Appendix A: Reading Health and Wellbeing Strategy 2017-20 - Action Plan - updated July 2019

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 – July 2019**
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	3 Reading schools took part in the young person's smoking and drinking attitudinal survey (across Berkshire West). 6 presentations in Reading 2ry schools Community Alcohol Partnership will be funding 10 Youth Health Champions in Reading 2019-20 – two schools are participating

				prevalence at age 15 – regular smokers (SDD survey) PHOF 2.09v – Smoking prevalence at age 15 – occasional smokers (SDD survey)	
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	643 successful quits measured at 4 weeks in 2018-19 – 65% from target populations 411* successful quits measured at 12 week in 2018-19 – 63% from target populatons (* provisional data – final figure expected to be higher Reduced capacity within the smoking cessation service planned for 2019-20 requires a review of health promotion activity to rive referrals into the service. Smokefreelife Berkshire continues to operate a mobile service in communities of high deprivation, and high footfall, e.g. Tesco on Portman Road in

					Battle ward
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		A Southeast region hotline is planned to report illegal tobacco and underage sales. Once this is live, the Tobacco Control Alliance will review promotion opportunities. The 'Challenge 25' campaign continues locally.
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.		RBC Workplace Health Review is progressing and will include local smoking policy. A draft Berkshire Wet Tobacco Control Delivery Plan 2019/20 has now been prepared. CLeaR tobacco self-assessment has been completed and best practice shred with colleagues across the BOB STP area.

Commissioned weight management/physical activity services targeting: - Adults - Children	Wellbeing Team	2017/18 – Contract for Tier 2 course runs until August and October 2018.	To contribute to halting the continued rise in unhealthy weight prevalence in adults. 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.	2.21 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). 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-	4 X Let's Get Going programmes have been commissioned for 2019-20. Two programmes will be run as holiday clubs to enable a comparison of performance and take-up with term-time provision. 11 X Eat 4 Health courses have been commissioned in Reading. A new Eat 4 Health Open course will be piloted to increase capacity and offer greater flexibility.

				day" at age 15	
To undertake local health promotion of healthy eating and physical activity across different local settings & groups including: - Children's 0-19's service - Promotion of oral health messages - Early years settings - Troubled families programme - Mental Health Services - Workplace Health - Community & Voluntary - General Population - National Diabetes Prevention Programme	Joint partnership working across RBC directorates and with partners and providers to broaden the reach of health promotion messages.	Health Promotion is an ongoing action required to support the consistent delivery of health promoting messages.	To promote understanding of the benefits of health eating and physical activity and what recommended guidelines are. To provide people with information, advice and support on how to maintain/improve diet and or physical activities. To promote local services and/or open spaces	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). 2.06i - % of children aged 4-5 classified as overweight or obese. 2.06ii - % of children aged 10-11 years classified as overweight	NHS Diabetes Prevention Week campaign was widely promoted across Reading including VCS partners. Re-launch of Eat4Health promoted through GP and RBC communications networks. #MovingIs promotion via RBC's social media raised awareness of getting active and promoting offers through Get Berkshire Active. NHS Live Well Seated Exercise Plan linked to the #MovingIs campaign. A comprehensive review of services and support available which impact on healthy weight and physical activity is being undertaken by Wokingham BC on behalf of the 3 Berkshire West authorities to inform

				or obese. 2.11iv – Proportion of the population meeting the recommended "5-a-day" at age 15	future priorities.
Promotion and use of local leisure services, green spaces and active travel - Local cycling and walking - Walking volunteer recruitment workshops - Work with partners to supporting bidding for funding Neighbourhood initiatives	Joint partnership working across RBC directorates and with partners and providers to broaden the promotion of local RSL, green spaces and active travel.	Ongoing	Increase in the number of people walking and 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.	1.16 - % of people using outdoor space for 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.	2018-19 performance shows: • 1,108,163 leisure centre attendances and hires • 280,225 parks and sports hire attendances • 546 programmed event days (parks & open spaces) • 3,534 families engaged in Reading Play • 8.801 child accesses to Reading Play after school clubs • 27,750 Reading Play educational support sessions run • 140 Pathway GP referrals (78 male /62 female)

