Appendix 1 - Hillingdon Health and Wellbeing Strategy - Partnership Action Plan 2013/2014

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
Priority 1 - Improved health and wellbeing and reducing inequalities As a priority we will focus on physical activity and obesity.						
1.1 To increase physical activity levels by 5% each year for the next three years to improve health, wellbeing and help tackle levels of obesity	Develop and begin to implement a three year strategy to increase participation in physical activity	Physical Activity Strategy Group	Increase the number of residents participating in regular exercise by 7,000 people through a range of targeted initiatives including; a) Develop a programme to increase activity for adults and older people	(a)-(h) 31/03/15	On track. Just over an estimated 3,500 additional adults, older people, children and young people are now taking part in regular exercise since the programme commenced from April 2012. a) A range of programmes have been developed and delivered which is proving successful in engaging residents of all ages and abilities in regular exercise. These include: • A new programme of dances (tea dance, disco, bollywood and line dancing) is in place. There has been an estimated 1,572 people attending these dances since April 2013. Take-up of free swimming sessions for older people is increasing. From the latest information available, between 1st April 2013 and 30th November 2013, a total of 19,564 free swimming sessions have been taken up by older people: 35% higher (+5,009 swims) than the same time last year. Typically 1,900 older people take up the free swimming every year. • The Specialist Health Promotion Team arranged for 5 staff from extra care schemes to be trained to run chair based exercise programmes. Exercise events are planned during February 2014 in community settings. • The 'drummunity' project for people with dementia is proving successful. From September to December 2013 48 service users took part. 10 staff have been trained to deliver the sessions. Feedack from relatives, carers and staff has been very positive. Participants were observed to be happier and with greater strength in their drumming. • 16 people have taken part in a new stroke exercise rehabilitation class and around 80 people are engaged in cardiac referral classes at Highgrove Pool. 62 people have engaged in the free jogging programme. • Back 2 Sport programme is proving successful (April – Sept) - 330 new participants with 107 classed as new to sport. 60% increase in overall participation over July – Sept from 1970 to 3331	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
			b) Develop a programme to increase activity for children and young people		(b) 23 new families have been engaged in the 2-4 programme at three Children's Centres. Training for Children's Centre staff organised. 40 young people have taken part in the 'Fit Teen' weight management programme and now expanded to Hayes and Uxbridge. 120 primary age children are engaged in the 'Ready, Steady, Boost programme'. A programme to increase delivery in Early Years settings established. Multi-sport programme for primary age children organised. Set-up dialogue with school games organisers to link with community delivery. 460 children completed bike ability levels 1 and 2. 2,651 children completed pedestrian safety training.	GREEN
			c) Set up travel plans		(c) Travel plans required for new residential and commercial development. 74 identified business travel plans in the database and 14 plans are being monitored For schools, 27 schools registered for Key stage 1 'Walk once a week': 53 schools involved with Walk on Wednesday.	
			d) Show an increase in cycling and walking		(d) New information has been produced to encourage residents to 'Explore Hillingdon'. Organised cycle rides 'Age Well on Wheels' have been organised. There are 30 residents who are registered and regularly take part in the rides. Further work is underway to encourage take-up of these cycle rides across the Borough. The Healthy Walks programme - there are 150 registered walkers who walk a minimum of once a month. Walks (Explore Hillingdon April – Sept) • Throughput 2,172 • 134 new walkers • 78 people registered with at least 1 health condition 2651 children completed pedestrian safety training.	
			e) Recruit volunteers to support local networks		(e) 'Sportunity' volunteering programme for 14-25 yr olds set up that provides incentives for young residents interested in sports leadership. Green spaces volunteering opportunities – approx 70 people with 10 new volunteers in last 12 months. Estimated 70+ volunteers at Eastcote House Gardens. New Cycle Ranger programme developed to help deliver LBH biking Borough programme.	

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
			f) Review and support opportunities for people with disabilities		(f) 'On Your Marks' scheme established in partnership with DASH, providing new swimming and multi-sport activities for disabled adults. A 'Shine the Light' sports event for disabled adults was held at Brunel University in the Summer to celebrate one year since the torch relay passed through Hillingdon. Around 80 people with disabilities attended.	GREEN
			g) Set up care pathways with Primary Care and Public Health		(g) Reviewed delivery of existing cardiac referral scheme. New trial scheme for stroke patients established with 'Fusion'. New 'Let's Get Moving' physical activity referral programme being explored. This will provide a general scheme available to all residents through GP's, Health Checks and other health practitioners. Diabetic patients referred by Specialist Diabetic nurses to the Walk programme. Pilot developed with Macmillan Cancer Research into walk programme to include linking in with new Cancer Information System at Hillingdon Hospital. Physical activity pathway for cancer patients in place. Opportunities for physical activity being included in training for health professionals administering NHS Health Checks.	
			h) Develop the Change 4 Life campaign to encourage residents of all ages to participate in physical activity.		(h) Pledge system established with incentives to encourage more people to be more active, more often. Regular articles in Hillingdon People, through social media etc.	

