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NOTICE

OF

MEETING

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Royal Borough of Windsor & Maidenhead

HEALTH AND WELLBEING BOARD

will meet on

TUESDAY, 2ND JULY, 2019

At 3.00 pm

in the

CONFERENCE ROOM - YORK HOUSE,

TO: MEMBERS OF THE HEALTH AND WELLBEING BOARD

HUW THOMAS (NHS), COUNCILLOR DAVID COPPINGER (CHAIRMAN), COUNCILLOR STUART CARROLL, TESSA LINDFIELD (PUBLIC HEALTH), HILARY HALL (STRATEGY AND COMMISSIONING (RBWM)), KEVIN MCDANIEL (CHILDRENS SERVICES (RBWM)), JACKIE MCGLYNN (NHS BRACKNELL AND ASCOT CCG), MARK SANDERS (HEALTHWATCH BRACKNELL FOREST), FIONA SLEVIN-BROWN, DR WILLIAM TONG, RUSSELL O'KEEFE AND COUNCILLOR DONNA STIMSON

Karen Shepherd Service Lead- Governance Issued: 24 June 2019

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 **Nabihah Hassan-Farooq** 01628796345

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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.	APPOINTMENT OF VICE-CHAIRMAN To appoint the Vice-Chairman of the Health and Wellbeing Board.			
5.	UPDATE ON BETTER CARE FUND To receive a verbal update on the Better Care Fund.	Hilary Hall		Verbal Report
6.	JOINT STRATEGIC NEEDS ASSESSMENT To receive the above report.	Hilary Hall		15 - 168
7.	UPDATE ON FRIMLEY HEALTH AND CARE INTEGRATED SYSTEM To receive the above presentation from Jane Hogg.	Jane Hogg		Verbal Report
8.	DEFINING THE ROYAL BOROUGH AS A PLACE WITHIN THE INTEGRATED CARE SYSTEM To receive the above report and presentation	Hilary Hall		169 - 176
9.	"THE FIRST 1,000 DAYS" SCOPING To receive the above report.	Kevin McDaniel		To Follow
10.	SEND PROGRESS UPDATE To receive the above update.	Kevin McDaniel / Sara Bellars		Verbal Report

11.	POTENTIAL FUTURE AGENDA ITEMS			
12.	QUESTIONS FROM THE PUBLIC To receive and answer questions from the Public.			Verbal Report
13.	STANDING ITEMS			
14.	FUTURE MEETING DATES Dates of future meetings are as follows: • 15 October 2019 • 14 January 2020			

ITEM	SUBJECT	PERSON	TIMING	PAGE NO

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 the discussion or vote at a meeting.** The speaking time allocated for Members to make representations is at the discretion of the Chairman of the meeting. In order to avoid any accusations of taking part in the discussion or vote, after speaking, Members should move away from the panel table to a public area or, if they wish, leave the room. 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.***

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HEALTH AND WELLBEING BOARD
COUNCIL CHAMBER - TOWN HALL AT 3.00 PM
15 January 2019

PRESENT**:** Councillors David Coppinger (Chairman), Natasha Airey, Stuart Carroll, Lindfield and Mark Sanders

Officers: Hilary Hall, Kevin McDaniel, Nabihah Hassan-Farooq

PART I

167/15 WELCOME AND INTRODUCTIONS

Councillor Coppinger welcomed all attendees to the meeting and asked that members introduce themselves.

168/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from Angela Morris, David Scott, Jackie McGlynn & Dr William Tong.

169/15 DECLARATIONS OF INTEREST

Councillor Carroll declared a personal interest as he works for a pharmaceutical company, Sanofi Pasteur. Cllr Carroll declared his employment in the interests of full transparency and to highlight that should for any reason during any point of the meeting, or indeed during future meetings, the HWB discussed anything directly related to Sanofi Pastuer's business he would abstain from the discussion and leave the room as required.

170/15 MINUTES

RESOLVED UNANIMOUSLY; That the minutes of the meeting held on the 16th October 2018 be approved.

171/15 APOLOGIES FOR ABSENCE

172/15 STANDING ITEM: UPDATE ON THE BETTER CARE FUND (BCF)

Hilary Hall, Deputy Director of Strategy and Commissioning (RBWM) gave an update on the above titled item. It was noted that the authority was awaiting guidance in relation to the rolled over BCF. The long term NHS plan had been published in early January 2019 but the green paper on adult social care was still awaited. Members were informed that non elective admissions had decreased by 0.4% and this had been mitigated by the impact of different work carried out in care homes and through CCG communication streams. There had been an increase, however,in 0-5 year old non elective admissions for fever related instances. Board Members were told that the telephone hotline and mechanisms were now in place to

support. It was noted that delayed transfers of care had not met target but that delays attributable to social care were very low. It was felt that a whole system approach was needed to address the wider challenges at hand, and that data was assessed monthly with each upload. There would be a peer review in March which would focus on learning from best practice particularly around health delays.

Current targets for 91 day re-admission were at 87.5% and it was reported that current performance was at 92.4%. Care homes had been set a target of 86 placements, and YTD 17 placements into care homes had been made. There had been an increase in nursing home placements and it was noted that there had been a higher increase in the rate of dementia diagnosis. It was highlighted that the BCF would continue delivery and to be realigned with the priorities.

At the conclusion of the update, the Chair commended officers on their commitment to work through the BCF and commended the positive metrics update. Dr Adrian Hayter stated that more consistency was needed and that the peer review would be a good way of analysing ways of improving performance further. The peer review was intended to provide a critical friend approach and was not intended as an inspection of services, it would serve as a reflective piece of work to delve further into more positive outcomes. Members discussed that leadership support was needed and that more work on social prescribing to inform residents of services was needed to reflect positive experiences. Members felt that it would be useful to have an update at the next HWB meeting to look at the positive advantages of social prescribing and how this is helping individuals to stay at home longer. Members were informed that social prescribing was a set of activities based in the community which aimed to support individuals. There had been three wellbeing practitioners employed across the borough and patients could be referred to this service through their GP surgery. The wellbeing practitioners were also able to provide advice, assistance and signposting to relevant services relating to money/debt/housing advice.

173/15 <u>UPDATE ON THE INTEGRATED CARE SYSTEM (ICS)- SYSTEM OPERATING PLAN</u>

Jane Hogg, Integration and Transformation Director, Frimley Health outlined the above titled item. Members of the Board were told that a refresh of the System Operating Plan (which had been agreed in 2016) was currently underway. It was highlighted that transformation initiatives would be looked at in more detail and that the already set out objectives for 2019/2020 would remain the same. Delivery of the System Operating Plan would be place based and GP networks would be strengthened for local delivery of service. The early draft plan had been shared with partners and would be submitted to NHS England by mid-February 2019.

It was noted Fiona Edwards had been selected as chair to replace Andrew Morrisand that the structure had been changed. Conversations were ongoing regarding the new structure, retaining alignment, ensuring that local and health partnerships were connected at system level whilst retaining their own individual importance. Councillor Coppinger highlighted that there had been regular Health and Wellbeing Alliance Board meetings involving the Chairs of the Wellbeing Boards across the Frimley CCG and that these meetings had provided the opportunity to ensure that all areas were working towards the same collaborative ambition. Members of the Board discussed ways in which residents could be engaged and ways to advance the dialogue of change moving forward. Dr Adrian Hayter highlighted that when engaging with the community, residents should be aware that place now played a key role in the way that services would be shaped. Kevin McDaniel highlighted that in East Berkshire, the Children's Board (0-5 year olds), had different funding arrangements and that it was important to hear all voices.

Tessa Lindfield noted that local authorities had a public health duty and that the duty to advise on commissioning had now ended. This had been explored through the ICS, and work

with primary care networks to utilise data for immunisations were fragmented and that work being carried out with primary networks was vital to ensuring that there would better outcomes for residents. Members of the Board discussed that the further work to enhance the launch of the JSNA was needed and that next steps would include looking at the online tools to ensure that the HWB had a broader view. Councillor Carroll suggested that there could be some work into the designing of a JSNA microsite which would support further development.

174/15 UPDATE ON HEATHERWOOD

Janet King, Director of HR and Corporate Services (Heatherwood Hospital Trust) gave a presentation on the above titled item. Members of the Board were informed that major transformational change was taking place and that the hospital had a great reputation but that the facilities had needed improvement. The Board were informed that Frimley Health Trust had taken over the management of the hospital facilities in 2014 with a promise to build a new hospital at the Heatherwood site. It was highlighted that there had been positive opinions from the local community and staff despite many services being taken off site, such as maternity and minor injuries. It was important that with the development of a new hospital, the services were shaped accordingly whilst maintaining the best modern healthcare for its patients and community.

The new facilities would include a dedicated elective care centre with state of the art facilities for multiple specialities and would provide the best patient experience. Members were informed that in order to deliver upon the Frimley Health vision, the existing hospital site would be sold for housing development and that planning permission to build within the green belt woodland would be applied for. The plan had some key advantages;

- Enabling ways to raise capital to re-invest into the new £95.8m facility
- Continued operational running of the current site until the new site was ready
- Retaining of staff throughout Heatherwood Hospital sites
- Re-development of the site would help the local authority meet its housing provision requirement
- Land alongside the hospital offering could be opened to public use (for example SANG development).

Members were informed that there was significant advantage in favour of the plans in respect of intrusion onto the green belt. There had been overwhelming support from the local community and local planners. Public engagement events had been held, and work with local planners, health and care partners and key stakeholders was vital. Working with these partners helped to address concerns relating to lowering height and scale, car parking, landscaping, fencing and security. The Board were informed that the new Hospital was scheduled to open in 2021 and would comprise; 6 operating theatres (all laminar flow); 40 beds (half en suite) plus eight private patient beds; 22 day case spaces & endoscopy; outpatient and diagnostic procedures/treatment rooms; surgeries running into the evening and space for primary care hub and a GP clinic. It was expected that within 10 years, the number of patients would double from 85,000 to 168,000. There was a focus on providing services where related procedures could be carried out together with extended hours and that there be a greater amalgamation between primary and community services. These linked services would be known as “one stop shops” and would enhance the current offer of services to be delivered in more efficient ways.

Members were told that great care and detail had been taken in designing the exterior and interiors of the new building and that this work had been co-designed with Friends of Heatherwood and other parties. The Board were informed that there were a number of details yet to be resolved following the planning decision, which included agreeing and approving a full business case to ensure sustainability of services; liaising with health and care partners to ensure that the plans fit within the ICS priorities and to seek approval from NHS improvement. There has been significant investment in the Greenwood offices (formerly

mental health unit) in bringing new life to the hospital. There had been up to 300 staff employed in IT, HR, Finance plus a number of meeting spaces. Members were informed that with the recent opening of the Greenwood offices, there was also the good news with the commencement of building work on site. It was proposed that the start of main construction work on site would begin in February 2019 and that by the end of 2021, commissioning would be complete with the ambition to open the hospital for use.

Tessa Lindfield, Director of Public Health; outlined that there had been a recent public health report which reported the advantages of green space and the positive results this had on recovery. It was queried whether the inclusion of green place had been taken into account with the plans and it was confirmed that this had been taken into account with various floors offering views and green space, and that this was already phased in on the acute site. Dr Adrian Hayter praised the trust for the efficient timeline of works and for the wider offer that would be available to local resident for specialised and non-specialised services. It was outlined that the GP space was an integral part of the hospital and that this service had been well received by patients; it was requested that these spaces be co-designed with the GP network to ensure collaborative aspirations were met and that there was enough practical space for clinics to be carried out. Mark Sanders, (Healthwatch WAM) highlighted that the pending expansion of Heathrow could also increase the population by 40,000 and that community engagement and feedback was incredibly useful in shaping future places of localised services. It was noted that there should be a greater effort to inform the public of the replaced services and current health provisions that were in place.

175/15 ADDRESSING LONELINESS AND ISOLATION- CASE STUDY FROM ST MICHAELS C OF E PRIMARY SCHOOL., ASCOT

Lorna Anderton, Head teacher of St Michael's C of E Primary School gave a presentation on the above titled item. The school was situated within Sunninghill and had served the community for over 200 years. The school had strong community and links with the local Church. The school recognised the value of working with local senior citizens and the value that could be added to pupils' learning and wellbeing, whilst giving importance to caring which was an important school value. It was felt that in giving back to the community children had felt the joy of giving and that it was importance to include vulnerable families and pupils who may have experiences loneliness and isolation. Ways in which the school had engaged with the community were as follows:

- Communications with local care homes and Ascot Day Centre
- Supporting fundraising with the Rotary Club
- Christmas Plays
- Church Services- Harvest & Easter
- Extended invitations to the local community to attend whole school outdoor events
- Remembrance Service
- Bi-Centenary Celebrations
- Sharing facilities with local Nursery School
- Pupils had sent letters and Christmas cards

A Designated Welfare Support lead had been designated at the school, and they had been able to provide a friendly point of contact; bereavement support; access to entitlements; discreet uniform re-cycling; safeguarding; outside agency support; finding support within school community and coffee mornings. Reported benefits of community well-being included taking/having time to listen; genuine engagement/ elevated self-esteem of participants; feeling valued; contributing positively to society. It was noted that SEN pupils had felt a huge sense of achievement without judgment and that research had shown that the positive impact of intergenerational engagement in both physical and emotional wellbeing. Future intergenerational engagement included the following;

- Regular reading sessions to be timetabled
- Nursery School and Day Centre visit St Michael's for community- 'play and learn dates'.
- Working with Nursery, Care Home and Day centre to evaluate the impact on the wellbeing of those involved and assess if feelings of isolation and loneliness had been reduced.
- Questionnaires to be sent to all involved to analyse further ways of support and engagement.
- Reaching out to the most "hard to reach" families to provide meaningful engagement and support.
- Increasing hours of dedicated family support worker.
- Improving holiday care to provide enriching experiences for most vulnerable pupils and families.

At the conclusion of the presentation, Dr Adrian Hayter queried whether consideration had been given to more hard to reach members of the community, such as young carers, overcoming GDPR issues and how to forge strong connections between all parts of the community? Lorna Anderton informed the Board that there were known young carers at the school presently and that they had assisted in transport to a function where the carer was unable to travel independently. More work would be carried out and Members of the Board were pleased with the work being carried out by the school.

176/15 FUTURE IN MIND- LOCAL TRANSFORMATION PROGRAMME CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING

Janette Fullwood, Head of Children, Young People's and Families- East Berkshire CCG gave a presentation on the above titled item. It was noted that the national strategy, Future in Mind, had been published in 2015 which outlined how local services would invest their resources to improve children and young people's mental health across the "whole system". It would also eliminate "tiers" within structures, look at early intervention and promote transformational change. East Berkshire's first local Transformational Plan was published in October 2016 with nine strategic priorities, this had been refreshed in March 2017 and retained the original priorities. It was highlighted that NHS England required all Local Transformation Plans to be refreshed by the end of October 2019. Board Members were told that additional services including online support and community counselling had been rolled out across the patch. PPEP care training had been delivered to all professionals including GPs and teachers. Eating Disorder and Rapid Response were now in place and that the new Anxiety and Depression support tier 2 support via the Andy Clinic (Reading University) was now on offer. It was noted that survey and focus groups had been set up to encourage children and young people's participation. The Board were informed that there had been an increase in Tier 4 admissions but that this had slowed down with the reduction in average length of stay.

Current challenges were outlined as follows;

- A fragmented service offer – children and young people do not always know about the additional support that has been commissioned
- Unfamiliarity among professional partners and school staff, who are often unaware of the services that exist in each area and how to access them
- Rising demand on specialist CAMHS (this continued in the first quarter of 2018, with the total number of referrals up by 14.5% compared to the same quarter in 2017)
- A lack of dedicated mental health roles for early intervention
- Weak links between targeted services within LAs and specialist mental health services
- Under-developed parent/carer participation
- A data-rich but intelligence-poor system with weak transparency of existing data

- The absence of a coordinated, system-wide approach to workforce development
- A high number of inappropriate referrals to specialist CAMHS – approximately 50% of East Berkshire referrals fall into this category
- Collaborative commissioning needs further development
- Transformation to date has focused heavily on the provision of additional services, as opposed to a system-wide approach
- A tiered approach to support, which in practice means that children and young people have to fit the services, rather than the services fitting the changing needs of the child or young person

Key areas of change with the refreshed Local Transformational Plan included, four key priority outcomes and enablers with clear information as to how these outcomes would be achieved. Greater alignment with partners' priorities through links and partnership working would be included in the refresh. There would be a move from consultation to co-production for delivery of the plan with greater multiagency ownership and delivery of the plan through new governance arrangements. There would also be a systematic and suitable approach towards transformation and this would be broader than the additional funds allocation from NHS England. It was noted that there would be four new outcomes and the first outcome was outlined as " Communities, Schools, families and young people will work together to build resilience, learning from young people themselves, how best to help them cope with life's ups and downs." This outcome would be promoted through good mental health and emotional wellbeing to allow young people to thrive and stay positive through the facilitation and development of peer support. The second new outcome- "Children and Young people will have access to early help to meet any emerging emotional and mental health needs", this would primarily focus on early intervention and to ensure that systems that care for children and young people would be easily accessible and effective for the service user. Outcome three- " Better communication- we will provide improved and coordinated information about the mental health and wellbeing support available and we will communicate this is in formation effectively to children, young people and families, communities and professionals; this would be addressed through the dissemination of clear information on the services in the locality relating to mental health and wellbeing. The final outcome was outlined as " improved coordinated care for children and young people with complex mental health needs and vulnerable children and young people- ensuring the right support at the right time in the right place; and it was noted that this would be achieved by providing immediate, round the clock help to children and young people in crisis.

As part of the ongoing work, there would also be strengthened direct governance arrangements for the delivery of the plan with the formation of the new Local Transformation Plan group. The Board were told that Directors of Children's Services and Public Health leads had nominated representatives for this group and that the voluntary sector were now an active part of the Local Transformation Plan group. Outcomes would be translated from the plan in a tangible local offer and that this would differ in each local authority area based on current provision and emerging needs. The group were currently meeting monthly to ensure that the plan was implemented at the pace needed, it was outlined that the CCG would remain the lead in coordinating the plan but that the delivery overall was in the remit of multiple stakeholders. The CCG would provide dedicated project leads to manage the workload and to ensure that there was strong project management with a focus on implementation. The priority concerns with the implementation of early intervention support would be supported by ongoing work with the nominated local authority leads and children/young people to co-produced a specification of early intervention support with a view to the model being implemented by May 2019.

At the conclusion of the presentation, Members were happy with the signed off plan and were keen to learn work together in regards to the local offer. It was noted that there was a new Mental Health team who were currently working with a cluster of schools and that this would be something likely to be rolled out across the patch as part of the refreshed Local Transformation Plan.

177/15 WINTER PLANNING ASSURANCE

Rachel Wakefield, Associate Director Urgent and Emergency Care and Specialist Services, East Berkshire CCG gave a presentation on the above titled item. It was highlighted that NHS England had provided guidance for a phased approach to winter planning. The Frimley ICS plan took into account the overarching resilience, flu plan, winter plan and infection control. Local schemes had been focused on the improvement plan, 111 line, GP services, ambulance services, urgent care centres, local schemes and hospital to home services. It was noted that there had been community step up and down services implemented and that there had been an increased number of staff employed where the demand was higher for those services. There had been notable challenges in WAM and additional staff were needed for the winter period.

It was highlighted that there had been some challenges with the communications programme process and it was difficult to see where services could be accessed. Work had been carried out with the 111 service to provide more information to residents and further work was being carried out with the walk in services. It was reported that there had been better performance for these services over the last twelve months and projected performance was expected to increase with the dissemination of information to patients. It was stated that there had been better performance throughout the severe weather period due to the 2018 projected milder weather with a delayed start to the announcement of the official flu period (25th December 2018). There had been challenges throughout the first week of the new year with a notably high rate of admissions at hospital with flu related symptoms, and it was noted that there had been increased pressures upon the urgent care and accident/emergency services. It was noted that other systems were working well and that this could change with the increased demand for health care with instances related to flu.

Members were informed that the out of hours service had seen a decrease in demand in the weeks leading up to Christmas but that the demand was now increasing with higher numbers of patient calls to the service. It was noted that partnership working with services was going well but that there was room for improvement once trends had been identified. Berkshire Healthcare Trust had been working effectively and the Board were informed that more nursing home beds had been commissioned. Further updates included the re-opening of the detox ward at Wexham park, which would be open for use in January 2019. At the conclusion of the presentation members agreed that there had been a many positives and that the work be commended.

178/15 STANDING ITEM: UPDATE ON THE SUB BOARDS

Kevin McDaniel, Director of Children Services updated the board on the above titled item. It was noted that all Boards had made significant progress and that the pace of delivery was good.

179/15 QUESTIONS FROM THE PUBLIC

No questions from the public were received.

180/15 ANY OTHER BUSINESS

None.

181/15 FUTURE MEETING DATES

Noted.

The meeting, which began at 3.05 pm, ended at 4.52 pm

CHAIRMAN…….

DATE…….....

Subject:	Joint Strategic Needs Assessment 2019
Reason for report:	To present the Joint Strategic Needs Assessment update for 2019, for sign off and publication
Responsible officer(s):	Hilary Hall, Interim Director of Adult Services and Deputy Director Strategy and Commissioning
Senior leader sponsor:	Hilary Hall, Interim Director of Adult Services and Deputy Director Strategy and Commissioning
Date:	2 July 2019

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Royal Borough of Windsor & Maidenhead

SUMMARY

This paper presents the 2019 update of the Joint Strategic Needs Assessment for sign off and publication. It also describes the long term plans for the Joint Strategic Needs Assessment. It provides an overview of the structure and priorities associated with the current update and details of the proposal for how the process will be adapted and improved moving forward.

1 BACKGROUND

1.1 The Joint Strategic Needs Assessment has been a joint duty between the local authority and the Clinical Commissioning Group, on behalf of the Health and Wellbeing Board, for 10 years. It looks at the current and future health and care needs of the local population to inform and guide local decision making. One of its key focuses is to highlight and encourage local decision makers to address any variations and inequalities that exist in the health and wellbeing of the borough.

1.2 The Joint Strategic Needs Assessment has a wide audience including the general public, voluntary sector and local businesses. However, the key audiences are health and social care commissioners.

1.3 Since 2013, the local authorities across Berkshire have followed a similar structure that splits the chapters into significant areas of life – e.g. developing well, living well, ageing well etc. Despite following a similar structure, the focus of the chapters remains based on the individual needs of each local authority area. This process has been supported by the shared public health team who provide data to facilitate any local updating.

1.4 Both locally and across Berkshire, it has been felt that the Joint Strategic Needs Assessment is:

- Underutilised.
- Often out of date/ not timely or relevant.
- Taking a disproportionate amount of time to produce in relation to its impact on evidence based decision making.
- Out of date with developments across the country.

1.5 The development of the current update has been running in parallel with a review of the Joint Strategic Needs Assessment structure and process across Berkshire. A new Berkshire approach is gradually introduced throughout 2019/20, which moves away from a traditional online document of reports to a suite of tools that can be used to interrogate data at any time during the year in response to need.

2 KEY IMPLICATIONS

2.1. The current update of the Joint Strategic Needs Assessment, see Appendix 1, will serve as an interim arrangement for the borough. It is up-to-date, reflects the needs of the borough and enables the Health and Wellbeing Board to fulfil its duty.

2.2. The new Berkshire approach have positive implications for the Royal Borough. By creating an online resource that is up-to-date and relevant, future Joint Strategic Needs Assessments can support decision makers to utilise and target public funds in the most cost-effective and timely manner.

3 DETAILS

Current update

3.1 The development of the 2019 Joint Strategic Needs Assessment has been informed by three rapid needs assessment. The priorities emerging from these assessments have been included within three chapters that cover the main stages of life; children and young people (developing well), working age adults (living well), and older adults (aging well).

3.2 The priority areas identified in the three rapid needs assessments are set out in table 1.

Table 1: Priority areas

Developing Well	Living Well	Ageing Well
• Autism. • Child obesity. • Child poverty. • Emotional and mental health. • Immunisations. • A&E admissions.	• Mental health. • Cardiovascular diseases (specifically diabetes). • Dementia. • Alcohol related road traffic accidents. • Excess weight. • Use of green spaces for exercise or health reasons. • Smoking in intermediate groups.	• Sight loss, including age related macular degeneration. • Falls. • Immunisations. • Dementia.

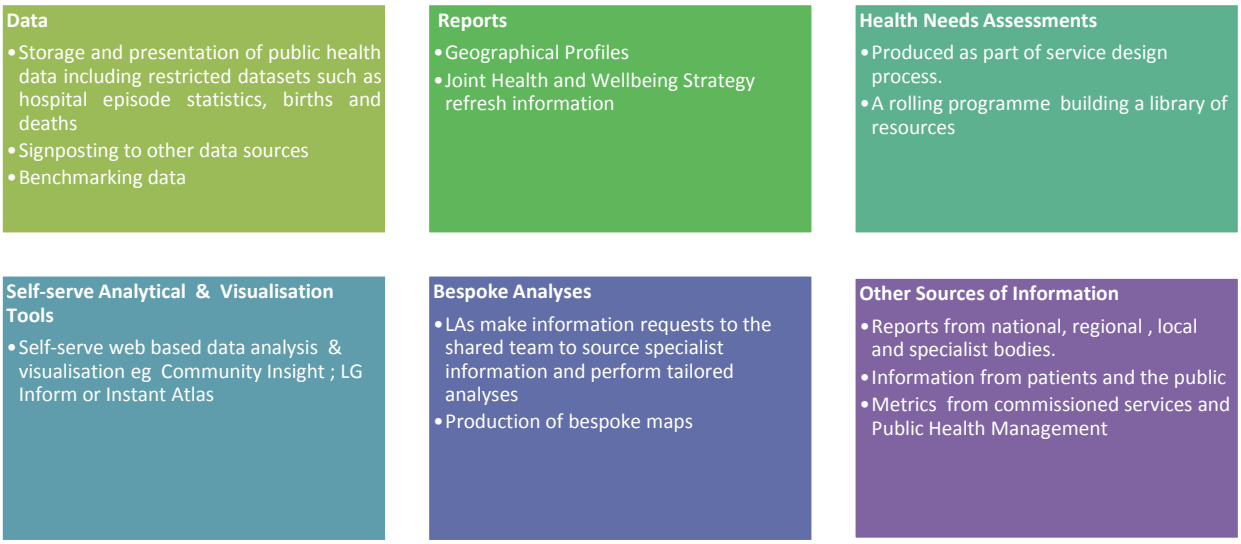
3.3 In addition to the three life stages chapters, the Joint Strategic Needs Assessment also includes chapters on: population, deprivation, life expectancy, employment and income, housing and homelessness, crime and disorder, domestic abuse, the environment and road safety. Recommendations from each of these chapters are summarised on pages i – iii of Appendix 1.

Long term plan – Berkshire Approach

3.4 The Berkshire approach sees the Joint Strategic Needs Assessment move away from a traditional online document of reports to a suite of tools that can be used to interrogate the data. Rather that updating chapters and reports each year, it is proposed that all six authorities will work to build a library of resources which will include analysis of local needs and evidence of intervention effectiveness. These can be tailored to align with the local commissioning cycle, ensuring that the Joint Strategic Needs Assessment remains timely and relevant, maximising its impact. There will also be an online data platform that will present data in a visual and accessible way.

3.5 The new suite of resources is shown in Figure 1. Many of these are in place already but work will be needed to develop a range of new local routine reports by the shared team; to roll out the self-serve tool and build the library of resources. A key new area of work will be the inclusion of data from patients and residents.

Figure 1: Joint Strategic Needs Assessment building blocks



3.6 The costs associated with the procurement of the self-service analytical and visualisation tool will be absorbed within the budget of the shared public health team, which is funded jointly by all six Berkshire authorities. The Joint Strategic Needs Assessment will continue to have an associated cost of officer time for the borough; however, it is not envisioned that this will be any more than currently utilised and even presents a possibility to lower this cost.

4 RISKS

4.1. There is a risk of inefficient use of limited resources if the Joint Strategic Needs Assessment process remains in its current format. The Berkshire approach aims to reduce this risk and make the best use of resources to produce a Joint Strategic Needs Assessment that is relevant, up-to-date and an asset to the local authority.

www.rbwm.gov.uk

Royal Borough of Windsor & Maidenhead

Royal Borough of Windsor & Maidenhead

Joint Strategic Needs Assessment

May 2019

“Building a borough for everyone – where residents and businesses grow, with opportunities for all”

Our vision is underpinned by six priorities:

Healthy, skilled and independent residents
Growing economy, affordable housing
Safe and vibrant communities
Attractive and well-connected borough
An excellent customer experience
Well-managed resources delivering value for money

CONTENTS

Frequently used acronyms

JSNA	Joint Strategic Needs Analysis
RBWM	Royal Borough of Windsor & Maidenhead

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SUMMARY OF RECOMMENDATIONS

Chapter	Theme	Reference	Recommendation
4	Deprivation	4.8	When designing services or undertaking campaigns, partners should not treat the borough with a blanket approach. Partners should target resources and messages proportionately to take into consideration the varying levels of deprivation and risks to health. This proportionate approach should be considered, where appropriate, when developing local plans, strategies and commissioning services for the borough.
		4.9	Detailed data reflecting the new ward boundaries should be produced as soon as possible to ensure commissioners can continue to target the most affected.
5	Life Expectancy	5.12	The Royal Borough should continue to monitor the life expectancy and mortality rates across the borough and ensure that this intelligence is available to partners and commissioners in order to help target resources where most needed.
		5.13	The Royal Borough should continue to work with primary care to champion early identification and prevention of the leading causes of mortality such as cancer and cardiovascular diseases. Consideration should be given to a range of health checks options and hypertension case finding.
		5.14	Promoting the health of the working age population can help to prevent diseases in later life and improve premature mortality rates. Public Health should focus on workplace health campaigns and support businesses to support their staff.
		5.15	Agencies across the borough should consider targeting health interventions and support to those areas that experience poorer life expectancy in order to help reduce health inequalities within the borough.
8	Employment and income	8.24	The Royal Borough should continue to offer targeted support for young people aged 16-24 through the ElevateMe programme run by Grow Our Own, including the Extended Support Programme for those aged 16-24 who have a mental health condition, autism and/or learning difficulties.

Chapter	Theme	Reference	Recommendation
		8.25	The Royal Borough should continue to look at ways of supporting vulnerable groups as a whole into work, ensuring pathways between employment and training services and services working with marginalised residents are strengthened.
		8.26	Whilst not directly within the control of the Royal Borough, leading by example as well as seeking ways to work with local business and organisations to address the gender pay gap should be considered.
9	Housing and Homelessness	9.32	The Royal Borough, with its partners, should implement the actions outlined in the council's Homelessness Strategy 2018-2023 and continue to progress the Borough Local Plan to provide the strategic framework for sustainable housing development, as well as the council's regeneration plans and provision of housing through its joint ventures and the work of the RBWM Property Company.
10	Crime and Disorder	10.25	Support the increased mental health support for children and young people who commit crimes/offences and evaluate impact of mental health worker being established within the Youth Offending Team.
		10.26	Continue to develop a trauma informed approach when supporting children and young people who have offended and continue to develop a holistic approach to work with the whole family when supporting young people who are offending.
		10.27	Continue to work in partnership to identify opportunities for early intervention to support children and young people at risk of falling victim to crime and making harmful decisions.
		10.28	Support the community to help manage the impacts of the night-time economy.
11	Domestic Abuse	11.21	Further multi agency working to raise awareness of the impacts of domestic abuse of children and young people and the support available.
		11.22	Explore how perpetrator support can be better utilised within the borough.
		11.23	Exploring how the council can support victims fleeing domestic abuse who could be viewed as making themselves intentionally homeless if leaving a tenancy in their name.

Chapter	Theme	Reference	Recommendation
		11.24	Explore options for extending support for male victims of domestic abuse
12	Our Environment	12.13	Continue to progress the Borough Local Plan to ensure development is sustainable and managed.
		12.14	Maintain and enhance access to the borough's parks and open spaces to ensure resident satisfaction remains high.
		12.15	Implement the actions of the cycling action plan.
		12.16	Implement the actions in the Air Quality Management Plan.
13	Road Safety	13.29	Maintain and continue to build close working relationships across partners to deliver road safety programmes.
		13.30	Continue to carry out campaigns aimed at improving cyclist safety (e.g. THINK Cycling, bike lights, Bikeability, including Level 3 in Secondary schools).
		13.31	Continue to work with young drivers to disseminate road safety messages (e.g. Safe Drive Stay Alive, Drive Start).
		13.32	Continue to work with retailers and nurseries to raise awareness of car seat safety, provide advice on correct fitment of car seats and carry out car seat checks.
		13.33	Maintain focus on Local Road Safety Schemes in areas with the highest casualty rates.

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1 INTRODUCTION

1.1 A Joint Strategic Needs Assessment (JSNA)[1] looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area. This JSNA aims to give all stakeholders a high level understanding of the population of the Royal Borough of Windsor and Maidenhead.

1.2 The main audience for the JSNA are health and social care commissioners who use it to plan services. It can also be used as an evidence base for preparing bids and business cases:

- by the voluntary and community sector to ensure that community needs and views are represented.
- by service providers to assist in the future development of their services.
- by the public to scrutinise local health and wellbeing information, plans and commissioning recommendations.

1.3 The findings and recommendations identified by the JSNA will provide an evidence base for system health and wellbeing decision making and commissioning.

1.4 The borough's JSNA has been co-produced with partners, supported by three rapid needs assessments, and focused on the three life course areas: children and young people, working age adults and older people.

1.5 This JSNA is seen as an interim measure to ensure the Royal Borough has up-to-date information published online, reflects the needs of the borough and that enables the Health and Wellbeing Board to fulfil its statutory duty.

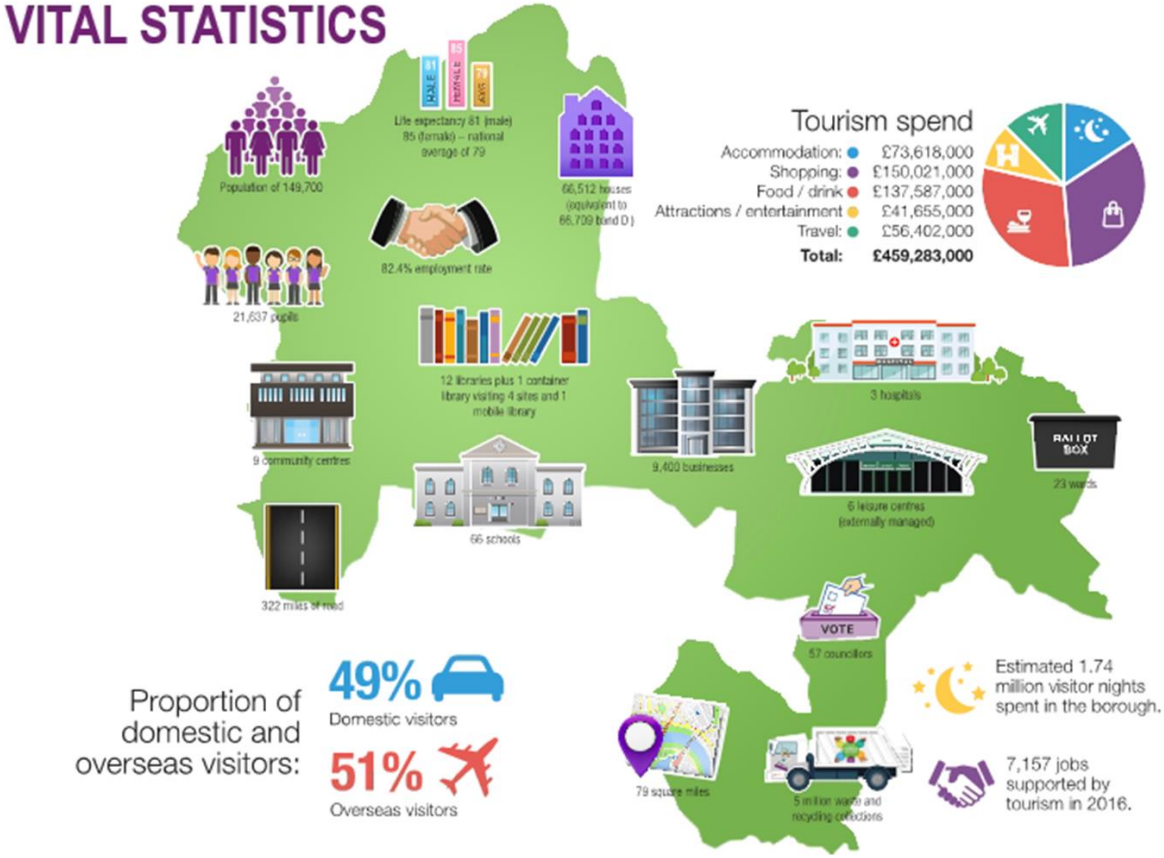
1.6 A new Berkshire-wide approach to the JSNA will be gradually introduced throughout 2019/20, which moves away from a traditional online document of reports to a suite of tools that can be used to interrogate data which enables commissioners to access real-time updated data to inform decision making.

[1] The requirement for all local areas to produce a Joint Strategic Needs Assessment (JSNA) is set out in the Local Government and Involvement in Public Health Act (2007). The Health and Social Care Act 2012 ('the Act') amends the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing boards in relation to JSNA and Joint Health and Wellbeing Strategies (JHWSs).

2 OUR BOROUGH PROFILE

2.1 The Royal Borough of Windsor and Maidenhead is 79 square miles, located in Berkshire at the heart of the Thames Valley, less than 30 miles west of central London. It comprises three main settlements; Ascot, Maidenhead and Windsor, and enjoys a predominantly rural setting, including Green Belt, Crown Estate and National Trust land, with 60 parks and open spaces.

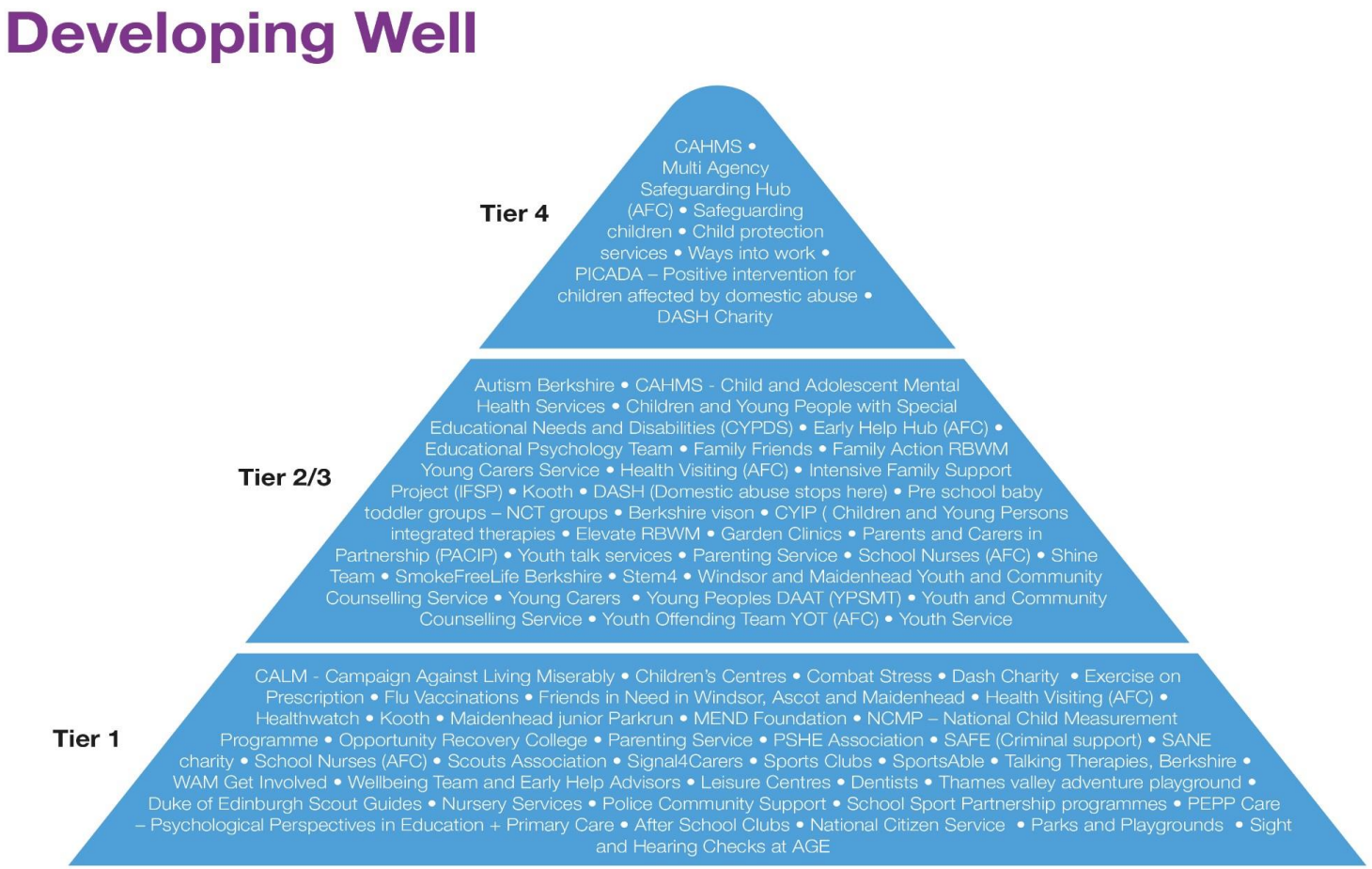
Figure 1: Snapshot of community facilities



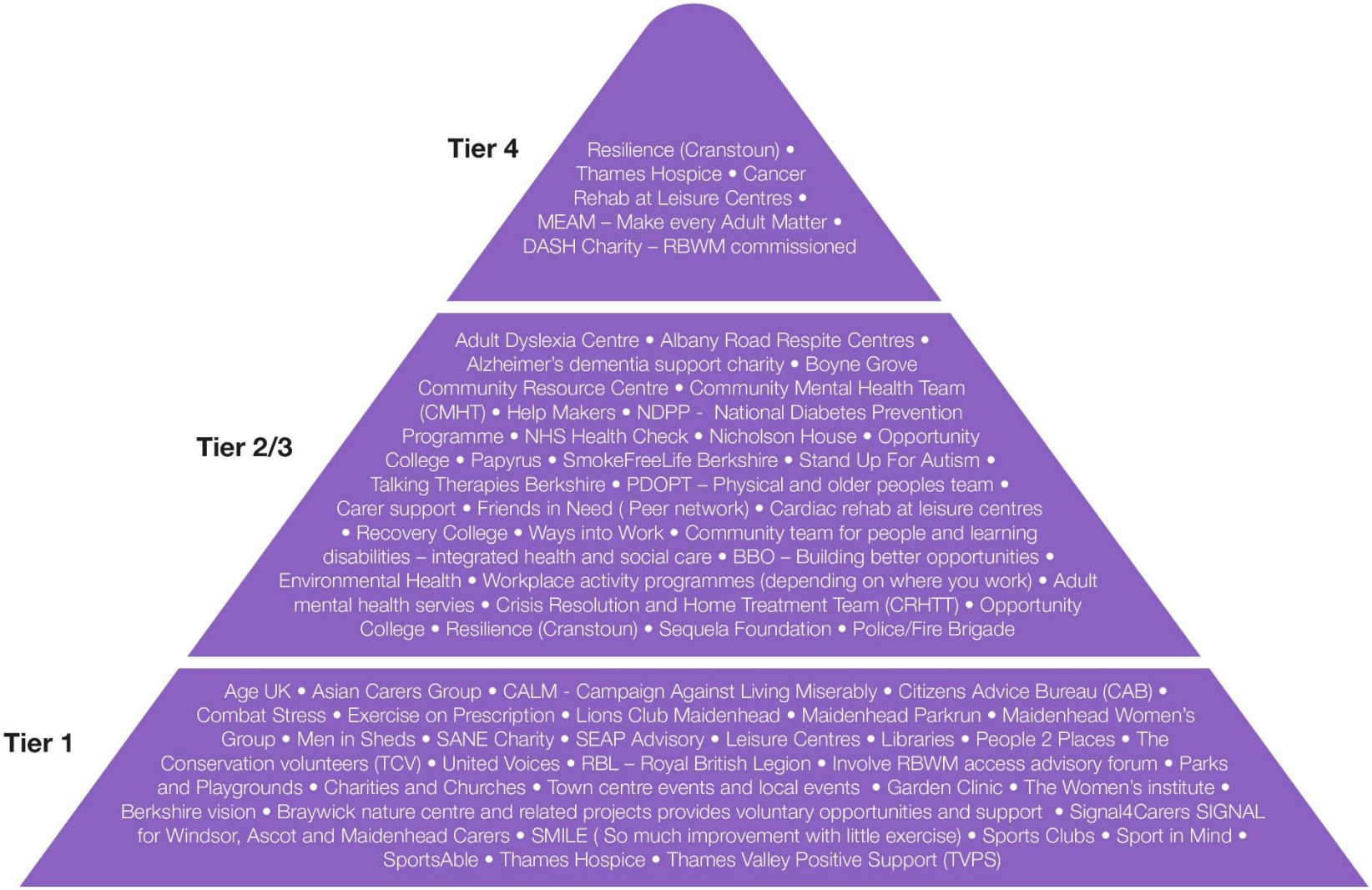
2.2 In addition to the variety of facilities outlined in Figure 1, the JSNA research mapped the services available to residents at the three stages; developing well, living well and ageing well, see Figure 2.

2.3 The range and breadth of universal and specialist services highlighted in Figure 2 demonstrates the range of support for residents of the borough provided by the council, its partners and the voluntary and community sectors.

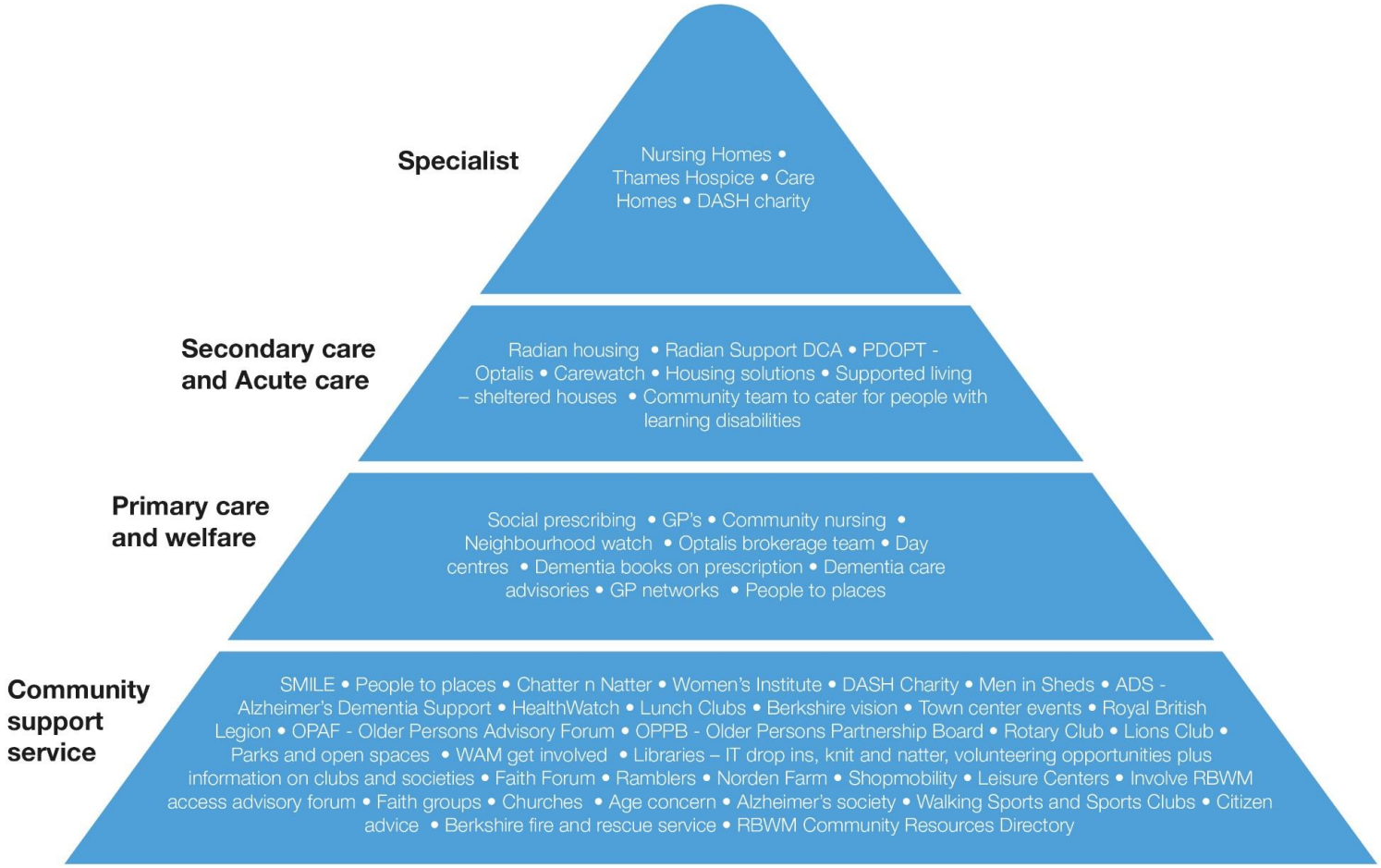
Figure 2: Community assets and services through the life course



Living Well Context



Ageing Well Context



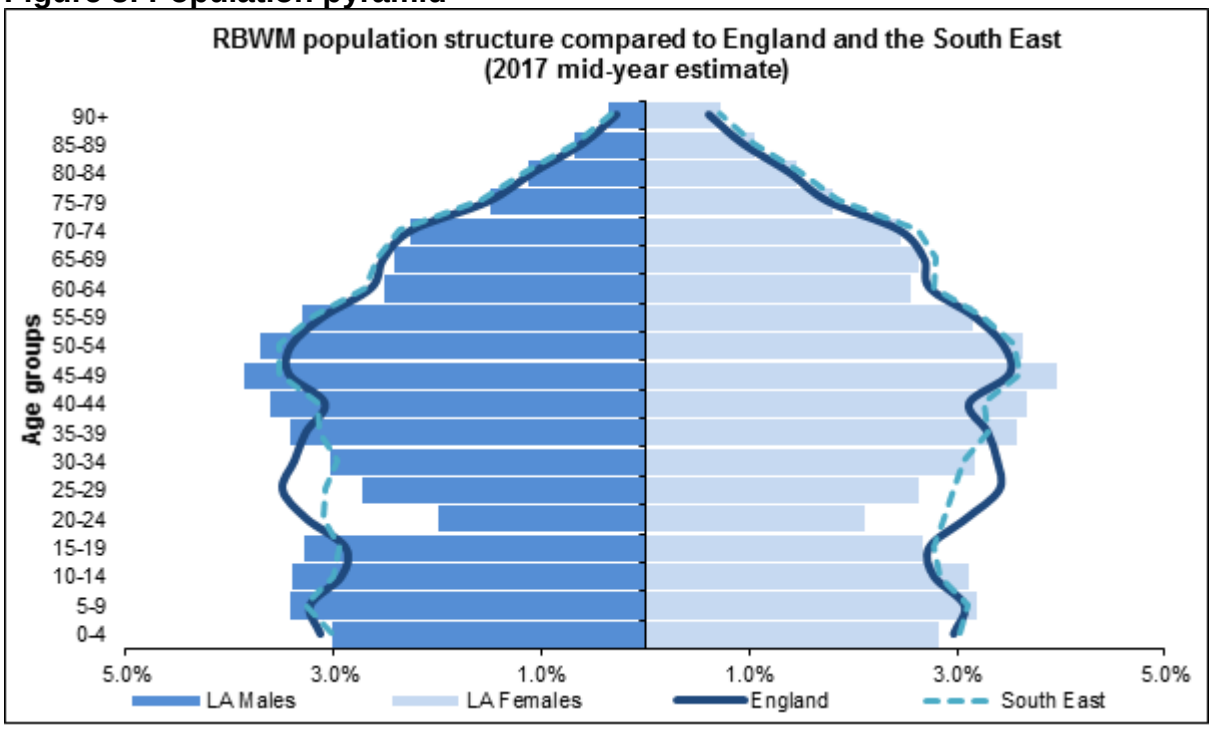
3 OUR POPULATION

3.1 According to the 2017 Mid-Year Estimates of population, published by the Office for National Statistics (ONS), England's estimated population was 55,619,400. This was an increase of 0.64% on the previous year (June 2016) and an 8.2% increase on the previous 10 years (June 2007). Approximately 50.6% of the population were female and 49.4% were male in June 2017.

The Royal Borough of Windsor and Maidenhead's age profile

3.2 The estimated population of the borough was 150,140 in June 2017. The median age was 41.8, compared to 39.8 in England. The population in the borough continues to age with 18.4% of the population aged 65 and over in 2017. This is similar to the England average figure of 18.0%.

Figure 3: Population pyramid[2]



3.3 In terms of overall breakdown, figure 3 demonstrates that the borough's population profile is similar to the national picture. However, there are some differing trends when looking at particular age groups. For instance, the borough has a lower proportion of adults aged 20-34 and a higher proportion of adults aged 35-59. There is also a slightly higher than average percentage of school-age children (5-19 years) when compared to the England average.

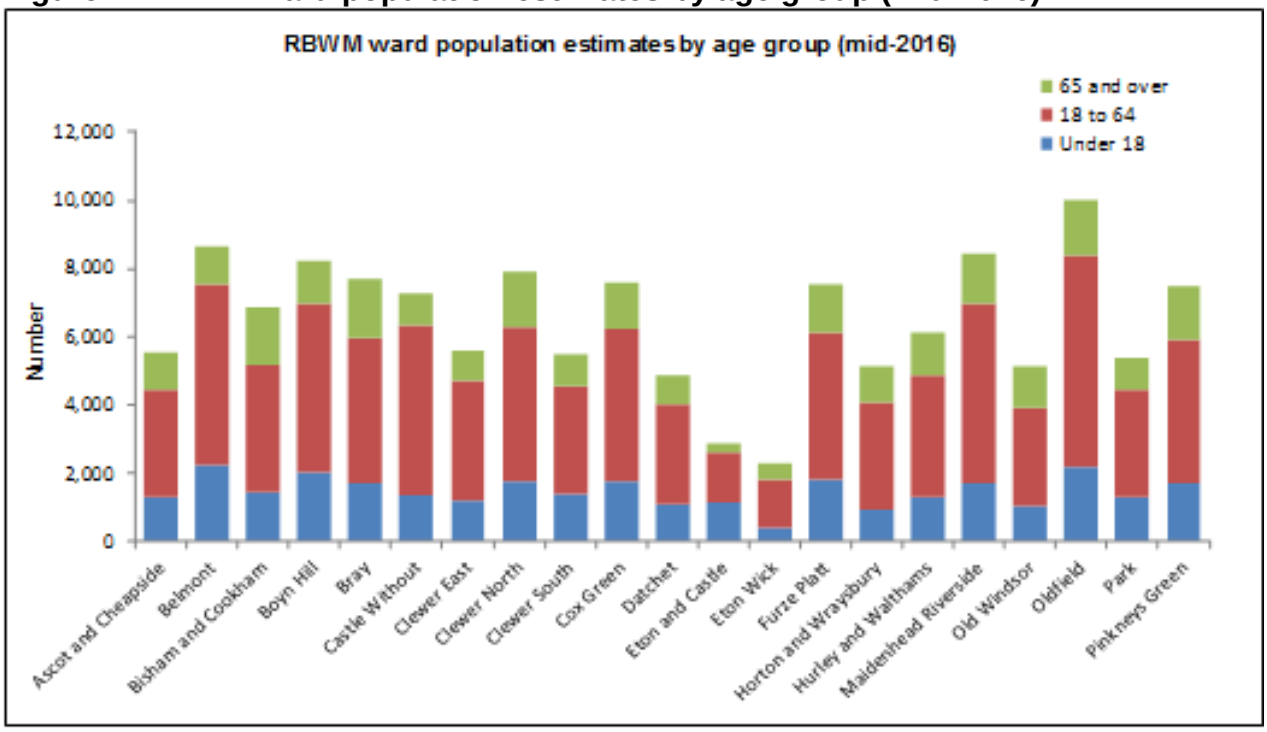
Ward level population

3.4 The largest wards in terms of population are Park (11,015) and Oldfield (10,020), and the smallest is Eton Wick (2,278). The age distribution within different wards in the borough varies considerably and this will impact on the service and access needs of people living in different areas. For example, almost 25% of people living in Bisham and Cookham are aged 65 and over, compared to 18.2% in the borough

[2] Windsor and Maidenhead data compared to England and the South East (source: Mid-Year Population Estimates 2017, Office for National Statistics (ONS))

overall. In contrast, about 40% of people living in Eton and Castle are aged under 18, compared to 23% in RBWM[3].

Figure 4: RBWM ward population estimates by age group (mid-2016)[4]



3.5 Effective May 2019, the borough has implemented new boundaries following recommendations from the Local Government Boundary Commission for England[5]. Data is not yet available for the new ward boundaries although interim ward profiles have been produced based on Lower Super Output Area data.

Components of population change

3.6 There are two main elements of population change: natural change and migration. Natural change is an expression of the number of births to mothers resident in an area minus the number of deaths of residents. Migration includes internal migration – people moving in and out of an area from within England and Wales, and international migration – people moving to or from other countries.

3.7 There was an increase of 456 people (0.3%) in the borough on 2016's estimated figures and an increase of 10,397 people (6.9%) on 2007's figures[6]. The increase in population in the borough from 2016 to 2017 was due to natural growth (net increase of 456 people), and international migration (net increase of 385 people). Internal migration was the one area that led to a reduction in population (net decrease of 386 people)[7].

