Appendix A

Priority 1 - Improving Health and Wellbeing and reducing inequalities				
Objective	**Task and Metric**	**Lead**	**Metric reporting frequency**	**Evidence of activity against task**
1.1 Protect resident's health	**1.1.1** From conception to year 2, Increase the confidence and participation of parents/women to have healthy babies by delivering the 'Having a Healthy Baby' Project	Public Health & Maternity Services	Annually	• A working group is assessing areas of action that will support pregnant women in having a healthy baby through action in maternity, children's centres and with health visitors. Recommendations from the rapid assessment process highlighted the need to understand local mother's experiences and perceptions about having a healthy baby. A questionnaire was developed with the members of the multi-agency 'Having a Healthy Baby' group – which is chaired by Public Health. Over 200 surveys were completed and returned from mothers across the borough. Focus groups with up to 60 mother's are being held to capture mother's experiences and perceptions of having a healthy baby.

				• The Smoking Cessation Midwife is focussed on reducing smoking in pregnancy and second hand smoking for babies so as to reduce likelihood of childhood mortality. At October 2014, Smoking at Time of Delivery has declined from 8.35% to below 8% over the year. • Hillingdon's Breast feeding rates for both 'breast feeding initiation' (82.3%) and 'breast feeding prevalence at 6-8 weeks' (61.9%) continues to be above the rates for England (73.9% and 47.2%).
	1.1.2 Develop a Children's Health Programme Board to agree with partners the strategic direction for children's health provision	CCG		• The proposed work streams of this group include: o Maternity and the Paediatric shift o Urgent care management o Mental and emotional health and wellbeing o Long term conditions o Complex care o Access for vulnerable groups
	1.1.3 Deliver a mental wellness and resilience programme	Public Health		There is a full programme of activity supporting this work. This includes: • Three community area-based wellbeing programmes for residents in Harefield, Yiewsley and West Drayton and Hayes. • The promotion of 'Five Ways to Wellbeing' messages as an awareness tool through community events, wellbeing publicity and training to frontline

				staff, community groups, faith groups and service providers. • Activities with partners including: delivering wellbeing session to Job Centre Plus staff with CNWL; support Hillingdon Mind's 'Our Voice, Our Mind Conference'; delivered a wellbeing event with Age UK Hillingdon for an Asian women's group and organised a Health and Wellbeing Grant Launch Event with the theme 'Feeling Good, Living Well' with Hillingdon Community Trust. • Training continues for Library Service staff to support the 'Wellbeing with Libraries' scheme.
	1.1.4 Deliver a smoking cessation service including supporting the further roll out of Smoke Free Homes in Hillingdon	Public Health	Annually	• Hillingdon's smoking prevalence rate is 16.2%. Those who attend the smoking service receive high quality evidence-based behaviour change intervention and medication – which is 4-5 times more effective than going 'cold turkey'. • Hillingdon Stop Smoking Service continues to perform well in terms of its quit rate (i.e. smokers who join the service have some of the best chances in London to quit) • <u>No Smoking Day</u>: During 'No Smoking Day', over 200 + residents across the borough were given

				advice on stopping smoking and where they can access help. There were 40+ direct referrals to the service. • <u>Training</u>: The service provided x2, two-day training programmes to skill up additional one to one stop smoking advisors across the Borough. In total there were over 40 participants. There were x2 smokefree homes and basic awareness courses delivered to children centres with around 20 staff trained.
	1.1.5 Reduce prevalence of obesity through a variety of initiatives including the delivery of the Child Measurement Programme, and raising awareness of the importance of physical activity across the life course	Community Sport and Physical Activity Network & Obesity Strategy Working Group	Quarterly	• The height and weight measurement of Reception and Year 6 children is delivered via the local School Nursing Service contract. By October 2014, 7208 children had been weighed and measured from Reception and Y6, participation rate was 98.8% and 98% respectively. • A stakeholder's workshop was held in June 2014 on the topic 'Addressing excess weight in Hillingdon'. The main aim of this workshop was to consult local professionals with vested interest in reducing excess weight in Hillingdon and to share ideas about future priorities. Actions identified included 'Healthy Catering Commitment', the Adults weight management programme, Healthy messages and Green Gyms.

