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

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update | RAG |
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| ***Priority 1 - Improved health and wellbeing and reducing inequalities***<br>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;<br><br>a) Develop a programme to increase activity for adults and older people | (a)-(h) 31/03/14 | a) Program of Tea Dances has been organised, 4 Tea Dances have taken place since the 1st April. There have been a total of 398 people who have attended.<br>Free Swimming increased following the re-opening of Highgrove Pool.<br>The Specialist Health Promotion team have developed an SLA with Age UK Hillingdon to train a further 3 volunteers in chair based exercise to enable us to offer this type of activity to sheltered housing, residential and nursing care and to people finishing physiotherapy | |
| | | | b) Develop a programme to increase activity for children and young people | | (b) A programme to increase delivery in Early Years settings established. Training for Children's centre staff organised. Fit Teen programme expanded to Hayes and Uxbridge. Multi-sport programme for primary age children organised. Set-up dialogue with school games organisers to link with community delivery. | |
| | | | c) Set up travel plans | | (c) Travel plans required for new residential and commercial development. Highest increase in London for modal change in school travel. System established to better monitor progress. | |

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| | | | d) Show an increase in cycling and walking | | (d) 'Explore Hillingdon' produced. New led cycle ride programme is in place for 2013. The Healthy Walks programme, there are 150 registered walkers who walk a minimum of once a month:<br>1. 2013/13: The target of 5% has been exceeded with a 13% increase in units of walking (3,400 to 3,846).<br>2. Q1 April – July 2013 - 746 unit of walking, of which 43 are new walkers. | GREEN |
| | | | 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. | |
| | | | f) Review and support opportunities for people with disabilities | | (f) 'On Your Marks' scheme established in partnership with DASH, providing new swimming and multi-sport activities for disabled adults. | |
| | | | g) Set up care pathways with primary care and Public Health | | (g) Reviewed delivery of existing Cardiac referral scheme. New trial scheme for Stroke patients established with 'Fusion'. New 'Let's Get Moving' physical activity referral programme being explored. This will provide a general scheme available to all residents through GP's, Health Checks and other health practitioners. | |
| | | | h) Develop the Change 4 Life campaign to encourage residents of all ages to participate in physical activity. | | (h) Pledge system established with incentives to encourage more people to be more active, more often. Regular articles in Hillingdon People, through social media etc. | |

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| 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.<br><br>• 30 heating measures<br>• 30 insulation measures<br>• Complete essential repairs to 10 homes for vulnerable & older households<br><br>(b) Deliver Age UK Hillingdon's Housing Options Service and Winter Warmth Campaign | (a) 31/03/14<br><br>(b) 31/03/14 | (a) Ongoing - Since April 2013, improvements have been made to 28 homes of older people in Hillingdon as follows:<br><br>• Heating improvements have been made to the homes of 6 older people.<br>• 17 homes with improved insulation measures.<br>• 5 homes of older residents received essential repairs as needed. Essential repairs can include roof and glazing repairs to reduce health and safety risks<br><br>Currently capital release has been given for another 8 Essential Repair Grants which will be completed this year, and additional cases are being prepared for submission.<br><br>(b) Ongoing – preparations are underway for the campaign. To be promoted at the scheduled day of older people on 1st October 2013, which includes an event in Uxbridge. | GREEN |

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| ***Priority 2. Prevention and early intervention***<br>As a priority we will focus on:<br>• Reducing reliance on acute and statutory services;<br>• Children's mental health and risky behaviours;<br>• Dementia and adult mental health;<br>• 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 on 4 July 2012 providing a joined up approach to patient care across health and local authority services based around GP practices. 80% of GP practices have signed up to the new ICP services. The project initially targeted older, frail people, those with diabetes and people with mental health needs (residents with complex care and support needs). From April 2013 the programme has been expanded to include those people with chronic obstructive pulmonary disease and patients with cardiac difficulties. | 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 is being specified and commissioned to meet bed-based care needs on a short-term basis. Service expected to be in place by Spring 2014. | |

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| 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<br>(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<br>(c) Identify local population needs and initial recommendations regarding meeting service gaps<br>(d) An evidence review of "what works"; and feedback from users<br>(e) Whole systems service design for child mental health support | a) 31/12/13<br>b) 31/12/13<br>c) 31/12/13<br>d) 31/01/14<br>e) 31/03/14 | (a-e) Senior Team to Team meeting established with health commissioners as overarching steering group.<br><br>CAMHS Working Group formed with health commissioner, local authority and provider representatives.<br><br>Project charter developed.<br><br>Identification of candidates completed, and interviews for project manager role to take place first week in September. | GREEN |

