Wokingham Borough Health & Wellbeing Strategy

Action Plan 2017-2020

Introduction

This is the Action Plan that we have put into place to deliver on the priorities identified in our Health and Wellbeing Strategy. We believe that doing this will make a significant difference to the people of Wokingham Borough, but we also believe it will take time and effort and needs the support and involvement of a range of groups and organisations, as well as our local communities.

Context

Wokingham is a prosperous place, but we believe there is much that can be done to make it a better place to live and work.

Also, increasing demand for health and social care services, at a time of downward pressure on NHS and local authority budgets, means that local authorities, the NHS and their partners have to consider new ways of working to deliver the outcomes that people need.

Local public bodies are re-drawing their roles and re-shaping their 'organisational boundaries', alongside a recognition that individuals and communities need to have a much greater say in promoting and maintaining their own health and well-being. We believe that delivering on our priorities through this action plan will help to carry that forward.

This Health and Well-Being Strategy sits alongside a number of other plans and strategies that cover either Wokingham Borough or a wider footprint. This wider planning framework (which includes the NHS-led Sustainability and Transformation Plan for Buckinghamshire, Oxfordshire and Berkshire West) is very complex and it is important that this Health and Wellbeing strategy adds value to the system overall. The focus of it therefore is to look at the 'bigger picture' and underlying approaches and particularly to address those areas where better and closer co-ordination is needed.

Finally, this is a new health and well-being strategy and we are taking an innovative approach with it. Whilst all the actions set out below are required, some will relate to the need to undertake further work in due course.

Measuring Success

The measure of success for this strategy will be how well we meet our priorities by 2020. However, we do also need to develop, in partnership with communities and other stakeholders, a suite of outcome measures to support each of the actions in this plan, with milestones along the way to ensure we are on track.

Our Priorities

Rather than looking to cover the whole health and wellbeing agenda the Health and Wellbeing Board has agreed four priority areas that it wishes to focus upon:

- **Enabling and empowering resilient communities**
- **Promoting and supporting good mental health**
- **Reducing health inequalities in our Borough**
- **Delivering person-centred integrated services**

These have been chosen as priority areas because of their importance to improving the health and wellbeing of the people in the borough and because they each require a co-ordinated approach from across the health and social care economy.

However, they are also closely connected to each other and provide an interlocking set of priorities - the delivery of each will support the delivery and the achievement of each of the others. In some instances, there are already relevant strategies and programmes being delivered within an area, and where appropriate these are referenced. In other areas, there is work in progress that has not, yet, been captured and co-ordinated with other areas of activity. This Health and Wellbeing Strategy Action Plan is intended to identify some of those connections and to assist in that process.

Enabling and empowering resilient communities

JSNA and evidence

In 2013, the House of Lords Select Committee on Public Service and Demographic Change received expert evidence that a new system of health and social care is needed to:

- be more focused on prevention, early diagnosis, intervention, and managing long-term conditions to prevent degeneration, with much less use of acute hospitals (be centred on the individual person, with patients engaged in decisions about their care and supported to manage their own conditions in their own homes so that they can be prevented from deteriorating
- have the home as the hub of care and support, including emotional, psychological and practical support for patients and caregivers
- ensure older people only go into hospitals or care homes if essential, although they must have access to good specialist and diagnostic facilities to ensure early

As demand increases and public resources remain under pressure people need to live in strong and resilient communities which support them to maintain their own health and wellbeing and encourage and enable them to support those around them to do the same.

Wokingham is the least deprived upper tier local authority in the country and enjoys better outcomes than most of England. However, inequalities do exist across the Borough and we need to focus on those areas where need is greatest. The most deprived areas are Norreys, Southlake Crescent and Finchampstead South. The people living within those areas are more likely to be unemployed and in receipt of benefits and have higher needs as ranked in the Indices of Multiple Deprivation (2015). These areas are within wards which all have child poverty levels at or above the Wokingham Borough average, although this data is not available for each LSOA separately. Concentration on LSOAs to highlight areas of need comes from the overall ranking of these in the Indices of Multiple Deprivation (IMD) 2015. It is a particular feature of areas of relative affluence such as Wokingham Borough that the low levels of deprivation mask areas with higher levels when dealing with larger populations such as wards. LSOAs, with populations between 1,000 and 2,000 people provide smaller populations which highlight more effectively the differences between neighbouring populations, although many datasets do not disclose full data at this level.

There are also groups spread across Wokingham that suffer significant degrees of deprivation, including the Gypsy, Roma and Traveller (GRT) community and people with Learning Disabilities.