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
1.2 Help to tackle fuel poverty to improve health and wellbeing	Reduce fuel poverty	LBH	(a) Improve 70 private sector homes for older vulnerable people. • 30 heating measures • 30 insulation measures • Complete essential repairs to 10 homes for vulnerable & older households (b) Deliver Age UK Hillingdon's Housing Options Service and Winter Warmth Campaign	(a) 31/03/14 (b) 31/03/14	(a) Since April 2013, improvements have been made to 83 homes of older people in Hillingdon as follows: • Heating improvements have been made to the homes of 27 older people. • 46 homes with improved insulation measures. • 10 homes of older residents received essential repairs as needed. Essential repairs can include roof and glazing repairs to reduce health and safety risks. Further improvements are scheduled by March 2014. (b) Ongoing – The campaign was promoted at the Older Persons day on 1st October 2013 including an event held in Uxbridge Town Centre. The event held was very successful with a good variety of stands offering a comprehensive range of information to older people and a good flow of visitors throughout the day. The Age UK Hillingdon Information and Advice stand saw 144 people and specifically gave out 21 Winter Warmth leaflets, following discussion with visitors about the campaign. Age UK continue to provide advice and guidance to older people through their outreach work to help older people keep warm and well this winter.	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
Priority 2. Prevention and early intervention As a priority we will focus on: • Reducing reliance on acute and statutory services; • Children's mental health and risky behaviours; • Dementia and adult mental health; • Sight loss.						
2.1 Reduce reliance on acute services and prevent avoidable hospital attendances, admissions and readmissions. Deliver the out of hospital strategy.	Develop and implement plans to prevent avoidable admission or readmission into hospital and avoidable demands on social care services by 31/03/15.	Integrated Care Steering Group	(a) Integrated Care Program to increase the number of people with long term conditions who have a multidisciplinary care plan, specifically targeting at risk groups with diabetes, respiratory disease and the frail elderly b) Enhance the number of people who are transferred home with support from emergency assessment beds at Hillingdon Hospital c) Increase the complexity of people managed in the community by intermediate care services to include dementia and older people with mental health needs	(a) 31/03/14 (b) 31/03/14 (c) 31/03/14	(a) Ongoing - The Integrated Care Programme (ICP) went live in 2012 providing a joined up approach to patient care across health and local authority services based around case discussion at GP practices. 87% of GP practices have now signed up to the new ICP services. The programme is targeting residents with complex care needs (older frail people, those with diabetes, people with mental health needs, chronic obstructive pulmonary disease and patients with cardiac difficulties). An evaluation of the programme from the first year is showing positive results including higher rates of agreed care plans completed, positive feedback from patients, high levels of involvement from teams and changes in the way of working which are delivering efficient practices. Further updates will be reported to the Board from ongoing monitoring and evaluation of the initiative. (b) Ongoing. Key services are in place and delivering benefits. This includes TeleCareLine, reablement and essential support from the voluntary sector through the 'prevention of admissions and re-admissions' service from Age UK. (c) On track – A flexible service will be commissioned to meet bed-based care needs on a short-term basis. Service expected to be in place by Spring 2014.	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
2.2 Improve access to local Child and Adolescent Mental Health Services (CAMHS)	A review of mental health provision for children and young people across the following sectors in the borough: the NHS, social care, education, schools, public health, criminal justice, third sector, adult social care.	CAMHS	(a) Clarify statutory responsibilities for all delivery partners regarding services in scope (b) A map of local CAMHS/mental health and Learning Disabilities/Challenging Behaviour provision at all tiers for services in scope: service provision, service capacity, referral access (c) Identify local population needs and initial recommendations regarding meeting service gaps (d) An evidence review of "what works"; and feedback from users (e) Whole systems service design for child mental health support	a) 31/12/13 b) 31/12/13 c) 31/12/13 d) 31/01/14 e) 31/03/14	(a-e) Senior Team to Team meeting established with health commissioners as overarching steering group. CAMHS Working Group formed with health commissioner, local authority and provider representatives. Project charter developed. The arrangements to progress proposals are in place and updates will be provided to future meetings of the Board.	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