					• 5 X weekly walks, attracting 5,286 participation sessions (367 individual walkers)
To offer Making every Contact Count (MECC) training to the local voluntary and community sector	Wellbeing Team	From January 2018 – March 2019	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.	MECC Train the Trainer sessions are being run in May, June and July to develop local capacity for rollout of a Reading MECC programme
To oversee and implement the local 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.	NCMP Progress Quarter 4 (January–March 2019): 1,413 children screened (71.6% of cohort) - two families contacted school nurses for support and advice - 20 further families accepted support when telephoned after a 'very overweight' or 'underweight' letter
To develop an oral health strategy based on the need of local residents	RBC Wellbeing Team & Shared Public Health Team (Bracknell)	2020	Partners will have access to dental epidemiological data in order to be able to monitor progress in relation to Public Health Outcomes Framework	PHOF 4.2: tooth decay in 5 year old children	RBC has commissioned a Dental Epidemiology Survey from PHE to be undertaken in the 2018/19 academic year. Full results will be available in Dec 2019 and a

			indicators on oral health		strategy that is informed by this data will be developed in early 2020.

PRIORITY No 2	**Reducing Loneliness and Social Isolation**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update - July 2019**
i. Establish a Reducing Loneliness Steering Group	Health & Wellbeing Board	February 2017	A cross-sector partnership is in place to oversee an all-age approach – covering prenatal, children and young people, working age adults and later life		COMPLETED - Steering Group now meeting bi monthly representing a range of interests.
ii. 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	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	COMPLETED - The Loneliness and Social Isolation Steering Group has overseen the development of an in-depth local loneliness analysis, which has now been published as JSNA module.

			loneliness	have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing	
iii. Refresh the Loneliness and Social Isolation JSNA module annually	Wellbeing Team, RBC	annually	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	Loneliness & Social Isolation module published at: http://www.reading.gov.uk/jana/loneliness-and-social-isolation Further literature analysis plus interviews and focus groups took place over summer 2018, and a report will be published in 2019.
iv. Map out community notice boards, including owners and access criteria	Ebony George (Neighbourhood Intiatives), Matt Taylor (AUKR), Steph Francis	Nov 2019	Partners will be enabled to share information about services and resources to reduce loneliness and		45 boards mapped as at Sep 2018: ○ 20 are RBC owned ○ 25 are managed by community groups

	(CCGs)		social isolation.		○ For 23 out of 45 notice board, we do not known who is key holder – including those owned by RBC A volunteer has been recruited to take this forward under AUKR's leadership.
v. Map local Facebook pages	Sarah del Tufo (RCLC)	Nov 2019	Partners will be enabled to share information about services and resources to reduce loneliness and social isolation.		Mapping commenced – administrator details to be collated across the group
vi. Raise Adult Social Care staff awareness of services to reduce loneliness and social isolation	Sarah Hunneman (Wellbeing Team, RBC)	ongoing	Adult Social Care staff will have up to date knowledge of local services so as to signpost or refer people at risk of social isolation.		The Neighbourhood Wellbeing Team is now working alongside the ASC 'Front Door' to raise awareness of community services, including running networking events and using RiPFA resources.
vii. Develop a plan for regular awareness raising with local NHS staff about services to reduce loneliness and social isolation.	Steph Francis (CCGs) Sarah Morland (RVA)		NHS staff will have up to date knowledge of local services so as to signpost or refer people at risk of social isolation.		SF/SM have arranged to include a 'VCS focus' section in the weekly newsletter to GP practices, with a focus on support to reduce loneliness and social isolation.

viii. Collate and share partner experiences of supporting peer support / social groups and community champions to develop and become self sufficient Review and promote tools to assess and evaluate services' impact on social connectivity	Rhiannon Stocking-Williams (RVA) / Michelle Berry (RBC Wellbeing Team)	May 2019	Tools are available to promote sustainable solutions		RVA Toolkit launched at Befriending Forum 14.05.2019 setting out how people can help themselves and other people to reduce loneliness. There is a printed summary and longer online toolkit. Being promoted through a series of roadshows.
ix. Develop and raise the profile of community transport solutions , and explore buddying options to encourage more people to use public transport	Reducing Loneliness Steering Group	Ongoing	At-risk individuals know how to access transport as needed to join in social networks		All members of the Steering Group committed to promoting: • the accessibility of general public transport in Reading • consideration of travel companions as part of service provision • Readibus's volunteer driver training scheme Readibus and Reading Buses represented on the Steering Group Age UK Berkshire exploring expansion of the Caversham Good Neighbours model across

