TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**13 JULY 2018**	**AGENDA ITEM:**	**11**
TITLE:	**READING HEALTH & WELLBEING ACTION PLAN 2017-20 UPDATE AND DASHBOARD REPORT**		
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ORGANISATION:	**READING BOROUGH COUNCIL**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents an update on delivery against the Health and Wellbeing Action Plan (Appendix A), alongside the Health and Wellbeing Dashboard (Appendix B), populated with the latest published data in relation to the Board's agreed strategic priorities. Taken together, these documents provide the Board with an overview of performance and progress towards achieving local goals as set out in the 2017-20 Health and Wellbeing Strategy for Reading.

1.2 The appendixed documents give the Board a context for determining which parts of the Health and Wellbeing Strategy it wishes to review in more depth. Some areas are already the subject of separate reports brought to today's Board. Other issues may be identified for further exploration at subsequent meetings. Identifying priorities from the Health and Wellbeing Strategy to provide themes for Health and Wellbeing Board meetings is in line with the 2016 Peer Review recommendation that the Health and Wellbeing Strategy should be used to drive the agenda of the Health and Wellbeing Board.

1.3 This latest Action Plan represents progress achieved 18m into delivery of a three year strategy. In some priority areas, Actions have already been reviewed and refreshed quite comprehensively. A full refresh across all priority areas in the Action Plan will be presented to the Board in January 2019.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board notes the progress to date against the 2017-20 Reading Health and Wellbeing Strategy Action Plan as set out at Appendix A.

2.2 That the Health and Wellbeing Board notes the following change to the Health and Wellbeing Dashboard at Appendix B:
- the snapshot of dementia diagnosis rate is now available on a monthly basis, and monthly performance for the last year has now been included.

Public Health England (PHE) publishes most data as part of a quarterly update cycle in August, November, February and May.

2.3 That the Health and Wellbeing Board notes performance indicators in the following areas in particular as these have been updated since the Dashboard was last presented to the Board:

- Health Checks indicators (Priority 1) have been updated with Quarter 4 performance data;
- Smoking prevalence indicators (Priority 1) have been updated with 2017 performance data;
- alcohol treatment completion data (Priority 5) has been updated with Q4 data
- estimated dementia diagnosis rate (aged 65+) (Priority 6) has been updated with monthly snapshot data for May 2017 to May 2018;
- statistics for % of adults physically active (Priority 1) has been updated with 2016-17 data;
- the number of Dementia Friends (local indicator for Priority 5) has been updated with figures to 31st May 2018 supplied by the Alzheimers Society.

2.4 That the Health and Wellbeing Board notes that updated data is expected to be available to populate the Dashboard as presented to the October 2018 meeting of the Board:
- Dementia Friends (Priority 5) – update to number trained to end August 2018
- dementia diagnosis rate – monthly updates expected for June, July and August 2018
- Q1 Healthcheck indicators expected in August 2018
- Q1 alcohol treatment completion rates expected in September 2018

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 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

3.4 The Strategy then sets out eight priorities:

- 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

3.5 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. SUMMARY POSITION (JULY 2018)

Priority 1: Supporting people to make healthy lifestyle choices (with a focus on smoking cessation, tooth decay, obesity and physical activity)

4.1 Actions relating to obesity and physical activity are now detailed in the Reading Healthy Weight Action Plan which the Health and Wellbeing Action Plan cross references. The Healthy Weight Action Plan has been modified as a result of needing to operate within a reduced Public Health Grant budget, as reported to the Council's Policy Committee in June 2018.

4.2 The details of how the Healthy Weight Strategy has been impacted are contained in a separate report being brought to this Board today. However, the budget dedicated to delivery of the Healthy Weight Strategy has now been removed, and both the adult and child commissioned weight management programmes are being decommissioned as of September 2018. The Wellbeing Team is working with partners, including those in other Council directorates, to identify opportunities to tackle obesity within other programmes, particularly those supported by Public Health Grant.

4.3 The funding available to commission smoking cessation support has also been reduced. Targets for 2018-19 are under active discussion with the provider in light of this, and a further update will be provided for the next Health and Wellbeing Board.

4.4 The Wellbeing Team is exploring options for developing an integrated hub model for the delivery of public health services in future to address the

forthcoming gaps in provision and so mitigate against these service reductions to reduce lifestyle-related ill health.

4.5 In relation to tooth decay, data published in March 2017 has now been analysed, and it is recommended that an Oral Health Strategy for Reading is developed on the back of this. The details are contained in a separate report being brought to this Board today.

4.6 Per the Dashboard, performance is currently below target for the following Priority 1 indicators.

2.06ii - % 4-5 year olds classified as overweight/obese
A slight increase earlier this year has put Reading slightly above target and above the percentage recorded last year. This follows three years of slight reductions and, statistically, may be the result of chance rather than a 'real' trend. Overweight and obesity has fallen significantly in older primary aged children this year. Performance against both indicators will be monitored to determine whether these represent real trends.

2.22 – Health check indicators.
Reading will not meet local or national targets for proportion of the population who are eligible for a health check (aged 40-74) to be invited for a health check by the end of 2017/18**.** Low performance against this indicator has had implications for the other two health check indicators. Other pressures within local service provision have had an impact on this performance.

Priority 2: reducing loneliness and social isolation

4.7 A cross-sector Loneliness and Social Isolation Steering Group has overseen the development of an in-depth local loneliness analysis. This has now been published as a module within our Joint Strategic Needs Assessment, and draws on national and local research to show how becoming lonely or socially isolated is a complex process affected by a range of interrelated factors. Individuals may be at greater risk if they:

- are single (have no current spouse or life partner;
- have recently experienced a significant life change; or
- face practical barriers to social contact - such as poor health, lack of transport or lack of economic or social resources,

4.8 The Needs Analysis confirms that, although loneliness and social isolation are important issues for people in older age groups, other age groups are also affected. Older people may be at greater risk because they are more likely to be affected by relevant life changes and/or practical constraints than because old age is a risk factor in itself. The Council has commissioned some further research from the University of Reading to explore issues in further detail – such as what the evidence is telling us about effective interventions to support younger people, and how different health conditions may affect the risk of loneliness and social isolation differently.

4.9 The Steering Group has refreshed its Action Plan to focus on some specific practical steps which can be taken to share information about support and services to strengthen social contact, as well as to set out targeted actions to support different at-risk groups. There are some groups, however, for which

this is still being explored and the Group has simply set a marker whilst awaiting the outputs further research.

4.10 Per the Dashboard, performance is currently below target for the following Priority 2 indicators.

1.18 - Adult Social Care users with as much social contact as they would like AND Carers with as much social contact as they would like.

Targets for these indicators were set based on previous performance (for carers) and - where Reading's performance was below national average - previous England averages (Adult Social Care (ASC) users). The proportion of ASC users in Reading reporting enough social contact has improved over the last two years, while the national average has stayed the same. The proportion in Reading is now only very slightly below the national average (45.2 vs 45.4) and the local target (also 45.4). Similarly, for carers in Reading, the proportion reporting enough social contact has remained the same, while the national average has fallen. Consequently, carers in Reading are now more likely to report enough social contact than nationally. Although targets have not yet been met, performance has improved and is in line or better than the national average.

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

4.11 The (appendixed) Health and Wellbeing Action Plan includes a link to the latest Future in Mind (FiM) Transformation Plan. The local FiM plan was driven by engagement work undertaken across the system in 2014, prior to FiM, echoing national FiM report findings and recommendations. The local plan is refreshed annually to provide a snapshot across the system across the Berkshire West CCG footprint. The last refresh was competed in October 2017 and approved by the Reading Health and Wellbeing Board as well as the Wokingham Health and Wellbeing Board and the West Berkshire Health and Wellbeing Board. Service user feedback, data and service information is gathered throughout the year and this shapes ongoing work.

4.12 Funding for FiM projects increased to £789,271 in 18/19 for the whole of Berkshire West. The CCG reviewed projects funded through FiM during 17/18 in light of national and local care pathway requirements, and all services have been commissioned to support wider emotional health and wellbeing care pathways. The FIM local transformation plan will be refreshed in October 2018 and we will include the projects funded in 18/19.

4.13 Berkshire West CCG requires the support of 2 voluntary sector organisations to add value to the ASD and ADHD care pathways. This funding will provide children and families with support both whilst they are waiting for an assessment to start, as well as once a diagnosis is has been made.

4.14 Funding has been put into new services such as an Anxiety and Depression intervention to be delivered by the University of Reading and recurrent funding of the CAMHs crisis/ urgent care service.

4.15 The CCG has continued to fund Number 5 Youth Counselling at the same level as last year and committed to a 3 year contract- this is in addition to Future In Mind funding. RBC are no longer funding youth counselling in Reading.

4.16 Per the Dashboard, performance is currently on or above target for all Priority 3 indicators.

Priority 4: reducing deaths by suicide

4.17 The updated Health and Wellbeing Action Plan summarises progress to date as overseen by the Berkshire-wide Suicide Prevention Strategy Group and by the Reading Mental Wellbeing Group.

4.18 A range of activities have been co-ordinated to maintain the profile of suicide prevention, including: a Media Summit on responsible suicide reporting; a mini conference to mark the formal launch of the Berkshire-wide Suicide Prevention Strategy; events across Council sites on Time to Talk today in support of RBC's Time to Change pledge to address mental health stigma as an employer; and partnership events to mark Mental Health Awareness Week.

4.19 Ongoing cross Berkshire work includes the preparation of a new four-year Suicide Audit and a review of commissioned support services to inform the refresh of Suicide Prevention Action Plans.

4.20 Per the Dashboard, performance is currently below target for the following Priority 4 indicator.

4.10- Mortality rate from suicide and injury of undetermined intent

The rate in Reading fell from 11 per 100,000 in 2013-15 (44 people) to 9.9 per 100,000 in 2014-16 (40 people). This is in line with the England average and slightly lower than similar LAs but did not meet the local target set by stakeholders.

Priority 5: reducing the amount of alcohol people drink to safe levels

4.21 Actions under Priority 5 are now aligned with the Reading Drug and Alcohol Commissioning Strategy for Young People and Adults 2018-2022, presented to the Board today under cover of a separate report. The strategy has a community-wide focus, including children, young people and adults - whether they are consuming alcohol or drugs themselves or whether they are affected by other people using these substances.

4.22 The strategy provides a framework for realising the vision of reducing the harm, or potential harm, that misusing alcohol and drugs has on the individual, on families and on the wider community. The aim is to enable individuals affected by drug and alcohol misuse to recover and reach their potential in leading a healthier lifestyle with the help of all agencies in Reading.

4.23 The strategy is built around three themes:

- Prevention - reducing the amount of alcohol people drink to safer levels and reducing drug related harm
- Treatment - commissioning and delivering high quality drug and alcohol treatment systems
- Enforcement and Regulation - tackling alcohol and drug related crime and anti-social behaviour.

4.24 Per the Dashboard, performance is currently below target for the following Priority 5 indicator.

2.18 - Admission episodes for alcohol related conditions
Alcohol-related hospital admissions, for many years much better than average, have been increasing gradually and are now in line with the national average.

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

4.25 Local action on dementia is overseen by the Reading Dementia Action Alliance (DAA) and the Berkshire West Dementia Steering Group. The DAA co-ordinated a series of Dementia Friends session across Reading during Dementia Action Week (19th May to 26th May 2018) for members of the public, hosted by DAA members at libraries in each community. This took the programme out to new people whereas in the past there has been a focus on linking with existing groups. Although the sessions were small, a media storm was created in Reading to raise the profile of dementia in the period leading up to and including Dementia Action Week. Dementia Friends sessions raise awareness of dementia to reduce the risk of harm to or discrimination against people living with dementia and their carers.

4.26 The DAA also arranged for the Alzheimer's Society to host a stand in Reading town centre (the Oracle) during Dementia Action Week, and this enabled 35 new contacts with support services for people with sensitive and personal issues around living with dementia. This event also facilitated contact with local retail businesses, and DAA members were encouraged by the number of local shops whose staff were already aware of the Dementia Friends campaign, the DAA and the issues around living with dementia. These events highlighted the need to take Dementia Friends sessions to where younger people are (schools, youth clubs etc), and this will be reflected in a refresh of the Action Plan.

4.27 Dementia prevention was the focus of a presentation delivered by the Wellbeing Team at a Health Inequalities event for the BME community in March 2018. The event was well attended by members of the public and community leads, leading to a commitment to future partnership working around health issues and preventative services. Dementia awareness is also now included in the NHS Health Check programme for all patients, but the budget for delivering NHS Healthchecks has been reduced, as report to RBC's Policy Committee in June.

