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. An estimated 3,435 additional adults, older people, children and young people are now taking part in regular exercise since the programme commenced from April 2012. a) A range of programmes have been developed and delivered which is proving successful in engaging residents of all ages and abilities in regular exercise. These include: • A new programme of dances (tea dance, disco, bollywood and line dancing) is in place. There have been a total of 2,126 attendances for these events equating to approximately 600 individuals. Take-up of free swimming sessions for older people is increasing. From the latest information available, between 1st April 2013 and 31st August 2013, a total of 12,697 free swimming sessions have been taken up by older people: 45% higher than the same time last year. Typically 1,900 older people take up the free swimming every year. • The Specialist Health Promotion Team are working with Age UK Hillingdon to train a further 3 volunteers in a chair based exercise programme to encourage regular exercise for people who have mobility difficulties. Training will take place during Nov/December 2013. • The 'drummunity' project for people with dementia is proving successful. An additional 45 participants are now engaged in the project. 14 staff are being trained to deliver the programme in a range of different settings. • 16 people have taken part in a new stroke exercise rehabilitation class and around 80 people are engaged in cardiac referral classes at Highgrove Pool. 62 people have engaged in the free jogging programme. • Adults engaged in the Back to Sport programme during year 2 reached 732 individuals with participation reaching 8,184 attendances.	

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			b) Develop a programme to increase activity for children and young people		(b) 23 new families have been engaged in the 2-4 programme at three Children's Centres. Training for Children's Centre staff organised. 40 young people have taken part in the 'Fit Teen' weight management programme and now expanded to Hayes and Uxbridge. 120 primary age children are engaged in the 'Ready, Steady, Boost programme'. A programme to increase delivery in Early Years settings established. Multi-sport programme for primary age children organised. Set-up dialogue with school games organisers to link with community delivery. 460 children completed bike ability levels 1 and 2. 2,651 children completed pedestrian safety training.	GREEN
			c) Set up travel plans		(c) Travel plans required for new residential and commercial development. Highest increase in London for modal change in school travel. System established to better monitor progress. 27 schools registered for Key stage 1 'Walk once a week'. 53 schools involved with 'Walk on Wednesday'.	
			d) Show an increase in cycling and walking		(d) New information has been produced to encourage residents to 'Explore Hillingdon'. A new cycle ride programme is in place for 2013. Organised cycle rides 'Age Well on Wheels' have been organised. There are 30 residents who are registered and regularly take part in the rides. 97 people have completed adult cycle training. The Healthy Walks programme - there are 150 registered walkers who walk a minimum of once a month. In the six months since 1st April 2013 there were 1467 attendances of people taking part in which involved 102 new walkers.	
			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. 20 volunteers trained to deliver walks from their setting or through the 'Walk Hillingdon' programme. 11 schools have registered mini road safety officers scheme launched in September to run alongside 18 registered with Junior scheme so children promote road safety and encourage sustainable school travel.	

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			f) Review and support opportunities for people with disabilities		(f) 'On Your Marks' scheme established in partnership with DASH, providing new swimming and multi-sport activities for disabled adults. A 'Shine the Light' sports event for disabled adults was held at Brunel University in July 2013 to celebrate one year since the torch relay passed through Hillingdon. Around 80 people with disabilities attended.	GREEN
			g) Set up care pathways with Primary Care and Public Health		(g) Reviewed delivery of existing cardiac referral scheme. New trial scheme for stroke patients established with 'Fusion'. New 'Let's Get Moving' physical activity referral programme being explored. This will provide a general scheme available to all residents through GP's, Health Checks and other health practitioners. 27 diabetic patients referred by Specialist Diabetic nurses into Walk programme. Pilot developed with Macmillan Cancer Research into walk programme to include linking in with new Cancer Information System at Hillingdon Hospital opening in November. Physical activity pathway for cancer patients resulting in 12 regular volunteers. Opportunities for physical activity being included in training for health professionals administering NHS Health Checks.	
			h) Develop the Change 4 Life campaign to encourage residents of all ages to participate in physical activity.		(h) Pledge system established with incentives to encourage more people to be more active, more often. Regular articles in Hillingdon People, through social media etc.	

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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. • 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 41 homes of older people in Hillingdon as follows: • Heating improvements have been made to the homes of 17 older people. • 18 homes with improved insulation measures. • 6 homes of older residents received essential repairs as needed. Essential repairs can include roof and glazing repairs to reduce health and safety risks The total number of homes to be improved are on track to be completed by the end of March 2014. (b) Ongoing – The campaign was promoted at the Older Persons day on 1st October 2013 including an event held in Uxbridge Town Centre. The event held was very successful with a good variety of stands offering a comprehensive range of information to older people and a good flow of visitors throughout the day. The Age UK Hillingdon Information and Advice stand saw 144 people and specifically gave out 21 Winter Warmth leaflets, following discussion with visitors about the campaign.	GREEN

