Bracknell Forest
Health and Wellbeing Board

Work Stream Action Plan for "Seamless Health"

Delivering the
Joint Health & Wellbeing Strategy

Version: JHWS Action Plan V2.3.Doc

May 2013

Bracknell Forest Council

healthwatch Bracknell Forest

NHS
Bracknell & Ascot GP Commissioning Consortium

Version Control

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Introduction

The JHWS set out 5 over arching themes under which sit 19 priority areas to improve health and wellbeing outcomes and reduce health inequalities:

Themes and Priorities

The JHWS set out 5 themes:

1. Long-term conditions
2. Sexual Health
3. Safeguarding
4. Cancers
5. Mental Health and wellbeing

Under which are grouped17 priority issue areas:

Appropriate/adapted Housing

Respiratory Illness

Dementia - Early diagnosis, treatment and support

Diabetes and diabetic retinopathy

Education, skills and employment

Falls

NHS Healthchecks

Vulnerable children and young people

Prevention of alcohol & substance misuse

Prevention of Domestic abuse

Sexual health

Prevention of Social and Emotional Isolation

Reduction of high rates of depression

Support for people who have had stroke

Tobacco and smoking cessation

Weight management, diet and nutrition and physical activity

Cancers

The action plan focuses on three delivery phases or work stream areas:

Prevention and Early Intervention

Treatment

Long-term care and support

In addition to setting out actions that will deliver improved health and wellbeing outcomes and reduce health inequalities, this plan identifies functions and activities that:

Are currently in planning, are being delivered or need to be delivered

Could be delivered in partnership for greater impact on the health and wellbeing of the local population through joint or integrated delivery

Could be resourced through the use of section 75 agreements or any other mechanism to pool resources

Progress will be reported to Health and Wellbeing Board through the Joint Health and Wellbeing Working Group.

Organisation of themes and priorities

The plan is structured around strategy themes with supporting priorities listed in number order beneath each theme.

Actions are set out under each priority.

Action plan headings

Outcomes	Actions do not always answer the question “in order to” An opportunity for the group to better understand and specify why actions are being undertaken and for what purpose.
Actions	What will the work stream do to achieve the outcome? This gives the Group opportunity to set out actions that the work stream needs to undertake to deliver against the priority.
Potential Integration	What connections can be made between activities so that a joint or integrated approach can be undertaken? The Duty to Integrate applies to all statutory partners of the Health and Wellbeing Board. Whilst partners can deliver action separately, more can be achieved by optimising the use of limited resources and work stream leads are asked to proactively identify what can be joined and integrated.
Barriers	Barriers and challenges to integration What have the partners learned or experienced that might prevent the delivery of this action, e.g. too big or complex, lacks understanding outside a particular agency or organisation, needs more senior buy in, needs better promotion, lacks capacity or funding, etc.
Resources	What assets or resources does the work stream have or need to draw upon? Resources might include money, time, tools, equipment, expertise, skills, knowledge, experience, volunteer capacity, organisational support (e.g. secondments) or use of local facilities.
Lead	Which member of the work stream will take responsibility for delivering this action? Which individual or organisation is best placed to make change happen?
Measures	How will change be measured? A number of overarching outcome measures apply to priorities and are identified in the strategy, these are separate from measures that will monitor the delivery of specific underpinning actions.
Progress	**How far has the work stream got in achieving the action?** To what extent are the outcomes being realised?

Way forward

Phase 1 – Actions, Barriers / Gaps and Measures

Demonstrating knowledge of our existing and emerging strategic and commissioning plans, each partner needs to populate the action plan with existing and planned actions and activities which they believe are relevant to each priority in each work stream. Barriers, challenges or gaps relevant to the delivery of actions should also be noted.

Phase 2 – Integration & Classification

All participants will then identify:

actions they could link to, join up with or integrate their activities for optimal use of limited resources

cluster common activities under high level outcomes for people for ease of understanding and answer the “in order to”

Phase 3 – Resources and Lead

what resources might be accessed

agree what role the lead officers need to play:

- direct action (to promote integration between teams) or a
- simple watching brief over an action (note progress of an action being delivered by another team)

Phase 4 – Asset based delivery & Optimisation of Resources

Distribution of plan beyond statutory health and social care partners to the wider health economy, other directorates and other sectors

Discrete Theme 1 - Long-term conditions

Priority 2 – Respiratory Illness

Respiratory disease is one of the top causes of death in England in people under the age of 75. Smoking is the major cause of major respiratory diseases. These measures will focus attention on the prevention of smoking and other environmental factors that contribute to people getting respiratory disease. Prevention and timeline treatment is key to saving lives and preventing long-term ill health, as well as reducing the number of new infections and development of drug resistance.

Overarching health improvement and equalities outcomes

COF	3.2 Emergency admissions for children and young people with Lower Respiratory Tract Infections
PHOF	3.5 Proportion of patients who successfully complete treatment for tuberculosis (by vulnerable group, including Nepali).
PHOF	4.7 (i) Age-standardised mortality rate from respiratory diseases for persons aged under 75 per 100,000 population.
PHOF	4.7 (ii) Age-standardised rate of mortality that is considered preventable from respiratory diseases in persons less than 75 years of age per 100,000 population (placeholder indicator)

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan Integrated teams around clusters of practices to deliver proactive case management for identified caseloads of people at high risk. Risk stratification used to identify cases across health and social care. Care plans will include escalation plans shared across the system including OOHs , 111 and SCAS. Specialist services will support cluster teams	Any actions relevant to JHWS outcomes		Support for cluster teams will include telehealth, community clinics (RACCs) , specialist nurses and end of life teams		Fast Action Short Term Treatment (FAST) care will be available 24/7 with a 2 hour response time for people being case managed	Community health staff to review appropriate referrals

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Public Health commissioning and development of NHS Stop Smoking Support Services. Review of existing contract with provider as well as development of new referral pathways for people in low socioeconomic groups, young people and pregnant women.		Contract with provider already established so may limit expansion of work.			Referrals. Successful quits.	
T	CCG Commissioning Plan Review of the primary care treatment of COPD in all general practices in line with NICE guidelines through the QOF framework using the Allen and Hanbury tool	Linking a planned care pathway with secondary care to better manage patients through an integrated pathway Engagement in general practices with the COPD specialist nurse service and medicines management	Engagement in general practices with the COPD specialist nurse service and medicines management	Quality and Outcomes framework Allen and Hanbury Tool	Rohail Malik (CCG)	Reduction in NEL and A&E activity	QOF commissioned and additional Allen and Hanbury tool in place in general practice
T	CCG Commissioning Plan Implementation of self care leaflets and website on common childhood illnesses – 'worried parent'	Link to other electronic resources Promote through libraries and children's centres (in line with Self care Project Plan)	Access to Technology for patients	Linked to the Website and Wider communication and promotion	Martin Kittel (CCG)	Reduction in NEL and A&E activity	Published on website – July 2013
T	CCG Commissioning Plan COPD - Monitoring and additional support to patients suitable for Telehealth	More integration with 111 and OOHs Community Matrons	Capacity in community matron services	Non recurring funding providing the service	Rohail Malik (CCG)	Reduction in NEL and A&E activity	Planned to be submitted into QIPP cycle

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
T	CCG Commissioning Plan Integrated teams around clusters of practices to deliver proactive case management for identified caseloads of people at high risk. Risk stratification used to identify cases across health and social care. Care plans will include escalation plans shared across the system including OOHs , 111 and SCAS. Specialist services will support cluster teams			Support for cluster teams will include telehealth, community clinics (RACCs) , specialist nurses and end of life teams		Fast Action Short Term Treatment (FAST) care will be available 24/7 with a 2 hour response time for people being case managed	Community health staff to review appropriate referrals
LTC&S	CCG Commissioning Plan Nothing recorded						

Priority 4 – Diabetes and diabetic retinopathy

Diabetes is on the increase and diabetic complications (including cardiovascular, kidney, foot and eye diseases) have a detrimental impact on quality of life. In the majority of cases, type 2 diabetes is partially preventable and can be prevented or delayed by lifestyle changes (exercise, weight loss, healthy eating). Earlier detection of type 2 diabetes followed by effective treatment reduces the risk of developing diabetic complications.

