- Child protection and safeguarding children are essential components of the service. Safeguarding children, which includes child protection and prevention of harm to babies and children is a public health priority. This will include working collaboratively with other agencies to intervene effectively with families where there are concerns about parenting capacity, adult mental health, alcohol or substance misuse, domestic abuse leading to levels of abuse of children. The service will implement child protection measures when required.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The integration of Public Health Nursing Services for children and young people aged 0-19 (25) will support the Council's Corporate Plan objective to provide the best start in life through education, early help and healthy living.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The remodelling of Reading Children's Centre offer has now been approved at ACE committee on 6th June 2017 following a 90 day public consultation. The approved actions to be implemented from October 2017 are:

- To establish four fully integrated Children's centre hubs with satellite delivery points.
- To fully integrate the Health Visiting Service into the Children's Centre offer to maintain universal contacts with young children.
- To strengthen the partnership with RBH Maternity Community services and support vulnerable pregnant women and unborn children.
- To provide a targeted support offer to young children and their families in the town that ensures key outcomes for young children and their families are met.
- To build on the partnerships with Reading's voluntary Sector to provide a wide range of universal activities and support for young children with undiagnosed/emerging needs.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment has been completed. This established that there were unlikely to be any disproportionate impacts on any groups or individuals with protected characteristics.

8. LEGAL IMPLICATIONS

8.1 The Health and Social Care Act 2012 transferred Public Health functions from the NHS to local authorities commencing on 1 April 2013, with the transfer of different services being staged. The relevant statutory provisions in respect of Health Visitor Services came into effect on 1 October 2015, including the mandated visits/reviews as outlined earlier in this report. The mandated reviews are currently subject to review by Public Health England.

9. FINANCIAL IMPLICATIONS

9.1 Health visiting and school nursing services have been funded according to modelled need through the Public Health Grant. However, the Reading Public Health grant has been cut by 6.2% in 15/16 and is to be subject to further cuts. The Government

announced that the 2015/16 grant funding reduction will be recurrent and confirmed further overall reductions.

9.2 The draft budget for the integrated 0-19 (25) Public Health Nursing was agreed as £3,275,247 "in the region of £3M" at ACE Committee on 12 December 2016.

10. BACKGROUND PAPERS

10.1 Children's centre offer consultation response and final proposal

A report providing an outline of the consultation response from service users, partners, voluntary sector and the general public to the Children's Centre Offer proposal and detailing the Children's Centre Offer going forward

http://www.reading.gov.uk/media/7253/Item08-4/pdf/Item08_(4).pdf

READING BOROUGH COUNCIL

REPORT BY DIRECTOR ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**14 JULY 2017**	**AGENDA ITEM:**	**14**
TITLE:	**DEVELOPMENT OF THE HEALTH AND WELLBEING DASHBOARD**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN**	**PORTFOLIO:**	**Health**
SERVICE:	**WELLBEING**	**WARDS:**	**All**
LEAD OFFICER:	**JO HAWTHORNE**	**TEL:**	**0118 937 3623**
JOB TITLE:	**HEAD OF WELLBEING, COMMISSIONING AND IMPROVEMENT**	**E-MAIL:**	**jo.hawthorne@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report has been developed to update the Board on the development of the Health and Wellbeing Dashboard, which will be used to keep Board members informed on local trends in priority areas identified in the Health and Wellbeing Strategy. Board members are asked to consider recommendations for frequency of the report and for setting targets for each indicator.

1.2 Development of a Health and Wellbeing Dashboard was agreed in principle in July 2016 and the final version of the Health and Wellbeing Strategy was approved by the Health and Wellbeing Board on 27th January 2017.

2. RECOMMENDED ACTIONS

2.1 Board to be informed of latest progress in development of a Health and Wellbeing Dashboard.

2.2 Task Priority/Action Plan Leads to agree appropriate targets for indicators with key stakeholders.

2.3 Agree to Wellbeing Dashboard being presented annually, with more regular updates on specific indicators by exception or on request.

3. POLICY CONTEXT

3.1 The final version of Reading's Health and Wellbeing Strategy was approved by the Health and Wellbeing Board on 27th January 2017 and an action plan based on the eight strategic priorities has been developed and sets out in detail how the priorities will be met.

3.2 In July 2016, Reading's Health and Wellbeing Board agreed to introduce a regular Health and Wellbeing Dashboard report to ensure that members of the board are kept informed about the Partnership's performance in its priority areas, compared to the national average and other similar local authority areas.

4. THE PROPOSAL

4.1 Current Position: A draft version of the Health and Wellbeing Dashboard has been partially developed. Decisions about targets and frequency of reporting are now required.

Indicators reflecting each priority area have been identified and included in the draft dashboard. These are mainly indicators published through publicly available performance frameworks – the Public Health Outcomes Framework (PHOF), the Adult Social Care Outcome Framework (ASCOF) and the NHS Outcomes Framework. These indicators are brought together from different policy and service areas and based on a range of data sources that are collected, collated and published according to varying timetables.

As agreed, the Dashboard will have three levels – a high level showing performance of all indicators against targets (met or not met and direction of travel), a second level showing more detailed information and benchmarking for the indicators in each priority area, and a third level showing more detailed trend data and source information for each indicator. (See Appendix 1 for an example).

While each performance framework benchmarks each indicator against national performance and performance of similar Local Authority or CCG areas, and while a small number may be subject to a nationally set target, there are currently no locally agreed targets for the indicators that will be included in the Dashboard.

In addition, while the Health and Wellbeing Dashboard is in development, two reports on Reading's performance against key indicators and Health and Wellbeing Strategy priorities are included as Appendices 2 (Performance Update) and 3 (Reading's PHE Health Profile, 2017).

4.2 Options Proposed:

Tasking Priority/Action Plan Leads to agree targets for each indicator in their priority area

Pros Allows Leads to use their expert local knowledge to set an appropriate target that will fit with their expectations for the outcomes from the activity that they have planned. Jointly agreeing these targets with stakeholders may help to promote ownership and accountability across the partnership.

Cons This may be a more lengthy process than simply using national average or developing a target based on previous performance.

Annual Dashboard Report to be presented at the end of each year with quarterly performance updates of specific indicators by exception or on request.

Pros The proposed option is expected to be sufficient to allow Board members strategic oversight on Reading's position. Most indicators are updated annually and would not therefore be expected to change each quarter. (In some cases the information published on the published outcome framework is updated on an annual basis but more frequent updates may be available locally or published elsewhere).

Cons For some indicators (for example, new policy areas, or where there are new contracts in place) it may be useful for the Board to be updated on performance more frequently. It is recommended that the Board requests these updates as required.

4.3 Other Options Considered:

Using national average or an average of similar areas to set targets

Pros Much quicker and easier to implement. Target will be a reasonable expectation based on performance of other Local Authority areas and will change to reflect general improvements seen across the country.

Cons May mean that local circumstances, including any limitations to planned activities, are not fully taken into account. The national or similar area averages will change with each update, which means that there will be no single, clear target for each indicator.

Basing targets solely on a standard improvement on previous performance (for example, a 10% improvement)

Pros Quicker and easier to implement. Single, clear target for each indicator allowing board members to see where improvements have been made.

Cons will not reflect local circumstances or take into account how reasonable expectations for improvement might differ for each indicator, or Reading's current position against national and similar area averages.

Quarterly Wellbeing Dashboard to be presented at each Health and Wellbeing Board meeting

Pros For some indicators more frequent updates allow the board to monitor Reading's position closely and react more quickly to a downturn in performance. This may be useful for new policy areas, where there are new contracts in place or where there are very serious concerns about a particular issue in Reading.

Cons Quarterly updates are only available for a small number of indicators so only a proportion of the report would change each quarter. There is a risk of increasing the administrative burden for the Board and for Priority/Action Plan Leads if there is a need to update on performance using local data.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 This proposal supports Corporate Plan priorities by ensuring that Health and Wellbeing Board members are kept informed of performance and progress against key indicators, including those that support corporate strategies.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 A wide range of voluntary and public sector partners and members of the public were encouraged to participate in the development of the Health and Wellbeing Strategy and, as described above, a draft of the proposed Strategy was made available for consultation between 10th October and 11th December 2016. The indicators included in this report reflect those areas highlighted during the development of the strategy and included in the final version.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment is not required.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications.

9. FINANCIAL IMPLICATIONS

9.1 The proposal to note the report in Appendix 2 offers value for money by ensuring that Board members are better able to determine how effort and resources are most likely to be invested beneficially in advance of the full Health and Wellbeing Dashboard.

10. BACKGROUND PAPERS

10.1 Minutes of the Health and Wellbeing Board 27th January 2017 - http://www.reading.gov.uk/article/9641/Health-and-Wellbeing-Board-27-JAN-2017

10.2 Reading Borough Council (2017) *Reading's Health and Wellbeing Strategy*

10.3 Minutes of the Health and Wellbeing Board 15th July 2016 - http://www.reading.gov.uk/article/9585/Health-and-Wellbeing-Board-15-JUL-2016

10.4 Health and Wellbeing Board Performance Update – February 2017

APPENDICES 1-3 – Separate documents

Priority	Indicator	Target Met/Not Met	Direction of Travel
1. Supporting people to make healthy lifestyle choices	2.12 Excess weight in adults		▲
	2.13i % of adults physically active		
	2.13ii % of adults physically inactive		
	2.11i % adults meeting 5-a-day		
	2.06i % 4-5 year olds classified as overweight/obese		
	2.06ii % 10-11 year olds classified as overweight/obese		
	2.11iv % 15 year olds meeting 5-a-day		
	2.11v 15 year olds average daily portions fruit		
	2.11vi 15 year olds average daily portions vegetables		
	1.16 % people using outdoor space for health		
	2.03 Smoking status at the time of delivery		
	2.09i Smoking prevalence at age 15 - current smoker		
	2.09ii Smoking prevalence at age 15 - regular smoker		
	2.09iii Smoking prevalence at age 15 - occassional smoker		
	2.09iv Smoking prevalence at age 15 - regular smoker		
	2.09v Smoking prevalence at age 15 - occasional smoker		
	2.14 Smoking prevalance - routine and manual - current smokers		
	NHS OF 2.4 Health related quality of life for carers		
	4.02 % of 5 year olds free from dental decay		
2. Reducing loneliness and social isolation	1.18i/1l % of adult social care users with as much social contact as they would like		
	1.18ii/1l % of adult carers with as much social contact as they would like		
	2.23i-iv Self reported wellbeing		
3.Reducing the amount of alcohol people drink to safer levels	2.15iii Successful treatment of alcohol treatment		
	2.18 Admission episodes for alcohol related conditions (DSR per 100,000)		
4.Promoting positive mental health and wellbeing in children and young people			
5.Living well with dementia	4.16/2.6i Estimated diagnosis rate for people with dementia		
	4.13 Health related quality of life for older people		
	2F PLACEHOLDER - post diagnosis care		
	1B People who use services who have control of daily life		
	NHS OF 2.1 Proportion of people who feel supported to manage their condition		
6.Increasing take up of breast and bowel screening and prevention services	2.19 Cancer diagnosed at early stage		
	2.20iii Cancer screening coverage - bowel cancer		
	2.20i Cancer screening coverage - breast cancer		
	4.05i Under 75 mortality rate from cancer		
	4.05ii Under 75 mortality rate from cancer considered preventable		
7.Reducing the number of people with tuberculosis	3.05ii Incidence of TB (three year average)		
8. Reducing deaths by suicide	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent		

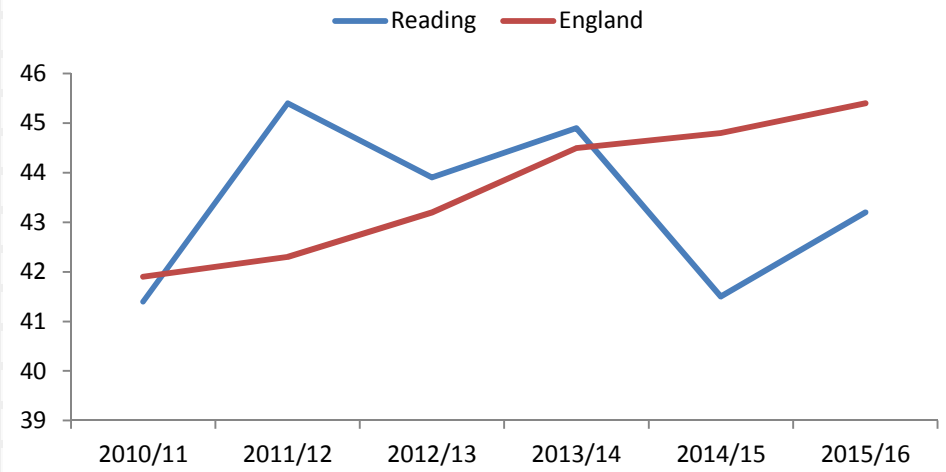
PRIORITY 2: Supporting people to make healthy lifestyle choices

Indicator Title	Framework	Source and frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
1.18i/1l % of adult social care users with as much social contact as they would like	Public Health Outcomes Framework/Adult Social Care Outcomes Framework		High	2015/16	43.2			-	45.4	NA
1.18ii/1l % of adult carers with as much social contact as they would like	Public Health Outcomes Framework/Adult Social Care Outcomes Framework		High	2015/16	36.3				38.5	NA
2.23i-iv Self reported wellbeing	Public Health Outcomes Framework	Annual Population Survey								
Low Satisfaction Score	Public Health Outcomes Framework	Annual Population Survey	Low	2015/16	3.8				4.6	NA
Low Worthwhile Score	Public Health Outcomes Framework	Annual Population Survey	Low	2015/16	NA				3.6	NA
Low Happiness Score	Public Health Outcomes Framework	Annual Population Survey	Low	2015/16	8				8.8	NA
High Anxiety Score	Public Health Outcomes Framework	Annual Population Survey	Low	2015/16	17.2				19.4	NA

Back to HWB Dashboard

Indicator number	**1.18i/1I**
Outcomes Framework	**Public Health Outcomes Framework/Adult Social Care Outcome Framework**
Indicator full name	**% of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey**
[Back to Priority 2](#)	
[Back to HWB Dashboard](#)	
Data source	Adult Social Care Survey - England
	http://content.digital.nhs.uk/catalogue/PUB21630 - Annex Tables
Denominator	The number of people responding to the question "Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?"
Numerator	All survey respondents who responded to the question (adult social care users identified by LA) NHS Digital - Personal Social Services Adult Social Care Survey England

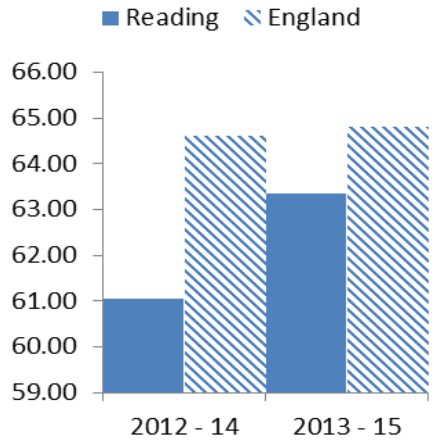
Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2010/11	41.4	36.7	46.1	-	41.9
2011/12	45.4	40.9	49.9	-	42.3
2012/13	43.9	39.6	48.2	-	43.2
2013/14	44.9	40.7	49.1	-	44.5
2014/15	41.5	36.4	46.6	-	44.8
2015/16	43.2	36.8	49.9	-	45.4



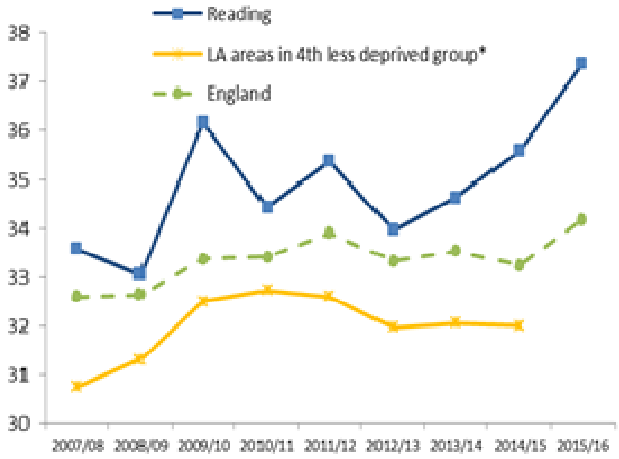
APPENDIX 2 - Performance Update (June 2017)

1. HEALTHY LIFESTYLE CHOICES

Excess weight in adults - Statistically similar to England average, but previously better than average **(No update since Feb 2017. data collected annually).**



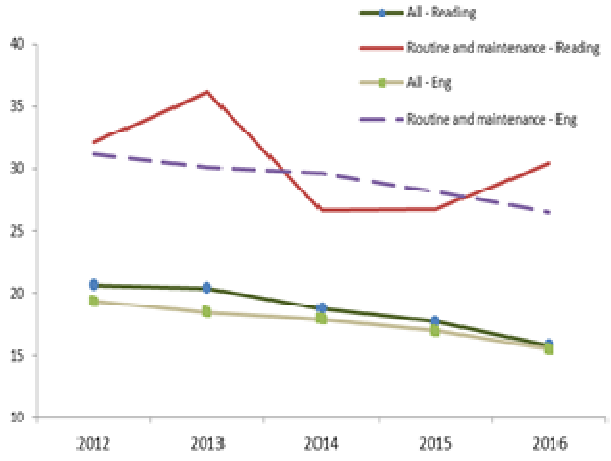
Prevalence of overweight and obesity in 10-11 year olds - in 2015/16 Reading was statistically worse than England average and other areas with similar IMD score **(No update since Feb 2017, data collected annually).**

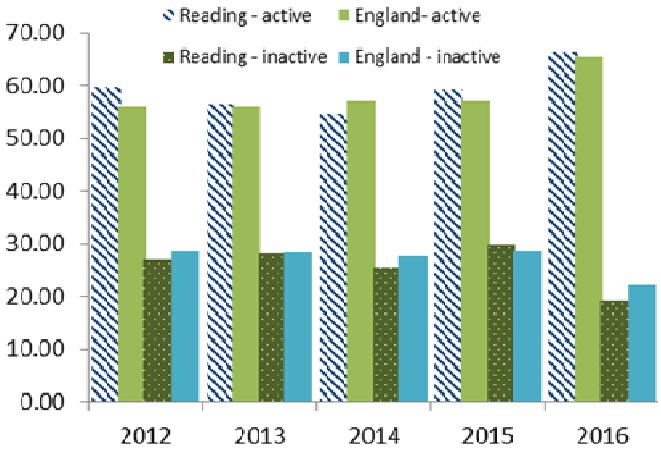


PUBLIC HEALTH OUTCOMES FRAMEWORK / ACTIVE PEOPLE SURVEY / NATIONAL CHILD MEASUREMENT PROGRAMME

Smoking Prevalence - In 2016 there has been an increase in smoking prevalence amongst those in routine and manual occupations not seen elsewhere in England or in the rest of the population.

% Adults active and inactive - Preliminary results for 2016 indicate improvements for Reading compared to England averages. These are <u>not</u> yet published by PHE but have been taken from the Active Lives survey results

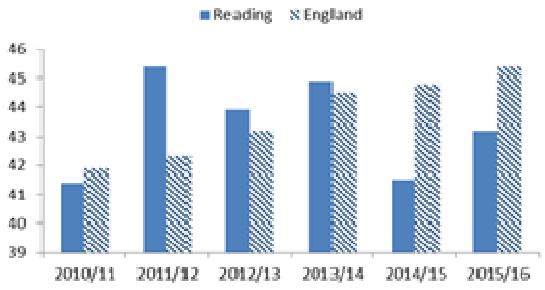




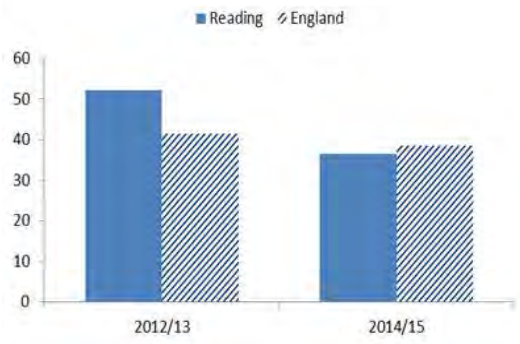
PUBLIC HEALTH OUTCOMES FRAMEWORK / ANNUAL POPULATION SURVEY / ACTIVE PEOPLE SURVEY

2. Loneliness and Social Isolation

% of Adult Social Care Service Users with as much social contact as they would like - remains similar to national average. **(No update since February 2017, annual data return (SALT))**



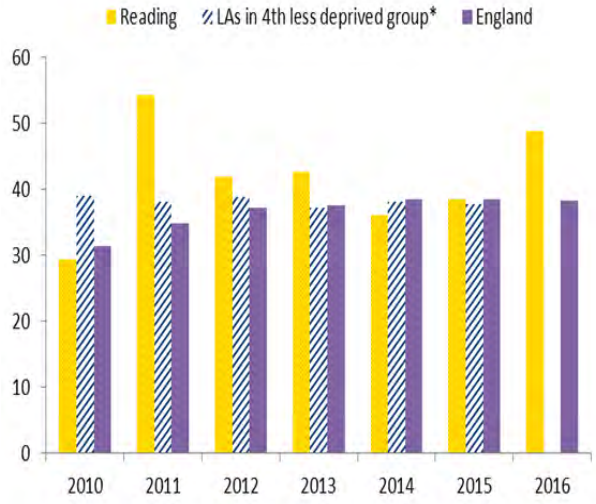
% of Carers with as much social contact as they would like - % has fallen significantly. Now similar to national average - previously better. **(No update since February 2017, bi-annual data return (SALT))**



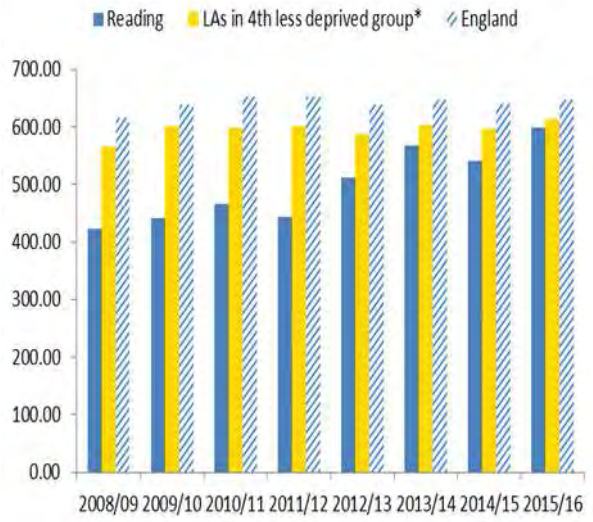
PUBLIC HEALTH OUTCOMES FRAMEWORK / ADULT SOCIAL CARE SURVEY

3. SAFE USE OF ALCOHOL

% of those in specialist alcohol treatment who successfully complete – NDTMS data suggests Reading above average in 2016 (this is not yet published by PHE).