2.3 To continue to reduce teenage pregnancy rates and reduce STIs in young people.	To promote awareness of the risks and to increase take-up of screening.	Public Health	(a) Pilot the extension of the Outreach Contraception and Sexual Health Advice to vulnerable Young People: Children Looked After, Homeless Young People, Young Carers, Drug and Alcohol Users. (b) Increase the Chlamydia Screening uptake by the Brunel University population: a) Increase Awareness of the Chlamydia Screening service on Campus, b) Refocusing the service to repeat Chlamydia testing annually or on change of partner/s.	a) 31/03/14 (b) 31/03/14	a) Currently, the focus of the pilot is on LGBT using LGBT Needs Assessment. A stakeholders meeting was held on 14.11.13 to assess current provision of services to LGBT and plan development work in partnership. Stakeholders include partners working with vulnerable groups-THT, Navigator, YMCA, Youth Service. b) Terrence Higgins Trust providers of Chlamydia Screening are investigating various ways of using IT to increase Chlamydia Screening awareness at Brunel i.e. via the university Intranet/emails. Training undertaken for University Medical Centre and Pharmacy in Term 1 (Oct-Dec).	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
			(c) Develop a proposal to extend the current Emergency Hormonal Contraception service, from under 18yrs to under 25yrs and based on local evidence, include a further 9 Pharmacies in the revised TP hotspot wards (ONS 2011)	c) 31/03/14	c) Potential interested eligible Pharmacists have been identified. Emergency hormonal contraception training being developed. Patient Group Direction (note: PGD is a specific written instruction for the supply or administration of a named medicine in an identified clinical situation) has been updated and signed by the CCG, Public Health Consultant, Service Lead and Pharmacist on 5.11.13	
2.4 Develop the model of care for dementia	Reduce dependency on institutional care, including hospital bed days and care home settings.	Mental Health Delivery Group	(a) Finalise and begin to implement a joint plan for dementia services to include a service model that delivers effective assessment, treatment and community based support and intervenes earlier in the course of the disease. (b) Agree a joint implementation plan for years 2 and 3 of the Adult Mental Health Strategy.	a) 31/03/14 b) 31/03/14	(a) On track. Adult Mental Health strategy in place including dementia. A mental health task and finish group has been established to co-ordinate and implement the agreed plan for adult services of all ages. The plan will complement work already underway and being delivered which includes befriending services, dementia cafes, programmes which promote healthy living and health improvement and increasing early intervention for memory assessment. (b) Ongoing. Plan will be recommended for consideration by the Health and Wellbeing Board.	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
2.5 Improve pathways and response for individuals with mental health needs	To ensure information and access to support is available for people with mental health needs, and that pathways are in place to enable appropriate responses to need	CCG	(a) to develop crisis response and ongoing support of 14 weeks for older people with mental health needs including dementia	(a) 31/03/14	(a) Service developed to an integrated model, which is embedded across the new service elements; the rapid response, ICP, memory service and intermediate care for people with mental health and dementia. The new provision will equip carers with the appropriate skills and resources to navigate patients away from unnecessary admissions and access home based care and support patients to be discharged back to home.	GREEN
			(b) to implement urgent assessment pathways and with all mental health providers to enable a consistent response and standards of care across the whole system	(b) 31/03/14	b) To implement common standards for urgent assessment and care so that service users experience a consistent response when referred for an urgent need. This will include: 1. develop and implement standardised processes for urgent referral agreed with stakeholders. Standards have been agreed. 2. Identify and address training needs and appropriate health and social care record-keeping to support effective shared care and provide high quality care pathway - local implementation plan under development with providers. 3. Ensure onward pathways are developed to support improved patient experience when accessing services via urgent referral - on track.	
			(c) to evaluate the liaison psychiatry pilot programme and identify benefits to improved liaison between physical and health care needs for 14/15 .	(c) 31/04/13	c) The psychiatric liaison pilot - interim evaluation showed benefits to service using qualitative and quantitative methods. Further work to review the extension of service model will require the development of a business case. Move to business case development stage for 14/15. Service Specification has been developed. LPS service will be based on costed service model for 14/15.	

