Appendix 1

Hillingdon's Health and Well-Being Strategy 2013-2016

DRAFT

1. Introduction – Why we have produced this strategy

All aspects of our everyday life have an impact on our health and wellbeing: from health services through to our environment, housing, employment, education, transport and our involvement in local communities. This means that working to improve community health and wellbeing is everybody's business and in everybody's interest.

For many years there has been a strong partnership between the statutory sector (the Council and the NHS) and the voluntary and community sector in identifying and tackling the specific health and wellbeing needs of people in Hillingdon.

This was strengthened further by the Health and Social Care Act 2012 which established local Health and Wellbeing Boards (HWBs) to improve the health and wellbeing of the local population and reduce health inequalities. The Act also transferred responsibility for public health to local authorities. HWBs must enable health or social care services to work in an integrated manner to advance the health and wellbeing of the people in their area. HWBs are also a forum to work with wider partners to address the other key influences on health such as housing and education.

HWBs bring together local councillors, GPs, directors of public health, adult and children's services. Together, their expertise delivers a collaborative and targeted approach to meet the needs of the local population, including carers. In Hillingdon, the HWB has been working in "shadow" form for the last year but will take up its full powers from April 2013.

The HWBs have the power to agree, in consultation with the local community, the health and social care priorities which would make the most difference to improving health and wellbeing and reducing inequalities in the local area. While the priorities are also informed by outcomes set out in a national framework, this represents a move away from centrally driven targets, enabling Hillingdon's HWB to have a very local focus on benefiting the community it serves.

HWBs must undertake a detailed assessment of local needs, called the Joint Strategic Needs Assessment (JSNA), and then develop a Health and Wellbeing Strategy focussing on how the outcomes which matter most can be achieved or improved. Local people, including the Local HealthWatch organisation from October 2013, will be fully involved in the development of future JSNAs and the HWB strategy. For more information on how to get involved next year please contact the Customer Engagement Team on 01895 250270.

These two documents – the supporting JSNA and the Strategy itself - give direction to the two key decision-making bodies (Hillingdon Council and the NHS's Clinical Commissioning Group) to develop and/or purchase the right services locally to deliver on the strategy. Indeed these bodies have a legal duty to have regard to this strategy.

Hillingdon's Clinical Commissioning Group (CCG) is made up of Hillingdon GPs, practice nurses, hospital staff and a representative from the public. On 1 April 2012 HCCG started work in shadow form, making decisions on how NHS Hillingdon budgets should be spent. It is working towards taking full control as a commissioning organisation on 1 April 2013.

The particular value of the role of the Health and Wellbeing Board is in identifying the issues that this partnership can most influence, for example:

- How working together can bring the most benefit to outcomes for Hillingdon residents

- How we can address the most important local needs, now and in the future
- How we can build on the strengths in our communities and what is already working well
- How we can best protect or include the most vulnerable people in our communities
- How we can work together at a time of public sector financial restraint to use our resources most efficiently.

We have a strong track record of partnership working in Hillingdon between Local Government, the NHS and the voluntary/community sector. This strategy sets out our plans to continue to work together with our residents in an attempt to tackle the most pressing health problems in Hillingdon.

Health and wellbeing is good overall, but we are determined to build on our record to date and make it even better for the longer-term.

2. Our approach and common principles

In order for this strategy to work, all of the various partners need to work to an agreed and common set of principles. We think that these principles should be:

- Residents want to have a say about the services they use
- Most residents prefer to be treated as close to their homes as possible
- Preventing disease and illness is always better than curing it
- When illness does occur, the sooner services can help people, the better
- People prefer to live as independently as possible, at home and within the community as opposed to institutional settings.
- Technology can help residents to live independently when they are unwell or have health and care needs
- Both statutory and voluntary sectors are working with limited resources so we all need to make sure we make best use of the finances that are available. This may lead to difficult choices but our collective focus must be on those services which offer the greatest benefits and the greatest value for money to Hillingdon's residents.
- All services need to evidence the benefits they offer to residents and be open and honest about how well they are performing generally
- All of the various services helping to deliver health and wellbeing in Hillingdon need to work together and communicate well with each other and with Hillingdon residents

We are facing unprecedented financial challenges at a time of major organisational change so it is imperative that the HWB is able to balance needs carefully and to influence its constituent organisations to make difficult decisions about priorities.

We will continue to find ways to build and sustain value for money local services as opposed to making blanket cuts. We want to continue to use available health and social care budgets to focus on delivering improvements to health outcomes for local people. We will look at all services to assess whether they are desirable, affordable and sustainable in order to prioritise our expenditure.

From 1 April 2013 public health services will be funded by a ring-fenced budget based on historic spending. In the future it will be based on relative population health need and weighted for inequalities but it is not clear at present when this needs-based funding will be introduced. Public health services funding will be kept separate from the budget managed through the NHS Commissioning Board for healthcare to ensure that investment in public health is maintained.

A further budgetary consideration is the government's proposed 'Health premium', designed to incentivise action to reduce health inequalities with a cash incentive. Payment will be dependent upon the Council making progress against certain public health indicators. However payments will not be made until 2015/2016.

3. Information that directs our strategy

Our health and wellbeing strategy has been developed to meet the needs identified in the joint strategic needs assessment (JSNA).

The JSNA is the process we use to identify the current and future health and social care needs of the population in the local authority area. It looks at the big picture of the local population over both the short term (3 to five years) and the long term.

