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# WOKINGHAM BOROUGH COUNCIL

A Meeting of the **WOKINGHAM BOROUGH WELLBEING BOARD** will be held in the Council Chamber - Civic Offices, Shute End, Wokingham RG40 1BN on **THURSDAY 14 OCTOBER 2021** AT **5.00 PM**

Susan Parsonage
Chief Executive
Published on 6 October 2021

This meeting may be filmed for inclusion on the Council's website.

**Note:** Although non-Committee Members and members of the public are entitled to attend the meeting in person, space is very limited due to the ongoing Coronavirus pandemic. You can however participate in this meeting virtually, in line with the Council's Constitution. If you wish to participate either in person or virtually via Microsoft Teams, please contact Democratic Services. The meeting can also be watched live using the following link: https://youtu.be/x3oPa7VD0ow

# Creating Healthy & Resilient Communities

Key Priorities


WOKINGHAM
BOROUGH COUNCIL

## MEMBERSHIP OF THE WOKINGHAM BOROUGH WELLBEING BOARD

| | |
|---|---|
| Charles Margetts | Wokingham Borough Council |
| Debbie Milligan | NHS Berkshire West CGC |
| Philip Bell | Voluntary Sector |
| Carol Cammiss | Director, Children's Services |
| Graham Ebers | Deputy Chief Executive |
| Nick Fellows | Voluntary Sector |
| John Halsall | Wokingham Borough Council |
| David Hare | Wokingham Borough Council |
| Graham Howe | Wokingham Borough Council |
| Nikki Luffingham | NHS England |
| Steve Moore | Director, Place and Growth |
| Susan Parsonage | Chief Executive |
| Meradin Peachey | Director Public Health – Berkshire West |
| Matt Pope | Director, Adult Social Care & Health |
| Katie Summers | Director of Operations, Berkshire West CCG |
| Jim Stockley | Healthwatch |

| ITEM NO. | WARD | SUBJECT | PAGE NO. |
|---|---|---|---|
| **13.** | | **APOLOGIES**<br>To receive any apologies for absence | |
| **14.** | None Specific | **MINUTES OF PREVIOUS MEETING**<br>To confirm the Minutes of the Meeting held on 10 June 2021. | **5 - 10** |
| **15.** | | **DECLARATION OF INTEREST**<br>To receive any declarations of interest | |
| **16.** | | **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 | |
| **17.** | | **MEMBER QUESTION TIME**<br>To answer any member questions | |

| | | | |
|---|---|---|---|
| **18.** | None Specific | **COVID UPDATE**<br>To receive an update on Covid locally. | **Verbal Report** |
| **19.** | None Specific | **WOKINGHAM HEALTH AND WELLBEING STRATEGY INTO ACTION AND ASSOCIATED ACTION PLANS**<br>To consider adoption of the Wokingham Health and Wellbeing Strategy into Action and Associated Action Plans. | **11 - 168** |
| **20.** | None Specific | **'FROM DIAGNOSIS TO END OF LIFE: THE LIVED EXPERIENCES OF DEMENTIA CARE AND SUPPORT' ALZHEIMER'S SOCIETY REPORT AND THE IMPLICATIONS FOR WOKINGHAM**<br>To receive a presentation from Laura Vicinanza, Regional Public Affairs and Campaigns Officer Alzheimer's Society, on the 'From diagnosis to end of life: The lived experiences of dementia care and support' Alzheimer's Society Report and the implications for Wokingham. | **169 - 204** |
| **21.** | None Specific | **ICP UNITED EXECUTIVE CHAIR'S REPORT**<br>To receive an update on discussions and developments from the Integrated Care Partnership (ICP) Unified Executive meeting, the most senior ICP meeting within Berkshire West. | **205 - 206** |
| **22.** | None Specific | **FORWARD PROGRAMME**<br>To consider the Board's work programme for the remainder of the municipal year. | **207 - 210** |

**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

**MINUTES OF A MEETING OF THE**
**WOKINGHAM BOROUGH WELLBEING BOARD**
**HELD ON 10 JUNE 2021 FROM 5.00 PM TO 6.00 PM**

**Present**

| | |
|---|---|
| Charles Margetts | Wokingham Borough Council |
| Debbie Milligan | NHS Berkshire West CGC |
| Philip Bell | Voluntary Sector |
| Carol Cammiss | Director, Children's Services |
| Nick Fellows | Voluntary Sector |
| John Halsall | Wokingham Borough Council |
| David Hare | Wokingham Borough Council |
| Graham Howe | Wokingham Borough Council |
| Susan Parsonage | Chief Executive |
| Matt Pope | Director, Adult Social Care & Health |
| Katie Summers | Director of Operations, Berkshire West CCG |
| Jim Stockley | Healthwatch |

**Also Present:**

| | |
|---|---|
| Madeleine Shopland | Democratic and Electoral Services Specialist |
| Narinder Brar | Community Safety Manager |
| Phil Cunnington | |
| Ingrid Slade | Public Health Consultant |
| Lewis Willing | Head of Health and Social Care Integration |

**1. ELECTION OF CHAIRMAN**

**RESOLVED:** That Councillor Charles Margetts be elected as Chairman of the Wokingham Borough Wellbeing Board for the 2021-22 municipal year.

**2. APPOINTMENT OF VICE CHAIRMAN**

**RESOLVED:** That Dr Debbie Milligan be appointed as Vice Chairman of the Wokingham Borough Wellbeing Board for the 2021-22 municipal year.

**3. APOLOGIES**

Apologies for absence were submitted from Steve Moore, Meradin Peachey and Martin Sloan.

**4. MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting of the Board on 11 March 2021 were confirmed as a correct record and signed by the Chairman.

At the request of the Chairman, Ingrid Slade provided an update on Covid surge testing. The case rate for Wokingham was 91.7. The South East rate had increased to 33 and the England rate had increased above 50. The rate was also rising in Reading, Bracknell Forest and Slough. The positivity rate was also rising locally.

Following the identification of Delta variation cases not associated with travel, surge testing was being undertaken in Bulmershe and Whitegates, Norreys, Wescott and Evendons of all those over 12 years old who lived, worked or attended secondary school, in these wards. There was a postcode checker available on the Council's website for people to identify if this applied to them.

The Board was reminded that the PCR tests should be taken even if the individual was fully vaccinated or undertaking regular lateral flow tests. The testing sites were listed on the Council's website. Door knocking was being undertaken in the relevant wards to advise and encourage people to get tested. Tests were being distributed to all schools and businesses in the area and support was being provided to vulnerable residents within the surge testing areas. Uptake so far had been good. It was noted that clear variant results would not be seen for at least 2 weeks.

**5. DECLARATION OF INTEREST**

There were no declarations of interest.

**6. PUBLIC QUESTION TIME**

There were no public questions.

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**7. MEMBER QUESTION TIME**

There were no Member questions.

**8. STRATEGY INTO ACTION**

The Board considered the Strategy into Action update.

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

- The existing Wokingham Wellbeing strategy needed to be rolled forwards for a couple of months. The Board was asked to note the proposed Berkshire West Strategy.
- It was proposed that a series of workshops be held throughout the summer to work through each of the priorities in more detail to produce a plan for Wokingham going forward. It was intended that this plan be signed off in September.
- Ingrid Slade commented that the Berkshire West Health and Wellbeing Strategy was a high-level strategy across all three local authorities which highlighted 5 key priorities. It had been in development since April 2019. For each priority current work relating to the priority would be identified. Specific local priorities under the overarching strategic priority and key partners would also be identified.
- Ingrid Slade outlined the development plan.
- Partnerships would take ownership of the delivery of the priorities and would report bi-monthly on their progress to the Wellbeing Board. It was anticipated that relevant stakeholders would be involved in the delivery.
- Councillor Hare was pleased to note the exploration of a universal approach for children, and the importance of that in Early Years. He was also pleased to note the preventative work.
- Katie Summers questioned whether an Equality Impact Assessment had been undertaken. The vaccination programme had identified some issues regarding how individuals from deprived areas, different ethnicities, those from the Gypsy and Romany traveller community, and those with disabilities, were supported. Ingrid

Slade commented that tackling health inequality was at the heart of what they did and needed to be a focus when looking at all the priorities.

- Katie Summers indicated that she had done some work on what the overarching population gross would be. There was likely to be a population gap in the 21-49 year olds so there also needed to be a focus on workforce and how new workforce could be brought in and the strategy delivered.

**RESOLVED:** That

1) the development plan for the Strategy into Action section of the Berkshire West Health and Wellbeing Strategy be reviewed and noted.

2) further input from Board members on this development plan be invited.

3) Board members be invited to participate in the workshops as part of the development of the Strategy into Action.

4) the plan of reporting against the Wellbeing Board Strategic priorities be noted.

5) the current draft of the Berkshire West Health and Wellbeing Strategy be noted.

## 9. WOKINGHAM INTEGRATED PARTNERSHIP UPDATE AND END OF YEAR BCF REPORTING

The Board were updated on the Wokingham Integrated Partnership and end of year reporting.

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

- Each year there was a requirement to report to NHS England with regards to the Better Care Fund. The Annual Return had been submitted but had been much shorter as this year did not have a formal submitted BCF Plan.
- A plan had been agreed locally and a Section 75 had been completed to appropriately share the funds between the Council and the CCG.
- It was noted that the national conditions had been met, income and expenditure targets had been matched and the programme had not overspent.
- A comment on three statements from NHS England had been required.
- Whilst many Integration Boards had not been meeting as frequently during the pandemic, the WIP had increased the frequency of meetings.
- The WIP had disagreed with the comment that 'Our BCF schemes were implemented as planned in 2020/21'. A very full programme had been planned, which had not all been delivered due to the pandemic.
- Lewis Willing outlined the challenges including supporting choice during the pandemic.
- The Board noted some of the work that had been delivered in 2020/21 and work undertaken so far in 2021/22.
- The Integration Team continued to support the WIP with the response to Covid, including undertaking a pilot to support the Council's Contract Tracers to contact people from Cohorts 1-9 who had not been vaccinated yet, which had had some success, increasing the uptake in this group by 26% for one GP practice.
- Councillor Margetts questioned when the MIND Service was likely to launch and was informed that work had already begun with a couple of practices so it was likely

to be the end of June/early July. Staff were currently going through their induction process.

**RESOLVED:** That the Wokingham Integrated Partnership Update and end of year BCF reporting be noted.

## 10. DRAFT WOKINGHAM COMMUNITY SAFETY STRATEGY 2021-2024

The Board received the Draft Wokingham Community Safety Strategy 2021-24.

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

- The current Community Safety Strategy was due to finish at the end of June. The Community Safety Partnership had a statutory duty to produce a Strategy for the Borough which looked at all of the crime and disorder issues and how the key issues would be tackled, including anti social behaviour, drug and alcohol issues and domestic abuse.
- The Partnership had reviewed the available data considered by the different partners across the last 5 years and established the key priorities.
- The Board noted the three strategic themes; Listening to the needs and concerns of local residents and taking action; Intervening early and preventing issues escalating and; Working together to protect vulnerable residents.
- It was noted that different neighbourhoods had different needs and would potentially require different responses.
- Narinder Brar went on to outline the specific aims of the Strategy.
- Covid 19 had produced an exceptional set of circumstances and challenges. It had also resulted in dramatically changing and unusual trends. Notable trends had included a fall in burglary and vehicle crime offences and a rise in domestic violence and anti-social behaviour in residential estates and parks and green spaces. This would continue to be monitored.
- A good response had been received to the consultation on the Strategy.
- Councillor Margetts asked whether the amount of domestic abuses services and funding open to women would the same or greater under the new contract. Narinder Brar indicated that due to an increased investment as a local authority the proportion available in terms of service amounts would have increased across the Borough. There would be a greater opportunity to respond to need.
- Katie Summers asked there had been a surge in the reporting of incidents following Covid. Narinder Brar stated that whilst it had been anticipated, there had not been a big increase in reporting. There had been a slight drop in the number of incidents reported to the Police. However, the level of service use remained consistent.
- Katie Summers asked if primary care was seeing an increase in those presenting with community safety and domestic abuse issues. Dr Milligan responded that early in the pandemic an increase in child abuse had been seen. She commented that sometimes adults found if difficult to view themselves as victims. There needed to be education and information available about accessing the relevant services, in the different communities. Narinder Brar indicated that the Domestic Abuse Act had come into force, bringing about a new definition of domestic abuse. Funding would allow an increase in communication, in different languages and different places. Covid had enabled the reassessment of social media platforms and accessing people via these means. Across Thames Valley training had been undertaken in supermarkets and pharmacies about recognising signs of abuse and safe spaces. Training and information would also be rolled out to hairdressers.

- Dr Milligan asked whether information from CAB was being used to better hear people's views. She was informed that during the first lockdown more information was being received from people who had phoned CAB on a different matter and had also revealed on the call that they were not in a safe position.
- Phil Cunnington requested whether a simple feedback summary could be provided to Neighbourhood Association Groups who had provided information regarding residents' concerns. This would help to reenforce the feeling of engagement.
- Councillor Halsall thanked the Officers for their hard work and outlined some of the improvements that had taken place in the community safety area.

**RESOLVED:** That the Draft Wokingham Community Safety Strategy 2021-24 be noted.

## 11. ANNUAL REPORT WOKINGHAM BOROUGH WELLBEING BOARD 2020-2021

The Board considered the Annual Report Wokingham Borough Wellbeing Board 2020-21.

**RESOLVED:** That

1) the annual Wellbeing Board report and achievements for 2020/21 be reviewed.

2) the establishment of the three Wellbeing Board Action Groups who will be support the Board to identify the ongoing priorities for 2021/22, be noted.

3) the report be recommended to Council to note.

## 12. FORWARD PROGRAMME

The Board considered the forward programme for the remainder of the municipal year.

Board members were reminded of the informal workshops that would be held across the summer.

**RESOLVED:** The forward programme be noted.

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|---|---|
| **TITLE** | **Wokingham Health and Wellbeing Strategy into Action and Associated Action Plans** |
| **FOR CONSIDERATION BY** | Wokingham Borough Wellbeing Board on 9th September 2021 |
| **WARD** | None Specific; |
| **DIRECTOR/ KEY OFFICER** | Ingrid Slade, Head of Public Health, Wokingham Borough Council<br>Matt Pope, Director of Adult Social Services |

| | |
|---|---|
| Health and Wellbeing Strategy priority/priorities most progressed through the report | This meets all three priorities in Wokingham's Wellbeing Strategy 2018-21:<br><br>• *Creating Physically Active Communities*<br>• *Reducing social isolation and loneliness*<br>• *Narrowing the health inequalities gap*<br><br>This also meets the five priorities in the new Berkshire West Health and Wellbeing Strategy:<br><br>1) *Reduce the difference in health between different groups of people.*<br>*2) Support individuals at high risk of bad health outcomes.*<br>*3) Help children and families during the early years of life.*<br>*4) Promote good mental health and wellbeing for all children and young people.*<br>*5) Promote good mental health and wellbeing for all adults.* |
| Key outcomes achieved against the Strategy priority/priorities | • Improved physical health of residents<br>• Creating healthy and resilient communities<br>• Support and collaboration of partners and accountability of local action<br>• Those most deprived will enjoy more years in good health<br>• Greater access to health promoting resources<br>• Create dynamic cross-cutting system partnership working |

| | |
|---|---|
| Reason for consideration by Wokingham Borough Wellbeing Board | Wokingham's Wellbeing Board to approve the health and wellbeing priorities for focus within the Borough, guided by the overarching principles set out within the new Berkshire West Health and Wellbeing Strategy. The Wokingham Wellbeing Board to maintain oversight of the delivery of the Wokingham Strategy into Action through a new Strategy into Action Steering Group (to be considered). |

| | |
|---|---|
| What (if any) public engagement has been carried out? | Local Strategy into Action leads have engaged and worked closely with local partners to identify key actions aligned to the delivery of Wokingham's priorities.<br><br>Extensive public engagement has been carried out in the development of the Berkshire West Health and Wellbeing Strategy. |
| State the financial implications of the decision | None |

**RECOMMENDATION**

- Approve the *Berkshire West Health and Wellbeing Strategy* (noting the methods and outcome of the *Berkshire West Health and Wellbeing Strategy Public Consultation* included for reference).
- Approve *Wokingham's Health and Wellbeing: Strategy into Action* including the priorities for focus within the Borough governed by the Board.
- To approve the proposed change to the local governance structure (page 20 of *Wokingham Health and Wellbeing Strategy into Action*).
- To note Wokingham's Strategy into Action – Action Plans. These plans will be dynamic and continue to develop, they will form the basis of quarterly reporting into the Strategy into Action Steering Group.

**SUMMARY OF REPORT**

**Background**

The *Wokingham Health and Wellbeing Strategy into Action* (Paper 3) determines the priorities for focus within the Borough governed by the Wokingham Wellbeing Board. The *Strategy into Action* is guided by the overarching principles within the *Berkshire West Health and Wellbeing Strategy (Paper 1)*.

The *Berkshire West Health and Wellbeing Strategy* has been in development since 2019, overseen by a Steering Group consisting of members from the three local authorities, the voluntary sector, the CCG, Healthwatch, and the NHS. Public consultation was carried out by an engagement task and finish group between December 4th 2020 and February 28th 2021, across the whole of Berkshire West, to determine which health and wellbeing priorities were important to local residents (Paper 2 included for reference). Wokingham Borough Council was well represented at all stages of this strategy development.

The final priorities of the Berkshire West Health and Wellbeing Strategy are:
1) Reduce the difference in health between different groups of people;
2) Support individuals at high risk of bad health outcomes;
3) Help children and families during the early years of life;
4) Promote good mental health and wellbeing for all children and young people;
5) Promote good mental health and wellbeing for all adults.

Once these priorities had been identified five Wokingham Wellbeing Board workshops were held where the relevant Wokingham data was presented and local priorities discussed and a suitable governance structure determined (see background paper 3, page 20). This governance structure identifies the partnership or action group that will take responsibility for the reporting on, and delivery of the action related to each local Wokingham priority. In addition, improving the physical activity levels of our residents has been, and remains, a key priority for the Wokingham Wellbeing Board. Therefore, physically active communities has been included as a cross-cutting theme across our Wokingham Strategy into Action. All locally determined priorities for Wokingham's Wellbeing Board are outlined in detail within the Strategy into Action document (Paper 3).

Underpinning the Wokingham Strategy into Action (Paper 3), each partnership and action group have defined a Wokingham Action Plan which outlines key areas of work/focus under each strategic priority and detailed the action to be taken locally (Paper 4). These Action Plans will form the basis of the way in which progress will be reported to the Board through the Strategy into Action Steering Group.

Each partnership and action group will be expected to take a leadership role around the delivery of the Wokingham priorities. Working with the relevant stakeholders they will report quarterly on the action plans as well as to present the work on their priority directly to the Wellbeing Board annually. Action Plans for each priority will be reviewed and updated annually to ensure they remain dynamic to changing data, evidence and circumstance, particularly in the context of the Covid-19 pandemic recovery.

The strategy, and Wokingham Strategy into Action, set out strategic priorities for the next 10 years, however it will remain responsive with regular review points overseen by the Wokingham Wellbeing Board. It summarises the Wokingham specific priorities that will drive work to improve the health and wellbeing of residents and the governance structure to ensure accountability and reporting of this work, as well as providing a commitment to action.

**Analysis of Issues, including any financial implications**

There are no financial implications to the report presented here.

| **Partner Implications** |
| --- |
| The success of the Berkshire West Health and Wellbeing Strategy Action Plans is dependent on partners having ownership and accountability of their priorities within plans and reporting their progress milestones on a quarterly basis. |

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

| **List of Background Papers** |
| --- |
| 1. Berkshire West Health and Wellbeing Strategy<br>2. Berkshire West Health and Wellbeing Strategy: Public Engagement Report<br>3. Wokingham Health and Wellbeing: Strategy into Action (September 2021)<br>4. Wokingham Wellbeing Board Strategy into Action: Action Plans which includes:<br>(a) Wokingham Wellbeing Board Health Inequalities Action Group Plan<br>(b) Community Safety Partnership Board Action Plan |

(c) Carers Strategy Action Group Action Plan
(d) Dementia Alliance Action Plan
(e) Learning Disabilities Partnership Board Action Plan
(f) Children and Young People Partnership Board Action Plan
(g) Wokingham Wellbeing Board Social Isolation and Loneliness Action Group Plan
(h) Wokingham Wellbeing Board Physically Active Communities Action Group Plan

| | |
|---|---|
| **Contact** Ingrid Slade | **Service** Public Health |
| **Telephone No** | **Email** Ingrid.Slade@wokingham.gov.uk |

# BERKSHIRE WEST HEALTH AND WELLBEING STRATEGY (HWBS)

2021- 2030











Reading Borough Council
Working better with you

West Berkshire Council

WOKINGHAM BOROUGH COUNCIL

# CONTENTS

# INTRODUCTION



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

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

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

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

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

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

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

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

# INTRODUCTION

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

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

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

*East Ilsley Volunteer group*

# READING

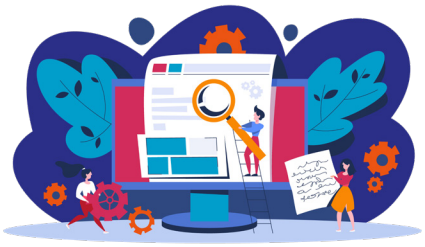
100%
Urban population

161,780
Total Resident Population

12.5%
Population aged 65+

25.3%
Ethnically diverse population

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



7,090
Total number of businesses

9.6%
Full time students age 18+


Unemployment rate
3.6%

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

50.2%
People with very good health

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

# WEST BERKSHIRE

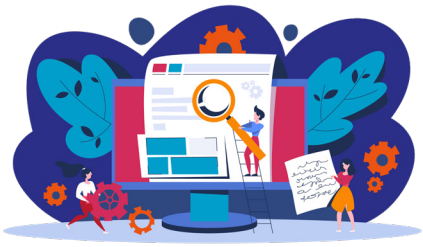
63%
Urban population

158,450
Total Resident Population

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

19.3%
Population aged 65+

5.2%
Ethnically diverse population



8,800
Total number of businesses

2.1%
Full time students age 18+


Unemployment rate
2.4%

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

51.6%
People with very good health

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

# WOKINGHAM

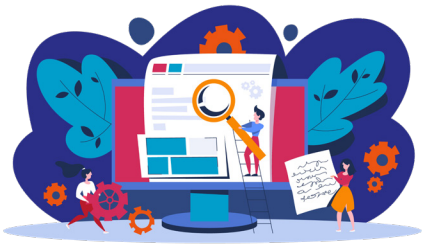
83%
Urban population

171,119
Total Resident Population

77%
Children achieving a good level of development at early years

17.6%
Population aged 65+

11.6%
Ethnically diverse population



9,005
Total number of businesses

3.2%
Full time students age 18+


Unemployment rate
2.35%

9.0%
**Percentage of unpaid carers**
(1-50+ hours of unpaid care per week)