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| 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.<br>(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.<br>(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) | a) 31/03/14<br>(b) 31/03/14<br>c) 31/03/14 | a) Outreach Contraception and Sexual Health Nurse newly recruited. Home visits with looked after children lead nurse underway.<br>b) Terrence Higgins Trust providers of Chlamydia Screening are investigating various ways of using IT to increase Chlamydia Screening awareness at Brunel i.e. via the university Intranet/emails. Training planned for University Medical Centre and Pharmacy in Term 1 (Oct-Dec)<br>c) Potential interested eligible Pharmacists have been identified. Emergency hormonal contraception training being developed. Patient Group Direction (note: PGD is a specific written instruction for the supply or administration of a named medicine in an identified clinical situation) currently in process of being updated. | GREEN |

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| 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.<br><br>(b) Agree a joint implementation plan for years 2 and 3 of the Adult Mental Health Strategy. | a) 31/03/14<br><br>b) 31/03/14 | (a) On track. Dementia strategy in place. A mental health task and finish group will be established to co-ordinate and implement the agreed plan. 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.<br><br>(b) Ongoing. Plan will be recommended for consideration by the Health and Wellbeing Board by 31 March 2014. | GREEN |

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| 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<br><br>(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<br><br>(c) to evaluate the liaison psychiatry pilot programme and identify benefits to improved liaison between physical and health care needs for 14/15 . | (a) 31/03/14<br><br>(b) 31/03/14<br><br>(c) 31/04/13 | (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.<br><br>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:<br>1. develop and implement standardise processes for urgent referral agreed with stakeholders.<br>2. Identify and address training needs and appropriate health and social care record-keeping to support effective shared care and provide high quality care pathway<br>3. Ensure onward pathways are developed to support improved patient experience when accessing services via urgent referral.<br><br>c) The psychiatric liaison pilot - interim evaluation showed benefits to service using qualitative and quantitative methods. Further work to review the extension of service model will require the development of a business case. | GREEN |

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| 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<br><br>(b) Increase the numbers and rate of alcohol clients successfully completing and exiting treatment. | (a) 31/03/14<br><br>(b) 31/03/14 | (a) 583 clients (where alcohol is the primary drug), presented to alcohol services in the 12 months ending Q4 2012-13.<br><br>(b) 335 clients (where alcohol is the primary drug) exited alcohol treatment in the 12 months ending Q4 2012-13 with a successful completion rate of 63%. (NB: Awaiting publication of Q1 data from National Drug Treatment Minimum Data Set NDTMS)<br>The commissioning of substance misuse services (drugs and alcohol) transferred to the London Borough of Hillingdon (LBH) on 1st April 2013. The service is currently under review as part of the BID Transformation review process. The aim of the review is to understand the current position and to identify priorities for a future model of delivery.<br>The service is currently weighted towards drug misuse in particular and alcohol has not been a priority in recent years as a result of the national policy which focuses on high end drug use (ie. opiates and crack use). However, alcohol misuse represents a significant issue for the borough ie. we are significantly worse than the England average in relation to the following indicators: (a) alcohol attributable hospital admission for both men and women (b) alcohol related violent crimes and (d) alcohol-related recorded crimes.<br><br>The redesign of local substance misuse services will take alcohol related needs into account. | GREEN |