					Reading.
x. Support the neighbourhood Over 50s groups to grow and be self-sustaining	Michelle Berry & Sarah Hunneman (Wellbeing Team, RBC)	Ongoing	Older residents are able to be part of developing opportunities for neighbours to know one another better	PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing	There are now four thriving Over 50s clubs – in Caversham, Southcote, Whitley and Coley.
xi. Support access to employment as a way of addressing loneliness and social isolation	Marc Murphy (Oracle)	Ongoing			Ongoing confidence building, interview skills and work experience programme at the Oracle for single parents Ongoing work shadowing programme for people who face challenges to work / integration The Step Into Retail network has so far assisted 60 people and supported 16 adults to secure employment

					Partnership developing with RCLC's pre-employment group- Supporting DWP's partner forum to get feedback on their services and how they can improve.
xii. Develop volunteering and employment opportunities for adults with care and support needs	Sarah Hunneman (Wellbeing Team, RBC) / Sarah Morland (RVA) / Kirsty Wilson (Connect Reading)	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 RVA has an officer who specialises in volunteering opportunities for people with additional needs. Berkshire West Your Way commenced delivery under a new contract 01.06.2018 which includes supporting people with mental health needs into

					employment RBC has made a 'Time to Change' pledge to end mental health discrimination – this campaign to be promoted to other Reading employers Connect Reading is promoting Mental Health First Aid as workplace training with Reading businesses Mental Health Week 2019 event received very positive feedback – provided good opportunities for volunteers to speak and gain confidence, and people have requested a similar event again.
xiii. Raise awareness of services to reduce loneliness and social isolation with people who are not literate or who speak little or no English	Sarah del Tufo (RCLC)	ongoing	People who are not literate or who speak little or no English will be enabled to access groups and services to reduce loneliness and social isolation.		RCLC, Reading Refugee Support and Communicare commenced delivery 01.06.2018 on a new contract for people facing language or cultural barriers to social contact. Independent report into the needs of ethnic minority

					women in Reading and how RCLC meets those needs published 19.07.2018. RCLC now runs a food sharing group regularly attracting 12-30 attendees. There is now a twinning arrangement with Swallowfield coffee mornings.
xvi. Raise awareness of services to reduce loneliness and social isolation with people who are not literate or whose first language is BSL	To be discussed following further analysis				Deaf people to be a priority group for further analysis within ongoing research
xvii. Raise awareness of loneliness and social isolation amongst and services to support children and young people	To be discussed following further analysis	ongoing			Children and young people to be a priority group for further analysis within ongoing research

PRIORITY No 3	**Promoting positive mental health and wellbeing in children and young people**

The Local *Future in Mind* (Transformation Plan for Children and Young People's Mental Health and Wellbeing) was last refreshed in October 2018.
This Plan is owned by the Berkshire West CCG working in partnership with the West Berkshire and Wokingham local authorities, and with Brighter Ftures or Children in Reading.

The full document describes how as a local system partners are improving the emotional wellbeing and mental health of all Children and Young People across Reading, West Berkshire and Wokingham in line with the national ambition and principles set out in the government document "*Future in Mind– promoting, protecting and improving our children and young people's mental health and wellbeing*" (2015).

This is an ambitious partnership with collaboration at its centre. Over recent years there has been a marked culture shift to a mature thriving system which has a collaborative solution focussed approach to improving services for children, young people and families. The local partners are bidding to become a trailblazer site for the Green Paper Reforms, having already being cited by the Children's Commissioner for England as an area of good practice. The intention is to build on well-established joint working arrangements between the CCG and local authorities to achieve further sustainable whole system change. Bids are being submitted for 2 Trailblazer lots- creating new local Mental Health Support Teams (MHSTs) and reducing waiting times for Specialist CAMHs and the Anxiety and Depression pathway.