54.3%
People with very good health

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

# WORKING TOGETHER: OUR LOCAL SYSTEM

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

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

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

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

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

# OUR CHALLENGES

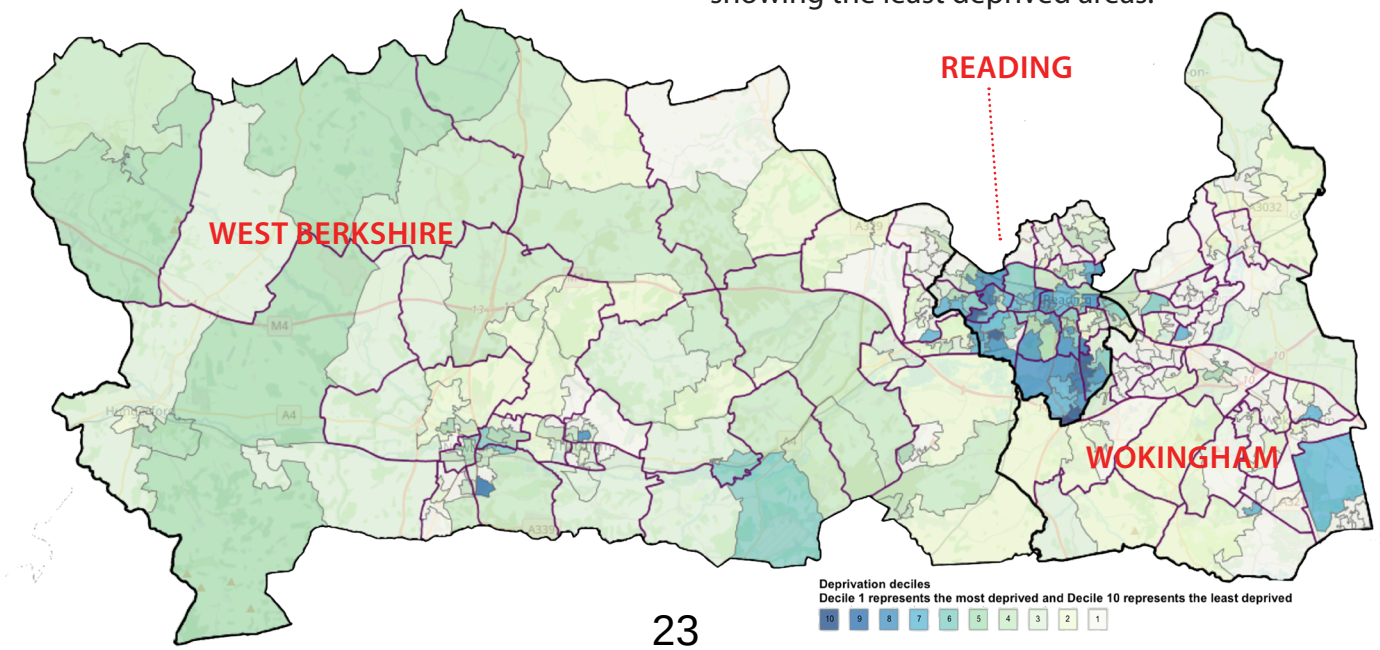
The three areas that make up Berkshire West have a lot to celebrate and be proud of. However, as people live longer with more complex health conditions; combined with the impact of Covid-19 and ongoing financial challenges, we must find new ways to deliver health and social care, strengthen partnerships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

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

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

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

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



# OUR CHALLENGES: THE IMPACT OF COVID-19

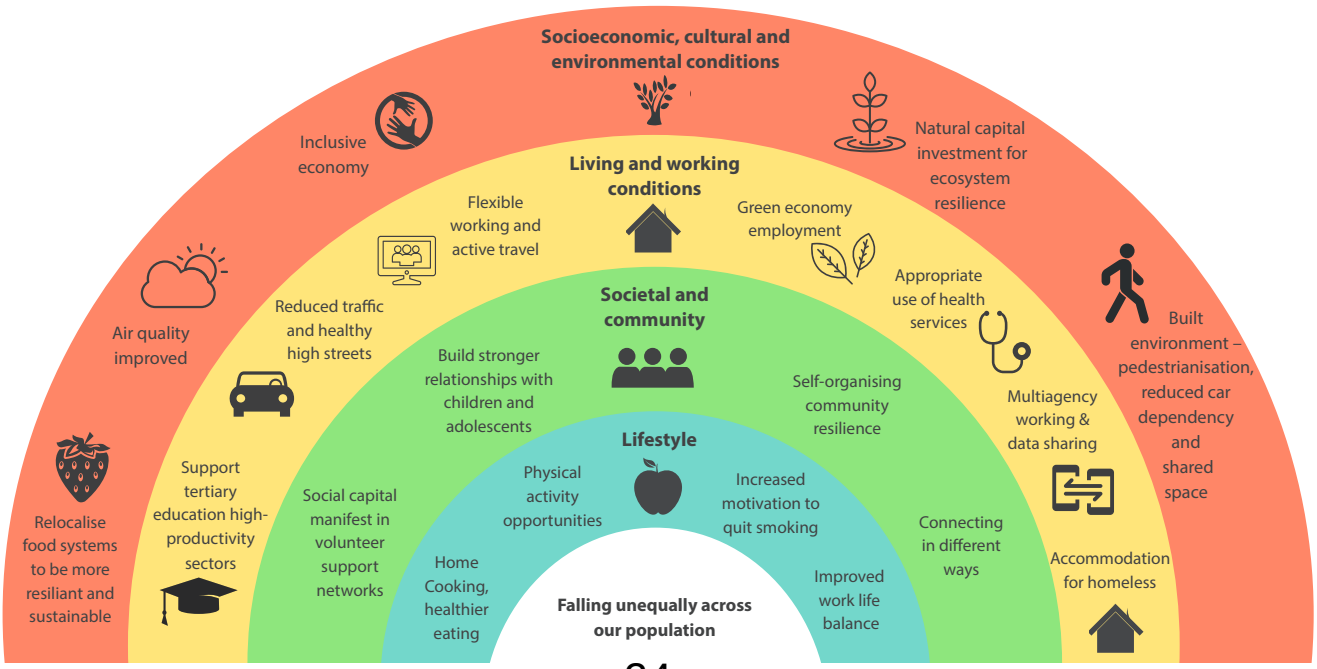
Covid-19 has had a powerful impact across the three areas; businesses have had to shut and health services have been stretched - sometimes to their limit. Covid-19 has affected segments of the local population differently, exacerbating existing inequalities.

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

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

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

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



# OUR VISION

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


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

# OUR PRINCIPLES

## RECOVERY FROM COVID-19

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

## ENGAGEMENT

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

## PREVENTION AND EARLY INTERVENTION

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

## EMPOWERMENT AND SELF-CARE

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

## DIGITAL ENABLEMENT

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

# OUR PRINCIPLES

## SOCIAL COHESION

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

## INTEGRATION

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

## CONTINUOUS LEARNING

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

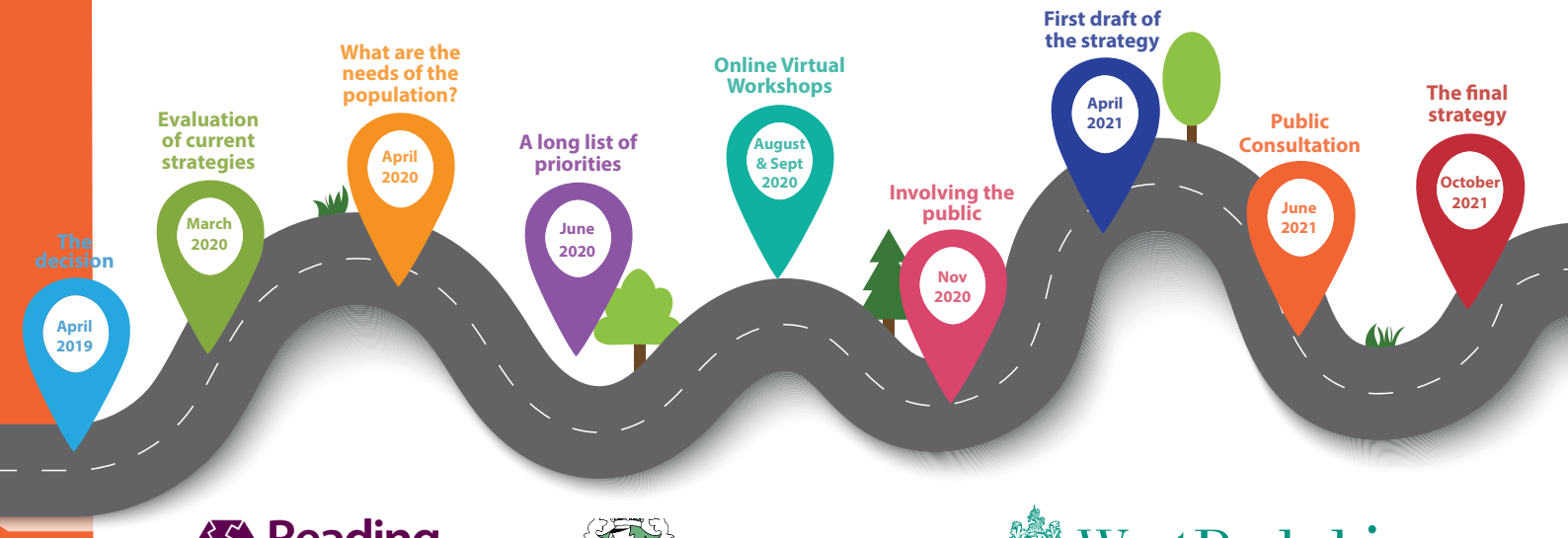
** An Integrated Care System (ICS) brings together health and care organisations to take responsibility for the cost and quality of care for a defined population within an agreed budget. The BOB ICS brings together the Integrated Care Partnerships (ICPs) for Buckinghamshire, Oxfordshire and Berkshire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

# HOW THE STRATEGY WAS DEVELOPED

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

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

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




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

# OUR PRIORITIES



## FIVE HEALTH AND WELLBEING PRIORITIES

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

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

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

**3** HELP CHILDREN AND FAMILIES IN EARLY YEARS.

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

**5** PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL ADULTS.

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

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

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

# 1

# REDUCE THE DIFFERENCES IN HEALTH BETWEEN DIFFERENT GROUPS OF PEOPLE

## WHY IS IT IMPORTANT?

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

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

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

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

## There are 3 key issues:

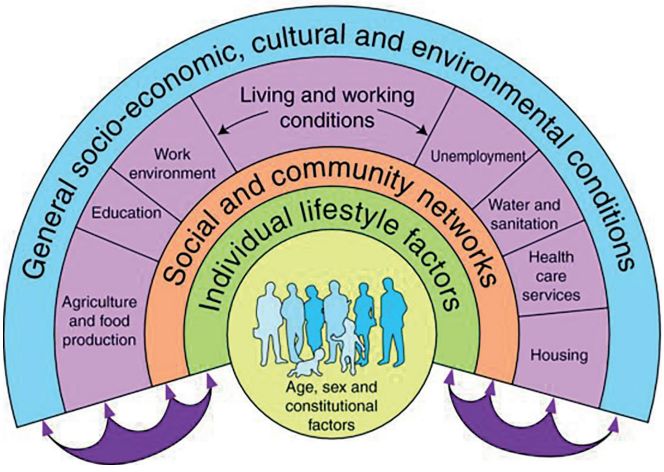
i. Inequities in opportunity and / or outcome: some people don't get a good start in life, have fewer social opportunities, live shorter lives or have longer periods of ill health;
ii. Inequities and lack of access – some people cannot access services, do not know about them cannot use them or need support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

## WHAT YOU TOLD US:

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

***"Lack of income should not mean poor health***

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




*Model of social determinants of health* [9]

# REDUCE THE DIFFERENCES IN HEALTH BETWEEN DIFFERENT GROUPS OF PEOPLE

## WHAT ARE WE ALREADY DOING?

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

## SPOTLIGHT

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

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

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

## TO MAKE A DIFFERENCE, WE WILL:

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

# 2

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

## WHY IS IT IMPORTANT?

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

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

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

### HOW DOES THIS IMPACT HEALTH INEQUITIES?

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

## WHAT YOU TOLD US:

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

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

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

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

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

## WHAT ARE WE ALREADY DOING?

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

### SPOTLIGHT

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

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

## TO MAKE A DIFFERENCE, WE WILL:

- Raise awareness and understanding of dementia, and ensure support for people for who have dementia is accessible and in place for them and their unpaid carers. We will work together to ensure the Dementia Pathway is robust, including pre-diagnosis support, improving early diagnosis rates, rehabilitation and ongoing support.
- Improve identification and support for unpaid carers of all ages. Work with unpaid carers and partner agencies to promote the health and wellbeing of unpaid carers.
- Work together to reduce the number of rough sleepers and improve the mental and physical health of rough sleepers and those who are homeless, through improved access to local services
- Prevent, promote awareness and provide support to those who have experienced domestic abuse in line with proposals outlined in the Domestic Abuse Bill.
- Support people with learning disabilities, engaging with and listening to them, through working with voluntary organisations, in order to concentrate on issues that matter most to them.
- Increase the visibility of existing services and signposting to them, as well as improving access for people at higher risk of bad health outcomes, working with and alongside voluntary and community organisations who are supporting these groups.

# 3 HELP FAMILIES AND CHILDREN IN EARLY YEARS

## WHY IS IT IMPORTANT?

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

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

## HOW DOES THIS IMPACT HEALTH INEQUITIES?

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

## WHAT YOU TOLD US:

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

**"I would like to have help with childcare".**

**"It's unclear what support is available."**

## WHAT ARE WE ALREADY DOING?

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

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

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

# HELP FAMILIES AND CHILDREN IN EARLY YEARS

## SPOTLIGHT

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

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

## TO MAKE A DIFFERENCE, WE WILL:

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

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

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

## WHY IS IT IMPORTANT?

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

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

## HOW DOES THIS IMPACT HEALTH INEQUITIES?

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



## WHAT YOU TOLD US:

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

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

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

## WHAT ARE WE ALREADY DOING?

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

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

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

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

## TO MAKE A DIFFERENCE, WE WILL:

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

# 5 PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL ADULTS

## WHY IS IT IMPORTANT?

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

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

## HOW DOES THIS IMPACT HEALTH INEQUITIES?

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

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

## WHAT YOU TOLD US:

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

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

**"(physical health is) linked to mental health"**

## WHAT ARE WE ALREADY DOING?

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

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

# PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL ADULTS

## SPOTLIGHT

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

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

## TO MAKE A DIFFERENCE, WE WILL:

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

# NEXT STEPS

## THE ROAD AHEAD

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

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

## STRENGTHENING PARTNERSHIPS AND COMMUNITY ENGAGEMENT AS A PLACE-BASED APPROACH

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

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

# NEXT STEPS

## HEALTH AND WELLBEING BOARD COMMITMENTS

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

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

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

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# APPENDIX

## APPENDIX A

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

# BERKSHIRE WEST HEALTH AND WELLBEING STRATEGY (HWBS)

2021- 2030











## Public Engagement Report

Reading Borough Council
Working better with you

West Berkshire Council

WOKINGHAM BOROUGH COUNCIL

# Contents

# Executive Summary



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

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

# 1. Background

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

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

1. All our children and young people have the best possible start in life and the opportunity to thrive, no matter what their circumstance.

2. Children and adults most at risk from bad health outcomes are safe and safeguarded.

3. Everyone of working age has access to decent employment opportunities.

4. All people have the best opportunities for good mental health and wellbeing – to realise their potential and connect with the community.

5. Our communities are strong, resilient, thriving and inclusive, with all residents benefitting from a healthy, accessible environment.

6. All people will be able to gain access to integrated health and social care services.

# 2. Overview and Methodology

## How we consulted

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

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

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

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

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

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

## What we consulted on

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

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

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

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

## Methodology for the qualitative data analysis

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

*Table 2: Description of the six phases of thematic analysis*

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

# 3. Results

## 3.1 The online survey

### Demographics of respondents

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

**What is your gender?**

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

**How old are you?**

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

**What is your ethnic group?**

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

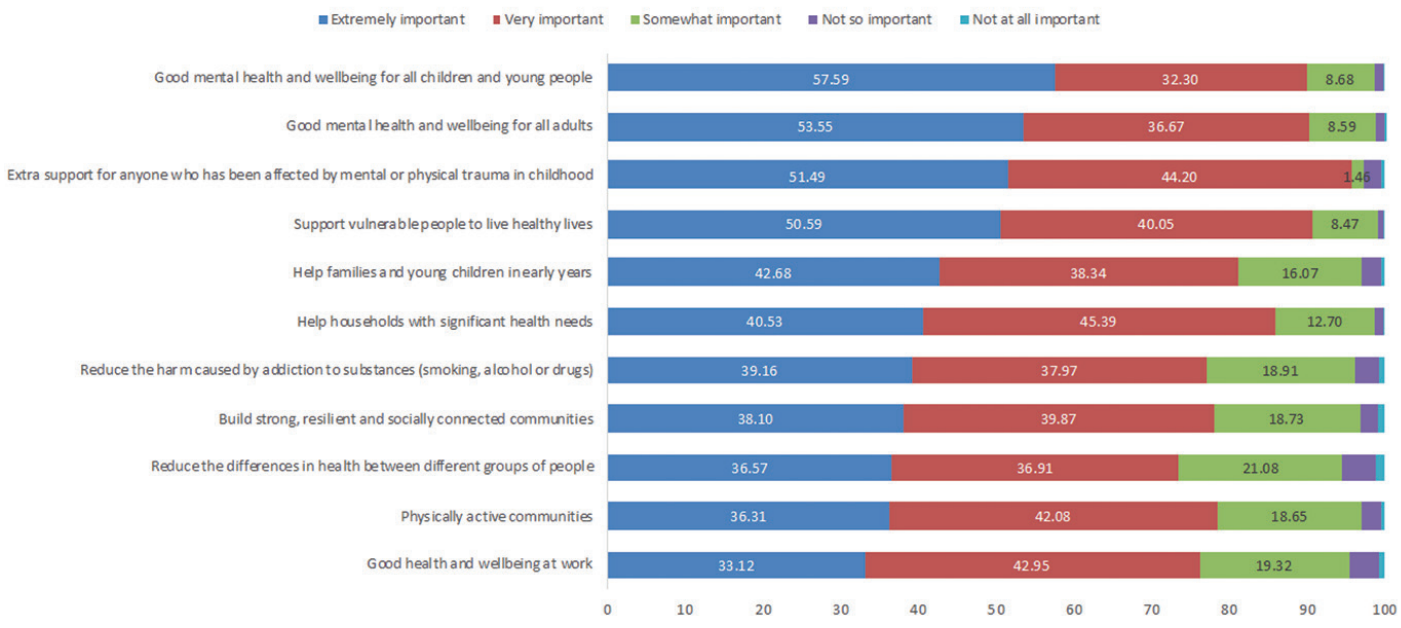
Of the 1786 people who specified, the majority of respondents were female (71.56%), followed by male (28.05%), and non-binary (0.39%). The most common age range specified was 55-64 (21.78%), closely followed by 65-74 (20.49%) and 45-54 (20.32%). A small minority of respondents were 24 or below (3.29%).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

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

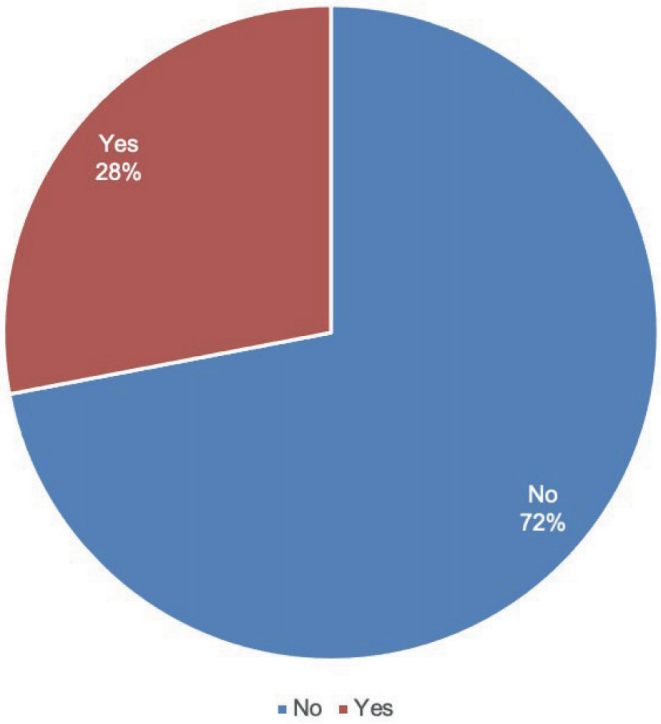
Regionally, most respondents were from Wokingham (39.5%), jointly followed by Reading (30.3%), and West Berkshire (30.3%). The majority of respondents provided feedback as individual respondents, with a small proportion responding on behalf of an organisation (158 responses).