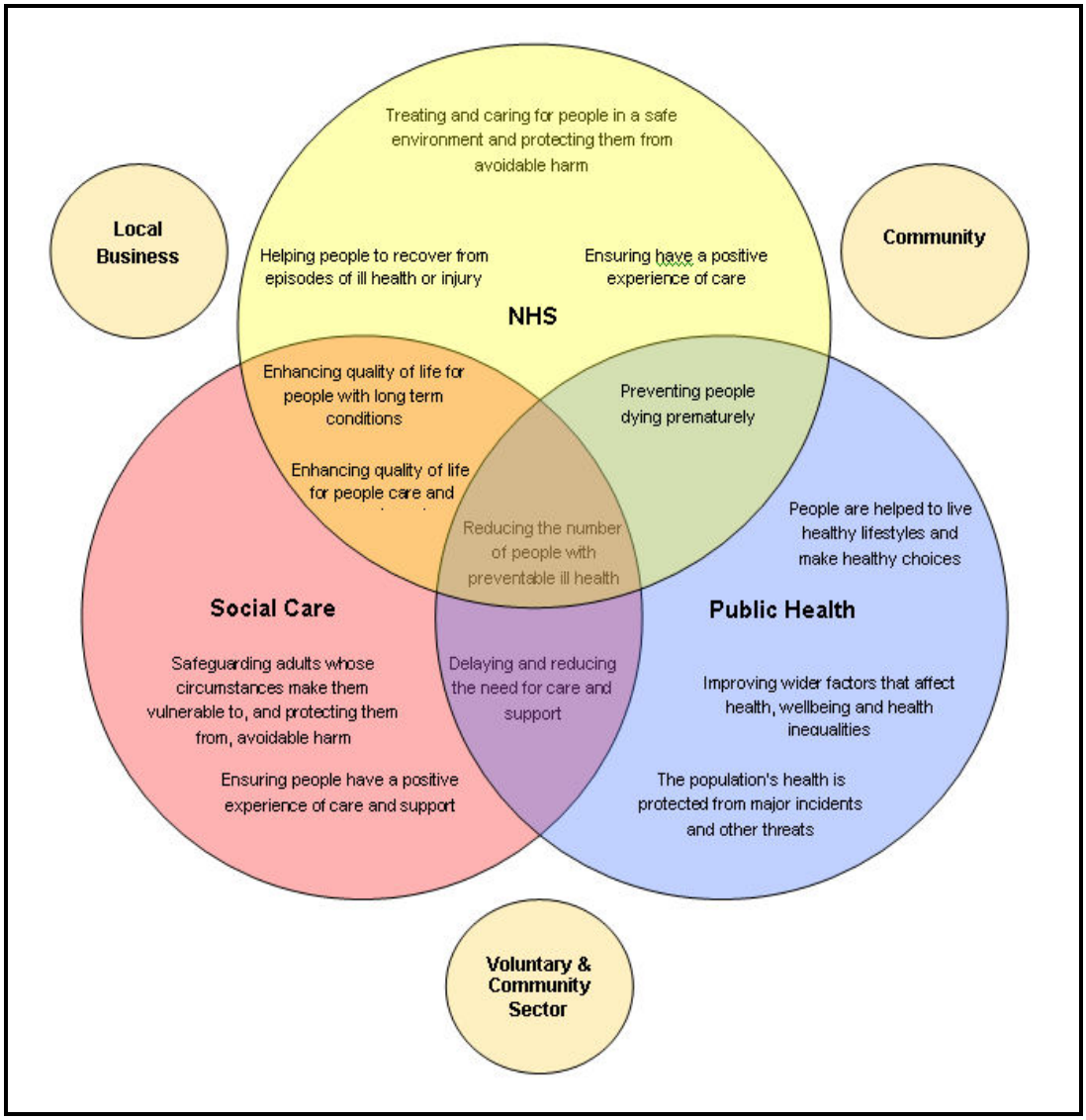
Among other things, it describes in detail the health, care and wellbeing needs or the local population, identifying those groups where health and care needs are not being met and those which are experiencing comparatively different outcomes. Once we have a collective understanding of the needs of people in Hillingdon, it is important that we also focus on those that we can most influence, change and improve.

Understanding Hillingdon and the characteristics of its population is critical for the development of our strategy as having this insight allows us to better judge current and future needs, eg for specific services such as maternity and the demand for the treatment of certain conditions which are more prevalent in specific population groups.

The JSNA looks at the evidence of what works in both the prevention and the treatment of health problems. In some cases there is limited evidence of effective prevention and/or treatment of serious health problems. Our strategy will tend to implement approaches that are known to be effective.

4. National Priorities by Sector and Outcomes

Focusing on what matters to local residents and making a difference to their lives is at the heart of improving health and wellbeing in Hillingdon. Across health and social care there are three national outcome based accountability frameworks covering health, public health and social care which seek to focus on achieving outcomes which matter to people. The following diagram summarises how the three outcome frameworks join together. They have been used to guide the development of Hillingdon's draft Joint Health and Wellbeing strategy and relevant outcome measures to check progress will be used where they fit local priorities.



5. Hillingdon at a glance

Hillingdon is a diverse, prosperous Borough in West London bordered by Hertfordshire, Buckinghamshire, Hounslow, Ealing, and Harrow. It's the second largest of London's 32 boroughs covering an area of 42 square miles (11571 hectares), over half of which is a mosaic of countryside including canals, rivers, parks and woodland. As the home of Heathrow Airport, Hillingdon is London's foremost gateway to the world, and is also home to the largest RAF airport at RAF Northolt. Hillingdon shares its borders with Hertfordshire, Buckinghamshire, Hounslow, Ealing, and Harrow.

The London Borough of Hillingdon has been in existence since 1965. In its current form, it is made up of 22 wards, or 163 Super Output Areas. The 2010 mid year population estimates from Office of National Statistics (ONS) estimated the population of Hillingdon at 266,100.

Hillingdon is a borough of contrasts. The north of the borough is semi-rural with a large proportion protected by green belt regulation, and Ruislip is the major centre of population. The south of Hillingdon is more densely populated, urban in character and contains administrative centre of Uxbridge and towns of Hayes and West Drayton.

Heathrow airport is situated in the south of the borough and is the largest employer offering a range of relatively well-paid skilled and unskilled manual positions. There are a number of major manufacturing and retail organisations with headquarters and sites in Hillingdon. Stockley Park, to the north of Heathrow, is one of Europe's largest business parks. Hillingdon council, RAF Northolt, Brunel University, Harefield and Hillingdon hospitals are major public sector employers within the area.

Hillingdon is a borough where town and country meet, boasting 800 acres of woodland, country parks, fields and farms, several rivers and the Grand Union Canal. We have more land under prestigious Green Flag status than any other London borough.

There are a range of opportunities to live well including:

- Ruislip Lido, which boasts one of London's few beaches
- Ruislip Woods National Nature Reserve
- The Hillingdon Sports and Leisure Complex, a multi-million pound indoor swimming pool and leisure complex, which includes a restored 1930s open-air pool. The swimming pool is the first 50m Olympic-sized to be built in London for more than 45 years.
- The country's first playground designed specifically for disabled children.
- The picturesque villages of Harefield and Harmondsworth
- Four 18-hole golf courses
- Various theatres, arts centres and state of the art libraries
- Uxbridge shopping centre, one of the top-ten shopping centres in London is also located in Hillingdon.

The council shares an almost co-terminus boundary with the NHS Hillingdon. Hillingdon has 48 GP practices; some of these patients come from surrounding boroughs.

There are good east west transport links in the borough, with the A40 and M4 offering direct access to central London, and respectively, Birmingham and the north; and Bristol and the west. Branches of the Metropolitan and Piccadilly lines of London Underground serving the north of the borough terminate in Uxbridge. Public transport in the south of the borough, with the exception of Heathrow airport is more limited. West Drayton and Hayes and Harlington national rail stations are on the London Paddington to Reading line. Travelling from north to south Hillingdon is much more complicated, with buses the sole form of public transport. Road journeys involve crossing the A40 at one of a number of traffic hotspots.

6. Hillingdon: Key Facts about Health and Wellbeing

Understanding the needs of Hillingdon is important in guiding this strategy to target priorities to improve health and social care and reduce inequality. Further information about the needs of Hillingdon's people can be found in Hillingdon's Joint Strategic Needs Assessment.