Diabetic retinopathy is the leading cause of preventable sight loss in working age people in the UK and early detection through screening halves the risk of blindness.

Overarching health improvement and equalities outcomes

PHOF	2.17 Number of QOF-recorded cases of diabetes per 100 patients registered with GP practices (17 years and over).
PHOF	2.21 (vii) The proportion of those offered screening for diabetic retinopathy who attend a digital screening event
COF	2.52 People with diabetes who have received nine care processes
COF	2.60/2.63 People with diabetes who have an emergency admission for diabetic ketoacidosis
Local	Number of children and young people (0-16) diagnosed with diabetes.

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan Integrated teams around clusters of practices to deliver proactive case management for identified caseloads of people at high risk. Risk stratification used to identify cases across health and social care. Care plans will include escalation plans shared across the system including OOHs , 111 and SCAS. Specialist services will support cluster teams			Support for cluster teams will include telehealth, community clinics (RACCs) , specialist nurses and end of life teams		Fast Action Short Term Treatment (FAST) care will be available 24/7 with a 2 hour response time for people being case managed	Community health staff to review appropriate referrals

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Actions to be developed as part of the Learning Disabilities Strategy development 2014-2019	Health Group of the Learning Disabilities Partnership Board)	Gaps to be identified as part of Learning Disabilities Strategy development 2014-2019		Health Group – Learning Disabilities Partnership Board & CTPLD		People with Learning disabilities are in a high risk group for developing diabetes.
P&EI	Public Health commissioning and development of NHS Health Check programme. This includes tests and advice related to diabetes. New points of access being developed including workplaces and leisure centres.		Current engagement in NHS Health Check programme among GPs is low.			Number of checks offered and delivered.	
T	CCG Commissioning Plan Allison has been asked to contribute to this – not back from leave until 19th july Additional education provision committed Dietetic advice provision improving 2014				CCG		
T	CCG Commissioning Plan Integrated teams around clusters of practices to deliver proactive case management for identified caseloads of people at high risk. Risk stratification used to identify cases across health and social care. Care plans will include escalation plans shared across the system including OOHs , 111 and SCAS. Specialist services will support cluster teams			Support for cluster teams will include telehealth, community clinics (RACCs) , specialist nurses and end of life teams		Fast Action Short Term Treatment (FAST) care will be available 24/7 with a 2 hour response time for people being case managed	Community health staff to review appropriate referrals
LTC&S	CCG Commissioning Plan Nothing recorded						

Priority 6 – Falls

Falls are the largest cause of emergency hospital admissions for older people. One in three people end up leaving their own home and moving to long-term care (resulting in social care costs) and one in one in three sufferers of hip fractures return to their former levels of independence. Hip fractures are almost as common and costly as strokes and the incidence is rising. Fall prevention and providing appropriate treatment should they occur will have a major impact on people's independence and quality of life.

Overarching health improvement and equalities outcomes

PHOF	2.24 Age-sex standardised rate of emergency hospital admissions for falls or falls injuries in persons aged 65 and over
PHOF	4.14 Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 and over per 100,000 population

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	PH Bid Holistic Health and Social Inclusion in Vulnerable Older People				Public Health Bank Workers	Vulnerable older people feel physically active and able to manage independently in their own homes	Project in development stage
P&EI	Public Health collaboration with Adult Social Care on Older People's 'Holistic Health' Programme. Aimed at social isolated older adults – this programme includes work on falls prevention. Funded by Public Health Project Grant.		New project piloting new ways of working.			Assessment of participant satisfaction, knowledge and confidence.	
P&EI	Public Health collaboration with Housing on Forest Care project aimed at preventing falls and other causes of hospital readmission or unnecessary ambulance attendances via the provision of a remote 'life line' and key holding service. Funded by Public Health Project Grant.		New project piloting new ways of working.			Assessment of participant satisfaction, knowledge and confidence. Data on falls and readmission to hospital.	

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan Integrated teams around clusters of practices to deliver proactive case management for identified caseloads of people at high risk. Risk stratification used to identify cases across health and social care. Care plans will include escalation plans shared across the system including OOHs , 111 and SCAS. Specialist services will support cluster teams			Support for cluster teams will include telehealth, community clinics (RACCs) , specialist nurses and end of life teams		Fast Action Short Term Treatment (FAST) care will be available 24/7 with a 2 hour response time for people being case managed	Community health staff to review appropriate referrals
T	CCG Commissioning Plan Not aware of any plans specifically around falls prevention lead by Health – in the past we have done multi medication reviews as required in QOF, nothing independent though				CCG		
T	CCG Commissioning Plan Integrated teams around clusters of practices to deliver proactive case management for identified caseloads of people at high risk. Risk stratification used to identify cases across health and social care. Care plans will include escalation plans shared across the system including OOHs , 111 and SCAS. Specialist services will support cluster teams			Support for cluster teams will include telehealth, community clinics (RACCs) , specialist nurses and end of life teams		Fast Action Short Term Treatment (FAST) care will be available 24/7 with a 2 hour response time for people being case managed	Community health staff to review appropriate referrals
LTC&S	CCG Commissioning Plan Nothing recorded						

Priority 14 – Support for people who have had a stroke

Cardiovascular disease (CVD) including heart disease and stroke, is one of the major causes of death in people aged under 75 in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment.

Overarching health improvement and equalities outcomes

ASCOF	1.1 Under 75 mortality rate from cardiovascular disease (see PHOF 4.4, COF 1.1)
COF	1.34 Mortality within 30 days of hospital admission for stroke
COF	2.87 People with stroke who are discharged from hospital with a joint health and social care plan
COF	2.89 People with stroke who are reviewed 6 months after leaving hospital
COF	2.90 People with stroke who are supported to leave hospital by a skilled stroke early supported discharge team
PHOF	4.4 (i) Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population
PHOF	4.4 (ii) Age-standardised rate of mortality that is considered preventable from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan To commission the provision of intense rehabilitation in the community, which corresponds to a similar level of care provided in the hospital for stroke patients. Specialist stroke rehabilitation provided to stroke survivors in their own home or normal place of residence for up to 6 weeks			ESD team of nurses, therapists, doctors and social care staff work collaboratively as a team, with the patient and their family..		Providing intensive rehabilitation at home for a period of up to 6 weeks, thereby reducing the risk of re-admission into hospital for stroke related problems and increasing independence and quality of life	The ESD service will provide support to the carer(s) and family of the stroke survivor irrespective of which acute hospital the patient is in
T	CCG Commissioning Plan Heart Failure - Monitoring and additional support to patients suitable for Telehealth	More integration with 111 and OOHs Community Matrons	Capacity in community matron services	Non recurring funding providing the service	Rohail Malik	Reduction in NEL and A&E activity	Planned to be submitted into QIPP cycle
T	CCG Commissioning Plan Early Supported Discharge – needs more detail	Secondary care and community care integration			CCG		
T	CCG Commissioning Plan QOF stroke indicators – aspire to deliver all QOF points including monitoring of essential diagnostics every 12 months				CCG		

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
T	CCG Commissioning Plan To commission the provision of intense rehabilitation in the community, which corresponds to a similar level of care provided in the hospital for stroke patients. Specialist stroke rehabilitation provided to stroke survivors in their own home or normal place of residence for up to 6 weeks			ESD team of nurses, therapists, doctors and social care staff work collaboratively as a team, with the patient and their family..		Providing intensive rehabilitation at home for a period of up to 6 weeks, thereby reducing the risk of re-admission into hospital for stroke related problems and increasing independence and quality of life	The ESD service will provide support to the carer(s) and family of the stroke survivor irrespective of which acute hospital the patient is in
LTC&S	CCG Commissioning Plan Nothing recorded						

Discrete Theme 2: Sexual health

Priority 11 – Sexual Health

Sexually transmitted infections cause avoidable sexual and reproductive ill-health, including symptomatic acute infection (i.e. infections with immediate symptoms) and later complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. It has been demonstrated that Chlamydia control activities result in changes in chlamydia prevalence (and thereby to changes in ill-health). Increasing the diagnostic rate will reduce the prevalence of asymptomatic infections (i.e. infections that shoe no immediate symptoms, and may therefore go undetected).