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Priority 2. Prevention and early intervention As a priority we will focus on: • Reducing reliance on acute and statutory services; • Children's mental health and risky behaviours; • Dementia and adult mental health; • Sight loss.						
2.1 Reduce reliance on acute services and prevent avoidable hospital attendances, admissions and readmissions. Deliver the out of hospital strategy.	Develop and implement plans to prevent avoidable admission or readmission into hospital and avoidable demands on social care services by 31/03/15.	Integrated Care Steering Group	(a) Integrated Care Program to increase the number of people with long term conditions who have a multidisciplinary care plan, specifically targeting at risk groups with diabetes, respiratory disease and the frail elderly b) Enhance the number of people who are transferred home with support from emergency assessment beds at Hillingdon Hospital c) Increase the complexity of people managed in the community by intermediate care services to include dementia and older people with mental health needs	(a) 31/03/14 (b) 31/03/14 (c) 31/03/14	(a) Ongoing - The Integrated Care Programme (ICP) went live in 2012 providing a joined up approach to patient care across health and local authority services based around case discussion at GP practices. 87% of GP practices have now signed up to the new ICP services. The programme is targeting residents with complex care needs (older frail people, those with diabetes, people with mental health needs, chronic obstructive pulmonary disease and patients with cardiac difficulties). An evaluation of the programme from the first year is showing positive results including: • 260 patients have been considered at multi-disciplinary group meetings • 3831 care plans have been completed • 65% of professional attendees have changed their clinical practice as a result of attending a case conference • Very positive feedback from patients post care planning • The changes in practice are helping to support the efficiency programme (b) Ongoing. Key services are in place and delivering benefits. This includes TeleCareLine, reablement and essential support from the voluntary sector through the 'prevention of admissions and re-admissions' service from Age UK. (c) On track – A flexible service 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.	GREEN

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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 (b) A map of local CAMHS/mental health and Learning Disabilities/Challenging Behaviour provision at all tiers for services in scope: service provision, service capacity, referral access (c) Identify local population needs and initial recommendations regarding meeting service gaps (d) An evidence review of "what works"; and feedback from users (e) Whole systems service design for child mental health support	a) 31/12/13 b) 31/12/13 c) 31/12/13 d) 31/01/14 e) 31/03/14	(a-e) Senior Team to Team meeting established with health commissioners as overarching steering group. CAMHS Working Group formed with health commissioner, local authority and provider representatives. Project charter developed.	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.
			
			(b) Increase the Chlamydia Screening uptake by the Brunel University population: a) Increase Awareness of the Chlamydia Screening service on Campus, b) Refocusing the service to repeat Chlamydia testing annually or on change of partner/s.
				a) 31/03/14
				
				(b) 31/03/14
					(a) Outreach Contraception and Sexual Health Nurse newly recruited. A programme of work is being implemented.
					
					(b) Terrence Higgins Trust providers of Chlamydia Screening are investigating various ways 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)
					A considerable amount of work is now being achieved on the Brunel University campus by the commissioned service providers, including:
					▪ This term the C-Card is being rolled out across campus.
					▪ Seven training workshops have been delivered to 30 staff across five outlets. Workshops are booked for October.
					▪ Targeted awareness raising of the risks on campus during November focusing on Chlamydia/C-Card/LGBT and Trans/HIV.
					▪ The following resources were partly designed and developed for use on campus:
					  ▪ Two new leaflets and a handy test voucher have been produced and distributed this quarter.
					  ▪ The leaflets cover Re-testing, Partner Notification and the voucher is a handy credit card sized test request.
						GREEN

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			(c) Develop a proposal to extend the current Emergency Hormonal Contraception service, from under 18yrs to under 25yrs and based on local evidence, include a further 9 Pharmacies in the revised TP hotspot wards (ONS 2011)	c) 31/03/14	(c) Potential interested eligible Pharmacists have been identified. Emergency hormonal contraception training being developed. Patient Group Direction (note: PGD is a specific written instruction for the supply or administration of a named medicine in an identified clinical situation) currently in process of being updated.	
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.	a) 31/03/14	(a) On track. Adult Mental Health strategy in place including dementia. A mental health task and finish group has been established to co-ordinate and implement the agreed plan for adult services of all ages. The plan will complement work already underway and being delivered which includes befriending services, dementia cafes, programmes which promote healthy living and health improvement and increasing early intervention for memory assessment.	GREEN
			(b) Agree a joint implementation plan for years 2 and 3 of the Adult Mental Health Strategy.	b) 31/03/14	(b) Ongoing. Plan will be recommended for consideration by the Health and Wellbeing Board by 31 March 2014.	

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

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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 (b) Increase the numbers and rate of alcohol clients successfully completing and exiting treatment.	(a) 31/03/14 (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. 541 clients (where alcohol is the primary drug), presented to alcohol services in Q1 2013/14 – a small reduction compared to the previous quarter. (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%. Q1 – 186 (34.4%) (where alcohol is the primary drug) exited alcohol treatment in the 12 months ending Q1 2013/14 with a successful completion rate of 34.4% of all in treatment, two per cent down on the baseline year. 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.	GREEN

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<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) <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.</td>
<td>(a) 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>
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<u>Q1 – 2013/14</u>: The Commissioning Support Unit have confirmed that the Department of Health will not be collecting maternity assessment data until the new year and that it will be obtained directly from the providers rather than CCGs.