				• A variety of projects are being delivered to raise awareness of good nutrition include: 'Feed my Family', 'Get up and go', 'Healthy Schools', 'Young Chef Award' and 'Food blog'. These work on all aspects of nutrition to ensure residents have access to accurate, evidence based obesity interventions and weight management programmes. • There are many schemes to encourage physical activity for Hillingdon residents. These include: Universal Walk Hillingdon which has seen 1800 people take part from January to September; Walking programmes at 3 Children Centres where on average 10 families per month engage in 60mins activity; the Older People's Dance programme which has seen a 7% increase on the number of people attending dances since last year; and Chair Based exercise for the less able which is now being delivered at Triscott house, Cottesmore House, Drayton Court and ASHA day centre.
1.2 Support adults with learning disabilities to lead healthy and fulfilling lives	**1.2.1** Increase the number of adults with a Learning Disability in paid employment	LBH	Quarterly	• In 2013/14, in-house day services reported 9 service users with learning and physical disabilities had received 41 payments for paid employment. 340 work experience opportunities were taken up and these included: support with mailshots, UPWARD group presentations to different

				departments, partners and schools (talking about their disabilities to raise awareness and understanding) and Genuine Dining roles. • The combination of work opportunities and support plans leave these service users well placed to apply for vacancies in the borough or with our partner organisations. • The Rural Activities Garden Centre (RAGC) works with 25 service users with learning disabilities. They sell plants outside the Oasis cafe. The plants they grow are also used in the planters outside the Civic. • Woodside Day Centre and the Phoenix Day Centres have been recently closed. On 02 September 2014 the Queens Walk Resource Centre opened. The Centre offers services to people with complex learning needs and physical disabilities. The centre offers many facilities, including hydro pool, gym, interactive room, teaching kitchen and snoozelum. An Employment Activities and Education Officer is scheduled to be recruited. The centre is there to help people to achieve their aspirations and have greater independence.

				• The Council works with' Dimension' an Outreach Service for people with low to moderate needs. They offer support with getting into college, employment etc. for those who are not eligible for social care.
	1.2.2 Increase the number of eligible adults with a learning disability having a GP Health Check	NHS England	Annually	• Adults with learning disabilities who are known to their local authority social services, and who are registered with a GP who knows their medical history, should be invited by their GP practice to come for an Annual Health Check. This scheme is separate to the National Scheme for adults aged 40-75.
1.3 Develop Hillingdon as an autism friendly borough	**1.3.1** Develop and implement an all age autism strategy	LBH	Quarterly	• The strategy is in development and will be presented to the Board for consideration if required.

Priority 2 - Prevention and early intervention

Objective	Task and Metric	Lead	Metric reporting frequency	Evidence of activity against task
2.1 Deliver the BCF workstream 2 - Intermediate Care under Strategy	**2.1.1** Deliver scheme six: Rapid response and joined up Intermediate Care	LBH/CCG	Quarterly	• A multi-agency project group has been meeting on a monthly basis and a proposed model of care will be presented in the New Year. The intention is that issues such as the following will also be addressed: ○ Patients who will be non-weight bearing for longer than 3 weeks and who have future rehab needs and need a bed based service. ○ Patients who have rehab needs but a mental health condition which can’t currently be managed on HICU. ○ Neuro rehabilitation in the community ○ Clarity about 'step up' from the community, i.e. crisis response • HICU/Beaconsfield East alignment, i.e. flexible working between providers to identify patients' care needs and to best address them
	2.1.2 Deliver scheme seven: early supported discharge	LBH/CCG	Quarterly	
2.2 Deliver Public Health Statutory Obligations	**2.2.1** Deliver the National NHS Health Checks Programme	Public Health	Annually	• The aim of the programme is the early identification of individuals at moderate to high risk of cardiovascular disease, diabetes, stroke, kidney disease and related metabolic risk.

