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

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 - Jan 2018**
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** **To monitor and evaluate the delivery and outcomes of the service to the stated objectives**	**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' (adults).**	**Contract commenced July 2017.**

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 principles of the course beyond the 10-week intervention.**	**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**	**Of those attending the course:** **- 50% of those not already eating '5 a day' increased their fruit and vegetable intake;** **- 50% reduced their intake of sugary snacks and drinks;** **- 50% reduced their sedentary behaviour;** **- 50% achieved an improvement in the shuttle run challenge.** **Legacy pack (Let's Keep Going) launched September 2017.**

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.**
To seek opportunities to promote and support local walking and cycling programmes for leisure and active travel. For example: **'Develop a Local Cycling &**	**Transport, Leisure and Wellbeing Teams**	**From April 2017**	**Increase in the number of people walking and cycling to work** **Increase in the number of children benefitting from**	**1.16 - % of people using outdoor space for exercise/health reasons.** **2.13i Percentage of physically active and**	**RBC Transport team now delivering EMPOWER supported programmes, including** **-Training & education (e.g.**

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.**	**Reading Museum / Wellbeing team.**	**January 2017**	**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.**	**inactive adults – active adults.** **2.13ii Percentage of physically active and inactive adults – active adults.**	**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** **Walks Programme being sustained by Leisure Team.**
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.**	**Online MECC training module developed. 'In principle' resource agreed from STP for further development.**
To ensure delivery of the National Child Measurement Programme	**Wellbeing Team**	**Ongoing**	**Weight and height measurements offered to all children attending**	**2.06i - % of children aged 4-5 classified as overweight or obese.**	**Meeting uptake of 95%**

			state funded primary school children who are in Reception Year (age 5) and Year 6 (aged 10,11) in accordance with NCMP guidance	**2.06ii - % of children aged 10-11 years classified as overweight or obese.**	
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** **Increase uptake of smoking cessation >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 – 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**	**Health promotion activity is ongoing and has included:** **- Stoptober** **- Raising awareness of illegal tobacco sales** **- health education sessions delivered to Yr 9 pupils** **- work in Targeted primary schools year 6 pupils on development of peer resilience and health harms.** **- Smokefreelife Berkshire has completed a programme of targeted work with routine and manual workers on smoke free homes**

				survey) **PHOF 2.09v – Smoking prevalence at age 15 – occasional smokers (SDD survey)**	**Planning for the 2017/18 schools survey is at an advanced stage.**
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;** **Increase self-referrals to S4H**	**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 related quality of life for carers**	**Provider is continuing to meet targets per contract specification.**
To take action to tackle illegal tobacco and prevent sales to <18 - **Health promotion**	**Tobacco Control Co0rdinator, Trading Standards; S4H**	**From April 2017**	**Increase awareness of impact of illicit/illegal sales have on community** **Improve the no of**		**Sniffer Dog was used by Trading Standards to raise awareness of illegal tobacco sales.**

- **Act on local intelligence** - **Retailer training – challenge 25** - **Test purchasing**			**successful completions of Retail Trainer Training (challenge 25)** **Reduce the number of retailers failing test purchasing**		
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.**		**Ongoing Wellbeing Team input into local development plans**
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**	**Report to be compiled from 16-17 data now collected.**

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 - Jan 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**		**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**	**Tthe Loneliness and Social Isolation Steering Group has overseen the development of an in-depth local loneliness analysis, which is due to published in March 2018, including a summary as a JSNA module.**

				PHOF 2.23 i-iv – self-reported wellbeing	
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	**Wellbeing Team, RBC**	**Ongoing**	**Older residents are able to be part of developing opportunities for**	**PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as**	**There are now four thriving Over 50s clubs – in Caversham,**

be self-sustaining			**neighbours to know one another better**	**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**	**Southcote, Whitley and Coley.**
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**

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.**
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 and Social Isolation Steering Group has identified a programme of focus groups to develop local understanding of risk factors and effectiveness of various interventions.**

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://www.southreadingccg.nhs.uk/our-work/children/camhs-transformation

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 - Jan 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 now agreed for Reading Mental Wellbeing Group to include 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 'Brighter Berkshire' Year of Mental Health 2017** **- marking World Suicide Prevention Day (10 September)**	**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 11th September to mark Suicide Prevention Day** **RBC signed Time to Change pledge on 6th October.** **Berkshire Suicide Strategy formally launched on 17th October.**
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**	**Wellbeing Team, RBC**	**October 2017**	**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**	**Work being led by Wokingham BC - On target** **Completed**

