished admission episode (FAE) is the first period of inpatient care under one consultant within one healthcare provider. FAEs are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

The primary diagnosis is the first of up to 20 (14 in 2006-07) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was admitted to hospital.

This is the tip of the iceberg – very few people are admitted to hospital with obesity as the primary diagnosis, but obesity is a major contributor to many other conditions.

ICD-10 Codes: E66 - Obesity.

**Figure X:** Hospital admissions with a primary diagnosis of obesity




*Source: NHS Digital (http://digital.nhs.uk/pubs/sopad18)*

**Figure X:** Hospital admissions with a primary or secondary diagnosis of obesity

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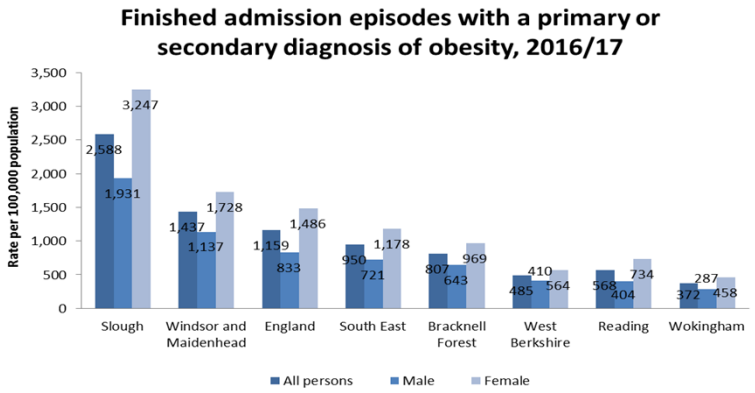
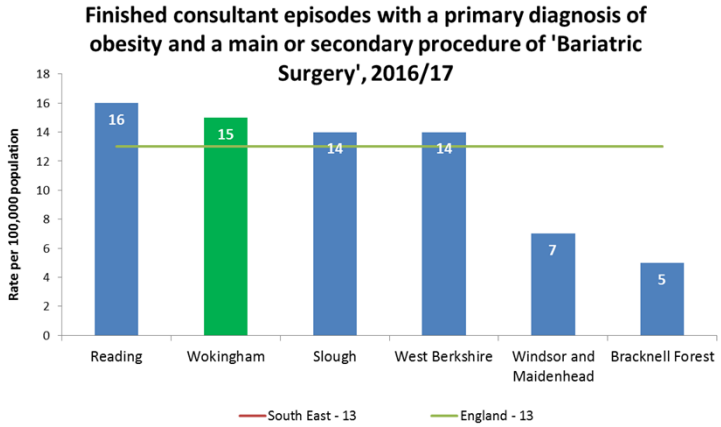



*Source: NHS Digital (http://digital.nhs.uk/pubs/sopad18)*

**Figure X:** Hospital admissions with a primary diagnosis of obesity and a main or secondary procedure of 'Bariatric surgery'




*Source: NHS Digital (http://digital.nhs.uk/pubs/sopad18)*

Obesity is very strongly related to diabetes, both at population and at personal level.

Losing weight and being more physically active can reduce the risk of developing diabetes, and even reverse "pre-diabetes" – people whose blood sugar levels are higher than the normal range. This is the rationale for the introduction of the National Diabetes Prevention Programme.

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## 3.2 Diabetes

On 31st March 2017, the recorded prevalence of diabetes for people aged 17 and over was 6.9% in England, which is over 3 million people.

*Source: NHS Digital (2016); Quality and Outcomes Framework 2016/17: Report for England.*

Public Health England estimate that the actual prevalence of diabetes in England was 8.7% in 2017, which means that there are a significant number of people who haven't been diagnosed with the condition. This is expected to increase to 9.5% by 2030.

*Source: Public Health England (2015); Diabetes prevalence model for local authorities.*

Wokingham CCG Comparator Group England

Number of people on the register in Wokingham CCG

| | | | | | |
|---|---|---|---|---|---|
| Diabetes | 4.8% | 5.7% | 6.9% | 6,208 | x |

*Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England*

The estimated prevalence of diabetes for people aged 17 and over in Wokingham CCG was 7.3%, which means that there were 3,142 people missing from Wokingham GP Registers in 2017.

The estimated number of people in Wokingham aged 16 and over with diabetes was 9,594 in 2017. This is 7.4% of the total population. The number of people with diabetes is estimated to rise to 12,328 people by 2039, which would be 8.5% of the projected population.

Nearly 3% of disability adjusted-life years (DALYs) in England are caused by diabetes, which is the 11th leading cause. DALYs are the number of healthy life years lost due to premature death combined with the number of years living in ill health, and are used to measure the total burden of a disease globally and nationally.

Key risk factors for diabetes in England include high body-mass index, high waist circumference, diet and low physical activity. There is a genetic component to propensity to diabetes. Diabetes is more commonly found in certain ethnic groups, e.g. Afro-Caribbeans and the risk of diabetes increases in people of Indian, Pakistani and Bangladeshi heritage when their BMI is only 23.5, compared to 27.5 in British whites.

*Source: Global Burden of Disease (2015); GBD Compare Data Hub*

Wokingham CCG Comparator Group England

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| | | | | | |
|---|---|---|---|---|---|
| Number of people on the register in Wokingham CCG | | | | | |
| Diabetes | 4.8% | 5.7% | 6.9% | 6,208 | x |

*Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England*

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*Source: Public Health England (2017); Diabetes prevalence model for local authorities*

Care of people with diabetes

All people with diabetes aged 12 years and over should annually receive nine NICE recommended care processes and attend a structured education program when diagnosed. These include tests for glucose control, cholesterol, blood pressure and kidney function, as well as measurement of body mass index, foot examination and smoking history. The NHS Diabetes Eye Screening Programme provides the ninth care process and is required to complete a digital retinal screening annually to check for eye risk.

The National Diabetes Audit (NDA) measures the effectiveness of diabetes care against the NICE Clinical Guidelines and Quality Standards. The NDA found that in 2016/17, only 34% of people with Type 1 Diabetes and 48% of people with Type 2 diabetes received all 8 of NICE recommended care processes. This was the lowest level in the previous 5 years for both diabetes groups. Urine albumin and foot surveillance were the most missed care processes.

In 2016/17, 49% of people with type 1 diabetes in Wokingham CCG and 66% of people with type 2 diabetes received all 8 NICE recommended care processes in the year. These were both higher proportions than England'

In 2016/17, 22% of people with type 1 diabetes in Wokingham CCG and 42% of people with type 2 diabetes met all three treatment targets for glucose control, blood pressure and serum cholesterol. These were both similar to England's figures of 19.0% and 41.1% respectively.

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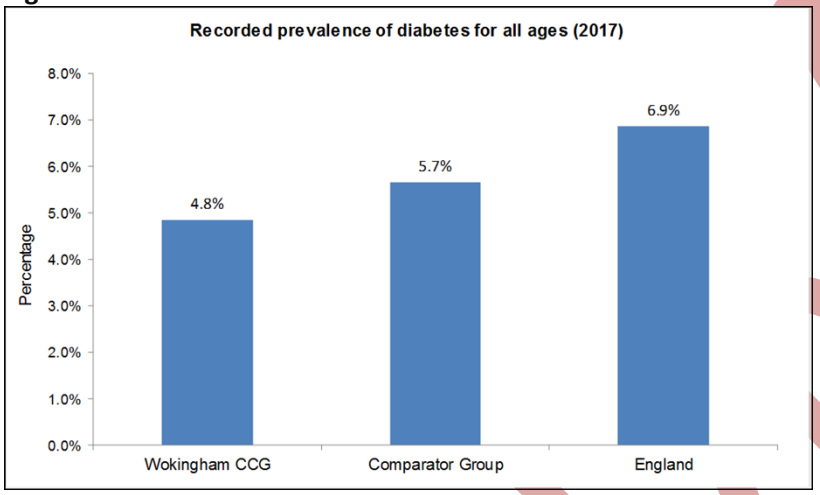
In 2015, 390 people were newly diagnosed with diabetes in Wokingham CCG and 82% of these were referred to structured education. Nationally, 76% of newly diagnosed people were referred.

NHS Digital (2017); National Diabetes Audit Report 1: Care Processes and Treatment Targets 2016/17
Estimated vs QoF prevalence.

**Figure X:**




*Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17*

Hospital admissions for diabetes

**Prevalence estimates of diabetes by clinical commissioning group (CCG) and England**

The data below gives the estimated number of people age 16 years or older who have diabetes (diagnosed and undiagnosed) by clinical commissioning group (CCG). The data relating to diabetes prevalence has been taken from the latest Health Surveys for England. Population data are based on the number of patients registered at a GP practice in April 2015. The year-on-year change in population by age, sex and CCG produced by the ONS was applied to the GP practice populations to produce population projections until the year 2035. The data has been adjusted for age, sex, ethnic group and deprivation. For further details of the methodology used to produce these estimates please refer to the technical document on the NCVIN website www.ncvin.org.uk

| | | | |
|---|---|---|---|
| South East | E12000008 | 684,830 | 8.2% |
| NHS Wokingham CCG | E38000209 | 9,529 | 7.3% |
| England | E92000001 | 4,089,864 | 8.6% |

https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations

*ource: http://digital.nhs.uk/catalogue/PUB30124*

### 3.2.1 Mental health services (Shared services April 2018)

IAPT

Hospital data (not very good)

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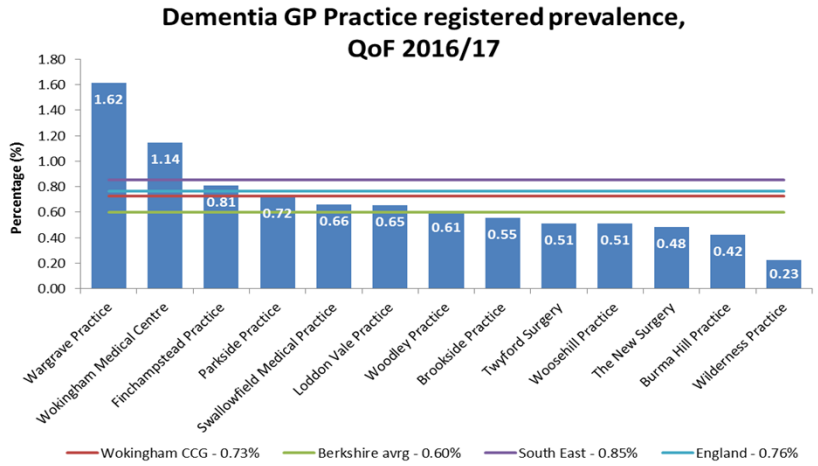
Mental health dual diagnosis – Shared services TBC

LTC/Neurological conditions - Shared services TBC

### 3.2.2 Dementia

**Figure X:** Dementia prevalence by GP Practice




## 3.3 more indicative of probable mental ill health. Women were more likely than men to report a GHQ-12 score of 4 or more (21% of women and 16% of men).

Alcohol and smoking – Shared Services May/July 2018)

## 3.4 Sexual health and HIV

Add GUMCad data and data from PHE sexual health profile

# 4. Health protection

## 4.1 Antimicrobial Resistance

## 4.2 Cancer screening

## 4.3 Non cancer screening

## 4.4 Communicable diseases (Shared services TBC)

TB – Shared services April 2018

# 5. Health conditions

## 5.1 Cancer

Cancer is the leading cause of disability adjusted-life years (DALYs) in England at 18.8%. DALYs are the number of healthy life years lost due to premature death and years living in ill health. Lung cancer has the biggest impact (3.9% of all DALYs), followed by breast cancer (2.0%) and colorectal cancer (1.9%).

The main risks attributed to cancer deaths and DALYs in England are tobacco smoke, occupational risks, diet, high body mass index and alcohol and drug use. (*Source: Global Burden of Disease (2015); GBD Compare Data Hub*)

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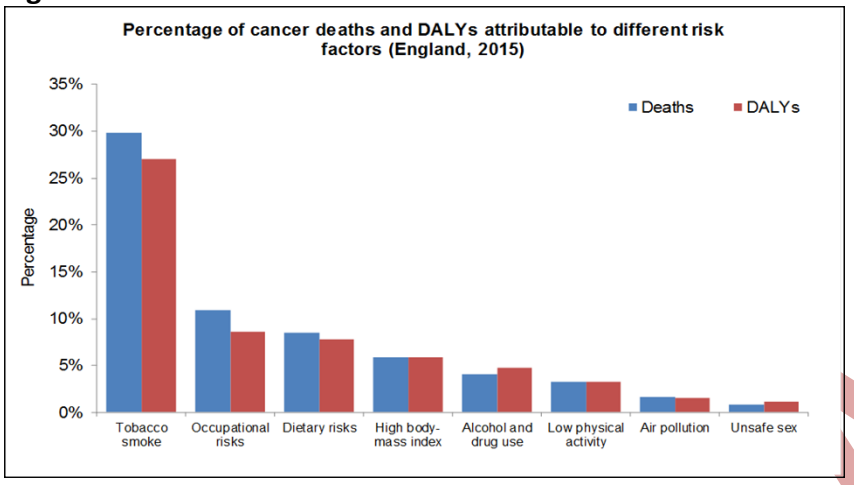
**Figure X:**




*Source: Global Burden of Disease, 2015*



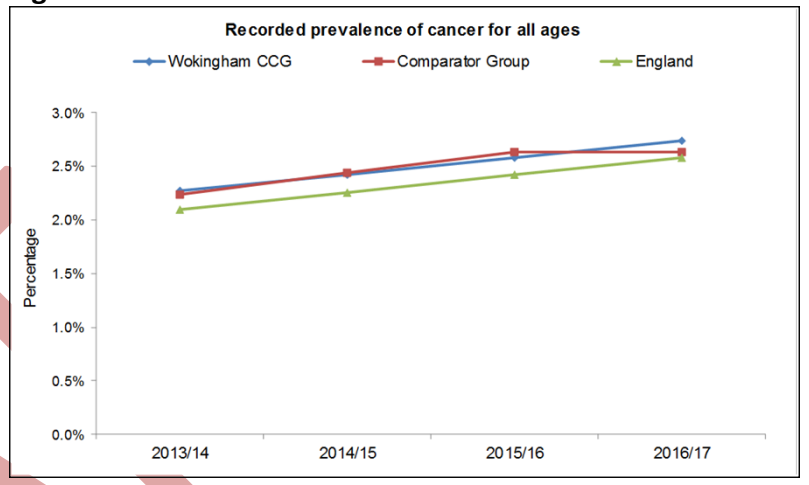
The GP Practice recorded prevalence of cancer in Wokingham has increased from 2.6% in 2015/16 to 2.7% in 2016/17. In terms of numbers this increase accounted to 309 additional patients on the register.

On 31st March 2017, the recorded prevalence of cancer was:

| Wokingham CCG | Comparator Group | England | Number of people on the register in Wokingham CCG |
|---|---|---|---|
| 2.7% | 2.9% | 2.6% | 4,445 |

*Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England*

**Figure X:**




*Source: Public Health England (2017); Public Health Outcomes Framework*

Figure X shows recorded cancer prevalence by GP Practice.

**GP Practice recorded cancer prevalence in 2016/17**

**Figure X:** Cancer prevalence by GP Practice

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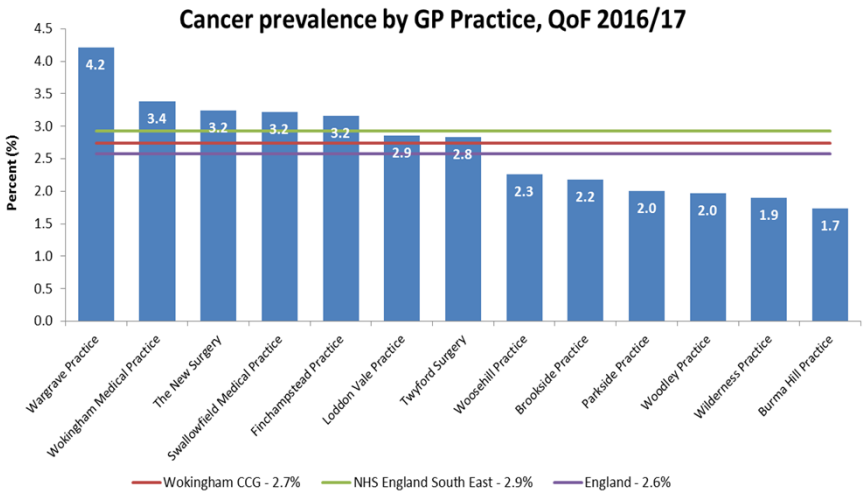
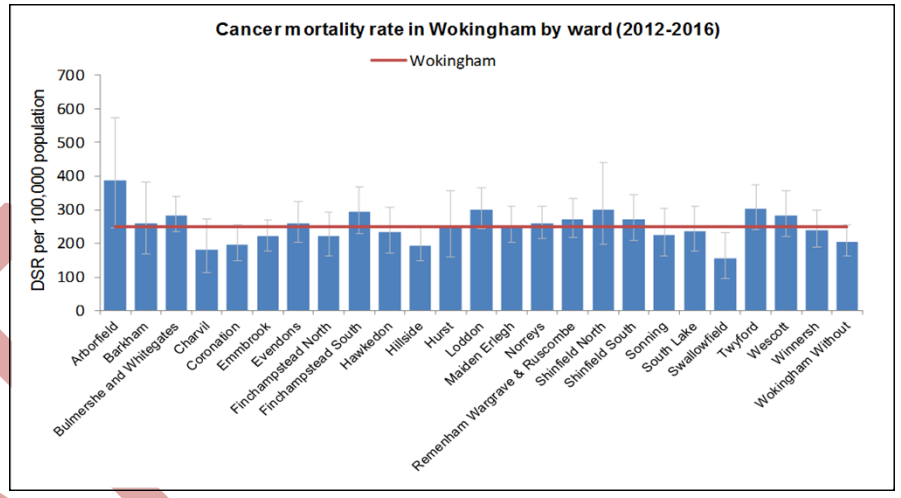



*Source: QoF 2016/17 (http://digital.nhs.uk/catalogue/PUB30124)*

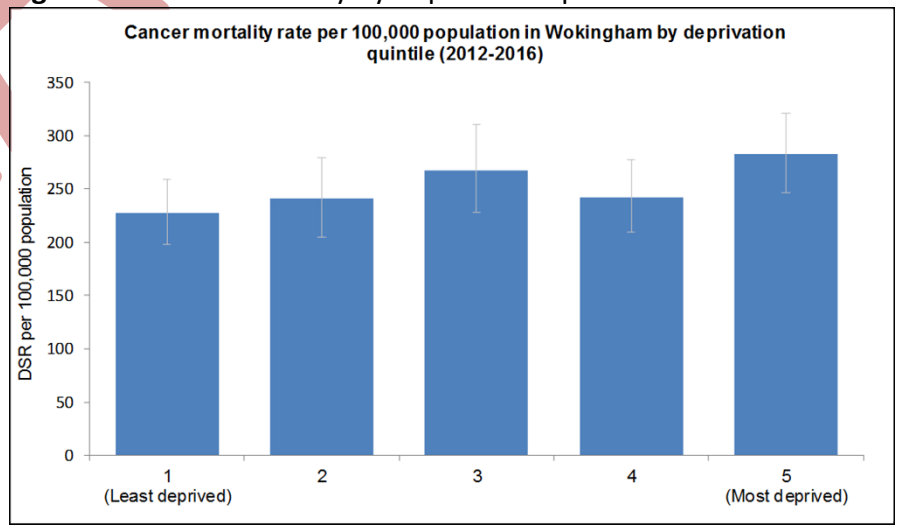
In 2016, 29.1% of all registered deaths in Wokingham were caused by cancer, compared to 28.0% in England. The percentages were different for men and women in Wokingham at 32.7% and 25.5% respectively.

**Figure X:** Cancer mortality by ward




*Source: NHS Digital (2017); Primary Care Mortality Database*

**Figure X:** Cancer mortality by deprivation quintile




*Source: NHS Digital (2017); Primary Care Mortality Database*

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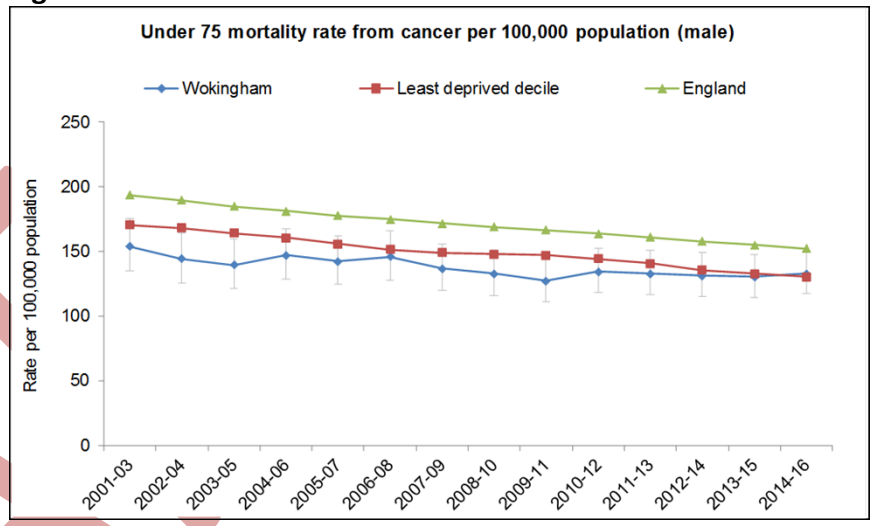
Further, 45.8% of premature deaths (people aged under 75) in Wokingham were caused by cancer, compared to 40.2% in England. These varied between men and women - 42.4% for men; 51.4% for women. (Source: NOMIS (2017); Mortality statistics - Underlying cause, sex and age (2013 - 2016))

In 2014-16, the under 75 mortality rate from cancer was 119.3 per 100,000 people in Wokingham. This was significantly better than the England rate of 74.6 per 100,000 population and similar to the comparator group rate of 120.8. Wokingham's rate for men was higher at 130.1 per 100,000 population, compared to 104.6 for women. This is in line with the national picture.

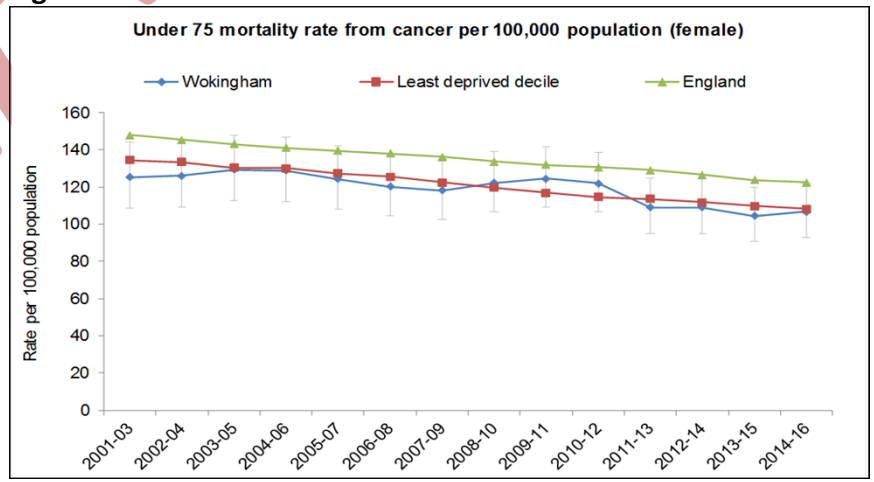
In Wokingham, 54.0% of premature deaths from cancer were considered preventable, compared to 58.0% nationally. In 2014-16, there were 64.3 premature deaths from cancer per 100,000 people that were considered preventable. The rate for men was higher again at 69.0 per 100,000 compared to 60.2 for women. (Source: Public Health England (2017); Public Health Outcomes Framework)

**Figure X:**




*Source: Public Health England (2017); Public Health Outcomes Framework*

**Figure X:**




*Source: Public Health England (2017); Public Health Outcomes Framework*

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**Figure X:** Male premature mortality from cancer considered preventable

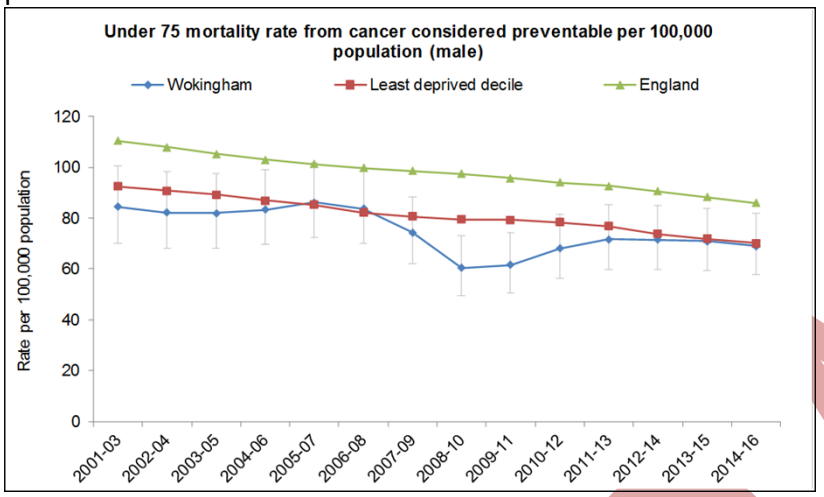
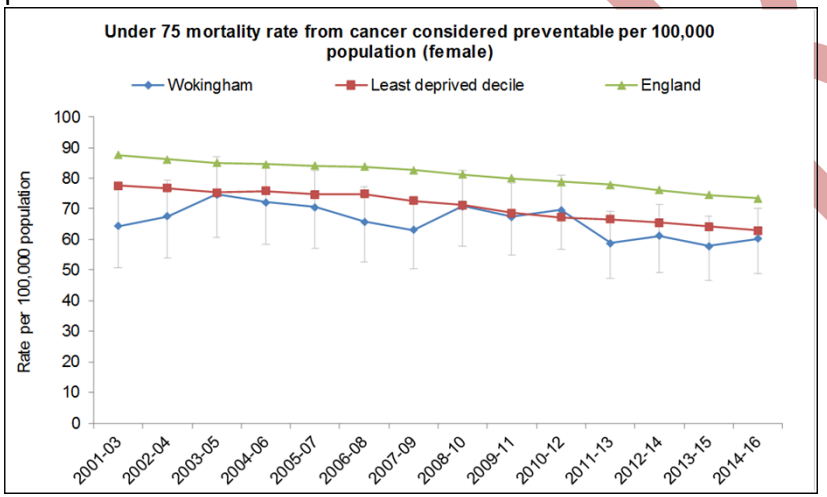



**Figure X:** Female premature mortality from cancer considered preventable




**Cancer Information Network data**

Cancer incidence

Cancer survival

Cancer recovery rates (low in females – CCG data)

Hospital admissions for cancer – CCG data

QoF data on cancer

## 5.2 Respiratory disease

The prevalence of disease is captured through the GP Quality and Outcomes Framework (QOF) on an annual basis. On 31st March 2016, the recorded prevalence of asthma in England was 5.9% and the prevalence of Chronic Obstructive Pulmonary Disease (COPD) was 1.9%.

Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England

6% of disability adjusted-life years (DALYs) in England are caused by chronic respiratory diseases, which is the 7th leading cause. DALYs are the number of healthy life years lost due to premature death and years living in ill health and are used to measure the total burden of a disease globally and nationally. When disease are looked at individually, COPD has the biggest impact (3.4% of all DALYs), followed by asthma (2.1% of all DALYs).

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The main risks attributed to respiratory disease deaths and DALYs in England are tobacco smoke (72%) and air pollution (14%).

Source: Global Burden of Disease (2015); GBD Compare Data Hub

Respiratory diseases are the 3rd main cause of death in England, behind cancer and circulatory diseases. In 2016, 13.7% of all registered deaths in England were caused by respiratory diseases. The percentage was similar for men and women, at 13.7% and 13.6% respectively. 10.4% of premature deaths (people aged under 75) were caused by respiratory diseases.

Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables

In 2014-16, the under 75 mortality rate from respiratory diseases was 33.8 per 100,000 people. The rate for men and women differs, with a higher rate of 39.2 deaths per 100,000 for men compared to 28.7 for women.

55% of premature deaths from respiratory diseases were considered preventable in 2014-16. This means that the underlying cause could potentially be avoided by public health interventions in the broadest sense. In 2014-16, there were 18.6 premature deaths from respiratory diseases per 100,000 people that were considered preventable. The rate for men was higher again at 20.8 per 100,000 population, compared to 16.5 for women.

Source: Public Health England (2017); Public Health Outcomes Framework

"The National COPD Audit Programme published a report in November 2016, which looked at primary care. The aim was to provide recommendations regarding the care and diagnosis of people with COPD and support primary care clinicians. Key recommendations from the audit included:

- a diagnosis of COPD should be made accurately and early. If the diagnosis is incorrect, any subsequent treatment will be of no value

- people with COPD should be offered interventions according to value-based medicine principles

- people with severe disease should be identified for optimal therapy. COPD encompasses a broad spectrum of conditions and health statuses and a personalised approach is essential

- there should be better coding and recording of COPD consultations, prescribing and referrals"

Source: Royal College of Physicians (2016); National COPD Audit Programme: COPD in England - Finding the measure of success

On 31st March 2017, the recorded prevalence of respiratory diseases was:

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| | | Wokingham CCG | Comparator Group | England | Number of people on the register in Wokingham CCG |
|---|---|---|---|---|---|
| Asthma | | 6.3% | 5.8% | 5.9% | 10,277 |
| COPD | | 1.0% | 1.3% | 1.9% | 1,698 |

Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England

In 2016, 12.7% of all registered deaths in Wokingham were caused by respiratory diseases, compared to 13.7% in England. The percentages were different for men and women in Wokingham at 12.4% and 13.1% respectively.

6.3% of premature deaths (people aged under 75) in Wokingham were caused by respiratory diseases, compared to 10.4% in England. These varied between men and women: 8.4% for men; 3.5% for women.

Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables

In 2014-16, the under 75 mortality rate from respiratory diseases was 19.4 per 100,000 people in Wokingham. This was significantly better than the England rate of 33.8 per 100,000 population and significantly better than the comparator group rate of 24.3.

Wokingham's rate for men was higher at 25.3 per 100,000 population, compared to 14.1 for women. This is inline with the national picture.

In Wokingham, 49% of premature deaths from respiratory diseases were considered preventable, compared to 55% nationally. In 2014-16, there were 9.8 premature deaths from respiratory diseases per 100,000 people that were considered preventable.

Source: Public Health England (2017); Public Health Outcomes Framework

## 5.3 Cardiovascular disease

The prevalence of disease is captured through the GP Quality and Outcomes Framework (QOF) on an annual basis. On 31st March 2016, the recorded prevalence of circulatory disease in England was as follows:

"- Atrial Fibrillation: 1.8%

- Coronary Heart Disease: 3.2%

- Heart Failure: 0.8%

- Hypertension: 13.8%

- Stroke and Transient Ischaemic Attack (TIA): 1.7%"

*Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England*

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Over 24% of people in England are estimated to have hypertension (high blood pressure), which is 13.5 million people. However, over 5.6 million of these are not diagnosed.

*Source: British Heart Foundation (2016); High Blood Pressure: How can we do better?*

High blood pressure is one of the leading causes of premature death and disability in England, according to the Global Burden of Disease study. In 2015 over 15% of all deaths were attributable to high blood pressure, which makes this the third main cause, behind tobacco smoke and dietary risks. 8% of all disability-adjusted life years (DALYs) were attributable to high blood pressure. (A DALY is the number of healthy life years lost due to premature death and years living in ill health).

The main causes of cardiovascular disease deaths and DALYs in England are high blood pressure, poor diet, high cholesterol and high body-mass index.

*Source: Global Burden of Disease (2015); GBD Compare Data Hub*

In 2016, 25.4% of all registered deaths in England were caused by diseases of the circulatory system. The percentage was marginally higher for men at 26.6%, compared to 24.2% of women. 21.5% of premature deaths (people aged under 75) were caused by diseases of the circulatory system. The percentage for these was also higher for men at 24.8%, compared to 16.8% of women.

*Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables*

In 2014-16, the under 75 mortality rate from cardiovascular disease was 73.5 per 100,000 people. This mortality rate has continued to decrease since 2001-03, when the figure was 138.0 per 100,000 people. The rate for men and women varies significantly, with a much higher rate of 102.7 deaths per 100,000 for men compared to 45.8 for women.

64% of premature deaths from cardiovascular were considered preventable in 2014-16. This means that the underlying cause could potentially be avoided by public health interventions in the broadest sense. In 2014-16, there were 46.7 premature deaths from cardiovascular disease per 100,000 people that were considered preventable. The rate for men was significantly higher again at 70.4 per 100,000 population, compared to 24.3 for women.

*Source: Public Health England (2017); Public Health Outcomes Framework*

On 31st March 2016, the recorded prevalence of circulatory diseases was:

| | | ***Wokingham CCG*** | ***Comparator Group*** | ***England*** | ***Number of people on the register in Wokingham CCG*** |
|---|---|---|---|---|---|

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| | | | | |
|---|---|---|---|---|
| *Atrial Fibrillation* | *1.8%* | *2.0%* | *1.8%* | *2,869* |
| *Coronary Heart Disease* | *2.4%* | *2.7%* | *3.2%* | *3,862* |
| *Heart Failure* | *0.6%* | *0.6%* | *0.8%* | *994* |
| *Hypertension* | *12.4%* | *13.2%* | *13.8%* | *20,196* |
| *Stroke or TIA* | *1.4%* | *1.6%* | *1.7%* | *2,328* |

*Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England*

In 2016, 26.0% of all registered deaths in Wokingham were caused by diseases of the circulatory system, compared to 25.4% in England. The percentages were different for men and women in Wokingham at 28.4% and 23.7% respectively.

22.3% of premature deaths (people aged under 75) in Wokingham were caused by diseases of the circulatory system, compared to 21.5% in England. These were also higher for men at 27.1%, compared to 16.7% for women.

*Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables*

In 2014-16, the under 75 mortality rate from cardiovascular disease was 52.6 per 100,000 people in Wokingham. This was significantly better than the England rate of 73.5 per 100,000 population and similar to the comparator group rate of 56.3.

Wokingham's rate for men was higher at 68.4 per 100,000 population, compared to 35.5 for women. This is in line with the national picture.

In Wokingham, 66.4% of premature deaths from cardiovascular were considered preventable, compared to 63.6% nationally. In 2014-16, there were 33.7 premature deaths from cardiovascular disease per 100,000 people that were considered preventable. The rate for men was significantly higher again at 48.6 per 100,000, compared to 19.4 for women.