The Local Transformation Plan is reviewed, refreshed and published annually in line with the requirements of Five Year Forward View for Mental Health and the Green Paper. The full document is available on the CCG website at:
https://www.berkshirewestccg.nhs.uk/media/2516/berkshire-west-future-in-mind-ltp-refresh-oct2018.pdf

The new plan builds on the 2017 plan and provides an update through a THRIVE lens of
What we have achieved so far
Our commitment to undertake the further work that is required
Local need and trends
Resources required

PRIORITY 4	**Reducing Deaths by Suicide**

What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update – July 2019**
Map local services and contact points relevant to people experiencing relationship difficulties, including third sector services	RBC Wellbeing Team	Nov 2019	Local suicide prevention communications and support can be targeted more effectively on people at risk through relationship breakdown	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Identify key partners who are in communication with people in financial difficulty, including third sector services	RBC Wellbeing Team	Nov 2019	Local suicide prevention communications and support can be targeted more effectively on people at risk through financial difficulty	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Review access to support for work-related stress within key employer organisations	Time to Change Champions & partners	Nov 2019	Strengths and gaps will be identified to support targeting suicide prevention support to complement existing resources	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	new
Identify networks and forums through which support can be offered to people who are self	RBC Wellbeing Team	Nov 2019	Strengths and gaps will be identified to support targeting suicide	4.10 Age-standardised mortality rate from suicide and injury of	New

employed or working in small organisations without a formal HR service			prevention support to complement existing resources	undetermined intent	
Through the Compass Recovery College, develop and deliver a range of recovery-focused courses for people living with mental health challenges and/or supporting others with experience of mental health challenges	Compass	ongoing	People living with or affected by mental health challenges are able to access support to develop self-management skills	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Review Compass enrolment and feedback data to identify any gaps in reaching groups at higher risk of suicide and use this to develop the college	Compass	Ongoing	Compass is accessible to groups which face a higher suicide risk.	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Map local services and contact points relevant to reaching men who may face a raised suicide risk, and identify suitable resources to offer targeted awareness raising	RBC Wellbeing Team	Nov 2019	Men have greater awareness of support available to help reduce suicide risk	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	new

Support the delivery and evaluation of a 12m 'Support After Suicide' pilot	RBC Wellbeing Team	Sep 2020	Availability of one-to-one support for people bereaved by suicide; improved understanding across partners of how to support those bereaved by suicide	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Support colleagues of people who die by suicide by sharing information and resources with relevant employers and HR departments as identified	RBC Wellbeing Team	Ongoing	People affected by the suicide of a work colleague have greater awareness of support available.	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Map local services and contact points to reach those bereaved by suicide, e.g. funeral directors, places of worship, community settings and counselling services	RBC Wellbeing Team	Nov 2019	People bereaved by suicide have greater awareness of support available.	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Promote a media summit to refresh awareness of the Samaritans Responsible Suicide Reporting guidelines across Reading media partners	RBC Wellbeing Team	Jan 2020	Improved awareness across Reading media of how to report suicide in a sensitive way	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	new

Incorporate the Berkshire Suicide Audit findings into the Reading Joint Strategic Needs Assessment	Public Health Intelligence	July 2019	Local suicide prevention planning can be informed by Berkshire Suicide Audit findings being made public	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New

PRIORITY No 5	**Reducing the amount of alcohol people drink to safer levels**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update – July 2019**
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 Drug and Alcohol Commissioner, CCG Leads, IRIS Reading Borough Manager, GP Lead	Ongoing	Lower level drinkers understand the risks to their drinking and prevent become more harmful/ hazardous drinkers. Other Stakeholders become a part of the alcohol pathway and understand their role in preventing people becoming harmful/ hazardous drinkers.	PHOF 2.15iii – Successful completion of alcohol treatment PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	Alcohol Pathway under review.
Promote knowledge and change behaviour by promoting understanding of the risks of using alcohol and	All partners	Ongoing		PHOF 2.15iii – Successful completion of alcohol treatment	NHS Health Check provides opportunistic conversation around alcohol use as Audit C is part of a check. Number of