				• During the first six months of 2014/15, 4,940 Hillingdon residents received a first offer of an NHS Health Check and, of these, 2,680 people went on to receive an assessment. Source: NHS England October 2014 • 37 GP practices and 19 pharmacies were providing a NHS Health Check service in the first half of the year. The number of active GP practices should rise during the second half of the year as nearly all of the 48 sites have now signed up to the new Local Primary Care Contract. This should result in increased activity. • Public Health will be working with the Communications Team to raise the profile of the NHS Health Check locally, e.g. through articles in the Hillingdon People and local Gazettes, poster campaigns etc. • In September, a training day was held for 25 general practice and pharmacy staff. Evaluation questionnaires show that this training was well received and a further session is planned for December.
	2.2.2 Deliver Open Access Sexual Health	Public Health	Quarterly	• Teenage pregnancy (TP) was at its lowest in 2012. There were 139 conceptions recorded with a conception rate of 27.7.

				• The Maternity rate (those who choose to keep their baby) rose to 12.6 from 7.8 in 2011, along with the lowest Abortion rate of 15.2 that Hillingdon had experienced. The percentage of conceptions leading to an Abortion in 2012 was 54.7% a significant reduction from 2011 when it was at its highest at 72%. The number of under 16 years conceptions in 2010-2012 in Hillingdon was 85 conceptions with a 6.1 conception rate and 81% of conceptions opting for an Abortion. The high percentage of abortions in the under 16yrs for the last two consecutive three year periods is a concern. Approximately 28 under 16yrs may be getting pregnant annually with three quarters of them (21) choosing to have an Abortion and a quarter (7) having the baby. • A range of evidenced based interventions provided by GPs, Pharmacists and Community Nursing and LBH early intervention and prevention services are in place with a focus on reducing both teenage pregnancies and the incidence of STIs in this age group. • Young People Friendly Contraceptive services; Clinic in a Box outreach – to identify at risk individuals including those who may be at risk of a second teenage pregnancy; Emergency Hormonal Contraception and advice on prevention of STIs; Chlamydia Screening; Self Esteem Raising Project for young women

				• Performance demonstrates that many young people were being screened in 2013, however, the commissioned service was not reaching those who are infected with Chlamydia. Therefore in year 2013/14, we worked with providers to change direction to a more targeted outreach based programme aimed at testing the "seldom seen" in services – ie. also known as vulnerable groups who do not ordinarily access main stream services and those most often experiencing the most inequalities.
	2.2.3 Delivery of information to protect the health of the population against infection or environmental hazards and extreme weather events	Public Health		• Ebola: During the summer at the request of Public Health England, guidance containing advice and risk assessment for educational, early years, childcare and young persons' settings, colleges and universities were disseminated. • Avian influenza (bird flu) H5N8 outbreak in Yorkshire: PHE have requested that local authority Directors of Public Health assure themselves that the local health economy is prepared and able to respond to a similar situation in their own patch. Information disseminated to the relevant officers and feedback received.
2.3 Prevent premature mortality	**2.3.1** Ensure effective secondary prevention for people with Long Term Conditions including cancer, diabetes and dementia	NHS	Quarterly	• In 2012, the GP-recorded prevalence of diabetes was 14,514 people while in the same year, Hillingdon was estimated to have 18,790 GP patients who should have diabetes (modelled prevalence) This means over 4,000 people in Hillingdon do not know that they have diabetes. • Currently, consideration is being given to how to