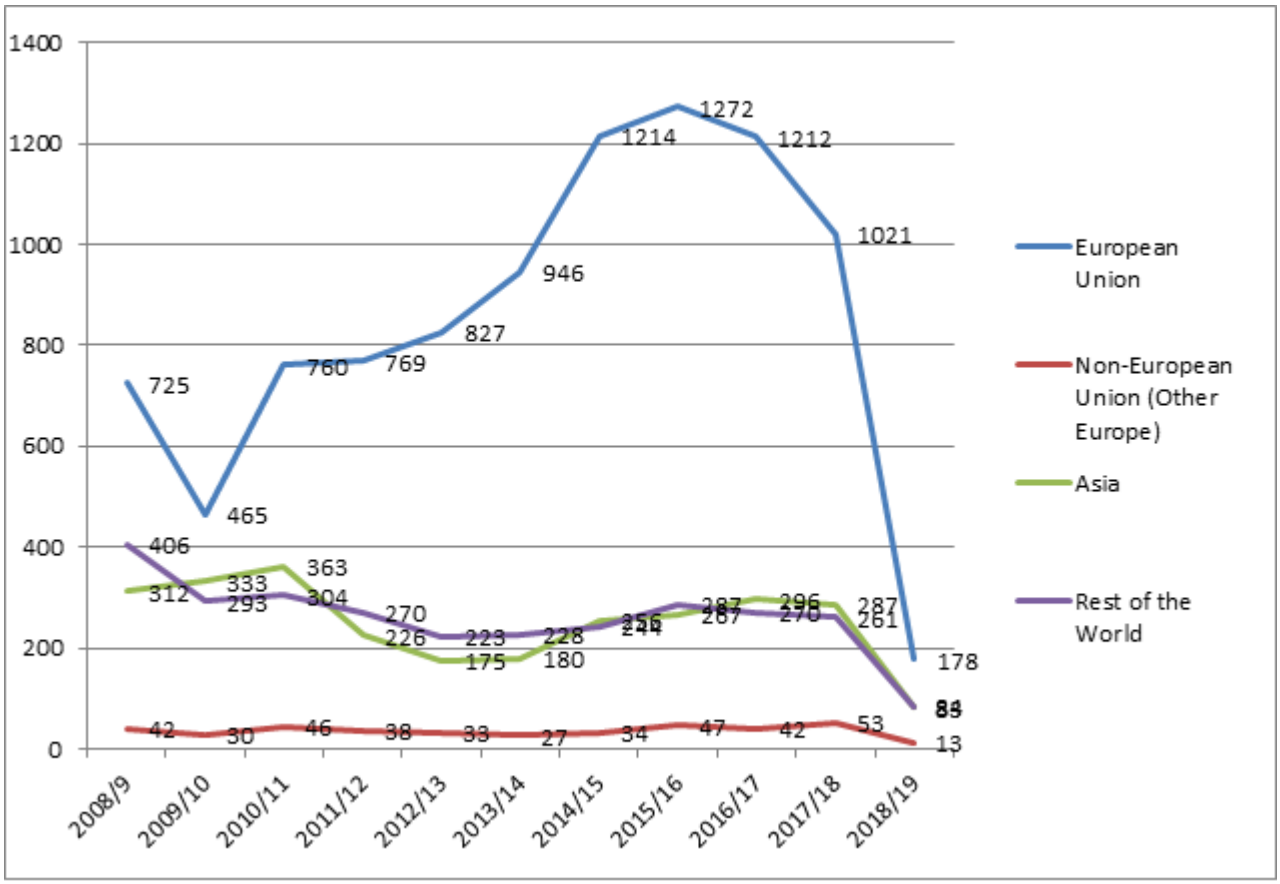
[3] Mid-Year Population Estimates 2016, Office for National Statistics (ONS)
[4] Office for National Statistics (2018); Population Estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2016 (revised by ONS in Mar-18)
[5] Detail on the LGBCE report: https://www.lgbce.org.uk/all-reviews/south-east/berkshire/windsor-and-maidenhead
[6] Mid-Year Population Estimates 2017, Office for National Statistics (ONS)
[7] Mid-Year Population Estimates 2017, Office for National Statistics (ONS)

3.8 When looking at the longer term population estimates, the borough population is expected to grow. By 2041 it is estimated that the population will be 159,700. This is similar to the national picture with almost all local authority populations projected to grow, with only 15 local authorities projected to fall by mid-2026.

Impact of Brexit

3.9 Brexit is likely to have some impact on migration into and out of the United Kingdom and consequently the borough. Figure 5 shows the economic migration into the borough, it shows that economic migration from the European Union grew exponentially (46.6% increase) up until 2015/16, however between 2015/16 and 2017/18 the trend reversed and it began to drop. In 2017 it reduced by 15.7%. Figure 5 also shows that in migration from Non EU, Asia and the Rest of the world accounted for 41.1% of migration in 2017/18.

Figure 5: Economic migration to the Royal Borough of Windsor and Maidenhead[8]



3.10 Further analysis investigating the industries that employ these workers shows that industries employing higher percentages of EU Nationals also employ a good percentage of employees from the rest of the world. This suggest that these industries have some built in resilience with regard to the undetermined impacts of Brexit, such as migration back to the EU.

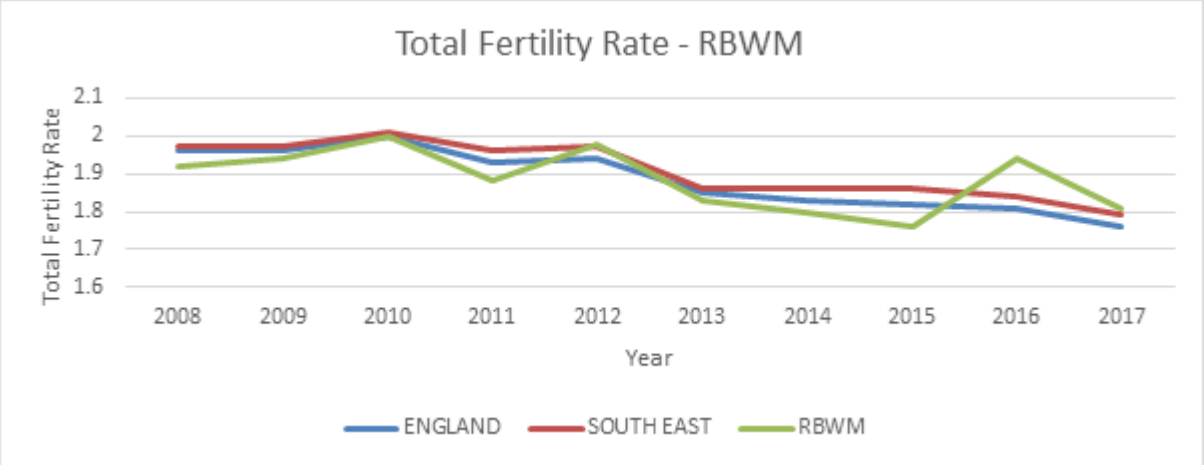
[8] (Source: DWP National Insurance number allocations to adult overseas (NINO) 2018,Stats Xplore View)

Birth rate

3.11 The number of births in an area is dependent on the number of women of childbearing age and the likelihood of them giving birth. There are two measures for birth rate: total fertility rate and general fertility rate.

3.12 The Total Fertility Rate (TFR) is the average number of children that a group of women would have if they experienced the age-specific fertility rates for the calendar year in question throughout their child bearing lifespan. Figure 6 shows that in in 2017, the borough had a slightly higher TFR (1.81) than England (1.76) and the South East region (1.79)[9].

Figure 6: Total Fertility Rate in RBWM compared with England and the South East between 2018 and 2017

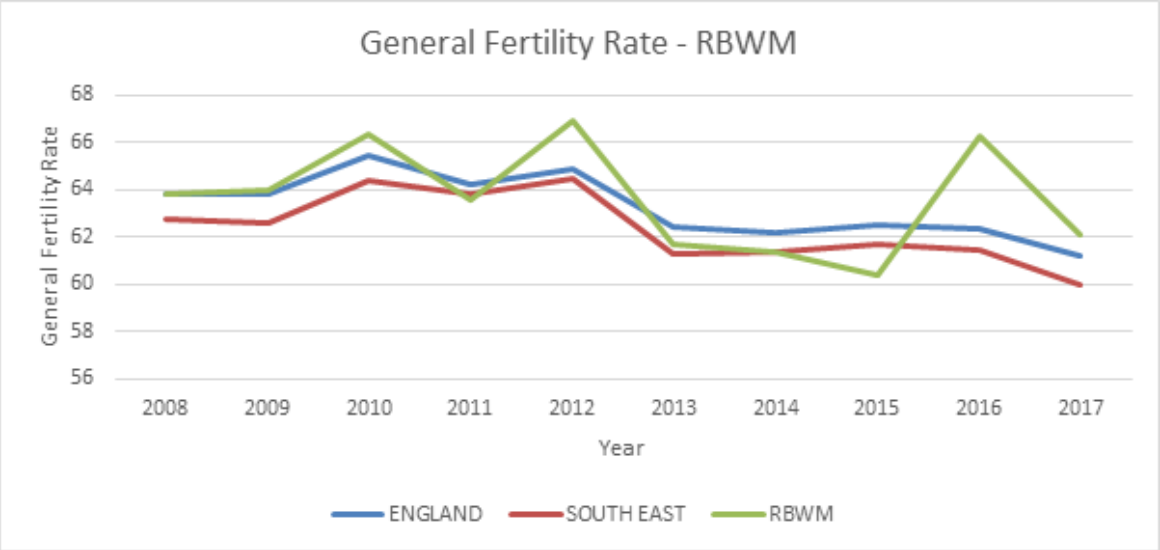


3.13 The General Fertility Rate (GFR) is the number of live births per 1,000 females aged 15-44 years. GFR in the borough was 62.1 in 2017, slightly higher than the rate for England (61.2) and the South East region (60.0)[10], shown in figure 7.

[9] Births in England and Wales, 2017 - Office for National Statistics (ONS)

[10] Births in England and Wales, 2017 - Office for National Statistics (ONS)

Figure 7: General Fertility Rate in RBWM compared with England and the South East between 2018 and 2017



What does this mean for the borough?

3.14 When compared with the England average, the borough has a larger population of adults aged 35-59 years and school age children (5-19 years). The borough also has a smaller population of adults aged 20-34 years when compared with the national average. There are also differing age profiles across the wards. These differing age profiles need to be taken into consideration when commissioning and placing services within the borough.

3.15 Whilst the implications and terms of Brexit are unclear, there is currently not an over reliance on EU national workforces by industries within the borough and this will help minimise any potential negative implications of Brexit.

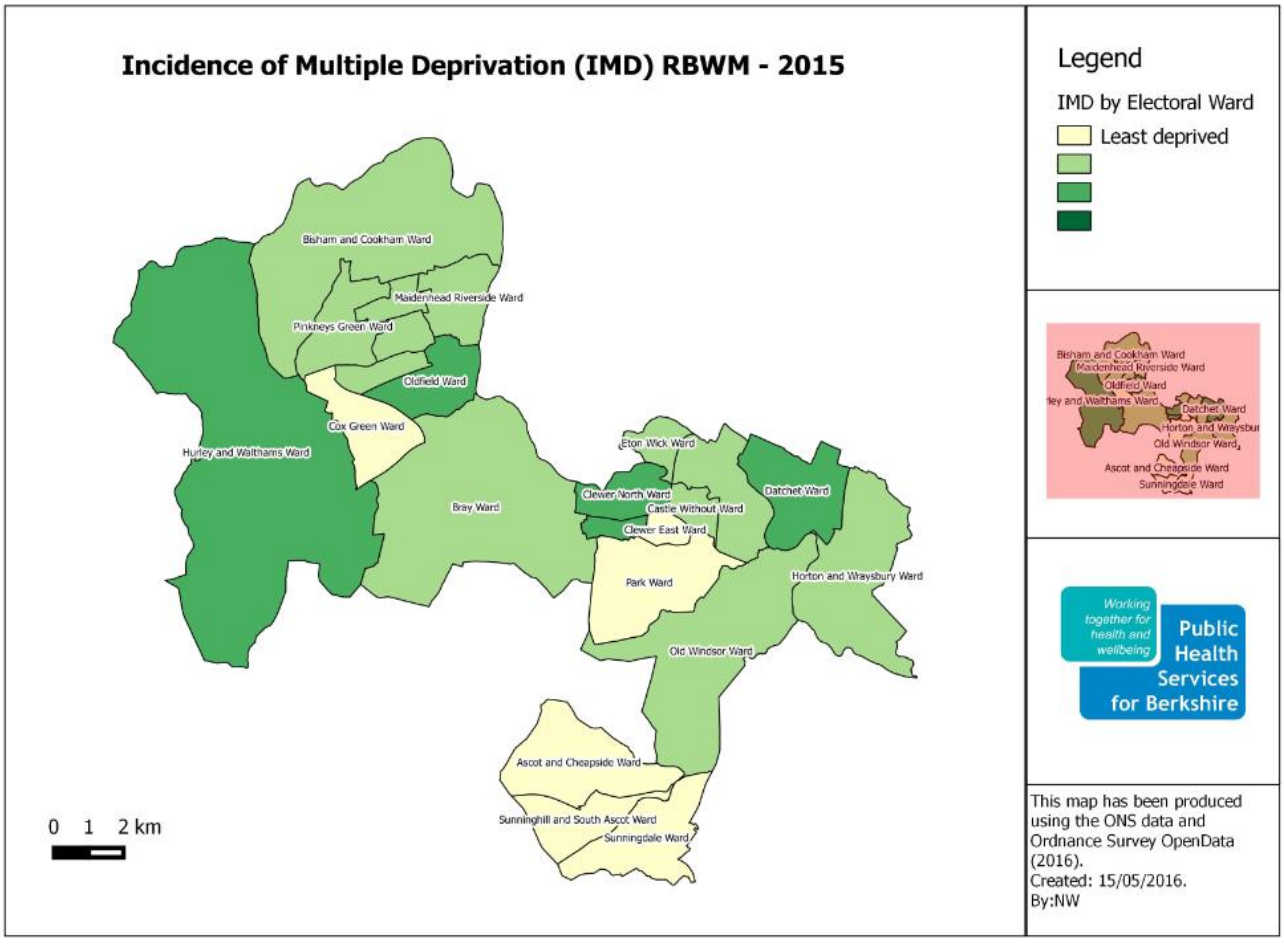
4 DEPRIVATION

4.1 The Index of Multiple Deprivation (IMD) scores an area on its level of deprivation relative to the country as a whole. Deprivation is multi-faceted, and whilst commonly references are made to income poverty, the IMD actually breaks the concept into several distinct areas or 'domains', each measuring a particular aspect of deprivation. These include crime, income, employment, education, health, housing and the environment.

Facts, Figures and Trends

4.2 The Royal Borough of Windsor and Maidenhead is an affluent borough. Based on IMD 2015, the borough is ranked 306 out of 326 local authorities (1st being most deprived, 326th being least deprived). This means the borough falls into the 10% of least deprived areas in England. An overview of how the borough and its constituent wards compare to the national picture is provided in figure 8 below. Figure 8 shows that although no wards within the borough fall within the 10% most deprived wards nationally, there are still variations across the borough with areas of relative deprivation, such as Clewer North and Oldfield.

Figure 8: Index of Multiple Deprivation[11]



4.3 Figures 9 and 10 show the income deprivation affecting both children and older people respectively within the borough at ward level. Comparing the two figures, it is

[11] Data source for figure 8-10: Office for National Statistics, 2016

clear that there is a greater variation in income deprivation for children when compared to older people. It also shows that some wards can be featured within the least deprived for income deprivation affecting older people but one of the more deprived for income deprivation affecting children, for example Horton and Wraysbury.

Figure 9: Income deprivation affecting children

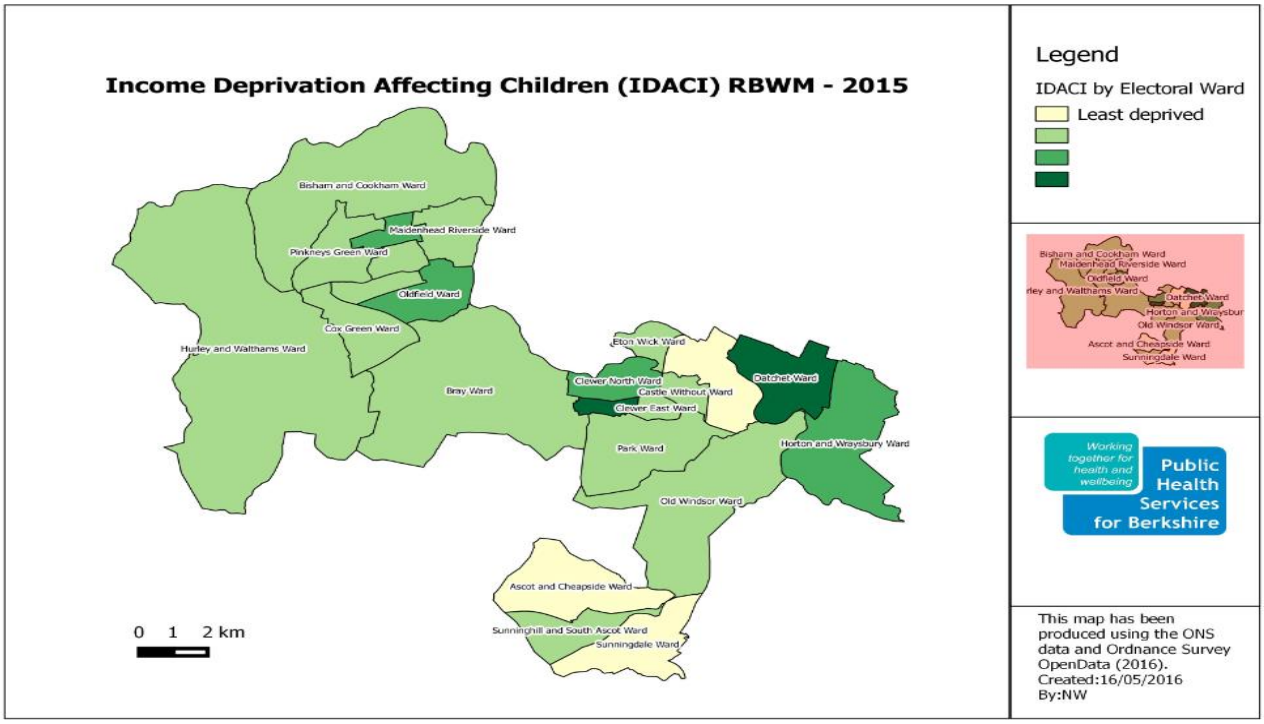
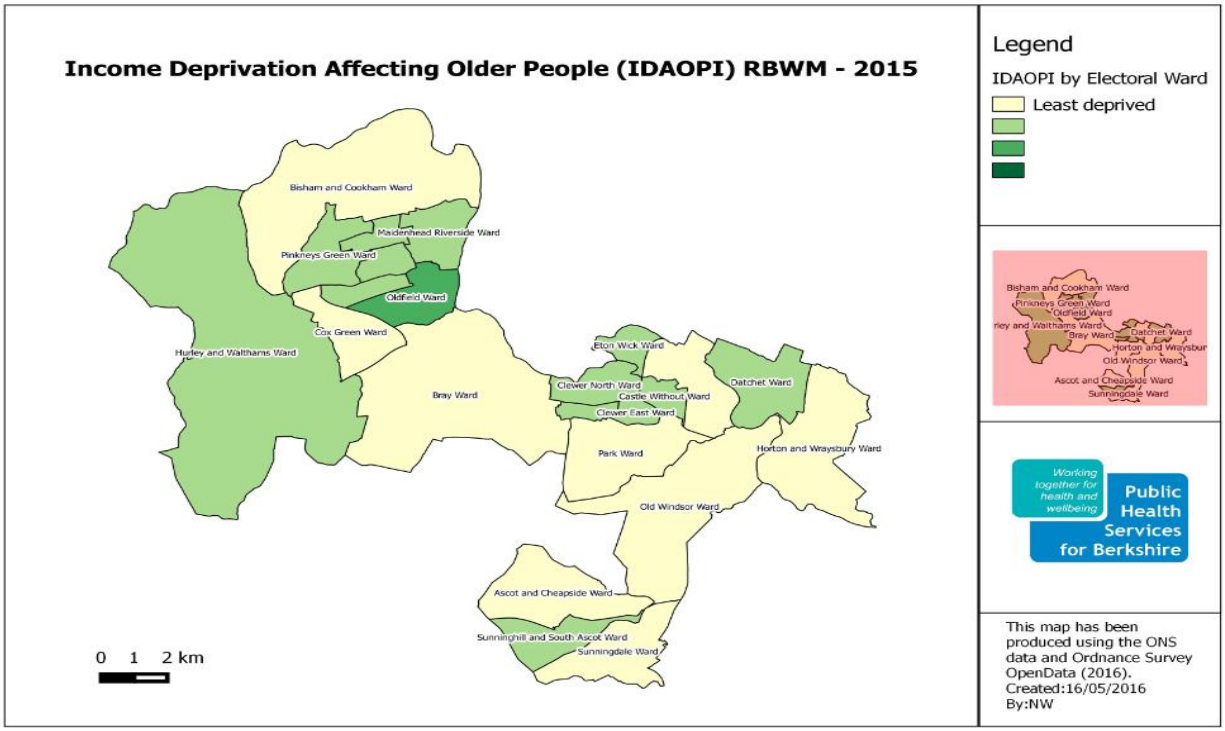


Figure 10: Income deprivation affecting older people



4.4 As a result of the borough's electoral review, the boundaries of all but five wards have changed. This will, in turn, have an impact on the IMD scores, meaning the above figures will be out of date until the next IMD release, likely in 2020.

4.5 Until the new release, ward level data can be broken down further into smaller areas called Lower Super Output Areas (LSOAs). LSOAs are commonly referred to as 'neighbourhoods'. This is helpful as it reveals more information about deprivation. When looking at LSOAs it becomes even more apparent that whilst the borough, as a whole, can be largely characterised as affluent, there are pockets of relative deprivation; however, no LSOAs feature within the 10% most deprived LSOAs nationally.

National and local strategies (current best practice):

4.6 Nationally the 'Fair Society Healthy Lives' report (The Marmot Review, 2010) outlines proposals for reducing inequalities in relation to health. It found that there is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health. Action on health inequalities requires action across all the social determinants of health. As the report is approaching 10 years old, it is currently being reviewed by The Health Foundation and the Institute for Health Equity. The specific areas of focus being examined are:

1. Overarching issues
- Widening health inequalities
- Place and communities

2. Early years and education
- Good level of development in early years and GCSE attainment
- Child poverty

3. Work and income
- Quality of work
- Minimum income

4. Housing, places and communities
- Housing quality, affordability and supply
- Social isolation and loneliness

What are the key inequalities?

4.7 The domains measured (e.g. employment, education, crime etc.) to produce the IMD scores will all have an influence on an individual's and a community's health. The data has shown that there is variance within the borough which, in turn, would suggest that those residents who live in the more deprived areas are at greater risk of having / developing poorer health outcomes when compared with residents who live in the areas of less deprivation.

Recommendations for consideration

4.8 When designing services or undertaking campaigns, partners should not treat the borough with a blanket approach. Partners should target resources and messages proportionately to take into consideration the varying levels of deprivation and risks to health. This proportionate approach should be considered, where appropriate, when developing local plans, strategies and commissioning services for the borough.

4.9 Detailed data reflecting the new ward boundaries should be produced as soon as possible to ensure commissioners can continue to target the most affected.

5 LIFE EXPECTANCY

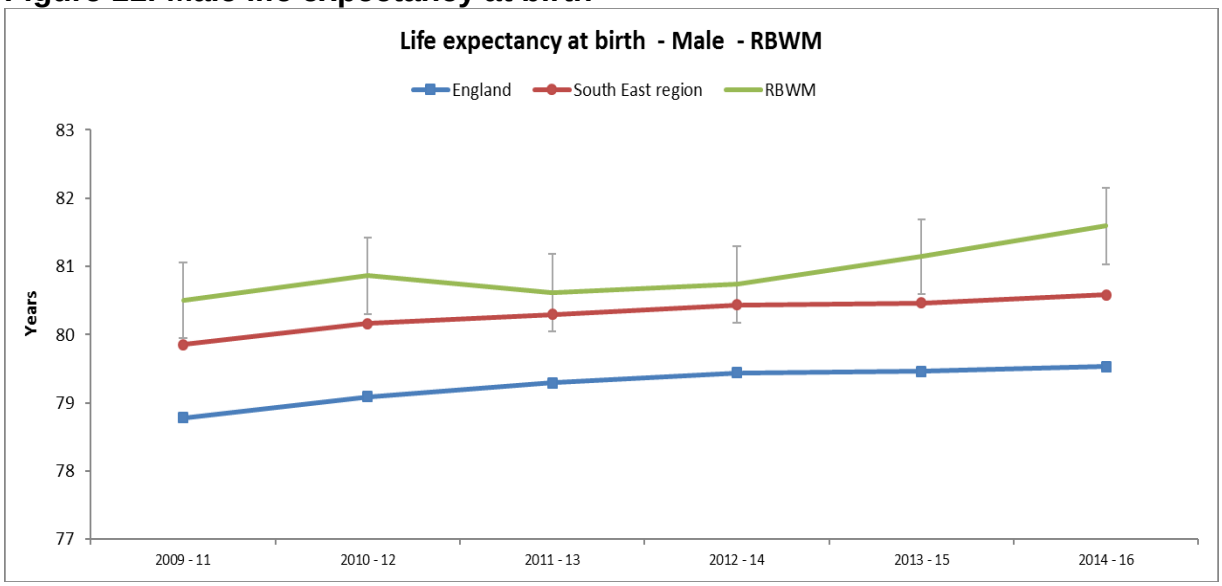
5.1 Life expectancy is considered to be an effective measure for the health and wellbeing of an area and a useful tool for identifying health inequality. When measuring life expectancy, there are indicators to measure the overall length of life as well as the time spent in good health (healthy life expectancy at birth). These indicators complement other indicators by showing the overall trends in major population health measures, setting the context in which local authorities and partners can assess local health needs.

Life expectancy at birth

5.2 In England, life expectancy at birth for males was 79.5 years and for females it was 83.1 years, these are based on mortality rates between 2014 and 2016. Nationally life expectancy has improved, however the rate of this improvement has slowed between 2010-2012 and 2014-2016; compared to previous years (1980-1982 and 2009-2011).

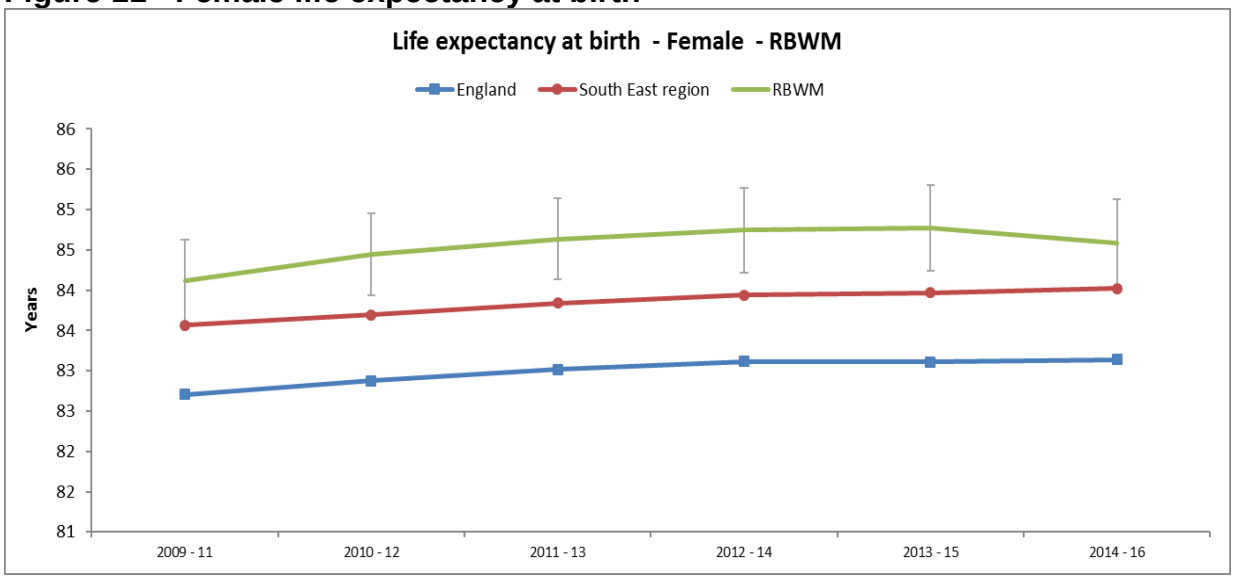
5.3 In the borough, life expectancy at birth for males is 81.6 and life expectancy at birth for females is 84.6. Life expectancy in the borough for both males and females is better than the England average and the South East region as shown in figures 11 and 12.

Figure 11: Male life expectancy at birth[12]



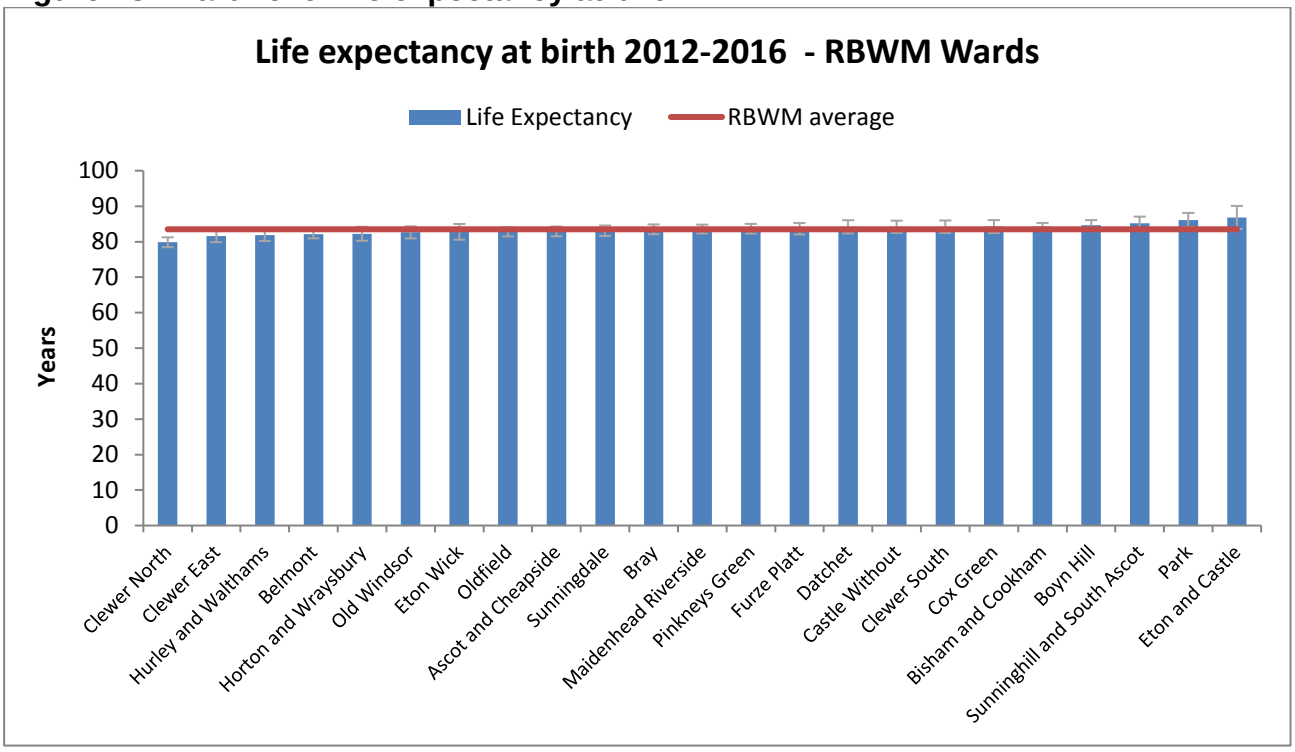
[12] Figures 11 and 12 source: Public Health Outcomes Framework

Figure 11 - Female life expectancy at birth



5.4 Analysis of life expectancy at birth at ward-level shows the health equality differences within the borough. While life expectancy in the borough is better than England and the South East region, there are some wards which experience statistically lower life expectancy at birth than the borough's overall average of 83.5 years in 2012-2016; these wards were Clewer North, Clewer East, Hurley and Walthams and Belmont.

Figure 13: Ward-level life expectancy at birth[13]



5.5 Not only are residents in borough living longer than the England and regional average, they are also living statistically longer lives in good health. The healthy life

[13] Data source: Primary Care Mortality Database Copyright © 2017, re-used with the permission of NHS Digital. All rights reserved

expectancy at birth between 2014 and 2016 for males was 69.7 years and for females it was 70.8 years.

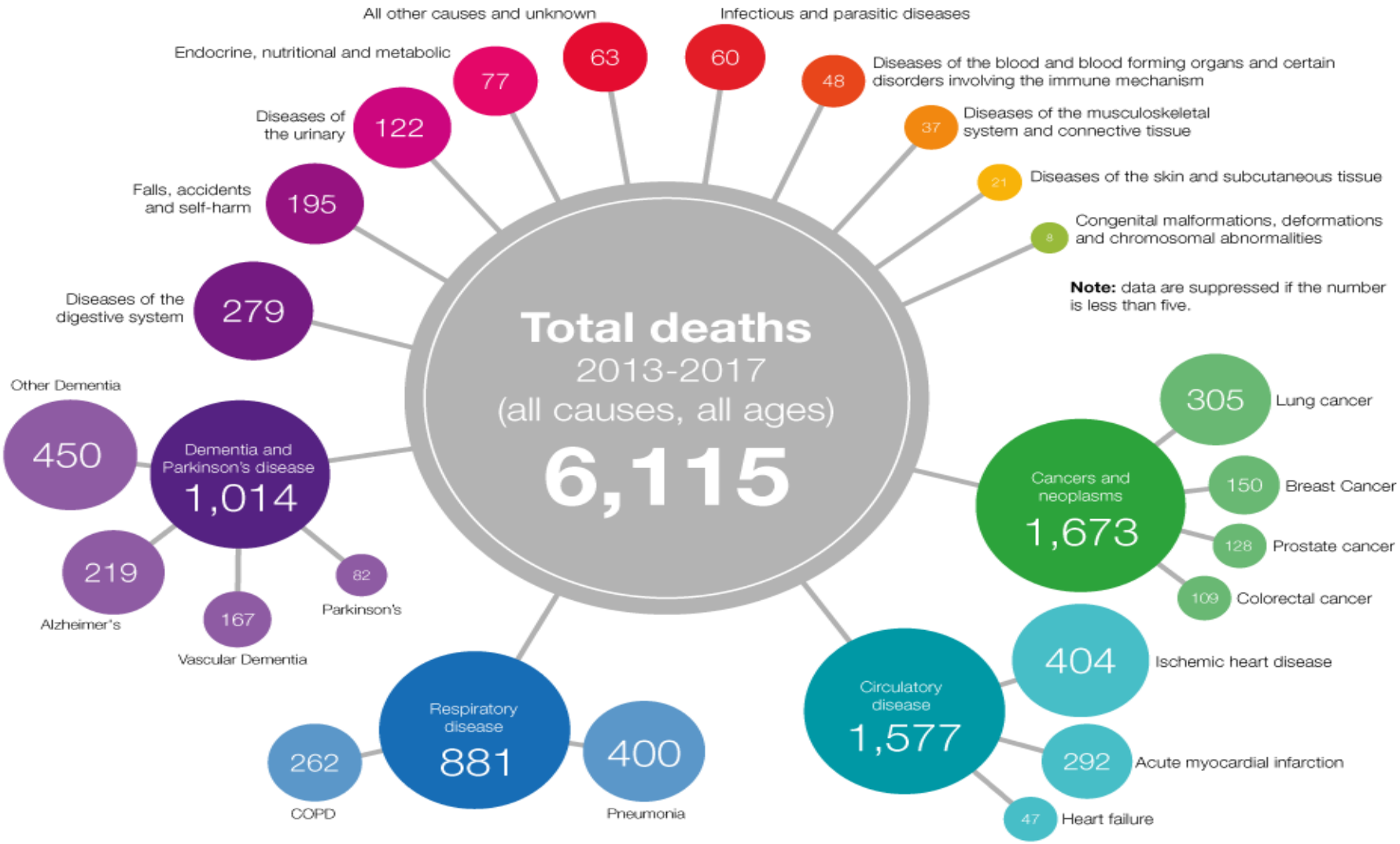
Mortality

5.6 Although the residents living in the borough are living longer relatively, there are some key causes of deaths identified by hospital episode statistics (HES). In 2017, there were 1,262 deaths registered in the borough. In 2016, there were 1,224 deaths registered, of these 27.6% (578) were for people aged under 75 years; these are termed premature deaths. This was an age-standardised rate of 139.6 per 100,000 population in RBWM, which is significantly better than the England rate of 182.8 and similar deprivation decile rate of 143.5 per 100,000 population.

5.7 In 2016, cancer was the most comment broad cause of death in the borough with 27.7% of all deaths. The single main cause of death in the borough was dementia and Alzheimer's disease (14%) followed by Ischaemic heart disease (9.5%). When the single main cause of death was analysed by gender, Alzheimer's disease was the leading cause for women and ischaemic heart disease for men; this reflects the national picture.

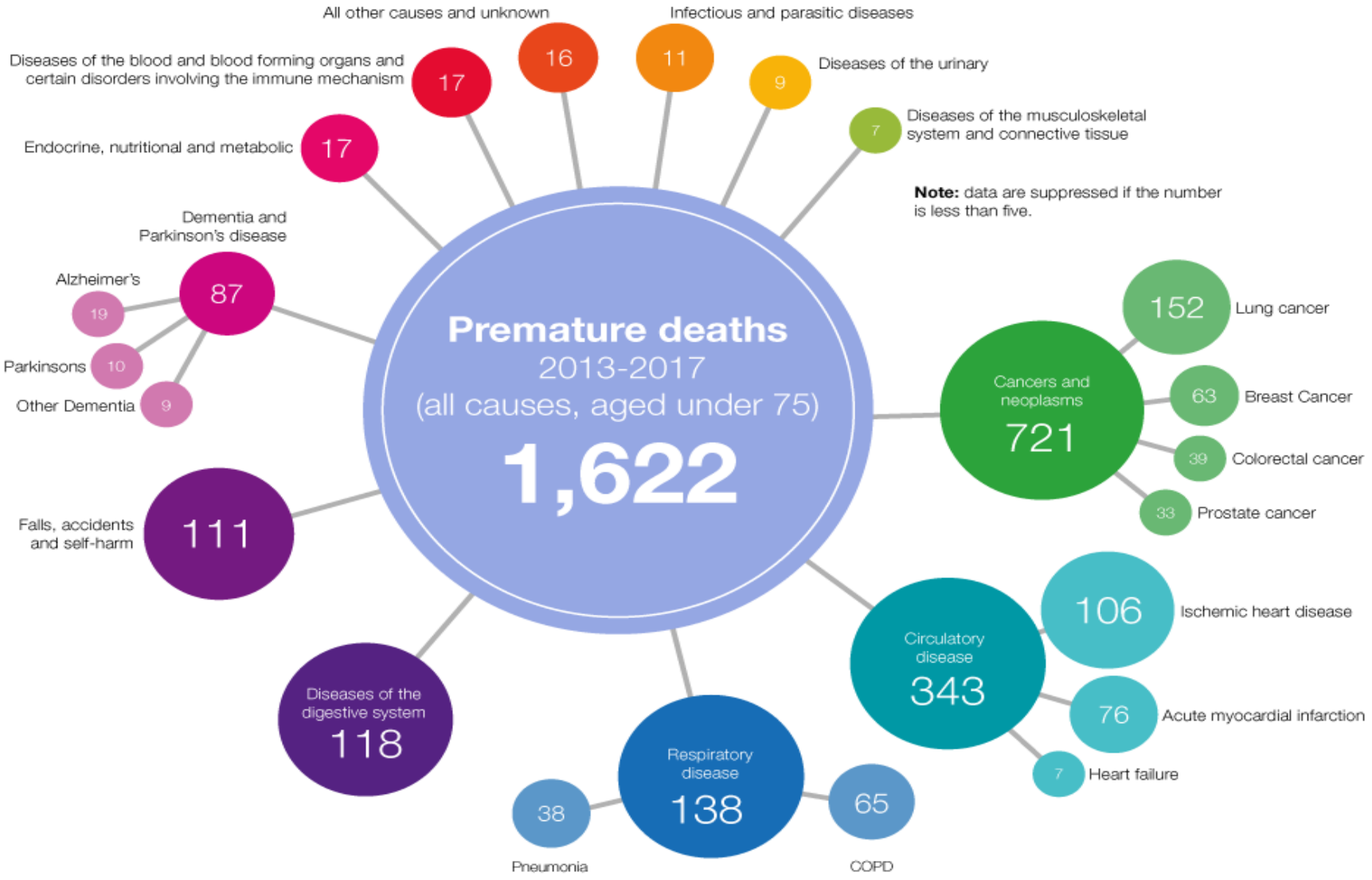
5.8 Figure 14 shows the number of deaths amongst borough residents of all ages broken down by broad underlying causes in 2013-2017 and figure 15 shows the number of deaths of those aged under 74 by broad underlying causes in the same time period.

Figure 14: Distribution of number of deaths amongst the Royal Borough of Windsor and Maidenhead residents of all ages by broad underlying causes (with four biggest broken down further), in 2013-2017[14]



[14] Figures 14 and 15 data source: Primary Care Mortality Database (Office for National Statistics)

Figure 15: Distribution of number of deaths amongst the Royal Borough of Windsor and Maidenhead residents of those aged under 75 by broad underlying causes, in 2013-2017



National and local strategies (current best practice)

5.8 In order to address and improve life expectancy, healthy life expectancy and premature mortality, there needs to be a focus on preventing diseases that can be delayed/ influenced by lifestyle choices.

5.9 Nationally, prevention has been highlighted as a priority by the Health Secretary. Prevention has been described as 'helping people stay healthy, happy and independent for as long as possible'[15]. A vision for how the government's approach to prevention, 'Prevention is better than cure' was published in 2018 and this is due to be followed by a green paper in 2019 which will set out the government's plans in more detail.

5.10 Locally, there are a multitude of plans across the borough that will address and positively affect life expectancy and premature mortality. For example, the Health and Wellbeing Board is delivering the Joint Health and Wellbeing Strategy through three boards based on the life courses: developing well, living well and ageing well. Partners and local agencies are working to address the issues that affect life expectancy and premature mortality. For example, East Berkshire Clinical Commissioning Group (CCG) has identified improving cancer services in their three year improvement plans.[16]

What does this tell us?

5.11 Life expectancy and health life expectancy in the borough is better than both the England and South East region average. Despite the good levels of life expectancy, there are inequalities that exist at ward level, with some wards expected to live seven years fewer than others. Mortality rates are better than the England average and similar to those of local authorities with a comparable deprivation decile. Overall, this projects a positive picture of health within the borough.

Recommendations for consideration

5.12 The Royal Borough should continue to monitor the life expectancy and mortality rates across the borough and ensure that this intelligence is available to partners and commissioners in order to help target resources where most needed.

5.13 The Royal Borough should continue to work with primary care to champion early identification and prevention of the leading causes of mortality such as cancer and cardiovascular diseases. Consideration should be given to a range of health checks options and hypertension case finding.

5.14 Promoting the health of the working age population can help to prevent diseases in later life and improve premature mortality rates. Public Health should focus on workplace health campaigns and support businesses to support their staff.

5.15 Agencies across the borough should consider targeting health interventions and support to those areas that experience poorer life expectancy in order to help reduce health inequalities within the borough.

[15] https://publichealthmatters.blog.gov.uk/2018/11/05/better-health-for-all-a-new-vision-for-prevention/
[16] Windsor, Ascot and Maidenhead Clinical Commissioning Group Annual Report 2017/18.

6 HEALTH NEEDS: DEVELOPING WELL, LIVING WELL, AGEING WELL

6.1 The Royal Borough of Windsor and Maidenhead's Health and Wellbeing Board was formally established as a statutory committee of the council in April 2013. Health and Wellbeing Boards are statutory in every upper tier local authority, ensuring they bring together key leaders from the local health and care system to improve the health and wellbeing of their population and reduce health inequalities.

6.2 The Board brings together local leaders to ensure that the health and wellbeing needs of local residents are addressed and championed. It also seeks to empower residents to make informed choices about their own wellbeing, and strives to ensure that the right support, at the right time in the right place is available, thus making our vision for residents a sustainable reality.

6.3 Established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.

6.4 In August 2017, the Board agreed a new governance structure which created three sub-Boards, aligned with the strategic themes of the Joint Health and Wellbeing Strategy. The three are Developing Well, Living Well and Ageing Well.

6.5 Each of the sub-boards have developed an action plan using local insights and analysis, see appendices 1, 2 and 3.

7 WIDER DETERMINANTS OF HEALTH

7.1 Wider determinants, also known as social determinants, are a diverse range of social, economic and environmental factors which impact on people's health. Such factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances[17]. Addressing the wider determinants of health has a key role to play in reducing health inequalities.

7.2 The wider determinants of health considered in the borough include employment and income, housing and homelessness, crime, domestic abuse, road safety and the environment, see section 8 to 13.

[17] https://fingertips.phe.org.uk/profile/wider-determinants

8 EMPLOYMENT AND INCOME

8.1 Unemployment levels across the borough are lower than the South East region, with the number of people claiming Job Seekers Allowance decreasing year on year since 2011. The number of people accessing benefits in the borough is lower than the South East region and a larger proportion of claimants were men. The majority of claimants were aged 25 and over.[18]

8.2 There are three wards in the borough which have a higher rate of claimants than the borough's rate of 0.7%, but they are still lower than the national rate of 1.8%:

- Oldfield 1.1%
- Riverside 0.8%
- Clewer North 0.9%

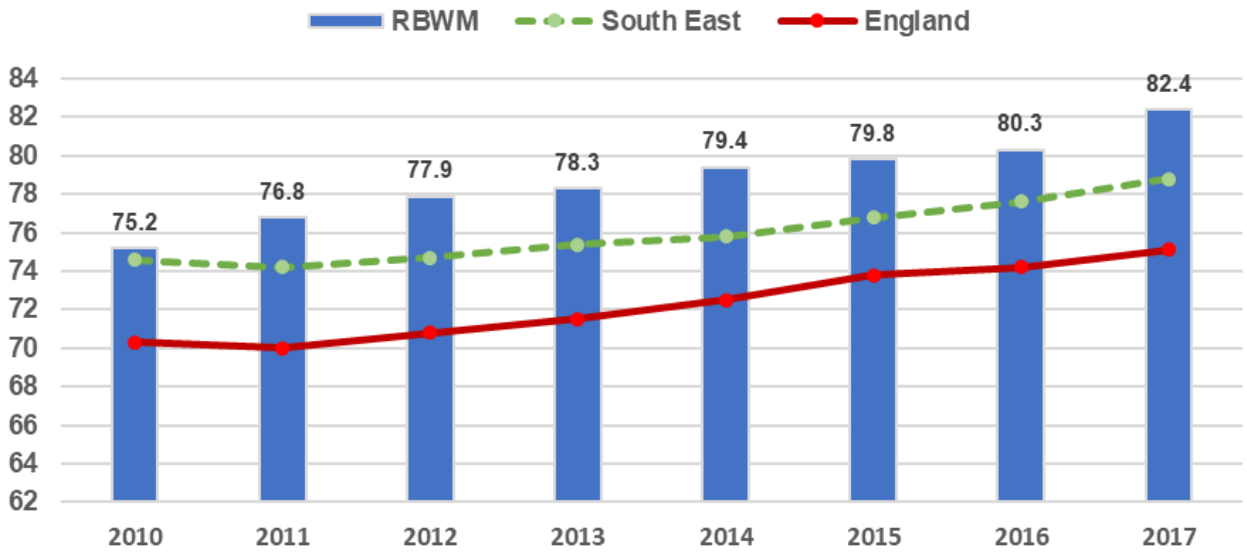
8.3 Evidence suggests that there are some additional factors which can influence a person's ability to gain employment, including low educational attainment, disability, learning disability and having caring responsibility.

8.4 The Royal Borough of Windsor and Maidenhead has a workforce that is generally more economically active, higher qualified and better paid compared with other regions of the UK. In 2017, 61.1% of the workforce is reported as employed within professional, managerial and/or technical roles, and most recently between October 2017 and September 2018, this has increased to 63%.

Facts, figures and trends

8.5 In 2017, 82.4% of people aged 16-64 years old were classed as employed. This was higher than the South East region (78.8%) and England (75.1%) and reflects a broadly upward trend in employment since 2011/12 in the borough.

Figure 16: Percentage of people aged 16-64 in employment (2010 – 2017)[19]

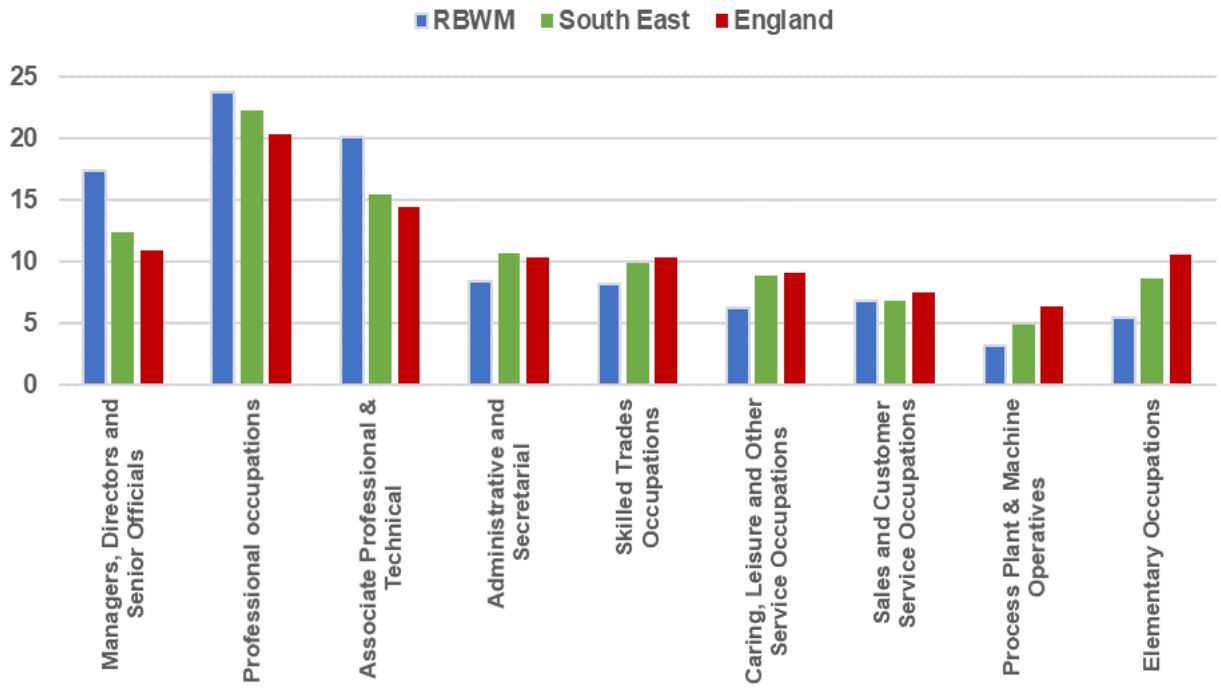


[18] https://www.nomisweb.co.uk/articles/788.aspx

[19] https://www.nomisweb.co.uk/reports/lmp/la/1946157289/subreports/ea_time_series/report.aspx?c1=2013265928&c2=2092957699

8.6 In 2017, 61.1% of economically active people in the borough worked in high-skilled roles, including Professional Occupations (23.7%), Associate Professional & Technical (20.1%) and Managers, Directors and Senior Officials (17.3%). This is higher than the South East region and England.

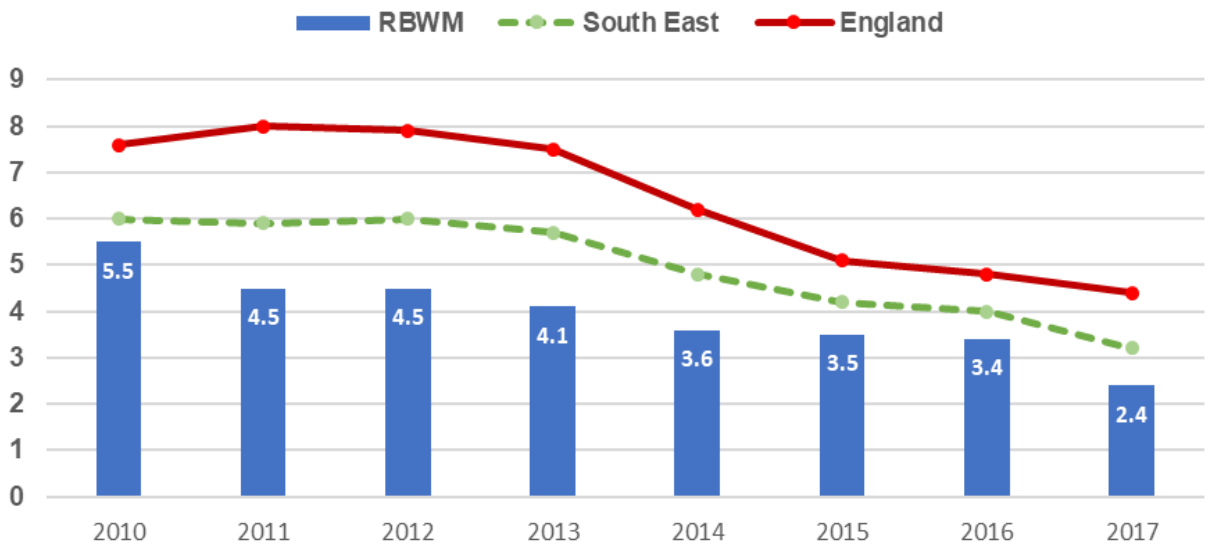
Figure 17: Percentage of people in employment by occupation (2017)[20]



8.7 The proportion of economically active people who are unemployed in the borough has been steadily decreasing from 5.5% in 2010 to 2.4% in 2017. This mirrors the South East region trend, which decreased from 6.0% in 2010 to 3.2% in 2017, and the England rate, which decreased from 7.6% in 2010 to 4.4% in 2017.

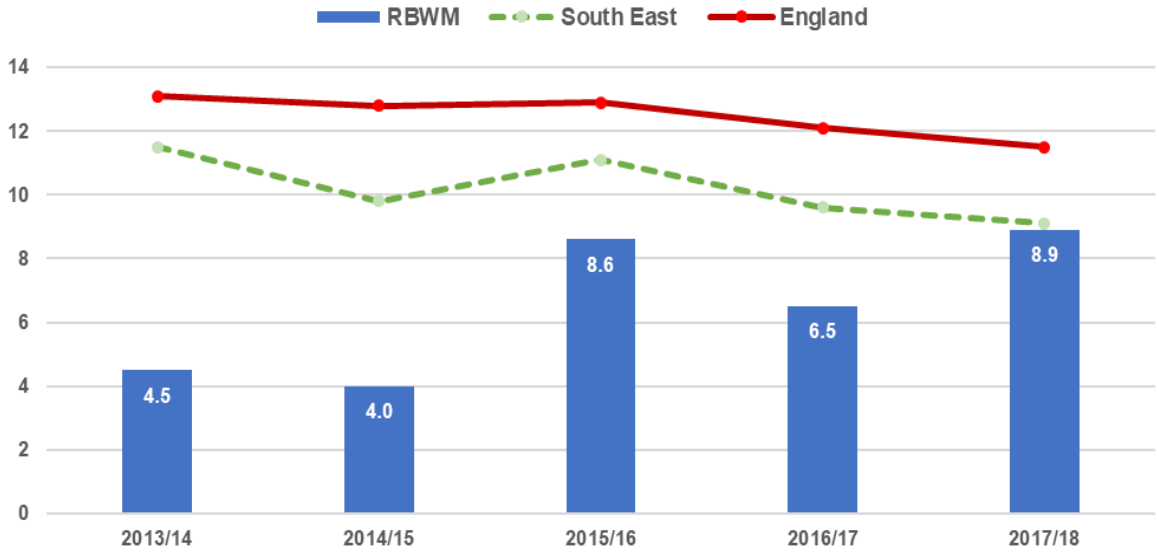
[20] https://www.nomisweb.co.uk/reports/lmp/la/1946157289/report.aspx

Figure 18: Percentage of economically active people who are unemployed (2010 – 2017)[21]



8.8 The percentage point gap in the employment rate between those with a long-term health condition (aged 16-64 years) and the overall employment rate in the borough in 2017/18 was 8.9. This was lower than the South East (9.1) and England (11.5); however, this is currently at its highest point since 2013/14.