- Hillingdon has a significantly higher *birth rate* than England as a whole. Between 2003 and 2010, there was a 25.7% increase in the total number of births in Hillingdon; higher than London and England. Over 40% of pregnant women in Hillingdon do not have an antenatal assessment within 12 weeks. This is significantly worse than the national average.
- In 2010, Hillingdon had a *significantly larger proportion of people in younger age groups* (5-19 years) when compared with England and London. The higher proportion of this age group is more notable in boys than girls. The population of older age groups is also larger than London but smaller than England. However, the population of 25-44 year olds is less than the London average but still larger than England especially the female population.
- The number of *older people* in the population is increasing. People are living longer meaning that we need to make sure we have services in place to meet these needs. In 2011/12 4,122 older people were supported by the Council with community care services. There were 3,419 packages of care, 450 residential placements and 378 nursing placements for older people during this period.
- *Black and minority ethnic (BME) communities* make up approximately 32% of population of Hillingdon in 2011, an increase of 12% compared to 2001. The largest ethnic minority community is Asian (20%), of which the Indian category forms 12%. The Black African population is 4% of the total population.
- *Infant mortality rates* in Hillingdon are not significantly different to the England average. However, the proportion of babies born with low birth weight is significantly higher than the national average.
- *Life expectancy* for males in Hillingdon for 2008-10 was 78.7 years which was similar to London and England averages; and the female life expectancy for Hillingdon was 83.4 years, significantly higher than the England average, but similar to London average. Life expectancy has increased on average by at least 2.5 years, for males and females, during the past 15 years.

- Despite rates of *smoking during pregnancy* being lower than the England average, the rate of women recorded to be smoking during pregnancy in Hillingdon is significantly higher than the London average with 10% of pregnant women in the borough smoking at the time of delivery.
- *Major causes of death* for residents of all ages are cancers (31% in Males and 26% in females), circulatory diseases (30% in males and 34% in females) and respiratory diseases (14% in males and females).
- As regards *morbidity*, hypertensive disease is the most prevalent condition recorded in GP registers (12%), followed by obesity (9.5%), depression (9.1%) and diabetes (5.9%).
- Over a quarter (26.4%) of all children in Hillingdon are living in *poverty* as compared with 21.9% in England and 29.7% in London.
- *Levels of overweight and obesity* are a growing threat for population health in Hillingdon as in the rest of the country. Ten per cent of children attending Reception Year and 21% in Year 6 are classified as obese. Twenty three percent of the adult population is estimated to be obese, which is lower than England (24.2%) and higher than London (20.7%).
- Historically Hillingdon is a higher user of *long term residential and nursing placements* for older people in comparison with other areas of London. The all London average when measured on a per 10,000 population basis for 2010/11 and based on Department of Health data shows Hillingdon to be the 3rd highest in London for residential and nursing expenditure. The same pattern is repeated for people with learning disability, physical disability and mental health services. Conversely the Council has the 2nd lowest spend on non-residential services of all London boroughs, a trend the borough is actively seeking to reverse.
- Dementia presents major challenges for health and social care services. Currently there is a significant gap between the estimated prevalence of dementia and the actual numbers on the GP registers suggesting there are possible issues with diagnosis with primary care. From a social care perspective, during 2011/12 490 older people with dementia were supported with services and of these 285 received packages of care, 130 received a residential placement and 85 a nursing placement.
- Learning Disabilities - In 2011/12 490 adults with learning disabilities were supported by the council . 285 people received a community based package and 235 were supported either in residential or nursing care.
- Physical Disabilities - In 2011/12 655 people of working age with physical and/or sensory disabilities received services from the Council. There were 602 community based packages of care, 33 residential and 30 nursing placements.
- Mental Health - In Hillingdon 400 adults with mental health needs were supported by Adult Social Care during 2011/12. Of these 340 received community based packages of care, 55 were placed in residential home care and 10 in nursing home care.
- Sensory Disabilities – In 2011/12 65 people with a visual impairment as their main need were provided with services by the Council and of these 15 were aged below 65. There were 5 people with dual sensory loss, i.e. both deaf and blind, supported during this period and all were aged 65 and over.

7. Improving Health and Wellbeing

Clearly, there are challenges ahead but we are not starting from scratch. The partnership of statutory and voluntary sectors in Hillingdon has led to a number of improvements to health and wellbeing over the years. Here is a summary of some of the more recent improvements:

- There have been improvements in breastfeeding initiation rates (81%) and continuation (60%) as compared to 77% and 54% in the previous year.
- Improvements in childhood immunisations have led to Hillingdon being ranked one of the best in London for take-up of immunisations
- The MEND programme was commissioned to tackle the increasing rates of childhood obesity for ages 5-7 years and 7-13 years across geographic areas in Hillingdon. MEND Barnhill received a Quality Assurance Gold Award as one of the top five performing sites.
- Within the Healthy Schools Programme, Hillingdon school children won an award under the NHS London initiative for their ideas on how to promote responsible sexual behaviour, resist peer pressure and access local services.
- In Hillingdon, the percentage of NEET (people Not involved in Education, Employment or Training) decreased by 1.1% which is an improvement from last year. This moves Hillingdon's position to 'significantly better than England average'.
- The NHS Health Check programme assessed over 6,500 people between age group 40-74 years.
- The take-up of personal budgets for social care is increasing which helps people who need care to be in control of the care and support they need.
- Hillingdon's stop smoking service helped 1647 smokers quit smoking and achieved a conversions to quit rate (4%) similar to England (4%) and higher than London (3.8%).
- Department of Health funded project HAEDI (Hillingdon Awareness and Early Diagnosis Initiative) was delivered to raise awareness of Bowel Cancer in Hillingdon.
- A new physical activity scheme for cancer survivors was developed in partnership with Hillingdon Hospital and Hillingdon Leisure Services
- A Specialist Alcohol Nurse in Hillingdon Hospital A&E has been funded to pilot brief intervention and diverting patients from presentations at A&E into community based treatment.
- Hillingdon has established an integrated Sexual Health Service where all services work in partnership to provide a one stop approach for service users
- Telecareline assistive technology in combination with the Council's Reablement Service are proving very effective in helping people to feel safe in their own homes and to regain their mobility to live independently. The services are critical in helping to prevent unnecessary admissions to hospital and/or residential / nursing homes.
- The provision of extra care and supported housing is helping older people and people with disabilities to live independently in the community with support.

