Public Document Pack

NOTICE

OF

MEETING

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

HEALTH AND WELLBEING BOARD

will meet on

TUESDAY, 8TH AUGUST, 2017

At 3.00 pm

in the

OLD WINDSOR MEMORIAL HALL, STRAIGHT ROAD, OLD WINDSOR, SL4 2RN,

TO: MEMBERS OF THE HEALTH AND WELLBEING BOARD

MARK SANDERS (HEALTHWATCH BRACKNELL FOREST), COUNCILLOR DAVID COPPINGER (CHAIRMAN), DR ADRIAN HAYTER (VICE-CHAIRMAN), COUNCILLOR NATASHA AIREY, COUNCILLOR STUART CARROLL, LISE LLEWELLYN, DR WILLIAM TONG, ALISON ALEXANDER, ALEX TILLEY (NHS) AND KEVIN MCDANIEL

Karen Shepherd
Democratic Services Manager
Issued: Date Not Specified

Members of the Press and Public are welcome to attend Part I of this meeting. The agenda is available on the Council's web site at www.rbwm.gov.uk or contact the Panel Administrator **Wendy Binmore** 01628796251

Fire Alarm - In the event of the fire alarm sounding or other emergency, please leave the building quickly and calmly by the nearest exit, situated through the Mayor's Parlour (opposite the Chamber), and proceed down the back staircase. Do not stop to collect personal belongings and do not use the lifts. Congregate on the cobbled area, outside Hamptons Estate Agents and do not re-enter the building until told to do so by a member of staff.
Recording of Meetings – The Council allows the filming, recording and photography of public Council meetings. This may be undertaken by the Council itself, or any person attending the meeting. By entering the meeting room you are acknowledging that you may be audio or video recorded and that this recording will be available for public viewing on the RBWM website. If you have any questions regarding the council's policy, please speak to the Democratic Services or Legal representative at the meeting.

AGENDA

PART I

ITEM	SUBJECT	PERSON	TIMING	PAGE NO
1.	APOLOGIES FOR ABSENCE To receive apologies for absence.			
2.	DECLARATIONS OF INTEREST To receive any Declarations of Interest.			5 - 6
3.	MINUTES To confirm the Part I minutes of the previous meeting.			7 - 14
4.	UPDATE ON SUSTAINABILITY AND TRANSFORMATION PLAN To receive the above verbal update from Alison Alexander, Managing Director.			
5.	ANNUAL PUBLIC HEALTH REPORT To receive the above presentation and report from Judith Wright, Interim Director of Public Health			15 - 44
6.	UPDATE ON CHANGES TO PARTNERSHIP BOARDS To receive the above presentation from Teresa Salami-Oru, Service Leader – Commissioning/Consultant in Public Health.			45 - 50
7.	UPDATE ON OUTREACH PROJECT IN OLD WINDSOR To receive the above presentation from Debra Dulake			
8.	JOINT AUTISM STRATEGY To receive the above paper from Debbie Dickinson, Service Development Officer			51 - 92
9.	JOINT HEALTH AND WELLBEING STRATEGY SCORECARD To receive the above presentation from Teresa Salami-Oru, Service Leader – Commissioning/Consultant in Public Health			93 - 96

10.	QUESTIONS FROM THE PUBLIC				

This page is intentionally left blank

MEMBERS' GUIDE TO DECLARING INTERESTS IN MEETINGS

Disclosure at Meetings

If a Member has not disclosed an interest in their Register of Interests, they **must make** the declaration of interest at the beginning of the meeting, or as soon as they are aware that they have a DPI or Prejudicial Interest. If a Member has already disclosed the interest in their Register of Interests they are still required to disclose this in the meeting if it relates to the matter being discussed.

A member with a DPI or Prejudicial Interest **may make representations at the start of the item but must not take part in discussion or vote at a meeting.** The term 'discussion' means a discussion by the members of meeting. In order to avoid any accusations of taking part in the discussion or vote, Members should move to the public area or leave the room once they have made any representations. If the interest declared has not been entered on to a Members' Register of Interests, they must notify the Monitoring Officer in writing within the next 28 days following the meeting.

Disclosable Pecuniary Interests (DPIs) (relating to the Member or their partner) include:

- Any employment, office, trade, profession or vocation carried on for profit or gain.
- Any payment or provision of any other financial benefit made in respect of any expenses occurred in carrying out member duties or election expenses.
- Any contract under which goods and services are to be provided/works to be executed which has not been fully discharged.
- Any beneficial interest in land within the area of the relevant authority.
- Any licence to occupy land in the area of the relevant authority for a month or longer.
- Any tenancy where the landlord is the relevant authority, and the tenant is a body in which the relevant person has a beneficial interest.
- Any beneficial interest in securities of a body where:
  a) that body has a piece of business or land in the area of the relevant authority, and
  b) either (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body **or** (ii) the total nominal value of the shares of any one class belonging to the relevant person exceeds one hundredth of the total issued share capital of that class.

Any Member who is unsure if their interest falls within any of the above legal definitions should seek advice from the Monitoring Officer in advance of the meeting.

A Member with a DPI should state in the meeting*: 'I declare a Disclosable Pecuniary Interest in item x because xxx. As soon as we come to that item, I will leave the room/ move to the public area for the entire duration of the discussion and not take part in the vote.'*

*Or, if making representations on the item: **'I declare a Disclosable Pecuniary Interest in item x because xxx. As soon as we come to that item, I will make representations, then I will leave the room/ move to the public area for the entire duration of the discussion and not take part in the vote.'***

Prejudicial Interests

Any interest which a reasonable, fair minded and informed member of the public would reasonably believe is so significant that it harms or impairs the Member's ability to judge the public interest in the item, i.e. a Member's decision making is influenced by their interest so that they are not able to impartially consider relevant issues.

A Member with a Prejudicial interest should state in the meeting*: 'I declare a Prejudicial Interest in item x because xxx. As soon as we come to that item, I will leave the room/ move to the public area for the entire duration of the discussion and not take part in the vote.'*

Or, if making representations in the item: 'I declare a Prejudicial Interest in item x because xxx. As soon as we come to that item, I will make representations, then I will leave the room/ move to the public area for the entire duration of the discussion and not take part in the vote.'

Personal interests

Any other connection or association which a member of the public may reasonably think may influence a Member when making a decision on council matters.

Members with a Personal Interest should state at the meeting: ***'I wish to declare a Personal Interest in item x because xxx'. As this is a Personal Interest only, I will take part in the discussion and vote on the matter.***

This page is intentionally left blank

HEALTH AND WELLBEING BOARD
COUNCIL CHAMBER - TOWN HALL, MAIDENHEAD AT 3.00 PM

25 April 2017

PRESENT**:** Councillors David Coppinger (Chairman), Dr Adrian Hayter (Vice-Chairman) and Natasha Airey

Also Present: Mark Sanders, Dr William Tong, Judith Wright Jeanette Bailey, Teresa Salami-Oru Karen Stevens

Officers: Wendy Binmore, Angela Morris, Hilary Hall and Nick Davies

PART I

89/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Stuart Carroll, Alison Alexander and Dr Lise Llewellyn.

90/15 DECLARATIONS OF INTEREST

None received.

91/15 MINUTES

RESOLVED UNANIMOUSLY: That the minutes of the meeting held on 15 February 2017 were signed as a true and accurate record.

Mark Sanders, Healthwatch wanted to reassure the Board and the public that Healthwatch had been commissioned as a service and therefore, nothing would change. All email addresses and phone numbers had not changed; it was just a more efficient way of doing things.

92/15 STP UPDATE ON THE SOCIAL CARE WORK STREAM

Hilary Turner, Dr Adrian Hater and Angela Morris gave the Board a presentation on the latest update on the Sustainability and Transformation Plan. The main points of the presentation included the following key points:

Priorities for the next five years:

- Priority one: making a substantial step change to improve wellbeing. Increase prevention, self-care and early detection.
- Priority two: Action to improved long term condition outcomes including greater self management and proactive management across all providers for people with single long term conditions.
- Priority three: frailty management – proactive management of frail patients with multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays.
- Priority four: redesigning urgent and emergency care, including integrated working and

primary care models providing timely care in the most appropriate place.

- Priority five: reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.
- Many residents had the skills, confidence and support to take responsibility for their own health and wellbeing.
- The Frimley Health & Care STP could do more to assist them and were committed to developing integrated decision making hubs with phased implementation across the area by 2018.
- Integrated hubs provided a foundation for a new model of general practice provided at scale.
- An underpinning programme of transformational enablers included:
    - Becoming a system with a collective focus on the whole population.
    - Developing communities and social networks so that people had the skills and confidence to take responsibility for their own health and care in their communities.
    - Developing the workforce across the system so that is is able to deliver new models of care.
    - Using technology to enable patients and the workforce to improve wellbeing, care, outcomes and efficiency.
    - Developing the estate.

Next steps for the NHS Five Year Forward View:

- The Five Year Forward View (5YFV) set out why the NHS needed to change; the 5YFV next steps set out what changes the public would see in the next two years.
- The STP now stood for 'Sustainability and transformation Partnerships', better reflecting the purpose.
- The plan addressed the top five issues citizens wanted to see improved:
    - Mental Health services
    - Convenient access to GPs
    - Easier hospital discharge
    - Better social care
    - Reduced cancer waits
- The plan recognised access and the way GP services were run needed to change.
- The STP enabled the NHS to work more closely with local authorities.
- There would be more investment in primary care which would also look at extra places for talking therapies.

Mental Health and what would be different:

- 60,000 extra places for talking therapies meaning more residents could benefit from the service
- Better care for expectant and new mothers
- Improved CAMHS and increase in patient in-beds meaning residents could receive specialist care closer to home
- Specialist mental health care in A&E with a four hour target so residents received the same standards of care for mental and physical health emergencies.

How it would happen:

- Local investment standards
- 800 extra mental health specialists embedded in Primary Care
- Commissioning reform to expand local services and reduced out of area placements.
- Support from local authorities to reduce DTOC for mental health patients
- Greater transparency through new mental health dashboard.

Primary Care – What would be different:

- Increased convenient access to GPs, meaning more residents can get a same day appointment
- Streaming emergency appointment to alternative professionals (pharmacists, therapists, physicians assistants) so that GP time is freed up to see only those residents who need to see a GP
- 100% access to out of hours bookable appointments by 2019 – WAM CCG already met that standard
- 5000 extra GPs; 1,300 extra clinical pharmacists; 1,00 extra mental health practitioners; 3000 extra physicians assistants.

How it would happen:

- Increased investment in GP services, including workforce and premises
- Encourage practices to work in 'hubs' for population size 30,000 to 50,000 at a joint location with improved access to diagnostics and clinical practice rooms
- Sharing community nursing, mental health and clinical pharmacy teams

Urgent and Emergency Care – what would be different:

- By September 2017, all trusts must achieve:
    - 90% on the four hour target – Wexham Park regularly achieving between 86-91%
    - Front door clinical streaming so residents presenting at A&E who need a GP appointment could be redirected to a GP within A&E
    - Appropriate patient flow including D2A, Trusted Assessors and seven day discharges – Wexham Park already discharged seven days a wee.

How it would happen:

- Free up 2,000 to 3,000 acute beds across England by providing a discharge to assess service
- 85% of CHC assessments to happen in the community, either in community beds of people's homes
- Enhanced support to care homes to prevent admissions and speed up discharge by adopting a Trusted Assessor model
- Implementing the high impact change model for managing transfers of care.

Integrated Health Care – What would be different:

- New partnership models encouraged to reduce the growing demand on the emergency services
- Increased integration of health and social care based on the BCF
- Creation of integrated (or 'accountable') health systems through STPs so that all partners are working as an integrated health systems.

How it would happen:

- New STP boards incorporating GPs, local authority and non-executive partners
- STP programme supported by pooling skilled resources from CCGs, trusts and local authorities
- NHSE will allow CCGs to realign their governance and management teams to the STP Geography
- Consider proposed changes to geographical boundaries to support patient flows
- NHSE will produce a policy framework under which STPs will operate and be judge by success.

Cancer – What will be different:

- Better survival rates – an additional 5,000 survivors by 2020
- Expanded screening for prevention and early diagnosis for bowel and cervical cancer
- Faster test results
- New standard of definitive diagnosis within 28 weeks from 2020

How it will happen:

- £130m targeted investment
- Workforce expansion for endoscopy and radiology
- Clearer accountability through a new cancer dashboard.

Nick Davies, Service Lead Adult Commissioning provided the board with an update stating there had been a lot of work carried out on care home quality and there was a need for investing and understanding relationships. Care homes in the Borough required a huge amount of work to be done to reduce falls. There had been better hydration rates in care homes due to support from the Hydration Project. Work had also been done around medication management with medication reviews being carried out and making sure medication management was robust and reducing anti-psychotic medication. There had also been investment in the workforce.

Councillor Airey stated the work done had been fantastic and asked if views of the under 18 year olds had been incorporated in developing services, particularly mental health services. Dr Hayter responded that there had been a lot of work done over an extended period of time including consultation work which was used to develop services such as CAMHS. Dr Tong highlighted the issue that the NHS required money to deliver projects. Connections could be improved and the steering groups did include young people too. The Chairman said that the planning application for the new Heatherwood Hospital had been submitted and would be heard at the Borough-Wide Planning Panel.

93/15 THE CHANGING FACE OF GP SURGERIES

Dr Hayter gave Members a brief presentation on the changing face of General Practice. Members noted the following key points:

- Things were changing while services continued to be provided, the situation was fluid and ever changing.
- The GP Forward View came after the Five Year Forward View.
- GPs were part of the community looking after patients.
- GPs recognised the historical model was not fit for the future so they were talking about joining up services to provide wraparound care.
- GPs needed to think about how care was redesigned.
- GPs were less well funded and more investment had gone into hospitals instead of GP practices. GP investment would now be increased.
- GPs were starting to think as providers and were coming up with solutions such as having Clinical pharmacists being resident in GP surgeries; that would help patients manage conditions such as diabetes.
- Federation WAM was helping smaller practices to survive as they were doing things more to scale.
- GP practices were also working more collaboratively with staff being shared across surgeries.
- In Dr Hayter's Practice, Runnymede Medical Practice, the CQC said some things could be done differently, the practice saw triple the number of people with sever frailty compared with other practices in other areas.
- The Runnymede Medical Practice began to think about doing things differently and put a bid in for funding to help support carers.

- Support for carers included things such as providing training or information to keep them well, offering annual health checks for carers and informing them on how to receive practical support as a carer.
- A carers event was held in March with the Runnymede Medical Centre working hard to identify young carers; they carried out their own young carers week, worked with local schools and held a coffee morning. The work went well and 10 young carers were identified and now receiving support.
- Overall, there were 320 carers identified across all groups which was up from 40.

94/15 DEMENTIA CARE ADVISORS UPDATE

Jeanette Bailey, Team Manager for the Short Term Support and Rehabilitation Service gave a brief presentation on Dementia Care Advisers. Members note the following key points:

- The role was originally established in 2014 to provide supportive advice and signposting for all newly diagnosed residents. This was linked to Memory Clinics and third sector dementia support services.
- The role was well established and valued by all stakeholders over two years.
- 2014-2016 saw a period of growth and change such as:
    - As dementia diagnosis rates increased, there was an increased demand for services.
    - The profile of dementia raised as a specific condition and as part of complex needs with other long term needs.
    - Care Act implementation – there was more focus on carers needs.
    - Additional network of supportive services and liaison – through older person as Mental Health Sub-Group.
    - Launch of Each Step Together programme.
- Maternity leave offered an opportunity to take stock, review and absorb learning from other models of DCA support – nationally and across Berkshire.
- Activities from September 2016 – to date have included:
    - Increased staffing to 1.2 WTE – two DCAs with complementary and different skills and experience to widen scope of the role.
    - One nurse and one specialist in Cognitive Stimulation therapy
    - 136 new referrals in seven months with a wide spectrum of neurological conditions.
    - Refresh all promotional information and proactive engagement with all contact points across wider H&SC systems i.e. practice nurses, public Daily Living Made Easy event in October 2016.
    - Speedy response and onward referral to targeted community support – EST approach.
    - Proactive relationship with the Memory Clinic – DCAs involved in last week of introductory course for better client/carer face to face contact.
    - Holistic and sustained support to dementia patient and family – better carer identification and support.
    - Targeted advice on acquisition of relevant equipment and use of assistive technology (with demonstrable impact on falls related NEL admissions), telephone triaging to identify those near crisis and offer immediate pre-emptive support with immediate access to other health and social care specialist advice.
- Impact – Resident stories:
    - More joined up information sharing – reinforces the ‘tell your story once’ objectives for residents and targeted support without repeating historical information.
    - More timely and creative interventions to promote independence and reduce risk of crisis.
    - Tailored support for different types of dementia diagnosis – and links to other long term conditions.
    - Shorter waiting times for referral implementation e.g. reduced six week waiting

time for Day Centre referrals to one week – EST
    - Whole person – lifelong support – not just at initial diagnosis – gateway to ongoing advice and support throughout patient journey.
    - Patient and carer – supported individually and together – multigenerational households.
    - Better/increased use of other dementia related services.
- Dementia Care Advisors tried to personalise the service based on need
- DCAs acted as key workers; they tried to avoid unnecessary hospital admissions and establish any longer term support requirements.

95/15 TRANSFORMING CARE PARTNERSHIPS UPDATE

The Berkshire Transforming Care Partnership Board held a shared vision and commitment to support the implementation of the national service model to ensure that children, young people and adults with learning disabilities, behaviour that challenges and those with mental health and autism receive services to lead meaningful lives through tailored care plans and subsequent bespoke services to meet individuals needs.

The Berkshire Transforming Care Plan had four big aims:

1. Making sure less people were in hospitals by having better services in the community.
2. Making sure people did not stay in hospital longer than they needed to.
3. Making sure people got good quality care and the right support in hospital and the community.
4. To avoid admissions to and support discharge from hospital, people would receive and be involved in a Care Treatment review (CTR).

There were the following work streams and project groups:

- Works Streams (Themes)
    - Demand and Capacity
    - Market Shaping – Housing and care Providers
    - Inpatients
    - Intensive Support Team
    - Communities and engagement
    - Communications and engagement
    - Children and Young people
    - Workforce Development and Culture
    - Co-production
    - Joint Commissioning and Integration
    - Risk Management
    - Programme Management
    - High Impact Actions.
- Project Groups
    - Finance and Activity
    - Housing and Accommodation
    - Autism
    - Intensive Intervention service
    - Occupation and Employment
    - Berks East Capital ‘Home’ Project
    - Co-productions (People’s Voice Service)
    - Experts by experience Steering Group
    - Communications and Engagement.
- 2016 TCP Achievements
    - Regular TCP briefings to all partners and communication teams to keep them up to date with national and local news
    - Secured:
        - 2016-2017 funding from NHS England for Shared Housing Provision in RBWM for up to three individuals from across Berkshire with complex

LD and challenging behaviours
    - 2016-2018from the DfH for 10 x Hold Ownership Schemes for people with long term disability
    - 2017-2018 national funding for interim intensive support service and respite
  - Co-opted carer and family experts by experience into the programme on voluntary appointment contracts, as members of the finance and activity project group, capital 'home' project group, and TCP Board, with further appointments planned in 2017
  - Commenced experience based co-design project with Point of Care Foundation – weekly BHFT led group with service users
  - Undertaken a desk top gap analysis of local authority LD and ASD strategies and, reviewed capacity and demand projections until 2019, to inform prioritising of the work plan for 2017/18
  - Started to map local authority and CCG work streams already in place for Children and Young People, to avoid duplication in work
  - Developed a repatriation timetable for NHS England specialist commissioned patients and Clinical Commissioning Group out of area placements.
  - Will be linked into STP funding
  - Autism was a key part with agencies working much more collaboratively
- Intensive Support Team:
  - All TCPs nationally were looking to commission a new service model in the community called an Intensive Support Team (IST) or Intensive Intervention Service
  - An IST would provide proactive community based support for people with a learning disability and/or autism who have associated mental health needs and/or present with behaviour that can challenge. Offering support to people in their own homes and preventing in-patient admissions where possible, the IST would provide access to specialist health and social care support.
  - There was a stream of work that was centred around primary care and that linked in with services for health checks and accessing services. The work was ongoing.

96/15 <u>BCF UPDATE</u>

Hilary Hall, Head of Commissioning - Adult, Children and Health gave a brief presentation and Members noted the following key points:

- National context – Admissions and delayed transfers of care
  - A&E attendances in 2016 had been 5% higher than in 2015
  - The number of emergency admissions rose by 4.5%. the rate was currently 10% higher than raw population increase
  - In 2016, each month's total admissions had been higher than the same month in each previous year
- Build up of pressure in the national 'system'
  - 21% of patients spent more than four hours in major A&E departments in December 2016, compared with 13% in December 2015 and 6% in December 2011
  - Long waits for emergency admission were 58% higher in 2016 than in 2015, and five times higher than 2011
  - However, the Borough was not performing as badly nationally
- Emphasises the need for integrated approach to managing front and back door in acute rusts reflected in BCF targets
  - Delayed transfers of care had increased substantially over the past three years
  - There were 23% more delayed transfers of care in 2016 than in 2016
  - Compared with 2015, delays where NHS was at least partially responsible rose by 17% whereas social care delays rose by 37%

- There were lots of ongoing actions to try and keep on top of the figures and the situation was being reviewed weekly.

- Local actions to address Delayed Transfers of Care (DTC)
  - Integrated weekly meetings with Wexham, Royal Borough Hospital team, Short Term Support and Rehabilitation Team and Carewatch to review individual cases and agree packages of support
  - Support from GP practices to identify and support frail patients using new electronic frailty index
  - Pilot in Old Windsor with support of parish council to identify those who live alone or are vulnerable – and offer them proactive support and advice
  - Focus on choice – proactive support for carers via SIGNAL and Dementia Advisors to enable residents to continue to live at home where possible
  - Review of third sector support from Red Cross to ensure that Royal Borough residents had access to the home from hospital service, e.g. milk in the fridge, settling in, prescriptions etc.
  - Proactive engagement with wider East Berkshire programme, including:
    - Monitoring patient flow – daily telephone calls with Wexham and partners to identify patients 'fit for discharge' and use of Alamac data set
    - Pilot of Discharge to Assess model in new Windsor Care Home for East Berkshire residents
    - Review/mapping of service pathways between Optalis and Berkshire Healthcare Foundation Trust to meet resident needs – June 2017
- Non-elective admissions – average stay post non-elective admission was decreasing as lots of work was ongoing with partners.
- Proportion of adults (65+) who were home 91 days after discharge from hospital –
  - The data showed the proportion of people who were at home 91 days after discharge from hospital from April 2015 onwards. That excluded those residents who had passed away, the target for the year was 87.5% and performance was currently at 87.09%
  - Significant increase in referrals direct from acute rather than community discharges – those were often more frail residents that needed more support and recovery time
  - Increase in falls related referrals and service users with long term/complex conditions
  - Slight increase in older age groups 85-94
  - More remaining in need of continuing support for longer at home due to having more complex needs and longer recovery times.