## Responses to individual questions

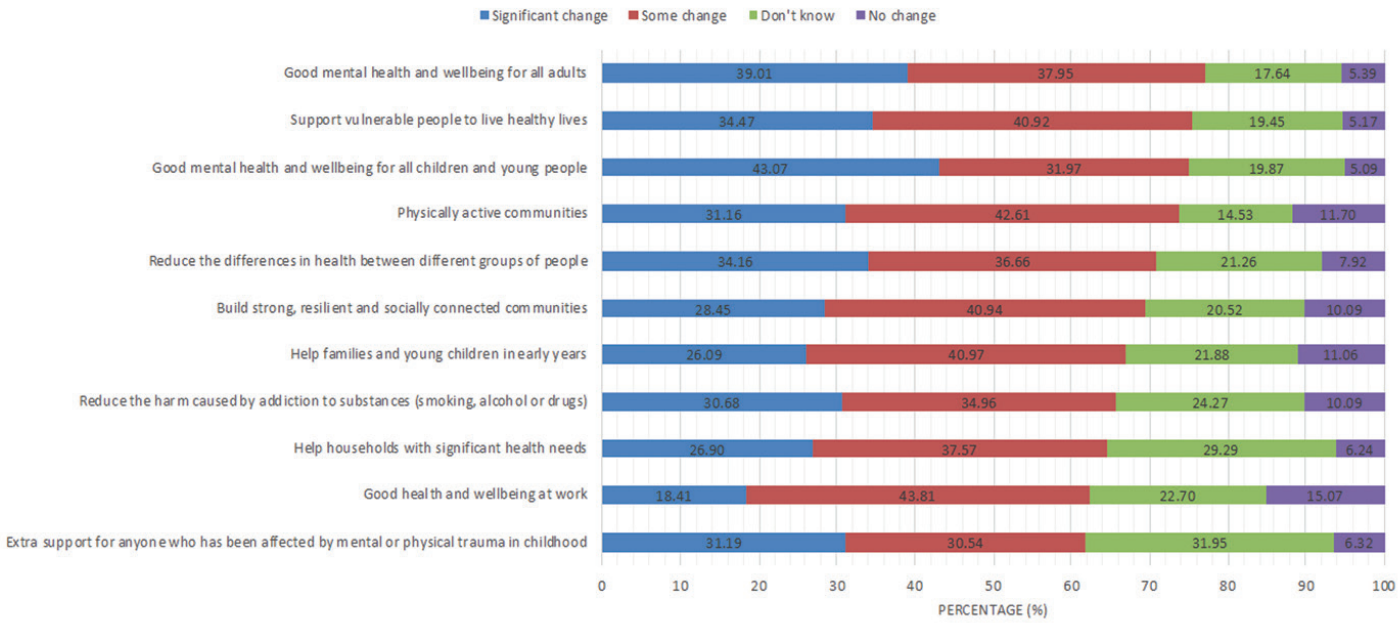
**Q2. In order of importance, one being the most important, how would you rank the potential priorities?**



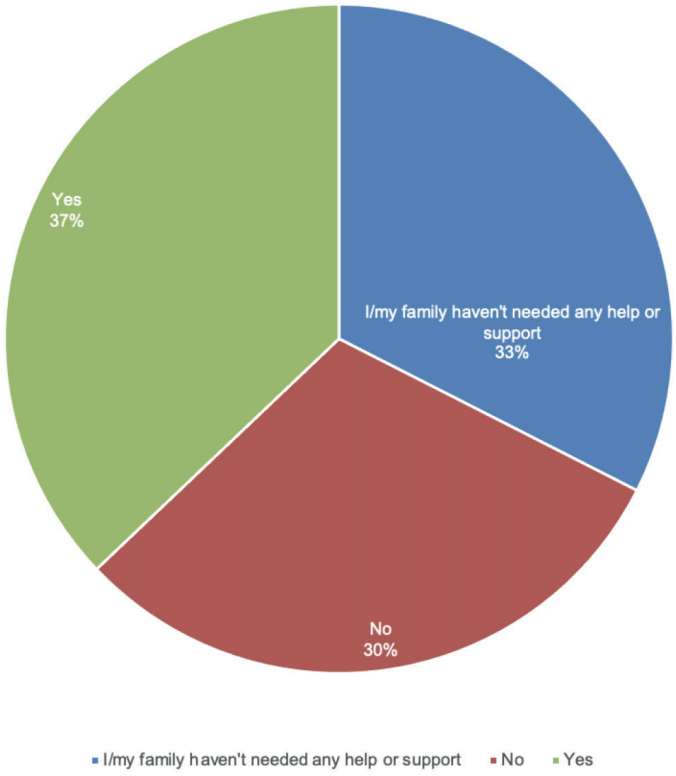
**Q3. Are there any other priorities you think we should consider including in the draft Strategy that we haven't mentioned in previous questions?**



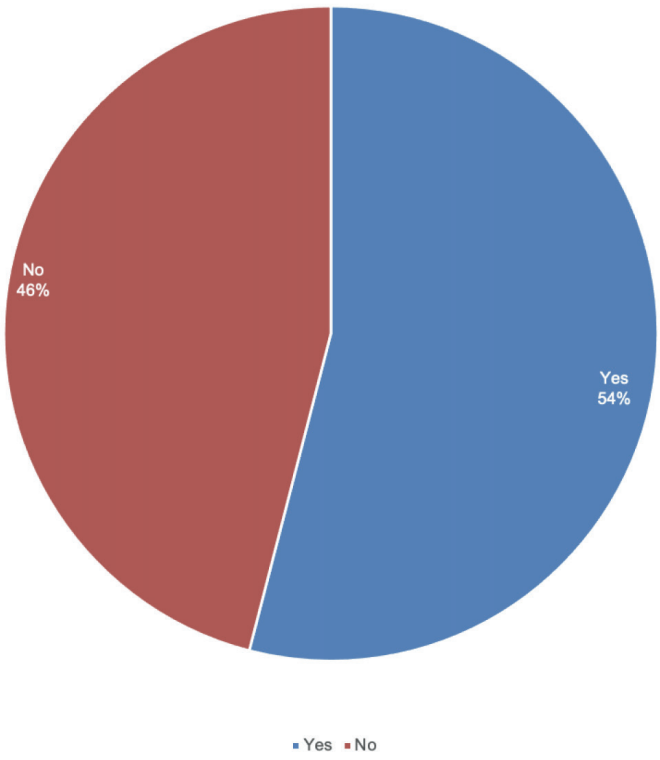

**Q4. How much change do you think is required for each priority?**



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




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



## Responses to the free-text questions

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

> Are there any other priorities you think we should consider including in the draft strategy that we haven't mentioned in previous questions? *Please tell us what priorities you like to see included and why.*
>
> How much change do you think is required for each priority ("no change", "some change", "significant change", "don't know"). *Please tell us the reasons for your response, including details of any changes you think are needed.*
>
> Are you, your family or other people you care for able to get all the help or support you/they need for any health and wellbeing problems? *If no, please tell us about the issues you/ your family have encountered.*

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

### Guiding framework to achieve person-centred health and social services

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

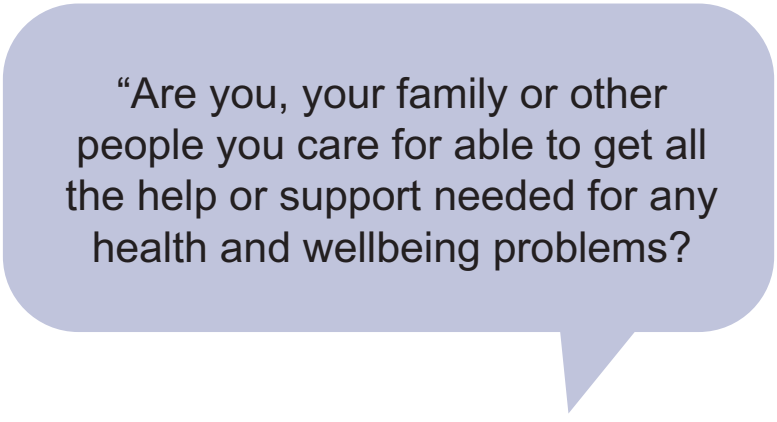



*Figure 1: Survey question about issues in accessing help and support for health and wellbeing problems.*

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

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

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

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

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

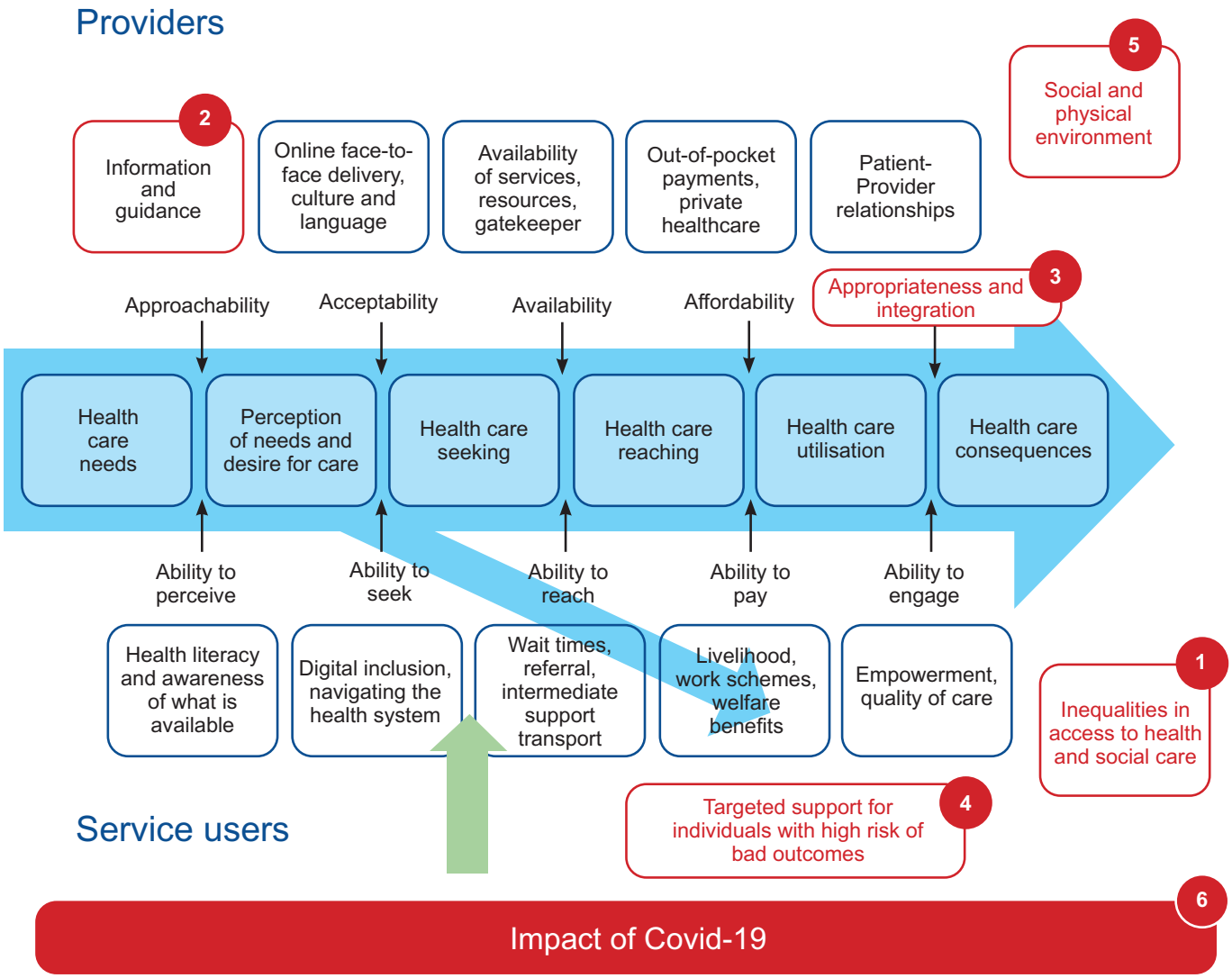



*Figure 2: Conceptualisation of the challenges to person-centred access to health and social care services in Berkshire West, as adapted by Chuah et al., 2018 from Levesque et al.'s framework. The red boxes indicate six themes from our public engagement survey and focus group findings.*

# Theme 1: Health Inequalities

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

## (a) Public versus private healthcare

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

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

*"Don't feel I can talk to GP as they are so busy. Don't know who else to turn to."*

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

*"We basically get on with life and address the issues ourselves."*

*"Only by paying privately for treatment. This feels like "queue jumping" to us."*

## (b) Mental health versus physical health

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

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

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

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

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

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

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

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

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

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

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

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

# Theme 2: Information and Guidance

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

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

*"Huge stigma surround health and well-being issues which make them hard to talk to"*

*"Honestly, like a lot of guys, I didn't really talk about my depression or seek help"*

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

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

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

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

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

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

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

# Theme 3: Service Integration and Appropriateness

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

## (a) Integrated Services

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

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

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

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

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

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

## (b) Appropriate care

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

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

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

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

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

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

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

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

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

## Theme 4: Targeted Support

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

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

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

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

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

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

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

There were also concerns about eligibility criteria for support.

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

# Theme 5: Social and Physical Environment

## (a) Social Environment

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

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

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

## (b) Physical Environment

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

*"... we literally can't open the car doors enough to get the infant carriers out in normal spaces"*

# Theme 6: Covid-19

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

## (a) Usual services being put on hold

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

*"It's all about either having the virus or not. The rest of health seems to be ignored."*

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

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

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

*"Didn't want to add more to an already overloaded NHS"*

*"I would have seen the Doctor, face to face to discuss my condition - arthritis - but I know it is probably going to be a 'live with it' situation."*

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

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

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

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

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

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

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

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

*"I'm not managing the internet 'help'."*

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

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

*"...many have been shielding to protect themselves and their mental health has suffered greatly"*

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

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

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

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

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

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

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

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

## 3.2 Focus group findings

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

## Theme 1: Health Inequalities

### (a) Waiting time

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

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

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

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

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

### (b) Eligibility

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

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

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

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

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

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

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

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

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

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

# Theme 2: Information and Guidance

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

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

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

*"Could local councils be used to distribute health and wellbeing information more effectively?"*

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

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

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

*"Interpretation on helplines is really important"*

*"There needs to be a redefinition of 'crisis', that's coming from the person that needs help"*

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

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

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

## (b) Training for healthcare and social care professionals

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

*"I was once told by someone who works in the homeless sector that I don't look autistic"*

*"Why isn't the disabled blue badge recognised as the disabled parking card?"*

*"Education/support needed so that cycles of trauma are not continued through generations"*

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

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

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

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

*"Mental health --there's still a big stigma and increasing awareness will help"*

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

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

*"We're seeing more frontline staff take part in Mental Health First Aid training, but we need senior managers taking part too"*

## (c) Transparency in governance and resource allocation

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

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

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

# Theme 3: Service Integration and Appropriateness

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

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

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

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

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

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

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

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

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

# Theme 4: Targeted support

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

## (a) Culturally sensitive care

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

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

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

*"access for women only fitness /swimming sessions for some cultural groups is an issue"*

## (b) Trauma-informed care (TIC)

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

*"Extra support for anyone who has been affected by mental or physical trauma in childhood"*

## (c) Specific roles, identities and health conditions

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

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

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

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

# Theme 5: Social and Physical Environment

## (a) Social environment

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

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

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

## (b) Physical environment

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

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

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

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

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

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

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

Participants also raised issues on active transport and general safety.

*"Physical activity is about so much more than exercise. It's about safe and healthy ways of travelling to and from school and work."*

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

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

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

## Theme 6: Covid-19

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

*"Covid has increased addictive behaviour."*

*"It's been extremely difficult to keep my weight this down."*

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

*"Having to isolate just because you're over 70 has been hard"*

*"The pandemic really hasn't helped my mental health and being cooped up all day with no escape is very disheartening"*

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

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

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

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

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

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

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

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

*"Post Covid, people are going to need a lot of support to re-adjust"*

*"It's not clear how the impact of Covid is being considered. We need a 'new deal' for health and wellbeing because of this."*

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

# 4. Developing the priorities

## Shortlisting of priorities

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

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

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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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

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

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


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

## Priority 3: Help families and children in early years

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

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

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

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

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

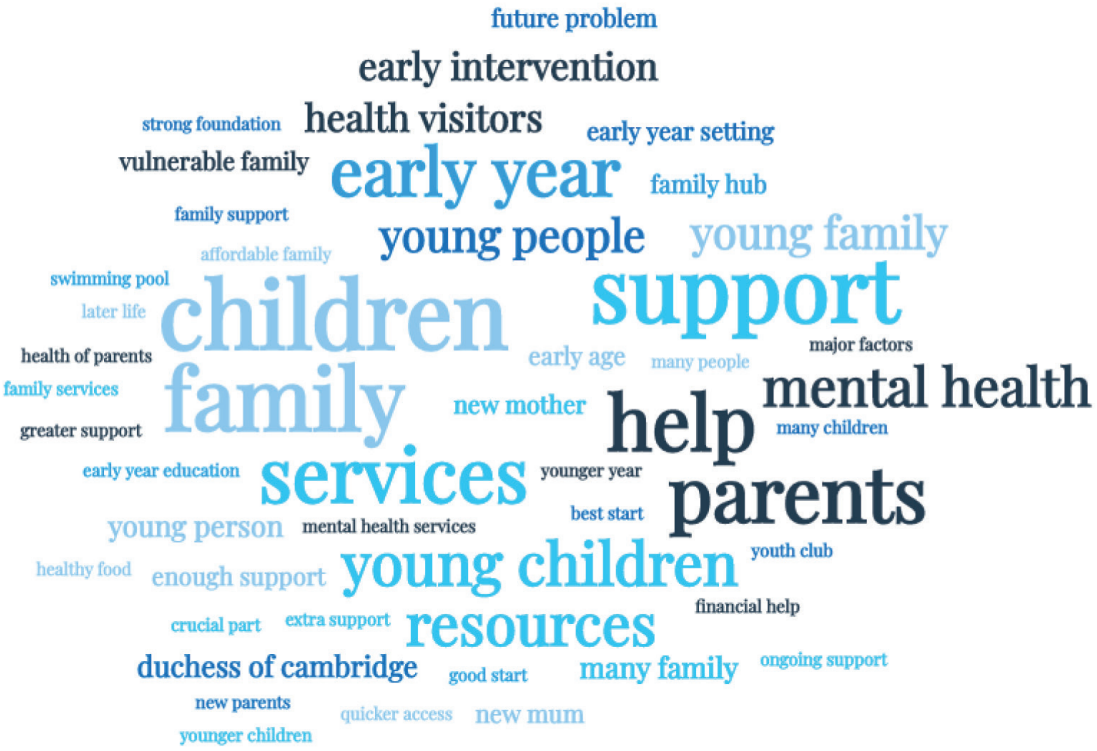



*Figure 3. Visualisation of words frequently used by focus group participants and survey respondents for priority 3*

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

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

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

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

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


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

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

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

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

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

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


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

# 5. Conclusion

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

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

# 6. References


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

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# 7. Appendices

## Appendix A: Scoring Systems

### Survey data analysis

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

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

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

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

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

### Focus group and free text analysis

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

# Appendix B: Overall results on the ranking of priorities

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

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

## Appendix C: Questions included in the online survey

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

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

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

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

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

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

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

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

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

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

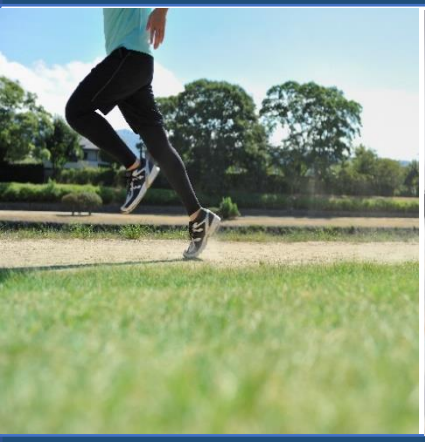
7. Are you, your family or other people you care for able to get all the help or support you/they need for any health and wellbeing problems?

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

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

# Wokingham Health and Wellbeing Strategy Into Action

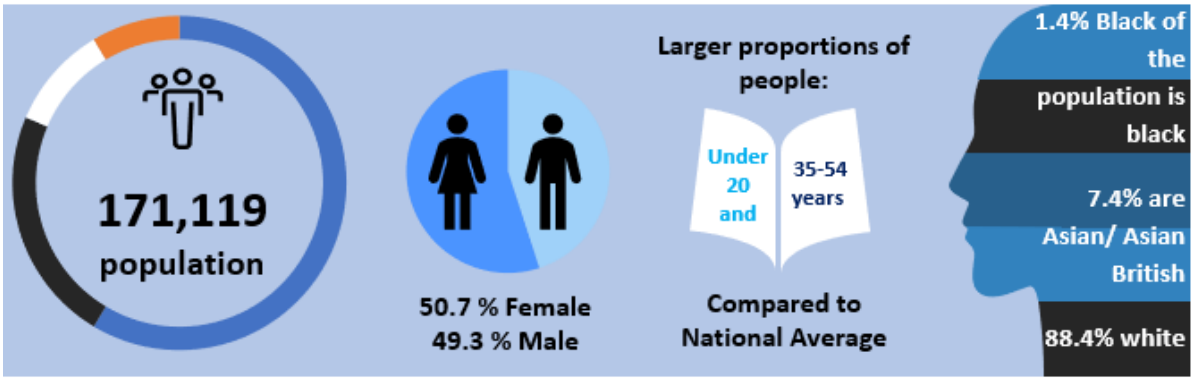
September 2021



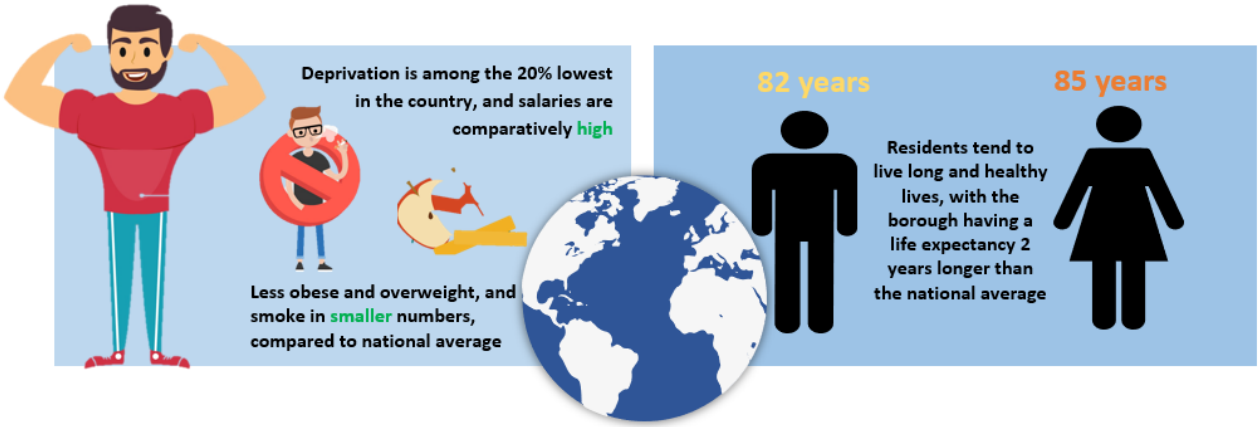
WOKINGHAM BOROUGH COUNCIL

# CONTENTS

Wokingham Borough is a mixed urban and rural local authority, with a population of about 171,119, of which 50.7% is female (ONS 2019). Approximately 7.9% of residents are non-UK nationals which is lower than the national average of 10%. Ethnically, 88.4% of the population is White, while 7.4% is Asian/Asian British and 1.4% Black, as per the 2011 census, with wards bordering Reading having the greatest ethnic diversity. The largest minority ethnic group is of Indian ethnicity and makes up 3.5% of the borough's population. Wokingham has larger proportions of people under age 20, and people between ages 35-54, compared with the national average.

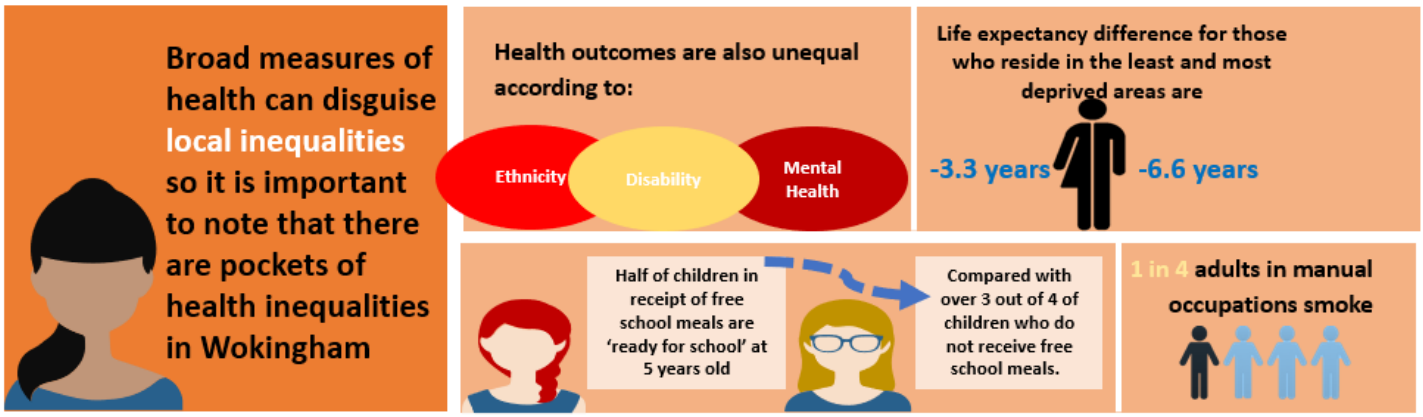



The majority of Wokingham residents tend to live long and healthy lives, with the borough having a life expectancy at birth for both men and women over 2 years longer than the England average (82.0 and 85.8 years respectively). Overall deprivation is among the 20% lowest in the country, and salaries are comparatively high. The Wokingham population is less obese and overweight, and smoke in smaller numbers, compared with the national average.



However, it is important to note that there are health inequalities in Wokingham. The difference in life expectancy between those who reside in the least and most deprived areas in the borough are 6.6 and 3.3 years for men and women respectively. Health outcomes are also unequal according to ethnicity, disability and mental health. For example, four times as many people with serious mental illness (aged 18+) smoke in comparison to our general population.

In 2019 there were 1,705 live births in Wokingham. Overall, health in pregnancy and early years of life is generally good in Wokingham. However, approximately 6 out of 100 babies born are to mothers who smoke which puts them at risk; these mothers on average are likely to be young and from areas of higher deprivation in the Borough. In addition only half of children in receipt of free school meals are 'ready for school' at 5 years old, compared with over 3 out of 4 of children who do not receive free school meals.