2,000 children were living in poverty within the Borough in 2015, many concentrated in the above areas.

We expect that the increase in population that will come with the planned 13,500 new homes will generate significant additional revenue for public services, with a relatively small increase in demand. Again, however, it is vitally important that as the

population increases in those locations real communities are encouraged and supported to grow and to develop their own community infrastructure.

What we can do

We need to ensure that our community infrastructure grows and develops both in areas where the need is high and in areas with an increasing population.

Key partnerships already collaborate to drive community resilience and preventative approaches to health and wellbeing, appropriately coordinated and targeted (Community Safety Partnership, Young People's partnership, STP Prevention strand). The Health and Well-Being Board also has its own Children's sub-group.

Ultimately, the strength and resilience of communities depends primarily upon those communities themselves and the willingness of the people within them to work together for their mutual benefit. However, outside bodies can act as a catalyst for this, and we will look to build social capital and resilience in and with our communities, targeting our most deprived LSOAs and the SDLs across Wokingham, including supporting the work of voluntary and community sector services.

Health and wellbeing extends beyond services and into the physical environment and community infrastructure. Our models of care and the services we provide must reflect this.

Frontline staff need to be capable and well equipped to act as a first point of contact, dealing with many issues themselves, but also signposting on and recognising when there is a need for more urgent or long term interventions. They also need to think and work in a restorative way, supporting families to identify their own strengths and goals and to build up their own communities and supportive networks.

This priority links clearly to the '*Resilient Wokingham'* approach championed within the borough and being followed within a range of partnerships, including two sub-groups of the Health and Wellbeing Board (the Community Safety Partnership, and the Children and Young People's Partnership) and other partnerships including the Local Safeguarding Children's Board.

Enabling and empowering resilient communities - Actions

	Priority Area	**Action**	**Lead**	**Timescale**
1.1	Build social capital in most deprived LSOAs and each SDL	1.1.1 Undertake community asset mapping exercise in each most deprived LSOA	Mark Redfearn	April 2018
		1.1.2 Undertake community strengths assessment exercise in each most deprived LSOA.	Mark Redfearn	April 2018

	Priority Area	Action	Lead	Timescale
		1.1.3 Undertake locality physical assets Mapping exercises in each LSOA	Mark Redfearn	April 2018
		1.1.4 Working with the local communities, establish co-production community plans in each most deprived LSOA	Paul Feven	June 2018
		1.1.5 Explore with communities the scope for a strong locality focus from all services in their activity (with an emphasis upon the most deprived LSOAs)	Mark Redfearn	June 2018
		1.1.6 Support the development of a community association in each SDL	Mark Redfearn	Sept. 2018
		1.1.7 Through developer infrastructure contributions, provide community facilities in each SDL	Mark Cupit	April 2020
		1.1.8 Support residents in establishing their own community groups /organisations	Mark Redfearn	April 2020
		1.1.9 Establish virtual teams for each most deprived LSOA and SDL to deliver co-produced community plans	Mark Redfearn	April 2018

	Priority Area	Action	Lead	Timescale
		1.1.10 Co-production of the key narratives and interventions (by 'virtual teams' and communities), for the issues identified as needing to be addressed (ie smoking cessation, healthy eating, exercise, stress management, routines for children)	Darrell Gale	Sept. 2017
		1.1.11 Identify Community Navigator lead for each most deprived LSOA and SDL	Phil Cooke	June 2018
1.2	Co-terminosity of boundaries between the CHASC localities and Children centres in each area, along with the Thames Valley Neighbourhood Policing teams and emerging designs within the Council.		Paul Feven	June 2018
1.3	Promoting *'Making Every Contact Count'* approach across all services, beginning with most deprived LSOAS and new SDLs.	1.3.1 Establish and launch the training '*Making Every Contac*t *Count'* with key staff	Darrell Gale	April 2018
		1.3.2 Evaluate and review effectiveness of the approach.	Darrell Gale	July 2018
1.4	Testing in one or more Neighbourhood Policing Teams a Police Officer taking role of Community Navigator.	1.4.1 Identify team(s) to test the approach 1.4.2 Deliver Community Navigator to Policing Team members 1.4.3 Provide	Rob France / Borough Commander	Sept. 2017

