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	• 17 one-to-one interviews have been completed with mothers in three Children Centres about their experiences of ante-natal and post-natal care, specifically they received information and support. The results will support stakeholder engagement process of the new Maternity Health Needs Assessment. • By December 2014 there had been two training sessions for midwives aimed at: raising awareness of risks of smoking while pregnant, the pathway for opt out referral scheme and the use of the diagnostic carbon monoxide monitors. • For Quarter 2, Smoking at Time of Delivery has fallen from 8% to 7% since previous year. 34 women have been supported since the start of the year with 23 quitters by time of delivery.
	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

				• The Programme Board have met and work is progressing on agreeing strategic direction and actions across the work streams.
	1.1.3 Deliver a mental wellness and resilience programme	Public Health		The programme of activity includes: • The 'Five Ways to Wellbeing' initiative that delivers publicity material to libraries, provides training to partners and coordinates wellbeing events. • A programme of Wellbeing Initiatives at Stockley Park School including a wellbeing survey for year 8 students which will gauge whether wellbeing interventions have made a difference to them. • Older People Wellbeing Projects aimed at reducing social isolation and increasing levels of physical activity and wellbeing which include the popular tea dances and wellbeing events.
	1.1.4 Deliver a smoking cessation service including supporting the further roll out of Smoke Free Homes in Hillingdon	Public Health	Annually	• 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) - with a rate of 55% (in Q2, 318 set a quit date and 179 successfully quit) • During Stoptober, there were 10 health promotion events, including at the Somali Outreach Café in Hayes. Residents across the borough were given advice on stopping smoking and where to access help. There were 56 direct referrals to the service as a result of the initiative.

				• Two 2-day training programmes have also been delivered to skill up additional one to one stop smoking advisors across the Borough. In total there were over 50 participants.
	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 overall proportion of children carrying excess weight (overweight + obese) in both years has remained unchanged. • The programme of activity includes: o The 'Get up and Go' weight management programme with the next cohort planned for April 2015. o Food and diet sessions delivered to residents as part of the CCG diabetes management programme. o Lifestyle weight management programme for children targeting families at high risk o A workshop for health and social care professionals focussing on the drive to reduce excess weight in the borough. o Training for children's centres in the 'Feed My Family' model. o The annual Rotary Club Young Chef competition. 11 senior schools competed to create a healthy balanced 2 course meal on a budget. o A Hillingdon Breakfast club review in 91 of 93 schools to develop recommendations and actions. A physical activity needs assessment is being

				undertaken to inform a refreshed strategy from March 2015 with suggested focus on reducing inactivity, i.e engaging people who are not doing 30 minutes of activity a week • The activity supporting this work includes: ○ Buggy monitoring and removing chairs from stay and play sessions at children's centres. ○ 'Ready Steady Groove' physical activity programme for parents currently in 9 children's centres ○ 5 schools applying for Healthy Schools silver award by addressing physical activity ○ 10 children centres running activity session for parents with free crèche facility ○ 60 cycle loans and 15 bikes sold through cycle loan scheme ○ Exercise on referral programme ○ Free swimming for 65+ yrs is full at HSLC and Botwell and 50% full at William Byrd.
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	• Out of 5393 adults with a learning disability (2015 PANSI predictions from 2011 Census), the % of those in paid employment has increased from 1.1% in 2013-14 to 1.9% as of 31 January 2015. • So far in 2014/15, 12 service users with learning and physical disabilities have received 30 opportunities for paid employment. • 17 service users had undertaken 69 work experience opportunities

				• There has been a slight decrease in number of service users undertaking work experience opportunities because a number of service users who accessed in-house day services have now implemented their support plans and are being supported by a Personal assistant to access community based activities. This includes work experience placements which better meet their assessed needs. • Since September 2014 the Queens Walk Resource Centre has been supporting 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 being recruited to Adult Community Learning to develop a programme of college courses to build on people's independent skills. 15 service users will be undertaking the first cohort of courses and this will be a rolling programme delivered at Queens Walk throughout the year. This means 34% of service users accessing Queens Walk are been given the opportunity to access college courses.
1.3 Develop Hillingdon as an autism friendly borough	**1.3.1** Develop and implement an all age autism strategy	LBH	Quarterly	• A strategy is being developed with more required prior to sign off.