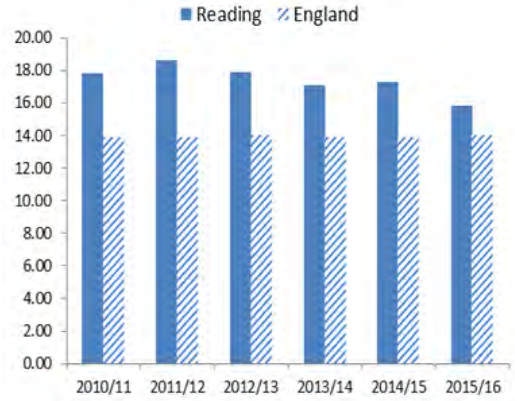
Rate of hospital admissions for alcohol-related conditions – remains narrowly better than national average and average of areas with similar IMD scores, but admission rates increasing.



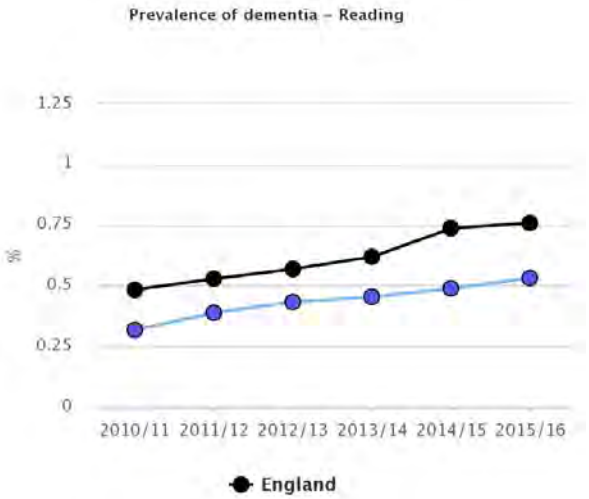
PUBLIC HEALTH OUTCOMES FRAMEWORK / NATIONAL DRUG TREATMENT MONITORING SYSTEM / HOSPITAL EPISODE STATISTICS

4. MENTAL HEALTH AND WELLBEING OF CHILDREN AND YOUNG PEOPLE

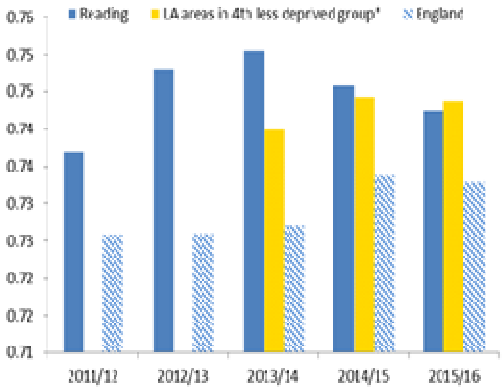
Average difficulties score for all looked after children aged 5-16 years - % continues to be higher than national average (no update since February 2017)



5. LIVING WELL WITH DEMENTIA



Health score status (quality of life) for older people (65+) – continues to be similar to national average and average for areas with similar IMD scores (no update since Feb 2017)

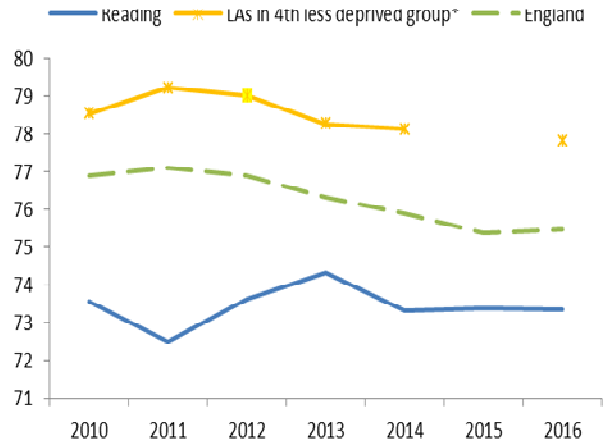


Prevalence of dementia is significantly lower in Reading than in England or in areas with similar IMD scores (**no update since February 2017**).

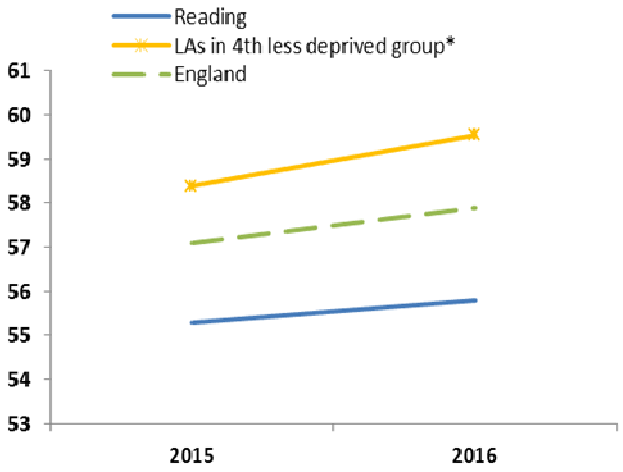
PHE DEMENTIA PROFILE / QUALITY OUTCOMES FRAMEWORK / PUBLIC HEALTH OUTCOMES FRAMEWORK / GP PATIENT SURVEY

6. BREAST AND BOWEL CANCER SCREENING

Breast cancer screening coverage - continues to be significantly worse than England average and average for areas with similar IMD scores (no PHE update since Feb 2017)

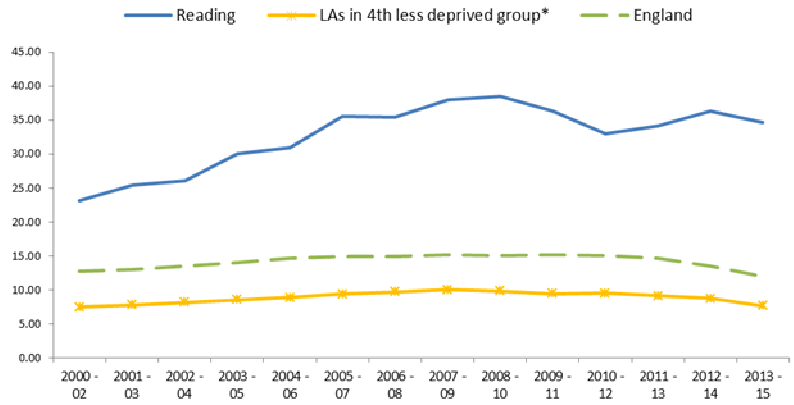


Bowel cancer screening coverage - continues to be significantly worse than England average and average for areas with similar IMD scores (no update since Feb 2017*)



PUBLIC HEALTH OUTCOMES FRAMEWORK / HEALTH AND SOCIAL CARE INFORMATION CENTRE

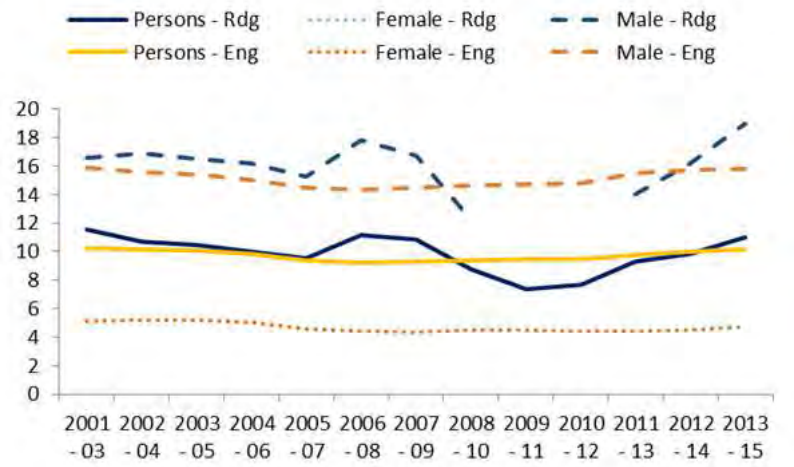
7. INCIDENCE OF TUBERCULOSIS



PUBLIC HEALTH OUTCOMES FRAMEWORK / ENHANCED TB SURVEILLANCE SYSTEM (ETS) AND ONS

Rate of new TB cases per 100,000 people is significantly worse than the England average and average of areas with similar IMD scores. Incidence has increased significantly in the last 15 years. (**No update since February 2017**)

8. SUICIDE RATE



PUBLIC HEALTH OUTCOMES FRAMEWORK / ONS

Suicide rates for all persons and for men are similar to England average. The number of suicides by women is too small to allow rate to be calculated. (**No update since February 2017**).

Public Health England

Protecting and improving the nation's health

Reading

Unitary authority

This profile was published on 4th July 2017

Health Profile 2017

Health in summary
The health of people in Reading is varied compared with the England average. About 19% (5,800) of children live in low income families. Life expectancy for men is lower than the England average.

Health inequalities
Life expectancy is 7.8 years lower for men and 6.5 years lower for women in the most deprived areas of Reading than in the least deprived areas.

Child health
In Year 6, 22.0% (360) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 20*, better than the average for England. This represents 7 stays per year. Levels of GCSE attainment are worse than the England average. Levels of breastfeeding initiation and smoking at time of delivery are better than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 599*, better than the average for England. This represents 831 stays per year. The rate of self-harm hospital stays is 223*, worse than the average for England. This represents 382 stays per year. The rate of smoking related deaths is 281*. This represents 175 deaths per year. Rates of sexually transmitted infections and TB are worse than average. Rates of hip fractures and people killed and seriously injured on roads are better than average. The rate of violent crime is worse than average. The rate of long term unemployment is better than average.

Local priorities
Priorities in Reading include preventing and reducing early deaths from cardiovascular disease & cancer, promoting positive mental health & wellbeing, reducing levels of infectious disease e.g. TB, and reducing alcohol consumption to safe levels. For more information see www.reading.gov.uk/jsna

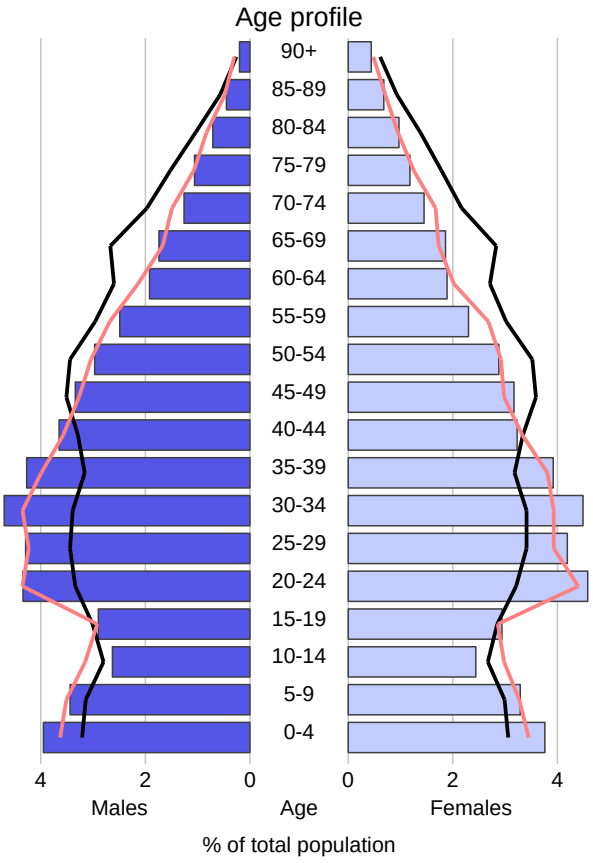
* rate per 100,000 population

This profile gives a picture of people's health in Reading. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

Follow @PHE_uk on Twitter

Population: summary characteristics



	Males	Females	Persons
Reading (population in thousands)			
Population (2015):	81	80	162
Projected population (2020):	85	83	168
% people from an ethnic minority group:	22.1%	23.2%	22.6%
Dependency ratio (dependants / working population) x 100			49.8%
England (population in thousands)			
Population (2015):	27,029	27,757	54,786
Projected population (2020):	28,157	28,706	56,862
% people from an ethnic minority group:	13.1%	13.4%	13.2%
Dependency ratio (dependants / working population) x 100			60.7%

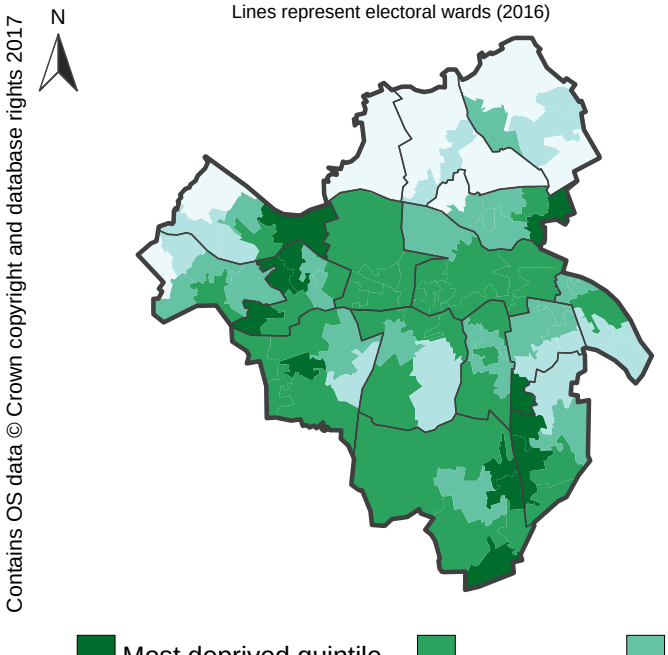
The age profile and table present demographic information for the residents of the area and England. They include a 2014-based population projection (to 2020), the percentage of people from an ethnic minority group (Annual Population Survey, October 2014 to September 2015) and the dependency ratio.

The dependency ratio estimates the number of dependants in an area by comparing the number of people considered less likely to be working (children aged under 16 and those of state pension age or above) with the working age population. A high ratio suggests the area might want to commission a greater level of services for older or younger people than those areas with a low ratio.

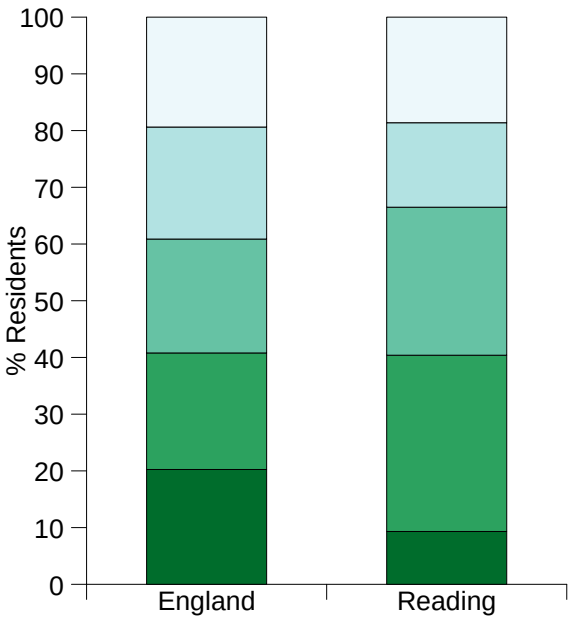
Reading 2015 (Male)
Reading 2015 (Female)
England 2015
Reading 2020 estimate

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



This chart shows the percentage of the population who live in areas at each level of deprivation.

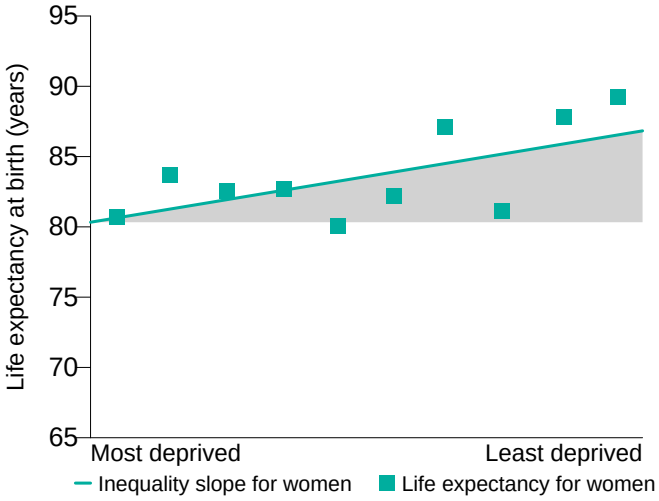


Life expectancy: inequalities in this local authority

The charts show life expectancy for men and women in this local authority for 2013-15. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy the line would be horizontal.

Life expectancy gap for men: 7.8 years

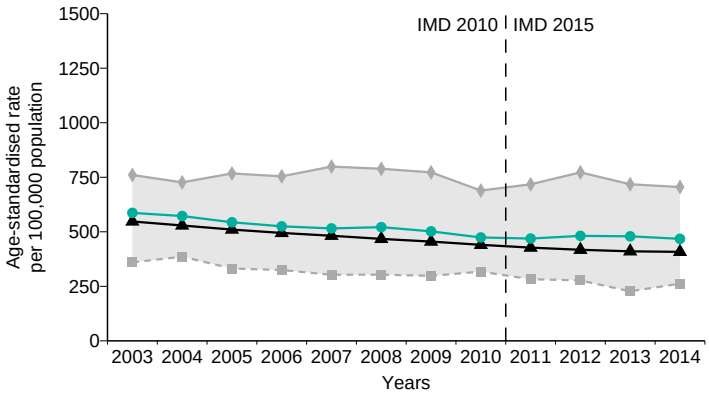
Life expectancy gap for women: 6.5 years



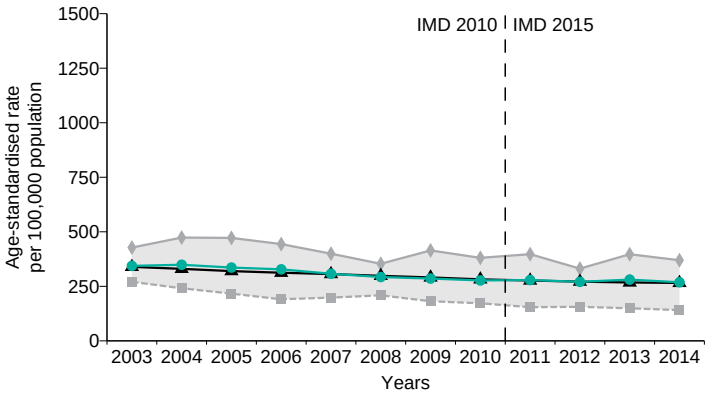
Health inequalities: changes over time

These charts provide a comparison of the changes in death rates in people under 75 (early deaths) between this area and England. Early deaths from all causes also show the differences between the most and least deprived local quintile in this area. Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with time period of the data. This provides a more accurate way of discriminating changes between similarly deprived areas over time.

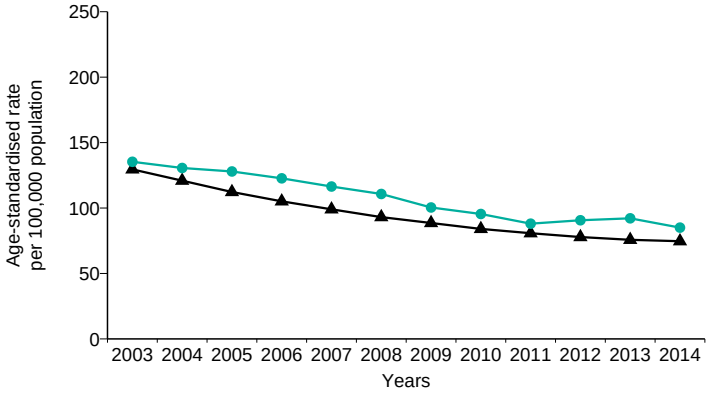
Early deaths from all causes: men



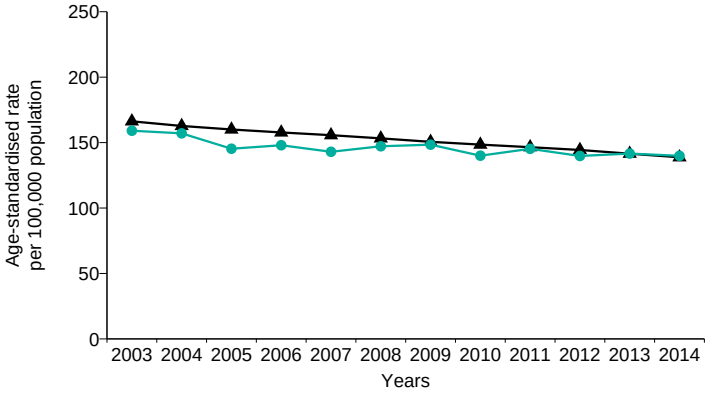
Early deaths from all causes: women



Early deaths from heart disease and stroke



Early deaths from cancer



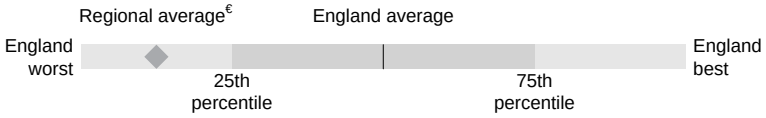
Data points are the midpoints of three year averages of annual rates, for example 2005 represents the period 2004 to 2006. Where data are missing for local least or most deprived, the value could not be calculated as the number of cases is too small.