The impacts of COVID-19 on health and wellbeing - both the disease itself and the lockdown measures put in place to counter it - are likely to be great and varied. The full picture of the long-term consequences of COVID-19 and the pandemic on our residents are not yet fully understood. Missed opportunities for early diagnosis of disease, increased waiting times for operations and other treatments are apparent. It is likely we will see similar inequalities for health service provision as are already seen in other outcomes, impacting a diverse number of areas such as vaccination coverage, sexual health services, contraception and pregnancy services, mental health services and cancer services. Lifestyle behaviours of Wokingham residents have changed as a result of the pandemic. Evidence suggests that weight gain, increased alcohol consumption, social isolation and reportedly more mental ill health have all

occurred. There will also be secondary effects from the economic impact following the necessary restrictions implemented to reduce spread of the virus.

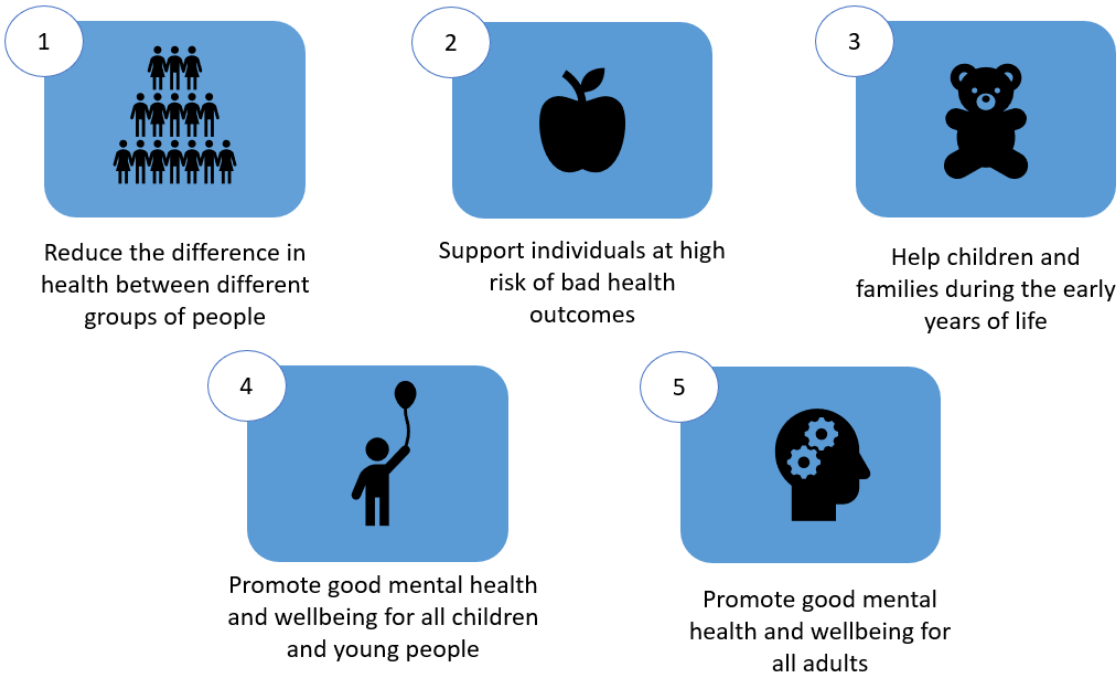
# BACKGROUND TO WOKINGHAM HEALTH AND WELLBEING STRATEGY INTO ACTION

The Wokingham Health and Wellbeing Strategy into Action determines the priorities for focus within the Borough governed by the Wokingham Wellbeing Board. This Strategy into Action is guided by the overarching principles within the Berkshire West Health and Wellbeing Strategy. The Berkshire West Health and Wellbeing Strategy has been in development since 2019, overseen by a Steering Group consisting of members from the three local authorities, the voluntary sector, the CCG, Healthwatch, and the NHS. Public consultation was at the core of the strategy development and was carried out by an engagement task and finish group. The public engagement was carried out between December 4th 2020 and February 28th 2021, across the whole of Berkshire West, to determine which health and wellbeing priorities were important to local residents.

The public engagement included an online survey and focus groups in different settings. Local residents of the three areas were asked about the importance of potential health and wellbeing priorities to help them and their communities live happier and healthier lives. A full description of the engagement work can be found in the Berkshire West Health and Wellbeing Strategy Public Engagement Report.

The survey had a total of 3967 respondents. Wokingham residents were the majority with 1566 respondents (39.5%). Residents were asked to rank different priorities and they were also invited to comment on whether they thought there were missing priorities. When scoring the survey, three different ranking systems were used, but the top five priorities were the same regardless of which system was used.

The final priorities of the Berkshire West Health and Wellbeing Strategy are:

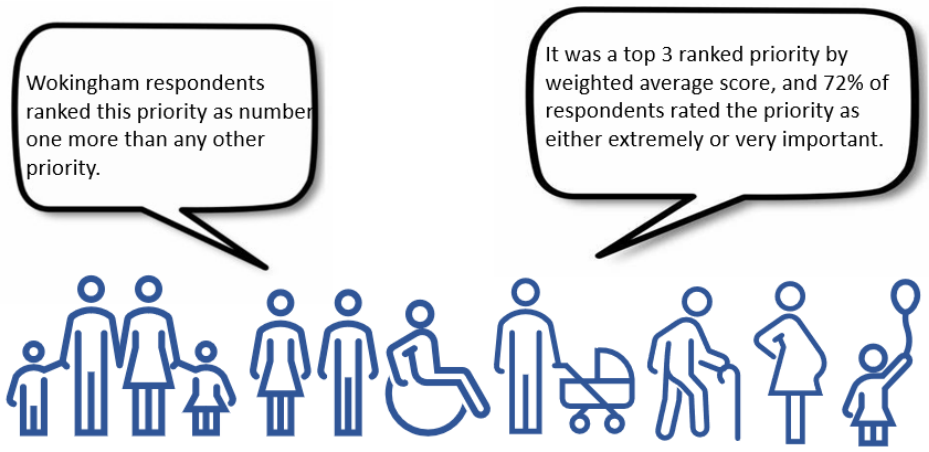



Once these priorities had been identified, five Wokingham Wellbeing Board workshops were held, one for each priority, the relevant Wokingham data was presented and local priorities discussed, relevant interdependencies acknowledged and a suitable governance structure determined. In addition, improving the physical activity levels of our residents has been, and remains, a key priority for the Wokingham Wellbeing Board. Physically active communities is included as a cross-cutting theme across our local Strategy into Action.

This Strategy into Action sets out the residents' voice, as represented in the Berkshire West public engagement, and the local need in Wokingham under these five priorities. It summarises the Wokingham specific priorities that will drive work to improve the health and wellbeing of residents and the governance structure to ensure accountability and reporting of this work. This strategy sets out strategic priorities for the next 10 years, however it will remain responsive with review points overseen by the Wokingham Wellbeing Board and with yearly review of action plans.

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

**Wokingham Residents' Voice within Berkshire West Public Engagement:**




**Wokingham in Focus:**

Health inequalities represent the avoidable differences in health which exist between different groups of people. These are often related to the wider determinants of health: your opportunities and start in life, your environment, and inequities in access to services.

In Wokingham, there is a life expectancy gap between the most and least deprived populations of 6.6 and 3.3 years for men and women, respectively. This difference is due to different outcomes in several major disease categories, the two with the biggest contribution to this difference are cardiovascular disease and cancer.

In Wokingham smoking, obesity, hypertension and cardiovascular disease are all unevenly distributed in our residents, with level of deprivation, sex, and ethnicity all having an impact. As an example, in Wokingham, adults working in manual occupations smoke at about three times at the rate of the overall population (23.4% vs 8.4%). Whilst some of these health determinants cannot be modified, health outcomes can be improved by reducing risks associated with lifestyle behaviours.

Cancer is also not distributed equally across our population and is a large contributor to the life expectancy difference in men between the most and least deprived. National data indicates that there are differences in screening uptake based on deprivation and socioeconomic factors, and national and local data show that cancer risk factors are not evenly spread, such as smoking.

Covid-19 has both exacerbated and been exacerbated by existing inequalities in society. There has been and remains a difference in risk of mortality and morbidity from Covid-19 infection by differences in deprivation level and ethnicity. Covid-19 has also had a large impact on inequalities through the wider determinants of health: financial loss, job loss, and subsequent impact on health behaviours. An equitable recovery from the pandemic requires understanding these differences, including further study into Long Covid (which will likely follow similar inequality patterns as Covid-19 infection), as well as ensuring Covid-related health and wellbeing recovery meets the needs of different populations. We know that cancer referrals went down locally during the pandemic, and other services likely follow a similar pattern, which means that catching up equitably is going to be key to ensuring health inequalities are not further exacerbated.

**Commitment to Action: The priorities we will focus on are**

Cardiovascular Disease

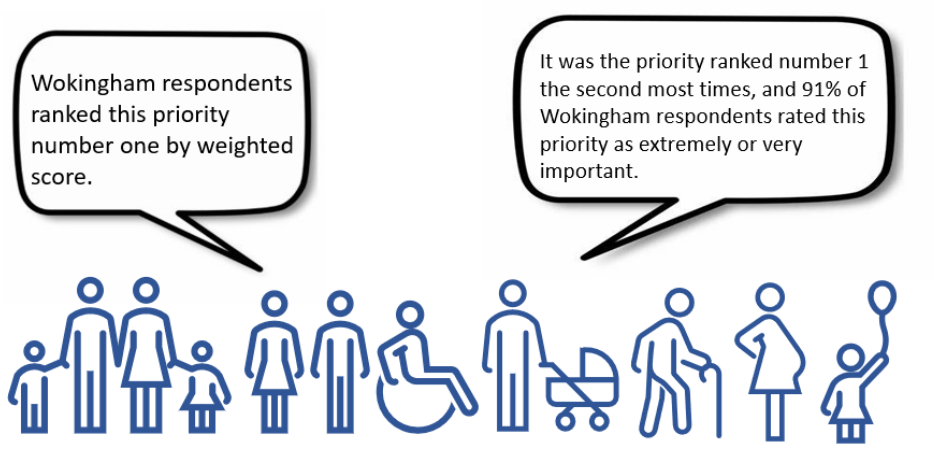
Cancer

Covid-recovery

- Specific actions for the first year are detailed in the Health Inequalities Action Plan (see accompanying Wokingham Action Plan).
- As the impacts of the Covid-19 pandemic will continue to develop, it is important that this plan and these local priorities are reviewed yearly to allow for a dynamic response to changes in data.
- The Health Inequalities Action Group, made up of multiple partners working in this area, will lead on the delivery of this strategic priority.
- Interdependencies and overlap with the Physically Active Communities Action Group will be identified and incorporated.
- They will report to the Steering Group of the Wellbeing Board quarterly, and ensure all relevant stakeholders are involved in the delivery of the priorities.

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

**Wokingham Residents' Voice within Berkshire West Public Engagement:**




**Wokingham in Focus:**

Certain groups of people may be more vulnerable to poor health outcomes than others, and their health needs require proactive support to limit harm and improve health and wellbeing. These risks to poor health outcomes may relate to barriers to care, lack of access to a healthy environment and lack of information to enable healthy choices. These issues often interplay in a complex nature and can affect people throughout their life-course.

Wokingham has a higher per capita number of adults with learning disabilities (LDs) receiving long-term support than other Boroughs within England, with 517 residents supported by the council in 2020. We know from national data that the average life expectancy of people with learning disabilities is 23 years lower than the general adult population, and that prevalence of mental health disorders, dementia, and epilepsy is much higher in people with learning disabilities.

The Covid-19 pandemic has further exacerbated and laid bare these differences, with people with LDs dying of Covid-19 at 4.1 times the rate of the general population in England.

In Wokingham, 1.5% of residents are unpaid carers, which is equivalent to approximately 2,500 residents. We know that in Wokingham, 63% of local adult carers do not have as much social contact as they would like, and this is likely to have worsened due to the Covid-19 pandemic and its effects on social isolation. From national data, we know that unpaid carers who provide high levels of care are over twice as likely to suffer poor health in comparison with people who do not have caring responsibilities. The 2013 State of Caring Survey reported that 84% of carers believe that caring has had a negative impact on their health.

In Wokingham, we have seen an increase in substance misuse treatment presentations during the Covid-19 pandemic compared with the previous year, which is in keeping with national data. About a third of those presenting for substance misuse treatment live with children, half have regular employment, and less than 10% have a housing problems. This picture shows that substance misuse can and does affect residents across our Borough. In addition we know from national data that about 1 in 10 A&E visits are due to alcohol, and that half of people with drug dependence receive mental health treatment.

Domestic abuse has also increased nationally during the Covid-19 pandemic, and incidents were rising locally pre-pandemic as well. Substance abuse features in around half of intimate partner homicides, and exposure to domestic abuse has a significant impact on both the victim's and exposed children's mental health. It is important that domestic abuse, substance misuse, and mental health issues are all considered together.

Young offenders are at higher risk of mental health difficulties as well as substance misuse, and broader risks to physical and mental health such as unstable housing. These young people have complex emotional health needs which interplay with their offending behaviour.

Over half of children and young people who offend have themselves been victim of crime and thirty-nine percent of children and young people in custody have been on a child protection plan or experienced neglect or abuse. Nationally amongst children and young people on community orders, 43% have emotional and mental health needs. In the year 19/20 there were 25 convictions/cautions in under 18-year-olds in Wokingham, and given their complex health needs and the effect on society of youth offending, early and targeted intervention is key.

**Commitment to Action: The priorities we will focus on are**

**People with Learning Disabilities**

**Unpaid Carers**

**Domestic Violence**

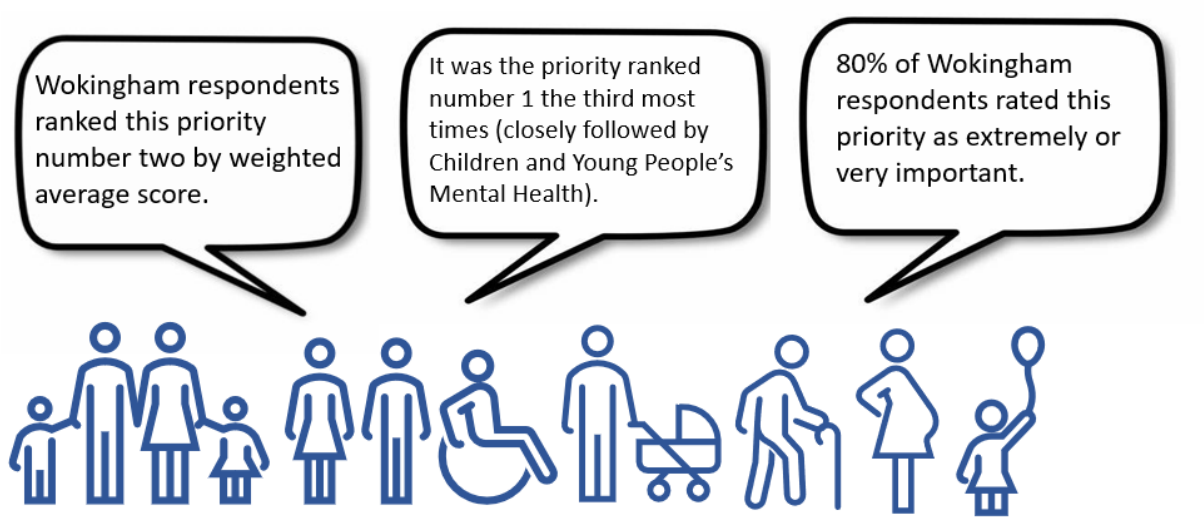
**Substance Misuse**

**Young Offenders**

- Specific actions for the first year are detailed in the relevant Action Plans (see accompanying Wokingham Action Plan).
- The Community Safety Partnership Board will lead on three priorities: Substance misuse, domestic violence, and young offenders.
- The Wokingham Learning Disability Partnership Board will lead on the people with learning disabilities priority, and
- The Carers Strategic Group will lead on the delivering health and wellbeing priority for unpaid carers.
- These three Boards will report quarterly on their respective priorities to the Wokingham Wellbeing Board Steering Group.

## 3. HELP FAMILIES AND CHILDREN IN EARLY YEARS

**Wokingham Residents' Voice within Berkshire West Public Engagement:**




### Wokingham in Focus:

Focus on targeted support for children during their early years and their families is key to reducing inequality and achieving long-term positive health and wellbeing outcomes in our population.

Early intervention and prevention is a key priority of the Wokingham Children and Young People Partnership Plan 20-23. In addition a recent Government Review of Early Years Healthy Development has focussed attention on the 1001 critical days from start of pregnancy to age 2, when building blocks for lifelong emotional and physical health are laid down.

In England, on starting school (age 5), children's progress and "school readiness" is measured through assessment against a series of standards for Communication & Language, Speaking, Personal, Social and Emotional Development, Physical Development, Literacy Mathematics, Understanding the World, and Expressive Arts & Design. The standard expected for a child to have the best foundation for starting school is a "Good Level of Development" across all these areas.

In Wokingham, we know that inequalities exist in "school readiness", 51% of children who are in receipt of Free School Meals (FSM) achieve a "Good Level of Development", compared with 79% of those who do not receive FSM. There is an even larger gap for children with Special Educational Needs (SEN) based on national data, with only 25% of SEN pupils reaching a "Good Level of Development".

**Commitment to Action: The priorities we will focus on are**

**SEND and Inclusion**

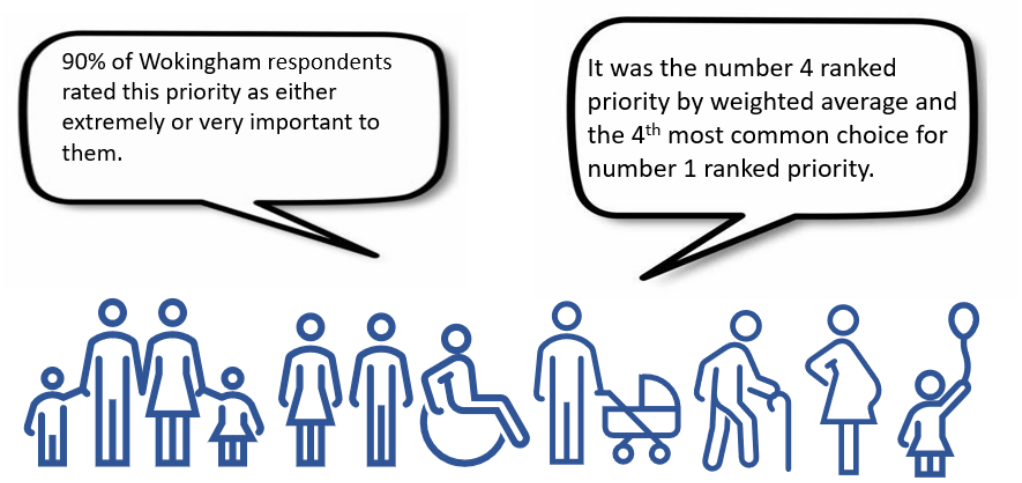
**Safeguarding**

**Early Intervention and Prevention**

- These priorities are derived from the Wokingham Children and Young People Partnership Plan 20-23.
- Specific actions for the first year are detailed in the relevant Action Plan (see accompanying Wokingham Action Plan).
- An Early Years Action Group (derived from the existing Children and Young People Partnership) will lead on the delivery and quarterly reporting of these priorities to the Wellbeing Board Steering Group.

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

**Wokingham Residents' Voice within Berkshire West Public Engagement:**




## Wokingham in Focus:

Mental health problems often begin in childhood, with 50% of those suffering from lifetime mental illness beginning to experience symptoms by the age of 14. Early identification and prevention are thus of the utmost importance in ensuring good mental health and wellbeing through the life-course as well as ensuring that services are available for those with serious mental health needs requiring direct intervention. The NHS Long Term Plan commits to increase access to emotional and mental health services for children and young people as well as expanding support for perinatal mental health conditions. It is also important that we acknowledge the link between mental health and wellbeing and general health and physical activity.

In Wokingham, we know that anxiety among under 18s is almost twice as common in girls compared with boys, rising with increasing age in both genders. A diagnosis of depression is also more prevalent in girls, with around 3 times as many girls reporting depression.

This is similar to national data, although may also demonstrate a reluctance in boys to seek help for their mental health. In the wider local area of Berkshire West, children from households in the poorest areas are four times more likely to suffer from severe mental health problems than those in the areas which are the richest.

In Wokingham, waiting times for children and young people waiting for Common Point of Entry screening for CAMHs was on average 7.6 weeks in March 2021. The Covid-19 pandemic appears to have had a clear effect on these numbers, with a peak of referrals in March 2021.

**Commitment to Action: The priorities we will focus on are**

**Prevention and Early Help**

**Reduce waiting time**

**Covid-recovery**

- Specific actions for the first year are detailed in the relevant Action Plan (see accompanying Wokingham Action Plan).
- A Children & Young People's Mental Health & Wellbeing Action Group (derived from existing Children and Young People Partnership) will take ownership of the delivery of these priorities, to report to the Wellbeing Board Steering Group as per the governance structure, and to ensure all relevant stakeholders are involved in the delivery.

# 5. PROMOTE GOOD MENTAL HEALTH AND WELLBEING FOR ALL ADULTS

**Wokingham Residents' Voice within Berkshire West Public Engagement:**


## Wokingham in Focus:

Poor mental health in adults makes up the largest single cause of disability in the United Kingdom. It can affect anyone at any stage of life, and both affects and is affected by physical health. The Covid-19 pandemic has highlighted mental health as an area requiring key focus and has also exacerbated already existing inequalities in the distribution of mental health issues across the population.

Prior to the Covid-19 pandemic, in Wokingham, over 10,000 elderly residents were estimated to be living alone, with a projected 25% rise by 2025. From national data we know that loneliness and social isolation is likely to increase risk of death by 26%, highlighting how key this is to both mental and physical health. The effects of the Covid-19 pandemic are likely to have increased the prevalence of loneliness and social isolation.

We know from the 2020 Covid-19 survey in Wokingham that 47% of residents struggled with 'ability to connect with friends and family', 46% struggled with 'levels of stress and anxiety', and 21% reported mental health issues including depression.

Early identification and action are key to preventing further exacerbation and serious mental health issues.

Dementia is a particular concern for the 1 in 4 people aged over 55 who already have a close relative with dementia. The prevalence of dementia increases with age however, dementia is not inevitable as we age and there is a lot that can be done to reduce chances of developing it. Risk factors include higher blood pressure, decreased mental stimulation and cardiovascular disease. Within Wokingham care home residents 61% are known to have cognitive problems and the number of emergency admissions related to dementia is higher in Wokingham when compared with the national average.


- Specific actions for the first year are detailed in the relevant Action Plans (see accompanying Wokingham Action Plan).
- The WBC Dementia Steering Group and Dementia Alliance will deliver and report on the Dementia priority
- The Loneliness and Social Isolation Action Group will deliver on the other two priorities.
- This involves both delivering on the action plans as well as reporting on them on a quarterly basis, and ensuring all relevant stakeholders are involved in the delivery.

## Wokingham in Focus:

Improving the physical activity levels of our residents has been, and remains, a key priority for the Wokingham Wellbeing Board. Physically active communities will be included as a cross-cutting theme across our local Strategy into Action. This will enable a focus on the reduction in the number of residents who are obese and overweight, as well as an improvement in mental and general physical health, including inequalities related to these. Having physically active communities as a crosscutting theme across all the priorities compliments the Prevention cross-cutting theme within the Berkshire West Health and Wellbeing Strategy.

The prevalence of obesity in the UK has more than doubled in the last 25 years. By 2050 it is predicted that 60% of men, 50% of women and 25% of children in the UK would be obese, with factors such as ethnicity and gender increasing the risks and the evidence indicating that there is a strong association between obesity and deprivation. Obesity is a risk factor for heart disease, stroke, type 2 diabetes, some cancers (endometrial, breast, and bowel), musculoskeletal disorders, hypertension and significantly increases the risk of death at any age. More recently in 2020 research has identified an association between individuals who have excess weight and are overweight or obese and poorer health outcomes after contracting Covid-19 with higher risk of hospitalisation and or death.

