Reading Health and Wellbeing Strategy 2017-20 - Action Plan agreed 27.01.2017

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PRIORITY 1: Supporting people to make healthy lifestyle choices – dental care, reducing obesity, increasing physical activity, reducing smoking

Note – The section below should be considered alongside the Healthy Weight Position Statement for Reading which provides an analysis of local data, scoping of current service provision and reports on the emerging priorities have been identified to help focus work on key areas of need.

Actions included below detail work in progress by the council that contribute to the healthy weight agenda. However, to tackle overweight and obesity effectively requires a multi-agency approach and as such we will invite partners, including but not limited to schools, local health services and the voluntary and community sector, private sector to join an action planning group following the January Health and Wellbeing Board to help shape a comprehensive strategy delivery plan.

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
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).

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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).
§ To seek opportunities to promote and support local walking and cycling programmes for leisure and active travel. For example: § 'Develop a Local Cycling & Walking Infrastructure Plan, as a sub-strategy to the Local Transport Plan.	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 Bikeability Increase in the number of children walking or cycling to school Reduce congestion	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.

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Hold a 'Walking Volunteer recruitment workshop' 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	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.	
§ 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.
§ To ensure delivery of the National Child Measurement Programme	Wellbeing Team	Ongoing	Weight and height measurements offered to all children attending state funded primary school children who are in Reception Year (age 5) and Year 6 (aged 10,11) in accordance with NCMP guidance	2.06i - % of children aged 4-5 classified as overweight or obese. 2.06ii - % of children aged 10-11 years classified as overweight or obese.

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Active Nation	Wellbeing team, Leisure and Recreation service / Transport	2017	Funding opportunities identified to help increase physical activity levels in target groups.	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. 2.21 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. 1.16 - % of people using outdoor space for exercise/health reasons.

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
To Prevent Uptake of Smoking s Education in schools s Health promotion s Quit services targeting pregnant women/families s 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 survey) PHOF 2.09v – Smoking prevalence at age 15 – occasional smokers (SDD survey)

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ To provide support to smokers to quit s Health promotion s Referrals into service s VBA training to staff s 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
§ To take action to tackle illegal tobacco and prevent sales to >18 s Health promotion s Act on local intelligence s Retailer training – challenge 25 s Test purchasing	CS; 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	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Local Smoking Policy – workplace, communities s Update workplace smoking policy (wellbeing policy) s 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.	

PRIORITY 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
§ 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	
§ Develop a reducing loneliness and social isolation module as part of the Reading Joint Strategic Needs Assessment	Wellbeing Team, RBC	April 2017	We will understand the local loneliness issue, in particular which groups of Reading residents are at greatest risk of experiencing health inequalities as a result of loneliness	PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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	
§ 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	
§ Support the neighbourhood Over 50s groups to grow and be self-sustaining	Wellbeing Team, RBC	Ongoing	Older residents are able to be part of developing opportunities for neighbours to know one another better	PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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	
§ 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
§ 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
§ 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

PRIORITY 3: promoting positive mental health and wellbeing in children and young people

Actions to support delivery of this priority are set out in the Reading Future In Mind Transformation plan that covers the key issues. This has been published at: http://nwreadingccg.nhs.uk/mental-health/camhs-transformation (Appendix 1)

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
§ 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	
§ Develop a communication plan to raise awareness of Reading's Suicide Prevention Action Plan, including: s the formal launch of the Berkshire Suicide Prevention Strategy s contributions to the 'Brighter Berkshire' Year of Mental Health 2017 s 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	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Support the review of CALMzone and development of future commissioning plans for support services which target men § Review local DAAT contracts to ensure suicide prevention objectives are included § Develop post discharge support for people who have used mental health services via the Reading Recovery College	Wellbeing Team, RBC	October 2017 April 2017 Ongoing	Suicide risk will be mitigated for higher risk groups: men, people who abuse drugs or alcohol, people who have been in contact with mental health services	PHOF 4.10 – suicide rates