97/15 PUBLIC QUESTIONS

The Chairman regretted that there was no time left to take questions from the public.

98/15 FUTURE MEETING DATES

Members noted the future meeting dates.

The meeting, which began at Time Not Specified, ended at Time Not Specified

CHAIRMAN…….

DATE…….....

Subject:	Director of Public Health Annual Report 2017
Reason for briefing note:	To provide an overview of the Director Public Health's annual report 2017
Responsible officer(s):	Judith Wright, Interim DPH Berkshire Report Author: Dr Lise LLewellyn
Senior leader sponsor:	Hilary Hall
Date:	8th August 2017

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

SUMMARY: In England men are expected to live up to 79.5 years and women up to 83 years. This varies across the country and people dying earlier are considered to have died prematurely. This year, the Director of Public Health Annual Report for the Royal Borough of Windsor and Maidenhead (RBWM) considers premature deaths which could be Avoidable and Preventable. Almost a quarter of all deaths in England and Wales in 2014 were considered avoidable through effective healthcare or public health interventions

1 BACKGROUND

1.1 Directors of Public Health have a statutory duty to write an Annual Public Health report which informs people about the health of their community, health gaps and priorities that need to be addressed. It enables the Director of Public Health to make an independent judgement about the state of health of the local population and ensures that the report will be published and in the public domain. The report provides necessary information for decision making in local health and wellbeing services

1.2 In RBWM the rate of preventable deaths is lower than the national average, and reducing year on year, in both men and women. These figures are not surprising given that RBWM has the 9th best rate of premature deaths in England with fewer people dying before the national life expectancy age. However, we need to continue to reduce these premature deaths with more sustained public health interventions by health and social care organisations, communities and individuals. This will reduce early deaths and also the demand on services and improve health and wellbeing considerably at a local level.

1.3 Multiple poor health behaviours are associated with increased risk of hospital admissions among older people in the UK and life course interventions to reduce the number of poor health behaviours could have a substantial beneficial impact on health and use of healthcare in later life.

2 KEY IMPLICATIONS

2.1 Within this report, there are five commonly agreed risk factors that if addressed would reduce preventable deaths; alcohol use, tobacco use, high blood pressure, obesity and physical inactivity. These lifestyle factors not only cause early death within our communities, but are also a major cause of illness, driving our increasing use of health and care services.

2.2 It should be noted that whilst the report looks at the individual lifestyle factors and their effects, risky health behaviours interact and have a multiplicative impact. That is, they have a greater effect together than the sum of each individual risk.

3 DETAILS & RISKS

3.1 Smoking:

- Smoking remains the biggest single lifestyle cause of preventable death and ill health in the world. The Tobacco Control Plan for England states that it accounts for 1 in 6 of all deaths in England.
- In 2012-14, there were 275 deaths attributed to smoking per 100,000 population aged 35 and over in England. The rate in RBWM was 224 per 100,000.
- The impact of smoking related ill health on the social care system, is estimated to be a cost of £1.4 billion every year, up from £1.1 billion in 2014. This is made up of £760 million in costs borne by local authorities, with a further £630 million being spent by those who have to self-fund their care.

3.2 High blood pressure:

- Over 24% of people in England are estimated to have high BP and it is one of the leading causes of premature death and disability in England.
- At least half of all heart attacks and strokes are associated with high BP and it is a major risk factor for chronic kidney disease, heart failure, stroke, heart attack and vascular dementia.
- Across Windsor, Ascot and Maidenhead (WAM) CCG, there are estimated to be 31,000 people with high blood pressure, with 17,300 currently being treated. This means that there are approximately 14,000 people unaware of their high BP.

3.3 Alcohol:

- Alcohol is the leading cause of death among 15 to 49 year olds and heavy alcohol use has been identified as a cause of more than 200 health conditions. Among those aged 15 to 49 in England, alcohol it is now the leading risk factor for ill-health, early mortality and disability.
- Alcohol caused more years of life lost to the workforce than from the 10 most common cancers combined in 2015, totalling 167,000 years of working life lost.
- Within RBWM there are over 21,000 people drinking above the recommended levels, which increases the risk of damaging their health and just under 9,000 admissions annually due to alcohol - not unexpected since alcohol accounts for 3% of all NHS costs.

3.4 Obesity:

- In the UK obesity is estimated to affect around one in every four adults and around one in every five children aged 10 to 11.
- The annual costs associated with obesity to the NHS and social care systems are estimated to be £6.1 billion a year and £352 million respectively.
- Obesity prevalence increased very steeply between 1993 and 2000 and continued to rise more steadily between 2000 and 2006. Since 2006 however the prevalence of obesity has remained at a similar level.
- Locally in RBWM, we can see that we are below the national average with regards to obesity levels, however we exceed the national average for percentage of residents who are overweight.
- In RBWM in 2015/16 17.9% of children in reception were measured as overweight or obese, rising to 25.8% in year 6 (England figures were higher at 22.1% and 34.2% respectively).

3.5 Physical Activity:

- Low physical activity is one of the top 10 causes of disease and disability in England. UK studies have estimated that around 1% of cancers in the UK (around 3,400 cases every year) are linked to people doing less than the recommended 150 minutes of physical activity each week.
- Lack of physical activity is costing the UK an estimated £7.4 billion a year, including £0.9 billion to the NHS alone.
- It is estimated that physical inactivity contributes to almost one in ten premature deaths from coronary heart disease (CHD) and one in six deaths from any cause.

4 NEXT STEPS

4.1 Smoking:

- The biggest short-term savings opportunity lies in helping smokers who are in contact with the NHS to quit. The greatest long-term savings would come from preventing people from ever smoking altogether.
- Smoking cessation services are widely available and the RBWM service continues to see more residents than the England average. Although we offer some support to patients within health care settings to give up smoking, we have still to maximise this approach.

4.2 High Blood Pressure:

- Reduce the number of patients with known high blood pressure for whom treatment is not adequate using annual audits of GP practice registers to identify affected patients. A 20% improvement in blood pressure control can be cost saving for health and care services within 5 years.
- Wider use of self-monitoring by patients. Encourage them to develop the skills and understanding to monitor their blood pressure in their daily lives to minimise false readings.
- Identify residents in the community who are unaware that they have high blood pressure using programmes such as NHS Health checks to identify those people.

4.3 Alcohol:

- The public health ambition for alcohol is to reduce excessive alcohol consumption and therefore the associated burden on NHS and local authorities and the wider society.
- Deliver a brief intervention in health care settings; including giving advice to raise knowledge on safe alcohol levels, potential harm and ways to reduce alcohol intake.

4.4 Obesity:

- Professionals need consistently to raise the issue of weight at every opportunity. Primary care can increase the effectiveness of community based approaches through discussion and referral.
- The locally developed intervention called ‘Eat for Health’, in it’s second year had 529 people attend courses with more than 50% losing more than 3% of their original body weight. 197 people with high BP attended and 55 (28%) lost weight with a resultant return to normal levels in their BP, no longer requiring their medication and achieving significant on going health benefits.

4.5 Physical Activity:

- Persuading inactive people (those doing less than 30 minutes per week) to become more active could prevent one in ten cases of stroke and heart disease in the UK and one in six deaths from any cause.
- Four areas of action are identified by Public Health England, at national and local level: active society, moving professionals, active lives and moving at scale.

This page is intentionally left blank

Director of Public Health Annual Report – RBWM

Lise Llewellyn

2017

Avoidable and preventable mortality

Life expectancy has improved through the ages. In the middle ages the average life expectancy was thought to be around 35 years, rising to 47 in 1900, 65 in the 1950's, and 65 in 1971 and in 2015 it was 79 (men) [1].

Now the focus is on reducing avoidable deaths. Avoidable deaths can be divided into 2 major area: amenable and preventable deaths. Avoidable deaths in general focus on those deaths that occur prematurely before 75 years.

> **"People who die prematurely from avoidable causes lose an average of 23 potential years of life"**

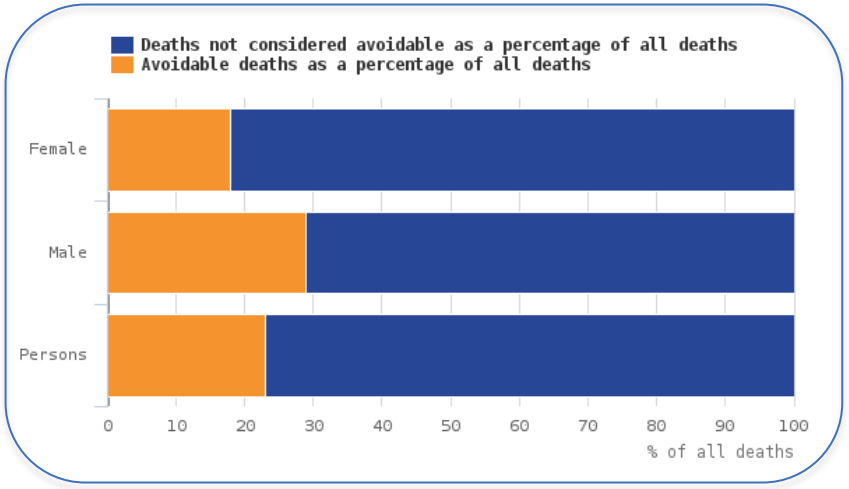
In 2014, nearly a quarter of all deaths (23%; 116,489 out of 501,424) in England and Wales were from causes considered potentially avoidable either through timely and effective healthcare (amenable) or public health interventions (preventable) [2].

While we may say that a particular condition can be considered avoidable, this doesn't mean that every death from that condition could be prevented. Analysis focuses on deaths prior to 75 years.

Males were more likely to die from an avoidable cause than females and accounted for approximately 60% of all avoidable deaths.

Approximately 29% of all male deaths were from avoidable causes (70,108 out of 245,142 deaths) compared with 18% of all female deaths (46,381 out of 256,282 deaths).

Figure 1: Percentage of deaths nationally that are avoidable



Source: *ONS: Avoidable Mortality England and Wales 2014*

Cancers were the leading cause of avoidable deaths accounting for 35% of all avoidable deaths in England and Wales in 2014.

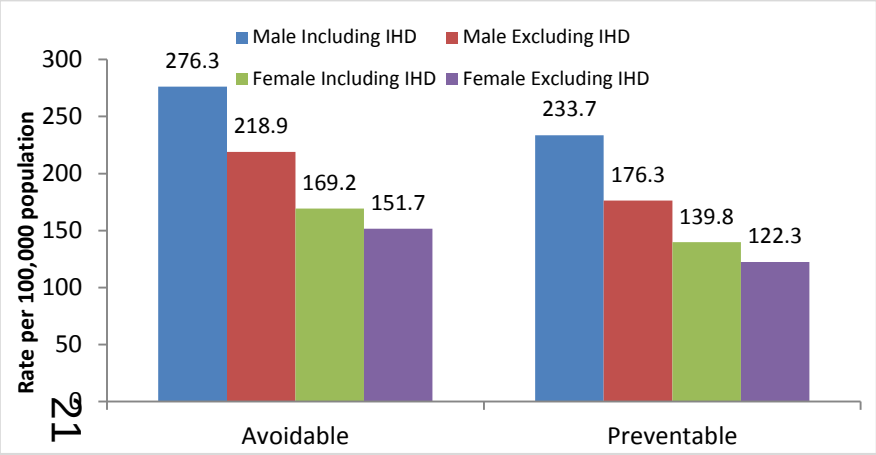
Ischaemic heart disease is the most common single disease that leads to avoidable death.

Amenable deaths are those where the causes of death are amenable (treatable) if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare.

Preventable deaths are those that through our understanding of the determinants of health at time of death, all or most deaths from that Cause (subject to age limits if appropriate) could be avoided by public Health interventions in the broadest sense.

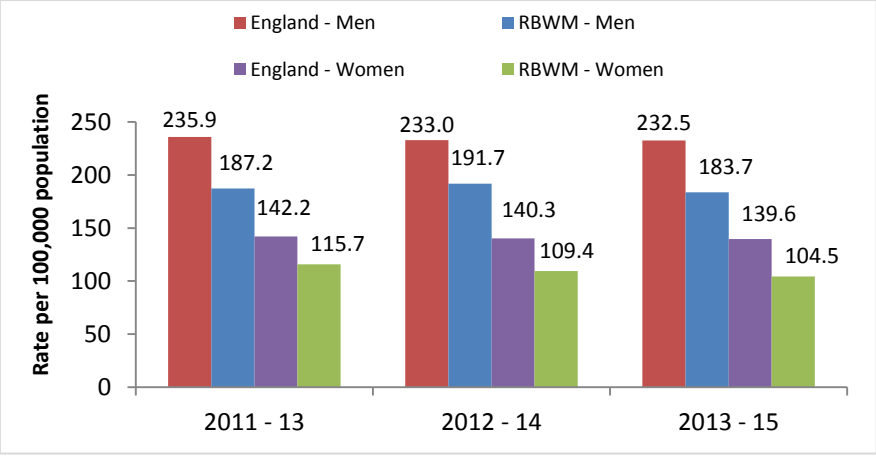
Local preventable deaths

Figure 2: Rates of avoidable and preventable deaths



Source: PHE: Public Health Outcomes Framework

Figure 3: Mortality rate from causes considered preventable 2011-2015



Source: PHE: Public Health Outcomes Framework

As shown in **(Fig 2)**, addressing these would have the biggest impact on reducing total numbers of avoidable deaths .

We can measure preventable death rates in our own locality. The England age standardised rate for preventable deaths is 184 deaths per 100,000, with the rate in RBWM being lower at 150 per 100,000 (2013-2015) meaning fewer preventable deaths in RBWM **(Fig 3).**

We can see that the rate of preventable deaths is lower than the national average, and reducing, in both men and women in RBWM.

These figures could be expected given that RBWM has a low rate of premature deaths 266/100,000 (2013-15)[26], the 9th best in England.

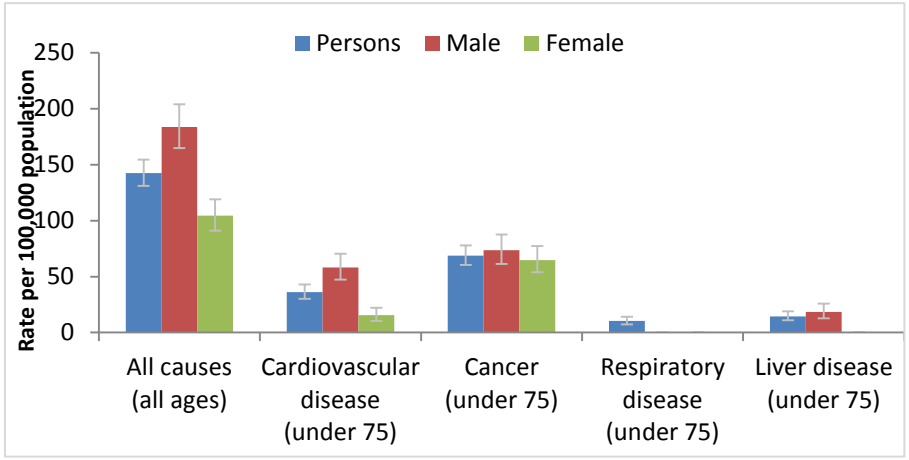
Nevertheless the impact on health, early death and the use of health care by more sustained application of public health measures by health and social care organisations, communities and individuals will reduce early deaths and hence also the demand on our services, and improve health considerably at the local level.

Causes

If we look at the major causes of early preventable death within RBWM, we see a similar picture to that seen nationally with the biggest generic cause being cancer for all persons and impact being greater for all preventable causes on male deaths **(Fig 6)**.

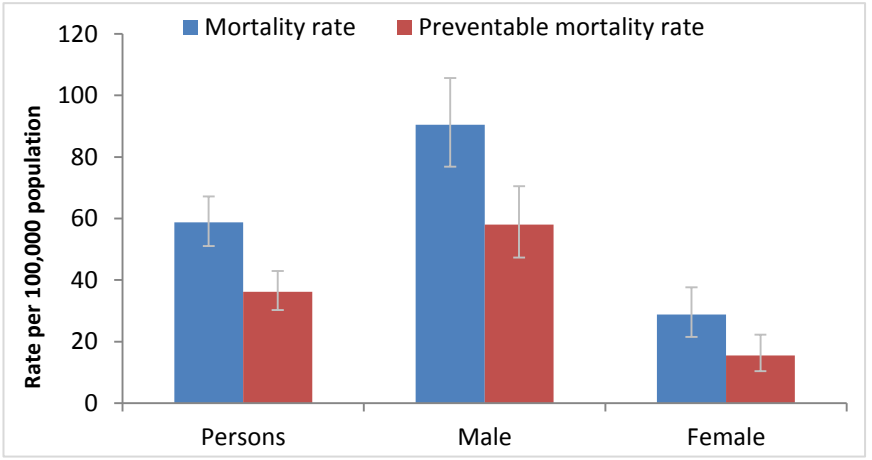
Local preventable deaths

Figure 4: Preventable mortality per 100,000 population in RBWM (2013-15)



Source: PHE: Public Health Outcomes Framework

Figure 5: Under 75 mortality rates for Cardiovascular disease in RBWM (2013-15)



Source: PHE: Public Health Outcomes Framework

22

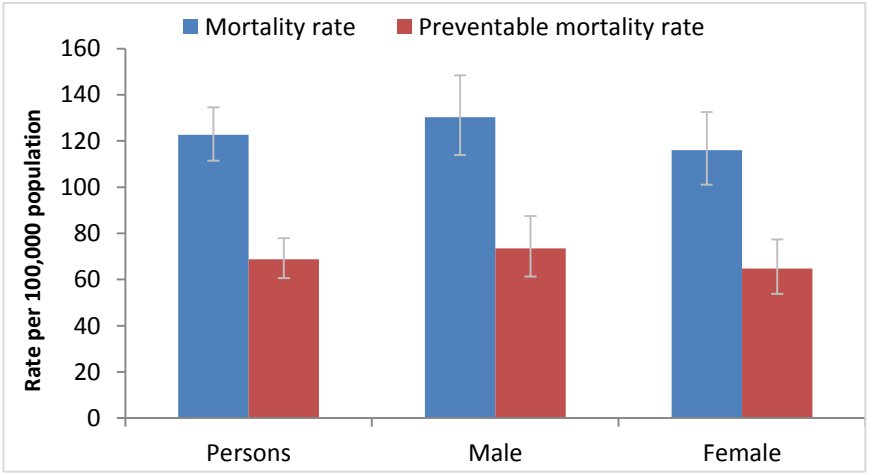
If we examine premature preventable mortality in RBWM in more detail by clinical groups then we see that mortality rates are higher in men.

In RBWM, liver mortality has much more impact on men, with over 70% of male mortality being preventable. The female figure is too low to be calculated. This is the same for respiratory disease where the numbers of preventable deaths in males and females is too small to be calculated

For cardiovascular causes, male preventable mortality rate is 3.7 times that of females **(Fig 5)**.

In cancer locally we see that the percentage of preventable cancers is similar to the national picture for persons with a greater percentage being preventable in men (74%) versus women (65%). This is against the national trend **(Fig 6)**.

Figure 6: Under 75 mortality rates for Cancer in RBWM (2013-15)



Source: PHE: Public Health Outcomes Framework

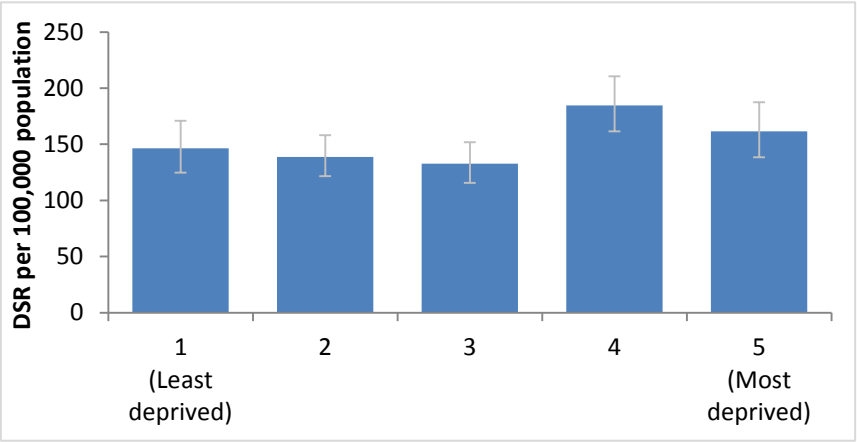
Preventable deaths

The impact of premature mortality from preventable causes can be examined by geography and deprivation. Across all preventable deaths there is a link with deprivation when we group wards by their level of affluence [3]. However this is not clearly seen within RBWM, though groups 4&5 do have higher rates.

The evidence shows a consistent pattern in the prevalence of multiple unhealthy behaviours, at the core of preventable causes of ill health, with men, younger age groups and those in lower social classes and with lower levels of education being most likely to have exhibited these multiple lifestyle risks [4].

In 2008 4.2% of professional men exhibited all 4 unhealthy lifestyle behaviours, compared to 8.4% of male unskilled manual workers. Similarly, 3.1% of professional women exhibited these behaviours, compared to 7.0% of female unskilled manual workers.

Figure 7: All cause preventable mortality rate per 100,000 population in RBWM by deprivation quintile (2011-2015)



Source: NHS Digital (2016); Primary Care Mortality Database – Restricted

Worryingly this pattern is persisting with improvement in lifestyle being greatest in those in most affluent groups so the gap is widening [4].

The strongest risk factors for avoidable hospital admission are age and deprivation [5].

Clustered poor health behaviours are associated with increased risk of hospital admissions among older people in the UK. Life course interventions to reduce the number of poor health behaviours could have substantial beneficial impact on health and use of healthcare in later life [6]. Studies have shown that among men and women, an increased number of poor health behaviours was strongly associated ($p<0.01$) with a greater risk of long stay and emergency admissions and 30-day emergency readmissions.