In Wokingham 21.2% of reception-year children (approximately 1 in 5) were overweight or obese in 2019/20, slightly below the national average. In 10-11 year old children this figure rose to 29.2%. In the same year 60.2% of adults in Wokingham were overweight or obese. Evidence also shows that locally there is an association between obesity and both deprivation and some minority ethnic groups.

In 2018/19, 41.1% of children and young people were physically active, which decreased from the previous year's number of 45.3%. In adults the same figure was 75.3% in 2019/20. Physical activity is crucial for maintaining a healthy weight but also for physical and mental health and wellbeing in children and adults. Creating physically active communities is an aim that incorporates work from multiple partners from creating a built environment that encourages active transport to building a social environment where physical activity is incorporated into everyday life. The Covid-19 pandemic is likely to have had an impact on activity levels across the life course and the impact of this is yet to be fully understood.

**Commitment to Action: The priorities we will focus on are**

**Children, Young People & Families**

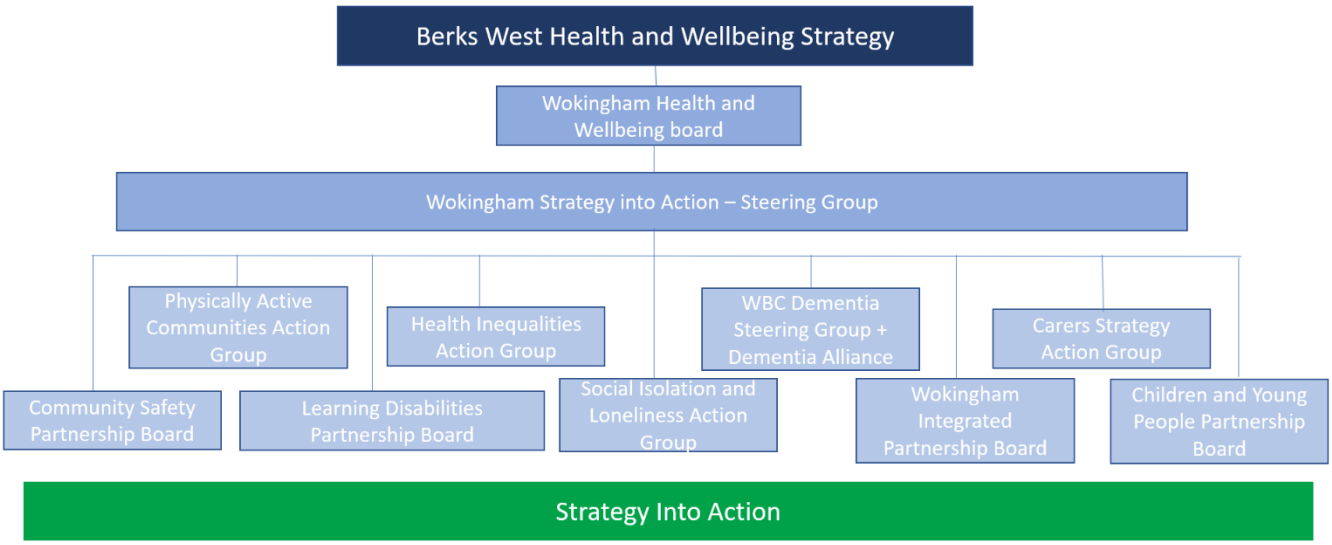
**Covid-19 recovery**

**Ethnic Minority Groups**

- Specific actions for the first year are detailed in the relevant Action Plan (see accompanying Wokingham Action Plan).
- The Physically Active Communities Action Group will deliver and report on this priority, as well as work with other groups to ensure the overarching strategic priorities are considered with physical activity as a crosscutting theme.

## GOVERNANCE

The Wokingham Wellbeing Board will maintain oversight of the delivery of this Strategy into Action. A Strategy into Action Steering Group will monitor quarterly reporting from each of the component groups leading on Wokingham's priorities.




Each Wokingham Health and Wellbeing priority and its lead group can be seen in this table:

| Partnerships and Action Groups: | Priorities |
|---|---|
| CYPP Board | Children and families in early years and Good Mental health and Wellbeing for all Children and Young People |
| CSP Board | Substance misuse, Domestic Abuse and Youth Offending |
| WIP | Cross-cutting |
| Learning Disabilities Partnership Board | People with Learning Disabilities |
| Carers Strategy Action Group | Unpaid Carers |
| WBC Dementia Steering Group + Dementia Alliance | Dementia |
| Health Inequalities | Health inequalities (across life course) – CVD/Cancer/Covid recovery |
| Physically Active Communities | Cross-cutting |
| Loneliness and Social Isolation (Mental Health) | Loneliness and Social Isolation/Covid recovery |

Each partnership and action group will be expected to take a leadership role around the delivery of the Wokingham priorities as detailed in this Strategy into Action document. Working with the relevant stakeholders each group will report quarterly on the action plans (in accompanying Wokingham Action Plan), as well as to present the work on their priority directly to the Wellbeing Board annually. The Wellbeing Board will monitor this quarterly reporting and progress against milestones set out.

The Action Plans for each priority are dynamic, acknowledge the overlap with other partnership groups, and will evolve over the course of working on the Wellbeing Board priorities. In addition each will be reviewed and updated annually to ensure they remain relevant and responsive to changing data, evidence and circumstance, particularly in the context of the Covid-19 pandemic recovery. Wokingham Integrated Partnership and the Physically Active Communities Action Group are cross-cutting throughout the strategy, and will therefore have action plans relating to several different priorities.

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## Wokingham Priorities and Action Plans 2021/22

1. Reduce the differences in health between different groups of people
    (a) Wokingham Wellbeing Board Health Inequalities Action Group Plan

2. Support individuals at high risk of bad health outcomes to live healthy lives
    (b) Community Safety Partnership Board Action Plan
    (c) Carers Strategy Action Group Action Plan
    (d) Dementia Alliance Action Plan
    (e) Learning Disabilities Partnership Board Action Plan

3. Help children and families in early years
    (f) Children and Young People Partnership Board Action Plan

4. Good mental health and wellbeing for all children and young people
    (g) Children and Young People Partnership Board Action Plan

5. Good mental health and wellbeing for all adults
    (h) Wokingham Wellbeing Board Social Isolation and Loneliness Action Group Plan

6. Cross-functional Action Plans*
    (i) Wokingham Wellbeing Board Physically Active Communities Action Group Plan

**There are other Action Plans which contribute to Wokingham priorities which will continue to be reported through to Wokingham Wellbeing Board separately e.g. Wokingham Integration Strategic Partnership*

**1. Reduce the differences in health between different groups of people**

**(a) *Wokingham Wellbeing Board Health Inequalities Action Group Plan***

| Wokingham Priority | | Activity | Lead and Partner | Progress Milestones | Outcomes |
|---|---|---|---|---|---|
| To support individuals at high risk of developing cardiovascular disease (CVD) | Hypertension | To understand the avoidable difference in the distribution of disease and health outcomes in Wokingham residents through data and evidence | Public Health<br><br>Berkshire West CCG | Existing data and evidence provided by all partners<br><br>Analysis of evidence undertaken | Agreed list of local priority groups<br><br>To be able to demonstrate progress in understanding of avoidable difference across health measures in Wokingham residents. |
| | | To undertake health promotion of lifestyle choices around nutrition<br><br>To support residents with healthy food and healthy eating education, champion existing work which aims to reduce health-based food inequalities | Public Health<br><br>Community Engagement<br><br>Voluntary & Community Services [VCS]<br><br>Healthwatch | To run healthy eating campaigns in collaboration with partners and providers | To have delivered local healthy eating activities which residents report having a positive impact on nutrition/eating. |
| | | To re-vitalise Health Checks programme to help with the identification of individuals with cardiovascular risk factors | Public Health | Re-established a local NHS Health Checks programme | To increase the number of health checks being offered and accepted.<br><br>Individuals at high risk of CVD or poor health |

| Wokingham Priority | | Activity | Lead and Partner | Progress Milestones | Outcomes |
|---|---|---|---|---|---|
| | | | | | outcomes are identified.<br><br>Support the reduction of risk in those at greatest risk of CVD through local health programmes; |
| To support individuals at high risk of developing cardiovascular disease (CVD) | Hypertension | To increase the uptake of annual health checks for individuals with a learning disability [LD]<br><br>*See also Learning Disability* | Berkshire West CCG and Primary Care | To monitor health check uptakes in LD population | Increased number of annual health checks being offered and accepted.<br><br>People with a LD at high risk of poor health outcomes are identified and supported.<br><br>Support the reduction of risk in those at greatest risk of CVD through local health programmes; |
| | | To utilise the "Blood pressure at Home" project to equip patients with blood pressure machines followed by management and lifestyle advice provided by individual practices – patients searched via deprivation postcodes and clinical judgement | Berkshire West CCG<br><br>Primary Care<br><br>WBC Population Health Management [PHM] Steering Group | Number of BP machine per practice<br><br>Number of patients engaging in the project<br><br>Patient demographics | More levels of controlled hypertension and self-empowerment of patients to manage their health |

| Wokingham Priority | | Activity | Lead and Partner | Progress Milestones | Outcomes |
|---|---|---|---|---|---|
| | | | | Patient feedback<br><br>Reduction in BP<br><br>To plan virtual group consultations for patients from the "BP at Home" cohort | |
| To support individuals at high risk of developing cardiovascular disease (CVD) | Hypertension | To support the use and implementation of Population Health Management approach to improve understanding of the distribution of disease risk and lifestyle risk in Wokingham's population, improve population health, understand at risk groups and reduce health inequalities | Public Health<br><br>WBC PHM Steering Group | PHM projects that support local priorities designed, implemented, and evaluated | PHM Approach used to improve population health and reduce health inequalities |
| | Obesity | To encourage the implementation of motivational Interviewing techniques and non-judgemental ways to engage patients in accessing weight loss services. | Get Berkshire Active<br><br>Primary care | Number of primary care staff attending training<br><br>Number of referrals to adult weight management services; | Greater number of staff trained in motivational interviewing techniques.<br><br>Improved communication between patients and practitioners regarding healthy weight.<br>Increased number of referrals to weight management service provision. |

| Wokingham Priority | | Activity | Lead and Partner | Progress Milestones | Outcomes |
|---|---|---|---|---|---|
| To support individuals at high risk of developing cardiovascular disease (CVD) | Obesity | To work in partnership with VCS to reduce food poverty and increase accessibility to healthy foods (fresh fruit and veg) across the Borough. | Community Engagement<br><br>VCS | To monitor number of families supported, demographic and geographical data | To improved understand of local food poverty and increased geographical accessibility to health foods |
| | | *Also see Physical Activity Section* | | | |
| | Smoking | *see Smoking Cessation/Tobacco* | | | |
| To support communities in accessing cancer screening services and to support those affected by cancer | | To gather and consolidate existing data and evidence on Wokingham population cancer outcomes to identify at risk population(s) and prioritise type of cancer | Public Health<br><br>Berkshire West Public Health Hub | To have a final Cancer Pack by end of September 2021 which will inform the local picture | At risk populations identified, type of cancer prioritised. |
| | | To support communities in identifying signs and symptoms of cancer and encouraging them to see their GP/ attend screenings via Thames Cancer Alliance Programme | Thames Valley Cancer Alliance [TVCA]<br><br>VCS<br><br>Community Engagement<br><br>Healthwatch | Co-produced messages that resonate with target communities leading to increased engagement<br><br>Increased attendance and participation in screening programmes by ethnic minority communities and Health Inclusion Groups<br><br>Increased awareness and better understanding of the signs and symptoms of various types of cancer<br><br>Monitor and evaluate programme via | Increased awareness of signs and symptoms of cancer within communities.<br><br>Increased screening attendance. |

| Wokingham Priority | Activity | Lead and Partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| To support communities in accessing cancer screening services and to support those affected by cancer | | | surveys/focus groups/screening data | |
| | To support our partners to maintain Cancer Community Champions programme | Public Health<br><br>VCS<br><br>Involve | Quarterly performance data pertaining to the individual e.g., cancer condition, services within the network being utilised (befriender), access to network leisure activities, WhatsApp group etc. | Continued support of Cancer Community Champions and plans made for programme to actively tackle health inequalities |
| To ensure that coronavirus [COVID-19] recovery is done in an equitable way, so that health inequalities are not exacerbated further | To develop an understanding about the impact of the interaction between COVID-19 and health inequalities and to address it appropriately. | Public Health<br><br>Healthwatch | Analysing national and local data sets to understand local health inequalities within Wokingham communities to identify key areas of work.<br><br>Utilise Health Equity Assessment Tool. | Increased understanding of COVID-19 impact which will inform actions for Year 2 |
| | To develop an understanding of the health challenges (including mental health) exacerbated by the COVID-19 pandemic across the life course. | Public Health<br><br>Healthwatch | Conduct a literature review in a year's time<br><br>Data mapping exercise across the life course | |
| | To understand the impact of interruptions to healthcare business during the pandemic, and how these have impacted health outcomes. | Public Health<br><br>Primary Care<br><br>Berkshire West CCG | Analyse national and local data to understand impact of pandemic on healthcare. | Increased understanding of the COVID-19 impact on healthcare business which will inform |

| Wokingham Priority | Activity | Lead and Partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| To ensure that coronavirus [COVID-19] recovery is done in an equitable way, so that health inequalities are not exacerbated further | | | | actions from Year 2 to help support healthcare business experiencing very high demand. |
| | To address the impact of wider economic and social consequences of COVID-19 on the health of our communities. | Public Health<br><br>Healthwatch<br><br>WBC – Insight, Strategy & Inclusion Team | Foodbank usage (Number of people supported. Breakdown of data by ward, age and makeup of household e.g., single parent, couple etc)<br><br>Free School Meals<br><br>Housing benefits<br><br>Residents' voice<br><br>Equality Profile – gaining insight & understanding of Wokingham borough communities in terms of the 9 protected characteristics and considering the impacts of Covid-19 on these communities. Socio-economic<br><br>Govmetrics – regular reporting and monitoring. | Clearer understanding of the demographics and changing needs of our residents. Further understanding of those with multiple characteristics. Becoming a more equal, diverse and inclusive borough.<br><br>Improved understanding of levels of poverty in Wokingham borough. Identifying those most in need, their experiences, and how we can better help |

| Wokingham Priority | Activity | Lead and Partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| To ensure that coronavirus [COVID-19] recovery is done in an equitable way, so that health inequalities are not exacerbated further | | WBC – Insight, Strategy & Inclusion team, Customer Delivery team<br><br>WBC – Insight, Strategy & Inclusion team<br><br>WBC – Insight, Strategy & Inclusion team, CEM team, Customer Delivery | Poverty scorecard – developing a suite of measures (real-time information) giving an indication of poverty levels in Wokingham borough.<br><br>Resident surveys<br>Staff satisfaction<br>Indications of health of our working and wider communities | them directly and reduce poverty overall. |
| | To understand and address the avoidable differences in access to health care services (including COVID-19 catch-up services), including screening and immunisations | Public Health<br><br>Berkshire West CCG<br><br>BHFT<br><br>Primary Care<br><br>Healthwatch | Monitor local data on access to services<br><br>Analyse impact that interruptions to healthcare have had on residents (and health inequalities) | Improved understanding of access to services and plan put in place to address avoidable differences |
| | To support individuals who became unpaid carers during lockdown – *see Carers Action Plan* | Healthwatch | Analyse resident surveys and report which will provide insight into the needs of unpaid carers | Support provided to unpaid carers, including support for physical and mental health |

| Wokingham Priority | Activity | Lead and Partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| To ensure that coronavirus [COVID-19] recovery is done in an equitable way, so that health inequalities are not exacerbated further | To support the needs to patients diagnosed with Long COVID-19 via virtual group consultations | Primary Care (to be piloted in Wokingham North Primary Care Network [PCN] in the first instance)<br><br>Public Health | To monitor:<br>- Number of patients engaging in the VGCs<br>- Patient demographics<br>- Patient feedback<br>- Improved symptoms of Long COVID-19 | Increased understanding of the complexities of Long COVID-19.<br><br>Patients with Long COVID-19 supported and provided with the tools needed to manage their conditions. |
| | To establish a Community Ambassador Network with a workstream to health inequalities | Community Engagement<br><br>Public Health | Monitor priorities emerging from this group based on geographical/demographic insights | Established, engaged group with a defined role and outcome (Terms of Reference – champion health issues, support with access to services, etc) |
| | To recruit a Grassroots Worker who will seek to unlock community health provision | Involve | Reporting will include number of groups assisted and obstacles to unlocking their provision | Increased number of groups offering support to residents around an assortment of health relate matters. |

## 2. Support individuals at high risk of bad health outcomes to live healthy lives

**(b) *Community Safety Partnership [CSP] Board Action Plan***

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Identify and agree local priority groups at high risk of bad health outcomes and risk factors associated with risk; | Gather and consolidate existing data and evidence on Wokingham population health and wellbeing outcomes to identify at risk population/s and risk factors.<br><br>To identify gaps in data or evidence.<br><br>Produce a baseline of evidence/data (needs assessments) for the priority vulnerable groups. | Public Health<br><br>Berkshire West CCG | Existing data and evidence provided by all partners.<br><br>Analysis of evidence undertaken.<br><br>Mitigation action is taken in response to identified gaps in data/evidence.<br><br>Baseline needs assessment produced for each priority vulnerable group. | Needs assessment published and used to inform local action.<br><br>Mitigation is agreed and monitored.<br><br>Reporting set up, received and monitored by Governance Board/s. |
| | To support the implementation of Population Health Management *see Priority 1* | | | |
| Provide support and services to residents who are affected by substance misuse. | Mobilisation of the new substance misuse service provision/s for Wokingham residents.<br><br>To identify and work with key groups on the co-development of a local Substance Misuse Strategy and Action Plan.<br><br>To undertake a review of comorbidities and other health and wellbeing outcomes in substance misusers and their families. | Public Health<br><br>Cranstoun (Provider) | Key milestones of mobilisation and implementation achieved.<br><br>New service provision is 'live' and residents/interdependent services are engaged and referring to the service.<br><br>Wokingham Substance Misuse Strategy and Action Plan agreed by partners. | Adults remain in treatment for at least 12 weeks or more and do not make an unplanned exit.<br><br>The number of young people/children in the service have a planned exit. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| | | | Provider to submit quarterly contract monitoring and performance data and achieving expected service outcomes in line with service specification. | The number of planned exits increase in line with or above the national average.<br><br>To identify and reduce tobacco smoking dependency.<br>The number of people within treatment are offered and accept a test and or vaccination against BBVs, protecting them from further harm. |
| Reduce the harm caused by tobacco in Wokingham residents most at risk e.g., young people, pregnant women, routine & manual workers | Mobilisation of the new Stop Smoking/Smoking Cessation service provision/s for Wokingham residents<br><br>Undertaken test purchasing/underage sales activity with Wokingham retailers<br><br>Deliver targeted education to KS2 pupils on tobacco, smoking, alcohol and drugs as an extension to PSHE offer. | Public Health<br><br>Public Protection Partnership<br><br>Berkshire West Tobacco Control Alliance Members<br><br>Cranstoun & Smokefreelife Berkshire (Providers) | Key milestones of service mobilisation and implementation achieved.<br><br>New service provision is 'live' and residents/interdependent services are engaged and referring to the service.<br><br>Provider to submit quarterly contract monitoring and performance data and achieving expected service outcomes in line with service specification including number of successful quits by population group. | Increase the number of women smoking in pregnancy engaged with stop smoking service provision (community AND through maternity services)<br><br>Increase the number of Routine & Manual Workers successfully quit at 4 weeks<br><br>Increase the number of residents from |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| | | | 10 primary school sessions (KS2) are offered and delivered in 2021/22.<br><br>Evaluation of school session is carried out. | target groups accessing stop smoking services and reporting quit attempts.<br><br>No of test purchases (involving tobacco); No of retailers passed; No of retailers who failed; No of illegal seizures; Outcome of prosecutions.<br><br>Evidence of improved knowledge and understanding amongst participants of the use of smoking, alcohol and tobacco. |
| To protect and promote the health and wellbeing of those at risk of or affected by domestic abuse. | Coordinate multi-agency response to domestic abuse.<br><br>Finalise commissioning of and mobilisation of the new domestic abuse service provision/s for Wokingham residents including set up of local refuge.<br><br>Undertake multi-agency training (DA related but covering wide range of other issues such as health). | Public Health<br><br>CSP lead | Multi agency pathways/response mapped and agreed.<br><br>Key milestones of mobilisation and implementation achieved.<br><br>New service provision is 'live' and residents/interdependent services are engaged and referring to the service. | Victims / survivors and their children are assessed and have individual safeguarding needs assessed and receive support to address these.<br><br>All victims and children affected by |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| | Raise awareness of domestic abuse in order to encourage interventions at the earliest possible stage.<br><br>Networking across agencies to promote health and wellbeing activities for adults and children who are, or have, experienced domestic abuse (e.g. Recovery College Programme/Kicks Programme etc). | | Provider to submit quarterly contract monitoring and performance data and achieving expected service outcomes in line with service specification.<br><br>Training Programme developed with key partners.<br><br>Health promotion plan developed and implemented.<br><br>Regular networking meeting/s with key agencies set up and held. | domestic abuse in Wokingham are able to access information, help and support through a 24/7 helpline which addresses immediate safety concerns and facilitates a smooth pathway to domestic abuse support<br><br>Victims and Survivors feel able to support criminal and civil justice options, improving their safety and holding perpetrators to account<br><br>Perpetrators of domestic abuse who acknowledge some level of understanding as to the effect of their behaviour, are supported to access perpetrator interventions to achieve long term |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| | | | | positive behavioural change.<br><br>Increased independence for survivors of domestic abuse/violence and their children and can feel safe in their homes |
| To protect and promote the health and wellbeing of those at risk of or affected by domestic abuse | Develop a domestic abuse dataset between key relevant organisations to monitor number of health presentations where there is a domestic abuse marker | Public Health<br><br>Domestic Abuse Partnership Board<br><br>Berkshire West CCG<br><br>Berkshire Healthcare Foundation Trust [BHFT]<br><br>Royal Berkshire Hospital [RBH]<br><br>Frimley Park Hospital | Meeting convened of key partner organisations to establish if it is possible to interrogate data collection systems to gather meaningful data and feasibility of this data collection leading to positive outcomes<br><br>Pilot area(s) established to test feasibility and training needs Training input delivered to achieve meaningful data inputting<br><br>Collection, review and adaptations of pilot to roll out if beneficial. | Consistent agreed data set to enable monitoring of number of people presenting to health settings as a result of domestic abuse, broken down into key demographics (e.g., age, gender, having a disability) |
| To protect and promote the health and wellbeing of those at risk of youth offending | Wokingham Prevention and Youth Justice Service [PYJS] to review and develop its working partnership with Cranstoun to enhance the Youth Offending Service [YOS] substance misuse offer. | Wokingham PYJS & Cranstoun | Cranstoun worker to be co-located at PYJS office on a weekly basis. | Increased number of PYJS referrals to Cranstoun. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
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| and/or engaged with youth offending services | PYJS to improve children/young people's understanding of sexual consent and to promote positive and healthy relationships.<br><br>PYJS to raise community awareness around criminal exploitation of children, substance misuse and inappropriate sexualised behaviour. | Wokingham PYJS & BHFT<br><br>Wokingham PYJS. | Cranstoun worker to deliver a tailored intervention for those children involved with substance misuse and/or at risk of "county lines" involvement.<br><br>YOS Nurse to deliver a targeted intervention to every child involved in an offence/ behaviour of concern of sexual nature.<br><br>YOS workers to deliver outreach events in the community (and in schools) around criminal exploitation, substance misuse and inappropriate sexualised behaviour. | Increased access to substance misuse support for those children at risk of or involved with offending.<br><br>Targeted intervention delivered in every circumstance where inappropriate sexualised behaviour has been raised as a concern/reason for PYJS involvement.<br><br>Adults and carers in the community have an increased awareness and understanding of criminal exploitation, substance misuse and inappropriate sexualised behaviour and know where resources and support services can be accessed. |