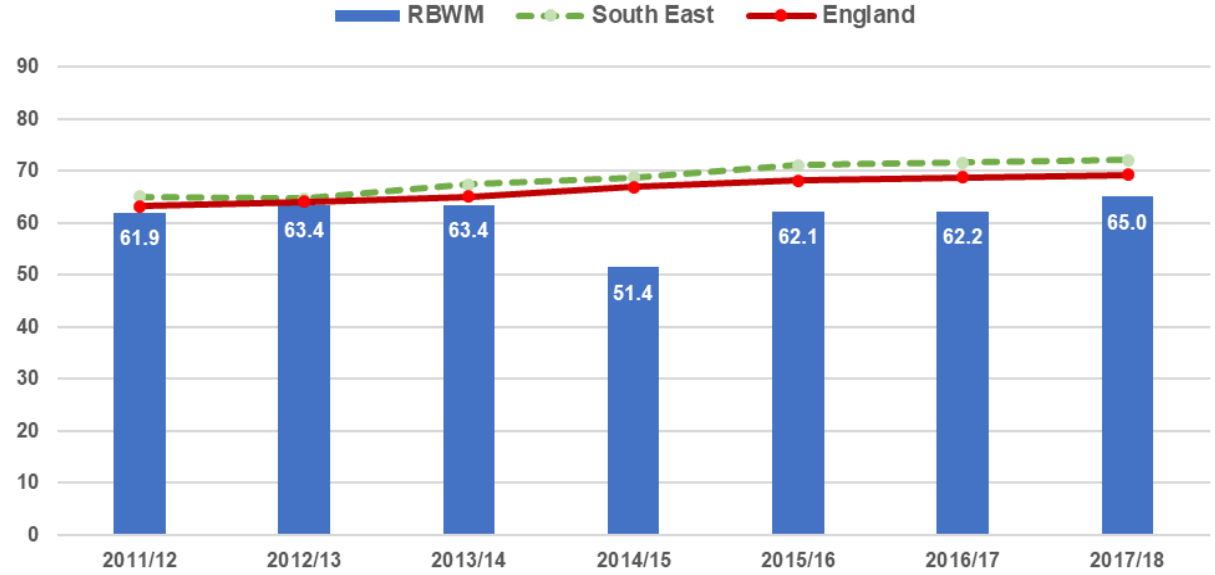
Figure 19: Percentage point gap in the employment rate between those with a long-term health condition and the overall employment rate (2013/14-2017/18)[22]



8.9 The percentage point gap in the employment rate between those with a learning disability (aged 16-64 years) and the overall employment rate in the borough in 2017/18 was 65%. This was lower than the South East region (72%) and England (69.2%); however, it is currently at its highest point since 2011/12.

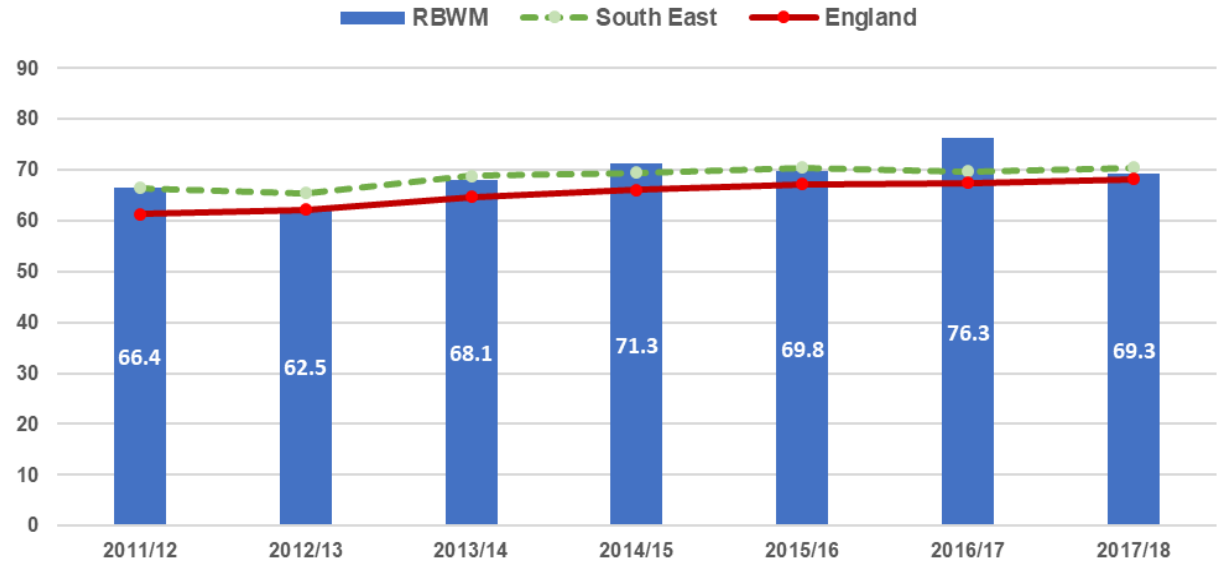
[21] https://www.nomisweb.co.uk/reports/lmp/la/1946157289/report.aspx?c1=2013265928&c2=2092957699#ls
[22] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework.

Figure 20: Percentage point gap in the employment rate between those with a learning disability and the overall employment rate (2011/12 - 2017/18)[23]



8.10 The percentage point gap between working-age adults (16-64yrs) who are receiving secondary mental health services and who are recorded on the Care Programme Approach as being employed (aged 18-69yrs) and the percentage of all respondents in the Labour Force Survey classed as employed in 2017/18 was 69.3. This was lower than the South East region (70.5) and higher than England (68.2); however, it is at its lowest point since 2014/15.

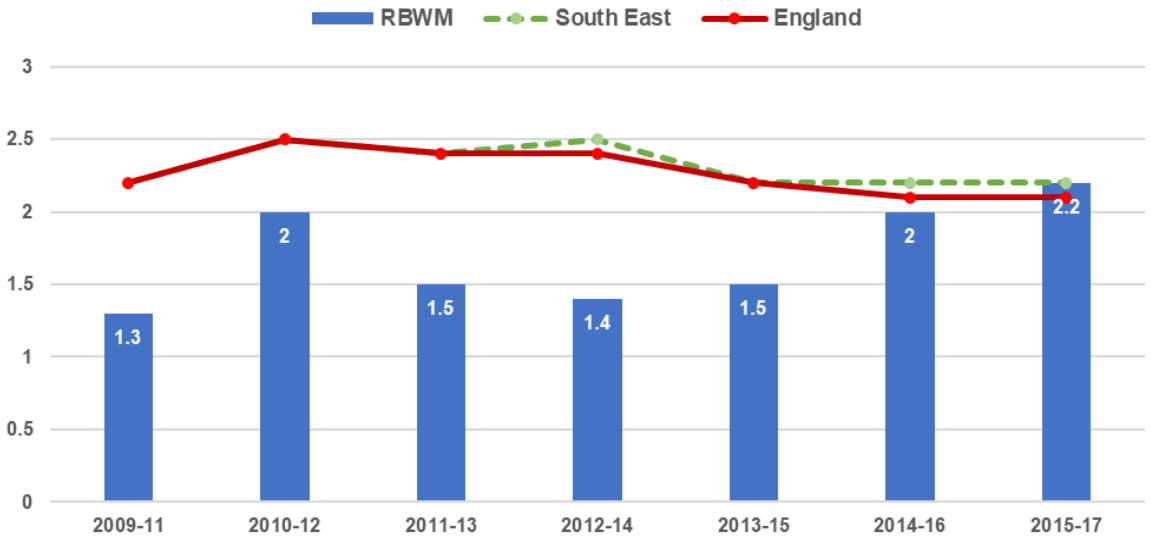
Figure 21: Percentage point gap between the percentage of working age adults receiving secondary mental health services and the percentage of all respondents in the Labour Force Survey classed as employed (2011/12 - 2017/18)[24]



[23] Office for National Statistics, Annual Population Survey and NHS Digital. Taken from the Public Health Outcomes Framework https://fingertips.phe.org.uk/profile/public-health-outcomes-framework.
[24] Office for National Statistics, Annual Population Survey and NHS Digital. Taken from the Public Health Outcomes Framework https://fingertips.phe.org.uk/profile/public-health-outcomes-framework.

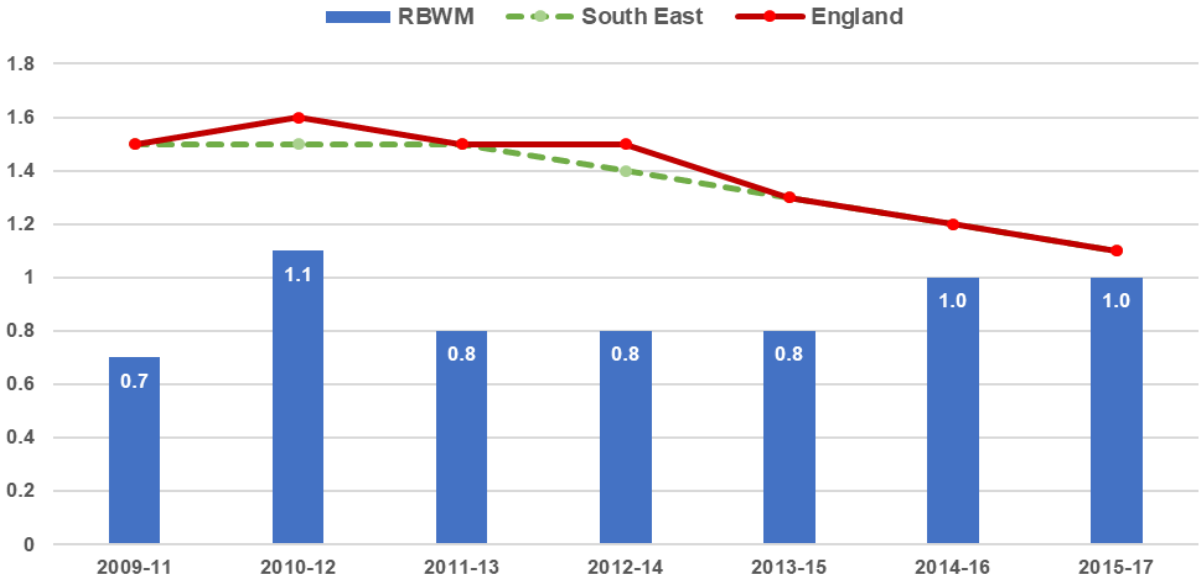
8.11 In the period of 2015-17, about 2.2% of employees had at least one day off due to sickness absence in the previous working week. This was the same as the South East and slightly higher than England (2.1%); however, it is at its highest point in the last 7 years.

Figure 22: Percentage of employees who had at least one day off due to sickness absence in the previous working week (2009-11 to 2015-17)[25]



8.12 In the period 2015-17, 1% of working days were lost due to sickness absence in the previous working week. This is slightly lower than the South East region and England, both 1.1%.

Figure 23: Percentage of working days lost due to sickness absence in the previous working week (2009-11 to 2015-17)[26]



[25] Office for National Statistics, Labour Force Survey. Taken from the Public Health Outcomes Framework https://fingertips.phe.org.uk/profile/public-health-outcomes-framework.
[26] Office for National Statistics, Labour Force Survey. Taken from the Public Health Outcomes Framework https://fingertips.phe.org.uk/profile/public-health-outcomes-framework.

8.13 In 2017, 15.7% of people aged 16-64 years were economically inactive. This is lower than the South East region (18.6%) and England (21.4%). In the same period, 20.4% of the economically inactive in the borough wanted a job. This was higher than the South East region (24.1%) and England (22.6%).

8.14 In 2016, 90 people (1%) aged 16-64 were long-term claimants of jobseeker's allowance in the borough, claiming for longer than 12 months. The South East region figure was 2% whilst the England figure was 3.7%.

8.15 In November 2016, 730 people in the borough claimed carers allowance, which is 0.8% of the working age population. In the South East and England, 1.3% and 1.7% of the working age population respectively claimed carers' allowances.

8.16 In November 2016, 510 people in the borough claimed disability living allowance. This equals approximately 0.6% of working age population living in the borough, compared with the South East and England rates of 0.8%.

Income

8.17 In 2018, the gross weekly pay (median earnings) for all full-time workers in the borough was £662.70, higher when compared with the South East (£589.20) and England (£574.90). Within the borough, a comparison of male and female gross weekly pay in 2018 shows a gender equality pay gap as the median earnings for males was £815.90 whereas for females it was £560.90.

8.18 In 2018, the hourly pay (median earnings) for all full-time workers (excluding overtime) in the borough was £17.35 for full-time workers, higher when compared to the South East (£14.91) and England (£14.41)[27].

Workforce

8.19 In 2017, the borough's working-age population (16-64yrs) was 92,100 people, which represents 61.4% of the total population. This is slightly lower than the South East region (61.8%) and England (62.8%). In 2017, 82.4% of the borough's working age population are reported as being in employment, which is higher than the South East region (78.8%) and England (75.1%)[28].

Skills and qualification levels

8.20 In 2017, about 54.4% (49,000) of those aged 16-64 were qualified to NVQ4 or above in the borough, which is higher than the South East (41.4%) and England (38.3%). About 4.0% (3,600) of the borough's working age population have no qualifications, which is less than South East (5.2%) and UK (7.6%).[29]

National and local strategies (current best practice):

8.21 There are a number of national and local initiatives which seek to support people into employment and to secure training and development and employment opportunities. These include:

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[27] Source: Office for National Statistics, Annual Survey of Hours and Earnings – Resident Analysis. https://www.nomisweb.co.uk/reports/lmp/la/1946157289/report.aspx?c1=2013265928&c2=2092957699#ld

[28] Source: Office for National Statistics, Annual Population Survey. https://www.nomisweb.co.uk/reports/lmp/la/1946157289/subreports/ea_time_series/report.aspx?

[29] Source: Office for National Statistics, Annual Population Survey. https://www.nomisweb.co.uk/reports/lmp/la/1946157289/subreports/quals_time_series/report.aspx?

- **Job Centre Plus**: A government-funded agency helping people of working age find and maintain employment in the UK.
- **Ways into Work**: A locally-commissioned service supporting individuals with employment barriers of either disability or disadvantage to find and maintain work, apprenticeships, traineeships, and work experience opportunities. The service also provides job coaching support, employment-related training, and support in writing CVs and completing application forms. http://waysintowork.com/about/
- **Elevate Me**: A programme run by the Royal Borough's employment service "Grow Our Own" supporting local 16-24 year olds in the borough to get help, advice and guidance on careers, employment, education, apprenticeships, volunteering, and work experience. An Extended Support Programme is available for those aged 16 – 24 who have a mental health condition, autism, learning difficulty. http://rbwm.elevateme.org.uk/

What does this tell us?

8.22 The borough has a well-skilled and well-paid workforce in comparison to the South East and England. The workforce is generally economically active and the unemployment rate has decreased since 2010. Within the last five years, however, there has been an increased gap between the overall employment rate and the employment rate of those with a long-term health condition and those with a learning disability.

8.23 Within the borough, a comparison of male and female gross weekly pay in 2018 shows a gender equality pay gap.

Recommendations for consideration

8.24 The Royal Borough should continue to offer targeted support for young people aged 16-24 through the ElevateMe programme run by Grow Our Own, including the Extended Support Programme for those aged 16-24 who have a mental health condition, autism and/or learning difficulties.

8.25 The Royal Borough should continue to look at ways of supporting vulnerable groups as a whole into work, ensuring pathways between employment and training services and services working with marginalised residents are strengthened.

8.26 Whilst not directly within the control of the Royal Borough, leading by example as well as seeking ways to work with local business and organisations to address the gender pay gap should be considered.

9 HOUSING AND HOMELESSNESS

9.1 Sustainable development featuring housing of good quality and affordable to the local population plays a significant role in shaping people's lives and communities. The planning system can play a positive role in the development of communities, supporting appropriate and sustainable development to meet the full range of needs of the local population.

Facts, figures and trends

9.2 The Royal Borough of Windsor and Maidenhead has over 67,200 domestic dwellings; seeing an increase of over 1,660 over the last two years to 2018/19. Housing growth is expected to continue if not accelerate over the coming years in the borough.

9.3 In addition to growth in housing and issues around affordability and quality, consideration needs to be given to reducing homelessness which has seen a growth nationally, a trend which has also affected the borough.

The Borough Local Plan and housing need

9.4 The Borough Local Plan (BLP)[30] is a vital tool in addressing the scale, distribution and type of new homes that need to be provided up to 2033. It is currently at examination stage.

9.5 As part of the BLP preparation, the 2016 Berkshire Strategic Housing Market Assessment (SHMA)[31] identified a need for two and three bedroom properties in the market housing sector and an emphasis on one bedroom units in the affordable sector[32]. The overall annual need was assessed as 712 homes per annum.

Housing affordability

9.6 Housing affordability is a particular challenge in the borough. House prices have consistently been above the average for England but have widened further since 2014.

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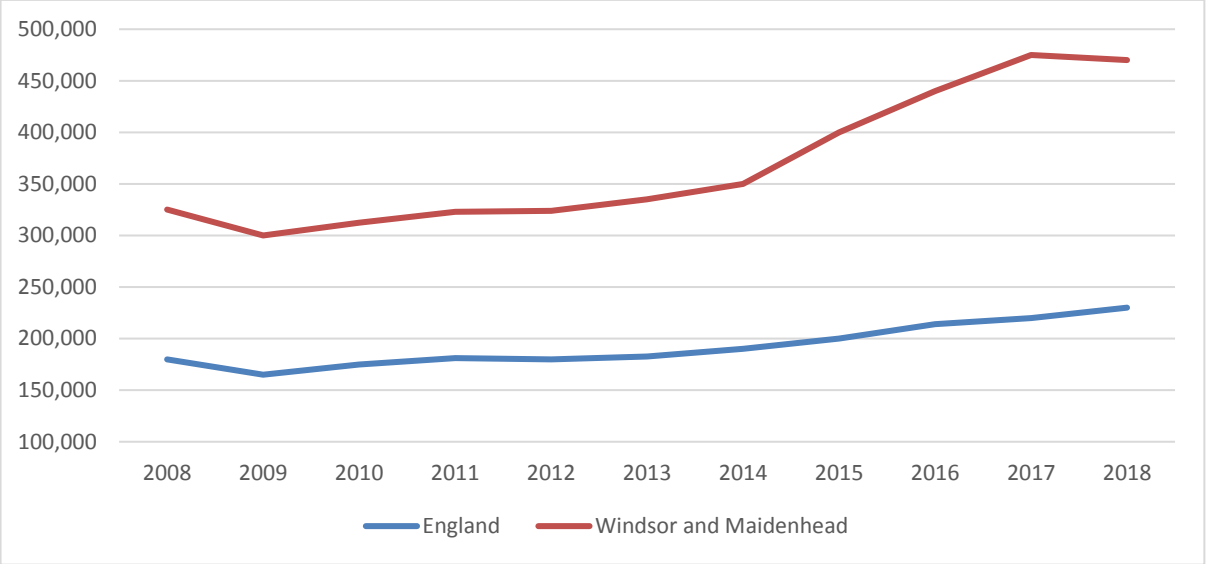
[30] *Borough Local Plan: Submission Version (2017), Royal Borough of Windsor and Maidenhead* https://www3.rbwm.gov.uk/info/201026/borough_local_plan/1351/submission

[31] https://www3.rbwm.gov.uk/info/200209/planning_policy/483/berkshire_strategic_housing_market_assessment

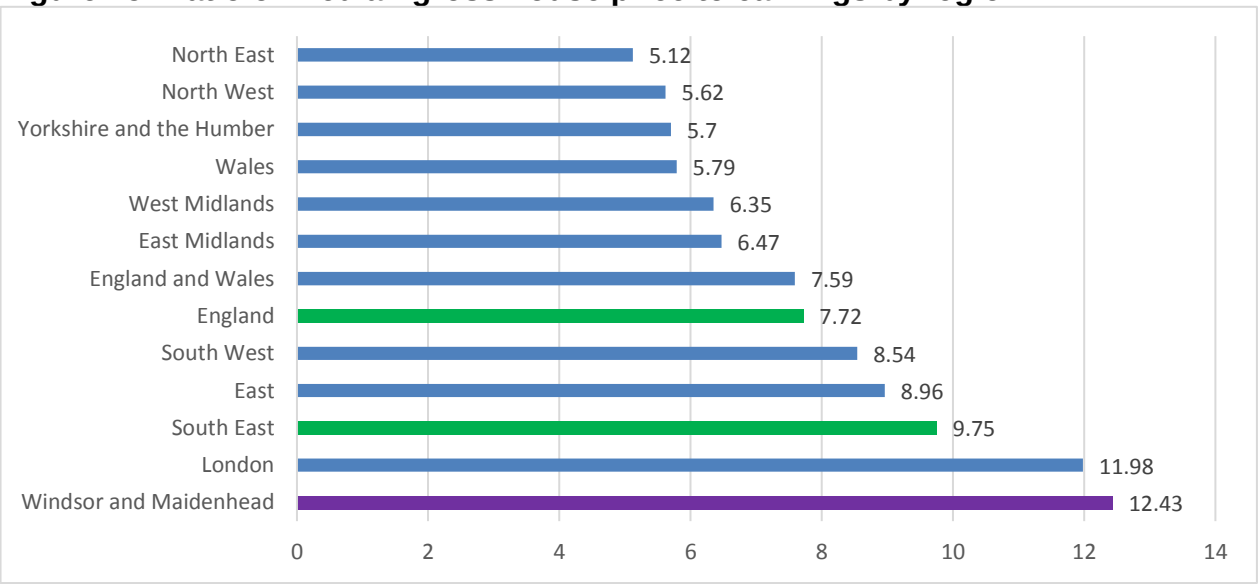
[32] Affordable housing is defined as social rented, affordable rented and intermediate housing, provided to eligible households whose needs are not met by the market. See pg. 64 National Planning Policy Framework (NPPF); https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/740441/National_Planning_Policy_Framework_web_accessible_version.pdf

Figure 24: Median price paid (existing dwellings, all house types)[33]



9.7 The median house price in the south east (year ending Sept 2017) was £310,000 and the median annual gross earnings in the south east were £31,644. The ratio of median gross house price to earnings in the south east was, therefore, 9.79. In Windsor and Maidenhead for the same period, the median house price was £485,000, the median annual gross earnings were £39,021 and the ratio of house price to earnings 12.43. This compares to a ratio of 7.72 for England.

Figure 25: Ratio of median gross house price to earnings by region[34]



9.8 Rental affordability is also an issue. Median rents in Windsor and Maidenhead (monthly rents recorded between 1 October 2015 and 30 September 2016 by

[33] ONS: https://www.ons.gov.uk/peoplepopulationandcommunity/housing/datasets/medianhousepricefornationalandsubnationalgeographiesexistingdwellingsquarterlyrollingyearhpssadataset11

[34] ONS: https://www.ons.gov.uk/peoplepopulationandcommunity/housing/datasets/ratioofhousepricetoresidencebasedearningslowerquartileandmedian

administrative area for England) were £1,200 compared to the England median of £650 and South East median of £850.

9.9 For the same time period, median gross weekly pay was £621.80 in the borough[35]. Showing median monthly rent as a percentage of median gross monthly salary provides a useful indicator of the affordability of private renting. In 2016, median monthly private rent for England was 27% of median gross monthly salary. This means that someone working in England could expect to spend 27% of their monthly salary on private rent. In Windsor and Maidenhead this is 48%.

Housing standards

9.10 The standard of housing in the borough is generally good with low levels of overcrowding. 3.8% of households in the borough had an occupancy rating of -1 or less (this implies that a household has one fewer bedroom than required). This is below both the south east and England average. There are also more homes in the borough with central heating than the England and south east average.

Figure 26: Rooms, bedrooms and central heating, local authorities in England and Wales[36]

Area name	All categories: Type of central heating in household	Does not have central heating	Does have central heating	Occupancy rating (rooms) of -1 or less	Occupancy rating (bedrooms) of -1 or less
	Number	%	%	%	%
England and Wales	23,366,044	2.7	97.3	8.5	4.7
England	22,063,368	2.7	97.3	8.7	4.8
South East	3,555,463	2.4	97.6	7.5	3.8
Windsor and Maidenhead	**58,349**	**1.7**	**98.3**	**6.7**	**3.8**

9.11 In the borough, 57% of residents occupied two more rooms/bedrooms than the standard requirement in 2011.

Figure 27: Overcrowding/under occupied in 2011

	Number	%
Occupancy rating (rooms) of +2 or more	33,277	57
Occupancy rating (rooms of +1	11,804	20.2
Occupancy rating (rooms) of 0	9,368	16.1
Occupancy rating (rooms) of -1 or less	3,900	6.7

Housing tenure and composition

9.12 Housing tenure refers to the financial arrangements under which someone has the right to live in the property. In the borough, about 68.6% of the residents were

[35] Annual Survey of Hours and Earnings https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/previousReleases

[36] https://www3.rbwm.gov.uk/download/downloads/id/1074/data_ks403_-_rooms_bedrooms_and_central_heating.xls

home owners (those who own outright and those who bought with a mortgage including shared ownership) in 2011. This is above the England figure of 64.2%.

Figure 28: Tenure in 2011

Area name	Owned: Owned outright	Owned: Owned with a mortgage or loan	Shared ownership (part owned and part rented)	Social rented: Rented from council	Social rented: Other	Private rented: Private landlord or letting agency	Private rented: Other
	%	%	%	%	%	%	%
England and Wales	30.8	32.7	0.8	9.4	8.2	15.3	1.4
England	30.6	32.8	0.8	9.4	8.3	15.4	1.4
South East	32.5	35.1	1.1	5.8	7.9	14.7	1.6
Windsor & Maidenhead	**32.6**	**35.4**	**0.6**	**1.2**	**12.1**	**13.9**	**2.3**

9.13 In the borough, 31.2% of residents lived in a detached house, 25.3% of residents lived in a semi-detached house. 18.8% of residents lived in a terraced house, whilst 23.6% of residents lived in a flat, maisonette or apartment. There is a lower proportion of residents living in terraced housing, a higher proportion living in detached housing and flats or apartments than England and south east averages. There are also higher proportions of people living in caravan or other mobile housing.

Figure 29: Accommodation types in 2011

Area name	Whole house or bungalow			Flat, maisonette or apartment			Caravan or other mobile or temporary structure
	Detached	Semi-detached	Terraced (including end-terrace)	Purpose-built block of flats or tenement	Part of a converted or shared house (including bed-sits)	In a commercial building	
England and Wales	22.6	30.7	24.7	16.3	4.2	1.1	0.4
England	22.3	30.7	24.5	16.7	4.3	1.1	0.4
South East	28.0	27.6	22.4	16.1	4.0	1.1	0.7
Windsor and Maidenhead	**31.2**	**25.3**	**18.8**	**18.9**	**3.3**	**1.4**	**1.1**

9.14 Household composition data provides useful information about the domestic circumstances of people living in the borough. The most prominent household composition was one family, at 64.5% (see variants below) in 2011. The borough has slightly lower than England and south east proportions of one person households aged 65 and over and households of full-time students (0%).

Figure 30: Household composition in 2011[37]

Area name	One person household: Aged 65 and over	One person household: Other	One family only: All aged 65 and over	One family only: Married or same-sex civil partnership couple: No children	One family only: Married or same-sex civil partnership couple: Dependent children	One family only: Married or same-sex civil partnership couple: All children non-dependent	One family only: Cohabiting couple: No children	One family only: Cohabiting couple: Dependent children	One family only: Cohabiting couple: All children non-dependent	One family only: Lone parent: Dependent children	One family only: Lone parent: All children non-dependent	Other household types: With dependent children	Other household types: All full-time students	Other household types: All aged 65 and over	Other household types: Other
ENGLAND & WALES	12.4	17.8	8.2	12.3	15.2	5.6	5.3	4.1	0.5	7.2	3.5	2.6	0.6	0.3	4.4
ENGLAND	12.4	17.9	8.1	12.3	15.3	5.6	5.3	4.0	0.5	7.1	3.5	2.6	0.6	0.3	4.5
SOUTH EAST	12.7	16.1	9.0	13.3	17.1	5.5	5.5	3.9	0.5	6.1	3.1	2.3	0.5	0.3	4.2
Windsor and Maidenhead UA	**11.9**	**16.5**	**8.7**	**13.2**	**19.6**	**5.9**	**5.4**	**3.3**	**0.4**	**5.0**	**3.0**	**2.5**	**0.0**	**0.2**	**4.4**

[37] https://www3.rbwm.gov.uk/download/downloads/id/1050/data_ks105_-_household_composition.xls

Homelessness

9.15 Homelessness is associated with severe poverty and is a social determinant of mental health. In line with national trends, there has been a rise in homelessness in the borough. In the latest Rough Sleeping statistics, there were 11 people identified as rough sleeping in the borough, see Figure 31. There are more male than females rough sleeping, and all were over the age of 26.

Figure 31a: Rough sleeping – street counts, evidence based estimates, and estimates informed by a spotlight street count, autumn 2010-2018[38]

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total	6	7	4	7	6	35	8	11	11
% change from previous year		*17*	*-43*	*75*	*-14*	*483*	*-77*	*38*	*0*

Figure 31b: Rough sleeping – breakdown by gender, nationality and age

	2016	2017	2018
Gender			
Male		9	8
Female	2	2	3
Gender unknown	0	0	0
Nationality			
UK national	-	10	10
EU non-UK national	5	1	1
Non-EU national	1	0	0
Nationality unknown	-	0	0
Age			
25 and under	0	1	0
26 and over	-	10	11

9.16 The 2018 rough sleeping rate in the borough was 1.8, compared to 2.0 in England. Despite the rise in homelessness, the borough is broadly in line, if not slightly below, average. Due to the changes in relation to the Homelessness Reduction Act and the provision of data, some data is only available up to 2017. Since 2010, there has been a rise in numbers of households accepted as homeless and also a rise in the numbers in temporary accommodation, figure 32[39].

38 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778662/RS_STATS_2018_LiveTables.xlsx

39 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/764201/Table_784_2017_18.xlsx

Figure 32: Numbers accepted as homeless and temporary accommodation

1. Numbers accepted as being homeless and in priority need	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
White	23	15	19	--	59	56	15	17	23	52
Black or Black British	1	2	1	--	--	0	-	-	--	--
Asian or Asian British	3	3	2	--	10	8	-	-	--	--
Mixed[1]	-	0	0	--	--	0	-	-	--	--
Other ethnic origin	0	0	0	--	--	0	-	-	--	--
Ethnic Group not Stated	0	1	1	--	5	0	5	10	--	--
Total	27	21	23	64	78	64	22	30	24	54
Number per 1,000 households	0.47	0.37	0.40	1.12	1.32	1.07	0.37	0.49	0.39	0.87
2. Decisions made										
Eligible, homeless and in priority need, but intentionally	0	0	1	1	--	0	5	-	--	--
Eligible, homeless but not in priority need	0	0	0	0	--	11	-	-	--	--
Eligible, but not homeless	0	0	0	0	--	0	-	-	--	--
Total decisions	27	21	24	51	80	75	31	31	24	54
3. Temporary Accommodation										
Bed and breakfast (including shared annexe)	0	0	2	--	10	0	7	6	11	35
Hostels	0	0	0	--	--	0	10	15	14	--
LA/HA stock	8	13	0	--	--	0	-	-	--	--
Private sector leased (by LA or HA)	0	0	0	--	--	0	-	-	--	14
Other types (including private landlord)	4	0	18	--	33	0	-	-	--	14
Total in temporary accommodation	12	13	20	37	43	0	17	24	29	75
Number per 1,000 households	0.21	0.23	0.35	0.65	0.73	0.00	0.28	0.39	0.47	1.21
Duty owed but no accommodation has been secured at end of March	0	0	0	0	--	0	-	-	--	--

9.17 Although the number of people in temporary accommodation per 1,000 households has risen in the borough, it remained below the south east average of 2.23. In the borough, the number of households with dependent children in temporary accommodation was decreasing between 2006 and 2016. As at 31 December 2018 there were 186 children (89 households) in temporary accommodation. None of these were in bed and breakfast accommodation.

National and local strategies (current best practice):

9.18 Nationally, improvements to housing affordability and homelessness reduction are key priorities for the government with the Homelessness Reduction Act 2017[40] and national targets to build 300,000 homes per annum. In support of these ambitions are a number of initiatives such as:

- Reforms to the planning system / the NPPF.
- Government funded schemes such as Help to Buy.
- Incentives such as Housing Infrastructure Funds to enable development of otherwise constrained sites.
- Investment in social housing.
- Strategies to reduce and prevent homelessness such as Housing First[41].

9.19 Locally, "Growing Economy, Affordable Housing" is one of the council's six strategic priorities and there are a number of more detailed council strategies and services that underpin housing and homelessness in the borough including:

- The Borough Local Plan (submission version).
- Joint ventures with house builders for redevelopment of the council's identified regeneration sites.
- The work of the Royal Borough of Windsor and Maidenhead Property Company to provide new housing including affordable housing.
- The council's Homelessness Strategy (2018).
- The work of the Housing service.

Regeneration and the RBWM Property Company

9.20 The borough is developing a range of housing options through large regeneration projects including addressing priorities for key workers. The RBWM Property Company was created as a dedicated and wholly owned arm's length property management and development trading subsidiary of the Royal Borough of Windsor and Maidenhead. Its aim is to create and manage a property portfolio that meets the needs of people who live and work in the borough.

9.21 The portfolio will offer market rent, sub market rent (affordable, social and shared ownership) and provide affordable housing with a priority focus on key workers. The company has an aspiration to create, own and manage 1000 new homes within a 10 year timeframe and works with a range of partners, having established joint venture partnerships with a number of house builders as well as working with housing associations, to achieve this. It reports progress against its business plan to the council[42].

[40] http://www.legislation.gov.uk/ukpga/2017/13/contents/enacted
[41] https://www.gov.uk/government/news/housing-secretary-james-brokenshire-awards-funding-to-reduce-rough-sleeping
[42] RBWM Property Company: https://www3.rbwm.gov.uk/property/info/4/governance-performance

Homelessness Strategy 2018-2023

9.23 The borough refreshed its homelessness strategy in 2018[43], adopting an action plan and highlighting five priorities:

- Reducing the numbers of people becoming homeless.
- Reducing the numbers of households in temporary accommodation and improving the quality of that accommodation.
- Supporting people into good quality, affordable and sustainable accommodation options.
- Reducing rough sleeping and supporting those who find themselves on the street.
- Improving the customer service provided to people approaching housing services.

9.24 The strategy focuses on working collaboratively with partners and providing early intervention. Progress against the action plan will be monitored and reviewed annually.

What does this tell us?

9.25 The cost of housing locally is a considerable financial pressure for residents, particularly those on lower incomes. These pressures can result in difficulties in maintaining the basic requirements for living, such as fuel, food and a healthy lifestyle. In order to mitigate these difficulties, the council's Housing service is working with a number of organisations and private sector landlords to provide more affordable homes as well as reducing the numbers in temporary accommodation.

9.26 The standard of housing is generally high but affordability of both rent and ownership is a growing and acute problem. The borough is progressing its Local Plan and has a local strategy to deliver housing across a range of housing tenures, including affordable housing (including social housing) and shared ownership through its property company.

What are the key inequalities?

9.27 Vulnerable groups (e.g. elderly, young and those suffering from mental and physical ill-health) are more frequently at risk of living in poor quality homes. Such groups are more likely to experience poverty; and poverty is linked to poor housing, which can adversely affect their health.

9.28 Poor quality housing can have a detrimental effect on both physical and mental health, resulting in morbidity and direct costs to the health service. Although the exact relationship is complex, poor quality, damp and cold homes are associated with higher levels of physical illness (for example cardiovascular disease and asthma) and mental health (for example depression and anxiety). Furthermore poor housing conditions increase the risk of serious accidents. With an increasing elderly population, home adaptations are becoming a more cost effective method of ensuring elderly and vulnerable occupiers are adequately housed.

[43] Homelessness Strategy 2018-2023
https://www3.rbwm.gov.uk/download/downloads/id/3571/homelessness_strategy_2018-2023.pdf

9.29 The borough's data on housing tenure and composition suggests this is a lower risk in the borough. The causes of homelessness are often complex and can reflect a wider range of health needs (physical and mental).

Are there unmet needs or service gaps?

9.30 The borough is seeking to proactively address housing affordability through its regeneration plans and through the work of the property company, including prioritising key workers often on lower incomes. There are a greater range of macro-economic factors that make this challenge difficult to address. The progression of the Borough Local Plan also seeks to ensure housing develops sustainably.

9.31 The borough's Homelessness Strategy has been refreshed and will be monitored regularly to address the causes and effects of homelessness, offering appropriate support and solutions to prevent and reduce homelessness through an early help approach while minimising reliance on temporary accommodation.

Recommendations for consideration

9.32 The Royal Borough, with its partners, should implement the actions outlined in the council's Homelessness Strategy 2018-2023 and continue to progress the Borough Local Plan to provide the strategic framework for sustainable housing development, as well as the council's regeneration plans and provision of housing through its joint ventures and the work of the RBWM Property Company.

10 CRIME AND DISORDER

10.1 An incident will be recorded as a crime[44] for offences against an identified victim if, on the balance of probability: The circumstances as reported amount to a crime defined by law (the police will determine this, based on their knowledge of the law and counting rules), and there is no credible evidence to the contrary.

10.2 Nationally, there have been continued falls in overall levels of crime; however this trend looks to be stabilising with no change observed in the year September 2017 to September 2018. Despite the overall crime figures moving in a positive direction, there is still variation within the various different crime types:

- Nationally as of March 2018 police had recorded an increase in offences involving knives or sharp instruments. This increasing trend has continued through to September 2018.45
- Latest estimates from the Crime Survey for England and Wales (CSEW) showed a 17% increase in vehicle-related thefts compared with the previous year; this is consistent with rises seen in the number of such offences recorded by the police.
- The number of burglary offences recorded by the police has increased by 6% compared with the previous year.

10.3 Despite these figures, most people do not experience crime. In the year ending March 2018, nationally only two out of ten adults experienced any of the crimes asked about in the Crime Survey of England and Wales (CSEW).

10.4 Locally, a multiagency partnership called the Community Safety Partnership (CSP) is responsible for scrutinising and holding partners to account around crime levels in the borough. This multiagency group consists of police, local authority partners, probation, the local Community Rehabilitation Company, elected Members, amongst others. Within the borough, the CSP is focused on local priorities which include: domestic abuse, exploitation and youth crime, drug exploitation, violence against persons and homelessness. In addition to these priorities, locally the police are also focusing on burglary of dwellings.

Facts, figures and trends

10.5 Figure 33 shows the three year pooled rate of emergency hospital admissions for violence in the borough between 2015/16 and 2017/18 was 32.5 per 100,000 population. This is better than the England rate of 43.4 per 100,000 and similar to the South East region rate of 30.4 per 100,000.

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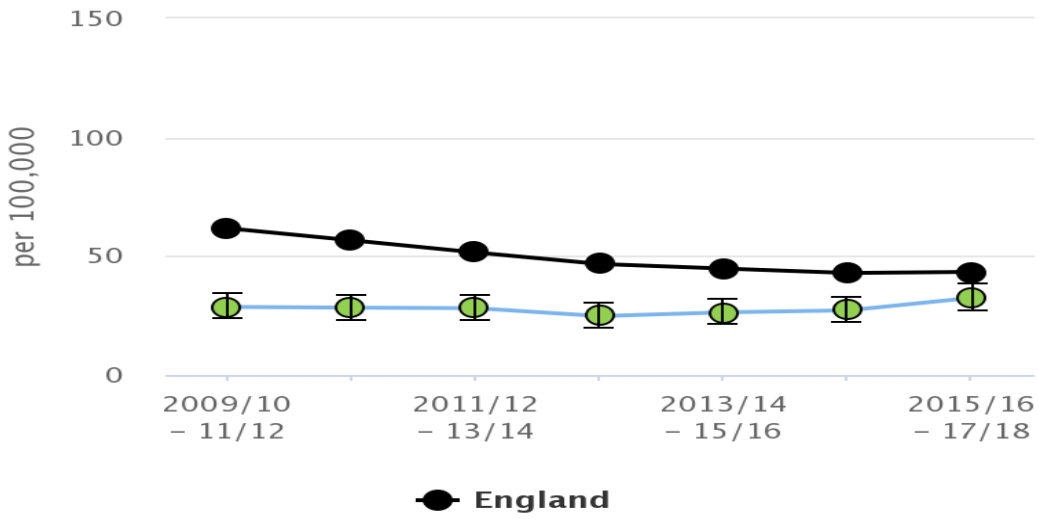
[44] *Home Office Counting Rules For Recorded Crime, April 2018.* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756997/count-general-nov-2018.pdf*

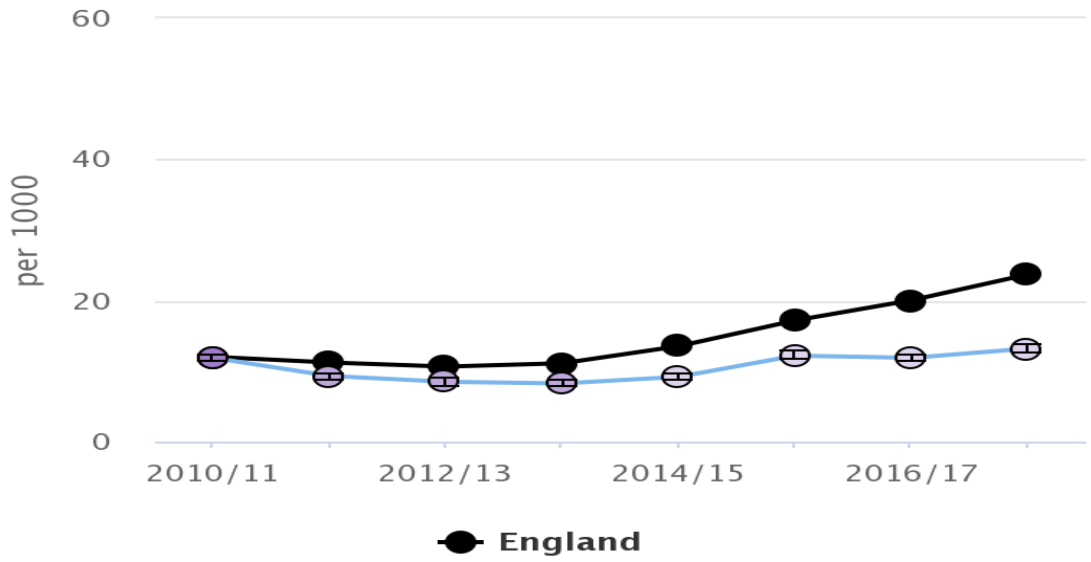
[45] *ONS: Crime in England and Wales: year ending March 2018*

Figure 33: Age-standardised rate of emergency hospital admissions for violence (per 100,000 population) [46]



10.6 Police recorded crime data shows that there was a rate of 13.2 per 1,000 population in the borough for violence against the person offences in 2017/18. This is significantly less than that the England (23.7 per 1,000) and South East regional rates (23.2 per 1,000). Figure 34 shows this rate to be increasing nationally; locally, there has been no significant change in the rate between 2015/16 and 2017/18.

Figure 34: Violence against the person offences (crude rates per 100,000) [47]



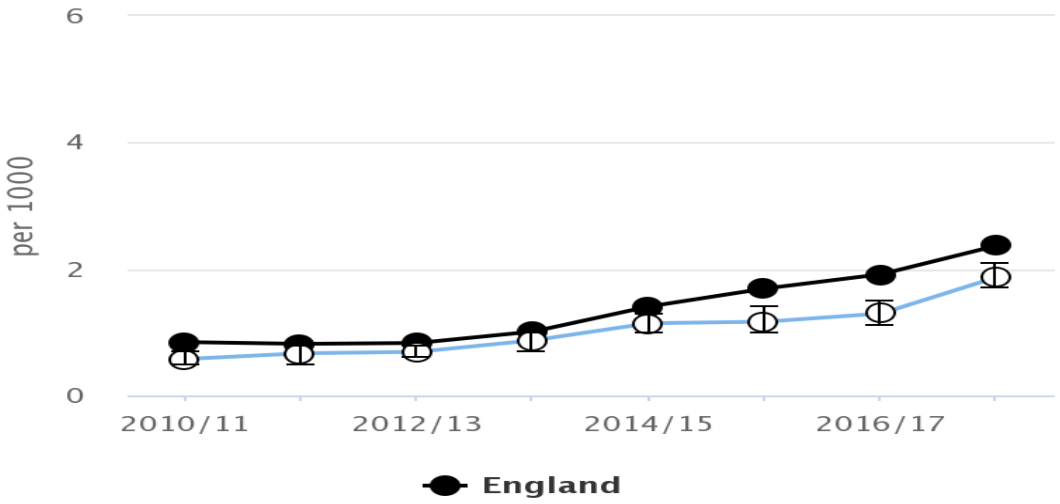
10.7 The rate of sexual offences in the borough was 1.9 per 1,000 population in 2017/18, as shown in figure 35. This is significantly below the national and regional

[46] RBWM compared to England and the South East region between 2009/10 and 2017/18, (source: Public Health Outcomes Framework, 2018)

[47] Compared to England and the South East region between 2010/11 and 2017/18, (source: Public Health Outcomes Framework, 2018)

rates of 2.4 per 1,000 population. Despite being below the national average, the rate increased between 2016/17 and 2017/18. Locally prior to this the rates had remained similar for a period of three to four years. This puts the borough in line with the nationally increasing trend in sexual offences.

Figure 35: Sexual offences (crude rates per 1,000)[48]



10.8 Local data from Thames Valley Police Windsor and Maidenhead team helps to provide further context to the nationally reported statistics. Figure 36 shows the recorded number of offences relating to violence against the person and the associated outcomes from these offences. It supports the national data showing that there has been limited fluctuation in the number of offences with injury and therefore those likely to be hospitalised. However, it does show that when breaking down the violence against person offences there has been an increase in violence without injury (ex. Harassment) and harassment. Figure 36 also shows that there has been a noticeable decrease in the number of outcomes associated with violence against the person outcomes.

10.9 Further local intelligence reports that violence against persons, both with and without injury, peak in the months of May to July with Friday and Saturday being the highest week days for offences.

[48] Compared to England between 2010/11 and 2017/18, (source: Public Health Outcomes Framework, 2018)

Figure 36: Finally recorded and outcomes of violence against the person offences[49]

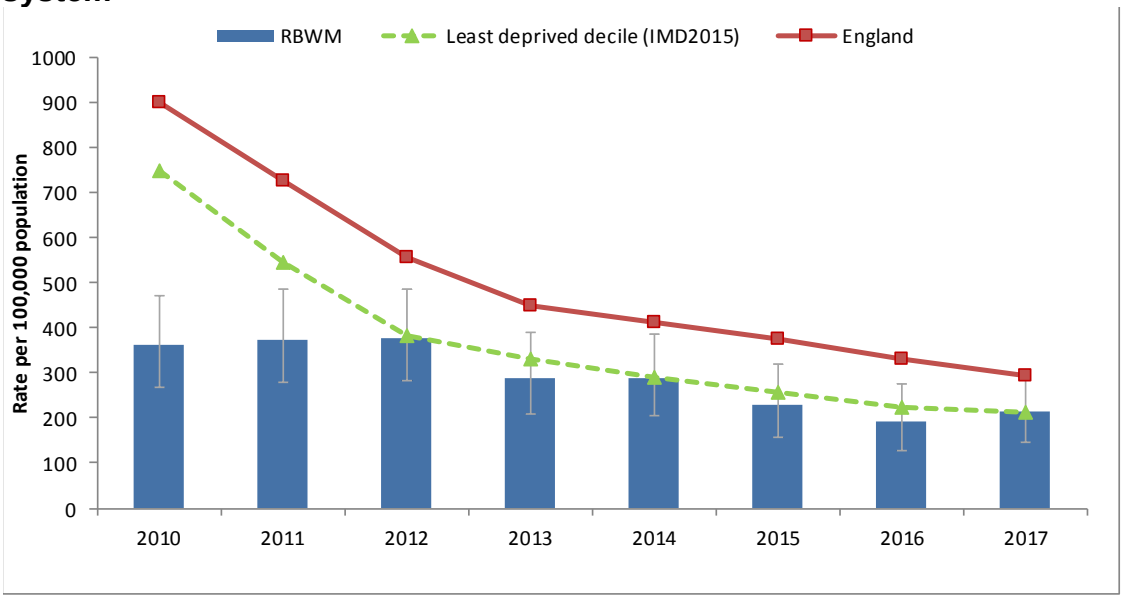
Offence	Finally Recorded				Outcomes		
	2015/16	2016/17	2017/18	% change	2015/16	2016/17	2017/18
Violence against the person	1795	1760	1972	12	559	468	367
Violence with injury	798	754	785	4.1	277	239	160
Violence without injury (ex. Harassment)	833	852	1006	18.1	240	185	169
Harassment	164	154	179	16.2	42	44	37

Youth crime and exploitation

10.10 Youth crime within the borough is low and the figures associated with it reflect this. Due to these low numbers, a small fluctuation in numbers can cause a significant impact on the presentation of the statistics. This should be a consideration when analysing the data associated with youth crime and exploitation. It is also worth considering that often young people who commit offences can be victims of crime themselves and could be being exploited by an adult.

10.11 The rate of first time entrants to the youth justice system (young people who received their first conviction, youth caution or youth conditional caution) in 2017 in the borough was 213.6 per 100,000 10-17 year old population. This is statistically similar to the England and South East rate, see Figure 37. Typically within this cohort, one to two young persons will enter custody per year.

Figure 29: Rate of 10-17 year olds first time entrants to the youth justice system[50]



[49] Source: https://www.thamesvalley.police.uk/SysSiteAssets/foi-media/thames-valley-police/priorities_and_how_we_are_doing/summary-of-notifiable-offences-in-windsor-and-maidenhead---april-2017---march-2018.pdf April 2017- March 2018

[50] Source: Public Health Outcomes Framework, 2018

10.12 The data from the Youth Offending service provides some more context to youth crime and exploitation. When looking at the crimes committed by young people in the borough, drug offences and violence against others consistently appear as the top two offences. These categories are very broad and encompass a wide range of offences; however, when analysing the data closer, there is an increasing trend in weapons offences and possession of drugs with intent to supply. The majority of offences committed are by white males and locally, there is no overrepresentation of ethnic minority groups within the youth crime cohort.

10.13 The data associated with child sexual exploitation (CSE) for the borough has been suppressed due to small numbers. In addition to this data, the Royal Borough has supported 39 young people with CSE prevention work in 2017/18 and as of February 2019, for 2018/19, the Royal Borough has supported 31 young people with CSE prevention work.

Drug Exploitation

10.14 Data relating to drugs exploitation is supplied by the local police and is too sensitive for publishing. However, local intelligence suggests that there has been an increase in drug exploitation within the borough. This includes activities such as County Lines (where gangs use 'mobile phone lines' to extend their drug dealing business into new locations outside of their home areas) and cuckooing (a crime where a drug dealer befriends a weak, old or vulnerable person and takes over their home to use as a drug den).

Burglary

10.15 Burglary of a residential property is a crime that has far reaching implications that are wider than the loss of property. These crimes can have significant effects on the emotional wellbeing and sense of safety of the victim, which can be long lasting. In addition to the impact of these crimes, they are becoming much more difficult to secure a positive outcome as perpetrators become more forensically aware.

10.16 In the borough, there has recently been a change in how burglary crimes are recorded. As a result of this change, it is not possible to show comparisons across the financial years (March – April). Figure 38 shows the data for Windsor and Maidenhead between February and January 2017/18 and 2018/19. It shows that, overall, the number of burglaries in the borough has decreased by 11.9%; this is in comparison with the increase seen nationally. Intelligence from the police suggests that more recently there has been a 4% decrease specifically for residential burglaries (March 2019).

Table 9: Burglary offences recorded by the police for Windsor and Maidenhead for February to January 2017/18 and 2018/19

Offence	Finally Recorded		
	2017/18	2018/19	% change
Burglary	**891**	**785**	**- 11.9**
Burglary Dwelling	67	0	n/a
Burglary Non-Dwelling	100	0	n/a
Residential Burglary - dwelling	354	392	10.7
Residential Burglary - sheds/ Garages	164	177	7.9
Business & Community Burglary	206	216	4.9

What does this tell us?

10.17 The borough performs better than the England average for violence against a person offences and sexual offences. Locally, between 2015/16 and 2016/17, there has not been a statistically significant increased rate of violent offences, which is contrary to national trends. There has, however, been an increase in sexual offences, which follows the national trend.

10.18 Locally, violence against the person without injury is increasing, and the outcomes associated with all violence against the person offences is decreasing.

10.19 Drug and violence against others are the top two offences committed by the youth crime cohort.

10.20 For many types of crime, police recorded crime statistics do not provide a reliable measure of levels of, or trends in, crime. The statistics only cover crimes that come to the attention of the police. These can be affected by changes in policing activity, recording practice and the willingness of victims to report a crime.

10.21 An increase in the number of crimes recorded by the police does not necessarily mean the level of crime has increased. Many crimes, such as sexual offences, are underreported and an increase can be due to an increase in public awareness or reporting, such as the recent national publicity around sexual offences.

What are the key inequalities and unmet needs?

10.22 The youth offending service has anecdotally found that the majority of young people on their case load are negatively affected by their mental health to a varying degree; a disproportionate amount of the violence against a person crime is taking place as a result of the night-time economy and County Line dealing disproportionately affects young people.

10.23 Mental health support for young people involved in crime is an identified need that should be addressed.

10.24 The wider partnership needs to continue to develop its understanding of gang life, the wider vulnerabilities and the challenges that young people face.

Recommendations for consideration

10.25 Support the increased mental health support for children and young people who commit crimes/offences and evaluate impact of mental health worker being established within the Youth Offending Team.

10.26 Continue to develop a trauma informed approach when supporting children and young people who have offended and continue to develop a holistic approach to work with the whole family when supporting young people who are offending.

10.27 Continue to work in partnership to identify opportunities for early intervention to support children and young people at risk of falling victim to crime and making harmful decisions.

10.28 Support the community to help manage the impacts of the night-time economy.

11 DOMESTIC ABUSE

11.1 Whilst both men and women may perpetrate or experience domestic abuse, it is more commonly experienced by women. Women are also more likely to experience repeated and severe forms of violence, including sexual violence and are also more likely to have sustained psychological or emotional effects. At its extreme, domestic abuse can result in death.

11.2 There is evidence of a relationship between the severity of domestic abuse and the use of health services[51]. Women who experience domestic abuse present more frequently to health services. They are admitted to hospital more often than their non-abuse counterparts and are issued with more prescriptions. SafeLives (2015) found that almost a quarter (23%) of high risk victims and 1 in 10 medium risk victims attended A&E because of their physical injuries. Another study found that a high proportion of women attending A&E, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic abuse at some point[52].

11.3 The effects of domestic abuse are greater than the potential short term injuries sustained, victims can suffer long-term health problems including: gynaecological disorders, chronic pain, neurological symptoms, gastro-intestinal disorders, and self-reported heart disease.[53] The most prevalent effect is on mental health including post-traumatic stress disorder, depression, anxiety, suicidal thoughts, and substance misuse.[54]

11.4 In families where there is domestic abuse, children witness about three-quarters of the abusive incidents. Children living with domestic abuse have an increased risk of developing acute and long term physical and emotional health problems[55]. Many will be traumatised by what they witness, whether it is the violence itself or the emotional and physical effects the abuse has on someone in the household.

Risk factors associated with domestic abuse

11.5 The following have been identified by the World Health Organisation (WHO)[56] and the National Institute of Health and Clinical Excellence[57] as risk factors associated with becoming a victim of domestic abuse. It is important to note that domestic abuse results from the interaction of a number of factors:

- Gender.
- Having a long term illness or disability (this almost doubles the risk).
- Age.
- Pregnancy - about 30% of domestic abuse starts or will intensify during pregnancy (Department of Health, 2004)[58].
- Mental health issues.

[51] Povey D. et al, 2009, cited in Smith et al, 2011
[52] Alhabib, S. et al, 2010
[53] Source: Feder et al, 2011.
[54] Coid, J et al, 2003
[55] Felitti VJ, Andrea RF, Nordenberg et al, 2002
[56] Harvey A et al, 2007
[57] National Institute for Health and Care Excellence, 2014
[58] However for some pregnancy can act as a protective factor (Bowen et al. 2005)

- Separation.
- Drug and alcohol abuse.
- Low income.
- Bisexual, lesbian, gay and transgender people.

Mortality

11.6 Domestic abuse in extreme cases can result in death, both as a direct and indirect result of the abuse. Every day almost 30 women attempt suicide as a result of experiencing domestic abuse and every week three women take their own lives[59]. Seven women a month are killed by a current or former partner in England and Wales. This equates to two women a week / one every 3 days[60].

Impact of domestic abuse on the wider determinants of health

11.7 Domestic abuse can have a number of wider impacts on those living with it. These include homelessness, loss of work and social impacts. Research carried out by the homeless charity, Shelter, found that domestic violence is "the single most quoted reason for becoming homeless". The study found that 40% of all homeless women stated domestic violence as a contributor to their homelessness[61].

11.8 The British Crime Survey showed that more than one fifth of women (21%) who were employed and who had suffered domestic violence took time off work as a result of the worst incident[62]. Other impacts can be social; feelings of isolation can also occur during, and after leaving an abusive relationship since victims might have had to move to a new area away from friends and family. Building new social networks and pursuing new work or educational opportunities whilst recovering from the effects of an abusive relationship, can be very hard especially where the victim has experienced mental health issues.

National and local strategies (current best practice)

11.9 At national level, in 2010 the Government published its first *'Call to End Violence Against Women and Girls'* strategy. In March 2016, a refreshed strategy '*Ending Violence against women and girls – strategy 2016-2020'* was published, outlining the Government's plans to tackle violence against women and girls in all its forms over the next four years. The four key areas of focus remain unchanged from the 2010 strategy:

- Prevention
- Provision of services
- Partnership working
- Pursuing perpetrators.

11.10 Locally, The Community Safety Partnership Domestic Abuse Strategy 2017-2020 sets out our priorities for three years across these four key areas. The annual action plan is reviewed and updated quarterly. The Royal Borough of Windsor and Maidenhead Domestic Abuse Executive Group (DAEG) is responsible for the delivery of this strategy. In addition, the group provides strategic leadership of the multi-agency response to domestic abuse in the borough.