Overarching health improvement and equalities outcomes

PHOF	3.2 Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24.
PHOF	2.20 (ii) The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period
PHOF	2.21 (ii) Syphilis, hepatitis B and susceptibility to rubella uptake: The proportion of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella
PHOF	3.4 Proportion of persons presenting with HIV at a late stage of infection

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan Nothing recorded						
P&EI	Learning Disabilities Strategy 2008 -2013 5.2 Support people with a learning disability who want to have a baby or who want advice about family planning.		Gaps to be identified as part of Learning Disabilities Strategy 2014-2019 development		Health Group – Sub Group of the Learning Disabilities Partnership Board	To have parenting classes for people	Health groups are running throughout the year. Parenting groups have been run.

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Public Health commissioning and development of Sexual Health Services. Many of these services are preventative (eg: contraception). This includes a Sexual Health Needs Assessment in preparation for review of commissioning arrangements for 2014/15.		Quality of data.			Completion of Needs Assessment. Successful tendering process. Ongoing measures of sexual health outcomes as per service specification.	
P&EI	Continue to support and target young people in relation to teenage pregnancy and sexual health via universal services, health drop-In and targeted youth support activity.	Links to sexual health services as this is developed and commissioned	Data re TP is always 18 months in arrears and local intelligence not easily available.	Specialist lead in Youth Services – School Health Drop-ins	Children Young People and Learning – Yotuh Service	Sustained reduction in Teenage Pregnancy Reduced incidences of STI.	
T	CCG Commissioning Plan	Link to Public health as commissioners CYP services Schools and school nurses	Providers willing to deliver the commissioned services		CCG		
T	Public Health commissioning and development of Sexual Health Services. Many of these services are preventative (eg: contraception). This includes a Sexual Health Needs Assessment in preparation for review of commissioning arrangements for 2014/15.		Quality of data.			Completion of Needs Assessment. Successful tendering process. Ongoing measures of sexual health outcomes as per service specification.	
LTC&S	CCG Commissioning Plan Nothing recorded						

Discrete Theme 4: Cancers

Priority 17 – Cancers

Overarching health improvement and equalities outcomes

PHOF	2.19 Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed"
PHOF	4.5i Age-standardised mortality rate from all cancers for persons aged under 75 per 100,000 population.
PHOF	4.5ii Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population
PHOF	2.20 (i) The percentage of women in a population eligible for breast screening at a given point in time who were screened adequately within a specified period
PHOF	2.20 (ii) The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period
Local	The percentage of people in a population eligible for bowel screening at a given point in time who were screening adequately within a specified period.
Local	Male Cancers – PI to be developed

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan Nothing recorded						
P&EI	Public Health work to increase uptake of cancer screening programmes (eg: breast, bowel)		Commissioning carried out by NHS England not by local team.			Screening uptake.	
P&EI	Public Health commissioning and development of NHS Stop Smoking Support Services. Review of existing contract with provider as well as development of new referral pathways for people in low socioeconomic groups, young people and pregnant women.		Contract with provider already established so may limit expansion of work.			Referrals. Successful quits.	
T	Assess ASCHH PH team action plans for smoking cessation	Any actions relevant to JHWS outcomes					

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
T	CCG Commissioning Plan Improve the uptake of screening	National screening campaigns delivered through local communications		Macmillan Cancer Support piloting electronic support tool for GPS	Anant Sachdev (CCG)		
T	CCG Commissioning Plan Reduce smoking prevalence	Smoking cessation providers and general practice as commissioned by Public Health			Anant Sachdev (CCG)		
T	CCG Commissioning Plan Improve the specificity of cancer referrals	Education through cancer clinical leads on improving detection of suspected cancers			Anant Sachdev (CCG)		
LTC&S	CCG Commissioning Plan Nothing recorded						

Discrete Theme 5: Mental health

Priority 5 – Education, skills and employment

(Also proxy measures for prevention of social and emotional isolation)

The recent review "Is work good for your health and wellbeing?" concluded that work was generally good for both physical and mental health and wellbeing. Young people who are not engaged in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood.

Overarching health improvement and equalities outcomes

ASCOF	1F The proportion of adults in contact with mental health services in paid employment (see NHSOF 2.5, PHOF 1.8)
ASCOF	1E The proportion of adults with learning disabilities in paid employment
NHS	2.2 Employment of people with long term conditions
Local	Number of adults participating in skills bank, knowledge bank or timebank
Local	Number of adults access DAAT services in paid employment
Local	(Adult Lifelong Learning Measures to follow
Local	6 (d) To help you as a carer over the last 12 months, have you used any of support or services provided by different organisations, such as a voluntary organisation, a private agency or Social Services, but not from unpaid help from family and friends to keep you in employment? Source: 2012-13 Personal Social Services User Experience Survey of Carers

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Public Health Survey – will include questions around mental health and social isolation.		Challenge to adequately assess social isolation as part of larger survey – although nationally valid and standardised items are available.			Survey data.	

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Suggestion Workshops for young adult carer NEETS Rationale Most young adult carers aged 18-24 experience significant financial hardships as a consequence of caring and living in a low income family where there is physical or mental ill health, disability, and alcohol or drug misuse. Family income is very tight and there is strong evidence of poverty and social exclusion for all family members and of young adult carers using their own money to subsidise the needs of parents. Some unemployed young adult carers feel very much alone and unsure of how to make progress in accessing the labour market. Low self-confidence and not having the necessary qualifications impeded their success or they simply felt that combining caring and work was not feasible.	Personal and health budget policies Phil Ellis-Martin's work on small and micro-enterprise Carers' Strategy Young Carers' programmes Benefits strategy Mental health strategy Programmes addressing social and emotional isolation	Capacity/resources unknown Identification of ongoing sources of assistance for aspects such as: identification of skills, CV writing, interview techniques Peers support groups	Development of small businesses/micro-enterprises in the social care market Development of personal budgets Development of personal Health Budgets			
P&EI	Local Economic Partnership Plan Skills, knowledge and time banking schemes						

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Learning Disabilities Strategy 2008 - 2013 4.5. We will work with colleges so that people with a learning Disability can choose courses which will help them get the life they want.	Local Economic / Regeneration Partnership Breakthrough Employment Bracknell and Wokingham College	Courses are not always pitched at the right level.		1. Fulfilling Lives Work sub groups of the Learning Disabilities Partnership Board/ Breakthrough/ LD management team.	To develop courses that meet local needs and helps people into jobs.	Developed links and courses with Bracknell and Wokingham College. Introduced buddying scheme at the college.
P&EI	CCG Commissioning Plan Comprehensive CAMHS Strategy – We all have a part to play,		Reliable data Waiting list for CAMHS Tier 3		CAMHS Partnership		
T	CCG Commissioning Plan IAPT utilisation and delivery of prevalence Quality indicator	Mental health and IAPT services Social care			CCG		
T	CCG Commissioning Plan Work to include the MH services in the Integrated care team model	Integrated care team			CCG		