**(c) Carers Strategy Action Group Action Plan**

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| **YEAR 1** | | | | |
| Identify & recognise carers | To develop a local offer for carers so that they are better informed on what support they can access. | Wokingham Strategy & Commissioning Team [Strategy & Commissioning]<br><br>Adult Social Care [ASC] leads<br><br>VCS lead | Establish working party 8/7/21<br><br>Review what is currently offered when carers are initially assessed 8/8/21<br><br>Survey carers to establish where carers go to for advice/support in the first instance | Enable carers to access the advice and support that is available. |
| | To actively promote identification of carers and pathways to assessment. | ASC<br><br>VCS lead | Establish working party 8/7/21<br><br>Review current pathways internally<br><br>Review current pathways VCS | Reduce the number of carers whose first point of contact with services are when they are in crisis |

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| | To develop strategies for publicising carers' support services. | Carers Strategy Group [CSG]<br><br>Public Health<br><br>Healthwatch | Arrange working party meeting 15/7/21.<br><br>Benchmark number of G.P. Surgeries/community advertising space.<br><br>Develop strategies to reach out through community navigator scheme.<br><br>Develop strategies to reach out at community events.<br><br>Establish relationship with PCN leads. | Increase the visibility of carers advice, support, and information services so that carers can make informed choices. |
| | To develop systems and processes for engaging with a broader spectrum of carers within our communities. | CSG<br><br>ASC Carers leads | Establish links with community leads. | Enable equitable access to support for carers of people with: mental health [MH] issues, substance misuse issues, LGBTQ+ community, Gypsy, Roma and Traveller [GRT] community, Ex-military, Children and Young People. |
| | To work collaboratively with partners in promoting services within minority communities. | Strategy & Commissioning<br><br>VCS | Carers orgs have a presence at the mosque during vaccinations (completed). | Enable equitable access to support for carers of people within ethnic minority communities and foster |

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| | | | Establish links with Wokingham Borough's Black and Minority Ethnic forum. | broader representation on carers forums. |
| | To co-produce services that WBC commission with carers from a broad spectrum of the community, including those from underrepresented groups. | Strategy & Commissioning | Ensure this is covered in VCS procurement 8/7/21.<br><br>Incorporate carers into the co-production work WBC is doing 6/7/21. | Ensure wider representation enabling us to develop services that will be more inclusive of carers who live in our community. |
| Supporting young carers | To develop a 'whole family approach' with clear pathways for assessment between Adult and Children's Social Care Teams. | Strategy & Commissioning<br><br>VCS | Quarterly meeting Tu Vida (Provider) monitor Key Performance Indicators [KPI's]. | Ensure young carers have their needs assessed as part of a wider systems approach. |
| | To improve emotional well-being for young carers. | Strategy & Commissioning<br><br>VCS | Attend webinar 21/7/21.<br><br>Benchmark number of young carers currently accessing MH services/ or in need of MH services.<br><br>Tu Vida staff to do MH first aider training | Improving mental health and reducing the need for statutory services. |

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| | | | Tu Vida to incorporate emotional health and wellbeing sessions into their offer for young carers | |
| | To provide regular group activities and events throughout the year for young carers, in both school term time and in school holidays. | Strategy & Commissioning<br><br>Tu Vida | Map other young carers groups<br><br>Re-establish face-to-face groups<br><br>Re-establish schools work | Foster a community of support and provide opportunities for young carers to have access to activities that other children and young people who are not carers have. |
| | To work with schools and VCS organisations in establishing drop-in sessions and peer to peer support | Strategy & Commissioning<br><br>Tu Vida | Continue to work with schools | Reduce social isolation and improve emotional health and well-being. |
| | To establish a young carers forum | Tu Vida | Set a date to re-launch group | Ensure the voice of young carers is heard, enabling young carers to influence decisions that affect their lives and to support their active contribution to the carers strategic group. |
| Supporting working carers | To create opportunities for working carers to access support, advice, and information and training in a variety of ways that fit in with their lifestyle. | Strategy & Commissioning | To include KPI's around delivery of services in a variety of ways/outside 9-5 in carers services we commission | Support carers to care whilst remaining in employment. |
| | To work with Supported Employment Service [SES] in helping carers who chose to access or remain in employment. | SES | Ensure SES are invited to have a presence at events e.g., carers week/carers rights day | Enable carers to remain independent and reduce social isolation. |

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| | | Strategy & Commissioning<br><br>VCS | Develop carers material | |
| | To work with partners in developing opportunities for working carers to engage in social activities outside their working day | CSG<br><br>VCS | Survey working carers to establish need and format | Support working carers to maintain their health and well-being and foster peer support. |
| Enabling carers to have a life outside of caring | To increase preventative measures including use of AT and respite for the cared for. | ASC | Establish uptake of AT with lead<br><br>Review carers breaks/respite. | Ensure carers are able to take a break. |
| | To work collaboratively with partners to actively promote free health checks/flu jabs/coronavirus vaccinations. | Strategy & Commissioning<br><br>Public Health | PH to reach out to carers to promote healthy lifestyles.<br><br>Commission equitable service to ensure carers can go to medical appointments. | To improve the health of carers. |
| | To improve the uptake of carers engaging in activities outside of their caring role. | Tu Vida | Survey carers on what they would be most interested in | Carers will have the opportunity for leisure activities, and time away from their caring responsibilities to enhance their sense of well-being and reduce social isolation |
| | To support carers in developing strategies to enable them to feel able to take a break, or to have time to themselves. | Tu Vida<br><br>CSG | Review contingency planning/carers assessments. | Helping carers to continue to care. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| **YEARS 2-5** | | | | |
| Identify & recognise carers | To review the assessment pathway including the process of self-assessment | | Establish how many carers use the on-line self-assessment | To ensure an efficient digital pathway to services |
| | To develop our care act training | | Review Care Act training | For all staff to improve identification and recognition of carers |
| | To improve joined up working: across departments, with multi-agency, with the VCS | | Establish Carers champions/leads in key departments (JD - expectations?)<br><br>Flow charts/swim lanes to ensure single point of contact | Reducing the delay of carers getting linked into services quickly and ensure they get the right support at the right time |
| | To work with our independent care providers in identifying and signposting carers | Strategy & Commissioning | Link to care provider framework | Increase choice |
| Supporting young carers | To increase the number of young carers identified at WBC front door | | | Reduce the delay in young carers getting access to services |
| | To undertake a review of the transport issues and services | Tu Vida | Survey young carers to establish what their transportation issues are | Remove barriers that prevent young carers accessing opportunities to engage in recreational and social opportunities and get the support they need. |
| | To work with schools to improve the transition between primary, secondary schools and colleges | Tu Vida | | Young carers have the support and understanding they need to be able to |

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| | | | | maximise their learning and achievement. |
| | To establish a seamless pathway for transition from Children's to Adult services | Tu Vida<br><br>ASC | Tu Vida to establish working relationship with transition/ASC team | All young carers have an assessment prior to their 18th birthday which reflects future aspirations for adult life |
| Supporting working carers | To affiliate to the Employers for Carers scheme | Strategy & Commissioning<br><br>HR | Update Flexible working policy to include carers (Completed)<br><br>Determine process for affiliating under Cares UK Employers for Carers Scheme | WBC to become a 'carer friendly' workplace |

**(d) Dementia Alliance Action Plan**

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| To support individuals living with dementia and their carers | To establish a task and finish group to oversee the commissioning of additional and improved support for individuals living with dementia and their carers, and be responsible for the delivery of this action plan | Assistant Director, Adult Social Care (ASC), Transformation & Integration<br><br>Commissioning Team<br><br>ASC Integration Team<br><br>VCF representative<br><br>ASC<br><br>Public Health | Set up initial project meetings and project plan (first week of Sept)<br><br>Finish action plan<br><br>Produce an inequalities statement for each commissioned service<br><br>Write a commissioning spec. | List of additional support commissioned along with insight into their usage |
| | To create Dementia Friendly Wokingham Steering Group. | ASC Long term team/ COAMHS<br><br>Strategy & Commissioning<br><br>ASC Integration Team<br><br>VCS<br><br>Member with lived experience | Established group<br><br>Selected Chair<br><br>Set Terms of Reference<br><br>To recruit a specialist Dementia Co-ordinator | Dementia Friendly Wokingham Steering Group established and overseeing the delivery of commissioned services and championing the work to support residents affected by dementia. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| To support individuals living with dementia and their carers | | Public health<br><br>BHFT (older people's mental health team)<br><br>Primary Care | | |
| | To foster a Dementia Friendly Wokingham movement which builds on the existing Wokingham Dementia Alliance (WDA). | VCS lead (chairing) steering group<br><br>Specialist Dementia Co-ordinator<br><br>Joint Membership VCS/WBC<br><br>Place representative<br><br>Transport representative | Increased awareness and understanding of dementia among the wider community, thereby reducing the stigma that still exists. | Continued work to create a Dementia Friendly Wokingham. |
| | Task and finish group to establish the mechanisms to oversee and report the incremental WBC investment funding for dementia 2021/22 and onwards. | ASC Integration Team<br><br>Strategy & Commissioning<br><br>WIP | Invest in infrastructure and projects<br><br>(Report to WIP via DFW Steering Group) | Dementia Friendly Wokingham Fund being used to support projects and pilots |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| To support individuals living with dementia and their carers | To assess the immediate gaps in support for those with or affected by dementia created by Covid-19 pandemic. | Dementia Friendly Wokingham (DFW) Steering Group | Use local data and insights to identify gaps in support.<br><br>Produce and enact an Emergency Investment plan. | Needs assessments which includes analysis of those affected by dementia. |
| | To create a partnership between the DFW Steering Group and Wokingham Dementia Alliance to ascertain wider views on local priorities | DFW Steering Group and WDA | Local listening event organised to determine dementia priorities | Dementia priorities established and agreed upon with actions emerging from the priorities. |
| | To establish a Commissioning / tendering process to invest in local services to address priorities. | Strategy & Commissioning<br><br>Task & Finish group | Procured dementia services<br><br>Services start 1st April 2022 | To have commissioned dementia prevention services to address local priorities. Enable local VCFS organisations to innovate in partnership over the next 5 years. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| To support individuals living with dementia and their carers | To establish an ongoing process of reviewing support across:<br>• The Dementia Journey (pathways)<br>• Best practice<br>• Demographic/epidemiology evidence<br>• Culture and education<br>• Training awareness<br>• How to address health inequalities in relation to dementia | DFW Steering Group | Encourage local businesses, shops, employers etc to provide awareness training for staff, by accessing the Dementia Friends information sessions | Review completed and plans put in place to address these areas. |
| | To work in partnership with people and their carers from ethnic minority communities to offer support, raise awareness of existing services and groups, and customised prevention relevant to that community. | ASC Commissioning<br><br>DFW Steering Group | Spec for specifically commissioned dementia services for ethnic minority communities.<br><br>Ethnic minority groups to be included as part of Dementia Alliance (also other Alliances going forward) | Improved engagement by ethnic minority communities, organisations and people with dementia and their carers.<br><br>Improved outcomes for people with living dementia and their carers i.e. more years in better health, more support for carers, more integration with health services where applicable |

**(e) Learning Disabilities Partnership Board Action Plan**

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Supporting individuals with a learning disability [LD] in the Wokingham Borough to live independent, healthy and safe lives. | To create a dedicated Learning Disability Service providing focused social work support and access to social care and voluntary services. | ASC<br><br>Learning Disability Partnership Board [LDPB]<br><br>Positive Inclusion | To implement the Learning Disability Team as part of the Adult Social Care Re-structure by April 2020 | To have a dedicated service set up to respond to the needs of people with a learning disability.<br><br>To have named workers for customers.<br><br>To have the correct level of specialist training and skills within the team to meet the needs of people with a learning disability.<br><br>To work in a strengths-based approach to enhance the independence of people with a learning disability. |
| | To develop a LD Commissioning and Market Development Plan that fosters greater choice and control within the market | ASC<br><br>Strategy & Commissioning | To implement the Care and Support Framework by October 2021<br><br>To assess the quality of providers through the Care Governance process and | To implement the Care and Support Framework for supported living and complex care and support.<br><br>To attract a wider pool of skilled providers to work with people |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Supporting individuals with a learning disability [LD] in the Wokingham Borough to live independent, healthy and safe lives. | | | annual KPI's set through the Care and Support Framework. | with a learning disability and complex needs. |
| | To create an enhanced and sustainable offer of support for carers get the support they need to help them continue caring. | Positive Inclusion<br><br>Carers Lead<br><br>ASC<br><br>Strategy and Commissioning | Carers Strategy has now been implemented to provide direction and support<br><br>To update the website to ensure that the Carers Offer is available - April 2022<br><br>All ASC carers literature to be reviewed and updated – Sept 2022<br><br>Carers for people with a learning disability Task and Finish Group to be set up – April 2022 | For carers to know where to go to get up to date and relevant information about Carers Group and the ASC offer for their loved one including respite opportunities. |
| | To embed the Approaching Adulthood Team to support young people with a learning disability to transition into adulthood | ASC<br><br>Children's Services | Full permanent staffing compliment by August 2021 | To provide a seamless service to young people with a learning disability aged 14+, and their carers |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Supporting individuals with a learning disability [LD] in the Wokingham Borough to live independent, healthy and safe lives. | | SEND<br><br>Health<br><br>Customer Experience Champion<br><br>Send With Voices [SWV] | To map all essential services and pathways 0-25 – April 2022, include all local offer options including day activities, supported employment services, support to achieve independence, education, training and housing.<br><br>Improve the accessibility and promotion of the Local Offer for 18-25 year olds.<br><br>Map proportion of Care Act Assessments completed by a young persons 18th birthday.<br><br>Engage SWV in customer feedback. | To ensure the eligible needs of young people are assessed and a plan implemented by their 18th birthday |
| | To embed our Accommodation Strategy for people with a Learning Disability | ASC<br><br>Strategy and Commissioning<br><br>Wokingham Housing Team | To have a clear list of all individuals that need current accommodation, and a pipeline forecast for forthcoming accommodation needs – October 2021 | To ensure that people with a learning disability have appropriate accommodation available within WBC.<br><br>To increase the number of people with a learning disability |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Supporting individuals with a learning disability [LD] in the Wokingham Borough to live independent, healthy and safe lives. | | Berkshire West CCG | To match individuals to new accommodation being commissioned with the aim of a move in in by April 2022 (e.g. Transitions House, Hatch Farm and Ryeish Green)<br><br>Plan phase 2 of ASC Accommodation Project for further new and refurbished accommodation to meet the needs of those identified as needing housing over the next few years.<br><br>SALT returns to evidence increase in individuals living in their own home | who have their own secure tenancy.<br><br>To increase independent living for people with a learning disability. |
| | To increase the number of people with a Learning Disability who are in employment | ASC<br><br>Optalis SES<br><br>VCS | To increase levels of access to supported employment including developing of local KPI's to assist with monitoring this. | To drive, increase and offer a number of opportunities for people with a learning disability to access supported employment |
| | To review access to and availability of day care provision for people with a learning disability | Strategy and Commissioning | To complete Day Service Review and Strategy by May 2020 | To provide a variety of services and opportunities in the |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| | | VCS | | community for people with a learning disability |
| Supporting individuals with a learning disability [LD] in the Wokingham Borough to live independent, healthy and safe lives. | To work with our partners in health to integrate services and improve outcomes for residents with a learning disability<br><br>*See also Health Inequalities Action Plan* | BHFT<br><br>Berkshire West CCG<br><br>ASC<br><br>LDPB / CLASP<br><br>Public Health | To arrange joint meetings with the Learning Disability Health Team – April 2022<br><br>Arrange a Task and finish group to identify priority areas regarding health inequalities – April 2022<br><br>To work with GP practices to understand the percentage of people with a LD who have an Annual Health check - April 2022<br><br>To continue to share information and educate people with a learning disability about health needs and access to services – through LDPB roadshows and CLASP sessions – review April 2022 | To improve health outcomes, joint working and fair access to health services for people with a learning disability |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Supporting individuals with a learning disability [LD] in the Wokingham Borough to live independent, healthy and safe lives. | To keep people with a learning disability safe and free from harm or abuse | ASC<br><br>Thames Valley Police<br><br>LDPB<br>VCS<br><br>Health | To monitor the number of Safeguarding Section 42 enquiries for people with a learning disability and monitor themes – quarterly<br><br>To develop a task and finish group around keeping safe - April 2022 | That people with a Learning Disability feel safe in their community and know who to go to if they do not feel safe. |
| | To support an active LDPB and a Voluntary Sector that supports the voice, needs and wishes of people with a learning disability. | LDPB<br><br>CLASP<br><br>ASC<br><br>PINC<br><br>VCS<br><br>Customer Experience Champion | Quarterly LDPB meetings to take place<br><br>Task and Finish groups to be set up to support the implementation of the LD strategy<br><br>Co-production to be considered with all new projects | To ensure the voice of people with a learning disability are involved in all projects pertaining to their needs<br><br>To support with the implementation of the Learning Disability Strategy |

## 3. Help children and families in early years

***(f) Children and Young People Partnership [CYPP] Board Action Plan***

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Governance | Establish CYPP "Action Group" including Terms of Reference with a view to assigning responsibility to members for developing and agreeing action plans, monitoring progress and outcomes, and exception reporting to the Wellbeing Board. | CYPP | CYPP Action Group established | Clarity of governance route, responsibility and accountability for action planning and monitoring. |
| Early Intervention and Prevention | Implement recommendations resulting from the Leadsom Review of Early Years Healthy Development pending review of further details coming from Government. | WBC Children's Services, WBC Commissioning, CYPP Action Group | Recommendations implemented in Wokingham. | Better, more coordinated support for families and children in first 1001 days from conception to age 2.<br><br>Improved health outcomes at key milestones.<br><br>Improved school readiness. |
| | Capture and analyse local data on school readiness/health milestones to determine which children with specific backgrounds/characteristics may need enhanced support (*also see SEND and Inclusion priority below*). | WBC Children's Services and CYPP Action Group | Sources of data identified and collated.<br><br>Analysis complete. | Understanding of school readiness support gaps. |
| | Produce options paper for service design/adjustments to meet school readiness support gaps/needs. Decision on preferred option(s). | WBC Children's Services and CYPP Action Group | Options paper produced. Decision made. | Clarity on preferred option(s) for support design. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Early Intervention and Prevention | Implementation of preferred option(s), including development of SMART targets/outcomes, and outcomes reporting dashboard. | WBC SEND Service; Early Years Service; Project Manager; CYPP Action Group | Option(s) implemented.<br><br>Outcomes monitored and regularly reported. | Reduction in school readiness gaps. |
| | Commission and mobilise new service provision for the mandated healthy child programme (health visitors and school nursing). | Children Services and Public Health | Key milestones of mobilisation and implementation met by provider.<br><br>New service provision is 'live' and residents/interdependent services are engaged and receiving the service.<br><br>Service provider is capturing and reporting on data according to an agreed schedule which is being used to inform local health outcomes and progress against any action(s).<br><br>Service provider is compliant with contract reporting requirements. | Statutory children's health outcomes are being capture, reported an monitored for improvement (where required)<br><br>Gaps in health outcomes across the key indicators are highlighted, monitored and assessed for further action/s; |
| | Set up/deliver and evaluate Virtual Group Consultations (VGC) pilot for postnatal care in partnership with Wokingham PCN leads. | Wokingham PCN's and Public Health | Partnership set up for the delivery of quarterly VGC sessions. | No of Wokingham families engaging in postnatal care sessions (by demographics) |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| | | | Quarterly VGCs offered and delivered within participating areas.<br><br>Evaluation up of VCGs carried out.<br><br>Evaluation summary submitted to Wokingham Integration Strategic Partnership and Wellbeing Board. | No of Wokingham families engaged in sessions reporting positive experience; |
| Early Intervention and Prevention | Deliver local campaign promoting smoke free settings (homes, side-lines) which support the prevention of uptake of smoking in CYP. | Wokingham Public Health, Public Protection Partnership. | Design and produce local campaign materials – including working with CYP/Schools;<br><br>Evaluation of impact of local initiatives | Increase in the number of local settings which are smoke free or implement smoke free policy. |
| | Support the design of specialist stop smoking services and pathway for pregnant women and their partners. | Royal Berkshire Hospital including Maternity Services, Shared Public Health Team Reading and Royal Berkshire Trust and Public Health | Bid for funding to BOB ICS submitted (part 1 completed).<br><br>To establish a Local Berkshire West Working Group.<br><br>Berkshire West NHS Tobacco Dependency Treatment Plan for implementation of smoke | Increase in the number of pregnant women accessing stop smoking services.<br><br>Increase in the number of pregnant women who have quit smoking at 4 weeks from set a quit date. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| | | | free agenda and treatment by 2023/24 produced. | |
| Early Intervention and Prevention | Undertake a review of the local breastfeeding peer support programme. | Public Health and Children Services | Local data relating to breastfeeding and breastfeeding support captured and analysed.<br><br>Options paper to inform future service provision produced and presented. | Improved breastfeeding take-up and maintenance rates. |
| SEND and Inclusion | Undertake a School Readiness Analysis/Needs Assessment/Support and Services Audit for Children with SEND aged 0-5 years | Early Help Service/Children's Centres; Early Years Service; CYPP Action Group | Sources of data identified and collated.<br><br>Needs Analysis complete. | Baseline of school readiness support gaps for children and young people with SEND is produced. |
| | Scope and coproduce a fully costed options paper for service design to address support school readiness needs/gaps for children with SEND. | Early Help Service/Children's Centres; Early Years Service; CYPP Action Group; | Co-produced options paper complete.<br><br>Options paper submitted.<br><br>Decisions made. | Clarity on service design. |
| | Implementation of preferred service design option(s), development of SMART targets/outcomes for service and production of an outcomes reporting dashboard. | Early Help/Children's Centres; Early Years Service; Project Manager; | Service design implementation complete.<br><br>SMART Targets/measurable outcomes agreed.<br><br>Dashboard produced and implemented. | Improved school readiness in children with SEND. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Safeguarding | Work with key partners to undertake a review of local safeguarding policies and procedures to ensure they address risks for children from conception to 5 years of age. | WBC Quality Assurance and Safeguarding; Berkshire West Safeguarding Children Partnership; CYPP Action Group | Key participants identified and roles/responsibilities to undertake review assigned.<br><br>Relevant policies identified.<br><br>Local procedures reviewed.<br><br>Updated safeguarding policies and procedures published. | Assurance that children from conception to 5 years of age are safeguarded. |