England average | Local average | Local least deprived | Local most deprived | Local inequality

Health summary for Reading

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain		Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1	Deprivation score (IMD 2015)	2015	n/a	19.3	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2014	5,800	18.7	20.1	39.2		6.6
	3	Statutory homelessness	2015/16	51	0.8	0.9			
	4	GCSEs achieved	2015/16	767	52.1	57.8	44.8		78.7
	5	Violent crime (violence offences)	2015/16	3,353	20.9	17.2	36.7		4.5
	6	Long term unemployment	2016	308	2.8 ^20	3.7 ^20	13.8		0.4
Children's and young people's health	7	Smoking status at time of delivery	2015/16	206	8.0	10.6 $1	26.0		1.8
	8	Breastfeeding initiation	2014/15	2,321	79.0	74.3	47.2		92.9
	9	Obese children (Year 6)	2015/16	360	22.0	19.8	28.5		9.4
	10	Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	21	19.6	37.4	121.3		10.5
	11	Under 18 conceptions	2015	55	22.2	20.8	43.8		5.4
Adults' health and lifestyle	12	Smoking prevalence in adults	2016	n/a	15.8	15.5	25.7		4.9
	13	Percentage of physically active adults	2015	n/a	59.3	57.0	44.8		69.8
	14	Excess weight in adults	2013 - 15	n/a	63.4	64.8	76.2		46.5
Disease and poor health	15	Cancer diagnosed at early stage	2015	235	51.6	52.4	39.0		63.1
	16	Hospital stays for self-harm†	2015/16	382	223.2	196.5	635.3		55.7
	17	Hospital stays for alcohol-related harm†	2015/16	831	599.0	647	1,163		374
	18	Recorded diabetes	2014/15	8,568	4.7	6.4	9.2		3.3
	19	Incidence of TB	2013 - 15	167	34.7	12.0	85.6		0.0
	20	New sexually transmitted infections (STI)	2016	1,051	949.0	795	3,288		223
	21	Hip fractures in people aged 65 and over†	2015/16	94	456.9	589	820		312
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2013 - 15	n/a	78.7	79.5	74.3		83.4
	23	Life expectancy at birth (Female)	2013 - 15	n/a	83.2	83.1	79.4		86.7
	24	Infant mortality	2013 - 15	28	3.6	3.9	8.2		0.8
	25	Killed and seriously injured on roads	2013 - 15	130	26.9	38.5	103.7		10.4
	26	Suicide rate	2013 - 15	44	11.0	10.1	17.4		5.6
	27	Smoking related deaths	2013 - 15	525	280.9	283.5			
	28	Under 75 mortality rate: cardiovascular	2013 - 15	244	85.0	74.6	137.6		43.1
	29	Under 75 mortality rate: cancer	2013 - 15	404	139.9	138.8	194.8		98.6
	30	Excess winter deaths	Aug 2012 - Jul 2015	258	25.7	19.6	36.0		6.9

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15 to 17 (crude rate) 12 Current smokers (aged 18 and over), Annual Population Survey 13 % adults (aged 16 and over) achieving at least 150 mins physical activity per week, Active People Survey 14 % adults (aged 16 and over) classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 Admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people (aged 17 and over) on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding chlamydia under age 25), crude rate per 100,000 population aged 15 to 64 21 Directly age-sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged under 1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10 and over) 27 Directly age standardised rate per 100,000 population aged 35 and over 28 Directly age standardised rate per 100,000 population aged under 75 29 Directly age standardised rate per 100,000 population aged under 75 30 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
^20 Value based on an average of monthly counts $1 There is a data quality issue with this value

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk

READING BOROUGH COUNCIL
REPORT BY THE DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**14 JULY 2017**	**AGENDA ITEM:**	**15**
TITLE:	**READING HEALTH & WELLBEING ACTION PLAN 2017-20: PROGRESS REPORT**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN / COUNCILLOR EDEN / COUNCILOR GAVIN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE / CHILDREN'S SERVICES**
SERVICE:	**ALL**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**JANETTE SEARLE / KIM WILKINS**	**TEL:**	**0118 937 3753 / 3624**
JOB TITLE:	**PREVENTATIVE SERVICES MANAGER / SENIOR PROGRAMME MANAGER**	**E-MAIL:**	**Janette.Searle@reading.gov.uk / Kim.Wilkins@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents an update on delivery against the Health and Wellbeing Action Plan which supports the 2017-20 Health and Wellbeing Strategy.

1.2 Alongside the Health and Wellbeing Dashboard (presented today under cover of a separate report), the Health and Wellbeing Action Plan update provides the Board with an overview of performance and progress towards achieving local goals. This also gives the Board a context for determining which parts of the Action Plan it wishes to review in more depth at its next then subsequent meetings. This would be in line with the recent Health and Wellbeing Peer Review recommendation that the Health and Wellbeing Strategy should be used to drive the agenda of the Health and Wellbeing Board.

1.3 As priorities (2), (3) (4) and (5) form a natural cluster around emotional wellbeing and with a planned focus on priority (4) in the autumn to align with an international awareness day, this grouping is suggested for the first set of in-depth progress reports. The October 2017 Health and Wellbeing Board will also take place shortly before World Mental Health Day (10th October).

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board:

(a) notes the progress to date against the 2017-20 Reading Health and Wellbeing Strategy Action Plan as set out at Appendix A; and
(b) requests in-depth reports on progress towards achieving priorities (2), (3), (4) and (5) of the Health & Wellbeing Strategy to be brought to the next meeting of this Board.

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 sets out the requirement on Health and Wellbeing Boards to use a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) to develop plans which:

- improve the health and wellbeing of the people in their area;
- reduce health inequalities; and
- promote the integration of services.

3.2 Reading's 2017-20 Health and Wellbeing Strategy sets out local plans as required under the Health and Social Care Act, and also addresses the local authority's obligations under the Care Act 2014 to promote the wellbeing of individuals and to provide or arrange services that reduce needs for support among people and their (unpaid/family) carers in the local area.

3.3 The 2013-16 Health & Wellbeing Vision for Reading has been affirmed in the 2017-20 strategy:

a healthier Reading

The current strategy also adopts and localises the Public Health England mission statement:

to improve and protect Reading's health and wellbeing – improving the health of the poorest, fastest

Partner engagement to develop the 2017-20 strategy identified a strong appetite for a focus of partners' collective effort on fewer priorities than had been set out in the previous strategy, so as to target the biggest health and wellbeing risks for Reading.

3.4 The current strategy is founded on three 'building blocks' – issues which underpin and are expected to be considered as part of the implementation plans to achieve all of the strategic priorities. These are:

- Developing an integrated approach to recognising and supporting all carers
- High quality co-ordinated information to support wellbeing
- Safeguarding vulnerable adults and children

3.5 The Strategy then sets out eight priorities for the next three years:

- Supporting people to make healthy lifestyle choices (with a focus on tooth decay, obesity and physical activity)
- Reducing loneliness and social isolation
- Promoting positive mental health and wellbeing in children and young people
- Reducing deaths by suicide
- Reducing the amount of alcohol people drink to safe levels Making Reading a place where people can live well with dementia
- Increasing breast and bowel screening and prevention services
- Reducing the number of people with tuberculosis

4. HEALTH AND WELLBEING STRATEGY 2017-20: PROGRESS TO DATE AGAINST ACTION PLAN

Priority 1: Supporting people to make healthy lifestyle choices – focused on dental care, reducing obesity, increasing physical activity and reducing smoking

4.1 This priority is developed in the Healthy Weight Position Statement for Reading which provides an analysis of local data and current service provision to help focus work on key areas of need. A separate report to the Health and Wellbeing Board sets out progress to date in further detail. The Council's Wellbeing Team is co-ordinating work in this area, but recognises that tackling overweight and obesity effectively requires a multi-agency approach. A planning group including representation from schools, local health services, voluntary and community sector plus private sector partners is shaping the plan outlined in the Health and Wellbeing Action Plan.

4.2 Good progress has been made in commissioning healthy lifestyle and weight management services. The recently re-commissioned 0-19 service includes the promotion of healthy eating and physical activity in the service specification. Opportunities / support for walking and cycling are on the increase. Support to quit smoking is being offered from a wider range of locations. Work is in hand to update local data on dental health to track and drive further progress.

Priority 2: reducing loneliness and social isolation

4.3 This priority continues to attract interest from a wide range of partners. A Loneliness and Social Isolation Steering Group has now been formed following a very well attended multi agency workshop. This group is overseeing the development of a local loneliness needs analysis, ongoing community asset mapping and work to raise awareness of the health risks of loneliness and the support available to build community connections. The group is sharing ideas and good practice, including approaches to evaluating the impact of services.

Priority 3: Promoting positive mental health and wellbeing in children and young people

4.4 Actions to support delivery of this priority are set out in the Reading Future In Mind Transformation Plan that covers the key issues. A report was brought to the March 2017 meeting of this Board where a refreshed implementation plan was endorsed:
http://nwreadingccg.nhs.uk/mental-health/camhs-transformation

Priority 4: Reducing Deaths by Suicide

4.5 Actions under this priority support both the Reading Health and Wellbeing Strategy and the Berkshire-wide Suicide Prevention Strategy which was adopted by the Reading Health and Wellbeing Board in March 2017. Local actions are overseen by the Reading Mental Wellbeing Group.

4.6 Work is ongoing to raise awareness of suicide risk and support available. Bereavement through suicide advice has been added to the Reading Services Guide, and the JSNA module on suicide and self harm has been updated. Working with partners across Berkshire, the intention is hold an event in the autumn to link in with International Suicide Prevention Day on 10th September.

Priority 5: Reducing the amount of alcohol people drink to safer levels

4.7 Work under this priority is focused on taking key health messages out to a wider audience - engaging a range of organisations to understand their opportunities to prevent people from becoming harmful/ hazardous drinkers as well as offering a variety of routes into support services. Plans are at an advanced stage to introduce alcohol peer mentors onto selected wards at the Royal Berkshire Hospital. A street drinking initiative is underway to promote more responsible behaviour.

4.8 A comprehensive Drug and Alcohol Strategy is currently being updated by partners. This will incorporate and develop the Health & Wellbeing Action Plan in relation to excess consumption of alcohol.

Priority 6: Making Reading a place where people can live well with dementia

4.9 Through the Berkshire West Dementia Steering Group and the Reading Dementia Action Alliance (DAA), work is ongoing to raise awareness of how to reduce the risk of dementia, spot early signs and manage the condition. Innovative ways to reach a wider audience have included a stall at the Southcote May Fayre and a town centre music festival during Dementia Awareness Week

4.10 The DAA is rolling out Dementia Friends training, and supporting Southcote to be recognised as Reading's first dementia friendly community. Dementia awareness training has been offered to all GP practice staff across the South

Reading and North & West Reading CCG areas. All practices in Reading have now put plans in place to become dementia friendly.

Priority 7: Increasing take up of breast and bowel screening and prevention services

4.11 GP practices with a low take-up of screening are being supported to improve patient engagement. This is complemented by a programme to raise awareness of cancer signs and symptoms aimed at a wide audience.

Priority 8: Reducing the number of people with tuberculosis

4.12 A separate report to the Health and Wellbeing Board sets out progress to date on this priority in further detail. The public consultation on the 2017-20 Health and Wellbeing Strategy proved very effective in raising awareness of the TB risk amongst a range of organisations and in generating demand for training. A workshop in January attracted 29 participants including health professionals, community workers and voluntary sector workers. An RBC training session in March attracted 28 workers from across services and directorates.

4.13 A local campaign has been launched to raise awareness of latent TB, including a town centre event and a presence at the Southcote Community Fair. BCG vaccine shortages have now been addressed, and all eligible babies are on track to have received BCG vaccine by end of June 2017.

Foundation for delivery plans

4.14 Delivery against all of the Health and Wellbeing strategic priorities is expected to take into account and be founded on the three 'foundation' issues, i.e. carer recognition, safeguarding and a co-ordinated approach to wellbeing information. This is something which could be scrutinised further as more in depth progress reports are brought to the Board relating to each action.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The 2017-20 Health and Wellbeing Strategy and accompanying Action Plan draw on the findings of the Joint Strategic Needs Assessment (JSNA) for Reading to identify priorities. The Strategy complements plans for health and social care integration, and supports the drive towards co-commissioning across the Health and Wellbeing Board's membership. The 2017-20 strategy also incorporates wellbeing responsibilities towards residents with current or emerging care and support needs so as to be comprehensive and Care Act compliant.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 Delivery of the Health and Wellbeing Action Plan is through a range of multi agency forums which bring together representatives of the Health and Wellbeing Board with other local partners. These are outlined in the annexed schedule.

7. LEGAL IMPLICATIONS

7.1 The Health and Social Care Act (2012) gives duties to local authorities and clinical commissioning groups (CCGs) to develop a Health and Wellbeing Strategy and to take account of the findings of the JSNA in the development of commissioning plans. In addition, the Council has a duty under the Care Act (2014) to develop a clear framework for ensuring it is meeting its wellbeing and prevention obligations under the Care Act.

8. EQUALITY IMPACT ASSESSMENT

8.1 The Health and Wellbeing Strategy and Action Plan are vehicles for addressing health inequalities, and accordingly delivery is expected to have a differential impact across groups, included those with protected characteristics. This differential impact should be positive, and so delivery of the Action Plan supports the discharge of Health and Wellbeing Board members' Equality Act duties.

9. FINANCIAL IMPLICATIONS

9.1 There are no new financial implications arising from this report.

10. APPENDICES

Appendix A – Reading Health and Wellbeing Strategy 2017-20 – Action Plan updated June 2017

11. BACKGROUND PAPERS

Reading Health and Wellbeing Strategy 2017-20
CAMHS Transformation Plan – Implementing Future in Mind across Berkshire West – report taken to March 2017 Health and Wellbeing Board

Reports coming to July 2017 Health and Wellbeing Board:

A Healthy Weight Statement for Reading – Implementation plan update
Tuberculosis (TB) and antimicrobial resistence (AMR) programme update

Reading Health and Wellbeing Strategy 2017-20 - Action Plan updated June 2017

PRIORITY No 1	**Supporting people to make healthy lifestyle choices – dental care, reducing obesity, increasing physical activity, reducing smoking**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
Weight Management **To commission and implement an accessible tier 2 lifestyle adult weight management service that aligns with NICE guidance for overweight and obese adults aged 16 and over within the locality. This will form an integral part of the weight management service in Reading.** **To target access to the service in line with local Joint Strategic Needs Assessments**	**Wellbeing Team**	**Currently mid-contract. New contract to be procured to commence June / July 2017.**	**To contribute to halting the continued rise in unhealthy weight prevalence in adults.**	**2.21 Excess weight in adults.** **2.13i Percentage of physically active and inactive adults – active adults.** **2.13ii Percentage of physically active and inactive adults – active adults.** **2.11i - Proportion of the adult population meeting the recommended '5-a-day' on a 'usual day'**	**Procurement undertaken and preferred provider recommended subject to agreement of the final contractual terms and conditions.**

To monitor and evaluate the delivery and outcomes of the service to the stated objectives				**(adults).**	
To commission and implement a school based Tier 2 children's healthy lifestyle and weight management programme in line with NICE guidance within the locality. This will form an integral part of the weight management service in Reading. **To target access to the service in line with local Joint Strategic Needs Assessments** **To monitor and evaluate the delivery and outcomes of the service in line with the stated objectives** **To pilot a legacy pack for schools who host our Tier 2 children's healthy lifestyle and weight management programme in order to encourage schools to continue supporting the**	**Wellbeing Team**	**Currently mid-contract for tier 2 service.** **Legacy pack to be developed for spring 2017.**	**To contribute to halting the continued rise in unhealthy weight prevalence in children and young people.** **To promote a 'whole family approach' to healthy eating and physical activity.**	**2.06i - % of children aged 4-5 classified as overweight or obese.** **2.06ii - % of children aged 10-11 years classified as overweight or obese.** **2.11iv – Proportion of the population meeting the recommended "5-a-day" at age 15**	**79% of children completing the LGG course in Reading during quarter 1 of 2017 live in wards in the 2 most deprived deciles.** **Legacy pack (Let's Keep Going) to be launched September 2017.**

principles of the course beyond the 10-week intervention.					
To include promotion of healthy eating and physical activity within the 0-19s service **Take proactive steps to raise awareness in schools of priority Public Health messages especially around healthy life-styles, including oral health** **To look at options for programmes that could be delivered in Early Years settings with colleagues from children's services.**	**Wellbeing Team/Children's Services**	**From October From April 2017**	**Lead, co-ordinate and provide services for children and young people as set out in the Healthy Child Programme 5 – 19 years**	**2.06i - % of children aged 4-5 classified as overweight or obese.** **2.06ii - % of children aged 10-11 years classified as overweight or obese.** **2.11iv – Proportion of the population meeting the recommended "5-a-day" at age 15** **2.11v – Average number of portions of fruit consumed daily at age 15 (WAY survey)** **2.11vi – Average number of portions of vegetables consumed daily at age 15 (WAY survey).**	**Completed April 2017. Promotion of healthy eating and physical activity included in the service specification.** **An annual health promotion plan will be agreed between RBC and the 0-19/25 service provider to raise awareness in priority Public Health messages – including in school settings.**
To seek opportunities to promote and support local walking and cycling	**Transport, Leisure and**	**From April 2017**	**Increase in the number of people walking and**	**1.16 - % of people using outdoor space for**	**Transport team to deliver EMPOWER**

programmes for leisure and active travel. For example: **'Develop a Local Cycling & Walking Infrastructure Plan, as a sub-strategy to the Local Transport Plan.** **Hold 'Walking Volunteer recruitment workshops' for voluntary and community services who work with people who have low physical activity levels** **To work with partners in support of bidding for funding to develop more walking and cycling initiatives e.g. Reading Museum, transport.**	**Wellbeing Teams** **Reading Museum / Wellbeing team.**	**January 2017**	**cycling to work** **Increase in the number of children benefitting from Bikeability** **Increase in the number of children walking or cycling to school** **Reduce congestion** **Increase the local capacity to deliver health walks to people who have low physical activity levels** **Support planned bid in development by Reading museum linking local heritage and walking.**	**exercise/health reasons.** **2.13i Percentage of physically active and inactive adults – active adults.** **2.13ii Percentage of physically active and inactive adults – active adults.**	**supported programmes e.g.** **-Training & education (e.g. cycle training)** **-Travel advice & marketing campaigns** **-Advice on the development of school & workplace travel plans.** **41 walk leaders have trained as of 31.03.2017** **Increase from 4 to 12 weekly / monthly walks now taking place attracting 925 participants in 18 months** **Esmee Fairburn bid submitted by Reading Museum with support from Wellbeing May 2017. Outcome expected mid-June**

					2017. **Sport England local pilot EOI submitted March 2017 – awaiting outcome.**
To offer MECC training to the local voluntary and community sector	**Wellbeing Team**	**From January 2017**	**To increase knowledge, skills and confidence to make appropriate use of opportunities to raise the issue of healthy lifestyle choices and signpost to sources of support.**	**Potentially all PHOF indicators highlighted in this section relating to healthy weight, healthy eating and physical activity.**	**Train the Trainer model for MECC being developed**
To ensure delivery of the National Child Measurement Programme	**Wellbeing Team**	**Ongoing**	**Weight and height measurements offered to all children attending state funded primary school children who are in Reception Year (age 5) and Year 6 (aged 10,11) in accordance with NCMP guidance**	**2.06i - % of children aged 4-5 classified as overweight or obese.** **2.06ii - % of children aged 10-11 years classified as overweight or obese.**	**Ongoing to ensure minimum of 95% uptake**
To Prevent Uptake of Smoking **- Education in schools** **- Health promotion**	**Wellbeing Team; Trading Standards; CS; S4H; Youth**	**From April 2017**	**Maintain/reduce the number of people >18 years who are estimated to smoke in Reading**	**PHOF 2.03 - Smoking status at the time of delivery** **PHOF 2.09i – Smoking**	**Health promotion activity carried out at Southcote May Fayre, Dementia Festival,**

- **Quit services targeting pregnant women/families** - **Underage sales**	**Services;** **Schools;**		**Improve awareness of impact of smoking on children** **Reduce the illegal sale of tobacco to >18 years** **Increase uptake of smoking cessation >18 years**	**prevalence at age 15- current smokers (WAY survey)** **PHOF 2.09ii – Smoking prevalence at age 15 – regular smokers (WAY survey)** **PHOF 2.09iii – Smoking prevalence at age 15 – occasional smokers (WAY survey)** **PHOF 2.09iv – Smoking prevalence at age 15 – regular smokers (SDD survey)** **PHOF 2.09v – Smoking prevalence at age 15 – occasional smokers (SDD survey)**	**press and social media used to promoted the local Quit for Ramadan campaign. The provider has successfully linked in with some local mosques to help disseminate the message.** **2 secondary school visits (since April) targeting year 9 pupils. Additional health harms resources have been provided to a further 2. Includes what is in a cigarette and health harms of smoking presentations.** **Schools survey 2016/17 published. Planning for 2017/18 underway.** **Work in Targeted primary schools year 6 pupils on development**

					of peer resilience and health harms. **Targeted work with routine and manual workers on smoke free homes-The Whole 9 Yards, pilot work at Reading depots. 11 Depots in Reading have been visited and provided with information, advice and support.**
To provide support to smokers to quit - **Health promotion** - **Referrals into service** - **VBA training to staff** - **Workplace and community smoking policies**	**S4H; RBC; CCGs;**	**From April 2017**	**Achieve minimum number of4 week quits - 722** **Achieve minimum number of 12 week quits** **Supporting national campaigns – 463** **Achieve minimum of 50% quitters to be from a priority group** **Increase referrals to S4H by GPs;**	**PHOF 2.03 - Smoking status at the time of delivery** **PHOF 2.14 – Smoking prevalence in adults – current smokers (APS)** **PHOF 2.14 – Smoking prevalence in adults in routine and manual occupations – current smokers (APS)** **NHS OF 2.4 - Health**	**Provider is using the mobile vehicle to support quitters across Reading, provider a confidential space for advice and support to be given. Fixed service remains in Broad Street Mall shopping centre. Will support the Depot that have been visited.** **Number of referrals to**