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 three: Rapid response and joined up Intermediate Care	LBH/CCG	Quarterly	• The multi-agency project group has been working on the development of the model of care and will report with recommendations in March. Much closer working between the Council's Reablement Team, CNWL staff at the Hillingdon Intermediate Care Unit (HICU) and THH staff on Beaconsfield East ward has accelerated the discharge of patients medically fit for discharge. During Q4 work will continue to secure permission for the District Nurse Service to administer intravenous medicines to patients in nursing homes. This will help to prevent unnecessary hospital admissions. Permission will also be secured to enable the Reablement Team to make referrals to Rapid Response, which will ensure that appropriate clinicians are supporting Hillingdon's older residents. A business case will also be developed to secure additional consultant geriatrician capacity to support the management of the needs of frail older residents in the community.
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 nine months of 2014/15, 6743 Hillingdon residents received a first offer of an NHS Health Check and, of these, 4272 people went on to receive an assessment. This is an increase on

				previous year performance at 3740. • Nearly all of the 48 sites have now signed up to the new Local Primary Care Contract. This should result in increased activity, but need careful monitoring of offers to ensure it is recorded appropriately. • The local EMIS (GP data system) support is no longer in place which may affect quality of future returns. • A campaign will be launched 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 December, a training day was held for 20 general practice and pharmacy staff. Evaluation questionnaires show that this training was well received.
	2.2.2 Deliver Open Access Sexual Health	Public Health	Quarterly	• <u>HIV:</u> An HIV health and care needs assessment is in progress. The outputs of the needs assessment will be used to inform future sexual health and disabilities commissioning/procurement decisions post October 2015. • <u>Emergency Hormonal Contraception (EHC)/Chlamydia Screening and treatment:</u> Training updates have been provided for those Community Pharmacists who are part of the scheme. Six new Community Pharmacists were trained in November 2014.

				• <u>Chlamydia Screening:</u> Performance against the indicator: 'Rate of Chlamydia detection per 100,000 young people aged 15-24 years' is low at 1485 for the year 2013 when compared to London at 2179 per 100,000. Service providers (CNWL) have been informed and are working to improve Chlamydia positivity rates by increasing outreach work to more targeted groups/areas
	2.2.3 Delivery of information to protect the health of the population against infection or environmental hazards and extreme weather events	Public Health		• Weekly Ebola briefings are received from Public Health England and the Department of Communities and Local Government. A revised Ebola public awareness poster for use in healthcare settings has been uploaded to Gov.uk and is being distributed to GP practices, A&E departments and pharmacies by NHS England. • Members of the public can also find more information and advice about Ebola on NHS Choices website. • There has been a recent outbreak of Avian Flu at a farm in Hampshire. Tests have shown the outbreak is of the "low severity" H7 strain of the disease, a much less serious form than the H5N8 strain found at a Yorkshire duck farm, in November 2014. There are no links between the case at Upham and the outbreak in Yorkshire. PHE confirm that the risk to public health is extremely low. Local authorities are asked to be aware of the current situation.

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	• Hillingdon CCG are investigating the expansion of Risk Stratified Cancer Pathways that change the way that support is provided to Cancer patients post substantive treatment. The CCG is under-taking research into how we might expand work already undertaken at The Hillingdon Hospital and support a wider cohort of patients. • Hillingdon CCG have engaged with CNWL, The Hillingdon Hospital, Public Health and with members of the public and have got a first draft of an Integrated Diabetes Service Model that links together weight management services for patients both pre and post diagnosis of diabetes, patient empowerment programmes and changes to how community and secondary care services are delivered. HCCG expect the final business case to go to its Governing Body in April 2015. • Hillingdon CCG has developed an Integrated Service Model for patients with Cardio Diseases and is working with THH, The Royal Brompton and CNWL on how this can be realised. The final Business Case is expected to go to HCCG Governing Body in April 2015. Public Health has been actively involved in the development of this model. • Hillingdon CCG is also developing an Integrated Service Model that will meet the needs of patients suffering from respiratory conditions such as COPD and Asthma. Again, like the Diabetes and Cardiology Integrated Service Models, this is expected this to go to the Governing Body in April