by embedding screening and brief intervention in primary care, social care and criminal justice settings, housing and environmental health contacts.				PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	invites and health checks completed by GPs (providers) have declined from 2015/17 to 2016/17. 250 staff received Alcohol Brief Intervention training in the last year, including Royal Berkshire Hospital and Police Community Support Officers. Chemist IBA training to take place over summer 2019
Deliver IBA Training across all sectors – Need to encourage uptake of more Alcohol Champions	CAP Lead and Source Team Manager	Ongoing	More individuals trained to deliver an intervention – Making every contact count approach to managing alcohol issues/ signposting		Ongoing See above Providing IBA referral packs to wards that have been trained to allow them to refer to for future use. 510 pupils attended alcohol awareness sessions across schools in the last year. Work is ongoing with the Parental Substance Misuse Team to deliver joint alcohol awareness sessions within children's centres.

					Community Alcohol Partnership to offer IBA training to all Reading services alongside a Prospect Park nurse.
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	ongoing	Peer mentors can advise patients on specialist community services and alcohol service available locally. To prevent re-admissions to hospital.	PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	Peer mentors are supporting patients on Sidmouth Ward at RBH – Complete and ongoing CAP working with IRIS and the Trust CQUIN Lead to ensure all RBH staff are aware of the process is now complete.
Alcohol CQUIN - preventing ill health caused by alcohol. RBH to identify and support inpatients who are increasing or higher risk drinkers	RBH/ Public Health/ IRiS Reading/ CAP	June – Sept 2018	Reduction in alcohol admissions to hospital.	PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	Specialist drug and alcohol services and CAP lead to support RBH in training Trust staff in IBA and ensuring referral pathway into specialist treatment services is robust. Completed October 2018 (See above for stats)
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	PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M	Street drinking initiative underway and ongoing Retailer conference organised,

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			public spaces.	and F)	which saw 24 retailers from across Reading attend. 4 presentatioms to include: CAP Alcohol awareness, Licensing re the importance of the 4 licensing objectives, Trading standards – Business improvement and CAP Reginal officer – Illicit alcohol and tobacco. Test purchases across the last two quarters had a 33% failure rate. There is now a focus on 'high harm areas' with 'Check 25' and Under 18 test purchase follow-ups if required. Performance or licence reviews may follow, or training and healthcheck visits.
Review all extended new applications under the Licensing Act – Public Health review and consider all new applications. Make representations for anything that is of concern and attend Licensing Hearings, Performance review or Licence reviews. Reading Festival - work with	Public Health/ Licensing CAP/ Licensing	Ongoing July- Aug 18	Control of licensed outlets and review of Reading's late night economy.		Ongoing Reading Festival discussions taking place regarding onsite test purchasing

Festival Republic, the organisers of Reading Festival, in preparation for this year's event and consider how best to tackle the issue of alcohol (and illegal drug use)	Team/ Public Health				Send out Newsletter before Reading Festival to all Retailer's in the area to remind them of their 4 Licensing objectives and laws around Underage drinking and proxy purchases.
Licencing to promote responsible retailing, 4 Licensing objectives. CAP to increase Test Purchasing – Challenge 25, Under 18. Training Log to be rolled out to all retailers. Retailer Training to commence.	CAP / Licensing	Ongoing	Stricter licensing restrictions will be in place. There is a minimum price for a unit of alcohol as a mandatory condition of a License.		Commenced – CAP arranged joint retailer visits with licensing to complete the licensing surveys, licensing checks and Training log.

Encourage retailers to restrict the sale of higher ABV % cans					
Encourage neighbourhoods to report street drinking to the Police via NAG meetings	All	Ongoing	Reduce street drinking and ASB		Ongoing. RSG to include a link for reporting alcohol issues. Promote CAP Role within the community to build relationships and encourage reporting.
Education					
Education if for all ages. Alcohol awareness sessions for all.	CAP Lead	Ongoing	Educating everyone on the risks of alcohol and promote drinking responsibly.		Developed a Needs assessment and sent out to all Secondary schools with the CAP Young Peoples survey.; to be able to give Alcohol awareness sessions that fit the schools and pupils needs. Distributed June 2019 CAP to offer joint IBA training sessions to Reading Services with Prospect Park Misuse Nurse. Ongoing School children at Katesgrove Primary School benefitted from alcohol awareness sessions (