			Increase self-referrals to S4H	**related quality of life for carers**	**the service from local GPs remain mixed. This could be for a number of reason i.e. patients accessing other online support.** **Workplace/community policy work is on hold whilst Officers conduct a review of the contract.** **North & West Reading CCG report number of referrals to S4H each quarter. 2016/17 local target was in place to increase referrals to >156. Data on achievement of target is awaited. 2017/18 a target will be set to again increase referrals rates to above the 16/17 year end number.**

To take action to tackle illegal tobacco and prevent sales to >18 - **Health promotion** - **Act on local intelligence** - **Retailer training – challenge 25** - **Test purchasing**	**Tobacco Control Co0rdinator, Trading Standards; S4H**	**From April 2017**	**Increase awareness of impact of illicit/illegal sales have on community** **Improve the no of successful completions of Retail Trainer Training (challenge 25)** **Reduce the number of retailers failing test purchasing**		**Illegal tobacco roadshow last September which was successful in raising awareness with the public and in intelligence gathering. This has been used to inform Trading Standards work.**
Local Smoking Policy – workplace, communities - **Update workplace smoking policy (wellbeing policy)** - **Smoking ban in community (RBC sites, school grounds; RSL; Broad Street)**	**Wellbeing Team; Health & Safety; Trading Standards; Environmental health;**	**From April 2017**	**Increase referrals to S4H smoking cessation services** **Prevent harm to community through restriction of exposure to second hand smoke.**		**Officer/s have provided input in to Dee Park Development and comments on Local Plan i.e. making spaces in the community smoke free.** **Workplace/community policy work is temporarily on hold whilst Officers conduct a review of the contract.**
To collect dental epidemiology data for	**Wellbeing Team**	**From January 2017**	**Reading Borough Council will have access to dental**	**PHOF 4.2: tooth decay in 5 year old children**	**Data collection visits in progress and will be**

Reading			**epidemiological data in order to be able to monitor progress in relation to Public Health Outcomes Framework indicators on oral health**		**completed by the end of June 2017.**

PRIORITY No 2	**Reducing Loneliness and Social Isolation**

What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update June 2017**
Establish a Reducing Loneliness Steering Group	**Health & Wellbeing Board**	**February 2017**	**A cross-sector partnership is in place to oversee an all-age approach – covering prenatal, children and young people, working age adults and later life**		**There were 22 nominations for the Loneliness and Social Isolation Steering Group representing a range of interests. The Group met on 21st June and identified some gaps which we are now recruiting to.**

Develop a reducing loneliness and social isolation module as part of the Reading Joint Strategic Needs Assessment	**Wellbeing Team, RBC**	**April 2017**	**We will understand the local loneliness issue, in particular which groups of Reading residents are at greatest risk of experiencing health inequalities as a result of loneliness**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-reported wellbeing**	**It has been agreed that the Loneliness and Social Isolation Steering Group will oversee the development of a more in-depth local loneliness analysis, which will be published in summary form as a JSNA module.**
Map community assets for building social networks (groups, agencies and services which have the potential to have a direct or an indirect impact)	**Reducing Loneliness Steering Group**	**April 2017**	**Shared understanding of existing assets to underpin better targeting of resources and development at a neighbourhood level**		**Initial community asset mapping completed in April, but this is being developed and extended through other forums.**

Produce a communication plan to raise awareness of community assets for building social networks, targeting potential community navigators and community champions	**Reducing Loneliness Steering Group**	**June 2017**	**Those in a position to identify and signpost individuals at risk of loneliness can access tools to help them integrate people into enabling and supportive social networks**		**Members of the Loneliness Steering Group have committed to this as an ongoing action.**
Support the neighbourhood Over 50s groups to grow and be self-sustaining	**Wellbeing Team, RBC**	**Ongoing**	**Older residents are able to be part of developing opportunities for neighbours to know one another better**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-reported wellbeing**	**There are now four thriving Over 50s clubs – in Caversham, Southcote, Whitley and Coley. The Coley Club has just celebrated its first anniversary.**
Develop and raise the profile of community transport solutions	**Reducing Loneliness Steering Group**	**Ongoing**	**At-risk individuals know how to access transport as needed to join in social networks**		**There is a community transport representative on the Loneliness and Social Isolation Steering**

					Group
Develop volunteering and employment opportunities for adults with care and support needs	**Wellbeing Team, RBC**	**Ongoing**	**There will be more opportunities for adults with care and support needs to enjoy supportive and enabling social connections through work**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like**	**New volunteering and employment opportunities have been created as part of:** **- The relocation and reshape of The Maples Day Service** **- The development of the Recovery College** **- The development of the Over 50s clubs within**
Review and promote tools to assess and evaluate services' impact on social connectivity	**Reducing Loneliness Steering Group**	**August 2017**	**Local commissioners and providers will be able to measure the contribution of a range of services to reducing loneliness, and ensure provision is sensitive to local need**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-**	**The Loneliness Steering Group is being used a a vehicle to share ideas and best practice on evaluation.**

				reported wellbeing	
Prioritise local actions for reducing loneliness for 2017-19	**Reducing Loneliness Steering Group**	**October 2017**	**Activity and resources will be targeted based on local 'loneliness need'**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like** **PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like** **PHOF 2.23 i-iv – self-reported wellbeing**	**The Loneliness Steering Group is on target to progress with prioritisation.**

PRIORITY No 3	**Promoting positive mental health and wellbeing in children and young people** **Actions to support delivery of this priority are set out in the Reading Future In Mind Transformation plan that covers the key issues. This has been published at: http://nwreadingccg.nhs.uk/mental-health/camhs-transformation (Appendix 1)** **A separate update on actions to promote positive mental health and wellbeing in children and young people was provided to Board in March 2017.**

PRIORITY 4	Reducing Deaths by Suicide

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
Identify local sponsors to oversee Reading's Suicide Prevention Action Plan	Health & Wellbeing Board (Berkshire West Mental Health Strategy Group / Reading Mental Health Strategy Group)	February 2017	Reading actions to reduce deaths by suicide will be co-ordinated across agencies / There will be consistent local representation on the Berkshire Suicide Prevention Planning Group		Reading's Suicide Prevention Action Plan will be overseen by the Reading Mental Wellbeing Group
Develop a communication plan to raise awareness of Reading's Suicide Prevention Action Plan, including: - the formal launch of the Berkshire Suicide Prevention	RBC Communications Team	April 2017	Individuals will have increased awareness of support available / Partners will know how to engage with and support the Reading Suicide		The adoption of the Berkshire-wide Suicide Prevention Strategy was promoted was internally and externally. Plans are on target for further

Strategy **- contributions to the 'Brighter Berkshire' Year of Mental Health 2017** **- marking World Suicide Prevention Day (10 September)**			**Prevention Action Plan**		**communications focused on the autumn time.** **Launch of Berkshire Strategy will be scheduled around International Suicide Prevention Day which is 10th September**
Support the review of CALMzone and development of future commissioning plans for support services which target men **- Review local DAAT contracts to ensure suicide prevention objectives are included** **- Develop post discharge support for people who have used mental health services via the Reading Recovery**	**Wellbeing Team, RBC**	**October 2017** **April 2017** **Ongoing**	**Suicide risk will be mitigated for higher risk groups: men, people who abuse drugs or alcohol, people who have been in contact with mental health services**	**PHOF 4.10 – suicide rates**	**On target**

College					
Tailor approaches to improve mental health in specific groups: - **Support delivery of the local 'Future in Mind' programme to improve mental health in children and young people** - **Recognise the mental health needs of survivors and links to suicide prevention in the implementation of the Reading Domestic Abuse Strategy** - **Raise awareness of support available to survivors of sexual abuse through Trust House Reading**	**Local sponsors (see above)** **DENS, RBC** **Local sponsors (see above)** **Local sponsors (see above)**	**Ongoing** **tbc** **ongoing**	**Mental health will be improved for some specific groups (children and young people, survivors of domestic or sexual abuse) through tailored approaches** **Future commissioning of community based interventions will be informed by a review of impact**	**See Action Plan for Priority 3 for details in relation to children and young people.**	**On target**

- **Contribute to a Berkshire wide review of targeted community based interventions, including suicide prevention and mental health first aid training**					
Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and recommend appropriate action(s)	**Wellbeing Team, RBC**	**ongoing**	**Access to the means of suicide will be reduced where possible**		**Real-time surveillance has not highlighted any concerns regarding deaths in Reading residents. Berkshire-wide audit is planned for later in year.**
Review pages on the Reading Services Guide to include national resources (e.g. 'Help is at Hand' and National Suicide Prevention Alliance resources) and signposting to local services **Map local bereavement**	**Wellbeing Team, RBC**	**June 2017**	**Those bereaved or affected by suicide will have access to better information and support**		**Reading Services Guide has been developed to include these additional resources.**

support and access to specific support for bereavement through suicide					
Ensure local media and communications staff are aware of Samaritans guidance on responsible suicide reporting **Support a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting.**	**Wellbeing Team, RBC**	**February 2017** **July 2017**	**Local media will be supported to report on suicide and suicidal behaviour in a sensitive manner**		**Guidance has been shared locally. Local media event planned for summer 2017**
Update Reading JSNA module on suicide and self-harm **Refresh Reading Mental Health Needs Analysis**	**Wellbeing Team, RBC** **Adults Commissioning Team, RBC**	**tbc** **May 2016**	**Local and county-wide Suicide Prevention Action will be informed by up to date research, data collection and monitoring**		**The refreshed Suicide and Self Harm module of the Reading JSNA was published in March.** **A data update on the Reading Mental Health Needs Analysis was taken to the Reading Mental Wellbeing**

					Group in May.

PRIORITY No 5	**Reducing the amount of alcohol people drink to safer levels**

What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update June 2017**
Treatment					
Increase the number of people receiving support at the appropriate level to address risky, harmful and dependent use of alcohol. **Review current alcohol pathways to enable the specialist service to gain capacity to work with more risky, harmful and dependent drinkers.**	**All Partners required to support an alcohol pathway** **DAAT Contract Manager, CCG Leads, IRIS Reading Borough Manager, GP Lead**	**Ongoing** **April 2017**	**Lower level drinkers understand the risks to their drinking and prevent become more harmful/ hazardous drinkers.** **Other Stakeholders become a part of the alcohol pathway and understand their role in preventing people becoming harmful/ hazardous drinkers.**	**PHOF 2.15iii – Successful completion of alcohol treatment** **PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**Alcohol Pathway under review.**
Business Case for a Community Health Bus	**CAP Lead**	**August 2017**	**Encourage IBA in the community. More 'Community Alcohol Champions' to promote lower drinking levels and behaviours.**	**PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**Business case still being drafted**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
			Alcohol Champions, via the Community Health Busin the community will be able to deliver information and brief advice to members of the public.		
Promote the IRIS clinic at Longbarn Lane Surgery to all GPs for those clients whom do not wish to receive treatment at the Specialist drug and alcohol service – and future plans	IRIS Reading/ Dr. Helen George	January 2017	Clients can access treatment in the GP surgery rather than access via specialist drug and alcohol treatment service at Waylen Street. Reduce the impact on GP capacity with an additional specialist service in GP setting.		Specialist service offer to GPs for support with alcohol is being drafted.
Promote knowledge and change behaviour by promoting understanding of the risks of using alcohol and by embedding screening and brief intervention in primary care, social care and criminal justice settings, housing and environmental health	All partners	Ongoing		PHOF 2.15iii – Successful completion of alcohol treatment PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	NHS Health Check provides opportunistic conversation around alcohol use as Audit C is part of a check. Number of invites and health checks completed by GPs (providers) have

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
contacts.					declined from 2015/17 to 2016/17. Alcohol brief intervention training programme being drafted for the Autumn
Deliver IBA Training across all sectors – Need to encourage uptake of more Alcohol Champions	CAP Lead and Source Team Manager	Ongoing	More individuals trained to deliver an intervention – Making every contact count approach to managing alcohol issues/ signposting		Alcohol training for Older People during June and July.
Alcohol Mapping Group to present a business case for an Alcohol Liaison Nurse to help reduce alcohol related admissions to hospital.	Alcohol Mapping Group	April 2017		PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	Work ongoing with CCGs – update to follow
First Stop Bus – in Town Centre Friday & Saturday nights Explore an option of a fixed service with TVP, to deliver an extended service in Town Centre	Licensing and TVP	Ongoing	Option for people to dry out on the First Stop Bus rather than RBH First Stop Bus can offer advice and information on alcohol use.		The Community Health Bus business case will replace this initiative.
Need to gain authority for Peer Mentors to be on the	DAAT Contract Manager and	January 2017	Peer mentors can advise patients on specialist	PHOF 2.18 – Admission episodes for alcohol-	SLA drafted and awaiting sign off with

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
(selective) Wards at RBH Alcohol Peer mentors – to visit clients on hospital wards and assist in transition into community (including following detox).	CCG Project Manager IRIS Peer mentors	March 2017	community services and alcohol service available locally. To prevent re-admissions to hospital.	related conditions (narrow) (Persons, M and F)	peer mentors and RBH
GP Lead to promote IBA training in primary care. Promotion of IBA training in secondary care	Dr. H George DAAT contract Manager	Ongoing	Primary and secondary care professionals have the skills to deliver IBA and knowledge to make appropriate referrals on discharge	PHOF 2.15iii – Successful completion of alcohol treatment PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	Ongoing
Monitor and review existing interventions and develop a robust multi agency model to reduce alcohol-related hospital admissions.	All	Ongoing		PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	PH DAAT lead, South Reading CCG Lead and RBH exploring a joint funded alcohol post.
Licensing					
A community free of alcohol related violence in homes and in public places, especially the town centre.	CAP Lead	Ongoing	Reduction in alcohol admissions to hospital. Responsible drinking in public spaces.	PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	Street drinking initiative underway throughout June.

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
Create responsible markets for alcohol by using existing licensing powers to limit impact of alcohol use on problem areas and by promoting industry responsibility. **Address alcohol-related anti-social behaviour in the town centre and manage the evening economy** **Address alcohol-related anti-social Neighbourhoods**					
Review all extended new applications under the Licensing Act – Public Health review and consider all new applications.	**Public Health/ Licensing**	**Ongoing**	**Control of licensed outlets and review of Reading's late night economy.**		**Ongoing**
Licencing to promote responsible retailing, 4 Licensing objectives. **CAP to increase Test Purchasing – Challenge 25, Under 18.** **Licensed Retailer Passport to be rolled out to all retailers.**	**CAP / Licensing**	**Ongoing**	**Stricter licensing restrictions will be in place.** **There is a minimum price for a unit of alcohol as a mandatory condition of a License.**		**Commenced** **Qtrly test purchasing of Challenge 25. Test Purchasing of under 18 to take place during August.**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
Retailer Training to commence. Encourage retailers to restrict the sale of higher ABV % cans					Ongoing Can marking to commence June 2017
Promotion of better marketing of soft/ mixer-diluted drinks in Bars and Pubs.	CAP/ licensing	January 2017	Promote healthier non-alcoholic options to customers		Work to commence in Autumn
Encourage neighbourhoods to report street drinking to the Police via NAG meetings	All	Ongoing	Reduce street drinking and ASB		Ongoing. RSG to include a link for reporting alcohol issues
Education					
Parent education – School age children to be set an alcohol questionnaire to complete with their parents to promote knowledge on alcohol and the health risks	CAP lead	2017			Completed Collation of figures to inform future educational activites
Education if for all ages. Alcohol awareness sessions for all. Comic Project to encourage alcohol awareness.	CAP Lead	Ongoing	Educating everyone on the risks of alcohol and promote drinking responsibly.		Christmas and Easter project completed; weekly drop in at

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
Increase PHSE lessons in schools. **Commence a Youth Health Champion role – encourage youngsters to be active in tackling alcohol and understanding the risks of drinking alcohol.** **Work in partnership with Colleges and University to promote alcohol awareness to students** **Volunteers from the Specialist Treatment Service to visit school age children to educate them about the risks of alcohol and how their lives have been affected.**					**Library – Further Summer Holiday activities to be planned.** **Ongoing – 2 qualified Youth Health Champions. 12 children are signed up and involved in the programme. Workshops to continue – Looking at a Wellbeing initiative.** **PSHE presentations are taking place. Peer Mentors are willing to visit schools and this is co-ordinated when required.**
Promote diversionary activities to all – via schools, colleges, website	**CAP Lead**	**Ongoing**	**Promote social activities and exercise as alternatives to drinking alcohol.** **Resolve the "boredom" and social issues associated with alcohol.**		**Ongoing**
Prevention					

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
Promotion of Dry January campaign. **Promotion of January alcohol detox via IRIS Reading as part of the Dry January campaign**	**CAP Lead, DAAT Contract & Project Manager, IRIS Reading IRIS Reading Borough Manager & RBC Press team**	**December 2016 and January 2017**	**Encourage awareness of effects of alcohol on staff, clients and local community.** **Promote drinking responsibly.**		**Completed**
Explore with the street care team whether we can promote drinking responsibly at recycling depots.	**DAAT / Street Care Team**	**January 2017**	**Encourage drinking responsibly and increase public awareness of the risks of alcohol**		**Action still needed**
Work in partnership with RVA to promote Public Health messages through their newsletter	**Public Health Lead/ RVA**	**January 2017/ Ongoing**	**Encourage healthier lifestyles.**		**Action still needed**

PRIORITY NO 6	**Making Reading a place where people can live well with dementia**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017

Establish a Berkshire West Dementia Steering Group to implement the Prime Ministers Dementia 2020 challenge and ensure up-to-date local information about dementia can be reflected into dementia care services and that there is an opportunity to influence and inform local practice			**The Berkshire West Dementia Steering Group will report to the three Berkshire West Health and Wellbeing Boards as required from time to time, contributing updates and commentary on performance in relation to local dementia priorities and issues identified by those Boards. The Berkshire West Dementia Steering Group will also report to the Berkshire West Long Term Conditions Programme Board and will in addition keep the Thames Valley Commissioning Forum updated**		**Berkshire-wide dementia steering group set up comprising representatives from the three unitary authorities in Berkshire, a GP, Berkshire West CCGs and voluntary sector groups.**
Raise awareness on reducing the risk of onset and progression of dementia through building on and promoting the evidence base for dementia risk reduction (including education from	**Public Health (LAs), GPs, Schools**	**May 2017**	**By 2020 people at risk of dementia and their families/ carers will have a clear idea about why they are at risk, how they can best reduce their risk of dementia and have the**	**PHOF 4.16 and NHS 2.6i– Estimated diagnosis rate for people with dementia** **PHOF 4.13 – Health related quality of life**	**Dementia component of NHS Health Checks is targeted at those aged 65-74 years. It involves a brief awareness raising of signs of dementia, support and**

early years/school age about the benefits of healthy lifestyle choices and their benefits in reducing the risk of vascular dementia) and health inequalities and enhancing the dementia component of the NHS Health Check.			**knowledge and know-how to get the support they need.** **This will contribute towards the national ambition of reduced prevalence and incidence of dementia amongst 65-74 year olds, along with delaying the progression of dementia amongst those that have been diagnosed.**	**for older people** **ASCOF 2F and NHS Outcomes Framework 2.6ii – effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia.** **ASCOF 1B – People who use services who have control over their daily life** **NHS OF 2.1 - Proportion of people feeling supported to manage their condition**	**advice. Public Health England have a number of useful resources available, including online training, for providers of Health Checks.** **The Wellbeing Team have provided 2 public information sessions at Dementia Awareness Week (town centre) and Southcote May Fayre. Both events raising awareness of preventative health services specifically around Dementia and the links to alcohol, exercise and general health** **The Alzheimer's society implements through the core of their work**

Identify patients early including those from Black, Asian and Minority Ethnic origin and other seldom heard groups enabled through greater use by health professionals of diagnostic tools that are linguistically or culturally appropriate; encourage self-referral by reducing stigma, dispelling myths and educating about benefits of obtaining a timely diagnosis	**Primary care, Social Care (LAs), Memory Clinics, Care homes**	**March 2018**	**More people diagnosed with dementia are supported to live well and manage their health**	**ASCOF 2F - a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** **NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence for people with dementia**	**Currently happening via engagement with BME groups.** **Alzheimer's Society do this and have tools at the Society to support this**
Play a leading role in the development and implementation of personalised care plans including specific support working in partnership with memory assessment services and care plan design and implementation.	**Primary Care/BWCCGs/ BHFT**	**March, 2018**	**GPs ensuring everyone diagnosed with dementia has a personalised care plan that covers both health and care and includes their carer. This will enable people to say "I know that services are designed around me and my needs", and "I have personal choice and control or influence over decisions about me"**	**PHOF 4.13 - Health related quality of life for older people** **ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** **NHS OF 2.6ii - effectiveness of post-diagnosis care in**	**Care Plans uploaded on DXS, easily accessed by GPs and practice staff.** **DCA's who are commissioned through the CCG's at the Alzheimer's Society complete a support plan for every service user**

				sustaining independence for people with dementia **ASCOF 1B - People who use services who have control over their daily life** **NHS OF 2.1 - Proportion of people feeling supported to manage their condition**	
Ensure coordination and continuity of care for people with dementia, as part of the existing commitment that everyone will have access to a named GP with overall responsibility and oversight for their care.	**BWCCGs**	**March, 2018**	**Everyone diagnosed with dementia has a named GP as well as a personalised care plan that covers both health and care and includes their carer.**	**PHOF 4.13- Health related quality of life for older people** **ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** **NHS OF 2.6ii - effectiveness of post-diagnosis care in**	**Every diagnosed dementia patient has a named GP** **DCA service support in this with a robust referral route from GP.**

				sustaining independence and improving quality of life for people with dementia. **ASCOF 1B - People who use services who have control over their daily life** **NHS OF 2.1- Proportion of people feeling supported to manage their condition**	
Provide high quality post-diagnosis care and support, which covers other co-morbidities and increasing frailty.	**Primary care/ Memory Clinics/ Social Care (LAs),**	**Ongoing**	**Reduced: unplanned hospital admission, unnecessary prolonged length of stay, long-term residential care**	**ASCOF 1B - People who use services who have control over their daily life** **NHS OF 2.1- Proportion of people feeling supported to manage their condition**	**Patients and carers are routinely supported and sign-posted to services for on-going support. Post-diagnostic support are mainly provided by Alzheimer's society, BHFT and other voluntary sector organisations**