4.28 Per the Dashboard, performance is currently below target for the following Priority 6 indicator.

4.16/2.6i - Estimated diagnosis rate for people with dementia
The estimated rate of diagnosis fell slightly below target in May 2018, after being above target for almost every month in the preceding year.

Priority 7: increasing the take-up of breast and bowel screening and prevention services

4.29 The local authority (Wellbeing Team) and CCGs are continuing to work in partnership to raise awareness of cancer risks, signs and symptoms, and support available. This has included: supporting PHE's Be Clear on Cancer campaign; sharing messages on breast cancer in women over 70 via local authority webpages, digital media and during community events; and promoting bowel screening at the Southcote Over 50s group.

4.30 A Macmillan Cancer Educator has been appointed to raise awareness of the signs and symptoms of cancer among hard to reach groups in South Reading. Macmillan Cancer Champion training has been organised for volunteers, and these champions will now organise cancer awareness sessions for their community groups. Over 30 people from the community have signed up to become cancer champions.

4.31 Per the Dashboard, performance is currently on or above target for all Priority 7 indicators.

Priority 8: reducing the number of people with tuberculosis (TB)

4.32 A wide range of partners is being engaged in raising awareness of TB and signposting people to appropriate services. This work is being driven by the outputs of a Berkshire-wide workshop in December 2017 including clinical representation from Slough and Reading, along with local stakeholders and representatives from NHS England and Public Health England. The groups worked through how to reduce the DNA rate, how to improve community engagement and data reporting.

4.33 Similarly, work to develop campaign materials was initially co-ordinated by a cross Berkshire working group. Responsibility for further communication and engagement is now with the local Operational Group, with oversight from the Berkshire TB Strategy Group. Key information on active and latent TB and a map of high risk countries has been made available on the Reading Services Guide and JSNA profile to facilitate public access to TB information.

4.34 Per the Dashboard, performance is currently on or above target for all Priority 8 indicators.

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 referred to in the appendixed update.

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 July 2018

Appendix B – Health and Wellbeing Dashboard – July 2018

11. BACKGROUND PAPERS

Reading Health and Wellbeing Strategy 2017-20
Healthy Weight Strategy
Oral Health report

Appendix A: Reading Health and Wellbeing Strategy 2017-20 - Action Plan - updated July 2018

PRIORITY No 1	**Supporting people to make healthy lifestyle choices – dental care, reducing obesity, increasing physical activity, reducing smoking** ***The original Health and Wellbeing Strategy Action Plan contained a number of actions within this priority area which are now set out in the updated Action Plan for the Healthy Weight Strategy – see separate report submitted to the Health and Wellbeing Board 13.07.2018.***				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update - July 2018**
To Prevent Uptake of Smoking - **Education in schools** - **Health promotion** - **Quit services targeting pregnant women/families** - **Underage sales**	**Wellbeing Team; Trading Standards; CS; S4H; Youth Services; Schools;**	**From April 2017**	**Maintain/reduce the number of people >18 years who are estimated to smoke in Reading** **Improve awareness of impact of smoking on children** **Reduce the illegal sale of tobacco to >18 years**	**PHOF 2.03 - Smoking status at the time of delivery** **PHOF 2.09i – Smoking prevalence at age 15- current smokers (WAY survey)** **PHOF 2.09ii – Smoking prevalence at age 15 –**	**Prevention in Schools is delivered by PHSE Leads but is supported by local Tobacco Control Alliance.** **Whole 9 Yards campaign regarding Smoke-free Homes with Routine and Manual workers recommenced – this targeted local depot and**

			Increase uptake of smoking cessation >18 years	**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)**	**warehouse workers.** **Work with target groups on illegal tobacco, involves presentations and Trading Standards contact details for reporting –report and awareness campaign.**
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**	**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**	**Quarter 4 2017/18 Quit Performance is as follows:** **4 week successful quits – 179** **12 week successful quits – 56** **Of which 28 were routine and manual workers and 2 were pregnant women.**

			Increase referrals to S4H by GPs; **Increase self-referrals to S4H**	**smokers (APS)** **NHS OF 2.4 - Health related quality of life for carers**	**2018/19 targets are under negotiation. Budget decision set by Policy Committee 2018 resulted in discussions with the provider. Further update will be given at the next HWB.**
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**		**Sniffer Dog was used by Trading Standards to raise awareness of illegal tobacco sales.**
Local Smoking Policy – workplace, communities - **Update workplace smoking policy (wellbeing policy)** - **Smoking ban in community (RBC**	**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.**		**Ongoing Wellbeing Team input into local development plans**

sites, school grounds; RSL; Broad Street)					
To collect dental epidemiology data for Reading	**Wellbeing Team**	**From January 2017**	**Reading Borough Council will have access to dental epidemiological data in order to be able to monitor progress in relation to Public Health Outcomes Framework indicators on oral health**	**PHOF 4.2: tooth decay in 5 year old children**	**Data published in March 2017 has now been analysed, and it is recommended that an Oral Health strategy for Reading is developed on the back of this.**

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 - July 2018**
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**		**COMPLETED - Steering Group now meeting bi monthly representing a range of interests.**

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**	**COMPLETED - The Loneliness and Social Isolation Steering Group has overseen the development of an in-depth local loneliness analysis, which has now been published as JSNA module.**
Refresh the Loneliness and Social Isolation JSNA module annually	**Wellbeing Team, RBC**	**June 2019** **June 2020**	**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**	**A student has been recruited via the University of Reading to carry out a further literature analysis plus interviews and focus groups over the months of summer 2018.**

				PHOF 2.23 i-iv – self-reported wellbeing	
Map out community notice boards, including owners and access criteria	**Ebony George (Neighbourhood Intiatives), Matt Taylor (AUKR), Steph Francis (CCGs)**	**November 2018**	**Partners will be enabled to share information about services and resources to reduce loneliness and social isolation.**		
Start to map local Facebook pages	**Sarah del Tufo (RCLC)**	**September 2018**	**Partners will be enabled to share information about services and resources to reduce loneliness and social isolation.**		
Reinstate lunchtime learning sessions for Adult Social Care staff to raise awareness of services to reduce loneliness and social isolation	**Sarah Hunneman (Wellbeing Team, RBC)**	**September 2018**	**Adult Social Care staff will have up to date knowledge of local services so as to signpost or refer people at risk of social isolation.**		
Develop a plan for regular awareness raising with local NHS staff about services to reduce loneliness and social	**Steph Francis (CCGs)** **Sarah Morland**		**NHS staff will have up to date knowledge of local services so as to signpost or refer people at risk of**		**Members of the LSI Steering Group are able to disseminate information via the weekly GP practice newsletter from the**

isolation.	**(RVA)**		**social isolation.**		**CCGs.** **The weekly RVA e-newsletter is promoted to NHS staff.**
Link the Loneliness and Social Isolation Steering Group into plans to co-ordinate the maintenance of online directories of service for Reading	**Kirsty Wilson (Connect Reading)**	**Ongoing**	**People will be enabled to access groups and services to reduce loneliness and social isolation.**		
Collate and share partner experiences of supporting peer support / social groups to develop and become self sufficient	**Sarah Morland (RVA)**	**January 2019**	**Tools are available to promote sustainable solutions**		
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**		**All members of the Steering Group to promote the accessibility of general public transport in Reading, and consideration of travel companions as part of service provision** **All to promote Readibus's volunteer driver training scheme**

					Maintain good links with Readibus (a LSISG member) and Reading Buses to raise and resolve issues
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-reported wellbeing**	**Ongoing - the Loneliness Steering Group is being used as a vehicle to share ideas and best practice on evaluation.**
Support the neighbourhood Over 50s groups to grow and be self-sustaining	**Michelle Berry & Sarah Hunneman (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**	**There are now four thriving Over 50s clubs – in Caversham, Southcote, Whitley and Coley.**

				like **PHOF 2.23 i-iv – self-reported wellbeing**	
Support access to employment as a way of addressing loneliness and social isolation	**Marc Murphy (Oracle)**	**Ongoing**			**Ongoing confidence building, interview skills and work experience programme at the Oracle for single parents** **Ongoing work shadowing programme for people who face challenges to work / integration** **Retail Business Manager from the Oracle spoke at 'Make Reading Friendlier' conference to encourage businesses to do more to support people who are lonely or isolated**
Develop volunteering and employment opportunities for adults with care and support needs	**Sarah Hunneman (Wellbeing Team, RBC) / Sarah Morland (RVA) / Kirsty Wilson (Connect**	**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**	**New volunteering and employment opportunities have been created as part of:** **- The relocation and reshape of The Maples Day Service** **- The development of the**

	Reading)			**have as much social contact as they would like**	**Recovery College** **- The development of the Over 50s clubs** **RVA has an officer who specialises in volunteering opportunities for people with additional needs.** **Berkshire West Your Way commenced delivery under a new contract 01.06.2018 which includes supporting people with mental health needs into employment** **RBC has made a 'Time to Change' pledge to end mental health discrimination – this campaign to be promoted to other Reading employers** **Connect Reading is promoting Mental Health First Aid as workplace training with Reading businesses**
Raise awareness of services to reduce loneliness and	**Sarah del Tufo (RCLC)**	**ongoing**	**People who are not literate or who speak little**		**RCLC, Reading Refugee Support and Communicare commenced**

social isolation with people who are not literate or who speak little or no English			**or no English will be enabled to access groups and services to reduce loneliness and social isolation.**		**delivery 01.06.2018 on a new contract for people facing language or cultural barriers to social contact.** **Independent report into the needs of ethnic minority women in Reading and how RCLC meets those needs to be published 19.07.2018.**
Raise awareness of services to reduce loneliness and social isolation with people who are not literate or whose first language is BSL	**To be discussed following further analysis**				**Deaf people to be a priority group for further analysis within ongoing research**
Raise awareness of services to reduce loneliness and social isolation with people who aren't literate because of cognitive limitations	**To be discussed following further analysis**				**Further research which has been commissioned includes considering how different long terms conditions or disabilities affect people's ability to form social connections differently**
Raise awareness of loneliness and social isolation amongst and services to support children and young people	**To be discussed following further analysis**	**ongoing**			**Children and young people to be a priority group for further analysis within ongoing research**

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:
https://www.berkshirewestccg.nhs.uk/media/1742/october-2017-refreshed-transformation-plan-final-for-submission.pdf

Building on the October 2016 refresh of plans, the latest Future in Mind plan contains the following sections.

1. Our journey so far- A snap shot of how services are delivered now compared to 2014 pp 7- 8
2. An overview in the local paradigm shift from a traditional tiered system to a THRIVE framework pp 9-11
3. A review of progress and achievements since October 2016 through a THRIVE lens

- **Thriving pp12-15**
- **Getting advice pp 15-19 include Emotional Health Academy**
- **Getting help pp 19- 25**
- **Getting more help pp25- 26**
- **Getting risk support -risk management and crisis response pp 26-30**

4. A summary of progress against Five Year Forward View for Mental Health, key planning guidance p 31-39
5. Further work which needs to be undertaken over coming years. This is our action plan which picks up on issues identified earlier in the document pp 40- 56
6. Current challenges in achieving this pp 57- 60
7. A summary of workforce concerns and plans pp 61-63
8. An overview of financial investment pp 64- 68
9. An update on data submissions to the national Mental Health Services Data Set (MHSDS) p 69
10. Governance p 72- 73
11. Need and activity pp 74- 81
Appendix 1 workforce data pp 81-85

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 - July 2018**
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**		**Terms of Reference for Reading Mental Wellbeing Group includes oversight of Reading's Suicide Prevention Action Plan**
Develop a communication plan to raise awareness of Reading's Suicide Prevention Action Plan, including: **- the formal launch of the Berkshire Suicide Prevention Strategy** **- contributions to the**	**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 Prevention Action Plan**		**Media Summit on responsible suicide reported held on 11.09.2017 to mark Suicide Prevention Day** **RBC signed Time to Change pledge on 06.10.2017.** **Berkshire Suicide Strategy formally launched on**

'Brighter Berkshire' Year of Mental Health 2017 **- marking World Suicide Prevention Day (10 September)**					**17.10.2017.** **Events were organised at five different Council sites to mark 'Time To Talk Day 2018' on 01.02.2018.** **25 members of staff across RBC teams and directorates have now signed up as Time to Change employee champions, and 10 champions received formal training from the Time To Change National Team on 27.04.2018.** **The Wellbeing Team in partnership with the Recovery College and Meadway Sports Centre organised multiple events to mark Mental Health Awareness Week (14-20 May 2018), including a dog friendly mental health walk, free yoga, bake off competition, fundraising for MIND and talks from an anorexia recovery speaker**