8. The priority needs of Hillingdon's residents

The following is a summary of the key needs of people in Hillingdon, including carers, which this strategy will focus in reducing:

Children engaged in risky behaviour *Too many young people engage in potentially harmful behaviours that can risk their health, such as alcohol abuse, drug taking, smoking, taking risks with sexual behaviour or being overweight.*
Dementia *As we live longer, more of us will suffer from dementia, and we are not currently doing enough to diagnose or support its treatment*
Physical activity *If we can increase the amount of physical activity for people, then we can improve physical and mental health and reduce chronic disease*
Obesity *Obesity is the most widespread threat to the health and wellbeing of the population*
Adult and Child Mental Health *Mental illness is the largest single cause of disability in our society, and we can be more imaginative in the design of services to support adults and children*
Type 2 Diabetes *Type 2 Diabetes is a major cause of morbidity and mortality but good management of the condition can significantly improve outcomes for those with the condition*
Increasing Child Population and Maternity Services *With an above average birth rate in Hillingdon, we need to do more to support pregnant mothers*
Older People including sight loss *With more of us living longer, the range of services for older people needs to be updated and improved*
Dental Health *Our children have above average levels of dental decay and we need to educate families about the value of good oral health*

9. The Health and Wellbeing Strategy - objectives and priorities

We have four broad objectives (the shaded areas below) as well as a number of more specific priorities to focus on. Each of these has a more detailed section within this.

1. IMPROVE HEALTH & WELLBEING AND REDUCE INEQUALITIES

We know that people will feel better and be healthier if they are more active and have access to better facilities across Hillingdon.

As a priority we will focus on physical activity and obesity.

2. INVEST IN PREVENTION AND EARLY INTERVENTION

We need to refocus resources on preventing disease and illness. The sooner health and social care are delivered, the better the chance of a good outcome.

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

3. DEVELOP INTEGRATED, HIGH QUALITY SOCIAL CARE AND HEALTH SERVICES WITHIN THE COMMUNITY OR AT HOME

The changes in health and social care legislation are designed to create a more joined up set of services for our patients, their families and carers. We want to make this the normal experience for the people of Hillingdon.

As a priority we will focus on:

- Integrated approaches for health and well-being, including telehealth;
- Integrated Care Pilot for frail older people and diabetes.

4. CREATING A POSITIVE EXPERIENCE OF CARE

We will tailor our services in a more personalised way. We can only achieve this if we hear your views and experiences.

As a priority we will focus on:

- Tailored, personalised services;
- An ongoing commitment to stakeholder engagement.

OBJECTIVE 1 - IMPROVE HEALTH & WELLBEING AND REDUCE INEQUALITIES

KEY PRIORITY - Physical Activity and Obesity
What is happening in Hillingdon? • £3.6 million is spent annually on treating chronic illness due to physical inactivity • Only 52% of adults are physically active in Hillingdon for 30 minutes or more per week • We have some key partners for our strategy • Hillingdon is well placed to support physical activity with first class facilities and natural resources • There is a gap of 16.9% between disabled and non-disabled participation in physical activity of 3 x 30 minutes per week

Trends/Information

Compared to other Boroughs in England, there is typically a lower number of adults and older people taking part in physical activities on a regular basis in Hillingdon and a higher number of children who are displaying signs of obesity (see published Hillingdon health profile 2012). There is an opportunity to encourage residents in Hillingdon to get involved in activities which improve their health and wellbeing.

What are we going to do?

Key tasks for 2012/13

- To continue to develop sports programmes for children, young people, adults and older people
- Set up care pathways with primary care and Public Health
- Review the support and facilities for people with disabilities in partnership with DASH
- Set up Change4Life campaign (over 3 years) to encourage residents of all ages to participate in 150 minutes of physical activity a week
- Recruit Sport Makers across the borough (including LBH staff)
- Increase in walking and cycling
- Set up Active Travel plans and develop Walk Hillingdon plan

We will succeed if we can:	**Linked to:**
• Increase percentage of physically active population exercising for 30 minutes per	JSNA – promoting a healthier lifestyle

week by 15% or 21,000 • Decrease gap between disabled and non-disabled people's participation in sport (as measured by Active People Survey) to less than 14.4% (currently 16.9%)	

OBJECTIVE 2 - INVEST IN PREVENTION AND EARLY INTERVENTION

KEY PRIORITY - Reducing reliance on acute and statutory services

What is happening in Hillingdon?

Generally speaking, there are a number of ways we already work together to reduce reliance on statutory and acute health and social care services.

- *Universal services aimed at preventing ill-health before its onset*; they can improve quality of life and prevent problems escalating thus avoiding or delaying the need for intensive and more costly interventions or services later on.
    - For example, the Council funds a range of voluntary and community sector organisations to deliver a range of community based clubs and societies for older people, people with mental health needs and people with other disabilities to support and develop social networks in order to prevent social isolation.
    - The Council also funds Age UK to provide the Ageing Well service which utilises the common facilities in seven sheltered schemes to support scheme residents and people from the local community living with dementia and their carers.
- *Services aimed at detecting and treating pre-symptomatic disease* that, if left undetected, could become harmful.
    - For example, NHS Hillingdon has screening programmes in place for cervical cancer for women aged 25 – 64; breast cancer for women aged 47 – 73 and bowel cancer for men and women aged 60 – 74. The uptake and coverage of these programmes in Hillingdon are higher than the London average.
    - Annual health checks by Hillingdon's GPs of 178 people with learning disabilities was under-taken in 2011/12.
- *Interventions aimed at improving the quality of life for people with various conditions* by limiting complications and disabilities, reducing the severity and progression of disease, and aiding rehabilitation or recovery. Examples include the TeleCareLine and Reablement services referred to below.

Here are some other specific areas of progress:

- Specialist information and advice services: organisations like Age UK, the Disablement Association Hillingdon, Hillingdon Carers, the Stroke Association and the Alzheimers' Society receive funding from the Council to provide information and advice services to Hillingdon residents.
- Access to information and advice: an online directory of services called Careplace and including information and advice services has been developed by the Council in partnership with other West London Councils.
- The Council has developed its Telecareline service which includes a range of sensors, e.g. exit sensors, epilepsy sensors and detectors, e.g. carbon monoxide, flood, fire, etc, that all link to a central contact centre and include a mobile response service. This is available free of charge to people aged 85 and over and those eligible for community care services (subject to a financial assessment) and in 2011/12 supported 1,168

Hillingdon residents to live safely in their own homes.

- The range of skills within the Central & North West London Rapid Response Team working with Hillingdon Hospital is being extended to include psychology in order to assist older residents with dementia back into the community following a hospital attendance to prevent unnecessary admission.
- The Central & North West London Rapid Response team has also been further expanded to ensure on-site Monday to Sunday provision in the A&E Department at Hillingdon Hospital to facilitate discharge home into the community and avoid unnecessary hospital admission.
- Hillingdon are implementing the Coordinate my Care Register across all partner organisations which provides advanced care planning to support more individuals at the end of their life to die in their preferred place of care.
- Age UK provides a service that provides support to older people that have returned home following a hospital admission for up to six weeks to enable them to grow in confidence and prevent a hospital readmission.
- A major programme of commissioning and building supported housing for people with learning and physical disabilities, mental health issues, frail older people and people with dementia is in progress. This will reverse the trend of too many people being referred to residential or nursing care when they could be supported within the community and at home.
- We are working with partners to deliver health care in the right place at the right time by ensuring easy access to high quality care and shifting settings of care to provide more services out of hospital and closer to home.
- The 111 service has been introduced 24/7 single point of access for non-emergency help.
- The Urgent Care Centre at Hillingdon Hospital has been improved to provide easy access to high quality care.
- The Council's Reablement service is helping people to live independently in their own home, helping to reduce reliance on residential/nursing care and prevent placements made directly from hospital as well as increase people's ability to support themselves. Eligible people approaching the Council for assistance with their care receive a free service up to six weeks.