Target and promote support and training to all GP practices, with the aim of achieving 80% Dementia Friendly practice access to our population	**BW CCGs project Lead/ DAA co-ordinators**	**March, 2018**	**80% of practices in Berkshire West will have adopted the iSPACE and sign up to the Dementia Action Alliance to become dementia-friendly.**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii- effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia** **PHOF 4.13 – Health related quality of life for older people**	**Tier 1 training has been offered to all Practice staff across South Reading and North & West Reading CCGs. All practices in Reading have put plans in place to become dementia friendly. This will be further assessed using the iSPACE model and supported by the Dementia Action Alliance** **Alzheimer's Society representative through the DAA presented at the May CCG meeting to talk about Dementia friendly GP practices to share best practice** **Dementia GP champion**
Work with local organisations, care homes and hospitals to support more providers to achieve	**DAA/ LAs/ Alzheimers society/BHFT**	**Ongoing - reviewed in December 2017, 2018 and 2019**	**More services will be staffed or managed by people with an understanding of**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii -**	**7 new members of the DAA and local action plans completed. Includes John Lewis**

Dementia Friendly status			**dementia and the skills to make practical changes to make their service more accessible to those with dementia**	**effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia** **PHOF 4.13 – Health related quality of life for older people**	**Partnership, Launchpad, Reading libraries and Get Berkshire active, salvation army. Dementia friends sessions delivered for each location on request.** **Dementia Friends sessions/ AS training consultancy**
Maximise the use of Dementia Care Advisors & training opportunities & roll out a training package/train the trainer model for NHS & Social Care staff and other frontline workers	**BWCCGs/Alzheimers Society/ HEE/BHFT**	**March, 2018**	**People with dementia and their carers will be supported by health and care staff in all types of service that will have the appropriate level of dementia awareness and training.**	**NHS OF 2.1- Proportion of people feeling supported to manage their condition**	**All DCAs are trained in Tier 1 dementia training. BWCCGs offered Tier 1 dementia training to all GP practice staff and social care staff in December 2016.**
Ensure commissioned services contractually specify the minimum standards of training required for providers who care for people with dementia	**Local authority and NHS commissioning teams**	**March, 2018**	**People with dementia and their carers will be supported by health and care staff in all types of service that will have the appropriate level of**	**NHS OF 2.1- Proportion of people feeling supported to manage their condition**	**A minimum standard of training for providers already exists for many health and social care commissioned services primarily where staff**

including residential, nursing and domiciliary care settings.			**dementia awareness and training.**		**are directly supporting people living with dementia. This action is being broadened out into identify and working with commissioned services who people living with dementia and their carers will frequently access, for example GPs and social care staff (e.g. housing). Dementia Friendly initiatives specific to these staff groups are being made available and delivered.**
Review benchmarking data, local JSNA , variation, & other models of Dementia Care to propose a new pathway for Dementia Diagnosis/Management.	**BWCCGs/ Public Health/BHFT – not clear who leads on what here**	**March, 2017**	**National dementia diagnosis rate maintained at two-thirds prevalence, and reduced local variation between CCGs following agreement and implementation of an appropriate and**	**PHOF 4.16 - Estimated diagnosis rate for people with dementia** **NHS 2.6ii - effectiveness of post-diagnosis care in sustaining**	**The current pathway is still being used. A review of the local JSNA data will inform the proposal of a new pathway for diagnosis/management**

			affordable plan to bring services into line within the national framework for treatment and care.	independence and improving quality of life for people with dementia	Review of Dementia JSNA chapter has commenced. Officers have sought comments and are currently writing an updated draft for further/final consultation.
Identify & map opportunities, learning from similar and neighbouring CCGs, Providers and Local Authorities, for future service delivery to meet the 2020 Challenge. e.g. annual assessment, shared care, carer identification & support	BWCCGs/ BHFT	April, 2017	Diagnosis rate maintained at two-thirds prevalence, and reduced local variation between CCGs following agreement and implementation of an appropriate and affordable plan to bring services into line within the national framework for treatment and care	PHOF 4.16 - Estimated diagnosis rate for people with dementia NHS 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia	On-going quarterly Dementia Commissioners forum enables sharing and learning from national and regional initiatives to improve dementia diagnosis rates and post-diagnostic care and support.
Raise awareness of and ensure that at least 80% of people with dementia and their carers have a right to a social care assessment.	LAs/ Memory Clinics/ Primary Care/ CMHT/ DCAs	March, 2018	At least, 80% of people with dementia and their carers are able to access quality dementia care and support.	PHOF 4.13– Health related quality of life for older people ASCOF 2F- a measure of the effectiveness of	This action has been amended to clarify that anyone with the appearance of need is entitled to a social care assessment.

				post-diagnosis care in sustaining independence and improving quality of life **NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia** **ASCOF 1B- People who use services who have control over their daily life** **NHS OF 2.1- Proportion of people feeling supported to manage their condition**	

Provide opportunities for people with dementia and their carers to get involved in research through signposting them to register with joint dementia research (JDR)	**BHFT/Alzheimers Society /LA/BWCCGs/ University of Reading**	**March, 2018**	**More people being offered and taking up the opportunity to participate in research and to support the target that 10% of people diagnosed with dementia are registered on JDR by 2020. Future treatment and services to be based on and informed by the experiences of people living with dementia**		**Alzheimers Society and BHFT signpost people living with dementia and their carers to research opportunities and the JDR register.**
Enable people to have access to high quality, relevant and appropriate information and advice, and access to independent financial advice and advocacy, which will enable access to high quality services at an early stage to aid independence for as long as possible.	**BHFT/LAs**	**March, 2018**	**People with dementia and their carers are able to access quality dementia care and support, enabling them to say "I have support that helps me live my life", "I know that services are designed around me and my needs", and "I have personal choice and control or influence over decisions about me"**		**This happens routinely**

Evaluate the content and effectiveness of dementia friends and dementia friendly communities' programme.	**AS/DAA/UoR**	**March, 2018**	**More research outputs on care and services.**		**Awaiting stats on actual increased number of Dementia Friends sessions/ champions. Progress has been made in developing Southcote as the first Dementia friendly community in Reading. 4 dementia friends' sessions delivered during April & May. The Grange community café are now a Dementia friendly environment with all volunteers signed up and engaged.**

PRIORITY NO 7	**Increasing take up of breast and bowel screening and prevention services**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
Identify Practices where screening uptake is low and target initiatives and practice support visits to increase uptake.	**NHSE/PHE Screening Team** **Cancer Research UK Facilitator**		**Improved Screening Coverage and detection of cancers in early stages.**	**PHOF 2.19 Cancer Diagnosed at early stage** **2.20iii Cancer Screening coverage-bowel cancer** **2.20i Cancer screening coverage- breast cancer** **4.05i Under 75 mortality rate from cancer (persons)** **4.05ii Under 75 mortality rate from cancer considered preventable (persons)**	**Teachable moment pilot project for South Reading to be roll out from August.** **GP practices have signed up to the bowel screening non-responders clinical alerts.** **Tailored GP Surgery bowel screening letters to be sent to patients from the Hub** **Offer from Cancer Research UK Facilitator to visit all South Reading practices to improve cancer screening uptake**
To work in partnership with key stakeholders to increase public /patient awareness of signs and symptoms and	**Public Health Berkshire** **Macmillan**		**Patients seek advice and support early from their GP**		**Local authority supporting the promotion and engagement of**

screening programmes			**Increase uptake of screening programmes**		**Macmillan Cancer Education Project. The project is being led by Rushmoor Healthy Living with funding from Macmillan Cancer Support.** **Macmillan Cancer Educator has been appointed to raise awareness of the signs and symptoms of cancer among hard to reach groups in South Reading,** **CRUK bowel screening promotional video has been shared through local authority web pages.**
To plan and implement a pilot project that provides motivational behaviour change interventions to patients who have had a	**Public Health Berkshire** **Cancer Research UK**		**Patients motivated to make significant changes to lifestyle behaviours that will help to reduce their**		**Project re-designed and approved by the Cancer Steering Group.** **Invitation sent to South**

2WW referral and a negative result ("teachable moments")	**Facilitator**		**risk of developing cancer**		**Reading practices to get on board with the pilot project.** **Project likely to be rolled out from August 2017.**

PRIORITY NO 8	**Reducing the number of people with tuberculosis**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update June 2017
Offer training in Reading for health professionals , community leaders and other professionals who come in contact with at risk population	**FHFT & RBH TB service /South Reading CCG**	**Jan-17**	**Increase awareness about TB amongst local health and social care professionals as well as third sector organisations**	**PHOF 3.05ii - Incidence of TB (three year average)**	**TB update training was provided to 29 participants in Reading including health professionals, community workers and voluntary sector workers in Reading on 5th January.**

Develop resources / training materials for wide range of LA staff to enable them to discuss TB and signpost to local services	**Berkshire shared PH team / TB Alert**		**Increase awareness about TB amongst local authority staff working with those at increased risk of TB**	**PHOF 3.05ii - Incidence of TB (three year average)**	**TB awareness session for the local authority staffs was organised on 16th March. There were 28 participants from different departments including Children, Education and Early Help services, Corporate services, Environment & Neighbourhood services and Adult care & Health services.**
Develop and run a joint public-facing communications / social marketing campaign to raise awareness of TB, latent TB and the local New Entrant Screening Service in order to reduce stigma and encourage those invited for LTBI screening to attend	**Berkshire shared PH team / CCG comms / NESS nurses**	**March 2017**	**Address social and economic risk factors related to TB**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Sleeping TB campaign has been developed and phase 1 delivered. Campaign leaflets and posters were disseminated to libraries, children's centres and leisure centres in Reading. This work-stream will be reviewed when CCG project officer is in post to identify**

					opportunities to ensure continued communication of campaign messages. **'World TB Day' promotion event was organised in Broad St Mall, Reading on 24th March 2017 to raise public awareness on latent TB and new entrant screening services.** **Latent TB community engagement events was organised by the Wellbeing team during Southcote Fair and Women's World Café Day.** **The Reading Wellbeing team has been working facilitate a TB Knowledge, attitude and belief survey in South Reading which is being funded by the SRCCG and is being led by Health Watch Reading**

Include TB data and service information in JSNA	**Reading Wellbeing team**	**February 2017**	**Address social and economic risk factors related to TB**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Key information on active and latent TB and map of high risk countries has been made available on Reading Services Guide and JSNA profile to facilitate public access to TB information.**
Provide service users with a means to feed into service design discussions	**PH / TB Teams**	**Ongoing**	**Future treatment and services are based on and informed by the experiences of people living with TB** **Repeat service user survey annually**	**PHOF 3.05ii - Incidence of TB (three year average)**	**The TB team utilises the Friends and Family test**
Continue to work closely with PHE health protection colleagues to ensure robust and effective contact tracing takes place as standard	**TB Nurses / Berkshire TB Strategy Group**		**Contract tracing is monitored through the Thames Valley TB Cohort Review**	**PHOF 3.05ii - Incidence of TB (three year average)**	
Maintain robust systems for providers to record and report BCG uptake	**NHS England**		**Monitor provision and uptake of BCG vaccination as new policies are implemented**	**PHOF 3.05ii - Incidence of TB (three year average)**	

				Local indicator on BCG update could be developed in partnership with NHSE	
Develop / maintain robust systems for providers to record and report uptake and to re-call parents	**Midwifery teams in FHFT and RBH**	**January 2017**	**Ensure registers of eligible infants who have missed vaccination due to shortages are kept to up to date and a mechanism exists to re-call when vaccine is available**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Registers are being kept by RBH midwives and communicated to NHSE immunisation lead. Babies are being re-called for vaccination. There is a high rate of non-attendance for re-calls.**
Continue to communicate clearly on BCG shortage and ordering arrangements to allow planning	**NHS England**	**Ongoing**	**Vaccinating teams have timely information on which to base decisions**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Vaccinating Teams are kept informed by NHSE regional team and through 'Vaccine Update' publication. All eligible babies are on track to have received BCG vaccine by end of June 2017**
Ensure processes are in place to identify eligible babies, even in low-incidence areas	**Midwifery teams in FHFT and RBH**	**Ongoing**	**Midwifery Teams use agreed service specification to identify eligible babies**	**PHOF 3.05ii - Incidence of TB (three year average)**	**This has been challenging due to BCG shortages in 2016. A new service specification was sent to heads of midwifery in 2017.**

Tackle the clinical and social risk factors associated with development of drug resistance in under-served populations by maintaining high treatment completion rates and ensuring thorough contact tracing around MDR cases	**Reading Wellbeing Team / Reading** **Reading Housing Team / NESS nurses/CCGs**	**Jan-17**	**Work to develop the provision of appropriate and accessible information and support to under-served and high-risk populations.**	**PHOF 3.05ii - Incidence of TB (three year average)**	
Ensure patients on TB treatment have suitable accommodation	**Reading Wellbeing Team / Reading** **Reading Housing Team / NESS nurses/CCGs**		**Development of robust discharge protocol**	**PHOF 3.05ii – Treatment completion for TB**	**PHE have developed Thames Valley guidance which is available to localise.**
Develop and promote referral pathways from non-NHS providers	**LA public health / NESS nurses/CCGs**		**Align local service provision to these groups as per NICE recommendations**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Work with under-served groups is priority for CCG LTBI Project Manager and LA PH in 2017**
Develop robust pathways to enable timely discharge of patients into appropriate accommodation	**LA public health / NESS nurses**	**Jan-17**	**Develop robust pathways to enable timely discharge of patients into appropriate**	**PHOF 3.05ii - Incidence of TB (three year average)**	**PHE have developed Thames Valley guidance which is available to localise.**

			accommodation		
Engagement with SE TB Control Board to share best practice	**DPH / PHE CCDC**		**Work to decrease the incidence of TB in Berkshire through investigating how co-ordinated, local latent TB screening processes can be improved**	**PHOF 3.05ii - Incidence of TB (three year average)**	
Fully implement EMIS and Vision templates in all practices in South Reading	**South Reading CCG**	**Ongoing**	**Ensure that new entrants are referred routinely to local services for screening through addressing issues with local pathways**	**PHOF 3.05ii - Incidence of TB (three year average)**	**Templates installed in all practices. Majority of practices are returning monthly lists to NESS**

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**14 JULY 2017**	**AGENDA ITEM:**	**16**
TITLE:	**UPDATE ON BOB STP PREVENTION WORKSTREAM**		
LEAD COUNCILLORS:	**COUNCILLOR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**WELLBEING**	**WARDS:**	**All**
LEAD OFFICERS:	**JO HAWTHORNE**	**TEL:**	**01189373623**
JOB TITLES:	**HEAD OF WELLBEING, COMMISSIONING & IMPROVEMENT**	**E-MAIL:**	**jo.hawthorne@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report is intended to give the Health and Wellbeing Board an information update on the work of the Prevention Workstream that is part of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability Transformation Plan (BOB STP). The report sets out the 6 themes that are the focus of this work, giving the vision, deliverables and progress to date. The 6 themes are: obesity, physical activity, tobacco, Making Every Contact Count, Digital solutions and Healthy Workforce. The work going on in the BOB STP Prevention Workstream is variable across the themes however there has been considerable progress made and collaboration across the 3 geographical areas within BOB and the different disciplines. The Prevention Workstream is chaired by an Operational Director for the Berkshire West CCGs and there is a presence of Directors of PH and their representatives from Buckinghamshire, Oxfordshire and Berkshire West.

1.2 Appendix 1 – Tiers of weight management interventions
Appendix 2 – London Clinical Senate – Helping smokers quite campaign
Appendix 3 – Making every contact count (MECC) stocktake

2. RECOMMENDED ACTION

2.1 The Board to note progress against delivery of the six STP themes within the BOB STP Prevention Workstream

3. POLICY CONTEXT

3.1 Sustainability and transformation partnerships build on collaborative work that began under the NHS Shared Planning Guidance for 2016/17 – 2020/21, to support implementation of the Five Year Forward View. They are supported by six national health and care bodies: NHS England; NHS Improvement; the Care Quality Commission (CQC); Health Education England (HEE); Public Health England (PHE) and the National Institute for Health and Care Excellence (NICE).

- The development of STPs is driven by Joint Strategic Needs assessments and health and Wellbeing Strategies. Reading is part of the Buckinghamshire, Oxfordshire and Berkshire West STP footprint (BOB STP). *The agreed Council strategy and/or policy within which the decision is being made:*
  Health and Wellbeing Strategy, Joint Strategic Needs Assessment,
- *All relevant past decisions of Council and other decision-making bodies*

4. THE PROPOSAL

The challenges and opportunities facing NHS and care services across Buckinghamshire, Oxfordshire and Berkshire West (BOB) are set out in a five-year Sustainability and Transformation Plan (STP). The plan demonstrates how the NHS will work to improve health and wellbeing within the funds available and also highlights how it will work in partnership with the Local Authorities to address the many challenges that exist including growing populations, higher proportion of older people, inequalities in health, increase in complex and costly treatments etc.
The BOB STP has as its focus the following areas:

- Shifting the focus of care from treatment to **prevention**
- **Ensuring Access** to the highest quality primary, community and urgent care
- Facilitating collaboration of the three acute trusts to deliver **quality and efficiency**
- Maximising value and patient outcomes from **specialised commissioning**
- **Developing Mental health services** to improve the overall value of care provided
- Establishing a flexible and collaborative approach to **workforce**
- **Developing Digital interoperability** to improve information flow and efficiency

The BOB STP Prevention Workstream
Vision
A proactive approach to disease prevention within all that we do, shifting the focus of care from treatment to prevention , addressing unhealthy behaviours that may lead to serious conditions further down the line and thus reducing the burden on the healthcare system. We will take action to motivate people to take ownership of their own health and encourage healthy environments to enhance the quality of life for our population.
There are a wide range of programmes that support the aim of shifting the focus of care from treatment to prevention in all settings. The programmes that have been identified for the BOB STP are:

- Obesity
- Physical activity
- Making Every Contact Count
- Tobacco
- Improving Workforce Health
- Digital self care
-

The overall objectives for all of these areas of work are twofold:

1. To embed prevention within the local transformation programmes
2. To collaborate across BOB on areas where there is benefit of working at scale.

There is also an aim to continue working together to identify other BOB wide opportunities, that may include alcohol and social prescribing.
The most appropriate level at which each programme should be led and delivered within the health and care system has been agreed through the STP. This has been based on the partnerships and scale required to best implement the specific programmes. A stocktake of all initiatives was undertaken and schemes were chosen based on the following principles:

1. There is a clear opportunity/ benefit in doing it jointly, to deliver improvement in terms of finance, quality and/or capacity
2. Doing something once is more efficient and offers scale and pace
3. Collective system leadership is required to make the change happen

The case for change in Buckinghamshire, Oxfordshire and Berkshire West

The overall health and wellbeing of the populations across the BOB STP footprint is generally good however areas of deprivation and poor health are often masked. Inequalities in health exist across all three localities. Higher levels of obesity and smoking are more prevalent in certain groups including those on low incomes and living in deprived areas. There is a commitment in the BOB STP Prevention Workstream to focus on developing system wide initiatives to reduce the burden of ill health due to physical inactivity, poor diet and smoking as well as a recognition that this needs to be done in partnership with CCGs, Local Authorities, Public Health, NHS Trusts and The Academic Health Sciences Network (AHSN).

There is a strong evidence base showing that the health and wellbeing of residents can be improved and demand on health and social care services reduced though people changing to healthier lifestyle behaviours, including being more physically active, eating a healthier diet, maintaining a healthy weight and not smoking. Return on investment tools have shown that for the BOB footprint the savings could be as much as £9 million over a 4 year period.

There are already examples of joint commissioning in prevention across Berkshire West for smoking cessation and tier 2 weight management services and these demonstrate the advantages of commissioning at a wider level with multiple partners. There are also examples of joint commissioning with CCGs and LAs through the Better Care Fund. All this can be built upon and extended across the BOB STP.

Update on Progress to date in the five areas of work of the BOB STP Prevention Workstream

Through 2016/17 work has begun including mapping of services already being commissioned, visioning/ planning what might be achieved and setting up subgroups to initiate and take the work forward. Throughout 2017/18 the work is being further developed and plans implemented.

Update for Obesity

Vision: To agree and develop a pathway for commissioning obesity prevention and treatment services which is consistent across the BOB area.

Deliverables: A task and finish group of commissioners from CCGs and local authorities will meet in Q4 of 2016-17 to:

1. Agree definitions of "tiers" of weight management treatment (see appendix 1)
2. Map current provision of obesity prevention and weight management services
3. Identify best practice and funding opportunities
4. Discuss opportunities for joint work by CCGs and /or local authorities in commissioning.
5. Agree a further project plan for 2017-18

Progress to date

1. Mapping of current services has been further refined, based on a Stocktake exercise from Sept 16 but with additional input from commissioners in CCGs and Local Authorities
2. The Task and Finish group has met twice (Feb and April 2017) and agreed tier definitions for weight management services
3. Mapping of existing services is complete and gap analysis has demonstrated that tier 3 weight management interventions are a gap for Oxfordshire and Berkshire West.
4. A survey is being completed to map thresholds for access to services
5. A workshop has been planned to take place on July 12th in Reading to explore the joint commissioning of tiers 3 and 4 weight management services across BOB STP. The aims of the workshop are

- To inform BOB level commissioning for Tier 3 and 4. (these are the two levels that we believe might benefit from collaborative commissioning.
- To provide an opportunity to discuss current positive practice and learn from local and national experiences (good or bad) and scope potential pathway

- To provide a safe and informative environment to discuss and seek 'buy in' to vision and direction.