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
2.6 Reduce alcohol-related harm for hazardous, harmful and dependent drinkers in Hillingdon	Commission a range of interventions to reduce alcohol-related harm and to increase the numbers of alcohol clients referred from acute and primary care settings into community-based treatment services.	Public Health	(a) Increase numbers of alcohol clients presenting to the treatment system and in structured treatment (b) Increase the numbers and rate of alcohol clients successfully completing and exiting treatment.	(a) 31/03/14 (b) 31/03/14	(a) from the latest available data, 519 clients in treatment in quarter 2 (where alcohol is the primary drug) – a small reduction compared to the previous quarter. (b) from the latest available data – 178 clients exited treatment in the 12 months ending quarter 2 2013/14, this represents a 'successful completion' rate of 34.3% - which is a slight reduction on the baseline position. The commissioning of substance misuse services (drugs and alcohol) transferred to the London Borough of Hillingdon (LBH) on 1st April 2013. The service is currently under review as part of the BID Transformation review. The aim of the review is to understand the current position and to identify priorities for a future model of delivery. The redesign of local substance misuse services will take alcohol related needs into account.	GREEN

<table>
<tr><th>Objective</th><th>Key Task</th><th>Lead</th><th>Subtasks</th><th>Deadline for Subtask</th><th>Progress Update</th><th>RAG</th></tr>
<tr>
<td>2.8 to reduce the extent of low birth rate

<u>Smoking in Pregnancy:</u> Babies from deprived backgrounds are more likely to be born to mothers who smoke and to have much greater exposure to secondhand smoke in childhood. Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality.</td>
<td>To develop a targeted programme in geographical areas with high rates of low birth weight babies, to increase the confidence and participation of parents/women to have healthy babies.</td>
<td>Public Health</td>
<td>(a) <u>12 week assessments</u> -Increase the percentage of women who have seen a midwife or a maternity healthcare professional, or had an assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy. (National indicator target 90%)

(b) <u>Low Birth Weight</u> - Decrease the percentage of Live and Still Births less than 2500 grams.

(c) Low Birth Weight of Term Babies: (ie. less than 2,500 grams):</td>
<td>(a) 31/03/14

(b) 31/03/14

(c) 31/03/14</td>
<td>(a) There has been a proactive effort to ensure that our target rate has been achieved.

12 Week Assessment - 2012/13 Performance:
<table>
<tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>79.9%</td><td>79.9%</td><td>94.3%</td><td>90.2%</td></tr>
</table>
<u>2013/14</u>: The Commissioning Support Unit have confirmed that the Department of Health will not be collecting maternity assessment data until the new year and that it will be obtained directly from the providers rather than CCGs.

<u>b) Task and finish group ('Having a Healthy Baby')</u>: To plan interventions for the south of the borough which has higher rates of late bookers and low birth weight babies. Interventions include:
o Referrals to Stop Smoking Prevention and support
o Referrals to Healthy weight management courses
o Linking up with Hillingdon Maternity volunteers to promote and sign-post to Stop Smoking services, Healthy Weight Management courses, 'First Aid in the home' courses.
o Agreeing ways to gather information to help plan services including what having a healthy baby means for women (i.e. those of child bearing age and older women) living in the South of the borough and how this impacts on the uptake of pre-conception and maternity services.
o Director of Public Health to meet with the Chair of the Hillingdon Maternity Services Liaison Committee to discuss proposed action plan regarding sign-post to Stop Smoking services, Healthy Weight Management courses, 'First Aid in the home' courses via the service users 'Walking the Patch Team'.

c. Stocktake of 'Conception to Age 2 Framework' has been completed. The outcomes of this will feed into the Maternity Services Liaison Committee, Public Health and early Years Group, Perinatal Depression Group to inform and align work around local maternity services.</td>
<td>GREEN</td>
</tr>
</table>

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update	RAG
2.9 To prevent vaccine preventable childhood diseases	To increase uptake of childhood immunisations	NHS England	To provide independent scrutiny and challenge the plans of NHS England, Public Health England and providers. (NB The national target for childhood immunisations is 95% for each of the vaccines for the under-fives childhood immunisation schedule and 90% coverage for HPV in school-aged girls).	31/03/14	NHS England Historically Hillingdon has a high take-up level of immunisations. The latest data for MMR shows take-up is improving and is higher than England take-up rates. From the latest available data; <u>MMR data for Apr-Sept 2013</u> MMR 24 Months = 93.1% (England, 92.7%) MMR (1 dose) 5 years = 94.6% (England 94.3%)	GREEN
2.10 Tackling the issues which can cause sight loss	To develop support and services locally which reduce the effects of sight loss	Vision Strategy Working Group	(a) Working with the Thomas Pocklington Trust and other local partners develop a vision plan and local support services.	(a) 31/03/14	(a) Pocklington Trust is in the process of collating needs information provided by stakeholders. A project group meeting will be taking place in December 2013 to review needs data and identify gaps. An action plan will be developed for consideration in Q4. Intention is to have priorities agreed by 31/03/14 that will inform commissioning plans.	GREEN