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
T	CCG Commissioning Plan We will work in partnership with stakeholders to develop outcome and evidence based care pathways for mental health and learning disability services. The involvement of stakeholders, users and carers will be key. This will allow us to introduce Payment by Results [PBR] and allow future commissioning to focus on key outcomes and quality/performance standards. Key outcomes for this work will include: Quality standards for liaison with other key services, such as primary care and physical health services Improving the availability of outcome-based psychological therapies to all patients in specialist mental health services We will ensure there is a single care pathway so children and young people can seamlessly and safely access “step up/ step down” (repatriation) care. We will within our mental health contract focus as a priority on the continuing improvement of NHS services’ response to patients presenting with a risk of suicide or serious self-harm through CQUINs, Quality standards and			Services based upon clinical and patient recorded outcomes We will review availability of services locally over weekends and bank holidays and how these services interface with emergency/ urgent care. We will review the provision of alternative Places of Safety for under 18s. building upon the CQUIN developed and implemented from 2011onwards. to be implemented through the joint Learning Disability Self-Assessment standards, in partnership with the Unitary Authorities and the Learning Disability Partnership Boards.		Improved patient and carer involvement in the development of service outcomes Services provided where appropriate within Berkshire with minimal usage of out-of-area treatment and residential care Improved access to services for people from BME and minority groups, and for older people Reduced admissions of young people to Tier 4 inpatient units. Shorter lengths of stay of young people in Tier 4 inpatient units. Reduced out of county fostering, community home and residential school placements for young people, reducing the potential for family	

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
T	Children and Young People's Plan Prioritiy: Improve outcomes for children and young people, especially those more vulnerable : Focus on targeted work with young people who are NEET, or at risk of becoming NEET				11 – 19 Partnership		
LTC&S	Long Term Conditions Strategy 1.2.2 Support training to enable the development confidence and personal skills for individuals with long term conditions				Head of Long Term Community Support	Individuals will have the confidence and personal skills they need to engage in the community	As above
LTC&S	Autism Strategy Increase employment opportunities ASD training for Breakthrough staff and employing Managers within Adult Social Care & Health and NHS				Development Officer		Implemented. Some staff have had training some still to have.
LTC&S	Autism Strategy Increase employment opportunities Breakthrough to develop employment plan specific to people with ASD				Development Officer		Specific plan designed and implemented

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
LTC&S	Autism Strategy Increase employment opportunities Delivery of awareness sessions / training to local employers				Employment Plan		Employment Plan provided
LTC&S	Autism Strategy Increase employment opportunities Micro Enterprise initiatives				Development Officer & Berkshire Autistic Society		Work commenced with BAS.
LTC&S	Autism Strategy Increase employment opportunities Development of Social enterprise giving people with ASD employment opportunities				Development Officer		Work commenced with BAS.
LTC&S	Autism Strategy Increase employment opportunities Support / Services provided by a range of partner agencies (Connexions / Job Centre / Further Education etc) are reviewed to ensure that all needs are addressed but minimises duplication of effort				Development Officer		Review completed.
LTC&S	Autism Strategy Increase employment opportunities Coaching and or mentoring services for managers/employers in order to enhance employment opportunities				Development Officer		Mentoring scheme being developed with B&W College as pilot. Programme designed and implemented.

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
LTC&S	Autism Strategy Increase education and training opportunities Liaise with FE establishments to identify further education training opportunities and apprenticeships meet and support needs of people ASD				Development Officer		Completed. Adult Learning have agreed two separate specific courses. Review of effectiveness needed.
LTC&S	Learning Disabilities Strategy 2008 - 2013 6.5. Encourage businesses to employ people with disabilities and help set up social firms	Local Economic / Regeneration Partnership	Finding suitable placements and employment. Note: There is an opportunity to work with the Regeneration Partnership to explore work opportunities.			The Council and NHS will lead the way in making at least 6 jobs in their organisations accessible for people with learning disabilities by 2013.	Working with business to promote job carving, easy read job application packs and interview processes.

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
LTC&S	Learning Disabilities Strategy 2008 - 2013 6.2. Continue to help more people to get jobs that pay proper wages	Local Economic / Regeneration Partnership				More people are in employment or Paid Work. Every year 5 more people are supported to find and keep jobs.	Breakthrough Employment are contracted to support people with Learning Disabilities into employment – scope for opening referrals across Adult Care. Fulltime (16hrs) "Ways for Living and Work" course now underway. Pre-employment workshops and travel training courses are also running. There is ongoing development of the employment service.
LTC&S	CCG Commissioning Plan Nothing recorded						

Priority 12 – Prevention of Social and Emotional Isolation

Overarching health improvement and equalities outcomes

Local	Number of people receiving befriending support (proxy indicator)
Local	Number of people volunteering (based on NI6) (proxy indicator)
PHOF	Connected to community measure (in development)

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Long Term Conditions Strategy 1.1.3 Review Befriending/Listening services				Older People's Partnership Board	People who require befriending or listening services will be appropriately supported	Meeting to take place with BFVA regarding current support provided
P&EI	PH Bid Holistic Health and Social Inclusion in Vulnerable Older People				Public Health Bank Workers	Vulnerable older people have the skills and tools to build and maintain relationships and to avoid isolation	Project in development stage
P&EI	Learning Disabilities Strategy 2008 – 2013 2.3 Carry on with our work to make activities for people more interesting, easier to get to and that people can use when they want to – not just at special times		Access to transport.		Fulfilling Lives Group – sub group of the Learning Disabilities Partnership Board	More people are taking part in activities that they want to do in the community	More activities are available. Centres such as the SPACE are located centrally and easier to travel to on public transport.

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Learning Disabilities Strategy 2008 – 2013 5.1 Make sure that there are chances for people with a learning disability to make new friends and have a special relationship with someone if they want to.		Access to transport.		Fulfilling Lives Group – sub group of the Learning Disabilities Partnership Board	There is the right support available to suit everyone's needs those that are eligible.	People can now do the same activities as others which has helped people to make new friendships. The ARK is running Natural networks to help people to meet and pursue mutual interests. The ARK also runs "The Umbrella" – a supported friendship and relationship service.
P&EI	Public Health Survey – will include questions around mental health and social isolation.		Challenge to adequately assess social isolation as part of larger survey – although nationally valid and standardised items are available.			Survey data.	
P&EI	Public Health collaboration with Adult Social Care on Older People's 'Holistic Health' Programme. Aimed at social isolated older people. Funded by Public Health		New project piloting new ways of			Assessment of participant satisfaction,	

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
	Project Grant.		working.			knowledge and confidence.	
P&EI	Public Health collaboration with Housing on Forest Care project. Aims to reduce anxiety by providing extra support and monitoring at home. Funded by Public Health Project Grant.		New project piloting new ways of working.			Assessment of participant satisfaction, knowledge and confidence.	
T	Long Term Conditions Strategy 1.2.4 Review the opportunities and social benefits through assistive technology and ICT	Joint Commissioning Older People's Partnership Board (comms plan in development to promote AT)			Joint Commissioning Lead	Individuals will have the technology they need to be part of the community and not isolated	Options available through use of Personal Budgets and Age Concern Small Grant funded for a project on this topic
T	Long Term Conditions Strategy 3.5.1 Help to develop support groups for individuals with long term conditions, to be led by individuals with long term conditions	Older people's partnership board wants to explore innovative ways of using personal budgets for common interests			Joint Commissioning Lead	People will feel supported by their peers in the community	ULO Report completed. Organisations such as BADHOGS have been successful with small grants.
T	Autism Strategy Support / Prevention Support to develop social interaction opportunities and developing natural sustainability				Mencap / Just Advocacy / Nas / other		Social group and self advocacy group set up.