Mini Police Project - a fun and interactive volunteering project for children in Years 5 and 6. The aim is for children to work with neighbourhood police teams on local issues. The pupils will also spread the word among their school friends about the work they are involved in and gain awareness of a variety of issues. CAP to expand on this and set up new project 'Young CAP Champions' to encourage YP to promote important messages about alcohol amongst their peers (Primary schools in Reading).					age appropriate awareness of alcohol, including risks, health impacts and associated laws), as part of a 'Mini Police' project. Primary Schools being encouraged to sign up to this initiative. Third round being organised for summer 2019 CAP are part of the RVA Youth Partnership Working Group to review youth provision in Reading. Funding secured for 5 X Youth Health Champions across Reading Girls and Reading Boys 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.					
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.		
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.		New programme to be developed in Nov / Dec for 2019
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		To be reviewed. Additional recycling bins to be in place in and around Reading Festival Site in summer 2019.
New Reading University Community Alcohol Partnership	CAP	Ongoing	Better working relationships with students and young people		Action plan being developed – will address issues and support objectives across Reading i.e. night time economy and health and wellbeing of young people

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

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update – July 2019
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. The Reading DAA is also represented on this group to ensure a working partnership

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 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.	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 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.	PHOF 4.16 and NHS 2.6i– Estimated diagnosis rate for people with dementia PHOF 4.13 – Health 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	The Dementia Action Alliance organised an event to mark Dementia Action Week 2019, promoting the benefits of physical activity, singing and social engagement and attracting over 100 people livening with dementia, mostly younger people with dementia and their carers. The event also showcased the benefits of community connections, volunteering and services to support people to live well with dementia. The Wellbeing Team has provided 2 public information sessions at Dementia Awareness Week (town centre) and Southcote May Fayre, both raising awareness of preventative health services specifically around dementia and the links to alcohol, exercise and general health.

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	There is an ongoing programme of outreach and engagement with BME groups. The DAA includes ACRE which hosts annual dementia forums and invites speakers to help break down the barriers and discrimination around a dementia diagnosis.
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-	Care Plans are uploaded on DXS, easily accessed by GPs and practice staff.

				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	
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 -	Every diagnosed dementia patient has a named GP

				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 manage their condition	Patients and carers are routinely supported and sign-posted to services for on-going support. Post-diagnostic support is mainly provided by Alzheimer's society, BHFT and other voluntary sector organisations. The Dementia Action Alliance is developing a signposting pathway for all stages of

					dementia. This will be a comprehensive guide to maintaining relationships, employment and finances as well as finding equipment and services to support people with dementia ad their carers.
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
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	PHOF 4.16 - Estimated diagnosis rate for people with dementia NHS 2.6ii - effectiveness of post-	DAA has a total of 24 local businesses and partners signed up to the Reading Dementia Action. A partnership has been formed with Thames Water,

			make practical changes to make their service more accessible to those with dementia	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	the Oracle shopping centre and MERL. Work for the coming year will focus on town centre locations including all shops and services in the Oracle to ensure dementia friendly shopping for all. The Dementia Action Alliance is supporting St Lukes and The Oaks to develop a dementia friendly café on site. This service will be available to the wider community.
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 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	Dementia training is offered by RBC to all private voluntary and independent providers, although it is not compulsory for domiciliary care providers to ensure staff are trained in dementia
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	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 A dementia friendly community pathway is being designed by the DAA for 2019. This pathway will be post diagnosis support and activities that will improve health and wellbeing for persons diagnosed with dementia and their carers.

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	An 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. The DAA is currently mapping services and support. Age UK Berkshire is seeking funding to address gaps. Early analysis indicates a need to support those likely to receive a dementia diagnosis ahead of that diagnosis being given.
Raise awareness of and ensure that at least 80% of people with dementia and their carers have a right to a social care assessment.	LAs/ Memory Clinics/ Primary Care/ CMHT/ DCAs	March, 2018	At least, 80% of people with dementia and their carers are able to access quality dementia care and support.	PHOF 4.13– Health related quality of life for older people ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of	Awareness raising is ongoing. Anyone with the appearance of a care or support need is entitled to a social care assessment.

