KEY PRIORITY AREAS FOR WOKINGHAM

Priority 1 | **STARTING & DEVELOPING WELL** | **Reducing the inequalities gap**

Why have we chosen this as a priority for Wokingham?

A key priority area is to narrow the gap between the best and worth health outcomes within the Borough. While Wokingham has seen excellent outcomes, in fact some of the best in the country, there are local variations. Targeting inequalities is absolutely key if we are going to reduce the inequalities gap, and giving children the best start in life will set the foundations for physical, emotional health and wellbeing for life. This includes the 1000 critical days and maternal health and wellbeing from conception to birth and school age.

Where do we want to be?

With Local Authorities now leading on the commissioning of 0-19 public health services provides a real opportunity to address any gaps and maintain the high level of outcomes we see in Wokingham. It also provides the opportunity to integrate services and address some of the challenges identified in the Councils Children and Young Peoples Plan (2019) and the CCG priority areas in relation to children, young people and families, with a particular focus on maternity, mental health and wellbeing.

Public Health intelligence in the JSNA and the recent Outcomes framework also provide baseline data in relation to priority areas that impact on children, young people and families within Wokingham. These are summarised below and are focused on reducing the gap between children born in the most deprived and least derived areas. A key focus will therefore be school readiness and educational attainment:

Priority 1: Best start, good schools	
To reduce the gap between a child born in the most and least deprived area will experience over their life time	1) Improved mother and baby health and wellbeing, especially for those at risk and in most need 2) Increase in the percentage of children with free school meal status achieving a good level of development at the end of reception 3) Increase in the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check 4) Reduce the gap in attainment of 5 A*-C GCSEs between those in receipt of Free School Meals and those not 11% 5) Improved mental health for all children and young people 6) Reduce access weight in 4-5 year olds and 10-11 years olds as measured by the National child measurement Programme in Reception and Year 6.

How will we get there?

- We will ensure all children are provided a universal health visiting service from antenatal up to the age of 5 so children are school ready. This will include delivery of the 5 mandated health visits and a targeted service for those women, children and families who need it most.
- We will ensure the commissioning of 0-19 services is focussed on areas of need and priority is given to those high impact areas which will support early intervention and prevention.
- We will ensure there is a clear focus on school readiness and identifying developmental needs early with appropriate signposting to Early Help and specialist services

- ❖ We will ensure delivery of school nursing services with a focus on health needs assessment and identifying children with social, emotional problems early, signposting to specialist mental health services as required.
- ❖ We will work with key partners from education, health, social care and our VCS partners to ensure delivery of integrated support to families when they need it most
- ❖ We will ensure a range of activities and support to target mild to moderate mental health issues
- ❖ We will provide education and learning opportunities for parents and children in disadvantaged and socially isolated areas

How will we measure success?

We will develop a robust performance dashboard as part of the Children and young people plan with key performance indicators as part of an integrated 0-19 Public Health offer. This will be overseen by the Health and wellbeing Board and will include the development and delivery of local action plans to achieve the outcomes.

The overall aim will be to ensure that we improve outcomes using a baseline for both our neighbouring boroughs and the national average for that area so that we are ambitious in our targets.

PRIORITY 1: To reduce the gap between a child born in the most and least deprived area will experience over their life time				
Objective	**Performance Measure**	**Indicator ref**	**Local value**	**England Value**
1.1 To ensure all children have a best start in life	❖ Ensure the effective commissioning, procurement of a 0-19 Public Health Healthy Child service to meet the universal and targeted needs of Wokingham.	See KPIs on mandated health checks		(90% targets)
1.2 Increase the number of children who are school ready (Reception)	❖ The percentage of children with free school meal status achieving a good level of development at the end of reception	PHOF 1.02i (17/18)	54.1	56.6
1.3 Increase the number of children who are school ready (Year 1)	❖ The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	PHOF 1.02ii (17/18)	67.9	70.1
1.4 Increase the number of children who are in employment, education and training	❖ 16-17 year olds not in education, employment or training (NEET) or whose activity is not known	PHOF 1.05	5.51	6.00
1.5 Increase the number of children aged 2-2½yrs receiving ASQ-3	❖ Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	PHOF 2.05ii	79.3	90.2
1.6 Reduce the gap in attainment of 5 A*-C GCSEs between those in receipt of Free School Meals and those not	❖ Increase in the levels of attainment of 5 A*-C GCSEs for those in receipt of Free School Meals			

1.7 Reduce hospital admissions caused by unintentional and deliberate injuries in children and young people	❖ Hospital admissions caused by unintentional and deliberate injuries in young people (age 0-14)	2.07i	68.8	96.4
	❖ Hospital admissions caused by unintentional and deliberate injuries in young people (age 15-24)	PHOF 2.07ii	133.1	132.7
1.8 Reduce emergency hospital admissions for intentional self-harm	❖ Emergency hospital admissions for intentional self-harm	PHOF 2.10ii	172.4	185.5

Priority 2 | **Living and Working well** | **Increase Physical activity**

Why have we chosen this as a priority for Wokingham?