- 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**		**April 2017** **Ongoing**			**There were a total of 558 attendances at Reading Recovery College sessions in 2016-17. In addition, 51 people attended 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**	**Reading Mental Wellbeing Group as local sponsors (see above)**	**Ongoing**	**Mental health will be improved for some specific groups (children and young people, survivors of domestic or sexual abuse) through tailored approaches**	**See Action Plan for Priority 3 for details in relation to children and young people.**	**See Priority 3 update**

Domestic Abuse Strategy - **Raise awareness of support available to survivors of sexual abuse through Trust House Reading** - **Contribute to a Berkshire wide review of targeted community based interventions, including suicide prevention and mental health first aid training**		**ongoing** **ongoing**	**Future commissioning of community based interventions will be informed by a review of impact**		**Survivors Trust hosted a workshop at the Berkshire Suicide Strategy launch in October** **Wrk being led by Wokingham BC – on target**
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 11th September, 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 e 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 - Jan 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.**
	CAP Lead		**Encourage IBA in the**	**PHOF 2.18 – Admission**	**Business case still being drafted**

Business Case for a Community Health Bus		**April 2018**	**community. More 'Community Alcohol Champions' to promote lower drinking levels and behaviours.** **Alcohol Champions, via the Community Health Bus in the community will be able to deliver information and brief advice to members of the public.**	**episodes for alcohol-related conditions (narrow) (Persons, M and F)**	
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 contacts.	**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 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 completed during June and July 2017.**
Alcohol Mapping Group to	**Alcohol**	**April 2018**		**PHOF 2.18 – Admission**	**Work ongoing with CCGs –**

present a business case for an Alcohol Liaison Nurse to help reduce alcohol related admissions to hospital.	**Mapping Group**			**episodes for alcohol-related conditions (narrow) (Persons, M and F)**	
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)**	**SLA drafted and awaiting sign off with 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 – 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.
Licensing					
A community free of alcohol related violence in homes and in public places, 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**	**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 since June.**
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	**CAP / Licensing**	**Ongoing**	**Stricter licensing**		**Commenced**

responsible retailing, 4 Licensing objectives. **CAP to increase Test Purchasing – Challenge 25, Under 18.** **Licensed Retailer Passport to be rolled out to all retailers.** **Retailer Training to commence.** **Encourage retailers to restrict the sale of higher ABV % cans**			**restrictions will be in place.** **There is a minimum price for a unit of alcohol as a mandatory condition of a License.**		**Qtrly test purchasing of Challenge 25. Test Purchasing of under 18 to take place during August each year** **Ongoing** **Can marking to commence June 2017**
Promotion of better marketing of soft/ mixer-diluted drinks in Bars and Pubs.	**CAP/ licensing**	**Ongoing**	**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**	**completed.** **New questionnaire to be developed during 2018**			**Completed** **Collation of figures to inform future educational activities**
Education if for all ages. **Alcohol awareness sessions**	**CAP Lead**	**Ongoing**	**Educating everyone on the risks of alcohol and promote drinking**		

for all. **Comic Project to encourage alcohol awareness.** **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.**			**responsibly.**		**Christmas and Easter project completed; weekly drop in at 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					
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 2017 and January 2018**	**Encourage awareness of effects of alcohol on staff, clients and local community.** **Promote drinking responsibly.**		**10th Jan 2018 – Massage session for RBC staff.** **18th Jan – RBH staff welfare day (alcohol session)**
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**
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 - Jan 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 patients aged 65-74.**
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 Tames Valley Cincal trategic 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.** **973 people in the Reading have completed online Dementia Friends training.** **238 Dementia Friends sessions have been delivered in Reaing.** **4,919 people in the Reading area have become a Dementia Friend following a session**

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**	**Updated JSNA module due to be completed by March 20018.** **ACS Outpatient workstream is currently reviewing the memory service pathway against vanguard/best practice examples and this will be used to inform the JSNA. Thical 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**	**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.**

				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**		**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 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**		**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**

			control or influence over decisions about me"		**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 Jan 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 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 rolled out from August (see below).** **Tailored GP Surgery bowel screening letters 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 screening programmes	**Public Health Berkshire** **Macmillan**		**Patients seek advice and support early from their GP** **Increase uptake of screening programmes**		**Local authority supporting the promotion and engagement of 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, **Over 30 people from the community have signed up to become cancer champions. A number of community events and meetings have been held.** **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 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**		**Project rolled out in August with 7 practices participating** **Evaluation report due in February**

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 - Jan 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 5th December 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 (8th Sep);** **- Compass Recovery College Prospectus Launch event (16th August);** **- New Directions event (16th Sept)** **- Older People's Day event (9th Oct)**
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 partnership with NHSE**	**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**
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 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)**	**Reading Healthwatch has conducted a Knowledge and Behaviours Survey. Over 300 people have taken part indicating their views and knowledge towards TB. The 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**
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.**

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 team in 2018**
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.