				address early intervention and prevention programmes for those with pre-diabetes, and weight loss programmes for obese adults. • Hillingdon CCG is working on a business case regarding remodelling of cardiology services, The CCG, as part of the 'Core Offer' arrangement, has asked for assistance from Public Health. The initial review, based on demographic information and national data, has been discussed with the CCG. This is an ongoing piece of work. • Hillingdon is currently achieving lower rates of coverage for Breast Cancer Screening (70.8%) and Cervical Screening (67.1%), than the average for England (Breast 76.3% and Cervical 73.9%). • Geographical coverage data and details of improvement activity have been requested of NHS England. This information will inform local activity.
	2.3.2 Reduce the risk factors for premature mortality and increase survival across care pathways	PH/CCG	Quarterly	• There is improvement in recording of cancer staging and diagnosis data at The Hillingdon Hospital, from around 30% to 52%, however, it remains a long way away from some of the Trusts in the London Cancer Alliance, which are above 80% . • Public health team is working with HCCG on the new CHD integrated model of care and diabetes

				care pathway. • A Survivorship event for cancer sufferers was held on 14 October at the Civic Centre. The event was attended by over 65 people, where support on surviving cancer and leading a healthy lifestyle for patients and carers was highlighted. Participants were also made aware of the Council's new Exercise Referral Programme, as well as its walk schemes. There were also various displays by agencies such as the Red Cross and Hillingdon Carers • Alcohol Misuse (a) A question on alcohol use has been included in the NHS Health Checks (b) It is essential that Substance Misuse services are commissioned robustly, as currently they are accessed by approximately 1,000 residents, in various stages of drug and alcohol recovery. An outcome based service model with greater levels of integration, based on all levels of need, has been developed with existing providers, service users and support from Public Health England. The service is currently out to tender.
	2.3.3 Reduce excess winter deaths	Public Health/NHS		• There are a number of activities that aim to reduce excess winter deaths in the borough. These include: ○ Providing Flu immunisation to people at risk

				○ Screening for Chronic Obstructive Pulmonary Disease screening as part of smoking cessation project to identify smokers at high risk ○ Monitoring Inferior Wall Myocardial Infarction over Coronary Heart Disease remodelling of services ○ Age UK providing a 'Getting ready for Winter' scheme that works towards reducing the number of older people becoming ill, being admitted to hospital or dying as a result of the winter conditions. This includes offering older people a free winter warmth check by the handyperson service. This will cover safety (home security and the environment generally), warmth (heating, insulation etc) and energy efficiency with referrals on to appropriate agencies where issues are identified. They will also have a range of winter warmth items available – draught excluders, blankets, thermal items and room thermometers together with emergency food parcels.
	2.3.4 Reduce the number of children with one or more decayed, missing or filled teeth	Public Health & NHS England		• Dental caries is one of the top causes for hospital admissions in under 4's in Hillingdon. Public Health will be reviewing this issue with NHS England to determine how access to dentists can be improved and what preventative action can be undertaken eg: ○ Commissioning of fluoride varnish for all children above age 3 twice a year

				○ Raising awareness about the importance of registering with dentist ○ Raising awareness about improvements in diet, action against sugary drinks in nurseries, early year settings and schools. • The 'Brush for Life' scheme in Children's centres is the main route to inform parents on good oral health. An update on this work will be provided in the next report.
	2.3.5 Deliver a project to make Hillingdon a Dementia Friendly borough	Mental Health Delivery Group	Quarterly	• Since January 2014, 345 people have been trained to be 'Dementia Friends'. This includes front line council staff, police officers, faith leaders and GP staff. • The Drummunity project continutes to enable older people with dementia to take part in an activity which allows them to communicate creatively, fully participate, works on their short term memory skills, increases their relaxation and helps to develop strength and coordination. Since January 2014, Drumunity Sessions have continued at Grassy meadows, Triscott House and Asha Day centre with a regular 30 service users taking part.
	2.3.6 Improve pathways and response for individuals with mental health needs across the life course including the	CCG	Annually	• The CCG Commissioning Intentions for 2015/16 include the commitment to improve transition arrangements for service users between CAMHs and adult services, and adult services and services