Trends/Information

a) Supported housing programme

Supported housing programme by client group and planned year of delivery, 2012/13 to 2014/15					
	Learning disabilities	**Physical disabilities**	**Mental health**	**Older people**	**Total**
2012/13	23	7	5	-	**35**
2013/14	86	6	26	-	**118**
2014/15	72	37	24	136	**269**
Total	**181**	**50**	**55**	**136**	**422**

b) Reablement

The Reablement service is achieving its aims of increasing people's independence and reducing reliance on statutory services. In terms of trends:

- Over 60% of people have no ongoing care needs once the 6 week Reablement service has been provided
- 38% of people had an ongoing care need but 68% of people left the Reablement service with a reduced care package i.e. they could do more for themselves as a result of their recovery and the impact of the service.

c) Residential and nursing care

The Council remains a high user of long term placements for Older People which is an unsustainable position. The all London average when measured on a per 10,000 population basis for 2010/11 shows Hillingdon Council to be 3rd highest in London for residential and nursing expenditure. This same pattern is repeated for Learning Disability, Physical Disability and Mental Health services. Conversely the Council is 2nd lowest spend on non-residential services of all London Boroughs, a trend the borough is actively seeking to reverse.

The success of TeleCareLine (see Objective 3) and Reablement will significantly contribute to the service objective of reducing the spend on residential care from its current 53% to below 35%; the DH state that good practice would be no more than 40%.

d) Urgent Hospital care

Benchmarking against London and NHS averages show that Hillingdon has a higher activity for emergency attendances at A&E and admission to hospital rates for some conditions. Hillingdon is consulting on ways to improve access to high quality responsive primary and community care to make out of hospital care the first point of contact for people with urgent but not life threatening needs.

The UCC will aim to see approximately 80,000 patients each year. This will reduce usage of A&E by around 50,000 attendances allowing A&E specialists to focus on the most serious and life threatening conditions and reducing patient waiting times.

In addition, the scope and range of skills within the community Rapid Response team will

prevent more avoidable admissions and provide enhanced support for people to remain independent at home following a crisis.

What are we going to do?

- Allow easy access to high quality, responsive primary care
- Develop clearly understood planned care pathways
- Create a rapid response to urgent needs
- Develop a wide range of supported housing to ensure that people have real alternatives to residential and nursing care.
- Ensure that providers work together to proactively manage your care
- Ensure you spend an appropriate time in hospital with supported discharge

We will succeed if:	**Linked to:**
• We complete the delivery of 422 self-contained flats for older people, people with learning disabilities, people with physical disabilities and people with mental health needs by April 2015 • Access times reduce • Patient satisfaction increases • Alternative care pathways enable a reduction in the need for hospital outpatient attendances • Rapid response to urgent needs is provided so that 1,500 fewer people need to access hospital emergency care. • Lengths of stay in hospital reduce, especially for frail and elderly people • The number of falls related admissions to hospital is reduced • Readmission to hospital rates reduce • Referral rates to residential and nursing care continue to reduce • Reablement is even more successful in reducing people's ongoing reliance on statutory services	JSNA Priority – older people Hillingdon out of hospital strategy

KEY PRIORITY - Children's Mental Health & Risky Behaviours

What is happening in Hillingdon?

- Hillingdon has a growing population of 0-19 year olds which forms 25.7% of the local population. National data suggests that about 4,600 children in Hillingdon have a specific

mental health need which requires support.

- Partners are working together on shared priorities including developing early intervention, improved multi agency pathways for vulnerable groups, and reducing the need for inpatient care.
- An early intervention service has enabled improved access to specialist help for young people with psychosis and other intensive home support.

Trends/Information

- A recent study suggests that about 380 high school population in Hillingdon are self harming
- Rates for sexually transmitted infections, for young women between 16-19 are rising.
- A comparative analysis shows there is a London wide increase in specialist admissions for under 18ys as a result of mental health needs including eating disorder. 909 inpatient bed days were used in 11/12 by young people from Hillingdon for specialist care.
- Some vulnerable groups are more likely to require support for mental health needs and other risky behaviours. These include those living in poverty, looked after children, people with a learning disability, young offenders, and those not in employment, education or training. Data suggests that 61 Looked after Children in Hillingdon need support for mental health needs.

What are we going to do?

- To develop our workforce to be better at identifying and supporting children who need targeted support from universal services including schools.
- Improve information sharing between the agencies about vulnerable children
- Improve the uptake of screening for sexually transmitted diseases in young people
- To decrease the number of children who need out of area specialist hospital based care.
- Improve local pathways for children and young people who are experiencing crisis including for mental health needs and challenging behaviour

We will succeed if we:	**Linked to:**
• Launch a tracker system and single information portal and introduce a fast track inter-agency referral process to improve links across local services • Develop good practice models and local	• JSNA Priority – risk behaviour • JSNA Priority – CAMHS • CAMHS DAS challenge

pathways (Risky behaviour subgroup) and cascade via the Children's Trust • Prioritise the commissioning of effective parenting services • Reduce inappropriate use of specialist services	

KEY PRIORITY - Dementia and Adult Mental Health

What is happening in Hillingdon - Adult Mental Health?

- NHS Hillingdon and London Borough of Hillingdon are increasingly working together to deliver and improve services; there is potential to improve services by exploring and establishing models of joint commissioning and joint delivery
- There is an increased focus on prevention, early intervention and recovery orientated care with a recognition of the ongoing over reliance on secondary mental health services.
- There is significant potential to "shift settings of care", transferring the management of people with serious mental illness who are stable from secondary to primary care and to increasing the assessment, diagnosis treatment of people in primary care settings
- Too many people with mental health issues are living in residential care when they could be living in a more independent supported housing environment with care and support on-site. A major programme of commissioning and building supported accommodation is starting to address this and will seek to provide over 400 units of supported accommodation (including those for people with mental health issues) over the next 3-4 years.
- The need to improve the management of the physical health care needs of people with mental health problems in both primary and secondary care has been acknowledged with strategies to achieve this being implemented through improvements in assessment and treatment in both primary and secondary care and establishment of a psychiatric liaison service
- The specialist needs of people with an eating disorder, forensic need or personality disorder can be improved
- People experiencing a mental health crisis and their carers feel unsupported and unsure about how to access timely support and treatment, particularly "out of hours"
- The potential of the voluntary sector and organisations in the wider community to contribute to effective and efficient service provision and improved patient experience and outcomes has been acknowledged; the potential to maximise this contribution has been recognised
- Services can be improved by improving co-ordination and partnership working across sectors; improvement can be achieved through the development of integrated care pathways and service redesign