	Priority Area	Action	Lead	Timescale
		support material and access to signposting information		
1.5	Development of the Borough Council Locality Service	1.5.1 Continue to support the practice of coproduction with residents and groups	Paul Feven	Sept.2017
		1.5.2 Redesign staffing roles to produce consistent community based working across the borough	Mark Redfearn	Sept. 2017
		1.5.3 Identify, with communities, key community facilities to act as a focal point for community based working in an area	Mark Redfearn	April 2018
1.6	Commissioning for 2017/18 Adult Education courses specifically aimed at improving the health and well-being outcomes of the targeted groups - vulnerable young adults, parents who have no qualifications, work in the most derived LSOAs, those with Learning Disabilities (LD).	1.6.1 Review the Wokingham Adult and Community Learning Plan 2017/18 in light of the revised Health and Wellbeing strategy 1.6.2 Revise the proposed provision for 2017/18	Lorraine Barker	July 2017
1.7	Explore with other services the scope for a strong locality focus in their activity (with an emphasis upon the most deprived LSOAs)		Mark Redfearn	April 2018

	Priority Area	Action	Lead	Timescale
1.8	Scope the potential of the schools nursing service to contribute to the development of resilience in children and young people.	1.8.1 School nursing to take account of the children who may be ‘on the edge of schooling’ and live in the priority areas.	Darrell Gale	April 2018

Promoting and supporting good mental health

JSNA and evidence

About half of adults who experience mental health conditions experience their first symptoms before the age of 14.

There has been an increase in demand for CAMHS services across the Children's population, with long waiting times between referral and assessment. There are relatively low numbers of referrals of children looked after by the local authority.

In common with surrounding localities adults in Wokingham have relatively low levels of identified common mental health problems, and this level should remain relatively stable through to 2012. Males in have a higher suicide rate compared to women in Berkshire, which is consistent with national figures (81% male; 19% female in 2012-14).

However, the numbers of people with dementia in Wokingham are projected to increase steeply and to be greater than those in neighbouring boroughs. By 2025 the numbers will be over 2300, compared to just over 1800 in 2014. By 2035 they will be up to some 3400, an 87% increase over the 2014 figure.

There is a complex, dynamic relationship between mental and physical health. People with mental illness experience poor physical health with higher than expected mortality, which is not explained by suicide.

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. Enhancing management in mental health may improve outcomes in physical health and vice versa.

People with a chronic medical condition have a 2.6-fold increase in the odds of having a mental illness, compared to those without a chronic medical condition. Between 12% and 18% of spending on long-term conditions is related to "poor mental health and wellbeing", translating to between £8 and £13 billion in NHS expenditure in England.

Estimates suggest that about 60% of the excess mortality in people with mental illness is avoidable, but it is unclear how best to improve life expectancy in this group. The diverse range of drivers of excess mortality and morbidity in people with mental illness means that strategies for health improvement should ideally be multi-pronged.

What we can do to meet the priority narrative

Mental health continues to be a significant issue in Wokingham as it is elsewhere in the UK. To address it, we must continue to implement the recommendations from the 5 Year Forward View for Mental Health. One particular area that needs addressing is the fragmented and poorly coordinated specialist mental health services and out of area placements.

Wokingham is revising its joint (LA and CCG) Emotional Health and Wellbeing Strategy for CAMHS across all tiers of the service. The local work to ensure the most

effective offer from Universal level and Tier 2, is being carried out alongside the wider review and transformation plan for the tier 3 and 4 services that are commissioned by the NHS. Locally, this is being undertaken in partnership with the Council.

Serious mental health problems require specialist treatment and input, but at a more general level maintaining good mental health within the population is 'everybody's business' and that is reflected in both the *'Enabling and empowering resilient communities'* and '*Reducing health inequalities*' sections in this plan.

So, we will develop better systems for early intervention and prevention, building community resilience and ensuring timely information and support for people facing crises.

Also, we will support carers within our communities (including young carers) to access the support they need

	Priority Area	**Action**	**Lead**	**Timescale**
2.1	Review of the CAMHS Service/ EWHBS	2.1.1 Review and re-commission provision of universal and tier 2 services provided by the local authority	Paul Feven	Sept. 2017
		2.1.2 Consider the implications of the Transformation plan for tiers 3 & 4 and respond accordingly.	Paul Feven/Sally Murray	Sept. 2017
		2.1.3 Analyse the causes and impacts of self-harm in CYP in order to ensure the right preventative measures.	Darrell Gale	April 2018
2.2	Berkshire Health Trust Mental Health Strategy Implementation Plans for • Child and adolescent mental health • Adults of working age • Older adults	2.2.1 Contribute to Berkshire West Strategy Steering Group for Mental Health	Chris Dale	April 2018