Target initiatives on groups at higher risk of death by suicide: **- 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 College**	**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**	**PHE has now been commissioned by Wokingham BC to progress this work** **Completed** **There were a total of 686 attendances on formal tuition sessions offered by the Reading Recovery College sessions in 2017-18 (a 23% increase on the 2016-17 figure). There were a further 1,188 attendances at informal sports, leisure ad social groups**

					linked to the 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** - **Contribute to a Berkshire wide**	**Reading Mental Wellbeing Group as local sponsors (see above)**	**Ongoing** **ongoing** **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**	**See Action Plan for Priority 3 for details in relation to children and young people.**	**- See Priority 3 update in relation to 'Future in Mind'** **- links established** **- Survivors Trust hosted a workshop at the Berkshire Suicide Strategy launch in October** **- A evaluation report is being**

review of targeted community based interventions, including suicide prevention and mental health first aid training			**interventions will be informed by a review of impact**		**prepared by a PHE Practitioner which will be shared with Berkshire suicide prevention group** **- Reading DAAT providers are aware of the Suicide Prevention Strategy and objectives. They attended a workshop delivered by BHFT in February 2018 with substance misuse professionals from Wokingham and Newbury.**
Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and recommend appropriate action(s)	**Public Health Team, Wokingham**	**ongoing**	**Access to the means of suicide will be reduced where possible**		**Next audit deferred until after April 2018 so as to encompass a four year data period (based on date of inquest rather than date of death)**

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 support and access to specific support for bereavement through suicide**	**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.**
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**		**Media summit held on 11.09.2017, with information cascaded to those who were unable to attend**
Update Reading JSNA module on suicide and self-harm	**Wellbeing Team, RBC**	**tbc**	**Local and county-wide Suicide Prevention Action**		**A refreshed Suicide and Self Harm module of the Reading**

Refresh Reading Mental Health Needs Analysis	**Adults Commissioning Team, RBC**	**May 2016**	**will be informed by up to date research, data collection and monitoring**		**JSNA was published in March 2017. An update is due to be published by September 2018.** **Am updated Mental Health Needs Analysis is due to be published by September 2018.**

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 - July 2018**
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**	**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.**
Promote knowledge and	**All partners**	**Ongoing**		**PHOF 2.15iii –**	**NHS Health Check provides**

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 contacts.				**Successful completion of alcohol treatment** **PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**opportunistic conversation around alcohol use as Audit C is part of a check. Number of invites and health checks completed by GPs (providers) have declined from 2015/17 to 2016/17.** **Alcohol brief intervention training programme being drafted for the Summer**
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**		**Ongoing**
CCG and Public Health to present a business case for an Alcohol Liaison Nurse to help reduce alcohol related admissions to hospital.	**Alcohol Mapping Group**	**April 2018**		**PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**A Business Case for Berkshire West has been prepared for presentation to the BW10 Delivery Group**
Need to gain authority for Peer Mentors to be on the (selective) Wards at RBH **Alcohol Peer mentors – to visit clients on hospital wards and assist in transition into community (including following detox).**	**IRIS Reading Borough Manager/ Peer mentors**	**April 2018**	**Peer mentors can advise patients on specialist community services and alcohol service available locally.** **To prevent re-admissions to hospital.**	**PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**Peer mentors are supporting patients on Sidmouth Ward at RBH from Qtr 1 2018/19**

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 – this has been to the South Reading GP council and a list of resources provided, and also included in GP newsletter.** **RBC Trading Standards has also run a course for local stakeholders.**
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)**	**South Reading CCG has reviewed the alcohol pathway with IRIS, Reading Borough Council DAAT, BHFT, RBH inpatients and A&E. Service improvements from other CCGs have also been reviewed. A proposed model for a community alcohol nurse, initially developed and piloted by Brighton and Hove CCG, has been developed into a business case for funding.**
Alcohol CQUIN - preventing ill health caused by alcohol. RBH to identify and support inpatients who are increasing or higher risk drinkers	**RBH/ Public Health/ IRiS Reading/ CAP**	**June – Sept 2018**	**Reduction in alcohol admissions to hospital.**	**PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)**	**Specialist drug and alcohol services and CAP lead to support RBH in training Trust staff in IBA and ensuring referral pathway into specialist treatment services is robust.**
Licensing					
A community free of alcohol related violence in homes and in public places,	**CAP Lead**	**Ongoing**	**Reduction in alcohol admissions to hospital.**	**PHOF 2.18 – Admission episodes for alcohol-related conditions**	**Street drinking initiative underway**

especially the town centre. **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**			**Responsible drinking in public spaces.**	**(narrow) (Persons, M and F)**	
Review all extended new applications under the Licensing Act – Public Health review and consider all new applications. Make representations for anything that is of concern and attend Licensing Hearings, Performance review or Licence reviews. **Reading Festival - work with Festival Republic, the organisers of Reading Festival, in preparation for**	**Public Health/ Licensing** **CAP/ Licensing Team/ Public Health**	**Ongoing** **July- Aug 18**	**Control of licensed outlets and review of Reading's late night economy.**		**Ongoing** **Send out Newsletter before Reading Festival to all Retailer's in the area to remind them of their 4 Licensing objectives and laws around**

this year's event and consider how best to tackle the issue of alcohol (and illegal drug use)					**Underage drinking and proxy purchases.** **Test Purchasing on site at Reading Festival**
Licencing to promote responsible retailing, 4 Licensing objectives. **CAP to increase Test Purchasing – Challenge 25, Under 18.** **Training Log to be rolled out to all retailers.** **Retailer Training to commence.** **Encourage retailers to restrict**	**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 – CAP arranged joint retailer visits with licensing to complete the licensing surveys, licensing checks and Training log.** **Qtrly test purchasing of Challenge 25. CAP to do a 6 month trial of monthly test purchasing with PCSO in all hotspot area.** **Ongoing - Updated Retailer training offered after Test Purchasing. These will run more frequently with the increased of TP C25 being monthly. If this is popular will offer regular free quarterly training for all retailers.** **Map out those retailers that have agreed to this initiative**

the sale of higher ABV % cans					**and cross reference against ASB intelligence in those areas.**
Promotion of better marketing of soft/ mixer-diluted drinks in Bars and Pubs.	**CAP/ licensing**	**Ongoing**	**Promote healthier non-alcoholic options to customers**		**Competiton being launched as part of a Diversionary activity to design a Manga CAP Hero Character, across all schools in Reading. Once character designed, used this to promote the Soft drink messages in Universities/young people's bars.** **Attend Pubwatch to discuss ideas for future projects.**
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.** **Promote CAP Role within the community to build relationships and encourage reporting.** **CAP work in Whitley within the WDCA Café -training members of staff re Proxy purchased, Challenge 25 and IBA training.** **Attending WDCA every other Monday morning to have a presence in the Café and speak to the community about**

					Alcohol awareness.
Education					
Parent education – **2018 Parents Survey 'Howmuchis enough' trialled with 250 parents to empower parents when making decisions about allowing their children to drink alcohol.**	**CAP lead**	**completed.**			**Collation of figures to inform future educational activities**
Education if for all ages. **Alcohol awareness sessions for all.** **Mini Police Project - a fun and interactive volunteering project for children in Years 5**	**CAP Lead**	**Ongoing**	**Educating everyone on the risks of alcohol and promote drinking responsibly.**		**Developed a Needs assessment and sent out to all Secondary schools with the CAP Young Peoples survey.; to be able to give Alcohol awareness sessions that fit the schools and pupils needs.** **CAP to offer joint IBA training sessions to Reading Services with Prospect Park Misuse Nurse.** **SCHOOL children at Katesgrove Primary School benefitted from alcohol awareness sessions (**

and 6. The aim is for children to work with neighbourhood police teams on local issues. The pupils will also spread the word among their school friends about the work they are involved in and gain awareness of a variety of issues. **CAP to expand on this and set up new project 'Young CAP Champions' to encourage YP to promote important messages about alcohol amongst their peers (Primary schools in Reading).** **MANGA Comic Project to encourage alcohol awareness.**					**age appropriate awareness of alcohol, including risks, health impacts and associated laws), as part of a 'Mini Police' project. Primary Schools being encouraged to sign up to this initiative.** **Summer weekly drop in at Library – arty activities for young people, in a bid to raise awareness of the dangers of alcohol consumption. It will enable young people to create their own manga style comic strip/story based around the theme of alcohol awareness. Drop in sessions will be held at Reading libraries over the summer – days and times to be confirmed**

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.**					**Ongoing – 2 qualified Youth Health Champions. 12 children are signed up and involved in the programme. Workshops to continue – Looking at a Wellbeing initiative. Further funding for 2018 being secured to roll out this programme.** **PSHE presentations are taking place. Peer Mentors are willing to visit schools and this is co-ordinated when required. Film being produced by CAP and IRiS Reading Peer mentors on risks of alcohol – to be shown in schools.**
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** **Work with CAP and specialist drug and alcohol service to produce a flm on the risks of drugs and alcohol (see above).**
Prevention					
Promotion of Dry January campaign.	**CAP Lead, DAAT Contract & Project**	**December 2017 and January 2018**	**Encourage awareness of effects of alcohol on staff, clients and local**		**10th Jan 2018 – Massage session for RBC staff.**

Promotion of January alcohol detox via IRIS Reading as part of the Dry January campaign	**Manager, IRIS Reading IRIS Reading Borough Manager & RBC Press team**		**community.** **Promote drinking responsibly.**		**18th Jan – RBH staff welfare day (alcohol session)** **Campaign planning to commence Autumn 2018**
Explore with the street care team whether we can promote drinking responsibly at recycling depots.	**DAAT / Street Care Team**		**Encourage drinking responsibly and increase public awareness of the risks of alcohol**		**Action still needed.** **In light of Reading Festival, CAP to organise for Streetcare team to install Recycling bins at the Mothercare/Aldi site to reduce alcohol cans and bottles being discarded on the streets in this area.**
Work in partnership with RVA to promote Public Health messages through their newsletter	**Public Health Lead/ RVA**	**Ongoing**	**Encourage healthier lifestyles.**		**Ongoing**

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 - July 2018**

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**		**The Berkshire West Dementia Steering Group is representative of local partners involved in dementia awareness and care. Quarterly meetings provide the opportunity to influence and inform local practice.**
Raise awareness on reducing the risk of onset and progression of dementia through building on and promoting the evidence base for dementia risk reduction	**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**	**PHOF 4.16 and NHS 2.6i– Estimated diagnosis rate for people with dementia** **PHOF 4.13 – Health**	**Reading DAA delivered 20 awareness raising sessions throughout 2017, including presentations at Older People's Day.**

(including education from 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.			**of dementia and have the 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.**	**related quality of life 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**	**Dementia awareness is now included in the NHS Health Check programme for all patients. However, the number of NHS Health Checks completed in Reading for 2018/19 will potentially be impacteded by budgets set by RBC's Policy Committee in April 2018.**
Identify patients early including those from Black, Asian and Minority Ethnic origin and other seldom heard groups enabled	**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**	**'Top Ten Tips' pack launched to assist non-medical staff recognise dementia signs** **Care home assessments use**

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				**improving quality of life** **NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence for people with dementia**	**the Diagnosis of Advanced Dementia[1] [DiADeM] and General Practitioner Assessment of Cognition[2] [GPCOG] tools to identify missed cases of memory impairment.** **Ongoing community engagement, including work led by Alliance for Cohesion and Racial Equality** **Annual reports from the Memory Clinics enable the monitoring of progress.**
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**	**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**	**Care Plans uploaded on DXS, easily accessed by GPs and practice staff.** **DCAs who are commissioned through the CCG's at the Alzheimer's Society complete a support plan for every service user. These are not yet directly accessible in primary care pending interoperability**

[1] DiADeM is a protocol developed by the Yorkshire and Humber Dementia Strategic Clinical Network aimed at supporting Gps to diagnose dementia for people living advanced dementia in a care home setting. See https://dementiapartnerships.com/resource/diadem-diagnosis-of-advanced-dementia-mandate-in-care-homes/ for further information.

