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

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**14 JULY 2017**	**AGENDA ITEM:**	**15**
TITLE:	**READING HEALTH & WELLBEING ACTION PLAN 2017-20: PROGRESS REPORT**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN / COUNCILLOR EDEN / COUNCILOR GAVIN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE / CHILDREN'S SERVICES**
SERVICE:	**ALL**	**WARDS:**	**BOROUGHWIDE**
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

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

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

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

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board:

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

3. POLICY CONTEXT

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

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

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

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

a healthier Reading

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

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

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

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

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

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

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

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

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

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

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

Priority 2: reducing loneliness and social isolation

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

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

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

Priority 4: Reducing Deaths by Suicide

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

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

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

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

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

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

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

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

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

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

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

Priority 8: Reducing the number of people with tuberculosis

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

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

Foundation for delivery plans

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

5. CONTRIBUTION TO STRATEGIC AIMS

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

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

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

7. LEGAL IMPLICATIONS

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

8. EQUALITY IMPACT ASSESSMENT

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

9. FINANCIAL IMPLICATIONS

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

10. APPENDICES

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

11. BACKGROUND PAPERS

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

Reports coming to July 2017 Health and Wellbeing Board:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRIORITY 4	Reducing Deaths by Suicide

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

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

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

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

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

					Group in May.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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