Dementia

- As part of a joint approach to dementia, NHS Hillingdon and Hillingdon Council will shortly deliver a joint strategy on adult mental health needs including dementia
- Many dementia patients present to services in a crisis that could have been avoided through earlier diagnosis, intervention and more effective support
- The rate of diagnosis of dementia is being improved through improved assessment and treatment processes in primary care and establishment of memory assessment services

(subject to consultation)

- Improved community based assessment, treatment and support is needed along with improved co-ordination of care in primary and secondary care
- Steps have been taken in-year to move from a bed to community based service; the potential to further reduce reliance on beds and to re-invest in community services needs further exploration
- The importance of the role of carers has been acknowledged; including supporting them in their essential caring role
- The potential role of the voluntary sector and the wide range of organisations that work with older people in supporting people with dementia and their carers has been and must be continue to be acknowledged and explored to maximise outcomes, effectiveness and efficiency

Trends/Information

Adult Mental Health

- The adult population in Hillingdon is projected to rise by 1% per annum over the next 5 years
- There is potential to significantly improve effectiveness, efficiency, experience and outcomes by shifting the setting of care from secondary to primary care settings and reducing use of acute and rehabilitation beds and specialist placements
- 30% of the population of Hillingdon is from a black and minority ethnic (bme) community; the mental health needs of these groups have not been fully addressed and identified and is a priority

Dementia

- 13% of our population is over 65, and 7% of these have dementia
- The number of people with dementia is expected to increase by 9% within 5 years
- Rate of diagnosis of dementia is currently low (27%) of estimated numbers
- There is potential to improve efficiency, patient experience and outcomes by ensuring early diagnosis, early intervention and improved assessment, treatment and support in the community
- There is potential to improve efficiency, patient experience and outcomes by reducing reliance on acute beds – physical and mental health care - and residential placements

What are we going to do?

Adult mental health

- Explore cost effective methods to promote mental health and wellbeing in all communities
- Establish a joint approach to assessment, treatment and support for mental health and physical health care needs between primary and secondary care, ensuring early diagnosis and intervention and shifting responsibility for the care of people with serious

mental illness who are stable from secondary to primary care

- Establish a robust primary care based mental health service through service redesign (including IAPT services)
- Continue to promote a community based model of care including exploring the potential to reduce use of acute and rehabilitation beds and specialist placements
- Ensure that arrangements are in place to support people and their carers when they are in crisis
- Work with faith and other groups to identify and start to address the mental health needs of black and minority ethnic (BME) communities
- Maximise the contribution of voluntary and community services to the support and recovery of people with mental health problems through service redesign and ensuring maximum benefit of the investment in these services
- Bring together and progress all of the above in a joint strategy agreed by NHS Hillingdon and Hillingdon Council and explore models to promote improved joint commissioning and service delivery

Dementia

- Address the needs of people with dementia within the out of hospital strategy
- Reduce reliance on acute mental health beds and through service reconfiguration (closure of under used beds) and establish a memory assessment service (subject to consultation)
- Improve the infrastructure for community based assessment, treatment and support over time
- Specialist dementia extra care housing will be part of the major programme of supported accommodation being developed and delivered by the Council
- Improve the co-ordination of care through improved assessment and multi-disciplinary working in primary care (Elderly ICP) and integration of the work of all relevant agencies in a care model
- Bring together and progress all of the above in a joint strategy agreed by NHS Hillingdon and Hillingdon Council

We will succeed if we:	**Linked to:**
• Take action to promote mental health and wellbeing in local communities and address the needs of BME communities • Ensure effective early diagnosis and intervention approaches • Ensure effective community and primary care based services and approaches in	• JSNA Priority – "Transforming Pathways of Care; Planned Care" • NHS Hillingdon Community Strategy 2009-14: care priority pathway • Elderly ICP, NWL • MH ICP, NWL

order to enable and support primary care to assess, treat and support people with mental health needs and their carers effectively • Maximise the potential contribution of the voluntary sector and other community based organisations to address the needs of people with mental health problems including ensuring that the resources invested are use effectively and efficiently • Continue to review care pathways and redesign services to deliver cost effective services based on community rather than bed based models of care • Ensure the appropriate use of acute beds • Acknowledge the essential role of and provide effective support to carers • Ensure an effective joint approach to commissioning and service delivery by NHS Hillingdon and London Borough of Hillingdon	• DAS Challenge, NHS Hillingdon • Hillingdon Health and Wellbeing Strategy, 2012

OBJECTIVE 3 – DEVELOP INTEGRATED, HIGH QUALITY SOCIAL CARE AND HEALTH SERVICES WITHIN THE COMMUNITY OR AT HOME

KEY PRIORITY - Integrated approaches to HWB

What is happening in Hillingdon?

- The Council's Telecareline service has been very successful in providing simple as well as sophisticated equipment to help people live independently that would otherwise rely more heavily on statutory care provision. Telecare can range from the simple lifeline and pendant to bed, chair and exit sensors and safer wandering devices (linked to a central contact centre and mobile response service) and is an integral part of the Reablement Service. Telecareline is free to anyone aged 85 +, to those receiving the six week reablement service and to residents on an ongoing basis who are eligible for community care services (subject to financial assessment).
- Health and social care partners are developing a new model of supported hospital discharge that enables a seamless patient journey back to their usual place of care with enhanced support when need. This could include joined up intermediate care for up to 6 weeks at home or in a step-down bed, and access to supportive services such as equipment, telecare, rehabilitation and reablement. This will also help patients to return to their home rather than institutional care after discharge from hospital.
- Central & North West London NHS Foundation Trust are currently piloting a psychiatric liaison service in Hillingdon Hospital. This service will help diagnose mental health problems while the patient is in hospital. The service will improve coordination with out-of-hospital care providers and housing services, meaning a higher proportion of patients can be discharged directly to their own homes, or appropriate accommodation.
- The voluntary sector has a key role in co-developing services with patients to enable greater choice and control as well as promoting and supporting self-directed care. Voluntary sector services can also work collaboratively with each other, and with statutory services, and their role in communities can also support the new networks with co-developing services and involving patients and the public
- The integrated care pilot was launched in Hillingdon in July 2012 to bring together health and social care services to jointly review and co-ordinate care plans for patients with complex needs (please see next section for further information).

Trends/Information

a) TeleCareLine

The number of new users of the TeleCareLine Service in 2011/12 was 1,178. The target for the number of new clients taking up the service for 2011/12 was a net increase of 750 which has been exceeded with a total of 1120 new users during the year. Although this first year take up is very encouraging particularly amongst the older population it is noticeable that take up by younger disabled people is lower than anticipated. In the six months since April 2012 to

the end of September 2012, 536 people have taken up telecareline technologies in their home.