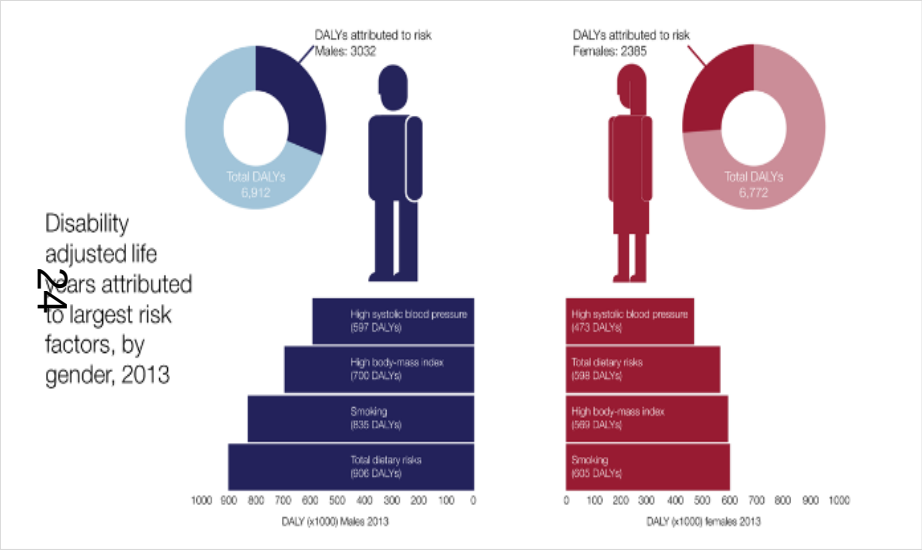
Those with three to four poor health behaviours were, in men, 1.37 [95% CI:1.11,1.69] times more likely to be admitted to hospital than those with no poor health attributes. In women, this figure was 1.84 [95% CI:1.22,2.77]. Associations were unaltered by adjustment for age, BMI and co-morbidity.

The impact of improving lifestyle behaviours is not restricted by age. In a study of over 65 year olds that examined the impact of having higher self-care confidence and being on an exercise program on decreasing avoidable hospitalizations, it was found that starting an exercise program at an older age decreased hospital admissions and utilization of emergency services in the short and medium term [7].

Addressing early preventable deaths

There are eight commonly agreed risk factors that if addressed would reduce preventable deaths; alcohol use, tobacco use, high blood pressure, high body mass index, high cholesterol, high blood glucose, low fruit and vegetable intake and physical inactivity.

Figure 8: Disability adjusted life years attributed to largest risk factors, 2013



Source: PHE: Burden of Disease Study for England

It is estimated that 80% cases of heart disease, stroke and type 2 diabetes, and 40% of cases of cancer could be avoided if common lifestyle risk factors were eliminated (WHO 2005).

An estimated 42% of cancer cases each year in the UK are linked to a combination of 14 major lifestyle and other factors [8]. The proportion is higher in men (45%) than women (40%), mainly due to gender differences in smoking (CRUK).

The impact of these lifestyle factors is not only key in causing early death within our communities but also as a major cause of illness it drives our increasing utilisation of health and care resources.

In the following section we will briefly review five of the major lifestyle and risk factors for preventable deaths, where there is significant evidence regarding interventions that make a difference. We will briefly describe the pattern of these factors in our community, the impact of each in terms of illness and death, but also in terms of impact on our services.

It should be noted that whilst we look at each individually there is data that shows that risky health behaviours interact and have a multiplicative rather than simply additive impact. That is, they have a greater effect together than the sum of each individual risk. For example, obesity and alcohol consumption which interact to increase risks of liver disease mortality to a greater extent than the sum of each individual risk [9].

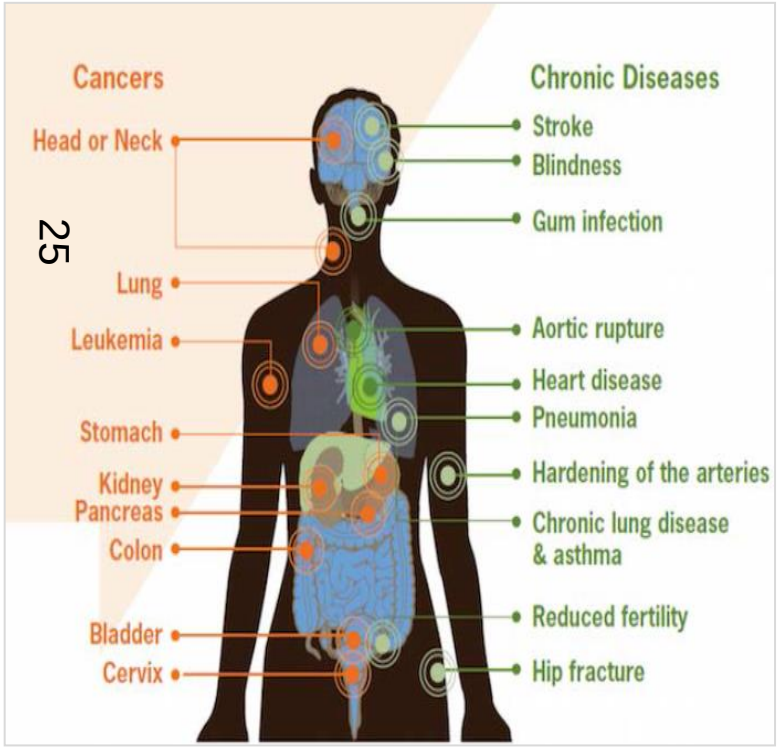
Or alcohol and smoking, which together are associated with a greater combined risk for cancer than the sum of the two individual effects [10]. This may be one reason why we see greater alcohol related harm in socioeconomically deprived groups compared to affluent groups, even when the level of alcohol consumption is held constant. It's because the more deprived groups are more likely to be engaging in multiple risky lifestyle behaviours.

Smoking

Smoking remains the biggest single lifestyle cause of preventable mortality and morbidity in the world. The Tobacco Control Plan for England states that it accounts for 1 in 6 of all deaths in England.

Its impact is seen on every organ of the body.

Figure 9: Health Effects of Tobacco Use



Source: CDC: Smoking & Tobacco Use - Health Effects of Tobacco Use

Nationally the prevalence of smoking is decreasing; 19% of people smoked in 2016 v 46% at its peak in 1976 and average daily consumption is also reducing; 11 cigarettes a day in 2016 from 16 in 1974.

Smoking is more prevalent in adult men (20% v 17%), more prevalent deprived communities (30% routine and manual v 11% professional) and more prevalent in those with less formal education (9% in those with degrees). Younger people are more likely to smoke (9255 16-34 v 11% >60). In children and young people, more girls smoke regularly and the major influence is smoking in the home [11].

Figure 10: Local Tobacco Profiles Annual Population Survey

2015/16	RBWM	England
Never smoked (APS*)	49.5%	48.6%
Adult current smokers prevalence (APS*)	13.0%	16.9%
Manual and routine smoking rate (APS*)	19.5%	26.5%
Current smokers aged 15 – 2014/15 (WAY Survey)	7.6%	8.2%
Smoking in residents with severe mental illness - 2014/15	31.7%	40.5%

Source: PHE: Local Tobacco Control Profiles for England

**APS – Annual Population Survey*

It is recognised that smoking has a profound impact on health inequalities. There is greater health inequality between smokers and people who have never smoked than between people of the same sex and smoking status but different social positions.

In both women and men, people who are the most deprived in our society who had never smoked had substantially better survival rates than smokers in even the highest social classes [12]. 85% of the observed inequalities between socioeconomic groups can be attributed to smoking [13].

Smoking - impact

In 2012-14, there were 275 smoking attributable deaths per 100,000 population in England. The rate in RBWM was 224 per 100,000, aged 35+.

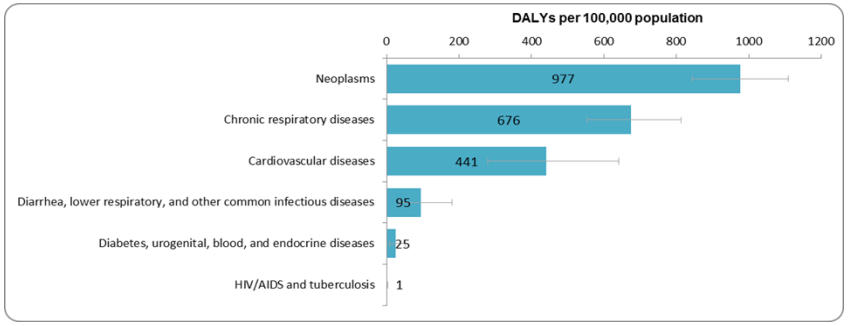
In 2012/14 551 deaths were attributed to smoking in RBWM. That's 3.5 deaths a week.

Disability adjusted life years (DALYs) are an important measure used in health care as they not only measure the number of years of life lost (early deaths) but also the number of years lived with disability – so give an assessment of the impact on the life of the individual affected and the impact on health and care service usage. This analysis is now available for the South East.

Smoking is the most significant single lifestyle factor that causes the highest number of DALYs lost both regionally and nationally. 9.1% of DALYs in the South East Region were attributable to smoking in 2013 (2,215 per 100,000 population).

Figure 11 shows the wide impact of tobacco in the South East [14]. The largest numbers of DALYs attributable to smoking in general causes were for cancers, chronic respiratory diseases and cardiovascular diseases.

Figure 11: DALYs attributable to smoking in South East England (2013)



Source: *Global Burden of Disease (GBD)*

If we look at data for specific clinical illnesses and the impact of smoking on each of these then we see a different pattern; smoking accounts for at least 56% of all chronic lung disease conditions, 70% of COPD and 80% of lung cancer [14].

23% of DALYs for neoplasms were attributable to smoking. Again, this was higher for certain cancers; 79% of DALYs for tracheal, bronchus and lung cancer, 54.1% lip and oral cavity cancer, 53% oesophageal cancer.

We know that smoking prevalence is greater in men and in the most deprived communities and its impact increases over time.

If we look at men aged 55-79, smoking is, as could be expected, the single largest cause of DALYS (accounting for 12 – 14%) in the most affluent areas. In the most deprived communities however smoking accounts for 19 – 21% of DALYS which translates into one in five. This is significantly more than in wealthier areas. A similar pattern is seen in women.

In a study which looked at chances of survival and smoking after 28 years, people in the lowest socioeconomic groups who had never smoked had substantially better survival rates (56% women and 36% of men) than smokers in the highest social classes (41% women and 24% men) [12].

Tobacco accounts for 90% of health inequalities

Smoking - impact

With the major impact on illness, it is not surprising that smoking is also responsible for significant care use both in primary and hospital settings. Tobacco use accounts for approximately 5.5% of the NHS budget.

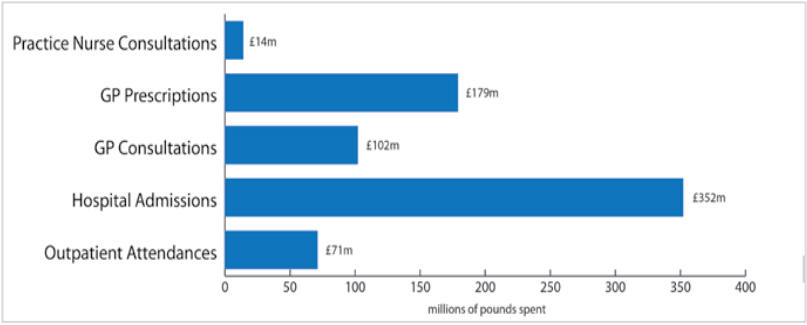
There were 1.7 million admissions in 2014/15 across the UK for conditions that could be caused by smoking, an increase of 22% from 2004/5. With 475,000 hospital admissions attributable to smoking in 2014/15, up from 452,000 in 2004/05. This represents 4% of all hospital admissions (6% of male admissions and 3% of females) [14,16].

23% of respiratory, 15% of cardiac and nearly 10% of Cancer admissions are attributable to smoking.

Individuals with mental health problems smoke more heavily than the general population, contributing to as much as 43% of tobacco consumption in the UK [16] and it is estimated 3 million UK adults with mental health disorders who are also smokers incur Total smoking-attributable costs of £2.34 billion .

A total of £719 million was spent treating smoking-related disease among people with mental health disorders of which £352m were due to hospital admissions, while other cases were treatments of cancer, cardiovascular disease and respiratory diseases [18].

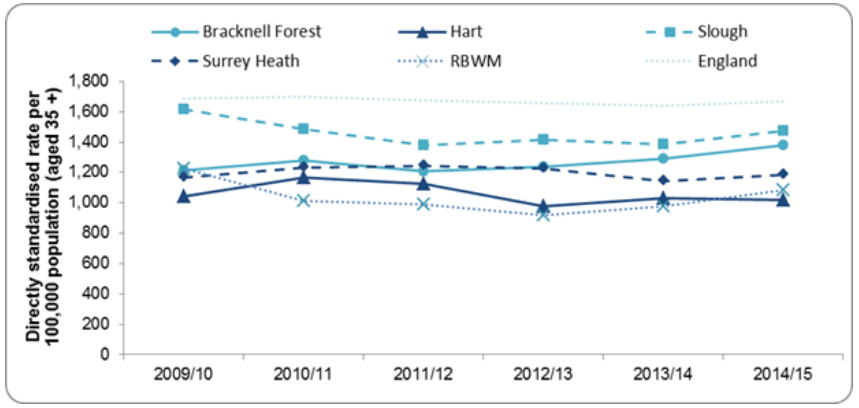
Figure 12: Costs due to smoking-related diseases among people with mental health conditions (2009/10)



Source: Ash: The Stolen Years, the mental health and smoking action report

Locally, in line with the lower prevalence of smoking (and our lower than average admissions in general) our rates of smoking related admissions are lower than the England average [15,17].

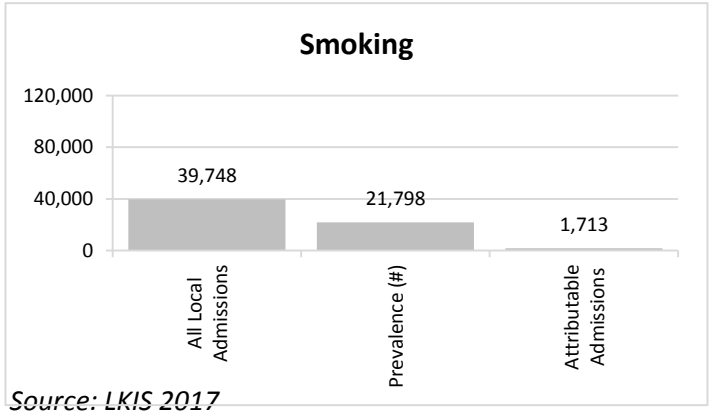
Figure 13: Smoking attributable hospital admissions in people aged 35 and over



Source: PHE: Local Tobacco Control Profiles for England

Though in RBWM it can be seen that over 1700 admissions a year are solely attributable to the effects of smoking [16].

Figure 14: Smoking figures



Source: LKIS 2017

Smoking - impact

The costs of smoking to the NHS and to the economy in general are well understood, however, there are also costs to the social care system, which are less well known [19].

Recent research, based on adults over 50, compared the care needs of current and former smokers with those of never smokers. The key findings were that whilst no difference could be seen in use of residential care (small sample size), smokers were more likely to have difficulties in the majority of activities of daily living and so were at double the risk of developing care needs. In just over half of the activities of daily living, ex-smokers also showed more difficulties.

The impact of smoking related ill health on the social care system, is estimated to be a cost of £1.4 billion every year, up from £1.1 billion in 2014. This is made up of £760 million in costs borne by local authorities, with a further £630 million being spent by those who have to self-fund their care.

Figure 15: Smoking Cessation figures

2015/16	Rates per 100,000 population (actual numbers)		
	Setting quit date	Successful quitters	Validated quitters (CO)
England	862	440	314
South East	674	375	271
RBWM	937 (1,105)	675 (796)	443 (522)

Source: Calculated figures from PHE: Local Tobacco Control Profiles for England and ONS 2015 Mid Year Estimates

Interventions - What Works

The biggest short-term savings opportunity lies in helping smokers who are in contact with the NHS to quit. The greatest long-term savings would come from preventing people from ever smoking altogether. Prevention of smoking requires strong partnership working including the promotion of smoke free environments and reducing counterfeit and illegal tobacco sales.

Smoking cessation services are widely available and the RBWM service continues to see more residents than the England average. In 2015/16, 937 per 100,000 set a quit date (v 862 England) and 675 per 100,000 reporting quitting at 4 weeks (v 440 England) [20].

Interventions - Local Gaps

Although we offer some support to patients within health care settings to give up smoking, we have still to maximise this approach.

Recently Berkshire Healthcare Foundation Trust have been proactive in ensuring that all mental health facilities are smoke free, with patients being offered nicotine replacement therapy. However all smokers should be identified during treatment and at minimum offered brief intervention and advice to promote smoking cessation as part of their treatment plans. Pregnant women should be screened via carbon monoxide screening and offered specialist support [20] as a matter of course [21].

For those unable or unwilling to stop smoking permanently then temporary abstinence supported by nicotine replacement medication will deliver harm reduction. Smokers having elective surgery are six times more likely to have a surgical site infection and so have lengthier post operative stays and recovery periods. Simply supporting abstinence prior to surgery can reduce this risk, improve outcomes and reduce costs associated with care .

Lifestyles – High blood pressure

Blood pressure is recorded with two numbers. The systolic pressure (higher number) is the force at which your heart pumps blood around your body. The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels. They are both measured in millimetres of mercury (mmHg).

As a general guide:

- high blood pressure is considered to be 140/90mmHg or higher
- ideal blood pressure is considered to be between 90/60mmHg and 120/80mmHg

High blood pressure is normally distributed in the population and the risk associated with increasing blood pressure is progressive, with each 2 mmHg rise in systolic blood pressure being associated with a 7% increased risk of death from ischaemic heart disease and a 10% increased risk of mortality from stroke.

Risk factors for high blood pressure

Overweight or obese
Poor diet: high salt & less than 5 a day fruit and vegetables
Low physical activity levels
High alcohol use
Smoker
Over the age of 65
Don't get much sleep or have disturbed sleep
African or Caribbean descent
Family history of high blood pressure

At least one quarter of adults (and more than half of those older than 60) have high blood pressure [22].

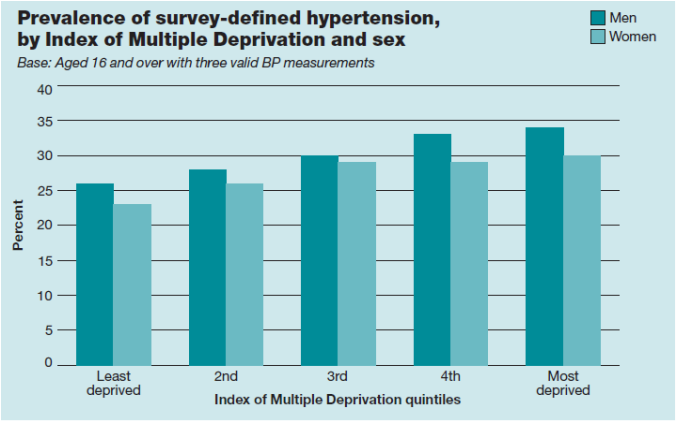
Over 24% of people in England are estimated to have high BP and it is one of the leading causes of premature death and disability in England. At least half of all heart attacks and strokes are associated with high BP and it is a major risk factor for chronic kidney disease, heart failure, stroke, myocardial infarction and vascular dementia.

Lowering blood pressure per se reduces risk for myocardial infarction by 20% - 25% [23].

High BP costs the NHS an estimated £2bn, while social care and productivity costs are likely to be much higher.

High BP is much more common in deprived communities. The Department of Health's 2010 'Health Survey for England' noted that prevalence increased from 26% of men and 23% of women in the least deprived fifth of the population to 34% and 30% respectively in the most deprived 20%.

Figure 16: Prevalence of hypertension by Index of Multiple Deprivation (IMD) and sex (2011)



Source: NHS Digital: Health Survey for England (2011)

High blood pressure

For every ten people diagnosed with high BP, seven remain undiagnosed and untreated - this is more than 5.5 million people in England. Those in more deprived communities are less likely to have high BP detected though with the introduction of the quality scheme this gap has reduced [24,25]. In addition we can see the percentage of those in treatment and also adequately controlled reduces with increasing deprivation [25].

Figure 17: High Blood Pressure

Income level	n	Aware (%)	Treated (%)	Controlled (%)
High	6263	49.0	46.7	19.0
Upper Middle	18123	52.5	48.3	15.6
Lower Middle	23269	43.6	36.9	9.9
Low	10185	40.8	31.7	12.7
Total	57840	46.5	40.6	13.2

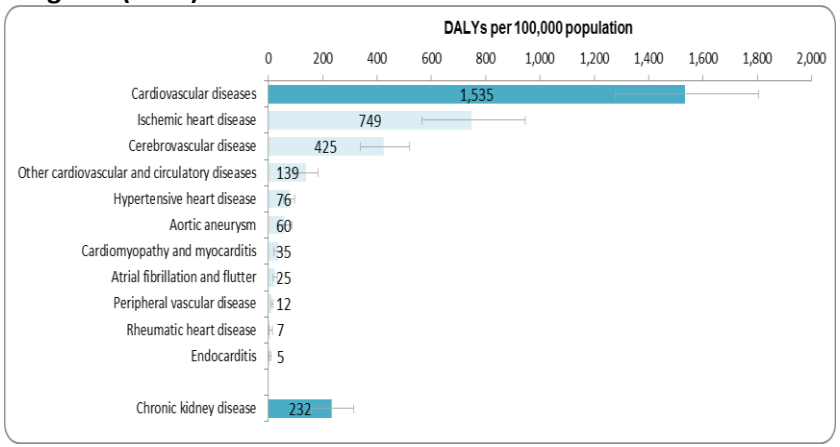
Source: PHE: Health matters: combating high blood pressure

13.1% of all deaths in South East England were attributable to high blood pressure [14].

7.2% of all disability-adjusted life years (DALYs) in the South East Region were attributable to high blood pressure in 2013 (1,766 per 100,000 population).

The largest number of DALYs attributable to high blood pressure were for cardiovascular diseases and chronic kidney disease. Within the cardiovascular diseases group, ischemic heart disease and cerebrovascular disease had the largest number of DALYs attributable to high blood pressure.

Figure 18: DALYs attributable to High Blood Pressure in South East England (2013)



Source: Global Burden of Disease (GBD)

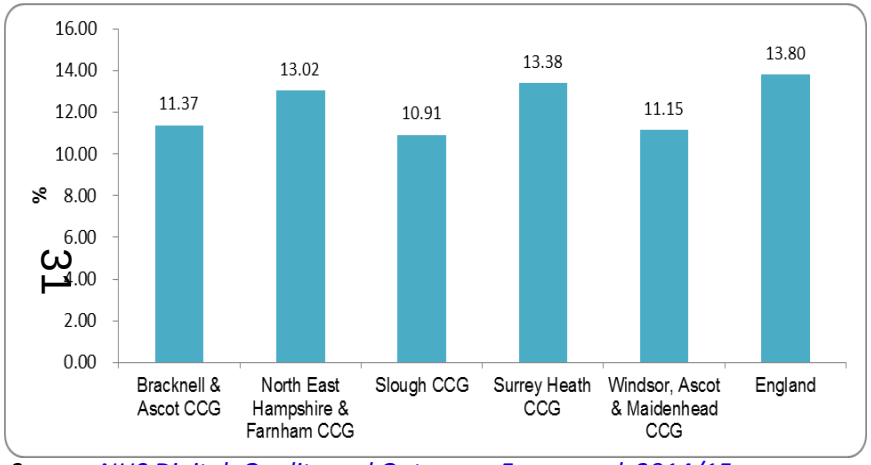
For all cardiovascular events high systolic BP accounts for 43% DALYs; 1,535 per 100,000.