[2] GPCOG is an instrument to screen for dementia specifically in primary care settings. For more information about CPCOG please visit http://gpcog.com.au/index/more-about-the-gpcog

			decisions about me"	**NHS OF 2.6ii - effectiveness of post-diagnosis care in 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**	**solution.** **Personalised care plans for use in GP practices are being developed by TVSCN.**
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**	**Every diagnosed dementia patient has a named GP – now a requirement.** **DCA service support in this with a robust referral route from GP.**

				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 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**	**Initial referrals are to the Memory Clinic, accredited with MSNAP.** **Dementia Care Advisors employed by the Alzheimers Society are commissioned to provide support to a Pathway**

				manage their condition	**devised by the Thames Valley Clincal Strategic Network.** **BHFT, RBH and GP practices all have programmes to increase staff awareness of and responsiveness to dementia.** **RBC commissioned care services are required to meet minimum training standards.**
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.** **Training is under development specifically focused on GP practices which will encourage participation. All practices are encouraged to have a Dementia Champion to facilitate. This will be further assessed using the iSPACE**

					model and supported by the Dementia Action Alliance.
Work with local organisations, care homes and hospitals to support more providers to achieve Dementia Friendly status	**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 dementia and the skills to make practical changes to make their service more accessible to those with dementia**	**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**	**7 new members have joined the Reading DAA and completed local action plans, including John Lewis Partnership, Launchpad, Reading libraries, Get Berkshire Active, Salvation Army.** **Up until 31st May 2018:** **- 1,148 people in the Reading have completed online Dementia Friends training.** **- 272 Dementia Friends sessions have been delivered in Reading.** **- 5,530 people in the Reading area have become a Dementia Friend following a session** **All of these figures are in excess of targets.**

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.** **Plans for Tier 2 are underway through the TVSCN, and need identified for a rolling Tier 1 programme led by champions who have undertaken Train the Trainer.** **RBH has a Dementia Champions programme.** **BHFT have achieved their target of training 80% of staff in dementia awareness**
Ensure commissioned services contractually specify the minimum standards of training required for providers who care for people with dementia including residential, nursing and domiciliary care settings.	**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 dementia awareness and training.**	**NHS OF 2.1- Proportion of people feeling supported to manage their condition**	**RBC commissioned services contractually specify minimum standards of training required for providers who care for people with dementia in residential, nursing and domiciliary care settings. Providers are expected to have in place a learning and development framework for staff to ensure a skilled workforce is available to meet the diverse needs of**

					the individuals who access their service. Dementia awareness is currently desirable training for support staff. All providers carrying out registered activities in Reading are inspected by the Care Quality Commission. Reading Borough Council's Quality and Performance Monitoring Team in Adult Care and Health Services also monitor local services.
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 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**	**ACS Outpatient workstream is currently reviewing the memory service pathway against vanguard/best practice examples and this will be used to inform the JSNA. Ethical pathway will be linked to a national MCI pathway currently being developed through the TVSCN.**

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**	**The Berkshire West Steering Group meets quarterly and brings together key health, social care, community and voluntary sector partners to share progress and identify opportunities for learning.** **A webinar and checklist is under development specifically focused on GP practices to improve identification, coding and raising awareness of dementia in primary care.**
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 post-diagnosis care in sustaining independence and improving quality of life**	**Action update:** **Anyone with the appearance of care or support needs is entitled to a social care assessment. The local priority is to raise awareness of this statutory right and the national eligibility criteria.**

				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**		**Several Memory Clinics are installing Joint Dementia Research (JDR) kiosks which enable people with dementia and/or their carers to register.** **BHFT Research Team also provide information about**

			2020. Future treatment and services to be based on and informed by the experiences of people living with dementia		**JDR and how to join.** **In addition to JDR, patients and carers attending memory clinics are routinely asked about participation in research.**
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"**		**DAA partners include local information and advice hubs and solicitors who specifically provide independent advice and advocacy. These partners support the larger community events to raise awareness of this information. This has also been fed into the local Dementia Friends sessions.** **The Berkshire Dementia handbook for Carers is offered to the main carer of all who are newly diagnosed. Carers are also offered a place on the 6 session Understanding Dementia Course for Carers.** **PWD and Carers are all**

					advised that they can contact the Memory Clinic for advice/information.
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.**		**This is led by the Alzheimers Society nationally.**

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 July 2018**
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**	**Teachable moment pilot project for South Reading rolled out from August 2017 (see below). Pilot ended in January after implementation by only two practices. Lack of time, workload constraints and**

				coverage- breast cancer **4.05i Under 75 mortality rate from cancer (persons)** **4.05ii Under 75 mortality rate from cancer considered preventable (persons)**	**capacity of the team to support the implementation were seen as barriers.** **Tailored GP Surgery bowel screening letters are now sent to patients from the Hub.** **The Cancer Research UK Facilitator has offered 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 screening programmes	**Public Health Berkshire** **Macmillan**		**Patients seek advice and support early from their GP** **Increase uptake of screening programmes**		**Local authority is supporting the promotion and engagement of Macmillan Cancer Education Project, 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,**

					Over 30 people from the community have signed up to become cancer champions. A number of community events and meetings have been held. **Macmillan Cancer Champion training have been organised for volunteers from different community groups. These champions will now organise cancer awareness sessions for their community groups** **CRUK bowel screening promotional video has been shared through local authority web pages.** **Wellbeing team has been promoting various cancer awareness campaigns including PHE's Be Clear on cancer: Breast Cancer in women over 70 by sharing key messages via local authority webpages digital media and during community events** **Wellbeing team in partnership**

					with CCG promoted bowel screening among Southcote over 50s group. Participants completed questionnaires around bowel cancer screening and they were provided information on using the test kit
To plan and implement a pilot project that provides motivational behaviour change interventions to patients who have had a 2WW referral and a negative result ("teachable moments")	**Public Health Berkshire** **Cancer Research UK Facilitator**		**Patients motivated to make significant changes to lifestyle behaviours that will help to reduce their risk of developing cancer**		**See above – take up too low for a formal evaluation**

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 - July 2018**

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)**	**Workshops were held for health professionals and for RBC staff during March 2017. Sessions have also been delivered to other groups by the New Entrant Screening Nurse / TB nurse team from RBH.** **A dedicated TB project manager has been appointed to South Reading CCG using with funding from NHS England to work with clinicians and the TB operational group to support delivery of the LTBI New Entrant Screening Service, this includes scoping a suitable training programme.**
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)**	**A workshop was held on 05.12.2017 with clinical representation from Slough and Reading along with local stakeholders and representatives from NHS England and Public Health England. The groups worked through how to reduce the DNA rate, how to improve community engagement and data reporting. The outputs of this will form an action plan for**

					the next 12 months.
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)**	**Work to develop campaign materials was initially co-ordinated by a cross Berkshire working group. Responsibility for further communication and engagement is now with the LTBI Operational Group, with oversight from Berkshire TB Strategy Group.** **Reading Wellbeing team organised 2 TB awareness sessions for the Nepalese & Pakistani community in partnership with Healthwatch Reading and SRCCG** **- 40 participants and 32 surveys filled in total including both sessions** **TB information stands organised during four local events to raise awareness on LTBI screening services** **– Health & Wellbeing Week targeting staffs at RBH (**

					08.09.2017 Sep); **- Compass Recovery College Prospectus Launch event (16.08.2017);** **- New Directions event (16.09.2017)** **- Older People's Day event (09.10.2017)**
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 a map of high risk countries has been made available on the Reading Services Guide and JSNA profile to facilitate public access to TB information.** **TB data will be refreshed in 2018 as part of the JNSA rolling update schedule.**
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)**	**Public Health England is routinely notified of cases of Tuberculosis (TB) and implements public health actions to prevent and control onward transmission, including identification of close contacts of active TB cases and offer of appropriate TB testing. Eight cases of TB infection that were notified to the Thames Valley Health Protection Team over the previous two years have been found to be linked by genetic testing. Further genetic testing of all cases is being undertaken using an alternative technique that can provide higher discriminatory power. Investigation is ongoing to further explore any links.**
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**	**A risk-based strategy to offer BCG to infants at increased risks of TB (based on National Guidance) has been adopted by RBH Maternity Services and is supported by the Berkshire TB Strategy Group**

				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)	Catch up campaign was successful. BCG vaccine is no longer in short supply.
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)	BCG vaccine is no longer in short supply. See above
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)	A risk-based strategy to offer BCG to infants at increased risks of TB (based on National Guidance) has been adopted by RBH Maternity Services and is supported by the Berkshire TB Strategy Group.
Tackle the clinical and social risk factors associated with development of drug resistance in under-served populations by maintaining	Reading Wellbeing Team / Reading Reading Housing Team /	Jan-17	Work to develop the provision of appropriate and accessible information and support to under-served and high-risk	PHOF 3.05ii - Incidence of TB (three year average)	Reading Healthwatch has conducted a Knowledge and Behaviours Survey. Over 300 people have taken part indicating their views and knowledge towards TB. The

high treatment completion rates and ensuring thorough contact tracing around MDR cases	**NESS nurses/CCGs**		**populations.**		**results of this will provide a baseline to measure impact of communication and engagement work.** **This information will also be used to further shape engagement with under-served and other at-risk groups** **Resources shared with providers including IRIS**
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 to inform the process for assessment and discharge of homeless TB patients - both with and without recourse to public funds.** **This guidance has been used to inform process across the Berkshire LAs during 2017, demonstrating it is fit for purpose.** **Work is in progress to develop an MOU between the CCGs and local authorities across Berkshire West to ensure provision of accommodation to**

					homeless TB patients with no recourse to public funds
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 a priority for CCG LTBI Project Manager and LA PH team in 2018** **LA public health team co-ordinated this year's Reading event to mark the 'Light up the World for TB ' awareness-raising on 24.03.2018. Christchurch Pedestrian Bridge was lit up in Red to highlight the issue of TB in Reading and raise awareness in the fight against TB and the event was attended by Cllr Graeme Hoskin , Reading's Lead Councillor for Health, Wellbeing Team, representatives from the CCGs and TB teams from RBH** **TB information stands were organised at Central and Battle library where members of the public were given TB related information and information on New Entrant screening services.**

					World TB Day was promoted by the local authority via web pages and digital media. **A TB awareness session was organised for the Nepalese community in partnership with the charity Communicare** **Wellbeing Team has developed links with different community groups to identify TB Champions who could raise awareness of TB and NESS within their groups**
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)**	**The SE TB Control Board held a workshop in Reading in November 2017 to review its objectives for 2018.** **There are 2 face to face board meetings a year, and 2 TB network lead meetings to share work streams.** **There is a public facing website with links to general information, and a TB nurse forum**

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 16 South Reading practices are returning monthly lists to NESS. 199 patients were screened from April-November 2017 compared with 55 in the previous year.** **DNA rates are still higher than ideal, work is ongoing to identify and address barriers.**

Priority	Indicator	Target Met/Not Met	Direction of Travel
1. Supporting people to make healthy lifestyle choices	2.12 Excess weight in adults	Met	Better
	2.13i % of adults physically active	Met	Better
	2.06i % 4-5 year olds classified as overweight/obese	Not Met	Worse
	2.06ii % 10-11 year olds classified as overweight/obese	Met	Better
	2.03 Smoking status at the time of delivery	Met	Better
	2.14 Smoking prevalence - all adults - current smokers	Met	Better
	2.14 Smoking prevalance - routine and manual - current smokers	Met	Better
	2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2013-2018	Not Met	No change
	2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2013-2018	Not Met	No change
	2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2013-2018	Not Met	No change
2. Reducing loneliness and social isolation	1.18i/1l % of adult social care users with as much social contact as they would like	Not Met	Better
	1.18ii/1l % of adult carers with as much social contact as they would like	Not Met	No change
	Placeholder - Loneliness and Social Isolation	*NA*	*NA*
3.Reducing the amount of alcohol people drink to safer levels	2.15iii Successful treatment of alcohol treatment	Not Met	Worse
	2.18 Admission episodes for alcohol related conditions (DSR per 100,000)	Not Met	Worse
4.Promoting positive mental health and wellbeing in children and young people	Pupils with social, emotional and mental health needs (primary school age)	Met	No change
	Pupils with social, emotional and mental health needs (secondary school age)	Met	Worse
	Pupils with social, emotional and mental health needs (all school age)	Met	No change
5.Living well with dementia	4.16/2.6i Estimated diagnosis rate for people with dementia	Not Met	No change
	No. Dementia Friends (Local Indicator)	Met	Better
	Placeholder - ASCOF measure of post-diagnosis care	*NA*	*NA*
6.Increasing take up of breast and bowel screening and prevention services	2.20iii Cancer screening coverage - bowel cancer	Met	No change
	2.20i Cancer screening coverage - breast cancer	Met	No change
7.Reducing the number of people with tuberculosis	3.05ii Incidence of TB (three year average)	Met	Better
8. Reducing deaths by suicide	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	Not met	Better