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
					Partners & Development Officer		Review to be undertaken.
LTC&S	CCG Commissioning Plan Significant additional funding will be used to increase the coverage of IAPT to population. We will continue the work to ensure access to people from BME and minority communities We will increase the numbers of older people entering treatment We will continue to develop competencies and the provision of psychological services to people with co-morbid clinical psychological illness and a physical long-term condition The Chronic Disease Self-Management Programme (otherwise known as the Expert Patients Programme) is a self-management education programme for individuals with any long term condition including COPD; Diabetes; CHD including Heart Failure; Asthma ;Stroke; Depression and Asthma which aims to equip participants with the confidence, skills and motivation to better manage their condition, work more effectively with social and healthcare professionals and take control of their health, thus improving their quality of life and reducing utilisation of healthcare resources.					Talking Therapies service for 13/14 will deliver services to not less than 13.9% of the national predicted population for Berkshire East, while simultaneously exceeding the national requirement of 50% recovery rate and meeting the national 28 day waiting time KPI for the commencement of treatment. By 2014/15, 15% of the national predicted population will be receiving IAPT services.	

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
						1 in 8 people will reduce their harmful drinking through IBAs with cost avoidance from this activity realised in the long term; contribution to the reduction in liver diseases realised in the long term. There will be a reduction in alcohol related A & E admissions and attendances amongst 30 “frequent Flyers”	

Priority 13 – Reduction of high rates of depression

Teenage parents are at increased risk of postnatal depression and poor mental health in the three years following birth.

The prevalence rate of depression and anxiety disorders in veterans is estimated at 53% and 18% respectively. Treatment of veterans should be prioritised of their mental health difficulties are related to their military service, but whether an individual is a veteran is not consistently recorded1. An outcome indicator for this will be developed.

Overarching health improvement and equalities outcomes

ASCOF	1H The proportion of adults in contact with secondary mental health services living independently, with or without support
PHOF	Proportion of teenage mothers with mental health problems, including post-natal depression
NHSOF	4.7 Patient experience of community mental health services
QoF	DEP7. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 2 - 12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care
	Numbers of successful IAPT interventions (to be defined - Angela)
	Depression in CYP- Sandra

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan Nothing recorded						
P&EI	Public Health Survey – will include questions around mental health and social isolation.		Challenge to adequately assess mental health as part of larger survey – although nationally valid and standardised items are available.			Survey data.	

[1] Raising awareness of Veterans' needs within Berkshire. M Nicholson 2012.

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Public Health delivery of Mental Health First Aid training will aim to increase capacity of agencies, services and employers to support those experiencing mental health problems.		New programme.			Training sessions delivered. Organisational action plans put in place.	
P&EI	Public Health collaboration with Adult Social Care on Older People's 'Holistic Health' Programme. Aimed at social isolated older people. Funded by Public Health Project Grant.		New project piloting new ways of working.			Assessment of participant satisfaction, knowledge and confidence.	
T	CCG Commissioning Plan Alcohol Reduction. The project aims to develop an aspect of the pathway for the prevention and treatment of alcohol related illness through Identification Brief Advice (IBA) and work with frequent flyers to reduce alcohol related harm and the utility of secondary care services. The Chronic Disease Self-Management Programme (otherwise known as the Expert Patients Programme) is a self-management education programme for individuals with any long term condition including COPD; Diabetes; CHD including Heart Failure; Asthma ;Stroke; Depression and Asthma which aims to equip participants with the confidence, skills and motivation to better manage their condition, work more effectively with social and healthcare professionals and			Commissioning of 1 WTE Alcohol Health Worker through the DAATs to provide intensive and holistic support to the frequent flyer cohort identified (potentially 30 patients annually).		An Alcohol Specialist Nurse provision will work with the Alcohol Health Worker to ensure the number of A&E attendances and Admissions were reduced for this cohort 1 in 8 people will reduce their harmful drinking through IBAs with cost avoidance from this activity realised in the long term; contribution to the reduction in liver diseases realised in the long term. There will be a reduction in alcohol related A & E admissions and attendances amongst 30 "frequent Flyers" People will be able to manage their Long Term Conditions better and there will be reduced A & E Admissions Talking Therapies service for 13/14 will deliver services to not less than 13.9% of the national	

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
	take control of their health, thus improving their quality of life and reducing utilisation of healthcare resources. Significant additional funding will be used to increase the coverage of IAPT to population. We will continue the work to ensure access to people from BME and minority communities We will increase the numbers of older people entering treatment We will continue to develop competencies and the provision of psychological services to people with co-morbid clinical psychological illness and a physical long-term condition.					predicted population for Berkshire East, while simultaneously exceeding the national requirement of 50% recovery rate and meeting the national 28 day waiting time KPI for the commencement of treatment. By 2014/15, 15% of the national predicted population will be receiving IAPT services.	
LTC&S	CCG Commissioning Plan Nothing recorded						

Multi Theme: 1. Long-term conditions & 4. Cancers

Priority 7 – NHS Healthchecks

Local health organisations will have to provide NHS Health Checks and an increased uptake is important to identify early signs of poor health leading to opportunities for early interventions and preventative action.

Overarching health improvement and equalities outcomes

PHOF 2.22 Age standardised percentage of eligible people who receive an NHS Health Check for diabetes, stroke, heart disease and/or kidney disease

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan Nothing recorded						
P&EI	PH Bid Holistic Health and Social Inclusion in Vulnerable Older People				Public Health Bank Workers	Vulnerable older people know about and have access to NHS Healthchecks	Project in development stage
P&EI	Carers Strategy 1.4 Strengthen and provide support service for carers including tailored training and development programmes which improve their health and wellbeing during their caring role.		Need a lead within the CCG to work with in developing services for carers.		1.4 Phil Ellis-Martin (Development manager)	1.4 Training is in place 1.4 Numbers of people using training	

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Learning Disabilities Strategy 2008-2013 1.3. Carry on our work with staff in hospitals and at doctors surgeries so that they know how to support people better.		Gaps to be identified as part of Learning Disabilities Strategy development 2014-2019		Health Group – Subgroup of the Partnership Board.	By the end of 2011 everyone has the chance to have an annual health check.	Training for NHS staff is in place. There is a named nurse linked to each GP practice and acute trust. LD register is in place and updated There is better liaison with GP's and CTPLD and referrals from GP's are up. Most practices carry out annual health checks.
P&EI	Public Health commissioning and development of NHS Health Check programme. New points of access in the community will be developed.		Current engagement in NHS Health Check programme among GPs is low.			Number of checks offered and delivered.	
T	Carers Strategy 1.5 Promote carers rights to have a health check from their GP.		Need a lead within the CCG to work with in developing services for carers.		1.5 Bracknell and Ascot CCG	1.5 Increase in numbers of carers having health checks.	1.4 Berkshire carers are taking lead on encouraging carers to go for health checks and are publishing a carers guide. Bracknell Forest Voluntary Action runs the group for ex-carers.
LTC&S	CCG Commissioning Plan Nothing recorded						

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
LTC&S	Carers Strategy 1.7 Training and awareness amongst GPs about carers roles, responsibilities and the impact on health and well being.		Need a lead within the CCG to work with in developing services for carers.		1.7 Lynne Lidster	1.7 Training in place. Number of GPs attending.	Carers aware training is on the external website.