[59] Walby, S 2004
[60] Crime Survey for England and Wales, 2015
[61] Cramer H and Carter M, 2002
[62] British Crime Survey, 2009/10

11.11 Within the borough, there are a number of services and activities including:

- Awareness raising and publicity campaigns.
- Training – for both council staff and anyone working in the borough to ensure staff are well equipped to understand and respond to domestic abuse.
- Refuge accommodation is available outside of the borough – this helps to protect the safety of the victim seeking refuge.
- The Dash (Domestic Abuse Stops Here) Charity is commissioned by the Royal Borough to provide support for adults and children who are living, or have lived, with domestic abuse. The service has three main support arms – adult IDVA (high risk victims), outreach (medium and standard risk victims) and children IDVA services (one to one support for children who have witnessed domestic abuse).
- The Dash Charity Schools Prevention Worker – offering talks/assemblies/ workshops with schools and youth settings on healthy relationships.
- PICADA (Positive Intervention for Children Affected by Domestic Abuse) - this is a 12 week support group for children affected by domestic abuse (post abuse). A parallel group for mothers runs to help create links and build relationships between themselves and their children.
- The Freedom Programme – a 12 week support group for women who are or have experienced domestic abuse.
- MARAC (Multi-agency risk assessment conference) – a monthly multi-agency victim-focused meeting where information is shared on high risk cases of domestic abuse between statutory and voluntary agencies with the aim of improving the safety of the victim.
- DARIM (Domestic abuse repeat incident meeting) – a multi-agency partnership approach to safeguarding high repeat victims and families involved in continuous and prolonged domestic abuse situations, that do not fall into the category of high risk (not managed through the MARAC).
- The Sanctuary scheme – a victim-focused initiative aimed at reducing homelessness as a result of domestic abuse. The scheme provides professionally installed security measures to the homes of those living with domestic abuse to increase their safety whilst remaining in their own home.
- Positive Relationship Programme (PRP) – a programme run across Thames Valley and commissioned by the Police and Crime Commissioner aimed at supporting men who have evidenced aggression in their intimate relationships.
- Thames Valley BAMER (Black, Asian, Minority Ethnic and Refugee) Project – a project that aims to assess, improve and better coordinate the multi-agency response to Violence against Women and Girls in BAMER communities across the region.
- Building Resilience and Valuing Emotions (BRAVE) project - A service providing therapeutic support for victims of domestic abuse with additional emotional or psychological difficulties in East Berkshire.
- SAFE! – a service commissioned by the Office of the Police and Crime Commissioner across Thames Valley to support young victims of crime including those who have witnessed domestic abuse.

Facts, figures and trends

11.12 Collecting reliable data on domestic abuse is often difficult due to the hidden and underreported nature of the crime. Unlike approaches with other types of crime,

one of the key objectives in tackling domestic abuse is to encourage and subsequently increase the reporting of incidents.

11.13 The CSEW[63] asks respondents about their experiences of crime, regardless of whether or not it was reported to the police, and therefore offers the best estimates of actual prevalence of crime, including domestic abuse. In the 2017/18, nationally, it was found that 6.1% of people aged 16-59 years (2 million victims) had experienced some form of domestic abuse in the last year, this wasn't a statistically significant change from the previous year. It also showed that there has been little change in the prevalence in recent years. However, when looking at the data over a longer time period, the data shows that there has been an overall significant reduction in prevalence between 2011/12 and 2017/18 (7% to 6.1% respectively).

11.14 The main indicators as to the level of known domestic abuse in the borough is the number of incidents reported and recorded by Thames Valley Police and the number of referrals to the Dash Charity. Police data can be broken down into recorded crime (where a crime has been committed e.g. assault) and a non-crime occurrence (where a crime has not taken place but the incident has been reported to police e.g. verbal argument). Figure 39 shows domestic abuse crimes and non-crime between 2015/16 and 2017/18. This shows that there is an overall increasing trend in reports to the police. The largest increase (108 reports) was seen between 2015/16 and 2016/17.

Figure 39: Domestic abuse local data (Thames Valley Police)

	2015-16	**2016-17**	**2017-18**
Domestic abuse crime	516	762	777
Domestic abuse non crime	1,115	1,667	1,699
Total	**2,321**	**2,429**	**2,476**

11.15 Figure 40 outlines the number of domestic abuse cases referred to The Dash Charity over the last three years. This shows that the number of Independent Domestic Violence Advisor (IDVA) referrals have fluctuated very little; however, the number of outreach and children IDVA cases has reduced. The reduction in 2016/17 was likely due to the service having to temporarily close referrals. The reduction in children IDVA cases in 2017/18 was due to a drop in referrals and lack of capacity within the service. As of 2018/19, the domestic abuse service has moved from a grant to contract. Early indications show that children IDVA referrals are increasing and are being fully utilised.

Figure 40: Caseload undertaken by the Dash Charity, 2015/16-2017/18

	2015-16	**2016-17**	**2017-18**
IDVA cases	145	136	148
Outreach cases	147	115	112
Children's IDVA cases	73	49	17

11.16 Figure 41 outlines the police data specifically relating to children, and it demonstrates that there has been an increase in both domestic abuse incidents and crimes involving children.

[63] https://www.ons.gov.uk/releases/crimeinenglandandwalesyearendingjune2018

Figure 41: Royal Borough of Windsor and Maidenhead Thames Valley Police data relating to children and young people, 2016/17-2017/18

Measure	2016/17	2017/18
Number of domestic abuse incidents involving children	1,208	1,346
Number of domestic abuse crime involving children	390	454
Total number of MARAC cases reviewed to date	446	505
Percentage of repeat MARAC cases (%) (rolling 12 months)	32%	23%
Total number of children in households of MARAC referrals	172	133

What does this tell us and what are the key inequalities?

11.17 Locally, there has been an increase in both domestic abuse crime and non-crime occurrences. This could be due to an increase in the reporting of domestic abuse crimes and non-crimes locally, which in turn would reflect a more accurate picture of the number of crimes and non-crimes within the borough. In addition to the increase of reports, the demand for high risk support from the Dash Charity has not significantly changed between 2015/16 and 2017/18. This supports the theory that the increase in crimes and non-crimes is due to an increase in reporting rather than a real increase in incidents of domestic abuse. This is further supported by the national recognition that domestic abuse is an underreported crime.

11.18 There was a large disparity between the number of domestic abuse crimes and incidents involving children and the number of children supported by the Dash children's IDVA service, however the numbers supported by DASH are now increasing.

11.19 Domestic abuse disproportionately affects women.

What are the unmet service gaps?

11.20 There is currently no dedicated work focused on adolescent to parent violence. There is a potential gap in services to support children and young people who are currently still living with, or have contact with, the perpetrator of the abuse. There is no dedicated Domestic Abuse expertise within the front door of children services to support the triage process.

11.21 There are also very limited services available to support male victims of domestic abuse.

Recommendations for consideration

11.21 Further multi agency working to raise awareness of the impacts of domestic abuse of children and young people and the support available.

11.22 Explore how perpetrator support can be better utilised within the borough.

11.23 Exploring how the council can support victims fleeing domestic abuse who could be viewed as making themselves intentionally homeless if leaving a tenancy in their name.

11.24 Explore options for extending support for male victims of domestic abuse.

12 OUR ENVIRONMENT

12.1 There is evidence that the natural environment has an influence on health in a variety of ways.[64] The ways in which the natural environment can improve health are complex and intertwined with many other factors. There are broad themes that have appeared from the research in this field:

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

12.2 The borough has 83% of its land designated as Green Belt; the council manages over 60 parks and open spaces[65] and the River Thames runs through the local authority area so there is a wealth of natural environment resource through the many green spaces.

National and local strategies (current best practice)

12.3 At a national level, the government's 25 year environment plan sets out how the government intends to protect and enhance the natural environment within a generation[66]. This focuses on clean air; clean water; thriving plants and wildlife; reducing the risks of harm from environmental hazards; using resources from nature more sustainably and efficiently; enhancing beauty, heritage and engagement with the natural environment; mitigating and adapting to climate change; minimising waste; managing exposure to chemicals and enhancing biosecurity.

12.4 Locally, there are a number of ways that the council seeks to both protect and enhance the local environment as well as encourage engagement with it, including:

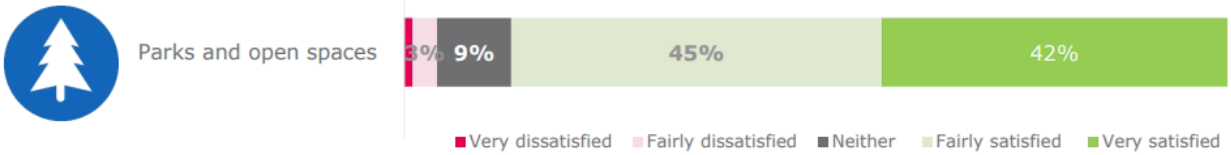
- The Borough Local Plan.
- Air Quality Action Plan[67].
- Local Transport Plan 2012-2026[68].
- Energy Strategy 2019-2023[69].
- Cycling Action Plan 2018-2028.
- Playing Pitch Strategy[70].

[64] *WHO Regional Office for Europe, "Urban green spaces and health," Copenhagen, 2016.*
[65] https://www3.rbwm.gov.uk/info/200200/parks_and_open_spaces
[66] https://www.gov.uk/government/publications/25-year-environment-plan
[67] https://www3.rbwm.gov.uk/download/downloads/id/2082/air_quality_action_plan.pdf
[68] https://www3.rbwm.gov.uk/download/downloads/id/238/local_transport_plan_-_part_one.pdf
[69] https://www3.rbwm.gov.uk/download/downloads/id/4437/energy_strategy.pdf
[70] https://www3.rbwm.gov.uk/info/200209/planning_policy/486/playing_pitch_strategy

Facts, figures and trends

12.5 In the most recent survey of residents, commissioned by the council using the LGA recommended methodology, when asked what they liked most about their local area, 43% said the parks and open spaces and 87% of residents said that they were fairly or very satisfied with the parks and open spaces[71], figure 42.

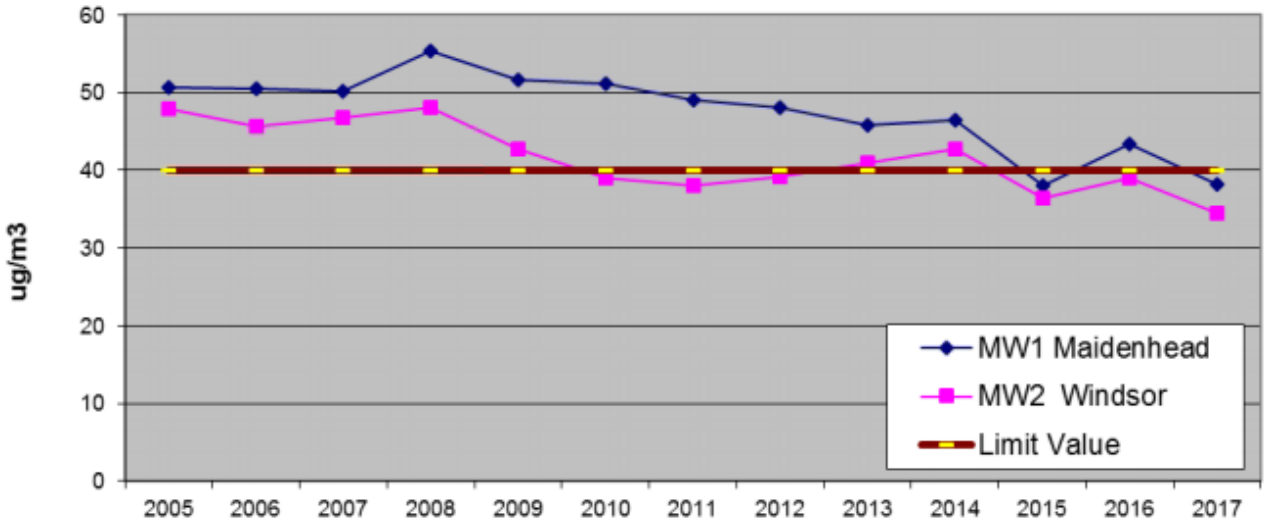
Figure 42: Residents' satisfaction with parks and open spaces



Air quality

12.6 The council has declared five Air Quality Management Areas (AQMAs), for exceedance of the annual mean objective for nitrogen dioxide, in Windsor (two areas), Maidenhead, Bray (near the M4) and Wraysbury (near the M25)[72]. Air quality across the Borough is generally good and in recent years has been improving. Current monitoring suggests that there are some localised exceedances of the annual mean air quality objective (AQO) for nitrogen dioxide (NO2).

Figure 43: Trends in annual mean NO2 concentration[73]



12.7 The council has an active programme of measures in place to reduce the impact of emissions on local air quality. These form an integral part of the Local Transport Plan (LTP) which informs the Highways Capital Programme with the council's efforts to improve air quality. The LTP also implements a suite of 'soft' measures and smarter choices: influencing better travel choices, such as encouraging public transport use, walking and cycling that can all contribute to reduce road traffic emissions.

71 https://rbwm.moderngov.co.uk/documents/s24628/meetings_190131_cab_Residents%20Survey%20Cabinet%20Report.pdf

72 https://uk-air.defra.gov.uk/aqma/local-authorities?la_id=315

73 https://www3.rbwm.gov.uk/download/downloads/id/3129/air_quality_annual_report_june_2018.pdf

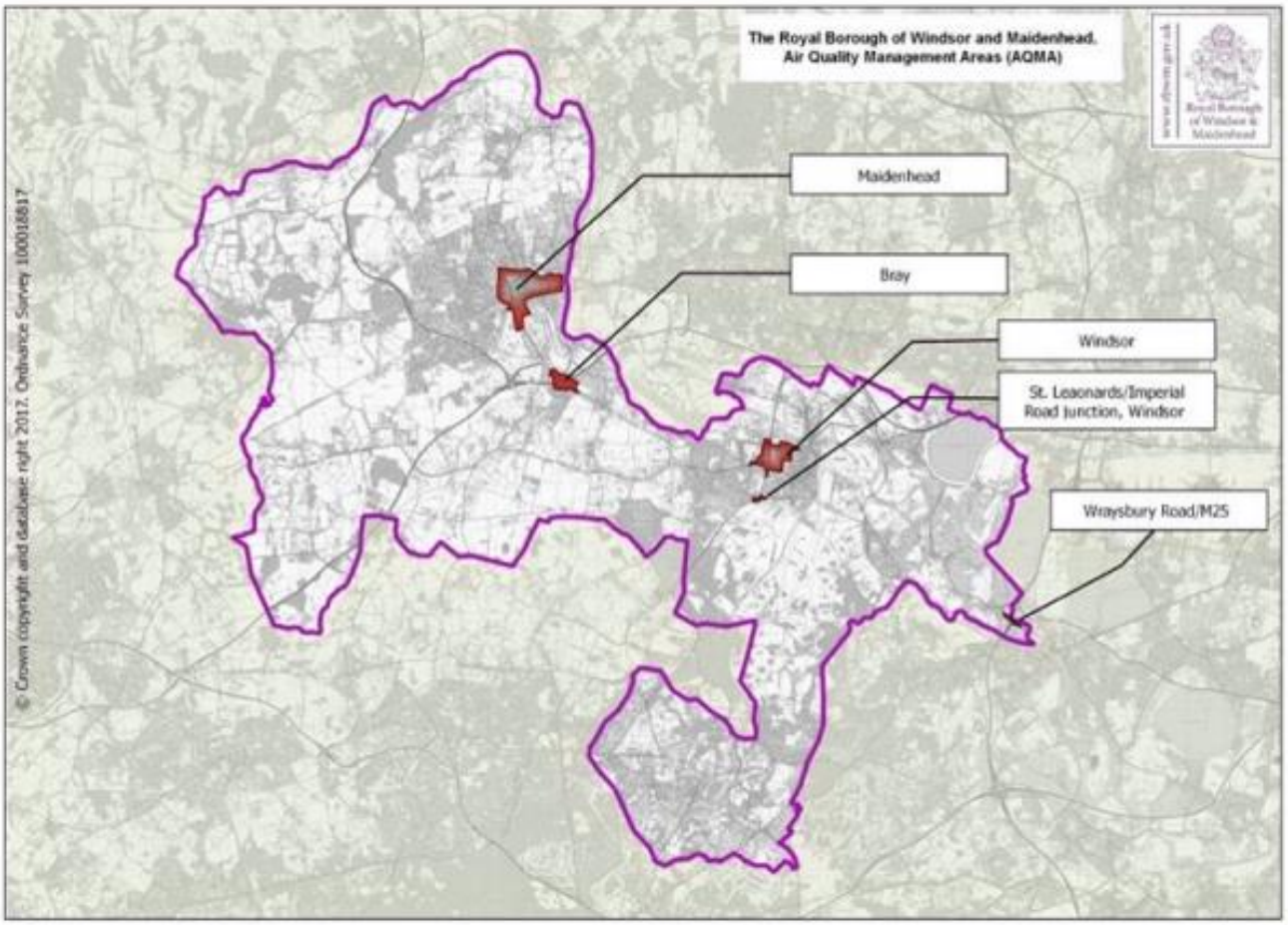
What does this tell us and what are the key inequalities?

12.8 Overall, the borough benefits from having a wealth of resources in the natural environment to support residents in living active, healthy lifestyles. The borough's parks and open spaces are valued by residents.

12.9 Although the borough has some AQMAs, there are robust action plans in place and generally air quality in those areas has been improving, with some localised exceptions.

12.10 In the UK, approximately 40,000 deaths per year are linked with exposure to outdoor air pollution. Outdoor air pollution has been linked to cancer, asthma, stroke, heart disease, diabetes, obesity and changes linked with dementia. These health problems resulting from outdoor air pollution costs over £20 billion per year.[74] It has long been recognised that reducing vehicle emissions is a major factor in improving air quality as they are the major source of emissions. A number of the AQMAs are in residential areas and therefore residents in those areas are disproportionately affected.

Figure 44: Air Quality Management Areas



[74] Royal College of Physicians: Every breath we take: the lifelong impact of air pollution, 2016.

What are the unmet service gaps?

12.11 Access to the borough's parks and open spaces are universal and the council should continue to promote them widely and seek to increase access or opportunities, where possible, to maintain the high levels of satisfaction.

12.12 The Royal Borough takes part in the annual National Highways and Transport Benchmarking Survey, which asks residents for their views on a wide range of highways and transport services, including various aspects of cycling provision. The results from the 2017 survey show that 47% of residents are satisfied with cycle routes and facilities in general. The survey results show that satisfaction levels in the borough are lower than average for all cycling aspects, with the largest satisfaction differential relating to the provision and location of cycle routes[75]. Whilst there is an unmet need / service gap identified here, the cycling action plan has a series of costed and detailed activity and has set the following targets for improvement:

- To achieve a 20% increase in cycling trips between 2017 and 2022, and a 50% increase by 2027
- To reduce cyclist casualties by 20% between 2016 and 2021
- To increase resident satisfaction score for cycle routes and facilities from a baseline of 47% in 2017 to 60% by 2022

Recommendations for consideration

12.13 Continue to progress the Borough Local Plan to ensure development is sustainable and managed.

12.14 Maintain and enhance access to the borough's parks and open spaces to ensure resident satisfaction remains high.

12.15 Implement the actions of the cycling action plan.

12.16 Implement the actions in the Air Quality Management Plan.

[75] https://www3.rbwm.gov.uk/download/downloads/id/4341/cycling_action_plan.pdf

13 ROAD SAFETY

13.1 Local authorities have a statutory duty under the Road Traffic Act 1988 to carry out a programme of measures designed to promote road safety. This includes studies into accidents and taking measures to protect such accidents, including the dissemination of information and advice relating to the use of roads, training to road users as well as the construction, improvement, maintenance or repair of roads. These road safety activities help to improve health and prevent injuries and deaths. Safer roads and safer road user behaviours not only save lives, but also help to reduce pressure on the NHS and emergency services.

13.2 In 2016, there were 1,792 fatalities on Britain's roads with a further 24,101 people seriously injured and 155,491 slightly injured. Of the fatalities, by road user type, 46% were car users, 25% were pedestrians and 18% were motorcyclists. Since 2015 fatalities for car users and pedestrians have increased by 8% and 10% respectively and fatalities from motorcycle accidents have decreased by 13%. The South East had the highest number of fatalities in England in 2016 with a total number of 280, a 19% increase from 2015.

13.3 Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. Road traffic collisions are a major cause of deaths in children and comprise higher proportions of accidental deaths as children get older. Parents cite vehicle speed and volume as reasons why they do not allow their children to walk or cycle, thereby reducing opportunities for physical activity. For males aged 20-64 years, death rates from motor vehicle traffic accidents are higher in lower socioeconomic groups than the general population.

13.4 In addition to the immediate impact of a collision, road traffic casualties and injuries can have a long-term impact on the mental and physical health of individuals affected, including families and communities. Many road traffic collisions are preventable and costs to life can be avoided through investment in improved education, awareness, and road infrastructure and vehicle safety.

National and local strategies (current best practice)

13.5 'Working Together to Build a Safer Road System - British Road Safety Statement' (Dec 2015) sets out the Department for Transport's vision, values and priorities in relation to British road safety. Their key priorities include:

- Adopting the Safe Systems approach based on the five pillars of:
  - Road safety management.
  - Safer roads and mobility.
  - Safer vehicles.
  - Safer road users.
  - Post-crash response.
- Protecting vulnerable road users through: infrastructure and vehicle improvements; promotion of safer behaviour and equipment; and ensuring other road users are aware of the risks posed to these groups and adapt accordingly.
- Taking tough action against those who speed, exceed the drink-drive limit, take drugs or use their mobile phone while on the road.
- Ensuring that the driver testing and training regime prepares new drivers for a wide range of real life driving conditions and situations.

- Working with the insurance industry to incentivise safer behaviours and to reward the uptake of those new technologies and opportunities to improve skills that are proven to reduce collisions.
- Helping employers to reduce road related collisions at work, including through improved heavy goods vehicle (HGV) safety.
- Encouraging the faster uptake of safer vehicles via the promotion of clear consumer information and the procurement of safer vehicles.
- Promoting the development and adoption of connected and autonomous vehicle technologies in a way that maximises safety benefits.

13.6 The council's Local Transport Plan (2012) sets out the policies and investment priorities for road safety. This concentrates on the key areas of:

- Education, training and publicity.
- Enforcement activity.
- Engineering measures.

13.7 The council takes an evidence-led approach to guide its investment in road safety schemes and initiatives. It has an annual programme of Local Road Safety Schemes. These are targeted at higher risk casualty sites where there is a clear pattern of causation factors that can be addressed by engineering measures. This is considered to be the most appropriate use of existing resources. It has built up an education, training and publicity programme that tackles all aspects of road safety from infancy to old age. Ongoing initiatives have included:

- Car seat safety.
- Road safety education in schools for years 3, 4 and 6.
- Hi Visibility school bags for primary schools.
- Bikeability training for school pupils in years, 4, 5, 6 and 7.
- Pre-driver education.
- Drink-drive campaigns.
- A bike light campaign.
- 'Flourish' - a campaign aimed at older drivers.

13.8 The Royal Borough is working with the other local authorities across Berkshire to ensure consistent delivery of messages on road safety issues by the most economical means possible. This programme is targeted at higher risk groups which means that other groups such as adult pedestrians, cyclists and motorcyclists are not covered or have only limited coverage by our road safety education programmes.

13.9 Cycling is supported by the Cycling Action Plan (2018-2028). This action plan aims to connect residential areas with destinations such as town centres, education settings and local centres. It aims to encourage more cycling trips through capital and revenue investment in cycling infrastructure and supporting this with a programme of information, training and appropriate support.

13.10 Hampshire constabulary and Thames Valley Police joint operations unit also operate a yearly programme of road safety activities. This programme focuses around four main target groups; speed, seatbelts, drink and drug driving and mobile phone use. There are two main campaigns around drink and drug driving that run in

the summer and over the Christmas period. They also conduct speed enforcement, digital camera upgrades and community speed watch initiatives.

Facts, figures and trends

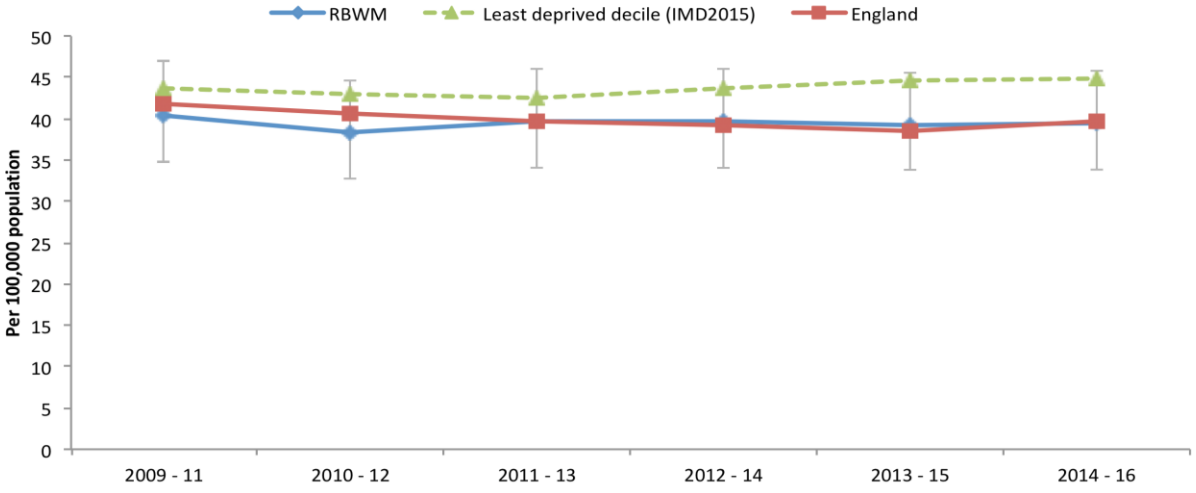
13.11 Following Hampshire Constabulary and Thames Valley Police joint operations unit latest drink and drug driving campaign in 2018, it was found that across the whole area the number of drivers testing positive for drugs had increased and the number of drink drivers had slightly decreased. It is likely that the observed increase in drug drivers is linked to the improved ability of the police to conduct drug tests and may not be as a result of a real increase in numbers of drivers driving with drugs within their system.

13.12 Road casualty data is collected by the police and includes information from collisions that have resulted in at least one injury. Collisions that do not include any injuries (damage-only crashes) or are not reported are not recorded and are not, therefore, included within these records. Hospital admission records indicate under-reporting of crashes, mainly those involving injuries to pedestrians and cyclists, but there are no reliable figures to indicate the extent of this under-reporting.

Killed and seriously injured casualties

13.13 The rate of people who were killed or seriously injured on roads in the borough was 39.5 per 100,000 population for 2014-16. This is similar to the comparator group and England's rate (44.9 and 39.7 respectively).

Figure 45: The rate of people killed or seriously injured on the roads, all ages, per 100,000 population[76]

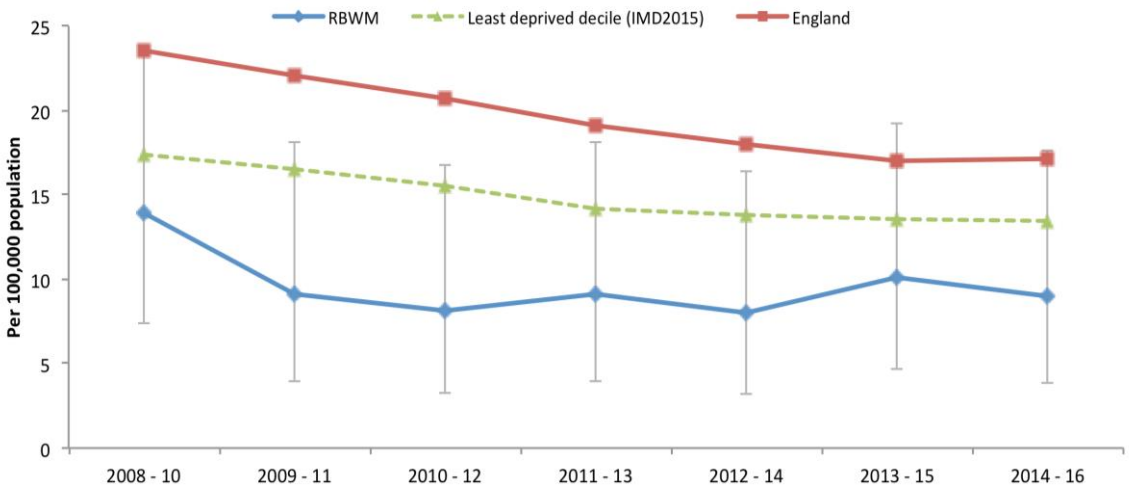


Children killed or seriously injured

13.14 Of children aged 0-15 years, the rate of those killed or seriously injured in road traffic accidents in the borough was 8.9 per 100,000 population for 2014-16. This is similar to England's rate (17.1 per 100,000 population) and the comparator group (13.5 per 100,000 population).

[76] Compared to England and the least deprived decile (IMD 2015) between the period of 2009-11 and 2014-16; Data source: Public Health England (2018); Public Health Outcomes Framework

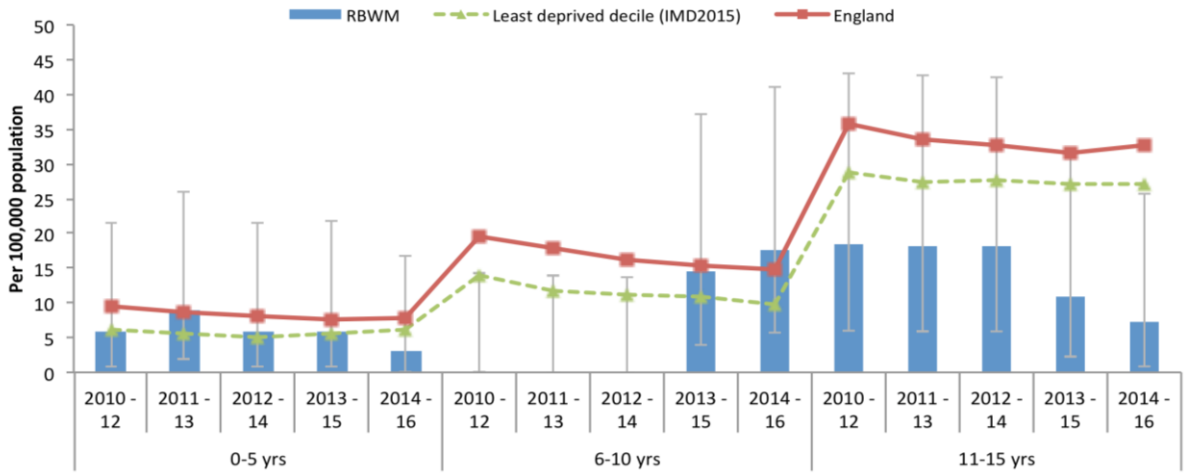
Figure 46: Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population[77]



13.15 Broken down to smaller age bands, the rate of those aged five and under was 3.0 per 100,000 in the borough for the period of 2014-16. This is lower than the England rate of 7.7 per 100,000 and the comparator group (6.1 per 100,000).

13.16 Of children aged 6-10 years, the rate was 17.6 per 100,000. This is statistically similar to England's rate of 14.8 per 100,000 and the comparator group (9.8 per 100,000). Of those aged 11-15 years, the rate was 7.1 per 100,000 population. This is lower than the England's rate of 32.6 per 100,000 and the comparator group (27.0 per 100,000).

Figure 47: Children who were killed or seriously injured in road traffic accidents per 100,000 population, by age groups[78]



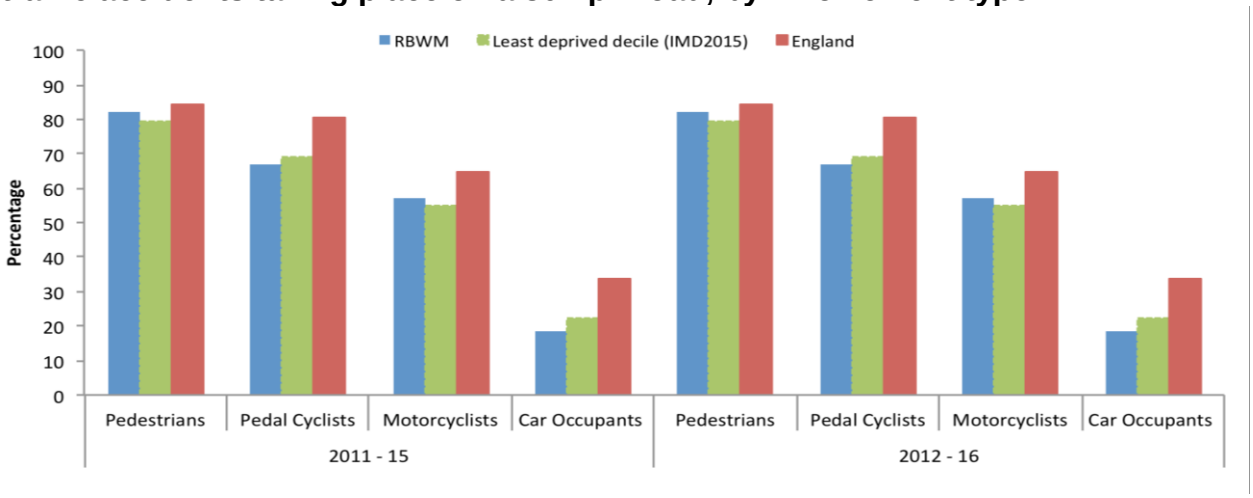
[77] Compared to England and the least deprived decile (IMD 2015) between the period of 2008-10 and 2014-16; Data source: Public Health England (2018); Public Health Outcomes Framework

[78] Compared to England and the least deprived decile (IMD 2015) between the period of 2010-12 and 2014-16; Data source: Public Health England (2018); Public Health Outcomes Framework

13.17 The rate of children and young people aged 0-24 years who were in a fatal traffic accident was 0.5 per 100,000 population, statistically similar to England (2.1) and the comparator group (2.1).

13.18 Figure 48 shows that pedestrians are the highest proportion of people aged 0-24 years that are killed or seriously injured in accidents taking place on a 30mph road. The overall pattern has remained the same between 2011-15 and 2012-16 with car occupants forming the smallest proportion of those killed or seriously injured on a 30mph road.

Figure 48: Percentage of people aged 0-24 killed or seriously injured in road traffic accidents taking place on a 30mph road, by involvement type[79]



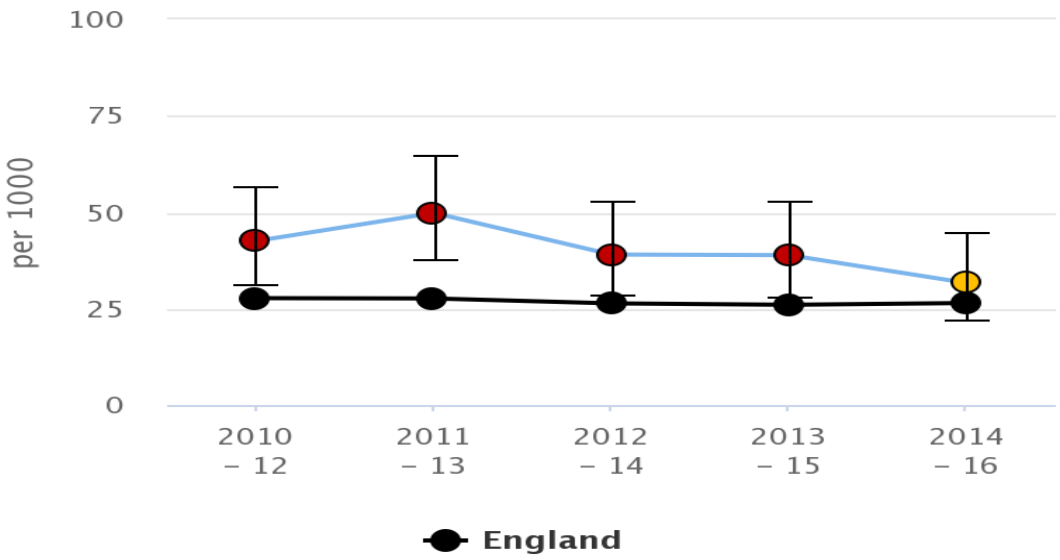
Alcohol-related road traffic accidents

13.19 The legal limit of alcohol within the blood in the UK is 35 micrograms of alcohol per 100ml of breath. However, any amount of alcohol affects a person's ability to drive safely, it negatively impacts on reaction times, stopping distances and field of vision.

13.20 Figure 49 shows the rate of road traffic accidents in which one driver failed a breath test. In 2014-16, the rate for the borough was 31.6 per 1,000 population. This is statistically similar to the England rate of 26.4 per 1,000 population. The rate in the borough also indicates a downward trend between 2011-13 and 2014-16.

[79] Compared to England and the least deprived decile (IMD 2015) between the period of 2011-15 and 2012-16; Data source: Public Health England (2018); Public Health Outcomes Framework

Figure 49: Alcohol related road traffic accidents in which at least one driver failed a breath test (2014-16)[80]



13.21 Local data collected within the borough where police attend a collision allows further analysis of the trends around alcohol related collisions. Locally, between 2015 and 2017, there were total of 716 drivers involved in collisions with police attendance. Of these collisions, 5.4% (n=39) were assigned the contributory factor 'impaired by alcohol'. Whilst this is a small fraction of the overall collisions within the borough, this figure is higher than both the England and South East figures (3.1% and 3.6% respectively). This figure is also the highest in Berkshire. The local data shows a similar pattern to the national data with a downward trend between 2015 and 2017 for the number of vehicles attributed 'impaired by alcohol' as seen in. This is following the trend of all collisions within the borough, which is also showing a shallow downward trend.

13.22 Of the 39 collisions attributable to alcohol, 33% were involved in 'killed or seriously injured' collisions. This is a higher proportion of serious collisions when compared with the proportion of killed or seriously injured collisions in the borough for all types of collisions with and without police attendance (18% and 16% respectively).

What does this tell us and what are the key inequalities?

13.23 The borough experiences similar and, in some cases, lower rates of both adults and children being killed or seriously injured on the roads. This could be down to a number of reasons and no direct causation can be drawn at this time. It is likely to be down a combination of factors such as safe road practices within the borough, safe design of the roads, targeted road safety improvements at higher risk sites, effective road safety education for children and good policing of the road systems within the borough.

13.24 Alcohol related road traffic accidents are showing a downward trend which is seen in both the national and local data. Locally, collisions attributable to alcohol form a very small proportion of the total collisions within the borough. However despite this

[80] Data source: Public Health England (2018); Public Health Outcomes Framework

small number, a great proportion of these collisions involve someone who is killed or seriously injured. Therefore, whilst these collisions are fewer, more of them are of a serious nature and cause serious harm or death.

13.25 Local data shows that the borough has the highest proportion of collisions attributable to alcohol when compared with the other local authorities in Berkshire; Reading has the second highest proportion. This is not surprising as both the borough and Reading have the largest night time economies within Berkshire.

13.26 Research shows that pedestrian accidents and fatalities are generally more common in poor and low-income areas.[81] The local data analysis does not provide sufficient detail to see if this applies to areas of relative deprivation within the borough.

13.27 Local data suggests that a greater proportion of people are killed or seriously injured as a result of a collision attributable to alcohol when compared with the proportion of those killed or seriously injured from the all attributable types of collisions within the borough.

What are the unmet needs and service gaps?

13.28 A multi-agency response to road safety is key. A Thames Valley road safety working group, which has representatives from across the police, ambulance, local authorities, third sector organisations and Fire and Rescue Services has been set up to increase joint working. Whilst this is a positive step, this group covers a wide geographical area, including Berkshire, Buckinghamshire, Oxfordshire and Hampshire, and therefore continued efforts are needed locally to ensure there is good join up between the local branches of these organisations.

Recommendations for consideration

13.29 Maintain and continue to build close working relationships across partners to deliver road safety programmes.

13.30 Continue to carry out campaigns aimed at improving cyclist safety (e.g. THINK Cycling, bike lights, Bikeability, including Level 3 in Secondary schools).

13.31 Continue to work with young drivers to disseminate road safety messages (e.g. Safe Drive Stay Alive, Drive Start).

13.32 Continue to work with retailers and nurseries to raise awareness of car seat safety, provide advice on correct fitment of car seats and carry out car seat checks.

13.33 Maintain focus on Local Road Safety Schemes in areas with the highest casualty rates.

[81] http://www.governing.com/gov-data/pedestrian-deaths-per-capita-by-poverty-rates-for-metro-areas.html

Appendices (separate documents)

Appendix 1: Developing Well needs assessment

Appendix 2: Living Well needs assessment

Appendix 3: Ageing Well needs assessment

Document Name	Joint Strategic Needs Assessment 2019		
Document Author	Anna Robinson, Strategy and Performance Manager Holli Dalgliesh, Service Lead - Public Health Programmes		
Document owner	Hilary Hall, Interim Director of Adult Services and Deputy Director Strategy and Commissioning		
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Royal Borough of Windsor & Maidenhead

Developing well in the Royal Borough of Windsor & Maidenhead

Exploring Children's Health

2018

Autism, Child Obesity, Child Poverty, Low Birth Weight, Emotional Wellbeing and Mental Health, Immunisations A&E admissions, Tobacco Product Use

Locality and Ward Level Insights

Executive Summary

Children in the Royal Borough experience good health in general. However, children living in some parts of the Royal Borough experiencing poor health. About 56% of our residents live in the 20% least deprived areas in the country, however, the Royal Borough is the home to four of the 20% most deprived LSOAs in Berkshire, namely Clewer North, Belmont, Furze Platt and Oldfield. [1]

The following represents a summary of the needs identified:

In 2016, there were 44 live births (2.80%) with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks in RBWM. This was similar to the England average (2.79%), but higher than the deprivation decile comparator group's of 2.20%.	The trends of overweight and obese children in Years 6 remained steady between 2007/08 and 2014/15, but the proportion substantially increased from 25.8% in 2015/16 to 30.8% in 2017/18.	In 2015, 2,463 children (8.4%) locally were living in poverty. This was increased by 0.82% to a total of 2,756 children (9.22%) over 2 years. In real terms, this means an increase of 293 children living in poverty.
In 2011, 4,448 (7.8%) households experienced fuel poverty in the Royal Borough. This was increased by 0.4% to a total of 4,976 (8.2%) households in 2015. In real terms, this means an increase of 528 households experienced fuel poverty.	411 children with autism known to schools in the Royal Borough at a rate of 15.0 per 1,000 pupils in 2017. This information tells us that there is a large number of children in the Royal Borough with autism known to schools and is higher than the national average (12.5 per 1,000) and the deprivation decile comparator group's rate of 11.8 per 1.000.	
In 2016/17, there were 838 emergency admissions at a rate of 115.7 per 1,000 population aged 1-4 years in the Royal Borough. This was worse than the England average (106.4 per 1,000) and the South East region (101.5 per 1,000). The upward trend should be noted too.	In 2014/15, smoking prevalence at age 15 in the Royal Borough was 7.6%. This was similar to the national average of 8.2% and better than the regional average of 9.0%. However, the prevalence of use of other tobacco products (e.g. shisha pipe, hookah, hubble-bubble, waterpipe) at age 15 years in the Royal Borough was 22.0%. This was worse than the national average of 15.2% and the regional average of 16.1%.	

[1] *The Better Care Fund: Windsor & Maidenhead Better Care Fund Narrative Plan 2017-19.*

Contents

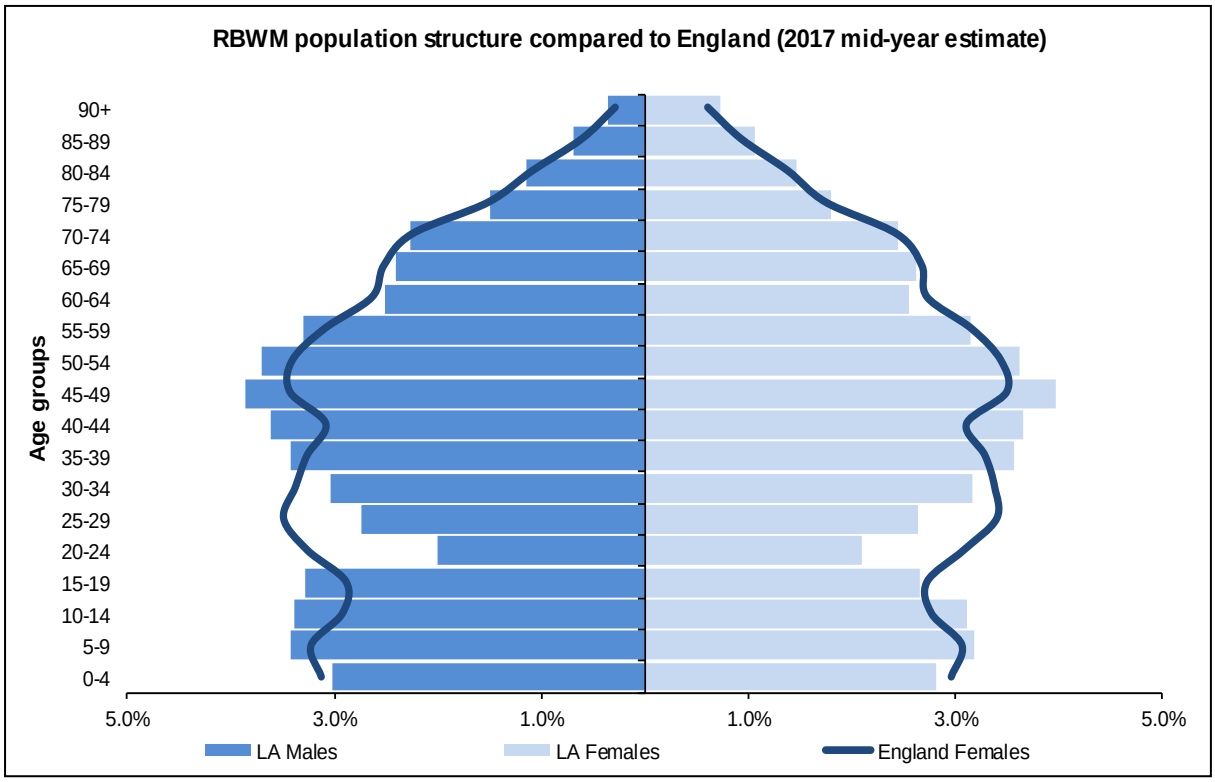
Introduction

This document has been prepared to support the development of plans aligned with the Developing Well Board, which is a sub board of the Health & Wellbeing Board. The report seeks to highlight the health needs of children aged 0-19 years in the borough (up to 25 years old if SEND) and make recommendations for board consideration. Needs were identified by recently published Child Health Profile, Public Health Outcomes Framework and Learning Disability Profiles, produced by Public Health England, with the most recent update in June 2018.

Our young People

The Royal Borough of Windsor and Maidenhead is a Royal Borough of Berkshire, in South East England. It is home to Windsor Castle, Eton College, Legoland Windsor and Ascot Racecourse. It is one of four boroughs entitled to be prefixed *Royal* and is one of six unitary authorities in its county which has Historic and Lieutenancy county status. It is a great place for children to have the best start in life. The population pyramid in Figure 1 compares the population figures for the Royal Borough of Windsor and Maidenhead with England by five-year age bands. It shows the population structure in children 0-19 years is higher than England. Table 1 below is a summary of the child population in this area, compared to the Region and England.

Figure 1: The Royal Borough of Windsor and Maidenhead and England Mid-2017 Population Pyramid



Data source: Mid-Year Population Estimates 201, Office for National Statistics (ONS).

Table 1: The child population in this area

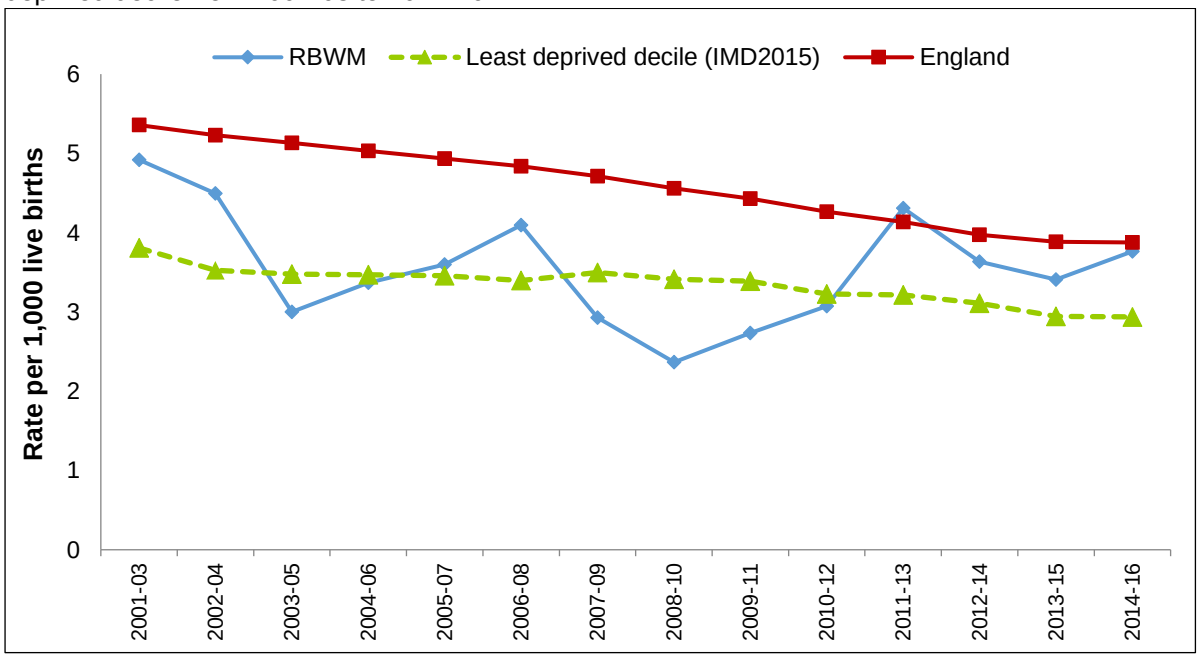
	RBWM	South East Region	England
Live births (2016)	1,757	101,982	663,157
Children aged 0 to 4 years (2016)	9,000 (6.0%)	542,000 (6.0%)	3,429,000 (6.2%)
Children aged 0 to 19 years (2016)	37,200 (25.0%)	2,148,500 (23.8%)	13,107,000 (23.7%)
Children aged 0 to 19 years in 2026 (projected)	39,500 (24.8%)	2,315,600 (23.8%)	14,065,900 (23.8%)
School children from minority ethnic groups (2017)	6,458 (34.6%)	256,375 (23.5%)	2,132,802 (31.0%)
School pupils with social, emotional and mental health needs (2017)	536 (2.5%)	29,021 (2.3%)	186,792 (2.3%)

Data source: Child Health Profile 2018 – Public Health Profiles

1. Infant mortality

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and other determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn. Reducing infant mortality overall and the gap between the richest and poorest groups are part of the Government's Strategy for public health.[2]

Figure 2: Rate of deaths in infants aged under 1 year in RBWM compared to England and the least deprived decile from 2001-03 to 2014-16



Data source: Public Health England (2018); Public Health Outcomes Framework

[2] *Healthy Lives, Healthy People: Our Strategy for Public Health November 2010*

In 2014-16, there were 19 infant deaths in RBWM at a rate of 3.8 per 1,000 live births. This was similar to the England rate of 3.9 and similar to the comparator group rate of 2.9 per 1,000 live births.

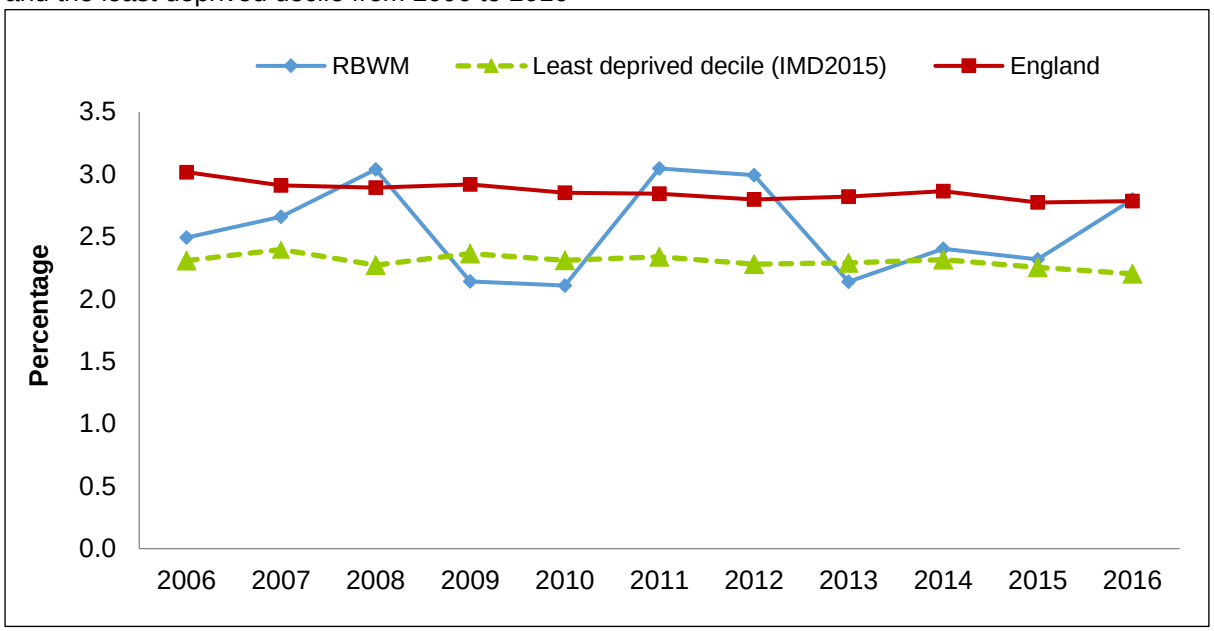
In 2014-16, there were 21 still births in RBWM at a rate of 4.1 per 1,000 live births. This was similar to the England rate of 4.5 per 1,000 live births.

2. Low birth weight of term babies

Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are variations in low birth weight in both national level and the Royal Borough.[3]

Low Birthweight is a risk factor for infant death and can be caused by a number of factors including smoking. There is an average difference of 200g between babies born to mothers who smoke and those who don't.[2]

Figure 3: Percentage of all live births at term with a low birth weight in RBWM compared to England and the least deprived decile from 2006 to 2016



Data source: Child Health Profile - Office for National Statistics (ONS)

In 2016, there were 2.80% of all live births with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks in RBWM. This was similar to the England average (2.79%), but higher than the deprivation decile comparator group's (IMD 2015) of 2.20%. Actions are needed to narrow the gap.

[3] *PHE: Public Health Outcomes Framework*

3. Child poverty

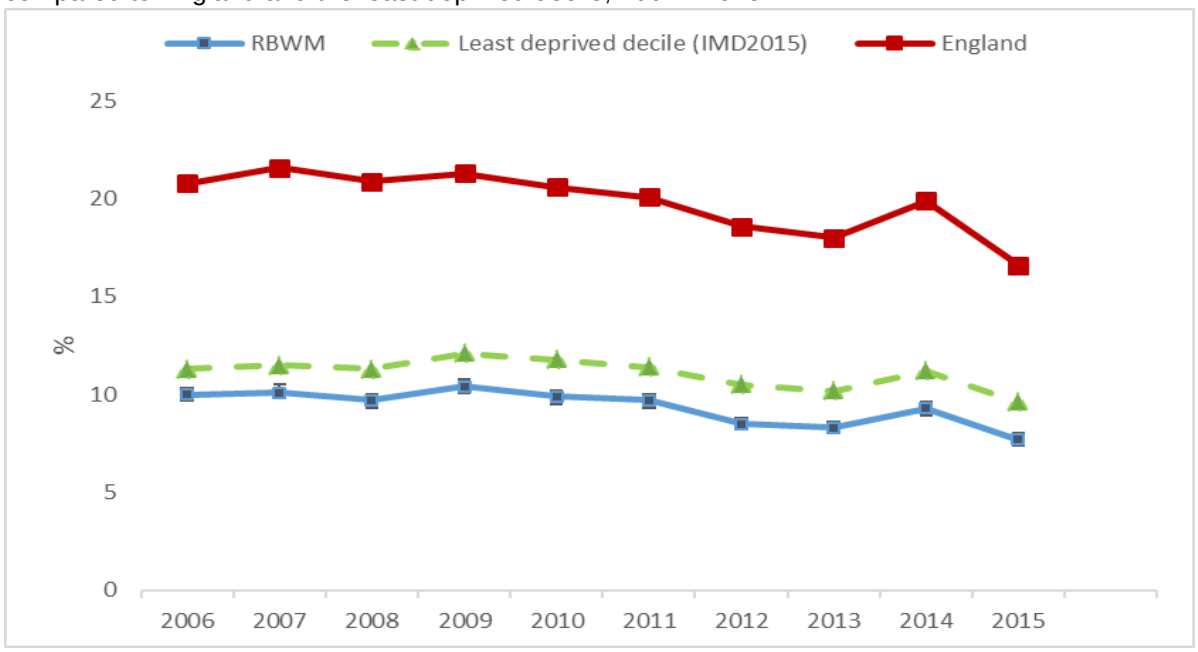
3.1 Children in low-income families

Poverty affects more than one in four children in the UK today. When children grow up poor they miss out. They miss out on the things most children take for granted: warm clothes, school trips, having friends over for tea. They also do less well at school and earn less as adults, but poverty isn't inevitable. With the right interventions in place, every child can have the opportunity to do well in life, and we all share the rewards of having a stronger economy and a healthier, fairer society.[4]

In 2016-17, there were 4.1 million children living in poverty in the UK, equating to 30% of children. Between 1998/99 to 2011/12 child poverty rates reduced substantially with 800,000 children being lifted out of poverty.

