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 under an estimated 4,000 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: • Programme of dances delivered (tea dance, disco, bollywood and line dancing). There has been an estimated 2,338 people attending these dances since during 2013/14. July 2013 evaluation: 51% valued tea dances as a way of being active and 77% reporting wellbeing benefits. • Chair based exercise class at Wellbeing days delivered - Northwood 45 people, Harefield 40 people. • Back to sport programme proved successful - 498 new participants - 137 being new to sport (participating in sport less than 5 times in the last 2 days). 856 people registered on database with 38% going on to join a regular B2S programme. Continued evidence of adults joining clubs from back to sport programmes (7 Hockey, 4 Fencing, 3 Tennis). • Take-up of free swimming sessions for older people has been high. During 2013/14 a total of 25,971 free swimming sessions have been taken up by older people: 27% higher (+5,438 swims) than the same time last year. Typically 1,900 older people take up the free swimming every year. • The 'drummunity' project for people with dementia is proving successful. Sessions continued at Grassy Meadow, Triscott House and Asha Day Centre. 31 people regularly take part in sessions. New sessions offered in 2 new settings. Feedback from relatives, carers and staff has been very positive. Participants were observed to be happier and with greater strength in their drumming. • Jog it off programme - 6 weekly sessions averaging 20 runners per week. All sessions have a Run England trained leader. Total attendance for all sessions during 2013/14: 788	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) Regular drop in sports sessions developed as a 'StreetGames' programme for young people now includes football, girls football, boxing, dodgeball and multisport. Additional activities planned for the Uxbridge area. Throughput - 2519, Participants - 222, New Participants - 55 School walking and cycling (2013-14) • 1,048 children completed bikeability level 1 and 2 • 5,411 children completed pedestrian safety training • We are currently in the process of recruiting additional cycle instructors and pedestrian trainers to allow an increase in training that can be provided.	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 22 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 during the year to encourage residents to 'Explore Hillingdon'. 3 new volunteers trained to deliver Walk Hillingdon programme. Over 400 volunteering hours given through Walk Hillingdon programme. 60 cycle rangers in place. The Healthy Walks programme - there are 150 registered walkers who walk a minimum of once a month. 172 adults received cycle training (2013-14).	
			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 g) Set up care pathways with Primary Care and Public Health h) Develop the Change 4 Life campaign to encourage residents of all ages to participate in physical activity.		(f) 'On Your Marks' scheme established in partnership with DASH, providing new swimming and multi-sport activities for disabled adults. Programmes continue. 30 participants in Panathlon. DASH sessions average 140 people per week (g) Reviewed delivery of existing cardiac referral scheme. Let's Get Moving programme - 2 advisers recruited. Presentation to 30 pharmacy managers. Links identified within clinical care pathways and referral linked to NHS Healthchecks. Links made with CCG Communications. (h) Lamppost banners promoting a wide range of opportunities. Regular articles in Hillingdon People.	GREEN

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 121 homes of older people in Hillingdon as follows (some older people benefited from more than one of the following): • Heating improvements have been made to the homes of 44 older people. • 63 homes with improved insulation measures. • 104 homes of older residents received essential repairs as needed. Essential repairs can include roof and glazing repairs to reduce health and safety risks. Overall, the target has been exceeded. (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	(a) 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. Most (87%) 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). The programme 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.	GREEN
			b) Enhance the number of people who are transferred home with support from emergency assessment beds at Hillingdon Hospital	(b) 31/03/14	(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) Increase the complexity of people managed in the community by intermediate care services to include dementia and older people with mental health needs	(c) 31/03/14	(c) On track – A flexible service will be commissioned to meet bed-based care needs on a short-term basis.	

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 was established with health commissioners as overarching steering group. CAMHS Working Group formed with health commissioner, local authority and provider representatives. The review of CAMHS has been completed and the recommendations are being considered.	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.	a) 31/03/14	(a) Teenage pregnancy was at its lowest in 2012. There were 139 conceptions recorded and a conception rate of 27.7 per 1,000 females under 18 years old. The maternity rate (those who choose to keep their baby) rose to 12.6 from 7.8 in 2011 along with the lowest abortion rate of 15.2 that Hillingdon has experienced since the baseline period of 1998. The percentage of conceptions leading to an abortion in 2012 was 54.7% - a significant reduction from 2011 when it was at its highest at 72%. (Note: The 2013 teenage conception data will be released in April 2015). The changes may be due to a number of initiatives– which include the appointment of a Sexual Health Outreach Nurse working with young people who ordinarily would not access mainstream community sexual health services; the SRE Officer who worked closely with schools; the commissioned Chlamydia Screening Team's outreach work in educational settings including - Colleges and Brunel University; the 'trusted professionals' sign posting young people to local services.	GREEN
			(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.	(b) 31/03/14	(b) Throughout 2013/14 Terrence Higgins Trust providers of Chlamydia Screening investigated and implemented various ways to increase Chlamydia Screening awareness at Brunel University (eg. via the university Intranet/emails). Training was provided for the University Medical Centre and Pharmacy in (Oct-Dec); rolling out of the C-Card across campus; 7 training workshops for 30 members of staff across five outlets; Targeted awareness raising of the risks on campus focusing on Chlamydia/C-Card and Transgender issues/HIV. In Q3 and Q4 of 2013/14 the Chlamydia Screening Service increased its focus on delivering a more targeted approach using the Diagnostic Outcomes Measure (DOM) and reducing the 'mass screening' approach.	