				2015. • Pilot projects being developed in the Hayes area focussing on diabetes prevention and delivering patient education for diabetes with BME groups.
	2.3.2 Reduce the risk factors for premature mortality and increase survival across care pathways	PH/CCG	Quarterly	• A new CHD integrated model of care and diabetes care pathway is being developed as per information above. • The Survivorship event for cancer sufferers held in October and a Prostate Cancer awareness session in February has resulted in referrals into exercise. • 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 tender process is near conclusion.
	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 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		• Brush for Life (BFL) packs, training and 'stay and play' sessions are available in all 18 children's centres. The evaluation of the Brush for Life programme in 2014 across Hillingdon showed that: ○ Knowledge of dental visiting had improved with 79% of parents thinking that children should attend the dentist before the age of 2 years (60% before BFL initiative) ○ The reported dental visiting has increased since the BFL initiative with a 21% increase in

				reported visits. ○ A 13% increase in the number of parents reporting brushing their children's teeth twice daily. ○ There did not appear to be a significant change in overall knowledge of age to start brushing (57% when the teeth erupt). ○ More parents appeared to be aware of the correct amount of toothpaste and there was a reduction in the number of parents using too much paste from 27% to 15% with no parents reporting using no paste after the training. • A referral pathway has been developed for the health visitors to support parents around brush for life with the community dental service.
	2.3.5 Deliver a project to make Hillingdon a Dementia Friendly borough	Mental Health Delivery Group	Quarterly	A Council working group, in partnership with the Alzheimer's Society, is coordinating a project for Hillingdon to sign up to the Dementia Action Alliance. The intention is to launch Hillingdon's Dementia Action Alliance during Dementia Awareness Week in May 2015. The Dementia Friends Scheme continues to be very popular. • From October until December 2014, 535 people attended Dementia Friends sessions. This included pupils, sheltered housing scheme managers, library staff, residents and care home staff. The local Met Police have now agreed to run sessions for Police Officers.

				Work is also underway with the local Alzheimer Society to develop more support for people living with dementia. The Drummunity project continues 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. • Due to the success of the pilots at Cottesmore and Sibley Court, the Council will fund a further 12 weeks of sessions at these locations. • Since September 2014, a total of 18 people have taken part in 12 weeks of sessions. • Triscott house, Grassy meadows and Asha day centre also continue to offer the drumming sessions as part of their core activity.
	2.3.6 Improve pathways and response for individuals with mental health needs across the life course including the provision of Child and Adolescent Mental Health Services (CAMHS)	CCG	Annually	• Single Point of Access - a Business Case has now been completed to develop a single point of access in the urgent care pathway. This is now under consideration alongside other funding priorities. • Improving Access to Psychological Therapies - a Business Case has been approved to expand IAPT Services to target hard to reach groups and those with Long Term Health conditions such as Diabetes. • A Children Adolescent Mental Health Service

				(CAMHS) health and care needs assessment is also being developed. 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 for older adults. • A joint working group has been established to agree an integrated emotional and mental health and wellbeing service for children locally. A strategy and delivery plan is being developed. • Additional resources for specialist MH provision for children and young people with LD were agreed with an integrated pathway with LBH disability team • HCCG also invested in specialist perinatal MH provision. Service implemented January 2015 • The provision of Liaison Psychiatry services has been expanded 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.
	2.3.7 Develop a Vision Strategy for Hillingdon	Vision Strategy Working Group	Annually	• A Needs Assessment has been drafted which will inform the local 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: • 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. • The 'Pan London Leaver Notification Process', a monthly return made by schools, colleges and other post-16 training providers, informs the local authority of any young person who has 'dropped out' of their course early. In the return, there is a 'wobbler' column, in which young people who could be on the verge of dropping out are identified and are provided with additional support to prevent them becoming NEET. • As of December 2014: o NEET 2.4% down from 3.6% in 2013 o Y11 leavers continuing in learning 98.9% up from 98.4% in 2013