	Priority Area	Action	Lead	Timescale
2.3	Closer integration of adult mental health services in Wokingham	2.3.1 Review potential to further integrate mental health services for adults in Wokingham	Chris Dale	June 2018
		2.3.2 Review Single Point of Entry to Mental Health services with a view to incorporating social care services	Chris Dale	June 2018
		2.3.3 Review links between Mental Health single point of Entry and CHASCH	Chris Dale	June 2018
2.4	Perinatal mental health support	2.4.1 Review provision of perinatal mental health support t	Paul Feven	April 2018
2.5	Mental Health support to Carers	2.5.1 Review mental health support to carers	Paul Feven	April 2018
2.6	Local Suicide Prevention Action Plan, in line with the Berkshire Suicide Prevention Strategy, 2017-2020	2.6.1 Deliver local Suicide Action Plan	Darrell Gale	April 2020

Reducing health inequalities in our Borough

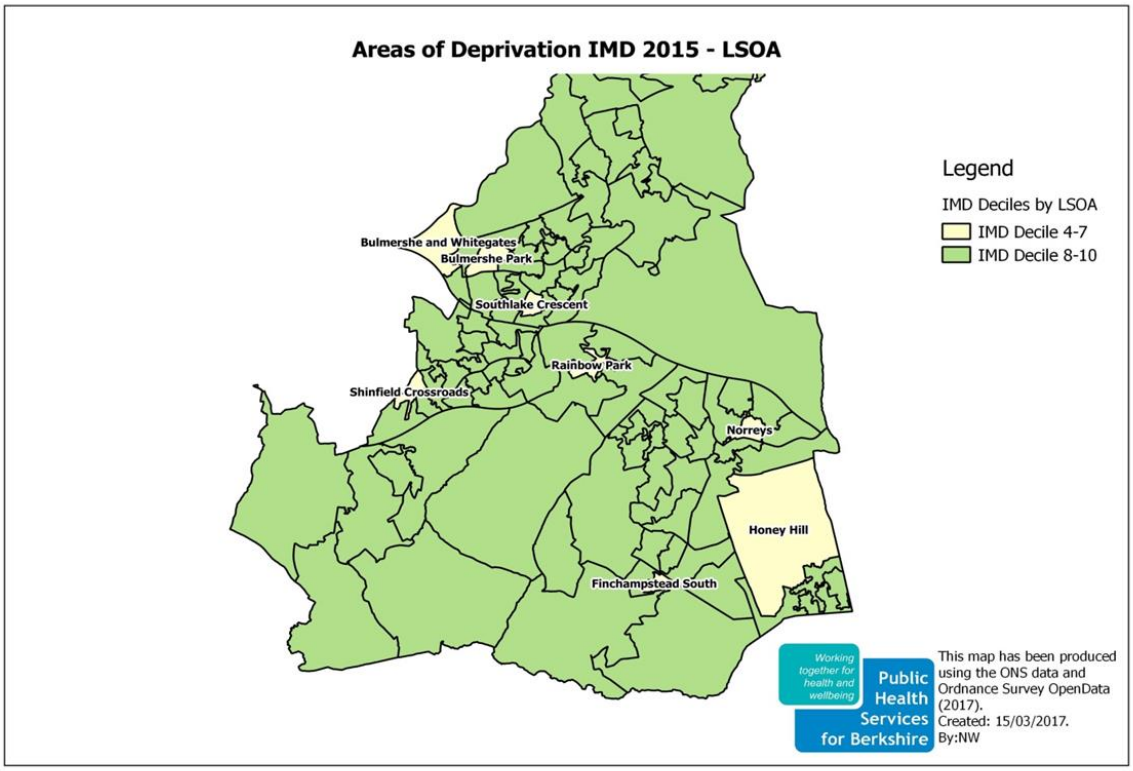
JSNA and evidence

Overall Wokingham enjoys health and wellbeing that is comparable or better than the national average.

Yet there are pockets of deprivation and health inequality that are hard to overcome and influence the outcomes for some of our most vulnerable citizens. There are also groups of people, more widely dispersed across the borough who may also experience health inequalities. Addressing these issues is important not only for those individuals and groups but also because they call disproportionately on the resources held within the health and social care system.

One area identified in the JSNA is children and young people where there is an increase in those who are presenting with emotional health and wellbeing issues.

Health inequalities are often linked to indices of deprivation, and the most deprived areas of the borough are shown in the map below. Again, we see the links between the four priorities within this strategy and delivery plan.