	provision of Child and Adolescent Mental Health Services (CAMHS)			for older adults. • In addition, the development of a single point of access and streamlined care pathway for those requiring access to urgent care is being reviewed. • We have also increased the provision of Liaison Psychiatry services to improve access to specialist mental health services for those patients presenting at A+E and receiving clinical services for other conditions in an Acute Hospital setting. • Finally, following additional investment the CCG is achieving its national target for access to Improving Access to Psychological Therapies (IAPT) Services.
	2.3.7 Develop a Vision Strategy for Hillingdon	Vision Strategy Working Group	Annually	• A Needs Assessment is being produced which will inform the strategy.
2.4 Ensure young people are in Education, Employment or Training	**2.4.1** Identify those at risk of becoming Not in Education, Employment or Training (NEET) and implementing appropriate action to prevent it	LBH	Quarterly	• There is a range of activity to identify those at risk of becoming NEET and action to prevent it. This includes: o SWEET event: support with education, employment and training. It was held in early September at the Civic Centre and brought together 20+ education and training providers and 60 young people. o Targeted programmes: Unique Swagga (young women aged 13-19 identified as at risk through social health and economic outcomes); ichoose (boys and young men,

				aged 11-15 - identified as above). ○ Access Point: drop-in sessions for young people to receive information, advice and guidance available at Fountain's Mill and Harlington Young People's Centres. ○ SIAG Team: 121 support for those at risk of becoming NEET. Youth Support Advisers are placed in the YOS Team, LACE team 16+ and generic advisers based are Fountain's Mill. ○ A Risk of NEET Indicator has been created to identify students in Years 9-12 at risk of NEET.

Priority 3 - Developing integrated, high quality social care and health services within the community or at home				
Objective	**Task and Metric**	**Lead**	**Metric reporting frequency**	**Evidence of activity against task**
3.1 Deliver the BCF Workstream 1 - Integrated Case Management	**3.1.1** Deliver scheme one: joined up tool for health and social care risk stratification	LBH/CCG	Quarterly	• Reporting on the assumptions in the CLARHC tool will take place in Q4. • GP practices are actively identifying vulnerable patients through production of a practice based risk registry, which includes identifying those likely to be susceptible to falls, suffering from dementia and social isolation, using local practice intelligence. • As at 30th September 2014, 45% of care plans in GP practices were undertaken using BIRT 2 information in addition to practice based intelligence, which means the use of BIRT 2 is being used consistently.
	3.1.2 Deliver scheme two: early identification of people susceptible to falls, social isolation and dementia	LBH/CCG	Annually	• Adult Social Care lead now identified for this scheme and scoping workshop to take place in Q3. This will bring together the following work strands: ○ Work being led by the five organisations within the third sector consortium Hillingdon4All (Age UK, DASH, Harlington Hospice, Hillingdon Carers and Mind), to develop a model that provides a single point of access to voluntary and community organisations based in the north of the borough for the 65 + population.

				◦ Drawing together the results of research into the support required by smaller third sector organisations in order to develop sustainable community capacity to enable the 65+ population with low or moderate needs to remain at home in the community. ◦ Falls prevention ◦ Early identification of people living with dementia and providing suitable support to them and their families. ◦ Mapping of services across the economy undertaking key working activities and/or who are visiting residents in their own homes and making available training in how to identify people susceptible to falls, dementia and/or social isolation and how to respond. • Work is in progress to develop a screening tool that could be used by partners to identify older residents at risk of a loss of independence and avoidable demand on statutory services.
	3.1.3 Deliver scheme three: further development of care plans that are shared, agreed and implemented jointly	LBH/CCG	Quarterly	• A care planning tool was implemented in August and completed care plans will be reviewed based on trigger events and updated accordingly. Further discussions are taking place about the care planning tool with the intention that this is capable with the requirements of organisations across the health and social care economy and workshops will be taking place over the next two weeks to take this forward.