*Source: Public Health England (2017); Public Health Outcomes Framework*

**Figure X:** Mortality from cardiovascular disease and DALYs attributable to different risk factors

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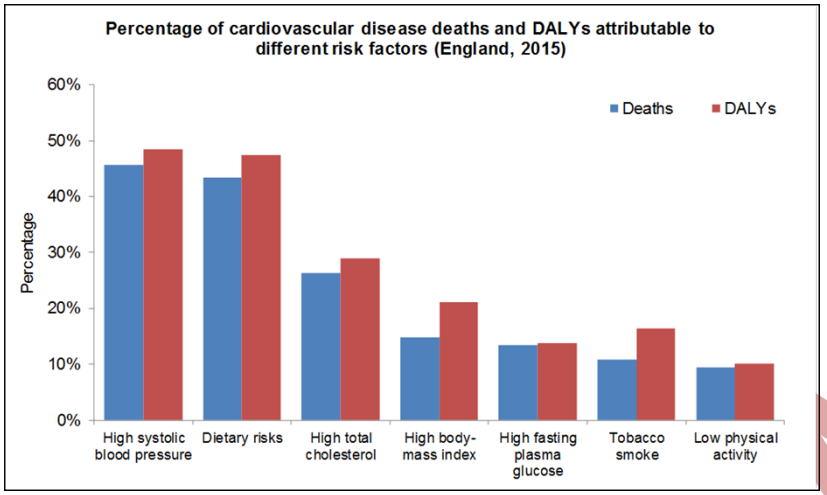



**Figure X:** GP Practice recorded prevalence of cardiovascular disease

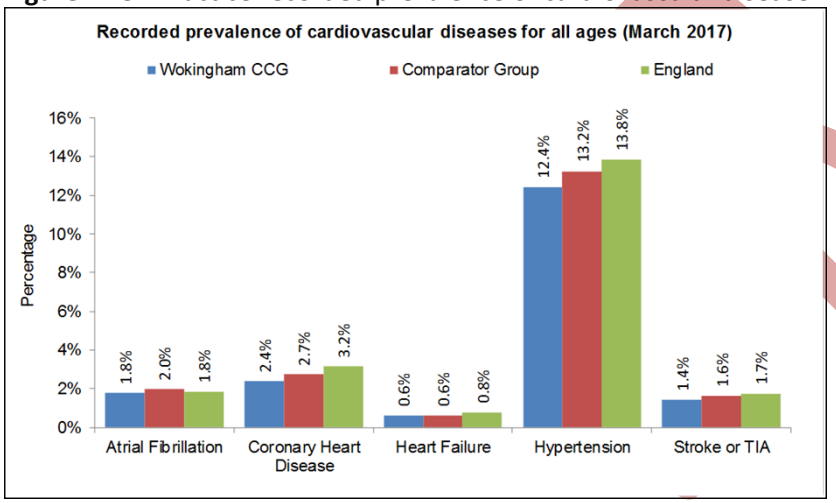



**Figure X:** Mortality from circulatory disease by ward

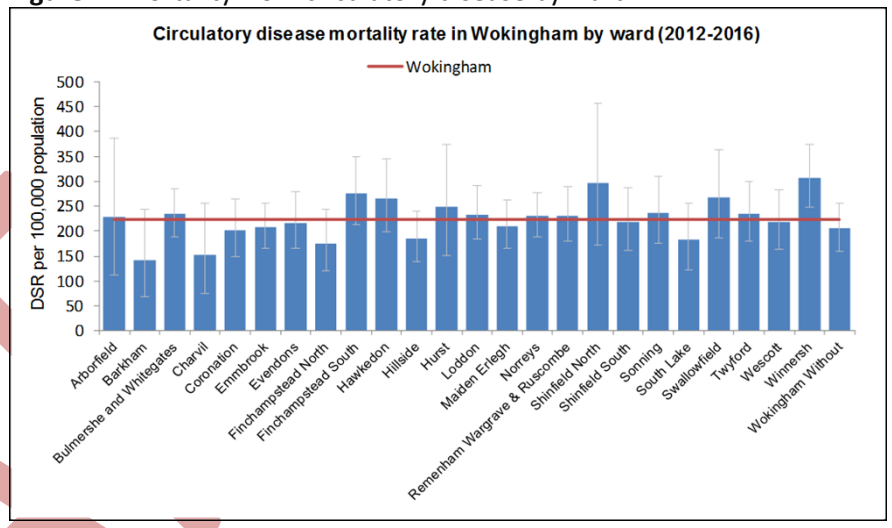



**Figure X:** Mortality from circulatory disease by deprivation quintile

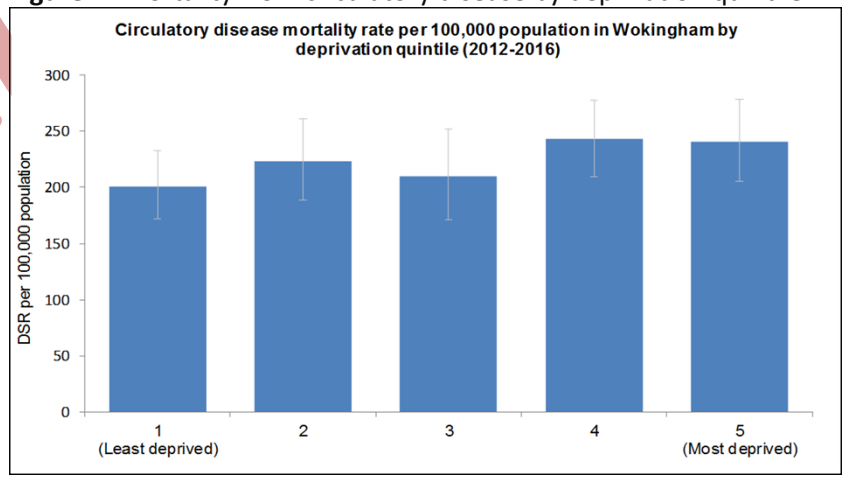


**Figure X:** Premature mortality from all cardiovascular diseases

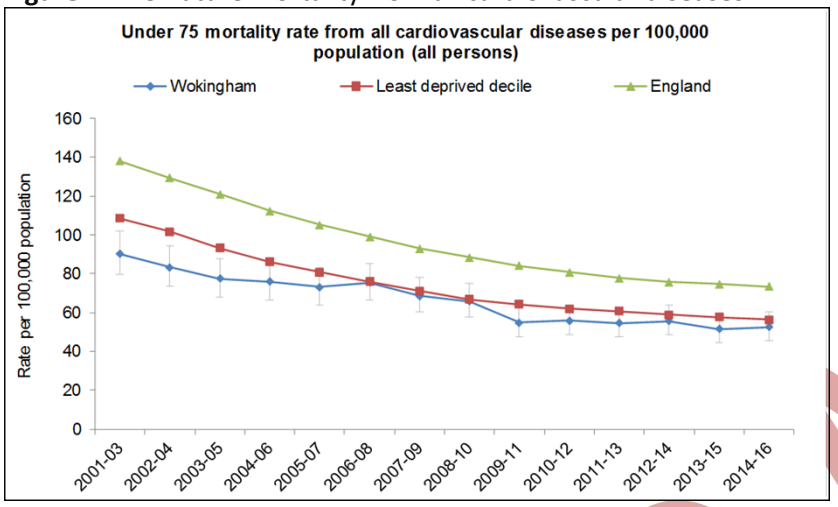
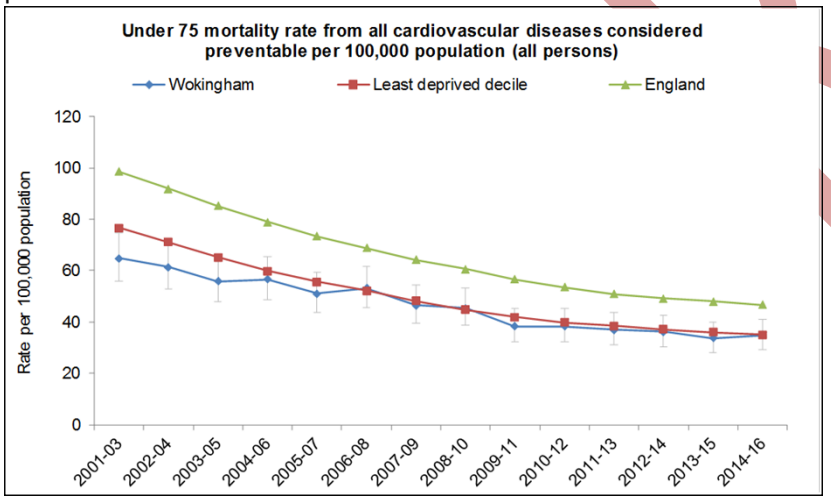



**Figure X:** Premature mortality from all cardiovascular diseases considered preventable




Cardiac arrest

CVD

Stroke

Qof prevalence vs. estimated prevalence

Hospital admissions

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## 5.4 Chronic Kidney Disease

Chronic Kidney Disease (CKD) is a long term condition where the kidneys do not function properly. It does not usually cause symptoms until reaching a more advanced stage, but can be detected at earlier stages with blood and urine tests. There are five stages of CKD. For many people the disease can be halted in its progress if diagnosed early enough and managed effectively. In some people the disease is progressive and may be diagnosed too late for effective management. (Source: NHS Digital (2017); Quality and Outcomes Framework 2015/16: Report for England)

The prevalence of CKD is captured through the GP Quality and Outcomes Framework (QOF) on an annual basis. On 31st March 2017, the recorded prevalence of CKD in England was 4.1% and this included people that were at stage 3a to 5 of the disease. This was the same as the 2016 prevalence rate. (Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England)

Chronic Kidney Disease causes just under 1% of deaths and disability adjusted-life years (DALYs) in England. DALYs are the number of healthy life years lost due to premature death and years living in ill health.

Key risk factors for CKD in England include high blood pressure, high fasting glucose and high body-mass index.

A low glomerular filtration rate is also attributable to other deaths and DALYs from other causes, such as cardiovascular diseases. In total low glomerular filtration rate is attributable to over 3% of all deaths in England and 2% of DALYs.

Source: Global Burden of Disease (2015); GBD Compare Data Hub

In 2016, 0.7% (3,300) of all registered deaths in England were caused by glomerular and renal tubolo-intestinal diseases or renal failure.

Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables

On 31st March 2017, the recorded prevalence of Chronic Kidney Disease for people aged 18 and over was:

| | Wokingham CCG | Comparator Group | England | Number of people on the register in Wokingham CCG |
|---|---|---|---|---|
| **Chronic Kidney Disease** | 3.8% | 3.9% | 4.1% | 4,770 |

**Figure X:**

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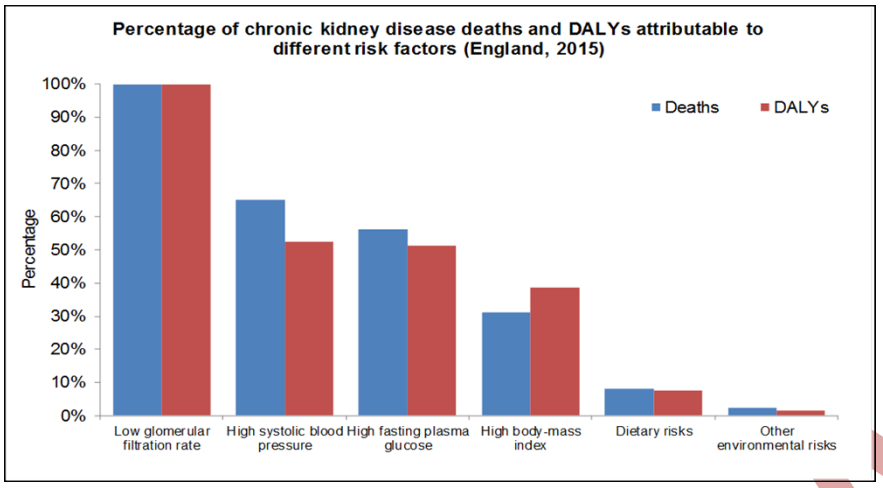


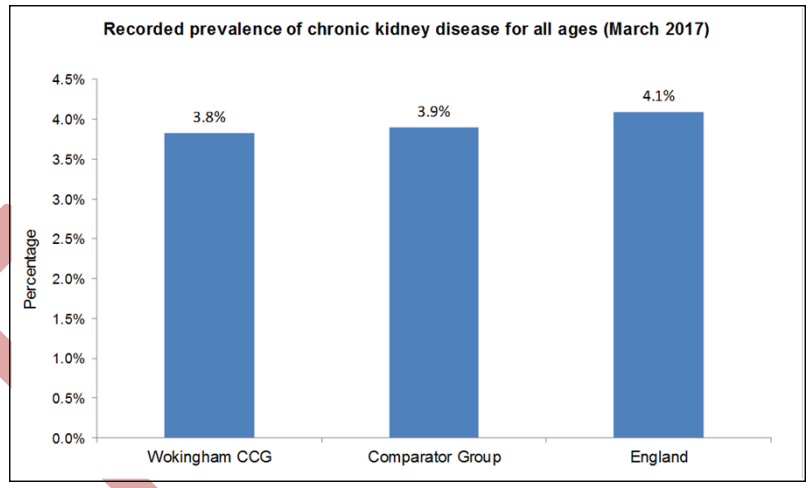




**Figure X:**

QoF registers vs hospital admissions

## 5.5 Liver disease

Hospital admissions

QoF register

Approximately 1.5% of disability adjusted-life years (DALYs) in England are caused by cirrhosis and other chronic liver diseases, which is the 14th leading cause. DALYs are the number of healthy life years lost due to premature death and years living in ill health and are used to measure the total burden of a disease globally and nationally.

The main risks attributed to cirrhosis and other chronic liver disease are alcohol use (58%) and drug use (28%).

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*Source: Global Burden of Disease (2015); GBD Compare Data Hub*

"In 2014/15, there were over 61,000 hospital admissions in England with a primary diagnosis of liver disease. This was a rate of 119 per 100,000 population, which was a significant increase on the previous year. Rates for men were higher at 150.6 per 100,000 population, compared to 90.9 for women.

The rate of alcohol-specific hospital admissions in 2014/15 decreased slightly on the previous year. In total there were 191,370 admissions at a rate of 364 per 190,000 population. Again, the rate for men was much higher are 502 per 100,000 population, compared to 235 for women."

*Source: Public Health England (2017); Liver Disease Profiles*

"In 2016, there were 7,650 registered deaths in England from diseases of the liver, which was 1.6% of all deaths. 59% of these were from alcoholic liver disease.

The percentage of premature deaths (people aged under 75) from diseases of the liver were higher at 4.0% and 67% of these are from alcoholic liver disease."

*Source: NOMIS (2017); Mortality statistics - Underlying cause, sex and age (2013 - 2016)*

In 2014-16, the under 75 mortality rate from liver disease was 18.3 per 100,000 people. The rate for men and women differ, with a higher rate of 23.9 deaths per 100,000 for men compared to 12.8 for women.

88% of premature deaths from liver disease were considered preventable in 2014-16. This means that the underlying cause could potentially be avoided by public health interventions in the broadest sense. Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence. In 2014-16, there were 18.3 premature deaths from respiratory diseases per 100,000 people that were considered preventable. The rate for men was higher again at 23.9 per 100,000 population, compared to 12.8 for women.

*Source: Public Health England (2017); Public Health Outcomes Framework*

"Public Health England's Liver Disease Profile includes a number of other premature mortality rate indicators for specific types of liver disease. The table below highlights this data for 2014-16:

| "Type of liver disease | Number of premature deaths - Rate of deaths per 100,000 population | % of deaths from liver disease |
|---|---|---|
| Alcoholic Liver Disease | | |
| 12,501 | 8.20 | 49.0% |
| Non Alcoholic Fatty Liver Disease | | |
| 813 | 0.54 | 3.2% |

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| | | |
|---|---|---|
| Hepatitis B related end-stage liver disease | | |
| 189 | 0.13 | 0.7% |
| Hepatitis C related end-stage liver disease | | |
| 1009 | 0.67 | 4.0% |

*Source: Public Health England (2017); Liver Disease Profiles*

*In 2014/15, there were 116 hospital admissions in* Wokingham with a primary diagnosis of liver disease. This was a rate of 76.8 per 100,000 population, compared to England's rate of 119.2. 58.6% of these admissions were for men.

The rate of alcohol-specific hospital admissions in Wokingham increased in 2015/16, however the rate was still significantly better than both England and the deprivation decile comparator group. There were 514 hospital admissions in Wokingham with a primary diagnosis of liver disease, which was a rate of 332.6 per 100,000 population. The majority (57.4%) of these admissions were for men.

*(Source: Public Health England (2017); Liver Disease Profiles)*

*In 2016, 1.0% of all registered deaths in Wokingham were caused by liver disease, compared to 1.6% in England.*

*(Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables)*

In 2014-16, the under 75 mortality rate from liver disease was 11.8 per 100,000 people in Wokingham. This was significantly better than the England rate of 18.3 per 100,000 population and significantly better than the comparator group rate of 13.3.

In 2014-16, there were 9.3 premature deaths from liver disease per 100,000 people that were considered preventable in Wokingham. This was significantly better than the England rate of 16.1 per 100,000 population and significantly better than the comparator group rate of 11.7.

*(Source: Public Health England (2017); Public Health Outcomes Framework)*

**Figure X:** Premature mortality from liver disease

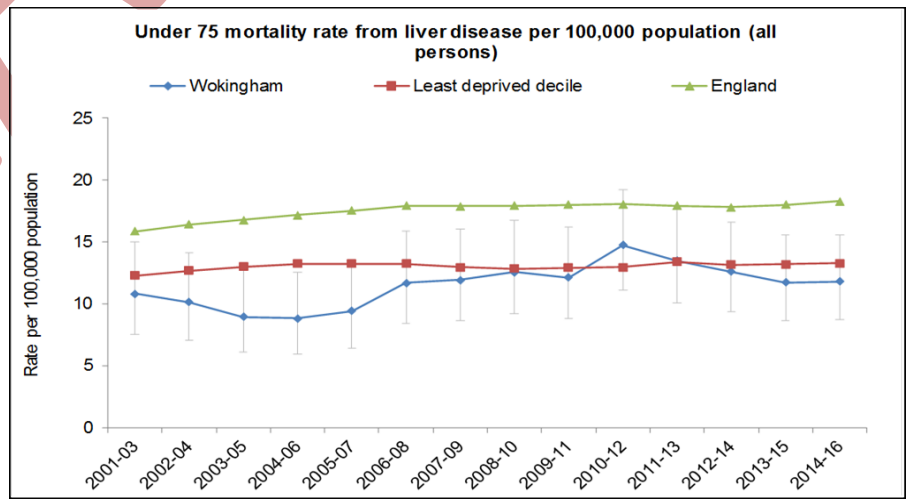


**Figure X:** Premature mortality from liver disease considered preventable

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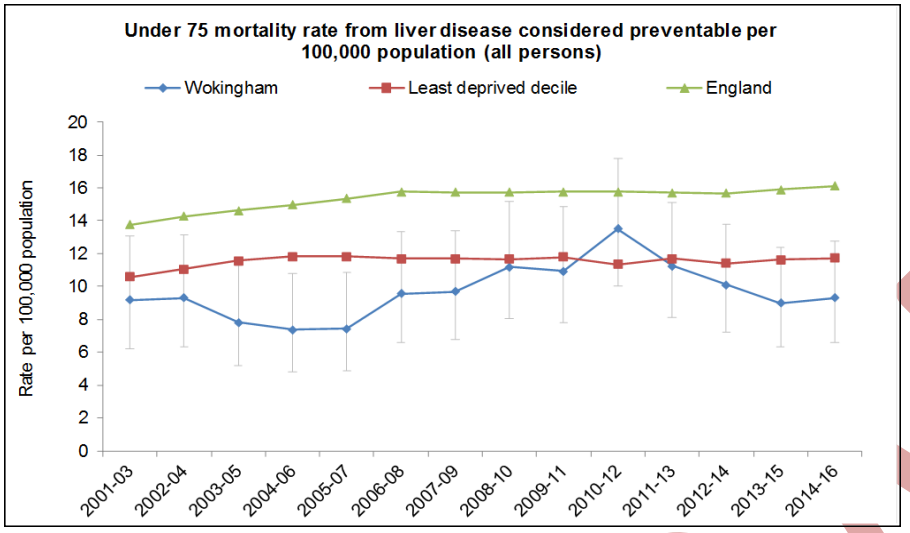


## 5.6 Long term neurological conditions

Neurological conditions result from damage to the brain, spinal column or peripheral nerves. There are over 600 types of neurological conditions. Examples include Parkinson's disease, motor neurone disease, and epilepsy. Some of these conditions are life threatening and many carry a significant burden to the individual, their family and to health and social care.

Approximately 4% of NHS spend is spent on neurological services and 14% of the social care budget is spent on people living with neurological conditions. An average clinical commissioning group (CCG) will have 59,000 patients with a neurological condition. People with a neurological condition are 35% more likely to die prematurely than those without a neurological condition. People with a neurological condition have the lowest health-related quality of all people with any long term condition. (*Source: NHS England)*

In order to analyse local data in relation to neurological conditions, we first need to define the relevant diseases and conditions we are referring to. Two data sources have been used. These use slightly different criteria in order to capture data around neurological conditions. NHS England's Rightcare Neurology Focus Packs use the NHS Programme Budgeting definition and Public Health England's Neurology Hospital Activity Data Packs use the National Neurology Intelligence Networks definition. There are 335 diagnosis codes that are common to both definitions.

There are an additional 138 diagnosis codes included in the Neurology Intelligence Networks definition that are not included in the Programme Budgetting definition and a further 138 codes that are included in the Programme Budgetting definition but not in the Neurology Intelligence Network definition. For further information around defining neurological conditions for health intelligence purposes please follow this link: PHE Neurology Data Compendium Definitions

NHS England's RightCare programme aims to ensure the best possible care is delivered as efficiently as possible. It is grounded in ensuring that patients access the right care, in the right place, and at the right time. It has three components; intelligence, innovation, and implementation. As part of the intelligence component, NHS England has developed CCG data packs including a Neurological conditions focus pack. The packs identify variation in outcomes which commissioners should use, together with other local

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intelligence, to ensure that plans focus on the biggest areas for potential improvement in outcomes, resource allocation, and in reducing inequalities. The data in the table below has been taken from the Neurological conditions focus pack. For further information on the Right Care programme including the full focus pack dataset and analysis tools please follow the link below.

**Table X:**

| Indicator Name | Date | Numerator | Denominator | Value | National | Similar 10 Average* | 5/Lowest 5 Average* | Compared to Similar 10 | Compare to best/lowest 5 |
|---|---|---|---|---|---|---|---|---|---|
| Headaches and migraine - Number of day case admissions per 1,000 population | 2014/15 | 15 | 161,987 | 9 | 23 | 21 | 16 | lower | lower |
| Epilepsy - Number of day case admissions per 1,000 population | 2014/15 | 6 | 161,290 | 4 | 9 | 11 | 6 | lower | same |
| Epilepsy - Number of emergency admissions by children per 1,000 population | 2014/15 | 32 | 37,937 | 84 | 118 | 106 | 78 | same | same |
| Tumours of the Nervous System - Number of day case admissions per 1,000 population | 2014/15 | Supressed | Supressed | Supressed | 18 | 12 | 6 | N/A | N/A |
| Multiple Sclerosis and Inflammatory Disorders - Number of day case admissions per 1,000 population | 2014/15 | 112 | 162,791 | 69 | 80 | 105 | 64 | lower | same |
| Parkinsonism and other Extrapyramidal Disorders - Number of day case admissions per 1,000 population | 2014/15 | 7 | 163,551 | 4 | 10 | 21 | 8 | lower | same |
| Epilepsy (18+) - Prevalence | 2014/15 | 802 | 123,295 | 1 | 1 | 1 | 1 | same | same |
| Epilepsy mortality rate | 2011-13 | Supressed | Supressed | Supressed | 1 | 2 | Unable to calculate | N/A | N/A |
| New outpatient neurology appointments for those aged 20+ DSR per 100,000 population (consultant) | 2013/14 | 1,298 | 117,567 | 1,120 | 944 | 818 | 986 | higher | higher |
| % of the total population with a limiting long term illness or disability | 2014/15 | 18,380 | 154,380 | 12 | - | 14 | 13 | lower | lower |

*Source: Rightcare Neurology Focus Packs, NHS England*

**Table X:**

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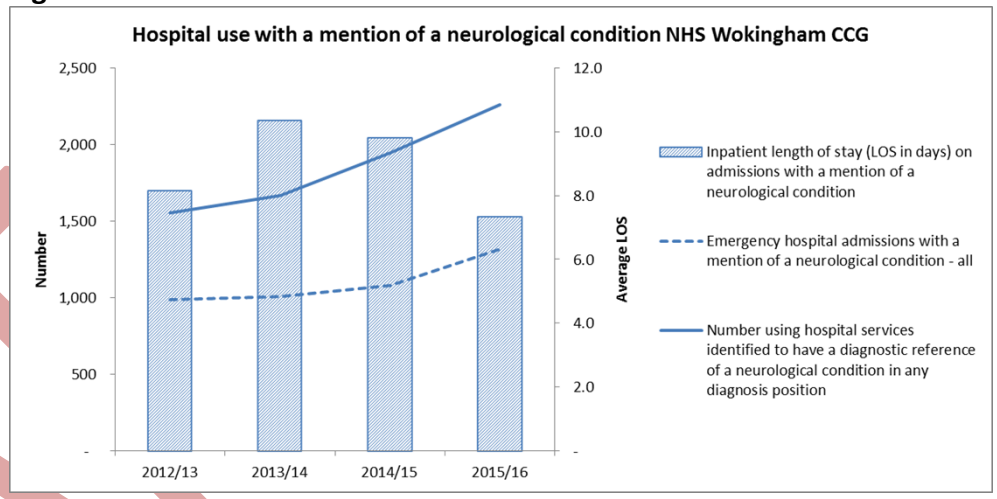
| Primary diagnosis | Date | Emergency hospital admissions with a mention of a neurological condition - all | Emergency hospital admissions with a mention of a neurological condition - under neurology consultant | Emergency hospital admissions with a mention of a neurological condition - neurology ward | Inpatient length of stay (LOS in days) on admissions with a mention of a neurological condition | Number using hospital services identified to have a diagnostic reference of a neurological condition in any diagnosis position |
|---|---|---|---|---|---|---|
| **ALL DIAGNOSES** | **2015/16** | **1,317** | **29** | **8** | **7** | **2,259** |
| Ataxia | 2015/16 | - | N/A | N/A | | 7 |
| Central nervous system infections | 2015/16 | 12 | N/A | N/A | 17 | 24 |
| Cranial nerve disorder | 2015/16 | 10 | N/A | N/A | 1 | 41 |
| Development disorders | 2015/16 | * | N/A | N/A | | 23 |
| Epilepsy | 2015/16 | 98 | N/A | N/A | 5 | 296 |
| Functional Disorders | 2015/16 | 7 | N/A | N/A | 6 | 20 |
| Headaches and migraine | 2015/16 | 129 | N/A | N/A | 1 | 264 |
| Motor neurone disease and Spinal muscular atrophy | 2015/16 | * | N/A | N/A | | 14 |
| Multiple sclerosis and inflammatory disorders | 2015/16 | 8 | N/A | N/A | 3 | 92 |
| Neuromuscular diseases | 2015/16 | 10 | N/A | N/A | 8 | 58 |
| Parkinsonism and other Extrapyramidal disorders/Tic disorder | 2015/16 | 11 | N/A | N/A | 16 | 219 |
| Peripheral nerve disorders | 2015/16 | 6 | N/A | N/A | 9 | 379 |
| Rare and other neurological diseases | 2015/16 | 28 | N/A | N/A | 5 | 230 |
| Sleep disorders | 2015/16 | - | N/A | N/A | | 16 |
| Spondylotic myelopathy and Radiculopathy | 2015/16 | 20 | N/A | N/A | 4 | 467 |
| Traumatic brain and spine injury | 2015/16 | 45 | N/A | N/A | 6 | 52 |
| Tumours of the nervous system | 2015/16 | 22 | N/A | N/A | 14 | 57 |
| Other primary diagnosis on admission* | 2015/16 | 906 | N/A | N/A | 9 | N/A |

*Source: Neurology services: hospital activity data, Public Health England*

**Figure X:**




*Source: Neurology services: hospital activity data, Public Health England*

## 5.7 Preventable sight loss (shared service – August 2018)

PANSI estimates

**Visual impairment**

This above table is based on the prevalence of visual impairment in the UK, A review of the literature, by Tate, Smeeth, Evans, Fletcher, Owen and Rudnicka, RNIB, 2005. They report that "Most studies have been done in the older population and there is a scarcity of data in younger adult age groups in the UK. A review by Nissen et al of epidemiological studies performed in Western Europe, North America and Australia covering the age group 20 to 59 years found the prevalence of blindness was 0.08 and of visual acuity 6/24 to

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6/48 was 0.07%. These figures agree well with the prevalence of registrations in a similar age range and we conclude that registration data provide reasonably accurate estimates of the prevalence of serious vision impairment in the younger adult age groups". The RNIB suggest a lower figure of 1 in 500 as an estimated basis of people who would be registerable. The Tate study also argues, as do others, that estimates of less than severe visual impairment are unreliable with a high degree of variance reported in self-report studies. A mean of the three figures, 0.065%, has been used as an estimate of the numbers of people with a severe visual impairment.

The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a serious visual impairment and require help with daily activities, projected to 2035.



## 5.8 Physical and sensory impairment

**Hearing loss**

*Prevalence of hearing loss in the better ear averaged across the mid-frequencies (0.5, 1, 2 and 4KHz). Hearing loss is recorded in decibels Hearing Level (dBHL).

The term hearing loss is intended to be inclusive of those who identify as hard of hearing, deaf and Deaf, including those who use British Sign Language (BSL) as their first or preferred language.

Hearing loss is usually measured by finding the quietest sounds someone can hear using tones with different frequencies, which are heard as different pitches. The person being tested is asked to respond, usually by pressing a button, when they can hear a tone and the level of the tone is adjusted until they can just hear it. This level is called the threshold. Thresholds are measured in units called dBHL: dB stands for 'decibels' and HL stands for 'hearing level'.

The greater the threshold level is in dBHL the worse the hearing loss. Anyone with thresholds between 0 and 20 dBHL across all the frequencies is considered to have 'normal' hearing. The threshold of 25 dBHL indicates hearing loss; the threshold of 65 dBHL indicates severe hearing loss.

Evidence shows that unsupported hearing loss can have an adverse impact on a person’s health and quality of life, for example people with hearing loss may find it difficult communicate with other people and have an increased risk of social isolation and other problems such as anxiety and depression. People with hearing loss may also face barriers to employment due to poor deaf awareness or the lack of communication support.

The prevalence rates have been applied to ONS population projections of the 18-64 population to give estimated numbers predicted to have some, or severe, hearing loss to 2035.

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| Age | Some hearing loss (%) | Severe hearing loss (%) |
|---|---|---|
| **18-30** | **1.8** | **0** |
| **31-40** | **2.8** | **0.7** |
| **41-50** | **8.2** | **0.3** |
| **51-60** | **18.9** | **0.9** |
| **61-70** | **36.8** | **2.3** |
| **71-80** | **60.3** | **4** |
| **80+** | **93.4** | **22.3** |

**Table X:** People aged 18-64 predicted to have some hearing loss, by age, projected to 2035

| | 2017 | 2020 | 2025 | 2030 | 2035 |
|---|---|---|---|---|---|
| 18-24 | 184 | 176 | 181 | 203 | 205 |
| 25-34 | 392 | 398 | 388 | 370 | 378 |
| 35-44 | 1,182 | 1,168 | 1,163 | 1,171 | 1,162 |
| 45-54 | 3,146 | 3,108 | 3,076 | 3,004 | 3,017 |
| 55-64 | 4,924 | 5,366 | 5,865 | 5,868 | 5,799 |
| **18-64** | **9,829** | **10,217** | **10,673** | **10,616** | **10,561** |

**Table X:** People aged 18-64 predicted to have severe hearing loss, by age, projected to 2035

| | 2017 | 2020 | 2025 | 2030 | 2035 |
|---|---|---|---|---|---|
| 18-24 | 0 | 0 | 0 | 0 | 0 |
| 25-34 | 52 | 54 | 54 | 51 | 48 |
| 35-44 | 125 | 123 | 123 | 124 | 119 |
| 45-54 | 136 | 134 | 133 | 130 | 130 |
| 55-64 | 271 | 296 | 327 | 327 | 324 |
| **Access to social care18-64** | **585** | **608** | **637** | **632** | **622** |

## 5.8 Access to social care/personalisation (shared services April 2018)

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# Ageing Well 2017/18

Public Health Intelligence

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# 1. Key messages

- The number of people aged over 65 in Wokingham borough is estimated to increase by 17% between 2018 and 2025, from 29,600 to 34,514 respectively.
- Estimated number of elderly population living alone
- Self-assessed health of older people (POPPI)
- Falls and mobility
- End of life care
- Excess winter deaths
- Delayed transfers of care



# 2. Introduction

This chapter looks at the public health issues of the elderly population. The elderly population is usually categorised as people aged 65 and over. However, with the increase in life expectancy and in pensionable age, the age threshold for the elderly population will soon increase.

Older people have specific public health needs and may often require specialised services, especially those suffering from a long-term condition such as dementia. The Local Authority provides a number of services for elderly people. Some of these are……(name services)

The table below shows numbers of population 65 and over by age and gender in Wokingham borough. The data comes from the ONS 2014-based sub-national population projections for Local Authorities.

| | Females | | | | | Males | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Year** | **65-74** | **75-84** | **85-89** | **90 and over** | **65+** | **65-74** | **75-84** | **85-89** | **90 and over** | **65+** |
| **2018** | 8,439 | 5,185 | 1,526 | 988 | 16,139 | 7,515 | 4,426 | 1,060 | 460 | 13,462 |
| **2019** | 8,398 | 5,431 | 1,591 | 1,033 | 16,453 | 7,545 | 4,626 | 1,090 | 507 | 13,767 |
| **2020** | 8,438 | 5,643 | 1,637 | 1,088 | 16,806 | 7,554 | 4,789 | 1,135 | 547 | 14,026 |
| **2021** | 8,431 | 5,839 | 1,708 | 1,147 | 17,124 | 7,678 | 4,895 | 1,179 | 597 | 14,348 |
| **2022** | 8,252 | 6,270 | 1,742 | 1,214 | 17,476 | 7,563 | 5,228 | 1,265 | 641 | 14,696 |
| **2023** | 8,243 | 6,554 | 1,830 | 1,260 | 17,887 | 7,605 | 5,507 | 1,319 | 686 | 15,117 |
| **2024** | 8,288 | 6,748 | 1,898 | 1,324 | 18,257 | 7,685 | 5,671 | 1,357 | 732 | 15,444 |
| **2025** | 8,359 | 6,991 | 1,933 | 1,389 | 18,671 | 7,900 | 5,766 | 1,399 | 782 | 15,847 |

In the Borough Profile chapter of the JSNA on page X there is a map showing distribution of population aged 65+ by ward.

Add life expectancy for people aged 65+ and healthy life expectancy at 65+

The last Census counted the majority (96.3%) of the population over 65 in Wokingham being from the White ethnic group. This is slightly higher than the national equivalent with 95.3%. In 2017 it was estimated that there were 10,442 people aged 65 and above in Wokingham borough who lived alone (source: POPPI). This was equivalent to 36% of the resident population aged 65 and over, which meant that nearly four out of ten persons aged 65 and over were living alone.

The majority of the elderly population in Wokingham own their homes. Figure 1 bellow illustrates tenure by age group as recorded during the

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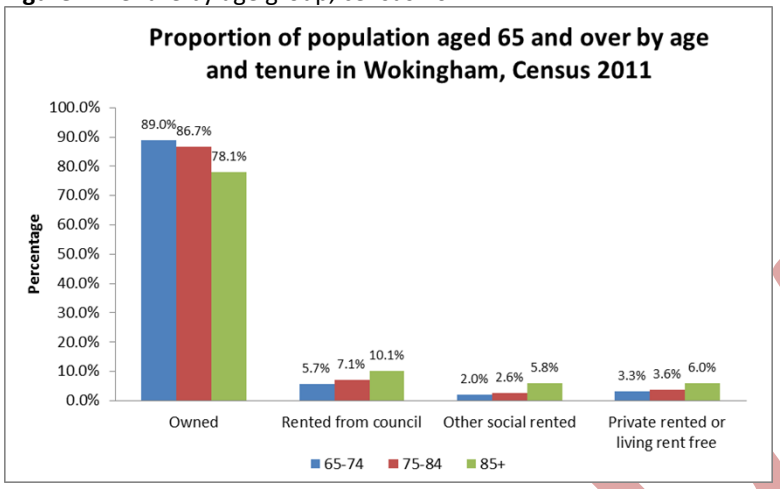
2011 Census. However there is a small proportion that rents and this is higher in the 85+ age group.

**Figure 1:** Tenure by age group, census 2011




The table below shows estimated numbers of people aged 65+ living in a local authority and non-local authority care home. Numbers have been calculated by applying percentages of people living in care homes/nursing homes in 2011 to projected population figures.

| | People aged 65+ living in a LA care home with or without nursing | People aged 65-74 living in a non-LA care home with or without nursing |
|---|---|---|
| 2017 | 42 | 1698 |
| 2020 | 47 | 1900 |
| 2025 | 57 | 2328 |
| 2030 | 67 | 2783 |
| 2035 | 81 | 3437 |

*Source: POPPI June 2018*

# 3. Living well

## 3.1 Falls and mobility

Requested five cumulative years admissions to hospital by ward from CCG

Compare with POPPI estimates

## 3.2 End of life care

Public Health England's National End of Life Care Intelligence Network has developed End of Life Care Profiles, as part of the Fingertips suite of tools. The Profile provides data at a CCG and local authority level to help with the planning and delivery of local services that impact on end of life care.

In 2015, 1,184 Wokingham residents died at a rate of 867 per 100,000 population. This was significantly lower than the national rate of 1,001 per 100,000 population.

In 2016, cancer was the main underlying cause of death for people in Wokingham at 29%, followed by circulatory disease (26%) and respiratory disease (13%). This reflected the national picture.

In 2016, 44% of Wokingham resident deaths were in a hospital, which was similar to the England figure of 47%. 24% of deaths in Wokingham were at home, which was similar to the England figure of 23%. 21% of

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deaths were in care homes, which was similar to the England figure of 22%. The percentage of deaths at home or in a care home have increased in Wokingham over the last 10 years, while the percentage of deaths in hospital has decreased.

The proportion of deaths in usual place of residence (DiUPR) is a key indicator for end-of-life care, as it acts as a proxy quality marker for choice and access. Survey data suggests that many people would prefer to die at home, given the choice, with few wishing to die in hospital. A Usual Place of Residence is counted as a person's own home, care home or religious establishment.

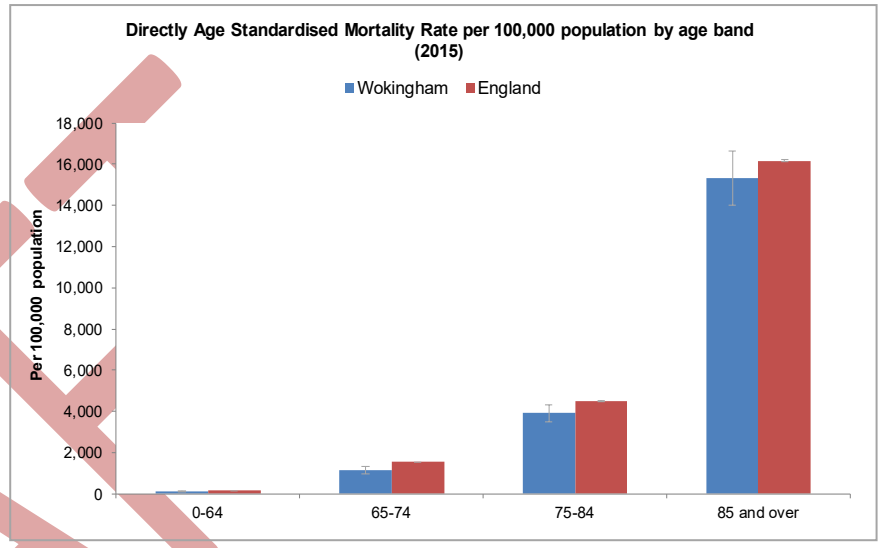
In 2015, 46% of deaths in Wokingham were in a person's Usual Place of Residence, which was similar to the England figure of 46%. Locally, this is an increase of 10% points since 2005, which reflects the national trend.

The percentage of deaths in a Usual Place of Residence differs by underlying cause of death. In 2015, 39% of deaths with an underlying cause of circulatory disease in Wokingham were in a usual place of residence, compared to 42% of deaths from respiratory disease.

In 2015, 131 people with Dementia or Alzheimer's Disease died in Wokingham. 73% of these deaths were in the person's usual place of residence, which is similar to the England figure of 71%.