In reviewing premature deaths (deaths before age 75)RBWM fares well with regards to heart disease and stroke being ranked 14th out of 150 authorities, with 59 deaths per 100,000 (2013-2015) and ranked 10th out of 15 in comparison to similar local authority areas [26].

High blood pressure - Impact

Across Windsor and Maidenhead (WAM) CCG, there are estimated to be 31,000 people with high blood pressure, with 17,3000 currently being treated. This means that there are 14,000 people unaware of their high BP.

Figure 19: High Blood Pressure Prevalence by CCG



Source: NHS Digital: Quality and Outcomes Framework 2014/15

In addition, of those that are being treated by their GP not all are achieving target BP control: 555 patients[27].

Locally it is possible to measure the impact high BP has on disease and deaths but we can also estimate the impact of reducing high BP by 10 mm Hg in those with this condition in WAM CCG. Every 10 mmHg reduction in systolic BP reduces the risk of major cardiovascular events by 20%.

Thus it is possible to calculate the impact of this improvement on Cardiovascular disease locally.

Figure 20:

Condition	Current number of events	Current number if treated	Reduction in number of deaths
Stroke	172	126	46
Heart failure	117	84	33
Cardiovascular disease	293	243	50
Deaths	1,119	974	135

Source: British Heart Foundation: How can we do better?

However, treatment is not simply reliant on medication. Across the long term conditions, more than half of all patients do not take their medication as prescribed. Modification of lifestyle factors can have a major impact on high BP with no side effects (and additional positive health impacts).

Studies show this impact and in one, the clear results were that in those who changed lifestyle behaviour for a period of 10 weeks a significant percentage achieved a 10 mmHg reduction in BP: [28]

- Weight reduction 40%
- Increased physical activity 30%
- More relaxation 25%
- Reduced alcohol intake 30%
- Reduced salt intake 25%

Advice given during the consultation for high BP is likely to be acted upon. Compared with those who did not recall being given advice, adults with high BP who recalled being given advice were more likely to change their eating habits, reduce salt, exercise and reduce alcohol consumption [29].

Indeed lifestyle modification is indicated for all patients with high BP, regardless of drug therapy, because it may reduce or even abolish the need for antihypertensive drugs.

High blood pressure - Intervention

High blood pressure management in the community from a long term perspective is focussed on reducing the risk factors within the population; obesity, physical inactivity, smoking and high salt intake. However in the short and medium term there are clear programmes that can reduce the impact of high BP [21].

A clear priority is to reduce the number of patients with known high blood pressure for whom treatment is not adequate. This can be achieved by annual audits of GP practice registers to identify affected patients and develop the role of pharmacists and other professionals to maximise achievement of treatment goals through lifestyle changes and drug therapy. A 20% improvement in blood pressure control can be cost saving within 5 years.

Another key priority is the wider use of self-monitoring by patients. They can be encouraged to develop the skills and understanding to monitor their blood pressure in their daily lives to minimise false readings.

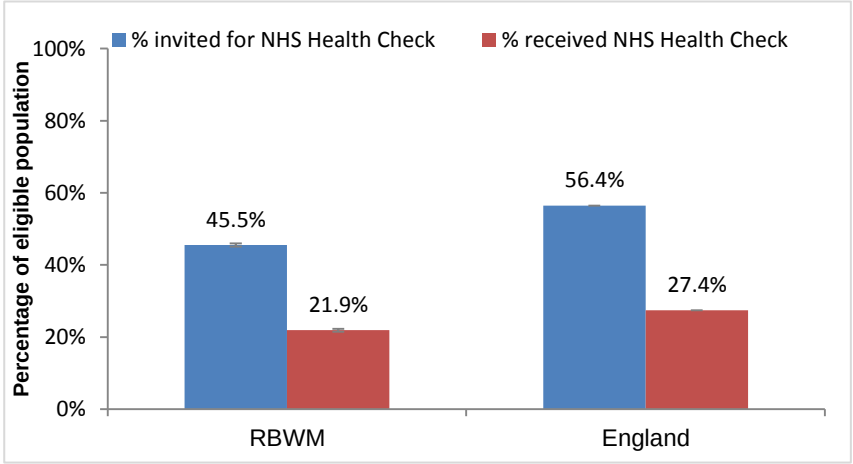
Of course it is also key to identify residents in the community who are unaware that they have high blood pressure. Programmes such as NHS Healthchecks identify those with high blood pressure and support them to make lifestyle changes or provide them with medical management will help to prevent longer term damage and reduce demands for more specialist health and social care.

Figure: 21 The number of people who were invited/received an NHS Health Check from 1st April 2013 to 31st March 2016.

	Invited for NHS Health Check (2013/14 to 2015/16)		Received NHS Health Check (2013/14 to 2015/16)	
	No. of people	% of eligible population	No. of people	% of eligible population
RBWM	20,122	45.5%	9,674	21.9%
England	8,792,518	56.4%	4,271,889	27.4%

This is cumulative, as part of the 5-year cycle of the programme.

Figure: 22 Percentage of eligible population who were invited/received an NHS Health Check from 1st April 2013 to 31st March 2016.



Source: PHOF 2017

Lifestyle - Alcohol

It is known that alcohol is harmful to health and the CMO guidelines to reduce risk state that it is safest for men and women not to drink more than 14 units a week on a regular basis. These should be spread over 3 or more days [29,30].

Alcohol is measured in units - one unit is 10ml or 8g of pure alcohol. Since drinks differ in the proportion of alcohol the number of units varies. Alcohol drinks are often described as alcohol by volume percentage e.g. some wines are 11% ABV - this means that a 1 litre bottle contains 11 units .

Therefore one 125ml glass contains 1.64units, a 175 ml glass has 1.9 units and a 250 ml glass has 2.5 units.
A pint of 4% beer has 2.3 units [30].

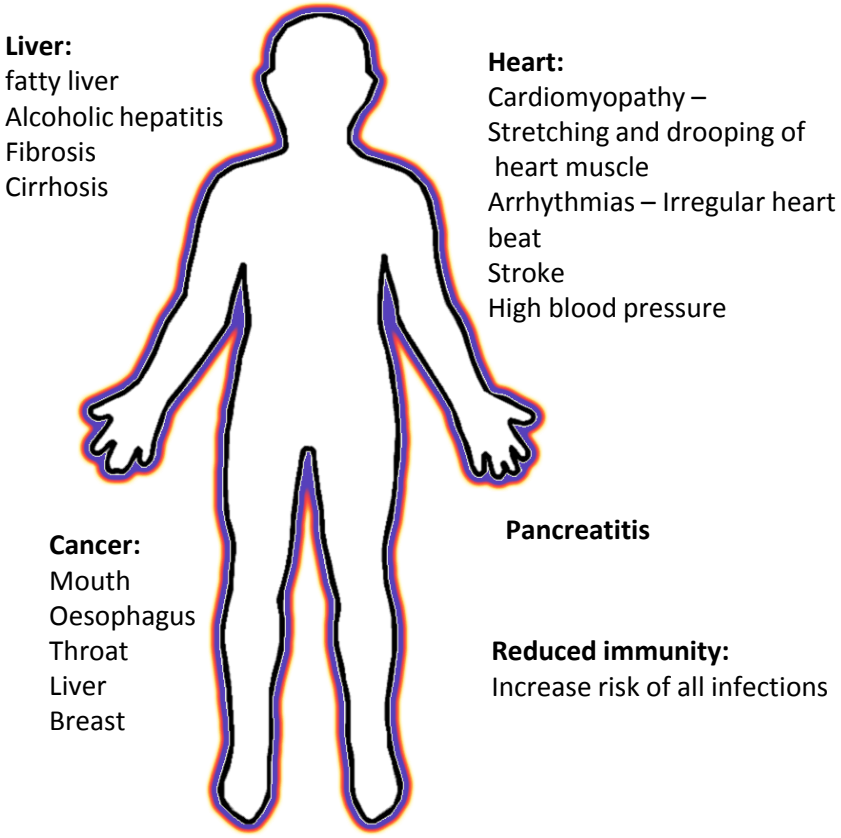
To keep to safe limits, an adult in a week should not drink more than

Figure 23: Alcohol limits and unit guidelines

Source: *Drinkaware.co.uk: Alcohol limits and unit guidelines*

Alcohol is the leading cause of death among 15 to 49 year olds and heavy alcohol use has been identified as a cause of more than 200 health conditions [31].

Figure 24: Effects of Alcohol on the body



Alcohol - Impact

The burden of health, social and economic alcohol-related harm is substantial, with estimates placing the annual cost to be between 1.3% and 2.7% of annual GDP.

Currently over 10 million people are drinking at levels that increase their risk of harm to their health.

- 5% of the heaviest drinkers account for one third of all alcohol consumed

Alcohol caused more years of life lost to the workforce than from the 10 most common cancers combined. in 2015 there were 167,000 years of working life lost [32].

Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability.

With increasing consumption, there is increasing risk. For example, all alcohol-related cancers exhibit this relationship [33].

Figure 25: Alcohol Harm Map

Condition		
	3 units of alcohol per day	6 units of alcohol per day
Liver disease	3 times	7 times
Mouth cancer	2.5 times	5 times
Throat cancer	1.8 times	3 times
Breast cancer	1.3 times	2 times
Hypertension	1.7 times	3 times
Ischaemic stroke	No change	2 times
Haemorrhagic stroke	1.8 times	3 times
Pancreatitis	1.3 times	2 times

Source: Alcohol Concern: Alcohol Harm Map

The health and social harm caused by alcohol is determined by:

- the volume of alcohol consumed
- the frequency of drinking occasions
- the quality of alcohol consumed

In addition a number of individual risk factors moderate alcohol-related harm, such as [34]:

- age: children and young people are more vulnerable
- gender: women are more vulnerable
- familial risk factors: exposure to abuse and neglect as a child and a family history of alcohol use disorders (AUD)

Also in the English population, rates of alcohol-specific and related mortality increase as levels of deprivation increase and alcohol-related liver disease is strongly related to the socioeconomic gradient [32].

This despite the fact that lower socioeconomic groups often report lower levels of average consumption. This gives rise to what has been termed the 'alcohol harm paradox' whereby disadvantaged populations who drink the same or lower levels of alcohol, experience greater alcohol-related harm than more affluent populations. The reason for this is not known but may be due to a greater impact of alcohol due to lower resilience: possible higher rates of binge drinking or poorer access to services

Public Health England has estimated the increase on average life expectancy for men and women if all alcohol-related deaths were prevented. Nationally, this would be 12 months for men and 5.6 months for women (Source: Alcohol Concern, Alcohol Harm Map).

Alcohol - Impact

Figure 26:

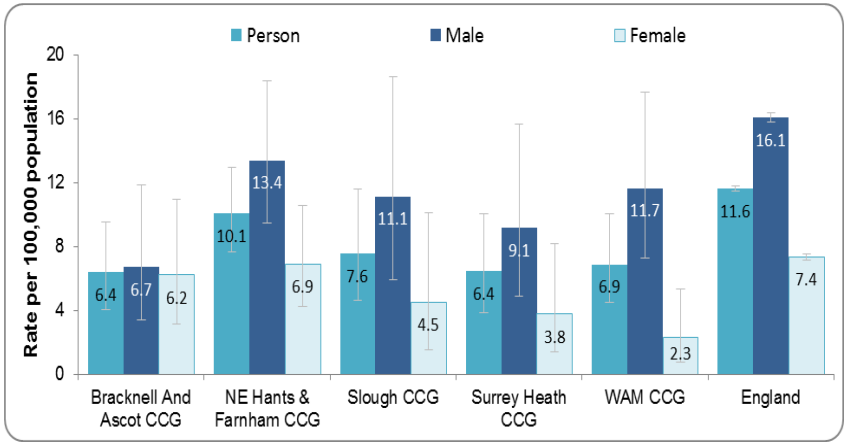
Cause of death	No. of deaths	Average age at death
All causes (England & Wales	501,424	77.6
All alcohol-specific causes	4,329	54.3
Mental and behavioural disorders due to use of alcohol	489	57.5
Toxic effects of alcohol (unspecified)	395	42.4
Accidental poisoning by exposure to alcohol	369	49.1

9% of all early death and poor health (DALYs) in the South East Region were attributable to alcohol use in 2013 (965 per 100,000 population)[12].

The largest number of DALYs attributable to alcohol use were for cancers, cirrhosis, mental and substance use disorders and unintentional injuries.

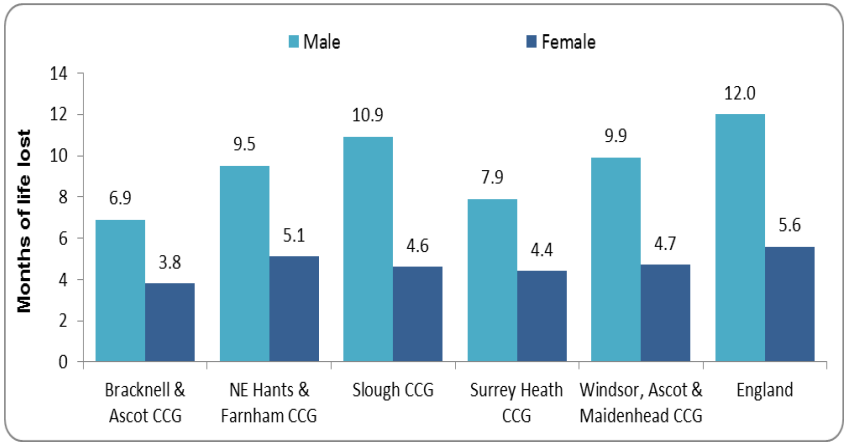
In 2012-14, 153 people died from alcohol-specific conditions in the Frimley Heath STP footprint, 75% of these were men. The rate of deaths per 100,000 population varied in the area but was 6.9 per 100,000 population in Windsor and Maidenhead CCG[27].

Figure 27: Alcohol-specific mortality per 100,000 population (2012-14)



If we look at the months of life lost due to alcohol locally then we can see a similar picture where men in RBWM lose 6.9 months – (Fig. 28)

Figure 28: Months of life lost due to alcohol (2012-14)



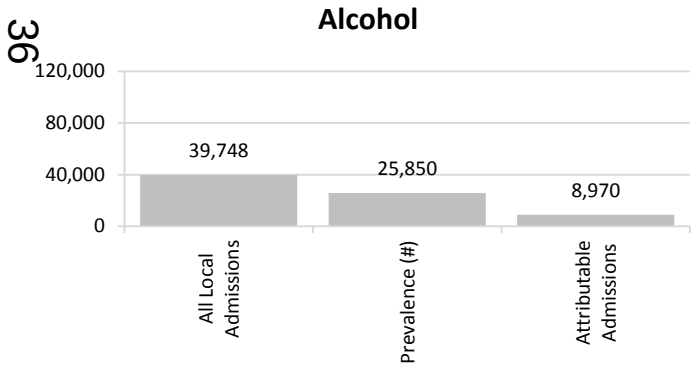
Source: Public Health England (2016); Local Alcohol Profiles for England

Alcohol - Interventions

With such an impact on early death and illness alcohol has a significant impact on hospital use. Nationally alcohol related and attributable admissions have been rising: According to the broad measure, admissions for cardiovascular disease account for almost half of all alcohol-related admissions in 2014/15. For the narrow measure, hospital admissions for cancer represent the most common condition for admissions accounting for 23% of all alcohol-related conditions.

Within RBWM there are over 25,000 residents who consume alcohol and just under 9,000 admissions annually due to alcohol - not unexpected since alcohol accounts for 3% of all NHS costs [16].

Figure 29: Alcohol figures



Source: LKIS 2017

The impact of alcohol in our society is driven by a variety of factors including limited awareness of health risks from alcohol consumption, addictive nature of alcohol, failure of health professionals to address alcohol as a causal factor in patients' ill health and lack of local system join-up [34,31].

The public health ambition for alcohol is to reduce excessive alcohol consumption and therefore the associated burden on NHS and local authorities and the wider society [31].
This will result in:

- A reduction in alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs
- A reduction in the burden on NHS, police and social care services from high volume service users
- A reduction in the impact of parental alcohol misuse on children

Much of the work on addressing alcohol needs to be done at a national level: continued media and awareness raising on safe alcohol consumption, national policy changes in minimum pricing, taxation and licensing of alcohol.

However there are further key actions that can be taken forward locally including:
Screening patients throughout health care settings to deliver a brief intervention, including giving advice to raise knowledge on safe alcohol levels, potential harm and ways to reduce alcohol intake [21].

The development of alcohol care teams, to support patients admitted to hospital through alcohol with specialised support , coupled with assertive outreach and case management for patients and residents in whom alcohol is causing repeated hospital admissions or use of other services.

Lifestyle - Physical Activity

Physical Activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure

Physical activity levels can be measured either through asking people to report how much exercise they do, or by objectively measuring the amount of exercise a person is doing. Most reports use self reported activity.

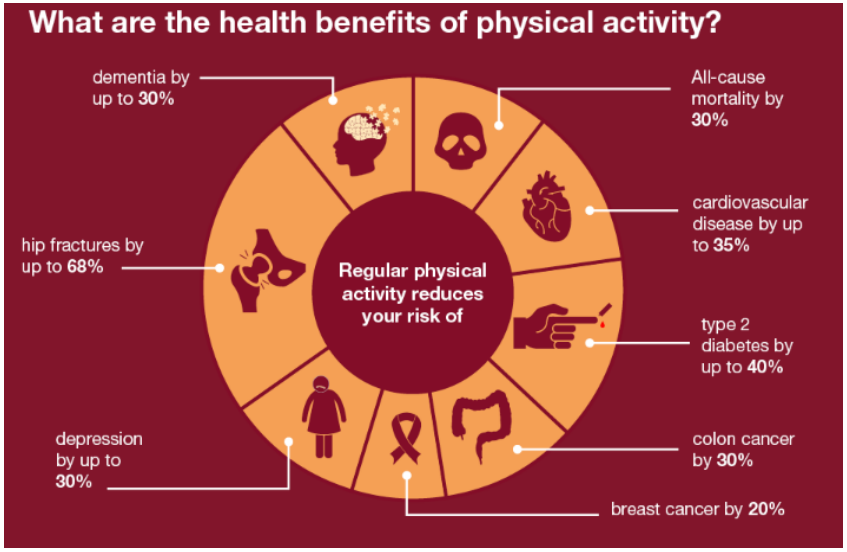
Physical inactivity is defined as less than 30 minutes of physical activity a week. The Chief Medical Officer guidelines for physical activity not only suggest recommended activity levels but also recommend the amount of time in which we are sedentary, and encourage weight bearing exercise [35] .

Figure 30: Adult activity recommendation

Source: Health matters: getting every adult active every day

The link between physical inactivity and obesity is well known, but physical activity is not just a way of addressing obesity.
Low physical activity is one of the top 10 causes of disease and disability in England.

Figure 31: Health benefits of physical activity



Source: Health matters: getting every adult active every day

UK studies have estimated that around 1% of cancers in the UK (around 3,400 cases every year) are linked to people doing less than the recommended 150 minutes of physical activity each week.

1 in 8 women in the UK are at risk of developing breast cancer at some point in their lives. By being active every day they could reduce their risk by up to 20% [36].

Physical activity is also important for people diagnosed with cancer and cancer survivors. Not only increasing ability to manage recovery but also reducing rate of recurrence in key cancers.

Macmillan has estimated that in the 2 million cancer survivors in the UK - 1.6 million do not meet the recommended levels of physically active [37].

Physical Activity

One in four women and 1 in 5 men are inactive. Only 24% of women and 34% of men do muscle strengthening exercises twice a week. Men are more likely to be sedentary for more than 6 hours a Day [36].

Levels of activity are reducing. People in the UK are around 20% less active now than in the 1960s. This pattern is also seen in children and young people with the proportion who met the weekly physical activity guidelines falling between 2008 and 2012 [36].

People living in in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas [38].

South East England has the highest proportion of both men and women meeting recommended levels of physical activity, while North West England has the lowest.

Age

Physical activity declines with age to the extent that by 75 years only 1 in 10 men and 1 in 20 women are sufficiently active for good health.

Disability

Disabled people are half as likely as non-disabled people to be active. Only 1 in 4 people with learning difficulties take part in physical activity each month, compared to over half of people without a disability.

Race

Only 11% of Bangladeshi women and 26% of and Bangladeshi men are sufficiently active for good health, compared with 25% of women and 37% men in the general population.

Sex

Men are more active than women in virtually every age group, with 6 in 10 women not participating in sport or physical activity [38].

Sexual orientation and Gender Identity

Over a third of lesbian, gay, bisexual and transgender youth do not feel they can be open about their gender identity in a sports club [26].

Lack of physical activity is costing the UK an estimated £7.4 billion a year, including £0.9 billion to the NHS alone [36].

Inactivity causes 9% (range 5·1–12·5) of premature mortality, or more than 5·3 million of the 57 million deaths that occurred worldwide in 2008 [14].

Physical inactivity in developed countries is responsible for :
an estimated:

22-23% of CHD
16-17% of colon cancer
15% of diabetes
2-13% of strokes and
1% of breast cancer [16]

It is estimated that physical inactivity contributes to almost one in ten premature deaths (based on life expectancy estimates for world regions) from coronary heart disease (CHD) and one in six deaths from any cause.

Persuading inactive people (those doing less than 30 minutes per week) to become more active could prevent:
- one in ten cases of stroke and heart disease in the UK and
- one in six deaths from any cause [38].

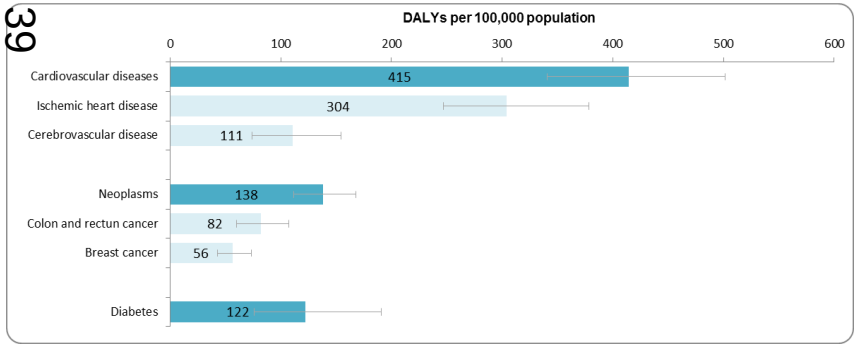
Physical Activity - Interventions

In the UK the Global Burden of Diseases found physical inactivity to be the fourth most important risk factor in the UK for limiting illness and early death [14].