Prevention is absolutely key and behaviours and lifestyles are an important driver of health, this includes diet and exercise. Physical activity is a very important part of overall physical and mental health and wellbeing and is recognised as an important part in reducing obesity and reduction in falls as well as many other benefits both to individuals, communities and the health economy overall. Places and communities therefore play a key role in our health, such as our local environment which influence our health behaviours and there is strong evidence of the impact of social relationships and community networks, including on mental health.

Lack of physical activity can lead to obesity which can lead to preventable ill health and a huge burden on health and Social Care services. However we have to ensure early intervention and management of health issues as well as prevention if we are to reduce inequalities in health of people who may be affected unequally. For example some groups such as South Asian groups are more likely to be affected by heart disease and diabetes. Preventing falls in the elderly population is key and the early identification of health concerns and issues at an early stage through health checks and early diagnosis of diabetes are an important part of prevention. Hence the priority areas identified highlight the importance of prevention, early intervention and the management of long term conditions so communities can live independently for as long as possible.

Where do we want to be?

The government guidelines for physical activity state that young people aged 5-18 years should have 60 minutes and up to several hours every day of moderate to vigorous intensity activities. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at last three days a week. The government's physical activity guidelines for adults (aged 18-64) is to have at least 150 minutes, over a week, of moderate to vigorous intensity activity. It is also advised that adults should undertake physical activity to improve muscle strength on at least two days a week.

A focus on physical activity will have long term benefits in terms of reduction in cardiovascular disease and preventable ill health. Interventions and programmes aimed at vulnerable groups is key.

How will we get there?

- We will ensure we create opportunities and programmes to increase access to physical activity across all age groups and abilities
- We will ensure we provide opportunities for vulnerable groups such as those with long term conditions, dementia, elderly and mental health to access community exercise and activity programmes

- We will ensure we plan, develop and commission sports and leisure facilities which are fit for purpose and closer to home
- We will encourage use of different modes of transport including cycle streets and access to green and blue spaces
- We will ensure we work with our partners so we ensure we provide a variety of programmes and activities which support the needs of people on rehabilitation and offer services to people who are referred through GPs and healthcare professionals

Priority 2: Living & Working well, Physical Activity	
To increase physical activity and reduce inequalities in health and wellbeing of people with long term conditions	1) To get people of all ages and abilities more physically active 2) To increase more people to get out and using green and blue spaces 3) Increase in the number of children getting at least one hour of physical activity every day 4) Improved physical and mental health for all ages 5) Full utilisation of new green and blue spaces 6) Increasing access to local sports clubs 7) Lower percentage of overweight people 8) Increase in the number of people receiving health checks 9) Increase in the number of people diagnosed with diabetes early

How will we know when we get there?

Priority 2: Physical activity and the management of associated long term conditions				
Objective	**Performance Measure**	**Indicator ref**	**Local value**	**England Value**
2.1 To reduce the number of children who are obese	❖ Reception: Prevalence of overweight (including obesity)	PHOF 2.06i	16.2	22.4
	❖ Year 6: Prevalence of overweight (including obesity)	PHOF 2.06ii	26.1	34.3
2.2 To reduce the % of adults who are classified as overweight or obese	❖ Percentage of adults (aged 18+) classified as overweight or obese	PHOF 2.12	50.9	62.0
2.3 To increase the number of adults who are physically active	❖ Percentage of physically active adults	PHOF 2.13i	73.5	66.3
	❖ Percentage of physically inactive adults	PHOF 2.13ii	15.4	22.2
2.4 To increase the number of people diagnosed with diabetes	❖ Estimated diabetes diagnosis rate	PHOF 2.17	67.7	78.0
2.5 To increase the number of health checks for people age 40-74	❖ The number of people eligible offered an NHS check	PHOF 2.22iii	46.9	90.0
	❖ Number of people eligible who received an NHS Health Check	PHOF 2.22v	22.6	43.3
2.6 To reduce the number of falls in people aged 65 and over	❖ Hip fractures in people aged 65 and over	PHOF 4.14i	588.5	577.8
	❖ Hip fractures in people aged 65 and over aged 65-79	4.14ii	242.1	246.3
	❖ Hip fractures in people aged 65 and over aged 80+ (PER 100,000)	PHOF 4.14iii	1593	1539
2.7 To reduce cardiovascular disease among people aged 65 and over	❖ Reduction in the number of deaths from cardiovascular disease among people aged 65 and over			

Priority 3 | **Ageing well** | **Reduce Social isolation and improving mental health**

Why have we chosen this as a priority for Wokingham?