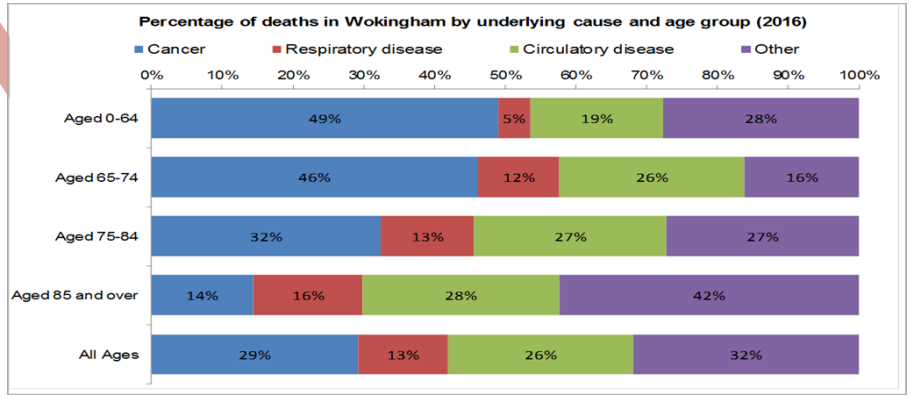
*Source: Public Health England: End of Life Profiles*

**Figure X:** Directly Age Standardized Mortality Rate by age band (2015)




*Source: Public Health England: End of Life Profiles*

**Figure X:**




*Source: Public Health England: End of Life Profiles*

**Figure X:** Place of death by age group

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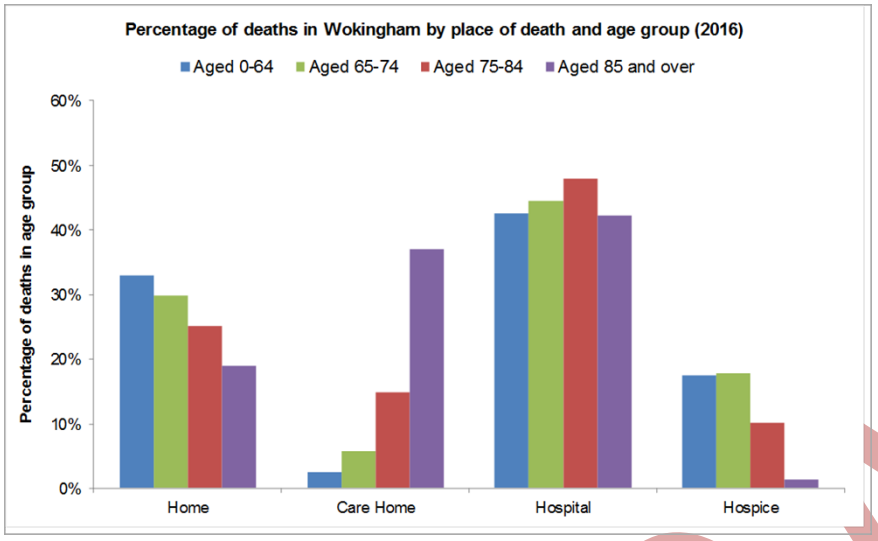
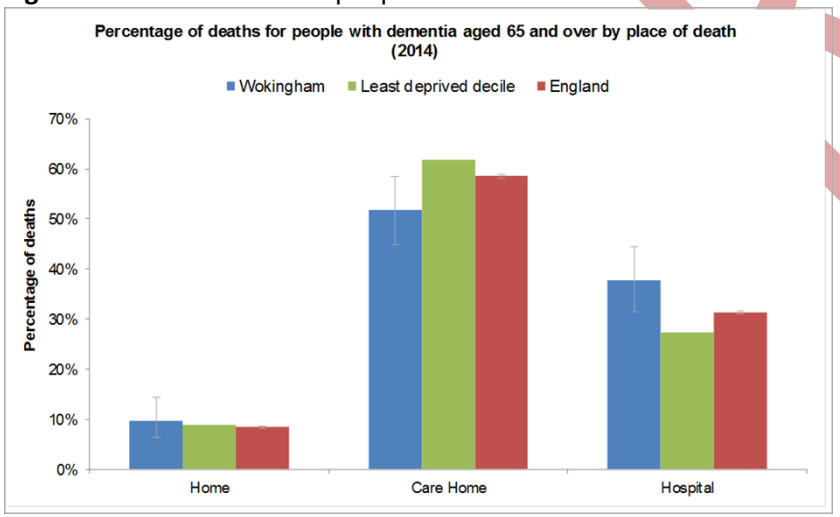


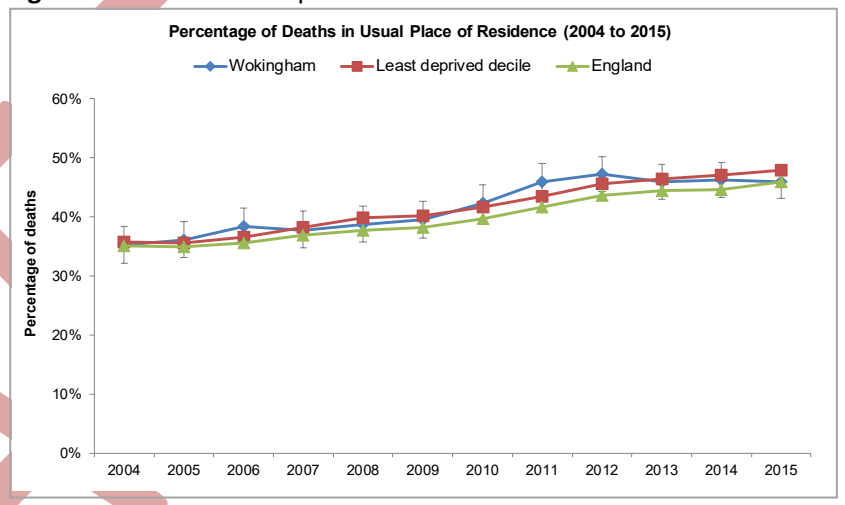

*Source: Public Health England: End of Life Profiles*

**Figure X:** Place of death for people with dementia



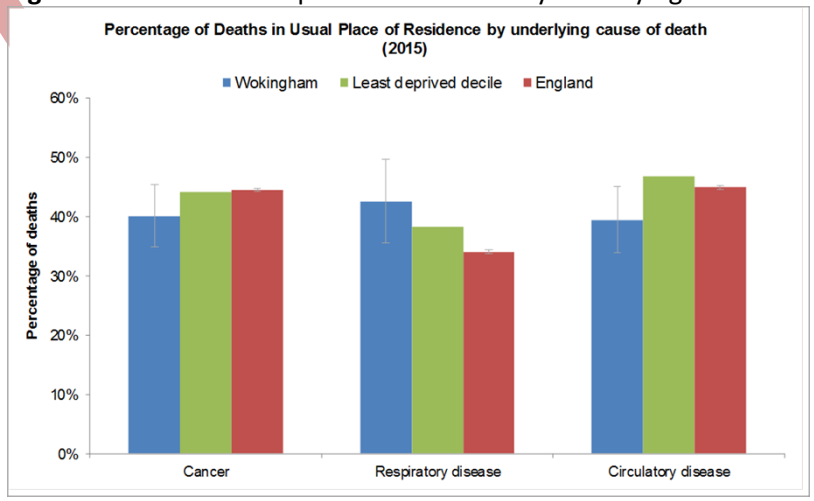

*Source: Public Health England: End of Life Profiles*

**Figure X:** Death in usual place of residence trend




*Source: Public Health England: End of Life Profiles*

**Figure X:** Death in usual place of residence by underlying cause

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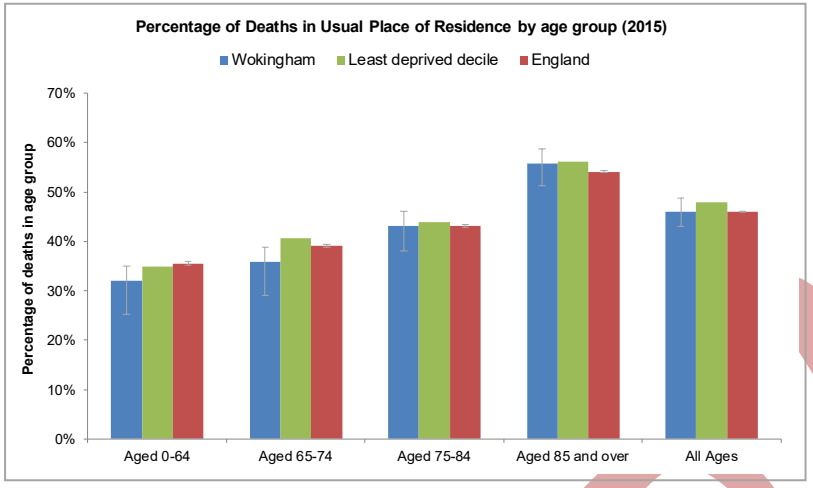
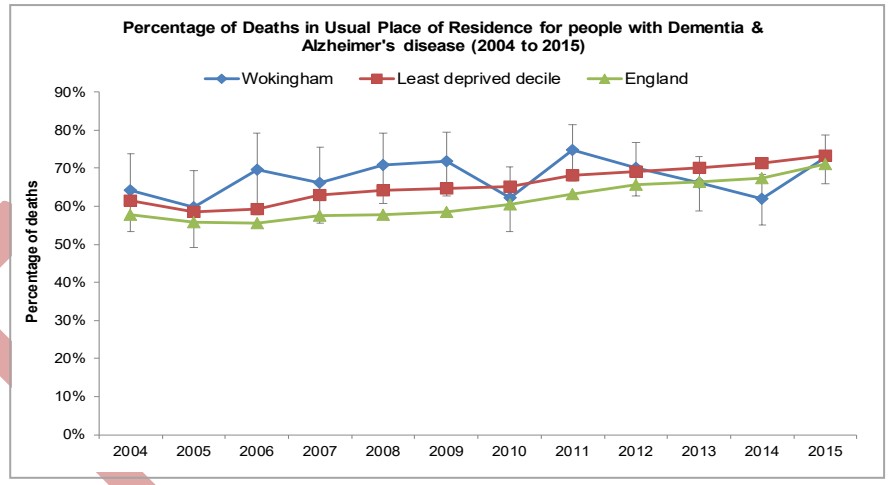
*Source: Public Health England: End of Life Profiles*

**Figure X:** Death in Usual Place of Residence by age group (2015)




*Source: Public Health England: End of Life Profiles*

**Figure X:** Death in Usual Place of Residence for people with Dementia and Alzheimer's disease, all ages (2004 to 2015)




*Source: Public Health England: End of Life Profiles*

Look at NHS Digital for further information

## 3.3 Excess winter deaths

More people die in the Winter than in the Summer in England and Wales as is common with other countries. Excess Winter Deaths (EWD) are calculated by comparing the number of death in Winter (Dec to Mar) with the number of deaths in the Summer. Figures for the 2016 to 2017 winter period are considered provisional as not all deaths may have been registered at the time of their calculation.

The Excess Winter Mortality (EWM) Index is calculated as a percentage of the average number of non-winter deaths showing the percentage of extra deaths that occurred in the winter. In the 2016 to 2017 winter

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period there were 34,300 EWDs in England a Wales which represents an EWM index of 20.9%.

There was an increase in EWDs in 2016 to 2017 compared to 2015 to 2016. It was the second highest peak over the last five winter periods. The highest seen in the 2014 to 2015 winter period. Females and the elderly were most affected by excess winter mortality in the 2016 to 2017 winter period and over one-third of all excess winter deaths were caused by respiratory disease.

Excess Winter Deaths in Local Authority areas are monitored as part of the Public Health Outcomes Framework. Final figures are used as provisional figures are not calculated at this local level. Therefore, the most recent available Local Authority data relates to the 2015 to 2016 winter period.

There were 24,850 EWDs in England and Wales in 2015 to 2016 which represents an EWM index of 14.9%. Females and the elderly were most affected by excess winter mortality in the 2015 to 2016 winter period and the majority of all excess deaths were caused by respiratory disease.

*Source: Excess Winter Mortality in England and Wales, ONS*

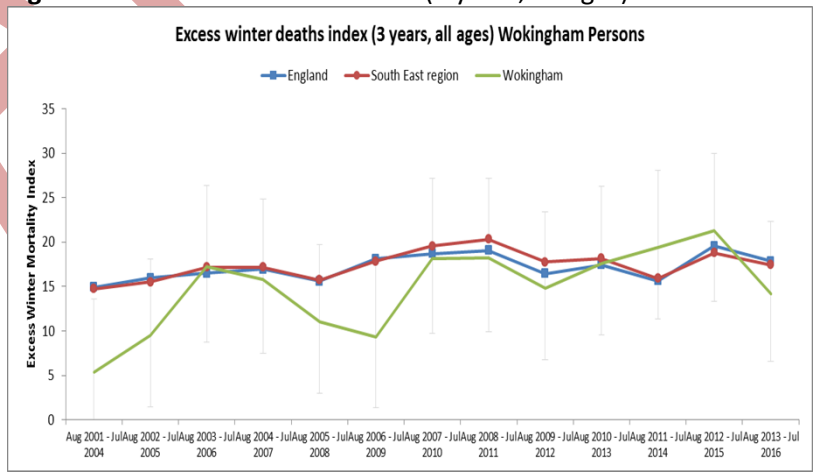
During the winter periods of 2013/14, 2014/15, and 2015/16, there were 159 excess winter deaths amongst people of all ages living in Wokingham. This equates to an Excess Winter Mortality Index of 14%. This is the same as the National average and is the same as the average for the South East Region.

Excess winter mortality is greatest in males in Wokingham. This is different to the National pattern where excess winter mortality is higher in females.

Excess winter mortality is greatest in The all age group when compared to the older 85 plus age group. In Wokingham. This is different to the national pattern where excess winter mortality is higher in the older age group aged 85 plus when compared to the all age group.

*Source: Public Health Outcomes Framework*

**Figure:** Excess winter deaths index (3 years, all ages)




*Source: Public Health Outcomes Framework*

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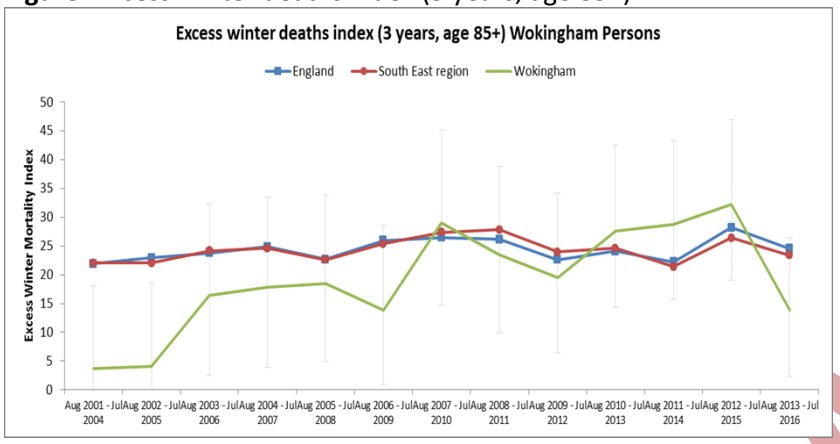
**Figure:** Excess winter deaths index (3 years, age 85+)




*Source: Public Health Outcomes Framework*

# 4. Keeping well

The Adult Social Care Outcomes Framework (ASCOF) states a key objective is to put service users in control of their care and support by ensuring that support more closes matches their individual needs and wishes. The ASCOF includes a measure of the proportion of service users who report having control over their daily lives as a measure of this outcome.

In England in 2016/17 75% of adults aged 65 and over report having control over their daily life. This is significantly lower than the proportion of services users age 18-64 reporting having control over their daily life (83%).

In 2016/17 43% of adults aged 65 an over report having as much social contact as they would like. This is significantly lower than the proportion of service users aged 18-64 reporting having as much social contact as they would like (49%).

The ASCOF states that avoiding permanent placements in residential and nursing homes is a good measure of delaying dependency. In England in 2016/17 there were 611 admissions per 100,000 population aged 65 and over. The number of admissions has fallen year on year since 2014/15

Reablement seeks to support people and maximise their levels of independent, in order to minimise their need for ongoing support and dependence on public services. The proportion of older people (age 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services is used to measure the benefit to individuals from reablement, intermediate care and rehabilitation.

In 2016/17 2.7% of all over 65s discharged from hospital reported having received reablement/rehabilitation services after discharge from hospital. 82.5% of older people were reported as still being at home 91 days after discharge from hospital into reablement/rehabilitation services. This is a slight drop from 82.7% in 2015/16. The proportion of people receiving reablement/rehabilitation services after discharge increase with age in 2016/17.

During 2016/17, 76.7% of Wokingham service users aged 65 and over reported that they felt that they had control over their daily life. This can be compared against the average for England of 74.7%. People aged 65 and over are less likely to feel in control over their daily lives than people aged 18 to 64.

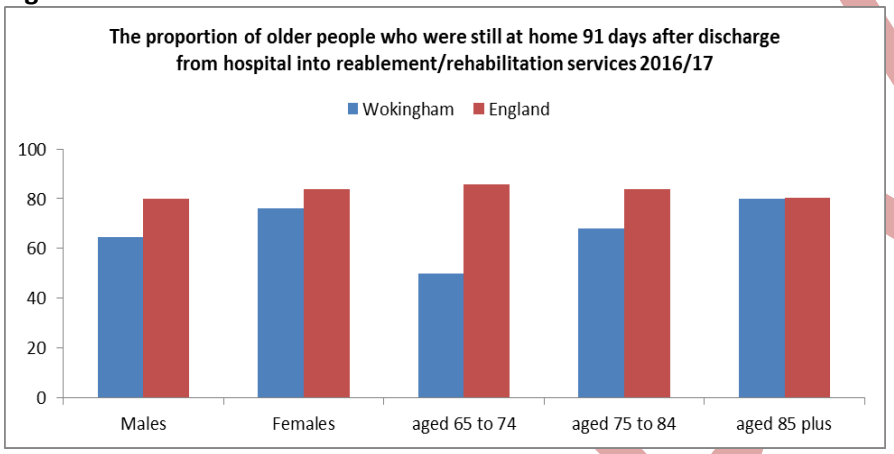
During 2016/17, 47.8% of Wokingham service users aged 65 and over reported that they felt that they had as much social contact as they would

like. This can be compared against the average for England of 43.2%. People aged 65 and over are less likely to feel that they have as much social contact as they would like than people aged 18 to 64.

During 2016/17, 72.7% of older people resident in Wokingham were still at home 91 days after discharge from hospital into reablement/rehabilitation services. This can be compared against the average for England of 82.5%.

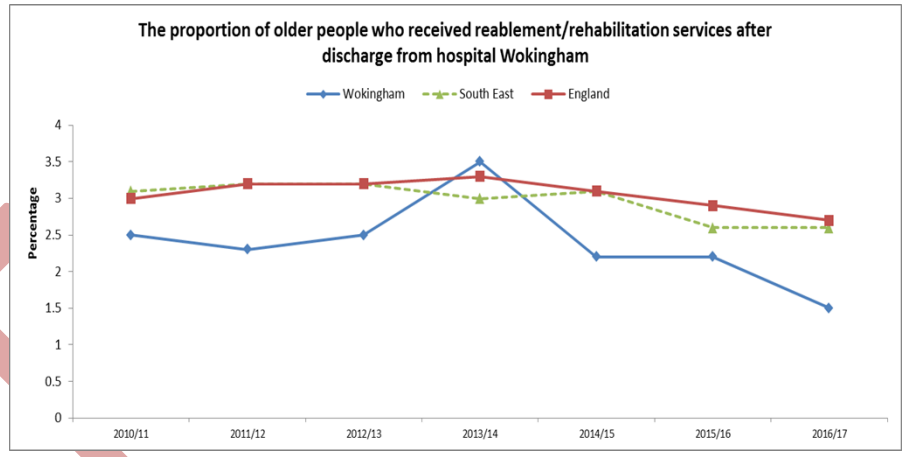
Breakdowns by gender and age group can be seen in the chart below compared to the values for England.

**Figure X:**



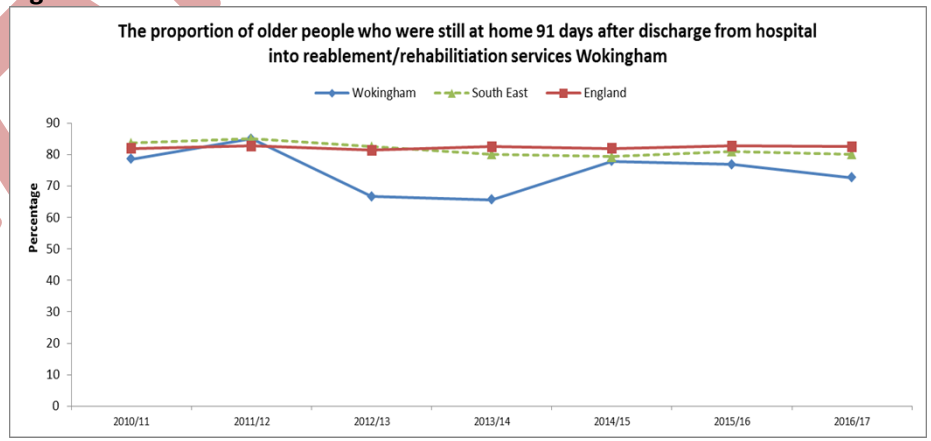

*Source: [Measures from the Adult Social Care Outcomes Framework, NHS Digital]*

**Figure X:**




*Source:*

**Figure X:**




*Source:*

**Figure X:**

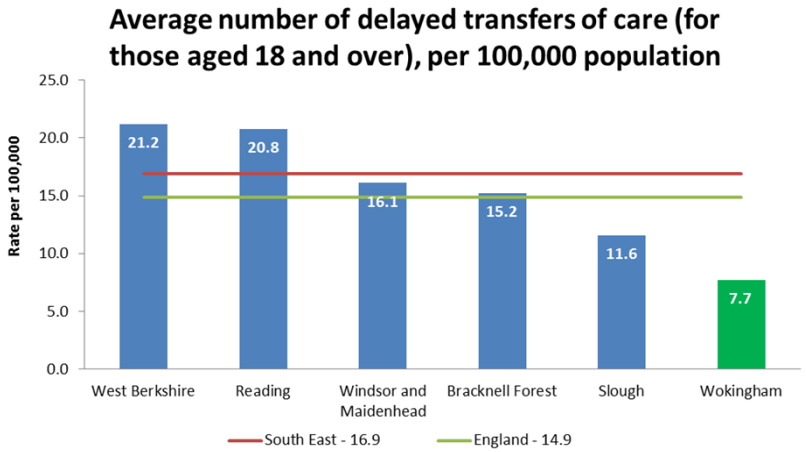
## 4.1 Delayed transfers of care

Delayed transfers of care from hospital, per 100,000

Average number of delayed transfers of care on a particular day taken over the year (aged 18 and over) - this is the average of the 12 monthly snapshots collected in the monthly Situation Report (SitRep).

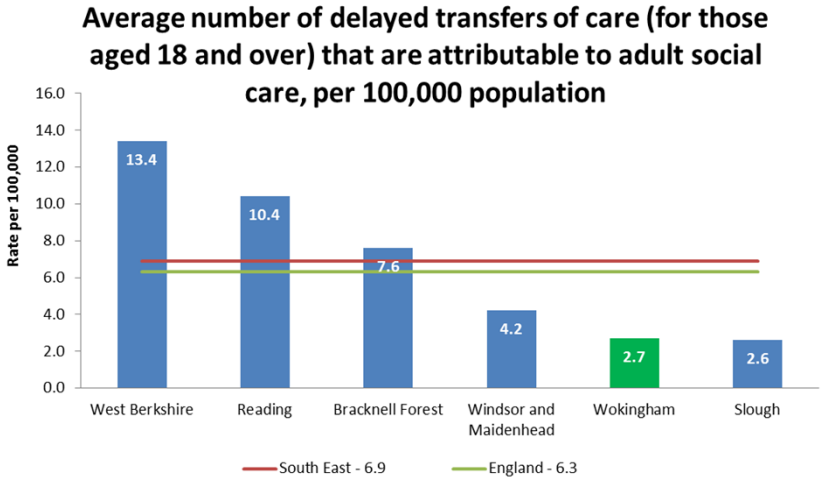
Average number of delayed transfers of care on a particular day taken over the year that are attributable to social care or jointly to social care and the NHS (aged 18 and over) - this is the average of the 12 monthly snapshots.

**Figure X:** Delayed transfers of care




*Source: ASCOF 2016/17*

**Figure X:** Delayed transfers of care that are attributable to social care




*Source: ASCOF 2016/17*

Look at ASCOF for further information

Add a section with performance of key local services for the elderly population including sports and leisure and social care.

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# People and Places 2017/18

Public Health Intelligence

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# 1. Key messages

- Licensing
- Environment
- Road safety
- Transport
- LDs
- Suicide and self-harm
- Domestic abuse
- Adult safeguarding
- Offenders
- Armed forces, their families and veterans
- Gypsy, Roma and Travelers
- LGBT

# 2. Introduction

To add

# 3. Wider Determinants of Health

# 3.1 Employment & income

# 3.2 Crime & Disorder

# 3.3 Environment (parks & open spaces, leisure, food safety)

## Environmental Health

### Introduction

Since 2012, Wokingham and West Berkshire Councils work jointly to deliver environmental health and licensing services across both local authority areas. Commercial team

## Air Quality

### Introduction

Air quality is associated with a number of adverse health impacts. It is recognised as a contributing factor in the onset of heart disease and cancer. Air pollution particularly affects the most vulnerable groups in society; for example children and older people and those with limiting health conditions.

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## Context & policy

Levels of air pollution in the UK remain well above the European Union targets. The government estimates that meeting targest for the pollutant nitrogen dioxide will not be achieved until 2026. Need to explain what these targets are. The Governments current air quality plan focusses primarily on transport; since road transport contributes around 80% of nitrogen oxides emissions causing the UK to exceed it legal limits.

The Department for Environment, Food and Rural Affairs (DEFRA) publish national air quality objectives for the UK. The joint Environmental Health Team produce annual reports to monitor and assess quality across West Berkshire and Wokingham.

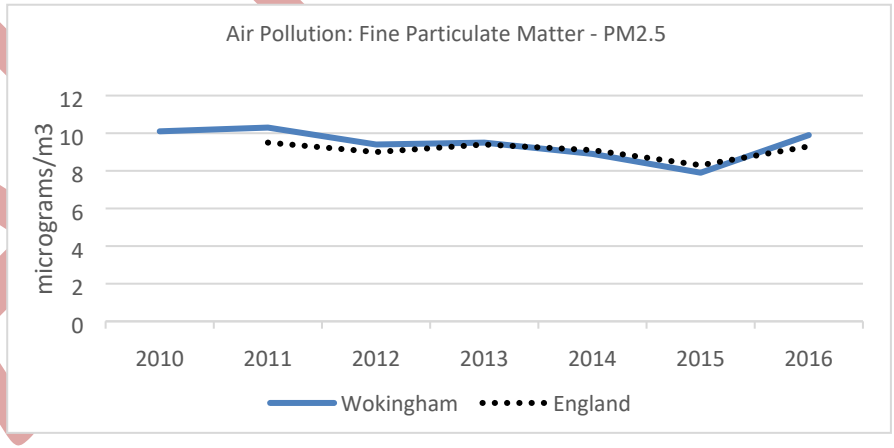
## The Wokingham Picture

The majority of Wokingham borough has good air quality however, like most areas, there are a few hotspots where levels are worse than the recommended government guidelines. 2017 Air Quality Annual Status Report identifies road transport to be a major source of air quality pollutants in Wokingham borough and in particular the contribution from the M4 has been identified as significant.

The report highlights nitrogen dioxide ($NO_2$) as the main pollutant in the borough and identifies three Air Quality Management Areas (AQMAs) which exceed the national average objectives for $NO_2$ levels. These areas are: 1) Wokingham Town Centre, 2) Twyford Crossroads and 3) an area encompassing properties along the M4 and along part of the A329 where it passes under the M4. Larger quantities of $NO_2$ are commonly found in areas where there is traffic congestion and Wokingham borough's road network serves one of the highest car ownership ratios in the UK as well as having major strategic routes such as A329M and M4.

## Facts & Figures

Levels of air pollution in Wokingham borough, (measuring particulate matter PM2.5) appear to be similar to others in the South East region and are slightly higher than the national average.




## Inequalities

Three AQMAs identified in Wokingham borough where there are high levels of $NO_2$.

## Recommendations

Wokingham Borough Council are formulating Air Quality Action Plans to address air quality and involve local people in how to shape it. Have we got air quality action plans in place and are implementing these? Add reference to Council tackling traffic congestion, developing greenways etc – green routes for getting to school or work & for leisure time.

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# 3.4 Parks & Open Spaces

## Introduction

## Context & policy

## The Wokingham Picture

Wokingham Borough Council Countryside Services look after 381 hectares of countryside sites that includes 217 hectares of country parks, 105 hectares of nature reserves and 59 hectares of Suitable Alternative Natural Greenspaces (SANGs).

## Facts & Figures

## Inequalities

## Recommendations

# 3.5 Homelessness & Housing Need

## Introduction

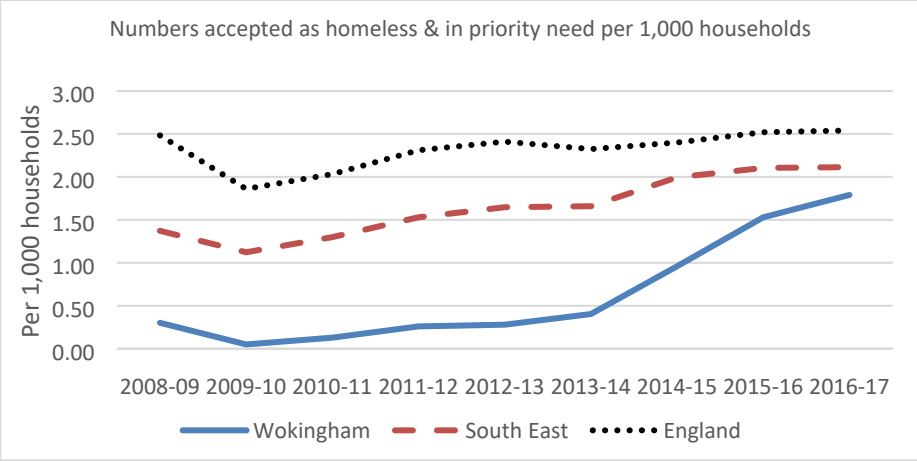
Some info already covered around housing register figures in the demographics profile of JSNA –don't want to duplicate.

## Context & policy

## The Wokingham Picture

## Facts & Figures

Despite the number of households in Wokingham borough remaining below the regional and national average, there has an increase in the numbers accepted as homeless & in priority need year on year. In particular the rate of increase within Wokingham has been higher than national trends since 2014/15 despite overall figures remaining low.

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The majority of households who are placed in temporary accommodation are housed in bed & breakfast in the borough. The proportion of households placed in temporary accommodation is much lower per 1,000 households than the rates across England. *Where are households generally placed if not in temporary accommodation – review & discuss with Jude Whyte & her team if possible.*

## Inequalities

In 2015/16, Wokingham had 23% of supported working adults with learning disabilities living in unsettled accommodation; in-line with regional trends however above the national average. However improvements have been made in recent years with 78% of adults with a learning disability living in stable & appropriate accommodation in 2016/17; which is better than both regional & national average.

## Recommendations

# 3.6 Road Safety

## Introduction

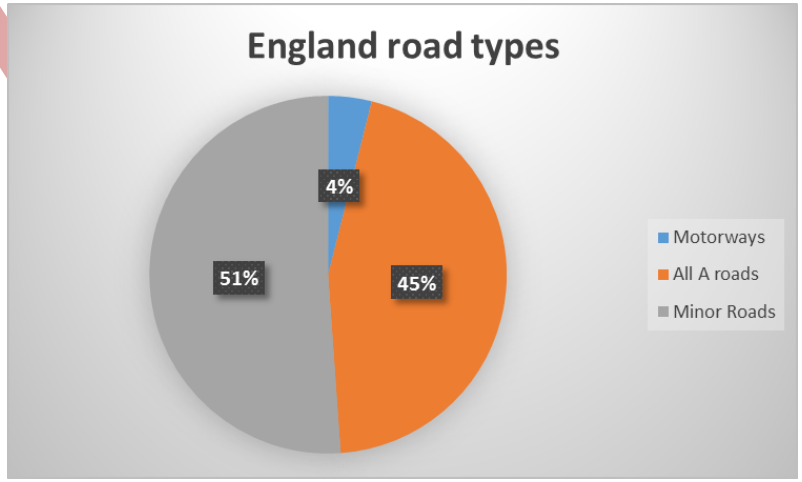
Road safety methods and measures are crucial to reducing the likelihood of road accidents and to avoid the risk of road users getting seriously injured or killed. The United Kingdom on the whole has one of the best road safety records in the world and has some of the lowest incident rates in the EU. Never the less, even though the U.K and Wokingham have seen drops in the amount of road traffic casualties over the last decade, there are still to many traffic casualties, indicating more could still be done to reduce the figures.

## Context & policy

In 2016, there were 1,792 fatalities, 24,101 seriously injured and 155,491 slightly injured on Britian's roads. The numbe rof fatlities represents 0.3% of all deatsh in the U.K 2016 saw a 44% reduction in the number of fatilities that occurred across England compared with levels in 2006. Similarly casualties have reduced by around 30% in the last ten years across England.

The highest proportion of fatalities were in cars, at 46%, with pedestrians making up 25%, motorbike users 18% and cyclists 6%. Of those travelling by car killed, 68% were drivers and 32% were passengers. 19% of driver deaths were aged 17-24. There was roughly an equal split bewteen male and female for all casualty types. Amongst pedestrians killed, 26% were between th ages of 0-15.

In England, minor roads accounted for 51% of all caulaties reported , whilst all A roads represented 45% and Motorways just 7%.

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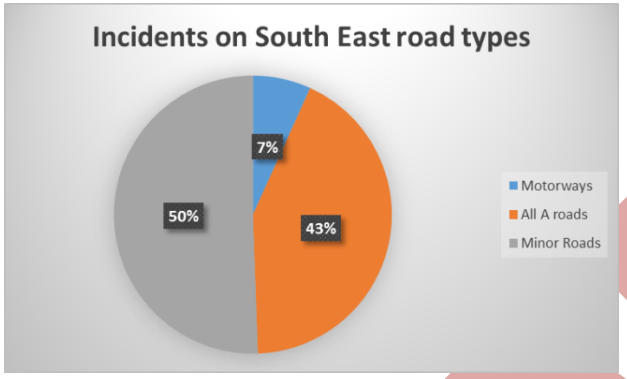
Despite this national trend, in 2016 there was an 18% increase in fatalities occuring in the South East compared to the previous year. The South East had the higehst number of recorded fatalities, at 265. There were 22, 179 incidences recorded overall across the South east, the second highest regional number after Greater London. The South east also recoreded the highest number of serous injuries (3970) and the second higehst number of slight injuries (17,944). 1,530 incidences were recorded on motorways, 9,460 on A roads and 11,216 on minor roads.




## The Wokingham Picture

Wokingham Borough has a wide and varied road network. Our borough has 736 KM of roads and 764 km of roadside footpaths. We have a major national motorway, the M4, of which 8 KM runs through the borough, several major A roads and a large number of B roads and other minor roads. As we are a more urbanized borough (Classed as *Predominately Urban*) our roads are classed as less rural than neighboring authorities such as West Berkshire. As a result, our residents are exposed to more roads than other local authority populations.

Overall, the number of casualties in Wokingham borough has reduced in recent years. However the numbers of residents Killed or Seriously Injured (KSI) has increased over the last ten years; with the number of KSI in 2016 being at it's highest since 2008. Despite this increase in Wokingham, comparing with neighbouring authorities, Wokingham has the third lowest rate of KSI per 100,000 population between 2014-16 and remains well below the South East regional average.

## Facts & Figures

In Wokingham, the total number of casualties (fatal, seriously wounded and slightly wounded) stood at 212 in 2017. This is lower than in any year since 2013. The following table charts the breakdown of casualties from road traffic accidents from 2013-2017:

| **Wokingham** | | | | |
|---|---|---|---|---|
| | **Fatal** | **Serious** | **Slight** | **Total** |
| **2013** | 1 | 49 | 200 | 250 |
| **2014** | 3 | 44 | 219 | 266 |
| **2015** | 1 | 47 | 226 | 274 |
| **2016** | 3 | 39 | 204 | 246 |
| **2017** | 4 | 39 | 169 | 212 |
| **Total** | 12 | 208 | 1018 | 1238 |

(WBC Highways and transport teams)

We compare favorably to our neighboring authorities. Wokingham recorded the lowest number of total casualties in any Berkshire authority, aside from Bracknell Forest:

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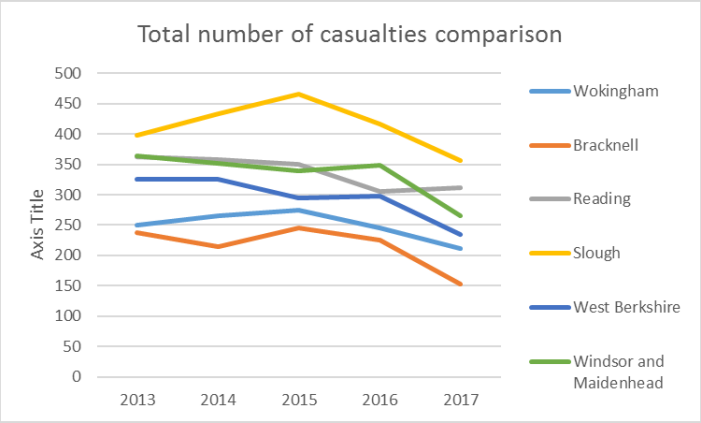
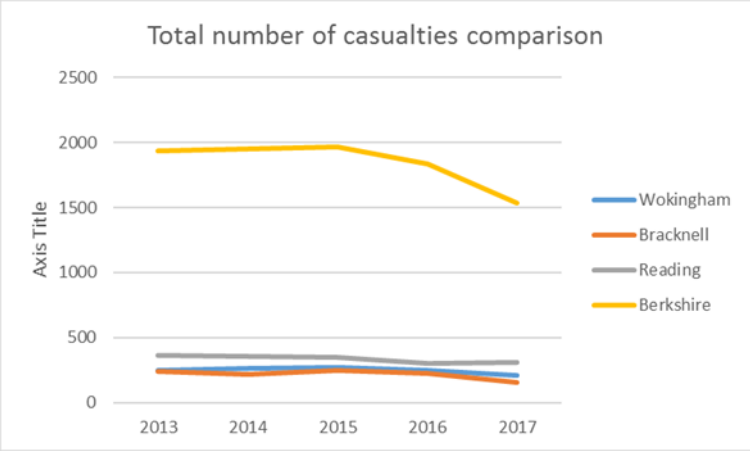


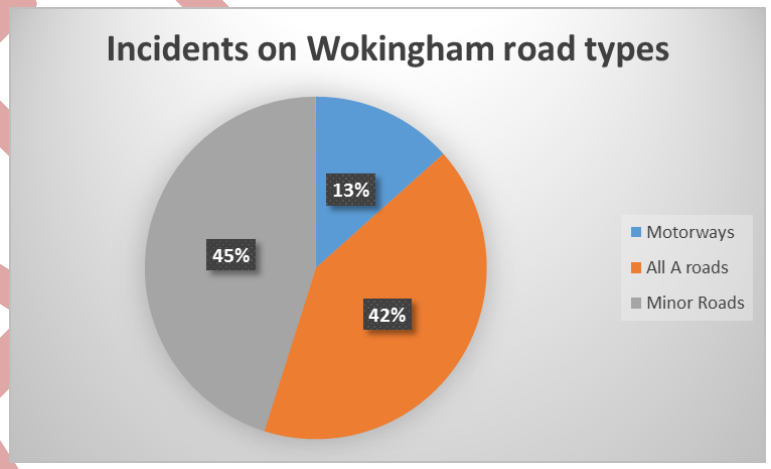

(WBC Highways and Transport teams)

The trend seen in Wokingham for a decline in road traffic casualties since 2013 has been repeated across Berkshire, with a decline in casualties recorded in each year from 2015-2017.