In the South East, 2.8% of all disability-adjusted life years (DALYs) in the South East Region were attributable to low physical activity in 2013 (675 per 100,000 population) [12].

The largest number of DALYs attributable to low physical activity were for cardiovascular diseases, neoplasms and diabetes

Figure 32: DALYs attributable to low physical activity in South East England (2013)



Source: Global Burden of Disease (GBD)

The Health Impact of Physical inactivity (HIPI) tool quantifies the impact of physical inactivity for people aged 40 – 79. Within RBWM each year if 100% of this group were active then:

- 82 annual deaths (40-79) could be prevented
- 18 out of 92 annual cases of breast cancer could be averted
- 719 new cases of diabetes could be prevented

A body of evidence now exists that links physical inactivity to increasing risk of hospital admission - emergency and other use of health and social care [39].

In Scotland it was shown that minutes of moderate-to-vigorous physical activity (MVPA) per day predicted subsequent numbers of prescriptions: those with less than 25 minutes of moderate to vigorous physical activity per day had 50 per cent more prescriptions over the following four to five years.

Similarly the number of steps taken per day and MVPA also predicted unplanned hospital admissions. Those in the most active third of the sample were at half the risk of emergency hospital admissions than those in the low active group [40].

The solution is clear: Everybody needs to become more active, every day [36]. Physical activity does not need to be strenuous, it can be 30 minutes of brisk walking, a swim, gardening or dancing .

Each ten minute bout that gets the heart rate up has a health benefit. Being active is not just about moving more, we need to build our muscle strength and skills.

In addition adults need twice a week muscle strength and stability improvements which helps prevent the development of musculoskeletal disease.

A number of common characteristics are apparent in effective action to increase population levels of physical activity. These include two common factors: persistence and collaboration [40].

Four areas of action are identified by Public Health England, at national and local level.

- active society: changing our attitude to physical activity
- moving professionals: professionals across all sectors promoting activity in their work
- active lives: creating environments that make activity easy
- moving at scale: scaling up interventions that make us active

Lifestyle - Obesity

Being overweight or obese is when a person has more body fat than is optimally healthy. Poor diet and physical inactivity are causal factors of obesity with excess weight being caused by an imbalance between energy consumed and energy expended.

In the UK obesity is estimated to affect around one in every four adults and around one in every five children aged 10 to 11.

The annual costs associated with obesity to the NHS and social care systems are estimated to be £6.1 billion a year and £352 million respectively [41].

For most adults, BMI measures are :

- healthy weight 18.5 to 24.9 kg/m_2
- overweight 25 to 29.9 kg/m_2
- obese 30 to 39.9 kg/m_2
- severely obese 40 or above kg/m_2

Another simple measure of excess fat is waist circumference. Normal waist size values are for men - 94cm (37in) or more
For women - 80cm (31.5in). If these measures increase an individual is more likely to develop obesity-related health problems.

Obesity prevalence increased steeply between 1993 and 2000. Rates of obesity and overweight were similar in 2013 to recent years. *Health Survey for England 2013* [41].

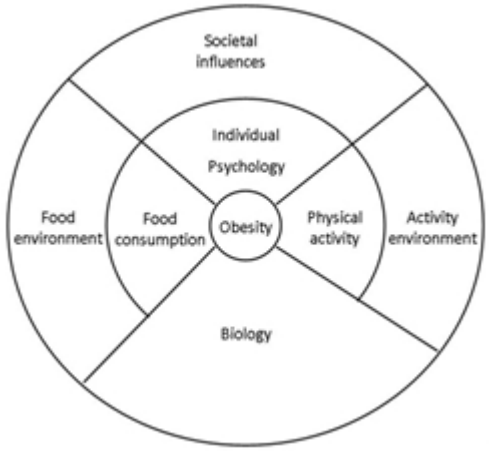
Mortality

9.0% of all deaths in South East England were attributable to a high body-mass index (GBD2013) . This was the 3rd most important risk after smoking and high blood pressure (12).
The impact of weight on life expectancy is linked to the levels of excess weight.

People with a BMI of 22 – 25 kg/m_2 have the best life expectancy:
obese individuals live 2 – 4 years less
People with BMI of over 40 live 8 – 10 years less [42]

Increased mortality is as a result of higher rates of cardiovascular disease, high BP and type 2 diabetes and hormone sensitive cancer - e.g. breast .

Figure 33: Foresight Obesity Systems Map (2007)

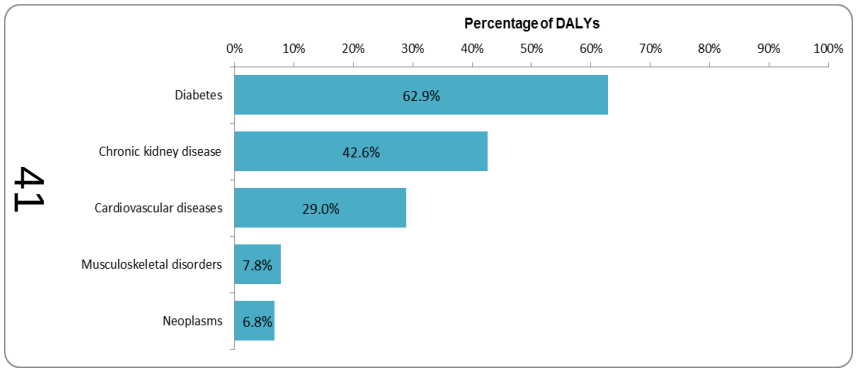


Source: Foresight Systems Map (2007)

Obesity – local impact

Obesity causes 9% of all DALYs lost in the South East of England, with most overall impact being seen through cardiovascular disease and diabetes. But its impact as a cause of diabetes (63%), chronic kidney disease and cardiovascular disease due to high BP (56%) is very stark [14].

Figure 34: Percentage of DALYs attributable to High BMI in South East England by cause (2013)



Source: Global Burden of Disease (GBD)

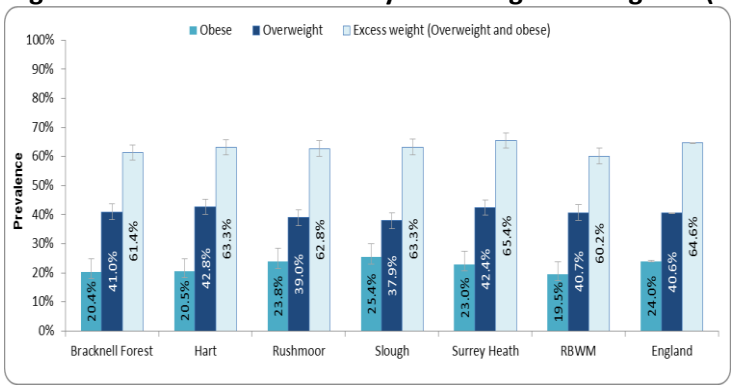
Obesity levels in the population vary with a variety of factors e.g. obesity levels increase until late middle age and then reduce in old age. More women in communities with higher deprivation are obese (NICE guidelines 2014).

Women from the higher socioeconomic groups have the lowest prevalence of obesity while those in the lowest groups consistently have the highest prevalence of obesity [42,43]. This is not seen in men, though for both men and women obesity is significantly reduced in those with a degree or equivalent.

Prevalence of obesity is highest in women from Black African, Black Caribbean and Pakistani ethnic groups.

Locally in RBWM Forest we can see that we are below the national average with regards to obesity levels, however we exceed the national average for percentage of residents who are overweight. Whilst obesity has more adverse health effects, maximum life expectancy is seen with a normal BMI.

Figure 35: Prevalence of obesity and being overweight in (2012-14)



Source: Active People Survey (2012-14)

In our children the figures are a concern. In RBWM in 2015/16 17.9% of children in reception were measured as overweight or obese, rising to 25.8% in year 6 (England figures were higher at 22.1% and 34.2% respectively).

We know that obesity is linked to health conditions and so impacts on hospital admissions. We would therefore expect that with our lower rates of obesity, this would have less of an impact on our adult hospital admissions. However even with our lower than average obesity levels RBWM still have just over 4,700 admissions being attributable to obesity [16].

Obesity - Interventions

Interventions to reduce obesity are less visible and accepted than others such as smoking cessation. There are a number of ways that can be adopted to reduce the burden of obesity for the individual and the community.

Our environments tend to promote obesity: encouraging high calorie food intake and physical inactivity. Local government partners, employers and communities can work together to change this. Promoting active travel and ensuring healthy food options in work are two examples of work to address our environment.

In addition we need to ensure our weight management services are evidence based and cost effective. However the first step is for professionals to consistently raise the issue of weight at every opportunity. There is evidence that professionals believe programmes to have no lasting impact. However the evidence from published research is that interventions do work, with community based approaches being more effective than those based in primary care (44). Primary care can increase the effectiveness of community based approaches through discussion and referral. People referred via primary care had greater weight loss [45] - 50%, but even just mentioning weight loss as part of a consultation results in weight loss still seen at 2 years [45].

A brief intervention, resulting in 1.5 kg weight loss, delivered once a year to all eligible people visiting their GP, could halve the prevalence of obesity by 2035 (Jebb 2017).

One other reason given for reluctance to refer is the belief that impact is short lived, whilst weight does gradually increase weight loss is still seen at 2 years and crucially even in patients who regain their weight the incidence of diabetes is significantly reduced at 10 years - the impact of the weight loss outlives the actual weight loss [47].

Furthermore Health professionals do not routinely address weight loss issues as some voice concern about the impact of the topic on the clinical relationship. However research on patients receiving weight loss advice showed that less than 2% found it to be unacceptable or unhelpful and over 40% very helpful. Moreover 77% accepted the referrals to weight management services with nearly 50% completing the course [47].

It should be remembered that weight management interventions aim to have lifelong benefits. In Berkshire in the second year of a locally developed intervention, Eat for Health, 529 people have attended courses with more than 50% losing more than 3% of their original body weight. 197 people with high BP attended and 55 (28%) lost weight with a resultant return to normal levels in their BP, needing no on-going medication and achieving significant on going health benefits.

References

- 1 *A brief history of life expectancy in Britain* by Tim Lambert
- 2 Statistical bulletin : Avoidable mortality in England and Wales: 2014
- 3 LOCAL
- 4 11 Source: Buck, D et al (2012)*; Clustering of unhealthy behaviours over time: Implications for policy and practice; The King's Fund*
- 5 Purdey S[1], Huntley A. Predicting and preventing avoidable hospital R Coll Physicians Edinb 2013; 43:340–4
- 6. Holly E Sydell, Ph *Understanding poor health behaviours as predictors of different types of hospital admission in older people: findings from the Hertfordshire Cohort Study*D,[1] Leo D Westbury, MSc, Shirley J Simmonds, MSc, Sian Robinson, PhD, Professor of Human Nutrition, Cyrus Cooper, DM FRCP FMedSci, Professor of Rheumatology, Director,[1,2,3] and Avan Aihie Sayer, PhD FRCP, Professor of Geriatric Medicine[1,2,4,5,6]
- 7 *Effects of self-care behaviours on medical utilization of the elderly with chronic diseases - A representative sample study*.
- Chen IH[1], Chi MJ[2].
- 8 CRUK website - lifestyle impacts
- 9 Hart CL, Morrison DS, Batty GD, Mitchell RJ, Davey Smith G. *Effect of body mass index and alcohol consumption on liver disease: analysis of data from two prospective cohort studies*. BMJ. 2010;340:c1240
- 10 Tuyns AJ, Esteve J, Raymond L, Berrino F, Benhamou E, Blanchet F, et al*. Cancer of the larynx/hypopharynx, tobacco and alcohol: IARC International Case–control Study in Turin and Varese (Italy), Zaragoza and Navarra (Spain), Geneva (Switzerland) and Calvados (France)*. Int J Cancer. 1988;41:483–91
- 11 NHS digital report on smoking cessation services
- 12 *Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study* BMJ 2009; 338 doi: http://dx.doi.org/10.1136/bmj.b480 (Published 18 February 2009) Cite this as: BMJ 2009;338:b480 Laurence Gruer, Carole L Hart, David S Gordon, Graham C M Watt
- 13 Law M, Morris J. *Why is mortality higher in poorer areas and in more northern areas in England and Wales?* J Epidemiol Community Health1998;52:344-52
- 14 Global Burden Of Disease 2015
- 15 Berkshire shared service report on lifestyle and DALYS
- *16 PHE attributable admissions analysis 2106 KIT*
- *17 PHOF outcomes*
- 18 Tobacco Control (Wu et al, 2014)
- 19 *The Cost of Smoking to the Social Care System in England* January 2017, ASH in 2014 Carole L Hart, research fellow, David S Gordon, Graham C M Watt,
- 20 Local tobacco profiles and Berkshire contract data
- 21 PHE menu of interventions
- 22 British Hypertension Society

- 23 *Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis* Dena Ettehad,Connor A Emdin,Amit Kiran,Simon G Anderson,Thomas Callender,Jonathan Emberson, Prof John Chalmers,Prof Anthony Rodgers, Prof Kazem Rahimi, http://dx.doi.org/10.1016/S0140-6736(15)01225-8
- 24 *Effect of social deprivation on blood pressure monitoring and control in England: a survey of data from the quality and outcomes framework* Mark Ashworth,Jibby Medina,, Myfanwy Morgan, *BMJ 2008;337:a2030*
- 25 Prevalence, awareness, treatment, and control of hypertension in rural and urban communities in high-, middle-, and low-income countries CK Chow, KK Teo, S Rangarajan, S Islam, R Gupta… JAMA. 2013;310(9):959-968. doi:10.1001/jama.2013.184182
- 26 PHE longer lives
- 27 British Heart foundation : how can we do better CCG profile 2016
- *28 Lifestyle modifications to lower or control high blood pressure: is advice associated with action? The behavioural risk factor surveillance survey*. Viera AJ[1], Kshirsagar AV, Hinderliter AL.
- 29 UK CMO guidelines on alcohol intake 2016
- 30 Drinkaware.co.uk
- 31 The Public Health Burden Of Alcohol: Evidence Review
- 32 Bagnardi V, Rota M, Botteri E, Tramacere I, Islami F, Fedirko V, et al. *Alcohol consumption and site specific cancer risk: a comprehensive dose-response meta-analysis*. Br J Cancer. 2015;112:580–93
- 33 National Cancer Institute
- 34 Global status report on alcohol and health World Health Organization; 2014
- 35 Health matters: getting every adult active every day July 2016
- 36 Everybody Active Everyday PHE UK
- 37 Macmillan UK cancer and physical activity
- 38 *Physical Activity Statistics 2015 British Heart Foundation Centre on Population Approaches for Non-Communicable Disease Prevention.* Nuffield Department of Population Health, University of Oxford
- 39 *Disease activity and low physical activity associate with number of hospital admissions and length of hospitalisation in patients with rheumatoid arthritis* George S Metsios Antonios Stavropoulos-Kalinoglou, Gareth J Treharne, Alan M Nevill, Aamer Sandoo, Vasileios F Panoulas, Tracey E Toms, Yiannis Koutedakis and George D Kitas.
- 40 *Objectively Assessed Physical Activity and Subsequent Health Service Use of UK Adults Aged 70 and Over: A Four to Five Year Follow Up Study* Bethany Simmonds , *Fox, Davies, Powen Ku, Gray et al
- 41 HSCIC Health survey England 2013
- 42 NOO : Obesity And Health Matters 2016
- 43 General household survey 2014
- 44 *Meta analysis of weight intervention* Hartmann-Boyce, Johns, Jebb, Summerbell, Aveyard. Obes Rev. 2014 Nov; 15 (11):920-32
- 45 Jebb et al Lancet. 2011;378 (9801): 1485-92
- 46 DPP. Lancet, 14 (2009), pp. 1677–1686
- 47 *Ettehad et al 2016: http://dx.doi.org/10.1016/S0140-6736(15)01225-8 Data -NHS digital 2015

Partnership Boards across RBWM

Building the model for change

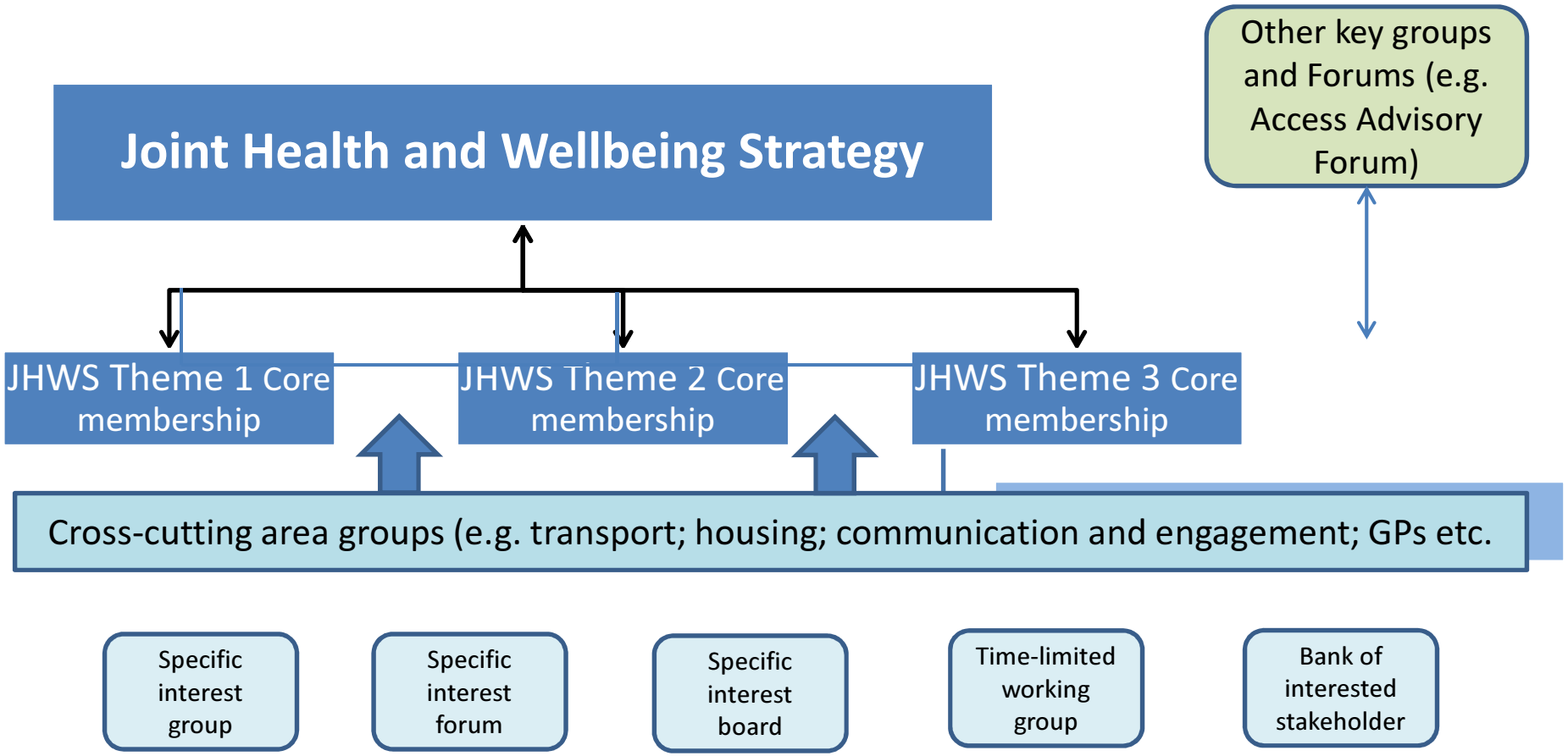
Teresa Salami- Oru, Consultant in Public Health/ Service Leader

Purpose of a revised model

To develop a sustainable model that:

- Ensures greater capture of stakeholder voice.
- Refocuses the resources of the boards on delivering the required actions to achieve the Joint Health and Wellbeing Strategy outcomes.
- Supports the assessment and monitoring of the performance scorecard for the Strategy.

Proposed Model



Timetable of Activity

Date	Activity
Feb 2017	Consultation with current Partnership Board Chairs
May 2017	Agree review approach and papers
May 2017	Circulate briefing note and slide deck for Chairs to discuss at their next Partnership Board meetings
May – Aug 2017	Discussions led by Chairs at the Partnership Board meetings to gather thoughts and insights from each Board to develop the new model
Aug – Oct 2017	Commissioning & Strategy leads to attend Partnership Board meetings to gather feedback and address questions
Sept – Oct 2017	Ghost Boards developed to model new arrangements (three new Boards in line with JWHB priorities and themes)
By Mar 2018	New arrangements in place

Progress Update- July

- Broad support for the aims of the proposal overall as felt to support delivery of the Strategy.
- Groups would like to continue to meet in some form until at least April 2018.
- Keenness to see current Chairs support the development of the new strategic boards to ensure focus and momentum of current Boards is maintained.
- Continued consideration needed about how to include the voice of service users and carers.
- Project group meetings being held to review delivery and plan next steps.

Next Steps

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

- Collate feedback from all boards in order to finalise options.
- Finalise the design of the new strategic partnership boards, and have them operating before the end of the financial year.
- Collate the terms of reference and action plans for the new proposed groups.
- Confirm how the new structure will support the measurement and monitoring of the Strategy's performance framework.
- Confirm any legacy arrangements for existing partnership boards.
- Ensure all required administrative support is in place.
- Deliver a robust communication plan regarding the final design and implementation.
- .

Subject:	Royal Borough Windsor & Maidenhead Joint Autism Strategy 2017 – 2022.
Reason for briefing note:	To present the Joint Autism Strategy for information and strategic oversight by the Health and Wellbeing Board.
Responsible officer(s):	Debbie Dickenson, Public Health Commissioning Officer.
Senior leader sponsor:	Hilary Hall, Deputy Director Strategy & Commissioning.
Date:	8th August 2017.

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

SUMMARY

This paper presents The Royal Borough of Windsor and Maidenhead's Joint Autism Strategy 2017 -2022.

1 BACKGROUND

1.1 The Royal Borough Commissioning Strategy for Adults with Autism was published in 2012 and was developed in line with the National Autism Strategy – Fulfilling and Rewarding Lives 2010.

1.2 The vision for the Royal Borough Joint Autism Strategy 2017-2022 updates the previous strategy and puts the person with autism and their family at the heart of all that we do. It explains how support and services will be developed in the next five years to achieve this outcome and describes an integrated approach reflecting the priorities of the Health and Wellbeing Strategy and future vision for residents.

1.3 By including both children and adults in this strategy and accompanying action plan, the Royal Borough is aiming to take a more holistic approach, developing opportunities and realising potential for people with autism at all stages in their lives.

1.4 The following areas formed the basis for engagement with stakeholders during development of the refreshed strategy:

- Improving information and awareness of Autism.
- Autism friendly services and environment.
- Independent living.
- Housing support.
- Employment support.
- Social inclusion.
- Opportunities in education

1.5 To make the engagement as inclusive as possible, feedback was taken from diverse multiple stakeholder workshops to:

- Gain a balance of clinical, social care and service user feedback, including families of people with autism, both children and adults, and workshops for older children.
- Survey public perspectives from different sources.
- Involve Partnership Boards and members of the Health and Wellbeing Board.