Whilst life expectancy in Wokingham is one of the best in the country and people are living longer, we are seeing new challenges in relation to isolation and the management of physical and mental health and wellbeing in older people and the impact this has on their carers. 25% of people in Wokingham are living alone and loneliness is linked to poor mental health and physical health.

People with chronic physical diseases have a higher prevalence of depression and other mental disorders, and co-morbidity is associated with a range of poor outcomes and increased costs. Reducing social isolation and enhancing management in mental health may improve outcomes in physical health and vice versa.

According to the local JSNA the elderly population is typically categorised as people aged 65 and over. However, with the increase in life expectancy and in pensionable age, the age threshold for what we call “older” and “elderly” is changing. In Wokingham the average healthy life expectancy for men and women is 70 years. The vast majority of adults requiring social care (excluding learning disabilities) are 75 plus.

1 in 5 people are over 65 and this is set to rise to 1 in 3 by 2033. The number of "oldest old" (over 85) has doubled in the past decade and the percentage of people dying before 65 has remained constant for the past 20 years. Older people are the biggest and costliest users of health and social care - those with complex needs, long-term conditions, and functional, sensory or cognitive impairment are the highest cost and volume group of service users. Dementia also accounts for more expenditure than heart disease and cancer combined.

Where do we want to be?

In order to reduce the inequalities gap we need to ensure we are integrating support available and ensuring the areas identified in priority 1 and 2 above are meeting needs of older people and people with long term conditions who require rehabilitation and specialist support.

We want to ensure we are meeting the prime minister’s challenge for dementia to include a commitment to increase the number of people living with dementia who have a formal diagnosis. The rationale being that a timely diagnosis enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes.

How do we get there?

- We will ensure we identify people who are at risk of social isolation and loneliness early
- We will ensure access and support for people who are socially isolated and lonely through interventions aimed at building resilience and supporting people living in isolation and alone
- We will ensure any new developments support and recognise the needs of service users, carers and the elderly both in terms of new homes/buildings and activities
- We will ensure we target support and community activities to address loneliness and support for people with mental health through for example community cafes, luncheon clubs, social clubs and courses
- We will ensure that we address inequalities in heath of those looking after lonely people through public health programmes such as physical activity but also increasing take up of flu vaccinations by both those over 65 and their carers

- We will ensure we target inequalities to reduce winter deaths in elderly population
- We will ensure we provide opportunities and programmes for vulnerable groups such as those with long term conditions, dementia, elderly and mental health to access community exercise and activity programmes.

Priority 3: Ageing well: Social Isolation and mental health	
To reduce Social isolation and improve outcomes for older people, people with mental health problems and Carers.	1) Increase access to social contact by adult carers 2) Increase access to social contact by service users 3) Increased awareness and uptake up of flu vaccinations in eligible people aged 65 and above and their carers 4) Reduce the number of falls in older people 5) Increase awareness about dementia and diagnosis 6) Reduce excess winter from all causes in the winter months

How will we know when we get there?

An important part of the health and wellbeing priority and action plan is establishing the baseline and being able to manage progress in the areas identified. There are national indicators and outcomes for Health and Social care as well as Public Health.

Those relating to the outcomes identified for this population group will include the following indicators which will be a measure of whether we are meeting needs of communities.

Priority 3: To reduce Social isolation and improve outcomes for older people, people with mental health problems and Carers				
Objective	**Performance Measure**	**Indicator ref**	**Local value**	**England Value**
3.1 To reducing Social isolation of Adult Social Care Users	❖ Increase the % of adult social care users who have as much social contact as they would like	PHOF 1.18i	48.1	46.0
3.2 Reducing Social isolation of Adult Carers	❖ Percentage of adult carers who have as much social contact as they would like	PHOF 1.18ii	34.5	35.5
3.3 To increase Self-reported wellbeing happiness score	❖ Self-reported wellbeing - people with a low happiness score	PHOF 2.23iii	4.05	8.20
3.4 To increase Population vaccination coverage - Flu (aged 65+)	❖ Population vaccination coverage - Flu (aged 65+)	PHOF 3.03xiv	73.3	72.8 [e]
3.5 To reduce the number of excess winter deaths	❖ Excess winter deaths index (single year, age 85+)	PHOF 4.15ii	57.9	30.8
3.6 To reduce the number of sickness days lost due to sickness absence	❖ Sickness absence - the percentage of working days lost due to sickness absence	PHOF 1.09ii	1.18	1.12

3.7 Ensure the effective delivery of the Better Care Fund	❖ Number of Care Homes (Community Support) incorporating RRaT (Rapid Response and Treatment; Connected Care; Integrated Discharge Team (IDT) and Trusted Assessment; Street Triage – Mental Health; and Falls and Frailty.	Tbc - CCG		

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