(WBC Highways and Transport teams)

In 2016, of the 246 incidences reported on Wokingham roads, 33 occurred on motorways, 102 on all A roads and 111 on Minor roads. This data shows that Wokingham recorded a higher number of road traffic casualties on motorways than the SE as a whole, likely due to the presence of the M4 running directly through the borough.




The highest proportion of casualties between 2012-2016 were reported in the Middle Super Output Area Wokingham 017; which covers Shinfield South and Swallowfield wards.

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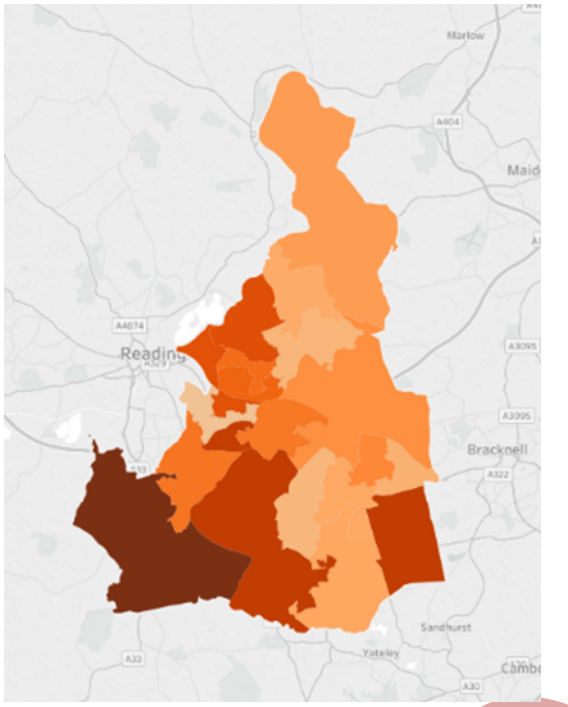


## Inequalities

Younger pedestrians remain more at risk than older pedestrians. Teaching young children about road safety remains a key road safety strategy.
Cyclists face higher risks than ordinary car users: a greater emphasis

http://www.saferroads.org/

## Recommendations

The My Journey Programme, currently run by WBC Highways and Transport team, has been focusing in recent years….

# 3.7 Transport

## Introduction

## Context & policy

Local Transport Plan setting out the long-term transport strategy for the borough; particularly for the four new communities being created to accommodate the majority of the construction of over 13,000 new homes in the borough as identified in the Local Development Framework Core Strategy.

## The Wokingham Picture

## Facts & Figures

## Inequalities

## Recommendations

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# 4. Vulnerable groups

## 4.1 Adults with learning disabilities

Report for Darrell– Thursday 3rd May

PANSI

MOSAIC0331

## 4.2 Suicide and self-harm

### Introduction

Suicide is defined as the act of ending one's own life intentionally. Suicide is a major issue for society and a leading cause of years of life lost. Suicide is a devastating event. It is an individual tragedy, a life-altering crisis for those bereaved, and a traumatic event for communities and services. The impacts are immediately and profoundly distressing.

Self-harm is when somebody intentionally damages or injures their body. It's usually a way of coping with or expressing overwhelming emotional distress.

Whilst around 50% of people who commit suicide have a history of self-harming and non-fatal self-harm is the strongest risk factor in subsequent suicide, the vast majority of people who self-harm are not trying to kill themselves (Samaritans, NHS choices). It is therefore important to understand the various reasons why people may want to self-harm.

### Context & policy

In 2015, over 6,000 people committed suicide in the U.K. Over three quarters of those were men. The most common age bracket was the 40-44, although suicides occurred at all ages, minus the very young. It is notable that suicide is the most common cause of death in Men under the age of 35. For many years, Female suicide rates have been decreasing at a quicker pace than male suicide rates. The suicide rate stood at 10.9 per 100,000 of the population. The south east had one the third lowest suicide rate, at 9.7 per 100,000. There is a clear link between suicide and mental health disorders with 90% of suicides and suicide attempts being associated with a psychiatric disorder.

Nationally the U.K has one of the highest self-harm rates in Europe, with over 400 in 100,000 people self-harming, however this is likely to be an underestimate as many people who self-harm do not report it. The Majority of people who report self-harm are between the ages of 11-25 and that 13% of young people are believed to attempt to self-harm themselves between the ages of 11-16 (*self-harm UK*). In 2014-2015 the number of hospital admissions for self-harm in the U.K stood at 112,096, split between 69,800 female admissions and 43,282 male admissions (*NHS digital*). The highest rates of self-harm were reported by women aged 16-24. Risk factors include employment status, especially the economically inactive amongst working age adults and living alone.

Samaritans In their 2017 report urged the focus to be on local suicide prevention strategies, in particular focusing on suicide prevention and targeting areas with high levels of socio-economic deprivation. They call for raising greater awareness of the issue and for multi-authority and agency linking of their work (*Samaritans*).

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In 2012 the government published its Suicide prevention Strategy, which aimed to focus on reducing the risk of suicide in high risk groups, tailoring approaches to mental health in specific groups, reduce means of access to suicide and providing a better approach to bereavement *(Suicide prevention strategy).* It urges for more joined up working between mental health, public health and adult social care and, in particular, urges a focus on suicide prevention at the local level. The 2017 update of the plan has called for a 10% reduction in the suicide rate across England by the year 2020-2021. The strategy is increasing its focus on bereavement, on self-harm and the male populace. By the end of 2016 95% of local authorities had plans in place to tackle suicide prevention *(Preventing suicide in England, Third progress report).*

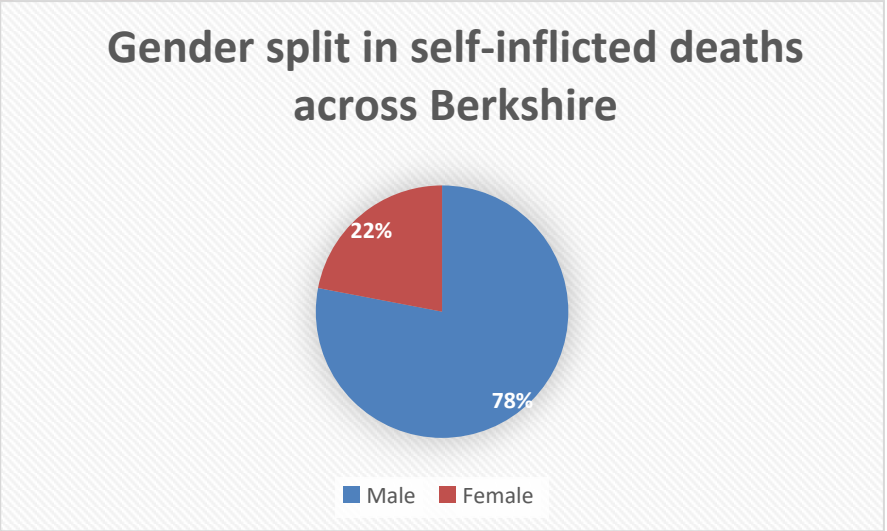
In Berkshire, the 2017-2020 suicide prevention strategy is a cross authority strategy to tackle suicide across the county. The aim is for a 25% reduction in suicide by 2020-2021, above the government's own target. It recommends achieving this by reducing the risk of suicide in key groups, tailoring approaches to mental health in specific groups, reducing access to means of suicide, proving better support to those bereaved by suicide and helping to forge a more sensitive approach to suicide in the media *(Berkshire Suicide prevention strategy 2017-2020).*

## The Wokingham Picture

The Berkshire suicide audit is carried out every year and provides a picture of the situation in Berkshire's local authorities. It is carried out by the Berkshire wide Public Health England team and Wokingham's Public Health service plays joined dup role with the other Local authorities. The 2016-2018 audit is being compiled at the time of writing and therefore, the data presented in this chapter is not reflective of the current picture but never the less gives an accurate representation of the data over a three year reporting period (2014-2016) which is in line with national best practice.

In 2014-2016, there were 96 deaths that were recorded as suicides as suicides or undetermined by the coroner. 93% of these were residents who were in the borough whilst 7% lived outside of Berkshire.

The gender split was 78% male and 22% female for the whole of Berkshire. This was reflective of the national picture. Across Berkshire, the most common age brackets were 40-49 and 50-59. The most common ethnicity reflected in the audits was White British, which was statistically lower than that group's prevalence in Berkshires population as a whole.

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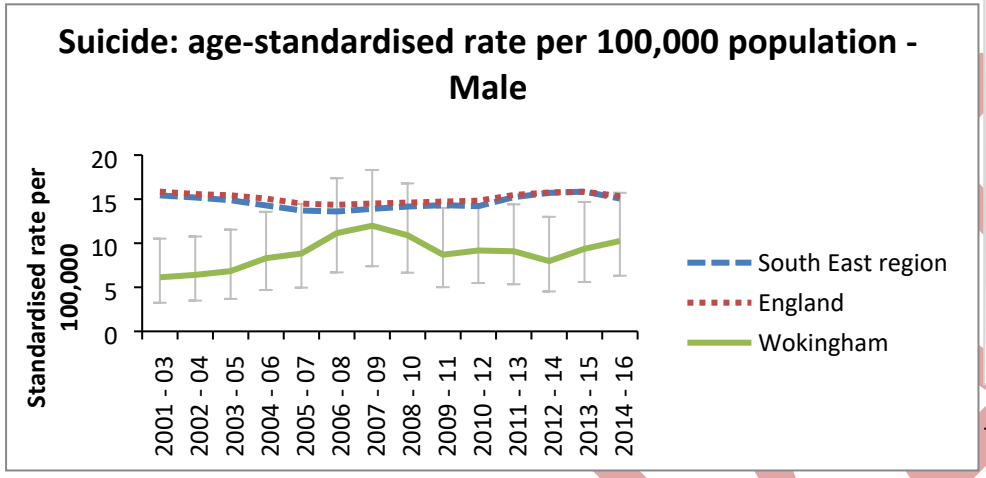
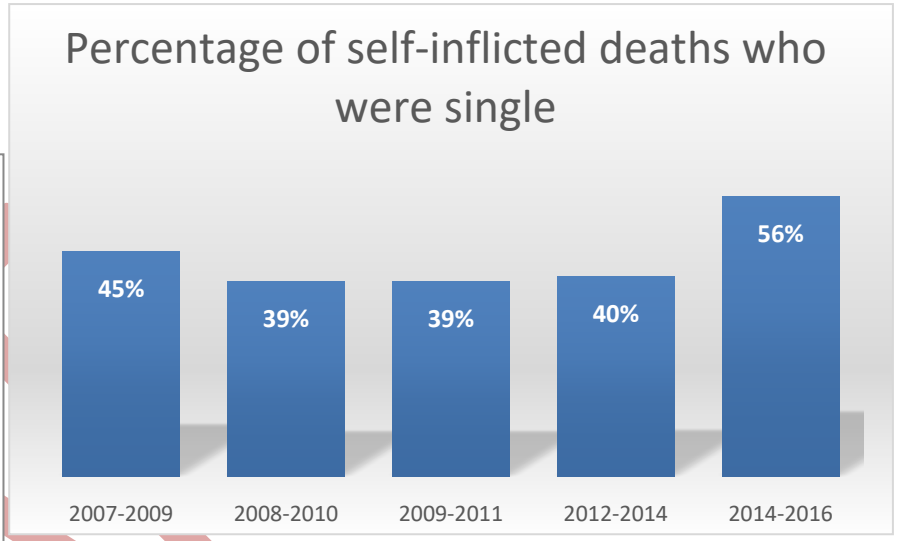
Our rate of male suicide per 100,000 of the population remains below both regional and national level statistics, although there has been a small closing of the gap in recent years.




The data on martial and living status amongst self-inflicted deaths shows a clear trend towards those living alone and single being particularly at risk. In 2014-2016, 56% of all reported suicides were from people whose martial status was single, by far the highest demographic. This was also the highest it had been for several years.




The same is also true for those living alone, where 28% of all deaths in 2014-2016 were from this demographic, once again the highest, but not by so much of a wide margin. Again, however, this was a clear trend across all years observed.

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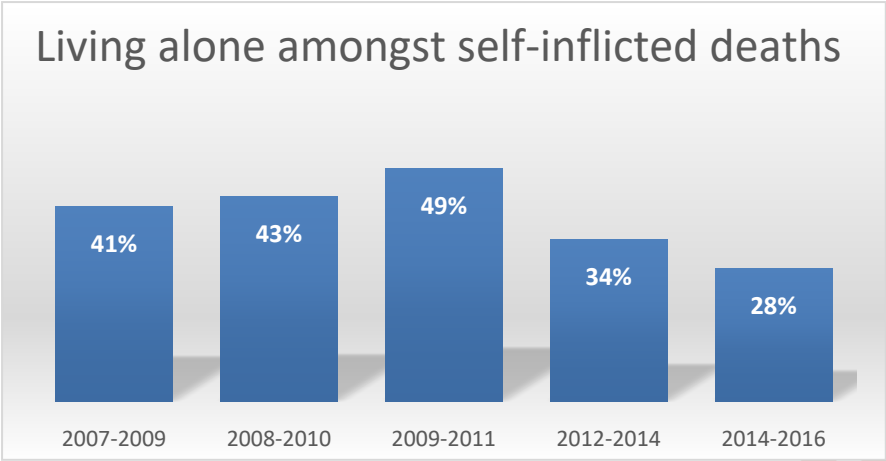
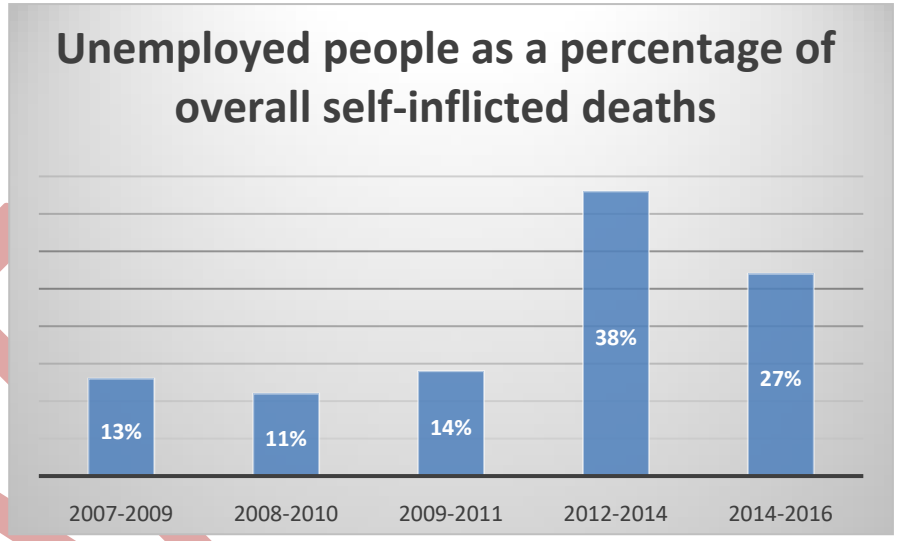



The economic status of those who commit suicide shows that those who are unemployed are much more at risk of suicide than other groups. Across the whole of Berkshire, 27% of those who committed suicide were unemployed. This is notable as unemployment was between 4-5% in this period. This is also a notable increase from previous years.




Amongst Berkshire authorities, whilst 45% of self-inflicted deaths from slough were from those who were unemployed, for Wokingham the figure was 15%. Factors for this will include the degree of employment status amongst each LA's population.

Finally, the deprivation status of resident deaths deserves attention. Across the whole of Berkshire, there was no clear trend as to the deprivation that was most common amongst self-inflicted deaths. Most deaths recorded fell between the 4th-7th least deprived deciles. This is perhaps higher than would be expected judged against the national picture.

Broken down by Local authority, Wokingham had a self-inflicted death rate of 7.3% per 100,000 of the population. This was the second lowest in

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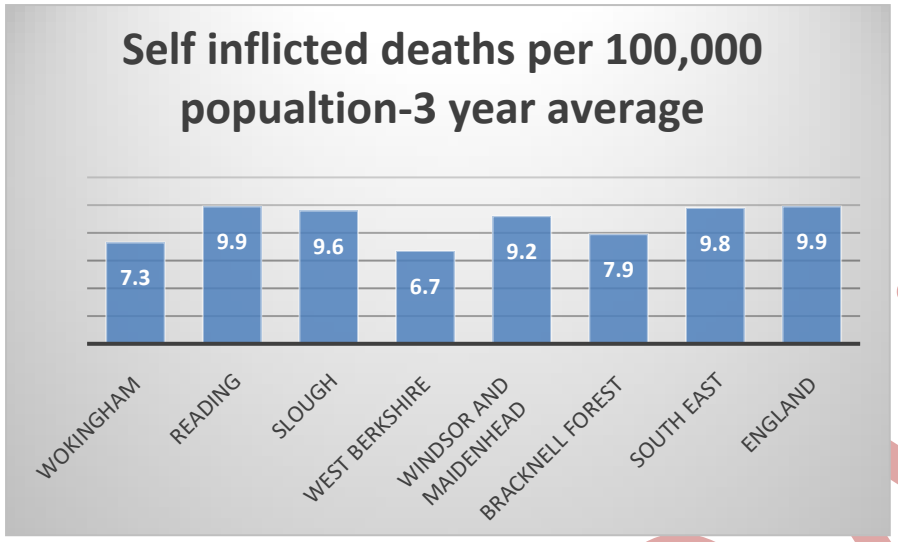
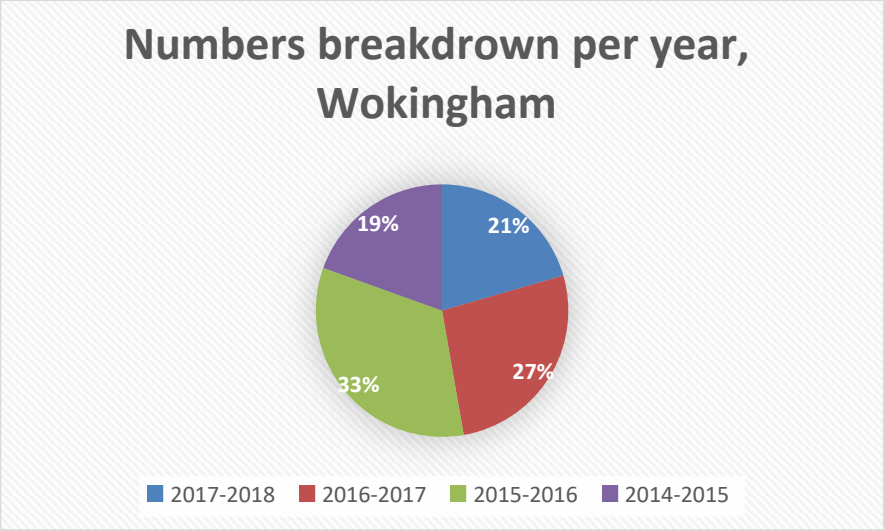



Berkshire and below the regional and national figures.

Self-harm:

The Royal Berkshire NHS Foundation Trust collects statistics on the number of incidences of self-harm that A & E records. This data is to be treated with some caution as it 1. Does not capture data accurately from all 6 Berkshire LA's and 2. Does not capture data for self-haring which is not reported, which is an issue with the national picture as well. Never the less, the data from RBNHSFT provided gives us a good idea of the picture in Wokingham.

Between 2014-2018 the number of incidences across all Berkshire was 2817 across 2014-2018.




On a yearly basis, the year 2015-2016 accounts for a third of Wokingham's total admissions, a sharp increase from 2014-2015, which

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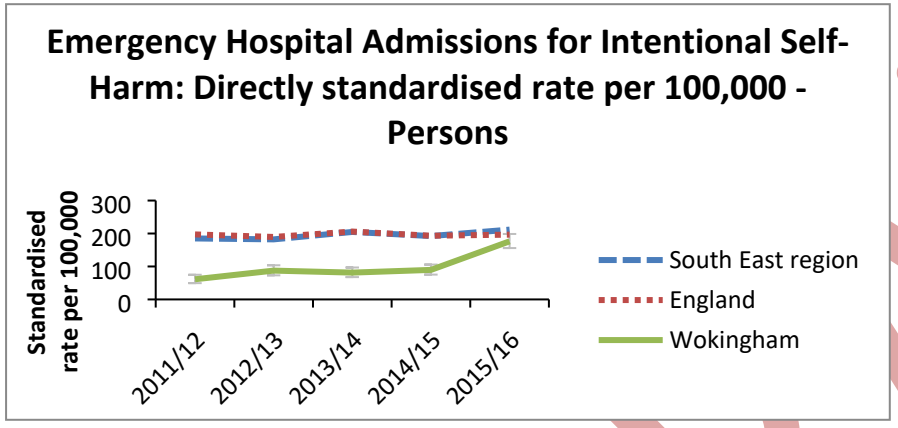
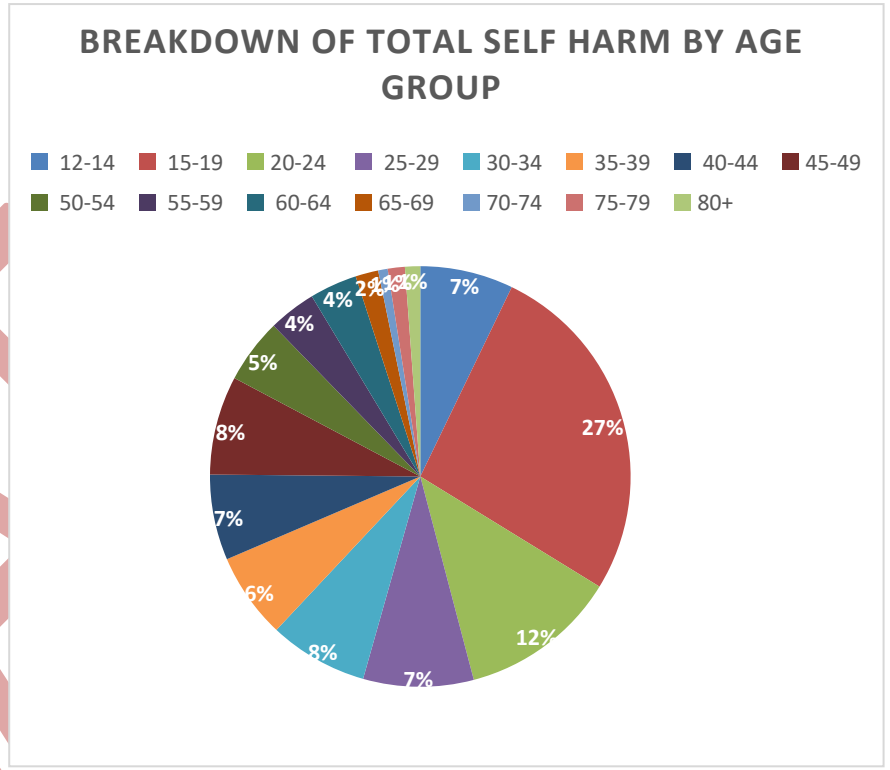
then slowly declines over the subsequent two years. This trend is repeated across all of Berkshire:

Wokingham's standardized rate of admissions per 100,000 of the population came to 176 per 100,000 of the population.




This rate has been statistically better than the regional and national picture, although in the 2015-2016 year there was a notable closing of the gap.

The age distribution of admissions deserves close attention. In Wokingham, the range of ages of those admitted to A & E was from 12-89. The median age was 26, whilst the mode was 15. Nearly half of all self-harming was reported in people under the age of 25. There is a notable spike in incidences from age 15-19 and a slow decline thereafter.




Taken as a whole, people aged 12-19 accounted for a third of all admissions.

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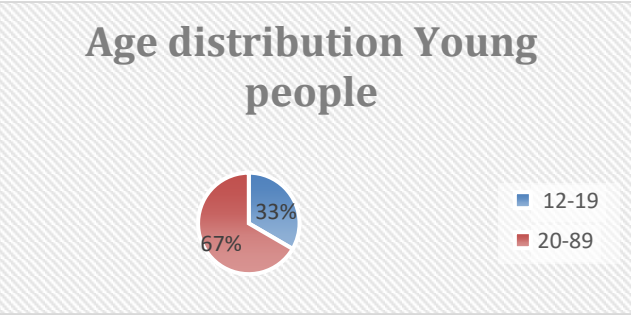
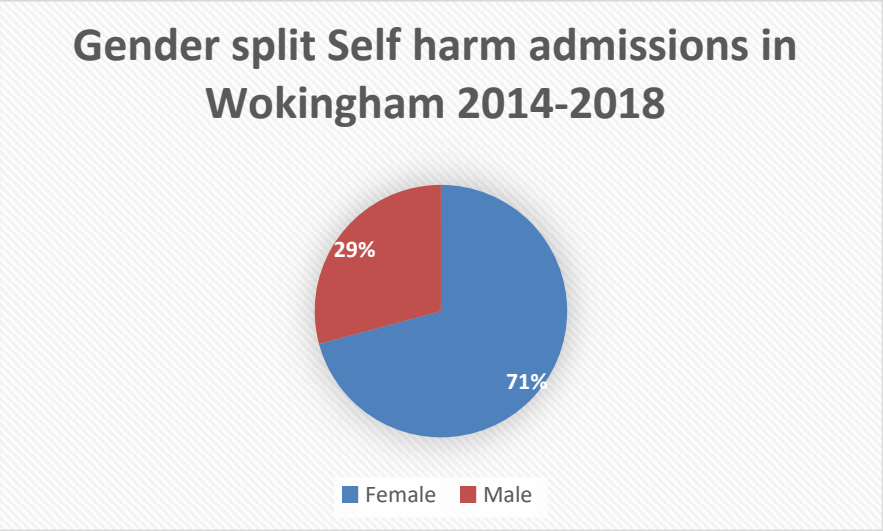
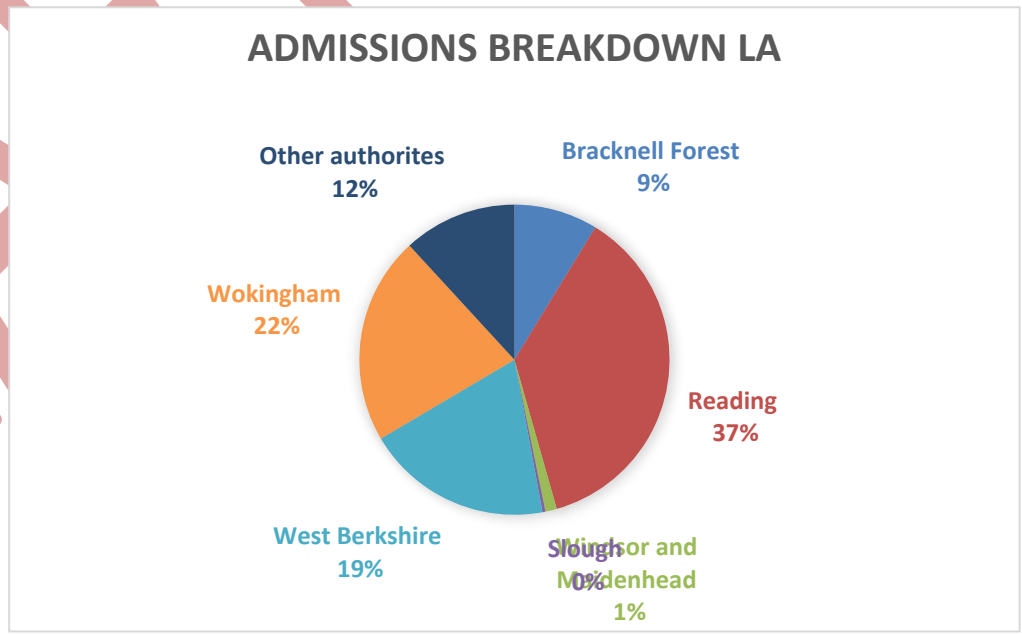



By far the most common ethnic group reported was white British. This correlates to the proportion of this demographic in the Borough.

Much like the figures for suicide, self-harm shows a clear gender bias, only this time towards women. In Wokingham, 71% of all admissions were reported to be female.




Comparison with the other Berkshire authorities is difficult, as the RBNHSFT is the only trust which has provided data. As such, the boroughs of West Berkshire, reading and Wokingham are disproportionately represented in the data provided, despite similar population levels between all boroughs. As a result, a meaningful comparison of Wokingham's overall position in relation to the local area is not present, but the data is presented below which gives a good indication.




## Inequalities

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The statistics show, similar to the national picture, that men, particularly younger men, are more at risk if suicide than any other demographic.

Amongst employment status however, the Berkshire and Wokingham picture correlates to the national picture-those who are unemployed are more at risk of suicide than other employment groups. The two other risk factors present are living alone and long term single.

Similarly, self-harm is significantly more prevalent amongst the younger demographic, particularly late teens, and young teenage girls in particular. The amount of young people in relation to all other ages shows a clear trend and a need to link self-harm prevention with young people's mental health strategy.

## Recommendations

In regards to suicide, the emphasis should be focused on suicide prevention, in particular focusing on outreach to those groups who display the clearest risk factors. Additional help should be given to tackling loneliness and long term unemployment amongst the male population.

The other area that the council can focus resources on is towards services for bereaved families who have lost a loved one to suicide. This would help to raise awareness amongst the population of suicide, the warning signs and how to help and also help promote a more honest discussion around suicide to remove the taboo that still exists around it including and reducing stigma. Both of these recommendations are in line with both Samaritans and central government recommendations to local authorities.

In regards to self-harm, more outreach in schools and in youth and community centers to the late teenage demographic is the most effective way to raise awareness and, again, reduce the stigma and taboo around this subject. A focus most be looking at the causes of why people self-harm and linking it to a wider young person's mental health strategy. Hawing an outreach service would also help sufferers to talk about their feelings which lead to self-harm. An educational approach towards raising awareness should be implemented.

## 4.3 Domestic abuse

Domestic abuse is defined as

Any incident or pattern of incidents of controlling, coercive, threatening behaviours, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to

- Psychological
- Physical
- Sexual
- Financial
- Emotional

Controlling behaviour is a range if acts designed to make person subordinate and or dependant by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

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Coercive behaviour is an act or pattern of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim.

The government is currently running a consultation to set out how it will respond to domestic abuse moving forward. Within this consultation they are proposing to adjust the definition of domestic abuse. The full details of the consultation including the proposed new definition can be found here – https://consult.justice.gov.uk/homeoffice-moj/domestic-abuse-consultation/supporting_documents/Transforming%20the%20response%20to%20domestic%20abuse.pdf

The British Crime Survey (BCS) self-completion module on intimate violence found that 7 percent of women and 5 percent of men were estimated to have experienced domestic abuse in the last year. This is equivalent to an estimated 1.2 million females and 800,000 male victims. In addition to this women's aid estimate that two women are killed each week by their partner or ex partner (2011).

The BCS (2011) also looked into the nature of the abuse and found that around a quarter (27 percent ) of partner abuse victims suffers a physical injury as a result of the abuse. Among those who had experienced any physical injury or other effects (such as emotional problems) around a quarter (28 percent) received some sort of medical attention. When domestic violence is happening not all people take themselves out of the situation, and when asked for the reasons why they did not leave shared accommodation, 38 percent mentioned the presence of children as the reason, 34 percent stated love or feelings for their partner and 21 percent stated that they had nowhere to go. Domestic abuse is not exclusive to women and the British Crime Survey (2016/17) – Focus in violent crime and sexual offences, found that 15% of men aged 16-59 had experience some form of domestic abuse since the age of 16, this is equivalent to 2.4 million male victims.

NICE guidance has identified some of the risk factors associated with domestic violence, these include

- Is female
- Is aged 16-24 (women) or 16-19 (men) (Smith et al. 2011)
- Has a long-term illness or disability ( this has been shown to almost double the risk) (Smith et al. 2011)
- Has a mental health problem ( Trevillion et al. 2012)
- Is a woman who is separated ( Smith et al. 2011)
- Is pregnant or has recently given birth ( Bowen et al 2005 and Harry Kissoon et al 2002)
- Are lesbian, gay, bisexual or transgender (Roch et al 2010) (Donovan et al. 2006)
- Have a alcohol or drug misuse problem (Smith at al. 2012)

## Facts and figures

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For more details read our domestic abuse facts and figures (PDF document.)

**What do we do?**

In Wokingham the Domestic Abuse Strategy was updated in 2016. Wokingham's vision is the following,

'Wokingham Borough is committed to parity and equality between all aspects of life; mental and physical health, women and men, girls and boys and differing economic social cohorts. Domestic abuse and violence in all of its forms is not tolerated under any circumstance, and residents have the right to live their life free of abuse and violence. The Borough will offer support to anyone who needs it, tailoring that support to put the individual at the centre and ensuring that their wishes are respected at all times.'

The strategy sets out three themes, Prevention, Provision and Risk Reduction. These three themes and what they focus on are described below.

- **Prevention -** Increase understanding of professionals, work with schools and early education settings, and the wider community and broaden promotional campaigns to help prevent domestic abuse from happening in the first place.
- **Provision** – Ensuring those living with domestic abuse and/or violence have a safe and supportive environment enable them to report when abuse is occurring/ is likely to occur.
- **Risk reduction -** Take action to prevent repeat abuse, this includes working with perpetrators.

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**National and Local Strategies and strategic drivers/links**

Local

- Domestic abuse strategy 2016-2020

National

- NICE: Domestic violence and abuse: multi-agency working
- Ending violence against women and girls strategy: 2016-2020 https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020



**Facts, figures and trends**

**Data from the Police**

The Thames Valley Police Data from 2017/18 shows that the number of domestic incidents reported to Thames Valley Police, both recordable and non-crime occurrence, have follows the increasing trend from 2015/16. The data shows that recordable crimes have increased by 6% between 2016/17 and 2017/18 and non-crime occurrences have increased by 11% between 2016/17 and 2017/18. This suggests that more residents are reporting the crime to the Police. By increasing resident's reporting of domestic abuse we can as a Borough work to support people quicker, getting them the help they need.

The definition of recordable and non-recordable crimes are as follows;

**A recorded crime** is all offences reported to the Police **minus** any offence that has the below criteria of Crime Related Occurrence or Offence is Cancelled.

**A Non-Crime Occurrence** will be a domestic incident non crime that doesn't have a Home Office statistic code (used to identify crimes when analysing crime data).

**Crime Related Occurrences**: This term is used to describe a record of an occurrence which has come to the attention of the police, which, on the Balance of Probabilities would normally amount to a notifiable crime, but a resultant crime has not been recorded. The specific circumstances where this would happen are:

1) The occurrence is reported by a third party and either
a) The alleged victim declines to confirm the crime or
b) The alleged victim cannot be traced
2) The occurrence is being dealt with by another police force
3) The National Crime Recording Standard or Home Office Counting Rules for Recording Crime direct that a crime should not be recorded

Whilst the increase of reports are positive there has also been an increase in the percentage of repeat reports of domestic abuse to the Police. Currently Wokingham has a repeat rate of 26%. This has increased by 3.1% between 2016/17 and 2017/18. This shows that 26% of reports have previously been a victim in the 12 month period. This has been highlighted locally and further work will be undertaken to explore this further and understand the reasons behind this.

**Data from the commissioned Domestic Abuse Support Service**

The commissioned service is not following the same trend as seen in the police data. This would suggest that the increased reporting to the Police is not leading to an increase in specialist support currently. This could be because the same residents have increased their reporting, we might not be meeting the current demand, or support is being provided through different agencies. Figure 1 shows the pattern of calls to the helpline. There doesn't appear to be a clear trend of when the calls come through and although quarter 4 for 2017/18 isn't available it is estimated that the

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total number of calls will likely remain similar or slightly higher than those in 2016/17.