2 KEY IMPLICATIONS

2.1 The consultation which received 112 responses reflected five important priorities to people living in the Royal Borough:

1. I want support as I need it, throughout my education to fulfil my potential and enhance my skills.
2. I want to be able to live as independently as possible and have access to housing support.
3. I want support to get a job and support from my employer to help me keep it.
4. I want to be safe in my community and free from the risk of discrimination, hate crime and abuse.
5. I want to know that my family can get help and support when they need it.

2.2 In relation to children and young people, the increase in demand has had the greatest impact in the secondary and special school sectors. Between 2014 and 2017 the percentage increase of children with Autism in special school has been 51.6%. If demand was to grow by the same amount, there would be a need for over 500 children in special school by 2025.

2.3 For adults, the number predicted to be on the autistic spectrum in The Royal Borough aged 18-64 years by 2025 is 917.

2.4 The Royal Borough currently provides out of borough placements to some people where it is the best option in terms of meeting their needs such as dual diagnosis, which could mean autism and a mental health condition such as bipolar. The cost of this over the last two years has been:

1. 2015/2016 - Yearly cost £403,200 for seven people.
2. 2016/2017 - Yearly cost £456,000 for seven people.

3 DETAILS

3.1 The Action Plan, see Appendix 1, has been developed by the Autism Partnership Board and takes into account all elements of the needs analysis – the expected need and what people have expressed a need for through the consultation. It aims to link the needs identified to achievable priorities and on to items for action which will be reviewed and assessed by the Autism Partnership Board regularly throughout the strategy lifetime.

4 RISKS

4.1 Not delivering the actions presented in the Autism Strategy and Action Plan could lead to less positive outcomes for residents with autism.

5 NEXT STEPS

5.1 To launch the Joint Autism Strategy and Action Plan at a conference planned for the end of the year.

5.2 Continue to develop and monitor the outcomes in the action plan, reporting back on an annual basis to the Health and Wellbeing Board.

www.rbwm.gov.uk

Royal Borough of Windsor & Maidenhead

Royal Borough Windsor & Maidenhead

Joint Autism Strategy

2017 – 2022

“The Royal Borough of Windsor & Maidenhead is a great place to live, work, play and do business supported by a modern, dynamic and successful Council”

Our vision is underpinned by four principles:

Putting residents first
Delivering value for money
Delivering together with our partners
Equipping ourselves for the future

CONTENTS

Appendices

Frequently used acronyms

JSNA – Joint Strategic Needs Assessment
NAS – National Autistic Society
SEN - Special Educational Needs
SENCO - Special Educational Needs Co-ordinator
ADHD - Attention Deficit Hyperactivity Disorder
EHC Plan - Education, Health and Care Plan

1. EXECUTIVE SUMMARY

1.1 It is timely to update and extend the previous Royal Borough Commissioning Strategy for Adults with Autism 2012 which was developed in line with the National Autism Strategy – Fulfilling and Rewarding Lives 2010.

1.2 Highlights of progress since the last local strategy are:

- Specialist autism supported employment provision.
- Additional social care support for children and young adults in transition up to 25 years of age.
- Social care Family Carers Support Worker.
- Set up an Adult Autism Partnership Board in 2013.
- Autism for children and adults is included in the Royal Borough Joint Strategic Needs Assessment (JSNA).
- Awareness session at General Practitioner (GP) Continuing Professional Development (CPD) conference in 2015.
- Annual Autism Awareness promotional stand.
- Successful Innovation Fund bid for £36,000 to develop 10 apprenticeships per year.
- Successfully applied for £18,500 Capital Grant enabling many activities including life skill such as cooking.
- Autistic Spectrum Conditions Support Directory.

1.3 The vision for the Royal Borough Joint Autism Strategy 2017 - 2022 puts the person with autism and their family at the heart of all that we do. This strategy explains how support and services will be developed in the next five years to achieve this outcome. It describes an integrated approach which reflects the priorities of the Health and Wellbeing Strategy and future vision for residents.

1.4 It takes account of the needs of people with autism and their carers, and responds to the priorities identified within the updated Royal Borough Health and Wellbeing Strategy,http://www3.rbwm.gov.uk/info/200745/health_advice/137/joint_health_and_wellbeing_strategy_jhws, national policy, and current best practice in line with national and local research. This will be regularly reviewed and updated. The underpinning action plan is to be the enabler that brings the strategy to life.

1.5 This joint strategy goes beyond the requirements of the Autism Act 2009 and the associated national policy guidance, which refers only to adults. Instead, the Royal Borough has adopted a more ambitious approach, developing a strategy that relates to both children and adults. The reason for this is because people with autism often face obstacles starting at childhood. Transition from being a child to adulthood can, also be a particularly difficult stage for young people.

1.6 By including both children and adults, in this strategy and accompanying action plan, The Royal Borough is aiming to take a more holistic approach, developing opportunities and realising potential for people with autism at all stages in their lives.

1.7 Improving diagnosis rates, access to early intervention and improving the knowledge and awareness of the whole community are all important in achieving better outcomes for people with autism and their carers. We wanted to build on our existing knowledge of key issues affecting people with autism and also wanted to embrace the borough wide perspective and local community opportunities.

1.8 The following areas formed the base for our professional stakeholder engagement:

- Improving information and awareness of Autism.
- Autism friendly services and environment.
- Independent living.
- Housing support.
- Employment support.
- Social inclusion.
- Opportunities in education.

1.9 To make our consultation as inclusive as possible, feedback was taken from diverse multiple stakeholder workshops to:

- Gain a balance of clinical, social care and service user feedback, including families of people with autism, both children and adults, and workshops for older children.
- Survey public perspectives from different sources.
- Involve Partnership Boards and members of the Health and Wellbeing Board.

1.10 The public consultation reflected five important priorities to people living in the Royal Borough:

1. I want support as I need it, throughout my education to fulfil my potential and enhance my skills.
2. I want to be able to live as independently as possible and have access to housing support.
3. I want support to get a job and support from my employer to help me keep it.
4. I want to be safe in my community and free from the risk of discrimination, hate crime and abuse.
5. I want to know that my family can get help and support when they need it.

1.11 However, this strategy reflects all of the key issues recognised as individually tailored approaches that are at the heart of personal care planning.

1.12 Alongside the questions The Royal Borough asked about the care and support given to the person with autism and their carers, The Royal Borough wanted to know how it could develop a more autism friendly borough. These two areas of work are complementary as community support for the individual cannot be achieved if the community is not autism aware and able to respond to, and support, the person with autism and their carers.

1.13 The changes that are required for success are not quick fix but all of the elements will remain in The Royal Borough's strategic approach. The action plan identifies the

framework through which services are commissioned, delivered and outcomes are measured and monitored. Their success will be reflected in achieving day to day quality of life, independence and wellbeing of people with autism and their families.

2. INTRODUCTION

2.1 In producing this strategy, The Royal Borough recognised that there are a number of terms that different individuals and groups prefer to use, including Autistic Spectrum Disorder (ASD) or Autistic Spectrum Conditions (ASC) and Autism. These are umbrella terms for all such conditions including Asperger Syndrome.

The term autism will be used throughout this strategy unless a direct extract from another source is being quoted.

2.2 For the purposes of this strategy, autism is defined as a lifelong condition that affects how a person communicates with, and relates to, other people. It also affects how a person makes sense of the world around them. The three main areas of difficulty, which all people with autism share in varying degrees, are known as the 'triad of impairments'. They are difficulties with:

- **social communication** e.g. problems using and understanding verbal and non-verbal language, such as gestures, facial expressions and tone of voice
- **social interaction** e.g. problems in recognising and understanding other people's feelings and managing their own
- **social imagination** e.g. problems in understanding and predicting other people's intentions and behaviour and imagining situations outside their own routine

2.3 Many people with autism may experience some form of sensory sensitivity or under-sensitivity, for example to sounds, touch, tastes, smells, light or colours. People with autism often prefer to have a fixed routine and can find change incredibly difficult to cope with. Many people with autism may also have other conditions such as attention deficit hyperactivity disorder (ADHD), a learning disability or dyspraxia.

2.4 These difficulties result in the inability to make friends and obtain employment amongst other things, leading to isolation, poor quality of life, depression and even suicide.

2.5 Asperger Syndrome is a form of autism. People with Asperger Syndrome typically have fewer problems with speaking than others on the autism spectrum, but they do still have significant difficulties with communication that can be masked by their ability to speak fluently. They are also often of average or above average intelligence.

2.6 Autism is much more common than many people think. There are around 700,000 people in the UK living with autism – that is more than 1 in 100 and similar to the

number of people that have dementia. Including their families, autism touches the lives of 2.8 million people every day[1]

2.7 Autism is sometimes described as a 'mild' disability, but often people with autism, without proper help, are amongst the most vulnerable and socially excluded in society.

2.8 In many cases, those older adults who do have a diagnosis of autism will not have received their diagnosis until relatively late in life. One National Autistic Spectrum (NAS) survey found that 71% of respondents over 55 had received their diagnosis in the past decade.[2] NAS interviewees diagnosed later in life reported that the diagnosis was immensely valuable, with many saying that it enabled them to understand themselves fully for the first time.

2.9 Professor Francesca Happé, speaking to the Autism and Ageing Commission, 11 March 2013 said that, "We simply do not know what autism spectrum conditions look like in older age. We just don't know. We don't know whether particular sorts of physical health problems are greatly raised. We should suspect that they would be because living with stress, living with anxiety, has a proven link with, for example, heart conditions. We don't know how best to diagnose in the very elderly, we don't know how dementia looks overlaid on top of autism, for example. We don't know what the potential is for new insights both into autism, and into ageing itself. If you look at the example of Down's syndrome, where so much has been discovered, both about Alzheimer's, and about how people with Down's syndrome themselves age – we might expect similar insight for autism…"[3]

[1] 1The NHS Information Centre, Community and Mental Health Team, Brugha, T. et al (2012). *Estimating the prevalence of autism spectrum conditions in adults: extending the 2007 Adult Psychiatric Morbidity Survey*. Leeds: NHS Information Centre for Health and Social Care

[2] Unpublished survey (2012), The National Autistic Society

[3] [16]Prof Francesca Happé, speaking to the Autism and Ageing Commission, 11 March 2013.

3. KEY INFORMATION

3.1 Key information about autism includes:

- Autism is a serious, lifelong and disabling condition. Without the right support, it can have a profound - sometimes devastating - effect on individuals and families[4].

- Autism is much more common than many people think. There are around 700,000 people in the UK living with autism – that is more than 1 in 100 and similar to the number of people that have dementia. Including their families, autism touches the lives of 2.8 million people every day.[5]

- At least one in three autistic adults are experiencing severe mental health difficulties due to a lack of support.[6]

- Only 10% of autistic adults receive employment support but 53% say they want it.[7]

- Autism is a hidden disability - you cannot always tell if someone has it.[8]

- While autism is incurable, the right support at the right time can make an enormous difference to people's lives.

- 34% of children on the autism spectrum say that the worst thing about being at school is being picked on.[9]

- 63% of children on the autism spectrum are not in the kind of school their parents believe would best support them.[10]

- Only 16% of autistic adults in the UK are in full-time paid employment and only 32% are in some kind of paid work.[11]

---

[4] Rosenblatt, M (2008). *I Exist: the message from adults with autism in England*. London: The National Autistic Society, p5-7

[5] The NHS Information Centre, Community and Mental Health Team, Brugha, T. et al (2012). *Estimating the prevalence of autism spectrum conditions in adults: extending the 2007 Adult Psychiatric Morbidity Survey*. Leeds: NHS Information Centre for Health and Social Care

[6] Rosenblatt, M (2008). *I Exist: the message from adults with autism in England*. London: The National Autistic Society, p3

[7] Bancroft et al (2012). *The Way We Are: Autism in 2012*. London: The National Autistic Society

[8] Rosenblatt, M op.cit.p37

[9] Reid, B. (2011). *Great Expectations*. London: The National Autistic Society, p7

[10] Reid, B. (2011). *Great Expectations*. London: The National Autistic Society, p18

[11] The National Autistic Society (2016). *The autism employment gap: Too Much Information in the workplace*. p5

4. NATIONAL CONTEXT

4.1 The national strategy has evolved over the last seven years and will continue to be dynamic. The Royal Borough has reflected this evolution in this strategy and built on the understanding, experience and programmes of work over that time.

4.2 This strategy builds on the following legislation and national policy:

- The **Autism Act 2009** was a unique and ground breaking piece of legislation. It signalled a new commitment across government to transforming the way public services support adults with autism. But, more importantly, it is the foundation stone for a wider programme of activity across the public sector, designed to drive that change.

- **The national autism strategy 'Fulfilling and rewarding lives'** published in March 2010 as a requirement of the Autism Act 2009, it set out a clear agenda for how public services must transform, to better address the needs of adults with autism. It set out key areas of action to target the root causes of social exclusion. This was closely followed by statutory guidance to ensure implementation of the national strategy and to help local authorities; NHS bodies and NHS Foundation Trusts to develop services that supported and meet locally identified needs of people, their families and carers.

  'All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents.'[12]

- **'Think Autism Fulfilling and Rewarding Lives, the strategy for adults with autism in England: an update 2014.'** This updated strategy continued to focus on priorities outlined in the original strategy. However, there was a renewed focus for cross government department activity in order to improve outcomes for people with autism. It also outlines 15 priority challenges for action identified by people with autism. These are grouped under three areas:
  - An equal part of my local community.
  - The right support at the right time.
  - Developing my skills and independence and working to the best of my ability.
- **Health and Social Care Act 2012** changed the way the health service works to deliver person- centred healthcare by:
  - Giving patients greater choice, control and involvement – "no decisions about me without me."
  - Improving health outcomes.

[12] National Autism Strategy: 'Fulfilling and rewarding lives' http://www.dh.gov.uk/en/publication-sandstatistics/publications/publicationspolicyandguidance/DH113369

- Removing unnecessary bureaucracy, cutting waste and making the NHS more efficient.
- Creating Clinical Commissioning Groups (CCG) where local GPs deliver health services based on their community's needs. Health and Wellbeing Boards have also been created in each local authority area with the specific role to improve health and wellbeing for all, and reduce health inequalities between different people.

- **The Children and Families Act 2014** was a significant piece of legislation which introduced a number of changes in order to improve services for vulnerable children and their families. This included transforming the system for children and young people with Special Educational Needs (SEN) through a new SEN Code of Practice. The changes for children with SEN including autism and their families are:
  - Replacing Statements of Special Educational Needs with a single assessment process and an Education Health and Care Plan.
  - Placing a requirement on health services and local authorities to jointly commission and plan services for children, young people and families.
  - Provide statutory protection comparable to those Statements of Educational Needs for young people who are in education or training up to the age of 25 instead of ending at 16.
  - Giving parents or young people the right to a personal budget for their support.

- **The Care Act 2014** placed new duties and responsibilities about how care and support for adults was delivered. It embedded within statute the nation policy drivers which focus on wellbeing, prevention, independence and outcomes. It introduced clearer and fairer processes, including caps to care costs for individuals. The Act adopted a 'whole family approach' as well as ensuring a more effective delivery of personalisation. Enshrined within the Act were increased rights for carers to receive support from local authorities. It introduced a duty on them to meet eligible carers' support needs. Carers no longer have to show they provide substantial care and on a regular basis in order to request a Carers Assessment. This increased emphasis on preventative provision should improve outcomes for adults with autism as many people do not meet the threshold for adult social care support.

- **National Autistic Society (NAS)** has led a number of high profile campaigns aimed at raising awareness and promoting positive change for people with autism. These include:
  - **Make School Make Sense** (2006) – what families want from the education system.
  - **I Exist** (2007) – understanding the needs of adults with autism.
  - **You need to know** (2009) – mental health for children with autism.

- **Don't write me off** (2009) – support into employment.
- **Supporting adults with autism** (2009) – good practice guidance fro NHS and local authorities.
- **Great Expectations** (2011) – developing and an education system that sets children up for life.
- **Push for Action** (2013) – getting the right services and support in place.
- **Getting on** (2013) – growing older with autism.

5. LOCAL PROFILE

5.1 The Autism Partnership Board is responsible for overseeing the delivery of this Joint Autism Strategy and its accompanying Action Plan ensuring that this is in line with emerging changes in legislation and guidance.

5.2 The Autism Partnership Board is a multi-disciplinary group representing local interests relating to the needs of all people with autism and their carers. This group does not work in isolation but networks with a number of other key stakeholder groups such as the Learning Disability Partnership Board and the Mental Health Partnership Board.

5.3 The Autism Board also has overlay with the Adult Partnership Board which in turn feeds into the Health and Wellbeing Board ensuring strategic involvement at the highest level locally.

5.4 Below are some of the highlights that we achieved as a result of the last strategy 2012 which the Autism Board monitored and seen implemented:

- **Specialist autism supported employment provision** – employment support was the number one priority identified in the consultation for the last strategy and as a result a full time supported employment post was recruited to through Ways into Work an award winning local service. See box 1 for a case study on page 14.
- **Additional social care support for children and young adults** - preparing for adulthood, (sometimes called 'Transitions') is used to describe the period from Year 9 (14 years old) to when a young person becomes an adult at age 18 and as they develop through young adulthood to 25. It can be an exciting but also challenging time as services and support may change and therefore we ensure very careful planning.
  A range of professionals work closely with young adults and their family to enable participation in further studies or training, finding a job, living as independently as possible, being healthy and taking part in enjoyable leisure and social activities.
  Further information can be found on the "Local Offer" here
- **Social Care Family Carers Support** – currently the Family and Carers support worker supports approximately 50 carers through one to one support and provides Carers Assessments to ensure that their needs are addressed. Carers are also offered advice, signposting and advocacy support in meetings. Group support is also available through regular a Carers Support Group meeting which provides advice, emotional support and invaluable informal befriending and support from fellow carers. The support worker also networks with and works with multi disciplinary teams to enhance the service for carers.

- **Adult Autism Partnership Board** – The Autism Partnership Board was established to ensure community participation and challenge. It is a multi disciplinary Board which represents the views of service users indirectly through organisations that support them and directly through service user representation and family carers. It has provided an effective voice for autism services to the Health and Wellbeing Board, through the Adult Partnership Board. The Autism Partnership Board has also been accountable for the monitoring and implementation of the action plan.
- **Autism for children and adults is included in the Royal Borough Joint Strategic Needs Assessment (JSNA)** – there are comprehensive sections in the JSNA for both children and adults with autism in line with statutory guidance. It also reflects the needs of older adults which was a recommendation in the Autism Self Assessment 2014.
- **Awareness session at General Practitioner (GP) Continuing Professional Development (CPD) conference** – the Autism Partnership Board aim was to deliver regular autism awareness sessions at GP CPD conferences. This included a presentation from Trevor Powell, Consultant Psychologist on identifying autism in patients and how to make reasonable adjustments. What support is then available on diagnosis from the Autism Social Care Lead and finally the perspective from a parent on the type of support an adult with autism needs in a primary care setting and the challenges they face.
- **Annual Autism Awareness promotional stand** – there has been successful engagement with the public with a timetable of events in Autism Awareness Week and in 2016 at a key event in the Nicholson's Shopping Centre in Maidenhead 56 people were supported and signposted and 68 leaflets given out. Many people had specifically come to the stand after reading the article in the Maidenhead Advertiser. All the people who approached the stand wanted in depth support and signposting which meant a real service was offered to these residents and made a difference.

- **Successful Innovation Fund bid for £36,000** to develop 10 apprenticeships per year – the proposal was to use the funding to establish within Ways into Work (WIW), City Deal supported employment programme an Autism Employment Challenge through which they would offer the opportunity for ten local employers to sign up and commit to becoming local "Autism Employment Champions". This approach has enabled WiW to highlight to local employers the challenges which people with autism experience in finding sustainable employment. The objective has been to identify 10 local businesses committed to helping address this disadvantage by creating an apprenticeship within their organisation specifically for someone with Autism.
  Each organisation committing to do so has become "Autism Employment Champions" and have been entitled to receive a package of support designed to enable them to establish and manage the apprenticeship, including:
  - Support to establish the apprenticeship.
  - A package of training for their staff including "Train the Trainer" and disability awareness training.
  - A financial contribution designed to enable them to build the organisational capacity and capability to effectively manage and support an apprentice who has autism.
  - The support and expertise of the WiW team including a nominated Job Coach.

  This scheme has led to real jobs at the end of successful apprenticeships.

- **Successfully applied for £18,500 Capital Grant** - all the equipment has been used and accessed by a wide range of services supporting people with autism enabling many activities:
  - The Royal Borough purchased technology which promoted a more creative adaptable approach. Such as Go Pro Cameras, Bloggies, Apple Macbooks, I pads etc. This enabled individuals to film and create their own vocational profiles, visual CV's and promote the benefits of employing people with autism.
  - Similar equipment to the above was also purchased to support a post diagnostic group enabling the production of tailored material as requested by previous attendees.
  - The aim was also to empower people with autism to produce autism awareness DVD's and training material for different communities and organisations such as GP's to support diagnosis and how to make reasonable adjustments.
  - Cooking courses have also been developed which as a result of purchasing cooking equipment, enabled life skills. It has also focussed on social interaction needs as well as health needs. It has also taught planning skills

and transferrable skills which will help people to become more independent.
  - Hi Viz gilets will enable a running group.
  - Musical instruments and a Karaoke machine for a music group which will provide a means of communication and expressing emotions.
  - Sensory protective equipment is available on loan and has made a huge difference to people managing with sensory sensitivities.
  - Two book clubs are planned with the use of Kindles which will help forge friendships and promote turn taking.
  - The Community Mental Health Team offices have had some rooms made autism friendly to accommodate hypersensitivities and be more welcoming and friendly.

- **Autistic Spectrum Conditions Support Directory –** this directory of autism support was specifically designed to provide information on the help, support and services available in the area, as well as more general information around benefits and where to access further information. This was launched in Autism Awareness Week in March 2015.

Box 1: Case study

CD is a young man with autism, he left college and was referred to Ways into Work. CD wanted to do a job that was practical, where he could use his customer service skills and also where there was room for progression. Ways into Work undertook a full vocational profile and then developed an action plan. CD would struggle to make it through a traditional recruitment process as his impairment means that he finds it hard to articulate his many strengths and talents.

Ways into Work started working with the HR team at the Holiday Inn in Maidenhead, who were really open to looking at different ways of recruiting and happy to consider a working interview rather than a sit down interview.

Ways into Work gathered all the information about the role and three potential candidates were identified as a positive match. The individuals came for an informal look around and CD was so positive and passionate about the role, Holiday Inn offered him a work trial.

Ways into Work provided job coaching support within the workplace for the trial and ensured the staff team working alongside CD understood his autism. CD impressed everyone with his positive attitude on the day and was offered a 15 hour a week position with the view to increasing his hours in the future.