**4. Good mental health and wellbeing for all children and young people**

***(g) Children and Young People Partnership [CYPP] Board Action Plan***

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Governance | Establish a CYPP "Action Group" including Terms of Reference with a view to assigning responsibility to members for developing and agreeing action plans, monitoring progress and outcomes, and exception reporting to the Wellbeing Board. | CYPP | CYPP Action Group established | Clarity of governance route, responsibility and accountability for action planning and monitoring. |
| Prevention and Early Help | Carry out a Mental Health Needs Assessment for Wokingham, including mapping of current governance across Berkshire of mental and emotional health service design. | Public Health Wokingham and Berkshire West Public Health Hub | Mental health needs assessment complete. | Understanding of local need and current governance process.<br><br>Baseline set for future monitoring. |
| | Review availability and take-up of current universal and targeted mental health preventative and early intervention activity in schools and elsewhere. | WBC Children's Services; CYPP; Schools | Review complete | Understanding of preventative activity in Wokingham. |
| | Engage with staff, students, parents, the community and mental health support teams to inform interventions for emotional health and wellbeing, supporting a Whole School Approach to MH and embedding wellbeing as a priority across the school environment. | ICP | Engagement activity complete.<br><br>Report produced. Interventions identified. | Contribution to understanding of gaps in preventative services/support. |
| | Engage with Berkshire "Be Well" Campaign which is a joint local authority and health initiative across Berkshire which is being planned for three years Oct 21 – July 24 | Public Health Wokingham and Strategy & Commissioning | Establish how the "Be Well" campaign supports Wokingham priorities. | Be Well campaign supports Wokingham priorities |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Prevention and Early Help | Develop options paper for meeting gaps in preventative services and activity and improving take-up (if necessary). Make decision on option(s). | WBC Children's Services; CYPP | Options paper produced. Decision made. | Clarity on next steps. |
| | Implement chosen option(s) for development of preventative services, including putting in place SMART targets/outcomes and reporting mechanisms. | WBC Children's Services; CYPP; Schools. | Implementation complete.<br><br>Reporting mechanisms in place. | Reduced demand for CAMHS and other emotional wellbeing services. |
| Reduce Waiting Times for Screening and Referral to CAMHS Services/ Demand Management | Tackle the waiting times in both specialist/Core CAMHS for access and interventions in key areas: anxiety, depression, Specialist CAMHS, Autism and ADHD. | ICP | 2-year investment plan with BHFT created for Core CAMHS to cover 2022 – 2024 created. | Waiting times reduced. |
| | Build a formal Delivery Partnership arrangement including:<br>1. *A single access and decision-making point that all delivery aligns to;*<br>2. *A joint communication approach and set of tools that explains to children and young people, parents and carers, schools and primary care colleagues how to access support and the type of response and offer they can expect.*<br>3. *A joint workforce development programme* | ICP | Autumn conference with Oxfordshire MIND brings together key parties to discuss arrangement.<br><br>Proposal for arrangement produced.<br><br>Partnership arrangements agreed. | Reduced uncertainty about services available and how to access them for children and young people needing support.<br><br>Better prevention.<br><br>Less demand for higher need services. |
| COVID-19 Recovery | Continue to commission temporary contract during Covid for Kooth (online support) | ICP | Recurrent funding from August secured. | Continuity of support for young people during COVID-19 recovery phase. |
| | Meet the COVID-19 surge demand as it arises | CCG | Operational partnership set up in August 2021 and has begun meeting every three weeks. | Emerging needs understood and addressed. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| COVID-19 Recovery | Expand the trauma-informed approach among formal and informal service providers, including charities and voluntary organisations, supporting recovery and resilience in children and young people. | ICS Children's Board | Mapping exercise and options appraisal for TI training across BOB completed.<br><br>Brief prepared for partners.<br><br>List of potential partners produced.<br><br>Partners approached. | Charities and Voluntary organisations equipped with skills and knowledge to support recovery and resilience in Children and Young People. |

**5 Good mental health and wellbeing for all adults**

***(h) Wokingham Wellbeing Board Social Isolation and Loneliness Action Group Plan***

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| To understand mental health and wellbeing need | Carry out a Mental Health Needs Assessment [MHNA] for Wokingham | Public Health Wokingham and Berkshire West Public Health Hub | Mental health needs assessment project plan<br><br>Mental health needs assessment drafted for comments and circulated to key groups<br><br>Publication of a Wokingham MH needs assessment | Understanding of local need.<br><br>Baseline set for future monitoring. |
| Connect vulnerable residents with quality-assured services and activities | To support residents to access local services and charities. | WBC/Citizen's Advice Bureau [CAB] | To report: number of people using the service; number of people who used the service and had improved mental wellbeing after receiving support | Increase number of people accessing essential services |
| | Connecting residents to community services/classes which can improve their social wellbeing through: Community Navigation, Social Prescribing | Involve/WBC | To report: numbers and demographics of people using the service; and outcomes following support. Quarterly KPIs | Increase social contact and improve social wellbeing |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Connect vulnerable residents with quality-assured services and activities | To offer digital referral signposting service for healthcare professionals | PCNs North, Phoenix, and East | To report: number of people using the service/demographics | To improve digital inclusion |
| | To connect those struggling with serious impact of loneliness with matched volunteer for face-to-face visits and phone calls. | WBC/Project Joy | To report: Number of people using the service including demographics | Increase social contact and improve social wellbeing |
| | To offer variety of weekly and monthly activities to encourage new friendships and provide opportunities for Link friends to join small Friendship Groups. | LINK Visiting Scheme | To report: Number of people using the service including demographics | To increase social opportunities |
| | To run 'Link Online' service, enabling those with no experience of digital devices with a tablet computer, coaching and support | LINK Visiting Scheme | To report: How the coordinated support impacted individuals. Service KPI | To improve access to digital services |
| | To support young people not in education or employment [NEET] to enter employment, education or training | NEET Prevention Service | Monthly service KPIs | Increase number of NEET's to receive support to essential services |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Connect vulnerable residents with quality-assured services and activities | Enabling residents covered under the disability provision of the Equality Act from 16+ to access education, work experience, volunteering, and employment by:<br>• Support via 1-1's meetings, Job coaching in the workplace, and retention team to support to maintain employment.<br>• Groups, job clubs, interview practice, confidence building, assertive training, and employer introductions.<br>• Support to client and employers around reasonable adjustments in the workplace, college, or work experience placement.<br>• Provide and facilitate education courses for Activate Learning. One within Reading College (employment) and another at Optalis Head Office in Wokingham (ACE@Optalis).<br>• Facilitate employment related workshops for Wokingham's Recovery College.<br>• Provide Travel Training (Ability Travel) to residents from 13+ to access public transport. Via 1-1 specialist travel training coaches.<br>Build confidence, learn routes, problem solve, support to use electronic booking and timetables. Working with ASC, CTU, Network Rail and Reading Buses. | Optalis Supported Employment Service | Monthly service KPI's | Increased wellbeing, employability skills, employment outcomes, reduce reliance on benefits and increased financial independence and disability awareness, positive contribution to local communities. Reduce isolation and loneliness |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Tackling risk factors for social isolation and loneliness: E.g., language barriers, education & employment, mental illness, financial difficulty, old age.) | Delivering adult education courses supporting ages | Adult Education Service | To report on: demographic/target group attendance and outcomes | Increased wellbeing, employability skills, employment outcomes, reduce reliance on benefits and increased financial independence and disability awareness, positive contribution to local communities. |
| | To provide and support community engagement to adults, children and young people and target groups | Community Engagement | To report on community engagement within target areas<br>To report on engagement with: Communities | Increase access to positive community activities |
| | To provide activities and community engagement in Library setting to communities and those digitally excluded | Libraries | To report on engagement with: Communities, digitally excluded residents and impact of engagement | Reducing social isolation and providing digital support |
| Tackling risk factors for social isolation and loneliness: E.g., language barriers, education & employment, | Provide specialist employment/job coaching to Wokingham residents. Coaches trained via Centre for mental health IPS – individual placement and support.<br>• Provide “next step” courses within Wokingham’s recovery colleges | Optalis Supported Employment Service | Provide monthly outcomes of employment/education and volunteering/ via WBC KIPS | Increased wellbeing, employability skills, employment outcomes, reduce reliance on benefits and increased financial independence and |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| mental illness, financial difficulty, old age.) | • Support/upskill employers on mental health awareness<br>• Provide group sessions and peer support<br>• Provide online/virtual support<br>• Work in partnership with adult social care/CMHT. Schools and employers to increase opportunities<br>• Employment/education/volunteering Recovery college course facilitated by SES.<br>• Support to obtain/retain employment for Wokingham residents covered under the disability provision of the equality act + carers and people misusing substances.<br>• Supporting employers on disabilities and reasonable adjustments.<br><br>Work alongside CMHT, MIND. Provide information stands/virtual courses and meetings for those not able to access venues. From age 16 + | | | disability awareness, positive contribution to local communities. |
| Helping people to build better social relationships to protect and improve physical and mental health. | To provide support for individuals to join online sessions including friendship café and face to face sessions | Friendship Alliance Service | To report on support given to target groups | Increasing opportunities for digital and social interaction |

| Wokingham Priority | Activity | Lead and partner | Progress Milestone | Outcomes |
|---|---|---|---|---|
| Helping people to build better social relationships to protect and improve physical and mental health. | To connect volunteers and Link Friends to gardens and nature as part of 'Link to Nature' project with the aim of improving physical and mental health with a focus on growing plants, feeding birds, growing vegetables and pollinator plants. Project in partnership with Wokingham in Bloom | The Link Visiting Scheme | To report on positive outcomes | Connecting older people and volunteers to their gardens and nature |
| | To deliver and monitor engagement with local leisure programmes which aim to support and promote positive mental and physical health – see Physically Active Communities Action plan for details. | Sports and Leisure | To report on service KPIs | |

## 6 Cross Function Action Plan

***(i) Wokingham Wellbeing Board Physically Active Communities Action Group Plan***

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Creating Physically Active Communities Facilitating physical activity to improve health outcomes irrespective of whether individuals achieve weight loss. | To maintain Physical Activity as a prevention priority with ICP. Actions include:<br><br>Form a PA sub-group to draft a BW ICP PA strategic intent outlining a vision, purpose and high-level ambition around PA<br><br>To determine the ongoing role of the sub-group and the responsibilities of the Prevention Board | Berkshire West NHS Integrated Care Partnerships Group/ Public Health GBA | Subgroup created and role & responsibilities determined | Highlight Physical Activity as a priority for Wokingham<br><br>BW ICP PA Strategic Intent |
| | To review pathways into local walking and cycling training programmes | Transport/ My Journey | To report on outcomes of review including internal discussion held annually by the My Journey team | Measure the percentage of physically active adults accessing open spaces |
| | To have developed, completed, and evaluated QR Walks. To review how to capture further data. | Transport/ My Journey | To report on information and number of walks held | Measure the percentage of residents participating in programme |
| | To facilitate Active Medicine Programme by; delivering 'Helping People Become Physically Active' training to frontline workers and HCP's. Promoting Training hub targeting HCP's support training and induction for the non-medical support staff in WBC H&SC system | GBA/Public Health/Adult Social Care | To report on number of Wokingham individuals trained | Increased confidence and skills talking about PA with residents/patients |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Creating Physically Active Communities<br>Facilitating physical activity to improve health outcomes irrespective of whether individuals achieve weight loss. | To support individuals to Live Longer Better by:<br>Championing PA amongst WBC networks<br>Embedding PA within WBC pathways<br>Promoting resources to provide learning opportunities for WBC partners | GBA/Public Health | Feedback/quotes of service users<br><br>Attendance and outcomes of projects | Changing the mindset of professionals and the public regarding ageing and physical activity |
| Encouraging people to be physically active as a means to reduce premature mortality | Wokingham Borough Council/ICP/GBA to promote and engage internal offers for WBC staff to support a healthy workforce including Healthy Staff exercise sessions and promotion of:<br>Buddy Boost campaign<br>REACH app<br>Workplace Movement | Wokingham Borough Council/ Public Health/ ICP/GBA | To report on engagement numbers of staff and the overall health impacts of the interventions | Increased numbers attending Physical Activity sessions |
| | To co-produce communications plan to enable partners to utilise the NHS England Better Health campaign locally | Comms Team/Public Health | Work underway on draft communication plan | Create localised health and wellbeing communication plan |
| | To promote PA messaging from GBA website and provide content for Berkshire West GP websites (to feature on Virtual wellbeing rooms) | GBA | Provide updates on resource and content changes | Up to date and relevant resources on PA |
| | To encourage Wokingham residents, employees, and visitors in sustainable travel behaviour. To Continue to deliver walking and cycling interventions | My Journey team/ WBC | To report on one off interventions and give detailed session statistics and engagement details and numbers after each intervention. | Increase the percentage of adults walking /Cycling for travel at least three days per week |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Encouraging people to be physically active as a means to reduce premature mortality | To maintain and promote use of Wokingham Country parks | Local Countryside team | To report on updates and engagement of all customers | Increased numbers attending PA sessions in countryside and Dinton Activity Centre |
| Promoting physical activity among target groups to reduce the risk of long-term conditions such as coronary heart disease and stroke. | To have delivered and monitored Sports & Leisure Services to target groups and through GP referral including:<br>GP referral<br>Long Term Health Conditions<br>SHINE (Some Health Improvements Need Exercise) physical activity programme for adults 60<br>Long Term Health Programme<br>GP Referral Programme<br>Escape Pain for New Diagnoses Hip or Knee Osteo-arthritis<br>Mental Health<br>Mindful Health and Wellbeing programme<br>Cardiovascular Disease<br>Cardiac Rehabilitation<br>Cancer<br>Cancer Rehabilitation<br>Falls Prevention<br>Steady Steps<br>Movement with confidence programme to decrease falls and prevent hospital admission | Sports & Leisure Services | To report on detailed service KPI | Reduction in risk of long-term conditions such as coronary heart disease and stroke<br><br>Decrease the number of falls and hospital admissions |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Promoting physical activity among target groups to reduce the risk of long-term conditions such as coronary heart disease and stroke. | Targeted activities<br>Adult with Learning difficulties<br>Wokingham Active Adults with Additional Needs<br>Dementia<br>Activities for people with dementia | Sports & Leisure Services | To report on detailed service KPI<br><br>See Dementia Full Action plan* | Increase the numbers attending Physical Activity sessions |
| | Older People<br>Ageing Actively - activities for older people<br>Residents over 60 can swim for free at 2 leisure centre 4 x a week | Sports & Leisure Services | To report on detailed service KPI | Decrease the percentage of physically inactive adults |
| | To deliver and monitor adult tier 2 weight management programme including targeted programmes. | Public Health | Service KPI<br>Highlights | Reduce number of adults (18years +) classified as overweight and or obese |
| | To offer targeted cycling opportunities including: inclusive cycling sessions for adult with Learning difficulties<br>Over 60's Cycling SHINE rides, Adult cycle training, Woky Wheels 4 All and Breeze rides for women | My Journey | Service KPI<br>Highlights | To increase participation in cycling/ active travel to targeted groups |
| | To promote/provide tackling inequalities funding opportunities available for local community groups to deliver projects designed to encourage specific audiences to move more including:<br>Low Socio-economic Groups<br>Ethnically diverse communities<br>Individuals with LTHCs<br>Individuals with disabilities | GBA | Report on number of participants attending activities | Funded groups provide health related outcomes specific to their project |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Promoting physical activity among target groups to reduce the risk of long-term conditions such as coronary heart disease and stroke. | To create positive experiences in School Games festivals and competitions, to improve physical literacy, social, emotional and physical well-being for pupils in KS2 and in years 7/8<br>Target groups:<br>SEND<br>Low socio-economic backgrounds<br>Ethnic minority communities<br>Low self esteem | SGO, Wokingham Borough Council, schools and sports clubs | To report on number of Wokingham projects funded and details of outputs from these projects<br><br>The percentage of primary and secondary schools who have engaged in any of the targeted festivals/ competitions.<br><br>The number of pupils in years 3/4, 5/6 and 7/8 who have engaged in each separate targeted festival/competition.<br><br>Data available in December 2021, April and July 2022 as per Youth Sports Trust requirements. | Baseline set of the percentage of schools to have engaged in 2 or more festivals/competitions for years 3/4 and 2 or more, for years 5/6.<br><br>Baseline set of the percentage of secondary schools to have engaged in 2 or more festivals/ competitions for years 7/8.<br><br>Baseline set of the number of different pupils to have engaged in the festivals/ competitions across each age group (3/4, 5/6, 7/8) |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Cross link<br>Health inequalities<br>Vulnerable groups<br>Social isolation and loneliness<br>Dementia | Facilitating 'talk and walk' sessions in Woodley targeting Older people (50+) | Wokingham Friendship Alliance | Numbers attending the monthly walk. | Increase percentage of older people accessing local parks to remain mobile and connect with others to support their mental wellbeing. |
| | Sending fortnightly e-newsletter to promote local activities for members of the community to engage with. Targeting Older people (50+). | Wokingham Friendship Alliance | Number of physical activities promoted in the newsletter and numbers of newsletters sent. | Raising awareness to increase the percentage of older people accessing physical activities |
| Facilitating healthy choices for families and children; encouraging physical activity, reducing sedentary behaviour, and promoting healthy behaviours. | Physical activity offer for children;<br>Active Movement in schools targeted one year offer to be reviewed with evaluation | Public Health, Education team and Schools | Publication of an evaluation of the pilot shared with the Children's Board and Wellbeing Board | Increase activity levels in primary school children/ Reduce the prevalence of overweight (including obesity) Reception (4 - 5 years and Year 6) |
| | To co-produce Healthy Schools offer including connecting schools and physical activity. | Public Health, Public Protection Partnership and Education/Schools | To report on engagement and impact | Increase the percentage of physically active children accessing recommended amount of Activity (60 mins per day) |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| Facilitating healthy choices for families and children; encouraging physical activity, reducing sedentary behaviour, and promoting healthy behaviours. | To have delivered Wokingham Active Kids (WAK) programme | Sports & Leisure Services | To report on engagement areas in target areas | Increase the percentage of activity levels for children and young people |
| | To support disadvantaged children in physical activity offering:<br>Free holiday swimming for children on pupil premium at local leisure centres<br>Programme of sporting activities (ad hoc) to Tenant Supervision Children's Services | Sports & Leisure Services | Service KPI | To encourage opportunities to activity to disadvantaged groups |
| | To ensure delivery of cycling sessions including:<br>Bikeability / Scooter training sessions<br>Balance Bike Club 2- 4 years<br>Learn to ride sessions 5-9 years | My Journey | Duration of courses - demographics<br>Safe road cycling - demographic<br>The total number of children trained places.<br>Level 1 / 2 and 3. | Encourage families to be active together |
| | To develop new opportunities for Physical Activity including:<br>QR trails in Open Spaces<br>new school resources encouraging active travel | Eco Travel and Air Quality Team/ Active Travel Officer | Report on trails delivered/ number of School engaging with the project. | Supporting children to achieve the 60 minutes activity a day recommendation. |
| | To promote/provide Starting Life Well funding for local clubs and community groups to deliver projects designed to encourage 5-18yr olds to be more active | GBA/Public Health | To report on projects funded and details of outputs from these projects | Funding for local groups |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| | To promote/provide a Mums Zone project targeting pregnant and new mum's promoting good mental health and reducing the stigma associated with PND. Virtual and face to face options available. | GBA/Public Health | To report on projects funded and details of outputs from these projects | Improvements in mental wellbeing |
| Facilitating healthy choices for families and children; encouraging physical activity, reducing sedentary behaviour, and promoting healthy behaviours. | To support schools to prioritise the delivery of 60 active minutes per day to every KS2 pupil, to support improvements in their physical literacy, social, emotional and physical well-being.<br>30 minutes in school and 30 minutes at home.<br><br>To create a wide range of positive experiences, ensuring School Games festivals/ competitions always have a clear intent, to reflect the motivation, competence and confidence of pupils at KS2 and years 7/8.<br><br>To encourage key stake holders i.e., teachers, to develop an understanding of School Games priorities regarding reframing competition. | GBA/Sports and Leisure/ Public Health<br><br>SGO/ Wokingham Borough Council<br><br>SGO, Wokingham Borough Council, schools and sports clubs<br><br>SGO, Wokingham | Funded groups provide health related outcomes specific to their project<br><br>The total number of schools who have engaged their KS2 pupils with 30 active minutes at school, and who have supported parents with 30 active minutes at home.<br><br>Data available in December 2021, April and July 2022 as per Youth Sports Trust requirements.<br><br>The percentage of primary and secondary schools who have engaged in any of the festivals/ competitions.<br><br>The total number of pupils in years 3/4, 5/6 and 7/8 who have | All primary schools to have embedded some additional active minutes in the school day.<br><br>Baseline set of the percentage of schools to have engaged in 4 or more festivals/ competitions for years 3/4 and 4 or more, for years 5/6.<br><br>Baseline set of the percentage of secondary schools to have engaged in 4 or more festivals/ competitions for years 7/8. |

| Wokingham Priority | Activity | Lead and partner | Progress Milestones | Outcomes |
|---|---|---|---|---|
| | | Borough Council, schools and sports clubs | engaged in School Games festivals/competitions (with gender split).<br>Data available in December 2021, April and July 2022 as per Youth Sports Trust requirements.<br><br>Review of the festival/competition intent | Baseline set of the number of different pupils to have engaged in the festivals/ competitions across each age group (3/4, 5/6, 7/8). |

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# From diagnosis to end of life: the lived experiences of dementia care and support

Laura Vicinanza

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Alzheimer's Society
United Against Dementia

From diagnosis to end of life

# Berkshire West Joint Health and Wellbeing Strategy

170

- Supporting people living with dementia and their carers as a group of people at high risk of bad health outcomes to live healthy lives is a priority across West Berkshire, Reading and Wokingham
- Commitment to introduce an integrated programme in partnership with other sectors for the early diagnosis, rehabilitation and support for people affected by dementia

# Where did it start?

171

## How we structured the report:

- Diagnosing Well
- Supporting Well
- Living Well
- Dying Well

## How we gathered the evidence:

- Used national guidance and legislation as a benchmark
- Literature review of existing pathways, standards and datasets
- Focus groups and interviews with people affected by dementia
- Interviewed and surveyed professionals

# Key theme: a sense of disjoined and fragmented care

‘For us, there was no dementia pathway. Everywhere I turned for help, I felt like I was walking through candy floss – everywhere I turned I met a sticky end.’

***Carer for a person with dementia***

‘The only support my husband and I had were things I had to discover and instigate myself. We were given a life-changing diagnosis, then left to our own devices to navigate the complexity of the health and social care system.’

***Wife of a person living with dementia***

‘In the 13 months from December 2017, when [mum] was first identified for palliative needs, right up until her death, absolutely nothing was done to provide mum with the palliative care and support she required.’

***Daughter of a person with dementia***

# DIAGNOSING WELL





KEY FINDINGS
AND
RECOMMENDATIONS

# Summary of key findings





- People are being misdiagnosed or opportunities are being missed
- Referral processes can be confusing
- Service improvements can be challenging due to variation between memory services and limited performance data
- Delivery of a diagnosis, including a subtype and tailored information, is variable

# Local recommendations

175

- CCGs to have a dedicated dementia lead to train GPs on referral criteria and diagnosis
- Multidisciplinary team meetings between memory service clinicians, neurology and neuroradiology
- Clear referral pathways to enable access to Allied Health Professionals
- Memory services to include dementia adviser services, with people automatically referred to the service unless they opt out
- Access to follow-up opportunities to discuss diagnosis

# Diagnosis rates during Covid-19

176

- Dementia diagnosis rates have declined since lockdown
- Referrals from primary care to memory services have decreased
- There is a backlog of assessments which will worsen waiting times
- Need to ensure people can access their GP, face-to-face, to discuss concerns with cognitive impairment or memory
- Secondary care specialist diagnostic services need sufficient workforce and resources to cope with current and expected backlog of appointments

# SUPPORTING WELL



KEY FINDINGS
AND
RECOMMENDATIONS

# Summary of key findings



- Information provided at point of diagnosis is not being delivered in the right way, if at all
- People are struggling to access a care coordinator
- Care planning, including advance care planning, if undertaken, can be insufficient and dementia-specific needs are not considered
- The provision of post-diagnostic support interventions can be variable and inappropriate

# Local recommendations



- All people should have a named care coordinator
- Appropriate and tailored post-diagnostic support interventions for people with dementia and their carers
- Integration of dementia adviser services within primary care
- Clear local responsibility for advance care planning

# LIVING WELL

180

KEY FINDINGS
AND
RECOMMENDATIONS

# Summary of key findings



- Limited access to coordinated, proactive, ongoing care and support
- Follow-up care is not the same for everyone
- Carers are struggling to access support services
- Hospital and care homes need to identify and accommodate dementia specific needs

# Local recommendations



- Straightforward methods of booking day care and overnight care in advance
- Accessible lists of recommended local respite care services
- Care homes to have enhanced access to professionals through local multidisciplinary teams
- All professionals trained to at least Tier 2 of the Dementia Training Standards Framework

# Cognitive decline and the need for rehabilitation

183

- Deterioration of people’s mental health and significant cognitive decline
- Worsening of dementia symptoms, including memory loss, agitation and depression
- Decrease in the numbers of people receiving care plans or care plan reviews over the last year
- Need to bring forward care plan reviews to proactively identify rehabilitation needs and offer rehabilitation services

# The carers' experience during Coronavirus

184

**73%**

of carers reported that their caring responsibilities have increased during lockdown.