What we can do to meet the priority narrative

We can seek to reduce health inequalities and provide services to those areas which need most support in a variety of ways. For example, we can adopt more effective preventative approaches in our health and social care services, working more effectively with local with communities develop integrated services and target public health resources more effectively. There are a number of Public Health programmes focused upon doing this.

Some services and activities can address some of the underlying causes of health inequalities, for example the Early Help services for children operated by the council.

Wider services can also contribute to this priority is the NHS Health Check programme that focuses on how to prevent long term conditions and use evidence-based interventions related to the management of cholesterol, blood pressure, diabetes, obesity and alcohol problems.

	Priority Area	**Action**	**Lead**	**Timescale**
3.1	Reducing the gap in school achievement between identified disadvantaged children and the wider population.	3.1.1 Disseminate more widely the materials identifying all the areas of development and skills children need to be school ready and the foundations of how parents can support their children from birth.	Alison Pugh	Sept. 2017
		3.1.2 Continued working in partnership with Children's Centre Staff to focus on children from traveller heritage.	Alison Pugh	Sept. 2017
		3.1.3 Ensuring data is shared between early years' providers and schools- particularly for children who have been funded as 2 year olds, LAC or children in receipt of EYPP.	Alison Pugh	Sept. 2017
		3.1.4 Engage with LA staff services supporting disadvantaged	Alison Pugh	Sept. 2017

	Priority Area	Action	Lead	Timescale
		families so that all professionals around the family (including those in the Locality Service) are empowered with the message and interventions about what can make a difference for school readiness		
		3.1.5 Offer sessions at Children's Centres to inform parents about all things related to Early Years.	Clive Seall	Sept. 2017
		3.1.6 Develop an area on the WBC website specifically for school readiness support	Alison Pugh	Sept. 2017
3.2	Increase smoking cessation rates in targeted areas in ways and model that is supported by the community.		Darrell Gale	April 2018
3.3	Increase in proportion of the adult population achieving the CMO's physical activity guide levels and reduce the number of those who are deemed inactive in the priority areas and in ways that community support	3.3.1 Co-produce with the community the models that can work and make a difference and pilot approaches- this could include investment in equipment, groups, community led initiatives	Darrell Gale	April 2020
3.4	Produce a profile of the most deprived LSOAs across the Borough to inform how all targeted		Darrell Gale	Sept. 2017

	Priority Area	Action	Lead	Timescale
	services work in these areas.			
3.5	An increase in the proportion of the adult population achieving the advised CMOs physical activity guide levels from 66% to 68% in the next 2 years particularly those who live in the HWB prioritised areas		Darrell Gale	April 2021
3.6	Reduce percentage of those who are deemed inactive from 20.9% to 18% by 2018 in the specific areas		Darrell Gale	April 2021
3.7	Increased access to physical activities suitable for adults with mental health illnesses and learning disabilities		Darrell Gale	April 2021

Delivering person-centred integrated services

JSNA and evidence

The Wokingham Core (development) Strategy will deliver in excess of 13,000 new homes by 2026. This will result in a 22% growth in our population. There are four strategic development locations:

We predict that the development will accentuate the proportions of children and adults in their 30s, with a small net migration away from Wokingham of people between the ages of 45 and 80. But we expect a continued increase in the 85+ age group.

The population aged 65+ will increase by 48% by 2030 based on current census information.

Also, there will also be an increase of 13% of those with limiting long term illnesses whose day to day activities are significantly limited.

Without effective action, this demographic change alone will result in a growth in demand for services over both the short term and the longer term. Based on demographics alone, for example between 2014 – 2020, there would be a 20% increase in the number of admissions to hospital as a result of falls within this age group.

What we can do to meet the priority narrative

In line with national policy we need to promote self-management and ensure services care for people in their own homes where possible. This should prevent people being unnecessarily using A&E services or being admitted to hospital.

We will continue to use the Better Care Fund (BCF) to develop innovative integrated services and develop enhanced partnerships across statutory services (including, for example, Fire Rescue and Police services) and the third sector to identify and support frail elderly people.

We are delivering our BCF both locally and through a wider Berkshire West approach. The Berkshire West system has a shared governance structure to ensure effective delivery. The Berkshire West Integration programme has identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health. We have subsequently further prioritised joint work on a Frail Elderly Pathway which reported back in March 2016, with the findings and actions to be used to inform further pathway redesign.

We are working together to deliver our own local BCF Plan, which is fully detailed and available here (Do hyperlink).