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Tailor approaches to improve mental health in specific groups: § Support delivery of the local 'Future in Mind' programme to improve mental health in children and young people § Recognise the mental health needs of survivors and links to suicide prevention in the implementation of the Reading Domestic Abuse Strategy § Raise awareness of support available to survivors of sexual abuse through Trust House Reading § Contribute to a Berkshire wide review of targeted community based interventions, including suicide prevention and mental health first aid training	Local sponsors (see above) DENS, RBC Local sponsors (see above) Local sponsors (see above)	Ongoing tbc ongoing	Mental health will be improved for some specific groups (children and young people, survivors of domestic or sexual abuse) through tailored approaches Future commissioning of community based interventions will be informed by a review of impact	See Action Plan for Priority 4 for details.
§ Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and recommend appropriate action(s)	Wellbeing Team, RBC	ongoing	Access to the means of suicide will be reduced where possible	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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	
§ 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	
§ Update Reading JSNA module on suicide and self-harm § Refresh Reading Mental Health Needs Analysis	Wellbeing Team, RBC Adults Commissioning Team, RBC	tbc May 2016	Local and county-wide Suicide Prevention Action will be informed by up to date research, data collection and monitoring	

PRIORITY 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
Treatment § Increase the number of people receiving support at the appropriate level to address risky, harmful and dependent use of alcohol. § Review current alcohol pathways to enable the specialist service to gain capacity to work with more risky, harmful and dependent drinkers.	All Partners required to support an alcohol pathway DAAT Contract Manager, CCG Leads, IRIS Reading Borough Manager, GP Lead	Ongoing April 2017	Lower level drinkers understand the risks to their drinking and prevent become more harmful/ hazardous drinkers. Other Stakeholders become a part of the alcohol pathway and understand their role in preventing people becoming harmful/ hazardous drinkers.	PHOF 2.15iii – Successful completion of alcohol treatment PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)
§ Reinstate the Whitley project. § CAP Lead to co-ordinate a meeting with all stakeholders to kick start the project.	CAP Lead	April 2017	Encourage IBA in the community. More 'Community Alcohol Champions' to promote lower drinking levels and behaviours. Alcohol Champions in the community will be able to deliver information and brief advice to members of the public.	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Promote the IRIS clinic at Longbarn Lane Surgery to all GPs for those clients whom do not wish to receive treatment at the Specialist drug and alcohol service – and future plans	IRIS Reading/ Dr. Helen George	January 2017	Clients can access treatment in the GP surgery rather than access via specialist drug and alcohol treatment service at Waylen Street. Reduce the impact on GP capacity with an additional specialist service in GP setting.	
§ 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)
§ 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 Mapping Group to present a business case for an Alcohol Liaison Nurse to help reduce alcohol related admissions to hospital.	Alcohol Mapping Group	April 2017		PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ First Stop – in Town Centre Friday & Saturday nights § Explore an option of a fixed service with TVP, to deliver an extended service in Town Centre	Licensing and TVP	Ongoing	Option for people to dry out at First Stop (St Mary's Church) rather than RBH First Stop can offer advice and information on alcohol use.	
§ 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).	DAAT Contract Manager and CCG Project Manager IRIS Peer mentors	January 2017 March 2017	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)
§ 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)
§ 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)

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
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)
§ 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.	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Licencing to promote responsible retailing, 4 Licensing objectives. § CAP to increase Test Purchasing – Challenge 25, Under 18. § Licensed Retailer Passport to be rolled out to all retailers. § Retailer Training to commence. § Encourage retailers to restrict the sale of higher ABV % cans	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.	
§ Promotion of better marketing of soft/ mixer-diluted drinks in Bars and Pubs.	CAP/ licensing	January 2017	Promote healthier non-alcoholic options to customers	
§ Encourage neighbourhoods to report street drinking to the Police via NAG meetings	All	Ongoing	Reduce street drinking and ASB	
Education Parent education – School age children to be set an alcohol questionnaire to complete with their parents to promote knowledge on alcohol and the health risks	CAP lead	2017		

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Education if for all ages. § Alcohol awareness sessions 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.	CAP Lead	Ongoing	Educating everyone on the risks of alcohol and promote drinking responsibly.	
§ 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.	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
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 2016 and January 2017	Encourage awareness of effects of alcohol on staff, clients and local community. Promote drinking responsibly.	
§ Explore with the street care team whether we can promote drinking responsibly at recycling depots.	DAAT / Street Care Team	January 2017	Encourage drinking responsibly and increase public awareness of the risks of alcohol	
§ Work in partnership with RVA to promote Public Health messages through their newsletter	Public Health Lead/ RVA	January 2017/ Ongoing	Encourage healthier lifestyles.	