				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		The DAA is supporting Amanda Walsh, Clinical Research Assistant at The Berkshire Memory and Cognition Research Centre, University Of Reading. The DAA is recruiting individuals who have a diagnosis of Alzheimer's or mixed Alzheimer's who

			be based on and informed by the experiences of people living with dementia		showed symptoms of the disease between the ages of 66-70 years. The purpose of the Study is to learn more about the genetics that may affect the risk of developing Alzheimer's before the age of 70, with the hope that this leads to improved treatments and diagnosis in the future. Individuals need to be of Caucasian origin, and have no current diagnosis of substance abuse or psychosis and should also be willing to provide a blood sample.
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	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		This happens routinely

aid independence for as long as possible.			around me and my needs", and "I have personal choice and control or influence over decisions about me"		
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.		The DAA has exceeded the target to reach 6000 dementia friends during 2018 by achieving over 7000 and is on track to meet or exceed a target to train 10,000 dementia friends by January 2020. The DAA is continuing to support Southcote to work towards being a dementia friendly community and has now created a dementia friendly – memory café running every week, offering mental stimulation and activities to support mental wellbeing. The group is run by the Grange Café volunteers.

PRIORITY NO 7	**Increasing take up of breast and bowel screening and prevention services**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update July 2019**
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)	South Reading Cancer Education Project extended to 30.06.2019, linking volunteer champions (the Reading Cancer Support Group) to 16 general practices Bowel screening & breast screening were above the Thames Valley Alliance and England averages at Sep 2018 Most Reading surgeries have now singed up to the bowel screening non-responder alert. Teachable moment pilot project for South Reading rolled out from August 2017 (see below). Pilot ended in January after implementation by only two practices. Lack of time, workload constraints and capacity of the team to support

					the implementation were seen as barriers. Tailored GP Surgery bowel screening letters are now sent to patients from the Hub. The Cancer Research UK Facilitator has offered to visit all South Reading practices to improve cancer screening uptake
To work in partnership with key stakeholders to increase public /patient awareness of signs and symptoms and screening programmes	Public Health Berkshire Macmillan		Patients seek advice and support early from their GP Increase uptake of screening programmes		Reading Cancer Champions organised multiple events to mark World Cancer Day 2019 (February 4th) South Reading Cancer Educator has delivered 24 Cancer education and awareness sessions in South Reading Cancer awareness event organised by Cancer Champions on 29th September 2018. Local authority is supporting the promotion and engagement

					of the Macmillan Cancer Education Project, led by Rushmoor Healthy Living with funding from Macmillan Cancer Support. Macmillan Cancer Educator has been appointed to raise awareness of the signs and symptoms of cancer among hard to reach groups in South Reading, Over 23 people from the community have signed up to become cancer champions. A number of community events and meetings have been held. Fifteen community volunteers from South Reading have completed their training as Cancer Champions. Macmillan Cancer Champion training have been organised for volunteers from different community groups. These champions will now organise

					cancer awareness sessions for their community groups CRUK bowel screening promotional video has been shared through local authority web pages. Wellbeing team has been promoting various cancer awareness campaigns including PHE's Be Clear on Cancer: Breast Cancer in women over 70 by sharing key messages via local authority webpages, digital media and during community events Wellbeing team in partnership with CCG promoted bowel screening among Southcote over 50s group. Participants completed questionnaires around bowel cancer screening and they were provided information on using the test kit

To plan and implement a pilot project that provides motivational behaviour change interventions to patients who have had a 2WW referral and a negative result ("teachable moments")	Public Health Berkshire Cancer Research UK Facilitator		Patients motivated to make significant changes to lifestyle behaviours that will help to reduce their risk of developing cancer		See above – take up too low for a formal evaluation

PRIORITY NO 8	**Reducing the number of people with tuberculosis (TB)**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update – July 2019**
Offer training in Reading for health professionals , community leaders and other professionals who come in contact with at risk populations	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)	A year on year decrease in TB incidence in Reading has been achieved, this is in line with national and South East trends. TB incidence in the 2015-2017 period was 20.9 per 100,000 compared to 36.4 per 100,000 in 2012 .