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: early identification of people susceptible to falls, social isolation and dementia	LBH/CCG	Annually	• A multi-agency scoping meeting has taken place, which will be used to develop an action plan. This will include at least one proposal for developing a preventative model aligned to a GP network that brings together statutory and third sector organisations to support local people. • A screening tool for identifying frailty and susceptibility to falls, dementia and/or social isolation has been developed and will be tested during Q4 by the third sector.
	3.1.2 Deliver scheme two: better care for people at the end of their life (EoL)	LBH/CCG	Quarterly	• The EoL action plan has been developed and work undertaken to identify what needs to be in place to enable a person to have a 'good' death. A review of current provision against the ideal will be undertaken in Q4. • Adult Social Care is currently exploring options for establishing a fast access care service with a specialist third sector provider in consultation with Corporate Procurement.
3.2 Deliver the BCF Workstreams 3 & 4 - Seven day working and Seamless Community Services	**3.2.1** Deliver scheme four: seven day working	LBH/CCG	Quarterly	• A review of the needs of inpatients at Hillingdon Hospital and the Perfect Week in November has identified some gaps in provision 7-days a week, e.g. GP cover, ability to make community equipment referrals, specialist nursing to cover wound dressing, ability to make homecare referrals.

				• Mapping of services operating 5 and 7 days was completed and the 7-day working action plan completed. • Q4 will see 7-day working priorities being agreed and a gap analysis against those priorities being undertaken. 7-day working Key Performance Indicators will also be established.
	3.2.2 Deliver scheme six: Care homes initiative	LBH/CCG	Quarterly	• The Council's Care Services Inspection Team and CCG Care Home Pharmacist have established monthly meetings with Community Matron Team in order to establishing mutually supportive network. A recent incident where a nursing home was identified by an inspector as not having any nursing staff available was referred to the Community Matron team lead and emergency cover was arranged to ensure that the needs of residents were attended to, thus avoiding a potentially serious issue. This matter has been reported to CQC. • Monthly meetings between the THH geriatrician and the community matrons to identify patients frequently attending at A & E and/ or admitted to hospital have been established. This will help to inform input to the relevant care homes and the areas of care for which support is most needed. • Actions to be taken in Q4 include engaging with care homes that have not responded to offers of support and also scoping the medical support required to support care homes.

	3.2.3 Deliver scheme five: Review and realignment of community services to emerging GP networks	LBH/CCG	Quarterly	• Work on transitioning the Integrated Care Pilot to the GP networks, including care planning and care coordination, has been started and is due to be completed by the end of March. • A nursing conference in Q4 will help to shape the model of the District Nursing Service and its relationship 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 December 2014, a total of 140 homes have had adaptations completed to enable disabled occupants to continue to live at home. This includes adaptations to the homes of 88 older people, of which 62 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	• As at 5th January 2015, 4,033 service users (3,596 households) were in receipt of a TeleCareLine equipment service, of which 3,044 people (2,783 households) were aged 80 years or older. Between 1st April 2014 and 31st December 2014 there have been 833 new service users taking up TeleCareLine.
3.3 Implement requirements of the Care Act 2014	**3.3.1** Develop the prevention agenda including Info and Advice Duty	LBH	Quarterly	• Agreement on the Connect2Support portal being the platform for all information about information, advice and advocacy services as well as other services to meet the care, support and socialisation needs of residents with social care needs. This new system will also enable residents to undertake self-assessment, check their care accounts (relevant to self-funders) and shop on line for appropriate services to meet their needs.