				• An information sharing agreement has been signed off by the CCG which will provide the framework to facilitate greater sharing of information, which will prevent the need for residents to tell their story more than once. The Council is currently exploring the scope for this to be used as a template that will permit information to be shared between Social Care and local NHS and third sector partners.
	3.1.4 Deliver scheme four: integrated case management and care coordination	LBH/CCG	Quarterly	• Six Health and Social Care Coordinators (HSCC) have been appointed to work with GP practices to support care planning for people identified through risk stratification as being at risk. A key role for the HSCC is to actively support the delivery of care plans. One of the HSCC posts has recently become vacant. • Support for the HSCC is being provided by Prof David Sines (Emeritus Professor and Associate at Buckinghamshire New University/Health Care Consultant), which includes monthly action learning sets of issues identified • At the end of M6 practices had achieved 48.5% of the 6,560care plans against targets. • The appointment of 6 Primary Care Navigators (PCNs) by Age UK is intended to support people with lower level needs in order to prevent deterioration in need leading to loss of independence and increased demand on statutory services. The PCNs will work closely with the HSCCs.

	3.1.5 Deliver scheme eight: better care for people at the end of their life (EoL)	LBH/CCG	Quarterly	• A sub-group of the EoL Forum is being formed to refine the scheme 8 action plan with the intention of directly linking it to the benefits. It is intended that this will meet late in November. • Options for a fast track end of life service are currently being explored by Adult Social Care with the intention of having proposals in December. • The CCG will be making interim arrangements following the retirement of the current EoL lead at the end of November.
	3.1.6 Deliver scheme eleven: development of IT systems across health and social care with enhanced interoperability	LBH/CCG	Quarterly	• Development of interoperability between IT systems across health and social care has been moved into the broader ICT project to reflect that it should not be considered as a model of care scheme but rather an enable for the delivery of other schemes.
3.2 Deliver the BCF Workstreams 3 & 4 - Seven day working and Seamless Community Services	**3.2.1** Deliver scheme ten: seven day working	LBH/CCG	Quarterly	• Review of services being provided 7- days has revealed some gaps, e.g. GP cover, community equipment referrals, CNWL Contact Centre, specialist nursing to cover wound dressing. • Perfect Week will be taking place between the 10th and 18th November 2014 that will provide useful intelligence on how well the health and social care system is working. Learning points from Perfect Week to be considered by the 7-day working project group.

	3.2.2 Deliver scheme nine: Care homes initiative	LBH/CCG	Quarterly	• The Care Home Delivery Group will finalise the action plan for this scheme at its meeting on the 13th November 2014. The trajectory of this project is to support a change in culture that will prevent unnecessary non-elective admissions and provide early intelligence of where a home is at risk of this happening.
	3.2.3 Deliver scheme five: Review and realignment of community services to emerging GP networks	LBH/CCG	Quarterly	• Discussions are taking place between the CCG and CNWL regarding the alignment of the District Nursing Service with the GP Networks.
	3.2.4 Provide adaptations to homes to promote safe, independent living including the Disabled Facilities Grant	LBH	Quarterly	• From April to September, a total of 44 homes have had adaptations completed to enable disabled occupants to continue to live at home. This includes adaptations to the homes of 30 older people, of which 20 were in the private sector.
	3.2.5 Increase the number of target population who sign up to TeleCareLine service which is free for over 80's	LBH	Quarterly	• TeleCareline technology continues to help people to live safely and independently at home. To date there are 5443 users and 119 new clients over the age of 80.
3.3 Implement requirements of the Care Act 2014	**3.3.1** Develop the prevention agenda including Info and Advice Duty	LBH	Quarterly	• The Care Act Implementation team are at the final stages of selecting a provider for an online solution to support ASC to meet the requirements of the Care Act. The tool will enable more dynamic use of