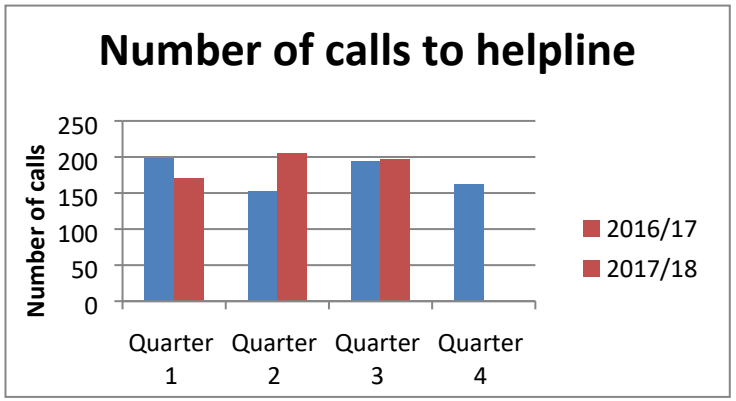


*Figure 1- Number of calls to the helpline (service level data)*

Figure 2 shows the numbers of referrals received for outreach support by our commissioned service. This shows that the number of referrals has dropped in quarter 2 and 3 of 2017/18. It is estimated that the total number of referrals is expected to decrease in 2017/18, however this isn't unexpected. 2016/17 experienced a large irregular spike of referrals in quarter 4 of 2016/17. This is not expected in quarter 4 of 2017/18.

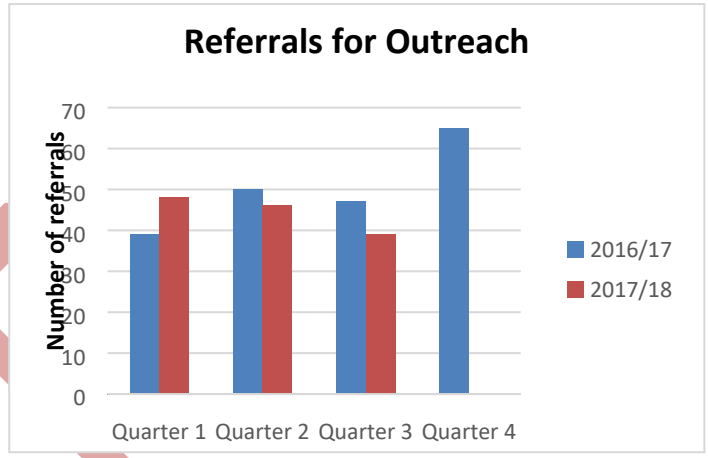


*Figure 2 - Adult referrals for outreach support (service level data)*

Figure 3 shows the number of referrals received by our commissioned service for children and young people support/group work. It is expected that the total numbers in 2017/18 will be similar to those in 2016/17. There has been a spike in referrals for children and young people in quarter 4 in both 2016/17 and 2017/18, and it is estimated that this spike will occur in 2017/18. It could be that this is due to the fact that support is offered mainly in a school setting so children and young people need support before the school breaks for summer in July.

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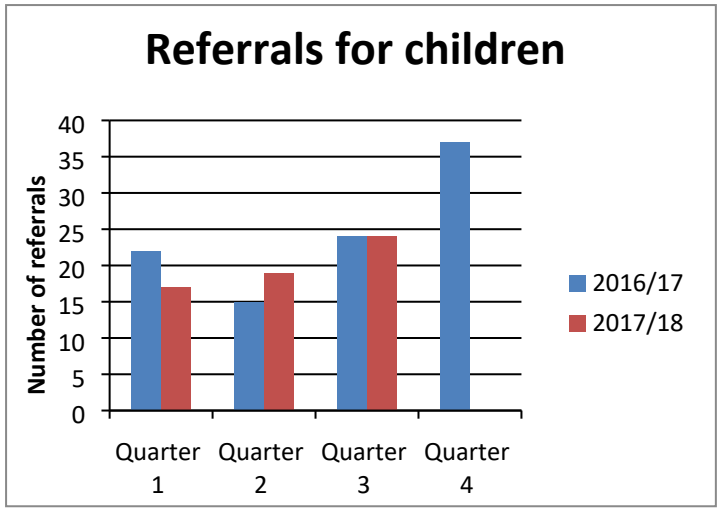


*Figure 3 - Number of referrals for children support/group work (service level data)*

## 4.4 Adult safeguarding

The Care Act 2014 came into effect on 1 April 2015. It reformed the way the adult social care system works in England including how care is delivered. The changes included a range of new obligations for local authorities around the provision of care, and also strengthened the rights and recognition of carers, and provided a legal basis for safeguarding adults from abuse or neglect.

Safeguarding Adults is now a statutory duty. Under Section 42 of the Act, where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

(a) has needs for care and support (whether or not the authority is meeting any of those needs) and

(b) is experiencing, or is at risk of, abuse or neglect and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it,

the local authority must then make whatever enquiries deemed necessary to decide whether any action should be taken and if so, what and by whom.

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There were 109,145 individuals with enquiries under Section 42 of the Care Act that commenced during 2016-17; this represents an increase of 6 per cent on the previous year (102,970). When directly standardised for age and population this shows that 250 adults per 100,000 were involved in Section 42 enquiries during 2016-17, up from 238 per 100,000 in 2015-16.

*Source: NHS Digital: Safeguarding Adults Collection (SAC), Annual Report for England 2016-17, Experimental statistics*

Wokingham had a rate of 411 per 100,000 population aged over 18 of individuals involved in a Section 42 enquiry starting within 2016/17. This is up from 389 per 100,000 population in 2015/16.

The largest number of section 42 enquiries started within the year, by age group, was the 85 and over category (4,351). The lowest number of section 42 enquiries by age group were aged 18-64 (144). This is in line with England and the South East Region.

When looking at the concluded section 42 enquiries within the year by the type of risk, Wokingham's highest risk type was 'Neglect and Acts of Omission' with 330 recorded with this risk, and second highest risk type was 'Psychological Abuse' (125).

Please Note: There can be more than one risk type selected for each concluded Section 42 enquiry, therefore the numbers may be higher than the total concluded.

Source: NHS Digital: Safeguarding Adults Collection (SAC), Annual Report for England 2016-17, Experimental statistics

Safety is fundamental to the wellbeing and independence of people using social care (and others). There are legal requirements about safety in the context of service quality, including CQC's essential standards for registered services. There is a question within the Adult Social Care Survey that is used to determine the measure: 'The proportion of people who use services who feel safe'. This uses the percentage of all those responding who choose the answer "I feel as safe as I want".

For Wokingham this was 67.3% of respondents to the 2015/16 survey. This is similar to England (69.2%) and the South East Region (70.1%).

Another question drawn from the Adult Social Care Survey determines the proportion of people who use services who say that those services have made them feel safe and secure. This is the percentage of respondents who choose "Yes" to the question: "Do care and support services help you in feeling safe?".

78.8% of respondents, from the 2015/16 Adult Social Care Survey, feel the services they use do help them feel safe and secure. This is significantly worse than England (85.4%) and the South East Region (86.1%).

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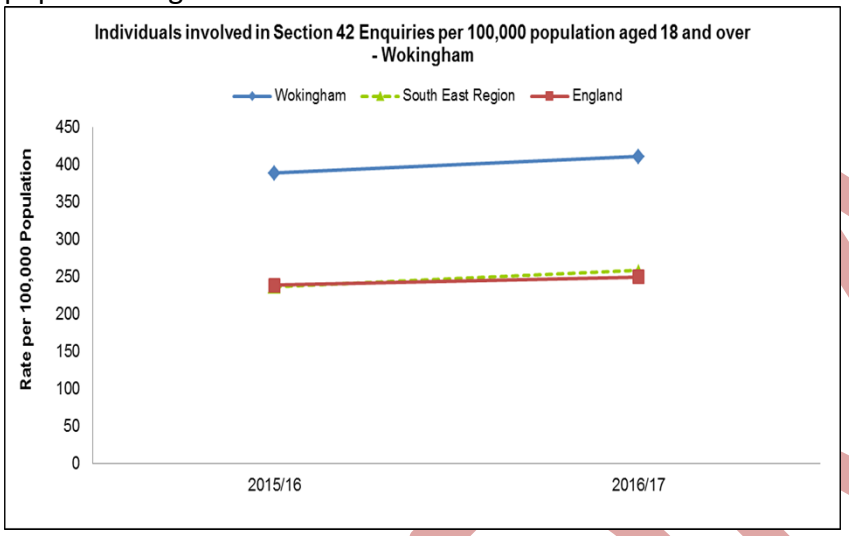
Source: PHE Adult Social Care Profile: Safeguarding Vulnerable Adults

**Figure X:** Individuals involved in Section 42 Enquiries per 100,000 population aged 18 and over




*Source: NHS Digital: Safeguarding Adults Collection (SAC), Annual Report for England 2016-17, Experimental statistics*

# 4.5 Offenders

## Introduction

An individual who is convicted by the criminal justice system as having committed a crime, violated a law or transgressed a code of conduct is referred to as an "offender."

The government estimates that re-offending costs the tax payer £13 Billion a year. Almost half of those who are released from prison go onto re-offend within a year. For those serving shorter sentences the figures are even worse. Offending is therefore a cycle which must be broken to prevent new victims of crime.

This chapter considers the population and health of "offenders" in the Wokingham Borough. Generally offenders are a socially disenfranchised group who are far more likely to have mental illness, learning disability, substance or alcohol misuse, poor educational achievement and unemployment than the general population. All of these factors contribute to first time offences and to offenders going on to re-offending.

## Context & policy

Since 2014 the Probation Service has been split into two organizations: National Probation Service is for high risk violent and sexual offenders including those under Multi-Agency Public Protection Arrangements (MAPPA). There are three categories of offender: Category one covers all sex offenders, category 2 covers all offenders receiving a custodial sentence of 12 months or more for a violent offence and category three covers others wo are deemed a serious risk to public safety.

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The second is the 21 Community Rehabilitation Companies (CRCs). The CRC covering Berkshire is the Thames Valley CRC.

In 2016, there were 267,146 offenders on probation in England and Wales. This was 14% higher than 10 years ago. There were 73,560 releases from prison; this figure is relatively stable from 10 years ago. The rate of re-offenders across England was 25%, which is a slight decrease over the last 5 years. The number of first time offenders was 218.4 per 100,000 in 2016, a decrease from 2015 figures. There were 71,905 offenders who were covered by MAPPA, of which the majority (73%) were Category 1 offenders a rate of 104 per 100,000 of the population.

In 2016, there were around 16,000 young people aged 10-17 receiving their first reprimand, warning or conviction in England and 36,000 being monitored by a youth offending team. This equates to a rate of 3278 new entrants into the youth justice system and the rate of children aged 10-17 in the Youth Justice System in 2016 was 3.2 per 100,000. This showed a continuing decline from the previous 6 years. A majority of these are male rather than female.

In 2013, the government published *'Transforming Rehabilitation: a strategy for reform'* which aimed to recue rates of re-offending, provide a new support system for offenders just released from prison (especially to those who have served under 12 months, of which little support is provided) open up markets to new providers who can tailor their support to specific conditions.

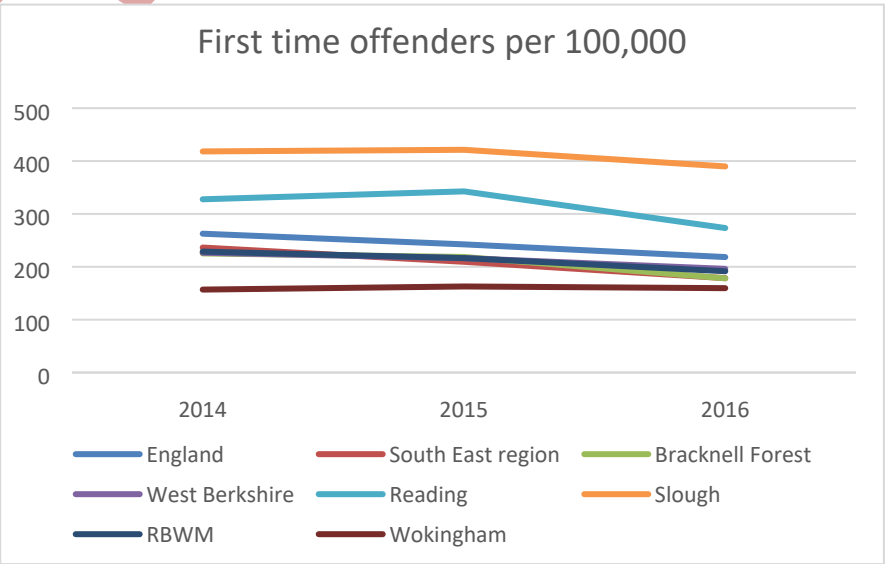
## The Wokingham Picture

In general, the number of offenders and the rate of offenders in Wokingham is low compared to the regional and national picture.

The previous JSNA's findings highlighted that people between the ages of 26-35 are the most likely to be using probation services, that around 19% suffered from a mental illness or learning disability. Those who offended were more likely to have problems related to drugs, alcohol and have poor employment prospects or educational attainment.

In the Thames Valley area in 2016, there were 5,281 offenders on probation, a 20% increase over the previous year, of which there were 1,767 MAPPA-eligible offenders in the Thames Valley. Of these, 82% were Category 1, a rate of 73 per 100,000 of the population.

In Wokingham, the rate of first time offenders per 100,000 of the population stood at 160, a slight decrease from 2015. This compared favorably to the South East's figure of 179 and England at 218. This was also the lowest observed amongst all Berkshire Authorities.

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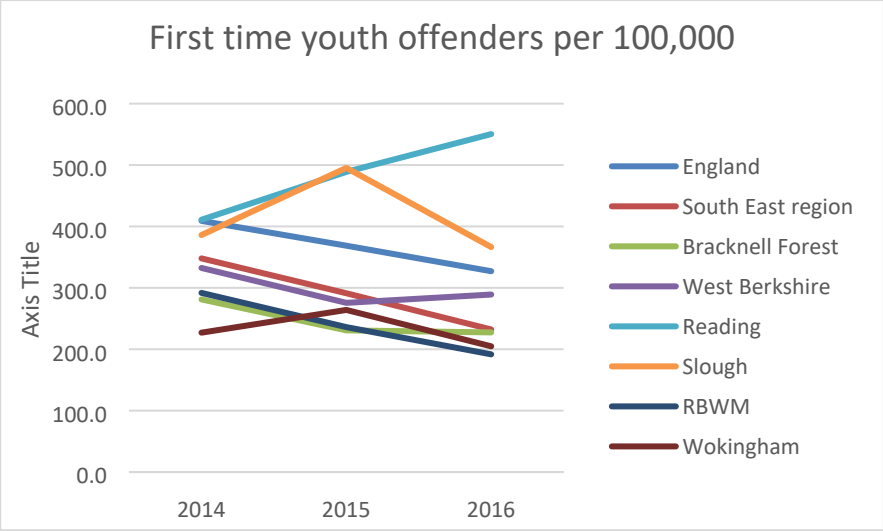
The rate of re-offenders in Wokingham was 21%, slightly below the national figure and below the South East figure of 24%. This was also the lowest rate observed across all Berkshire authorities.

| | 2014 |
|---|---|
| England | 25.4 |
| South East region | 23.6 |
| Bracknell Forest | 21.0 |
| West Berkshire | 26.3 |
| Reading | 27.0 |
| Slough | 24.5 |
| RBWM | 21.4 |
| Wokingham | 20.7 |

In Wokingham, the rate of new youth offenders was 204 per 100,000 of the population and the rate of young people in the youth justice system was 2.6 per 100,000. Both indicators are significantly better than both the national, regional and local comparators.




Amongst youth offenders, the most commonly reported crime types were 'criminal damage' 'violence against the person' and 'theft and handling of stolen goods.'

## Inequalities:

The Thames Valley Rehabilitation Company had the following to say regarding inequalities:

*'There are widely acknowledged health inequalities between people in the criminal justice system end the general population. They are more likely to have disability, have a mental health problem, misuse drugs and alcohol, self-harm, smoke, attempt suicide, and die prematurely. Offenders in the community are less likely to access health services and are less likely to be registered with a GP.'*

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## Recommendations

# 4.6 Armed forces, their families and veterans

Andrew Price – CCG- Mid-May

# 4.7 Gypsy, Roma and Travelers

## Introduction

This chapter looks at the current picture of the Gypsy, Roma and Traveler (GRT) community in Wokingham. The GRT are one of the protected characteristics defined under the 2010 equalities act and therefore the council must give due-regard to this group in implementing our polices, projects or services.

GRT is a broad term. Not all Gypsies, Roma and Travelers identify with one another and the term GRT is sued to describe a diverse ethnic group and diverse lifestyles.

For centuries, the GRT community has suffered extreme levels of discrimination, persecution, violence and genocide across Europe. Even to this day, the needs and priorities of this community are largely missing from government policies, strategies and interventions.

## Context & policy

According to the 2011 census data, the total U.K population of GRT ethnicity stood at 61, 892. This was 0.1% of the total population (ONS UK population 2015). However, this is based largely on self-identification and is thereof likely an underestimate. The Council of Europe estimates the U.K's GRT population at around 150-300,000. Approximately 1/5 of the population do not own a fixed living site (house or Caravan Park) and therefore move around the country between sites (*National Association of Teachers of Travelers*). A major problem throughout the history of the GRT community in Britain has been inadequate record keeping and monitoring of this group. As such, data that is held is never as complete as it should be.

A report on the health and wellbeing of the GRT community published in 2008 found that the overall health of the GRT community is much poorer than the general population, in particular noting that it was the poor uptake of health services that was compounding the problem. Mental health is also a significant problem among the community, likely a side factor of discrimination that is faced.

The government published the *Planning Policy for Traveler Sites* in 2012, this set out the Government's aims. These aims include that local planning authorities should develop fair and effective strategies to meet need through the identification of land for sites, and to promote more private traveler site provision.

## The Wokingham Picture

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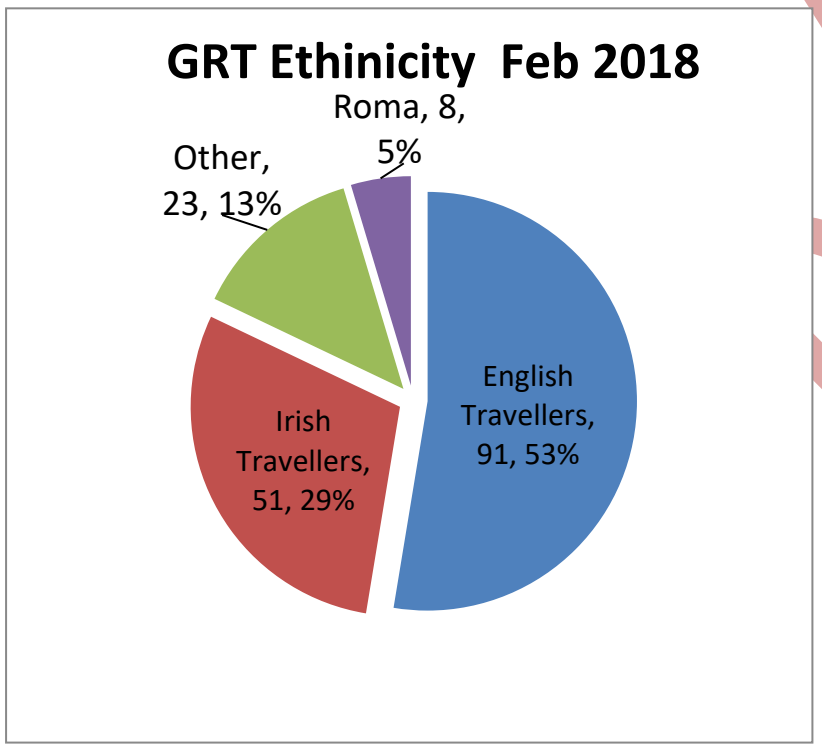
Wokingham Borough Council has a GRT Multi-agency and a strategic group. The groups are made of up of professionals from a wide range of agencies who work with the GRT community, as well as those who provide services to ensure that the community are involved. They have a good knowledge about services and how to access them and promote and empower community cohesion for our local GRT communities. A monthly report is published on the GRT community in the borough.

The most recent version is the February 2018 report. The report identified 173 GRT within Wokingham. Of these, they identified as the following ethnic groups:




## 4.8 Lesbian, Gay, Bisexual and Trans (LGBT) people

There is no robust evidence that will tell us how many LGBT people there are in the population although we can use what evidence we have to make some estimates and these are described below. A key theme throughout this assessment is the lack of high quality, large scale research around the needs of LGBT people. However, what is included in the sections below is based on the evidence that we do have and clearly indicates numerous inequalities in the health and wellbeing of LGBT people compared to the general population as well as inequalities in health and social care service access and provision. Therefore, the main focus of the following section of this assessment will focus on the known and indicated inequalities experienced by LGBT people both as a group as a whole and separately for groups within the LGBT population.

### Estimates of the number of LGBT people within the population

- The "I exist" survey respondent characteristics (sample = 2,580)
- 41% had a religion or belief 6% of whom said they were Christian
- 68% were in employment (similar to general population)
- 1/10 identified as carers (similar to general population

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- 42% said they had realised that they might be LGB between the ages of 13-15
- Only 14% had come out by this age
- By 25 years old 25% had not come out
- 3% have never come out (The Lesbian and Gay Foundation, 2012a)

Sexual orientation is not asked on the National Census and is not monitored for consistently in employment or services. Research allowing us to make a reasonably reliable estimate indicates that 5-7% of people are LGB (LGBT Foundation). There will be variation between different areas with sexual minorities more likely to migrate to larger cities.



An estimated 1% of the population identify with a gender that is not the same as the sex that they were born with. 0.2% may seek gender reassignment intervention with the median age for presentation for reassignment being 42 years of age. There are now an increasing number of people presenting in adolescence (Varney, 2013).

## Key health issues and inequalities for all LGBT people

Qualitative evidence coming from the LGBT community and peer reviewed research both provide a wealth of evidence of the health inequalities faced by LGBT people. Key areas where inequalities are described are; lifestyle behaviours (e.g. smoking and drug use), sexual health, mental health, workplace health, and service access and quality. Lifestyle, sexual health, and mental health inequalities are discussed in more detail later in this assessment. The experiences reported by LGBT people in relation to workplace health and services access are outlined in the table below.

**Table 1: Experiences of LGBT people relating to healthcare and workplace health**

| Topic | Experience | Source |
|---|---|---|
| Healthcare service quality (data relates to service using Stonewall's Healthcare Equality Index Tool so are likely to represent the more positive experiences of care) | 38% felt the organisation was lesbian, gay and bisexual friendly | (Stonewall, 2015b) |
| | 63% felt they were treated with dignity and respect at all time | |
| | 53% felt comfortable telling healthcare professionals their sexual orientation all of the time | |
| | 68% would recommend services to friends or family if they needed similar care or treatment | |
| Workplace health and wellbeing | 33% of LGB people have not disclosed their orientation to any service user | (Stonewall, 2015c) |
| | Bisexual men are the least likely to have told any colleagues about their sexual orientation (35% had not disclosed their orientation to any colleague) | |
| | Older LGB respondents were less likely to be out with anyone at work than younger respondents | |
| | Those who are out with colleagues are more satisfied with their sense of achievement (86% versus 54%) | |
| | Those who are out with colleagues are more satisfied with their job security (76% versus 50%) | |
| | Those who are out with colleagues are more satisfied with the support from their manager (86% versus 51%) | |
| | Those who are out with colleagues are more satisfied with the training that they receive (76% versus 46%) | |
| | 3/10 LGB people missed work in the last 12 months due to stress and 7% missed a month or more 1/10 had missed work due to their alcohol use and 4% had missed work due to their drug use | (The Lesbian and Gay Foundation, 2014a) |

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Experiences of LGBT people relating to healthcare and workplace health

Research shows that; patients want to talk to healthcare professionals about their sexual orientation; patients want the healthcare professional to initiate these conversations; but clinicians feel uncomfortable discussing issues around sexual orientation due to different reasons such as a lack of confidence of dealing with sexual health, having fears of offending the patients and a lack of understanding of new sexual terminology (Rogers, 2014).

The Public Health Outcomes Framework Companion Document (Williams, Varney, Taylor, Fish, Durr, & Elan-Cane, 2013); describes the health inequalities experience by LGBT people across each Public Health Outcomes Framework (PHOF) indicator. These inequalities flow through all domains of the framework beginning with the wider factors which are known to lead to inequalities in health. These stem from discrimination which impact on housing provision, education, and experiences of crime and violence. There is much evidence that shows that LGBT people are more likely to engage in lifestyle behaviours that are damaging to health including smoking, alcohol misuse, and drug use. They are less likely to engage with health improvement services which support people to improve their own health as well as to engage with screening services such as cancer screening. LGBT people are more likely to experience inequality in relation to healthcare services and are more likely to die prematurely.

The Adult Social Care Outcomes Framework Companion Document (The National LGB&T Partnership, 2015) brings together existing evidence on the needs of LGBT people in a similar way to the Public Health Outcomes document but, this time, with a focus on care and support needs. Providers of social care services have commented that sexual orientation and gender identity were never mentioned in regards of the provision of services.
There is evidence that inequalities exist between LGBT people and the general population against the majority of the indicators within these two frameworks and these are included in the additional information provided along with this assessment.

ONS? – Thursday 3rd May

PHE?

Wokingham council?

## 4.9 Carers

6.5 million people in the UK are carers and this number continues to rise. The 2011 Census figures for the UK show an 11% rise in the number of carers since the last Census in 2001 - increasing by over 620,000 to 6.5 million in just 10 years.

Every year over 2.1 million adults become carers and almost as many people find that their caring responsibilities come to an end. This 'turnover' means that caring will touch the lives of most of the

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population, estimated to be 3 in 5 people will be carers at some point in their lives.

Carers UK estimates a 40% rise in the number of carers needed by 2037 – an extra 2.6 million carers, meaning the carer population in the UK will reach 9 million.

1.4 million people provide over 50 hours of unpaid care per week. Almost 4 million of the UK's carers care for 1-19 hours each week. But the numbers caring round the clock, for 50 or more hours or more each week, are rising faster than the general carer population - an increase of 25% in the last ten years compared to an 11% rise in the total number of carers. According to the Personal Social Services Survey of Adult Carers in England 2014-15, over a third of carers (38%) are caring for over 100 hours a week.

Most carers care for just one person (83%), but 14% care for two people and 3% are caring for at least three people.

58% of carers look after someone with a physical disability, 20% look after someone with a sensory impairment, 13% care for someone with a mental health problem and 10% care for someone with dementia.

Source: Carers UK - Facts and figures

The Personal Social Services Survey of Adult Carers in England (SACE) takes place every other year and is conducted by Councils with Adult Social Services Responsibilities (CASSRs). The survey seeks the opinions of carers aged 18 or over, caring for a person aged 18 or over, on a number of topics that are considered to be indicative of a balanced life alongside their unpaid caring role.

The largest proportion of carers are aged 55-64 (24.2 per cent) or approximately 82,750 people. Carers aged 18-24 represent the smallest group at 1.4 per cent or approximately 4,850.

90.1 per cent of older carers, those aged 85 and over have caring responsibility for someone aged 75 or over. For all carers aged over 45, the highest percentage of the people they care for are aged 75 or over.

Providing care and support can have a detrimental impact on the health of the carer themselves, indeed nearly 20 per cent of carers reported that in the last 12 months, their health had been adversely affected by their caring role and made an existing condition worse. There are other ways in which the carer's health is directly impacted as a result of their carer role:

76.0 per cent reported 'feeling tired' and 64.0 per cent of carers reported they experienced 'disturbed sleep' as a result of their caring role

A third of carers reported feeling the 'physical strain' of caring

Nearly 60 per cent reported a 'general feeling of stress and 43.4 per

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cent stated they were 'feeling depressed'

Satisfaction with support or services is directly linked to a positive experience of care and support. Overall, for carers who received support or services along with the person they care for, 71.0 per cent were extremely, very or quite satisfied with the support or service they received. This compares to 13.4 per cent who were extremely, very or quite dissatisfied and 15.5 per cent that were neither satisfied nor dissatisfied.

Loneliness is linked to poor mental and physical health. A key aspect for social care is for it to tackle loneliness and social isolation. Overall 35.5 per cent of carers reported they have as much social contact as they want with people they like, 48.3 per cent have some social contact but not enough and 16.2 per cent reported they have little social contact and feel socially isolated.

Source: NHS Digital - Personal Social Services Survey of Adult Carers in England, 2016-17

**Carer-reported quality of life scores 2016-17**

Responses to six questions from the Survey of Adult Carers in England (SACE) are used to calculate carer-reported quality of life (QoL) scores. The questions cover six domains; occupation, control, personal care, safety, social participation and encouragement and support. Each respondent is assigned a score based on their answers to the six questions, which has three answers (no unmet needs, some needs met or no needs met) to choose from. Higher scores are assigned to better outcomes so the higher the overall score the better the average social care related quality of life. The maximum possible score is 12.

The overall QoL score for Wokingham in 2016-17 was 7.9. This is made up of 320 respondents to the six questions within the SACE. The overall score for the South East was 7.6 and 7.7 for England.

The new indicator included in the Dementia Profiles is for the carer-reported quality of life score, for carers who self-reported that they cared for a person with dementia. In Wokingham the score was 7.7, which is above the England and South East Region scores that both scored 7.5 out of a possible 12.

When looking at the quality of life scores by the health condition of the person being cared for, those carers who look after a person with a learning disability or difficulty have the highest score (8.6) and those who care for someone with a long standing illness, or problems connected to ageing have the lowest (7.0).

Source: NHS Digital - Personal Social Services Survey of Adult Carers in England, 2016-17

**Social Isolation**

There is a clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social

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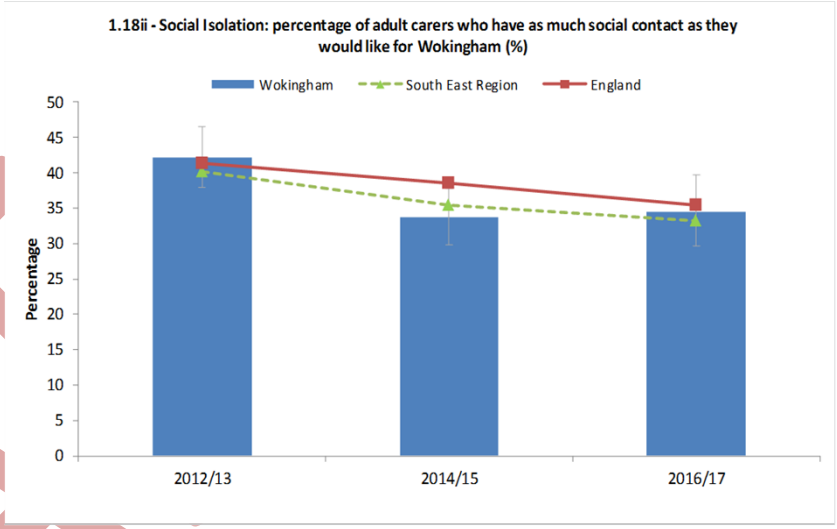
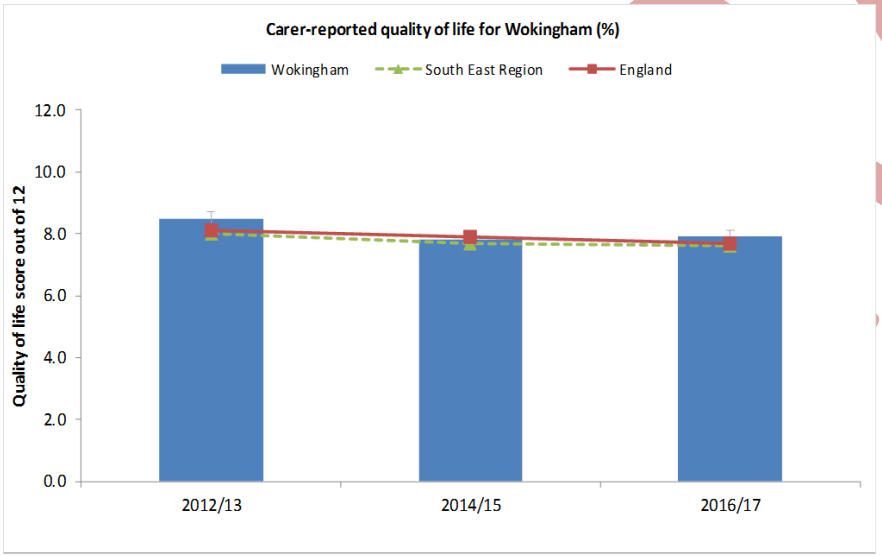
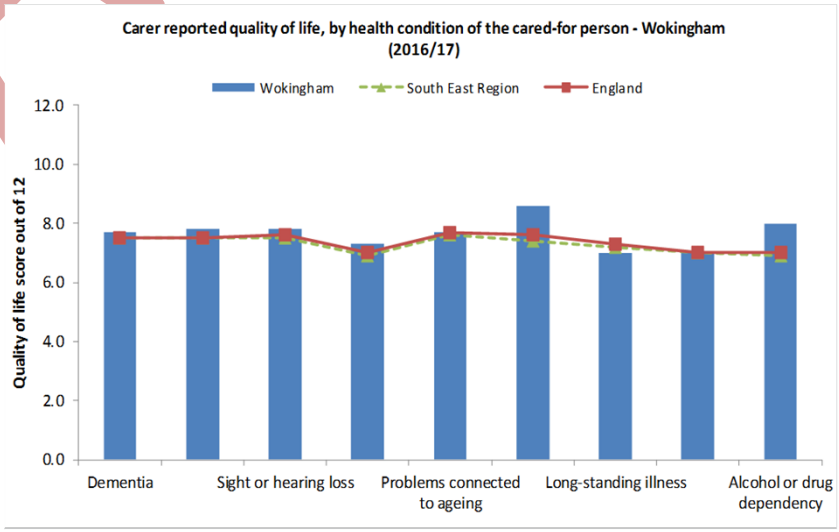
care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family.

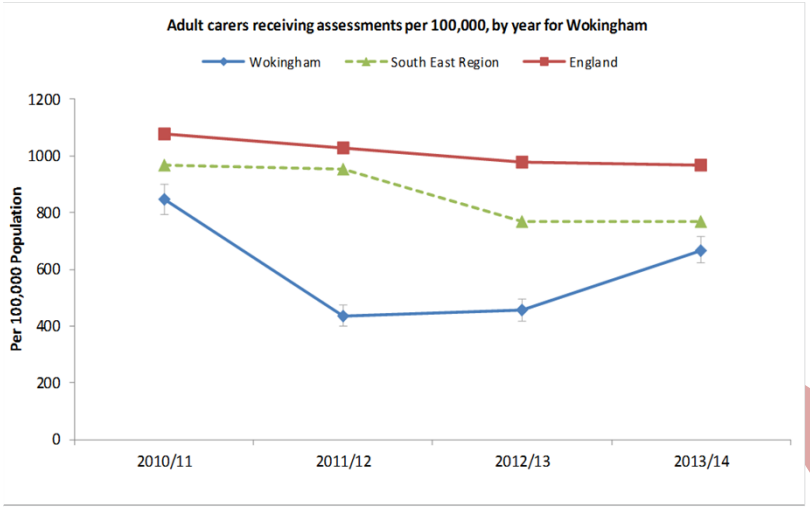
"Locally, the percentage of respondents to the Personal Social Services Carers Survey who responded to the question ""Thinking about how much contact you have had with people you like, which of the following best describes your social situation?"", with the answer ""I have as much social contact I want with people I like"" was 34.5%. This is similar to England (35.5%) and the comparator group (34.2%)."