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update	RAG
Priority 3. Developing integrated, high quality social care and health services within the community or at home As a priority we will focus on: • Integrated approaches for health and well-being, including telehealth; • Integrated Care Pilot for frail older people as well as diabetes and mental health.						
3.1 Assist vulnerable people to secure and maintain their independence by developing extra care and supported housing as an alternative to residential and nursing care	Increase independent accommodation in line with housing support plan	LBH Officer Group/HIP	(a) Provide adaptations to homes to promote safe, independent living. (b) Extend the TeleCareLine service to a further 750 people (c) Provide extra care and supported accommodation to reduce reliance on residential care	(a) 31/03/14 (b) 31/03/14 (c) 31/03/14	(a) A total of 138 homes have had adaptations completed to enable disabled occupants to continue to live at home. This is made up of 90 Disabled Facilities Grants for owner/occupiers and private tenants, and 48 Council tenants. (b) As at 31st December 2013, 2,645 new service users were in receipt of a TeleCareLine equipment service. The technology is helping people to live safely and independently at home. The take-up of TeleCareline is exceeding the target of 750 new service users set for each year of the scheme. The scheme is being extended from April 2014. (c) On average 1 placement is made per month into extra care for older people who would otherwise have to move into residential care. Glenister Gardens, a 12 bed supported living scheme for clients with learning disabilities, is fully occupied. The supported living building programme is currently being reviewed to ensure it meets the current and future needs. 4 bespoke small schemes are being developed for clients with mental health needs or learning disabilities who will benefit from shared accommodation.	GREEN

3.2 Deliver end of life care and support services	Improve the quality of end of life care for residents	End of Life Forum	(a) Develop work with the ICP programme to assist in identification of 1% people expected to die within a 12 month period.	(a) 31/03/14	(a) The ICP for Frail Elderly patients is well developed and in use by GP's to develop advanced care plans utilising 'Co-ordinate My Care' (CMC). CMC is an electronic patient care record system that allows all organisations with access to an N3 connection to view the patients care plan and their wishes in terms of the end of life phase of their illness. Macmillan and Hillingdon CCG are working in collaboration to fund a three year GP clinical lead to provide assistance in the form of education and training to Hillingdon GPs with the process of identification of patients who should have an advanced care plan.	GREEN
			(b) Develop information sharing protocols between statutory, voluntary, private and independent sector partners regarding early identification of people approaching end of life.	(b) 31/03/14	(b) A three year strategy (2013-2016) has been documented by the Pan Hillingdon End of Life Forum.	
			(c) Develop a process for measuring quality for end of life care in Hillingdon.	(c) 31/03/14	c) Agreements are in place to measure quality in relation to documented preferences as recorded in the CMC Care plan. Patients who have their preferences recorded on CMC are more likely to achieve their preferred place of care at end of life. Figures received in November from Public Health demonstrated that for the first 6 months of this financial year, 50% of patients died in hospital – compared to the previous 6 months when 68% died in hospital .	

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update	RAG
4. A positive experience of care As a priority we will focus on: • Tailored, personalised services; • An ongoing commitment to stakeholder engagement.						
4.1 Deliver personalised adult social care services through the Support, Choice and Independence programme.	Increase the number of people in receipt of a personal budget to give residents greater choice and control over the outcomes they consider to be important.	LBH	(a) Promote take up of personal social care budgets to provide greater choice and control	(a) 31/03/14	(a) A personal care budget gives people who need care and support a greater say on deciding their support arrangements to suit their own needs. As at 31st December 2013, overall 75% of social care clients (2,317 clients) were in receipt of a personal budget (based on services which are subject to a personal budget). Take-up of personal budgets is higher for older people (81%).	GREEN

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update	RAG
4.2 Ensure that local residents have opportunities to get involved in and have a say about services which improve health and wellbeing.	Develop opportunities for residents to get involved.	Task and Finish Group to review	(a) Establish the current requirements and arrangements for stakeholder engagement across health and the Council to support improvements in health and wellbeing (b) Make recommendations to the Health and Wellbeing Board to establish a co-ordinated plan of stakeholder engagement in Hillingdon for Health and Wellbeing	(a) 31/03/14 (b) 31/03/14	(a) On track. A group has been established to review and co-ordinate stakeholder engagement across health and social care. The leads for engagement across health and social care will develop recommendations for consideration. The recommendations will be practical and focus on supporting meaningful involvement of local residents. (b) On track – recommendations will be presented to a meeting of the Board in 2014. Under the auspices of the Better Care Fund work, a stakeholder group has been formed to provide feedback on the plan. An initial meeting was held on 17th January 2014 and a further public engagement event is proposed for February 2014. A communications plan for the Better Care Fund has been drafted.	GREEN