[In total (taking into account new and existing customers) there were 5,344 registered individual service users of the Council's TeleCareLine Service in June 2012.]

b) Intermediate care

A total of 74731 emergency patients per year get admitted to the Hillingdon Hospital NHS Foundation Trust (THHFT) who are 65 years or over. A proportion of these patients (22%) continue to stay for more than the required length of time after they are medically fit to move from an acute hospital setting. Patients can benefit spending more appropriate time in hospital by introducing joined up intermediate care and discharge planning.

What are we going to do?

- Extend the Telecareline service to 3000 people by March 2015
- Enable patients over 65 years admitted to hospital as an emergency to experience supported discharge from hospital to their usual place of residence. This will enable people to leave hospital as soon as they are medically fit to do so, by hospital and community services to work seamlessly together taking a joint approach across health and social care. This will enable older people to maintain an optimum level of independence in the community.
- Develop and submit a bid to the Integrated Care Pilot (ICP) Innovation Fund for a pilot telehealth initiative in 2012. A local case for telehealth as a way of helping to prevent ill health and reducing hospital admission for some long term conditions is being explored, based on the recently published evaluation of the National Whole System Demonstrator Pilots.
- Develop a model of early supportive discharge from hospital care to community settings to enable individuals to return home from hospital at the earliest opportunity with care coordinated and in place to prevent unnecessary hospital readmission.

We will succeed if we:	**Linked to:**
• Achieve 750 new TeleCareLine registrations by the end of 2013 • Up to 1,600 patients benefiting from supported hospital discharge and maintain an optimum level of independence in the community.	• Adult Social Care Transformation Plan: Priority 2 (p7) and target (p24) • CCG commissioning priority: "Transforming Pathways of Care • JSNA Priority theme: "Community-based Resident-focused Services" • QIPP Plan project (OOH/111)

KEY PRIORITY - Integrated Care Pilot

What is happening in Hillingdon?

- The integrated care service for older people pilot was launched in July 2012. It will provide a joined up approach to patient care which puts the patient at the centre, and proactively manages their care across health and social care. GPs and other members of the multi-disciplinary group will identify the most complex patients who require integrated care from a number of professionals
- The pilot is based on multidisciplinary teams of GP practices and provider partners working in geographical networks. 38 out of 48 practices have so far joined the pilot
- The Pilot will focus on older people who are frail and over 75, those with diabetes, coronary heart disease or respiratory disease.
- The multidisciplinary teams have now started discussing patients identified as needing integrated care and co developing care plans with these patients.

Trends/Information

How the integrated care model will work in practice

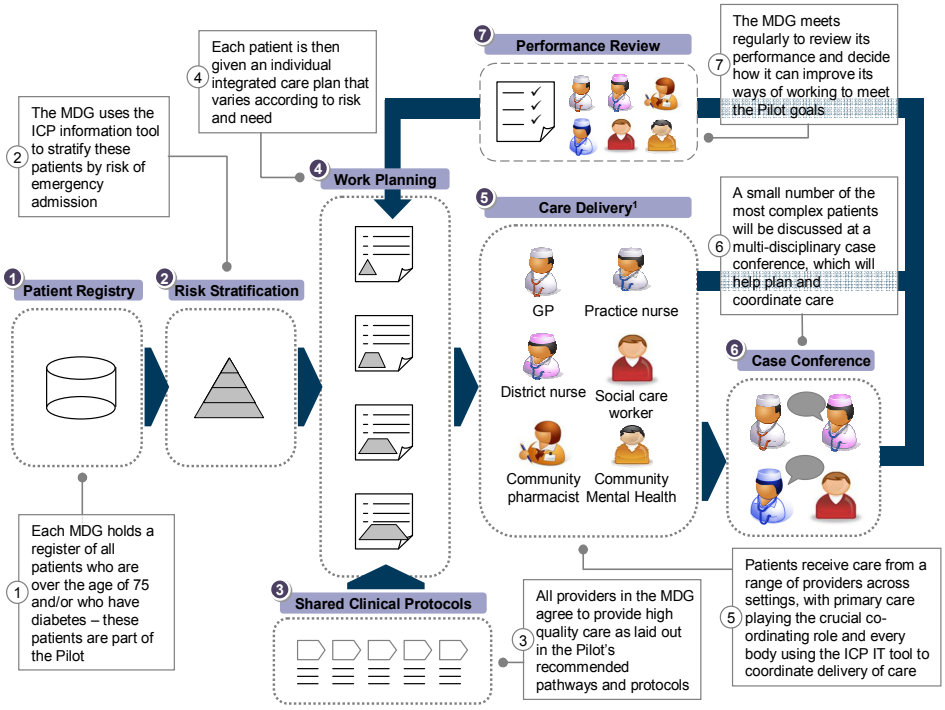


Exhibit 6 Model Diagram

What are we going to do?

1. Regular multi-disciplinary case conferences will bring together hospital specialists, GPs, community health providers, social workers, mental health specialists and others to discuss how best to provide for complex patients. A care plan will be co-developed with the patient (and their carer where appropriate), ensuring all the services that the patient needs are working together.
2. This proactive case management and secondary prevention will provide ongoing support to patients with risk of deterioration, including enhanced support to patients in care homes.
3. Pursue development of an improved falls pathway through the ICP Innovation Fund.

We will succeed if we:	**Linked to:**
• All patients who have had three or more emergency admissions in the previous year are offered case management by a dedicated team of community nurses, with care plans and support to reduce the number of avoidable health crises and their need for hospital based care. • Greater support at end of life, with an increasing proportion of people dying in their place of choice. • More use is made of services such as telehealth and telecare to help keep people, such as those with respiratory conditions, healthy and in their own homes. • Achieve full roll out of the integrated care service to all Hillingdon's GP practices by the end of 2013	• CCG Commissioning Priority: "Scaling-up Integrated Care" • Hillingdon Out of Hospital strategy • HWBB Integrated Care for Older People case for change and implementation plan.

OBJECTIVE 4 - CREATING A POSITIVE EXPERIENCE OF CARE

KEY PRIORITY - Tailored and personalised services

What is happening in Hillingdon?