Source: PHE: Public Health Outcomes Framework

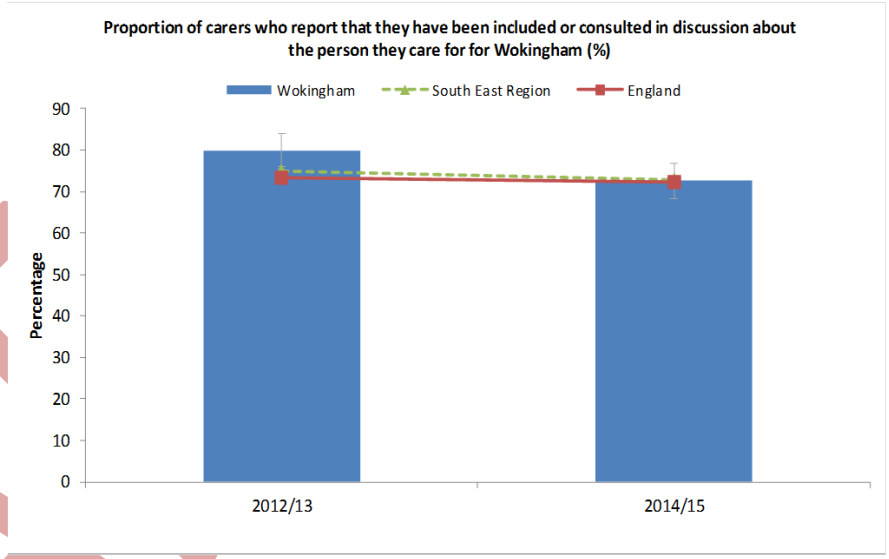


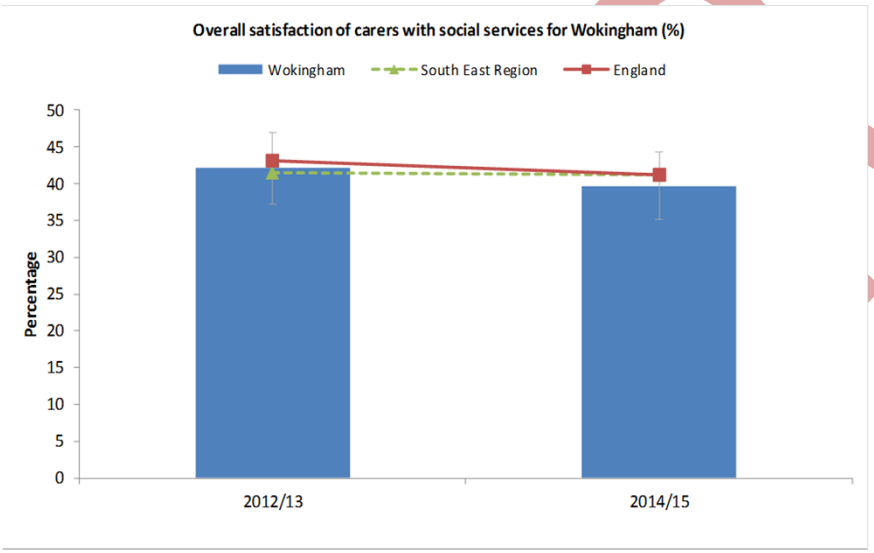






Source: PHE: Adult Social Care Profile



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| JSNA Chapter | Theme | Key services | Key service achievements | Key service gaps | Future recommendations/suggestions |
|---|---|---|---|---|---|
| Borough profile | Healthwatch | 1.<br>2.<br>3.<br>4. etc | 1.<br>2.<br>3. | 1.<br>2.<br>3. | |
| Borough profile | Housing | | | | |
| Borough profile | Homelessness | | | | |
| Starting Well | Maternal health | | | | |
| Starting Well | Newborn health | | | | |
| Developing Well | Teenage pregnancy | | | | |
| Developing Well | Children's Mental Health | | | | |
| Developing Well | Substance abuse | | | | |
| Developing Well | Youth offending | | | | |
| Developing Well | School life | | | | |
| Developing Well | Children in care | | | | |
| Developing Well | Children with disabilities | | | | |
| Developing Well | Children safeguarding | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Developing Well | NEET | | | | |
| Developing Well | FGM | | | | |
| Living and Working Well | Healthy weight and physical activity | | | | |
| Living and Working Well | Mental health | | | | |
| Living and Working Well | Sexual health | | | | |
| Living and Working Well | Health protection (screening, immunisations) | | | | |
| Living and Working Well | People with a LTC including disability | | | | |
| Ageing Well | Falls and mobility | | | | |
| Ageing Well | End of life care | | | | |
| Ageing Well | Excess winter deaths | | | | |
| People and Places | Environmental health and licensing | | | | |
| People and Places | Road safety | | | | |
| People and Places | Transport | | | | |
| People and Places | Suicide and self-harm | | | | |

| | | | | | |
|---|---|---|---|---|---|
| People and Places | Domestic abuse | | | | |
| People and Places | Adult safeguarding | | | | |
| People and Places | Offenders | | | | |
| People and Places | Armed forces, their families and veterans | | | | |
| People and Places | Gypsy, Roma and Travelers | | | | |
| People and Places | LGBT | | | | |
| People and Places | Carers | | | | |

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|---|---|
| **TITLE** | **Health and Wellbeing Performance Dashboard** |
| **FOR CONSIDERATION BY** | Health and Wellbeing Board on Thursday, 14 June 2018 |
| **WARD** | None Specific; |
| **DIRECTOR/ KEY OFFICER** | Julie Hotchkiss, Consultant in Public Health |

| | |
|---|---|
| Health and Wellbeing Strategy priority/priorities most progressed through the report | All 4 priorities will be measured by the dashboard. |
| Key outcomes achieved against the Strategy priority/priorities | The indicators proposed will give a baseline against which achievement of outcomes can be assessed, |

| | |
|---|---|
| Reason for consideration by Health and Wellbeing Board | The Board has used indicators previously, and now needs to receive current data and agree indicators to assess progress on the Health and Wellbeing Strategy 2017 – 2020. |
| What (if any) public engagement has been carried out? | None. |
| State the financial implications of the decision | None. |

**RECOMMENDATIONS**

1. That one or two of the new proposed indicators are substituted for the existing two in Priority 1.
2. That a small group be convened to assess the value of and the cost-feasibility of commissioning an annual survey to assess community's fear of crime.
3. That support be given to the analysts working on the 5 Year Forward View to produce the synopsis statistic.
4. That the specific changes to the indicators in Priority 2B, C and D be approved.
5. That Priority 3 indicators are adjusted so that they measure inequality, and that the recommendations with regards to these indicators are accepted.
6. That support be given to Wokingham Integrated Service Partnership analysts to produce the synopsis statistic for Priority 4.

**SUMMARY OF REPORT**
At the April 2018 HWB meeting a small set of proposed indicators were presented. The data for the first 3 priorities, with trends and comparators have been collated are presented back to the Board now for refinement and final selection.

**Background**

A new Health and Wellbeing Strategy was agreed last year, covering 2017 to 2020. In December 2017 a list of Key Performance Indicators were proposed. At the April 2018 HWB meeting a smaller subset of indicators were presented, but without data.

Data for the first 3 priorities, with trends and comparators have now been collated are shown below with recommendations for refinement. The comparators chosen are the South East, England and the "Least Deprived Decile".

**Analysis of Issues**

**Existing proposed Indicators**

## 1. Enabling and empowering resilient communities

1A Population living with a long-term condition aged under & over 65 (see Appendix 2)
1B Emergency admissions for hip fractures in 65

*These are not measures of a community's resilience and Wokingham already scores very well comparatively two indicators, and they are not good measures of community resilience. It is recommended these be dropped.*

1C Resident's Perception of Fear of Crime

*A bespoke survey of residents is required for this, therefore a decision needs to be taken on whether or not to undertake this survey, when and who will fund it.*

**New proposed indicators for Priority 1**

Gap in employment rate between certain groups and the overall employment rate:

- Those with long term conditions (gap = 19.7 staying same)
- Those with learning disabilities (gap = 65.66 and increasing)
- Those in contact with secondary mental health services (gap = 66.1 and decreasing)

(see Appendices 3 and 4)
*It is recommended that one or two of these 3 be chosen for the dashboard.*

## 2. Promoting and supporting good mental health

**2A West of Berkshire; Five Year Forward View for Mental Health Delivery Plan**
"The delivery group is developing a series of measures tracking progress on the five year forward view for mental health, which incorporates Future in Mind work on CAMHS services. This indicator will give a synopsis of progress towards the delivery plan, based upon the detailed metrics behind it, which include:

- Perinatal Mental Health;

• Children and Young people (CYP) Mental Health;
• Adult mental health: common mental health problems – focus on Improving Access to Psychological Therapies (IAPT) services;
• Adult mental health: community, acute and crisis care;
• Adult mental health: secure care pathway & Health and Justice;
• Suicide prevention; and
• Dementia."

*It is recommended that responsibility for developing this measure be clarified. The Public Health Team will work with the relevant analysts to produce synopsis indicator*.

**2B Self-reported wellbeing**

*It is recommended that "Self-reported wellbeing – high anxiety score" (2Bii) be chosen, although Wokingham (19.5%) is not statistically different from England (19.87% or South East (19.5), it should be better considering the population characteristics.*

**2C Prevalence (%) of Dementia (registered and estimated)**

The indicator in the spreadsheet is prevalence of dementia in the under 65s. Only one year's data is available. (see Appendix 5) Better would be to calculate predicted numbers and actual registered by practice and for Wokingham, all age, and use the gap in prevalence as the indicator. This would help us assess the extent to which dementia was being found and diagnosed. This will require cooperation of the practices, and would require analysts time to produce. It does not in itself report good mental health.
*If it were to be used* i*t is recommended that we use the* ***gap*** *between predicted numbers and actual registered as the prevalence as the indicator. It is not recommended.*

**2D Prevalence (%) of Mental Health illness (registered & estimated)**

The best indicator of mental illness prevalence is probably 2Div-Long-term mental health problems (from the GP Patient Survey). However this would not be a good indicator to choose as Wokingham is already very much better than the comparators. Better to use an indicator where there is room for improvement.
*It is recommended that we use 2Dvi - Pupils with behavioural, emotional and social support needs, as the indicator, as it is higher 1.65 (worse) than our least deprived comparators 1.36, and increasing.* (see Appendix 6)

## 3. Reducing health inequalities in our Borough

**3A Life Expectancy at Birth (Male/Female)**

Life expectancy itself does not measure inequalities, but the difference between the most affluent 10% and most deprived 10% within the Borough shows internal inequalities. A statistic called the Slope of Inequality converts this difference into a single figure. Note that the gap is higher in females than in males. (see Appendices 7 and 8).
*It is recommended that we use indicators 3Aiii (male)- currently 4.5 - and 3Aiv (female) – currently 5.5 - Slope of inequality as the baseline, and therefore do not use indicators 3Ai and 3Aii.*

**3B Children in Poverty (Under 16s)**

The latest figures show that 6.1% of children in Wokingham come from low income families, this is very much lower than England (16.8%) and even our least deprived comparators at 9.8. However, in itself it is not a helpful indicator to use to show how inequalities are being reduced. It would be possible to compare *attainment between*

*children in receipt of Free School Meals, and those who are not, and use the gap as an indicator.*
*It is not recommended to use 3B.*

**3C Overweight and obese school children in Reception (%) and at Year 6 (%)**
The numbers of children with excess weight is certainly a cause for concern, but as a measure of health inequalities it is better to measure the gap. Public Health England have not released the small area child measurement data, but when they do (expected July 2018) the analysts will calculate the gap between excess weight (overweight and obesity combined) in the most and least deprived 10% of children in the Borough.
*It is recommended to use the gap between prevalence of overweight and obesity in children most deprived and least deprived. The Board to decide whether to use Reception age or Year 6 or both.*

## 4 Delivering Person-centred Integrated Services

The production of the "Indicator" for Priority 4 (Delivering Person-centred Integrated Services) is the responsibility of Wokingham Integrated Services Partnership (WISP) and is not presented here. Because these two indicators are actually composites for several other indicators it is methodologically complex. The Public Health Team will work with WISP's analysts to produce two composite indicators/ synopses from the list presented to the April meeting and a report and bring a report back to the August HWB on current status, with trends if possible.

**Appendices**
Appendix 1 Wokingham HWBB indicators 5 June 2018 (pdf of the front sheet)
Appendix 2 Wokingham HWBB KPIs ind1Aiii
Appendix 3 Wokingham HWBB KPIs ind 1di
Appendix 4 Wokingham HWBB KPIs ind 1dii
Appendix 5 Wokingham HWBB KPIs ind 2c
Appendix 6 Wokingham HWBB KPIs ind 2dvi
Appendix 7 Wokingham HWBB KPIs ind 3aiii
Appendix 8 Wokingham HWBB KPIs ind 3aiv

| **Partner Implications** |
|---|
| CCG and WISP analysts will need to work on indicators for Priorities 2 and 4 |

| **Reasons for considering the report in Part 2** |
|---|
| N/A |

| **List of Background Papers** |
|---|
| N/A |


| **Contact** Julie Hotchkiss | **Service** Public Health |
|---|---|
| **Telephone No** Tel: 0118 974 6628 | **Email** julie.hotchkiss@wokingham.gov.uk |

| Domain | Indicator ID | Indicator | Value | Trend* | England | South East region | Least deprived decile (IMD2015) | Data Source | Value type | Polarity | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Enabling and empowering reislient communities | 1Aiii - not recommended | 1Aiii - Health-related quality of life for people with long-term conditions | 0.8 | Increasing | 0.74 | - | 0.77 | NHS Outcomes Framework: NHS Digital | Directly standardised | RAG - High is good | Data from 2014/15 does not include learning disability as a long term condition in the GP Patient Survey |
| | 1B - not recommended | 1B - Emergency admissions for hip fractures in people aged 65 and over | 468.28 | Increasing | 574.97 | 560.39 | 537.17 | Public Health Outcomes Framework: Public Health | Directly standardised rate | RAG - Low is good | |
| | *1C* | *1C - Residents perception of fear of crime* | - | - | - | - | - | | | | |
| | 1Di -recommend | 1Di - Gap in employment rate between those with a long-term health condition and the overall employment rate | 19.7 | Same | 29.4 | 30.3 | 30.96 | Public Health Outcomes Framework: Public Health | Gap | RAG - Low is good | |
| | 1Dii - recommend | 1Dii - Gap in employment rate between those with a learning disability and the overall employment rate | 65.66 | Increasing | 68.73 | 71.65 | 72.41 | Public Health Outcomes Framework: Public Health | Gap | RAG - Low is good | |
| | 1Diii - recommend | 1Diii - Gap in employment rate between those in contact with secondary mental health services and the overall employment rate | 66.1 | Decreasing | 67.4 | 69.7 | 70.63 | Public Health Outcomes Framework: Public Health | Gap | RAG - Low is good | There is a data quality issue for the 2016/17 data |
| 2. Promoting and supporting good mental health | *2A* | *2A - West of Berkshire; Five Year Forward View for Mental Health Delivery Plan* | - | - | - | - | - | | | | |
| | 2Bi | 2Bi - Self-reported wellbeing - low happiness score | 5.86 | Decreasing | 8.54 | 7.77 | - | Public Health Outcomes Framework: Public Health | Proportion | RAG - Low is good | |
| | 2Bii - recommend | 2Bii - Self-reported wellbeing - high anxiety score | 19.32 | Decreasing | 19.87 | 19.5 | - | Public Health Outcomes Framework: Public Health | Proportion | RAG - Low is good | |
| | 2C - not recommend | 2C- Dementia: Indirect Age-Standardised Recorded Prevalence (aged under 65 years) per 10,000 | 2.45 | - | 2.94 | 2.5 | - | Public Health England Dementia Profiles | Indirectly standardised | BOB - Blue orange blue | No trend data yet available |
| | 2Di | 2Di - Depression recorded prevalence (QOF): % of practice register aged 18+ | 7.8 | Decreasing | 9.09 | 9.3 | 8.82 | Public Health England Mental Health and Wellbeing JSNA | Proportion | BOB - Blue orange blue | |
| | 2Dii | 2Dii - Severe mental illness recorded prevalence (QOF): % or practice register all ages | 0.55 | Decreasing | 0.92 | 0.83 | - | Public Health England Mental Health and Wellbeing JSNA | Proportion | BOB - Blue orange blue | |
| | 2Diii - recommend | 2Diii - Depression and anxiety prevance (GP Patient Survey): % of respondents aged 18+ | 8.11 | Decreasing | 12.7 | 11.31 | 10.07 | Public Health England Mental Health and Wellbeing JSNA | Proportion | BOB - Blue orange blue | |
| | 2Div | 2Div - Long-term mental health problems (GP Patient Survey): % of respondents aged 18+ | 1.97 | Increasing | 5.17 | 4.68 | 4.1 | Public Health England Mental Health and Wellbeing JSNA | Proportion | BOB - Blue orange blue | |
| | 2Dv | 2Dv - Proportion of adults in the population in contact with secondary mental health services | 3.21 | Decreasing | 5.36 | 4.53 | 3.58 | Public Health Outcomes Framework: Public Health | Proportion | RAG - Low is good | |
| | 2Dvi - recommend | 2Dvi - Pupils with behavioural, emotional and social support needs | 1.65 | Increasing | 1.66 | 1.73 | 1.36 | Public Health England Public Health Profiles | Crude rate | RAG - Low is good | |
| 3. Reducing health inequalities in our Borough | 3Ai - not recommend | 3Ai - Life expectancy at birth - males | 81.56 | Increasing | 79.53 | 80.58 | 83.26 | Public Health Outcomes Framework: Public Health | Life expectancy | RAG - High is good | |
| | 3Aii - not recommend | 3Aii - Life expectancy at birth - females | 85.11 | Decreasing | 83.14 | 84.02 | 86.18 | Public Health Outcomes Framework: Public Health | Life expectancy | RAG - High is good | |
| | 3Aiii - recommend | 3Aiii - Inequality in life expectancy at birth - males | 4.5 | Decreasing | - | - | - | Public Health Outcomes Framework: Public Health | Slope Index of Inequality | RAG - Low is good | |
| | 3Aiv - recommend | 3Aiv - Inequality in life expectancy at birth - females | 5.5 | Same | - | - | - | Public Health Outcomes Framework: Public Health | Slope Index of Inequality | RAG - Low is good | |
| | 3B - not recommend | 3B - Children in low income families (under 16s) | 6.1 | Increasing | 16.8 | 12.5 | 9.8 | Public Health Outcomes Framework: Public Health | Proportion | RAG - Low is good | |
| | 3Ci | 3Ci - Prevalence of overweight (including obese) - reception year | 17.77 | Increasing | 22.63 | 21.35 | 19.68 | Public Health England NCMP Profiles | Proportion | RAG - Low is good | |
| | 3Cii | 3Cii - Prevalence of overweight (including obese) - year 6 | 26.6 | Increasing | 34.25 | 30.57 | 28.43 | Public Health England NCMP Profiles | Proportion | RAG - Low is good | |
| | 3Ciii - recommend | 3Ciii - Inequality in prevalence of overweight (including obese) - reception year | - | - | - | - | - | National Child Measurement Programme: NHS Digital | Proportion | RAG - Low is good | |
| | 3Civ - recommend | 3Civ - Inequality in prevalence of overweight (including obese) - year 6 | - | - | - | - | - | National Child Measurement Programme: NHS Digital | Proportion | RAG - Low is good | |
| 4. Delivering person-centred integrated | *4A* | *4A - Wokingham Integrated Services Partnership Local Performance* | - | - | - | - | - | | | | |
| | *4B* | *4B - Wokingham Integrated Services Partnership National Performance* | - | - | - | - | - | | | | |

**RAG ratings based on 95% confidence interval significance testing**

- Same
- Better
- Worse
- Lower
- Higher

* The text refers to the direction of movement since the previous years figures; statistical testing has been applied where possible and the results of this are represented by the RAG rating. Caution should be taken when interpreting trends without a test of statistical significance.

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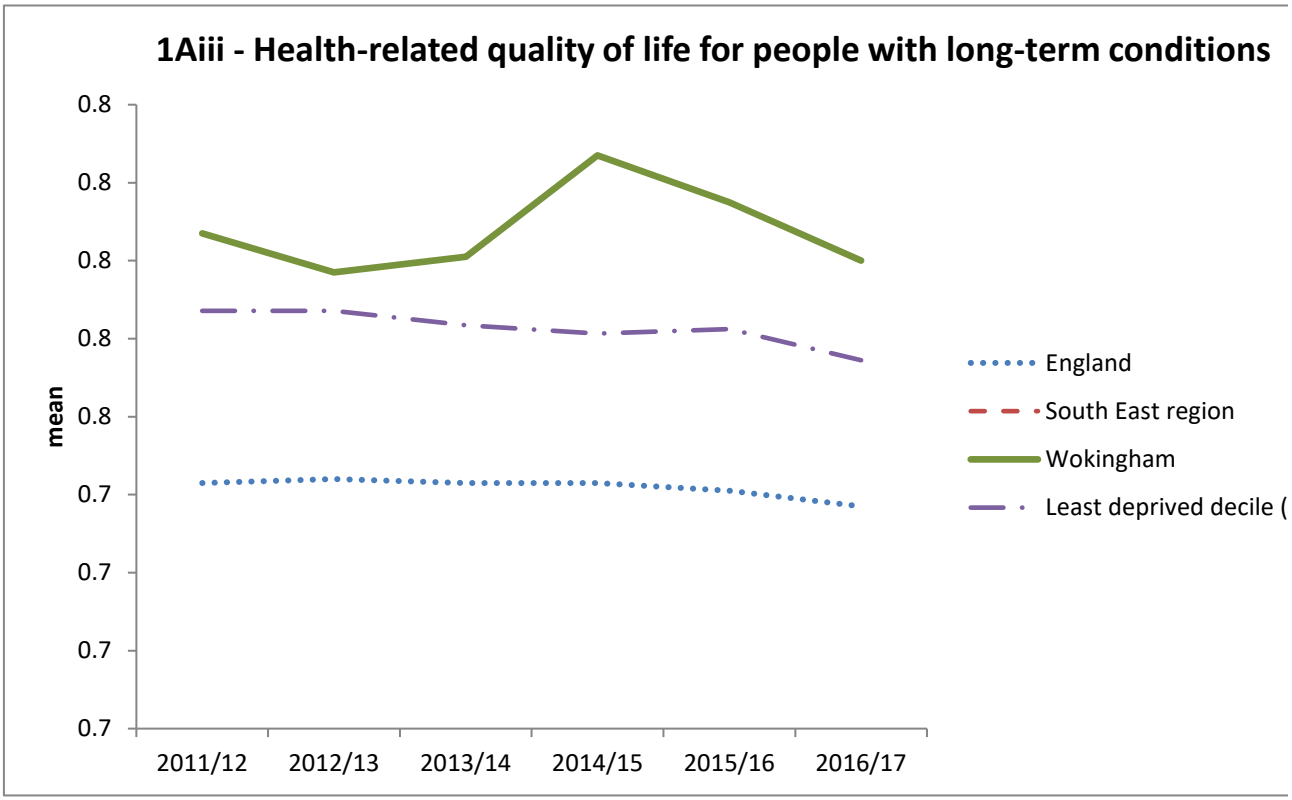
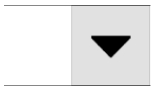
1Aiii - Health-related quality of life for people with long-term conditions




*Source:* *NHS Outcomes Framework: NHS Digital*

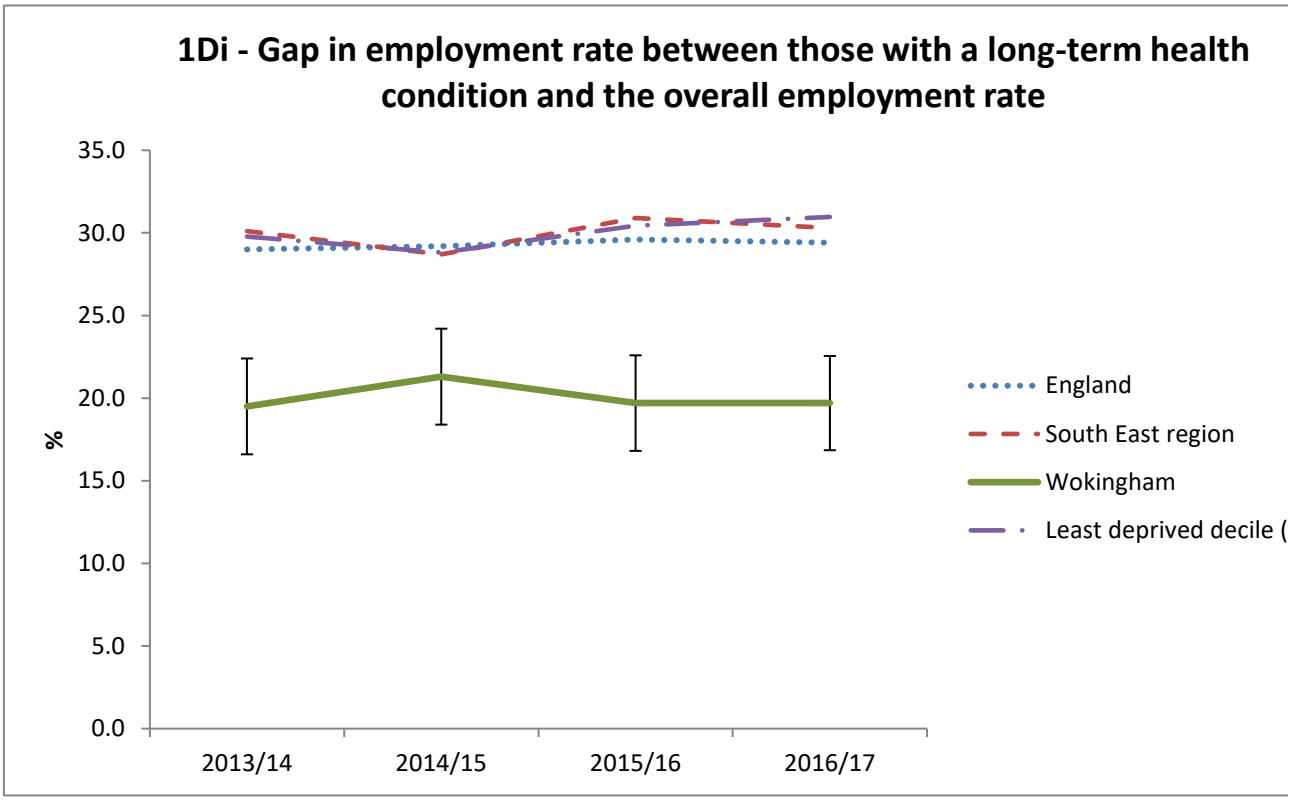
*Notes:* *Data from 2014/15 does not include learning disability as a long term condition in the GP Patient S*



(IMD2015)

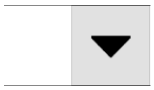
*Survey*

1Di - Gap in employment rate between those with a long-term health condition and the overall employment rate



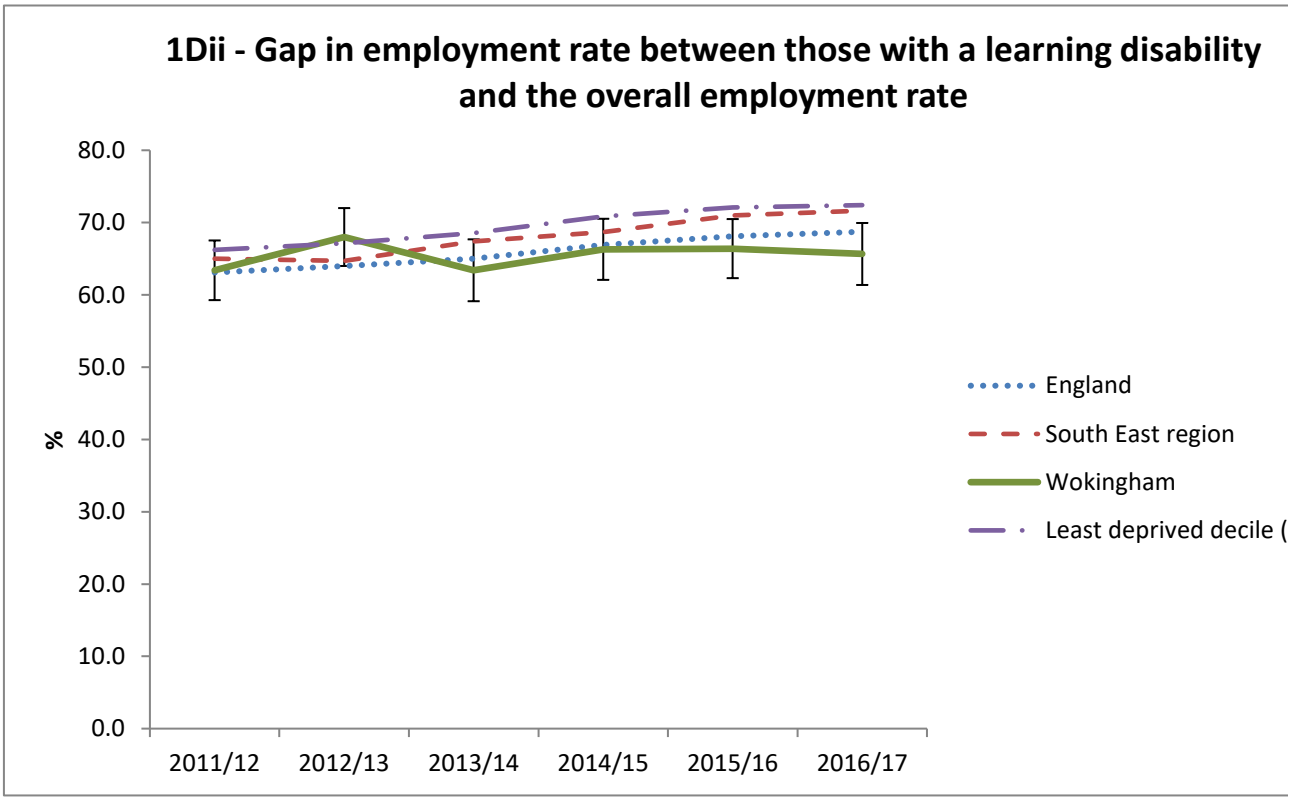

*Source:* *Public Health Outcomes Framework: Public Health England*

*Notes:*



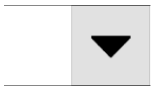
(IMD2015)

1Dii - Gap in employment rate between those with a learning disability and the overall employment rate



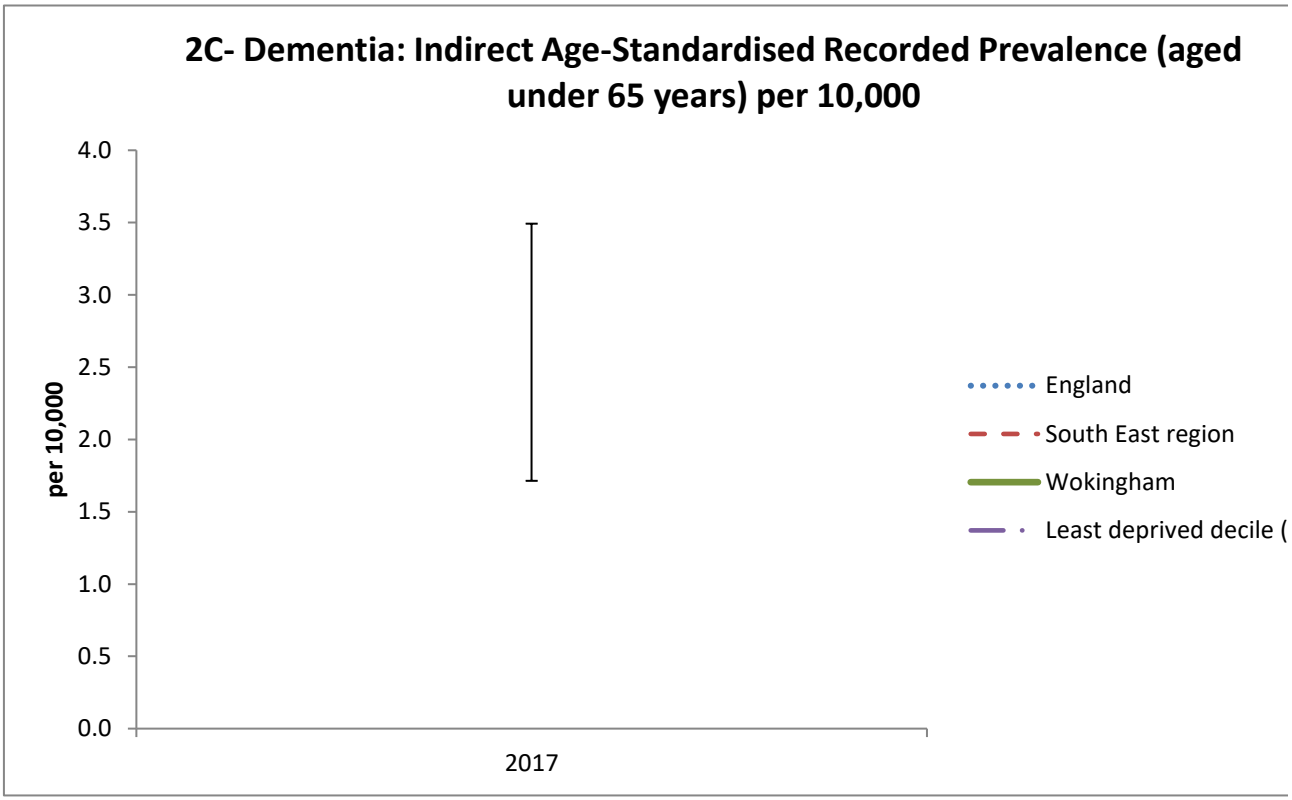

*Source:* *Public Health Outcomes Framework: Public Health England*

*Notes:*

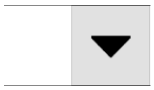


(IMD2015)

2C- Dementia: Indirect Age-Standardised Recorded Prevalence (aged under 65 years) per 10,000

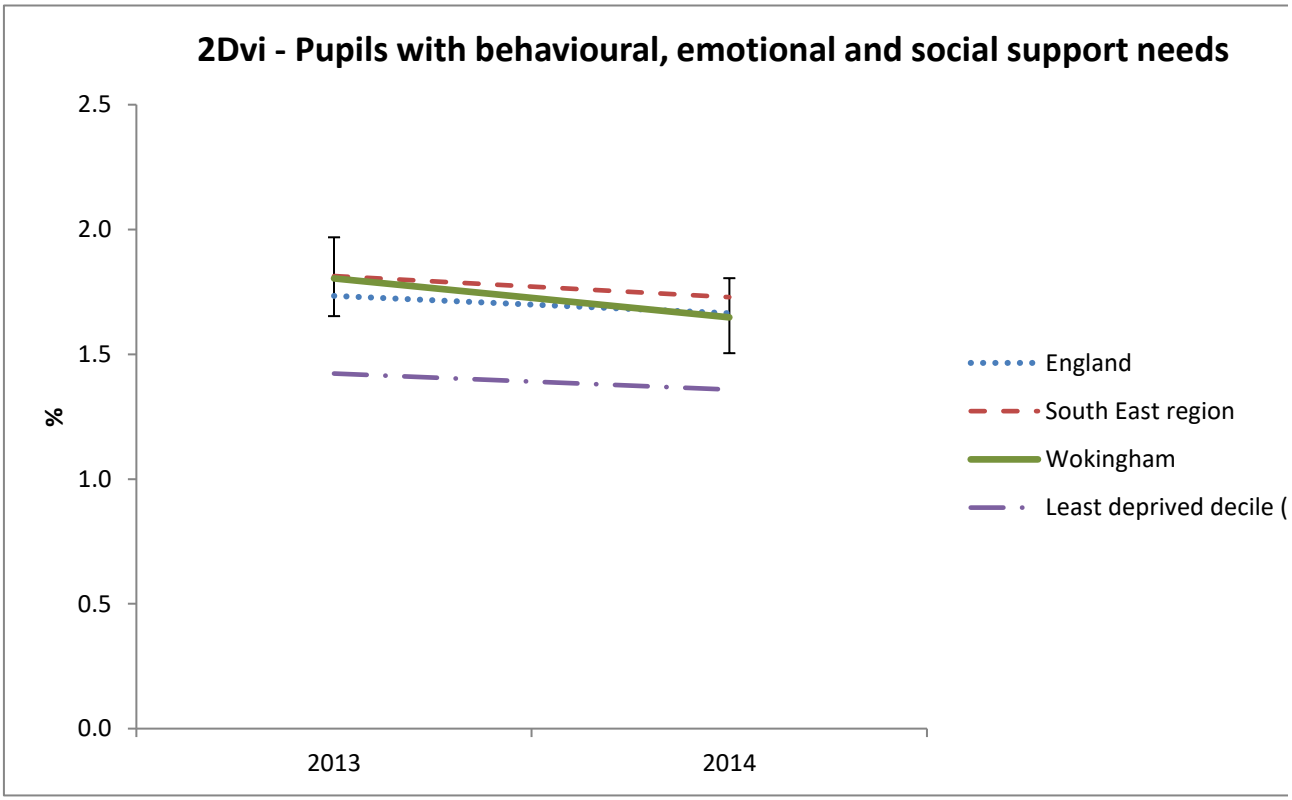



*Source:* *Public Health England Dementia Profiles*
*Notes:* *No trend data yet available*



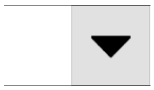
(IMD2015)

2Dvi - Pupils with behavioural, emotional and social support needs



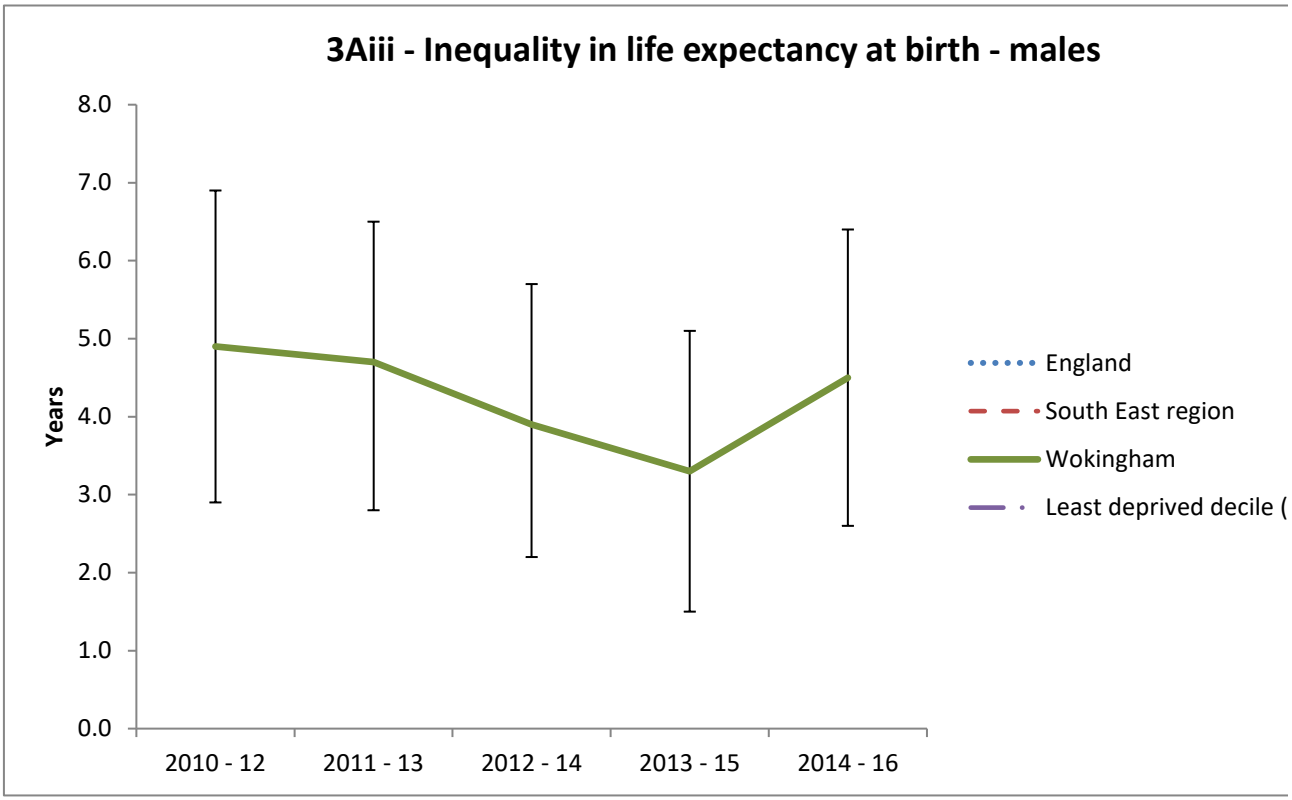

*Source:* *Public Health England Public Health Profiles*

*Notes:*



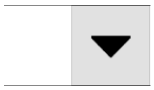
(IMD2015)

3Aiii - Inequality in life expectancy at birth - males



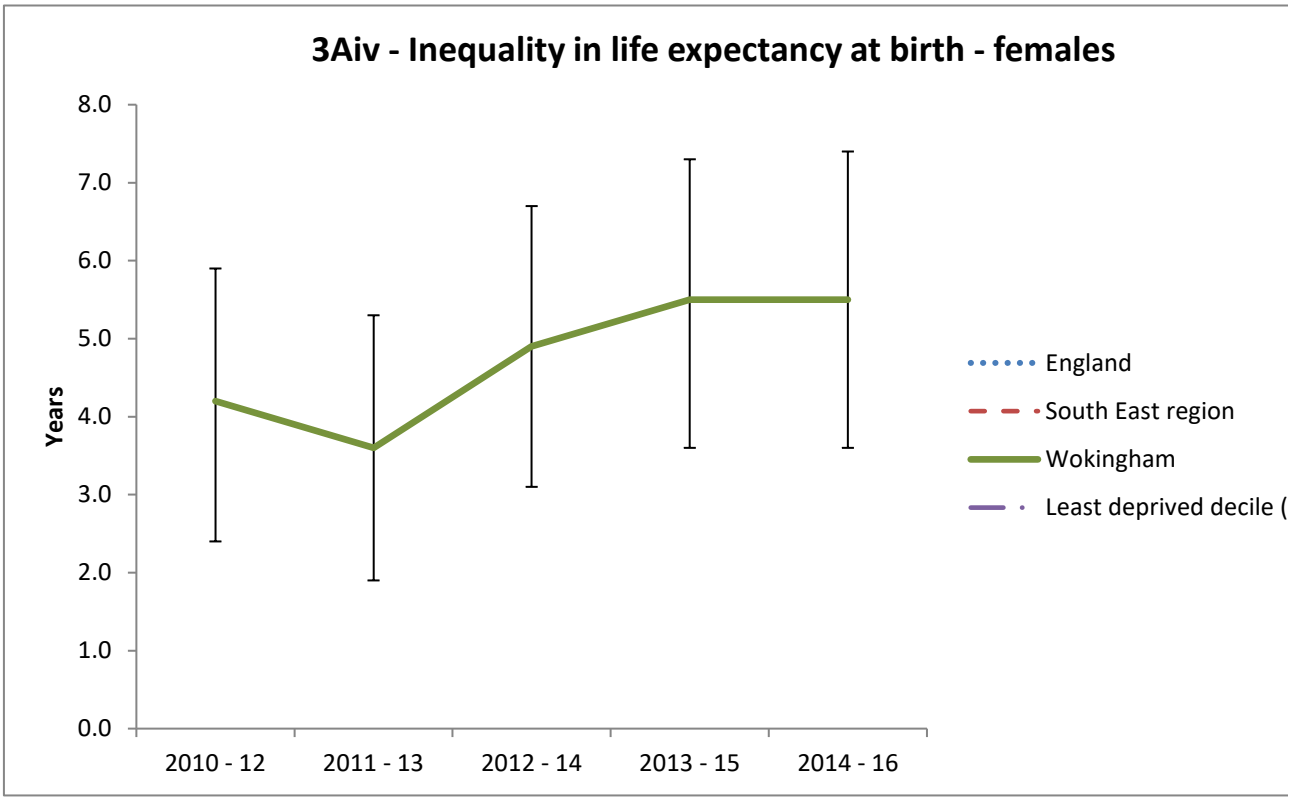

*Source:* *Public Health Outcomes Framework: Public Health England*

*Notes:*



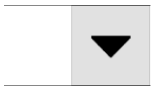
(IMD2015)

3Aiv - Inequality in life expectancy at birth - females




*Source:* *Public Health Outcomes Framework: Public Health England*

*Notes:*



(IMD2015)

| | |
|---|---|
| **TITLE** | **Better Care Fund Programme Performance 2017/18** |
| **FOR CONSIDERATION BY** | Health and Wellbeing Board on Thursday, 14 June 2018 |
| **WARD** | None Specific |
| **DIRECTOR/ KEY OFFICER** | Paul Senior, Interim Director of People Services, Wokingham Borough Council (WBC) and Katie Summers, Director of Operations, NHS Berkshire West Clinical Commissioning Group (CCG), Wokingham Locality |

| | |
|---|---|
| Health and Wellbeing Strategy priority/priorities most progressed through the report | This report meets three of the four priorities of the HWB Strategy<br><br>Priority 1 – Enabling and empowering resilient communities;<br>Priority 3 – Reducing health inequalities in our Borough;<br>Priority 4 – Delivering person-centred integrated services |
| Key outcomes achieved against the Strategy priority/priorities | To provide assurance to the Board on the activities of the Better Care Fund Programme, this focuses on delivery of the Boards strategic priorities. |

| | |
|---|---|
| Reason for consideration by Health and Wellbeing Board | To provide an update of Wokingham's Better Care Fund (BCF) Programme performance for 2017-18. |
| What (if any) public engagement has been carried out? | None |
| State the financial implications of the decision | None |

**RECOMMENDATION**

That the Health and Wellbeing Board notes the performance of the Better Care Fund in 2017/18.