	3.3.2 Develop a Carers Strategy that reflects the new responsibilities and implementation of the Care Act 2014	LBH/CCG	Biennially	• Consultation activity has taken place at a number of locations including Hillingdon Hospital, Uxbridge and Botwell libraries, Young Carers Group, Disability Assembly and Hillingdon Carers Cafe. Carers have provided feedback via online and paper surveys and by engaging in activities to explore what assistance they may need with regards their health and wellbeing, financial situation and enjoying a life outside of caring. • Results of the consultation activity will inform the delivery plan of the strategy. • The strategy and draft delivery plan will be presented to CCG Governing Body and Council Cabinet in April 2015.
	3.3.3 Deliver BCF scheme seven: Care Act Implementation Task: To implement the following aspects of new duties under the Care Act, primarily in respect of Carers: a) increasing preventative services; b) developing integration and partnerships with other bodies; c) providing quality information, advice and advocacy to residents; d) ensuring market oversight and diversity of provision;	LBH/CCG	Quarterly	a. A gap analysis was undertaken of information, advice, advocacy and preventative service provision, which identified that a gap in availability of independent financial advice and personal assistant (PA) support. b. Scope of a review of care practice procedures identified to ensure compliance with Care Act requirements and key actions were allocated for delivery during Q4; c. Clarification of the offer for carers will be achieved during Q4 and market provision mapped against this. d. Guidance was published in December 2014 about the new market oversight regime operated by the Care Quality Commission (CQC) covering approx 60 major providers. Officers will be working with CQC to determine how this will work in practice. A new

	and e) strengthening the approach to safeguarding adults.			provider risk matrix was also produced against which providers of services to adults and children will be assessed. The Council's Care Governance Board, which is chaired by the Director of Adult Care, will monitor the outcome of assessments. e. A peer review of adults' safeguarding process was undertaken to test compatibility with new statutory requirements. Verbal feedback did not reveal any unknown issues. A report with recommended actions will be available in Q4.
	3.3.4 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 Market Position Statement is currently being finalised and, subject to Member approval being given, it will be launched with providers in Q4.
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 planning for children, young people and families	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. • 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 come to the Health and Wellbeing Board for consideration. 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 has been approved and published. More detailed development work is taking place.
	3.5.2 Develop a short breaks strategy for carers of children and young people with disabilities	LBH	Quarterly	• The short break statement has been approved and published. Work is taking place on developing an improved strategy for 2016 which better meets the needs of carers and will result in an updated statement.
3.6 Assist vulnerable people to secure and maintain their independence by developing extra care and supported housing as an alternative to residential and nursing care	**3.5.1** Provide extra care and supported accommodation to reduce reliance on residential care	LBH	Quarterly	• Sessile Court, a MH unit with 14 places is on track to open in March. • Two LD schemes, Honeycroft Hill (16 units) and Church Road, Cowley (6 units) are on track to open early summer 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	• Following approval of Hillingdon's BCF plan an updated Stakeholder Communication and Engagement Strategy focussing on implementation will be developed in February. • A series of awareness raising events have been arranged in February for GPs and clinical staff at Hillingdon Hospital about the BCF and the Integration Programme in Hillingdon. The strategy is intended to set out how a broader range of stakeholders will be engaged.
	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	
	4.1.4 Improve social care quality of life of carers	LBH/CCG	Annually	It is proposed that the Council will undertake a survey in Q4 2015/16 to test improvements against the results of the 2014 Carers Survey in the following domains: • *Control*: how much control the carer has over their daily life; • *Personal care*: whether the carer feels that they have enough time to look after themselves in terms of getting enough sleep and/or eating well;

				• *Social participation*: whether the carer feels that they have enough social contact with people they want to be with; • *Encouragement and support*: whether the carer considers that they have enough support in their caring role.
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 called 'Headliners' who will provide recommendations through a film on how to develop a programme to actively listen to and engage with C&YP with SEND. Initial viewings are expected in April 2015. • A project has commenced to engage CYP with SEND in the development of information for their peers in relation to Preparation for Adulthood. • An outline plan is being developed to produce short films, with CYP, explaining various key points of the SEND Reforms. These are intended to support and enrich the Local Offer.