- Personal budgets for social care services helps to ensure that people are in the driving seat, able to choose and then control the services and the support they receive. By 31 March 2012, 26% of people receiving community care services were receiving self directed services. Since then, the use of personal budgets by eligible social care service users has increased to 48% with a likely increase to 80% by March 2013.
- The Council works in partnership with the voluntary sector to make sure that service users have support and hands-on advice about how to use their personal budgets.
- In partnership with other west London authorities, the Council has produced an online directory of providers – CarePlace- to help inform personal budget holders about the choice of services, help and support available in the local community.
- In partnership with three other West London authorities, we will develop a new voluntary sector support planning and brokerage service – helping people to develop support plans to meet their assessed social care needs as well as helping people to purchase the services and activities that will turn the support plan into action.
- Developing an on-line directory to enable residents and professionals identify the services that residents eligible for community care services may wish to purchase with their personal budgets
- An extensive supported housing programme which will see the development of 422 self-contained flats over a four-year period. The care and support services for these schemes will be developed on a “core and flexi” basis so that residents have a choice about who delivers those aspects of care and support services that are not critical to the safe management of the supported housing scheme. This also enables the Council to commission the “core” services while not removing choice from service users who want to be actively involved in the management of their personal care and support.
- The Council is currently working with providers of existing supported housing schemes for people with learning disabilities and people with mental health needs to personalise the service model on a core and flexi basis.
- Hillingdon Council is working jointly with providers to develop replacement services for both planned and unplanned situations when the personal assistant (PA) of a resident receiving community care services is unavailable, i.e. due to sickness, holiday, etc.
- 54% of people say they would prefer to die at home but in NW London this is only achieved for 18%

Trends/Information

- The Council employs a small team of inspectors to work with providers of social care and support (across the statutory, private and voluntary sectors) and ensure that quality services are being offered. Inspectors use a mixture of contract monitoring, planned *and* unscheduled inspections, and meetings with service users to develop a picture of what services are like on the ground. The over-riding objective is to improve the experience of care services and help to raise and then maintain standards where things are not as good as they could be.
- The take-up of personal budgets for adult social care is continuing to increase providing more and more people with choice and greater control over their care and support needs. To date, 48% of people in receipt of a social care service are organising their care and support using a personal budget.

What are we going to do?

- We are working to increase the percentage of adults in receipt of community care services with a personal budget to 80%.
- We will put in place a new Personal Budgets Support Service by April 2013, to support and advise people with their personal budgets.
- Work with providers to ensure that residents who are eligible for community care services can access emergency and planned replacement care arrangements to cover periods when their PAs are not available, e.g. sickness, holidays, etc.
- We will continue to develop CarePlace including adding functions that enable people to share their experiences of local services (similar to 'Trip Advisor') which will help the social care market to more effectively respond to people's needs.
- We will work with voluntary and community sector providers to support them to provide services that people may want to purchase using their Personal Budgets.
- Ensure that community based services are in place to support people with terminal conditions to die at home if that is their choice
- Complete the delivery of 422 self-contained flats for older people, people with learning disabilities, people with physical disabilities and people with mental health needs by April 2015.

We will succeed if we:	Linked to:
• Deliver Personal Budgets to all those eligible by April 2013 • Launch the Personal Budgets Support Service by April 2013	• Adult Social Care Personalisation and Commissioning Plan 2011/2015

KEY PRIORITY - Stakeholder engagement: our commitment

What is happening in Hillingdon?

Ensuring that our residents are informed and involved in decisions that affect them or their families helps to make sure that service improve their health and well-being at an early stage and prevent health needs deteriorating. Improved communication is a key part of increasing capability for prevention and early intervention.

- NHS partners are committed to engaging and involving patients and the public as set out in the NHS constitution:

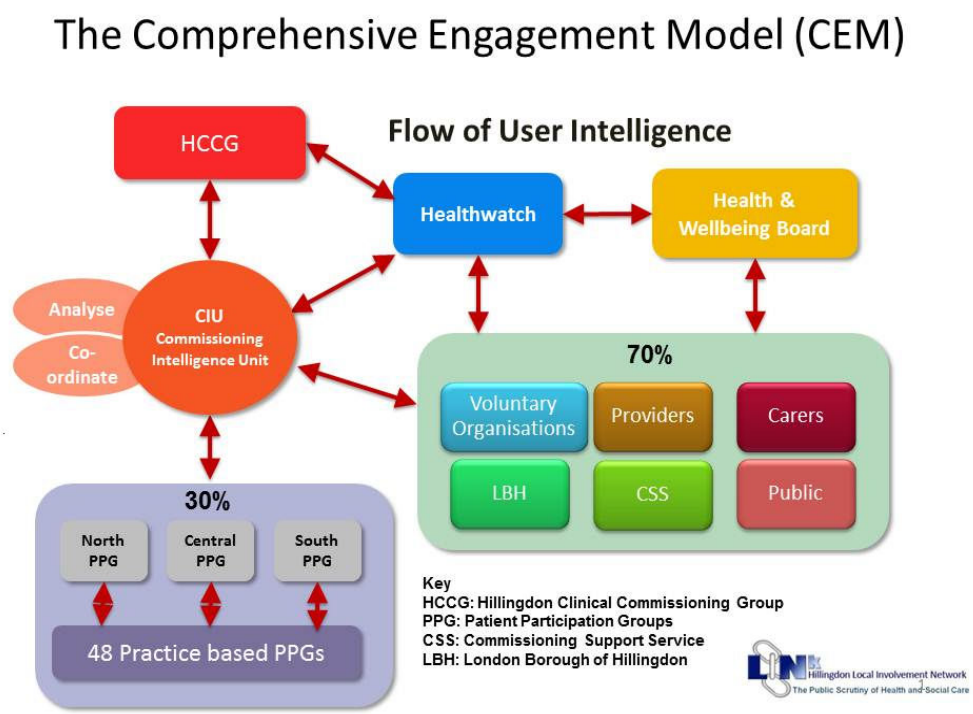
'You have the right to be involved, directly or through a representative, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services'

- The Council involves residents and their families in the development of services including agreeing the tender specification and taking part in the evaluation of organisations bidding to deliver services.

Our approach is to create and sustain an on-going dialogue. This will ensure our residents are aware of any changes proposed and have had the opportunity to share their views about health and social care changes. In practice, this will include :

- *Strategic planning:* patient and resident representatives will contribute to the development of health and social care strategy and plans, for example dementia care in Hillingdon
- *Development of services:* we will involve patient and resident representatives in service developments such as the community-based pathways.
- *Wider communication:* we will use a range of channels to communicate with Hillingdon residents and specific groups on key priorities to access information on local services, for example out of hospital services.

Trends/Information



This diagram shows how we are working together across partners to co-ordinate services which support improvements in health and wellbeing.

What are we going to do?

- Systematically gather patient and resident experience data and analyse then respond to it and use other data to develop services
- Ensure that the Hillingdon HWB is a major contributor to the emerging Hillingdon CCG Patient, Public, Involvement Model
- Establish relationship and communication points with HealthWatch on all aspects of the HWB's agenda in a planning cycle

We will succeed if we can:	**Linked to:**
• Focus on improving the experience of care using the feedback from residents who have used services • Focus on improving the lives of our residents by measuring outcomes and listening to their views about service	• Link PPI strategy • HCCG Commissioning Strategy for patient and public engagement • Adult Social Care Personalisation and Commissioning Plan, 2011 - 2015

improvements • Publish an annual report on Patient Experience and the HWB's response to it • Publish a list of contacts for all aspects of the HWB's business • Agree and publish a communications planning cycle for the HWB	

8. Keeping in touch

We will provide regular updates on how this strategy is doing, and we hope that you use this document to assess how all the various organisations in Health, Social Care and Public Health in Hillingdon are doing – and particularly how their own plans match this one.

If you have any thoughts or questions on this Strategy, please get in touch by one of the methods described below:

(by email, telephone etc……)