PRIORITY 1: Supporting people to make healthy lifestyle choices

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
2.12 Excess weight in adults	Public Health Outcomes Framework	Active People Survey	Annual	Low	2015-16	59.2	63.4	Met	Better	61.3	61.8
2.13i % of adults physically active	Public Health Outcomes Framework	Active Lives Survey	Annual	High	2016-17	68.7	64	Met	Better	66.0	67.2
2.06i % 4-5 year olds classified as overweight/obese	Public Health Outcomes Framework	National Child Measurement Programme	Annual	Low	2016-17	22.9	22.0	Not Met	Worse	22.6	22.6
2.06ii % 10-11 year olds classified as overweight/obese	Public Health Outcomes Framework	National Child Measurement Programme	Annual	Low	2016-17	32.9	36	Met	Better	34.2	32.6
2.03 Smoking status at the time of delivery	Public Health Outcomes Framework	Smoking Status At Time of Delivery (SSATOD) HSCIC	Annual	Low	2016-17	6.8	8.0	Met	Better	10.7	12.0
2.14 Smoking prevalence all adults	Public Health Outcomes Framework	Annual Population Survey	Annual	Low	2016	13.6	14.8	Met	Better	14.9	13.2
2.14 Smoking prevalance - routine and manual - current smokers	Public Health Outcomes Framework	Annual Population Survey	Annual	Low	2016	27.6	28.9	Met	Better	25.7	23.7
2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2013-2018	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2013-2018 Q4	72.4	100%	Not Met	No change	90.9	Not available
2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2013-2018	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2013-2018 Q4	48.1	50%	Not Met	No change	44.3	Not available
2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2013-2018	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2013-2018 Q4	34.8	50%	Not Met	No change	48.7	Not available

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PRIORITY 2: Supporting people to make healthy lifestyle choices

Indicator Title	Framework	Source	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	Adult Social Care Survey - England	Annual	High	2016-17	45.2	45.4	Not Met	Better	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	Carers Survey	Bi-Annual	High	2016-17	36.2	38.5	Not Met	No change	35.5	32.4
Placeholder - Loneliness and Social Isolation	NA	TBC	Annual							NA	NA

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PRIORITY 3:Reducing the amount of alcohol people drink to safer levels

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
2.15iii Successful treatment of alcohol treatment	Public Health Outcomes Framework	National Drug Treatment Monitoring System	Quarterly	High	Q4 2017/18	37.8%	38.3%	Not Met	Worse	38.6%	Not available
2.18 Admission episodes for alcohol related conditions (DSR per 100,000)	Public Health Outcomes Framework	Local Alcohol Profiles for England (based on HSCIC HES)	Annual	Low	2016/17	602	599	Not Met	Worse	636	602

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Priority 4: Promoting positive mental health and wellbeing in children and young people

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
Pupils with social, emotional and mental health needs (primary school age)	Children and Young People's Mental Health and Wellbeing	DFE Special Needs Education Statistics	Low	2017	2.3%	2.3%	Met	No change	2.1%	2.0%
Pupils with social, emotional and mental health needs (secondary school age)	Children and Young People's Mental Health and Wellbeing	DFE Special Needs Education Statistics	Low	2017	3.3%	3.3%	Met	Worse	2.4%	2.0%
Pupils with social, emotional and mental health needs (all school age)	Children and Young People's Mental Health and Wellbeing	DFE Special Needs Education Statistics	Low	2017	3.0%	3.0%	Met	No change	2.3%	2.1%

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Priority 5: Living well with dementia

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
4.16/2.6i Estimated diagnosis rate for people with dementia	Public Health Outcomes Framework/NHS Outcomes Framework	NHS Digital	Annual	High	2017	67.5	67.7	Not Met	No change	67.3	66.2
No. of Dementia friends	NA (Local only)	Local Report	Quarterly	High	Reported locally	5800	4500	Met	Better	Not available	Not available

PLACEHOLDER - Post diagnosis care

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Priority 6: Increasing take up of breast and bowel screening and prevention services

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
2.20iii Cancer screening coverage - bowel cancer	Public Health Outcomes Framework	Health and Social Care Inform	Annual	High	2017	56.5	52%	Met	No change	58.8	60.6
2.20i Cancer screening coverage - breast cancer	Public Health Outcomes Framework	Health and Social Care Information Centre (HSCIC)	Annual	High	2017	72.9	70%	Met	No change	75.4	77.6

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Priority 7: Reducing the number of people with tuberculosis

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
3.05ii Incidence of TB (three year average)	Public Health Outcomes Framework	Public Health	Annual	Low	2014-2016	26.4	30	Met	Better	10.9	7.1

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Priority 8: Reducing deaths by suicide

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	Public Health Outcomes Framework	Health England (based on	Annual	Low	2014-16	9.9	8.25	Not met	Better	9.9	10.2

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Indicator number	**2.12**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Excess weight in adults**
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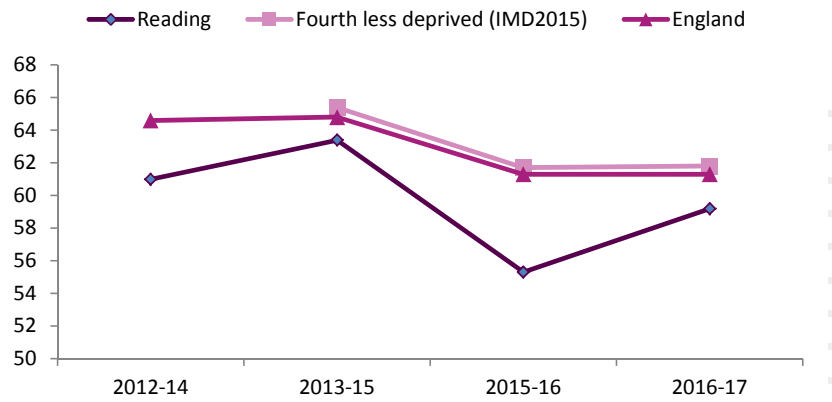
Data source	Active Lives Survey (previously Active People Survey) Sport England
	* Note change in methodology in 2015-16
Denominator	Number of adults with valid height and weight recorded. Active lives Survey. Historical (before 2015-16) Number of adults with valid height and weight recorded. Data are from APS year 1, quarter 2 to APS year 3, quarter 1
Numerator	Number of adults with a BMI classified as overweight (including obese), calculated from the adjusted height and weight variables. Active Lives Survey. Previously (before 2015-16) from Active People survey. Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m2.

Period	Reading	Fourth less deprived (IMD2015)	England
2012-14	61		64.6
2013-15	63.4	*65.4*	64.8
2015-16	55.3	*61.7*	61.3
2016-17	59.2	*61.8*	61.3



Indicator number	**2.13**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**% Physically Active Adults**

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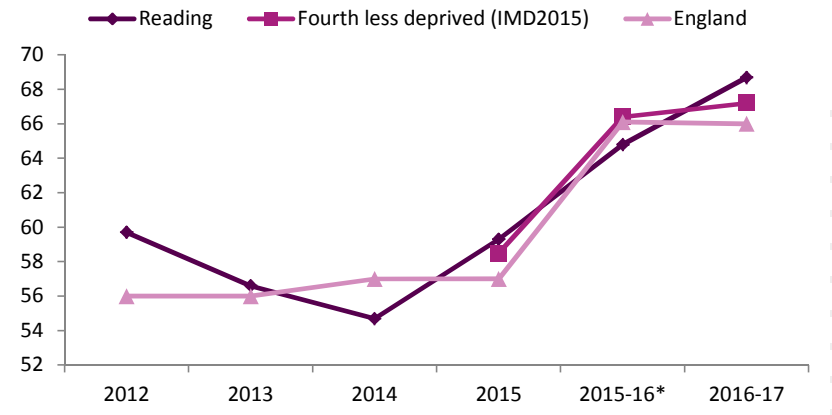
Data source	Until 2015 - Active People Survey, Sport England
	2015-16 onwards - Active Lives, Sport England
	* Note change in methodology in 2015-16
Denominator	Weighted number of respondents aged 19 and older with valid responses to questions on physical activity
Numerator	Weighted number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 MIE minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days.

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	59.7	55.3	64.2		56
2013	56.6	52.3	60.8		56
2014	54.7	50.4	58.9		57
2015	59.3	55	63.6	*58.5*	57
2015-16*	64.8	61.7	67.7	*66.4*	66.1
2016-17	68.7	65.8	71.5	*67.2*	66



Indicator number	**2.06i**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Child excess weight in 4-5 year olds**

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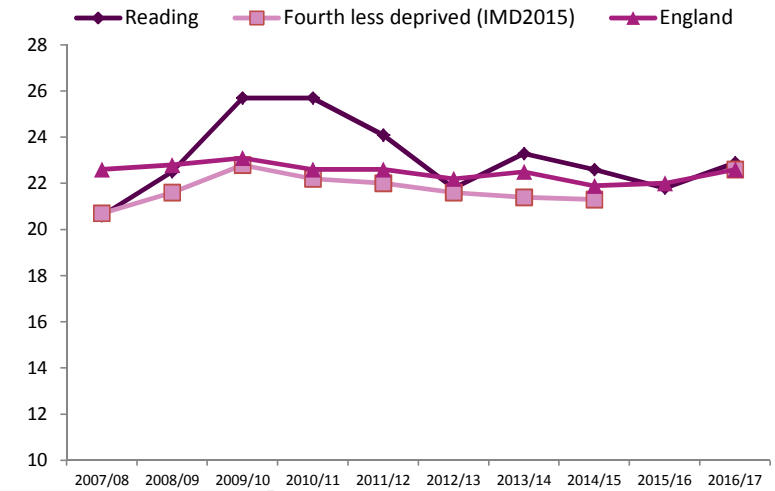
Data source	National Child Measurement Programme
Denominator	Number of children in Reception (aged 4-5 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Numerator	Number of children in Reception (aged 4-5 years) classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2007/08	20.6	18.5	22.9	*20.7*	22.6
2008/09	22.5	20.5	24.6	*21.6*	22.8
2009/10	25.7	23.7	27.9	*22.8*	23.1
2010/11	25.7	23.7	27.8	*22.2*	22.6
2011/12	24.1	22.1	26.1	*22*	22.6
2012/13	21.8	20	23.9	*21.6*	22.2
2013/14	23.3	21.3	25.5	*21.4*	22.5
2014/15	22.6	20.9	24.5	*21.3*	21.9
2015/16	21.8	20.1	23.6	-	22
2016/17	22.9	21.1	24.7	*22.6*	22.6



Indicator number	**2.06i**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Child excess weight in 10-11 year olds**

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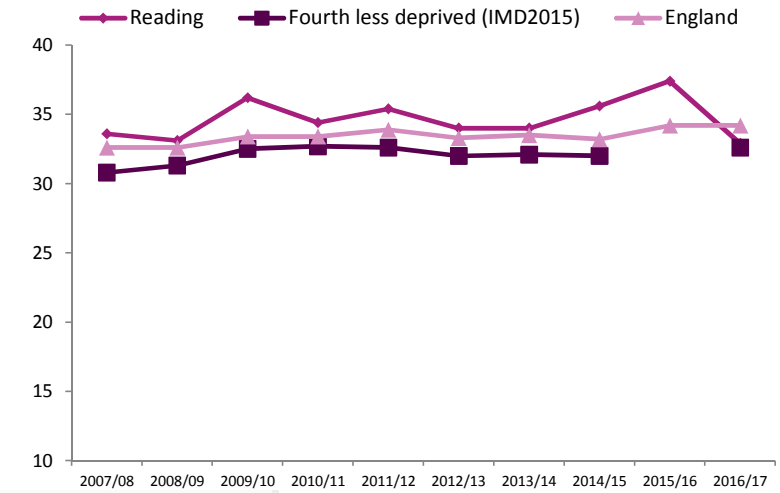
Data source	National Child Measurement Programme
Denominator	Number of children in Year 6 (aged 10-11 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Numerator	Number of children in Year 6 (aged 10-11 years) classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.



Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2007/08	33.6	31	36.2	*30.8*	32.6
2008/09	33.1	30	35.7	*31.3*	32.6
2009/10	36.2	33.6	38.8	*32.5*	33.4
2010/11	34.4	32	36.9	*32.7*	33.4
2011/12	35.4	32.9	37.9	*32.6*	33.9
2012/13	34	31.6	36.5	*32*	33.3
2013/14	34	32.2	37.1	*32.1*	33.5
2014/15	35.6	33.2	38	*32*	33.2
2015/16	37.4	35.1	39.7	-	34.2
2016/17	32.9	30.7	35.2	*32.6*	34.2

Indicator number	**2.14**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Smoking Prevalence in Adults - Current Smokers**

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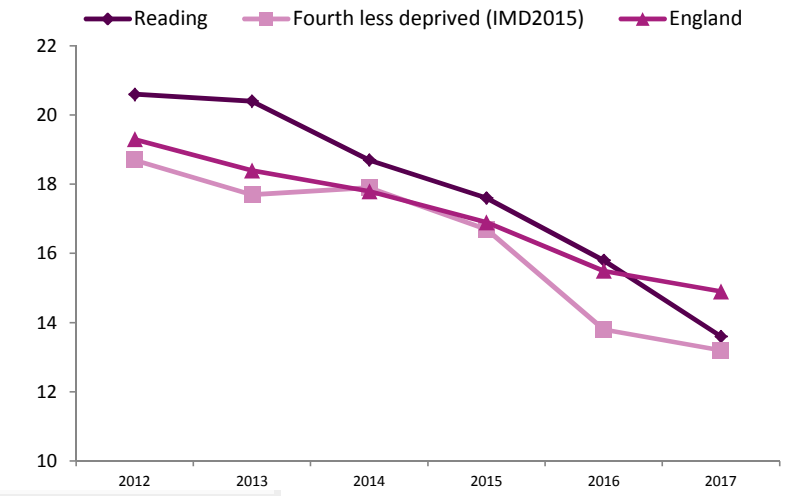
Data source	Annual Population Survey
Denominator	Total number of respondents (with valid recorded smoking status) aged 18+ from the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Numerator	The number of persons aged 18 + who are self-reported smokers in the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	20.6	18.4	22.8	*18.7*	19.3
2013	20.4	18.2	22.6	*17.7*	18.4
2014	18.7	16.7	20.7	*17.9*	17.8
2015	17.6	15.5	19.8	*16.7*	16.9
2016	15.8	13.5	18.1	*13.8*	15.5
2017	13.6	10.9	16.3	*13.2*	14.9



Indicator number	**2.03**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**% of women who smoke at the time of delivery**

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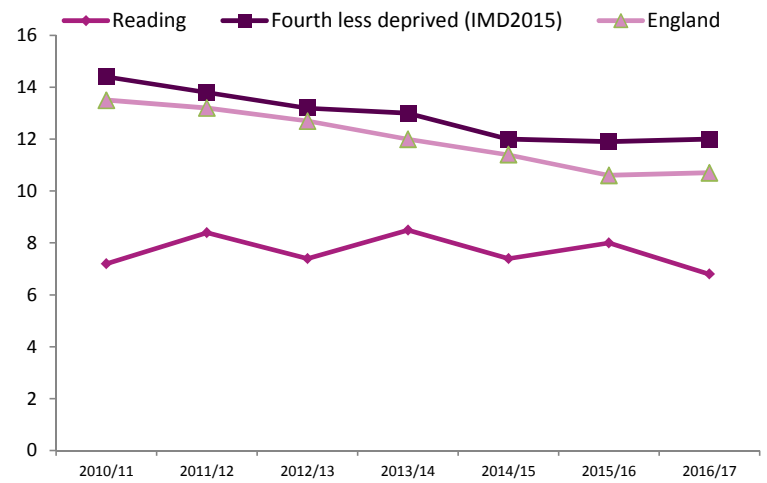
Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2010/11	7.2	6.1	8.2	*14.4*	13.5
2011/12	8.4	7.4	9.6	*13.8*	13.2
2012/13	7.4	6.3	8.2	*13.2*	12.7
2013/14	8.5	7.4	9.6	*13*	12
2014/15	7.4	6.4	8.5	*12*	11.4
2015/16	8	7	9.1	*11.9*	10.6
2016/17	6.8	5.9	7.9	*12*	10.7

Data source	Calculated by KIT East from the Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SSATOD)
Denominator	Number of maternities (estimated based on counts for CCGs)
Numerator	Number of women known to smoke at time of delivery (estimated based on counts for CCGs)



Indicator number	**NA**
Outcomes Framework	**Local Tobacco Control Profiles**
Indicator full name	**Smoking prevalence in routine and manual occupations - Current smokers**

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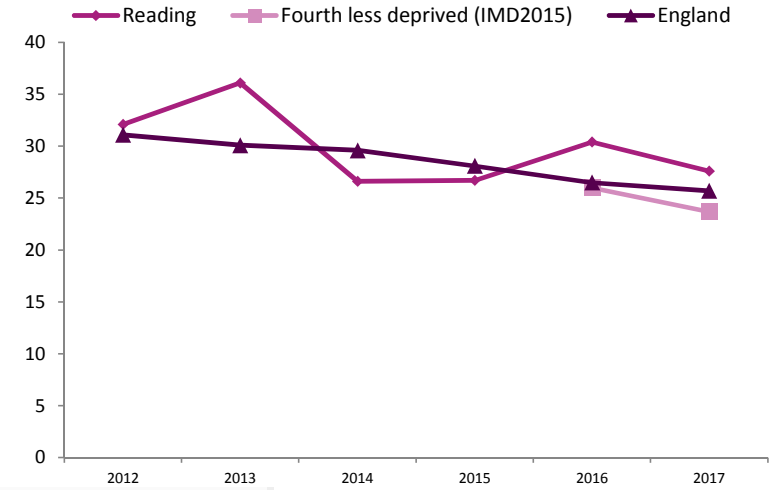
Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	32.1	26.4	37.8	*NO DATA*	31.1
2013	36.1	30.1	42.1	*NO DATA*	30.1
2014	26.6	21.2	32	*NO DATA*	29.6
2015	26.7	20.6	32.7	*NO DATA*	28.1
2016	30.4	23	37.9	*26*	26.5
2017	27.6	19.4	35.8	*23.7*	25.7

Data source	Annual Population Survey
Denominator	Total respondents with a self-reported smoking status aged 18-64 in the R&M group. Weighted to improve representativeness.
Numerator	Respondents who are self-reported smokers in the R&M group. Weighted to improve representativeness



Indicator number	**2.22ii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check**

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Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the five year period

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2013/14-16/17	65.2	64.8	65.7	75.7	74.1
2013-2018 Q2	68.72				82.54
2013-2018 Q3	70.33				86.36
2013-2018 Q4	72.44				90.91

Indicator number	**2.22iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received a Health Check**

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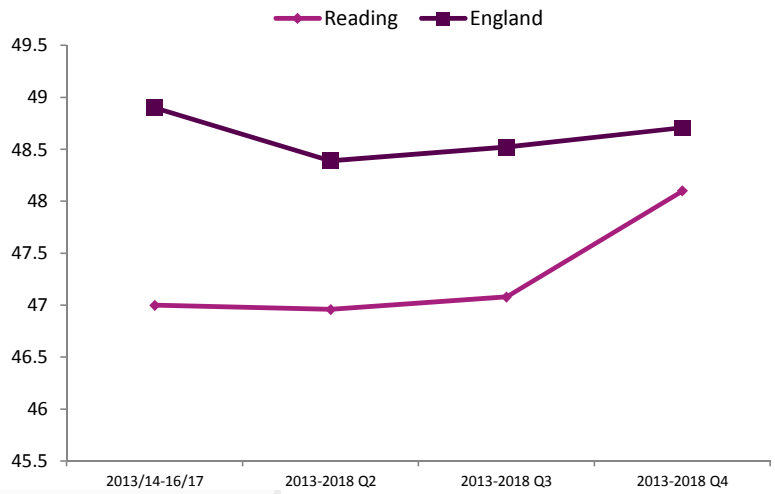
Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 offered an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check received an NHS Health Check in the five year period

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2013/14-16/17	47	46.1	47.8	*50.7*	48.9
2013-2018 Q2	46.96				48.39
2013-2018 Q3	47.08				48.52
2013-2018 Q4	48.1				48.71



Indicator number	**2.22iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cumulative percentage of the eligible population aged 40-74 who received a Health Check**

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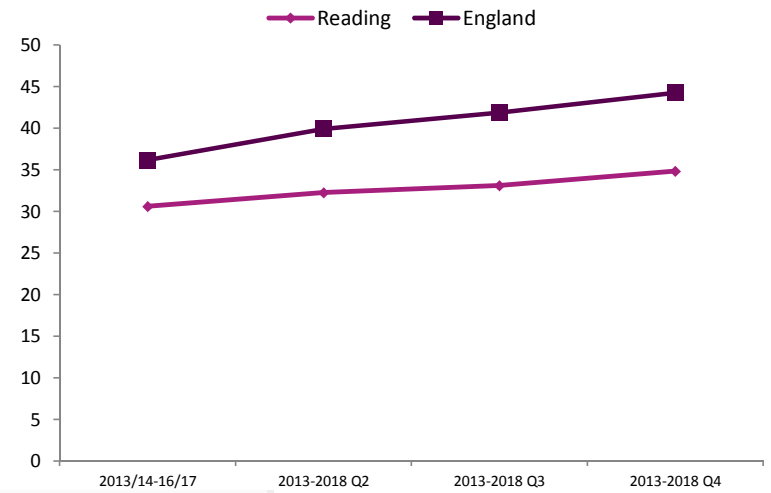
Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check in the five year period

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2013/14-16/17	30.6	30.2	31.1	*38.4*	36.2
2013-2018 Q2	32.27				39.94
2013-2018 Q3	33.11				41.91
2013-2018 Q4	34.84				44.28



Indicator number	**1.18i/1l**
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**

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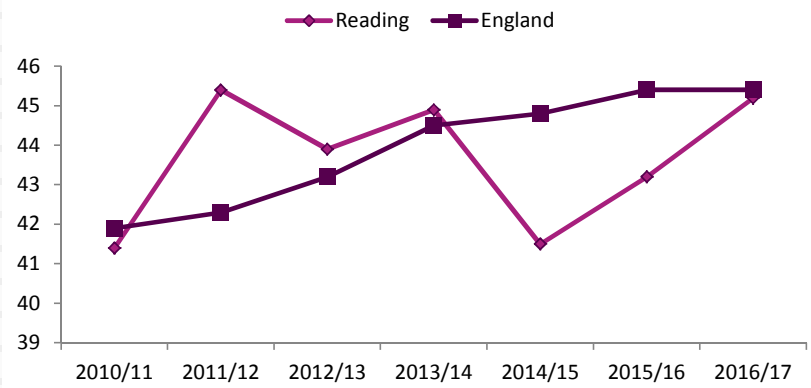
Data source	Adult Social Care Survey - England
	http://content.digital.nhs.uk/catalogue/PUB21630 - Annex Tables
Denominator	The number of people responding to the question "Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?"
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	Fourth less deprived (IMD2015)	England
2010/11	41.4	-	41.9
2011/12	45.4	-	42.3
2012/13	43.9	-	43.2
2013/14	44.9	-	44.5
2014/15	41.5	-	44.8
2015/16	43.2	-	45.4
2016/17	45.2	-	45.4

Indicator number	**1.18ii/1l**
Outcomes Framework	**Public Health Outcomes Framework/Adult Social Care Outcome Framework**
Indicator full name	**% of adult carers who have as much social contact as they would like according to the Adult Social Care Users Survey**

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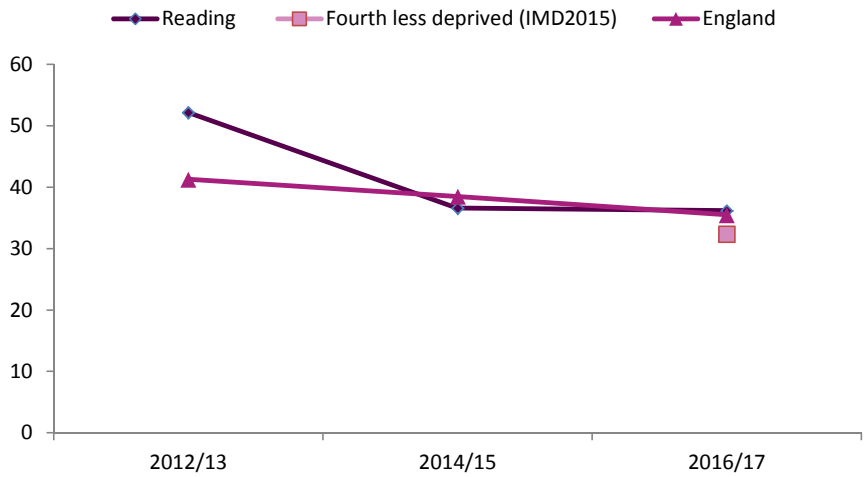
Data source	Carers Survey
Denominator	The number of people responding to the question "Thinking about how much contact you've had with people that you like, which of the following statements best describes your social situation?", with the answer "I have as much social contact as I want with people I like" divided by the total number of responses to the same question.
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
2012/13	52.2	48.1	56.3		41.3
2014/15	36.6	31.8	41.4		38.5
2016/17	36.2	30.4	42.4	*32.4*	35.5



Indicator number	**2.15iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Successful completion of alcohol treatment**