					Reading's ongoing work has been acknowledged by PHE and TB control Boards. TB awareness sessions are for housing colleagues and partners took place in January and April 2019. Workshops were held for health professionals and for RBC staff during 2018-19 A workshop led by the TB Team and Berkshire Shared PH Team for Looked After Children's nurses and link workers across Berkshire West was held in May 2019 with a similar session for Community Paediatricians in June 2019 Sessions have also been delivered to other groups by the New Entrant Screening Nurse / TB nurse team from RBH with support from Public Health.
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)	Training materials developed previously continue to be used in awareness sessions and community events

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)	TB awareness sessions have been run during community events including Reading University Fresher's Fayre, Disability Awareness Day, Older People's Day, Carers Rights Day, and a Health and Wellbeing event at Royal Berkshire Hospital. A TB awareness session for the Zambian community took place in January 2019. For World TB Day 24th March a joint news release between the CCG, RBH and Reading Borough Council was featured on local TV, newspapers and on social media sites and included interviews with a TB patient praising the treatment from RBH. Information was shared via GP practice screens and RBH TB Nurses & Public Health also hosted an information stall at Whitley Community Centre.
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 2019 as part of the JNSA rolling update

					schedule. Data on all TB Strategy Monitoring Indicators is available on PHE Fingertips https://fingertips.phe.org.uk/profile/tb-monitoring
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
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	Reading Wellbeing Team / Reading	Jan-17	Work to develop the provision of appropriate and accessible information and support to under-	PHOF 3.05ii - Incidence of TB (three year	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

populations by maintaining high treatment completion rates and ensuring thorough contact tracing around MDR cases	Reading Housing Team / NESS nurses/CCGs		served and high-risk populations.	average)	provide a baseline to measure impact of communication and engagement work. This information will also be used to further shape engagement with under-served and other at-risk groups Resources shared with providers including IRIS A TB awareness session was delivered to IRIS staff in 2018
Ensure patients on TB treatment have suitable accommodation	Reading Wellbeing Team / Reading Reading Housing Team / NESS nurses/CCGs		Development of robust discharge protocol	PHOF 3.05ii – Treatment completion for TB	PHE have developed Thames Valley guidance to inform the process for assessment and discharge of homeless TB patients - both with and without recourse to public funds. This guidance has been used to inform process across the Berkshire LAs during 2017, demonstrating it is fit for purpose. Work is in progress to develop an MOU between the CCGs and local authorities across Berkshire West to ensure provision of accommodation to homeless TB patients with no recourse to public funds

Develop and promote referral pathways from non-NHS providers	LA public health / NESS nurses/CCGs		Align local service provision to these groups as per NICE recommendations	PHOF 3.05ii - Incidence of TB (three year average)	Work with under-served continued to be priority for the CCG and RBC Wellbeing Team in 2018-2019 The RBC Wellbeing Team worked with TB nurses and CCG colleagues to promote World TB Day on 24.03.2019 by engaging with local residents World TB Day was promoted by the local authority via web pages and digital media. A TB awareness session was organised for the Nepalese community in partnership with the charity Communicare The RBC Wellbeing Team has developed links with different community groups to identify TB Champions who could raise awareness of TB and NESS within their groups
Engagement with SE TB Control Board to share best practice	DPH / PHE CCDC		Work to decrease the incidence of TB in Berkshire through investigating how co-ordinated, local latent TB screening processes can be improved	PHOF 3.05ii - Incidence of TB (three year average)	The SE TB Control Board held a workshop in Reading in November 2017 to review its objectives for 2018. There are 2 face to face board meetings a year, and 2 TB network lead meetings to share work streams. There is a public facing website with links to general information, and a TB

					nurse forum
Fully implement EMIS and Vision templates in all practices in South Reading	South Reading CCG	Ongoing	Ensure that new entrants are referred routinely to local services for screening through addressing issues with local pathways	PHOF 3.05ii - Incidence of TB (three year average)	Templates are installed in all practices. The majority of 16 South Reading practices are returning monthly lists to NESS and practices have been offered training/support to continue this. 563 patients were screened from April-2018 - March 2019 compared with 382 in the previous year. DNA rates have reduced substantially during 2018-19 following changes in follow up process with invited patients and implementation of an evening clinic.