(b) Task and finish group (‘Having a Healthy Baby’) to plan interventions for the south of the borough which has higher rates of late bookers and low birth weight babies. Interventions include:
○ Referrals to Stop Smoking Prevention and support in community settings
○ Referrals to Healthy weight management courses
○ 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.

<u>Smoking in Pregnancy Update:</u> Since April 2013 to the end September 2013, the Smoking Cessation Midwife Service has received 131 referrals.

<u>Referrals to Healthy weight management courses</u>: Q1 2013/14 – None. Health Visitor specialist in Community Engagement to develop referral links with maternity services to current Healthy Weight management workshops in south of the borough. Latest available data (for the period 2011) - 8.4 per cent of all live and stillbirths weighed less than 2,500 grams. Higher than the England average (7.4)</td>
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			(c) Low Birth Weight of Term Babies: (ie. less than 2,500 grams):		(c) 'Conception to age 2 – The age of opportunity' Framework for local areas services: A stock take of local maternity and health visiting services is underway against recommended standards in the recently published 'Conception to age 2 – The age of opportunity' Framework for local areas services. Latest available data (for the period 2011) - 8.4 per cent of all live and stillbirths weighed less than 2,500 grams. Higher than the England average (7.4) Latest available data (for the period 2011) - 3.45 per cent of *all live births* were born with low birth weight. Higher than the England average (2.85)	GREEN

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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. (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 Q2 data for 2013/14 is expected December 20th 2013. MMR data for Apr-Jun 2013 MMR 24 Months 92.4% (this is just lower than England, 92.6%, but higher than London, 87.5%) MMR (1 dose) 5 years 93.8% (this is lower than England, 94.4%, but higher than London, 91.6%) MMR Catch-up Programme: So far this year (ie. 2013) Hillingdon has not had any confirmed cases of Measles. There was a single confirmed case in 2012. Information regarding uptake of the MMR vaccine amongst the target age group will not be available until later in the year – As of 12-10-2013.	GREEN
2.10 Tackling the issues which can cause sight loss	To develop support and services locally which reduce the effects of sight loss	Vision Strategy Working Group	(a) Working with the Thomas Pocklington Trust and other local partners develop a vision plan and local support services.	(a) 31/03/14	(a) Pocklington Trust is in the process of collating needs information provided by stakeholders. A project group meeting will be taking place in December 2013 to review needs data and identify gaps. An action plan will be developed for consideration in Q4. Intention is to have priorities agreed by 31/03/14 that will inform commissioning plans.	GREEN

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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) To the end of September 2013: A total of 86 homes have had adaptations completed to enable disabled occupants to continue to live at home. This is made up of 55 Disabled Facilities Grants for owner/occupiers and private tenants, and 31 Council tenants. There are 163 Disabled Facilities Grants which are in progress or about to start with 14 pending approval. (b) As at 30th September 2013, 2,455 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) On average 1 placement is made per month into extra care for older people who would otherwise have to move into residential care. Glenister Gardens, a 12 bed supported living scheme for clients with learning disabilities, is fully occupied. The supported living building programme is currently being reviewed to ensure it meets the current and future needs. 4 bespoke small schemes are being developed for clients with mental health needs or learning disabilities who will benefit from shared accommodation. These will be complete within the next 4 months.	GREEN

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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.	(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. Support mechanisms for General Practice are also in development.	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 and is in the process of being signed off by all Health, Social Care and Voluntary Sector organisations – for public launch late Autumn.	
			(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.	

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4. A positive experience of care As a priority we will focus on: • Tailored, personalised services; • An ongoing commitment to stakeholder engagement.						
4.1 Deliver personalised adult social care services through the Support, Choice and Independence programme.	Increase the number of people in receipt of a personal budget to give residents greater choice and control over the outcomes they consider to be important.	LBH	(a) Promote take up of personal social care budgets to provide greater choice and control	(a) 31/03/14	(a) A personal care budget gives people who need care and support a greater say on deciding their support arrangements to suit their own needs. As at 30th September 2013, 77% of social care clients (2,163 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

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4.2 Ensure that local residents have opportunities to get involved in and have a say about services which improve health and wellbeing.	Develop opportunities for residents to get involved.	Task and Finish Group to review	(a) Establish the current requirements and arrangements for stakeholder engagement across health and the Council to support improvements in health and wellbeing (b) Make recommendations to the Health and Wellbeing Board to establish a co-ordinated plan of stakeholder engagement in Hillingdon for Health and Wellbeing	(a) 31/03/14 (b) 31/03/14	(a) On track. A group has been established to review and co-ordinate stakeholder engagement across health and social care. The leads for engagement across health and social care are meeting regularly and will develop recommendations for consideration. The recommendations will be practical and focus on supporting meaningful involvement of local residents. (b) On track – recommendations will be presented to a meeting of the Board in the Spring 2014.	GREEN