Update for physical activity

Vision: To maximise the use of the IT patient portal, identify through consultations, patients who are physically inactive and use technology and social media approaches to improve their activity levels. To incorporate Physical Activity as a treatment prescription for condition pathways.

Benefits

- Additional resource into the connected care programme
- Focus on a comprehensive/digital programme to encourage the general population to increase activity (focussing on currently inactive residents) and support patients with long term conditions to increase activity
- Align with the stepped approach to care developing through GP and self-care workstreams.

Progress to date

A workshop took place in Oxford in May to agree priorities and the following 4 themes were agreed as priorities:

a. digital solutions
b. communication
c. clinical activity
d. workforce development

Each theme was then identified as being a quick win or a longer term development or needing more definition. Consideration was also given to the cost likely to be incurred for each of the themes.

- The first quick win identified as a priority was the opportunity to make digital apps and local information more immediately available to residents. The following actions will take place: identify a suite of apps to promote physical activity to be promoted across the NHS in BOB; ensure all NHS websites include links to local key physical activity programmes and resources (such as Active Bucks, Go Active Get Healthy); review the physical activity content in the Making Every Contact Count training to ensure it is robust and links to local pathways
- The first developmental action identified as a priority was care pathway work as this offers the potential to integrate promotion of physical activity into core business. Any actions selected will need the appropriate commitment from NHS organisations in order to ensure implementation is possible. The following actions will take place: select one clinical condition and develop a best practice pathway indicating where physical activity can be incorporated as either a preventative or therapeutic input. Pathway to also identify points when patients may be particularly motivated to make changes.

Update for tobacco

Vision : To reduce significantly the number of smokers who have surgical interventions.

Deliverables:

- It is well recognised that smoking cessation is one of the most effective ways to improve health. Whilst most savings are calculated on the medium and long term impact, savings can be delivered in year within health care settings if a focussed and concerted effort is made on reducing significantly the number of smokers who have surgical interventions. This investment would see a new programme run in conjunction with surgical departments within hospitals and primary care to contact and support all surgical elective admissions to stop smoking.

- Acute Trust to support a position prescribing smoking cessation prior to surgical elective admission.

Benefits: In a study by Moller et al, 23% of patients smoking up to the time of surgery had a surgical site infection (SSI). This reduced to 4% among those smokers who quit just a few weeks prior to surgery. A recent study shows that most of the infection risk difference between smokers and non-smokers is mainly observed during the period between surgical procedure and discharge from hospital. So all savings will be in-year
For the BOB STP, the figures show 154,500 elective procedures were carried out last year. If 20% of those procedures are on smokers then we have the chance to make 30,900 offers of quit support. Even if only 5% of those result in setting a quit date – that results in 1545 smokers going into a smoking cessation programme. If there is an achievement of at least a 60% quit rate (which was achieved by Moller and locally exceeded) we will reduce an estimated 355 infections down to just 62. If we assume an average surgery cost of £7000 is doubled to £14,000 if an SSI occur (Broex et al, 2009) then that means a reduced annual cost **of £2,054,917.**

Progress to date
Berkshire West CCG Federation is currently developing a proposal to consider how individuals being referred for elective surgery can be supported and encouraged to make healthy lifestyle changes before their surgery. This will decrease the risks of elective surgery for people who smoke or are obese thus improving patient outcomes and saving valuable resources by decreasing length of stay post operatively.

Another approach being considered is adopting the model of the London Clinical Senate 'Helping Smokers Quit Campaign'. This would include primary prevention with the vision that 'every BOB clinician knows the smoking status of each patient they care for and has the competence and the commitment to encourage and support that patient to quit or reduce their consumption through direct action or referral.' (appendix 2)

Update for Making Every Contact Count (MECC)
Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly. Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. Making Every Contact Count (MECC)

Vision: The programme of work aims to embed MECC across organisations to enable the workforce to recognise their role in prevention and reducing inequalities to support the sustainability of the health and social care system; building on existing initiatives in place across the BOB STP footprint.

Deliverables: The MECC project will be informed by stages. The focus for the first 6 months will be to develop and implement an agreed MECC strategy across BOB's acute services where significant impact can be made on influencing population health through staff, patients and visitors. The second phase will develop training and implementation across acute services. In parallel to phase 2, the Programme Manager using learning from phase 1, will engage with community and primary care organisations for further MECC roll out.

Progress to date
1. A detailed MECC stocktake is currently being undertaken across BOB STP. This will identify what MECC activity is currently in operation, what level of buy in exists at senior level management, what resources and infrastructure will be needed to fully implement MECC, how can staff be engaged and what training will be required and how will the programme be evaluated? (appendix 3)

2. Michael Mullholland (lead on the Primary Care BOB STP Workstream) will be contacted to discuss how MECC fits in across the 2 workstreams. A Programme Co-ordinator has been appointed to carry out the stock take and set targets and trajectories for MECC in the BOB STP.

Update on Digital self care

Vision:

1. **Supporting general wellbeing through use of digital**
2. **Supporting patients with managing their conditions through digital**
3. **Clinically/social care professional led prioritisation**
4. **Joined up and informed investment around patient facing technology (opposite of as is state)**

Deliverables: Digital Self-Care

- Mapping existing digital approaches and identifying what are the quick wins
- A register of apps that are being recommended for patients
- Identification of patient journeys/scenarios to support with navigation
- Agree priorities of pathways
- Identification of unintended consequences e.g. loneliness if we are removing interactions with care professionals face to face
- Establish a workshop to capture wider professional views.

Progress to date

- Mapping exercise currently being undertaken
- A 12 month pilot project is being developed in Berkshire involving the NHS and Microsoft. This will involve 400 volunteers who are NHS staff wearing a digital device (Fitbit) 24 hours a day for the period of one year. A number of parameters will be monitored including BP, HR, activity levels and sleep and the aim is to understand if the wearing of an electronic monitoring device can in fact have a positive effect on health and wellbeing.

Update on improving workforce health

Vision: To improve and sustain workforce health and wellbeing and employee confidence to promote healthy lifestyles to others

Deliverables:

- Improve collaboration across BOB to enable the sharing of measures and initiatives
- Using CQUIN as a template, develop new initiatives to further enhance staff wellbeing initiative
- Embed good practice already in place to encourage consistency of wellbeing offer across BOB, disseminate case studies, success, evaluation measures and offer peer support
- Create a culture where staff Health and Wellbeing is used proactively within organisations e.g. during organisational change and is considered in conjunction with other organisational activities e.g. Education and Training, retention programmes etc.
- To engage other employers / providers within the footprint to work collaboratively, including opportunities to use resources at reduced cost e.g. University Gyms, Fire service premises etc.
- Identify further collaborative opportunities over and above local delivery to improve workforce health and wellbeing and additional financial savings, e.g. through NHS employers, National Conferences, Occupational Health and Wellbeing Networks.

- Promote and encourage the role of staff as role models and/or ambassadors for healthier lifestyles
- Making Every Contact Count (MECC) – training staff how to have confident conversations around health and wellbeing and raising awareness of onward signposting opportunities

Progress to date

- Mapping exercise across BOB STP completed and collated on what healthy workforce initiatives are currently happening
- Raising awareness of healthy workforce issues e.g. presented to Bucks Health and Wellbeing Board on healthy workforce mental health initiatives
- Identified achievement of CQUIN (Commissioning for Quality and Innovation) targets for healthy workforce for all NHS Provider Trusts across BOB
- Exploration of a Health and Wellbeing Information Hub for staff and residents (already up and running in Bucks) to identify how this can improve health and wellbeing for NHS staff.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The work being undertaken as part of the BOB STP Prevention Workstream contributes to the following Corporate Plan priority:

Providing the best start in life through education, early help and healthy living;

5.2 The Preventative work within BOB STP contributes to the following Council Strategic Aim:

To promote equality, social inclusion and a safe and healthy environment for all

5.3 There is also contribution to the aims of the Health and Social Care Act (2012) and the Public health Outcomes Framework

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- Under The Health and Social Care Act (2012) local authorities now have a much stronger role in shaping services, and have taken over responsibility for local population health improvement. The Health and wellbeing boards have brought together local commissioners of health and social care, elected representatives and representatives of Healthwatch to agree an integrated way to improving local health and well-being. The aims for each LA are set out in the Health and Wellbeing Strategy that is based on the local JSNA.
- The Public Health Outcomes Framework (PHOF) *Healthy lives, healthy people: Improving outcomes and supporting transparency* sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected
- The BOB STP Prevention workstream will help to improve the health and wellbeing of residents by preventing many long term conditions including diabetes, coronary heart disease, stroke, Chronic obstructive pulmonary disease (COPD), osteoporosis, and some cancers. This will be achieved through helping residents to take responsibility for their own health and wellbeing and adopt healthier lifestyles including being more physically active, not smoking, eating a healthier diet and maintaining a healthy weight. In addition workforce health and digital solutions can also help to improve mental and emotional health and wellbeing of those who live and work in Reading.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The Berkshire West CCGs have presented the concept of the BOB STP to their residents at a Public Consultation meeting. For North and West Reading and South Reading CCGs these meetings took place in March 2017 in local venues. Details of the Prevention workstream were touched upon only in general terms without details of the work planned.

7. EQUALITY IMPACT ASSESSMENT

7.1 The work of the BOB STP Prevention Workstream will continue to be developed with an awareness of inequalities of health identified through robust local data sets.

8. LEGAL IMPLICATIONS

8.1 We do not anticipate there to be any legal implications at this stage.

9. FINANCIAL IMPLICATIONS

9.1 The work being undertaken by the BOB STP Prevention Workstream is being delivered within existing resources. Some funding may be made available from a variety of sources for specific pieces of work for example the Making Every Contact Count project has been funded through the STP process.

10. BACKGROUND PAPERS

10.1 BOB STP Prevention Workstream Update April 2017.

Appendix 1

Weight Management Tier Definitions

	Appendix 9 Guidance for Clinical Commissioning Groups (CCGs): Service Specification Guidance for Obesity Surgery	Notes from BOB weight management task and finish group meeting discussion (21st February 2017)	Combined definition
Tier 1	**Preventative programmes:** Public health interventions aimed at prevention and reinforcement of healthy eating and physical activity messages.	• None	**Preventative programmes:** Public health interventions aimed at prevention and reinforcement of healthy eating and physical activity messages.
Tier 2	**Weight management services:** Lifestyle weight management advice. This may be given in primary care as part of on-going personalised care. Weight management services delivered in the community led by a health care professional (e.g. dietician) trained in obesity. This may also include additional support by commercial weight management services. These commercial programmes will be well defined with scientific leadership and with clear protocols.	• It is multi-component .e.g. looking at a range of lifestyle habits (physical activity as well as diet) • It is a structured intervention • Setting/venue is less important than the structured modality of the intervention	**Weight management services:** Multi-component lifestyle weight management structured advice. This may be given in various community settings and venues including, primary care (as part of on-going personalised care) or leisure centres. It is led by a health care professional (e.g. dietician) trained in obesity. This may also include additional support by commercial weight management services. These commercial programmes will be well defined with scientific leadership and with clear protocols.
Tier 3	**Specialist care**: 1:1 management by a medically qualified specialist in obesity. This may be community or hospital based +/- outreach and delivered by a team led by a specialist obesity physician. Patient management will also include specialist dietetic, psychological and physical activity input. This will include group work and access to leisure services. There will be access to a	• Face-to-face component is required but doesn't have to be one-to-one • For further discussion - Tier 2 should be a pre-requisite to being offered tier 3	**Specialist care**: Face-to-face weight management by a medically qualified specialist in obesity. This may include one-to-one support but is not restricted to one-to-one support. This may be community or hospital based +/- outreach and delivered by a team led by a specialist obesity physician. Patient management will also include specialist dietetic, psychological and physical

	full range of medical specialists as required for co-morbidity management.		activity input. This will include group work and access to leisure services. There will be access to a full range of medical specialists as required for co-morbidity management.
Tier 4	**Specialist care:** 1:1 management provided by specialist obesity medical and surgical MDTs with full access to a full range of medical specialists as required. All patients will be referred to Tier 4 by a Tier 3 service. The difference between the medical specialty at tiers 3 and 4 will be a qualitative level of experience in complex patient management. All surgical procedures will take place in tier 4.	• Support has to be offered in preparation for and follow-up after surgery • Is moving to be commissioned by CCG's in 2017	**Specialist care:** 1:1 management provided by specialist obesity medical and surgical MDTs with full access to a full range of medical specialists as required. All patients will be referred to Tier 4 by a Tier 3 service. All patients who go on to have surgery will have support in preparation for the surgery and support in follow-up to the surgery. The difference between the medical specialty at tiers 3 and 4 will be a qualitative level of experience in complex patient management. All surgical procedures will take place in tier 4.

Appendix 2

London Clinical Senate 'Helping Smokers Quit' Campaign

The London Clinical Senate established a 'Helping Smokers Quit Programme' to run from September 2014 until May 2016, chaired by Dr Mike Gill. The values underpinning this work are:

- Reduce the harm caused by tobacco.
- Reduce health inequalities.
- Champion value-based care because treating tobacco dependence is THE value proposition for the NHS.

The vision is that every London clinician knows the smoking status of each patient they care for and has the competence and the commitment to encourage and support that patient to quit or reduce their consumption through direct action or referral.

All London clinicians should complete the Very Brief Advice Training from NCSCT. It has deliberately moved to a different language which explicitly recognises that smoking is not a "lifestyle choice" but a sign of tobacco dependency, a long term relapsing condition that usually starts in childhood and 'treating it is the highest value intervention for today's NHS and Public Health system, saving and increasing healthy lives at an affordable cost.' People who are tobacco dependent deserve to have the same access to high quality, integrated, person-centred, and evidence based services as people with other long term conditions.

The Clinical Senate is asking all London's health organisations to commit to CO4:

- The 'right' **CO**nversation for every patient and staff member who smokes that gives him or her a chance to quit, referring if necessary.
- Make routine near-patient (i.e. desk-top, bed-side and home) exhaled carbon monoxide (**CO**) monitoring by clinicians possible: "Would you like to know your level?"
- **CO**de smoking status and the intervention so we can evaluate effectiveness – including death certification.
- **CO**mmission the system to do this right: so the right behaviours are incentivised systematically.

Three key messages for developing STP's:

1. Tobacco dependence is a major problem for the NHS.
2. Helping people stop smoking is the single highest value contribution to health that any clinician can make.
3. Effective diagnosis and treatment of tobacco dependence requires an urgent improvement in clinical training, use of carbon monoxide monitoring and medicines optimisation.

Examples of best practice:

- Royal Free – In-house hospital stop smoking service. Smoke free Steering Group. Clinical leads take responsibility for ensuring that the programme is at the heart of the Trust's clinical strategy. Also leadership within the respiratory, infection and HIV teams.

- Kings College - Taking CO levels are a standard part of respiratory assessment in the lung function lab and oxygen assessments.
- Whittington – Two specialist advisors join the daily ward round and train all staff.
- Barking and Dagenham – Funds the maternity service to deliver the BabyClear model.
- CNWL - Made level 2 training 'Essential to role' for Clinicians, and Level 1/VBA for all other staff.
- UCL – Include 'treating tobacco dependence' in the first year of training to medical students.
- Oxleas – Use of CO monitors on all wards, CO4 used as a CQUIN.

Recommendations from the report:

- CO monitors are cheap (£130) and should be made available to all clinicians.
- Every NHS organisation should have a clear pathway for people who are tobacco dependent, which ensures access to local specialised services.
- Sustainability and Transformation Plans offer a real opportunity for a step change and should clearly set out responsibilities and actions for addressing tobacco dependence agreed by all partners.
- Every NHS Trust should have a board level clinician responsible for addressing tobacco dependence and Clinical leads should be identified in each area to support this action.
- All London's health organisations should commit to CO4, a four pronged approach to identifying and treating tobacco dependence.
- All formularies should include a full range of Nicotine Replacement Therapy products as well as Varenicline.
- All patients should be offered a combination of interventions, with combined behavioural support and pharmacotherapy being most effective.
- The smoking status of all NHS patients should be established, recorded and updated as necessary at every patient contact, with appropriate referral to stop smoking services as required. Both the smoking status and intervention should be coded so the effectiveness can be evaluated.
- All NHS organisations should make VBA part of all health professionals 'mandatory training requirements.

Useful Links:
http://www.londonsenate.nhs.uk/helping-smokers-quit/

Appendix 3

BOB STP Making Every Contact Count

Eight Steps diagram: for planning and implementing MECC across BOB

The diagram below illustrates the steps involved in scoping, planning and implementing a BOB MECC initiative. In addition to these steps, there is a backdrop of encouraging staff to take responsibility for the own health and wellbeing.

BOB STP MECC Stocktake

Action point	Stocktake response	Indicate: Achieved Part Achieved or Development area (RAG – red, amber, green)	Action required for BOB STP to implement
1. Organisational strategy **To shape why MECC should be taken forward** • What is your organisation's vision? • How does MECC fit the organisational goals? • Are there shared goals? • What are other organisations within your area or region doing in relation to MECC? • Have you identified where MECC activity can fit into wider health improvement plans or activity across your area or region? • Have the benefits for patients / clients and staff been identified?			
2. Senior leadership **Senior leadership buy-in is crucial to the successful implementation of MECC** • Is the organisation's senior leadership aware of MECC?			
Action point	**Stocktake response**	**Indicate: Achieved**	**Action required for BOB STP to implement**

		Part Achieved or Development area (RAG – red, amber, green)	
• Is there an opportunity to increase senior leadership involvement? If so, who needs to be involved and how?			
3. Planning **To implement MEXX, a team of people is needed to lead and champion the approach. This section will assist you to identify key individuals to support implementation.** • Who will lead the MECC implementation (developing, reviewing, and monitoring an action plan) in the organisation and teams? • Do you need to form a MECC implementation team from across the organisation to lead the programme? • Who are the key stakeholders who should be involved? • Who will be the MECC champions? • How will you identify and engage them? • Do you need MECC meetings? Should they be face to face or virtual? Who will attend and how often do meetings need to happen?			
Action point	**Stocktake response**	**Indicate: Achieved**	**Action required for BOB STP to implement**

		Part Achieved or Development area (RAG – red, amber, green)	
4. Identifying resources **What resources are needed and available to support implementation? For example:** • Time • Budget • Staff capacity for training • How will training be delivered? (e.g. delivery using a train-the-trainer model; at face-face-face workshops, or distance learning) • Facilities and equipment needed e.g. rooms, laptops, etc. • Physical areas where staff work e.g. are there any barriers to holding healthy conversations?			
Action point	**Stocktake response**	**Indicate:** **Achieved** **Part Achieved or**	**Action required for BOB STP to implement**

		Development area (RAG – red, amber, green)	
5. Infrastructure – systems and processes **Consider what systems and processes are required to embed MECC and whether existing infrastructure can be modified to support staff. How can MECC be embedded and sustained long term?** Issues to consider include: • Activity and outcome monitoring – how will you know how many healthy conversations have taken place? • Can you integrate monitoring forms into existing systems? If so, how? • How will the referrals and signposting to other services be managed? Who will be responsible for collating the information on services signpost to? How will you monitor signposting / referrals? • Will MECC be an agenda item at team meetings or at one-to-one meetings with staff? How can support be made available to staff when required e.g. via information displayed in organisational surroundings and staff intranet?			
Action point	**Stocktake response**	**Indicate:** **Achieved** **Part Achieved or**	**Action required for BOB STP to implement**

		Development area (RAG – red, amber, green)	
• Can MECC be written into organisational policies, processes and procedures? Can MECC link with or build on existing projects or initiatives within the organisation? • Can reporting on MECC activity be incorporated into existing core annual reports? • Can all new staff be trained in MECC? Can MECC training be part of an induction programme? • Can MECC be included in job descriptions, person specifications or as part of organisational codes of practice, or outlines of professional duties? • Consider how MECC activity can be captured and reflected during staff appraisals, e.g. via a MECC KPI. Can your organisation consider role modelling with a MECC champion? • Consider activity to support self-wellbeing for all staff			
Action point	**Stocktake response**	**Indicate:** **Achieved** **Part Achieved or**	**Action required for BOB STP to implement**

		Development area (RAG – red, amber, green)	
6. Staff readiness and engagement **Consider how staff can be engaged, empowered and their inside knowledge used to maximise opportunities to promote health and wellbeing** • Which workforces will be identified to be trained and engaged in MECC delivery? • What criteria will be used to determine which teams / groups / departments are selected? • How will teams / groups / departments be recruited? • How can staff be engaged from the beginning to support the implementation and to sustain MECC? • What can staff do to support the process of implementing MECC? E.g. questionnaires for staff / suggestion boxes or input into forms and systems / processes • How can staff assist with the identification and understanding of departmental pressures / barriers and the opportunities to embed MECC?			
Action point	**Stocktake response**	**Indicate:** **Achieved** **Part Achieved or** **Development area**	**Action required for BOB STP to implement**

		(RAG – red, amber, green)	
• Is a facility available for staff to share their challenges and learning from providing healthy conversations?			
7. Implementation – training **MECC is about organisational change and workforce development. Use this section to plan to prepare staff to MECC.** • What knowledge and skills do staff have already? How will you identify these and any gaps? • How will the training be implemented? How will you accommodate roles / shift patterns, etc.? • Training the trainers – who will become the trainers? • How will staff be introduced to MECC? • How will staff be trained? E-learning for knowledge and face to face healthy conversation skills delivery. How will it be contextualised to fit with staff roles? • How will training be evaluated? • In addition to the initial training is subsequent skills practice or training opportunities identified for staff?			
Action point	**Stocktake response**	**Indicate:** **Achieved** **Part Achieved or Development area** **(RAG – red, amber, green)**	**Action required for BOB STP to implement**

8. Review and evaluation **To ensure that MECC implementation has been effective, it is essential to monitor and review the process, outcomes and impact of activity in order to improve future delivery.** • How will you know whether the systems for monitoring progress are effective? • How will you provide evidence of impact? • Will you capture outcomes from patients/ clients where possible? • Will this include assessing the impact of MECC on patients / clients' levels of motivation and outlook for health related behaviour change? E.g. what action did they take following the MECC intervention / healthy conversation? • Have you considered using the friends and family test to capture feedback on MECC? • How will you capture feedback on uptake of referrals?			
Action point	**Stocktake response**	**Indicate:** **Achieved** **Part Achieved or** **Development area**	**Action required for BOB STP to implement**

		(RAG – red, amber, green)	

• Are there wider benefits beyond helping service users / patients / clients?
  o Staff health and wellbeing, staff sickness levels
  o Staff feedback
  o Cost savings, monitoring of outcomes
  o Credibility of the benefits
• Who do you need to keep informed, of what and how? How will you report and share the benefits and findings with others?
WHAT NEXT?
• How will you further cascade MECC
• Which other teams within and outside your organisation could take MECC forward?			