**76%**

reported their caring responsibilities had increased because of worsening dementia symptoms of the person they care for.

**92 million**

**extra hours** have been spent by family and friends caring for loved ones with dementia.

**95%**

of carers of people living with dementia reported a negative impact on their mental or physical health.

# DYING WELL

185

KEY FINDINGS
AND
RECOMMENDATIONS

# Summary of key findings

- People often struggle to access palliative care, including end of life care
- Advanced decisions are sometimes ignored, meaning the interests of people and their wishes at end of life are not being fulfilled

# Local recommendations

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- Manage hospitalisations through integrating services, upskilling care home staff and increasing access to out-of-hours specialist support
- Local multidisciplinary teams should be formed to assist local care homes, and include palliative care teams
- Local services should be set up to ensure that professionals involved in end of life care can easily and quickly access advance care plans

# To conclude…

- From diagnosis to end of life, people with dementia face challenges in accessing effective care and support
- A recurring theme at each stage of the pathway is the sense of disjointed, fragmented care
- Government and national bodies must make further progress on dementia care quality and outcomes
- But local decision-makers, services and professionals are best-placed to take ownership of developing dementia pathways, to promote streamlined and consistent support.

PETER SOWERBY FOUNDATION

Alzheimer's Society
United Against Dementia

# From diagnosis to end of life:

## The lived experiences of dementia care and support

# Introduction

**This is a short summary of Alzheimer's Society's report on the lived experiences of dementia care and support from diagnosis to end of life.**

The report found that people with dementia are not consistently receiving good quality, integrated care and support that enables them to live well. While there is good practice happening in parts of the country, we heard many accounts of places where care is failing to provide what's needed.

We spoke with 75 people affected by dementia to understand their experiences of care and support from pre-diagnosis to end of life. We also spoke with a range of health and care professionals to identify the barriers to providing effective care. This evidence was benchmarked against what the National Institute for Health and Care Excellence (NICE) and the Government say people in England should receive, as well as the Dementia Statements, which reflect the things people with dementia have said are essential to their quality of life.

Our research revealed a range of issues facing people across the dementia pathway. It also identified actions that would create positive change, both locally and nationally, to improve care and support.

# Key findings

**The results of this research are presented according to four stages of NHS England's Well Pathway for Dementia:**

- **Diagnosing Well**
- **Supporting Well**
- **Living Well**
- **Dying Well.**

While prevention is a critical part of the pathway, this report doesn't focus on Preventing Well.

**'For us, there was no dementia pathway. Everywhere I turned for help, I felt like I was walking through candy floss – everywhere I turned I met a sticky end.'**

Carer for a person with dementia

# Diagnosing well

**‘Because he didn’t have a formal diagnosis, they treated him like he didn’t have dementia at all.’**

Carer for a person with dementia

Our research found that opportunities to identify dementia early are being missed. Due to difficulties identifying symptoms – for professionals as well as non-professionals – people are being misdiagnosed or facing unnecessary delays. GP training on referral criteria and diagnosis can also be a barrier to facilitating an early diagnosis, as can the short consultation time GPs can offer to patients. Success will require new ways of working within primary care to improve assessment of a person's cognitive, mental, physical and emotional wellbeing.

Dementia assessment tools may also have an impact on the timeliness of a diagnosis, as they can identify who needs referral for specialist assessment. It's important that appropriate tests are used to avoid misclassification due to biases, such as age, education and ethnicity. Professionals told us that diagnosing people from ethnic minorities can be challenging, due to people being concerned about shame and stigma and not viewing dementia as an illness. During assessments, challenges included language and a lack of familiarity with the concept of cognitive functions.

For people needing referral, processes can be confusing. People told us they felt daunted about 'what comes next' due to a lack of information. There must be a clear referral pathway between different providers, and written information to help address questions and concerns. Another issue is variation in the number of people being diagnosed and starting treatment within six weeks of referral. However, there's limited data on memory service performance, so assessment of variation currently relies on ad hoc audits. Regular audits of memory service data and performance would support the initiation of service improvement projects.

Key to facilitating a high quality and timely diagnosis are the appropriate staffing of memory services and good referral pathways. This must include occupational therapists to conduct functional assessments, which are important for non-English speaking communities. It must also include multidisciplinary meetings between memory service clinicians, neurology and neuroradiology to facilitate clinical case discussions.

**'It's so daunting when you get that diagnosis and think "what's life going to be like now?"... It's getting that message across, to get out there – your life isn't over.'**

Person living with dementia

The way a diagnosis is given has an impact on people's experiences. But we heard about diagnoses being given insensitively, focusing on what people can no longer do rather than what they can. People should also receive a subtype diagnosis (a diagnosis of which type of dementia they have). This should be accompanied by appropriate, tailored information to support the person to understand symptoms. A subtype diagnosis can affect future medication, care plans, interventions and opportunities to engage in, or benefit from, research. However, not all memory services can view brain scans, which is a barrier to diagnosing a subtype.

Hospitals and care homes also present opportunities to identify dementia. Systems must therefore be put in place within these settings to facilitate a diagnosis. People with advanced dementia living in care homes, as well as their families and staff, still benefit from a formal diagnosis. It enables them to access the appropriate care for their needs, and prompts staff to consider Mental Capacity Act issues where relevant.

# Supporting well

## This chapter looks at a person's immediate support needs, up to about a year after diagnosis.

Our research found that people can feel overwhelmed with information after receiving a diagnosis. To manage this, opportunities for follow-up discussions should be an integral part of the diagnostic process. Consideration must be given to how this support can be delivered, as often memory services are commissioned to provide a diagnostic service only.

Following a diagnosis, access to a care coordinator could significantly help people navigate the complexity of the health and social care system to get the right care and support. However, there's a lack of clarity around the role of a care coordinator – specifically who does it and what it involves. This means people may not know who their care coordinator is, and professionals may not know they are someone's named care coordinator. National guidance on this role is essential.

People told us that access to a dementia adviser-type service is also beneficial. It gives them a single identifiable point of contact with knowledge of, and direct access to, a range of available local services. However, more work needs to be done to consider availability. To support access, the service should be integrated within memory services and primary care.

Uncertainty over who should do what in dementia care is a key barrier preventing people from accessing the consistent care they need. This is clear when people with dementia who need medication follow a different pathway to those who don't need medication. The distinction between care plans that fall under the remit of a GP and care plans that fall under the remit of the local council can also be confusing. People with dementia will need to access a range of services and professionals, who will need to access the same care plan. However, people told us they have to explain their story multiple times to different professionals. Professionals told us they have to try to piece together disjointed information, which can lead to 'scattergun' referrals. There must be more integration of care and support plans between different services involved in a person's care.

Advance care planning is an integral part of the pathway. But there are mixed views on when these conversations should happen, and on whether professionals are trained and comfortable to have these conversations. As dementia is a progressive condition that affects mental capacity, there must be a more prominent role for advance care planning within post-diagnostic support. This should be accompanied by clear levels of responsibility outlined at a local level. These measures should ensure early, necessary and repeated conversations.

After a diagnosis, people should be offered post-diagnostic support interventions to help them maintain cognitive function, independence and wellbeing. However, immediate and ongoing access to this support can be variable. We also heard accounts of inappropriate interventions that weren't tailored to individual preferences. The provision of interventions must be reviewed and made more appropriate and tailored. They must consider age, ethnicity, gender and sexual orientation, and reflect the diversity of our society.

People should also have access to occupational therapists, who support functional ability and independent living. We heard positive stories of people feeling supported to improve their ability to carry out daily living tasks and other meaningful activities after accessing an occupational therapist. Other Allied Health Professionals (AHPs) can also offer rehabilitation, such as physiotherapists, dieticians, speech and language therapists and podiatrists. AHP leadership on dementia, and enhanced dementia awareness for AHPs, are critical to ensure people can access these therapeutic services but also realise the contribution they can make in developing supportive self-management strategies.

**'Occupational therapists saved my life when I would have been happy to drink and eat myself to death.'**

Person living with dementia

# Living well

## This chapter looks at the period following initial post-diagnostic support – we refer to this as around a year after diagnosis until end of life.

Our research found that people receive limited access to coordinated, proactive and ongoing care and support. Follow-up care, particularly from GPs, is not the same for everyone living with dementia, meaning some people are left to manage their own condition. Because dementia is a complex condition, people encounter a range of different services and professionals that can provide support for different symptoms. But the route of access to these services is also complex. A lack of ownership means that people are falling through the gaps and aren't receiving the support they need from the professionals they need it from. There must be more consistent support throughout the dementia pathway.

Annual care plan reviews are important. They assess whether people's needs have changed and what support is required. But these reviews aren't happening consistently, and they're not matching people's expectations of understanding how their dementia is progressing. Future service design should consider how primary care can be enabled to provide more appropriate and integrated care. Or it should consider where responsibility for dementia lies in terms of primary or secondary care.

Inconsistency of follow-up is shown by therapeutic interventions coming to an end. Within a dementia pathway, few non-pharmacological interventions are provided after the initial diagnosis, or they're harder for people to access once they've been discharged from the memory service. Initiating more opportunities within the pathway to access post-diagnostic support interventions, both for people with dementia and for carers, would help ensure that people who declined the initial offer, or are in crisis, can access these. People who are in crisis also need access to timely specialist input.

Many people receive most of their support from their primary informal carer. But carers are struggling to access support services due to inconsistent assessments of their needs. We also heard that many carers are left to research local respite care services themselves, and an accessible list of recommended places would be preferable. Formal support for people with dementia can also help non-professional carers to continue in their role. But having to pay for care and endure financial assessments can deter people from seeking support. Another deterrent is the lack of culturally appropriate care, which must be addressed by local authorities.

**'I am constantly having to search for culturally appropriate carers, speak to the council, and get different healthcare professionals and services to speak to each other. It all became too much and I had what I would describe as a nervous breakdown.'**

Carer for a person with dementia

While a person can live well with dementia, there will come a time where decisions about more advanced care need to be agreed. However, dementia care in hospitals and care homes can be variable. Within hospitals, there are issues with discharge processes and NHS Continuing Healthcare assessments. Within care homes, there must be access to clinical input to reduce unnecessary hospital admissions. This includes access to Allied Health Professionals who can transform health, care and wellbeing. All health and social care professionals involved in dementia care should be trained to at least Tier 2 of the NHS-backed Dementia Training Standards Framework.

# Dying Well

## Because there is much focus on living well, end of life care for people with dementia is often overlooked.

This is made worse by a lack of awareness that dementia is a terminal condition. People told us they struggled to access palliative care, including end of life care, because professionals told them that:

- the person isn't nearing the end of their life, they just have 'good days and bad days'
- Alzheimer's disease is a mental illness, not a physical condition (this is incorrect)
- it isn't their responsibility
- the person already has carers coming to the home
- there isn't enough funding.

**‘In the 13 months from December 2017, when she was first identified for palliative needs, right up until her death, absolutely nothing was done to provide mum with the palliative care and support she required.’**

Daughter of a person with dementia

People with advanced dementia who are nearing the end of life will have complex needs. They typically have a high level of symptoms, leading to frequent hospital admissions and in turn high health and social care costs. Some people with dementia are unable to communicate their symptoms, which can affect how far they are managed. Action should be taken to manage hospitalisations, such as better integration of services and the upskilling of care home staff. This should help ensure that people can access the right services for their needs.

To date, there’s been a strong policy focus on place of death. Preferred place of death is a commonly used quality marker. Care homes are key to reducing the number of people with dementia who die in hospital, so more must be done to improve comfort and quality at end of life within care homes. The number of people dying at home and in care homes is set to increase. There must be an expansion of capacity, and end of life care training for staff in care homes and in home care services, to sustain deaths outside of hospital.

Advance care planning enables people to plan ahead and can support healthcare professionals and families to carry out the wishes of a person at the end of their life. It’s essential that healthcare professionals providing care to dementia patients in the last stages of life have access to a person’s advance decisions. They must adhere to the wishes of the attorney with authority to act, if the person has one.

# Conclusion and recommendations

## Dementia causes complex cognitive and behavioural symptoms and is unpredictable by nature.

This means that the provision of appropriate care and support, across the entire dementia pathway, is also complex. This has led to significant variation in practice and a debilitating lack of ownership.

This report showcases the need to drive change, and builds the case for a streamlined dementia pathway. Local decision-makers, services and professionals are best placed to take ownership of developing dementia pathways. But these must be underpinned by clear roles and responsibilities at each stage. Consideration and implementation of the local recommendations should be coordinated through Integrated Care Systems where they're already in place.

The recommendations below provide a roadmap for action to improve dementia care, from pre-diagnosis to end of life. They offer insight from people affected by dementia about what makes a good pathway and how meaningful change can be implemented.

## National recommendations

### The Department of Health and Social Care should:

- work with NHS England and NHS Improvement to produce clear guidance on care coordination. This should include who can do it, what it involves and transition requirements if the care coordinator changes along the pathway. This should be supported by regular data collection and publication.
- review the NHS Continuing Healthcare process to ensure it is fit for purpose for people with dementia.
- clearly identify dementia as a terminal condition, and conduct a national review of capacity and access to palliative care in care home settings. This must include an audit of training for care home staff, as well as access to out-of-hours support.
- establish a National Dementia Observatory that brings together new and existing data. This must inform wider policy, research and implementation of high quality, effective and evidence-based care and support.

### The Care Quality Commission should:

- include end of life as a separate entity for inspection within care homes. Evidence of access to palliative care and personalised care and support planning should be reviewed.

### NHS England and NHS Improvement should:

- further recognise the growing challenge of dementia, which requires solutions from health and care. The revised NHS Long Term Plan must make further progress on dementia care quality and outcomes.
- develop and publish good practice guidance for the commissioning of dementia assessment, diagnosis and ongoing post-diagnostic support.
- ensure that all memory services have access to picture archiving and communication systems, so that memory services can view brain scans.
- ensure that people with dementia have a single digital health and care record that is accessible to all health and care professionals involved in their care. This must include advance care planning.
- publish regular, accurate memory service data, including memory service waiting times. It should also commission an annual national memory service audit to measure performance and initiate service improvement projects.
- add further indicators for dementia on the Quality and Outcomes Framework to include:
  - identification of a main carer and the number of carers offered annual access to relevant NICE-recommended carer interventions
  - the number of patients diagnosed with dementia given opportunities to participate in advance care planning discussions
  - the number of people with dementia added to the palliative care register, and who have been offered a personalised care planning discussion as a result.
- ensure that named clinical leads for care homes:
  - facilitate dementia assessment and diagnosis to ensure access to appropriate care within care home settings
  - identify people who need advance care planning.
- monitor and publish data on the implementation of the Enhanced Health in Care Homes model.

## Local recommendations

While it's recognised that local pathways need some flexibility, there are considerations that must be factored into their development. These include:

- Each Clinical Commissioning Group (CCG) should have a dedicated dementia lead. They should be responsible for ensuring the delivery of training to GPs on referral criteria, diagnosis and personalised care and support planning. Leads must have dedicated time to fulfil this role.
- To facilitate dementia diagnosis, particularly complex cases, there must be formalised arrangements that enable multidisciplinary team meetings between memory service clinicians, neurology and neuroradiology.
- Memory services should have clear referral pathways to enable access to psychiatrists, psychologists, occupational therapists, social workers, dementia advisers, as well as linguists and interpreters during the diagnostic process.
- Memory services should all include dementia adviser services, with people automatically referred to the service unless they opt out. There must also be integration of dementia adviser services within primary care.
- All people with a dementia diagnosis should have a named care coordinator. For example, this could be allocated during the initial post-diagnostic support meeting with the memory service but could be reviewed within primary care.
- Evidence-based, post-diagnostic support interventions should be provided for people with dementia and their carers. These must be appropriate and tailored, considering age, ethnicity, religion, gender and sexual orientation.
- There should be clarity on where responsibility sits for the initiation of medicines and follow-up appointments for people with all types of dementia.
- People diagnosed with dementia should have access to follow-up opportunities to discuss their diagnosis and this should be embedded within the local pathway. For example, this could be delivered through follow-up within primary care by a GP, specialist nurse, dementia adviser, or through memory services. There must be opportunities to step up care when more support is needed.
- Memory services should consider accepting referrals from sources other than primary care, including social services and patients and carers themselves. This would support access to timely specialist input, especially in urgent or crisis situations.
- There should be support for carers, which includes providing straightforward methods of booking overnight care in advance, and accessible lists of recommended local respite care services identified by local authorities.
- Appropriate post-diagnostic support interventions and social care services should be provided to ensure language, communication or cultural needs are met. This should consider projected future population trends and needs.
- There should be ongoing opportunities for people with dementia and carers to access support following diagnosis.
- Local multidisciplinary teams should be formed to assist local care homes. These teams should include (but not be limited to) palliative care teams, Allied Health Professionals and wider support services such as dentistry.
- Every health and social care professional involved in dementia care should be trained to at least Tier 2 of the NHS-backed Dementia Training Standards Framework. This must be accompanied by protected training time, targets for numbers of staff trained and training standards being a part of inspections by regulators.

The report also highlights many examples of good practice from across the country, so that these can be learned from and adapted to local contexts. For these examples, and the evidence underpinning this summary, see the full report at **alzheimers.org.uk/diagnosis-end-of-life**

For more information contact Ella Robinson, Senior Policy Officer at Alzheimer's Society by emailing **policy@alzheimers.org.uk**

**People affected by dementia need our support more than ever. With your help we can continue to provide the vital services, information and advice they need.**

To make a regular donation please call us on **0330 333 0804** or go to alzheimers.org.uk/donate



Alzheimer's Society operates in England, Wales, Isle of Man and Northern Ireland. Registered charity number 296645 and Isle of Man (1128)

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Alzheimer's Society
United Against Dementia

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Berkshire West
Integrated Care Partnership

| ICP Unified Executive Chair's Report | |
|---|---|
| **Title:** | ICP Unified Executive update |
| **Programme / Project Sponsor (SRO):** | Julian Emms, Chief Executive, Berkshire Healthcare NHS Foundation Trust |
| **Author(s):** | Amanda Clubley, ICP PMO Support |
| **Purpose:** | *To brief the Health and Wellbeing Boards on key issues discussed at the ICP Unified Executive on 12th August* |
| **Previously considered by:** | N/A |

The key points to note from the ICP Unified Executive on 12th August are as follows:

Rapid Community Discharge

A paper discussing funding the continuation of the RCD service to the end of Q4 was presented. All members were in agreement to the principles subject to the details being worked through at pace, with emphasis on understanding headroom, LA costs and mapping and timetabling risks, without disruption to current hospital flow. LAs expressed concerns around financial risk, particularly around funded support being reduced from 6 weeks to 4. Each local authority may have different issues to address and this needs to be considered as part of this piece of work. Feedback from the meeting will be discussed and actions and next steps will be agreed at the Senior Leaders Winter Planning meeting on 13th August. Proposals to be agreed at August UEC board and Sept UE.

Primary Care demand

Demand has increased across all urgent care services over recent months resulting in significant pressure on the system, particularly in ED and primary care. A system wide workshop was convened on Tuesday 18 May, with a subsequent Task and Finish Group, to identify a set of actions that could be taken to address these pressures both in the short term and moving into Autumn / Winter. The work of the Task and Finish Group concluded that in the short-term actions to increase immediate capacity were required that included a need for additional Primary Care capacity through overflow / additional appointment arrangements and streaming / divert system in ED. Unified Executive were asked to agree the proposal to build additional capacity within PCNs to support the increased demand currently being seen in GP Practices. It was noted that the formal decision making process sits with the CCG and would need to follow the appropriate governance route. Further work is required around the data presented and a more robust business case is required to support the ask for further funding. There is support for increased capacity in Primary Care but speed of decision making is critical.

ICP Priorities 2021/22

Mental Health and Learning Disabilities project brief was signed off generating an additional ICP priority for 21/22.

Elected Member/Health Chairs workshop – 16th September
Following a stock take of ICP Governance earlier in the year, one outcome was to hold a Workshop bi-annually to review pertinent issues and topics for our leadership team – Chief Execs, NHS chairs and Elected members. The first Workshop has been scheduled in September. Unified Executive approved the agenda.

**Recommendation**

Health and Wellbeing Boards to note feedback from ICP Unified Executive Group.

**WOKINGHAM BOROUGH WELLBEING BOARD**

**Forward Programme from June 2021**

**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.**

# WOKINGHAM BOROUGH WELLBEING BOARD FORWARD PROGRAMME 2021/22

| DATE OF MEETING | ITEM | PURPOSE OF REPORT | REASON FOR CONSIDERATION | RESPONSIBLE OFFICER / CONTACT OFFICER | CATEGORY |
|---|---|---|---|---|---|
| **11 November 2021** | **Berkshire Suicide Prevention Strategy 2021-2026** | | | Public Health | |
| | **Refresh of the Berkshire West Local Transformation Plan, improving the response to Children and Young Peoples Emotional Wellbeing and Mental Health** | Update | Update | CCG | |
| | **Updates from the ICP Unified Executive** | Update | Update | Director Adult Services | |
| | **Covid Update** | Update | Update | Public Health | |
| | **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 |
|---|---|---|---|---|---|
| **9 December 2021** | **Better Care Fund** | Submission | Submission | Lewis Willing | |
| | **Designing our Neighbourhoods** | Update | Update | | Performance |
| | **Updates from the ICP Unified Executive** | Update | Update | Director Adult Services | |
| | **Strategy into Action** | Update | Update | Wellbeing Board | Performance |
| | **Covid Update** | Update | Update | Public Health | |
| | **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 |
|---|---|---|---|---|---|
| **10 February 2022** | **Designing our Neighbourhoods** | Update | Update | | Performance |
| | **Updates from the ICP Unified Executive** | Update | Update | Director Adult Services | |
| | **Strategy into Action** | Update | Update | Wellbeing Board | Performance |
| | **Covid update** | Update | Update | Public Health | |
| | **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 April 2022** | **Designing our Neighbourhoods** | Update | Update | | Performance |
| | **Updates from the ICP Unified Executive** | Update | Update | Director Adult Services | |
| | **Strategy into Action** | Update | Update | Wellbeing Board | Performance |
| | **Covid Update** | Update | Update | Public Health | |
| | **Forward Programme** | Standing item. | Consider items for future consideration | Democratic Services | |

To be scheduled:

- **BOB ICS Plan**
- **Children and Young people's partnership priorities**
- **Review of sub committees and priorities**