Ways into Work provided in work support for the first six weeks and helped CD to prioritise, put together visual sheets and facilitated the communication with his colleagues. This support was then gradually reduced as CD built the confidence and layered up the skills needed to do the job. Ways into Work provided Autism training for the staff team which enabled CD to grow in confidence and independence.

Ways into Work also supported CD with travel training so that he can get home from work independently.

CD is now the Breakfast chef within the Holiday Inn Maidenhead; he has a smile for every customer that comes to see him and has learnt to make a whole range of different types of egg as requested.

6. UNDESTANDING FUTURE DEMAND

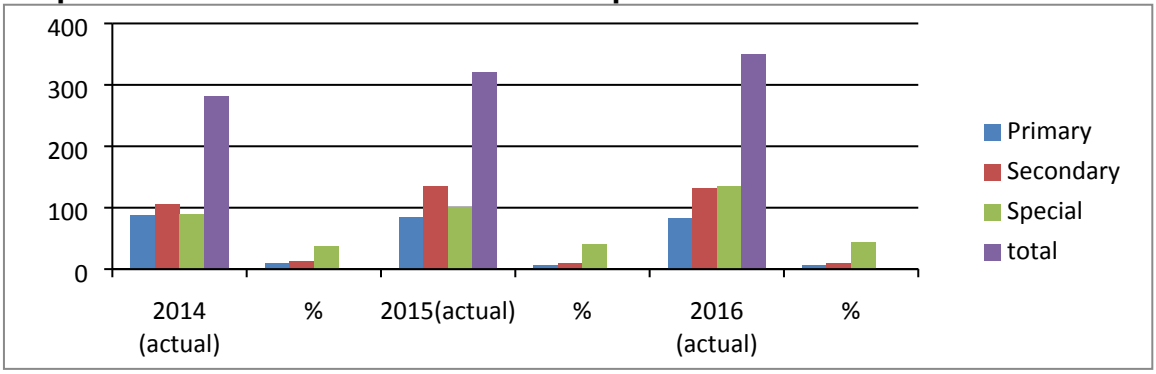
6.1 Children and young people

In January 2016, 349 Children of school age were on the Autistic Spectrum and being educated in Royal Borough schools. This reflects an increase in demand of 24.1% (68 pupils) over the last two years.

Table 1: Actual[13] and predicted numbers of children with Autistic Spectrum Conditions in The Royal Borough

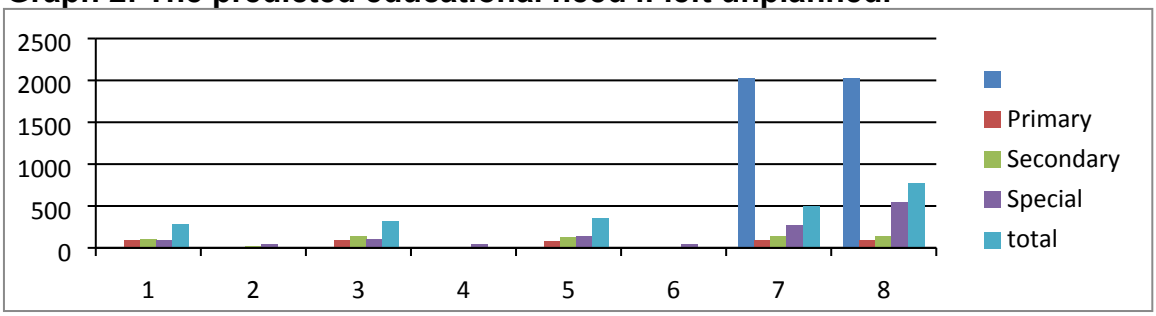
	2014 (actual)	%	2015(actual)	%	2016 (actual)	%	2020	2025
Primary	87	10.1	85	6.7	83	6.1	*85*	*87*
Secondary	105	13.4	135	9.0	131	9.1	*137*	*140*
Special	89	37.6	101	39.6	135	44.1	*270*	*540*
total	281		321		349		*492*	*767*

Graph 1: Where children with Autistic Spectrum Conditions are educated.



6.2 The increase in demand has had the greatest impact in the secondary and special school sectors. Between 2014 and 2017 the percentage increase of children with Autism in special school has been 51.6%. If demand was to grow by the same amount, there would be a need for over 500 children in special school by 2025.

Graph 2: The predicted educational need if left unplanned.



The predictions illustrated above reinforce the need for action over the next few years to enable a higher percentage of children with ASD to be educated in the mainstream. This will be achieved through a number of initiatives including;

[13] National Statistics Special educational needs in England: January 2014
National Statistics Special educational needs in England: January 2015
National Statistics Special educational needs in England: January 2016

training, specialised units and the full implementation of the Children and Families Act 2014.

6.3 Adults

A robust needs analysis is an important way of estimating what the needs of a population are so that appropriate support can be planned. In this strategy The Royal Borough has identified the expected local need through the Joint Strategic Needs Assessment 2016, Census and other data sources. Local people and organisations were also asked for their feedback on needs and priorities for people affected by autism.

Table 2: People predicted to have Autistic Spectrum Conditions in RBWM

	2014	2015	2020	2025	2030
People aged 18-24 predicted to have autistic spectrum disorders	93	90	85	89	99
People aged 25-34 predicted to have autistic spectrum disorders	184	185	188	184	178
People aged 35-44 predicted to have autistic spectrum disorders	214	214	213	220	226
People aged 45-54 predicted to have autistic spectrum disorders	220	222	221	216	217
People aged 55-64 predicted to have autistic spectrum disorders	162	164	190	208	206
People aged 65-74 predicted to have autistic spectrum disorders	135	137	141	143	167
People aged 75 and over predicted to have autistic spectrum disorders	108	114	133	163	179
Total population aged 18 and over predicted to have autistic spectrum disorders	**1119**	**1126**	**1170**	**1224**	**1272**

Projected Adult Needs and Services Information (PANSI)

6.4 The Projected Adult Needs and Services Information (PANSI) System using Office for National Statistics population projections provide estimates of the numbers of adults on the autistic spectrum aged 18 and over. This is based on 1% of adult population having autism. Estimated numbers from this source show numbers are predicted to increase.

Table 3: Numbers predicted to be on the autistic spectrum in The Royal Borough aged 18-64 years by gender

	2015	2020	2025	2030
Total males	787	806	826	833
Total females	88	90	91	92
Total population of adults with autism 18-64	**875**	**896**	**917**	**925**

Projected Adult Needs and Services Information (PANSI)

6.5 Autism is more common in males than females as can be seen by the predicted table above, however, campaign groups believe the condition may currently be under diagnosed in females.

6.6 The Autism Self Assessment 2016 identified that during the year to March 2016:

- 149 people had received social care support, or information and advice or were signposted to other services.
- 97 people with autism were referred to our Autism Specialist. 37 were assessed as needing social care support. 60 did not meet assessed social care criteria so received advice, information and signposting to other services.
- Of the above 97 people above 20 also had a mental health condition.
- In addition 52 people had a dual diagnosis of a learning disability and autism.
- 80 people in the year to March 2016 were diagnosed with autism and none were referred out of area.

6.7 The Royal Borough commissions Ways into Work to provide supported employment to clients with autism. Ways into Work:

- are currently working with 82 individuals.
- have currently supported 37 of the 82 people to both gain and maintain employment.
- supported a further 16 people who are currently undertaking targeted work experience.
- are achieving a 45% employment outcome for people with autism in the Royal Borough whilst the national average is 15%.
- to address the growing demand for the service, Ways into Work have set up a job specialist job club, which enables people to be connected to the service and begin building a profile while they wait to be allocated.

7. LOCAL DRIVERS

Children and young people

East Berkshire Local Transformation Plan for Children & Young People's Mental Health and Wellbeing – October 2015

7.1 By working in partnership across East Berkshire, the main objective for the future of Children and Young People's Mental Health services is a whole system approach, removing the tiers and barriers between services and ensuring a focus on the needs of children, young people and their families.

7.2 There are a substantial number of children and young people requiring mental health support in East Berkshire. Berkshire Healthcare NHS Foundation Trust, the local mental health services provider, is facing a number of challenges including a year on year increase in the numbers of referrals, difficulty in recruiting appropriately qualified staff and increasing waiting times. Whilst children are placed on waiting lists, there is a risk that there mental health could also deteriorate. There is pressure on all of the children's services across all tiers in East Berkshire.

7.3 A clear, overarching priority has been identified with stakeholders who provide services that support children and young people's mental health and wellbeing that will support greater transparency and accountability going forward.

Our Vision

- More children and young people will have good mental health, and grow up being resilient
- More children and young people will get the right support at the right time

7.4 A diagnosis only service is available through the current Tier 3 CAMHS service. Those children and young people with a single diagnosis will be signposted on to support services including Berkshire Autistic Society and other Local Authority funded services. In the future there will be a range of support services available including behaviour support for parents, which will be tailored to meet the needs of the child/young person and their family.

Autism

7.5 A diagnosis only service is available through the current Tier 3 CAMHS service. Those children and young people with a single diagnosis will be signposted On to support services including Autism Berkshire and other Local Authority funded services. In the future there will be a range of support services available including behaviour support for parents, which will be tailored to meet the needs of the child/young person and their family.

Table 4: Actual number of children with autistic spectrum disorders in NHS Windsor, Ascot and Maidenhead, 2016

Total ASDs in children 11-16yrs	Total ASDs in children 5-10yrs	ASDs in children pre school (<5ys)
231	118	30

7.6 The children highlighted in the table above are the actual numbers of children in RBWM with a diagnosis of autistic spectrum disorder. They are educated in a variety of settings and have a range of difficulties from mild to severe.

Adults

Older adults

7.7 Older adults with autism are a neglected group. They have received little attention to date in policy, research or service provision. In large part, this is because autism was only identified in the 1940s and the first generation of adults to be diagnosed in childhood are only now moving into older age. The challenges ahead will be providing support services for older people who have not received a diagnosis in the past and how their condition will affect them as they age in combination with other factors such as dementia.

7.8 The Royal Borough's aim is to plan appropriate services for older people with autism who live in the area, and take steps to ensure that mainstream services are autism appropriate. Data collection will be integral to the success of local planning and commissioning services.

Housing

7.9 A survey by the National Autistic Society showed that 49% of adults with autism still lived with their parents. This may reflect the fact that people with autism require ongoing support into adulthood due to their needs or that support to enable them to live independently is limited.

7.10 There are several housing options available for individuals with autism depending on their level of support need. These options are aimed at encouraging independence and empowering individuals to be able to live independent lives in the community while enabling them to obtain the support they need in a suitable environment. Options can include supported housing; general needs housing and home ownership.

Supported housing

7.11 Supported housing usually consists of an independent purpose built property, for example a flat with its own front door but with a member of support staff based on site. Staffing would be 24 hours a day with an allocated key worker for each service user.

7.12 The objective of a supported housing placement would be to provide the opportunity for residents to learn the life skills required to enable them to enter and sustain a tenancy in mainstream housing. Each resident would occupy the accommodation via a tenancy which sets out the criteria they have to adhere to and would provide them with experience in managing that tenancy.

General needs housing

7.13 General needs housing would be suited to individuals who are ready to move into independent living in mainstream housing, with a floating support package of 2 hours per week to help with living skills such as managing correspondence and budgeting. This could be through a placement in a council property or in the private market.

7.14 For individuals over 55 years of age, there is the additional option of general needs sheltered accommodation which can provide the opportunity for independent living within an age restricted development. These may particularly suit individuals that require a quieter living environment or those who are especially vulnerable.

Shared ownership

7.15 Individuals who are working and have access to the funds for a deposit can apply for a Shared Ownership property. Also known as part buy part rent, this would give individuals the opportunity to buy a share of a property, minimum of 25% enabling them to gain a foot on the property ladder. Rent is paid on the unowned element to a social housing provider who owns the balance of the property value.

7.16 Over time shared owners can purchase additional shares of their property until they own the property outright. The value of future shares purchased is determined by an independent valuation of the market value of the property at the time the additional share is purchased.

Support need in the Royal Borough

7.17 The Royal Borough currently provides out of borough placements to some people where it is the most robust placement in terms of meeting a person's needs such as dual diagnosis, which could mean autism and a mental health condition such as bipolar. The cost of this over the last two years has been:

1. 2015/2016 - Yearly cost £403,200 for seven people.
2. 2016/2017 - Yearly cost £456,000 for seven people.

7.18 The Royal Borough also offers a variety of other housing options, and categorised into low, medium and high need:

- Low could be living in mainstream housing with floating support provided by Housing Solutions (usually two -three hours a week).
- Medium could be supported living in own flat with support workers involvement similar to sheltered accommodation, two to 30 hours dependable on need.
- High need could be Residential or supported but with 24 hour staffing.

7.19 The Royal Borough currently provide 47 clients with a variety of housing options with a further 59 living with parents.

7.20 A significant percentage of the 59 people living with their parents would like to move to independent living for a variety of reasons. In recognition of this the Royal Borough as part of the strategy will develop a pilot project to support five people with autism to live independently using several models such as shared ownership, floating support with access where appropriate to assistive technology.

8. OUR APPROACH TO UPDATING AND REFRESHING THE AUTISM STRATEGY

8.1 The development of this strategy was informed by workshops attended by lead managers, commissioners, clinical and social care professionals, people with autism and family carers who looked at key areas of *need* as outlined in the executive summary. This provided a wealth of ideas and suggestions on how to improve the current good work already underway in those areas.

8.2 The next most important step was to ask residents, people with autism and their informal carers what were priority areas for them. To do this the 15 Priority Challenges for Action criteria were used. Permission from the Department of Health had been given to amalgamate, amend and add to, to make them relevant to this locality. 'I' statements were used to reinforce the primary aim to put the person with autism and their carers at the centre of all that is done. Residents were asked from their point of view, which four statements they thought were the most important to them from the list below, as well any further feedback.

- I want a timely diagnosis from a trained professional.
- I want to know how to connect with other people.
- I want support as I need it, throughout my education to fulfil my potential and enhance my skills.
- I want the everyday services that I come into contact with to know how to make reasonable adjustments to include me, accept me as I am and adapt the support they give me.
- I want to be accepted as who I am within my local community and I want my views and aspirations to be taken into account when decisions are made in my local area.
- I want to know that my family can get help and support when they need it.
- I want staff in health and social care services to understand that I have autism and how this affects me differently through my life.
- I want support to get a job and support from my employer to help me keep it.
- I want to be able to live as independently as possible and have access to housing support.
- I want to be safe in my community and free from the risk of discrimination, hate crime and abuse.

8.3 There were 112 responses to the consultation, see Table 4, from which the following top five priorities emerged:

1. **I want support as I need it, throughout my education to fulfil my potential and enhance my skills.**
2. **I want to be able to live as independently as possible and have access to housing support.**

=3. I want support to get a job and support from my employer to help me keep it.

=3. I want to be safe in my community and free from the risk of discrimination, hate crime and abuse.

5. **I want to know that my family can get help and support when they need it.**

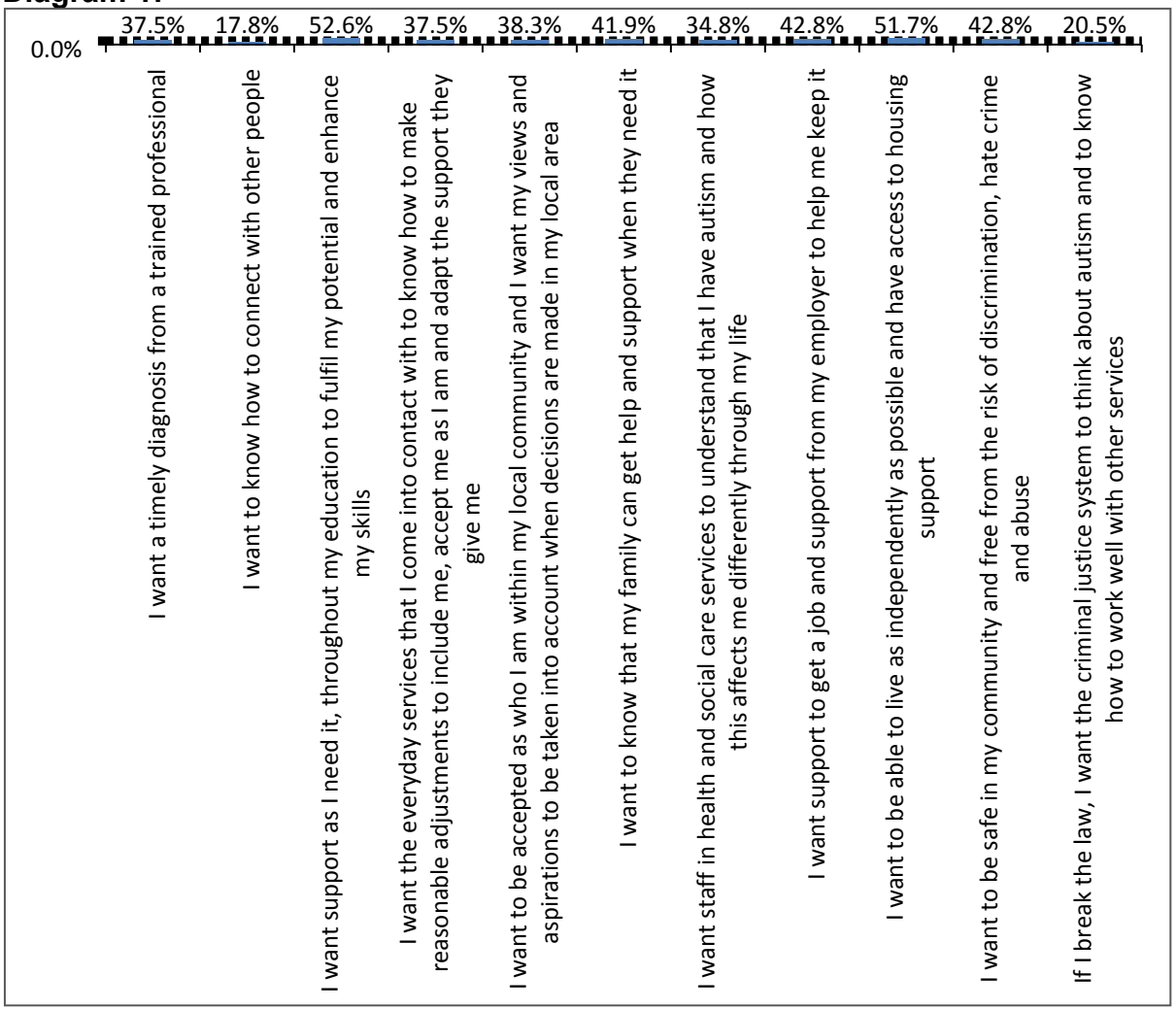
8.4 As was rightly pointed out in the public consultation all these are priorities for someone with autism! It is important to note that it does not mean that The Royal Borough is not working in the other areas, just responding to our residents stated needs.

8.5 All 11 priorities form the basis of the action plan which will be developed over the life of the strategy.

Table 5: Number of responses

	Response Percentage	Response Count
I want a timely diagnosis from a trained professional	37.5%	42
I want to know how to connect with other people	17.8%	20
I want support as I need it, throughout my education to fulfil my potential and enhance my skills	52.6%	59
I want the everyday services that I come into contact with to know how to make reasonable adjustments to include me, accept me as I am and adapt the support they give me	37.5%	42
I want to be accepted as who I am within my local community and I want my views and aspirations to be taken into account when decisions are made in my local area	38.3%	43
I want to know that my family can get help and support when they need it	41.9%	47
I want staff in health and social care services to understand that I have autism and how this affects me differently through my life	34.8%	39
I want support to get a job and support from my employer to help me keep it	42.8%	48
I want to be able to live as independently as possible and have access to housing support	51.7%	58
I want to be safe in my community and free from the risk of discrimination, hate crime and abuse	42.8%	48
If I break the law, I want the criminal justice system to think about autism and to know how to work well with other services	20.5%	23
answered question		112

Diagram 1:



The Action Plan

8.6 The Action Plan, see Appendix 1, has been developed by the Autism Partnership Board and takes into account all elements of the needs analysis – the expected need and what people have expressed a need for through the consultation. The Action Plan is the document that will, to an extent, govern the actions The Royal Borough and the Clinical Commissioning Group undertakes over the next five years. It aims to link the needs identified to achievable priorities and on to items for action which will be reviewed and assessed by the Autism Partnership Board regularly throughout the strategy lifetime.

8.7 The 11 consultation priorities in the Autism Action Plan have been listed in ranking order based on the consultation feedback and actions, future recommendations and suggestions.

9. CURRENT SERVICES - Children & Young people

9.1 Universal

- Autism Berkshire – information and support, helpline, training, social and interest groups, drop ins, internet safety courses, social skill and life skills, home visits.
- Counselling - Talking Therapies, No. 22, Youthtalk and psychologists.
- The Autism Group - Special Interest Groups for 11 – 25 year olds, Parent Support Groups for parent/carers of 11-25 year olds, Autism training for parents and professionals, @Home service – 1-1 support and information in the privacy of the parent/carer's home. For parents of children, young people and adults of any age.
- Stand out for Autism – provides support to people and families living with autism. The aims are raise awareness and provide support with an annual activities schedule.
- Odeon cinema autism friendly screenings.
- Signal – carers support and information.
- RBWM Autistic Spectrum Conditions Support Directory.
- Autism awareness training.
- Health Visitor or General Practitioner (GP).
- Local children's centres.
- Speech and language drop in clinics.
- Child's class teacher or key person.
- Parenting Special Children (offer pre-diagnosis advice and support).
- The Royal Borough "Local Offer."

9.2 Targeted

- Family Carers Social Care Support.
- East Berkshire College – specialist education provision.
- Speech and language suppor.t
- Occupational health provision.
- Shared lives and home share schemes.
- School, Early Years or F.E. Special Educational Needs Co-ordinator (SENCO)
- Children and Young People Disability Service (CYPDS)
- Information, Advice and Support Service for Windsor and Maidenhead (formerly the Parent Partnership Service)
- SHaRON *(a new dedicated social support network, with a section called 'Jupiter' for parents and carers of young people who are either waiting for their child to have an assessment for autism or who have a child who has already been given a diagnosis of an Autism Spectrum Condition.)*
- The "Look and Listen Group" (provided by the Children and Young People Disability Service for children aged 3-5yrs with autism. The purpose of the group is to provide a safe learning environment for children with autism to

experience the structure and expectations of a nursery or school setting. Parents also attend the sessions and have the opportunity to meet other parents/carers in similar circumstances to their own and to share knowledge, experiences and any concerns.)