PRIORITY 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
§ 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	

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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
§ Play a leading role in the development and implementation of personalised care plans including specific support working in partnership with memory assessment services and care plan design and implementation.	Primary Care/BWCCGs/BHFT	March, 2018	GPs ensuring everyone diagnosed with dementia has a personalised care plan that covers both health and care and includes their carer. This will enable people to say "I know that services are designed around me and my needs", and "I have personal choice and control or influence over decisions about me"	PHOF 4.13 - Health related quality of life for older people ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life NHS OF 2.6ii - effectiveness of post-diagnosis care in 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

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Ensure coordination and continuity of care for people with dementia, as part of the existing commitment that everyone will have access to a named GP with overall responsibility and oversight for their care.	BWCCGs	March, 2018	Everyone diagnosed with dementia has a named GP as well as a personalised care plan that covers both health and care and includes their carer.	PHOF 4.13- Health related quality of life for older people ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life NHS OF 2.6ii - effectiveness of post-diagnosis care in 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

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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
§ 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
§ 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

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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
§ 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

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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, affordable plan to bring services into line within the national frame-work 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

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Raise awareness of and ensure that at least 80% of people with dementia and their carers have a right to a social care assessment.	LAs/ Memory Clinics/ Primary Care/ CMHT/ DCAs	March, 2018	At least, 80% of people with dementia and their carers are able to access quality dementia care and support.	PHOF 4.13– Health related quality of life for older people ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life 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

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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	
§ Enable people to have access to high quality, relevant and appropriate information and advice, and access to independent financial advice and advocacy, which will enable access to high quality services at an early stage to aid independence for as long as possible.	BHFT/LAs	March, 2018	People with dementia and their carers are able to access quality dementia care and support, enabling them to say "I have support that helps me live my life", "I know that services are designed around me and my needs", and "I have personal choice and control or influence over decisions about me"	
§ 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.	

PRIORITY 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
§ 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)
§ To work in partnership with key stakeholders to increase public /patient awareness of signs and symptoms and screening programmes	Public Health Berkshire Cancer Research UK Facilitator Bridget England		Patients seek advice and support early from their GP Increase uptake of screening programmes	
§ 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	

PRIORITY 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
§ 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)
§ 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)
§ 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)
§ 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)

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ 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)
§ 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		Outcome to be added	PHOF 3.05ii - Incidence of TB (three year average)
§ Maintain robust systems for providers to record and report BCG uptake	NHS England		Monitor provision and uptake of BCG vaccination as new policies are implemented	PHOF 3.05ii - Incidence of TB (three year average) Local indicator on BCG update could be developed in partnership with NHSE
§ Develop / maintain robust systems for providers to record and report uptake and to re-call parents	Midwifery teams in FHFT and RBH	January 2017	Ensure registers of eligible infants who have missed vaccination due to shortages are kept to up to date and a mechanism exists to re-call when vaccine is available	PHOF 3.05ii - Incidence of TB (three year average)
§ 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)

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Ensure processes are in place to identify eligible babies, even in low-incidence areas	Midwifery teams in FHFT and RBH	Ongoing	Outcome to be added	PHOF 3.05ii - Incidence of TB (three year average)
§ Tackle the clinical and social risk factors associated with development of drug resistance in under-served populations by maintaining high treatment completion rates and ensuring thorough contact tracing around MDR cases	Reading Wellbeing Team / Reading Reading Housing Team / NESS nurses/CCGs	Jan-17	Work to develop the provision of appropriate and accessible information and support to under-served and high-risk populations.	PHOF 3.05ii - Incidence of TB (three year average)
§ Ensure patients on TB treatment have suitable accommodation	Reading Wellbeing Team / Reading Reading Housing Team / NESS nurses/CCGs		Development of robust discharge protocol	PHOF 3.05ii – Treatment completion for TB
§ 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)
§ Develop robust pathways to enable timely discharge of patients into appropriate accommodation	LA public health / NESS nurses	Jan-17	Develop robust pathways to enable timely discharge of patients into appropriate accommodation	PHOF 3.05ii - Incidence of TB (three year average)

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
§ Engagement with SE TB Control Board to share best practice	DPH / PHE CCDC		Work to decrease the incidence of TB in Berkshire through investigating how co-ordinated, local latent TB screening processes can be improved	PHOF 3.05ii - Incidence of TB (three year average)
§ Fully implement EMIS and Vision templates in all practices in South Reading	South Reading CCG	Ongoing	Ensure that new entrants are referred routinely to local services for screening through addressing issues with local pathways	PHOF 3.05ii - Incidence of TB (three year average)