**SUMMARY OF REPORT**

To provide a summary of Wokingham's BCF Programme performance for 2017-18 (financial year), including progress of integration, milestones, challenges, performance metrics and finances.

**Background**

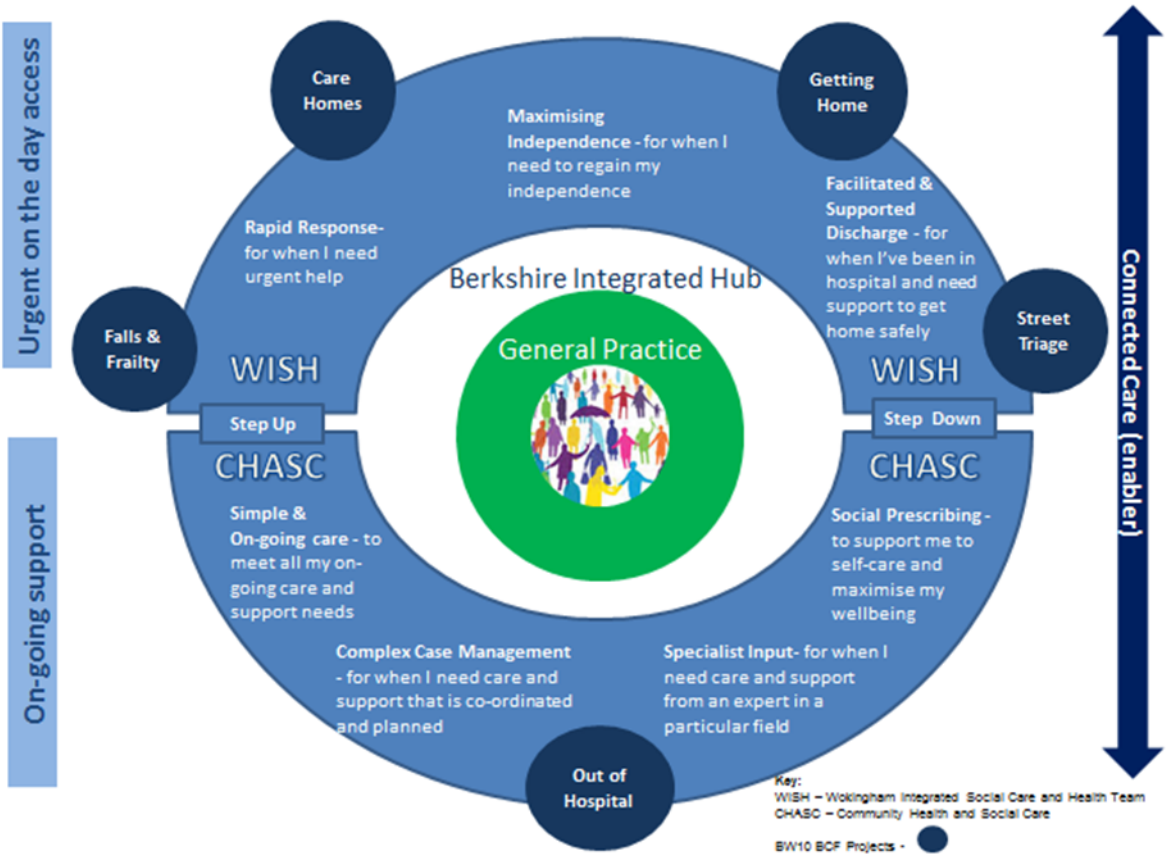
Wokingham's Better Care Fund (BCF) Programme is jointly funded by the Wokingham Borough Council and NHS Berkshire West Clinical Commissioning Group, Wokingham Locality.

The BCF Programme has the following key objectives which are seen as essential to delivering integrated health and social care services:

- Achieving the best outcomes for Wokingham residents through early intervention and prevention, case management and maintenance and end of life care
- Reducing unnecessary hospital admissions through a co-ordinated, focussed response
- Providing management and maintenance of people with long term conditions, including dementia, moving towards self-care
- Providing services which promote faster recovery and maximise independent living

This Programme began in January 2014 and has funding approved to March 2019, with an aim of integrated services being fully in place by 2020. Objectives are reviewed regularly to ensure they remain relevant and to set achievement criteria.

The Programme has 4 local schemes and 6 Berkshire West wide schemes.




*Local Schemes:*

- BCF 01 –Integrated Hub (Health and Social Care) – A 7 day single point of contact, resolving as many issues as possible at first point of contact, triaging

enquiries and handover to statutory teams if needed. *(TELLING YOUR STORY ONCE)*

- BCF 02 - WISH (Wokingham Integrated Social Care and Health) team. Integrating Short Term Health and Social Care Services; WBC Health Liaison team, Optalis START team and Berkshire Healthcare NHS Foundation Trust (BHFT) Intermediate Care Team and Step Down Beds – Reducing Delayed Transfers of Care, reducing avoidable admissions and reducing admissions to residential care homes, fewer handoffs for the public. *(TELLING YOUR STORY ONCE, STAYING IN YOUR OWN RESIDENCE, SHIFTING CARE TO THE COMMUNITY)*
- BCF 03 - Step Up Beds (community medical model) – Sub-acute Intermediate care beds supporting the prevention of unnecessary acute hospital admissions and premature admissions to long term care via community based, in-patient facilities for residents experiencing an exacerbation of an existing condition or a decline in health. *(SHIFTING CARE TO THE COMMUNITY)*
- BCF 08 – CHASC (Community Health and Social Care) Integrating long-term social care and community health services; BHFT Community Nursing, Optalis Brokerage and Support, Primary Care and Involve Community Navigators. - Keeping the residents of Wokingham fit, well and living as independently as they can be in their own homes for as long as possible by working as a single health and social care system that supports people, promotes self-care and prevention. *(TELLING YOUR STORY ONCE, STAYING IN YOUR OWN RESIDENCE, SHIFTING CARE TO THE COMMUNITY)*

*Berkshire West Wide Schemes:*

- BCF 06 - Care Homes (Community Support) Project incorporating Rapid Response and Treatment (RRAT ) and Care Homes Support Team (CHST) - Offering care home residents a co-ordinated, joined up health and social care service, reducing unnecessary admissions to hospital, improving the flow of residents from home to acute and back to home, avoiding unnecessary delays in discharges back to the care homes. *(TELLING YOUR STORY ONCE, STAYING IN YOUR OWN RESIDENCE, SHIFTING CARE TO THE COMMUNITY)*
- BCF 07 - Connected Care - Integrating IT systems sharing patient information with professionals across the partners. *(TELLING YOUR STORY ONCE)*
- BCF 10 - Getting Home - Reducing the time people spend in an acute, community or mental health inpatient bed at the point that they no longer need clinical care and to prevent avoidable admissions. *(TELLING YOUR STORY ONCE, STAYING IN YOUR OWN RESIDENCE)*
- BCF 11 - Out of Hospital - Promoting independence and improving quality of life by delivering community services to residents in their own homes and in places of residential care. *(SHIFTING CARE TO THE COMMUNITY)*
- BCF 12 - Street Triage – Mental Health - Reducing use of police custody and use of section 136 of the mental health act allowing the police to take the person to a place of safety from a public place. *(SHIFTING CARE TO THE COMMUNITY)*
- BCF 13 - Falls and Frailty - Improving the patient experience of emergency care by providing an acute, blue light multi-disciplinary response to the frail elderly who have fallen in their own homes to prevent conveyance and/or admission to an acute hospital. *(STAYING IN YOUR OWN RESIDENCE, SHIFTING CARE TO THE COMMUNITY)*

**Wokingham's BCF Programme 2017-18 Performance Summary**

**1. Progress against Local Plan for Integration of Health and Social Care**

Our local integration plan is based upon effectively developing and embedding our BCF schemes - The Integrated Hub, Wokingham Integrated Social Care and Health (WISH) [now including Time to Decide aka Step Down], Community Health and Social Care (CHASC) and Step Up services alongside the Berkshire West 10 (BW10) schemes in order to meet the four National Metrics – Non Elective Admissions (NEAs), Admissions to Residential and Care Homes, Effectiveness of Reablement (91 day target), and Delayed Transfers of Care (DToC) .

To support and build on this work, we have agreed that our governance will now be through a Memorandum of Understanding (MoU) between the partners; this has been implemented in a shadow format from the 1st April 2018.

**2. Integration Success Story Highlights**

2.1. Between April and September 2017 (Q1 & 2), our key success stories were:

2.1.1. National Metric Performance – we sustained or improved our performance in three out of the four National Metrics: DToCs, people remaining at home 91 days after reablement and permanent admissions to care homes.

2.1.2. Community Navigator Service – this service continued to grow with referrals increasing by 55% in Q2. Service user feedback also demonstrates the success of this service with users reporting that they have moved from being ready to accept help to believing and learning how to support themselves.

2.1.3. As a result of a 'deep dive' review to capture our learnings, BCF 03 Step Up/Step Down was split into 2 separate schemes for 2017/18. The Step Up PID was approved in Q2 with the remit of providing sub-acute care to reduce Accident and Emergency (A&E) attendance and NEAs, with the service due to launch December 2017. Step Down (renamed Time to Decide) was incorporated into WISH team provision.

2.1.4. Plans progressed for closer working between the Disabled Facilities Grant (DFG), with the Housing Services Manager attending Wokingham Integration Strategic Partnership (WISP) on a quarterly basis to report on agreed performance metrics. Adults and children's referral pathways were mapped in order to improve access and processes in the pathways.

2.2. Between October and December 2017 (Q3), our key success stories were:

2.2.1. National Metric Performance – continuation of sustained/improved performance as per 2.1.1.

2.2.2. Local Metric Performance – whilst we did not achieve the national NEA metric we showed significant improvement in our local NEA metric, which measures NEAs in the over 70s in 13 targeted conditions. We achieved a YTD monthly average of 99 NEAs, 13% lower than the 16/17 monthly average of 114 NEAs.

2.2.3. CHASC Staff Engagement Event held on the 31st October which brought together all the health and social care staff involved in supporting service users with long term needs. The overriding theme of the feedback was the positive outcomes created by bringing health and social care professionals together. The event provided a setting where stakeholders got to know each other and their respective roles in a locality setting, building a basis for closer working relationships in the future.

2.2.4. Continuation of development of an MoU. The 4 partners agreed to the proposal developed. Partner Governance arrangements were drafted and agreed. The

impact on this change was to move from a commissioner led model to a partnership between commissioners and providers to deliver integrated health and social care services.

2.2.5. Yearly Review of Schemes – In November 2017 all of the local BCF schemes were evaluated by WISP, with an action plan created to focus on further developments for schemes to be completed by May 2018. Actions focussed around performance, finances, processes and procedures, communication, workforce and dependencies.

2.3. Between January 2018 and March 2018 (Q4) our key success stories were:

2.3.1. National Metric Performance – continuation of sustained/improved performance as per 2.1.1.

2.3.2. Further CHASC Staff Engagement Event held in March 2018, which brought together all the health and social care staff involved in supporting users with long term needs in the West locality which will be the first locality area in Wokingham to test the CHASC model.

2.3.3. The MoU was drafted during March 2018, with the first consultation phase during April 2018. N.B. following consultation, Royal Berkshire NHS Foundation Trust (RBFT) was included as a fifth partner to the MoU.

2.3.4. Programme Plan/Roadmap to 2020 was drafted during Q4 for anticipated agreement in Q1 of 2018/19.

2.3.5. Review of Voluntary Sector Sustainability – Due to the move towards direct payments and reduction in the Partnership Development Fund monies, we reviewed CCG/WBC voluntary sector spend over previous years to see how much impact the reduction in funding would be likely to have and review all schemes funded to remove duplication and maximise investment.

2.3.6. Review of Time to Decide (aka Step Down) service – The review was carried out during January and February 2018 and presented to WISP in March 2018. It was agreed to retain the three Time to Decide flats and improve performance in order to continue to reduce DToC and meet agreed BCF targets for 2018/19. All changes to be implemented by the end of Q1 2018/19.

2.3.7. DFG Performance Metrics – Q3 metrics were presented for the first time to WISP in January 2018. The feedback on reporting was positive with further questions from the members of WISP for consideration. The BCF Programme Management Team worked with the DFG team during Q4 to further refine reporting and to start to explore benchmarking performance against other Local Authorities.

2.3.8. Agreed local Stakeholder Engagement and Communication Framework - Aim is to keep staff, public, Members, GPs etc. informed with progress of the BCF and integration, commencing Q2 of 2018-19.

2.3.9. During Q4 the Local Government Association (LGA) carried out a DToC Peer Challenge over 3 days, commissioned by the BW10 Integration Board. A draft report was released in March 2018 and Wokingham felt that the peer challenge was a positive exercise and we have identified potential learning and actions to take that will further improve DToC performance and the patient experience. Once the final report is published an action plan will be prepared and implemented.

2.3.10. A review of the BCF Programme management of risks was carried out during Q4 and a new risk register format developed to better manage and mitigate risks for the programme. This will be used from the 1st April 2018.

## 3. Milestones for 2017/18

3.1. Quarters 1 and 2

3.1.1. At the end of Q2 WISH, CHASC and Step Up met their planned milestones.

- WISH sustained DToC performance and implemented all actions from the High Impact Model action plan.
- CHASC completed a review of the Multidisciplinary Team Meeting (MDT) process and redesigned the process for Wokingham, with go live planned for the 1st October 2017. The 3 locality areas for Wokingham were agreed around the primary care practices, Lower Super Output Areas (LSOA) deprivation and Strategic Development Locations (SDL). Plans were made for the first staff engagement event on the 31st October, using an external consultancy to support this. The Community Navigator Service (social prescribing) continued to grow with referrals up from 10 per month at the start of Q2 to 28 per month at the end of Q2.
- Step Up – all point of care equipment was identified and orders placed. The SOP and service specification were drafted. There were difficulties in recruiting to the ANP post.

3.1.2. The Integrated Hub did not meet its agreed milestones. Phase 2 roll out delayed as it is dependent on WBC's 21st Century Council restructure, which is complex.

3.2. Quarter 3

3.2.1 At the end of Q3 WISH, CHASC and Step Up met their planned milestones.

- WISH sustained its reablement, permanent admissions to care homes and DToC performance. In order to support the maintenance of performance, iBCF funding was allocated to WISH to support funding of CHS Healthcare private brokerage service at RBFT, additional ASC staff for reablement and additional support for home care packages from December 2017 to March 2018. A review of Time to Decide beds was planned for Q4 to compare usage versus costs/benefits.
- CHASC launched its redesigned MDT process which went live as planned on the 1st October 2017, with 105 patients reviewed compared to 24 in the same period last year. The MDT design is being continually reviewed to ensure best processes and following a first review in December adaptations were made. The first CHASC Staff Engagement Event was held on the 31st October, with the highlights being what is working well, what the barriers are and the aspirations. The Community Navigator Service (social prescribing) maintained its growth in Q3.
- Step Up – this service went live on the 4th December 2017 with the ANP post filled. Whilst no suitable referrals were received there was an increase in community referrals into the community hospital beds.

3.2.1. As the Integrated Hub had not met its agreed milestones a partner meeting was held on 11th December 2017. It was agreed that the Integrated Hub team would review the scheme in the early part of Q4 against the following key lines of enquiry:

- Where they have got to against the plan?
- Is the plan still for purpose and where do we want to get to – perhaps a refreshed plan needs to be produced?
- What are the barriers/blockers to plan, what are the solutions to barriers/blockers and what actions need to be taken?

3.3 Quarter 4

3.3.1. At the end of Q4 WISH, CHASC and Step Up met their planned milestones.

- WISH sustained its reablement, permanent admissions to care homes and DToC

performance. A review of the Time to Decide (Step Down) beds was completed.

- CHASC continued to review and develop the MDT process and this approach was shared with West Berkshire and Reading localities. Development of the CHASC locality model continued with a West Locality Workshop held in March 2018 to design elements of the model. The Community Navigator Service (social prescribing) maintained its growth in Q4 and is now available in 12 out of the 13 GP Practices in Wokingham.
- Step Up – Referral numbers were lower than expected since the launch in December 2017, therefore the source of referrals was expanded to include the Acute Trust and for the service to support capacity in the Rapid Response service.

3.3.2. The Integrated Hub Phase 2 milestone continued to be delayed. Review of the scheme and key lines of enquiries (as noted in 3.2.1) was initiated with a programme report review to be shared in May 2018 with the BCF Senior Responsible Officers for agreement and/or further consideration.

**4. Challenges during 2017/18**

4.1. Recruitment of staff remained the biggest challenge across Wokingham's health and social care system. In 2017/18 the lengthy delay in recruitment of the Advanced Nurse Practitioner (ANP) for the Step Up service being an example of this as well as recruitment and sustainability of the local care market. Mitigation was as follows:

4.1.1. Nursing staff were used in a slightly different way whilst there wasn't an ANP in post in order for the Step Up scheme to go live as planned in December 2017.

4.1.2 The 2017 spring budget Department of Communities and Local Government (DCLG) provided additional Adult Social Care funding, known as the Improved Better Care Fund (iBCF) of £169k in part supported sustainability of the care market, although this was a small sum.

4.1.3 During Q3 the BCF team carried out a high level workforce review in order to understand the key issues across all partners. The purpose was to inform the BW10 Workforce project, highlight the top 3 workforce issues to this programme and identify areas for development locally.

4.2 NEA performance was not sustained. The reasons for this are multifactorial, but one challenge that Wokingham did not resolve (and remains outstanding for 18/19) was the NEA target set, a reduction in growth of 1.8% on 16/17 outturn, which was not agreed locally by WISP as it was felt this was an overly ambitious target. Wokingham had been a top performer for years for numbers of NEAs per year, achieving a 1% growth reduction from 15/16 to 16/17, which was the first year in recent years where a reduction had been achieved (from 14/15 to 15/16 NEAs grew by 10.6%). Mitigation was as follows:

4.2.1. Two of our schemes, CHASC (MDTs) and Step Up, went on line in Q3 and Q4; both aim to reduce NEAs and contributed towards figures for 17/18.

4.2.2. Discussions with the CCG and NHS England (NHSE) around the reduction set to agree a more realistic target were unsuccessful.

4.2.3. Whilst the national NEA performance metric has not been sustained we sustained our local NEA performance metric for over 70s with 13 targeted conditions.

4.3. Performance across the Berkshire West system was not the same, with Wokingham achieving the greatest success overall. As the Berkshire West system is moving towards an Integrated Care System (previously Accountable Care

System) model it was felt it would be beneficial to have all 3 unitary areas performing at a similar level. Mitigation was as follows:

4.3.1. Sharing of best practice and support for other areas in Berkshire West in place. Monthly meetings between the Integration leads for Reading, West Berkshire, Wokingham and Berkshire West 10 Programme Office were held throughout the year and this will continue throughout 17/18 and into 18/19.

4.3.2. In particular, analysis of positive progress within WBC to identify ideas for improving DToC performance was a key factor.

4.4 Wokingham's iBCF for 17/18 was £169,000. Wokingham was one of the very few out of 150 LAs to receive only 10% of the iBCF money due of the Relative Needs Formula allocation methodology. Due to the small amount of funding Wokingham was unable to develop any new schemes or services. Mitigation was as follows:

4.4.1 The iBCF did not affect decisions on the budget and there were no new metrics introduced to isolate and measure the iBCF improvements

4.5 Demand and pressure on the health and social care system continued to grow. Mitigation was as follows:

4.5.1. We continually need to ensure our services and processes are fit for purpose. Our scheme review process and highlight reporting refinement aims to ensure we are able to capture performance and value for money, and make adjustments where necessary. These measures will continue throughout 18/19.

4.5.2 An integration programme plan/roadmap to 2020 was developed to understand the pressures and minimise the impact through an effective plan.

4.6 Change in Senior Leadership of the CHASC Team. The original Head of CHASC took a 9 month secondment within BHFT towards the end of Q4. There was a risk the change in leadership at a critical time in the project could lead to delays in planned implementation timescales. Mitigation was as follows:

4.6.1. Recruitment to an Interim Head of CHASC was actioned, alongside a review of the project plan to revise go-live dates once the Interim Head of CHASC was appointed.

## 5. Performance Metrics

The BCF performance is measured and reports against 4 National Metrics.

5.1 Non-Elective Admissions (NEAs)

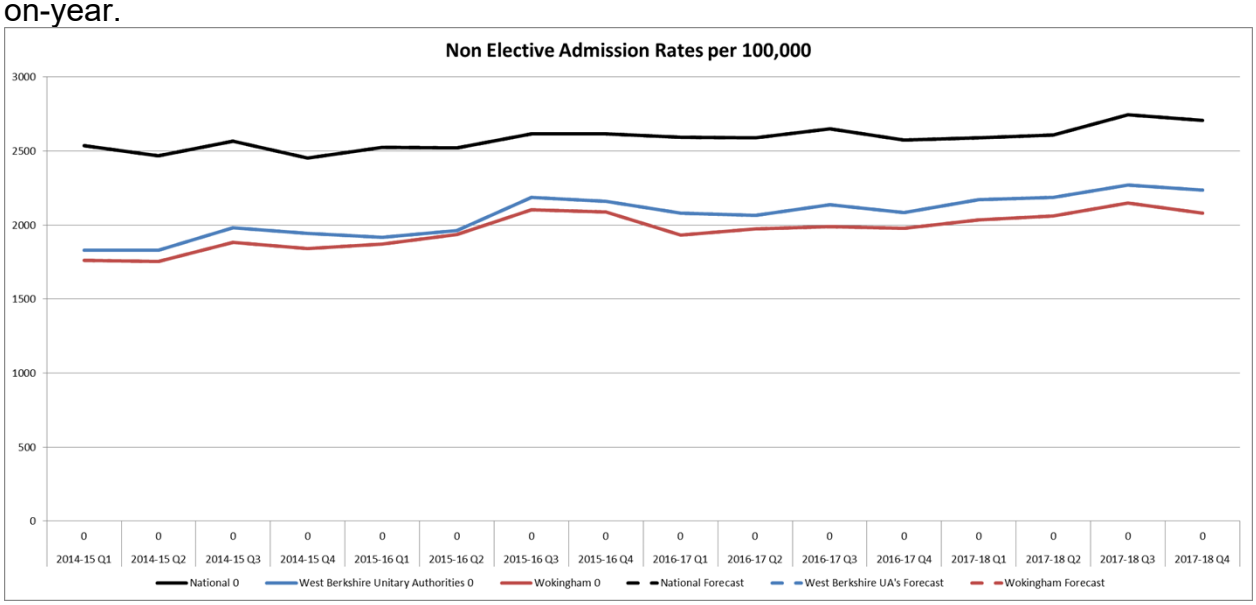
NEAs for 2017/18 were 13,630 versus plan of 12,612, (8.1% above plan). This compares to 12,845 in 2016/17, an increase of 6.1%. Following confirmation of the Quarter 4 figures, the overall RAG rating for 17/18 is now amber, having improved from the red rating which has been the case for most of the year.

| | | Baseline | | | | | Pay for performance period | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2015-16 Q4 | 2016-17 Q1 | 2016-17 Q2 | 2016-17 Q3 | 2016-17 Q4 | 2017-18 Q1 | 2017-18 Q2 | 2017-18 Q3 | 2017-18 Q4 |
| Total non-elective admissions in to hospital (general & acute), all-ages. | Plan | 2,923 | 3,102 | 3,131 | 3,393 | 3,230 | 3,036 | 3,113 | 3,231 | 3,232 |
| | Actual | 3,401 | 3,151 | 3,219 | 3,245 | 3,230 | 3,324 | 3,367 | 3,512 | 3,427 |
| Quarterly Variance | | 478 | 49 | 88 | - 148 | - | 288 | 254 | 281 | 195 |
| Quarterly Variance % | | 16.3% | 1.6% | 2.8% | -4.4% | 0.0% | 9.5% | 8.2% | 8.7% | 6.0% |
| RAG Rating | | | | | | | | | | |

RAG
Less than 5%
Between 5 & 10%
Greater than 10%

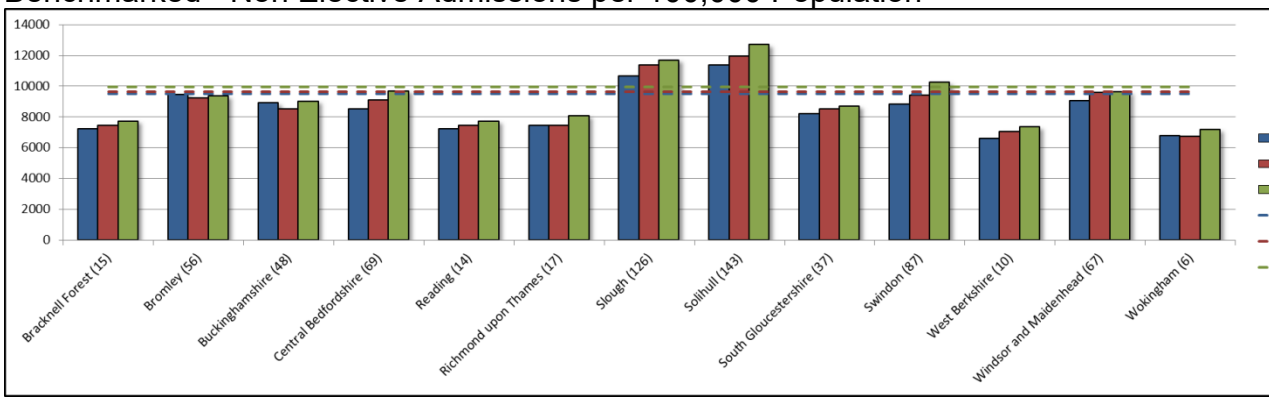
NEAs by Age Band continue to show a static picture for >75 years old for the last three years. Somewhat surprisingly the <18 year old band is showing a reduction during since November 2017.
Length of Stay (LoS) for < 24 hours is lower than the prior year. However > 48 hours is an increase of 4.4% on 2016/17.

WISH team NEAs for the Target Conditions and > 70 years of age are cumulatively 1,330 for 2017/18, compared to 1,329 for 2016/17. This is consistent with the picture shown by the overall statistics of a static level of admissions for the >75 age band year-on-year.




We have compared our performance regionally and nationally over 2017/18: Wokingham's Normalised for Population Monthly NEA rate is ranked 3rd best (out of 207 CCGs) for performance, the best performance of the 4 Berkshire West CCG areas. This is the same ranking as 2016/17.

Benchmarked - Non Elective Admissions per 100,000 Population



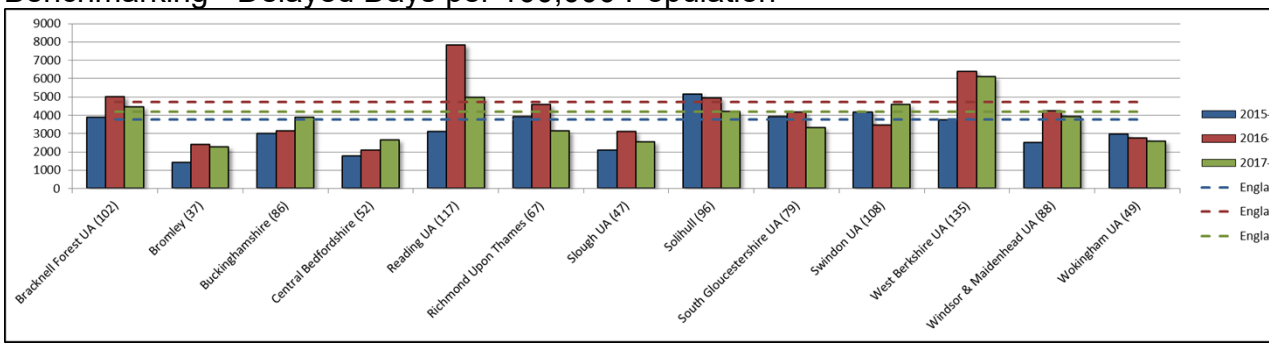

Source: National CCG Monthly Hospital Activity Return (MAR) data is used for this comparator as National Secondary Uses Services (SUS) data is not available. Local authorities based on Commissioning for Value packs as 10 most comparable areas and local Berkshire Unitary Authorities. Current rank in brackets (1 lowest, 150 highest)

5.2 Delayed Transfers of Care (DToC)
DToC for 2017/18 was 3,689 days compared to a plan of 3,840 (4% below plan). This compares to 3,751 days in 2016/17 and represents a 1.7% reduction on the prior year. Overall for the year the performance was good, but Q4 showed an above plan figure,

although a similar peak was seen in Quarter 4 in the prior year.

| BCF SUBMISSION TARGETS | | 2015-16 | 16/17 | | | | 17-18 plans | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2015-16 Q4 | 2016-17 Q1 | 2016-17 Q2 | 2016-17 Q3 | 2016-17 Q4 | 2017-18 Q1 | 2017-18 Q2 | 2017-18 Q3 | 2017-18 Q4 |
| Delayed transfers of care /delayed | *Plan* | 924 | 924 | 924 | 839 | 829 | 960 | 960 | 960 | 960 |
| | *Actuals* | #REF! | 697 | 1,063 | 950 | 1,041 | 744 | 984 | 838 | 1,123 |
| Quarterly Variance | | #REF! | - 227 | 139 | 111 | 212 | - 216 | 24 | - 122 | 163 |
| Quarterly Variance % | | #REF! | -25% | 15% | 13% | 26% | -23% | 3% | -13% | 17% |
| RAG Rating | | #REF! | | | | | | | | |

Benchmarking - Delayed Days per 100,000 Population



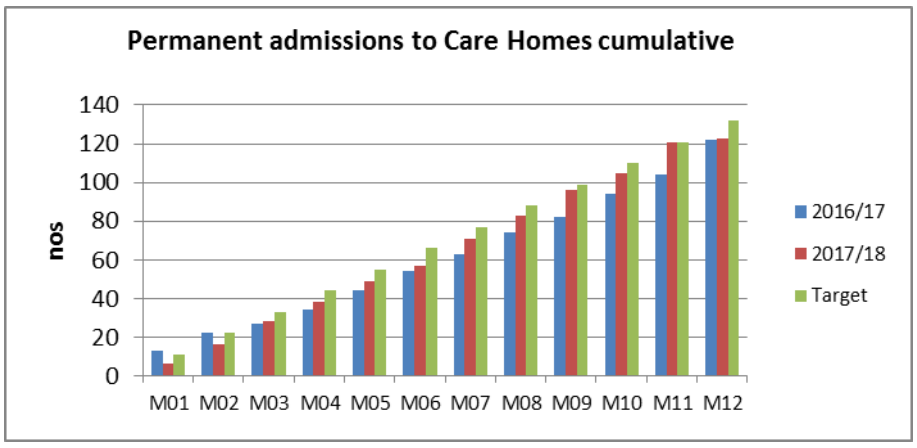

Local authorities based on Commissioning for Value packs as 10 most comparable areas and local Berkshire Unitary Authorities. Current rank in brackets (1 lowest, 150 highest)

We have compared our performance regionally and nationally over 2017/18:

- Wokingham's Absolute DToC ranking April 2017 to Feb 2018 24th out of 152 Authority areas
- Wokingham's Normalised for Population DToC ranking April 2017 to Feb 2018 49th out of 152 Authority areas
- Wokingham's Normalised for population South East and South West only ranking April 2017 to Feb 2018 4th out of 34 Authority areas

5.3 Permanent Admissions to Care Homes

For the 12 months to March 2018 admissions were 123, compared to target of 132 (9 less). This is 1 more than in 2016/17. March data is provisional and may be subject to revision.




Whilst we have reduced the demand on admissions to care homes year on year we

recognise that due to increasing care home costs WBC remain financially challenged, but without the work of the BCF schemes would be in an even more financially challenged position.

5.4 91 day target
YTD on average 79% of older people remain at home against a target of 78% for Q2 & Q3 for 17/18. Q4 target is higher at 85%.

5.5 Local Metrics
We do collect further metrics to understand our performance.

## 6. Finances (including initial benefits realisation)

*6.1 BCF Budget 2017/18*
The Wokingham BCF budget for 2017/18 was £9,865,900 and finished 2017/18 with a small aggregate overspend of £40.2k (0.4%) against budget. The Wokingham Borough Council hosted schemes finished on budget, while Wokingham CCG hosted schemes had an underspend of £29.9k. CHASC project management costs at £72.5k were £14.9k higher than budget, reflecting the slower than anticipated start-up of the scheme and hence increased project management required, but there were corresponding savings against budget for training and additional MDT co-ordinators.