- 'Post ASD Diagnosis Parenting Group'. Provides parents with an understanding of autism and strategies to support their children's behaviour and communication needs.
- The Shine Outreach team offer National Autistic Society training on the Early Bird Plus Programme. (This is a three-month programme for parents/carers of young children (4-8 years) with autism and for the professionals supporting them).
- Berkshire Healthcare Foundation Trust provide the Children and Young People's Integrated Therapies to provide specialist services to support the development and learning of young children including Occupational Therapy, Physiotherapy, Speech and Language Therapy and specialist Dietetic services for children throughout Berkshire.
- Educational Psychology Service.
- Autistic Girls and Young Women workshop and support group.

9.3 Specialist

- Diagnostic service.
- Specialist Autism Adult Social Care Support.
- 24 hour Residential care.
- Special School/unit/Further Education college.
- Short Breaks.
- Personal Budgets.
- Education, Health and Care (EHC) planning. To be eligible for an EHC Plan, a child or young person must have special educational needs (SEN), which can not be met by SEN support within their educational setting. If a child or young person (0-25yrs) has shown significant delays or difficulties with their learning, then the Local Authority will consider whether an EHC needs assessment is necessary or whether their needs can be met through the services in the Local Offer.

10. CURRENT SERVICES - Adults

10.1 Universal

- Autism Berkshire – information and support, helpline, training, social and interest groups, drop ins, internet safety courses, social skill and life skills, home visits.
- The Autism Group - @Home service – 1-1 support and information in the privacy of the parent/carer's home.
- Counselling - Talking Therapies, No. 22, Youthtalk and psychologists.
- Stand out for Autism – provides support to people and families living with autism. The aims are raise awareness and provide support with an annual activities schedule.
- Odeon cinema autism friendly screenings.
- Signal – carers support and information.
- RBWM Autistic Spectrum Conditions Support Directory.
- Friends in Need – mental health peer support.
- Advocacy – SEAP mental health advocacy.
- Autism awareness training.

10.2 Targeted

- Family Carers Social Care Support.
- Ways into Work – supported employment.
- East Berkshire College – specialist education provision.
- Kingwood Trust – supports people to live in their own home.
- Richmond Fellowship – community mental health support.
- Resilience – drug and alcohol support.
- Speech and language support.
- Occupational health provision.
- Shared lives and home share schemes.

10.3 Specialist

- Diagnostic service including Post diagnosis groups - 'Being me' for Autism and 'Manage Your Mind' for Attention Deficit Hyperactivity Disorder (ADHD).
- Specialist Autism Adult Social Care Support.
- Supported Living.
- 24 hour Residential care.
- Personal budgets.

Appendix 1

Our aims in ranking order based on public feedback	Core themes	Action required	Risk	Time scales	Owner	Future recommendations and suggestions	Impact
1. I want support as I need it, throughout my education to fulfil my potential and enhance my skills	*To achieve full potential whilst in full time education*	ASD training offered to all mainstream schools.	Lack of skill in managing specific needs.	March 2018	CYPDS	Devise impact measures. pre/post impact measures.	Increased knowledge within mainstream schools
		Outreach service (SHINE) to offer advice and support for children with more complex difficulties.	Service offer not maximised.	Nov2017	SHINE team	SHINE to ensure schools know how to access the service.	More CYP will be able to stay within a mainstream school.
		Regular Educational Psychology and emotional wellbeing input in all schools.	Needs may not be met in mainstream school.	March 2018	Psychology, Wellbeing and School Support	Devise impact measures. pre/post measures.	Development of Tier 2 services (as highlighted in CAMHS strategy) Ensure that more CYP with ASD educated in the mainstream
	Opportunities to continue education and skills development after 18 +	A comprehensive local offer across a wide range of FE providers.	Providers unable to increase their individual offers.	July 2018	CYPDS	Proposal are considered on a pan Berkshire basis to increase range and scope of provision.	Young people are able to remain within their local community and become economically viable.

Our aims in ranking order based on public feedback	Core themes	Action required	Risk	Time scales	Owner	Future recommendations and suggestions	Impact
2. I want to be able to live as independently as possible and have access to housing support	*Housing provision increased*	Pilot project - Support 5 autistic clients to live independently using several models such as shared ownership, floating support etc. with access to Assistive Technology (AT)	Managing budgets from several sources/ Lack of partnership working	Dec 2017	Housing Options Officer, Lead Autism Practitioner	Begin process to access various funding streams and identify clients who would be eligible	To enable 5 clients with Autism to live independently
	More supported living schemes	Access to Shared Lives and Full Lives	People unaware of Shared Lives/ Full Lives			Invite Ategi to Autism Partnership Board to discuss promotion of scheme	
		Develop AT equipment by diagnosis document to include autism	Lack of staff to implement	Nov 2017	Assistive technology lead, Lead Autism Practitioner	• Equipment list available to people with autism and their families and staff • People assessed for eligibility for equipment or purchase privately	• Enable clients to live more independently • Enable clients to live more independently
	Independent living skills	Cooking and budgeting sessions	Lack of resources to deliver	Annual 2017	Autism Berkshire	Autism Berkshire delivering x sessions during 2017	Improve independent living skills

Our aims in ranking order based on public feedback	Core themes	Action required	Risk	Time scales	Owner	Future recommendations and suggestions	Impact
		More Social eyes courses	Lack of capacity	Feb 2018	Autism Berkshire	Investigate funding	More social opportunities for clients
		Support assistants promoted to people with Autism	Lack pf Personal Assistants	Jan 2018	Nuway, Lead Autism Practitioner	Invite Nuway to Autism Partnership Board to discuss promotion of service	More clients able to live independently
	Travel	Companionship promoting independent travel	Companions available	Dec 2017	People to Places, Autism Berkshire	Invite People to Places to Autism Partnership Board to discuss delivery	Clients with autism supported to travel and access activities
3. I want support to get a job and support from my employer to help me keep it	*Increased employment provision*	Bid to increase supported employment provision	No funds available to support extra provision	Jan 2018	Ways into Work	An extra part time post to support more clients	More clients supported into employment
		Continue the WiW apprenticeship scheme	No funds available	Jan 2018	Ways into Work	Update on progress to date and forward plans for development	Continue apprenticeship scheme providing essential opportunities into employment
		RBWM Autism Apprenticeship scheme	Lack of engagement	Nov 2017		Investigate the number of apprenticeships for people with autism at the council	Increase the number of people with autism into apprenticeships

Our aims in ranking order based on public feedback	Core themes	Action required	Risk	Time scales	Owner	Future recommendations and suggestions	Impact
	Increase training, knowledge, awareness for employers	Multi agency training programme to deliver training and awareness to employers	Lack of engagement	Jan 2018	Autism Partnership Board	Discuss and develop with all stakeholders a training plan	Employers autism aware
4. I want to be safe in my community and free from the risk of discrimination, hate crime and abuse	*Increased training around personal safety*	Internet safety training	Lack of funds to deliver, no attendees referred	Sessions during 2017	Autism Berkshire	Autism Berkshire (AB) have delivered x sessions	People with autism less vulnerable when using the internet
		Autism Awareness Week events promoting awareness and understanding of autism	Lack of commitment by partners	Events delivered annually March 2017	Autism Partnership Board	Information stands around the borough	Increase autism awareness and provide information and support on local services to people with autism and those that support them
	Autism friendly services and environment	Training available to community ie. shops, transport	Cost to employers	Oct 2017	Autism Partnership Board	Stakeholders pool training resources to provide a programme of delivery	Autism awareness training enables the community to support people with autism
		Information leaflets available in libraries	Cost of leaflets	Dec 2017	Autism Partnership Board	Liaise with libraries to provide and maintain supply and make the public aware of resource	People able to access information to support their needs

Our aims in ranking order based on public feedback	Core themes	Action required	Risk	Time scales	Owner	Future recommendations and suggestions	Impact
5. I want to know that my family can get help and support when they need it	*Increase formal identification of carers*	Autism Awareness Week identifies and supports carers, signposting to services available	Lack of commitment by partners	Programme of events delivered annually March 2017	Autism Partnership Board	Organise Autism Awareness events	More carers supported
	Informal support networks for carers and families	Carers support group	Family and carer support worker not able to deliver sessions	Ongoing	Family Carer Support Worker	Monthly evening carers group with discussion on particular topics	Provide peer support and information to carers to assist them in their caring role
	Increase support for carers	Personal Assistants (PA) can provide at a reasonable cost assistance for carers	Lack of PA's	Nov 2017	Nuway, Lead Autism Practitioner	Publicise PA availability	The use of PA's to support and provide carers respite
6. I want to be accepted as who I am within my local community and I want my views and aspirations to be taken into account when	*Promote kite marking services to ensure all are working to same delivery standard and principles*	Develop a kite marking scheme	Lack of engagement	Nov 2017	Autism Partnership Board, Slough Autism Partnership Board	Develop a kite marking scheme with Slough and the National Autistic Society	A more autism aware and supportive community

Our aims in ranking order based on public feedback	Core themes	Action required	Risk	Time scales	Owner	Future recommendations and suggestions	Impact
decisions are made in my local community	*Ensure regular feedback from service users and carers*	Ask established groups their views	Lack of engagement	Ongoing	Autism Partnership Board, 'Bear Social Group'		Ensure that people with autism are able to input into future developments
	Ensure continued participation of service users in the Autism Partnership Board	Continue to encourage and invite service user participation in Board	Lack of interest from service users	Ongoing	Autism Partnership Board	Work through operational colleagues to identify participants and encourage participation	People with autism are able to express their views in the development of initiatives
7. I want a timely diagnosis from a trained professional	*Integrated and prompt approach to early diagnosis*	• Increase early diagnosis by GP's • Awareness of reasonable adjustments in primary care		Sept 2017 Oct 2017	Health Subgroup of Autism Partnership Board	• Produce a GP awareness DVD that covers diagnosis and reasonable adjustments in GP surgeries • Promote DVD through EPIC Conference	• GP's aware of autism and are able to make reasonable adjustments to support • All local GP's autism aware
8. I want the everyday services that I come into contact with to know how to make reasonable adjustments to include me, accept me as I am and	*Autism friendly community with autism awareness to make reasonable adjustments*	Promote kitemarking services to ensure all are working to same delivery standard and principles	Lack of engagement	Sept 2017 – Mar 2022	Autism Partnership Board, Slough Autism Partnership Board	Work with Slough/ NAS to set up a kite marking scheme locally	As in point 6
		Autism training available to the	Lack of engagement	Ongoing	Autism Partnership	Use social media to communicate messages	As in point 4

Our aims in ranking order based on public feedback	Core themes	Action required	Risk	Time scales	Owner	Future recommendations and suggestions	Impact
adapt the support they give me		wider community			Board	around autism	
		Produce or identify DVD to deliver messages	Lack of engagement	2018	Autism Partnership Board	Research DVD training material currently available	As in point 7
9. I want staff in health and social care services to understand that I have autism and how this affects me differently through my life	*Increased provision for Autism awareness training in health*	• Increase GP's awareness • Training for hospital staff	Lack of engagement		CCG lead	• DVD for GP's • Autism session at EPIC conference	Health professionals better able to support people with autism
	• *Increased provision for autism awareness training across social care, council and other statutory services*	• Continued programme of autism training in adult social care • Library staff and volunteers trained	Lack of engagement	Feb 2017	• Human resources training team • Lead Autism Specialist	• Training for library volunteers running book club	• Social care staff able to support people with autism • Volunteers able to support people with autism in a book club
	• *Provision for older people with autism*	Develop services for older people with autism	Lack of engagement	Nov 2017	Autism Partnership Board		Ensure support is age appropriate

Our aims in ranking order based on public feedback	Core themes	Action required	Risk	Time scales	Owner	Future recommendations and suggestions	Impact
10. If I break the law, I want the criminal justice system to think about autism and to know how to work well with other services	• *Autism awareness across the whole justice system*	Deliver Autism awareness training across the justice system	Lack of engagement	Ongoing	Autism Partnership Board		The criminal justice system is autism aware and able to make reasonable adjustments
	• *Continue to promote the Berkshire Alert Card*	• Promote alert cards during Autism Awareness Week • Event to promote alert cards	Lack of staff to deliver events Stakeholders not engaged	Mar 2017 Nov 2017	Autism Partnership Board	• Promotional stand in the Nicholson Shopping Centre during Autism Awareness Stand • Through the Autism Partnership Board organise an event to promote cards	People carrying Alert Cards can access appropriate support
11. I want to know how to connect with other people	*Increase provision for social inclusion both autism specific and ensure general services are more accessible*	• Increase in provision of social / interest groups		Nov 2017 Mar 2017	• Autism Berkshire • Lead Autism Specialist, Library staff	• Courses that teach people how to manage friendships outside of specific groups • Book club with the Kindles from the Capital Fund • Music group with instruments from Capital Fund • Running group using Hi Viz jackets from Capital	Improve wellbeing and social integration of people with autism

Our aims in ranking order based on public feedback	Core themes	Action required	Risk	Time scales	Owner	Future recommendations and suggestions	Impact
						Fund	

Document Name	The Royal Borough Joint Autism Strategy 2017 - 2022		
Document Author	Debbie Dickenson, Public Health Commissioning Officer		
Document owner	Hilary Hall, Deputy Director Strategy & Commissioning.		
Accessibility	This document can be made available in other formats upon request		
File location	S drive/ Public health / Autism		
Destruction date	N/A		
How this document was created	Version 1	Author.	April 2017.
	Version 2	Strategy & Commissioning Team.	May 2017.
	Version 3	Public.	July 2017.
Circulation restrictions	None		
Review date	June 2018.		

Subject:	Joint Health and Wellbeing Strategy: performance and progress reporting
Reason for briefing note:	To present new monitoring tools and structures for consideration and approval in order to provide oversight and governance of the Joint Health and Wellbeing Strategy.
Responsible officer(s):	Teresa Salami-Oru, Public Health Consultant/Service Leader
Senior leader sponsor:	Hilary Hall, Deputy Director Strategy & Commissioning
Date:	8th August 2017

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

SUMMARY

Work has been undertaken to develop a monitoring tool which adequately captures the health impact made by the Joint Health and Wellbeing Strategy on local residents. This paper presents the proposed impact measurement tool and proposals to revise the Strategy's overarching strategic themes to enhance future monitoring.

1 BACKGROUND

1.1 The Health and Wellbeing board has a statutory duty to produce a joint strategic needs assessment and a joint health and wellbeing strategy for the local population. The refreshed Strategy was published in 2016 and work has been undertaken to develop an outcomes-focused scorecard, to track progress and provide opportunity to respond to changes and emerging issues.

1.2 The process was underpinned by the adoption of the Council Plan in July 2017, and associated developments in performance reporting capabilities across the Council.

2. DETAILS

2.1 The Strategy provides a framework of 12 priorities and associated activities that are aligned to three overarching strategic themes, and is one of several key plans and strategies supporting delivery of the Council's strategic intentions as set out in the Council Plan.

2.2 The proposed scorecard, see appendix 1, focuses on outcome-based measures as this will more accurately measure the impact of the Strategy. The Public Health Outcomes Framework was used to determine suitable outcome-based measures for the Strategy. Outcomes Framework also enables local areas to benchmark themselves against others at a local, regional and national level.

2.3 It is proposed that within this review of measures, there is scope to adjust the existing strategic themes to better align with the Outcomes Framework measures as follows: (1) *Starting & Living Well*, (2) *Ageing Well*, (3) *Lifelong Mental Health*, and (4) *Supportive communities*. This approach does not alter the content of the Strategy but it enables the

existing objectives to be accommodated against these four themes for the purposes of the scorecard.

2.4 Appendix 1 sets out the proposed performance scorecard and illustrates how the existing 12 priorities have been accommodated under the proposed four themes. The Scorecard presents the Borough's results, benchmarked against both the South East and England, according to the following tolerance thresholds:

Best	≥ 3% better than England/South East
Good	0.1 - 2.9% better than England/South East
Some improvement required	0 – 2.9% worse than England/South East
Significant improvement required	≥3% worse than England/South East

2.5 The tolerance thresholds have been selected to enable easy visual oversight of performance, with the ability to identify where improvement efforts may need to be targeted and the extent of effort required. Trend arrows have been included to illustrate the borough's overall direction of travel across reporting periods: Better ↑; Same →; Worse ↓.

2.6 The measures in the scorecard are predominantly reported on an annual basis. It is, therefore, proposed that performance against the Strategy is formally considered by the Board on an annual basis. A mid year report would also be produced summarising progress of the Strategy's delivery and including key activities undertaken and planned, key risks and issues and their mitigations.

3 SUMMARY DECISIONS

3.1 The HWB is asked to:

1. Approve the revision of the existing strategic themes to the following: (1) *Starting & Living Well*, (2) *Ageing Well*, (3) *Lifelong Mental Health*, and (4) *Supportive communities;* and the proposed alignment of the existing 12 priorities to these themes, see Appendix 1.

2. Approve the measures selected for reporting, the overall structure of the Scorecard and the benchmarking targets applied.

3. Approve the production of a formal Annual Report on performance and a mid-year progress report.

4 RISKS

4.1 None identified.

Appendix I

JOINT HEALTH & WELLBEING STRATEGY: OVERVIEW SCORECARD (DRAFT)

Benchmarking scale used:	Best ≥ 3% better than England/South East	Good 0.1 - 2.9% better than England/South East	Some improvement required 0 – 2.9% worse than England/South East	Significant improvement required ≥ 3% worse than England/South East

V.4_HWB Scorecard (18.07.17) DRAFT pending confirmation of benchmarking calculation formula

STARTING & LIVING WELL			Period	Results			W&M Trend since previous reporting period	Benchmarking: (WM % difference from)	
				W&M	South East	England		South East	England
Enable more children and adults to be at a healthy weight	1.1	Low birth weight of term babies (%)	2015	2.3	2.3	2.8	↑	0	4.9
	1.2	Prevalence of overweight children (4-5yr olds) (%)	2015/16	17.9	20.9	22.1	↓	3.9	5.3
	1.3	Prevalence of overweight children (10-11yr olds) (%)	2015/16	25.8	30.8	34.2	↑	4.4	7.0
	1.4	Excess weight (adults) (%)	2013-15	62.4	63.3	64.8	↓	0.4	0.9
Lower risky levels of alcohol intake	1.5	Admission episodes for alcohol-related conditions (narrow definition) (Persons) (per 100,000)	2015/16	490	527	647	↓	1.8	6.9
	1.6	Successful completion of alcohol treatment (18-75yrs) (%)	2015	44.6	40.5	38.4	↑	2.4	3.7
Get more people to be active more often	1.7	% Adults (16+yrs) achieving at least 150mins physical activity per week	2015	61.3	60.2	57.0	↓	0.5	1.8
Empower people to be educated to "self care"	1.8	% Eligible children who have received 2 doses of MMR vaccine between 1 and 5yrs of age	2015/16	87.6	86.4	88.2	↑	0.3	0.2
	1.9	Proportion of people (40-74yrs) that received an NHS health-check of those offered (%)	2016/17	43.5	46.9	49.9	↓	1.9	3.4
	1.10	Smoking prevalence at age 15 - current smokers (%)	2014/15	7.6	9.0	8.2	-	4.2	1.9
	1.11	Smoking prevalence in adults - current smokers (%)	2015	13.0	15.9	16.9	↓	5.0	6.5
	1.12	Mortality rate from causes considered preventable (per 100,000) (Persons)	2013-15	142.5	161.2	184.5	↑	3.1	6.4

AGEING WELL			Period	Results			W&M Trend since previous reporting period	Benchmarking: (WM % difference from)	
				W&M	South East	England		South East	England
Promote and enable greater independence for people	2.1	Health-related quality of life for older people	2015/16	0.78	0.76	0.73	↓	0.6	1.4
	2.2	Emergency hospital admissions due to falls in people aged 65+ (per 100,000) (Persons)	2015/16	2,239	2,137	2,169	↑	1.2	0.8
	2.3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (%)	2015/16	77.6	81.1	82.7	↑	1.1	1.6
Enable a reduction in levels of cardiovascular disease	2.4	Under 75 mortality rate from all cardiovascular diseases (per 100,000) (Persons)	2013-15	58.7	62.3	74.6	↑	1.5	6.0
	2.5	Under 75 mortality rate from cardiovascular diseases considered preventable (per 100,000) (Persons)	2013-15	36.2	39.4	48.1	↑	2.1	7.1
Assist and empower people with long-term conditions	2.6	Proportion of people reporting that they feel supported to manage their condition (%)	2015/16	59.7	64.8	64.3	↑	2.0	1.9
	2.7	Gap in the employment rate between those with a long-term health condition and the overall employment rate	2015/16	4.5	6.9	8.8	↓	10.5	16.2

SUPPORTIVE COMMUNITIES			Period	Results			W&M Trend since previous reporting period	Benchmarking: (WM % difference from)	
				W&M	South East	England		South East	England
Enable health and wellbeing through regeneration, and sustainable planning, including housing	3.1	% Adults with a learning disability who live in stable and appropriate accommodation (Persons)	2015/16	67.0	70.2	75.4	↓	1.2	2.9
	3.2	% Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)	2015/16	76.0	48.2	58.6	↓	11.2	6.5
	3.3	Statutory homelessness - households in temporary accommodation	2015/16	0.4	1.9	3.1	↓	32.6	38.6
Facilitate participation in education, training, work, social and community activities	3.4	% 16-18yr olds not in education, employment or training	2015	5.4	3.9	4.2	↓	8.1	6.3
	3.5	Gap in the employment rate between those with a learning disability and the overall employment rate (Persons) (% point)	2015/16	62.1	71.0	68.1	↓	3.3	2.3
	3.6	Gap in the employment rate for those in contact with secondary mental health services and who are on the Care Programme Approach and the overall employment rate (Persons) (% point)	2015/16	69.8	70.5	67.2	↑	0.2	0.9
Support carers of all ages	3.7	Health-related quality of life for carers	2015/16	0.831	0.810	0.800	↑	0.6	1.0
	3.8	Proportion of adult carers who have as much social contact as they would like	2014/15	36.5	35.5	38.5	↑	0.7	1.3

LIFELONG MENTAL HEALTH			Period	Results			W&M Trend since previous reporting period	Benchmarking: (WM % difference from)	
				W&M	South East	England		South East	England
Support adults and children with mental health needs	4.1	Self-reported wellbeing - people with a low happiness score	2015/16	6.9	8.0	8.8	↑	3.7	6.1
	4.2	Self-reported wellbeing - people with a high anxiety score	2015/16	19.9	19.0	19.4	↑	1.2	0.6
	4.3	Proportion of adults in the population in contact with secondary mental health services	2014/15	3.7	4.5	5.4	↓	4.9	9.3
	4.4	Emergency hospital admissions for intentional self-harm (per 100,000)	2015/16	150.5	211.8	196.5	↓	8.5	6.6
	4.5	Suicide rate (Persons)	2013-15	7.1	10.2	10.1	↓	9.0	8.7
Support people to have an early diagnosis of dementia	4.6	Recorded diagnoses of dementia as a percentage of estimated cases (65+yrs) (%)	May-17	70.9	64.5	67.8	-	2.4	1.1