Priority 15 – Tobacco and smoking cessation

Smoking is the primary cause of preventable illness and premature death, accounting for 81,400 deaths in England in 2009, some 18% of all deaths of adults aged 35 and over. There is a large body of evidence showing that smoking behaviour in early adulthood affects health behaviours later in life and reducing the uptake of smoking among children is as important as reducing the prevalence of smoking among adults.

The Tobacco Control Plan includes a national ambition to reduce adult (aged 18 or over) smoking prevalence in England to 18.5% or less by the end of 2015.

Overarching health improvement and equalities outcomes

NHSOF	1.2 Under 75 mortality rate from respiratory disease (see PHOF 4.7, NHS, 1.2, COF 1.2)
COF	1.26 Maternal smoking in pregnancy (see PH 2.3 ii)
PHOF	2.14 Prevalence of smoking among persons aged 18 years and over.
PHOF	2.9 Prevalence of smoking among 15 years olds

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan Nothing recorded						
P&EI	PH Bid Holistic Health and Social Inclusion in Vulnerable Older People				Public Health Bank Workers	Vulnerable older people will appreciate the risks of tobacco and will be able to make informed choices around smoking cessation	Project in development stage
P&EI	Public Health commissioning and development of NHS Stop Smoking Support Services. Review of existing contract with provider as well as development of new referral pathways for people in low socioeconomic groups, young people and pregnant women.		Contract with provider already established so may limit expansion of work.			Referrals. Successful quits.	

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
LTC&S	CCG Commissioning Plan Nothing recorded	Any actions relevant to JHWS outcomes					

Multi Theme: 1. Long-term conditions & 5. Mental health

Priority 1 – Appropriate / adapted housing

Settled and appropriate accommodation improves people's feelings of safety and security and helps reduce their risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital of more costly residential care and ensures a positive experience of social care.

Overarching health improvement and equalities outcomes

PHOF	1.6 (ii) Percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi disciplinary care planning meeting.
ASCOF	2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
PHOF	1.15 (i) Homelessness acceptances (per thousand households)
PHOF	1.15 (ii) Households in temporary accommodation (per thousand households)
Local	L 029 Number of households prevented from becoming homeless through casework intervention
Local	Number of people who feel safe as a result of the social care support received Do care and support services help you in feeling safe? (Adult Social Care Survey)
Local	L029 Number of households who considered themselves as homeless, who approached the local authority's housing advice services and for whom housing advice casework intervention resolved their situation (Quarterly)

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Bracknell Forest Assistive Technology Strategy	Bracknell & Ascot CCG Telehealth strategy	Awareness of benefits of integration of teleheath & telecare is low Benefits of understanding of telehealth & telecare to assist improved outcomes on discharge from hospital/reablement need promotion Perceptions of teleheath for more remote monitoring are negative	ForestCare Assistive Technology eLearning course (being developed by BFC Adult Social Care team)			

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Assess BFC Housing Strategy action plan and EIA for related actions	Any actions which could be aligned with JHWS outcomes					
P&EI	Learning Disabilities Strategy 2008 – 2013 2.2 Help people living in care homes to move into their own homes and choose who they want to live with – we need to work with people who are planning for housing so that they know what accommodation people with a learning disability need.		Problems with finding suitable accommodation		Nick Ireland/ Hannah Doherty/ Clare Dawning	Each year more people are living in their own homes with a better range of accessible and adaptable accommodation	86% of people with a Learning Disability are in settled accommodation. The "Out of Borough Project" reviewed all people with a learning disabilities living in care settings, out of borough. The majority wanted to stay were they were currently living.
P&EI	Public Health collaboration with Housing on Forest Care project aimed at preventing falls and other causes of hospital readmission or unnecessary ambulance attendances via the provision of a remote 'life line' and key holding service. Funded by Public Health Project Grant.		New project piloting new ways of working.			Assessment of participant satisfaction, knowledge and confidence. Data on falls and readmission to hospital.	
P&EI	CCG Commissioning Plan Nothing recorded						
T	Assess Assistive Technology Strategy for related actions	Any actions which could be					

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
		aligned with JHWS outcomes					
T	Assess BFC Housing Strategy action plan and EIA for related actions	Any actions which could be aligned with JHWS outcomes					
T	Assess BFC Older People's Accommodation Strategy action plan and EIA for related actions	Any actions relevant to JHWS outcomes					
T	Long Term Conditions Strategy 1.4.1 Ensure individuals are aware of services and resources which are available to enable them to make full use of their existing home				Housing Options Lead	Individuals are aware of Disabled Facilities Grants and Flexible Home Loans as options for enabling them to fully utilise their home	Some progress towards this on-going aim but more work is needed.
T	Long Term Conditions Strategy 1.4.2 Enable new accessible housing as part of new affordable housing developments				Housing Lead	New homes will cater for the needs of individuals with long term conditions	
T	Long Term Conditions Strategy 1.4.3 Work with housing providers to ensure sheltered housing provision in the borough meets the housing needs of local people and enables independent living				Housing Lead	Individuals have the most appropriate accommodation to enable independent living	BFH reviewed sheltered housing arrangements and new structure in place

	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
T	Autism Strategy Housing and Accommodation Support Undertake Housing needs analysis of young people and adults with ASD				Head of LD & Development Officer		Analysis complete and in place
T	Autism Strategy Housing and Accommodation Support Work with Colleagues in Housing and other Partners to meet local need				Head of LD & Development Officer		Implemented
T	CCG Commissioning Plan Nothing recorded						
LTC&S	CCG Commissioning Plan Nothing recorded						
LTC&S	Assess Assistive Technology Strategy for related actions	Any actions which could be aligned with JHWS outcomes					
LTC&S	Assess BFC Housing Strategy action plan and EIA for related actions	Any actions which could be aligned with JHWS outcomes					
LTC&S	Assess BFC Older People's Accommodation Strategy action plan and EIA for related actions	Any actions relevant to JHWS outcomes					

Priority 3 – Dementia: Early Diagnosis, treatment and support

There are an estimated 610,000 people in England with dementia, a number expected to double in the next 30 years. Dementia accounts for more expenditure than heart disease and cancer combined and costs society over £20bn a year. These indicators recognise the importance of recognising and minimising the effects of dementia or preventing it through promoting better lifestyle and exercise, as half of dementias have a vascular component.

Overarching health improvement and equalities outcomes

COF	1.23 People with dementia prescribed anti-psychotic medication
ASCOF	2A Permanent admissions to residential and nursing care homes, per 1,000 population
NHSOF	2.3 (i) Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
NHSOF	2.6 Enhancing quality of life for people with dementia
PHOF	4.16 Dementia and its impacts - placeholder indicator
QoF	DEM1 Number of people diagnosed with Dementia by GP practice
Local	Number / Percentage of people with a new diagnosis of dementia referred to the dementia advisor
Local	Number / Percentage of people with a diagnosis of dementia receiving support from ASCH&H
Local	Dementia friendly communities: the number of organisations that have signed up for the safe place scheme

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Bid for PH Funds to identify Local Approach to Loneliness using new research evidencing people who feel lonely are much more likely to develop dementia in old age	ASCHH Dementia Strategy	Lack of understanding of connection between loneliness and dementia	Capacity/resources unknown Awaiting outcome of PH bid			
P&EI	CCG Commissioning Plan Nothing recorded						