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) Patient Group Direction (PGD) for Emergency hormonal contraception (EHC) and Chlamydia Treatment developed and signed off in 2013 as well as training for the 28 Pharmacists participating in the scheme. Community Pharmacists are now delivering Condom Card Service as part of the EHC PGD. The proposal to extend the Emergency Hormonal Contraception service to under-25 year olds was developed and is currently being piloted.	
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) 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 a 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 services using qualitative and quantitative methods. Further work to review the extension of service model will require the development of a business case. 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) 528 clients in treatment in Quarter 4, a reduction of 12%. (b) <u>Successful completions (Q4 – 2013-14):</u> 176 clients successfully completed treatment in the 12 months ending Q4 2013/14. This represents a successful completion rate of 33.3% which is slightly lower than the baseline period (ie. 36.4%). (please note: Successful completions is a key measure of a recovery focussed treatment system. On average, alcohol dependent clients assessed as requiring structured treatment, stay in treatment for 6-7 months). <u>Trend Analysis:</u> A request has been made to Public Health England to receive data on performance over the past five years in order to gain a clearer understanding of performance over time. <u>Category Management:</u> The commissioning of substance misuse services (drugs and alcohol) is currently under review as part of the BID Transformation review process. The aim of the review is to fully understand the current position in terms of: the range and quality of services being provided; assessing whether services are meeting the needs of residents and to identify priorities for a future model of delivery. The existing substance misuse contracts that are due to end on 31st October 2014 will be extended to 31st March 2015. A full competitive tender exercise for these services will be undertaken.	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>
The Commissioning Support Unit have confirmed that the Department of Health will commence the collection of maternity assessment data in 2014 and that it will be obtained directly from the providers rather than CCGs.

<u>(b + c) Task and finish group ('Having a Healthy Baby')</u>: Questionnaire has been developed to establish what having a healthy baby means for women (ie. those of child bearing age and older women. The latter often advise younger women on pregnancy) living in the South of the borough and how this impacts on the uptake of pre-conception and maternity services. The questionnaires are being administered via the children's centres and the Maternity Services Liaison Committee's 'Walking the Patch' Team.

Stocktake of 'Conception to Age 2 Framework' has been completed. The outcomes of this assessment has been fed into Public Health and Early Years Group and Perinatal Depression Group to inform and align work around local maternity services. In addition the key outputs regarding Perinatal Mental Health issues have been fed into the children and young people's commissioning group.

Continuing actions include:
• Regular training to maternity and children centre staff.
• Circulation of national promotion/ media.
• Ensure all monitors and equipment maintained and in use across all sites.
• Provide assertive support to pregnant smokers.</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	Historically Hillingdon has a high take-up level of immunisations. The latest data for MMR shows take-up is high and Hillingdon is close to being on par with England take-up rates. From the latest available data; <u>MMR data for October – December 2013</u>, (quarter 3) MMR 24 months = 91%, England 93% MMR (1 dose) 5 years = 92.7%, England 94.4%	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 took place in December 2013 to review needs data and identify gaps. An action plan will be developed for consideration.	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 260 homes have had adaptations completed to enable disabled occupants to continue to live at home. This includes adaptations to the homes of 170 older people. (b) As at 31st March 2014, 2,760 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 has been extended to be free to people aged 80 years or older. (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. Schemes are being developed for clients with mental health needs or learning disabilities who will benefit from shared accommodation.	GREEN

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update	RAG
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 2013 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.	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 March 2014, overall 76.9% of social care clients (2,807 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 (82.2%).	GREEN
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 met 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 to support improved health and wellbeing. (b) Completed – under the auspices of the Better Care Fund work, a one-off meeting of a small stakeholder group was held on 17th January 2014 to discuss engagement. Further work will take place on engagement during 2014/15.	GREEN