BOB
Sustainability & Transformational Plan

Prevention Workstream Update

April 2017

V1.1

Initiative map

Our approach

There are a wide range of programmes that support our aim of shifting focus of care form treatment to prevention in all that we do. These our outlined in our narrative plan for BOB We have agreed through the STP the most appropriate level at which each programme should be led and delivered within the health and care system., We have done this based on the partnerships and scale required to best implement the specific programmes. A stocktake of all initiative was undertaken and schemes were chosen based on

1. There is a clear opportunity/ benefit in doing it jointly, to deliver improvement in terms of finance, quality and/or capacity
2. Doing something once is more efficient and offers scale and pace
3. Collective system leadership is required to make the change happen

We have set out below the results of the stocktake as it related to this delivery plan and the BOB STP level programme

BOB STP LEVEL

- Obesity
- Physical Inactivity
- Workforce health
- 'Make every contact count'
- Digital Self Care
- Development of other initiatives including; Tobacco, Alcohol
- Embeding digital self care
- Embed prevention throughout our transformation plans

LOCALITY LEVEL

- Diabetes – BOB – wide coverage of the NDPP
- Implementation of element of the STP Level plan may be delivery at a locality area level where appropriate
- Reducing avoidable admissions through secondary prevention, falls, alcohol, AF, hypertension, smoking

CCG/BOURGH LEVEL

- Health and Wellbeing Board Strategies in each of the 6 boroughs,
- Prevention priorities identified in each borough
- Self care management
- Social prescribing
- Obesity
- Physical health
- Suicide prevention intervention
- Diabetes
- Screening
-

BOB Prevention Delivery Plan on a Page

Vision

A proactive approach to disease prevention within all that we do, shifting the focus of care from treatment to prevention , addressing unhealthy behaviours that may lead to serious conditions further down the line and thus reducing the burden on the healthcare system. We will take action to motivate people to take ownership of their own health and encourage healthy environments to enhance the quality of life for our population.

Priorities and Objectives

1.To embed prevention within our local transformation programmes

3.To collaborate across BOB on areas where there is benefit of working at scale. Initially these have been identified as:

- Obesity
- Making Every Contact Count
- Tobacco
- Improving Workforce Health
- Digital self care

4.To continue working together to identify other BOB wide opportunities, which may include alcohol and social prescribing

Background and Case for Change

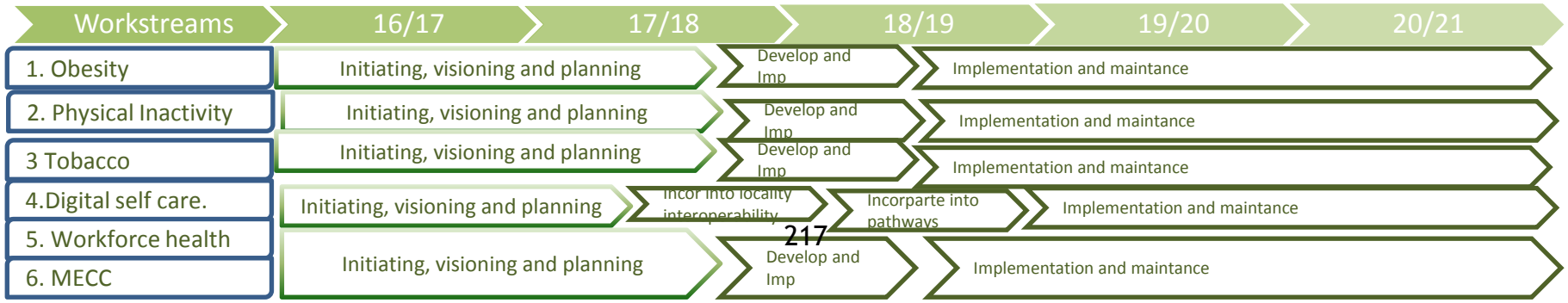
- Our plans seek to encourage people to help themselves and take control of their lives. Overall BOB good health status mask variation and inequalities
- Child and adult obesity has doubled

•We are committed to working across the three localities of BOB focusing on system wide initiatives to reduce the burden of obesity and physical inactivity., working in partnership with Public Health, CCGs, AHSN, and NHS Trusts

Research that suggests we can improve the lives of residents and reduce demand on services through enabling people to change their behaviours. This is especially true with smoking, drinking and physical activity. Evidence suggests we could save up to £10M.

•BOB is unique in have three distinct localities , Berkshire West , Oxfordshire, and Buckinghamshire. We will build on our existing local health and wellbeing strategies and public health initiatives, as well and integrated care services to ensure services wrap around and support neighbourhoods,

•To support this, we are identifying where there is benefit of working at scale to develop new models of care, focused on prevention. These currently include obesity, physical inactivity and workforce health and we are also developing other initiatives, including strengthening prevention across our STP. This includes systematic approaches to ensure we '*Make Every Contact Count*' across all our interactions with the public.



Return of Investment (ROI) opportunities

Our financial requirements includes a £3m saving. We plan to deliver this by scaling up our combined effort across a range of prevention intervention. The figures below have been reached from Public Health Resource modelling produced to support STP Planning. The below table set out an intervention level view of how we believe a significant portion of those saving can be delivered

Programme	Intervention	Outcomes	Investment – over the 4 years - total	Recurrent Gross savings	Recurrent Net savings
Diabetes	Roll out of NDPP across BOB	X% of diabetic to have good glucose control		£1.03m	£1.03m
Physical Inactivity	Promotion of digital self care	X% of exercise more than 30 minutes per day	£200k	£430k	£230k
Obesity	NHS referrals to evidence based weight management service BOB mapping of service	To expand the tier 2 services to focus on patients with obesity and existing long term conditions by x%	£1.2m	-£900k	- £ £340k
MECC	Requires further development	Requires further development	£200k		
Workforce health	Requires further development	Requires further development			
Tobacco		Reduce smoking prevalence to X% Reduction in average LOS for smokers undergoing elective surgery	£1.28m	£10.25m	£8.65m
Total costs/savings identified to date			**£2.68m**	**£10.81 m**	**£ 9.57m**

- Currently under development with support from Public Health England and CSU

Detailed plans and monthly status reports

Detailed plan, Workstream: Reducing the burden of Obesity

SRO	•Jackie Wilderspin, Public Health Specialist Oxfrodshire County Council
Delivery Lead	

Vision

- To agree and develop a pathway for commissioning obesity prevention and treatment services which is consistent across the BOB area.

Deliverables

A task and finish group of commissioners from CCGs and local authorities meet in Q4 of 2016-17 to:

1. **Agree definitions of "tiers" of treatment**
2. **Map current provision of obesity prevention and weight management services**
3. **Identify best practice and funding opportunities**
4. **Discuss opportunities for joint work by CCGs and /or local authorities in commissioning**
5. **Agree a further project plan for 2017-18**

Benefits

1. Services of consistent quality across BOB
2. Improved access to self care and appropriate behaviour change services
3. Financial savings in preventing diabetes, reducing the number of overweight and obese adults, reducing the number of people who are physically inactive.

Timeline

- Available to:-

Q4 2017	Initiation
Q4 2017	Visioning
	Planning
TBC	Design
TBC	Implementation
TBC	Maintenance

Key enabler

Reducing the burden of Obesity
Status Report: April/ 2017

Status

Summary of where we are:

1. A project brief was agreed at the BOB prevention group

Recent Achievements

What has happened since last update:

2. Mapping of current services was further developed, based on the Stocktake exercise from Sept 16 but with additional input from commissioners from CCGs and local authorities
3. The Task and Finish group has met once (21st Feb 2017) and agreed tier definitions.
4. Mapping of existing services is complete and gap analysis has started.
5. A survey is being completed to map thresholds for access to services

Challenges/Roadblocks

Any outstanding actions or roadblocks that require board input:

Information on funding availability for CCGs to commission services for obesity (tier 3)

Next Steps

Plan and action for activity over the next month:

Further meeting of Task and Finish group to be held in early April. This will complete the current tasks and prepare recommendations for action in 2017-18 for consideration by the BOB prevention group in April 2017.

Detailed plan, Workstream: Reducing the burden of physical inactivity

SRO	•Tracey Ironmonger, Public Health Specialist , Buckingham County Council
Delivery Lead	•Brett Nicholls CEO, Get Berkshire Active

Vision

The approach that is anticipated will be to maximise the use of the IT patient portal , identify through consultations patients who are physically inactive and use technology and social media approach to improve their activity levels

Incorporate Physical Activity as a treatment presciption for pathways

BENEIFITS

- additional resource into the connected care programme
- focus on a comprehensive / digital programme to encourage the general population to increase activity (focussing on currently inactive residents), and support patient with long term conditions to increase activity
- align with the stepped approach to care developing through GP and self care workstreams.

Benefits

	Percentage inactive	Number inactive	To reduce to 20%	% reduction	Cost saving
Oxon	23.4	124347	-18067	3.4%	£203,705
Bucks	22	88660	-8060	2%	£93,275
Reading	29.7	37125	-12125	Total for W Berks - 18631/367300 = 5%	£133,723
Wokingham	21	25662	-1222		
West Berks	24.4	29304	-5284		
total		305,098	-44758		£430,703

Timeline

27/3/17	Initiation
2/5/17	Visioning
Q1	Planning
TBC	Design
TBC	Implement
TBC	Review
TBC	Maintenance

Key enabler

Reducing the Burden of Physical Inactivity
Status report April 2017

Status A proposal for a workshop and key invitees were discussed at the February STP Prevetion meeting	**Recent Achievements** Date for workshop set for 2 May with Oxford Venue Invite produced to be circulated to the STP group and wider networks w/c 27th March
Challenges/Roadblocks Will be key to get clinical input into the workshop. STP Prevention workstream are requested to follow up specifically with any clinical staff they would like to be targeted for attendance	**Next Steps** Workshop to generate proposed priorities for STP prevention workstream Proposals to come to STP meeting for discussion and final actions to be agreed.

Detailed Plan, Workstream Tobacco

SRO	•Katie Summers, Director of Operations, NHS Wokingham CCG
Delivery Lead	

Vision

To Be

reducing significantly the number of smokers who have surgical interventions. This investment would see a new programme run in conjunction with surgical departments within hospitals and primary care to contact and support all surgical elective admissions to stop smoking.

Deliverables

- It is well recognised that tobacco cessation is one of the most effective ways to improve health. Whilst most savings are calculated on the medium and long term impact, savings can be delivered in year within health care settings if a focussed and concerted effort is made on reducing significantly the number of smokers who have surgical interventions. This investment would see a new programme run in conjunction with surgical departments within hospitals and primary care to contact and support all surgical elective admissions to stop smoking
- Acute Trust to support a position prescribing smoking cessation prior to surgical elective admission

Benefits

In a study by Moller et al, 23% of patients smoking up to the time of surgery had an surgical site infection (SSI). This reduced to 4% among those smokers quit just a few weeks prior to surgery. A recent study on this shows that most of the infection risk difference between smokers and non-smokers is mainly observed during the period between surgical procedure and discharge from hospital. So all savings will be in-year (or indeed in-month!)

For the BOB STP, the figures show 154503 elective procedures were carried out last year. If 20% of those procedures are on smokers then we have the chance to make 30,901 offers of quit support. Even if only 5% of those result in a quit date – that makes 1541 smokers into the programme. If we then achieve at least a 60% quit rate (which was achieved by Moller and locally exceeded) we will reduce an estimated 355 infections down to just 62. If we assume an average surgery cost of £7000 is doubled to £14,000 if an SSI occur (Broex et al, 2009) then that means a reduced annual cost **of £2,054,917**

Timeline

TBC	Initiation
TBD	Visioning
TBD	Planning
TBD	Design
TBD	Implementation
TBD	Maintenance

Tobacco
Status report. April 2017

Status

Summary of where we are:

- Berkshire West Locality is consulting on a Tobacco safe Surgery Proposal during April

Recent Achievements

Berkshire West had led a review of positions across the NHS on Safe Surgery approaches

Berkshire West currently within consultation

Challenges/Roadblocks

Any outstanding actions or roadblocks that require board input:

Next Steps

To share consultation with Oxford and Bucks Locality :

Status Takeaway Message- On track, significant progress, etc.

Detailed Plan, Workstream MECC

SRO	•Juliet Anderson Assistant Director HHE
Delivery Lead	

Vision

The programme of work aims to embed MECC across organisations to enable the workforce to recognise their role in prevention and reducing inequalities to support the sustainability of the health and social care system; building on existing initiatives in place across the BOB STP footprint

Deliverables

The MECC project will be informed by stages. The focus for the first 6 months will be to develop and implement an agreed MECC strategy across BOB's acute services where significant impact can be made on influencing population health through staff, patients and visitors. The second phase will develop training and implementation across acute services. In parallel to phase 2, the Programme Manager using learning from phase 1, will engage with community and primary care organisations for further MECC roll out

Benefits

Activity	Who is responsible	Start Date	End Date
Establishment of strategic steering group to provide leadership and guidance to MECC Strategy	Prevention Board, LWAB representation	April 2017	End March
Recruitment of Programme Manager who understands the NHS acute sector and can influence engagement from senior andmiddle managers	CCG	March 2017	April 2017
Scoping of current MECC initiatives across acute sector and build in evaluation model	Programme Manager	April 2017	2 weeks
'Winning hearts and minds' across acute services	PM with support from Board and LWAB to identify trust board lead, and trust MECC operational lead to implement MECC strategy in conjunction with PM	April	July
Establishment of operational steering group	Steering group representing trust MECC leads co-ordinated by PM	April	July

Key enabler for all 5 STP priorities

MECC
Status report: April 2017

Status

Summary of where we are

Recent Achievements

- **LWAB agreed MECC project bid for £140k**

Challenges/Roadblocks

- **Issues with recruiting PM. Initial proposal of support from RBFS, was unfortunately not supported due to restructure at RBFS**

Next Steps

- **Recruitment of PM with support from HEE**
- **Identification on a Clinical SRO to oversee leadership of MECC working with NHS executive teams**

Status Takeaway Message- On track, significant progress, etc.

Detailed Plan, Workstream Digital – Self care

SRO	•Lise Llewllyn, Strategic Director of Public Health
Delivery Lead	•Mark Sellman, Associate Director Digital Transformation SCWCSU

Vision
As Is

- Organisations investing in patient facing technology in isolation
- No standards, security dubious, not joined up, limited support for organisations.
- Pockets of good practice not being shared.
- Patients are already engaging with digital for health in isolation of the NHS/social care.

To Be

Agreed definition of digital self-care:
1. Supporting general wellbeing through use of digital
2. Supporting patients with managing their conditions through digital

- Clinically/social care professional led prioritisation
- Joined up and informed investment around patient facing technology (opposite of as is state)

Deliverables

Digital Self-Care
- What have we got/what are we doing- Mapping existing digital approaches and identifying what are the quick wins
- Register of apps that are being recommended for patients
- Patient journeys/scenarios to support with navigation
- Agree priorities of pathways
- Identifying unintended consequences- loneliness if we are removing interactions with care professionals face to face
- Establish a workshop to capture wider professional views.

Workforce
TBD
Prevention (Public Health)
TBD

Benefits

- Act as an advisory group for organisations looking to invest in patient facing technology
- Share best practice across BOB and Frimley STP's
- Support broader STP and local transformation plans

Timeline

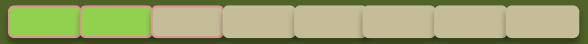
To have a baseline and workshop delivered within the next 6 months

Key enabler for all 5 STP priorities

Digital Self Care

March 2017

Status



Summary of where we are

Visioning- Generating baseline and developing future state aspirations.

Recent Achievements

What has happened since last update

- Kick off meeting with key digital representatives from BOB and Frimley
- Agreed to baseline existing projects and to continue to meet monthly

Challenges/Roadblocks

Any outstanding actions or roadblocks that require board input

Next Steps

Follow up meeting in late April

Status Takeaway Message- On track

Detailed Plan Workstream
Improving workforce health

SRO	•Karon Hart, Buck Helah
Delivery Lead	• Paul Durrand, Amy Sherman

Vision

To improve and sustain workforce health and wellbeing and employee confidence to promote healthy lifestyles to others

Benefits

Improved Health and Wellbeing within the workforce in scope of this paper

Anticipated correlated reduction in sickness absence levels, without raising levels of presenteeism

Deliverables

- Improve collaboration across BOB to enable the sharing of measures and initiatives
- Using CQUIN as a template, develop new initiatives to further enhance staff wellbeing initiative
- Embed good practice already in place to encourage consistency of wellbeing offer across BOB, disseminate case studies, success, evaluation measures and offer peer support
- Create a culture where staff Health and Wellbeing is used proactively within organisations e.g. during organisational change and is considered in conjunction with other organisational activities e.g. Education and Training, retention programmes etc.
- To engage other employers / providers within the footprint to work collaboratively, including opportunities to use resources at reduced cost e.g. University Gyms, Fire service premises etc.
- Identify further collaborative opportunities over and above local delivery to improve workforce health and wellbeing and additional financial savings, e.g. through NHS employers, National Conferences, Occupational Health and Wellbeing Networks.
- Promote and encourage the role of staff as role models and/or ambassadors for healthier lifestyles
- Making Every Contact Count (MECC) – training staff how to have confident conversations around health and wellbeing and raising awareness of onward signposting opportunities

Key enabler for all 5 STP priorities

Improving workforce health

Status

- Workforce PID approved by STP Prevention Group
- BOB Healthy workforce group established – 1st meeting held to clarify understanding, agree direction and clarify learning points
- Mapping exercise - 1st exercise completed and been collated – further information requested

Recent Achievements

- BHT Health and Wellbeing CQUIN targets achieved
- Meetings with STP members re workforce wellbeing initiatives
- Raising awareness of Workforce wellbeing via;
  - Presentation to Health and Wellbeing Board (Bucks) on Healthy Workplace mental health
  - Presented at AHSN road show re Healthy Workplaces
  - Represented Healthy Workforce Stream at Workforce STP meeting

Challenges/Roadblocks

- **Review membership of BOB healthy workforce group – need higher level representation from some areas.**
- **AHSN going through internal transformation process so limited resource available (Now resolved)**
- **SRO change of role (now incorporated into new role)**

Next Steps

- **CQUIN update from all BOB NHS Trusts (end of year reports for 16/17)**
- **Collate new mapping information and publish**
- **BOB Healthy Workforce meeting 9th June to agree actions. Also focus on improving Mental Health/Stress initiatives (As requested by group)**
- **Further meetings with STP members re implementing good practice in workforce wellbeing**

Status Takeaway Message- On track, significant progress, etc.

READING BOROUGH COUNCIL

REPORT BY CHIEF EXECUTIVE

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**14 JULY 2017**	**AGENDA ITEM:**	**17**
TITLE:	**READING'S ARMED FORCES COVENANT AND ACTION PLAN – MONITORING REPORT**		
LEAD COUNCILLOR:	**CLLR LOVELOCK**	**PORTFOLIO:**	**LEADER OF THE COUNCIL**
SERVICE:	**CORPORATE POLICY**	**WARDS:**	**ALL**
LEAD OFFICER:	**JILL MARSTON**	**TEL:**	**0118 937 2699**
JOB TITLE:	**SENIOR POLICY OFFICER**	**E-MAIL:**	**jill.marston@reading.gov.uk**

1.0 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Armed Forces Covenant is a voluntary statement of mutual support between a civilian community and its local armed forces community.

1.2 This report presents an annual update on progress against the actions outlined in the action plan, in particular the heath related actions, and on the general development of the Community Covenant.

2.0 RECOMMENDED ACTION

2.1 To note the progress against the actions set out in the Armed Forces Covenant action plan (appendix A).

2.2 To note that RBC is nominating itself for the bronze award of the Defence Employer Recognition Scheme (paras 4.14-16).

3.0 POLICY CONTEXT

3.1 In 2011, the Government published a new Armed Forces Covenant, as a tri-Service document which expresses the enduring, general principles that should govern the relationship between the Nation, the Government and the Armed Forces community.

3.2 The Community Covenant complements the Armed Forces Covenant but enables service providers to go beyond the national commitments. It allows for measures to be put in place at a local level to support the Armed Forces and encourages local communities to develop a relationship with the Service community in their area.

4.0 THE PROPOSAL

Background

4.1 A Community Covenant is a voluntary statement of mutual support between a civilian community and its local armed forces community. It is intended to complement the Armed Forces Covenant, which outlines the moral obligation between the nation, the government and the armed forces, at the local level.