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Joint Dementia Commissioning Strategy 2014-2019		Barriers and gaps will be identified during the strategy development process. The Dementia Partnership Board would benefit from regular representation from the CCG.		Kim Helman is the lead on the development of the strategy, reporting to BF Dementia Partnership Board	An accompanying Action Plan will be monitored by the BF Dementia Partnership Board	Strategy is on schedule to be published January 2014
T	Monitor progress of development of ASCHH Dementia Strategy	Actions that are identified for action which could be aligned with JHWS		As identified by the Dementia Partnership Board			
T	Joint Dementia Commissioning Strategy 2014-2019		Barriers and gaps will be identified during the strategy development process. The Dementia Partnership Board would benefit from regular representation from the CCG.		Kim Helman is the lead on the development of the strategy, reporting to BF Dementia Partnership Board	An accompanying Action Plan will be monitored by the BF Dementia Partnership Board	Strategy is on schedule to be published January 2014
T	Learning Disability Strategy (not noted specifically in strategy but is part of the work of the Health Group of the Learning Disabilities Partnership Board)		Gaps to be identified as part of Learning Disabilities Strategy development 2014-2019		Health Group – Learning Disabilities Partnership Board and CTPLD		Care pathway for dementia has been developed. Screening project completed for people with Downs Syndrome. Awareness training completed. CTPLD working more closely with

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
							dementia services was planned for 2012/13 – progress to be identified as part of Learning Disabilities Strategy development 2014-2019
T	CCG Commissioning Plan Nothing recorded						
LTC&S	CCG Commissioning Plan Nothing recorded						
LTC&S	Joint Dementia Commissioning Strategy 2014-2019		Barriers and gaps will be identified during the strategy development process. The Dementia Partnership Board would benefit from regular representation from the CCG.		Kim Helman is the lead on the development of the strategy, reporting to BF Dementia Partnership Board	An accompanying Action Plan will be monitored by the BF Dementia Partnership Board	Strategy is on schedule to be published January 2014
LTC&S	Healthy Minds: Joint Mental Health Commissioning Strategy 2013 – 2018		Supporting people with dementia has been identified as a priority in this strategy. Representation from the CCG on the BF Mental Health Partnership Board would be beneficial for implementing this.		BF Mental Health Partnership Board with over see this action.	Using depression rate data.	This focussed work has not started

Priority 16 - Weight management, diet, nutrition and physical activity

England, along with the rest of the UK, has one of the highest rates of obesity in Europe and one of the highest in the developed world. Excess weight is a leading cause of type 2 diabetes, heart disease and cancer, and blights lives affected by back pain, breathing problems or infertility leading to low self-esteem and reduced quality of life.

Overarching health improvement and equalities outcomes

PHOF	2.12 Proportion of adults classified as overweight or obese.
PHOF	2.6 (i) Proportion of children aged 4-5 classified as overweight or obese
PHOF	2.6 (ii) Proportion of children aged 10-11 classified as overweight or obese
PHOF	2.6 (iii) Healthy weight of children and young people
PHOF	4.16 Dementia – placeholder indicator to measure better lifestyle and exercise on prevention or mitigation of dementia as half of dementias have a vascular component
Local	Health Survey % of adult population 16+ that eat healthily \\fs_zdm\vol1\Applications\BFBC Apps\Statistical Data Hub\People\Lifestyle-Risk Factors v1.xls
Local	NI057 - Children and young people's participation in high-quality PE and sport (Annually) – no longer measured as an indicator

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	PH Bid Holistic Health and Social Inclusion in Vulnerable Older People				Public Health Bank Workers	Vulnerable older people will have the skills and tools to eat nutritionally balanced meals and to engage in appropriate physical activity	Project in development stage

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Learning Disabilities Strategy 2008 – 2013 1.2 More people will be able to go to the Leisure Centre or other healthy activities at the time that they want to.		Gaps to be identified as part of Learning Disabilities Strategy 2014-2019 development		Health Group – subgroup of the Learning Disabilities Partnership Board.	Everyone who wants to do sports and other activities at the leisure centre and others places in Bracknell can do by 2010	E+ membership card in place reducing costs of leisure activities. Pre-pay cards to be added in September 2013. Access at leisure centres improved.
P&EI	Public Health commissioning and development of NHS Health Check programme. This includes assessment and advice related to weight management. Programme also includes funding for places on Slimming World programme as well as new points of access at leisure centres that will facilitate uptake of physical activity.		Current engagement in NHS Health Check programme among GPs is low.			Number of checks offered and delivered.	
P&EI	Public Health collaboration with learning Disability Services on health Lifestyles programme tailored for people with LD.		New programme.			Sessions delivered. Knowledge and confidence of participants in relation to living a healthy lifestyle.	
P&EI	Public Health collaboration with Children and Young People on deliver of project aimed at increasing physical activity among inactive children and their families.		Maintenance of participation.			Sessions delivered and measures of activity.	
P&EI	CCG Commissioning Plan Nothing recorded						
T	Promote and encourage take up of Activate – GP prescribed exercise scheme				CCG?		

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
T	Promote and encourage take up of Mind for Eating – GP prescribed diet management programme						
T	Learning Disabilities Strategy 2008 – 2013 1.1 More people will be offered a Health Action Plan about what you can do to be health and tells people the		Gaps to be identified as part of Learning Disabilities Strategy 2014-2019 development		Health Group – subgroup of the Learning Disabilities Partnership Board.	More people feel that they know what to do to stay fit and healthy.	Health groups are running. Extensive work completed on people having health action plans. Health needs of people with Learning Disabilities are known.
T	CCG Commissioning Plan Nothing recorded	Any actions relevant to JHWS outcomes					
LTC&S	CCG Commissioning Plan Nothing recorded	Any actions relevant to JHWS outcomes					
LTC&S	Mainly would be health led re school weighing and measuring programme.	Any actions relevant to JHWS outcomes					

Multi Theme: 3. Safeguarding & 5. Mental health

Priority 8 – Vulnerable children and young people

With half of adult mental health problems starting before the age of 14, early intervention to support children and young people with mental health and emotional wellbeing issues is very important. Looked-after children are a particularly vulnerable group at risk of developing mental health problems. These indicators seek to address risks to this group of increased rates of undiagnosed mental health problems, placement breakdown, alcohol and substance misuse, convictions and care leavers not in education, employment or training.

Overarching health improvement and equalities outcomes

Local	NI058 - Emotional and behavioural health of looked after children (Annually)
Local	L092 - Number of children on protection plans
Local	NI072 - Achievement of at least 78 points across the EYF Stage with at least 6 in each of the scales in Personal Social and Emotional Development and Communication, Language and Literacy (Annually)
Local	NI092 - Narrowing the gap between the lowest achieving 20 percent in the Early Years Foundation Stage Profile and the rest (Annually)
Local	NI102.1 - Achievement gap between pupils eligible for free school meals and their peers - Key Stage 2 (Annually)
Local	NI102.2 - Achievement gap between pupils eligible for free school meals and their peers - Key Stage 4 (Annually)
Local	NI104 - The Special Educational Needs (SEN)_non-SEN gap - achieving Key Stage 2 English and Maths threshold (Annually)

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	CCG Commissioning Plan Nothing recorded						
P&EI	Public Health commissioning of School Nursing services.		Poor data. Time devoted to safeguarding work acts as barrier to preventative work.			As per school nursing contract. Includes data relating to National Child Measurement Programme.	