				advice and information, supporting residents to make informed decisions and access preventative services. The system will facilitate the provision of personalised advice following on-line assessment, or assisted self assessment accessible to all residents and carers with the ability to progress through an e-marketplace to purchase support or to ASC services if required.
	3.3.2 Develop a Carers Strategy that reflects the new responsibilities and implementation of the Care Act 2014	LBH	Biennially	• A working group has been established to develop a new strategy. Consultation will take place with key stakeholders in January 2015. Feedback from consultation will inform activity to deliver on priorities.
	3.3.3 Engage with providers through the development of the Market Position Statement to maintain a diverse market of quality providers that offers residents choice	LBH	Quarterly	• The first draft of the Market Position Statement is being developed. Once approval is sought, there will be a launch to promote the statement to local suppliers and the voluntary sector. The markets will then be developed by Category Management.
3.4 Implement requirements of the Children and Families Act 2014	**3.4.1** Implement the SEND reforms including introducing a single assessment process and Education, Health and Care (EHC) Plans and joint commissioning and service	LBH/CCG	Quarterly	• The new Education, Health and Care (EHC) assessment process has been implemented and EHC Plans are being produced. This is an outcome focussed and person centred process and is providing an improved experience for families. The new approaches need to be fully embedded in all services and there remain opportunities for greater integration.

	planning for children, young people and families			• The Local Offer was published in September and ongoing development work is taking place. • The joint commissioning activity has seen a draft strategy prepared which will require approval from the Health and Wellbeing Board. There will be an initial focus on provision for children and young people with speech, language and communication needs as the JSNA indicates this is an area of unmet need. • Personal budgets for children and young people with EHC Plans are being rolled out and where families are eligible for these services they can now take a direct payment for home to school transport, care packages and continuing health care using the same systems as adult service users.
3.5 Enable children and young people with SEND to live at home and be educated as close to home as possible	**3.5.1** Develop a strategy to identify local educational priorities supported by specialist services across education, health and care	LBH	Quarterly	• The strategy is in development and will be presented to the Board for consideration.
	3.5.2 Develop a short breaks strategy for carers of children and young people with disabilities	LBH	Quarterly	• The strategy is in development and will be presented to the Board for consideration.
3.6 Assist	**3.5.1** Provide extra care and	LBH	Quarterly	• Two extra care schemes for the 55 and over

vulnerable people to secure and maintain their independence by developing extra care and supported housing as an alternative to residential and nursing care	supported accommodation to reduce reliance on residential care			population were opened, one in 2011 and one in 2012. These were Cottesmore House in Ickenham and Triscott House in Hayes. • Two purpose built supported living schemes for people with learning disabilities have also recently been opened and these are Glenister Gardens, which opened in 2012 and Swan House, which opened in 2014. Two more schemes are due to open in 2015. • A supported living scheme for people with mental health called Sessile Court is due to open in early 2015.

Priority 4 - A positive experience of care				
Objective	**Task and Metric**	**Lead**	**Metric reporting frequency**	**Evidence of activity against task**
4.1 Ensure that residents are engaged in the BCF scheme implementation	**4.1.1** Improve service user experience by 1%	LBH/CCG	Annually	• Development of the Stakeholder Communication and Engagement Strategy will be undertaken in January following the submission of the revised plan.
	4.1.2 Improve social care related quality of life by 2%	LBH/CCG	Annually	
	4.1.3 Increase the overall satisfaction of people who use services with their care and support	LBH/CCG	Annually	
4.2 Ensure parents of children and young people with SEND are actively involved in their care	**4.2.1** Develop a more robust ongoing approach to participation and engagement of Children and Young People (C&YP) with SEND	LBH	Quarterly	• Work is underway with a company 'Headliners' who will provide recommendations on how to develop a programme to actively listen to and engage with C&YP with SEND.