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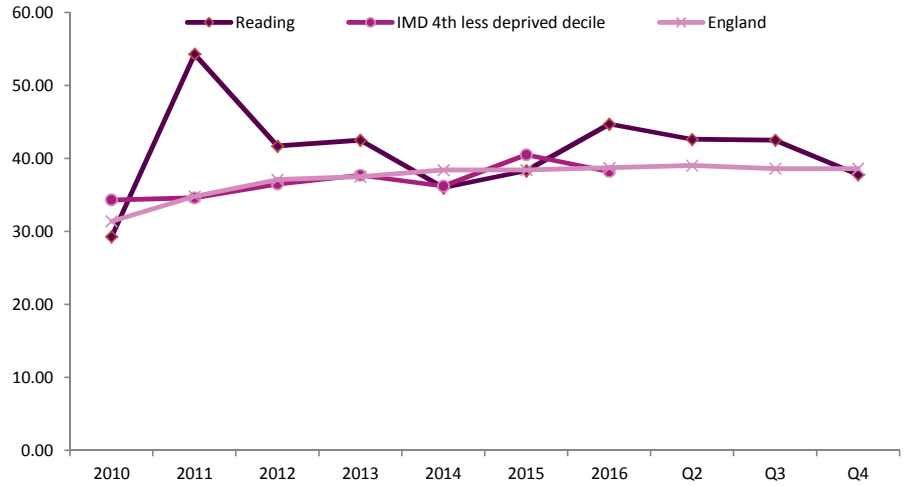
Data Source	National Drug Treatment Monitoring System
Denominator	Total number of adults in structured alcohol treatment in a one year period
Numerator	Adults that complete treatment for alcohol dependence who do not re-present to treatment within six months

Period	Reading	IMD 4th less deprived decile	England
2010	29.30	34.30	31.40
2011	54.30	34.60	34.80
2012	41.70	36.50	37.10
2013	42.50	37.70	37.50
2014	36.00	36.20	38.40
2015	38.30	40.50	38.40
2016	44.70	38.20	38.70
Q2	42.60		39.00
Q3	42.50		38.60
Q4	37.80		38.60



Indicator number	**2.18**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Admission episodes for alcohol-related conditions per 100,000 people**

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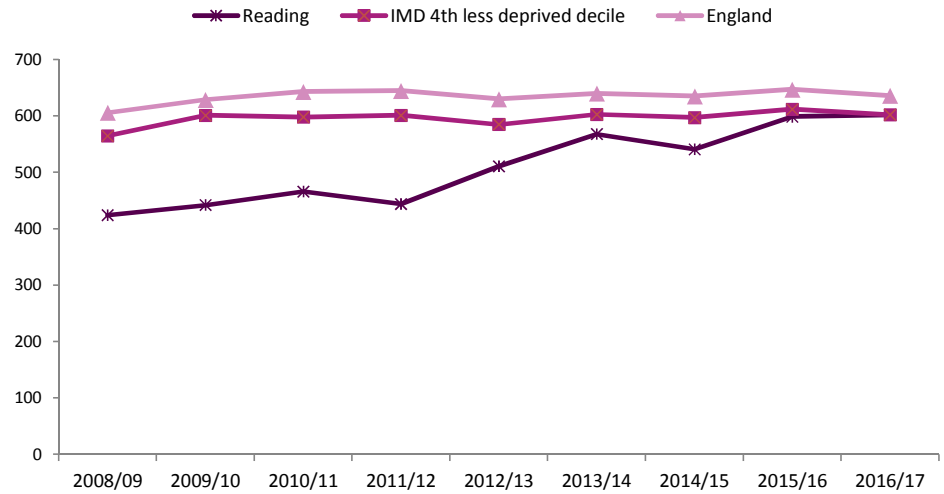
Data Source	Health and Social Care information Centre - Hospital Episode Statistics. Via Local Alcohol Profiles for England
Denominator	Mid-Year Population Estimates (ONS)
Numerator	Admissions to hospital where primary diagnosis is an alcohol-related condition or a seconday diagnosis is an alcohol-related external cause. Uses attributable fractions to estimate.

Period	Reading	IMD 4th less deprived decile	England
2008/09	424	565	606
2009/10	442	601	629
2010/11	466	598	643
2011/12	444	601	645
2012/13	511	585	630
2013/14	568	603	640
2014/15	541	597	635
2015/16	599	612	647
2016/17	602	602	636



Indicator number	**NA**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (primary school age)**

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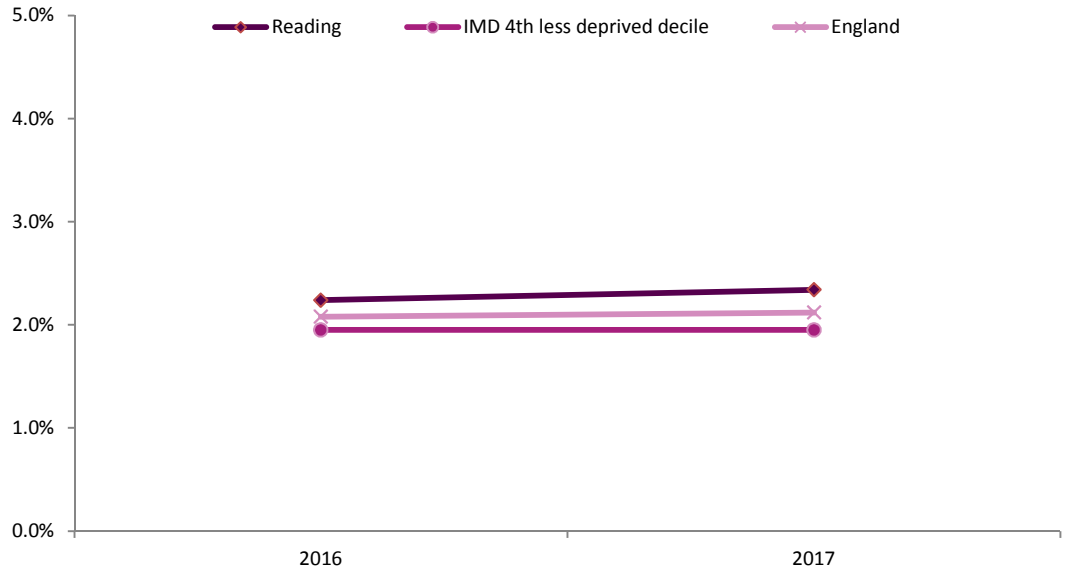
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations) https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health

Period	Reading	IMD 4th less deprived decile	England
2016	2.2%	2.0%	2.1%
2017	2.3%	2.0%	2.1%



Indicator number	**NA**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (secondary school age)**

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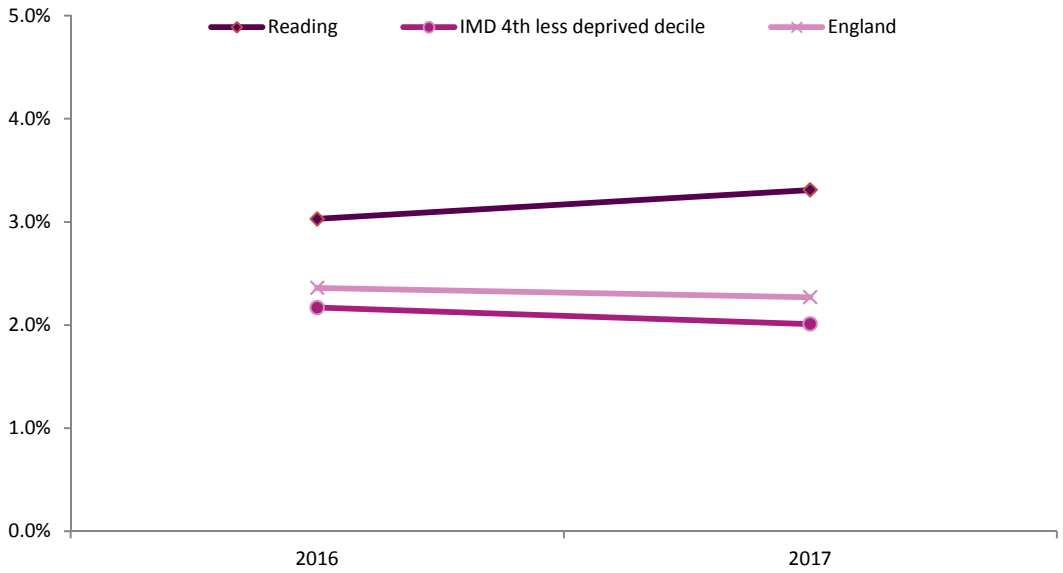
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations) https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health

Period	Reading	IMD 4th less deprived decile	England
2016	3.0%	2.2%	2.4%
2017	3.3%	2.0%	2.3%



Indicator number	**NA**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (all school age)**

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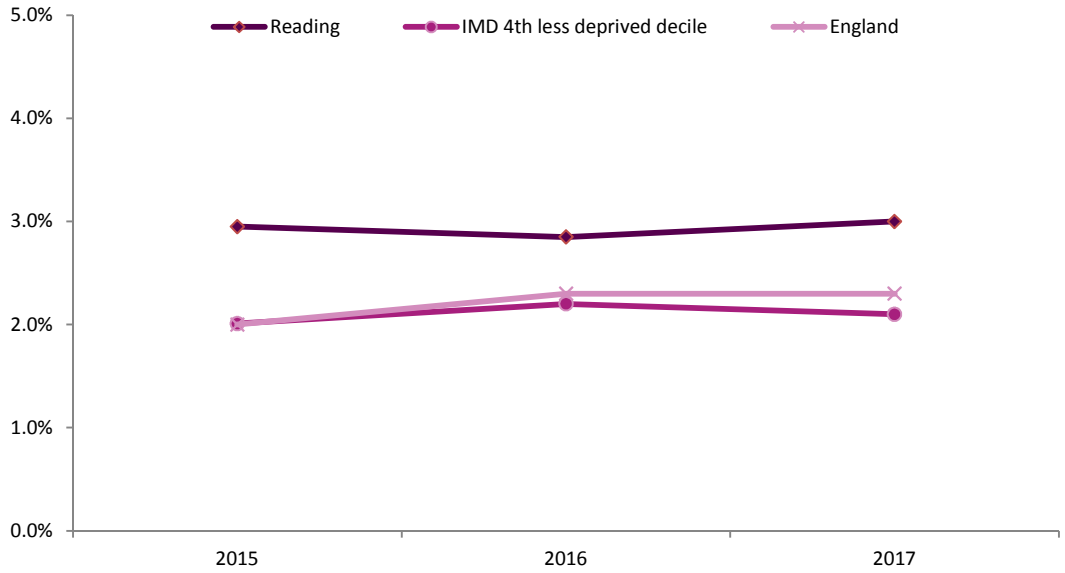
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations)
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health https://www.gov.uk/government/collections/statistics-special-educational-needs-sen

Period	Reading	IMD 4th less deprived decile	England
2015	3.0%	2.0%	2.0%
2016	2.9%	2.2%	2.3%
2017	3.0%	2.1%	2.3%



Indicator number	**4.16 / 2.6i**
Outcomes Framework	**Public Health Outcomes Framework / NHS Outcomes Framework**
Indicator full name	**Estimated diagnosis rate for people with dementia**

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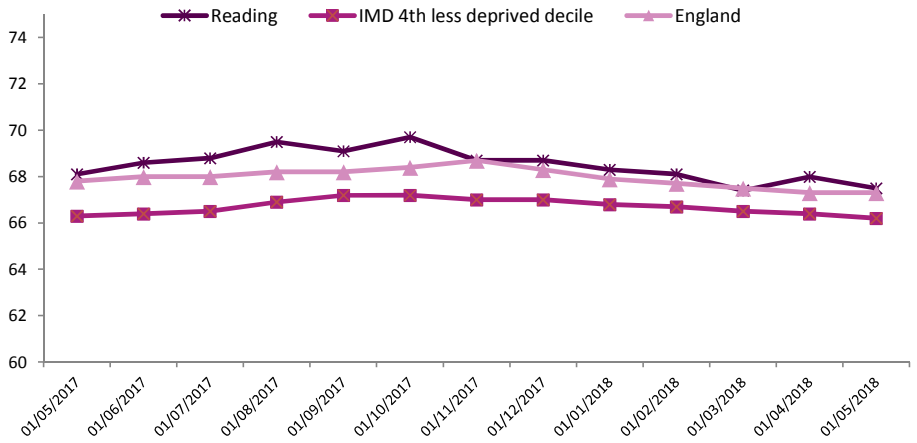
Data Source	NHS Digital
Denominator	Applying the reference rates to the registered population yields the number of people aged 65+ one would expect to have dementia within the subject population where:
Numerator	**Registered population** Patients aged 65+ registered for General Medical Services, counts by 5-year age and sex band from the National Health Application and Infrastructure Services (NHAIS / Exeter) system; extracted on the first day of each month following the reporting period end date of the numerator. **Reference rates: sampled dementia prevalence** Age 65+ age and sex-specific dementia prevalence rates. Source: MRC CFAS II.