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Learning Disabilities Strategy 4.3. We will carry on working with young people and their families to plan the support that they need when they become an adult		Supporting parents to help their children who are approaching adulthood to make decisions for themselves and become more independent.		LD Management Team	All young people aged 16-18 have a person centred plan.	Just Advocacy support people at Kennel Lane School to develop a person centred plan. Approaching Adulthood strategy has been developed.
T	Continue to target and support vulnerable groups to achieve their potential and narrow the gap in attainment.					Learning and Achievement	Performance at the end of key stage tests. Progress made by children match against national averages
T	Monitor and support looked after children and care leavers in their education career				Looked After Child Education Service	Virtual School Head Learning, Developmentn and Commissioning Manager.	Each LAC has a PEP in place. Care leavers are supported to move into education, employment or training.
T	CCG Commissioning Plan Nothing recorded						
LTC&S	CCG Commissioning Plan Nothing recorded						
LTC&S	Comprehensive CAMHS Strategy – We all have a part to play,		Reliable data Waiting list for CAMHS Tier 3		CAMHS Partnership	Comprehensive CAMHS Strategy – We all have a part to play,	

Priority 10 – Prevention of Domestic Abuse

Overarching health improvement and equalities outcomes

Local	CSP1.01 - Reduce the number of repeat incidents of DA committed by the 2011/12 DASC cohort (Quarterly)
Local	CSP1.02 - Reduce the number of children on Child Protection Plans (CPPs) where DA is a factor and the perpetrator has participated in the DAPS programme (Quarterly)
Local	CSP1.03 - Achieve the detection rate for domestic abuse assaults with injury (Quarterly)
Local	L152 - Overall repeat incidences of domestic abuse (Quarterly)

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Learning Disabilities Strategy 2008-2013 5.4 Make sure that people with learning disabilities are not harmed.		Gaps to be identified as part of Learning Disabilities Strategy development 2014-2019		Multiagency Community Safety Partnership/ Safeguarding Board, LD Partnership Board/ Be Heard.	Set up Safe Place Scheme Locally	Community Safety partnership have Mate and Hate Crime Awareness Campaigns. Also locally operating is Safe Place and Third party reporting schemes which enables people to go to identified people/services for assistance other than police or the local authority. People with learning disabilities are involved in training police officers
P&EI	CCG Commissioning Plan Nothing recorded						
P&EI	a. Equality Action Plan 5.1 (a) Develop Domestic Abuse Service Co-ordination Project (DASC) to address repeat offenders b. Equality Action Plan 5.1 (b)	Community Safety Partnership action plan (Enhanced support packages for victims of domestic abuse in place)			Ian Boswell, Community Safety Manager	a. Full cohort of offenders identified and number of repeat incidents falling b. Offender manager engaged with appropriate members of	a.  Domestic Abuse Co-ordination Project (DASC) has now been running for over a year. There has been a significant reduction in the number of repeat victims/perpetrators as a result of this work. The cohort has now been enlarged to 20. More funding has now been made

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
	Use offender management techniques with perpetrators c. Equality Action Plan 5.1 Work with partners to reduce overall repeat incidents of domestic abuse d. Equality Action Plan 5.1 (c) Raise awareness of DA among professionals e. Equality Action Plan 5.1 (d) Use one to one perpetrator programme to engage with fathers of children on Child Protection Plans as a result of Domestic Abuse (DA)	Domestic Abuse Forum LSCB Children and Young People's Partnership Domestic Abuse Forum Action Plan				cohort c. Reduce by 2% annually based on the baseline of the previous year. (2011-12 – 673 incidents = 41%). Monitoring at quarterly Domestic Abuse Forum meetings d. Training provided to all partner agencies to raise awareness of DA	available, through TVP, to increase this cohort to 50 and Cambridge University are in negotiations to undertake an evaluation exercise. b.  The principals of offender management are now being employed to work with some of the DA perpetrators through the use of the Community Safety Team Offender Manager. This has contributed to the success of reducing repeat incidents of DA among the targeted cohort. The extra funding secured for 2013-14 from TVP will allow extra resources to be engaged to deliver more of these interventions to the increased DASC cohort c.  The overall level of repeat incidents of domestic abuse has not reduced significantly. This is due, in part, to the high number of incidents recorded and the high number of those where there is only 1 repeat incident making intervention difficult. There has been substantial success with a cohort of 11 persistent repeat victims will high numbers of repeats. This has been achieved through the Domestic Abuse Co-ordination Project

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
							(DASC) project. Extra resources will allow the DASC project to be extended during 2013/14 which may have an impact on the overall numbers d.  The Bracknell Forest Domestic Abuse Forum and Executive meet monthly. These meetings include a wide range of partners from the public and voluntary sector. There is a full action plan with good engagement from all the attendees. DA remains the main priority for the Bracknell Forest Community Safety Partnership. The membership includes reps from Children's Social Care, Adult Social Care, Education, Schools, the Probation Service, The Magistracy, Police, Victim Support, Berkshire Women's Aid, Housing Associations and a lay representative. e.  To date 29 children have been removed from Child Protection Plans in cases where the father has worked with the Domestic Abuse Perpetrators Service (DAPS).

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Adult Safeguarding Action Plan Poor awareness of abuse and neglect, information, advice and support and how people access them						
T	CCG Commissioning Plan Nothing recorded						
T	Adult Safeguarding Action Plan Poor understanding of how people are involved in their own safeguarding planning		Poor / misunderstood perception of the support individuals will received				
LTC&S	CCG Commissioning Plan Nothing recorded						

All Themes: 1. Long-term conditions, 2. Sexual health, 3. Safeguarding, 4. Cancers & 5. Mental health

Priority 9 – Prevention of alcohol and substance abuse

People who misuse substances often commit crimes to pay for their drugs or alcohol. There is significant evidence that treatment interventions for the management of substance misuse can help to reduce re-offending. These indicators will be measures of successful outcome of treatment interventions in the community.

It will also serve as a measure of primary and secondary prevention work on the development of problematic substance misuse among vulnerable groups.

Alcohol and drug misuse is a known factor in Domestic Abuse.

Overarching health improvement and equalities outcomes

COF	2.77 Emergency admissions for alcohol related liver disease
Local	Number of alcohol related hospital admissions \\fs_zdm\vol1\Applications\BFBC Apps\Statistical Data Hub\People\Lifestyle-Risk Factors v1.xls Source: Stats.Share
Local	Number of people in treatment, abstinent, completing treatment and re-presenting following treatment – indicators being determined

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	Community Safety Partnership action plan Programmes in place to engage with under 25s who use mephedrone Systems in place to collect intelligence around local problem crime groups and locations				Ian Boswell	Increase engagement levels by under 25s who use mephedrone by 5%	
P&EI	CCG Commissioning Plan Nothing recorded						

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
P&EI	PH Bid Holistic Health and Social Inclusion in Vulnerable Older People				Public Health Bank Workers	Vulnerable older people will appreciate the risks of alcohol and will be able to make informed choices around drinking alcohol	Project in development stage
P&EI	Public Health Survey work will obtain new data on patterns and drivers of alcohol misuse.		Gaining adequate sample.			Survey data.	
P&EI	Public Health work on coordination of Drug & Alcohol Learning Sets aimed at sharing best practice across Berkshire.		Significant time required for planning and coordination.			Participation and reports detailing new strategies and plans.	
P&EI	Public Health work on Alcohol Brief Interventions and other promotional work via pharmacies and other settings.		Maintaining participation in programme among partner agencies.			Interventions and campaigns delivered.	
P&EI	Children and Young People's, Plan: To improve strategic links to the Alcohol and Substance Misuse Group, and continue multi-agency work to address issues.	Links to DAAT Strategy and Action Plan		Young People's Drugs Worker Targeted Youth Support in Schools and Youth Slubs Mephedrone Action Group	Youth Offending Service Targeted Youth Service	Number of young people in treatment. Numbers of programmes delivered to young people	
T	Older People's Partnership Board Older People's Strategy 2013-2016 New evidence on older people's consumption of drugs and alcohol is emerging and a report is due to be sent to Sept board	DAAT Community Safety Team	At this stage, poor understanding of issue, extent and impact		Mira Haynes /		

Work stream	Actions	Potential Integration	Barriers	Resources	Lead	Measures	Progress
LTC&S	CCG Commissioning Plan Nothing recorded						