At the UK level, absolute poverty is projected to remain roughly unchanged between 2015-16 and 2021-22. Absolute child poverty is projected to rise by 4.1%, primarily due to the impact of planned changes to working-age benefits. Variation in health outcomes is projected to rise between 2015-16 and 2021-22, as working age benefits are cut and real earnings growth boosts the income of higher income households.[5]

Figure 4: The percentage of all dependent children under the age of 20 in relative poverty in RBWM compared to England and the least deprived decile, 2007 - 2015

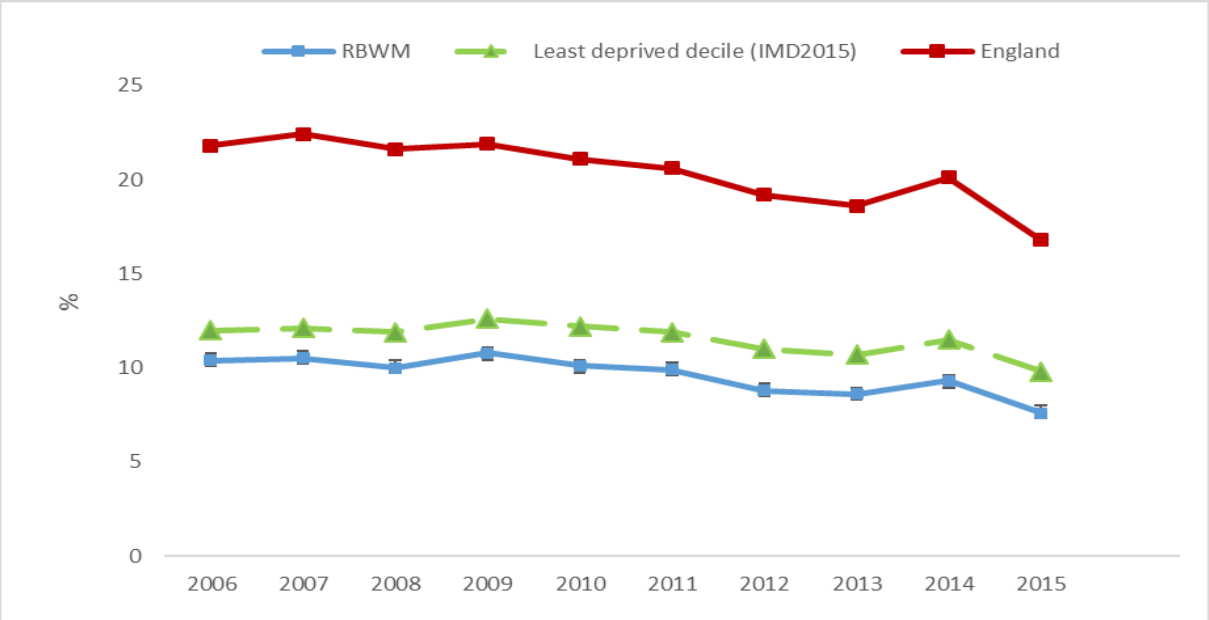


Data source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics); Public Health Outcomes Framework – June 2018

[4] *Child Poverty Action Group: Child poverty facts and figures*
[5] *Joseph Rowntree Foundation: Child Poverty*

In 2015, before housing costs, the percentage of all dependent children under the age of 20 in relative poverty (defined as those living in households where the income is less than 60% of the median household income before housing costs) is 7.7%. This is better than the comparator (9.6%) and England (16.6%).

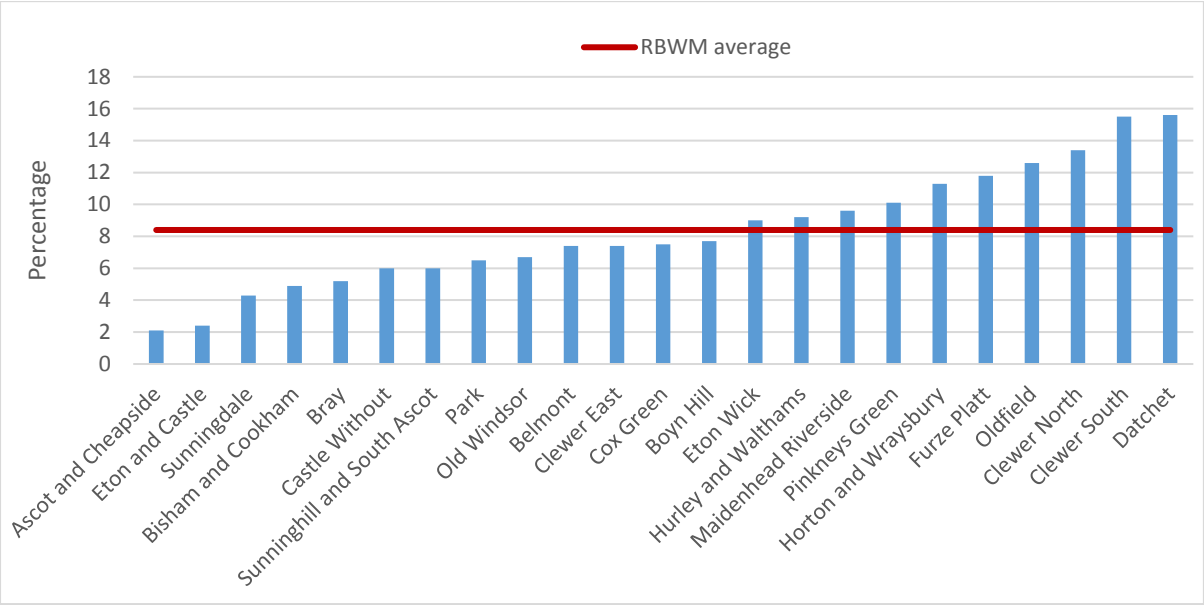
Figure 5: The percentage of children in low income families for under 16's only in RBWM compared to England and the least deprived decile, 2007 - 2015



Data source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics); Public Health Outcomes Framework – June 2018

In 2015, 7.6% of children, under 16, were within low income families in RBWM, which is defined as children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% of the median income. This is better than England (16.8%) and the deprivation decile comparator group's (9.8%) proportions.

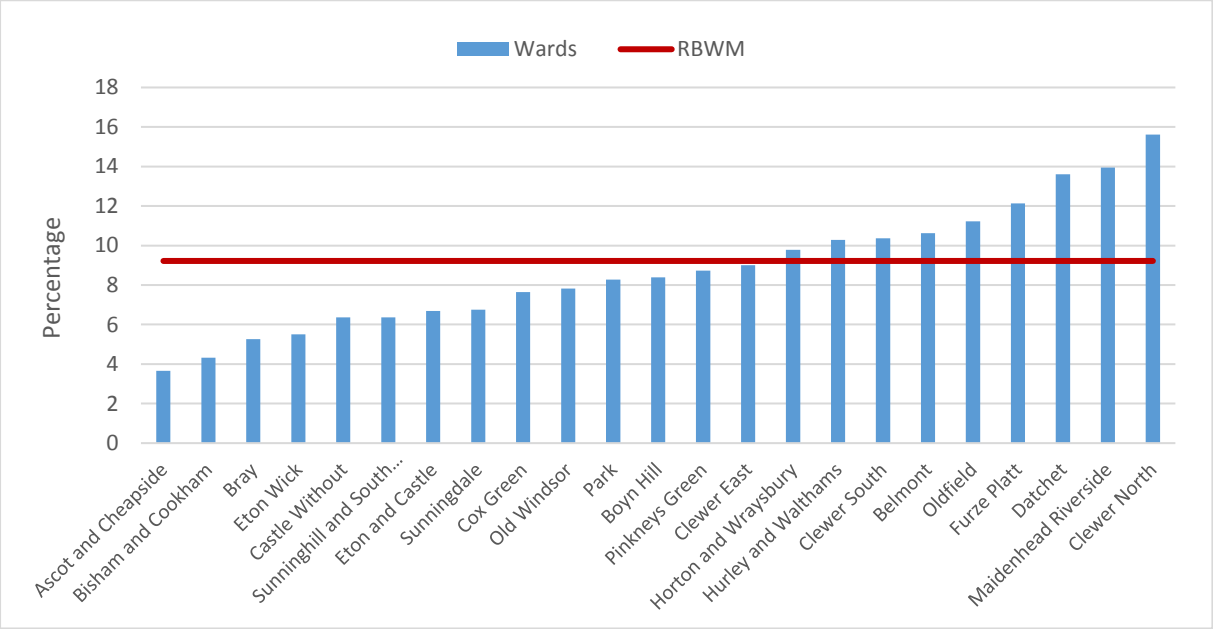
Figure 6: Percentage of children living in poverty by ward in RBWM in 2015



Data source: PHE: Local Health - Child Poverty

In 2015, 19.9% of children in England were living in poverty. For RBWM, this was 8.4% of children, which equates to 2,463 children locally who are living in poverty.

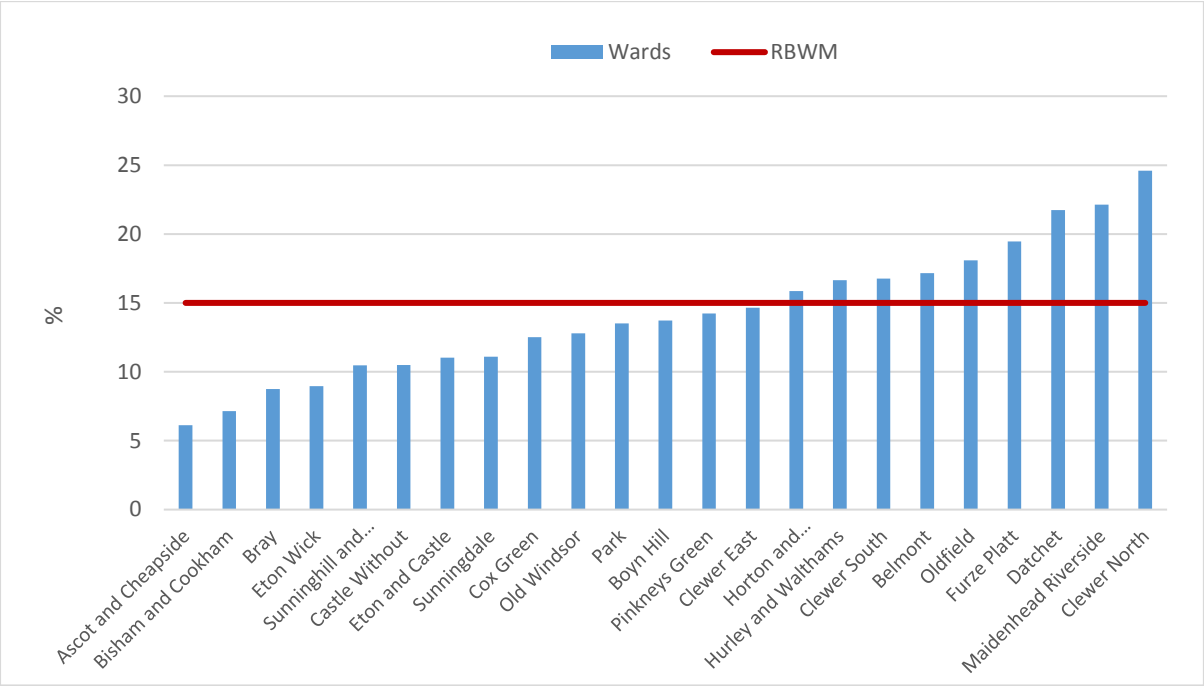
Figure 7: Percentage of children in poverty, before housing costs, by ward in RBWM, in 2017



Data source: End Child Poverty

In 2017, 9.22% of children were living in poverty in RBWM, which equates to 2,756 children locally. The proportion of children living in poverty has increased compared to 2015.

Figure 8: Percentage of children in poverty, after housing costs, by ward in RBWM, in 2017



Data source: End Child Poverty

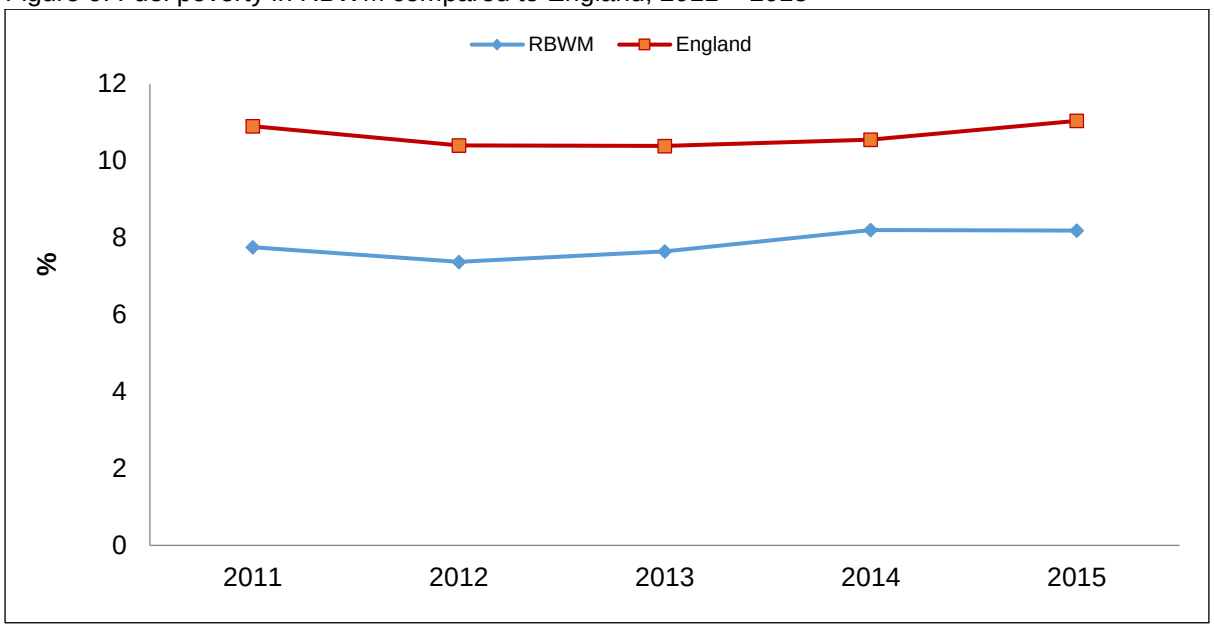
When considering after housing costs, about 15% of children were living in poverty in RBWM, which equates to 4,483 children locally.

3.2 Fuel poverty

The fuel poverty status of a household depends on the interaction between three key drivers; low income, poor energy efficiency and energy prices. There is compelling evidence that these drivers are strongly linked to living at low temperatures which is linked to a range of negative health outcomes. The independent Fuel Poverty Review interim report suggested that a conservative estimate of the number of excess winter deaths caused by fuel poverty would be 1 in 10; this equates to 2,700 people per year, more than die on the roads each year.[6]

[6] *Department for Business, Energy and Industrial Strategy: June 2017*

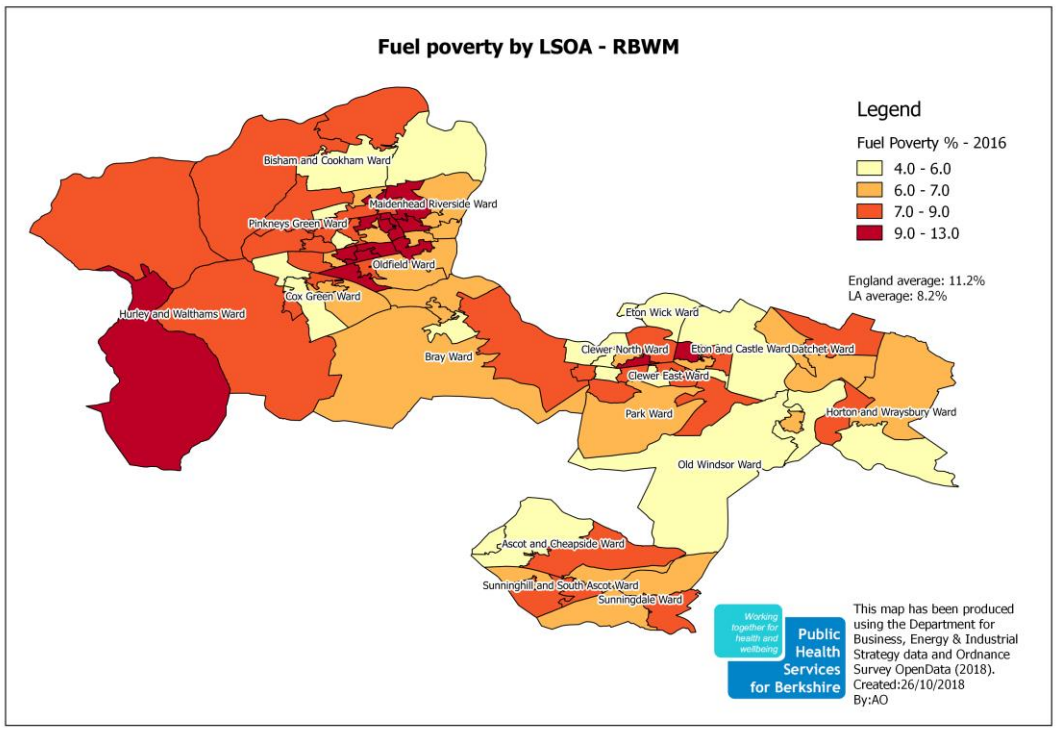
Figure 9: Fuel poverty in RBWM compared to England, 2011 – 2015



Data source: PHE: Public Health Outcomes Framework

The trend for fuel poverty shows an upward trend and has increased by approximately 0.4% (528 households). In 2011, 7.8% of households that experience fuel poverty in RBWM, which equates to 4,448 households locally. Compared to 2015, the figure has increased to 8.2%, which equates to 4,976 households in RBWM, although this is lower than the England average of 11.0%. There was an increase of 528 households experienced fuel poverty in the Royal Borough.

Figure 10: Fuel poverty by LSOA in RBWM in 2016



Data source: Public Health England - Local Health

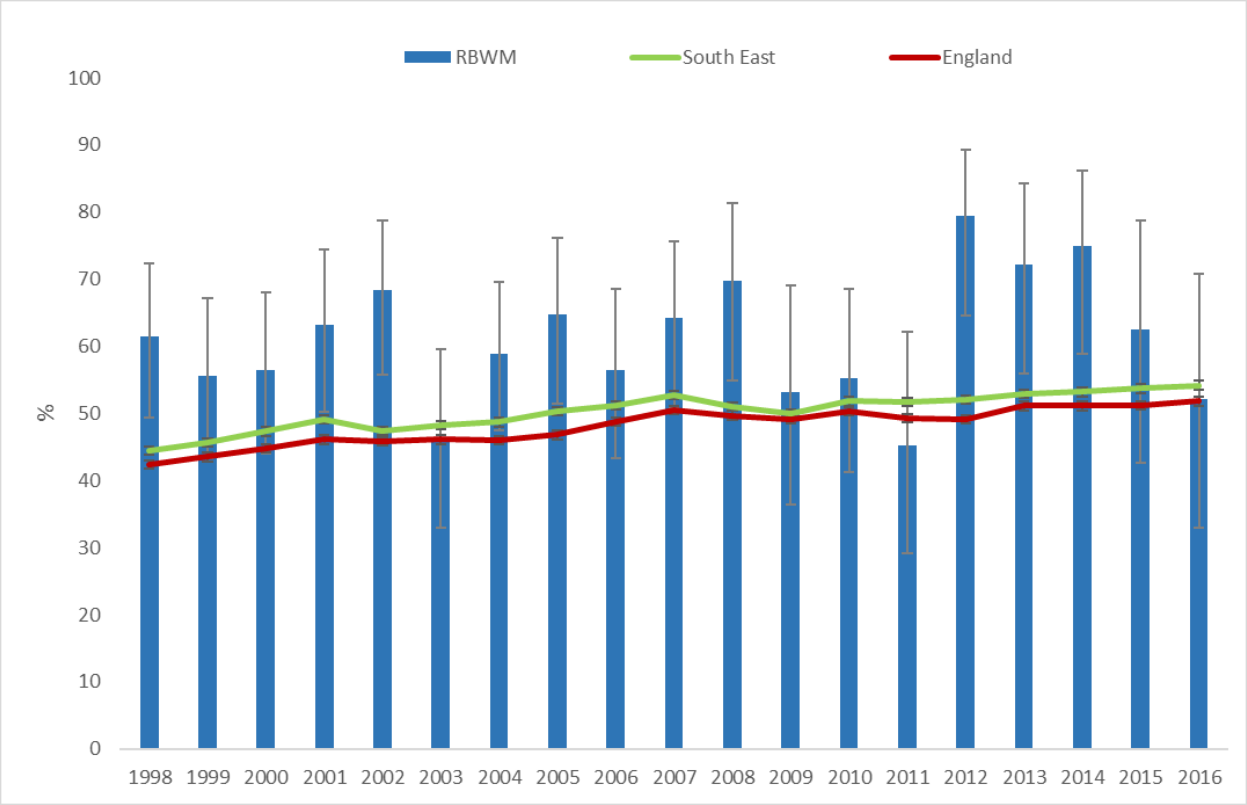
While we know we are better than England, there are some wards experience fuel poverty above the England average of 11.1% in 2016. These wards are Belmont, Boyn Hill, Furze Platt and Maidenhead Riverside.

4. Teenage pregnancies

Evidence shows that children born to teenage mothers are more likely to experience a range of negative outcomes in later life and are more likely, in time, to become teenage parents themselves – perpetuating the disadvantage that young parenthood brings from one generation to the next.[7]

Teenage pregnancy is both a contributory factor as well as an outcome of child poverty. However, with the right level of support, the life chances of young parents can be significantly improved.

Figure 11: Percentage of conception to those aged under 18 years that led to an abortion in RBWM compared to the South East region and England between 1998 and 2016



Data source: Child Health Profile - Office for National Statistics (ONS)

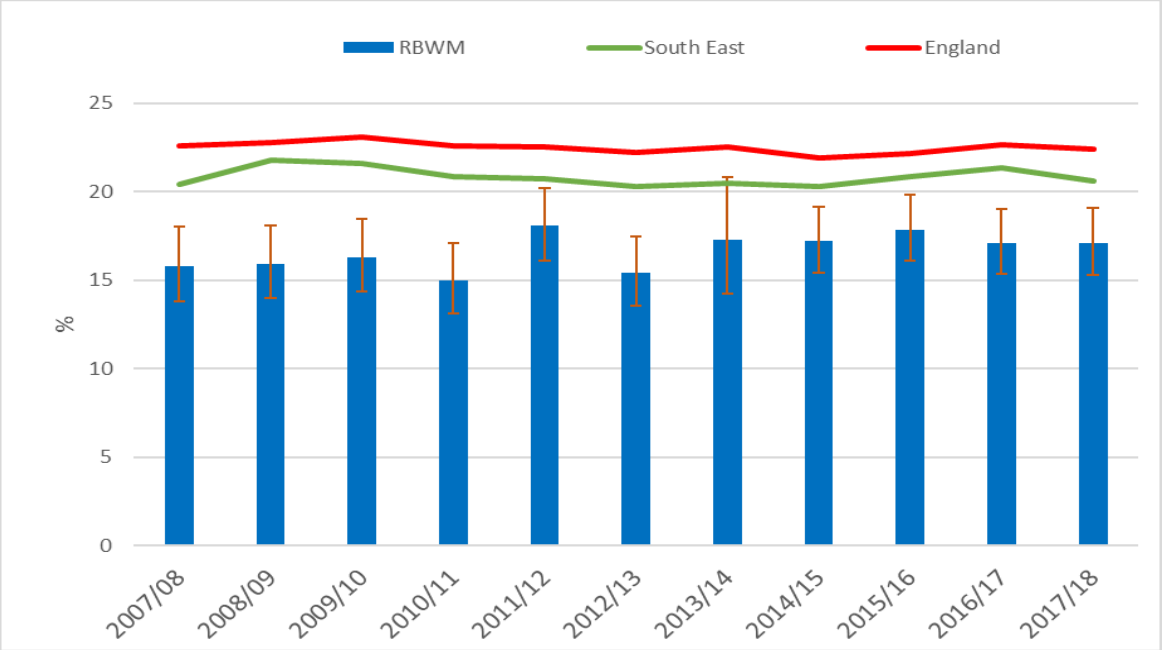
In 2016, there were 12 conceptions (52.2%) to those aged under 18 years that led to an abortion in RBWM. This was similar to the England average (51.8%) and the South East region of 54.2%. The figure above shows that there is a downward trend in abortion rates in young people over the age of 16 years in the Royal Borough.

[7] *Department of Health. The Family Nurse Partnership in England – Third Year Report, published on January 5, 2011.*

5. Childhood obesity (4-5 years and 10-11 years)

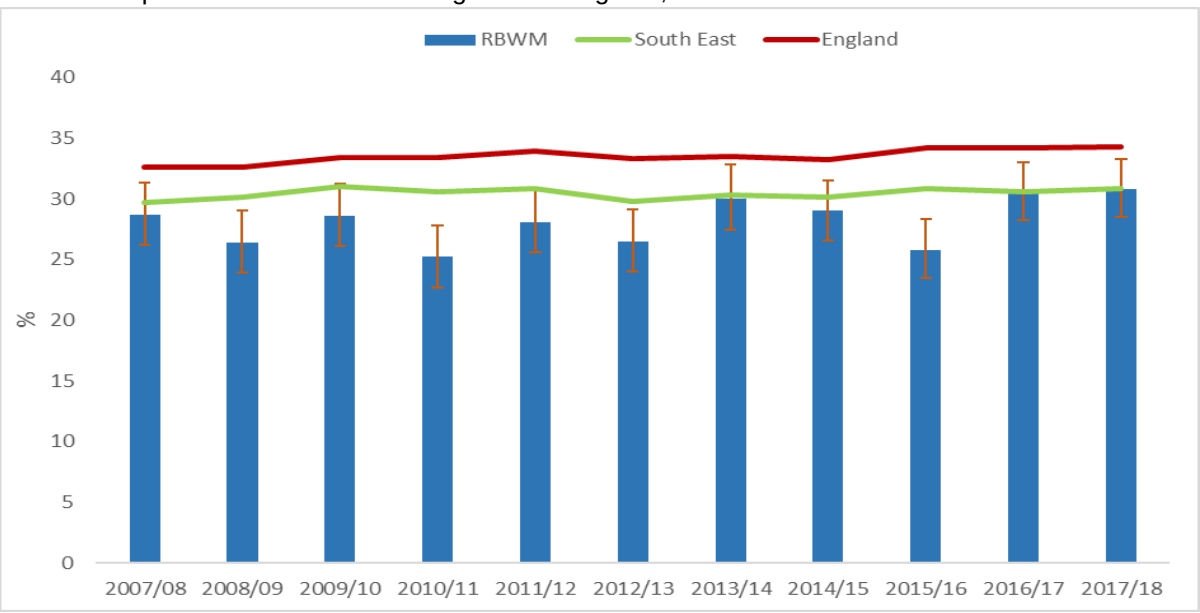
The main health risks associated with being overweight or obese are diabetes, heart disease and cancer.[8]

Figure 12: Proportion of children in Reception year (aged 4-5 years) classified as overweight or obese, RBWM compared to the South East region and England, 2007/08 to 2017/18



Data source: Public Health Outcomes Framework - NHS Digital, National Child Measurement Programme

Figure 13: Proportion of children in Year 6 (aged 10-11 years) classified as overweight or obese, RBWM compared to the South East region and England, 2007/08 to 2017/18



Data source: Public Health Outcomes Framework - NHS Digital, National Child Measurement Programme

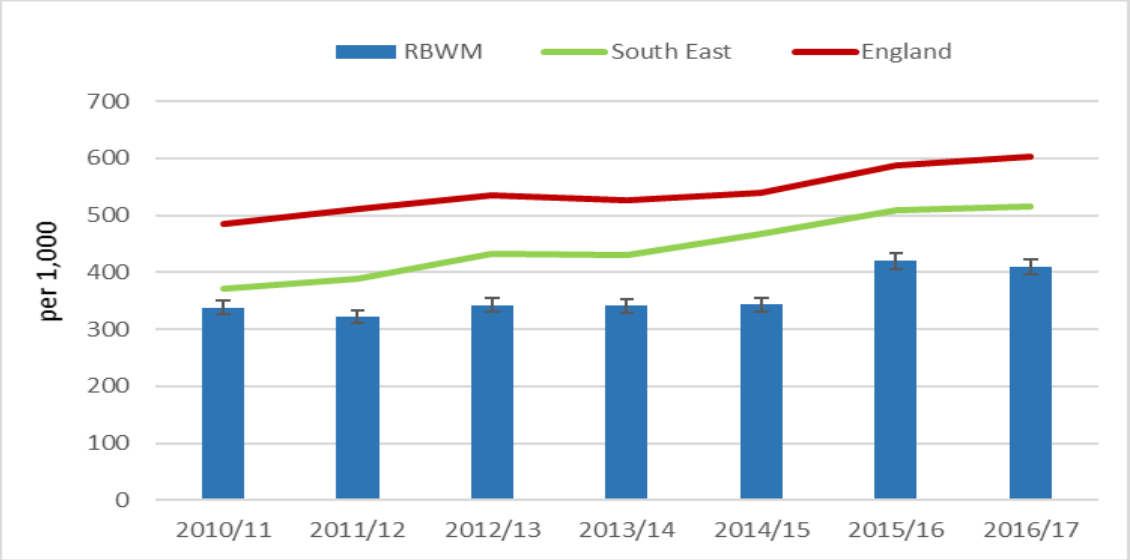
[8] National Obesity Observatory

On average, about one in six children (17.1%) in Reception Year and one in three children (30.8%) in Year 6 in the Royal Borough's schools are overweight or obese. In 2017/18, the proportion of Year 6 children in the Royal Borough that are overweight or obese is the same to the South East region (30.8%), but is lower than the England average (34.3%).[9]

6. A & E attendances (0-4 years)

A&E attendances in children aged under five years are often preventable, and commonly caused by accidental injury or by minor illnesses which could have been treated in primary care. [10]

Figure 14: A&E attendance rate per 1,000 population in 0-4 years in RBWM, South East region and England, 2010/11 – 2016/17



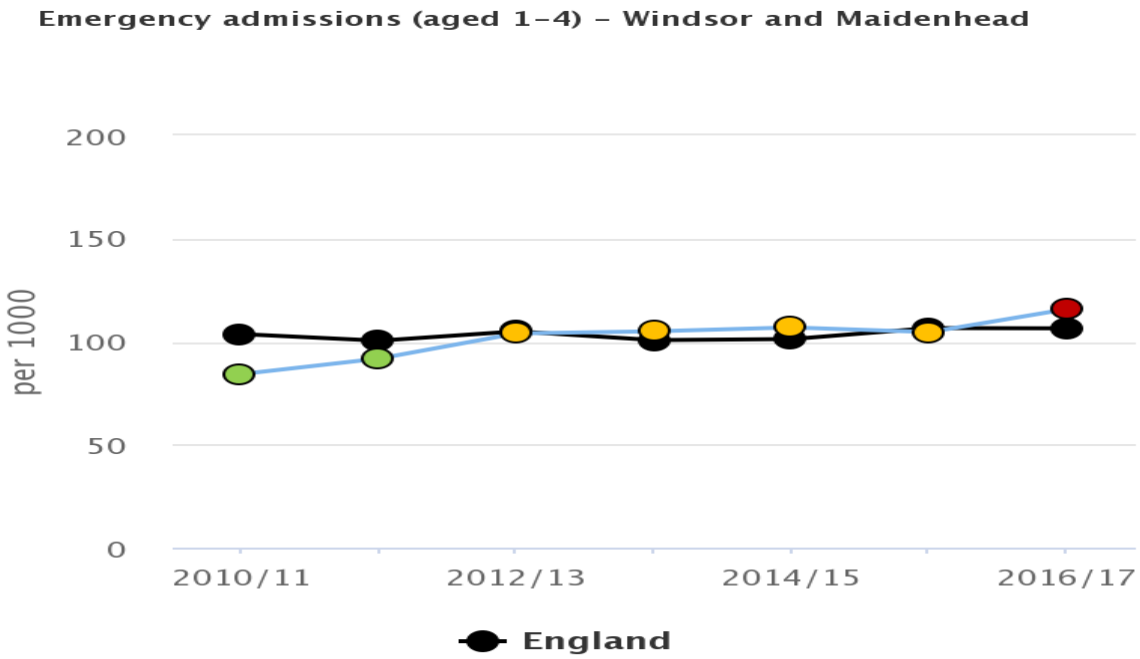
Data source: Public Health England (2018); Child Health Profile

In 2016/17, there were 3,668 A&E attendance at a rate of 409.6 per 1,000 population aged 0-4 years in RBWM. This was lower than the England average (601.8 per 1,000) and the South East region (514.4 per 1,000). Although the rate was lower in 2016/17 than in 2015/16 (419.3 per 1,000), it was higher than all previous years from 2010/11 to 2014/15.

[9] *National child Measurement programme, Health and Social Care Information Centre*

[10] *Overview of Child Health – Public Health Outcomes Framework*

Figure 15: Emergency admissions in aged 1-4 years in the Royal Borough, compared to England between 2010/11 and 2016/17



Data source: Public Health England (2018); Child and Maternal Health Profile

In 2016/17, there were 838 emergency admissions at a rate of 115.7 per 1,000 population aged 1-4 years in the Royal Borough. This was worse than the England average (106.4 per 1,000) and the South East region (101.5 per 1,000). The upward trend should be noted too.

7. Emotional Wellbeing and Mental Health

It is estimated that 1 in 10 Children and Young People (CYP) have poor mental health and 70% of CYP have not had appropriate interventions at a sufficiently early age. The Royal Borough's 0-19 year old demographic is higher than England average. With a projected growth of the Royal Borough's CYP population and a greater awareness of the need for good emotional wellbeing and mental health there could be an increase in demand on child and adolescent mental health services.

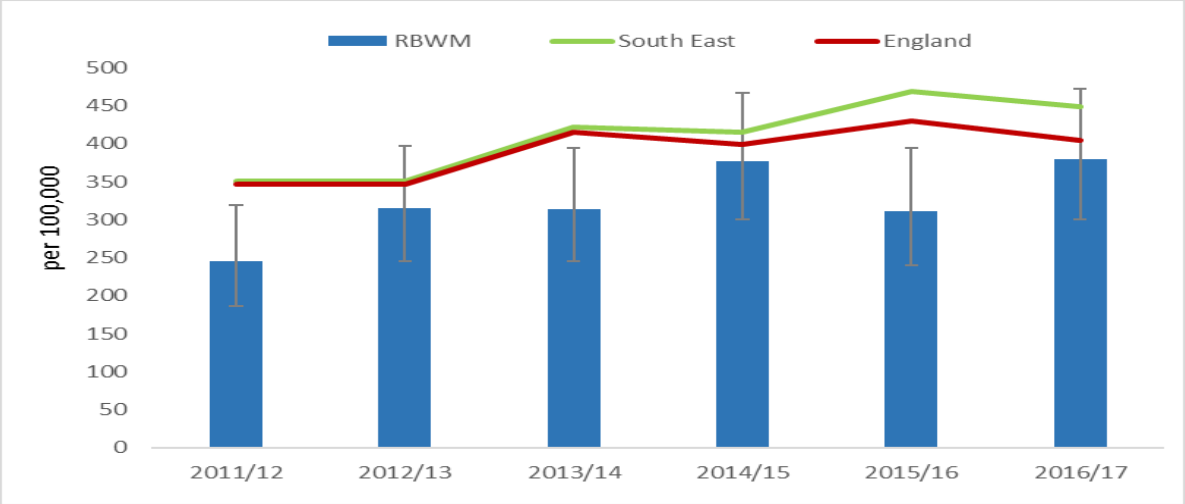
A person can develop poor mental health and lower levels of resilience at any stage of their life however key factors can increase the likelihood of a young person experiencing poor mental health.

7.1 Self-harm (10-24 years)

The NHS defines self-harm as: 'when somebody intentionally damages or injures their body. It's usually a way of coping with or expressing overwhelming emotional distress.' Mental health conditions which are closely associated with self-harming are depression, eating disorders, anxiety, post-traumatic stress disorder and borderline personality disorder. Teenagers and young adults are more susceptible to self-harm, in particular individuals who have been neglected, experienced trauma or abuse. About one in ten young people self-harm and girls are more likely to report self-harm than boys. Due to the nature of self-harm it can be hard to estimate how many children and young people are using self-harm as a coping mechanism if they are not accessing services.

Hospital admissions for self-harm in children have increased in recent years, with admissions for young women being much higher than admissions for young men. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment.[11]

Figure 16: Directly standardised rate of finished admission episodes for self-harm per 100,000 population aged 10-24 years in RBWM, South East region and England, 2011/12 – 2016/17



Data source: Public Health England (2018); Child Health Profile - Hospital Episode Statistics (HES)

In 2016/17, there were 84 hospital admissions as a result of self-harm in young people aged 10-24 years (at a rate of 379.1 per 100,000 population) in RBWM. This was lower than the England average (404.6 per 100,000) and the South East region (449.3 per 100,000). However, the figure above (figure 16) shows an overall upward trend since 2011/12 (246.0 per 1,000).

[11] *Overview of Child Health – Public Health Outcomes Framework*

8. Screening and immunisation

8.1 Immunisations

Routine childhood vaccination coverage statistics show the number of children vaccinated as a proportion of the eligible population (coverage), and are derived from information collected by Public Health England through the COVER (Cover of Vaccination Evaluated Rapidly) and Seasonal Influenza programmes.

The European Region of the World Health Organization (WHO) currently recommends that on a national basis at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control (specifically, diphtheria, tetanus, pertussis, pneumococcal, polio, Hib, measles, mumps and rubella). The routine childhood immunisation programme for the UK[12] includes these immunisations recommended by WHO as well as a number of others as defined by Public Health England (PHE) in 'Immunisation against infectious diseases' – the Green Book[13]. There is an expectation that UK coverage for all routine childhood immunisations evaluated up to five years of age achieve 95%. This is in order to reduce transmission by providing herd immunity.

Table 2: Local, Regional and National Coverage of routine immunisations for children in RBWM compared to the South East region and England at 12 months, 24 months and 5 years - 2016/17

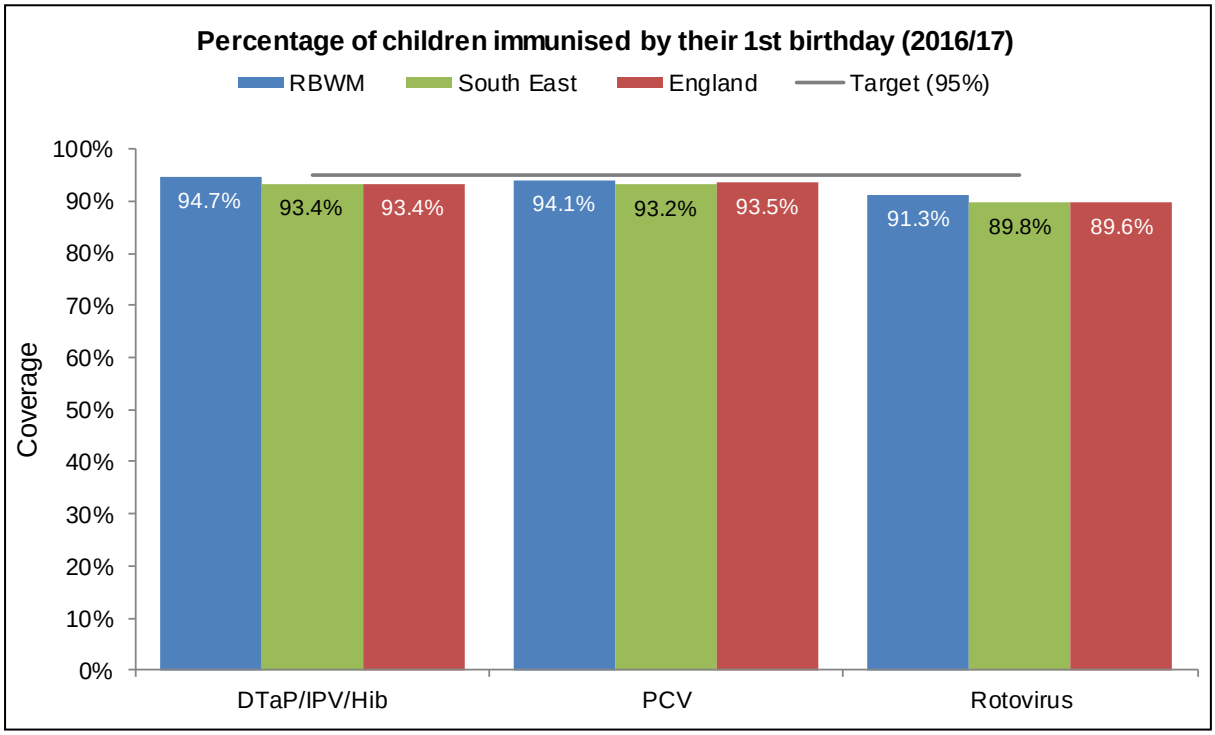
Area	12 months			24 months				5 years				
	DTaP/IPV/ Hib	PCV	Rotovirus	DTaP/IPV/ Hib	MMR 1st Dose	Hib/MenC Booster	PCV Booster	DTaP/IPV/ Hib	DTaP/IPV Booster	MMR 1st Dose	MMR 2nd Dose	Hib/MenC Booster
RBWM	94.7%	94.1%	91.3%	94.8%	88.5%	88.6%	88.4%	94.9%	81.7%	92.6%	82.8%	92.4%
South East	93.4%	93.2%	89.8%	93.8%	90.8%	90.7%	90.8%	94.3%	84.4%	93.4%	86.2%	91.2%
England	93.4%	93.5%	89.6%	95.1%	91.6%	91.5%	91.5%	95.6%	86.2%	95.0%	87.6%	92.6%

Data source: NHS Digital (2017); Childhood Vaccination Coverage Statistics, England 2016-17: Report
*DTaP/IPV/Hib = diphtheria (D), tetanus (T) and acellular pertussis (aP) (whooping cough)/ inactivated polio vaccine/ Haemophilus influenzae type b; PCV = *pneumococcal conjugate vaccine; MMR* = measles (M), mumps (M) and rubella (R); MenC = meningitis C

[12] *Guidance: Routine childhood immunisation schedule.* https://www.gov.uk/government/publications/routine-childhood-immunisation-schedule

[13] https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Figure 17: Percentage of children immunised by their 1st birthday in RBWM compared to the South East region and England in 2016/17



Data source: NHS Digital (2017); Childhood Vaccination Coverage Statistics, England 2016-17: Report

The majority of immunisation indicators in RBWM achieved 90%. As shown in table 1, in 2016/17, 94.7% of children received a three dose course of DTaP/IPV/Hib, also known as 5-in-1 vaccine, by their 1st birthday in RBWM. This compares to 93.4% in both the South East region and nationally. This did not meet the World Health Organization (WHO) target of 95% coverage and was the same level of coverage as 2015/16.

In 2016/17, 88.5% of children received the first dose of the MMR vaccination by their 2nd birthday in RBWM. This compares to 90.8% in the South East region and 91.6% nationally. This did not meet the World Health Organization (WHO) target of 95% coverage and was a reduction on 2015/16's coverage.

In 2016/17, 82.8% of children received the second dose of the MMR vaccination by their 5th birthday in RBWM. This compares to 86.2% in the South East region and 87.6% nationally. This did not meet the World Health Organization (WHO) target of 95% coverage and was lower than 2015/16's coverage level.

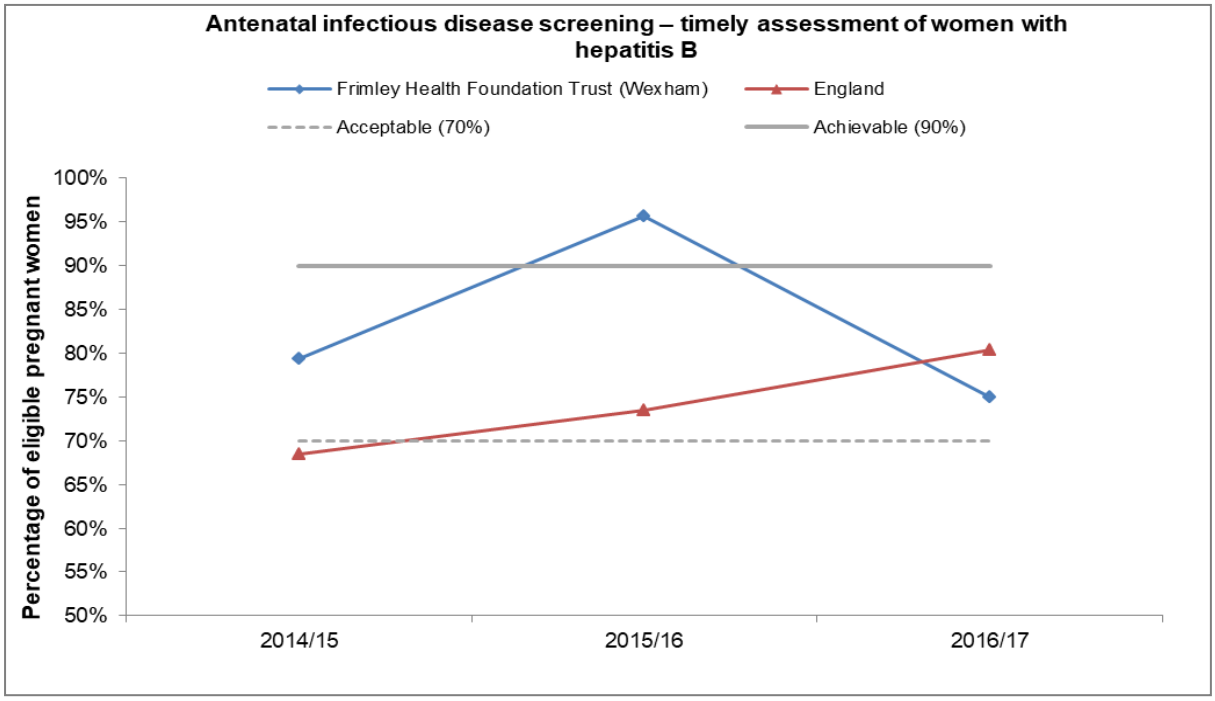
8.2 Antenatal and newborn screening

Screening tests are used to find people at higher chance, or risk, of a health problem. This means they can get earlier, potentially more effective, treatment or make informed decisions about their health. The screening tests offered during

pregnancy in England are either ultrasound scans or blood tests, or a combination of both.[14]

There are fourteen indicators available to monitor the antenatal and newborn screening programme. Reporting by exception, there are 3 indicators of note below. For more details in relation to screening, please see Appendix 1.

Figure 18: Antenatal infectious disease screening – timely assessment of women with hepatitis B in Frimley Health Foundation Trust (Wexham) compared to England, 2014/15 to 2016/17

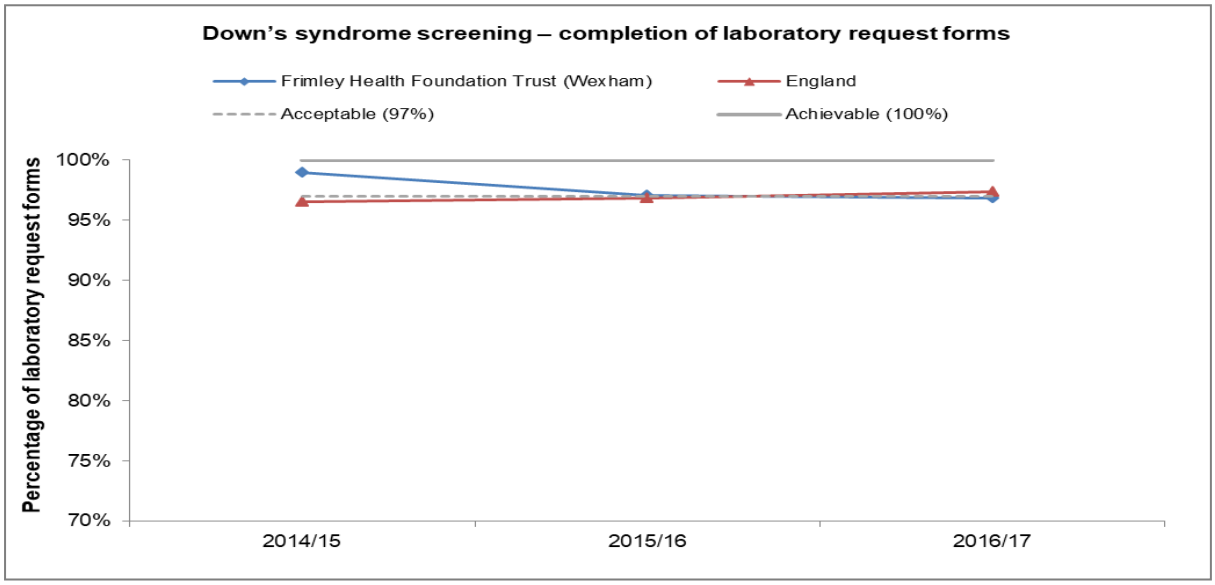


Data source: NHS Digital (2017); Childhood Vaccination Coverage Statistics, England 2016-17: Report

In 2016/17, 9 out of 12 (75%) pregnant women attending Frimley Health Foundation Trust (Wexham) who are hepatitis B positive attending for specialist assessment within 6 weeks of the positive result being reported to maternity service had timely assessment. This is above the acceptable level of 70%, but lower than the national average of 80.3%. In addition, the proportion was lower in 2016/17 than in 2014/15.

[14] *NHS Choices: screening tests in pregnancy*

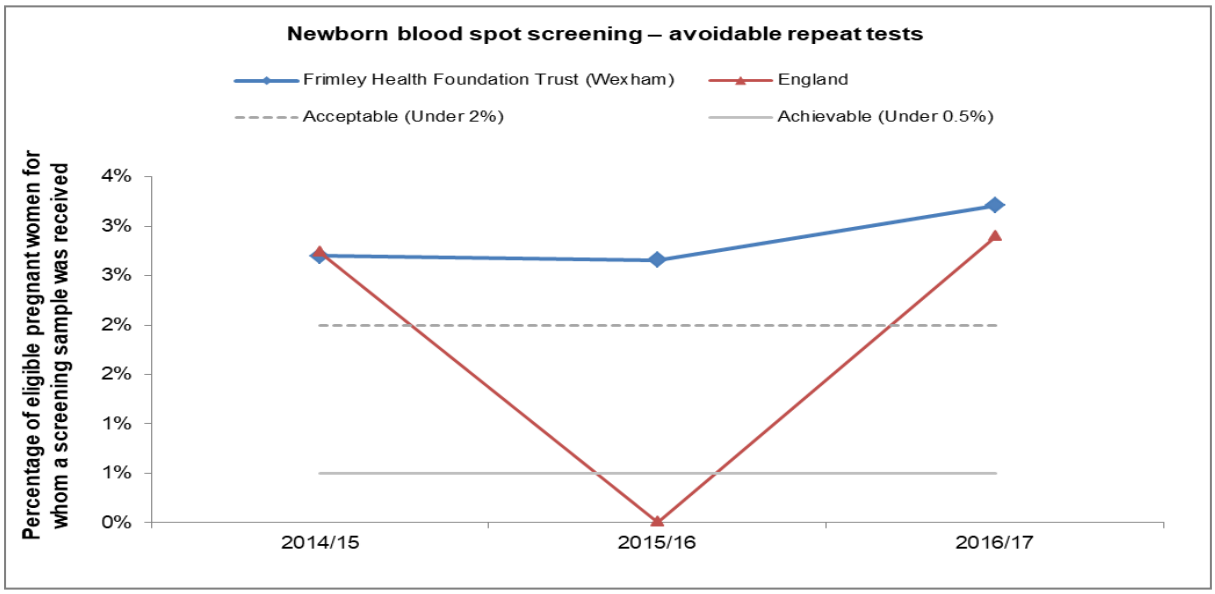
Figure 19: Down's syndrome screening – completion of laboratory request forms in Frimley Health Foundation Trust (Wexham) compared to England, 2014/15 to 2016/17



Data source: NHS Digital (2017); Childhood Vaccination Coverage Statistics, England 2016-17: Report

In 2016/17, 96.9% of laboratory request forms including complete data prior to screening analysis, were submitted to the laboratory within the recommended timeframe of 10+0 to 20+0 weeks' gestation in Frimley Health Foundation Trust (Wexham). This is slightly below the acceptable level of 97%, and lower than the national average of 97.4%. In addition, the proportion was dropped from 98.9% in 2014/15 to 96.9% in 2016/17.

Figure 20: Newborn blood spot screening – avoidable repeat tests in Frimley Health Foundation Trust (Wexham) compared to England, 2014/15 to 2016/17



Data source: NHS Digital (2017); Childhood Vaccination Coverage Statistics, England 2016-17: Report

In 2016/17, 3.2% of first blood spot samples in Frimley Health Foundation Trust (Wexham) required repeating due to an avoidable failure in the sampling process.

This is above the acceptable level of 2%, and higher than the national average of 2.9%. In addition, the trend was getting worse. NHS England commissions screening and immunisation services. A local plan is required for antenatal screening to address current concerns.

9. Autism

Autism is a serious, lifelong and disabling 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

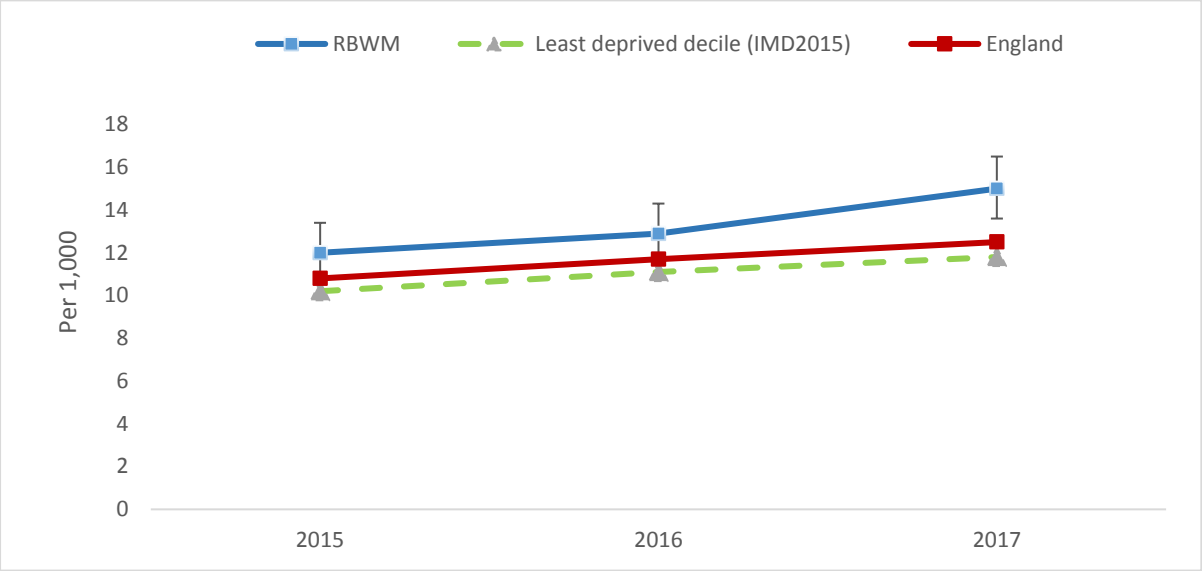
Autism is much more common than many people think. There are around 700,000 people in the UK living with autism – that is more than 1 in 100 and similar to the number of people that have dementia. Including their families, autism touches the lives of 2.8 million people every day.[15] One in three (34%) children on the autism spectrum said that the worst thing about being at school is being picked on.[16] About 63% of children on the autism spectrum are not in the kind of school their parents believe would best support them.[17]

[15] *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*

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

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

Figure 21: Children with autism known to schools in RBWM compared to England and the least deprived decile between 2015 and 2017



Data source: Department for Education statistical collections: Special Educational Needs, local authority tables https://www.gov.uk/government/collections/statistics-special-educational-needs-sen

In 2017, there were 411 children with autism known to schools in RBWM at a rate of 15.0 per 1,000 pupils. The above figure showed that there is a larger number of children in the Royal Borough with autism known to schools than the national average (12.5 per 1,000 pupils) and the deprivation decile comparator group (11.8 per 1,000).

10. Smoking

Figure 22: Smoking prevalence at age 15 – current smokers in the Royal Borough, compared to England and the other LAs in the South East region in 2014/15

Smoking prevalence at age 15 - current smokers (WAY survey) 2014/15 — Proportion - %

Area	Recent	Count	Value	95% Lowe	95% Upp
England	–	-	8.2	8.1	8.3
South East region	–	-	9.0	8.6	9.4
Brighton and Hove	–	-	14.9	12.9	16.9
East Sussex	–	-	12.8	10.9	14.7
Southampton	–	-	11.7	9.8	13.6
Isle of Wight	–	-	11.2	9.3	13.1
Portsmouth	–	-	10.9	8.9	12.9
West Sussex	–	-	10.6	8.9	12.3
Kent	–	-	10.5	8.7	12.3
Oxfordshire	–	-	10.4	8.6	12.2
Medway	–	-	10.0	8.3	11.7
Milton Keynes	–	-	9.6	7.9	11.3
Reading	–	-	8.2	6.5	9.9
Windsor and Maidenhead	–	-	7.6	5.9	9.3
Hampshire	–	-	7.2	5.7	8.7
Surrey	–	-	6.8	5.3	8.3
Bracknell Forest	–	-	6.1	4.4	7.8
West Berkshire	–	-	6.0	4.7	7.3
Buckinghamshire	–	-	5.1	3.8	6.4
Wokingham	–	-	4.9	3.7	6.1
Slough	–	-	4.0	2.8	5.2

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

Data source: Local Tobacco Profiles for England; Public Health England

Figure 23: Prevalence of Use of other tobacco products at age 15 in the Royal Borough, compared to England and the other LAs in the South East region in 2014/15

Use of other tobacco products at age 15 years (WAY survey) 2014/15 — Proportion - %

Area	Recent	Count	Value	95% Lower CI	95% Upper CI
England	–	-	15.2	14.9	15.4
South East region	–	-	16.1	15.4	16.8
Brighton and Hove	–	-	24.2	21.7	26.7
Windsor and Maidenhead	–	-	22.0	19.3	24.7
Reading	–	-	20.1	17.5	22.7
Milton Keynes	–	-	19.5	17.2	21.8
East Sussex	–	-	18.8	16.6	21.1
Surrey	–	-	18.6	16.3	20.9
Oxfordshire	–	-	17.4	15.1	19.6
Bracknell Forest	–	-	17.1	14.4	19.7
Kent	–	-	16.7	14.5	18.9
Slough	–	-	16.3	13.9	18.7
Buckinghamshire	–	-	16.3	14.2	18.4
Medway	–	-	15.4	13.3	17.4
West Sussex	–	-	15.1	13.0	17.1
Portsmouth	–	-	13.8	11.6	16.0
Southampton	–	-	13.2	11.2	15.2
Isle of Wight	–	-	13.0	11.0	15.0
West Berkshire	–	-	12.3	10.5	14.2
Wokingham	–	-	12.0	10.2	13.8
Hampshire	–	-	11.4	9.5	13.3

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

Data source: Local Tobacco Profiles for England; Public Health England

In 2014/15, smoking prevalence at age 15 in the Royal Borough was 7.6%. This was similar to the national average of 8.2% and better than the regional average of 9.0%.