Wokingham received £169k of funding from the iBCF, which was utilised as follows:

| | £ 000's |
|---|---|
| Wokingham contribution to the CHS contract for the period Nov 2017 – Mar 2018 | 30 |
| Reablement: Funding of short-term posts from Dec 2017 to March 2018 ( 1 x agency Social Worker + 2 x OTs) | 75 |
| Additional support for Adult Social Care (Home Care packages) | 64 |

Cross Berkshire West schemes showed an overspend of £70.0k.This was made up of Connected Care £61k cost pressure, RBFT DToC scheme (CHS contract) overspent by £32k and a £23k underspend on the South Central Ambulance Service (SCAS) Falls & Frailty scheme.

The Wokingham Contingency of £113k was unspent during the year. In accordance with the terms of the Section 75 Agreement, an amount of £56.4k (50%) has been returned to NHS Berkshire West CCG, with the balance being carried forward to fund schemes in the BCF for 2018/19.

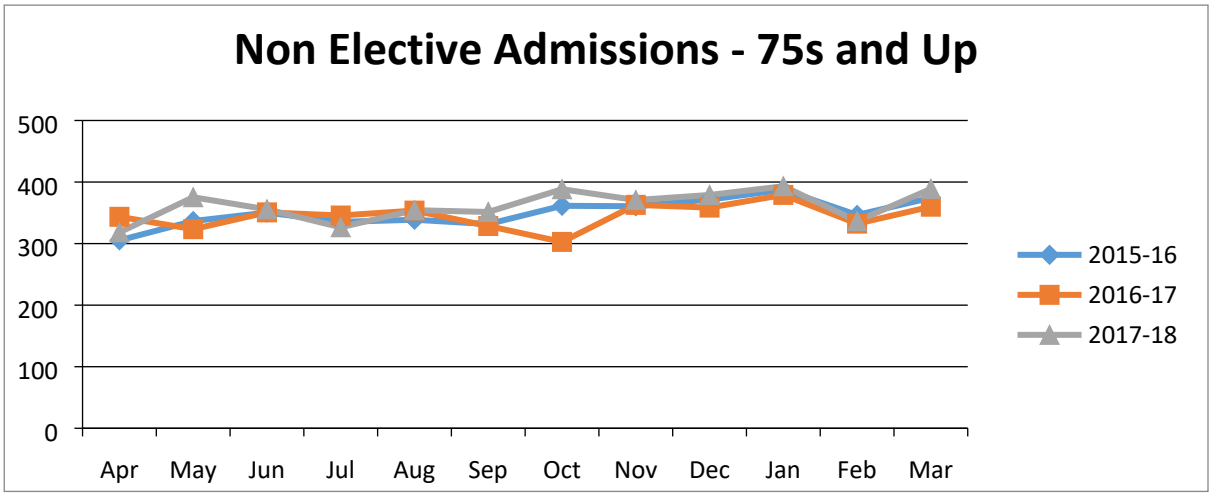
*6.2. Risk share*
The Wokingham BCF budget for 2017/18 included an amount of £477.3k in respect of risk share. Release of this money was contingent on the achievement of the NEA targets contained in the BCF Plan for 2017/18. The risk share was split up across the following BCF schemes: WISH; Step Up; CHASC and Care Homes/Rapid Response and Treatment. Each of these schemes individually contributed to reductions in NEAs; however the overall target for the year was not achieved (as shown in para 5.1 above). Actual was 13,630 v a plan of 12,612 (8.1% above plan). This compares to 12,845 in

2016/17, an increase of 6.1%. Since the NEA target was not met, the Risk Share has been retained by the CCG to cover the increased cost of the above plan NEAs.

*6.3. Benefits realisation*

6.3.1.Non Elective Admissions (NEAs)

The priority focus of schemes in the BCF was the Frail Elderly and the +75 age group. As can be seen from the graph and table below, this investment in BCF schemes and in particular the WISH team and the Rapid Response and Treatment scheme in Care Homes, has been successful in keeping the level of NEAs for this target group largely static over the last three years.



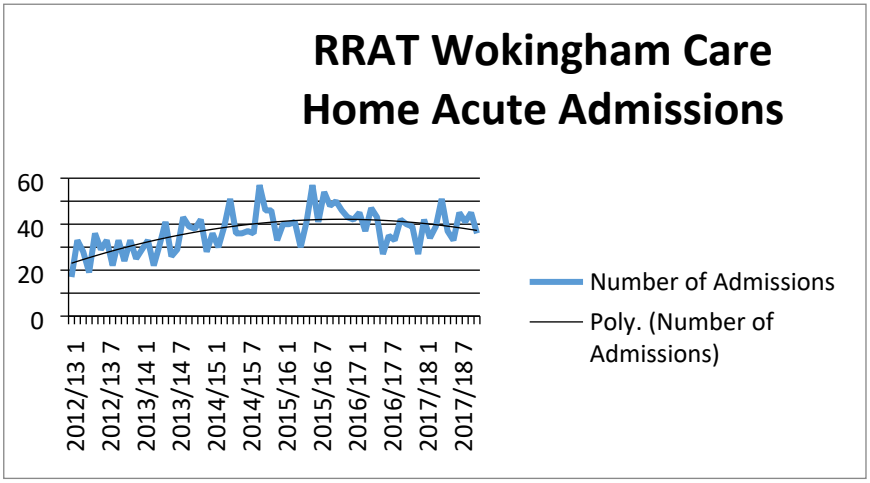

| Non Elective Admission Actuals | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total non-elective admissions in to hospital (general & acute), 75s and Up | 2015-16 | 305 | 337 | 350 | 335 | 339 | 332 | 361 | 361 | 372 | 387 | 347 | 374 |
| | 2016-17 | 344 | 323 | 351 | 346 | 354 | 329 | 303 | 363 | 358 | 379 | 332 | 360 |
| | 2017-18 | 318 | 375 | 356 | 326 | 354 | 351 | 388 | 371 | 379 | 393 | 336 | 389 |

| | | |
|---|---|---|
| Totals: | 2015-16 | 4,200 |
| | 2016-17 | 4,141 |
| | 2017-18 | 4,338 |

This compares to an increase of 17% in NEAs over the same period for the aggregate total for all ages.

The Rapid Response and Treatment scheme in Care Homes has played a key part in achieving this performance as can be seen from the table and graph below for Wokingham Care Homes.

| Year | Av monthly admissions from Care Homes | Total NEAs from Care Homes | Change from previous year | % increase/ (decrease) |
|---|---|---|---|---|
| 12/13 | 27.6 | 332 | | |
| 13/14 | 33.4 | 401 | 69 | 20.8% |
| 14/15 | 40.2 | 483 | 82 | 20.4% |
| 15/16 | 44.2 | 531 | 48 | 9.9% |
| 16/17 | 39.3 | 472 | -59 | (11.1)% |
| 17/18 Est | 40.3 | 484 | 12 | 2.5% |




The improvement over time is as shown above, but is understated as it does not take account of any demographic growth. Wokingham Care Homes had been on a 20% increase year-on-year prior to the introduction of the BCF scheme. Had this trend been maintained, then NEAs from Care Homes might have been of the order of 830 for 2017/18, which provides support for a reduction of 346 admissions annually from the Care Homes scheme.

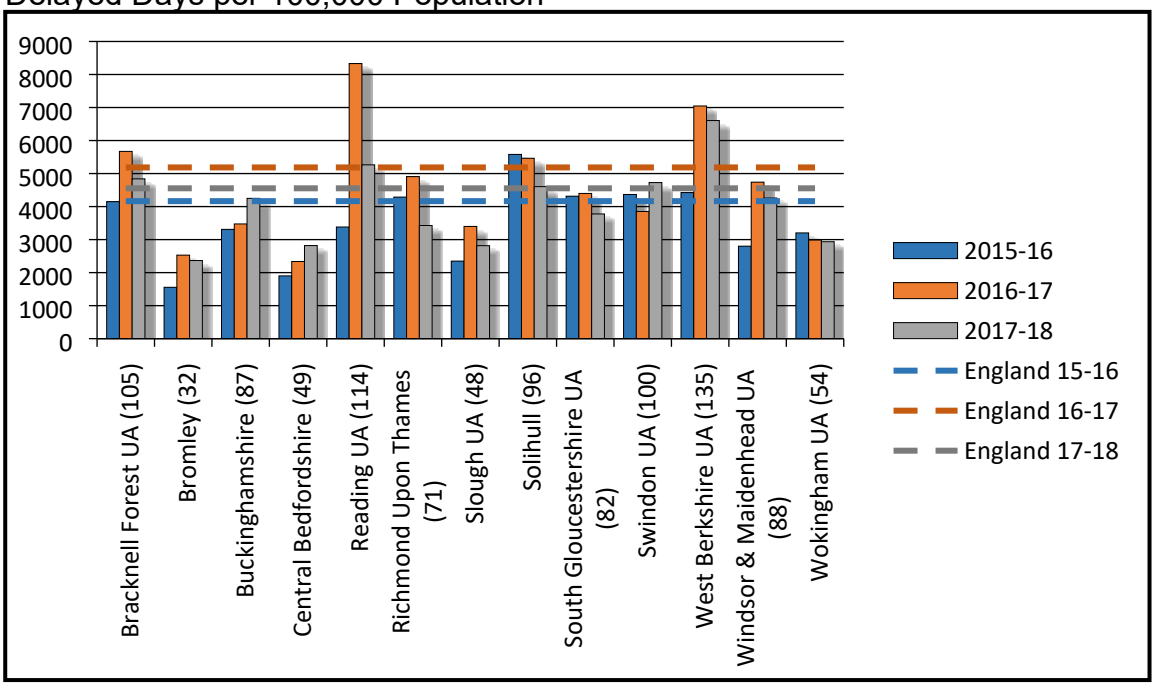
Despite only being in its first year of operation, CHASC achieved a reduction in NEAs of 118 and a reduction of 123 A&E attendances.

Based on the original business case cost of an NEA of £1,074 and the cost of an A&E attendance of £170 for these schemes, the financial benefit to the NHS in 2017/18 was £372,000 and £148,000 respectively.

6.3.2. Delayed Transfers of Care (DToC)
Wokingham has recorded a good performance against its DToC target in 2017/18 as is shown by the table below. DToC for 2017/18 was 3,689 days compared to a plan of 3,840 (4% below plan). This compares to 3,751 days in 2016/17 and represents a 1.7% reduction on the prior year.

| Delayed Transfers of Care | BCF SUPPORTING METRIC (NATIONAL) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| BCF SUBMISSION TARGETS | | 2015-16 | 16/17 | | | | 17-18 plans | | | |
| | | 2015-16 Q4 | 2016-17 Q1 | 2016-17 Q2 | 2016-17 Q3 | 2016-17 Q4 | 2017-18 Q1 | 2017-18 Q2 | 2017-18 Q3 | 2017-18 Q4 |
| Delayed transfers of care (delayed | *Plan* | 924 | 924 | 924 | 839 | 829 | 960 | 960 | 960 | 960 |
| | *Actuals* | 892 | 697 | 1,063 | 950 | 1,041 | 744 | 984 | 838 | 1,123 |
| Quarterly Variance | | - 32 | - 227 | 139 | 111 | 212 | - 216 | 24 | - 122 | 163 |
| Quarterly Variance % | | -3% | -25% | 15% | 13% | 26% | -23% | 3% | -13% | 17% |
| RAG Rating | | | | | | | | | | |

Delayed Days per 100,000 Population




Wokingham also benchmarks well against its peer group of local authorities based on Commissioning for Value packs as 10 most comparable areas and local Berkshire Unitary Authorities. Cumulative data for month 12 for each fiscal year.

The Wokingham Time to Decide (Step Down) scheme has operated at close to capacity for the whole year and has contributed to a saving of 128 bed days. Based on a cost of £400/day for an acute hospital bed, the financial benefit from Time to Decide to the NHS in 2017/18 was £51,000.

6.3.3. WISH

In 2015 a 5 Year detailed business case was prepared as part of the BCF submission of the total costs and benefits from the investment in WISH. The summary 5 year financial plan was as shown below.

| **WISH overall Business case** | | **Full Business Case** | | | | |
|---|---|---|---|---|---|---|
| | | **Revised** | | | | |
| **Costs of operation & implementation** | | **16/17** | **17/18** | **18/19** | **19/20** | **20/21** |
| **Total costs** | | **999,729** | **1,294,410** | **1,344,662** | **1,344,662** | **1,344,662** |
| **Total Benefits** | | **-495,858** | **-1,406,094** | **-1,919,930** | **-2,131,461** | **-2,211,345** |
| **Net cost / (Benefit)** | | **503,871** | **-111,684** | **-575,268** | **-786,799** | **-866,683** |
| **Cumulative Net Cost / (Benefit)** | | **503,871** | **392,187** | **-183,080** | **-969,880** | **-1,836,563** |

Benefits were derived from reductions in residential care, nursing home care, Home Care packages, reductions in DToC and NEAs.

An assessment of actual costs and benefits as at the end of year 2 shows that in broad terms the aggregate benefits are in line with the original business case, while costs are £644,000 less than planned. This is due to savings made in the Time to Decide scheme and the early termination of the Domiciliary Care Plus Night Responder scheme. Cumulatively then, at the end of year 2, WISH is ahead of its planned net benefit position and is on track to meet or exceed the planned 5 year savings target.

**In summary**

- National Performance Metrics – We exceeded performance in DToCs and Admissions to Care Homes and we have further work to improve NEA and 91 day reablement performance
- Financial Performance – Overall with we came in on budget as we are expecting to receive £61,000 from the CCG for the Connected Care Overspend. More importantly we are able to demonstrate for our business as usual schemes (WISH and TTD) that the planned benefits are being delivered.

| **Partner Implications** |
|---|
| N/A |

| **Reasons for considering the report in Part 2** |
|---|
| N/A |

| **List of Background Papers** |
|---|
| Nil |

| | |
|---|---|
| **Contact** Rhian Warner | **Service** Better Care Fund Programme |
| **Telephone No** Tel: 07989 346744 | **Email** rhian.warner@wokingham.gov.uk |

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# HEALTH AND WELLBEING BOARD

# ANNUAL REPORT

# 2017-18

WOKINGHAM BOROUGH COUNCIL

NHS Berkshire West Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

healthwatch Wokingham Borough

NHS England 70 YEARS OF THE NHS 1948 - 2018

# HEALTH
# AND WELLBEING BOARD

# ANNUAL REPORT 2017-18

## Introduction

The Health and Wellbeing Board has recently completed its fifth year as a formal committee.

Under the Health and Social Care Act 2012 all upper tier local authorities were required to establish Health and Wellbeing Boards from April 2013. Health and Wellbeing Boards are forums where key representatives from health, social care and the community can work in partnership to reduce health inequalities locally and to improve the overall health and wellbeing of residents.

The membership of the Board for 2017-18 was as follows:

- Councillor Julian McGhee-Sumner (Chairman) (Executive Member for Health and Wellbeing), Wokingham Borough Council (WBC) (until February 2018)
- Councillor Richard Dolinski (Chairman) (Executive Member for Health and Wellbeing), Wokingham Borough Council (WBC) (from February 2018)
- Councillor Mark Ashwell (Executive Member for Children's Services)
- Councillor Charlotte Haitham Taylor (Leader of the Council, WBC)
- Councillor Ian Pittock, WBC
- Dr Johan Zylstra (Vice Chairman) (NHS Wokingham Clinical Commissioning Group) (until April 2018)
- Dr Debbie Milligan (NHS Wokingham Clinical Commissioning Group) (from April 2018)
- Dr Cathy Winfield (NHS Clinical Commissioning Group)
- Katie Summers (NHS Wokingham Clinical Commissioning Group)
- Darrell Gale (Interim Strategic Director of Public Health for Berkshire)
- Paul Senior (Director People Services, WBC)
- Nick Campbell-White (Healthwatch Wokingham Borough)
- Nikki Luffingham (NHS England, Thames Valley Area Team) (currently substituted by Kevin Johnson)
- Superintendent Shaun Virtue (Community Safety Partnership)
- Beverley Graves (Business, Skills and Enterprise Partnership) (until December 2017)
- Clare Rebbeck (Voluntary, Community and Faith Sector) and (Place and Community Partnership)

The membership for 2018-19 is as follows:

- Councillor Richard Dolinski (Executive Member for Adult Social Care, Health and Wellbeing), Wokingham Borough Council (WBC)
- Councillor Pauline Helliar Symons (Executive Member for Children's Services)
- Councillor Charlotte Haitham Taylor (Leader of the Council, WBC)
- Councillor David Hare WBC

- Dr Debbie Milligan (NHS Berkshire West Clinical Commissioning Group)
- Dr Cathy Winfield (NHS Berkshire West Clinical Commissioning Group)
- Katie Summers (NHS Berkshire West Clinical Commissioning Group)
- Darrell Gale (Interim Strategic Director of Public Health for Berkshire)
- Nick Campbell-White (Healthwatch Wokingham Borough)
- Nikki Luffingham (NHS England, Thames Valley Area Team) (currently substituted by Kevin Johnson)
- Superintendent Shaun Virtue (Community Safety Partnership)
- Clare Rebbeck (Voluntary, Community and Faith Sector) and (Place and Community Partnership)

The core functions of the Health and Wellbeing Board are:

- To prepare a Joint Strategic Needs Assessment, which gives an overview of the Borough's current and likely future health and wellbeing needs;
- Based on evidence detailed within the Joint Strategic Needs Assessment, produce a Joint Health and Wellbeing Strategy, which details how needs identified will be met;
- To create and publish a pharmaceutical needs assessment, an overview of local pharmaceutical needs, services and any gaps in provision;
- To encourage integrated working between commissioners of health services, Public Health and social care services, for the purposes of advancing the health and wellbeing of the people in its area;
- To consider how resources can be shared effectively between partners and where appropriate, to pool budgets;
- The local Clinical Commissioning Groups must involve the Health and Wellbeing Board in the preparation or revision of their commissioning plans.

***Work Programme 2017-18:***
The 2017-18 Annual Report highlights key areas of work undertaken by the Health and Wellbeing Board during the previous municipal year, which included the following:

***Health and Wellbeing Strategy 2017-20:***

The Health and Wellbeing Board has worked to update the Borough's Health and Wellbeing Strategy. Board members during 2017-18 previously discussed where the Health and Wellbeing Board could make the biggest impact and key health and wellbeing indicators.

A refreshed Health and Wellbeing Strategy for 2017-2020 was designed around four main priorities:

- Enabling and empowering resilient communities;
- Promoting and supporting good mental health;
- Reducing health inequalities in our Borough;
- Delivering person-centred integrated services.

During 2018/19 the Health and Wellbeing Board will continue to work with its partners to address health inequalities, targeting those in the community who are most vulnerable.

***Better Care Fund (BCF):***

The BCF is the national programme, through which local areas agree how to spend a local pooled budget in accordance with the programme's national requirements. The pooled budget is made up of CCG funding as well as local government grants, of which one is the Improved Better Care Fund (iBCF).

The iBCF was first announced in the 2015 Spending Review, and is paid as a direct grant to local government, with a condition that it is pooled into the local BCF plan. The iBCF grant allocations were first given in April 2017. In 2017/18 we received £169,000, which drops to £112,000 for 2018/19. Our iBCF funding was considerably less than other surrounding local authority areas e.g. Reading £1,600,000 and West Berks £700,000.

For 2017/18 NHS England (NHSE) and the Department for Communities and Local Government (DCLG) required Health and Wellbeing Boards to submit quarterly returns for the BCF and iBCF. Throughout the year the Health and Wellbeing Board noted how the Better Care Fund plan was progressing against nationally set conditions and local performance targets.

In April 2017 all local authority areas in England were asked to express their interest in being a first wave graduate from the BCF and Wokingham applied in May 2017. We received confirmation in June 2017 that we were one of seven areas shortlisted.

| **Shortlisted** |
|---|
| Bexley |
| Greater Manchester |
| Lincolnshire |
| North East Lincolnshire |
| Nottinghamshire and Nottingham |
| Wokingham |
| Surrey |

In September 2017 the Chairman of the Health and Wellbeing Board signed off the 2017/19 Better Care Fund Narrative Submission to NHSE and DLCG on the 11th September 2017 and we received confirmation on the 27th October that our plan has been approved by NHS England.

In January 2018 the Health and Wellbeing Board considered an evaluation matrix of the current Better Care Fund schemes which had been completed by the Wokingham Integration Strategic Partnership (WISP). WISP is one of the partnerships which helps to implement the work of the Health and Wellbeing Board. This evaluation would help to inform whether investments in projects continued and the best use of resources. It was important that projects demonstrated value and benefited residents.

It is planned that in June 2018 the Board members will be presented with the Better Care Fund Annual Report 2017/18 which will provide a high level overview of performance against the budget of the Better Care Fund for 2017/18 in accordance with the Section 75 agreement.

***Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (BOB STP):***
Sustainability and Transformation Plans were introduced by NHS England to support the delivery of the Five Year Forward View. There are 44 'footprints' across the country, of which Buckinghamshire, Oxfordshire and Berkshire West (BOB) is one. BOB covers a population of approximately 1.8million and a place based budget of £2.5billion.

The Board received a number of updates on and commented on the likely approach, workstreams and proposed BOB STP finances. Board members felt that further clarification regarding governance arrangements and accountability in particular, was required.

***Clinical Commissioning Group (CCG) Operational Plan 2017-19:***

At its February 2017 meeting the Health and Wellbeing Board endorsed the NHS Wokingham Clinical Commissioning Group Operational Plan 2017-19.

The HWB Board previously discussed urgent care, A&E targets, and cancer waits. For 2017/18, key performance metrics in these areas were:

- 91% of patients waited less than four hours in A&E (from arrival to admission, transfer or discharge) against the national target of 95%. Performance was very challenged in the last quarter of 2017/18 due to the high numbers of very sick patients requiring admission. In March 2018 national performance was 85%. The Government's mandate to NHS England for 2018-19 stated that the NHS must "deliver aggregate A&E performance in England above 90% in September 2018, with the majority of trusts meeting 95% in March 2019". In order to meet these the A&E delivery board (partners include Royal Berkshire, CCG, LAs, Healthwatch and Berkshire HealthCare Foundation Trust) are actively working through NHS England and LGA High Impact Changes in order to continue to achieve performance.
- Delayed Transfers of Care for Wokingham in 2017/18 was 3,689 days. This compares to 3,751 days in 2016/17 and represents a 1.7% reduction on the prior year.
- 87% of people in Wokingham with urgent GP referral had their first definitive treatment for cancer within 62 days of referral, against a national target of 85%. In February 2018 national performance was 81%.

The Wokingham CCG Quality Premium Target was to increase the number of patients diagnosed with diabetes (diagnosed for less than a year) who attended a structured education course from 5.86% to 15%. We are awaiting final performance data on this measure and will provide it to the Board in due course.

The Wokingham CCG Operational Plan 2017-19 has been superseded by the 2018/19 Berkshire West CCG Plan. This sets out how the CCG will deliver the NHS Five Year Forward View, working as part of the BOB STP and driving the establishment of the Berkshire West Integrated Care System. The CCG will continue to build on strong partnership working with the three local authorities in Berkshire West to deliver the BW10 programme and maximise the impact of the Better Care Fund investment.

***Health and Wellbeing Performance Dashboard:***

The Health and Wellbeing Board received reports on the existing performance dashboard. Information regarding a variety of key indicators selected by the Board including Adult Obesity (those with a BMI over 30), Number of Patients per GP and Number of affordable dwellings completed, was considered at each meeting. The last time these indicators was reported to the Health and Wellbeing Board was April 2017

To complement the development of the new Health and Wellbeing Strategy, a decision was taken to update the dashboard, to reflect the 4 new priorities and a list of 44 proposed Key Performance Indicators was presented to the Board in October 2017.

The latest updates of the Public Health Outcomes Framework are presented as new data is available (different indicators at each update). The good performance is not repeated here, just those of concern. The August update showed increases in hospital admissions for self-harm and falls. The October update showed that the 3 indicators around NHS Health Checks which had all deteriorated (action is being undertaken to address NHS Health Check performance in the borough). The update presented in December 2017 identified three findings of concern:

- The crude rate of households that were classified as statutory homeless in temporary accommodation was increasing
- The proportion of people living in fuel poverty was increasing.
- The proportion of population aged 65+ who are vaccinated against pneumococcus infection (PPV) was decreasing.

In April 2018 a new shortlist of 11 indicator areas were proposed and they have been taken away to develop further, as some were not actually indicators themselves but an assessment of progress based on a basket of indicators. A refreshed dashboard is being presented to the June 2018 meeting.

The majority of nationally collected indicators reflect good health and wellbeing across the Borough.

***Berkshire Transforming Care Partnership:***

The Partnership had a shared vision and commitment to support the implementation of the national service model to ensure that those with learning disabilities, behaviour that challenged and those with mental health difficulties and autism, received services to lead meaningful lives through tailored care plans and subsequent bespoke services to meet individual needs.

We have continued to reduce inappropriate hospitalisation of people with a learning disability, autism or both, so that the number in hospital reduces at a national aggregate level by 35% to 50% from March 2015 by March 2019. There are continuous efforts to move people out of long stay hospitals into appropriate community settings. The TCP Board has set a plan to reduce Berkshire East and West CCGs commissioned in-patient beds to 10-15 beds per million population by the end of 2018/19, this work continues to be in progress. Working with the provider, Berkshire Heath Care NHS Foundation and NHS England Specialist Commissioning Team the plan is on track to reduce CCG and NHS

England commissioned bed capacity from 44 to 28 within the time line and working with the best of local experience, skills and knowledge a new service model has been created that incorporates Positive Behavioural Support and increased level of community based provision resulting in a reduction in beds.

We have continued to improve access to healthcare for people with a learning disability, so that the number of people receiving an annual health check from their GP is 64% higher than in 2016/17. The Programme Board is working in partnership with GP practices to ensure that reasonable adjustments are made to enhance access for annual health checks. GP practices are encouraged to ensure that the right coding is used to ensure that people have timely access to annual health checks. We are presently on track to meet this target.

We have made further investment in community teams to avoid hospitalisation. Berkshire West has developed an intensive support team, the remit of this team has been developed to ensure that people are supported in the community to manage risks and avoid hospital admissions. We are working closely with our provider to continue the development of this team.

We have ensured more children with a learning disability, autism or both get a community Care, Education and Treatment Review (CETR) to consider other options before they are admitted to hospital. We are continuing to work with our provider on this to ensure that the earliest intervention point is realised to gain better outcomes for our children. We are also working with NHS England on developing joint CETR for cohorts that are currently in tier 4 provision.

We continue to develop the work on tackling premature mortality by supporting the review of deaths of patients with learning disabilities, as outlined in the National Quality Board 2017 guidance. NHS Berkshire West CCGs have implemented the LeDer progamme that oversees the review of all deaths and have appointed reviewers.

We also continue with the provision of Little House and are working with the providers to establish a selected co-hort of residents that will able to make effective use of this scheme.

In addition to these Berkshire Transforming Care Plan has 4 key aims:

1. More care in the community, with personalised support provided by multi-disciplinary health and care teams
2. More innovative services to give people a range of care options, with personal budgets, so that care meets individuals needs
3. Early, more intensive support for those who need it, so that people can stay in the community, close to home
4. Inpatient care, but only as long as is needed and is necessary

To achieve those aims the TCP Board has established a programme and governance structure built around a number of work streams, with children and young people and those in transition being a core component of each

There are seven work streams:-

1. Joint commissioning and integration – aligning financial processes, explore joint commissioning, jointly managing the market
2. Communication and engagement – stakeholder identification, creation of communications plan, effective communication and engagement
3. Workforce development and culture – cultural audit, workforce development programmes for staff, creating a cultural change programme
4. Children and young people – engaging services, developing new joint ways of working and person led plans
5. Autism – engaging with service users, including people in developments, enhancing support
6. Service reconfiguration – deliver intensive support team service, reducing reliance on bed based care, growing housing and support services, developing meaningful day accommodation and employment opportunities, enhance services to meet needs of children and young people in transition, further support for people with autism
7. Risk management – shared financial, quality, relational risk plan, mitigate risks through a programme management approach

These form our priority actions for 2018 – 2019

***CAMHS Transformation Plan - Implementing Future in Mind across Berkshire West CCGs and Wokingham Borough Council and Wokingham CCG Emotional Health and Wellbeing Strategy:***

Children and young peoples' mental health and wellbeing continue to be a main priority. The Health and Wellbeing Board continued to be updated on the CAMHS Transformation Plan - Implementing Future in Mind across Berkshire West CCGs and the Wokingham Borough Council and Wokingham CCG Emotional Health and Wellbeing Strategy.

At its meeting in Feb 2018, the Health and Wellbeing Board was informed of continued action being taken to improve service delivery locally. Waiting times for specialist CAMHs in Wokingham are generally better than the national average and overall waiting times for services have reduced since 2015. However with the service now at full capacity unfortunately waiting times are likely to increase unless demand can be managed better at an earlier stage and additional resources can be secured. A number of important achievements locally to Wokingham were noted in improving children's emotional and mental health, including work with Schools, Voluntary Sector (ARC youth counselling) and a new urgent care team based at the hospital. Board members agreed that it was vital that children and young people emotional and mental health continue to be a priority.

***Berkshire Suicide Prevention Strategy and Wokingham Suicide Prevention Action Plan:***

The Berkshire Suicide Prevention Strategy was received and endorsed at the meeting in April 2017. The Health and Wellbeing Board supported the target of a 25% reduction rate in suicides locally by 2020 and the aspiration to go beyond this.

A Wokingham Borough specific Wokingham Suicide Prevention Action Plan contained within the Strategy was agreed.

***Health and Wellbeing Board Member Training:***
Leadership training specifically for Health and Wellbeing Board Chairs and Deputies is being arranged to take place in 2018.

***Partnerships:***
The work of the Health and Wellbeing Board is supported by the following partnerships:

- Business, Skills and Enterprise Partnership;
- Children and Young People's Partnership;
- Community Safety Partnership;
- Place and Community Partnership;
- Wokingham Integration Strategic Partnership.

The Health and Wellbeing Board received regular updates from the relevant Board members on the work of the Business, Skills and Enterprise Partnership, Community Safety Partnership, Place and Community Partnership, the Voluntary Sector and Healthwatch Wokingham Borough.

**2018/19 Work Programme:**
The Health and Wellbeing Board's work programme for 2018/19 will be an evolving document and will be developed over the next few months. The outcomes from the emerging Joint Strategic Needs Assessment will inform the priorities for the work of the Health and Wellbeing Board's work programme for 2018/19.

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| | |
|---|---|
| **TITLE** | **Community Safety Partnership Update** |
| **FOR CONSIDERATION BY** | Health & Wellbeing Board on 14 June 2018 |
| **WARD** | None Specific |
| **DIRECTOR/ KEY OFFICER** | Shaun Virtue, Graham Ebers (Joint Chairs of CSP) |

| | |
|---|---|
| Health and Wellbeing Strategy priority/priorities most progressed through the report | Enabling and empowering resilient communities |
| Key outcomes achieved against the Strategy priority/priorities | Community safety and crime reduction priorities can support the achievement of health improvement outcomes and vice versa. |

**SUMMARY OF REPORT** The Community Safety Partnership (CSP) continues to deliver its work plan through the actions of the various subgroups which report into it. Health partners including Public Health Officers, the Clinical Commissioning Groups (CCG), and the Mental Health Trusts are actively engaged in each subgroup, supporting the operational delivery of key projects.

One of the subgroups of the CSP, the Problem Solving Task Group continues to meet on a monthly basis with multiagency membership. The group are currently working to reduce anti-social behaviour (ASB) and reported increase in substance misuse in Wokingham particularly in the Woosehill area through the implementation of Operation Orca as discussed at your previous Board. Operation Orca has now been rolled out and is impacting the community in a positive way with Police seeing a decline in the report of instances of ASB over the last two weeks although the fear of crime is still prevalent.

One of the actions taking place to combat the reported increase in substance misuse is to increase the awareness and knowledge of the issue amongst parents. To do this Thames Valley Police in partnership with the CSP and Wokingham Safeguarding Children's Board will be sending a letter to all parents with students attending Wokingham Secondary Schools advising them of the increase in drug and alcohol use by young people in the Borough and what support is available. The letter will also include a fact sheet entitled, 'Cannabis – Risks, Signs and What To Do' and 'Xanax'.


Wokingham Federation drugs lett


Cannabis - Risks Signs and What to Do


XANAX information sheet.pdf

Following reports of young people using bags of dog mess from bins to throw at resident's properties, the problem solving task group are looking at whether the introduction of tamper proof dog fouling bins can be installed in high risk areas to stop access to the contents of the bins.

The KICKS project run by Reading FC Community Trust and supported by the Wokingham CSP are working with the Problem Solving Task Group to implement a 6 week project in

every secondary school in the Borough to educate young people around the effects of substance misuse; not only medically but also the effects on their family and their future. This programme will also educate young people on County Lines Dealing and how to stay safe and what support available.

Partnership working between Thames Valley Police and our drugs service provider SMART is underway to look at a Drugs Worker accompanying a police patrol to offer support and advice to drug users immediately on contact.

The Community Safety Partnership Strategy 2018-21 is being presented to the People's Services Leadership Team on 14th June and will then be brought to the Health and Wellbeing Board for review and approval. The four priorities identified in the strategy are;

- Addressing Violence Against Women and Girls
- Reducing Organised Crime including the impact of County Lines Dealing
- Reduce and prevent exploitation and address the needs of vulnerable victims and offenders
- Empower and enable the resilience of local communities

**Partner Implications**

Health partners are fully engaged in the CSP and its various subgroups, and are therefore well placed to support the Police, Council and other partners to deliver the crime reduction priorities.

**Recommendations**

- The increase in substance misuse amongst the Boroughs young people is a concern for all agencies and residents. The support of Health colleagues is paramount to addressing these through projects run by the CSP and the Problem Solving Task Group.

- The CSP continue to evaluate County Lines Dealing and any impact this has or could have in Wokingham. The CSP Manager attends regular meetings with CSP managers from other authorities in Berkshire and Police Intelligence and any impact that County Lines Dealing has on Wokingham will be cascaded through partners and acted upon.

- It is understood that the Councils current policy is that dog waste bins are not installed but due to the current trend in certain areas of using dog mess from standard bins, Health and Wellbeing Board members are asked to support requests for tamper proof bins to be installed in high risk areas once the full impact both financial and practical has been presented to the relevant directorates.

**List of Background Papers**

None

**HEALTH AND WELLBEING BOARD**

**Forward Programme from June 2018**

**Please note that the forward programme is a 'live' document and subject to change at short notice.**

*The order in which items are listed at this stage may not reflect the order they subsequently appear on the agenda.*

**All Meetings start at 5pm in the Civic Offices, Shute End, Wokingham, unless otherwise stated.**

# HEALTH AND WELLBEING BOARD FORWARD PROGRAMME 2018/19

| DATE OF MEETING | ITEM | PURPOSE OF REPORT | REASON FOR CONSIDERATION | RESPONSIBLE OFFICER / CONTACT OFFICER | CATEGORY |
|---|---|---|---|---|---|
| **10 August 2018** | **Adult Social Care Strategy 2020 and beyond** | Update | Update | Director of People Services | Integration |
| | **Berkshire West Integrated Care System Operating Plan** | To note | To note | NHS Berkshire West CCG | Organisation and governance |
| | **Health and Wellbeing Board Refresh** | To monitor performance | To monitor performance | Director Corporate Services | Performance |
| | **Updates from Board members** | To receive an update on the work of Board members | To update on the work of Board members | Health and Wellbeing Board | Organisation and governance |
| | **Forward Programme** | Standing item. | Consider items for future consideration | Democratic Services | |

| DATE OF MEETING | ITEM | PURPOSE OF REPORT | REASON FOR CONSIDERATION | RESPONSIBLE OFFICER / CONTACT OFFICER | CATEGORY |
|---|---|---|---|---|---|
| **11 October 2018** | **Health and Wellbeing Board Refresh** | To monitor performance | To monitor performance | Director Corporate Services | Performance |
| | **Updates from Board members** | To receive an update on the work of Board members | To update on the work of Board members | Health and Wellbeing Board | Organisation and governance |
| | **Forward Programme** | Standing item. | Consider items for future consideration | Democratic Services | |

| DATE OF MEETING | ITEM | PURPOSE OF REPORT | REASON FOR CONSIDERATION | RESPONSIBLE OFFICER / CONTACT OFFICER | CATEGORY |
|---|---|---|---|---|---|
| **13 December 2018** | **Health and Wellbeing Board Refresh** | To monitor performance | To monitor performance | Director Corporate Services | Performance |
| | **Updates from Board members** | To receive an update on the work of Board members | To update on the work of Board members | Health and Wellbeing Board | Organisation and governance |
| | **Forward Programme** | Standing item. | Consider items for future consideration | Democratic Services | |

| DATE OF MEETING | ITEM | PURPOSE OF REPORT | REASON FOR CONSIDERATION | RESPONSIBLE OFFICER / CONTACT OFFICER | CATEGORY |
|---|---|---|---|---|---|
| **14 February 2019** | **Health and Wellbeing Board Refresh** | To monitor performance | To monitor performance | Director Corporate Services | Performance |
| | **Updates from Board members** | To receive an update on the work of Board members | To update on the work of Board members | Health and Wellbeing Board | Organisation and governance |
| | **Forward Programme** | Standing item. | Consider items for future consideration | Democratic Services | |

| DATE OF MEETING | ITEM | PURPOSE OF REPORT | REASON FOR CONSIDERATION | RESPONSIBLE OFFICER / CONTACT OFFICER | CATEGORY |
|---|---|---|---|---|---|
| **5 April 2019** | **Health and Wellbeing Board Refresh** | To monitor performance | To monitor performance | Director Corporate Services | Performance |
| | **Updates from Board members** | To receive an update on the work of Board members | To update on the work of Board members | Health and Wellbeing Board | Organisation and governance |
| | **Forward Programme** | Standing item. | Consider items for future consideration | Democratic Services | |