4.2 The aims of the Armed Forces Community Covenant are to:

- encourage local communities to support the armed forces community in their areas
- nurture public understanding and awareness amongst the public of issues affecting the armed forces community
- recognise and remember the sacrifices faced by the armed forces community
- encourage activities which help to integrate the armed forces community into local life
- to encourage the armed forces community to help and support the wider community, whether through participation in events and joint projects, or other forms of engagement

4.3 The Reading Armed Forces Community Covenant was launched at the Afghanistan Homecoming Parade at Brock Barracks on 7th July 2012.

4.4 In addition to the Council, the covenant has been signed by 7 Rifles on behalf of the Armed Forces, and a range of other key partners.

4.5 Reading doesn't have a large military 'footprint', with no regular forces stationed in the town. However, Brock Barracks is the headquarters for the Territorial Army unit 7th Battalion The Rifles, and Reading is home to a large ex-Gurkha community. Reading's Community Covenant therefore focuses on Veterans and Reservists and aims to be proportionate in its scope to the size of the Armed Forces community in Reading.

Further development of the Community Covenant and action plan

4.6 The Community Covenant working group with key stakeholders meets on a six monthly basis, the most recent held on 16th March 2016.

4.7 Progress to date against the actions in the action plan is shown in Appendix A. Several of the actions in action plan have now been completed. Successes to date include:

- Reading was awarded £21,730 from the Community Covenant grant scheme for an integration project for Veterans, aimed at raising awareness of health and social care services amongst the ex-Gurkha community in particular.

- The Museum service was awarded £10,000 to support their exhibition, 'Reading at War', to mark the centenary of the beginning of the First World War in 2014.

- Reading Ex-British Gurkha Association was awarded £14,500 under the new Covenant Fund for two Nepalese community development workers.

- SSAFA was awarded £1,000 to further update their leaflet on accessing health services, which has been translated into Nepalese and is being used by to run classes.

- Armed Forces personnel can now be given extra priority when applying for social housing on the Housing Register, as part of the Council's Housing Allocations Scheme.

- A domestic violence protocol is in place between the Service and the Police, to recognise military needs and ensure equitable service.

- Reading Borough Council now has a protocol in place for employment of Reserve Forces personnel.

- 'Operation Reflect' activities to mark the centenary of the beginning of the First World War included 7 Rifles visits to 5 primary schools.

- Job Centre Plus staff now receive regular briefings from 7 Rifles.

<u>Health related actions</u>

4.8 The action plan includes a section on health and wellbeing with the following actions:

- Feedback and input to Health and Wellbeing Board
- Devise protocol for GPs to register Veteran status
- Raise awareness of and signpost to Veteran's Mental Health Service for the South Central region
- Development of a leaflet on accessing health services to be translated into Nepalese

- Develop and promote a discount scheme for serving personnel for arts and leisure facilities in Reading
- Consolidation of appropriate contact/ support lists in order to provide better signposting

4.9 Progress on each of these is summarised in the attached action plan. In particular, re GPs recording Veteran status, a number of measures have been put in place by CCGs:

- 'READ' codes provided to practices from Spring 2016.
- CCGs have developed guidance for practices on registering patients from the armed forces community
- Information on CCG web sites and social media (from June 2016).
- CCG attendance at Armed Forces Day event in Wokingham, together with South Central Veterans Service and associated media coverage (June 2016).
- Parkside Family Practice piloted registering status as part of flu immunisation programme (Autumn 2016); other practices now being encouraging to do the same.

<u>New Covenant fund</u>

4.10 A new Covenant fund has recently been launched, with £10 million available every year.

4.11 The following priorities have been set for 2017/18:

- families in stress
- strengthening local government delivery of the covenant
- Armed Forces Covenant: local grants
- a single grant to produce a map of need for the Covenant Fund
- a single grant to produce an outcomes framework for the Covenant Fund
- a single grant for the provision of a digital support programme for the Covenant Fund

4.12 Under the local grants priority, the MOD will fund projects of up to £20,000 that respond to the local needs of the Armed Forces Community and improve recognition of the Armed Forces Covenant, and that:

- help integrate Armed Forces and civilian communities across the UK
- deliver valuable local services to the armed forces community.

4.13 There are two application rounds this year for priority 4, with deadline dates of 6th Oct 2017 and 5th Jan 2018.

<u>Defence Employer Recognition Scheme</u>

4.14 The Defence Employer Recognition Scheme encourages employers to support defence and inspire others to do the same.

4.15 'Bronze' award holders are self-nominated by employers who pledge to support the Armed Forces, promote being Armed Forces-friendly and are open to employing reservists and veterans.

4.16 Reading Borough Council meets the criteria for this award through our work to develop the Armed Forces covenant with partners in Reading, and through our own housing allocations policy and protocol for employment of Reservists.

5.0 CONTRIBUTION TO STRATEGIC AIMS

5.1 The development of an Armed Forces Community Covenant for Reading contributes in particular to the Council's strategic aim to 'promote equality, social inclusion and a safe and healthy environment for all' by working to ensure that both serving and ex-Armed Forces personnel can access appropriate support and are able to integrate well into the community.

5.2 This work also relates particularly well to the Sustainable Community Strategy's 'people' theme where 'we look after each other' and the 'prosperity' theme by aiming to ensure that veterans and reservists are not excluded from the economy.

6.0 COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Two of the key aims of the Armed Forces Community Covenant are to:

- encourage local communities to support the armed forces community in their areas
- encourage the armed forces community to help and support the wider community, whether through participation in events and joint projects, or other forms of engagement

7.0 EQUALITY IMPACT ASSESSMENT

7.1 The covenant is intended as a vehicle for partners across Reading to help enable Veterans or Reservists to access health services, particularly mental health services, training and employment opportunities.

8.0 LEGAL IMPLICATIONS

8.1 The general power of competence, introduced as part of the Localism Act 2011, replaces the well-being power from February 2012. The Act gives local authorities the power to do anything which an individual generally may do, which they consider is likely to be of benefit (directly or indirectly) to the whole or any part of their area. It therefore gives local authorities the power to do anything they want, so long as it is not prohibited by other legislation.

9.0 FINANCIAL IMPLICATIONS

9.1 £30m of central government funding was allocated over four years to 2014/15 to financially support Community Covenant projects at the local level which strengthen the ties or the mutual understanding between members of the armed forces community and the wider community in which they live. Reading submitted bids in three bidding rounds. £10m per annum was made available in perpetuity from 2015/16 onwards through the new Armed Forces Covenant fund.

10.0 BACKGROUND PAPERS

10.1 Armed Forces Covenant Fund
https://www.gov.uk/government/collections/covenant-fund

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**14 JULY 2017**	**AGENDA ITEM:**	**18**
TITLE:	**INTEGRATION AND BETTER CARE FUND**		
LEAD COUNCILLOR:	**CLLR HOSKIN / CLLR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**ADULT SOCIAL CARE & HEALTH**	**WARDS:**	**ALL**
LEAD OFFICER:	**GRAHAM WILKIN**	**TEL:**	**0118 37 2094**
JOB TITLE:	**Interim Director Adult Social Care and Health**	**E-MAIL:**	**graham.wilkin@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an update on the progress of the Integration programme, including Better Care Fund Performance (BCF).

1.2 The report includes the information received to date in relation to 2017/18 & 2018/19 Better Care Fund requirements. At the time of this report, the final policy framework has been released and the technical guidance has yet to be published and is not expected until after June 8th 2017. This means that the planning requirements are still unclear.

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing Board are asked to note the general progress to date.

3. POLICY CONTEXT

3.1 The Better Care Fund (BCF) is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups (CCG) and Local Authorities to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation to promote / deliver on integration ambitions.

3.2 As in previous years, the BCF has a particular focus on initiatives aimed at reducing the level of avoidable hospital stays and delayed transfers of care as well a number of national conditions that partners must adhere to. These National conditions have been revised and streamlined for the 2017-19 period and are now as follows:

- Plans to be jointly agreed (Local areas must ensure that their Better Care Fund (BCF) Plan covers the minimum of the pooled fund specified, and the Plan should be signed off by the Health and Wellbeing Board or by delegated authority, and by the constituent councils and Clinical Commissioning Groups.

- NHS contribution to adult social care is maintained in line with inflation (The NHS contribution to adult social care at a local level must be increased by 1.79% and 1.9% (in line with the increases applied to the money CCGs must pool) in 2017-18 and in 2018-19 respectively).
- Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care
- Managing Transfers of Care through the adoption of the National best practice "High Impact Change Model for Managing Transfer of Care"

4. PERFORMANCE TO DATE – BCF Key performance indicators (KPI)

4.1 In line with BCF policy requirements each Health & Wellbeing Board (HWB) is required to report progress against four key performance metrics:

- **Reducing delayed transfers of care (DTOC) from hospital**
  - *Metric: Delayed transfer of care from hospital per 100,000 (average per month)*
- **Avoiding unnecessary non-elective admissions (NEA)**
  - Metric: No. of non-elective admission (General & Acute)
- **Reducing inappropriate admissions of older people (65+) in to residential care**
  - *Metric: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population*
- **Increase in the effectiveness of reablement services**
  - *Metric: Proportion of older people (65 & over) who were still at home 91 days after discharge*

These four KPI were selected as good year on year performance, allowing for growth, is seen as an indication of an effective and integrated health and social care system.

Commentary and figures for the KPI can be found below.

4.2 Reducing delayed transfers of care (DTOC) from hospital

DTOC performance has been a challenging area with more people experiencing delayed transfers of care than were planned. Performance has however improved in Q4 as a number of planned initiatives have begun to take effect such as implementation of a weekly multi-disciplinary team forum (MDT) to address issues affecting all people who are experiencing delays by assigning clear leads and actions to promote timely move on. The MDT has already had a positive impact on weekly delayed discharge list / fit to go lists.

DTOC performance is a key element of the A&E Delivery Board Improvement Plan and in addition to the actions agreed via the board, to improve performance Reading has Via the Berkshire West 10 Delivery Group, the three Berkshire West localities continue to share best practice / process where it is deemed to have had a beneficial impact on reducing / managing DTOCS. This has included on-site reviews of key integration projects in other Berkshire areas, such as the Wokingham integrated hub and short term support teams, which could be duplicated in Reading.

When analysing Q4, the three most prevalent reasons for people waiting for onward health or social care were as follow:

Patient awaiting -

- Further non acute NHS care (27% of all delays)
- Care package in own home (25% of all delays)
- Residential placements (15% of all delays)

Reading Delayed transfers of care performance – Actual days delayed, 18+:

	Q1	*Q2*	*Q3*	*Q4*
Plan	*980*	*956*	*914*	*853*
Actual	*2038*	*3133*	*3240*	*2001**
variance %	*+108%*	*+228%*	*+254%*	*+135%*

** The actual figures are taken from NHS England published information April 2016 – March 2017.*

4.3 Avoiding unnecessary non-elective admissions (NEA)

NEA performance against target improved steadily throughout the year, reflecting the contribution from the Rapid Response and Treatment (RRaT) element of the care home project which is focussed on the reduction of NEA from care homes. Therefore across the year fewer Reading residents were admitted to hospital than had been planned.

Reading Non-elective admissions performance – all admissions, all ages:

	Q1	Q2	Q3	Q4
Plan	3514	3561	3915	3804
Actual	3674	3576	3747	3619*
variance to plan %	+4.5%	+0.4%	-4.3%	-4.9%*

**Figures taken from the SUS data. April 2016 – March 2017.*

4.4 Increase in the effectiveness of reablement services

More residents are now benefiting from reablement, via the Willows 'step down' facilities and via increased numbers of people accessing the community reablement team (CRT). We are continuing to see a higher proportion of residents still being at home 91 days post discharge against the metric target (85% of people discharged to still be at home 91 days post discharge).

Proportion of Reading older people (65 & over) who were still at home 91 days after discharge:

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2015/16	80%	86%	83%	84%	78%	82%	86%	90%	84%
2016/17	82%	87%	88%	94%	91%	92%	93%	92%	78%

** Figures taken from Mosaic, RBC Adult Social Care IT System.*

4.5 Reducing inappropriate admissions of older people (65+) in to residential care

Reading saw a substantial fall in residential care placements for older people in 2015/16 (circa. 30% less than 2014/15) thus a further significant reduction was deemed unrealistic, based on demographics and comparator areas. Therefore, a moderate reduction in placements was set for 2016/17, equal to approximately one

fewer placements per month, and whilst we have not been able to achieve this target we have been able to maintain similar performance levels to 2015/16.

This has been achieved by ensuring that only people who need intensive support live in residential care settings, and this has enabled us to hold on to "Year on year" good performance despite demographic pressure.

Permanent admission to residential care (Reading residents) – 65+ year on year comparison, cumulative

	Q1	Q2	Q3	Q4
2015 / 16	28	62	89	107
2016 / 17	22	52	78	109

** Figures taken from Mosaic, RBC Adult Social Care IT System.*

PERFORMANCE TO DATE – update on key integration / BCF schemes

4.6 Discharge to assess – Willows

The DTA (discharge to assess) service is part of the Willows residential care complex operated by the Council. The home consists of both residential units and self-contained assessment flats with 14 units appointed as DTA units.

DTA is a 'step up / step down' rehab and reablement service with the primary aims being:

- To reduce the length of stay for individuals who are fit to leave acute hospital care
- To reduce permanent admission to residential and nursing care

To date the service continues to perform well against key performance indicators with bed utilisation in excess of 80% in the final quarter of the year. Satisfaction levels amongst people who have used the services and their family and carers remains high.

Whilst the service is supporting a high number of people to be discharged from an acute setting in a timely manner Reading is seeing an increase in delayed discharges, system wide. Focus will remain on ensuring / improving efficient movement through the Willows DTA service and onto other community services, to help alleviate discharge pressures.

4.7 Community Reablement Team (CRT)

CRT continues to provide a short term flexible service for up to 6 weeks for customers who have been assessed as being able to benefit from a reablement programme. The service is delivered in the clients own home and available 7 days a week, 24 hours a day.

CRT has continued to greatly contribute to a reduction in the number of permeant care home admissions and non-elective admissions. More Reading residents are benefiting from the CRT service, with 1200 people using the service comparted to the plan of 919 in 2016/17.

4.8 Enhanced support to care homes

The Enhanced Support to Care Homes project will implement improvements to the quality of care and provision of service to and within care homes for residents, in collaboration with all Health and Social Care providers across Berkshire West, to improve people's experience of care and avoid unnecessary non-elective admissions.

Delivery of project objectives is through four core streams of work:

- Implementation of the Rapid Response and Treatment Team (RRaT) and Care Home Support Team to provide; fast track support to care homes to avoid the need for residents to be admitted to hospital, and, bespoke training and leadership to care homes to enable them to better support residents and reduce the need for acute admission

- Review and revision of the key Protocols and Standards related to admissions and discharges between local care homes and hospitals to promote consistency and best practice

- Implementation of a unified system of care home performance monitoring across Berkshire West

- Review and revision of GP support and medication management to care homes to promote consistency and best practice

4.9 Connected Care

The Connected Care project will deliver a solution that will enable data sharing between the health and social care organisations in Berkshire and provide a single point of access for patients wanting to view their care information. The project will support delivery of the 10 universal capabilities as defined in the Berkshire West Local Digital Roadmap and enable service transformation as specified in the BCF.

The projects primary objectives are to:

- Enable information exchange between health and social care professionals.

- Support self-care by providing a person held (health and social care) record (PHR) for the citizens of Berkshire.

- Enable population health management by providing a health and social care dataset suitable for risk stratification analysis.

Position as at the end of Q2, key achievements / developments:

- RBFT, BHFT and General Practice are now live across Berkshire and are now able to access and share relevant data via the portal. Other Berkshire West and East partners will join up throughout 2017/18 with Reading social services

due to have access by October 2017. Work to finalise the Reading IG Toolkit by 31.07.17 is ongoing.

- The information governance subgroup continues to revise policy and data sharing agreements, as required, to ensure lawful handling and sharing of data.

2017 –19 BCF Planning

4.10 NHS England has confirmed that the Better Care Fund will continue in the 2017/18 and 2018/19 financial years. As the time of this report, the final policy framework was released in March 2017, however the technical guidance has still not been formally been released by NHS England, instead we have a draft copy of the technical guidance from the Local Government Association. This means that the final funding and planning requirements are still not confirmed. There is therefore a risk of abortive work should the final planning guidance differ from the draft version which has been made available.

4.11 Planning sessions including CCG and LA representatives are in progress to ensure a collective agreement of the BCF plans for 2017/19.

4.12 HWBB's are required to submit a narrative plan, outlining the local vision for integration and case for change, and a detailed expenditure plan setting out the projects, schemes, initiatives that will be funded via the BCF pooled fund to deliver said vision / change. Work on the narrative document is advanced by at the time of this report there has been no formal communication from NHS England in relation to the timescales for the delivery of the technical guidance or any indication of when the final submission date will be.

4.13 Again, in line with previous submissions, the BCF monies must be held in a pooled CCG / Local Authority budget.

4.13.1 The final submission of the Reading Better Care Fund for 2017/19 requires approval by the chair of the Health and Wellbeing board. Whilst the deadlines for submission have not been confirmed by NHS England it is likely that the timing of the next Health and Wellbeing board will not match the national deadlines. The Health and Wellbeing board were therefore asked to delegate authority to the Director Adult Social Care & Health, and the CCG Accountable Officer at the Reading Clinical Commissioning Groups, in consultation with the chair of the Health and Wellbeing board and this plan is being followed.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Better Care Fund and integration agenda contributes to the following strategic aims:

- To promote equality, social inclusion and a safe and healthy environment for all
- To remain financially sustainable

5.2 The Better Care Fund and integration agenda supports the following council commitments:

- Ensuring that all vulnerable residents are protected and cared for
- Enabling people to live independently, and also providing support when needed to families

- Changing the Council's service offer to ensure core services are delivered within a reduced budget so that the council is financially sustainable and can continue to deliver services across the town

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 N/A – no new proposals or decisions recommended / requested.

7. EQUALITY IMPACT ASSESSMENT

7.1 *Members are under a legal duty to comply with the public sector equality duties set out in Section 149 of the Equality Act 2010. The relevant provisions are as set out below.*

Section 149 (1) – A public authority must, in the exercise of its functions, have due regard to the need to:
(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act;
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Section 149 (7) - The relevant protected characteristics are:
- *age;*
- *disability;*
- *gender reassignment;*
- *pregnancy and maternity;*
- *race;*
- *religion or belief;*
- *sex;*
- *sexual orientation.*

In order to comply with the Public Sector Equality Duty, Members must seek to prevent discrimination, and protect and promote the interests of vulnerable groups who may be adversely affected by the proposals. Members must be therefore give conscious and open minded consideration to the impact of the duty when reaching any decision in relation to the Better Care Fund and Integration programmes. The Public Sector Equality Duty (S.149) to pay 'due regard' to equalities duties is higher in cases where there is an obvious impact on protected groups. This duty, however, remains one of process and not outcome.

8. LEGAL IMPLICATIONS

8.1 N/A – no new proposals or decisions recommended / requested.

9. FINANCIAL IMPLICATIONS

9.1 The Reading Better Care Fund pooled fund is expected to see a small underspend of £115k. No new funding decisions are being requested through this report.

9.2 In line with the governance arrangements set out in the s75 pooled budget agreement, use of any underspends is subject to unanimous agreement of the contracting partners (CCG and LA). In line with these arrangements the Reading Integration Board will formulate and approve the use of any spends and update the HWBB, as required.

10. BACKGROUND PAPERS

10.1 None

Pharmaceutical Needs Assessment 2017 – Briefing for Health and Wellbeing Boards

Report by: Jo Jefferies **Job title:** Consultant in Public Health (Health Protection), Berkshire Shared PH Team

Date of report 02/05/2017

Summary The purpose of this briefing is to update Health and Wellbeing Boards regarding their role in the three-year refresh of the Pharmaceutical Needs Assessment.

1. What is a Pharmaceutical Needs Assessment (PNA)?

Since April 2013, every Health & Wellbeing Board in England has had a statutory responsibility to publish, and keep up to date, a statement of the needs for pharmaceutical services in their area. This is referred to as the Pharmaceutical Needs Assessment (PNA). Each Health & Wellbeing Board had to publish their first PNA by 1st April 2015, and is required to undertake a revised assessment at least every 3 years.

The refreshed PNAs therefore need to be signed-off and published by 31st March 2018.

2. Plan for 2017/18

The PNA is a key priority in the Shared Public Health Team's 2017/18 Business Plan, under the direction of Judith Wright Interim Strategic Director of Public Health

The major components of the PNA will be informed by the results of two surveys. One of residents using local pharmacy services and the other of pharmacy staff in each borough. In 2017 it is proposed that these surveys will be carried out in June, July and August. They will be electronic and managed through the HWBB member usual dissemination channels for a public survey.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements for PNAs and detail the minimum information to be contained. These also state that there should be a minimum period of 60 days for public consultation on the draft PNA, before they can be adopted and signed-off by the Health & Wellbeing Board. The proposal is to carry out the public consultation between October and December.

While the PH Shared Team will lead on the development and delivery of the PNA on behalf of HWBBs, certain actions need to be undertaken at a local level to ensure success of the project including promotion to local residents.

- ***Initial Support –*** This paper seeks support from HWBB chairs for the PNA project as outlined above
- ***Communication and promotion of PNA with residents -*** A Communication Plan for the dissemination of the electronic survey in each HWBB area will be developed by the Shared Team, in collaboration with local teams. Plans and resources will be shared with HWBBs in May 2017
- ***Consultation -*** The consultation period for the PNA will be between October and December 2017. HWBB members are asked to add this to their corporate consultation schedule for this period and to identify any processes that need to be completed to ensure this consultation occurs.

Actions for HWBBs:

- **May 2017 -** HWBB Chairs to note and sign off their PNA plan
- **October 2017** - HWBB Chairs to sign off draft for public consultation
- **October to December 2017** - Support public consultation on the draft PNA
- **31st March 2018** – Agree final PNA at HWBB meeting in public, including any recommendations and publish in formal papers