However, the prevalence of use of other tobacco products (e.g. shisha pipe, hookah, hubble-bubble, waterpipe) at age 15 years in the Royal Borough was 22.0%. This was worse than the national average of 15.2% and the regional average of 16.1%.

11. Stakeholder consultation

On September 25th, a stakeholder event was held to understand the views of local residents with respect to local assets and need. Over 80% of stakeholders agreed that the priorities for Developing Well should be autism, child obesity, child poverty, low birth weight, self-harm, immunisations, A&E admissions, and smoking in young people.

This was also echoed by findings from a recent voluntary stakeholder survey completed in September 2018, which demonstrated a 88% agreement with current priorities.

The underpinning themes from all stakeholder conversation was the need to embed prevention across the life course and implement “enablers” to make this happen. Enablers included, accessibility to services, integration and community action.

12. What does this mean for residents and providers?

Based on the findings of this report, the Developing Well Board is advised to action and note the following areas:

- Embed prevention within all plans. Develop/support production of plans which address the priorities identified in this report—self-harm, childhood obesity, low birth weight, and tobacco product use
- Work with partners across the system to address emotional wellbeing and mental health in children, champion the delivery of the Local Transformation Plan, through existing system structures
- Support parents/families to improve their circumstances and parenting skills: child poverty, fuel poverty, autism, teenage pregnancy, A&E attendances
- Work with commissioners to address screening and immunisation performance
- Champion a system wide approach to local challenges: childhood obesity

Appendix 1: Antenatal and newborn screening

Antenatal and newborn screening data are available at maternity service, Trust and CCG level depending on the indicator. Information for Frimley Health Foundation Trust (Wexham) is shown for RBWM as the majority of RBWM births were at this Trust. CCG level data is shown for Windsor, Ascot & Maidenhead CCG and Bracknell & Ascot CCG.

Acceptable level: Lowest level of performance considered safe. All programmes are expected to exceed the acceptable threshold and to implement service improvement plans that develop performance towards an achievable level. Programmes not meeting the acceptable threshold are expected to implement recovery plans to ensure rapid and sustained improvement.

Achievable level: Level at which the programme is likely to be running effectively; screening programmes should budget for and aspire towards performance at this level. Local constraints may sometimes result in programmes failing to meet this threshold. Service improvement plans should focus on the delivery of a balanced service with as many standards as possible meeting the achievable threshold.

Appendix 2: Developing Well action plan

Developing Well Action Plan

JHWBS aims	Theme	Action required	Owner	Timescales	Outcome
1. Prevention and early intervention.	1. Mental Health – reducing the number of young people with an Education and Care Plan.	Reduce anxiety behaviours that prevent learning through awareness and training. Investigate PEP care training anxiety model for whole school approach.	Head of Children, Young People's & Families CCG / Schools.	December 2018.	TBC
	2. Reduce online harm.	Strategies to manage online harm and net addiction. Clive Haines play's Youth/Schools	TBA	September 2019	TBC
2. Supporting a healthy population.	1. Obesity – increase exercise &lifestyle choices for children and young people.	PHSE work continued.	TBA	September 2019	TBC
	2. Increase drug and alcohol awareness.	• Stocktake of what is available. • Engage with young people to express their views and use these ideas to reinforce national campaign messages.	All. Rachael P-D	January 2019 March 2019	TBC
	3. Embed flu and immunisation plan.	Develop a myth busting campaign locally to		January 2019	TBC

		increase all immunisations to target of 75%.	Teresa Salami-Oru Head of Public Health		
3. Enable residents to maximise capabilities and life chances.	1. Maximise opportunities the SEND strategy provides.	See through the changes of the SEND strategy.	CYPDS/PacIP/CCG	March 2020	TBC
	2. Monitor the uptake of the Inclusion Charter.	Comms on little card	TBA	March 2020	TBC
Overarching theme 2018 – Loneliness & Isolation.	Reducing isolation through community outreach.	Twinning between schools and care homes / day centres to provide intergenerational support and get connected.	All	March 2020	TBC

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Royal Borough of Windsor & Maidenhead

Living Well in the Royal Borough of Windsor & Maidenhead

Exploring Adults' Health

2018

Mental Health
Cardiovascular Diseases (Diabetes, Dementia)
Alcohol-related Road Traffic Accidents, Excess Weight
Inequalities (access to green space, smoking in intermediate groups)

Locality and Ward Level Insights

Executive Summary

The Royal Borough benefits from high levels of connectivity via its strategic road networks. Maidenhead is due to become a significant stop for Crossrail during 2019-20, the new fast, high frequency, high capacity railway will link the City of London with the South East and reduce journey times between Maidenhead and Canary Wharf. More households in the Royal Borough are employed in either professional or managerial/technical occupations compared to the national average.[1]

The Royal Borough has a large number of 35-59 year olds. It is therefore recommended that consideration is given to workplace health initiatives across the Royal Borough and wider. Supporting local employers to implement workplace health improvement initiatives should be a key priority. An agreed workplace health network and charter are potential evidenced local solutions.

Dementia prevalence is projected to double (about 9.1%) by 2030. It would be prudent to engage in actions which prevent or delay the onset of dementia, such as physical activity, obesity and smoking. Similar actions could be employed to address diabetes prevalence.

Collaborative action between the local government and police is recommended to address the rise in alcohol-related road traffic accidents.

The following represents a summary of the needs identified:

<table>
<tr><td>In the Royal Borough, the prevalence of dementia is 4.7% in people aged 65 and above in 2017. It is higher than the England average of 4.33% and the deprivation decile comparator group's (IMD 2015) of 4.16%. Dementia care is likely to be an increasing challenge for health and social care services, considering the ageing population, service capacity and costs.</td><td>The prevalence of depression in people aged 18 years and over in the Royal Borough has almost doubled over the past 4 years, from 3.8% in 2013/14 to 7.1% in 2016/17. Prevalence overall is however lower in the Royal Borough than in England (9.1%) and the South East region (8.8%) in 2016/17.</td><td>In England, there was a rate of 26.0 per 1,000 population alcohol related road traffic accidents between 2013-15, where at least one of the drivers failed a breath test. In the Royal Borough, the rate was significantly worse than England's at 38.9 per 1,000 population.</td></tr>
<tr><td>In 2015/16, approximately 5% residents in the Royal Borough used outdoor space for exercise or health reasons. This is the lowest in the South East region</td><td colspan="2">In the Royal Borough, the number of people living with diabetes aged 17 years and above is on the increase, from 4.9% to 5.2% over the past 5 years, although the trend is lower than the national average and the comparator's group.</td></tr>
</table>

[1] *Royal Borough of Windsor and Maidenhead Electoral Review Stage One - Council Size, June 2017*

(18.2%), and lower than the England average (17.9%).	
In 2016/17, 57.9% of people aged 18 and over in the Royal Borough were classified as overweight or obese. This was similar to the England average of 61.3% and deprivation decile comparator group of 58.4%, however, excess weight in adults has increased by 6% since 2015/16.	In 2017, smoking prevalence for adults in the Royal Borough was 11.2%. This was significantly better than the national average of 14.9% and similar to the comparator group's 12.3%. However, the smoking prevalence for adults in intermediate[2] occupation in the Royal Borough was 17.7%. This was higher than the England average of 16.3% and the comparator group's 16.2%.

[2] *Intermediate occupation - Positions in clerical, sales, service and intermediate technical occupations that do not involve general planning or supervisory powers (Office for National Statistics)*

Contents

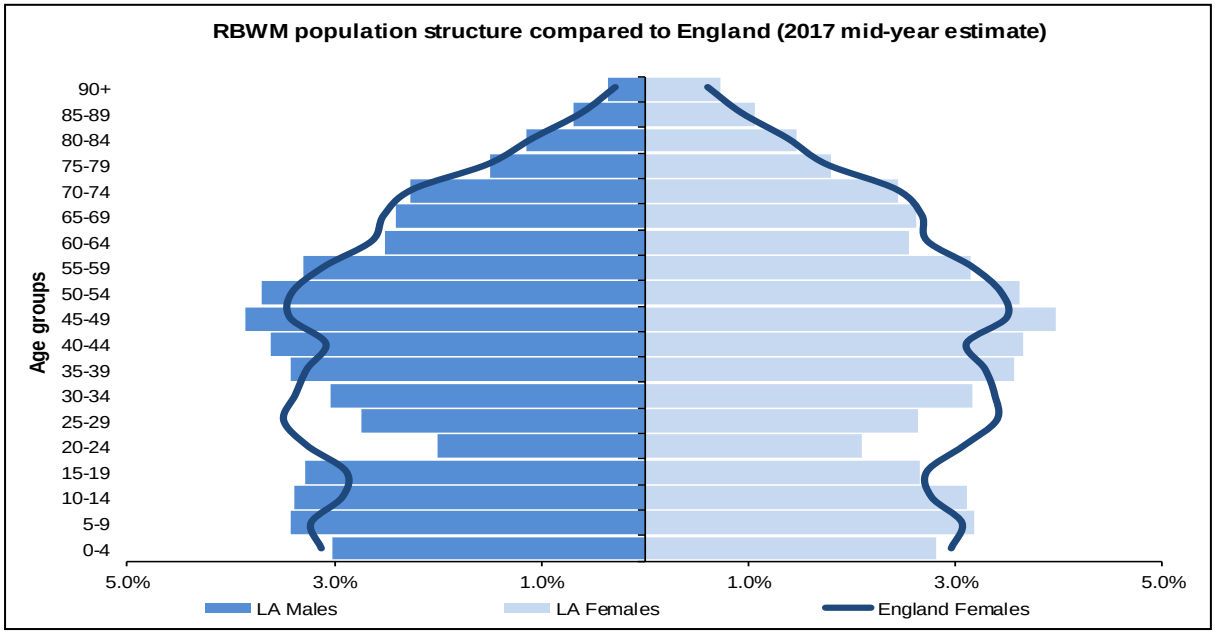
Introduction

This document has been prepared to support the development of plans aligned with the Living Well Board, which is a sub board of the Health & Wellbeing Board. The report seeks to highlight the health needs of adults in working age in the borough and make recommendations for board consideration. Needs were identified by reviewing the publishing documents Common Mental Health Disorders, Dementia Profile, Diabetes Profile, Local Tobacco Control Profiles, Public Health Outcomes Framework and Suicide Prevention Profiles, produced by Public Health England, with the most recent update being September 2018.

1. Our people of working age

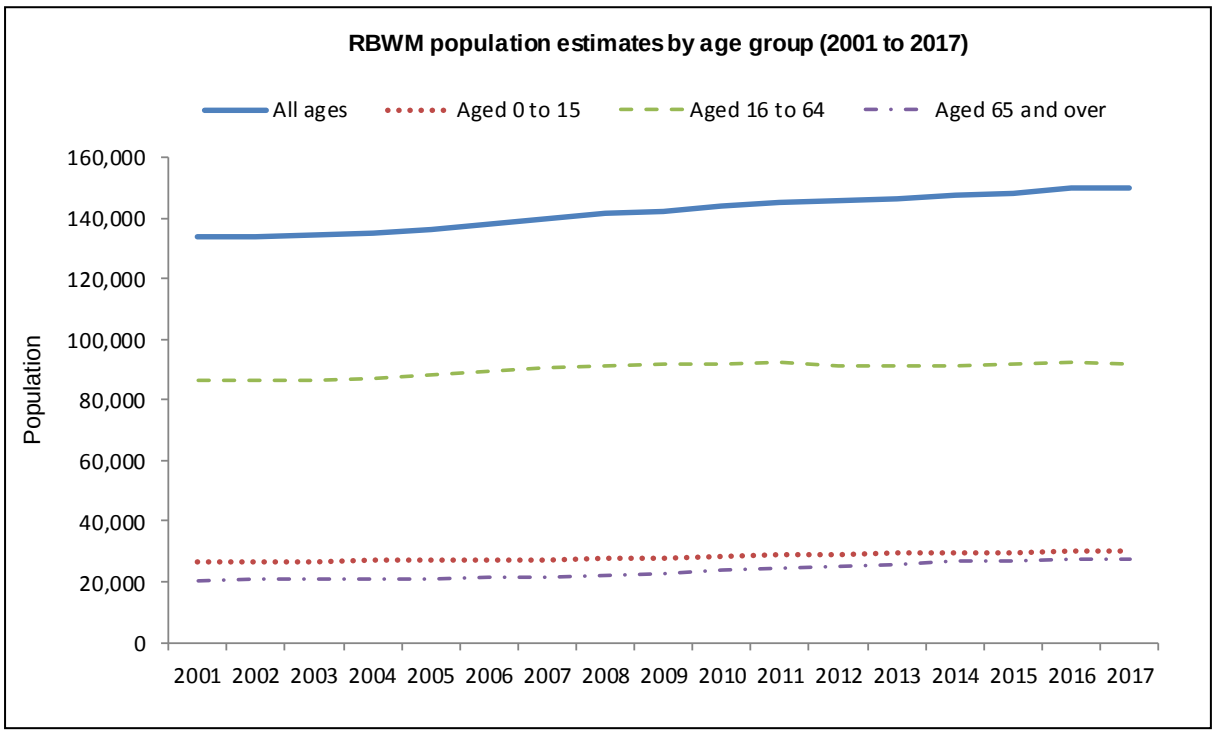
The Royal Borough of Windsor and Maidenhead is a Royal Borough of Berkshire, in South East England. It is home to Windsor Castle, Eton College, Legoland Windsor and Ascot Racecourse. It is one of four boroughs entitled to be prefixed *Royal* and is one of six unitary authorities in its county which has Historic and Lieutenancy county status. The population pyramid in Figure 1 compares the population figures for the Royal Borough of Windsor and Maidenhead with England by five-year age bands. Referring specifically to people of working age, the population profiles suggest a higher proportion of adults aged between 35-59 than the national average, but a lower proportion of adults aged 20-34. Careful consideration needs to be given to these adults in view of opportunities to embed good healthy behaviours which could delay or prevent the onset of illness in present day and later life. Figure 2 suggests the trend of population growth in people aged 16-64 between 2001 and 2017 is steady.

Figure 1: The Royal Borough of Windsor and Maidenhead and England Mid-2017 Population Pyramid



Data source: Mid-Year Population Estimates 2017, Office for National Statistics (ONS).

Figure 2: The Royal Borough's population estimates by age group between 2001 and 2017



Data source: Mid-Year Population Estimates 2017, Office for National Statistics (ONS).

2. Risky behaviours

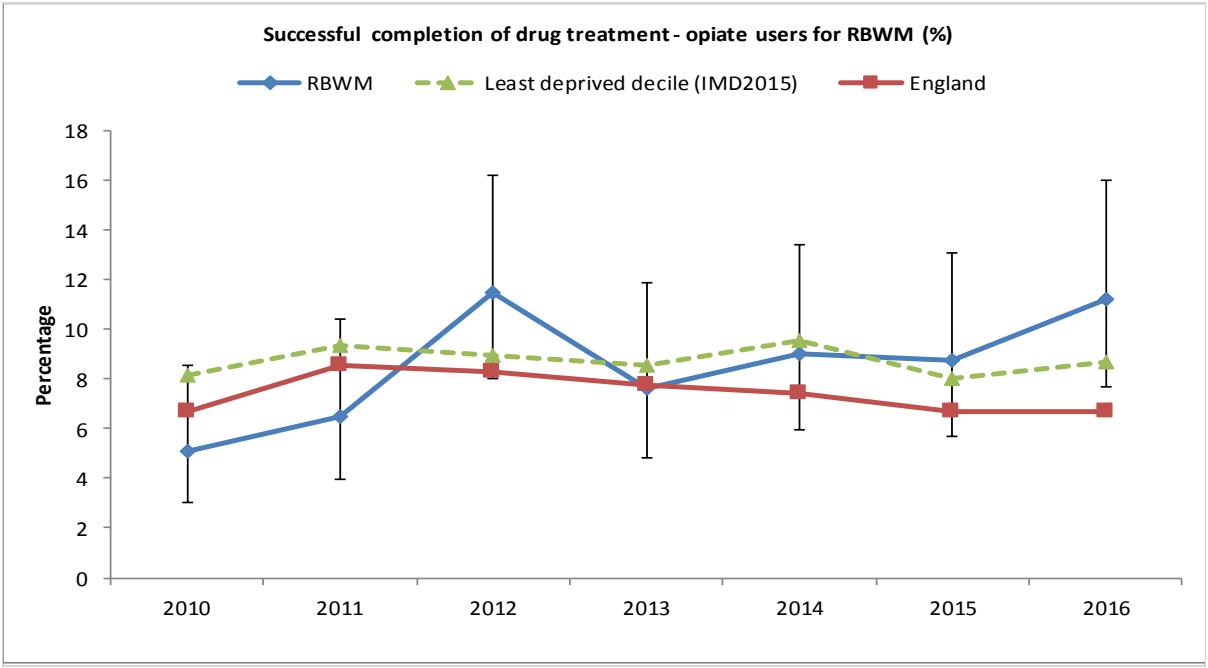
2.1 Drug and alcohol misuse

2.1.1 Drug misuse

According to the findings from the 2015/16 Crime Survey for England and Wales, around 1 in 12 (8.4%) adults aged 16 to 59 had taken an illicit drug in the past year. This equates to around 2.7 million people. This level of drug use was similar to the 2014/15 survey (8.6%), but is significantly lower than a decade ago (10.5% in the 2005/06 survey).[3]

[3] *Statistics on Drugs Misuse: England, 2017 - NHS Digital*

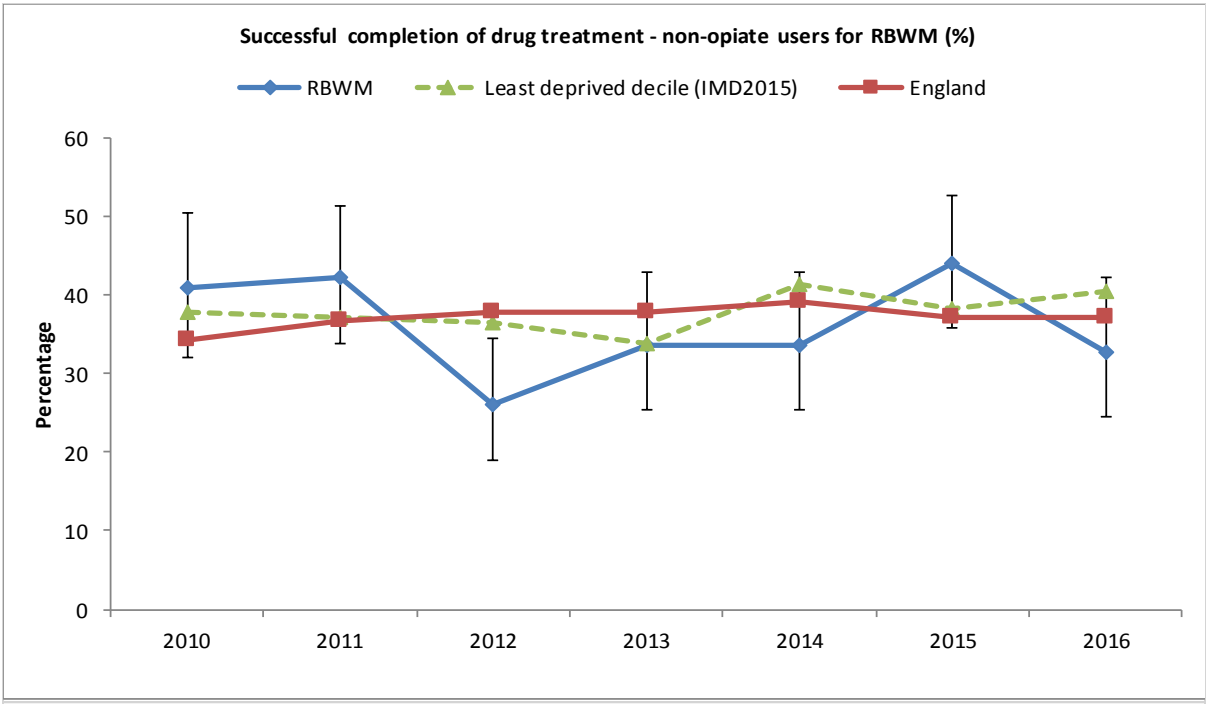
Figure 3: Successful completion of drug treatment – opiate users for the Royal Borough, compared to England and the least deprived decile (IMD 2015) between 2010 and 2016



Data source: Public Health England (2018); Public Health Outcomes Framework

In 2016, of the total number of opiate users in treatment, the Royal Borough saw 11.2% leave drug treatment successfully and not re-present within six months. This is significantly better than England (6.7%) and similar to the deprivation decile's (8.7%).

Figure 4: Successful completion of drug treatment – non-opiate users for the Royal Borough, compared to England and the least deprived decile (IMD 2015) between 2010 and 2016



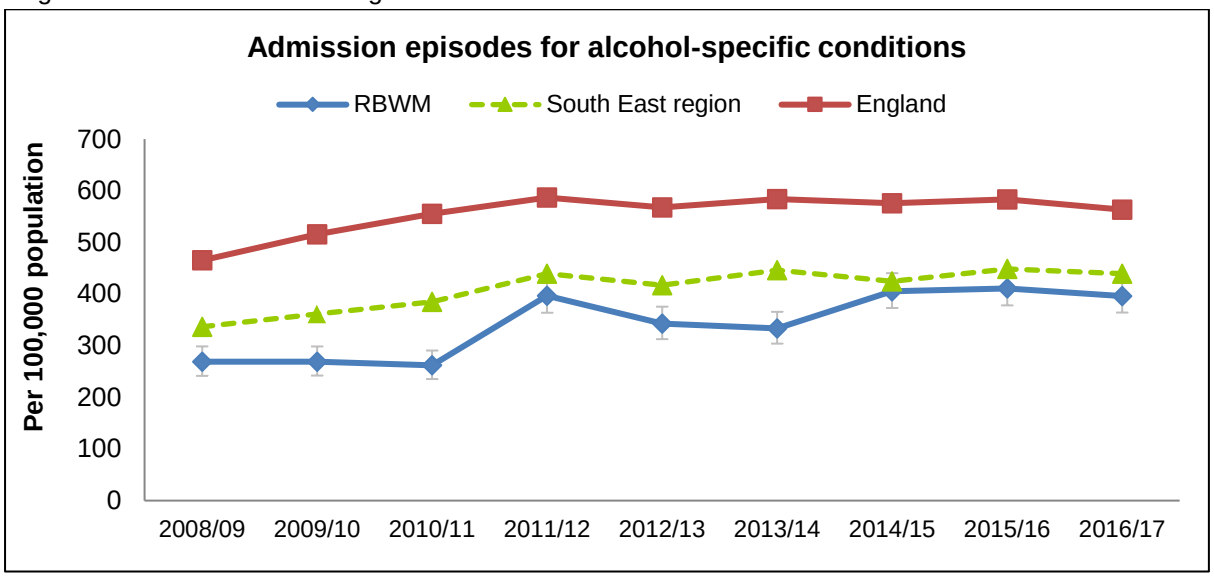
Data source: Public Health England (2018); Public Health Outcomes Framework

In 2016, of the total number of non-opiate users in treatment, who successfully left and did not re-present within six months, the Royal Borough (32.7%) has a similar rate to both the deprivation decile (40.4%) and England (37.1%).

2.1.2 Alcohol misuse

Drinking alcohol above recommended limits (14 units per week for women and 21 units per week for men) increases the risk of cancers, liver and heart diseases. This is also associated with anti-social behaviour, domestic violence and other criminal offences. However, the majority of drinkers (72%) in the Royal Borough do so safely[4].

Figure 5: Admission episodes for alcohol-specific conditions in the Royal Borough, compared to England and the South East region between 2008/09 and 2016/17



Data source: Public Health England (2018); Local Alcohol Profiles

The Royal Borough had better alcohol related admissions to hospital (449 per 100,000 hospital admissions for alcohol-related conditions) in comparison to the South East (525 per 100,000) and England (636 per 100,000) in 2016/17[5].

2.1.2.1 Alcohol-related road traffic accidents

Any amount of alcohol affects your ability to drive safely, including slower reactions, increased stopping distance and reduced field of vision. The legal limit in the UK is 35 micrograms of alcohol per 100ml of breath.

[4] *Alcohol Harm Map by Alcohol Concern accessed September 2018*

[5] *Indicator 10.01: Admission episodes for alcohol-related conditions (Narrow) Local Alcohol Profile for England (accessed March 2018), Public Health England*

Figure 6: Reported road accidents (of all severities) in which at least one driver failed a breath test, per 1,000 accidents in the Royal Borough, compared to England and the least deprived decile (IMD 2015) between 2010-12 and 2013-15

Data source: Public Health England (2018); Public Health Outcomes Framework

In England, there was a rate of 26.0 per 1,000 population alcohol related road traffic accidents between 2013-15, where at least one of the drivers failed a breath test. In the Royal Borough, the rate was significantly worse than England's at 38.9 per 1,000 population.

2.1.3 What does this mean for the Royal Borough?

Alcohol consumption and hospital admissions in the Royal Borough are better than the England average, however, alcohol-related road traffic accidents are worse. The Royal Borough has an annual programme of Local Road Safety Schemes. These are targeted at casualty cluster sites where there is a clear pattern of causation. This is considered to be adequate to meet existing needs.

The Royal Borough has built up an education, training and publicity programme that tackles all aspects of road safety from infancy to old age and includes drink drive campaigns.

The Council is working with the other local authorities across Berkshire to ensure consistent delivery of messages on road safety issues.

The Community Safety Partnership is the recommended strategic group able to address the following unmet needs / service gaps:

- Work with young drivers to disseminate road safety messages (e.g. Safe Drive Stay Alive, Drive Start).

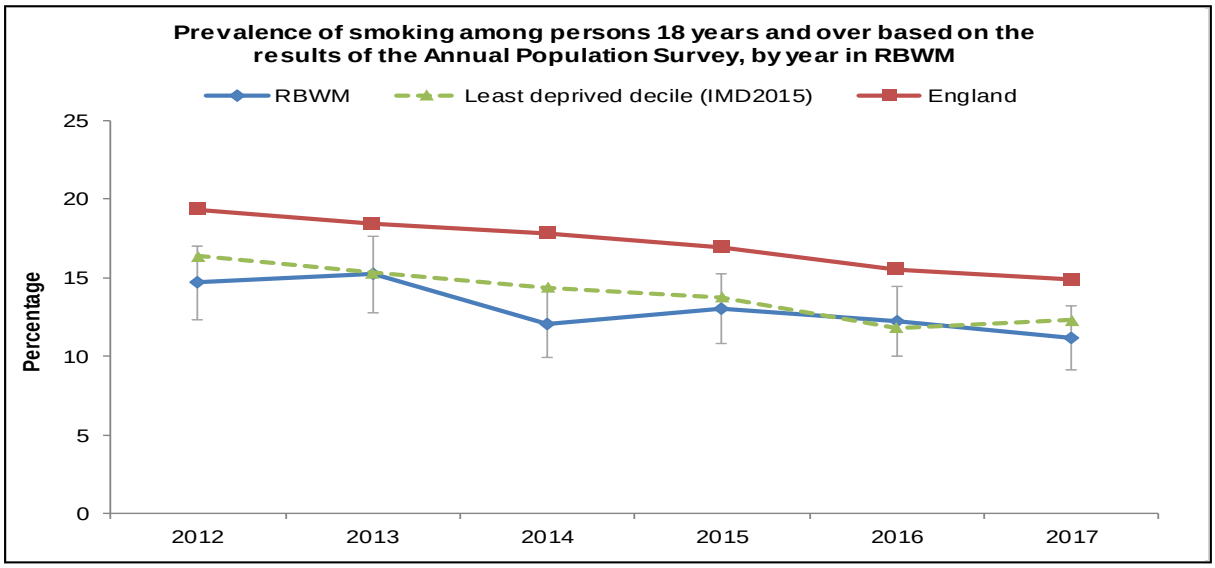
• Increase roadside stop checks to address specific offences (e.g. drink-drive, drug-drive).
• Carry out campaigns to reduce instances of drink driving around major international sports events, (Blazed & Wasted, Morning After campaigns),
• Focus Local Road Safety Schemes in areas with the highest casualty rates.

Evaluations are recommended for all programmes as a means of service improvement. A small area analysis is recommended investigating alcohol-related road traffic accidents.

2.2 Smoking

Smoking remains the biggest single cause of preventable mortality and morbidity in the world. The Global Burden of Disease (2015) showed that smoking was attributable for almost 18% of deaths in England and 16% in South East England and was the highest attributable-risk both regionally and nationally. While people are living longer, they are spending more years in ill health. The burden of a disease can be measured by disability-adjusted life years (DALYs), which combine the years of life lost to premature mortality and those lived with disability, illness or injury. The Global Burden of Disease (2015) showed that smoking was also the largest cause of preventable ill health in England, attributing to over 11% of disability adjusted life years in England and 9% in South East England.[6]

Figure 7: Prevalence of smoking among persons 18 years and over based on the results of the Annual Population Survey, by year in the Royal Borough, compared to England and the least deprived decile (IMD 2015) between 2012 and 2017

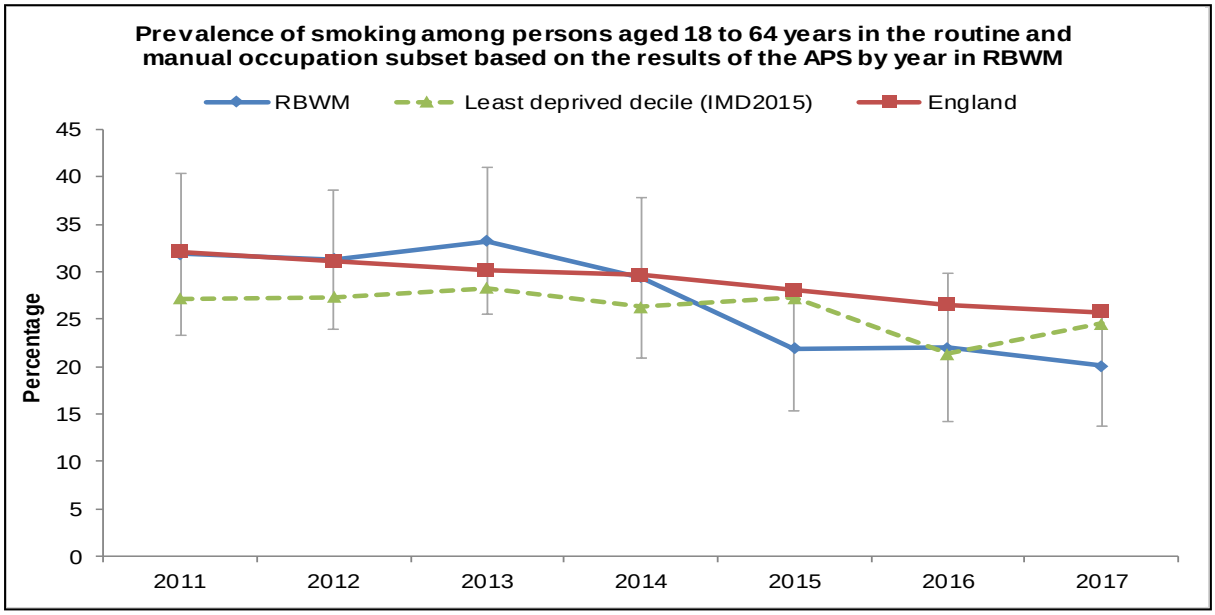


Data source: Local Tobacco Profiles for England; Public Health England

[6] *Global Burden of Disease Compare Data Visualization (2016)*

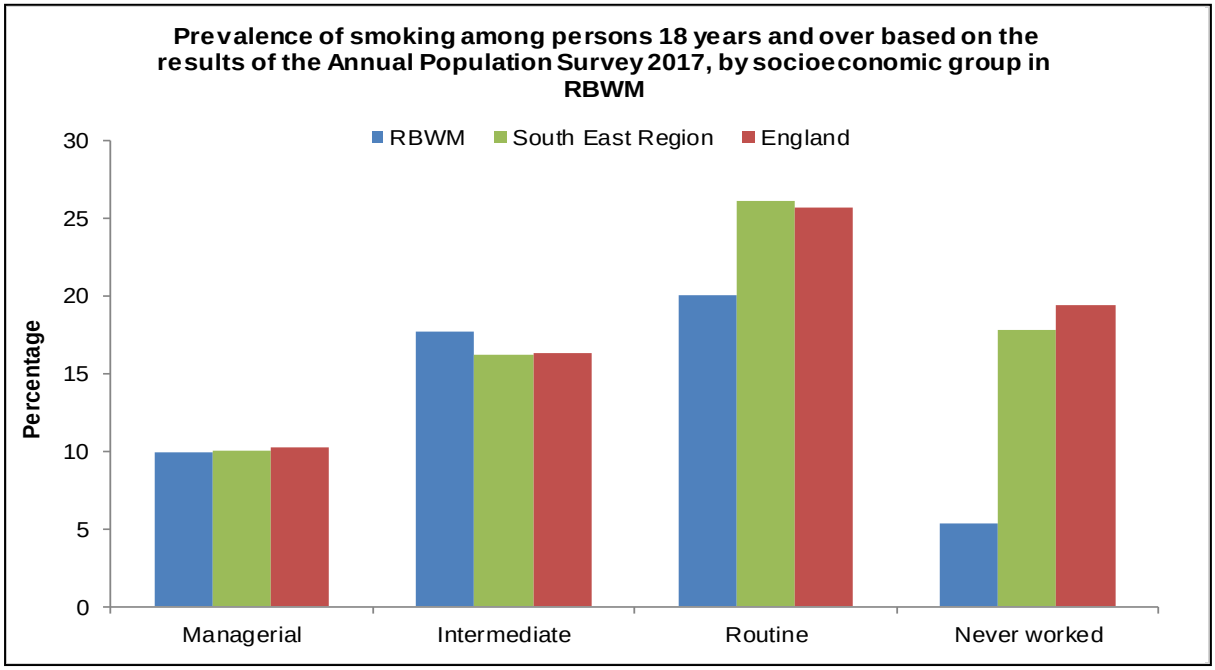
In 2017, smoking prevalence for adults in the Royal Borough was 11.2%. This was significantly better than the national average of 14.9% and similar to the comparator group's 12.3%.

Figure 8: Prevalence of smoking among persons 18 to 64 years in the routine and manual occupation subset based on the results of the Annual Population Survey, by year in the Royal Borough, compared to England and the least deprived decile (IMD 2015) between 2011 and 2017



Data source: Local Tobacco Profiles for England; Public Health England

Figure 9: Prevalence of smoking among persons 18 years and over based on the results of the Annual Population Survey 2017, by socioeconomic group in the Royal Borough, compared to England and the South East region between 2012 and 2017



Data source: Local Tobacco Profiles for England; Public Health England

In 2017, the smoking prevalence for adults in intermediate occupation in the Royal Borough was 17.7%. This was higher than the England average of 16.3% and the comparator group's 16.2%.

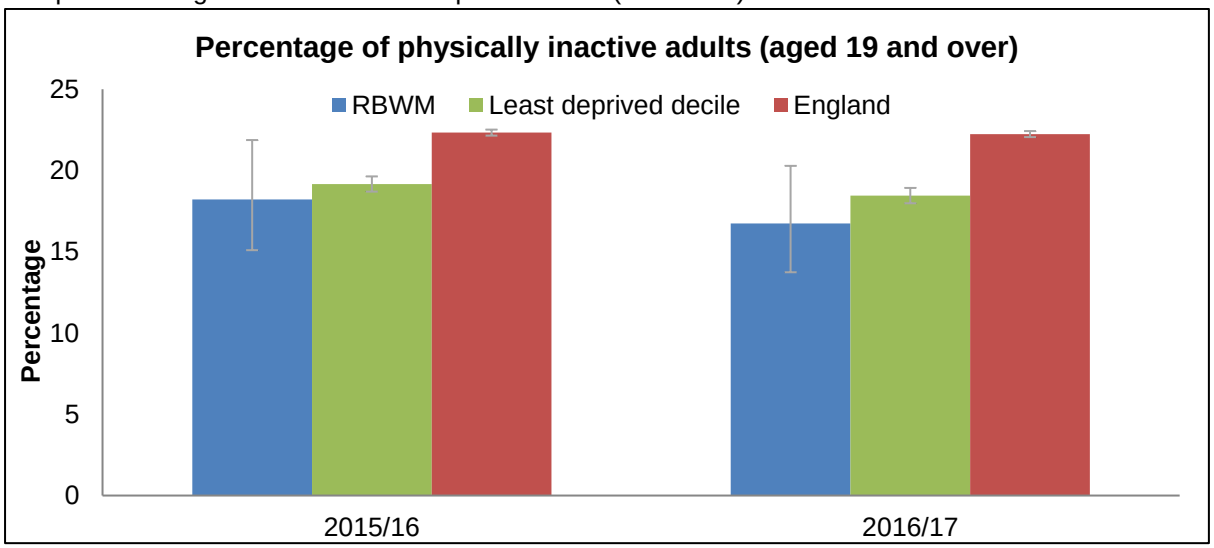
2.2.1 What does this mean for the Royal Borough?

Smoking prevalence is lower in the Royal Borough than in England, with trends going in the right direction since 2012. However, there is a clear health inequality observed here. Smoking prevalence for adults in intermediate occupations in the Royal Borough is higher than the England and comparator's average. This is in line with our population profile (large proportion of population aged 35-59 years and higher proportion of workforce is employed within managerial and technical roles). This cohort are likely to experience poorer health compared to the rest of our population.

2.3 Physical inactivity and unhealthy diet (malnutrition, excess weight, obesity)

2.3.1 Physical inactivity

Figure 10: Percentage of physically inactive adults (aged 19 and over) in the Royal Borough, compared to England and the least deprived decile (IMD 2015) between 2015/16 and 2016/17



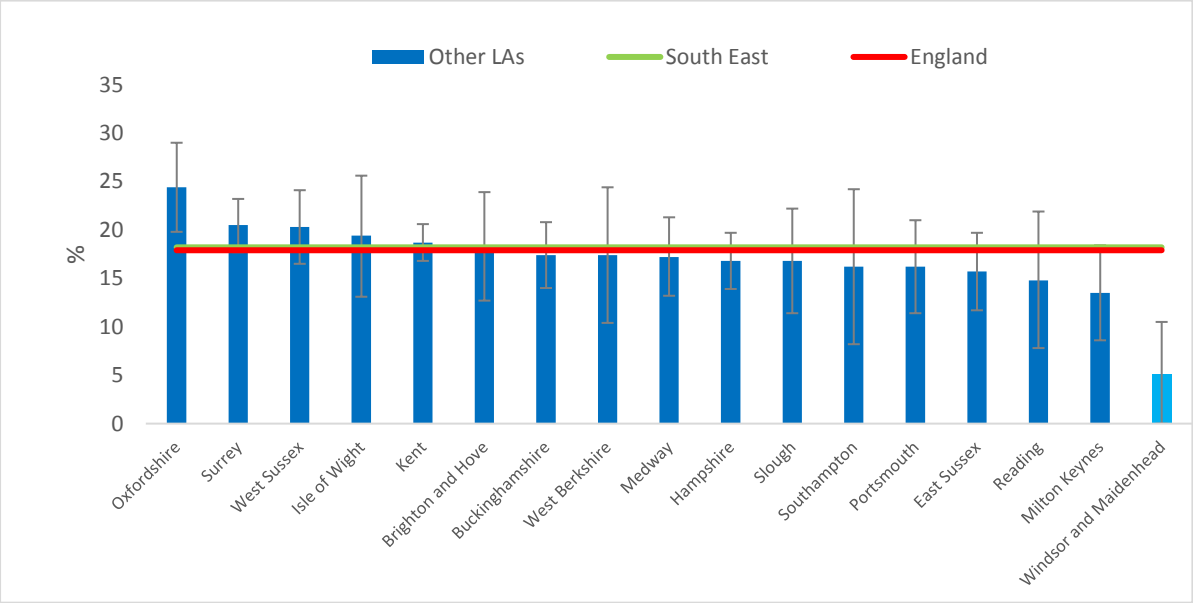
Data source: Public Health England (2018); Public Health Outcomes Framework

In 2016/17, 16.7% of adults aged 19 and over in the Royal Borough completed less than 30 minutes of physical activity per week and were therefore defined as 'physically inactive'. This was significantly better than the England average of 22.2% and similar to the deprivation decile average of 18.4%.

2.3.2 Access to green spaces

There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage.[7]

Figure 11: Percentage of people using outdoor space for exercise/health reasons in the Royal Borough, compared to other LAs in the South East region and England in 2015/16



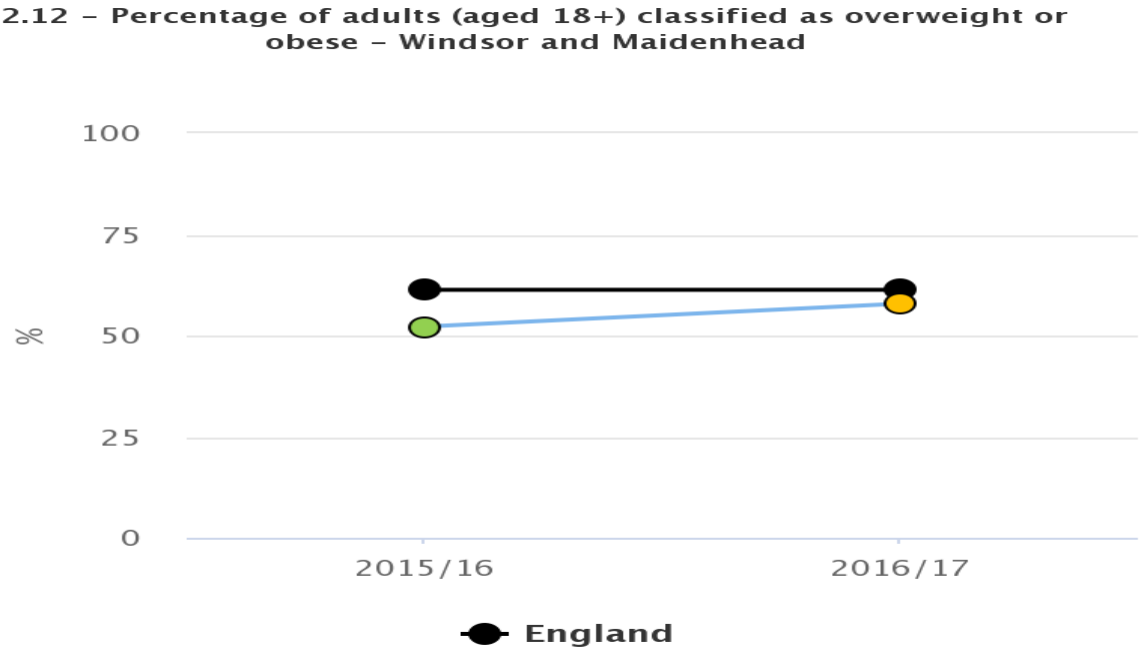
Data source: Natural England–Monitor of Engagement with the Natural Environment (MENE) survey

In 2015/16, about 5% residents in the Royal Borough used outdoor space for exercise or health reasons. This is the lowest in the South East region (18.2%), and lower than the England average (17.9%).

[7] *Public Health Outcomes Framework 2018: indicator - 1.16 Utilisation of outdoor space for exercise/health reasons*

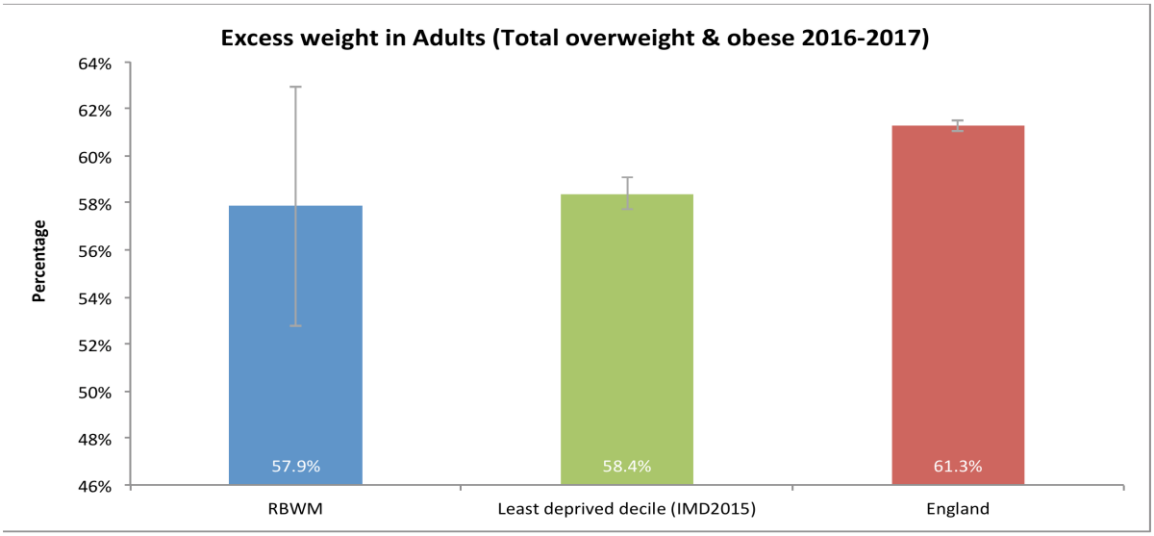
2.3.3 Excess weight in adults

Figure 12: Percentage of adults (aged 18+) classified as overweight or obese in the Royal Borough, compared to England



Data source: Sport England – Active Lives Survey 2017

Figure 13: Percentage of adults classified as overweight or obese in the Royal Borough, compared to England and the least deprived decile (IMD 2015) in 2016/17



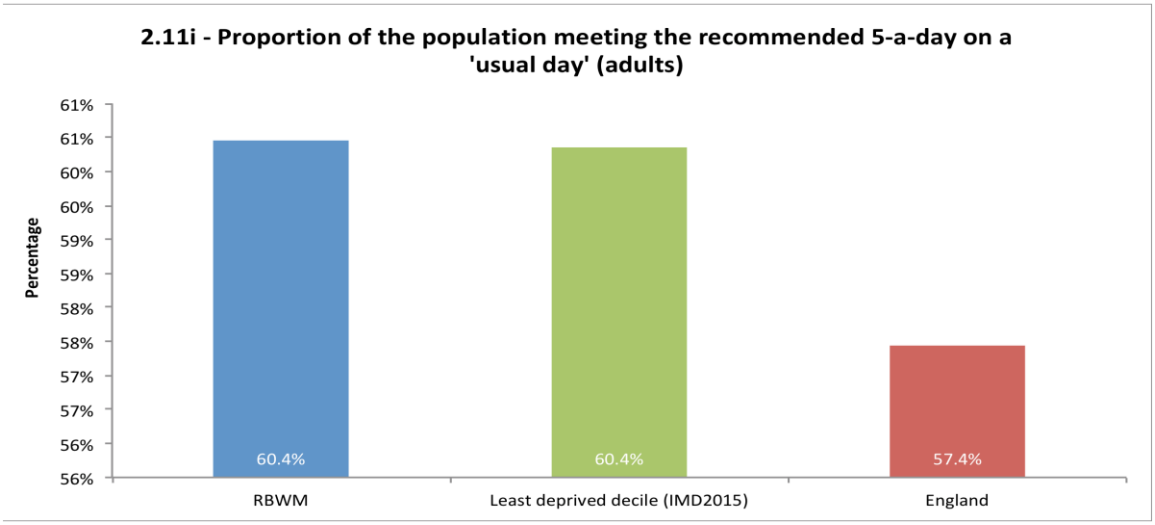
Data source: Sport England – Active Lives Survey 2017

In 2016/17, 57.9% of people aged 18 and over in the Royal Borough were classified as overweight or obese. This was similar to the England average of 61.3% and deprivation decile comparator group of 58.4%.

2.3.4 Fruit and vegetable consumption

2.3.4.1 5-a-day

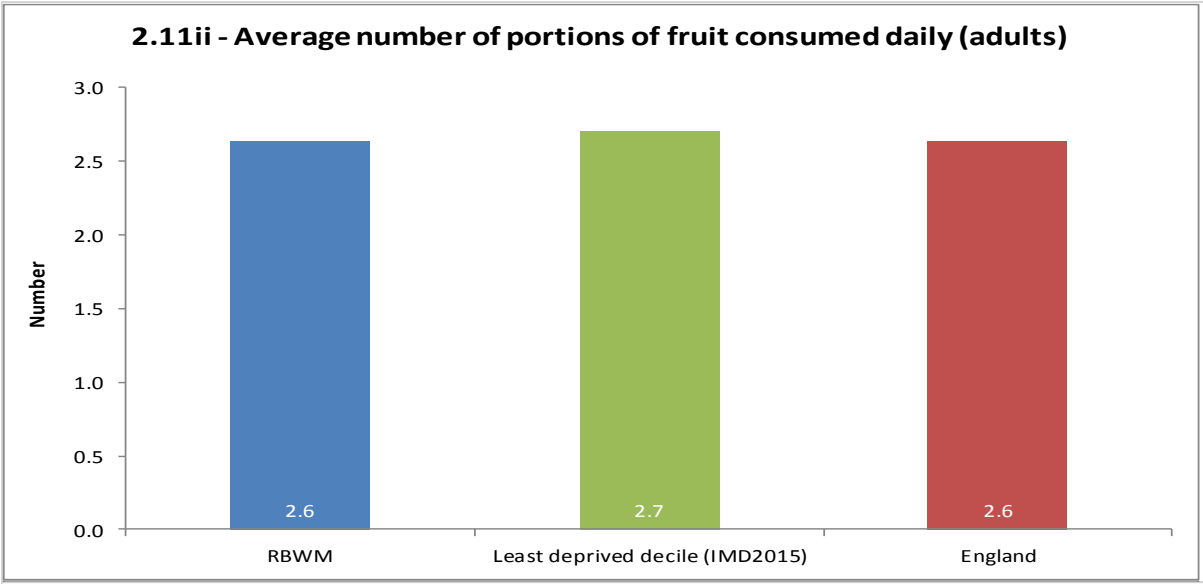
Figure 14: Proportion of the population meeting the recommended '5-a-day' in the Royal Borough, compared to England and the least deprived decile (IMD 2015) in 2017



Data source: Sport England – Active Lives Survey 2017

In 2017, 60.4% of the population aged 16 years and over in the Royal Borough met the recommended '5-a-day'. This was similar to the England average of 57.4%.

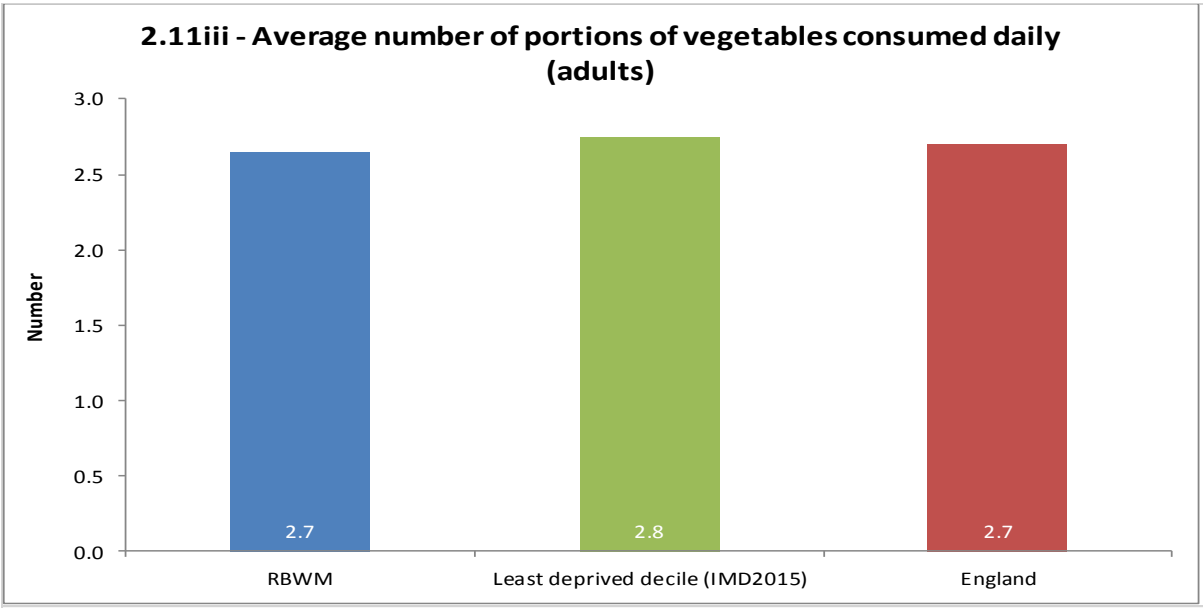
Figure 15: Average number of portions of fruit consumed per day in the Royal Borough, compared to England and the least deprived decile (IMD 2015) in 2016/17



Data source: Sport England – Active Lives Survey 2017

In 2017, the average number of portions of fruit consumed daily of the population aged 16 or over in the Royal Borough was 2.64 portions. This was similar to the England average of 2.6.

Figure 16: Average number of portions of vegetables consumed per day in the Royal Borough, compared to England and the least deprived decile (IMD 2015) in 2016/17



Data source: Sport England – Active Lives Survey 2017

In 2017, the average number of portions of vegetables consumed daily of the population aged 16 or over in the Royal Borough was 2.65 portions. This was similar to the England average of 2.7.

2.3.5 What does this mean for the Royal Borough?

In the Royal Borough, the percentage of local residents being physically active is significantly better than the comparators, however, the Royal Borough has the lowest percentage of residents using outdoor space for exercise or health reasons.

Additionally, excess weight in adults has increased by 6% since 2015/16. Thought needs to be given to the fact that the physical activity evidence does not align with the increased prevalence of excess weight, as one could expect the trend in excess weight to be different. The Royal Borough has also seen increases in hypertension and diabetes prevalence. It is possible that hypertension, excess weight and physical inactivity are the drivers behind the increased prevalence of diabetes (the Royal Borough: 5.2% vs England: 6.7%) and dementia (the Royal Borough: 4.7% vs England: 4.3%). The increased prevalence may however also be due to active case finding.

It is recommended that targeted tier 3 weight management interventions are procured locally. Other options include the procurement of an integrated healthy lifestyle service which addresses multiple risky behaviours.

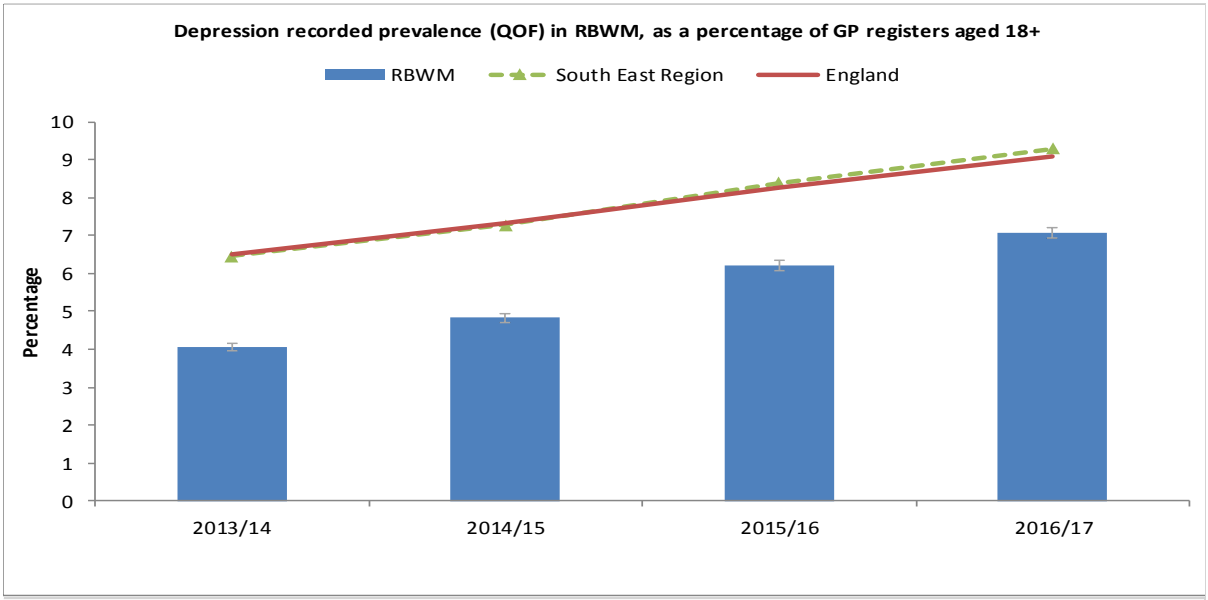
The Planning Department is currently undertaking an Open Space study. This study will help us better understand the access to open space in the Royal Borough.