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<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</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) 12 week assessments - 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%)<br><br>(b) Low Birth Weight - Decrease the percentage of Live and Still Births less than 2500 grams.<br><br>(c) Low Birth Weight of Term Babies: (ie. less than 2,500 grams):</td><td>(a) 31/03/14</td><td>(a) There has been a proactive effort to ensure that our target rate has been achieved.<br>12 Week Assessment - 2012/13 Performance:<br><table><tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>79.9%</td><td>79.9%</td><td>94.3%</td><td>90.2%</td></tr></table>2013/14 performance data - there has been a delay in the release of Q1 data. CSU have confirmed that Q1 and Q2 data will be available by mid October 2013.<br><br>(b) Task and finish group (‘Having a Healthy Baby’) to plan interventions for south of the borough which has higher rates of late bookers and low birth weight babies. Interventions include:<br>o Referrals to Stop Smoking Prevention and support in community settings<br>o Referrals to Healthy weight management courses<br>o Linking up with Hillingdon Maternity volunteers to promote and sign-post to Stop Smoking services, Healthy Weight Management courses, ‘First Aid in the home’ courses.<br>Latest available data (for the period 2011) - 8.4 per cent of all live and stillbirths weighed less than 2,500 grams. Significantly worse than the England average (7.4)<br><br>(c) Stocktake of local maternity and health visiting services underway against recommended standards in the recently published ‘Conception to age 2 – The age of opportunity’ Framework for local areas services<br>Latest available data (for the period 2011) - 3.45 per cent of all live births were born with low birth weight. Significantly higher than the England average (2.85)</td><td>GREEN</td></tr>
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| 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.<br><br>(NB The national target for childhood immunisations is 95% for each of the vaccines for the under-fives childhood immunisation schedule and 90% coverage for HPV in school-aged girls). | 31/03/14 | NHS England<br>Q1 data for 2013/14 will be available in mid to late September 2013.<br>MMR data for Jan-Mar 2013<br>MMR 24 Months 91.4% lower than England – 92.2% but higher than London – 86.6%<br>MMR (1 dose) 5 years 93.8% lower than England – 94.0% but higher than London – 90.2%.<br><br>MMR Catch-up Programme: Data for Hillingdon not yet available from NHS England. | 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) Multi-agency meeting held on 17th June chaired by the Pocklington Trust to scope content of a local vision strategy. Members of a project group agreed. First meeting of project group to take place in September. Intention to have priorities agreed by 31/03/14 that will inform commissioning plans. | GREEN |

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| ***Priority 3. Developing integrated, high quality social care and health services within the community or at home***<br>As a priority we will focus on:<br>• Integrated approaches for health and well-being, including telehealth;<br>• 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. | (a) 31/03/14 | (a) To the end of July 2013:<br>A total of 47 homes have had adaptations completed to enable disabled occupants to continue to live at home. This is made up of 25 Disabled Facilities Grants for owner/occupiers and private tenants, and 22 Council tenants.<br>There are 161 Disable Facilities Grants which are in progress or about to start with 60 pending approval. | GREEN |
| | | | (b) Extend the TeleCareLine service to a further 750 people | (b) 31/03/14 | (b) As at 31st July 2013, 2,251 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. | |
| | | | (c) Provide extra care and supported accommodation to reduce reliance on residential care | (c) 31/03/14 | (c) Placements continue to be made into Triscott House and Cottesmore House for residents with extra care support needs to prevent the need for resident placements. On average 1 placement is made per month. The council continues to work with providers to develop additional supported living accommodation. This includes de-registering a number of existing care homes and remodelling these as supported living accommodation. Work has started on six schemes which will provide supported living accommodation for approximately 26 residents. | |

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| 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.<br><br>(b) Develop information sharing protocols between statutory, voluntary, private and independent sector partners regarding early identification of people approaching end of life.<br><br>(c) Develop a process for measuring quality for end of life care in Hillingdon. | (a) 31/03/14<br><br>(b) 31/03/14<br><br>(c) 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. Support mechanisms for General Practice are also in development.<br><br>(b) A three year strategy (2013-2016) has been documented by the Pan Hillingdon End of Life Forum and is in the process of being signed off by all Health, Social Care and Voluntary Sector organisations – for public launch late Autumn.<br><br>(c) Agreements are in place to measure quality in relation to documented preferences as recorded in the CMC Care plan. | GREEN |

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| ***4. A positive experience of care***<br>As a priority we will focus on:<br>• Tailored, personalised services;<br>• An ongoing commitment to stakeholder engagement. | | | | | | |
| 4.1 Deliver personalised adult social care services through the Support, Choice and Independence programme. | Increase the number of people in receipt of a personal budget to give residents greater choice and control over the outcomes they consider to be important. | LBH | (a) Promote take up of personal social care budgets to provide greater choice and control | (a) 31/03/14 | (a) A personal care budget gives people who need care and support a greater say on deciding their support arrangements to suit their own needs. As at 30 June 2013, 78% of social care clients (1,596 clients) were in receipt of a personal budget (based on services which are subject to a personal budget). The take-up of personal budgets is exceeding the national target of 70%. | GREEN |
| 4.2 Ensure that local residents have opportunities to get involved in and have a say about services which improve health and wellbeing. | | 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<br><br>(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<br><br>(b) 31/03/14 | (a) On track. A group has been established to review and co-ordinate stakeholder engagement across health and social care. The leads for engagement across health and social care are meeting regularly and will develop recommendations for consideration.<br><br>(b) On track – recommendations will be presented to a meeting of the Board in the spring 2014. | GREEN |