Period	Reading	IMD 4th less deprived decile	England
31/05/2017	68.1	66.3	67.8
30/06/2017	68.6	66.4	68
31/07/2017	68.8	66.5	68
31/08/2017	69.5	66.9	68.2
30/09/2017	69.1	67.2	68.2
31/10/2017	69.7	67.2	68.4
30/11/2017	68.7	67	68.7
31/12/2017	68.7	67	68.3
31/01/2018	68.3	66.8	67.9
28/02/2018	68.1	66.7	67.7
31/03/2018	67.4	66.5	67.5
30/04/2018	68	66.4	67.3
31/05/2018	67.5	66.2	67.3



Indicator number	**NA**
Outcomes Framework	**NA**
Indicator full name	**No. of Dementia Friends**

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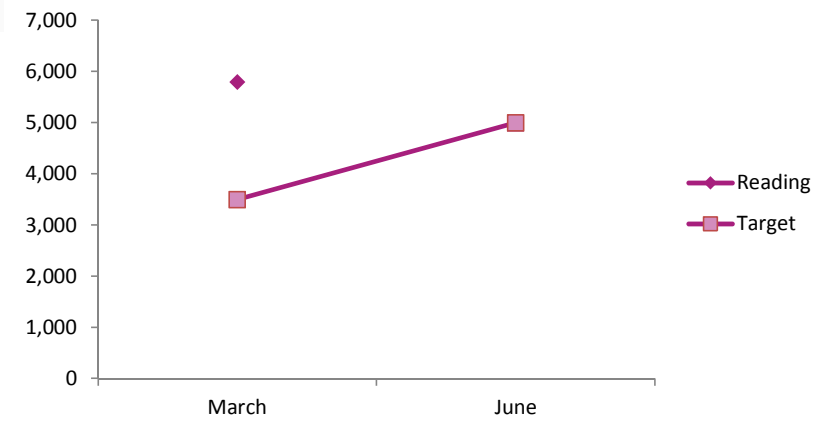
Period	Reading	Target
March	5,800	3,500
June		5,000

Data Source	Locally Recorded
Definition	No. of people who have completed a 45 minute training session and agreed to be a dementia friend



Indicator number	**2.20iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cancer screening coverage - bowel cancer**

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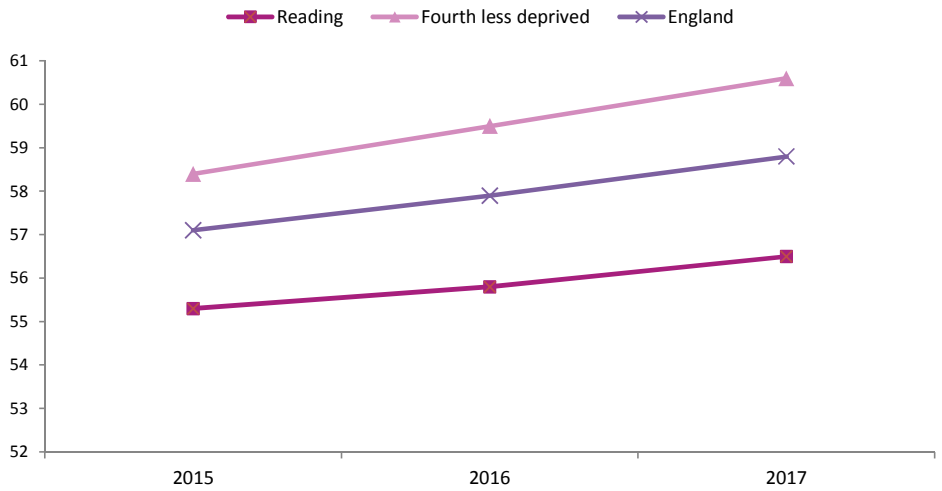
Period	Reading	Fourth less deprived	England
2015	55.3	58.4	57.1
2016	55.8	59.5	57.9
2017	56.5	*60.6*	58.8

Data Source	Health and Social Care Information Centre (Open Exeter)/Public Health England
Denominator	Number of people aged 60-74 resident in the area (determined by postcode of residence) who are eligible for bowel screening at a given point in time (excluding those with no functioning colon (e,g, after surgery) or have made an informed decision to opt out.
Numerator	Number of people aged 60-74 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous 2½ years Target is the NHS England minimum coverage standard https://www.england.nhs.uk/wp-content/uploads/2017/04/service-spec-26.pdf



Indicator number	**2.20i**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cancer screening coverage - breast cancer**

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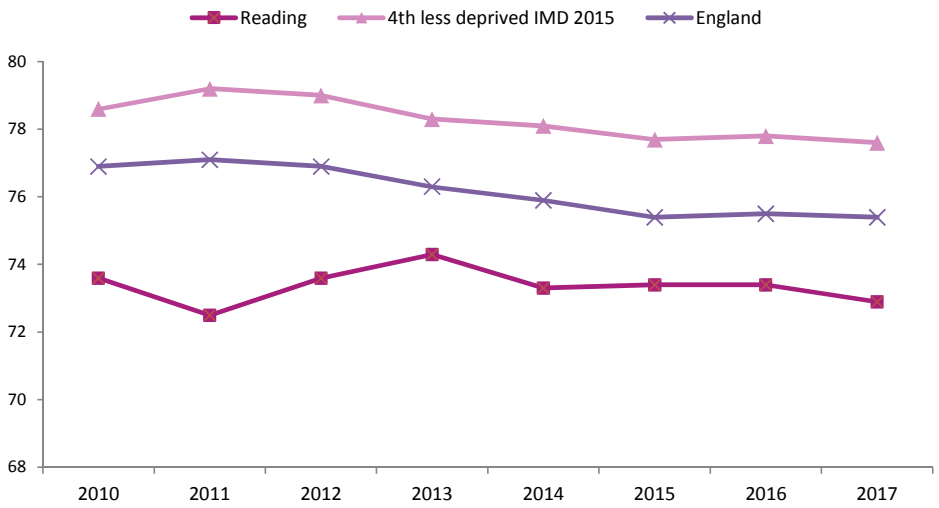
Period	Reading	4th less deprived IMD 2015	England
2010	73.6	78.6	76.9
2011	72.5	79.2	77.1
2012	73.6	79	76.9
2013	74.3	78.3	76.3
2014	73.3	78.1	75.9
2015	73.4	77.7	75.4
2016	73.4	77.8	75.5
2017	72.9	77.6	75.4

Data Source	Health and Social Care Information Centre (Open Exeter)/Public Health England
Denominator	Number of women aged 53-70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time.
Numerator	Number of women aged 53-70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years Target is the NHS England minimum coverage standard https://www.england.nhs.uk/wp-content/uploads/2017/04/service-spec-24.pdf



Indicator number	**3.05ii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Incidence of TB (three year average)**

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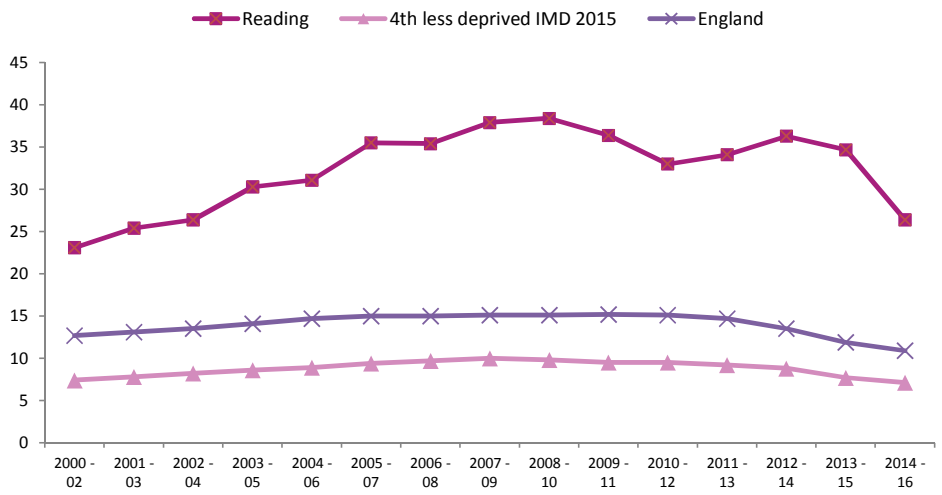
Data Source	Enhanced Tuberculosis Surveillance system (ETS) and Office for National Statistics (ONS)
Denominator	Sum of the Office for National Statistics (ONS) mid-year population estimates for each year of the three year time period
Numerator	Sum of the number of new TB cases notified to the Enhanced Tuberculosis Surveillance system (ETS) over a three year time period



Period	Reading	4th less deprived IMD 2015	England
2000 - 02	23.1	7.4	12.7
2001 - 03	25.4	7.8	13.1
2002 - 04	26.4	8.2	13.5
2003 - 05	30.3	8.6	14.1
2004 - 06	31.1	8.9	14.7
2005 - 07	35.5	9.4	15
2006 - 08	35.4	9.7	15
2007 - 09	37.9	10	15.1
2008 - 10	38.4	9.8	15.1
2009 - 11	36.4	9.5	15.2
2010 - 12	33	9.5	15.1
2011 - 13	34.1	9.2	14.7
2012 - 14	36.3	8.8	13.5
2013 - 15	34.7	7.7	11.9
2014 - 16	26.4	7.1	10.9

Indicator number	**4.10**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population**

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Data Source	Public Health England (based on ONS)
Denominator	ONS 2011 census based mid-year population estimates
Numerator	Number of deaths from suicide and injury from undetermined intent ICD10 codes X60-X84 (age 10+), Y10-34 (age 15+).

Period	Reading	4th less deprived IMD 2015	England
2001 - 03	11.5	-	10.3
2002 - 04	10.7	-	10.2
2003 - 05	10.4	-	10.1
2004 - 06	10	-	9.8
2005 - 07	9.6	-	9.4
2006 - 08	11.2	-	9.2
2007 - 09	10.9	-	9.3
2008 - 10	8.8	-	9.4
2009 - 11	7.4	-	9.5
2010 - 12	7.7	-	9.5
2011 - 13	9.3	-	9.8
2012 - 14	9.8	-	10
2013 - 15	11	10.5	10.1
2014 - 16	9.9	*10.2*	9.9

Updates to the health and wellbeing dashboard

- **Updates since last report**

  No. of Dementia Friends (local indicator) (Priority 5) updated with Q1 performance
  Health checks indicators updated with Q4 (13th June 2018)
  Alcohol treatment completion updated with Q4 performance (10th May 2018)
  Dementia diagnosis rate (14th June 2018 - updated with April and May performance)
  % Physically active (May 2018)
  Smoking Prevalence - all adults
  Smoking Prevalence - routine and manual professions

- **Updates expected before October 2018 (dates are provisional)**

  No. of Dementia Friends (local indicator) (Priority 5) updated with Q2 performance
  Health checks indicators updated with Q1 (Expected end of August 2018)
  Alcohol treatment completion updated with Q1 performance (expected September 2018)
  Dementia Diagnosis rate - monthly
  % pupils with social, emotional and mental health needs (primary, secondary and all schools)

Indicator	Expected date of update (PHOF Indicators)	Local/Quarterly data available?
2.12 Excess weight in adults	November	No
2.13i % of adults physically active	May	No
2.06i % 4-5 year olds classified as overweight/obese	February	No
2.06ii % 10-11 year olds classified as overweight/obese	February	No
2.03 Smoking status at the time of delivery	November	No
2.14 Smoking prevalence - all adults - current smokers	August	No
2.14 Smoking prevalance - routine and manual - current smokers	August	No
2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2013/14 - 16/17	NA	Updates are published quarterly
2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2013/14 - 16/17	NA	Updates are published quarterly
2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2013/14 - 16/17	NA	Updates are published quarterly
1.18i/1l % of adult social care users with as much social contact as they would like	November	Local data but collected annually
1.18ii/1l % of adult carers with as much social contact as they would like	November	Local data but collected bi-annually
Placeholder - Loneliness and Social Isolation	NA	
2.15iii Successful treatment of alcohol treatment	NA	Updates are published quarterly
2.18 Admission episodes for alcohol related conditions (DSR per 100,000)	May	No
% pupils with social, emotional and mental health needs (primary, secondary and all schools)	August	No
4.16/2.6i Estimated diagnosis rate for people with dementia	August	Monthly
No. Dementia Friends (Local Indicator)	NA	Yes
Placeholder - ASCOF measure of post-diagnosis care	NA	
2.20iii Cancer screening coverage - bowel cancer	February	No.
2.20i Cancer screening coverage - breast cancer	February	No.
3.05ii Incidence of TB (three year average)	November	No.
4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	November	No.