3. Long-term conditions

3.1 Mental health

Mental health encompasses a range of conditions such as depression, anxiety, psychoses and schizophrenia. Risk factors for the development of mental illness are multifactorial. However, physical illness, stress and alcohol and substance misuse are important risk factors.[8]

Figure 17: Percentage of adults aged 18+ registered as having depression in the Royal Borough, compared to England and the South East region, 2013/14 to 2016/17



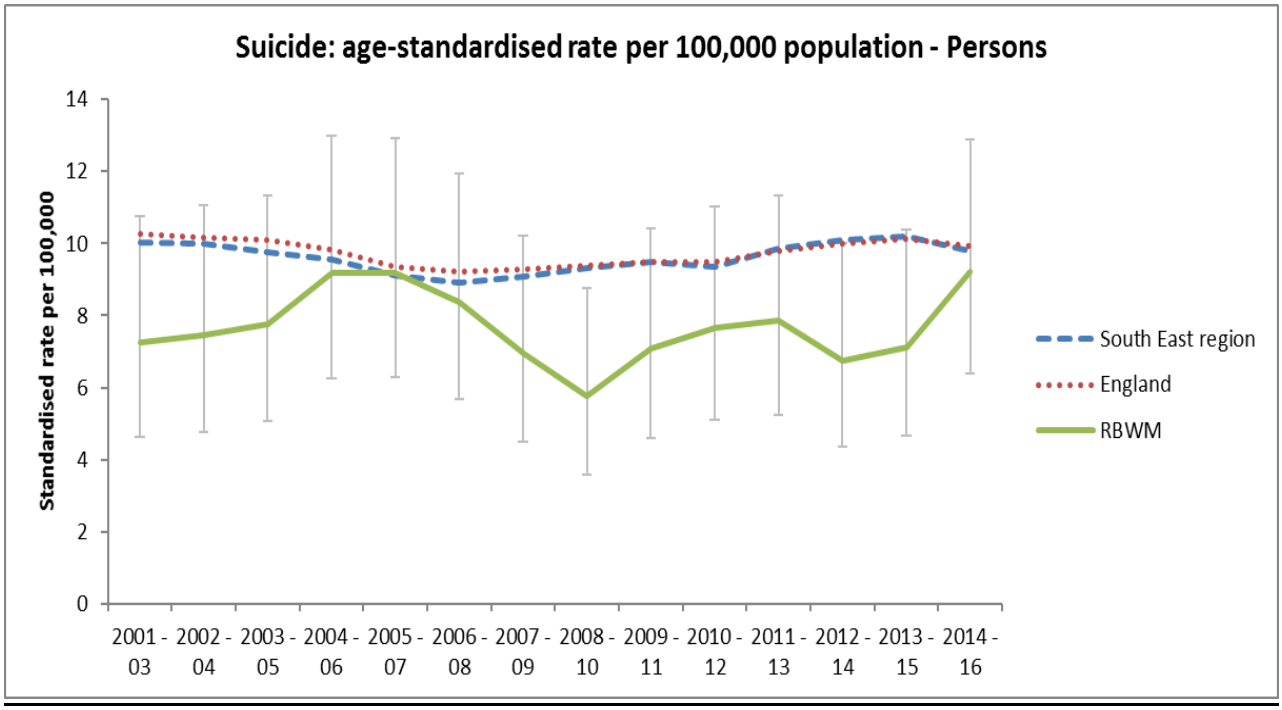
Data source: Common Mental Health Disorders; Public Health England

The prevalence of depression in people aged 18 years and over in the Royal Borough was almost doubled over the past 4 years, from 3.8% in 2013/14 to 7.1% in 2016/17.[9] But the prevalence is lower in the Royal Borough than in England (9.1%) and the South East region of 8.8% in 2016/17.

[8] *Improving the physical health of people with mental health problems: Actions for mental health nurses. Department for Health, Public Health England and NHS England, 2016.* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/532253/JRA_Physical_Health_revised.pdf*

[9] *Common Mental Health Disorders, Public Health Profile.* *https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders*

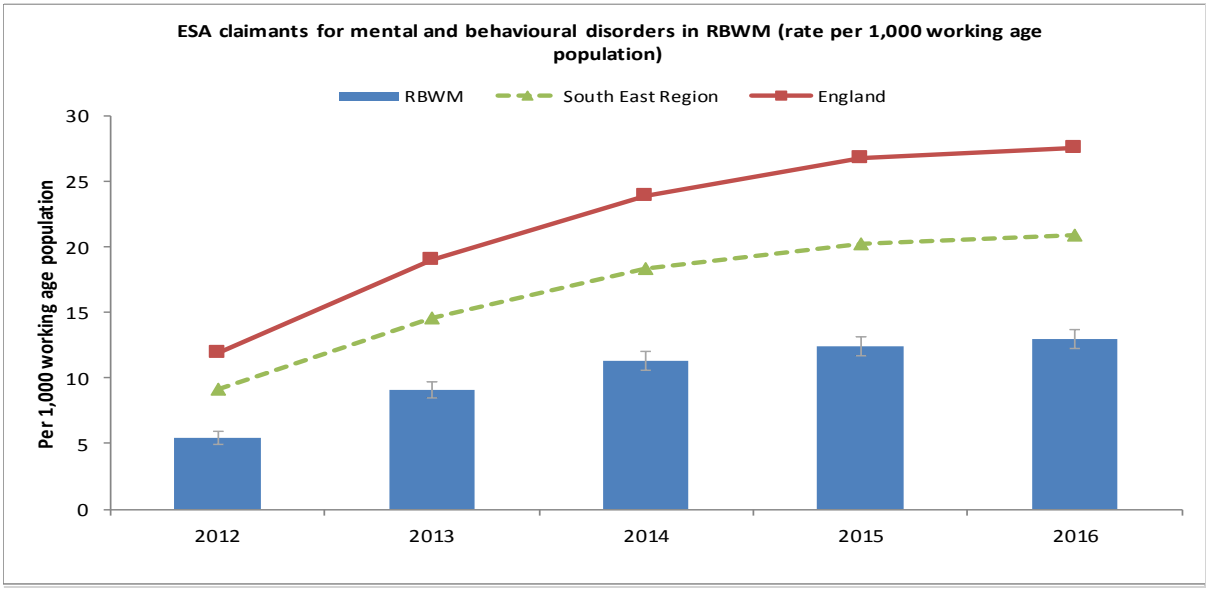
Figure 18: Suicide age-standardised rate per 100,000 population (Persons) in the Royal Borough, compared to the South East region and England between the period of 2001-03 and 2014-16



Data source: Suicide Prevention Profile; Children and Young People's Mental Health and Wellbeing, Public Health England

In the period between 2014 and 2016, 35 people from the Royal Borough died from suicide or an injury of undetermined intent. This equates to a standardised rate of 9.2 per 100,000. This rate is similar as the National and Regional average. Among them, about 68.6% were male. Nationally, about 75% of people who died were male.

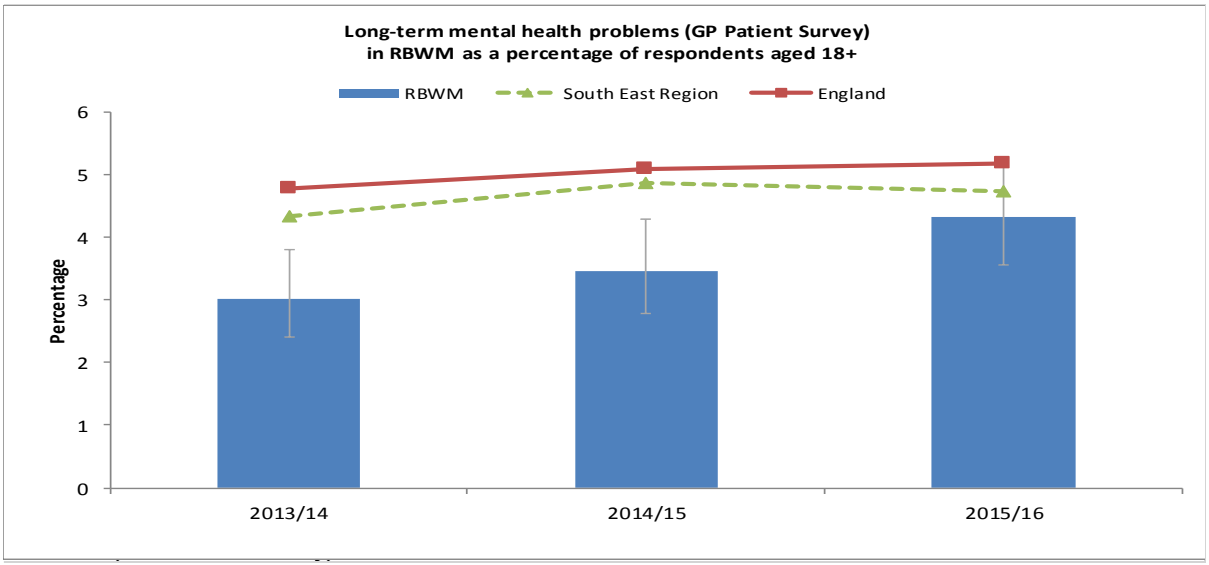
Figure 19: ESA claimants for mental and behaviour disorders in the Royal Borough, compared to England and the South East region between 2012 and 2016



Data source: Public Health England; Mental Health JSNA Profile

In 2016, the number of claimants for Employment Support Allowance (ESA) for mental health and behavioural conditions in the Royal Borough, was 13.0 per 1,000 working age population. This is significantly lower than England's rate of 27.5 per 1,000 population and the comparator group rate of 20.9 per 1,000 population.

Figure 20: Long-term mental health problems (GP Patient Survey) in the Royal Borough as a percentage of respondents aged 18+, compared to England and the South East region between 2013/14 and 2015/16

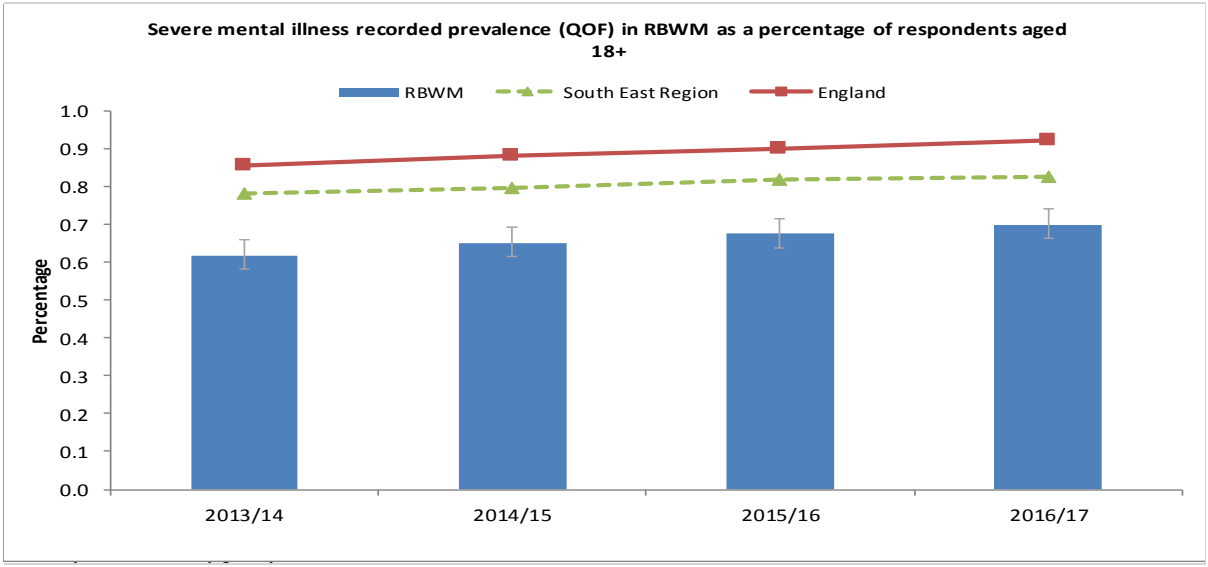


Data source: Public Health England; Mental Health JSNA Profile

The prevalence of long-term mental health problems in people aged 18 years and over in the Royal Borough has increased over the past 3 years, from 3.0% in 2013/14 to 4.3% in 2016/17.[10] But the prevalence is lower in the Royal Borough than in England (5.2%) and the South East region of 4.7% in 2016/17.

[10] *Common Mental Health Disorders, Public Health Profile*. *https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders*

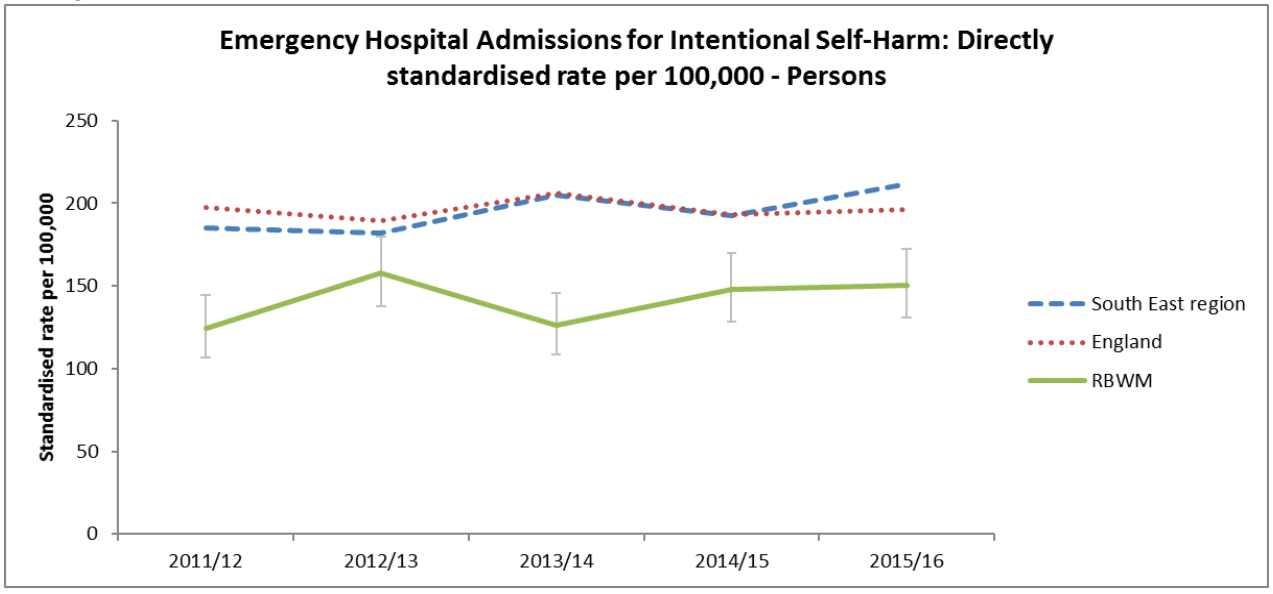
Figure 21: Percentage of adults aged 18+ having severe mental illness (QOF) in the Royal Borough, compared to England and the South East region between 2013/14 and 2016/17



Data source: Public Health England; Mental Health JSNA Profile

The prevalence of severe mental illness in people aged 18 years and over in the Royal Borough has increased slowly over the past 3 years, from 0.6% in 2013/14 to 0.7% in 2016/17.[11] But the prevalence is lower in the Royal Borough than in England (0.9%) and the South East region of 0.8% in 2016/17.

Figure 22: Emergency hospital admissions for intentional self-harm: Directly standardised rate per 100,000 (Persons), in the Royal Borough, compared to the South East Region and the England average.



Data source: Suicide Prevention Profile; Children and Young People's Mental Health and Wellbeing, Public Health England

[11] *Common Mental Health Disorders, Public Health Profile*. https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

During 2015/16, 215 people from the Royal Borough were admitted to hospital as an emergency due to intentional self-harm. This equates to a standardised rate of 150.5 per 100,000. This rate is lower than the National average and the Regional average. About 67% of people from the Royal Borough who were admitted were female. Nationally 63% of people who were admitted were female.

3.1.1 What does this mean for the Royal Borough?

Mental ill health is an area of challenge for the Royal Borough. Increasing trends have been noted in a number of areas including:

- Depression
- Mental health and behaviour conditions in claimants for Employment Support Allowance (ESA)
- Long-term mental health problems
- Severe mental illness

Evidence suggests that people with mental health issues would die on average twenty years earlier than the general population. Across the Frimley ICS, mental health is being addressed at a system level. Locally workplace mental health is being driven by the Living Well Board.

3.2 Cardiovascular diseases

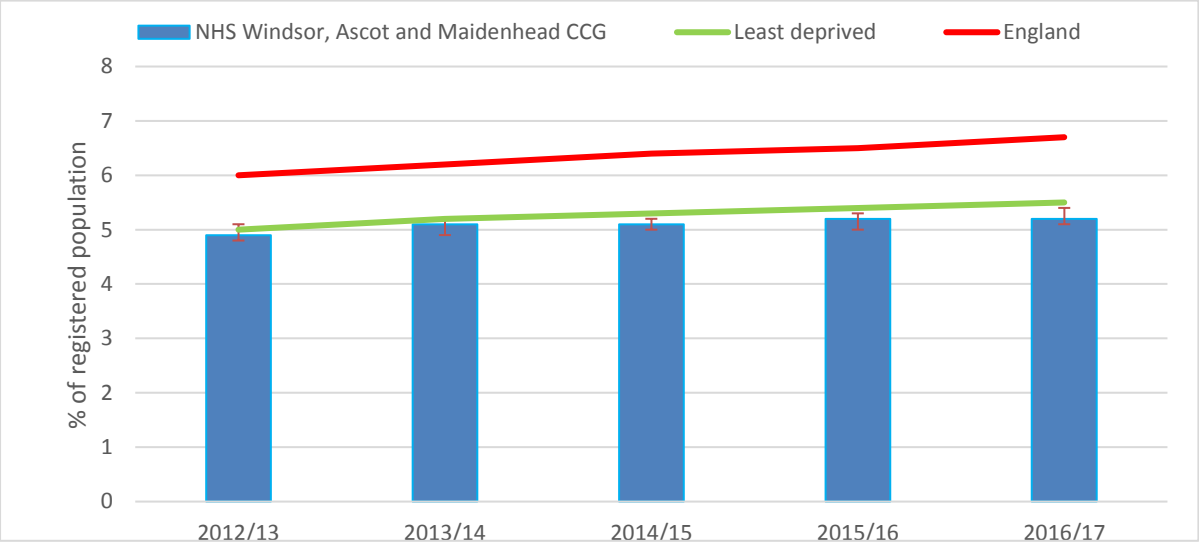
3.2.1 Diabetes

Approximately 10% of the NHS budget is spent on patients with diabetes, 90% of whom have Type 2 or adult onset diabetes.[12] The main risk factors are a diet rich in unrefined sugars, physical inactivity and being overweight or obese. The risk is increased in people from certain Black, Asian, and minority ethnic (BAME) groups – South Asian and Afro-Caribbean backgrounds.[13]

[12] *Diabetes UK – Diabetes Facts and Stats; Version 4. Revised: May 2015*

[13] *Diabetes and ethnicity, Diabetes UK. https://www.diabetes.org.uk/about_us/what-we-do/communities*

Figure 23: Percentage of patients aged 17+ with diabetes in the Royal Borough compared to England and least deprived decile (IMD 2015), 2012/13 to 2016/17



Data source: Diabetes – Public Health Profiles (2018)

In NHS Windsor, Ascot and Maidenhead CCG, the number of people living with diabetes aged 17 years and above is on the increase, from 4.9% (2012/13) to 5.2% (2016/17) over the past 5 years (2012-2017). The trend is lower than the national average and the comparator's group.

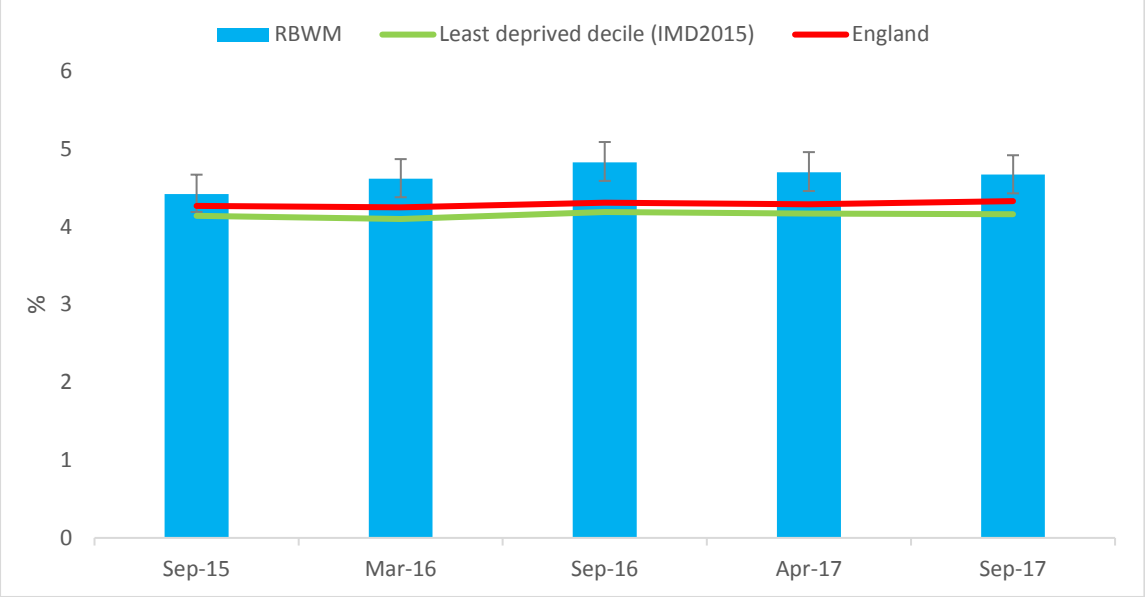
In 2016/17, the prevalence of patients aged 17 years and over with diabetes in NHS Windsor, Ascot and Maidenhead CCG was about 5.2%. This is lower than England (6.7%), but similar to the comparator group's average of 5.5%.

3.2.2 Dementia

Dementia is a clinical syndrome of deterioration in mental function which interferes with activities of daily living (ADLs). It affects more than one cognitive domain (for example memory, language, orientation, or judgement) and social behaviour (for example, emotional control or motivation). Early (or young) onset dementia is generally defined as dementia that develops before 65 years of age. Modification of specific risk factors (in particular, cardiovascular risk factors such as smoking, diabetes and lack of physical activity) can delay or prevent the onset of dementia.[14]

[14] *Dementia: Summary. Clinical Knowledge Summaries, NICE.* https://cks.nice.org.uk/dementia#!topicsummary

Figure 24: Percentage of patients aged 65+ with a recorded diagnosis of dementia in the Royal Borough, compared to England and the South East region, Sep 2015 to Sep 2017

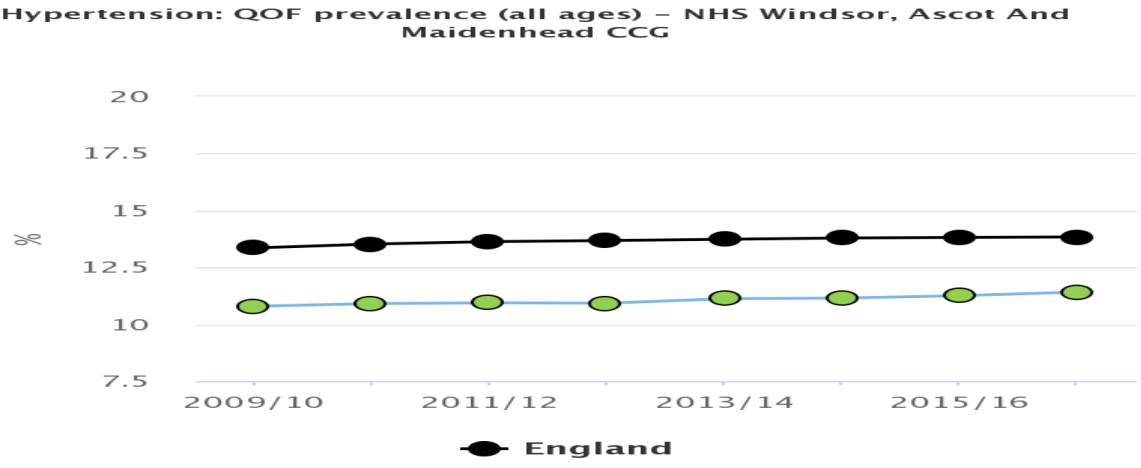


Data source: Dementia Profile – Public Health Profiles

In the Royal Borough, the prevalence of dementia is 4.7% in people aged 65 and above in 2017. It was higher than the England average of 4.33% and the deprivation decile comparator group's (IMD 2015) of 4.16%.

3.2.3 Hypertension

Figure 25: Percentage of patients of all ages with established hypertension in the Royal Borough, compared to England, 2009/10 to 2016/17



Data source: Dementia Profile – Public Health Profiles

In 2016/17, the prevalence of patients with hypertension in the Royal Borough was 11.4%. This was better than the England average. However, the increasing trend should be noted.

3.2.4 What does this mean for the Royal Borough?

The number of people with dementia in the Royal Borough is projected to increase from 1,348 in 2017 to 3,620 in 2035.[15] The cost of dementia in the UK is expected to more than double in the next 25 years, from £26bn to £55bn in 2040.[16] This will have implications to the Royal Borough's future dementia costs.

It is likely that dementia prevalence will continue to increase in the Royal Borough, in line with its ageing population, and active local case finding. Cost implications are likely to affect both LAs and CCGs. Stakeholders across the system should consider embedding prevention into the adult health agenda. Considerations should be given to preventing /delaying onset of dementia and diabetes through the following evidence-based approaches:

- Healthy eating
- Hypertension management
- Smoking cessation
- Weight management

Primary care and local public health should consider opportunities to deliver innovative health check initiatives.

4. Stakeholder consultation

On September 25th, a stakeholder event was held to understand the views of local residents with respect to local assets and need. Over 80% of stakeholders agreed that the priorities for Living Well should be mental health, cardiovascular diseases (diabetes and dementia), alcohol-related road traffic accidents, excess weight, inequalities (access to green space and smoking in intermediate groups).

This was also echoed by findings from a recent voluntary stakeholder survey completed in September 2018, which demonstrated a 81% agreement with current priorities.

The underpinning themes from all stakeholder conversation was the need to embed prevention across the life course and implement "enablers" to make this happen. Enablers included, accessibility to services, integration and community action.

[15] *Projecting Older People Population Information System (POPPI)*

[16] *Prince, M et al (2014) Dementia UK: Update Second Edition report produced by King's College London and the London School of Economics for the Alzheimer's Society*

Appendix 1: Living Well Board Action Plan

Living Well Board Action Plan

2018-2019

JHWBS aims	Theme	Action required	Owner	Completion Date	Outputs	Outcome
Prevention and early intervention.	1. Workplace mental health	E Learning mental health tools, including suicide awareness training	Service Lead – Public Health Programmes HR Lead Consultant	December 2019	Development and implementation of workplace health plan 4 x RBWM Mental Health Champions recruited Workplace Charter Developed Delivery of Mental Health Summit and Event Write Up	Improved sickness absence *(Measure – 1.099ii – Sickness absence – the % of working days lost due to sickness absence. Baseline = 1% (2014-16) and 1.09i – sickness absence- the % of employees who had at least one day off in the previous week. Baseline = 2% (2014-16)*) Reduction in workplace stress (%) *– RBWM staff survey*
		Mental Health & Wellbeing Impact Assessments championed/delivered in RBWM				
		Development of workplace health charter and audit	Service Lead – Public Health Programmes	December 2019		
		Summit on how to improve mental health in the workplace	Service Lead – Public Health Programmes	December 2019		

JHWBS aims	Theme	Action required	Owner	Completion Date	Outputs	Outcome
						Increase in workplace satisfaction (%) – *RBWM staff survey*
	2. Make Every Contact Count (MECC). Embedding prevention in organisational activities	Training for public facing staff *Priority target group – Carers*	Head of Communities	December 2019	50 staff trained + 1 x Public Health Team member	Changes in own behaviour/practice of MECC trained staff – *Staff survey* Percentage of people who made a positive change in their behaviour following a MECC interaction - % of residents who set themselves a goal
Supporting a healthy population.	Cardiovascular Disease Prevention	Increase identification of hypertension. Identify community options for health checks (e.g. wellbeing kiosks) and integrate MECC trained individuals into the options	Head of Public Health	December 2019	Pilot wellbeing kiosks in Windsor and Ascot	Increase the number of patients aged 45+ who have a blood pressure reading. in last 5 years. *Baseline for CCG = 88.4% 2016/17*

JHWBS aims	Theme	Action required	Owner	Completion Date	Outputs	Outcome
	Lower risky alcohol intake	Reduce alcohol related road traffic accidents	Head of Communities	December 2019	As agreed through existing community plans	RTA's reduced by 5% compared to 14/16. *Baseline = 26.1 per 1000*
Enable residents to maximise capabilities and life chances.	Improving self-care and independence	Residents to access digitalised health awareness information through the public health microsite/ health apps	Public Health Practitioner / Public Health Commissioning Officer	July 2019	Increasing trend of website visits *Baseline – Jan-July 2018 = 2,441 visitors*	Feedback that the website information was helpful to residents – *public survey*
	Use of green spaces for exercise	Implementation of green spaces rapid review	Parks and Countryside Team Leader	June 2019	Review completed.	Plans in place to action recommendations
Overarching theme 2018 – Loneliness & Isolation.	Asset Mapping Loneliness & Isolation Campaign	Data linkage – local assets mapped onto neighbourhood two platform. #Reachout campaign	Ageing Well Lead Public Health Practitioner / Public Health Commissioning Officer	November 2018	Development of campaign plan	Successful Delivery of campaign throughout November #ReachOutRBWM 1st – 31st

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Royal Borough of Windsor & Maidenhead

Ageing Well in the Royal Borough of Windsor & Maidenhead

Exploring Older People's Health

2018

Falls, Dementia, Immunisations
Age-related Macular Degeneration, Cancer

Locality and Ward Level Insights

Executive Summary

Increased longevity in many high-income countries has transformed old age. Life expectancy in the UK continues to increase by two years per decade, although recent data reveal this is not the case in more socio-economically deprived areas nationally.[1] Life expectancy in the UK for males is 79.2 years, and for females was 82.9 years. Compared with national average, the life expectancy was higher in the Royal Borough, 81.6 years for men and 84.6 years for women. However, people are living longer in poorer health. The majority of the health challenges identified on older adults stem from unhealthy lifestyles. The key challenge therefore for over 65s is how to maintain a healthy lifestyle.

The population in the Royal Borough continues to age with 18.2% of the population aged 65 years and over in 2016. This is similar to the England figure of 17.9%. This age group is predicted to increase to 22% by 2030. It is therefore imperative that older adults age healthily.

The following represents a summary of the needs identified:

About 68.7% of people aged 65 and over received a flu vaccination in the 2016/17 flu season. This was worse than the England value of 70.5% and the South East region of 70.2%.	In 2016/17, the total number of emergency hospital admissions for falls amongst people aged 65 and over in the Royal Borough was 701. This was a standardised rate of 2390 per 100,000. This was worse than the rate of admissions in the South East region (2134.6 per 100,000) and the England average (2113.8 per 100,000).	
In the Royal Borough, the prevalence of dementia is 4.7% in people aged 65 and above in 2017. It is higher than the England average of 4.33% and the deprivation decile comparator group's of 4.16%. Dementia care is likely to be an increasing challenge for health and social care services, considering the ageing population, service capacity and costs.	The number of people aged 70 who have received a dose of shingles vaccine has declined from 2014 to 2017 by 16.8%. In 2016/17, the coverage of shingles vaccine in people aged 70 in the Royal Borough was 47%. This was worse than the least deprived decile comparator group (50.4%) and the England (48.3%) average.	In 2016/17, 46 new certificate of vision impairment were issued due to age-related macular degeneration in people aged 65 and above in the Royal Borough. This is a rate of 168.5 per 100,000, compared to 111.3 per 100,000 people in England, and 113.1 per 100,000 in the least deprived decile comparator group.

[1] *Robinson L., Successful ageing. Lancet 391: 300.*

Contents

List of glossaries

Age-related macular degeneration is a common condition that affects the middle part of your vision. It usually first affects people in their 50s and 60s.

Glaucoma is a common eye condition where the optic nerve, which connects the eye to the brain, becomes damaged.

Screening is the process of identifying healthy people who may have an increased chance of a disease or condition.

Shingles is an infection that causes a painful rush.

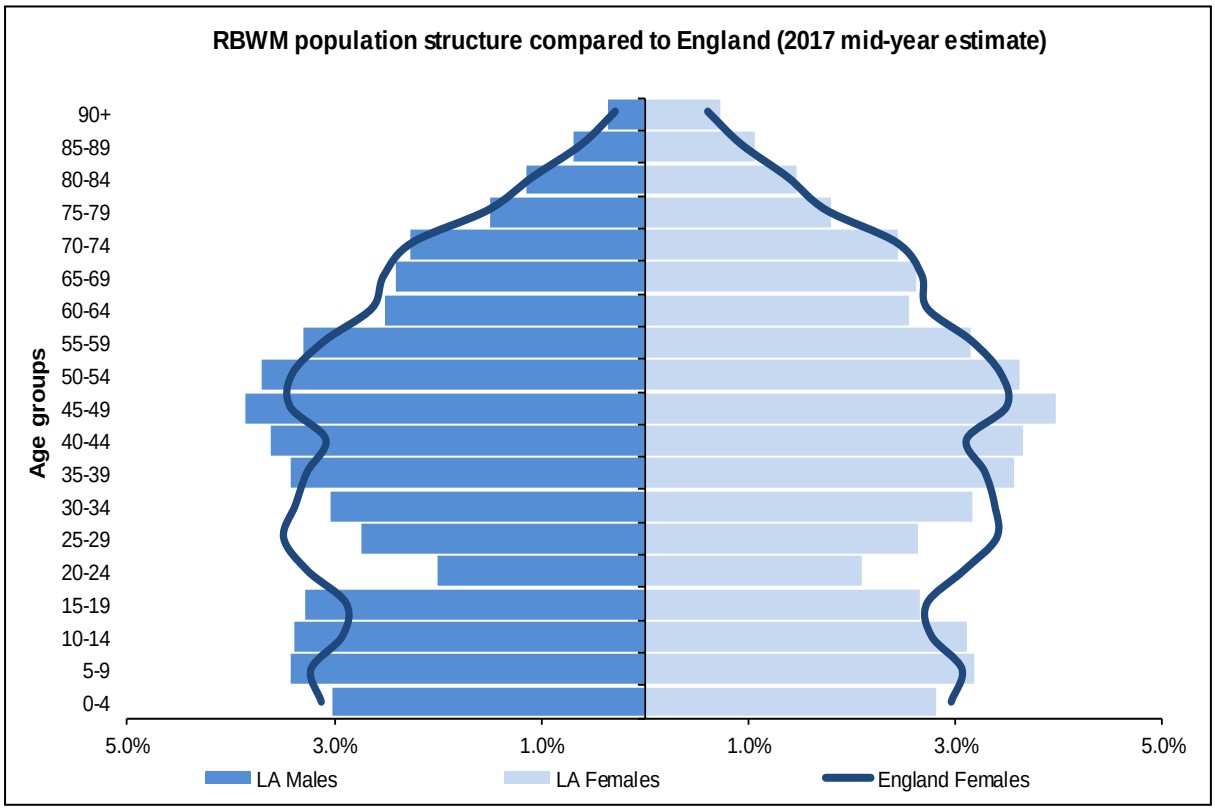
Introduction

This document has been prepared to support the development of plans aligned with the Ageing Well Board, which is a sub board of the Health & Wellbeing Board. The report seeks to highlight the health needs of older people aged 65 years and above in the borough and make recommendations for board consideration. Needs were identified by recently published Common Mental Health Disorders, Dementia Profile, Health Protection Profile, Hypertension Profile, and Public Health Outcomes Framework, produced by Public Health England, with the most recent update in September 2018.

1. Our older people

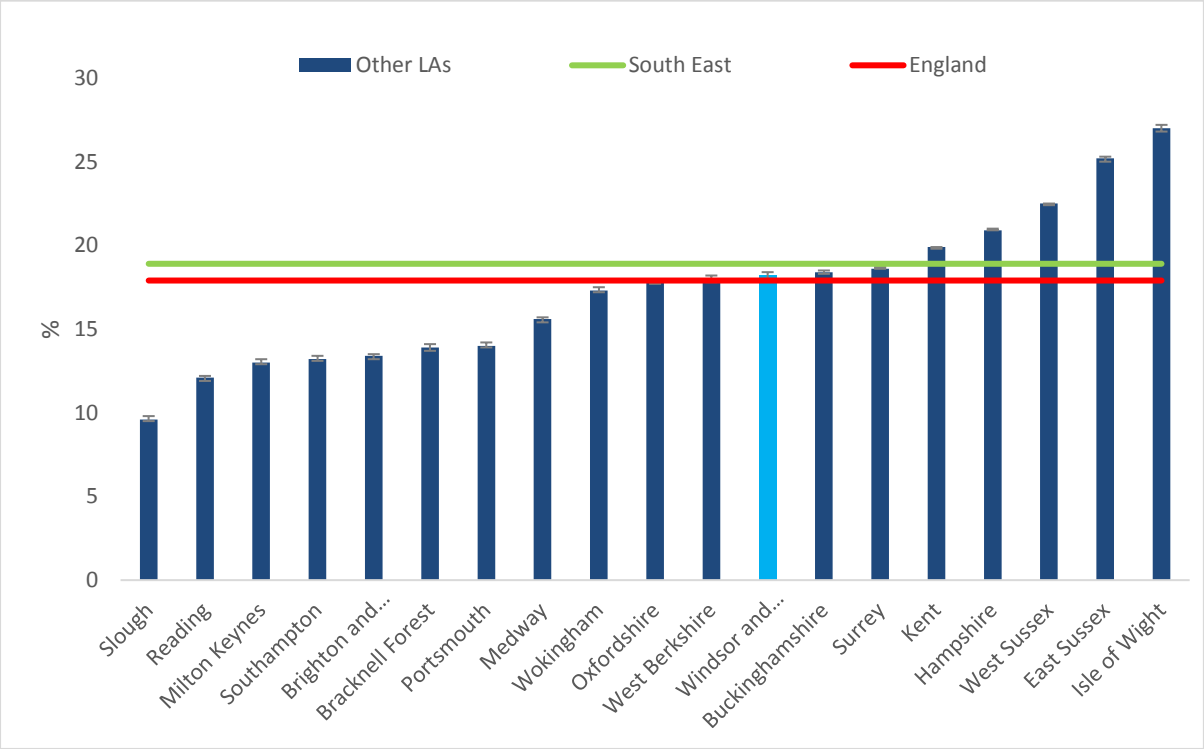
The Royal Borough of Windsor and Maidenhead is a Royal Borough of Berkshire, in South East England. It is home to Windsor Castle, Eton College, Legoland Windsor and Ascot Racecourse. It is one of four boroughs entitled to be prefixed *Royal* and is one of six unitary authorities in its county which has Historic and Lieutenancy county status. The population pyramid in Figure 1 compares the population figures for the Royal Borough of Windsor and Maidenhead with England by five-year age bands. The population in the Royal Borough continues to age with 18.2% of the population aged 65 and over in 2016. This is similar to the England figure of 17.9% but lower than the South East region of 18.9%.

Figure 1: The Royal Borough of Windsor and Maidenhead and England Mid-2017 Population Pyramid



Data source: Mid-Year Population Estimates 2017, Office for National Statistics (ONS).

Figure 2: The percentage of the resident population aged 65 and over in the Royal Borough, compared to other LAs in the South East region and England in 2016/17



Data source: Mid-Year Population Estimates 2016, Office for National Statistics (ONS).

2. Risk factors for health and social care

2.1 Preventable sight loss

The Royal National Institute of Blind People (RNIB) estimates that there are about two million people living with significant sight loss in the UK and 50% of this sight loss is avoidable. By 2050 the number of people with sight loss is set to double to four million as the impact of an ageing population makes itself felt.

In England, NHS commissioners spent on average £40,900 per 1,000 head of population on vision problems in 2010/11; a total cost of £2.14 billion that year. The savings are more significant when factoring in health and social care complications that are sustained or exacerbated as a direct result of sight loss.

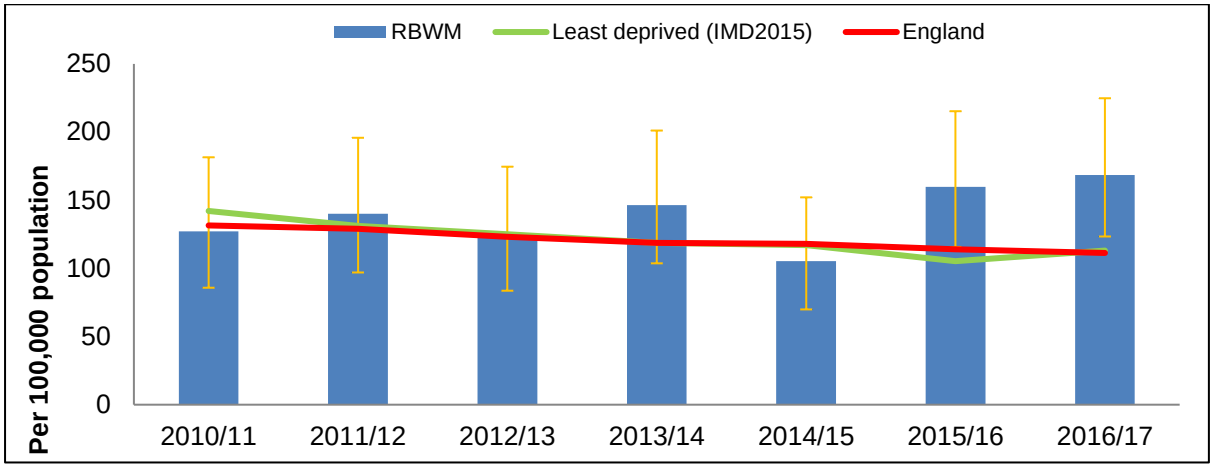
In 2016, there were an estimated 4,920 people living with some degree of sight loss in the Royal Borough of Windsor and Maidenhead. Of this total, 3,170 are living with mild sight loss, 1,090 are living with moderate sight loss and 660 are living with severe sight loss. This equates to 3.3% of the total population of the Royal Borough living with sight loss, compared to 3.1% of the total population of England.

By 2030, it is expected that there will be 6,980 people in the Royal Borough of Windsor and Maidenhead living with sight loss, an increase of 41.9%. By 2030, the

number of people living with severe sight loss is estimated to be 970, an increase of 47.0%.

2.1.1 Age related macular degeneration (AMD)

Figure 3: Crude rate of sight loss due to age related macular degeneration (AMD) in those aged 65+ in the Royal Borough, compared to England and the least deprived decile (IMD 2015), in 2010/11 to 2016/17

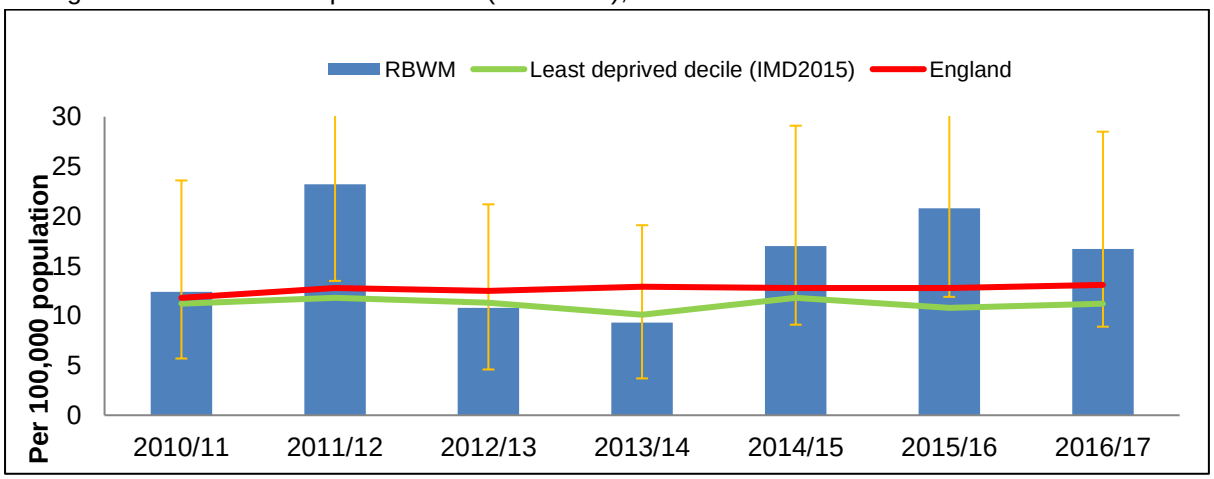


Data source: Calculated by Public Health England Knowledge and Intelligence Service (Epidemiology & Surveillance) from data provided by Moorfields Eye Hospital and Office for National Statistics

In 2016/17, 46 new certificates of vision impairment (CVIs) were issued due to age-related macular degeneration (AMD) in people aged 65 and above in the Royal Borough. This is a rate of 168.5 per 100,000, compared to 111.3 per 100,000 people in England, and 113.1 per 100,000 in the least deprived decile comparator group, which was shown a statistical significance.

2.1.2 Glaucoma

Figure 4: Crude rate of sight loss due to glaucoma in those aged 40+ in the Royal Borough, compared to England and the least deprived decile (IMD 2015), in 2010/11 to 2016/17

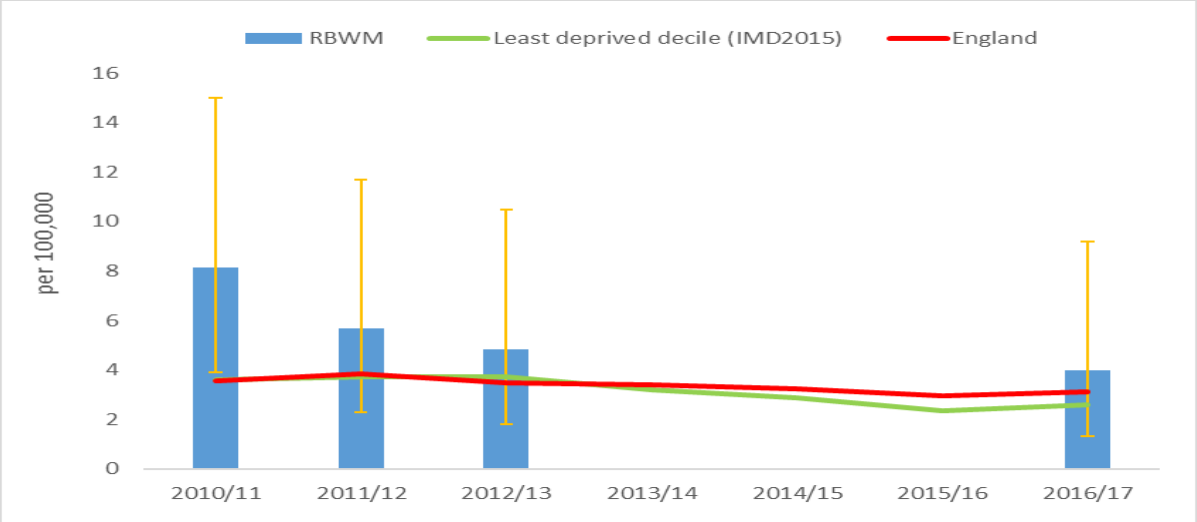


Data source: Calculated by Public Health England Knowledge and Intelligence Service (Epidemiology & Surveillance) from data provided by Moorfields Eye Hospital and Office for National Statistics

In 2016/17, 13 new CVIs were issued due to glaucoma in people aged 40 and above in the Royal Borough of Windsor and Maidenhead. This is a rate of 16.7 per 100,000, compared to 13.1 per 100,000 people in England, and 11.2 per 100,000 in the least deprived decile comparator group. The rate was decreased from 20.8 per 100,000 in 2015/16 to 16.7 per 100,000 in 2016/17.

2.1.3 Diabetic eye disease

Figure 5: Crude rate of sight loss due to diabetic eye disease in those aged 12+ in the Royal Borough, compared to England and the least deprived decile (IMD 2015) comparator group, in 2010/11 to 2015/16



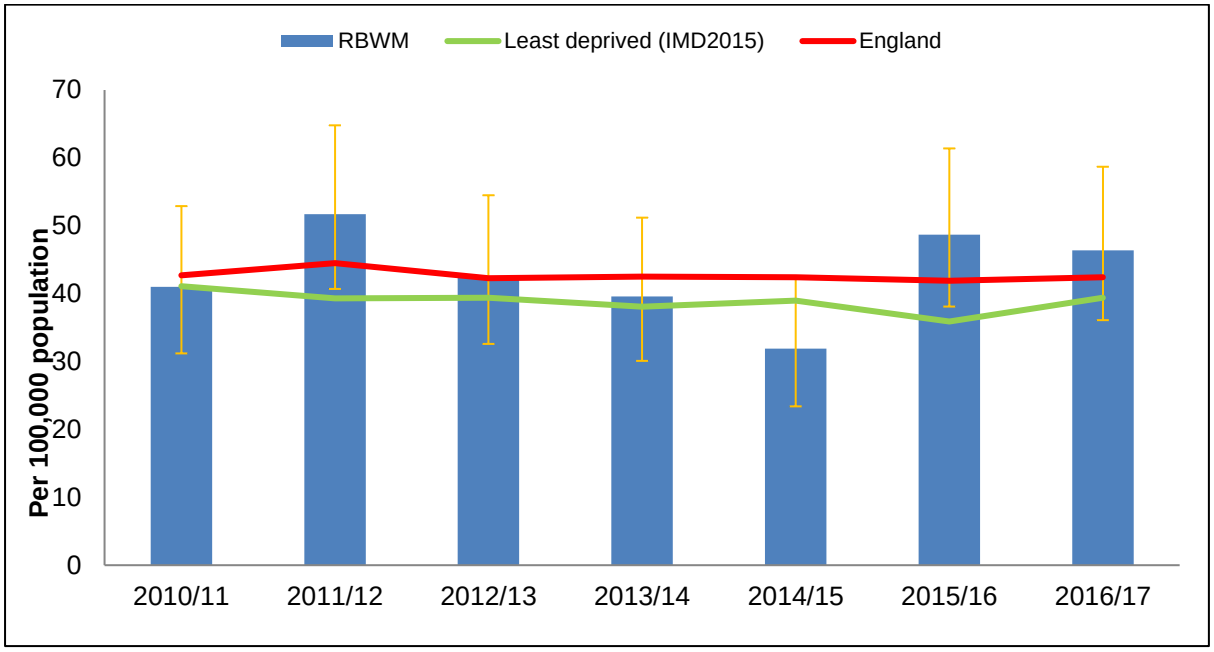
Data source: Calculated by Public Health England Knowledge and Intelligence Service (Epidemiology & Surveillance) from data provided by Moorfields Eye Hospital and Office for National Statistics

In 2016/17, 5 new CVIs were issued due to diabetic eye disease in people aged 12 and above in the Royal Borough of Windsor and Maidenhead. This is a rate of 4.0 per 100,000, compared to 3.1 per 100,000 people in England, and 2.6 per 100,000 in the least deprived decile comparator group.

2.1.4 Sight loss certification

A Certificate of Vision Impairment (CVI) formally certifies a person as either sight impaired (partially sighted) or severely sight impaired (blind). Each CVI form is completed by a consultant ophthalmologist in an eye clinic, with a copy send to the local social care services department which provides a formal route to social care services.

Figure 6: Crude rate of sight loss certifications in the Royal Borough, compared to England and the South East region, in 2010/11 to 2016/17



Data source: Calculated by Public Health England Knowledge and Intelligence Service (Epidemiology & Surveillance) from data provided by Moorfields Eye Hospital and Office for National Statistics

In 2016/17, 69 certificates of vision impairment were issued in the Royal Borough of Windsor and Maidenhead. This is a rate of 46.4 CVIs issued per 100,000, compared to 42.4 per 100,000 people in England, and 39.4 per 100,000 in the least deprived decile comparator group.

2.1.5. What does this mean for the Royal Borough?

The exact cause of AMD is unknown but it is noted that it usually first affects people in their 50s and 60s and generally affects older people.

AMD is linked to an unhealthy lifestyle. Older adults should be encouraged to eat a healthy diet, be active and stop smoking.

The rate of AMD in the Royal Borough is significantly different from comparators. Residents should be encouraged to have regular sight test with an optometrist.

Older people's sight in the Royal Borough has worsened to the point of requiring registration. CVIs are helpful in improving access to benefits and social service support. The increase in CVIs suggests that more people are at workplace dependent of beyond and having accidents as they cannot see. Sight impairment also contributes to reduced independency, self-care and contributes to falls. Community and voluntary organisations should play a role in supporting vulnerable citizens.

2.2 Falls and mobility (admission [65+] due to falls, hip fracture)

The natural ageing process means that older people are at increased risk of having a fall. Older people are more likely to have a fall if they have balance problems and muscle weakness; poor vision; or a long-term health condition, such as heart disease, dementia or low blood pressure (hypotension), which can lead to dizziness and a brief loss of consciousness. Another common cause of falls, particularly among older men, is falling from a ladder while carrying out home maintenance work.[2]

In England 2,114 per 100,000 people aged 65 and over were admitted to hospital during 2016/17 as a result of a fall. The trend in admissions has remained fairly stable over the past seven years. Admissions are correlated with deprivation with people living in the most deprived areas of the country being more likely to be admitted to hospital as a result of a fall and people living in the least deprived areas of the country being less likely to be admitted to hospital as the result of a fall.

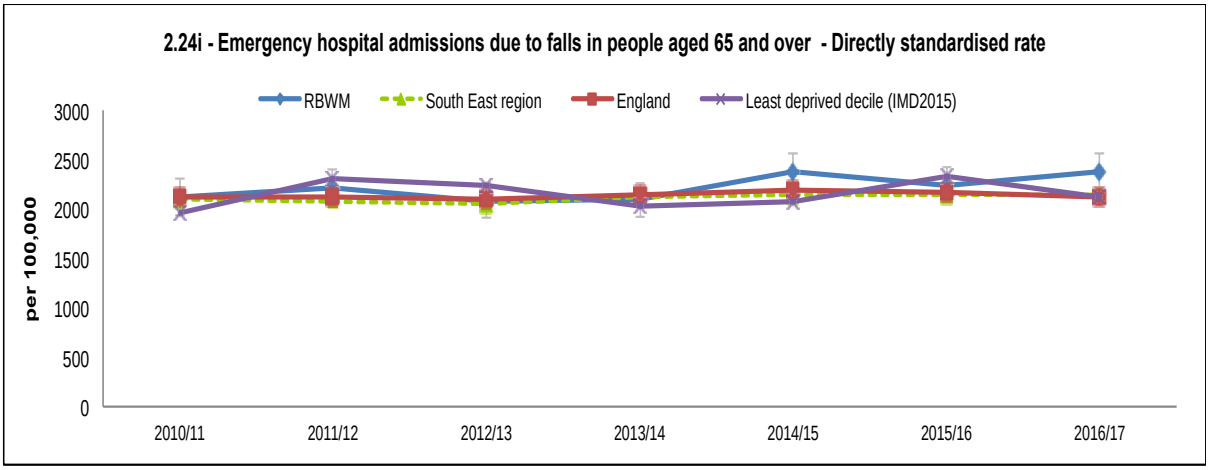
Falls are more likely to occur in older age groups with rates of admission rising from 993 per 100,000 people in the 65 to 79 year age group up to 5,363 per 100,000 people in the 80 years and older age group. Females are significantly more likely than males to be admitted as a result of a fall with 2,396 per 100,000 females aged 65 and over admitted compared to 1,715 males per 100,000. However, rates of males falling are showing more of an increasing trend compared to a decreasing trend in females.

In England, 575 per 100,000 people aged 65 and over were admitted to hospital during 2016/17 with a hip fracture. The trend in admissions has decreased slightly over the past couple of years from 614 per 100,000 in 2013/14. Similarly to falls admissions, admissions for hip fractures are correlated with deprivation with people living in the most deprived areas of the country being more likely to suffer a hip fracture and people living in the least deprived areas of the country being less likely to suffer a hip fracture.

Hip fractures are significantly more likely in older age groups with rates of admission rising from 241 per 100,000 people in the 65 to 79 year age group up to 1,545 per 100,000 people in the 80 years and older age group. Females are significantly more likely than males to be admitted as a result of a hip fracture with 693 per 100,000 females aged 65 and over admitted compared to 408 males per 100,000.

[2] *Falls: overview - NHS Choices.*

Figure 7: Directly-standardised rate of emergency hospital admission due to falls in people aged 65 and over in the Royal Borough, compared with the South East region, England and the least deprived decile comparator groups (IMD 2015) between 2010/11 and 2016/17

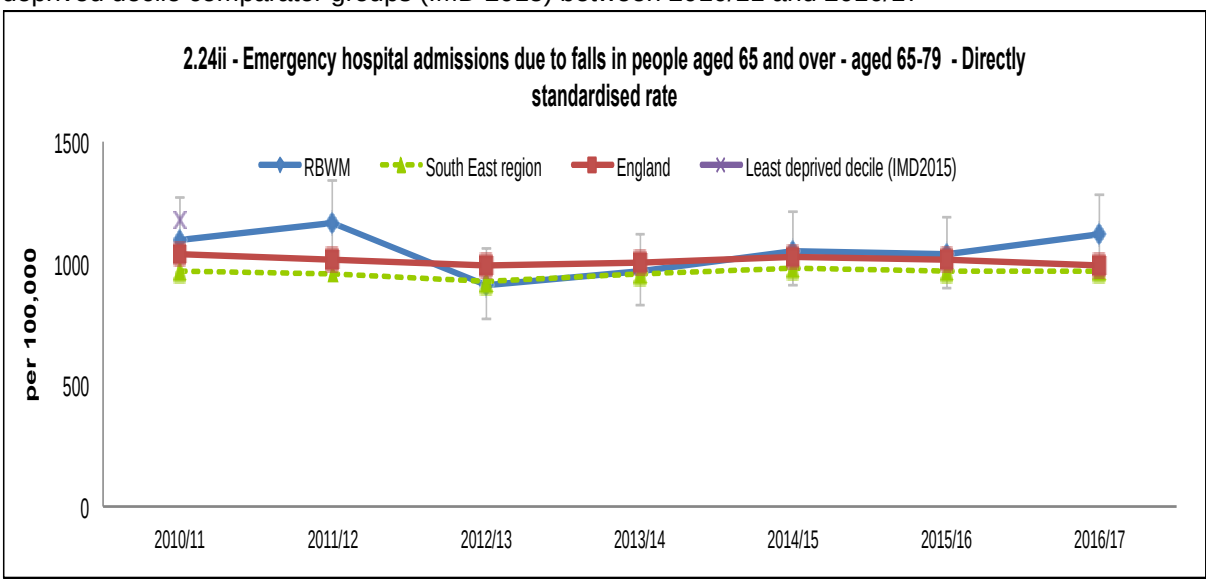


Data source: Public Health England (2018); Public Health Outcomes Framework

The total number of emergency hospital admissions for falls amongst people aged 65 and over in the Royal Borough for 2016/17 was 701. This is a standardised rate of 2390 per 100,000. This is worse than the rate of admissions in the South East region (2134.6 per 100,000) and the England average (2113.8 per 100,000).

Females from the Royal Borough are more likely to be admitted at a rate of 2725 per 100,000 compared to a rate of 1915 for males. This is a significant difference.

Figure 8: Directly-standardised rate of emergency hospital admission due to falls in people aged 65-79 years old in the Royal Borough, compared with the South East region, England and the least deprived decile comparator groups (IMD 2015) between 2010/11 and 2016/17

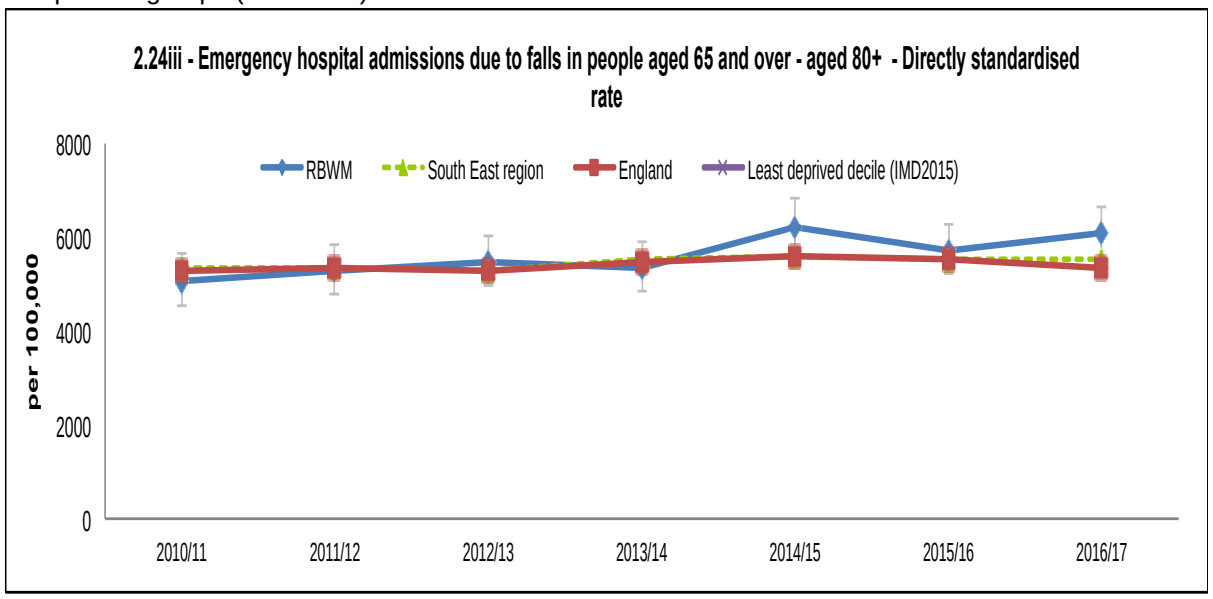


Data source: Public Health England (2018); Public Health Outcomes Framework

The total number of emergency hospital admissions for falls amongst people aged 65-79 years old in the Royal Borough for 2016/17 was 210. This is a standardised

rate of 1117.3 per 100,000. This is worse than the rate of admissions in the South East region (969.0 per 100,000) and the England average (993.3 per 100,000).

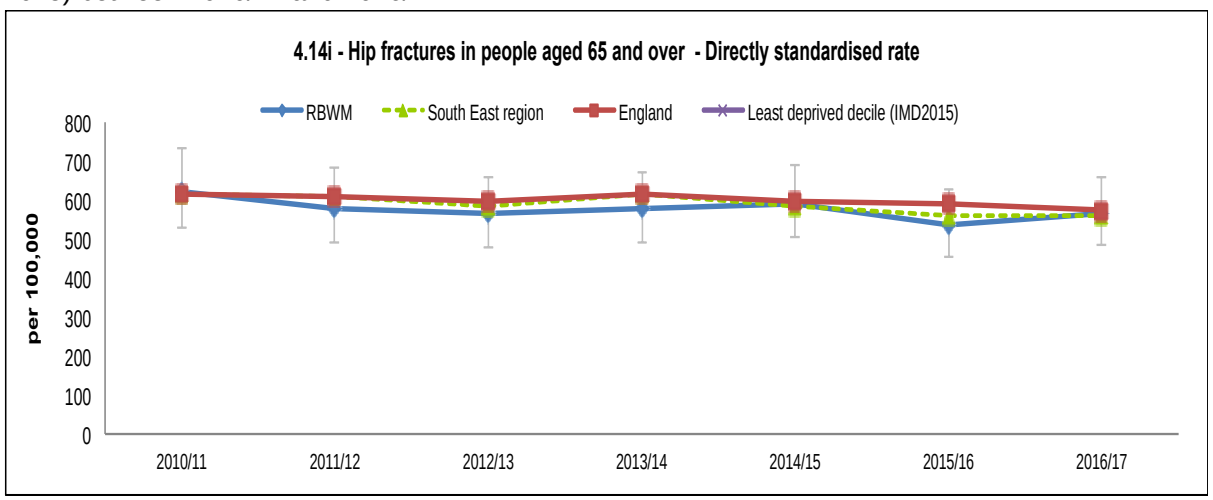
Figure 9: Directly-standardised rate of emergency hospital admission due to falls in people aged 80+ in the Royal Borough, compared with the South East region, England and the least deprived decile comparator groups (IMD 2015) between 2010/11 and 2016/17



Data source: Public Health England (2018); Public Health Outcomes Framework

People aged 80+ from the Royal Borough likely to be admitted at a rate of 6080.2 per 100,000 compared to a rate of 5514.8 per 100,000 in the South East region, and 5363.2 per 100,000 in England. The total number of emergency hospital admissions for falls amongst people aged 80+ in the Royal Borough for 2016/17 was 491.

Figure 10: Directly-standardised rate of hip fracture in people aged 65 and over in the Royal Borough, compared with the South East region, England and the least deprived decile comparator groups (IMD 2015) between 2010/11 and 2016/17

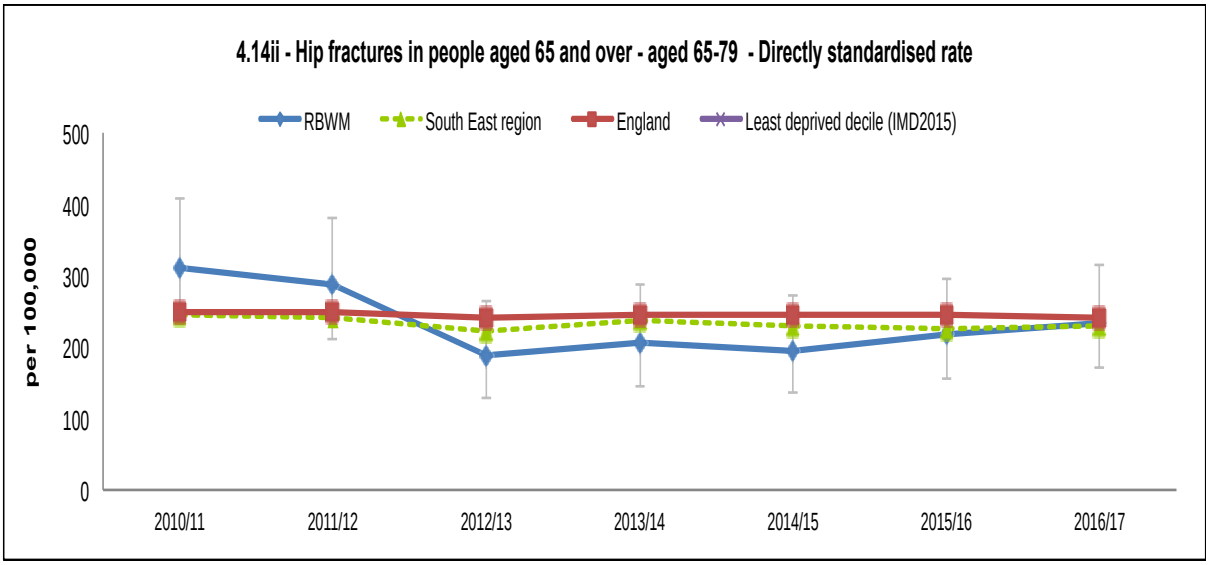


Data source: Public Health England (2018); Public Health Outcomes Framework

The total number of emergency hospital admissions for hip fracture amongst people aged 65 and over in the Royal Borough for 2016/17 was 168. This is a standardised rate of 568 per 100,000. This is similar to the rate of admissions in the South East region (560.4 per 100,000) and the England average (575.0 per 100,000).

Females from the Royal Borough are more likely to be admitted at a rate of 703 per 100,000 compared to a rate of 372 for males. This is a significant difference.

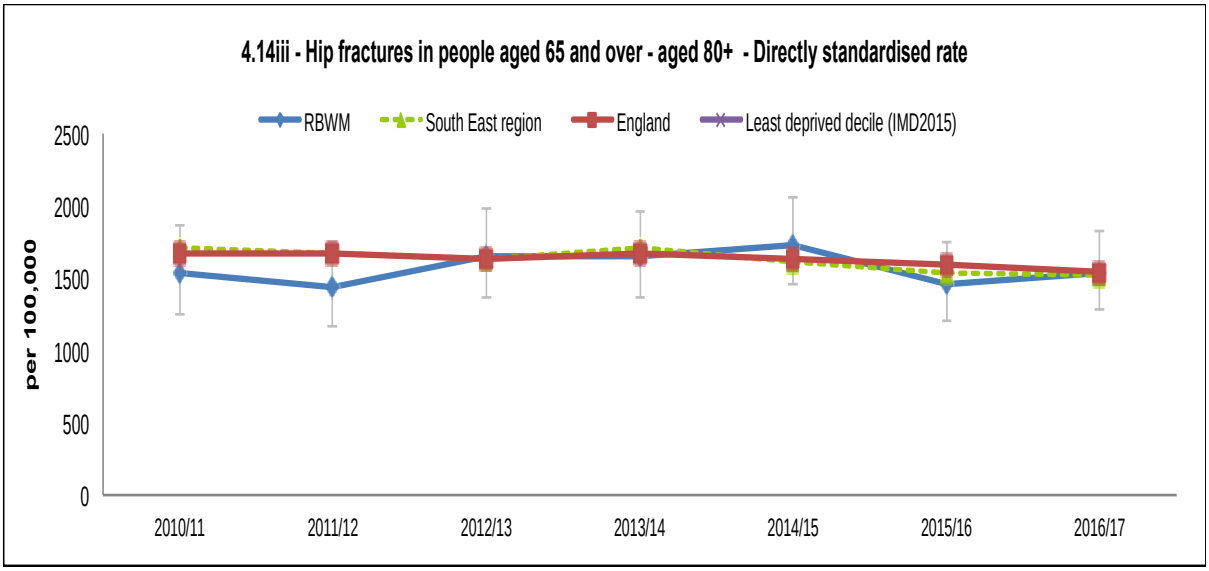
Figure 11: Directly-standardised rate of hip fracture in people aged 65-79 years in the Royal Borough, compared with the South East region, England and the least deprived decile comparator groups (IMD 2015) between 2010/11 and 2016/17



Data source: Public Health England (2018); Public Health Outcomes Framework

The total number of emergency hospital admissions for hip fracture amongst people aged 65-79 years old in the Royal Borough for 2016/17 was 44. This is a standardised rate of 234.6 per 100,000. This is worse than the rate of admissions in the South East region (228.7 per 100,000) and the England average (240.6 per 100,000).

Figure 12: Directly-standardised rate of hip fracture in people aged 80+ in the Royal Borough, compared with the South East region, England and the least deprived decile comparator groups (IMD 2015) between 2010/11 and 2016/17



Data source: Public Health England (2018); Public Health Outcomes Framework

People aged 80+ from the Royal Borough likely to be admitted at a rate of 1533.5 per 100,000 compared to a rate of 1522.3 per 100,000 in the South East region, and 1544.5 per 100,000 in England. The total number of emergency hospital admissions for falls amongst people aged 80+ in the Royal Borough for 2016/17 was 124.

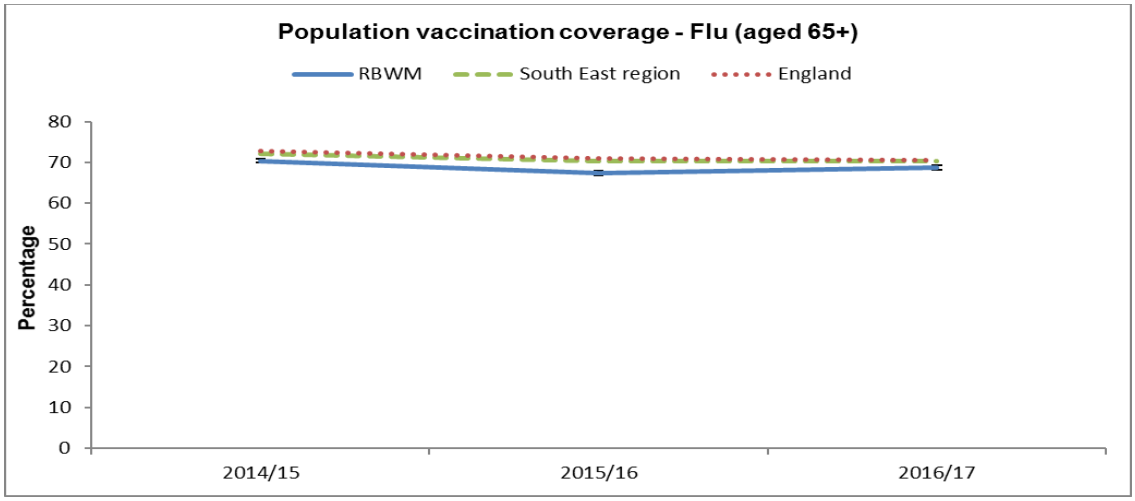
3. Protective interventions for health

3.1 Flu

Influenza, usually called flu, is a condition which can result in serious complications, such as hospitalisation, disability and death, for older people, infants, pregnant women and people with certain long term conditions. Flu vaccination remains the best way to protect people from flu. The aims of the immunisation programme in 2016-17 were to:

- Offer flu vaccine to 100% of people in eligible groups (children, people in clinical risk groups, pregnant women, people aged 65 and over, carers, frontline health and social care workers)
- Vaccination of at least 75% of those aged 65 years and over
- Vaccination of at least 75% of healthcare workers with direct patient contact
- Immunise at least 55% in all of the clinical risk groups, and maintain higher rates where those have already been achieved
- Immunise 40-65% of children (aged two, three and four and school years one to three) with consistent uptake across all localities and sectors of the population with a minimum 40% uptake in each school.

Figure 13: Percentage of people aged 65 years and above who have received a dose of flu vaccination within the Royal Borough, compared with the South East region and England between 2014/15 and 2016/17



Data source: Health Protection – Public Health Profiles

About 68.7% of people aged 65 and over in the Royal Borough of Windsor and Maidenhead received a flu vaccination in the 2016/17 flu season. This was significantly worse than the England value of 70.5% and the South East region of 70.2%.

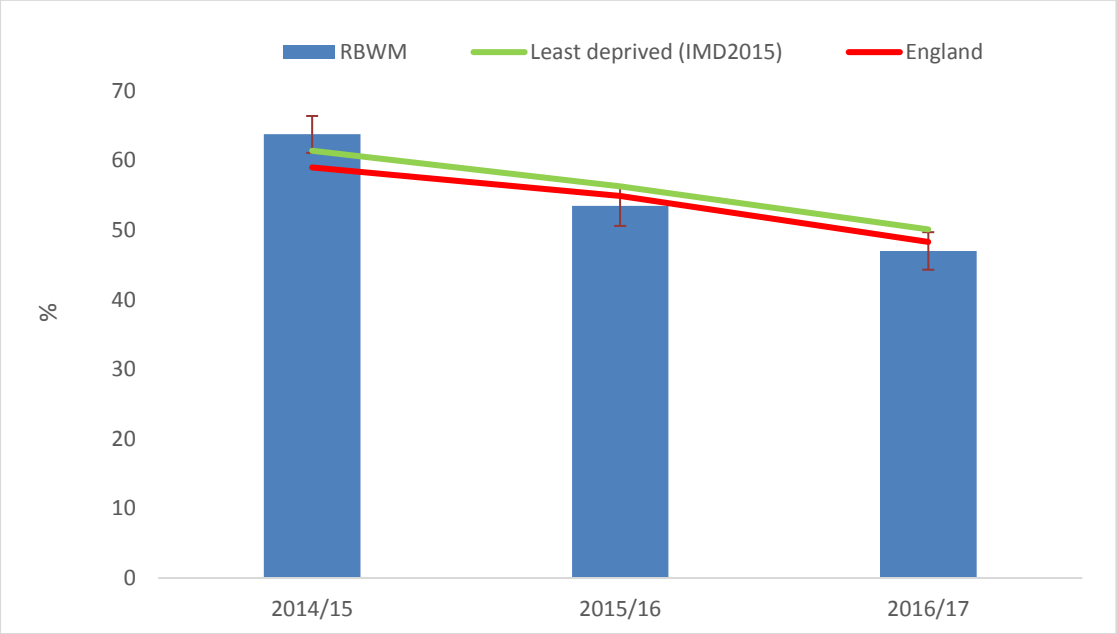
3.2 Shingles

In 2010, the UK's Joint Committee on Vaccination and Immunisation (JCVI) recommended that a herpes zoster (shingles) vaccination programme should be introduced for adults aged 70 years, with a catch up programme for those aged 71 to 79 years.

Shingles typically presents with a unilateral vesicular rash, usually limited to a single dermatome. The diagnosis is almost exclusively made on clinical suspicion with very few cases being laboratory confirmed. Shingles is caused by the reactivation of a latent varicella zoster virus (VZV) infection, following a decline in cell mediated immunity and the incidence of disease is known to increase with age. The purpose of the vaccination programme is to reduce the incidence and severity of shingles in those targeted by the programme by boosting individuals' pre-existing VZV immunity.[3]

[3] *Health Protection – Public Health Profiles*

Figure 14: Percentage of people aged 70 years who have received a dose of shingles vaccine within the Royal Borough, compared with the least deprived decile comparator group and England between 2014/15 and 2016/17



Data source: Health Protection – Public Health Profiles

In the Royal Borough, the number of people aged 70 who have received a dose of shingles vaccine has been declining, from 63.8% in 2014/15 to 47.0% in 2016/17. In 2016/17, the coverage of shingles vaccine in people aged 70 in the Royal Borough was 47%. This was lower than the least deprived decile comparator group (50.4%) and was similar to the England (48.3%) average.

3.3 What does this mean for the Royal Borough?

Immunisation services are commissioned by NHS England. It is recommended that NHS England works with East Berks, Public Health England and CCG to develop a local immunisation plan in partnership with Public Health team in the Royal Borough.

The action plan should aim to: gain a more granular understanding of practice-level variation and of demand and supply barriers to vaccination uptake; develop processes and interventions to support practices and local residents in order to improve uptake in the locality; with a view to rolling out successful outcomes to other parts of Berkshire and potentially beyond.

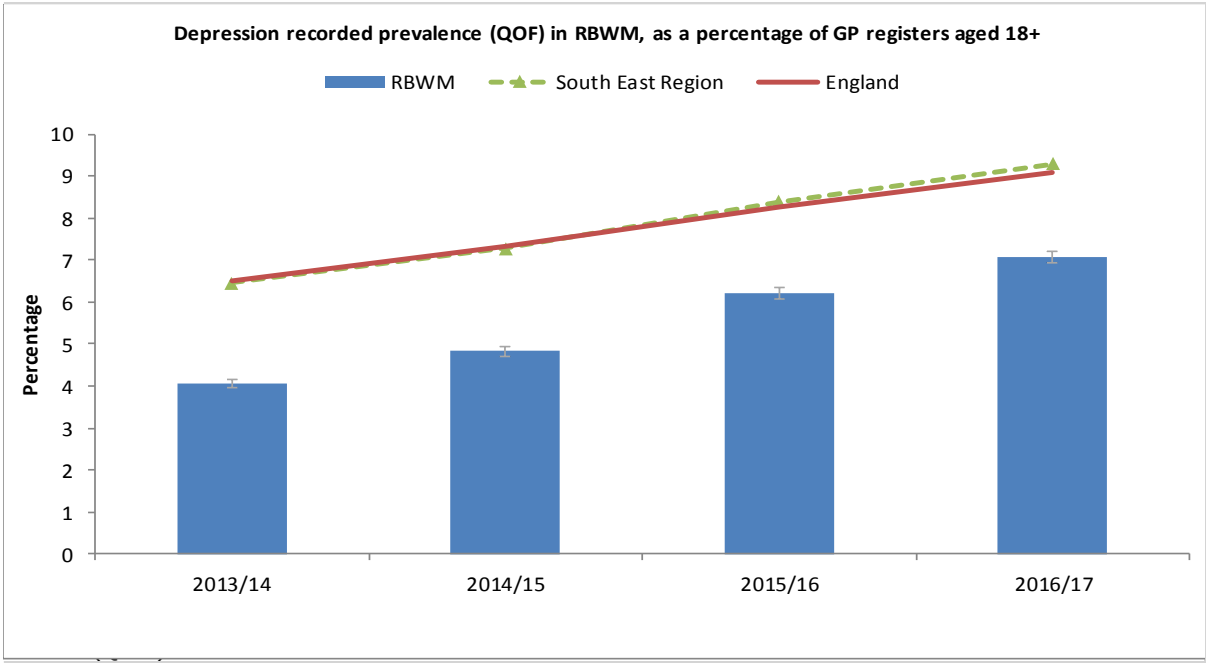
4. Long-term conditions

4.1 Mental illness

Mental illness encompasses a range of conditions such as depression, anxiety, psychoses and schizophrenia. Risk factors for the development of mental illness are

multifactorial. Risk factors for mental illness include physical illness, stress and alcohol and substance misuse are important risk factors.[4]

Figure 15: Percentage of adults aged 18+ registered as having depression in the Royal Borough, compared to England and the South East region, 2013/14 to 2016/17



Data source: Common Mental Health Disorders – Public Health Profiles

The prevalence of depression in people aged 18 years and over in the Royal Borough has almost doubled over the past 4 years, from 3.8% in 2013/14 to 7.1% in 2016/17.[5] The prevalence is lower in the Royal Borough than in England (9.1%) and the South East region of 8.8% in 2016/17.

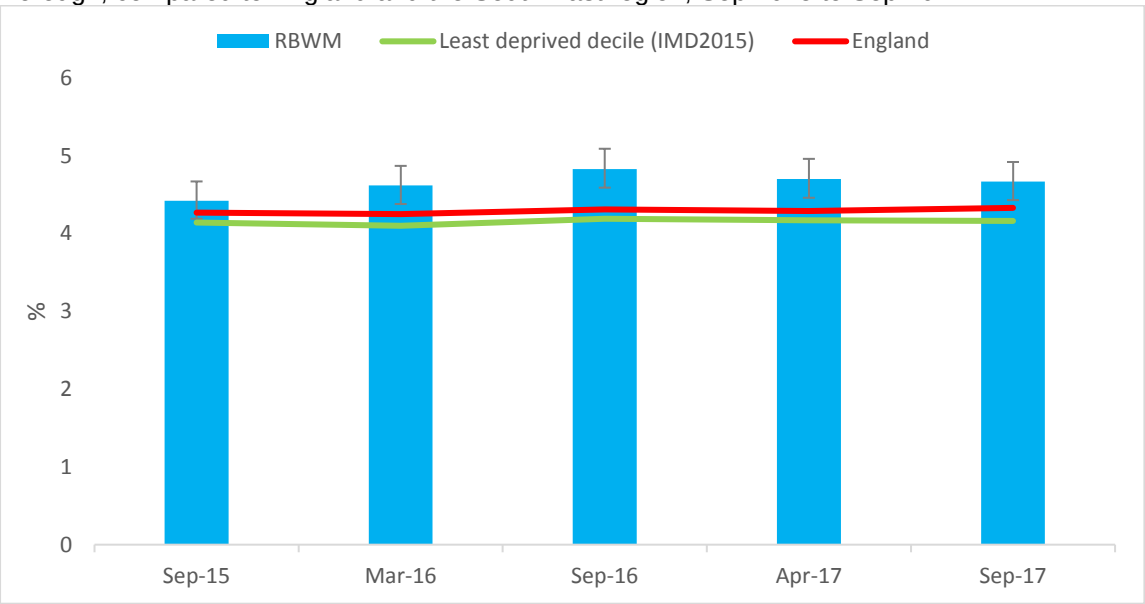
[4] *Improving the physical health of people with mental health problems: Actions for mental health nurses. Department for Health, Public Health England and NHS England, 2016.* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/532253/JRA_Physical_Health_revised.pdf*

[5] *Common Mental Health Disorders, Public Health Profile.* *https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders*

4.2 Dementia

Dementia is a clinical syndrome of deterioration in mental function which interferes with activities of daily living (ADLs). It affects more than one cognitive domain (for example memory, language, orientation, or judgement) and social behaviour (for example, emotional control or motivation). Early (or young) onset dementia is generally defined as dementia that develops before 65 years of age. Modification of specific risk factors (in particular, cardiovascular risk factors such as smoking, diabetes and lack of physical activity) can delay or prevent the onset of dementia.[6]

Figure 16: Percentage of patients aged 65+ with a recorded diagnosis of dementia in the Royal Borough, compared to England and the South East region, Sep 2015 to Sep 2017



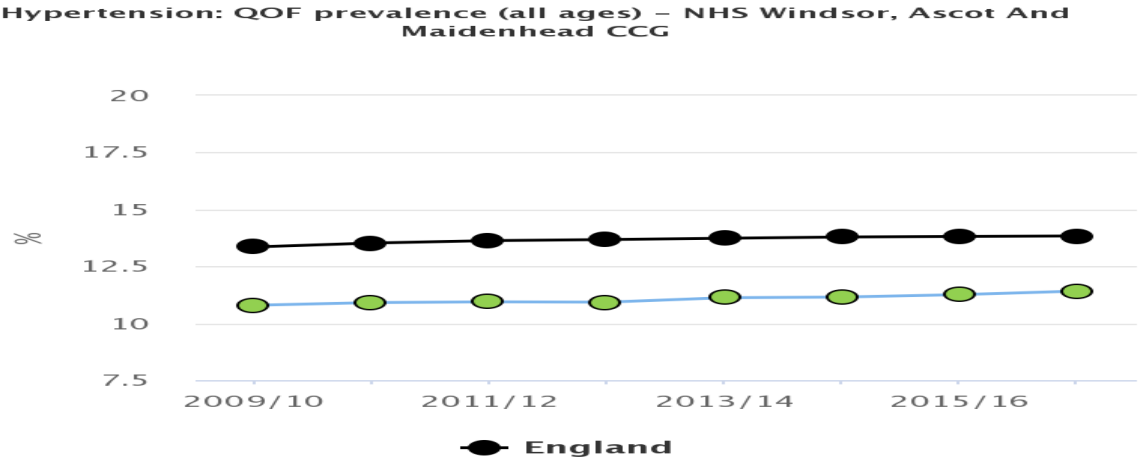
Data source: Dementia Profile – Public Health Profiles

In the Royal Borough, the prevalence of dementia is 4.7% in people aged 65 and above in 2017. It is higher than the England average of 4.33% and the deprivation decile comparator group's (IMD 2015) of 4.16%. However, according to Projecting Older People Population Information System (POPPI)[7], the prevalence of dementia is 7.5% in people aged 65 and over in the Royal Borough (2017).

[6] *Dementia: Summary. Clinical Knowledge Summaries, NICE.* https://cks.nice.org.uk/dementia#!topicsummary
[7] http://www.poppi.org.uk/

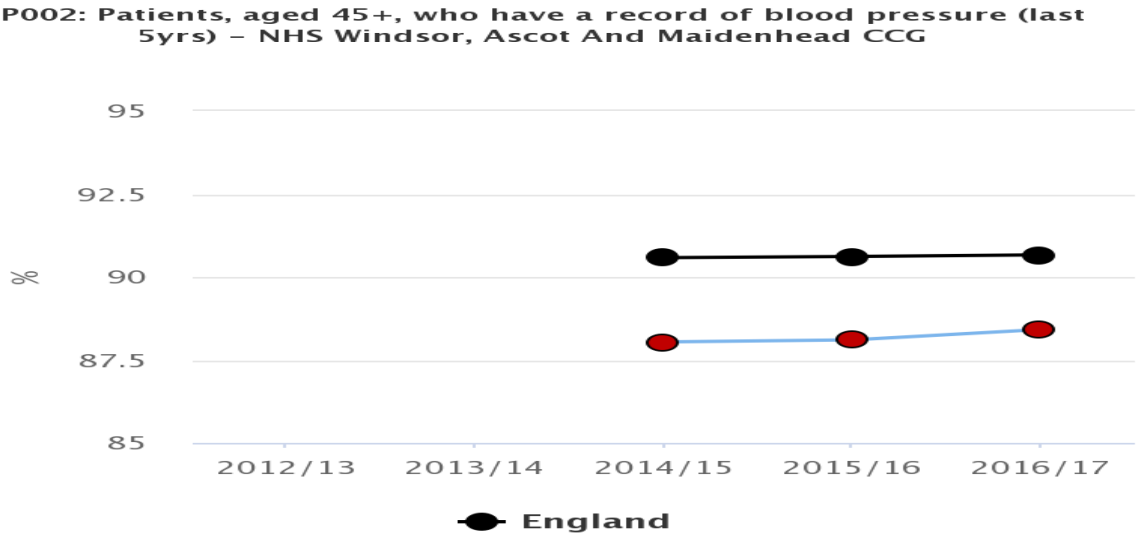
4.3 Hypertension

Figure 17: Percentage of patients of all ages with established hypertension in the Royal Borough, compared to England, 2009/10 to 2016/17



Data source: Hypertension Profile – Public Health Profiles

Figure 18: The percentage of patients aged 45 or over, who have a record of a blood pressure in the preceding 5 years in the Royal Borough, compared to England, 2014/15 to 2016/17



Data source: Hypertension Profile – Public Health Profiles

In 2016/17, the prevalence of patients with hypertension in the Royal Borough was 11.4%. This was better than the England average. However, the increasing trend should be noted. Additionally, the percentage of patients aged 45 or over with hypertension in the Royal Borough was 88.4%. This was worse than the England average of 90.7%.

4.4 Cancer

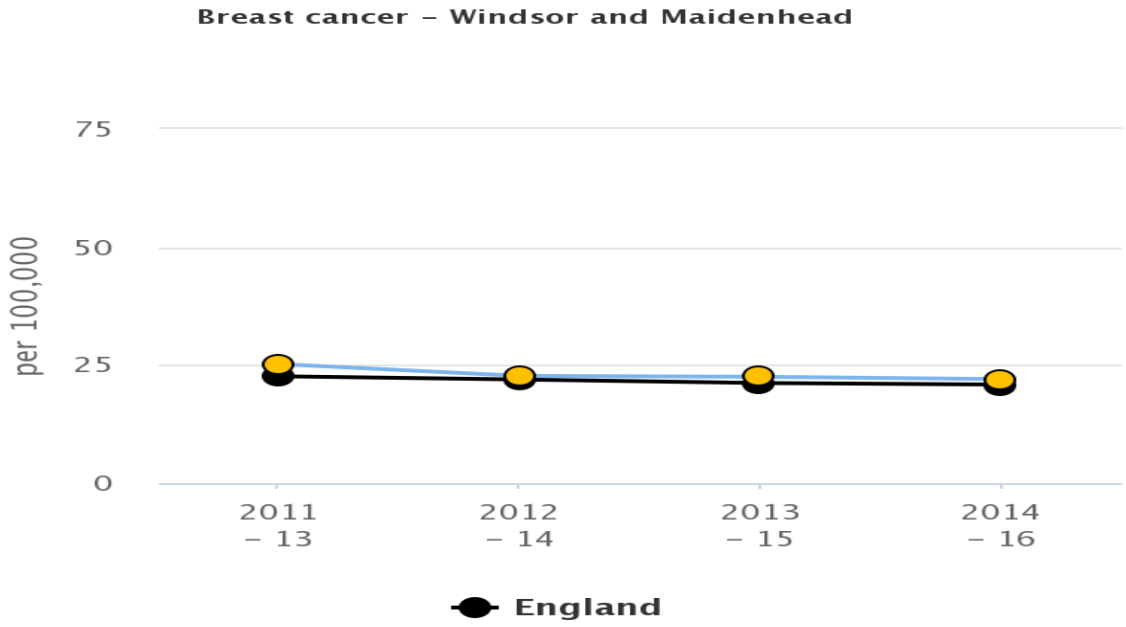
In 2016, 28% of all registered deaths in England were caused by cancer, which was the leading broad cause of death. The percentage was higher for men at 31%, compared to 26% for women. 40% of premature deaths (people aged under 75) were caused by cancer. Of this figure, 45% can be attributed to women and 36% to men.[8]

The rate of premature mortality from breast cancer locally is worse than both the England and comparator Local Authorities (based on deprivation scores).

4.4.1 Breast cancer deaths

Breast cancer is the 4th most common cause of cancer death in the UK, accounting for 7% of all cancer deaths (2016).[9,10,11] Breast cancer mortality is strongly related to age, with the highest mortality rates being in older people. Nationally, age-specific mortality rates rise steadily from around aged 30-34 years and more steeply from around aged 70-74 years.

Figure 19: Age-standardised rate of mortality from breast cancer in females less than 75 years of age per 100,000 population in the Royal Borough, compared to England between 2011-13 and 2014-16



Data source: Public Health England (2018); Public Health Profiles

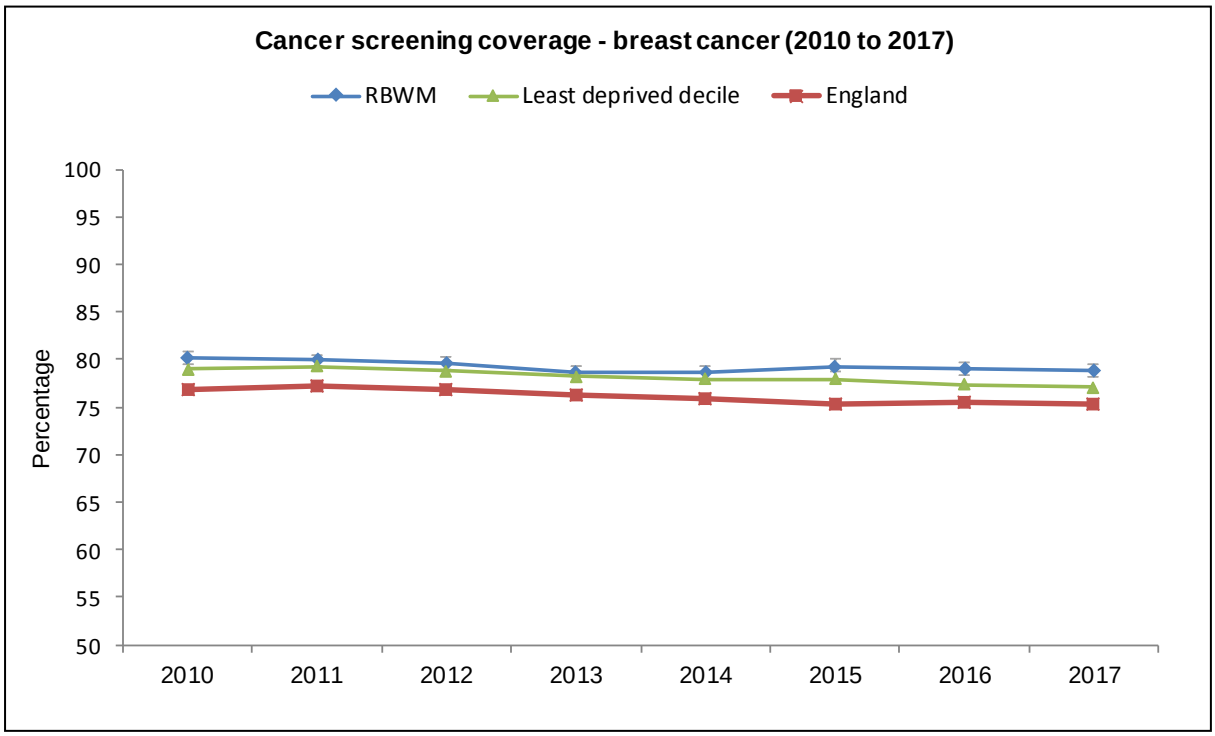
[8] *Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables*
[9] *Office for National Statistics, October 2017*
http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths
[10] *The Information Service Division, National Service Scotland, October 2017*
http://www.isdscotland.org/Health-Topics/Cancer/Publications/index.asp
[11] *Northern Ireland Cancer Registry, December 2017 http://www.qub.ac.uk/research-centres/nicr/*

In 2014-16, the under 75 mortality rate for breast cancer was 22 per 100,000 people in the Royal Borough. This was worse than the England average of 20.9 per 100,000 population. The total number of premature deaths from breast cancer in 2014-16 was 43 in the Royal Borough.

4.4.2 Breast cancer screening

As of 31st March 2017, the coverage for breast cancer screening for women aged 53-70 in England was 75.4%, compared with 75.5% at the same point in 2016. Coverage has remained largely static in the last 3 reporting years and remains above the NHS Cancer Screening Programmes' minimum standard of 70%. In total, about 2.2 million women aged 45 and over were screened within the programme in 2016-17. This compares with 2.16 million in 2015-16 which represents an increase of 1.8%.

Figure 20: Cancer screening coverage – breast cancer in the Royal Borough, compared to England and the least deprived decile (IMD 2015) between 2010 and 2017



Data source: Public Health England (2018); Public Health Outcomes Framework

As of 31st March 2017, the breast cancer screening coverage for eligible women in the Royal Borough was 79.0%. This was better than the England figure of 75.5% and the comparator group's figure of 77.4%. The Royal Borough's coverage level met the minimum standard of 70%, but did not reach the national target of 80%.

4.4.3 What does this mean for the Royal Borough?

Further analysis is required to understand what is driving the high number of deaths from breast cancer. It is hypothesised that these could be a result of late presentation, cultural beliefs and lack of awareness.

A local action plan which aims to build on uptake of breast cancer screening within the Royal Borough should be developed involving Public Health England, East Berkshire CCG and NHS England. A Primary Care Immunisation Tool Kit has been developed by NHS England for GP practices. GPs should be encouraged to use this.

It is recommended that the system identifies clinical and Public Health Consultant leads for cancer and dementia.

Providers (Optalis) should consider auditing their service against NICE guidelines, starting from NG16, as part of ongoing quality assurance.

Support should continue for improving breast cancer screening coverage.

The number of people aged 65 and over with dementia in the Royal Borough is projected to increase from 2,059 in 2017 to 3,620 in 2035.[12] The cost of dementia in the UK is expected to more than double in the next 25 years, from £26bn to £55bn in 2040.[13] This will have implications to the Royal Borough's future dementia costs.

It is likely that dementia prevalence will continue to increase in the Royal Borough, in line with its ageing population, and active local case finding. Cost implications are likely to affect both LAs and CCGs. Stakeholders across the system should consider embedding prevention into the older people's health agenda. Considerations should be given to preventing /delaying onset of dementia and diabetes through the following evidence-based approaches:

- Healthy eating
- Hypertension management
- Smoking cessation
- Weight management

Primary care and local public health should consider opportunities to deliver innovative health check initiatives.

[12] *Projecting Older People Population Information System (POPPI)*

[13] *Prince, M et al (2014) Dementia UK: Update Second Edition report produced by King's College London and the London School of Economics for the Alzheimer's Society*

5. Stakeholder consultation

On September 25th, a stakeholder event was held to understand the views of local residents with respect to local assets and need. Over 80% of stakeholders agreed that the priorities for Ageing Well should be falls, dementia, immunisations, age-related macular degeneration, and cancer.

This was also echoed by findings from a recent voluntary stakeholder survey completed in September 2018, which demonstrated a 94% agreement with current priorities.

The underpinning themes from all stakeholder conversation was the need to embed prevention across the life course and implement “enablers” to make this happen. Enablers included, accessibility to services, integration and community action.

Appendix 1: Ageing Well Action Plan (DRAFT)

Ageing Well Action Plan (DRAFT)

JHWBS aims	Theme	Action required	Owner	Timescales	Outcome
Prevention and early intervention.	Empower people to engage in self-care	Promote the uptake Telecare and Assistive technology	Michaela Helman	Sept to April 2019	Have an increased number of people using AT supporting them at home
		Develop falls pathway to support residents	Jesal Dhokia	July – Sept 2018	More integrated approach to preventing falls
		Increase the number of organisations that are dementia friendly	Dementia Action Alliance – Paula King, supported by Dawn Cannon	March 2019	Increase of number of dementia friendly organisations
		Promote Fire Safety Checks	Martin Simmonds – RBFS	March 2019	Number of fire safety checks within the home
		Ensuring older residents are empowered	Andy – TVP Julie Willis	March 2019	Number of awareness sessions across RBWM
Supporting a healthy population.	Residents remain active and live independently for longer	Engaging older people in exercise programmes and physical activity	Helen Preedy/ Sarah Hill	End March 2019	Increased number of older residents taking up physical activity
		Make Every Contact Count (MECC) concept.	Training for staff commissioned services and front facing services.		Cross reference and Teresa if this is possible

JHWBS aims	Theme	Action required	Owner	Timescales	Outcome
Enable residents to maximise capabilities and life chances.	Support residents with LTC/frailty to access a wide range of services	To ensure that residents are connected with the right health services and voluntary sector support services	ICS frailty lead	March 2019	Number of referrals to the frailty team within Frimley - Staff are aware of specialist and frailty services
	Support older carers to manage caring responsibilities Create a hospital self-help booklet for carers	Increase support groups across RBWM	Sharon Bowden Sharon Bowden /Dawn Cannon	March 2019	Carers community who feel more supported. Increased number of carers groups and completed self-help booklet
Overarching theme 2018 – Loneliness & Isolation.	Mapping.	Digital resources available and used by residents across the Borough	Jesal Dhokia	March 2019	Digital database
		Add social prescribers			
	Increase funding across VCS to support older residents	Big Lottery fund applied to	OCE	Oct 2018	Number of groups
	WAM GI	Events and activities Calendar	WAM GI	Ongoing	Number people using this google analytics
	Encourage participation in social and community activities	Social Prescribing team and adult social care, ABCD	Hayley Edwards / Pauline	March 2019	Increased referrals to social prescribers and stronger connections with the community

Document Name	Ageing Well in the Royal Borough of Windsor and Maidenhead – Exploring Older People's Health		
Document Author	Teresa Salami-Oru, Consultant in Public Health/ Head of Public Health Lin Guo, Public Health Specialist		
Document owner	Hilary Hall, Deputy Director Strategy & Commissioning		
Accessibility	This document can be made available in other formats upon request.		
Destruction date	N/A		
Document approval dates	Version 1		
	Version 2		
Circulation restrictions			
Review date	November 2019		

Subject:	Defining the Royal Borough of Windsor and Maidenhead as Place within the Integrated Care System
Reason for report:	To present some principles for defining the Royal Borough of Windsor and Maidenhead as Place and to agree the implications for current structures and representation.
Responsible officer and senior leader sponsor:	Hilary Hall, Interim Director of Adult Services and Deputy Director Strategy and Commissioning
Date:	2 July 2019

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Royal Borough of Windsor & Maidenhead

SUMMARY

The Royal Borough of Windsor and Maidenhead is located within the Frimley Integrated Health and Care System which is recognised as a national exemplar. The NHS Long Term Plan, published in January 2019, identifies Integrated Care Systems as central to the delivery of integrated primary and specialist care, physical and mental health and health and social care. Given the breadth of the Integrated Care System (ICS), the importance of 'place' as a driver for responding to local needs and improving population health is crucial. The Royal Borough is defined as "place" within the ICS which has implications for the current role of the Health and Wellbeing Board and its future direction. Principles and suggestions are set out in the papers for the Board to explore.

1 BACKGROUND

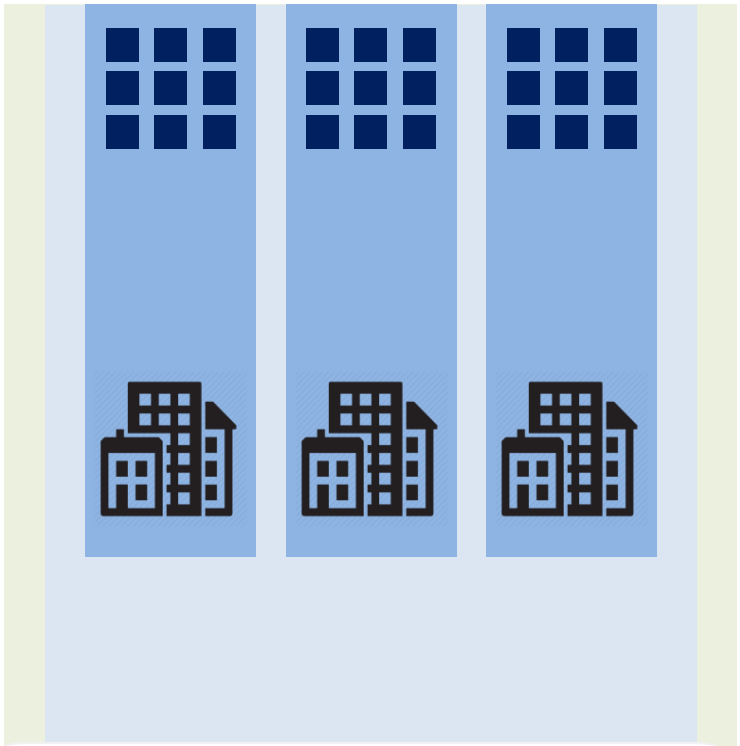
1.1 The Royal Borough of Windsor and Maidenhead is located within the Frimley Integrated Health and Care System which is recognised as a national exemplar. The Integrated Care System (ICS) covers East Berkshire, North East Hampshire and Farnham and Surrey Heath, a total population of just under 800,000.

1.2 The NHS Long Term Plan, published in January 2019, identifies Integrated Care Systems as central to the delivery of integrated primary and specialist care, physical and mental health and health and social care. Integration in order to respond appropriately to need is required at different levels – there will be services/interventions that can best be delivered at a system wide level and there will equally be services/interventions that are better delivered at local area level.

1.3 Given the breadth of the ICS, the importance of 'place' as a driver for responding to local needs and improving population health is crucial. The Royal Borough is defined as "place" within the ICS which has implications for the current role of the Health and Wellbeing Board and its future direction.

1.4 It is recognised that the ICS operates at a number of levels, see figure 1. By Place, the expectation is that it means where local authority boundaries fall within the system - Slough, Bracknell Forest, Surrey, Windsor and Maidenhead, Hampshire – and by Neighbourhood, it means the Primary Care Networks. Clearly some elements do not fit neatly and there will need to be flexibility as the model evolves.

Figure 1: ICS operational levels



Each level performs specific functions under the following common headings:

Leadership and workforce
Strategy and planning
Population health management and care redesign
Performance and improvement
Managing collective resources

Key Level	Pop. Size	Purpose
Person	**1**	• People are able to lead and plan their own health and wellbeing, managing their own resources, with appropriate information
Neighbourhood	**~50k**	• Strengthen primary care • Network practices and other out of hospital services • Proactive & integrated models for defined population
Place	**~250k**	• Typically borough/council level • Integrate hospital, council and primary care teams/services • Develop new provider models for 'anticipatory' care
System	**~1m**	• System strategy and planning • Develop accountability arrangements across system • Implement strategic change and transformation at scale • Manage performance and budget
Region	**5-10m**	• Agree system 'mandate' • Hold systems to account • System development • Intervention and improvement

2 KEY IMPLICATIONS

2.1. The evolution of the ICS and the Royal Borough's role within it provides an opportunity to:

- Use the Joint Strategic Needs Assessment (see elsewhere on the agenda) to refine the existing Joint Health and Wellbeing Strategy, in line with the emerging Five Year Strategy for the ICS (see elsewhere on the agenda).

- Review the membership of the Health and Wellbeing Board in order to broaden it to respond to, and plan for, "place" in its widest sense and the wider determinants of health.

- Confirm the supporting governance structure beneath the Health and Wellbeing Board.

- Provide a consistent response to system issues at all levels, based on a clear understanding of the impact on the residents of the Royal Borough.

- Develop a dashboard of performance reporting that demonstrates the effectiveness of the partnership in developing and implementing an integrated response to need and reducing health inequalities in the borough.

3 DETAILS

Joint Health and Wellbeing Strategy

3.1 The current four-year Joint Health and Wellbeing Strategy was approved and published in April 2016. It identified three theme areas and within that, 12 priorities. As a result, the scope of the Strategy is very broad and it has not always been easy to identify the difference made to residents as a result of its implementation.

3.2 In the light of the refreshed Joint Strategic Needs Assessment and the emerging analytics developed to support the ICS Five Year Strategy, it would be timely and appropriate to update the Strategy for the next four years. The focus would be on a more targeted Strategy where the Board could be assured that actions being delivered were having an impact on key areas of need.

Health and Wellbeing Board

3.3 The Health and Wellbeing Board became a formal committee of the Royal Borough in April 2013 as part of the Health and Social Care Act 2012. Unlike other panels/boards of the council, it is not subject to political balance under regulation 7 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The current agreed terms of reference are at appendix 1 to this report.

3.4 The role of the Board is to:

- Implement the national and local requirements on Health and Wellbeing Boards to improve the life outcomes, health and wellbeing of residents in the Borough.
- Act as a high level strategic partnership to agree the priorities that will improve the health and wellbeing of the residents of the Royal Borough of Windsor and Maidenhead.
- Deliver the statutory functions placed on Health and Wellbeing Boards through the Health and Social Care Act 2012 and other statutory or local priorities.

3.5 The current membership of the Board is set out in the terms of reference and is predominantly representative of health and social care. Whilst that is essential, the Board equally recognises the importance of the wider determinants of health, specifically the natural and built environment. It is proposed that, as a minimum, representation from that

part of the council is included on the Board to provide a wider perspective and input to addressing the health and wellbeing priorities of the borough.

3.6 The Health and Wellbeing Board feeds into the ICS in a number of ways. The Chair of the Health and Wellbeing Board is a member of the Health and Wellbeing Alliance which is an important avenue for elected Member input to the ICS development. Other members of the Board are members of the ICS Board, including the CCG Accountable Officer and the Interim Director of Adult Services, and members of other sub boards of the ICS, including the Director of Children's Services on the Children's Joint Commissioning Board.

Supporting governance structure

3.7 Reporting to the Health and Wellbeing Board currently are the three life course sub groups – Developing Well, Living Well and Ageing Well – and the Better Care Fund Board. All four sub groups are focused on delivery and there has been limited strategic partnership focus on shaping the agenda and work of the wider Board.

3.8 A group of senior leaders across adult, children's and public health services, clinical commissioning, community health and primary care has started to meet over the last six months with a focus on helping to shape the strategic direction of health and wellbeing in the borough and support the Health and Wellbeing Board. There is a desire to formalise this Connected Leaders group to provide executive support for the Board and ensure that actions are carried through.

3.9 It is proposed that the three life course sub groups remain and that the Better Care Fund Board broadens its remit to manage local delivery of wider integration/ICS projects, including the integrated care decision making model and falls prevention. At the moment, there is no clarity on the future direction of the Better Care Fund itself but there is a need for a local delivery group around integration projects.

Consistent response

3.10 The changes to the Board and the supporting governance structure outlined above, together with elected Member and senior leader engagement at different levels of the ICS, will enable a more direct line of sight from the ICS through to the Health and Wellbeing Board and its delivery.

3.11 Developing community resilience to support the strengths based approach to assessing need, alongside integration of health and care services, is key to improving population health across the ICS and within the borough. The changes proposed in this report will enable the Board to better direct and monitor that way of working and its evolution.

Performance reporting

3.12 As outlined in point 3.1, the wide ranging nature of the Joint Health and Wellbeing Strategy has led to an equally wide ranging set of performance indicators that have been used to measure its implementation. Some of the data sources have been acknowledged to be out of date, due to the nature of national reporting, and it has not always focused on key areas of need. In addition, the mandated metrics of the Better Care Fund do not form part of this wider performance report and are reported separately at each meeting. This ensures that the Board is fully sighted on performance in these areas more regularly than in others.

3.13 It is proposed that a more outcome focused place report is developed that can be considered at each Board meeting but which will focus on key outcomes where improvement is required. Given the approach of the Board, it is proposed that the report would be structured across the three life course stages – developing well, living well and ageing well. A suggested

format is included at appendix 2 to this report and is intended to show the flow through from demographics into need and then into outcomes, supported by a view of resources across the partnership.

3.14 The Board's initial views on this emerging work would be welcomed.

4 RECOMMENDATIONS

4.1 The Board is asked to note the report and:

- Consider the implications of the Royal Borough of Windsor and Maidenhead as Place within the Integrated Care System.
- Agree to the update of the Joint Health and Wellbeing Strategy with a more targeted focus.
- Propose any amendments to the terms of reference of the Health and Wellbeing Board and agree to a broadening of its membership, making any further suggestions for additional members.
- Endorse the supporting governance structure for the Board.
- Endorse the direction of travel for place reporting and provide feedback on the emerging format.

Appendix 1: Terms of reference – Health and Wellbeing Board

Purpose

- To implement the national and local requirements on Health and Wellbeing Boards to improve the life outcomes, health and wellbeing of residents in the Borough.

- To act as a high level strategic partnership to agree the priorities that will improve the health and wellbeing of the residents of the Royal Borough of Windsor and Maidenhead.

- To deliver the statutory functions placed on Health and Wellbeing Boards through the Health and Social Care Act 2012 and other statutory or local priorities.

Background

Social policy changes from Central Government have changed the requirements for health and social care nationally in order to bring more local democracy into local services. The Health and Social Care Act 2012 brought in the most wide-ranging reforms of the NHS since it was founded in 1948 including significant changes to local governance structures for health and wellbeing, to improve health outcomes for the local population.

Each locality now has a statutory requirement to create a Health and Wellbeing Board, which has specific functions for the associated area. The Board is hosted by the local authority and the Health and Social Care Act, and accompanying regulations, have detailed the requirements and functions of a Health and Wellbeing Board.

Requirements of Health and Wellbeing Boards

1. Assess the needs of the local population and lead the statutory Joint Strategic Needs Assessment (JSNA).

2. Prepare a Joint Health and Wellbeing Strategy based on the needs identified in the JSNA.

3. Oversee the delivery of the Better Care Fund.

4. Promote integration and partnership, including joined up commissioning plans across the NHS, social care and public health.

5. Support joint commissioning and pooled budgets where all parties agree it makes sense.

6. Offer strategic and organisational leadership to meet local priorities.

Accountability

The Board is locally accountable to the community it services and elected members through the Royal Borough's Cabinet. Royal Borough of Windsor and Maidenhead Constitution Part 6 Part 6 - 23

Reporting Structures

Any deviation from these terms of reference will be agreed by the statutory partners of the Board, specifically the Royal Borough, the Berkshire NHS Cluster Board and the Clinical Commissioning Groups' governing bodies.

Review of the Health and Wellbeing Board

The terms of reference and membership will be reviewed annually.

Membership

- Chairman - a Member of the Council nominated by the Leader
- Deputy-Chairman - East Berkshire Clinical Commissioning Group.
- Lead Member(s) with responsibility for Adult and Children's Services.
- Director of Adult Social Services
- Director of Children's Services
- Director of Public Health Berkshire.
- Representative of East Berkshire Clinical Commissioning Group.
- Representative of Windsor and Maidenhead Healthwatch.

Named substitutes will attend meetings of the Board in place of core members as required.

Other partners and stakeholders may be co-opted into temporary or permanent membership to help address the identified strategic priorities as agreed by the Board.

Frequency of Meetings

Four meetings per year. All meetings will be public unless there are confidential (Part II) items as applicable by the Local Government Act 1972.

Quorum

Minimum representation of four members for a meeting to take place with at least two members each from the Council and the NHS.

Relevant outside bodies shall communicate and/or provide the Board with relevant updates and briefings as deemed necessary.

The Chairman will, in consultation with the Board members, identify material and items suitable for recommending as a press release to be issued on behalf of the Council.

Appendix 2: Example format/layout of a place report

	Developing Well *Up to 18 years of age (Transitions….up to 25 years of age)*	**Living Well** *18 to 65 years of age*	**Ageing Well** *65+ years of age*
Demographics ↓			
Identified needs ↓			
Outcomes	**Non elective admissions** **Obesity** **Mental health**	**Non elective admissions** **Physical activity** **Resident satisfaction**	**Delayed transfers of care** **Admissions to care homes** **Non elective admissions** **Reablement**
↑ **Services available**			
	Workforce		
AfC			
Optalis			
RBWM			
GPs			
Police			
BHFT			
Schools			
Hospitals			
Care homes			